

Board of Directors Meeting Held in Public

To be held on Wednesday, 29th July 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 27th May 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
SECTION 2: Ambition: Best Quality, Safest Care				
2.1	Board Assurance Framework: Best Quality, Safest Care	Executive Director of Nursing, Midwifery and AHPs & Quality Committee Chair	Approve	Attached
2.2	Learning From Deaths Q4 Report	Executive Medical Director	Note	Attached
2.3	Health & Safety Annual Report	Director of Finance	Note	Attached
2.4 2.4.1	Nursing and Midwifery Quality and Safe Staffing Report Community Nursing Quality and SFE Staffing Report	Executive Director of Nursing and Midwifery and AHPs	Note	Supp. Pack Attached
2.5	Bi-annual Safer Staffing Establishment Reviews	Executive Director of Nursing, Midwifery and AHPs	Note	Attached

Item No.	Item	Lead	Action	Paper
2.6	Integrated Board Report – PowerBi Link: Title Page - Integrated Board Report - Power BI	Chief Operating Officer	Note	Supp Pack Attached
SECTION 3: Ambition: Great Start in Life				
3.1	Board Assurance Framework: Great Start in Life	Executive Director of Nursing, Midwifery and AHPs & Quality Committee Chair	Approve	Attached
3.2	Strengthening Maternity and Neo-Natal Safety Report	Executive Director of Nursing, Midwifery and AHPs / Associate Director of Midwifery and Children's Services	Note	Attached
SECTION 4: Ambition: Person Centred; Integrated Care; Strong Partnerships				
4.1	Board Assurance Framework: Person Centred; Integrated Care; Strong Partnerships	Chief Operating Officer (Interim)/ Resource Committee Chair	Approve	Attached
4.2	Board Assurance Framework: Finance	Finance Director / Resource Committee Chair	Approve	Attached
4.2.1	AP Finance Board Report			Supp Pack Awaited
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	Guardian of Safe Working Annual Report	Acting Chief People Officer	Note	Attached
SECTION 6: Ambition: Enabling Ambitions				
6.1	Board Assurance Framework: Digital Transformation and Maturity to Integrate Care and Improve Patient, Child and Staff Experience	Medical Director & Innovation Committee Chair	Approve	Attached
6.2	Board Assurance Framework: Healthcare Innovation to Improve Quality and Safety	Medical Director & Innovation Committee Chair	Approve	Attached
6.3	Board Assurance Framework: An Environment that Promotes Wellbeing	Director of Finance / Resources Committee Chair	Approve	Attached

Item No.	Item	Lead	Action	Paper
6.4	Green Plan Annual Update <i>Tim Wilkinson to attend</i>	Director of Finance	Note	Verbal
SECTION 7: BAF Summary and Escalation from Committees				
7.1	Escalation from Sub-Committees of the Board	All Executive and Non-Executive Directors	Discuss	Verbal
SECTION 8: Governance Arrangements				
8.1	Use of Trust Seal Updating Report	Director of Governance and Improvement	Note	Attached
8.2	Code of Conduct	Director of Governance and Improvement	Approve	Attached
9.0	Any Other Business <i>By permission of the Chair</i>	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 30th September 2026 at 1.00 – 3.45pm Venue: Boardroom, Trust Headquarters, Harrogate District Hospital			

Confidential Motion – the Chair to move:

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

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

Board of Directors – Register of Interests

As at 10th July 2026

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

Board Member	Position	Relevant Dates From	To	Declaration Details
	March 2025 to March 2026)			
Breeda Columb	Executive Director of Nursing, Midwifery & AHPs	June 2025	Current	1. Familial relationship with a Leeds Teaching Hospitals NHS Trust employee
Jonathan Coulter	Finance Director Chief Executive from March 2022	March 2022	Current	No interests declared
Jeremy Cross	Non-executive Director	January 2020	Current	1. Chairman, Tipton Building Society 2. Chairman, Forget Me Not Children's hospice, Huddersfield 3. Member, Kirby Overblow Parish Council 4. Stakeholder Non-executive Director, Harrogate Healthcare Facilities Management Limited t/a Harrogate Integrated Facilities (a wholly owned subsidiary company of Harrogate and District NHS Foundation Trust)
Chiara De Biase	Non-executive Director	May 2024 February 2026 May 2026	Current Current Current	1. Director of Health Services, Equity & Improvement, Prostate Cancer UK 2. Interim Fundraising and Health Strategy Director, Prostate Cancer UK 3. Senior Independent Trustee for Yorkshire Cricket Foundation
Jordan McKie	Director of Finance (from July 2023)	August 2022	Current	1. Chair, Internal Audit Provider Audit Yorkshire
Colin Melville	Non-Executive Director	September 2025	Current	1. Trustee, Faculty of Medical Leadership and Management 2. Fellow, Royal College of Physicians, London 3. Fellow, Royal College of Anaesthetists 4. Fellow, faculty of Intensive Care Medicine 5. Honorary Fellow, Academy of Medical Educators 6. Senior Fellow, Faculty of Medical Leadership and Management 7. Honorary Professor, University of Manchester 8. Visiting Professor, Anglia Ruskin University 9. Nephew is an employee of HDFT (non-decision maker)

Board Member	Position	Relevant Dates From	To	Declaration Details
Andrew Papworth	Non-executive Director	March 2020 April 2026	Current Current	1. Chief Finance Officer, Insight222 2. Ambassador for Action for Sport 3. Director of PPY Advisory and Consulting
Laura Robson	Non-executive Director	September 2017	Current	No interests declared
Wallace Sampson OBE	Non-executive Director	March 2020 July 2023 August 2023 September 2023 October 2023 August 2024	Current Current Current March 2025 Current Current	1. Member of Society of Local Authority Chief Executives 2. Advisory Board Consultant – Commercial Service Kent Ltd. 3. Commissioner – Local Government Boundary Commission for England 4. Chair – Middlesbrough Independent Improvement Advisory Board. 5. Director and Shareholder – Sampson Management Services Ltd. 6. Member – Council of Governors, Leeds University
Kate Southgate	Director of Governance and Improvement	May 2025	Current	1. Familial relationship with senior manager at NHS England.
Julia Weldon	Non-executive Director	May 2024 September 2025 June 2026	Current Current Current	1. Fellow of the Faculty of Public Health (FPH) FPH Assessor and Advisor 2. Associate of Local Government Association (LGA) 3. Director of Julia Weldon Executive Leadership Ltd 4. Trustee and Director for Action on Smoking and Health

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

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

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

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

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

BOARD OF DIRECTORS MEETING – PUBLIC (DRAFT)

Wednesday 27th May 2026

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

Present:	
Sarah Armstrong	Trust Chair
Jonathan Coulter	Chief Executive
Jacqueline Andrews	Executive Medical Director, Deputy Chief Executive
Andrew Alldred (AA)	Non-Executive Director
Jeremy Cross (JCr)	Non-Executive Director, Chair of Resource Committee
Chiara DeBiase (CdB)	Non-Executive Director, Chair of Audit Committee
Colin Melville (CM)	Non-Executive Director
Andy Papworth (AP)	Non-Executive Director, Vice-Chair
Laura Robson (LR)	Non-Executive Director, Chair of Quality Committee
Julia Weldon (JW)	Non-Executive Director, Chair of People & Culture Committee
Denise Chong (DC)	Associate Non-Executive Director
Breeda Columb	Executive Director of Nursing, Midwifery and Allied Health Professionals
Jordan McKie	Director of Finance
Rob Armstrong	Acting Chief Operating Officer
Rob Eames	Acting Director of People & Culture

In Attendance:	
Rachel Hewson	Company Secretary
Paula Chyzy	Corporate Governance Officer
Jimmy Parvin	Deputy Director of Strategy and Improvement
Julia Nixon	Chief Operating Officer (Designate)
Jenny Nolan	Deputy Director of Nursing, Midwifery and AHPs <i>for the Patient Story</i>
Leanne Likaj	Associate Director of Midwifery and Children's Services for the <i>Strengthening Maternity and Neonatal Safety report</i>

Apologies:	
Wallace Sampson OBE (WS)	Non-Executive Director, Chair of Innovation Committee
Kate Southgate	Executive Director of Governance and Improvement

Observers:	
Governors	Rick Sweeney
Member of the public / press	0
Colleagues	Giles Latham, Communications Manager
External Partners	0

Item No.	Item
BD/05/27/1.1 1.1.1	Welcome and Apologies for Absence The Chair welcomed everyone to the meeting, thanking the observers for attending the public meeting of the Trust Board.
1.1.2	Apologies for absence were noted as above.
BD/05/27/1.2 1.2.1	Patient Story The Chair introduced the patient story, noting that it helps to shape the Board's thinking and discussion.

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1.2.2	The Deputy Director of Nursing, Midwifery and AHPs outlined the case of a 66-year-old patient who, following a diagnosis of breast cancer in 2021, experienced prolonged difficulties with wound healing. The patient was initially treated by teams who did not fully recognise the need to navigate multiple pathways. Once the Tissue Viability Nursing (TVN) team became involved, the wound healed more quickly. The case highlighted the need to improve clarity of internal pathways.
1.2.3	The Executive Director of Nursing, Midwifery and AHPs noted that while the Trust has a range of specialist teams, there is not always sufficient awareness of the support available. The TVN team is often associated primarily with pressure ulcers, however it has extensive expertise in complex wound management. The patient's experience demonstrated that earlier involvement of specialist teams could have resulted in more joined-up care.
1.2.4	The Deputy Director of Nursing, Midwifery and AHPs added that effective multidisciplinary working is critical. The Breast Wound Care team were noted as a valuable asset, but they are relatively new and referral pathways are not yet consistently understood across services.
1.2.5	The Non-Executive Director (CM), reflecting on recent personal experience as a patient, emphasised the importance of understanding not only the existence of specialist services but also the threshold for referral. The Non-Executive Director (AA) queried whether referrals to the TVN team had increased. It was noted that while this is difficult to quantify precisely, referrals through multiple routes (including Emergency Department, Surgical Assessment Unit and TVN team) appear to have increased.
1.2.6	The Non-Executive Director (CdB) raised a question regarding factors involved in the patient's experience of healing and it was agreed to review this further.
1.2.7	The Non-Executive Director (AP) thanked the team for bringing multiple patient stories to the Board and upon asking about the patient's current condition, was advised that she had since taken a holiday, during which no dressings were required, resulting in a significant improvement in quality of life.
1.2.8	The Non-Executive Director (JW) highlighted the relevance of the case to community services and the management of wound care in these settings. It was confirmed that this is being addressed through collaborative work with primary care and system partners, with a programme of work underway over the past year to improve pathways for complex wound care. In response to a query regarding the availability of specific dressings (PICO dressings), it was confirmed that these would be provided where clinically required.
1.2.9	The Chief Executive reflected that the case illustrated the importance of integrated care, noting that even internal teams had experienced challenges in aligning care effectively. The Trust Chair emphasised the importance of considering the issues raised more broadly and asked that thanks be conveyed to both the patient and the TVN team.
1.2.10	At the conclusion of the patient story discussion, the Chair welcomed Julia Nixon, Chief Operating Officer (Designate), to the meeting, and noted that the Executive Medical Director's title had recently been updated to Professor, offering congratulations on this achievement.
1.2.11	Resolved: The patient story was noted.

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BD/05/27/1.3 1.3.1	Declarations of Conflicts of Interest and Register of Interests There were no new Declarations of Interest and it was noted that a review would be taken of the current register.
1.3.2	Resolved: The register of interests was received and noted.
BD/05/27/1.4 1.4.1	Minutes of the Previous Board of Directors meeting held on 25th March 2026 The following amendments were noted: • Postcode at heading of meeting to read HG2, instead of HS2. • Numbering to be corrected at points 1.7.13 and 2.1.9. • Small typo to be corrected at 8.1.2. • Correction of name of University of York at 6.2.2.
1.4.2	Resolved: The minutes of the meeting on the 25 th March 2026 were approved as an accurate record of the meeting noting the amendments.
BD/05/27/1.5 1.5.1	Matters Arising and Action Log BD/11/26/5.1.10 - The Director of People and Culture and the Chief Executive to discuss a mechanism to make Executive Director's EDI objectives more visible – this was deferred to the next People and Culture Committee meeting in July. The Acting Chief People Officer noted that there would also be some detail added regarding objectives into the annual report. Action closed.
1.5.2	BD/03/25/3.2.11 Maternity and Neonatal Voice Partnership (MNVP) funding. Action remained open.
1.5.3	No further matters arising were raised which were not already noted on the agenda.
1.5.4	Resolved: All actions were agreed as above.
BD/05/27/1.6 1.6.1	Overview by the Chair The Chair noted a range of activities that had taken place since the last meeting of the Board and highlighted the following points:
1.6.2	• The start of the year had been particularly busy. While a final operational plan had not yet been formally agreed, every effort was being made to resolve this. It was acknowledged that this presents challenges for the day-to-day running of the organisation and thanks were extended to finance colleagues for their continued work in navigating these complexities.
1.6.3	• There was reflection on the wider national context, including the appointment of a new Secretary of State, ongoing political pressures and the progression of forthcoming health legislation. Despite these factors, it was emphasised that the Trust's primary focus remains on the delivery of high-quality care.
1.6.4	• The Board was advised of several positive developments and examples of patient and community engagement. In particular, the recent Great Start in Life (GSIL) conference in Durham celebrated services for children and young people aged 0–19, with strong involvement from young people themselves throughout the event. This was highlighted as an important step forward in ensuring meaningful engagement.
1.6.5	• The success of recent open days held as part of the Trust's 200-year celebrations in Harrogate was noted, which had provided valuable opportunities for community engagement.

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1.6.6	The following week is National Volunteers' Week, and the significant contribution of the Trust's approximately 450 volunteers was recognised, equating to around 10% of the workforce.
1.6.7	The 60th anniversary of the Friends of Harrogate Hospital was imminent, noting their exceptional contribution, having raised over £2.4 million to support the Trust. The charity is aiming to raise at least £100,000 this year and is currently identifying a suitable project for investment.
1.6.8	Implementation of the Electronic Patient Record (EPR) had progressed well and was already delivering benefits for patients and staff.
1.6.9	The Non-Executive Director (JCr) commented on the strong contribution of young people at the GSIL event, including presentations from across the region demonstrating how best practice is being shared and implemented across the system. It was agreed to share slide/videos of the event with the Board.
1.6.10	Resolved: The Chair's report was noted.
BD/05/27/1.7 1.7.1 1.7.2 1.7.3 1.7.4 1.7.5 1.7.6 1.7.7 1.7.8 1.7.9 1.7.10	Chief Executive Report The Chief Executive presented his report as read. The following points were highlighted: - The planning position would ordinarily have been expected to be finalised. An initial plan had been developed that delivered standards (including cancer, emergency care and elective care) with a deficit of £15 million. At the end of March, a plan with a £19 million deficit was agreed, however further challenge was received in early May to improve this position resulting in a Waste Reduction and Productivity (WRAP) programme of £32 million. - The Trust remains in the national escalation process. A meeting is scheduled with the NHS England executive team in London to discuss the underlying drivers of the Trust's financial position, including issues relating to service funding. A meeting had been held with the Deputy Finance Director, North East & Yorkshire Region which provided productivity challenges, noting that there is some variation in funding allocations across providers. A draft report from KPMG on areas to deliver greater efficiencies has been received and will be reviewed. - A permissive national approach to neighbourhood health is emerging. Work is being led locally to determine the Trust's approach, with further discussion to be scheduled at a Board workshop in the coming months. - The relationship with Leeds remains strong, with ongoing engagement at Board level, including collaboration in relation to Wharfedale services. - The level of influence the Trust continues to have in relation to 0–19 services was highlighted. - Improvements to the stroke pathway were noted; however, a risk has emerged relating to the resilience of services, which will require ongoing monitoring. - Further industrial action by resident doctors has taken place. While the operational impact has been managed with limited disruption to services, the burden on staff and organisational resources was acknowledged. - Performance in April was reported as positive across Cancer, Referral to Treatment (RTT), Urgent and Emergency Care (UEC), and 0–19 services. However, May has been more challenging, particularly in urgent care. While

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1.7.11	there may be some impact associated with the implementation of the EPR, this should not be relied upon as an explanation for performance variation. Diagnostic capacity continues to present a risk. However, the Trust has received letters of support from the Integrated Care Board in relation to the Community Diagnostic Centre (CDC), which is a positive development.
1.7.12	The Trust is financially behind the position anticipated at the end of April. Some of this had been expected, reflecting the additional stretch incorporated into plans for the new financial year, but notwithstanding this, there is work to do to get back on plan.
1.7.13	The successful implementation of the EPR was noted and the GSIL event commended as a positive and impactful initiative. Congratulations were noted that there was another Professor among Board members.
1.7.14	The Non-Executive Director (AP) noted that year-on-year productivity comparisons can be difficult to interpret where services have changed and emphasised the need for like-for-like comparisons. The Chief Executive highlighted the importance of applying appropriate challenge in interpreting data and ensuring clear communication particularly externally.
1.7.15	The Non-Executive Director (AA) questioned whether the approach to neighbourhood health would have a level of support available from national or regional teams and the Chief Executive advised that while there is a significant volume of national guidance and supporting documentation, delivery will ultimately sit at local level through place-based partnerships. The Executive Medical Director has drafted a paper for further discussion by the Executive Team.
1.7.16	The Non-Executive Director (JCr) raised concern regarding waiting times for autism assessments, noting that waits are now in excess of 126 weeks. The Chief Executive advised that Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) has been asked to review the service model, including the possibility of acting as lead or host organisation.
1.7.17	The Non-Executive Director (JW) referenced the forthcoming Health Bill and sought assurance that the Trust is sighted on potential opportunities and implications. The Chief Executive suggested that this would benefit from further consideration at a future Board workshop.
1.7.18	The Non-Executive Director (CM) referred to the Community Diagnostic Centre (CDC) business case and queried, in light of the Mike Richards review, whether CDCs are likely to be loss-making. The Chief Executive advised that there is variation nationally: some CDCs are financially sustainable where tariff arrangements are favourable, while others are underutilised. For this Trust, given existing capacity constraints and demand, the case for a CDC remains strong. The Acting Chief Operating Officer noted that some schemes, particularly new builds, carry additional revenue consequences, the business case will be subject to the usual approval processes and must demonstrate financial neutrality. The Chief Executive confirmed that the proposal is driven by the need to establish permanent diagnostic capacity.
1.7.19	Resolved: The Chief Executive's Report was noted.
BD/05/27/1.8 1.8.1	Board Assurance Framework – 2025-26 Close Down The Chief Executive presented the Board Assurance Framework (BAF) closedown report noting its role as a tool supporting delivery of the Trust's strategic ambitions. It was reported that the BAF has been reviewed through the relevant committees.

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1.8.2	The Chief Executive highlighted that the BAF is subject to internal audit review and had received a high level of assurance in the current year, reflecting positively on its effectiveness. It was recommended that the current BAF be closed and refreshed to align with the Trust's priorities for the forthcoming year.
1.8.3	The Non-Executive Director (CM) raised a number of drafting points under section 2.1, noting that the wording should clarify that 96% relates to respondents, rather than all patients and under section 2.8, it was noted that the reference to "4 percent" should be corrected to "4 percentage points".
1.8.4	Resolved: The BAF Closedown Report was approved.
BD/05/27/2.1 2.1.1	Board Assurance Framework – Best Quality, Safest Care The Executive Director of Nursing, Midwifery and AHPs provided the Board with an update on the Strategic Ambition: Best Quality, Safest Care.
2.1.2	The first metric was eliminating moderate and above harm. The Trust is now in the third year of this measure, having successfully achieved its targets in years one and two. For the current year, the objective is to deliver a further 20% year-on-year reduction. Focus remains on reducing harm associated with falls and pressure ulcers, embedding these improvements into business-as-usual (BAU) practice. It was confirmed that there have been no never events or Patient Safety Incident Investigations (PSIIs) of significant concern, and that reporting of no and low harm incidents remains high, which was recognised as a positive indicator of a strong reporting culture.
2.1.3	A new metric relating to clinical effectiveness has been introduced. The Executive Medical Director outlined a programme of work to review all 108 Trust services against best practice standards, including Getting It Right First Time (GIRFT) and National Institute for Health and Care Excellence (NICE) guidance. This involves benchmarking services to identify gaps in delivery as a proxy measure for effectiveness. To date, 40 services have been reviewed, with the remaining services on track to be completed by July. Following the initial benchmarking, individual teams will take forward actions to address identified gaps, where possible, with areas requiring further focus being identified through the strategic filter.
2.1.4	The Non-Executive Director (AA) welcomed the approach, noting the positive discussion at the Quality Committee and expressing interest in seeing the outputs. The Executive Medical Director confirmed that, rather than adopting a traditional Red Amber Green (RAG) rating, the methodology focuses on recognising achievement through an 'award'-based approach.
2.1.5	The Non-Executive Director (AP) queried how best practice standards will be kept up to date. The Executive Medical Director advised that the intention is to embed this work into BAU, with departments undertaking reviews of best practice on a six-monthly basis.
2.1.6	The final metric relates to patient experience and engagement. The Board noted ongoing work to increase the number of Friends and Family Test (FFT) responses by 10% over the year, recognising that higher response volumes provide more meaningful qualitative insights for teams. A 12-month engagement plan is in place, including consideration of implementing a real-time engagement tool to complement FFT feedback. It was reported that FFT response rates have varied, ranging from approximately 30–40% up to 90% in some areas. A dip to around

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2.1.7 2.1.8 2.1.9 2.1.10 2.1.11 2.1.12	60% was noted in April. Actions are being taken to improve consistency and sustain higher levels of patient feedback. The Non-Executive Director (AP) requested a more detailed understanding of the patient engagement plan. The Executive Director of Nursing, Midwifery and AHPs advised that, while a longer-term engagement strategy had previously been considered, the current focus is on delivering a one-year plan, which will be shared with the Board. The Non-Executive Director (JW) noted that progress on a broader strategy had been paused pending anticipated changes in national policy but that this had been under consideration for a significant period. The Non-Executive Director (AP) also requested clarity on the timeline for developing a more comprehensive piece of work in this area. The Interim Non-Executive Director (DC) queried the purpose of developing a repository of patient stories. The Executive Director of Nursing, Midwifery and AHPs advised that the intention is to establish a bank of stories that can be drawn upon to ensure relevance to Board discussions and current priorities. This would also support use of patient stories across a range of forums beyond the Board, including in response to emerging issues or areas of focus. The Executive Director of Nursing, Midwifery and AHPs further advised that the "Making Experiences Count" Committee will take oversight of this work, with reporting through to the Quality Governance Management Group and the Quality Committee. The Non-Executive Director (LR) commented that reliance on a bank of stories may reduce the impact of direct patient engagement at Board meetings, noting the value of hearing from individuals in person. The Executive Medical Director provided an update on the Clinical Services strategy, noting that work is ongoing. It was reported that the Single Point of Contact (SPOC) programme has been further refined for the next 12 months and is expected to evolve into a broader programme aligned to neighbourhood health. In relation to safety, it was noted that checklist completion is the Breakthrough Objective and is intended to provide assurance that triangulation is taking place effectively across services. Resolved: The Board Assurance Framework: Best Quality, Safest Care was noted and approved.
BD/05/27/3.2 3.2.1 3.2.2 3.2.3	Item 3.2 was taken next Strengthening Maternity and Neonatal Safety The Associate Director of Midwifery and Children's Services was welcomed to the meeting and took the report as read. Divert activity has reduced over the past two months, attributable to changes in funded establishment. The regional heat map score has also improved, reflecting this reduction. The organisation is due to receive discretionary funding from the MAT incentive scheme at the end of the month. The rate of third-degree tears is above the national average, with supporting narrative provided within the report. Pannal Ward staffing acuity is currently below 50%; however, appropriate mitigations are in place to manage associated risks.

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3.2.4	Funding for the Maternity and Neonatal Voices Partnership (MNVP) remains a concern, with ongoing discussions regarding its allocation and positioning.
3.2.5	Work is progressing on the Maternity Care Bundle and the Postnatal Toolkit. In addition, the Maternity Assessment Centre (MAC) is preparing to launch Birmingham Symptom-specific Obstetric Triage System (BSOTS) within the next couple of months.
3.2.6	The appendices include: • A bi-annual staffing report • Perinatal Mortality Tool data, with no issues identified • Neonatal readmissions data for oversight, with no significant concerns; however, further work and a deep dive into readmissions at Woodlands is underway • A report on avoiding term admissions for oversight
3.2.7	The Non-Executive Director (CdB) raised concerns regarding third-degree tears, specifically whether sufficient staffing is available to enable senior staff to deliver live teaching and reinforce best practice. The Associate Director of Maternity and Children's Services confirmed that two midwives are present at every birth, and a Pelvic Health Specialist Midwife will provide additional support and assurance. This training is also included for all new starters, and assurance was provided that these measures are in place.
3.2.8	The Non-Executive Director (AA) noted that it was helpful for this to be raised as it was also discussed during the Non-Executive handover and Maternity Safety Champions meeting. A recent Safety Champion walkaround was described as very positive, with the unit demonstrating strong leadership and good staff engagement. The Non-Executive Director (AP) confirmed that the role had been formally handed over to the Non-Executive Director (AA).
3.2.9	The Chief Executive highlighted the need to reword references to acuity and staffing levels to ensure clarity. Although staffing meets acuity needs under 50% of the time, however this is often associated with a marginal shortfall at each calculation and mitigations are in place. The Non-Executive Director (CM) noted the potential to use AI to interrogate Board papers.
3.2.10	Resolved: The Strengthening Maternity and Neonatal Safety report and the Maternity incentive Scheme report were approved.
Item 2.2 was taken next	
BD/05/27/2.2 2.2.1	Delivering Same Sex Accommodation The Executive Director of Nursing, Midwifery and Allied Health Professionals reported six breaches. Following the Supreme Court ruling, guidance from NHS England had been expected; however, this has not yet been received. It has been indicated that this guidance is imminent, after which a review of relevant policies will be undertaken to determine whether any amendments are required.
2.2.2	The Acting Chief People Officer advised that the Code of Practice is currently being reviewed.
2.2.3	The Executive Director of Nursing, Midwifery and AHPs also noted an incident whereby a patient was placed in a side room located within a bay. As the patient needed to walk through the bay to access toilet facilities, this arrangement was

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2.2.4	identified as non-compliant. The patient was subsequently moved to an appropriate bay; however, this constituted a technical breach. Resolved: The Delivering Same Sex Accommodation Update was noted.
BD/05/27/2.3 2.3.1	Nursing and Midwifery Quality and Safe Staffing Report Resolved: Following review at the Quality Committee, The Nursing and Midwifery Quality and Safe Staffing Report was noted.
BD/05/27/2.4 2.4.1	Emergency Preparedness Resilience and Response (EPRR) Update The Acting Chief Operating Officer advised that, in December, assurance was provided regarding core EPRR standards. While the organisation is not yet compliant, improvements have been observed; the figures will need to be verified. The recommendation was for the paper to return to report on progress, with a focus on strengthening governance arrangements associated with the action plan. It has now been brought back, outlining the anticipated position on self-assessment. By October, compliance is expected to reach approximately 82% based on current actions, which would result in partial compliance. External pressures were noted, particularly relating to limited resources within the EPRR team.
2.4.2	The evidence submission portal is now open, and the Board is asked to note the update and defer any decisions regarding additional resource at this stage.
2.4.3	The Non-Executive Director (CdB) referenced a previous discussion with Russell Nightingale, the previous Chief Operating Officer, querying what measurable differences would be evident over the next six months and it was confirmed that the action plan is appended to the paper. Progress has been impacted by a period of absence within the team, which could not be backfilled. The Acting Chief Operating Officer meets fortnightly with the team lead to review the action plan in detail. Governance has improved through the Emergency Preparedness Steering Group (EPSG), including revised Terms of Reference and more effective membership. The Business Continuity Group is also focusing on improving the quality of plans; it meets every six weeks to review documentation and share learning. Evidence submission has now commenced.
2.4.4	The Non-Executive Director (CM) noted that one of the figures did not reconcile and the Acting Chief Operating Officer advised this would be reviewed.
2.4.5	Resolved: The EPRR Update was noted.
BD/05/27/3.1 3.1.1	Board Assurance Framework – Great Start in Life The Executive Director of Nursing, Midwifery and AHPs provided the Board with an update on the Strategic Ambition: Great Start in Life.
3.1.2	Regarding children at risk of vulnerability, the target is to achieve 90% delivery of mandated contacts within national timeframes by Year 2. As of April 2026, 52 out of 55 contacts have been delivered within the required timeframe, based on data from 11 local authority services. A 12th local authority will be incorporated into reporting from July. Two areas are currently breaching the standard: one case within Westmoreland and one within Cumberland. Improvements have been noted in both areas.
3.1.3	Child patient experience: the objective is to engage effectively with children and young people and to achieve a survey response rate of at least 10% of those seen. A number of countermeasures have been implemented to support this aim. Of the responses received, 88% of children and young people rated their care as good or

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3.1.4 3.1.5 3.1.6	very good, while six respondents indicated that their experience was poor or very poor. The associated risk relates to autism. Consideration is being given to incorporating a strategic programme within the Children and Young People (CYP) Strategy. This includes a particular focus on CYP involvement in research, alongside an ambition to increase the volume and scope of research activity undertaken in this area. Resolved: The Board Assurance Framework: Great Start in Life was noted and approved.
BD/05/27/4.1 4.1.1 4.1.2 4.1.3 4.1.4 4.1.5 4.1.6 4.1.7 4.1.8 4.1.9 4.1.10	Board Assurance Framework – Person Centred, Integrated Care, Strong Partnerships The Chief Operating Officer provided the Board with an update on the Strategic Ambition: Person Centred, Integrated Care, Strong Partnerships. For 2025–2026, the Strategic Ambition is underpinned by four True North metrics. ED Four Hour standard: April was reported as a strong month, with performance exceeding 79% against the relevant standard, despite the implementation of Nervecentre. No further issues were noted. Frailty Length of Stay (LOS): the target is to achieve top quartile LOS by 2027. The organisation has performed within the top quartile for the past three months. Discussions have taken place regarding resource allocation, and work is underway to develop an A3 plan to establish a more nuanced frailty programme. This A3 is expected to be presented within the next two months. Referral to Treatment (RTT): performance has improved compared to that reported in the Board pack, following validation, with April performance at 76.3%. The organisation is in a strong position to deliver against targets over the course of the year. Internally, more stretching targets have been set; however, there is ongoing discussion as to whether these should be realigned with the trajectory agreed in the operational plan. Action: The Acting Chief Operating Officer to provide update at the next Board meeting. Cancer performance was reported at 78.11% on an unvalidated basis, with expectations that this will improve to approximately 80% once validation is complete. The Breakthrough Objective - target for time to admission to a medical bed was not achieved. This will inform the development of a revised objective focused on time to next destination. Follow-up performance for April remains unclear due to outstanding activity coding. There is also a backlog of follow-up patients who are not captured within national measures. The Non-Executive Director (JCr) commented on the close of the previous year, noting that performance had been very impressive. Resolved: The Board Assurance Framework: Person Centred, Integrated Care, Strong Partnerships was noted and approved.

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BD/05/27/4.2	Board Assurance Framework – Finance
4.2.1	The Director of Finance provided the Board with an update on the Strategic Ambition: Overarching Finance 2025-26.
4.2.2	The first key metric relates to financial performance for the current year. At Month 1, the organisation is reporting a deficit of £4.9 million, which is £3.5 million behind the planned trajectory. There has been increased expenditure relating to activity delivered in the final period of the previous financial year. A prudent approach has been taken to income recognition, particularly in light of ongoing coding issues. Strike-related costs totalled approximately £300k in Month 1.
4.2.3	There is a potential deficit of approximately £50 million (red line projection), compared with a planned deficit of £15 million. With £32 million related to WRAP and a possible further number relating to risks and issues this takes the deficit closer to £40 million.
4.2.4	Directorate-level WRAP indicate an anticipated £11 million improvement in the run rate. Good progress has been made with directorates over the past month. Delivery of activity plans is progressing well, and there is confidence in achieving these outputs.
4.2.5	The recent KPMG review has identified approximately £9 million of potential savings through various schemes. Some of these schemes will require Equality Impact Assessments (EQIA) prior to implementation.
4.2.6	Segmentation: Work is underway to ensure community service reviews are scheduled and that associated contracts are agreed. Further work is required to strengthen understanding and consistency of clinical coding processes.
4.2.7	Strategic programmes will be further developed, with stronger focus on multi-year programmes. Greater emphasis on forward planning will be needed to support sustainable delivery. The Breakthrough Objective is on budget and balances, 313 out of 718 cost centres are currently overspent.
4.2.8	Given the drivers of the deficit and the scale of outstanding payments which had carried forward from 2025/26, cash remained a significant risk for the Trust, rated at 25. The Director of Finance outlined that, despite the actions which were underway to improve revenue through the year, challenged through Resource Committee and Board, there would still be a requirement for working capital support (PDC revenue). Current forecasts estimated this to be £4.7m for the period June to August. The Finance Director outlined that this is a reflection of the monthly planned deficit, rather than addressing the backlog which would require further discussion with NHS England. The Resource Committee Chair noted that there had been a robust discussion at the committee on this and supported the proposal.
4.2.9	The Non-Executive Director (AP) queried whether now that we are two months into the financial year rather than one, if the current run rate were to continue, is there a need to allocate additional resources into the WRAP programme to mitigate the trajectory?
4.2.10	The Director of Finance noted that consideration was being given to the level of additional resource needed and would be guided by Impact methodology, ensuring resource is prioritised towards areas with the greatest potential benefit.

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4.2.11	The Executive Medical Director noted that this is being treated as an emergency with finance being the number one focus at Performance Review Meetings (PRM) and being allocated more time at the Trust Strategy Deployment Room (SDR) meeting. There are firm targets for next months' PRMs on the number of budgets that should be in balance.
4.2.12	The Chief Executive noted the requirement to pick up further discussion on addressing shortfalls in relation to the Long-Term, Urgent, Cancer and Community (LTUCC) Directorate. The Acting Chief Operating Officer advised that these conversations have already commenced with the Planned, Surgical and Childrens Care (PSCC).
4.2.13	The Non-Executive Director (AA) noted that there are only 10 months to deliver a full year position, with required improvements becoming more difficult each month. The Trust Chair noted that additional Resource Committee meetings have been valuable in providing focused oversight and the Director of Finance noted that these additional sessions have provided a clearer understanding of directorate-level financial positions.
4.2.14	Resolved: The Board Assurance Framework: Finance was noted and approved.
BD/05/27/5.1	Board Assurance Framework – At Our Best: Making HDFT the Best Place to Work
5.1.1	The Acting Chief People Officer provided the Board with an update on the Strategic Ambition: At Our Best: Making HDFT the Best Place to Work.
5.1.2	Metric 1: Staff Engagement Index and to continually improve the Employee Engagement Score – this is achieving well against ambitions. In the National Staff Survey the Trust was 15 th of 121 in it's benchmark group. In January's Inpulse survey the Trust was 5 th of 98 Trusts and is the highest scoring acute Trust for overall experience.
5.1.3	Metric 2: Staff Availability – there has been a positive start to the year in relation to workforce availability, with sickness noted as in a good position. At the point the initial assessment was undertaken, 764 staff were unavailable, reflecting a more challenging position than in the previous year. This has since improved to approximately 679. In April, the organisation started with 556 unavailable staff, representing around 100 fewer than at the same point last year. This improvement reflects the impact of a range of initiatives coming together across the organisation.
5.1.4	Progress continues on the medical rostering programme, with further advancements made in strengthening workforce planning and utilisation. In particular, the Optima rostering system has now been implemented for SAS doctors and consultants, supporting more effective management of medical staffing.
5.1.5	The Non-Executive Director and Chair of the People & Culture Committee (JW) noted her agreement to sign off last years' BAF and support this years.
5.1.6	Resolved: The Board Assurance Framework: At Our Best: Making HDFT the Best Place to Work was noted and approved.
BD/05/27/5.2 5.2.1	Public Sector Equality Duty The Acting Chief People Officer noted the statutory requirement under the Equality Act 2010 to monitor and report on workforce equality data, demonstrating year-on-year progress. The organisation continues to make progress in this area. The

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5.2.2	current workforce profile indicates that 84% of staff are female and 32% are aged between 50 and 70. These demographics highlight the importance of robust workforce planning to ensure sustainability and future capacity. Information relating to the Equality Delivery System (EDS 2022) is also included within this reporting. A key area of focus is to increase the rate of disability disclosure among staff, to better inform support and inclusion initiatives.
5.2.3	A further paper will be brought forward regarding the appointment of Equality Champions and independent panel members. This will be presented to the People and Culture Committee in July.
5.2.4	The Non-Executive Director (CM) requested clarification on the definition of “reasonable adjustments” referenced on page 173. The Acting Chief People Officer confirmed he would respond following the meeting. A further query was clarified - reference to “1.5 employees” related to Whole Time Equivalent (WTE) rather than headcount.
5.2.5	Resolved: The Public Sector Equality Duty statement was approved.
BD/05/27/5.3 5.3.1	Modern Slavery Annual Report The Acting Chief People Officer presented the Modern Slavery Annual Report.
5.3.2	Resolved: The Modern Slavery Annual Report was approved.
BD/05/27/6.1	Board Assurance Framework – Enabling Ambition: Digital Transformation and Maturity to Integrate Care and Improve Patient, Child and Staff Experience
6.1.1	The Executive Medical Director provided the Board with an update on the Enabling Ambition: Digital Transformation for 2025-26: Digital Transformation and Maturity to Integrate Care and Improve Patient, Child and Staff Experience.
6.1.2	The Enabling Ambition had one True North metric: Achieve a score of 5/5 across all seven What Good Looks Like (WGLL) pillars with the goal to achieve 3 out of 5 this year.
6.1.3	Work continues on A3s, with more than 50 expected to be in place by the end of May. These are being reviewed collectively and prioritised through the strategic filter. The Digital Maturity Assessment Tool, expected from NHS England, has been delayed.
6.1.4	A number of major projects are being progressed, one such project is the development of a radiology booking system, which will enable patients to book appointments directly. This is expected to reduce the need for manual transactions by approximately 80%.
6.1.5	The EPR programme has now reached its fifth year. The system successfully went live at the end of April. Implementation is largely complete. Remaining modules will transition into BAU delivery and will be implemented as and when funding becomes available.
6.1.6	Resolved: Board Assurance Framework: Digital Transformation and Maturity to Integrate Care and Improve Patient, Child and Staff Experience 2025-26 was noted and approved.

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BD/05/27/6.2	Board Assurance Framework – Enabling Ambition: Healthcare Innovation to Improve Quality & Safety
6.2.1	The Executive Medical Director provided the Board with an update on the Enabling Ambition: Healthcare Research and Innovation to Improve Quality and Safety 2025-26 which had three True North metrics: Healthcare Innovation, Children's Public Health, and Clinical Trials.
6.2.2	Innovation functions have expanded, and there has been growth in research activity, including an increase in the number of studies delivered. There is a particular focus on Children and Young People's Health (CYPH).
6.2.3	A key strategic issue remains the Clinical Research Facility (CRF), specifically the requirement to secure a dedicated physical space to support ongoing and future research activity.
6.2.4	A significant Trust-wide project is the development of a research MRI scanner, which is required to be implemented by Quarter 1 of 2027. While external funding is anticipated, the Trust will be required to secure match funding. A business case is currently in development.
6.2.5	The Deputy Director of Strategy and Improvement reported on the Impact programme. Training delivery remains on track. The current data represents an initial "first cut" of a self-assessment, which will provide more sensitive and meaningful insight as it develops. Approximately 130 teams are expected to report, with around 20 responses received to date. While this indicates further work is required to increase response rates, this was anticipated at this stage. Current scoring indicates performance at approximately level 2–3 in relation to quality. Awareness data is primarily drawn from the Inpulse survey. While actions have been implemented, this has not yet translated into improved awareness levels. As a result, elements of the A3 approach will be revisited.
6.2.6	The Non-Executive Director (CM) reinforced the point raised by the Executive Medical Director regarding the risks associated with the CRF needing a dedicated space. The Non-Executive Director (JCr) reported that there is strong support for the Impact methodology from Harrogate Integrated Facilities (HIF) colleagues following a recent Board meeting.
6.2.7	Resolved: Board Assurance Framework: Healthcare Innovation to Improve Quality & Safety was noted and approved.
BD/05/27/6.3	Board Assurance Framework – Enabling Ambitions: An Environment that Promotes Wellbeing
6.3.1	The Director of Finance provided the Board with an update on the Enabling Ambition: An Environment that Promotes Wellbeing.
6.3.2	Wellbeing (capital programme delivery): the £30 million programme remains focused on key developments including Block C and the Community Diagnostic Centre (CDC), alongside a number of smaller schemes.
6.3.3	Backlog maintenance: work continues on RAAC eradication and fire alarm upgrades are required. There are risks associated with ventilation systems and the overall condition of the theatre complex.
6.3.4	Impact on environment: The Trust's Green Plan has been refreshed and updated, with actions to reduce carbon emissions. Internal audit work has been

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6.3.5	undertaken, and further work will be required to refine reporting arrangements following the audit findings. There remains a gap in terms of a longer-term strategic plan for site development, including clarity on the future configuration of services and estate utilisation. Key risks and developments include CAT2 room risk – this is anticipated to be operational by June.
6.3.6	Good progress has been made by HIF on security, particularly in strengthening physical security presence on site. Replacement of fire systems remains a priority as well as ongoing challenges relating to space constraints in Histopathology:
6.3.7	The Non-Executive Director (JW) welcomed the inclusion of violence and aggression metrics within this report, noting the importance of aligning this with work being undertaken through the People and Culture Committee.
6.3.8	Resolved: Board Assurance Framework: An Environment that Promotes Wellbeing was noted and approved.
BD/05/2/7.1 7.1.1	Escalations from Sub-Committees of the Board The Chair welcomed the Committee Chairs to raise any areas that they wished to escalate from the Committees that had taken place earlier in the day.
7.1.2	The Non-Executive Director (AP) raised concerns regarding the transfer of dental services, specifically in relation to the future provision of the service and clarity on the organisation to which the service is transferring.
7.1.3	The Chief Executive confirmed that the ICB undertook a formal procurement process for the service. The Trust did not submit a bid, as it was not considered feasible to deliver the service within existing resource constraints. The transfer is scheduled to take effect from 1 June. Teams are working closely to ensure a seamless transition, although a small number of issues remain in progress and are being actively managed.
7.1.4	Resolved: The Committee Chairs noted that all areas of escalation had been discussed earlier in the meeting.
BD/05/27/8.1 8.1.1	Going Concern Report It was noted that a discussion took place at the Audit Committee regarding the appropriateness of adopting a going concern basis for the preparation of the Trust's accounts.
8.1.2	External auditors are expected to raise questions, particularly in relation to recent requests for cash support. However, it was confirmed that there is sufficient evidence and explanation available to address these queries. Following consideration, the Audit Committee recommended that the accounts be prepared on a going concern basis.
8.1.3	Resolved: The Board approved the preparation of the accounts on a going concern basis.
BD/05/27/8.2 8.2.1	NHS Provider Licence Annual Self-Assessment It was noted that the Annual Self-Assessment had been discussed and approved at the Audit Committee
8.2.2	Resolved: The Board approved the NHS Provider Licence Annual Self-Assessment.

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BD/05/27/8.3 8.3.1	Fit and Proper Person Test Annual Report The Acting Chief People Officer noted the requirement to submit an annual return for the Fit and Proper Person Test Annual Report which includes HIF Non-Executive Directors as well as departing and incoming Executives. This had been approved at the People and Culture Committee
8.3.2	Resolved: The FPPT Annual Report was approved.
BD/05/27/9.0 9.1	Any Other Business No further business was received.
BD/05/27/10.0 10.1.1	Board Evaluation It was noted that a wide range of business had been discussed. The Trust Chair thanked everyone for their attendance.
BD/05/27/11.0 11.1	Date and Time of the Next Meeting The next meeting would be held on Wednesday 29 th July 2026.
BD/05/27/12.0 12.1	Confidential Motion Resolved: to exclude members of the press and public in accordance with the Health Services Act 2006 (Schedule 7, Section 18 (E), (as amended by the Health and Social Care Act 2012) and in view of publicity being prejudicial to the public interest.

Signed:

Dated:

BOARD OF DIRECTORS (PUBLIC)
29th July 2026

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

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

CHIEF EXECUTIVE'S REPORT

National and system issues

1. As we move into the summer period, there is no let-up in the need for the NHS to deliver for the public. Demand nationally is higher for both urgent and elective care, the need to deliver the priorities of neighbourhood health, outpatient transformation, and an improved urgent care service continue, and we have received a flurry of communications from NHSE which we need to manage appropriately.
2. The most important communication that has been published recently is the Ockendon review into maternity and neonatal services at Nottingham, which alongside the report from Baroness Amos into maternity services at a selected group of Trusts, describes some significant concerns and unacceptable failures in care. The failures are a result of poor leadership, poor culture, lack of accountability, unacceptable racism and discrimination, and women and families being disbelieved or dismissed when concerns have been raised.
3. An immediate ten-point plan has been set out, and you will see later in the Board papers, our position against the ten immediate recommendations. We have a good maternity service here in Harrogate, but we are aware of the impact that these national reviews can have on both the service and the women using the service in terms of confidence.
4. We will respond appropriately, challenge ourselves to be better, and reinforce the positive multi-disciplinary culture that we have in our maternity unit. It is the culture that will drive the quality of any service, and I am confident that our local leadership team is focused on the things that matter most and do listen to women and families. Clearly, we have a range of indicators to help us triangulate the quality of service, and the Board will continue to receive detailed information from both our Associate Director of Midwifery and Clinical Director.
5. It was interesting and noteworthy to hear the first remarks from our new Secretary of State, who referenced taking action to improve maternity services (alongside improving social care), which serves to further emphasise the importance of the actions that are needed.
6. Away from maternity services, we have had communications in respect of the new staffing standards, the Lord Mann report, a national quality strategy, protecting patient experience for people on our waiting lists, ensuring no unauthorised access to medical records, model discharge guidance, and most recently, winter planning for the winter ahead. We have picked up the asks and expectations and will respond appropriately alongside the priorities we have set ourselves to deliver.
7. In positive news, it is pleasing to see the agreement reached with the Resident Doctors which removes the threat of further industrial action. However, this is counter-balanced by the vote by Consultants, which gives the BMA a mandate for industrial action should they wish to exercise this opportunity.

8. In terms of our plan for 2026/27, we are still in a position of not having the plan signed off, due to the financial deficit. As part of the escalation process, we met with the national NHSE team at the beginning of June to discuss our position. There were a number of actions following that meeting, which we have responded to.
9. In terms of actions we have taken to improve our financial position, we have engaged Simon Worthington to review our plans and produce some recommendations, we have liaised with NHSE (nationally and regionally) in respect of appointing a Turnaround Director who starts in August, appointing a Board Advisor, and creating a small turnaround team including finance, digital, PMO, and clinical expertise. This will provide us with the necessary capacity and knowledge to deliver the improvements necessary.
10. As part of this engagement with the national NHSE team, we have helpfully received some cash support, which will give us some breathing space over the coming few months.
11. As part of our response to the challenging financial position across the system, ourselves and York and Scarborough FT jointly commissioned a piece of work from KPMG to identify areas where we could deliver greater productivity and efficiency. We are taking forward recommendations in relation to contract management, VAT recovery, and the use of our wholly owned subsidiary, all of which will produce financial benefit.
12. In relation to the ICB, I can report that we have a signed contract for 2026/27. The national mechanism for payment is a part of the contract and will assist the system to manage financial risk appropriately.
13. Given the recognised pressures on the urgent care system across HNY ICB, an emergency summit is taking place this week to discuss whether there is further work that can be delivered to manage the demand more effectively. Jackie will be attending and will be able to feedback any actions that would be helpful for us or the wider system to take.
14. We have previously referenced reviewing community services across the ICB. This is due to be undertaken over the next few months, with a report out of recommendations in October. This will follow the publication of the new financial payment mechanism for community services which is due in September and will inform planning for 2027/28. In the meantime, we are reviewing some specific community services as part of our financial improvement work.
15. We received support in May from HNY ICB to progress our business case in respect of developing a community diagnostic centre in Harrogate. This has now also been agreed by the Regional team and we are now just awaiting the sign-off from the national team. The funding is earmarked, and we will begin this exciting development as soon as we receive the green light from NHSE.
16. As we have discussed, we are well placed to lead the delivery of neighbourhood health in the Harrogate and District area given the services we provide and the relationships we have across the local system. This will be delivered through the Local Care Partnership, and significant work is ongoing with our local partners, including the local authority and primary care. The discussions have moved on to how this is delivered rather than whether it is the right thing to do, and there is a common agreement about neighbourhood boundaries, recognition of the need to focus on frailty, build on existing assets, pilot some

work quickly, and identify how we coordinate delivery across the partnership. We have a workshop in September to progress this further.

17. In relation to the West Yorkshire system and WYAAT in particular, we continue to focus on delivering the priorities identified in the Case for Change. We are continuing to work through the future options in respect of our collective microbiology services, recognising the need to change in a way that provides a local service where necessary and a consolidated service where efficient and effective to do so.
18. In addition to microbiology discussions, the WYAAT aseptics programme is progressing well, with the new facility opening next year, and there is work continuing in relation to stroke services and their resilience across the system.
19. We continue to work in partnership with Local Authority colleagues across twelve areas in relation to the provision of our 0-19 services. These relationships continue to be positive with all Local Authorities, as we work with them to deliver services to children and young people. The impact of health inequalities on children in particular was highlighted at a Regional NHS event last week by the Regional Director of NHSE, and I have reached out to suggest following up this discussion with ourselves, given that we are the children's public health services provider for the vast majority of the NEY Region.
20. As referenced at our last Board meeting, our strategy of leading the way in respect of 0-19 services, of developing the out of hospital service as part of neighbourhood health, and working with WYAAT and LTHT in particular to improve the resilience of services and also the productivity of our already efficient elective services, are the right responses to the short-term planning issues and the longer-term sustainability challenge. The Board will also be aware that these reflect the findings from the Carnall Farrar review undertaken a number of years ago, which recommended modernising community services, utilising our productive elective services across WYAAT, and developing networks for services that were needed within HDFT but required a partnership to ensure resilience and best value. We are therefore clear about the direction we need to take; we need to ensure we are organised in a way that delivers this strategic intent. As part of our turnaround programme, it is important that we take action now to improve our financial runrate, which will give us the best opportunity to deliver our strategy going forward and take advantage of the many positive elements of our health and care provision currently.
21. To repeat a common observation from myself, there are a lot of moving parts that we are managing at the moment across a number of issues and systems. These all contribute to our coherent strategic approach as we seek to deliver the best care and outcomes for our population, both now and into the future.

HDFT issues

Introduction

22. As is appropriate, the first part of this report has focused significantly on the important national and regional issues that impact upon HDFT, whilst also outlining the appropriate engagement we have with partners across a number of systems to deliver high quality care. We will continue to focus on maintaining the appropriate balance that engages externally for the benefit of patients across our systems whilst recognising the absolute

importance of supporting colleagues within the organisation, which is where the improvements to services will actually be delivered.

23. As part of this balance, the Board should be aware of the ask we are making of our leadership team in particular in relation to our financial improvement programme, which we have had good engagement on. The expectation is that this will be delivered alongside maintaining the delivery of services that our patients and population rely on. Our colleagues are stepping up as you would expect, and the delivery of the improvements will only be achieved because of the culture and engagement of people across HDFT.

Our people

24. In terms of staff engagement, our inpulse surveys continue to report positively. We are awaiting the latest results this week.
25. In respect of availability, our sickness rate of 5.1% is higher than our ambition and is an area of focus for the Trust.
26. As referenced earlier, our turnaround programme is currently focusing on a recruitment pause alongside variable pay controls. In respect of the recruitment pause, we are tracking the number of adverts which have reduced significantly over the last four weeks. Our use of temporary staff has reduced as a result of our controls by around 20%. We have also reduced our NHSP bank rate in line with WYAAT Trusts and also agreed to phase out the real living wage. Linking this back to our staff engagement, we are very mindful of the potential impact that these measures could have as we go through the next few months, and we will be both watching this closely but also making sure we listen to colleagues about any concerns that they might have.
27. Our reciprocal mentoring programme for this year has concluded, with a celebration event last month with people who have taken part. This again has been a positive programme to be involved in, and I have certainly taken some learning from the different perspective that this programme brings to how some colleagues experience working for HDFT.
28. The NHS Leadership and Management framework has recently been launched. We are reviewing the framework, and we will ensure that this is part of a future Board development workshop.

Our Quality

29. As the Board will be aware, we have identified the need to assess our services against the relevant standards as part of our focus on clinical effectiveness. This work is underway with over sixty services (out of 108) now initially assessed. This will give us very helpful insight into areas where we might need to focus our improvement over the coming years.
30. We have seen a slight uptick in moderate harm events, from a low baseline. This remains within our business rules, and there are no specific areas of concern, but we will continue to watch this through our normal governance processes.

31. Our complaints response times remain inconsistent from month to month. This has been discussed through our SDR, and we have worked through some countermeasures to assist us to improve how we respond in a timely way to patients who have raised concerns about their care or experience of our services. The current performance is better, but we need to ensure that we can sustain this position.
32. As referenced earlier, there continue to be concerns about the robustness of the stroke pathway between us and local partners. There is a national concern about stroke services, but we need to ensure that the service for our patients is good and reliable. There are workforce challenges that we recognise, and which are affecting the resilience of the service at present.
33. In respect of our maternity services, there are no risks escalated to the corporate risk register. We have seen a reduction in the number of diverts over the last four months which is positive for women in our service and reflects the impact of the business case we approved last year in respect of maternity staffing. As referenced earlier, we have reviewed the immediate actions that have come out of the recent national maternity reviews, which are included later within this Board pack.

Our Services

34. Our 0-19 services continue to deliver strong performance across the majority of our geographic footprint and across the vast majority of the KPIs that we measure ourselves against. We are delivering against 49 of 55 indicators, with the only areas where we don't quite meet the Healthy Child Programme metrics being in Cumberland and Westmoreland & Furness, where there has been a huge improvement since we took over the service provision. We will be incorporating the South Tyneside service into this reporting from July, following the successful transfer in April.
35. Our urgent care pathway performance is below the standard that we set ourselves in June. This compounds our performance in May, which was also below plan. The plan is to achieve a performance of 82% by March 2027, so there is work to do to improve the position. Given the performance, this was an area of focus at our SDR this month. This standard is a measure of the quality and safety of our urgent care pathway, it is a priority for the public, and it is a priority for all of us. We have strengthened the leadership in the Emergency Department, and we will be working through improvements that we can make in advance of winter. Our performance hasn't been to the level we are seeking to achieve and will continue to be a focus for us as we support the Directorate and Care Group team to deliver the necessary changes.
36. In relation to cancer, our performance remains a positive one, with significant improvement achieved over the last twelve months which has continued into 2026/27. We are ensuring that our work to reduce payments for additional activity (e.g. WLIs or LLPs) do not impact upon work needed to be delivered for our cancer pathway.
37. We continue to deliver our elective recovery plan, and our RTT position is around 75% (national average 65%). This remains within the top ten nationally. We have an ambition to return to the constitutional standard by 2028/29, which we are continuing to target for the benefit of our patients.

38. We continue to struggle to meet our diagnostic waiting times standards due to the ongoing mismatch between capacity and demand for our CT/MRI services. We are protecting urgent scans and cancer pathway requests, but this puts pressure on routine scanning. As discussed previously, we will be creating additional permanent capacity through a Harrogate based Community Diagnostic Centre. Whilst the facility itself will not be up and running in 2026/27, as part of the proposal we will have access to revenue funding to make some necessary improvements this year in advance of the CDC being fully operational. Along with the new Imaging department on the Harrogate site, and our Trust-wide project to improve our Imaging services, we should expect to be in a much better place later in the year.
39. The provision of autism assessments in a timely way continues to be a significant risk to HDFT. Discussions with the Commissioner continue, and we are seeking greater clarity about future arrangements and resources, recognising the financial context of the ICB system. This remains a risk and we continue to keep this high on the agenda with our partners as we seek a sustainable solution.

Our money

40. As the Board will know through many discussions over the last few months, we have a challenging financial plan to deliver this year. Our Q1 deficit is £12m. This will be addressed through our turnaround programme.
41. As referenced earlier, we have created a financial turnaround programme and associated governance arrangements. Focus is on a recruitment pause whilst we develop affordable establishments, reducing variable pay, and controlling variable activity payments. As this work develops and our turnaround team gets to work, we will be reporting progress and ensuring sufficient control and oversight through the turnaround committee.
42. We have a significant cash risk as a result of the financial position. We received some cash support during 2025/26, but not to the extent that we required. We have been managing this on a daily basis, with payments being delayed, with a cost to the suppliers, our team, and also directly in terms of late payment fines. We continue to work with partners to support our requirements, and have this week received a cash injection from NHSE.
43. The route to financial balance and sustainability lies in the strategic solutions that I have outlined earlier, alongside a clear agreement with our Commissioners in respect of the services we deliver. Our financial turnaround programme alongside our HDFT Futures strategic programme will be the framework within which we will organise ourselves to plan and deliver the immediate short-term changes consistent with the transformational change that will result in higher quality, more efficient services for our patients for the years ahead.

Corporate Risk Register

44. On the 8th and 9th July 2026, the monthly directorate Performance Review Meetings (PRM) took place in line with Trust protocol. The Directorate Risk

Registers - which include risks scoring 9 or above - were reviewed, and consideration given to any which should be escalated to, or de-escalated from, the Corporate Risk Register.

45. The Executive Risk Review Group (ERRG) met on 9th July 2026. The executives reviewed all risks currently held on the Corporate Risk Register and considered all directorate requests for escalation and de-escalation. The following was agreed:

- **ID 1314 - CYPPEH Risk of clawback in underspent contract areas:**
Following CYPPEH PRM on Wednesday 8th July, this risk was discussed at ERRG on Thursday 9th July and accepted onto the corporate risk register.

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

Other

47. Our capital scheme to deliver new theatres and a new imaging department is progressing very well, with the contractors due to leave the site within the next two months. We will then need to instal the equipment before we are ready to open the facility later in the year. We are also progressing the plans to redevelop the front entrance with an expected delivery in the first half of 2027.
48. I had the pleasure of attending the Harrogate Healthcare 200 conference earlier this month. This was a brilliantly organised and brilliantly delivered day, with a mixture of looking back and looking forward into the future of healthcare. It reinforced the strength of our teams and the engagement of our colleagues in developing services going forward.
49. Finally, it is important to always remind ourselves that despite some of the challenges that we and the NHS are facing at the moment, that we maintain our focus on our values and the engagement with colleagues. I have already referenced the ask we are making of our leaders and managers in particular, and whilst we have great staff across the Trust who are committed to improvement and delivering the best for our patients, we need to be aware of the pressure and be supportive and open to any concerns that are raised. Our role is to harness their collective talent and provide an environment within which they can shine. It is easy to refer to a positive culture of engagement when things are straightforward, we need to ensure that this positive culture is maintained and respond in line with our values when there are difficult issues to resolve. Knowing our teams, I am confident that we have the people to continue to strengthen the outcomes for our patients and population, provided that we continue to focus on doing the right things in the right way.

