

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 Briefing note	Deputy Director Nursing, Midwifery and AHPs	Discuss	Attached
1.3	Register of Interests and Declarations of Conflicts of Interest	Chair	Note	Attached
1.4	Minutes of the meeting held on 27 th 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	Director of Finance ? or Director of Governance and Improvement	Note	To Follow
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.

CORPORATE RISK REGISTER

(July 2026)

We Value



Summary Corporate Risk Register

Ambition.	Workstream.		True North Metric.	Risk Appetite.	Level of Risk to Achieve Metric – Linked to Risk Appetite							
					1 – 3	4 – 6	8 – 9	10	12	15	16	>20
Best Quality, Safest Care	Ever Safer Care		Moderate & Above Harm	Clinical: Minimal	<							

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

Executive Risk Review Group

Summary - July 2026

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.

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 - CYPH Risk of clawback in underspent contract areas:** Following CYP PRM on Wednesday 8th July, this risk was discussed at Exec risk review group on Thursday 9th July and accepted onto the corporate risk register.

No further risks were escalated from the Directorate Risk Registers to the Corporate Risk Register.

No further risks were de-escalated from the Corporate Risk Register for management on the Directorate Risk Registers.

Risk Scores

Initial	The score given prior to any controls (mitigating actions) being put in place.
Current	The score as it stands following the implementation of controls / mitigating actions, but with gaps in controls (i.e. actions the Trust are currently unable to take) identified.
Target	The score at which the Trust feels able to tolerate the risk and remove it from the Corporate Risk Register (CSU or corporate function).

Gaps in Control

may self-harm or have mental health issues. This policy is in the approval process as of April 2024.

Ligature Assessments: Ligature risk assessments are under review due to ward and therapy area changes. Training provision for ligature risks is also being addressed after delays caused by staffing changes.

Conflict Resolution Training: A new Conflict Resolution training program is being developed with three levels tailored to staff risk levels. The content will align with the CQC-supported Restraint Reduction Network, with ongoing discussions to ensure appropriate training needs assessments (TNA) across the Trust. A business case is being prepared to expand training provision.

Community Security and Lone Working: Visits to all community teams and locations are underway to assess current security and lone working procedures.

Domestic Abuse and Sexual Violence: Meetings are being held to integrate issues of domestic abuse, sexual violence, and workplace sexual safety into the Violence Prevention and Reduction Strategy. A new policy and training package for line managers is in development, with plans for a team talk session by September/October.

Policy Reviews: New policy and procedure are under development for staff safety.

The Lockdown Policy and Bomb Alert Policies are under review to ensure they are up-to-date and effective.

New Risk Assessment Process: A Trust-wide risk assessment has been developed and is now being used to inform team and department-level assessments. This is part of an ongoing effort to implement a new risk assessment process across the Trust.

Strategic Ambition: An Environment that Promotes Wellbeing

Type: Operational / Health & Safety

Risk Description

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

Summary of Recent Activity

The risk was reviewed at a meeting of the Exec Risk Review Group on Thursday 9th July 2026.

The Current Score remained the same. No changes to note.

Escalated to CRR: July 2024
CQC Domain: Effective
Executive Committee:
Date reviewed: 30/06/2026
Previous month's rating: 15
Previous Target Date: April 2025
June 2026

Current Position

Cat 3 work is nearly completed, at the commissioning stage. Likely to go live 1st or 2nd week of July.

From last review: enabling work continues with an end date aimed at July 2026

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

These include:

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

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

Key Targets

1. Minimise delay to patient treatment
2. Zero staff harms resulting from exposure to unexpected hazard group 3 pathogens
3. Zero lost samples
4. Cessation of outsourcing & transport cost pressure

Current Controls

Selected work being sent off site with results entered manually when returned. This is having a huge financial impact - approx. £53K for 12 months (this would have cost approx. £27K to do in house).
Daily list of specimens packed provided.

Gaps in Control

Delay to results due to referral to Leeds and time taken to input results until issue resolved. No secure electronic transfer of results available.

- Escalation procedures for staff in response to incidents and the procedures to follow when dealing with patients is limited and not consistently applied.
- Lack of dedicated 24/7 security provision at HDH site limit's ability to support clinical staff – clinical resources redirected to find absconded patients or deal with V&A incidents.
- CCTV provision is limited, does not provide cover for entire HDH site, currently managed by HIF (potential IG issues).
- Site access control – existing swipe card access system is no longer supported and requires replacement. In addition, control of keys / combination lock codes is poor, control of keys has previously not been suitably managed both with Trust staff and contractors.
- It should also be noted that Martyn's Law, Terrorism (Protection of Premises) Bill, is expected to come into law this year, and this will generate significant work to ensure the Trust is compliant.
- Management of Security, as specified in the HIF contract, is unclear as to where responsibility for the above sits, in particular the provision of security presence at the HDH site.
- Recent high-risk incidents has further highlighted difficulties faced both in acute and community settings – lack of resource to support all areas, i.e. ONE security team member and ONE dedicated H&S team member to support the entire community footprint.
- County Lines gang warnings from NY Police also highlighted no formal communication between Safeguarding Team and Trust Security management, this was primarily due to lack of clear security structure.
- Trust Security Forum in place – now reports directly to the Trust H&S Committee – current review of membership and TOR
- Policies for Security and other related, being carried out by HIF and H&S Team
- Replacement of door access system has been costed; current plans are to replace area by area as part of wider Backlog Maintenance work
- HIF obtaining legal advice relating to provision of Security Guards at HDH site, licensing implications. This will be reflected in HIF business case for funding Security Guards at HDH site.
- Training is being reviewed and amended as part of the V&A Risk entry response.
- H&S team are currently carrying out building checklists within our community footprint which includes security – this will inform Building Security assessments.

CRR ID #597: Histopathology Space and Safety			Target Date: Dec 2026	Very Low Risk			Low Risk			Medium Risk				High Risk			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25	
Strategic Ambition:			C = 3	15			TARGET					INITIAL			CURRENT		
Type: Clinical / Patient Safety			L = 5														
Risk Description The Histopathology laboratory area has limited space due to expansion over the last 10 years. Expansion has been essential to ensure that the service provided to the trust is appropriate to the requirements aligned to cancer pathways. Additional analysers and essential equipment have been installed, which has now resulted in the area being extremely cramped. Due to increase in specimen numbers the storage capacity of the laboratory is now critical and imposing a safety concern to both staff and patient specimens. Ability to expand the service is also compromised.														Escalated to CRR: Nov 2025 CQC Domain: Executive Committee: Date reviewed: 30/06/2026 Previous month's rating: 15 Previous Target Date: December 2025			
Summary of Recent Activity The risk was reviewed at a meeting of the Exec Risk Review Group on Thursday 9 th July 2026. The Current Score remained the same. No changes to note.																	
Current Position May 2026: GEMBA visit and space was discussed as part of this. Will require capital investment June 2026: No changes from May.																	
Key Targets			Current Controls • Risk of specimen loss - controlled by specimen disposal performed by x2 staff members with quality control checks in place • Risk of spillage due to specimens being stacked and at height - Disposal carried out weekly in order to try and create space and reduce specimens being stacked at height. • Wax deliveries (20kg) each are having to be stored under benches in the lab - this poses a health and safety risk to staff having to move the bulk boxes from under benches. • Blocks are required to be stored for a minimum of 30 years. Blocks are kept on site for a minimum of 2 years due to additional tests that may be required. They are then transferred to an offsite secure facility to store for the remaining 30 years. The capacity for storage has been reached and there are limited options for further storage due to the requirement for a reinforced floor. • A significant amount of flammable reagent (alcohol, xylene and formalin) are used daily and more frequently due to additional strainers being required to keep up with the increased demand. Due to limited space majority of this is being stored in the outside flammable store. This results in staff having to make frequent trips to the store and poses a manual handling issue. • When receiving a breast mastectomy specimen national standards state that the specimen should be opened within 4 hours. this is not always possible due to a downdraft bench being unavailable. This may lead to degradation of the specimen								Gaps in Control • Specimens being stacked at height - we ensure that disposal is regular, but this is not always sufficient to ensure that specimens are not stacked at height. Risk assessment complete and staff trained in spill procedure, spill kits available if required. Datix completed if a spill occurs • Breast mastectomy specimens - in order to meet national standards, the team try to reorganise workload to enable a downdraft bench to be freed up. If this is not possible a different bench is used but this requires the movement of all reagents to an area where there is no downdraft ventilation. This poses a health and safety risk • Inability to expand the service to support additional workload i.e. - expansion of specific services, TIF2 project. Discussion underway with cancer alliance regarding funding opportunity and if this can be used for expansion either additional equipment or capital work. Paper submitted to environment board to highlight space issues						

CRR ID #642: Cardiology Acute Services

Strategic Ambition: Person-Centred / Integrated Care / Strong Partnerships

Type: Clinical / Patient Safety

Target Date:
Dec 2026

Very Low Risk

Low Risk

Medium Risk

High Risk

C = 3

L = 4

12

1

2

3

TARGET

4

5

6

8

9

10

12

CURRENT

INITIAL

15

16

20

25

Risk Description

Risk to HDFT being able to deliver acute DGH services due to the fragility of the cardiology service.

