

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.

CORPORATE RISK REGISTER

(September 2026)



We Value

Summary Corporate Risk Register

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

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

Executive Risk Review Group

Summary – September 2026

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.

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:

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

Risk Scores

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

Gaps in Control

None at present

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

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

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

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

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

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

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

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

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

CRR ID #597: Histopathology Space and Safety			Target Date: Dec 2026	Very Low Risk			Low Risk			Medium Risk				High Risk				
Strategic Ambition:			C = 3	15	1	2	3	4	5	6	8	9	10	12	15	16	20	25
Type: Clinical / Patient Safety			L = 5			TARGET						INITIAL			CURRENT			
Risk Description The Histopathology laboratory area has limited space due to expansion over the last 10 years. Expansion has been essential to ensure that the service provided to the trust is appropriate to the requirements aligned to cancer pathways. Additional analysers and essential equipment have been installed, which has now resulted in the area being extremely cramped. Due to increase in specimen numbers the storage capacity of the laboratory is now critical and imposing a safety concern to both staff and patient specimens. Ability to expand the service is also compromised.															Escalated to CRR: Nov 2025 CQC Domain: Executive Committee: Date reviewed: 20/08/2026 Previous month's rating: 15 Previous Target Date: December 2025			
Summary of Recent Activity This risk was reviewed at the Exec risk review group on Thursday 10 th September 2026. The Current Score remained the same. No changes to note.																		
Current Position August 26 - meeting planned for September with capital team and lab team to discuss the current issues and proposal for how this can be improved. We are due UKAS in to inspect the department in early September, and the concern is that this has been flagged by inspectors at the last two inspections.																		
Key Targets None at present					Current Controls • Risk of specimen loss - controlled by specimen disposal performed by x2 staff members with quality control checks in place • Risk of spillage due to specimens being stacked and at height - Disposal carried out weekly in order to try and create space and reduce specimens being stacked at height. • Wax deliveries (20kg) each are having to be stored under benches in the lab - this poses a health and safety risk to staff having to move the bulk boxes from under benches. • Blocks are required to be stored for a minimum of 30 years. Blocks are kept on site for a minimum of 2 years due to additional tests that may be required. They are then transferred to an offsite secure facility to store for the remaining 30 years. The capacity for storage has been reached and there are limited options for further storage due to the requirement for a reinforced floor. • A significant amount of flammable reagent (alcohol, xylene and formalin) are used daily and more frequently due to additional strainers being required to keep up with the increased demand. Due to limited space majority of this is being stored in the outside flammable store. This results in staff having to make frequent trips to the store and poses a manual handling issue. • When receiving a breast mastectomy specimen national standards state that the specimen should be opened within 4 hours. this is not always possible due to a downdraft bench being unavailable. This may lead to degradation of the specimen								Gaps in Control • Specimens being stacked at height - we ensure that disposal is regular, but this is not always sufficient to ensure that specimens are not stacked at height. Risk assessment complete and staff trained in spill procedure, spill kits available if required. Datix completed if a spill occurs • Breast mastectomy specimens - in order to meet national standards, the team try to reorganise workload to enable a downdraft bench to be freed up. If this is not possible a different bench is used but this requires the movement of all reagents to an area where there is no downdraft ventilation. This poses a health and safety risk • Inability to expand the service to support additional workload i.e. - expansion of specific services, TIF2 project. Discussion underway with cancer alliance regarding funding opportunity and if this can be used for expansion either additional equipment or capital work. Paper submitted to environment board to highlight space issues					

CRR ID #642: Cardiology Acute Services

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

Type: Clinical / Patient Safety

Target Date:
Dec 2026

Very Low Risk

Low Risk

Medium Risk

High Risk

C = 3

L = 4

12

1

2

3

TARGET

4

5

6

8

9

10

12

CURRENT

INITIAL

15

16

20

25

Risk Description

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

Escalated to CRR: Nov 2024

CQC Domain: Safe

Executive Committee: Quality

Date reviewed: 19/08/2026

Previous month's rating: 12

Previous Target Date: Dec 2025

Summary of Recent Activity

This risk was reviewed at the Exec risk review group on Thursday 10th September 2026. The Current Score remained the same. No changes to note.

Current Position

- August 2026 - 1 new consultant in post, 1 new consultant to start in September. Ongoing work to review service delivery priorities to start when in post.

Key Targets**Staffing and Workforce KRIs:**

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

Quality and Outcomes KRIs:

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

Readmission rates for cardiology patients within 30 days of discharge.

Current Controls

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

Gaps in Control

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

CRR ID #721: Group Cash Position

Strategic Ambition: Overarching Finance

Type: Financial

Target Date:
March 2027

Very Low Risk

Low Risk

Medium Risk

High Risk

1

2

3

4

5

6

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12

15

16

20

25

C = 5

25

L = 5

TARGET

INITIAL

CURRENT

Risk Description

The cash position for 26/27 will require support throughout the financial year due to the planned £15.3m deficit. However £13.5m revised deficit plan and DSF are now due to be received for the year (agreed Auguts26).

Month End cash position, £1m which is well below the minimum cash balance £2m. Emergency cash request submitted to NHSE beginning of September otherwise we would not be able to cover any Supplier payments in month.

The Trust is managing cash flow on a week by week basis, several older supplier payments have been made in month however there are still invoices outstanding over 30days.

PDC is being chased for capital schemes, RAAC business case being prepped, CDC case submitted and Estate funding outstanding.

£14.4m cash support received in 25/26, year end deficit £23.75m.

Cash support requested in April, May and June. April received 1/2 of the £9.2m application, May and June received the deficit plan and July NHSE supported as cash application of £10m which incorporated £8.3m of working capital. Cash support requests will continue to be submitted throughout the year as per the deficit plan.

Despite Supplier relationships being maintained to date, relationships are becoming strained despite the payment teams best efforts.

Escalated to CRR: May 2025

CQC Domain: Well-Led

Executive Committee:
Resources

Date reviewed: 08/09/2026

Previous month's rating: 25

Previous Target Date: March 2026

Summary of Recent Activity

This risk was reviewed at the Exec risk review group on Thursday 10th September 2026. The Current Score remained the same. No changes to note.

Current Position

NHSE supported the cash application which also covers working capital £8.4m (July). August application declined.

Run rate reduction is critical to maintain payments over upcoming months.

DSF agreed for 26/27 £13.5m.

Key Risk Indicators

Unable to pay Suppliers/Staff/Mandatory requirements (Pension/Tax/NI)

More Supplies being added to the immediate payment register

Team morale - phones calls and emails being received

Fines for late payments

Threat of accounts going on hold

WRAP delivery

unpaid suppliers increasing / Emergency cash application

Key Targets

Payment of suppliers within 60days and returning back to payments within 30 days.

Current Controls

- Emergency Case Protocol to be developed to prioritise cash payments which factors in cash support not being offered.
- Regular monitoring of cash position and forecast.
- Review of Council payment terms.
- Cash support requests being submitted in NHSE timeframes.
- WRAP delivery
- Turnaround actions under review

Gaps in Control

- Aged Debt - Although more focused is still needed, due to supplier payments being delayed it is impacting payments from other Trusts.
- Balanced financial plan - Financial Plan for 25/26 remains challenging.
- NHSE timeframes for review of capital cases and issuing MOUs.
- Financial position.

CRR ID #1314: CYPH Risk of clawback in underspent contract areas Strategic Ambition: Overarching Finance Type: Financial / Financial management	Target Date: April 2027		Very Low Risk			Low Risk			Medium Risk				High Risk			
	C = 4	12	1	2	3	4	5	6	8	9	10	12	15	16	20	25
	L = 3					TARGET							CURRENT			
												INITIAL				
Risk Description There is a risk that commissioners may seek to reclaim (claw back) underspends from individual service contracts where expenditure is below the contracted value. Should commissioners require or request the return or redirection of contract-level underspends, this could reduce the Directorate's ability to manage financial pressures across its portfolio of services, resulting in a destabilisation of the overall Directorate financial position.													Escalated to CRR: July 2026 CQC Domain: Executive Committee: Date reviewed: 03/09/2026 Previous month's rating: 12 Previous Target Date: N/A			
Summary of Recent Activity This risk was reviewed at the Exec risk review group on Thursday 10 th September 2026. The Current Score remained the same. No changes to note.																
Current Position Wakefield – clawback clause that has been enacted North Yorkshire – risk sharing with precedent for underspend to be split Cumberland – clawback clause if elements of service not delivered South Tyneside – option to propose contract variation if there is a material underspend Northumberland – material underspend to be discussed and reinvested into service																
03/09/2026 Risk remains the same in the context of: Limited clawback risk: North Yorkshire is forecasting an overspend and Cumberland a balanced position; Wakefield: Clawback provisions have been enacted and are reflected within the Directorate forecast; Northumberland and South Tyneside: Forecast collective underspend of c.£700k. Ongoing discussions with commissioners under open-book arrangements regarding management of year-end variances. In Northumberland, there is previous precedent for underspends being carried forward into future service delivery plans, which may create financial pressure in subsequent years.																
Key Risk Indicators • Variations in demand, activity, and service delivery across different contracts resulting in over- and under-performance against budget. • Financial pressures within individual contract areas impacting the overall financial position of the Directorate. • Potential commissioner interpretation that underspends should be returned rather than retained within the wider contract portfolio.																
Key Targets • Each contract area achieving financial balance by April 2027 • Achievement of a sustainable Directorate financial position without reliance on non-recurrent measures. • Effective management of contract performance within agreed funding allocations.			Current Controls • Regular contract monitoring and financial reporting. • Ongoing discussions with commissioners regarding contract performance and financial positions. • Forecasting and financial risk assessment processes.						Gaps in Control • There is limited contingency planning should commissioners seek repayment of underspends.							

	• Deep-dive reviews into the drivers of variance for all overspending contracts, with associated recovery actions identified and monitored.	
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Trust
Wednesday 30th September 2026

Title:	Integrated Board Report – August 2026
Responsible Director:	Julia Nixon, Chief Operating Officer
Author:	<i>Rachel McDonald, Head of Analytical Services</i>

Purpose of the report	Approval		
	Assurance		
	Discussion		
	Information	x	
Summary of key issues:	<i>The Integrated Board Report presents the latest data on metrics from the Trust's Strategic Planning Framework and nationally mandated performance standards.</i> <i>The Innovation Committee is asked to note the content of this report.</i>		
Trust Strategy and Strategic Ambitions	The Patient and Child First		
	Improving the health and wellbeing of our patients, children and communities		
	Best Quality, Safest Care		x
	Person Centred, Integrated Care; Strong Partnerships		x
	Great Start in Life		x
	At Our Best: Making HDFT the best place to work		x
	An environment that promotes wellbeing		x
	Digital transformation to integrate care and improve patient, child and staff experience		x
	Healthcare innovation to improve quality		x
Corporate Risks	None		
Prior Committee Review / Governance Route:	This report is also presented to Innovation Committee.		
	A draft version of this report was presented to Strategy Deployment Room earlier this month.		
Recommendations:	The Board are asked to note the items contained within this report.		
Impact Assessments	Financial		
	Workforce		
	Quality & Safety		
	Legal/Regulatory		

	Equality & Diversity		
	Risk		
Consultation / Engagement			
Freedom of Information	Our Policies and Procedures		

Integrated Board Report

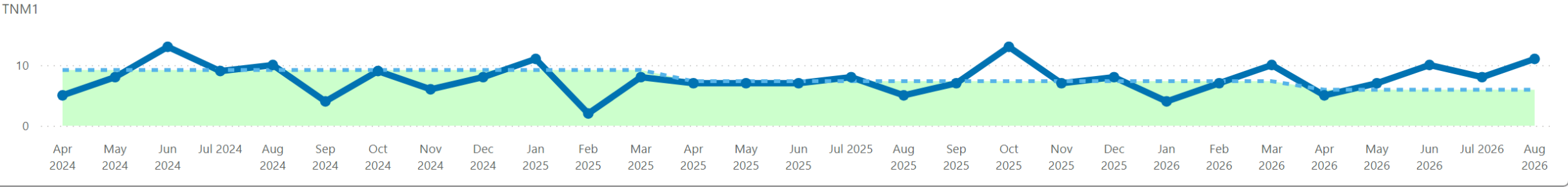
September 2026

True North Metrics

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Moderate+ harm events



TNM2 - Placeholder - Clinical effectiveness metric

TNM3 - Placeholder - Patient experience / FFT

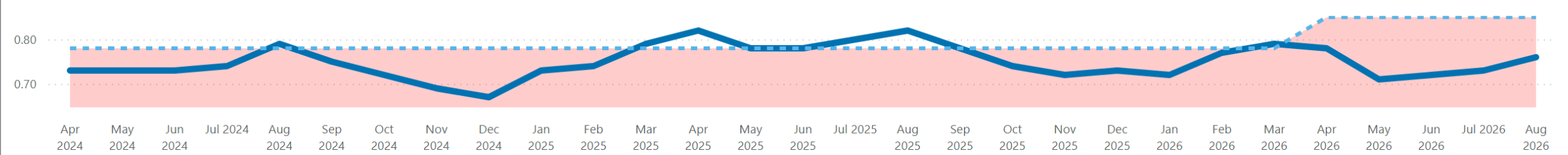
True North Metrics

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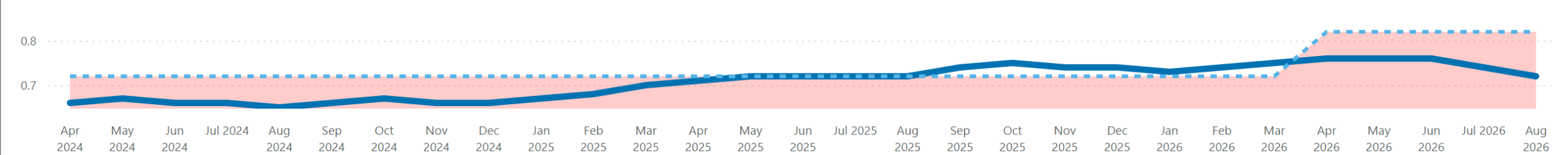
Emergency Care Standard – 4-hour ED

TNM4



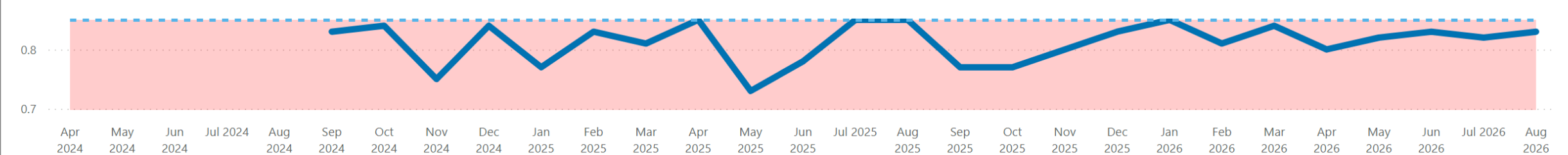
18-week RTT standard

TNM5



62-day cancer standard

TNM6



True North Metrics

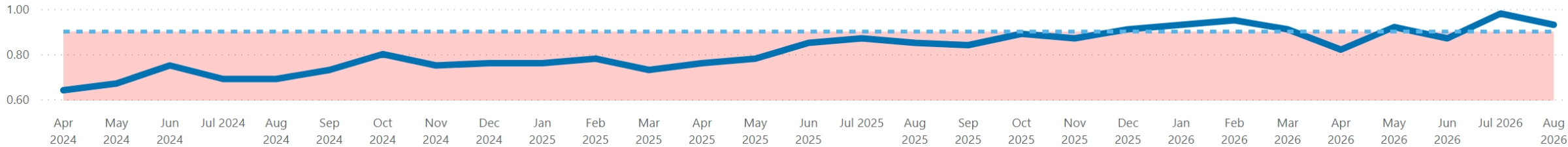
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TNM 7 - Placeholder - [Frailty](#)

Early intervention & prevention

TNM8



TNM 9 - Placeholder - [Children's patient experience](#)

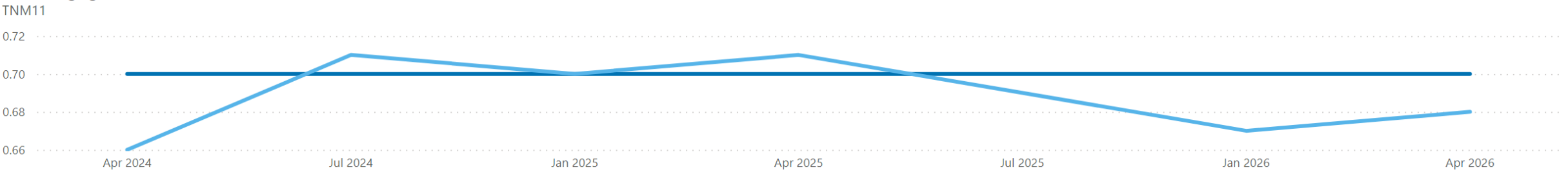
True North Metrics

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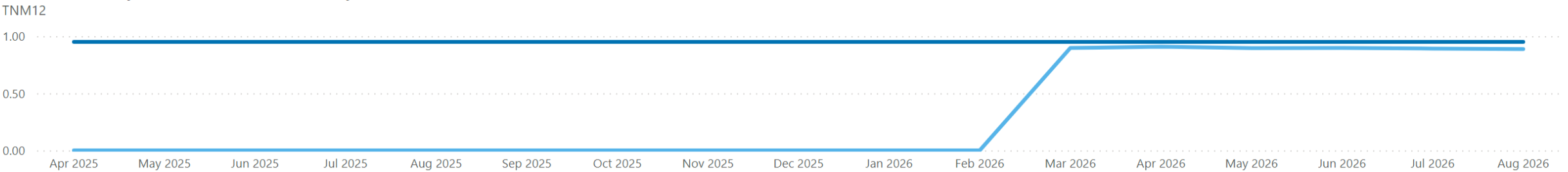


TNM 10 -Placeholder - [Waiting for children's services \(Non-CYPH\)](#)

Staff engagement



Staff availability / workforce sustainability

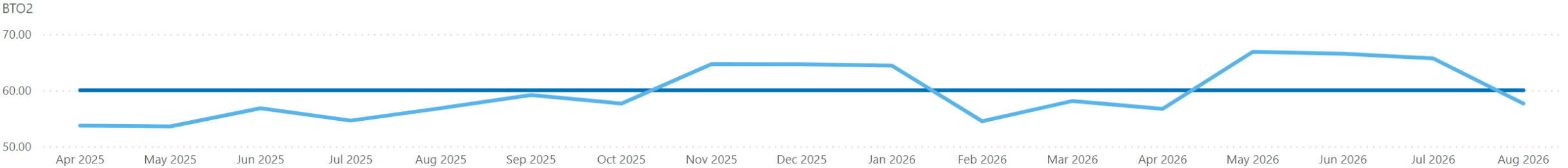


Breakthrough Objectives



BTO1 - Placeholder - Checklist Completion

Time to next destination



BTO3 -Placeholder - CYP in research

Watch Metrics Summary

Status	Metric Count	Metric %
▼ Sustained Below Target	37	40.7%
Newly Below Target	8	8.8%
Newly Achieving	17	18.7%
Sustained Achieving	29	31.9%

Watch Metrics – Sustained below target (1)

ID	Name	Strategy Group	Strategy Sub Group	Current Value	Target	Length of current performance run	Success is High/Low	Month	Range Lower	Range Upper	Graph
1.12	Infant health - % women initiating breastfeeding	Great Start in Life	Maternity	0.88	0.95	77	Higher	Aug 2026	0.95	0.95	
1.13	VTE risk assessment - inpatients	Best Quality Safest Care	safety & effectiveness	0.88	0.95	21	Higher	Aug 2026	0.95	0.95	
1.4	Infection control - Hospital acquired C.difficile cases, lapse in care identified	Best Quality Safest Care	safety & effectiveness	2.00	1.00	4	Lower	Aug 2026	1.00	1.00	
1.8.1	Safer staffing levels - fill rate	Best Quality Safest Care	safety & effectiveness	0.91	0.95	9	Higher	Aug 2026	0.95	0.95	
1.9	Maternity - % women seen by a midwife (or healthcare professional) by 12w 6d	Great Start in Life	Maternity	0.95	0.95	5	Higher	Aug 2026	0.95	0.95	
1.9.3	Maternity - Number of Admissions to SCBU per month	Great Start in Life	Maternity	21.00	8.00	5	Lower	Aug 2026	8.00	8.00	
1.9.5	Maternity - Maternity Role Specific Training Compliance	Great Start in Life	Maternity	0.83	0.95	20	Higher	Aug 2026	0.95	0.95	
2.2.1	Complaints - numbers received	Person Centred, Integrated Care	Patient Experience	32.00	12.00	9	Lower	Aug 2026	12.00	12.00	
3.1	HSMR (Hospital Standardised Mortality Ratio)	Clinical Outcomes	Mortality		100.00	20	Range	Aug 2026	90.00	110.00	
3.2	Mortality - SHMI	Best Quality Safest Care			100.00	3	Range	Aug 2026	96.00	104.00	

Watch Metrics – Sustained below target (2)

ID	Name	Strategy Group	Strategy Sub Group	Current Value	Target	Length of current performance run	Success is High/Low	Month	Range Lower	Range Upper	Graph
3.3.1	Readmissions to the same specialty within 30 days - following elective admission - as % of all elective admissions	Person Centred, Integrated Care	RTT	0.05	0.04	37	Lower	Aug 2026	0.04	0.04	
3.3.2	Readmissions to the same specialty within 30 days - following non-elective admission - as % of all non-elective admissions	Person Centred, Integrated Care	UEC	0.10	0.09	37	Lower	Aug 2026	0.09	0.09	
4.1	Appraisal rate - Non Medical and Medical Staff	Best Place to Work	Engagement	0.87	0.90	77	Higher	Aug 2026	0.90	0.90	
4.3	Staff sickness rate	Best Place to Work	Availability	0.05	0.04	62	Lower	Aug 2026	0.04	0.04	
5.1.3	RTT Incomplete pathways - total	Person Centred, Integrated Care	RTT	21,733.00	20,000.00	6	Lower	Aug 2026	19,750.00	20,250.00	
5.1.4	RTT Incomplete pathways - 52-<104 weeks	Person Centred, Integrated Care	RTT	12.00	0.00	11	Lower	Aug 2026	0.00	0.00	
5.10	Cancer - 14 days maximum wait from urgent GP referral for all urgent suspect cancer referrals	Person Centred, Integrated Care	Cancer	0.63	0.90	77	Higher	Aug 2026	0.90	0.90	
5.13.2	Children's Services - 2-3 years caseload	Great Start in Life	CYP PH	2,311.00	2,100.00	6	Range	Aug 2026	1,900.00	2,300.00	

Watch Metrics – Sustained below target (3)

ID	Name	Strategy Group	Strategy Sub Group	Current Value	Target	Length of current performance run	Success is High/Low	Month	Range Lower	Range Upper	Graph
5.15	Children's Services - Ante-natal visits	Great Start in Life	CYP PH	0.92	0.95	13	Higher	Aug 2026	0.95	0.95	
5.27	GPOOH - Telephone clinical assessment for URGENT cases within 20 minutes of call prioritisation	Person Centred, Integrated Care	UEC	0.32	0.95	77	Higher	Aug 2026	0.95	0.95	
5.28	GPOOH - Home visit: Face to face consultations started for URGENT cases within 2 hrs	Person Centred, Integrated Care	UEC	0.90	0.95	7	Higher	Aug 2026	0.95	0.95	
5.29	Community SITREP waiting times- percentage of waiters over 52 weeks	Person Centred, Integrated Care	RTT	0.02	0.02	9	Lower	Aug 2026	0.02	0.02	
5.3	Diagnostic waiting times - 6-week standard	Person Centred, Integrated Care	RTT	0.69	0.75	18	Higher	Aug 2026	0.75	0.75	
5.5	Data quality on ethnic group - inpatients RESPONSIVE - Digital	Person Centred, Integrated Care	Digital	0.89	0.90	9	Higher	Aug 2026	0.90	0.90	
5.6	A&E 4 hour standard	Person Centred, Integrated Care	UEC	0.76	0.80	12	Higher	Aug 2026	0.80	0.80	
5.7	Ambulance handovers - % within 15 mins	Person Centred, Integrated Care	UEC	0.75	0.90	25	Higher	Aug 2026	0.90	0.90	

Watch Metrics – Sustained below target (4)

ID	Name	Strategy Group	Strategy Sub Group	Current Value	Target	Length of current performance run	Success is High/Low	Month	Range Lower	Range Upper	Graph
5.9.1	62 Day Cancer Performance	Person Centred, Integrated Care	Cancer	0.83	0.85	29	Higher	Aug 2026	0.85	0.85	
5.9.2	Number of Cancer Treatment waits over 104 days	Person Centred, Integrated Care	Cancer	7.00	0.00	77	Lower	Aug 2026	0.00	0.00	
6.1	Agency spend	Finance		54,000.00	20,000.00	77	Lower	Aug 2026	20,000.00	20,000.00	
6.5.2	Long stay patients - superstranded (>21 days LOS)	Person Centred, Integrated Care	UEC	57.00	50.00	10	Lower	Aug 2026	50.00	50.00	
6.6	Occupied bed days per 1,000 population	Person Centred, Integrated Care	UEC	58.06	50.00	11	Lower	Aug 2026	50.00	50.00	
6.7.2	Length of stay - non-elective	Person Centred, Integrated Care	UEC	7.96	6.50	20	Lower	Aug 2026	6.50	6.50	
7.1	GP Referrals against 2019/20 baseline	Person Centred, Integrated Care	RTT	0.88	1.00	5	Range	Aug 2026	0.95	1.05	
7.3	Outpatient Procedures vs Plan	Person Centred, Integrated Care	RTT	0.83	1.00	8	Range	Aug 2026	0.98	1.02	
7.4	DayCase incl Endoscopy vs Plan	Person Centred, Integrated Care	RTT	0.90	1.00	7	Range	Aug 2026	0.98	1.02	
7.5	Elect. IP vs Plan	Person Centred, Integrated Care	RTT	0.94	1.00	6	Range	Aug 2026	0.98	1.02	
7.7	Follow Ups vs Plan	Person Centred, Integrated Care	RTT	1.03	1.00	4	Lower	Jul 2026	1.00	1.00	

Watch Metrics – Newly below target (1)

ID	Name	Strategy Group	Strategy Sub Group	Current Value	Target	Length of current performance run	Success is High/Low	Month	Range Lower	Range Upper	Graph
1.6	Incidents - ratio of low harm incidents	Best Quality Safest Care	safety & effectiveness	95.55	200.00	1	Range	Aug 2026	100.00	300.00	
1.9.1	Maternity - - Number of Stillbirths per month	Great Start in Life	Maternity	1.00	0.00	1	Lower	Aug 2026	0.00	0.00	
1.9.2	Maternity - - Number of Third and Fourth Degree Tears	Great Start in Life	Maternity	7.00	4.00	1	Lower	Aug 2026	4.00	4.00	
5.13.1	Children's Services - 0-12 months caseload	Great Start in Life	CYPPIH	2,504.00	2,100.00	1	Range	Aug 2026	1,900.00	2,300.00	
5.14	Children's Services - Safeguarding caseload	Great Start in Life	CYPPIH	853.00	1,200.00	1	Range	Aug 2026	1,000.00	1,400.00	
6.7.1	Length of stay - elective	Person Centred, Integrated Care	RTT	2.69	2.50	1	Lower	Aug 2026	2.50	2.50	
6.8	Avoidable admissions	Person Centred, Integrated Care	UEC		290.00	1	Lower	Aug 2026	290.00	290.00	
7.2	First Outpatient vs Plan	Person Centred, Integrated Care	RTT	0.76	1.00	1	Range	Aug 2026	0.98	1.02	

Watch Metrics – Newly achieving (1)

ID	Name	Strategy Group	Strategy Sub Group	Current Value	Target	Length of current performance run	Success is High/Low	Month	Range Lower	Range Upper	Graph
1.3	Inpatient falls per 1,000 bed days	Best Quality Safest Care	safety & effectiveness	5.26	6.00	1	Lower	Aug 2026	6.00	6.00	
1.7.1	Incidents - comprehensive serious incidents (SI)	Best Quality Safest Care	safety & effectiveness	0.00	0.00	1	Lower	Aug 2026	0.00	0.00	
1.9.7	Maternity - Maternity Unit Service Suspensions per month	Great Start in Life	Maternity	2.00	4.00	1	Lower	Aug 2026	4.00	4.00	
2.2.2	Complaints - % responded to within time	Person Centred, Integrated Care	Patient Experience	1.00	0.90	1	Higher	Aug 2026	0.90	0.90	
3.4	Returns to theatre - % returns within 30 days	Person Centred, Integrated Care	RTT	0.02	0.02	1	Lower	Aug 2026	0.02	0.02	
4.2	Mandatory and Essential Skills Training rate	Best Place to Work	Engagement	0.92	0.90	1	Higher	Aug 2026	0.90	0.90	
4.4	Staff turnover rate	Best Place to Work	Availability	0.10	0.12	1	Lower	Aug 2026	0.12	0.12	
4.5	Vacancies	Best Place to Work	Availability	0.05	0.05	1	Lower	Aug 2026	0.05	0.05	
5.1.2	RTT Incomplete pathways performance - 92nd centile (days)	Person Centred, Integrated Care	RTT	31.00	126.00	1	Lower	Aug 2026	126.00	126.00	
5.2.1	RTT waiting times (days different) - by ethnicity(gap between BME & White (positive is shorter wait for BME)	Person Centred, Integrated Care	RTT	0.00	0.00	2	Lower	Aug 2026	0.00	0.00	

Watch Metrics – Newly achieving (2)

ID	Name	Strategy Group	Strategy Sub Group	Current Value	Target	Length of current performance run	Success is High/Low	Month	Range Lower	Range Upper	Graph
5.2.4	RTT Waiting times - differential wait in days for patients with LD Flag	Person Centred, Integrated Care	RTT	0.00	0.00	1	Lower	Aug 2026	0.00	0.00	
5.23	Community Care Adult Teams - performance against new timeliness standards	Person Centred, Integrated Care	Elderly	0.92	0.90	2	Higher	Aug 2026	0.90	0.90	
5.8	A&E - number of 12 hour trolley waits	Person Centred, Integrated Care	UEC	0.00	5.00	1	Lower	Aug 2026	5.00	5.00	
6.4	Cash balance	Finance		1,438,000.00	500,000.00	1	Higher	Aug 2026	475,000.00	525,000.00	
7.6	Combined Elect (excl F'up) vs Plan	Person Centred, Integrated Care	RTT	1.01	1.00	1	Range	Jul 2026	0.98	1.02	
7.8	Non Elective IP vs Plan	Person Centred, Integrated Care	UEC	0.99	1.00	1	Range	Jul 2026	0.98	1.02	
7.9	ED Attends vs Plan	Person Centred, Integrated Care	UEC	0.98	1.00	2	Range	Jul 2026	0.98	1.02	

Watch Metrics – Sustained achieving (1)

ID	Name	Strategy Group	Strategy Sub Group	Current Value	Target	Length of current performance run	Success is High/Low	Month	Range Lower	Range Upper	Graph
1.1	Pressure ulcers - hospital acquired - moderate harm or above - per 1,000 bed days	Best Quality Safest Care	safety & effectiveness	0.12	0.30	8	Lower	Aug 2026	0.30	0.30	
1.101	Moderate Harm or Above - community acquired pressure ulcers - raw numbers	Best Quality Safest Care		1.00	2.00	8	Lower	Aug 2026	2.00	2.00	
1.102	Moderate Harm or Above - hospital acquired pressure ulcers - raw numbers	Best Quality Safest Care		1.00	2.00	10	Lower	Aug 2026	2.00	2.00	
1.11	Infant health - % women smoking at time of delivery	Great Start in Life	Maternity	0.01	0.05	10	Lower	Aug 2026	0.05	0.05	
1.14	Sepsis screening - inpatient wards	Best Quality Safest Care	safety & effectiveness	1.00	0.95	185	Higher	Aug 2026	0.95	0.95	
1.15	Sepsis screening - Emergency department	Best Quality Safest Care	safety & effectiveness	0.99	0.95	157	Higher	Aug 2026	0.95	0.95	
1.2	Pressure ulcers - community acquired - moderate harm or above - per 1,000 patient contacts	Best Quality Safest Care	safety & effectiveness	0.00	0.13	29	Lower	Aug 2026	0.13	0.13	
1.5	Infection control - Hospital acquired MRSA cases, lapse in care identified	Best Quality Safest Care	safety & effectiveness	0.00	0.00	10	Lower	Aug 2026	0.00	0.00	