Jonathan Coulter
Chief Executive

July 2026

STRATEGIC AMBITION: BEST QUALITY, SAFEST CARE 2026-2027

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

GOALS:

Safety

Ever safer care through continuous learning and improvement

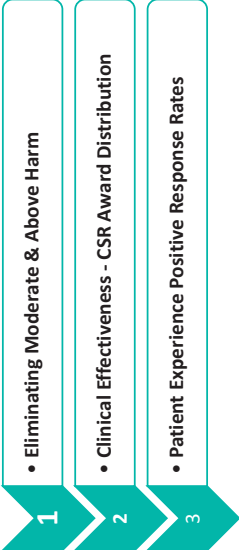
Effectiveness

Excellent outcomes through effective, best practice care

Patient Experience

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

GOVERNANCE:



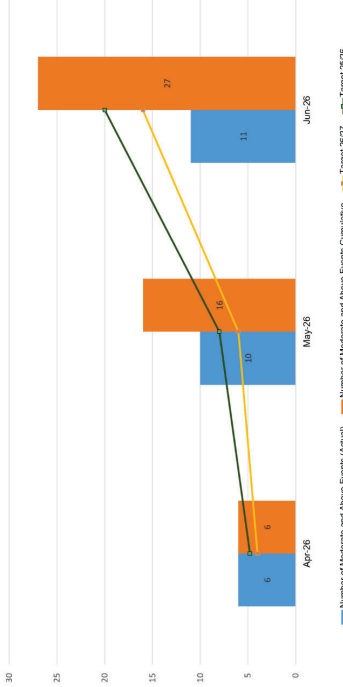
True North Metrics (Executive Lead: 10-15 Year deliverable)

Trustwide Project	N/A
Strategic Programme	Clinical Services Strategy
Breakthrough Objectives	Checklist Completion
Overarching Risk Appetite:	Clinical - Minimal

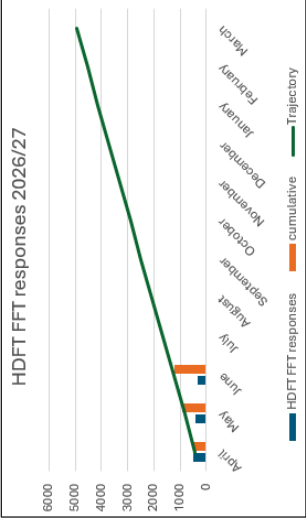
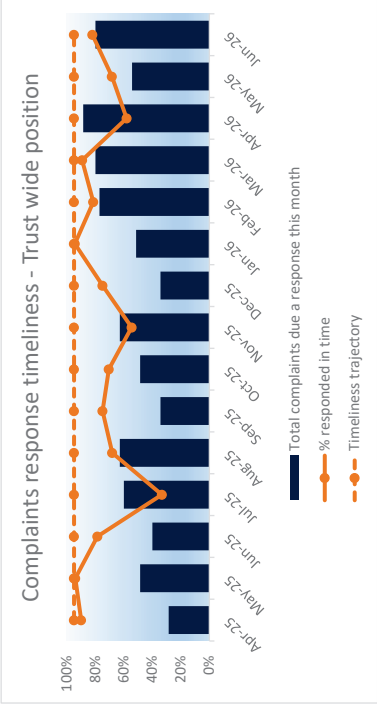
Overarching Risk Summary:

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

True North Summary:

Workstream	True North Metric	Vision	Goal	Current State	Countermeasures	Level of Risk to Achieving in year goal	Level of Risk for progressing actions
Ever Safer Care 	Eliminate Moderate & Above Harm	Decrease the total number of moderate & above harm incidents while increasing reporting of low or no harm	Long term: Eliminate moderate & above harm Short term: 20% reduction each year for 3 years Baseline: 140 per annum Year 1: 110 (achieved) Year 2: 88 (achieved) Year 3: 71 (approx.. 6 per month)	The True North Metric of eliminating moderate and above harm continues into its third year (2026-27). The target of a 20% reduction in harm was achieved in 2024-25 and in 2025-26. 2026-27 sees a step change of a further 20% reduction. This is a target of less than 71 moderate and above incidents for the year, which equates to approximately 6 per month. Of note: - There were 6 moderate and above events reported in April 2026 (of note one of these was reported under Corporate Services) - There were 10 moderate and above events reported in May 2026 - validation continues - There were 11 moderate and above events reported in June 2026 – validation ongoing The year to date total is 27 against a threshold of 18. Performance is currently above the trajectory required to achieve the overall targeted reduction, although this may change once validation for the months of May and June have been completed.  An increase in moderate harm incidents has been observed during the reporting period with the highest contributing categories relating to patient slips, trips and falls, pressure ulcers and diagnosis accounting for 15 of the 27 reported incidents. The increase does not appear to be attributable to a single systemic issue rather; it reflects a range of incidents occurring across multiple clinical and operational processes. Watch Metrics: - Number of Never Events – 0 declared in year - Number of PSiIs – 1 declared in year	Breakthrough Objective: Checklist Completion – programme for 2026-27 Pressure Ulcers Improvement Plan Deteriorating Patient Thematic Review – Implementation Plan Trauma Pathway Thematic Review – Implementation Plan Falls Improvement Plan Core Service Review Programme Directorate Countermeasures		

Workstream	True North Metric	Vision	Goal	Current State	Countermeasures	Level of Risk to Achieving in year goal	Level of Risk for progressing actions
Excellent Outcomes 	Clinical Effectiveness – Clinical Standards Review (CSR) Award Distribution	Increase the proportion of services that are compliant with evidence based clinical standards	Long term: All services to be compliant with evidence based clinical standards. Goal 1: Short term: increase the number of services that have completed a CSR. Baseline: 25 services Goal 2: Medium term: increase the proportion of services moving from Bronze to Silver	- Level of low and no harm events reported – ratio maintaining at 98.6% with numbers maintaining approximately 1,194 This is a new True North metric focusing on the delivery of effective care by developing professional curiosity into patient outcomes and achieving sustained compliance with evidence-based clinical standards. The focus for Quarter 2 will be to complete the number of services (108 in scope) that have completed the Clinical Standards Review within the Clinical Standards Review Project. Currently this stands at 61 services. The focus for Q2 is to complete the assessment of current services. When a CSR has been completed, an award of Gold, Silver and Bronze will be awarded depending on the level of compliance. The focus will then move towards moving bronze status services to silver status. The True North Metric has been defined as the number of Bronze Services with the trajectory of reduction in number of bronze services to be developed following full analysis in Q3. Watch Metrics: % Guidelines in date – 95% % SOPs in date – 88%	Establish a Trust-level Clinical Effectiveness True North Metric Implement a Bronze / Silver / Gold Standards Maturity Model Complete and Maintain a Trust wide baseline of standards compliance Create an explicit escalation and prioritisation route for system-level gaps Embed clinical effectiveness into business-as-usual governance Shift culture from compliance judgement to improvement and learning		
A Positive Experience 	Patient Experience Response Rates	For every patient to recommend our services	Long term: Development of a bespoke Engagement Strategy Short term: Increase the response to FFT by 10% over the next 12 months for inpatient: 413 (baseline 375)	Despite ongoing efforts to improve patient experience across HDFT, the current systems for collecting and acting on patient feedback are often delayed fragmented and inconsistently used. Traditional methods such as surveys (e.g., Friends and Family Test) and complaints processes typically capture feedback retrospectively, meaning opportunities to respond to patient concerns in real time are missed. As a result, staff may lack timely insight into patient needs and experiences during care delivery, limiting their ability to make immediate improvements. Over the last 12 months, the Trust has used the FFT as the primary Trust-wide measure of patient experience, with an average of 375 responses per month. Over the last 12 months, the percentage of patients reporting a "Very Good" or "Good" experience has remained consistently high, with an average of approximately 94.7%, showing stable and sustained positive patient experience across the year. The priority for 2026/27 is to increase Friends and Family Test (FFT) response rates by 10% over the 12 months, strengthening the breadth and representativeness of patient feedback. In parallel, there will be an increased focus on maximising the value of the insight gained from FFT data by strengthening analysis and ensuring feedback informs service improvement. This approach will be supported through the development of a Trust Engagement Strategy, aligned to the forthcoming guidance associated with the 10-Year Health Plan.	Development of a real time engagement tool Development of a 12-month engagement plan Development of an Engagement Strategy Develop a bank of patient stories		

Workstream	True North Metric	Vision	Goal	Current State	Countermeasures	Level of Risk to Achieving in year goal	Level of Risk for progressing actions
				Watch Metrics: - There were 513 responses received in April - There were 412 responses received in May - There were 308 responses received in June – further data still being inputted  HDFT FFT responses 2026/27 Watch Metrics: 52 complaints of all types (standard, multiagency, early resolution and cases requiring a meeting) were submitted in June 2026 39 of these were standard complaints. 28 standard complaints were due to be responded to in June - Response rate of standard complaints due in June was 82%  Complaints response timeliness - Trust wide position			

Strategic Programme:

Workstream	True North Metric	Vision	Goal	Current State	Countermeasures	Level of Risk to Achieving in Year Goal	Level of Risk for progressing actions
Clinical Services Strategy	Best Quality, Safest Care	A coherent, clinically led model of care where services are standardised where appropriate, redesigned to meet changing demand, and delivered through the right setting with the right workforce, improving outcomes for patients while maintaining system sustainability.	To progress delivery of priority Clinical Services Strategy projects, notably Clinical Services Review (CSR), Single Point of Contact (SPOC) for UEC, and Neighbourhood Health, embedding agreed clinical standards and service models that support quality, workforce resilience and operational sustainability.	CSS remains an active strategic programme for 2026–27, with delivery primarily progressed through three major transformation programmes: <u>Clinical Services Review (CSR)</u>: progressing achievement of a clear, consolidated picture of clinical effectiveness using service compliance against national standards, enabling prioritised trust wide transformation (for cross cutting issues) and local QI (for service level issues), aligned to Green Plan, health inequalities, and EDI improvements. <u>Single Point of Contact (SPOC) for UEC</u>: developing more coordinated access and referral pathways to improve flow, reduce duplication and support timely clinical decision making. A central coordination hub for HDFT@Home, providing seamless and consistent management of integrated urgent care pathways across acute and community settings. During Quarter 2, planned work focuses on progressing the pilot by finalising key foundations including updating the urology pathway, securing SAU admission criteria and establishing KPIs. Preparatory activity also includes site visits, workforce planning, identifying a physical location and strengthening links with community teams to support implementation. <u>Neighbourhood Health</u>: advancing place-based models of care to support population health management, integration and care closer to home. To deliver Neighbourhood Health across Harrogate and Rural District to enable the shifts from treatment to prevention and from hospital to community by implementing the six components of Neighbourhood Health. During Quarter 2, planned activities focus on continuing existing work while progressing key projects across several areas. Priorities include advancing the Health Inequalities Rural MDT project, introducing monthly digital Communities of Practice for benchmarking, and progressing wound care and community partnership initiatives. Key meetings and workshops are scheduled (including July milestones).	- Programme-level oversight via SDR with regular assurance against agreed CSS priorities - Translation of CSS priorities into defined workstreams with accountable clinical and executive leads - Alignment with Clinical Standards framework to support consistent quality and safety expectations - Use of A3s to articulate problem definition, benefits, risks and countermeasures for priority areas - Active management of interdependencies (workforce, finance, digital and estates) via CSS Operational Board to support delivery		

Breakthrough Objective:

Workstream	True North Metric	Vision	Goal	Current State	Countermeasures	Level of Risk to Achieving in Year Goal	Level of Risk for progressing actions
Checklist completion	Best Quality, Safest Care	To significantly reduce safety-critical variation by embedding the reliable use of safety-critical checklists and checks as a routine part of delivery across clinical, corporate and enabling services, thereby strengthening patient safety and organisational assurance.	Reduction in safety events linked to checklists Baseline: TBC	The current state is characterised by significant variation and lack of clarity across the organisation: - As reported last month it is not consistently clear which services should have checklists, and which do not. We have already identified a number of areas that are using checklists. - During Quarter 2 further work will be undertaken to identify other areas which perform procedures requiring consent form completion and don't appear to be using a checklist. - During Quarter 2 work will take place with the clinical directorates to determine the baseline for which checklists are currently in use and areas that need developing. Once this work has been completed, further clarification will be provided on the process for reviewing and formally signing off the appropriateness of these checklists. - A clearly defined process is needed to identify the appropriate individuals within each directorate, outlining how compliance with the checklists is audited, and establishing mechanisms to ensure alignment with national documentation and guidance Confirmation on frequency of updates for this workstream will be provided in next month's BAF.	Establish services requiring safety-critical checklists Review and rationalise checklist content to ensure safety-critical steps are included Embed checklist completion into routine workflow, including stop moments Strengthen human-factors reliability, including speaking up culture and role clarity Standardise and strengthens training for safety critical checklist Improve visual and digital support, including use of electronic systems where possible Share learning from Never Events		

Related Corporate Risks

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

Related External Risks

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

Board Meeting Held in Public

Title:	Learning from Deaths Quarterly Report Q4: January-March 2026
Responsible Director:	Executive Medical Director
Author:	Deputy Medical Director for Quality and Safety

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

Board Meeting Held in Public

Learning from Deaths Quarter 4 Report

Executive Medical Director

1.0 Executive Summary

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

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

20 cases have undergone a structured judgement review since the last report. No cases were identified as receiving poor overall care. 10 cases with a diagnosis of chronic obstructive pulmonary disease (COPD) were scrutinised following an alert of possible excess mortality - no significant lapses in care were found.

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

2.0 Introduction

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

3.0 Findings

3.1 Crude Mortality Data

The crude mortality rate for admissions gives a long-term view of trust mortality. In total, 183 deaths were recorded in Q4, up from 167 in the preceding Q2 but down from Q4 in 24/25 which had 204 deaths. This data is not risk-adjusted so takes no account of the unique characteristics of individual admissions. Comparison with the national mortality rate is also shown where data is available (shown in the darker blue line in Figures 1 and 2). This demonstrates that the peaks and troughs we see in HDFT are often mirrored at the national level. Figure 2 gives a “zoomed in” view of data from the last 2 years.

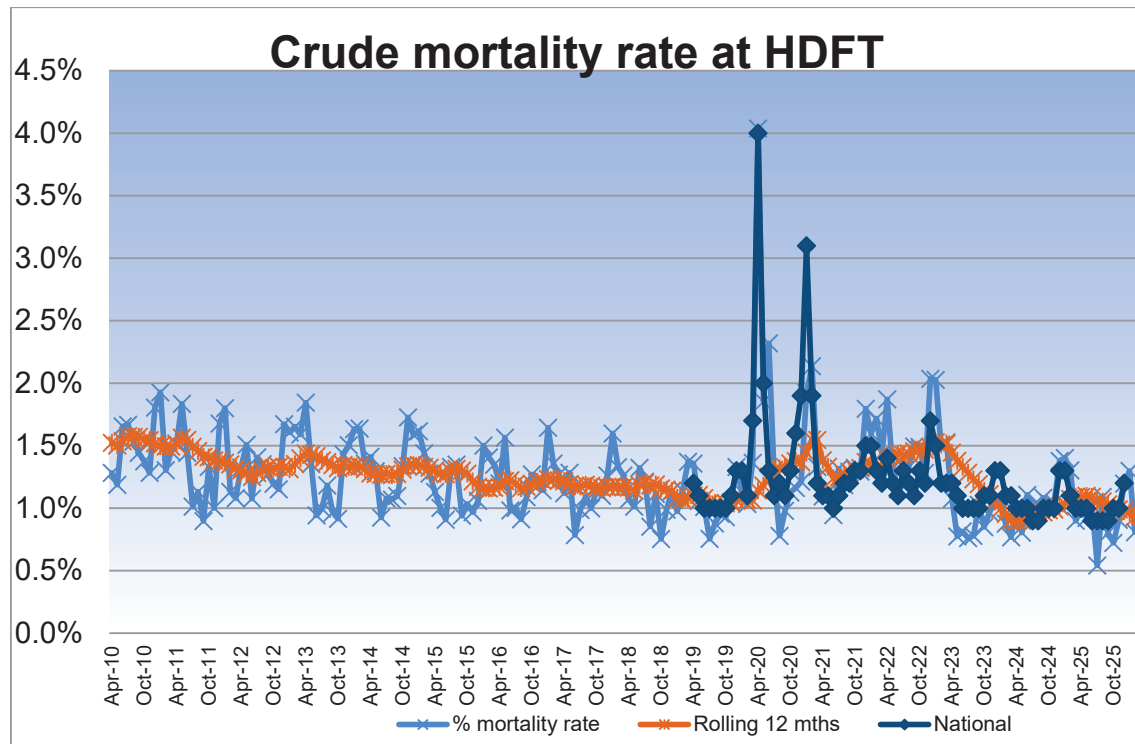


Figure 1: Crude mortality rates over the last 15 years (%deaths per hospital episode)

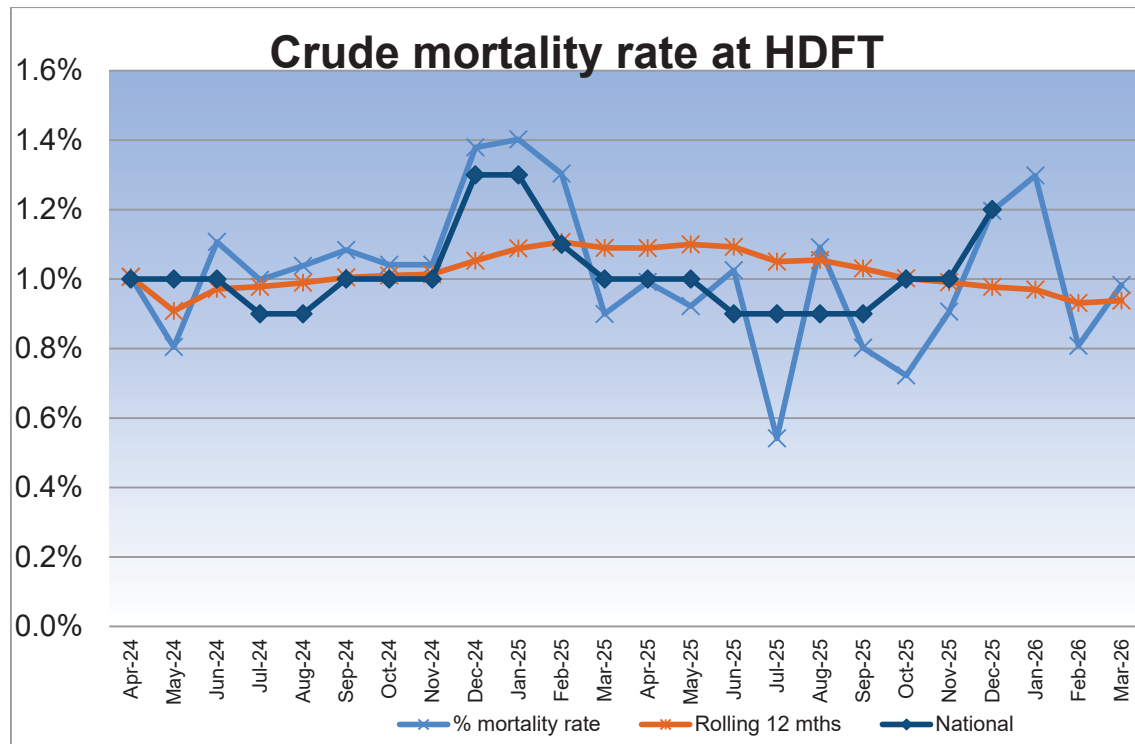


Figure 2: Expanded crude mortality rates over the last 2 years (%deaths per hospital episode)

3.2 Standardised Hospital Mortality Index (SHMI)

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

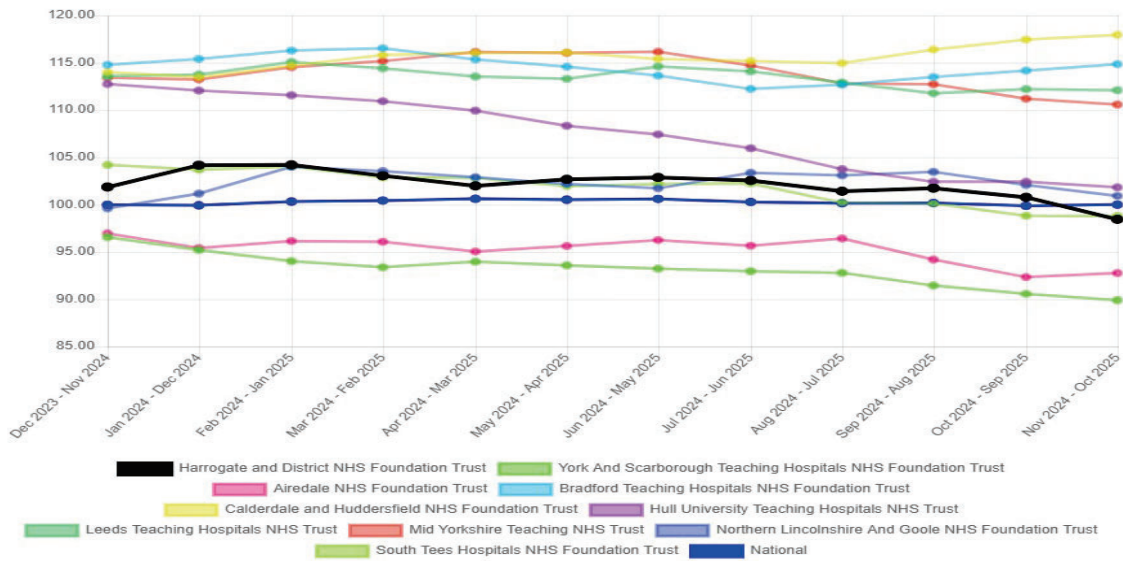


Figure 3: HDFT SHMI since Dec 2023 versus regional peers

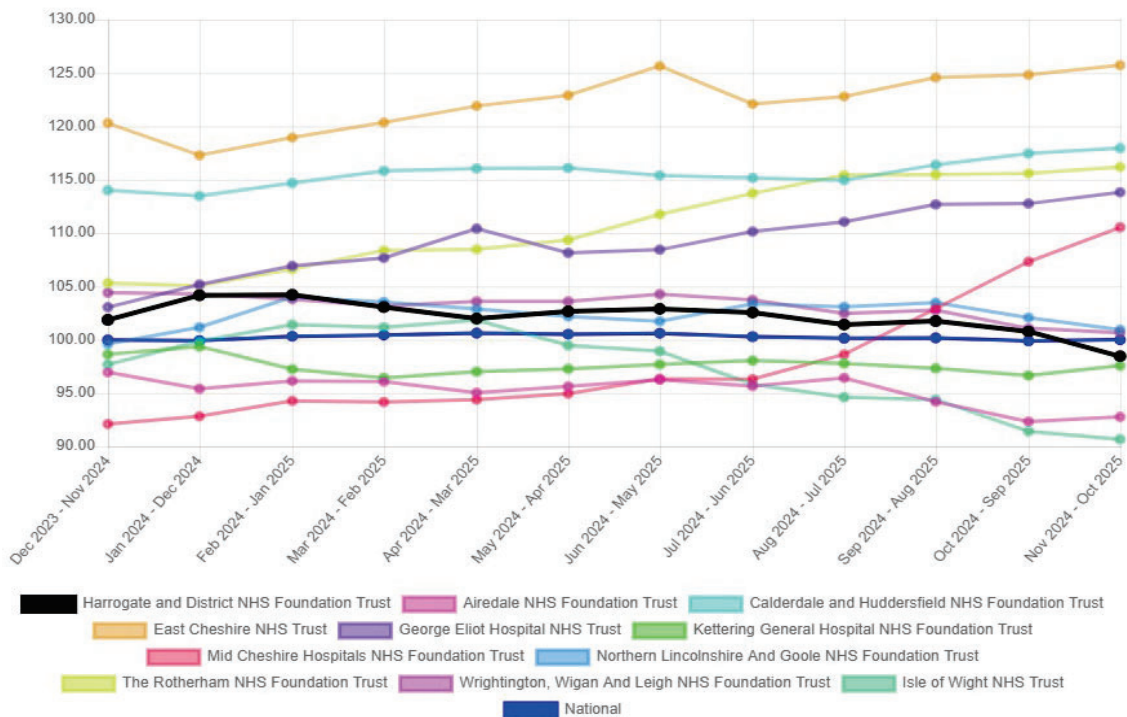


Figure 4: HDFT SHMI since Dec 2023 versus national peers

As can be seen, our SHMI peaked in the period Feb 2024-Jan 2025 having slowly climbed previously. This rise was primarily driven by a precipitous fall of expected deaths (see below for explanation). Currently, these 2 metrics match, combining to give our SHMI of approximately 1.

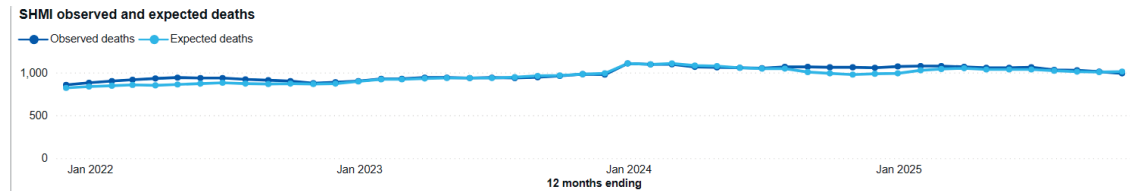


Figure 5: Observed (dark blue) and expected (light blue) number of deaths (in hospital or within 30 days of discharge – rolling 12 months)

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

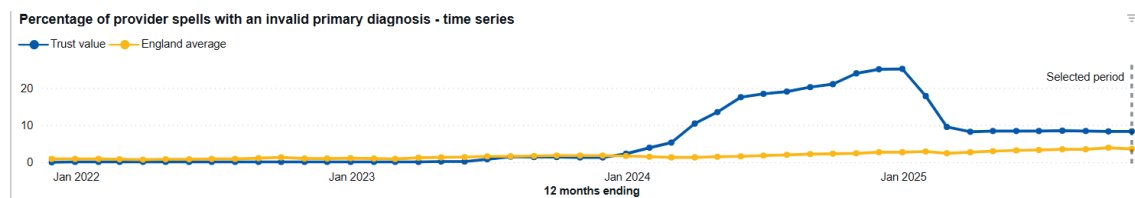


Figure 6: Spells with an "Invalid primary diagnosis" coding. Note how the number has fallen but not fully returned to baseline

3.3 Structured judgement reviews (SJR)

20 cases have been reviewed in this quarter with 1 relating to a death in this period and the remaining predating this. Exact date of admission for each case is shown in Table 3.

Reasons for cases selection are shown in table 1. 10 cases were chosen following a breach in our watch-metric – this related to deaths with a coding of “chronic obstructive pulmonary disease (COPD)” as a diagnostic category. The 10 selected were those with the lowest predicted mortality rate. 1 case had been reviewed in a previous quarter. These case were admitted between August 2024 and October 2025.

	25/26 Q1	25/26 Q2	25/26 Q3	25/26 Q4	Total
Death within 30 days of elective surgery	0	0	1	0	1
Diagnostic category	10	0	1	9	20
Learning Disability/Mental Health	5	6	1	1	13
Medical Examiner	1	2	0	0	3
Quality Team/Trust concern	0	1	1	0	2
Random selection	6	10	14	1	31
Specialty concern	2	2	3	9	16
Other	1	0	0	0	1
Total	25	21	21	20	87

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

1 case was a patient with a learning disability who will receive a second external review as part of the LeDeR process.

Table 2 shows the breakdown of the quality of overall care received. In this quarter, 19 of the 20 cases received good or excellent care, with 1 case rated as adequate. Figure 7 shows the overall care rating for all cases reviewed this financial year.

	25/26 Q1	25/26 Q2	25/26 Q3	25/26 Q4	Total
Poor care	0	1	2	0	3
Adequate care	6	5	5	1	17
Good care	17	9	8	16	50
Excellent care	2	6	6	3	17
Total	25	21	21	20	87

Table 2: Overall care rating for each case

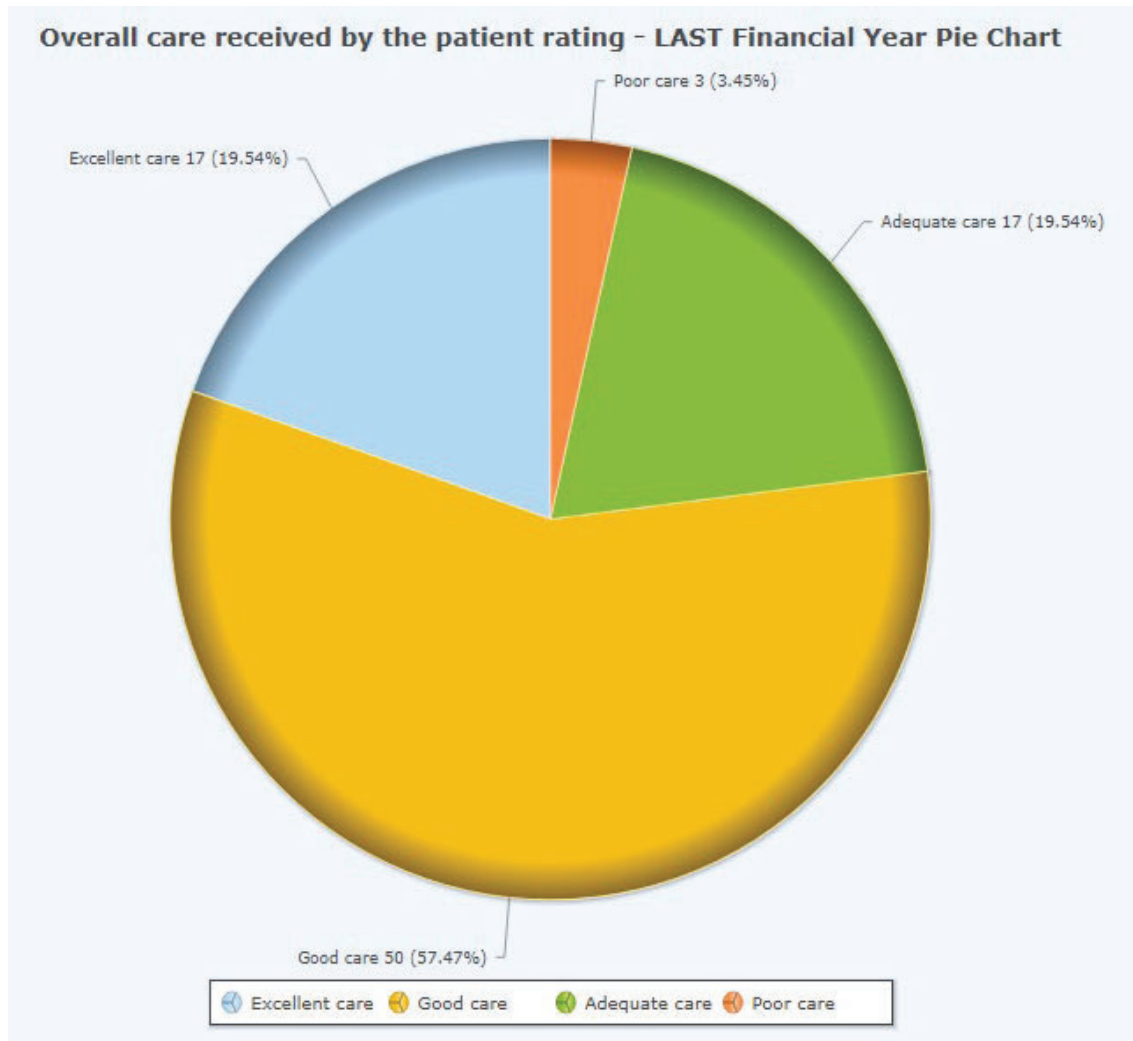


Figure 7: Breakdown of Overall Care rating in all cases reviewed this financial year

Table 3 shows the overall assessment of the standard of care for each case. A number of cases flagged as “Room for improvement in organisational care”. In all instances, this referred to patients waiting more than 4 hours in the Emergency Department before admission to a ward bed.

Date of admission	Care in First 24 hours	Ongoing Care	Avoidability of Death	Clinical/Organisational score (NCEPOD)	Overall Care
16/09/2025	Excellent care	Good care	Definitely not avoidable	Room for improvement in clinical care	Good care
28/12/2025	Good care	Not Applicable	Definitely not avoidable	Room for improvement in organisational care	Good care

16/11/2025	Adequate care	Good care	Definitely not avoidable	Room for improvement in organisational care	Good care
09/12/2025	Excellent care	Not Applicable	Definitely not avoidable	Good practice	Excellent care
25/11/2025	Good care	Adequate care	Definitely not avoidable	Room for improvement in organisational care	Good care
23/10/2025	Good care	Excellent care	Definitely not avoidable	Good practice	Excellent care
06/10/2025	Good care	Good care	Definitely not avoidable	Good practice	Good care
23/11/2025	Excellent care	Good care	Definitely not avoidable	Room for improvement in clinical care	Good care
06/08/2025	Good care	Good care	Definitely not avoidable	Room for improvement in organisational care	Good care
21/07/2025	Good care	Good care	Definitely not avoidable	Good practice	Good care
11/04/2025	Good care	Good care	Definitely not avoidable	Good practice	Good care
31/05/2025	Good care	Good care	Definitely not avoidable	Good practice	Good care
19/05/2025	Good care	Adequate care	Slight evidence of avoidability	Room for improvement in clinical care	Adequate care
17/02/2025	Adequate care	Good care	Definitely not avoidable	Room for improvement in organisational care	Good care
06/12/2025	Excellent care	Excellent care	Definitely not avoidable	Good practice	Excellent care
07/01/2025	Good care	Good care	Definitely not avoidable	Good practice	Good care
30/11/2024	Good care	Good care	Definitely not avoidable	Good practice	Good care
14/09/2024	Good care	Good care	Definitely not avoidable	Good practice	Good care
14/01/2026	Adequate care	Good care	Definitely not avoidable	Room for improvement in organisational care	Good care
06/02/2026	Good care	Good care	Definitely not avoidable	Good practice	Good care

Table 3: Details of the cases reviewed this quarter

Table 4 shows the quality of end-of-life care received. Note this is recorded as “not applicable” in the case of a sudden death.

	25/26 Q1	25/26 Q2	25/26 Q3	25/26 Q4	Total
Not Applicable	7	7	6	3	23
Poor care	2	1	0	0	3
Adequate care	3	5	3	2	13
Good care	11	4	8	10	33
Excellent care	2	4	4	5	15
Total	25	21	21	20	87

Table 4: End of Life Care provided

The 10 cases with a diagnostic coding of “chronic obstructive pulmonary disease (COPD)” did not show any significant lapses in care. Many of the cases died of other conditions (such as disseminated malignancy), but because they also had COPD, this is captured by the SHMI methodology. The Respiratory Team are also doing their own review of other cases to provide assurance.

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

4.0 Recommendation

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

Appendix 1

“Watch Metrics”

Month HED Alert Received	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
SHMI (monthly SHMI - use last month in period)												
111:205-Spondylosis												
58:101-Coronary atherosclerosis			X									
110:204 Other nontraumatic joint disorders												
75:127 COPD and bronchiectasis												
93 :: 150 - Liver disease; alcohol-related												

1 diagnostic category (liver disease, alcohol related) is currently breaching our rules, so cases will be selected for review in the forthcoming quarter.

Deaths related to COPD have been reviewed in this report and are no longer breaching.

**Trust Board
JULY 2026**

Title:	2025-26 Annual Health & Safety Report
Responsible Director:	Jordan McKie, Director of Finance
Author:	<i>Paul Yeadon, Head of Health & Safety</i>

Purpose of the report	Approval	X	
	Assurance	X	
	Discussion		
	Information		
Summary of key issues:	<i>The 2025-26 Annual Report sets out our performance against key health and safety deliverables, and assurance relating to legal compliance. The report also outlines our ambitions for 2026-27, as well as the development of a 3-year Health & Safety Strategy to be launched during the next 12 months.</i>		
Trust Strategy and Strategic Ambitions	The Patient and Child First		
	Improving the health and wellbeing of our patients, children and communities		
	Best Quality, Safest Care		X
	Person Centred, Integrated Care; Strong Partnerships		
	Great Start in Life		
	At Our Best: Making HDFT the best place to work		X
	An environment that promotes wellbeing		X
	Digital transformation to integrate care and improve patient, child and staff experience		
	Healthcare innovation to improve quality		
Corporate Risks	117 Violence & Aggression 577 Security 116 Risk from Fire		
Prior Committee Review / Governance Route:	H&S Committee / QGMG / SDR / Quality Committee		
Recommendations:	For assurance / approval.		
Impact Assessments	Financial		
	Workforce		

	Quality & Safety	X	Annual report to provide assurance
	Legal/Regulatory	X	Annual report to provide assurance
	Equality & Diversity		
	Risk	X	Annual report to provide assurance
Consultation / Engagement	Report shared across multiple safety groups within the Trust.		

Freedom of Information	Release without reference to the author
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Annual Report

HS Foundation Trust

Harrogate and District NHS Foundation Trust

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1. INTRODUCING OUR ANNUAL HEALTH & SAFETY REPORT

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The Annual Health & Safety Report reviews our performance and progress for the period 1st April 2025 – 31st March 2026 and will set out our key health and safety priorities for 2026-27.

This report demonstrates our commitment to provide an environment that promotes wellbeing and to make HDFT the best place to work. By providing a safe environment for staff and a positive safety culture it will positively impact on patient outcomes.

Welcome to the 2025-26 Annual Health and Safety Report.

In a change to our previous reports, the Annual Health and Safety Report will now cover the financial year reporting period. In doing so we will be able to use more current data to support this report, bringing it in line with other relevant reporting areas such as finance and HR, as well as externally with the publication of NHS staff Survey results, and HSE's Annual Statistics.

During the last 12 months we have continued to build on previous work to establish a robust health and safety system that benefits those who come in contact with HDFT as employees, patients, visitors and all others, whilst taking steps to foster a proactive cultural change in how we view health and safety across the organisation.

As with previous reports this will outline the data around our health and safety performance, whilst also detailing the work we have completed across the last 12 months to improve several priority areas.

In another change to previous versions there will be a significant addition, as we not only outline our priorities for the next 12 months, but also introduce the focus of what will be the first of its kind at HDFT, with our new HDFT 3 Year Health & Safety Strategy, which will be published in late 2026.

I can confirm that the Board of Directors has reviewed the 2025-26 Annual Health and Safety Report and can confirm that to the best of my knowledge, the information contained within this report is an accurate and fair account of our performance.

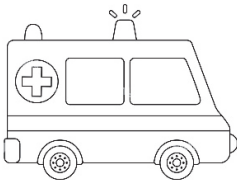
We hope that you enjoy reading this year's Health and Safety Report.

With best wishes



Jordan McKie
Director of Finance
Executive Lead for Health & Safety

2. ABOUT HDFT IN 2025-26

LARGEST EMPLOYER IN HARROGATE AND DISTRICT	OVER 5000 COLLEAGUES 	3 INTEGRATED CARE SYSTEMS AND 3 CLINICAL DIRECTORATES
c320,000 HOSPITAL CATCHMENT AREA 	c621,000 COMMUNITY SERVICES POPULATION 	c620,000 CHILDREN SUPPORTED 
£401 MILLION TURNOVER	60,000 EMERGENCY DEPARTMENT ATTENDANCES 	120,000 HOME VISITS 

3. OUR HEALTH & SAFETY SYSTEM / GOVERNANCE STRUCTURE

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The Health & Safety Team at HDFT is led by the Head of Health & Safety and supported by a Health & Safety Advisor (Acute) and Health & Safety Advisor (Community), and works closely with the Moving & Handling Co-ordinator, Fire Safety team and Security team. In addition to this 2026-27 will see the H&S team joined by the Trust Colleague Wellbeing Manager who will support the delivery of a Trust wide workstream focussed on work-related stress.

Supporting our strategic priorities to provide the best quality, safest care and making HDFT the best place to work, include our aim to excel in health and safety. Harrogate and District NHS Foundation Trust (HDFT) will accomplish this by continually seeking to improve our health and safety management system so that it meets with our vision, values and the expectations of those affected by what we do. We will ensure that our responsibilities for health and safety are clearly allocated, understood, monitored, fulfilled and that legal requirements will be regarded as the minimum standard to be achieved.

After major changes in 2023 to re-establish the key elements of a health and safety system appropriate for an organisation of our type and size, including a new Health & Safety Team, Health & Safety Committee, and clear governance structures for relevant Groups/Forums to report and escalate matters of concern, 2025-26 has been seen a number of minor changes to support our continuous improvement.

In addition to this we have:

- Continued to refine the membership and terms of reference for our recently established COSHH Steering Group, chaired by our Chief Pharmacist, and reporting to H&S Committee.
- Re-established the Electrical Safety Group through HIF and reporting to H&S Committee.
- Increased membership of the H&S Committee to now include staff representation from the Clinical Directorates and our Corporate Directorate.
- Reformed the Electrical Safety Group, Asbestos Safety Group and established a new HACCP Food Safety Group, all three of which will report and escalate through the HIFH&s Committee.

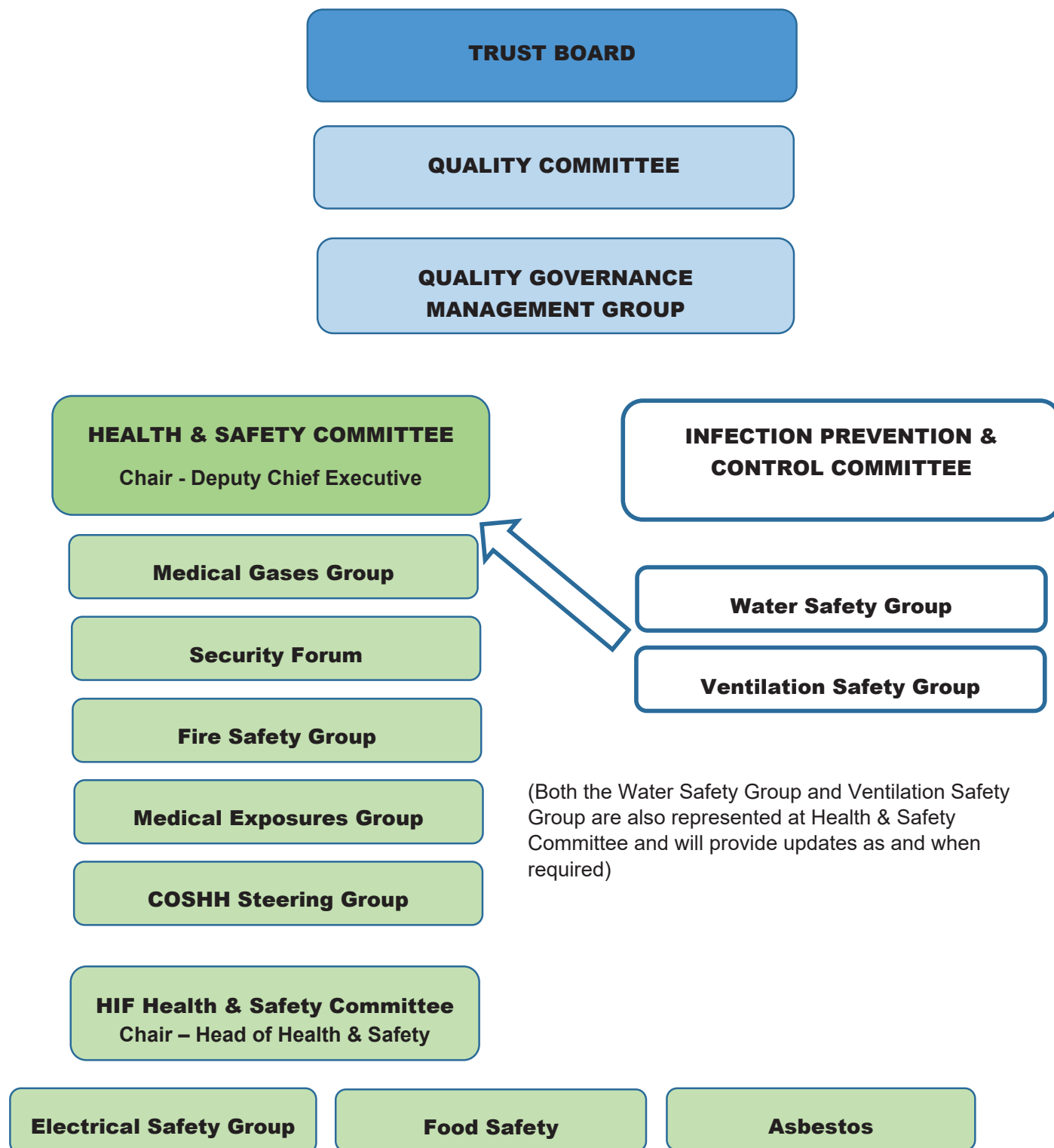
As stated in previous reports we continue to base our legal compliance, and establishing best practice in our H&S system in line with the following Healthcare approved publications:

- HSG65 Managing for Health and Safety (published by Health & Safety Executive) [Managing for health and safety \(HSG65\) \(hse.gov.uk\)](https://www.hse.gov.uk/hs65/)
- Workplace health and safety standards (published by the NHS Staff Council's HSWPG) [hswpg_workplace-health-safety-standards_may_2022_final.pdf \(nhsemployers.org\)](https://www.nhs.uk/hsmpg/workplace-health-safety-standards-may-2022-final.pdf)

Where appropriate these are supplemented by topic focussed guidance such as:

- The NHS Violence Prevention and Reduction (VPR) Standards
- The Terrorism (Protection of Premises) Act 2025: Statutory Guidance

HEALTH & SAFETY GOVERNANCE STRUCTURE 2025-26



4. HEALTH & SAFETY - THE DATA

The Trust must ensure that we do all that is reasonably practicable to comply with the Health and Safety at Work etc. Act 1974, and all regulation stemming from it, such as the Management of Health and Safety at Work Regulations 1999, Control of Substances Hazardous to Health Regulations 2002, and the Construction (Design and Management) Regulations 2015.

After upgrading our incident reporting system to DatixIQ in 2024 to support effective reporting of events and provide greater analysis of the data that is generated. Further analysis of the reporting sub-categories has resulted in a reduction in the number of these categories, and a simplification of the headings to further support staff in effective reporting.

These categories are detailed in the table below, whilst we still retain six legacy categories, the use of these over the last 6 months has virtually ended, and it is evident these will no longer be required by the end of the next financial year.

With the above changes and promotion of reporting **ALL** health and safety / security / violence and aggression incidents we are now gathering significant data that can be analysed and help inform the decisions we make in relation to health and safety at HDFT.

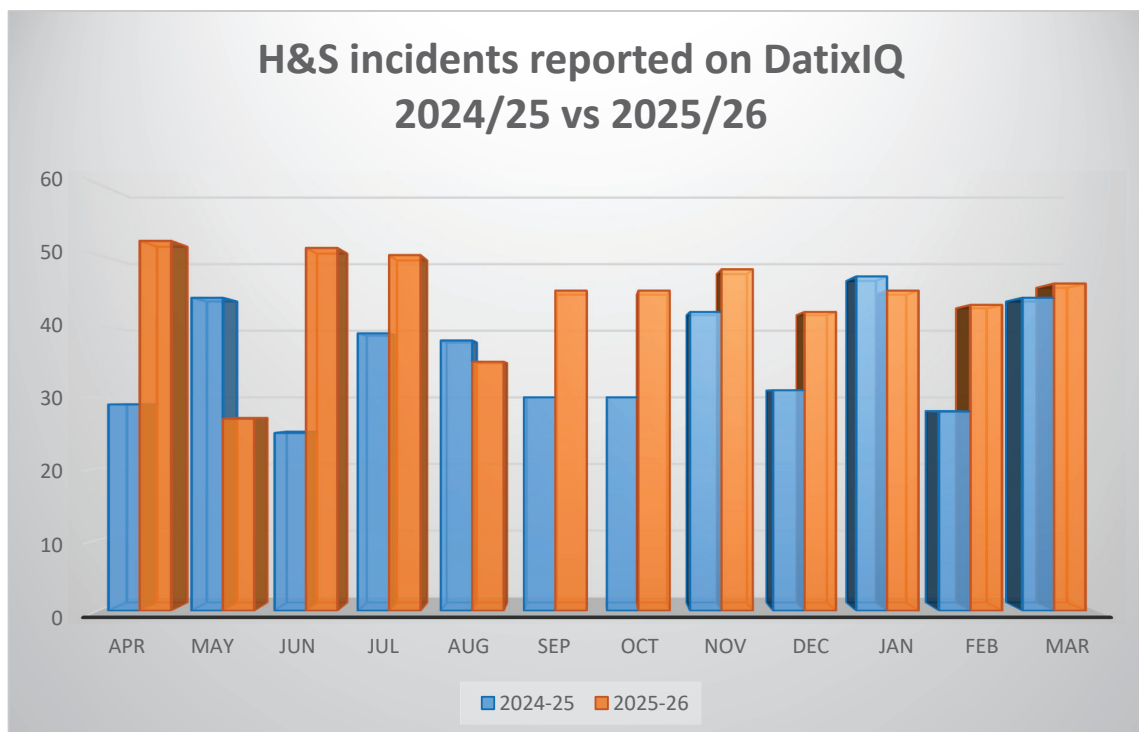
This data is now being used to inform health and safety metrics reported at Health & Safety Committee and is informing the use of HDFT Impact methodology to develop A3 thinking that will support improvement in line with the Trusts True North Ambitions.

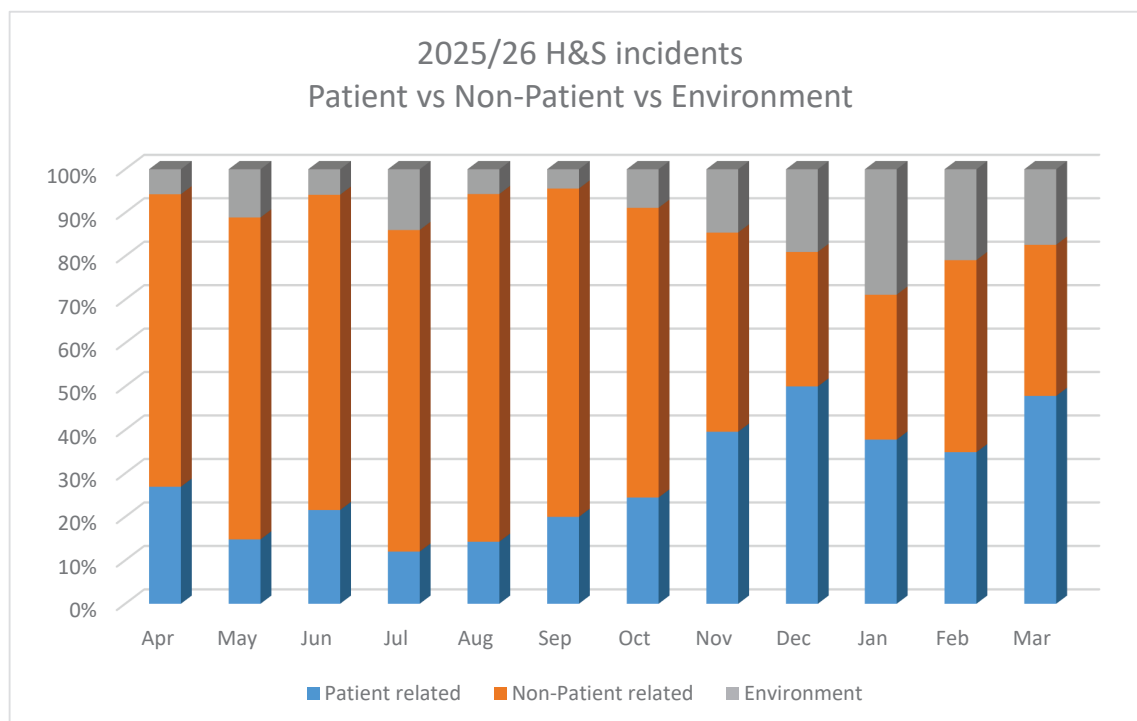
HEALTH & SAFETY INCIDENTS

	2024-25	2025-26
TOTAL NUMBER OF H&S INCIDENTS	483	557
STAFF, VISITOR OR OTHER RELATED	336	306
- ANIMAL BITE	8	8
- BANGS, BUMPS, TRAPS	34	27
- BURNS AND SCALDS	5	7
- SHARPS, CUTS, NEEDLESTICK (INCLUDING TRAY RETURNED WITH SHARPS IN SITU)	90	107
- EXPOSURE TO RADIATION, SUBSTANCES, BIOLOGICAL AGENTS OR BODILY FLUIDS	40	56
- CONTACT WITH MOVING MACHINERY / EQUIPMENT	8	9
- CONTROL OF SUBSTANCES HAZARDOUS TO HEALTH (COSH) INCIDENT	7	5
- MOVING AND HANDLING INJURY	27	37
- FAINT, COLLAPSE, OCCUPATIONAL ILL HEALTH	18	21
- ROAD TRAFFIC COLLISION	15	11
- SLIPS, TRIPS AND FALLS	81	44
- STRUCK BY MOVING OBJECT	3	5
PATIENT RELATED	73	154
- BANGS, BUMPS, TRAPS	22	43
- BURNS AND SCALDS	9	9
- CANNULA IN SITU	7	17
- CHEST OR NECK ENTRAPMENT IN BED RAILS	1	0
- FALL FROM POORLY RESTRICTED WINDOWS	0	1

- FAINT, FIT, COLLAPSE	22	40
- MOVING AND HANDLING OF PATIENT.	4	35
- SHARPS, NEEDLESTICK OR CUTS	8	9
ENVIRONMENT	18	69
- DAMAGE – ESTATES / PROPERTY	3	24
- SMOKE, FIRE, EXPLOSION	9	12
- TEMPERATURE	0	2
- UNSUITABLE WORKING ENVIRONMENT	6	49
LEGACY CATEGORY (PRE CHANGES TO DATIX)	56	28
- INJURY SUSTAINED BY PATIENT CIRCUMSTANCES UNKNOWN	21	6
- INJURY SUSTAINED BY STAFF / NON-PATIENT CIRCUMSTANCES KNOWN	13	11
- INJURY SUSTAINED BY STAFF / NON-PATIENT CIRCUMSTANCES UNKNOWN	7	1
- INJURY SUSTAINED WHILST BEING TRANSFERRED BY NON-STAFF	3	1
- INJURY SUSTAINED WHILST BEING TRANSFERRED BY STAFF	6	8
- INJURY SUSTAINED WHILST BEING TREATED BY STAFF	6	1

Health and safety incidents are now gathered in 3 main categories of Patient related, non-patient related and environment, with a much-reduced number of sub-categories that will provide a meaningful volume of data, and going forward allow a further breakdown based on certain criteria such as Directorate, Care Group etc...





The first 7 months of 2025-26 clearly showed (chart above) that most of our health and safety incidents were happening to staff, visitors or others, however the final 5 months have shown a trend of a more even split between the 3 categories, and particularly an increase in incidents involving patients.

Action for 2026-27: Further analysis of this trend to identify the areas creating this perceived increase in risk to patients.

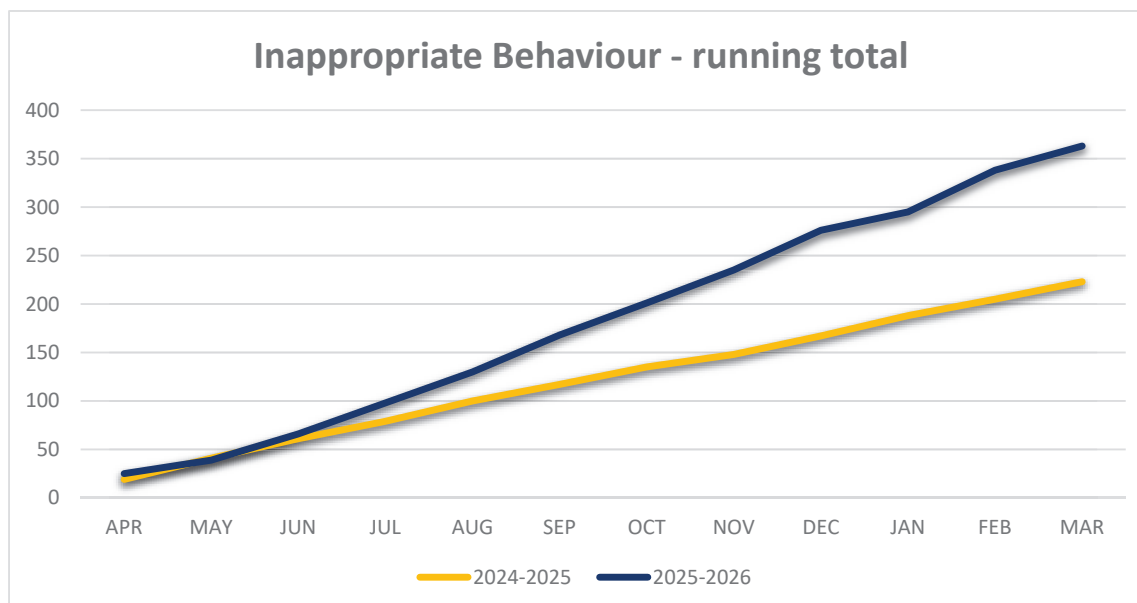
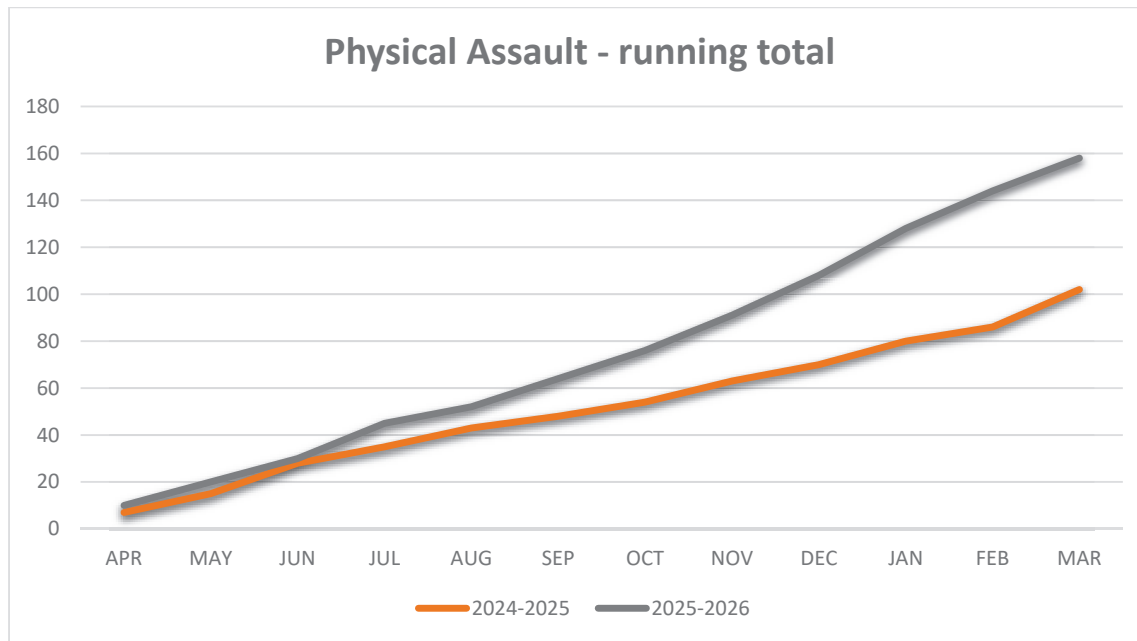
SECURITY / VIOLENCE & AGGRESSION INCIDENTS

Unlike the minor increase we have seen in the reporting of health and safety incidents during 2025-26, the same period has shown a significant rise in the number of violence and aggression incidents reported.

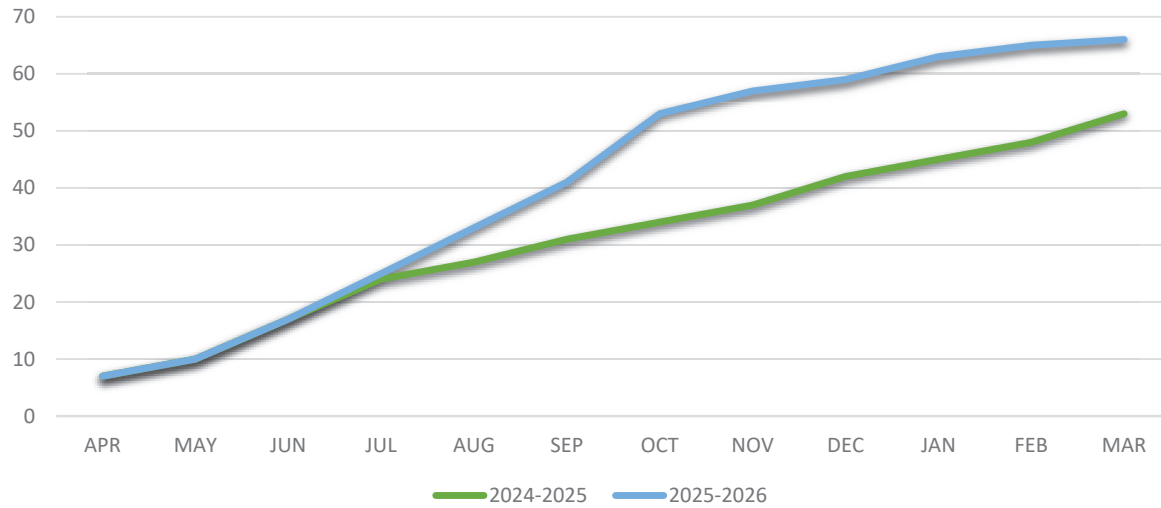
The increase can in part be attributed to successful promotion to staff of the need to report and no longer tolerate the circumstances, however it would be wrong to ignore that such a significant rise in numbers also suggests an increased level of risk.

	2024-25	2025-26
TOTAL NUMBER OF SECURITY INCIDENTS	495	772
SPECIFIC V&A CATEGORY	378	588
- PHYSICAL ASSAULT	102	158
- INAPPROPRIATE BEHAVIOUR	223	363
- VERBAL ABUSE	53	66
- SEXUAL ABUSE	0	1
OTHERS	163	184
- ABSCONDING PATIENTS	66	77
- ALCOHOL / DRUGS / WEAPONS	4	7

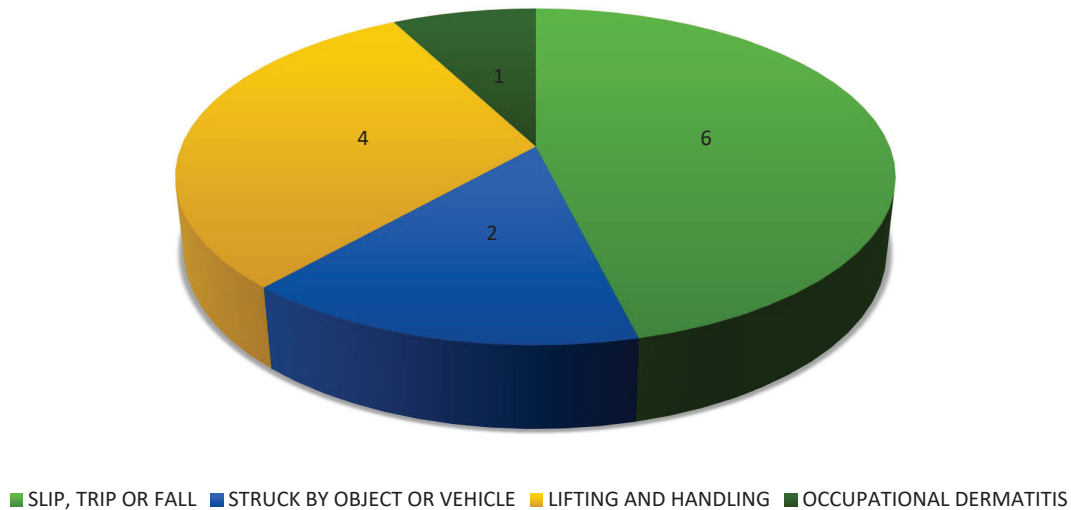
- BOGUS STAFF OR COMMUNICATION	4	5
- CONCERNS RELATING TO RADICALISATION	2	3
- DAMAGE TO TRUST PROPERTY	7	0
- DISRUPTIVE BEHAVIOUR	0	7
- LACK OF IDENTIFICATION OR ADHERENCE TO SECURITY POLICIES	0	2
- LONE WORKER IN COMMUNITY SETTING	0	7
- SELF-HARM (INCLUDING ATTEMPTED SUICIDE)	14	33
- THEFT OR LOSS OF PERSONAL BELONGINGS	22	17
- THEFT OR LOSS OF STAFF BADGE	33	18
- THEFT OF TRUST PROPERTY	11	8



Verbal Abuse - running total



RIDDOR incidents 2025-26



	2025-26	ACUTE SETTING	COMMUNITY SETTING	2024-25
TOTAL NUMBER OF RIDDORS	13	9	4	17
SLIP, TRIP OR FALL	6	3	3	7
STRUCK BY OBJECT OR VEHICLE	2	2	0	3
BURN	0	-	-	1
PHYSICAL ASSAULT	0	-	-	4
LIFTING AND HANDLING	4	3	1	2
OCCUPATIONAL DERMATITIS	1	1	0	0

2025-26 has seen a positive reduction in RIDDOR incidents for the year in comparison to 2024-25. The category of RIDDOR also highlights the reasoning behind some of our priority areas (from the 2024 Annual Report) of moving and handling and slips, trips and falls.

All RIDDOR incidents are investigated by the health and safety team, with findings shared both with the local team / department and with the wider Trust through both the Trust H&S Committee and HIF H&S Committee.

The cost of these incidents and in particular RIDDOR continue to rise and the estimated costs to the Trust are detailed in the following tables.

Estimated costs (based on HSE 2024 analysis across all industries / 2023 figure in brackets)

TYPE OF INCIDENT	FINANCIAL COST (PER INCIDENT)
WORKPLACE FATAL ACCIDENTS*	£553,000 (£119,200)
NON-FATAL INJURIES	
• 7 OR MORE DAYS ABSENCE*	£16,600 (£7,800)
• UP TO 6 DAYS ABSENCE	£740 (£120)
ILL HEALTH	
• 7 OR MORE DAYS ABSENCE*	£23,000 (£9,200)
• UP TO 6 DAYS ABSENCE	£810 (£170)

Estimated total cost to Health and Social Care Industry in 2023-24 £3.1 billion (ill health), £0.8 billion (injury)

SICKNESS ABSENCE DATA 2025-26

With the change to the reporting period for the H&S report we can now directly measure this against our annual sickness absence figures. In the table below we can see that while there has been a relatively small increase in the average monthly absence rate for anxiety, stress and depression, there has been a significant increase in the actual number of monthly absences and the number of FTE days lost.

Whilst concerning, this data for the last two reporting periods supports our efforts to look directly at the causes of work-related stress and begin to implement changes in how this area of risk is managed across the Trust. (Detail provided in section 5 Health & Safety Workstreams)

As with the 2024-25 data, back problems and other musculoskeletal ill health continue to be an area of concern which is of course supported by the number of DatixIQ incidents relating to moving and handling

HDFT's number one sickness absence reason for each month of 2025-26 was anxiety / stress / depression / other psychiatric illnesses, a repeat of 2024-25.

It is common for anxiety/stress to be a combination of personal and work issues, and it is therefore difficult to identify where the individual is absent primarily due to personal or work, similarly MSK or back problems developed during personal activities may be made worse by poor work practices or workstations that have not been assessed to comply with the Display Screen Equipment Regulations.

