Board of Directors Meeting Held in (Public)

To be held on Wednesday, 25th November 2026 at 1.00pm – 3.45pm

Venue: Boardroom, HDFT, Strayside Wing, Harrogate District Hospital

Lancaster Park Road, Harrogate, HG2 7SX.

AGENDA

All items listed in blue text (throughout the agenda), are to be received for information/ assurance and no discussion time has been allocated within the agenda. These papers can be found in the supplementary pack.

Item No.	Item	Lead	Action	Paper
SECTION 1: Opening Remarks and Matters Arising				
1.1	**Welcome and Apologies for Absence**	Chair	Note	Verbal
1.2	**Patient Story**	Deputy Director Nursing, Midwifery and AHPs	Discuss	Verbal
1.3	**Register of Interests and Declarations of Conflicts of Interest**	Chair	Note	Attached
1.4	**Minutes of the meeting held on 30th September 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	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

Item No.	Item	Lead	Action	Paper
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 4.2.1	**Board Assurance Framework:** Finance AP Finance Board Report	Finance Director / Resource Committee Chair	**Approve**	Attached Supp Pack 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	Freedom To Speak Up Guardian Annual Report	Chief People Officer	Note	Attached
SECTION 6: Ambition: Enabling Ambitions				
6.1	**Board Assurance Framework:** Digital Transformation and Maturity to Integrate Care and Improve Patient, Child and Staff Experience	Medical Director & Innovation Committee Chair	**Approve**	Attached
6.2	**Board Assurance Framework:** Healthcare 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	**Emergency Preparedness Statement**	Chief Operating Officer	Note	Attached

Item No.	Item	Lead	Action	Paper
SECTION 8: Governance Arrangements				
8.0	**Any Other Business** *By permission of the Chair*	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 27th January 2027 at 1.00 – 3.45pm Venue: Boardroom, Trust Headquarters, Harrogate District Hospital			

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

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

Board of Directors – Register of Interests

As at 26th October 2026

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

Board Member	Position	Relevant Dates From	To	Declaration Details
	March 2025 to March 2026)			
Breeda Columb	Executive Director of Nursing, Midwifery & AHPs	June 2025	Current	1. Familial relationship with a Leeds Teaching Hospitals NHS Trust employee
Jonathan Coulter	Finance Director Chief Executive from March 2022	March 2022	Current	No interests declared
Jeremy Cross	Non-executive Director	January 2020	Current	1. Chairman, Tipton Building Society 2. Chairman, Forget Me Not Children's hospice, Huddersfield 3. Member, Kirby Overblow Parish Council 4. Stakeholder Non-executive Director, Harrogate Healthcare Facilities Management Limited t/a Harrogate Integrated Facilities (a wholly owned subsidiary company of Harrogate and District NHS Foundation Trust)
Chiara De Biase	Non-executive Director	May 2024 February 2026 May 2026	Current Current Current	1. Director of Health Services, Equity & Improvement, Prostate Cancer UK 2. Interim Fundraising and Health Strategy Director, Prostate Cancer UK 3. Senior Independent Trustee for Yorkshire Cricket Foundation
Adrian Ennis	Financial Recovery Director	August 2026	Current	No interests declared
Ann Johnson	Advisor to the Board	July 2026	Current	1. Advisor to NHS England CFO and NEY region
Chris Mannion	Chief People Officer	September 2026	Current	No interests declared
Jordan McKie	Director of Finance (from July 2023)	August 2022	Current	1. Chair, Internal Audit Provider Audit Yorkshire
Colin Melville	Non-Executive Director	September 2025	Current	1. Trustee, Faculty of Medical Leadership and Management 2. Fellow, Royal College of Physicians, London 3. Fellow, Royal College of Anaesthetists

Board Member	Position	Relevant Dates From	To	Declaration Details
		October 2026		4. Fellow, College of Intensive Care Medicine 5. Honorary Fellow, Academy of Medical Educators 6. Senior Fellow, Faculty of Medical Leadership and Management 7. Honorary Professor, University of Manchester 8. Visiting Professor, Anglia Ruskin University 9. Nephew is an employee of HDFT (non-decision maker) 10. Non-Executive Director, Sheffield Teaching Hospitals NHS Foundation Trust
Julia Nixon	Chief Operating Officer	July 2026	Current	No interests declared
Andrew Papworth	Non-executive Director	March 2020 April 2026	Current Current	1. Chief Finance Officer, Insight222 2. Ambassador for Action for Sport 3. Director of PPY Advisory and Consulting
Wallace Sampson OBE	Non-executive Director	March 2020 July 2023 August 2023 September 2023 October 2023 August 2024	Current Current Current March 2025 Current Current	1. Member of Society of Local Authority Chief Executives 2. Advisory Board Consultant – Commercial Service Kent Ltd. 3. Commissioner – Local Government Boundary Commission for England 4. Chair – Middlesbrough Independent Improvement Advisory Board. 5. Director and Shareholder – Sampson Management Services Ltd. 6. Member – Council of Governors, Leeds University
Kate Southgate	Director of Governance and Improvement	May 2025	Current	1. Familial relationship with senior manager at NHS England.
Julia Weldon	Non-executive Director	May 2024 September 2025 June 2026	Current Current Current	1. Fellow of the Faculty of Public Health (FPH) FPH Assessor and Advisor 2. Associate of Local Government Association (LGA) 3. Director of Julia Weldon Executive Leadership Ltd 4. Trustee and Director for Action on Smoking and Health

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

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

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

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

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

BOARD OF DIRECTORS MEETING – PUBLIC (DRAFT)

Wednesday 30th September 2026

Held at Trust HQ, Harrogate District Hospital, Harrogate, HG2 7SX

Present:	
Sarah Armstrong	Trust Chair
Jonathan Coulter	Chief Executive
Jacqueline Andrews	Executive Medical Director, Deputy Chief Executive
Andrew Alldred (AA)	Non-Executive Director
Jeremy Cross (JCr)	Non-Executive Director, Chair of Resource Committee
Chiara DeBiase (CdB)	Non-Executive Director, Chair of Audit Committee
Colin Melville (CM)	Non-Executive Director, Senior Independent Director, Chair of Quality Committee
Andy Papworth (AP)	Non-Executive Director, Vice-Chair
Wallace Sampson OBE (WS)	Non-Executive Director, Chair of Innovation Committee
Julia Weldon (JW)	Non-Executive Director, Chair of People & Culture Committee
Denise Chong (DC)	Associate Non-Executive Director
Breeda Columb	Executive Director of Nursing, Midwifery and Allied Health Professionals
Chris Mannion	Chief People Officer
Jordan McKie	Director of Finance
Julia Nixon	Chief Operating Officer
Kate Southgate	Executive Director of Governance and Improvement

In Attendance:	
Rachel Hewson	Company Secretary
Laura Daffern	Corporate Affairs Team Leader
Kat Johnson	Clinical Director, PSCC *for the Strengthening Maternity and Neonatal Safety report*
Leanne Likaj	Associate Director of Midwifery and Children's Services for the *Strengthening Maternity and Neonatal Safety report*

Observers:	
Governors	Emily Legge, Richard Farrar
Member of the public / press	3
Colleagues	1

Item No.	Item
BD/09/30/1.1 **1.1.1**	**Welcome and Apologies for Absence** The Chair welcomed everyone to the meeting. There were no apologies for absence noted.
BD/09/30/1.2 **1.2.1** **1.2.2**	**Patient Story** The Executive Director of Nursing, Midwifery and AHPs introduced the patient story highlighting improvements in the HDFT asthma pathway, demonstrating collaborative working and improved patient outcomes. The Non-Executive Directors discussed the appropriate use of outpatient services, the impact of specialist review in reducing readmissions and improving outcomes, and opportunities for earlier intervention through primary care prescribing. Members welcomed the improvements in practice, multidisciplinary working and environmental benefits arising from the pathway.

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1.2.3	The Executive Director of Nursing, Midwifery and AHPs agreed to confirm whether the patient story had been shared with the Integrated Care Board.
1.2.4	**Resolved:** The patient story was noted.
BD/09/30/1.3 **1.3.1**	**Declarations of Conflicts of Interest and Register of Interests** There were no new Declarations of Interest.
1.3.2	**Resolved:** The register of interests was received and noted.
BD/09/30/1.4 **1.4.1**	**Minutes of the Previous Board of Directors meeting held on 29 July 2026** The following amendments were noted:
1.4.2	Numbering on CEO report section to be updated to reflect July date.
1.4.3	4.2.1 references finance for 25/26 to be amended to 26/27.
1.4.4	6.4.1 Tim Wilkinson spelling to be corrected.
1.4.5	**Resolved:** The minutes of the meeting on the 29 July 2026 were approved as an accurate record of the meeting noting the amendments above.
BD/09/30/1.5 **1.5.1**	**Matters Arising and Action Log** The Board reviewed the action log.
1.5.2	**BD/03/25/3.2.11**- MNVP funding. Action closed.
1.5.3	**BD/05/27/5.2.2** – GoSW report to be added to workplan. Action closed.
1.5.4	**Resolved:** All actions were agreed as above.
BD/09/30/1.6 **1.6.1**	**Overview by the Chair** The Chair provided an update on the Trust's current position, noting the continued focus on financial recovery and delivery of the agreed financial plan. Significant progress had been made and confidence was expressed that a whole-organisation approach to financial improvement had been embedded. The position had recently been reviewed with NHS England colleagues, including consideration of how financial recovery plans align with the Trust's commitment to providing safe and effective care. It was noted that robust winter planning remained a key priority, particularly given the unusually high levels of demand experienced during the summer period. Members also noted that the annual flu vaccination programme had commenced.
1.6.2	The Chair reflected on the recent Annual Members' Meeting, noting that it had provided a valuable opportunity for engagement with members, governors and the public. Thanks were extended to all those involved in organising and supporting the event.
1.6.3	An update was provided on recent governor development activity, including discussions relating to the Health Bill and potential future changes affecting governors' roles. The Chair welcomed the appointment of former governors as Specialist Advisors to the Council.
1.6.4	The Chair also reflected on the recent Non-Executive Director appraisal process, noting the important role played by governors in providing feedback. Thanks were extended to all governors who participated, particularly the Lead Governor for

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	leading the process. It was noted that governors had invested considerable time and effort in supporting the appraisal process.
1.6.5	**Resolved:** The Chair's report was noted.
BD/09/30/1.7 1.7.1	**Chief Executive Report** The Chief Executive presented his report as read.
1.7.2	The following points were highlighted:
1.7.3 1.7.4	• The Thirlwall Inquiry Report had recently been published and was described as a difficult but important read, particularly in relation to the cultural lessons identified. At the same time, the report into Breast Services at County Durham and Darlington Trust had also been published. It was emphasised that the Trust has a strong organisational culture and a well-established approach to speaking up, but that as a Board we need to constantly reflect and challenge our approach.
        1.7.5	• Nationally, the NHS continues to face challenges in urgent and emergency care performance, elective waiting lists and financial sustainability, reflecting many of the issues experienced locally. There remains a wider challenge regarding public confidence in the NHS. The recently appointed Secretary of State had referenced these issues. The National Oversight Framework (NOF) comprises 57 indicators and the Trust performs strongly across many of these measures, whilst recognising the relative weighting and hierarchy of the indicators. The Trust's financial recovery plan was approved in early August and includes a planned deficit of £13.5 million, supported through agreed deficit funding.
          1.7.6	• The Trust's Mid-Year Review with NHS England had taken place on Monday. Key risks highlighted included the pace of delivery required over the remaining seven months of the financial year, the need to manage the very difficult cash position, the challenge of managing winter pressures, and maintaining constructive relationships with the Integrated Care Board (ICB). The review also considered plans for 2027/28, with an expectation of achieving a balanced financial position. The current improvement work is intended to ensure the Trust starts next year from a stronger position. Discussion also included community services, where resources may need to be recommissioned in future. The Community Services Review is expected to complete its planning phase by December; however, formal approval to commence the review has not yet been received and it will therefore not inform planning for the current year.
1.7.7	• The Trust's Futures Programme, which had been discussed at a recent Board development session had formally launched the previous day. The development of neighbourhood health models was also highlighted, following a health and wellbeing workshop held several weeks earlier.
1.7.8	• At West Yorkshire level, discussions are underway regarding priorities for the coming year, including opportunities to consolidate pathology services, the delivery of the aseptics programme and maximising the capability and utilisation of Wharfedale Hospital.
	• The importance maintaining staff engagement was emphasised to ensure the organisation continues to listen to colleagues and respond appropriately to concerns and feedback. The Trust continues to benefit from strong quality governance arrangements, which will be particularly important as it enters the winter period. Performance against the NOF remains positive, with strong outcomes in cancer services, maternity services and community

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1.7.9	services. The Electronic Patient Record (EPR) system is now established, and patient feedback is generally positive.
1.7.10	The Non-Executive Director (AP) sought clarification on the Community Services Review. The Chief Executive confirmed that the review is led by the ICB and requires regional approval. It was noted that some recovery actions would proceed ahead of the review and that the Trust had requested clarity on the timetable.
1.7.11	The Non-Executive Director (WS) highlighted the importance of clear communications to articulate the vision and intended future state of the organisation through the HDFT Futures Programme and noted that this narrative had not yet been clearly communicated.
1.7.12	The Chief Executive acknowledged the point and advised that further discussion was planned for the Board development workshop in October, including how the various transformation and improvement programmes align and fit together.
	Resolved: The Chief Executive's Report was noted.
BD/09/30/2.1	**Board Assurance Framework – Best Quality, Safest Care**
2.1.1	The Executive Director of Nursing, Midwifery and AHPs provided the Board with an update on the Strategic Ambition: Best Quality, Safest Care.
2.1.2	The first metric was eliminating moderate and above harm with the goal of a 20% reduction in number of events reported. Performance is currently on track to achieve the target, although 11 incidents remain subject to validation. One Never Event has been declared during the current year.
2.1.3	Under the Clinical Effectiveness programme, all services have been reviewed and awarded a Bronze, Silver or Gold rating. The next phase of work will focus on understanding how services benchmark against peers and embedding the framework into business-as-usual arrangements.
2.1.4	An update was provided on the patient experience metric. The initial objective is to increase Friends and Family Test response rates by 10% over the course of the year. Improvement has been seen up to August.
2.1.5	On the Clinical Services Strategy (CSS) the Single Point of Contact work has been paused pending a review of strategic priorities. Neighbourhood Health work will transfer into the Futures Programme.
2.1.6	The Breakthrough Objective checklist review is assessing compliance, the effectiveness of existing controls, and arrangements for auditing checklist completion.
2.1.7	It was confirmed that there are currently no corporate risks associated with this area of work.
2.1.8	The Non-Executive Director (CM) noted that the Quality Committee had undertaken a more detailed review and deep dive into the BAF and had considered the issues carefully. The Committee was assured that there had been no deterioration in patient safety performance as a consequence of the Trust's current financial position.
2.1.9	**Resolved:** The Board Assurance Framework: Best Quality, Safest Care was noted and approved.

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BD/09/30/2.2 **2.2.1**	**Thirlwall Report** The Executive Director of Nursing, Midwifery and AHPs provided an update on the publication of the Thirlwall Inquiry Report on 15 September, which followed the events at the Countess of Chester Hospital. The report highlighted concerns that staff voices were not being heard at Board level and identified significant failures in governance. A letter has subsequently been issued by Duncan Burton and Sarah-Jane Marsh on 21 September, which sets out a number of immediate actions and longer-term recommendations for NHS organisations.
2.2.2	Key national recommendations highlighted in the report included a programme of work to ensure all neonatal cots are fitted with baby monitoring systems, a review of safeguarding arrangements for children, the development of regulatory arrangements for NHS managers, and the implementation of a national bereavement pathway.
2.2.3	Members were advised that immediate action had been taken in relation to the Sudden Unexpected Death in Childhood (SUDIC) protocol. Staff had been reminded urgently of when and how the SUDIC process should be applied, namely in any death of a child under the age of 18 that would not reasonably have been expected 24 hours previously. It was confirmed that this communication had been issued directly to all staff and reinforced through team briefings and the staff bulletin.
2.2.4	The Board noted the requirement to review access to insulin storage. Where access controls are dependent on biometric verification, arrangements must be in place by March 2027. Where this is not achievable, CCTV monitoring must be implemented by November 2026. It was noted that insulin is not stored within the neonatal unit. Insulin stored on the children's ward is held within an Omnicell system requiring biometric access. A full risk assessment will be completed by 30 November 2026.
2.2.5	Assurance was provided that both staff and Board members remain compliant with safeguarding requirements. Information relating to the Thirlwall recommendations has been published on the Trust website, and letters have been sent to all staff working within neonatal and paediatric services, including details of support available to them.
2.2.6	The Non-Executive Director (CM) advised that regular meetings are held with the Freedom to Speak Up Guardians. Referring to safeguarding training compliance data included within the report, he noted that he was satisfied that the required training was being undertaken.
2.2.7	The Non-Executive Director (AP) queried safeguarding compliance figures and was advised that the apparent shortfall related largely to a recording issue within one staff group, with staff booked onto the required training. The Non-Executive Director (AA) referenced previous discussions on safeguarding and speaking up, and suggested consideration be given to renaming the Maternity Champion role to better reflect neonatal responsibilities.
2.2.8	The Non-Executive Director (CdB) sought assurance on the bereaved parents pathway and was advised that maternity services have a dedicated Bereavement Midwife, supported by wider bereavement training for staff. The Non-Executive Director (JCr) highlighted the value of links with children's hospices and noted that, while the recommendation regarding neonatal cot cameras was clear, there are differing views on its implementation.

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2.2.9	The Chair emphasised the importance of Board visibility and accessibility and noted that concerns raised directly with Board members would be listened to and taken seriously.
2.2.10	**Resolved:** The Report was noted.
BD/09/30/2.3 **2.3.1**	**Learning from Deaths Q1 Report** The Executive Medical Director advised that the Trust's Medical Examiner service scrutinises all deaths occurring within the organisation, including neonatal deaths, and also reviews deaths occurring within community services.
2.3.2	**Resolved:** The report was noted.
BD/09/30/2.4 **2.4.1**	**Safeguarding Annual Report** **Resolved:** Following review at the Quality Committee, the Safeguarding Annual Report was noted.
BD/09/30/2.5 **2.5.1**	**IPC Annual Report** **Resolved**: Following review at the Quality Committee, the IPC Annual Report was noted.
BD/09/30/2.6 **2.6.1**	**Nursing and Midwifery Quality and Safer Staffing Report** **Resolved**: Following review at the Quality Committee, the Nursing and Midwifery Quality and Safer Staffing Report was noted.
BD/09/30/3.1 **3.1.1**	**Board Assurance Framework – Great Start in Life** The Executive Director of Nursing, Midwifery and AHPs provided the Board with an update on the Strategic Ambition: Great Start in Life.
3.1.2	On the Early Intervention and Prevention programme for children at risk of vulnerability, performance against the mandated contacts metric remains strong, with 90% of mandated contacts achieved. The reported data now includes South Tyneside. Across the 12 local authorities, there are five mandated contacts, with 56 of the required 60 contacts completed during August. South Tyneside achieved all mandated contacts in its first month of reporting.
3.1.3	In relation to child and patient experience, the objective to increase engagement with children and young people and improve response rates was achieved in August. Feedback remained positive, with no respondents rating their care as poor or very poor.
3.1.4	On the Breakthrough Objective to create a research active culture, 14 participants were recruited during the reporting period, representing an increase of three compared with the previous month. Performance remains on track to deliver the agreed target.
3.1.5	The Board noted that autism assessment waiting times remain on the Corporate Risk Register. There had been no material change in position since the previous report.
3.1.6	The Non-Executive Director (CM) commended the service's performance, noting that a small number of metrics did not fully reflect the scale of the service or the improvements achieved, particularly in Cumberland and Westmorland & Furness and following the inclusion of South Tyneside.

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3.1.7	The Non-Executive Directors discussed autism assessment waiting times, noting that the Trust is delivering the level of service commissioned by the ICB but that waiting times remain unacceptably long. The Chief Executive advised that this is a commissioning issue linked to wider community services reviews, with the Trust continuing to escalate the risk and seek action and assurance from commissioners. Assurance was provided that a range of actions were underway, with a more formal update to follow.
3.1.8	The Non-Executive Director (CM) also highlighted the importance of ensuring appropriate support is available for autistic children and young people through safeguarding and related services.
3.1.9	**Resolved:** The Board Assurance Framework: Great Start in Life was noted and approved.
BD/09/30/3.2 **3.2.1**	**Strengthening Maternity and Neonatal Safety Report** The Associate Director of Midwifery and Children's Services and Dr Kat Johnson, Clinical Director, PSCC and Consultant Obstetrician and Gynaecologist were welcomed to the meeting and took the report as read.
3.2.2	The Chair began by recognising the significant amount of work currently taking place within maternity services and thanked colleagues for their continued commitment during a period of considerable activity and change.
3.2.3	The Associate Director of Midwifery and Children's Services presented the report and highlighted that there had been zero no harm incidents reported during August. Workforce establishment remains fully recruited, with a significant reduction in NHS Professionals usage. During August, the maternity service experienced three periods of unit diversion, resulting in 11 women being redirected to neighbouring maternity services. It was noted that this represents one of the busiest periods of the year; however, processes continue to be closely monitored and managed. There had also been 14 delays to induction of labour exceeding 24 hours. Actions are in progress to reduce the number of delays and improve patient flow.
3.2.4	Safeguarding Children Level 3 training compliance for some medical staffing groups remains under review. A themed analysis of complaints identified recurring issues relating to communication, personalised care, responsiveness and postnatal support.
3.2.5	The maternity triage review as part of the Amos response has identified potential workforce requirements. This would be reviewed as part of future planning.
3.2.6	Progress against the Maternity and Neonatal Care Bundle remains on track to meet the March 2027 implementation deadline, although further work is required to ensure all elements are delivered within the timescale.
3.2.7	An update was provided regarding the Trust's response to the Amos and Ockenden recommendations. Strengthened accountability arrangements are now in place, including the shared executive accountability model for maternity and neonatal services. Members noted the attendance of the Clinical Director PSCC, Dr Johnson, during consideration of this item.
3.2.8	Work continues nationally and locally to prepare for the implementation of Martha's Rule. The Maternity and Neonatal Voices Partnership (MNVP) currently has

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	temporary arrangements in place pending longer-term solutions. Ongoing work in support of the Saving Babies' Lives programme was also noted.
3.2.9	The Non-Executive Director (AA) sought clarification regarding where the minutes from the relevant maternity meetings were reported.
3.2.10	The Non-Executive Director (AP) queried progress regarding the investment identified for maternity triage services and the Associate Director of Midwifery and Children's Services advised that she did not have the full detail available at the meeting. She explained that the newly introduced benchmarking requirements had identified a potential staffing requirement. Further information is required by NHS England, and there remained hope that additional funding support may become available.
3.2.11	The Non-Executive Director (AP) noted that staffing is often moved between areas to manage pressures and specifically sought assurance regarding staffing acuity on Pannal Ward. The Associate Director of Midwifery and Children's Services explained that the mechanisms for monitoring staffing requirements on Pannal Ward differ from those used within the Delivery Suite. She advised that the report includes a detailed breakdown of instances where staffing acuity levels fell below target and by what margin. It was also noted that staffing on Pannal Ward is not solely dependent upon midwives. The service continues to prioritise the provision of one-to-one care for women in established labour.
3.2.12	Dr Johnson added that the Trust is also supporting neighbouring organisations by accepting inductions of labour when other maternity units reach capacity. This work is coordinated across West Yorkshire ICB.
3.2.13	Dr Johnson reiterated the need for funding to support the required improvements in medical staffing of the Maternity Assessment Centre, noting that a risk assessment would also be brought back to Board in due course if national funding was not forthcoming. She further commented that workforce challenges were less focused on consultant staffing and more related to specialty doctor roles. She noted that the service had been previously successful in both recruiting to and retaining these posts.
3.2.14	The Non-Executive Director (CM) referred to section 3.2.9 of the report and noted that the Board had previously reviewed the adverse trend identified within that measure. He commented that, based on the information presented and the actions underway, the Board could currently be assured regarding the management of the associated risks.
3.2.15	**Resolved:** The report was noted.
BD/09/30/4.1	**Board Assurance Framework – Person Centred, Integrated Care, Strong Partnerships**
4.1.1	The Chief Operating Officer provided the Board with an update on the Strategic Ambition: Person Centred, Integrated Care, Strong Partnerships.
4.1.2	**Emergency Department (ED) Four-Hour Standard**, Performance continued to improve gradually but remained below plan in August at 75.5%, with a deterioration seen in September. Significant work was undertaken during July and August to understand the underlying drivers of performance. The main challenge relates to the non-admitted pathway and patients waiting more than four hours in the Emergency Department. Actions are underway to restore performance to Quarter 4

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	levels, including workforce modelling, strengthening departmental leadership and reviewing operational processes. Performance against "time to next destination" has improved, although further work is required.
4.1.3	**Referral to Treatment (RTT):** RTT performance remains below plan. During August, detailed work was undertaken to better understand the position, which identified an increase in 'clock starts' and a reduction in 'clock stops'. Five specialties remain at risk. Capacity and demand modelling has commenced, alongside a 40-week amnesty review of booking processes for patients waiting over 18 weeks. Two of the specialties previously identified as at risk have already shown improvement. Delivery of both the RTT improvement trajectory and the financial recovery plan will remain challenging. The Chief Executive commented that there is a balance to be struck between improving RTT performance, delivering the financial plan and responding to the broader system position and expectations of the ICB.
4.1.4	**Cancer Performance**: Significant work was highlighted that had been undertaken by clinical teams to deliver the Faster Diagnosis Standard. The majority of key metrics being monitored remain rated green.
4.1.5	A key risk remains in relation to stroke services. An urgent meeting had been convened due to the fragility of the service, particularly following the reduction in consultant numbers at York and Scarborough to two posts. The Executive Medical Director advised that the Digital team had recently undertaken a roadshow regarding the proposed future stroke service model.
4.1.6	The Chief Operating Officer reported that Executive Directors are working together to strengthen arrangements relating to information governance, cyber security risks and oversight of staff access to patient records. The Non-Executive Director (CdB) highlighted the range of cyber security training resources available to staff through Audit Yorkshire.
4.1.7	**Resolved:** The Board Assurance Framework: Person Centred, Integrated Care, Strong Partnerships was noted and approved.
BD/09/30/4.2 **4.2.1**	**Board Assurance Framework – Finance** The Director of Finance provided the Board with an update on the Strategic Ambition: Overarching Finance 2026-27.
4.2.2	A year to date deficit of £18.8 million was reported at the end of August. Detailed consideration of the position had taken place at the Resources Committee, with particular challenges identified in relation to non-pay expenditure and some partnership arrangements. Pay expenditure trends have continued to improve. There has been no significant change to the forecast outturn position. The Trust remains planning for a £13.5 million deficit and, if achieved, will receive the associated support funding.
4.2.3	Members noted feedback received on the Affordable Establishment Review (AER) process. Adrian Ennis, Financial Recovery Director is leading a number of workstreams to ensure the required actions are progressed.
4.2.4	It was noted that a key determinant of long-term sustainability will be how the Trust addresses internal challenges. Externally, the delay to the Community Services

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	Review continues to present a challenge. The HDFT Futures Programme will also play a key role in supporting future sustainability.
4.2.5	The Executive Medical Director reported that the HDFT Futures Programme had been formally launched the previous day, with approximately 30 to 40 colleagues attending. The programme will bring together a number of transformation initiatives, including Neighbourhood Health and outpatient transformation, to support future service delivery.
4.2.6	The Director of Finance provided an update on the Trust's cash position, noting that this had been discussed at the Resources Committee. Working capital support remains necessary, and improving payment performance for suppliers continues to be a priority. Members noted that risks associated with the Local Authority pay award are reducing. A residual risk remains in relation to National Insurance costs.
4.2.7	The Non-Executive Director (JCr) referred to previous discussions regarding the distinction between turnaround activity and other improvement programmes, noting that the detailed actions sit within the Turnaround Programme and will continue to be monitored through the Resources Committee.
4.2.8	The Non-Executive Director (WS) sought clarity on when the Board would receive a high-level overview of the Futures Programme. The Executive Medical Director added that the immediate priority is to agree and refine the key programme areas, with further detail expected to be available within the coming weeks.
4.2.9	**Resolved:** The Board Assurance Framework: Finance was noted and approved.
BD/09/30/4.3 **4.3.1**	**Winter Plan** The Chief Operating Officer presented the Winter Plan, developed to provide assurance on the Trust's preparedness for winter pressures, and sought approval for up to £612k of associated expenditure. It was noted that robust escalation and de-escalation processes were in place and that actions were focused on mitigating both operational and financial risks.
4.3.2	The Non-Executive Directors noted that the proposal reflected a recognised risk should winter pressures materialise rather than approval of additional budget expenditure and observed that demand patterns remained broadly consistent year on year. Assurance was provided regarding joint planning arrangements with local authorities and the strength of partnership working.
4.3.3	Members noted that elements of the plan were already being tested through business-as-usual operations. The Chief Executive highlighted the strength of the Trust's operational leadership and the clear escalation framework established to support timely decision-making throughout the winter period**.**
4.3.4	**Resolved:** The Winter Plan was approved.
BD/09/30/5.1 **5.1.1**	**Board Assurance Framework – At Our Best: Making HDFT the Best Place to Work** The Chief People Officer provided the Board with an update on the Strategic Ambition: At Our Best: Making HDFT the Best Place to Work.
5.1.2	**Metric 1: Staff Engagement Index** The NHS Staff Survey is now open, and the Trust continues to perform strongly compared to NHS peers. The July Inpulse survey showed generally positive results, with the Trust ranked 8th nationally for

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	staff engagement and 3rd for response rate, although some indicators had shown a slight deterioration.
5.1.3	The Non-Executive Director (AA) welcomed the qualitative staff feedback provided through the Inpulse survey and emphasised the importance of ensuring that delivery of the financial recovery programme was not adversely affecting staff. The Non-Executive Director (JW) outlined the People and Culture Committee's focus on monitoring culture, engagement and emerging concerns, and highlighted the importance of continuing conversations with staff and supporting leaders through change.
5.1.4	The Non-Executive Director (AP) noted the slight reduction in engagement scores and observed that, whilst financial pressures had featured in staff feedback, the extent of their impact was not yet clear. He commented that the Inpulse survey provides a useful early indication of emerging issues between annual staff surveys.
5.1.5	**Metric 2: Staff Availability**. Performance against the KPIs remains within established tolerances. Vacancy controls continue to influence vacancy rates across the organisation. Sickness absence reduced slightly in August. Current performance places the Trust fifth out of 33 organisations across the North East and Yorkshire region. Significant work continues to be undertaken to address workplace stress and support staff wellbeing. The Medical Rostering Project has now been completed and formally closed.
5.1.6	**Resolved:** The Board Assurance Framework: At Our Best: Making HDFT the Best Place to Work was noted and approved.
BD/09/30/5.2 **5.2.1**	**Annual Workforce Race Equality Standards Report (WRES)** The Chief People Officer presented the report and noted that progress in increasing representation through appointments had been slower than anticipated. Members noted the introduction of Independent Panel Members to support recruitment processes. The impact of this change is being evaluated, with early indications suggesting it is making a positive difference. It was also highlighted that the Trust continues to have strong representation from Black and Minority Ethnic (BAME) colleagues within its workforce.
5.2.2	**Resolved**: The Report was noted.
BD/09/30/5.3 **5.3.1**	**Annual Workforce Disability Equality Standards Report (WDES)** The Chief People Officer presented the report, highlighting increased rates of disability declaration, improvements in bullying and harassment measures, and progress in the implementation of reasonable adjustments. It was noted that the higher likelihood of disabled staff entering formal capability processes related to very small numbers.
5.3.2	The Associate Non-Executive Director (DC) emphasised the importance of embedding EDI metrics within leadership discussions. The Non-Executive Director (WS) welcomed the overall positive results but noted that improvements in shortlisting candidates from under-represented groups were not yet consistently translating into appointments. He also highlighted the need to continue strengthening representation at Executive Team level and to consider how future recruitment processes could widen participation and attract a broader pool of candidates.

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5.3.3	The Chief Executive acknowledged the importance of increasing diversity within senior leadership and agreed that future recruitment approaches should consider how best to broaden reach and attract a more diverse field of applicants.
5.3.4	The Non-Executive Director (JW) stressed the importance of supporting colleagues from under-represented groups through coaching, development and career opportunities to enable progression into senior roles. The Non-Executive Director (CM) sought clarification on relevant benchmarks and expected levels of representation to ensure actions remained appropriately targeted.
5.3.5	The Executive Medical Director welcomed the increase in disability declarations and highlighted the contribution of staff network engagement to this improvement.
5.3.6	**Resolved:** The report was noted.
BD/09/30/6.1 **6.1.1**	**Board Assurance Framework – Enabling Ambition: Digital Transformation and Maturity to Integrate Care and Improve Patient, Child and Staff Experience** The Executive Medical Director provided the Board with an update on the Enabling Ambition: Digital Transformation for 2026-27: Digital Transformation and Maturity to Integrate Care and Improve Patient, Child and Staff Experience.
6.1.2	Three key areas of focus were highlighted: the future workforce model, digital maturity and delivery of EPR benefits.
6.1.3	In relation to the future workforce model, it was noted that delivery of AERs has been challenging within Digital Services, as many posts are capital-funded, making longer-term workforce planning more complex. It was recognised that the team may need to grow rather than reduce in size. A business case had been developed but is currently on hold. Members agreed that further discussion is required regarding the long-term workforce vision for digital services.
6.1.4	An update was provided on digital maturity. Improvements are being delivered, with an interim assessment undertaken by HIMSS showing progression from Level 0 to Level 4 maturity. The original EPR business case anticipated that implementation would support progression to Level 5.
6.1.5	Members received an update on EPR benefits realisation. Regular reporting continues through the Innovation Committee, including tracking delivery against the assumptions set out in the original business case. The Non-Executive Director (WS) reiterated previous comments regarding the business case and the importance of maintaining focus on the planned benefits and future workforce requirements..
6.1.6	**Resolved:** Board Assurance Framework: Digital Transformation and Maturity to Integrate Care and Improve Patient, Child and Staff Experience 2026-27 was noted and approved.
BD/09/30/6.2 **6.2.1**	**Board Assurance Framework – Enabling Ambition: Healthcare Innovation to Improve Quality & Safety** The Executive Medical Director provided the Board with an update on the Enabling Ambition: Healthcare Research and Innovation to Improve Quality and Safety 2026-27 which had three True North metrics: Healthcare Innovation, Children's Public Health, and Clinical Trials.

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6.2.2	Research income is performing against a modest target for the year. Recruitment to portfolio studies remains strong; however, overall participant recruitment has reduced following the closure of several high-recruiting studies. Commercial research income continues to be the main area of challenge.
6.2.3	On the MRI research programme, funding has been secured for the MRI scanner itself, but additional funding is required to support implementation and the associated infrastructure works. A business case is progressing to ensure the Trust can deliver both the MRI project and the necessary structural works. The equipment must be purchased before the end of March, although installation is not required by that date.
6.2.4	The Non-Executive Director (WS) advised that the business case would be considered at the next Innovation Committee meeting to ensure all relevant issues and risks have been appropriately addressed.
6.2.5	The Executive Director of Nursing, Midwifery and AHPs noted a typographical error within the report and requested that the correct version be uploaded before publication of the Board papers.
6.2.6	The Non-Executive Director (JCr) commented that increasing use of technology is likely to require continued investment in specialist teams, although advances in technology should also generate efficiencies and support cost reduction over time.
6.2.7	**Resolved:** Board Assurance Framework: Healthcare Innovation to Improve Quality & Safety was noted and approved.
BD/09/30/6.3	**Board Assurance Framework – Enabling Ambitions: An Environment that Promotes Wellbeing**
6.3.1	The Director of Finance provided the Board with an update on the Enabling Ambition: An Environment that Promotes Wellbeing.
6.3.2	The Director of Finance highlighted three key areas of focus: the physical environment, quality and safety requirements, and reducing the Trust's environmental impact.
6.3.3	Members noted that further work is required to strengthen the measurement of environmental performance beyond carbon and gas usage. The capital programme is currently ahead of plan. Work has commenced on the development of a new Estates Strategy. Initial work is focusing on identifying priorities and gathering ideas before wider stakeholder engagement takes place.
6.3.4	A number of key risks were highlighted within the report. It was anticipated that the risk relating to the security team may be downgraded following recent improvements.
6.3.5	The Non-Executive Director (JW) noted that Paul Yeadon, Head of Health and Safety had attended the People and Culture Committee to discuss violence and aggression. She highlighted that the most significant risk related to staff working in community settings and suggested this area should continue to receive close scrutiny.
6.3.6	**Resolved:** Board Assurance Framework: An Environment that Promotes Wellbeing was noted and approved.

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BD/09/30/7.1 **7.1.1** **7.1.2** **7.1.3**	**Escalations from Sub-Committees of the Board** The Chair welcomed the Committee Chairs to raise any areas they wished to escalate from the Committees that had taken place earlier in the day. The Non-Executive Director (CM) highlighted ongoing concerns regarding paediatric nurse staffing on Woodlands. Members noted that staffing pressures relate primarily to maternity leave and sickness absence. The Executive Director of Nursing, Midwifery and AHPs assured the Board that safe staffing levels are being maintained and patient care remains safe, although resilience remains a concern due to the small size of the team. Agency staff have been used where necessary to maintain safe staffing levels. **Resolved**: The escalation items were noted.
BD/09/30/7.2 **7.2.1** **7.2.2**	**Audit Committee Chair's Quarterly Report** The Non-Executive Director (CdB) presented the Quarterly Audit Committee Chair's Report, noting that the issue relating to paediatric nursing cover within the Emergency Department had also been raised at the Audit Committee. A further update will be presented to the Audit Committee in December. **Resolved:** The Audit Committee Chair's Quarterly Report was noted.
BD/09/30/8.0 **8.1**	**Any Other Business** No further business was received.
BD/09/30/9.0 **9.1** **9.2**	**Board Evaluation** It was noted that a wide range of business had been discussed. The Chair thanked everyone for their attendance. The Non-Executive Director (WS) noted that the impact assessment sections included in Board reports were often not completed meaningfully and suggested a review of the current approach to ensure the implications of decisions are properly considered and evidenced. The Director of Governance and Improvement acknowledged the point and agreed to review the use and completion of impact assessments within Board reports..
BD/09/30/10.0	**Date and Time of the Next Meeting** The next meeting would be held on Wednesday 25th November 2026.
BD/09/30/11.0	**Confidential Motion** **Resolved:** To exclude members of the press and public in accordance with the Health Services Act 2006 (Schedule 7, Section 18 (E), (as amended by the Health and Social Care Act 2012) and in view of publicity being prejudicial to the public interest.

Signed:

Dated:

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Board of Directors (held in Public) Action Log
for September 2026 Board Meeting

Minute Number	Date of Meeting	Subject	Action Description	Responsible Officer	Due Date	Comments
BD/09/30/1.2.7	30 September 2026	Patient Story	The Executive Director of Nursing, Midwifery and AHPs agreed to confirm whether the patient story had been shared with the Integrated Care Board.	Executive Director of Nursing, Midwifery and AHPs	25 November 2026	
BD/09/30/3.2.9	30 September 2026	Minutes of maternity meetings	The Non-Executive Director (AA) sought clarification regarding where the minutes from the relevant maternity meetings were reported.	Associate Director of Nursing, Midwifery and Childrens' Services	25 November 2026	

BOARD OF DIRECTORS (PUBLIC)
25th November 2026

Title:	Chief Executive's report
Responsible Director:	Chief Executive
Author:	Chief Executive

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

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

CHIEF EXECUTIVE'S REPORT

National and system issues

1. We are entering the period of the year when across the NHS a number of things collide. There is an increased focus on needing to deliver the plans and priorities we have set ourselves for the year, there is an NHS planning process to undertake in preparation for 2027/28, and there is a collective and organisational need to deliver safe care to the public during winter.

2. The correspondence from NHSE at both national and regional level predominantly reflects these three areas. In terms of delivering for this year, there are now regional control totals set in relation to finance and performance delivery, with regular oversight. In terms of planning for 2027/28, the timetables have been tentatively issued but we are still awaiting any detailed guidance, beyond the need to build on the second year of the plans we submitted last year. And in terms of winter planning, the plans have been agreed at organisational level, and the regular rhythm of delivery and performance oversight has been initiated.

3. The national position in relation to delivery of NHS priorities this year remains challenging. In all areas of the country, the urgent care pathway has become harder to navigate within the timescales that we should deliver, the referral to treatment time (the 18 week performance) is not in line with the improvement plans we set ourselves, and the financial position is that collectively we are significantly behind where we should be. The concern that these standards were not met during the first half of the year means that there is little flexibility going into the winter period, and it is important to get back on track as a matter of urgency.

4. As I have referred to before, it is important to retain the confidence of the public and by proxy politicians in the services delivered by the NHS, particularly given the economic climate and the choices that are having to be made in relation to public services across the country. The recent budget at the end of October emphasised the state of the public finances and included a transfer of NHS capital resource back to central government to help manage other priorities.

5. Following a number of discussions nationally and regionally, our plan for 2026/27 was agreed and signed off with a deficit financial plan of £13.5m, and a commitment to meeting our trajectories in relation to urgent care, planned care waiting times, and cancer and diagnostics.

6. We had a Mid-Year Review on 28th September with the Regional Team at NHSE, focused on the delivery of our plan for the year, and subsequently we had a further Executive to Executive meeting at the end of October. These were focused upon our financial recovery programme and our urgent care and elective waiting times improvements plans.

7. Following these meetings with our Regional colleagues there are a number of actions that we have committed to delivering in relation to finance and performance improvement. We have picked these up within our finance and performance recovery plans and will monitor and oversee delivery through our governance arrangements, but there are two particular actions that are of a higher strategic significance to highlight. Firstly, in order to ensure that our leadership and management capacity is as focused as possible on our immediate recovery actions, we will not be pursuing any 0-19 expansion opportunities this year. And secondly, whilst the HNY ICB has now initiated an ICB-wide community services review, we will agree an approach with the ICB for the Harrogate and District community services in advance of this review being completed.

8. The local community services approach is a vital component of our return to financial balance in 2027/28, as there are a number of community services where the resources provided do not meet the cost of delivery. Our deconstruction of the block exercise in relation to community services demonstrates that our services are relatively efficient but that we do not receive the resource to cover the costs. This will mean that we need to agree with the ICB which services are to be recommissioned and which might need to be decommissioned, as the option of simply being more productive in this area to the scale required, when we are already relatively efficient, would be a challenge. We are committed to making this position clearer before Christmas, to inform our plans for next year.

9. As previously reported, we received support from HNY ICB to progress our business case in respect of developing a community diagnostic centre in Harrogate. We have now had approval from the national NHSE team to negotiate and enter into a lease, and we are now progressing this exciting development.

10. As we have discussed, we are well placed to lead the delivery of neighbourhood health in the Harrogate and District area given the services we provide and the relationships we have across the local system. This will be delivered through the Local Care Partnership, and significant work is ongoing with our local partners, including the local authority and primary care. Local discussions have moved on to how this is delivered rather than whether it is the right thing to do, and there is a common agreement about neighbourhood boundaries, recognition of the need to focus on frailty, build on existing assets, pilot some work quickly, and identify how we coordinate delivery across the partnership. Helpfully our approach to neighbourhood health (along with North Yorkshire Council's approach) and the focus on delivering some practical benefits for people, is completely aligned with the new health secretary's comments this week. The SoS emphasised that ICBs must commission a new service aimed at keeping the frailest and most vulnerable out of hospital, and that neighbourhood health must not be focused on boundaries or organisational constructs but on practical support for the population.

