

Board of Directors Meeting Held in (Public)

To be held on Wednesday, 30th September 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 – World Patient Safety Day 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 29th July 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 1.7.2	Chief Executive's Report - Corporate Risk Register - Integrated Board Report - Powerbi	Chief Executive	Note Note	Attached Supp. Pack – Attached Attached
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	Thirwall Report	Executive Director of Nursing, Midwifery and AHPs	Discuss	Attached
2.3	Learning from Deaths Q1 Report	Executive Medical Director	Note	Supp Pack Attached
2.4	Safeguarding Annual Report	Executive Director of Nursing, Midwifery and AHPs	Note	Supp Pack Attached

Item No.	Item	Lead	Action	Paper
2.5	IPC Annual Report	Executive Director of Nursing, Midwifery and AHPs	Note	Supp Pack Attached
2.6	Nursing and Midwifery Quality and Safe Staffing Report	Executive Director of Nursing, Midwifery and AHPs	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 - presented by Dr Kat Johnson, Consultant Obstetrician and Gynaecologist and Leanne Likaj ADoM&CS	Executive Director of Nursing, Midwifery and AHPs / Executive Medical Director	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 / 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 Attached
4.3	Winter Plan	Chief Operating Officer	Approve	Attached
SECTION 5: Ambition: At Our Best: Making HDFT the Best Place to Work				
5.1	Board Assurance Framework: At Our Best: Making HDFT the Best Place to Work	Chief People Officer/ People & Culture Committee Chair	Approve	Attached
5.2	Annual Workforce Race Equality Standards Report (WRES)	Chief People Officer	Note	Attached
5.3	Annual Workforce Disability Equality Standards Report (WDES)	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

Item No.	Item	Lead	Action	Paper
6.2	Board Assurance Framework: Healthcare Research and Innovation to Improve Quality and Safety 2026-2027	Executive Medical Director & Innovation Committee Chair	Approve	Attached
6.3	Board Assurance Framework: An Environment that Promotes Wellbeing	Director of Finance / Resources Committee Chair	Approve	Attached
SECTION 7: BAF Summary and Escalation from Committees				
7.1	Escalation from Sub-Committees of the Board	All Executive and Non-Executive Directors	Discuss	Verbal
7.2	Audit Committee Chair's Quarterly Report	Director of Finance/Chair of Audit Committee	Note	Attached
SECTION 8: Governance Arrangements				
8.0	Any Other Business <i>By permission of the Chair</i>	Chair	Discuss/ Note/ Approve	Verbal
9.0	Board Evaluation	Chair	Discuss	Verbal
10.0	Date and Time of next Board Meeting to be held in public: Wednesday 25 th November 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.

Patient Story for Board: World Patient Safety Day 2026

For World Patient Safety Day this year, we have produced a short video highlighting the improvements made to our asthma pathway.

The theme for 2026 focuses on *safe care for non-communicable disease*, with attention on four key areas:

- cardiovascular disease;
- cancer;
- respiratory disease and
- diabetes.

We have chosen to focus on respiratory disease, showcasing the collaborative work across Respiratory, the Emergency Department, Pharmacy and wider teams, to demonstrate how strengthened processes are supporting safer, more consistent care for patients living with long-term respiratory conditions.

Board of Directors – Register of Interests

As at 8th September 2026

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

Board Member	Position	Relevant Dates From	To	Declaration Details
	March 2025 to March 2026)			
Breeda Columb	Executive Director of Nursing, Midwifery & AHPs	June 2025	Current	1. Familial relationship with a Leeds Teaching Hospitals NHS Trust employee
Jonathan Coulter	Finance Director Chief Executive from March 2022	March 2022	Current	No interests declared
Jeremy Cross	Non-executive Director	January 2020	Current	1. Chairman, Tipton Building Society 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
Chris Mannion	Chief People Officer	September 2026	Current	No interests declared
Jordan McKie	Director of Finance (from July 2023)	August 2022	Current	1. Chair, Internal Audit Provider Audit Yorkshire
Colin Melville	Non-Executive Director	September 2025	Current	1. Trustee, Faculty of Medical Leadership and Management 2. Fellow, Royal College of Physicians, London 3. Fellow, Royal College of Anaesthetists 4. Fellow, faculty of Intensive Care Medicine 5. Honorary Fellow, Academy of Medical Educators 6. Senior Fellow, Faculty of Medical Leadership and Management 7. Honorary Professor, University of Manchester

Board Member	Position	Relevant Dates From	To	Declaration Details
				8. Visiting Professor, Anglia Ruskin University 9. Nephew is an employee of HDFT (non-decision maker)
Julia Nixon	Chief Operating Officer	July 2026	Current	No interests declared
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
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
Jimmy Parvin	Deputy Director of Strategy and Improvement	No interests declared (TBC)
Rob Eames	Deputy 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)

Name	Position	Declaration Details
Karen Scarth	Deputy Director of Finance	No interests declared
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 September 2026

Board Member	Position	Relevant Dates From	To	Declaration Details
Matt Graham	Director of Strategy	September 2021 April 2022 November 2025	December 2025 April 2026 May 2026	1. Member: Local Governing Body, Malton School (part of Pathfinder Multi-Academy Trust) 2. Stakeholder Non-executive Director, Harrogate Healthcare Facilities Management Limited t/a Harrogate Integrated Facilities (a wholly owned subsidiary company of Harrogate and District NHS Foundation Trust) 3. Trustee of Harrogate & District Community Action
Russell Nightingale	Chief Operating Officer & Deputy Chief Executive	April 2021	April 2026	1. Director of ILS and IPS Pathology Joint Venture
Laura Robson	Non-executive Director	September 2017	August 2026	1. No interests declared
Julia Weldon	Non-Executive Director	November 2022	September 2025	2. Director of Public Health / Deputy Chief Executive, Hull City Council 3. Co-chair of the Population Health Committee, Humber & North Yorkshire Integrated Care Board
Angela Wilkinson	Director of People & Culture	October 2019	May 2026	4. Director of ILS and IPS Pathology Joint Venture
Rob Armstrong	Acting Chief Operating Officer	April 2026	June 2026	1. No Interests Declared

BOARD OF DIRECTORS MEETING – PUBLIC (DRAFT)

Wednesday 29th July 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, Chair of Quality Committee
Laura Robson (LR)	Non-Executive Director
Julia Weldon (JW)	Non-Executive Director, Chair of People & Culture Committee
Wallace Sampson OBE (WS)	Non-Executive Director, Chair of Innovation Committee
Denise Chong (DC)	Associate Non-Executive Director
Breeda Columb	Executive Director of Nursing, Midwifery and Allied Health Professionals
Jordan McKie	Director of Finance
Kate Southgate	Executive Director of Governance and Improvement
Rob Eames	Acting Chief People Officer

In Attendance:	
Rachel Hewson	Company Secretary
Paula Chyzy	Corporate Governance Officer
Matt Shepherd	Deputy Director, Business Intelligence, Planning, Performance and Productivity
Chris Mannion	Chief People 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>
Ann Johnson	Adviser to the Board

Apologies:	
Julia Nixon	Chief Operating Officer
Andy Papworth	Non-Executive Director, Vice Chair

Observers:	
Governors	Mike Fisher, Jackie Lincoln, Kevin Parry
Member of the public / press	1
Colleagues	Giles Latham, Communications Manager
External Partners	Sue Stanton, CQC. Kim Betts, Audit Yorkshire

Item No.	Item
BD/07/29/1.1 1.1.1	Welcome and Apologies for Absence The Chair welcomed everyone to the meeting, in particular Ann Johnson, recently appointed Advisor to the Board, Chris Mannion, newly appointed Chief People Officer and Matt Shepherd, Deputy Director, Business Intelligence, Planning, Performance and Productivity who was representing Julia Nixon and gave a note of thanks to the observers for attending the public meeting of the Trust Board.

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1.1.2	Apologies for absence were noted as above.
BD/07/29/1.2 1.2.1	Patient Story The Chair introduced the patient story which was a patient with Multiple Sclerosis (MS) and epilepsy who had experienced a seizure whilst attending an Ophthalmology appointment. Following this experience the Ophthalmology team had looked at how they could better communicate with and support the patient.
1.2.2	The Deputy Director of Nursing, Midwifery and AHPs noted the importance of the feedback provided. She highlighted that the patient's description of feeling overwhelmed and anxious formed a key part of the debrief discussion. She also commented on the Ophthalmology service as an example of a truly multidisciplinary team approach.
1.2.3	The Executive Medical Director commented that the patient story prompted reflection on other areas where further work may be needed to ensure staff are aware of the support and processes available to them.
1.2.4	The Non-Executive Director (LR) asked how the learning and feedback would be shared more widely. The Deputy Director of Nursing, Midwifery and AHPs confirmed that arrangements for wider dissemination would be taken forward.
1.2.5	The Executive Director of Nursing, Midwifery and AHPs suggested that the learning should also be taken through the Making Experiences Count Forum to support broader organisational learning and awareness.
1.2.6	Resolved: The patient story was noted.
BD/07/29/1.3 1.3.1	Declarations of Conflicts of Interest and Register of Interests There were no new Declarations of Interest.
1.3.2	Resolved: The register of interests was received and noted.
BD/07/29/1.4 1.4.1	Minutes of the Previous Board of Directors meeting held on 27th May 2026 The following amendment was noted.
1.4.2	Minute to be amended to reflect the title of 'Acting Chief People Officer'.
1.4.3	Resolved: The minutes of the meeting on the 27 th May 2026 were approved as an accurate record of the meeting noting the amendment above.
BD/07/29/1.5 1.5.1	Matters Arising and Action Log The Board reviewed the action log.
1.5.2	Item 4.1.5 and 4.1.6 were discussed as one and it was agreed that the Deputy Director, Business Intelligence, Planning, Performance and Productivity would provide an update outside the meeting.
1.5.3	3.2.11 The action relating to Maternity Voices Partnership (MVP) can be closed as partial funding has now been identified. 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/07/29/1.6 1.6.1	Overview by the Chair The Chair noted it had been a busy period both internally and externally. This included recent changes in national leadership, with a new Secretary of State

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	appointed in recent months and a new Prime Minister and Secretary of State now in post.
1.6.2	It was noted that Directorates were fully engaged in the financial turnaround positioning, the appointed advisor to the Board was already involved in the focused work and a Turnaround Director had been appointed and soon to commence in role. An ideas portal was now open and ideas were being received.
1.6.3	The Chair highlighted a number of recent events that had provided valuable opportunities for engagement and learning, including the NHS England Regional Roadshow and the WYAAT network meeting for Chairs and Chief Executives, which had taken place the previous day.
1.6.4	The Chair thanked everyone involved in their appraisal, in particular Non-Executive Directors CM and LR and Lead Public Governor JL.
1.6.5	Finally, the Chair gave thanks to Non-Executive Director LR who was attending their last Public Board session after almost 9 years and decades of service to the NHS. It was noted that Non-Executive Director LR had been an integral part of the Board for a long time and had made important contributions to the organisation and the wider NHS.
1.6.6	<i>The Non-Executive Director (CdB) left the meeting.</i>
1.6.7	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	Chief Executive Report The Chief Executive presented his report as read. The following points were highlighted: • There had been little mention of the NHS within Andy Burnham's campaign, with significantly greater emphasis placed on social care reform. • It was noted that recent guidance from NHSE had included a quality strategy, guidance on communicating with patients regarding waiting lists, actions to ensure control of access to health records and the Lord Mann report. • Further to the Ockenden review and the Baroness Amos report an immediate 10 point plan had been developed which will be picked up with the Associate Director of Midwifery and Children's Services. The Clinical Director, PSCC would attend future Board meetings to strengthen oversight of maternity developments. • A number of actions had been taken as a result of the national escalation meeting relating to our plan, including commissioning Simon Worthington. • The ICB have supported the case for a Community Diagnostic Centre. • All are aware of the financial risks and some actions have already been taken including phasing out the real living wage, reducing bank rates, pausing recruitment and asking all areas to look at their establishments. The Non-Executive Director (LR) sought assurance regarding progress made through the pathology joint venture and whether current arrangements continued to meet the needs of the organisation.

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1.7.10	The Chief Executive advised that services were in a significantly stronger position than previously and highlighted the progress made through collaborative working across partner organisations.
1.7.11	The Chief Executive referenced the IBR which was included in the supplementary papers pack and noted that the watch metrics summary was included in the report, adding that this was the first time the IBR had come to board in this format and it was intended that this would be presented in future immediately after the Chief Executive's Report.
1.7.12	Resolved: The Chief Executive's Report was noted.
BD/07/29/2.1 2.1.1 2.1.2 2.1.3 2.1.4 2.1.5 2.1.6 2.1.7 2.1.8	Board Assurance Framework – Best Quality, Safest Care The Executive Director of Nursing, Midwifery and AHPs provided the Board with an update on the Strategic Ambition: Best Quality, Safest Care. The first metric was eliminating moderate and above harm with the goal of a 20% reduction in number of events reported. This is now in year 3, having achieved in year 1 and 2. There had been no more than 71 incidents for the year, about 6 per month although these had not yet been validated as waiting Rapid Review of Safety Event (RROSE) reviews. There had been 1 Patient Safety Incident Investigation (PSII) declared this year and no never events. The Executive Medical Director provided an update on work relating to clinical effectiveness and adherence to best practice guidance. Good progress had been made, and the Trust remained on track to complete all planned reviews by the end of August. The next phase of work would involve supporting teams currently assessed at bronze level to progress towards silver level. An update was provided on the Trust's True North patient experience goal of increasing the Friends and Family Test (FFT) recommendation rate by 10% over a 12-month period, improvements had been achieved in April, May and June. It was noted that the Trust had experienced an increase in complaints, reflecting a trend seen nationally across the NHS. In relation to complaints handling, the Trust's target is to respond to written complaints within 30 days. Current performance stands at 82%, although this has varied over the past six to eight months. The Executive Medical Director provided an update on the Clinical Services Review which was progressing and would shortly transition into business-as-usual arrangements. In relation to the Single Point of Contact (SPOC) programme, this remained the most challenging area of work due to the range of different pathways currently in place. The Neighbourhood Health programme was reported to be well advanced, with the Trust considered to be ahead of the curve and actively working with local partners to develop the approach. The Executive Medical Director suggested that a future Board development workshop would provide a suitable opportunity to explore this area in greater detail. It was reported that work was underway in relation to the Breakthrough Objective (BO) checklist completion process.

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2.1.9	The Non-Executive Director (CM) noted that a positive discussion had taken place at the Quality Committee where it was agreed that it was preferable to set ambitious stretch targets and potentially fall short, rather than establish targets that were easily achievable.
2.1.10	The Executive Director of Nursing, Midwifery and AHPs confirmed that there were currently no corporate risks or external risks associated with the programme.
2.1.11	The Non-Executive Director (AA) reported that a detailed discussion had also taken place at the Quality Committee, particularly in relation to the clinical effectiveness programme.
2.1.12	Resolved: The Board Assurance Framework: Best Quality, Safest Care was noted and approved.
BD/07/29/2.2 2.2.1	Learning from Deaths Q4 Report The Executive Medical Director took the paper as read and provided a brief overview of the report.
2.2.2	It was noted that Mortality indicators remained within expected limits and no significant quality concerns were identified. The previous issues were identified as data issues in the coding team, which have now been resolved.
2.2.3	Resolved: The Report was noted.
BD/05/27/2.3 2.3.1	Health & Safety Annual Report The Director of Finance presented the report, which was taken as read.
2.3.2	Referring to page 84 of the Board pack, positive movement was highlighted against a number of key risks, including the eradication of Reinforced Autoclaved Aerated Concrete (RAAC) and progress relating to the Goods Yard development. Further work remained necessary in relation to risks associated with violence and aggression, stress, and ongoing challenges linked to the Trust estate. Paul Yeadon was thanked for his contribution and support in this area.
2.3.3	The Non-Executive Director (CM) noted that this was the first time the report had been aligned to the financial year allowing it to be viewed as a true annual report.
2.3.4	The Non-Executive Director (JW) commented that the inclusion of clearly defined priorities was particularly helpful and represented a valuable addition, providing greater clarity on areas of focus and progress.
2.3.5	Resolved: The report was noted.
BD/07/29/2.4 2.4.1	Nursing and Midwifery Quality and Safe Staffing Report and Community Nursing Quality and Safe Staffing Report Resolved: Following review at the Quality Committee, the Nursing and Midwifery Quality and Safe Staffing Report and Community Nursing Quality and Safe Staffing report were noted.
BD/07/29/2.5 2.5.1	Bi-Annual Safer Staffing Establishment Reviews The Executive Director of Nursing, Midwifery and AHPs presented the paper and took it as read highlighting that the paper provides evidence of how the establishment reviews are undertaken and documents the relevant areas for review on pages 3 and 4.

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2.5.2	It was noted that the recent Safer Nursing Care Tool (SNCT) Audit agreed the current staffing establishment was safe.
2.5.3	Resolved: The reviews were noted.
BD/05/27/3.1 3.1.1 3.1.2 3.1.3 3.1.4 3.1.5 3.1.6 3.1.7 3.1.8 3.1.9 3.1.10 3.1.11 3.1.12	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. There had been a slight dip in performance during June on the mandated contacts for Children and Young People with 49 out of 55 checks completed. Performance issues were primarily associated with Westmorland and Cumberland. Patient experience target is to achieve 10% response rate for the FFT outpatient surveys. June saw a 9.3% response rate. The Non-Executive Director (AA) commented on the importance of obtaining feedback from children and young people, whilst acknowledging the challenges involved in securing engagement from this group. The Executive Director of Nursing, Midwifery and AHPs advised that work was progressing on the Children and Young People Strategy. The strategy sets out the future direction of services, including how the organisation will meet growing demand, respond to changing needs, and ensure services are appropriately designed for the future. The Non-Executive Director (JCr) asked about the proposed timescales for completion and it was confirmed that the strategy was expected to be completed by the end of Quarter 2 and would subsequently be presented to the Board. The Non-Executive Director (JW) noted that several discussions had taken place at the Quality Committee regarding the proposed content of the strategy. She welcomed the progress being made and expressed willingness to review draft versions as the work developed. The Chief Executive confirmed that the relevant strategic programmes would be aligned with future Board development workshops. The Non-Executive Director (WS) noted the importance of ensuring that work on the Neighbourhood Health Model is viewed in the wider context of the Trust's strategic programmes. The Non-Executive Director (LR) queried whether the issue of clawback should be reflected as an additional risk and sought clarification on whether this represented an in-year risk for the organisation. The Chief Executive explained that where there is an underspend in one area, the focus is on the effective in-year management of resources and ensuring that funding is utilised appropriately across services. The Director of Finance added that the key consideration is ensuring that funding allocated for a specific population is spent for the benefit of that population, with robust financial oversight in place to ensure resources are used as intended. <i>The Non-Executive Director CdB rejoined the meeting.</i>

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3.1.13	The Non-Executive Director (JW) highlighted the importance of considering the strategy for Public Health (PH) services within the context of the Trust's broader strategic intentions, ensuring alignment with the organisation's long-term priorities. The Executive Director of Nursing, Midwifery and AHPs reported on the Breakthrough Objective (BO) relating to Children and Young People (CYP) research. The objective for the current year is to increase research participation by 10%. She advised that the Trust had signed up to two research programmes, with a further three programmes currently under discussion. She also noted that the associated corporate risk relates to autism assessment services.
3.1.14	The Chief Executive commented that the current focus remains on delivering the service the organisation is commissioned to provide. While consideration continues to be given to how services may develop in the future, discussions regarding the longer-term position, particularly in relation to autism assessment services, are ongoing and have not yet been resolved.
3.1.15	Resolved: The Board Assurance Framework: Great Start in Life was noted and approved.
BD/07/29/3.2 3.2.1	Strengthening Maternity and Neonatal Safety Report The Associate Director of Midwifery and Children's Services was welcomed to the meeting and took the report as read. The Chair noted the significant level of activity and scrutiny taking place within the maternity landscape.
3.2.2	The Associate Director of Midwifery and Children's Services highlighted a number of positive developments. These included a sustained reduction in service diverts. The team had implemented the Birmingham Symptom-specific Obstetric Triage System (BSOTS) in June and were subsequently reassured when the national triage guidance was published, confirming that this was the appropriate approach. There were no moderate harm incidents reported during June.
3.2.3	An update was also provided on funding for the Maternity and Neonatal Voices Partnership (MNVP) - the Integrated Care Board (ICB) had confirmed partial funding the previous day and work would now be undertaken to progress the arrangements.
3.2.4	Induction delays continued to have an impact on patient experience and remained an area of focus. Work was progressing on the maternity care bundle, which incorporates the Ockenden/Amos 10 urgent actions and a delivery plan to address these requirements. The Associate Director of Midwifery and Children's Services reassured the Board that there were no issues within the report that should cause significant concern.
3.2.5	The Annual Baby Friendly Initiative summary was included within the report, alongside a detailed review of neonatal readmissions, providing greater insight into the reasons neonates required readmission. The report also included information relating to the Perinatal Mortality Review Tool (PMRT).
3.2.6	The Non-Executive Director (JW) congratulated the team on maintaining its gold-standard accreditation, noting that achieving the standard was a significant accomplishment and sustaining it was even more challenging.
3.2.7	The Non-Executive Director (AA) also congratulated the team on the quality of the report and welcomed the clear response to the Amos recommendations.

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3.2.8	The Associate Director of Midwifery and Children's Services advised that the maternity team remained resilient and supportive of one another. While the team did not welcome the negative media attention, it was recognised that such coverage could increase anxiety among service users and have an impact on appointment discussions and consultation times.
3.2.9	The Non-Executive Director (CM) highlighted the importance of the data relating to neonatal readmissions and third and fourth-degree tears. He noted that trends could be identified within the data and that it was important for the Board to formally acknowledge these issues, demonstrate awareness of them and maintain appropriate oversight.
3.2.10	The Chair asked for thanks and appreciation to be passed on to the maternity and neonatal teams from the Board in recognition of their continued hard work and commitment.
3.2.11	Resolved: The report was noted.
BD/07/29/4.1	Board Assurance Framework – Person Centred, Integrated Care, Strong Partnerships 4.1.1 The Deputy Director, Business Intelligence, Planning, Performance and Productivity provided the Board with an update on the Strategic Ambition: Person Centred, Integrated Care, Strong Partnerships. 4.1.2 Emergency Department (ED) Four-Hour Standard, performance had not achieved the target for the third consecutive month. Performance fell below 80% in April and has remained significantly below the desired level in recent months, with June performance recorded at 71.7%. While performance has begun to improve gradually, it remains below the level expected. 4.1.3 The Breakthrough Objective (BO) on measuring the time taken between key stages of a patient's ED journey breaks the pathway into a series of steps, including arrival to initial assessment by ED, completion of the ED assessment, transfer to the next stage of care such as a ward or Same Day Emergency Care (SDEC), and, where required, access to complex imaging following a clinical decision. The aim is for each element of the pathway to take approximately 60 minutes, supporting an overall journey of less than four hours. 4.1.4 Current median performance exceeds the expected timeframe and remains below the desired standard. Whilst individual elements of the pathway have been the focus of improvement activity for some time, successfully linking the stages together into a seamless patient journey remains a challenge that has yet to be fully resolved. 4.1.5 The Non-Executive Director (CdB) asked whether any organisations were ahead of the Trust in breaking down and measuring the patient pathway in this way and was advised that a number of different approaches and models had been observed across the NHS, with various organisations developing their own iterations of pathway-based measures to better understand delays and improve patient flow. 4.1.6 Frailty Length of Stay (LOS): The target remains to achieve top quartile performance for frailty length of stay by 2027. Performance continues to be positive, and the team is now developing a refined metric to support ongoing monitoring and improvement. An updated measure will be presented to the Board at the next meeting.

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4.1.7	Referral to Treatment (RTT): Performance against the 18-week standard was reported at 75.4%, slightly below target. However, positive progress had been made overall, with the total waiting list reducing in size. Supporting metrics continued to demonstrate favourable trends.
4.1.8	Cancer Performance: It was noted that consistency of performance had been a challenge during the previous year. However, performance against the cancer standard had improved significantly and remained on track to achieve 85% by the end of the year.
4.1.9	In relation to the Breakthrough Objective (BO), performance against the target for time to admission to a medical bed was discussed. Consultant follow-up activity remained on track, while nurse-led follow-ups were exceeding planned levels. Further work is being undertaken to ensure that the Trust is measuring the most appropriate indicators and focusing on the right outcomes.
4.1.10	The Non-Executive Director (JCr) stressed the importance of maintaining momentum in efforts to improve Emergency Department performance. He commented that the data being presented was powerful and should support a pace of improvement commensurate with the level of challenge.
4.1.11	The Non-Executive Director (WS) welcomed the positive progress against the cancer standard and enquired about the Trust's national benchmarking position. He further queried the cohort of patients who fall outside the 62-day cancer target and asked what the maximum waiting times were. It was reported that no patients were currently waiting in excess of 100 days, which had previously been a key measure of performance. Patients exceeding the 62-day standard were typically doing so by around 10 days.
4.1.12	The Chief Executive added that, at the end of May, the Trust ranked 9th out of 117 organisations nationally for the 62-day cancer standard and 8th out of 108 organisations for the Faster Diagnosis Standard.
4.1.13	The Non-Executive Director (CM) noted that, whilst the overall performance figures were encouraging, it was important not to lose sight of those patients who fall outside the target standards and whose experience may be significantly affected by longer waits. He emphasised the need to maintain a focus on individual patient experience alongside overall performance metrics.
4.1.14	Resolved: The Board Assurance Framework: Person Centred, Integrated Care, Strong Partnerships was noted and approved.
BD/07/29/4.2 4.2.1	Board Assurance Framework – Finance The Director of Finance provided the Board with an update on the Strategic Ambition: Overarching Finance 2025-26.
4.2.2	The year-to-date position was a £12.5 million deficit, which was £7.4 million adverse to plan. The variance was primarily attributable to the delivery of the base reduction programme, together with a number of smaller variances arising from costs carried forward from the previous financial year and the impact of industrial action.
4.2.3	The current forecast year-end position ranged from a best-case deficit of £13 million to a worst-case deficit of £40 million. The immediate priority was to agree a

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	financial plan with NHS England, and a further update would be provided to the Board at the next meeting on progress towards this.
4.2.4	An update was also provided on the Workforce Recovery Programme. Actions arising from the Turnaround Committee were being implemented, including the establishment of stronger workforce controls. Relevant committees had also considered the broader programme of work, including how the Trust could maximise the benefits and outputs arising from the KPMG review.
4.2.5	The Director of Finance noted the importance of effective communication across the organisation and confirmed that work was underway to ensure existing structures were being utilised appropriately. As part of this, the Financial Recovery Oversight Group (FROG) had been established.
4.2.6	Further work remained necessary in relation to the Community Services Review, and the Trust continued to work with NHS England on 0-19 productivity measures.
4.2.7	An update was also provided on clinical coding, with work continuing to ensure coding is accurate and up to date to support both performance reporting and income recovery.
4.2.8	The Breakthrough Objective (BO) had been reset to reflect the ongoing establishment review work currently being undertaken.
4.2.9	It was noted that the HDFT Futures strategic programme required greater focus and visibility within the Trust's wider strategic programme framework.
4.2.10	The Executive Medical Director emphasised the importance of maintaining a focus on sustainable long-term improvement, noting that while the Financial Turnaround Programme is designed to deliver the savings required today, the HDFT Futures programme is intended to shape and deliver the organisation of tomorrow.
4.2.11	The Director of Finance drew attention to a number of key risks. In particular, he highlighted the Trust's cash position and noted that only around one-fifth of suppliers were currently being paid within the required timescales, creating challenges on several levels. He also referenced risks associated with the Workforce Recovery Programme and confirmed that clawback issues were being actively managed through ongoing discussions with local authority-commissioned services.
4.2.12	The Non-Executive Director (WS) referred to the innovation aspects of the programme and expressed support for the direction of travel being proposed through HDFT Futures. He stressed the importance of undertaking engagement work in parallel with programme development so that staff and stakeholders are fully involved and prepared ahead of launch.
4.2.13	The Chief Executive advised that the Turnaround Programme would set out the priorities and actions for the next six months. He indicated that work would be undertaken to bring together a consolidated overview for presentation at the next meeting.
4.2.14	The Non-Executive Director (CM) noted that the financial plan had not yet been formally approved and asked whether there was an indication of when sign-off might be expected.

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4.2.15	The Chief Executive confirmed that discussions on this matter were scheduled with Sam Allen, Regional Director (interim) NHS England – North East and Yorkshire. In the meantime, the Trust had submitted a plan which it would continue to work towards and deliver.
4.2.16	Resolved: The Board Assurance Framework: Finance was noted and approved.
BD/07/29/5.1	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 The Trust performed strongly in the most recent NHS National Staff Survey, ranking 15th out of 121 organisations, and in the January inPulse survey ranked 5th out of 98 organisations. However, the latest inPulse results, received during the previous week, showed a 3% reduction in staff engagement scores, which will require further analysis and response.
5.1.3	Metric 2: Staff Availability. The number of staff unavailable for work has reduced from 764 in August 2023 to 629 currently, representing an improvement of approximately 150 staff. Sickness absence continues to represent the most significant challenge and remains a key area of focus.
5.1.4	An update was provided on the Embedding Equality Programme, including work to strengthen assurance around sexual safety. Significant activity is underway across both staff and patient-facing services, including the review and implementation of violence and aggression, dignity and safety-related policies and procedures.
5.1.5	The Medical and Dental Workforce Transformation Project continues to progress. Electronic rostering is being rolled out across specialties and will ultimately cover all areas with the exception of three services. Additional work is required within Emergency Department services, while Imaging and Anaesthetics currently face technical limitations due to system functionality.
5.1.6	The Non-Executive Director (JW) reported that the People Plan had been discussed in detail at the People and Culture Committee meeting and thanked Shirley Silvester, Deputy Chief People Officer and the Acting Chief People Officer for their comprehensive update. She noted the importance of aligning staff engagement initiatives with the actions being taken to support financial sustainability and organisational improvement. It was noted that the committee had heard directly from representatives of the staff networks, describing this as a particularly valuable discussion, providing rich insight into staff experiences and perspectives across the organisation.
5.1.7	ACTION – The Non-Executive Director (JW) to summarise network discussions and meet with Richard Dunston-Brady to produce a report.
5.1.8	The Associate Non-Executive Director (DC) commented on the value of the trend analysis presented within the report and the importance of continuing to monitor performance over time.
5.1.9	The Acting Chief People Officer acknowledged that while there were many positive indicators within the data, staff experiences were not always consistent across all areas of the organisation. Continued focus would therefore be required to ensure improvements are experienced equitably across the workforce.

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5.1.10	The Non-Executive Director (CM) commented that the progress made represented great credit to the organisation, particularly given the relatively short period in which many of the improvements had been achieved.
5.1.11	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	Guardian of Safe Working Hours Annual Report The Annual Report had been considered in detail by the People and Culture committee in March.
5.2.2	ACTION: GoSW annual report to be amended on workplan to be brought to Board at March meeting.
5.2.3	The Non-Executive Director (CM) referred to the exception reports and noted that Foundation Year 1 (F1) doctors, and to a lesser extent Foundation Year 2 (F2) doctors, featured prominently. He asked whether any underlying themes or trends had been identified.
5.2.4	The Executive Medical Director advised that findings from the Guardian report had been triangulated with feedback from the General Medical Council (GMC), noting that LTUCC had undertaken significant work to strengthen medical rotas through the employment of locally employed doctors. The concerns identified related primarily to F2 doctors, with no comparable issues being reported amongst more senior medical staff. She suggested that this may reflect the relative experience of junior doctors and the fact that some may not yet have had exposure to working in other NHS organisations.
5.2.5	The Non-Executive Director (AA) raised questions regarding workload pressures and the frequency of late finishes among resident doctors.
5.2.6	The Executive Medical Director noted that a new cohort of doctors would be commencing employment the following day and emphasised the importance of ensuring they receive a positive induction and support from the outset.
5.2.7	Resolved: The Guardian of Safe Working Annual Report was noted.
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	It was noted that all areas of performance remained green and within the agreed risk tolerance.
6.1.3	An update was provided on delivery of the Digital Strategy, which has been benchmarked against national standards. The programme was nearing completion of the current phase, with the end of July milestone largely achieved, and would shortly transition into the implementation phase.
6.1.4	It was reported that the Trust typically has between 50 and 60 digital projects underway at any given time, reflecting the scale and breadth of digital transformation activity across the organisation.

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6.1.5	The Non-Executive Director (WS) commented positively on the progress made and noted that attention should now begin to shift towards benefits realisation. He emphasised the importance of understanding whether the Trust is fully maximising the benefits that were anticipated and built into the original business cases once technology has been implemented.
6.1.6	The Chief Executive agreed and highlighted the importance of ensuring that benefits are clearly identified, tracked and attributed to the relevant programmes so that the overall value delivered by digital investments can be effectively demonstrated.
6.1.7	The Non-Executive Director (WS) further emphasised the importance of ensuring that process redesign is undertaken in advance of digital implementation, noting that technology should support redesigned pathways and ways of working rather than simply digitising existing processes.
6.1.8	The Executive Medical Director noted that a number of the digital initiatives had been driven by externally mandated timelines, meaning that opportunities for wider process redesign had not always been able to progress at the same pace as system implementation. However, benefits were already being realised, with £1 million of savings identified to date.
6.1.9	Resolved: Board Assurance Framework: Digital Transformation and Maturity to Integrate Care and Improve Patient, Child and Staff Experience 2025-26 was noted and approved.
BD/07/29/6.2 6.2.1 6.2.2 6.2.3 6.2.4 6.2.5	Board Assurance Framework – Enabling Ambition: Healthcare Innovation to Improve Quality & Safety 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. The Executive Medical Director reported that performance against the relevant objectives remained green across all measures, with progress on track to deliver the agreed goals and strategic priorities. The Executive Medical Director highlighted continued progress from a research perspective, with increasing numbers of patients being recruited into research studies and clinical trials, supporting both improved patient access to innovation and the Trust's research ambitions. An update was also provided on the MRI Research Scanner programme – there would be a dedicated research MRI, procurement is ongoing but this is dependent on getting the old MRI out. Resolved: Board Assurance Framework: Healthcare Innovation to Improve Quality & Safety was noted and approved.
BD/07/29/6.3 6.3.1	Board Assurance Framework – Enabling Ambitions: An Environment that Promotes Wellbeing The Director of Finance provided the Board with an update on the Enabling Ambition: An Environment that Promotes Wellbeing.

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6.3.2	He noted that there were a number of significant challenges associated with the scale of the estate and the costs required to maintain and develop it. The eradication of RAAC remained a key priority and continued to progress as planned.
6.3.3	He also advised that work was underway to update the Premises Assurance Model (PAM) for 2026/27. A more detailed update on the emerging plan, priorities and investment requirements would be presented to the Board over the coming months.
6.3.4	A longer term strategy for the estate would be the subject of a future Board workshop.
6.3.5	In relation to Histopathology, concerns were noted regarding the suitability and availability of space within the department. The issue is being monitored and forms part of the wider consideration of estate capacity and future service requirements.
6.3.6	Theatres were the biggest area of concern for backlog maintenance, this would be addressed once Block C work had been completed which was due to receive it's first patients in December 2026.
6.3.7	Resolved: Board Assurance Framework: An Environment that Promotes Wellbeing was noted and approved.
BD/07/29/6.4	Green Plan Update
6.4.1	The Director of Finance gave a brief update adding that Tim Wilkinson would have delivered the update but was on annual leave. It was noted that Tim Willkinson had attended Council of Governors in June and given an excellent update.
6.4.2	Progress had been made in reducing carbon emissions, including completion of the original Salix-funded scheme and the installation of additional solar panels across the estate. Digital transformation was supporting sustainability objectives at multiple levels across the organisation, with a range of positive initiatives underway. Success continued to be measured against key indicators, including reductions in gas consumption.
6.4.3	A recent audit had provided a different perspective on assurance arrangements and identified opportunities for further improvement. Learning from other organisations had formed an important part of this work, with the audit highlighting examples where alternative approaches had delivered stronger outcomes elsewhere.
6.4.4	Looking ahead, key priorities for the coming year include the successful delivery of funding secured for sub-metering in key areas of the estate, alongside a target to achieve a 5% reduction in electricity consumption.
6.4.5	The Non-Executive Director (WS) asked for an update on the proposed geothermal project and the Director of Finance advised that discussions were continuing; however, reaching agreement on the arrangements required to progress the project remained challenging. Conversations with relevant stakeholders were ongoing with the aim of securing a workable solution that would allow the project to move forward.
6.4.6	Resolved: The Green Plan Annual Update was noted.

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BD/07/29/7.1 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	Resolved: No matters were identified requiring formal escalation to the Board that had not already been discussed earlier in the meeting.
BD/07/29/8.1 8.1.1	Use of Trust Seal The Director of Governance and Improvement presented the report, which was tabled for assurance and the recommendation was that it be authorised.
8.1.2	Resolved: The use of the Trust Seal was authorised and the report noted.
BD/07/29/8.2 8.2.1	Code of Conduct The Director of Governance and Improvement presented the revised Code of Conduct noting that amendments had been made to reflect Charity Trustee responsibilities and governance requirements.
8.2.2	Resolved: The Code of Conduct was approved.
BD/07/29/9.0 9.1	Any Other Business No further business was received.
BD/07/29/10.0 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/07/29/11.0 11.1	Date and Time of the Next Meeting The next meeting would be held on Wednesday 30 th September 2026.
BD/07/29/12.0 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 (held in Public) Action Log
for September 2026 Board Meeting**

Minute Number	Date of Meeting	Subject	Action Description	Responsible Officer	Due Date	Comments	Status - completed is defined as confirmation received from ED responsible lead that the proposed action is completed as described in the comments column. Completed actions will not be closed until the Board has confirmed that action taken is satisfactory.
BD/03/25/3.2.11	25-Mar-26	MVP Funding	Chief Executive to seek clarity from ICB on future of MVP funding	Chief Executive	Jul-26	Held over from May meeting.	Completed
BD/05/27/5.2.2	29 July 2026	GoSWH report	To be amended in workplan to bring to March meeting	Company Secretary	Sep-26	Adrded to workplan	Completed

BOARD OF DIRECTORS (PUBLIC)

30th September 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)
SEPTEMBER 2026**

CHIEF EXECUTIVE'S REPORT

National and system issues

1. Last week the report of the Thirlwall inquiry into the deaths of babies at Countess of Chester Hospital was released. This is a sobering report into the awful events in Chester and is something that the wider NHS must reflect on and ensure doesn't happen again. The report describes voices not heard by the Board, a lack of visibility of these services, a lack of curiosity, and a serious failure of governance which no-one on the Board seemed to have noticed.
2. There are some immediate actions that we are asked to implement and some other improvements to make that will take a bit longer and require a national approach. These will be outlined in a separate item on the Board agenda. The wider reflection has to be in relation to culture and the culture in all areas of the Trust, and how we as a Board are assured that whatever happens, that all colleagues in all of our services feel both confident to raise concerns and confident in the reaction of leaders to these concerns being raised.
3. The national position in relation to delivery of NHS priorities is challenging. In all areas of the country, the urgent care pathway has become harder to navigate within the timescales that we should deliver, the referral to treatment time (the 18 week performance) is not in line with the improvement plans we set ourselves, and the financial position is that collectively we are around £200m behind where we should be. There is rightly regional and national focus on these priorities, which are quality as well as performance criteria and are the things that the public want to see improved. The concern that these standards are not being met in the summer months means that there is little flexibility going into the winter period, and it is important to get back on track as a matter of urgency.
4. It is important to retain the confidence of the public and by proxy politicians in the services delivered by the NHS, particularly given the economic climate and the choices that are having to be made in relation to public services across the country. As leaders, we need to retain our focus on delivering the improvements to the core standards that will ensure that the public receive the service that they should expect.
5. Following a number of discussions nationally and regionally, our plan for 2026/27 has been agreed and signed off. This agreement – alongside our commitment to deliver our plans in relation to urgent care, waiting times, cancer standards and other key measures - means that we have a deficit financial plan of £13.5m for this year. If this position is delivered, we will receive £13.5m of support funding from NHSE, which is a significant incentive and a commitment to the organisation.
6. Funding has also been provided to support additional financial recovery capacity, which is helpful. A financial recovery plan has been developed as we discussed at our Board workshop, and this is presented as a separate Board item.