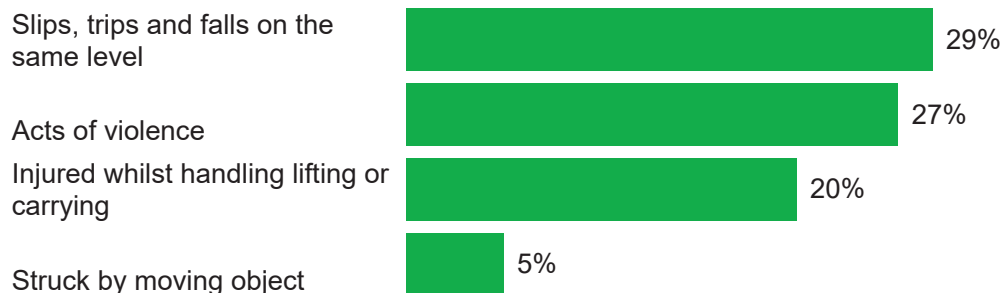
Absence Reason	Average no. of absences per month*	Total FTE Days Lost*	Average % of HDFT sickness absence per month*	Estimated salary cost*
Anxiety/stress/depression/other psychiatric illnesses	165 (130.8)	30,357.4 (24,121)	33.9% (30.3%)	£3,674,012 (£2,766,148)
Other Musculoskeletal	48 (45.5)	6181.8 (5671.9)	7% (7.2%)	£758,645 (£657,302)
Back problems	29 (26.4)	3014.1 (3250.8)	3.3% (4.1%)	£357,647 (£374,297)

(*2024-25 data in brackets)

Total Trust Sickness Absence Cost (Salary only)	Anxiety/stress/depression/other psychiatric illnesses	Other Musculoskeletal / Back Problems
2025-26 £10,837,795	£3,674,012 – 33.9%	£1,116,292 – 10.3%
2024-25 £9,129,203	£2,766,148 – 30.3%	£1,031,599 – 11.3%

HSE KEY FIGURES FOR GREAT BRITAIN 2024 TO 2025

- 1.9 million working people suffering from a work-related illness, **255,000 in human health / social care**, of which
- 964,000 workers suffering work-related stress, depression or anxiety – **134,000 in human health / social care**
- 511,000 workers suffering from a work-related musculoskeletal disorder – **52,000 in human health / social care**
- 124 workers killed in work-related accidents – **4 in human health / social care**
- In Human health and social work activities there were 11,157 non-fatal injuries to employees reported by employers under RIDDOR in 2024-25.
 - 2,499 (22%) were specified injuries, 8,658 (78%) were injuries resulting in the incapacitation of a worker for over seven days
- In Human health and social work activities around 5.6 million working days (full-day equivalent) were lost each year due to RIDDOR workplace injury (7%) and work-related illness (93%) at a cost of 3.9billion.
- Percentage of non-fatal injuries (RIDDOR) by accident kind in human health and social care:





HDFT NHS STAFF SURVEY RESULTS 2025

In the last 12 months have you experienced musculoskeletal problems as a result of work activities? – Yes 36.4%
(2024 – 27.2% / Comparator – 41.1%)

In the last 12 months have you felt unwell as a result of work-related stress? – Yes 39.6%
(2024 – 40.9% / Comparator – 42.9%)

In the last 3 months have you ever come to work despite not feeling well enough to perform your duties? – Yes 49.9%
(2024 – 52.6% / Comparator – 56.1%)

Have you felt pressure from your manager to come to work in the last 12 months? – Yes 14.3%
(2024 – 15.8% / Comparator – 20.6%)

In the last 12 months have you experienced at least one incident of physical violence at work? – Yes 9%
(2024 – 9% / Comparator – 13.9%)

The last time you experienced physical violence did you or a colleague report it? – No 38.2%
(2024 – 36.8% / Comparator – 40.4%)

In the last 12 months have you experienced at least one incident of harassment, bullying or abuse at work from patients, relatives or MoP's? – Yes 18.3%
2024 – 19.5% / Comparator – 25%

The last time you experienced harassment, bullying or abuse did you or a colleague report it? – No 49.3%
2024 – 46.6% / Comparator – 50.9%

In the last 12 months have you experienced at least one incident of harassment, bullying or abuse at work from managers? – Yes 6.5%
2024 – 7.7% / Comparator – 9.3%

In the last 12 months have you experienced at least one incident of harassment, bullying or abuse at work from colleagues? – Yes 14.7%
2024 – 14.7% / Comparator – 17.7%

5. HEALTH & SAFETY WORKSTREAMS 2024

This section of the Annual Health and Safety Report provides an update on:

- Work to comply with H&S Legislation and support HDTF's strategic ambitions.
- Work in high-risk areas, or those with significant non-compliance (in relation to health and safety legislation).
- Work to address health and safety risks added to the Trust Health and Safety Risk Register

2025 PRIORITY WORKSTREAM - WORK-RELATED STRESS

Strategic Ambition Making HDFT the Best Place to Work

Aims for 2026-27

Analysis of the NHS Staff Survey results for 2025 continues to support the need for the implementation of the HSE Management Standards Approach across the Trust, through the delivery of department / team work-related stress sessions. We will also continue to prioritise work to reduce the impact of common causes of stress within the NHS, violence and aggression and musculoskeletal disorders.

Work-related Stress

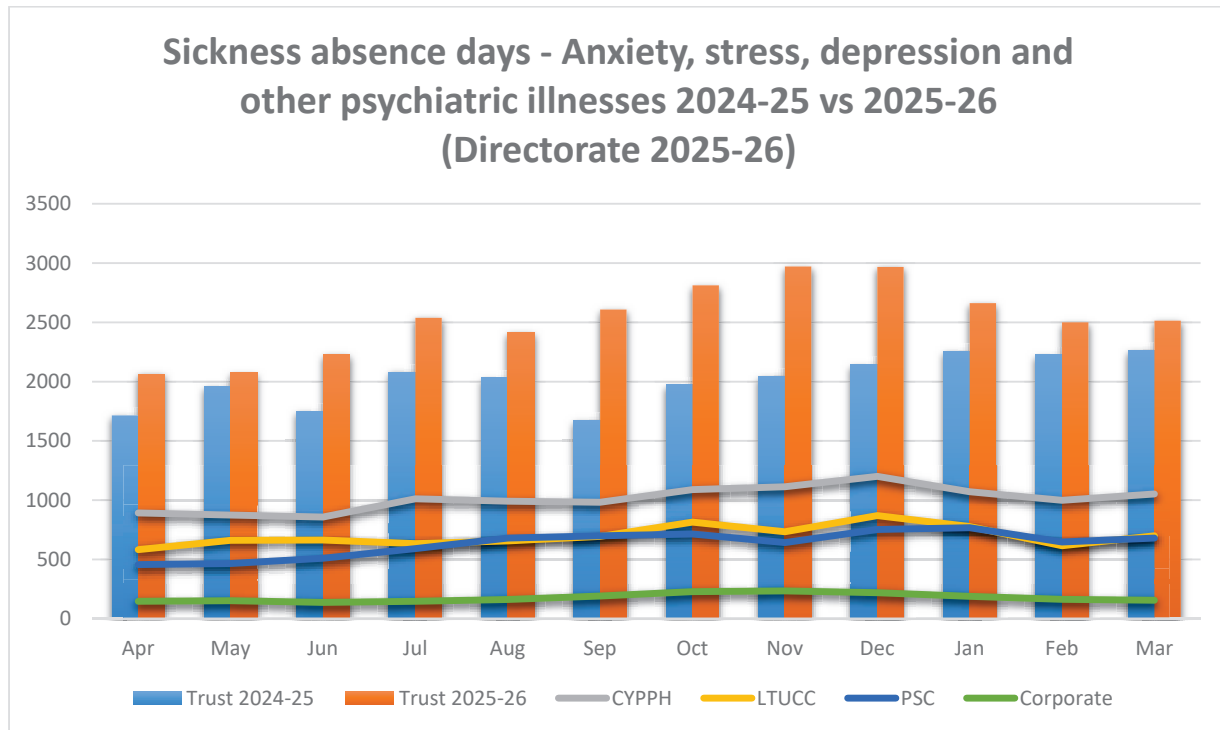
Standard	The Trust has effective arrangements in place to manage the risks related to work-related stress, with a focus on proactive prevention.
Rationale	The combined demands of work and home-life may result in staff at all levels being exposed to adverse levels of pressure / stress, leading to short and long-term episodes of ill health, increased sickness absence, lower staff morale and poor patient care.
Legal reference	Health and Safety at Work etc. Act 1974 Management of Health and Safety at Work Regulations 1999

What action has been taken in 2025-26

Anxiety, stress and depression continues to be the top sickness absence reason across the Trust in 2025-26, accounting for 33.9% (monthly average, compared to 30.3% in 2024-25).

This clearly remains the largest cause of ill health for staff at HDFT and is again supported by the HSE statistics and costs detailed in section 4.

The NHS Staff Survey results for 2025 showed a small decrease to 39.6% of staff who have felt unwell as a result of work-related stress in the last 12 months in comparison to 40.9% in 2024. However, our key sickness absence statistics for this period not only show an increase in the monthly absence percentage, but a significant increase in the actual number of FTE days lost, increasing from 24,121 to 30,357. As such we continue prioritising the identification of stressors at HDFT.



During 2025-26 we have:

- Delivered work-related stress sessions across the Trust to develop local risk assessments.
- 2025-26 has seen half and full day sessions delivered to:
 - Finance team
 - Operational HR team
 - Referral to Treatment team
 - x3 sessions for Theatres staff
 - x3 sessions for Imaging Service staff
 - 15+ Community team sessions
- Continued to deliver work to reduce the risk associated with two main stressors in healthcare settings – Violence and Aggression and Musculoskeletal Disorders has been targeted. (This work is detailed on pages 16-21)

2026-27 will see us continue to:

- Deliver sessions to teams based on the Management Standards Approach, sessions will continue with teams in Main Theatres, Day Surgery Unit, Imaging Services, and our community-based teams in Cumberland, Westmoreland and Furness, Sunderland and Durham.
- Planning is also underway to provide sessions for our Pharmacy teams and clinical teams based on our acute wards.
- To support enhanced delivery of the work-related stress sessions, the Trust Wellbeing Lead will be seconded to the H&S team for an initial period of 2 years to provide targeted resource for this work.

2025 PRIORITY WORKSTREAM - MOVING AND HANDLING

Strategic Ambition Best Quality & Safest Care / Making HDFT the Best Place to Work

Aims for 2026-27

Continue to create task specific assessments across all areas of the Trust and support this with tailored training and equipment. Additional work will be focussed on the use of lifting aids in patient care.

Moving & Handling

Standard	Effective arrangements are in place to manage the risks from manual handling, both patient and non-patient related activities.
Rationale	All staff are exposed to certain manual handling activities, whether it be moving equipment, laundry, office supplies or waste to assisting in the movement of patients. Injuries and ill health relating to manual handling account for a significant amount of sickness absence at HDFT.
Legal reference	Health and Safety at Work etc. Act 1974 Management of Health and Safety at Work Regulations 1999 Manual Handling Operations Regulations 1992 Provision and Use of Work Equipment Regulations 1998 Lifting Operations and Lifting Equipment Regulations 1998

What action has been taken in 2025-26

The year has seen a significant increase in DatixIQ reporting relating to moving and handling, with the changes to our reporting categories highlighting that this predominately relates to incidents involving the moving of patients. In addition, there have been for moving & handling related RIDDOR notifications, an increase on the previous 12 months.

As with previous years compliance levels for level 2 training have fluctuated between 80% and 85% and reinforces once again the challenges in being able to increase and maintain this figure without additional training resource.

- Level 1 e-learning training remained over 95% for 2025-26.
- Regular review of training means that we have continued to deliver tailored training to multiple clinical and non-clinical teams. This has included:
 - Team training delivered on Wards as part of routine patient care.
 - On-the-job training for our transportation team, challenges as part of their delivery work.
 - New drop-in sessions delivered over the year focussing on specific moving and handling equipment.
 - Moving & Handling Co-ordinator nominated for a national award for innovation in delivery training.
- Individual staff DSE assessments continue to be supported by the H&S and Occupational Health teams, identifying reasonable adjustments and supporting equipment use.
- Work has been ongoing in identifying and creating ease of access for clinical staff to obtain bariatric equipment, and its safe use.

- We continue to expand the creation and use of task specific moving and handling risk assessment templates. This has resulted in multiple tasks being made safer, including the installation of anti-slip flooring on the ramp to the CT scanner, reducing the risk to staff whilst moving patients.

The following task specific assessment within our Domestics team has resulted in the purchase of motorised trolley pullers to reduce the risk of injury from moving the linen cages around site.

PUSHING AND PULLING MOVING AND HANDLING ASSESSMENT FORM

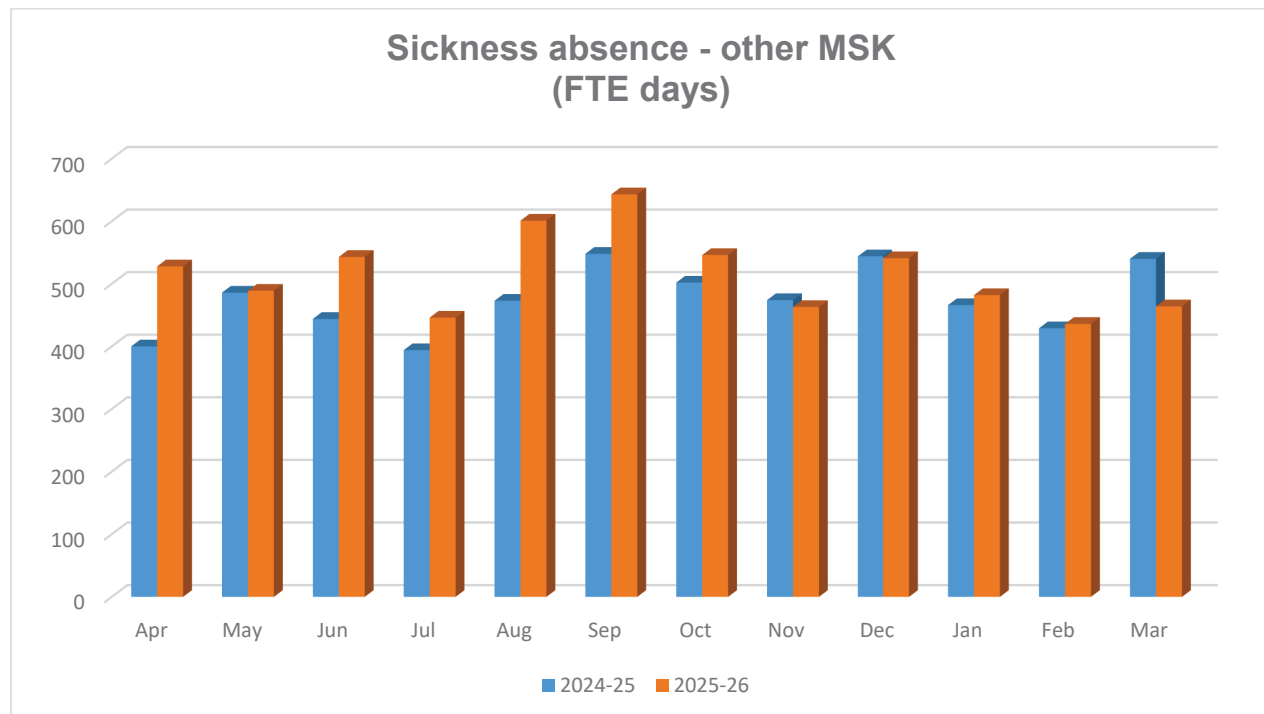
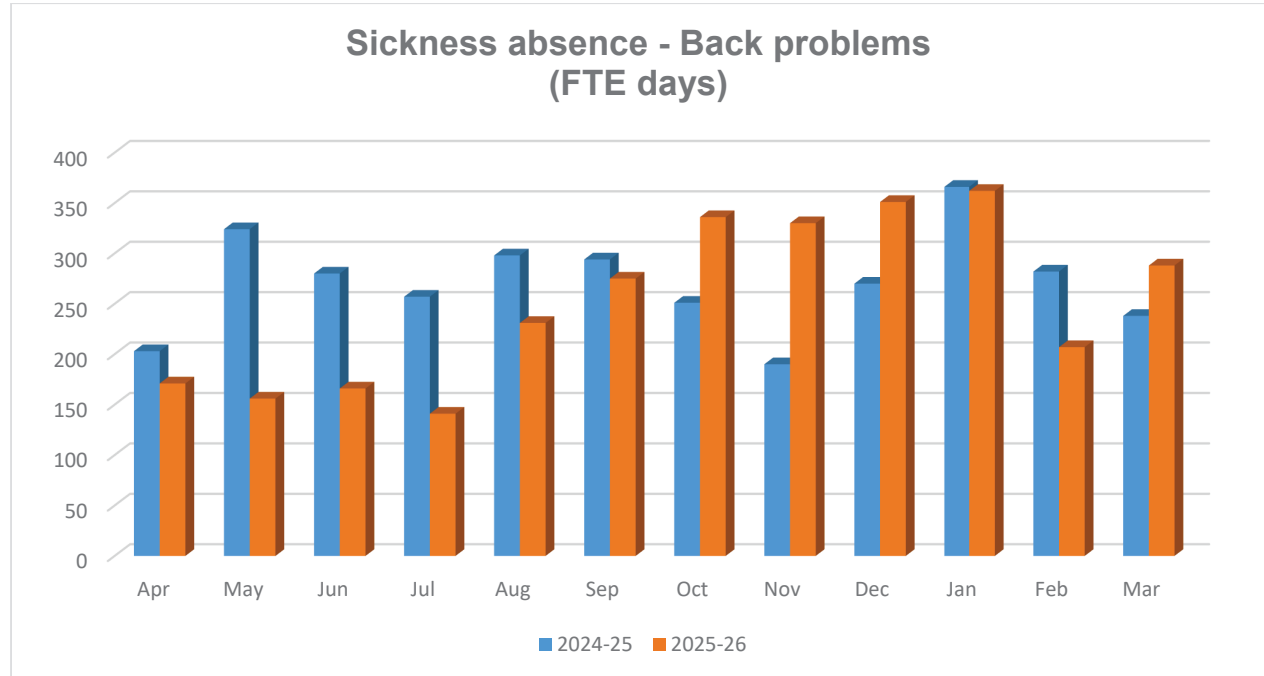


Locality									
Building(Please tick): Harrogate Hospital Site ☒ Other Trust Site ☐ Non-Trust Site ☐ Community ☐									
Department		Domestic & Linen		Location		HDH		Speciality	
The Activity									
Description of Activity: (Include details of weight and distances)	Distribution of linen and moving cages with linen around hospital.								
	- Line cages will be transported(pulled) using a towing machine to reduce manual handling. - Staff will need to push/pull cages slightly to align and attach them to the towing tractor.								
Who will be undertaking this activity?	Linen staff			Are other manual handling tasks carried out by these members of staff?		Yes	No	Risk Assessment discussed with members of staff?	
Can the task be avoided by:									
Amending work procedures Yes ☐ No ☒ Rearranging the work space Yes ☐ No ☒ Mechanisation of the process Yes ☒ No ☐									
If 'Yes' above, and task can be avoided, specify how here, ensure implementation, and sign the form at the end of the document. No further sections need completing.									
If 'No' above, and activity is to be undertaken, continue the assessment in the following sections.									
If there are any diagrams or photographs of the activity, please insert them here:									
									

During the last 12 months we have also started a review of the use of specific lifting equipment, patient hoists. This has focussed on the maintenance of the hoists to ensure they are safe for both patient and staff, and the availability of hoists when needed.

This has shown a number of challenges which will require further investigation and remedial action over the next 12 months.

Sickness absence days related to back problems and other musculoskeletal injuries continue to be in the top 10 absence reasons on a monthly basis, the following two tables outline the current figures in comparison to the previous 12 months.



In 2026-27 we will continue:

- Tailored changes to training to provide task specific content relevant to the staff being trained.
- Review and implement task specific moving and handling risk assessments to all teams across the Trust.
- Review of Medical Devices, including patient lifting aids to ensure all equipment is suitably maintained, serviced and where appropriate inspected (regulatory requirement). This will include improvements to asset management and instruction to staff.
- H&S team will continue to work closely with the clinical leads and Falls Strategy Group to support safe recovery of patients post fall, in particular the availability of equipment and ease of access for staff.

2025 PRIORITY WORKSTREAM – VIOLENCE & AGGRESSION

Strategic Ambition Best Quality & Safest Care / Making HDFT the Best Place to Work

Aims for 2026-27

To build on previous years, including focus on V&A SOPs relating to specific care pathways (such as dementia, mental health and substance dependency), lone working in our community teams, management of high-risk patients.

Violence & Aggression, Security & Lone Working

Standard	Effective arrangements in place to manage the risks associated with violence and aggression.
Rationale	A safe and secure working environment provided to all, no matter the location. That the Trust ensures that neither it or any of its staff accept or tolerate incidents of violence and aggression and that measures, including adequate security and lone working procedures are in place to prevent and reduce risk.
Legal reference	Health and Safety at Work etc. Act 1974 Management of Health and Safety at Work Regulations 1999

What action has been taken / planned

2025-26 has continued to see a significant increase in the number of events relating to violence and aggression being reported via DatixIQ, in particular the categories of physical assault and inappropriate behaviour.

	2024-25	2025-26
PHYSICAL ASSAULT	102	158
INAPPROPRIATE BEHAVIOUR	223	363

Whilst this trend is of concern, we must still consider the impact of the promotion and encouragement to staff to report these incidents and no longer tolerate as just part of the job, and feedback from teams indicates that this continues to be relevant.

2025-26 has seen us continue to develop in line with the 2024 Health and Safety Executive findings around violence and aggression: Risk Assessment, Training, Roles & Responsibilities, Monitoring & Review and the reluctance to report violence & aggression incidents.

In addition, we have:

- Actively attend partnership groups to improve joined up working and access to best practice. This has included attendance at the North Yorkshire Right Care, Right Person Group led by North Yorkshire Police. Attendance at the NPAG (National Performance Advisory Group) Violence Reduction & Security Management Network, and new in 2025-26 become a member of the new NHSE Regional VPR Network meetings.
- Attendance at these has allowed us to gain valuable best practice solutions from other NHS Trusts and has also allowed to address specific issues with North Yorkshire Police in relation to incidents on the HDH site and high-risk patients.
- The Trust Lone Working Policy has been amended to reflect an identified risk for community-based staff in dealing with dangerous animals.
- Level 1 eLearning training, mandatory for all HDFT staff, compliance has remained over 97% all year.
- Lone worker training provided to all Community based staff; compliance has remained over 96% all year.
- Area specific violence and aggression risk assessments continue to be developed for departments and teams across the Trust.
- Upgrades to the door access system continue to be made area by area, as part of wider refurbishment work (AMU, Bolton, Silverdale).
- Additional funding has been secured to deliver Conflict Resolution: Breakaway Skills training to approximately 200 additional staff. This began in the final quarter of 2025-26 and will continue in 2026-27.
- On site security (external contractor) presence at the HD site (to provide cover 24/7 Friday - Monday and nighttime cover Tuesday – Thursday) continued through 2025-26. Work then began on the creation of an in-house security team, managed through HIF, that will provide a 24/7 security presence at the HDH site from June 2026.
- Joint working between the H&S team, Security Manager and the Safeguarding team led to the development of a new operational document to be used in the management of high-risk patients, ensuring a more consistent approach to controlling risk, and providing staff with suitable instruction and assurance.

2026-27 will see us:

- Deliver a new in-house security team at the HDH site, this will allow for 24/7 support to staff, patients and others, including:
 - Structured patrols of the site.
 - Security staff trained in appropriate restraint techniques.
 - Direct liaison and support to the Police.

- Work has started in 2025-26 to develop a series of SOPs to support work on violence & aggression and provide a consistent approach for staff, and these will be delivered during 2026-27. They will include:
 - Managing Patients with Dementia, Delirium, Mental Health issues, Substance Dependency.
 - Yellow and Red Card escalation process in response to incidents of violence and aggression.
 - Escalation process for Security support / response.
 - The SOPs will be clinically led and focus on prevention and de-escalation
- We will ensure violence and aggression risk assessments are produced for all departments and wards at the HDH site, and that security assessments are in place for all our community locations.
- The passing into law of The Terrorism (Protection of Premises) Act 2025 (Martyn's Law), will result in the publishing of new statutory guidance on how this will be implemented across public spaces. In 2026-27 we will review the guidance and assess what and where action needs to be taken for the Trust to be compliant, both for premises owned by the Trust and supporting staff who work at other locations.

2025 PRIORITY WORKSTREAM - PHYSICAL WORKING ENVIRONMENT

Strategic Ambition Best Quality & Safest Care / Making HDFT the Best Place to Work

Aims for 2026-27

The aim for 2026-27 continues to be the improvement of our physical working environment through addressing the backlog maintenance position as well as identifying and controlling risk associated with fire, water safety, RAAC and others.

Estates / Backlog Maintenance

Standard	Effective arrangements in place to manage the risks associated with the physical workplace environment, and the provision of suitable welfare conditions.
Rationale	The hazards of workplace environments, such as asbestos, legionella, electricity, poor welfare (toilets, hand basins), temperature, or icy walkways can put staff, patients and others at risk of injury.
Legal reference	Health and Safety at Work etc. Act 1974 Management of Health and Safety at Work Regulations 1999 Workplace (Health, Safety and Welfare) Regulations 1992 Construction (Design and Management) Regulations 2015 Control of Substances Hazardous to Health Regulations 2002 Control of Asbestos Regulations 2012 Electricity at Work Regulations 1989

What action has been taken / planned

Management of our estate and improvements to our physical environment continue to be based on the recommendations of the backlog maintenance survey carried out in 2022/23, and the in-

year review of this position in relation to Critical Infrastructure Risk (CIR) and Non-Critical Infrastructure Risk (NCIR).

Our CIR backlog relates to four key areas:

- Fire Safety: fire alarms, compartmentation.
- Theatre Refurbishment: Main Theatres 1-5, DSU and Delivery Suite.
- Mechanical & Electrical Infrastructure: AHUs, equipment, pipework, bed head services, UPS.
- Building and Environment: road surfacing, roofing, gutters, windows, doors, flooring.

Fire safety was the primary focus of backlog investment in 2025-26, with additional works delivered targeting the highest-priority CIR elements across the site.

Main schemes completed in 2025-26:

- **Fire Alarm Systems** - Design of addressable detection and alarm systems, installation of new backbone fire alarm loop and front-end panel. Works completed March 2026
- **Fire Doors & Hardware** - Replacement of non-compliant doors with 30/60-min rated assemblies' devices. Phase 1 (Main site Ground Floor circulation corridors and stairwells) completed April 2026.
- **Emergency Lighting Installation** - Emergency lighting installation and Replacement carried out at 26 WRD and on Nidderdale ward. Works completed February 2026.
- **Ward Refurbishment (Littondale)** - Fire alarm, fire doors and other fire elements. Works completed as part of wider refurbishment of the whole environment.

Over the next 12 months we will continue with the Ground Floor corridor fire door installation and begin the fire alarm phase 2 (subject to funding), whilst also finalising the design and logistics planning in relation to Theatres refurbishment.

In addition to the CIR works, further Capital Projects have started, continued or been completed during 2025-26:

- Construction of the new Theatres and Imaging Wing (TIF2) continues to progress through the build and commissioning phases, to provide new theatre capacity and Imaging Services Department by late 2026 / early 2027.
- Completion of upgrades to the main site kitchens.
- Reinforcement work to the steel columns supporting the Ambulance Bay canopy. Completed March 2026.
- Resurfacing of the visitor multi-storey car park top deck. Completed April 2025.

Water and Ventilation Safety

Critical Ventilation System Verifications:

Critical ventilation systems are required to support critical clinical activity whereby failure of the ventilation system would potentially have a significant detrimental effect on patient and staff safety. Annual verification of each critical ventilation system is required, and the Ventilation Safety Group has a schedule for ensuring all systems are verified every 12 months. The verification is undertaken by an external specialist company with verification reports initially reviewed by the Estates Mechanical Officer, Authorising Engineer for Ventilation and a representative from Infection Prevention and Control.

Actions from the verification reports have been captured and reviewed at the Ventilation Safety Operational Group meeting. Items are discussed by exception at the Quarterly Ventilation Safety Group Meeting.

In addition:

- Estates have completed a review of LEV systems, to provide an annual verification scheme.
- Drafted a new Ventilation Management Plan, which will be agreed and progressed in 2026-27.

Water Safety Audits and Risk Assessments:

- 6-monthly audits continue to be conducted by our Authorising Engineer, with our last 2 audits providing Substantial overall assurance.
- Annual Pseudomonas Risk Assessments have been completed in February 2026 for 7 augmented care areas.
- Legionella Risk Assessments have been completed across the main site, as well as for satellite buildings, including SROMC, Lascelles and 26 Wetherby Road.
- Strayside flushing regimen - All outlets in non-augmented care areas are routinely flushed twice weekly by facilities staff. Two years ago, issues with temperature control were identified in Strayside wing. As mitigation, flushing of Strayside wing outlets was increased too once daily. Remedial works have now taken place to improve temperature control in this area. Work is underway to acquire satisfactory evidence that flushing can be returned to twice weekly.
- Water cooler machines - are to be phased out and replaced with stainless steel drinking waterspouts. The new drinking water outlets will be placed according to an IPC risk assessment (based on available access to drinking water in the area). A cost plan has been approved. The enablement works are largely complete. Procurement of the new stainless-steel spouts is now underway. Once procured and delivered they will be fitted and the old cooler machines removed.
- Thermostatic Mixing Valve Placement Strategy - Thermostatic mixing valves (TMV's) are scald prevention devices which automatically stop very hot water coming out of taps and showers. Whilst effective at preventing scalding they increase the risk of microbial proliferation and therefore infection. To date the Trust hasn't had a written risk assessed strategy for placement of TMV's balancing both the need for scald prevention with infection prevention. A strategy has now been written and approved by the Health and

Safety Committee. Implementation for the time will be via new schemes and outlets where the TMV has failed its 6-monthly test.

Management of RAAC

Standard	Effective arrangements in place to manage the risks associated with the physical workplace environment
Rationale	To manage, monitor and mitigate the risks associated with the uncontrolled collapse of RAAC (Reinforced Autoclaved Aerated Concrete), and ultimately eradicate the presence of RAAC from HDFT premises (owned and
Legal reference	Health and Safety at Work etc. Act 1974 Management of Health and Safety at Work Regulations 1999

What action has been taken / planned

We have continued to carry out remedial work to mitigate against the risk of RAAC panels collapsing, and ultimately the eradication of all RAAC panels from the HDH site.

In 2025-26 we have delivered:

- Annual surveying of the HDH site by a structural engineer was completed, including both visual and deflection surveys.
- Completion of safety netting within the Energy Centre.
- Eradication of RAAC on the Water Tank room and Swaledale Fire Escape
- M&E designs and sequencing programme developed for all remaining RAAC areas, starting with the eradication of RAAC from the back Estates area of site.
- To facilitate this a refurbishment of 50LPR (including the removal of asbestos containing materials) has commenced to provide an office decant facility.

Work will now continue to look at the wider eradication of RAAC from the HDH site, with design, decanting strategies and logistical operational planning to be confirmed, to ensure the Trust is able to meet the NHSE target of full eradication by 2035.

2025 ADDITIONAL WORKSTREAMS

Fire Safety – Assessment, Control Measures & Evacuation

Standard	To manage the risks associated with Fire.
Rationale	To allow the Trust to carry out a suitable assessment of the risk from fire and implement reasonably practicable control measures, develop appropriate evacuation plans, and provide suitable information, instruction and training to all affected.
Legal reference	Health and Safety at Work etc. Act 1974 The Regulatory Reform (Fire Safety) Order 2005 Management of Health and Safety at Work Regulations 1999

What action has been taken / planned

The identification and management of risk associated with fire remains on the H&S Risk Register and escalated to the Executive Risk Group. However, changes have been made to separate the risk into two risk entries: 1. Fire Infrastructure – fire alarm, fire compartmentation, 2. Fire Assessment, Policies and Procedures. This will allow for more focussed delivery of the separate areas, with the infrastructure risk being managed through the Backlog Estates work (as detailed above), and the assessment and policy work being progressed by the Fire Safety Manager and H&S team.

- The Fire Safety Manager continues to review existing Fire Risk Assessments for all areas at HDH and is completing new assessments where appropriate, i.e. for the newly refurbished AMU ward. This includes a review an escalation, where appropriate, of outstanding actions when the last assessment was carried out (or reviewed).
- New Extinguisher training being provided to staff across the Trust.
- We have now provided several staff with training so that they can in turn train staff in the use of evacuation chairs. Delivery of this training has already started for both acute and community-based staff.
- The H&S team continue to progress the creation of new Fire Risk Assessments for all community locations as well as newly acquired premises.
- A new Emergency and Evacuation Procedure has been developed to support the general Fire Safety Policy, along with action cards provided to all patient areas for completion in supporting area specific evacuation plans.

Control of Substances Hazardous to Health (COSHH)

Standard	Effective arrangements in place to manage the risks from substances hazardous to health.
Rationale	Hazardous substances including both chemical and biological agents can cause significant ill health to employees, patients, and others. Examples include: • Exposure to blood borne viruses, such as HIV, Hep B and C, from handling bloods • Exposure to wet work, causing skin diseases such as dermatitis • Handling of chemicals such as formaldehyde and cytotoxic drugs • Handling of cleaning and maintenance products.

	• Exposure to infectious diseases such as SARs
Legal reference	Health and Safety at Work etc. Act 1974 sections 2 & 3 Management of Health and Safety at Work Regulations 1999 Control of Substances Hazardous to Health Regulations 2002 Personal Protective Equipment at Work Regulations 1992

What action has been taken / planned

Staff at HDFT work with a varied and significant number of hazardous substances on a daily basis, examples of hazardous substances, found in many areas of HDFT and HIF, include: medicines, chemicals, bleach, air fresheners, spray paints, WD40, medical gases, laundry tablets, sawdust, photocopier toner and bodily fluids (blood, vomit, urine etc.).

In 2025-26 we have continued to work on the five key areas identified in the previous Annual Report:

1. **COSHH Risk Assessments**
2. **Selection, Use, Maintenance, Examination and Testing of control measures**
3. **Exposure Monitoring**
4. **Health Surveillance**
5. **Storage, Spillage & Disposal**

- New COSHH assessments have continued to be created, with significant progress made across of Estates and Facilities teams.
- HIF have carried out an assurance review of Local Exhaust Ventilation used across multiple departments as a control measure, and this will support further review of the suitability and effectiveness of current controls.
- Further progress has been made in delivering a COSHH Basics eLearning module, provided to **289** estates and facilities staff, and Fit Mask Testing to **154** estates and facilities staff.

Exposure to bodily fluids (cuts / splash / needlestick incidents) have seen an increase in reporting over the last 7 months, and the Occupational Health team have been leading on work to support staff who are exposed to cuts, splash or needlestick incidents.

- New Management of Bodily Fluid Exposure Policy now in place (previously Blood Borne Viruses Policy).
- Policy provides a clear process for staff and the immediate actions that need to be taken when a Bodily Fluid Exposure. Occupational Health have promoted this across the Trust.
- Occupational Health actively monitoring Datix reports to ensure any staff members who initially do not access Occupational Health support are contacted ASAP.

During this reporting period the Trust had our first Reportable Disease, highlighting the risks associated with COSHH and the importance of health surveillance and monitoring. One notable

area is that of contact dermatitis through hand washing, we currently have no standard process for monitoring staff hands for potential signs of dermatitis.

To help address this the Occupational Health team have developed new policies for Health Surveillance and Dermatitis and have commenced a new skin surveillance programme (April 2026) which will continue over the next 6-12 months, providing a baseline position for the Trust and will include further assessment / staff referral where appropriate. This will be followed up by work to provide health assessments for staff designated as Night Workers.

The work on skin surveillance and night workers health assessments is part of a wider review of our compliance with the requirements of exposure monitoring and health surveillance across HDFT.

Health Surveillance is a legal requirement if you have employees who are exposed to specific workplace hazards, such as noise, vibration, radiation, lead solvents, fumes, dust and other substances hazardous to health. Health surveillance for all employees must be considered where there is an identifiable disease or adverse health outcome, and the disease or health effect may be related to exposure to a hazard, substance, process or procedure within the workplace. To date there are limited records of routine health surveillance having been undertaken at HDFT within Occupational Health staff records that are held by the Trust.

We will therefore continue to use new and reviewed risk / COSHH assessments to identify specific monitoring and screening. Challenges to the delivery of health surveillance have already been identified, including:

- Additional resource to ensure Occupational Health Nurses are trained and updated to use the required screening equipment and interpret results.
- Limited Consultant time does not allow for monitoring and assessment for surveillance in specialist areas (which only they have the expertise for and are registered to do).
- The current IT software within Occupational Health does not have a mechanism for routine/annual health surveillance screening.

Health and Safety Risk Register Entries – March 2026

CHS2 – HDH Goods Yard	Organisational risk to compliance with legislative requirements, with the risk of major injuries, fatality, or permanent disability to employees, patients and others, and the unauthorised access of persons to restricted areas of the hospital through the loading bay entrance. RISK SCORE REDUCED – ONGOING WORK CONTINUES
CHS3 - Managing the risk of injury from fire*	Organisational risk to compliance with legislative requirements, with the risk of major injuries, fatality, or permanent disability to employees, patients and others due to the failure to ensure that suitable and sufficient assessment of the risk from fire has been carried out, and that the necessary control measures are in place. RISK SCORE REDUCED – ONGOING WORK CONTINUES AS DESCRIBED ABOVE – AS DESCRIBED RISK SEPARATED TO REFLECT INFRASTRUCTURE RISK vs ASSESSMENT / POLICIES
CHS5 - Violence and Aggression*	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. RISK SCORE REDUCED – ONGOING WORK TO MEET TARGET SCORE
CHS6 – Moving & Handling	Organisational risk to compliance with legislative requirements, with the risk of major injuries, fatalities, or permanent disability to employees, patients and others due to failure to provide suitable and sufficient training for moving and handling. ONGOING
CHS8 – RAAC Roofing	Organisational risk to compliance with legislative and NHSE requirements, with the risk of major injuries, fatalities, or permanent disability to employees, patients and others, due to the failure to manage the risk associated with RAAC roofing. RISK SCORE REDUCED – ONGOING WORK CONTINUES AS DESCRIBED ABOVE
CHS10 - Security*	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. RISK SCORE TO BE REDUCED ON IN_HOUSE SECURITY TEAM GOING LIVE IN JUNE 2026

* Currently escalated to Corporate Risk Register

6. HEALTH & SAFETY PRIORITIES

FOR 2026-27

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HDFT HEALTH & SAFETY STRATEGY 2026 - 2029

As with previous years 2026-27 will see us continue to ensure health and safety standards are raised to acceptable levels, achieving legal compliance and matching industry best practice, whilst also striving for Continuous Improvement that will ultimately lead to HDFT being an exemplar for health and safety management within the NHS and beyond.

Our priorities as in 2025-26 will continue to focus on four key areas that will support us in improving the health, safety and wellbeing of our staff, patients and others, whilst also contributing to HDFTs strategic ambitions **Making HDFT the Best Place to Work** and **Best Quality & Safest Care**.

These choices continue to be supported by the increasing amount of health and safety data that we have gathered since 2022, as well as statistics, reports and guidance provided by external dutyholders (HSE and CQC) and wider NHS staff survey results.

Our four Health & Safety priorities will therefore continue to support our Trust Strategic Ambitions, whilst also targeting high risks activities faced by our staff and others.

- **Work-Related Stress**
- **Moving and Handling**
- **Violence and Aggression**
- **Physical Working Environment**

However, in a change from previous years, 2026 will see the development and publication of a first ever HDFT Health & Safety Strategy to provide a clear and consistent framework for the next three years and beyond.

HDFT established a new H&S Team in September 2022 to address the identified gap in ensuring the Trust was compliant with all relevant aspects of health and safety legislation.

The following period has seen many developments in the way we manage health and safety and strive to ensure legal compliance; this has included the development of a new risk assessment process, the identification of existing health and safety hazards, and the creation of clear reporting / assurance routes through the Health & Safety Committee (and newly established safety sub-groups).

However, a large amount of this time has been spent in a “Reaction” to specific events or immediate risks not previously being managed, such as managing contractors or the lack of risk assessment. The challenge now is to move to a more systematic approach which creates a “Proactive” approach to health and safety, which will deliver:

- A proactive health and safety culture across all parts of HDFT.
- Compliance with all relevant health and safety legislation, through proactive identification of hazards / risk.
- The implementation of appropriate control measures to prevent harm to staff, patients, visitors, and others.

- Enable us to then move beyond this strategy and develop systems and procedures that go above and beyond the minimum legal standards and make us NHS leaders for health and safety.

The key challenge in developing the strategy is to ensure that it builds on the work we have already done whilst also targeting areas that will have the biggest impact over the next three years. The strategy will also support the Trusts overall strategy and our Ture North Ambitions, in particular:

- Making HDFT the Best Place to Work
- Best Quality, Safest Care
- And our enabling ambition, An Environment that Promotes Wellbeing

Since 2022 the data we have been able to collect has supported the identification of key health and safety priorities; Work-related stress, Moving & Handling, Violence & Aggression, and our Working Environment. Work done by our sub-groups has also identified several themes that overlap between areas, i.e. the impact of our working environment on work-related stress or the link between health surveillance across clinical and non-clinical teams, and the work we are doing on COSHH assessment.

Therefore, our strategy must reflect work we can do to support the overlapping nature of health and safety hazard / risk, and the challenges faced by both our clinical staff and the colleagues from our corporate, estates and facilities teams.

We must also consider the objectives of external partners:

- NHS 10 Year Plan – Reduce sickness absence / create staff standards that cover; reducing violence against staff, tackling racism and sexual harassment.
- HSE 10 Year Strategy – Reduce work-related ill health (focus on stress); ensure safety of the environment where people work.

And address key questions from the NHS Staff Survey:

- Have you experienced musculoskeletal injuries at work?
- Have you been unwell as a result of work-related stress?
- Have you experienced physical assault at work?
- Have you experienced bullying or harassment at work?

By taking a longer-term view, we will be better positioned to deliver sustainable improvements, monitor progress and respond effectively to emerging risks and challenges. The strategy will allow us to support the delivery of in year priorities set in the Annual Report (Work-Related Stress, Moving and Handling, Violence and Aggression, Physical Working Environment) ensuring a planned and proactive approach to improving health, safety and wellbeing across the Trust.

The three-year strategy will focus on 5 key themes:

1. **Leadership & Management** - proactive approach to building a positive health and safety culture reflected in how all our staff work.

2. **Risk management** - effective and proportionate risk system that allows us to identify hazards / associated risk and suitable control measures.
3. **Safe People** - provided with the necessary skills, training, information, and instruction, so that they can recognise hazards / risk and take suitable steps to eliminate or control them.
4. **Safe Environment** - allows us to support staff in protecting both their own health and safety as well as that of others.
5. **Partnership Working** – establishing effective partnerships to manage shared risks, such as shared premises, safeguarding, contractor management.

Safer Staffing Bi-Annual Establishment Review

DATA COLLECTED IN MARCH 2026

ESTABLISHMENT REVIEW COMPLETED JULY 2026

Brenda Mckenzie, Workforce Assurance and Compliance Lead Nurse

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Purpose of Report

This report provides the Board of Directors with assurance regarding the nursing workforce establishments across Harrogate and District NHS Foundation Trust's Adult inpatient wards, Emergency Department and Children and Young People's inpatient services following completion of the Trust's bi-annual safer staffing establishment review.

The review has been undertaken in accordance with NHS England's Developing Workforce Safeguards (DWS) standards and the National Quality Board (NQB) publication Supporting NHS Providers to Deliver the Right Staff, with the Right Skills, in the Right Place at the Right Time. Together these frameworks set the national expectations for evidence-based workforce planning, safe staff deployment and Board assurance.

The review considers whether current nursing establishments remain sufficient to safely meet patient demand, acuity and dependency, whilst ensuring the workforce remains sustainable, productive and financially responsible.

Evidence from the licensed Safer Nursing Care Tool (SNCT) has been triangulated with professional judgement, patient quality indicators, workforce metrics, operational intelligence and financial information to determine whether existing funded establishments continue to provide quality, safe and effective care.

This report also demonstrates Harrogate and District NHS Foundation Trust's compliance with national safer staffing requirements, Care Quality Commission Regulation 18 (Staffing), the NHS England Developing Workforce Safeguards standards, National Quality Board expectations and the Trust's Safer Staffing Policy.

Background

Delivering safe, high-quality care depends upon ensuring that the right staff, with the right skills, are available in the right place at the right time. Safe staffing is therefore a fundamental component of patient safety, clinical effectiveness, patient experience and workforce wellbeing.

Harrogate and District NHS Foundation Trust have embedded the principles of NHS England's DWS within its nursing workforce governance arrangements. These safeguards recognise that workforce establishments should never be determined by financial considerations alone but instead should be informed through a triangulated assessment of:

- evidence-based workforce planning tools;
- professional judgement;
- patient outcomes and quality indicators;
- workforce indicators;
- operational intelligence;
- local service configuration.

The Trust undertakes formal bi-annual establishment reviews across adult inpatient wards, the Emergency Department and Children and Young People's inpatient services using the nationally recognised licensed SNCT.

The SNCT remains the only evidence-based workforce planning tool endorsed by NICE for adult inpatient nursing establishments and provides an objective assessment of nursing workload based upon patient acuity and dependency. However, both NHS England and the NQB are clear that no workforce planning tool should be used in isolation. This approach ensures that workforce decisions reflect the complexity of modern healthcare delivery, local patient need and the operational context of each clinical area rather than reliance upon numerical outputs alone.

HDFT Safer Staffing Governance

Harrogate and District NHS Foundation Trust have established a comprehensive safer staffing governance framework that provides assurance from ward to Board that nursing workforce establishments are safe, evidence based and responsive to changing patient need. Rather than relying on periodic establishment reviews alone, the Trust has embedded safer staffing into daily operational management and strategic workforce governance, ensuring that staffing is continually monitored, reviewed and challenged.

Safe staffing assurance is therefore achieved through multiple interconnected governance processes operating at operational and strategic levels. These arrangements ensure that workforce risks are identified promptly, mitigated appropriately and escalated where necessary, whilst maintaining oversight of patient safety, workforce wellbeing and financial sustainability.

The Trust's governance framework includes:

Strategic Governance

Formal Establishment Review Panel, where recommendations are subject to multidisciplinary scrutiny by Corporate Nursing, Finance and Operational leaders prior to approval.

Bi-Monthly Ward-to-Board Safer Staffing Reporting, providing transparent assurance on planned versus actual staffing, Care Hours Per Patient Day (CHPPD), fill rates, temporary workforce usage and quality indicators.

Bi-annual Establishment Reviews, using the licensed Safer Nursing Care Tool (SNCT) alongside professional judgement to determine evidence-based nursing establishments.

Operational Governance

Daily Staffing Escalation Processes, providing clear operational oversight and timely executive escalation where staffing risks cannot be mitigated locally.

Weekly Roster Assurance Meetings, reviewing roster quality, temporary staffing utilisation, headroom, annual leave, study leave and workforce availability to maximise safe substantive staffing.

Daily SafeCare Staffing Meetings to review staffing levels across all clinical areas, identify workforce risks, agree mitigation plans and ensure safe deployment of staff for every shift.

Weekly Matron Review of Future Rosters, ensuring upcoming rosters continue to meet safer staffing standards, roster key performance indicators and anticipated patient demand.

Quality Assurance

Monthly Fundamentals of Care Triangulation Meetings, bringing together staffing, quality, patient experience and clinical outcome data to identify emerging themes and ensure staffing establishments continue to support safe, effective and compassionate care.

Professional Judgement Review Meetings, ensuring SNCT outputs are interpreted alongside ward-specific operational factors, patient acuity, ward layout, patient flow, enhanced care requirements and workforce experience before any establishment changes are agreed.

SNCT Training and Inter-rater Reliability Programme, providing assurance that patient acuity data is collected consistently and accurately across all inpatient areas.

Matron Peer Review of Daily SNCT Data, strengthening the validity of acuity and dependency scoring through independent clinical oversight.

Supporting Frameworks

Daily Staffing Escalation Processes, providing clear operational oversight and timely executive escalation where staffing risks cannot be mitigated locally.

Weekly Roster Assurance Meetings, reviewing roster quality, temporary staffing utilisation, headroom, annual leave, study leave and workforce availability to maximise safe substantive staffing.

Safer Staffing Policy, establishes the Trust's governance framework for determining, reviewing and monitoring nursing and midwifery workforce establishments, ensuring compliance with national safer staffing standards and defining clear accountability from ward to Board.

SafeCare Standard Operating Procedure, providing a structured approach to the daily review, escalation and deployment of the nursing workforce, enabling timely operational decision-making to maintain safe staffing levels across all clinical areas.

Temporary Workforce Standard Operating Procedure, defines the governance and approval processes for the use of temporary staffing, promoting safe, effective and value-based workforce deployment while supporting the Trust's ambition to maximise substantive staffing and minimise reliance on temporary workforce.

Redeployment Standard Operating Procedure, supporting the safe and efficient deployment of substantive staff across clinical areas in response to changes in patient demand.

Equality, Quality Impact Assessments (EQIAs) undertaken for all substantive workforce establishment changes to ensure decisions are equitable, evidence based and fully consider any potential impact on patients, staff and protected groups.

Collectively, these governance arrangements provide robust assurance that nursing workforce establishments remain responsive to changes in patient acuity, dependency and service demand. They enable Harrogate and District NHS Foundation Trust to demonstrate that staffing decisions are not based solely on numerical workforce planning tools but are informed through continuous professional oversight, quality surveillance and organisational governance, ensuring the right staff, with the right skills, are available in the right place at the right time.

March 2026 Results

Adult Inpatient Wards

The March 2026 SNCT review was completed across all adult inpatient wards. The review concluded that the current nursing establishments continue to provide safe and effective staffing aligned to patient acuity, dependency and service demand. Demonstrating that the existing funded establishments remain appropriate across the majority of adult inpatient wards, providing assurance that previous establishment reviews and workforce investment continue to reflect the clinical needs of patients (ap. Quality indicators remained stable, with no evidence of systemic staffing concerns that would require significant changes to funded establishments.

Only three minor establishment refinements were identified through the review. Within the Long Term Unscheduled and Community Care Directorate, a minor adjustment to the Registered Nurse skill mix, on Granby Ward, was recommended to better align staffing with increasing daytime patient acuity and dependency. Within the Planned, Surgical and Children's Care Directorate, an unused Clinical Support Worker vacancy was approved for transfer from Rowan Ward to Bolton Ward, strengthening overnight staffing resilience where patient demand is greatest. These changes optimise the deployment of the existing workforce, improve alignment between staffing resource and patient need, and were approved through the Establishment Review Panel (ERP) and Executive governance processes. All changes are cost neutral and are being implemented within existing funded establishments.

The outcome of the review provides assurance that Adult inpatient nursing establishments remain evidence based, responsive to patient need and compliant with the DWS standards, NQB expectations and the Trust's Safer Staffing Policy.

Headroom Review

Alongside the March 2026 establishment review, the Trust completed a comprehensive review of the headroom provisions applied to adult inpatient nursing establishments. This work was undertaken to ensure roster resilience is based upon contemporary workforce data, current organisational policies and national workforce standards, replacing the previous compounded methodology with a more transparent and evidence-based approach.

The revised model aligns headroom to the predictable workforce unavailability experienced across adult inpatient wards and provides funded capacity to support safe roster production, reduce reliance on temporary staffing and improve resilience within substantive establishments. The review incorporated twelve months of workforce data, analysis of actual staff unavailability, organisational leave policies and the legislative training requirements, together with national recommendations regarding evidence-based headroom calculations.

The revised headroom provision comprises:

- Annual Leave: 14.96%
- Sickness Absence: 4.10%
- Study, Training and Professional Development: 3.34%
- Other Planned and Unplanned Leave: 1.00%

This results in a total headroom provision of 23.40%, replacing the previous compounded provision of approximately 25.76%. The revised methodology more accurately reflects modern workforce requirements by recognising statutory and discretionary leave provisions, enhanced education and training requirements, and realistic sickness allowances whilst removing the historic "headroom on headroom" calculation. The outcome delivers a more accurate, sustainable and transparent approach to workforce planning, supporting safe staffing, improved roster resilience and consistent application across all adult inpatient wards.

Care Hours Per Patient Day (CHPPD) Benchmarking

Care Hours Per Patient Day (CHPPD) provides an established national metric that supports Board assurance by demonstrating the amount of Nursing and Midwifery care delivered to patients in relation to occupied bed days. Whilst CHPPD should not be used in isolation to determine workforce establishments, it provides an important benchmarking measure when triangulated alongside evidence-based staffing tools, professional judgement, quality indicators and other workforce metrics.

Analysis of Model Hospital benchmarking data demonstrates that Harrogate and District NHS Foundation Trust continues to deliver nursing care hours broadly in line with comparable NHS organisations. During the March 2026 reporting period, the median CHPPD for peer organisations was 8.1 hours, compared with 8.3 hours delivered by HDFT. This places the Trust slightly above the peer median, indicating that the nursing workforce is delivering care hours consistent with organisations of a similar size and case mix.

The alignment between planned and actual staffing delivery, together with CHPPD performance above the national peer median, provides additional assurance that funded nursing establishments are translating into safe staffing levels in practice. When considered alongside the positive findings from the SNCT review, stable quality indicators, daily operational oversight and robust safer staffing governance arrangements, the CHPPD data supports the conclusion that adult inpatient nursing establishments remain appropriately resourced to meet patient demand.

Emergency Department

The March 2026 Emergency Department (ED) establishment review was undertaken using the Emergency Department Safer Nursing Care Tool (ED SNCT), with findings triangulated against professional judgement, workforce metrics, patient quality indicators, activity, operational performance and service demand (appendix 1).

The review provided assurance that the current funded nursing establishment remains appropriate to safely support the delivery of emergency care within a complex and continually changing operational environment. The review recognised sustained growth in Emergency Department attendances, increasing patient acuity, rising mental health presentations and ongoing operational pressures associated with ambulance handover standards and patient flow. Despite these challenges, the current establishment continues to provide a safe staffing model supported by daily operational oversight, dynamic deployment of staff and continuous review through the Trust's safer staffing governance arrangements.

The review confirmed that no further substantive establishment changes were required. This reflects the workforce refinements approved through the ERP following the previous ED SNCT review, which introduced a cost-neutral redistribution of staffing from overnight shifts to twilight shifts to better align Registered Nurse and Clinical Support Worker availability with periods of peak patient demand. Evaluation of this revised workforce model demonstrates improved alignment of staffing resource with departmental activity while maintaining the overall funded establishment.

The outcome of the review provides assurance that the Emergency Department nursing establishment remains evidence based, responsive to patient demand and aligned with DWS standards, NQB expectations and the Trust's Safer Staffing Policy. The establishment will continue to be monitored through routine operational and strategic safer staffing governance processes to ensure it remains responsive to future changes in activity, acuity and service delivery.

Children and Young People Inpatient Ward

The March 2026 review of the Children and Young People's inpatient service was undertaken using the Children and Young People Safer Nursing Care Tool, with findings triangulated alongside professional judgement, patient quality indicators, workforce metrics, activity data and operational intelligence to determine whether the current workforce establishment continues to meet patient need (appendix 1).

The review confirmed that the existing nursing establishment continues to support the delivery of safe and effective care across Woodlands Ward. The review recognised the unique operational characteristics of the service, including the Children's Assessment Unit (CAU) and Day Surgery Unit (DSU) provision, both of which require professional judgement to complement the SNCT methodology. Quality indicators remained positive throughout the review period, with no falls, hospital-acquired pressure ulcers, staffing-related Datix incidents or formal complaints identified.

The review identified several refinements to the workforce model to further strengthen alignment between the rostered establishment and service delivery. These include

adoption of the Trust's evidence-based headroom methodology, formal recognition of supervisory management time, allocation of headroom for the Play Specialist role, refinement of the DSU Registered Nurse provision and separation of management time for the Special Care Baby Unit to improve governance and roster performance monitoring. In addition, it was agreed that future SNCT data collections will focus on inpatient activity only, with the CAU continuing to be managed through activity data and professional judgement rather than the inpatient SNCT methodology.

These proposed workforce refinements are currently being finalised through detailed financial modelling and establishment review processes prior to submission to the ERP. Subject to approval, the changes will further strengthen the alignment of the workforce model with patient demand whilst remaining consistent with the Trust's safer staffing governance framework.

Conclusion

Following completion of the March 2026 bi-annual safer staffing establishment review, the Board can be assured that Harrogate and District NHS Foundation Trust have robust governance arrangements in place to determine, monitor and review nursing workforce establishments across Adult Inpatient Wards, the Emergency Department and Children and Young People's inpatient services.

The triangulated review demonstrates that the current funded nursing establishments across all three services remain evidence-based, appropriate to patient acuity, dependency and service demand, and continue to support the delivery of safe, effective and high-quality patient care. Where minor refinements to workforce models have been identified, these are focused on improving alignment between staffing resource and patient need rather than addressing deficits in safe staffing. All proposed changes have been subject to professional judgement, Equality, Quality Impact Assessments, financial scrutiny and Executive governance through the Establishment Review Panel.

The review provides assurance that:

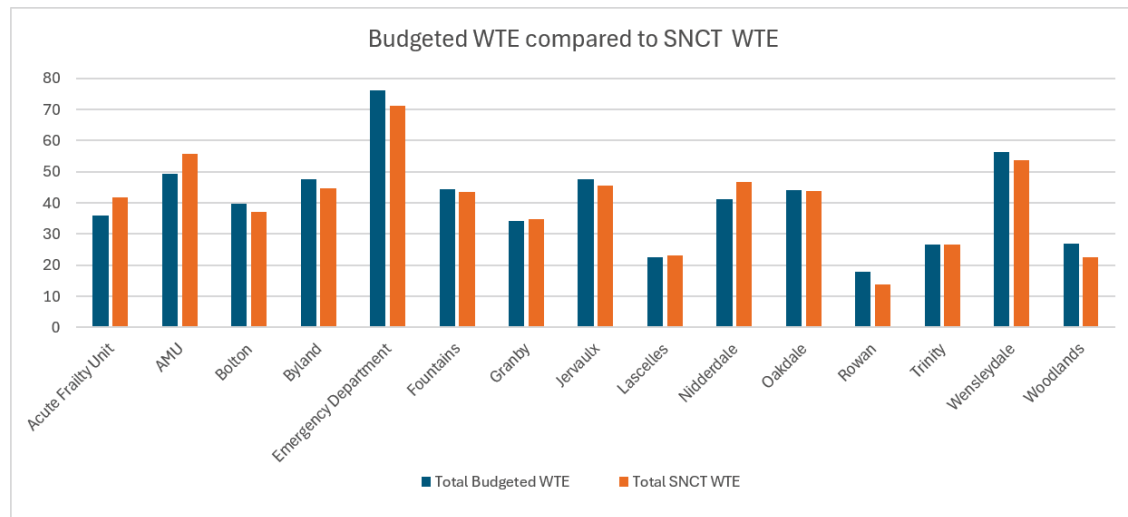
- Adult Inpatient Ward establishments remain safe, evidence-based and aligned to the SNCT, with only minor cost-neutral refinements required to optimise skill mix and workforce deployment.
- The Emergency Department nursing establishment continues to provide a safe staffing model that is responsive to increasing patient demand and operational pressures, supported by robust daily operational oversight and the workforce improvements implemented following the previous review.
- The Children and Young People's inpatient establishment continues to safely meet patient need, with proposed refinements further strengthening roster resilience, supervisory capacity and alignment of staffing to service delivery.
- Care Hours Per Patient Day (CHPPD) benchmarking demonstrates that HDFT continues to deliver nursing care hours above the Model Hospital peer median (8.3 compared with 8.1), providing further assurance that funded nursing establishments are translating into safe staffing delivery in practice.

Collectively, these findings demonstrate continued compliance with the Developing Workforce Safeguards standards and National Quality Board expectations. Together with the Trust's comprehensive safer staffing governance framework, including daily SafeCare oversight, enhanced roster governance, professional judgement, quality triangulation and evidence-based establishment reviews, the Board can be assured that Harrogate and District NHS Foundation Trust continues to provide patients with the right staff, with the right skills, in the right place, at the right time, whilst maintaining a sustainable and financially responsible nursing workforce.