Watch Metrics – Sustained achieving (2)

ID	Name	Strategy Group	Strategy Sub Group	Current Value	Target	Length of current performance run	Success is High/Low	Month	Range Lower	Range Upper	Graph
1.7.2	Incidents - Never events	Best Quality Safest Care	safety & effectiveness	0.00	0.00	6	Lower	Aug 2026	0.00	0.00	
1.8.2	Safer staffing levels - CHPPD	Best Quality Safest Care	safety & effectiveness	10.61	8.00	47	Higher	Aug 2026	7.00	9.00	
1.9.4	Maternity - 1:1 Care delivered in labour	Great Start in Life	Maternity	1.00	0.95	20	Higher	Aug 2026	0.95	0.95	
1.9.6	Maternity - Maternity Complaints per month	Great Start in Life	Maternity	2.00	9.00	20	Lower	Aug 2026	9.00	9.00	
2.1.1	Friends & Family Test (FFT) - All Patients	Best Quality Safest Care	Patient Experience	0.96	0.90	77	Higher	Aug 2026	0.90	0.90	
2.1.2	Friends & Family Test (FFT) - Adult Community Services	Best Quality Safest Care	Patient Experience	0.95	0.90	3	Higher	Aug 2026	0.90	0.90	
3.5	Delayed Transfer of Care - % inpatients not meeting the criteria to reside	Person Centred, Integrated Care	UEC	0.11	0.12	4	Lower	Aug 2026	0.12	0.12	
5.1.1	RTT Incomplete pathways performance - median days wait	Person Centred, Integrated Care	RTT	10.00	110.00	77	Lower	Aug 2026	110.00	110.00	
5.11	Cancer - 28 days faster diagnosis standard (suspected cancer referrals)	Person Centred, Integrated Care	Cancer	0.89	0.80	7	Higher	Aug 2026	0.80	0.80	
5.12	Cancer - Combined 31 day wait (First and Subsequent Treatments)	Person Centred, Integrated Care	Cancer	0.99	0.95	41	Higher	Aug 2026	0.95	0.95	

Watch Metrics – Sustained achieving (3)

ID	Name	Strategy Group	Strategy Sub Group	Current Value	Target	Length of current performance run	Success is High/Low	Month	Range Lower	Range Upper	Graph
5.16	Children's Services - 10-14 day new birth visit	Great Start in Life	CYP PH	0.97	0.95	8	Higher	Aug 2026	0.95	0.95	
5.17	Children's Services - 6-8 week visit	Great Start in Life	CYP PH	0.95	0.95	11	Higher	Aug 2026	0.95	0.95	
5.18	Children's Services - 12 month review	Great Start in Life	CYP PH	0.97	0.95	13	Higher	Aug 2026	0.95	0.95	
5.19	Children's Services - 2.5 year review	Great Start in Life	CYP PH	0.97	0.95	9	Higher	Aug 2026	0.95	0.95	
5.2.2	RTT waiting times - by level of deprivation-differential average wait in days (negative gap reflects high deprivation waiting a shorter time)	Person Centred, Integrated Care	RTT	0.00	0.00	20	Lower	Aug 2026	0.00	0.00	
5.2.3	RTT Waiting Times - - Differential RTT waiting times in days for gender(positive means females wait longer)	Person Centred, Integrated Care	RTT	0.00	0.00	5	Lower	Aug 2026	0.00	0.00	
6.10	Day case conversion rate	Person Centred, Integrated Care	RTT	0.01	0.03	77	Lower	Aug 2026	0.03	0.03	
6.2	Surplus/ Deficit and variance to plan	Finance		-5,519,000.00	0.00	17	Lower	Aug 2026	0.00	0.00	
6.3	Capital spend	Finance		8,526,000.00	500,000.00	76	Higher	Aug 2026	475,000.00	525,000.00	
6.5.1	Long stay patients - stranded (>7 days LOS)	Person Centred, Integrated Care	UEC	132.00	175.00	54	Lower	Aug 2026	175.00	175.00	
6.9	Theatre utilisation (elective sessions)	Person Centred, Integrated Care	RTT	0.82	0.80	4	Higher	Aug 2026	0.80	0.80	

Board Meeting Held in Public

Title:	Learning from Deaths Quarterly Report Q1: April-June 2026
Responsible Director:	Executive Medical Director
Author:	Deputy Medical Director for Quality and Safety

Purpose of the report	Approval		
	Assurance	X	
	Discussion		
	Information		
Summary of key issues:	Presents HDFT Mortality statistics in comparison to regional and national data. Details themes from case reviews and any shared learning opportunities.		
Trust Strategy and Strategic Ambitions	The Patient and Child First		
	Improving the health and wellbeing of our patients, children and communities		
	Best Quality, Safest Care		X
	Person Centred, Integrated Care; Strong Partnerships		
	Great Start in Life		
	At Our Best: Making HDFT the best place to work		
	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		

Prior Committee Review / Governance Route:	Review at QGMG and End of Life and Mortality Committee prior to submission to Quality Committee		
Recommendations:	The Board is asked to note the contents of the report, including the metrics and methodology used.		
Impact Assessments	Financial		
	Workforce		
	Quality & Safety	X	Provides overall assurance and details actions if any themes are identified for improvement
	Legal/Regulatory		
	Equality & Diversity		
	Risk		
Consultation Engagement /	Not applicable		

Freedom of Information	
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Board Meeting Held in Public

Learning from Deaths Quarter 1 Report

Executive Medical Director

1.0 Executive Summary

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

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

29 cases have undergone a structured judgement review since the last report. No cases were identified as receiving poor overall care. 10 cases with a diagnosis of alcohol-related liver disease) were scrutinised following an alert of possible excess mortality - no significant lapses in care were found but opportunities for improvement were identified.

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

2.0 Introduction

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

3.0 Findings

3.1 Crude Mortality Data

The crude mortality rate for admissions gives a long-term view of trust mortality. In total, 162 deaths were recorded in Q1, down from 183 in the preceding Q4 and down from Q1 in 25/26 which had 168 deaths. This data is not risk-adjusted so takes no account of the unique characteristics of individual admissions. Comparison with the national mortality rate is also shown where data is available (shown in the darker blue line in Figures 1 and 2). This demonstrates that the peaks and troughs we see in HDFT are often mirrored at the national level. Figure 2 gives a “zoomed in” view of data from the last 2 years.

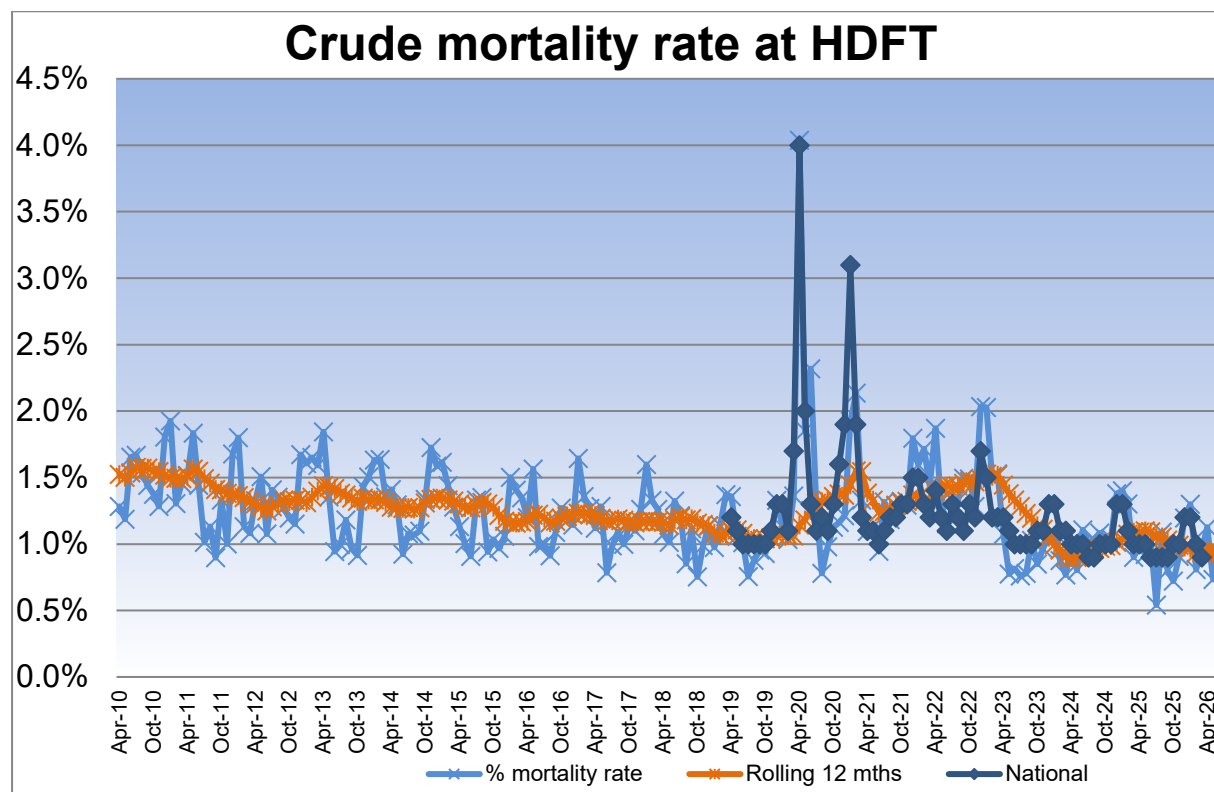


Figure 1: Crude mortality rates over the last 15 years (%deaths per hospital episode)

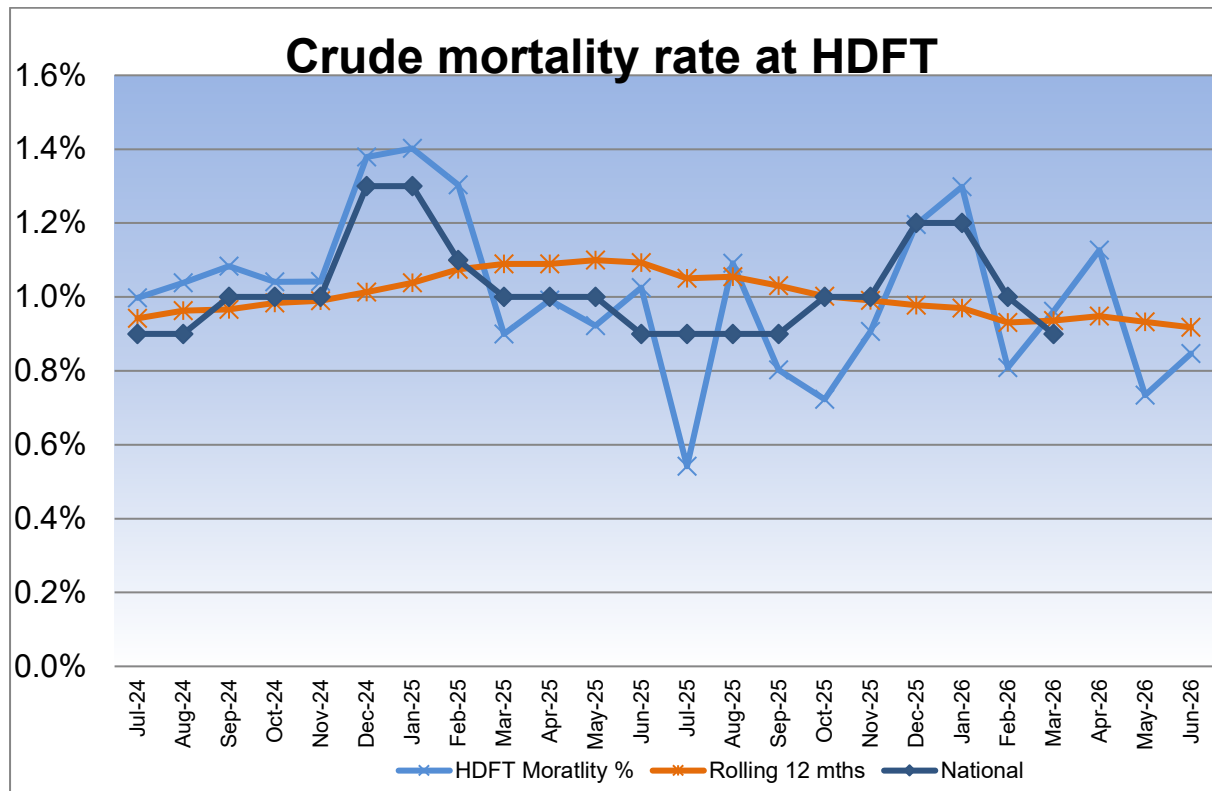


Figure 2: Expanded crude mortality rates over the last 2 years (%deaths per hospital episode)

3.2 Standardised Hospital Mortality Index (SHMI)

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

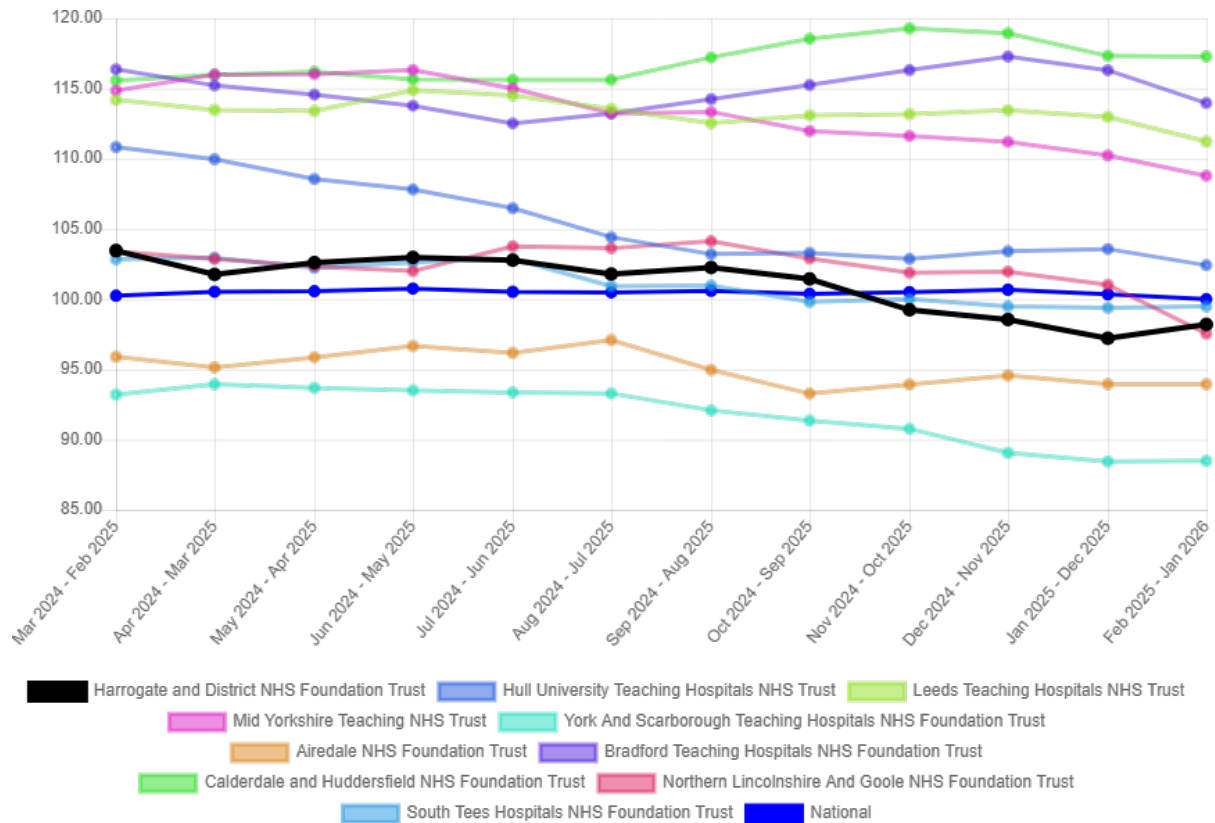


Figure 3: HDFT SHMI since Dec 2023 versus regional peers

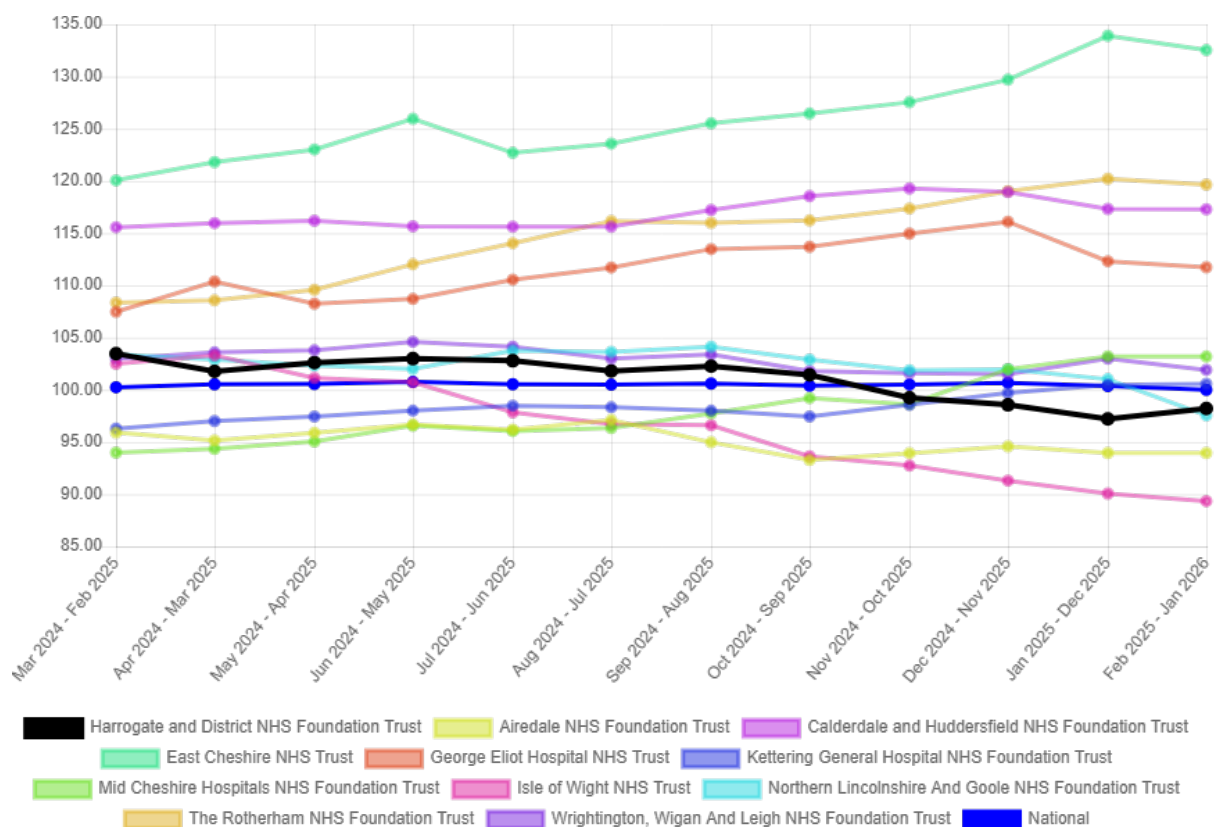


Figure 4: HDFT SHMI since Dec 2023 versus national peers

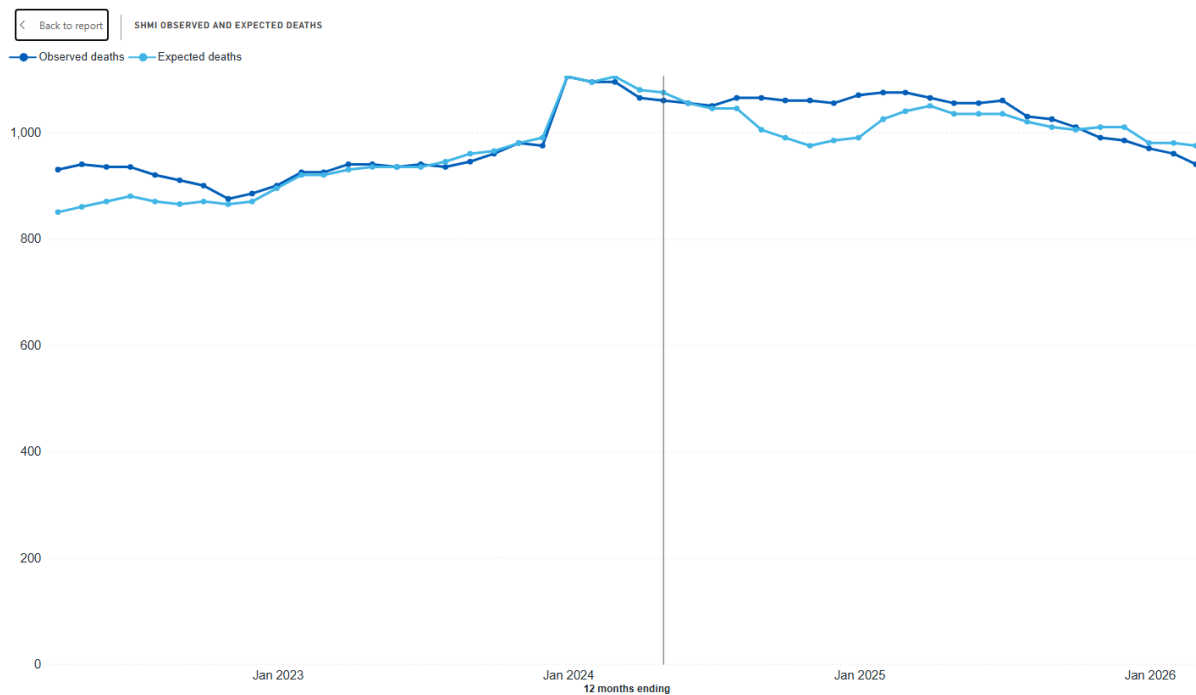


Figure 5: Observed (dark blue) and expected (light blue) number of deaths (in hospital or within 30 days of discharge – rolling 12 months)

A fall in expected death numbers, as seen from July to December 2024, raises concerns of a data quality issue. We identified an increase in patients' diagnostic code in the category "Invalid primary diagnosis". We normally have very few spells in this category, but it sharply rose in 24/25 year. The reason behind the rise of this category is likely due to incomplete clinical coding by the time of SHMI generation. The number of cases with "invalid primary diagnosis" has now fallen significantly to around 5%. There remains some challenges affecting our coding team capacity currently, but actions are being taken to support the team.

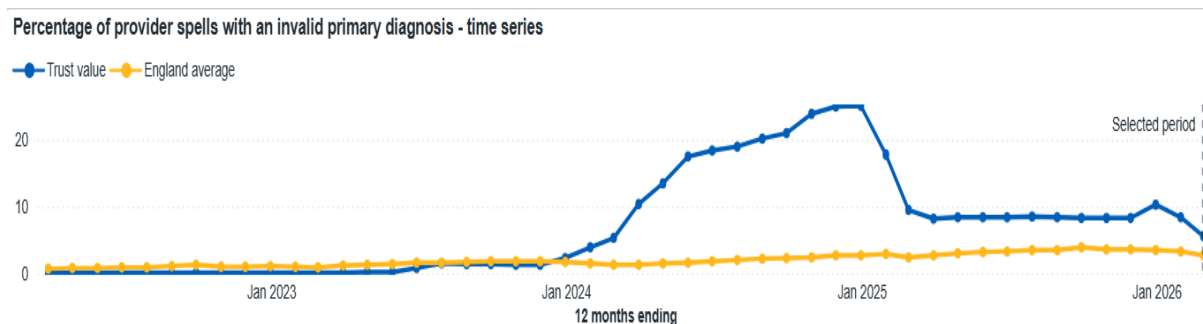


Figure 6: Spells with an "Invalid primary diagnosis" coding. Note how the number has fallen but not fully returned to baseline

3.3 Structured judgement reviews (SJR)

29 cases have been reviewed in this quarter with 7 relating to a death following admission in this period and the remaining 22 predating this. Exact date of admission for each case is shown in Table 3.

Reasons for case selection are shown in table 1. 10 cases were chosen following a breach in our watch-metric relating to deaths with a coding of alcohol-related liver disease as a diagnostic category. The 10 selected were those with the lowest predicted mortality rate. No contributory lapses in care were identified but areas for improvement were identified which are being addressed by relevant specialties.

SJR's Completed THIS Financial Year by Reason & Overall Care				
	Adequate care	Good care	Excellent care	Total
Death within 30 days of elective surgery	0	1	0	1
Diagnostic category - Liver/Alcohol	2	6	2	10
Learning Disability/Mental Health	1	0	0	1
Medical Examiner	0	4	0	4
Quality Team/Trust concern	1	1	0	2
Random selection	1	6	3	10
Specialty concern	0	1	0	1
Total	5	19	5	29

Table 1: Breakdown of Overall Care rating by reason for case selection for 2026-2027

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

Figure 7 shows the proportion of overall care received this financial year, with Figure 8 showing the results from the preceding 2025-2026 year.

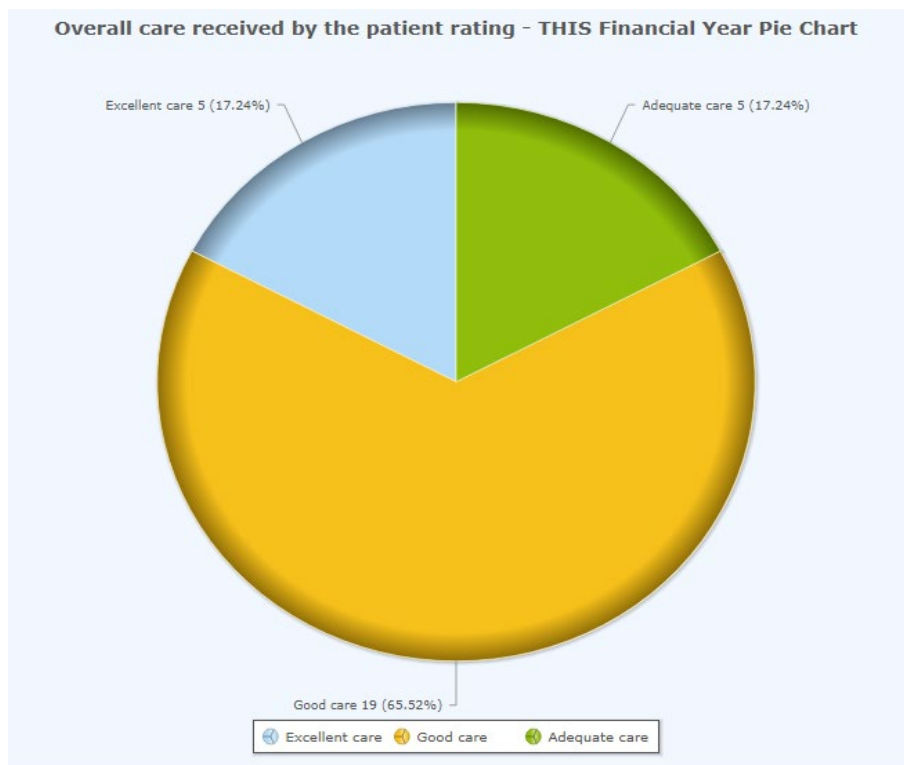


Figure 7: Breakdown of Overall Care rating in all cases reviewed this financial year

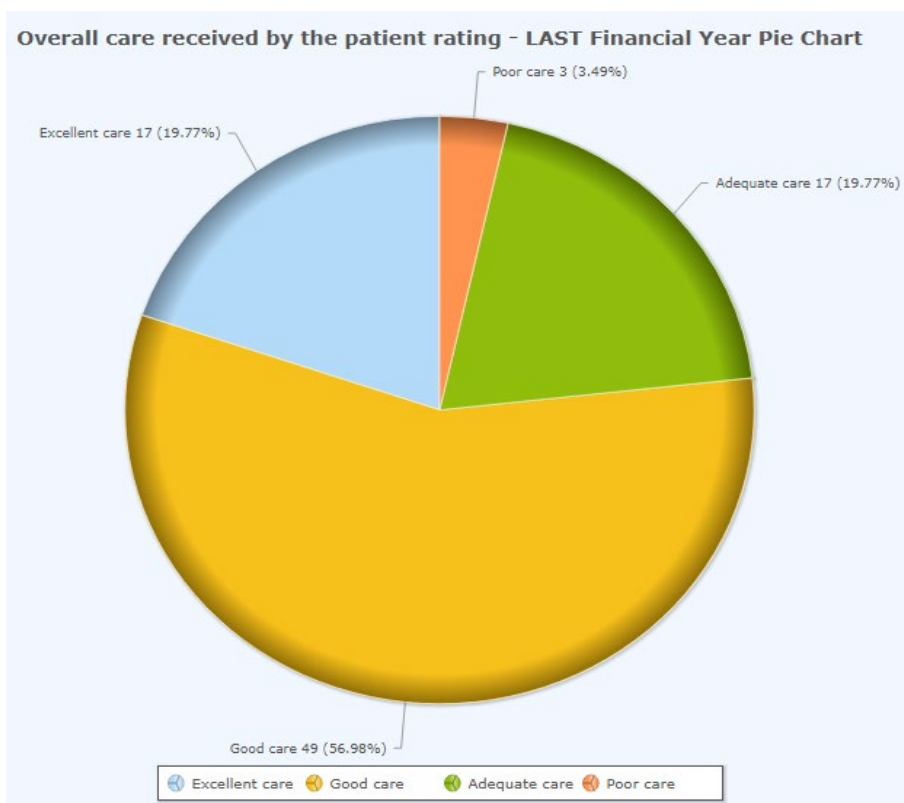


Figure 8: Breakdown of Overall Care rating in all cases reviewed last financial year

Table 2 shows the overall assessment of the standard of care for each case. A number of cases flagged as “Room for improvement in organisational care”. In all instances, this referred to patients waiting more than 4 hours in the Emergency Department before admission to a ward bed.