11. The SoS has also been keen to reference the need to improve services and the public service response to people who are currently rough sleepers. Guidance has been issued recently with all public services having a responsibility to work together to help reduce this inequality. We are reviewing this with local partners to ensure that we play our appropriate part in this important work.

12. In relation to the West Yorkshire system and WYAAT in particular, we continue to focus on delivering the priorities identified in the Case for Change. The aseptics programme is on track, and I had a visit to the new facility near Leeds which will open in the new year. This will bring significant quality and efficiency benefits to WYAAT trusts and is a great

example of the benefit of our collaboration. Work has also progressed in relation to developing a sustainable clinical service for neurology across WYAAT.

13. We have had discussions with LTHT about the way in which we can jointly maximise the opportunity available from the elective centre that we share at Wharfedale Hospital. This is focused on two elements, namely, managing the best position we can financially this year for both partners, recognising that the utilisation is not where it could be, and building a longer-term plan to ensure that the strategic opportunities are maximised.

14. We continue to work in partnership with Local Authority colleagues across twelve areas in relation to the provision of our 0-19 services. These relationships continue to be positive with all Local Authorities, as we work with them to deliver services to children and young people. As part of this work, we continue to connect into neighbourhood health discussions where appropriate to do so in a number of areas.

15. Our focus on financial recovery, elective care recovery and urgent care mirrors the national and system priority. Our work is aligned with the system, and it is important for us as an organisation to work within the national and regional context whilst owning the improvement work we need to do within the organisation. We are also ensuring that the work of financial recovery this year flows into our HDFT Futures programme, which has now been launched with the remit to ensure we remain clinically and financially sustainable for the long term. Our strategy is clear and consistent, and reflects the Carnall Farrar report of 2020 which highlighted the need to integrate and develop out of hospital services (effectively neighbourhood health), work with partners to ensure sustainable and financially viable local services (our WYAAT network development, and our work to increase our maternity capacity) and to offer our effective and productive elective services to the local system (our development of Wharfedale Hospital with LTHT). Alongside our bespoke and successful 0-19 service offer across the North of England, if we ensure that our immediate financial runrate improves, we will be well-placed going into 2027/28 and beyond as a strong provider of health services for our population.

HDFT issues

Introduction

16. As always, the first part of this report has focused on the important national and regional issues that impact upon HDFT, whilst also outlining the appropriate engagement we have with partners across a number of systems to deliver high quality care and deliver our performance and financial plans. We continue to engage externally, whilst recognising that the improvements that we will make will be led and delivered largely by colleagues who work within the organisation. We continue to support our colleagues and emphasise as often as we can the positive culture that will both enable the improvements to take place and also protect our patients from harm by enabling people to speak up openly if there are any concerns to patient safety.

Our people

17. In terms of staff engagement, we are currently in the middle of the national staff survey window, which closes at the end of this month. We don't undertake an Inpulse survey during this period. Whilst not having any data update, we recognise the risk of declining staff engagement as we implement some of the decisions and changes in relation to our financial recovery programme. There are a couple of areas of concern in terms of staff engagement, and we are taking pro-active measures to listen to colleagues' concerns that have been raised.

18. In respect of availability, sickness has increased recently and is an area of focus. This includes reinforcing the basics of sickness management and support but also includes relaunching our health and wellbeing offer for colleagues over the winter period.

19. Our financial recovery programme is currently focusing on recruitment controls alongside variable pay controls. There has been a reduction in the recruitment of new staff, and also a marked reduction in agency and bank spend which is positive.

20. The flu vaccination campaign is well underway. This is the single contribution that all staff can make to protecting patients, their family and themselves, and help also ensure that staff are available for work more often through the winter period. This has quality, safety and financial benefits for everyone, and we are currently at a vaccination rate of over 60%. This is the highest rate of any acute, community or mental health trust in the country, which is a fantastic response from our colleagues and the team leading the programme.

Our Quality

21. The CQC visited the Trust in an unannounced inspection of our paediatric and neonatal services for two days in October. There was a subsequent follow-up visit for a day in early November. We also received the usual Provider Information Request (PIR), which we will be submitting this week. I will keep the Board informed of the progress of this inspection, as we will receive a draft report at some point for checking before a final report is issued.

22. As the Board will be aware, we have identified the need to assess our services against the relevant standards as part of our focus on clinical effectiveness. This work has been completed and was discussed with our senior leaders at a workshop in October. This will now inform future planning discussions and will highlight where we might need to focus our improvement over the coming years.

23. We continue to remain on track in respect of moderate and above harms reduction this year. This oversight is part of our quality governance system that we are using to triangulate any impact of the financial recovery work that we are undertaking.

24. Guidance has been received in respect of single sex accommodation, which we are assessing to determine any issues that we need to resolve. This guidance also covers staff accommodation, and a similar assessment will be undertaken.

25. We had our engagement meeting with NHSE in October in relation to the quality of education and training across all learner groups. This was a positive meeting and NHSE were impressed and complimentary about the work we do in this area.

26. In respect of our maternity services, there are no risks escalated to the corporate risk register. We have had a number of service diverts during October due to pressure upon our capacity. These are managed appropriately across the network. It should be noted that this pressure on the service is in the context of a 7% increase in births in our unit this year compared to the same period last year, and we are discussing this with Commissioners, particularly West Yorkshire ICB.

Our Services

27. Our 0-19 services continue to deliver strong performance across the majority of our geographic footprint and across the vast majority of the KPIs that we measure ourselves against. We are delivering the Healthy Child Programme across twelve local authorities, and we are delivering the required standards in 58/60 indicators. This is testament to the leadership and teams in our 0-19 services who continue to deliver high quality services to children across the North of England. We will have an opportunity as a Board at our workshop in December in Darlington to discuss our 0-19 service development.

28. Our urgent care pathway performance is below the standard that we set ourselves. In September and October, we have delivered 72% and 66% respectively against the ED 4 hour standard. This standard is a measure of the quality and safety of our urgent care pathway, it is a priority for the public, and it is a priority for all of us. Our performance hasn't been to the level we are seeking to achieve and will continue to be a focus for us as we support the Directorate and Care Group team to deliver the necessary changes. We have improvement actions covering the three elements of people, processes, and technology, and we have introduced the Urgent Care Board internally to provide oversight. On a more positive note, we still compare well against other organisations in respect of people waiting over 12 hours in the ED and our ambulance handover time.

29. In relation to cancer, our performance remains a positive one against both the 62 day standard and the FDS, with significant improvement achieved over the last twelve months which has continued into 2026/27. Our DM01 performance (diagnostic waiting times) has also improved significantly over the last twelve months, which will improve further once we have the CDC in place in Harrogate.

30. In terms of elective recovery, we are behind our plan at the end of October, with an 18-week performance of 70%. This is forecast to improve to 72% during November, and we have clear recovery plans in place to further improve. Some of the reduction during the year has been as a direct result of the focus on reducing expenditure, which was appropriate and is being constantly reviewed. It should be noted that we compare well on this metric when compared with other organisations, but we are not achieving the standard that we want to achieve for our patients.

Our money

31. As the Board will know through many discussions over the last few months, we have a challenging financial plan to deliver this year. Our month 7 year to date deficit is £25m. This is being addressed through our financial recovery programme.

32. As referenced previously, we have agreed a financial recovery programme and associated governance arrangements. Focus is on recruitment controls, new affordable establishments, reducing variable pay, and delivering our activity as productively and profitably as possible. The Turnaround Committee is overseeing delivery of the programme and will report into the Board.

33. We have a significant cash risk as a result of the financial position. This risk is the highest risk on our corporate risk register. We are managing this on a daily basis, with payments being delayed, and our current position is that only 33% of the value of our invoices are paid within 30 days. We are working with NHSE to improve the cash management arrangements and currently are having a peer review from a trust in WYAAT.

34. As we communicated to colleagues in the summer, the solution to our cash challenges is through delivering our financial recovery programme, and this is a key benefit to the Trust of improving our runrate and qualifying for deficit support funding.

35. Looking to next year, our route to financial balance and sustainability lies in delivering the immediate runrate reductions alongside the strategic solutions related to Neighbourhood health, the Community Services review, delivering elective productivity at Wharfedale Hospital, and consolidating our position as the leading 0-19 provider in the country. A key part of this is to ensure we have strategic alignment with our commissioners in respect of the services to be commissioned, in particular our local community services. The full year impact of the changes being made this year, the productivity improvements we will make through our HDFT Futures transformation programme, and the clarity of how services are commissioned going forward, will drive delivery of a balanced financial plan for 2027/28.

Corporate Risk Register

36. On the 11th and 12th November 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.

37. The Executive Risk Review Group (ERRG) met on Thursday 12th November 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.
    - No risks were de-escalated from the Corporate Risk Register

Other

40. Our capital scheme to deliver new theatres and a new imaging department continues to progress. There is a slight delay in completion due to some specific estate issues, with the likely completion date now being around March/April. The redevelopment of the front entrance is ongoing and on track to be finished in the spring of 2027.

41. It was great to attend the opening of the revamped Friends Garden at the hospital. This is a great space for both staff and visitors, and thanks to the Friends of Harrogate Hospital and others who made this happen.

42. There is a lot of work happening across the Trust at the moment in relation to the three key areas of priority that I highlighted at the start of the report, but more importantly there is a lot of work ongoing as there always is to ensure that we provide the best care we can to the individual people who rely on us every day for their health and wellbeing. And this is happening in every service across our wide geography. There can be occasions when there is uncertainty or when we don't get things right, and at these times it is important to always recognise and appreciate this, to focus on what can be controlled, and remind ourselves of the difference everyone is making. If it feels difficult sometimes, I would encourage everyone to look around their team and the people that they work with, because that should give confidence in our ability to continue to do what we need to do. Knowing our teams as we do, we should remain positive and optimistic and, most importantly, constantly available and open to anyone raising concerns about anything that we do – this long-standing approach will ensure more than anything else that we continue to deliver for our patients and population.

Jonathan Coulter
Chief Executive
November 2026

STRATEGIC AMBITION: BEST QUALITY, SAFEST CARE 2026-2027

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

GOALS:

Safety

Ever safer care through continuous learning and improvement

Effectiveness

Excellent outcomes through effective, best practice care

Patient Experience

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

GOVERNANCE:

Quality Framework

- Board Assurance: Quality Committe
- Programme Board: Quality Governance Management Group (QGMG)
- SRO: Executive Director of Nursing, Midiwfery & AHPs and Executive Medical Director
- Operational Lead: Associate Director of Quality & Corporate Affairs

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

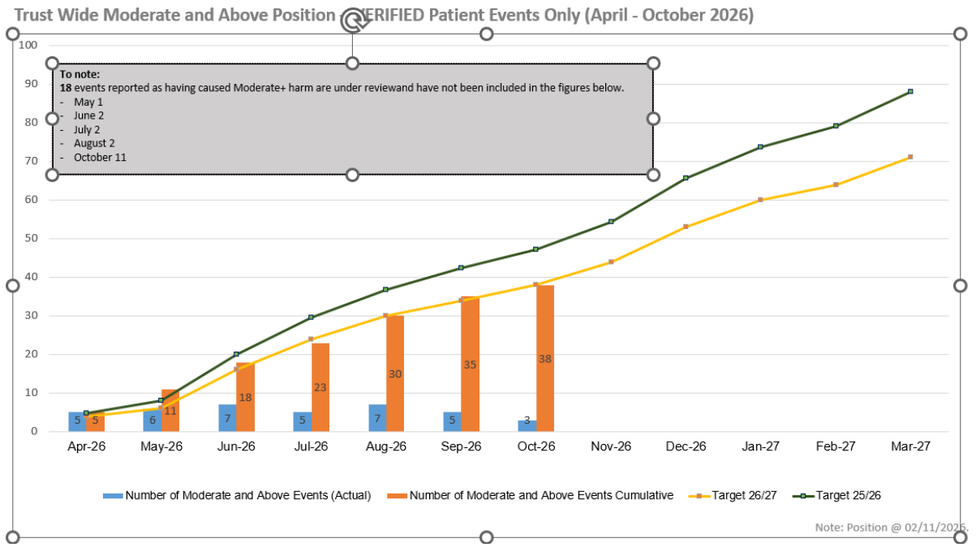
1. Eliminating Moderate & Above Harm
2. Clinical Effectiveness - CSR Award Distribution
3. Patient Experience Positive Response Rates

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

Overarching Risk Summary:

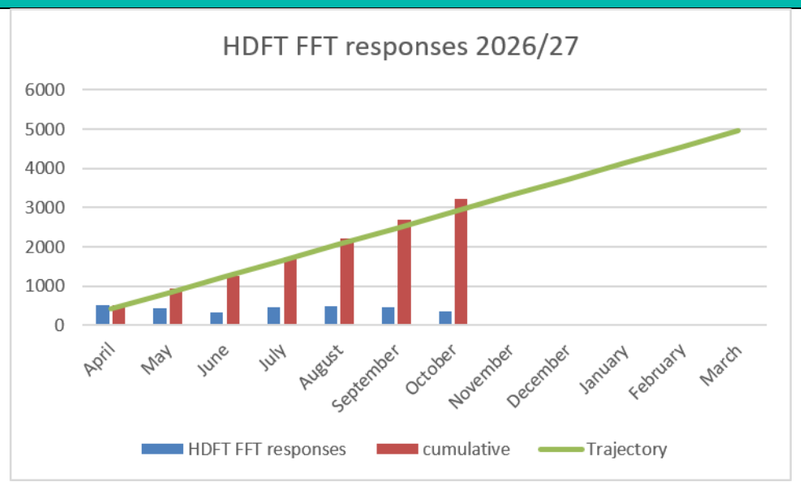
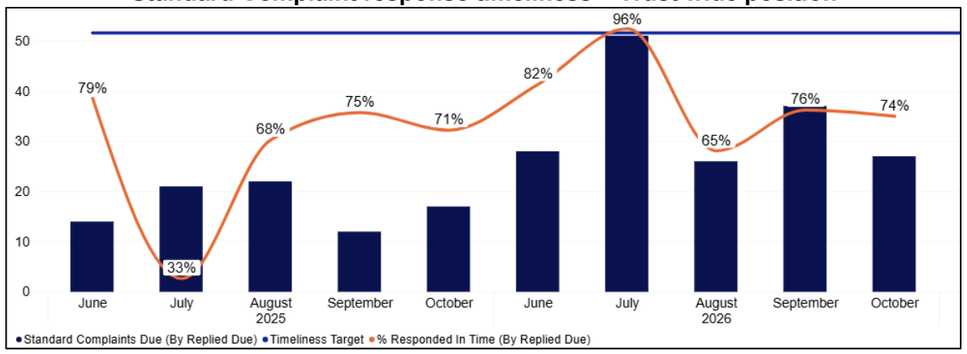
Ambition	Workstream	True North Metric	Risk Appetite	Level of Risk to Achieve Metric – Linked to Risk Appetite
				1 – 3 | 4 – 6 | 8 – 9 | 10 | 12 | 15 | 16 | >20
Best Quality, Safest Care	**Ever Safer Care**	**Moderate & Above Harm**	**Clinical: Minimal**	
	Excellent Outcomes	**Clinical Effectiveness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

True North Summary:

Workstream	True North Metric	Vision	Goal	Current State	Countermeasures	Level of Risk to Achieving in year goal	Level of Risk for progressing actions
Ever Safer Care	Eliminate Moderate & Above Harm	Decrease the total number of moderate & above harm incidents while increasing reporting of low or no harm	Long term: Eliminate moderate & above harm Short term: 20% reduction each year for 3 years Baseline: 140 per annum Year 1: 110 **(achieved)** Year 2: 88 **(achieved)** **Year 3: 71 (approx.. 6 per month)**	The True North Metric of eliminating moderate and above harm continues into its third year (2026-27). The target of a 20% reduction in harm was achieved in 2024-25 and in 2025-26. 2026-27 sees a step change of a further 20% reduction. This is a target of less than 71 moderate and above incidents for the year, which equates to approximately 6 per month. Of note: • There were **5** moderate and above events reported in April 2026 *(of note one of these was reported under Corporate Services)* • There were **6** moderate and above events reported in May 2026 *(1 undergoing validation)* • There were **7** moderate and above events reported in June 2026 (*2 undergoing validation)* • There were **5** moderate and above events reported in July 2026 *(2 undergoing validation)* • There were **7** moderate and above events reported in August 2026 *(2 undergoing validation)* • There were **5** moderate and above events reported in September 2026 *(0 undergoing validation)* • There were **3** moderate and above events reported in October 2026 (11 undergoing validation)  The year-to-date total is 38 against a threshold of 42. 18 events reported as having caused Moderate+ harm are under review and have not been included in the figures below.	Breakthrough Objective: Checklist Completion – programme for 2026-27 Pressure Ulcers Improvement Plan Deteriorating Patient Thematic Review – Implementation Plan Trauma Pathway Thematic Review – Implementation Plan Falls Improvement Plan Core Service Review Programme Directorate Countermeasures		

Workstream	True North Metric	Vision	Goal	Current State	Countermeasures	Level of Risk to Achieving in year goal	Level of Risk for progressing actions
				A small number of recurring themes continue to account for the majority of reported incidents. Slips, Trips and Falls involving patients remained the most frequently reported patient safety theme during the reporting period, accounting for 11 of the 38 cases reviewed (29%). Diagnosis-related issues were the second most common category (6 cases), followed by Procedure and Surgery Issues and Pressure Ulcers (3 cases each). The remaining cases were spread across a range of categories, including Appointment and Booking Issues, Obstetrics and Maternity, medication-related concerns and discharge issues, with no other significant trends identified. Watch Metrics: • Number of Never Events – **1** declared in year • Number of PSIIs – **4** declared in year • Level of low and no harm events reported – **1320/1337** (1320 low and no harm events of a total reported of 1337) maintaining **99%**			
Excellent Outcomes	Clinical Effectiveness – Clinical Standards Review (CSR) Award Distribution	Increase the proportion of services that are compliant with evidence based clinical standards	Long term: All services to be compliant with evidence based clinical standards. Goal 1: Short term: increase the number of services that have completed a CSR. Baseline: 25 services Goal 2: Medium term: increase the proportion of services moving from Bronze to Silver	The Clinical Standards Review is progressing, with the findings due to be presented to the Executive Team. Review outcomes will identify the award level achieved by each speciality and highlight any clinical standards preventing services from progressing beyond Bronze or Silver status. Once results are available any significant investment or transformational requirements will be considered alongside Trust priorities. A proposed business-as-usual process is being developed through the Clinical Services Forum which will oversee applications for changes in award status, supported by a validation and sign-off process. Ongoing engagement with directorates and speciality teams will focus on promoting the benefits of the framework, including its use in informing service improvement, business planning, prioritisation of resources, and organisational decision-making. Watch Metrics: • % guidelines in date 88.3% (55 out of 471 overdue, including 11 maternity and 8 theatres/anaesthetics that became overdue in Oct) • % SOPS in date 87.9% (112 out of 928 overdue - improvement is partly due to maternity and paediatric docs being updated)	Establish a Trust-level Clinical Effectiveness True North Metric Implement a Bronze / Silver / Gold Standards Maturity Model Complete and Maintain a Trust wide baseline of standards compliance Create an explicit escalation and prioritisation route for system-level gaps Embed clinical effectives into business-as-usual governance Shift culture from compliance judgement to improvement and learning		

Workstream	True North Metric	Vision	Goal	Current State	Countermeasures	Level of Risk to Achieving in year goal	Level of Risk for progressing actions
A Positive Experience 	Patient Experience Response Rates	For every patient to recommend our services	Long term: Development of a bespoke Engagement Strategy Short term: Increase the response to FFT by 10% over the next 12 months for inpatient: 413 (baseline 375)	The Patient Experience and Engagement Team is leading a programme of work to review and strengthen how patient feedback is collected, analysed and used across the organisation. This includes establishing existing collection methods, mapping patient feedback routes, and identifying opportunities to improve the volume and representativeness of feedback. Alongside this, work is underway with Analytical Services to develop a BI dashboard that will provide directorates and clinical teams with improved oversight of FFT response rates, trends and patient experience data to better inform quality improvement activity. A number of digital solutions are also being explored to make it easier for patients to provide feedback. These include integrating FFT requests into discharge processes through Nervecentre, embedding FFT links within discharge documentation and digital communications, and utilising the Patient Knows Best (PKB) platform to send automated FFT invitations following patient appointments. Early findings from other NHS organisations suggest these approaches can significantly increase FFT participation. Collectively, these workstreams aim to improve the accessibility, visibility and utilisation of patient feedback, ensuring the patient voice continues to drive learning, service improvement and positive patient experience across HDFT. The priority for 2026/27 is to increase Friends and Family Test (FFT) response rates by 10% over the 12 months, strengthening the breadth and representativeness of patient feedback. Over the last 12 months, the Trust has used the FFT as the primary Trust-wide measure of patient experience, with an average of 375 responses per month. Over the last 12 months, the percentage of patients reporting a “Very Good” or “Good” experience has remained consistently high, with an average of approximately 94%, showing stable and sustained positive patient experience across the year. Watch Metrics: • There were **511** responses received in April • There were **424** responses received in May • There were **322** responses recieved in June • There were **471** responses recieved in July • There were **494** responses received in August • There were **461** responses received in September • There were **364** responses received in October	Development of a real time engagement tool Development of a 24-month engagement plan Development of an Engagement Strategy Develop a bank of patient stories		

Workstream	True North Metric	Vision	Goal	Current State	Countermeasures	Level of Risk to Achieving in year goal	Level of Risk for progressing actions
				 Watch Metrics: • **56** complaints of all types (complaint, multiagency and cases requiring a meeting) were submitted in October 2026 ○ **51** of these were complaints. • **27** complaints were due to be responded to in October with a percentage response rate of **74%** **Standard Complaint response timeliness – Trust wide position** 			

Workstream	True North Metric	Vision	Goal	Current State	Countermeasures	Level of Risk to Achieving in Year Goal	Level of Risk for progressing actions
Clinical Services Strategy	Best Quality, Safest Care	A coherent, clinically led model of care where services are standardised where appropriate, redesigned to meet changing demand, and delivered through the right setting with the right workforce, improving outcomes for patients while maintaining system sustainability.	To progress delivery of priority Clinical Services Strategy projects, notably Clinical Services Review (CSR), Single Point of Access (SPOA) for UEC, and Neighbourhood Health, embedding agreed clinical standards and service models that support quality, workforce resilience and opeional sustainability.	The Clinical Services Strategy (CSS) Programme has substantially delivered its original strategic purpose, establishing a clinically led framework for service development and identifying future transformation opportunities through the Clinical Standards Review (CSR), Single Point of Access (SPOA) development work and Neighbourhood Health programme activity. The Clinical Standards Review continues to strengthen the Trust's understanding of service performance, variation and opportunities for pathway, workforce and service model redesign. Findings are being translated into prioritised improvement opportunities and will inform future transformation planning and delivery. Neighbourhood Health development continues in line with national and local priorities, with increasing engagement across primary care, local authority and system partners. The programme has helped establish strategic direction and identify opportunities for integrated pathways, prevention-focused models and delivery closer to home. The programme is now entering a transition phase, with consideration being given to the future governance and delivery arrangements for emerging transformation priorities. Focus is shifting towards embedding programme outputs within operational management arrangements, organisational improvement priorities and future transformation programmes, whilst ensuring momentum and benefits realisation are maintained.	• Complete remaining Clinical Standards Review assessments and agree priority recommendations. • Translate agreed CSR findings into directorate and service improvement plans. • Conclude CSS Programme deliverables and benefits review. • Agree future governance and ownership arrangements for outstanding transformation priorities. • Ensure Neighbourhood Health priorities are incorporated into organisational planning and future transformation activity. • Support transition of relevant workstreams into operational management, HDFT Futures and other agreed governance routes. • Maintain oversight of risks, dependencies, benefits and implementation planning during transition.		

Breakthrough Objective:

Workstream	True North Metric	Vision	Goal	Current State	Countermeasures	Level of Risk to Achieving in Year Goal	Level of Risk for progressing actions
Checklist completion	Best Quality, Safest Care	To significantly reduce safety-critical variation by embedding the reliable use of safety-critical checklists and checks as a routine part of delivery across clinical, corporate and enabling services, thereby strengthening patient safety and organisational assurance.	Reduction in safety events linked to checklists Baseline: TBC	Progress against the Clinical Checklist Programme remains on track across Stage 1 priority services. Focus during the next reporting period will be on progressing the remaining Stage 1 critical services and obtaining updated progress reports from areas where implementation has recently commenced. Services are being followed up to confirm progress ahead of the next programme meeting in October. Early preparatory work has also commenced within a small number of Stage 2 services, with both reporting initial progress (20% complete). Continued oversight is being maintained through the established project governance arrangements to ensure implementation remains on track and that evidence of compliance and effectiveness is obtained through validation and audit activity.	Establish services requiring safety-critical checklists Review and rationalise checklist content to ensure safety-critical steps are included Embed checklist completion into routine workflow, including stop moments Strengthen human-factors reliability, including speaking up culture and role clarity Standardise and strengthens training for safety critical checklist Improve visual and digital support, including use of electronic systems where possible Share learning from Never Events		

Related Corporate Risks

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

Related External Risks

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

STRATEGIC AMBITION: GREAT START IN LIFE 2026-2027

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

GOALS:

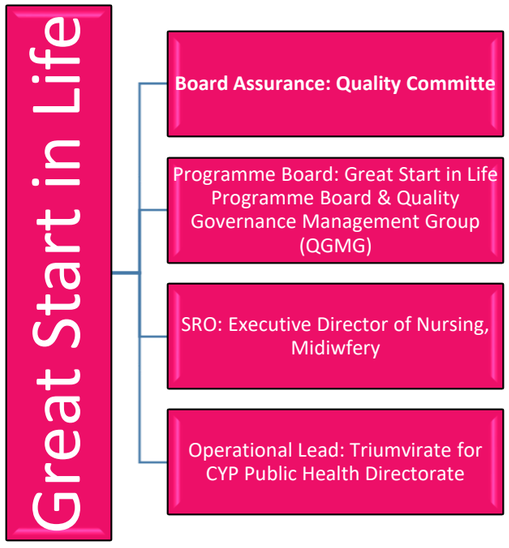
Public Health

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

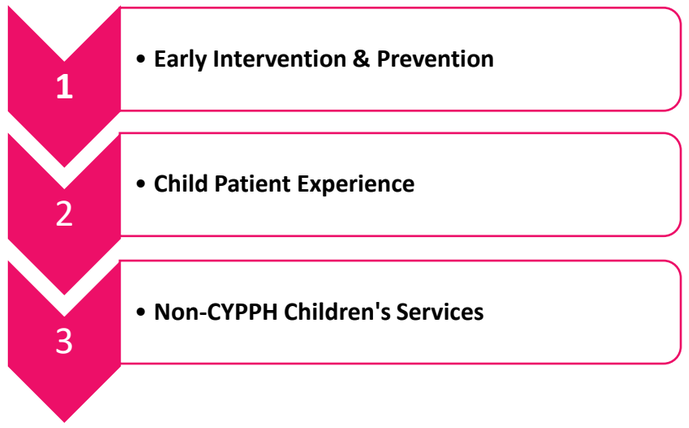
Hopes for Healthcare

Services which meet the needs of children & young people

GOVERNANCE:



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



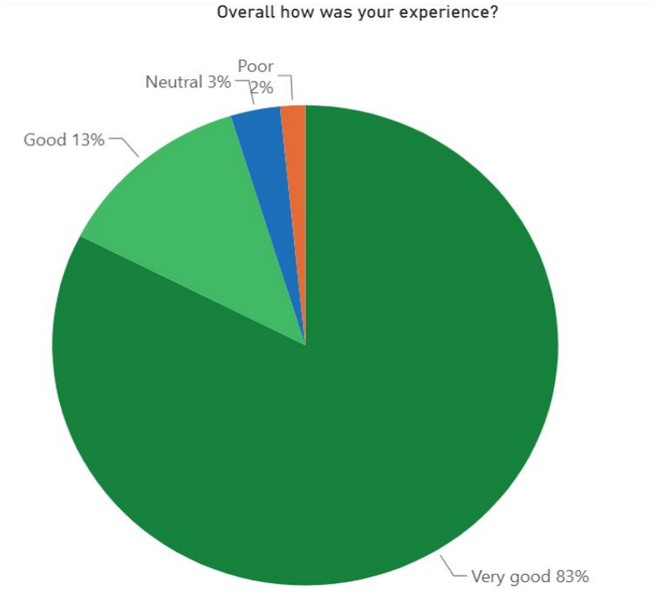
Trustwide Project:	
Strategic Programme	CYP Strategy
Breakthrough Objective:	Children's PH Research
Overarching Risk Appetite:	Clinical - Minimal

Overarching Risk Summary:

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

True North Metrics Summary:

Workstreams	True North Metric	Vision	Goal	Current State	Countermeasures	Level of Risk To Achieving Goal (CxL)	Level of Risk for progressing actions
Public Health	Great Start in Life: Early intervention & prevention – Children at Risk of Vulnerability	'As an organisation we aim to reduce the number of children who are vulnerable to poor health and wellbeing and to take action to mitigate risks of poor outcomes'.	Goal 1: To achieve 90% delivery of mandated Healthy Child Program Contacts within national timescales. Goal 2: To deliver the HDFT Great Start in Life pathway launching April 25 to all eligible children in Darlington and report outcomes linked to Public Health high impact areas.	We have 12 LA Commissioned 0-19 Services. There are five mandated contacts in each service making 60 contacts (South Tyneside added from August 2026). Target is to have 60 at 90% (delivering with HCP Timescales). In October 26, the service delivered **58 / 60** mandated contacts within the HCP timescales. **Great start in Life *Improve outcomes by identifying children by ensuring we achieve >90% for all mandated contracts*** Zero mandated contacts in all our contract areas breaching business rules: 11 8 7 6 5 4 2 2 2 2 1 1 All mandated contacts at 90% or above (60 contracted metrics from July 26 – an increase from 55): 41 43 43 43 42 46 48 48 50 51 51 52 52 52 59 58 CYPH Directorate has a Driver to focus on HCP Mandated Contacts not delivered within timescales over four consecutive months with associated countermeasures. Goal 2: Watch Metrics will report and include the outcomes of the Great Start in Life (GSIL) Pathway linked to High Impact Areas. Targeted improvement activity is underway to strengthen identification and referral of eligible children to the Great Start in Life (GSIL) Pathway, supported by staff refresher training and a comprehensive pathway review. Enhanced reporting is being developed through Power BI to provide greater assurance on pathway reach, uptake and outcomes. Reporting expected to resume from November.	Working to deliver HDFT Impact for all frontline teams in Cumberland and Westmoreland and Furness. Cumberland Impact commenced October 13th and will run until mid-November. Working to embed HDFT standard processes into South Tyneside.		

Workstreams	True North Metric	Vision	Goal	Current State	Countermeasures	Level of Risk To Achieving Goal (CxL)	Level of Risk for progressing actions
Hope for Healthcare	Children's Patient Experience	Improve experience of care by considering elements that matter most to children & young people so we can measure their experience of care and shape services according to their specific needs	Goal 1: Engage with children and young people with lived experience across HDFT geography to consult with on our CYP Strategy which will for part of the Clinical Strategy Goal 2: CYP Patient Experience Tool Developed- Return rate significantly low - distribution, engagement, and accesses to the tool to be developed with CYP and approach embedded with teams and professionals working with CYP.	The Trust North Metric of improving Children's Patient Experience continues into its second year (2025-26). **Target return rate 10%;** October 8% Active Countermeasures are noted. • Darlington, Tees Valley CIC & Wakefield are developing Countermeasures using HDFT Impact methodology to increase return rate. We will review each of these approaches at the Learning & Best Practice Group and evaluate approach and impact. We will use this to determine a standard work. • New learning best practice workstream established footprint-wide to drive increase in CYP survey returns using best practice examples from every contract area. • Working with CYPD Digital team to explore how best to get themes from paper CYP survey returns. • Data will be reported as a percentage for each Contract area and monitored via Governance Huddle with each HoN. 	CYP Patient Experience Tool 'engagement methods' to increase uptake and return being developed with involvement of CYP representatives. • Focus Groups held with GSIL Young Advisor Committees and individual advisors. • Standardise paper version of survey for use with digital options available. • Hopes for Health presentation to increase staff awareness and importance of gathering feedback (at all team huddles) • Assurance Survey for completion by staff to review awareness - this will inform future promotion and target support. • Application to charity for adaptable devises to support completion of survey by CYP All above completed.		

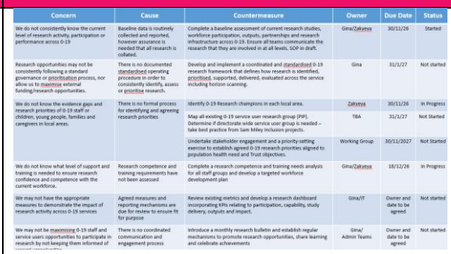
Trustwide Project:

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

Strategic Programme:

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

Breakthrough Objective: CYP in Research

Workstreams	True North Metric	Vision	Goal	Current State	Countermeasures	Level of Risk to Achieving Goal (CxL)	Level of Risk for progressing actions
	10% increase in participants from threshold in 2025, 5 new approaches for research participation in year.	The overarching ambition is to provide services that meet the needs of the children, young people and their families and caregivers informed by good quality research to ensure a great start in life. We need to demonstrate safe practice to provide assurance that our services have evidence of impact on children and young people's health and wellbeing.	• Create a research active culture, where staff have the opportunity to be research active, engaged with critical thinking practice, and have completed Good Clinical Practice (GCP) training. • NHSE eLFH: What is Health Research - training module • Complete literature reviews - library • GCP - as needed • Disseminate in Learning & Best Practice quarterly • Conference findings disseminated	**Approached:** • Blue Grass insights. Work postponed, due to commence Oct. Update requested • Postnatal Contraception Choices training evaluation (Durham County Council PH Team). HDFT County Durham 0-19 PIC only. Next Mtg 14/10: This project is delayed until 2027 and is now taking place as part of a MSc project with Newcastle University that will be looking at viewpoint from service users. • Early Years Kickstarter Project: W&F **In discussion:** • NCMP Impact study NIHR 207678? Aim to have study open by end Oct in line with school nurse measurement prog (HDFT SN Northumberland), Uptake has been minimal therefore may not proceed. **In delivery:** • Coastal/Care Integrated Responses & Children's Lived Experience (CIRCLE by the sea)(5 recruits) NIHR 162162, Will close 30 November 26. Aiming for 10 in total. **Closed/Not Progressed:** • Escalator (ELIM -1) NIHR 20705(11 recruits) • Represent Study NIHR 302504. Sponsor Newcastle Uni. HDFT SN Gateshead and Northumberland. • Young Father's & Domestic Abuse Study. University of Surrey PhD project. HDFT 0-19 HV wide, PIC and HV focus groups for professional perspective by end Oct. **Research Course:** • Course 1 went on live on 01/05/2026 and Course 2 on 23/05/2026. • 24 people enrolled on course 1,16 people completed it with only 5 uploading certification • 8 people enrolled on course 2, 7 people completed it with 2 of those uploading certification	 Updated October 26		

Related Corporate Risks:

Datix ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
CRR34/ID1	Autism Assessment	Risk to quality of care by not meeting NICE guidance in relation to the commencement of autism assessment within 3 months of referral. Risk that children may not get access to the right level of support without a formal diagnosis and that this could lead to deterioration in condition. There is a need to reduce the backlog of referrals back to the NICE standard of three months (reduce the waiting list to approximately 120)	3 x 5 = 15	3 x 3 = 9 ~~March 2025~~ ~~March 2026~~ December 2026	Clinical: Patient Safety	Minimal

Related External Risks:

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

Harrogate and District NHS Foundation Trust

November 2026

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

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

Freedom of Information	

Strengthening Maternity and Neonatal Safety Report

1) Summary

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

2) Introduction

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

3) Proposal

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

4) Quality Implications and Clinical Input

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

5) Equality Analysis

Not applicable.

6) Risks and Mitigating Actions

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

7) Recommendations - Board Assurance Summary

Domain	RAG	Position
Safety	🟠	Four maternity service suspensions occurred during October, resulting in seven women being diverted to neighbouring units. Sixteen induction of labour delays exceeding 24 hours were reported, alongside ongoing staffing pressures requiring significant redeployment of specialist midwives and team leaders into clinical areas. No moderate harm incidents were reported during the month.
Workforce	🟢	Workforce establishments remain stable with only 1.14 WTE midwifery vacancy and SCBU fully recruited. NHSP demand continues to reduce across maternity and neonatal services.

		Delivery Suite maintained 100% one-to-one care in labour and supernumerary coordinator provision however one breach in one-to-one care noted on Pannal Ward. Recruitment and retention work remains underway in response to increasing turnover trends and sickness absence pressures.
Quality	🟠	Continued progress against MIS Year 8, Saving Babies' Lives and the Maternal Care Bundle, with 17 safety actions meeting compliance and 10 on track. Homebirth services were maintained throughout October with no suspensions. Further improvement is required in maternity triage performance, induction of labour delays, elective caesarean section capacity and mandatory training compliance within some staff groups.
Patient Experience	🟢	Feedback from women, families and SCBU parents remained overwhelmingly positive, highlighting compassionate, supportive and professional care. A small number of complaints were received during October, with recurring themes relating to communication, delayed induction of labour, service diversion and consent processes.
Governance	🟢	Strong oversight continues through Maternity Safety Champions, Maternity Risk Management Group, Quality Committee and Board reporting. Progress continues against Baroness Amos and Ockenden recommendations, with compliance achieved in 19 of 26 baseline standards and improvement plans in place for remaining areas. No new requests for action were received from NHS Resolution, MNSI or CQC in October.

8) Appendices –

Appendix A – Bi – annual workforce report for midwifery, obstetrics and obstetric anaesthetics

Appendix B – Saving Babies Lives Quarterly report.

Appendix C – Avoiding Term Admissions into the Neonatal Unit (ATAIN)

Appendix D – Neonatal Readmissions

Appendix E– Explanatory Notes

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

1) Introduction

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

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

2) Obstetric cover on Delivery Suite, gaps in rota

Safe levels of cover on Delivery Suite have been maintained. All locum shifts have been covered either by internal workforce or doctors who have previously worked within the maternity service within the last five years, fully compliant with Maternity Incentive Scheme requirement for all locums.
A doctor has been recruited on a fixed term basis utilising MIS discretionary funding to support with improving staffing cover for MAC / ANDU and antenatal clinic.

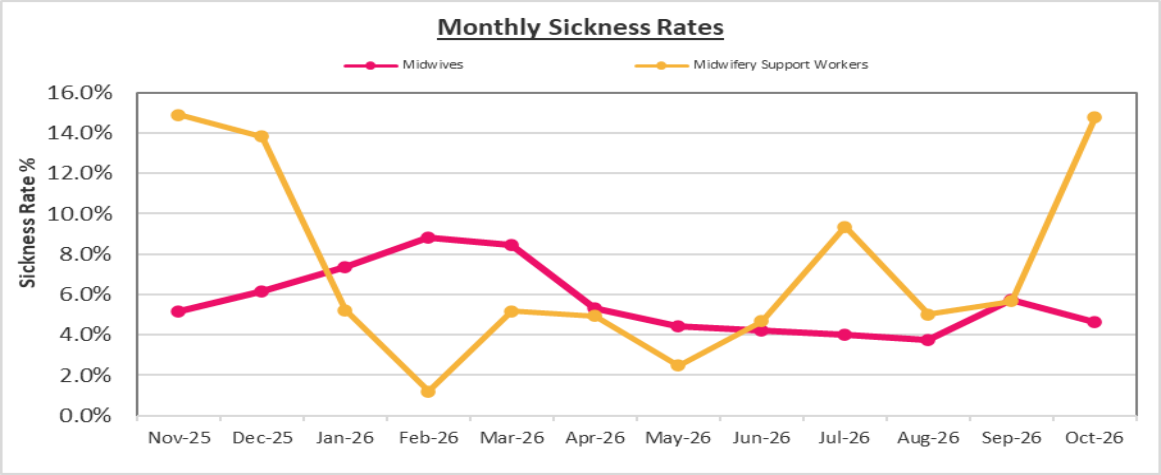
3) Midwifery safe staffing, vacancies and recruitment update

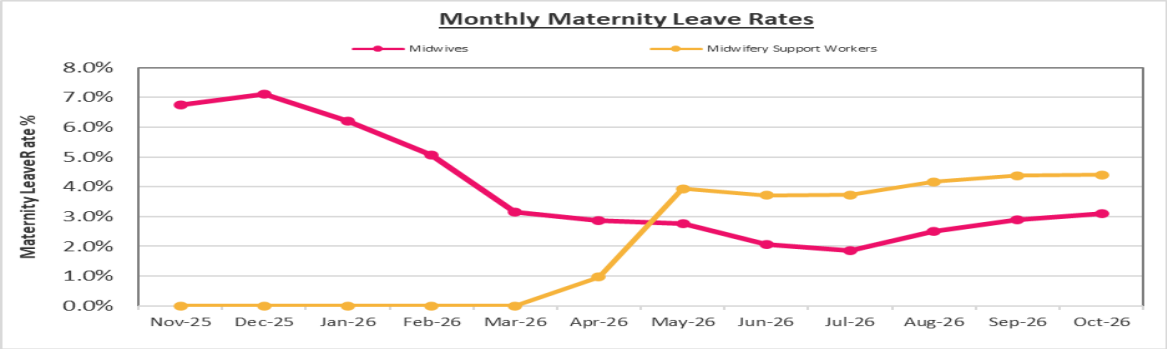
The bi-annual staffing report is included at Appendix A.

a) Absence position

Total sickness absence in October for midwifery was 4.47 WTE and increased in month for maternity support workers absence at 2.95 WTE. The main cause of absence for midwives relates to stress with this at 1.54 WTE however this has reduced this month.

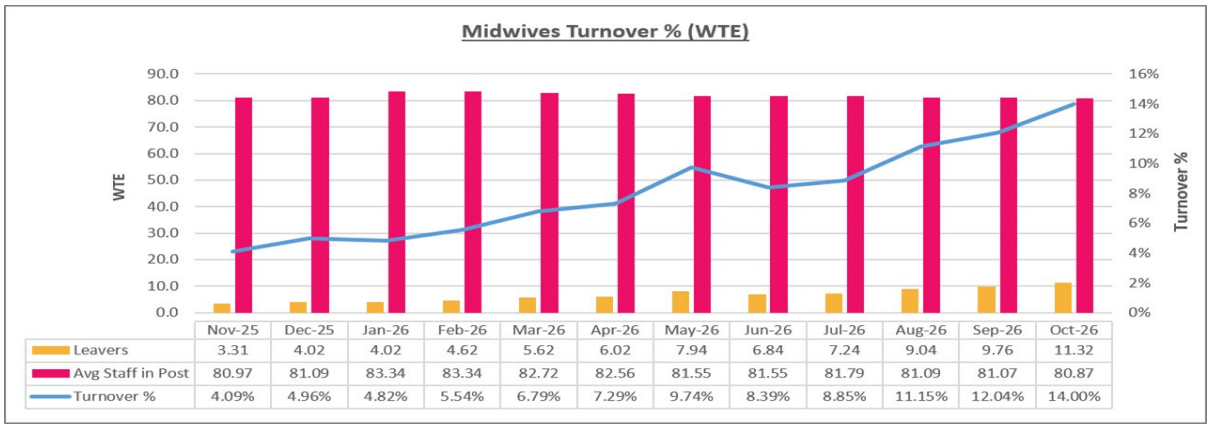
2.95 WTE midwives and 0.63 WTE support workers are on maternity leave at present.
The monthly sickness and maternity leave percentages and trend can be seen below up to October.





b) Vacancy position

There is 1.14 WTE Band 6 midwifery vacancy at present and 0.5 WTE newly qualified Band 5 midwifery posts created with top up funding from NHS England to Band 3 vacancy to band 5. Three Band 5 midwives have been interviewed and are in recruitment. Midwifery turnover appears to be increasing over the last year. A reinvigorated review of the recruitment and retention actions are underway.