Appendix 1

March 2026 SNCT Raw Data (before triangulation)

Clinical Area	Current Budgeted Establishment (WTE)			March 2026 SNCT Requirement (WTE)			Variance
	Registered	Unregistered	Total	Registered	Unregistered	Total	
Acute Frailty Unit	20.32	15.72	36.04	23.02	18.84	41.86	-5.82
AMU	32.00	17.44	49.44	32.41	23.34	55.75	-6.31
Bolton	22.30	17.50	39.80	22.26	14.84	37.10	2.70
Byland	24.79	22.88	47.67	26.73	17.82	44.55	3.12
Emergency Department	59.34	16.63	75.97	57.00	14.30	71.30	4.67
Fountains	24.76	19.76	44.52	26.04	17.36	43.40	1.12
Granby	19.34	14.99	34.33	20.82	13.88	34.70	-0.37
Jervaulx	24.79	22.88	47.67	27.27	18.18	45.45	2.22
Lascelles	12.69	9.99	22.68	13.85	9.23	23.08	-0.40
Nidderdale	24.97	16.28	41.25	28.08	18.72	46.80	-5.55
Oakdale	24.79	19.38	44.17	26.29	17.52	43.81	0.36
Rowan	11.67	6.14	17.81	8.33	5.55	13.88	3.93
Trinity	14.63	12.09	26.72	16.02	10.68	26.70	0.02
Wensleydale	38.67	17.68	56.35	37.56	16.10	53.66	2.69
Woodlands	19.20	7.60	26.80	18.00	4.50	22.50	4.30

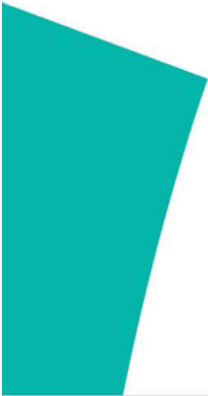


Integrated Board Report - Print Version

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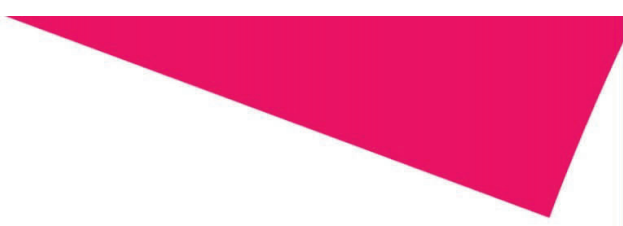
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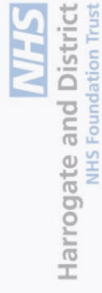
Integrated Board Report

July 2026



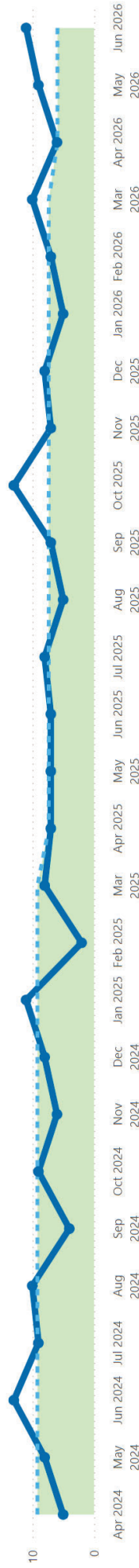
True North Metrics

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Moderate+ harm events

TNM1



TNM2 - Placeholder - Clinical effectiveness metric

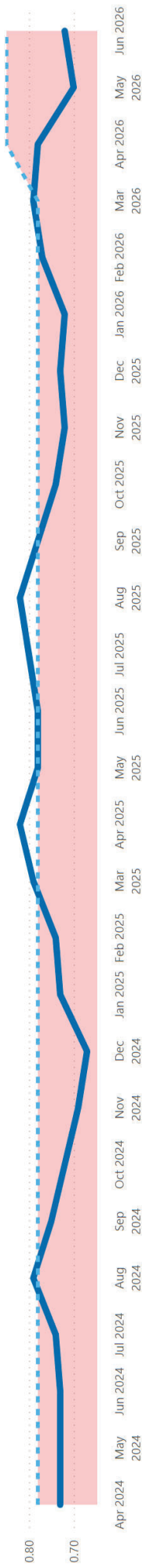
TNM3 - Placeholder - Patient experience / FFT

True North Metrics

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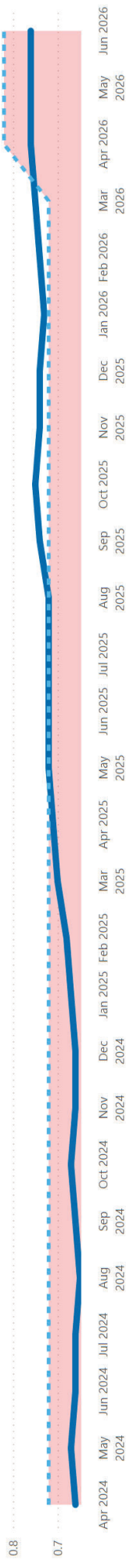
Emergency Care Standard – 4-hour ED

TNM4



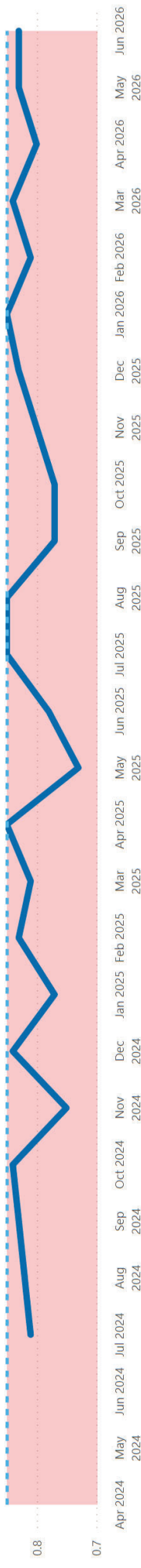
18-week RTT standard

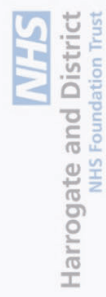
TNM5



62-day cancer standard

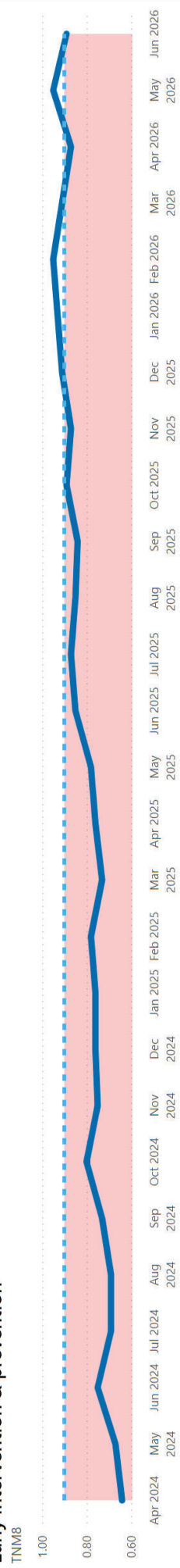
TNM6



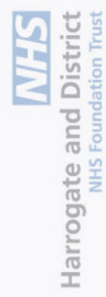


TNM 7 - Placeholder - Frailty

Early intervention & prevention

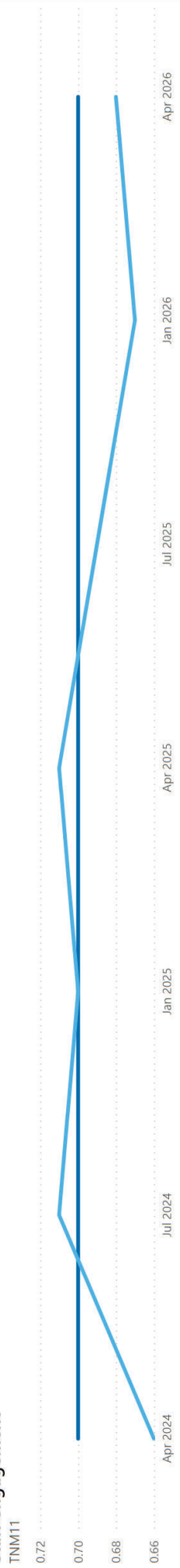


TNM 9 - Placeholder - Children's patient experience

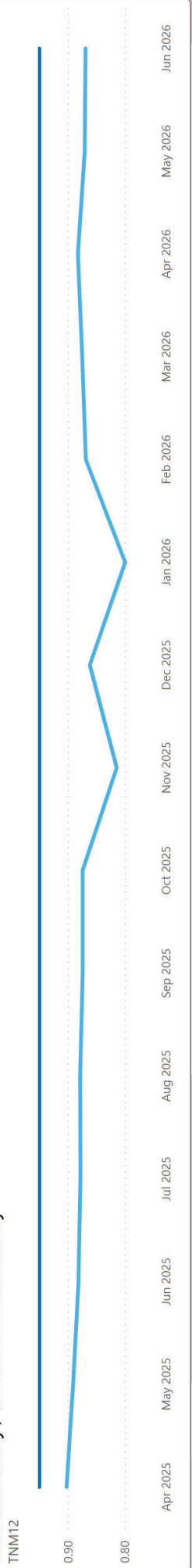


TNM 10 -Placeholder - Waiting for children's services (Non-CYPPh)

Staff engagement



Staff availability / workforce sustainability



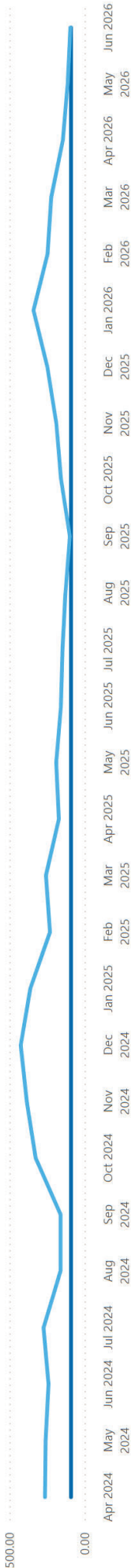


Breakthrough Objectives

BTO1 - Placeholder - Checklist Completion

Time to next destination

BTO2



BTO3 - Placeholder - CYP in research

Watch Metrics Summary

Status	Metric Count	Metric %
Sustained Below Target	38	42.2%
Newly Below Target	7	7.8%
Newly Achieving	10	11.1%
Sustained Achieving	35	38.9%

Watch Metrics – Sustained below target (1)

ID	Name	Strategy Group	Strategy Sub Group	Current Value	Target	Length of current performance run	Success is High/Low	Month	Range Lower	Range Upper	Graph
1.12	Infant health - % women initiating breastfeeding	Great Start in Life	Maternity	0.82	0.95	75	Higher	Jun 2026	0.95	0.95	
1.13	VTE risk assessment - inpatients	Best Quality Safest Care	safety & Effectiveness	0.93	0.95	19	Higher	Jun 2026	0.95	0.95	
1.8.1	Safer staffing levels - fill rate	Best Quality Safest Care	safety & Effectiveness	0.91	0.95	7	Higher	Jun 2026	0.95	0.95	
1.9	Maternity - % women seen by a midwife (or healthcare professional) by 12w 6d	Great Start in Life	Maternity	0.93	0.95	3	Higher	Jun 2026	0.95	0.95	
1.9.3	Maternity - Number of Admissions to SCBU per month	Great Start in Life	Maternity	19.00	8.00	3	Lower	Jun 2026	8.00	8.00	
1.9.5	Maternity - Maternity Role Specific Training Compliance	Great Start in Life	Maternity	0.85	0.95	18	Higher	Jun 2026	0.95	0.95	
2.2.1	Complaints - numbers received	Person Centred, Integrated Care	Patient Experience	46.00	12.00	7	Lower	Jun 2026	12.00	12.00	
3.1	HSMR (Hospital Standardised Mortality Ratio)	Clinical Outcomes	Mortality		100.00	18	Range	Jun 2026	90.00	110.00	
3.2	Mortality - SHMI	Best Quality Safest Care			100.00	3	Range	Jun 2026	96.00	104.00	
3.3.1	Readmissions to the same specialty within 30 days - following elective admission - as % of all elective admissions	Person Centred, Integrated Care	RTT	0.04	0.04	33	Lower	Jun 2026	0.04	0.04	

Watch Metrics – Sustained below target (2)

ID	Name	Strategy Group	Strategy Sub Group	Current Value	Target	Length of current performance run	Success is High/Low	Month	Range Lower	Range Upper	Graph
3.3.2	Readmissions to the same specialty within 30 days - following non-elective admission - as % of all non-elective admissions	Person Centred, Integrated Care	UEC	0.10	0.09	33	Lower	Jun 2026	0.09	0.09	
4.1	Appraisal rate - Non Medical and Medical Staff	Best Place to Work	Engagement	0.83	0.90	3	Higher	Jun 2026	0.90	0.90	
4.5	Vacancies	Best Place to Work	Availability	0.94	0.05	15	Lower	Jun 2026	0.05	0.05	
5.1.2	RTT Incomplete pathways performance - 92nd centile (days)	Person Centred, Integrated Care	RTT	215.00	126.00	18	Lower	Jun 2026	126.00	126.00	
5.1.3	RTT Incomplete pathways - total	Person Centred, Integrated Care	RTT	21,611.00	20,000.00	4	Lower	Jun 2026	19,750.00	20,250.00	
5.1.4	RTT Incomplete pathways - 52-<104 weeks	Person Centred, Integrated Care	RTT	3.00	0.00	9	Lower	Jun 2026	0.00	0.00	
5.10	Cancer - 14 days maximum wait from urgent GP referral for all urgent suspect cancer referrals	Person Centred, Integrated Care	Cancer	0.73	0.90	75	Higher	Jun 2026	0.90	0.90	
5.13.2	Children's Services - 2-3 years caseload	Great Start in Life	CYP PH	2,390.00	2,100.00	4	Range	Jun 2026	1,900.00	2,300.00	
5.15	Children's Services - Ante-natal visits	Great Start in Life	CYP PH	0.91	0.95	11	Higher	Jun 2026	0.95	0.95	

Watch Metrics – Sustained below target (3)

ID	Name	Strategy Group	Strategy Sub Group	Current Value	Target	Length of current performance run	Success is High/Low	Month	Range Lower	Range Upper	Graph
5.2.1	RTT waiting times (days different) - by ethnicity(gap between BME & White (positive is shorter wait for BME)	Person Centred, Integrated Care	RTT	3.00	0.00	5	Lower	Jun 2026	0.00	0.00	
5.27	GPOOH - Telephone clinical assessment for URGENT cases within 20 minutes of call prioritisation	Person Centred, Integrated Care	UEC	0.34	0.85	75	Higher	Jun 2026	0.85	0.85	
5.29	Community SITREP waiting times- percentage of waiters	Person Centred, Integrated Care	RTT	0.03	0.02	7	Lower	Jun 2026	0.02	0.02	
5.3	Diagnostic waiting times - 6-week standard	Person Centred, Integrated Care	RTT	0.70	0.75	16	Higher	Jun 2026	0.75	0.75	
5.5	Data quality on ethnic group - inpatients RESPONSIVE - Digital	Person Centred, Integrated Care	Digital	0.89	0.90	7	Higher	Jun 2026	0.90	0.90	
5.6	A&E 4 hour standard	Person Centred, Integrated Care	UEC	0.72	0.80	10	Higher	Jun 2026	0.80	0.80	
5.7	Ambulance handovers - % within 15 mins	Person Centred, Integrated Care	UEC	0.74	0.90	23	Higher	Jun 2026	0.90	0.90	
5.8	A&E - number of 12 hour trolley waits	Person Centred, Integrated Care	UEC	10.00	5.00	9	Lower	Jun 2026	5.00	5.00	
5.9.1	62 Day Cancer Performance	Person Centred, Integrated Care	Cancer	0.83	0.85	27	Higher	Jun 2026	0.85	0.85	

Watch Metrics – Sustained below target (4)

ID	Name	Strategy Group	Strategy Sub Group	Current Value	Target	Length of current performance run	Success is High/Low	Month	Range Lower	Range Upper	Graph
5.9.2	Number of Cancer Treatment waits over 104 days	Person Centred, Integrated Care	Cancer	9.00	0.00	75	Lower	Jun 2026	0.00	0.00	
6.1	Agency spend	Finance		84,000.00	20,000.00	75	Lower	Jun 2026	20,000.0	20,000.0	
6.5.2	Long stay patients - superstranded (>21 days LOS)	Person Centred, Integrated Care	UEC	62.00	50.00	8	Lower	Jun 2026	50.00	50.00	
6.6	Occupied bed days per 1,000 population	Person Centred, Integrated Care	UEC	60.29	50.00	9	Lower	Jun 2026	50.00	50.00	
6.7.2	Length of stay - non-elective	Person Centred, Integrated Care	UEC	7.49	6.50	18	Lower	Jun 2026	6.50	6.50	
7.3	Outpatient Procedures vs Plan	Person Centred, Integrated Care	RTT	0.96	1.00	6	Range	Jun 2026	0.98	1.02	
7.4	Day/Case incl Endoscopy vs Plan	Person Centred, Integrated Care	RTT	1.04	1.00	5	Range	Jun 2026	0.98	1.02	
7.5	Elect. IP vs Plan	Person Centred, Integrated Care	RTT	1.06	1.00	4	Range	Jun 2026	0.98	1.02	
7.7	Follow Ups vs Plan	Person Centred, Integrated Care	RTT	1.07	1.00	3	Lower	Jun 2026	1.00	1.00	
7.8	Non Elective IP vs Plan	Person Centred, Integrated Care	UEC	1.04	1.00	3	Range	Jun 2026	0.98	1.02	

Watch Metrics – Newly below target (1)

ID	Name	Strategy Group	Strategy Sub Group	Current Value	Target	Length of current performance run	Success is High/Low	Month	Range Lower	Range Upper	Graph
1.2	Pressure ulcers - community acquired - moderate harm or above - per 1,000 patient contacts	Best Quality Safest Care	safety & effectiveness	0.30	0.13	1	Lower	Jun 2026	0.13	0.13	
1.4	Infection control - Hospital acquired C.difficile cases, lapse in care identified	Best Quality Safest Care	safety & effectiveness	4.00	1.00	2	Lower	Jun 2026	1.00	1.00	
1.8.2	Safer staffing levels - CHPPD	Best Quality Safest Care	safety & effectiveness	10.26	8.00	1	Range	Jun 2026	7.00	9.00	
4.3	Staff sickness rate	Best Place to Work	Availability	0.05	0.05	1	Lower	Jun 2026	0.05	0.05	
4.4	Staff turnover rate	Best Place to Work	Availability	0.15	0.12	2	Lower	Jun 2026	0.12	0.12	
5.2.4	RTT Waiting times - differential wait in days for patients with LD Flag	Person Centred, Integrated Care	RTT	12.00	0.00	1	Lower	Jun 2026	0.00	0.00	
5.2.3	Community Care Adult Teams - performance against new timeliness standards	Person Centred, Integrated Care	Elderly	0.89	0.90	1	Higher	Jun 2026	0.90	0.90	

Watch Metrics – Newly achieving (1)

ID	Name	Strategy Group	Strategy Sub Group	Current Value	Target	Length of current performance run	Success is High/Low	Month	Range Lower	Range Upper	Graph
1.9.2	Maternity - - Number of Third and Fourth Degree Tears	Great Start in Life	Maternity	3.00	4.00	2	Lower	Jun 2026	4.00	4.00	
2.1.2	Friends & Family Test (FFT) - Adult Community Services	Best Quality Safest Care	Patient Experience	1.00	0.90	1	Higher	Jun 2026	0.90	0.90	
2.2.2	Complaints - % responded to within time	Person Centred, Integrated Care	Patient Experience	1.00	0.90	1	Higher	Jun 2026	0.90	0.90	
3.4	Returns to theatre - % returns within 30 days	Person Centred, Integrated Care	RTT	0.01	0.02	1	Lower	Jun 2026	0.02	0.02	
3.5	Delayed Transfer of Care - % inpatients not meeting the criteria to reside	Person Centred, Integrated Care	UEC	0.12	0.12	2	Lower	Jun 2026	0.12	0.12	
4.2	Mandatory and Essential Skills Training rate	Best Place to Work	Engagement	0.91	0.90	1	Higher	Jun 2026	0.90	0.90	
6.9	Theatre utilisation (elective sessions)	Person Centred, Integrated Care	RTT	0.81	0.80	2	Higher	Jun 2026	0.80	0.80	
7.1	GP Referrals against 2019/20 baseline	Person Centred, Integrated Care	RTT	1.03	1.00	2	Range	Jun 2026	0.95	1.05	
7.6	Combined Elect (excl F up) vs Plan	Person Centred, Integrated Care	RTT	1.00	1.00	1	Range	Jun 2026	0.98	1.02	
7.9	ED Attends vs Plan	Person Centred, Integrated Care	UEC	0.99	1.00	1	Range	Jun 2026	0.98	1.02	

Watch Metrics – Sustained achieving (1)

ID	Name	Strategy Group	Strategy Sub Group	Current Value	Target	Length of current performance run	Success is High/Low	Month	Range Lower	Range Upper	Graph
1.1	Pressure ulcers - hospital acquired -moderate harm or above - per 1,000 bed days	Best Quality Safest Care	safety & effectiveness	0.11	0.30	6	Lower	Jun 2026	0.30	0.30	
1.101	Moderate Harm or Above - community acquired pressure ulcers - raw numbers	Best Quality Safest Care		1.00	2.00	6	Lower	Jun 2026	2.00	2.00	
1.102	Moderate Harm or Above - hospital acquired pressure ulcers - raw numbers	Best Quality Safest Care		2.00	2.00	8	Lower	Jun 2026	2.00	2.00	
1.11	Infant health - % women smoking at time of delivery	Great Start in Life	Maternity	0.03	0.05	8	Lower	Jun 2026	0.05	0.05	
1.14	Sepsis screening - inpatient wards	Best Quality Safest Care	safety & effectiveness	1.00	0.95	183	Higher	Jun 2026	0.95	0.95	
1.15	Sepsis screening - Emergency department	Best Quality Safest Care	safety & effectiveness	0.99	0.95	155	Higher	Jun 2026	0.95	0.95	
1.3	Inpatient falls per 1,000 bed days	Best Quality Safest Care	safety & effectiveness	5.71	6.00	3	Lower	Jun 2026	6.00	6.00	
1.5	Infection control - Hospital acquired MRSA cases, lapse in care identified	Best Quality Safest Care	safety & effectiveness	0.00	0.00	8	Lower	Jun 2026	0.00	0.00	

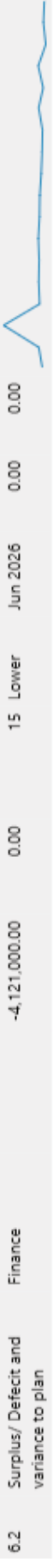
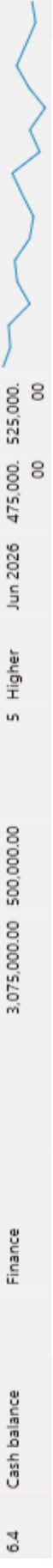
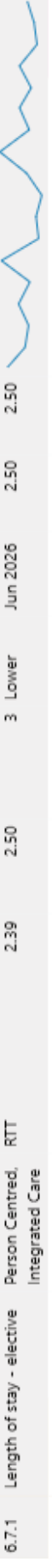
Watch Metrics – Sustained achieving (2)

ID	Name	Strategy Group	Strategy Sub Group	Current Value	Target	Length of current performance run	Success is High/Low	Month	Range Lower	Range Upper	Graph
1.6	Incidents - ratio of low harm incidents	Best Quality Safest Care	safety & effectiveness	112.45	200.00	16	Range	Jun 2026	100.00	300.00	
1.7.1	Incidents - comprehensive serious incidents (SI)	Best Quality Safest Care	safety & effectiveness	0.00	1.00	3	Lower	Jun 2026	1.00	1.00	
1.7.2	Incidents - Never events	Best Quality Safest Care	safety & effectiveness	0.00	0.00	4	Lower	Jun 2026	0.00	0.00	
1.9.1	Maternity - Number of Stillbirths per month	Great Start in Life	Maternity	0.00	3.00	18	Lower	Jun 2026	3.00	3.00	
1.9.4	Maternity - 1:1 Care delivered in labour	Great Start in Life	Maternity	1.00	0.95	18	Higher	Jun 2026	0.95	0.95	
1.9.6	Maternity - Maternity Complaints per month	Great Start in Life	Maternity	3.00	9.00	18	Lower	Jun 2026	9.00	9.00	
1.9.7	Maternity - Maternity Unit Service Suspensions per month	Great Start in Life	Maternity	0.00	4.00	4	Lower	Jun 2026	4.00	4.00	
2.1.1	Friends & Family Test (FFT) - All Patients	Best Quality Safest Care	Patient Experience	0.99	0.90	75	Higher	Jun 2026	0.90	0.90	
5.1.1	RTT Incomplete pathways performance - median days wait	Person Centred, Integrated Care	RTT	64.00	110.00	75	Lower	Jun 2026	110.00	110.00	
5.11	Cancer - 28 days faster diagnosis standard (suspected cancer referrals)	Person Centred, Integrated Care	Cancer	0.84	0.80	5	Higher	Jun 2026	0.80	0.80	

Watch Metrics – Sustained achieving (3)

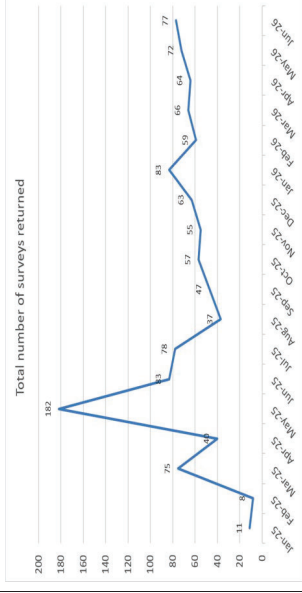
ID	Name	Strategy Group	Strategy Sub Group	Current Value	Target	Length of current performance run	Success is High/Low	Month	Range Lower	Range Upper	Graph
5.12	Cancer - Combined 31 day wait (First and Subsequent Treatments)	Person Centred, Integrated Care	Cancer	0.98	0.95	39	Higher	Jun 2026	0.95	0.95	
5.13.1	Children's Services - 0-12 months caseload	Great Start in Life	CYP PH	2,144.00	2,100.00	5	Range	Jun 2026	1,900.00	2,300.00	
5.14	Children's Services - Safeguarding caseload	Great Start in Life	CYP PH	1,369.00	1,200.00	8	Range	Jun 2026	1,000.00	1,400.00	
5.16	Children's Services - 10-14 day new birth visit	Great Start in Life	CYP PH	0.96	0.95	6	Higher	Jun 2026	0.95	0.95	
5.17	Children's Services - 6-8 week visit	Great Start in Life	CYP PH	0.95	0.95	9	Higher	Jun 2026	0.95	0.95	
5.18	Children's Services - 12 month review	Great Start in Life	CYP PH	0.98	0.95	11	Higher	Jun 2026	0.95	0.95	
5.19	Children's Services - 2.5 year review	Great Start in Life	CYP PH	0.97	0.95	7	Higher	Jun 2026	0.95	0.95	
5.2.2	RTT waiting times - by level of deprivation- differential average wait in days (negative gap reflects high deprivation waiting a shorter time)	Person Centred, Integrated Care	RTT	-21.00	0.00	18	Lower	Jun 2026	0.00	0.00	
5.2.3	RTT Waiting Times - Differential RTT waiting times in days for gender(positive means females wait longer)	Person Centred, Integrated Care	RTT	0.00	0.00	3	Lower	Jun 2026	0.00	0.00	

Watch Metrics – Sustained achieving (4)

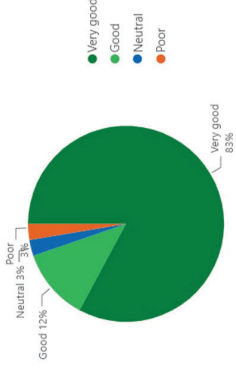
ID	Name	Strategy Group	Strategy Sub Group	Current Value	Target	Length of current performance run	Success is High/Low	Month	Range Lower	Range Upper	Graph
5.28	GPOOH - Home visit: Face to face consultations started for URGENT cases within 2 hrs	Person Centred, Integrated Care	UEC	0.91	0.85	6	Higher	Jun 2026	0.85	0.85	
6.10	Day case conversion rate	Person Centred, Integrated Care	RTT	0.01	0.03	75	Lower	Jun 2026	0.03	0.03	
6.2	Surplus/ Deficit and variance to plan	Finance		-4,121,000.00	0.00	15	Lower	Jun 2026	0.00	0.00	
6.3	Capital spend	Finance		4,508,000.00	500,000.00	74	Higher	Jun 2026	475,000.00	525,000.00	
6.4	Cash balance	Finance		3,075,000.00	500,000.00	5	Higher	Jun 2026	475,000.00	525,000.00	
6.5.1	Long stay patients - stranded (>7 days LOS)	Person Centred, Integrated Care	UEC	142.00	175.00	52	Lower	Jun 2026	175.00	175.00	
6.7.1	Length of stay - elective	Person Centred, Integrated Care	RTT	2.39	2.50	3	Lower	Jun 2026	2.50	2.50	
7.2	First Outpatient vs Plan	Person Centred, Integrated Care	RTT	1.01	1.00	3	Range	Jun 2026	0.98	1.02	

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

Workstreams	True North Metric	Vision	Goal	Current State	Countermeasures	Level of Risk to Achieving Goal (CtL)	Level of Risk for progressing actions
Hope for Healthcare 	Children's Patient Experience	Improve experience of care by considering elements that matter most to children & young people so we can measure their experience of care and shape services according to their specific needs	Goal 1: Engage with children and young people with lived experience across HDFT geography to consult with on our CYP Strategy which will form part of the Clinical Strategy Goal 2: CYP Patient Experience Tool Developed-Return rate significantly low - distribution, engagement, and access to the tool to be developed with CYP and approach embedded with teams and professionals working with CYP.	The True North Metric of improving Children's Patient Experience continues into its second year (2025-26). Target return rate 10%. May 26 10% return- Target Achieved. June 9.39% return. Active Countermeasures are noted. - Darlington, Tees Valley CIC & Wakefield are developing Countermeasures using HDFT impact methodology to increase return rate. We will review each of these approaches at the Learning & Best Practice Group and evaluate approach and impact. We will use this to determine a standard work. - We will ensure a number of ways of receiving feedback are used by staff for the benefit of service users. This will include hard copies along with QR codes (digital returns). - New learning best practice workflow established footprint-wide to drive increase in CYP survey returns using best practice examples from every contract area. - Working with CYPD Digital team to explore how best to get themes from paper CYP survey returns. - Data will be reported as a percentage for each Contract area and monitored via Governance Huddle with each HoN.	CYP Patient Experience Tool 'engagement methods' to increase uptake and return being developed with involvement of CYP representatives. - Focus Groups held with GSIL Young Advisor Committees and individual advisors. - Standardise paper version of survey for use. - Hopes for Health presentation to increase staff awareness and importance of gathering feedback (at all team huddles) - Assurance Survey for completion by staff to review awareness - this will inform future promotion and target support. - Application to charity for adaptable devices to support completion of survey by CYP All above completed.		



Watch Metrics:

Workstreams	True North Metric	Vision	Goal	Current State	Countermeasures	Level of Risk to Achieving Goal (CxL)	Level of Risk for progressing actions
				Overall how was your experience?   ...  Very good 83% Good 12% Neutral 3% Poor 3% Legend: ● Very good ● Good ● Neutral ● Poor Directorate CYP Patient Experience Champions produces a monthly report with themes, trends and areas for improvement. This will be shared with the central patient experience team and reported into MEC Forum.			

Trustwide Project:

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

Strategic Programme:

Workstreams	True North Metric	Vision	Goal	Current State	Countermeasures	Level of Risk to Achieving Goal (CxL)	Level of Risk for progressing actions
	Refresh of the public health strategy	To create a sustainable, high-performing CYPH operating model and structure capable of delivering outstanding outcomes for children, young people, families and local communities, delivering fully on the Trust's True North ambition to deliver a great start in life for children vulnerable to poor health and wellbeing.	The future model will strengthen strategic influence, operational excellence and innovation, enabling the service to be recognised as a trusted partner locally, regionally and nationally. It will ensure the right leadership, workforce, governance and enabling infrastructure are in place to deliver the CYPH strategy sustainably into the future.	- Growth has increased the scale, geographical spread, workforce complexity, service diversity, contractual requirements and commissioner expectations across the portfolio. - The directorate is now required to deliver across a wider range of priorities, including operational grip, financial and productivity delivery, strategic partnerships, innovation, transformation, estates and business development and national policy influence. - The current structure remains broadly aligned to a traditional hospital directorate model, despite the directorate now operating across multiple systems with a wider strategic, partnership and growth agenda. - Enabling infrastructure has evolved incrementally alongside growth, with corporate support supplemented by directorate-led work in key areas such as business development, transformation and strategic positioning. - Continued growth will amplify existing capacity tensions between operational delivery, strategic influence, partnership development, transformation and business development. - Without deliberate consideration of the organisational form, operating model and enabling infrastructure required for the next stage of growth, there is a risk that operational demands will displace the work needed to deliver the directorate's wider ambitions. - Continued need for our structure and operations to align with the NHS 10-year plan and developing neighbourhood agenda.	Stage one – develop a discussion paper to describe the drivers for change, key functions of the directorate and the approach of growth in delivering strategic ambitions. Stage two – appraise future-state operating model and phased implementation roadmap, including priority actions, resource implications, risks, dependencies and transition arrangements. Stage three – seek sign-off of preferred option.		

Breakthrough Objective: CYP in Research

Workstreams	True North Metric	Vision	Goal	Current State	Countermeasures				Level of Risk to Achieving Goal (CxL)	Level of Risk for progressing actions																												
	Increase in CYP in Research	The overarching ambition is to provide services that meet the needs of young children, young people and their families and care givers informed by good quality research to ensure a great start in life. We need to demonstrate safe practice to provide assurance that our services have evidence of impact on children and young people's health and wellbeing	10% increase in participants from threshold in 2025, 5 new approaches for research participation in year. - Create a research active culture, where staff have the opportunity to be engaged with critical thinking practice, and have completed Good Clinical Practice (GCP) training. - NHSE eLFH: What is Health Research - training module - Complete literature reviews - library - GCP - as needed - Disseminate in Learning & Best Practice quarterly - Conference findings disseminated	Approached: Blue Grass insights In discussion: Represent Study NIHR 302504 NCMP Impact study NIHR 207678 In delivery: Coastal/Care Integrated Responses & Children's Lived Experience (CIRCLE by the sea) NIHR 162162 Escalator (ELIM -1) NIHR 20705: 6 participants; equating to 55% as the total recruitment cohort potential is 11. - Submitted an abstract for the Trust conference - Currently developing process map to develop research ideas - E-learning modules has gone live called What is Research from NHSE eLFH: Course 1 & 2 now available - Course: 1. What is Health Research? Awareness and Foundation - Course: 2. What is Health Research? - Supporting Research Participants - Successfully recruited to NIHR funded 0.6 wte Band 6, 0-19 research health visitor to R&I team to start in September 26	<table><tr><th>Concern</th><th>Cause</th><th>Countermeasure</th><th>Owner</th><th>Due Date</th></tr><tr><td>We don't currently understand the barriers to engaging in research activity</td><td>No process or pathway for review of research ideas</td><td>Review process and pathway all research ideas across the children and young people's environment</td><td>DA & G</td><td>Sept 2025</td></tr><tr><td>Current environment does not support research activity</td><td>No pathway or platform for research ideas - Lack of awareness - Disconnected - Researching and creating </td><td>Establish working group to review the barriers and solutions - Review process - Disconnected - Researching and creating </td><td>DA & G</td><td>July 2024</td></tr><tr><td>We don't know what research is currently ongoing</td><td>Research is not visible across the Trust - Research is not visible across the Trust - Research is not visible across the Trust </td><td>Establish a research working group with representation from across the Trust - Research is not visible across the Trust - Research is not visible across the Trust </td><td>DA & G</td><td>Sept 2025</td></tr><tr><td>We do not know the funding needs and current research data has not been used</td><td>Research is not visible across the Trust - Research is not visible across the Trust - Research is not visible across the Trust </td><td>Establish a research working group with representation from across the Trust - Research is not visible across the Trust - Research is not visible across the Trust </td><td>DA & G</td><td>Sept 2025</td></tr><tr><td>We do not know the funding needs and current research data has not been used</td><td>Research is not visible across the Trust - Research is not visible across the Trust - Research is not visible across the Trust </td><td>Establish a research working group with representation from across the Trust - Research is not visible across the Trust - Research is not visible across the Trust </td><td>DA & G</td><td>Sept 2025</td></tr></table>	Concern	Cause	Countermeasure	Owner	Due Date	We don't currently understand the barriers to engaging in research activity	No process or pathway for review of research ideas	Review process and pathway all research ideas across the children and young people's environment	DA & G	Sept 2025	Current environment does not support research activity	No pathway or platform for research ideas - Lack of awareness - Disconnected - Researching and creating	Establish working group to review the barriers and solutions - Review process - Disconnected - Researching and creating	DA & G	July 2024	We don't know what research is currently ongoing	Research is not visible across the Trust - Research is not visible across the Trust - Research is not visible across the Trust	Establish a research working group with representation from across the Trust - Research is not visible across the Trust - Research is not visible across the Trust	DA & G	Sept 2025	We do not know the funding needs and current research data has not been used	Research is not visible across the Trust - Research is not visible across the Trust - Research is not visible across the Trust	Establish a research working group with representation from across the Trust - Research is not visible across the Trust - Research is not visible across the Trust	DA & G	Sept 2025	We do not know the funding needs and current research data has not been used	Research is not visible across the Trust - Research is not visible across the Trust - Research is not visible across the Trust	Establish a research working group with representation from across the Trust - Research is not visible across the Trust - Research is not visible across the Trust	DA & G	Sept 2025			
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Related Corporate Risks:

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

Related External Risks:

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



June 2026

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

Purpose of the report	Approval		
	Assurance	x	
	Discussion		
	Information		
Summary of key issues:	The purpose of this report is to provide a summary and update on the board level safety measures for the month of June as set out in the Perinatal Quality Oversight Model (2025).		
Trust Strategy and Strategic Ambitions	The Patient and Child First Improving the health and wellbeing of our patients, children and communities		
	Best Quality, Safest Care		x
	Person Centred, Integrated Care; Strong Partnerships		x
	Great Start in Life		x
	At Our Best: Making HDFT the best place to work		x
	An environment that promotes wellbeing		x
	Digital transformation to integrate care and improve patient, child and staff experience		x
	Healthcare innovation to improve quality		x
Corporate Risks	No new corporate risks		
Prior Committee Review / Governance Route:	Maternity Risk Management Group Maternity Safety Champions Strategy Deployment Room (Senior Management Team) Quality Committee		
Recommendations:	Note the assurance provided by the Quality Committee.		
Impact Assessments	Financial		
	Workforce		
	Quality & Safety		
	Legal/Regulatory	x	Requirements for Maternity Incentive Scheme and NHS England for Board Oversight of Maternity Services.
	Equality & Diversity		
	Risk		
Consultation / Engagement	Not applicable		

Freedom of Information	
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Strengthening Maternity and Neonatal Safety Report

1) Summary

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

2) Introduction

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

3) Proposal

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

4) Quality Implications and Clinical Input

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

5) Equality Analysis

Not applicable.

6) Risks and Mitigating Actions

No new risks have been added to the risk register this month.
See below Section 4 for details.

7) Recommendations

Board Assurance Summary

Domain	RAG	Position
Safety		No moderate harm incidents in June but ongoing monitoring of neonatal death and elevated rates of Apgar <7 and OASI
Workforce		Fully recruited midwifery establishment but increased turnover of experienced staff
Quality		Good progress with SBLCB and MIS requirements, ongoing work on Maternity Care Bundle
Patient Experience		Strong neonatal feedback, low complaint numbers
Governance		Robust oversight through Safety Champions, Quality Committee and Board reporting

Overall assurance level:

Moderate Assurance with targeted risks requiring continued oversight.

Narrative in support of the Provider Board Level Measures
June 2026 data

1. Introduction

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

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

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

2. Obstetric cover on Delivery Suite, gaps in rota

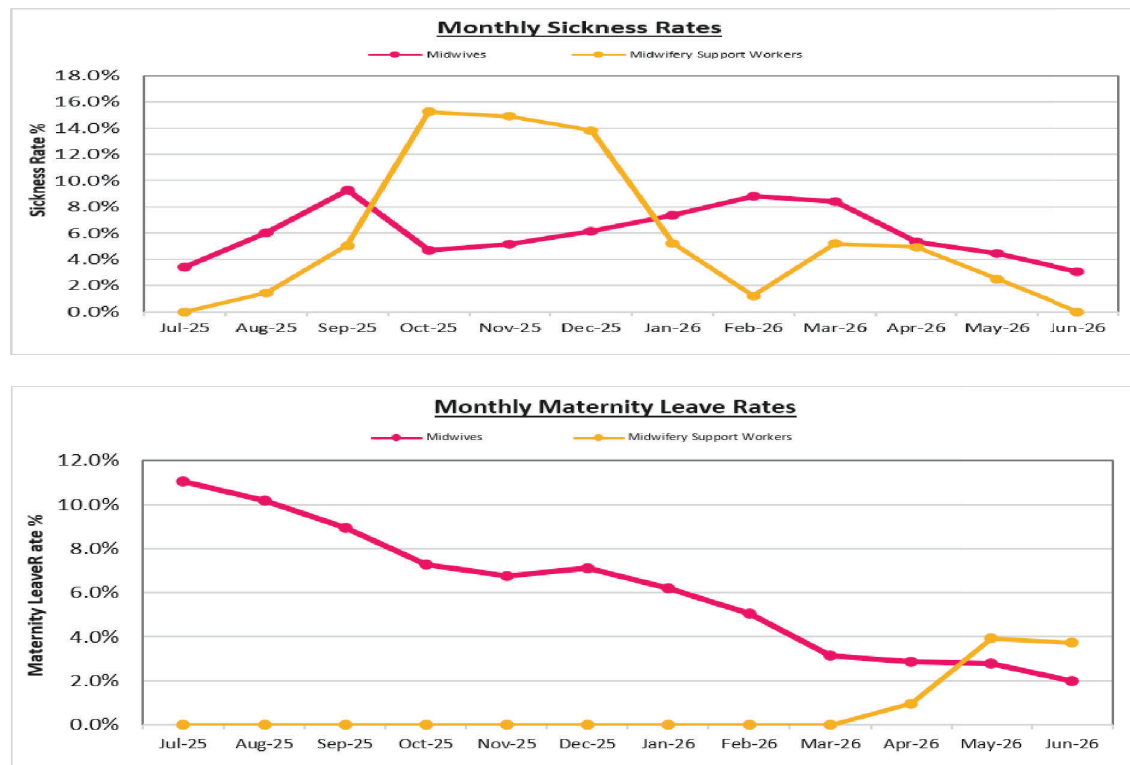
Safe levels of cover on Delivery Suite have been maintained with any gaps filled by locum shifts, extra sessions from the substantive team, and a small number of external bank doctors. A clinical teaching fellow and a locally employed doctor (LED) have been recruited. Recruitment is ongoing for the one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

3. Midwifery safe staffing, vacancies and recruitment update

a. Absence position

Total sickness absence in June remained fairly static this month for midwifery at 4.32 WTE, and maternity support workers absence has increased to 1.18WTE. The main causes of absence for midwives relates to stress which has remained static this month at 1.71WTE.

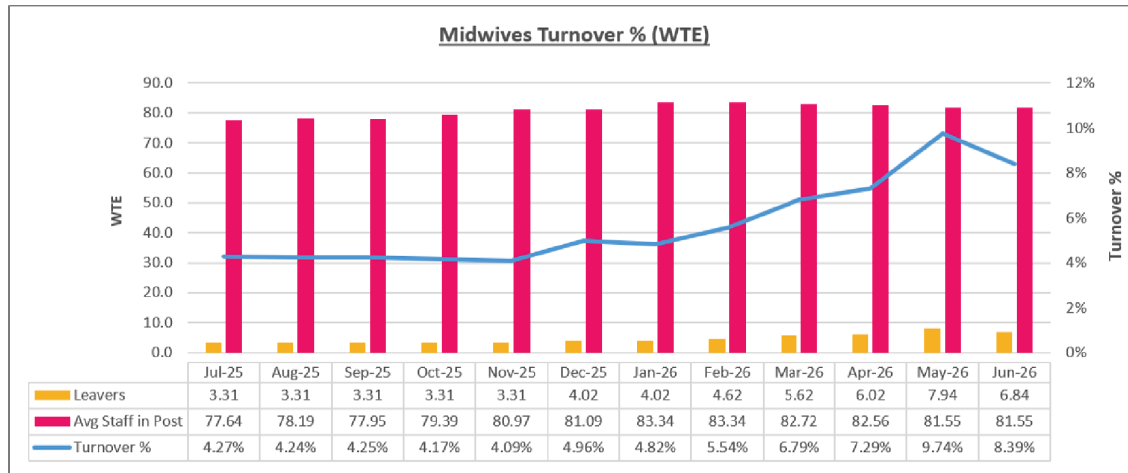
1.79 WTE midwives and 0.74 WTE support workers are on maternity leave at present. The monthly sickness and maternity leave percentages and trend can be seen below.



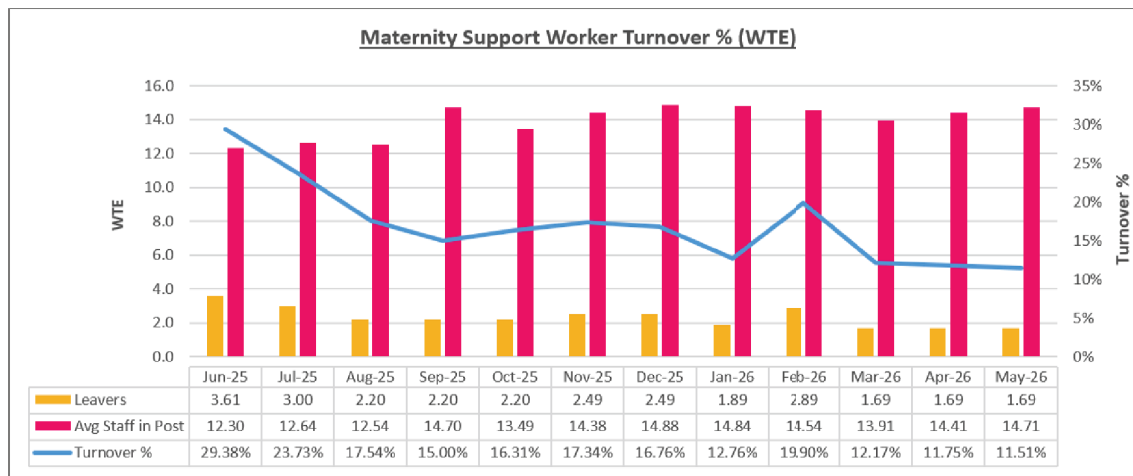
b. Vacancy position

There is no midwifery vacancy at present however recruitment is underway for maternity leave cover, a planned retirement and an NHS Resolution funded Maternity Incentive Lead Matron role. There is 1 WTE Band 6 Fixed term post to cover secondments in the recruitment process. There is a 2.6 WTE maternity support workers vacancy position.

While midwifery staffing levels have remained relatively stable, there has been a notable and sustained increase in turnover since early 2026, reaching a high of 9.74% in May 2026. This trend is driven predominantly by voluntary resignations linked to work-life balance and is characterised by a higher proportion of experienced staff leaving. Retention work is on-going and several workforce wellbeing initiatives are in place.

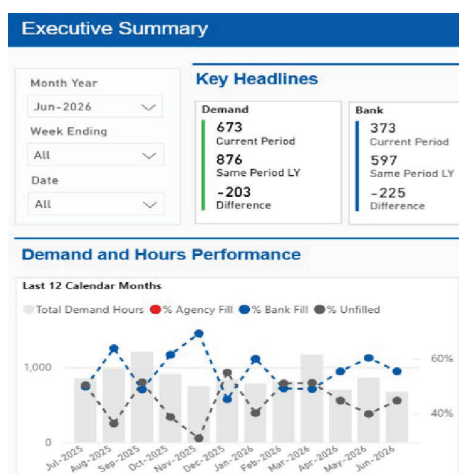


The Maternity Support Worker workforce has grown steadily over the past 12 months following the increase in budgeted establishment. This has been accompanied by a significant reduction in turnover from 29% to 11.5%. Leaver numbers remain low in May 2026, and there is no clear pattern of concern in terms of length of service or reasons for leaving. This reflects a stable and improving workforce position, although work-life balance continues to be a consistent theme across maternity staffing groups.

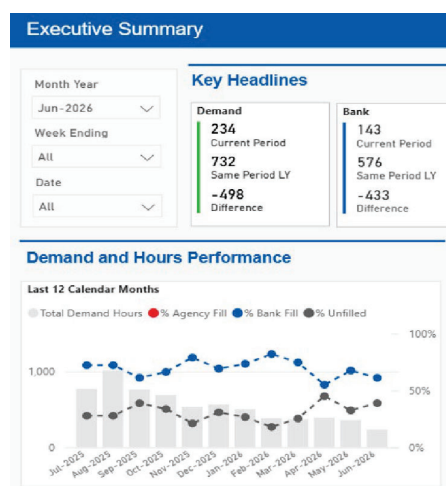


c. NHSP provision

Midwives – There continues to be a significant decrease in the requirement for NHSP cover improving from 876 hours in June 2025 and 1427 in June 2024, to 673 hours in June 2026. This is a reduction of 4.64WTE since 2024. Work is ongoing to ensure all midwifery staff are registered with NHSP to enable them to be able to support the service in times of high demand.



Maternity Support workers – Demand has shown a consistent reduction following increasing the maternity support worker establishment. Demand in June 2023 was 929, June 2024 it was 861 and in June 2025 it was 732. Demand in June 2026 was 234 hours, a reduction of 695 hours a month (4.27 WTE).



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

a. Neonatal absence position

There was 0.41 WTE nurse sickness absence during June 2026. 1.58 WTE QIS nurses and 0.80 WTE Clinical support worker are currently on maternity leave.

b. Neonatal Vacancy

Special Care Baby unit is fully recruited.

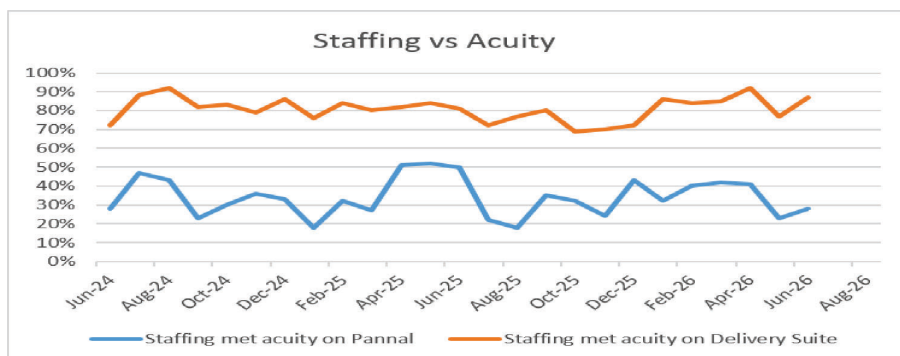
c. Qualified in Speciality (QIS) Nurses

To meet British Association Perinatal Medicine (BAPM) standards 70% of the budget establishment is required to be QIS nurses. The Operational Delivery Network (ODN) state that the QIS compliance is based on staff in post excluding any vacancy. One nurse has

recently passed her QIS training and is in her consolidation period until October. Two nurses are on a pathway to complete their QIS qualification. QIS compliance for June was 77%.

5. Birthrate Plus Acuity Staffing Data

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



a. Delivery Suite Staffing and impact on clinical workload

A supernumerary delivery suite co-ordinator was rostered and available at the start of every shift in June. 100% compliance with one-to-one care in labour was maintained throughout the month. According to the data captured in Birthrate Plus acuity tool staffing met the acuity requirements 82% of the time, was up 1.5 midwives short 21% of the time and the service was over 1.5 midwives short 2% of the time. Compliance with data capture was 91.4%.

b. Pannal Ward Staffing and impact on clinical workload

According to the data capture in the Birthrate plus acuity tool, 28% of the time staffing has met acuity on Pannal with an 85.83% compliance with data capture. A deeper dive into the data demonstrates that the ward staffing was as follows across the 120 opportunities for data capture -

Staffing position	Number of occasions	Percentage	Trajectory
1-2 staff over acuity requirement	3	2%	↑
Up to one staff over acuity requirements	26	22%	↑
Up to one staff below acuity requirement	46	38%	↑
1-2 staff below acuity requirement	26	22%	↓
Over two staff below acuity requirement	2	1.6%	↔
Data not captured	17	14%	↓

To manage workload across both Delivery Suite and Pannal during times of high activity and acuity inductions of labour were delayed and staff were redeployed from other areas of maternity services, including Pannal, Community and Specialist midwives. Clinical risk was mitigated and delays were kept as minimal as possible. In June there was a total of 73.45 hours recorded as having been worked clinically by team leaders and specialist midwives on an ad hoc basis which is a reduction from the previous month. 25.95 of these hours were on Pannal Ward, 7.5 hours were on Delivery Suite, 13 hours were in Maternity Assessment Centre, 22.5 hours were in Antenatal Clinic/Antenatal Day Unit and 4.5 hours in Early Pregnancy Assessment Unit to cover acuity.

6. Homebirth provision

Home birth provision is covered by community midwives working clinically in the day and a first and second on-call midwife every night between 17:00 – 08:00. Two midwives on call are required every night to cover the service equating to approximately 62 on call shifts requiring cover each month. Each midwife is therefore allocated three or four on calls per month depending on their WTE.

In June 2026 the home birth on call provision was unavailable on one occasion at night due to no volunteers to cover short term sickness absence. Unfortunately, this suspension resulted in a woman birthing before a baby arrived/ freebirthing. Learning has been identified about how the service could have been maintained and actions are in place to reduce the chance of a similar occurrence. Work is ongoing to review the working pattern and improve the resilience of the homebirth service.

Three homebirths were booked for the month of June, of these three; one woman birthed in hospital, one woman birthed in hospital due to medical reasons and the remaining woman experienced a BBA as described above.

A further two women's babies were born before arrival (BBA) of the midwife following a rapid labour.

7. Red Flag Events Recorded on Birthrate Plus

a. Delivery Suite Red Flags

There was one Red Flag event noted on Birthrate plus in June on Delivery Suite. This related to a delay between admission for induction and beginning of the process. Short term sickness was reported as a factor in this event. An on-call midwife was available to support but was not called in to the unit.

b. Pannal Ward Red Flags

There were two Red Flags recorded on Birthrate Plus on Pannal during June, one was due to a delayed time critical activity and one was due to delay in providing pain relief. As described above the staff were moved internally to manage the risks.

c. Elective Caesarean Sections (LSCS)

There were 11 elective caesarean section lists, with 37 caesareans performed. There were six elective LSCS on Delivery Suite during June.

d. Delayed Induction of Labour (IOL)

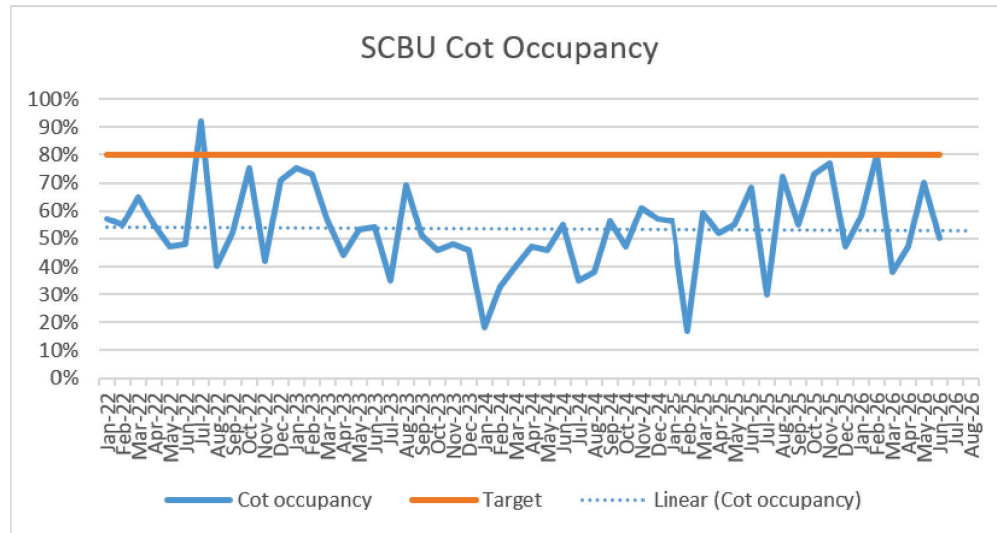
During June there were 15 episodes of delayed induction of labour over 24 hours:

- two were delays greater than 24 hours in admission to commence IOL,
- seven were delays greater than 24 hours in transferring to labour ward for artificial rupture of membranes (ARM) without the administration of prostaglandins or cervical ripening balloon (CRB).
- six occurrences were a delay greater than 24 hours in transfer for ARM, following administration of prostaglandins/CRB

This is a slight improvement since last month.

8. SCBU Cot Occupancy

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



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

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

a. Mandatory training (as at 01/07/26)

Department	Assignment Count	Percentage Compliant
421 Level 4 Obs & Gynae - Medical Staffing	32	76%
421 Level 4 Ante Natal Clinic	13	80%
421 Level 4 Community Midwifery	21	82%
421 Level 4 Pannal Ward	32	87%
421 Level 4 Maternity Staffing	64	90%
421 Level 4 Early Pregnancy Assessment Unit	4	93%

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

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

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

which is required for Maternity Incentive Scheme requirements.

Course Name	Midwives			Obs&Gynae Consultants			Obs&Gynae (Other Staff)		
	No. Required	No. Certified	Compliance	No. Required	No. Certified	Compliance	No. Required	No. Certified	Compliance
Resuscitation Courses									
Resuscitation - Level 2 - Adult Basic Life Support (CSTF)	84	82	98%	9	8	89%	20	17	85%
Resuscitation Level 3 - Newborn Intermediate Life Support (HNILS)	99	95	96%						
RCUK Newborn Life Support	20	19	95%						
Resuscitation - Level 3 - Adult Immediate Life Support (RCUK eILS) - (CSTF)	20	12	60%						
Maternity Specific Courses									
Fetal Wellbeing Competency Assessment	100	99	99%	9	9	100%	11	11	100%
MAT - Birthing Pool Hoist	92	82	89%						
MAT - Growth Assessment Protocol (GAP)	102	89	87%	9	6	67%	8	7	88%
MAT – Maternity Training Day 2	100	99	99%	9	8	89%	11	11	100%
MAT - Saving Babies Lives	102	71	70%	9	5	56%	11	8	73%
MAT 3 - Personalised Care & Care in Labour	102	94	92%						
MAT-PROMPT - Emergency Skills Facilitator Led	102	99	97%	9	8	89%	20	17	85%
Mandatory Training - Safeguarding									
Safeguarding Adults	102	97	95%	9	8	89%	13	10	77%
Safeguarding Children	102	97	95%	9	4	44%	13	3	23%

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

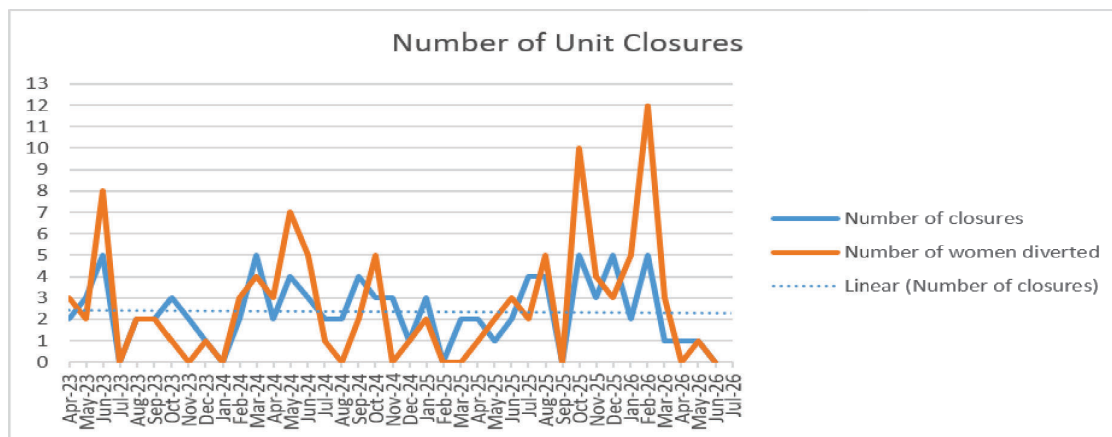
Work is ongoing for rotational medical staff to ensure compliance with Safeguarding Children training is passported into the Trust on rotation in line with the Intercollegiate guidance. SCBU nurses have all been booked on to Safeguarding training.

Course Name	Anaesthetic Consultants			Anaesthetic s (Other Staff)			Paediatric Consultants			Paediatric Medical (Other Staff)			Maternity Support Worker			SCBU		
	N o. R eq uir ed	N o. C er tif ied	C o m pl ian ce	N o. R eq uir ed	N o. C er tif ied	C o m pl ian ce	N o. R eq uir ed	N o. C er tif ied	C o m pl ian ce	N o. R eq uir ed	N o. C er tif ied	C o m pl ian ce	N o. R eq uir ed	N o. C er tif ied	C o m pl ian ce	N o. R eq uir ed	N o. C er tif ied	C o m pl ian ce
Resuscitation Courses																		
Resuscitation - Level 2 - Adult Basic Life Support (CSTF)							9	7	78 %	12	9	75 %	22	20	91 %	18	15	83 %
RCUK Newborn Life Support							9	9	100 %	12	8	67 %				14	12	86 %
Maternity Specific Courses																		
MAT - Birthing Pool Hoist													17	16	94 %			
MAT - Saving Babies Lives - Smoking Cessation													22	6	27 %			
MAT- PROMPT - Emergency Skills Facilitator Led	11	11	100 %	9	7	78 %							22	21	95 %			
Mandatory Training - Safeguarding																		
Safeguarding Adults	19	18	95 %	22	16	73 %	9	8	89 %	12	9	75 %	22	21	95 %	18	17	94 %
Safeguarding Children	19	17	89 %	22	18	82 %	9	8	89 %	12	9	75 %	22	21	95 %	18	12	67 %

10. Risk and Safety

a. Maternity Unit Divert

There has been no diverts of the unit in June 2026. This demonstrates a sustained improvement in the number of diverts of service, having had one divert a month for the previous three months. The situation remains under monitoring.



b. Maternity Accepted Diverts

A daily (Monday – Friday) regional meeting is in place to review staffing, activity and the number of women awaiting induction of labour across the HNY and WY regions. During the month of June three women were transferred to Harrogate and District NHS Foundation Trust (HDFT) maternity service from elsewhere in the region for artificial rupture of membranes, ongoing induction process or labour care.

c. SCBU Incidents

No moderate harm incidents have occurred in May.

Further to the letter from the Yorkshire and Humber Neonatal Operational Delivery Network (ODN) Clinical Lead stating that as a Neonatal ODN they are concerned regarding the ability of the permanent members of paediatric medical staff to maintain their airway skills for babies it was asked to start monitoring the number of neonatal intubations undertaken in HDFT as a watch metric. Please see below.

Metric	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26
Number of Neonatal Intubations	1	4	1	0	1	1	1	2

The ask from the ODN is also to ensure that all permanent members of paediatric medical staff log at least one intubation and chest drain insertion per year either in clinical practise, or simulation. Two simulation sessions are required to be run by the department each year.

Skills simulations days have previously taken place once a year (June 2024, March 2025 and April 2026) however plans are in place for an additional day to run each year starting from this year and the additional session this year is planned for September 2026. All medical staff who didn't attend in April this year are scheduled to attend in September.

d. SCBU Risk Register

No new risks have been added to the risk register.

e. Maternity Risk Register Summary

The risk register was formally reviewed in May 2026 and is next due for formal review in August. There are sixteen current active risks and one new risk has requested to be added.

New risk -

- **Risk to patient safety due to inability to provide senior obstetric cover for MAC (Maternity Assessment Centre) (Score 8).** Unable to provide daily senior obstetric cover for MAC causing delays in review of antenatal and postnatal patients. This contributes to delayed discharges and delays induction of labour and senior review of gynaecology patients. This is currently covered by the on-call team causing breaches of triage timescales.

16 previously active risks -

- **Risk to patient experience and safety and breach of triage timescales due to delays in Obstetric review in Maternity Assessment Centre (Score 8).** Obstetric Team may have delayed attendance due to competing clinical demands in other areas of the trust with risk to clinical management and patient experience, as well as potentially not meeting the requirements of the recommended triage pathway.
- **Risk to patient satisfaction, safety and staff morale due to inability to provide gold standard level of care (Score 8).** Midwifery staff reporting poor morale due to peaks of activity and perceived insufficient staffing, despite being fully recruited to Birthrate+. Additional frustrations experienced with equipment, IT systems and functionality issues affecting working capability and time to care. Associated impact on patient care.
- **Risk to safe monitoring and management of Perinatal Mental Health due to insufficient clinic capacity for PNMH appointments (Score 8).** Requirements and national guidance still under review. Excessive number of referrals and communications shared with community team to exclude low level referrals. Still to review consultant clinic attendance and understanding that clinic is not a treatment service.
- **Risk to patient satisfaction and safety, resulting from delays in facilitating induction of labour (IOL) (Score 8).** Peaks and troughs in delayed induction. Outpatient induction of labour plans ongoing. Situation being managed according to clinical priority to mitigate risk and communication improved with Patient Flow Coordinator. Risk score to remain the same at present
- **Risk to Information Governance and breach of confidentiality resulting from lack of training in redaction of patient record requests (Score 6)** Risk remains and limited progress to date. Exploration of use of AI and external company to complete redaction for local sign-off. Redaction SOP now produced. Decision by PSCC Directorate Risk Review to downgrade risk score.
- **Risk to patient safety due to lack of appropriate interfacing between EPR systems and ASCOMS within Maternity (Score 6).** Lack of interfacing capability between Badgernet maternity EPR system with Trustwide NerveCentre and ASCOM devices. Risk of lack of effective alerting to appropriate staff to potentially deteriorating patients or those requiring urgent review. Risk reviewed at PSCC Directorate Risk Review and downgraded.
- **Risk to reputation and patient experience due to possible discontinuation of Maternal and Neonatal Voices Partnership (MNVP) (Score 6).** Lack of clarity about continuation of funding arrangements for the MNVP service which may result in inability for the service to be maintained.
- **Risk to patient satisfaction and safety, resulting from delays in facilitating ultrasound growth scans (USS) (Score 6).** Some ongoing issues with incorrect requesting of scans. Plan to have period of vetting requests to determine level of issue. Scanning capacity increased with staff member returning from Maternity leave and

suggestion to reduce scan duration to create additional capacity (as safe to do so). Currently issues not occurring weekly. Score downgraded.

- **Risk to delivery of safe and quality care due to inability to share records electronically between healthcare providers when patients being transferred or receiving shared care between Trusts (Score 6).** Remains a regional issue. LMNS Passport produced. YHCR still has some limitations. Work ongoing. Not having moderate impact on regular basis, so consider that on review risk is not significant. Downgraded in relation to frequency.
- **Risk to operational running and governance surrounding safety and quality of homebirth service (Score 6).** Work ongoing and action plan in place. No change to risk score.
- **Risk to patient safety and experience associated with need to divert patients to other units in times of escalation (Score 6).** Diverts reduced in frequency. Situation improved but occurrence to remain monthly. Score to remain the same.
- **Risk to patient experience and exposure to financial claim due to inadequate counselling and documentation of informed consent (Score 6).** Informed consent embedded within Mandatory training and embedding of BRAIN acronym. Some ongoing incidents of inadequate informed consent and will take time to improve. Situation being monitored and risk score to remain the same.
- **Risk to patient experience and key performance indicators due to antenatal clinic process and clerical staffing issues (Score 6).** Incidents continue to be monitored and some improvement. Weekly meetings ongoing with continuous improvement work. Risk currently remains the same.
- **Risk due to inability to meet gold standard requirements for clinical documentation (Score 5).** Some improvement noted in personalisation and updating of management plans and risk assessments. For update following Records Audit. Risk score to remain the same.
- **Risk to reputation and patient satisfaction for failing to meet national target and provide evidence-based care in relation to Continuity of Carer (Score 4).** Enhanced Continuity of Care midwife role working well. Some feedback received about general lack of continuity in community areas with current team model. Baseline audit work ongoing to determine current continuity levels. Plan for buddy system in antenatal continuity and work ongoing. Risk score to remain the same in relation to reputational impact.
- **EPAU is not compliant with HDFT policy for Codeine which is now a controlled drug (Score 2).** *Transferred from Gynaecology risk register.* Agreement with Pharmacy about dispensing arrangements. Awaiting update and consideration of exemption. Risk score remains the same.