Date of admission (m/y)	Care in First 24 Hours	Ongoing Care	Avoidability of Death	Clinical/Organisational score (NCEPOD)	Overall Care
01/2026	Poor care	Good care	Definitely not avoidable	Room for improvement in organisational care	Good care
09/2025	Good care	Good care	Slight evidence of avoidability	Room for improvement in clinical care	Good care
11/2025	Excellent care	Good care	Definitely not avoidable	Good practice	Excellent care
12/2025	Good care	Good care	Definitely not avoidable	Good practice	Good care
08/2025	Adequate care	Adequate care	Slight evidence of avoidability	Room for improvement in clinical care	Adequate care
09/2025	Adequate care	Good care	Slight evidence of avoidability	Room for improvement in clinical care	Good care
01/2026	Good care	Good care	Definitely not avoidable	Good practice	Good care
02/2026	Good care	Good care	Definitely not avoidable	Good practice	Good care
01/2026	Excellent care	Good care	Definitely not avoidable	Good practice	Good care
01/2026	Adequate care	Good care	Definitely not avoidable	Good practice	Excellent care
01/2025	Adequate care	Adequate care	Slight evidence of avoidability	Room for improvement in clinical care	Adequate care
03/2025	Excellent care	Good care	Definitely not avoidable	Good practice	Excellent care
05/2025	Good care	Good care	Definitely not avoidable	Good practice	Good care
06/2025	Good care	Good care	Definitely not avoidable	Good practice	Good care
04/2026	Good care	Good care	Definitely not avoidable	Room for improvement in organisational care	Good care

04/2026	Good care	Good care	Definitely not avoidable	Room for improvement in organisational care	Good care
01/2026	Good care	Adequate care	Definitely not avoidable	Room for improvement in clinical care	Adequate care
05/2025	Good care	Good care	Slight evidence of avoidability	Room for improvement in clinical care	Good care
01/2026	Good care	Good care	Definitely not avoidable	Good practice	Good care
03/2026	Good care	Good care	Definitely not avoidable	Good practice	Good care
04/2026	Good care	Good care	Definitely not avoidable	Good practice	Good care
03/2026	Good care	Good care	Definitely not avoidable	Room for improvement in organisational care	Good care
05/2026	Adequate care	Good care	Slight evidence of avoidability	Room for improvement in clinical care	Adequate care
03/2026	Excellent care	Excellent care	Definitely not avoidable	Good practice	Excellent care
03/2026	Good care	Good care	Definitely not avoidable	Good practice	Good care
04/2026	Good care	Excellent care	Definitely not avoidable	Good practice	Excellent care
04/2026	Good care	Adequate care	Definitely not avoidable	Room for improvement in clinical care	Adequate care
04/2026	Good care	Good care	Definitely not avoidable	Room for improvement in clinical care	Good care
01/2026	Good care	Good care	Definitely not avoidable	Room for improvement in clinical and organisational care	Good care

Table 2: Details of the cases reviewed this quarter

Table 3 shows the quality of end-of-life care received. Note this is recorded as “not applicable” in the case of a sudden death. The reviewer of the one case scored as “poor” felt that end of life care could have started sooner, but the care once commenced was good.

Care received by the patient during end of life care rating - THIS Financial Year by Quarter		
	26/27 Q1	Total
Not Applicable	1	1
Poor care	1	1
Good care	21	21
Excellent care	6	6
Total	29	29

Table 3: End of Life Care provided

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

4.0 Recommendation

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

Appendix 1

“Watch Metrics”

Month HED Alert Received	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
SHMI (monthly SHMI - use last month in period)															
111:205-Spondylosis															
58:101-Coronary atherosclerosis															
110:204 Other nontraumatic joint disorders															
75:127 COPD and bronchiectasis															
93 :: 150 - Liver disease; alcohol-related															

1 new diagnostic category (coronary atherosclerosis) is currently breaching our rules, so cases will be selected for review in the forthcoming quarter.

Deaths related to alcohol-related liver disease have been reviewed in this report and will not be further investigated unless the rate remains high for a total of 12 months.

Quality Committee
30.09.26

Title:	Safeguarding Annual Report
Responsible Director:	Breeda Columb
Author:	<i>Frances Aldington</i>

Purpose of the report	Approval		
	Assurance	X	
	Discussion		
	Information		
Summary of key issues:	<i>The report provides an overview of safeguarding activity across the HDFT footprint from 01.08.25 – 31.07.26.</i> <i>The report provides assurance to Board that HDFT is meeting its statutory safeguarding responsibilities.</i>		
Trust Strategy and Strategic Ambitions	The Patient and Child First Improving the health and wellbeing of our patients, children and communities		
	Best Quality, Safest Care		X
	Person Centred, Integrated Care; Strong Partnerships		X
	Great Start in Life		X
	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	N/A		
Prior Committee Review / Governance Route:	Safeguarding Committee – 29.09.26		
Recommendations:	Board is asked to note the assurance provided by the report.		
Impact Assessments	Financial		
	Workforce		
	Quality & Safety		
	Legal/Regulatory		

	Equality & Diversity		
	Risk		
Consultation / Engagement	Named Safeguarding Professionals		

Freedom of Information	
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Safeguarding Annual Report (2025-26)

Title:	Safeguarding Annual Report
Responsible Director:	Breeda Columb, Executive Director of Nursing, Midwifery and AHP
Author:	Frances Aldington – Head of Safeguarding

Purpose of the report and summary of key issues:	The purpose of this report is to provide assurance of safeguarding activity within Harrogate and District NHS Foundation Trust (HDFT) and identify how this meets our statutory safeguarding responsibilities under the Children Act 1989/2004; the Care Act 2014 and the Mental Capacity Act 2005. The report is aligned to the six safeguarding principles and Section 11 of the Children Act (2004) to align with the HDFT All-Age Safeguarding Strategy (2024-27). Key Trust developments and activity for patients with learning disabilities is also provided.	
	The Patient and Child First Improving the health and wellbeing of our patients, children and communities	x
	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	N/A	
Report History:	Safeguarding Committee – 29.09.26 Quality Committee - 30.09.26	
Recommendation:	The Board are asked to receive this report and note the content, activity and progress in safeguarding delivery, governance and leadership improvements over the last 12 months	

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INTRODUCTION

This Safeguarding Annual Report covers the period 1st August 2025 – 31st July 2026.

The report provides an overview of activity and outlines key achievements and developments on HDFT safeguarding priorities. Its structure is based on the key principles of adult safeguarding, which are central within HDFT's *All Age Safeguarding Strategy* (2024-2027). It aligns to progress and compliance with Section 11 of the Children Act (2004). HDFT's Safeguarding Strategy aligns with the Safeguarding Adults Board and Safeguarding Children's Partnerships' priorities. The report also outlines key activity in relation to patients with learning disabilities.

The NHS England *Safeguarding Accountability and Assurance Framework* (SAAF, 2024) states the following in relation to provider leadership responsibilities aligned to safeguarding:

- Health providers are required under statute and regulation to have effective arrangements in place to safeguard and promote the welfare of children and adults at risk of harm and abuse in every service that they deliver.
- Providers must demonstrate safeguarding is embedded at every level in their organisation with effective governance processes evident.
- Providers must assure themselves, the regulators, and their commissioners that safeguarding arrangements are robust and are working.

Key Successes and Risks:

Successes:

- In May 2026, Audit Yorkshire reported their audit findings on safeguarding arrangements in HDFT. The audit found that the Trust has effective safeguarding governance arrangements in place, clearly defined roles and responsibilities, comprehensive safeguarding policies, and robust operational processes. A high assurance rating was awarded. A copy of the audit report can be found in Appendix 1.
- Domestic Abuse Routine Enquiry (DARE) has been rolled out across acute Trust (see section 1.1)
- HDFT Impact was implemented across the 0-19 footprint, with drivers for safeguarding teams evidencing positive outcomes, for example, in relation to safeguarding supervision and the timeliness of health needs assessments and initial health assessments.
- As part of North Yorkshire Safeguarding Week in June 2025, the acute safeguarding team delivered training sessions to multi-agency partners on the Mental Capacity Act (MCA), Female Genital Mutilation (FGM) and asylum seekers' journey within maternity services.
- The acute safeguarding team now support the Trust's KITE accreditation process, recognising good safeguarding practice and supporting continuous improvement.

Risks:

At the end of the reporting period, there were five risks on the corporate safeguarding risk register:

- Safeguarding training and supervision, including compliance (see Section 6.2 and 6.3).
- Lack of autism lead and learning disability service resilience (see Part 2).
- Out of date safeguarding policies and procedures. This risk will be removed once the FGM policy is ratified as all key policies will then be up to date. The FGM policy has been drafted and will be presented for ratification at August's Safeguarding Committee.
- Multiple IT systems in place, with limited interface. This risks key safeguarding information not being visible to all services. This risk has reduced since the introduction of Nervecentre but remains a concern.
- CP-IS (Child Protection Information Sharing System) phase two implementation (see Section 3.1).

All risks are reviewed monthly. Safeguarding teams across the HDFT footprint have local risks, which are held on local risk registers.

Part 1: Safeguarding Activity

There are 6 main principles of safeguarding as outlined in the Care Act (2014): *empowerment, prevention, protection, proportionality, partnerships and accountability.*

1. EMPOWERMENT – *people being supported and encouraged to make their own decisions, which are supported by informed consent.*

1.1 Voice of the Child:

The Voice of the Child is a golden thread that runs through safeguarding in HDFT. Regular training is provided to staff to ensure that the voice of the child is captured. Record keeping audits, safeguarding supervision and thematic reviews ensure learning and good practice is disseminated. In response to findings from audits and Child Safeguarding Practice Reviews (CSPRs), the North Yorkshire partnership has developed a range of practitioner resources, including a Voice of the Child Toolkit. HDFT has contributed to the development of this resource, and associated training and guidance have been widely promoted to 0–19 practitioners and across the acute Trust

The Trust has continued to strengthen its safeguarding arrangements through the introduction and embedding of domestic abuse routine enquiry (DARE) across acute services. DARE has been implemented as a component of assessment and care processes, enabling practitioners to sensitively and consistently ask patients about factors that may impact their safety and wellbeing. This addresses the gap found in the North Yorkshire Joint Targeted Area (JTAI) inspection of January 2025.

To facilitate implementation the acute safeguarding team provided a programme of staff training, awareness raising and professional support. This included 20+ staff members from across a variety of disciplines attending a trainer for trainers' event. These staff members are now trained to provide support and training to their peers. The safeguarding team have also

produced an e-learning training presentation which is available on Learning lab giving staff the flexibility to complete at a time that suits them.

1.2. Voice of the Adult:

The key way to capture the adult voice in safeguarding is through applying the principles of Making Safeguarding Personal (MSP). During this reporting period, an MSP audit was completed to establish how well the principles are embedded in the acute trust. The findings showed that the individual's capacity to consent to a safeguarding concern was not always being established and their wishes were not always ascertained (only in 34% of cases were their desired outcomes documented). As a result, an action plan has been initiated, which focuses on support in the form of departmental briefings and training.

1.3 Mental Capacity Act (MCA):

During this reporting period, the Named Professional for Safeguarding Adults and MCA Lead updated the Trust's MCA policy and assessment documentation to ensure alignment with current case law. Level 2 MCA training has also been amended to reflect changes in case law and to support staff in completing robust, legally compliant mental capacity assessments. The Named Professional has also taken on the lead role for the North Yorkshire Safeguarding Adults Board (NYSAB) Mental Capacity Working Group. This group reports into the Continuing Learning and Practice subgroup of the NYSAB, supporting wider system learning and assurance.

In response to actions identified through the Patient Safety Incident Response Framework (PSIRF), ward-based MCA training sessions have been delivered. These sessions have supported staff awareness, confidence and practice in relation to mental capacity assessments and best interests decision-making. Engagement with hospital matrons and ward managers has continued on a regular basis within their formal management meetings.

Content for mental capacity assessment was updated in both training packages and policy, towards the end of the reporting period training was temporarily paused as a result of the AGNI (Attorney General of Northern Ireland) case law implementation (see section 1.4, below). Prior to the AGNI ruling, staff were accessing level 1 MCA (including DOLs awareness) and Mental Capacity Level 2 including DoLS; content is being reviewed and updated. Training figures to date at end of reporting period stand were:

Category	Certification Name	Required	Not Achieved	Compliance %
Mandatory Training	Mental Capacity Act - Level 2	1325	350	74%
Mandatory Training	Mental Capacity Act (Including DOLs Awareness) Level 1	2651	133	95%

Category	Certification Name	Required	Not Achieved	Compliance %
Mandatory Training	Mental Capacity Act - Level 2	56	13	77%
Mandatory Training	Mental Capacity Act (Including DOLs Awareness) Level 1	23	6	71%

MCA training compliance is monitored through Safeguarding Committee (see Section 6.2).

1.4 Deprivation of Liberty Safeguards (DoLS):

During this reporting period, the Trust submitted 330 DoLS applications. This is an increase from 260 applications in the previous reporting year. This increase is likely to be linked to a renewed focus on recording and reporting processes linking to the available DoLS Trust policy. This work has supported improved recognition of when DoLS applications may be required. Only one standard authorisation was approved by the Supervisory Body during this period.

Looking ahead, it is anticipated that there may be a significant reduction in urgent and standard authorisation referrals during the next reporting year. This is due to recent changes arising from the AGNI 2026 case law. As a result, the Trust's DoLS policy and associated training modules are currently being reviewed to ensure they remain legally accurate and reflect current guidance.

1.5 Children in Care (CIC)

HDFT's CIC teams support and empower children and young people to participate meaningfully in their care and future planning.

1.5.1 Initial Health Assessment (IHA) and Review Health Assessment (RHA) Data

The table below shows the number of children in care in each area and the percentage of IHAs and RHAs completed within timescales. Assurance is provided to NHS England on a quarterly basis through the NHS England safeguarding data collection framework portal.

Area	Number of CIC	Performance
Tees Valley	2506; an increase of 7% since 2024/25-year end.	IHAs completed within statutory timeframes across the Tees Valley has decreased to 49% from 57.3% from the previous year. RHAs completed within statutory timeframes across the Tees Valley has had a slight increase to 87% from 86.4% on the previous year.
Durham	1467; a decrease of 17% since 2024/25-year end. (Durham children placed in Durham)	RHAs completed within statutory timeframes for Durham Local Authority children living in Durham was 80.8%. This is a decrease from 83.9% the previous year.

Area	Number of CIC	Performance
North Yorkshire	1188; a small increase from 1171 2024/25	IHAs: YTD 36% completed within timescales; this is a slight decrease from 37% last year.

		RHAs: YTD 87.5% were completed within timescales. Increase of 3% from last year.
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1.5.2. Developments / Improvements

Tees Valley CIC introduced HDFT Impact to address performance across IHA's and RHA's. It is understood and acknowledged that while HDFT are responsible for co-ordinating IHAs, HDFT performance is heavily reliant upon partners (local authorities and acute hospital trusts) undertaking their role in achieving statutory timescales. Durham CIC team continues to build relationships County Durham and Darlington Foundation Trust (CDDFT), the commissioned service, to ensure that timely intervention continues for children and young people. This has been particularly challenging due to staff capacity within CDDFT CIC service and as a result HDFT Durham CIC team provided mutual support in ensuring that RHA requests continued to be accessed in a timely manner.

North Yorkshire continues to work with five IHA providers, each facing different operational pressures. Efforts to improve compliance remain ongoing across all providers. There continue to be challenges in achieving compliance for North Yorkshire children and young people placed out of area, particularly in ensuring that their health needs are assessed and met in a timely manner. These issues have been escalated through the appropriate channels and are subject to regular review and monitoring.

Over the past year, substantial progress has been made in relation to the North Yorkshire and York IHA and RHA data, with improvements implemented in its preparation, presentation, and sharing with partner agencies. These changes have enhanced the quality, consistency, and usefulness of the information provided.

1.5.3. Key Successes

Tees Valley CIC (TVCIC) team capacity was a concern as the service specification had evolved with additional responsibilities for TVCIC staff. IHA follow up was requested by the ICB as anecdotally it was reported that health needs weren't being addressed between the IHA and RHA. Staff were spending time on ensuring the child / young person's health needs were addressed following their IHA. Tees Valley CIC staff addressing health needs identified from IHAs was impacting on the capacity and ability to undertake RHAs in statutory timeframes. The team worked closely with the ICB and Designated Nurse to ensure a safe exit strategy from undertaking this additional role. By ensuring the team were working towards the service specification and ensuring that practitioner roles were no longer being used as a gate keeper for all health economies and 'fill gaps' in services capacity was released in the team. This has had a positive impact on staff health and wellbeing.

Tees Valley CIC have implemented a safe process for offering virtual contacts to children and young people in care. This supports capacity within the team and also provides a mechanism for additional choice for children and young people to engage with their RHA process.

County Durham CIC team continues to offer a robust, high-quality service to our children and young people in care and our care leavers. The hard work and dedication demonstrated by the Specialist Nurses Children in Care (SNCIC) was recognised by the Care Leavers service in the local authority and were awarded with Durham Care Leavers New Year Honours List. The New Year Honours List recognises people who have gone above and beyond to make a positive difference to the lives of care-experienced young people over the year.

In North Yorkshire there has been a significant multi-agency collaboration in supporting some extremely complex and challenging cases involving children and young people. Throughout these cases, the team has worked closely together, proactively sought supervision and support, and maintained a child-centred approach. As a result, there have been positive outcomes for our children and young people, despite the complexity of the circumstances.

1.5.4. Care Leavers

The SNCICs are now representing HDFT at a strategic level on the transition group led by Durham Safeguarding Children's Partnership to shape services for care leavers in the future. SNCICs also attend the monthly care leavers hubs to provide ad-hoc health advice and support which is always well attended.

Tees Valley CIC have provided health passports for 273 young people who have left the care system over the last year. The health passport has been reviewed and made more user friendly for young people.

2 PREVENTION – *it is better to take action before harm occurs.*

2.1. Safeguarding Learning and Improvement Framework

The Safeguarding Learning and Improvement Framework, which provides a mechanism for the identification and dissemination of learning from safeguarding reviews, continues to embed across all safeguarding teams and through safeguarding and directorate governance structures. Themes are identified and an action plan has been developed. There is now safeguarding representation in all 0-19 workstreams, which supports actions being taken forward in a timely manner.

Common learning themes identified: parental mental health; neglect; domestic abuse; hidden/unseen males; cross-boundary challenges; information sharing; professional curiosity; professional optimism; cumulative risk; and application of the MCA.

Actions include: targeted training delivered locally and footprint wide; reviewing the Family Health Needs Assessment to explore neurodiversity and parental health; and introducing a SystmOne template for the recording of mental capacity in children and young people.

The next steps are to evidence the impact of the programme of actions that are being developed, to achieve the objective of preventing recurrence of harm. The development of a footprint wide safeguarding audit plan is key to evidencing impact.

2.2. Prevent

The Counterterrorism and Security Act (2015) places a duty on organisations to have; 'due regard to the need to prevent people from being drawn into terrorism.' HDFT's safeguarding teams continue to respond to information requests and share these with partner agencies. Safeguarding teams continue to attend their local area Channel panels, and the Head of Safeguarding attends the North Yorkshire Prevent Partnership Board.

HDFT have been able to demonstrate compliance with NHS England's quarterly mandated submission training compliance across the year. The 25-26 Q1 position is of 95% compliance for both basic Prevent training and Prevent training.

During the reporting period, HDFT did not make any referrals into Prevent.

2.3. Maternity Update

During the reporting period, maternity safeguarding has continued to develop, with a particular focus on strengthening the identification and management of vulnerability, improving multidisciplinary working and providing greater assurance around safeguarding practice.

A key development has been the establishment of the Maternity Vulnerability (Violet) Team, bringing together safeguarding, perinatal mental health and enhanced continuity of care expertise. This provides a more coordinated approach to women experiencing complex safeguarding, mental health, social and wider vulnerability needs, and has strengthened oversight and support for high-risk cases.

The introduction of the Maternity Disadvantage Assessment Tool (MatDAT) has further supported a more proactive approach to identifying women experiencing multiple disadvantage and vulnerability. This work supports enhanced continuity of care, personalised care planning and earlier multidisciplinary intervention.

There has been significant development in perinatal mental health provision, including updated guidance, strengthened links with commissioned perinatal mental health services and continued development of the maternity perinatal mental health pathway. Further work is planned to strengthen the pathway for women accessing the Emergency Department (ED) during a perinatal mental health crisis, ensuring clear communication, timely maternity involvement, appropriate risk assessment and coordinated follow-up across services.

Safeguarding governance and practice have been strengthened through the review and approval of the Child Protection Information Sharing (CP-IS) Standard Operating Procedure (SOP), development of new Child Abduction Guidance, incorporation of DARE training into mandatory maternity education, and continued participation in multi-agency safeguarding processes including MARAC (Multi-Agency Risk Assessment Conference).

Further work has strengthened FGM identification, data quality and assurance, including development of an enhanced dataset. Domestic abuse remains a significant area of safeguarding activity, with routine enquiry well embedded. Review of domestic abuse risk assessment documentation has identified an area requiring further assurance, and a focused audit is being undertaken to ensure that risk assessment, escalation and safeguarding actions are consistently documented.

Overall, maternity safeguarding has continued to move towards a more proactive, vulnerability-focused model, with stronger integration between safeguarding, perinatal mental health, continuity of care and wider multidisciplinary services. The next phase of work will focus on embedding the Vulnerability/Violet Team and MatDAT pathways, strengthening the management of women presenting to ED in perinatal mental health crisis, improving documentation and assurance, and continuing to develop workforce capability and partnership working.

3. PROTECTION – *keeping people safe by help, support and stopping abuse.*

3.1. CP-IS (Child Protection Information Service)

CP-IS ensures that those responsible for safeguarding the welfare of children, have access to child protection information when required. CP-IS is well embedded in ED and identifies to staff, children and young people with a Child Protection flag/Looked after Children flag as part of gold standard information sharing practices. CPIS Phase 2, which covers scheduled care settings, is mandated by NHS England for implementation by December 2026. A task and finish group was established in early 2026 to roll out CP-IS into 0-19 services and community paediatric service. The successful stages of the implementation of the pilot contract to Wakefield Growing Healthy Wakefield 0-19 Service were completed going live on the 1st of June with Phase 2 of the CPIS, with go live dates being planned across the remainder of the HDFT 0-19 footprint.

In July 2026, the scope for services to implement CP-IS was widened to include all services that see 16 and 17-year-olds. Nationally and locally, Trusts are raising concerns that the timescale for implementation is not achievable. A risk has been added to the corporate safeguarding risk register to this effect.

3.2. Domestic Abuse

As highlighted in Section 1.1. of this report, DARE continues to embed in the acute Trust. DARE commenced in ED in January, with the rolling out across acute wards and departments to coincide with the introduction of Nervecentre. Data from July 2026 shows a 27% compliance rate with DARE across the acute Trust. Compliance will increase as more staff undertake the DARE training linked to safeguarding training.

All safeguarding teams across the footprint continue to contribute to local area MARAC meetings through the submission of information gathering. A three-month pilot is underway in Northumberland for attendance at all MARAC cases to evidence whether there are improved outcomes for children as a result of attendance. The acute safeguarding team now attend MARAC where the referral has been made by HDFT staff, or where the acute trust has had significant involvement in the case. This approach has been adopted as the team were unable to evidence a positive contribution to the multi-agency risk assessment in cases where the individual was not known to, or had not had significant involvement from, the acute Trust.

In Durham, domestic abuse audit results demonstrated strong compliance, including 100% recording of Significant Event Reports and 100% task allocation in line with the SOP. There was an increasing numbers of referrals through front doors involving high risk cases and cases involving children. More than 11,500 children were screened through domestic abuse triage across the reported periods, with activity increasing by 21% from Q2 to Q4.

In Wakefield, the safeguarding partnership introduced the Integrated Domestic Abuse Response Team (IDART). The team's objective *'to jointly manage a risk response to Domestic Abuse within Wakefield in a timely manner completing live time actions and safety planning which will be shared between all partner'*.

The SNCP's in the team were instrumental in continuing their contribution to the Daily Risk Assessment Meetings (DRAM) and MARAC. Both domestic abuse processes are supported through a '365 App' a platform for coordinating the information sharing of multi-agency partners to ensure effective safety planning and accessibility of support. The coordinated approach further aims to reduce risk, reduce repeats of incidents and offer early intervention and prevention.

In January 2026 'Cranstoun' was launched, the new provider of the Wakefield Domestic Abuse Support Service (DASS). Wakefield DASS commenced delivery by 'Cranstoun' bringing together an integrated range of programmes and interventions to support victims and survivors of domestic abuse.

A multi-agency audit of the response to domestic abuse in Northumberland identified a reduction in routine domestic abuse enquiry within the 0–19 service. This is now an Impact driver metric with counter measures focusing on a lack of consistent training, inconsistencies in recording of domestic abuse routine enquiry and a lack of referrals into domestic abuse services.

3.3. Managing Safeguarding Allegations Against Staff:

During the reporting period, the *Managing Safeguarding Allegations Against Staff* policy was updated to include staff who work with adults and care support needs, as well as those who work with children, and a clearer process for acute staff to follow.

LADO (Local Area Designated Officer) and PiPoT (Person in a Position of Trust) referrals must be made when an individual who works with children, or with adults with care and support needs, has harmed a child/adult, or where there are concerns about their suitability to work with children and/or adults with care and support needs. The table, below, presents data on the number of LADO referrals made by HDFT, or raised to HDFT, about HDFT staff, split by contract area.

Area	Total Number of LADO/PiPoT	HDFT Staff member	Non HDFT staff	Notification made externally
Acute	8 LADOs 0 PiPoT	6	2	0
Durham	4 LADO	3	1	1
Wakefield	1 LADO	1		1
Gateshead	1 LADO			1
Middlesbrough	1 LADO	1		1
Sunderland	1 PiPoT		1	
North Yorkshire	2 LADO	2	0	0
Darlington	1 LADO	1		

Of the above cases, four did not progress due to the threshold not having been met. Two allegations were substantiated and five were ongoing at the end of the reporting period. Failure to protect children (linked to domestic abuse) was a theme that came out strongly.

The number of LADO notifications made is lower than would be expected coming from the acute Trust. Towards the end of the reporting period, there was an increase in activity, which is likely to coincide with increased awareness and work undertaken to coincide with the launch of the revised policy. This work included briefing sessions at matrons and ward manager meetings; presentation at the line managers' webinar; and a training session undertaken during safeguarding week. This work will continue during 2026-27.

4. PROPORTIONALITY – *the least intrusive response appropriate to the risk presented*

4.1. Safeguarding Referrals and Front Door Activity

4.1.1 Safeguarding Adult Concerns

Data relating to safeguarding adults' referrals and DoLS referrals can be found in Appendix 2. Referral numbers remained roughly static across the reporting period, with small variations between quarters. There is a downward trend of internal safeguarding referrals being raised against HDFT. The acute safeguarding team continue to attend PSIRF meetings to ensure that safeguarding referrals are raised where required. It is difficult to be clear on outcomes of referrals due a lack of consistent feedback from the local authority.

4.1.2. Safeguarding Children Activity

Data on strategy numbers can be found in Appendix 3. The start of this reporting period showed an increase in strategy meetings, which was causing pressure on teams. For example, in Darlington, the increase in strategy numbers and the resulting effect that this was having on the timeliness of health needs assessments prior to initial child protection conferences (ICPCs) was the subject of Impact. Although in some areas, strategy meeting numbers show ongoing increases for example, in Durham, strategy meetings have shown a 27% increase over the year, data across the footprint shows that numbers have reduced in recent quarters. Data is reported by exception through Safeguarding Committee.

Activity in relation to attendance at other statutory safeguarding meetings (core groups; initial child protection conferences and review child protection conferences) across the 0-19 footprint is shown in Appendix 4. Activity has remained at a consistent level, with only small variations across the months.

Appendix 4 also shows acute safeguarding referral data. The acute safeguarding team will be undertaking Impact in 2026-27, with a focus on *Think Family*, to support wards and departments where the vast majority of patients are adults, to consider unseen children who may be at risk.

4.2. Front Door/Multi Agency Safeguarding Hubs/Teams (MASH/MAST)

MAST brings together professionals from social care, the police and health organisations to share information, assess risk and make timely decisions about children who may need help, protection, or additional support.

In North Yorkshire, current partnership risks remain centred on demand and capacity within MAST. Referral screening volumes continue to increase, but health representation has remained unchanged despite additional resource investment by partner agencies. A further challenge is the duplication of documentation across NHS SystemOne and local authority recording systems, creating operational inefficiencies.

In Durham, the move away from traditional MASH processes towards local authority-led decision-making reduced opportunities for joint risk assessment and professional challenge. Health organisations continued to raise concerns regarding reduced multi-agency decision-making arrangements.

In Stockton, there was a significant increase in activity within the Front Door following the deaths of three children in quick succession. There was vicarious trauma support identified for staff impacted by the deaths that included significant safeguarding concerns and a high level of national media interest.

5. PARTNERSHIP – collaboration with partner agencies and communities.

As part of multi-agency responsibilities to safeguarding adults/children and children looked after, HDFT is represented at North Yorkshire Safeguarding Adults Board (NYSAB), ICB Safeguarding and Executive arrangements. The Named Nurses/ Professionals represent the Trust on the sub-groups of Adults Boards/Partnerships across the HDFT footprint, supporting the delivery of strategic priorities and the dissemination of learning from safeguarding practice reviews and both statutory and non-statutory safeguarding adult reviews. Safeguarding teams embedded within 0-19 locality teams work closely with multi-agency stakeholders across all footprints. Assurance reports are provided to commissioners, that detail evaluation against the key performance indicators.

5.1. Multi-Agency Safeguarding Reviews

The table, below, details the multi-agency safeguarding reviews initiated during the reporting period.

Area	Type of review	Number
Acute	Rapid Review	2
	SAR (Safeguarding Adult Review)	4
Durham	Rapid Review	5
	DARDR (Domestic Abuse Related Death Review)	1
Wakefield	Rapid Review	1
	Local Learning Circle	1
	DARDR	4
Northumberland	Rapid Review	6
	CSPR (Child Safeguarding Practice Review)	2
Middlesbrough	Rapid Review	3
	JAR	3
Gateshead	Rapid Reviews	3
	JAR	6
Sunderland	Rapid Review	2
	CSPR	2
North Yorkshire	Rapid Review	3
Stockton	Rapid Review	5
	Learning Review	2
Darlington	Rapid Review	2
Cumberland	Local Learning Review	2
Westmoreland and Furness	Rapid Review	2
South Tyneside	Near Miss	1

Multi-agency learning themes include: developing trauma-informed practice; parenting capacity; neglect; domestic abuse; transitional safeguarding; care leaver vulnerability and contextual safeguarding. As well as implementing HDFT single agency learning and service improvement initiatives, as described in Section 2.1. of this report, HDFT safeguarding teams have contributed to multi-agency service improvements resulting from the learning identified during the reviews. Some examples are:

Child Sexual Abuse (CSA):

CSA is acknowledged nationally as a significant and underreported issue. In Gateshead and Sunderland during this reporting period, the Named Nurses worked closely alongside partners and the NSPCC to begin a more focused and informed approach to CSA. The work completed alongside the NSPCC served as a foundation for developing local action plans, to inform the development of local sexual abuse strategies.

The NSPCC completed a snapshot assessment, the findings of which in Gateshead reflect, but were not limited to, there being an urgent need for specific training on CSA and to develop trauma informed multi-agency training. Although there is broadly a shared understanding of CSA, the understanding of peer on peer and intrafamilial abuse remained inconsistent.

Other areas requiring attention included: strengthening public awareness; data collection and analysis; training and prevention initiatives. There was a clear need for a coordinated, evidence-informed strategy is essential to ensure timely, consistent, and trauma-informed responses to CSA across the partnership.

HDFT have secured funding for safeguarding team representation at the CSA Centre's Train the Trainer – Intrafamilial Child Sexual Abuse course, which will ensure that staff are more confident in identifying and responding to CSA.

In March 2026, Gateshead underwent a Joint Targeted Area Inspection (JTAI) focused on Child Sexual Abuse in the Family Environment (CSAFE). JTAI summarised findings can be found here: [JTAI Summarised Findings](#). In summary, inspectors noted that Gateshead benefits from a mature, committed, and collaborative safeguarding partnership with strong leadership through the multi-agency safeguarding arrangements. They recognised CSA is already identified as a strategic priority, supported by developing a cross-partnership strategy informed by a 2025 NSPCC-led audit. It is positive to note that the inspection identified an embedded learning culture, with reflective practice and continuous improvement. Recent multi-agency audits themed on Child Sexual Abuse evidence this.

In Wakefield, The NNCP maintained attendance at the JTAI working group on CSAFE throughout the year and with the support of the SNCP's the continued contribution to the Multi Agency Case Audit (MACA) group. Through a multi-agency approach of dip sampling identified cases, this provided assurance of the positive outcome of the completed 'Wakefield Self-Assessment and Draft Performance Data'. The joint commissioning arrangements were received and reviewed and continually guides the planning for any future.

Multi-Agency Audits:

Multi-agency auditing continues to provide valuable learning opportunities. Recent audit themes have included child exploitation and child sexual abuse (NY), generating learning that has informed both strategic and operational developments across the partnership. Themes from across partnerships include: domestic abuse, child mental health.