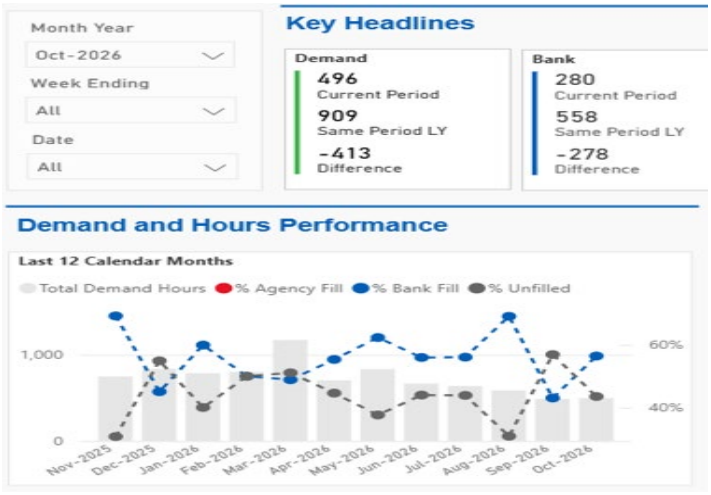


	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26
Leavers	3.31	4.02	4.02	4.62	5.62	6.02	7.94	6.84	7.24	9.04	9.76	11.32
Avg Staff in Post	80.97	81.09	83.34	83.34	82.72	82.56	81.55	81.55	81.79	81.09	81.07	80.87
Turnover %	4.09%	4.96%	4.82%	5.54%	6.79%	7.29%	9.74%	8.39%	8.85%	11.15%	12.04%	14.00%

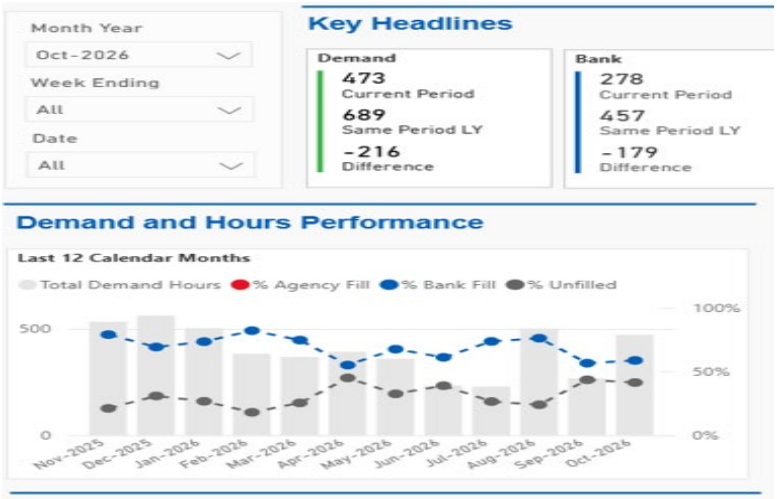
There is also currently a 0.41 WTE maternity support worker vacancy. 1.41 MSWs are also in recruitment.

c) NHSP provision

Midwives – There continues to be a sustained decrease in the requirement for NHSP cover with 496 hours demand in October 2026. Bank fill shifts have significantly reduced this month which is likely to be related to the reduced rate of pay.



Maternity Support workers – This month has seen an increase in demand for maternity support workers at 473 hours, this is still a reduction of 216 hours (1.32 WTE) since last year. Fill of shifts available has significantly reduced this month, it is not clear what is driving this.



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

a. Neonatal absence position

There was 1.88 WTE neonatal nurse sickness absence during October 2026. 0.92 WTE QIS nurses and 0.72 WTE Clinical support worker are currently on maternity leave.

b. Neonatal Vacancy

Special Care Baby unit remains fully recruited against the funded establishment.

c. NHSP Provision

Demand in October 2026 was 151 hours, 78 hours less than October 2025. Fill of shifts available remains high thanks to the dedicated team picking up NHSP shifts to ensure that SCBU is covered.

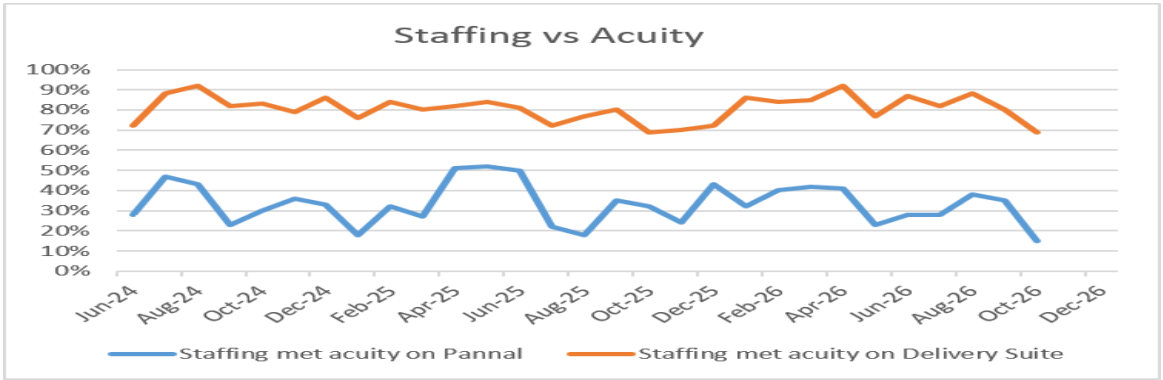


d. Qualified in Speciality (QIS) Nurses

To meet British Association Perinatal Medicine (BAPM) standards 70% of the budget establishment is required to be QIS nurses. The Operational Delivery Network (ODN) state that the QIS compliance is based on staff in post excluding any vacancy. One nurse has recently passed her QIS training and is consolidating. Two nurses are on a pathway to complete their QIS qualification and will be completed by the end of the year. The QIS compliance for October was 84%.

5) Birthrate Plus Acuity Staffing Data

The trend in Birthrate Plus staffing versus acuity, on both Delivery Suite and Pannal, can be seen in the below graph. Staffing matched acuity requirements considerably more often within Delivery Suite than Pannal throughout the reporting period. Delivery Suite consistently achieves between 70% and 90% compliance, whereas Pannal remains predominantly between 20% and 40%. Point 5b explores this further.



a. Delivery Suite Staffing and impact on clinical workload

A supernumerary delivery suite co-ordinator was rostered and available at the start of every shift in September. 100% compliance with one-to-one care in labour was maintained throughout the month on Delivery Suite however there is one breach in compliance noted for care of a woman on Pannal. The unit was in Divert at this point however a review of the care is on-going. According to the data captured in Birthrate Plus acuity tool, staffing met the acuity requirements 69% of the time, was up to 1.5 midwives short 26% of the time and the service over 1.5 midwives short 5% of the time.

b. Pannal Ward Staffing and impact on clinical workload

According to the data capture in the Birthrate plus acuity tool, 15% of the time staffing met acuity on Pannal. A deeper dive into the data demonstrates that the ward staffing was as follows across the 120 opportunities for data capture.

Staffing position	Number of occasions	Percentage	Trajectory
1-2 staff over acuity requirement	2	1.6%	⇩
Up to one staff over acuity requirements	13	10.5%	⇩
Up to one staff below acuity requirement	38	30.6%	⇧
1-2 staff below acuity requirement	34	27.4%	⇧
Over two staff below acuity requirement	14	11.3%	⇧
Data not captured	23	18.6%	⇧

Whilst staffing levels met the calculated acuity requirement on 15% of recorded occasions, the data demonstrates that workforce levels were reasonably aligned with demand. Staffing was within one staff member above or below the calculated requirement on 41.1% of recorded occasions, indicating that the ward was operating close to its recommended establishment more often than indicated by the staffing meeting acuity as a sole indicator. More significant staffing deficits were identified on 11.3% of occasions. However, these shortfalls are largely attributable to long-term staff absences and existing workforce vacancies. Recruitment to vacant posts is currently underway following active advertisement of these positions. Given the inherent variability in patient acuity and the practical limitations of matching workforce deployment precisely to demand at all times, these findings suggest that Pannal Ward staffing was broadly responsive to acuity requirements across most of the reporting period.

To manage workload across both Delivery Suite and Pannal during times of high activity and acuity, inductions of labour were delayed, and staff were redeployed from other areas of maternity services, including Pannal, Community and Specialist midwives. Clinical risk was mitigated, and delays were kept as minimal as possible. In October there was a significant increase in the number of hours worked clinically by the specialist midwives. A total of 203 hours is recorded as having been worked clinically by team leaders and specialist midwives. 54.5 of these hours were on Pannal Ward, 99 hours were on Delivery Suite, 11 hours were in Maternity Assessment Centre, 33.5 hours were in Antenatal Clinic/Antenatal Day Unit and 5 hours in SCBU.

6) Homebirth provision

Home birth provision is covered by community midwives working clinically during the day, and a first and second on-call midwife every night between 17:00 – 08:00. Two midwives on call are required every night to cover the service equating to approximately 62 on call shifts requiring cover each month.

In October there were no homebirth service suspensions demonstrating a sustained significant improvement in the service provision for the last two months.

Five homebirths were booked for the month of October, two of these women had care in labour at home and one birthed at home. Two women were induced and birthed in hospital, and one woman birthed in hospital at maternal choice.

7) Red Flag Events Recorded on Birthrate Plus

a. Delivery Suite Red Flags

During October, there were six red flags reported according to the data obtained from Birthrate Plus. These were as follows:

- Delayed or cancelled time critical activity – three delayed induction of labour and one other delayed care
- Delay between admission for induction and beginning of process – two delays in induction of labour process

b. Pannal Ward Red Flags

During October, there were eleven red flags reported according to the data obtained from Birthrate Plus. These were as follows:

- Delay in providing pain relief – five episodes
- Delay between admission for induction of labour and beginning of process – five episodes
- Any occasion when one midwife is not able to provide one-to-one care to a woman in established labour – one episode

c. Elective Caesarean Sections (LSCS)

There were 13 elective caesarean section lists scheduled during October, inclusive of one additional list which was required to support demand, with 34 caesareans performed. Due to the high demand an additional eight elective LSCS were performed on Delivery Suite during October. A demand and capacity review has been completed with the following outcome.

- Overview

Between April and September 2026 (six months) demand has exceeded the capacity available within the timetabled elective section lists. Additional lists in Main Theatres (MT) and the use of Delivery Suite (Strayside) capacity have been required to support activity.

Capacity and Demand Summary

Measure	Total
Timetabled elective section lists in Main Theatres (MT)	73
Additional elective section lists MT	5
Elective sections undertaken on delivery suite	32
Average total number of lists the sections on delivery suite equates to (average sections per list is 2.3)	32/2.3= 14 lists

Capacity/demand

Section list capacity over 6-month period = 73 lists
Section list demand over 6-month period = 92 lists

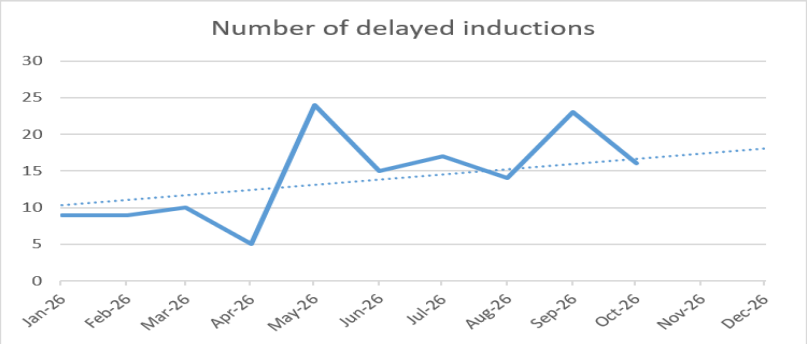
Projected across a full year:

Annual capacity: 146 timetabled lists (73 in 6-month period x 2)
Annual demand: 184 elective caesarean sections (92 in 6-month period x 2)
Difference: 184 -146 = 38 lists per year or 3 per month.

Conclusion

Demand for elective caesarean sections exceeds the capacity available within the current timetabled elective section lists. Between April and September 2026, additional theatre sessions and the utilisation of delivery suite capacity, were required to maintain service delivery. Conversations are on-going regarding next steps.

d. Delayed Induction of Labour (IOL)



During October there were 16 episodes of IOL delayed over 24 hours:

- Two of these were delays greater than 24 hours in admission to commence IOL
- Ten occurrences were a delay greater than 24 hours in transfer for ARM, without the administration of prostaglandins or cervical ripening balloon (CRB).
- Three occurrences were a delay greater than 24 hours in transfer for ARM, following administration of prostaglandins/CRB
- Two occurrences were delays greater than 24 hours for augmentation of labour, following SROM

The table below shows inductions delayed by more than 24 hours, grouped by duration of delay beyond the 24-hour threshold:

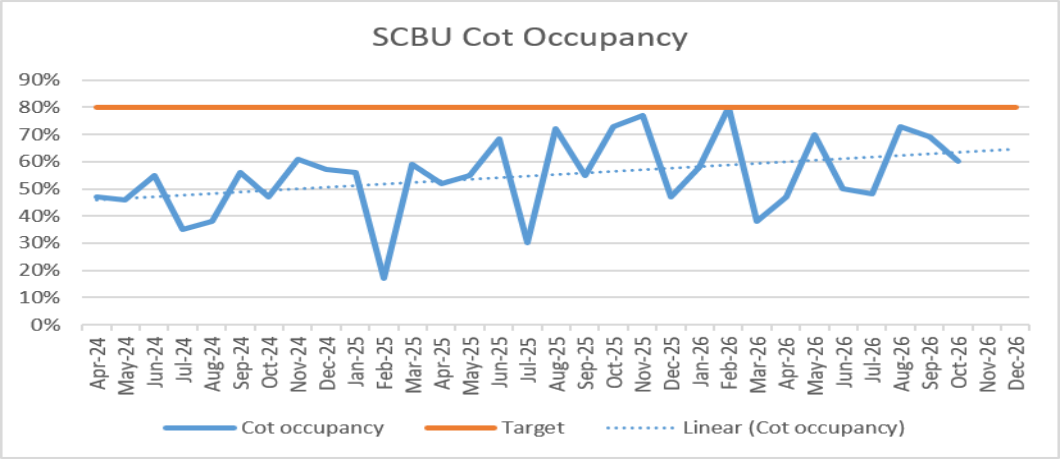
24-29 hours	30-35 hours	36-41 hours	42-47 hours	48-53 hours	54-59 hours	60-65 hours
3	3	1	4	1	1	3

The increase in induction of labour delays is a recognised National issue. A daily sit rep is utilised to capture delays of labour of more than six hours across the country. In October of the 31 required data submissions HDFT submitted 26 data points. Work is ongoing to ensure data is submitted each day as required. The National dashboard demonstrates a significant number of delays being experienced across the country ranging from 0 - 20 delays per unit on any a single day, however the data capture is still relatively new and embedding. They advise that results are to be treated with caution.

An NHS England Maternity and Neonatal Programme webinar is being held in November to launch a Framework on addressing delays to induction of labour. The event will be chaired by Dr Tony Kelly, National Specialty Advisor and Victoria Cochrane, Deputy Chief Midwifery office for England. Appropriate actions will be taken following this to ensure the framework is embedded at HDFT.

8) SCBU Cot Occupancy

September cot occupancy was 60%, which remains in the ideal occupancy of between 50% and 80%.



In October three babies were transferred out to tertiary units for clinical reasons.
23 babies received transitional care on Pannal Ward.

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

a. Mandatory training (as at 03/11/26)

Department	Assignment Count	Percentage Compliant
421 Level 4 Obs & Gynae - Medical Staffing	33	76%
421 Level 4 Pannal Ward	25	77%
421 Level 4 Community Midwifery	19	82%
421 Level 4 Ante Natal Clinic	13	86%
421 Level 4 Maternity Staffing	63	88%
421 Level 4 Early Pregnancy Assessment Unit	4	95%

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

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

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

As identified in MIS year 8, a minimum of 90% compliance must be achieved for every required staff group, for the above listed training, at two points during MIS year 8 (April – Nov 2026). The mid-point checkpoint was 31st July 2026, and 90% compliance was achieved. Work is now on-going to maintain compliance and meet the mandatory checkpoint on 30th November 2026.

A PowerBI dashboard of training compliance has been created and can be accessed here - Maternity Training Dashboard

October compliance is shown below –

Course Name	Midwives			Obs&Gynae Consultants & SAS (Consultants & Specialty Doctors)			Obs&Gynae (Other Staff)			Maternity Support Worker		
				Consultant			Specialty Registrar					
				Specialty Doctor			Trust Grade Doctor or Dentist - Specialty Registrar					
							Foundat					
Resuscitation Courses	**No. Re**	**No. Ce**	**Compl**	**No. Re**	**No. Ce**	**Compl**	**No. Re**	**No. Ce**	**Compl**	**No. Re**	**No. Ce**	**Compl**
Resuscitation - Level 2 - Adult Basic Life Support (CSTF)	77	60	78%	16	13	81%	14	5	36%	16	14	88%
Resuscitation Level 3 - Newborn Intermediate Life Support (HNILS)/Resuscitation - Level 4 - Newborn Advanced Life Support	97	94	97%									
RCUK Newborn Life Support	21	19	90%									
Resuscitation - Level 3 - Adult Immediate Life Support (RCUK eILS) - (CSTF)	21	9	43%									
Maternity Specific Courses												
Fetal Wellbeing Competency Assessment	97	96	99%	16	16	100%	3	3	100%			
MAT - Birthing Pool Hoist	88	85	97%							13	12	92%
MAT - Growth Assessment Protocol (GAP)	98	76	78%	12	10	83%	4	0	0%			
MAT – Maternity Training Day 2	97	97	100%	16	16	100%	3	3	100%			
MAT - Saving Babies Lives	98	69	70%	16	7	44%	6	2	33%			
MAT - Saving Babies Lives - Smoking Cessation										16	11	69%
MAT 3 - Personalised Care & Care in Labour	95	85	89%									
MAT-PROMPT - Emergency Skills Facilitator Led	98	96	98%	16	14	88%	14	8	57%	16	16	100%
Mandatory Training - Safeguarding												
Safeguarding Adults	98	67	68%	16	14	88%	14	8	57%	16	14	88%
Safeguarding Children	99	96	97%	16	8	50%	14	6	43%	16	15	94%

Course Name	Anaesthetics Consultants			Anaesthetics (Other Staff)			Paediatric Consultants			Paediatric Medical (Other Staff)			SCBU		
	Consultant			Specialty Doctor			Consultant			Specialty Registrar					
				Specialty Registrar			Specialty Doctor			Trust Grade Doctor or Dentist - Specialty Registrar					
				Specialist						Foundation					
Resuscitation Courses	**No. Requ**	**No. Certi**	**Compliance**	**No. Requ**	**No. Certi**	**Compliance**	**No. Requ**	**No. Certi**	**Compliance**	**No. Requ**	**No. Certi**	**Compliance**	**No. Requ**	**No. Certi**	**Compliance**
Resuscitation - Level 2 - Adult Basic Life Support							15	11	73%	11	4	36%	15	11	73%
Support (HNILS)/Resuscitation - Level 4 - Newborn Advanced Life Support							15	14	93%	11	10	91%	15	15	100%
RCUK Newborn Life Support							15	15	100%	5	1	20%	11	11	100%
MAT-PROMPT - Emergency Skills Facilitator Led	11	10	91%	12	10	83%									
Mandatory Training - Safeguarding															
Safeguarding Adults	11	10	91%	12	11	92%	15	12	80%	11	6	55%	15	15	100%
Safeguarding Children	11	10	91%	12	11	92%	15	14	93%	11	6	55%	15	12	80%

GAP / Saving Babies Lives training email reminders have been sent and escalated to line managers where required.

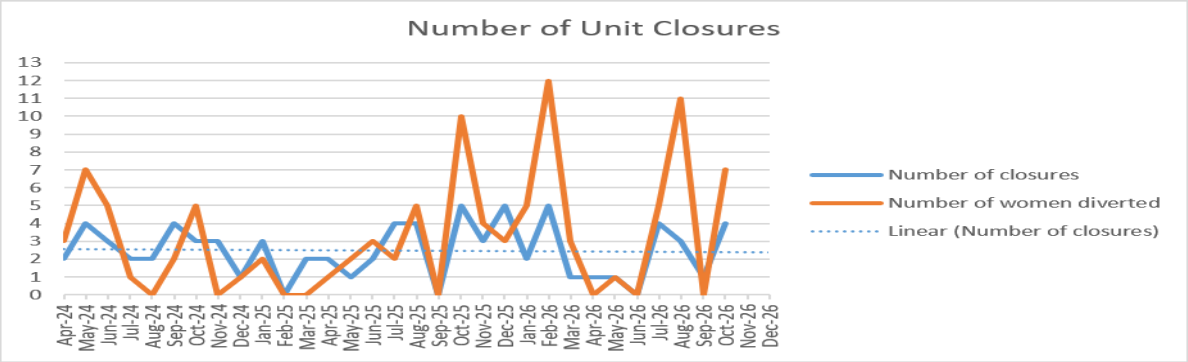
Safeguarding Level 3 Children training is booked for all 'other' medical staff onto the remaining 2026 dates and early 2027. Consultants are being booked on to training. There continues to be discrepancy in the way Learning Lab is reporting yearly compliance although the Intercollegiate guidance for training compliance states the requirement is triannual.

Level 3 Resuscitation for Adults will be >90% by end of 2026. All remaining staff are booked onto dates, and a plan is in place with the resus team to auto book for next year as a rolling programme to prevent low compliance.

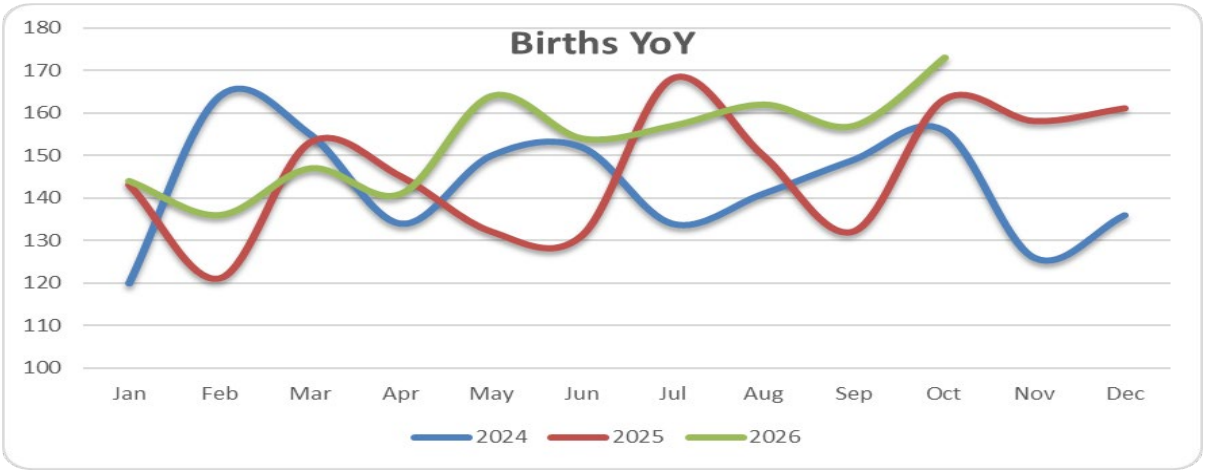
10. Risk and Safety

a. Maternity Unit Divert

During the month of October there has been four incidents of suspension of maternity services, with seven women being diverted to neighbouring maternity units.



Maternity and neonatal activity continues to increase during 2026. Year to date (YTD) bookings Jan-Sep 2026 have increased with 1,481 service users booked compared with 1,372 in 2025 (+7.9%). YTD births Jan-Sep 2026 have also increased with 1,362 compared with 1,275 in 2025 (+6.8%). 2026 activity exceeds 2025 levels in most reported months for both bookings and births. This increase in demand is having a demonstrable impact on the number of service users being diverted.



b. Maternity Accepted Diverts

A daily (Monday – Friday) regional meeting is in place to review staffing, activity and the number of women awaiting induction of labour across West Yorkshire. During the month of October three women were transferred to Harrogate and District NHS Foundation Trust (HDFT) maternity service for induction /labour care from elsewhere in the region due to period of divert of their services or delayed induction of labour.

c. SCBU Incidents

No moderate harm incidents have occurred on SCBU in September.

Further to the letter from the Yorkshire and Humber Neonatal Operational Delivery Network (ODN) Clinical Lead in January 2026 stating that as a Neonatal ODN they are concerned regarding the ability of the permanent members of paediatric medical staff across the region to maintain their airway skills for babies, it was asked to start monitoring the number of neonatal intubations undertaken in HDFT as a watch metric. Please see below.

Metric	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Sept 26	Oct 26
Number of Neonatal Intubations	1	4	1	0	1	1	1	2	1	2 – Both completed by Embrace	1 – Completed by Middle grade doctors (2 attempts)	2 – 1x SAS Dr 1x Embrace

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

d. SCBU Risk Register

No new risks have been added to the risk register –

Ongoing risks –

- Non-compliance with BAPM service and quality standards - shift coordinator needed on each shift on SCBU. Score 2
- Lack of transilluminator on SCBU to diagnose pneumothorax. Score 6
- Risk to patient safety due to lack of access to Badgernet EPR for neonate. Score 6

e. Maternity Risk Register Summary

Risk Register formally reviewed in August 2026. The next formal review will take place in November.

There are 13 currently active risks on the risk register;

- **Risk to patient experience and safety and breach of triage timescales due to delays in Obstetric review in Maternity Assessment Centre (Score 8).** Audits ongoing, and many breaches identified through data are not true breaches but reflection of incomplete documentation of fields. Some true breaches persist, commonly relating to inability to obtain timely obstetric review. Plan for additional obstetric staff to be resident on MAC but currently not possible within the staffing available.

- **Risk to patient satisfaction, safety and staff morale due to inability to provide gold standard level of care (Score 8).** Staff morale issues remain. No change to risk score. IT issues persist but have been reviewed by Digital Midwives but for further work.

- **Risk to patient satisfaction and safety, resulting from delays in facilitating induction of labour (IOL) (Score 8).** Peaks and troughs in delayed induction. Not a weekly occurrence now and some improvement but delays remain ongoing. Balloon catheter outpatient inductions not fully embedded.

- **Risk to safe monitoring and management of Perinatal Mental Health due to insufficient clinic capacity for PNMH appointments (Score 6).** No recent issues noted. Risk score downgraded.

- **Risk to patient safety due to lack of appropriate interfacing between EPR systems and ASCOMS within Maternity (Score 6).** Lack of interfacing capability between Badgernet maternity EPR system with Trust wide NerveCentre and ASCOM devices. To review requirements to support linking of Badgernet with NerveCentre.

- **Risk to patient satisfaction and safety, resulting from delays in facilitating ultrasound growth scans (USS) (Score 6).** Challenges with sonography staff availability and aware of staff member leaving which will bring additional capacity challenges.

- **Risk to operational running and governance surrounding safety and quality of homebirth service (Score 6).** Work ongoing. Plan for rotation of community midwives into unit for increased exposure to intrapartum care.

- **Risk to patient safety and experience associated with need to divert patients to other units in times of escalation (Score 6).** No recent incidents about safety of patient clinical condition at point of divert. Risk to remain the same until diverts reduced.

- **Risk to patient experience and key performance indicators due to antenatal clinic process and clerical staffing issues (Score 6)**. Incidents continue to be monitored and some improvement. Interviews taking place for Business Improvement Manager to support.

- **Risk due to inability to meet gold standard requirements for clinical documentation (Score 5)**. Multiple areas where limited staff time results in inability to complete required documentation. Multifactorial cause including having to switch between forms, EPR system issues, as well as significant amount of non-essential documentation. Audits showing non-compliance with documentation in bed-state, BSOTS. Ongoing training for staff, but restrictions in necessary time and unable to meet gold standard. Requests for change have been made to system suppliers. Limited ability to make local changes.

- **Risk to Information Governance and breach of confidentiality resulting from lack of training in redaction of patient record requests (Score 4).** SOP now in place Trust wide. No recent concerns identified relating to redaction. Frequency downgraded.

- **Risk to reputation and patient experience due to possible discontinuation of Maternal and Neonatal Voices Partnership (MNVP)(Score 4)**. Some discussions have been undertaken and draft plan in place to maintain MNVP. Downgrade likelihood of risk until plan finalised and then consider closure.

- **Risk to delivery of safe and quality care due to inability to share records electronically between healthcare providers when patients being transferred or receiving shared care between Trusts (Score 3).** Work ongoing regionally. Not recurrent problem. No further updates of Yorkshire and Humber Care Record (YHCR). No local control. Frequency downgraded as no recent related issues.

11. **Maternity Incidents**

In October 2026 there were 106 total incidents reported through DCIQ (with 74 reported within Maternity Services, 21 incidents occurring in SCBU location, one in EPAU and two in Main Theatres).

There were no incidents of Moderate Harm reported in October.

Other incidents of note reported in October include:

- 11 incidents reports under the Category of Appointment/Booking Issues
- 9 incidents reported for Incorrect Treatment/Test/Procedure
- 5 incidents reported under Category of Staff/Workload Issues

12. Perinatal Mortality Review Tool (PMRT)

PMRT completed for Neonatal death of a premature baby born in July 2026. RROSE review and PMRT completed and appropriate care identified. PMRT grading B for care of mother and baby to the birth of the baby. Care issues identified due to a delay in administration of nifedipine, and some patient experience feedback about the counselling around survival focused care, but not considered to have made a difference to the sad outcome.

13. Feedback

a. Maternity and Neonatal Staff Feedback

The NHS Staff Survey is currently on going.

b. SCBU Parent Feedback

Parent 1 - “Information/Communication from/between nurses and doctors was poor, during our stay at one point out of the blue a doctor said our baby was ‘breached’ and she wasn’t/never have been and had to constantly tell them it was wrong for weeks. Nurses was great however contradicting, they all have different ways of doing things which gets confusing. When asked how we was doing and we told them we was struggling, we got fobbed off to a QR code and that’s it. Some nurses was very pro-active, things progressed forward but some was scared to make a decision and seemed to hold us back. Nursery 4 bed space 9, a draft which affected our baby at night. But overall thankful for the help/care for our baby girl, these are just honest comments/feedback during our time but as mentioned, we appreciate and are thankful for the hard work and care you given to us and our baby!”

Parent 2 - “We firstly would like to thank ALL the staff on SCBU from start to finish, their support, guidance and overall level of care has been outstanding. Clearly a team who love what they do providing the highest quality of care and support. Any help we needed has been no trouble for them and our questions and queries have been resolved instantly. From feeding to general care for (baby) and us parents nothing has been too much to ask. Thank you (heart)”.

c. Maternity Service User Feedback

Positive feedback predominantly related to the care provided by midwives and maternity support staff during labour, birth and the postnatal period.

Women and their families consistently described staff as kind, compassionate, reassuring and professional. Several families reported feeling listened to, informed and actively involved in decision making throughout their maternity journey. Praise was received for staff supporting women through complex and unexpected birth experiences, helping them feel safe and empowered despite changes to their birth plans.

Families described receiving exceptional care, continuity of support and excellent emotional reassurance throughout labour, birth and early parenthood.

Key positive themes identified included:

- Compassionate and personalised care.
- Women feeling safe, listened to and supported.
- Excellent emotional support during labour and birth.
- Positive experiences despite unplanned interventions, including forceps delivery and caesarean birth.
- Strong support from student midwives.
- Effective breastfeeding support.
- Women feeling empowered to make informed decisions regarding their care.

Positive feedback and compliments have been shared directly with the individual staff members and teams named by patients and their families. This has included recognition of the compassionate care, emotional support and professionalism demonstrated throughout the maternity journey.

Examples of excellent practice have been highlighted to staff to promote learning and reinforce behaviours that support a positive patient experience.

d. Maternity and Neonatal Voice Partnership (MNVP) Feedback

Plans are in place to reinstate gaining feedback via the MNVP now arrangements are in place to ensure the individuals are in post. Most actions identified within the current MNVP action plan have now been completed. The small number of remaining actions will be reviewed with the MNVP now they have returned to the role. Following this review, actions will be updated and progressed as required ahead of the next Maternity Quality Assurance Meeting (MQAM).

14) Complaints, concerns, compliments

Two complaints/concerns received in September:

- FEE6432 – Complaint about management of hyperemesis and follow up of impact on PNMH [**Closed**]
- FEE6484 – Complaints relating to closure of a pregnancy record in error and patient receipt of automated message suggesting a miscarriage [**Ongoing**]

Three complaints/concerns received in October:

- FEE6664 – Complaint relating to diversion of patient during unit closure [**Ongoing**]
- FEE6637 – Complaint relating to administration of vitamin K without consent in 2021 [**Completed**]
- FEE6862 – Complaint relating to delayed IOL and management of discharge against advice for baby following delivery [**Ongoing**]

Actions Taken

Formal concerns received during the month have been acknowledged and assigned to investigating officers in line with the Trust's complaints process. Investigations are currently underway to review the issues raised, including communication, patient experience, clinical care and documentation.

Sub-subject (primary)	Ethnicity	Deprivation Score	Complaint Status	Final response sent	Themes	Actions
Clinical Treatment - Obstetrics & gynaecology	White - British	5	Closed	02/09/2026	Bladder care Staffing levels Lack of oversight Management of early labour Management of fluid balance	• Learning shared about fluid balance • For posters in room for patient awareness of appropriate fluid intake
Clinical Treatment - Obstetrics & gynaecology	Mixed - Other	9	Closed	04/09/2026	Incorrect recording of due date Not feeling listened to PNMH and birth planning Documentation issues Drug administration	• Work with MNVP around appropriate language • Consideration of birth preferences • Consideration of Health Passport and communication adjustments • Follow up with staff member about language use
Clinical Treatment - Obstetrics & gynaecology	White and Black Caribbean	10	Closed	15/09/2026	Clinical management Conflicting advice Management of appointments Behaviour and communication of staff Failure to act on abnormal measurements Lack of recognition of allergy	• Feedback provided to individuals and wider team • Learning to check patient record for conditions, including childhood asthma • Actions regarding allergy status checking and availability of latex-free equipment • Learning about medication counselling
Clinical Treatment - Obstetrics & gynaecology	Irish	5	Closed	22/10/2026	Delays In IOL Clinical skills Post-operative care and lack of support	• Feedback provided Coordinator and staff involved

					Behaviour/Poor communication Incorrect documentation	• Development of SOP for roles and responsibilities when transferring to theatre
Clinical Treatment - Obstetrics & gynaecology	Not stated	7	Closed	02/10/2026	Insufficient pain relief Clinical skills - balloon induction Cannula care post-operative pain Insufficient postnatal care Lack of debrief	• Feedback to staff about effective communication regarding balloon induction, compassionate communication and timely debrief
Access to Services	White - British	10	Closed	19/10/2026	Perinatal Mental Health support and pathway Clinical management	• Reinforcement about GAD-7/PHQ-9 questions
Communication with patient	Asian - Other	6	Open	Under investigation	ANC Clerical error	
Clinical Treatment - Obstetrics & gynaecology	White - British	7	Open	Under investigation	Management of diversion Clinical escalation	
Patient undergoes procedure without consent	White - British	9	Open	Under investigation	Informed Consent	• Reinforcement to all staff about provision of information to support informed consent
Clinical Treatment - Obstetrics & gynaecology	White - British	10	Open	Under investigation	Delayed induction of labour Communication Discharge against medical advice	

15. Coroner Regulation 28 made directly to trust

No direct requests received.

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

No new requests for action have been received from NHS Resolution, MNSI or the CQC this month.

17. Maternity and Newborn Safety Investigation (MNSI)

In October 2026: No new MNSI cases notified.

Ongoing MNSI investigation relating to an intrauterine death. RROSE review found no lapse in clinical care and initial feedback from investigator that no anticipated safety recommendations.

Additional MNSI investigation in relation to unexpected neonatal death has been completed and final report issued. No safety recommendations. Some prompts relating to early discharge of GBS positive mothers and ensuring full history checking and clinical assessment when mothers raise concerns. Coroner post-mortem completed, but still awaiting findings.

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

Work is ongoing locally at HDFT to ensure the Trust is compliant with the MIS requirements. The current assessment of compliance is as below.

Overview of progress on MIS year 8 safety action requirements

NHS Resolution

Safety Action	Not started	Compliance risk	In progress & on track	Meets compliance	Fully embedded	Total sub-actions
A	0	0	2	5	0	7
B	0	0	4	1	0	5
C	0	0	0	6	0	6
D	0	0	1	1	0	2
E	0	0	1	2	0	3
F	0	0	2	2	0	4
Local work	0	0	0	0	0	0
National	0	0	0	0	0	0
Total	0	0	10	17	0	

19. National priorities

a. Baroness Amos/Ockenden Review

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

Baseline assessment: 25 September 2026

Progress update: 31 December 2026

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

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

Progress is being made against all non-compliant standards and an update on progress will be submitted as planned in December.

b. Saving Babies Lives (SBL)

Please see attached quarterly board report at Appendix B. The key successes noted in the report are

- Recording smoking status at 36 weeks has improved and meets expected standard
- Referral to tobacco dependence service is 100%
- Mid-stream urine sampling at booking meets expected standard and has remained stable

The key concerns are -

- Reduction in the number of smokers who set a quit date
- Carbon Monoxide (CO) verified non-smokers at four weeks after initiating smoking cessation support and 36 weeks gestation are below expected standard
- CO and Very Brief Advice (VBA) training are below expected standard

- Six missed opportunities for uterine artery doppler screening, commencing serial scans at 28 weeks of pregnancy
- Ultrasound scan the next working day for recurrent reduced fetal movements has fallen, with errors in clinical management identified

Additional Saving Babies Lives' metrics for Board oversight -

Small-for-gestational age (SGA) detection rate *[AN detection of SGA user reported or EFW <10th: Proportion of babies SGA (<10th) at birth that were reported by users to be suspected antenatally as SGA <10th or detected by EFW <10th]* Fetal growth restriction (FGR) detection rate *[AN detection of SGA <3rd by EFW <3rd: Proportion of babies with birthweight<3rd centile who were detected as <3rd centile from one or more AN EFW]*	SGA – Q3 (calendar year): **51.1%** detection (<10th centile; 23 cases) (National average 48.7%) FGR – Q3 (calendar year): **60.0%** detection (<3rd centile; 3 cases) (National average 38.0%)	
Measure	**July-September 2026**	**October 2026**
Percentage of babies <3rd centile >37+6 weeks' gestation	0.63% (3/477)	0.58% (1/173) as % of all babies born
Percentage of babies <10th centile >39+6 weeks' gestation	3.98% (19/477)	1.73% (3/173) as % of all babies born
SBLv3 Element 2 report (2d): Percentage of babies <3rd centile who were born >37+6 weeks	27.3% (3/11)	25% (1/4)
Percentage of babies <10th centile who were born >39+6 weeks (% of all babies <10th centile)	32.8% (19/58)	16.7% (3/18)
Percentage of babies ≥3rd birthweight centile born <39+0 weeks	23.2% (108/466)	26.04% (44/169)
Incidence of women with singleton pregnancy (as % of all singleton births) giving birth (liveborn and stillborn):		
• In late second trimester (16+0-23+6 weeks)	0.44%	0.6%
• Preterm (24+0-36+6 weeks)	3.9% (18/459)	7.19% (12/167)

c. Maternity Care Bundle (MCB)

The maternity service remains on track to fully implement all five elements of the Maternity and Neonatal Care Bundle (MCB) by March 2027, in line with national expectations. Progress has been made across all workstreams, with clear governance arrangements, identified leads, and implementation plans in place.

Whilst most actions are being progressed within local control, there remains a number of dependencies and potential risks that require ongoing regional and national support. These external factors may influence the pace of delivery despite local commitment and progress.

The board should be aware that:

- Delivery of some elements is dependent upon the development, procurement, or implementation of national and regional digital solutions.
- Workforce capacity, training requirements, and specialist skill development continue to require sustained investment and support.

- Certain equipment requirements are dependent upon procurement processes.
- Collaboration with other health professionals and external stakeholders remains essential to achieve full compliance in some aspects of the programme.

The specific risks, dependencies and mitigating actions for each MCB element are outlined below.

- Element 1 - Venous Thromboembolic - Badgernet changes required and expected; ICB arrangements to prescribe LMWH; a contingency plan is progressing in the event the ICB arrangement are not confirmed in the required timescale.

- Element 2 - Pre-hospital and Acute care - dependent upon staff outside of maternity using MEW's, this is taking a longer period of time than anticipated to embed

- Element 3 - Epilepsy in Pregnancy - no risks

- Element 4 - Maternal Mental Health - Badgernet changes required and expected

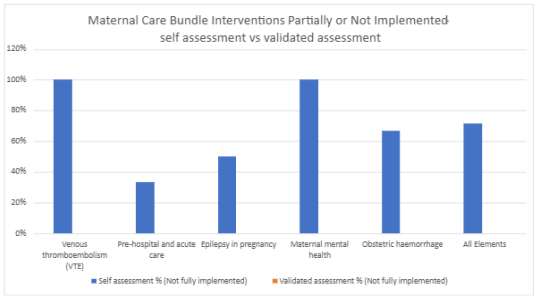
- Element 5 - Obstetric Haemorrhage - additional new equipment is awaiting approval to purchase

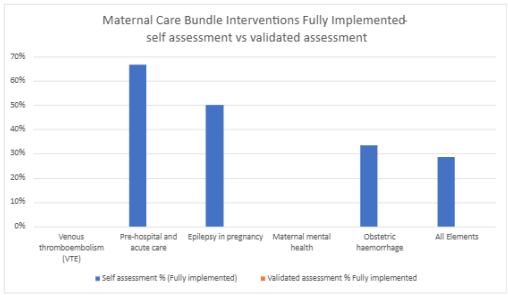
The below chart indicates our current position

Implementation Progress

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (Trust Board Validated)	% of Interventions Fully Implemented (Trust Board Validated)	Escalation required for board review*
Element 1	Venous thromboembolism (VTE)	Not Implemented	0%		0%	No
Element 2	Pre-hospital and acute care	Partially Implemented	67%		0%	No
Element 3	Epilepsy in pregnancy	Partially Implemented	50%		0%	No
Element 4	Maternal mental health	Not Implemented	0%		0%	No
Element 5	Obstetric haemorrhage	Partially Implemented	33%		0%	No
All Elements	TOTAL	Partially Implemented	29%		0%	

*If yes, please refer to 'Board summary - action plans' worksheet for details.