11. Maternity Incidents

In June 2026 there were 76 total incidents reported through DCIQ (including 10 incidents occurring in SCBU location).

There were no incidents of Moderate Harm or above recorded. However, advanced notification of an incident of Moderate Harm occurring in July relating to a difficult caesarean section delivery with an impacted fetal head. RROSE review being arranged.

Additional incidents noted in relation to missed or delay neonatal hip scans which are being followed up. Audit of hip scan completion is being undertaken.

12. Perinatal Mortality Review Tool (PMRT)

The stillbirth which occurred in March 2026 has been reviewed at Safety Incident Review Meeting (SIRM). A postmortem report has been received therefore a PMRT meeting is now planned for 27th July.

A fetal loss occurred in May 2026 on the threshold of viability and comfort care was undertaken on advice of Neonatologist. The PMRT meeting is to be arranged. No care issues have been identified.

In June there was a neonatal death following an unexplained collapse at home. MNSI and the Coroner have been notified and investigations are ongoing. A PMRT is to be arranged, though will be incomplete until the postmortem findings are received.

The Quarterly report for Quarter one is included at Appendix E.

13. Feedback

a. SCBU Feedback

"From the second we arrived we were greeted with such professionalism, friendliness and empathy from every member of staff. Throughout our stay we were made to feel like part of the family. We couldn't thank them enough for their continued care and support throughout, going above and beyond at every opportunity. The cleaner Sarah was absolutely fantastic and a credit to the team for not only looking after us on the ward but in the parents room. The love and passion from every member of staff shone through and we couldn't have wished for a better team of people to look after our son. We were delighted to see the care and enthusiasm from the Student Nurses and wish them every success in their career. We learnt so much from our stay that we will take away".

b. Maternity and Neonatal Voice Partnership Feedback

MNVP FEEDBACK MAY 26

HARROGATE Maternity Voices
Working in partnership to improve maternity & neonatal services

Anna MHMW was fantastic. Really made my entire experience. Can't thank her enough

My anesthetist was an angel/ So calming and lovely

Midwives were friendly

Can't fault the care I was given when I was pregnant. Midwife Ashley was amazing

Anna was phenomenal. Really made my whole experience so much easier. The lead up to labour was great. My midwife was great and ai felt well looked after

Dr Mitchell was amazing. I was a high risk pregnancy due to a blood condition and I felt like I was taken excellent care of by everyone involved in my journey. The bone doctors communicated with the consultants and midwives. I felt very safe.

Staff helpful. Never felt like can't ask questions. Midwives during labour were really helpful. Stayed longer than her shift to see how things went and to make sure stitches were ok. Ish name? Open and very honest, explained why she was doing everything. Midwife at Mowbry was really lovely too, saw the same one each time. Can't remember name

Everyone on SCBU was fantastic. We were regularly checked on by the midwife and health visitor once we were home which was a nice support.

Thank you!

14. Complaints, concerns, compliments

Five concerns/complaints were received in June. Three of these were regarding care in Antenatal Clinic. One was regarding care in MAC and one was regarding neonatal screening. Four of these have been responded to and one complaint remains under investigation.

15. Coroner Regulation 28 made directly to trust

No direct requests received.

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

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

17. Maternity and Newborn Safety Investigation (MNSI)

No new MNSI cases in June 2026. There is one ongoing MNSI investigation in relation to the unexpected neonatal death. The Coroner has been notified and post-mortem is being completed.

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

Work is ongoing locally at HDFT to ensure the Trust is compliant with the MIS requirements. Progress can be seen below. The area of compliance risk relates to

"Neonatal workforce establishment (nursing & medical) Trusts must have a clear plan for a fully funded neonatal nursing and medical establishment that aligns with the relevant BAPM standards for their unit designation (Neonatal Intensive Care Unit (NICU), Local Neonatal Unit (LNU), Special Care Unit (SCU)) and the neonatal nursing workforce calculator output (2020)."

This is being reviewed and work will be undertaken to enable the requirements to be met.

Overview of progress on MIS year 8 safety action requirements



Safety Action	Not started	Compliance risk	In progress & on track	Meets compliance	Fully embedded	Total sub-actions
A	0	1	6	0	0	7
B	0	0	5	0	0	5
C	0	0	6	0	0	6
D	0	0	2	0	0	2
E	0	0	2	1	0	3
F	0	0	4	0	0	4
Local work	0	0	0	0	0	0
National	0	0	0	0	0	0
Total	0	1	25	1	0	

19. National priorities

a. Baroness Amos Review

Baroness Amos published the final report and recommendations of the Independent National Maternity and Neonatal Investigation on 30th June 2026. The final report highlights key areas of concern, identifies barriers to delivering change and sets out a robust package of eight recommendations aimed at delivering long-term systemic and cultural transformation in maternity and neonatal care for the 21st century. The report also includes an additional set of actions that can be taken now, which will make a significant difference to the experience of women and families and the ability of staff to provide safe care.

The Investigation conducted reviews of maternity and neonatal services in 12 NHS trusts, to identify systemic issues affecting services across England and to inform the development of the national recommendations. The reports for each Trust have also been published.

The Ockenden Maternity Review has also published the Final Report of the Independent Review on 24th June 2026. This independent review of maternity services at the Nottingham University Hospitals NHS Trust considered the quality of care relating to newborn, infant and maternal harm at the Trust.

This report of the Review covers the findings, conclusions and essential actions of this independent review of maternity services.

Based on a review of over 2500 family cases that formed part of this investigation, the final report outlines:

Local Action for Learning (LAfL) that we say the Trust must do
System-wide learnings
Immediate and Essential Actions (IEAs) to improve maternity care

The Independent Maternity Review (known as the Ockenden review) was led by Donna Ockenden and involved a multi-professional team of more than 160 reviewers. The Review team held individual meetings with over 500 families and more than 830 current and former staff at NUH engaged with the Review.

As a result of the above two reports NHS England have created a 10-Point Plan for maternity and neonatal services, taking elements from Baroness Amos' national investigation and Donna Ockenden's recent review that services must focus on delivering now. This is a set of urgent actions in response to the recommendations in both reports that NHS England are asking trusts and the wider system to prioritise.

<https://www.england.nhs.uk/long-read/publication-of-baroness-amos-independent-investigation-into-maternity-and-neonatal-services-in-england/>

An action plan in relation to this ten-point plan can be found at Appendix B.

b. Maternity Care Bundle (MCB)

Work is progressing to ensure all services are in place in line with the requirements by March 2027. Concerns have been raised about whether Badgernet will be updated as required to enable compliance, for example to enable self-assessment at booking against venous thromboembolism risk factors and mental wellbeing questions. This is being raised nationally in Digital Midwifery forums with the system supplier SystemC.

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

Work is underway to improve services as required to meet the recommendations.

d. Saving Babies Lives Version 3.2

The trust updated the Saving Babies Lives Implementation tool and uploaded new evidence to the NHS Futures Platform in advance of meeting with West Yorkshire LMNS for the Quarter 4 review. The LMNS reviewed both the tool and the uploaded evidence in advance of the meeting. A comprehensive audit report was submitted as part of the evidence, which demonstrated a clear commitment to analysing data, reviewing processes and improving quality. There were no ongoing actions from the last quarterly meeting.

Overall Implementation Grading: Significant Assurance. 94% compliance

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)
Element 1	Smoking in pregnancy	Partially implemented	60%	Partially implemented	60%
Element 2	Fetal growth restriction	Fully implemented	100%	Fully implemented	100%
Element 3	Reduced fetal movements	Fully implemented	100%	Fully implemented	100%
Element 4	Fetal monitoring in labour	Fully implemented	100%	Fully implemented	100%
Element 5	Preterm birth	Fully implemented	100%	Fully implemented	100%
Element 6	Diabetes	Fully implemented	100%	Fully implemented	100%
All Elements	TOTAL	Partially implemented	94%	Partially implemented	94%

Except for specific weaknesses identified with smoking in pregnancy, the activities and controls are suitably designed and operating with sufficient effectiveness to provide reasonable assurance that the control environment is effectively managed.

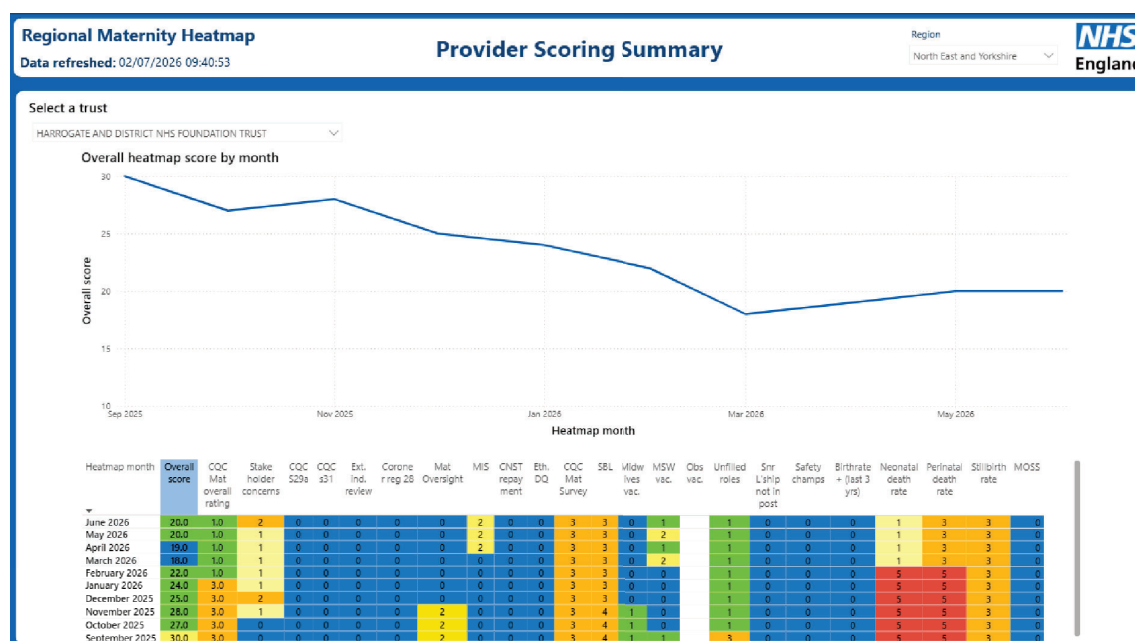
From Q1 2026-27 onwards, the Trust will oversee and gain assurance of the implementation of Saving Babies Lives, separately from the ICB, as per the Maternity Incentive Scheme year 8 requirements. Therefore, no further assurance meetings will be scheduled. However, if further support or information is required, the HNY & WY ICB maternity teams will endeavour to support where requested.

e. NHS England - Actions to improve care for women, babies and families: next steps <https://www.england.nhs.uk/long-read/actions-improve-care-women-babies-families-next-steps/>

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

- i) **Perinatal Equity and Anti-Discrimination Programme (PEAPD):** The Perinatal Leadership team will be attending PEADP in the autumn of 2026.
- ii) **Submit a Perinatal Event Notification (SPEN) service:** SPEN has been implemented at HDFT.
- iii) **Maternity and Neonatal Performance Dashboard:** The dashboard represents a balanced scorecard of operational, outcome and patient experience measures.
 - (1) Heatmap

The regional maternity heat map is an analytical tool that pulls information around trusts CQC status, regulatory notices and regulatory body/stakeholder concerns, progress towards national priorities, safe staffing, MBRRACE mortality, service user and staff feedback surveys. The heat map enables monthly oversight of the triangulated data and then scores each element to read the signals of trusts that require additional early intervention and support. The heat map is produced in a format for systems to use the information to direct work programmes to the right areas. The data is updated monthly and reports two months behind like the National Dashboard. The data for September is from the pilot month, with data completeness and accuracy work continuing throughout Q3 25/26. Please see below screenshot taken from the Regional Heatmap system. HDFT currently have a score of 20. This has increased from a score of 18 in March due to non-compliance with Maternity Incentive Scheme and concerns raised across the region by the Operational Delivery network regarding neonatal cot numbers. This additional 'stakeholder concern' has been added to all Trust Heatmaps in the region.



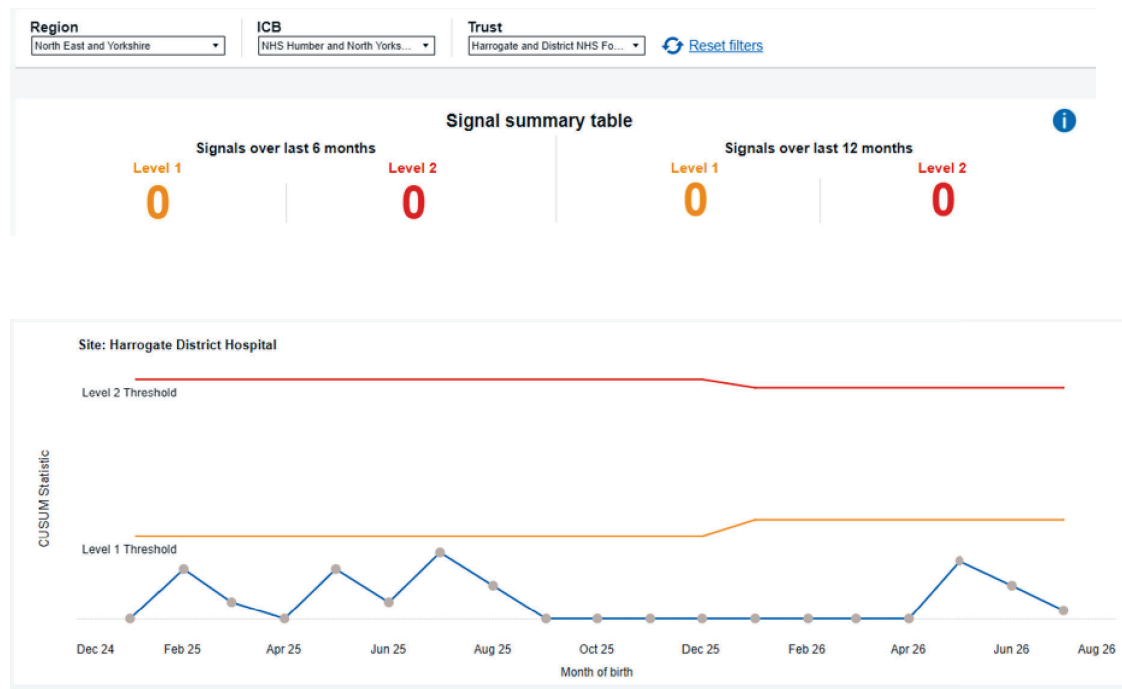
Significant changes have taken place within the Northern Neonatal Network from the 1st July 2026 that have directly affected cot capacity across Level 3 units. Due to the ongoing reconfiguration of Local Neonatal Units (LNUs) and Special Care Units (SCUs), the number of available cots within Level 3 services is reduced. This change has had a significant impact on the ability within the Yorkshire Neonatal Network to undertake both in utero transfers (IUTs) and, where necessary, ex utero transfers into these areas. A review of services is underway to ensure that neonatal intensive care cot capacity is safeguarded and utilised appropriately to meet the needs of the most vulnerable infants.

(2) Maternity and Neonatal Equalities Dashboard

A Maternity and Neonatal Equalities Dashboard can be accessed [here](#). The dashboard shows data from December 2025 and therefore hasn't changed since the previous report.

(3) Maternity Outcomes Signal System (MOSS)

The MBRRACE-UK Real Time Data Monitoring Tool extract has been checked for the past six months. No MOSS signal over last 6 months or last 12 months. However, noted increase in response to recent neonatal death in May 2026



f. Baby Friendly Initiative

The maternity department and SCBU received the Baby Friendly Initiative Gold Award for achieving sustainability standards in 2017 and 2020 respectively. This award requires a continued commitment to maintaining standards, implementing robust monitoring systems, and ensuring services are responsive to change, with measurable improvements in outcomes.

Please see Appendix C for the annual BFI report. This report provides assurance that work to support Baby Friendly accreditation within the Maternity Department and Special Care Baby Unit (SCBU) remains effective and continues to achieve the required outcomes and impact. It is structured around the Baby Friendly sustainability standards: Leadership, Culture, Monitoring, and Progress.

g. Vaccination

Of the 401 eligible patients in Quarter 1, 366 were offered the RSV vaccination (85%).

Of those offered:

- 241 were vaccinated before birth (66%)
- 43 patients declined the vaccination (12%)
- No vaccination data was recorded for 49 patients (12%)

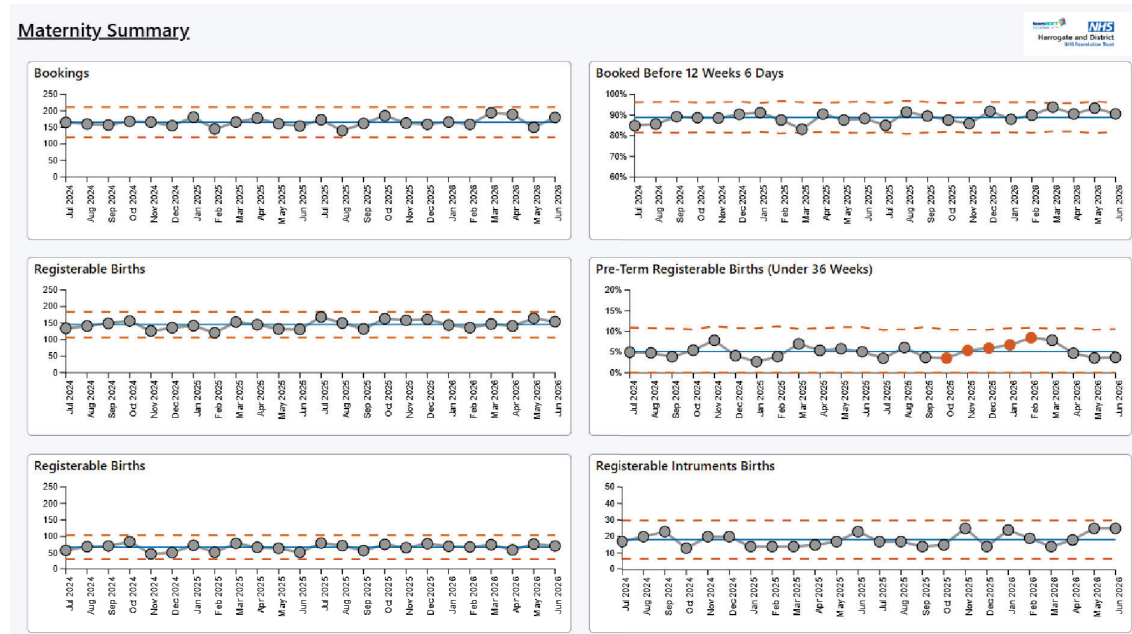
21. Local HDFT Maternity Services Dashboard

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

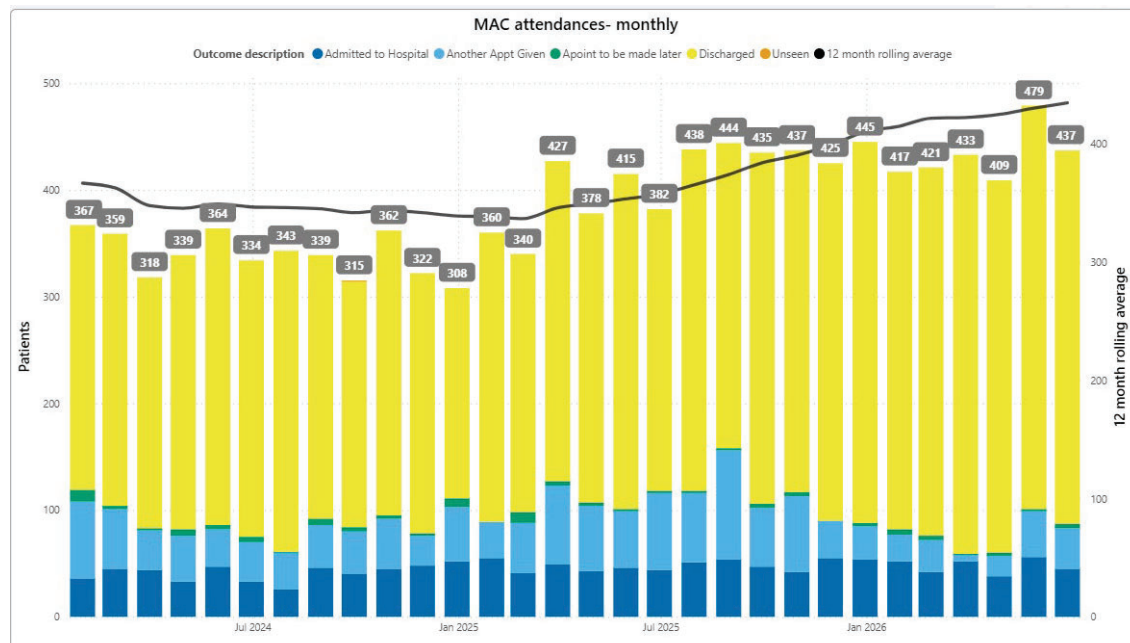
[Maternity Dashboard](#)

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

The below screenshot from the dashboard shows that births have remained within the normal rates for the month of June 2026.



Attendance at Maternity Assessment Centre has dropped slightly this month although activity remains high.



The National Maternity dashboard is available at the following link- [National Maternity Dashboard](#). The data available in the National dashboard is up to April 2026. The Clinical Quality Improvement Metric comparison (CQIM+) tabs gives the opportunity to compare HDET

Maternity services against National services, Regional Peers, the Local Maternity and Neonatal System (HNY LMNS) peers and MBRRACE peers (other maternity services with under 2000 births per year at 24 weeks or later).

It has been identified that HDFT Maternity Unit is significantly positive for the number of babies with a first feed of breastmilk, and full or partially breastfed at six to eight weeks old. HDFT are continuing to appear as above average but within upper and lower statistical bounds on the National Maternity Dashboard and/or Local Dashboard Power BI for several indicators. These indicators have been consistent for several months however work is ongoing.

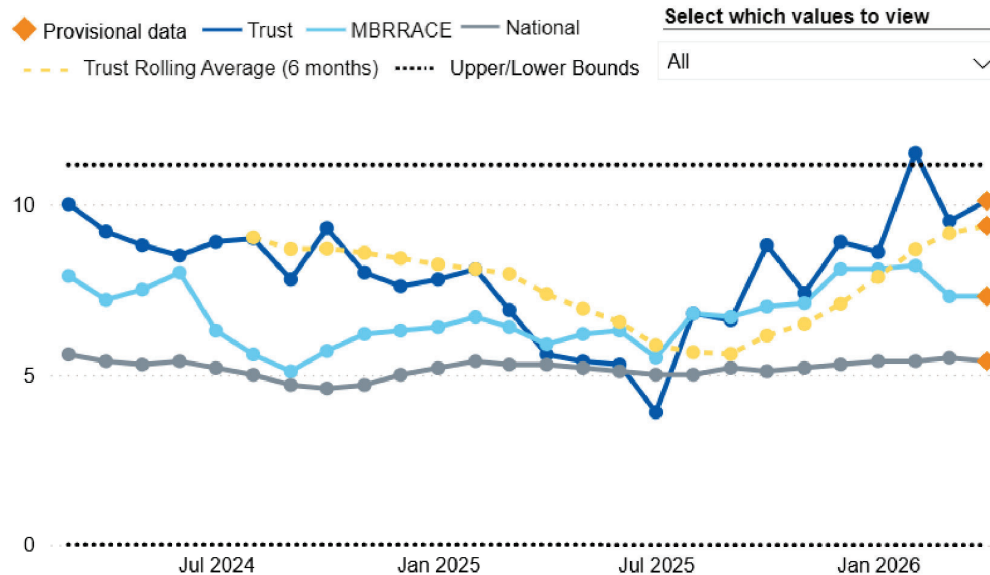
In particular, the following areas have been identified as requiring further interrogation:

- a. Neonatal Readmissions
- b. Apgar score at five minutes 0 - 6
- c. 3rd and 4th degree tear
- d. Caesarean section rate for Robson Group 1 (first pregnancies with a single cephalic pregnancy at least 37 weeks gestation with a spontaneous labour who go on to have a caesarean section)

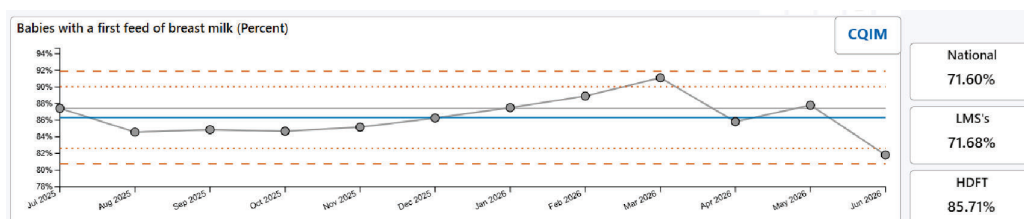
Each one of these elements will be discussed in turn below.

a. Neonatal Readmissions

Babies readmitted to hospital who were under 30 days old values comparison over time for Harrogate and District NHS Foundation Trust (Percent)



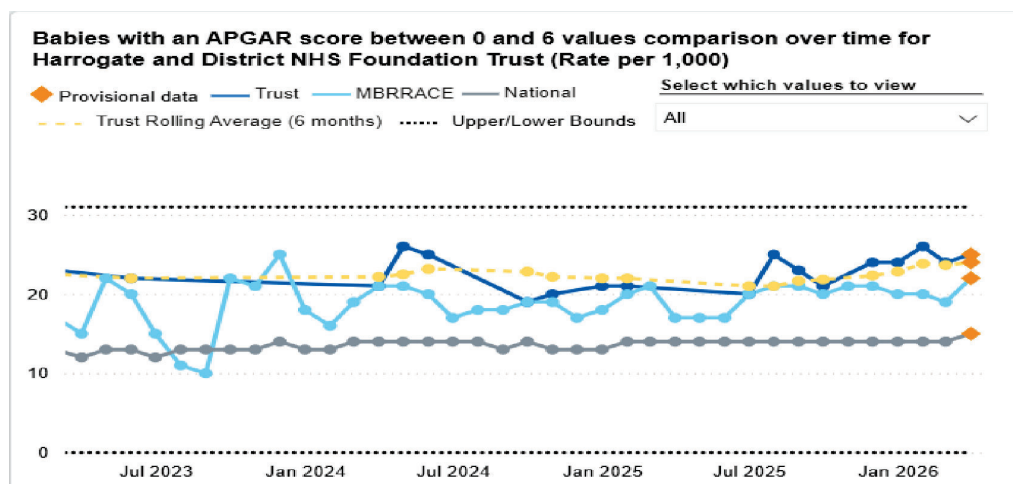
Admission criteria does differ across the UK making benchmarking across Trusts difficult. Although lower readmissions are often measured as a positive marker this may be at the detriment of exclusive breastfeeding. Breastfeeding initiation in HDFT is currently 85% which is significantly higher than the regional and national rate.



The Infant Feeding Coordinator provides a quarterly readmission report, analysing all neonatal readmissions. The report for Quarter 1 is attached at Appendix D. As part of this report, it is evident that readmissions to Maternity are most commonly for reasons of weight loss and/or jaundice. Further work is ongoing to establish reasonable actions to reduce the number of readmissions to the children's ward, Woodlands.

b. Apgar score at five minutes 0 - 6

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



The figure above shows the national Maternity Dashboard CQIM+ data since April 2023 for Apgar score below 7 at five minutes of age. Whilst the HDFT rate is not an outlier above the statistical upper limits, this is above the national average rate.

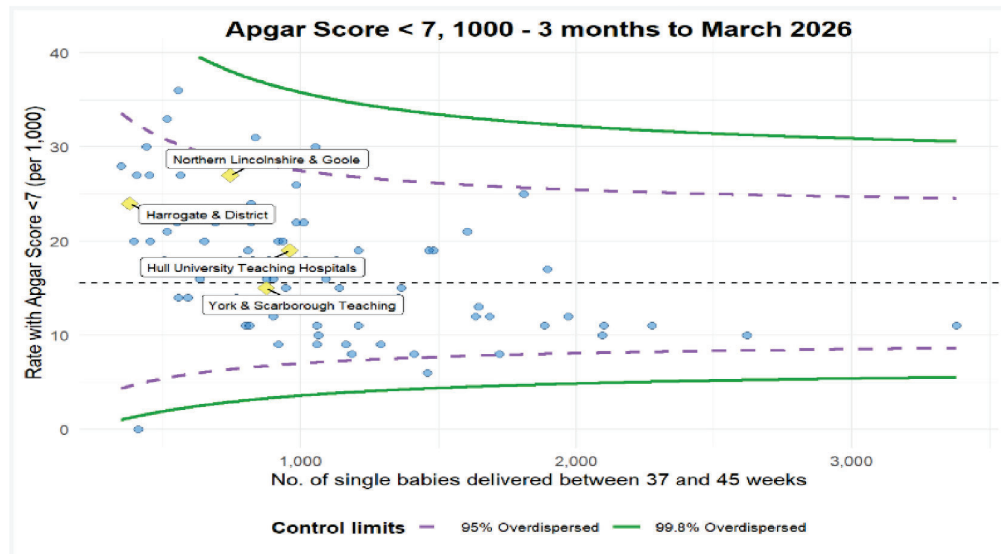
There are however known issues with duplicate pregnancy records being presented in the Maternity Services Data Set (MSDS) which is the data behind the National Dashboard, in particular when multiple providers have been involved in a pregnancy and they share the same system.

The issue can lead to births and associated outcomes being incorrectly assigned to more than one trust, which consequently leads to an inaccurate representation of variation at trust level and misrepresentation of outliers.

As a workaround, the North East and Yorkshire analytics team are in the process of removing duplicates for priority metrics. This process involves using patient-level data and site level information to correct the mapping of the trust and remove all other duplicate trusts. The measures currently in scope are indicated by those with the title ending 'De-duped'.

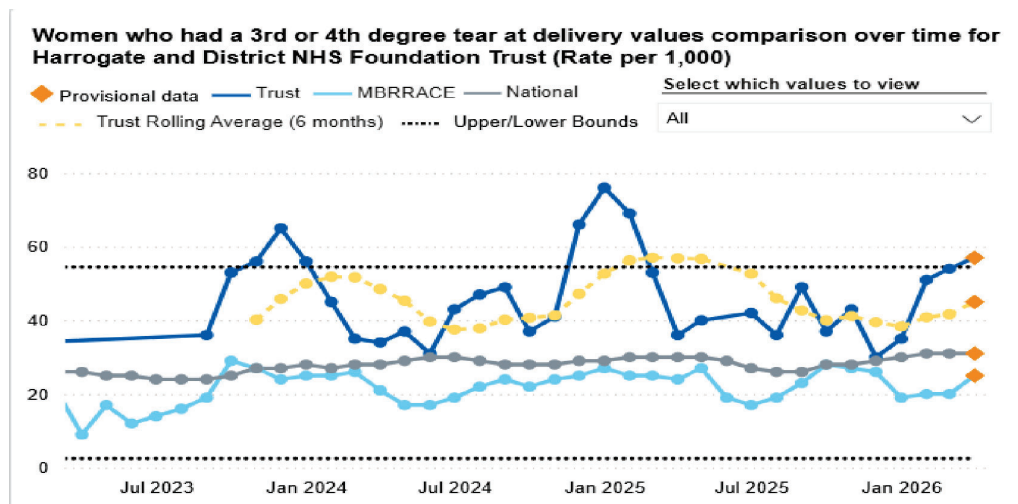
The below funnel plot shows the de-duped data. HDFT is positioned above the national average, with a rate of approximately 24 per 1,000 births, based on around 600-700 term deliveries during the reporting period. Whilst the Trust's rate is higher than the national mean, the data point remains within both the 95% and 99.8% control limits, indicating that performance is not statistically significantly different from that

expected for an organisation of this size. The Trust's position should be interpreted with caution due to the relatively small number of births compared with larger maternity providers. The indicator will continue to be monitored.



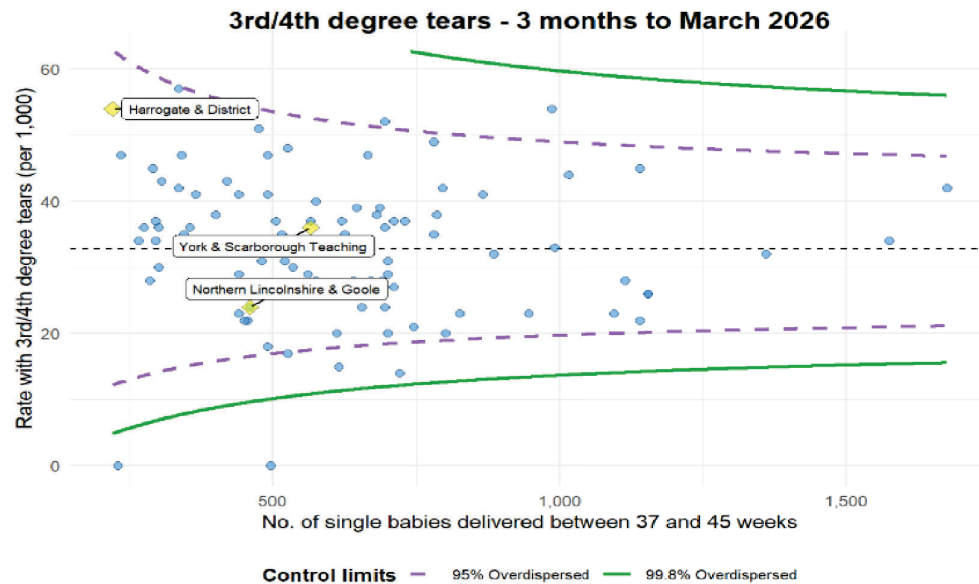
c. Third- and fourth-degree tears (local dashboard demonstrates a significant increase this month)

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

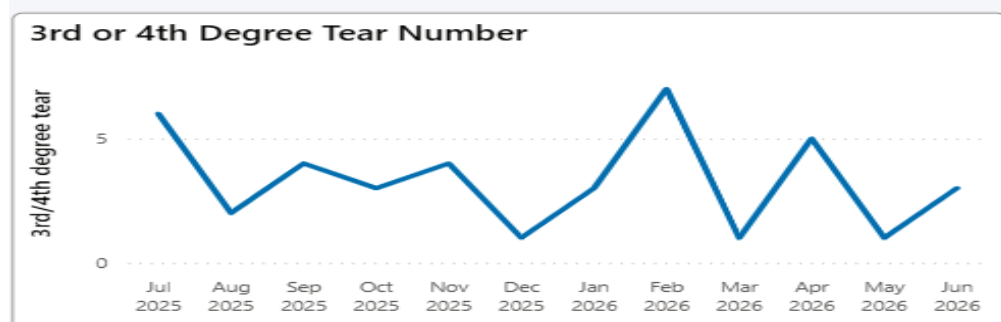


The figure above shows the national Maternity Dashboard CQIM+ data since August 2023 for 3rd or 4th degree perineal tears. The latest Trust data (dark blue line) shows a rate of 57 per 1,000 against a national rate of 31 per 1,000 for April 2026.

On review of the de-duped funnel plot data below, although the Trust's rate is elevated, the data point remains within the upper 95% control limit and well within the 99.8% control limit, indicating that performance is not statistically significantly higher than expected and the Trust is not an outlier for this indicator.



As shown in the graph below the actual number of 3rd or 4th degree tears are small with three 3rd degree tears occurring in the month of June.



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

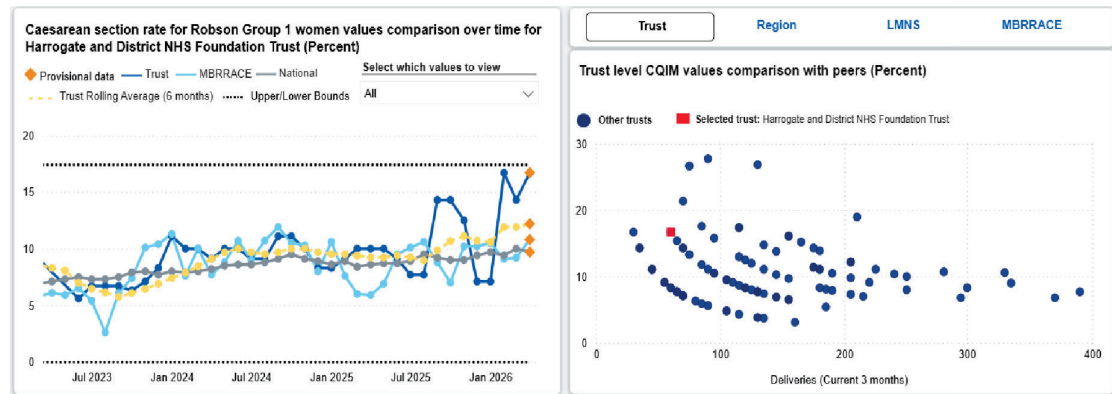
- Quality Improvement work to increase awareness of correct hands-on technique and supporting of the posterior shoulder at delivery, including at instrumental deliveries.
- Reinforcement about the correct angle of episiotomy
- Reinforcement of the RCOG OASI care bundle
- Additional training through the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

The impact of these interventions will be reviewed quarterly and reported through future Board reports.

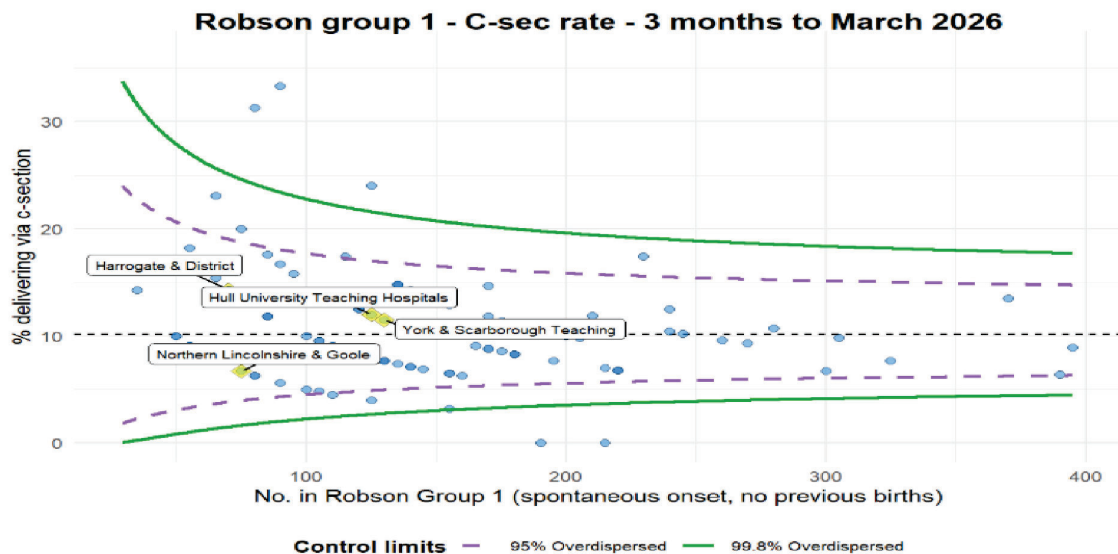
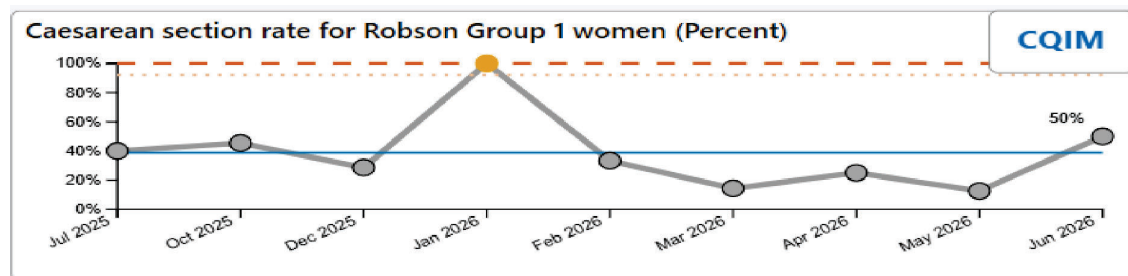
d. Caesarean section rate for Robson Group 1

Robson Group 1 is the group of women with a first pregnancy with a single cephalic pregnancy at least 37 weeks gestation with a spontaneous labour who go on to have a caesarean section.

The National dashboard shows the HDFT rate as being above average although not a statistical outlier and looking at the graph on the right the data is in line with other Trusts.



The local dashboard shows a 50% rate for June 2026. Again the de-duped data shows HDFT has a higher than average caesarean section rate within Robson Group 1 but remains within expected statistical variation and is not an outlier.



22. Avoiding Term Admissions in Neonatal Units (ATAIN)

Review of Badgernet Neonatal EPR system indicates that there were 10 Term Admissions to SCBU recorded in June (though one appears to have received Transitional Care on Pannal Ward only. All will be reviewed at ATAIN meeting:

- Three babies were admitted with an initial diagnosis of respiratory distress
- Three babies were admitted with feeding/weight loss issues
- One baby was admitted due to jaundice
- One baby was admitted with a suspected infection
- One baby was admitted with gastrointestinal issues

Current open actions identified from recent ATAIN reviews of Term babies admitted to SCBU:

Issue	Action	Due and Update
Inadequate guidance about management of Neonatal Herpes	For production of new guideline	30/6/2026
Lack of guidance about management of neonatal polycythaemia	For production of new guideline	30/6/2026
Lack of handover of clinical documentation for patient transferred from neighbouring unit	For agreement of SOP and regional agreement	30/6/2026
Hypoglycaemia policy not followed by paediatric staff	For sharing of learning as case study	30/6/2026

22. Maternity Safety Champions

Bi-monthly Safety Champion executive and non-executive director walk around and meetings continue. The last walkaround and meeting occurred on 18th May 2026. The Executive Safety Champion (Breeda Columb) and Non-exec Safety Champions (Andy Alldred and Andy Papworth) completed the walkabout. Andy Alldred has taken over from Andy Papworth in the non-exec champion for maternity and the group thanked Andy Papworth for his hard work supporting maternity services in his role over the past few years. On the walkaround staff raised concerns regarding a plumbing issue from the weekend which had taken some time to be resolved. Patients being received for care from across the region at times of significant delays in care elsewhere was perceived as a positive thing to do by staff. Staff raised concerns about low staffing numbers despite the increase in recruitment. Students provided good feedback about the support provided by maternity staff, and the culture and level of training provided.

The next walkaround is scheduled for 20th July 2026.

23. Conclusion and Recommendations

a) Positive news

- Sustained reduction in diverts over last four months.
- BSOTs launched in June.
- No moderate harm incidents

b) Areas of concern

- Funding for Maternity and Neonatal Voices Partnership not confirmed
- Induction of labour delays continue to impact patient experience

c) Work underway

- On-going work to review Maternity Care Bundle and new audit tool
- Amos ten urgent actions

d) Decisions required of Board/Board oversight

- None

Appendix A - Explanatory notes

1. Birthrate Plus Establishment

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

3.6 WTE Band 2 (Admin/Ward Clerks)

19.18 WTE Band 3 (Maternity Support Workers/Screening Admin)

0.6 WTE Band 4 (Tobacco Dependency Advisor)

81.69 WTE Band 5-8d (Midwives)

2. Birthrate Plus Acuity Staffing Data

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

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

3. Red Flag Events Recorded on Birthrate Plus

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

4. Perinatal Mortality Review Tool (PMRT)

Principles for the conduct of local perinatal mortality reviews:

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

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

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

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

Which perinatal deaths can we review using the PMRT?

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

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

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

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

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

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

From Year 8 onwards:

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

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

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

1. Workforce and capacity

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

2. Training

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

3. Learning from reviews and investigations

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

4. Service-user voice and equity

- This safety action focuses on ensuring that the voices of women, families and carers are heard, valued and acted upon, and that care is equitable.

- Trusts are expected to capture and use feedback from women and families, understand the needs of their local population, and address barriers to safe, accessible and inclusive care.
- This includes recognising and responding to differences in experience and outcomes across different groups.

5. Care bundles

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

6. Board oversight, governance, culture and leadership

- This safety action emphasises the role of Trust Boards in leading and overseeing maternity and neonatal safety. They are ultimately accountable for ensuring safe perinatal services in their organisation.
- Trusts are expected to demonstrate that Boards receive clear, regular information on safety and quality, that risks are identified and escalated appropriately, and that leadership supports a positive safety culture.
- Effective Board oversight is crucial to ensure that learning leads to sustained improvement, and to facilitate appropriate Trust resource allocation.

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

During the MIS year, Trusts are expected to:

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

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

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

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

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

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

6. Maternity Care Bundle (MCB)

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

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

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

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

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

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

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

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

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

6. Avoiding Term Admissions in Neonatal Units (ATAIN)

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

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

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

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

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

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

There are six elements of care:

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

In addition to the provision of safe and personalised care, achieving equity and reducing health inequalities is a key aim for all maternity and neonatal services and is essential to



achieving the national maternity safety ambition. In developing each element in SBLCBv3, actions to improve equity have been considered, including for babies from Black, Asian and mixed ethnic groups and for those born to mothers living in the most deprived areas, in accordance with the [NHS equity and equality guidance](#).

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

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

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



Appendix B –

Urgent Actions Following the Publication of Baroness Amos' Independent Investigation into Maternity and Neonatal Services in England

Action	Description	Comments	Actions	Lead Name	Due Date
1. Listening to women and their families by rolling out Martha's Rule	Commence roll out of Martha's Rule across all maternity and neonatal services in 2026/27. Building on the learning and insights from the recent pilot, this next phase will support implementation in all antenatal, intrapartum and postnatal inpatient maternity and obstetric settings, including maternity triage and assessment units, and neonatal settings. Implementation will be led by the national Martha's Rule programme team, working closely with patient safety collaboratives to provide coordinated local support, webinars, guidance and advice. We will contact provider organisations in the coming weeks to confirm expectations, resources and timelines.	Martha's Rule implementation being rolled out across Trust at present.	Roll out for maternity to be brought forward. Attend National meeting regarding the plans for implementation in August.	Dave Earl/Jenny Nolan	March 2027

2. Listen to women and their families using real-time and transparently reported outcomes and experience and clinical audit data that are acted upon at board level	All trusts should implement a monthly cycle of collecting and analysing real-time patient outcomes and experience data at their public boards, using locally meaningful measures like the friends and family test, selected elements of PREM (when available) and insights from maternity and neonatal voices partnerships (MNVPs). This should include regularly listening to women, families and neonatal parents at different points in the pathway, publishing data and patient commentary for full transparency, and ensuring a clear focus on the experiences of people from minority backgrounds. This will ensure the voices and experiences of women and families are heard, scrutinised and acted upon by boards. As part of this, trusts should also reinvigorate clinical audits focusing on key and relevant recommendations identified in the Ockenden and Amos reviews in a focused and effective way, and act on the findings. The aim is to support this approach through national webinars.	Patient outcome and experience data already included in monthly report and Board Paper. MNVP funding under review following disestablishment of LMNS.	PREM not yet available – will implement once arrangements confirmed nationally. Continue engagement with ICB and Regional NHS England team regarding MNVP funding and options for hosting service user representatives	Leanne Likaj	March 2027
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3. Dual board-level accountability between medical directors and chief nursing officers for maternity and neonatal care	All trusts must establish clear joint accountability at board level for maternity and neonatal services, with medical directors and chief nurses holding shared responsibility for oversight, performance and improvement. This must include consistent medical director engagement alongside the chief nurse, and parity between obstetric, midwifery, neonatal and operational leadership. Directors of midwifery and clinical directors leading maternity and neonatal services should attend boards when maternity or neonatal matters are discussed. This should also be implemented across all levels in the NHS including at system, regional, and NHS England boards to eliminate siloed working and strengthen system-wide leadership.	Medical director agreed to take on joint accountability.	Amended Exec names on all papers to Board to include Medical Director	Leanne Likaj / Kat Johnson	Completed
4. 'Amos into action' staff listening exercise	Following the listening conversation undertaken by Baroness Amos to understand the nature of the issues in maternity and neonatal services, NHS England will launch a full, open conversation with NHS staff and leaders to identify how the recommendations can be implemented across the system. It will explore and help address the role of culture, attitudes, approaches to	National action			To be in place from next Board Meeting – September 2027

	practice and ways of working – bringing staff into the single largest national conversation about what trusts and individual clinicians need to do differently to implement both the letter and spirit of the Amos recommendations. This will be done in a way that aligns to rather than duplicates the work of the taskforce and will report findings into it. It will focus on how we implement Baroness Amos's findings from the listening exercise and the findings of the Ockenden review of Nottingham University Hospitals NHS Trust (NUH).				
5. Addressing inequalities in maternity and neonatal outcomes	We can now confirm the timeline for national rollout of the Perinatal Equity and Anti-discrimination Programme, which will be available to all trusts by the end of 2026. The programme has been developed to support maternity and neonatal teams to tackle racism and discrimination, improve the experiences and outcomes of ethnic minority groups and those from deprived communities, and support staff to work in environments free from discrimination and racism. All boards must ensure that provision is in place to	Staff booked to complete training in Autumn 2026	Ensures actions from the programme are embedded in maternity services following attendance.	Leanne Likaj / Kat Johnson	March 2027

	allow enough staff to be released to complete the Perinatal Equity and Anti-discrimination Programme, with full participation expected across multi-disciplinary teams. Boards must also regularly review and act on trends identified by their inequalities data dashboards: Maternity and Neonatal Equalities dashboard - NHS England Digital	Trends in date are reviewed via Maternity Safety Champions meeting and shared with Quality Committee and Trust Board. Monitor via Safety Champions meeting and Board paper			Completed
	All NHS trusts providing maternity services are responsible for fully implementing the Maternal Care Bundle by March 2027. This includes providing regular reports to the trust board on implementation.		Actions are being taken to implement Maternity Care Bundle by March 2027.	Leanne Likaj / Kat Johnson	March 2027



6. Ensuring 24/7 safety and responsiveness of maternity and neonatal services	All boards must take accountability for ensuring safe and effective service arrangements, including reviewing staffing to ensure 24/7 availability and responsiveness across key workforce groups. Boards must also review internal resource deployment and consider whether roles not directly supporting frontline delivery can be redirected to strengthen service provision. Trusts must ensure that, where specialist posts exist (including in bereavement care and infant feeding), other staff have the knowledge and skills to ensure that care is not compromised when the specialist midwives are not immediately available. Commissioners also hold responsibility for ensuring that their maternity and neonatal service model aligns to local demographic needs. Boards and commissioners must address local gaps and eliminate siloed working to ensure services can consistently and safely respond to the needs of women, babies and families.	Plan in place for cover and training plans for staff All coordinators receive additional training in bereavement and infant feeding		Leanne Likaj / Kat Johnson	Completed
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7. Trusts to review their homebirth services	Trusts have a continuing responsibility to offer homebirth as a choice for women and are responsible for ensuring that they manage their workforce to enable this. In November 2025, the Chief Midwifery Officer for England asked trusts to urgently review the safety and quality of their homebirth services. Trusts should ensure that this review has been undertaken and reported to their board and that any safety concerns requiring urgent attention have been actioned. They should ensure that improvement plans are in place where necessary and that risks have been communicated to their regional NHS England team. NHS England is working with partners to develop homebirth standards and a homebirth framework, to support women's autonomy, choice and personalised care, and to help services provide safe homebirth care.	Local homebirth review completed in 2026. Reviewed via Maternity Safety Champions meeting.	Action plan in place and progressing.	Leanne Likaj / Kat Johnson	March 2027
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8. Responding to patient safety incidents, complaints and concerns with humanity, candour and a trauma-informed approach	Trust boards should review how they are responding to patient safety incidents, complaints and concerns within maternity and neonatal services, with openness, humanity and candour. We will work with trusts, in alignment with the work of the national taskforce, to develop a blueprint for how organisations and leaders can respond with more humanity and compassion when things go wrong with a patient's care.	Await blueprint to give guidance.		National Team	
9. Deliver safe and effective triage in maternity services (already committed by Government)	All trusts must commit to delivering safe and effective triage, starting by completing a board-level audit within 3 months, with a focus on ensuring that maternity triage services are consistently safe, responsive and appropriately resourced. This will be supported by new NHS England guidance, which will be published this week. This includes having dedicated midwifery staffing to answer calls and provide face-to-face assessments, separate from other services such as the labour ward. Services should also have enough clinical, antenatal and	Started BSOTs in July 2026 Work on-going across HNY to establish regional centre for receiving calls. Dedicated MAC staff for face to	Audit to be completed by 30 Sep 2026 Continue to push forward work across region.	Leanne Likaj / Kat Johnson Leanne Likaj / Kat Johnson	October 2027 October 2027

	bed capacity, with clear escalation routes in place at all times, including overnight and at weekends. Boards should have clear oversight of triage quality and performance, supported by regular data on waiting times, assessment and review times, redeployment, delays and outcomes. Triage records should capture women's preferences, and services should use evidence-based standards, such as BSOTS, supported by rapid assessment training for triage midwives. This should enable trusts to identify risks, address delays and provide women with timely, consistent and high-quality triage care. The outcomes of this audit should be reported to regions and the Department of Health and Social Care / NHS England. Within 12 months, trusts must implement improvements in line with national triage guidance to ensure women have consistent access to high-quality, responsive triage across the NHS. National maternity triage principles and a supporting measurement framework will	face assessments Escalation SOP's in place including nights and weekends	Include Triage audit data in Board report once available.	Leanne Likaj / Kat Johnson	October 2027
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	be provided to trusts this week to reduce unwarranted variation, strengthen consistency in how concerns are assessed and escalated, and provide a clearer basis for local, regional and national improvement.				
10. Post death care (already committed by Government)	All trusts must implement actions set out in the System letter following the Fuller and NUH reviews, including responding to the board assurance statement by 31 July and to the Human Tissue Authority requirement to review and assure completeness of incident records over the past 10 years. Every board should continue to review its local position and assure itself that all deceased people cared for in NHS settings are treated with the respect, dignity, security and compassion they deserve. This goes beyond compliance; it is fundamental to compassionate care.	Review on-going	Ensure actions implemented as required and embedded	Jackie Andrews / Breeda Columb	December 2026



Appendix C

Baby Friendly Initiative annual report 2025/26

This report provides assurance that work to support Baby Friendly accreditation within the Maternity Department and Special Care Baby Unit (SCBU) remains effective and continues to achieve the required outcomes and impact. It is structured around the Baby Friendly sustainability standards: **Leadership, Culture, Monitoring, and Progress**.

Background

The maternity department and SCBU received the Baby Friendly Initiative Gold Award for achieving sustainability standards in 2017 and 2020 respectively. This award requires a continued commitment to maintaining standards, implementing robust monitoring systems, and ensuring services are responsive to change, with measurable improvements in outcomes.

Overview of the UNICEF UK Baby Friendly Initiative Standards

Stage 1: Building a firm foundation

- 1** Have written policies and guidelines to support the standards.
- 2** Plan an education programme that will allow staff to implement the standards according to their role.
- 3** Have processes for implementing, auditing and evaluating the standards
- 4** Ensure that there is no promotion of breastmilk substitutes, bottles, teats or dummies in any part of the facility or by any of the staff.

Stage 2: An educated workforce

- 1** Educate staff to implement the standards according to their role and the service provided.

Stage 3: Parents' experiences of **maternity services**

- 1** Support those who are pregnant to recognise the importance of breastfeeding and early relationships for the health and wellbeing of their baby.
- 2** Support all mothers and babies to initiate a close relationship and feeding soon after birth.
- 3** Enable mothers to get breastfeeding off to a good start.
- 4** Support mothers to make informed decisions regarding the introduction of food or fluids other than breastmilk.
- 5** Support parents to have a close and loving relationship with their baby.

Stage 3: Parents' experiences of **neonatal units**

- 1** Support parents to have a close and loving relationship with their baby.
- 2** Enable babies to receive breastmilk and to breastfeed when possible.
- 3** Value parents as partners in care.

Re-accreditation

Embed all the standards to support excellent practice for mothers, babies and their families.

Achieving Sustainability (Gold)

Provide the leadership, culture and monitoring needed to maintain / progress the standards over time.

Code compliance

All accredited services must comply with *The International Code of Marketing of Breastmilk Substitutes (the Code)* and subsequent resolutions. The Code prohibits all promotion of milks and equipment related to bottle feeding and sets out requirements for labelling and information on infant feeding. Any activity that undermines breastfeeding also violates the aim and spirit of the Code.

- There have been no Code compliance issues reported locally this year.

Maternity

Maintaining and revalidating process for maternity

Required submissions to UNICEF Baby Friendly Initiative

- **Yearly progress reports** including breastfeeding statistics, audit results and action planning
- **Three yearly revalidation** includes: submission of a portfolio, including data and audit results together with supporting documents and evidence of progression. A presentation detailing progress since the initial Gold accreditation followed by questions and discussion
- **Short notice monitoring visits** are carried out on a percentage of facilities each year.

Next submission required to maintain gold accreditation

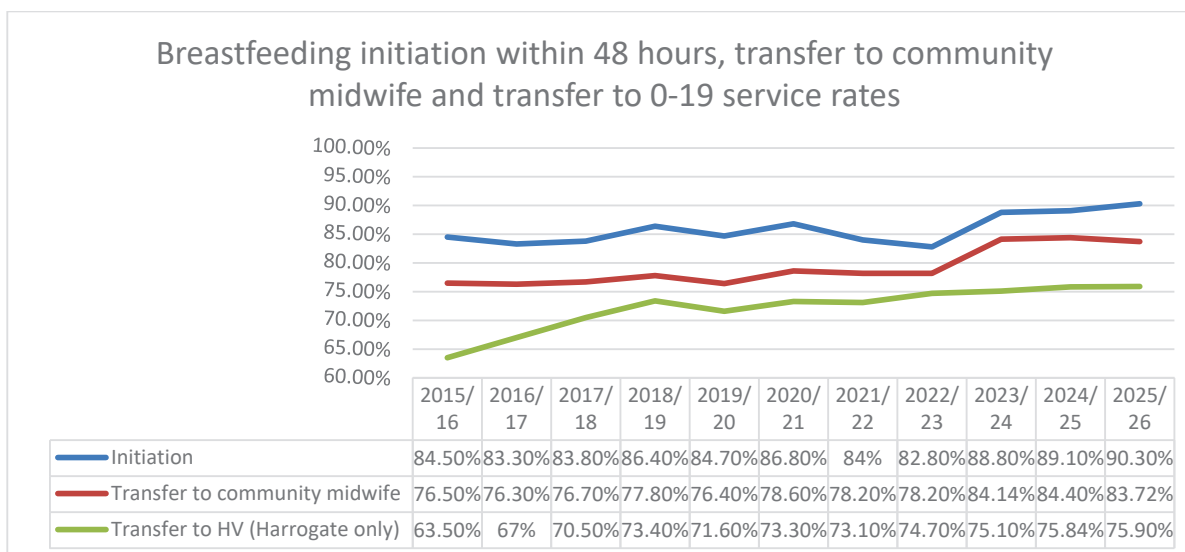
July 2026 – Yearly progress report

Training and leadership

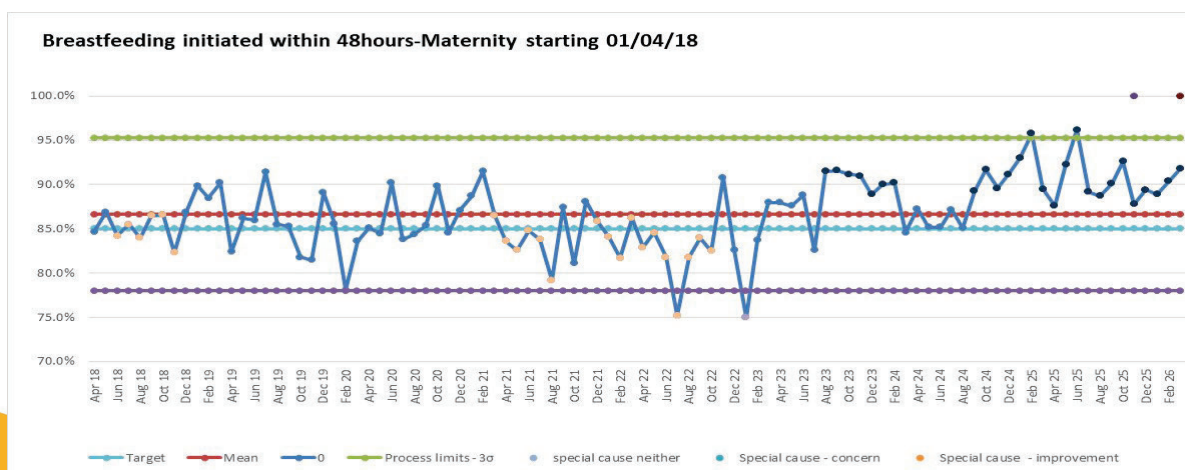
- Currently 96% of midwives and 95% of maternity support workers have completed *breastfeeding and relationship building* training (UNICEF requirements 80%). The remaining five new members of staff are booked on courses in May and July. One member of staff will not have completed the training within the required six-month time frame from commencement of employment due to long term sickness.
- Four managers are due to complete Baby Friendly Initiative *Achieving Sustainability* training; this session is booked on June 2nd 2026.
- Yearly mandatory infant feeding updates continue, with the 2026 focus on supporting lactation across a range of clinical circumstances.

Data and monitoring

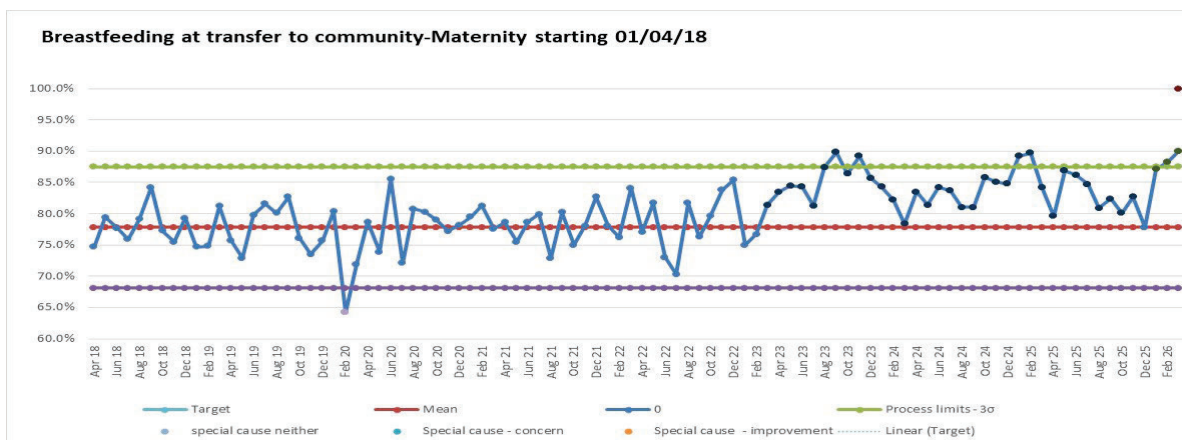
Graph 1 Breastfeeding rates



Graph 2 Statistical Process Control chart (SPC) for breastfeeding initiation within 48hours



Graph 3 Statistical Process Control chart (SPC) for breastfeeding rates on transfer to the community midwives



Over the past 12 months, infant feeding outcomes have remained consistently strong across the maternity and community pathway (Graphs 1, 2, and 3) with breastfeeding initiation within 48 hours reaching above 90%. Improvements seen in recent years for breastfeeding at transfer to community midwifery have been maintained, with performance now stable in the mid-80% range, suggesting good support in the hospital setting. Although breastfeeding rates at transfer to health visiting services continue to show steady, gradual improvement, there is an opportunity to look at further support beyond the early days, including bespoke infant feeding training for the community midwives and more robust pathways for supporting longer term weight loss in babies. Overall, the data demonstrates sustained progress, and a positive trajectory.