The Action Plan also incorporates areas for improvement identified through Sunderland 0-19's participation in a range of multi-agency audits. These have included a police-led Casey Audit, undertaken in response to recommendations from the national Casey Report; a domestic abuse audit which focused on children's lived experiences; and the most recent audit examining the experiences and support provided to children (prior) to being on remand. Sunderland 0-19 has actively contributed to these reviews and the planned actions for strengthening service delivery across the multiagency workforce.

In response to findings from audits and Child Safeguarding Practice Reviews (CSPRs), the North Yorkshire partnership has developed a range of practitioner resources, including a Voice

of the Child Toolkit, a Neglect Toolkit, and the ongoing development of a Cumulative Risk Toolkit. HDFT has contributed to the development of these resources, and associated training and guidance have been widely promoted to 0–19 practitioners and across the acute Trust.

National Safeguarding Reviews:

During the reporting period, safeguarding teams across the footprint have worked with local safeguarding children partnerships to develop multi-agency action plans in response to recommendations from the national child safeguarding practice reviews *I Wanted Them All to Notice* (Protecting Children and Responding to Child Sexual Abuse in the Family Environment) and *Protecting All Vulnerable Babies Better* (National Review into the Broader Safeguarding Issues Raised by the Death of Victoria Marten), and the Southport public inquiry.

Families First Partnership Programme:

HDFT safeguarding teams and 0-19 managers across the footprint are working closely with children's social care to develop services in line with national multi-agency child protection reforms. In Stockton and Darlington, Named Nurses were seconded into the Families First Reforms project teams in children's social care.

In Sunderland, the first pilot area seeing the introduction of the Multi-Agency Child Protection Team (MACPT) and Family Help model, was launched in September 2025. Sunderland 0-19 has adapted its ways of working to align with these changes, supporting effective partnership working and service delivery to children and families within the Families First framework. Further pilot sites and wider implementation are planned.

Working Together to Safeguard Children:

In 2026, the Working Together guidance was updated. Safeguarding teams across the footprint have been engaged with partnerships in developing a multi-agency approaches to embedding the guidance.

6. ACCOUNTABILITY – *safeguarding is everyone's responsibility. Everyone in contact with a vulnerable patient should be responsible for identifying and acting on any risks.*

6.1. Safeguarding Governance

During the reporting period, the Safeguarding Governance structure was revised. Safeguarding Governance Forum was dis-established, with the Safeguarding Senior Management Team (SMT) now reporting directly to Safeguarding Committee, chaired by the Chief Nurse monthly. The Safeguarding Committee reports to Quality Governance Management Group (QGMG) and subsequently the Quality Committee.

6.2. Safeguarding Training

6.2.1. Training Compliance

Safeguarding children and adults' level 3 training continues to be delivered through face to face or virtual sessions. Level 1 and 2 training is delivered through e-learning. This supports compliance with the Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff (2025); the Looked after Children: Roles and Competencies for Healthcare Staff (2020) and the Safeguarding Adults: Roles and Competencies for Healthcare Staff (2024).

Safeguarding training figures are reported monthly to safeguarding teams by Learning and Development. The reports are presented bi-monthly in Safeguarding Committee, with directorate leads being responsible for managing compliance when it is not at Trust target.

The table, below, shows the training compliance figures as of July 2026.

Category	Certification Name	Required	Not Achieved	Compliance %	Increased/Decreased since previous month
Mandatory Training	Safeguarding Adults: Level 1	1064	41	96%	Same
Mandatory Training	Safeguarding Adults: Level 2	2749	135	95%	Same
Mandatory Training	Safeguarding Adults: Level 3	1187	86	93%	Increased 1%
Mandatory Training	Safeguarding Adults: Level 4	2	0	100%	Same

Category	Certification Name	Required	Not Achieved	Compliance %	Increased/Decreased since previous month
Mandatory Training	Safeguarding Children: Level 1	1206	57	95%	Decreased 1%
Mandatory Training	Safeguarding Children: Level 2	1873	154	92%	Same
Mandatory Training	Safeguarding Children: Level 3	1902	395	79%	Decreased 2%
Mandatory Training	Safeguarding Children: Level 4	19	9	53%	Decreased 37%

Safeguarding training compliance for HDFT Bank employees

Category	Certification Name	Required	Not Achieved	Compliance %	Increased/Decreased since previous month
Mandatory Training	Safeguarding Adults: Level 1	39	5	87%	Decreased 3%
Mandatory Training	Safeguarding Adults: Level 2	201	57	72%	Increased 1%

Category	Certification Name	Required	Not Achieved	Compliance %	Increased/Decreased since previous month
Mandatory Training	Safeguarding Children: Level 1	148	39	74%	Increased 5%
Mandatory Training	Safeguarding Children: Level 2	16	2	88%	Decreased 6%
Mandatory Training	Safeguarding Children: Level 3	56	12	79%	Increased 3%

Bank staff training compliance is being addressed through directorates, with shifts only offered to staff who are compliant with training requirements. Level 4 safeguarding children training compliance is being monitored through Safeguarding SMT.

6.2.2. Safeguarding Training Activity

Level 3 adult safeguarding training has been reviewed and updated to align with the Adult Safeguarding: Roles and Competencies for Health Care Staff Intercollegiate Document. However, the current cohort of staff receiving Level 3 adult and children safeguarding training is not fully reflective of the staff groups identified within the intercollegiate documents. An options paper has been proposed to combine adult and children's safeguarding Level 3 training, and to widen the staff roles in the acute Trust who are required to do level 3 training. This would support a stronger "Think Family" approach and promote more integrated safeguarding practice across the organisation. The proposal is currently on hold pending the release of the national mandatory training framework.

During this reporting period, the Safeguarding Operational Training Steering Group was disbanded as there was significant crossover and duplication with the Strategic Training Steering Group, which remains in place.

6.3. Safeguarding Supervision

The community and acute safeguarding teams continue to provide quarterly safeguarding children's supervision for case load holders and bi-annual supervision for all other staff. Adult safeguarding supervision is currently not mandated but delivered in response to need. Further work will be undertaken for adult safeguarding supervision to consider the most appropriate model for delivery and how this could support staff in managing complex safeguarding concerns.

The Trust's Learning and Development Team are working with Learning Lab to achieve accurate reporting and recording of supervision compliance. Centralised reporting is currently on hold while this is being addressed, with local areas reporting their own compliance (linked to risk on corporate risk register). In areas where supervision compliance was a concern, e.g. Northumberland and Darlington, work has been undertaken between safeguarding teams and 0-19 management to improve compliance, in the case of Northumberland, using the HDFT Impact approach. Other areas, for example Cumberland, Westmoreland and Furness, and Durham, have maintained supervision compliance above 90% for the whole reporting period.

In Middlesbrough, through Impact, peer and SNCP safeguarding supervision are being strengthened and standardised through the introduction of SOPs, refresher training and audit activity. These measures aim to promote consistent, high-quality supervision, strengthen reflective practice and provide assurance that multi-agency assessment, history and analysis are appropriately considered and that safeguarding supervision standards are being met.

In Cumberland, Westmoreland and Furness, all deep dive supervision audits were targeted to vulnerable unborn infants identified within the antenatal period. One of the Impact drivers for Westmorland and Furness was to increase the number of antenatal core contacts, which meant that the impact metrics were complimenting each other. Additional supervision lists were established for all 0-19 practitioners who had children on their caseloads that were subject to a child protection plan for more than 12 months and/or children who were entering into PLO (Public Law Outline). This meant an early capture of families entering legal proceedings, robust safeguarding supervision was implemented in a consistent manner.

Peer supervisor resilience has been increased across the footprint through training of additional safeguarding staff using the integrated supervision model.

The next step for the supervision thematic leads is the audit of the quality of supervision provided.

6.4 Section 11 Audit:

The action plan for the Section 11 audit (the statutory safeguarding self-assessment required under Section 11 of the Children's Act 2004) is tracked through Safeguarding Committee. The self-assessment was submitted in September 2025. A copy of the Section 11 document and action plan can be found in Appendix 4. Over the course of the reporting period, there have been three domains where compliance has improved from partial to full compliance. These are: clear internal escalation processes; awareness of North Yorkshire Safeguarding Board managing different professional perspectives; and staff knowing how to respond to safeguarding allegations against staff.

Areas where partial compliance remains are:

1. *The organisation gives consideration to languages and/or use of non-verbal communication, different ways of communicating, and to make services accessible when working with children and/or adults*
2. *The organisations policies and procedures include reference to the importance of listening to and taking into consideration the views of children and/or adults and how to respond appropriately.*

A task and finish group is in place to look at these two objectives.

3. *The organisation has a process to ensure that all staff undertake the appropriate level of safeguarding training, depending on their role and responsibility, including induction if applicable. This includes the principles of multi-agency working*

This is addressed in section 6.2.2. of this report

4. *The organisation has robust procedures in place within children and adult services for the transition of children to adulthood, for example, safeguarding, preparing for adulthood, children in care, etc.*

This is a focus of the acute safeguarding team's Impact work for 2026-27.

Part 2: Supporting service users with a Learning Disability

Learning Disability Updates:

Support to patients with learning disabilities continues to be delivered by the Trust's learning disability liaison nurse. Service resilience has been highlighted in the safeguarding risk register, with mitigations being explored. HDFT does not currently have a dedicated specialist role for service users with autism. Clinical teams work collaboratively to meet the needs of service users with autism and are supported by corporate colleagues within the Patient Experience Team, as required.

In light of national mortality data and learning from case reviews, the acute liaison nurse worked with the Associate Medical Director (Primary Care) and key stakeholders during this reporting period to achieve the reduction of delays in diagnosis and treatment. This led to the initiation of a pathway to enable vulnerable patients to access appropriate investigations and procedures requiring anaesthetic or sedation where there was not a named clinically responsible Trust Consultant. The new SOP allows GPs to refer directly to the acute liaison nurse who will work with directorate managers to arrange for timely admission under the anaesthetic team and ensure the coordination of all required reasonable adjustments. This new pathway has been shared internally and with the Local Medical Committee (LMC) and has been positively received by HDFT colleagues and our partners in primary care.

HDFT received a donation of sensory kits from a Harrogate based Italian Catholic community. The kits are designed to support individuals who may find the busy environment of a hospital to be overwhelming. Based on individual need, these kits can include items such as fidget toys, noise cancelling headphones, face masks and activity books, all aimed at helping patients self-regulate, reduce distress, and feel more in control during periods of emotional or physical stress.

HDFT continue to participate in the *Learning Disability Improvement Standards* benchmarking exercise. The report for year 7 highlighted some areas where the Trust is performing well, which include: training, seeking feedback using the principles of 'Ask, Listen, Do' and the provision of reasonable adjustments. Areas for improvement include workforce planning, the availability of acute learning disability liaison, and board level engagement with patients with learning disabilities and those who support them. The staff survey was utilised to focus on the emergency department and prompted an audit and subsequent improvement plan. Actions taken include a bespoke training programme, patient leaflet and a daily Makaton sign of the day. Impact will be evaluated in the year 8 staff survey.

The National Confidential Enquiry into Patient Outcome and Death published *Learning Together: A review of the quality of care provided to adults with a learning disability when admitted to hospital acutely unwell* in July 2026. The Trust has committed to working towards the recommendations of this report. Actions include increased patient engagement, utilising Nervecentre (alongside the national reasonable adjustments digital flag) to prompt the provision of reasonable adjustments, considering the current resource of the learning disability liaison service and exploring the role of a learning disability physician.

Learning Disability Data

- Total number of bed days occupied by people with a learning disability (2024-25) – 1520
- Total number of outpatient attendances or community contacts by people with a learning disability (2024-25) – 1597
- Total number of people with a learning disability who died whilst on an active caseload, or within 3 months of being closed or discharged (2024-25) - 11

HDFT continue to contribute to the LeDeR programme (Learning from Lives and Deaths: People with a Learning Disability and Autistic People), submitting eight notifications between 1st August 2025 and 31st July 2026. A structured Judgement review (SJR) was completed for six of these cases concluding that 50% of patients received good care, 33.5% being rated adequate and 16.5 % excellent. No reviews were rated as poor or very poor. The SJR is not currently available for the two remaining cases who both passed away in June 2026.

These reviews highlighted examples of good practice which included: learning disability nurse input; proactive support from the critical care outreach team; involving families and carers; early senior input. Areas for learning were also identified which included: stronger medical leadership to drive the care of complex patients and more robust escalation planning when considering sedation of patients in respiratory distress.

Priorities and Next Steps:

The Safeguarding Strategic Delivery Plan has been updated for 2026/27, with some priorities carried over from the 25/26 plan, as well as new areas identified. The priorities are as follows:

Governance:

- 1) Continue to embed safeguarding governance arrangements across HDFT.
- 2) Commence the development of a new HDFT Safeguarding Strategy for 2027-2030.
- 3) Implement a footprint wide safeguarding audit programme.
- 4) Review self-assessment against CQC safeguarding standards and expectations working closely with the Quality team.
- 5) Delivery of outcomes of Section 11 audits / Audit Yorkshire report and other key audits / recommendations for HDFT.

Leadership:

- 1) Provide assurance around compliance with accepted national guidance on staff training, skills and competencies in line with their role.
- 2) Review the preceptorship programmes for all staff working in safeguarding roles.
- 3) Support HDFT to becoming a trauma informed organisation.
- 4) Provide leadership and guidance to wards and departments on the changes to DoLS.
- 5) Evidence the impact of service improvements linked to the Learning and Improvement Framework.

Policies/Procedures and Processes:

- 1) Continue to embed the Safeguarding Learning and Improvement framework.
- 2) Continue to embed PiPoT/LADO processes across the Trust in line with the *Managing Safeguarding Allegations against Staff* policy.
- 3) Develop a safeguarding transitions pathway in the acute Trust.
- 4) Continue to embed FGM processes across the Trust and ensure robust mandatory reporting.

Data:

- 1) Acute safeguarding team to continue to work with Nervecentre project leads to ensure safeguarding requirements are met.
- 2) Continue to work with Learning and Development to develop a solution to supervision recording.

Summary and Conclusion

This report has provided an overview of HDFT safeguarding work, including detailed activity and information with regard to focused improvement work across 2025/26, up to July 2026. The report has highlighted areas of good practice and has updated on areas previously requiring development, in addition to new areas of focus.

This annual report reflects safe and effective practices in line with our statutory and regulatory obligations, demonstrating overall strong compliance with both internal and external

safeguarding standards. The Trust continues to strengthen safeguarding governance, oversight and practice through a range of assurance activities. An embedded culture of learning continues to support reflection, improvement and the sharing of safeguarding learning across services.

Overall, the activity undertaken provides assurance that safeguarding arrangements are subject to ongoing monitoring, scrutiny and continuous improvement, with identified risks and areas for development being actively addressed through the appropriate governance structures.

Appendices

Appendix 1 – Audit Yorkshire Safeguarding Report	 Final Report HDFT 20 202526 Safeguarding
Appendix 2 – Safeguarding Adults and DoLS Referral Data – Q1 26-27	 Safeguarding Adults and DoLS Data Q1 26
Appendix 3 – Strategy meeting data – 0-19	 Strategy data reporting period pdf2
Appendix 4 – Safeguarding Data 0-19	  Safeguarding Data 2025-26 pdf2.pdf Acute safeguarding referrals 2025-26.doc:
Appendix 5 – Section 11 Audit and Action Plan	  S11 Action Plan NYSCP NYSAB CYSAB Update July 2026.doc:Governance and Secti

References

The Child Safeguarding Practice Review Panel – *Protecting All Vulnerable Babies Better. National Review into the Broader Safeguarding Issues Raised by the Death of Victoria Marten* (2026).

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Department for Education - *The Families First Partnership Programme Guide – Delivery Expectations for Statutory Safeguarding Partners in England: Year 2* (2026).

HM Government - *The Southport Public Inquiry – Phase 1* (2026).

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National Confidential Inquiry into Patient Outcome and Death – *Learning Together: A Review of the Quality of Care Provided to Adults with a Learning Disability when Admitted to Hospital Acutely Unwell* (2026).

NHS England - *Safeguarding Accountability and Assurance Framework – Version 4* (2024).

NHS England – *The Learning Disability Improvement Standards for NHS Trusts* (2018).

Royal College of Nursing – *Safeguarding Children and Young People and Children and Young People in Care. Competencies for Health Care Staff Intercollegiate Document* (2025).

Royal College of Nursing – *Adult Safeguarding – Roles and Competencies for Health Care Staff* (2024).



INFECTION PREVENTION & CONTROL ANNUAL REPORT

2025/26

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Abbreviations

APC	Area Prescribing Committee
APSG	Antimicrobial Prescribing Sub-Group
CEF	Clinical Effectiveness Forum
CYPPIH	Children and Young People's Public Health
DIPC	Director Infection Prevention Control
HCAI	Healthcare Associated Infection
HiF	Harrogate Integrated Facilities
IBR	Integrated Board Report
ICD	Infection Control Doctor
IPCC	Infection Prevention Control Committee
IPCT	Infection Prevention and Control Team
LTUCC	Long Term, Urgent, Cancer and Community
MRSA	Methicillin Resistant Staphylococcus Aureus
MSSA	Methicillin Sensitive Staphylococcus Aureus
NHSE	National Health Service Executive
PPE	Personal Protective Equipment
PSCC	Planned, Surgical and Children's Care
QC	Quality Committee
QGMG	Quality Governance Management Group
SMT	Senior Management Team
UKSHA	UK Security Health Agency

1.0 Introduction

Harrogate and District NHS Foundation Trust recognises that effective prevention of healthcare associated infections (HCAI) is essential to ensure that patients using our services receive safe and effective care. Effective infection prevention and control must be an integral part of everyday practice and applied consistently to ensure the safety of our patients.

This annual report covers the period 1st April 2025 to 31st March 2026 and has been written in line with the ten criteria outlined in the Health and Social Care Act 2008 Code of Practice in the Prevention and Control of infection (updated 2015). The ten criteria outlined in the code are used by the Care Quality Commission to judge a registered provider on how it complies with Cleanliness and Infection Prevention & Control requirements detailed in the legislation.

The ten criteria of the Health Act are below and will be discussed in more detail in the next section of this report.

Criterion	Detail
1	There are systems to monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other may pose to them
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections
3	Ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events of antimicrobial resistance
4	Provide suitable accurate information on infections to service user, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion
5	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people
6	Systems to ensure that all care workers including contractors and volunteers are aware of and discharge their responsibilities in the process of preventing and controlling infection
7	Provide or secure adequate isolation facilities
8	Secure adequate access to laboratory support as appropriate
9	Have and adhere to policies designed for the individuals care and provider organisations that will help to prevent and control infections
10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection

2.0 Criterion 1

There are systems to monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other may pose to them

Hospital Infection Prevention and Control Team

The Hospital Infection Prevention and Control Team (IPCT) provide advice and training on all aspects of infection prevention and control (IPC) to the Trust Directorates, wards, departments and Harrogate Integrated Facilities (HIF).

The members of the Hospital Infection Prevention and Control Team are as follows:

Role	Role holder	Responsibility
Director of Infection Prevention and Control (DIPC)	Dr Jaqueline Andrews (until June 2025) (Executive Medical Director) Breeda Columb (from June 2025) (Executive Director of Nursing, Midwifery, and Allied Health Professionals)	Executive authority and responsibility for the development and delivery of the Trust's IPC strategy
Deputy DIPC	Jenny Nolan (Deputy Chief Nurse)	Supports and deputises for the DIPC
IPC Matron	Sonya Ashworth	Manages the IPC team
Infection Control Doctor (ICD)	Dr Sarah Drake	Clinical IPC support and leadership
Consultant Medical Microbiologists	Dr Katharine Scott Dr Lauren Heath Dr Alison Muir	Deputises for the ICD
IPC Team Lead	Amanda Gooch	Operational management of the IPC team
IPC Specialist Nurses (3.2 WTE)	Iona Goodwin Jane Cozens Leisa Mark Sheeba Sojan	Provide specialist advice on all aspects of IPC
IPC Support Nurse (0.4 WTE)	Gillian Mitchell	Routine review of patients with transmissible infection
IPC Clinical Support Worker (0.6 WTE)	Dana Fedorockova	IPC audit programme, delivering IPC education to non-registered staff
IPC Admin and Surveillance Officers (2.0 WTE)	Karina Hess Jodie Fryer (until July 2025)	Data collection, mandatory external data reporting & surveillance of transmissible infection.
Ward Hygienists	James Wightman Rafal Gasiorowski	Carry out specialist cleaning of patient equipment and environment

Changes to the team 2025-26:

Breeda Columb (Executive Director of Nursing, Midwifery, and Allied Health Professionals) replaced Dr Jacqueline Andrews (Executive Medical Director) as DIPC in June 2025

Jodie Fryer left the IPC team in July 2025

Infection Prevention and Control Committee

The Trust Infection Prevention and Control Committee (IPCC) is held monthly and is chaired by the DIPC. (Appendix 1 – Terms of Reference for IPCC, Appendix 2 - meeting record for 2025/26).

The IPCC is responsible for maintaining the IPC Board Assurance Framework and the IPC risk register. The IPCC is responsible for the monthly review of IPC performance across the Trust. (Appendix 3 – IPC Board Assurance Framework)

The IPCC reports to Quality Committee (QC), which is chaired by a Non-Executive Director (NED). Infection Prevention and Control is a standing agenda item at this committee and IPC are represented by the DIPC. QC has responsibility for obtaining assurance that the Trusts IPC service is meeting the Standards set out in the Code of Practice. Assurance is provided through the monthly IPC report and Trust Integrated Board Report (IBR).

IPCC is also directly linked into the Quality Governance Management Group (QGMG). The monthly IPC report is presented at this meeting.

In addition to the routine work carried out by the IPC team there is an annual plan of work, which describes the quality improvement objectives for the year. The plan of work for 2025-26 can be viewed in Appendix 4.

The work plan consisted of 19 separate pieces of work. Fifteen (79%) have been completed and four items have been rolled over to next year's plan.

Trust Board

The Code of Practice requires that the Trust Board have a collective agreement recognising its responsibilities for Infection Prevention and Control. The Chief Executive has overall responsibility for the control of infection at the Trust. The Trust has a designated DIPC who attends Trust Board meetings with detailed updates on IPC performance and matters. Until June 2025, this role was undertaken by the Executive Medical Director. Responsibility was subsequently transferred to the Executive Director of Nursing, Midwifery and Allied Health Professionals.

Antimicrobial Prescribing Sub-Group (APSG)

The Antimicrobial Prescribing Sub-Group (APSG) is a multidisciplinary group responsible for the monitoring and review of good antimicrobial stewardship within the Trust. The group meets bi-monthly and is chaired by the Trust Lead for Antimicrobial Stewardship. The Antimicrobial Medicines Code describes the Trusts policy for antimicrobial stewardship. APSG is responsible for monitoring and auditing compliance with prescribing guidance and post-prescribing reviews. To realign the antimicrobial stewardship work more closely with IPC, APSG reports directly to IPCC. APSG produces a biannual report to the IPCC demonstrating compliance with the Code of Practice.

Decontamination Committee

The Trusts Decontamination Lead is the Chief Operating Officer. The management of Decontamination and compliance is overseen by the Decontamination Committee, which reports directly to IPCC. The Chair of the Decontamination Committee produces a quarterly assurance report for IPCC.

Water Safety Group

The Trust has a multi-disciplinary Water Safety Group. It is chaired by the Deputy Director of Estates and meets quarterly. A Consultant Microbiologist alongside the IPC Nurse Team Lead represent the IPC team on this group. This group produces a quarterly assurance report for IPCC.

Ventilation Safety Group

The Trust has a multi-disciplinary Ventilation Safety Group. It is chaired by the Deputy Director of Estates and meets quarterly. A Consultant Microbiologist alongside the IPC Nurse Team Lead represent the IPC team on this group. This group produces a quarterly assurance report for IPCC. The group over the last couple of years has been strengthened by the addition of Senior Surgical Clinical staff ensuring that operational concerns and queries can be directly voiced by the staff who are directly using our main specialist ventilation systems.

Harrogate Integrated Facilities (HIF): Cleanliness and Estate Services

Harrogate Integrated Facilities is a wholly owned subsidiary of Harrogate and District NHS Foundation Trust (HDFT). Cleaning and maintenance of the patient environment is the responsibility of HIF. The Trust has implemented the National Standards for Cleanliness (2021) including the 2025 update.

Infection Prevention and Control Assurance

To demonstrate compliance with the Trust IPC Policies there is an IPC programme of audit in place. All areas are now categorised as either High risk or Low risk, see Table 1.0. High risk areas are audited every quarter and low risk areas annually. There was a reclassification of high and low risk areas in July 2025.

The audits are undertaken by a member of the IPC team. The audits assess compliance with Standard, Transmission based IPC precautions and Hand Hygiene. Audit data is collected via the Trust digital audit software package, Tendable. Table 1.1 shows the average overall scores for all areas over the last 12 months.

Table 1.0

High Risk	Low Risk
Byland	Antenatal Clinic
Farndale	Cardiology/ Heart Centre (until July 25)
Granby	Dermatology
Jervaulx	Elmwood
Oakdale	Max Fax/Orthodontics
Wensleydale	Medical Day Unit (until July 25)
AFU	OPD Paediatrics
Emergency Dept.	OPC Ophthalmology in Outpatient
Lascelles	Orthopaedics=Silverdale
Ripon MIU	Pre-Assessment Admissions Unit
SDEC	Radiology
SROMC	Ripon Outpatients
Trinity	Women's Unit/Coverdale (until July 25)
DSU	Phoenix (eyes)

Delivery Suite	Main Outpatients Zone 1/CIA (until July 25)
Endoscopy	Main Outpatients Zone 2
Fountains	Main Outpatients Zone 3
ICU/HDU	Main Outpatients Zone 4
Littondale/Bolton	
Main Theatres	
Nidderdale	
Pannal	
Rowan	
SCBU	
Woodlands	
Medical Day Unit (from July 25)	
Women's unit/Coverdale (from July 25)	
Cardiology/Heart Centre (from July 25)	
CIA (from July 25)	

Table 1.1

Audit	Completed	Average Overall score April 2025 –March 2026 (all directorates)
High risk area General IPC Inspection	Quarterly	89%
High risk area Hand hygiene	Quarterly	93%
Low risk area General IPC Inspection	Annually	90%
Commode	Monthly	99%
Cannula Insertion	Monthly	92%

Audit results are reviewed at the monthly IPC team meeting. Where issues are identified, an action plan is devised by the IPCT and fed-back to the Matron and Ward/Department Manager. Wards/Departments of concern are escalated to the IPCC.

Healthcare Associated Infection Surveillance (including mandatory reporting)

The IPC team continues to monitor all alert organisms (defined as organisms of IPC significance). The microbiology department's laboratory information management system enables real-time digital communication of these alert organisms to the IPC team, who can electronically acknowledge receipt. This process ensures that appropriate IPC measures are implemented promptly where required.

Clostridioides difficile

Clostridioides difficile (*C. difficile*) is a bacterium found in the gut, which can cause diarrhoea after receiving antibiotics, particularly broad-spectrum antibiotics. It can rarely cause a severe and life-

threatening inflammation of the gut called pseudo-membranous colitis. The bacterium is capable of forming spores, which are very resistant and can survive in the environment for prolonged periods. The spores require effective (sporicidal) cleaning products to remove them from the environment and prevent transmission to others.

The Trust reports all cases of *C. difficile* diagnosed in the laboratory to UKHSA via the national Data Capture System (DCS). Every Trust is given a threshold level, which it should not exceed over the course of one year. The Harrogate threshold level for *C. difficile* in 2025/26 was 28.

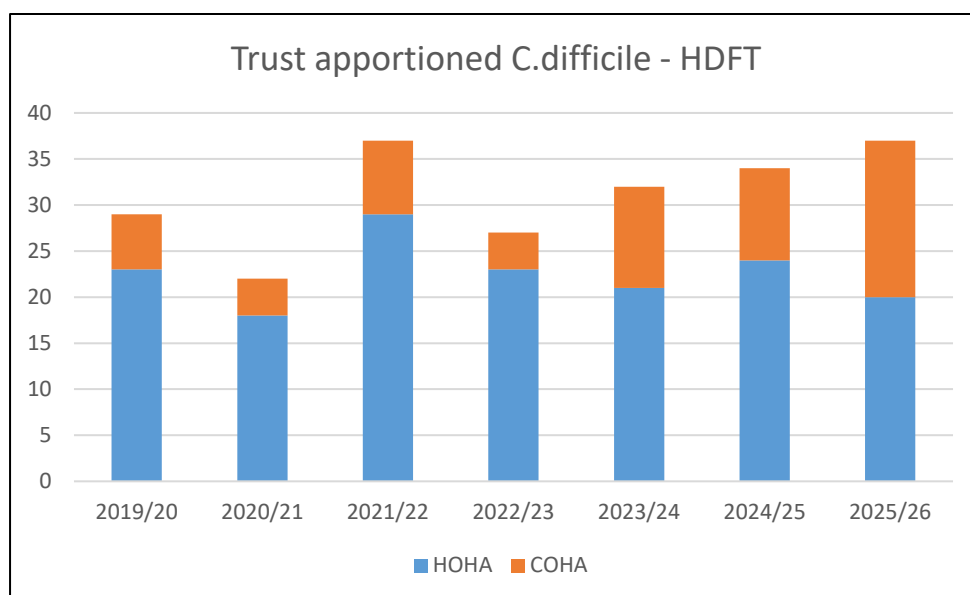
At the end of March 2026, there were 37 cases of *C. difficile* apportioned to the Trust. This is compared to 34 cases last year and means we exceeded our threshold by 9 cases. Three patients experienced repeat or relapsing *C. difficile* infection in 2025–26. All cases are reportable unless the infection occurs within 28 days of a previous episode.

We continue to undertake a local post infection review of all our community onset healthcare acquired (COHA) and hospital onset healthcare acquired (HOHA) *C. difficile* cases so that we can identify learning needs and trends.

Table 2.0

Learning themes (all COHA+ HOHA cases)	Number (%) 2026-26
Inappropriate antibiotic prescribing	8 (21.6%)
Delay in stool sampling	16 (43.2%)
Delay in isolation	3 (8.1%)
Delay in starting <i>C.difficile</i> treatment	2 (5.4%)

Figure 1.0.



HDFT threshold for 2025/26 = 28

Characteristics of our *C. difficile* patients:

Gender:

- COHA 35% male. HOHA 50% male

Average age:

- COHA 63 years. HOHA 72 years

There is continuous work by the IPC team to reduce the cases of *C. difficile*. This relies on the prompt identification, sampling and isolation of patients with loose stools and the appropriate use of antimicrobials. *C. difficile* diagnosis continues to be a major focus of the IPC education programme.

There have been no instances of known patient-to-patient transmission of *C. difficile* or outbreaks of *C. difficile* this year.

MRSA bacteraemia

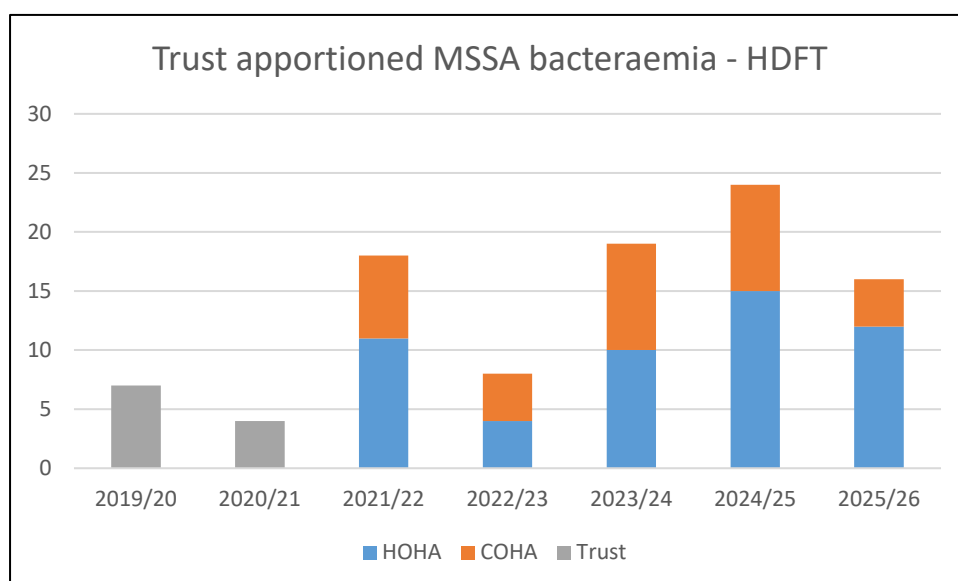
In 2025/26, there has been one trust apportioned MRSA bacteraemia. This was a COHA case. No lapses in care were identified from the post-infection review.