7. We have our Mid Year Review on 28th September with the Regional Team at NHSE. This will be focused upon our financial recovery programme but will also include testing our urgent care plans (and specifically our winter plans) as well as our plans to deliver the 18 week standard that we have set ourselves. This will be an appropriately challenging session and I will report feedback to the Board at the meeting.
8. The latest quarterly release of the National Oversight Framework has a score for HDFT that means that we rank 34th out of 134 comparable Trusts. This includes the impact of the financial override given our deficit position.
9. We are due to submit our provider self-assessment to NHSE on 2nd October, and this will be presented as a separate item for the Board to consider. I can also report that following our Extraordinary Board meeting last week that we submitted our maternity baseline assessment against the 10 point plan requirements following the Amos Report.
10. In relation to the HNY ICB, a key priority is to undertake a community services review to inform planning for 2027/28. This was agreed to be undertaken as part of our planning discussions in March. This has not yet commenced, and it is unlikely that the work will be completed in time for consideration in the next planning process. It is a vital component of our return to financial balance in 2027/28, as there are a number of community services where the resources provided do not meet the cost of delivery. Our deconstruction of the block exercise in relation to community services demonstrates that our services are relatively efficient but that we do not receive the resource to cover the costs. This will mean that we need to agree with the ICB which services are to be recommissioned and which might need to be decommissioned, as the option of simply being more productive in this area, when we are already efficient, would be a challenge.
11. As part of our financial recovery programme, we are not waiting for the community services review to assess a number of services where the income we receive is lower than the cost of provision. As a result of this we have already informed the ICB of our intention to no longer provide the GP out of hours service in the Hambleton and Richmond area. We will be working with the ICB on handover arrangements and transition to an alternative provider.
12. As previously reported, we received support from HNY ICB to progress our business case in respect of developing a community diagnostic centre in Harrogate. This has also been agreed by the Regional team of NHSE but we are still 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.
13. 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. A key milestone in respect of developing our neighbourhood health plan was met last week, as an update was presented to the North Yorkshire Health and Wellbeing Board. A further iteration of the plan is to be completed by December, to allow time for each organisation involved to sign off plans early in 2027 prior to the HWB approval in March. Local 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. There is a local workshop this week to progress this further with all local partners.

14. 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.
15. In addition to microbiology discussions, the WYAAT aseptics programme continues to progress well, with the new facility opening next year, and there is work continuing in relation to stroke services and their resilience across the system.
16. We are continuing discussions with LTHT about the way in which we can jointly maximise the opportunity available from the elective centre that we share at Wharfedale Hospital. Currently, the productivity delivered through this unit is not where it could be, and whilst there are significant strategic benefits to this facility for both organisations and the public who use it, we need to ensure that it operates in a way that maximises value for money.
17. 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. As part of this work, we are connecting into neighbourhood health discussions where appropriate to so in a number of areas.
18. Our focus on financial recovery, elective care recovery and urgent care mirrors the national and system priority. Our work is aligned with the system, and it is important for us as an organisation to work within the national and regional context whilst owning the improvement work we need to do within the organisation. We are also ensuring that the work of financial recovery this year flows into our HDFT Futures programme, which will continue the improvement journey over the next few years as we look to ensure we remain clinically and financially sustainable for the long term. Our strategy is clear and consistent, but it is important that we take action now to improve our financial runrate and performance standards, 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.

HDFT issues

Introduction

19. 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.

20. As referenced previously, but worthy of reminder is the ask we are making of our leadership team and other colleagues 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.
21. The financial recovery plan is a separate agenda item, but it is clearly a major priority for the organisation and is therefore interspersed within all discussion about our services and our people.

Our people

22. In terms of staff engagement, whilst our latest Inpulse survey showed a slight drop in engagement, we benchmarked well in comparison with other NHS organisations, as we remain within the top 10%. We will be tracking this alongside the delivery of our financial recovery programme, as we recognise that some of the measures we are taking will inevitably make the work undertaken by some colleagues more difficult to do.
23. In respect of availability, whilst sickness has reduced our sickness rate is higher than our ambition and is an area of focus for the Trust.
24. Our financial recovery programme is currently focusing on recruitment controls alongside variable pay controls. There has been a reduction in the recruitment of new staff, and also a marked reduction in agency and bank spend which is positive.
25. The National Staff Survey has been launched and we are encouraging colleagues to complete the survey so that we can understand how people are feeling about working at HDFT.
26. The flu vaccination campaign has also begun. This is the single contribution that all staff can make to protecting patients, their family and themselves, and help also ensure that staff are available for work more often through the winter period. This has quality, safety and financial benefits for everyone, and we are working to ensure that as many people as possible have the vaccination. We had the highest take-up rate in the country last year, and our aim is to repeat that.

Our Quality

27. 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 has been completed and will be discussed through our governance cycle in October. This will link into future planning discussions and will highlight where we might need to focus our improvement over the coming years.
28. We remain on track in respect of moderate and above harms reduction. This oversight is part of our quality governance system that we are using to triangulate any impact of the financial recovery work that we are undertaking.

29. We have received high assurance in respect of our safer staffing systems following an audit by NHSE. Again, this is positive and provides assurance to the Board about key quality governance processes that we have in place.
30. We have had a never event which we have declared in September. This will be investigated in the usual way and followed up through our quality governance cycle.
31. In respect of our maternity services, there are no risks escalated to the corporate risk register. We have robust staffing and our baseline assessment response in respect of the Amos report has been submitted. I attended the recent maternity safety champions session and was impressed with the openness of the discussion and the confidence to raise issues should they need to.

Our Services

32. 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 the Healthy Child Programme requirements across ten of our twelve local authorities (including South Tyneside who joined us in April), with the only areas where we don't quite meet the target being in Cumberland and Westmoreland & Furness, where there has been a huge improvement since we took over the service provision last year.
33. We have developed our plan for the winter which is based upon learning from last year, alongside our expected capacity requirements to ensure that we deliver safe care over the winter months. Any additional resource needed is targeted to areas where we'd make the most difference, and our daily operational controls and assessment will be in place to manage capacity as appropriate.
34. Our urgent care pathway performance is below the standard that we set ourselves. In August we have delivered 75.5% against the ED 4 hour standard. 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 alongside our winter plan 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. 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. On a positive note, our very low levels of people waiting over 12 hours in the department compares favourably with most other organisations, as does our ambulance handover performance, which reduces risk across the local system.
35. In relation to cancer, our performance remains a positive one against both the 62 day standard and the FDS, with significant improvement achieved over the last twelve months which has continued into 2026/27.
36. In terms of elective recovery, we are behind our plan at the end of August, with an 18-week performance of 72% against a plan of 77%. We are putting plans in place in particular specialties to recover this position and get back on plan. This will involve using additional capacity, but our approval control principles remain in place to ensure value for money.

37. The provision of autism assessments in a timely way continues to be a significant risk to HDFT. These are issues that are replicated across the country. Discussions with the Commissioner continue, but we recognise 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

38. As the Board will know through many discussions over the last few months, we have a challenging financial plan to deliver this year. Our month 5 deficit is £18.7m. This is being addressed through our financial recovery programme.
39. As referenced earlier, we have agreed a financial recovery programme and associated governance arrangements. Focus is on recruitment controls, new affordable establishments, reducing variable pay, and delivering our activity as productively and profitably as possible. The Turnaround Committee is overseeing delivery of the programme and will report into the Board.
40. We have a significant cash risk as a result of the financial position. This risk is the highest risk on our corporate risk register. 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. As a result of some particular challenges we submitted an emergency cash request at the beginning of September, and we are working with NHSE to improve the cash management arrangements.
41. Clearly, the solution to our cash challenges is through delivering our financial recovery programme, and this is a key benefit to the Trust of improving our runrate and qualifying for deficit support funding.
42. The route to financial balance and sustainability lies in delivering the immediate runrate reductions alongside the strategic solutions related to Neighbourhood health, the Community Services review, delivering elective productivity at Wharfedale Hospital, and developing our position as the leading 0-19 provider in the country. A part of this is to ensure we have strategic alignment with our commissioner in respect of the services to be commissioned. Our financial recovery 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

43. On the 9th and 10th September 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.

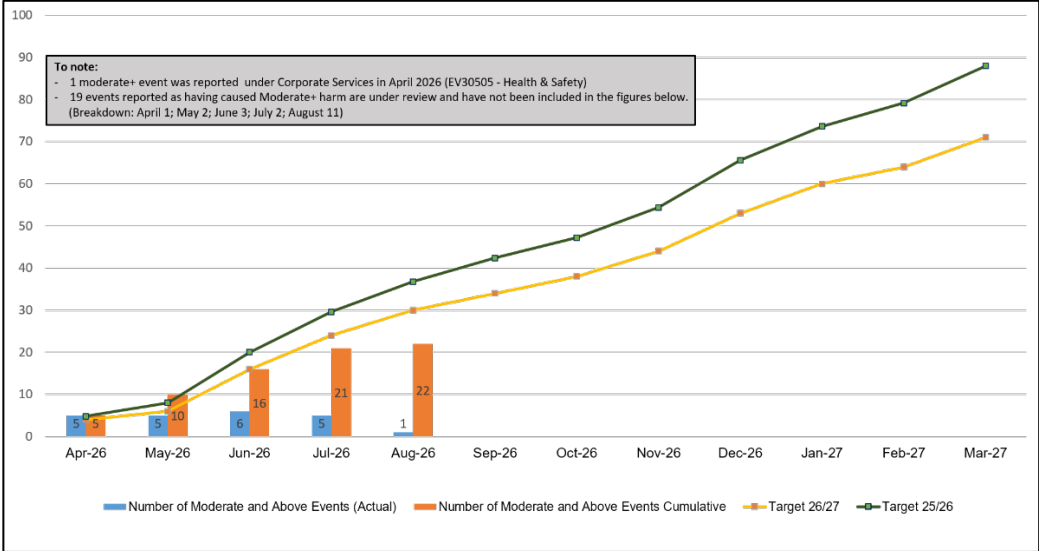
44. The Executive Risk Review Group (ERRG) met on Thursday 10th September 2026. The executives reviewed all risks currently held on the Corporate Risk Register and considered all directorate requests for escalation and de-escalation. The following was agreed:
45. No further risks were escalated from the Directorate Risk Registers to the Corporate Risk Register.
46. Risk ID 79 (Stroke) is to be considered for de-escalation from the Corporate Risk Register for management on the Directorate Risk Register at next month's Executive Risk Review Group Meeting. This is following a review carried out by the directorate and a reduction in the score to 8.

Other

47. Our capital scheme to deliver new theatres and a new imaging department continues to progress well. We are also progressing the plans to redevelop the front entrance with an expected delivery in the first half of 2027. A business case to mitigate the fire risk that we are currently managing is being prepared.
48. It was great to attend and be a part of the Annual Members' Meeting earlier this month. It was helpful both to reflect on how the organisation is delivering for our population and also to talk with people about how we can engage to improve services further.
49. Finally, I wanted to remind ourselves of the importance of engaging with our colleagues positively and reflecting our values. We have a very talented and positive group of people working across the organisation, and whilst the challenges are sometimes tricky to manage we will stand the best chance of delivering the improvements we all want to see by doing the right things in the right way. We have had an extreme and sobering reminder of what can happen to patients if we have a culture that doesn't value colleagues and where people are afraid or unwilling to raise concerns, or if concerns are raised and not acted upon. Let's disagree and let's challenge as a means to getting to the right solutions, but let's also support, encourage and do so in a kind way. That way we can be confident that we will deliver for our patients and population.

Jonathan Coulter
Chief Executive
September 2026

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 5 moderate and above events reported in April 2026 <i>(of note one of these was reported under Corporate Services.1 undergoing validation)</i> - There were 5 moderate and above events reported in May 2026 <i>(2 undergoing validation)</i> - There were 6 moderate and above events reported in June 2026 <i>(3 undergoing validation)</i> - There were 5 moderate and above events reported in July 2026 <i>(2 undergoing validation)</i> - There was 1 moderate and above events reported in August 2026 <i>(11 undergoing validation)</i> The year-to-date total is 22 against a threshold of 30. 19 events reported as having caused Moderate+ harm are under review and have not been included in the figures below.  The data indicates that slips, trips and falls involving patients were the most common issue, accounting for 5 of the 22 incidents (23%). The next most frequently reported problem was diagnosis, with 3 incidents (14%). Pressure ulcers, procedure and surgery issues, and appointment/booking issues each accounted for 2 incidents (9% each). Together, these five categories accounted for 14 of the 22 incidents (64%), highlighting that a relatively small number of categories represented almost two-thirds of all verified moderate and above patient safety incidents reported during the period.	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
				Watch Metrics: - Number of Never Events – 0 declared in year - Number of PSIs – 3 declared in year - Level of low and no harm events reported – 1,019/1039 (1,019 low and no harm events of a total reported of 1039) maintaining 98%			
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	Goal 1 of the Clinical Standards Review Project is nearing completion and is expected to be finalised by September 2026. The focus of Goal 1 has been to establish a baseline assessment of clinical standards across services. Upon completion, the programme will progress to Goal 2 with ownership and oversight transitioning into business as usual arrangements. Watch Metrics: % guidelines in date 94.3% (26 out of 458 are overdue) % SOPS in date 86.5% (125 out of 923 are overdue)	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)	The Patient Experience and Engagement Team is expected to be fully staffed by October 2026. A key workstream planned within Patient Engagement is to review and strengthen how patient feedback is collected, understood, shared, and used across the organisation. This includes developing a clearer understanding of existing feedback mechanisms, promoting the timely use of patient insight to inform service improvement, and sharing good practice across clinical teams to improve consistency. This work aims to ensure that patient feedback is used more effectively to support learning, quality improvement, and improvements in patient experience across HDFT. 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. 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.	Development of a real time engagement tool Development of a 24-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																																							
				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%, showing stable and sustained positive patient experience across the year. Watch Metrics: • There were 511 responses received in April • There were 424 resosonses received in May • There were 322 responses recieved in June • There were 470 responses recieved in July • There were 481 responses received in August HDFT FFT responses 2026/27 <table><caption>HDFT FFT responses 2026/27 Data</caption><tr><th>Month</th><th>Cumulative Responses</th><th>Trajectory</th></tr><tr><td>April</td><td>511</td><td>~511</td></tr><tr><td>May</td><td>424</td><td>~1035</td></tr><tr><td>June</td><td>322</td><td>~1559</td></tr><tr><td>July</td><td>470</td><td>~2083</td></tr><tr><td>August</td><td>481</td><td>~2607</td></tr><tr><td>September</td><td>-</td><td>~3131</td></tr><tr><td>October</td><td>-</td><td>~3655</td></tr><tr><td>November</td><td>-</td><td>~4179</td></tr><tr><td>December</td><td>-</td><td>~4703</td></tr><tr><td>January</td><td>-</td><td>~5227</td></tr><tr><td>February</td><td>-</td><td>~5751</td></tr><tr><td>March</td><td>-</td><td>~6275</td></tr></table> Watch Metrics: • 35 complaints of all types (complaint, multiagency and cases requiring a meeting) were submitted in August 2026 ◦ 32 of these were complaints. • 25 complaints were due to be responded to in August with a percentage response rate of 65%.	Month	Cumulative Responses	Trajectory	April	511	~511	May	424	~1035	June	322	~1559	July	470	~2083	August	481	~2607	September	-	~3131	October	-	~3655	November	-	~4179	December	-	~4703	January	-	~5227	February	-	~5751	March	-	~6275			
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Workstream	True North Metric	Vision	Goal	Current State	Countermeasures	Level of Risk to Achieving in year goal	Level of Risk for progressing actions																																																																			
				Complaints response timeliness - Trust wide position <table><tr><th>Month</th><th>Total complaints due a response this month</th><th>% responded in time</th><th>Timeliness trajectory</th></tr><tr><td>May-25</td><td>34</td><td>94%</td><td>94%</td></tr><tr><td>Jun-25</td><td>28</td><td>79%</td><td>94%</td></tr><tr><td>Jul-25</td><td>42</td><td>63%</td><td>94%</td></tr><tr><td>Aug-25</td><td>44</td><td>68%</td><td>94%</td></tr><tr><td>Sep-25</td><td>24</td><td>75%</td><td>94%</td></tr><tr><td>Oct-25</td><td>34</td><td>71%</td><td>94%</td></tr><tr><td>Nov-25</td><td>44</td><td>55%</td><td>94%</td></tr><tr><td>Dec-25</td><td>24</td><td>75%</td><td>94%</td></tr><tr><td>Jan-26</td><td>36</td><td>94%</td><td>94%</td></tr><tr><td>Feb-26</td><td>54</td><td>81%</td><td>94%</td></tr><tr><td>Mar-26</td><td>56</td><td>89%</td><td>94%</td></tr><tr><td>Apr-26</td><td>62</td><td>58%</td><td>94%</td></tr><tr><td>May-26</td><td>40</td><td>70%</td><td>94%</td></tr><tr><td>Jun-26</td><td>56</td><td>82%</td><td>94%</td></tr><tr><td>Jul-26</td><td>98</td><td>92%</td><td>94%</td></tr><tr><td>Aug-26</td><td>52</td><td>65%</td><td>94%</td></tr></table>	Month	Total complaints due a response this month	% responded in time	Timeliness trajectory	May-25	34	94%	94%	Jun-25	28	79%	94%	Jul-25	42	63%	94%	Aug-25	44	68%	94%	Sep-25	24	75%	94%	Oct-25	34	71%	94%	Nov-25	44	55%	94%	Dec-25	24	75%	94%	Jan-26	36	94%	94%	Feb-26	54	81%	94%	Mar-26	56	89%	94%	Apr-26	62	58%	94%	May-26	40	70%	94%	Jun-26	56	82%	94%	Jul-26	98	92%	94%	Aug-26	52	65%	94%		
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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 Access (SPOA) for UEC, and Neighbourhood Health, embedding agreed clinical standards and service models that support quality, workforce resilience and operational sustainability.	The Clinical Services Strategy (CSS) programme continues to progress through its priority workstreams, with current focus on Clinical Standards Review (CSR) and Neighbourhood Health. The programme remains clinically led and focused on developing future models of care that improve quality, effectiveness and patient experience whilst supporting long term sustainability. Clinical Standards Review (CSR) continues to progress and is strengthening the Trust's understanding of compliance with evidence based clinical standards. Service assessments completed to date are providing a clearer picture of variation in practice and highlighting opportunities for improvement across pathways, workforce models, digital enablement and service configuration. Emerging themes are being used to inform prioritisation of transformation activity and future programme planning. Neighbourhood Health continues to develop in line with national policy and local place priorities. Work is progressing on initiatives supporting prevention, reducing health inequalities and delivering more care closer to home. Collaboration with primary care, local authority and wider system partners remains central to delivery, with ongoing work to identify opportunities for pathway redesign and integrated models of care. Single Point of Access (SPOA) for UEC remains within the scope of the Clinical Services Strategy; however, active progression of the programme is currently paused pending further review of strategic priorities, dependencies and available capacity. The pause provides an opportunity to reflect learning gained during the development phase, review alignment with wider urgent and emergency care priorities, and ensure any future model is supported by the appropriate workforce, operational and digital infrastructure.	- Complete remaining Clinical Standards Reviews and establish a prioritised improvement pipeline. - Translate CSR findings into service level improvement plans and Trust-wide transformation priorities. - Progress Neighbourhood Health priorities through partnership working and place-based delivery models. - Review and maintain a clear strategic position for SPOA, including dependencies, benefits, risks and future delivery options. - Actively manage programme interdependencies with workforce, digital, estates and financial planning. - Maintain robust governance, benefits tracking and risk management through CSS Operational Board and SDR processes.		

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	Implementation of the clinical checklist programme continues to progress across priority services. During the last month the first area achieved full implementation and validation (100%) providing assurance that the required checklist, supporting SOP, validation and audit processes are in place. Progress is also being made within two other high priority clinical areas who are currently at 60% completion. A number of services have commenced implementation and are progressing through the development and validation stages (20% complete). The programme measures progress against five key criteria: establishment of a checklist, confirmation that it is fit for purpose, supporting standard operating procedure (SOP), validation of the process and completion of audit activity. Progress to date demonstrates that the programme is establishing the necessary governance controls and assurance mechanisms within services. Focus during the next reporting period will be on progressing the remaining Stage 1 critical services prior to formal completion of Phase 1. Planning for Stage 2 services has commenced, with initial progress evident within several areas. Continued oversight is being maintained through the project governance arrangements to ensure implementation remains on track and that evidence of compliance and effectiveness is obtained through validation and audit activity.	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.					

To: NHS trusts and integrated care boards:

- chief executives
- chief operating officers
- chief nursing officers
- chairs
- medical directors

cc. NHSE regional teams:

- regional directors
- chief nursing officers
- medical directors

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

21 September 2026

Thirlwall Inquiry report and recommendations

Dear colleagues,

Lady Justice Thirlwall's [report](#) is a sobering moment for all of us working in the NHS. From the devastating failure, both of individuals and the system, to act quickly enough to safeguard babies, to the questions it poses about the NHS culture that prevented this – the need for change goes beyond the walls of a single hospital ward. We must address these together now.

Our thoughts remain very much with the families affected who have experienced unimaginable loss and pain, and the NHS repeatedly failed them. The care, safety, and safeguarding of all patients is the principal duty of all of us, and this is why we must all act with the urgency, curiosity, and openness to ensure that the learning from this Inquiry is translated into clear action.

This is not just a matter for Trusts with neonatal services. It is a matter for every single Trust and ICB Board to consider, and for every member of staff across the NHS.

Recommendations

On Tuesday, the Secretary of State delivered a statement in Parliament that committed to commencing a series of actions recommended in the final report, while the Government considers the Inquiry's recommendations in full.

Specifically:

- Urgently work to develop plans for all cots and incubators in all neonatal units to be fitted with baby monitors (in-cot cameras with livestreaming video), so that parents can observe their baby remotely at any time. Taking learning from places where this is already used, we will develop a national approach to support neonatal units to implement this;
- Go further on [new guidance](#) on the safe use and storage of insulin and strengthened guidance for medical examiners reviewing neonatal death;
- Undertake a review of the 'Working Together to Safeguard Children' (April 2026) and safeguarding training nationally;
- Work through plans to regulate NHS managers through a barring scheme for senior leaders who fail in their responsibilities;
- Continue rollout of the National Bereavement Care Pathway for families experiencing neonatal loss.

Actions needed now

Trusts should immediately progress the following actions in response to the Inquiry's findings:

- **Every Trust and ICB Board to review the Thirlwall report and to consider its findings at the next available public Board meeting:** Boards should reflect on whether it would have been possible for similar events to occur at their own organisation and seek assurance that sufficient measures are in place to keep the babies and children in their care safe, no matter what setting. Central to this is a culture of professional curiosity, where both Board members and staff feel empowered, supported, and confident to speak up, challenge concerns, and raise issues without fear. Any risks to this must be urgently discussed with the regional team.
- **Sudden and Unexpected Death In Children (SUDIC):** The Inquiry rightly made clear that no member of staff should ever assert that they did not know what to do in response to a sudden and unexplained death. The [SUDIC protocol](#) is applicable for every death (or collapse leading to death) of an infant or child under the age of 18 which would not have been reasonably

expected to occur 24 hours previously and in whom no pre-existing medical cause of death is apparent, irrespective of the place of death. This includes sudden and unexpected deaths within neonatal units. **All Trusts with a neonatal unit must urgently communicate to all relevant staff and the Board that the SUDIC process applies as set out above. This must be completed by no later than Monday 28 September 2026.** It is important to note that SUDIC reporting runs alongside your own internal reporting processes.

- **National Bereavement Care Pathway for stillbirth and neonatal death:** ICBs and providers should take immediate action to improve care of the bereaved as has already been set out in the [NHS Medium Term Planning Framework](#) (October 2025).
- **Insulin:** By 31st March 2027, all neonatal units must meet requirements for access control and storage of insulin as set out in the [GIRFT neonatology Guide to safe insulin use](#). Until access to insulin requires the provision of biometric data, each Trust should urgently install CCTV cameras in neonatal units focused on storage fridges, cupboards or units by 30 November 2026 at the latest. The cameras should store recordings for at least 28 days.
- **Safeguarding:** Trusts and ICBs should ensure that all staff and Board members are compliant with safeguarding training requirements at the appropriate level and confirm that staff know who to raise and escalate concerns to. Boards must assure themselves that the safeguarding of babies and children is given the level of prominence required.

In addition, Trusts are reminded that the [Insightful Provider Board guide](#) is intended to help Boards identify the information they need and the cultures, behaviours and governance required to ensure that information is used effectively.

Health and wellbeing

We are mindful that the findings of this Inquiry may impact the confidence of parents and families whose babies are currently receiving neonatal care. We would urge you to consider what steps can be taken locally to provide parents with assurance of the care being given and support that is required during the care of their baby.

We also recognise that caring for very sick babies can be psychologically difficult for staff and this is an opportunity to review the support mechanisms in place for staff working in these services.

Next steps

The report firmly underlines why the urgent work we are doing through the Maternity and Neonatal Care 10-Point Plan must be a top priority for the NHS. As the Secretary of State has clearly set out, the safety, safeguarding and wellbeing of mothers and babies must never be treated as a side issue and must be a central priority for NHS boards.

The findings of this crucial report will be a key focus of our next CEO leadership event tomorrow. It is important that we challenge each other when we meet on whether we are all doing enough to ensure that babies and children are protected, no staff member is ignored when they raise concerns, and that we are consistently acting to the highest standards of governance and leadership.

Yours sincerely,



Duncan Burton

Chief Nursing Officer for England



Sarah-Jane Marsh

NHS England Chief Operating Officer

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

GOALS:

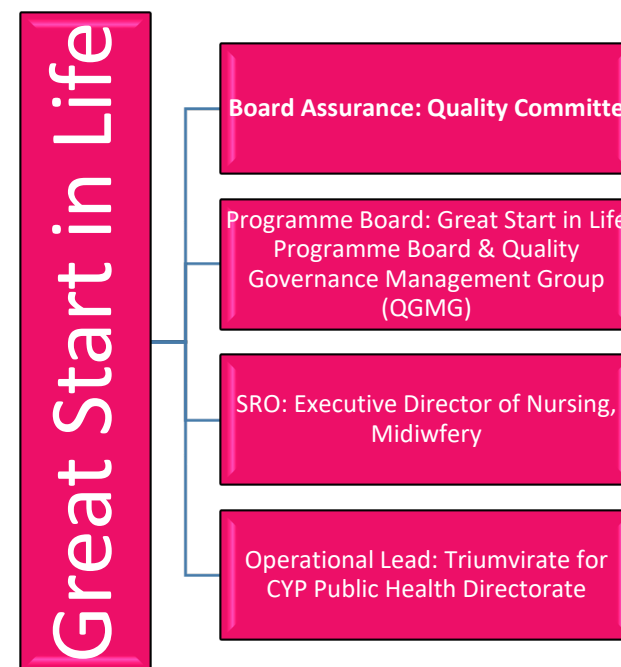
Public Health

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

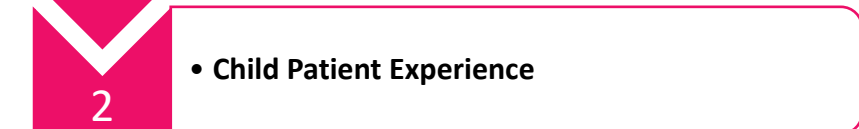
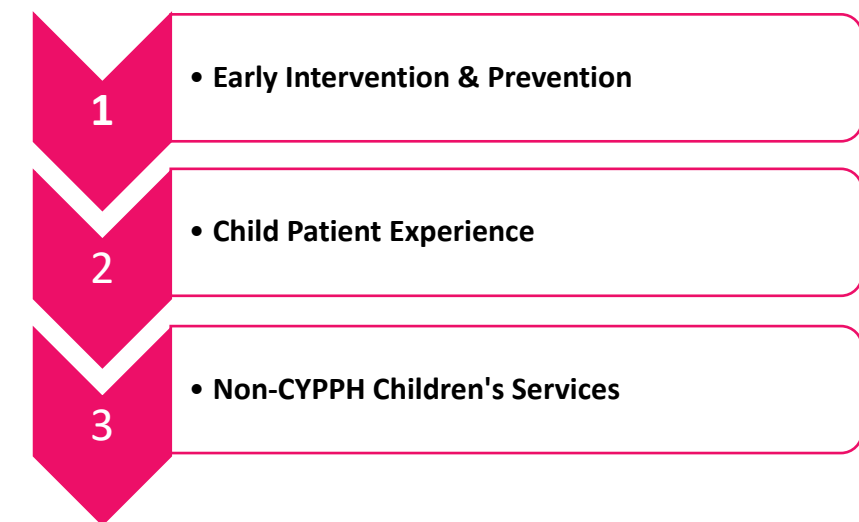
Hopes for Healthcare

Services which meet the needs of children & young people

GOVERNANCE:



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



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

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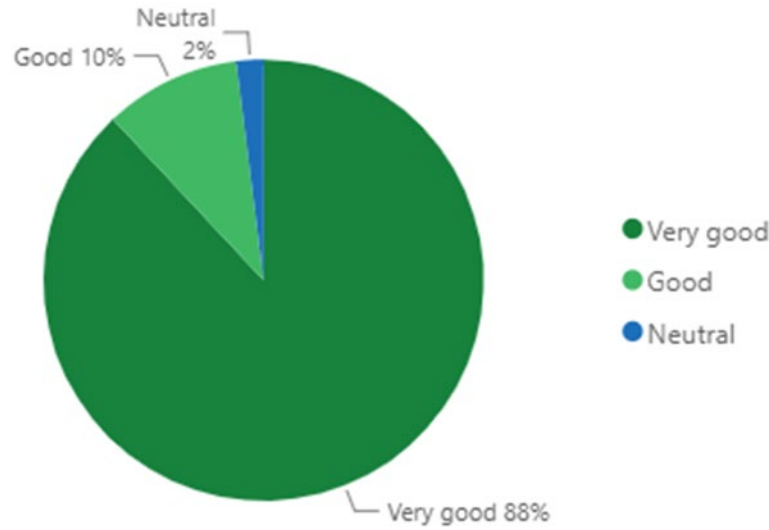
Overarching Risk Appetite:	Clinical - Minimal
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Overarching Risk Summary:

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

True North Metrics Summary:

Workstreams	True North Metric	Vision	Goal	Current State	Countermeasures	Level of Risk To Achieving Goal (CxL)	Level of Risk for progressing actions																																																	
Public Health 	Great Start in Life: Early intervention & prevention – Children at Risk of Vulnerability	‘As an organisation we aim to reduce the number of children who are vulnerable to poor health and wellbeing and to take action to mitigate risks of poor outcomes’.	Goal 1: To achieve 90% delivery of mandated Healthy Child Program Contacts within national timescales. Goal 2: To deliver the HDFT Great Start in Life pathway launching April 25 to all eligible children in Darlington and report outcomes linked to Public Health high impact areas.	We have 12 LA Commissioned 0-19 Services. There are five mandated contacts in each service making 60 contacts (South Tyneside added from August 2026). Target is to have 60 at 90% (delivering with HCP Timescales). In August 26, the service delivered 56 / 60 mandated contacts within the HCP timescales, with only one area breaching business rules. CYPH Directorate has a Driver to focus on HCP Mandated Contacts not delivered within timescales over four consecutive months with associated countermeasures. <table><tr><td rowspan="2">Great start in Life Improve outcomes by identifying children by ensuring we achieve >90% for all mandated contracts</td><td>Zero mandated contacts in all our contract areas breaching business rules</td><td>2</td><td>2</td><td>2</td><td>1</td><td>1</td></tr><tr><td>All mandated contacts at 90% or above (60 contracts)</td><td>52</td><td>52</td><td>49</td><td>59</td><td>56</td></tr></table> The Governments <i>Plan for Change</i> has set out measurable milestones to be achieved by the end of this Parliament. This includes the milestone for: 75% of children to reach a good level of development in the Early Years Foundation Stage assessment by 2028 (up from 67.7% currently). The 2-2 ½ year review is essential to help meet the 2028 milestone, so that developmental needs and delays can be detected early and children are able to receive additional targeted support prior to starting school. CYPH driver of maximising the 2-21/2 year review in Cumberland and Westmoreland and Furness has increased and sustained performance above 90% for four consecutive months and will not be a watch (This contact was not delivered universally in Cumbria and started in April 25 at 0%)). <table><tr><td></td><td>Apr-25</td><td>May-25</td><td>Jun-25</td><td>Jul-25</td><td>Aug-25</td><td>Sep-25</td><td>Oct-25</td><td>Nov-25</td><td>Dec-25</td><td>Jan-26</td><td>Feb-26</td><td>Mar-26</td><td>Apr-26</td><td>May-26</td><td>June</td><td>Jul 26</td><td>Aug-26</td></tr><tr><td>% of 2-2.5 year reviews completed by the time the child is 2.5 years old</td><td>0.0%</td><td>2.3%</td><td>8.2%</td><td>75.4%</td><td>72.3%</td><td>78.2%</td><td>65.5%</td><td>71.2%</td><td>83.3%</td><td>95.3%</td><td>89.7%</td><td>93.0%</td><td>88.4%</td><td>98.1%</td><td>95.4%</td><td>96.6%</td><td>96.1%</td></tr></table>	Great start in Life Improve outcomes by identifying children by ensuring we achieve >90% for all mandated contracts	Zero mandated contacts in all our contract areas breaching business rules	2	2	2	1	1	All mandated contacts at 90% or above (60 contracts)	52	52	49	59	56		Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	June	Jul 26	Aug-26	% of 2-2.5 year reviews completed by the time the child is 2.5 years old	0.0%	2.3%	8.2%	75.4%	72.3%	78.2%	65.5%	71.2%	83.3%	95.3%	89.7%	93.0%	88.4%	98.1%	95.4%	96.6%	96.1%	Working to deliver HDFT Impact for all frontline teams in Cumberland and Westmoreland and Furness by COP Q2. Working to embed HDFT standard processes into South Tyneside.		
Great start in Life Improve outcomes by identifying children by ensuring we achieve >90% for all mandated contracts	Zero mandated contacts in all our contract areas breaching business rules	2	2	2		1	1																																																	
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Workstreams	True North Metric	Vision	Goal	Current State	Countermeasures	Level of Risk To Achieving Goal (CxL)	Level of Risk for progressing actions
				Goal 2: Watch Metrics will report and include the outcomes of the GSIL Pathway linked to High Impact Areas. June data – Power BI Reporting dashboard created and in final stages of testing.			
Hope for Healthcare 	Children's Patient Experience	Improve experience of care by considering elements that matter most to children & young people so we can measure their experience of care and shape services according to their specific needs	Goal 1: Engage with children and young people with lived experience across HDFT geography to consult with on our CYP Strategy which will for part of the Clinical Strategy Goal 2: CYP Patient Experience Tool Developed-Return rate significantly low - distribution, engagement, and accesses to the tool to be developed with CYP and approach embedded with teams and professionals working with CYP.	The Trust North Metric of improving Children's Patient Experience continues into its second year (2025-26). Target return rate 10% - delivery for the previous months; May 10% June 9% July 8% August 10% Active Countermeasures are noted. - New learning best practice workstream established footprint-wide to drive increase in CYP survey returns using best practice examples from every contract area. - Standard work completed to transfer paper surveys to digital dashboards. Overall how was your experience?  Watch Metrics:	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 with digital options available. - 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.		