Supplementation rates

Supplementation of breastfed babies with formula milk has been shown to shorten the length of time a mother continues to breastfeed and may have an impact on the long-term health of their baby. The aim is to ensure supplements are given only for medical indication or following fully informed decision making by the mother.

Percentage of breastfed babies given formula in hospital before transfer to community.

2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
12.2%	10%	9.6%	10.5%	11.1%	10.3%	15.7%	11.5%	8.9%	11.4%	9.9%

The above rates for supplementation are taken via BadgerNet on transfer to community care. Regular audit via clinical notes and maternal feedback provides additional assurance that supplementation is used appropriately and that women are supported to make informed feeding choices.

Readmission rates

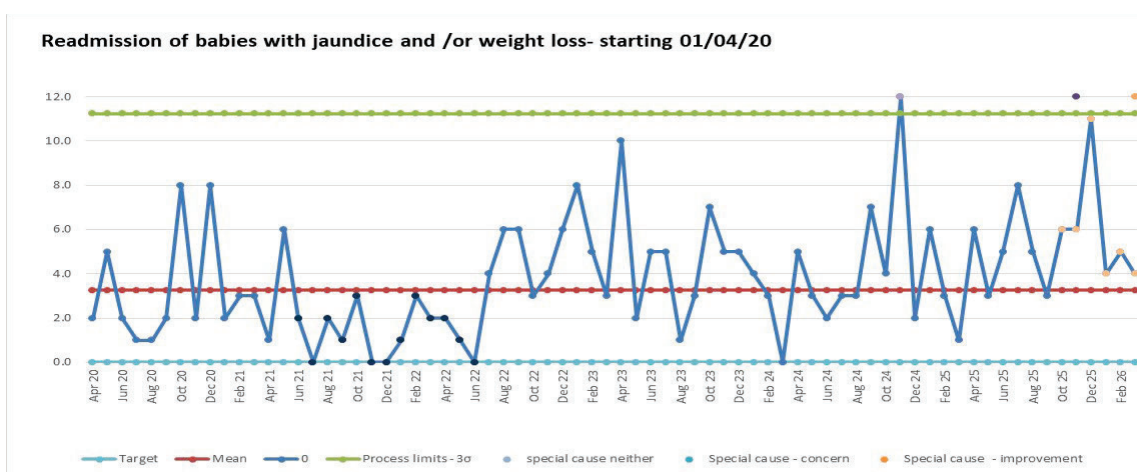
Readmission of a baby to hospital causes stress and anxiety for parents and families. Review of cases aim to find modifiable predictors and develop interventions to reduce the risk of readmissions when possible.

Monthly readmissions for jaundice and/or weight loss have generally remained within expected variation throughout the reporting period (Graph 4). However, during the last six months, rates have demonstrated special-cause variation. This has prompted a quality improvement project to explore in greater depth the risk factors and predictability of jaundice requiring treatment.

Alongside this project, a new pathway has been introduced for babies with weight loss. This includes the option for clinically well babies with normal sodium levels to be discharged home with a hospital breast pump and reviewed the following day for repeat weight assessment.

For further information, see the quarterly reports: *Hospital Readmissions of Babies Within 30 Days of Life*.

Graph 4 Statistical Process Control chart (SPC) for readmissions of babies with jaundice and weight loss



Frenulotomy service (tongue-tie division)

As part of the infant feeding service for babies with complex feeding issues, a frenulotomy service is available.

Over the past year, service delivery has relied on a single midwife supporting the clinics due to the maternity leave of another practitioner. Following her return, that midwife has left the Trust. This currently leaves two trained midwives within the service; however, one is due to retire in the Autumn. To address this, one midwife has secured a place on a training course commencing in September, and it is anticipated that funding will be secured for an additional training place. This will ensure that by April next year, the service is supported by three trained practitioners.

Year (April – March)	2025/26
Referrals received	268
Declined	91
Completed frenulotomies	177

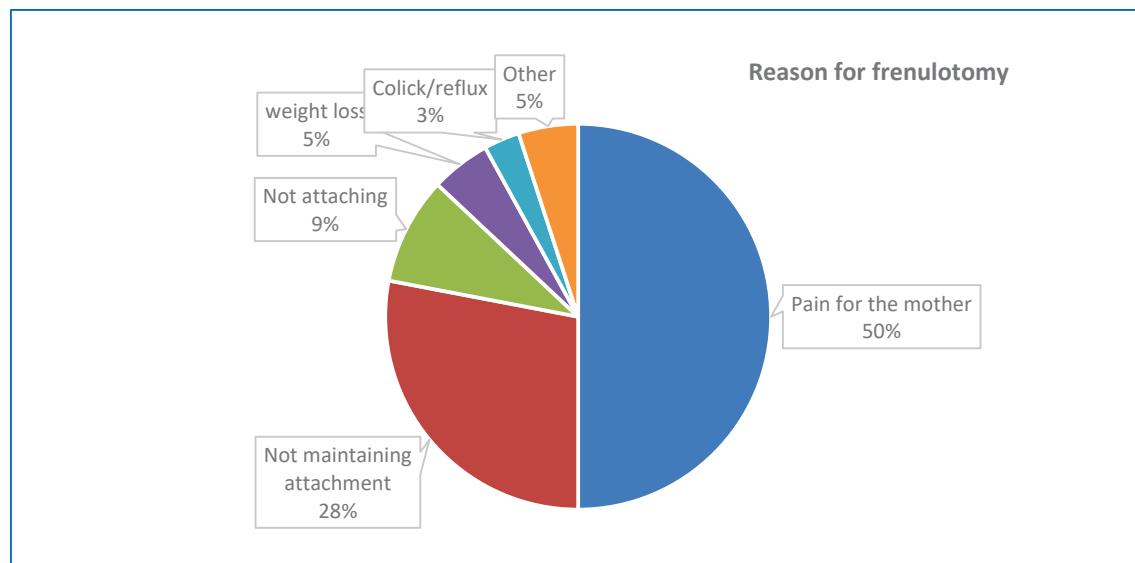
Of the 177 babies who underwent tongue-tie division during 2025/26, 74.5% were exclusively breast/breastmilk feeding, 24% were mixed feeding, and 2% were fully formula feeding. Two of the formula fed babies were having significant bottle-feeding issues in the other two cases the mothers both planned to recommence breastfeeding.

Follow-up contact was achieved with 83% of mother's post-procedure.

Post procedure issues: Three babies were treated for bleeding following the procedure, one baby was encouraged to feed again, one baby required pressure on the wound and one baby required pressure with an alginate dressing. The paediatric team were consulted for the baby being treated with the alginate dressing as this was the first case where second line treatment was required. All three babies were observed for an hour on the unit following treatment. None of the above babies had any issues once home.

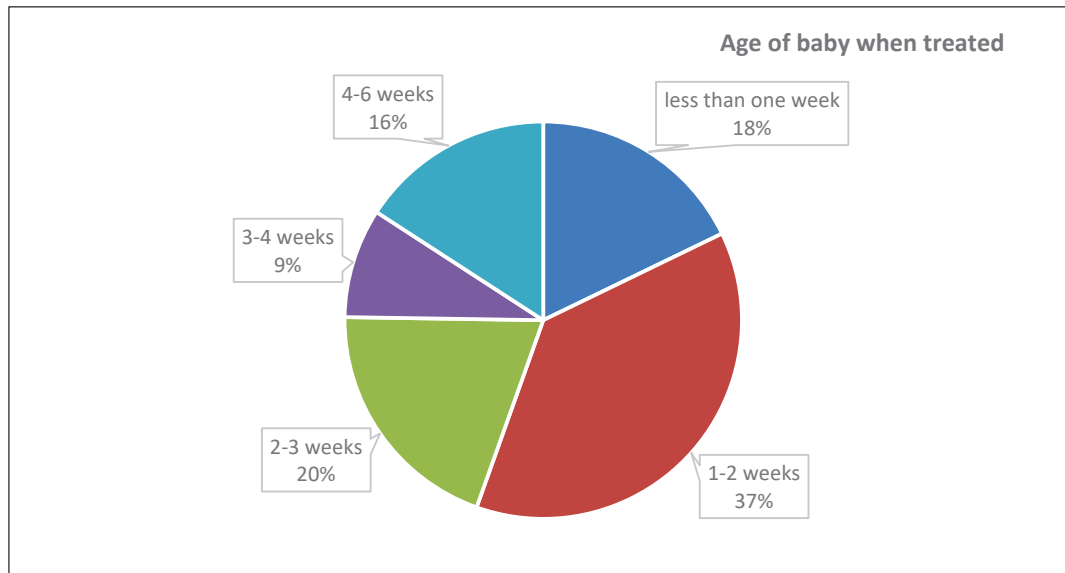
Following discharge from the clinic one baby was admitted to hospital due to being unwell. As part of the admission process the wound site was visualised and there were no concerns, the baby was diagnosed with a viral infection. There were no other issues reported by mothers once home.

Graph 5



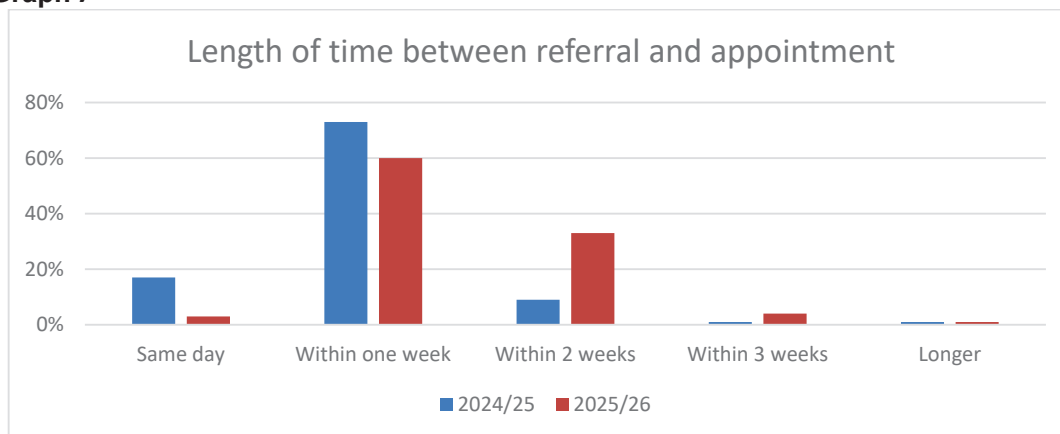
Graph 5 illustrates the reasons for referral for frenulotomy. The majority of cases were due to maternal pain and/or the baby's inability to maintain attachment at the breast. All referrals were made following an appropriate breastfeeding assessment and support.

Graph 6



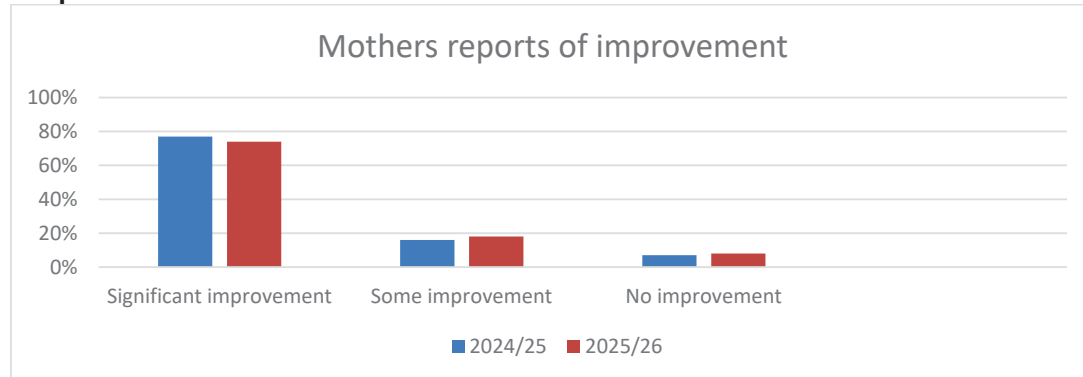
Graph 6 shows that the majority of babies received treatment before 2 weeks of age. However, the number of babies treated between 4-6 weeks has risen from 7% last year to 16%. The majority of these are Health Visitor referrals. Our aim is to ensure a timely referral to the service when there are problems, we will continue to monitor this rise. The service currently accepts referrals for babies up to 6 weeks old.

Graph 7



Graph 7 demonstrates an increase, compared to last year, in the number of babies waiting longer than one week for an appointment, alongside a reduction in those treated on the same day. This may be attributable to changes in clinic timings and a reduction in staffing, with only one practitioner available compared to two in the previous year.

Despite this, 96% of babies were seen within two weeks of referral. The two babies who experienced the longest waits were due to specific circumstances: in one case, a referral was recorded in BadgerNotes but not submitted, and in the other, the mother declined an earlier appointment while receiving support at the breastfeeding club, resulting in the referral remaining open.

Graph 8

Graph 8 illustrates mother-reported outcomes following tongue-tie division. Of the 83% of mothers successfully contacted, 92% reported some level of improvement, with 74% describing the improvement as significant—a small decrease of 3% compared to the previous year.

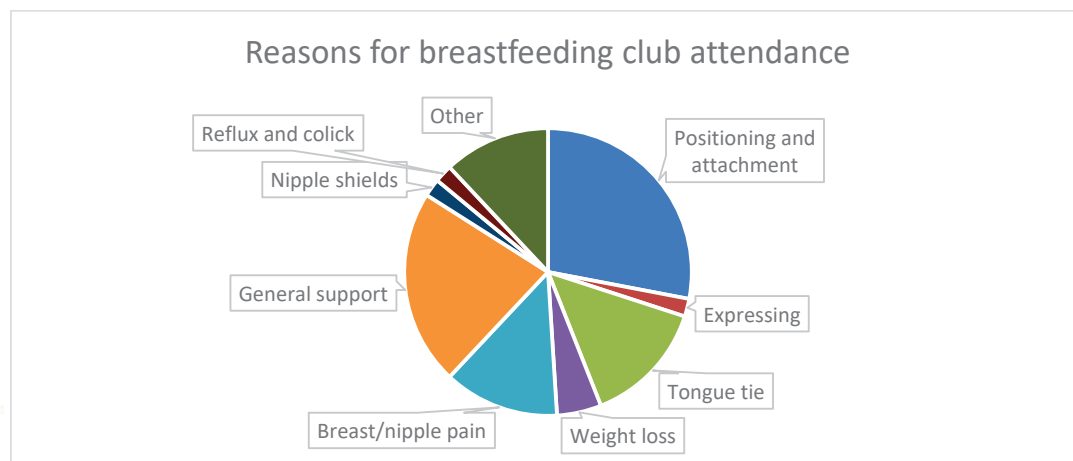
Among the mothers who reported no improvement, the reasons for referral were varied, with no single predominant cause identified.

Culture

Breastfeeding club

The Breastfeeding Club supports mothers with general and complex needs, run in partnership with Harrogate Library. Mothers self-refer or are referred by their community midwife, health visitor or general practitioner. The club runs on a Tuesday morning and ran for 52 weeks of last year.

- Total number of mothers seen: 229
- Total attendances: 478
- Average number of mothers seen per week: 9

Graph 9

Graph 9 presents the reasons for attendance at the infant feeding clinic. The most commonly cited issue was positioning and attachment, although most mothers reported experiencing multiple co-existing feeding challenges. Babies with suspected tongue-tie were assessed within the clinic setting to avoid unnecessary use of appointment slots in the frenulotomy clinic. Training sessions for midwives in the general diagnosis and referral for tongue tie have been held this year, and this will hopefully reduce unnecessary referrals to both the breastfeeding club and the frenulotomy clinic however a fully trained practitioner is still required for a complete diagnosis prior to treatment.

Special Care Baby Unit (SCBU)

Maintaining and revalidation process for neonatal

Required submissions to UNICEF Baby Friendly Initiative

- **Yearly progress reports** including breastfeeding statistics, audit results and action planning
- **Three yearly revalidation** includes: submission of a portfolio, including data and audit results together with supporting documents and evidence of progression. A presentation detailing progress since the initial Gold accreditation followed by questions and discussion
- **Short notice monitoring visits** are carried out on a percentage of facilities each year.

Next submission required to maintain gold accreditation

June 2026 – Yearly progress report

Training and leadership

- All managers have attended the Baby Friendly Initiative *Achieving Sustainability* training programme.
- 100% of neonatal nurses and support workers have completed the *Breastfeeding and Relationship Building* course. This training is now repeated on a three-yearly basis.
- Annual mandatory updates for nurses and support workers continue, with this year's focus on transitional care and supporting babies wherever they are receiving care.
- Doctors rotating into paediatrics continue to receive initial infant feeding training. Additional updates are delivered throughout the year for the paediatric team in response to identified clinical need.

Data and monitoring

Note: These numbers are very small and therefore fluctuation in rates is to be expected. Unlike most units HDFT SCBU support the postnatal ward with transitional care babies when this is thought to be in the best interest for mother and baby, and also take readmissions for babies with weight loss and jaundice when the postnatal ward is full.

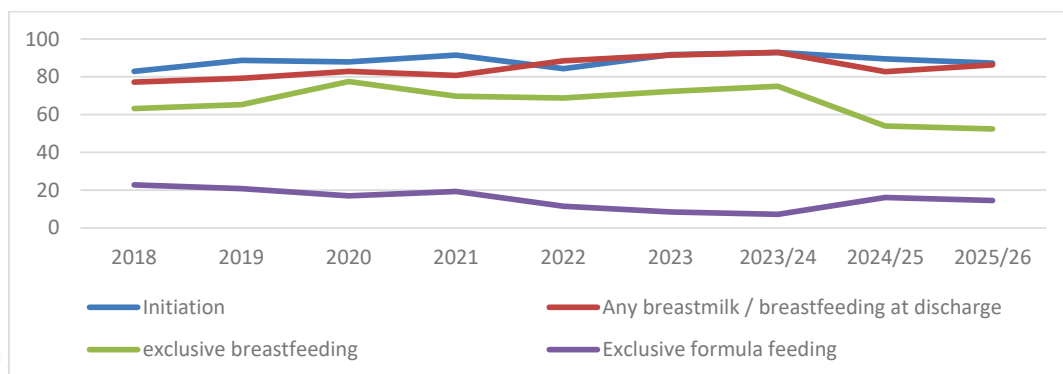
Initiation includes babies who's first feed was on SCBU, those who had a feed before admission are not included.

Discharge rates include babies transferred back to HDFT from other units who have provided high dependency/intensive care; these babies are not included in discharge figures on transfer out.

Year	2018	2019	2020	2021	2022	2023	2023/24	2024/25	2025/26
Initiation	82.9%	88.7%	87.9%	91.5%	84.3%	91.7%	92.9%	89.5%	*87.3%
Any breastmilk / breastfeeding at discharge	77.2%	79.2%	82.9%	80.7%	88.5%	91.5%	92.9%	82.7%	86.3%
Exclusive breastmilk / breastfeeding at discharge	63.2%	65.3%	77.5%	69.7%	68.8%	72.3%	75%	54%	52.4%
Formula feeding at discharge	22.8%	20.8%	17%	19.3%	11.5%	8.5%	7.1%	16.1%	14.5%

*Initiation: Seven babies did not receive breastmilk as a first feed on SCBU this year. One was a mother's decision not to express. The other babies were awaiting transfer out, three were ventilated and three were requiring emergency surgery. Previously, these six babies would have been classified as nil by mouth and opted out of the data; however, all babies should now receive buccal colostrum, and they have therefore been included in initiation rates. Work continues to support staff in providing buccal colostrum to all babies receiving intensive care.

Graph 10 Breastfeeding rates Special Care Baby Unit



The continued decline in the number of babies exclusively breastfed at discharge remains a concern. Staff have been made aware of the decline, and the issue has been discussed

through departmental updates. Review of individual cases has identified a range of contributing factors, including babies readmitted from home requiring supplementation to support weight gain, small or preterm babies needing one or two additional feeds to promote growth, and babies having short stay admissions on SCBU returning to the postnatal ward expressing colostrum to support establishment of breastfeeding. Monitoring will continue in order to identify any recurring trends or themes and to support targeted improvement work.

Culture

Staff on the SCBU continue to uphold the principle of partnering with parents in the care of their babies. Audit results reflect highly positive feedback from families who have spent time on the unit.

SCBU support group

SCBU coffee mornings are held every two months and are run by the staff on the unit. This year an average of eight families has attended each event. Families with older babies or young children often continue to attend, offering support and reassurance to those who have recently been discharged.

These sessions also serve as a valuable opportunity to gather feedback from parents once they've returned to their home environment. Their views on recent changes and suggestions for potential improvements on the unit are actively sought.

Our small team of allied health professionals (dietitians, physiotherapists, and speech and language therapists) attend the drop-in sessions, to support parents, answer concerns, and offer advice. This proactive approach helps ensure timely referrals and provides families with ongoing, accessible support.

Overall Conclusion

Both the Maternity and SCBU teams continue to demonstrate strong commitment to the Baby Friendly Initiative. Training compliance, consistent monitoring, and the cultural embedding of standards remain high. While some areas, such as exclusive breastfeeding rates, require renewed focus, overall standards have been sustained.

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Appendix D - Hospital readmissions of babies within 30 days of life

Quarter 1 April – June 2026

Report Overview

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

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

Process for data collection

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

External reporting

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

National guidance

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

Local guidance and preventative measures

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

Individual readmission data of babies with jaundice and/or feeding issues in the first month of life

Jaundice	Age when readmitted	Gestation at birth	Treatment	Feeding	Length of stay
Baby 1	3 days	39+5	Phototherapy	Breast	Overnight
Baby 2	2 days	41+1	Phototherapy	Breast	Overnight
Baby 3	6 days	37+3 (twin)	Phototherapy	Breast	48hours
Baby 4*	3 & 5 days	39+6	Phototherapy	Breast/EBM	3 days
Baby 5*	1 & 4 days	37+0	Intensive phototherapy	Breast	24hours + 40hrs
Baby 6*	2 days	37+6	Intensive phototherapy	Breast	49 hours
Baby 7	2 days	39+4	Phototherapy	Breast	28hours
Baby 8	7 days	35+0	Phototherapy	Mixed	31 hours
Baby 9	5 days	37+4	Phototherapy	Breast	Overnight

Feeding issues	Age when readmitted	Gestation At birth	Weight loss	Treatment	Feeding	Length of stay
Baby 1	4 days	39+1	12.7%	Feeding plan	Breast	38 hours
Baby 2	3 days	38+6	14.5%	Feeding plan	Breast	22 hours
Baby 3*	4 days	40+6	9.8%	Feeding plan	Mixed	12 hours
Baby 4	3 days	38+5	13.3%	Feeding plan	Mixed	48 hours
Baby 5	3 days	40+0	12.7%	Feeding plan	Breast	27 hours
Baby 6*	3days	39+4	12.6%	Feeding plan	Breast	24 hours

Comments *

Babies with jaundice:

- **Baby 4** was readmitted to Special Care Baby Unit (SCBU) due to acuity on the postnatal ward, they were treated with phototherapy and discharged appropriately. The baby was then readmitted a second time the same afternoon via the Emergency department due to parental concerns of low temperature and unable to waken from sleep. On admission there were no medical concerns, the parents stayed with the baby overnight for observations and reassurance.
- **Baby 5** was born in York hospital and discharged the same day to HDFT community midwives. The baby had a raised biliflash day 1 and a Serum bilirubin (SBR) plotted just under the transfusion threshold. Due to gestation and rhesus incapability the baby was transferred from Pannal ward to SCBU for intensified phototherapy. Treatment was effective, however on day 4 a repeat SBR was above the treatment threshold for the second time. The baby recommenced their treatment on SCBU.
- **Baby 6** was admitted at 2 days old, having had appropriate care prior to admission. The baby required intensive phototherapy and was nursed on Special Care Baby Unit. Weight loss was within normal parameters

Babies with weight loss:

- **Baby 1** was readmitted on Day 4 following a weight loss of 11.3% on Day 3. A feeding plan was commenced in accordance with guidance; however, despite these interventions, a further weight loss was identified on Day 4, prompting readmission.
- **Baby 3** was readmitted via the Emergency Department (ED) following parental concerns. Earlier that day, the baby had been reviewed by a community midwife and was noted to have a 9.8% weight loss, an appropriate feeding plan was commenced. Parents reported increased crying but stated that the baby settled after receiving formula milk. They attended ED for further reassurance.
- **Baby 6** was readmitted with a reported weight loss of 12.6%; however, the recorded weight loss on admission was 11%. The baby remained in hospital overnight to provide additional breastfeeding support.

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

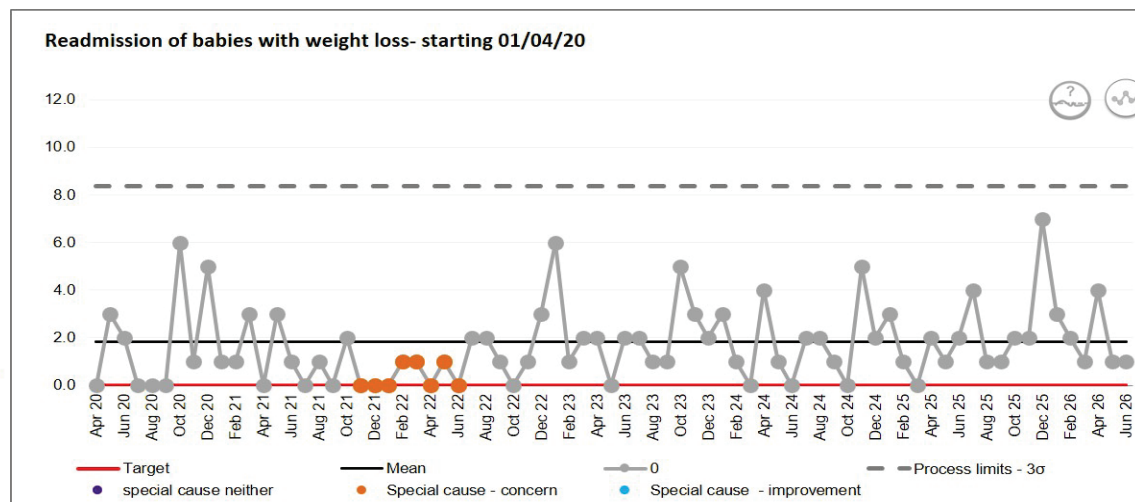


Chart 2 SPC chart for readmissions with jaundice

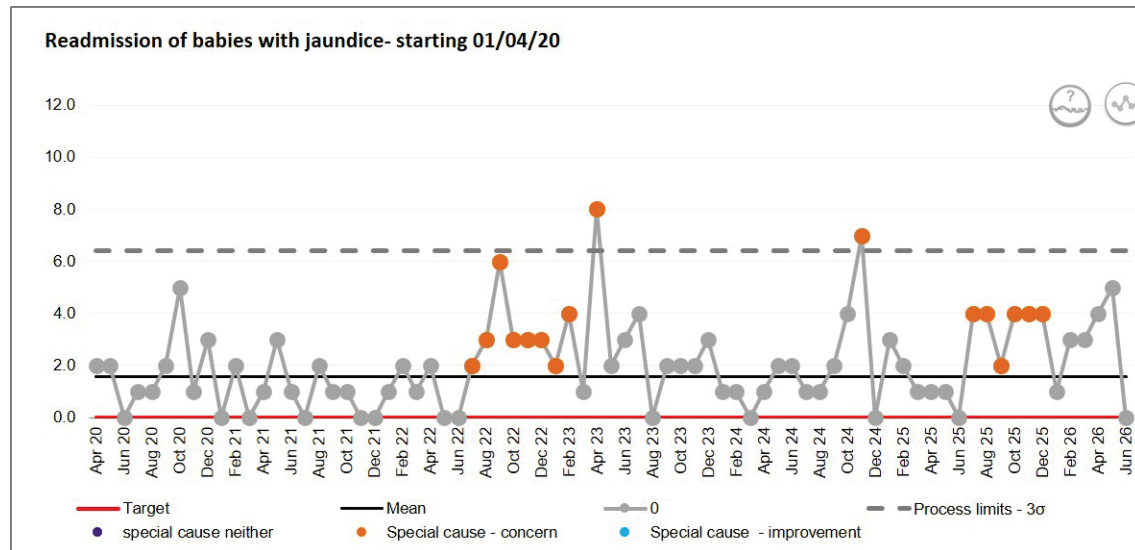
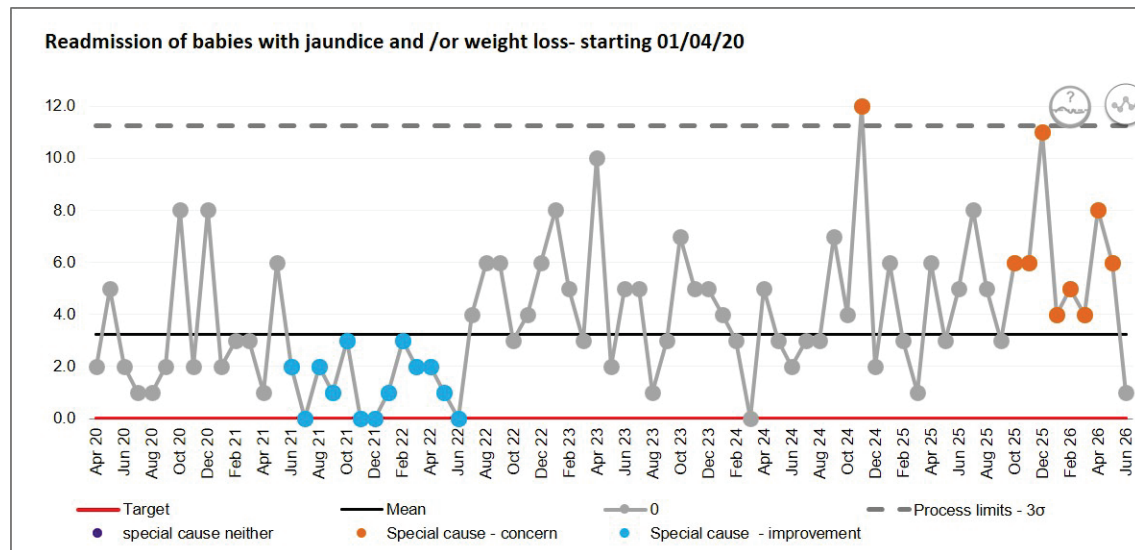


Chart 3 SPC chart including all babies readmitted for jaundice and/or feeding issues



Findings Summary

During Quarter 1, nine babies were readmitted due to jaundice and six due to feeding issues. The trend above the mean for the total number of readmissions persisted this quarter, although a reduction was observed in June. Work continues to ensure preventable factors are identified and best practice implemented (see action plan 1.8). All cases continue to be reviewed on an individual basis.

Recommendations

Action plan

Recommendations from Datix review	Action To Achieve Compliance with Recommendation (SMART)	Lead Responsible	Expected Completion Date	Comments
Review readmissions to paediatrics in more depth	Babies readmitted to paediatrics for causes other than jaundice or weight loss will be reviewed in more depth in future reports, with the aim of identifying any potentially preventable factors.	Jo Orgles, Infant Feeding Co-ordinator	Completed	June 2026 Readmissions to paediatrics reported
Review current practice to ensure all preventable measures to reduce readmissions of babies with jaundice have been identified and implemented	Review a cohort of babies previously admitted, and all new admissions over the next two quarters - Agree the data set to be collected, including a more comprehensive review of maternal history, and adapt the current proforma accordingly - Utilise previously collected data, alongside data from ongoing readmissions, to inform the analysis - Submit a report of findings to MRMG for review and discussion	Infant Feeding Co-ordinator Lead Midwife for Safety, Quality & Clinical Governance	Dec 2026	Jan 2026 Proforma adapted – Data set to be agreed at neonatal obstetric meeting
Ensure NICE guidance and local policies on newborn jaundice are followed	Refresher for midwives, neonatal nurses and paediatricians - NICE guidance on when to commence phototherapy including risks - Not relying on visual assessment to assess level of jaundice - Daily weight when being treated with phototherapy	Infant Feeding Co-ordinator	Completed	Care of babies with Jaundice included in yearly updates for midwives. Individual feedback given to paediatricians regarding commencing phototherapy below treatment thresholds.
Ensure weight loss guidance is followed	- Write a newsletter for staff to support weight loss guidance - Write supporting guidance for babies with further weight loss following day 3 - Ensure out of area Trusts have HDFT guidance - Discuss admissions that may not be required and length of stays at	Infant Feeding Co-ordinator	Sept 2026	June 2026 Meeting arranged with community midwife to write guideline for slow weight gain following initial loss Individual feedback given to all concerned this quarter

	neonatal obstetric meeting Individual feedback to be continued			
Ensure accurate weighing and recording of babies' weights in hospital and community	Ensure staff: - Check weight with another person, except where not possible in exceptional circumstances - Take a photograph for evidence. - Enter the weight on Badger Net immediately. - Take care not to transpose digits. - Make sure equipment is set to zero prior to placing baby on the surface. - Baby to be weighed naked.	Lead Midwife for Safety, Quality & Clinical Governance	Completed	'Learning from incidents' newsletter sent to all staff
Avoid overnight stays for babies with weight loss that have normal blood test results	- Explore cost of purchasing a hospital grade double breast pump to loan to parents overnight to help with feeding plan. - Remind staff to give parents an individual plan of care, which where appropriate, includes a plan to re weigh baby on the postnatal ward in 24 hours.	Infant Feeding Co-ordinator	Completed	October 2024: Bereavement support group contacted but no available funding at present. Jan 2025: Application submitted to HDFT Charities July 2025: No further response from Charities. Other funding to be considered. Oct 2025: Consideration to be given to using small loan pumps on a trial basis, to be discussed at neonatal obstetric meeting. March 2026: HDFT Charities have supported the purchase of a new breast pump.
Ensure feeding plans are consistent for babies readmitted with weight loss.	Arrange meeting with the Paediatric clinical lead for postnatal and the infant feeding co-ordinator to discuss more formal feeding plans for larger weight loss in babies. Include when to	Neonatal Clinical Lead Infant Feeding Co-ordinator	Completed	October 2024: Draft SOP completed. Requires discussion with paediatric clinical lead and then agreement at

	supplement and when to repeat weight and bloods. • Update guideline to reflect outcomes of decisions made at meeting. • Communicate updated guideline to staff. • Ensure training includes updated guidance.			Paediatric governance. Jan 2025: Meeting arranged with paediatric consultant. March 2025: 1. Draft plans agreed 2. Readmission guideline updated 3. Feeding plans added to Mat 3 update for 2026/7. Will be added to next infant feeding newsletter for staff 4. Readmissions and feeding plans included in full infant feeding training
Ensure moderately preterm babies on the postnatal ward receive the same level of care as babies on SCBU	• Work with neonatal nurses to develop a plan of care for moderate/late preterm babies on the postnatal ward. Include feeding, thermoregulation, increased risk of jaundice and neurodevelopmental care. • Train all midwives in care of late preterm babies • Develop an information package for parents. • Ensure any changes to care are included in appropriate guidelines	Infant Feeding Co-ordinator Neonatal Educator and Governance Lead	Completed	March 2025: 1. Plan of care developed and agreed 2. Care of late preterm babies is the theme for Mat 3 infant feeding update 2025/6. 3. Parent package in draft, nearly complete 4. Guidelines to be reviewed July 2025: 3) Parent package completed, to be agreed at MQAM. 4) Guideline updated
Share learning with the community team to improve care and consistency	• Arrange dates to meet with community midwives • Share good practice and discuss individual cases where care could possibly be improved • Develop plans of care for static weight / weight loss following introduction of a feeding plan	Infant Feeding Co-ordinator Community Team Leader	Completed	

Readmissions to Paediatrics

All babies with no concerns other than jaundice and/or feeding are seen directly on Pannal ward. This pathway ensures a suitable environment for the needs of mothers and babies,

supports breastfeeding and reduces the risk of hospital acquired infections. Babies returning to the hospital due to other reasons are admitted to Woodland's ward as appropriate.

Paediatric readmission data

During this quarter, there were 37 readmissions involving 36 babies to paediatrics. Readmissions of healthy term babies with jaundice and weight loss are reported earlier in this report and are therefore not included in these figures. The babies ranged in age from 2 to 26 days at the time of readmission. Sixty percent of babies were discharged home within 12 hours of admission, often with open access arrangements.

Chart 4 Length of stay of babies readmitted to paediatrics in the first 28 days of life.

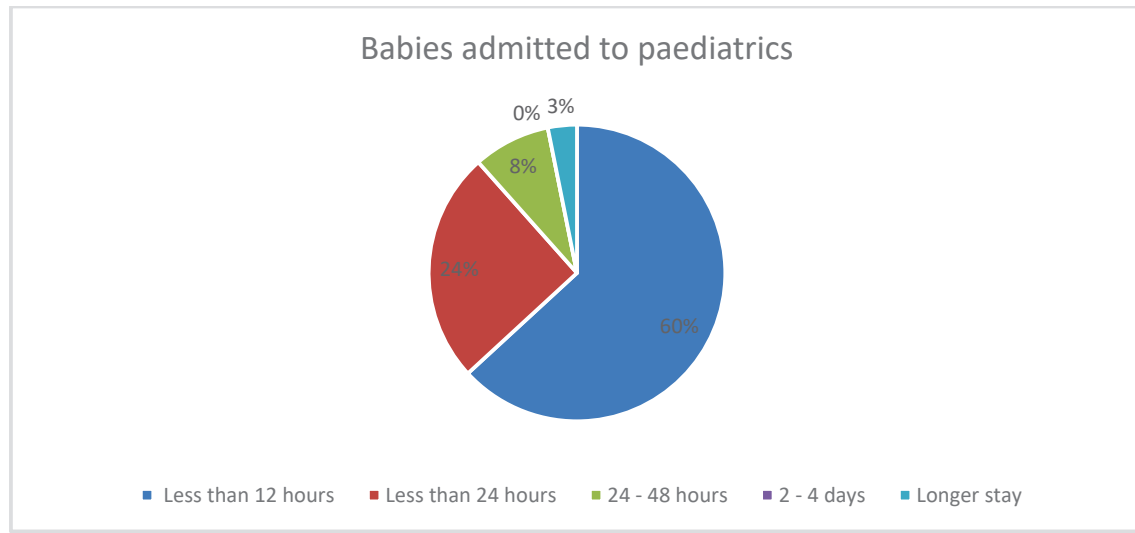
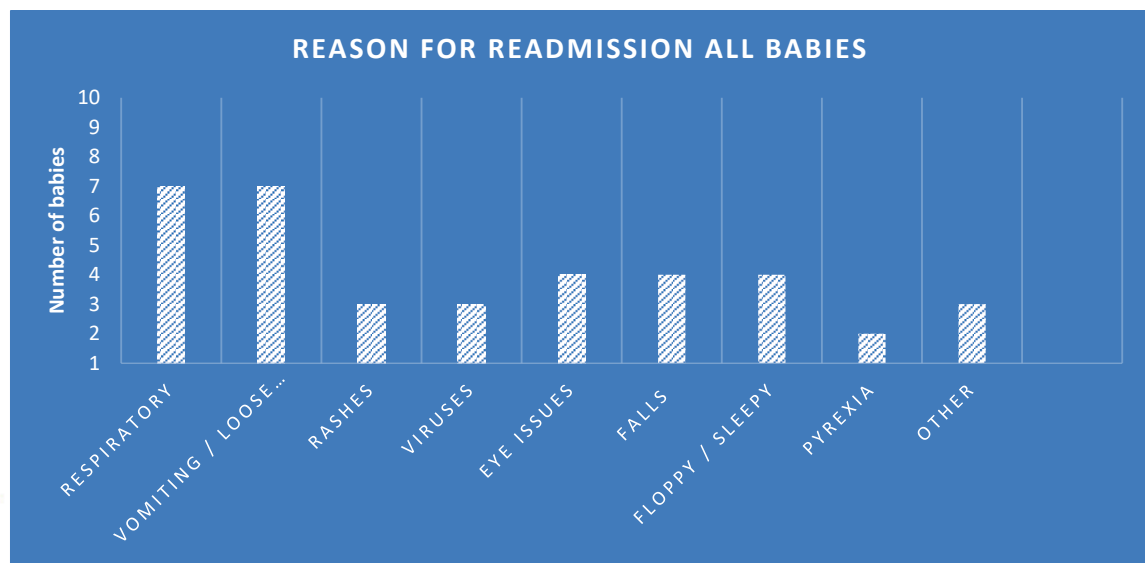
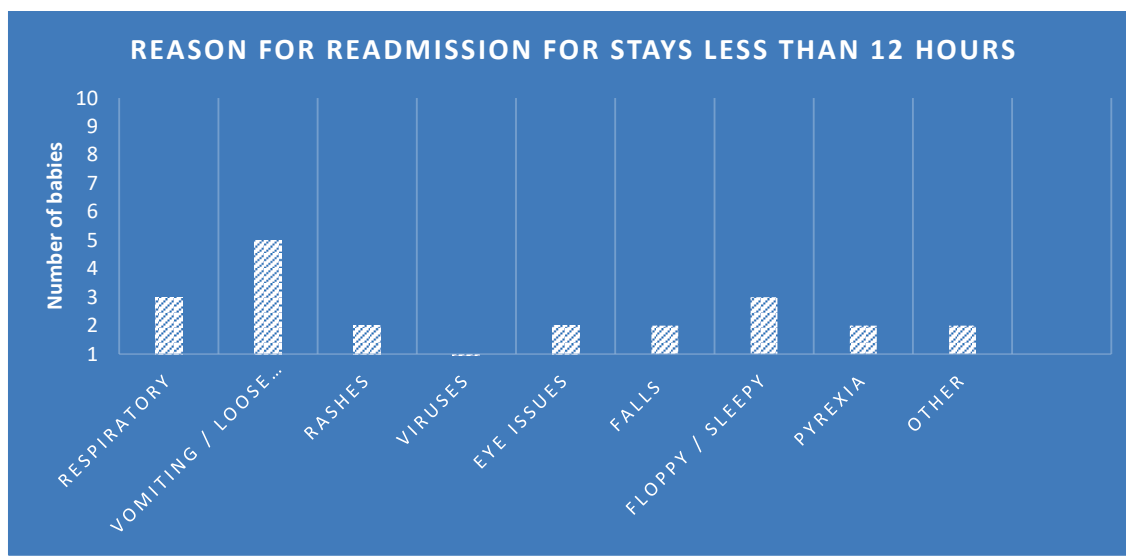


Chart 5 Reasons for readmissions to paediatrics



The seven babies readmitted for respiratory symptoms (Chart 5) include respiratory distress (n=1), apnoea (n=2), increased work of breathing (n=2) and tachypnoea (n=2). Four babies were readmitted following falls from a height onto the floor. Two fell from a parent's chest, one from a changing table, and one from a parent's arms. Skeletal surveys were performed in three of the four cases.

Chart 6 Reasons for readmissions for babies staying less than 12 hours



Fourteen of the babies (Chart 6) were admitted for less than 4 hours. The reasons for admission reflected the overall pattern shown above, with no common themes evident among babies requiring a shorter admission.

A significant number of babies were admitted via the Emergency Department; future reports will include this detail.

Conclusion

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

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

Appendix E

Compliance of completion of Perinatal Mortality Review Tool

Quarter 1, April to June 2026

This document provides a summary of current compliance against Safety Action 1 of the Maternity Incentive Scheme (MIS) for the first quarter, April to June 2026.

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

Requirements of the Maternity Incentive Scheme **Safety Action C – Learning from reviews and investigations**

Reporting and Review

1. **Notify all qualifying events:** All eligible events must be notified through the NHSE Submit a Perinatal Event Notification (SPEN) portal to MBRRACE-UK, NHR EN and MNSI as soon as possible after the death/diagnosis.
2. **Seek parents' views of care:** For the deaths of all babies in your trust eligible for PMRT review ensure parents are given multiple opportunities to meaningfully provide their experience of all elements of care and the impact of that care and raise any questions and comments they may have prior to the PMRT review starting.
3. **External multi-disciplinary reviewers:** For a minimum of 60% of deaths reviewed, external members of relevant specialties must be present at the multi-disciplinary review and this should be documented within the PMRT.

Sharing information with families

4. **Provide relevant information:** Provide relevant information regarding the role of MNSI, NHR EN scheme and PMRT reviews to families in a format that is relevant and accessible to them. Information about duty of candour must be provided for all parents where the event is eligible for duty of candour.
5. **Offer parents a meeting with relevant specialists:** Offer parents a meeting with relevant specialists to share the findings with them from reviews and investigations, and relevant incident reports.

Learning and governance

6. **Thematic reports of learning and actions:** The Trust must produce thematic reports that summarise learning and progress on actions arising from MNSI and NHR EN reports, local PMRT and PSIRF reviews, MOSS critical safety checks, NHR claims scorecards and relevant national reports. Trusts must also use demographic data to identify and understand any disparities in outcomes. These thematic reports must be reviewed with the Trust Perinatal and Board level Safety Champions and submitted to the Trust Executive Board at least quarterly. Reports should clearly demonstrate the measures implemented to address recurrent themes, and progress with these, including how learning has been shared and, where appropriate, incorporated into existing multidisciplinary training.

Compliance of eligible perinatal deaths with MIS requirements

During Quarter 1, there was three perinatal deaths eligible to be reported to MBRRACE-UK. This was an early neonatal death, and one second trimester stillbirth and one late fetal loss.

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

MBRRACE-UK Case ID	Reported to MBRRACE through SPEN	External multi-disciplinary reviewers	Parents informed of review and questions/concerns sought
102998	Yes	In progress	Yes
103948	Yes	In progress	Yes
104011	Yes	In progress	Yes
Overall Compliance against targets of Safety Action 1	100% - Compliant (Target 100%)	100% - Compliant (Target 100%)	100% - Compliant (Target 100%)

Table 1: Eligible perinatal death against MIS requirements

Ongoing Action Plan following PMRT review

Root Cause/Contributory Factor	Action/s	Responsible Lead	Target Date	ID no.	Risk at review (H/M/L or complete)
Management and escalation of pathology results	For clearer definition of roles and responsibilities, and pathway for checking and managing pathology results in all clinical areas. Ongoing action.	Team leaders	28/08/2026	98640	Medium
The baby was small for gestational age at birth, scans were indicated and performed but the baby was not identified as IUGR.	Continue auditing cases of fetal growth restriction and reporting to the LMNS and Trust Board in line with SBLCB. There is an ongoing audit on the accuracy of growth scans compared with birth weight, to	Risk Management Midwife and Clinical Effectiveness Midwife	01/01/2026	98640	Completed

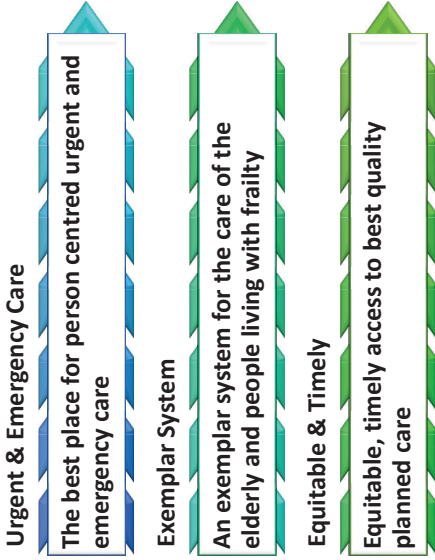
	confirm accuracy and offer learning points.				
Fundal height measurements performed alongside serial scanning pathway.	Reinforcement on mandatory training day and case study learning.	Professional Development Midwives	01/01/2026	98640	Completed
Delay in attendance with RFM's.	Learning to be shared with MDT and MNVP as part of case study. MNVP to share information about early attendance to hospital with any episode of RFM's.	Bereavement Midwives MNVP	30/11/2026	98640	Completed
Difference in perspectives on communication content and ongoing plan of care in relation to reduced fetal movements attendance.	Additional training for obstetric and midwifery staff regarding communication and discussions of recommendations for ongoing planning of care. Ongoing action	Professional Development Midwives	01/08/2026	99258	Medium
Missed opportunity for earlier antenatal clinic appointment with obstetric team to review low ferritin level.	Continuous improvement plans ongoing. Individual feedback to staff member. Case study to be shared with MDT.	Community Team Leader	31/03/2026	99258	Completed
Challenges in contacting community midwifery team with non-urgent queries.	Reinforcement of SPOC contact details to service users and communications from MNVP team.	MNVP	31/03/2026	99258	Completed
Additional opportunity for fundal height measurement following attendance with RFM's.	Case review to be shared with maternity staff. Education and training as part of mandatory training update.	Professional development midwives Bereavement midwives	05/04/2026	101309	Completed

RAYG rating at MAC attendance with absent FM's.	Case review to be shared with maternity staff. Ongoing implementation of BSOTS in MAC. Education and training.	Professional development midwives Bereavement midwives Delivery suite manager	31/05/2026	101309	Completed
Sleeper sofa not utilised correctly in Bereavement Suite for partner to use.	New sleeper sofa purchased and education and training of staff. Case review to be shared with maternity staff.	Bereavement midwives	05/04/2026	101309	Complete
Partner not provided with catering services during inpatient stay.	Case review to be shared with maternity staff.	Bereavement midwives	05/04/2026	101309	Complete

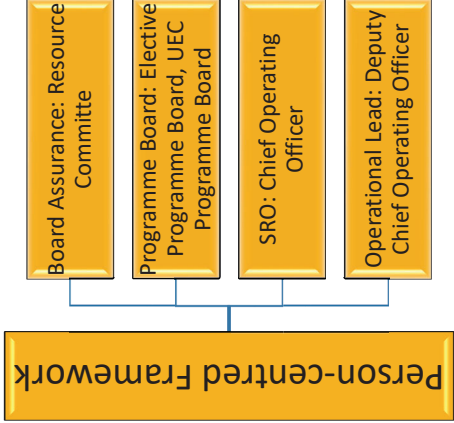
STRATEGIC AMBITION: PERSON CENTRED, INTEGRATED CARE; STRONG PARTNERSHIPS 2026-27

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

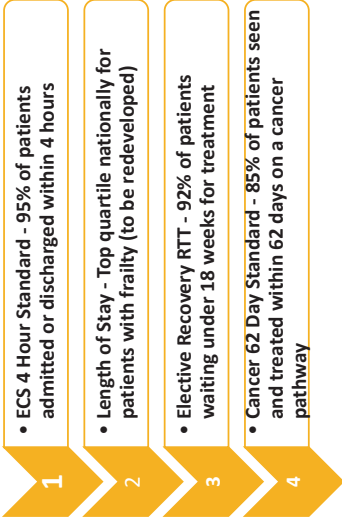
GOALS:



GOVERNANCE:



True North Metrics



Breakthrough Objectives:	Time to Next Destination Reduce Follow Up Activity
Overarching Risk Appetite:	Operational - Cautious

Overarching Risk Summary:

Ambition	Workstream	True North Metric	Risk Appetite	Level of Risk to Achieve Metric – Linked to Risk Appetite
Person Centred, Integrated Care, Strong Partnerships	The best place for person centred urgent and emergency care	ECS 4-hour Standard	Operational: Cautious	1 – 34 – 68 – 910121516>20
	An exemplar system for the care of the elderly	Length of Stay - Patients with Frailty (being redeveloped)	Operational: Cautious	
	Equitable, timely Access to Best Quality Planned Care	Elective Recovery RTT – 18 Weeks	Operational: Optimistic	
		Cancer 62 Day Standard – 62 Days Treatment	Operational: Optimistic	

Strategic Metrics Summary:

Workstreams	True North Metric	Vision	Goal	Current State	Countermeasures	Level of Risk to Achieving Goal (CxL)	Level of Risk for progressing actions
The Best Place for Person Centred, Integrated Care 	ECS 4 Hour Standard	95% of non-admitted patients not requiring a bed to be assessed, diagnosed, treated, and discharged with 4 hours.	By March 2027, we want 82% of patients having their care completed within 4 hours. By March 2028, we want 85% of patients having their care completed within 4 hours.	The True North Metric of ED 4 Hour Standard continues into its second year (2025-26). The target of a 78% compliance was achieved in March and April 2025. For the THIRD month in a row we remain significantly below target for the month. April 78.35% (t.79.97%), May 61.8% (t. 80.54%), June 71.64% (t. 80.56%) with ED Attendances below plan. Business rules dictate that this need additional focus to allow understanding on the root causes and then development of linked 'countermeasures'. Watch metrics covering the ED are all out of target for 3rd consecutive month with the exception of Sepsis Screening. Admitted Performance runs at 10-40% for Medicine and Surgery patients, 70-80% for Paediatrics however, this accounts for an average of 35-45 patients per day. The Non-admitted performance is currently running at 70% but this is a much greater number of patients and therefore has a significantly bigger impact on overall performance. Aspirationally non-admitted should be at 90%. (halving the non admitted breaches per day i.e. 20-40 fewer breaches delivers a 10-20% overall improvement in performance.) Breakthrough Objective: Time to Next Step	ED / Hospital Flow pathways work with Nervecentre deployment and particular focus on bed allocation. Digital team prioritisation and support for development of live operational flow data. COS now live with monthly review of feedback on issues delivering COS standards. New Group Clinical Lead for ED commenced. Developing expanded UTC space at Ripon. See further countermeasures in BO.	Orange	Green
		95% of admitted patients to be moved to required department within 60 minutes of medical decision.					



	Dedicated HVLC lists in Ophthalmology from June.	
	Gynae and Opthalmology have dedicated lists in WDH from June.	
	Elective SPOA group developed.	
	Patient not Present process in deployment across the Trust.	
	Developing workforce capability and expertise to better guide analyst time in creation of stratified data dashboard for cancer waiting times.	
	Ensure capacity to deliver first appointments within 19 days.	
	Accelerator funding increased CT capacity in Q1	
	Development of 6-4-2 in endoscopy to improve list utilisation and use of bowel cancer screening capacity.	
	Stratify impact of complex imaging waits on cancer performance - data now available (August 2024); Imaging - Power BI .	
	RCA's to be completed on all 104-day cancer breaches to understand themes and opportunities.	
	See Corporate Project updates: Bed Capacity and Patient Discharge.	
	Outpatient transformation, Theatre productivity board alongside PSCC PRM's will set and edit countermeasures: • Calling patients 48-hours pre-theatre to reduce on the day cancellations. • New theatre scheduling process gone live 1st Sept. • Theatre management team reaching out to individuals where performance <80%. Cancer Fast Track team transferred to PSC Appointment centre to increase resilience.	

Workstreams	True North Metric	Vision	Goal	Current State	Countermeasures	Level of Risk to Achieving Goal (CxL)	Level of Risk for progressing actions
Nonrelevant at present			.				

Strategic Programme:

Workstreams	True North Metric	Vision	Goal	Current State	Countermeasures	Level of Risk to Achieving Goal (CxL)	Level of Risk for progressing actions
Nonrelevant at present							

Breakthrough Objective: Time to Next Destination

Workstreams	True North Metric	Vision	Goal	Current State	Countermeasures	Level of Risk to Achieving Goal (CxL)	Level of Risk for progressing actions																														
Time to move to medical bed from decision to admit in Emergency Department	ECS 4 Hour Standard	95% of admitted patients to be moved to required department within 60 minutes of medical decision.	By March 2027, 75% of patients will move to an inpatient bed within 60mins of the decision to admit.	Time to Next Step Completion This table has ED journey into a series of steps (Admitted to Clinic, Clinician to GDT, GDT to Discharge and Imaging Request to Report) and shows the monthly median across the 4 steps against a target of 60 mins Median Time in Mins Target in Mins Percentage of days with 'step' median over 60 mins by step_label and Financial/Quarter/Time <table><tr><th>Year</th><th>Step Label</th><th>Percentage</th></tr><tr><td rowspan="4">2025Q2</td><td>Admitted to Clinic</td><td>14.5%</td></tr><tr><td>Clinician to GDT</td><td>77.0%</td></tr><tr><td>GDT to Discharge</td><td>68.0%</td></tr><tr><td>Imaging Request to Report</td><td>84.4%</td></tr><tr><td rowspan="4">2025Q4</td><td>Admitted to Clinic</td><td>23.0%</td></tr><tr><td>Clinician to GDT</td><td>76.0%</td></tr><tr><td>GDT to Discharge</td><td>75.0%</td></tr><tr><td>Imaging Request to Report</td><td>93.0%</td></tr><tr><td rowspan="4">2026Q1</td><td>Admitted to Clinic</td><td>32.5%</td></tr><tr><td>Clinician to GDT</td><td>56.7%</td></tr><tr><td>GDT to Discharge</td><td>43.9%</td></tr><tr><td>Imaging Request to Report</td><td>90.0%</td></tr></table> Step Definitions - Admitted to Clinic: Minutes from ED arrival to ED Clinician assigned to patient - Clinician to GDT: Minutes from ED Clinician assigned to patient to GDT - GDT to Discharge: Minutes from GDT decision to patient being discharged to ED - Imaging Request to Report: Minutes from request to report to complete imaging until imaging reported.	Year	Step Label	Percentage	2025Q2	Admitted to Clinic	14.5%	Clinician to GDT	77.0%	GDT to Discharge	68.0%	Imaging Request to Report	84.4%	2025Q4	Admitted to Clinic	23.0%	Clinician to GDT	76.0%	GDT to Discharge	75.0%	Imaging Request to Report	93.0%	2026Q1	Admitted to Clinic	32.5%	Clinician to GDT	56.7%	GDT to Discharge	43.9%	Imaging Request to Report	90.0%	Continuous flow embedded.		
Year	Step Label	Percentage																																			
2025Q2	Admitted to Clinic	14.5%																																			
	Clinician to GDT	77.0%																																			
	GDT to Discharge	68.0%																																			
	Imaging Request to Report	84.4%																																			
2025Q4	Admitted to Clinic	23.0%																																			
	Clinician to GDT	76.0%																																			
	GDT to Discharge	75.0%																																			
	Imaging Request to Report	93.0%																																			
2026Q1	Admitted to Clinic	32.5%																																			
	Clinician to GDT	56.7%																																			
	GDT to Discharge	43.9%																																			
	Imaging Request to Report	90.0%																																			
					Clinical Services strategy – now supported by GIRFT COS.																																
					Escalated as corporate risk - new ED Clinical lead for interface with imaging, sharing of data RE imaging delays.																																
					Ward discharge targets established for base wards and Driver Metric within Care Groups to improve delivery.																																
					Deployment of Nervecentre will improve data quality and consistency of clinically ready to proceed.																																
					ED / Hospital Flow pathways work with Nervecentre deployment and particular focus on bed allocation.																																
					Live flow developed and in place																																
					Granular data available for analysis and countermeasure development.																																

Workstreams	True North Metric	Vision	Goal	Current State	Countermeasures	Level of Risk to Achieving Goal (CxL)	Level of Risk for progressing actions
				Count of days with CTTP to Discharge - median over 48 mins by discharge_code_description Count of days with CTTP to Discharge - median over 48 mins by first_ward Median time to next step at 72 mins in June, deteriorated from 68 & 66mins for previous two month. Granular data now available(shown) to allow pareto analysis and countermeasure formulation from this breakthrough objective. Current data for the new measure below: ED performance breaches and LOS - Power BI			
Reduce Follow Up Activity	Elective Recovery (RTT) standard	Patients will avoid unnecessary follow up appointments using technology and patient initiated follow up enabling an increased in new patient capacity and reduced waiting times.	By March 2027, Keep follow up activity to meet or be below plan.	Follow ups – Consultant below plan, Nurse Led follow up >3000 over plan. Top 4 over specialities with follow ups over plan graphed below	Outpatient transformation project countermeasures: - Increased Patient Initiated Follow Up (PIFU) (also monitored through TPAM). - Develop performance data pack on outpatients for individual clinicians including benchmarking. - Use performance data of teams (Model Hospital) and individuals to challenge. - Influence change in practice through effective clinical leadership/ coaching.		

Workstreams	True North Metric	Vision	Goal	Current State	Countermeasures	Level of Risk to Achieving Goal (CxL)	Level of Risk for progressing actions
				Activity vs Plan FY to Date ● Activity Count FYTD ● Plan Count FYTD ... 60K 40K 20K 0K 56K 51K	- Introduce demand led, data driven job planning to optimise clinic configuration and reduce unnecessary follow ups. - Fortnightly TPAM with focus on FU activity.		

Related Corporate Risks:

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
ID3	ECS 4 Hour Standard	Risk of increased morbidity/ mortality for patients due to a failure to meet the 4-hour standard.	4 x 3 = 12	4 x 2 = 8 March 27	Clinical: Patient Safety	Minimal
ID79	Stroke: Provision at HDFT for Stroke	See the A3 & Breakthrough Objectives pertaining to this.	4 x 3 = 12	4 x 1 = 4 Aug 26	Clinical: Patient Safety	Minimal
ID292	Automated medicines supply services	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 its 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.	3 x 4 = 12	2 x 2 = 4 Dec 28	Operational: Business Continuity	
ID642	Cardiology: Risk to providing DGH urgent and emergency care services due to lack of 24/7 cover	Risk to HDFT being able to deliver acute DGH services due to the fragility of the cardiology service. Current Position/Issues: - Inadequate staffing 12.5 PAs down at consultant level currently filled with locum cover, - Lack of continuity of Registrar/middle grade ward cover, - Reliance on locum consultant and associated team and quality risks - Risk of burnout of current medical and ACP team due to workload pressures. - Other consequences to these factors include outpatient RTT, Angio and echo waiting time breaches.	3 x 4 = 12	3 x 1 = 3 Dec 26	Operational: Business Continuity	Cautious

ID884		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.				
	Risk to Patient Safety & Experience due to non-compliance with National KPI's for waiting times and reporting in Imaging Services	Due to the delays in routine diagnostic imaging there is an unknown risk of patients waiting up to 5.5 months for diagnostics which should be delivered within 6 weeks. This is causing delays in treatment, diagnosis and decision making for care plans for patients. It impacts on RTT performance, organisational reputation and patient experience. There is also a risk due to our non compliance with National KPI's for waiting times and reporting.	4 x 4 = 16	3 x 1 = 3 July 2026	Clinical: Patient Safety	Minimal

Related External Risks:

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

STRATEGIC AMBITION: OVERARCHING FINANCE 2026 - 27

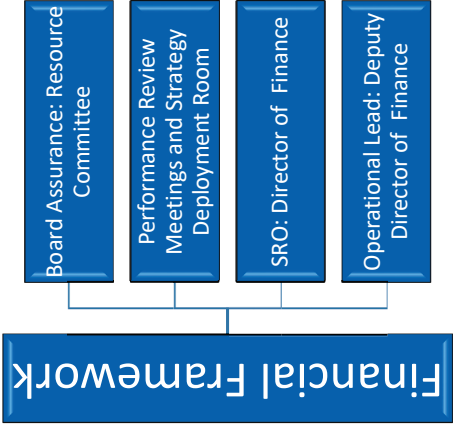
Our ambition is to provide the best quality, safest care whilst being a financially sustainable organisation.