MSSA bacteraemia

MSSA (methicillin sensitive *Staphylococcus aureus*) is the much more common and antibiotic sensitive version of *Staphylococcus aureus*. 16 MSSA bacteraemias were apportioned to the Trust in 2025/26; this was a decrease of eight cases compared to the previous year.

All of our HOHA MSSA bacteraemias have a detailed post infection review. See Table 2 for the trend analysis of our HOHA bacteraemias.

Figure 2.0



Gram negative bloodstream infections

There are three Gram negative organisms that are monitored: *E.coli*, *Klebsiella sp* and *Pseudomonas aeruginosa*. The Trust has seen a reduction in *E coli* and *Klebsiella species* bacteraemias compared to 2024-25

The HDFT annual thresholds for each of the Gram negative bacteraemias are as follows, *E.coli* = 37, *Klebsiella sp* = 14 and *Pseudomonas aeruginosa* = 3. HDFT have breached these thresholds for all. *E.coli* = 50, *Klebsiella sp* = 16 and *Pseudomonas aeruginosa* = 4. See Table 2 for the trend analysis of our HOHA bacteraemias.

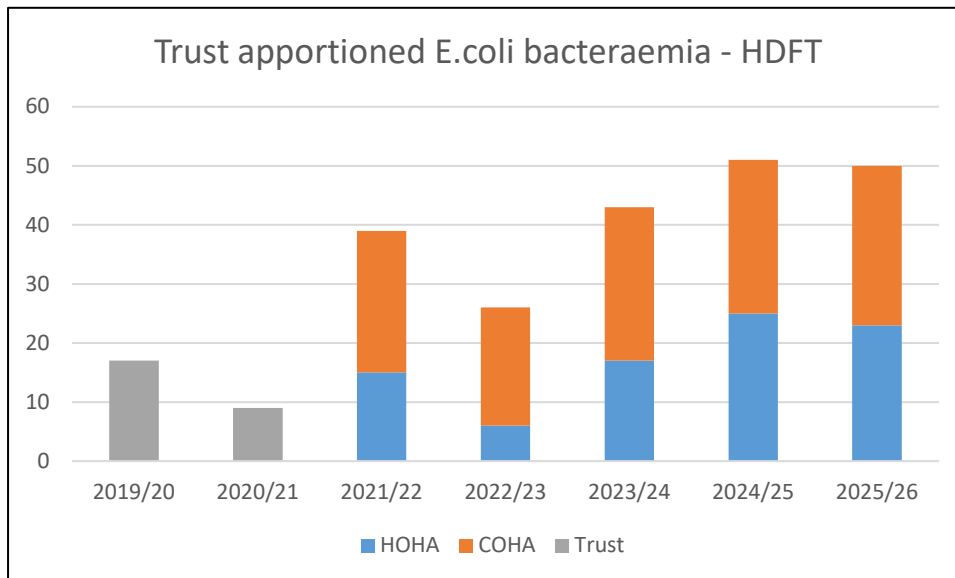
Review of 34 Healthcare associated E coli bacteraemias (January-June 2025)

A total of 34 healthcare-associated *E. coli* bacteraemia cases were reviewed. Of these, 6 cases (18%) were considered potentially avoidable.

Five of the six potentially avoidable cases had urinary catheters in situ at the time of bacteraemia. In these cases, there was no documented indication for catheter use, and no evidence of review of ongoing need recorded in the patient electronic record. Earlier assessment and removal of the catheter may have prevented the development of bacteraemia.

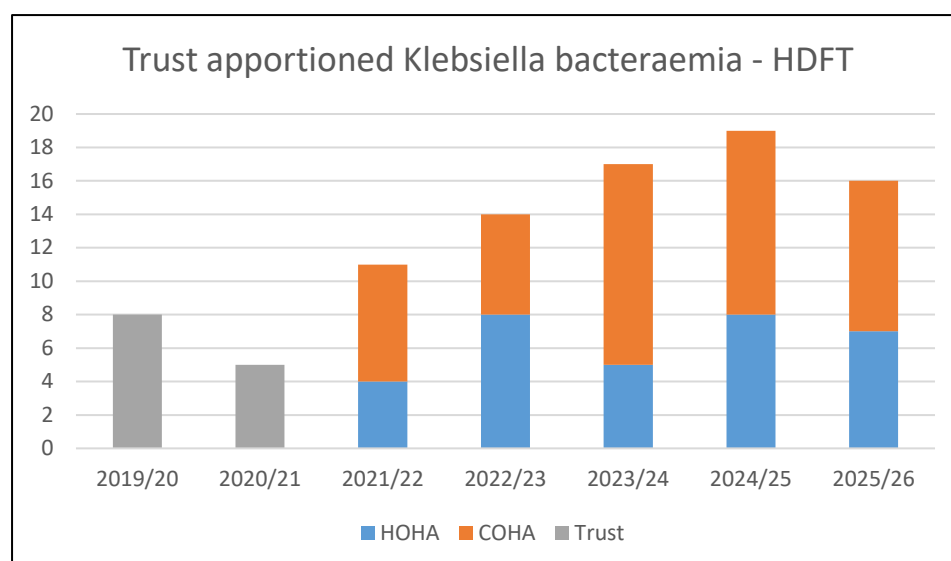
Review and optimisation of the catheter pathway is a priority area for the IPC team in 2026-27.

Figure 3.0



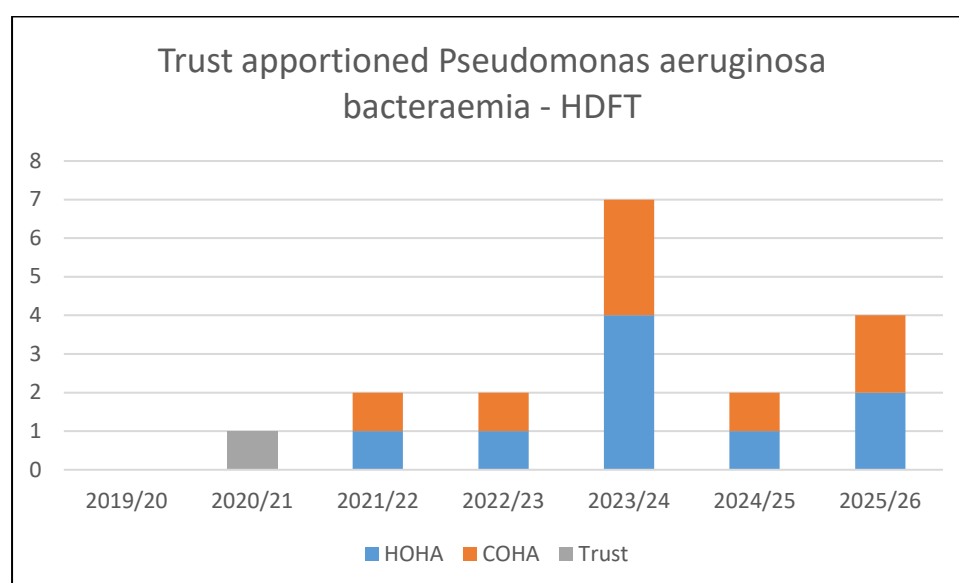
HDFT threshold for 2025/26 = 37

Figure 4.0



HDFT threshold for 2025/26 = 14

Figure 5.0



HDFT threshold for 2025/26 = 3

Table 2.0 – HOHA cases summary

Infection		MSSA	<i>E.coli</i>	<i>Klebsiella sp.</i>	<i>Pseudomonas aeruginosa</i>
Trend in cases	25-26	12	23	7	2
	24-25	15	25	8	1
	23-24	10	17	4	4

	22-23	4	6	8	1
	21-22	11	15	4	1
Gender	Male	9 (75%)	14 (60%)	6 (86%)	2 (100%)
	Female	3 (25%)	9 (40%)	1 (14%)	0 (0%)
Age (mean)		70 years	79 years	84 years	74 years
Average time since admission to positive blood cultures		15 days	12 days	11 days	10 days

Carbapenemase producing Enterobacteriaceae (CPE) cases

CPE are Gram-negative bacteria, which are so resistant to antibiotics that even our last line of defence, carbapenem antibiotics are ineffective. It is therefore extremely important to detect patients carrying these bacteria and prevent spread through isolation and cleaning. The Trust has a policy on the screening and management of patients with CPE, which reflects the guidance produced by UKHSA. HDFT has a very low incidence of CPE (<0.1%) with only four cases identified in 2025/26.

3.0 Criterion 2

Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections

The Trust cleaning strategy is based around the National Standards for Cleanliness and all areas are assigned a Functional Risk (FR) category of 1-4. Senior members of the IPC are involved in the categorisation of areas.

The cleaning provided at HDFT for all clinical and non-clinical areas is the responsibility of Harrogate Integrated Facilities (HIF) and completed by the in-house Domestic Services team. Domestics are responsible for ensuring that cleaning is performed in accordance with standard operating procedures. All Domestic staff play an essential role in ensuring the Trust reduces hospital-acquired infections. The Deputy Director of Estates and Facilities presents cleaning audit results at the monthly IPCC.

Cleanliness assurance

Role of the Domestic Supervisor –The Domestic Supervisors undertake weekly quality monitoring of the hospital wards and departments.

Deep Cleans

The Trust has an agreed list of circumstances / infections where a deep clean is required of a bed space or bay. A process is in place for Ward Managers (appropriate deputies) to request a deep clean by the Domestic Services Team 24 hours/day.

4.0 Criterion 3

Ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events of antimicrobial resistance

Antimicrobial Prescribing Sub-Group (APSG)

This group includes representation from pharmacy, microbiology, nursing and medical staff in both primary and secondary care. Its remit is to oversee the use of antimicrobial agents within the trust and promote prudent, safe and cost-effective prescribing of these drugs.

Assurance reports are received by IPCC on a biannual basis and are mapped to the code of practice criteria. APSG also produce an annual report.

Annual Report of the Antimicrobial Prescribing Subgroup 2025-26

The purpose of this annual report is to provide assurance that this group is working effectively within its terms of reference and achieving the required outcomes and impact.

Remit of the Group

To oversee the use of antimicrobial agents within the Trust and promote prudent, safe and cost-effective prescribing of these drugs.

Meetings held, membership and attendance

Title	May 2025	July 2025	Sept 2025	Nov 2025	Jan 2026	Mar 2026
Consultant Microbiologist (Chair)	✓	Apologies (Deputised by Sarah Drake)	✓	✓	✓	✓
Deputy Chief Pharmacist (Deputy Chair)	✓	✓	✓	✓	✓	Apologies
Chair of IPCC (Director of Infection)	Received papers; attendance at meetings not required					

Prevention & Control)						
Lead Antimicrobial Pharmacist	✓	✓	✓	✓	✓	✓
Specialist Antimicrobial Pharmacist		✓		✓		
ICB Pharmacist	✓	✓	✓	✓	✓	✓
ICB Lead General Practitioner	Unable to attend					
Lay Representative	✓	✓	✓	✓	Apologies	✓
Clinical Care Group Antimicrobial Link Physicians	Ian Cannings Apologies: Rick Mayers	Rick Mayers Apologies: Ian Cannings	Rick Mayers Ian Cannings	Rick Mayers Ian Cannings	Apologies: Rick Mayers	Ian Cannings Rick Mayers
Resident Doctor(s)						
Nursing Representative		Apologies			✓	
Lead Pharmacist - Medicines Quality & Safety	Apologies	✓				

Terms of Reference

Reviewed in December 2024; next due for review December 2026.

Key Areas of Responsibility

1. Development and implementation of evidence-based guidelines for antimicrobial use.
2. Monitoring antimicrobial use and compliance with guidelines within the Trust through a programme of audit.
3. Development of education and training resources for antimicrobial stewardship (AMS) and the means to deliver them.
4. Identification of antimicrobial agents for restricted use only and monitoring to ensure there is compliance with restriction policies.
5. Review of root cause analyses following cases of *Clostridioides difficile* infection.

6. Reviewing trends in local antimicrobial resistance patterns as well as data on prevalence of selected multi-resistant bacteria.
7. Encouraging and, wherever possible, supporting good antimicrobial prescribing in primary care settings.
8. Align local practice with UK AMR National Action Plan goals using AMR tools and resources, such as AMR local indicators produced by UKHSA.

The board receives a formal report on antimicrobial stewardship activities annually which includes the organisation's progress with achieving the UK AMR National Action Plan goals.

Summary of Work during 2025/26

1. Development and implementation of evidence-based guidelines for antimicrobial use.

Revisions to antimicrobial guidelines:

- New guideline added for sacral osteomyelitis
- Pelvic inflammatory disease guideline updated to include options for severe penicillin allergy
- Doxycycline added as an alternative to clarithromycin in community-acquired pneumonia guidelines
- Influenza treatment and prophylaxis guidelines updated according to 2025 UKHSA guidelines
- Aspiration pneumonia guideline:
 - Removal of routine addition of metronidazole for anaerobic cover, as per BTS statement.
 - Addition of further antibiotic options for patients with penicillin allergy and those with severe CAP, where there is diagnostic uncertainty about aspiration.
 - Antibiotic options added for patients known to be colonised with MRSA.
- Spontaneous bacterial peritonitis guideline: added oral option for metronidazole.

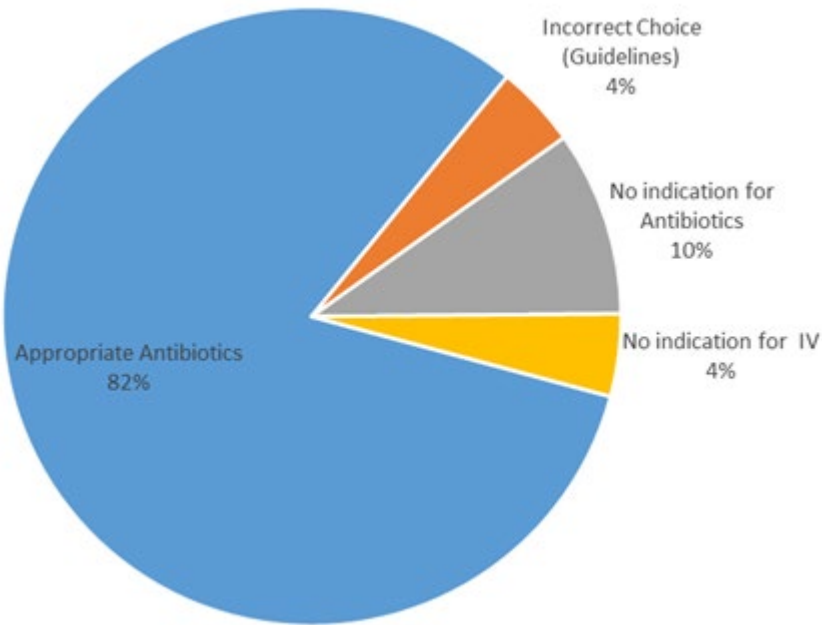
Addition of aztreonam/avibactam to the HDFT formulary. This is one of only two antibiotics currently active against New-Delhi metallo-beta-lactamase, which is now the most frequently detected carbapenemase in the UK.

2. Monitoring antimicrobial use and compliance with guidelines within the Trust through a programme of audit.

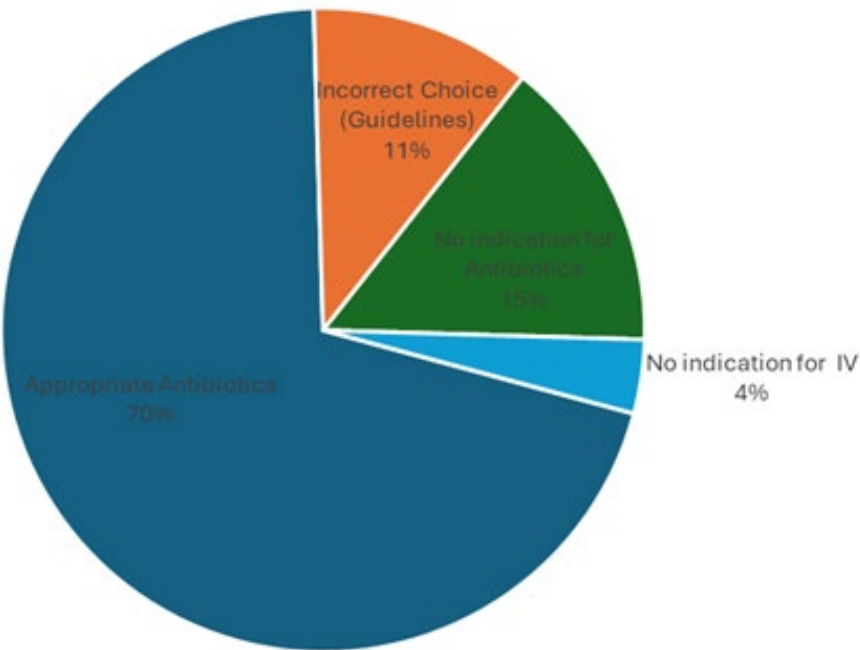
Trust-wide antibiotic point prevalence audit, April and October 2025 (Antimicrobial Stewardship Team)

All inpatient antibiotic prescriptions were reviewed on a given day. The results demonstrate appropriate prescribing in 82% of cases in April 2025 with a fall to 70% in October 2025. The reason for this reduction was multifactorial: incorrect choice according to guidelines, no clinical indication for antibiotics and no indication for IV antibiotics. The fall in standards was seen across specialties and types of infection.

Antibiotic Point Prevalence Audit April 2025



Antibiotic Point Prevalence Audit October 2025



Key successes

- HDFT is consistently meeting the CQUIN target: fewer than 15% of patients prescribed IV antibiotics meet the IV to oral switch criteria.
- The majority of antibiotic prescriptions were appropriate.

Key Concerns

- There is a stubborn proportion of prescriptions in successive audits where the reviewers judge antibiotic therapy is not indicated, either because of lack of evidence of bacterial infection, inappropriately long course length or prolongation of IV antibiotics despite meeting oral switch criteria
- The 'senior clinical review' template, rather than the 'ward round template', was sometimes used to document ward rounds in orthogeriatrics in WebV; this does not contain a field for antibiotic review.
- The October 2025 audit showed a high proportion of inappropriate prescriptions on AMU.

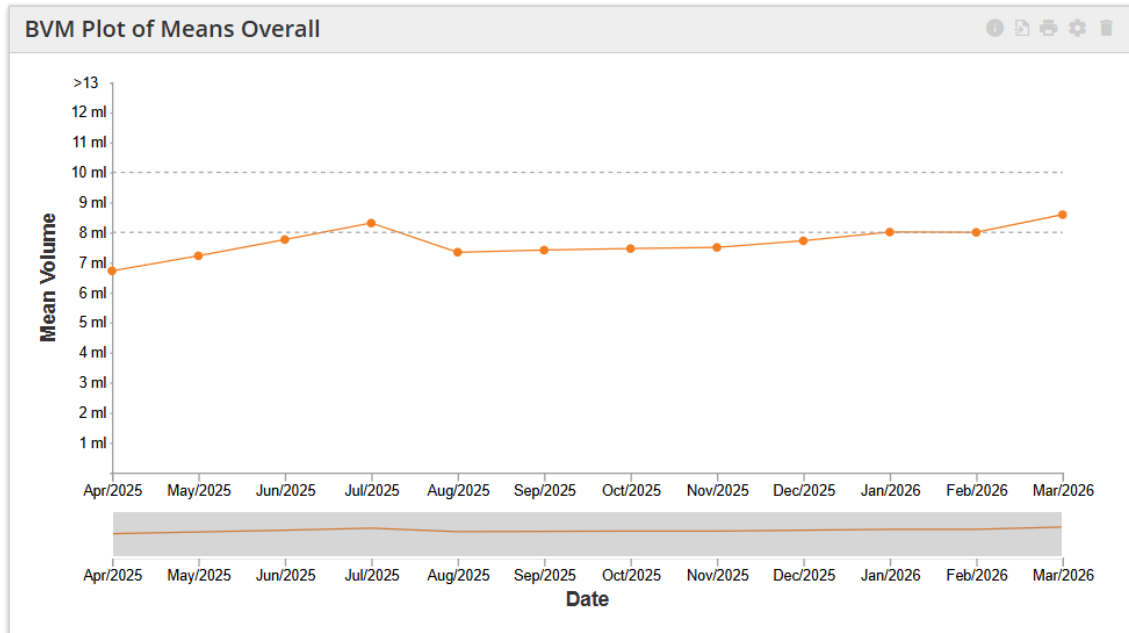
Recommendations

- Results were shared across the Trust via APSG, Clinical Pharmacists meeting and specialty audit meetings.
- Results were incorporated into teaching sessions for medical and pharmacy staff.
- Weekly antimicrobial stewardship ward rounds continue with the resident doctors in surgical specialties.
- Specific cases of inappropriate prescribing on AMU were shared with the Acute Medicine team at their clinical governance meeting.
- The reasons for 'senior clinical review' template being used in preference to ward round template in orthogeriatrics were explored.

Improving the Blood Culture Pathway

The volume of blood cultured is key to the detection of bloodstream infection. There is a direct relationship between blood volume and yield, with approximately a 3% increase in yield per mL of blood cultured. NHS England and NHS Improvement recommend the collection of two sets of blood cultures (two aerobic and two anaerobic bottles) from patients with suspected sepsis. At HDFT these bottles should be filled with 8-10mL of blood.

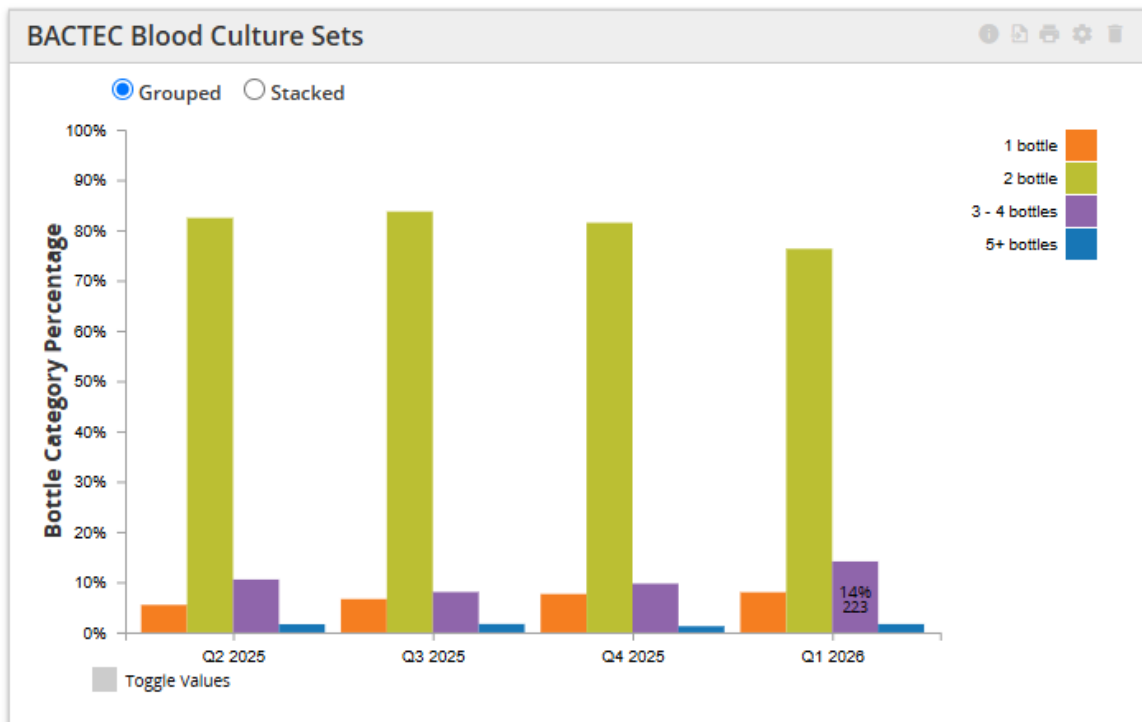
Graph to show average blood culture volume April 2025 –March 2026 – all wards and departments



Average blood culture volume per bottle increased across the Trust and for the first time exceeded the recommended 8-10mL across all wards and departments.

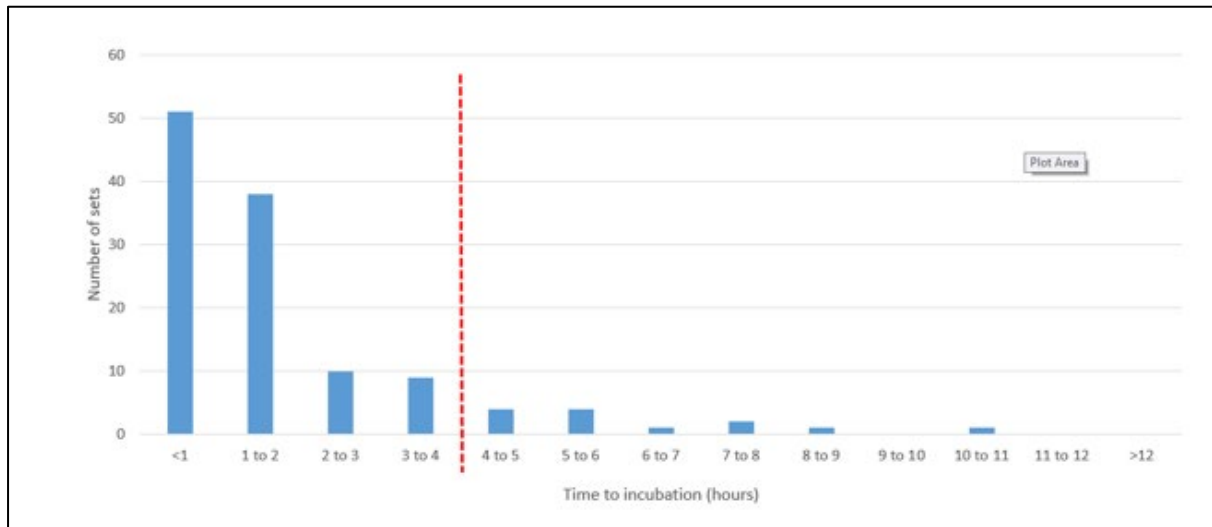
There was an increase in the proportion of patients for whom two sets of blood cultures were collected over this 12 month period (10%→14%).

Graph to show blood culture number of sets – all wards and departments



Nearly 90% of blood cultures were incubated on the blood culture analyser within 4 hours of collection.

Blood Culture Time to Incubation: Data collection from a 7 day period in March 2026



3. Development of education and training resources for antimicrobial stewardship and the means to deliver them

Alongside the antimicrobial stewardship training already provided for F1 doctors, enhanced training in prescribing and monitoring of gentamicin continues to be provided. An interactive teaching session was given to final year medical students on the Post Finals Assistantship (PFA) programme in May 2025 and this was repeated for all F1s in November 2025.

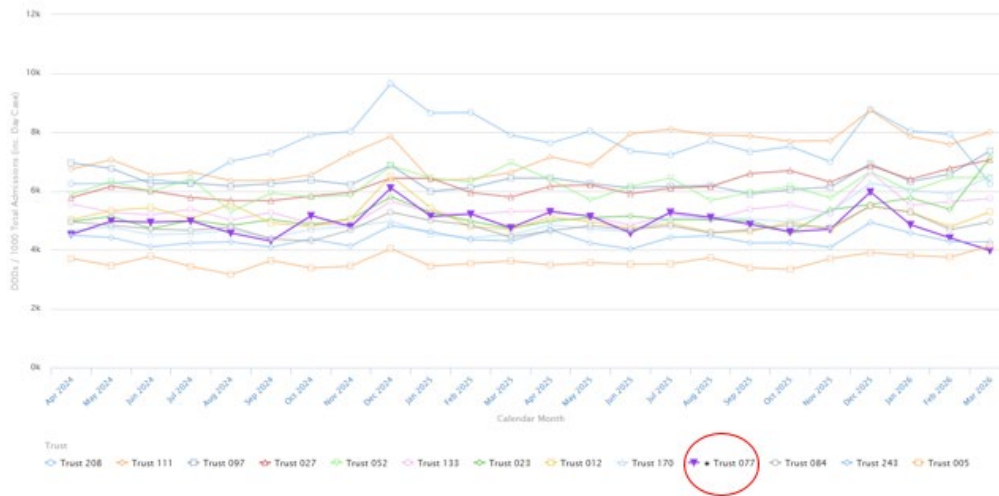
Weekly antimicrobial stewardship ward rounds were introduced with the surgical junior doctors in September 2022. These focus on duration of antibiotics, timing of iv to oral switch, restriction of gentamicin course length to 5 days, review of microbiology culture results and discussion of complex cases. These offer a further opportunity to provide education, as well as discussing patient cases.

4. Identification of antimicrobial agents for restricted use only and monitoring to ensure there is compliance with restriction policies.

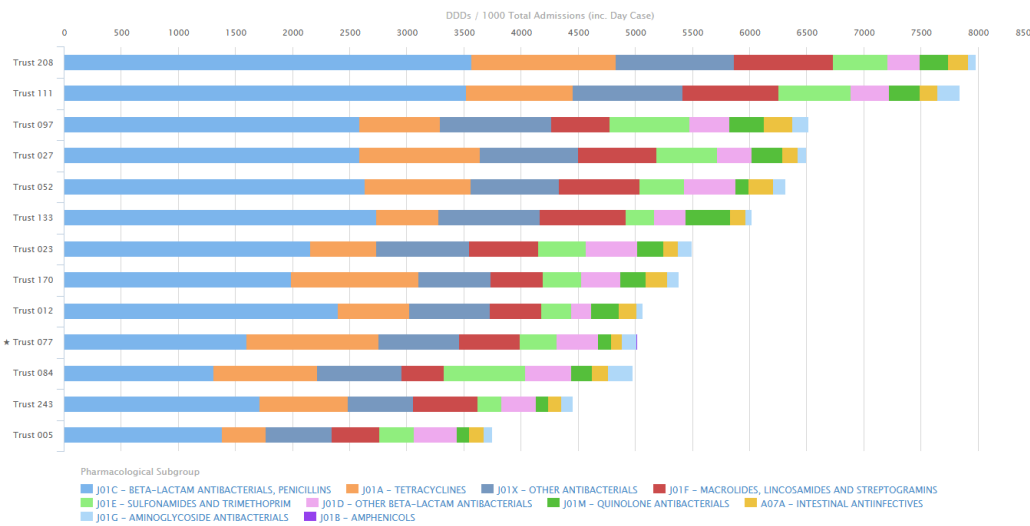
The following charts compare antibiotic consumption at HDFT with other Trusts in the region. HDFT is Trust 077.

HDFT continues to compare favourably to other Trusts in the region in terms of antibiotic use, particularly with regards to low use of broad spectrum agents (e.g. meropenem and piperacillin/tazobactam).