Escalated to CRR: Nov 2024

CQC Domain: Safe

Executive Committee: Quality

Date reviewed: 24/06/2026

Previous month's rating: 12

Previous Target Date: Dec 2025

Summary of Recent Activity

The risk was reviewed at a meeting of the Exec Risk Review Group on Thursday 9th July 2026.

The Current Score remained the same. No changes to note.

Current Position

- Inadequate staffing: 12.5 PAs down at consultant level currently filled with locum cover.
- Lack of continuity of Registrar/middle grade ward cover.
- Reliance on locum consultant and associated team and quality risks.
- Risk of burnout of current medical and ACP team due to workload pressures.
- Other consequences to these factors include outpatient RTT, angio and echo waiting time breeches.

Key Targets**Staffing and Workforce KRIs:**

Consultant Staffing Levels: Percentage of Consultant PAs filled with substantive staff versus locums. Number of unfilled Consultant posts after each recruitment round.

Quality and Outcomes KRIs:

Clinical Outcomes: Mortality rates for acute cardiology patients on CCU.

Readmission rates for cardiology patients within 30 days of discharge.

Current Controls

- Safety risk for acute patients on CCU
- Staffing - Substantive post for consultant back out to advert with R&R premia
- Current medical workforce do not have the skillset for temporary pacing wires and pericardiocentesis – excellent links with LGI
- Long waits for outpatient angios (30% waiting over 6 weeks) – using locum to reduce was 50% over 6 weeks – also review use of Cath lab
- ECHO service reliant on outsourcing workload (12 months ago 70% patients waiting over 6 weeks – now 22% waiting over 6 weeks – Sanus cor delivered activity and bank) – now recruited to a vacant post (starting Jan 25) and plans to grow our own.
- No weekend Consultant ward round or ECHO provision
- Increasing demand on pacemaker service due to increasing aging patient profile
- Not meeting GIRFT requirements with 7-day service and weekend cover/ on call - Cardiology strategy planning meeting scheduled for 7 November 24.
- Consultant of the week in place to cover in hours, Monday-Friday.

Gaps in Control

- Linking in with Clinical Lead at LHTT for specialty support – work in progress.
- Seeking a fellow for Cardiology for service continuity and ward cover. Locum reg in place.
- Consultant recruitment processes underway

Type: Clinical / Patient Safety

Risk Description

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

Summary of Recent Activity

The risk was reviewed at a meeting of the Exec Risk Review Group on Thursday 9th July 2026.

The Current Score remained the same. No changes to note.

Escalated to CRR: August 2025

CQC Domain: Responsive

Executive Committee:

Resources

Date reviewed: 09/03/2026

Previous month's rating: 16

Previous Target Date: March 2026

Current Position

09/03/26 Internal CT scanner (acute scanner) replaced with new scanner (was the TIF2 scanner in storage) is now operational. Last instance of unplanned downtime with CT scanners in mobile village was in February. Score downgraded - risk for this issue now back on departmental register. Lifespan of CT scanners now approx. 8 years. Still out of target for KPIs – to remain on exec register.

Current Wait Times			
CT – 863 pts	DEXA – 378 pts	MRI – 1067 pts	US – 1453 pts

Current Average Reporting Times			
CT - 33.7 days	DEXA - 26 weeks	MRI - 35 days	PLAIN FILM - 36 days

Key Targets

Current Controls

- MRI / CT clinical diaries have been reviewed and ringfenced capacity provided proportionately to each clinical group (cancer, urgent, planned oncology, routine).
- Patients are being booked in clinical and then chronological order (chronological from the date imaging received the referral).
- Clinicians are asking for expedited scan for patients of concern.
- Cancer clinicians using cancer pathway tag when requesting however this is not always successful in achieving a scan before clinic.

Gaps in Control

- Gaps in capacity. Business case prepared and agreed from resource committee. This will provide the staffing levels required to maintain demand in most specialities, but it will not support backlog reduction. The business case is currently being taken through board by CFO. Once agreed more radiographers will be recruited. Once individuals recruited and trained the CT and MRI services will operate for extended hours.
- Robotic process automation (RPA) worked through and due to be implemented end June/July. This will input RTT start dates into Imaging PAS system and allow patients to be booked in RTT order.
- Included as key driver metric for care group and directorate.
- Work ongoing to identify outsourcing providers to support backlog reduction.
- Work ongoing to identify capital resources to support sites for direct-access patient.

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

Purpose of the report and summary of key issues:	The report provides Quality Committee with: - Assurance on nursing and midwifery quality indicators triangulated with nurse and midwifery staffing data, - Assurance that daily monitoring of patient safety and quality risks in relation to the workforce are in place.	
Trust Strategy and Strategic Ambitions:	The Patient and Child First Improving the health and wellbeing of our patients, children and communities	
	Best Quality, Safest Care	x
	Person Centred, Integrated Care; Strong Partnerships	x
	Great Start in Life	x
	At Our Best: Making HDFT the best place to work	x
	An environment that promotes wellbeing	
	Digital transformation to integrate care and improve patient, child and staff experience	
	Healthcare innovation to improve quality	
Corporate Risks:	None	
Report History:	Report reviewed at the Quality Committee	
Recommendation:	The Board is asked to note the content of the report.	

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

HARROGATE AND DISTRICT NHS FOUNDATION TRUST

Quality Committee

Nursing and Midwifery Quality and Safe Staffing Report

1.0 Introduction

The purpose of the report is to provide assurance on key patient safety, quality and workforce data. Data in this report is provided for **April and May 2026**.

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

As per the Safer Staffing Policy, the threshold for enhanced monitoring of performance is where nursing establishment levels have fallen below the 80% threshold in month. Further information on all in-patient nurse staffing levels is present to NHS England on a monthly basis to provide assurance that the Trust is responding to National Quality Board (NQB) 2016 guidance in relation to: *Safe, Sustainable and Productive Staffing*.

2.0 Hard Truths Data

Harrogate and District NHS Foundation Trust reports monthly nursing and midwifery staffing data, including registered and unregistered staff, substantive staff and temporary workforce usage, to NHS England through the Nurse Staffing Return (Hard Truths).

HDFT has established an internal assurance threshold of **80%** achievement against planned registered and unregistered nursing staffing levels. Where staffing falls below this threshold, a comprehensive review is undertaken using a triangulated approach incorporating patient acuity and dependency, bed occupancy, quality indicators, patient outcomes and professional judgement to provide assurance that safe staffing has been maintained.

It was identified that Registered Nurse (RN) planned staffing fell below the Trust's 80% assurance threshold in Acute Medical Unit (AMU) and Woodlands during April and May 2026. For Unregistered workers, planned staffing fell below the 80% threshold in Acute Frailty Unit, Byland, Fountains, Granby, ITU, Jervaulx, Lascelles, Maternity, Rowan, Wensleydale and Woodlands. In each case, staffing levels were reviewed through the Trust's established safer staffing governance processes, taking into account patient acuity and dependency, bed occupancy, professional judgement and quality indicators. Where appropriate, staff were redeployed across inpatient areas to ensure the available workforce was aligned to clinical need, providing continued assurance that safe and effective care was maintained despite variation in planned versus actual staffing levels.

The table below summarises the planned versus actual staffing fill rates for all inpatient wards, showing day and night performance for registered and unregistered staff. The variation observed across wards reflects the dynamic deployment of staff in response to changing patient demand and demonstrates the effectiveness of the Trust's safer staffing arrangements in maintaining safe workforce levels across inpatient services.

May								April							
	Day		Night		CHPPD				Day		Night		CHPPD		
	RN	CSW	RN	CSW	RN	CSW	Overall		RN	CSW	RN	CSW	RN	CSW	Overall
Ward	Fill (%)	Fill (%)	Fill (%)	Fill (%)					Fill (%)	Fill (%)	Fill (%)	Fill (%)			
Acute Frailty Unit	91%	74%	104%	108%	4.6	3.3	7.9	Acute Frailty Unit	92%	86%	103%	127%	4.5	3.8	8.3
Acute Medical Unit	78%	89%	82%	98%	4.6	3.0	7.6	Acute Medical Unit	80%	81%	81%	93%	4.8	2.9	7.7
Bolton	99%	90%	109%	113%	4.3	3.3	7.7	Bolton	101%	89%	109%	110%	4.1	3.1	7.2
Byland	94%	77%	98%	101%	3.4	3.0	6.4	Byland	96%	81%	93%	100%	3.5	3.1	6.6
ITU/HDU	104%	59%	125%	61%	26.1	2.5	28.5	ITU/HDU	102%	42%	123%	35%	29.5	1.8	31.4
Fountains	90%	88%	97%	101%	3.7	3.0	6.8	Fountains	93%	90%	94%	105%	3.7	3.0	6.7
Granby	93%	83%	100%	96%	3.5	3.4	6.9	Granby	94%	76%	96%	80%	4.0	3.5	7.5
Jervaulx	90%	85%	99%	99%	3.4	3.2	6.5	Jervaulx	98%	78%	97%	97%	3.5	3.0	6.6
Lascelles	98%	61%	100%	100%	4.3	2.6	6.8	Lascelles	101%	63%	100%	100%	4.4	2.7	7.1
Maternity	88%	79%	90%	77%	6.4	1.7	8.1	Maternity	114%	89%	98%	92%	10.4	2.7	13.1
Nidderdale	90%	85%	95%	97%	4.4	3.1	7.5	Nidderdale	94%	82%	96%	110%	3.9	2.8	6.6
Oakdale	97%	92%	100%	99%	3.6	2.8	6.4	Oakdale	99%	89%	100%	131%	3.7	3.2	7.0
Trinity	96%	84%	100%	100%	3.5	2.9	6.3	Trinity	96%	82%	100%	100%	3.7	3.0	6.7
Rowan	99%	84%	100%	40%	8.6	2.5	11.1	Rowan	90%	53%	87%	28%	9.9	2.1	12.0
Special Care Baby Unit	85%	-	105%	-	19.0	-	19.0	Special Care Baby Unit	84%	-	105%	-	36.0	-	36.0
Wensleydale	93%	79%	99%	94%	5.7	2.7	8.4	Wensleydale	94%	76%	101%	95%	6.0	2.7	8.6
Woodlands	70%	56%	103%	98%	9.1	2.7	11.8	Woodlands	80%	65%	108%	76%	8.5	2.2	10.7
Total	91%	82%	99%	96%	4.9	2.9	7.8	Total	95%	78%	99%	96%	5.2	2.9	8.2