GOALS:

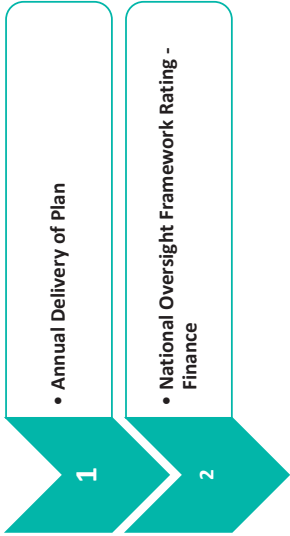
Financial Sustainability



GOVERNANCE:



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



Overarching Risk Summary:

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

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

True North Metrics Summary:

True North Metric	Vision	Goal	Current State	Countermeasures	Level of Risk to Achieving Goal	Level of Risk for progressing actions																																												
Financial Sustainability	HDFT to be a financially sustainable organisation	In 2026/27 the Trust, and therefore directorates, aim to live within the financial resources available to us.	Currently HDFT does not have an agreed plan with NHS England and the HNY contract remains unsigned. The current target and delivery is summarised below. YTD Summary & Forecast REVISED DEFICIT £12.3M PLAN NHSE ask to go further £3M DEFICIT £15.3M SUBMITTED PLAN £50 M - Run Rate £25.7M - WRAP £6.3M - KPMG £3M - Central Actions	<table><thead><tr><th>Countermeasure</th><th>Owner</th><th>Date</th><th>Status</th></tr></thead><tbody><tr><td>The Trust is aiming to agree a plan with NHS England by the end of May. discussions still ongoing.</td><td>Director of Finance</td><td>Original - March 2026 Updated – July 2026</td><td>In Progress</td></tr><tr><td>Directorate led programme of work in relation to core WRAP requirement</td><td>Directorate Snr Tri/Quad</td><td>March 2027</td><td>In Progress</td></tr><tr><td>Delivery of 2026/27 Activity Plan</td><td>Chief Operating Officer</td><td>March 2027</td><td>In Progress</td></tr><tr><td>KPMG Review Stage 1 output</td><td>Director of Finance</td><td>May 2026</td><td>In Progress</td></tr><tr><td>Trustwide actions to be developed</td><td>Executive Team</td><td>May 2026</td><td>In Progress</td></tr><tr><td>EQIA process to have more regular cadence given challenges which may emerge</td><td>Medical Director, Director of Nursing, Midwifery and AHPs, Director of Governance and Improvement</td><td>May 2026</td><td>Complete</td></tr><tr><td>Workforce Controls to be implemented</td><td>Chief People Officer</td><td>July 2026</td><td>In progress</td></tr><tr><td>Options paper assessed, recommendations being taken forward</td><td></td><td></td><td></td></tr><tr><td>Implementation of Trustwide vacancy control with more focused requirements</td><td></td><td></td><td></td></tr><tr><td>Weekly recruitment, overtime, bank, agency usage reporting usage refreshed and reforecast</td><td></td><td></td><td></td></tr></tbody></table>	Countermeasure	Owner	Date	Status	The Trust is aiming to agree a plan with NHS England by the end of May. discussions still ongoing.	Director of Finance	Original - March 2026 Updated – July 2026	In Progress	Directorate led programme of work in relation to core WRAP requirement	Directorate Snr Tri/Quad	March 2027	In Progress	Delivery of 2026/27 Activity Plan	Chief Operating Officer	March 2027	In Progress	KPMG Review Stage 1 output	Director of Finance	May 2026	In Progress	Trustwide actions to be developed	Executive Team	May 2026	In Progress	EQIA process to have more regular cadence given challenges which may emerge	Medical Director, Director of Nursing, Midwifery and AHPs, Director of Governance and Improvement	May 2026	Complete	Workforce Controls to be implemented	Chief People Officer	July 2026	In progress	Options paper assessed, recommendations being taken forward				Implementation of Trustwide vacancy control with more focused requirements				Weekly recruitment, overtime, bank, agency usage reporting usage refreshed and reforecast				4 x 4 = 16	3 x 3 = 9
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			Current performance and forecast positions is summarised below. 26/27 Plan, Actuals and Forecast Legend: 26/27 Cumulative Plan 25/26 Actual YTD - Straight Line Forecast (no WRAP) 26/27 Actual YTD - Forecast incl WRAP delivery (Libby) - Forecast incl WRAP delivery - Overall Risk no mitigations The month position for HDFT is a deficit of £12.5m, £7.4m adverse to plan. The key drivers are the adverse Waste Reduction and Productivity (WRAP) position of £1.4m, £0.4m Pathology LLP charges, £0.4m Drug income, £0.1m Grant income deferred and dental decommissioning costs £0.1m.																																															

True North Metric	Vision	Goal	Current State	Countermeasures	Level of Risk to Achieving Goal	Level of Risk for progressing actions																
			Currently the current run rate is trajectory against the worse case scenario. The proposed plan includes a number of challenges. The WRAP target is split into three areas - Core Delivery of initial planning requirement - £20m Delivery of activity plan in line with previous years outturn - £8m Further ask to improve and reduce deficit on journey to returning to break even - £4m Planning against this £32m target is outlined in the graphic below.  In addition the Trust is working with KPMG, alongside York and Scarborough Teaching Hospitals NHS Foundation Trust on further opportunities to improve the position. KPMG identified £6m opportunities with a further stretch of £3.4m. Given plans are not in place for the full target and the year is already progressing, a number of additional actions are under review. The scale of these actions currently equates to £700k per month, however, the list is developing further and will be subject to EQIA. There is a need to establish a more sustainable programme of work in future years which is transformational, engages colleagues and harnesses innovation from all areas of the organisation. Current approach focuses on cost control due to the void in this space. As well as the large scale change, there is a need to ensure resources are being well utilised at cost centre level. The current position is uneven across the Trust as evidenced by material numbers of cost centre overspends and variable access of reach reporting.	<table><tr><td>Strengthen Non-Pay Expenditure</td><td>Director of Finance</td><td>May 2026</td><td>Complete</td></tr><tr><td>Monitoring of previously discussed actions to be updated</td><td></td><td></td><td></td></tr><tr><td>Establish Financial Recovery Oversight Group and Escalation process</td><td>Chief Executive</td><td>June 2026</td><td>Complete</td></tr><tr><td>Establish Recovery/Turnaround Board – sub group of the Board of Directors</td><td>Director of Governance and Improvement</td><td>June 2026</td><td>Complete</td></tr></table>	Strengthen Non-Pay Expenditure	Director of Finance	May 2026	Complete	Monitoring of previously discussed actions to be updated				Establish Financial Recovery Oversight Group and Escalation process	Chief Executive	June 2026	Complete	Establish Recovery/Turnaround Board – sub group of the Board of Directors	Director of Governance and Improvement	June 2026	Complete		
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True North Metric	Vision	Goal	Current State	Countermeasures	Level of Risk to Achieving Goal	Level of Risk for progressing actions																															
	The Trust will move out of segment 3	Currently the National Oversight Framework has an override based on financial plans or performance being breakeven or worse. The Trust has established there is the ability to breakeven in 2027/28, however this would be dependent on the outputs of a community services review in conjunction with Humber and North Yorkshire ICB, the delivery of the Waste Reduction and Productivity Programme recurrently, and appropriate financial risk sharing mechanisms in place. Within the oversight framework there are three finance measures which are outlined below <table><tr><td>Metric</td><td>Q3 2025/26 Position</td><td>Q3 2025/26 scoring</td></tr><tr><td>Planned Surplus/Deficit</td><td>-1.39%</td><td>3</td></tr><tr><td>Year to date variance to plan</td><td>-£11.6m</td><td>4</td></tr><tr><td>Implied Productivity v previous year</td><td>-3.3%</td><td>4</td></tr></table> The data which supports the community element of the productivity metric is being challenging to reconcile. The productivity metric also appears to be influenced by coding position of activity which is currently behind plan. This will also influence income position.	Metric	Q3 2025/26 Position	Q3 2025/26 scoring	Planned Surplus/Deficit	-1.39%	3	Year to date variance to plan	-£11.6m	4	Implied Productivity v previous year	-3.3%	4	<table><tr><th>Countermeasure</th><th>Owner</th><th>Date</th><th>Status</th></tr><tr><td>Agreement with ICB to establish community services review scheduled for mid-2026/27.</td><td>Chief Executive</td><td>May 2026</td><td>Agreement in principle – plans to be developed.</td></tr><tr><td>Work with local commissioners to establish updated local pricing following change since covid.</td><td>Director of Finance</td><td>September 2026</td><td>In progress</td></tr><tr><td>Work with NHS England Informatics team to better understand and inform approach to costing of 0-19 services as part of implied productivity metric</td><td>Director of Finance</td><td>July 2026</td><td>In Progress</td></tr><tr><td>Address coding backlog through recovery plan</td><td>Deputy Director Business Intelligence, Planning, Performance and Productivity</td><td>July 2026</td><td>Complete</td></tr></table>	Countermeasure	Owner	Date	Status	Agreement with ICB to establish community services review scheduled for mid-2026/27.	Chief Executive	May 2026	Agreement in principle – plans to be developed.	Work with local commissioners to establish updated local pricing following change since covid.	Director of Finance	September 2026	In progress	Work with NHS England Informatics team to better understand and inform approach to costing of 0-19 services as part of implied productivity metric	Director of Finance	July 2026	In Progress	Address coding backlog through recovery plan	Deputy Director Business Intelligence, Planning, Performance and Productivity	July 2026	Complete		
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Trustwide Project: Productivity & Sustainability

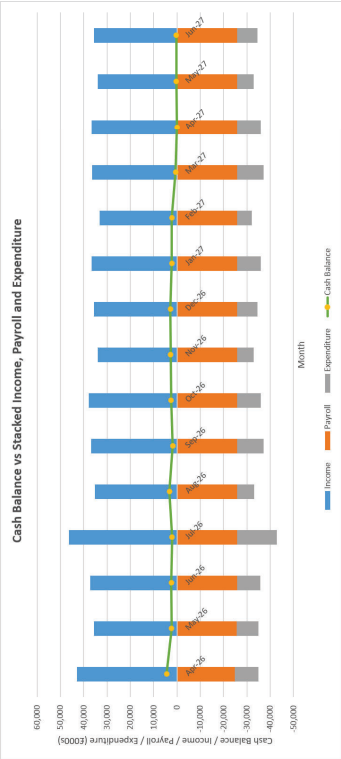
Workstream	True North Metric	Vision	Goal	Current State	Countermeasures	Level of Risk to Achieving in Year Goal	Level of Risk for progressing actions
Agreed move to strategic programme with tactical year one response							

Following Exec review a further countermeasure is the consideration on how the longer-term requirement will be resourced

Breakthrough Objective: % Budgets in Balance

Workstream	True North Metric	Vision	Goal	Current State	Countermeasures	Level of Risk to Achieving Goal	Level of Risk for progressing actions																																					
% Budgets in Balance	Annual Breakeven	For HDFT to deliver the financial annual plan as agreed with NHSE and return to a breakeven position by the end of 27/28. Monitoring through monthly financial reporting in year, recovery plans identified to ensure finances remain on track.	Every budget holder managing budgets to plan, which in turn will support the delivery of the annual plan, a reduced need for cash support and an improved reputational position in relation to managing taxpayer resources.	In 2025/26 313 cost centres were overspent across the organisation out of 774 cost centres. 305 OUT OF 758 £11.4M O/SPENT 103 CC OVER £20K O/SPENT 327 OUT OF 758 U/SPENT £7.8M *Central/B/Sheet and Other Services removed from analysis <table><thead><tr><th>Directorate</th><th>No. of CCs with negative YTD variance</th></tr></thead><tbody><tr><td>CAPITAL CHARGES</td><td>2</td></tr><tr><td>CYPH</td><td>49</td></tr><tr><td>COMMISSIONER INCOME</td><td>5</td></tr><tr><td>CORPORATE SERVICES</td><td>68</td></tr><tr><td>HIF</td><td>15</td></tr><tr><td>LTUC</td><td>83</td></tr><tr><td>pSC</td><td>83</td></tr></tbody></table> Key causes for the current position include - Budget holders outlined a lack of clarity around roles and responsibilities in relation to budget management, as well as an understanding of the information. - Reach reporting shows that access to budget report information is mixed for those responsible for overseeing budgets at a local level. - There is a cluster of overspends within Pathology which required a specific review. <table><caption>Comparing Users Who Have Logged in within Past 6 Months/Logged in For June</caption><tr><th>Department</th><th>Users Logged in within Past 6 Months</th><th>Users Logged in For June</th></tr><tr><td>Pathology</td><td>~1000</td><td>~1200</td></tr><tr><td>Other Departments</td><td>~500</td><td>~600</td></tr></table>	Directorate	No. of CCs with negative YTD variance	CAPITAL CHARGES	2	CYPH	49	COMMISSIONER INCOME	5	CORPORATE SERVICES	68	HIF	15	LTUC	83	pSC	83	Department	Users Logged in within Past 6 Months	Users Logged in For June	Pathology	~1000	~1200	Other Departments	~500	~600	<table><tr><th>Concern</th><th>Cause</th><th>Countermeasure</th></tr><tr><td>Financial management</td><td>CC's not in budget</td><td>Monitor No of CC's not in budget balance/agreed escalation process</td></tr><tr><td></td><td>Financial understanding</td><td>Refresh of Finance training offer.</td></tr><tr><td>Pathology</td><td>JV arrangements</td><td>Monitor uptake/link with mandatory training. External review, take forward recommendations</td></tr></table>	Concern	Cause	Countermeasure	Financial management	CC's not in budget	Monitor No of CC's not in budget balance/agreed escalation process		Financial understanding	Refresh of Finance training offer.	Pathology	JV arrangements	Monitor uptake/link with mandatory training. External review, take forward recommendations		
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Related Corporate Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite																		
ID 721	Group Cash Position	Cash support will be required throughout the year in line with the deficit plan, added to this there is the gap in cash awarded in 25/26 versus the deficit position (£14.4m awarded v's £23.75m deficit). There was £14m+ outstanding to Suppliers and the BPPC has declined below 23%. The impact of not meeting the BPPC 95% target will affect future business development opportunities including 0-19 contract. More Suppliers are threatening withholding deliveries unless accounts are settled.  Cash support requests submitted summarised below <table><thead><tr><th>Cash Support</th><th>Requested</th><th>Approved</th></tr></thead><tbody><tr><td>April</td><td>£9.5m</td><td>£4m</td></tr><tr><td>May</td><td>£4m</td><td>£2m</td></tr><tr><td>June</td><td>£1.8m</td><td>£1.8m</td></tr><tr><td>July</td><td>£3.2m</td><td>£10m**</td></tr><tr><td>August</td><td>£1.4m</td><td></td></tr></tbody></table> **pending formal approval Key actions being prioritised 1. Aged Debt 2. WRAP delivery (Run rate reductions) Turnaround Actions £30.2m WRAP target in totality. Central Schemes (EPR, Estate, Bed Base, Outpatients) and Directorate targets. Added to this £7.4m WRAP income target, this will be delivered if the activity plans submitted is delivered. Directorates are still working on schemes however there is a significant gap. The Trust has a planned deficit £15.3M for 26/27. The Trust has faced significant scrutiny for not delivering the 25/26 plan (Breakeven versus £23.75m reported deficit). WRAP delivery and managing costs within allocated budgets is key in delivering the financial plan for 26/27.	Cash Support	Requested	Approved	April	£9.5m	£4m	May	£4m	£2m	June	£1.8m	£1.8m	July	£3.2m	£10m**	August	£1.4m		5 x 5 = 25	4 x 2 = 8 March 2027	Financial: revenue, funding and liquidity	Cautious
Cash Support	Requested	Approved																						
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ID1241	26/27 Waste Reduction and Productivity	£30.2m WRAP target in totality. Central Schemes (EPR, Estate, Bed Base, Outpatients) and Directorate targets. Added to this £7.4m WRAP income target, this will be delivered if the activity plans submitted is delivered. Directorates are still working on schemes however there is a significant gap.	4 x 4 = 16	3 x 3 = 9 March 2027	Financial: Financial Management	Minimal																		
ID1242	Financial Plan Delivery 26/27	The Trust has a planned deficit £15.3M for 26/27. The Trust has faced significant scrutiny for not delivering the 25/26 plan (Breakeven versus £23.75m reported deficit). WRAP delivery and managing costs within allocated budgets is key in delivering the financial plan for 26/27.	4 x 4 = 16	3 x 3 = 9 March 2027	Financial: revenue, funding and liquidity	Cautious																		

Related External Risks

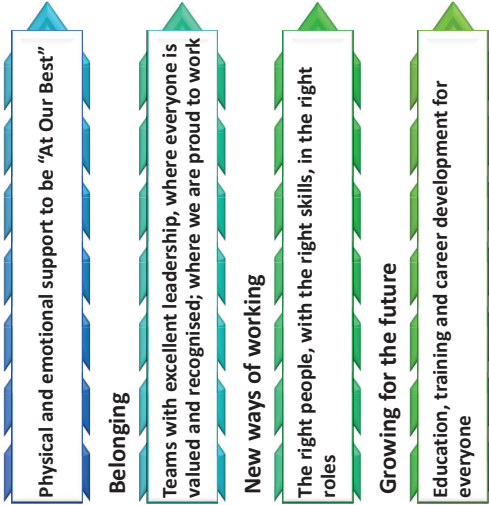
ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
	Local Authority Contract Changes for the Pay Award & NI Contributions	Pay Award and NI contributions for Local Authority organisations £1.3m still to be agreed. (To note £1.7m agreed). NHSE confirmed ICB should continue to provide the funding for NI changes from 22/23. ICB have confirmed that they will now recognise this however contract discussions are ongoing.	3 x 3 = 9	4 x 1 = 4 May 2026	Financial: revenue, funding and liquidity	Cautious
1314	Risk of Clawback in underspent contract areas	A number of Local Authority contracts have a clawback clause included which enables the LA to clawback any underspends in year. Only Wakefield has chosen to enact this to date due to not being able to recruit up to the proposed model.	4 x 4 = 12	1 x 4 = 4 April 2027	Financial: revenue, funding and liquidity	Cautious

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

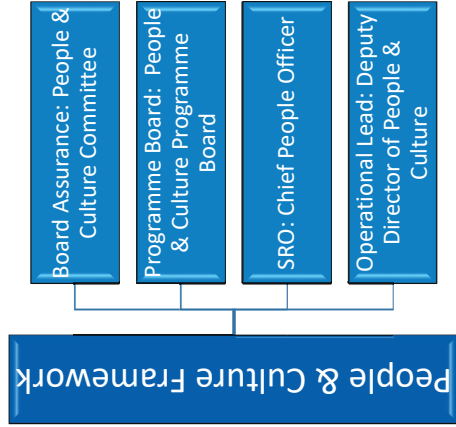
Our People & Culture Strategy, 'At Our Best', follows the NHS People Plan themes and our team HDFT 'KITE' values and culture. Our ambition is to make HDFT the best place to work. We will provide physical and emotional support to enable us all to be 'At Our Best'. We will build strong teams with excellent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

GOALS:

Looking after our people



GOVERNANCE:



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



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

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

Strategic Metrics Summary:

Workstream	True North Metric	Vision (People Plan)	Goal (True North Metric Target)	Current Status	Countermeasures	Level of Risk to Achieving in year Goal	Level of Risk for progressing actions
Looking after our people 	Staff Engagement Index	We will develop our leaders to deliver appreciative, compassionate, inclusive and improvement focused leadership that is aligned to our KITE behaviours and our IMPACT continuous improvement programme.		NHS Leadership and Management Framework launched nationally 06 July 2026. HDFT implementation planning underway. Work is underway to develop a package of support for managers managing in a financially challenged environment.			
Looking after our people 	Staff Engagement Index	We will have a clearly communicated and positive focus on all aspects of health and wellbeing with the aim that every colleague feels supported. We will ensure that we give thanks and recognise the invaluable contributions from our colleagues through the recognition schemes.		Staff Flu Vaccination programme in FY 25/26. Final percentage of staff vaccinated was 68.2% putting us at the highest level within NHS England. Programme close down paper sent to March 2026 Board of Directors. Kite Awards Celebration event took place on Friday 6 March 2026, including colleagues entitled to Long Service Awards Prep for 2027 starting now.			
Looking after our people 	Staff Engagement Index	We will create and maintain multiple channels for our colleagues to have a voice, be heard and feel empowered to speak up.	Maintain Inpulse survey response rate. Continuously tracking above our benchmark group engagement score. Validate the Improvement by seeing an improvement in the National Staff Survey Overall Engagement Score in the 2025 survey results. Maintain a continuously improving trend on both NQPS (Inpulse) and the NHS Staff Survey response rates and aspire to be best within our benchmark group. Achieve and maintain the best engagement score within our benchmark group.	The July Inpulse Survey is open 01 – 22 July 2026. The response rate achieved in the April 2026 Inpulse Survey was 25%, and the engagement score has increased slightly from the January survey (from 7.02 to 7.03) placing it 5th / 89 benchmark Trusts. (NB the 4 higher ranked trusts had response rates of 1% - 8%). The National Staff Survey for 25/26 closed on 28 November 2025 and HDFT response rate was 62% which is the highest response rate achieved. All Directorates qualified for funding under the newly introduced incentive scheme and a total of £240K will be distributed to support patient/colleague wellbeing initiatives. Three organizational priority areas of focus have been identified for FY 2026-27. National Education and Training Survey (NETS 2025): Total response rate 97 learners. Highest scoring acute Trust for overall experience in the region, 5th highest against all 22 regional Trusts – 81.26%. One red flag in Obs&Gynae, pink flag themes in Obs&Gynae and Sexual Safety from patients, action plans in place to improve placement experience and zero tolerance policy being reviewed to support harassment.			

Workstream	True North Metric	Vision (People Plan)	Goal (True North Metric Target)	Current Status	Countermeasures	Level of Risk to Achieving in year Goal	Level of Risk for progressing actions
				The Occupational Health Business Case was not supported at the meeting on 5 June 2026. The Head of OH is reviewing structures, we are working with finance to try and release funding and reviewing the risk score for Health Surveillance. Paper on health surveillance risk going to August H&S Committee and business case being re-reviewed along with health surveillance paper to go back to Business Case Review Group.			
Belonging 	Staff Engagement Index	We will promote equality and diversity, so everyone feels valued and recognised through the embedding of Equality Impact Assessments as expected practice, the continued development of our Staff Support Networks, leadership development and training of all colleagues. Our work on Equality, Diversity and Inclusion will be nationally aligned to the NHS Equality, Diversity and Inclusion Improvement Plan.	Embedding Equality by focussed work based around the 6 EDI High Impact Actions (HIA). Progress to be made on: HIA1: Chief Executives, Chairs and Board Members should put EDI objectives in place that they are personally responsible for. The goal is: - Each Director to have an EDI objective HIA 2: Employ & Develop Staff in a fair and inclusive way and target groups that are under-represented in the organisation. The goal is: - Improve the reported lived experience of colleagues who are BME or have a disability or long-term condition	The Reciprocal Mentoring Programme for colleagues with a disability or long-term condition started in September 2025. 12 pairs of aspiring and established leaders have attended their workshops and listening together events as well as meeting for their one to one development meetings. A listening event for colleagues with a disability or long-term condition is to be scheduled to give the opportunity for further learning about the lived experience. Recruitment is underway for our Equality & Diversity Champions - with 10 excellent colleagues signed up to the role. Training to take place in July 26. The Equality & Human Rights Commission ruling on transgender issues was launched for consultation in May, with the outcome that a persons sex is to be determined by their biological sex. A meeting with Planning Dept is has occurred and they are taking forwards a facilities review and also TIF2 review..			
Belonging 	Staff Engagement Index	We will seek to increase diversity in our leaders and decision makers and have a representative pool of leaders.	Improve WRES metric regarding relative likelihood of appointment from shortlisting and increase diversity within senior leadership roles.	17 Independent Panel Members (IPM) have been recruited – and are actively taking part in recruitment activity – currently across recruitment campaigns from clinical bands 7 to VSM which is a great start. We are recruiting for a second cohort which will be trained later this summer. IPMs are involved in any Trust Executive Recruitment processes.			
Growing for the future	Staff Availability	To ensure HDFT is the 'best place to work' there must be the right number of staffing available each day for deployment to ensure quality of care and to	Sickness levels throughout HDFT to not exceed 4.1% A vacancy rate that does not exceed 6%	The Trust vacancy rate is 4.58% at the end of June 2026, which is below the Trust target of 7% (this is below the A3 threshold of 6%). - Trust turnover is 9.29% - Sickness is 5.13% - Staff leaving within 1st year is 14.77%			

Workstream	True North Metric	Vision (People Plan)	Goal (True North Metric Target)	Current Status	Countermeasures	Level of Risk to Achieving in year Goal	Level of Risk for progressing actions
		enable those staff to have a good experience and do their best	Staff leaving within their first year of employment to not exceed 15% A Turnover rate that does not exceed 12% (HNY is 12%)	(This has remained at the same level as last month.) Staff unavailability reduced by 5.67wte in June, falling from 634.90wte in May to 629.23wte. The main drivers of this decrease were reductions in vacancies by 4.70wte and turnover by 3.76wte. However, sickness continued to rise in June, increasing from 4.97% in May to 5.13%, equating to an additional 4.06wte of unavailability.			
New Ways of Working 	Staff Availability	We will continue to embed e-rostering to ensure that safe staffing levels can be allocated and managed with maximum efficiency. The Trust has initiated a workstream within the Turnaround Programme to review bank, agency and additional payments, identifying opportunities to improve financial efficiency while maintaining safe and effective service delivery.	100% of rosters signed off and issued 6 weeks before Reduce agency spend by 30% and bank spend by 10% at least	Roster sign off at 89.8% (excluding HIF, non-medical only) The Trust has commenced focused work on bank, agency and additional payments as part of the Turnaround Programme. NHSP Rates are being reduced to mid-point of band from current bespoke rates which are higher.			
	Staff Engagement	The Trust has been selected as an early adopter of the Future Workforce Solution, providing an opportunity to help shape and influence the future workforce systems used across the NHS.	To support the successful design, testing, and implementation of the Future Workforce Solution, helping to shape a modern, integrated workforce system that improves the experience of colleagues and managers, streamlines workforce processes, and provides better workforce data and insights for decision-making	The project has just completed Phase 1, which had focused on information gathering, understanding the resource requirements, and establishing the scope of the work required by the Trust. This phase also included attendance at a series of informational webinars designed to provide an overview of the seven modules that the Trust is expected to adopt as part of the Future Workforce Solution programme.			

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

Workstream	True North Metric	Vision	Goal	Current Status	Countermeasures	Level of Risk to Achieving in year Goal	Level of Risk for progressing actions
Medical and Dental Workforce Scheduling and Payment Transformation Project	Staff Availability	To have all Medical Staff on the rostering system and managers really engaged in using it as a tool to help improve patient care delivery.	- To ensure medical and dental staff are deployed to maximum effect - To enable workforce gaps to be planned and managed - For the locum bank to be managed via the e-Rostering system achieving visibility and accountability - To ensure best practice roster rollout - To have full visibility of having the right people in the right place at the right time - To have all unavailability's of staff reported - For all additional payments to be digitised for payment and removing all paper/spreadsheet submissions	Job planning compliance is now at 81.9% at the end of June.			
		This will help enable us to fully align the workforce with service requirements/improvements		Go live for SAS and consultant Optima roll out was successful and was delivered on time.			
				Medical E-Rostering project has been extended for 6 weeks to try complete the final rosters before it moves across to BAU			

Strategic Project:

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

Breakthrough Objective: Staff Involvement.

Workstream	True North Metric	Vision	Current Status	Countermeasures	Level of Risk to Achieving Goal (CxL)	Level of Risk for progressing actions
Making HDFT the best place to work	Staff Engagement Breakthrough Objective - Involvement	To create an environment within HDFT where staff feel genuinely involved in decisions that affect their work and their team, and where they are able to contribute to and influence improvements to their work. This corresponds with the True North Ambition of improving Staff Engagement. Goals 1. The Trust score for Involvement in the NHS Staff Survey matches the best result for the benchmark group (2024 HDFT scored 6.85 vs best in benchmark of 7.27). 2. To achieve, at Trust level, a score on question 3f, "I am able to make improvements happen in my area of work," matching the best result in benchmark (2024 HDFT 55.37% vs 63.91%).	After review of breakthrough objectives at SDR and in light of positive performance, the Involvement Breakthrough Objective has been replaced for FY 2026-27 with new objectives.			

Related Corporate Risks.

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

Related External Risks.

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

Guardian of Safe Working Hours Quarterly Report and Annual

Quarter 4 of 2025-2026

18th March 2026

Dr Megan Atkinson – Guardian of Safe Working Hours

Executive Summary

This report of the Guardian of Safe Working Hours covers quarter 4 of 2025/2026, 1st January 2026 - 18th March 2026, with additional details for the annual report. Due to the timing of board papers, the Q4 data is incomplete and will be incorporated in full into the next report. The purpose of this report is to assure the Board of Directors of the state of safe working of resident and LED doctors in the trust.

I, Dr Megan Atkinson, am the Guardian of Safe Working Hours (GoSWH) for HDFT. I also hold the role of educational supervisor to one geriatric higher specialty trainee and clinical supervisor to one foundation year 1 trainee. I declare this as a potential conflict of interest in both roles. Nationally, other GoSWHs also act as supervisors. I am making this potential conflict of interests known to the board as well as explaining my role to supervisees. If at any point there is concern of a conflict, this will be escalated to Dr Jackie Andrews.

Version 13 of the Terms and Conditions for doctors in training came into effect on 4th February 2026. Because of this there have been significant changes to how exception reporting is handled by the trust. The reporting features of Allocate (exception reporting software) remain incomplete, and so this report comprises the data as it is currently available.

Introduction

Harrogate Hospital currently employs 231 LED/Resident doctors. Resident Doctor (RD) refers to doctors currently enrolled in a training programme. LED refers to “locally employed doctors,” doctors directly employed by the trust and not otherwise engaged in a training programme. Fellows are LEDs employed by the Trust and facilitated to have a portion of their time dedicated to research/quality improvement or education. For the purposes of this report, they are grouped with LEDs.

Harrogate hospital currently employs the following (accurate January 2026):

- Resident doctors = 182
- Locally employed doctors = 34
- Fellows = 15

An exception report (ER) is raised by a RD/LED when they are required to work outside their work schedule within 28 days of the occurrence. This is most commonly because of additional time worked but can also pertain to missed breaks and educational opportunities, loss of rest during non-residential on calls and difference in available support. There are new exception report categories for information breaches (when a doctor suspects the confidentiality of their exception report has been broken) and actual or threat of detriment as a result of exception reporting. HDFT uses software called Allocate to manage the exception reporting process. Major updates have been made to the Allocate software to support the changes in V13, although some major functionality is currently missing.

Medical Workforce handles exception reports for periods less than 2 hours. They undergo a 3-stage check before sign off with the RD/LED's preference of Time Owing in Lieu (TOIL) or payment (apart from occasions where TOIL is contractually mandated). If there are concerns about a single report, or pattern of reporting, this is escalated to myself to reach out to the RD/LED and investigate. Exception reports of greater than 2 hours are subject to a locally determined process agreed with the JLNC (appendix 1).

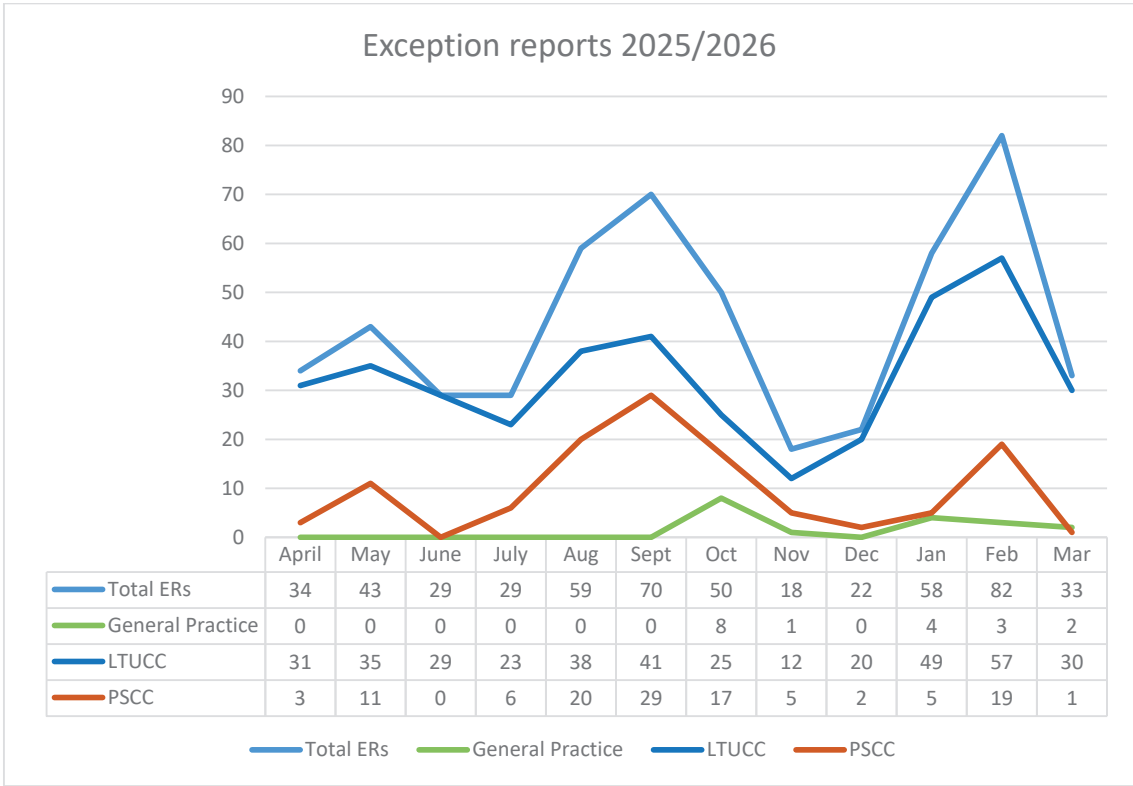
As Guardian of Safe Working Hours, I have oversight of all exception reports, apart from educational reports, which now go directly to the Director of Medical Education (Dr Simon Holbrook). I liaise with RD/LEDs and, with their consent, communicate with directorates about any patterns of concerns. In certain situations, fines are levied against departments for specific breaches of V13 2016 T+Cs of service.

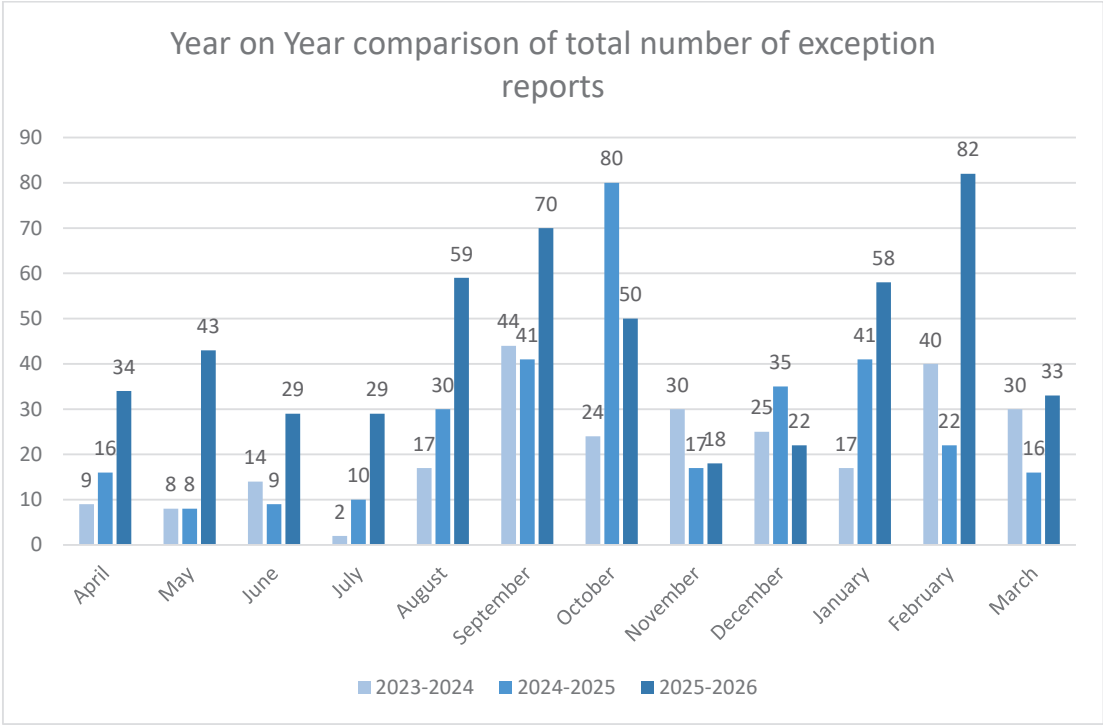
High-level data for Harrogate

a) Exception report data

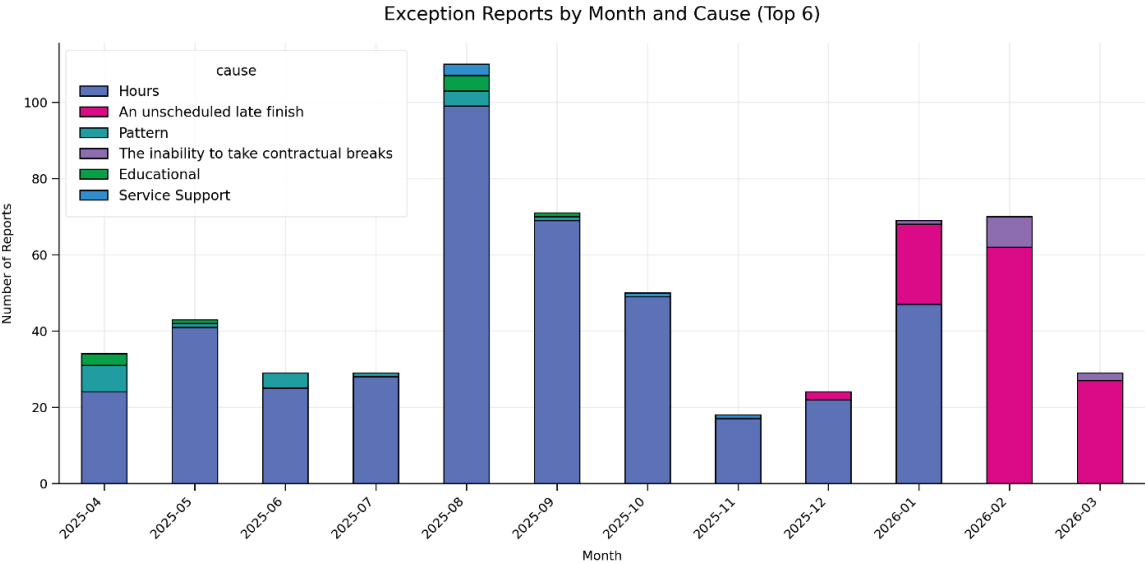
The following data is presented differently to previous reports. The new version of Allocate does not allow the exporting of representative tables and this data is only available for part of January. I have therefore presented an accumulation of data from both the old and new version of Allocate.

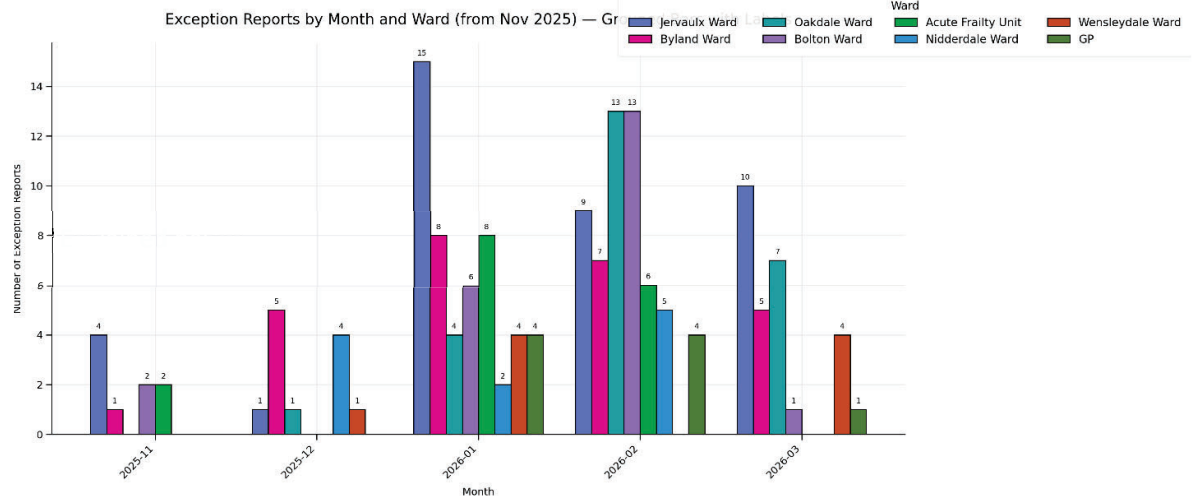
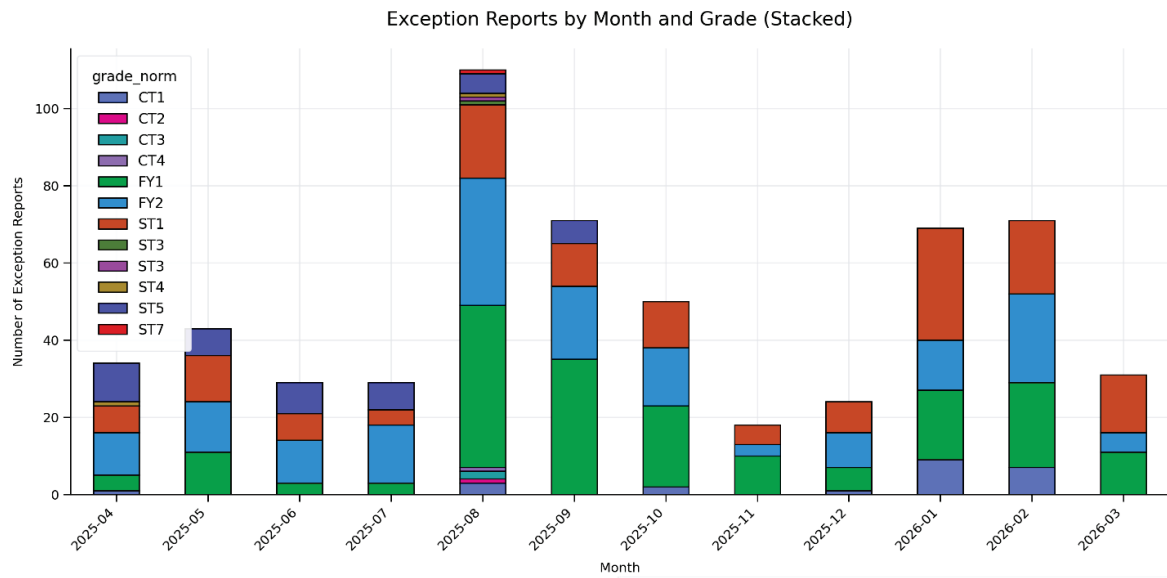
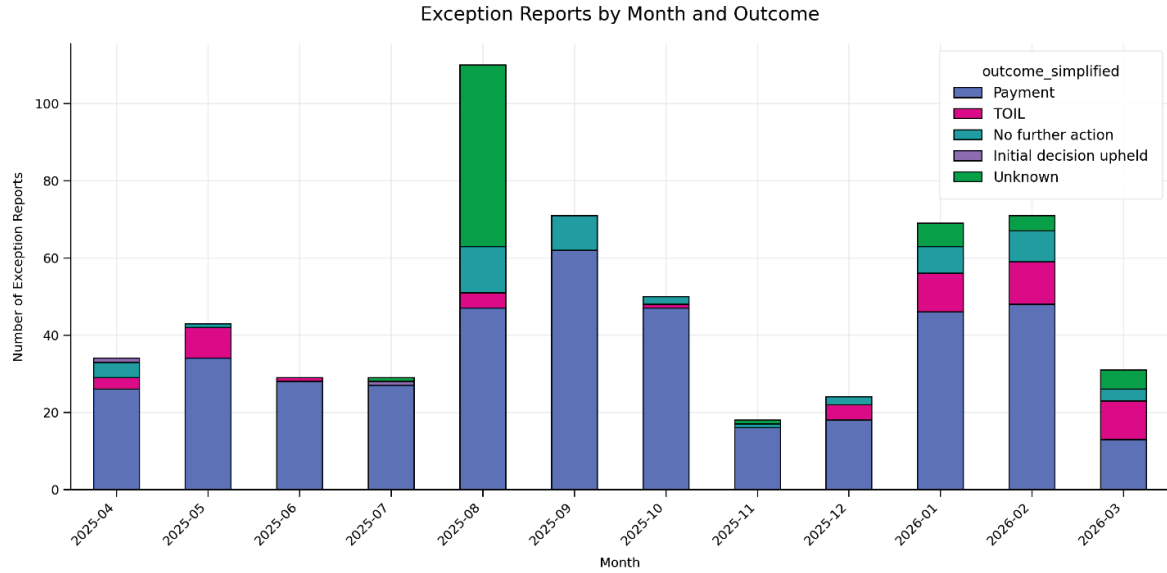
Please note the data for March is incomplete (ends 18th March 2026).





The following anonymised data was analysed with assistance from Copilot.





b) Below is a table supplied from Medical Workforce showing the relevant rota gaps across HDFT 1st April 2025 – 31st March 2026.

Directorate	Department	ROTATES	Grade	Deanery or Trust	WTE	Notes	Recruitment
LTUCC	Acute Medicine	Aug-Feb	ST3+	Deanery	1	Deanery gap	Gap until May 2026, current resident on maternity leave
	Elderly Medicine	Aug-Feb	GPST	Deanery	1	Deanery gap	Filled with LED - fixed term for 12 months
	Emergency Medicine	Feb-Aug	CT1	Deanery	1	Deanery gap	Gap from Feb-Apr due to resident being LTFT and rotations being out of sync as a result.
	Emergency Medicine	Feb-Aug	CT1	Deanery	1	Deanery gap	Gap from Feb-Aug, successfully recruited LED for 6 months
	Emergency Medicine	Feb-Aug	GPST	Deanery	1	Deanery gap	Gap from Feb-Aug, successfully recruited LED for 6 months
PSC	Diabetes and Endo	Aug/Dec/Apr	IM1	Deanery	1	Deanery gap	Unable to recruit to this vacancy
	Orthogeriatrics	Feb-Aug	GPST	Deanery	1	Deanery gap	Gap from Feb-Aug, successfully recruited LED for 12 months
	Obstetrics and Gynaecology	Feb-Aug	GPST	Deanery	2	Deanery gap/Maternity	1 deanery gap and 1 maternity gap, recruitment is ongoing for these posts.
	Paediatrics	Feb-Aug	GPST	Deanery	3	Deanery gap	3 deanery gaps from Feb-Aug, successfully recruited 2 x LED for 6 months.
	Paediatrics	Mar-Sep	ST4+	Deanery	1	Deanery gap	Deanery gap from March to September due to resident completing training. Department not recruiting to this vacancy.

c) Due to time constraints, data regarding locum usage has not been collated or analysed for this report

d) Fines from 2025/2026

Fine Number	Fine number by quarter	ER Submission Date	Directorate	Reason for fine	Fine Total	Payable to Doctor	Payable to GOSW Fund
53	1	May-25	LTUCC	B	£100.75	£37.78	£62.97
54	2	May-25	PSCC	B	£89.44	£33.54	£55.90
55	3	Aug-25	LTUCC	B	£87.66	£32.87	£54.80
56	4	Aug-25	PSCC	B	£50.39	£18.89	£31.50
57	5	Aug-25	LTUCC	B	£59.63	£22.35	£37.27
58	6	Aug-25	PSCC	B	£21.77	£8.16	£13.61
59	7	Aug-25	PSCC	B	£21.77	£8.16	£13.61
60	8	Aug-25	LTUCC	B	£29.81	£11.18	£18.64
61	9	Aug-25	LTUCC	B	£29.81	£11.18	£18.64
62	10	Aug-25	PSCC	B	£65.31	£24.49	£40.82
63	11	Sep-25	LTUCC	B	£50.51	£18.94	£31.57
64	12	Sep-25	PSCC	B	£151.13	£56.66	£94.47
65	13	Sep-25	PSCC	B	£87.08	£32.65	£54.43
66	14	Sep-25	PSCC	B	£87.08	£32.65	£54.43
67	15	Sep-25	PSCC	B	£130.62	£48.97	£81.65
68	16	Oct-25	PSCC	B	£130.62	£48.97	£81.65
69	17	Oct-25	PSCC	B	£237.72	£89.13	£148.59
70	18	Oct-25	LTUCC	B	£37.79	£14.17	£23.62
71	19	Oct-25	PSCC	B	£36.78	£13.79	£22.99
72	20	Oct-25	PSCC	B	£31.78	£11.91	£19.87
73	21	Jan-26	PSCC	B	£75.32	£28.25	£47.08
74	22	Feb-26	PSCC	B	£75.32	£28.25	£47.08
75	23	Feb-26	PSCC	B	£87.16	£32.68	£54.47
76	24	Feb-26	PSCC	B	£75.32	£28.25	£47.08
77	25	Feb-26	PSCC	B	£50.38	£18.89	£31.48
78	26	Mar-25	LTUCC	B	£113.20	£42.45	£70.75
* the final two fines have not yet been sent to payroll but are shown for information							

Reason for fine	
A	A breach of the 48-hour average working week (across the reference period agreed for that placement in the work schedule)
B	A breach of the maximum 13 hour shift length
C	A breach of maximum of 72 hours worked across any consecutive 168 hour period
D	where 11 hours rest in a 24 hour period has not been achieved (excluding on-call shifts)
E	where five hours of continuous rest between 22:00 and 07:00 during a non-resident on-call shift has not been achieved
F	where 8 hours of total rest per 24 hour non-resident on-call shift has not been achieved
G	breaks have been missed on at least 25% of occasions across a four week reference period

Fines from V13 T+C's service - payable to GOSWH-administered funds	
H	Access and completion breach - recurring weekly fine of £250 (£500 from 4th April 2026) for being unable to submit an ER 7 days from raising this as an issue with MW
I	Information breach - For a proven breach of a doctor's confidential ER information, including inferable details (determined by GoSWH). £500, per doctor, per instance

e) Fine expenditure

Number	Date submitted	Amount	Purpose of monies	Outcome
N/a	Ongoing	TBC	Pizza to cater for RD/LEDs who attend Resident Doctor Forum. With aim to improve attendance and involvement at these meetings.	Ongoing quarterly payment
1	May 25	£143.76	Ticket price of attending the Society of Radiologists in Training (SRT) Conference 2025 where RD/LED presenting an oral presentation and poster presentation. To further career aspiration.	Paid
2	Dec 25	£199.94	Two L'Or Passione Rossa Coffee Machine Nespresso Compatible £59.99 + delivery + extra pods. Ongoing maintenance and pod costs absorbed by Doctors Mess Committee. To improve the Mess environment	Paid
3	Jan 26	£150.00	Accommodation to attend Radiology Conference in London. Career aspiration support.	Rejected – covered by LED study budget.
4	Jan 26	£272.99	Pizza for RDF	Paid
5	Mar 26	Pending	Pizza for RDF	Payment pending
6	Feb 26	£150.00	Partial fees for MSA FRCA Exam Prep Course – not covered by Deanery as first attempt sitting exam. Attended January 26. Aim of increasing likelihood of passing exam on first attempt.	Approved – payment pending
7	Mar 26	£150.00	Partial cost of ATLS course – not covered by study budget. To aid career aspiration as an expedition medic.	Approved – payment pending.
8	Mar 26	£250+	Dishwasher for the Mess – exact model to be agreed. Doctors Mess Committee accepted ongoing responsibility for upkeep and expendables. To improve the Mess environment.	Approved – payment pending.

Current GoSWH Fund Total	£8,330.38
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f) Detriment survey

The full results are available in the appendix. Summary chart provided by co-pilot.

Question	Yes	No	Other / Not answered
Submitted ER in past 3 months	1	2	0
Experienced actual or threatened detriment	0	3	0
Experienced discouraging comments	0	3	0
Know who to raise concerns to	3	0	0
Provided comments	0	0	3

Qualitative information and summary

Exception reporting remained steady throughout the year, with notable surges in August 2025 (the highest monthly report count) and again in January–February 2026. February 2026 showed the highest total extra hours logged, accounting for 85.6 hours from 166.6 total over the year.

In August 2025 there was a marked increase in reports from FY1 level doctors in both general medicine and general surgery. This was felt, in part, to reflect an increase in reporting, but also the impact of the doctors' rotations into new roles at the start of August. There were concerns raised about FY1 working in SAU which were addressed with the department. This is discussed in more detail below.

January and February 2026 have seen a large increase in exception reports, with February reporting far exceeding previous years. These increases coincide with the implementation of V13 of the T+C's resident doctors. Removal of supervisors as part of the sign off process, guaranteed anonymity and increased awareness are all likely contributors to this increase. Anecdotal evidence has shown for a while that RD/LEDs often miss their breaks while working, and exception reporting of missed breaks is now increasing to reflect this.

More junior grades continue to be the highest reporters, with the majority of reports coming from doctors working at Tier 2, followed by Tier 1. Higher training grades submitted comparatively few reports. The data indicates more junior doctors shoulder the bulk of excess hours and late finishes. There most likely also continues to be under reporting in more senior groups.

There has been an increase in requests for TOIL since February, although the vast majority of RD/LEDs opt for payment.

From December 2025 we have been collecting the location the RD/LED was working when an exception report was triggered. The areas with the most frequent reporting have been the Frailty Wards (Jervaulx and Byland), Oakdale ward and Bolton ward respectively.

Themes and Outcomes

Frailty medicine

The two frailty base wards, Jervaulx and Byland, consistently make up the majority of exception reports in LTUCC. They also have the longest exception report in Q4 when an LED doctor worked an additional 4 hours and 18 minutes on a "normal" day shift. Resident doctors,

Whilst it may be possible to see 10 patients in working hours, it is almost impossible to deliver a thorough and high level of care.

consultants and ACPs (Advanced Clinical Practitioners) on the frailty wards have all fed back to the GoSWH about their experiences on the ward. They expressed that the numbers of late stays and missed breaks vastly exceeded the number of exception reports placed. RD/LEDs “have only finished on time on a handful of occasions, usually when staffing levels were better

I often feel anxious about not finishing work and have begun to dread ward days due to workload and regular overtime.

than minimum.” They report rarely attending teaching activities and regularly eating lunch at their desks, forgoing their contractual breaks. Factors highlighted were high workloads, high levels of medical complexity and frailty, many patients being in the last year of life, and the need for often sensitive and complex discussions with patients and their loved ones. Admissions are often long and discharges complex. There are also high levels of patients with behavioural problems and aggression, with several instances of physical harm to staff reported. This is all being managed by a relatively junior team of RD/LEDs, with occasional support from the frailty ACPs, and sporadic presence of the Tier 3 doctors due to their on call and training commitments. All RD/LEDs reported being very well supported by consultant colleagues. Consultants report high levels of stress supporting these areas and the regular loss of their SPA time to provide additional input.

As a result of the continual pressure, RD/LEDs reported a high level of stress and symptoms of burn out. They reported low job satisfaction and high morale injury at not being able to provide the level of care they wished.

“I would have sunk if it weren’t for you” – direct feedback to consultant supervisor, indicating near-crisis coping levels

The current staffing is a minimum of three RD/LEDs for 30 patients and it is apparent this is not adequate to provide the standard of care required and leads to delays in communication, progression of care and discharges. It is also evident that when there are a minimum of four RD/LEDs on these wards, exception reports drop sharply and the experience of working on these wards significantly improves.

When we have four clinicians on the ward, the difference is tangible, we are able to update families properly, address nursing concerns thoughtfully, and feel less like we are firefighting throughout the day. The atmosphere shifts, and the care feels more measured and patient-centred.

I have recommended that minimum staffing is increased to a minimum of four. Rachael Stray, on behalf of the directorate, has acknowledged this recommendation and wherever possible

the medical rota team try to keep staffing at four or above. However, there is no financial agreement to make this a formal increase, leaving these areas vulnerable when RD/LED numbers are low. The following further actions have been taken to try and improve working conditions on the wards:

- 2 planned “additional” posts across Jervaulx/Byland in January 2026
- Protecting staffing at 4 per ward wherever possible (without backfilling)
- Creation of a registrar cover rota to improve access to Tier 3 support

Despite this RD/LEDs report ongoing pressure and a group work schedule review is planned for 20th March 2026 with a representative RD/LED, Rachael Stray (Operational Director) and Dr Ip Scarott (Clinical Lead) to discuss the ongoing challenges.

Surgical Assessment Unit

Across 2025-26, the Surgical Assessment Unit (SAU) has been a significant area of concern for Tier 1 doctors, with clear patterns of workload saturation, staffing vulnerability, inconsistent senior support, and negative wellbeing impacts. These issues peaked in Q2, improved markedly following targeted changes, and remained stable through Q3 and the early part of Q4.

Concerns raised centred on excessive workload and a backlog of unwritten discharge letters, inconsistent or insufficient senior support, FY1 doctors being asked to accept referrals from A+E and high levels of emotional distress and burnout. There was also fear of detriment and reluctance to submit exception reports. The PSCC group leadership responded rapidly with a structured action plan addressing senior presence and support, workload distribution and expectations regarding roles of senior RD/LEDs on SAU. This appeared to have a positive impact in reducing the number of exception reports and fines relating to SAU.

Reporting from Bolton ward and SAU has risen in Q4 but not to the extent seen in Medical wards. This seems to be related to days with very high patient numbers on SAU and some ongoing difficulty with managing the volume of admissions and discharge letters. There has not been a return of the concerning style remarks that appeared on the Q2 reports.

Concerns do continue to be raised, predominantly by Tier 2 RD/LEDs, regarding working on SAU and in surgery through the Resident Doctor Forum. In January 2026 concerns centred on FY1s carrying the ASCOM and being responsible for referrals, the presence of the Tier 3 RD/LED on SAU being variable, new LED posts being deployed to areas other than SAU and variability in workload. There was pressure being created by patients being admitted directly from triage to the surgical wards without prior medical assessment and concerns this created delays, increased clinical risk and unnecessary work. There were no further comments regarding SAU/General surgery at the most recent forum on 11th March 2026.

Dr Simon Holbrook (DME) is planning to communicate with senior management in PSCC regarding the comments from January's forum.

Exception reports over two hours

There has been excellent engagement with the process for reports more than two hours (attached as an appendix) from the RD/LEDs. There have been seven occurrences of exception reports exceeding two hours, all from LTUCC. Four were from the frailty base wards and have triggered a group work schedule review.

Three of the long stays were on Oakdale. This ward sees the highest levels of reporting after the frailty base wards and will be an area of focus in the upcoming months.

Work Schedule Reviews

There were several work schedule reviews triggered prior to the V13 T+C's service. No meaningful outcomes were available to me. Due to the heightened levels of confidentiality, I will now have greater oversight of the triggering and outcomes of WSRs and will be able to report on these in more detail in future reports, with consent from the RD/LED involved.

A group work schedule review is planned for the Frailty Base Wards on 20th March 2026.

Immediate Safety Concerns

Allocate allows RD/LEDs to flag an exception report as containing an immediate safety concern. These are for the purposes of reporting only and all RD/LEDs flagging these are encouraged to follow the process as laid out in their T+C's service as well as raise their concerns in a DATIX.

Seven ISCs were raised in 2025/2026.

Two of the ISCs were raised in error and the remainder were split between general surgery (3) and general medicine (2). It is variable whether concerns are escalated at the time by the affected RD/LED. Most ISCs can be related to areas with greater concerns which were addressed through the course of the year. The common themes between these reports is feeling that staffing did not meet the requirement of the clinical acuity on that shift, often due to last minute staff sickness. Several reports mention higher than usual levels of patients and acuity, and most mention difficulty accessing, or lack of, senior support.

Fines and Disbursement

26 fines in total have been identified and actioned over the last year. These were universally related to long days or nights on call where the shift exceeded 13 hours. These shifts are routinely 12.5 hours long and so have a heightened risk of triggering this fine. Workload and patient acuity are the usual precipitants of these late stays with some mention of handover processes. There was an increase in this type of fine in Q2 and Q3 which corresponded with the rotation of new doctors to the trust in August and increased workload pressures over the early winter.

Previously fines had been identified manually by GoSWH. Since February 2026 RD/LEDs have been able to flag their exception reports when they believe it triggers a fine, for review by the GoSWH. This may mean the number of fines increases, but also that there will be more accurate identification.

The limit on a 13 hour shift is automatically breached when a RD/LED works a night shift over the end of British Summer Time (BST). This will be discussed later in the year with Medical Workforce to develop some trust wide guidance to manage this risk.

Care is now needed to protect against identifiable information being inferable from fines. As a result, fines are batched and sent to payroll on a monthly bases and only limited information will be published and seen in these reports. If more information is requested, I will approach the relevant RD/LED to seek their consent before disclosure.

There has been an increase in disbursement of fine money in Q4 as detailed in the tables above. Several of these help our RD/LEDs in activities to support career/exam progression and there have been several requests for items to improve the Doctors' Mess. All requests have been voted on, and passed, at the Resident Doctor's Forum. There is an emphasis on measures that will increase wellbeing and this is being communicated with the RD/LEDs. I am in discussion with Dr Matt Rabin-Smith (Chief SpR) about how he can aid the disbursement process.

Resident doctor forums

Resident doctor forums continue on a quarterly basis and are chaired by Dr Simon Holbrook (DME). They continue to have excellent attendance and engagement, providing a lively meeting for raising concerns and communicating outcomes.

Detriment Survey

The V13 T+Cs mandate a quartile survey of fear or actual detriment experienced by RD/LEDs as a result of exception reporting. There has not yet been the circulation of a national template and so a local survey was created and circulated. There was minimal engagement with this and the limited results are attached in full as an appendix. Work will be needed over the coming year to improve the response rate to gain more meaningful results. I intend to liaise with the Freedom to Speak Up Guardians to explore other avenues for this.

New Framework for exception reporting – February 2026

Full details of the changes are accessible via the following links:

V13 T+Cs: [NHS Doctors and Dentists in Training England TCS 2016 VERSION 13 Final.pdf](#)

The new T+Cs have been fully implemented at HDFT. I would like to pass my thanks to Kerry Kidd, Chloe Paxton-Lawrence and the rest of the Medical Workforce Team, who have put a lot of effort into bringing this to fruition. I have summarised some updates on precious concerns below.

Increased reporting

Other trusts have seen an increase in reporting since the introduction of new T+Cs. In HDFT we did see an increase in February of 273% on the previous year and already in March we have a 106% increase on the previous year. We have also seen an increase in longer exception reports >2 hours, especially in LTUCC, although not a marked increase in the number of fines. I predict this increase may continue, reflecting an increased workload for Medical Workforce and myself going forward.

Reduction of clinical supervision

Due to fears of detriment, oversight of exception reporting was removed from clinical/educational supervisors meaning that as Guardian of Safe Working Hours I retain sole clinical oversight of exception reports (with Dr Simon Holbrook (DME) overseeing educational reports). Because of a new emphasis on confidentiality, I was concerned this would limit my ability to share problems identified with appropriate management. My early experience has shown the RD/LED body are happy to engage with my requests for meetings and are also enthusiastic to work with management to solve problems leading to excessive exception reporting. This will need monitoring over time.

It has been communicated to the RD/LEDs that their confidentiality can only be broken in 2 specific circumstances. Following the placement of reports >2 hours (as per the T+Cs) and if there are serious concerns about their, or patient, wellbeing/safety.

It is important to highlight that any breach in confidentiality of exception reporting data (including inferable data) will be subject to a fine of £500 per doctor per instance of breach.

Geolocation technology

NHSE's position is that ERs should be evidenced using some form of geolocation technology. In HDFT we have agreed this is burdensome and does not provide adequate assurance of a late finish. We are relying on a probity statement, the RD/LED's rota and a statement explaining why the exception report was placed (which will not be challenged, as per the T+Cs). This approach has been welcomed by the RD/LED body and they are engaging with these requirements well. We will keep the possibility of geolocation under consideration pending further advice from NHSE. Any suspicion of financial fraud will be escalated with senior management in Medical Workforce and investigated using the trust's fraud policy.