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

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																														
	10% increase in participants from threshold in 2025, 5 new approaches for research participation in year.	The overarching ambition is to provide services that meet the needs of the children, young people and their families and caregivers 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.	• Create a research active culture, where staff have the opportunity to be research active, 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 • Post Natal Contraception Training: Durham County Council PH Team – at drafting proposal for funding stage with HDFT as partner In discussion: • Represent Study NIHR 302504 • NCMP Impact study NIHR 207678 In delivery: We now have 14 participants accrued into 2 active research projects. This is an increase by 3 compared to last month. There is one new approach of a research project involvement. • Coastal/Care Integrated Responses & Children's Lived Experience (CIRCLE by the sea) NIHR 162162 – 2 participants • Escalator (ELIM -1) NIHR 20705 – 8 participants • 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 • Survey: BrainBITE survey participation opportunity to be circulated from Sheffield Children’s Hopsital on behalf of 0-19 Research Network (Y&H)  •	<table><tr><th>Concern</th><th>Cause</th><th>Countermeasure</th><th>Owner</th><th>Due Date</th></tr><tr><td>We don't currently understand the barriers to engaging in research activity</td><td>No process or pathway for review of research offers</td><td>Create a process and pathway all research offers across the children and young people's environment</td><td>26.8.CS</td><td>Sept 2026</td></tr><tr><td>Current environment does not support research activity</td><td> • No process or pathway for review of research offers • Lack of clarity on skill sets, resources and capacity </td><td> Establish working group across the 12 teams within the directorate and R&I teams to understand: • Capacity • Skills sets • Resources • Governance Benchmark directorate for research readiness using NHS England's SCRT tool </td><td>26.8.CS</td><td>July 2026</td></tr><tr><td>We don't know what research is currently underway</td><td>Research offers occur across the directorate and there is no specific group looking at the offers systematically</td><td>Establish a research working group with representation from teams across the directorate, research lead in the trust and representation from R&I Team</td><td>26/CS</td><td>May 2025</td></tr><tr><td>We do not know the training needs and current research skills our team have</td><td>We do not review research interest and skills</td><td> Complete a research training audit for staff across the directorate. • Review themes from appraisal discussions • Create a monitoring dashboard for completion of Good Clinical Practice • NHS Future Cerebral Thinking Training • Principal investigator training </td><td>26/CS</td><td>June 2026</td></tr><tr><td>We do not have a way of monitoring completion of training in research and critical thinking</td><td>It is not currently available on Learning Lab - therefore difficult to monitor</td><td>Work with R&I Team to add to Learning Lab</td><td>R&I Team</td><td>June 2026</td></tr></table> To be updated at CYP PH Research Working Group on 10 August 2026. The A3 remains unchanged	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 offers	Create a process and pathway all research offers across the children and young people's environment	26.8.CS	Sept 2026	Current environment does not support research activity	• No process or pathway for review of research offers • Lack of clarity on skill sets, resources and capacity	Establish working group across the 12 teams within the directorate and R&I teams to understand: • Capacity • Skills sets • Resources • Governance Benchmark directorate for research readiness using NHS England's SCRT tool	26.8.CS	July 2026	We don't know what research is currently underway	Research offers occur across the directorate and there is no specific group looking at the offers systematically	Establish a research working group with representation from teams across the directorate, research lead in the trust and representation from R&I Team	26/CS	May 2025	We do not know the training needs and current research skills our team have	We do not review research interest and skills	Complete a research training audit for staff across the directorate. • Review themes from appraisal discussions • Create a monitoring dashboard for completion of Good Clinical Practice • NHS Future Cerebral Thinking Training • Principal investigator training	26/CS	June 2026	We do not have a way of monitoring completion of training in research and critical thinking	It is not currently available on Learning Lab - therefore difficult to monitor	Work with R&I Team to add to Learning Lab	R&I Team	June 2026		
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Related Corporate Risks:

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 4 = 15	3 x 3 = 9 March 2025 March 2026 December 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					



September 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) Dawn Edmundson (Head of Midwifery) Andrew Brown (Lead Midwife for Safety, Quality & Clinical Governance)

Purpose of the report	Approval		
	Assurance	x	
	Discussion	x	
	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 August 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 August 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 August. Ongoing monitoring required for maternity diverts, induction delays and operational pressures impacting ward acuity
Workforce		Midwifery and neonatal establishments fully recruited. NHSP usage continues to reduce significantly. Training compliance concerns remain within some professional groups.
Quality		Good progress with MIS, Saving Babies Lives and Maternity Care Bundle implementation. Further work required on triage standards and training compliance.
Patient Experience		Strong positive feedback and low complaint volume. Recurring concerns remain regarding communication, induction delays and postnatal experience.
Governance		Robust oversight through Safety Champions, Quality Committee and Board reporting. Amos and Ockenden actions actively monitored.

Overall assurance level:

Maternity and neonatal services remain safe, with stable staffing, strong governance processes, no reported moderate harm incidents in August and continued progress against

national safety programmes. Ongoing Board oversight is required in relation to maternity diverts, induction delays, training compliance, and maternity triage service development.

Narrative in support of the Provider Board Level Measures

August 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. All locum shifts have been covered either by internal workforce or doctors who have previously worked within the maternity service within the last five years, fully compliant with Maternity Incentive Scheme requirement for all locums.

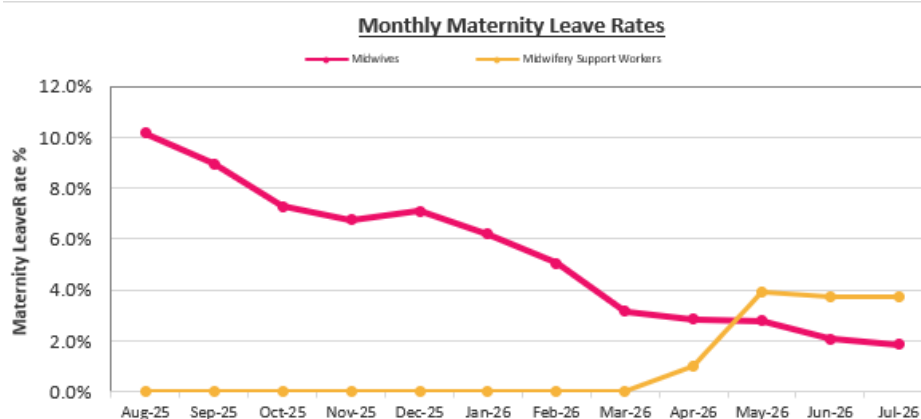
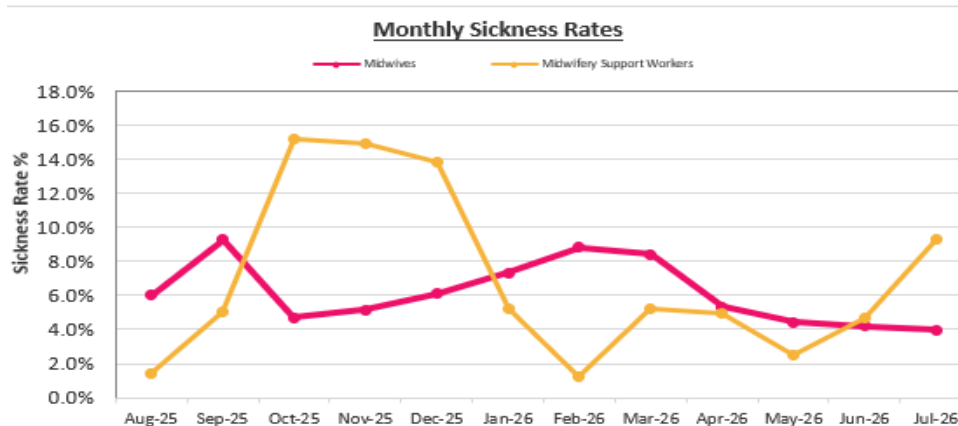
A clinical teaching fellow and a locally employed doctor (LED) have been recruited. Recruitment is ongoing for the one remaining LED post.

3) Midwifery safe staffing, vacancies and recruitment update

a) Absence position

Total sickness absence in August reduced slightly this month for midwifery at 3.96 WTE, and maternity support workers absence at 1.27WTE. The main cause of absence for midwives relates to stress with this remaining fairly stable at 1.58WTE.

1.97 WTE midwives and 0.67 WTE support workers are on maternity leave at present. The monthly sickness and maternity leave percentages and trend can be seen below up to July.



b) Vacancy position

There is no midwifery vacancy at present however recruitment is commencing for 1.8 WTE midwives due to people leaving in the coming months.

The National Midwifery Graduate support offer allows Midwifery units to request additional funding to support uplift from current band 3 MSW's to band 5 Midwives. A fixed amount of £10,000 per 1WTE is given to enable Trusts to recruit newly qualified midwives (NQM), to support recruitment above current funded establishment. In July, a bid to recruit 1.5WTE NQM was submitted to the national team which was accepted therefore an additional 1.5 WTE Band 5 midwifery post will also be going out to advert shortly.

There is currently a 1.9 WTE maternity support worker vacancy, which is out to recruitment.

c) NHSP provision

Midwives – There continues to be a sustained decrease in the requirement for NHSP cover improving from 1346 in August 2024 and 1053 hours in August 2025, to 586 hours in August 2026. This is a reduction of 760 hours a month (4.68WTE) since 2024. Bank fill shifts has been excellent this month demonstrating the dedication of the staff to cover the maternity services.



Maternity Support workers – This month has seen an increase in demand for maternity support workers however this remains a consistent sustained reduction in year on year NHSP usage. Demand in August 2023 was 959 hours, in August 2024 it was 1153 hours and in August 2025 it was 1016. Demand in August 2026 was 502 hours, a reduction of 512 (3.15 WTE) since last year. Fill of shifts available remains high.



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

a. Neonatal absence position

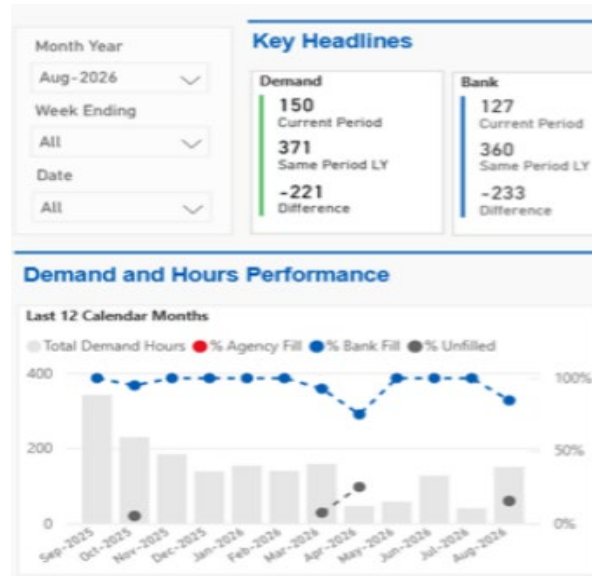
There was 2.55 WTE neonatal nurse sickness absence during August 2026. 1.43 WTE QIS nurses and 0.73 WTE Clinical support worker are currently on maternity leave.

b. Neonatal Vacancy

Special Care Baby unit is fully recruited.

c. NHSP Provision

This month has seen an increase in demand for neonatal nurses. Demand in August 2026 was however 221 hours less than in August 2025 at 150 hours. Fill of shifts available remains high thanks to the dedicated team picking up NHSP shifts to ensure that SCBU is covered.

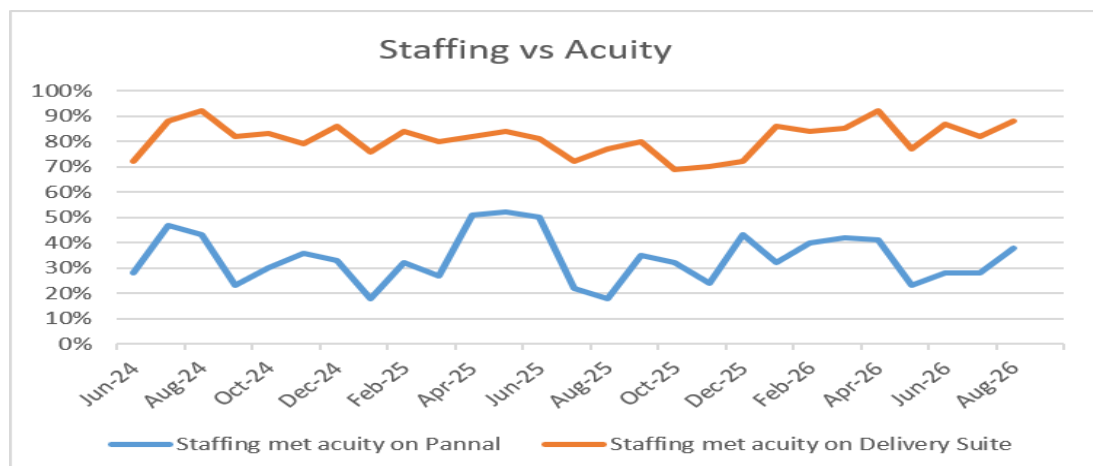


d. Qualified in Speciality (QIS) Nurses

To meet British Association Perinatal Medicine (BAPM) standards 70% of the budget establishment is required to be QIS nurses. The Operational Delivery Network (ODN) state that the QIS compliance is based on staff in post excluding any vacancy. One nurse has recently passed her QIS training, unfortunately she is currently unable to consolidate her learning due to being on sickness absence. Two nurses are on a pathway to complete their QIS qualification. Therefore, the QIS compliance for August remains unchanged at 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. Staffing matched acuity requirements considerably more often within Delivery Suite than Pannal throughout the reporting period. Delivery Suite consistently achieved between 70% and 90% compliance, whereas Pannal remained predominantly between 20% and 40%. Point 5b explores this further.



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 August. 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 88% of the time, was up to 1.5 midwives short 11% of the time and the service was over 1.5 midwives short 2% of the time (3 occasions).

b. Pannal Ward Staffing and impact on clinical workload

According to the data capture in the Birthrate plus acuity tool, 38% of the time staffing met acuity on Pannal with an 75% compliance with data capture. A deeper dive into the data demonstrates that the ward staffing was as follows across the 124 opportunities for data capture.

Staffing position	Number of occasions	Percentage	Trajectory
1-2 staff over acuity requirement	2	1%	
Up to one staff over acuity requirements	32	25%	
Up to one staff below acuity requirement	37	30%	
1-2 staff below acuity requirement	20	16%	
Over two staff below acuity requirement	1	1%	
Data not captured	31	25%	

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 August there was a total of 67 hours recorded as having been worked clinically by team leaders and specialist midwives on an ad hoc basis. 39.5 of these hours were on Pannal Ward, 8 hours were on Delivery Suite, 2.5 hours were in Maternity Assessment Centre, 9.5 hours were in Antenatal Clinic/Antenatal Day Unit.

6) Homebirth provision

Home birth provision is covered by community midwives working clinically during 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. From the 19/10/2026 all midwives will be rostered 08.30-16.30 or 08:30-17:30. This will streamline the roster as all midwives will start at the same time. It will also allow better flexibility within the roster, allow a rest period on working days for the on-call team and rostered shifts on Delivery Suite to maintain intrapartum skills.

In August 2026 the home birth on call provision was available every night except one occasion.

Two homebirths were booked for the month of August, both of these women successfully birthed at home.

7) Red Flag Events Recorded on Birthrate Plus

a. Delivery Suite Red Flags

There was five Red Flag events noted on Birthrate plus in August on Delivery Suite. Four of these events occurred concurrently with the unit being placed on divert and related to;

- Delayed or cancelled time critical activity,
- Missed or delayed care

- An occasion when a midwife is not able to provide 1:1 care to a woman in established labour. Short term sickness was a factor in this event and staff were redeployed from Pannal to resolve the issue.

The additional red flag event was a delayed time critical activity where again short-term sickness was a relevant factor.

b. Pannal Ward Red Flags

There were three Red Flags recorded on Birthrate Plus on Pannal during August, this is a decrease from the data provided in July. One was a delay between admissions to the ward and beginning the induction of labour process and two were related to delayed or cancelled time critical activity.

c. Elective Caesarean Sections (LSCS)

There were 15 elective caesarean section lists scheduled during August, inclusive of two additional list which was required to support demand, with 36 caesareans performed. Due to the high demand an additional six elective LSCS were performed on Delivery Suite during August.

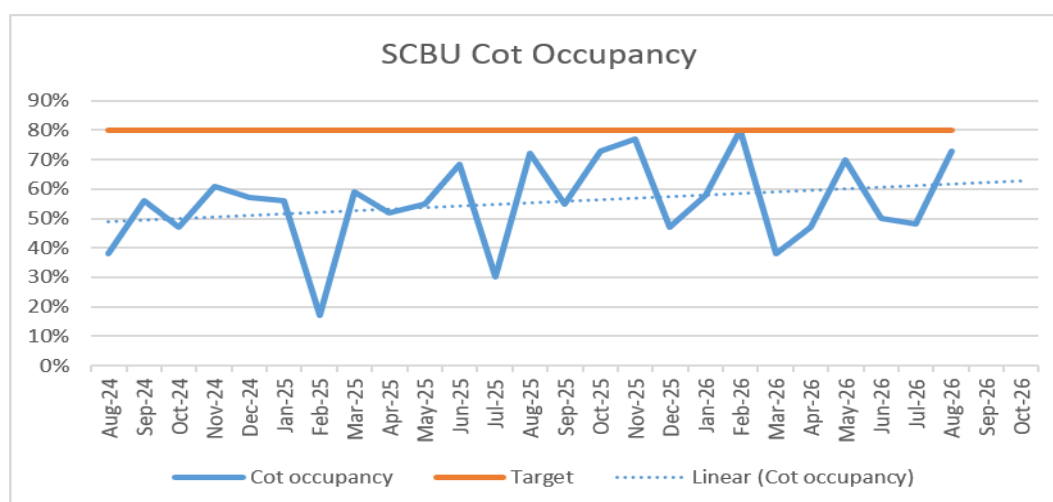
d. Delayed Induction of Labour (IOL)

During August there were 14 episodes of delayed induction of labour over 24 hours;

- two were delays greater than 24 hours in admission to commence IOL,
- eight 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).
- four occurrences were a delay greater than 24 hours in transfer for ARM, following administration of prostaglandins/CRB

8) SCBU Cot Occupancy

SCBU cot occupancy appears to be returning to a trend just below 60% (last 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. August cot occupancy was 73%. Ideally occupancy should remain between 50% and 80%.



In August five babies were transferred out to tertiary units for clinical reasons. Fourteen 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 01/09/26)

Department	Assignment Count	Percentage Compliant
421 Level 4 Ante Natal Clinic	13	88%
421 Level 4 Community Midwifery	19	81%
421 Level 4 Early Pregnancy Assessment Unit	4	88%
421 Level 4 Maternity Staffing	62	89%
421 Level 4 Obs & Gynae - Medical Staffing	26	75%
421 Level 4 Pannal Ward	30	87%

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

As identified in MIS year 8, a minimum of 90% compliance must be achieved for every required staff group for the above listed training at two points during MIS year 8 (April – Nov 2026). The mid-point checkpoint previously agreed at HDFT was 31st July 2026, compliance was achieved as detailed below.

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)	85	69	81%	15	8	53%	10	8	80%
Resuscitation Level 3 - Newborn Intermediate Life Support (HNILS)	103	102	99%						
RCUK Newborn Life Support	20	19	95%						
Resuscitation - Level 3 - Adult Immediate Life Support (RCUK eILS) - (CSTF)	18	12	67%						
Maternity Specific Courses									
Fetal Wellbeing Competency Assessment	101	101	100%	15	15	100%	5	5	100%
MAT - Birthing Pool Hoist	93	83	89%						
MAT - Growth Assessment Protocol (GAP)	103	92	89%	12	10	83%	5	4	80%
MAT – Maternity Training Day 2	101	101	100%	15	15	100%	5	5	100%
MAT - Saving Babies Lives	103	76	74%	15	10	67%	5	3	60%
MAT 3 - Personalised Care & Care in Labour	101	99	98%						
MAT-PROMPT - Emergency Skills Facilitator Led	103	102	99%	15	15	100%	9	9	100%
Mandatory Training - Safeguarding									
Safeguarding Adults	103	99	96%	15	13	87%	10	9	90%
Safeguarding Children	103	99	96%	15	3	20%	10	2	20%

Course Name	Anaesthetic s Consultants			Anaesthetic s (Other Staff)			Paediatric Consultants			Paediatric Medical (Other Staff)			Maternity Support Worker			SCBU		
Resuscitation Courses	N o. R eq ui re d	N o. C er tif ie d	C o m pl ia n ce	N o. R eq ui re d	N o. C er tif ie d	C o m pl ia n ce	N o. R eq ui re d	N o. C er tif ie d	C o m pl ia n ce	N o. R eq ui re d	N o. C er tif ie d	C o m pl ia n ce	N o. R eq ui re d	N o. C er tif ie d	C o m pl ia n ce	N o. R eq ui re d	N o. C er tif ie d	C o m pl ia n ce
Resuscitation - Level 2 - Adult Basic Life Support (CSTF)							17	12	71%	10	7	70%	20	16	80%	14	12	86%
RCUK Newborn Life Support							17	7	100%	5	3	60%				11	1	100%
Maternity Specific Courses																		
MAT - Birthing Pool Hoist													15	14	93%			
MAT- PROMPT - Emergency Skills Facilitator Led	12	12	100%	12	11	92%							20	20	100%			
Mandatory Training - Safeguarding																		
Safeguarding Adults	12	11	92%	12	9	75%	17	6	94%	11	6	55%	20	9	95%	14	14	100%
Safeguarding Children	12	10	83%	12	0	0%	17	4	82%	11	7	64%	20	9	95%	14	3	93%

Work is ongoing to create an SPC chart of training compliance over time. It should however be noted that the required staff groups have been changed mid-year which has moved Obstetric Speciality Doctors into the Consultant category, to be in-line with updated Maternity Incentive Scheme requirements.

In August training compliance is shown below.

Safeguarding Children Level 3 compliance is of concern - All obstetric staff have been booked onto training so compliance should improve over the coming months.

PROMPT - all new rotational doctors appear as out of date however all have been booked to complete their training in the coming months.

Adult Resuscitation Level 3 training compliance is also of concern however all staff requiring an update have been booked between now and December.

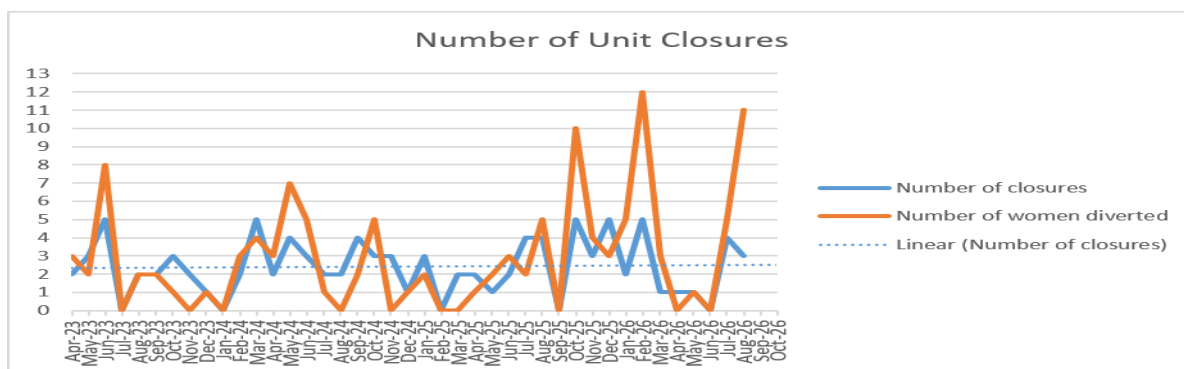
Course Name	Midwives			Obs&Gynae Consultants & SAS (Consultants & Specialty Doctors)			Obs&Gynae (Other Staff)			Maternity Support Worker		
				Consu ltant			Specialty Registrar					
				Speci alty Docto r			Trust Grade Doctor or Dentist - Specialty Registrar					
							Foundati on Year 2					
Resuscitation Courses	No. Requ ired	No. Certi fied	Co mpl ianc e	No. Requi red	No. Certi fied	Co mpl ianc e	No. Required	No. Certifie d	Co mpl ianc e	No. Requ ired	No. Certi fied	Co mpl ianc e
Resuscitation - Level 2 - Adult Basic Life Support (CSTF)	80	68	85%	15	9	60%	13	8	62%	18	15	83%
Resuscitation Level 3 - Newborn Intermediate Life Support (HNILS)/Resuscitation - Level 4 - Newborn Advanced Life Support	98	97	99%									
RCUK Newborn Life Support	21	19	90%									
Resuscitation - Level 3 - Adult Immediate Life Support (RCUK eILS) - (CSTF)	19	10	53%									
Maternity Specific Courses												
Fetal Wellbeing Competency Assessment	97	96	99%	15	15	100%	4	4	100%			
MAT - Birthing Pool Hoist	89	80	90%							15	14	93%
MAT - Growth Assessment Protocol (GAP)	99	89	90%	12	9	75%	5	3	60%			
MAT – Maternity Training Day 2	97	96	99%	15	15	100%	5	5	100%			
MAT - Saving Babies Lives	99	79	80%	15	11	73%	5	3	60%			
MAT - Saving Babies Lives - Smoking Cessation										18	10	56%
MAT 3 - Personalised Care & Care in Labour	96	94	98%									
MAT-PROMPT - Emergency Skills Facilitator Led	99	98	99%	15	15	100%	12	6	50%	18	18	100%
Mandatory Training - Safeguarding												
Safeguarding Adults	99	91	92%	15	12	80%	13	7	54%	18	17	94%
Safeguarding Children	99	96	97%	15	2	13%	13	2	15%	18	17	94%

Course Name	Anaesthetics Consultants			Anaesthetics (Other Staff)			Paediatric Consultants			Paediatric Medical(Other Staff)			SCBU		
	Con sult ant			Speci alty Doct or			Con sult ant			Speci alty Registr ar					
				Speci alty Regis trar			Spe cial ty Doc tor			Trust Grade Doctor or Dentist - Specialty Registrar					
				Speci alist											
Resuscitation Courses	No. Req uire d	No. Cer tifi ed	Co mp lia nce	No. Req uire d	No. Cer tifi ed	Co mp lia nce	No. Req uire d	No. Cer tifi ed	Co mp lia nce	No. Req uire d	No. Cer tifi ed	Co mp lia nce	No. Req uire d	No. Cer tifi ed	Co mp lia nce
Resuscitation - Level 2 - Adult Basic Life Support (CSTF)							16	11	69 %	9	6	67 %	14	12	86 %
Resuscitation Level 3 - Newborn Intermediate Life Support (HNILS)/Resuscitation - Level 4 - Newborn Advanced Life Support							16	16	100 %	9	8	89 %	14	13	93 %
RCUK Newborn Life Support							16	16	100 %	5	3	60 %	11	11	100 %
Maternity Specific Courses															
MAT-PROMPT - Emergency Skills Facilitator Led	23	22	96 %	12	11	92 %									
Mandatory Training - Safeguarding															
Safeguarding Adults	23	20	87 %	12	10	83 %	16	15	94 %	9	5	56 %	14	14	100 %
Safeguarding Children	23	21	91 %	12	11	92 %	16	14	88 %	9	6	67 %	14	13	93 %

10. Risk and Safety

a. Maternity Unit Divert

During the month of August there have been three incidents of suspension of maternity services, with eleven women being diverted to neighbouring maternity units. This reflects the increased demand during August, close monitoring and reviews of all diverts continue to be facilitated.



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 West Yorkshire. During the month of August four women were transferred to Harrogate and District NHS Foundation Trust (HDFT) maternity service for care from elsewhere in the region.

c. SCBU Incidents

No moderate harm incidents have occurred in August. SCBU has seen a period of time at OPEL 4 and additional staffing was established to sustain this increased demand.

Further to the letter from the Yorkshire and Humber Neonatal Operational Delivery Network (ODN) Clinical Lead in January 2026 stating that as a Neonatal ODN they are concerned regarding the ability of the permanent members of paediatric medical staff across the region 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	Jul 26	Aug 26
Number of Neonatal Intubations	1	4	1	0	1	1	1	2	1	2 – Both completed by Embrace

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

Risk Register formally reviewed in August 2026. The next formal review will take place in November. Three risks were archived at the review in August.

There are 13 currently active risks on the risk register;

- **Risk to patient experience and safety and breach of triage timescales due to delays in Obstetric review in Maternity Assessment Centre (Score 8).** Audits ongoing, and many breaches identified through data are actually not true breaches but reflection of incomplete documentation of fields. Some true breaches persist, commonly relating to inability to obtain timely obstetric review. Plan for additional obstetric staff to be resident on MAC but currently not possible within the staffing available.
- **Risk to patient satisfaction, safety and staff morale due to inability to provide gold standard level of care (Score 8).** Staff morale issues remain. No change to risk score. IT issues persist but have been reviewed by Digital Midwives but for further work.
- **Risk to patient satisfaction and safety, resulting from delays in facilitating induction of labour (IOL) (Score 8).** Peaks and troughs in delayed induction. Not a weekly

occurrence now and some improvement but delays remain ongoing. Balloon catheter outpatient inductions not fully embedded.

- **Risk to safe monitoring and management of Perinatal Mental Health due to insufficient clinic capacity for PNMH appointments (Score 6).** No recent issues noted. Risk score downgraded.
- **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. To review requirements to support linking of Badgernet with NerveCentre.
- **Risk to patient satisfaction and safety, resulting from delays in facilitating ultrasound growth scans (USS) (Score 6).** Challenges with sonography staff availability and aware of staff member leaving which will bring additional capacity challenges.
- **Risk to operational running and governance surrounding safety and quality of homebirth service (Score 6).** Work ongoing. Plan for rotation of community midwives into unit for increased exposure to intrapartum care.
- **Risk to patient safety and experience associated with need to divert patients to other units in times of escalation (Score 6).** No recent incidents about safety of patient clinical condition at point of divert. Risk to remain the same until diverts reduced.
- **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. Interviews taking place for Business Improvement Manager to support.
- **Risk due to inability to meet gold standard requirements for clinical documentation (Score 5).** Multiple areas where limited staff time results in inability to complete required documentation. Multifactorial cause including having to switch between forms, EPR system issues, as well as significant amount of non-essential documentation. Audits showing non-compliance with documentation in bed-state, BSOTS. Ongoing training for staff, but restrictions in necessary time and unable to meet gold standard. Requests for change have been made to system suppliers. Limited ability to make local changes.
- **Risk to Information Governance and breach of confidentiality resulting from lack of training in redaction of patient record requests (Score 4).** SOP now in place Trustwide. No recent concerns identified relating to redaction. Frequency downgraded.
- **Risk to reputation and patient experience due to possible discontinuation of Maternal and Neonatal Voices Partnership (MNVP)(Score 4).** Some discussions have been undertaken and draft plan in place to maintain MNVP. Downgrade likelihood of risk until plan finalised and then consider closure.
- **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 3).** Work ongoing regionally. Not recurrent problem. No further updates of Yorkshire and Humber Care Record (YHCR). No local control. Frequency downgraded as no recent related issues.

11. Maternity Incidents

In August 2026 there were 104 total incidents reported through DCIQ (including 11 incidents occurring in SCBU location, four in Main Theatres and one in Early Pregnancy Unit (EPAU)).

There were no incidents of Moderate Harm or above reported.

RROSE review completed for Intrapartum Stillbirth. There was considered to be no causative lapse in clinical care. Learning noted relating to storage and transfer of placenta.

Additional incidents of note –

- Three incidents of readmission of mothers one with wound infection, one with mastitis; one feeling unwell.
- Two incidents of an impacted fetal head.
- Two incidents of in utero transfer due to prematurity.
- One off pathway birth of a baby less than 32 weeks born in Harrogate.

12. Perinatal Mortality Review Tool (PMRT)

Fetal loss at 22+ weeks in May 2026 following attendance with bleeding and inevitable miscarriage. Threshold of viability and comfort care undertaken on advice of Neonatologist. PMRT to be arranged. No care issues identified. Sadly, the Bereavement room was already in use but positive feedback from family about care. PMRT arranged for 30th Sept 2026.

Neonatal death at 23+ weeks in July 2026 following attendance with bleeding and progress in labour. RROSE review completed and care appropriate. PMRT to be arranged.

Neonatal death in May 2026 following an unexplained collapse at home. MNSI and Coroner notified and investigation ongoing. PMRT arranged for 30th Sept 2026, though will be incomplete in absence of postmortem findings.

13. Feedback

a. Maternity Feedback

i. Positive Feedback

Lots of positive feedback received with families consistently praising the kindness, professionalism and support provided by maternity staff.

Key themes included:

- Compassionate and personalised care during labour, birth and postnatal care.
- Excellent emotional support for women and birth partners.
- Calm and reassuring communication during unexpected or complex situations.
- Positive experiences within theatre and following emergency interventions.
- Staff going above and beyond to ensure women felt safe, informed and cared for.
- Positive support and supervision provided to student midwives.
- Several individual staff members receiving specific recognition from families for exceptional care.

ii. Negative Feedback

The main themes identified through concerns and complaints were:

- Communication and information sharing
- Inclusivity
- Access to services
- Postnatal and inpatient experience

Actions taken:

- Apologies were provided to all women and families who raised concerns, either through face-to-face discussions or written responses.

- Formal complaints received through PALS and the Trust complaints process were responded to.
- Feedback and learning points were shared with relevant ward managers, team leaders and staff members for reflection and learning.
- Positive feedback was shared with individual staff members, and plans in place to share with the multidisciplinary teams to recognise good practice.
- Concerns regarding communication, induction of labour, responsiveness to concerns, inclusivity for same-sex couples, medication communication, and postnatal experience have been escalated to the appropriate service leads for review.

b. SCBU Feedback

Some feedback which we have received this month, highlights the excellent care which was received by the family despite the high activity.

To all Staff at Harrogate SCBU,

When we walked through the door with Theodore (Teddy) we both didn't know what to expect. We had a tricky pregnancy coupled with an unexpected early arrival and we were both shellshocked from the experience. However, what welcomed us into the unit was the most empathetic, caring, and competent team we have both had the pleasure of coming across.

Every person in the department has made us feel completely at ease from the moment we walked through the door, and it made it so incredibly easy (in a very difficult moment) to place the care of our little boy into other people's hands.

You have all been unfathomably busy throughout our time in the unit, but you always find time to answer any and all questions all of the parents throw at you, never losing your patience. You are all angels, you are all THE BEST of us.

Our entire experience has been positive, however there are two things I wanted to highlight that we are particularly grateful for. Firstly, the genuine care and support shown to Rebecca during periods where she couldn't see the light at the end of the tunnel. And secondly, the way you frequently welcomed Daisy and made her feel at home, that has had a huge impact on her understanding and acceptance of the situation.

c. Maternity and Neonatal Voice Partnership Feedback

There was limited progress against the MNVP action plan during August due to a pause in MNVP provision over the school summer holidays. Plans are in place to re-establish regular engagement activity during September.

14) Complaints, concerns, compliments

Four concerns/complaints were received in July. Two of these complaints has been responded to and closed and two remain under investigation at the end of August. Three complaints and two concerns were received in August, Both concerns have been responded to and the complaint responses remain on-going.

A thematic report regarding complaints received so far this year can be found in Appendix B.

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, MNSI or the CQC during August.

17. Maternity and Newborn Safety Investigation (MNSI)

In August 2026 there is one new MNSI case. This relates to an intrauterine death at 38+ weeks, meeting the defined criteria of Intrapartum Stillbirth. Sadly, there was no fetal heartbeat on arrival at the hospital. MNSI have accepted the case for investigation. RROSE review found no lapse in clinical care.

Additional ongoing MNSI investigation in relation to the neonatal death highlighted above. Coroner has been notified and a post-mortem has been completed, awaiting findings.

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/Ockenden Review

Following the publication of Baroness Amos' independent investigation into maternity and neonatal services in England and Donna Ockenden's independent review of maternity services at the Nottingham University Hospitals NHS Trust in the summer NHS England wrote to all Trusts on 12th August 2026 requesting that Trusts submit a standardised national reporting template to their NHS England region at two points:

Baseline assessment: 25 September 2026

Progress update: 31 December 2026

Both submissions must be approved by the trust board. Boards should provide visible ownership and scrutiny of delivery, ensuring actions are progressing at pace, risks are managed appropriately and any significant concerns are escalated through ICB and regional routes.

The baseline assessment demonstrates compliance across the majority of standards (19 out of 26), with key areas requiring further development including;

- implementation of Martha's Rule,
- evidence of changes to board-level accountability arrangements,
- further investment required into maternity triage services to enable compliance with 24-hour service provision, workforce, equity in access and patient experience.

Plans are in place to submit this as required with approval from Trust Board.

Part of this assessment also includes benchmarking the Maternity Triage services against the National Specification. The review demonstrates a number of areas of strong practice, including access arrangements, governance structures, risk management and clinical pathways.

The assessment identifies significant opportunities for improvement in maternity triage workforce provision, dedicated telephone triage services, estates and infrastructure, service user engagement, data collection and performance measurement. The estimated investment required to achieve full specification compliance is approximately £1.3 million.

Key workforce requirements include additional midwifery and medical staffing to support a dedicated 24/7 maternity triage service and telephone triage provision.

An action plan in relation to the ten-point plan can be found at Appendix C.

b. Maternity Care Bundle (MCB)

Work is progressing to ensure all services are in place in line with the requirements by the end March 2027. Working groups for each of the five elements are supporting the implementation of the required changes to ensure compliance is reached. Concerns have been raised nationally about whether Badgernet will be updated in a timely way to enable compliance, for example to enable self-assessment at booking against venous thromboembolism risk factors and mental wellbeing questions. This has been raised nationally in Digital Midwifery forums with the system supplier System-C.

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 quarterly report is included at Appendix D.

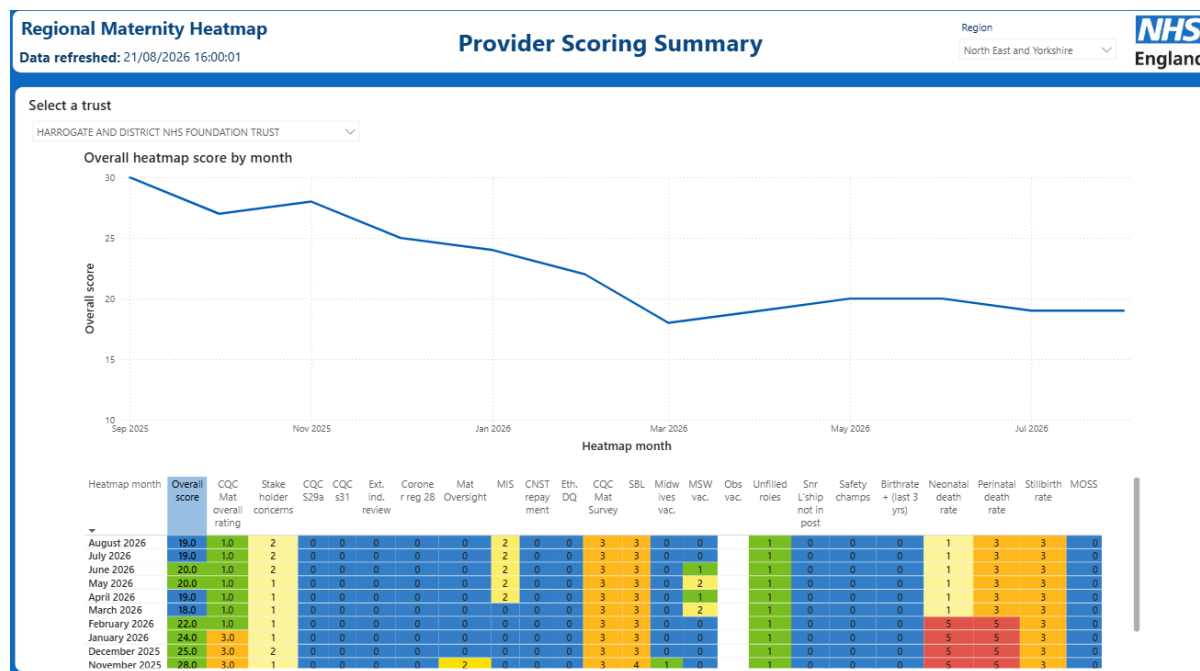
e. NHS England - Actions to improve care for women, babies and families: next steps <https://www.england.nhs.uk/long-read/actions-improve-care-women-babies-families-next-steps/>

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 (PEADP):** 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 heatmap 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. Please see below screenshot taken from the Regional Heatmap system. HDFT are currently scoring 19. This has reduced from a score of 20 in June, due to an updated MSW vacancy rate.