3.0 April and May 2026 Results

During April and May 2026, 17 eligible inpatient areas were reviewed. Planned versus actual staffing varied across wards for both registered and unregistered staff, with some areas operating below the 80% threshold and others above. This variation reflects the responsive deployment of the available workforce to meet changing patient demand and demonstrates the effectiveness of the Trust's safer staffing processes.

Care Hours Per Patient Day (CHPPD) measures the amount of direct nursing and midwifery care delivered to patients over a 24-hour period by registered nurses, midwives and care support workers.

HDFT continues to perform above the national recommended peer median CHPPD of 8.2, with a Trust CHPPD between 7.8 and 8.2 for this reporting period. This places the organisation within National Quartile 2, demonstrating staffing levels that are comparable with, and in many cases exceed, those of peer organisations. This provides further assurance that workforce deployment continues to support the delivery of safe, effective and high-quality patient care.

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

Maternity services had a **1.0 WTE midwifery vacancy** in April, which reduced to **0.0 WTE** in **May**, resulting in a fully established workforce. Midwifery sickness absence has continued to show a positive downward trend, decreasing from **5.33% in April** to **4.44% in May**. To support staffing requirements, shifts were released through **NHS Professionals (NHSP)**, with fill rates improving significantly over the last two months, increasing from **below 50%** to **62%**. This reflects a positive improvement in workforce availability and temporary staffing coverage.

Inpatient ward vacancies

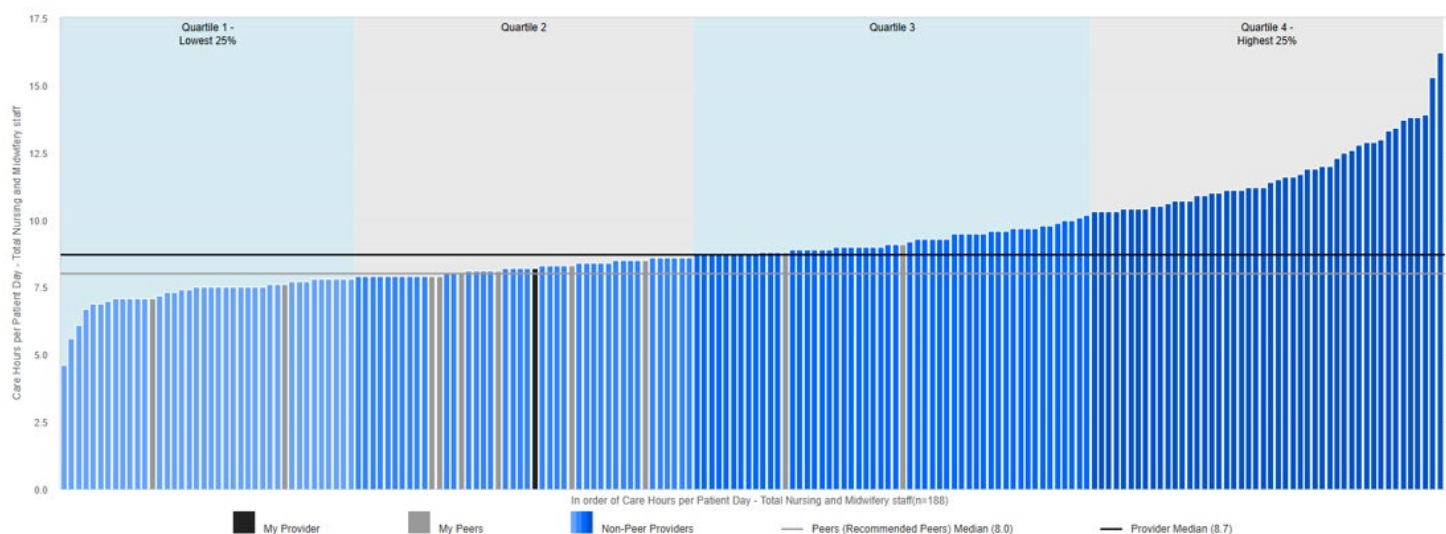
The table below summarises the substantive establishment position across the inpatient wards as at 30 June 2026, detailing the vacancy and over-establishment position for Registered and Unregistered staff.

Directorate Inpatient Wards - in-month substantive vacancies/(over-est)						
	Registered			Un-registered		
	Sum of WTE budget - Jun 26	Sum of WTE contracted - Jun 26	Sum of WTE variance - Jun 26	Sum of WTE budget - Jun 26	Sum of WTE contracted - Jun 26	Sum of WTE variance - Jun 26
LONG TERM URGENT CANCER AND COMMUNITY	205.35	202.18	3.17	152.52	135.39	17.13
CARE GROUP ACUTE MEDICINE	67.67	65.57	2.10	34.08	30.07	4.01
251101-Acute Medical Unit	32.00	30.56	1.44	17.04	15.71	1.33
251113-Wensleydale Ward	35.67	35.01	0.66	17.04	14.36	2.68
CARE GROUP FRAILITY	82.59	77.42	5.17	72.03	64.91	7.12
251100-Jervaulx Ward	24.43	22.07	2.36	22.56	18.11	4.45
251111-Acute Frailty Unit	19.31	17.28	2.03	14.99	13.40	1.59
251114-Byland Ward	24.43	23.93	0.50	22.56	22.11	0.45
255053-Ripon Trinity Ward	14.42	14.14	0.28	11.92	11.29	0.63
CARE GROUP LONG CONDITIONS	55.09	59.19	-4.10	46.41	40.41	6.00
251120-Oakdale Ward	24.43	25.72	-1.29	19.11	17.17	1.94
251121-Granby Ward	18.15	20.36	-2.21	17.44	14.35	3.09
251124-Lascelles	12.51	13.11	-0.60	9.86	8.89	0.97
PLANNED SURGICAL AND CHILDRENS	114.65	111.49	3.16	70.63	54.76	15.87
CHILDRENS	31.90	33.54	-1.64	8.35	6.22	2.13
251130-Woodlands Ward	18.61	18.70	-0.09	7.65	6.22	1.43
251131-S.C.B.U.	13.29	14.84	-1.55	0.70	0.00	0.70
MSK & IMAGING	36.34	32.98	3.36	27.98	19.32	8.66
251104-Fountains Ward	24.43	21.97	2.46	19.52	15.96	3.56
251110-Rowan Ward	11.91	11.01	0.90	8.46	3.36	5.10
SURGERY	46.41	44.97	1.44	34.30	29.22	5.08
251103-Farndale Escalation Ward	0.00	0.00	0.00	0.00	0.00	0.00
251105-Bolton Ward	21.98	21.26	0.72	17.26	14.37	2.89
251702-Nidderdale Ward	24.43	23.71	0.72	17.04	14.85	2.19
Grand Total	320.00	313.67	6.33	223.15	190.15	33.00

The table below demonstrates that HDFT CHPPD is in the second quartile (7.8 - 8.2), which places us inline with our peers (8.0) and lower than the national median (8.7). This data is taken from Model Health System on 31st May 2026.