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

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

e. Vaccination

Of the 466 eligible patients in Q2, 418 were offered the RSV vaccination (90%). This is an increase from 85% in Q1. 272 were vaccinated before birth (58%). 44 patients declined the vaccination (9.8%)

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

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

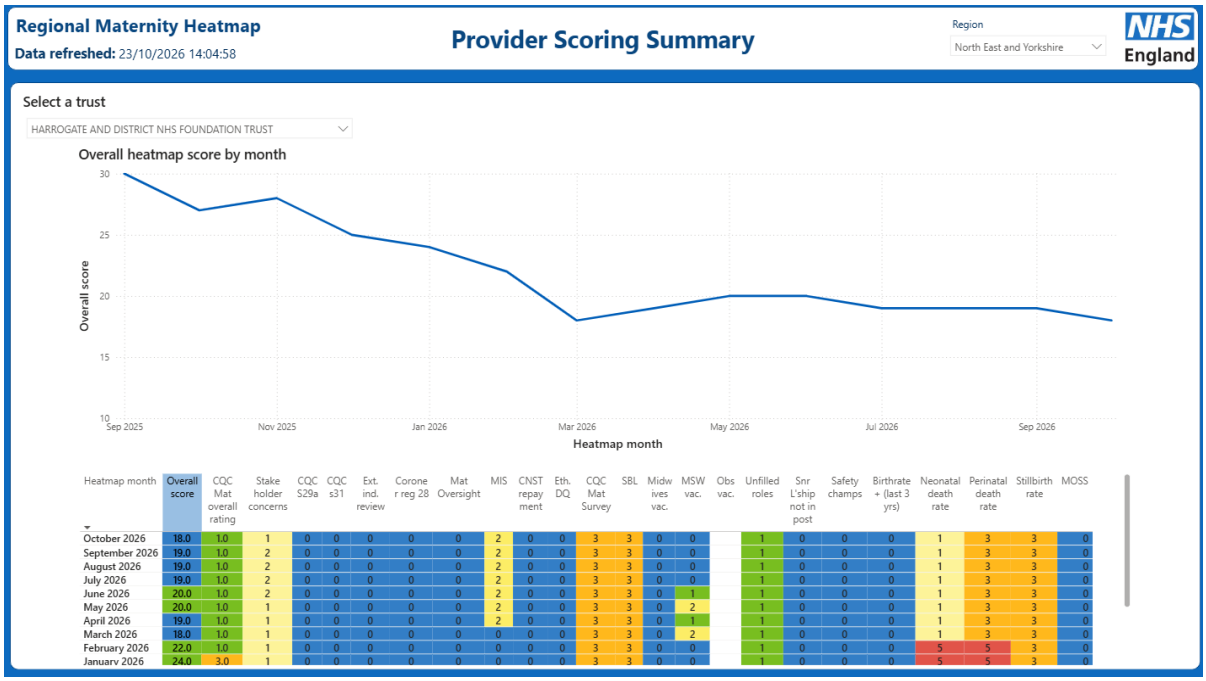
i) **Perinatal Equity and Anti-Discrimination Programme (PEAPD):** The Perinatal Leadership team have commenced on the PEADP in the autumn of 2026.

ii) **Submit a Perinatal Event Notification (SPEN) service:** SPEN has been implemented at HDFT.

iii) Maternity and Neonatal Performance Dashboard: The dashboard represents a balanced scorecard of operational, outcome and patient experience measures.

(1) Heatmap

The regional maternity heat map is an analytical tool that pulls information around trusts CQC status, regulatory notices and regulatory body/stakeholder concerns, progress towards national priorities, safe staffing, MBRRACE mortality, service user and staff feedback surveys. The heat map enables monthly oversight of the triangulated data and then scores each element to read the signals of trusts that require additional early intervention and support. The data is updated monthly and reports two months behind. Please see below screenshot taken from the Regional Heatmap system. HDFT are currently scoring 18. This has reduced from a score of 20 in June. There is one stakeholder concern which relates to nurse availability on SCBU. A business case is being written to increase the nurse staffing to BAPM standards to resolve this concern.



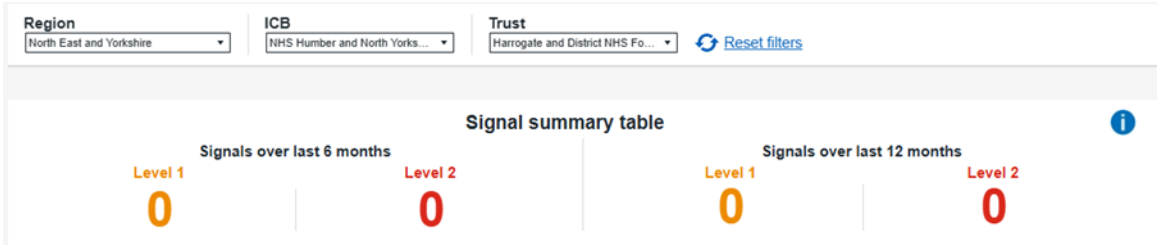
Heatmap month	Overall score	CQC Mat overall rating	Stake holder concerns	CQC S29a	CQC s31	Ext. ind. review	Coroner reg 28	Mat Oversight	MIS	CNST repay ment	Eth. DQ	CQC Mat Survey	SBL	Midwives vac.	MSW vac.	Obs vac.	Unfilled roles	Snr L'ship not in post	Safety champs	Birthrate + (last 3 yrs)	Neonatal death rate	Perinatal death rate	Stillbirth rate	MOSS
October 2026	18.0	1.0	1	0	0	0	0	0	2	0	0	3	3	0	0		1	0	0	0	1	3	3	0
September 2026	19.0	1.0	2	0	0	0	0	0	2	0	0	3	3	0	0		1	0	0	0	1	3	3	0
August 2026	19.0	1.0	2	0	0	0	0	0	2	0	0	3	3	0	0		1	0	0	0	1	3	3	0
July 2026	19.0	1.0	2	0	0	0	0	0	2	0	0	3	3	0	0		1	0	0	0	1	3	3	0
June 2026	20.0	1.0	2	0	0	0	0	0	2	0	0	3	3	0	1		1	0	0	0	1	3	3	0
May 2026	20.0	1.0	1	0	0	0	0	0	2	0	0	3	3	0	2		1	0	0	0	1	3	3	0
April 2026	19.0	1.0	1	0	0	0	0	0	2	0	0	3	3	0	1		1	0	0	0	1	3	3	0
March 2026	18.0	1.0	1	0	0	0	0	0	0	0	0	3	3	0	2		1	0	0	0	1	3	3	0
February 2026	22.0	1.0	1	0	0	0	0	0	0	0	0	3	3	0	0		1	0	0	0	5	5	3	0
January 2026	24.0	3.0	1	0	0	0	0	0	0	0	0	3	3	0	0		1	0	0	0	5	5	3	0

(2) Maternity and Neonatal Equalities Dashboard

A Maternity and Neonatal Equalities Dashboard can be accessed here link. The dashboard is updated bi-annually and therefore shows data from December 2025 and hasn't changed since the previous report.

(3) Maternity Outcomes Signal System (MOSS)

The MBRRACE-UK Real Time Data Monitoring Tool extract has been checked for the past six months. No MOSS signal has been triggered over last 6 months or last 12 months. A MOSS signal simulation drill is to be carried out in November.



Maternity Outcomes Signal - Cumulative sum (CUSUM)

Trends are plotted based on the accumulation of events compared to a national reference rate.

A rise indicates the rate of events is increasing compared to the reference rate.

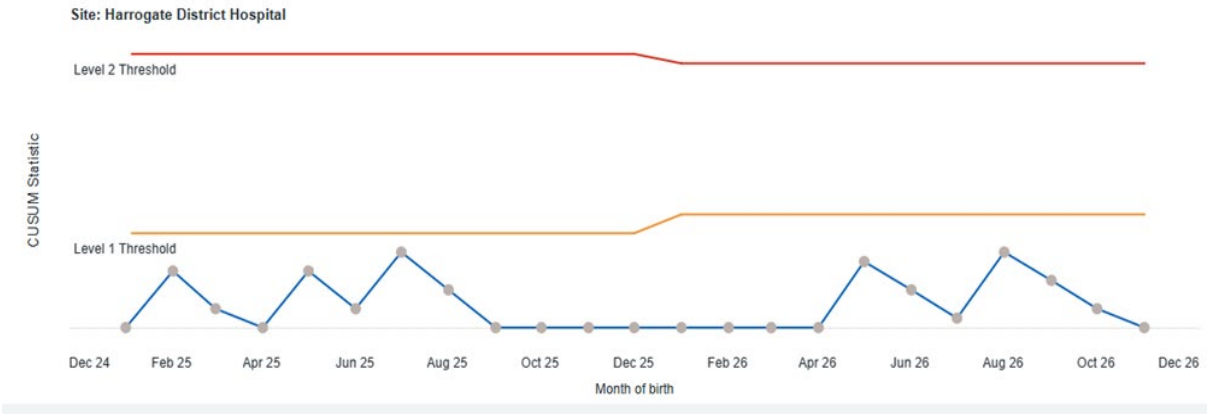
Signals are generated when there is a doubling in the rate of events compared to the reference rate. The colour of signals simply refers to statistical confidence – amber means we are 95% confident the rate has doubled (level 1) and red means we are 99% confident (level 2).

For detailed information, please see the 'Methodology' tab.

After a red (level 2) signal, the chart resets to remain sensitive to future signals. The reset does not mean that potential safety issues have been resolved, which should be clarified through local perinatal quality governance processes.

Note – thresholds are updated every year in January. These align with annually updated national reference rates to account for changes in the total numbers of births and events. For more information please visit the FAQs tab.

Further information on the governance and escalation of signals is included in the MOSS Standard Operating Procedures.



21. Maternity and Neonatal 10 Point Plan

a. Martha's Rule

Following recommendations arising from the independent review of maternity services at the Nottingham University Hospitals NHS Trust by Donna Ockenden and national patient safety priorities following Baroness Amos review of maternity and neonatal services, NHS England and the Department of Health and Social Care have committed to the rollout of Martha's Rule across all maternity and neonatal services in England. The initiative aims to ensure that women, families and staff can escalate concerns about a deteriorating mother or baby and access an independent rapid clinical review where required.

Across Maternity and SCBU at HDFT the planning phase of implementing Martha's Rule and are on track for rollout by the end of March 2027. Implementation leads have been identified and are overseeing the development of the programme. Work is underway to establish staff training, develop communication and engagement plans, and raise awareness across clinical teams to support a safe and effective rollout of the initiative.

22. Local HDFT Maternity Services Dashboard

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

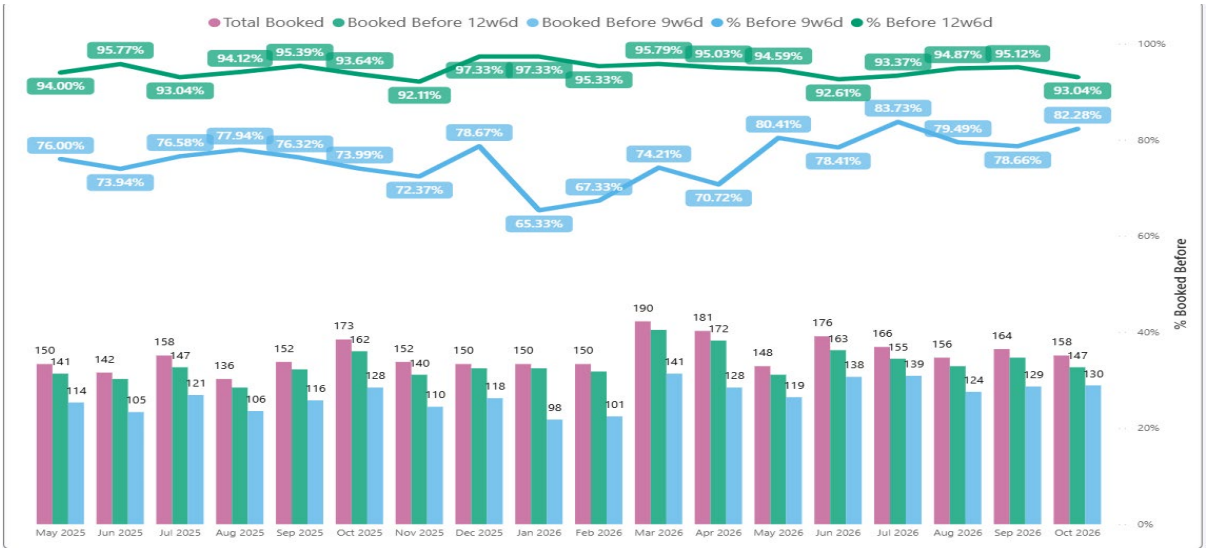
Maternity Dashboard

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

The key findings are summarised below:

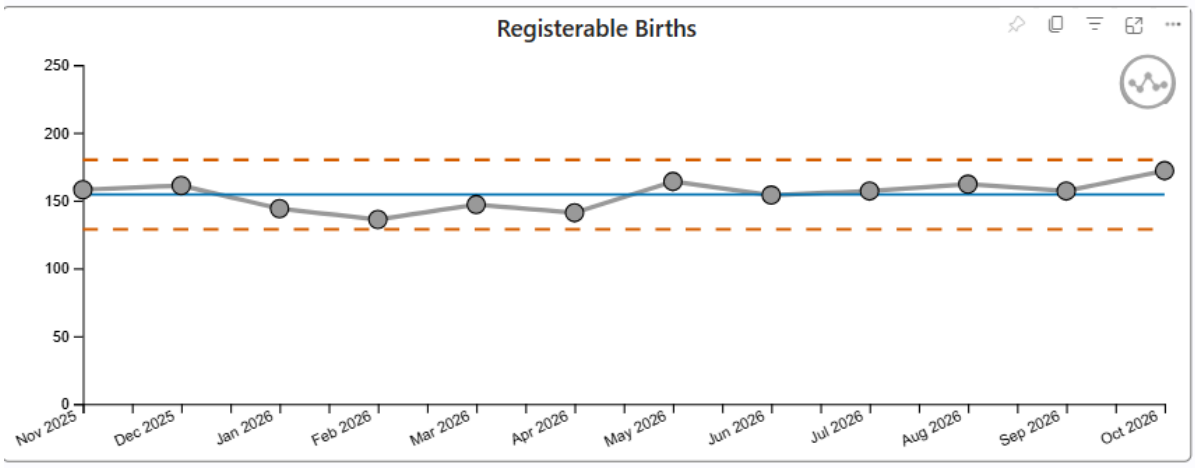
Bookings

991 women booked for maternity care at HDFT April – September 2026 (compared with 910 April – September 2025). Bookings and birth rates remain under surveillance to predict ongoing demand.



Births

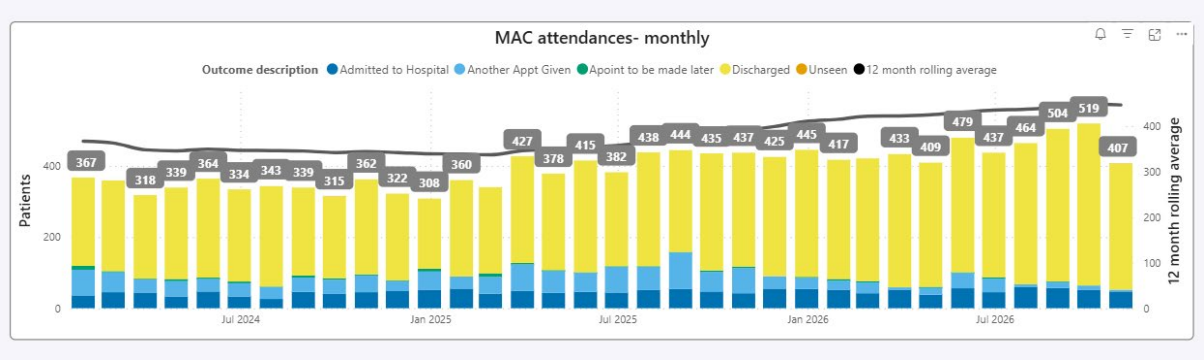
The below screenshot from the dashboard shows that births have remained within the expected range in October.



Maternity Assessment Centre (MAC) Attendances

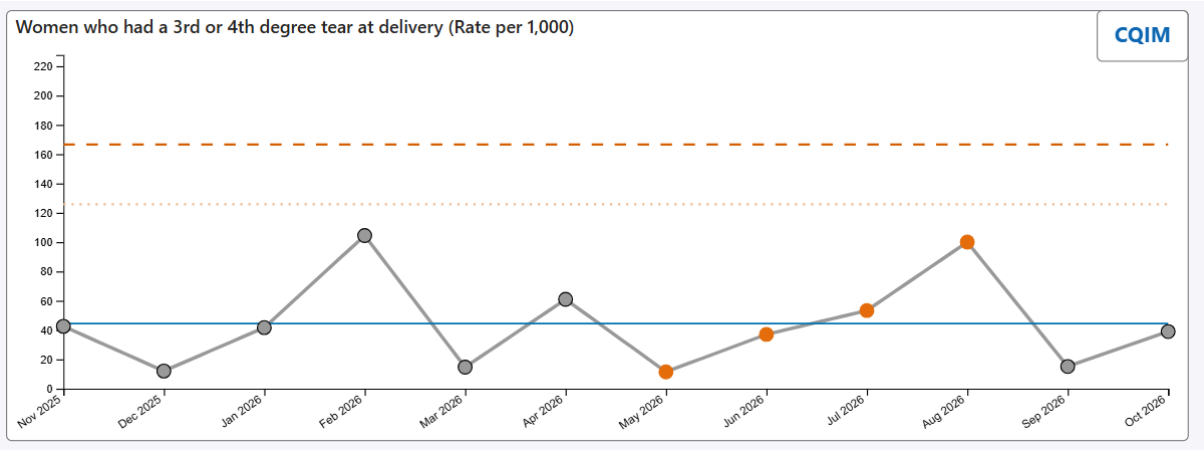
Maternity assessment attendances have shown a steady increase, with a small increase in admissions from MAC. Most women are discharged home from MAC. Safe and effective triage

through MAC is a key part of the maternity 10-point plan and has been an area of improvement since the most recent maternity CQC inspection.



Third- and Fourth-Degree Tears

There were 3 cases of third/ fourth degree tears in October. This is an ongoing area of improvement work and a more in-depth analysis will be published quarterly.

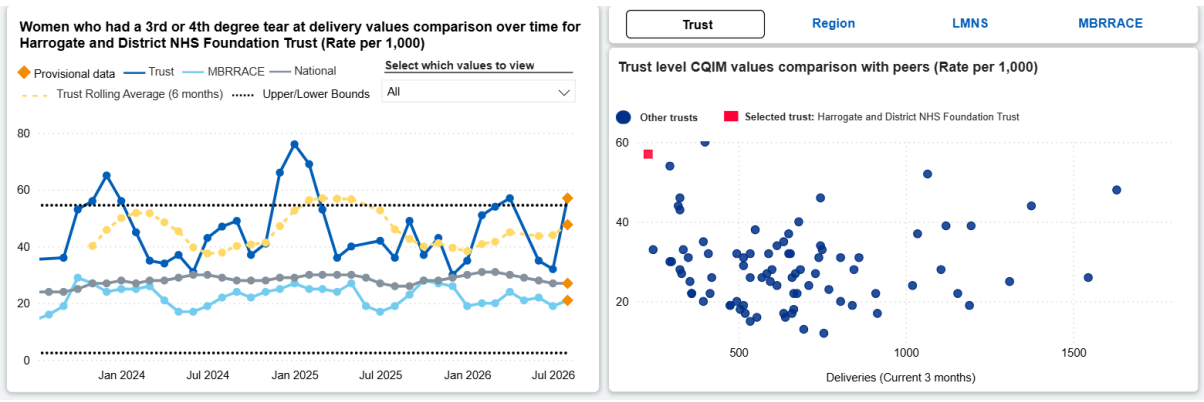


Benchmarking Data from National Maternity Dashboard

The National Maternity dashboard is available at the following link- National Maternity Dashboard. The current dataset reported is from August 2026. The only metric which was outside the upper bound was Robson group 1 caesarean sections included below. Metrics for third- and fourth-degree tears and post-partum haemorrhage are also included here due to their impact on maternal morbidity.

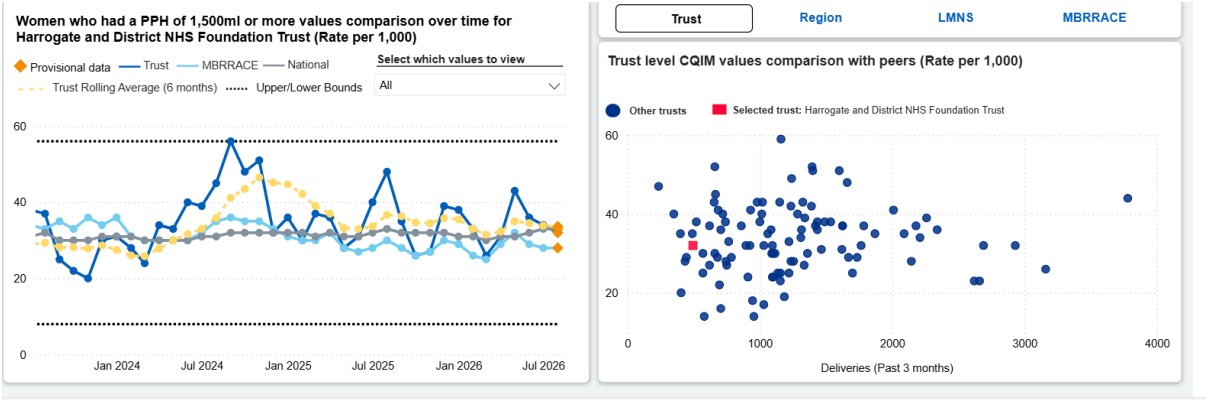
Third- and Fourth-Degree Tears

The data up in August 2026 showed an increased incidence of third- and fourth-degree tears. As the national dataset updates the improvement in the trust rates in September and October should be reflected in an improved position in comparison to other trusts.



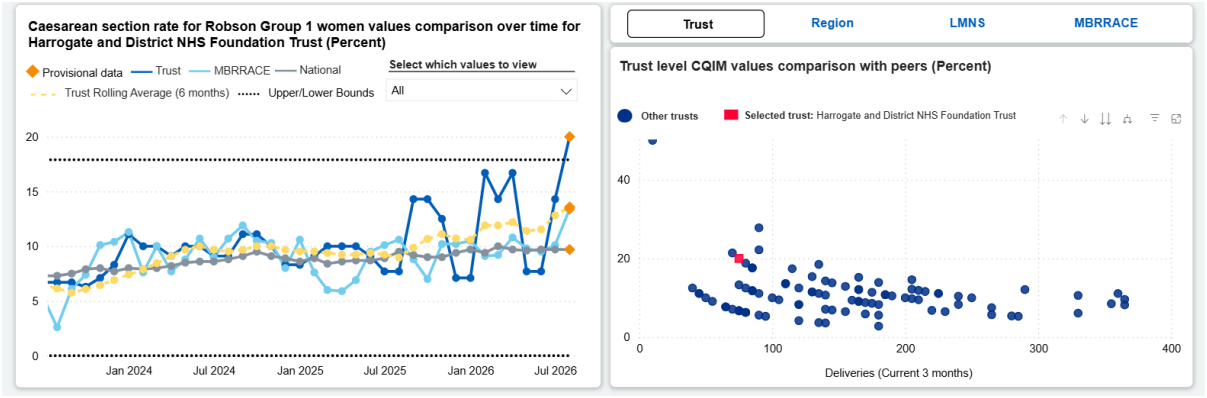
Post- partum Haemorrhage > 1500ml

The trust rolling average PPH rate > 1500ml has returned close to the national average. The national maternity care bundle is being rolled out across the country, standardising measurement and reporting of blood loss which should improve reliability of comparisons across trusts.



Caesarean Section Rate for Robson Group 1

Robson Group one contains women having their first baby at 37 weeks or more who labour spontaneously. The August data shows an increase, which lies outside the upper bound, in the % of women in this group having an emergency caesarean section. This requires monitoring. It should be noted that there is no 'correct' rate for caesarean section and there will always be underlying fluctuations in mode of birth and preferences of women.



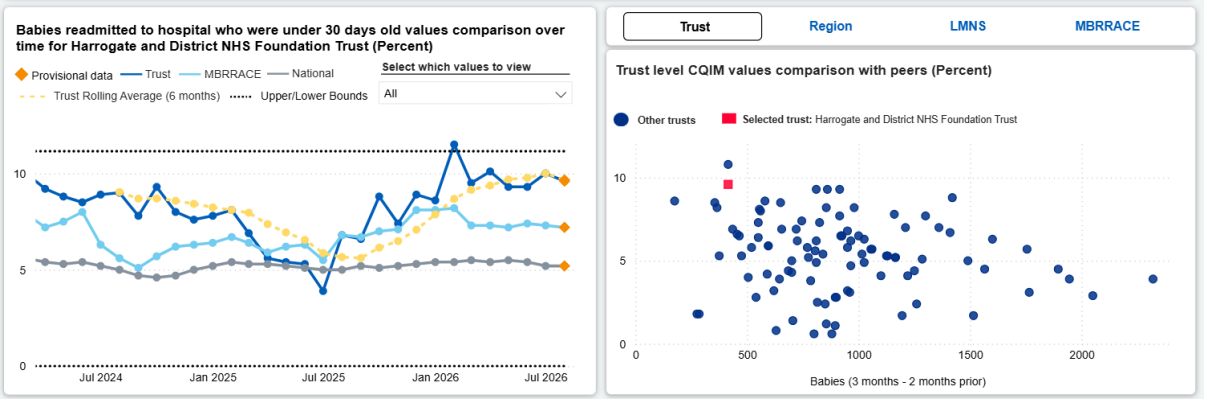
23. Avoiding Term Admissions in Neonatal Units (ATAIN)

Review of Badgernet Neonatal EPR system indicates that there were 12 Term Admissions to SCBU recorded in October (one baby admitted twice). All are being reviewed at ATAIN meeting:

- Three babies admitted with a principal diagnosis of Respiratory Distress
- Two babies admitted with Jaundice
- Five babies admitted with Infection
- One baby admitted with Poor condition
- One baby admitted due to Social Issues

Please see Appendix C for Quarter 2 report and action plan.

Neonatal readmissions also continues to be an area which is being reviewed and work is ongoing. Please see below data tracking neonatal readmissions over time.



Further details about the review and work underway can be found in Appendix D. During Quarter 2 there were 74 babies readmitted to SCBU, Woodlands or Pannal. Of these, 39.2% (29 babies) remained on the unit for <12hrs, and 60.8% (45 babies) remained on the unit >12hrs. This readmission data shows fewer than Quarter 1 (which saw ≥80 readmissions).

Approximately 16 babies were readmitted due to jaundice and 10 babies due to feeding issues, or a combination of the two. It appears that 'early-term' (between 36- and 37+5-weeks' gestation) babies are at a greater risk of being admitted with Jaundice, and babies born at a later 'term' gestation (38-41+ weeks') with a combination of an instrumental birth or maternal complication (PPH / PCOS) appear to be associated with admissions for weight loss.

There are readmissions due to feeding concerns that were *not* categorised as 'weight loss', or 'Jaundice' but have presented with behaviour of a baby that would align with both of those categories - however the diagnostic outcomes do not include them in the two categories outlined above. These account for 10 babies.

Work continues to ensure preventable factors are identified and best practice implemented (see action plan 1.8). All cases continue to be reviewed on an individual basis.

23. Maternity Safety Champions

Bi-monthly Safety Champion executive and non-executive director walk around and meetings continue. The last walkaround and meeting occurred on 21st September 2026. The Executive Safety Champion (Breeda Columb) and Non-exec Safety Champion (Andy Alldred) completed the walkabout. During the walkaround no concerns were raised with staff showing good morale and engagement despite increase in attendances.

Birmingham Symptom specific Obstetric Triage System (BSOTS) had been well received but there were some concerns over triage timescales raised which have been added to the maternity risk register. Staff reported being aware of the financial pressures the trust is currently experiencing but were not raising any safety concerns with shifts and staffing being met.

The next walkaround is scheduled for 16th November 2026.

24. Conclusion

Positive news

- No moderate harm incidents were reported during October.
- SCBU remains fully recruited with QIS compliance improving to 84%, exceeding BAPM requirements.
- Homebirth services were maintained throughout October with no service suspensions.

- Feedback from women, families and neonatal parents continues to be highly positive, particularly regarding staff compassion, professionalism and emotional support

Areas of concern

- Four maternity service suspensions occurred during October, resulting in seven women being diverted to neighbouring units.
- Sixteen induction of labour delays exceeding 24 hours occurred during the month.
- Demand for elective caesarean sections continues to exceed available capacity, requiring additional theatre sessions and delivery suite theatre utilisation.
- Ongoing challenges remain in meeting maternity triage standards and timely obstetric review within MAC.
- Safeguarding training compliance remains below target in several staff groups

Work underway

- Continued implementation of the Maternal Care Bundle to achieve full compliance by March 2027.
- Delivery of actions arising from the Baroness Amos and Ockenden reviews, including strengthening board oversight, roll out of Martha's rule, and maternity triage arrangements.
- Ongoing work to address induction of labour delays, including implementation of the forthcoming NHS England framework.
- Recruitment, retention and workforce sustainability actions to address turnover and maintain safe staffing levels.
- Re-establishment of MNVP arrangements and continued service-user engagement and co-production.

Appendix A

Bi-Annual Staffing Report

1st April 2026 – 30th September 2026

Name & designation of person completing the summary	**Dawn Edmundson, Head of Midwifery** **Leanne Likaj, Associate Director of Midwifery and Children's Services**
Clinical area/s covered by summary:	Delivery Suite Maternity Assessment Centre (MAC) Pannal Ward Community Midwifery Antenatal Clinic
Sources of data collection	Information obtained from E-Roster, Birthrate Plus acuity tool, NHS professionals.

Executive Summary

The purpose of this bi-annual report covering the period 1st April 2026 – 30th September 2026, is to provide assurance to the Trust Board that effective systems are in place for the Maternity and Neonatal workforce planning, and for the monitoring of safe staffing levels across the Maternity and Special Care Baby Unit (SCBU) services. The report presents workforce and staffing data across the Maternity and SCBU services, including staffing levels and rota gaps within the medical and anaesthetic workforce. This report meets the requirements of the NHS Resolution Maternity Incentive Scheme (MIS, year 8).

The report provides assurance that:

- A systematic evidence-based process that has been used to calculate midwifery staffing establishment within the last three years
- A midwifery staffing budget that reflects the establishment calculated above.
- The process is in place to manage daily workload activity and to address any shortfall in planned versus actual midwifery staffing levels.
- An appropriate percentage of specialist midwives are employed and mitigation to cover any inconsistencies.

- 100% compliance with a midwifery coordinator in charge of labour ward who has supernumerary status; (defined as having a rostered supernumerary coordinator and an actual supernumerary coordinator at the start of every shift) to ensure there is an oversight of all birth activity within the service.
- An escalation plan which includes the process of providing a substitute coordinator in situations where there is no coordinator available at the start of a shift.
- One-to-one midwifery care for all women in active labour
- Monitoring of red flag incidents associated with midwifery staffing
- Vacancy rates across all workforce groups are reported and any risks, mitigations and escalations are identified and closely monitored.

The evidence described in this paper provides assurance that Harrogate and District NHS Foundation Trust (HDFT) have an effective system of Obstetric, Anaesthetic, Neonatal Medical and Nursing and Midwifery workforce planning and monitoring of safe staffing levels in place.

Workforce

All vacancies across the maternity and neonatal workforce are actively recruited to as soon as they are evident, ensuring that establishments remain as close to funded levels as possible. Timely recruitment supports the delivery of safe, effective and high-quality care, helps maintain appropriate staffing levels, reduces reliance upon temporary staffing solutions and minimises the risk of gaps in service provision. Proactive recruitment also ensures the service has the workforce capacity and skill mix required to meet clinical demand, national standards and patient safely expectations.

There is an escalation policy for staff to use in the event of staffing short falls, this policy has recently been reviewed and updated.

Midwifery staffing is reviewed four times daily using the Birthrate Plus acuity tool to assess staffing and requirements against the acuity and activity of the service. Any staffing deficits identified are escalated in line with the escalation policy, with immediate actions implemented to mitigate risk and maintain safe care.

The table below lists the current vacancy rate per staff group as of 30th September 2026.

Staff group	Vacancy rate
Midwifery	No vacancies
Maternity Support workers	2.1wte
Obstetric Consultants **Resident Doctors**	No vacancies No vacancies *
Neonatal Nurses	No vacancies
ANNP	N/A
Paediatric Consultants **Resident Doctors**	No vacancies Tier 2 - 1 vacancy – 1:7 rather then 1:8 Tier 1 - no vacancies
Obstetric Anaesthetists **Resident doctors**	No vacancies

Obstetric Workforce

Risks	Mitigations	Escalations
*Additional middle grade doctor is required to support MAC/ ANDU service	Currently utilising MIS funding to support rota	Additional funding is required to support this service to achieve timely review in BSOT's

	Apr	May	Jun	Jul	Aug	Sept
Establishment (no of consultants)	10 cons	10 cons	10 cons	10 cons	10 cons	10 cons
Vacancy rate	0%	0%	0%	0%	0%	0%

Over the last six months, there have been a small number of episodes of short-term sickness absence across the medical workforce. These absences have been proactively managed through effective workforce planning, flexible redeployment of staff and the use of internal cover arrangements where required. As a result, the service has maintained safe medical staffing levels, ensured continuity of care and sustaining the acute maternity service provision without any significant adverse impact upon patient safety, service capacity or clinical delivery. Ongoing monitoring of staffing levels and escalation processes has enabled any gaps to be identified and mitigated promptly, supporting the continued delivery of safe and effective care.

Anaesthetic Workforce

Compliance with immediately available duty anaesthetist for the obstetric unit 24 hours a day

	Apr	May	Jun	Jul	Aug	Sept
% Compliance	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Compliance with immediately available duty anaesthetic assistants 24 hours a day

	Apr	May	Jun	Jul	Aug	Sept
% Compliance	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Plan	Escalation
Immediate "pair of hands" required	Page acute/ITU resident anaesthetist(s) on 0300 bleep
Senior help required	Page COTD in daytime hours –0204 Call general consultant at home either directly or via switchboard

Neonatal Workforce - Medical staffing

Neonatal medical funded posts	Gap to achieve BAPM standard	Mitigation	Plan
Tier 2 resident doctors	Currently 1:7, 1:8 required	We are meeting European work directive and have 24/7 tier 2 resident cover on SCBU	No plan for any change

Neonatal Nursing Staff

Neonatal nursing funded posts	Gap to achieve workforce identified in neonatal nursing workforce calculator	Mitigation	Plan

12.66wte (78% QIS)	Current staff in post 13.18WTE (to comply with BAPM standards & have a shift coordinator the deficit is 4.33wte)	No shift coordinator, this is on risk register. A management member of staff is available in the day Mon – Fri. Additional staff are being rostered Sat - Sun	Business case being developed

Plans have been shared with the ICB and the Neonatal Operational Delivery Network (ODN).

Neonatal capacity pressures

Issue	Mitigations	Escalations
No supernumerary shift coordinator	Non-clinical band 7 in the office Mon – Fri	Business case being developed so we are compliant with BAPM nursing workforce recommendations
2 qualified nursing staff on each shift	If acuity changes then the escalation process is followed involving bringing in more staff	Escalation policy under review following pilot period

Midwifery Establishment

NHS Resolution's maternity incentive scheme (MIS year 8) requires that a systematic, evidence-based process to calculate midwifery staffing establishment is completed and suggests Birthrate Plus (BR+) is utilised to provide this. The Royal College of Midwives (RCM) also strongly recommends using BR+ to undertake a systematic assessment of workforce requirements as it is the only recognised national tool for calculating midwifery staffing levels. Whilst birth outcomes are not influenced by staff numbers alone, applying a recognised and well-used tool is crucial for determining the number of midwives and support staff required to ensure each woman receives one-to-one care in labour (as per NICE (2018) recommendation 1.1.3).

A Birthrate Plus (BR+) establishment review was most recently completed in August 2024, utilising three months of acuity data (December 2023, January 2024 and March 2024) alongside annual birth activity for 2023/24. During the review period there were 1,714 births.

The BR+ methodology determines staffing requirements based on maternity staffing activity and workload rather than the specific locations where women receive care or the individual midwives providing that care. The 2024 review recommended a total establishment of 77.86WTE midwives, comprising clinical, specialist and management roles, of which 10.45 WTE were identified as specialist and management posts. This represented an increase of 1.68WTE compared to the previous BR+ review undertaken in 2021 and was based on the headroom uplift allowance on 20.78% for leave, sickness, training and other absences.

In recognition of the increased education and training requirements associated with the Core Competency Framework and the Maternity Incentive Scheme, the headroom uplift applied to the midwifery workforce was reassessed and an increase to 24% was agreed and applied to all midwifery posts. Applying this uplift increased the recommended establishment requirement to 80.56WTE midwives.

Two business cases were subsequently developed to increase midwifery staffing and maternity support worker establishments in line with BR+ recommendations and professional judgement. The first business case was approved and resulted in an increase of 5.48WTE Band 7 midwives, bringing the funded establishment to 82.68WTE. This additional staffing was intended to strengthen senior clinical support outside normal working hours, increase staffing levels overnight, reduce service diversions, enhance patient safety and improve staff wellbeing.

Birthrate plus recommendations don't include calculations for support staffing required in the clinical areas and this requires professional judgement. Previously there was a funded establishment for support staff of 13.6 WTE. An additional business case was approved at Business Case Review Group in April 2025 to increase the establishment by 5.58WTE Band 3 maternity support workers, giving us a total of 19.18. During this period, additional funding to support the vaccination programme was received giving an extra 0.6wte, having a total of 19.80 WTE.

The HDFT funding for midwives currently is 82.68 WTE and there is currently 82.71 WTE in post (plus 1.6 WTE midwives on Maternity Leave) as at the end of September 2026. See below month-on-month breakdown of WTE midwives in post.

Midwives (Band 5-8A)	April 26	May 25	June 26	July 26	Aug 26	Sept 26
Budgeted Establishment	82.68	82.68	82.68	82.68	82.68	82.68 (+0.8WTE LMNS funded post for Enhanced Continuity)
Staff in Post (including maternity leave)	82.46	83.57	81.72	82.44	82.24	82.71

In addition to establishment setting, BR+ also provides an acuity monitoring tool. The BR+ workforce planning calculation determines the required total midwifery workforce establishment for all hospital and community services, whilst the Acuity App assesses real time staffing based on the clinical needs of women and babies for intrapartum and ward areas. Together they support the provision of safe and effective care which is both sensitive and responsive to changes in acuity and workforce. The BR+ acuity tool was purchased in September 2018, and BR+ updated the ward tool in 2024. Information from this BR+ tool is included within this report. Information is collected from in-patient areas only (Delivery Suite and Pannal ward). Unfortunately, there isn't currently any system available to monitor acuity in a triage area like MAC. In February 2026, an independent review recommended further improvements to the wider BR+ workforce planning methodology, despite acknowledgement by BR+ of further developments and enhanced resources being planned no timescales for implementation of an updated tool has been shared.

The agreed staffing levels in all areas of the maternity department are outlined in the Minimum Staffing Guideline (Maternity). The minimum staffing levels have been agreed based on activity levels, current bed base and the numbers of midwives required to provide safe care to women and their babies. The maternity escalation policy provides clear guidance for the midwife in charge to follow to manage a shortfall in staffing (including the absence of a supernumerary Delivery Suite Coordinator) and the clinical and/or management actions to be taken. The clinical and management actions are also detailed in the BR+ acuity tool to capture the management of this shortfall. A review of the current and planned activity is undertaken to support each decision.

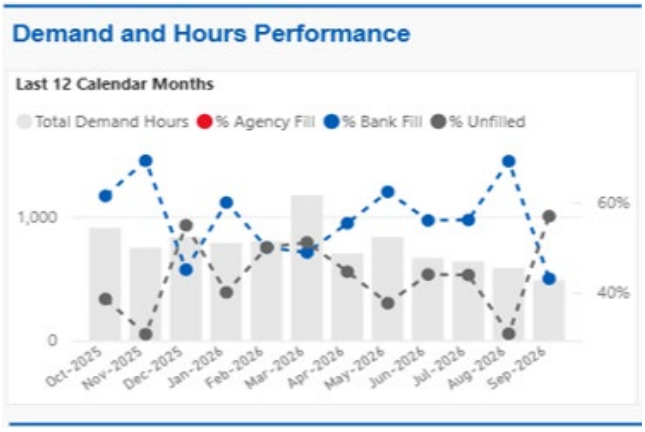
Planned Versus Actual Midwifery Staffing Levels

A weekly midwifery manager's huddle is in place to review the planned staffing against the agreed establishment for each clinical area with the ability to redeploy staff when required.

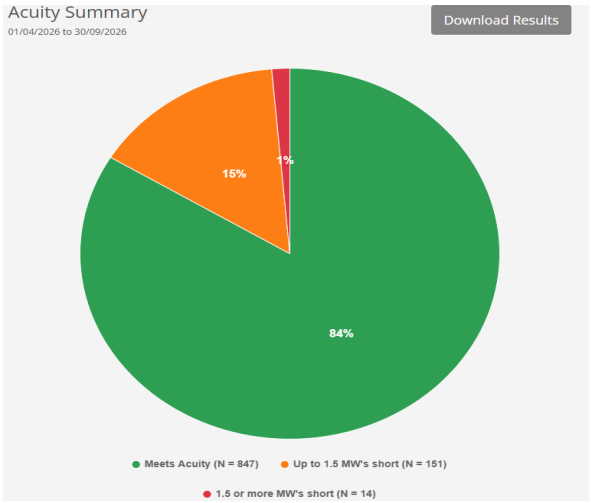
Daily staffing reviews are also completed by the patient flow midwife to ensure a fast response with mitigating actions to address any highlighted staffing shortfall.

Actions are undertaken in accordance with the Maternity Escalation Policy to mitigate the impact of unfilled shifts. These measures included the redeployment of staff between clinical areas, specialist midwives and team leaders undertaking clinical duties and the utilisation of the on-call midwife to address the staffing shortfall during the night shift, as reflected in the reported red flags. In addition, a specialist midwives' availability rota has been established to provide an additional layer of support during periods of intermittent escalation (Monday- Friday). This flexible approach supports the safety of women, babies and staff ensuring that appropriate clinical expertise is available to respond to fluctuations in activity and acuity across the service.

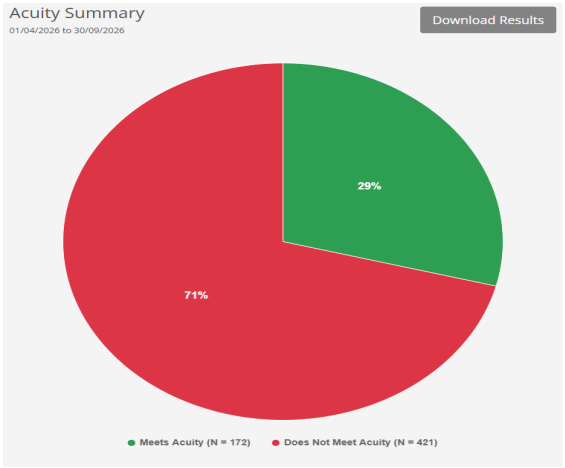
NHS Professionals (NHSP) is utilised to support staffing where required; however, in line with practical use of resources and cost improvement measures, opportunities to cover staffing shortfalls with substantive staff are explored first. This approach ensures safe staffing levels are maintained while minimizing NHSP expenditure and promoting continuity of care for women and families. If substantive staff cannot be used, NHSP bank staff are requested to fill roster gaps which most of the time are due to sickness or vacancy. NHS Professionals' midwifery demand and fill is demonstrated in the graph below.



From the data submitted on BR+ over the six-month period, staffing met the acuity on Delivery Suite 84% of the time, this is an increase of 4% on the previous 6 months data. 15% of the time staffing was up to 1.5 midwives short, this is a reduction of 3% on previous data and 1% of the time, it was reported to be more than 1.5 midwives short (this is a reduction of 1%). Compliance with completing the tool was 77.5%, which is an increase from 75.37% recorded in the previous report.