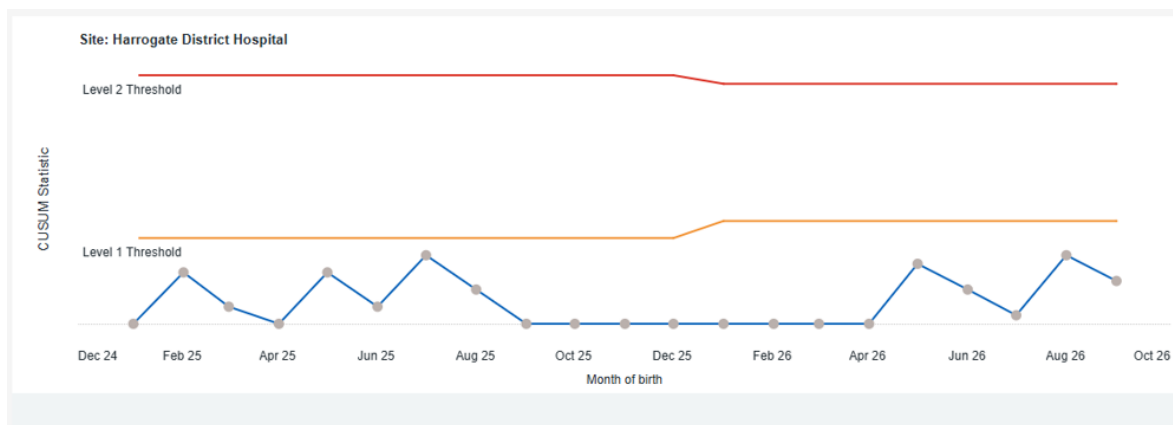
(2) Maternity and Neonatal Equalities Dashboard

A Maternity and Neonatal Equalities Dashboard can be accessed here [link](#). The dashboard is updated bi-annually and therefore shows data from December 2025 and 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.





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. AT the time of writing the report both the National and Local dashboard were unavailable therefore the report will be updated once the data becomes available.

22. Avoiding Term Admissions in Neonatal Units (ATAIN)

Review of Badgernet Neonatal EPR system indicates that there were eight Term Admissions to SCBU recorded in August. All will be reviewed at ATAIN meeting:

- One baby admitted with Respiratory Distress
- One baby admitted with Feeding/weight loss issues
- One baby admitted for Jaundice
- Two babies admitted for monitoring
- One baby admitted with Gastro-Intestinal disorder
- One baby admitted with Infection
- One baby admitted with Hypoglycaemia

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	30/9/2026
Lack of handover of clinical documentation for patient transferred from neighbouring unit	For agreement of SOP and regional agreement	30/9/2026
Hypoglycaemia policy not followed by paediatric staff	For sharing of learning as case study	30/9/2026
Babies recently off vapotherm not having additional oxygen saturations	For additional to SCBU handover and communication to Pannal Ward staff	30/9/2026
Lack of clarity about management of raised haematocrit	For additional guideline for SCBU	31/10/2026
Maternal and neonatal hyponatraemia	For additional guidance and patient information resources about fluid intake	30/09/2026

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 20th July 2026. The Executive Safety Champion (Breeda Columb) and Non-exec Safety Champion (Andy Alldred) completed the walkabout. During the walkaround no concerns were raised by staff, however one of the ward clerks informed the team that there had been a recent delay in the confidential waste being collected, this issue has now been resolved. It was also highlighted that the buzzer for the intercom is quiet and sometimes there was an issue identifying and hearing the visitors at the door; a new intercom system has now been installed, and the issue has been resolved.

The next walkaround is scheduled for 21st September 2026.

23. Conclusion and Recommendations

a) Positive news

- No moderate harm, severe harm or neonatal moderate harm incidents reported during August 2026.
- Midwifery and neonatal nursing establishments remain fully recruited.
- Significant reductions in NHSP usage continue, reducing reliance on temporary staffing and demonstrating workforce stability.
- Strong neonatal family feedback received despite periods of high operational pressure.

b) Areas of concern

- Three maternity unit diverts occurred in August, with eleven women redirected to neighbouring services.
- Fourteen delays to induction of labour over 24 hours continue to impact patient experience and remain a recurrent risk register issue.
- Safeguarding Children Level 3 compliance remains significantly below expected levels in some medical staff groups.
- Complaints analysis identifies recurring themes of communication, personalised care, responsiveness and postnatal support.
- The Maternity Triage review identified significant workforce and infrastructure gaps requiring approximately £1.3 million investment to achieve compliance with the national specification.

c) Work underway

- Ongoing implementation of the Maternity Care Bundle ahead of the March 2027 deadline.
- Delivery of the Baroness Amos and Ockenden national actions, including strengthened Board accountability arrangements.
- Development of an action plan following benchmarking against the National Maternity Triage Specification.
- Work with NHS England and regional partners regarding implementation of Martha's Rule.
- Continued improvement programme around induction of labour delays including implementation of balloon catheter pathways and patient flow roles.
- Actions underway to improve training compliance in safeguarding, adult life support and PROMPT training.
- Ongoing work to sustain MNVP arrangements and strengthen service user engagement.

d) Decisions required of Board/Board oversight

- Appendices – Themes of Complaints, 10-point Action Plan, Saving Babies Lives implementation report.
- On-going implementation of the Amos/Ockenden action plan, including strengthened Board accountability arrangements.
- National Maternity Triage Specification gap analysis.

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/>

Maternity Complaints and Concerns Report

2026

Prepared by Andy Brown, Lead Midwife for Safety, Quality & Clinical Governance

1. INTRODUCTION

As part of work to improve the quality of maternity care at Harrogate & District NHS Foundation Trust, work has been undertaken to provide an analysis of recent complaints and concerns received by Maternity Services. This work has also served to support compliance with the recommendations of the Ockenden report, and to provide assurance of appropriate oversight and triangulation of common themes to direct recommendations for quality and safety improvement.

2. AIMS

The aim of this report is to identify both historic and current areas of concern expressed by women receiving maternity care at HDFT. This will serve to provide evidence to focus areas of improvement within the service, with a view to improving patient experience, quality and safety.

3. OBJECTIVES

- Review historical complaints and concerns to determine normal levels of concerns received in order to view trends and allow monitoring of deviations from the norm
- Determine whether there are specific locations or areas of maternity care which are susceptible to poor patient experience
- Determine any common themes or trends of complaints and concerns for focused improvements
- Determine compliance with timeframe for response
- Provide assurance to the Board, CQC, Ockenden and other internal and external governance groups of ongoing work to improve the quality and safety of maternity services
- To drive improvements in quality of care at HDFT

4. METHODOLOGY

a. Sample Selection

This report has been compiled through review of all complaints and concerns received through the Patient Experience Team and recorded through the Datix system.

A search for Datix records was completed, for patient experience events received in the period 1st January 2026 to 11th September 2026 to date, and which were recorded under the Speciality of Maternity Services.

Records were analysed to interrogate primary location of the complaint, general themes and sub-themes of the complaint, as well as the outcome of the complaint investigation. A more detailed analysis of complaints and concerns received in 2026 was then undertaken, to review the full content of the complaint and to identify current areas of concern.

Within the defined period of the search, a total of 23 reports of complaint or concern were received by the Patient Experience Team and recorded through Datix.

5. RESULTS

a. Type of Patient Experience event received

Within the search period, 57 patient experience events were reported and recorded within Datix. Of these, 15 (26.3%) were logged as Compliments or positive patient feedback, 15 (26.3%) were logged as Complaints, a further 3 (5.3%) were complaints where the

complainant elected to receive a response through a face-to-face meeting, and 5 (8.8%) were recorded as Concerns. The 23 complaints and concerns were reviewed in detail (Figure 1).

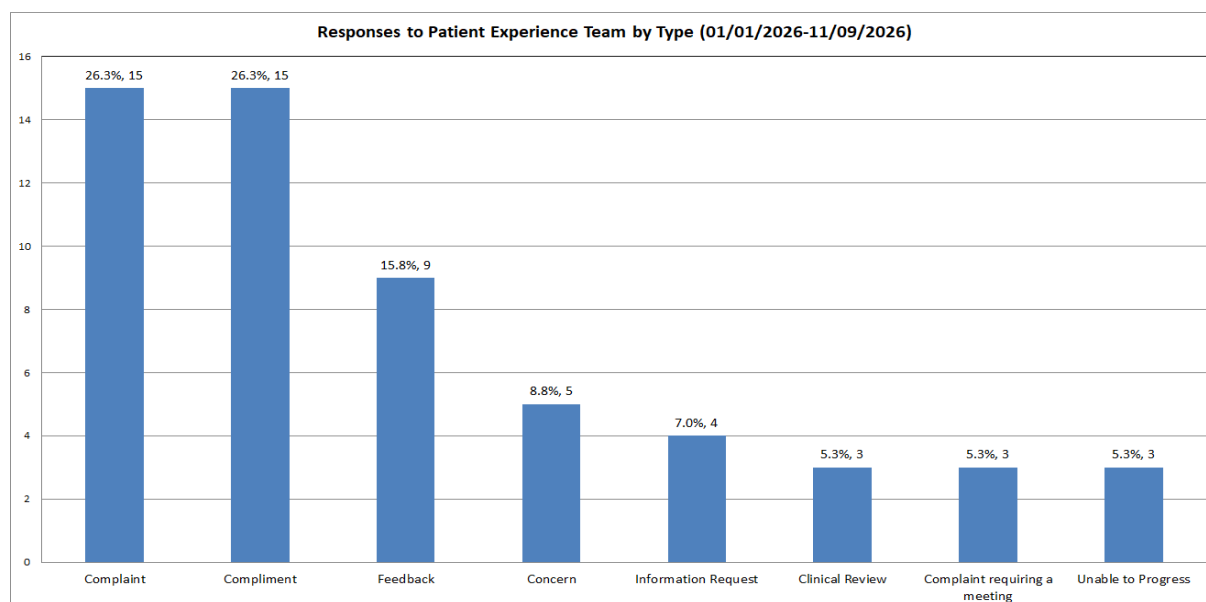


Figure 1: Breakdown of received patient experience events by type

6. Primary Location of Patient Experience event received

Figure 2 shows the primary location associated with the patient experience event. It appears that 34.8% of complaints and concerns received in this period occurred primarily on Pannal Ward, with other main areas of concern occurring within Delivery Suite (26.1%) and Antenatal Clinic (21.7%).

Similar trend was noted in a previous complaints report from 2021-2023. Though this would appear to be of concern, it should be noted that proportionally more time may be spent on Pannal Ward during a typical maternity admission (which may include antenatal, induction or postnatal episodes) and which cover a wide variety of care types. This would provide additional categories of care which might potentially lead to complaints.

Additionally it should be noted that staffing and activity levels vary markedly across the unit, with care on Delivery Suite being provided as 1:1 during the intrapartum period.

It must also be considered that the location entered within the Datix system may not always be accurate, and complaints covering cross-unit locations may be recorded under a single location. For example, complaints relating to both induction of labour (Pannal Ward) and intrapartum care (Delivery Suite) may be recorded with the index location and so may disproportionately reflect the location of care issues.

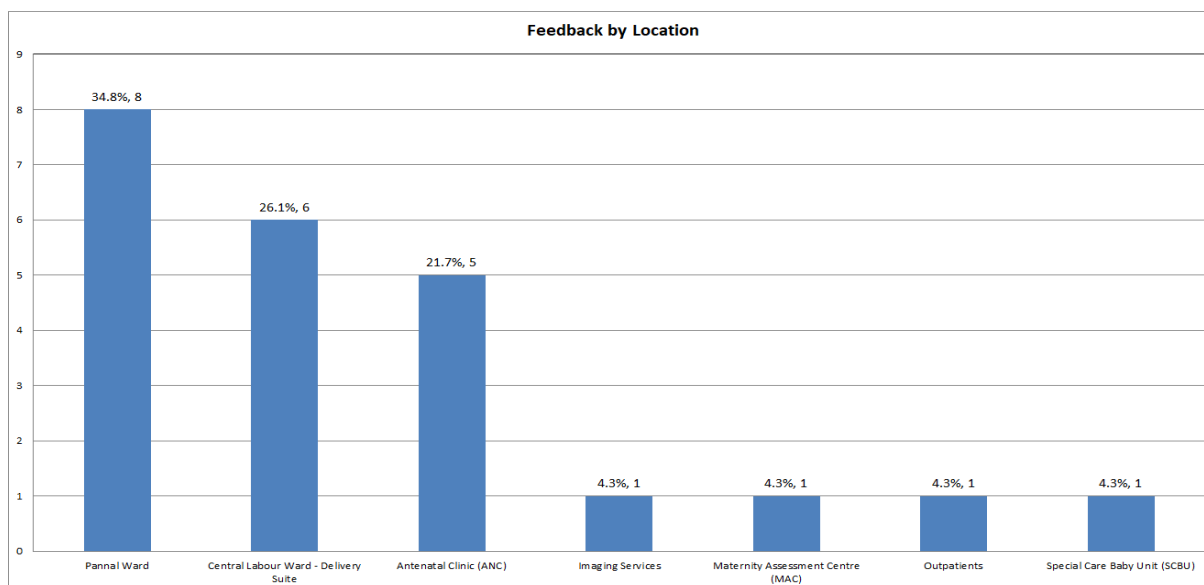


Figure 2: Breakdown of received patient complaint events by primary location

7. Primary Categories of Patient Experience event received

As part of the review process by the Patient Experience Team, the complaint/concern is recorded with key subject areas. The main broad themes associated with each complaint or concern are shown in Figure 3.

By far the most common themes associated with the complaints and concerns received, are issues with Clinical Treatment (34.8%) Communication (17.4%) and Care Needs not being adequately met. This shows some differences from the previous complaints review, where Communication themes were most prevalent and were making up almost 34% previously with Clinical Treatment concerns contributing 30.1% previously.

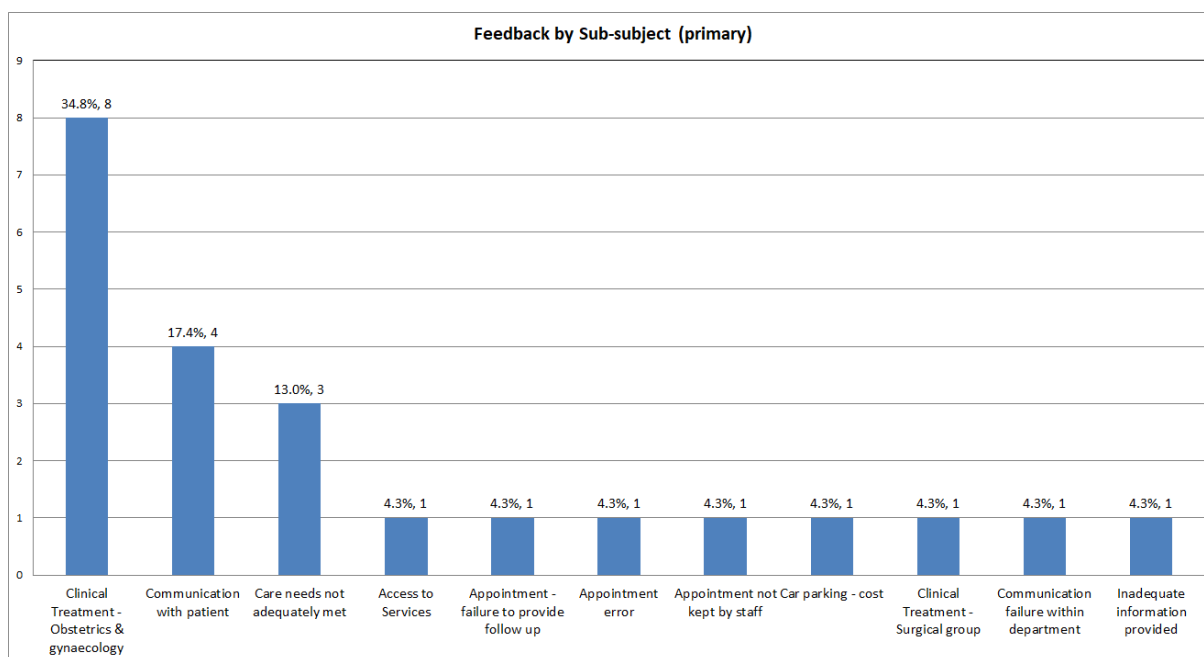


Figure 3: Breakdown of received patient complaint events by primary theme

8. DETAILED SPECIFICS OF CONCERN

In order to more effectively determine care issues and identify the specific areas for quality improvement, all complaints and concerns received since the beginning of 2026 have been reviewed. Attempts have been made to pick out common areas of complaint, and supported by direct quotes from the complainant.

All 23 complaints and concerns have been reviewed in detail. In addition, the timeliness of complaint response, as well as determination of any ethnicity or deprivation factors are evident. Patient ethnicity, and deprivation score determined by residential postcode have been assessed.

9. Common Themes of Patient Experience events received

Themes of complaints/concerns are shown in detail in the table below. Though there are some unique areas of complaint, there are recurring themes which appear throughout and these are summarised below:

Communication Issues

- Communication during induction, particularly relating to delays
- Insufficient clinical discussion of risks
- Unbalanced discussion of risk
- Staff communication
- Communication abrupt and dismissive
- Poor/insensitive communication
- Not feeling listened to
- Communication in MAC
- Conflicting advice

Lack of support

- Delays in postnatal attendance review with wound infection
- Delayed return in response to request for assistance
- Lack of post-operative support
- Lack of support from staff
- Lack of breastfeeding support
- Skin to skin
- Perinatal mental health and birth planning
- Lack of oversight and feeling isolated

Facilities

- Hygiene (linen not being changed)
- Inadequate partner/birth partner facilities
- Car parking

Clinical Management

- Lack of personalised care
- Management of medication
- Lack of debrief (including when there has been Neonatal Resuscitation)
- Clinical management
- Wound infection follow-up
- Delayed medication
- Delay in medical review
- Drug administration
- Delays In IOL
- Perinatal mental health follow-up
- Pain relief

Documentation and appointments

- Poor or inaccurate documentation
- Management of appointments
- Telephone contact issues
- Delayed/appointment issues in ANC
- Poor communication re: appointments
- Lack of reference to birth plan
- Management of appointments

10. Timeliness of completion

As noted in the table below, 16 out of 23 responses have been completed within required timeframe (69.6%), with 4 responses still under investigation or in the process of being finalised.

Only two complaint responses have been outside of the complaint response timeframe, with one being converted to a multi-agency complaint and the other being 3 days delayed in returning to patient experience team and with further delay in final sign-off. One complaint is being closed due to lack of response from patient following initial complaint.

11. Ethnicity and deprivation score

Breakdown of complaints and concerns, according to both deprivation score and ethnicity is shown in Figures 4 and 5 below.

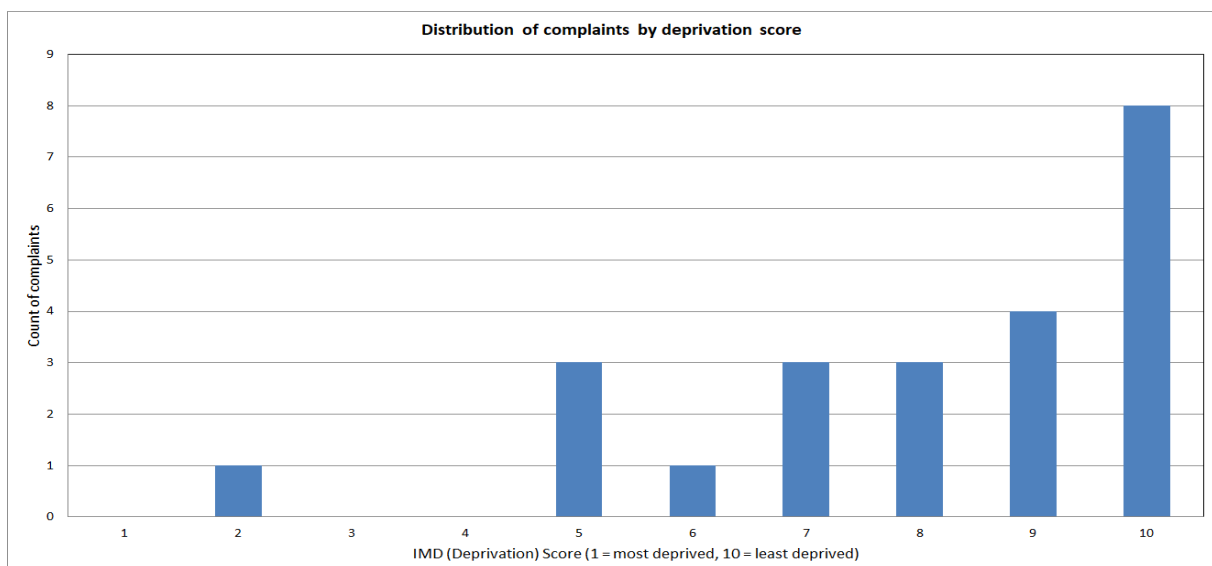


Figure 4: Breakdown of received patient complaint events by deprivation score

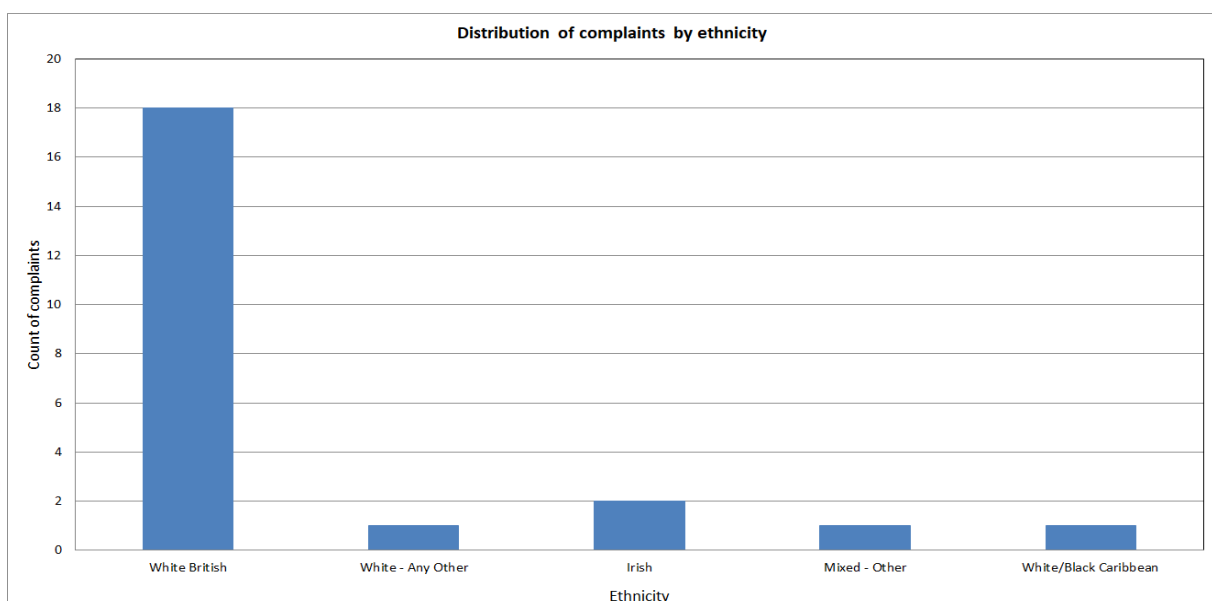


Figure 5: Breakdown of received patient complaint events by ethnicity

The above distributions are broadly in line with our population demographic as shown below.

Demographics at booking appointment

Ethnicity	Trust	Ethnicity	England
Any other ethnic group	2.2%	Any other ethnic group	4.5%
Asian or Asian British	4.3%	Asian or Asian British	18.4%
Black or Black British	3.1%	Black or Black British	7.5%
Mixed	1.4%	Mixed	3.1%
Unknown	5.3%	Unknown	3.8%
White	83.9%	White	62.8%

Deprivation quintile	Trust	Deprivation quintile	England
01 - Most deprived	2.6%	01 - Most deprived	24.9%
02	2.9%	02	22.0%
03	18.7%	03	19.2%
04	31.4%	04	17.0%
05 - Least deprived	39.3%	05 - Least deprived	14.9%
Other or unknown	5.0%	Other or unknown	1.9%

12. Actions taken to improve care provision

- Correction of documentation and follow up with the staff involved to ensure accuracy of timings and events recorded
- Ongoing work around informed consent and ensuring appropriate balance of risks in discussions. This has been fed back to the doctors involved and additional work done with MNVP.
- Additional work on PROMPT/mandatory training days around use of BRAIN acronym and supporting personalised care and informed choice
- Staff behaviour and inappropriate comments have been addressed with individuals involved
- Updated wound infection follow up processes, together with tissue viability and are exploring alternative dressings to reduce infection risk
- Work ongoing on delayed inductions and improvements in communication, including appointment of Patient Flow coordinators and work to launch balloon induction which may be undertaken as an outpatient procedure
- Previous work to support improvements in drug rounds and post-operative support.
- Additional staffing for Pannal Ward on night shifts
- Considerations of self-medication for patients
- Additional work planned around fluid balance and bladder care
- Additional recliner chairs and ward environment changes for partners on Pannal Ward
- Work through the Violet Team around Perinatal Mental Health support and personalised care planning
- Further recommendations made around debrief, and inclusion of Neonatal debrief options when newborn resuscitation involved
- HDFT Impact work ongoing around clerical issues with appointment management
- Planned work around ensuring appropriate antenatal clinic appointments which may help to reduce clinic delays

13. Conclusion

The review provides overview and triangulation of maternity complaints and concerns received through Maternity Services between 1 January and 11 September 2026. During this period, 57 patient experience events were recorded within Datix, including

15 compliments or positive feedback, 15 complaints, three complaints where a face-to-face response was requested, and five concerns.

The 23 complaints and concerns were reviewed in detail to identify common themes and areas of care contributing to poor patient experience, together with a review of response timeliness, and potential factors relating to ethnicity and deprivation.

The findings identified three broad areas for improvement: communication and personalised care; aspects of clinical care and responsiveness; and particularly postnatal support (particularly with post-operative care and pain relief).

Of note, there was a higher representation of themes relating to clinical management in this period, compared with a previous report reviewing complaints in 2021-2023, which had greater proportion of communication issues.

A number of actions have been taken to improve care provision.

Appendix C –

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. Clinical Director agreed to attend Trust board alongside Associate Director of Midwifery and Children's Services	Amended Exec names on all papers to Board to include Medical Director Clinical Director for PSCC to attend Board to present papers with Associate Director of Midwifery and Children's Services	Leanne Likaj / Kat Johnson Leanne Likaj / Kat Johnson	Completed To be in place from next Board Meeting – September 2027
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			

	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 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.	Trends in data are reviewed via Maternity Safety Champions meeting and shared with Quality Committee and Trust Board. Monitor via Safety Champions meeting and Board paper	Actions are being taken to implement Maternity Care Bundle by March 2027.	Leanne Likaj / Kat Johnson Leanne Likaj / Kat Johnson	Completed March 2027
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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 / Breedra Columb	December 2026

Appendix D

Planned and Surgical Care
Maternity
Saving Babies' Lives Exception Reporting to Board Q1 2026/2027
Author: Rachel Tabram

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Introduction

In April 2015 the National Health Service (NHS) in England launched the Saving Babies' Lives (SBL) care bundle specifically designed to reduce stillbirths and neonatal deaths. A third version of the [Saving Babies Lives care bundle](#) was published in June 2023. Version 3 builds on the achievements of previous iterations, and includes a refresh of all existing elements, drawing on national guidance such as from NICE or RCOG Green Top Guidelines, and frontline learning to reduce unwarranted variation where the evidence is insufficient for NICE and RCOG to provide guidance. It also includes a new, additional element on the management of pre-existing diabetes in pregnancy. There are 6 elements of care:

- Element 1: Reducing smoking in pregnancy
- Element 2: Fetal growth: Risk assessment, surveillance and management
- Element 3: Raising awareness of reduced fetal movement
- Element 4: Effective fetal monitoring during labour.
- Element 5: Reducing preterm births and optimising perinatal care
- Element 6: Management of pre-existing diabetes in pregnancy

Version 3.2, published April 2025, has slightly amended standards and audit requirements against which the last years data was reviewed (NHS England 2025). This led to eight quarters of comprehensive audit compliance and reporting that was reviewed by the Local Maternity and Neonatal System (LMNS).



HDFT WYH LMNS SBL Q4 2025 report
SBLCBv3.2 Ongoing V1 FINAL.docx



Previous data monitored through the LMNS was consistently achieving the LMNS expected standard and demonstrated the care bundle was very well embedded. At the last review of Quarter 4 in June 2026 implementation was judged to have been 94%, with Element 1 the only element not to achieve 100% implementation (Crookes 2026).



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425-26 HDFT.pdf

Following changes at NHS England and the ICB, the LMNS no longer monitor compliance with the Saving Babies' Lives care bundle and so this report to the Trust Board has been produced to enable oversight to be maintained by quarterly review of exception reporting, and to continue to monitor areas of identified concern, where previous compliance has been low or changeable. All process measures have been reviewed by the Audit and Clinical Effectiveness Lead midwife and Lead Midwife for Safety, Quality & Clinical Governance to focus areas of concern that require ongoing monitoring. As a result, it has been agreed that process measures with good compliance can be moved to less frequent monitoring. Previously well-embedded auditable standards can be found above (SBL Q4 2025 report V1 FINAL) and have been moved to annual review though will be upgraded to quarterly review if a concern or incident is highlighted.

Results

This review has demonstrated the following compliance with process measures of quarterly monitoring in Quarter 1 (2026/2027):

Element	Metric	Process Measure	Compliance Q1
1	1.3b	Percentage of women where their smoking status at 36 weeks is recorded	99.5%
	1.4	Percentage of smokers* that have an opt-out referral at booking to an in-house tobacco dependence treatment service	100%
	1.6a	Percentage of smokers* that are referred for tobacco dependence treatment to set a quit date	72.3%
	1.6b	Percentage of smokers* that set a quit date and are identified as CO verified non-smokers at 4 weeks	37.5%
	1.6c	Percentage of smokers* at antenatal booking who are identified as CO verified non-smokers at 36 weeks	28.6%
	1.8	Percentage of staff with in date training compliance on the use of a CO testing and discussion of results	63%
	1.9	Percentage of staff providing maternity care with annual in date training compliance on the delivery of VBA, making an opt-out referral and maternity pathway processes	76%
2	2.7	Percentage of women booked that are identified as high risk for FGR who have had a uterine artery doppler assessment between 18+0 and 23+6 weeks gestation	92.3%
3	3.2b	Proportion of women who attend with recurrent* RFM who had an ultrasound scan by the next working day to assess fetal growth.	62.5%
5	5.11	Test for asymptomatic bacteriuria in women who are assessed as being intermediate or high risk of preterm birth (see appendix E) by sending off a midstream urine (MSU) for culture and sensitivity at booking. Following any positive culture and treatment, a repeat MSU to confirm clearance is recommended.	88.2%

Figure 1: Areas of quarterly monitoring and their compliance in Quarter 1 (2026/2027)

Element 1

1.3b Percentage of women where their smoking status at 36 weeks is recorded

Previously compliance ranged from 64% to 95% month to month. In Quarter 1 Badgernet reports this as 99.5% with two patients having no smoking status recorded between 35 and

36+6. Both patients were seen on MAC at this point and had no community midwifery review in this date range. This has been overlooked by the MAC midwives (different midwife for each patient). The field has now been made mandatory in Badgernet which has improved compliance in this area.

1.4 Percentage of smokers* that have an opt-out referral at booking to an in-house tobacco dependence treatment service

Compliance has previously ranged from 63% to 100% for this measure. In Quarter 1 Badgernet reports this as 12/13 patients, 92.3%. This patient was booked postnatally on the date they gave birth as they had a concealed pregnancy and therefore had no opportunity to be referred in pregnancy. Compliance has been altered to 12/12 to reflect this, 100%.

1.6a Percentage of smokers* that are referred for tobacco dependence treatment to set a quit date

Compliance has previously ranged from 25% to 100% for this measure. In Quarter 1 Badgernet reports this as 8/12 patients, 66.7%. One patient does not smoke tobacco, only cannabis, and therefore was not required to set a quit date. Three patients did not engage with the Tobacco Dependency Advisor. Compliance has been adjusted to 8/11 patients, 72.3%.

1.6b Percentage of smokers that set a quit date and are identified as CO verified non-smokers at 4 weeks after initiating smoking cessation support

Badgernet reports this as 37.5% for Quarter 1, consistent with previous quarters and below expected standard. This will be escalated to the Public Health Midwife.

1.6c Percentage of smokers that set a quit date and are identified as CO verified non-smokers at 36 weeks gestation

Badgernet reports this as 28.6% for Quarter 1, consistent with previous quarters and below expected standard. This will be escalated to the Public Health Midwife.

1.8 Any staff member using a CO monitor, should have appropriate training on its use and discussion of the result.

The training database was reviewed to confirm compliance. All midwives and MSWs are expected to complete annual CO monitor training. CO monitoring training for 2025 was previously included with mandatory Maternity 3 Training Day, which occurs monthly for midwives to attend, however this was removed from the priority training programme. An alternative Learning Lab e-learning package was developed and launched in June 2026 with a view to maintaining compliance. Due to a gap in launching the new e-learning training, a fall in compliance was expected for Quarter 4 and Quarter 1.

CO training	April 2026	May 2026	June 2026	Q1 total
MSW's	19/19	19/19	14/22	
Midwives	68/98	52/99	55/102	
Total	87/117 (74%)	71/118 (60%)	69/124) (56%)	227/359 (63%)

Figure 2: CO training figures

Considering midwives and MSW's, both who use CO monitors daily; evidence of compliance for CO monitoring training was completed by 63% of staff in Quarter 1. This fell below the LMNS expected standard however since the launch of the mandatory e-learning package future quarters should see continual improvement.

1.9 All staff providing maternity care to pregnant women should receive training in the delivery of Very Brief Advice (VBA) about smoking, making an opt-out referral and the processes within their maternity pathway (e.g. referral, feedback, data collection).

The training database was reviewed to confirm compliance. The training for VBA in Quarter 4 was through combining compliance of MSW's, midwives and doctors. As discussed above, training of midwives and MSW's will be affected by a period of pause whilst the e-learning package was being developed, therefore a fall in compliance was expected for Quarter 1 and Quarter 4. Previous doctors had been trained in October 2025, however since then a few obstetricians will have changed and any doctors who have arrived since then are expected to complete the e-learning package too. Some doctors will remain compliant until October 2026, when they will be expected to complete the e-learning package.

VBA training	April 2026	May 2026	June 2026	Q1 total
MSW's	19/19	19/19	14/22	
Midwives	68/98	52/99	55/102	
Obstetricians	17/19	17/19	17/19	
Total	104/136 (76%)	88/137 (64%)	86/143 (60%)	278/416 (67%)

Figure 3: VBA training figures

Evidence of compliance for VBA training was completed by 67% of staff Quarter 1. This fell below the LMNS expected standard however since the launch of the e-learning package future quarters should see continual improvement.

Element 2

2.7 Women who are designated as high risk for FGR (for example see Appendix D) should undergo uterine artery Doppler assessment between 18+0 to 23+6 weeks gestation.

Uterine artery dopplers are not always recorded on Badgernet and therefore requires manual audit. Badgernet reports this as 46/73 (63%) compliance. All exceptions (27) were reviewed.

Each patient was reviewed to identify if their FGR risk was accurate. Eight patients were excluded as their risk was incorrectly recorded and there was either no antenatal clinic referral or the antenatal clinic appointment had identified the risk was not indicative of a uterine artery doppler (for example Chronic Kidney Disease, which was actually recurrent UTI's, or previous FGR which was actually a 49th centile baby).

Of the 19 remaining cases, five did not have evidence of a uterine artery doppler between 18+0 and 23+6 weeks being performed. Three patients commenced serial scans at 28 weeks with no reference to uterine artery doppler. A second patient declined an appointment to discuss low PAPP-A with the obstetrician and therefore possibly was not offered a uterine

artery doppler. One patient had a uterine artery doppler performed at 28 weeks by the fetal medicine unit.

Compliance has been adjusted to 60/65 (92.3%), meeting the stretch ambition for this audit standard. Compliance has previously ranged from 85-95%. In June 2026 changes to ICE ultrasound scan requesting for serial scans (28 weeks and 32 weeks) now both include a pop-up questioning if there are any risk factors for FGR. This change was made to help clinicians recognise that uterine artery doppler is required when there is a risk factor for FGR and to utilise this test instead of booking serial scans from 28 weeks.

Element 3

3.2b Proportion of women who attend with recurrent RFM (RRFM) who had an ultrasound scan by the next working day to assess fetal growth.

As ultrasound scans are not imported automatically into Badgernet this report requires manual cross referencing. Badgernet reports this as 20/37 (54.1%). All exclusions (17) were manually reviewed looking for evidence of whether an ultrasound scan was completed within the timeframe and reasons for non-compliance.

Two patients were excluded due to being in active labour, transferred straight to delivery suite and being booked for an EL LSCS which took place the next day, with no need for USS.

A further three patients were excluded following discussion with an obstetric consultant:

1. Although reported to have had RFM concerns when attending with abdominal pain, reported there was no longer concerns and fetal movements were normal at attendance therefor this patient had not attended with recurrent RFM and therefore was not arranged an USS.
2. A patient attended at 22:30 with RRFM and a scan request was put in the next day but same episode of care at 01:40, meaning the scan was not allocated until the following day (next working day from request). Following discussion with the consultant it is felt this is reasonable as otherwise there would be a period of many hours when the clerks are not working in which a scan cannot be facilitated. This would be the case for anyone who had an attendance overnight
3. A patient had a consultant plan made on 4/6/26 for daily CTG's due to RRFM with her last scan at 38 weeks. Attended on the 8/6/26 at 40+6 and midwife marked reason for attendance as RFM, however it is unclear whether this is a new period of RRFM or a continuing RRFM, for which a plan was being followed. This patient was also declining induction of labour. It was felt that an USS would not have been of benefit as the patient was already attending for daily CTG's as per consultant plan.