Care Hours per Patient Day - Total Nursing and Midwifery staff, National Distribution

Download



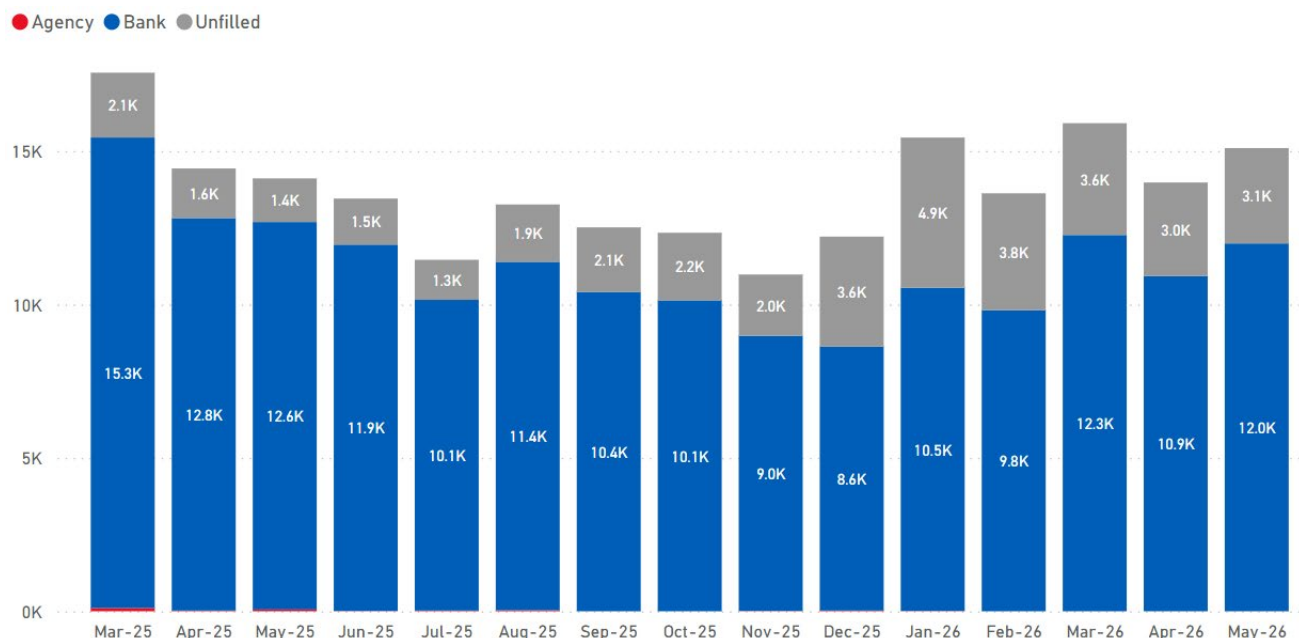
4.0 Temporary Workforce Usage

Temporary workforce utilisation continued to reduce during the reporting period, reflecting sustained improvements in workforce stability and recruitment. There was no agency usage across the 17 adult inpatient wards, with temporary staffing requirements being safely managed through NHS Professionals (NHSP) where required.

Within Adult Inpatient Services, strengthened governance arrangements for Enhanced Therapeutic Observation and Care (ETOC) and the implementation of the Temporary Workforce Standard Operating Procedure (SOP), have significantly reduced reliance on temporary staffing. Enhanced clinical oversight ensures that requests for temporary staffing are evidence-based and aligned to patient acuity, dependency and service need, with all internal staffing options explored before temporary workforce is utilised. Collectively, these measures are delivering a sustained reduction in NHSP demand, improved workforce stability and provided continued assurance that inpatient areas are staffed safely, effectively and in accordance with the Trust's safer staffing principles.

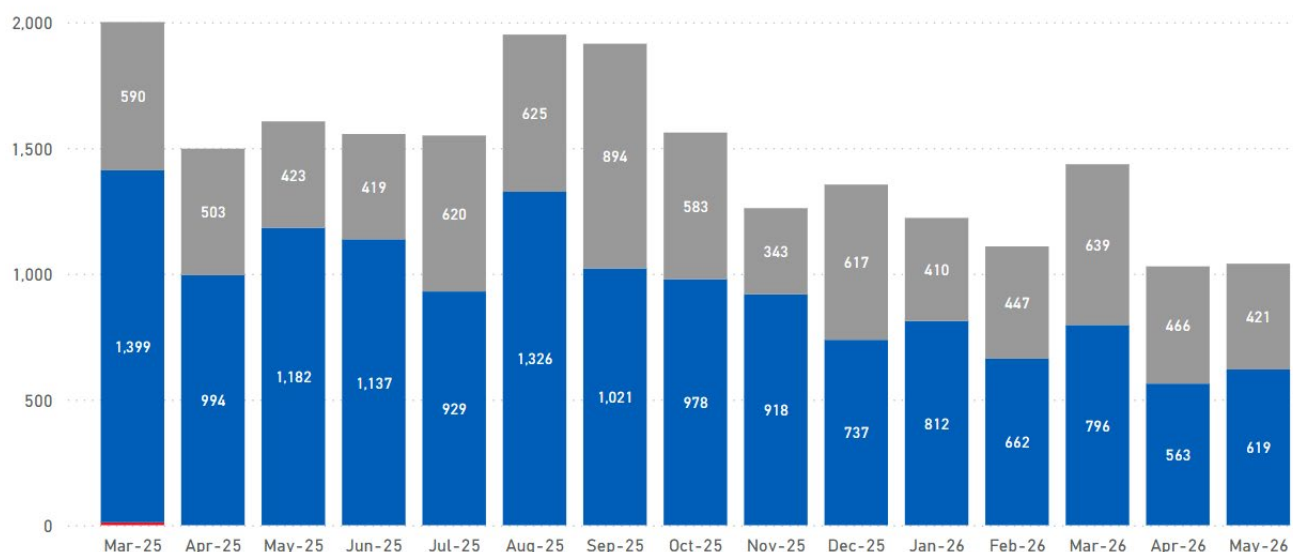
Overall, temporary workforce utilisation continues to reduce year-on-year, demonstrating the positive impact of strengthened workforce governance, successful recruitment, improved workforce planning and robust safer staffing processes. These measures provide assurance that patients continue to receive care from the right people, with the right skills, in the right place, at the right time.

Registered and Unregistered Nursing Temporary Workforce



Midwifery Temporary Workforce

● Agency ● Bank ● Unfilled



5.0 Key Performance Indicators

Between 1st April 2026 and 31st May 2026, **14** moderate and above events were reported (note: some of these events are still awaiting verification). All of these were patient events.

The events occurred across **8** event types: Appointments, Bookings Transfer & Discharge; Diagnosis, Tests & Imaging; Fundamentals of Care; Health & Safety; Medication (inc. IV gases); Obstetrics & Maternity; Pressure Ulcers & Skin Damage; Procedure & Surgery.

Falls:

In April there was one fall with severe harm. This was a trip in an outpatient's department. The trip hazard was removed and learning taken from the RIDDOR investigation report.

In May there were two falls with moderate harm reported.

When investigated at Quality Oversight panel one moderate harm fall had no omissions in care identified and the other is awaiting panel. Learning has been shared.

Pressure ulcers:

In April, one moderate harm pressure ulcer was identified. Investigation into this is ongoing and the report will be reviewed at Quality Oversight panel once finalised.

In May, there were no pressure ulcers with moderate harm across acute or community services.

6.0 Assurance Report

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

- no areas have fallen below the 80% threshold for three consecutive months for staffing.

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

The Trust has an updated Safe Staffing Policy and introduced SOPs for Safe Staffing and Temporary Workforce to strengthen governance, ensure consistent escalation processes, and provide robust oversight of staffing decisions. The Temporary Workforce SOP has been aligned to new principles of assurance, introducing a formal weekly review of all temporary workforce requirements across nursing, midwifery and AHP services. These review meetings are currently chaired by the Executive Director of Nursing, Midwifery and AHPs while the revised process is embedded, providing enhanced executive oversight, supporting safe staffing decision-making, and ensuring temporary workforce utilisation is appropriately scrutinised and aligned to patient need. A bespoke dashboard is also in development to further strengthen monitoring and assurance through the incorporation of key workforce and quality metrics.

Rapid reviews are undertaken at the request of the Executive Director of Nursing, Midwifery and AHPs, the Deputy Director of Nursing, Midwifery and AHPs, or Associate Directors of Nursing/Midwifery in response to concerns identified through a range of sources, including patient experience, Freedom to Speak Up concerns, Patient Safety Incident Investigations, and After Action Reviews. During the reporting period, no services required escalation for a rapid review.

7.0 Escalation and Reporting Nurse and Midwifery staffing concerns

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

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

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

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

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

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

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

If the ADoN for their directorate is not available, this should be escalated to another ADoN or ADoM. In the absence of an ADoN staffing concerns should be escalated to the Deputy Director of Nursing, Midwifery and AHP's. If staffing safety issues cannot be mitigated at this level, they must be escalated to the Director of Nursing, Midwifery and AHP's.

8.0 April - May 2026 SafeCare Red Shifts

There were no red shifts escalated to the Director of Nursing Midwifery and AHP's during the months of April and May 2026.

Recommendations

The Quality Committee is asked to:

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

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

10th July 2026

COMMUNITY NURSING SAFER STAFFING REPORT MARCH 2026

Date of CNSST data collection: 02/03/2026-16/03/2026

**Adult Community Nursing Teams,
Community Nursing Safer Staffing Tool
(CNSST) Bi-annual Safer Staffing Review.**

Holly Southcott- Matron

Purpose

This report provides assurance regarding Adult Community Nursing workforce establishments following completion of the March 2026 Community Nursing Safer Staffing Tool (CNSST) review. The report demonstrates compliance with NHS England Developing Workforce Safeguards and National Quality Board expectations through triangulation of evidence-based staffing recommendations, professional judgement, quality indicators, workforce metrics and operational intelligence.

Community Nursing Safer Staffing Tool (CNSST) Background

The Community Nursing Safer Staffing Tool (CNSST) is NHS England's evidence-based workforce planning methodology for community nursing services. It supports organisations to determine safe and sustainable workforce establishments by assessing patient demand, acuity and dependency alongside workforce capacity.

The CNSST is aligned to NHS England's Developing Workforce Safeguards and the National Quality Board (NQB) guidance Supporting NHS Providers to Deliver the Right Staff, with the Right Skills, in the Right Place at the Right Time. It supports providers in meeting the national expectation for six-monthly Board assurance and annual workforce establishment reviews.