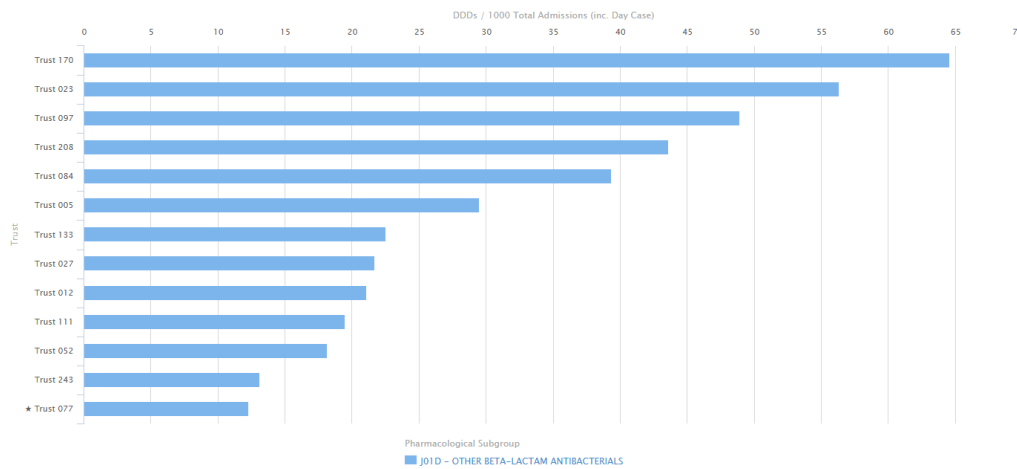
Total Antimicrobial Use in DDD/1000 Admissions



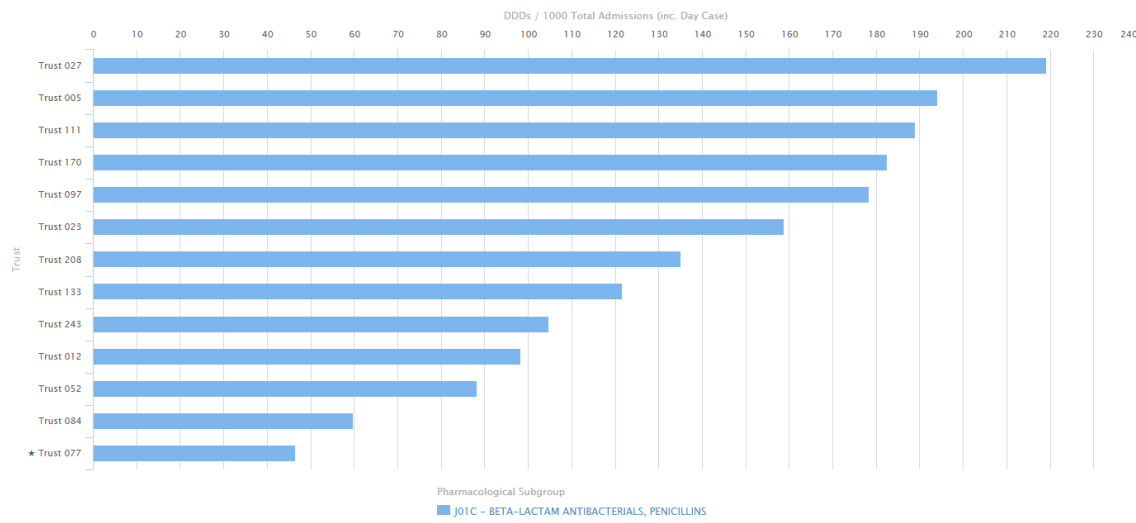
Breakdown of Antimicrobial Consumption into Antimicrobial Classes



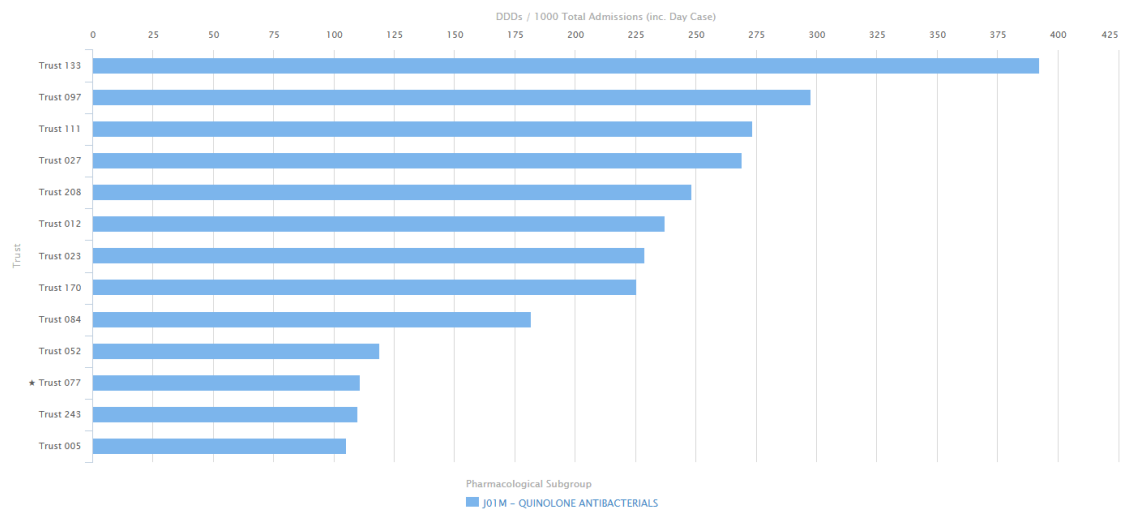
Meropenem



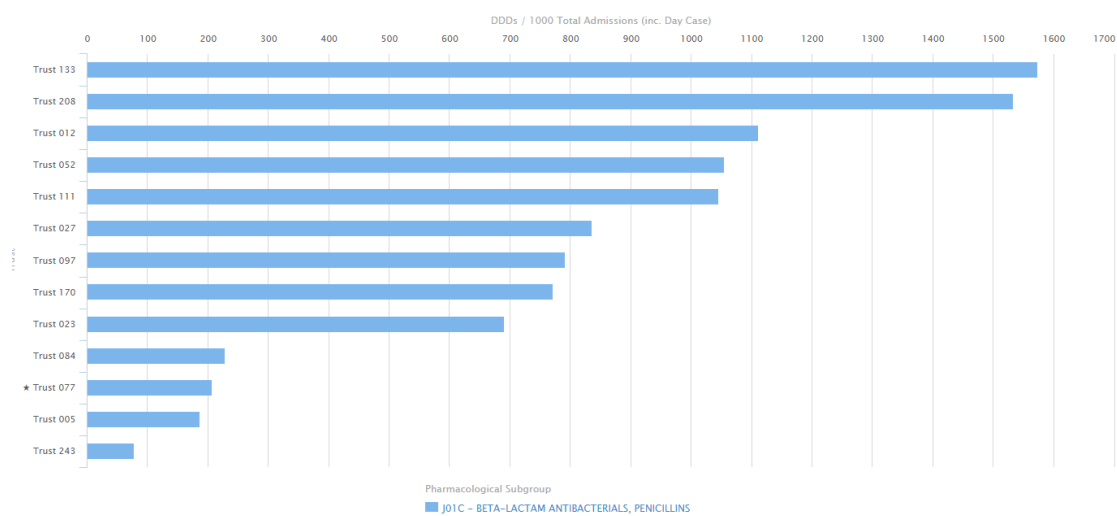
Piperacillin/tazobactam



Fluoroquinolones



Co-amoxiclav



AWaRe Categories

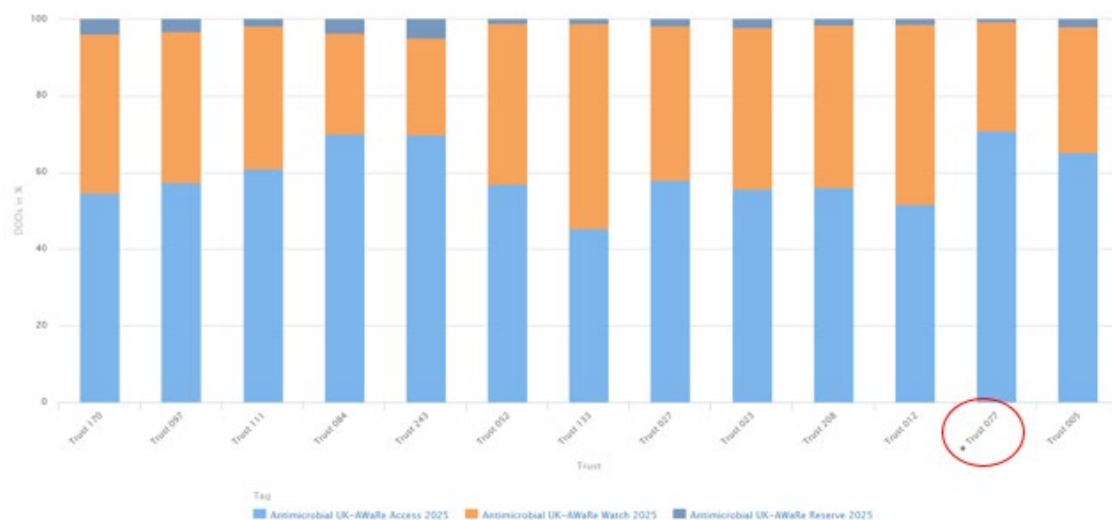
The AWaRe Classification of antibiotics was developed in 2017 by the WHO Expert Committee on Selection and Use of Essential Medicines as a tool to support antibiotic stewardship efforts at local, national and global levels. Antibiotics are classified into three groups, Access, Watch and Reserve, taking into account the impact of different antibiotics and antibiotic classes on antimicrobial resistance, to emphasize the importance of their appropriate use.

Access – first and second choice antibiotics for the empiric treatment of most common infectious syndromes;

Watch – antibiotics with higher resistance potential whose use as first and second choice treatment should be limited to a small number of syndromes or patient groups

Reserve – antibiotics to be used mainly as ‘last resort’ treatment options.

The following chart shows that HDFT is the highest user of ‘access’ antimicrobials, and the lowest user of ‘reserve’ antimicrobials in the region.



5. Review of cases of *Clostridioides difficile* infection where inappropriate antibiotic prescribing has been highlighted during post-infection review.

Since January 2022, antimicrobial prescribing lessons learnt from the CDI post-infection reviews have been formally fed back to the AMS team for discussion at APSG. In the 2025/26 financial year, inappropriate antibiotic prescribing was implicated in only 3 of 37 Trust-apportioned cases.

6. Reviewing trends in local antimicrobial resistance patterns as well as data on prevalence of selected multi-resistant bacteria.

This is reported annually. Since January 2025 this information has been uploaded to Eolas, under ‘Antibiograms’.

7. Encouraging and, wherever possible, supporting good antimicrobial prescribing in primary care settings.

National antibiotic prescribing data shows that the North Yorkshire Sub Integrated Care Board Level (SICBL) performs well against national antimicrobial prescribing targets, and is one of the lowest prescribers in the region. It should be noted that this is a much larger geographical area than the Harrogate and Rural District CCG for which data was previously reported.

The North Yorkshire Antibiotic Prescribing Guideline for Primary Care is overdue review (expired September 2019) and is currently archived. Review was delayed because of redeployment of key authors during the COVID pandemic. With the introduction of ICSs, the guidelines will apply to a much wider geographical area than before. Primary Care are directed to use the NICE guidelines in the meantime.

The Outpatient Parenteral Antimicrobial Therapy (OPAT) MDT meets every week. There is continued representation from Inizio, who provide the nursing service in the community, and Baxter, who supply the antimicrobials. This has vastly improved communication between the hospital and community and therefore positively impacted on patient care.

8. Align local practice with UK AMR National Action Plan goals using AMR tools and resources, such as AMR local indicators produced by UKHSA.

HDFT performance compared with peers is reviewed at APSG. This includes antimicrobial resistance for key pathogens, antibiotic prescribing, healthcare-associated infection and antimicrobial stewardship.

In November 2025, there was a 'call to action' from NHS England to Trust Chairs and Chief Executive Officers to work with prescribers and clinical leads to make the changes required in the national action plan for antimicrobial resistance. The following action was required by March 2026:

Board-level review and executive oversight

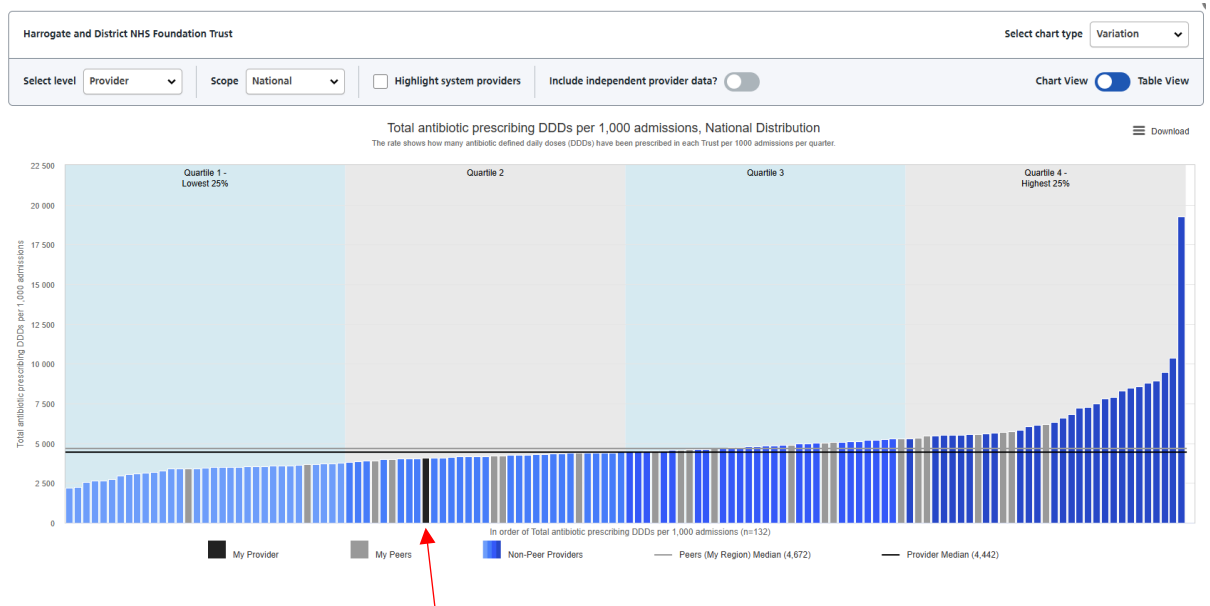
Schedule a joint presentation to your board from IPC and AMS teams covering:

- Current performance against national AMR targets
- Benchmarking using the latest English surveillance programme for antimicrobial utilisation and resistance (ESPAUR) report and AMR information found on Model Health System, together with the thresholds for each trust to reduce exposure to antibiotics, announced in the Medium Term Planning Framework, and shortly to be issued.
- Key concerns and immediate actions required

The following was presented at QGMG (March 2026) and Quality Committee (May 2026):

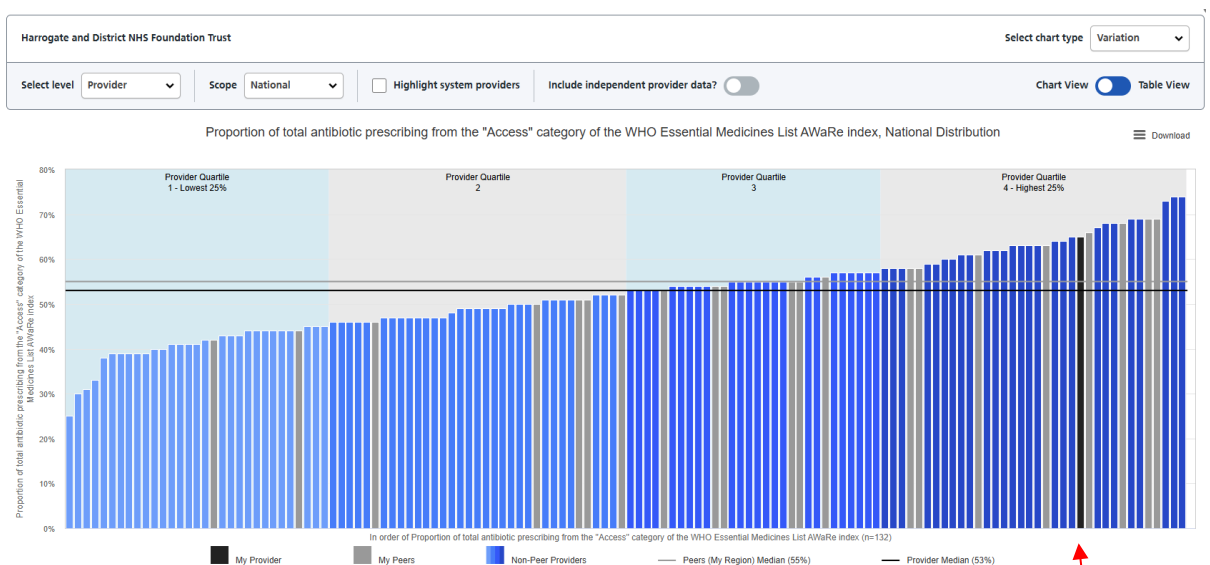
Target 4a: By 2029, we aim to reduce total antibiotic use in human populations by 5% from the 2019 baseline

- Reduction in antimicrobial consumption of 7% compared to 2019 baseline, which is on track to meet the target
- HDFT is a lower user of antimicrobials compared to other providers



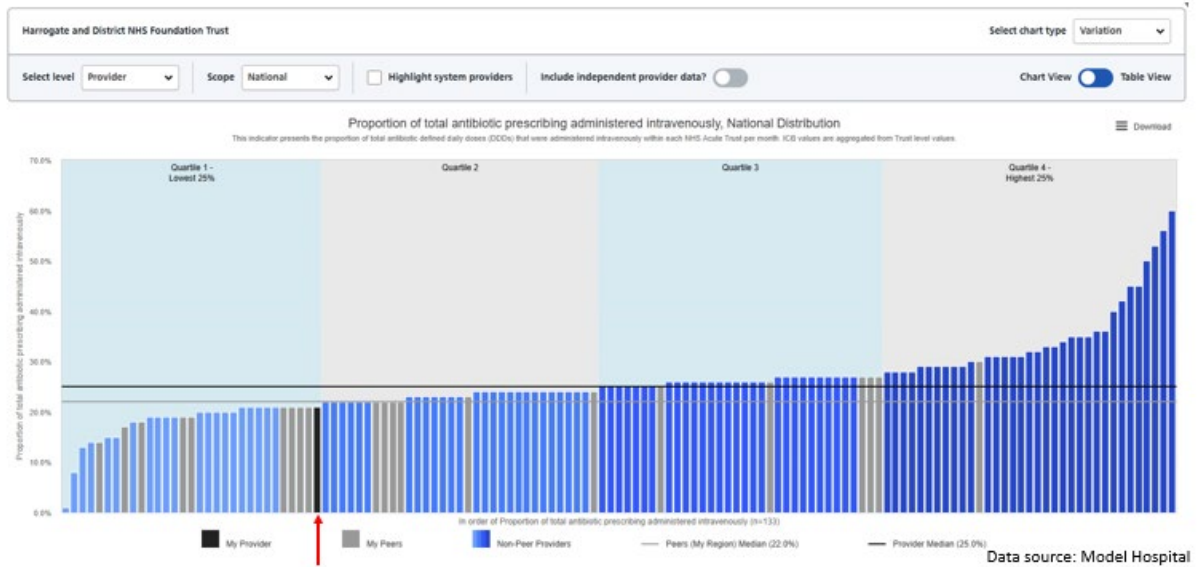
Target 4b: By 2029, we aim to achieve 70% of total use of antibiotics from the Access category across the human healthcare system

- 71% of antibiotic prescribing at HDFT is from the Access category
- HDFT is in the 13th highest provider in England for use of Access antimicrobials

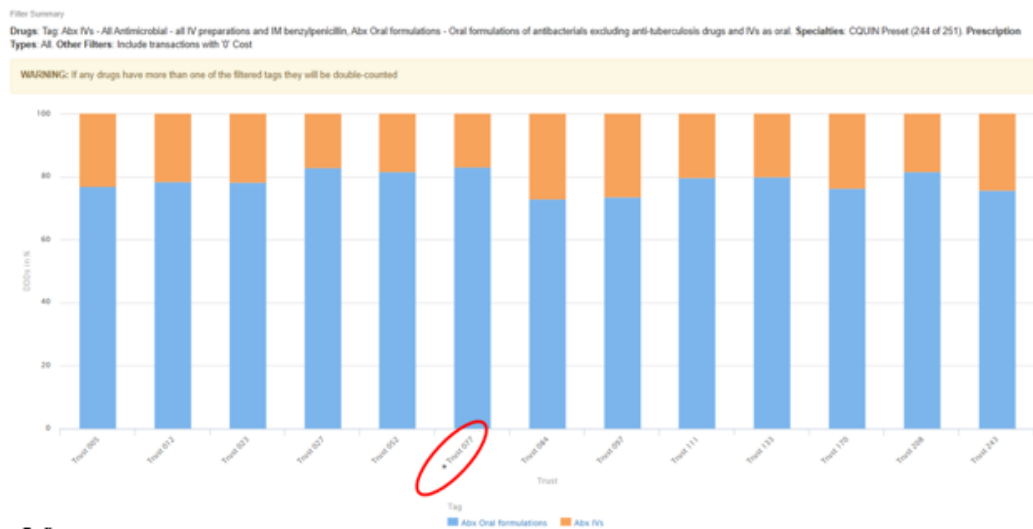


- HDFT is in the 25% lowest users of IV antimicrobials in England, and the highest user of oral antibiotics versus IV regionally

National Benchmarking – Proportion of IV Antibiotics



Regional Benchmarking: IV antimicrobial use vs oral last 12 months DDDs



Key Concerns and Immediate Actions

Concern	Action
Antibiotic prescribing in some clinical areas e.g. ED and outpatients is difficult to measure	Rolling programme of quarterly audit in Pharmacy to incorporate prescribing in these areas.
Inadequate antibiotic review on ward rounds	Use digital stewardship tools in new EPR/ePMA to encourage antimicrobial review. Consider expansion of targeted AMS ward rounds to additional clinical areas.
Reduced prioritisation of and engagement with antimicrobial stewardship across clinical teams	Explore options for funding AMS Pharmacy Technician or Specialist Pharmacist Support.
No formal penicillin allergy delabelling service. Inappropriate penicillin allergy labels encourages use of watch and reserve antibiotics, increases mortality, HCAIs and multi-drug resistant organism colonisation.	Explore options for funding AMS Pharmacy Technician or Specialist Pharmacist Support.

Progress Towards Proposed Objectives for 2025/26

Objective	Progress
Continue weekly targeted antimicrobial stewardship ward round with junior doctors in general surgery/urology/orthopaedics	Ongoing
Support antimicrobial audit in clinical specialties	Ongoing Audit of antibiotic prophylaxis in surgical specialties has stalled in the past 12 months
Provide guidance on the use of antimicrobials for the Hospital at Home service	No input required by the service in this time period
Promote and support Trust adherence to Improving the Blood Culture Pathway	MDT meeting every 2 months Ongoing programme of audit Rolling programme of teaching to ED nursing staff
Proactive focus on IVOS	Focus at surgical AMS ward rounds Submission of quarterly data regionally, although CQUIN not mandated
Penicillin allergy delabelling	Continue ad hoc delabelling on inpatients, where required, until funding is available for a formal service
Co-amoxiclav and fluoroquinolone use	Pharmacy-led audits in progress

5.0 Criterion 4

Provide suitable accurate information on infections to service user, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion

Communication

Advice leaflets have been produced for patients on a number of organisms / infections e.g. MRSA, CPE, *C. difficile* which are available to download from the website. This provides useful information to the patient and their family on the precautions required whilst they are in hospital and when they are discharged home. Notification of a patient's infectious status is documented in the discharge letter. A patient's infectious status is documented as an IR Flag on their electronic notes.

IPC Guidance is available via PolicyStat providing a single policy and procedure reference point.

6.0 Criterion 5

Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people

Alert organism system

The Infection Prevention and Control team are alerted on a daily basis by the laboratory when an alert organism is isolated on an inpatient. The notes are then electronically tagged with an IR Flag, which alerts ward staff that the patient has an infection.

Outbreak Management

The IPC team are involved in the identification and management of outbreaks and periods of increased incidence. The IPC team monitors (via the HCAI tracker) alert organisms to identify trends and potential links between cases based on their location. This is a manual task and is completed without the aid of an automated surveillance system. If links are identified then an investigation is undertaken to ascertain if the outbreak threshold has been reached. Outbreaks are managed in accordance with the IPC Outbreak policy.

In 2025/26 we had no *C. difficile* transmission events.

Respiratory viruses

The team updated the Respiratory Virus Procedure in line with national guidance, producing adult and paediatric pathways. Prior to December 2025 AMU was located on Farndale Ward. This provided 18 side rooms for isolation of infected patients preventing the spread of infection. Due to procedure, patient placement and the use of appropriate PPE we did not have an outbreak of viral respiratory infection.

529 patients who attended hospital with respiratory symptoms tested positive for influenza/RSV and 257 patients for COVID-19. Point of Care testing was undertaken in ED and Woodlands Ward. This contributed to correct patient placement and prevented inappropriate hospital admissions.

Serratia marcescens early prosthetic joint infections (August 2025)

In August 2025, two cases of early prosthetic joint infection (implant within the last 90 days) caused by *Serratia marcescens* were identified. This organism, while an uncommon cause of orthopaedic infection, is a recognised healthcare-associated environmental pathogen. Both primary procedures were undertaken in the same theatre.

An outbreak control meeting was convened on 16 September 2025. Microbiological typing demonstrated that the isolates were genetically distinct, suggesting the cases were not directly related; however, a common environmental source within the theatre setting could not be excluded.

A number of actions were agreed and implemented following the meeting, including review and strengthening of theatre cleaning standard operating procedures, assessment of Tristel Fuse use to ensure compliance with IPC and national standards, evaluation of scrub storage and practices, and review of theatre policies. Additional measures included review of practices such as mobile phone use and scrubbing variation, and assurance of routine flushing of changing room showers. These actions aim to reduce the risk of further healthcare-associated infections within the theatre environment.

7.0 Criterion 6

Systems to ensure that all care workers including contractors and volunteers are aware of and discharge their responsibilities in the process of preventing and controlling infection

At the Trust, Infection Prevention responsibilities are included in all job descriptions.

In relation to contractors, documented IPC advice is provided to the person managing the contractors, which covers current guidance on COVID-19 and other general IPC issues.

Staff Induction

All clinical staff receive IPC training on induction to the Trust. The IPC team have a face-to-face session at the Trust Induction Day, which allows us to introduce the team and convey that IPC is everyone's responsibility no matter his or her role in the organisation.

Staff Training and Education

All staff are required to complete a Mandatory Training session on Infection Prevention and Control, which includes Hand Hygiene. Level 1 is for non-clinical staff and is required every 3 years. Level 2 is for clinical staff and is required annually. Compliance with mandatory IPC training remains high.

Table 3.0 – figures as of 31/3/26.

	Level 1	Level 2
Corporate	97%	91%
HIF	96%	90%
LTUCC	94%	91%
PSCC	97%	89%
CYPPIH	99%	94%
Total Average Compliance	96.5%	91%

Throughout the year, the IPC team continue to raise the profile of Infection Prevention and Control by celebrating national IPC campaigns within the Trust. This has included:

- WHO hand hygiene awareness day (5th May)
- International IPC week (week commencing 19th October)
- World AMR awareness week (week commencing 18th November)

The IPC team held IPC Champions bi monthly MS Teams meetings with a presentation on a relevant IPC topic. Due to poor attendance the Team are reviewing alternative options on delivering education to staff in the work place and this will be a multi-faceted approach.

The IPC team hosted a stand at the new doctors to the Trust event in August, promoting Standard Precautions including hand hygiene and Bare Below the Elbow (BBE).

FIT testing Service

43 staff members in key areas have attended a HSE accredited training programme and can undertake Fit testing for HDFT staff who may be required to wear an FFP3 mask as part of their role. Members of the IPC team have already attended the accredited training programme.

A new fit testing policy has been developed and fit testing is now a mandatory role-based training requirement, which means we can monitor compliance and alert staff as to when they are due for re-testing.

High consequence infectious disease (HCID) preparedness

This year, several patients were initially managed as potential HCID cases before subsequently being downgraded. The HCID protocol has been revised to incorporate lessons learned from these incidents. One identified concern was the limited availability of personal protective

equipment (PPE) at the outset of case management; to address this, a 72-hour supply of PPE is now readily available. Given the rarity of HCID presentations, early recognition and identification continue to be a challenge and remains an area of ongoing focus.

8.0 Criterion 7

Provide or secure adequate isolation facilities

At HDFT, all inpatient wards have single room (isolation) facilities. The proportion of single rooms available across our inpatient beds is 26%, of these single rooms 60% are en-suite.

This can, at times of high demand, significantly impact the ability to isolate all patients who should be isolated according to national guidance. The change in location of AMU from Farndale Ward to Littondale Ward in December 2025 resulted in the loss of 13 acute medical side rooms affecting the isolation of influenza/RSV cases. When demand exceeds single room occupancy, a risk assessment is carried out to ensure the most appropriate patient is allocated a single room. The IPC Team work closely with the Clinical Site Team to support the risk assessment and decision-making. A priority isolation list is available to help the Clinical Site Team out of hours and ensure that practice is consistent.

Specialist isolation rooms are available in the Emergency Department and the Intensive Care unit. The Emergency Department has three single resus rooms, which can be put into negative pressure mode. *(This is the mode you want when caring for a patient with a suspected/confirmed infection, which spreads via the airborne route).* Intensive Care has two single rooms, which can be put into negative pressure mode.

9.0 Criterion 8

Secure adequate access to laboratory support as appropriate

Laboratory services for HDFT are located on-site. The Microbiology Laboratory has full UKAS ISO 15189 accreditation.

The IPC nurses work closely with the Consultant Microbiologists and the Senior Biomedical Scientists. One of the Consultant Microbiologists has the additional role (awarded 3PAs) of being the Infection Control Doctor and is the primary link between the IPC team and the laboratory service.

The Laboratory department have continued to work flexibly with the Trust and have maintained an extended working hour's rota to provide on-site respiratory virus testing until 5pm seven days per week. This has been key to maximising safe patient flow.

10.0 Criterion 9

Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections

The team have trained a number of staff in ED, Woodlands and AMU in the preparedness of a HCID case, including donning and doffing of PPE. A video and action cards have been produced to enable a train the trainer approach for Clinical Educators.

The IPC Policy and all of the supporting procedure documents are located on PolicyStat. The IPC team is committed to the continuous updating of IPC procedures, the IPC Matron has been given special permission to enable us to update policies in between the formal review dates when appropriate.

11.0 Criterion 10

Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection

The Trust has an Occupational Health Department who have responsibility for carrying out pre-employment health assessments and immunisation needs.

A major review of the Body Fluids Exposure policy has been completed

Staff are able to self-refer to the Occupational Health service at any time for additional advice and support.

The Occupational Health Manager is a core member of the IPCC.

All HDFT staff continue to be offered seasonal vaccinations as per NHSE guidance.

12.0 Conclusion

The IPC team continue to provide a dynamic and responsive service. The team continue to embrace new digital ways of working with their advice documented in the electronic patient record and continue to expand their expertise in the IPC aspects of the built environment by being involved in capital projects right from the start of the design phase.

The IPCC continues to be a well-attended and productive committee. Members of IPCC continue to develop their expertise in the very wide remit of infection prevention. The committee offers robust challenge and scrutiny to the work of the Trust, which has IPC implications.

The IPC team are committed to continuing the journey of improvement in order to deliver high quality care to the patients we serve.

13.0 Reference

Department of Health: The Health and Social Care Act 2008. Code of Practice on the prevention and control of infections and related guidance.

<http://www.gov.uk/government/publications/the-health-and-social-care-act-2008-code-of-practice-on-the-prevention-and-control-of-infections-and-related-guidance>

14.0 Appendices

1.0 Terms of reference IPCC

2.0 IPCC meeting attendance record 2025/26

3.0 IPC Board Assurance Framework

4.0 IPC annual plan of work 2025/26

Appendix 1 – IPCC Terms of Reference:

Terms of Reference

Infection Prevention and Control Committee (IPCC)

1. Accountable to:

- Quality Committee (QC)
- Board of Directors

2. Purpose of the group

The purpose of the IPCC is to provide strategic leadership and direction on infection prevention and control activities across the trust to ensure that the risks posed by transmission of avoidable infection is minimised.