Of the non-compliant cases (12), seven had an ICE request that was correct, 58.3%. these were facilitated between two and four days from attendance (one to three days late). Improvements could have been made for the following five patients, one of whom did not receive a reactive USS and attended her next scheduled USS 12 days later and the remaining four who received their USS between two and three days from attendance (one to two days late):

1. A request for USS was made but did not specify recurrent RFM and therefore was not allocated the next working day at 28+3.
2. A patient did not have a request put in as it was not recognised to be a recurrent episode of RFM and no scan took place at 34+2, attending her next scheduled scan at 36 weeks when her previous scan was at 32+0.

3. One patient at 34+5 had a request made for a single episode of RFM the day before which was re-requested with information regarding this recurrent episode and not re-prioritised. The scan also did not occur within the required timeframe, as this would have been the next working day from this attendance with RRFM (two days from single episode of RFM).
4. One patient had attended with a first episode on the 27/4/26 and then again on the 1/5/26 and the previous request was not re-prioritised and another request not put in. The USS did not take place until 5/4/26, which is out of the required timeframe for a single episode of RFM (two days) at 37+0.
5. A patient attended with RRFM at 28+2 and no scan request was made. The patient mentioned this to her community midwife two days later and an urgent scan request was made and facilitated the next working day.

One of the non-compliant cases with a correct ICE request and one patient with no ICE request both chased their USS, both completing the USS four days after attending with an episode of RRFM. One of these may never have taken place if the patient hadn't expressed this to her community midwife.

There were 12 non-compliant cases (20/32 compliant cases, 62.5%). This meets the LMNS expected standard and is higher than the last four quarters (2025/2026). Non-compliant cases will be escalated to the antenatal clinic team leader. Learning from previous quarterly reviews has been consistently shared with staff, including an email sent with high importance. Changes have also been made to ICE requesting for third trimester USS to enable appropriate risk stratification based on the patient's presentation and RFM episode number.

Element 5

5.11 Test for asymptomatic bacteriuria by sending off a midstream urine (MSU) for culture and sensitivity at booking. Following any positive culture and treatment, a repeat MSU to confirm clearance is recommended.

Badgernet confirms there were 36 patients labelled as high and intermediate risk preterm birth in Quarter 1. 15 (41.7%) had documentation of an MSU in the correct note on Badgernet. All others (21) were manually cross-referenced via ICE and Badgernet for evidence of an MSU.

Two patients were excluded from this sample. One patient was a transfer of care from London at 15 weeks, having booked there. A second patient was not preterm birth risk as was an iatrogenic preterm birth due to pre-eclampsia.

Of these, 15 further patients to those identified on Badgernet had an MSU at booking taken. Three had not had an MSU at booking, then were seen in antenatal clinic by the preterm birth consultant/midwife where no MSU was obtained and one patient experienced a miscarriage at 15 weeks, however due to previous LSCS at full dilatation should have had an MSU at her booking at 9 weeks.

Month	High intermediate and risk patients	MSU's obtained booking	Percentage at (%)
Q1 Total	34	30	88.2%

Figure 4: MSU at booking for high and intermediate risk PTB confirmed in ICE

88.2% of patients in Quarter 1 had an MSU at booking on either Badgernet or ICE for their preterm birth risk. This is consistent with all previous quarters. Where MSU's have not been

taken at booking for preterm birth risk, patients will be escalated to the preterm birth lead midwife.

Conclusion

Key successes

- Recording smoking status at 36 weeks has improved and meets expected standard
- Referral to tobacco dependence service is 100%
- Smokers who set a quit date meets expected standard
- Uterine artery dopplers has remained stable at 93%, meeting expected standard
- Ultrasound scan the next working day for recurrent RFM has improved, meeting expected standard
- MSU at booking meets expected standard and has remained stable

Key concerns

- CO verified non-smokers at 4 weeks after initiating smoking cessation support and 36 weeks gestation are below expected standard
- CO and VBA training have further reduced (as anticipated) and are below expected standard

Limitations

- Some elements have very small sample size, affecting compliance (for example CO verified non-smoker)

Re-audit

- Quarterly board assurance of these elements will continue until compliance is stable, above expected standard

Issues for escalation

Patients who did not receive their ultrasound scan the next working day following an episode of recurrent RFM have been escalated to the antenatal clinic team leader. Patients at risk of preterm birth who did not receive an MSU have been escalated to the preterm birth midwife.

Recommendations

- Escalate elements 1.4 and 1.6a to Public Health lead midwife for targeted action
- Professional Development Midwife has shared the Saving Babies' Lives e-learning with all MSW's, midwives and obstetricians and monitors compliance with this for Maternity Incentive Scheme
- ICE changes to ultrasound scans for RRFM and serial scans at risk of FGR took place in June 2026 and regular review of this have been taking place

References

Crookes (2026). Board Report and Action Plan on Implementation of the Saving Babies Lives Care Bundle (Version 3.2).

NHS England (2025). Saving Babies' Lives: version 3. [online]. Accessed at: [NHS England » Saving babies' lives: version 3](#)

STRATEGIC AMBITION: PERSON CENTRED, INTEGRATED CARE; STRONG PARTNERSHIPS 2026-2027

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.

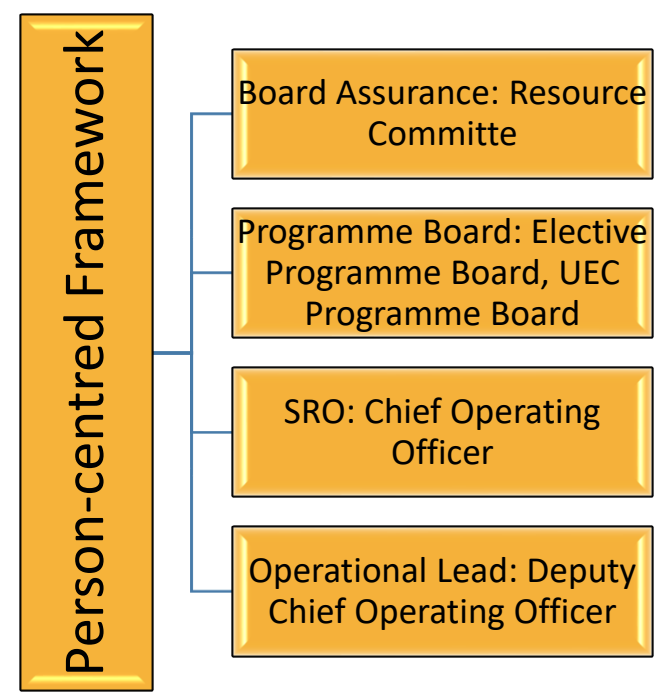
GOALS:

Urgent & Emergency Care
The best place for person centred urgent and emergency care

Exemplar System
An exemplar system for the care of the elderly and people living with frailty

Equitable & Timely
Equitable, timely access to best quality planned care

GOVERNANCE:



True North Metrics

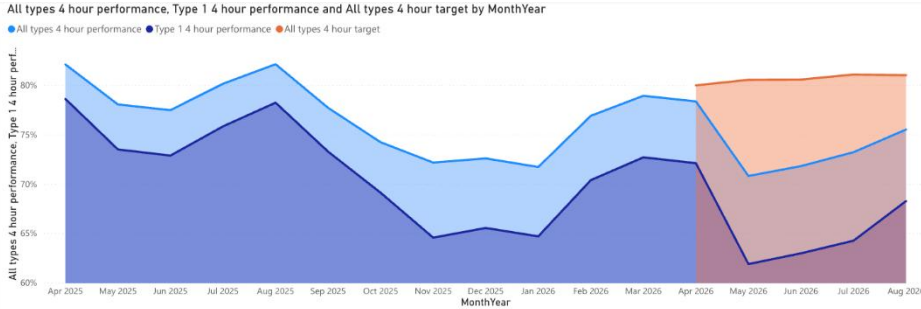
- 1 • ECS 4 Hour Standard - 95% of patients admitted or discharged within 4 hours
- 2 • Length of Stay - Top quartile nationally for patients with frailty (to be redeveloped)
- 3 • Elective Recovery RTT - 92% of patients waiting under 18 weeks for treatment
- 4 • Cancer 62 Day Standard - 85% of patients seen and treated within 62 days on a cancer pathway

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

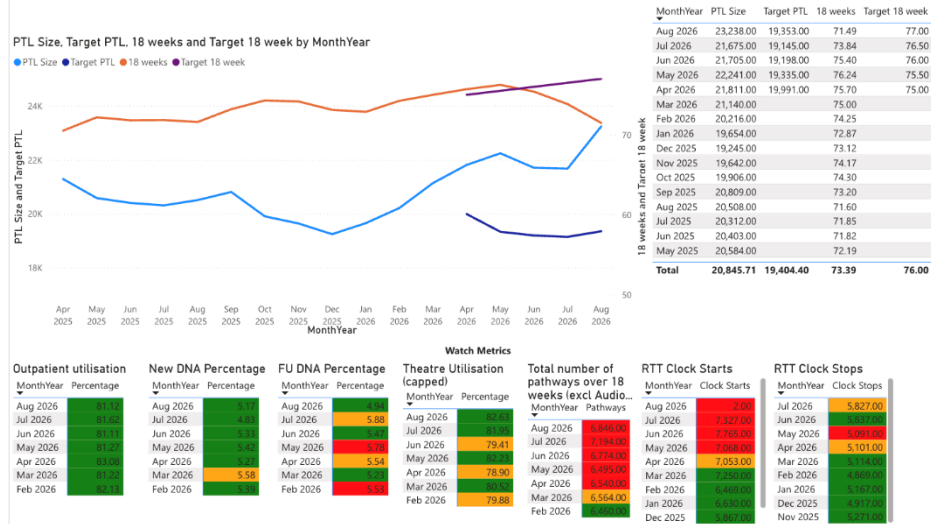
Overarching Risk Summary:

Ambition	Workstream	True North Metric	Risk Appetite	Level of Risk to Achieve Metric – Linked to Risk Appetite						
				1 – 3	4 – 6	8 – 9	10	12	15	>20
Person Centred, Integrated Care, Strong Partnerships	The best place for person centred urgent and emergency care	ECS 4-hour Standard	Operational: Cautious							
	An exemplar system for the care of the elderly	Length of Stay - Patients with Frailty (being redeveloped)	Operational: Cautious							
	Equitable, timely Access to Best Quality Planned Care	Elective Recovery RTT – 18 Weeks	Operational: Optimistic							
		Cancer 62 Day Standard – 62 Days Treatment	Operational: Optimistic							

Strategic Metrics Summary:

Workstreams	True North Metric	Vision	Goal	Current State	Countermeasures	Level of Risk to Achieving Goal (CxL)	Level of Risk for progressing actions
The Best Place for Person Centred, Integrated Care 	ECS 4 Hour Standard	95% of non-admitted patients not requiring a bed to be assessed, diagnosed, treated, and discharged with 4 hours. 95% of admitted patients to be moved to required department within 60 minutes of medical decision.	By March 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). For the FIFTH month in a row we remain significantly below target for the month. April 78.35% (t.79.97%), May 70.8% (t. 80.54%), June 71.64% (t. 80.56%) , July 72.85% (t. 81.08%) and August 75.5% (t. 81.08%) with ED Attendances marginally below plan. Watch metrics covering the ED are out of target for 5th consecutive month for predicted harms, 12 hour arrival waits but pleasingly ambulance handover, sepsis screening and 12 hour trolley waits are all green. The outcome of the work to analyse the current under performance has demonstrated the need to develop processes in the non-admitted pathway and the need to reduce >4hour breaches within 15 minutes. Breakthrough Objective: Time to Next Step By September to agree targets for improvement through the A3/driver refresh.   Emergency Department Data	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. Developing expanded UTC space at Ripon, awaiting HIF works timeline. Agreed action to develop ED focused A3 in September, which is nearly complete and will focus on; - Workforce modelling to maximise capacity to demand. - The Nurse in charge (NIC) and Emergency Physician in charge (EPIC) role consistency to promote the culture of performance. - Enhancements to nerve centre to increase efficiency and productivity. - Using 'time to next destination' as a tool within the dept to improve flow. Wider Trust actions on time to next destination also underway. Successful application to join NHSE regional EMMAC 'sprint' with ED clinical leadership engagement. However this has been stood down due to the inability to have a dedicated estate out of ED for this now. Breakthrough objective for time to next step agreed at 60 minutes, will focus on countermeasures that support in ED flow		

					the non admitted pathway and admitted flow into ward areas.		
An exemplar system for the care of the elderly and people living with frailty. 	Length of Stay with Frailty	Top quartile Length of Stay nationally for patients with Frailty by March 2027.	By March 2026, we will achieve top half Length of Stay for Frailty nationally. By March 2027, we will achieve top quartile Length of Stay for Frailty nationally.	We remain upper quartile for LOS in frailty. The new A3 is now underway. Data is being produced now nervecentre in place to then decide on the final metric: Frailty Dataset produced with clinical team and data analysts to work through A3 and agree drivers. By Clinical Frailty Score : OBD's , LOS , Time to move off AFU to base ward , Patients not in frailty with high CFS – numbers, LOS's.	Full review of A3 for this project underway with wider frailty team for new metric and countermeasures by September 2026 having consistently achieved upper quartile LOS. Suggestion that we pause this driver to focus on ED and 'time to next destination' given consistent performance and quality care delivery.		
Equitable & Timely 	Elective Recovery (RTT) Standard	Sustained achievement of the 92% of patients being treated within 18 weeks.	By March 2027, we will achieve 18-week performance at 80.5% By March 2028, we will achieve 18-week performance at 87%. By March 2028, we will achieve 18-week performance at 92%.	18 week performance is reducing for the third month in a row despite activity delivery being in line with plan. Reduced premium/ outsourcing is contributing to a drop in performance – this is 'ok' in specialties performing but the impact on overall performance where those specialties were above target is causing the drop. Key specialties remain challenged in delivery , this is also resulting in 52 week breaches particularly in T&O, Vascular. Additional watch metrics have been added : total pathways over 18 weeks , Clock Starts and Clock Stops (these update a month in arrears) End of June 75.40 %. (t.76%), End of July (t. 79.7%), Forecasting End of August 71.5%. (close date not until 3rd week Sept) With numbers of pathways over 18 weeks remaining high although slight reduction on last month. The PTL size is likely to grow slightly despite the extended validation window. With clock_start numbers continuing out or target demand seems to be driving this. Detailed analysis has been undertaken, two core drivers; 1. Increase in demand 2. Reduction in planned activity (additional above core in planning cycle) Five specialties causing reduction; • T+O • ENT • Max fax/vascular • Gynaecology • Gen surgery Watch metrics – apart from clock starts and pathways over 18 weeks are green.	HDH Additional Theatres (TIF2) build on track for 2026 delivery. Outpatient Transformation, rollout of further faster programme and track key metrics: • New: Follow Up ratios • Absolute reduction in follow ups • DNA rates • Clinic cancellation rates • Patient Initiated Follow Up Rate TPAM meetings. Increased to weekly to review RTT performance and focusing on 5 specialties recovery plans. T+O is a specific issue related to a unexpedid sickness – plan now on place, but has caused 52w breaches in month. ENT recovery plan currently being enacted. Max/fax and vascular – plans to in place to strengthen SLA with YSFT and transfer vascular patients back to YSFT. Gyne/gen surgery recovery plans due by 21/9/26 Dedicated HVLC lists in Ophthalmology from June. Elective SPOA group developed. Patient not Present process in deployment across the Trust.		

						
	62 Day Cancer standard	85% of our patients will commence treatment within 62 days of referral.	By March 2027, 85% of patients will have commenced definitive treatment within 62 days of referral for suspected cancer.	Cancer Performance Report - Power BI 84.5% for March 80.5% April 83.06% May 83.33% June (validated) 86.0%. July (validated) 85% August (unvalidated)  Colorectal largest contributor to breaches of 62 days. Watch metrics- all green	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. RCAs to be completed on all 104-day cancer breaches to understand themes and opportunities. See Corporate Project updates: Bed Capacity and Patient Discharge. Outpatient transformation, Theatre productivity board alongside PSCC PRM's will set and edit countermeasures: - Calling patients 48-hours pre-theatre to reduce on the day cancellations. - New theatre scheduling process gone live 1st Sept.	



					Theatre management team reaching out to individuals where performance <80%. Cancer Fast Track team transferred to PSC Appointment centre to increase resilience.		
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Trustwide Project:

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.	BT02 This divides the ED journey into a series of steps (Arrival to Clinician, Clinician to CRTP, CRTP to Discharge and Imaging Request to Report) and shows the monthly median across the 4 steps against a target of 60 mins Percentage of days with 'step' median over 60 mins by step_label and FinancialYearQuarterName Step Definitions: ED_Clinician: Minutes from ED arrival to ED Clinician assigned to patient ED_complete: Minutes from ED Clinician assigned to Clinically ready to proceed CRTP_to_Discharge: Minutes from clinically ready to proceed until leaving the ED Imaging_report: Minutes from request logged for complex imaging until imaging reported. Median time to next step improved to 70.62 mins in July from 72 mins in June and improved again in August to 63.6 mins but remains outside target. The two highest step over 60mins are time to ED Clinician and Time from image request to report. Move from CRTP to discharge in ED remains stubbornly at 33% of days over 60mins. Agreed action to develop ED focused A3 on improving non-admitted performance in September, which is nearly complete and will focus on; • Workforce modelling to maximise capacity to demand. • Reviewed against data on in dept acuity. • The Nurse in charge (NIC) and Emergency Physician in charge (EPIC) role consistency to promote the culture of performance. • Enhancements to nerve centre to increase efficiency and productivity. • Using 'time to next destination' as a tool within the dept to improve flow. ED performance breaches and LOS - Power BI	Continuous flow embedded. 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. Perfect week planned 28/9/26 where we will test adherence and learning to implementation. Clinical engagement commenced prior to this. Ward discharge targets established for base wards and Driver Metric within Care Groups to improve delivery. Monthly delivery on plan for discharge targets. 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. The build new A3/driver for ED and time to next destination to improve non-admitted performance using the granular data, with IMPACT team support, which is nearly completed. BI team to support with finalised data set on acuity. Successfully applied to regional EMMAC sprint, with engagement from ED clinical team/ PA input. Unfortunately NHSE did not support the team continuing on the sprint at tis time due to our inability to have a separate EMMAC space. Despite a number of other trusts nationally using a similar virtual model.		



Workstreams	True North Metric	Vision	Goal	Current State	Countermeasures	Level of Risk to Achieving Goal (CxL)	Level of Risk for progressing actions
					Perfect week 28/9/26 will focus on adherence to the COS and any learning or counter measures for wider 'Time to next destination' will e formed from this.		
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 specialties with follow ups over plan graphed below Year to date 3,000 over plan Activity - Plan Above Plan Treatment Functions Activity - Plan Below Plan Treatment Functions Above plan contributors Below Plan contributors	Outpatient transformation project countermeasures: - Increased Patient Initiated Follow Up (PIFU) (also monitored through TPAM). - Develop performance data pack on outpatients for individual clinicians including benchmarking. - Use performance data of teams (Model Hospital) and individuals to challenge. - Influence change in practice through effective clinical leadership/ coaching. - Introduce demand led, data driven job planning to optimise clinic configuration and reduce unnecessary follow ups. - Weekly TPAM with focus on FU activity. - Care groups/Specialties to review their position and look for PIFU, clock stop unseen opportunities - Developing HDFT Futures strategic program with an OP transformation workstream against best practice guidelines.		

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. See the A3 & Breakthrough Objectives pertaining to this.	4 x 4 = 16	4 x 2 = 8 March 27	ini	Minimal
ID79	Stroke: Provision at HDFT for Stroke	Ongoing cross ICB planning on stroke provision and the pathway. Stroke risk likelihood to be reviewed due to perceived reducing datix reporting of harm. Need to test if this is 'true'.	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. Cardiology Strategy Planning meeting scheduled for November 24. Current position managed through HDFT IMPACT and regular updates provided to LTUC Tri-Team for escalation to the executive team.	3 x 4 = 12	3 x 1 = 3 Dec 26	Operational: Business Continuity	Cautious
ID884	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. PSC Risk – reduced July 2026 as waiting times improving.	4 x 3 = 12	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

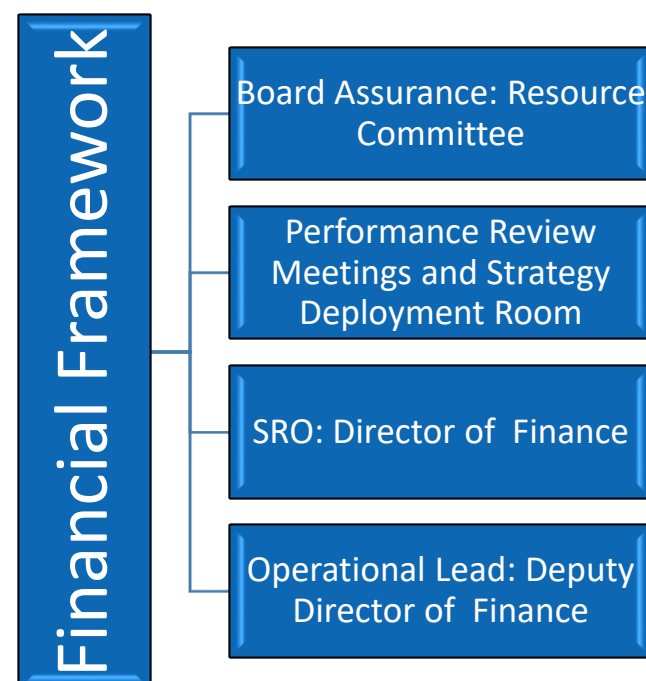
Our ambition is to provide the best quality, safest care whilst being a financially sustainable organisation.

GOALS:

Financial Sustainability

HDFT To be a financial sustainably organisation

GOVERNANCE:



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



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

Overarching Risk Summary:

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

True North Metrics Summary:

True North Metric	Vision	Goal	Current State	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.	The Trust reported a deficit of 3.8m in August, £3.8m behind plan. This takes the year to date position to a £18.8m deficit, £10.8m behind plan. The Finance Board Report contains further information on the position including – - Detailed variance analysis - Trends and Forecast scenarios - Top down turnaround trajectories - Development and delivery of the bottom up delivery programme - Monthly trend information for a number of key financial metrics The current forecast outturn position is reported at the previous proposed plan, however, the Trust now has an updated agreed plan which has been accepted. This is a breakeven position, supported by £13.5m deficit support funding. Forecast outturn will be reported to deliver this plan by year end. The scenario analysis in the supporting information show the challenge related to this, with a Best, Mid and Worst scenario deficits of £13.5m, £27.7m and £36.9m (all excluding deficit support funding). The WRAP programme, KPMG outputs, Central actions and outputs of the Simon Worthington review has been combined and updated to reflect an updated framework which is outlined as – - Turnaround Delivery Programme (£22.5m) - Income Assurance Programme (£11.4m) - Technical/Balance Sheet delivery (£3.7m) The total impact is £37.6m.	<table><tr><th>Countermeasure</th><th>Owner</th><th>Date</th><th>Status</th></tr><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>Complete</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>Delivery of workforce controls in relation to – - Recruitment Pause - Variable Pay Reduction of 46% - RLW change - Reduction in premium rate activity </td><td>Chief People Officer and Director of Finance</td><td>July 2026</td><td>Implemented</td></tr><tr><td>Delivery of wider turnaround programme</td><td>Various</td><td>July 2026</td><td>Implemented</td></tr><tr><td>Refocus various strands of work to reflect updated position</td><td>Director of Finance</td><td>August 2026</td><td>Complete</td></tr></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	Complete	Delivery of 2026/27 Activity Plan	Chief Operating Officer	March 2027	In Progress	Delivery of workforce controls in relation to – - Recruitment Pause - Variable Pay Reduction of 46% - RLW change - Reduction in premium rate activity	Chief People Officer and Director of Finance	July 2026	Implemented	Delivery of wider turnaround programme	Various	July 2026	Implemented	Refocus various strands of work to reflect updated position	Director of Finance	August 2026	Complete	4 x 4 = 16	3 x 3 = 9
		Countermeasure	Owner	Date	Status																									
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Delivery of wider turnaround programme	Various	July 2026	Implemented																											
Refocus various strands of work to reflect updated position	Director of Finance	August 2026	Complete																											
The Trust will move out of segment 3	Currently the National Oversight Framework has an override based on financial plans or performance being breakeven or worse. The Trust has established there is the ability to breakeven in 2027/28, however this would be dependent on the outputs of a community services review in conjunction with Humber and North Yorkshire ICB, the delivery of the Waste Reduction and Productivity Programme recurrently, and appropriate financial risk sharing mechanisms in place. Within the oversight framework there are three finance measures which are outlined below	<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</td><td>Director of Finance</td><td>September 2026</td><td>In progress</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	Director of Finance	September 2026	In progress																
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True North Metric	Vision	Goal	Current State			Countermeasures				Level of Risk to Achieving Goal	Level of Risk for progressing actions										
			<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>-5.70%</td><td>4</td></tr><tr><td>Implied Productivity v previous year</td><td>0.05%</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	-5.70%	4	Implied Productivity v previous year	0.05%	4	pricing following change since covid.					
Metric	Q3 2025/26 Position	Q3 2025/26 scoring																			
Planned Surplus/Deficit	-1.39%	3																			
Year to date variance to plan	-5.70%	4																			
Implied Productivity v previous year	0.05%	4																			
			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	Complete															
			Address coding backlog through recovery plan	Deputy Director Business Intelligence, Planning, Performance and Productivity	July 2026	Complete															

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							

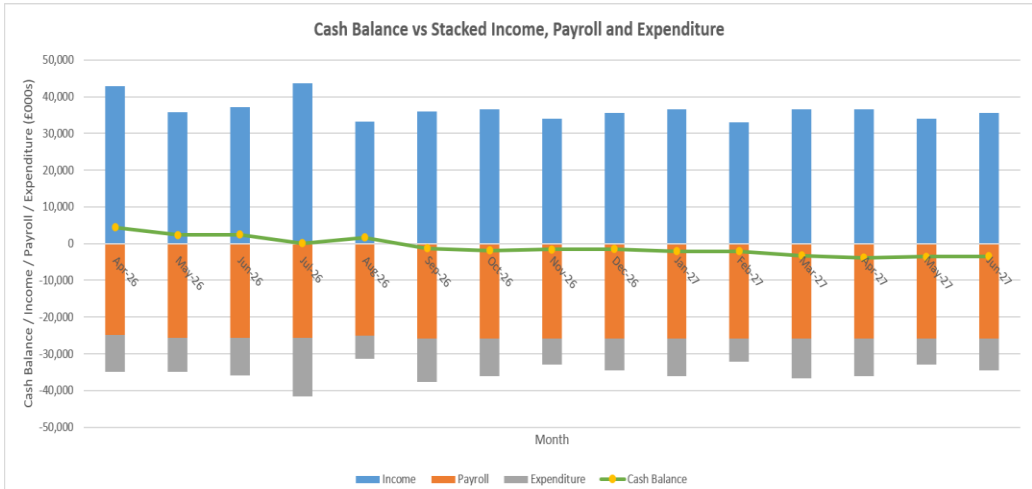
Strategic Project: Productivity & Sustainability

Workstream	True North Metric	Vision	Goal	Current State	Countermeasures	Level of Risk to Achieving Goal	Level of Risk for progressing actions
Productivity and Sustainability	Financial Sustainability	Short Term Deliver a 12-month WRAP / financial recovery project that stabilises the Trust's finances and cash position while protecting safe, high-quality care—by coordinating and assuring directorate-led schemes (existing and new), tightening key controls, improving contract and income recovery, and delivering practical productivity improvements that makes savings recurrent where possible. Long Term Build a Trust-wide 3–5-year Programme that leverages IMPACT methodology to free up time and capacity for care and strengthen financial sustainability through digital/AI, safe workforce change, service redesign / decommissioning and income growth.	Short Term Month 2: One Trust-wide WRAP delivery plan agreed. Month 3: Every directorate has a clear plan to deliver its schemes and has identified further opportunities to close the gap (with the main risks and gaps clearly shown). Delivery underway. Month 4: Core controls in place so overspends are visible and acted on quickly (workforce controls, approval gates, and benefit tracking). Month 11: High-impact directorate-led and Trust-wide schemes delivered Month 11: Pipeline for the following year identified Long Term Month 6: A small number of Trust-wide "big moves" agreed, with named leads and clear measures. Year 1: Clear, up to date strategies defined for digital/workforce/estates/finance and a joined-up roadmap established. Year 1 - Deliver a tactical WRAP/Financial Recovery Project under this Strategic Programme Year 2: Digital/automation wave 1 delivered, with evidence it reduces manual work and frees up capacity. Year 2: First tranche of 'service redesign/stop-doing' delivered safely (quality, safety and equality checked). Years 3–5: Safe workforce change and income growth delivered and scaled; expanding what works.	The current state is detailed in the Finance Board Report		4 x 4 = 16	3 x 3 = 9

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.	The position will be updated following the finalisation of affordable establishment reviews, with countermeasures developed at that stage.			

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. The situation is becoming more critical and September currently all supplier payments will need to withheld to ensure enough cash to cover payroll without emergency cash support. Supplier's are placing accounts on hold until invoices settled.  The chart, titled 'Cash Balance vs Stacked Income, Payroll and Expenditure', shows monthly data from April 2026 to June 2027. The Y-axis represents 'Cash Balance / Income / Payroll / Expenditure (£000s)' ranging from -50,000 to 50,000. The X-axis represents 'Month'. The chart uses a stacked bar format where blue represents Income, orange represents Payroll, and grey represents Expenditure. A green line with diamond markers represents the Cash Balance. The Cash Balance starts at approximately £5,000 in April 2026 and shows a general downward trend, reaching approximately -£10,000 by June 2027. The total expenditure (Payroll + Expenditure) is consistently higher than the income, leading to the negative cash balance.	5 x 5 = 25	4 x 2 = 8 March 2027	Financial: revenue, funding and liquidity	Cautious

		Cash support requests submitted summarised below <table><tr><th>Cash Support</th><th>Requested</th><th>Approved</th></tr><tr><td>April</td><td>£9.5m</td><td>£4m</td></tr><tr><td>May</td><td>£4m</td><td>£2m</td></tr><tr><td>June</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>£0m</td></tr><tr><td>September</td><td>£1.3m</td><td></td></tr><tr><td>October</td><td>TBC</td><td></td></tr></table> **September – emergency cash applied for £4.5m in addition to the £1.3m. Key actions being prioritised 1. Aged Debt 2. WRAP delivery (Run rate reductions) 3. Turnaround Actions	Cash Support	Requested	Approved	April	£9.5m	£4m	May	£4m	£2m	June	£1.8m	£1.8m	July	£3.2m	£10m	August	£1.4m	£0m	September	£1.3m		October	TBC					
Cash Support	Requested	Approved																												
April	£9.5m	£4m																												
May	£4m	£2m																												
June	£1.8m	£1.8m																												
July	£3.2m	£10m																												
August	£1.4m	£0m																												
September	£1.3m																													
October	TBC																													
ID1241	26/27 Waste Reduction and Productivity	Full refresh over August on schemes that need to be delivered in year. Further detail available in Finance Board pack.	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 £13.5M 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. NHSE have now agreed a deficit plan £13.5m and deficit support funding will be allocated to this value bringing the plan to breakeven.	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 September 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

Trust Board (Public)
30/09/2026

Title:	Winter Plan
Responsible Director:	Julia Nixon Chief Operating Officer
Author:	Julia Nixon Chief Operating Officer

Purpose of the report	Approval	X	
	Assurance	X	
	Discussion		
	Information		
Summary of key issues:	The winter plan addresses NHS England's four priorities: attendance, ambulances, admissions and acuity. Modelling indicates that without 20 additional beds, occupancy could reach 103%, with more than 12 patients consistently bedded in the Emergency Department during December and January. The proposed approach prioritises admission avoidance, shorter lengths of stay, earlier discharge and greater use of Urgent Community Response and Hospital at Home before opening additional capacity. Support would then be phased in from late December according to operational demand. The proposed countermeasures have a headline cost of approximately £715,495, mitigated to £612,412 and include escalation beds, additional clinical cover, rapid assessment, therapy, transfer-team capacity and supporting services. Potential savings are available, but the deck identifies associated risks including slower discharge, longer waits and reduced patient experience, and impact on UEC performance. The escalation framework progressively increases capacity to 390 adult beds and spaces. Later stages require repurposing SDEC, SAU, Day Surgery and Rowan Ward, affecting assessment services, elective activity and infection-control arrangements. The wider plan includes additional local-authority care capacity, maintaining staff flu-vaccination uptake at or above the 60–65% national target, and stress-testing against a 10% increase in emergency demand, 2% higher sickness and 5% improved vaccination performance. Executive decisions required: confirm the funding envelope and mitigations, endorse the phased escalation model and triggers, and provide Board assurance that the organisation is prepared for the modelled winter scenarios.		
Trust Strategy and Strategic Ambitions	The Patient and Child First		
	Improving the health and wellbeing of our patients, children and communities		
	Best Quality, Safest Care		X
	Person Centred, Integrated Care; Strong Partnerships		X
	Great Start in Life		
	At Our Best: Making HDFT the best place to work		
	An environment that promotes wellbeing		X

	Digital transformation to integrate care and improve patient, child and staff experience	
	Healthcare innovation to improve quality	
Corporate Risks	CRR ID #3: Risk to Emergency Care Standard Performance (National Standard 78%)	
Prior Committee Review / Governance Route:	Winter Planning Task and Finish Group / SDR	
Recommendations:	To agree the funding envelope and associated mitigations, approve the phased escalation model and triggers, and provide assurance to the Board that appropriate plans are in place to manage the modelled winter scenarios.	
Impact Assessments	Financial	x
	Workforce	X
	Quality & Safety	x
	Legal/Regulatory	
	Equality & Diversity	
	Risk	x
Consultation / Engagement	Directorate Tri Team	

Freedom of Information	Our Policies and Procedures
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Winter Planning 2026/27

1. National Position
2. Winter 25/26
3. Seasonal Infections Profile
4. Proposed Winter Counter Measures
5. Capacity Escalation Arrangements
6. Staff and patient Vaccination
7. ICB Stress Testing & Plan Submission



National Expectations for Winter 26/27

In July 2026 NHSE identified the '4A's' as a framework for Trusts to plan winter. Winter briefing sessions are planned for September 2026.

The 4A's are;

1. Attendance
 2. Ambulances
 3. Admissions
 4. Acuity
- 

Ambulance arrivals

- Expected +2 arrivals higher than summer months.
- Strong ambulance handover processes and data.
- POC Testing supports respiratory attendance increases and flow
- Focus on flow/discharge for frail members of the community
- Focus on prehab/rehab and assessment for those post fracture

Winter Preparation

Harrogate and District NHS Trust

Have you planned for your 4As?

UEC Winter Planning



Attendances

Ambulances

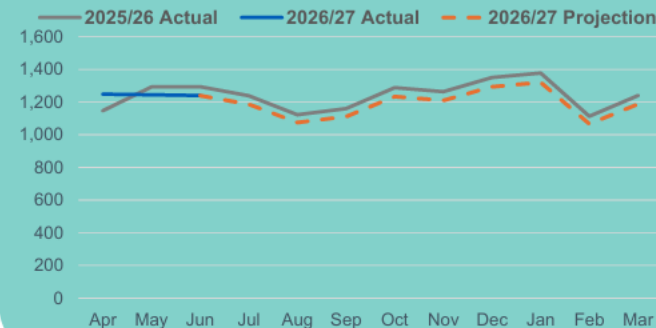
Acuity

Admissions

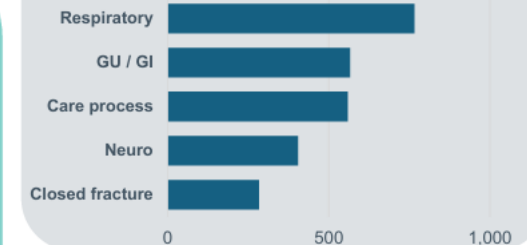
NE&Y Analytics
Delivering trusted analytical insight
Improving healthcare outcomes for all

NHS
England

Attendances conveyed by ambulance during the winter months (Nov-Feb) are expected to be, on average, 2 per day higher than in summer. Winter demand often coincides with higher sickness absence and higher acuity levels alongside other pressures.