The tool compares funded, actual and recommended staffing establishments and provides an objective assessment of workforce requirements. However, in line with national guidance, CNSST outputs are not used in isolation. Workforce recommendations are triangulated with professional judgement, patient quality indicators, workforce metrics, operational intelligence and local service configuration before any establishment changes are considered.

This six-monthly review forms part of Harrogate and District NHS Foundation Trust's safer staffing governance framework, providing assurance that community nursing workforce establishments remain safe, evidence-based and responsive to changes in patient need.

Consistent with Developing Workforce Safeguards and National Quality Board expectations, the CNSST findings were reviewed alongside:

- Patient outcomes – including falls, pressure ulcers, infections, complaints and clinical outcomes.
- Patient and staff experience – including Friends and Family Test, patient feedback and workforce experience.
- Workforce indicators – including vacancies, turnover, sickness absence, temporary staffing utilisation and retention.
- Operational intelligence – including caseload complexity, geography, travel time, deferred care and service demand.

- Professional judgement – provided by community nursing leaders to ensure local operational factors are fully considered.

This triangulated approach provides assurance that workforce decisions are informed by a broad range of quality, safety and operational evidence rather than relying solely on the numerical outputs of the CNSST.

Developing workforce safeguards

This document provides a comprehensive set of guidelines on workforce planning and includes recommendations on reporting and governance approaches. It also shares best practice on workforce decision-making, including stronger board engagement. NHS providers are assessed against their compliance with the recommendations in this guidance to support a consistent approach to workforce decision-making.

- [Developing workforce safeguards](#)
- [Developing workforce safeguards – appendices](#)

Principles of Safe Staffing



NHS Improvement (2018). Developing Workforce Safeguards. *Supporting providers to deliver high quality care through safe and effective staffing*. London. NHSI

National Quality Board guidance on safe staffing

This guidance sets out the [National Quality Board's](#) expectations for nursing and midwifery staffing to help NHS provider boards make local decisions that will deliver high-quality care for patients within the available staffing resource.

- [Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time: safe, sustainable and productive staffing](#) – July 2016

This guidance should also be referred to when using our setting-specific safe staffing improvement resources.

NQB's guidance states that providers:

- must deploy sufficient suitably qualified, competent, skilled and experienced staff to meet care and treatment needs safely and effectively.

- should have a systematic approach to determining the number of staff and range of skills required to meet the needs of people using the service and keep them safe at all times.
- must use an approach that reflects current legislation and guidance where it is available.

Meeting NQB's expectations helps providers comply with CQC's fundamental standards on staffing – for example, in the well-led framework and related legislation.

Safe, Effective, Caring, Responsive and Well- Led Care		
Measure and Improve -patient outcomes, people productivity and financial sustainability- -report investigate and act on incidents (including red flags)- -patient, carer and staff feedback-		
-implement Care Hours per Patient Day (CHPPD) - develop local quality dashboard for safe sustainable staffing		
Expectation 1	Expectation 2	Expectation 3
Right Staff 1.1 evidence based workforce planning 1.2 professional judgement 1.3 compare staffing with peers	Right Skills 2.1 mandatory training, development and education 2.2 working as a multi-professional team 2.3 recruitment and retention	Right Place and Time 3.1 productive working and eliminating waste 3.2 efficient deployment and flexibility 3.3 efficient employment and minimising agency

HDFT Community Care Teams (CCT) CNSST Methodology

The March 2026 CNSST review was undertaken across all Community Nursing teams using the licensed NHS England methodology. Data collection was supported by trained clinical staff and subjected to validation processes to ensure reliability. The CNSST outputs were triangulated through professional judgement, workforce metrics, quality indicators and operational intelligence before review by senior nursing leadership.

CNSST Community Care Teams Data

Adult Community Services District Nursing teams cover four localities: Harrogate North, Harrogate South, Knaresborough and Ripon working across a large geographical area. The majority of patients are housebound and are seen either in their own homes or in residential care settings. Harrogate North also provides clinic appointments for patients who are not housebound. A catheter and PICC clinic runs three times a week at Knaresborough Road Health Centre, supporting patients from all four teams. Current patient caseloads load figures: Harrogate North: 293, Harrogate South: 301, Ripon: 273 and Knaresborough: 291.

This dataset, taken over a two week period in March 2026, compares each team's funded establishment, current workforce in post and CNSST recommended levels.

Knaresborough CCT:

Team Name:	Knaresborough CCT		
Date:	01/03/2026		
Team Leader:	Gail Beaumont		
Role	<i>Funded Staffing WTE</i>	<i>Inpost staffing WTE</i>	<i>CNSST WTE</i>
Registered	14.8	15	19.2
Unregistered	10	10.2	6.2
Total	24.8	25.2	25.4

Harrogate North CCT:

Team Name:	Harrogate North		
Date:	01/03/2026		
Team Leader:	Gillian Robinson		
Role	<i>Funded Staffing WTE</i>	<i>Inpost staffing WTE</i>	<i>CNSST WTE</i>
Registered	14.44	11.3	15.65
Unregistered	7	5.8	4.79
Total	21.44	17.1	20.44

Ripon CCT:

Team Name:	Ripon CCT		
Date:	01/03/2026		
Team Leader:	Emma Harvey		
Role	<i>Funded Staffing WTE</i>	<i>Inpost staffing WTE</i>	<i>CNSST WTE</i>
Registered	11.86	11.55	14.66
Unregistered	7.96	7.48	4.56
Total	19.82	19.03	19.22

Harrogate South CCT:

Team Name:	South CCT		
Date:	01/03/2026		
Team Leader:	Cath Wesbroom		
Role	<i>Funded Staffing WTE</i>	<i>Inpost staffing WTE</i>	<i>CNSST WTE</i>
Registered	14.16	12.79	14.13
Unregistered	6.8	4.8	4.54
Total	20.96	17.59	18.67

Summary

The March 2026 Community Nursing Safer Staffing Tool (CNSST) review demonstrates that the current District Nursing workforce continues to support the delivery of safe and effective care. While the CNSST identifies opportunities to optimise the workforce through an increase of 8.38 WTE Registered Nurses and a corresponding reduction of 11.67 WTE unregistered

staff (a net reduction of 3.29 WTE), these recommendations have been considered alongside professional judgement, quality indicators and local operational factors.

The CNSST recommends a workforce skill mix of 75% Registered Nurses. The current District Nursing skill mix is 65.19%, indicating that future workforce planning should continue to strengthen registered nursing capacity. However, the review group concluded that the recommended reduction in unregistered staff is not appropriate at this time, as it would increase operational risk within a service supporting a high proportion of patients requiring routine interventions across a large, predominantly rural geographical area, where travel time and productivity have a significant impact on workforce demand.

This position is supported by CNSST benchmarking data, which demonstrates that Category 1 (routine, non-complex) patients account for 39.3% of the Trust's community caseload compared with the national benchmark of 19.3%, reinforcing the continued requirement for a balanced registered and unregistered workforce.

Despite workforce pressures during the review period, including the deferral of some patient visits, triangulation with quality and workforce indicators provides assurance that patient care has remained safe and effective. Clinical quality measures remained positive, with consistently strong audit (captured via Tendable) performance, low levels of reported harm, positive clinical outcomes and no formal complaints attributable to staffing levels.

Recommendations

Following a workforce review held on 22nd of May 2026 with the Executive Director of Nursing, Midwifery and AHPs, Matron, Locality Managers and District Nursing teams, it was agreed that no establishment changes would be made at this time due to the wider Community Services Review taking place this year. The triangulated review demonstrates that the current funded nursing establishments across all community nursing 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.

It was agreed that Knaresborough and Ripon teams would be supported to skill mix unregistered workforce hours into Registered Nurse hours when vacancies arise, as required. An Equality Impact Assessment (EQIA) will be submitted to support this proposal.

To strengthen the reliability and validity of future CNSST data, all waiting lists will be incorporated into the District Nursing daily caseload. This will ensure that any deferred care is accurately captured across all teams.

While the service review is ongoing, work is underway to improve service delivery. This includes the development of self-care initiatives, deferred care, care undone reporting and improvements to roster governance. In addition, the Matron is sourcing a pool car for

Knaresborough CCT to support the challenges associated with high mileage and a large geographical patch.

Prior to the next planned CNSST further work is required to review headroom allocation, review and standardise maternity leave allowance percentage and the introduction of daily fill rate reporting is to be coordinated by the Matron.