Specifically to include the following:

- To ensure compliance with the Health and Social Care Act 2008 Code of Practice (CoP) on the prevention and control of infections and related guidance by having appropriate monitoring and management systems in place to identify risk of infection to susceptible service users and any risk that their environment may pose to them.
- To approve and monitor the IPC Board Assurance Framework (BAF) to ensure CQC registration compliance with the Code's criteria.
- To approve and monitor the IPC Annual Plan of Work (APW) and any incidents arising which would impact upon compliance with the code of practice.

3. Responsibilities

The key responsibilities of the group are *to lead and monitor the work of its subgroups and to:*

- Set annual objectives and a plan of work.
- Report effectiveness against objectives and terms of reference at year end.
- Produce the IPC annual report for the Trust Board.
- *Approve annual objectives, work plan and terms of reference of subgroups.*
- Show leadership in setting a culture of continuous improvement in delivering high quality care.
- *Lead work to ensure compliance with the CQC fundamental standards.*
- Set relevant strategy, policies and processes to support the objectives of the Trust, and ensure that these are reviewed and updated appropriately.
- Support the delivery of the Trusts annual quality improvement priorities.
- Promote high reliability processes to deliver consistent high quality care by using standard operating procedures, pathways, checklists etc.
- Employ performance and outcome measures through dashboards to triangulate quality information and benchmark against other organisations, and share with relevant staff and stakeholders.
- Promote actions to reduce risk.
- Identify and escalate risks that present a threat to Trust objectives, including from audit results.
- Identify and disseminate learning to relevant staff.
- Address substandard performance.

- Empower staff to make changes to improve quality.
- Ensure participation in national and local audits, patient surveys and quality improvement projects.
- Identify audits for the clinical audit plan.
- Track performance against standards by reviewing audit reports and ensuring the development and progression of action plans.
- Provide information and assurance to the Quality Committee as required.

The key standards for this group are:

The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance (UKHSA 2015)

Mandatory enhanced MRSA, MSSA, and Gram negative bacteraemia, and Clostridium difficile infection surveillance. (PHE 2016)

HM Government (2019): Tackling antimicrobial resistance 2019-2024: The UK's 5 years National Action Plan

4. Membership

The core membership comprises:

Title	Deputy
Director of Infection Prevention and Control (DIPC)(Chair)	Deputy DIPC (Deputy Chair)
Matron for IPC and TB services	Infection Control Doctor (ICD)
Infection Control Doctor	Matron for IPC and TB services
Associate Director of Nursing (LTUCC)	LTUCC Matron
Associate Director of Nursing (PSCC)	Head of Nursing (PSCC)
Associate Director of Midwifery	Head of Midwifery
Associate Director of Nursing (CYPPH)	Deputy Associate Director of Nursing (CYPPH)
Head of Occupational Health and Wellbeing	Member of Occupational Health and Wellbeing Team
Deputy Director of Estates and Facilities	Head of Estates / Head of Facilities
Head of Health and Safety	Health and Safety Advisor
Deputy Chief Operating Officer	Clinical Operations Manager
Secretary to the Consultant Microbiologist's	N/A

Ad hoc attendance may be by invitation of the Chair.

5. Quorum

To be decided by the Chair according to representation present and agenda content

6. Administrative support

Secretary to the Consultant Microbiologist's

7. Subgroups

Hospital IPC Team, Community IPC Team and TB Team Groups responsible for implementation of the IPC APW, acute and community IPC services and TB Service.

Antimicrobial Prescribing Sub-Group (APSG)

- Group responsible for developing and implementing the Trusts antimicrobial stewardship strategy

-

Water Safety Group

- Group responsible for the provision of safe water by the management of waterborne risks

-

Ventilation Safety Group

- Group responsible for the provision of safe air by the management of ventilation related risks

Decontamination Committee

- Group responsible for ensuring the reusable medical devices undergo effective decontamination

8. External relationships

ICB

North East and Yorkshire IPC Team

9. Frequency of meetings

Monthly

10. Communication

Minutes and action log to be produced for each meeting by the administration support.

Escalation of issues to Quality Committee.

11. Review

Annually (April)

12. Date

24/11/2025

Appendix 2 – IPCC Meeting Record 2025/26

Meeting	1	2	3	4	5	6	7	8	9	10	11	12
Date	28/4	19/5	23/6	28/7	18/8	22/9	27/10	24/11	15/12	26/1	23/2	23/3
DIPC	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	R	✓
Executive Medical Director (From July 25)				✓	✓	A	✓	✓	✓	✓	✓	✓
Matron IPC	✓	✓	R	✓	✓	✓	✓	✓	✓	✓	A	R
ICD	✓	✓	✓	R	✓	✓	R	✓	✓	✓	✓	✓
Deputy Chief Operating Officer	A	✓	A	✓	✓	A	✓	A	A	A	A	A
LTUCC ADoN	R	R	R	✓	R	✓	R	✓	R	R	R	R
PSCC ADoN	✓	A	R	✓	✓	R	✓	✓	R	R	R	✓
CYP PH Deputy ADoN	A	✓	R	✓	✓	R	✓	✓	R	✓	✓	✓
Associate Director of Midwifery and Children's Services	A	✓	A	✓	A	✓	A	A	A	✓	A	A
Head of Occupational Health and Wellbeing	✓	✓	R	✓	A	✓	A	✓	A	✓	A	✓
Deputy Director of Estates and Facilities (HiF)	R	R	R	✓	✓	R	R	✓	R	✓	R	R
Head of Health and Safety	A	✓	✓	✓	✓	✓	A	✓	✓	✓	✓	✓

Key:

R – Representative sent

A – Apologies received

Appendix 3: IPC Board Assurance Framework:



Infection Prevention and Control Board Assurance Framework – 2025-2026

The Infection Prevention and Control (IPC) Board Assurance Framework(BAF) has been developed to support HDFT self-assess compliance with the 10 criteria set out in the Health and Social Care Act (2008) Code of Practice on the prevention and control of infection.

[Health and Social Care Act 2008: code of practice on the prevention and control of infections - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/publications/health-and-social-care-act-2008-code-of-practice-on-the-prevention-and-control-of-infections)



NIPC BAF - HDH
2025-26.xlsx

Appendix 4: IPC Annual Work Plan 2025-26

The HIPCT Work Plan describes the IPC improvement work to be undertaken in 2025-2026. The plan is ratified at the Infection Prevention and Control Committee (IPCC).

Item	Task	Task Lead	Target Date	Progress
Policy and Guidelines				
	Develop C auris IPC/screening procedure	SD	31/03/2026	Complete: procedure has now been approved by IPCC. The CPE/MRSA/MRGNB procedure also needs a review. Aiming to launch all policies at the same time.
	Section 031: Principles of asepsis – redraft	IG	30/09/2025	Completed January 2025
	Section 012: Procedure for MRSA - redraft	SD	31/03/2026	Ongoing to add to next year's work plan
	Section 005: Tuberculosis – alter policy to include which wards these patient should be isolated	SA	30/09/2025	Completed July 2025
	Section 024: Carbapenemase-Producing Enterobacteriaceae (CPE)	SD	31/03/2026	Ongoing to add to next year's work plan
	Section 018: Procedure for Multi-Resistant Gram-Negative Bacilli (MRGNB) Bacteria and Glycopeptide-Resistant Enterococcus (GRE)	SD	31/03/2026	Complete March 2026– awaiting review at IPCC
	Section 038: Procedure for the Prevention of Catheter-Associated Urinary Tract Infection (CAUTI)	SA	30/09/2025	Completed July 2025
Quality Improvement and Audit				
	Review of Staph aureus (MSSA/MRSA) infection prevention strategy	SD	31/03/2026	Ongoing to add to next year's work plan
	Assess potential impact of in-house Norovirus PCR by collecting real-time data	SD	31/03/2026	On hold indefinitely. Capacity for Cepheid being used for increased CPE screening (January 2026)
	Spectricept business case	SA	31/03/2026	On hold indefinitely following negative feedback from another trust (January 2026)
	Isolation audit and education programme	AG	30/09/2025	Initial audit completed August/September 2025. IPC team provided an IPC champions educational session on isolation (completed September 2025). Audit to be repeated in August/September 2026
	Gram negative BSI review	SD	30/09/2025	Completed September 2025, findings presented to IPCC
	Quantitative fit testing business case (Steve Burns in theatres)	SB	30/09/2025	Not progressing due to lack of funds
Education and Training				
	Ensure HCID training is added as a role based mandatory requirement (like FFP3 FiT teaching)	SA	30/09/2025	The focus of HCID preparedness has shifted to ensuring appropriate staff are fit tested, policies are accurate and up to date, and training sessions are delivered in clinical areas. Incorporating HCID training into role-based mandatory requirements is unlikely to be feasible. Removed from work plan January 2026
	Toolbox talks on isolation	SA	30/09/2025	Completed November 2025
	Delivery of bi-monthly training to IPC champions on MS Teams	SA	31/03/2026	Complete. Action for next year – to review method of delivery for IPC teaching

New items to be added throughout the year				
	Consider introduction of ANTT	SA	31/03/2026	To add to work plan for 26-27
	Compile a record of IPC delivered education/training	LM	31/03/2026	Completed September 2025
	New fit testing policy and review of staff who are required to be fit tested as part of their role plus adding this to their mandatory training	SD	31/03/2026	Procedure has been approved by IPCC (November 2025). Application to expand staff members who are required to be fit tested is ongoing

Quality Committee
30/9/26

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

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

	Quality & Safety		
	Legal/Regulatory		
	Equality & Diversity		
	Risk		
Consultation / Engagement			

Freedom of Information	Paper can be made available under the Freedom of Information Act once published on the HDFT website.
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HARROGATE AND DISTRICT NHS FOUNDATION TRUST

Quality Committee

Nursing and Midwifery Quality and Safe Staffing Report

1.0 Introduction

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

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

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

2.0 Hard Truths Data

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

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

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

3.0 June and July 2026 Results

During June and July 2026, 17 eligible inpatient areas were reviewed. Planned versus actual staffing varied across wards for both registered and unregistered staff, with some areas operating below the 80% threshold and others above.

It was identified that Registered Nurse (RN) planned staffing fell below the Trust's 80% assurance threshold for, two areas in June (Special Care Baby Unit and Woodlands) and two areas (Bolton and Woodlands) in July 2026. For Unregistered workers, planned staffing

fell below the 80% threshold for eight areas in June (Bolton, ITU, Granby, Lascelles, Nidderdale, Rowan, Wensleydale and Woodlands). In July seven areas fell below 80% fill rate (Bolton, ITU, Fountains, Lascelles, Maternity, Rowan, and Woodlands).

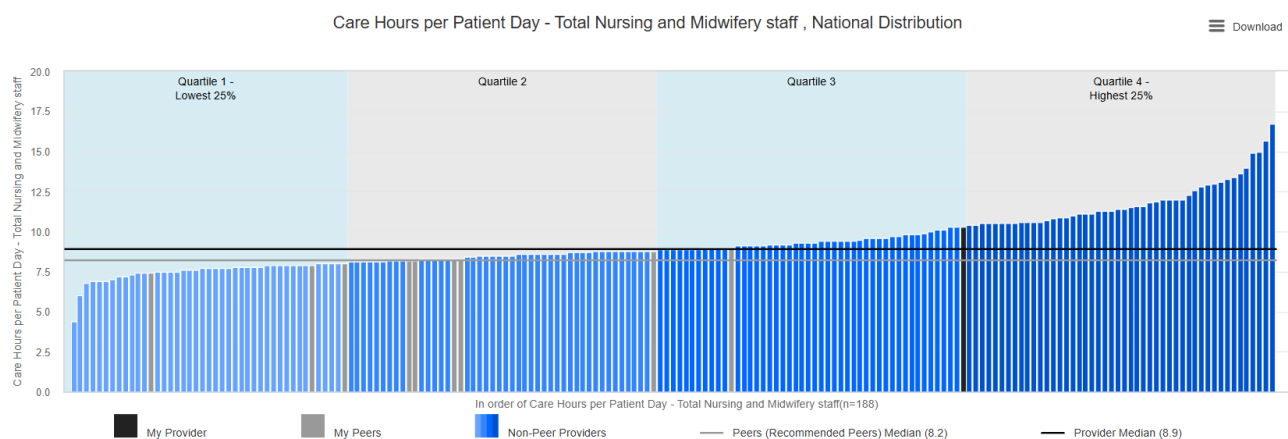
In each case, staffing levels were reviewed through the Trust's established safer staffing governance processes, considering patient acuity and dependency, bed occupancy, professional judgement and quality indicators. Where appropriate, staff were redeployed across inpatient areas to ensure the available workforce was aligned to clinical need, providing continued assurance that safe and effective care was maintained despite variation in planned versus actual staffing levels. ITU worked within GPICS (Guidelines for the Provision of Intensive Care Services) standards at all times.

This variation reflects the responsive deployment of the available workforce to meet changing patient demand and demonstrates the effectiveness of the Trust's safer staffing processes.

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

HDFT continues to perform above the national recommended peer median CHPPD of 9.0, with a Trust CHPPD between 10.2 and 10.9 for this reporting period. This places the organisation within National Quartile 3, demonstrating staffing levels that are comparable with, and in many cases exceed, those of peer organisations. This provides further assurance that workforce deployment continues to support the delivery of safe, effective and high-quality patient care.

The table below demonstrates that HDFT CHPPD is in the third quartile (8.9), which places us above our peers (8.2) and lower than the national median (9.0). This data is taken from Model Health System.



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

4.0 Vacancies

4.1 Maternity

Maternity services had a 0.0 WTE vacancy in June and July, resulting in a fully established workforce. Midwifery sickness absence has continued to show a stable position of 4% over these last two months. To support staffing requirements, shifts were released through NHS Professionals (NHSP), with fill rates remaining stable at 60%. This reflects a positive improvement in workforce availability and temporary staffing coverage.

4.2 Inpatient ward

The table below summarises the substantive establishment position across the inpatient wards as of 31st July 2026, detailing the vacancy and over-establishment position for Registered and Unregistered staff.

Directorate Inpatient Wards - in-month substantive vacancies/(over-est)						
	Registered			Un-registered		
	Sum of WTE budget - Jul 26	Sum of WTE contracted - Jul 26	Sum of WTE variance - Jul 26	Sum of WTE budget - Jul 26	Sum of WTE contracted - Jul 26	Sum of WTE variance - Jul 26
LONG TERM URGENT CANCER AND COMMUNITY	206.54	201.78	4.76	150.07	143.49	6.58
CARE GROUP ACUTE MEDICINE	67.67	65.60	2.07	34.08	31.27	2.81
251101-Acute Medical Unit	32.00	29.68	2.32	17.04	15.91	1.13
251113-Wensleydale Ward	35.67	35.92	-0.25	17.04	15.36	1.68
CARE GROUP FRAILTY	82.59	78.90	3.69	72.03	70.50	1.53
251100-Jervaulx Ward	24.43	22.95	1.48	22.56	21.70	0.86
251111-Acute Frailty Unit	19.31	18.28	1.03	14.99	14.40	0.59
251114-Byland Ward	24.43	23.53	0.90	22.56	23.11	-0.55
255053-Ripon Trinity Ward	14.42	14.14	0.28	11.92	11.29	0.63
CARE GROUP LONG CONDITIONS	56.28	57.28	-1.00	43.96	41.72	2.24
251120-Oakdale Ward	24.43	24.81	-0.38	19.11	18.08	1.03
251121-Granby Ward	19.34	19.36	-0.02	14.99	14.35	0.64
251124-Lascelles	12.51	13.11	-0.60	9.86	9.29	0.57
PLANNED SURGICAL AND CHILDRENS	114.65	109.46	5.19	70.63	58.27	12.36
CHILDRENS	31.90	32.71	-0.81	8.35	6.99	1.36
251130-Woodlands Ward	18.61	18.79	-0.18	7.65	6.99	0.66
251131-S.C.B.U.	13.29	13.92	-0.63	0.70	0.00	0.70
MSK & IMAGING	36.34	31.98	4.36	27.98	20.83	7.15
251104-Fountains Ward	24.43	20.97	3.46	19.52	15.56	3.96
251110-Rowan Ward	11.91	11.01	0.90	8.46	5.27	3.19
SURGERY	46.41	44.77	1.64	34.30	30.45	3.85
251103-Farndale Escalation Ward	0.00	0.00	0.00	0.00	0.00	0.00
251105-Bolton Ward	21.98	20.26	1.72	17.26	16.60	0.66
251702-Nidderdale Ward	24.43	24.51	-0.08	17.04	13.85	3.19
Grand Total	321.19	311.24	9.95	220.70	201.76	18.94

5.0 Temporary Workforce Usage

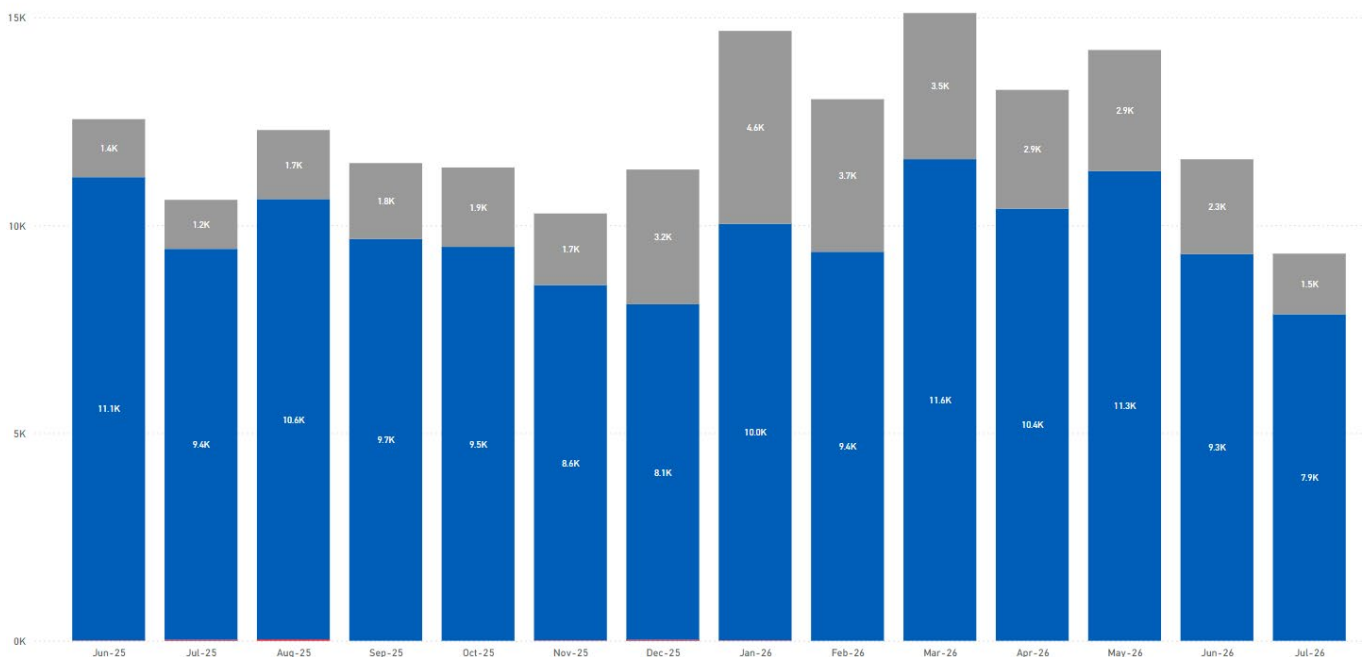
Temporary workforce utilisation continued to reduce during the reporting period, reflecting sustained improvements in workforce stability and recruitment. There was £13k of agency usage on one PSCC ward for specialist reasons and no other use across the other 16 inpatient wards, with temporary staffing requirements being safely managed through NHS Professionals (NHSP) where required.

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

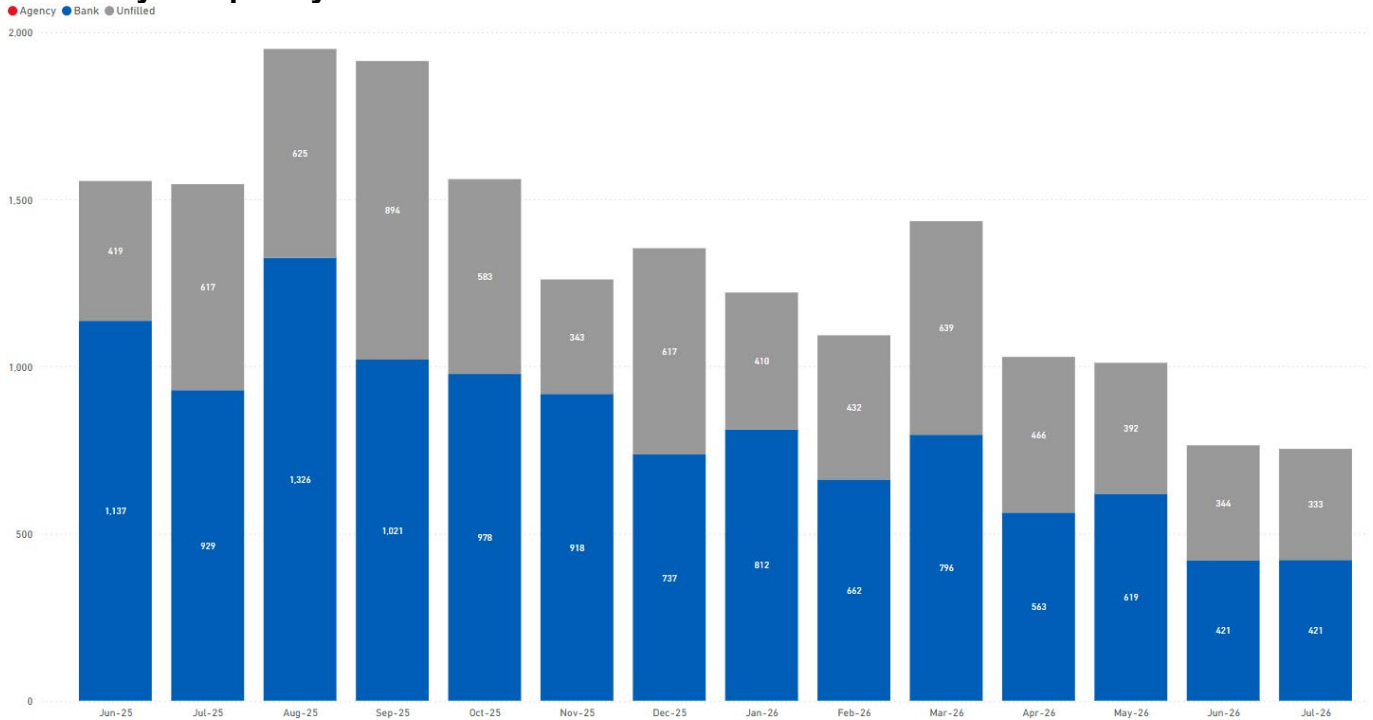
Overall, temporary workforce utilisation continues to reduce year-on-year, demonstrating the positive impact of strengthened workforce governance, successful recruitment, improved workforce planning and robust safer staffing processes. This now includes strengthened governance around the use of the temporary workforce through weekly Temporary Workforce Oversight meetings, chaired by the Chief Nurse. These measures provide assurance that patients continue to receive care from the right people, with the right skills, in the right place, at the right time.

Registered and Unregistered Nursing Temporary Workforce

● Agency ● Bank ● Unfilled



Midwifery Temporary Workforce



6.0 Key Performance Indicators

Between 1st June 2026 and 31st July 2026, 17 moderate and above harm events were reported (note: some of these events are still awaiting verification). All of these were patient events.

The events occurred across 10 event types: Appointments, Bookings Transfer & Discharge; Diagnosis, Tests & Imaging; Equipment; Fundamentals of Care; Health & Safety; Medication (inc. IV gases); Mortality, Mortuary & Bereavement; Obstetrics & Maternity; Pressure Ulcers & Skin Damage; Procedure & Surgery.

In addition, one non-patient related moderate and above harm event occurred.

6.1 Falls

In June there was one fall with severe harm and one fall with moderate harm. One has been investigated through Quality Oversight Panel and omissions identified therefore learning has been shared. The moderate harm fall is awaiting investigation. No concerns were identified regarding staffing at the time of either event.

In July there was one fall with moderate harm which is awaiting Quality Oversight Panel review.

There was also a fall with fatal harm which is currently under investigation. No concerns were identified regarding staffing at the time of either event.

6.2 Pressure ulcers

In June, three moderate harm pressure ulcers were identified. Investigations are ongoing and the report will be reviewed at Quality Oversight panel once finalised.

In July, there was one pressure ulcer with moderate harm. Appropriate investigation is ongoing and the report will be reviewed at Quality Oversight panel once finalised.

7.0 Assurance Report

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

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

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

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

8.0 Escalation and Reporting Nurse and Midwifery staffing concerns

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

The Nurse in Charge on each adult inpatient ward is responsible for scoring the acuity and dependency of every patient using SNCT levels of care. The patients must be assessed at

the start of the early shift (before 10am) and the start of the night shift, and the scores entered into the SafeCare census. Concerns about patient need exceeding available nursing care hours, must be escalated in a timely manner to the matron or designated deputy for that area. Patients will receive a care score level between 0 and 3, with four sub sections of level 1 (a-d).

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

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

Matrons review staffing with the nurse in charge/unit manager and record professional judgement and mitigation on SafeCare. All matrons or deputies then participate in the daily 10.30 safe staffing meeting, where each clinical area is systematically reviewed for staffing risks and outstanding concerns. Where risks cannot be mitigated within the care group, the lead matron reviews enhanced care requirements, supernumerary staff and available capacity across other areas. Agreed staffing moves and redeployment are recorded on SafeCare, with additional professional judgement documented where required. A rating of a 'red' shift in SafeCare indicates unmitigated safety concerns remain.

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

Staffing concerns are escalated through the nursing leadership structure, from ADoN/ADoM to the Deputy Director of Nursing, Midwifery and AHPs, and, where risks cannot be mitigated, to the Director of Nursing, Midwifery and AHPs.

9.0 June and July 2026 SafeCare Red Shifts

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

10.0 Recommendations

The Quality Committee is asked to:

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

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

3rd September 2026

Finance Report Month 5 August – 2026/27

Author

Director of Finance – Jordan Mckie

Deputy Director of Finance – Karen Scarth

26/27 Finance summary as at August

26/27 ACTUAL YTD

£-18.9M

PLAN £-8M DEFICIT

CASH POSITION

£1.4M

MINIMUM BALANCE £2M

CAPITAL SPEND YTD

£8.5M

PLAN £5.2M

RISKS 12+

25 - Cash Position

16 - Delivery of
Financial Plan

16 – Recurrent WRAP
Delivery

26/27 FORECAST

£-0.0M

BEST CASE including £13.5m
deficit support funding.

PAY GROWTH

0.00%

14.17WTE

*49.98 WTE S.TYNESIDE NEW
CONTRACT

*-48.70 WTE DENTAL
DECOMMISSIONED

MTH ON MTH MOVEMENT EXPENDITURE £'s

2%

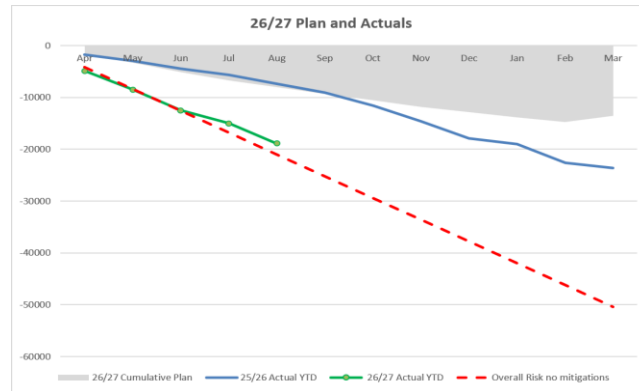
INCREASE

BANK AND AGENCY USE

Agency on target
Bank forecast £2M
off track

In Mth/YTD Summary

	Annual Plan	Mth Budget	Prior Mth Actual	Mth Actual	Movement Mth on Mth	Variance	YTD Budget	YTD Actual	YTD Variance
High Level Analysis	£000's	£000's	£000's	£000's	%	£000's	£000's	£000's	£000's
Commissioner Income	290,113	24,164	24,475	23,979	98%	-185	121,958	121,546	-412
Directorate Income	131,818	11,144	11,335	10,909	96%	-235	55,415	55,628	214
Pay Costs	-301,792	-26,397	-25,886	-25,901	100%	496	-132,695	-132,346	349
Non Pay Costs	-120,139	-9,439	-12,298	-12,941	105%	-3,501	-46,481	-63,835	-17,354
Expenditure	-421,931	-35,836	-38,184	-38,841	102%	-3,005	-179,176	-196,181	-17,005
Surplus / (Deficit)	0	-528	-2,374	-3,953	166%	-3,425	-1,803	-19,006	-17,203
Budget phasing		-741				741	-6,229		6,229
Donated Assets/Depreciation			5	134		134		141	141
Revised Surplus/(Deficit)	0	-1,269	-2,369	-3,819	161%	-2,550	-8,032	-18,865	-10,833



In Mth/YTD Variance Summary

£-3.8M
ACTUAL
£-2.3M
PLAN
£-2.5M
VARIANCE

£-18.8M
ACTUAL
£-8M
PLAN
£-10.8M
VARIANCE

Type	Prior Mth £000's	Current Mth £000's	Narrative	YTD £000's	Narrative
Income	£-0.4m	£0.4m £130k £38k	- Additional Income (Cancer Alliance and Misc Income) - Drug contract - Ripon N House over accrued income - EQA Income no longer will receive	£0.4m	Drugs under contract plan
Pay		£70k £20k	- Ripon N House GP contract issue - VSM Pay award April-August	£73k £300k £100k £70k	- Dental decom - Strike - Thornbury 247 care - Ripon NHouse GP contract dispute
N Pay	£1.3m	£1.6m £30k £170k £100k	- WRAP delivery - NHSP Property True up 25/26 - In tariff Drugs - Joint Venture CUF Increase and additional charge	£6.1m £25k £30k £100k £1.7m	- WRAP delivery CR - Dental decom - NHSP True Up 25/26 - JV CUF increase and reconciliation items - Prior Year (P and N Pay)
Total	£0.8m	£3.8m	Decline from prior month	£10.8m	

Key Items in Month

- ICB top up for pay award factored into the position, still awaiting final settlement.
- Cash support requirement continues September application being submitted. Cash support for July rejected/awaiting outcome for August.
- Capital spend on track, further queries to respond back to NHSE for CDC case.
- Agency spend within NHSE targets however bank spend is forecasting £3.5m overspend against target. (10% and 30% reduction expected).
- Plan now finalised with NHSE, £13.5m deficit supported with DSF £13.5m along with £0.5m turnaround support.