Most common winter attendance reasons for patients conveyed by ambulance:



During winter months, 4 Hour Performance for patients conveyed by ambulance decreases by:

10.5%

During winter months, 12 Hour Waits in Department for patients conveyed by ambulance increase by:

5.3%

During winter months, Mean Time in Department for patients conveyed by ambulance increases by:

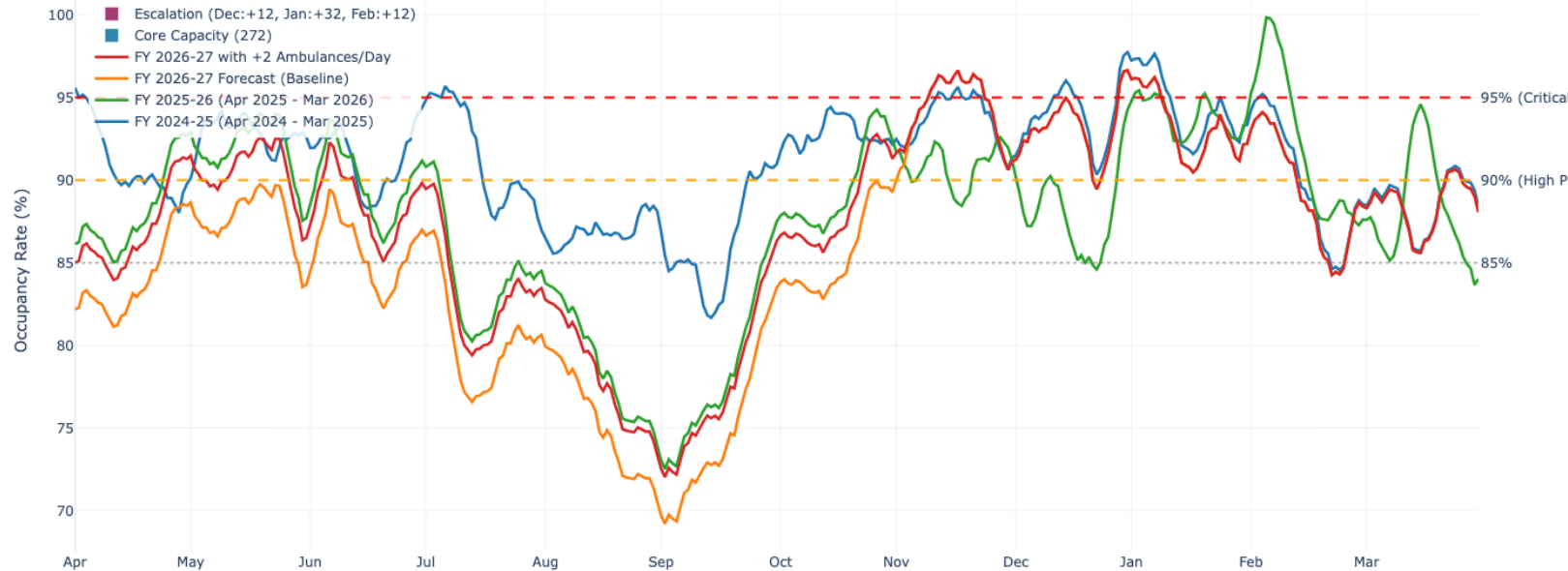
0:59:17

Attendance and Admission and impact on occupancy

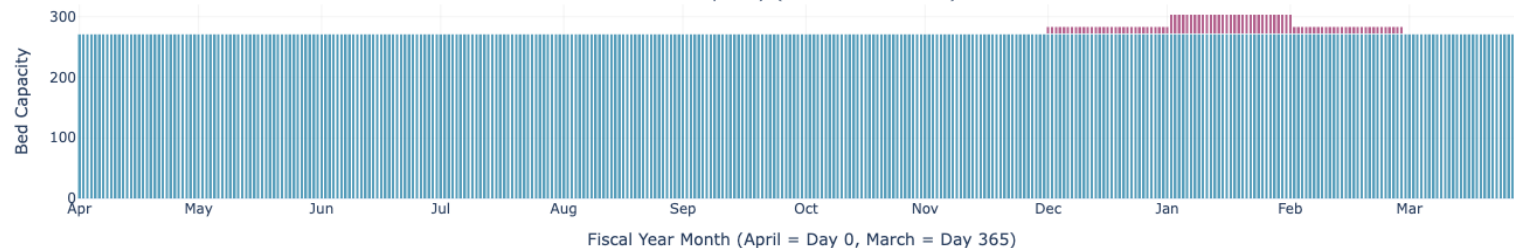
Fiscal Year Bed Occupancy Analysis (April - March)

Variable Bed Capacity: 272 (Apr-Nov), 284 (Dec), 304 (Jan), 284 (Feb), 272 (Mar)

Occupancy Rate (%)



Bed Capacity (Core + Escalation)



- September Occupancy drops – how can we reduce core bed base/additional staffing variable spend.
- November risk in occupancy –how can we mitigate through;
 - LOS Reduction/LLOS reviews
 - SDEC increases
 - UCR/VW/H@H increases
- If we don't open additional 20 beds the impact will be occupancy of 103% = 12 + patients bedded in ED consistently over Dec/Jan.
- Risk to patient safety and cost of additional staffing.

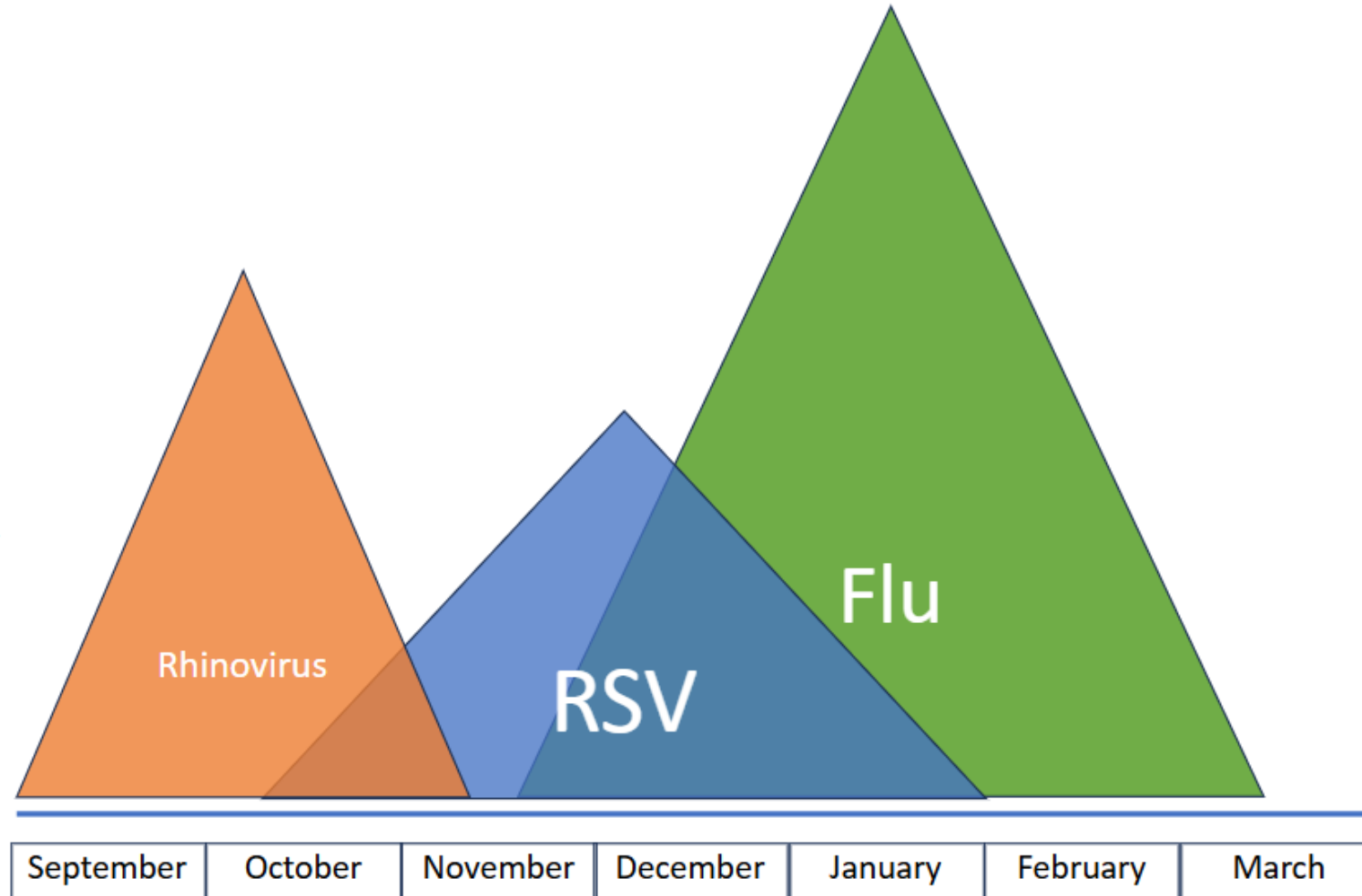
Standard Patterns of Infections

- There is a back to school rise in infections every September- ED pressures but fewer admissions
- There is a seasonal rise in RSV peaking at the end of November- impacts paediatrics
- Flu cases usually peak in January with infection rate increasing in December with consequent increase in ED attendances / hospitalisations



Expected Seasonal Infection Profile

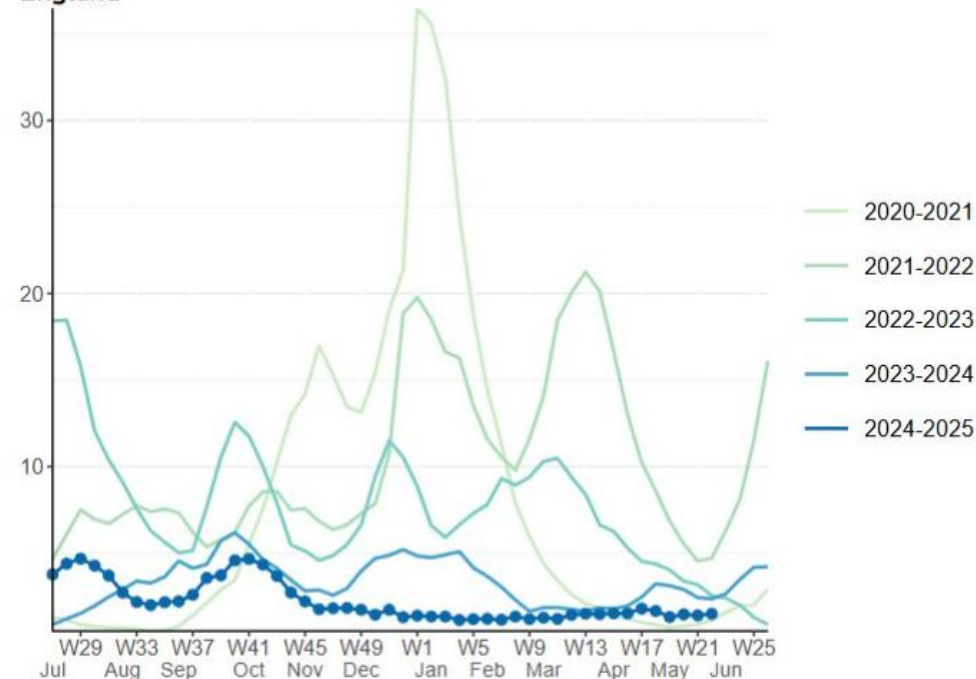
Positivity in
the community



What about COVID?

- UK current approach to prevention is Hybrid Immunity- a mixture of regular infection and primary vaccination, with boosters for the immune compromised
- Nationally we have had several months of very low COVID admissions across England in all ages plus low infections rate internationally

Figure 6. Weekly overall COVID-19 hospital admission rates per 100,000 trust catchment population reported through SARI Watch mandatory surveillance, England



Three principles anchor the 2026/27 winter plan

- Every winter decision should protect care, demonstrate value and sustain delivery.

01 PROTECT QUALITY & SAFETY

Maintain quality of care and safeguard patients and staff throughout winter.

02 SECURE VALUE

Ensure every additional cost delivers value for money.

03 DELIVER CORE STANDARDS

Maintain constitutional standards across UEC, RTT and Cancer.

QUALITY • VALUE • STANDARDS

Proposed Winter Counter Measures -LTUCC

Priority	Proposal	Staffing / Hours	Total Cost	Benefit
1	AFU Escalation beds – from 1 st December to 2 nd February (8 weeks)	1 x additional RN 7-days per week	£34, 463*	Patients cared for on a ward rather than bedded in ED. Cost on AFU rather than ED. Ensures continued MDT working minimising LOS
2	ED Rapid Assessment, Treatment and Discharge (RATD) Dr	7-weeks, 18:00 – 00:00	£85,945	Rapid assessment and discharge of low acuity patients in ED Costed at worst case – less year spent 50% of this.
3	7-day consultant cover (inc. SDEC) – 7 weeks starting 26/27 December	7-day cover with enhanced cover Sat & Sun	£19,424.16	Maximizing acute and ward flow, COS delivery, weekend discharge and decision making plus 7-day SDEC and 7-day Hospital @ Home
4	Additional twilight 4 hours med reg to match core demand	Change to 16:00 – 20:30 weekdays	£13,835.54	Timely review of acutely unwell patients to support UEC flow, decision making & discharge from ED at times of peak pressure.

Proposed Winter Counter Measures -LTUCC

Priority	Proposal	Staffing / Hours	Total Cost	Benefit
5	Gastro resident (Farndale, Tier 2)	1 x Tier 2 8-4, M-F	£16,272.90	Required to support Farndale during period of escalation
6	Respiratory Therapy	1 x wte to support ICU/Resp patients	£6,683.25	To manage peak admissions & discharges for patients with resp conditions. Opportunity to appoint rotating therapist (B5) fixed term to minimize spend (Releasing highly qualified resp specialist)
7	Outlier Doctor	8-4 , M-F	£16,272.90	Improved flow and support for outlier patients to avoid delays in enacting consultant plans

Proposed Winter Counter Measures - PSCC

Priority	Proposal	Staffing / Hours	Total Cost	Benefit
1	FY2 ED Support Shift From 1st December to 31st January	08:00 - 20:30	£36,752	Based in ED to review/clerk Surgical Patients. Assist with flow, quicker decision making and clinical interventions.
2	FY2 Discharge Lounge * From 28th December for 4 weeks FIRST PRIORITY GREEN	09:00 - 17:00	£16,380	Based in Discharge Lounge to complete TTO's for patients so they can be sent without to expedite early discharges. They would also be used to support with seeing patients in SAU.
3	Open escalation beds on Bolton Ward x 5 Beds Best Case from 1st December to 22nd February (12 Weeks) Worst Case 1st November - 31st March (22 Weeks)	1 RN LD & ND, 1CSW LD & ND	£75,401	Additional surgical and gastro capacity
4	Opening Farndale as an escalation ward. Additional 23 beds. Requires nursing workforce and non pay (eg pharmacy, consumables et c)	Nursing Model 5/3 day model 4/3 overnight Medical staffing cost neutral through gastro Pharmacy Technician Mon – Fri 9-5pm	£299,657 + £5,681	Improved flow, opportunity to relocate gastro/gen med from surgical wards to protect winter elective activity. Increase side room capacity to help minimise IPC risks. Flex in RN model phased open/close from 28 th Dec 26

Proposed Winter Counter Measures - Corporate

Priority	Proposal	Staffing / Hours	Weeks	Total Cost	Benefit
1	Increase Transfer team. Two team members on a Monday and Tuesday. 12 weeks	B3 x1 Working a 10 am to 22:00 rota.	10	£17,796	Support quicker flow to the downstream wards and transfer of patients from ED
1	HIF additional cleaning/sheets/meals and portering for additional beds	Linen Deep clean 3 FTE Additional cleaning of winter ward and meals	7	£58,972.54	

Total Predicted Winter Counter Measure Costs

Scheme	Description	Weeks	Total
AFU Escalation	1 RN Night 7 days	12	£34,462.66*
Twilight Med Reg	1600-0000 (+4hrs)	8	£13,856.54
B5 Physio	Support flow/discharge to additional beds	7	£6,683.25
Tier 2 Dr	0800-1600 weekends	12	£12,398.40
Consultant	7 day cover SDEC/H@H	7	£19,424.16
Outlier Dr/Farndale Dr	Tier 2 for additional beds	7	£32,485.80
Senior ED RAT	Consultant/SAS/ST7+	7	£85,945.02*
Transfer team	10-2200hrs	10	£17,796
Bolton ward bed escalation		12	£75,401*
Farndale winter ward	Nursing cost Pharmacy Tech cost	7	£299,657 £5,681
PSc F2 ED	0800-2030	8	£36,752
PSC F2 Discharge	0900-1700	8	£16,380
HIF additional	Linen/meals/cleaning	7	£58,572.04

Total
£715,494.83
* Some
already in
YTD run rate

Financial mitigations- to be discussed

- Directorate RAG rated that the Discharge Dr could be removed, the impact would be on slower discharge on day, but not a safety risk.
- ED RATD shift, costed at consultant rate, last year filled by 50% MG, could also be profiled for 'peak days' (Mon/Tues/Fri/Sat/Sun) or removed completely. However last year ED sprint in Q4, this supported both flow and performance in UEC pathway. Costing TBC via finance but c 50% 42K.
- PSC ED F2, mitigation plan. However surgical patients have long waits in ED currently due to model – this requires some focused work to change and will take beyond winter 26/27. The risk is long waits for assessment/treatment. Impact on quality/safety/experience.
- Leading to indicative mitigated costs of £621,412
- We could reduce this further with the risk on quality/safety and performance in UEC pathway.
- NHSE clear steer on maintaining performance delivery over winter at NEY Winter planning event 17/9/26.

Use existing capacity first, then phase winter support

WHY THIS APPROACH

12 WEEKS beds remained open last winter

Flow and discharge remained challenging, while additional bed capacity created an overspend of X.

OPERATING PRINCIPLE

Expand existing resource and processes before adding capacity.

Prioritise admission avoidance, UCR/H@H utilisation, LLOS actions and earlier discharge decisions.

PHASED ACTIONS



Perfect Week

Optimise pre-winter pathways; test admission avoidance and increase UCR/H@H utilisation.

Add flow support

Strengthen flow and discharge ahead of bank-holiday demand.

Open profiled beds

Phase bed opening using last year's learning and modelling data. Phased opening and closing, caveated with we will only open if needed.

1.5 beds per 10,000

Lowest quartile nationally and lowest in the region — supporting evidence we manage an efficient bed base.

Capacity Escalation Arrangements – 1st December

Jervaulx (30) Frailty	Byland (30) Frailty	Lascelles (13) Rehab	Trinity (19) Rehab/ Stepdown	Nidderdale (30) Female Surgical	Bolton (24) Male Surgical with protected SAU trolleys
MAU (31) Medical Assessment Unit	Swaledale (18) Acute Frailty Admissions & Short Stay	Wensleydale (28) Cardiology, Respiratory, MECU/ CCU		Rowan (16) Elective Ring Fenced Orthopaedic	Fountains (28) Trauma Surgery
Granby (22) Stroke, Neurology	Oakdale (30) Endocrine/ Gen Med/ Onc & Haem	TOTAL 271 Adult G&A Beds			



Capacity Escalation Arrangements – Post Winter Ward

Phase 1

AVAILABLE FROM 1 DECEMBER 2026

AFU — increase beds (+4
frailty beds)

Bolton — open additional beds
(+5 beds)

1 | INTERNAL FLEX

MAU — 2 trolleys; in hours
only

1 UP implemented — 7 non-
headed bed spaces; in hours
only

ED — up to 8 patients “bedded
down”

ADDITIONAL 20 SPACES

9 beds + 11 spaces/trolleys

323 adult beds/spaces open

**ENACT FULL CAPACITY
ACTION CARD**

Phase 2 – OPEL 3 +

2 | EXPAND CLINICAL SPACES

Discharge lounge — may
affect elective arrivals and
discharge-lounge use (+6 beds)

ADDITIONAL 20 SPACES

10 beds + 10 spaces/trolleys

343 adult beds/spaces open

**CONSIDER AMBULANCE
DIVERT**

**CONSIDER CALLING
CRITICAL INCIDENT**

SAU spaces — bed down
patients; loss of SAU increases
ED pressure and slows
recovery (+4 beds)

Medical SDEC — loss of SDEC
assessment; additional staffing
if 24/7 (+10 trolleys/spaces)

Phase 3 – OPEL 4

3 | DAY SURGERY

Day Surgery — additional
staffing; loss of Day Surgery
(+8 beds)

351 adult beds/spaces open

**CALL CRITICAL
INCIDENT**

4 | ROWAN

Rowan — cross-
contamination risk for existing
patients; loss of orthopaedic
elective work; prolonged
recovery (+16 beds)



Capacity Escalation 29th December 2026 onwards

Medical Wards – 189 Beds + 32 Rehab				Surgical Wards – 98 Beds	
Jervaulx (30) Frailty	Byland (30) Frailty	Lascelles (13) Rehab	Trinity (19) Rehab/ Stepdown	Nidderdale (30) Female Surgical	Bolton (24) Male Surgical with protected SAU trolleys
MAU (31) Medical Assessment Unit	Swaledale (18) Acute Frailty Admissions & Short Stay	Wensleydale (28) Cardiology, Respiratory, MECU/ CCU		Rowan (16) Elective Ring Fenced Orthopaedic	Fountains (28) Trauma Surgery
Granby (22) Stroke, Neurology	Oakdale (30) Endocrine/ Gen Med/ Onc & Haem	TOTAL 294 Adult G&A Beds			Farndale (23) Escalation Ward Gen Med/ Gastro

Capacity escalation: sequence and triggers

Escalate in sequence; capacity rises from 346 to 390 adult beds/spaces.

STAGE	ACTION	CAPACITY	TRIGGER
SURGE	AFU +4 frailty beds • Bolton +4 surgical beds MAU +2 trolley spaces (in hours only) 1 Up implemented up to 8 patients “bedded down”	346 +20 spaces 9 beds + 11 trolley spaces	ENACT FULL CAPACITY ACTION CARD
02 CONVERT	Discharge Lounge +6 beds — impacts elective arrivals and lounge capacity Medical SDEC +10 trolley spaces — loses SDEC assessment; staffing needed for 24/7 SAU +4 beds — loses SAU; increases ED pressure and slows recovery	366 +20 spaces 10 beds + 10 trolley spaces	CONSIDER AMBULANCE DIVERT CONSIDER CALLING CRITICAL INCIDENT
03 DAY	Day Surgery +8 beds — additional staffing; loss of Day Surgery	374 +8 beds	CALL CRITICAL INCIDENT
04 ROWAN	Rowan +16 beds — cross-contamination risk; loss of orthopaedic elective work; long recovery	390 +16 beds	LAST RESORT

Remaining surge locations: Endoscopy • Cath Lab Recovery • Theatre Recovery

Farndale capacity de-escalates in three planned stages

- Open Farndale only if required, then step capacity down as winter pressure eases.

FARNDALE DE-ESCALATION

28 DECEMBER

AFTER 4 WEEKS

BY 12 FEBRUARY 2027

OPEN IF REQUIRED

Run the additional Farndale beds for 4 weeks.

STEP DOWN

Reduce Farndale to 15 beds for 3 weeks.

CLOSE FARNDALE

Over the following month, reduce additional capacity on Bolton and Farndale.

TRIGGERS TO CONSIDER WHEN OPENING/CLOSING ADDITIONAL WINTER CAPACITY

01 OPEL 3+

02 Discharge targets missed for >3 days
because of acuity or respiratory illness

03 ≥50% of ED2 capacity unavailable for >3 consecutive days
due to “bedding down”

North Yorkshire Council – winter plans

Scheme	Hours	Benefit
4 x dementia nursing beds purchased in Harcourt House	24/7 provision from end of Oct 26	Will enable patients with higher level dementia related needs to access a bed faster than currently
Station View to lift admission cap from 2 per day to 3 per day (agreed with new HARA manager)	24/7 provision from Dec 26	Facilitate improved access to intermediate care beds and reduce delays
Ensure NYC discharge hub team are at a minimum of 50% between Christmas and New Year	9-5 all days	Ensure discharge capacity remains in place through minimum staffing levels higher than previous years

Vaccination plan

- The 2026/27 staff flu campaign aims to protect staff and patients, support winter resilience, and meet NHS England vaccination requirements.
- HDFT achieved **66% frontline healthcare worker uptake** in 2025/26 and is aiming to maintain or exceed the **60–65% national target**.
- The campaign will offer vaccination to **100% of eligible staff and volunteers**, with most vaccinations delivered between **28 September and 30 November 2026**.
- Delivery will combine bookable/drop-in clinics, roving teams, extended hours, weekends, and community hubs to maximise access.
- Additional Band 5 vaccinators, admin support, training, stock, IT, and governance arrangements will support delivery.
- Progress will be monitored through weekly reports, directorate-level tracking, benchmarking, and escalation through People & Culture Committee and Trust Board.
- Approval is recommended because the model is proven, cost-effective, and supports staff wellbeing, patient safety, and operational resilience.

Stress Testing of Winter Plan

HDFT provided our initial winter readiness submission to the ICB on the 30st September with supporting Board Assurance Document.

In preparation, providers are asked to consider the following scenarios

- 10% increase in ED attendances and admissions
- 2% increase in sickness rates
- and demonstrating the robustness of their staff vaccination plan – 5% improvement

The Trust is required to provide a Board Assurance sign off of the plan by September 30th 2026



Appendix A – Quality Impact Assessment Template

OVERVIEW

This tool provides a template for carrying out a quality impact assessment on a new or existing project, programme, savings scheme. It is intended to support quality governance by assessing the impact of savings schemes and service change on quality. It is also intended to support the Trust in meeting its obligations under the Equality Act (2010), to undertake race, disability and gender impact assessments. Where potential adverse impacts are identified they should be risk assessed using the risk scoring matrix to reach a total risk score.

Quality is described in 7 areas, each of which must be assessed at stage 1. Where a potentially adverse risk score is identified and is ≥ 8 this indicates that a more detailed assessment is required in this area. All areas of quality risk scoring greater than 9 must go on to a detailed assessment at Stage 2.

SCORING

Each proposal will need to be assessed whether it will impact positively, adversely or have a neutral impact on patients / staff / organisations. Where adverse impacts are identified scores must be produced by assessing the level of impact and the likelihood of this occurring and assigning a score to each. These scores are multiplied to reach a total score. A fuller description of these can be found at Appendices C & D. (These will be recorded in Part A below)

Where adverse impact score ≥ 8 is identified in any area this will result in the need to then undertake a more detailed Quality Impact Assessment. Where there are more than 3 adverse impacts but the total scores are < 8 the Executive Director of Nursing, Midwifery & AHPs and Executive Medical Director following review may request a full assessment to be completed

Quality Impact Assessment (QIA)

Scheme/project/ savings programme	Winter Plan 26/27		
Description of new or existing project, programme, savings scheme.	The winter plan addresses NHS England's four priorities: attendance, ambulances, admissions and acuity. Modelling indicates that without 20 additional beds, occupancy could reach 103%, with more than 12 patients consistently bedded in the Emergency Department during December and January. The proposed approach prioritises admission avoidance, shorter lengths of stay, earlier discharge and greater use of Urgent Community Response and Hospital at Home before opening additional capacity. Support would then be phased in from late December according to operational demand. The proposed countermeasures have a headline cost of approximately £715,495, mitigated to £612,412 and include escalation beds, additional clinical cover, rapid assessment, therapy, transfer-team capacity and supporting services. Potential savings are available, but the deck identifies associated risks including slower discharge, longer waits and reduced patient experience, and impact on UEC performance. The escalation framework progressively increases capacity to 390 adult beds and spaces. Later stages require repurposing SDEC, SAU, Day Surgery and Rowan Ward, affecting assessment services, elective activity and infection-control arrangements.		
Directorate Sponsor	Name: Julia Nixon	Author/ Project Lead	Name : Julia Nixon
Approval			
Directorate Project Sponsor (name)	Signature	Date	☐ Approved ☐ Declined

QIA Panel Member (name)	Signature	Date	☐ Approved ☐ Declined
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Part A: Initial Quality Impact Assessment Screening

Answer positive, neutral or adverse (P/N/A) against each area. If A score the impact, likelihood and total in the appropriate box. If score ≥ 8 insert Y for full assessment (see Part 2)

Area of Quality	Impact question	P/N/A	Impact	Likelihood	Score	Full Assessment required
Regulatory/ Legal	Could the proposal impact on any of the following - compliance with the NHS Constitution, partnerships, safeguarding children or adults and the duty to promote equality?	P	3	2	6	N
Patient/Staff Experience	Could the proposal impact on any of the following - positive survey results from patients and staff, patient choice, personalised & compassionate care?	P	3	2	6	N

Patient/Staff Safety	Could the proposal impact on any of the following – safety, systems in place to safeguard patients to prevent harm, including infections?	P	2	2	4	N
Clinical Effectiveness	Could the proposal impact on evidence based practice, clinical leadership, clinical engagement and high quality standards?	P	5	1	5	N
Prevention	Could the proposal impact on promotion of self-care and improving health equality?	N	1	1	1	N
Area of Quality	Impact question	P/N/A	Impact	Likelihood	Score	Full Assessment required
Productivity and Innovation	Could the proposal impact on - the best setting to deliver best clinical and cost effective care; eliminating any resource inefficiencies; low carbon pathway; improved care pathway?	P	3	2	6	N
Equality & Diversity	What is the equality impact on race, gender, age, disability, sexual orientation, religion and belief, gender reassignment, pregnancy and maternity?	N	1	1	1	N

Please describe your rationale for any positive impacts here:

Implementing the plan as described by increasing winter capacity in line with demand modelling, will support quality and safety of care and staff wellbeing.

Not opening capacity will impact our patients and staff negatively from quality/safety/performance/wellbeing and wellbeing perspective as this will increase the likelihood of harms to both groups.

Part B: Full Quality Impact Assessment

Area of Quality	Indicators	Description of impact (Positive, Neutral or Adverse)	Risk score (5x5 matrix)			Mitigation strategy, monitoring and review arrangements
			Impact	Likelihood	Overall score	
	What is the impact on the organisation's duty to secure continuous improvement in the quality of the healthcare that it provides in accordance with the Trust Strategy					

Regulatory & Legal	Does it impact on the organisation's commitment to the public to continuously drive quality improvement as reflected in the rights and pledges of the NHS Constitution?					
	Does it impact on the organisation's commitment to high quality workplaces, with commissioners and providers aiming to be employers of choice as reflected in the rights and pledges of the NHS Constitution?					
	What is the impact on strategic partnerships and shared risk?					
	Will it impact on the Trust Quality Priorities?					

Area of Quality	Indicators	Description of impact (Positive, Neutral or Adverse)	Risk score (5x5 matrix)			Mitigation strategy, monitoring and review arrangements
			Impact	Likelihood	Overall score	
	Will this impact on the organisation's duty to protect children, young people and adults?					

Patient & Staff Experience	What impact is it likely to have on reported experience of patients and service users? e.g - Response to local surveys - complaints/concerns - patient feedback - Dignity & respect - Service user satisfaction					
	How will it impact on staff satisfaction?					

Area of Quality	Indicators	Description of impact (Positive, Neutral or Adverse)	Risk score (5x5 matrix)			Mitigation strategy, monitoring and review arrangements
			Impact	Likelihood	Overall score	

Patient & Staff Safety	How will it impact on patient choice? e.g. - choice being influenced by wait times - access to services - straightforward & timely access to care & treatment - Clinical outcomes.					
	Does it support the Trust's ambition to provide person centred care, integrated services through strong partnerships?					
	How will it impact on PSIRF, patient safety events, their reporting and learning?					
	How will it impact on violence and aggression experienced by service users and staff?					
	What is the impact on clinical workforce capability care and skills?					
Area of Quality	Indicators	Description of impact (Positive, Neutral or Adverse)	Risk score (5x5 matrix)			Mitigation strategy, monitoring and review arrangements

			Impact	Likelihood	Overall score	
	How will it impact on staff safety incidents?					
Clinical Effectiveness	How does it impact on implementation of evidence based practice?					
	Does it reduce/impact on variations in care?					
	Are systems for monitoring clinical quality supported by reliable information?					
	How will it impact on either the National or Trust annual Audit Programme?					
Prevention	Does it support people to stay well?					
	Does it promote self-care for people with long term conditions?					
	Does it tackle health inequalities, focusing resources where they are needed most?					

Area of Quality	Indicators	Description of impact (Positive, Neutral or Adverse)	Risk score (5x5 matrix)			Mitigation strategy, monitoring and review arrangements
			Impact	Likelihood	Overall score	
Productivity and Innovation	Does it ensure care is delivered in the most clinically and cost effective way?					
	How will it impact on clinical leadership?					
	Does it eliminate inefficiency and waste?					
	Does it support HDFT's Green / Sustainability Programme?					
	Does it lead to improvements in care pathway(s)?					
Equality & Diversity	What is the equality impact on race, gender, age, disability, sexual orientation, religion and belief, gender reassignment, pregnancy and maternity for individual access to services and experience of using the NHS (Refer to HDFT Equality Impact Assessment Tool)?					

Part C: Record of review

Area of Quality	Indicator	Risk score (5x5 matrix)				Comments & Date of review
		Original score	Impact	Likelihood	Overall score	

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.

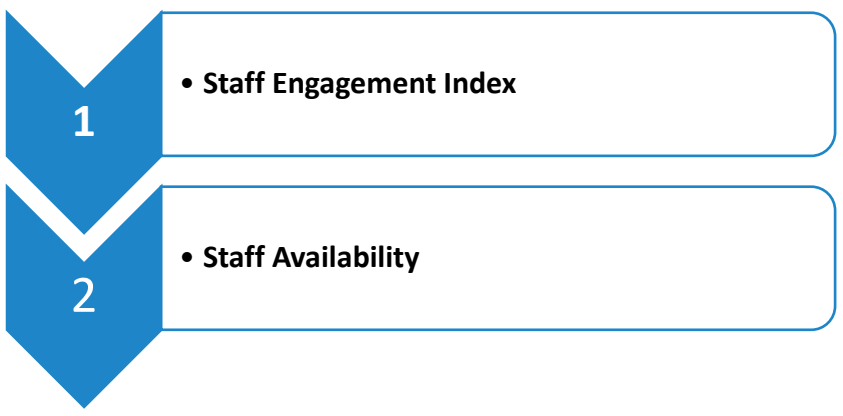
GOALS:

- Looking after our people
 - Physical and emotional support to be “At Our Best”
- Belonging
 - Teams with excellent leadership, where everyone is valued and recognised; where we are proud to work
- New ways of working
 - The right people, with the right skills, in the right roles
- Growing for the future
 - Education, training and career development for everyone

GOVERNANCE:



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



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
At Our Best – Making HDFT the Best Place to Work	Looking After our people	Staff Engagement	Workforce: Cautious							
	Belonging									
	Growing for the future	Staff Availability	Workforce: Cautious							
	New ways of working									

Strategic Metrics Summary:

Workstream	True North Metric	Vision (People Plan)	Goal (True North Metric Target)	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 on 06 July 2026. HDFT implementation planning underway. A package of support/courses for managers/managing in a financially challenged environments has been publicised to support them and staff.			
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 and planning for FY26/27 underway. KITE Awards Celebration event took place on Friday 6 March 2026, including colleagues entitled to Long Service Awards KITE Awards 2027 have now been launched and a decision taken to de-couple long service awards from the event to increase capacity and allow more staff receiving awards to attend.			
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 ran from 01 – 22 July 2026 achieving a 24% response rate (down from 25% in April 26). The engagement score dropped from 68% to 65%. The national benchmark scores are not available until mid-August. (The engagement score in the April 2026 Inpulse Survey placed it 5th / 89 benchmark Trusts.) 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 organisational priority areas of focus have been identified for FY 2026-27. National Education and Training Survey (NETS 2025): Total response rate 97 learners. Highest scoring acute Trust for overall experience in the region, 5th highest against all 22 regional Trusts – 81.26%. One red flag in Obs & Gynae, pink flag themes in Obs & Gynae and Sexual Safety 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 again 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. A paper on health surveillance risk went to the August Health and Safety Committee and the business case is again being re-reviewed for the 5th time along with the health surveillance paper with a plan to go back to Business Case Review Group once again. (The People & Culture department has also undertaken its affordable establishment review and cannot at this stage identify resource to move across to support OH).			
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 has been scheduled for November as well as one for the REACH Network. 8 Equality & Diversity Champions have just completed the training. The Equality & Human Rights Commission ruling on transgender issues was launched for consultation in May, with the outcome that a person's sex is to be determined by their biological sex. A meeting with Planning Dept 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. IPMs are also involved in any Trust Executive Recruitment processes.			

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
		systems used across the NHS.	colleagues and managers, streamlines workforce processes, and provides better workforce data and insights for decision-making	A series of webinars were held in August and domain leads have been established, This phase of the programme has a mandatory completion deadline of 13 November 2026, with no flexibility to extend this timescale, making timely engagement and delivery essential.			
		Job Planning compliance	95%	Job plans effective from 1st April - overall 78.23% (LTUCC 80.36% and PSCC 76.73%) – 30 job plans in dispute (15 in LTUCC and 15 in PSCC). 86.39% is the level of compliance reported to NHSE (rolling and signed off by individual and clinical lead only)			

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. This will help enable us to fully align the workforce with service requirements/improvements	- To ensure medical and dental staff are deployed to maximum effect - To enable workforce gaps to be planned and managed - For the locum bank to be managed via the e-Rostering system achieving visibility and accountability - To ensure best practice roster rollout - To have full visibility of having the right people in the right place at the right time - To have all unavailability's of staff reported - For all additional payments to be digitised for payment and removing all paper/spreadsheet submissions	This project has now ended and work has transitioned to business as usual. Only General Surgery and Radiology were not able to be completed within the project itself. A decision was also taken not to move Anaesthetics across to the Optima system as it does not yet have the level of required functionality. This will be reviewed at the appropriate time in the future as Optima continue to develop their system.			

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 (last year)

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 a different area of focus

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

Related Corporate Risks.

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

Related External Risks.

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

Board of Directors Meeting (Public)
30 September 2026

Title:	Workforce Race Equality Standard Report 2026
Responsible Director:	Chief People Officer (Chris Mannion)
Author:	Equality, Diversity, and Inclusion Manager (Richard Dunston Brady)

Purpose of the report	Approval	x	People and Culture Programme Board are asked to approve the 2026 Workforce Race Equality Standard (WRES) Report and Action Plan.
	Assurance	x	The WRES is a mandatory NHS England national workforce equality standard. It is designed to help measure and improve the experiences of people from Black and Minority Ethnic communities. The report provides assurance regarding workforce representation, recruitment, staff experience, career progression, organisational culture, and Board representation. The report supports compliance with the Equality Act 2010, the NHS People Promise, and the Trust's commitment to creating an inclusive workplace. The report benchmarks the Trust's 2026 position against the previous year, and identifies areas of progress, and those requiring further improvement.
	Discussion	x	The continued disparity in appointment outcomes from shortlisting, where White candidates remain more likely to be appointed than BME candidates. The under-representation of BME colleagues at Board level, particularly within Executive roles.
	Information	x	This annual report provides assurance to the People and Culture Programme

		Board regarding the Trust's workforce equality performance and fulfils the NHS England reporting requirements. The report highlights HDFT's position across nine different metrics with actions to support further improvement.
Summary of key issues:	• This report presents the Workforce Race Equality Standard (WRES) 2026 position using the Trust's data snapshot on 31 March 2026. • The overall proportion of staff recorded as Black and Minority Ethnic (BME) is 16.44% (900 staff), compared with 16.47% (864 staff) in 2025. The BME headcount has increased, although the percentage has remained broadly stable because the overall workforce has also grown. • The relative likelihood of White candidates being appointed from shortlisting has increased from 2.97 in 2025 to 3.52 in 2026. This remains the poorest performing WRES metric. • The relative likelihood of BME staff entering the formal disciplinary process has improved from 1.01 in 2025 to 0.64 in 2026. This is a positive position, but interpretation should remain cautious because the number of BME staff entering the process is small. • BME staff remain more likely than White staff to access non-mandatory training and CPD. The relative likelihood of White staff accessing training compared with BME staff is 0.89 in 2026, compared with 0.83 in 2025. • Board representation remains below the proportion of BME staff in the workforce. BME voting Board membership is 6.25% compared with 16.44% (900 staff) in the workforce. There are no BME Executive Board members recorded in the 2026 return.	
Trust Strategy and Strategic Ambitions	The Patient and Child First Improving the health and wellbeing of our patients, children and communities	

	Best Quality, Safest Care			
	Person Centred, Integrated Care; Strong Partnerships			
	Great Start in Life			
	At Our Best: Making HDFT the best place to work			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	The relative likelihood of White candidates being appointed from shortlisting has worsened from 2.97 in 2025 to 3.52 in 2026. Board representation remains below the proportion of BME staff in the workforce.			
Prior Committee Review/Governance Route	Belonging Subgroup 11 August 2026. People and Culture Programme Board 1 September 2026. People and Culture Committee 30 September 2026.			
Recommendations	For board members to approve the report and monitor the action plan during the year. Seeking approval for publication October 2026.			
Impact Assessments	Financial			
	Workforce			
	Quality & Safety			
	Legal/Regulatory			
	Equality & Diversity			
	Risk			
Consultation/Engagement				
Freedom of Information	N/A			

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Workforce Race Equality Standard 2026
People and Culture Programme Board

1 September 2026

Presented by Richard Dunston Brady

Equality, Diversity and Inclusion Manager

Introduction

This report sets out the Trust's 2026 WRES data position and identifies both areas of progress and areas requiring further action. The analysis is based on the Trust's WRES data collection template on 31 March 2026 and is benchmarked with the 2025 report to support year-on-year interpretation.