Finance Report Month 3

May – 2026/27

Author

Director of Finance – Jordan Mckie

Deputy Director of Finance – Karen Scarth

26/27 Finance summary as at June

26/27 ACTUAL YTD

£-12.5M

PLAN £-5.2M DEFICIT

CASH POSITION

£2.4M

MINIMUM BALANCE £2M

CAPITAL SPEND YTD

£4.5M

PLAN £4.5M

RISKS 12+

25 - Cash Position

16 - Delivery of
Financial Plan

16 - Recurrent WRAP
Delivery

26/27 FORECAST

£-19.3M

LIKELY CASE

PAY GROWTH

-0.01%

-27.02WTE

*49.98 WTE S.TYNESIDE NEW
CONTRACT

*-48.70 WTE DENTAL
DECOMMISSIONED

WASTE REDUCTION AND PRODUCTIVITY ACTIONED (WRAP)

11%

22% BUDGETED PLAN M3 YTD

BANK AND AGENCY USE

Agency on target
Bank forecast £4M
off track

YTD Summary

£-12.5M

ACTUAL

£-5.2M

PLAN

£-7.4M

VARIANCE

Type	Prior Mth £000's	Current Mth £000's	Narrative	Future Mitigation
Income		£372k £100k	- Drug income phasing - Grant income deferred	- Alignment of Drug I&E. July 26 - N/A
Pay	£84K £72k £95k	 £73k	- Thornbury Agency costs relating to a specific patient - Imaging reporting - Elderly Medicine Agency Consultants - Dental Annual Leave (Decommissioned contract)	- Thornbury ended June - Job Planning to be concluded in Imaging PSC OD - Turnaround actions to offset costs incurred
N Pay	£1.5m	£1.4m £336k £25k	- WRAP delivery - Pathology LLP - Dental non pay items (Decommissioned contract)	- Prioritise focus on run rate reductions. ALL - Review of all Pathology charges July 26 - Turnaround actions to offset costs incurred
Total	£1.8m	£2.3m		

Key Items in Month

- ICB top up for pay award factored into the position, still awaiting final settlement.
- Dental contract decommissioned end of May, costs incurred in June relate to annual leave settlements and other decommissioning costs.
- Cash support requirement continues July application to be submitted. NHSE have recognised the shortfall in cash and have granted £8.4m in working capital in July.
- Capital spend on track, CDC business case submitted, £12.5m.
- Agency spend within NHSE targets however bank spend is forecasting £4m overspend against target. (10% and 30% reduction expected).
- Plan still not agreed nationally and run rate not reducing at the required pace needed.

YTD Summary & Forecast

£-8.5M

ACTUAL

£-15.3M

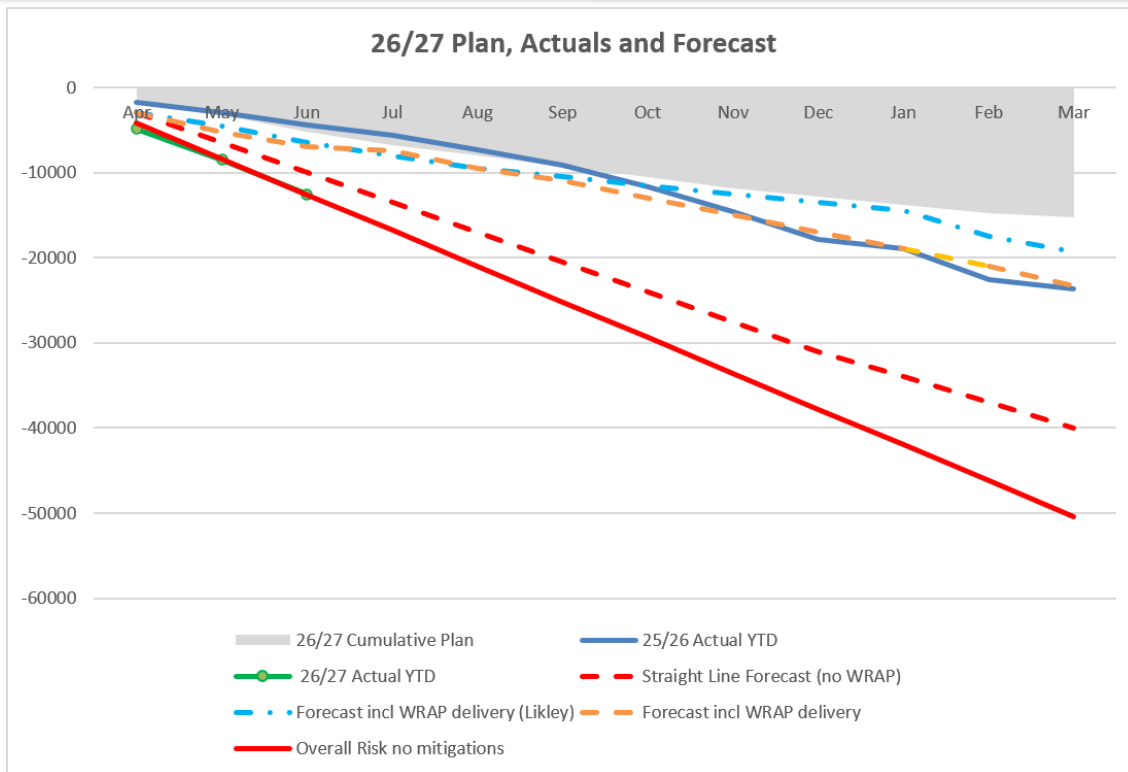
BEST

£-19.3M

LIKELY

£-40M

WORSE (RUN RATE)



Areas of concern for 26/27

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

Mitigations agreed

- **Recruitment pause 3 months**
- **LLP and WLI paused**
- **Affordable establishment reviews undertaken**
- **ADON to sign off all rostering changes or additional staffing requests**
- **Community reviews**
- **Turnaround governance introduced**

PFR reported forecast £15.3M

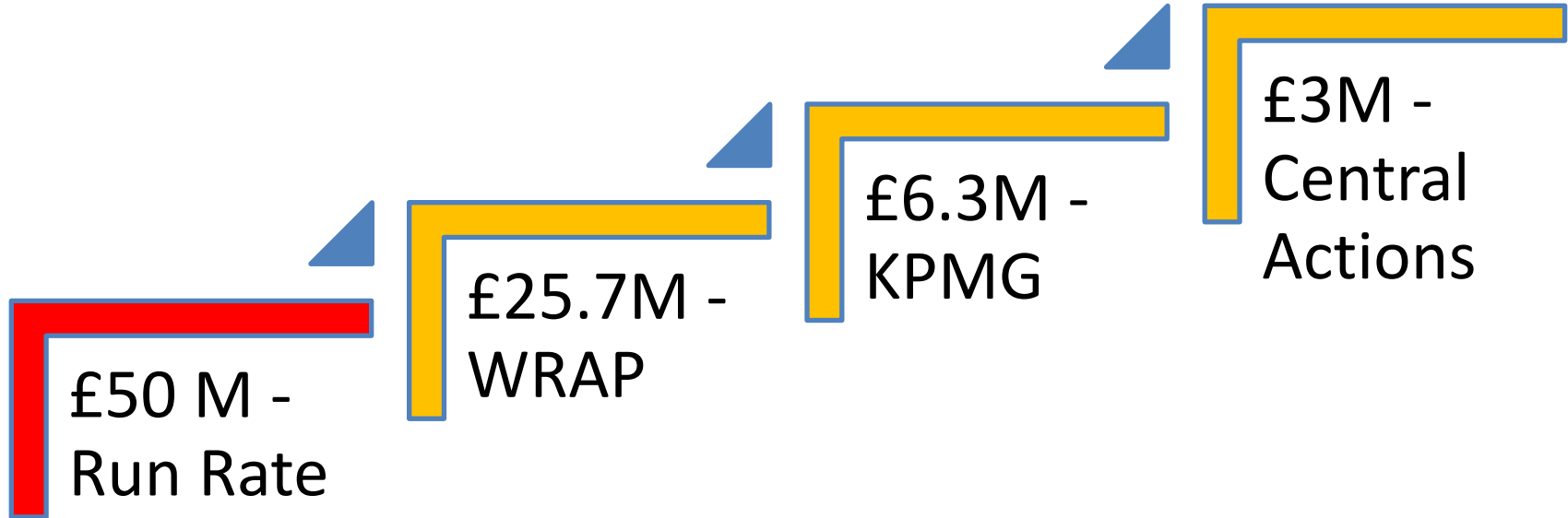
YTD Summary & Forecast

REVISED DEFICIT £12.3M PLAN



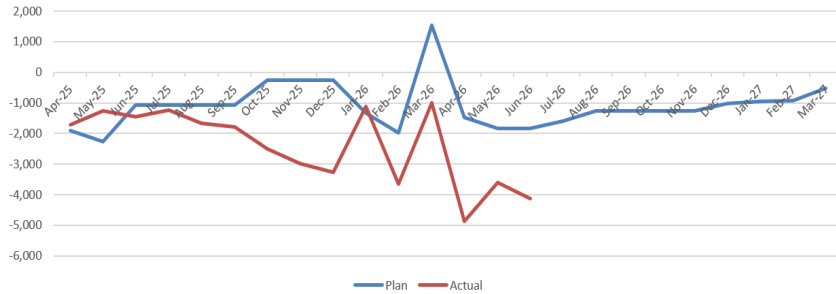
NHSE ask to go further £3M

DEFICIT £15.3M SUBMITTED PLAN



Year on Year

Year on Year Plan and Spend



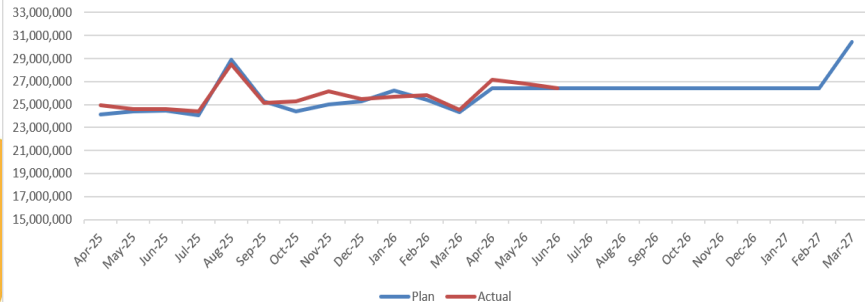
25/26 Plan went through a forecast protocol change, Qtr 4 plan amended.