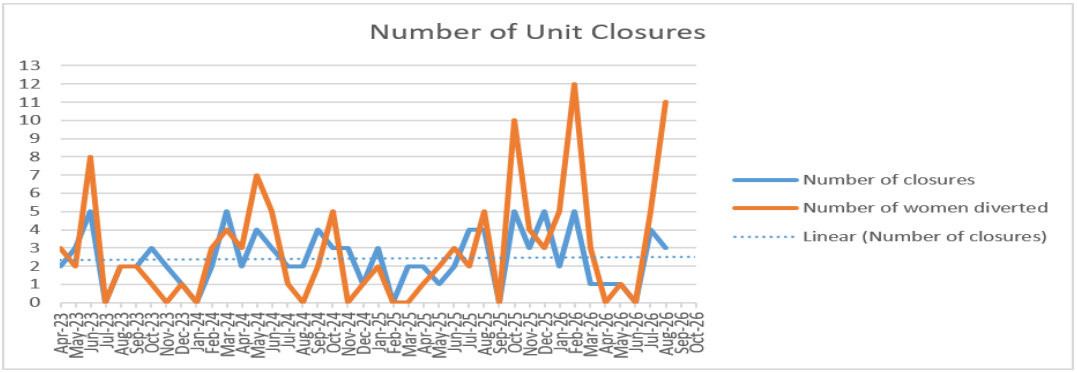


BR+ have developed an acuity app for Pannal ward, which measures antenatal and postnatal care acuity against staffing levels. Data from 1st April to 30th September demonstrated that staffing did not meet acuity requirements on 72% of occasions, representing a 7% increase compared to the previous 6 months. Further analysis identified 732 submission opportunities; however, data was not submitted on 140 occasions (19%. Of the remaining 592 completed submissions, 420 (72%) indicated that staffing levels did not meet the documented acuity requirements. The ward managers are actively monitoring compliance with data submission to improve reporting and accuracy and oversight.



Staff working within the maternity unit are redeployed flexibly between inpatient and outpatient areas according to activity levels and clinical activity. Where demand is higher in a particular area, staff may be temporarily redeployed to support delivery of safe care and maintain patient safety. Measures to mitigate staffing shortfalls are detailed within the Maternity Escalation Guideline and are implemented using professional judgement, supported by the Birthrate Plus acuity tool. Due to the unpredictable nature of maternity services, periods of fluctuating activity are anticipated; the service responds by reallocating staff resources as required, or where necessary temporarily closing to further admissions to preserve safe care standards.

During 1st April to 20th September the maternity unit was temporarily closed on 12 occasions (19 in previous 6 months) with 19 women being diverted to other hospitals (30 in previous 6 months), this is a decrease in both closures and diverts to the previous 6 months.



A Datix incident is completed whenever increased activity results in the temporary closure of the unit and women are diverted to an alternate maternity unit as a consequence. All

women affected by the diversion receive a letter of apology acknowledging any inconvenience caused. Following each closure, the matron and labour ward manager undertake a review of the activity levels, staffing position and decision-making process, with escalation documentation formally signed off following the review. Oversight of the unit closures and staffing concerns is provided through the Maternity Risk Management Group (MRMG), with trends and incidents monitored through Datix to support ongoing learning, governance and service improvement.

Specialist Midwives

To provide the specialist and managerial roles required, the service currently has a 15.5% uplift added to the clinical WTE (recommended by BR+). This is greater than what is seen in larger units, however it is reflective of the needs of smaller units like Harrogate, ensuring that these roles are secured in line with national recommendations and initiatives.

The current percentage of specialist midwives employed is 13.9%. All midwives within this staff group support the maternity unit by working clinically as required, during times of high activity or acute sickness, this is recorded and monitored within the specialist midwives' roster. A significant number of specialist midwives also provide clinical care as part of their specialist role.

The service has a wide range of specialist midwifery posts at Band 6, Band 7 and 8A as detailed below totalling 11.46 WTE;

Bereavement Specialist Midwife 0.96 WTE
Infant feeding Specialist Midwife 0.8 WTE
Quality and Safety & Governance Lead 1.00 WTE
Named Midwife for Safeguarding 1.0 WTE
Antenatal and Newborn Screening Specialist Midwife 1.0 WTE
Digital Midwife 0.8 WTE
Midwife Sonographer 0.80 WTE
Recruitment and Retention Midwife 0.8 WTE
Perinatal Pelvic Health Midwife 0.4 WTE
2 x Professional Development Midwives 1.05 WTE (Inc. Fetal Monitoring Lead role)
Clinical Educator Midwife 0.55 WTE
Perinatal Mental Health Midwife 0.8 WTE
Audit Midwife 0.7 WTE
Diabetes Specialist Midwife 0.6 WTE
Pre-term Birth Midwife 0.2 WTE
Professional Midwifery Advocate Lead Midwife 0.6 WTE (Corporate funding)
Research Midwives (research funded)

Compliance with Supernumerary Labour Ward Coordinator Status and Provision of One to One (1:1) Care in Active Labour

Data extracted from Birthrate plus during the six months shows there was a compliance completion rate of 77.5% on the Delivery Suite and 81.01% for Pannal. A higher

compliance completion rate provides more assurance that the interpretation of the results is accurate.

The labour ward coordinator has supernumerary status, defined as having a rostered planned supernumerary co-ordinator and an actual supernumerary co-ordinator at the start of every shift (NHS Resolution, Maternity Incentive Scheme, 2024) to enable oversight of all the birth activity within the service. MIS year 8 (2026), no longer requires this information to be submitted, however this is gold standard, and it will continue to be monitored and recorded at HDFT.

There is always a delivery suite coordinator (or suitably experienced band 6 midwife in exceptional circumstances) rostered to be in charge on Delivery Suite and they will aim to be supernumerary to provide oversight of all birth activity in the service at the beginning of every shift and to continue this throughout the shift. 100% compliance was achieved by having a planned supernumerary coordinator and an actual supernumerary coordinator at the start of every shift during this 6-month reporting period.

During this time period 1:1 care in labour was achieved 100% of the time for women admitted to the unit.

935 women birthed
7 women experienced a baby being born before the arrival (BBA) of the midwife
8 women had a homebirth

Red Flags

Red flag events have been agreed locally (including guidance from NICE) and are captured on the BR+ acuity tool on Delivery Suite. During the 6-month period between 1st April and 30th September the following red flag events were identified;

Number of Red Flags recorded
01/04/2026 to 30/09/2026

Red Flags	Breakdown of Red Flags	Times occurred	Percentage
RF1	Delayed or cancelled time critical activity	5	50%
RF2	Missed or delayed care	2	20%
RF3	Missed or delayed mediation > 30 mins	0	0%
RF4	Delay in providing pain relief > 30 mins	0	0%
RF5	Delay between presentation and triage >30 mins	0	0%
RF6	Full clinical examination not carried out when presenting in labour	0	0%
RF7	Delay between admission for induction and beginning of process	2	20%
RF8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	0	0%
RF9	Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	0	0%
RF10	Midwife unable to provide 1:1 high dependency care for AN or PN patient	1	10%
TOTAL		10	

*The % is rounded to nearest whole number

Birthrate Plus identifies a range of management actions that can be implemented to prevent a red flag incident escalating. These include measures such as delaying elective activity, redeploying staff between clinical areas and utilising specialist midwives and team leaders in clinical areas. Red flags are intended to highlight occasions where safety concerns have arisen despite the implementation of these mitigation measures. Whilst HDFT aims to minimise and prevent red flag incidents, periods of increased activity, or staffing shortfalls may result in one or more red flag events occurring. Staff are actively encouraged to record red flag incidents openly and accurately to provide oversight of service pressures and support timely intervention where required.

HDFT has a well-established Maternity Escalation Policy that is implemented during periods of high acuity or inadequate staffing levels. Whenever a red flag event occurs, a senior midwifery and/or obstetric review is undertaken, and an appropriate clinical management plan is agreed. These reviews consider whether alternative actions could have reduced service pressures, assess compliance with safety measures and identify opportunities for learning and improvement. Any learning arising from these reviews is shared with relevant teams to support ongoing learning and the safe delivery of high-quality maternity care.

If a red flag is identified and women and families are affected by this, they are kept informed throughout, with clear communication regarding any delays to care and expected timescales for resolution.

Summary

During the reporting period, maternity and neonatal services have continued to demonstrate a strong commitment to maintaining safe care despite ongoing workforce challenges. Midwifery staffing remains fully recruited to establishment with sustained achievement of 100% compliance for both one-to-one care in labour and supernumerary Labour Ward coordinator provision. Delivery suite staffing has shown improvement against acuity requirements, and there has been a reduction in maternity unit closures and diversions compared to the previous reporting period.

Whilst staffing pressures continue within inpatient services, particularly on Pannal Ward where acuity frequently exceeds available staffing resource, robust escalation processes, workforce redeployment and support of specialist midwives have enabled services to maintain safe care. Neonatal services continue to experience challenges in meeting all BAPM workforce recommendations, particularly regarding supernumerary leadership provision, and work is underway to strengthen resilience through workforce planning and business case development. Across all staffing groups, active recruitment, workforce monitoring and service improvement initiatives remain in place to ensure quality, safety and positive outcomes for women, babies and families.

Recommendations

- Continue active recruitment to all maternity and neonatal workforce vacancies as they arise to maintain safe staffing levels
- Review Pannal ward staffing and acuity requirements as data demonstrated staffing did not meet acuity on many occasions in this reporting period
- Strengthen workforce resilience within neonatal services to include progressing plans to achieve BAPM recommendations
- Improve compliance with Birthrate Plus data completion to provide accurate assurance and inform future workforce planning

Monitor and review Maternity unit closures and diversions, identifying any themes
Maintain regular staffing reviewing through governance processes and plan a formal Birthrate Plus review earlier than currently planned
Support the recruitment of an additional middle grade doctor to work in MAC to enhance medical workforce capacity and strengthen the provision of safe and timely maternity care

Appendix B

Planned and Surgical Care
Maternity
Saving Babies' Lives Exception Reporting to Board Q2 2026/2027
Author: Rachel Tabram

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Introduction

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

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

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


HDFT WYH LMNS SBLCBv3.2 Ongoing


SBL Q4 2025 report V1 FINAL.docx

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


_SBLCBv3.2_Tool_Q 425-26 HDFT.pdf

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

Results

This review has demonstrated the following compliance with process measures of quarterly monitoring in Quarter 2 (2026/2027) and previous compliance:

Element	Metric	Process Measure	Compliance Q1	Compliance Q2
1	1.3b	Percentage of women where their smoking status at 36 weeks is recorded	99.5%	95.6%
	1.4	Percentage of smokers* that have an opt-out referral at booking to an in-house tobacco dependence treatment service	100%	100%
	1.6a	Percentage of smokers* that are referred for tobacco dependence treatment to set a quit date	72.3%	25%
	1.6b	Percentage of smokers* that set a quit date and are identified as CO verified non-smokers at 4 weeks	37.5%	14.3%
	1.6c	Percentage of smokers*at antenatal booking who are identified as CO verified non-smokers at 36 weeks	28.6%	44.4%
	1.8	Percentage of staff within date training compliance on the use of a CO testing and discussion of results	63%	75%
	1.9	Percentage of staff providing maternity care with annual in date training compliance on the delivery of VBA, making an opt-out referral and maternity pathway processes	76%	77%
2	2.7	Percentage of women booked that are identified as high risk for FGR who have had a uterine artery doppler assessment between 18+0- and 23+6-weeks gestation	92.3%	91%
3	3.2b	Proportion of women who attend with recurrent* RFM who had an ultrasound scan by the next working day to assess fetal growth.	62.5%	53.2%
5	5.11	Test for asymptomatic bacteriuria in women who are assessed as being intermediate or high risk of preterm birth by sending off a midstream urine (MSU) for culture and sensitivity at booking. Following any positive culture and treatment, a repeat MSU to confirm clearance is recommended.	88.2%	94.6%

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

Element 1

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

In Quarter 2 Badgernet reports this as 95.6% with 17 patients having no smoking status recorded between 35 and 36+6. Only two of these patients had their CO level checked at this gestation, with CO not offered reason documented as 'monitor not available'. Although compliance meets expected standard, this will be escalated to the Public Health midwife as it is a fall in compliance from the last quarter.

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

In Quarter 2 Badgernet reports this as 10/11 patients, 90.9%. However this patient was only a social smoker who gave up prior to pregnancy, not smoking in the two weeks before booking and does not meet criteria for referral to smoking cessation. Compliance has been altered to 11/11 to reflect this, 100%.

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

Compliance has previously ranged from 25% to 100% for this measure. In Quarter 2 Badgernet reports this as 2/10 patients, 20%, significantly lower than previous quarter. The Maternity Health Advisor confirmed two patients experienced a miscarriage and have been excluded from this standard. Six patients did not engage with tobacco dependence treatment or set a quit date. [2/8 = 25% compliance]

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

Badgernet reports this as 14.3% for Quarter 2, below expected standard. This metric is impacted by small numbers as the total sample is only seven patients and only one patient set a quit date and was a verified non-smoker at 4 weeks.

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

Badgernet reports this as 44.4% for Quarter 2. This metric is impacted by small numbers as the total sample is only nine patients and only four patients set a quit date and were verified non-smokers at 36 weeks.

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

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

CO training	July 2026	August 2026	September 2026	Q2 total
MSW's	16/16	17/19	15/19	[redacted]
Midwives	72/103	75/99	72/99	
Total	88/119 (74%)	92/118 (78%)	87/118 (74%)	267/355 (75%)

Figure 2: CO training figures

Considering midwives and MSW's, both who use CO monitors daily; evidence of compliance for CO monitoring training was completed by 75% of staff in Quarter 2. This fell below the LMNS expected standard however has improved compliance since Quarter 1.

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

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

VBA training	July 2026	August 2026	September 2026	Q2 total
MSW's	16/16	17/19	15/19	[redacted]
Midwives	72/103	75/99	72/99	
Obstetricians	18/20	18/20	17/19	
Total	106/139 (76%)	110/138 (80%)	104/137 (76%)	320/414 (77%)

Figure 3: VBA training figures

Evidence of compliance for VBA training was completed by 77% of staff Quarter 2. This fell below the LMNS expected standard however has remained stable from Quarter 1. Since the launch of the e-learning package future quarters should see continual improvement.

Element 2

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

Uterine artery dopplers are not always recorded on Badgernet and therefore requires manual audit. Badgernet reports this as 43/82, 52.4% compliance. All exceptions (39) were reviewed to identify if their FGR risk was accurate.

Three patients were excluded as their care was being received by a local Trust and they incorrectly pulled into the automated Badgernet report. A further 12 patients were excluded as their risk was incorrectly recorded and there was either no antenatal clinic referral or the antenatal clinic appointment had identified the risk was not indicative of a uterine artery doppler and they commenced serial scans from 32 weeks.

18 patients had evidence of a uterine artery doppler performed between 18+0 and 23+6 weeks.

Six patients did not have evidence of a uterine artery doppler between 18+0 and 23+6 weeks being performed. Risk factors included autoimmune disease (1), previous FGR (1), low PAPP-A (1) and previous hypertension (3). These patients all commenced serial scans at 28 weeks with no reference to uterine artery doppler being performed previously.

Compliance has been adjusted to 61/67 (91%), meeting the stretch ambition for this audit standard. In June 2026 changes to ICE ultrasound scan requesting for serial scans (28 weeks and 32 weeks) now both include a pop-up questioning if there are any risk factors for FGR. This change was made to help clinicians recognise that uterine artery doppler is required when there is a risk factor for FGR and to utilise this test instead of booking serial scans from 28 weeks. There are consistently missed opportunities for 2nd trimester uterine artery doppler screening each quarter and this will be addressed in the recommendations for this report.

Element 3

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

As ultrasound scans are not imported automatically into Badgernet this report requires manual cross referencing. Badgernet reports this as 25/51 (49%). All exclusions (26) were manually reviewed looking for evidence of whether an ultrasound scan was completed within the timeframe and reasons for non-compliance.

Three patients were excluded who went on to have an IOL, LSCS and were in spontaneous labour. A USS would not be facilitated in these situations. A further patient was excluded where the documented reason for attendance was RFM, however the midwife had free text documented normal fetal movements, the patient was seen by the doctor for vaginal bleeding and the doctor also documented normal fetal movements. It is likely reason for attendance was a documentation error and should have been vaginal bleeding.

Of the non-compliant cases (22), six had an ICE request that was correct, 27.3%. These were performed between one and three days after the next working day (one to three days late). One patient with a correct ICE request attended subsequently with a further episode of RFM and had an IOL arranged prior to the USS for the original attendance being performed. These were managed appropriately by the clinicians responsible on MAC and will be escalated to the ANC manage to confirm whether these were escalated to her as being unable to be performed in the required timeframe.

16 patients did not have their USS within timeframe, with noted errors in why this was not facilitated, summarised in the table below. Their scans were performed between one and 13 days late for six patients (37.5%) and ten patients did not receive an USS following their episode of recurrent RFM (62.5%).

Error	No.	%
Not recognised RRFM	9	56%
Existing USS booked, not brought forward	2	13%
Recognised RRFM, no documented plan for USS, therefore no ICE request	3	19%
Documented plan for USS, no request on ICE	2	13%
Total	16	100%

Figure 4: Reasons for non-compliance

One patient with recurrent RFM over the weekend was noted by the midwife to have had an USS three weeks ago, after discussion with the doctor was advised to stick to follow-up USS in a further week. However, the area of error with the largest number of patients affected is not recognising recurrent RFM (56%). Figure 4 shows areas where learning from this audit standard can be targeted to address the need to facilitate an USS within one working day of an episode of recurrent RFM.

There were 22 non-compliant cases (25/47 compliant cases, 53.2%). This meets the LMNS expected standard, however this has fallen from the last quarter. Non-compliant cases will be escalated to the antenatal clinic team leader. Learning from previous quarterly reviews has been consistently shared with staff, including an email sent with high importance. Changes have also been made to ICE requesting for third trimester USS to enable appropriate risk stratification based on the patient's presentation and RFM episode number.

Element 5

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

Badgernet confirms there were 45 patients identified as high and intermediate risk preterm birth in Quarter 2. 15 (33.3%) had documentation of an MSU in the correct note on Badgernet. All others (30) were manually cross-referenced via ICE and Badgernet for evidence of an MSU.

Eight patients were excluded from this sample. Four were not at risk of preterm birth, three were transfers of care at gestations 29/40, 29/40 and 34/40 and the final patient was an out of area patient at term who attended triage due to her local maternity unit being closed.

Of the remaining 22 patients, 20 further patients to those identified on Badgernet had an MSU at booking taken. Two patients who were intermediate risk of preterm birth had not had an MSU at booking, then were seen in antenatal clinic by the preterm birth consultant/midwife where no MSU was obtained.

Month	High and intermediate risk patients	MSU's obtained at booking	Percentage (%)
Q1 Total	37	35	94.6%

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

94.6% of patients in Quarter 2 had an MSU at booking on either Badgernet or ICE for their preterm birth risk. This is an improvement from all previous quarters. Where MSU's have not been taken at booking for preterm birth risk, patients will be escalated to the preterm birth lead midwife.

Conclusion

Key successes

- Recording smoking status at 36 weeks has improved and meets expected standard
- Referral to tobacco dependence service is 100%
- MSU at booking meets expected standard and has remained stable

Key concerns

- Reduction in the number of smokers who set a quit date
- CO verified non-smokers at 4 weeks after initiating smoking cessation support and 36 weeks gestation are below expected standard
- CO and VBA training are below expected standard
- Six missed opportunities for uterine artery doppler screening, commencing serial scans at 28/40
- Ultrasound scan the next working day for recurrent RFM has fallen, with errors in clinical management identified

Limitations

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

Re-audit

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

Issues for escalation

- Reduction in smokers engaging with the Tobacco Dependency Service has been escalated to the Lead Midwife for Public Health *(Completed October 2026)*
- CO and VBA training below expected compliance has been escalated to the Lead Midwife for Public Health *(Completed October 2026)*
- Patients who did not receive their ultrasound scan the next working day following an episode of recurrent RFM have been escalated to the antenatal clinic team leader. *(Completed October 2026)*
- Patients at risk of preterm birth who did not receive an MSU have been escalated to the preterm birth midwife. *(Completed October 2026)*

Recommendations

- Saving Babie's Lives E-learning has been chased by the Maternity Training Team *(Completed October 2026)*
- Share learning of patients not receiving uterine artery doppler screening in the 2nd trimester
- Share learning of patients not receiving their USS the next working day for RRFM where clinical management was a contributing factor

References

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

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

Appendix C

ATAIN and Transitional Care provision report
Quarter 1 (1st July 2026 – 30th September 2026)

1. Report Overview

ATAIN is an acronym for Avoiding Term Admissions into Neonatal units. It is a national programme of work initiated under patient safety to identify harm leading to term neonatal admissions. The current focus is on reducing harm and avoiding unnecessary separation of mothers and babies.

2. The National Ambition

In August 2017 NHSI mandated a Patient safety alert to all NHS Trusts providing maternity care. The safety alert was issued to reduce harm from avoidable admissions to neonatal units for babies born at or after 37 weeks. This fell in line with the Secretary of State for Health's ambition to reduce stillbirth, neonatal brain injury and neonatal death by 50% by 2030. This ambition is also aligned with the vision created within Better Births (2016), which aims to drive forward the NHS England-led Maternity Transformation Programme, with a key focus on;

- Reducing harm through learning from serious incidents and litigation claims
- Improving culture, teamwork and improvement capability within maternity units.

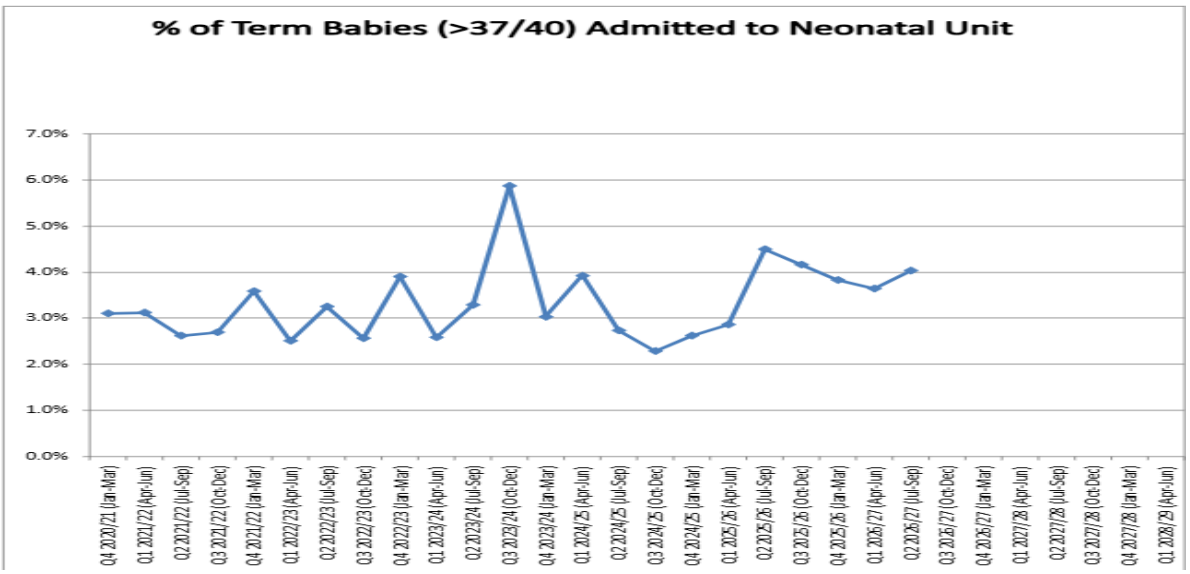
3. Why Is It Important?

There is overwhelming evidence that separation of mother and baby so soon after birth interrupts the normal bonding process, which can have a profound and lasting effect on maternal mental health, breastfeeding, long-term morbidity for mother and child. This makes preventing separation, except for compelling medical reason, an essential practice in maternity services and an ethical responsibility for healthcare professionals.
The maternity and neonatal teams review the babies born at or over 37 weeks (term) who were admitted to Special Care Baby Unit (SCBU) at designated monthly ATAIN meetings and the joint maternity and neonatal meeting. The monthly term admission rate for HDFT is reviewed and tracked on the dashboard and shared with the local maternity and neonatal system. Actions are also generated in response to any themes or concerns.

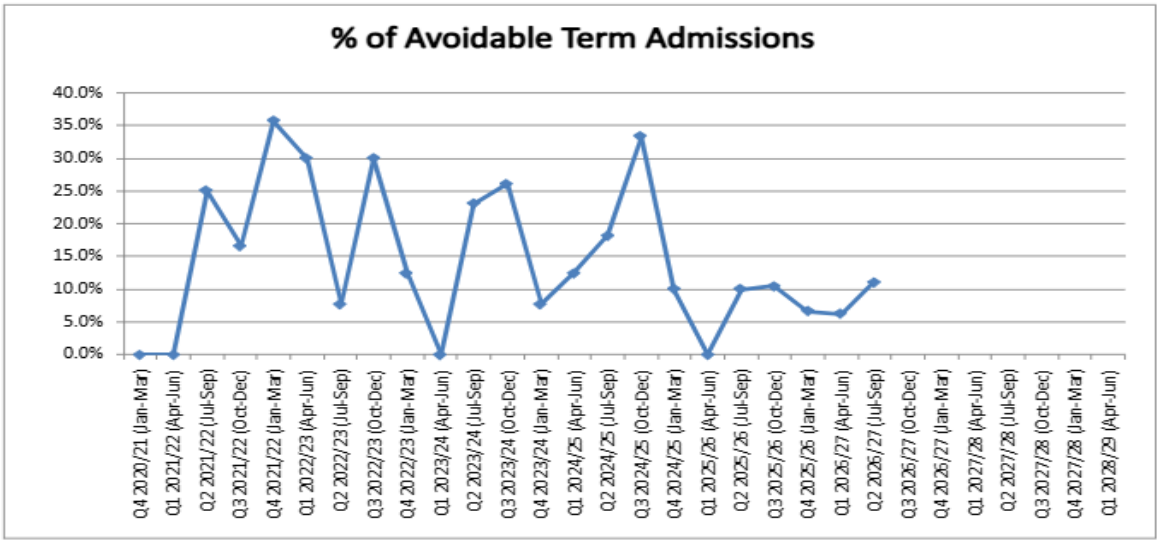
4. ATAIN Data: Quarter 2 2026/2027

During quarter 2 there were a total of 477 registerable babies of all gestations born at HDFT. 447 of these were born at term and therefore admissible for ATAIN audit. Of the 447, 18 babies (4%) were admitted to SCBU, which remains below the national benchmark of 6%. Reason for admissions to SCBU for this quarter are displayed below:

Reason for admission to SCBU	Respiratory distress syndrome (RDS)	Hypoglycaemia	Jaundice	Other	Total
Number of babies	10	1	0	7	18



5. Potentially Avoidable Admissions



Following review of sixteen of the cases of term neonates admitted to SCBU in the last quarter at monthly MDT ATAIN meetings, it was identified that fourteen of the admissions to SCBU were appropriate. In addition, it was found that of the fourteen appropriate admissions, one of these neonates could have been admitted to a TCU unit.

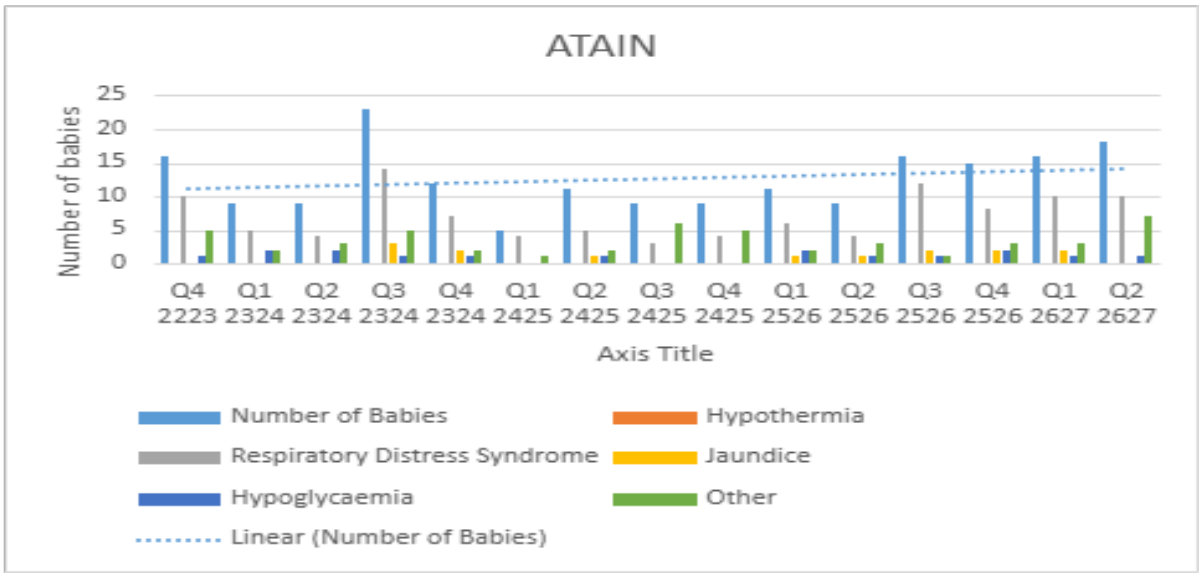
One of the admissions related to a neonate admitted for closer monitoring and observation, following two episodes of cyanosis on Pannal ward. The neonate was admitted to SCBU, had a chest x-ray and commenced prophylactic antibiotics and then remained on SCBU for an observatory period of over twenty-four hours – but never required further respiratory support. Although following review, this admission was deemed appropriate, it was concluded that this neonate could have been transferred back to Pannal ward sooner and that this neonate could have been admitted to a transitional care unit.

Two of the sixteen cases reviewed were identified as potentially avoidable admissions to SCBU. One case involved a neonate who was transferred to Leeds Teaching Hospitals NHS Trust (LTHT) for surgical review following episodes of bilious vomiting. In this instance, the neonate was admitted to SCBU solely to facilitate transfer via Embrace and was subsequently transferred directly back to Pannal Ward, after review at LTHT excluded intestinal obstruction. A review of the neonatal records, it was identified that there was no clear documentation to indicate that admission to SCBU had occurred as a requirement to enable the Embrace transfer. Therefore, it was concluded that the transfer could have been facilitated directly from Pannal Ward.

Additionally, a further potentially avoidable admission to SCBU during this quarter involved a neonate born by Category 1 emergency caesarean section following placental abruption. Although the neonate initially required respiratory support with Positive End-Expiratory Pressure (PEEP), this was administered in air only and no supplemental oxygen was required. At the time of transfer to SCBU, at 38 minutes of age, PEEP had been discontinued and the neonate's observations, including heart rate, respiratory rate and oxygen saturations, were all within normal parameters. The decision to transfer the neonate to SCBU was made following identification of abnormal cord gas results, to facilitate ongoing observation, repeat blood gas analysis, obtain intravenous access and commence prophylactic antibiotics. However, the neonate was transferred back to Central Labour Ward Suite (CLWS) less than one hour after admission to SCBU. Following review, this admission was considered inappropriate, as the observations, investigations and treatment required could have been safely undertaken on CLWS, thereby avoiding unnecessary maternal and neonatal separation.

In terms of clarity for the difference in number of admissions with the number of reviews undertaken, there are two reviews from this quarter which currently remain outstanding and will be reviewed at the next ATAIN MDT review meeting.

6. ATAIN Data Trend



7. ATAIN Action Log

No.	Action/Issue Identified	Action Required / Progress	Owner(s)	Measurable Outcome	Review Date / Status
1	Learning from ATAIN reviews requires wider dissemination to clinical staff.	Monthly ATAIN teaching sessions incorporated into MAT 3 study days from January 2026. Recent case reviews and updated ATAIN data included within teaching programme.	Neonatal Education and Governance Lead Pannal Team Leaders	≥90% attendance at eligible study days. Teaching delivered monthly.	Ongoing Quarterly review
2	Neonatal admission following airway obstruction during skin-to-skin contact highlighted need for further safety education.	'Skin to Skin After Birth' conversation prompt implemented. Safe positioning posters displayed in labour rooms and on Pannal Ward.	Pannal Team Leaders CLWS Team Leader	100% of clinical areas display posters. Skin-to-skin safety discussion	Ongoing Quarterly review

				included following birth. No further potentially avoidable SCBU admissions related to unsafe skin-to-skin positioning.	
3	Lack of local guidance to support management of Neonatal Herpes.	Completion, ratification and implementation of Neonatal Herpes Guidelines.	Paediatric Consultant Neonatal Education and Governance Lead	Guidelines ratified and published. Staff briefings completed. Availability via PolicyStat.	Target for production and ratification Q4 26-27
4	Variation identified in completion of neonatal observations and early recognition of deterioration.	Oxygen saturations incorporated into all neonatal observations in line with NEWTT2. Compliance audit planned.	Audit and Clinical Effectiveness Lead Midwife Pannal Team Leaders	≥95% compliance with documented oxygen saturation observations. Audit completed and presented through governance forum. Action plan developed for any areas of non-compliance.	Audit due Q3-Q4 2026
5	ATAIN reviews identified a need for clearer management guidance for neonates with raised haematocrit levels	Development of local guidance including assessment, escalation and management of neonates with raised haematocrit.	Paediatric Consultant Neonatal Education and Governance Lead	Guidance approved and implemented. Staff education delivered. Reduction in variation in clinical management identified through case review.	Polycythaemia guideline produced and approved at paediatric governance - Awaiting approval by transfusion prior to uploading on PolicyStat
6	ATAIN reviews identified insufficient documentation regarding rationale for SCBU admission and inconsistent documentation of handover following transfer from SCBU to Pannal Ward.	Feedback provided to neonatal medical team. Targeted education regarding admission rationale, documentation standards and transfer handovers to be delivered. Documentation standards to be	Neonatal Education and Governance Lead	100% of reviewed SCBU admissions contain documented rationale for admission. 100% of transfers back	Ongoing Quarterly review Learning shared – plan for audit of compliance Q3-Q4

		monitored through case review.		to Pannal Ward contain documented handover. Improvement demonstrated through quarterly ATAIN reviews.	

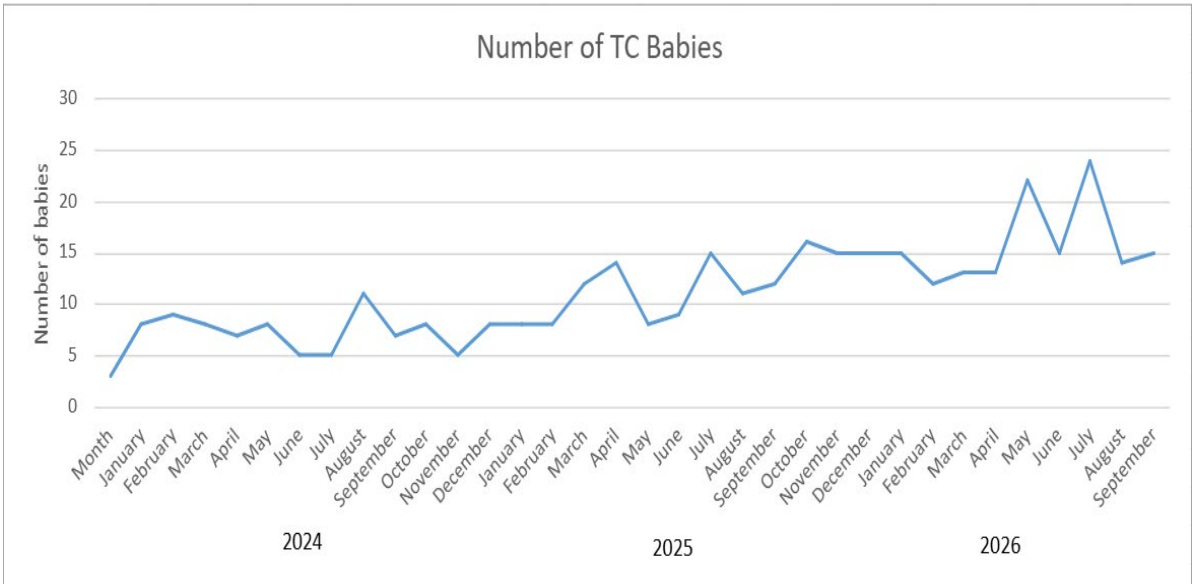
8. Transitional Care Provision and Standards

Through family integrated care, families have been encouraged to take an active role in caring for babies on the neonatal units (NNU/SCBU). Introducing Transitional Care (TC) follows the same philosophy and thus services should be created with the needs of the family at the forefront.
One of the key advantages of TC is offering early intervention makes it less likely the neonate's condition will deteriorate. Therefore, reducing the risk of maternal and neonatal separation, increases the chance that neonates remain well. This also ensures that care is cost effective. It is important that the staff working on SCBU and the postnatal ward understand the difference between 'normal' postnatal care and TC. It is also vital that maternity and neonatal staff can evaluate and respond to the maternal and neonatal needs whilst being able to detect signs of deterioration as early as possible, therefore multidisciplinary collaboration is essential.
At HDFT, a review of TC babies occurs daily during dedicated ward rounds, where assessment takes place and plans of care are made. This review takes place using the 'Transitional care' tab on Badgernet, enabling completion of the 'Daily summary' on each ward round. There is an escalation policy for any babies who are unwell, which is well known by the team and followed should the need arise. We are continuing, within our MDT, to ensure these occur at a set time every day and increase representation from both services.

9. Transitional Care Babies: includes pre-term as separate from ATAIN

Month	July	August	September	Total TCU
Number of babies	24	14	15	53

10. Transitional Care Provision January 2024 - September 2026



11. Quarter 2 2026/2027 Transitional Care Data

During this quarter 53 babies were admitted to on TCU on Pannal ward – this equates to 11.1% of all registerable births. The rationale for TCU is detailed below:

Reason for TCU	IV Antibiotics	Jaundice	Babies stepped down from SCBU	Gestation 35-35+6	Weight loss readmission >12%	Total
Number of babies	28	9	12	3	1	53

12. TCU Action Log

No.	Action	Owner(s)	Target Date	Measurable Outcome
1	SOP approved for 'Transitional Care on Central Labour Ward Suite for babies born 34-34+6 weeks gestation'. Pilot commenced February 2026 and continues whilst awaiting estates developments. Ongoing evaluation of the pilot to inform future service provision.	Neonatal Education and Governance Lead Pannal Team Leaders Maternity and Neonatal Obstetric Group	Ongoing, quarterly review	Number of eligible babies managed within TCU pathway. Monitoring of reduction of separation of in SCBU 34-34+6-week neonates.
2	Progress plans for widening SCBU doors to facilitate transfer of postnatal beds into SCBU, enabling greater parental presence and minimising separation of women/birthing people and neonates requiring enhanced care. Estates works currently deferred due to Trust financial position.	Neonatal Education and Governance Lead Capital Planning Team Estates Department	Q1 2027	Capital planning approval. Project commencement date. Completion of estates work. Implementation of postnatal bed transfers into SCBU.
3	Continue multidisciplinary planning with the Resuscitation Department regarding maternal emergency equipment requirements for safe care of postnatal women accommodated within SCBU following estates works.	Resuscitation Team Neonatal Education and Governance Lead Pannal Team Leaders	Q1 2027	Agreement of equipment required Completion of risk assessment Obtaining of required equipment
4	Continue cascade training and utilisation of Bilicocoon phototherapy system across the midwifery workforce to enhance management of neonatal jaundice within TCU settings and reduce admissions/readmissions requiring SCBU phototherapy.	Pannal Team Leaders	Ongoing	Percentage of staff trained Increase in Bilicocoon utilisation Reduction in length of stay/readmissions for jaundiced neonates.
5	Re-circulate and promote completion of the Serum	Pannal Team Leaders	Ongoing	Increase in percentage of competent staff

	Bilirubin (SBR) Competency Framework to increase the number of midwives able to independently undertake neonatal SBR sampling and facilitate timely investigation and treatment.			Reduced delays in obtaining SBR samples Reduced delays in commencing and ceasing phototherapy treatment in accordance with local guidance
6	Deliver neonatal IV antibiotic refresher and competency sessions to increase the number of midwives able to safely administer neonatal IV antibiotics within TCU settings.	Neonatal Education and Governance Lead	Ongoing	Further dates of Neonatal IV Antibiotics refresher sessions to be shared with midwifery staff Increase in number of competent midwifery staff resulting in increased availability of competent practitioners Reduction in delays to antibiotic administration.

Appendix D –

Hospital readmissions of babies within 30 days of life

Quarter 2. July – Sept 2026

1.1 Report Overview

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

There should be cautious interpretation of data between Trusts across the UK due to differing admission criteria, breastfeeding rates and levels of supplementation of breastfed babies in the community. Although lower readmissions are often measured as a positive marker this may be at the detriment of exclusive breastfeeding. Breastfeeding initiation in Harrogate is currently **92.9%** (an increase from Quarter 1: 91.7%) and supplementation rates continue to be within World Health Organisation and UNICEF UK parameters (2024/25).

1.2 Process for data collection

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

1.3 External reporting

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

1.4 National guidance

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

1.5 Local guidance and preventative measures

UNICEF UK Baby Friendly weight loss guidance has been adapted locally to ensure plans of care are introduced early and are supportive of long-term breastfeeding. Collaboration between Infant Feeding Coordinator and Community Management will develop this further to be more proactive, and less reactive to the weight-loss challenges we face - looking into themes that may crop up through an audit started in Autumn 2026.

A breast pump loan scheme supports mothers to implement plans of care. Additional training on how to maximise milk production while also trying to reduce the risk of mastitis will be included in the curriculum in 2027 for both ward and community maternity staff.

Specialist support with breastfeeding is available to all mothers via a weekly support group at Harrogate Library which can triage and act like a funnel into the Frenulotomy service for those requiring Frenulotomy to improve effective feeding and sustainable breastfeeding.

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

Jaundice	Age readmitted	Potential Contributing Factors	Gestation	Treatment	Feeding Method	Length of stay
Baby 1*	3 Days	Forceps birth	40	Phototherapy	Breast	24hrs
Baby 2*	3 Days	Early-Term + 3 hourly feeds, PROM	37+6	Phototherapy & IV Abx	Breast	72hrs
Baby 3*	1 Day	Early-Term + 3 - 4hourly feeds, PROM + PPH + Ankyloglossia.	37+1	Phototherapy	Breast	<48hrs
Baby 4*	4 Days	Forceps birth + Ankyloglossia.	39	Phototherapy	Breast	16hrs
Baby 5*	5 Days	Responsive / ineffective breastfeeding	40	Phototherapy	Mixed	48hrs
Baby 6	7 Days	Prematurity, C/S, PPH	36+4	Feeding Support	Breast	6hrs
Baby 7**	5 Days	Feeding challenges + Jaundice	38	Feeding support	Mixed	28hrs
Babies 8*	5 Days	DCDA Twin 1 & 2	38+6	Feeding support	Breast + EBM & Artificial milk Top-ups	25hrs

Feeding Issues	Age readmitted	Gestation At birth	Weight loss	Treatment	Feeding method	Length of stay
Baby A*	4 Days	39	12.6%	Build Milk supply + EBM Top-ups (some artificial milk)	Breast	24hrs
Baby B*	3 Days	37	12.8%	Feeding plan + EBM Top-ups	Breast	50hrs
Baby C*	3 Days	37+6	10.9%	Feeding Plan + EBM Top-ups	Breast	<24hrs
Baby D*	3 Days	39+3	13.4%	Feeding Plan + Artificial milk Top-ups	Breast	46hrs

Baby E*	5 Days	39+5	15%	Frenulotomy clinic appointment arranged + Supported to build maternal milk supply	Breast	28hrs
Baby F**	5 Days	38	10.9%	Observations of baby + Feeding support	Mixed	28hrs
Baby G*	4 Days	40+1	13%	Feeding Plan / Support + EBM & Artificial milk Top-ups	Breast	28hrs
Baby H*	10 Days	41	13.4%	Tongue-Tie, Feeding plan	Breast	44hrs
Baby I	3 Days	40+2	14.5%	Feeding Plan / Support + EBM Top-ups	Breast	19hrs

1.7 Findings Summary

During Quarter 2 there were **74** babies readmitted to SCBU / Woodlands or Pannal. Of these, 39.2% (**29 babies)** remained on the unit for <12hrs, and 60.8% (**45 babies**) remained on the unit >12hrs. This readmission data show fewer than Quarter 1 (which saw ≥80 readmissions).