The WRES metrics provide useful assurance information but do not identify specific reasons and causes behind these datasets. The differences across these metrics would require further analysis, which is outside of the scope of this report. However, Harrogate District NHS Foundation Trust has implemented additional data reporting at a local level to determine where a metric indicates a risk and act on this outside of the WRES guidance and requirements.

To provide context to the Trust's position on equality, four core ambitions, represented below as KITE, are embedded into the culture of the organisation and its workforce.

KITE Values

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**

As a Trust, we want to make Harrogate District Foundation NHS Trust (HDFT) a more inclusive place to work. To help achieve this, an Action Plan is included at the end of this report to evidence the ongoing work in this regard.

To provide additional understanding and interpretation of the data, a key to colour coding is shown below:

Improvement on previous year 

Worse than previous year 

Metric 1 – Workforce Ethnicity

In this section, we examine data regarding employees who are paid using Agenda for Change pay and Senior Manager pay bands.

Agenda for Change Pay Bands

1–4

5–7

8a–8b

8c–9

VSM (Very Senior Manager)

These pay bands are compared with the percentage of staff in the overall workforce.

Profile of HDFT BME employees versus the NHS average

	NHS Average	HDFT 2026	HDFT: 2025
Staff who identify as BME (%)	28.6%	16.44%	16.47%
Total number of BME staff	-	900	864
Staff who identify as White (%)	-	77.52%	78.01%
Total Number of White staff	-	4244	4093
Staff who identify as Unspecified (%)	-	6.05%	5.53%
Total Number of Unspecified staff	-	331	290

The overall number of BME staff who disclosed their ethnicity on 31 March 2026 was 900, representing 16.44% of the workforce. This compares with 864 staff (16.47%) in 2025. White staff accounted for 77.52% of the workforce in 2026, with ethnicity unknown or not stated accounting for 6.05%. The BME headcount has increased by 36 individuals, but the proportion has remained broadly the same because the overall workforce has also increased.

Total percentage of BME employees within each pay band

Non-Clinical Staff	HDFT: 2026	HDFT: 2025
Bands 1–4	9.0%	7.4%
Bands 5–7	11.6%	12.7%
Bands 8a–8b	12.5%	4.2%
Bands 8c–9 and VSM	0.0%	0.0%

Clinical Staff	HDFT: 2026	HDFT: 2025
Bands 1–4	16.1%	16.9%
Bands 5–7	15.9%	16.2%
Bands 8a–8b	6.7%	5.2%
Bands 8c–9 and VSM	7.7%	8.3%

Medical and Dental

2026				2025		
Medical and Dental Staff	BME	White	Unknown	BME	White	Unknown
Consultants	25.53%	69.15%	5.32%	24.44%	72.22%	3.33%
Non-consultant Career Grades	48.0%	40.0%	12.0%	48.59%	42.96%	8.45%
Trainee Grades	33.19%	50.44%	16.37%	34.25%	55.25%	10.50%

Medical and Dental Analysis

There has been a small increase in the number of BME Consultants from 2025 to 2026.

There has also been an increase in the proportion of Consultants and Trainee Grades who have not disclosed their ethnicity.

Metric 2 – Recruitment Shortlisting

Likelihood of staff being appointed from shortlisting across all posts

31st March 2026					
Indicator		BME	White	Not Declared	Total
Number of staff in the Workforce	Headcount	900	4244	331	5475
	%	16.44%	77.52%	6.05%	
Likelihood of staff being appointed from shortlisting across all posts	Number of shortlisted applicants	3256	2639	439	6334
	Number appointed from shortlisting	193	551	276	1020
	Likelihood of appointed from shortlisting	5.93%	20.88%	63.0%	
Relative likelihood of White candidates compared to BME candidates being appointed from shortlisting across all posts			3.52		

The 2026 WRES submission shows 3,256 shortlisted BME applicants and 2,639 shortlisted White applicants. Of those shortlisted, 193 BME applicants and 551 White applicants were appointed. This shows the likelihood of appointment from shortlisting at 5.93% for BME applicants and 20.88% for White applicants, with a relative likelihood of 3.52 for White candidates compared with BME candidates; a figure above 1 favours White candidates.

Compared with the 2025 report, this metric has worsened. In 2025 the relative likelihood for shortlisted White applicants was 2.97.

The ratio for Metric 2 is based on the number of BME and White candidates who are shortlisted and subsequently interviewed.

The WRES results for the shortlisting to appointment indicator published in October 2025 identified negative trends. In response to this, the Embedding Equality Programme commenced delivery in November 2025 and more fully in January 2026 to understand the factors contributing to these outcomes, and to identify opportunities for improvement. Since then, a team of trained Independent Panel Members (IPMs) have attended interviews for clinical band 7 roles and all other roles at bands 8a–VSM to audit and validate the equity of the interview process. The use of IPMs is one of four catalysts, which are in their pilot stages. It would be premature to consider those early findings in this analysis.

The table for the 2025 likelihood of staff being appointed from shortlisting across all posts can be seen below for comparison.

31st March 2025					
Indicator		White	BME	Not Declared	Total
Number of staff in the Workforce	Headcount	4093	864	290	5247
	%	78.01%	16.47%	5.53%	
Likelihood of staff being appointed from shortlisting across all posts	Number of shortlisted applicants	2830	2685	391	5906
	Number appointed from shortlisting	614	196	249	1059
	Likelihood of appointed from shortlisting	21.7%	7.3%	63.7%	
Relative likelihood of White candidates compared to BME candidates being appointed from shortlisting across all posts			2.97		

Metric 3 – Formal Disciplinary Process

The relative likelihood of BME staff entering the formal disciplinary process compared to White staff

2026	BME		White		Unknown	
	%	Number	%	Number	%	Number
Likelihood of staff entering the formal disciplinary process	0.56%	5	0.87%	37	0.30%	1
Relative likelihood of BME staff entering the formal disciplinary process compared to White staff	0.644					
2025	BME		White		Unknown	
	%	Number	%	Number	%	Number
Likelihood of staff entering the formal disciplinary process	0.35%	3	0.34%	14	1.03%	3
Relative likelihood of BME staff entering the formal disciplinary process compared to White staff	1.01					

Note: A relative likelihood above 1.00 indicates that BME staff are more likely than White staff to enter the formal disciplinary process.

For 2026, five BME staff and 37 White staff are recorded as entering the formal disciplinary process. This equates to 0.56% of BME staff and 0.87% of White staff, with a relative likelihood of 0.64 for BME staff.

This is more positive than in 2025, where the relative likelihood was reported as 1.01, indicating near parity but a slightly higher likelihood for BME staff.

The 2026 figure suggests that BME staff were less likely than White staff to enter the formal disciplinary process in the reporting year.

Metric 4 – Access to Non-mandatory Training and CPD

Relative likelihood of staff accessing non-mandatory training and CPD

		BME	White	Unknown		BME	White	Unknown
Total Headcount		900	4244	331		864	4093	290
Number of staff accessing non-mandatory training and CPD	2026	839	3504	309	2025	690	2734	220
Likelihood of staff accessing non-mandatory training and CPD		93.2%	82.6%	93.3%		79.8%	66.7%	75.8%
Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff.		0.89				0.83		

Note: A relative likelihood below 1.00 indicates that BME staff are more likely than White staff to access non-mandatory training and CPD.

The 2026 WRES submission shows 839 BME staff and 3,504 White staff accessing non-mandatory training and CPD. This equates to 93.2% of BME staff and 82.6% of White staff, with a relative likelihood of 0.89 for White staff compared with BME staff.

This metric remains positive, and is consistent with the data reported in 2025, when the relative likelihood was 0.83.

Metrics 5 to 8 – NHS National Staff Survey Indicators regarding Bullying and Harassment 2025/2026

Bullying and harassment by patients, staff, and managers, and the percentage of staff believing that their Trust provides equal opportunities for career progression or promotion.

Metric		2026		2025	
		BME	White	BME	White
5	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives, or the public in last 12 months	26.7%	16.8%	27.9%	18.3%
6	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	21.4%	15.3%	27.1%	16.42%
8	Percentage of staff experiencing harassment, bullying or abuse from their manager, team leader or other colleagues	14.8%	4.5%	14.8%	5.7%
7	Does your organisation act fairly with regard to career progression/ promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age (Yes)	51.8%	60.71%	50.84%	60.28%

Although several staff survey indicators have improved compared since 2025, BME staff remain more likely than White staff to experience bullying, harassment and abuse across all indicators. The largest disparity remains experiences involving managers, team leaders and colleagues.

Metric 9 – Board Representation

In 2026, the Trust recorded one BME Board member out of 16 voting Board members, equivalent to 6.25%. White Board membership is 87.5% and 6.25% of voting Board membership is recorded as unknown or not stated.

There are no BME Executive Board members recorded in the 2026 return.

	2026	BME Board Members	White Board Members	Unknown Ethnicity Board Members	2025	BME Board Members	White Board Members	Unknown Ethnicity Board Members
Total Board Members		6.25%	87.5%	6.25%		11.76%	82.35%	5.88%
Executive Board Members		0%	100%	0%		0%	100%	0%
Non-Executive Board Members		11.1%	77.8%	11.1%		22.22%	66.67%	11.11%
	2026	BME Board Members	White Board Members	Unknown Ethnicity Board Members	2025	BME Board Members	White Board Members	Unknown Ethnicity Board Members
Number of board members		1	14	1		2	14	1
Voting Board Member % by Ethnicity		6.25%	87.5%	6.25%		6.25%	87.5%	6.25%
Non-Voting Board Members % by Ethnicity		0%	100%	0%		0%	100%	0%

Executive Board Members % by Ethnicity		0%	100%	0%			0%	100%	0%
Non-Executive Board Members % by Ethnicity		11.1%	77.78%	11.1%			22.22%	66.67%	11.11%
	2026	BME Board Members	White Board Members	Unknown Ethnicity Board Members		2025	BME Board Members	White Board Members	Unknown Ethnicity Board Members
Overall workforce % by Ethnicity		16.44%	77.52%	6.05%			16.47%	78.01%	5.53%
Difference (Total Board – Overall Workforce)		-10%	10%	0%			-5%	4%	0%

The ethnic diversity is below overall workforce representation, where BME staff account for 16.4% of the workforce.

The 2026 WRES data reported BME Board membership at 6.25% compared to 2025 at 11.76% showing a reduction from two people to one. The current position indicates under-representation at Board level and no BME Executive representation.

Conclusion and recommendations

The 2026 WRES metrics shows areas of progression alongside areas which still require improvement. The Trust continues to sustain an ethnically diverse workforce overall, and BME

staff remain more likely than White staff to access non-mandatory training and CPD. The disciplinary indicator has also improved and currently provides a degree of assurance.

The largest risk remains in recruitment. The relative likelihood of White candidates being appointed from shortlisting has increased from 2.97 to 3.52, suggesting a widening disparity at the point of appointment. Board representation is a second area of concern, with BME representation lower than the workforce overall and no BME Executive Board members recorded in the current return.

The Board is asked to note that Embedding Equality is the Trust's strategic improvement programme for creating improvements in diversity across senior leadership roles. The programme includes a range of evidence-based interventions focused on recruitment equity and leadership representation. Subject to sufficient recruitment activity, a formal evaluation of programme outcomes will be undertaken and reported through People and Culture governance structures to assess whether measurable improvements have been achieved.

Appendix 1 – Action Plan Workforce Race Equality Standard 2026

Metric	Issue	Action	Owner	Timescale / measure
Metric 2	White candidates are 3.52 times more likely than BME candidates to be appointed from shortlisting.	Delivery of Embedding Equality programme: Independent Panel Members attending interviews at clinical band 7 and all other roles at 8a to VSM. Present findings and agreed mitigations to People and Culture Committee.	Deputy Director of People and Culture / Head of Resourcing / EDI Manager	Delivery of Cohort 2 and 3 of IPMs by the end of 2026. A reduction in Indicator 2 in the 2027 WRES return.
Metric 2	Current WRES data do not explain the mechanism behind the recruitment disparity.	Delivery of the Employee Experience Performance Pack each quarter from May 2026. These packs will be presented to each Directorate Board and Indicator 2 will be measured at each quarter point to measure impact of the Embedding Equality programme.	Head of Resourcing / Clinical Directorates/ Operational HR.	Each quarter from May 2026, Escalate outlier areas through Directorate governance.
Metric 9	BME Board representation is 6.25% against a 16.4% BME workforce, with no BME Executive Board members.	Governance oversight, for under-represented groups, transparent advertising of senior opportunities and an annual review of candidate diversity for Executive and NED appointments.	Trust Chair / Chief Executive / Chief People Officer	Ongoing
Data quality	Unknown ethnicity has increased from 5.53% to 6.05%, particularly in medical and dental roles.	Run a targeted ethnicity declaration improvement campaign focused on staff groups and specialties with higher unknown rates, combining ESR self-service prompts, manager prompts at appraisal and onboarding checks for new starters.	Workforce Information / ESR lead / EDI Manager	By Q4 2026/27. Measure: reduction in unknown ethnicity rate in ESR and in next WRES return.

Appendix 2 – Workforce Race Equality Standard 2026 Summary

Points to note:

- **Metric 2:** A figure above 1.00 indicates that BME staff are less likely than White staff to be appointed from shortlisting.
- **Metric 3:** A relative likelihood above 1.00 indicates that BME staff are more likely than White staff to enter the formal disciplinary process.
- **Metric 4:** A figure below 1.00 indicates that BME staff are more likely than White staff to access non-mandatory training and CPD.

Metric	Description		March 2026	March 2025
1	Percentage of BME staff (overall workforce)	Overall	16.4%	16.4%
2	Relative likelihood of White applicants being appointed from shortlisting compared with BME applicants		3.52	2.97
3	Relative likelihood of BME staff entering the formal disciplinary process compared with White staff		0.64	1.01
4	Relative likelihood of White staff accessing non-mandatory training and CPD compared with BME staff		0.89	0.83
5	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives, or the public in last 12 months	BME	26.7%	27.9%
		White	16.8%	18.3%
6	Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	BME	21.4%	27.1%
		White	15.3%	16.4%
7	Percentage of staff believing that their Trust provides equal opportunities for career progression or promotion	BME	51.8%	49.2%
		White	60.71%	60.28%
8	Percentage of staff personally experiencing discrimination at work from a manager/team leader or other colleagues	BME	14.8%	14.8%

		White	4.5%	5.7%
9	BME voting Board membership	BME	6.25%	11.76%
		White	87.5%	82.35%
9	Difference (total Board – overall workforce), BME	BME	-10%	-5%
		White	10%	4%

DRAFT

Board of Directors Meeting (Public)

30 September 2026

Title	Workforce Disability Equality Standard Report 2026		
Responsible Director	Chief People Officer (Chris Mannion)		
Author	Equality, Diversity, and Inclusion Manager (Richard Dunston Brady)		
Purpose of the report	Approval	x	People and Culture Programme Board are requested to approve the 2026 Workforce Disability Equality Standard (WDES) Report and Action Plan.
	Assurance	x	The WDES is a mandatory NHS England national workforce equality standard. It is designed to help measure and improve the experiences of people from staff with a disability or long-term condition. The report provides assurance regarding workforce representation, recruitment, staff experience, career progression, organisational culture, reasonable adjustments, engagement, and Board representation. The report supports compliance with the Equality Act 2010, the NHS People Promise, and the Trust's commitment to creating an inclusive workplace. The report benchmarks the Trust's 2026 position against the previous year, and identifies areas of progress, and those requiring further improvement.
	Discussion	x	The increase in disability declaration rates and what further actions are required to improve confidence in disclosure. The reduction in reported satisfaction regarding reasonable adjustments and opportunities to strengthen organisational support.
	Information	x	This annual report provides assurance to the People and Culture Programme Board regarding the Trust's workforce equality performance and fulfils the NHS England reporting requirements. The report highlights HDFT's position across ten different metrics with actions to improve the outcomes for colleagues with a disability or long-term condition.

Summary of key issues	• Disability declaration has continued to improve, increasing from 7.22% (379 staff) in 2025 to 8.02% (439 staff) in 2026. This provides greater visibility of the experiences of disabled colleagues and strengthens workforce intelligence. There are 9.53% of staff have not declared a disability or long-term condition. Improving declaration rates remains a priority. • Recruitment outcomes remain positive. Candidates with a disability or long-term condition were more likely than non-disabled candidates to be appointed from shortlisting in 2026, with a relative likelihood score of 0.92, representing continued improvement from 1.01 in 2025. Ongoing monitoring is required to ensure equitable recruitment outcomes are maintained. • Staff with a disability or long-term condition were 5.88 times more likely than Non-Disabled staff to enter the formal capability process, based on a two-year rolling average. However, in context, this equates to 2 people with a disability and 3.5 non-disabled people entering the formal capability process in the reporting period. • There were no Board members recorded as having a disability or long term condition highlighting the importance to improve representation at this level of the organisation. • Bullying and Harassment figures against disabled staff have improved since 2025 across the NHS Staff Survey metrics 4a–4d; however, there are opportunities to strengthen the confidence on the reporting of these incidents.														
Trust Strategy and Strategic Ambitions	<table> <tr> <td colspan="2">The Patient and Child First</td></tr> <tr> <td colspan="2">Improving the health and wellbeing of our patients, children, and communities</td></tr> <tr> <td>Best Quality, Safest Care</td><td></td></tr> <tr> <td>Person-Centred, Integrated Care; Strong Partnerships</td><td></td></tr> <tr> <td>Great Start in Life</td><td></td></tr> <tr> <td>At Our Best: Making HDFT the best place to work</td><td>x</td></tr> <tr> <td>An environment that promotes wellbeing</td><td>x</td></tr> </table>	The Patient and Child First		Improving the health and wellbeing of our patients, children, and communities		Best Quality, Safest Care		Person-Centred, Integrated Care; Strong Partnerships		Great Start in Life		At Our Best: Making HDFT the best place to work	x	An environment that promotes wellbeing	x
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Improving the health and wellbeing of our patients, children, and communities															
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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	There is under reporting of disabilities or long-term conditions on ESR. No Board members recorded as disclosing a disability or long-term condition which reinforces the importance of creating an environment where senior leaders feel confident to disclose.	
Prior Committee Review / Governance Route	Belonging Subgroup 11 August 2026. People and Culture Programme Board 1 September 2026. People and Culture Committee 30 September 2026.	
Recommendations	For board members to approve the report and monitor the action plan during the year. Seeking approval for publication October 2026.	
Impact Assessments	Financial	
	Workforce	
	Quality & Safety	
	Legal/Regulatory	
	Equality & Diversity	
	Risk	
Consultation / Engagement		
Freedom of Information		

**NHS Workforce Disability Equality Standard
(WDES)**

Annual Report 2026

Harrogate and District NHS Foundation Trust

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Introduction

The Workforce Disability Equality Standard (WDES) was introduced in 2019 to improve workplace and career experiences for Disabled people working in, or applying to work within, the NHS. Commissioned by the NHS Equality and Diversity Council and mandated through the NHS Standard Contract, the WDES provides a robust framework of metrics. These are drawn from Electronic Staff Record (ESR) data and responses to the NHS National Staff Survey, enabling NHS organisations to compare the experiences of Disabled and Non-Disabled staff.

This report presents our internal data and metrics from the past twelve months, highlighting key progress made to date. This 2026 report uses the 2025 HDFT WDES report as its benchmark to provide further context.

The report sets out a clear Action Plan to support the continued development of our approaches, initiatives, and activities to improve the experiences of Disabled colleagues across the Trust. For detailed metrics, please see Appendix 1.

The WDES supports compliance with the Public Sector Equality Duty under the Equality Act 2010. It also champions the insights and strengths of people with lived experience, reinforcing the NHS's commitment to becoming a model employer for people with disabilities, neurodivergence, and long-term conditions. The WDES plays an integral role in delivering the NHS People Promise and the Trust's People Plan.

The WDES ensures that equality, diversity, and inclusion remain central to the NHS's culture and operations. It helps organisations understand the lived experiences of Disabled colleagues and supports meaningful, lasting change by fostering a more inclusive working environment.

The data collected is drawn from the Electronic Staff Record (ESR) April 2025 to March 2026, and the National Staff Survey (NSS) from November 2025.

To provide additional understanding and interpretation of the data, a key to colour coding is shown below:

Improvement on previous year 

Worse than previous year 

KITE Values

Whether you are a patient, a visitor, or a member of staff, our KITE values are what describe and define our organisational culture:

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**

As a Trust, we want to make Harrogate District Foundation NHS Trust (HDFT) a more inclusive place to work and to help achieve this, an Action Plan is included at the end of this report to evidence the ongoing work in this regard.

Metric 1 – Workforce Declaration

The recorded disability declaration rate has increased to 8.02% of the workforce (439 of 5475 staff). The percentage of staff who did not declare their condition is 9.53% (522 staff – an increase of 44 since 2025).

The NHS average of staff declaring their disability was recorded in 2024 at 5.7% of the workforce (NHS Employers 2024).

Declaration	Disabled #	Disabled %	Non-Disabled #	Non-Disabled %	Unknown #	Unknown %	Total
2026	439	8.02%	4514	82.45%	522	9.53%	5475
2025	379	7.22%	4390	83.67%	478	9.11%	5247
Variance	60	0.8%	124	-1.22%	44	0.42%	228

The table below highlights the percentage of staff on Agenda for Change (AfC) pay bands, Medical and Dental subgroups, and Very Senior Managers (VSMs) compared with the percentage of staff in the overall workforce.

Agenda for Change Bandings Summary

Non Clinical Staff

Declarations AfC Bandings	2026			2025		
	Disabled %	Non-Disabled %	Unknown %	Disabled %	Non-Disabled %	Unknown %
Bands 1–4	8.8%	82.6%	8.6%	7.6%	84.5%	7.9%
Bands 5–7	10.1%	84.5%	5.4%	10.6%	83.9%	5.5%
Bands 8a–8b	7.5%	87.5%	5.0%	9.7%	86.1%	4.2%
Bands 8c–VSM	5.6%	94.4%	0.0%	0.0%	100.0%	0.0%

More non-clinical staff have declared their disability in 2026 than in 2025.

Disability declaration rates are higher in lower-banded clinical roles than in leadership posts across the organisation.

Clinical Staff

	2026			2025		
Declarations AfC Bandings	Disabled %	Non-Disabled %	Unknown %	Disabled %	Non-Disabled %	Unknown %
Bands 1–4	7.3%	81.1%	11.6%	6.7%	81.7%	11.6%
Bands 5–7	8.6%	83.5%	7.9%	7.9%	84.1%	8.0%
Bands 8a–8b	9.5%	84.3%	6.2%	8.4%	83.8%	7.9%
Bands 8c–VSM	0.0%	92.3%	7.7%	0.0%	91.7%	8.3%

While there is an increase in the number of clinical staff declaring their disability, declaration rates remain lower in some senior clinical grades.

Medical and Dental Summary

	2026			2025		
Declarations Medical and Dental group	Disabled %	Non-Disabled %	Unknown %	Disabled %	Non-Disabled %	Unknown %
Consultants	3.72%	77.13%	19.15%	2.22%	77.78%	20.00%
Non-consultant career grade	2.00%	81.33%	16.67%	1.41%	84.51%	14.08%
Medical and dental trainee grades	6.64%	73.45%	19.91%	4.57%	87.21%	8.22%

Disabled staff representation remains very low across all medical grades. However, there is an increase in the number of Consultants, Non-consultant career grades, and Medical and Dental trainee grades who have declared their disability or long term condition.

The number of staff who did not declare their disability has increased across most Medical and Dental grades. This may indicate a need to understand barriers to disability declarations amongst Medical and Dental staff.

Metric 2 – Recruitment Shortlisting

The relative likelihood of Non-Disabled candidates being appointed from shortlisting compared with Disabled candidates is 0.92.

Recruitment stage	Disabled	Non-Disabled	Unknown/Null
Shortlisted applicants	444	5432	458
Appointed from shortlisting	60	678	282
Appointment rate from shortlisting	13.51%	12.48%	61.57%
Relative likelihood		0.92	

A figure below 1.00 indicates Disabled candidates were more likely to be appointed from shortlisting in this dataset.

The relative likelihood shows continued improvement, year-on-year from 1.15 in 2024 to 1.01 in 2025 and 0.92 in 2026. This compares well with the national average of 0.80 (NHS England, 2023).

A potential risk for the organisation is the number of employees who have chosen not to disclose whether they have a disability or long-term health condition. While this does not indicate that these individuals have a condition, it may limit the organisation's understanding of workforce demographics and any associated support requirements.

Metric 3 – Formal Capability Process

Relative likelihood of colleagues with a disability compared to Non-Disabled staff entering the formal capability process on the grounds of performance.

Staff with a disability or long-term condition were 5.88 times more likely than Non-Disabled staff to enter the formal capability process, based on the two-year rolling average used for WDES Metric 3. This is an average of two disabled employees entering the process during the rolling period.

Capability measure	Relative likelihood in 2026	Relative likelihood in 2025
Relative likelihood of Disabled staff entering formal capability process compared to Non-Disabled staff	5.88	4.34

Metrics 4 – NHS Staff Survey Indicators: Bullying and Harassment

Percentage of colleagues with a disability compared to Non-Disabled staff experiencing harassment, bullying or abuse from patient/service users, their relatives or other members of the public, managers or other colleagues.

Metric	Indicator	2026		2025	
		Disabled Staff	Non-Disabled Staff	Disabled Staff	Non-Disabled Staff
4a	In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from patients/service users, their relatives or the public?	20.0%	17.72%	21.7%	18.49%
4b	In the last 12 months, how many times have you personally experienced harassment, bullying or abuse at work from managers?	9.62%	5.25%	11.7%	6.2%
4c	In the last 12 months, how many times have you personally experienced harassment, bullying or abuse at work from other colleagues?	19.22%	11.0%	20.6%	12.3%

4d	The last time you experienced harassment, bullying or abuse at work, did you or a colleague report it? (Yes)	53.6%	55.1%	57.5%	48.7%
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Experience of bullying and harassment reduced across indicators 4a–4c; however, disabled staff are still more likely to experience bullying and harassment.

It is also noted that reporting rates have reduced.

Metric 5 – NHS Staff Survey Indicators: Career Progression

Percentage of staff with a disability compared to Non-Disabled staff believing that the Trust provides equal opportunities for career progression or promotion.

Metric	Indicator	2026		2025	
		Disabled	Non-Disabled	Disabled	Non-Disabled
5*	Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion.	52.4%	61.7%		

* Due to changes in the wording of Q15 from the NHS Staff Survey in 2025, previous years' results for WDES metric 5 are not reported.

Metric 6 – NHS Staff Survey Indicators: Presenteeism

Percentage of colleagues with a disability compared to colleagues without a disability responding to whether they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.

Metric	Indicator	2026		2025	
		Disabled	Non-Disabled	Disabled	Non-Disabled
6	Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	19.9%	11.3%	20.3%	13.3%

There has been a reduction in disabled staff feeling pressured to attend work despite not feeling well enough.

Metric 7 – NHS Staff Survey Indicators: Feeling Valued

Percentage of colleagues with a disability compared to colleagues without, declaring whether they are satisfied with the extent to which their organisation values their work.

Metric	Indicator	2026		2025	
		Disabled	Non-Disabled	Disabled	Non-Disabled
7	Percentage of staff satisfied with the extent to which their organisation values their work.	42.7%	51.9%	39.7%	52.4%

The percentage of Disabled staff who feel the Trust values their work has improved by 3% since 2025.

Metric 8 – NHS Staff Survey Indicators: Reasonable Adjustments

Percentage of colleagues with a disability responding to their employer making reasonable adjustments to enable them to carry out their work.

This metric has worsened since 2025, showing a 2.3% decrease. There remains approximately 24.2% of disabled staff who do not believe adequate adjustments have been made.

The Trust aims to capture this data from the Reasonable Adjustments Passport; however, the reporting of these adjustments has not been consistent across the organisation.

Metric	Indicator	2026		2025	
		Disabled	Non-Disabled	Disabled	Non-Disabled
8	Percentage of staff with a long-lasting health condition or illness saying their employer has made reasonable adjustment(s) to enable them to carry out their work.	75.8%		78.1%	

Metric 9 – NHS Staff Survey Indicators: Staff Engagement

NHS staff survey and the engagement of staff with a disability (score 0–10).

The staff engagement score has improved for Disabled colleagues compared to 2025.

Metric	Indicator	2026			2025		
		Org. Average	Disabled Staff	Non-Disabled Staff	Org. Average	Disabled Staff	Non-Disabled Staff
9a	Staff engagement score	7.07	6.76	7.19	7.01	6.63	7.17

Metric 9b – Disabled Staff Voice

The Trust engages with the Disabilities and Long-Term Conditions Network throughout the year using different methods to maximise impact.

The network operates monthly meetings over MS Teams to ensure it is accessible to all colleagues across the organisation. Discussions around pain management, lived experiences, and barriers to success are a common theme for this group. In addition, they leverage the use of subject matter experts in the Trust such as Occupational Therapists, Dieticians, and Human Resources to raise awareness and dispel myths around different conditions.

The Equality, Diversity, and Inclusion (EDI) service has delivered the Reciprocal Mentoring programme for 2025/26 with a cohort of Aspiring Leaders who identified as having a disability, neurodivergence, or long-term condition. The programme commenced with 11 partners, with the Established Leaders being those who have roles across the organisation at bands 8b–VSM. This is the third year the programme has been delivered; however, this was the first time it was run for this particular group of staff. The positive outcomes from this collaboration of leaders were that the EDI service has already designed and delivered a new Deaf Awareness course delivered over a half day using lived experience speakers from the organisation. They will also develop a programme of

accessible training for all staff to learn about neurodivergent conditions and behaviours, reasonable adjustments, and allyship. Each programme will consist of HDFT colleagues, sharing their lived experiences as a component part of the course content.

A second Listening Event is programmed for the Autumn of 2026 to enable the staff network to raise their concerns regarding the outcomes of this report and to examine solutions to improve these metrics.

Metric 10 – Board Representation

Percentage difference between the organisation's Board voting membership and its overall workforce disaggregated. Voting and Non-voting membership of the Board, by Executive and Non-exec membership of the Board for 2025.

No Board members were recorded as disabled in 2026. The Board disability representation gap is -8.02 percentage points compared with the overall workforce.

2026	Disabled %	Non-Disabled %	Unknown %
Total Board Members	0.00%	87.50%	12.50%
Of which: Voting Board Members	0.00%	87.50%	12.50%
Non-Voting Board Members	0.00%	0.00%	0.00%
Non-Exec Board Members	0.00%	77.78%	22.22%
Difference (Total Board – Overall Workforce)	-8%	5%	3%
Difference (Voting Membership – Overall workforce)	-8%	5%	3%
Difference (Executive Membership – Overall Workforce)	-8%	18%	-10%
2025	Disabled %	Non-Disabled %	Unknown %
Total Board Members	0.0%	88.24%	11.76%
Of which: Voting Board Members	0.0%	87.50%	12.50%

Non-Voting Board Members	0.0%	100%	0.0%
Non-Exec Board Members	0.0%	77.78%	22.22%
Difference (Total Board – Overall Workforce)	-7%	5%	3%
Difference (Voting Membership – Overall workforce)	-7%	4%	3%
Difference (Executive Membership – Overall Workforce)	-7%	16%	-9%

Conclusions

- The 2026 WDES Metrics show improvement in overall disability declaration and recruitment outcomes from shortlisting.
- There are improvements in bullying and harassment from patients, visitors, other staff, and managers compared to 2025. However, the data highlights further opportunities for staff to report and record bullying and harassment issues they may experience.
- There is a decrease in the percentage of staff accessing reasonable adjustments compared to 2025; further work is needed to address this.
- Representation of Senior and Board Leaders declaring a disability creates a potential gap around visibility, progression, and leadership diversity.