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

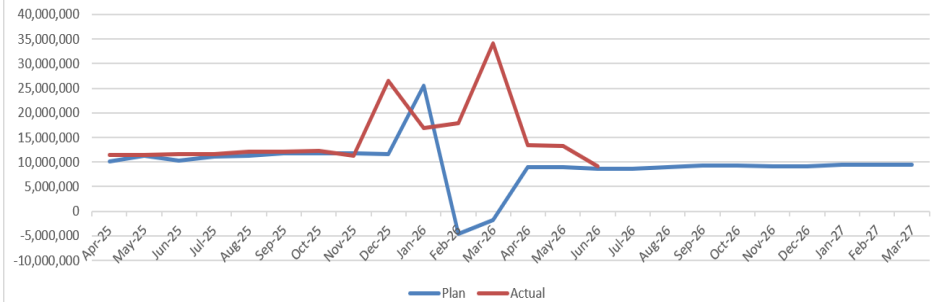
Non Pay budget plans include WRAP targets.

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

Year on Year Pay



Year on Year Non Pay Expenditure



Waste Reduction and Productivity (WRAP)

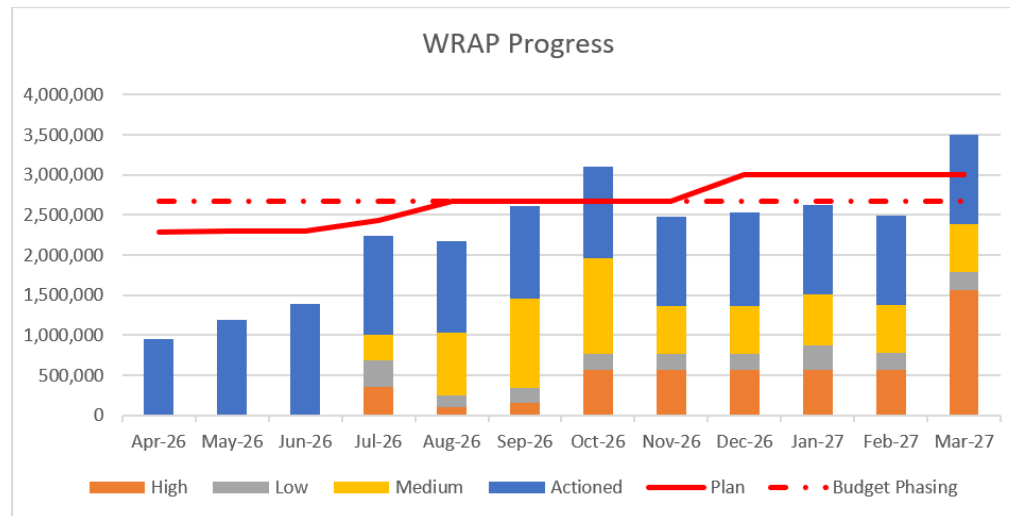
WRAP delivery £4.5m behind budgeted plan at Month 3, driven by delayed implementation and £4.7m gap in plans.

£32M TARGET

YTD
 £3.5M ACTUAL
 £8M PLAN

ACTIONED
 RECURRENTLY

84%



£13m of identified schemes remain unactioned, including £5m high-risk opportunities, alongside a £4.7m planning gap.

As highlighted in the external financial risk review, the primary challenge is to convert opportunities identified into fully developed, operationally owned and deliverable plans.

Recovery Plans – 26/27

	Scheme	Total
1	Variable Pay	£4.5m
2	Vacancy Freeze/Affordable Establishment	£2.7m
3	Wards LOS / other capacity	£1.7
4	Real Living Wage	£0.5m
5	Divisional actions (non pay)	£0.4m
6	Winter Costs	£0.3m
7	Elective premium	£2m
8 to 14	Non Pay (Procurement/Clinical demand mgt/Discretionary/Drugs/Estates/EPR)	£3.5m
15	VAT	£2.8m
16- 17	R&D/Commercial/Private Patients	£0.3m
18	Charity – staff sponsorship	£0.1m
19	Capital Charges	£1m
	Total	£19.4m

The external assessment identifies the schemes identified in the table.

In addition to the schemes further technical adjustments under review include

- Revenue to capital £2.4m
- Balance sheet £1.3m

Balance Sheet

	2024/25	2025/26	2026/27
	Ending balance	Ending balance	Ending balance
Non-current assets			
Intangible assets	12,856	18,942	18,301
On-SoFP IFRIC 12 assets	0	0	0
Interests in off-SoFP PFI/LIFT assets	0	0	0
Other property, plant and equipment (excludes leases)	163,703	194,429	198,459
Right of use assets - leased assets for lessee (excludes PFI/LIFT)	7,473	6,267	5,965
Investment property	0	0	0
Investments in joint ventures and associates	0	160	0
Other investments / financial assets	0	0	1,640
Receivables: due from NHS and DHSC group bodies	424	361	360
Receivables: due from non-NHS/DHSC group bodies	510	664	304
Credit Loss Allowances	-97	-98	-88
Other assets	0	0	0
Total non-current assets	184,869	220,725	224,941
Current assets			
Inventories	4,528	3,766	2,814
Receivables: due from NHS and DHSC group bodies	6,096	12,155	10,804
Receivables: due from non-NHS/DHSC group bodies	26,578	25,832	20,335
Credit Loss Allowances	-601	-380	-385
Other investments / financial assets	0	0	0
Other assets	0	0	0
Non-current assets held for sale and assets in disposal groups	0	0	0
Cash and cash equivalents: GBS/NLF	7,014	6,098	1,382
Cash and cash equivalents: commercial / in hand / other	1,164	262	1,039
Total current assets	44,779	47,733	35,989
Current liabilities			
Trade and other payables: capital	-8,098	-840	-1,665
Trade and other payables: non-capital	-28,811	-50,131	-44,413
Borrowings	-3,266	-2,476	-2,605
Other financial liabilities	0	0	0
Provisions	-96	-96	-96
Other liabilities: deferred income including contract liabilities	-1,934	-209	-1,175
Other liabilities: other	0	0	0
Total current liabilities	-42,205	-53,752	-49,954
Total assets less current liabilities	187,443	214,706	210,976
Non-current liabilities			
Trade and other payables: capital	0	0	0
Trade and other payables: non-capital	0	0	0
Borrowings	-11,847	-10,638	-9,768
Other financial liabilities	0	0	0
Provisions	-552	-459	-461
Other liabilities: deferred income including contract liabilities	0	0	0
Other liabilities: other	0	0	0
Total non-current liabilities	-12,399	-11,097	-10,229
Total net assets employed	175,044	203,608	200,747

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

Cash

£2.4M

(JUNE 2026)

£2.4M

(MAY 2026)

MINIMUM CASH BALANCE
£2M

BPPC

Paid within 30 days

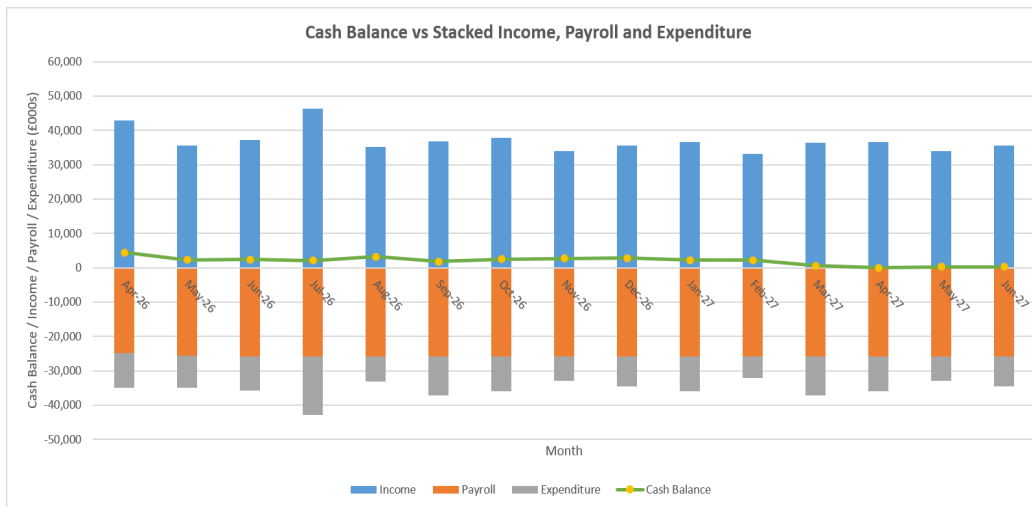
18.8%

No of Invoices

23.7%

Value of Invoices

TARGET 95%



Cash support total £14.6m received 25/26.