YTD Summary & Forecast

£-18.9M

ACTUAL
VARIANCE

£-13.5M

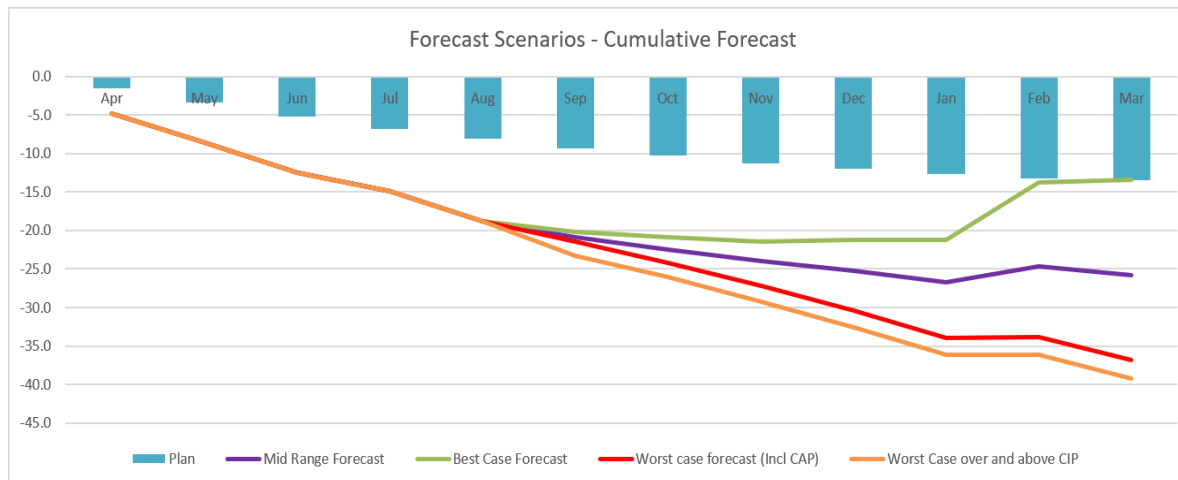
BEST

£-25.8M

MID

£-36.9M

WORSE (RUN RATE)



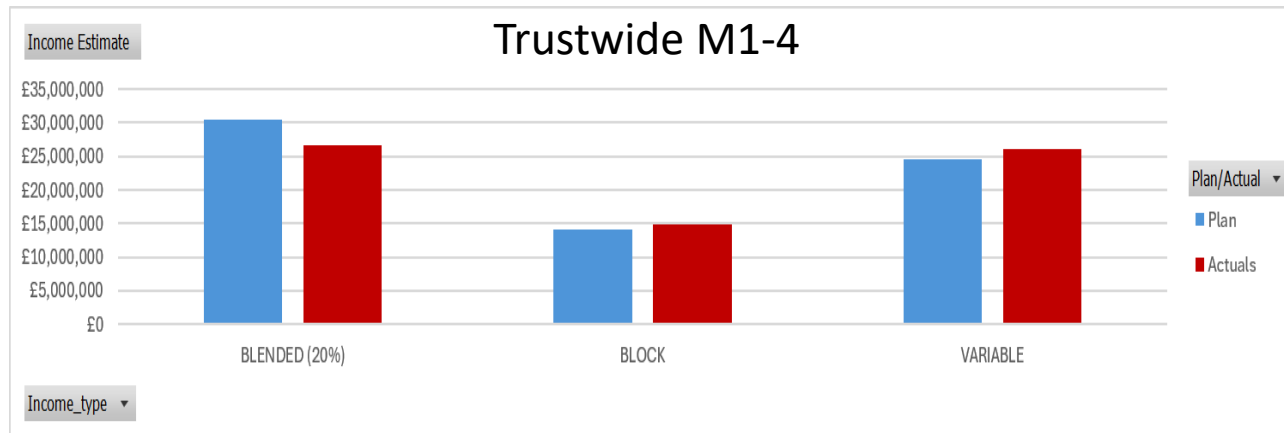
Areas of concern for 26/27

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

Mitigations agreed

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

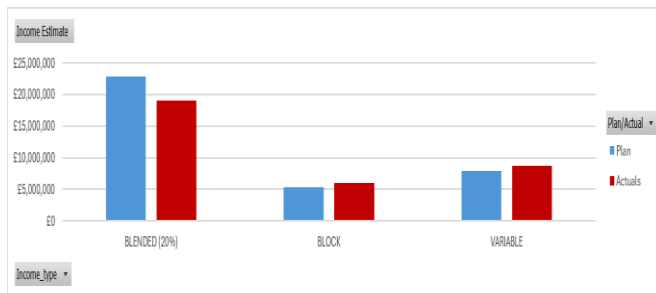
PFR reported forecast breakeven as assumed £13.5M Deficit Support Funding



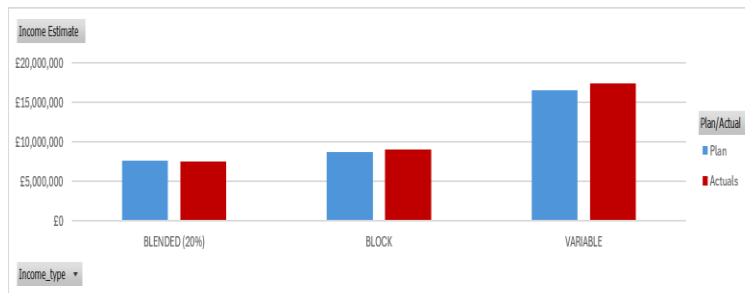
Headlines:

- Overtrading on block elements of contract (PSC and LTUC), no additional payment will be received for this.
- Risk - Coding proportion is 60% uncoded estimate is £9,711,811.

LTUC M1-4

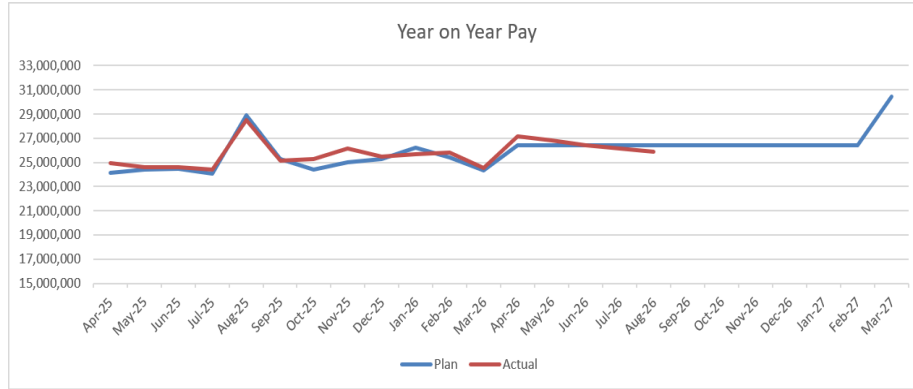


PSC M1-4



- LTUC – Under Acute Internal Medicine (Non Electives) £3.5m
20% £0.7m

Year on Year



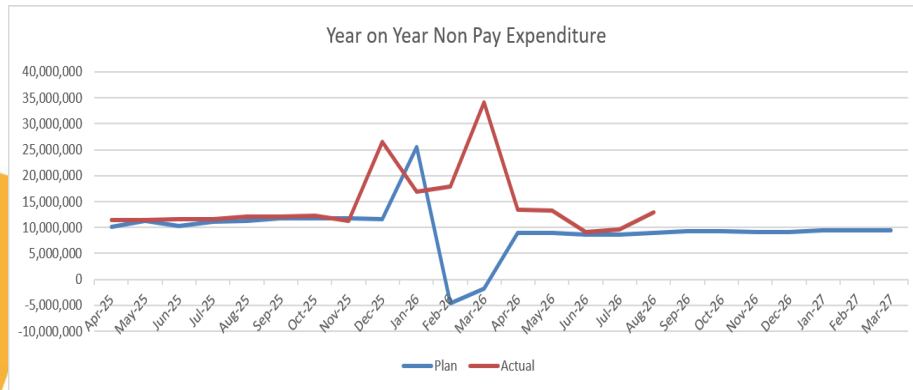
25/26 Plan went through a forecast protocol change, Qtr 4 plan amended.

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

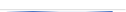
Non Pay budget plans include WRAP targets.

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

Plan phasing not been updated for NHSE signed off plan for 26/27, £15.3m deficit to £13.5m deficit supported by DSF (resulting in a breakeven position).



Non Pay Expenditure

Non Pay Expenditure	April	May	June	July	August	Trend	Mth on Mth Movement
Amortisation: Owned Assets	200,017	219,642	219,632	218,655	218,649		-6
Audit Fees and Other Auditor Remuneration	29,255	27,152	22,736	20,442	25,752		5,310
Clinical Negligence	814,237	814,237	728,219	822,839	814,237		-8,602
Consultancy	29,765	29,988	28,411	62,201	38,856		-23,345
Depreciation: Donated and Government Granted Assets	44,377	44,351	44,372	29,789	29,783		-6
Depreciation: Finance Leased Assets	186,504	186,502	186,183	186,172	182,002		-4,170
Depreciation: Owned Assets	673,759	673,916	673,769	665,488	665,531		43
Drugs Costs (Drug Inventory Consumed and Purchase Of Non-Inventory Drug	2,142,938	2,279,102	2,031,974	2,220,111	2,409,471		189,360
Education and Training - Non-Staff	27,458	36,330	2,496	-16,065	121,184		137,249
Establishment	209,674	178,830	215,185	191,763	197,957		6,194
Increase/(Decrease) In Impairment Of Receivables	-2,041	-730	-1,099	1,212	-842		-2,054
Interest On Finance Leases	64,254	65,213	62,593	62,363	63,906		1,543
Operating Lease Expenditure (net)	38,194	37,789	-26,415	-43,874	-61,323		-17,449
Other	595,193	530,442	664,415	566,490	599,324		32,834
Other Finance Costs	-59,267	-54,513	-40,099	-39,566	-41,648		-2,082
PDC Dividends Payable	555,000	555,000	555,000	555,000	555,000		0
Premises - Business Rates Payable To Local Authorities	120,825	118,510	124,324	111,512	137,315		25,803
Premises - Other	2,048,439	1,636,122	539,289	1,333,235	1,407,710		74,475
Purchase Of Healthcare From NHS Bodies	745	-14,415	792	792	792		0
Purchase Of Healthcare From Non-NHS Bodies	259,823	-100,495	69,963	48,651	72,850		24,199
Research and Development - Non-Staff	0	0	0	-5,679	0		5,679
Supplies and Services - Clinical (Excluding Drugs Costs)	2,908,346	3,363,588	3,272,352	2,720,843	2,932,647		211,804
Supplies and Services - General	2,378,658	2,406,065	2,449,033	2,439,838	2,427,087		-12,751
Transport	166,100	148,285	159,615	144,292	144,473		181
Unwinding Of Discount On Provisions	0	0	0	1,560	0		-1,560
Grand Total	13,432,253	13,180,911	11,982,740	12,298,064	12,940,713		642,649

Key Points

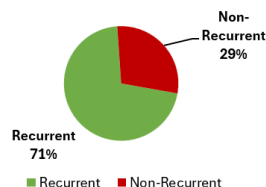
- Most noticeable movement in clinical supplies, prior month release of long standing accruals. £211k
- Drug costs £190k, can fluctuate month on month.
- Training costs £137k (Hosted Services SDN offset by income)

Waste Reduction and Productivity (WRAP)

£2.2m
achieved
£20m
Target

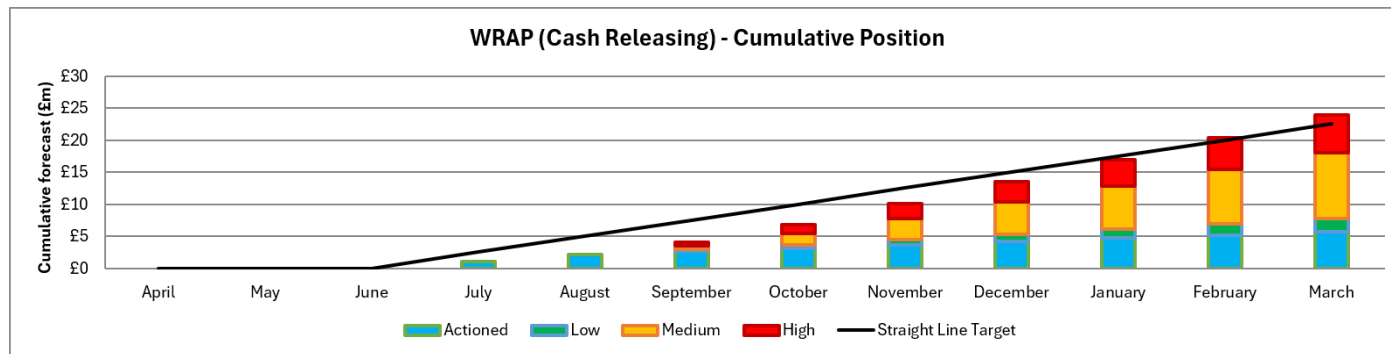
71%
Recurrent

Cash Releasing
Recurrent/Non-Recurrent



£35.9m recovery plans for month 4 onwards consist of **£20m cash releasing (WRAP) schemes**, £4.5m technical and £11.4m income schemes. Further details by recovery plan are shown in the appendix.

At Month 5, £2.2m cash releasing (WRAP) schemes have been actioned with a 26-27 full year impact of £5.7m. Current plans show £3.8m above the target though a gap of £6.2m risk adjusted.



26-27 Plans (Full Year)									
Directorate / Area	Target	Actioned	Low	Medium	High	Total	Shortfall	Risk Adjusted Plans	Risk Adjusted Shortfall
Central	676,532	£0	£770,833	£1,700,000	£0	2,470,833	-1,794,301	1,428,125	-751,593
Corporate	1,732,153	£276,968	£347,838	£1,203,443	£4,083	1,832,333	-100,180	1,140,589	591,564
CYP	0	£641,431	£0	£2,443	£695,944	1,339,818	-1,339,818	816,638	-816,638
HIF	1,900,000	£296,449	£0	£0	£1,600,219	1,896,668	3,332	696,504	1,203,496
LTUCC	6,978,266	£1,791,846	£69,333	£3,403,395	£1,613,007	6,877,582	100,685	3,948,796	3,029,471
PSC	8,713,049	£2,654,574	£845,795	£3,976,725	£1,998,414	9,475,508	-762,459	5,776,886	2,936,163
TOTAL	20,000,000	£5,661,268	£2,033,800	£10,286,007	£5,911,666	23,892,741	-3,892,741	£13,807,538	6,192,462

Balance Sheet

	2024/25	2025/26	2026/27
	Ending balance	Ending balance	Ending balance as at August
Non-current assets			
Intangible assets	12,856	18,942	20,228
Other property, plant and equipment (excludes leases)	163,703	194,429	196,534
Right of use assets - leased assets for lessee (excludes PFI/LIFT)	7,473	6,267	5,656
Investments in joint ventures and associates	0	160	0
Other investments / financial assets	0	0	3,634
Receivables: due from NHS and DHSC group bodies	424	361	361
Receivables: due from non-NHS/DHSC group bodies	510	664	298
Credit Loss Allowances	-97	-98	-87
Other assets	0	0	0
Total non-current assets	184,869	220,725	226,624
Current assets			
Inventories	4,528	3,766	3,285
Receivables: due from NHS and DHSC group bodies	6,096	12,155	10,854
Receivables: due from non-NHS/DHSC group bodies	26,578	25,832	26,061
Credit Loss Allowances	-601	-380	-387
Cash and cash equivalents: GBS/NLF	7,014	6,098	1,261
Cash and cash equivalents: commercial / in hand / other	1,164	262	178
Total current assets	44,779	47,733	41,252
Current liabilities			
Trade and other payables: capital	-8,098	-840	-1,144
Trade and other payables: non-capital	-28,811	-50,131	-49,203
Borrowings	-3,266	-2,476	-6,426
Provisions	-96	-96	-547
Other liabilities: deferred income including contract liabilities	-1,934	-209	-3,381
Total current liabilities	-42,205	-53,752	-60,701
Total assets less current liabilities	187,443	214,706	218,489
Non-current liabilities			
Borrowings	-11,847	-10,638	-5,355
Provisions	-552	-459	0
Total non-current liabilities	-12,399	-11,097	-5,355
Total net assets employed	175,044	203,608	208,375

Cash

- Continues to be a concern (separate slide details position).

Receivables

- Include York payment in advance £0.6m not been allocated against invoices yet.
- Pathology JV IPS/ILS reconciliation needed.

Cash

£1.4M
(AUGUST 2026)
£0.8M
(JULY 2026)
MINIMUM CASH BALANCE
£2M

BPPC
Paid within 30 days

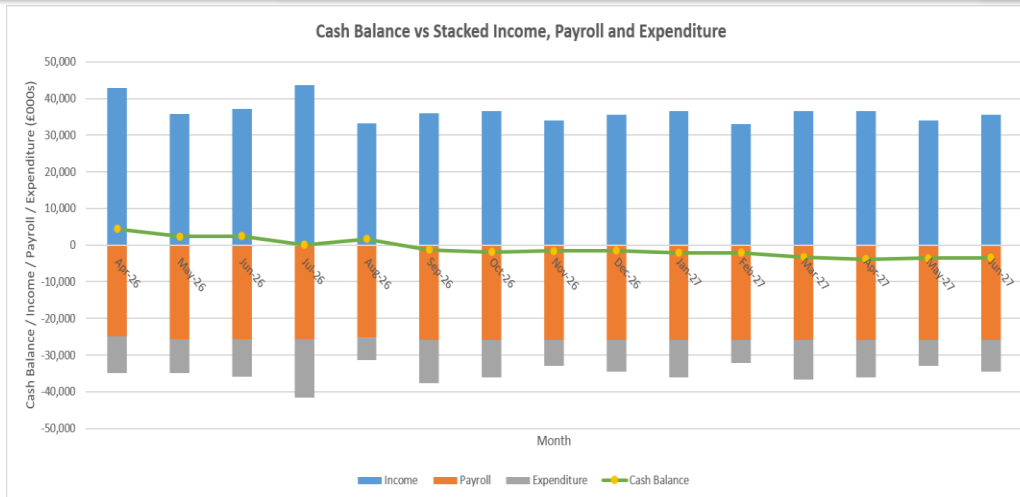
15.2%

No of Invoices

35.8%

Value of Invoices

TARGET 95%



Cash Support	In Plans	Requested	Approved
April	£31.7m	£9.5m	£4m
May	£4m	£4m	£2m
June	£4m	£1.8m	£1.8m
July	£3.8m	£3.2m	£10m
August	£1.3m	£1.4m	£0m
September	£1.3m	£1.3m + £4.5m	£5.8m
October	£1.3m	£4.3m	

****£4.5m Emergency cash applied for at the start of September due to the cash forecast for the month.**

Cash support total £14.6m received 25/26.

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

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

£14m+ approved Supplier payments on hold as cash is being managed within set weekly thresholds. Supplier relationships are becoming more strained and accounts have been put on hold.

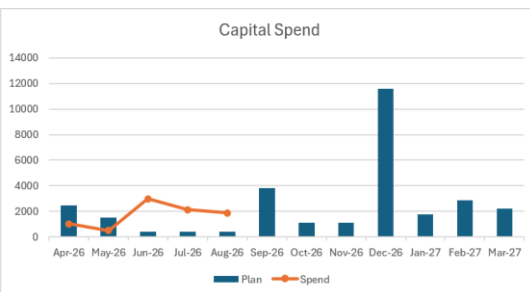
Revenue cash covering capital PDC schemes as MOU's/B/cases approval outstanding.

Future cash requests will build in working capital requirements.

Capital

£8.5M

SPEND YTD
INCL IFRS16



CDEL Assumptio	Description	Scheme ID	Plan	Actua	Foreca
CDEL Schemes					
	IT	IT	210	271	391
	RAAC/TIF2	RA/T2	2,200	2,476	4,922
	EPR	EPR	2,500	878	2,500
	Carry Forward Schemes from 25.26	PRIOR YEAR		128	227
	Staff Survey	SURVEY	250	8	190
	MRI Scanners		2,000	0	2,000
	HIF Management Fee		500	0	500
	Repayment to Hull/NLAG		1,051	1,051	1,051
	Aseptics £336k - reduced allocation				
	Interest 25/26	INTEREST	1,977	1,977	1,977
	Contingency	CONT		33	159
	Unknown - tbc	UNKNOWN		-4	0
	RTT Target delivered 25/26 - CDEL allocation £2m			0	0
	IFRS16			0	0
	Balance		-2,426		
Total Plans against CDEL			8,262	6,818	13,916
PDC Schemes (Non CDEL)					
Confirmed	Estates RAAC (Stores/IT/Energy Centre)	RAAC - OTHER	4,167	1,293	4,167
Confirmed	Estates RAAC Other		8,300	0	2,900
Confirmed	Constitutional Standards - Imaging CT Scanner	CSCT	660	0	660
TBC	Constitutional Standards - Ultrasound	CSUL	250	6	250
TBC	Constitutional Standards - CDC - Lease	CDCL	5,000	0	5,000
TBC	Constitutional Standards - CDC - Equipment	CDCE	3,000	244	3,000
TBC	Estate Safety - Fair Share	ESTFSAFE	1,800	20	1,800
	Balance		0		
Total Non CDEL Schemes			23,177	1,564	17,777
Grants					
	Research 3T MRI Scanner	3TMRI	1,225	0	1,225
	Salix Phase 4	SALIX4	1,950	144	1,950
Total Grants			3,175	144	3,175
Total Capital Programme			34,614	8,526	34,868

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

Agency

£54K

IN MTH

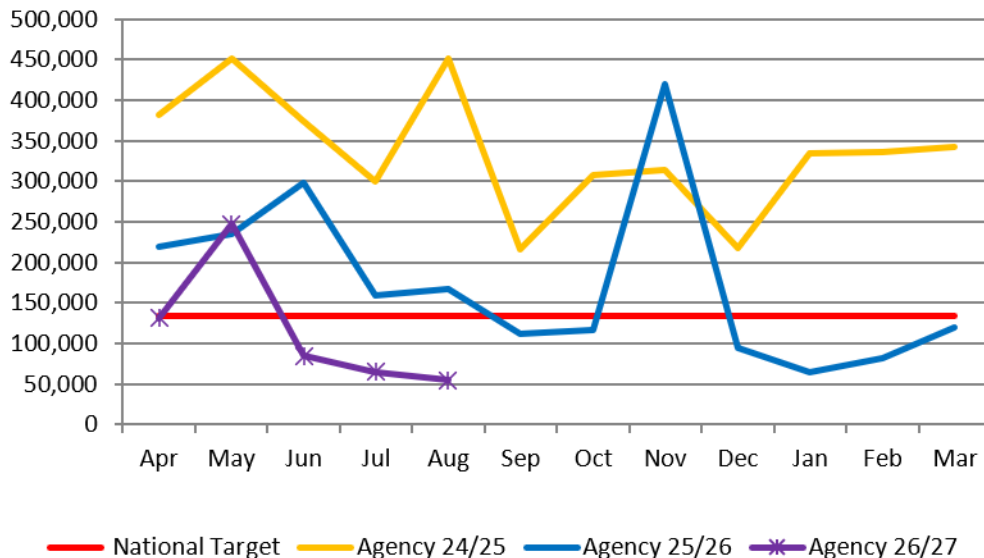
£1.4M

FORECAST

£1.6M

NHSE TARGET

Agency Expenditure By Month



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

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

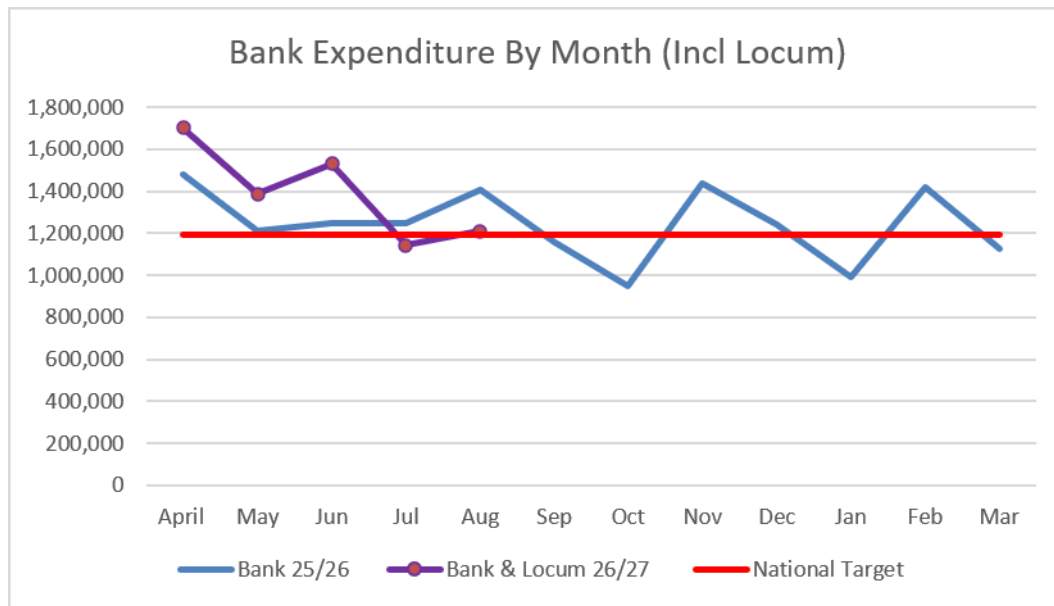
Consultant spend is the biggest driver of agency spend due to sickness and vacancies.

Bank & Locum

BANK
£495k
IN MTH
£7.3M
FORECAST

LOCUMS
£715k
IN MTH
£9M
FORECAST

£14.3M
NHSE TARGET



Slight increase in bank and locum spend in month.

NHSP rates are now at top of band versus mid point at the same point last year, £3m impact in 25/26. However, it has been approved to return to mid point for Qlfd bank nurses from August.

The majority of bank spend is around nursing.

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

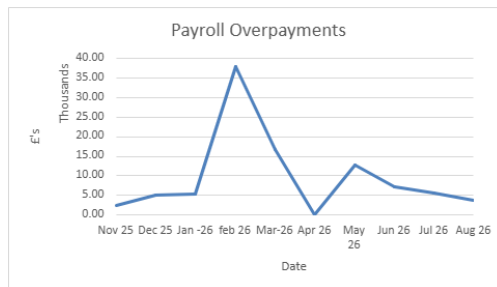
PFR reporting has been updated so that locum spend is now reported under substantive as per national mapping.

Watch Metrics

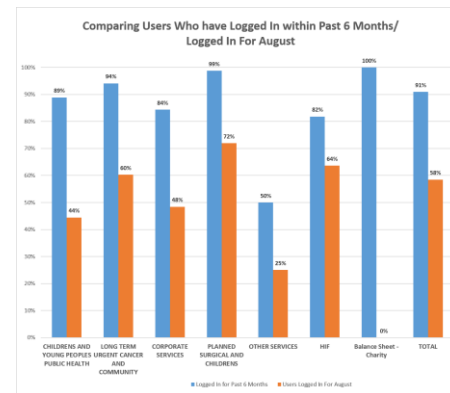
RETROSPECTIVE PO's

No of		Total No of PO's		% of PO's Raised	
Last Month	Current Month	Last Month	Current Month	Last Month	Current Month
51	30	993	830	5%	4%

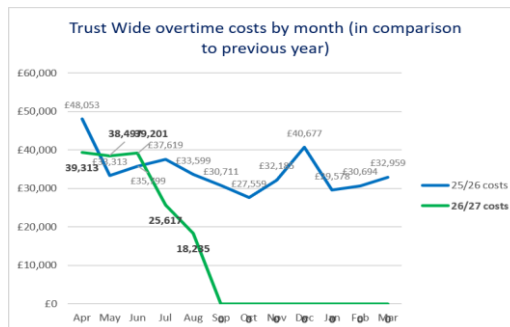
PAYROLL OVERPAYMENTS



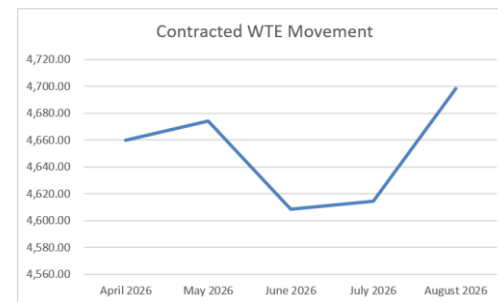
REACH ACCESS ACCESS BUDGET REPORTS



OVERTIME



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



Appendix:

Recovery Plans – 26/27

Recovery Plans – 26/27

Theme	Initiative/ Scheme	Overview	Key savings delivery assumptions	Delivery Assurance	SRO / Clinical & Ops Leads	Best case (£m)	Mid Case (£m)	Delivery (£m)
WORKFORCE	R1. Recruitment Pause	Recruitment Pause from M3 onwards.	•Trust turnover 8% and assume only recruit back to 2%. •Affordable establishment reviews undertaken by all areas aligned to specific targets. •Cross covers with work around community contracts and aligning within financial limits. •Enhanced vacancy controls with an extension of the recruitment pause •Trustwide panel to assess all recruitment requirements against agreed control criteria. •	Workforce Controls FROG	DoPC & DoF OD's	7.7	3.85	1.2
	R2. Limit Temporary Staffing	Limit Temporary Staffing to meet existing establishments	•Reduce baseline expenditure by 46% •NHSP rates reduced to mid-point. •Medical staffing rates reviewed •Absence management •Promote staff wellbeing and preventative initiatives to reduce avoidable absence	FROG	DoNMAHP, MD, DoPC	3.3	1.65	0.41
	R3 .Reduce Premium Capacity	Reduce premium capacity whilst maintaining activity levels (WLI)	•Maximise core capacity through enhanced productivity and approval controls •No subsequent loss in income •	FROG	COO & DoF	1	0.75	0.09
	R4. Real Living Wage	Remove Real Living Wage for future staff appointments	•New starters appointed at a lower cost than RLW leavers •No further inflation added to those in current receipt of RLW •No RLW applied to new starters •Pay Award 27/28 will exceed current top ups	FROG	DoPC & DoF	0.1	0.075	0.00
TOTALS						12.1	6.32	1.70

Theme	Initiative/ Scheme	Overview	Key savings delivery assumptions	Delivery Assurance	SRO / Clinical & Ops Leads	Best case (£m)	Mid Case (£m)	Delivery £m
NON PAY	R5. Divisional Non Pay Actions		•Linked to WRAP schedules prior to refresh.		OD's	1.5	0.75	0.21
	R6. Procurement BAU		•Managing of contracts due for renewal. •Product switches •Working in collaboration with WY and HNY systems.		DoF	0.5	0.37	0
	R7. Clinical demand Management	Clinical demand management	•Reduction in Direct Access in Pathology •Redesign of pathways with Primary Care •Reduction in inpatient referrals		COO			0
	R8. Discretionary Spend	Prevent discretionary spend	•Discretionary spend panel in place. •Weekly monitoring		DoF	Part of R5 & R6		0
	R9. Drugs	Drugs	•Biosimilar switches		DCEO/MD/COO	0.9	0.675	0
	R10. Estates General	Maintenance Improvement Space and Estate rationalisation	•Automated cleaning •Renegotiate Hard FM service contracts •Condense existing estate; Podiatry review post-dental •VAT on community sites •HDH site depreciation (technical adjustment)		MDHIF	0.3	0.15	0
	R11. Estates Utilities	Technology enablers to improve efficiency of Energy utilisation	•Occupancy review •AI driven HVAC optimisation/smart lighting •Smart water and waste management		MDHIF	0.2	0.1	0
	R12.EPR Anticipated benefits		•Delivery of ERP benefits described in B/Case		DCEO/MD	0.8	0.6	0
TOTAL						4.2	2.64	0.21

Theme	Initiative/ Scheme	Overview	Key assumptions	Delivery Assurance	SRO / Clinical & Ops Leads	Best case (£m)	Mid Case (£m)	
Managing Capacity	R14. Closing capacity	Community	Community service reviews to ensure costs are managed within contractual values, GP OOH (Ham & Rich and Harrogate), Podiatry and Specialist Children's.		COO	1.6	1.2	0
	R14. Closing capacity	Acute	- Contracting acute capacity - No additional winter capacity			1.7	0.86	0
TOTALS						3.3	2.06	0

Theme	Initiative/ Scheme	Overview	Key assumptions	Delivery Assurance	SRO / Clinical & Ops Leads	Best case (£m)	Mid Case (£m)	
COMMERCIAL	R16. Research and Development	Research and Development Income	- Commercial Income opportunities - Timely recruitment to studies - Timely invoicing		MD	0.15	0.112	0.11
	R17. Private Patients	Private Patients opportunities	- Review existing model and market comparison - Strategic decision on a dedicated area - Assessment current capacity, pricing and market position. - ensure payment in advance for self-payers - timely invoicing to insurance companies - prompt debt collection		COO	0.15	0.075	.06
	R18. Charity	Opportunities for charity to support services	- Enhancing patient care - Improving staff experience - Examples include play therapists and staff training - addition of Corporate overhead charge			0.1m	0.075	0
TOTALS						0.4	0.26	0.17