Action Plan 2026/27

WDES indicator	Action	Owner	Measure/evidence	Timescale
1 and 10	Improve disability declaration, targeting unknown/null ESR records and senior/medical groups through promotions via Cultural Ambassadors, Induction, HRBPs.	EDI Manager HR Ops HR Recruitment Recruiting Managers	Reduce unknown/null disability status from 9.53% to 8.50% or below. Add to EEPP for quarterly dashboard monitoring by directorate, staff group and band.	Nov 2026; quarterly reporting
8 and 3	Design and deliver EDI suite of training for staff: Reasonable Adjustments Neurodiversity Allyship Training Deaf Awareness	EDI Manager and Learning and Development	Track attendance at these sessions – to be diarised quarterly. Further evidence will be drawn from EEPP data.	Design by Q3 2026/27; implement by Q4
4–9b	Promote accessible reporting methods for staff to be able to raise cases of ableism.	DATIX, HR BP's Freedom to Speak up Guardians	Report to Belonging Subgroup and escalate cases to People and Culture Programme Board.	From Q2 2026/27

Appendix 1: 2026 WDES Metrics Summary

Metric		2026	2025
1	Percentage of staff in AfC pay bands or Medical and Dental subgroups and Very Senior Managers (including Executive Board members, but excluding Non-Executive Board members) compared with the percentage of staff in the overall workforce	8.02% (439 of 5475)	7.22% (379 of 5247)
	Cluster 1 (up to Band 4)	7.84%	7.03%
	Cluster 2 (Bands 5–7)	8.75%	8.11%
	Cluster 3 (Bands 8a–8b)	8.97%	8.75%
	Cluster 4 (Bands 8c–9 and VSM)	3.23%	0%
	Medical/Dental consultants	4.43%	2.96%
2	Relative likelihood of Non-Disabled staff compared to Disabled staff being appointed from shortlisting across all posts	0.92	1.01
3	Relative likelihood of Disabled staff compared to Non-Disabled staff entering the formal capability process, as measured by entry into the formal capability procedure (equal to 2 people).	5.88	4.34
4a	Percentage of Disabled staff compared to Non-Disabled staff experiencing harassment, bullying, or abuse from patients or other members of the public	20.0%	21.7%
4b	Percentage of Disabled staff compared to Non-Disabled staff experiencing harassment, bullying, or abuse from managers	9.62%	11.7%
4c	Percentage of Disabled staff compared to Non-Disabled staff experiencing harassment, bullying, or abuse from other colleagues	19.22%	20.6%
4d	Percentage of Disabled staff compared to Non-Disabled staff saying that the last time they experienced harassment, bullying, or abuse at work, they or a colleague reported it (Yes)	53.6%	57.5%
5	Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion	52.4%	

6	Percentage of Disabled staff compared to Non-Disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties	19.9%	20.3%
7	Percentage of Disabled staff compared to Non-Disabled staff saying that they are satisfied with the extent to which their organisation values their work	42.7%	39.7%
8	Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work	75.8%	78.0%
9a	The staff engagement score for Disabled staff compared to Non-Disabled staff (0–10)	6.76	6.63
9b	Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard?	Y	Y
10a	Percentage difference between the organisation's Board voting membership and the organisation's overall workforce (voting membership of the Board)	-8%	-7%
10b	Percentage difference between the organisation's Board voting membership and the organisation's overall workforce (Executive membership of the Board)	-8%	-7%

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

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

GOALS:

Quality & Safety

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

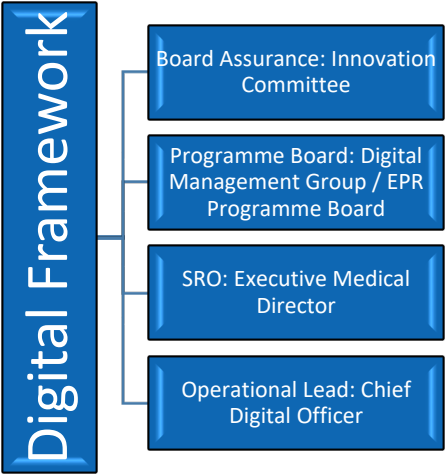
Information

Timely, Accurate Information to enable continuous improvement

Electronic Health Record

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

Governance:



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

1

- Achieve a score of 5/5 across all seven What Good Looks Like (WGLL) pillars

2

- EPR Programme Delivery

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

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

True North Metrics Summary:

True North Metric	Vision	Goal	Current Status	Countermeasures	Level of Risk To Achieving Goal (C x L)	Level of Risk for progressing actions										
Best Quality & Safest Care 	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). 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 have developed A3’s for all DMA Pillars and Domains and where actions plans have been agreed to improve digital maturity, these have been processed through the Trusts Strategic Filter and added to our digital maturity plan. The schedule for this year’s National Digital Maturity Assessment has been published: <table><tr><th>Milestone</th><th>Date</th></tr><tr><td>DMA assessment launch</td><td>7 September 2026</td></tr><tr><td>Assessment window</td><td>7 September to 19 October 2026 (six weeks)</td></tr><tr><td>Validation and amendments window</td><td>2 to 16 November 2026 (two weeks)</td></tr><tr><td>Results and finalised data</td><td>December 2026 onwards</td></tr></table> Given the work to improve our digital maturity over the past 12 months and the delivery of the new EPR solution, there is optimism that this year’s scores will have improved.	Milestone	Date	DMA assessment launch	7 September 2026	Assessment window	7 September to 19 October 2026 (six weeks)	Validation and amendments window	2 to 16 November 2026 (two weeks)	Results and finalised data	December 2026 onwards	- A3s that have been developed will be run through the strategic filter (Complete) - Actions will be prioritised and planned for delivery		
Milestone			Date													
DMA assessment launch	7 September 2026															
Assessment window	7 September to 19 October 2026 (six weeks)															
Validation and amendments window	2 to 16 November 2026 (two weeks)															
Results and finalised data	December 2026 onwards															
Person Centred, Integrated Care 	Seven Pillars of WGLL: 1. Well Led – A clear strategy for digital transformation & collaboration. Our leaders collectively own & drive the digital transformation journey, placing citizens & frontline perspectives at the centre. All leaders promote digitally enabled transformation to efficiently deliver safe, high-quality care	As above	Next 12 months actions: - Develop a five-year costed and funded plan to deliver the digital strategy - Develop a workforce plan to provide capacity to deliver the strategy - Develop a business case to enable the development of an Enterprise Architecture function.	- A3s that have been developed will be run through the strategic filter (Complete) - Actions will be prioritised and planned for delivery												
Great Start in Life 	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		Next 12 months actions: - Implement standards that enforce segmentation to manage the risk and blast radius of cyber-attack and an intrusion detection system (IDS) that monitors the network for malicious activity or policy violations - Implement accountability, capability and capacity to deliver the Digital Net-Zero/ Environmental sustainability plan - Improve % of health records digitised (including historic records but excluding those not to be digitised) from existing 21-40% to 81-99% - Integrate real-time data from external systems into EPR with appropriate provenance to identify source and validity (e.g., capture data from remote monitoring systems to monitor patient vital signs)? - Introduce a proactive approach to IT operations with formalised processes, documentation and standardisation in place to prevent issues from arising - Implement an automated help desk available 24/7 to help resolve user IT issues - Introduce proactive ITIL processes for incident, request, change, and problem management are established, prioritising and streamlining issue resolution - Develop a business case and obtain funding to deliver a blood management and tracking solution	- A3s that have been developed will be run through the strategic filter (Complete) - Actions will be prioritised and planned for delivery												
Making HDFT The Best Place to Work 																

True North Metric	Vision	Goal	Current Status	Countermeasures	Level of Risk To Achieving Goal (C x L)	Level of Risk for progressing actions
	Safe Practice - We maintain standards for safe care, as set out by the Digital Technology Assessment Criteria for health & social care (DTAC) & routinely review system-wide security, sustainability & resilience		Next 12 months actions: - A digital system is in place to support SAR processing, but automation is limited and manual processing is still required. The processing of SARs is moving towards a fully digital workflow, utilising EPR and EDMS functionality to reduce paper-based workflows. Exploring options for redaction solutions to enable a fully digital redaction process with automation in many parts to improve efficiency. - Strengthen our organisational capability by developing more of our Clinical Digital Leads and providing training to enable them to undertake Clinical Safety Officer (CSO) responsibilities. We also need to look at the resource time for activities relating to CSO responsibilities and whether we need more clinical colleagues trained up and have time to support. This will improve our capacity to maintain ongoing oversight and assurance of the Trust's digital systems and ensure future compliance assessments are undertaken consistently.	- A3s that have been developed will be run through the strategic filter (Complete) - Actions will be prioritised and planned for delivery		
	Support Workforce - Our workforce is digitally literate & able to work optimally with data & technology. Digital & data tools & systems are fit for purpose & support staff to do their jobs well		Next 12 months actions: - Develop a strategy to review the DDaT workforce for areas where there is a talent gap - Develop a plan to identify, assess and address the professional development, training and learning needs of the Digital, Data, and Technology (DDaT) workforce - Develop a strategy and plan to address hard-to-fill Digital, Data, and Technology (DDaT) skill areas through recruitment, contracting or shared resourcing delivery and obtain approval at DMG (and anywhere else required) - Complete alignment to - https://ddat-capability-framework.service.gov.uk/ - Digitally enable the supply chain management - Implement inventory management, including the use of RFID or other digital tracking technologies	- A3s that have been developed will be run through the strategic filter (Complete) - Actions will be prioritised and planned for delivery		
	Empower Citizens - Citizens are at the centre of service design & have access to a standard set of digital services that suit all literacy & digital inclusion needs. Citizens can access & contribute to their healthcare information, taking an active role in their health & well-being		Next 12 months actions: No action identified for next 12 months	- A3s that have been developed will be run through the strategic filter (Complete) - Actions will be prioritised and planned for delivery		
	Improve Care - We embed digital & data within our improvement capability to transform care pathways, reduce unwarranted variation & improve health & wellbeing. Digital solutions enhance services for patients & ensure that they get the right care when they need it & in the right place		Next 12 months actions: - Define an AI Governance framework with roles and responsibilities - Develop AI Strategy - Develop a tried-and-tested risk management approach for AI solutions - Explore ICB and Nation-wide AI solutions for economies of scale - The Trust has established governance expectations and accountability arrangements for AI use; however, assurance that these requirements are consistently understood by staff needs improving because AI training completion and awareness activity are not formally recorded or monitored - Replace Inheathcare with Nervecentre (Q224) and provide the ability for patients (and/or carers) to measure and input agreed health data (e.g., vital signs into an app or website) manually for patients we care for virtually. We will put methods in place to understand the level of acuity of patients and adjust monitoring frequency accordingly	- A3s that have been developed will be run through the strategic filter (Complete) - Actions will be prioritised and planned for delivery		

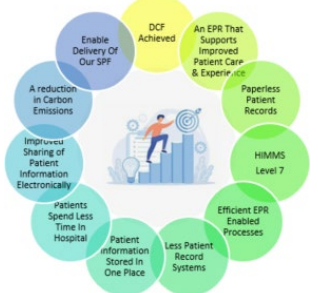
True North Metric	Vision	Goal	Current Status	Countermeasures	Level of Risk To Achieving Goal (C x L)	Level of Risk for progressing actions
	Healthy Populations - We use data to design & deliver improvements to population health & wellbeing, making best use of collective resources. Insights from data are used to improve outcomes & address health inequalities		Next 12 months actions: No action identified for next 12 months	- A3s that have been developed will be run through the strategic filter (Complete) - Actions will be prioritised and planned for delivery		

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	- Delivery in progress - Nov 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	- Delivery in progress - Jul 26 Go Live Completed - Sep 26 – Project Closed	- 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 3 Projects in planning and delivery - Nov 26 - Meal Ordering Pilot Go Live - Jan 27 – Meal Ordering Full roll out complete	- 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 - Jul 26 - Tender published - Oct 26 - Evaluation & moderation to be complete - Mar 27 - Preferred bidder & contract award - Apr 27 - Estimated delivery start	- 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	- 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	SystmOne Adult Optimisation	To optimise the use of SystmOne in Adult Community	- Approved by DDP - Project Manager appointed to complete discovery	- Complete discovery - Plan & deliver optimisation work		
	Best Quality & Safest Care	Blood Tracking solution to ensure end to end blood transfusion process	Blood Tracking Solution	- Aug/Sep 26 – Business Case to be developed - Aug/Sep 26 – WYATT funding TBC - Delivery plans being developed	- Develop business case - Procure solution - Plan and deliver solution		

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 – Oct 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 (Sep 26 – Oct 27) • 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. In addition to the National Digital Maturity Assessment, HDFT have recently completed a HIMSS Electronic Medical Record Assessment Model (EMRAM) to ascertain its EPR maturity. This globally recognised assessment was last completed in 2021, where HDFT score level 0 out of 7. The draft report for this year's assessment has been issued with a new score of level 4 out of 7 which is a significant improvement. Whilst HDFT has not achieved a level 5 score, it's important to note that elements of the Clinical User Adoption focus area in the HIMSS assessment have changed, where some items previously required for level 6, are now in level 5. Without this change, HDFT would have achieved a level 5. Progress is detailed in the table below. To achieve each stage, all minimum requirements need to be completed AND 70% compliance in ALL five focus areas.	• Deliver a new EPR solution • Optimise the solution & realise benefits • Enhance with additional modules and functionality • Perform HIMSS Assessment		

				<table><tr><td>Stage Achievement</td><td>4</td><td>Highest stage according to the online self-assessment</td></tr><tr><td>Percent Achievement</td><td>77%</td><td>% accomplishment against the model</td></tr><tr><td>Stage 7</td><td>69%</td><td>Stage not achieved</td></tr><tr><td>Stage 6</td><td>76%</td><td>Stage not achieved</td></tr><tr><td>Stage 5</td><td>79%</td><td>Stage not achieved</td></tr><tr><td>Stage 4</td><td>100%</td><td>Stage achieved</td></tr><tr><td>Stage 3</td><td>97%</td><td>Stage achieved</td></tr><tr><td>Stage 2</td><td>92%</td><td>Stage achieved</td></tr><tr><td>Stage 1</td><td>97%</td><td>Stage achieved</td></tr></table> Color Legend Stage criteria achieved 70% of Stage criteria not met Minimum requirements not met Breakdown by Focus Area <table><tr><td></td><td>Data Capture & Health Information Exchange</td><td>Patient Engagement</td><td>Healthcare Analytics & Outcomes Measurement</td><td>Resilience Management</td><td>Clinical User Adoption</td></tr><tr><td>Stage Achievement</td><td>5</td><td>5</td><td>6</td><td>7</td><td>4</td></tr><tr><td>Percent Achievement</td><td>93%</td><td>44%</td><td>78%</td><td>89%</td><td>68%</td></tr><tr><td>Stage 7</td><td>83%</td><td>22%</td><td>76%</td><td>92%</td><td>40%</td></tr><tr><td>Stage 6</td><td>93%</td><td>56%</td><td>86%</td><td>90%</td><td>57%</td></tr><tr><td>Stage 5</td><td>100%</td><td>78%</td><td>86%</td><td>79%</td><td>57%</td></tr><tr><td>Stage 4</td><td>100%</td><td>100%</td><td>100%</td><td>100%</td><td>100%</td></tr><tr><td>Stage 3</td><td>100%</td><td>N/A</td><td>87%</td><td>90%</td><td>100%</td></tr><tr><td>Stage 2</td><td>100%</td><td>N/A</td><td>87%</td><td>85%</td><td>100%</td></tr><tr><td>Stage 1</td><td>100%</td><td>N/A</td><td>75%</td><td>89%</td><td>100%</td></tr></table> N/A refers to stage not represented in area for assessment scoring. A follow up meeting with HIMSS is planned to validate and finalise the report. Plans are being developed to initially advance to level 5 and then to level 6 and 7.	Stage Achievement	4	Highest stage according to the online self-assessment	Percent Achievement	77%	% accomplishment against the model	Stage 7	69%	Stage not achieved	Stage 6	76%	Stage not achieved	Stage 5	79%	Stage not achieved	Stage 4	100%	Stage achieved	Stage 3	97%	Stage achieved	Stage 2	92%	Stage achieved	Stage 1	97%	Stage achieved		Data Capture & Health Information Exchange	Patient Engagement	Healthcare Analytics & Outcomes Measurement	Resilience Management	Clinical User Adoption	Stage Achievement	5	5	6	7	4	Percent Achievement	93%	44%	78%	89%	68%	Stage 7	83%	22%	76%	92%	40%	Stage 6	93%	56%	86%	90%	57%	Stage 5	100%	78%	86%	79%	57%	Stage 4	100%	100%	100%	100%	100%	Stage 3	100%	N/A	87%	90%	100%	Stage 2	100%	N/A	87%	85%	100%	Stage 1	100%	N/A	75%	89%	100%		
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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	This is under review as part of the Affordable Establishment Review (AER).			

Related Corporate Risks

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

Related External Risks

	No related external risks					

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

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

GOALS:
deliverable)

Healthcare Innovation

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

Children's Public Health Research

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

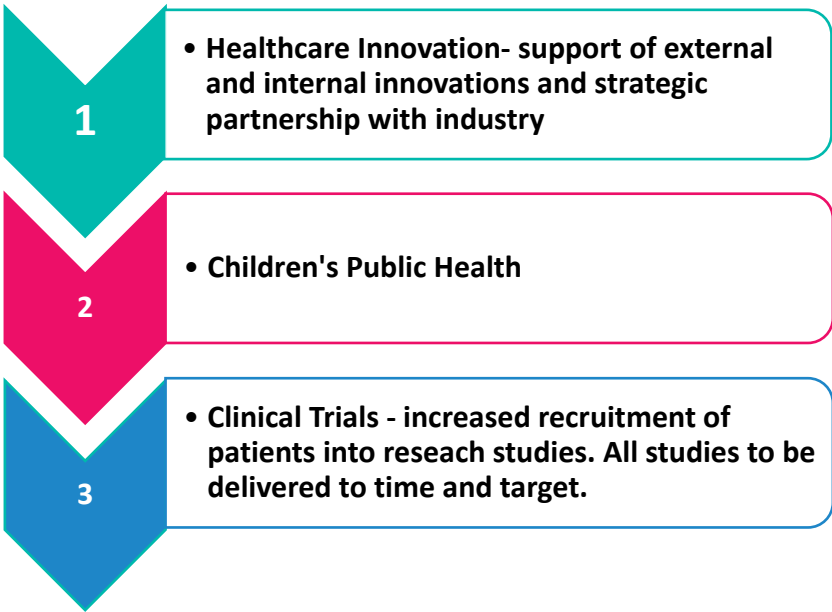
Research studies

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

GOVERNANCE:



True North Metrics (Executive Lead: 10-15 Year

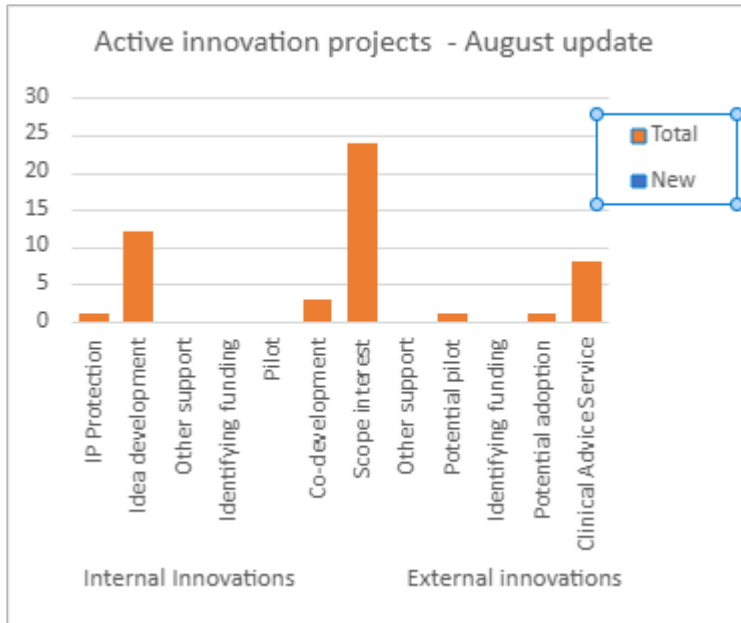


Trustwide Project:	3T MRI and CRF
Strategic Programme:	HDFT Impact
Breakthrough Objective:	
Overarching Risk Appetite:	Operational - Cautious

Overarching Risk Summary:

Ambition	True North Metric	Workstream	Ambition Metric	Risk Appetite		Level of Risk to Achieve Metric – Linked to Risk Appetite							
						1 – 3	4 – 6	8 – 9	10	12	15	16	>20
Healthcare Research and Innovation	All	Healthcare Innovation	Adopt / develop health innovations that improve the health and care of our patients and CY&P	Operational: Cautious									
		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 - Repeated advertising – no further applications - Approval given by TEG to trial children’s physiotherapy device (MotiMe) - Clinical Entrepreneur Fellows 3rd cohort (3 x FY1s Aug 26 – Jul 27) - have commenced and been assigned projects - Two more industrial partners recruited – Hertility Health and MindRay - Exploring managed clinical rollout out of nasal photosterilisation device for patients undergoing NOF surgery as part of WYAAT-wide project with Health Innovation Y&H - Planning second ‘Introduction to AI in Healthcare’ session with Health Innovation and other WYAAT Trusts – date postponed to Oct/Nov 26. - Continue to explore Heim Health as a digital workforce planning and optimisation solution for Adult Community Services. Opportunity to help service realise huge cost saving benefits. - Supporting Overseas Visitors Service Manager on ‘commercialisation’ of RPA project - Active innovation projects are summarised below: Active innovation projects - August update <table><thead><tr><th>Category</th><th>Total</th><th>New</th></tr></thead><tbody><tr><td>IP Protection</td><td>1</td><td>0</td></tr><tr><td>Idea development</td><td>12</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>3</td><td>0</td></tr><tr><td>Scope interest</td><td>24</td><td>0</td></tr><tr><td>Other support</td><td>0</td><td>0</td></tr><tr><td>Potential pilot</td><td>1</td><td>0</td></tr><tr><td>Identifying funding</td><td>0</td><td>0</td></tr><tr><td>Potential adoption</td><td>1</td><td>0</td></tr><tr><td>Clinical Advice Service</td><td>8</td><td>0</td></tr></tbody></table>	Category	Total	New	IP Protection	1	0	Idea development	12	0	Other support	0	0	Identifying funding	0	0	Pilot	0	0	Co-development	3	0	Scope interest	24	0	Other support	0	0	Potential pilot	1	0	Identifying funding	0	0	Potential adoption	1	0	Clinical Advice Service	8	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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Clinical Advice Service	8	0																																											
Clinical Trials	To excel in the governance and delivery of clinical research,	Generate income to match our research delivery costs.	Generate income to ensure financial sustainability																																										



expanding patient access to high-quality clinical trials through sustainable growth and collaborative partnerships.

We aim to be a highly recognised and valued department within the trust, fostering a strong culture of 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:

Ensure studies open are at least 80% are on time and target

Ensure a balance of the different types of studies are opened

Income is generated through two main funding streams, RRDN funding and income generating (including commercial) research. This year, the ambition is to generate income that matches expenditure.

Area	Metric	Target	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Sept 26
Research	Income	£1.2m	£839k	£839k	£924k	£974k	£1.08m	No Info as of Yet.

The income shown above includes trust budget plus RRDN and commercial research income. Work to continue to generate income and meet target continues through countermeasures.

Sustain Partnership (RRDN) funding

The Trust will sustain funding by meeting the key objectives agreed with the RRDN. These are:

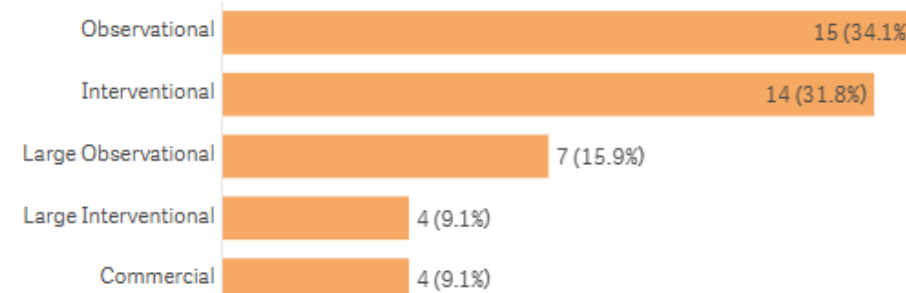
- Accelerating timelines for research
- Driving inclusivity for groups traditionally lacking access to research
- Shifting care settings for research away from secondary care
- Supporting the life sciences industry
- Workforce development

Area	Metric	Target	Mar 26	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Sept 26
Research	% of NIHR studies recruiting to time and target (RTT)	80%	96%	81.5%	81.25%	81%	85.7%	81.6%	82%

Ensure a balance of the different types of studies are opened:

Recruiting Trials by Complexity:

Study ABF Category



Through a balanced portfolio, the Trust will build a greater access to research year on year. 26/27 recruitment to date is shown in cumulative totals below:

Strengthen financial grip and diversify income (commercial trials, external funding bids, partnerships)

Establish permanent Clinical Research Facility to increase throughput and commercial attractiveness

Expand academic, industry, and system partnerships to align with national priorities and increase opportunities

Review and refine Research income distribution model. Options appraisal of future model(s) including review of other Trusts, and national guidance.

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 meet targets around study setup and recruitment, as well as other RRDN KPIs.

Implement trial prioritisation (scorecard approach) to focus on high-value, high patient impact and commercial studies

Selecting trials via the scorecard process that have potential to give varied access to Clinical Trials at HDFT.

			<table><tr><th>Area</th><th>Metric</th><th>Target</th><th>Apr 26</th><th>May 26</th><th>Jun 26</th><th>Jul2 6</th><th>Aug 26</th><th>Sept 26</th></tr><tr><td>Research</td><td>Patients Recruited</td><td>3000/yr.</td><td>172</td><td>335</td><td>495</td><td>627</td><td>756</td><td>827</td></tr></table> <table><tr><th>Area</th><th>Metric</th><th>Target</th><th>Mar 26</th><th>Apr 26</th><th>May 26</th><th>Jun 26</th><th>Jul 26</th><th>Aug 26</th><th>Sept 26</th></tr><tr><td>Research</td><td>% of Trials opened this year to have recruited within 30 days</td><td>90%</td><td>70%</td><td>0%</td><td>100%</td><td>100%</td><td>100%</td><td>100%</td><td>100%</td></tr></table> To increase the number commercial studies opened year on year: Commercial Trials Opened this Year: <table><tr><td>FY26/27:</td><td>4</td></tr><tr><td>FY25/26:</td><td>10</td></tr></table> ■ In the Pipeline: ■ Newly Opened: ■ Trials Opened in the Previous FY: Open a permanent Clinical Research Facility (CRF) on the Harrogate District Hospital site. Report; Pop up CRF opened on Farndale Ward in February and over 70 research patients have utilised the centre to date. Patients and team had felt that this valuable space is starting to increase the visibility and presence of research. The space also allows HDFT to maximise new opportunities for research as they flow through the system. Work is ongoing to find a permanent CRF solution before winter 26/27. External research financial funding bid Generate more income for the department through external funding bids applications/ and manage the KPIS associated with these funding bids. Two bids successful in 2026 to start April 2026 – associated KPIS to be monitored via RRDN 3 monthly. (see community collaboration project YHN &	Area	Metric	Target	Apr 26	May 26	Jun 26	Jul2 6	Aug 26	Sept 26	Research	Patients Recruited	3000/yr.	172	335	495	627	756	827	Area	Metric	Target	Mar 26	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Sept 26	Research	% of Trials opened this year to have recruited within 30 days	90%	70%	0%	100%	100%	100%	100%	100%	FY26/27:	4	FY25/26:	10		
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FY25/26:	10																																														

		Successfully apply for at least one external research financial funding bid per year to create funding for staffing . Continue to develop new partnerships to progress research via WYATT, NSO , YHN and academic and commercial alliances. To sustain and develop a patient partnership group and increase the feedback we receive year on year from our patients, sponsors and Pi's	HDFT). An Interim report on KPI's submitted to NIHR in August 26 and revised targets approved. A NIHR bid to support further staffing for the Generation Study was submitted on 2nd Sept. 26 Two further funding opportunities are now open via the NIHR and we are working towards submission in Mid-October and Mid November. We continue Horizon scanning ongoing to identify further funding opportunities. Develop new and existing partnerships to progress research Primary Care collaboration project June 26 -1 post started and work on submitting 6 EOIs trials for YHN begun. Recruitment to other post ongoing. Oncology Y&H partnership - Funding arrangements and contractual elements now in place. Academic partnerships: York University partnership in various departments established. Progressing ways to partners with Bradford CRDC re commercial study EOI submissions. Develop patient partnership group and increase the feedback we receive year on year Monitored via PRES target 25/26 and numbers received each quarter from RRDN. Cumulative totals below: Development of patient partner group in progress. Feedback on activity and impact 3 monthly. Below are the number of patient partners recruited to the Trust: <table><tr><th>Area</th><th>Metric</th><th>Target</th><th>Apr 26</th><th>May 26</th><th>Jun 26</th><th>Jul 26</th><th>Aug 26</th><th>Sept 26</th></tr><tr><td>Research</td><td>My Research Experience Forms Submitted.</td><td>81/yr.</td><td>1</td><td>1</td><td>1</td><td>2</td><td>7</td><td>7</td></tr></table> Work continues to now exceed this target.	Area	Metric	Target	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Sept 26	Research	My Research Experience Forms Submitted.	81/yr.	1	1	1	2	7	7	Identify and plan for permanent CRF space, building on delivery and lessons learned from pop up CRF space. New project manager (CRF/MRI) post recruited to support delivery. Meeting with RDN to discuss new format of PRES and learn from other organisations.		
Area	Metric	Target	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Sept 26																
Research	My Research Experience Forms Submitted.	81/yr.	1	1	1	2	7	7																

			<table><tr><th>Area</th><th>Metric</th><th>Target</th><th>Apr 26</th><th>May 26</th><th>Jun 26</th><th>Jul 26</th><th>Aug 26</th><th>Sept 26</th></tr><tr><td>Research</td><td>Total # of pt Partners</td><td>4</td><td>2</td><td>0</td><td>0</td><td>4</td><td>5</td><td>5</td></tr></table> Create a workforce culture where research is part of everyday practice. Number of successful applicants to NIHR funding for research-related courses, clinical academic pathways, or development routes.to be collated and published. Completion of the National SORT tool (Used to assess and strengthen research readiness and capability.) Promote the GCP on learning lab and developing other research related materials. Feedback report 6 monthly from sponsors and Professional investigators through development of survey. Note: 3 points above will have data to provide assurance in the coming months.	Area	Metric	Target	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Sept 26	Research	Total # of pt Partners	4	2	0	0	4	5	5		
Area	Metric	Target	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Sept 26															
Research	Total # of pt Partners	4	2	0	0	4	5	5															

Trustwide Project:

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

Strategic Programme: HDFT Impact

Workstream	True North Metric	Vision	Goal	Current Status	Countermeasures	Level of Risk To Achieving Goal (C x L)	Level of Risk for progressing actions
	All	To develop our capacity and capability and to embed the culture for continuous improvement through the Implementation of the Impact Improvement Operating Model.	Training: 70% of Teams will be trained to use HDFT Impact by Sept 2026	TO UPDATE	TO UPDATE		

			Sustainability: 90% of those who have completed training will have embedded the routines and processes of the Improvement Operating Model after 4 months.	TO UPDATE	TO UPDATE		
			75% of HDFT staff will answer positively to the question: 'I understand our trust strategy and how I can make improvements to support its delivery' by Mar 2026.	TO UPDATE	TO UPDATE		

Breakthrough Objective:

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

Related Corporate Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
	(TO UPDATE IF NEEDED)					

Related External Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
	(TO UPDATE IF NEEDED)					

ENABLING AMIBITION: AN ENVIRONMENT THAT PROMOTES WELLBEING 2026-27

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

GOALS:

Wellbeing

A patient and staff environment that promotes wellbeing

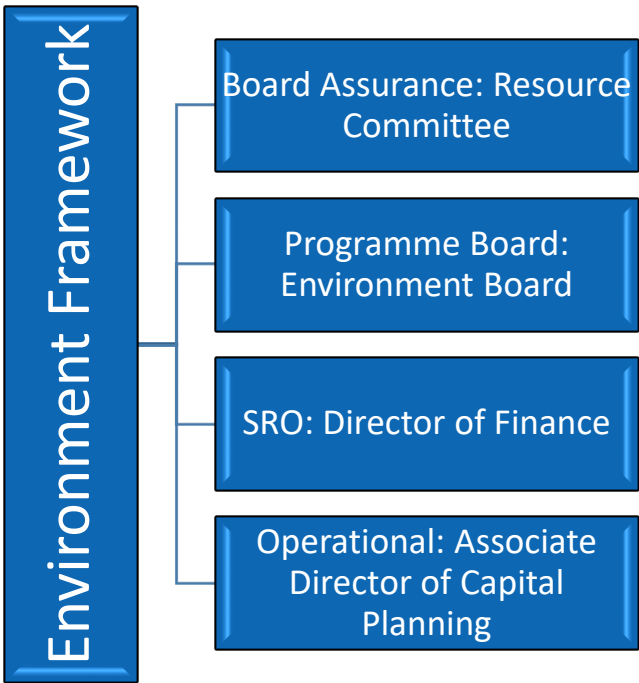
Quality & Safety

An environment and equipment that promotes best quality, safest care

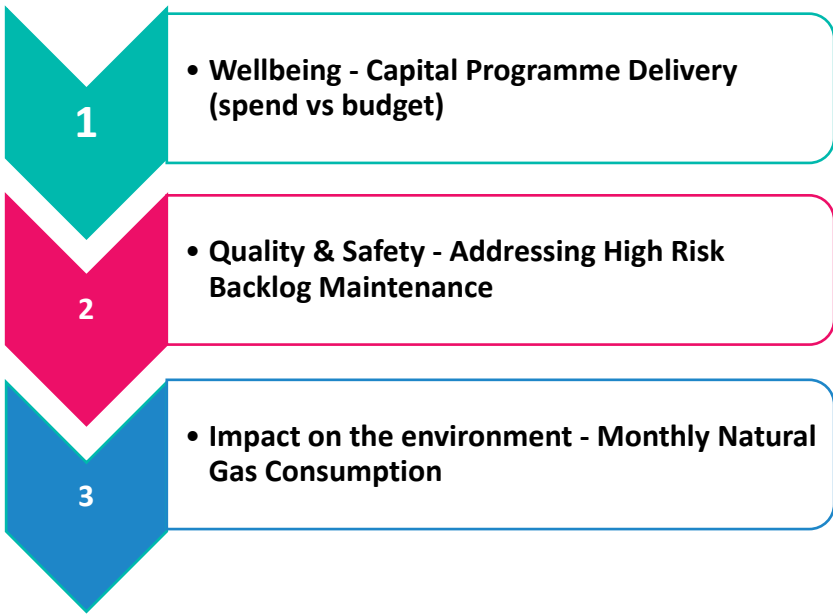
Environmental Impact

Minimise our impact on the environment

GOVERNANCE:



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



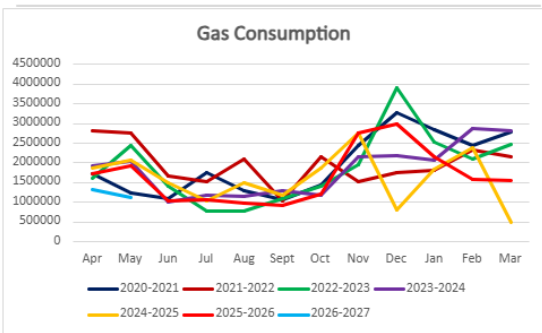
Overarching Risk Summary:

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	>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 - £35.3m 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		
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. - RAAC Eradication – Cost submission due from Contractors in September 2026. Initial forecast circa £28m plus sizable costed risk register, which will require additional NHSE funding. - Develop business case for Fire Alarm upgrade (circa £9m)	- Premises Assurance Model 26/27 submission – On track - Estates Safety Fund (Fire & Main Theatres design) – On track - Business case being submitted to NHS England for Estates RAAC Eradication Phases 1-4 (£12m). Additional business case for Phases 5-10 will be developed in due course and allow additional options appraisal for Energy Centre. - Design and Quote from supplier to undertake upgrade received, business case under development. Case anticipated for Board Q2 2026/27. No funding or timescale agreed.		
Environmental Impact 	Minimise our impact on the environment	HDFT to be carbon net zero by 2040. Achieve 1,700 tCO2e reduction in Scope 1 and 2 emissions by 2028.	- Refreshed Green Plan developed and approved. - Carbon accounting process implemented. - Estates & Facilities - Replacement of CHP with more modern, efficient system - Investigate geothermal energy. - Investigate onsite waste to energy system. - PSDS 4 Works Medicines- Complete nitrous oxide removal and develop Entonox reduction plan.	- Complete - On Track - TBC depending on funding. PLOI agreed between HIF and Trust – will update next month. External funding received for trolleys to house localised canisters. Piped network will be capped off. Entonox project to be initiated.		

Enabling Ambition Metric	Vision	Goal	Countermeasures	Current State	Level of Risk to Achieving Goal	Level of Risk for progressing actions																																																																																																								
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Trust wide 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
None relevant at present							

Related Corporate Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
ID 117	Violence and aggression against staff	Organisational risk to compliance with legislative requirements, with the risk of major injuries, fatality, or permanent disability to employees due to the failure to manage the risk of staff being subjected to acts of violence and aggression whilst carrying out normal duties, due to lack of suitable control measures and appropriate training. Multiple clinical and non- clinical changes being made.	4 x 3 = 12	4 x 2 = 8 March 2027	Operational	
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~~ September 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. Current rating reduced to reflect implementation of security team, but remains on Corporate Risk Register whilst work is completed on assurance processes around the team, and completed review of Martyn's Law position	4 x 3 = 12	4 X 2 = 8 October 2026	Operational: Health & Safety	Minimal
ID 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 December 2026	Clinical	
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	
n/a (not currently)	Fire Safety Compliance and Life Safety Risk Across the HDH Estate	Harrogate District Hospital (HDH) faces a significant and ongoing fire safety risk due to a combination of ageing fire alarm infrastructure, unreliable alarm zoning and location identification, unassured compartmentation, and widespread fire door compliance issues. Together, these weaknesses limit the Trust's ability to reliably detect, locate, contain and respond to fire incidents and support safe progressive horizontal evacuation across the estate.	4 x 5 = 20		Operational	

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
on Datix)		The risk is particularly acute within a live hospital environment where patients may be sleeping, clinically vulnerable, immobile, cognitively impaired, dependent on medical equipment, or otherwise reliant on staff-assisted evacuation. Failure of fire safety systems or barriers could lead to delayed emergency response, inappropriate evacuation decisions, fire and smoke spread, harm to patients, staff and visitors, service disruption, regulatory enforcement action, reputational damage and significant financial consequences.				

Related External Risks

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

BOARD OF DIRECTORS (PRIVATE)

30th September 2026

Title:	Audit Committee Quarterly Report for Board
Responsible Director:	Jordan McKie, Director of Finance
Author:	Chiara De Biase Non-Executive Director/Chair Audit Committee

Purpose of the report	Approval		
	Assurance	✓	
	Discussion		
	Information	✓	
Summary of key issues:	Financial Management Internal Audit External Audit Governance & Other Assurance		
Trust Strategy and Strategic Ambitions	The Patient and Child First Improving the health and wellbeing of our patients, children and communities		
	Best Quality, Safest Care		✓
	Person Centred, Integrated Care; Strong Partnerships		✓
	Great Start in Life		✓
	At Our Best: Making HDFT the best place to work		
	An environment that promotes wellbeing		
	Digital transformation to integrate care and improve patient, child and staff experience		
	Healthcare innovation to improve quality		
Corporate Risks	None noted.		
Prior Committee Review / Governance Route:	Board 30 th September 2026		
Recommendations:	The Board is asked to note the contents of the report		
Impact Assessments	Financial		
	Workforce		
	Quality & Safety		

	Legal/Regulatory		
	Equality & Diversity		
	Risk		
Consultation / Engagement	Director of Finance		

Freedom of Information	Paper can be made available under the Freedom of Information Act once published on the HDFT website.
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Audit Committee – September 2026

Chairs Report

Financial management

The Committee approved the Treasury Management Policy and noted the Annual Report. The Trust's cash position remains significantly constrained, with limited capacity for treasury activity. Supplier payment performance has deteriorated as a result, with 15% of invoices reported as being paid within 30 days during the first six months of the current year, against the national target of 95%. Payments are being prioritised according to clinical need and the risk of supplier action. The Committee will continue to maintain a clear line of sight over cash, payment controls and their effectiveness.

The Committee approved the Procurement Savings Report and welcomed the positive start to the year, with 80 schemes delivering a reported £711,000 impact in-year and £1.5 million over the life of the contracts. Members sought assurance on decision-making, benchmarking and the identification of further opportunities, including medicines and theatre procurement.

The Post-Project Evaluation Summary was approved. While the Committee recognised positive outcomes from the schemes reviewed, it challenged the consistency of benefits realisation, the limited evidence of cash-releasing benefits and the clarity of some measures and dates. The Committee welcomed the confirmation that business cases now receive greater challenge through Finance Managers and asked that learning from evaluations be applied more consistently to future investment decisions. A further response will be provided on the management of risks where adult nursing colleagues support paediatric patients in the Emergency Department.

Internal audit

Audit plan delivery was reported at 48% of planned days. The Committee received positive assurance from several completed reviews. Core financial controls were found to be operating effectively; payroll was described as a well-run process; the AI governance review provided significant assurance; and the review of 62 and 104-day cancer pathways found a well-organised service operating in line with national guidance, with diagnostic capacity being the principal area already known to the Trust.

The Committee approved the addition of an audit examining diverted payments and changes to supplier mandates. This will be accommodated within the existing audit plan at no additional cost and reflects the potential fraud and control risks associated with changes to payment instructions.

The emerging review of additional payments to medical staff has resulted in limited assurance and identified significant issues. The Committee requested that this matter remain with the Executive Team for further examination and return in December, with the Executive Medical Director invited to attend and provide clarity on the position and proposed response.

The Committee expressed concern that progress on outstanding internal audit recommendations appeared largely unchanged from the previous quarter. Members questioned whether repeated slippage reflected common root causes and emphasised the need for a firmer approach to ownership, evidence and timely closure. The Director of Governance and Improvement has been asked to provide a root-cause analysis at the next meeting. The Committee also noted the potential impact on future Head of Internal Audit Opinions if recommendations are not completed to the required standard.

External audit

The Committee approved the 2025/26 Annual Auditor's Report. External Audit reiterated that no significant weakness had been identified in the Trust's value-for-money arrangements. The report nevertheless recognises financial stability as a key risk. External Audit considered the Board's decision not to accept an unrealistic financial plan to be reasonable and confirmed that the subsequently agreed £13.5 million deficit plan did not constitute a significant weakness in arrangements.

Governance and other assurance

The Committee noted the Corporate Risk Register and requested clarification about the implications for staff and patients of OPEL scores no longer being accurate following the implementation of Nervecentre, including any impact on escalation for operational support.

The Security Management Service Annual Report provided evidence of progress and a reduction in incidents following the introduction of the security team. However, limitations in CCTV coverage and image quality continue to constrain the investigation of some incidents. The Committee also asked management to clarify the appropriate governance route for future security reporting to avoid duplication between committees.

The Committee noted that the Charity Annual Report and Accounts will now require a full audit following receipt of a £600,000 donation. The statutory filing deadline is 31 January 2027, and the audited accounts are expected to return to the Committee in December.