Software

Allocate have made significant changes to their exception reporting platform in order for the T+Cs to be implemented. There are several functions still awaited including the ability to produce a board report and problems with RD/LEDs not being notified of comments on their reports. Development is ongoing and Medical Workforce are engaged in communication with the developers.

Outstanding guidance

NHSE have yet to publish several documents, including a national template for board reports and for detriment surveys. This may change the way information is shared and presented in the future.

Further resource needed for Guardian work

In my last report, I recommended the appointment of a deputy GoSWH and consideration of additional resource for the Medical Workforce Team and GoSWH admin support. The board were supportive of this request. I am in discussion with Jackie Andrews and Kerry Kidd about how to proceed with this, but there are no firm updates for the Board at this time.

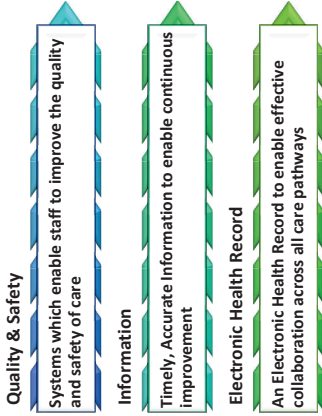
Recommendations for consideration

1. I ask the Board to note this report and the appendices.
2. To consider if locum data is of use in these reports and whether it can continue to be omitted.
3. To consider whether any further support can be given to increase staffing on Jervaulx and Byland ward to a minimum of four RD/LEDs.

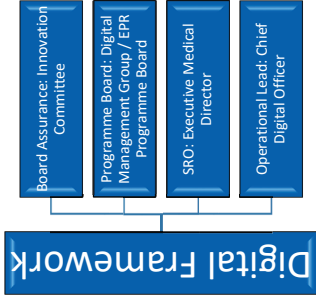
ENABLING AMBITION: DIGITAL TRANSFORMATION AND MATURITY TO INTEGRATE CARE AND IMPROVE PATIENT, CHILD AND STAFF EXPERIENCE 2025-2026

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

GOALS:



Governance:



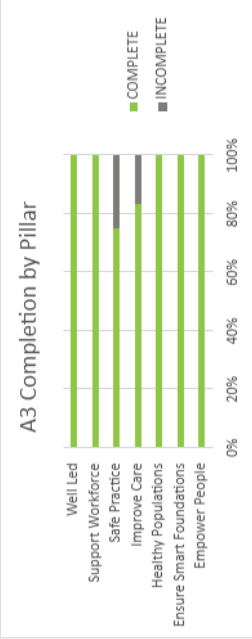
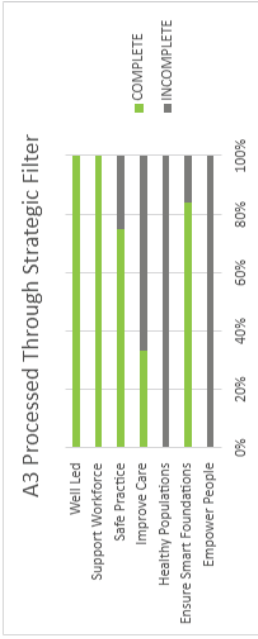
True North Metrics (Executive Lead: 10-15 Year deliverable)



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

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

True North Metrics Summary:

True North Metric	Vision	Goal	Current State	Countermeasures	Level of Risk to Achieving Goal (C x L)	Level of Risk for progressing actions
Best Quality & Safest Care 	Overarching Vision: To improve our Digital Maturity in keeping with the "What Good Looks Like" national programme for Digital Services in the NHS, so that our colleagues will have improved leadership skills, more advanced solutions, safe and secure digital foundations and practices, improved support and services, and will be better empowered to perform their roles. In turn, this will lead to better and more informative data and improvements in patient care and clinical services.	We aspire to achieve a score of 5/5 across all seven What Good Looks Like (WGLL) pillars. For our 26/27 submission, we aim to achieve an average score of 3/5 across the seven pillars.	Our ambition is to improve the organisations digital maturity that promotes best quality, safest care and now continues into its third year (2026-27). The delivery of the new EPR is well underway with a significant amount of functionality already live. We are focussing on how we can improve our overall digital maturity against WGLL. We assess ourselves annually using the National Digital Maturity Assessment (DMA) tool for both Acute and Community. To support this, we are developing A3's for all DMA Pillars and Domains and are aiming to have these complete and processed through the Trusts Strategic Filter by the end of July 2026. The current state is as follows:  	- A3s that have been developed will be run through the strategic filter (Jul 26) - They will then be prioritised and planned for delivery		
Person Centred, Integrated Care 						
Great Start in Life 						
Making HDFT The Best Place to Work 						
We are awaiting publication of this year's DMA.						

True North Metric	Vision	Goal	Current State	Countermeasures	Level of Risk to Achieving Goal (C x L)	Level of Risk for progressing actions																																																																																
	Seven Pillars of WGLL: 1. Well Led – A clear strategy for digital transformation & collaboration. Our leaders collectively own & drive the digital transformation journey, placing citizens & frontline perspectives at the centre. All leaders promote digitally enabled transformation to efficiently deliver safe, high-quality care Ensuring Smart Foundations - Digital, data & infrastructure operating environments are reliable, modern, secure, sustainable & resilient. We have well-resourced teams who are competent to deliver modern digital & data services	As above	A3 Progress <table><tr><th>What Good Looks Like Pilla .07</th><th>Domains</th><th>A3</th><th>Strategic Filter</th></tr><tr><td>Well Led</td><td>Digital and Data Strategy</td><td>COMPLETE</td><td>COMPLETE</td></tr><tr><td>Well Led</td><td>Digital Leadership and Board Membership</td><td>COMPLETE</td><td>COMPLETE</td></tr><tr><td>Well Led</td><td>Digital governance and assurance processes</td><td>COMPLETE</td><td>COMPLETE</td></tr><tr><td>Well Led</td><td>Enterprise Architecture</td><td>COMPLETE</td><td>COMPLETE</td></tr></table>	What Good Looks Like Pilla .07	Domains	A3	Strategic Filter	Well Led	Digital and Data Strategy	COMPLETE	COMPLETE	Well Led	Digital Leadership and Board Membership	COMPLETE	COMPLETE	Well Led	Digital governance and assurance processes	COMPLETE	COMPLETE	Well Led	Enterprise Architecture	COMPLETE	COMPLETE	- A3s that have been developed will be run through the strategic filter (Jul 26) - They will then be prioritised and planned for delivery																																																														
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	Support Workforce - Our workforce is digitally literate & able to work optimally with data & technology. Digital & data tools & systems are fit for purpose & support staff to do their jobs well		A3 Progress <table><tr><th>What Good Looks Like Pilla .07</th><th>Domains</th><th>A3</th><th>Strategic Filter</th></tr><tr><td>Support Workforce</td><td>Digital, Data and Technology (DDaT) Workforce Capacity and Capability</td><td>COMPLETE</td><td>COMPLETE</td></tr><tr><td>Support Workforce</td><td>Workforce Digital and Data Literacy</td><td>COMPLETE</td><td>COMPLETE</td></tr><tr><td>Support Workforce</td><td>Demand Led Management of Capacity</td><td>COMPLETE</td><td>COMPLETE</td></tr><tr><td>Support Workforce</td><td>Supply Chain Management</td><td>COMPLETE</td><td>COMPLETE</td></tr></table>	What Good Looks Like Pilla .07	Domains	A3	Strategic Filter	Support Workforce	Digital, Data and Technology (DDaT) Workforce Capacity and Capability	COMPLETE	COMPLETE	Support Workforce	Workforce Digital and Data Literacy	COMPLETE	COMPLETE	Support Workforce	Demand Led Management of Capacity	COMPLETE	COMPLETE	Support Workforce	Supply Chain Management	COMPLETE	COMPLETE	- A3s that have been developed will be run through the strategic filter (Jul 26) - They will then be prioritised and planned for delivery																																																														
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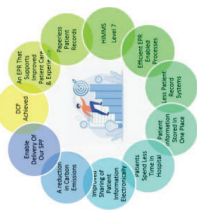
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	Empower Citizens - Citizens are at the centre of service design & have access to a standard set of digital services that suit all literacy & digital inclusion needs. Citizens can access & contribute to their healthcare information, taking an active role in their health & well-being		<table><tr><th>What Good Looks Like Pilla³⁷</th><th>Domains</th><th>A3</th><th>Strategic File³⁸</th></tr><tr><td>Empower People</td><td>Digital Consultations</td><td>COMPLETE</td><td>INCOMPLETE</td></tr><tr><td>Empower People</td><td>Citizen Accessible Health Records</td><td>COMPLETE</td><td>INCOMPLETE</td></tr><tr><td>Empower People</td><td>Public Engagement and Communications</td><td>COMPLETE</td><td>INCOMPLETE</td></tr><tr><td>Empower People</td><td>Appointment Booking and Check-in</td><td>COMPLETE</td><td>INCOMPLETE</td></tr><tr><td>Empower People</td><td>Self-triage and Self-referral Capabilities</td><td>COMPLETE</td><td>INCOMPLETE</td></tr><tr><td>Empower People</td><td>Digital Front Door and Patient Portals</td><td>COMPLETE</td><td>INCOMPLETE</td></tr><tr><td>Empower People</td><td>Condition Specific Care Apps and Portals</td><td>COMPLETE</td><td>INCOMPLETE</td></tr></table>	What Good Looks Like Pilla ³⁷	Domains	A3	Strategic File ³⁸	Empower People	Digital Consultations	COMPLETE	INCOMPLETE	Empower People	Citizen Accessible Health Records	COMPLETE	INCOMPLETE	Empower People	Public Engagement and Communications	COMPLETE	INCOMPLETE	Empower People	Appointment Booking and Check-in	COMPLETE	INCOMPLETE	Empower People	Self-triage and Self-referral Capabilities	COMPLETE	INCOMPLETE	Empower People	Digital Front Door and Patient Portals	COMPLETE	INCOMPLETE	Empower People	Condition Specific Care Apps and Portals	COMPLETE	INCOMPLETE	- A3s that have been developed will be run through the strategic filter (Jul 26) - They will then be prioritised and planned for delivery	
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	Improve Care - We embed digital & data within our improvement capability to transform care pathways, reduce unwarranted variation & improve health & wellbeing. Digital solutions enhance services for patients & ensure that they get the right care when they need it & in the right place		<table><tr><th>What Good Looks Like Pilla³⁷</th><th>Domains</th><th>A3</th><th>Strategic File³⁸</th></tr><tr><td>Improve Care</td><td>Shared Care Records</td><td>COMPLETE</td><td>INCOMPLETE</td></tr><tr><td>Improve Care</td><td>Care Co-ordination</td><td>COMPLETE</td><td>COMPLETE</td></tr><tr><td>Improve Care</td><td>Virtual Wards / Hospital at Home</td><td>INCOMPLETE</td><td>INCOMPLETE</td></tr><tr><td>Improve Care</td><td>Standards and Interoperability</td><td>COMPLETE</td><td>INCOMPLETE</td></tr><tr><td>Improve Care</td><td>Monitoring and Operational Performance</td><td>COMPLETE</td><td>INCOMPLETE</td></tr><tr><td>Improve Care</td><td>Artificial Intelligence</td><td>COMPLETE</td><td>COMPLETE</td></tr></table>	What Good Looks Like Pilla ³⁷	Domains	A3	Strategic File ³⁸	Improve Care	Shared Care Records	COMPLETE	INCOMPLETE	Improve Care	Care Co-ordination	COMPLETE	COMPLETE	Improve Care	Virtual Wards / Hospital at Home	INCOMPLETE	INCOMPLETE	Improve Care	Standards and Interoperability	COMPLETE	INCOMPLETE	Improve Care	Monitoring and Operational Performance	COMPLETE	INCOMPLETE	Improve Care	Artificial Intelligence	COMPLETE	COMPLETE	- A3s that have been developed will be run through the strategic filter (Jul 26) - They will then be prioritised and planned for delivery					
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	Healthy Populations - We use data to design & deliver improvements to population health & wellbeing, making best use of collective resources. Insights from data are used to improve outcomes & address health inequalities		<table><tr><th>What Good Looks Like Pilla³⁷</th><th>Domains</th><th>A3</th><th>Strategic File³⁸</th></tr><tr><td>Healthy Populations</td><td>Central Data Repository and Data Lakes</td><td>COMPLETE</td><td>INCOMPLETE</td></tr><tr><td>Healthy Populations</td><td>Metadata Management</td><td>COMPLETE</td><td>INCOMPLETE</td></tr><tr><td>Healthy Populations</td><td>Design of Interventions</td><td>COMPLETE</td><td>INCOMPLETE</td></tr><tr><td>Healthy Populations</td><td>Predictive Analytics for Population Health</td><td>COMPLETE</td><td>INCOMPLETE</td></tr><tr><td>Healthy Populations</td><td>Innovation and research</td><td>COMPLETE</td><td>INCOMPLETE</td></tr></table>	What Good Looks Like Pilla ³⁷	Domains	A3	Strategic File ³⁸	Healthy Populations	Central Data Repository and Data Lakes	COMPLETE	INCOMPLETE	Healthy Populations	Metadata Management	COMPLETE	INCOMPLETE	Healthy Populations	Design of Interventions	COMPLETE	INCOMPLETE	Healthy Populations	Predictive Analytics for Population Health	COMPLETE	INCOMPLETE	Healthy Populations	Innovation and research	COMPLETE	INCOMPLETE	- A3s that have been developed will be run through the strategic filter (Jul 26) - They will then be prioritised and planned for delivery									
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Healthy Populations	Predictive Analytics for Population Health	COMPLETE	INCOMPLETE																																		
Healthy Populations	Innovation and research	COMPLETE	INCOMPLETE																																		

Major Digital Projects (Equivalent to Trust Wide Projects):

Workstream	True North Metric	Vision	Goal	Current State	Countermeasures	Level of Risk to Achieving in Year Goal	Level of Risk for progressing actions
	Best Quality & Safest Care	Radiology booking office with ability for patients to book direct into appointments	Radiology Electronic Booking Office	- Feb 26 - Business case approved by BCRG - Mar 26 – Solution procured - PM resource allocated - Delivery in progress - Oct 26 Go Live planned	- Develop business case and secure funding - Complete procurement - Complete discovery - Plan & deliver solution		
	Best Quality & Safest Care	Replace the current Cardiology system	Cardiology System Replacement	- Feb 26 – Solution procured - Feb 26 - Project Initiated - Delivery in progress - Jul 26 Go Live planned	- Engage with supplier/service - Complete discovery - Plan & deliver solution		
	Best Quality & Safest Care	Electronic meal ordering system so patient can order their own meals and provide efficiencies to the catering team/Trust	Meal Ordering, Portering & Domestic System	- Synbiotix supplier confirmed for Meal Ordering, Portering and Domestic - Business case approved by BCRG and SDR 3 Projects being initiated and planned - Meal Ordering Pilot Go Live Oct 26 with full roll out complete by Jan 27	- Piggyback off LTHT procurement - Complete business case and secure funding - Engage with supplier/service - Complete discovery - Plan & deliver solution		
	Best Quality & Safest Care	Delivery of a regional integrated PACS and RIS solution	Regional PACS & RIS Replacement	- Awaiting procurement to be completed, business case to be developed and funding to be secured - Tender published Jul 26 - Evaluation & moderation to be complete Oct 26 - Preferred bidder & contract award Mar 27	- Regional procurement and business case to be developed and funding secured - Work with supplier/service - regional programme to plan delivery - Deliver solution		
	Best Quality & Safest Care	Job planning solution for AHP's	Job Planning for AHP's	- Project Manager allocated - Market testing complete - Preferred supplier confirmed - Business case to be developed by Autumn	- Developing requirement before testing the market - Complete discovery - Complete business case and confirm funding - Procure, plan & deliver solution		
	Best Quality & Safest Care	SystemOne Adult Optimisation	To optimise the use of SystemOne in Adult Community	- Approved by DDP - Project Manager appointed to complete discovery	- Complete discovery - Plan & deliver optimisation work		

Digital Portfolio Report - [Digital Delivery Process](#) - [Digital Portfolio Report - Power BI](#)

Strategic Programme: Electronic Patient Record

Workstream	True North Metric	Vision	Goal	Current State	Countermeasures	Level of Risk to Achieving Goal (C x L)	Level of Risk for progressing actions
	Best Quality & Safest Care		- EPR Live – Apr 26 - Paper-Lite – Apr 26 - HIMSS Level 5 – Aug 26 - Optimisation – Mar 27	This Strategic Programme for the delivery of the Nervecentre EPR continues into its third year (2026-27). The following are planned for delivery: - Optimisation (Apr 26 – Mar 27) - Medical Device Integration (Jun 26 – Mar 27) - Ambient Voice Technology Trial (Jun 26 – Aug 26) – Roll Out TBC - eConsent (Sep 26 – Mar 27) - ePMA (Dec 26 – Jul 28) - HIMSS Assessment – Aug 26 From a strategic planning framework perspective, the EPR Programme will be removed as a strategic programme after March 2027. Any further EPR work will be picked up by the Digital Services and supporting clinical teams, with EPR benefits capture and optimisation embedded with the HDFT Futures strategic programme.	- Deliver a new EPR solution - Optimise the solution & realise benefits - Enhance with additional modules and functionality - Perform HIMSS Assessment		

Breakthrough Objective:

Workstream	True North Metric	Vision	Goal	Current State	Countermeasures	Level of Risk to Achieving Goal (C x L)	Level of Risk for progressing actions																																			
Budgets in Balance	N/A	To support the organisations 2026/27 financial targets	All Digital Services budgets to remain in budget	There are six digital services budgets. Two are showing as behind plan. Whilst showing an overspend, the EPR budget is within plan, but this is linked to monthly spend estimates developed by finance which are lower than actual this month but will rectify themselves over the year, so no concerns. <table><thead><tr><th>Cost Group</th><th>Cost Centre</th><th>Budget</th><th>Year to Date Actual</th><th>Variance</th></tr></thead><tbody><tr><td>MEDICAL DIRECTORATE</td><td>253621-Electronic Patient Record Project</td><td>£27,365.37</td><td>£248,345.34</td><td>£15,562.59</td></tr><tr><td>MEDICAL DIRECTORATE</td><td>253607-IT Contracts</td><td>£810,799.97</td><td>£815,462.86</td><td>£4,662.89</td></tr><tr><td>MEDICAL DIRECTORATE</td><td>253626-Patient Systems</td><td>£246,249.95</td><td>£240,572.53</td><td>£5,677.42</td></tr><tr><td>MEDICAL DIRECTORATE</td><td>253606-Information Technology</td><td>£326,916.69</td><td>£320,346.80</td><td>£6,569.89</td></tr><tr><td>MEDICAL DIRECTORATE</td><td>253604-Telecommunications</td><td>£114,350.00</td><td>£105,470.29</td><td>£8,879.71</td></tr><tr><td>MEDICAL DIRECTORATE</td><td>253614-Project Management</td><td>£11,416.67</td><td>£1,165.35</td><td>£10,251.32</td></tr></tbody></table>	Cost Group	Cost Centre	Budget	Year to Date Actual	Variance	MEDICAL DIRECTORATE	253621-Electronic Patient Record Project	£27,365.37	£248,345.34	£15,562.59	MEDICAL DIRECTORATE	253607-IT Contracts	£810,799.97	£815,462.86	£4,662.89	MEDICAL DIRECTORATE	253626-Patient Systems	£246,249.95	£240,572.53	£5,677.42	MEDICAL DIRECTORATE	253606-Information Technology	£326,916.69	£320,346.80	£6,569.89	MEDICAL DIRECTORATE	253604-Telecommunications	£114,350.00	£105,470.29	£8,879.71	MEDICAL DIRECTORATE	253614-Project Management	£11,416.67	£1,165.35	£10,251.32	- Regular budget planning and monitoring - Actions taken where budgets are forecast to overspend		
Cost Group	Cost Centre	Budget	Year to Date Actual	Variance																																						
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Budgets in Balance	N/A	To support the organisations 2026/27 financial targets	Deliver a minimum Digital Services cash savings of £305,800 for 2026/27	Actioned and low risk savings on 22nd June 2026 – Confirms a surplus of £1,300 if the low-risk items are delivered, which is 100.43% of the target. Work will continue throughout the rest of 2026/27 to seek further cost saving opportunities.	- Review existing system contracts and opportunities for reduction or removal of costs - Identify vacancies where recruitment can be delayed																																					

Workstream	True North Metric	Vision	Goal	Current State	Countermeasures	Level of Risk to Achieving Goal (C x L)	Level of Risk for progressing actions													
				SUMMARY <table><tr><th>Metric</th><th>Value</th></tr><tr><td>Surplus1</td><td>£262,100</td></tr><tr><td>Actioned</td><td>£262,100</td></tr><tr><td>Low Risk</td><td>£45,000</td></tr><tr><td>Total</td><td>£307,100</td></tr><tr><td>Target</td><td>£305,800</td></tr><tr><td>Target Surplus/Deficit</td><td>-£1,300</td></tr></table>	Metric	Value	Surplus1	£262,100	Actioned	£262,100	Low Risk	£45,000	Total	£307,100	Target	£305,800	Target Surplus/Deficit	-£1,300		
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Related Corporate Risks

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

Related External Risks

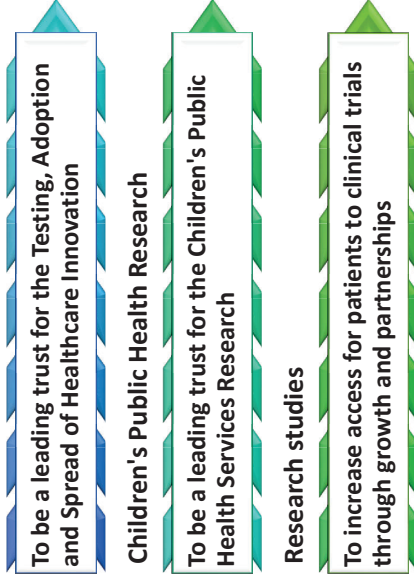
ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite

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

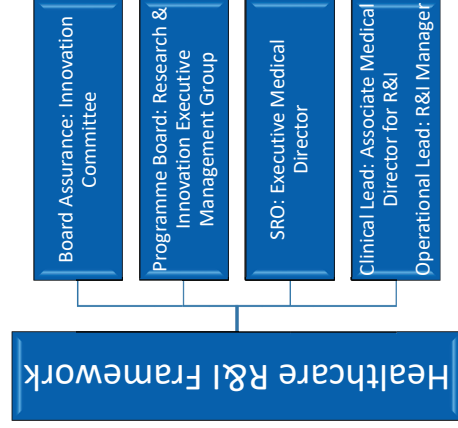
As an agile and innovative district general hospital and also the largest provider of children's public health services in England, HDFT has two key opportunities. First, to use our agility to become the first choice for testing healthcare innovations to improve care for patients. We will develop partnerships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

GOALS:

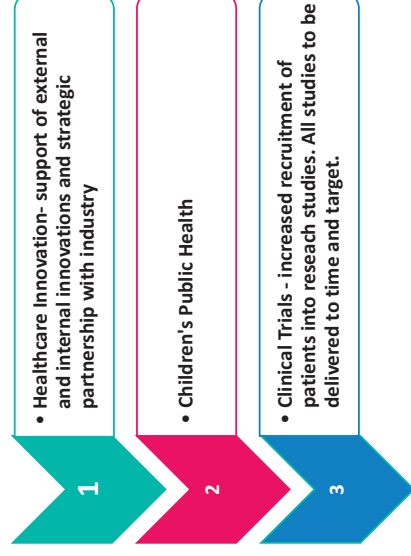
Healthcare Innovation



GOVERNANCE:



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

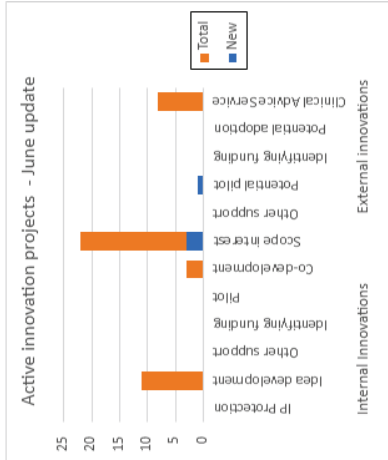


Trustwide Project:	3T MRI and CRF
Strategic Programme:	HDFT Impact
Breakthrough Objective:	CYPH Research
Overarching Risk Appetite:	Operational - Cautious

Overarching Risk Summary:

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

True North Summary:

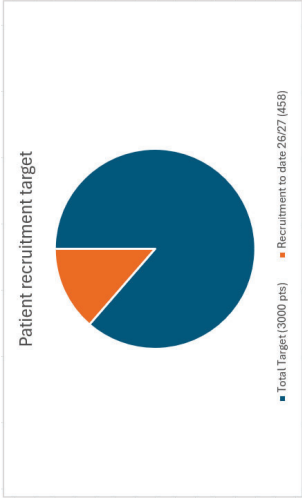
True North Metric	Vision	Goal	Current Status	Countermeasures	Level of Risk to Achieving Goal (C x L)	Level of Risk for progressing actions																																										
Healthcare Innovation 	To be a leading trust for the testing, adoption and spread of Healthcare Innovation and to facilitate and accelerate the growth of innovative healthcare solutions in HDFT	Generate, or create cost/time saving benefits equivalent to, >£100,000 to cover staffing costs of innovation team Assess all internally generated innovation ideas and support if deemed worth progressing Adopt at least 1 innovation that supports Trust priorities. Help create culture of innovation and develop relevant competencies in all staff by: Delivering a further 3 x Clinical Entrepreneur Fellows; Delivering at least 2 innovation training events per year. Develop strategic partnership with at least one organisation - academia, industry, charity, innovation support organisation	• Clinical Advice Service ◦ Advertised further via York council and at York and North Yorkshire Business Cluster networking event. ◦ Process to seek approval for Moti Me paed physio device continues • Clinical Entrepreneur Fellows ◦ 2nd cohort (3 x FY2s Aug 25 – Jul 26) - current cohort rounding off project and preparing handover ◦ 3rd cohort (3 x FY1s Aug 26 – Jul 27) - Interviewed new cohort and have begun assignment new projects, internal and external • Attended Europe's largest Health Innovation conference in June to represent HDFT as part of a Yorkshire and North East delegation promoting the region as a top destination for health care innovation. All costs were covered by YNY Combined Authority. • Planning second 'introduction to AI in Healthcare' session with Health Innovation and alongside LTHT as part of their Digital Festival in September. • Working with Adult Community service to explore Heim Health as a digital workforce planning and optimisation solution. Opportunity to help service realise huge cost saving benefits. • Active innovation projects are summarised below: Active innovation projects - June update <table><caption>Active innovation projects - June update</caption><thead><tr><th>Category</th><th>Stage</th><th>Total</th><th>New</th></tr></thead><tbody><tr><td rowspan="11">Internal innovations</td><td>IP Protection</td><td>0</td><td>0</td></tr><tr><td>Idea development</td><td>10</td><td>0</td></tr><tr><td>Other support</td><td>0</td><td>0</td></tr><tr><td>Identifying funding</td><td>0</td><td>0</td></tr><tr><td>Pilot</td><td>0</td><td>0</td></tr><tr><td>Co-development</td><td>0</td><td>0</td></tr><tr><td>Scope interest</td><td>20</td><td>0</td></tr><tr><td>Other support</td><td>0</td><td>0</td></tr><tr><td>Potential pilot</td><td>0</td><td>0</td></tr><tr><td>Identifying funding</td><td>0</td><td>0</td></tr><tr><td>Potential adoption</td><td>0</td><td>0</td></tr><tr><td rowspan="1">External innovations</td><td>Clinical Advice Service</td><td>0</td><td>0</td></tr></tbody></table>	Category	Stage	Total	New	Internal innovations	IP Protection	0	0	Idea development	10	0	Other support	0	0	Identifying funding	0	0	Pilot	0	0	Co-development	0	0	Scope interest	20	0	Other support	0	0	Potential pilot	0	0	Identifying funding	0	0	Potential adoption	0	0	External innovations	Clinical Advice Service	0	0	Develop benefit-realisation tool Continue to deliver Clinical Advice Service to generate income, support innovation developments and create partnerships Continue and develop new partnerships with industry to create sponsorship opportunities Continue development of innovation governance processes and pathway and communicate to all staff. Utilise project management tools to streamline innovation workflows and tracking. Develop innovation scorecard to aid project prioritisation. Continue to deliver Clinical Advice Service to generate income, support innovation developments and create partnerships. Work with WYAAT innovation partners, Medipex and Health innovation to develop innovation training offerings.		
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Children Young People Public Health (CYP PH) 	To be a leading trust for CYP PH research, delivering services that are underpinned by evidence of impact on health and wellbeing whilst informing national policy and best practice.	Continue to build workforce confidence, capability, and research literacy. Increase portfolio research activity and engagement that aligns to Trust priorities. Strengthen national research engagement, visibility, and impact of CYP PH research contributions.	Build workforce confidence, capability and research literacy Embed research learning opportunities on eLearning - Good Clinical Practice (GCP) initial / refresher training completion will be an output metric - NHSE e learning for Health gone live - What is Health Research Foundation - What is Health Research? Supporting Research Participants - Disseminating training opportunities - Mentorship & coaching x2 NIHR research applicants - CYP PH inclusion within R&I Strategy 2026-2030 Increase portfolio research 10% from threshold, 5 active projects NIHR bid Jan 26 for 0-19 delivery resource funding - o Feb 26 partial funding secured (0.6WTE B6) - o June 26 recruited - start date September • Study activity; - Approached: Blue Grass insights - Studies in discussion: Represent Study NIHR302504 NCMP Evaluation NIHR 207678 - Studies in delivery: Circle by the Sea NIHR 162162 Escalator (ELIM -1) NIHR 207059 • CYP PH Research concepts - o Top to Toe assessment - next meeting TBC - o 10-14 Day assessment partnering with Teesside University - o Housing project (service evaluation stage) - o Inclusion SCPHN research seeking partnership with Teesside University; Emma Giles; initial meeting arranged July • National engagement, visibility & impact - o Poster presentation HDT conference - o Participation in the Great Start in Life (GSIL) conference May 12th - o Participation with Yorkshire & Humber (Y&H) 0-19 Research Network - o Presented at Y&H ARC - o NIHR Children's Specialty Group – paediatric research involvement in regional collaborations • Data analysis / use - o University of York (UoY) MSc student; project suspended due to data quality Generate income to ensure financial sustainability Income is generated through two main funding streams, RRDN funding and Income generating (including commercial) research: Income predicted from RRDN ~£710k	Benchmark current research readiness via staff survey and completion / analysis of research SORT assessment. <i>July survey in development</i> Continue to expand research learning and delivery opportunities and reporting <i>July submitting a case for mandating GCP</i> Develop a clear governance process to governance research activity; including intellectual properties recognition. <i>July In progress; consultation phase</i> Develop a standard process to record research activity and outputs. Establish a PPI group to support co-production, capture lived experience to shape research delivery. Develop at least 1 sponsored research concept to a deliverable NIHR approved study that aligns to Trust priorities. Participate in at least 1 showcase event <i>July poster presented at HDT Conference</i> Develop processes to support data extraction and analysis to evaluate CYP PH datasets to inform service provision. Continue to develop research partnerships including further developing CAMHR at UoY, Y&H ARC, the Centre of excellence DAIM (Data Science, AI and Modelling) and the University of Hull.		
Clinical Trials 	To excel in the governance and delivery of clinical research, expanding patient access to high-quality clinical trials through sustainable	Generate income to match our research delivery costs.		Enhanced financial scrutiny through regular reporting and monitoring. Work through case for dedicated research finance support.		

	growth and collaborative partnerships. We aim to be a highly recognised and valued department within the trust, fostering a strong culture of research and innovation that drives improvement, empowers our workforce, and enhances outcomes for all patients.	Sustain partnership and funding for department with Y&H Research Delivery Network. Deliver contractual agreement and high-level objectives: Increase the number of patients recruited year on year.	Total forecasted staff costs including direct research delivery staff and support services including Pharmacy ~£1.14m. With expected non pay costs of £50k Forecasted deficit ~£200k Income in 26/27 to date is just over £100k, Research claim 45% of this. Therefore funds currently generated for R&I for 26/27: £45k. Deficit can continue to be improved by delivery of income generating trials. Sustain Partnership (RRDN) funding The Trust will sustain funding by meeting the key objectives agreed with the RRDN. These are: • Accelerating timelines for research • Driving inclusivity for groups traditionally lacking access to research • Shifting care settings for research away from secondary care • Supporting the life sciences industry • Workforce development The Trust will deliver by: To grow the numbers of recruited participants into clinical specialities including CYPH. To harness the potential of CYPH research in a community setting. CYPH= currently recruiting 1.75% of Trust patients involved in research	Open permanent CRF. Which will attract and enable more income generating and commercial research. Open Research MRI scanner and establish studies to boost utilisation. Develop academic partnerships further via York, Bradford and Leeds. YHN community collaboration project will strengthen partnership with GPs and RRDN. Ensure the success of this project to maintain government and RRDN strategic directions are followed. Continue to develop a trial scorecard to ensure prioritisation of studies, which ensures that we open trials that deliver against our ambitions and align to establishment. Review and consider new workforce operational models and structures for the delivery of CYPH studies. Develop Comms strategy and ensure research remains visible throughout trust and beyond to boost involvement in CYPH research.	
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			25/26 total recruitment: 2802 Patient recruitment target  ■ Total Target (3000 pts) ■ Recruitment to date 26/27 (458)	Continue to learn from trials at HDFT that are delivering above the national average for recruitment. Review and consider new workforce operational models and structures for the delivery of studies. Develop Comms strategy and ensure research remains visible throughout trust and beyond to boost involvement in research.		
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Trustwide Project: 3T MRI and CRF

True North Metric	Vision	Goal	Current Status	Countermeasures	Level of Risk to Achieving Goal (C x L)	Level of Risk for progressing actions
Best Quality Safest Care: Healthcare Innovation 	To have outstanding MRI technology and associated facilities that enable the delivery of our research and innovation ambitions	Procure and install a new 3T MRI scanner.	- Scoping phase behind original trajectory although not affecting overall plan at present. TIF2 timeline ahead of trajectory and therefore not a risk to this project at present. - Mechanical and Electrical Feasibility report received. - Premarket engagement completed. - Full market engagement requested through NHS Procurement route including timeline for purchase to ensure funding not lost. - Business Case awaiting Research requirements and final costings. - Budget costs are being developed to be included in the Business Case. At present it is expected that the cost to purchase the scanner and undertake the required building works to install will exceed the received funding.	Scoping completed, 3T MRI scanner out to full market engagement. Capital Planning pulling together final predicted costs for scanner and building works which will inform Business Case. BC to be updated by Research Team.		

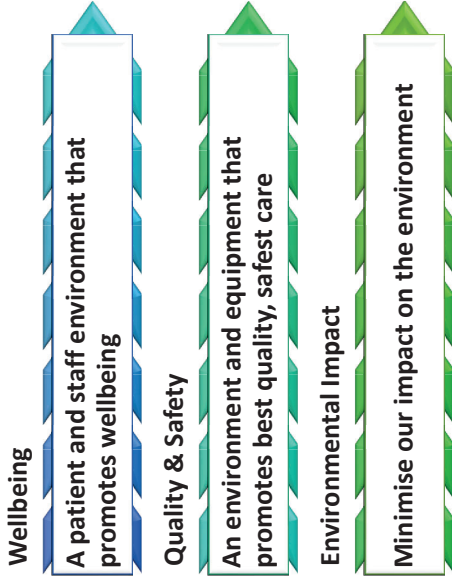
Strategic Programme: HDFT Impact

Workstream	True North Metric	Vision	Goal	Current Status	Countermeasures	Level of Risk to Achieving Goal (C x L)	Level of Risk for progressing actions
	All	To develop our capacity and to embed the culture for continuous improvement through the Implementation of the Impact Improvement Operating Model.	Training: 50% (92/184) of Teams will be trained to use HDFT Impact by Nov 2026 70% of teams trained (138/184) by Sept 27.	This Strategic Programme for HDFT Impact continues into its third year (2026-27). In year two we continued the development of HDFT Impact, refining our training offer to meet the needs of operational teams, re-designing our sustainability assessment to understand where the model was robust and where gaps exist that require attention, and exploring different approaches to increase engagement and awareness. Training, Sustainability, and Awareness are now established as our 3 key workstreams for this programme. Performance in these key elements is monitored with three driver metrics. The first is the percentage of teams trained across HDFT. - Wave 8 finished training in June meaning the number of teams who have completed moves to 76 (41%). - Wave 9 began in June with 12 participating teams. - Waves 10 & 11 had planned to include 14 teams each, however, current pressures on staff availability means this is likely to be revised down as gaps remained unfilled at the confirmation deadline. - To contribute to the financial recovery, recruitment to a 1.0 WTE Improvement Manager has been held. Mitigation for this loss capacity is in place. However, some impact on the trajectory is anticipated in Q3 & 4. Chart 1: HDFT Impact training delivery performance & trajectory Legend: Cumulative Number of Teams, Percentage of Teams Trained	Continue constructive conversations with team and directorate leaders via programme board to maximise use of available capacity for training. Deliver Impact for Leaders one-day training sessions as planned for July 16th and 8th Sept with ~20 participants enrolled. Refinement of the digital 'huddle' board piloted by CYPH teams is in progress. The ambition is to be able to integrate data flow from Power BI prior to scaling to other areas later in Q2. Similarly, standard work is being developed for the frontline 'rapid' PRM following successful testing in LTUCC. Significant changes to workshop 2 are planned for Wave 9 based on feedback and review of Wave 8 delivery. This will see the content tailored to the participating teams based on their progress in applying their learning. Continue to explore how Copilot AI functionality can be introduced as part of the Impact training content.		
			Sustainability: 65% of those who have completed training will have embedded the routines and processes of the Improvement Operating Model after 4 months.	The new self-assessment process for this metric was launched via the Impact programme board in late April 2026. Increasing response rates and validation via 'genba' visits is building confidence the data is representative. The Improvement Academy is seeking a 20% month-on-month increase in reporting.	Improvement academy coaches competed 17 genba visits in June to engage with teams around the barriers and support required for impact routines. This pro-active approach to support and validate reporting will continue as part of standard work.		

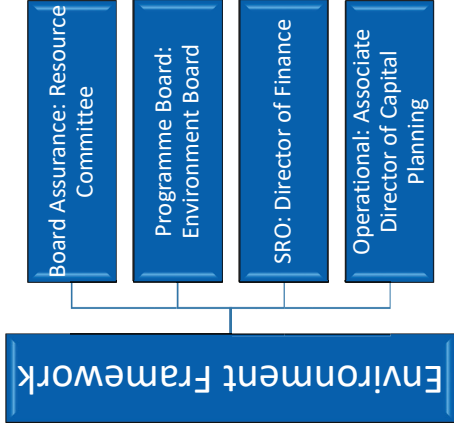
ENABLING AMBITION: AN ENVIRONMENT THAT PROMOTES WELLBEING 2026-27

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

GOALS:



GOVERNANCE:



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



Overarching Risk Summary:

Trustwide Project:	- Imaging Project (included in other BAF) - Harrogate Estates Plan
Strategic Programme	N/A
Breakthrough Objective:	N/A
Overarching Risk Appetite:	Operational - Cautious

Ambition	Workstream	True North Metric	Risk Appetite	Level of Risk to Achieve Metric – Linked to Risk Appetite									
				1 – 3	4 – 6	8 – 9	10	12	15	16	>20		
An Environment that promotes wellbeing	Wellbeing	Capital Programme Delivery (Spend vs Budget)	Operational: Cautious										
	Quality & Safety	High Risk Backlog Maintenance	Operational: Cautious										
	Environmental Impact	Natural gas consumption	Operational: Cautious										

Enabling Ambitions Metrics Summary:

Enabling Ambition Metric	Vision	Goal	Countermeasures	Current State	Level of Risk to Achieving Goal	Level of Risk for progressing actions
Wellbeing 	A patient and staff environment that promotes wellbeing	To improve the environment for patients and staff Capital spends vs budget – to ensure delivery against allocated budget.	- Deliver 2026/27 Capital Programme - Develop Capital Priorities for future years. - Deliver Block C Theatres & Imaging build. - Develop plans for Imaging Corporate Project - Deliver Harrogate Estates Plan	2026/27 Capital Programme - £30.4m Predicted spend forecast – 100%. - Block C build – On track. - Community Diagnostic Centre – Programme timescales to be confirmed, awaiting confirmation of funding from NHS England before being able to schedule updated case for Board of Directors. - Harrogate Estates Plan – A3 developed - Premises Assurance Model 26/27 submission – On track - Estates Safety Fund (Fire & Main Theatres design) – On track - RAAC Eradication – On track - Commissioned scoping exercise for the works across RAAC footprint in preparation for business case which will seek approval for funding to eradicate. Case anticipated for Board Q2 2026/27. No funding or timescale agreed. - Design and Quote from supplier to undertake upgrade received, business case under development. Case anticipated for Board Q2 2026/27. No funding or timescale agreed.		
Quality & Safety 	An environment and equipment that promotes best quality, safest care	To reduce high risk backlog maintenance risks and improve the Trust's premises infrastructure. 2023/24 PAM 37 Moderate Improvement SAQs 2024/25 PAM 28 Moderate Improvement SAQs	- Premises Assurance Model - Deliver 25/26 PAM action plan. - Assess Trust against 26/27 standards. - Deliver £1.8m Estates Safety Fund monies. - Deliver £4.2m RAAC Eradication programme for Estates department. - Develop business case for remaining Estates RAAC Eradication (circa £11m) - Develop business case for Fire Alarm upgrade (circa £9m)			
Environmental Impact 	Minimise our impact on the environment	HDFT to be carbon net zero by 2040. Achieve 1,700 tCO2e reduction in Scope 1 and 2 emissions by 2028.	- Refreshed Green Plan developed and approved. - Carbon accounting process implemented. - Estates & Facilities - Replacement of CHP with more modern, efficient system - Investigate geothermal energy. - Investigate onsite waste to energy system. - PSDS 4 Works - Medicines- Complete nitrous oxide removal and develop Entonox reduction plan.	- Complete - On Track - TBC depending on funding. PLOI agreed between HIF and Trust – will update next month. External funding received for trolleys to house localised canisters. Piped network will be capped off. Entonox project to be initiated.		

Enabling Ambition Metric	Vision	Goal	Countermeasures	Current State	Level of Risk to Achieving Goal	Level of Risk for progressing actions

Trustwide Project: Harrogate Estates Plan

Enabling Ambition Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk to Achieving Goal	Level of Risk for progressing actions
Wellbeing 	An Estates Plan for Harrogate District Hospital acute site to improve longer-term Capital Programme Planning to support the Clinical Strategy.	To agree principles of department locations, adjacencies, and priority workstreams for the Capital Programme and a more coherent site plan.	- Stakeholder events for involvement - Clinical, Workforce, Digital, Financial, ICS strategy alignment work. - Adjacencies mapping exercise - Links to High-Risk Backlog Maintenance & Green Plan goals	A3 has been developed and project approved.		

Strategic Programme:

Workstream	True North Metric	Vision	Goal	Countermeasures	Current State	Level of Risk to Achieving in Year Goal	Level of Risk for progressing actions
Nonrelevant at present							

Breakthrough Objective:

Workstream	True North Metric	Vision	Goal	Countermeasures	Current State	Level of Risk to Achieving in Year Goal	Level of Risk for progressing actions
Nonrelevant at present							

Related Corporate Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
ID 117	Violence and aggression against staff	Organisational risk to compliance with legislative requirements, with the risk of major injuries, fatality, or permanent disability to employees due to the failure to manage the risk of staff being subjected to acts of violence and aggression whilst carrying out normal duties, due to lack of suitable control measures and appropriate training.	4 x 3 = 12	4 x 2 = 8 March 2026 March 2027	Operational: Health & Safety	Minimal
ID 264	Containment Level 3 Laboratory	The unavailability of the onsite Containment Level 3 (CL3) laboratory at HDFT, deemed unfit for purpose in November 2022, has led to the outsourcing of Hazard Group 3 microbiology work to external providers. Initially outsourced to NHS Trusts within WYAAT and, since June 2024, to a private laboratory in London, this situation poses risks to quality, safety, and financial sustainability, including potential delays in clinical diagnosis, risk of inappropriate treatment, and significant ongoing cost pressures.	3 x 5 = 15	3 x 1 = 3 June 2026	Operational: Health & Safety	Minimal
ID 577	Physical security provisions, training, and support resources	Organisational risk to compliance with legislative requirements, and the risk of major injuries, fatality or permanent disability to employees, patients, visitors or others due lack of suitable policies and procedures, and the subsequent lack of suitable and sufficient control measures, including physical security provision, training, resources to support implementation.	4 x 4 = 16	4 X 2 = 8 April 2026 October 2026	Operational: Health & Safety	Minimal
Risk 597	Histopathology space and safety concern	The Histopathology laboratory is facing significant space constraints due to sustained service expansion over the past decade, resulting in overcrowded working conditions, insufficient storage capacity, and increasing safety risks to both staff and patient specimens. The need to retain specimens for 42 days has led to unsafe storage practices, including stacking at height, raising the likelihood of formalin spills, specimen loss or misidentification, and staff slips or trips. This issue has been highlighted by UKAS, requiring demonstrable action to maintain accreditation. Despite recognition at organisational level and submission of capital funding proposals, no immediate solution has been implemented, and space limitations continue to worsen due to equipment failures and contingency working. The inability to expand laboratory capacity restricts service growth, prevents participation in additional clinical work and trials, and risks failure to meet key cancer and RTT targets, with further pressure anticipated from planned service expansions.	3 x 5 = 15	3 x 1 = 3 December 2026	Clinical: Patient Safety	
ID 959	Risk to Theatre utilisation and scheduling due to aged condition of estates	Risk to Theatre utilisation and scheduling due to aged condition of estates. - Air handling system needs renewing. - General theatre area need refurbishment. - New doors that meet current standard - Theatre panels need renewing. - Inbuilt IT equipment - Cancellation of theatre lists - Short notice cancellation of patients Increased risk of infection. Impact on acute services	3 x 5 = 15	2 x 2 = 4 Sept-2026 Sept 2027	Operational: Business Continuity	

Related External Risks

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

**Board of Directors Meeting
29th July 2026**

Title:	Use of Trust Seal
Responsible Director:	Sarah Armstrong, Trust Chair
Author:	Rachel Hewson, Company Secretary

Purpose of the report	Approval		
	Assurance	X	To provide assurance on the use of the Trust's common seal
	Discussion		
	Information		
Summary of key issues:	To report the use of the Trust seal to the Trust Board		
Trust Strategy and Strategic Ambitions	The Patient and Child First Improving the health and wellbeing of our patients, children and communities		
	Best Quality, Safest Care		X
	Person Centred, Integrated Care; Strong Partnerships		X
	Great Start in Life		X
	At Our Best: Making HDFT the best place to work		X
	Financial Sustainability		X
	An environment that promotes wellbeing		X
	Digital transformation to integrate care and improve patient, child and staff experience		X
	Healthcare innovation to improve quality		X
Corporate Risks	All		
Prior Committee Review / Governance Route:	N/a		
Recommendations:	The Trust Board is requested to ratify the use of the Trust seal as detailed in the report.		
Impact Assessments	Financial	x	No financial implications
	Workforce	x	No workforce implications
	Quality & Safety	x	No quality & safety implications
	Legal/Regulatory	x	Supports compliance by providing assurance that the Trust Seal has been affixed and recorded in accordance with the Trust's approved governance arrangements.
	Equality & Diversity	x	No EDI implications
	Risk	x	No risk implications
Consultation / Engagement	N/a		

Freedom of Information	The paper can be made available under the Freedom of Information Act once published on the HDFT Website as part of the Board papers.
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**HARROGATE AND DISTRICT NHS FOUNDATION TRUST
USE OF TRUST SEAL
JULY 2026**

1.0 PURPOSE

The Trust Seal is used by the Board of Directors to execute legal documents (such as formal contracts and lease agreements) agreed on behalf of the Trust.

A register is to be kept recording the sealing of these documents and should be reviewed at least annually by the Board.

2.0 APPROVAL OF SIGNING AND SEALING OF DOCUMENTS

The Trust Board is requested to ratify the use of the Trust seal as follows:

SEAL	DESCRIPTION OF DOCUMENTS SEALED	DATE	DIRECTORS
No 215	Harrogate District Hospital Stage 1 Noviniti Scheme Document	28/01/26	Jonathan Coulter (Chief Executive) and Sarah Armstrong (Trust Chair)
No 216a	HDFT 0-19 Wakefield Team lease – Unit 14 and 15 Cedars Business Park, Wakefield	11/03/26	Jonathan Coulter (Chief Executive) and Sarah Armstrong (Trust Chair)
No 216b	HDFT0-19 South Tyneside lease – Block 22 Hi-Tech scheme, Boldon Business Park	28/01/26	Jonathan Coulter (Chief Executive) and Sarah Armstrong (Trust Chair)
No 217	Jack Laugher Wellness Centre Ripon – facilitation of Physio / MSK team	04/06/26	Jonathan Coulter (Chief Executive) and Jackie Andrews (Executive Medical Director)

3.0 RECOMMENDATION

The Trust Board is requested to authorise the use of the Trust's seal.

Rachel Hewson
Company Secretary
29 July 2026

BOARD OF DIRECTORS

29th July 2026

Title:	Review and update of Board of Directors Code of Conduct
Responsible Director:	Kate Southgate, Director of Governance and Improvement
Author:	Rachel Hewson, Company Secretary

Purpose of the report	Approval	x	Approve updated Code of Conduct
	Assurance		
	Discussion		
	Information		
Summary of key issues:	To seek Board approval for an updated Board of Directors Code of Conduct, incorporating charity trustee responsibilities and reflecting current governance best practice.		
Trust Strategy and Strategic Ambitions	The Patient and Child First Improving the health and wellbeing of our patients, children and communities		
	Best Quality, Safest Care	x	
	Person Centred, Integrated Care; Strong Partnerships	x	
	Great Start in Life	x	
	At Our Best: Making HDFT the best place to work	x	
	An environment that promotes wellbeing	x	
	Digital transformation to integrate care and improve patient, child and staff experience	x	
	Healthcare innovation to improve quality	x	
Corporate Risks	None identified.		
Prior Committee Review / Governance Route:	Charitable Funds Committee for assurance that responsibilities are accurately reflected. Approved at CFC on 21/7/26.		
	Board-level responsibility for ultimate approval.		
Recommendations:	The Board is asked to approve the updated Board of Directors Code of Conduct		
Impact Assessments	Financial		None identified
	Workforce		Minimal impact – applies to Board members only
	Quality & Safety		No direct impact
	Legal/Regulatory		Strengthens compliance with charity law

	Equality & Diversity		Positive impact – strengthens expectations on EDI.
	Risk		Positive – reduces risk of non-compliance (charity law)
Consultation / Engagement	Head of Charity		

Freedom of Information	Can be made available under the Freedom of Information Act 2000
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Harrogate and District NHS Foundation Trust Board of Directors – Code of Conduct

1. Introduction

High standards of corporate and personal conduct are an essential component of public service enabling public confidence and assurance. The purpose of this Code of Conduct ('the Code') is to provide clear guidance on the standards of conduct and behaviour expected of all directors.

As an NHS Foundation Trust, Harrogate and District NHS Foundation Trust (HDFT) complies with the principles of best practice applicable to corporate governance in the NHS/health sector and with any relevant code of practice. The HDFT Board of Directors is a unitary Board, meaning that Directors have equal and shared accountability. This code also applies to non-voting Associate and Clinical Directors who attend Board of Director meetings.

The purpose of this Code is to provide clear guidance on the standards of conduct and behaviour expected of all Directors. It seeks to outline the appropriate conduct for Directors of Harrogate and District NHS Foundation Trust ('the Trust'). It addresses both the requirements of office and of personal behaviour.

This Code, with the Board Code of Conduct and the NHS constitution, forms part of the framework designed to promote the highest possible standards of conduct and behaviour within the Trust. The Code is intended to operate in conjunction with the Trust's Constitution, Standing Orders and the Code of Governance for NHS Foundation Trusts. The Code applies at all times when Directors are carrying out the business of the Trust or representing the Trust.

2. Compliance, interpretation & concerns

All Directors are required to give an undertaking that they will comply with the provisions of this Code. Questions and concerns about the application of the Code should be raised with the Company Secretary. The Chair will be the final arbiter of interpretation of the Code.

3. Principles of public life

The principles underpinning this Code of Conduct are drawn from the 'Seven Principles of Public Life'¹, as follows:

- **Selflessness:** Holders of public office should act solely in terms of the public interest.
- **Integrity:** Holders of public office must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence them in their work. They should not act or take decisions in order to gain financial or other material benefits for themselves, their family, or their friends. They must declare and resolve any interests and relationships.
- **Objectivity:** Holders of public office must act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias.

- **Accountability:** Holders of public office are accountable to the public for their decisions and actions and must submit themselves to the scrutiny necessary to ensure this.
- **Openness:** Holders of public office should act and take decisions in an open and transparent manner. Information should not be withheld from the public unless there are clear and lawful reasons for so doing.
- **Honesty:** Holders of public office should be truthful.
- **Leadership:** Holders of public office should exhibit these principles in their own behaviour. They should actively promote and robustly support the principles and be willing to challenge poor behaviour wherever it occurs.

4. The Trust's vision & values

The Trust's purpose is "the patient and child first", meaning improving the health and wellbeing of our patients, children and communities. To do this the Trust's ambitions are to provide:

- Best quality, safest care;
- Person-centred, integrated care; strong partnerships;
- A great start in Life.

The Trust's values lie at the heart of who we are, what we do, and the culture we want to establish, having a direct impact upon both colleagues and the public we service.

Our KITE values are:

- **Kindness** - We show compassion and are understanding and appreciative of other people.
- **Integrity** - We display personal and professional integrity, are honest and bring a positive attitude.
- **Teamwork** - We are helpful to each other, listen intently and communicate clearly.
- **Equality** - We show respect, we are inclusive and we act fairly

5. General principles, directors' duties and liabilities

Foundation Trust Boards' of Directors have a duty to conduct business with probity, to respond to staff, patients and suppliers impartially, to achieve value for money from the public funds with which they are entrusted and to demonstrate high ethical standards of personal conduct. The general duty of the Board of Directors, and of each director individually, is to:

- Promote the success of the organisation so as to maximise the benefits for the members of the organisation as a whole and for the public.
- Work with the Trust's Council of Governors in an open and transparent way and observe and embed of a duty of candour throughout the organisation.
- Set an example in the conduct of its business and to promote the highest corporate standards of conduct.
- Ensure that the provisions of the Constitution, the Standing Orders, Standing Financial Instructions and accompanying scheme of delegation conform to best practice and

serve to enhance standards of conduct. The Board of Directors expects that this code will inform and govern the decisions and conduct of all Directors.

6. Additional responsibilities as Charity Trustees

The Board of Directors acts collectively as the Corporate Trustee of Harrogate Hospital & Community Charity (HHCC). When acting in this capacity, Directors are charity trustees and must comply with charity law alongside this Code.

Directors will:

- Act solely in the best interests of the charity and its beneficiaries.
- Ensure decisions and expenditure align with the charity's purposes and governing document.
- Safeguard and properly steward charitable funds, ensuring they are used appropriately, lawfully and in line with donor intent.
- Maintain clear distinction between Trust and charity decision-making, ensuring decisions are properly recorded in the correct capacity.
- Identify and manage conflicts of interest, particularly where Trust and charity interests may differ.
- Ensure accountability, transparency and proper reporting in relation to charitable funds and activities.
- Retain oversight where responsibilities are delegated, ensuring compliance with charity law and governance requirements.

These responsibilities apply whenever Directors are acting as charity trustees and complement (but do not replace) their duties as Trust directors.

7. Confidentiality and access to information

Directors must comply with the Trust's confidentiality policies and procedures. Directors must not disclose any confidential information, except in specified lawful circumstances, and advisably, only in consultation with the Company Secretary.

Information on decisions made by the Board of Directors and information supporting those decisions should be made easily available in a way that is understandable. Positive responses should be given to reasonable requests for information and in accordance with the Freedom of Information Act 2000 and other applicable legislation and Directors must not seek to prevent a person from gaining access to information to which they are legally entitled.

The Board of Directors has adopted policies and procedures to protect confidentiality of personal information and to ensure compliance with the Data Protection Act, the Freedom of Information Act and other relevant legislation which will be followed at all times by Board of Directors. Directors must also promote the responsible use of digital systems and data, including awareness of cyber security risks and data ethics.

Nothing said in this code precludes Directors from making a protected disclosure within the meaning of the Public Disclosure Act 1998.

Nothing said in this Code precludes Directors from making a protected disclosure within the meaning of the Public Disclosure Act 1998. The Company Secretary or the Freedom to Speak Up Guardian should be consulted for guidance.

8. Fit and proper person

It is a condition of the Trust's licence that each Director serving on the Board of Directors is a 'fit and proper person'. A person may not continue as a member of the Board of Directors if they are:

- (a) a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged,
- (b) a person who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it,
- (c) a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him/her,
- (d) subject to an unexpired disqualification order made under the Company Directors' Disqualification Act 1986.

Directors must certify on appointment, and each year, that they are/remain a fit and proper person. If circumstances change so that a Director can no longer be regarded as a fit and proper person, or if it comes to light that a Director is not a fit and proper person, they are suspended from being a Director with immediate effect pending confirmation and any appeal. Where it is confirmed that a Director is no longer a fit and proper person, their membership of the Board of Directors is terminated in accordance with the Constitution.

9. Register of interests

Directors are required to register all relevant interests in the Trust's register of interests in accordance with the provisions of the Constitution and the Trust's Conflicts of Interest Policy. It is the responsibility of each Director to provide an update to their register entry (within 7 days) if their interests change. Details can be updated via the Company Secretary. Failure to register a relevant interest in a timely manner may constitute a breach of this Code.

10. Conflicts of interest

Directors are required to comply with the Trust's Conflicts of Interest Policy. In particular, Directors must avoid a situation in which they have a direct or indirect interest that conflicts or may conflict with the interests of the Trust. Directors must not accept a benefit from a third party by reason of being a Director for doing (or not doing) anything in that capacity. Directors must not offer a benefit to a third party by reason of being a Director for doing (or not doing) anything in that capacity.

Directors are required to declare the nature and extent of any interest at the earliest opportunity. If such a declaration proves to be, or becomes, inaccurate or incomplete, a further declaration must be made. It is then for the Chair to advise whether it is necessary for the Director to refrain from participating in discussion of the item or withdraw from the meeting. Failure to comply is likely to constitute a breach of this Code.

11. Gifts & hospitality

The Board of Directors will set an example in the use of public funds and the need for good value in incurring public expenditure. The use of the Foundation Trust budget for hospitality and entertainment, including hospitality at conferences or seminars, will be carefully considered. All expenditure on these items should be capable of justification as reasonable in the light of the general practice in the public sector. The Board of Directors is conscious of the fact that expenditure on hospitality or entertainment is the responsibility of management and is open to be challenged by the internal and external auditors and that ill-considered actions can damage the reputation of the Foundation Trust in the eyes of the community.

The Board of Directors has adopted a policy on gifts and hospitality (The Conflicts of Interest Policy) which will be followed at all times by Directors. Directors must not accept gifts or hospitality other than in compliance with this policy.

12. Whistle-blowing / Speaking Up

The Board of Directors acknowledges that staff must have a proper and widely publicised procedure for voicing complaints or concerns about maladministration, malpractice, breaches of this code and other concerns of an ethical nature and positively establishes a culture for sharing concerns. The Board of Directors has adopted a Speaking Up (whistle-blowing) policy on raising matters of concern which will be followed at all times by Directors and all staff.

13. The Bribery Act 2010

The Board of Directors will ensure that it acts at all times in compliance with the Bribery Act 2010, acknowledging that it is a criminal offence to give, promise, or offer a bribe and to request, agree or receive a bribe.

14. Meetings

Directors have a responsibility to attend meetings of the Board of Directors and of any committees or working groups to which they are appointed. When this is not possible, apologies should be submitted to the Company Secretary in advance of the meeting. Persistent absence from Board of Directors' meetings without good reason is likely to constitute a breach of this Code.

15. Personal conduct

Directors are expected to adopt and promote the values of the Trust and the NHS. Moreover, Directors are expected to conduct themselves in a manner that reflects positively on the Trust and not to conduct themselves in a manner that could reasonably be regarded as bringing their office or the Trust into disrepute. Specifically, Directors must:

- Treat each other, Directors and Trust staff with respect; not breach the equality rights and not bully any person.
- Champion equality, diversity and inclusion, ensuring these principles are actively considered in decision-making as well as behaviour.
- Not seek to use their position improperly to confer an advantage or disadvantage on any person and must comply with the Trust's rules on the use of its resources.
- Uphold the seven principles of public life (see above).

- Be honest and act with integrity and probity at all times;
- Respect and treat with dignity and fairness, the public, service users, relatives, carers, NHS staff and partners in other agencies.
- Seek to ensure that fellow Directors are valued as colleagues and that judgements about colleagues are consistent, fair and unbiased and are properly founded;
- Accept responsibility for their actions.
- Show their commitment to working as a team member by working with colleagues in the NHS and wider community.
- Seek to ensure that the membership of the constituency they represent is properly informed and able to influence services.
- Seek to ensure that no one is discriminated against because of their religion, belief, race, colour, gender, marital status, disability, sexual orientation, age, social or economic status or national origin.
- Comply with the Standing Orders and Standing Financial Instructions of Harrogate and District NHS Foundation Trust.
- Respect the confidentiality of individual patients and comply with the confidentiality policies of the Trust.
- Not make, permit, or knowingly allow to be made, any untrue or misleading statement relating to their duties or the functions of the Trust.
- Seek to ensure that the best interests of the membership, general public, service users, stakeholders and staff are upheld in decision making and the decisions are not improperly influenced by gifts or inducements.
- Acknowledge that Harrogate and District NHS Foundation Trust is an apolitical organisation.
- Support and assist the Accountable Officer of the Trust in their responsibility to answer to the Independent Regulator, Commissioners and the public in terms of fully faithfully declaring and explaining the use of resources and the performance of the total NHS in putting national policy into practice and delivering targets.
- Must have regard to advice provided by the Chair, Chief Executive and Company Secretary pursuant to their duties.

It is essential that the conduct and behaviour of Directors at all times support the ethos and values of the Trust. Should there be any concern about the activities of a Director the nature of which might undermine public confidence then the Chair's decision on that person's role will be final.

16. Training & development

The Trust is committed to providing appropriate training and development opportunities for Directors to enable them to carry out their role effectively. Directors are expected to undertake to participate in training and development opportunities that have been identified as appropriate for them. To that end, Directors will participate in the appraisal process and any skills audit carried out by the Trust.

17. Visits to Harrogate and District NHS Foundation Trust Premises or other services provided by the Trust

Where Directors wish to visit the premises or services of Harrogate and District NHS Foundation Trust in a formal capacity, as opposed to individuals in a personal capacity, the Director should make arrangements in advance.

18. Review and revision of the Code

This Code has been agreed by the Board of Directors on *29 July 2026*. The Company Secretary will lead an annual review of the Code. It is for the Board of Directors to agree to any amendments or revisions to the Code.

19. Declaration

I hereby confirm that I will adopt and comply with this Code of Conduct for the Board of Directors.

I understand that I also act as a charity Trustee when the Board is acting as the corporate trustee of Harrogate Hospital & Community Charity.

Signed:

Name:

.....

.....

Date:

1. <https://www.gov.uk/government/publications/the-7-principles-of-public-life/the-7-principles-of-public-life-->