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

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

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

Key Areas of priority focus

1. Aged Debt
2. WRAP delivery
3. Recovery Actions

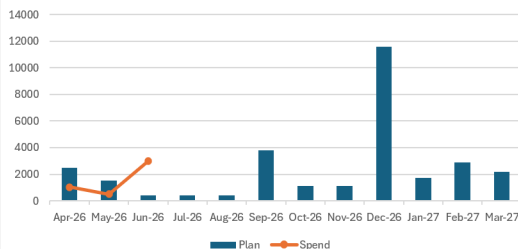
Cash Support	Requested	Approved
April	£9.5m	£4m
May	£4m	£2m
June	£1.8m	£1.8m
July	£3.2m	£10m**
August	£1.4m	
**pending formal approval		

Capital

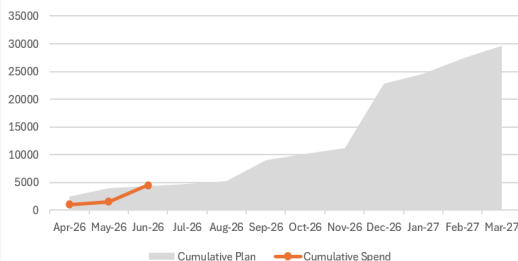
£4.5M

SPEND YTD
INCL IFRS16

Capital Spend



Cumulative Capital Spend



CDEL Assumption	Description	Scheme ID	Plan	Actual	Forecast
CDEL Schemes					
	IT	IT	210	242	391
	RAAC/TIF2	RA/T2	2,200	2,489	4,922
	EPR	EPR	2,500	745	2,500
	Carry Forward Schemes from 25.26	PRIOR YEAR		109	101
	Staff Survey	SURVEY	250	4	190
	MRI Scanners		2,000	0	2,000
	HIF Management Fee		500	0	500
	Unknown - tbc	UNKNOWN		1	
	IFRS16			0	0
	Balance		-2,113		
Total Plans against CDEL			5,547	3,590	10,603
PDC Schemes (Non CDEL)					
Confirmed	Estates RAAC	RAAC - OTHER	4,167	908	4,167
Confirmed	Constitutional Standards - Imaging CT Scanner	CSCT	660	0	660
Confirmed	Constitutional Standards - Ultrasound	CSUL	250	0	250
TBC	Constitutional Standards - CDC	CDC	12,250	0	12,250
Confirmed	RTT Target Delivered 25/26	RTT26	2,000	0	0
TBC	Estate Safety - Fair Share	ESTFSAFE	1,800	3	1,800
Total Non CDEL Schemes			21,127	911	19,127
Grants					
	Research 3T MRI Scanner	3TMRI	1,225	0	1,225
	Salix Phase 4	SALIX4	1,950	7	1,950
Total Grants			3,175	7	3,175
Total Capital Programme			29,849	4,508	32,905

- 26/27 capital position limited due to CDEL allocation and payback to Hull/NLAG (£3.5m 26/27 and £2m 27/28).
- 3 main schemes 26/27 EPR and completion of RAAC Block C and all other eradication.
- A CDC case, £12.5m has been submitted.

Agency

£84K

IN MTH

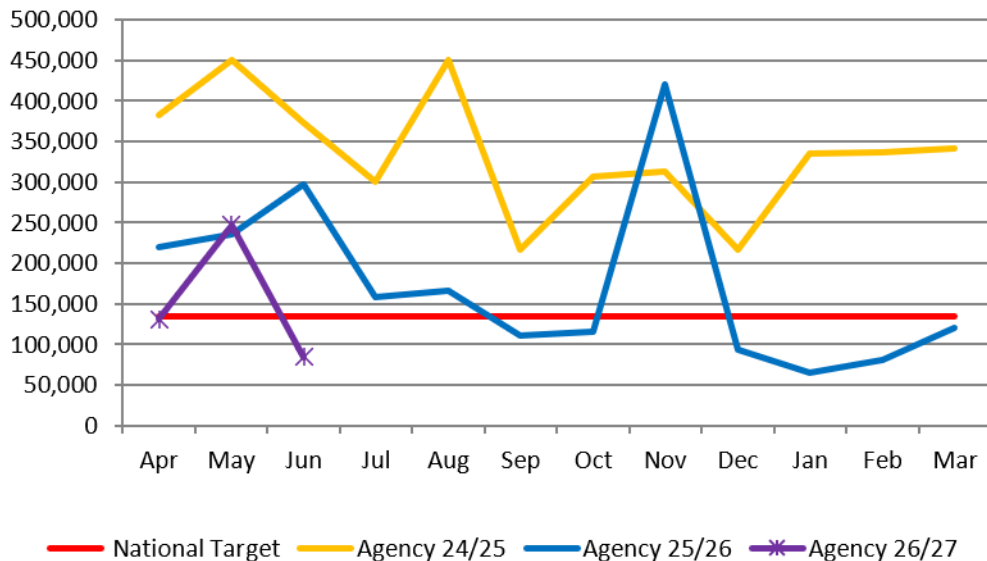
£1.6M

FORECAST

£1.6M

NHSE TARGET

Agency Expenditure By Month



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

Thornbury spend £84k in May providing 1:1 care for a specific patient. No external funding to support these costs.

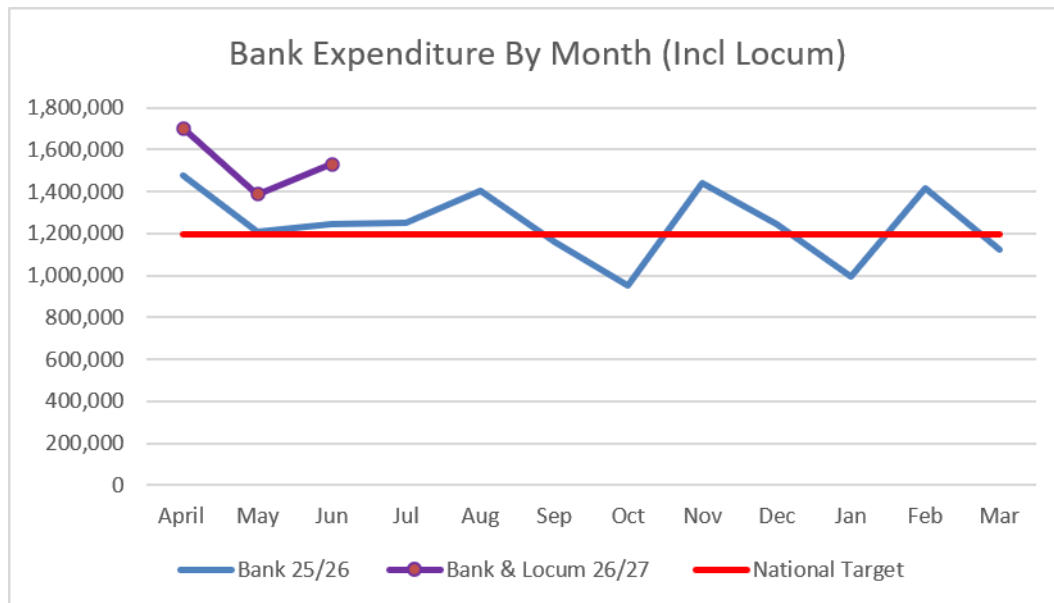
Consultant spend is the biggest driver of agency spend due to sickness and vacancies.

Bank & Locum

BANK
£707k
IN MTH
£9.3M
FORECAST

LOCUMS
£828k
IN MTH
£10M
FORECAST

£14.3M
NHSE TARGET



Although there has been good progress on reducing bank spend based on M1 and M2 we would not meet the NHSE target.

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

The majority of bank spend is around nursing.

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

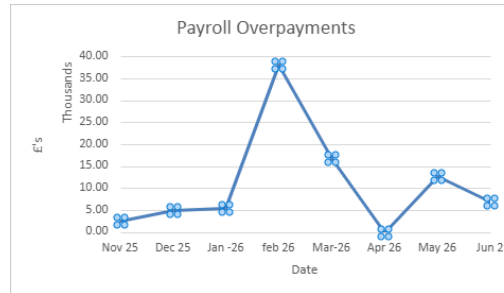
21% of Locum spend is linked to GP OOH service.

Watch Metrics

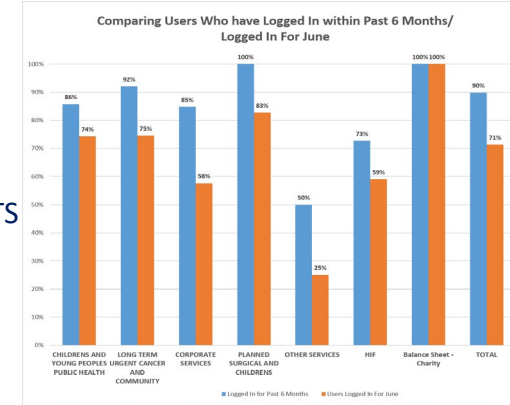
RETROSPECTIVE PO's

Trustwide include HIF				
Directorate	No of Retrospective PO's		Total No of PO's Raised	
	Last Month	Current Month	Last Month	Current Month
Directorate Total	108	48	1083	1009

PAYROLL OVERPAYMENTS



REACH ACCESS ACCESS BUDGET REPORTS



COST CENTRES NOT IN BALANCE

- 305 OUT OF 758 £11.4M O/SPENT
- 103 CC OVER £20K O/SPENT
- 327 OUT OF 758 U/SPENT £7.8M

OVERTIME



WTE CONTRACTED MOVEMENT

- *49.98 WTE S.TYNESIDE NEW CONTRACT
- *-48.70 WTE DENTAL DECOMMISSIONED