Approximately 16 babies were readmitted due to jaundice and 10 babies due to feeding issues. Or a combination of the two. There are some gaps in the data pulled from the reporting system at the time of writing this report however this looks proportionate. It appears that 'early-term' (between 36 and 37+5 weeks' gestation) babies are at a greater risk of being admitted with Jaundice, and babies born at a later 'term' gestation (38-41+ weeks') with a combination of an instrumental birth or maternal complication (PPH / PCOS) appear to be associated with admissions for weight loss.

There are readmissions due to feeding concerns that were *not* categorised as 'weight loss', or 'Jaundice' but have presented with behaviour of a baby that would align with both of those categories - however the diagnostic outcomes do not include them in the two categories outlined above. These account for 10 babies.

Work continues to ensure preventable factors are identified and best practice implemented (see action plan 1.8). All cases continue to be reviewed on an individual basis.

1.8 Recommendations - Action plan

Recommendations from Datix review	Action To Achieve Compliance with Recommendation (SMART)	Lead Responsible	Expected Completion	Comments
Review current practice to ensure all preventable measures to reduce readmissions of babies with jaundice have been identified and implemented	**Review** a cohort of babies previously admitted, and all new admissions over the next two quarters • Agree the data set to be collected, including a more comprehensive review of maternal history, and adapt the current proforma accordingly	Infant Feeding Co-ordinator Lead Midwife for Safety, Quality & Clinical Governance	**Dec 2026**	**Jan 2026** Proforma adapted – Data set to be agreed at neonatal obstetric meeting

	• Utilise previously collected data, alongside data from ongoing readmissions, to inform the analysis • Submit a report of findings to MRMG for review and discussion			
Ensure **weight loss guidance** is followed	• Write a newsletter for staff to support weight loss guidance • Write supporting guidance for babies with further weight loss following day 3 • Ensure out of area Trusts have HDFT guidance • Discuss admissions that may not be required and length of stays at neonatal obstetric meeting • Individual feedback to be continued	Infant Feeding Co-ordinator	**Sept 2026**	**June 2026** Meeting arranged with community midwife to write guideline for slow weight gain following initial loss Individual feedback given to all concerned this quarter
Ensure NICE guidance and local policies on **newborn jaundice** are followed	**Refresher** for midwives, neonatal nurses and paediatricians • NICE guidance on when to commence phototherapy including risks • Not relying on visual assessment to assess level of jaundice • Daily weight when being treated with phototherapy	Infant Feeding Co-ordinator	**Completed**	Care of babies with Jaundice included in yearly updates for midwives. Individual feedback given to paediatricians regarding commencing phototherapy below treatment thresholds.
Ensure **accurate weighing and recording of babies' weights** in hospital and community	**Ensure** staff: • Check weight with another person, except where not possible in exceptional circumstances • Take a photograph for evidence. • Enter the weight on Badger Net immediately. • Take care not to transpose digits. • Make sure equipment is set to zero prior to placing baby on the surface. • Baby to be weighed naked.	Lead Midwife for Safety, Quality & Clinical Governance	**Completed**	'Learning from incidents' newsletter sent to all staff
Avoid overnight stays for babies with weight loss that have normal blood test results	• Explore cost of purchasing a hospital grade double breast pump to loan to parents overnight to help with feeding plan.	Infant Feeding Co-ordinator	**Completed**	**October 2024:** Bereavement support group contacted but no available funding at present. **Jan**

	• Remind staff to give parents an individual plan of care, which where appropriate, includes a plan to re weigh baby on the postnatal ward in 24 hours.			**2025:** Application submitted to HDFT Charities **July 2025**: No further response from Charities. Other funding to be considered. **Oct 2025**: Consideration to be given to using small loan pumps on a trial basis, to be discussed at neonatal obstetric meeting. **March 2026**: HDFT Charities have supported the purchase of a new breast pump.
Ensure feeding plans are consistent for babies readmitted with weight loss.	• Arrange meeting with the Paediatric clinical lead for postnatal and the infant feeding co-ordinator to discuss more formal feeding plans for larger weight loss in babies. Include when to supplement and when to repeat weight and bloods. • Update guideline to reflect outcomes of decisions made at meeting. • Communicate updated guideline to staff. • Ensure training includes updated guidance.	Neonatal Clinical Lead Infant Feeding Co-ordinator	**Completed**	**October 2024:** Draft SOP completed. Requires discussion with paediatric clinical lead and then agreement at Paediatric governance. **Jan 2025:** Meeting arranged with paediatric consultant. **March 2025:** 1. Draft plans agreed 2. Readmission guideline updated 3. Feeding plans added to Mat 3 update for 2026/7. Will be added to next infant feeding newsletter for staff 4. Readmissions and feeding plans included in full infant feeding training
Ensure moderately **preterm babies** on the postnatal ward **receive the same level of care as babies on SCBU**	• Work with neonatal nurses to develop a plan of care for moderate/late preterm babies on the postnatal ward. Include feeding, thermoregulation, increased risk of jaundice and neurodevelopmental care. • Train all midwives in care of late preterm babies • Develop an information package for parents. • Ensure any changes to care are included in appropriate guidelines	Infant Feeding Co-ordinator Neonatal Educator and Governance Lead	**Completed**	**March 2025:** 1. Plan of care developed and agreed 2. Care of late preterm babies is the theme for Mat 3 infant feeding update 2025/6. 3. Parent package in draft, nearly complete 4. Guidelines to be reviewed **July 2025:** 3) Parent package completed, to be agreed at MQAM. 4) Guideline updated
Share learning with the community team to improve care and consistency	• Arrange dates to meet with community midwives • Share good practice and discuss individual cases where care could possibly be improved • Develop plans of care for static weight / weight loss following introduction of a feeding plan	Infant Feeding Co-ordinator Community Team Leader	**Completed**	

Reduce admission of babies under a month old to paediatrics	• Audit number of babies admitted and reasons for admission quarterly • Review reasons for admissions in the first two weeks following transfer home from maternity in more depth to find possible preventable causes • Meet with the Pannal team lead to discuss discharge processes and information given to families before home and consider face to face group discharge • Meet with the community team lead to discuss possible post-natal group at discharge visit	Infant feeding Co-ordinator Community Team Leader Postnatal team leads	**Completed**	

1.9 Readmissions to paediatrics

All babies with no concerns other than jaundice and/or feeding are seen directly on Pannal ward. This pathway ensures a suitable environment for the needs of mothers and babies, supports breastfeeding and reduces the risk of hospital acquired infections. Babies returning to the hospital due to other reasons are admitted to Woodland's ward as appropriate.

1.10 Paediatric readmission data **

During this quarter, there were 51 readmissions of babies to paediatrics. Readmissions of healthy term babies with jaundice and weight loss specifically are reported earlier in this report and are therefore not included in these figures. The babies ranged in age from 2 to 27 days at the time of readmission. 54.9% percent of babies were discharged home within 12 hours of admission, often with open access arrangements.

1.11 Benchmarking

Recent benchmarking with local Trusts has taken place to identify any learning and actions.

Jaundice appears to be the leading cause of readmission across all three Trusts benchmarked. Jaundice readmissions were most identified at Harrogate; it accounts for 55% of Calderdale's readmissions and 40% for Airedale.

Feeding difficulties are a major contributory factor for all three trusts with varying elements such as excessive weight loss (due to ineffective milk transfer featuring prominently across all three organisations); Tongue-tie, and delayed lactogenesis specifically were recurring themes in Harrogate case reviews.

Early-term babies appear overrepresented. Reviews undertaken at Harrogate identified several readmissions among babies born at early term (36+0 to 37+6 weeks' gestation). Similar trends were observed within jaundice-related readmissions reported by Calderdale and Airedale. In response, the Harrogate Maternity Infant Feeding Coordinator and SCBU UNICEF Lead are collaboratively reviewing and peer-assessing a proposed pilot pathway of care for early-term infants within the Transitional Care Unit (TCU), planned for implementation in October.

The pilot aims to strengthen feeding effectiveness, optimise physiological care, and improve the early identification and management of jaundice prior to discharge. By providing targeted support for this higher-risk group, the initiative is expected to enhance outcomes for babies

and families, while also contributing to a reduction in readmissions associated with jaundice and excessive weight loss.

1.12 Conclusion

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

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

Appendix E - Explanatory notes

1. Birthrate Plus Establishment

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

3.6 WTE Band 2 (Admin/Ward Clerks)
19.18 WTE Band 3 (Maternity Support Workers/Screening Admin)
0.6 WTE Band 4 (Tobacco Dependency Advisor)
81.69 WTE Band 5-8d (Midwives)

2. Birthrate Plus Acuity Staffing Data

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

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

3. Red Flag Events Recorded on Birthrate Plus

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

4. Perinatal Mortality Review Tool (PMRT)

Principles for the conduct of local perinatal mortality reviews:

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

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

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

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

Which perinatal deaths can we review using the PMRT?

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

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

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

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

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

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

From Year 8 onwards:

- the scheme focuses on six revised safety actions

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

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

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

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

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

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

4. Service-user voice and equity
    - This safety action focuses on ensuring that the voices of women, families and carers are heard, valued and acted upon, and that care is equitable.
    - Trusts are expected to capture and use feedback from women and families, understand the needs of their local population, and address barriers to safe, accessible and inclusive care.
    - This includes recognising and responding to differences in experience and outcomes across different groups.

5. Care bundles
    - This safety action focuses on the implementation of national maternity and neonatal care bundles, which bring together evidence-based practices to improve outcomes.

- Trusts are expected to prioritise implementation based on local safety intelligence, monitor progress through established governance routes, and ensure Board-level oversight of care bundle delivery.
- Care bundles support consistent, evidence-based care across services.

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

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

During the MIS year, Trusts are expected to:

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

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

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

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

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

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

6. Maternity Care Bundle (MCB)

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

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

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

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

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

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

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

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

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

6. Avoiding Term Admissions in Neonatal Units (ATAIN)

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

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

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

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

the past few years, but more recent data shows there is more to do to achieve the ambition in 2025.

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

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

There are six elements of care:

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

In addition to the provision of safe and personalised care, achieving equity and reducing health inequalities is a key aim for all maternity and neonatal services and is essential to achieving the national maternity safety ambition. In developing each element in SBLCBv3, actions to improve equity have been considered, including for babies from Black, Asian and mixed ethnic groups and for those born to mothers living in the most deprived areas, in accordance with the NHS equity and equality guidance.

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

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

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

teamHDFT At our best

NHS Harrogate and District NHS Foundation Trust

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

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

GOALS:

Urgent & Emergency Care

The best place for person centred urgent and emergency care

Exemplar System

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

Equitable & Timely

Equitable, timely access to best quality planned care

GOVERNANCE:

Person-centred Framework

- Board Assurance: Resource Committe
- Programme Board: Elective Programme Board, UEC Programme Board
- SRO: Chief Operating Officer
- Operational Lead: Deputy Chief Operating Officer

True North Metrics

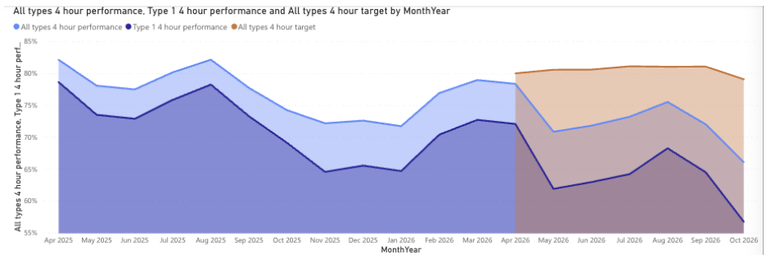
1. **ECS 4 Hour Standard - 95% of patients admitted or discharged within 4 hours**
2. **Length of Stay - Top quartile nationally for patients with frailty (to be redeveloped)**
3. **Elective Recovery RTT - 92% of patients waiting under 18 weeks for treatment**
4. **Cancer 62 Day Standard - 85% of patients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

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

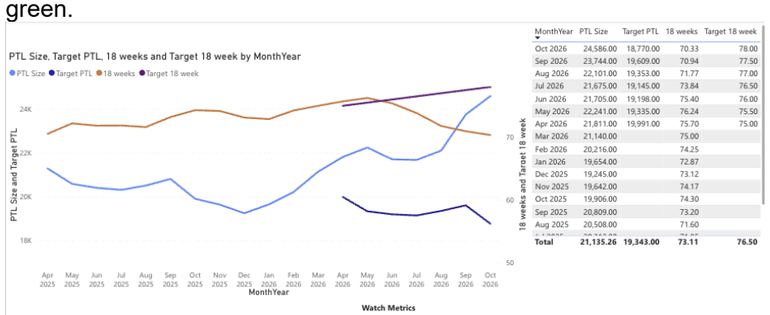
Overarching Risk Summary:

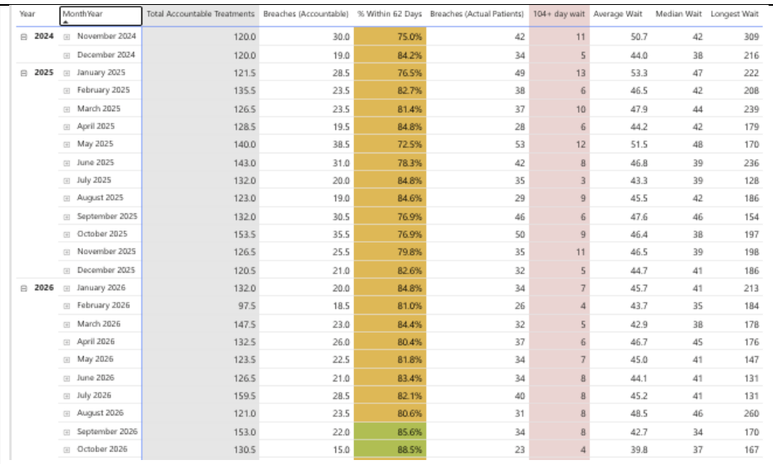
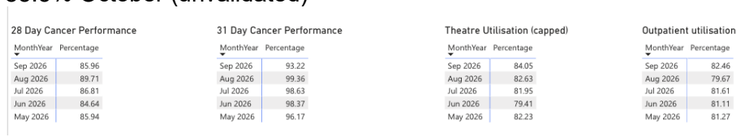
Ambition	Workstream	True North Metric	Risk Appetite	Level of Risk to Achieve Metric – Linked to Risk Appetite 1 – 3 | 4 – 6 | 8 – 9 | 10 | 12 | 15 | 16 | >20
Person Centred, Integrated Care, Strong Partnerships	**The best place for person centred urgent and emergency care**	**ECS 4-hour Standard**	**Operational: Cautious**	
	An exemplar system for the care of the elderly	**Length of Stay - Patients with Frailty (being redeveloped)**	**Operational: Cautious**	
	Equitable, timely Access to Best Quality Planned Care	**Elective Recovery RTT – 18 Weeks**	**Operational: Optimistic**	
		Cancer 62 Day Standard – 62 Days Treatment	**Operational: Optimistic**	

Strategic Metrics Summary:

Workstreams	True North Metric	Vision	Goal	Current State	Countermeasures	Level of Risk to Achieving Goal (CxL)	Level of Risk for progressing actions
The Best Place for Person Centred, Integrated Care	ECS 4 Hour Standard	95% of non-admitted patients not requiring a bed to be assessed, diagnosed, treated, and discharged with 4 hours. 95% of admitted patients to be moved to required department within 60 minutes of medical decision.	By March 2027, we want 82% of patients having their care completed within 4 hours. By March 2028, we want 85% of patients having their care completed within 4 hours.	The True North Metric of ED 4 Hour Standard continues into its second year (2025-26). For the **SIXTH** month in a row we remain significantly below target for the month. April 78.35% (t.79.97%), May 70.8% (t. 80.54%), June 71.64% (t. 80.56%) , July 72.85% (t. 81.08%) , August 75.5% (t. 81.08%) ,Sept 72% (t.81.03%) and Oct 66.05% (t.79%) with ED Attendances below plan. Watch metrics covering the ED are out of target for 6th consecutive month for predicted harms, 12 hour arrival waits with ambulance handover outside for the second month, 12 hour trolley waits for the first but pleasingly sepsis screening are green. The outcome of the work to analyse the current under performance has demonstrated the need to develop processes in the non-admitted pathway and the need to reduce >4hour breaches within 15 minutes. Breakthrough Objective: Time to Next Step  Emergency Department Data **Watch Metrics** **Unplanned ED Attends vs Plan** MonthYear / Percentage Oct 2026 -1.53 Sep 2026 -1.67 Aug 2026 -2.20 Jul 2026 -1.54 Jun 2026 -1.72 **ED Harms associated with 6hour plus wait** MonthYear / Percentage Oct 2026 19.57 Sep 2026 14.12 Aug 2026 12.04 Jul 2026 15.09 Jun 2026 15.17 **12 hour trolley waits** MonthYear / Percentage Oct 2026 58.00 Sep 2026 0.00 Aug 2026 3.00 Jul 2026 0.00 Jun 2026 16.00 **12 hour arrival waits** MonthYear / Percentage Oct 2026 277.00 Sep 2026 76.00 Aug 2026 68.00 Jul 2026 119.00 Jun 2026 126.00 **ED Sepsis Screening** MonthYear / Percentage Oct 2026 98.58 Sep 2026 98.26 Aug 2026 99.08 Jul 2026 99.29 Jun 2026 98.77 **ED Ambulance Handover Under 15mins** MonthYear / Percentage Oct 2026 63.38 Sep 2026 70.23 Aug 2026 74.90 Jul 2026 76.93 Jun 2026 73.82 A key metric impacting flow in M7 was LOS, which increased in 7/14/21 day LOS and compounded challenges to flow and performance in ED. This led to the addition of flow/discharge actions within the 'stood up' UEC transformation plan.	ED / Hospital Flow pathways work with Nervecentre deployment and particular focus on bed allocation. COS now live with monthly review of feedback on issues delivering COS standards. Developing expanded UTC space at Ripon, 'go live for this planned Jan 27. Agreed action to develop ED focused A3 in September, which is nearly complete and will focus on; • Workforce modelling to maximise capacity to demand. • The Nurse in charge (NIC) and Emergency Physician in charge (EPIC) role consistency to promote the culture of performance. • Enhancements to nerve centre to increase efficiency and productivity. • Using 'time to next destination' as a tool within the dept to improve flow. Wider Trust actions on time to next destination also underway. In month deterioration in performance in both non-admitted and admitted pathways deteriorating. Evoked a 'standing up' of a series of urgent meetings to understand the drivers for deterioration and urgent actions. Both operational directorate leadership teams have co-produced a 'UEC transformation plan' with currently 4 domains 1. ED (A3 non admitted pathway and embedding the COS) 2. Surgical SDEC (A3 and implementation of the COS) 3. Radiology COS 4. Flow and Discharge		

					The inaugural transformation session was had in early November, with good clinical and operational engagement. We have also deployed the clinical operations manager/EPRR lead to support ED for the ext 4 months to support implementation/embedding of the COS and support the ED team on escalation process/consistency. Breakthrough objective for time to next step agreed at 60 minutes, will focus on countermeasures that support in ED flow the non admitted pathway and admitted flow into ward areas. We have also submitted a recovery trajectory to NHSE until the end of the financial year.		
An exemplar system for the care of the elderly and people living with frailty.	Length of Stay with Frailty	Top quartile Length of Stay nationally for patients with Frailty by March 2027.	By March 2026, we will achieve top half Length of Stay for Frailty nationally. By March 2027, we will achieve top quartile Length of Stay for Frailty nationally.	We remain upper quartile for LOS in frailty. The new A3 is now underway. Data is being produced now nervecentre in place to then decide on the final metric: Frailty Dataset produced with clinical team and data analysts to work through A3 and agree drivers. By Clinical Frailty Score : OBD's , LOS , Time to move off AFU to base ward , Patients not in frailty with high CFS – numbers, LOS's.	Full review of A3 for this project underway with wider frailty team for new metric and countermeasures by September 2026 having consistently achieved upper quartile LOS. **Suggestion that we pause this driver to focus on ED and 'time to next destination' given consistent performance and quality care delivery.**		
Equitable & Timely	Elective Recovery (RTT) Standard	Sustained achievement of the 92% of patients being treated within 18 weeks.	By March 2027, we will achieve 18-week performance at 80.5% By March 2028, we will achieve 18-week performance at 87%. By March 2028, we will achieve 18-week performance at 92%.	18 week performance is reducing for the third month in a row despite activity delivery being in line with plan. Reduced premium/ outsourcing is contributing to a drop in performance – this is 'ok' in specialties performing but the impact on overall performance where those specialties were above target is causing the drop. Key specialties remain challenged in delivery , this is also resulting in 52 week breaches particularly in T&O, Vascular. Additional watch metrics have been added : total pathways over 18 weeks Clock Starts and Clock Stops (these update a month in arrears) End of June 75.40 **%**. (t.76%), End of July (t. 79.7%), Sept 71% (t. 77.5%) , Oct forecast 70.3% (close date not until 3rd week Nov) With numbers of pathways over 18 weeks remaining high although slight reduction on last month. The PTL size is likely to grow slightly despite the extended validation window. With clock start numbers continuing out or target demand seems to be driving this.	HDH Additional Theatres (TIF2) build delayed due to the need for further water testing and looking into 2027 go live. Outpatient Transformation, rollout of further faster programme and track key metrics: • New: Follow Up ratios • Absolute reduction in follow ups • DNA rates • Clinic cancellation rates • Patient Initiated Follow Up Rate TPAM meetings. Increased to weekly to review RTT performance and focusing on 5 specialities recovery plans. T+O is a specific issue related to a unexpected sickness – plan now in place , no predicted 52 w breaches for M8.		

				Detailed analysis has been undertaken, two core drivers; 1. Increase in demand 2. Reduction in planned activity (additional above core in planning cycle) Five specialities causing reduction; • T+O • ENT • Max fax/vascular • Gynaecology • Gen surgery Focus will return to validation on the over 18-week part of the PTL as per national instruction. Internally focus is on sequential booking of both outpatients and theatres, planned and costed targeted additional 1st outpatient and treatment capacity and a switch of non RTT to RTT activity where possible. The rest of 26/27 will focus on 'getting the basics right' end to end for OP and theatres. Managing demand through SPOA and pathway re-design, maximizing capacity and planning HDFT Futures programme. Watch metrics – apart from clock starts and pathways over 18 weeks are green.  MonthYear | PTL Size | Target PTL | 18 weeks | Target 18 week Oct 2026 | 24,586.00 | 18,770.00 | 70.33 | 78.00 Sep 2026 | 23,744.00 | 19,609.00 | 70.94 | 77.50 Aug 2026 | 22,101.00 | 19,353.00 | 71.77 | 77.00 Jul 2026 | 21,675.00 | 19,145.00 | 73.84 | 76.50 Jun 2026 | 21,705.00 | 19,198.00 | 75.40 | 76.00 May 2026 | 22,241.00 | 19,335.00 | 76.24 | 75.50 Apr 2026 | 21,811.00 | 19,991.00 | 75.70 | 75.00 Mar 2026 | 21,140.00 | | 75.00 | Feb 2026 | 20,216.00 | | 74.25 | Jan 2026 | 19,654.00 | | 72.87 | Dec 2025 | 19,245.00 | | 73.12 | Nov 2025 | 19,642.00 | | 74.17 | Oct 2025 | 19,906.00 | | 74.30 | Sep 2025 | 20,809.00 | | 73.20 | Aug 2025 | 20,508.00 | | 71.60 | Total | 21,135.26 | 19,343.00 | 73.11 | 76.50 Watch Metrics Outpatient utilisation MonthYear | Percentage Oct 2026 | 82.66 Sep 2026 | 80.87 Aug 2026 | 79.59 Jul 2026 | 81.61 Jun 2026 | 81.11 May 2026 | 81.27 Apr 2026 | 83.08 New DNA Percentage MonthYear | Percentage Oct 2026 | 5.57 Sep 2026 | 4.90 Aug 2026 | 5.09 Jul 2026 | 4.86 Jun 2026 | 5.33 May 2026 | 5.42 Apr 2026 | 5.26 FU DNA Percentage MonthYear | Percentage Oct 2026 | 5.05 Sep 2026 | 5.56 Aug 2026 | 5.13 Jul 2026 | 5.89 Jun 2026 | 5.46 May 2026 | 5.78 Apr 2026 | 5.53 Theatre Utilisation (capped) MonthYear | Percentage Oct 2026 | 83.60 Sep 2026 | 84.05 Aug 2026 | 82.63 Jul 2026 | 81.95 Jun 2026 | 79.41 May 2026 | 82.23 Apr 2026 | 78.90 Total number of pathways over 18 weeks (excl Audio... MonthYear | Pathways Oct 2026 | 7,559.00 Sep 2026 | 8,438.00 Aug 2026 | 7,568.00 Jul 2026 | 7,194.00 Jun 2026 | 6,774.00 May 2026 | 6,495.00 RTT Clock Starts MonthYear | Clock Starts Oct 2026 | 1.00 Aug 2026 | 6,172.00 Jul 2026 | 7,434.00 Jun 2026 | 7,832.00 May 2026 | 7,100.00 Apr 2026 | 7,077.00 Mar 2026 | 7,267.00 Feb 2026 | 6,490.00 RTT Clock Stops MonthYear | Clock Stops Sep 2026 | 5,293.00 Aug 2026 | 4,706.00 Jul 2026 | 5,827.00 Jun 2026 | 5,837.00 May 2026 | 5,091.00 Apr 2026 | 5,101.00 Mar 2026 | 5,114.00 Feb 2026 | 4,869.00	ENT recovery plan currently being enacted. However needs long term sustainable plan, commenced will require joint work with YSFT on this. Max/fax and vascular – plans to in place to strengthen SLA with YSFT and transfer vascular patients back to YSFT. Gyne cap/demand completed and identified areas of focus to increase first OP appointments – as a 'focus on firsts'. Dedicated HVLC lists in Ophthalmology from June. Elective SPOA group developed. Patient not Present process in deployment across the Trust. In month we have also a focused activity in; • RTT validation processes – increasing clock stopped c+20 per week. • One of operational validation in 3 core specialities to data cleanse and clock stops. • Map clinical validation requirement and opportunity to support further clock stops. • Mapping opportunities to convert non-RTT activity into RTT activity. We have also submitted a recovery plan to NSHE for the remainder of the year.		

	62 Day Cancer standard	85% of our patients will commence treatment within 62 days of referral.	By March 2027, 85% of patients will have commenced definitive treatment within 62 days of referral for suspected cancer.	 [Cancer Performance Report - Power BI] 84.4% for March 80.4% April 81.8% May 83.4% June 82/0%. July 80.3% August 83.6% Sept 88.5% October (unvalidated)  Colorectal largest contributor to breaches of 62 days. Watch metrics: all green	Developing workforce capability and expertise to better guide analyst time in creation of stratified data dashboard for cancer waiting times. Ensure capacity to deliver first appointments within 19 days. Accelerator funding increased CT capacity in Q1 Development of 6-4-2 in endoscopy to improve list utilisation and use of bowel cancer screening capacity. Stratify impact of complex imaging waits on cancer performance - data now available (August 2024): Imaging - Power BI. RCAs to be completed on all 104-day cancer breaches to understand themes and opportunities. See Corporate Project updates: Bed Capacity and Patient Discharge. Outpatient transformation, Theatre productivity board alongside PSCC PRM's will set and edit countermeasures: • Calling patients 48-hours pre-theatre to reduce on the day cancellations. • New theatre scheduling process gone live 1st Sept. • Theatre management team reaching out to individuals where performance <80%. Cancer Fast Track team transferred to PSC Appointment centre to increase resilience.		

Year	MonthYear	Total Accountable Treatments	Breaches (Accountable)	% Within 62 Days	Breaches (Actual Patients)	104+ day wait	Average Wait	Median Wait	Longest Wait
2024	November 2024	120.0	30.0	75.0%	42	11	50.7	42	309
	December 2024	120.0	19.0	84.2%	34	5	44.0	38	216
2025	January 2025	121.5	28.5	76.5%	49	13	53.3	47	222
	February 2025	135.5	23.5	82.7%	38	6	46.5	42	208
	March 2025	126.5	23.5	81.4%	37	10	47.9	44	239
	April 2025	128.5	19.5	84.8%	28	6	44.2	42	179
	May 2025	140.0	38.5	72.5%	53	12	51.5	48	170
	June 2025	143.0	31.0	78.3%	42	8	46.8	39	236
	July 2025	132.0	20.0	84.8%	35	3	43.3	39	128
	August 2025	123.0	19.0	84.6%	29	9	45.5	42	186
	September 2025	132.0	30.5	76.9%	46	6	47.6	46	154
	October 2025	153.5	35.5	76.9%	50	9	46.4	38	197
	November 2025	126.5	25.5	79.8%	35	11	46.5	39	198
	December 2025	120.5	21.0	82.6%	32	5	44.7	41	186
2026	January 2026	132.0	20.0	84.8%	34	7	45.7	41	213
	February 2026	97.5	18.5	81.0%	26	4	43.7	35	184
	March 2026	147.5	23.0	84.4%	32	5	42.9	38	178
	April 2026	132.5	26.0	80.4%	37	6	46.7	45	176
	May 2026	123.5	22.5	81.8%	34	7	45.0	41	147
	June 2026	126.5	21.0	83.4%	34	8	44.1	41	131
	July 2026	159.5	28.5	82.1%	40	8	45.2	41	131
	August 2026	121.0	23.5	80.6%	31	8	48.5	46	260
	September 2026	153.0	22.0	85.6%	34	8	42.7	34	170
	October 2026	130.5	15.0	88.5%	23	4	39.8	37	167

28 Day Cancer Performance

MonthYear	Percentage
Sep 2026	85.96
Aug 2026	89.71
Jul 2026	86.81
Jun 2026	84.64
May 2026	85.94

31 Day Cancer Performance

MonthYear	Percentage
Sep 2026	93.22
Aug 2026	99.36
Jul 2026	98.63
Jun 2026	98.37
May 2026	96.17

Theatre Utilisation (capped)

MonthYear	Percentage
Sep 2026	84.05
Aug 2026	82.63
Jul 2026	81.95
Jun 2026	79.41
May 2026	82.23

Outpatient utilisation

MonthYear	Percentage
Sep 2026	82.46
Aug 2026	79.67
Jul 2026	81.61
Jun 2026	81.11
May 2026	81.27

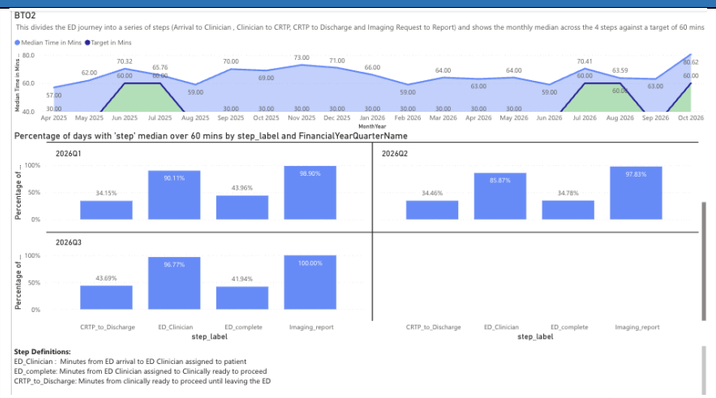
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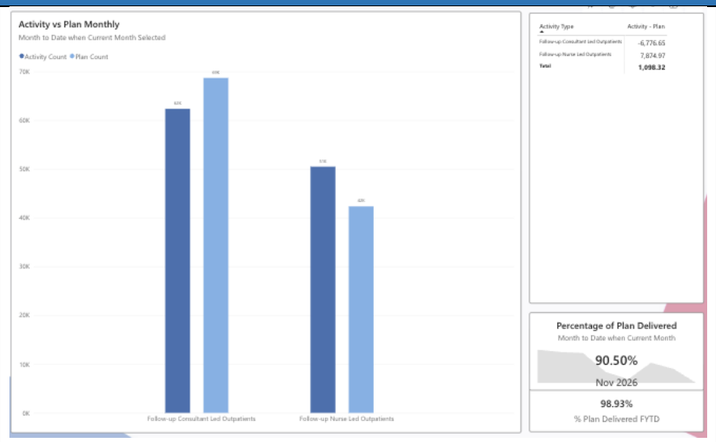
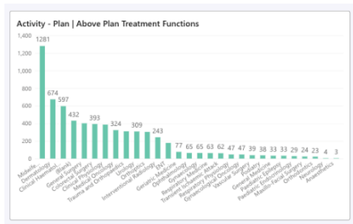
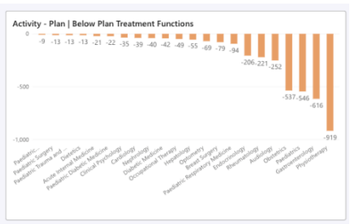
Workstreams	True North Metric	Vision	Goal	Current State	Countermeasures	Level of Risk to Achieving Goal (CxL)	Level of Risk for progressing actions
None relevant at present			.				

Strategic Programme:

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

Breakthrough Objective: Time to Next Destination

Workstreams	True North Metric	Vision	Goal	Current State	Countermeasures	Level of Risk to Achieving Goal (CxL)	Level of Risk for progressing actions
Time to move to medical bed from decision to admit in Emergency Department	ECS 4 Hour Standard	95% of admitted patients to be moved to required department within 60 minutes of medical decision.	By March 2027, 75% of patients will move to an inpatient bed within 60mins of the decision to admit.	 Median time to next step improved to 70.62 mins in July from 72 mins in June and again to August to 63.6 mins with September marginally better at 63mins and then a significant deteriorati0on in October to 80mins. The two highest step over 60mins are time to ED Clinician and Time from image request to report. Move from CRTP to discharge in ED remains stubbornly at 33% of days over 60mins. Agreed action to develop ED focused A3 on improving non-admitted perfomance in September, which is nearly complete and will focus on; • Workforce modelling to maximise capacity to demand. • Reviewed against data on in dept acuity. • The Nurse in charge (NIC) and Emergency Physician in charge (EPIC) role consistency to promote the culture of performance. • Enhancements to nerve centre to increase efficiency and productivity. • Using 'time to next destination' as a tool within the dept to improve flow. **ED performance breaches and LOS - Power BI**	Continuous flow embedded. Clinical Services strategy – now supported by GIRFT COS. Escalated as corporate risk - new ED Clinical lead for interface with imaging, sharing of data RE imaging delays. Perfect week planned 28/9/26 where we will test adherence and learning to implementation. Clinical engagement commenced prior to this. The perfect week identified further work is needed to support the embedding of the COS. Ward discharge targets established for base wards and Driver Metric within Care Groups to improve delivery. Monthly delivery on plan for discharge targets. Deployment of Nervecentre will improve data quality and consistency of clinically ready to proceed. ED / Hospital Flow pathways work with Nervecentre deployment and particular focus on bed allocation. Live flow developed and in place. Granular data available for analysis and countermeasure development.		
Reduce Follow Up Activity	Elective Recovery (RTT) standard	Patients will avoid unnecessary follow up appointments using technology and patient initiated follow up	By March 2027, Keep follow up activity to meet or be below plan.	Follow ups – Consultant below plan, Nurse Led follow up >3000 over plan. Top 4 over specialties with follow ups over plan graphed below Year to date 1098 over plan YTD (cf 2800 over last month-YTD)	Outpatient transformation project countermeasures: • Increased Patient Initiated Follow Up (PIFU) (also monitored through TPAM). • Develop performance data pack on outpatients for individual clinicians including benchmarking.		

Workstreams	True North Metric	Vision	Goal	Current State	Countermeasures	Level of Risk to Achieving Goal (CxL)	Level of Risk for progressing actions
		enabling an increased in new patient capacity and reduced waiting times.		  Above plan contributors  Below Plan contributors	• Use performance data of teams (Model Hospital) and individuals to challenge. • Influence change in practice through effective clinical leadership/ coaching. • Introduce demand led, data driven job planning to optimise clinic configuration and reduce unnecessary follow ups. • Weekly TPAM with focus on FU activity. • Care groups/Specialties to review their position and look for PIFU, clock stop unseen opportunities • Developing HDFT Futures strategic program with an OP transformation workstream against best practice guidelines. • Speciality plans in place in M8 to benchmark against GIFT standards to reduce avoidable FU and convert to New. • FU data cleanse also planned to support DQ and confidence in the PTL.		

Related Corporate Risks:

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
ID3	ECS 4 Hour Standard	Risk of increased morbidity/ mortality for patients due to a failure to meet the 4-hour standard. See the A3 & Breakthrough Objectives pertaining to this.	4 x 4 = 16	4 x 2 = 8 March 27	Clinical: Patient Safety	Minimal
ID79	Stroke: Provision at HDFT for Stroke	Ongoing cross ICB planning on stroke provision and the pathway. Stroke risk likelihood to be reviewed due to perceived reducing datix reporting of harm. Need to test if this is 'true'.	4 x 2 = 8	4 x 1 = 4 Dec 26	Clinical: Patient Safety	Minimal
ID292	Automated medicines supply services	There is a risk of failure of the inpatient dispensing robot caused by wear and tear over a number of years and the robot exceeding it predicting lifespan. The impact of this is inability to provide a lean and efficient medicines supply service for top-up, inpatient dispensing and discharge dispensing. The effect on patients would be delays in supplies of medicines for inpatient/discharge and potential delays to discharge as processes would revert to time-consuming manual processes.	3 x 4 = 12	4 x 1 = 4 September 28	Operational: Business Continuity	
ID642	Cardiology: Risk to providing DGH urgent and emergency care services due to lack of 24/7 cover	Risk to HDFT being able to deliver acute DGH services due to the fragility of the cardiology service. Current Position/Issues: • Inadequate staffing 12.5 PAs down at consultant level currently filled with locum cover, • Lack of continuity of Registrar/middle grade ward cover, • Reliance on locum consultant and associated team and quality risks • Risk of burnout of current medical and ACP team due to workload pressures. • Other consequences to these factors include outpatient RTT, Angio and echo waiting time breeches. Cardiology Strategy Planning meeting scheduled for November 24. Current position managed through HDFT IMPACT and regular updates provided to LTUC Tri-Team for escalation to the executive team.	3 x 4 = 12	3 x 1 = 3 Dec 26	Operational: Business Continuity	Cautious
ID884	Risk to Patient Safety & Experience due to non-compliance with National KPI's for waiting times and reporting in Imaging Services	Due to the delays in routine diagnostic imaging there is an unknown risk of patients waiting up to 5.5 months for diagnostics which should be delivered within 6 weeks. This is causing delays in treatment, diagnosis and decision making for care plans for patients. It impacts on RTT performance, organisational reputation and patient experience. There is also a risk due to our non compliance with National KPI's for waiting times and reporting. PSC Risk – reduced July 2026 as waiting times improving.	4 x 3 = 12	3 x 1 = 3 ~~Oct 2026~~ March 2027	Clinical: Patient Safety	Minimal

Related External Risks:

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

STRATEGIC AMBITION: OVERARCHING FINANCE 2026 - 2027

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

GOALS:

Financial Sustainability

HDFT To be a financial sustainably organisation

GOVERNANCE:

Financial Framework

- Board Assurance: Resource Committee
- Performance Review Meetings and Strategy Deployment Room
- SRO: Director of Finance
- Operational Lead: Deputy Director of Finance

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

1. Annual Delivery of Plan
2. National Oversight Framework Rating - Finance

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

Overarching Risk Summary:

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

True North Metrics Summary:

<table>
<tr><th>True North Metric</th><th>Vision</th><th>Goal</th><th>Current State</th><th>Countermeasures</th><th>Level of Risk to Achieving Goal</th><th>Level of Risk for progressing actions</th></tr>
<tr><td rowspan="2">Financial Sustainability</td><td rowspan="2">HDFT to be a financially sustainable organisation</td><td>In 2026/27 the Trust, and therefore directorates, aim to live within the financial resources available to us.</td><td>The Trust reported a deficit of £2.9m in October, £1.6m behind plan. This takes the year to date position to a £25.1m deficit, £14.5m behind plan.

The Finance Board Report contains further information on the position including –

• Detailed variance analysis
• Trends and Forecast scenarios
• Top down turnaround trajectories
• Development and delivery of the bottom up delivery programme
• Monthly trend information for a number of key financial metrics

The current forecast outturn position is reported at the previous proposed plan, however, the Trust now has an updated agreed plan which has been accepted. This is a breakeven position, supported by £13.5m deficit support funding.

Forecast outturn will be reported to deliver this plan by year end. The scenario analysis in the supporting information show the challenge related to this, with a Best, Mid and Worst scenario deficits of £13.5m, £25.8m and £36.9m (all excluding deficit support funding).

The WRAP programme, KPMG outputs, Central actions and outputs of the Simon Worthington review has been combined and updated to reflect an updated framework which is outlined as –

• Turnaround Delivery Programme (£22.5m)
• Income Assurance Programme (£11.4m)
• Technical/Balance Sheet delivery (£3.7m)

The total impact is £37.6m.</td><td>
<table>
<tr><th>Countermeasure</th><th>Owner</th><th>Date</th><th>Status</th></tr>
<tr><td>The Trust is aiming to agree a plan with NHS England by the end of May, discussions still ongoing.</td><td>Director of Finance</td><td>Original - March 2026

Updated – July 2026</td><td>Complete</td></tr>
<tr><td>Delivery of 2026/27 Activity Plan</td><td>Chief Operating Officer</td><td>March 2027</td><td>In Progress</td></tr>
<tr><td>Delivery of workforce controls in relation to –
• Recruitment Pause
• Variable Pay Reduction of 46%
• RLW change
• Reduction in premium rate activity</td><td>Chief People Officer and Director of Finance</td><td>July 2026</td><td>Implemented</td></tr>
<tr><td>Delivery of wider turnaround programme</td><td>Various</td><td>July 2026</td><td>Implemented</td></tr>
<tr><td>Refocus various strands of work to reflect updated position</td><td>Director of Finance</td><td>August 2026</td><td>Complete</td></tr>
</table>
</td><td rowspan="2">4 x 4 = 16</td><td rowspan="2">3 x 3 = 9</td></tr>
<tr><td>The Trust will move out of segment 3</td><td>Currently the National Oversight Framework has an override based on financial plans or performance being breakeven or worse.

The Trust has established there is the ability to breakeven in 2027/28, however this would be dependent on the outputs of a community services review in conjunction with Humber and North Yorkshire ICB, the delivery of the Waste Reduction and Productivity Programme recurrently, and appropriate financial risk sharing mechanisms in place.
Within the oversight framework there are three finance measures which are outlined below</td><td>
<table>
<tr><th>Countermeasure</th><th>Owner</th><th>Date</th><th>Status</th></tr>
<tr><td>Agreement with ICB to establish community services review scheduled for mid-2026/27.</td><td>Chief Executive</td><td>May 2026</td><td>Agreement in principle ICB scheduled work March 2027..</td></tr>
<tr><td>Work with local commissioners to</td><td>Director of Finance</td><td>September 2026</td><td>In progress</td></tr>
</table>
</td></tr>
</table>

True North Metric	Vision	Goal	Current State	Countermeasures				Level of Risk to Achieving Goal	Level of Risk for progressing actions
			Metric / Current Status Planned Surplus/Deficit: Planned Deficit Year to date variance to plan: Variance to Plan Implied Productivity v previous year: The data which supports the community element of the productivity metric is being challenging to reconcile. The productivity metric also appears to be influenced by coding position of activity which is currently behind plan. This will also influence income position.	establish updated local pricing following change since covid.					
				Work with NHS England Informatics team to better understand and inform approach to costing of 0-19 services as part of implied productivity metric	Director of Finance	July 2026	Complete		
				Address coding backlog through recovery plan	Deputy Director Business Intelligence, Planning, Performance and Productivity	July 2026	Complete		

Trustwide Project: Productivity & Sustainability

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

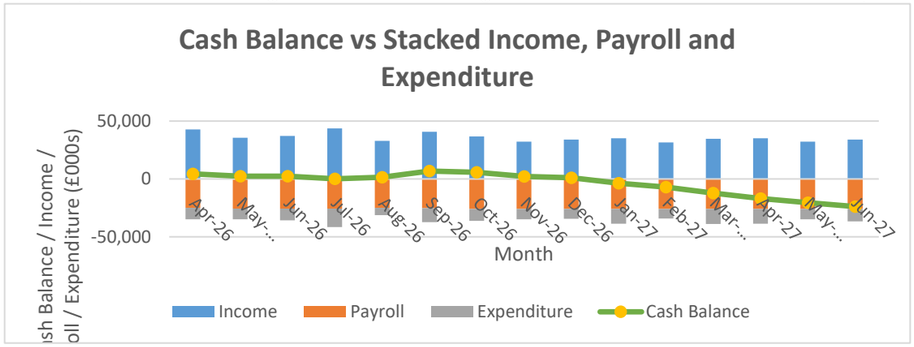
Strategic Project: Productivity & Sustainability

Workstream	True North Metric	Vision	Goal	Current State	Countermeasures	Level of Risk to Achieving Goal	Level of Risk for progressing actions
Productivity and Sustainability	Financial Sustainability	Short Term Deliver a 12-month WRAP / financial recovery project that stabilises the Trust's finances and cash position while protecting safe, high-quality care—by coordinating and assuring directorate-led schemes (existing and new), tightening key controls, improving contract and income recovery, and delivering practical productivity improvements that makes savings recurrent where possible. Long Term Build a Trust-wide 3–5-year Programme that leverages IMPACT methodology to free up time and capacity for care and strengthen financial sustainability through digital/AI, safe workforce change, service redesign / decommissioning and income growth.	**Short Term** Month 2: One Trust-wide WRAP delivery plan agreed. Month 3: Every directorate has a clear plan to deliver its schemes and has identified further opportunities to close the gap (with the main risks and gaps clearly shown). Delivery underway. Month 4: Core controls in place so overspends are visible and acted on quickly (workforce controls, approval gates, and benefit tracking). Month 11: High-impact directorate-led and Trust-wide schemes delivered Month 11: Pipeline for the following year identified **Long Term** Month 6: A small number of Trust-wide "big moves" agreed, with named leads and clear measures. Year 1: Clear, up to date strategies defined for digital/workforce/estates/finance and a joined-up roadmap established. Year 1 – Deliver a tactical WRAP/Financial Recovery Project under this Strategic Programme Year 2: Digital/automation wave 1 delivered, with evidence it reduces manual work and frees up capacity. Year 2: First tranche of 'service redesign/stop-doing' delivered safely (quality, safety and equality checked). Years 3–5: Safe workforce change and income growth delivered and scaled; expanding what works.	The current state is detailed in the Finance Board Report		5 x 4 = 20	3 x 3 = 9

Breakthrough Objective: Run Rate Reductions month on month

Workstream	True North Metric	Vision	Goal	Current State	Countermeasures	Level of Risk to Achieving Goal	Level of Risk for progressing actions
Run Rate Reduction Mth on Mth.	Annual Breakeven	For HDFT to deliver the financial annual plan as agreed with NHSE and return to a breakeven position by the end of 27/28. Monitoring through monthly financial reporting in year, recovery plans identified to ensure finances remain on track.	Every budget holder managing spend reductions month on month, which in turn will support the delivery of the annual plan, a reduced need for cash support and an improved reputational position in relation to managing taxpayer resources.	Budgets in balance moved to run rate reductions month on month. Each Directorate has been given revised targets to deliver which will be reported through the Finance Board pack.			

Related Corporate Risks

<table>
<tr><th>ID</th><th>Title</th><th>Description</th><th>Current Rating (CxL)</th><th>Target Rating (CxL) & Date</th><th>Risk Type</th><th>Risk Appetite</th></tr>
<tr><td>ID 721</td><td>Group Cash Position</td><td>Cash support will be required throughout the year in line with the deficit plan, added to this there is the gap in cash awarded in 25/26 versus the deficit position (£14.4m awarded v's £23.75m deficit). There was £14m+ outstanding to Suppliers and the BPPC has declined below 23%. The impact of not meeting the BPPC 95% target will affect future business development opportunities including 0-19 contract.

The situation is becoming more critical and future cash support requests will include the ask for working capital along with the deficit plan.
<table><tr><th>Cash Support</th><th>In Plans</th><th>Requested</th><th>Approved</th></tr><tr><td>April</td><td>£31.7m</td><td>£9.5m</td><td>£4m</td></tr><tr><td>May</td><td>£4m</td><td>£4m</td><td>£2m</td></tr><tr><td>June</td><td>£4m</td><td>£1.8m</td><td>£1.8m</td></tr><tr><td>July</td><td>£3.8m</td><td>£3.2m</td><td>£10m</td></tr><tr><td>August</td><td>£1.3m</td><td>£1.4m</td><td>£0m</td></tr><tr><td>September</td><td>£1.3m</td><td>£1.3m + £4.5m</td><td>£5.8m</td></tr><tr><td>October</td><td>£1.3m</td><td>~~£4.3m~~</td><td>TBC</td></tr><tr><td>November</td><td>£1.2m</td><td>£4.8m</td><td></td></tr><tr><td>December</td><td>£1m</td><td>£3m</td><td></td></tr></table>
**September – emergency cash applied for £4.5m in addition to the £1.3m.

Key actions being prioritised
1. Aged Debt
2. WRAP delivery (Run rate reductions)
3. Turnaround Actions</td><td>5 x 5 = 25</td><td>4 x 2 = 8
March 2027</td><td>Financial: revenue, funding and liquidity</td><td>Cautious</td></tr>
<tr><td>ID1241</td><td>26/27 Waste Reduction and Productivity</td><td>Full refresh of plans occurred in August.
Further detail available in Finance Board pack.</td><td>4 x 5= 20</td><td>3 x 3 = 9
March 2027</td><td>Financial: Financial Management</td><td>Minimal</td></tr>
<tr><td>ID1242</td><td>Financial Plan Delivery 26/27</td><td>The Trust has a planned deficit £15.3M for 26/27. The Trust has faced significant scrutiny for not delivering the 25/26 plan (Breakeven versus £23.75m reported deficit). WRAP delivery and managing costs within allocated budgets is key in delivering the financial plan for 26/27.
NHSE have now agreed a deficit plan £13.5m and deficit support funding will be allocated to this value bringing the plan to breakeven.
Current delivery is behind plan.</td><td>4 x 5 = 20</td><td>3 x 3 = 9
March 2027</td><td>Financial: revenue, funding and liquidity</td><td>Cautious</td></tr>
</table>

Related External Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
	Local Authority Contract Changes for the Pay Award & NI Contributions	Pay Award and NI contributions for Local Authority organisations £1.3m still to be agreed. (To note £1.7m agreed). NHSE confirmed ICB should continue to provide the funding for NI changes from 22/23, ICB have confirmed that they will now recognise this however contract discussions are ongoing.	3 x 3 = 9	4 x 1 = 4 September 2026	Financial: revenue, funding and liquidity	Cautious
1314	Risk of Clawback in underspent contract areas	A number of Local Authority contracts have a clawback clause included which enables the LA to clawback any underspends in year. Only Wakefield has chosen to enact this to date due to not being able to recruit up to the proposed model.	4 x 4 = 16	1 x 4 = 4 April 2027	Financial: revenue, funding and liquidity	Cautious

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

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

GOALS:

Looking after our people

Physical and emotional support to be "At Our Best"

Belonging

Teams with excellent leadership, where everyone is valued and recognised; where we are proud to work

New ways of working

The right people, with the right skills, in the right roles

Growing for the future

Education, training and career development for everyone

GOVERNANCE:

People & Culture Framework

- Board Assurance: People & Culture Committee
- Programme Board: People & Culture Programme Board
- SRO: Chief People Officer
- Operational Lead: Deputy Director of People & Culture

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

1. Staff Engagement Index
2. Staff Availability

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

Overarching Risk Summary:

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

Strategic Metrics Summary:

Workstream	True North Metric	Vision (People Plan)	Goal (True North Metric Target)	Current Status	Countermeasures	Level of Risk to Achieving in year Goal	Level of Risk for progressing actions
Looking after our people	Staff Engagement Index	We will develop our leaders to deliver appreciative, compassionate, inclusive and improvement focused leadership that is aligned to our KITE behaviours and our IMPACT continuous improvement programme.		NHS Leadership and Management Framework launched nationally on 06 July 2026. HDFT implementation planning underway. A package of support/courses for managers/managing in a financially challenged environments has been publicised to support them in their role.			
Looking after our people	Staff Engagement Index	We will have a clearly communicated and positive focus on all aspects of health and wellbeing with the aim that every colleague feels supported. We will ensure that we give thanks and recognise the invaluable contributions from our colleagues through the recognition schemes.		The 2026/27 Staff Flu Vaccination programme commenced on 26 September 2026 and will run for an intensive 8-week period. As of 10 November 60% of our workforce have been vaccinated. The national target is 65% as we are on track to meet this target. KITE Awards nominations have now closed with a total of 220 nominations received. Judging of nominations is scheduled to commence. The KITE Awards ceremony is scheduled for March 2027 and will be held in Durham. Long Service Awards have been de-coupled from this event, to allow larger numbers of KITE Award nominees to be invited to the event, particularly important for the team of the year category. Separate celebrations are being planned for the Long Service Awards.			
Looking after our people	Staff Engagement Index	We will create and maintain multiple channels for our colleagues to have a voice, be heard and feel empowered to speak up.	Maintain Inpulse survey response rate. Continuously tracking above our benchmark group engagement score. Validate the Improvement by seeing an improvement in the National Staff Survey Overall Engagement Score in the 2025 survey results. Maintain a continuously improving trend on both NQPS (Inpulse) and the NHS Staff Survey response rates and aspire to be best within our benchmark group. Achieve and maintain the best engagement score within our benchmark group.	The 2026 NHS Staff Survey (NSS) is open 21 Sept – 27 Nov 2026. As of 10 November the response rate is 39% which is behind last year's campaign by approximately 15%. National Education and Training Survey (NETS 2025): Total response rate 97 learners. Highest scoring acute Trust for overall experience in the region, 5th highest against all 22 regional Trusts – 81.26%. One red flag in Obs & Gynae, pink flag themes in Obs & Gynae and Sexual Safety from patients, action plans in place to improve placement experience and zero tolerance policy being reviewed to support harassment. The Occupational Health Business Case was again not supported at the meeting on 5 June 2026. The Head of OH is reviewing structures and reviewing the risk score for Health Surveillance. A paper on health surveillance risk went to the August Health and Safety Committee and the business case is again being re-reviewed for the 5th time along with the health surveillance paper with a plan to go back to Business Case Review Group once again. (The People & Culture department has also undertaken its affordable establishment review and cannot at this stage identify resource to move across to support OH).			

Workstream	True North Metric	Vision (People Plan)	Goal (True North Metric Target)	Current Status	Countermeasures	Level of Risk to Achieving in year Goal	Level of Risk for progressing actions
Belonging 	Staff Engagement Index	We will promote equality and diversity, so everyone feels valued and recognised through the embedding of Equality Impact Assessments as expected practice, the continued development of our Staff Support Networks, leadership development and training of all colleagues. Our work on Equality, Diversity and Inclusion will be nationally aligned to the NHS Equality, Diversity and Inclusion Improvement Plan.	Embedding Equality by focussed work based around the 6 EDI High Impact Actions (HIA). Progress to be made on: HIA1: Chief Executives, Chairs and Board Members should put EDI objectives in place that they are personally responsible for. The goal is: • Each Director to have an EDI objective HIA 2: Employ & Develop Staff in a fair and inclusive way and target groups that are under-represented in the organisation. The goal is: •Improve the reported lived experience of colleagues who are BME or have a disability or long-term condition	The Reciprocal Mentoring Programme for colleagues with a disability or long-term condition started in September 2025. 12 pairs of aspiring and established leaders have attended their workshops and listening together events as well as meeting for their one-to-one development meetings. A listening event for colleagues with a disability or long-term condition has been scheduled for November as well as one for the REACH Network. The Equality & Human Rights Commission ruling on transgender issues was launched for consultation in May, with the outcome that a person's sex is to be determined by their biological sex. A meeting with Planning Dept has occurred and they are taking forwards a facilities review and also TIF2 review. New working group established Shaping the Future Experience of Global Majority Colleagues at HDFT brings BME colleagues together to discuss results from WRES/ NSS and look at possible solutions to barriers. Black History Month was celebrated throughout October with colleagues providing content throughout the month. A suite of EDI training sessions have been developed to be rolled out from 2026 onwards. They will be delivered face to face, hybrid and online for greater accessibility with bookings made on Learning Labs. These courses will be presented by colleagues with lived experience of have their lived experiences included in the content. These include: Deaf Awareness Cultural Competency Reasonable Adjustments Neurodiversity Allyship EDI mandated training from NHSE (awaiting go live date) Cultural Ambassadors met for their first quarterly meeting to discuss barriers, content and communications they have shared. WRES 2026: The overall proportion of staff recorded as Black and Minority Ethnic (BME) is 16.44% (900 staff), compared with 16.47% (864 staff) in 2025. The relative likelihood of White candidates being appointed from shortlisting has increased from 2.97 in 2025 to 3.52 in 2026.			

Workstream	True North Metric	Vision (People Plan)	Goal (True North Metric Target)	Current Status	Countermeasures	Level of Risk to Achieving in year Goal	Level of Risk for progressing actions
				Board representation remains below the proportion of BME staff in the workforce. BME voting Board membership is 6.25% compared with 16.44% (900 staff) in the workforce. WDES 2026 Disability declaration has continued to improve, increasing from 7.22% (379 staff) in 2025 to 8.02% (439 staff) in 2026. Staff with a disability or long-term condition were 5.88 times more likely than Non-Disabled staff to enter the formal capability process, based on a two-year rolling average which equals two employees.			
Belonging	Staff Engagement Index	We will seek to increase diversity in our leaders and decision makers and have a representative pool of leaders.	Improve WRES metric regarding relative likelihood of appointment from shortlisting and increase diversity within senior leadership roles.	25 Independent Panel Members (IPM) have been recruited – and are actively taking part in recruitment activity – currently across recruitment campaigns from clinical bands 7 to VSM. IPMs are also involved in any Trust Executive Recruitment processes. The evaluation of this role has been deferred in the light of the recruitment pause.			
Growing for the future	Staff Availability	To ensure HDFT is the 'best place to work' there must be the right number of staffing available each day for deployment to ensure quality of care and to enable those staff to have a good experience and do their best	Sickness levels throughout HDFT to not exceed 4.1% A vacancy rate that does not exceed 6% Staff leaving within their first year of employment to not exceed 15% A Turnover rate that does not exceed 12% (HNY is 12%)	Staff unavailability increased by 32.45wte in October to 703.66wte, which is above the average of 665.55wte and equates to 15.0% of the workforce. Higher vacancies (+33.34wte) and sickness (+19.21wte) drove the increase, partially offset by lower turnover (-17.49wte). Sickness and vacancies account for 76% of all unavailability, with CYPPH contributing the greatest proportion of both. Trust KPIs (October 2026): • Vacancy is 5.32% • Turnover is 9.81% • Sickness is 6.06% • Staff leaving within the first year is 16.09% (this is a small increase from 15.75% last month)			
New Ways of Working	Staff Availability	We will continue to embed e-rostering to ensure that safe staffing levels can be allocated and managed with maximum efficiency. The Trust has initiated a workstream within the Turnaround Programme to review bank, agency and additional payments, identifying opportunities to improve financial efficiency while maintaining safe and effective service delivery.	80% of rosters signed off and issued 6 weeks before Reduce agency spend by 30% and bank spend by 10% at least	Agenda for change roster compliance for acute wards was 88.9% a small increase from last month. Variable Pay – As part of the Trust's Turnaround Programme, focused work has been completed to reduce expenditure on bank, agency and additional payments. NHSP bank rates are being aligned to the mid-point of the relevant pay band for Nursing and Midwfery, replacing the current bespoke rates as of 1st September. A variable pay dashboard has been developed to provide greater visibility of expenditure and support informed decision-making. In addition, strengthened approval processes have been introduced to ensure all requests for variable pay are appropriately scrutinised and authorised prior to approval.			

Workstream	True North Metric	Vision (People Plan)	Goal (True North Metric Target)	Current Status	Countermeasures	Level of Risk to Achieving in year Goal	Level of Risk for progressing actions
	Staff Engagement Job Planning compliance	The Trust has been selected as an early adopter of the Future Workforce Solution, providing an opportunity to help shape and influence the future workforce systems used across the NHS.	To support the successful design, testing, and implementation of the Future Workforce Solution, helping to shape a modern, integrated workforce system that improves the experience of colleagues and managers, streamlines workforce processes, and provides better workforce data and insights for decision-making 95%	Scoping Document Part 2 represents an important milestone in the Trust's preparation for implementation. It confirms the proposed scope of adoption alongside the Trust's responsibilities for governance, resourcing, business process change, testing, data migration and technical readiness. Formal sign-off is required by 13 November 2026 to enable progression from Foundational Readiness into the Implementation Phase. Job plans effective from 1st April - overall 80.22% (LTUCC 80.87% and PSCC 79.75%) – 31 job plans in dispute (16 in LTUCC and 15 in PSCC). 83.21% is the level of compliance reported to NHSE (rolling and signed off by individual and clinical lead only)			

Trustwide Project: None at present

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

Strategic Project: None at present

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

Breakthrough Objective: Staff Involvement (last year)

After review of breakthrough objectives at SDR and in light of positive performance, the Involvement Breakthrough Objective has been replaced for FY 2026-27 with a different area of focus

Workstream	True North Metric	Vision	Current Status	Countermeasures	Level of Risk to Achieving Goal (CxL)	Level of Risk for progressing actions
N/A						

Related Corporate Risks.

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

Related External Risks

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

TRUST BOARD

Freedom To Speak Up Annual Report 2026

Harrogate and District NHS Foundation Trust

Title:	Freedom to Speak Up Guardian Annual Report
Responsible Director:	Breeda Columb – Executive Director of Nursing, Midwifery & AHP's
Author:	Satty Ali and Eileen Watson - Freedom to Speak Up Guardians

Purpose of the report and summary of key issues:	Annual Assurance Report: To provide The Trust Board with an annual update on Freedom to Speak Up (FTSU) at Harrogate and District NHS Foundation Trust (HDFT)	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	√
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	√
	AIM 2: To work with partners to deliver integrated care	
	BAF2.1 To improve population health and wellbeing, provide integrated care and to support primary care	
	BAF2.2 To be an active partner in population health and the transformation of health inequalities	
	AIM 3: To deliver high-quality care	
	BAF3.1 and 3.4 To provide outstanding care and outstanding patient experience	√
	BAF3.2 To provide a high-quality service	√
	BAF3.3 To provide high-quality care to children and young people in adults community services	√

	BAF3.5 To provide high-quality public health 0-19 services	√
	AIM 4: To ensure clinical and financial sustainability	
	BAF4.1 To continually improve services we provide to our population in a way that are more efficient	
	BAF4.2 and 4.3 To provide high-quality care and to be a financially sustainable organisation	
	BAF4.4 To be financially stable to provide outstanding quality of care	
Corporate Risks		
Report History:	Previous annual FTSU board report provided November 2025 Last update provided to People & Culture Committee on 30 September 2026	
Recommendation:	Board is asked to receive and note this report and support the priorities identified for 2026/27	

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9. Fairness Champions

10. Executive Engagement

11. Organisational Learning and Impact

12. Equality, Diversity and Inclusion

13. National Developments

14. Risks and Challenges

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16. Priorities 2026/27

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Appendix 1: Freedom to Speak Up Reflection and Planning Tool 2026

Appendix 2: Manager Support Materials and Guidance Posters

1. Executive Summary

This annual report provides a comprehensive review of Freedom to Speak Up activity throughout 2025/26. It incorporates learning and themes reported through People and Culture Committee during January, March, May, July and September 2026. The report reflects staff voice, organisational learning, cultural intelligence and national developments within the speaking up agenda. The service has continued to strengthen visibility, accessibility and relationships across the Trust.

During the year, Freedom to Speak Up continued to provide independent and confidential support to workers who wished to raise concerns, seek advice, or share ideas for improvement. The service played an important role in ensuring concerns were heard, themes identified and learning shared to support continuous improvement across the organisation.

Alongside supporting individual workers, Freedom to Speak Up contributed to wider cultural improvement initiatives aimed at creating an environment where staff feel safe to speak up. This included promoting psychological safety through leadership development and delivering a dedicated psychological safety session as part of the Trust's Line Manager Webinar Programme, supporting managers to build cultures of openness, trust and compassionate leadership.

During 2026, Freedom to Speak Up also supported the Trust's sexual safety agenda through participation in a multidisciplinary Sexual Safety Working Group involving colleagues from Human Resources, People and Culture, Wellbeing and Safeguarding. This work has supported the development of reporting pathways, staff awareness initiatives, and organisational learning to strengthen sexual safety across the Trust. A dedicated sexual misconduct category was introduced within the anonymous reporting form in September 2026, providing an additional confidential route for staff to raise concerns.

This report demonstrates how Freedom to Speak Up continues to support organisational learning, promote psychological safety, strengthen speaking up

culture and contribute to creating a safe, respectful and inclusive working environment where staff feel confident that their voices will be heard and valued.

2. Annual Assurance Statement

Based on information received throughout the year, Freedom to Speak Up remains an important source of organisational intelligence. The service continues to provide independent support, facilitate resolution of concerns, and contribute to organisational learning. Regular reporting has been provided through governance structures including People and Culture Committee, and monthly discussions with executive leadership.

3. Purpose of Freedom to Speak Up

The Freedom to Speak Up Guardian role supports workers to raise concerns, ideas, and experiences safely. The service helps promote openness, transparency, psychological safety, and learning. Concerns raised relate to bullying and harassment, worker safety and wellbeing, patient safety and patient quality, inappropriate attitudes and behaviour all of which are reported on a quarterly basis to NHS England following the National Guardians Office (NGO) closing. In addition, during 2026 a specific sexual misconduct reporting category was introduced within the Trust's anonymous reporting process, providing an additional route for workers to raise concerns safely and confidentially.

4. Key Achievements During 2025/26

Significant progress has been made in strengthening the Trust's Freedom to Speak Up arrangements and fostering a culture of openness, transparency and psychological safety. Key achievements include:

- Delivery of a comprehensive communications and engagement programme, supported by ongoing executive engagement and increased visibility across clinical and corporate departments.
- Establishment and development of the Fairness Champion network and implementation of an anonymous reporting mechanism.
- Strengthened regional engagement and participation in networks to share learning and promote best practice.

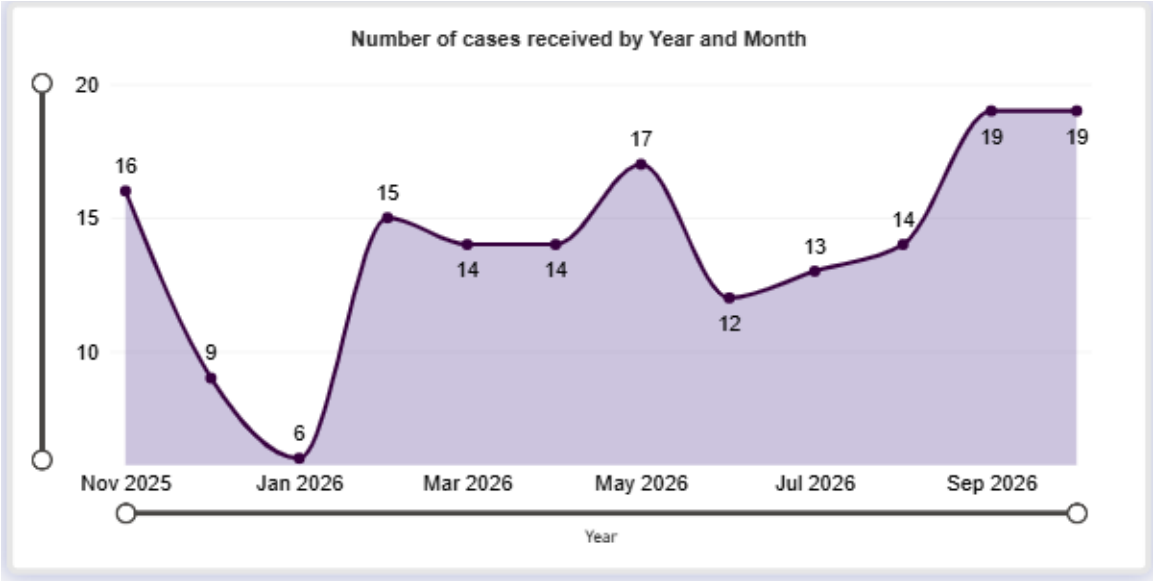
- Enhanced governance and assurance reporting, alongside a comprehensive refresh of the Trust's internal and external intranet and website content.
- Development and implementation of a dedicated Freedom to Speak Up operating procedure and an engagement, reflection and planning tool.
- Embedding learning and recommendations from national reviews and investigations, including Lord Mann's report, the AMOS report and the Thirlwall Inquiry.

The Trust's sexual safety programme has also been supported through active participation in the Sexual Safety Working Group and the introduction of a dedicated sexual misconduct reporting category within the anonymous reporting process. This provides an additional mechanism for identifying concerns, supporting appropriate responses and informing organisational learning.

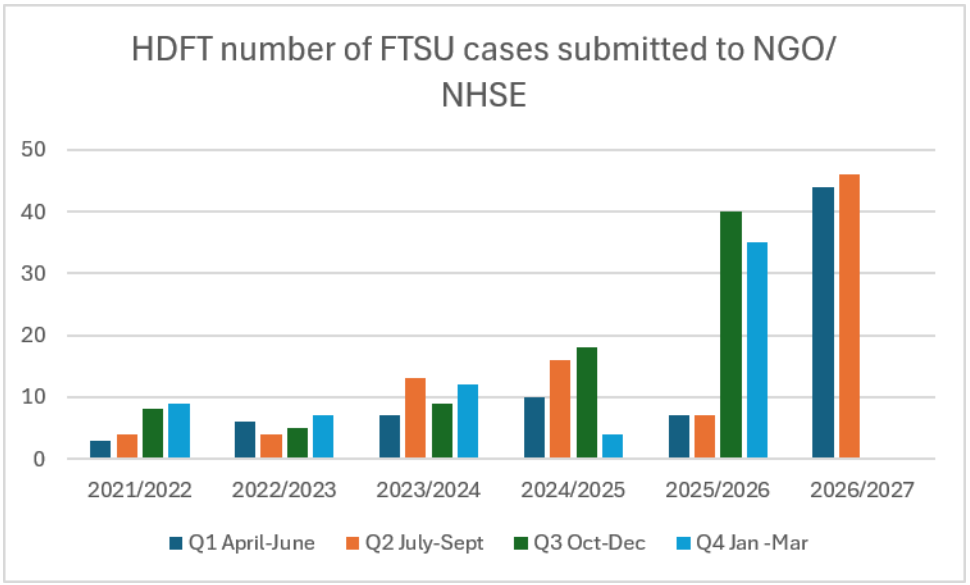
In addition, a Trust-wide psychological safety session was delivered through the Line Manager Webinar Programme, equipping managers with greater awareness of their role in fostering inclusive and supportive working environments where staff feel confident, safe and empowered to speak up and raise concerns.

Annual Speaking Up Activity

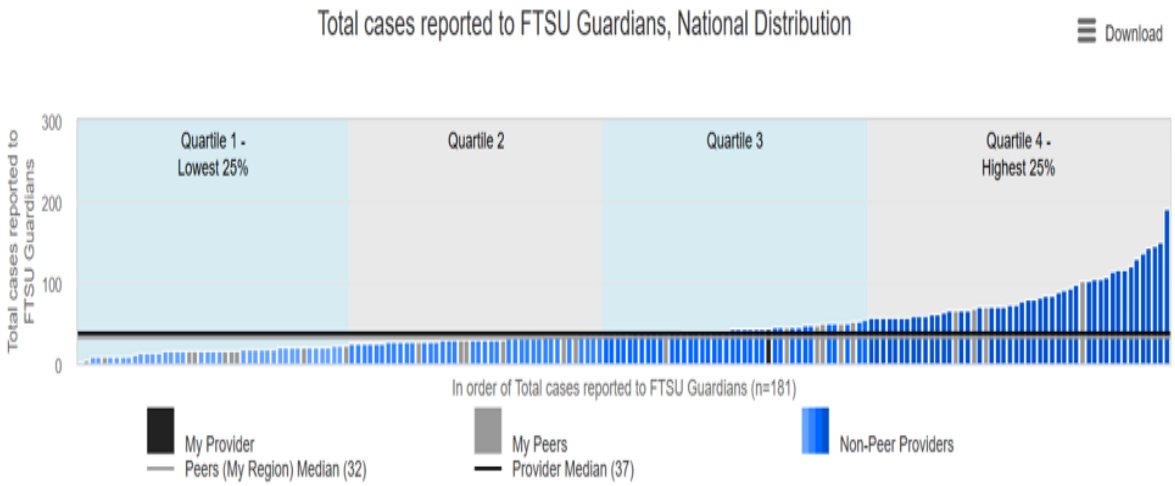
An average of 14 Freedom to Speak Up cases were received each month during the reporting period. Monthly reporting has fluctuated between 6 and 19 cases, with a notable increase during the latter part of the year. September and October recorded the highest monthly volumes (19 cases), continuing an upward trend from June.



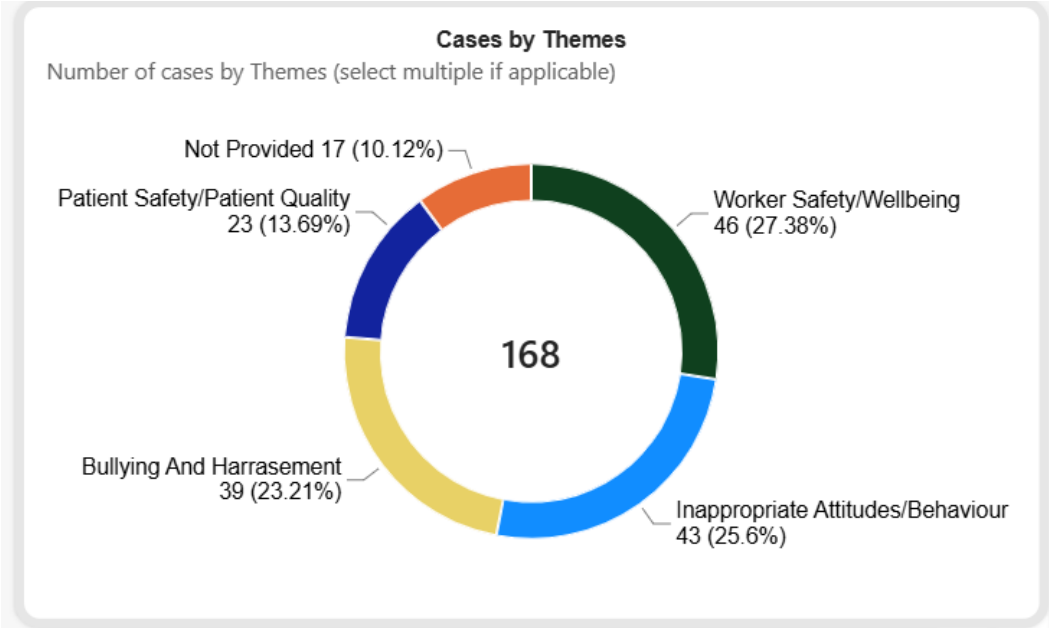
Following on from the increase in monthly reporting, the number of cases submitted by HDFT to the National Guardian's Office/NHSE has also continued to rise year-on-year. Data for 2026/27 indicates the highest level of reporting to date, reflecting increased utilisation of the Freedom to Speak Up process and growing confidence amongst staff to raise concerns. Ongoing monitoring will continue to assess whether this represents a sustained trend and to identify any emerging themes or risks.



Focusing on the national picture, in Quarter 1 2026/27, HDFT reported 43 cases to NHSE. This places the Trust within Quartile 3 (mid-high 25%) nationally and above both the provider median (37 cases) and peer group median (32 cases). Whilst higher reporting levels do not necessarily indicate increased concerns, they are often considered a positive indicator of staff awareness of, and confidence in, the Freedom to Speak Up process and culture.

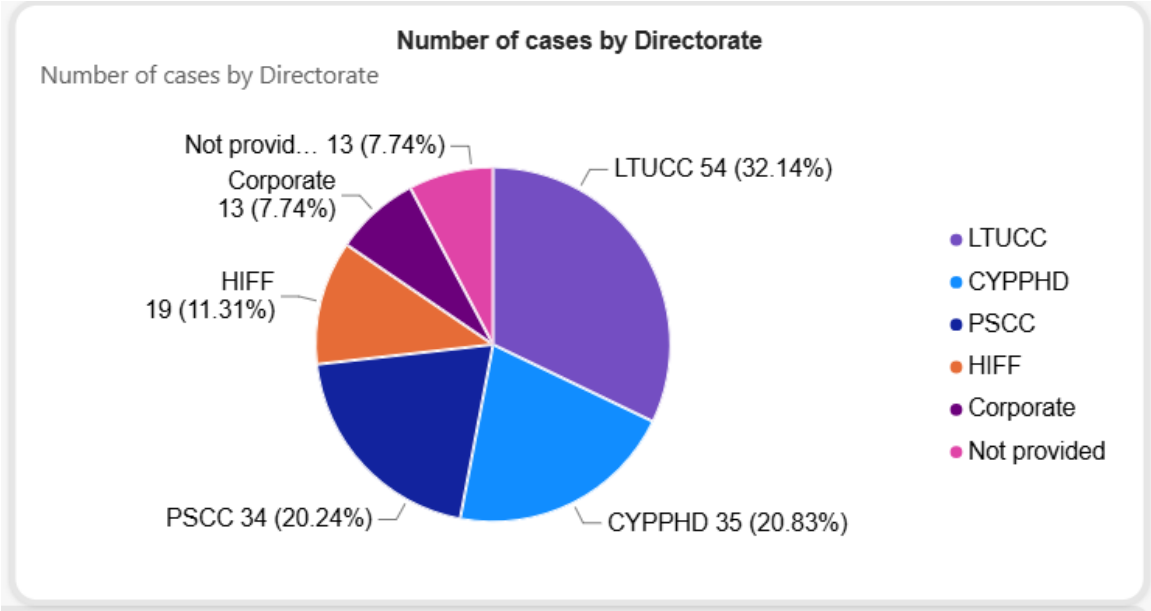


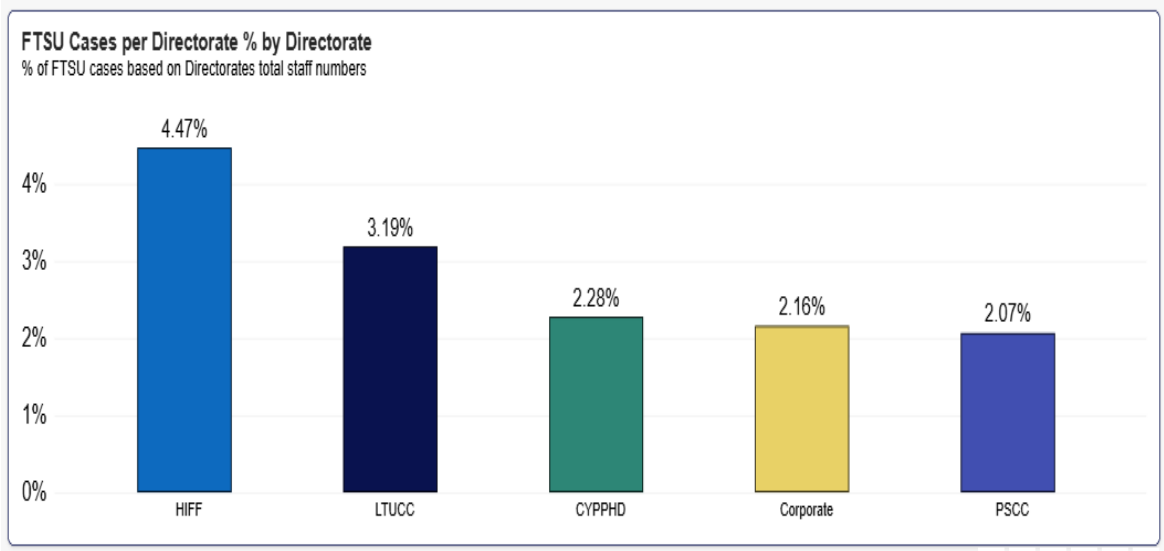
Themes identified throughout the year included bullying and harassment, inappropriate attitudes and behaviours, patient safety and patient quality, worker safety and wellbeing. These themes were shared with the National Guardians Office (NGO) until it closed on the 30th June 2026. Following this the Guardians now share these themes with NHS England on a quarterly basis.



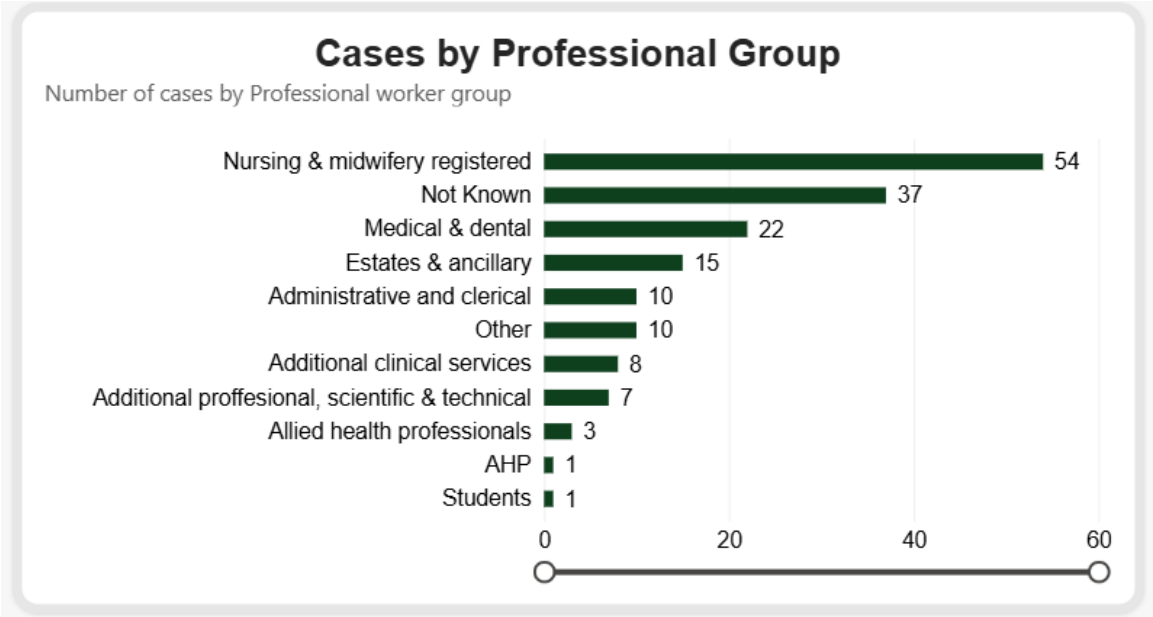
Worker Safety and Wellbeing (27.4%) remained the most frequently reported theme, followed by Inappropriate Attitudes and Behaviour (25.6%) and Bullying and Harassment (23.2%). Together, these themes account for over three quarters of all issues raised, highlighting the continued importance of promoting a respectful, inclusive working environment and supporting staff wellbeing.

Freedom to Speak Up cases were received from all directorates, with LTUCC accounting for the highest proportion of cases (32.1%), followed by CYPPHD (20.8%) and PSCC (20.2%). When adjusted for workforce size, HIFF recorded the highest reporting rate at 4.47% of staff, followed by LTUCC (3.19%). This suggests that while LTUCC generated the highest volume of cases overall, reporting rates relative to staff numbers are proportionately higher within HIFF.

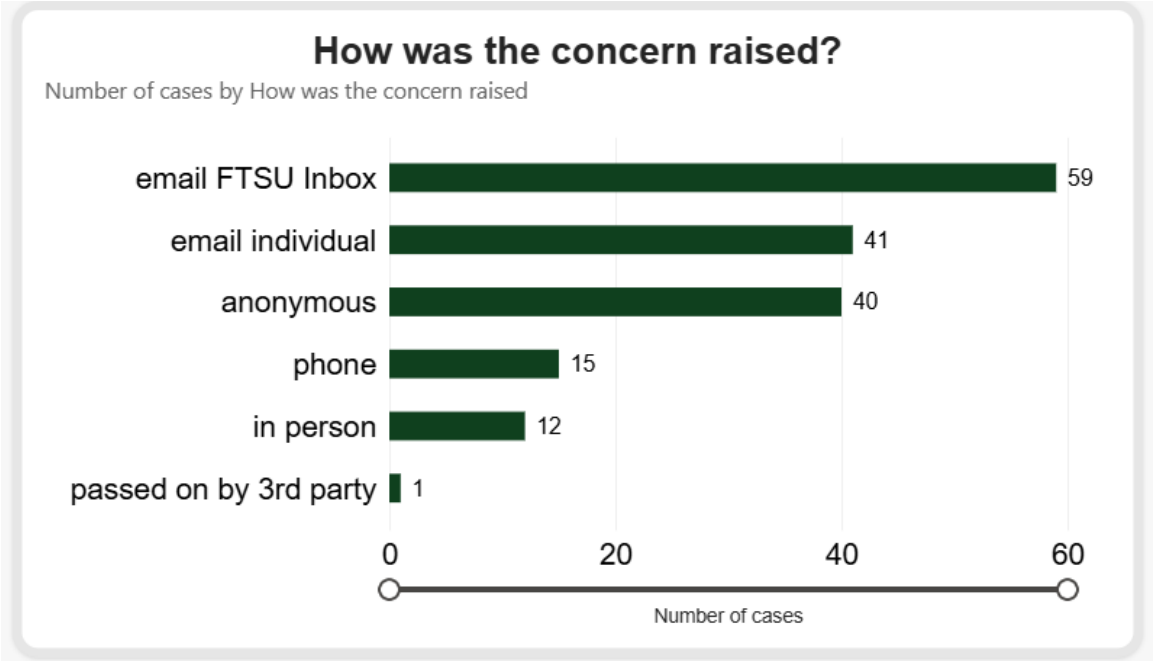




Nursing and midwifery staff accounted for the highest proportion of Freedom to Speak Up cases (54), followed by cases where the professional group was not recorded (anonymous route) and medical and dental staff (22). This distribution broadly reflects the composition of the Trust workforce and the visibility of the service across professional groups.



Since the introduction of the anonymous route, a notable increase in the number of concerns raised through this channel has been noted, with 40 cases reported anonymously during the reporting period. This may reflect the accessibility of the online reporting tool, particularly for staff working shifts who may find it difficult to make contact during normal working hours. It may also indicate that some individuals feel more comfortable remaining anonymous when raising concerns. Further work is planned to better understand the factors influencing the use of this reporting route. Nevertheless, the increase in anonymous reports demonstrates the value of offering multiple ways for staff to speak up and provides an important additional channel through which concerns can be raised and addressed.



The average response time for initial contact through the Freedom to Speak Up service is three working days.

5. Themes and Learning

Quarterly reports demonstrated the value of triangulating speaking up themes with workforce intelligence. Recurring themes were shared with leaders to support local improvement. Particular focus was given to respectful behaviours, psychological safety, staff wellbeing, equality and inclusion, leadership visibility and learning cultures.

During 2026, the Freedom to Speak Up Reflection and Planning Tool were completed to assess the maturity of the Trust's Freedom to Speak Up arrangements. The review identified a number of strengths, including strong leadership commitment, effective governance structures, Guardian capacity, service visibility, and staff engagement. Key priorities for the next phase of development include strengthening the measurement of impact, enhancing assurance processes, improving understanding of barriers to speaking up, and further demonstrating how Freedom to Speak Up contributes to organisational learning, cultural improvement and the delivery of high-quality care (Appendix 1).

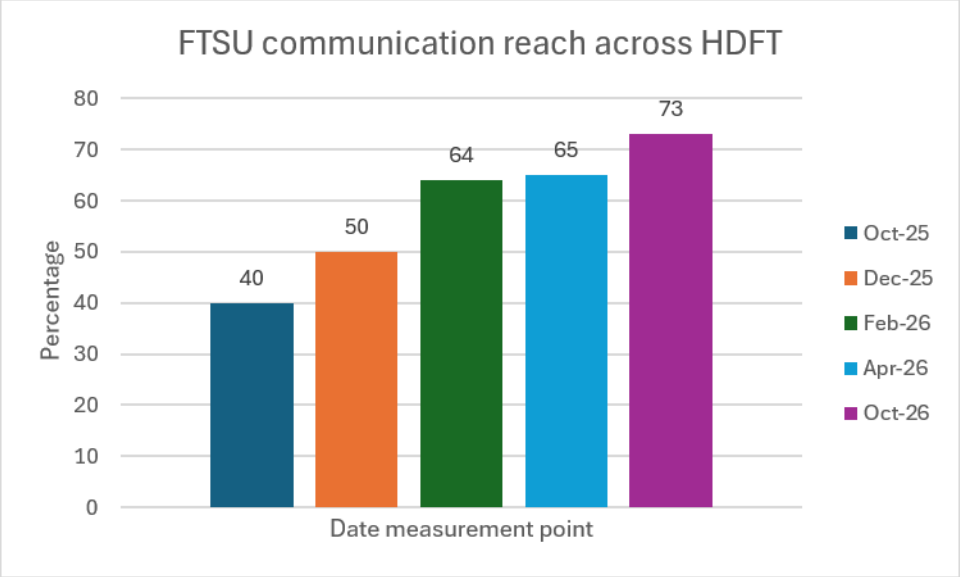
6. Communication and Visibility Programme

Visibility remained a major priority throughout the year. Activities included department visits, ward visits, team meetings, induction presentations, wellbeing events, leadership meetings, Whole Trust Day engagement, Team Talk communications and regular attendance at Line Manager Webinars.

Engagement with newly appointed staff has continued to be a key area of focus. Freedom to Speak Up Guardians have contributed to preceptorship programmes, midwifery new starter sessions, corporate inductions, resident doctor inductions, and multiprofessional student training events. We recognise that staff who are new to the NHS or the organisation are a particularly important group to engage with, as early awareness of Freedom to Speak Up helps foster a culture where individuals feel confident to raise concerns, ask questions, and seek support from the outset of their employment. These sessions have provided valuable opportunities to increase understanding of speaking up routes and reinforce the organisation's commitment to an open and supportive culture.

7. Department and Directorate Reach

The communications plan continued to expand the reach of Freedom to Speak Up across clinical, community, and corporate services. Support and engagement activities included maternity services, pharmacy, nursing services, corporate departments, and operational teams.



8. Fairness Champions Programme

The Fairness Champion network continues to support a culture of fairness, inclusion, and psychological safety. Work during the year focused on reviewing membership, strengthening promotion, recruitment activity, and improving visibility across services.

A joint staff champion and advocacy role networking event took place on the 20th October 2026, to bring together champions and advocates across the whole trust in person at Harrogate to connect with each other, find out more about the roles and share updates. An online event will follow in November 2026 for further outreach.

The fairness champions will have some specific training sessions in Q1 2027.

9. Executive Engagement

Regular monthly meetings took place with Chief Executive Jonathan Coulter and Chair Sarah Armstrong. These meetings provided opportunities to discuss organisational themes, emerging concerns, risks, staff experience, and cultural intelligence.

Bi-monthly attendance at the People and Culture Committee provided ongoing assurance and oversight.

10. Organisational Learning and Impact

Speaking up intelligence has supported service improvements, informed leadership conversations and strengthened understanding of staff experience. Learning has been shared through governance structures, local leadership teams, and workforce forums. The focus remains on ensuring concerns result in meaningful learning and improvement.

Examples include commissioning targeted work within specific areas of the Trust, undertaking focused HR analysis where themes have emerged, sharing learning through line manager webinars, and providing development opportunities for managers on psychological safety. In addition, management resources and awareness materials have been developed to support positive team cultures and effective speaking up practices (Appendix 2).

Alongside managing casework and engagement work, significant progress has been made in strengthening the strategic and governance arrangements that support the service during 2025/2026. This has included development of the Freedom to Speak Up Standard Operating Procedure, helping to ensure greater consistency, clarity and oversight in the management of cases.

Freedom to Speak Up has also contributed to organisational learning through collaboration with the Sexual Safety Working Group. This has supported the development of reporting pathways, awareness raising activities and assurance arrangements to ensure concerns relating to sexual misconduct can be raised, heard and responded to appropriately.

A recurring theme from Freedom to Speak Up cases continues to be the importance of psychological safety within teams. During the year, the Freedom to Speak Up Guardian supported organisational development by delivering training through the Line Manager Webinar Programme. This provided practical guidance for managers on creating inclusive team cultures where concerns can be raised openly and addressed constructively.

Considerable work has also been undertaken to establish a comprehensive case management database, enabling improved recording, monitoring and reporting of concerns. This will strengthen the ability to demonstrate the impact of the Freedom to Speak Up function, identify themes and trends, measure outcomes, and provide greater assurance regarding the effectiveness of actions taken in response to concerns raised.

These developments provide a stronger foundation for the continued evolution of the Freedom to Speak Up service.

11. Equality, Diversity and Inclusion

In response to recommendations arising from the Lord Mann Review, focus has been placed on improving psychological safety, fairness, and inclusion. Freedom to Speak Up data provides valuable insight into workforce experiences and supports

wider equality objectives. The Fairness Champions programme contributes to this work by promoting listening and inclusion.

Equality, Diversity, and Inclusion sessions were delivered by the Freedom to Speak Up Guardian and equality, diversity and inclusion (EDI) lead to specific departments where themes regarding fairness and inclusion had arisen. The feedback and impact of these sessions were very positive.

During 2026, Freedom to Speak Up has actively supported the Trust's sexual safety agenda through participation in a multidisciplinary Sexual Safety Working Group, alongside colleagues from Human Resources, People and Culture, Wellbeing and Safeguarding. The group has supported implementation of the Trust's sexual misconduct arrangements, development of reporting pathways and staff awareness initiatives to strengthen sexual safety across the organisation. In September 2026, a dedicated sexual misconduct category was added to the anonymous reporting form to provide an additional confidential route for staff wishing to raise concerns. This work supports the Trust's commitment to creating a safe, respectful and inclusive workplace where staff feel able to speak up and access support when needed.

Although reporting levels remain low, the introduction of this reporting category provides valuable assurance that staff have multiple routes available to raise concerns and access support. Freedom to Speak Up will continue to work with partners across the organisation to monitor trends, promote awareness, and support organisational learning regarding sexual safety.

12. National Developments

The closure of the National Guardians Office and transition to NHS England reporting arrangements represented a significant national change. Quarterly NHS England reporting has been implemented. During the year consideration has also been given to recommendations from the Amos Review, Thirlwall Inquiry and emerging national policy developments including discussions relating to Hillsborough Law and organisational accountability.

Following publication of the National Guardian's Office "Speaking Up for Safely: Temporary Workers' Experiences of Speaking Up" report relating to temporary

workers, the Freedom to Speak Up Guardian established links with NHS Professionals to strengthen awareness of speaking up routes for temporary staff. HDFT Freedom to Speak Up Guardian contact details have been provided for inclusion within induction and onboarding materials, helping to ensure temporary workers are aware of the support available and how to raise concerns safely.

13. Risks and Challenges

Key challenges include maintaining visibility across all services, ensuring equitable access for all staff groups, meeting increasing demand, evidencing organisational impact and continuing to strengthen psychological safety. Continued investment in relationships and communications will be important.

14. Guardian Annual Opinion

Our assessment is that the Trust continues to demonstrate commitment to openness, transparency and staff voice. Visibility of the Guardian service has increased throughout the year, and there is evidence of positive engagement from leaders and managers. Continued work is required to ensure consistency of staff experience and to further strengthen psychological safety across all areas of the organisation.

15. Priorities for 2026/27

1. Continue expanding the communications and engagement programme and developing clearer outcome measures to assess improving culture and confidence to speak up.

2. Increase visibility within all services and understand barriers to speaking up.

3. Strengthen thematic reporting through triangulation of data and organisational learning.

4. Expand the Fairness Champion network.

5. Embed learning from national reviews.

6. Continue executive engagement and governance reporting as well as promoting evidence of organisational learning from speaking up cases.

7. Strengthen equality and inclusion intelligence.

8. Support the delivery of the Trust's Sexual Safety Programme through promotion of reporting routes, monitoring themes and contributing to organisational learning regarding sexual misconduct and workplace safety.

16. Conclusion

Freedom to Speak Up continues to make an important contribution to organisational culture, staff wellbeing and patient safety. The work undertaken during 2025/26 demonstrates continued progress in creating a culture where staff feel able to speak up via multiple routes and where concerns contribute to learning and improvement through both reactive and proactive elements of the Guardian role.

17. Appendices

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Appendix 1

Freedom to Speak Up Reflection and Planning Tool 2026

Eileen Watson, Freedom to Speak Up Guardian

Board Summary

Feedback from six senior leaders and stakeholders demonstrates that HDFT has a well-established and increasingly mature Freedom to Speak Up (FTSU) culture. There is consistent recognition of strong Board and Executive commitment, increased investment in Guardian capacity, effective governance arrangements, and high visibility of the FTSU function across the organisation.

Respondents highlighted several key strengths:

- Visible commitment from the Chair, Chief Executive, Board and Executive Team to creating a culture where staff feel safe to speak up.
- Increased and ringfenced Guardian capacity, improving accessibility and responsiveness.
- Strong governance and regular reporting through Board and committee structures.

- Effective awareness raising through inductions, training, communications and engagement activities.
- Positive relationships between Guardians, senior leaders and staff.
- Evidence that concerns raised through FTSU are being listened to and used to support learning and improvement.

Collectively, the feedback suggests that the organisation has moved beyond establishing FTSU arrangements and is now focused on demonstrating their effectiveness and impact.

Key Development Priorities (6-24 months)

The consistent themes for further development are:

1. **Measuring Impact and Effectiveness**

Develop clearer outcome measures to assess whether communications, training and engagement activities are improving confidence to speak up and influencing culture.

2. **Triangulation of Data**

Strengthen the use of FTSU intelligence alongside Staff Survey, workforce, EDI, HR and patient safety data to identify trends, risks and opportunities.

3. **Understanding Barriers to Speaking Up**

Gain greater insight into staff groups, teams or communities that may experience barriers to raising concerns and develop targeted interventions where required.

4. **Psychological Safety and Detriment**

Enhance organisational understanding, monitoring and reporting of detriment and psychological safety to provide greater assurance that staff are protected when speaking up.

5. **Evaluation and Assurance**

Further strengthen Board assurance through more systematic evaluation, benchmarking and evidence of organisational learning arising from speaking-up concerns.

Key Strengths to Share and Promote

Over the next two years the Trust should actively share and celebrate:

- The investment in and development of the Guardian function.
- Visible Board and Executive leadership support for FTSU.
- Effective governance and oversight arrangements.
- Successful staff engagement and awareness initiatives.
- Examples where speaking up has led to tangible improvements for staff, services and patient safety.
- Learning from HDFT's experience through regional and national FTSU networks.

Overall Conclusion

The feedback presents a positive and consistent picture of a Trust with strong foundations for Freedom to Speak Up. The priority is not major structural change, but progressing to the next stage of maturity by strengthening evaluation, demonstrating impact, deepening organisational learning and ensuring all staff groups experience the confidence and psychological safety required to speak up. This provides a strong basis for the Stage 2 and Stage 3 improvement plans.

Appendix 2

Manager Support Materials and Guidance Posters



How managers should respond to concerns.docx

ENABLING AMBITION: DIGITAL TRANSFORMATION AND MATURITY TO INTEGRATE CARE AND IMPROVE PATIENT, CHILD AND STAFF EXPERIENCE 2026-2027

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

GOALS:

Quality & Safety

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

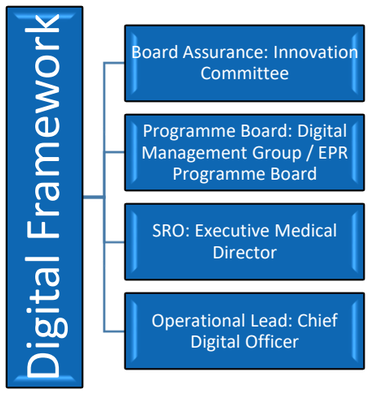
Information

Timely, Accurate Information to enable continuous improvement

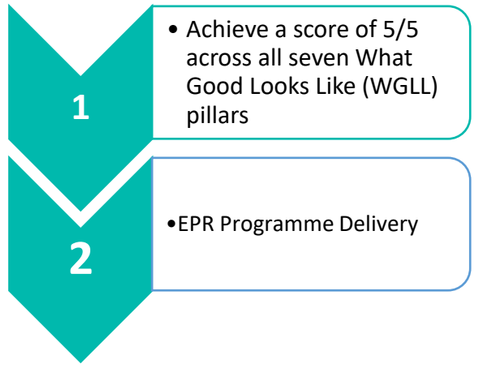
Electronic Health Record

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

Governance:



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



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

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

True North Metrics Summary:

True North Metric	Vision	Goal	Current Status	Countermeasures	Level of Risk to Achieving Goal (C x L)	Level of Risk for progressing actions
Best Quality & Safest Care  Person Centred, Integrated Care  Great Start in Life  Making HDFT The Best Place to Work 	***Overarching Vision:*** To improve our Digital Maturity in keeping with the "What Good Looks Like" national programme for Digital Services in the NHS, so that our colleagues will have improved leadership skills, more advanced solutions, safe and secure digital foundations and practices, improved support and services, and will be better empowered to perform their roles. In turn, this will lead to better and more informative data and improvements in patient care and clinical services.	We aspire to achieve a score of 5/5 across all seven What Good Looks Like (WGLL) pillars. For our 26/27 submission, we aim to achieve an average score of 3/5 across the seven pillars.	Our ambition is to improve the organisations digital maturity that promotes best quality, safest care and now continues into its third year (2026-27). We are focussing on how we can improve our overall digital maturity against WGLL. We assess ourselves annually using the National Digital Maturity Assessment (DMA) tool for both Acute and Community. To support this, we have developed A3's for all DMA Pillars and Domains and where actions plans have been agreed to improve digital maturity, these have been processed through the Trusts Strategic Filter and added to our digital maturity plan. The schedule for this year's National Digital Maturity Assessment has been published: **Milestone** / **Date** DMA assessment launch — **7 September 2026** Assessment window — **7 September to 19 October 2026 (six weeks)** Validation and amendments window — **2 to 16 November 2026 (two weeks)** Results and finalised data — **December 2026 onwards** Interim results have been published which show and improvement from 2.4, to 2.7 for Acute and 2.8 for Community. Validation will take place during November and December, with the validated results published in December.	• A3s that have been developed will be run through the strategic filter (Complete) • Actions will be prioritised and planned for delivery		
	Seven Pillars of WGLL: ***1. Well Led*** – A clear strategy for digital transformation & collaboration. Our leaders collectively own & drive the digital transformation journey, placing citizens & frontline perspectives at the centre. All leaders promote digitally enabled transformation to efficiently deliver safe, high-quality care	As above	**Next 12 months actions:** • JAN 27 - Develop a five-year costed and funded plan to deliver the digital strategy • JAN 27 - Develop a workforce plan to provide capacity to deliver the strategy • JAN 27 - Develop a business case to enable the development of an Enterprise Architecture function.	• A3s that have been developed will be run through the strategic filter (Complete) • Actions will be prioritised and planned for delivery		
	Ensuring Smart Foundations - Digital, data & infrastructure operating environments are reliable, modern, secure, sustainable & resilient. We have well-resourced teams who are competent to deliver modern digital & data services		**Next 12 months actions:** • OCT 26 - Develop a business case and obtain funding to deliver a blood management and tracking solution [Supported by BCRG in OCT 26 – Going to SDR in NOV 26] • DEC 26 - Integrate real-time data from external systems into EPR with appropriate provenance to identify source and validity (e.g., capture data from remote monitoring systems to monitor patient vital signs)? • JAN 27 - Implement standards that enforce segmentation to manage the risk and blast radius of cyber-attack and an intrusion detection system (IDS) that monitors the network for malicious activity or policy violations • JUN 27 - Implement accountability, capability and capacity to deliver the Digital Net-Zero/ Environmental sustainability plan • MAR 27 - Improve % of health records digitised (including historic records but excluding those not to be digitised) from existing 21-40% to 81-99% • MAR 27 - Introduce a proactive approach to IT operations with formalised processes, documentation and standardisation in place to prevent issues from arising • MAR 27 - Implement an automated help desk available 24/7 to help resolve user IT issues	• A3s that have been developed will be run through the strategic filter (Complete) • Actions will be prioritised and planned for delivery		

True North Metric	Vision	Goal	Current Status	Countermeasures	Level of Risk to Achieving Goal (C x L)	Level of Risk for progressing actions
			• MAR 27 - Introduce proactive ITIL processes for incident, request, change, and problem management are established, prioritising and streamlining issue resolution			
	Safe Practice - We maintain standards for safe care, as set out by the Digital Technology Assessment Criteria for health & social care (DTAC) & routinely review system-wide security, sustainability & resilience		**Next 12 months actions:** • MAR 27 - A digital system is in place to support SAR processing, but automation is limited and manual processing is still required. The processing of SARs is moving towards a fully digital workflow, utilising EPR and EDMS functionality to reduce paper-based workflows. Exploring options for redaction solutions to enable a fully digital redaction process with automation in many parts to improve efficiency. • MAR 27 - Strengthen our organisational capability by developing more of our Clinical Digital Leads and providing training to enable them to undertake Clinical Safety Officer (CSO) responsibilities. We also need to look at the resource time for activities relating to CSO responsibilities and whether we need more clinical colleagues trained up and have time to support. This will improve our capacity to maintain ongoing oversight and assurance of the Trust's digital systems and ensure future compliance assessments are undertaken consistently.	• A3s that have been developed will be run through the strategic filter (Complete) • Actions will be prioritised and planned for delivery		
	Support Workforce- Our workforce is digitally literate & able to work optimally with data & technology. Digital & data tools & systems are fit for purpose & support staff to do their jobs well		**Next 12 months actions:** • FEB 27 - Develop a strategy to review the DDaT workforce for areas where there is a talent gap • MAR 27 - Digitally enable the supply chain management • APR 27 - Develop a plan to identify, assess and address the professional development, training and learning needs of the Digital, Data, and Technology (DDaT) workforce • APR 27 - Develop a strategy and plan to address hard-to-fill Digital, Data, and Technology (DDaT) skill areas through recruitment, contracting or shared resourcing delivery and obtain approval at DMG (and anywhere else required) • APR 27 - Complete alignment to - https://ddat-capability-framework.service.gov.uk/ • JUN 27 - Implement inventory management, including the use of RFID or other digital tracking technologies • OCT 27 – Document the talent gaps and develop a plan to improve	• A3s that have been developed will be run through the strategic filter (Complete) • Actions will be prioritised and planned for delivery		
	Empower Citizens - Citizens are at the centre of service design & have access to a standard set of digital services that suit all literacy & digital inclusion needs. Citizens can access & contribute to their healthcare information, taking an active role in their health & well-being		**Next 12 months actions:** • No action identified for next 12 months	• A3s that have been developed will be run through the strategic filter (Complete) • Actions will be prioritised and planned for delivery		
	Improve Care - We embed digital & data within our improvement capability to transform care pathways, reduce unwarranted variation & improve health & wellbeing. Digital solutions enhance services for patients & ensure that they get the right care when they need it & in the right place		**Next 12 months actions:** • MAR 27 - Define an AI Governance framework with roles and responsibilities • MAR 27 - Develop AI Strategy • MAR 27 - Develop a tried-and-tested risk management approach for AI solutions • MAR 27 - Explore ICB and Nation-wide AI solutions for economies of scale • MAR 27 - The Trust has established governance expectations and accountability arrangements for AI use; however, assurance that these requirements are consistently understood by staff needs improving because AI training completion and awareness activity are not formally recorded or monitored • MAR 27 - Replace Inheathcare with Nervecentre (Q224) and provide the ability for patients (and/or carers) to measure and input agreed health data (e.g., vital signs into an app or website) manually for patients we care for virtually. We will put methods in place to understand the level of acuity of patients and adjust monitoring frequency accordingly	• A3s that have been developed will be run through the strategic filter (Complete) • Actions will be prioritised and planned for delivery		

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

Major Digital Projects (Equivalent to Trust Wide Projects):

Workstream	True North Metric	Vision	Goal	Current State	Countermeasures	Level of Risk to Achieving in Year Goal	Level of Risk for progressing actions
	Best Quality & Safest Care	Radiology booking office with ability for patients to book direct into appointments	Radiology Electronic Booking Office	• Delivery in progress • NOV 26 Go Live delayed due to supplier development delays – Exception report produced/approved and go live now planned for Feb 26	• Develop business case and secure funding • Complete procurement • Complete discovery • Plan & deliver solution		
	Best Quality & Safest Care	Replace the current Cardiology system	Cardiology System Replacement	• Delivery in progress • JUL 26 Go Live Completed • SEP 26 – Project Closed	• Engage with supplier/service • Complete discovery • Plan & deliver solution		
	Best Quality & Safest Care	Electronic meal ordering system so patient can order their own meals and provide efficiencies to the catering team/Trust	Meal Ordering, Portering & Domestics System	• Synbiotix supplier confirmed for Meal Ordering, Portering and Domestics • 3 Projects in planning and delivery • NOV 26 - Meal Ordering Pilot Go Live • JAN 27 – Meal Ordering Full roll out complete	• Piggyback off LTHT procurement • Complete business case and secure funding • Engage with supplier/service • Complete discovery • Plan & deliver solution		
	Best Quality & Safest Care	Delivery of a regional integrated PACS and RIS solution	Regional PACS & RIS Replacement	• Awaiting procurement to be completed, business case to be developed and funding to be secured • JUL 26 - Tender published • OCT 26 - Evaluation & moderation to be complete • MAR 27 - Preferred bidder & contract award • APR 27 - Estimated delivery start	• Regional procurement and business case to be developed and funding secured • Work with supplier/service - regional programme to plan delivery • Deliver solution		
	Best Quality & Safest Care	Job planning solution for AHP's	Job Planning for AHP's	• Preferred supplier confirmed • Business case to be developed by Autumn	• Developing requirement before testing the market • Complete discovery • Complete business case and confirm funding • Procure, plan & deliver solution		
	Best Quality & Safest Care	SystmOne Adult Optimisation	To optimise the use of SystmOne in Adult Community	• Approved by DDP • NOV 26 - Delivery planning started	• Complete discovery • Plan & deliver optimisation work		
	Best Quality & Safest Care	Blood Tracking solution to ensure end to end blood transfusion process	Blood Tracking Solution	• SEP 26 – Business Case developed • OCT 26 – Business Case supported by BCRG • NOV 26 – Approval by SDR • NOV 26 – WYATT funding confirmed - TBC • DEC 26 - Delivery plans being developed	• Develop business case • Procure solution • Plan and deliver solution		

Digital Portfolio Report - Portfolio List - Digital Portfolio - Power BI

Strategic Programme: Electronic Patient Record

Workstream	True North Metric	Vision	Goal	Current State	Countermeasures	Level of Risk to Achieving Goal (C x L)	Level of Risk for progressing actions
	Best Quality & Safest Care		• EPR Live – Apr 26 • Paper-Lite – Apr 26 • HIMSS Level 5 – Oct 26 • Optimisation – Mar 27	This Strategic Programme for the delivery of the Nervecentre EPR continues into its third year (2026-27). The following are planned for delivery: • Optimisation (Apr 26 – Mar 27) • Medical Device Integration (Jun 26 – Mar 27) • Ambient Voice Technology (Sep 26 – Oct 27) • eConsent (Sep 26 – Mar 27) • ePMA (Dec 26 – Jul 28) • HIMSS Assessment – Aug 26 From a strategic planning framework perspective, the EPR Programme will be removed as a strategic programme after March 2027. Any further EPR work will be picked up by the Digital Services and supporting clinical teams, with EPR benefits capture and optimisation embedded with the HDFT Futures strategic programme. In addition to the National Digital Maturity Assessment, HDFT have recently completed a HIMSS Electronic Medical Record Assessment Model (EMRAM) to ascertain its EPR maturity. This globally recognised assessment was last completed in 2021, where HDFT score level 0 out of 7. The draft report for this year's assessment has been issued with a new score of level 4 out of 7 which is a significant improvement. Whilst HDFT has not achieved a level 5 score, it's important to note that elements of the Clinical User Adoption focus area in the HIMSS assessment have changed, where some items previously required for level 6, are now in level 5. Without this change, HDFT would have achieved a level 5. Progress is detailed in the table below. To achieve each stage, all minimum requirements need to be completed AND 70% compliance in ALL five focus areas.	• Deliver a new EPR solution • Optimise the solution & realise benefits • Enhance with additional modules and functionality • Perform HIMSS Assessment		

Stage Achievement	4	Highest stage according to the online self-assessment
Percent Achievement	77%	% accomplishment against the model
Stage 7	69%	Stage not achieved
Stage 6	76%	Stage not achieved
Stage 5	79%	Stage not achieved
Stage 4	100%	Stage achieved
Stage 3	97%	Stage achieved
Stage 2	92%	Stage achieved
Stage 1	97%	Stage achieved

Color Legend
Stage criteria achieved
70% of Stage criteria not met
Minimum requirements not met

Breakdown by Focus Area

	Data Capture & Health Information Exchange	Patient Engagement	Healthcare Analytics & Outcomes Measurement	Resilience Management	Clinical User Adoption
Stage Achievement	5	5	6	7	4
Percent Achievement	93%	44%	78%	89%	68%
Stage 7	83%	22%	76%	92%	40%
Stage 6	93%	56%	86%	90%	57%
Stage 5	100%	78%	86%	79%	57%
Stage 4	100%	100%	100%	100%	100%
Stage 3	100%	N/A	87%	90%	100%
Stage 2	100%	N/A	87%	85%	100%
Stage 1	100%	N/A	75%	89%	100%

N/A refers to stage not represented in area for assessment scoring.

Plans are being developed to initially advance to level 5, then to level 6 and 7 and are included in the wider Digital Maturity plans.

Breakthrough Objective:

Workstream	True North Metric	Vision	Goal	Current State	Countermeasures	Level of Risk to Achieving Goal (C x L)	Level of Risk for progressing actions
Budgets in Balance	N/A	To support the organisations 2026/27 financial targets	All Digital Services budgets to remain in budget	This is under review as part of the Affordable Establishment Review (AED)			

Related Corporate Risks

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

Related External Risks

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

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

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

GOALS:

Healthcare Innovation

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

Children's Public Health Research

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

Research studies

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

GOVERNANCE:

Healthcare R&I Framework

- Board Assurance: Innovation Committee
- Programme Board: Research & Innovation Executive Management Group
- SRO: Executive Medical Director
- Clinical Lead: Associate Medical Director for R&I
  Operational Lead: R&I Manager

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

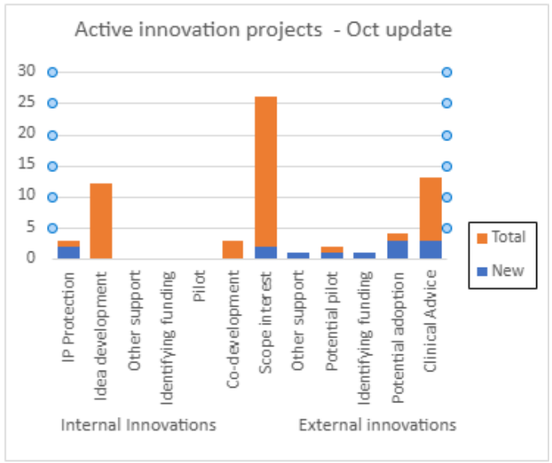
1. Healthcare Innovation- support of external and internal innovations and strategic partnership with industry
2. Children's Public Health
3. Clinical Trials - increased recruitment of patients into reseach studies. All studies to be delivered to time and target.

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

Overarching Risk Summary:

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

True North Summary:

True North Metric	Vision	Goal	Current Status	Countermeasures	Level of Risk to Achieving Goal (C x L)	Level of Risk for progressing actions
Healthcare Innovation	To be a leading trust for the testing, adoption and spread of Healthcare Innovation and to facilitate and accelerate the growth of innovative healthcare solutions in HDFT	Generate, or create cost/time saving benefits equivalent to, >£100,000 to cover staffing costs of innovation team Adopt at least 1 innovation that supports Trust priorities.	• Clinical Advice Service o 3 further requests for clinical advice received outside of CAS, including request to be part of funding bid Active innovation projects are summarised below: 	Continue to deliver Clinical Advice Service to generate income, support innovation developments and create partnerships Develop benefit-realisation tool Continue development of innovation governance processes and pathway and communicate to all staff. Utilise project management tools to streamline innovation workflows and tracking. Work with WYAAT innovation partners, Medipex and Health innovation to develop innovation training offerings.		
		Assess **all** internally generated innovation ideas and support if deemed worth progressing	• Scorecard developed to help prioritise projects based on Trust and departmental priorities • Supporting North Yorkshire Business Cluster event in December organised by Health Innovation to help businesses access the NHS and support local investment. • Supporting 2 projects from 0-19 services to assisting in protection of IP and commercialisation of novel pathways and tools they have developed.	Develop innovation scorecard to aid project prioritisation Continue and develop new partnerships with industry to create sponsorship opportunities		
		Develop strategic partnership with at least one organisation - academia, industry, charity, innovation support organisation	• Partnership established with University of York and Hull York Medical School o Progressing through process to formally recognise partnership			
		Help create culture of innovation and develop relevant competencies in all staff by: Delivering at least 2 innovation training events per year. Delivering a further 3 x Clinical Entrepreneur Fellows	• Clinical Entrepreneur Fellows o 3rd cohort (3 x FY1s Aug 26 – Jul 27) - have commenced and been assigned projects o Partnership formed with Herility Health, a femtech start-up developing women's hormone and fertility testing. • Planning second 'Introduction to AI in Healthcare' session with Health Innovation and other WYAAT Trusts – delayed due to lack of response from Health Innovation.	Work with NHS-E to continue and expand CEF programme. Work with partners in WYAAT and Health Innovation to develop training offerings		

teamHDFT At our best

NHS Harrogate and District NHS Foundation Trust

Clinical Trials



To excel in the governance and delivery of clinical research, expanding patient access to high-quality clinical trials through sustainable growth and collaborative partnerships.

We aim to be a highly recognised and valued department within the trust, fostering a strong culture of research and innovation that drives improvement, empowers our workforce, and enhances outcomes for all patients.

Generate income to match our research delivery costs.

Sustain partnership and funding for department with Y&H Research Delivery Network. Deliver contractual agreement and high-level objectives:

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

Ensure a balance of the different types of studies are opened

Generate income to ensure financial sustainability

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

	Target	April	May	Jun	Jul	Aug	Sep	Oct
Income	£100k	£121k	£76k	£93k	£113k	£142k	£86k	£120k

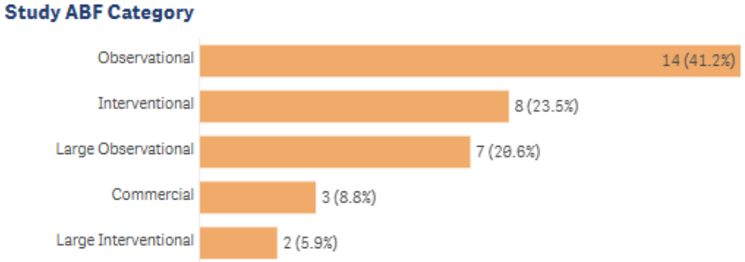
Sustain Partnership (RRDN) funding

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

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

Area	Metric	Target	Apr	May	Jun	Jul	Aug	Sept	Oct
Research	% of NIHR studies recruiting to time and target (RTT)	80%	81.5%	81.3%	81%	85.7%	81.6%	82%	71%

Ensure a balance of the different types of studies are opened:
Recruiting Trials by Complexity:



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

Area	Metric	Target	Apr 26	May 26	Jun 26	Jul26	Aug26	Sept 26	Oct
Research	Patients Recruited	3000/ yr	172	335	495	627	756	827	1092

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

Establish permanent Clinical Research Facility to increase throughput and commercial attractiveness

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

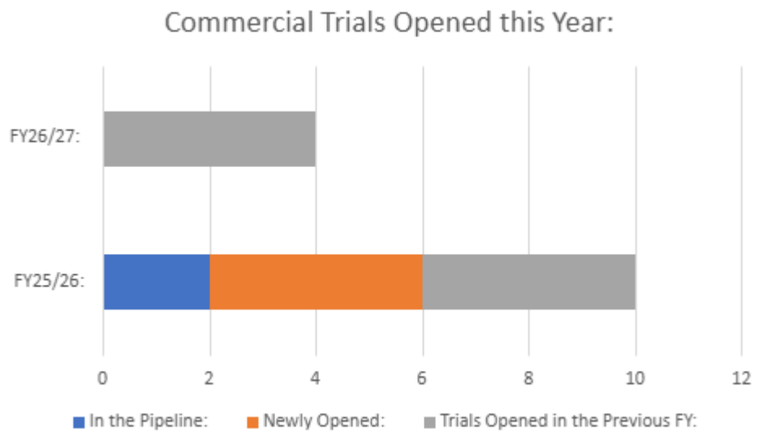
Review and refine Research income distribution model. Options appraisal of future model(s) including review of other Trusts, and national guidance.

YHN community collaboration project will strengthen partnership with GPs and RRDN. Ensure the success of this project to maintain government and RRDN strategic directions are followed.

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

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

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

		Recruit to opened studies within 30 days of opening Open all studies within 60 days of approval). Increase the number commercial studies opened year on year Successfully apply for at least one external research financial funding bid per year to create funding for staffing .	<table><tr><th>Area</th><th>Metric</th><th>Target</th><th>Mar</th><th>Apr</th><th>May</th><th>Jun</th><th>Jul</th><th>Aug</th><th>Sept</th><th>Oct</th></tr><tr><td>Research</td><td>% of Trials opened this year to have recruited within 30 days</td><td>90%</td><td>70%</td><td>0%</td><td>100%</td><td>100%</td><td>100%</td><td>100%</td><td>100%</td><td>100%</td></tr></table> <table><tr><th>Area</th><th>Metric</th><th>Target</th><th>Mar</th><th>Apr</th><th>May</th><th>Jun</th><th>Jul</th><th>Aug</th><th>Sept</th><th>Oct</th></tr><tr><td>Research</td><td>Studies opened with 60 days of approval</td><td>90%</td><td>100 %</td><td>100 %</td><td>100 %</td><td>100 %</td><td>100 %</td><td>100 %</td><td>86%</td><td>86%</td></tr></table> **To increase the number commercial studies opened year on year:**  **External research financial funding bid** Two bids successful for FY 26/27 started in April 2026 – associated KPIs continue to be monitored via RRDN 3 monthly. (see community collaboration project YHN & HDFT). An Interim report on KPI's submitted to NIHR in August 26 and revised targets approved. A NIHR bid to support further staffing for the Generation Study was submitted on 2nd Sept. 26 and was successful. Two further funding opportunities are now open via the NIHR and we are working towards submission in Mid November. We continue Horizon scanning ongoing to identify further funding opportunities.	Work to establish new expression of interest process for studies, including new fast track expression for suitable studies. Prioritisation of commercial studies over non-commercial where appropriate to do so.		

		Continue to develop new partnerships to progress research via WYATT, NSO , YHN and academic and commercial alliances. To sustain and develop a patient partnership group and increase the feedback we receive year on year from our patients, sponsors and Pi's Increase the number of trust staff who have completed a recognised research course or qualification. Create a workforce culture where research is part of everyday practice.	**Develop new and existing partnerships to progress research** Primary Care collaboration project June 26 -1 post started and work on submitting 6 EOIs trials for YHN begun. Recruitment to other post ongoing. Oncology Y&H partnership - Funding arrangements and contractual elements now in place. Academic partnerships: York University partnership in various departments established. Progressing ways to partners with Bradford CRDC re commercial study EOI submissions. **Develop patient partnership group and increase the feedback we receive year on year** Monitored via PRES target 25/26 and numbers received each quarter from RRDN. Cumulative totals below: Development of patient partner group in progress. Feedback on activity and impact 3 monthly. Below are the number of patient partners recruited to the Trust: Work continues to now exceed this target. **Create a workforce culture where research is part of everyday practice.** Number of successful applicants to NIHR funding for research-related courses, clinical academic pathways, or development routes.to be collated and published. Completion of the National SORT tool (Used to assess and strengthen research readiness and capability.) Promote the GCP on learning lab and developing other research related materials. Feedback report 6 monthly from sponsors and Professional investigators through development of survey.	Meeting with RDN to discuss new format of PRES and learn from other organisations.		

Area	Metric	Target	Apr	May	Jun	Jul	Aug	Sept	Oct
Research	My Research Experience Forms Submitted.	81/yr.	1	1	1	2	7	7	28

Area	Metric	Target	Apr	May	Jun	Jul	Aug	Sept	Oct
Research	Total # of pt Partners	4	2	0	0	4	5	5	5

Clinical Trials (MRI)	To establish a state-of-the-art 3T Research MRI imaging service at Harrogate and District NHS Foundation Trust that expands access to advanced diagnostic and research imaging.	To successfully implement and operationalise the 3T MRI scanner, with the workforce, governance, and research infrastructure required to deliver safe, sustainable clinical capacity and support growth in commercially sponsored and NIHR portfolio research studies by 2028.	The 3T MRI Scanner Research Capacity Project remains in the development and funding assurance phase, supporting the Trust's ambition to increase participation in high-value commercial and non-commercial studies. Workforce and operational requirements have been established through business case development. Key risks relate to funding approval for capital enabling works, procurement timescales, and alignment of clinical and research imaging capacity; however, these are being actively managed through stakeholder engagement and implementation planning. Issues in capital costs/funding allocations are being escalated to execs. Funding confirmation is the primary milestone for progression to delivery.	Escalation to Executive Team for re-prioritisation of capital funds. Revisions of capital enabling works required to reduce costs.		
Clinical Trials (CRF)	To establish a dedicated Clinical Research Facility that provides a high-quality, patient-centred environment for the delivery of clinical research, enabling more people across Harrogate and the surrounding region to access innovative treatments and participate in research that improves health outcomes.	To develop and operationalise a sustainable Clinical Research Facility that increases research capacity, supports delivery of NIHR and commercial studies across multiple specialties, and strengthens HDFT's position as a leading research-active NHS organisation.	The pop-up Clinical Research Facility, launched on Farndale Ward in February 2026, has already supported over 100 research participants. Its early success demonstrates the growing demand for local research opportunities and provides a strong foundation for a permanent facility that will enable more patients to access and benefit from research as part of routine care. Patients and team have felt that this valuable space is starting to increase the visibility and presence of research. The space also allows HDFT to maximise new opportunities for research as they flow through the system. Work is ongoing to establish a permanent CRF solution on the acute site. One option is in advanced plans and looks likely to deliver in Q4 26/27 or Q1 the following year.	Identify and plan for permanent CRF space, building on delivery and lessons learned from pop up CRF space.		

Trustwide Project: 3T MRI and CRF

True North Metric	Vision	Goal	Current Status	Countermeasures	Level of Risk to Achieving Goal (C x L)	Level of Risk for progressing actions
Best Quality Safest Care: Healthcare Innovation 	To have outstanding MRI technology and associated facilities that enable the delivery of our research and innovation ambitions	Procure and install a new 3T MRI scanner.	• Scoping phase behind original trajectory although not affecting overall plan at present. TIF2 timeline ahead of trajectory and therefore not a risk to this project at present. • Mechanical and Engineering Feasibility report received. • Premarket engagement completed. • Full market engagement received and assessed by team nominated by Board. • Business Case awaiting Research requirements and final costings. • Costs to be reviewed in full with costs currently exceeding funding.Costs to be reviewed in full with a “Must have” and “Nice to have” approach, with costs currently exceeding funding.	• Scoping completed, full market engagement completed. • Best and Final offer received by Trust. Business Case in review following the BCRG in September.		

Strategic Programme: HDFT Impact

Workstream	True North Metric	Vision	Goal	Current Status	Countermeasures	Level of Risk to Achieving Goal (C x L)	Level of Risk for progressing actions
	All	To develop our capacity and capability and to embed the culture for continuous improvement through the Implementation of the Impact Improvement Operating Model.	Training: **50%** (92/184) of Teams will be trained to use HDFT Impact by Nov 2026 **70%** of teams trained (138/184) by Sept 27.	This Strategic Programme for HDFT Impact continues into its third year (2026-27). In year two we continued the development of HDFT Impact, refining our training offer to meet the needs of operational teams, re-designing our sustainability assessment to understand where the model was robust and where gaps exist that require attention, and exploring different approaches to increase engagement and awareness. Training, Sustainability, and Awareness are now established as our 3 key workstreams for this programme. Performance in these elements is monitored with three driver metrics. --- The first is the percentage of teams trained across HDFT which is 52% (95 / 184 teams). This means the goal to train 50% of teams by Nov ‘26 has been met which is testament to the commitment of the Improvement Academy to develop and expand the training offer. • In total 6 teams from Wave 10 completed training, an increase of one from the last report due to validation. • Wave 11 began early in October involving 15 new teams across all directorates. 2 of these teams are at risk of withdrawal due to operational pressures. • Schedule of Wave 12 in progress with 11 teams listed of which 6 area confirmed. • The first test of the 3-day compressed format for wave training with the CYPPH Directorate was completed with Cumberland	Delivery of Wave 11 training content and workshops using revised model. Increased flexibility is being offered by the Improvement Managers to support teams affected by operational pressures to stay on track with training. Use the initial feedback from participants and facilitators to inform adjustment to the next test of the 3-day format in Q4. Monitor the implementation of the concepts over the next 6-8weeks as part of the overall evaluation		

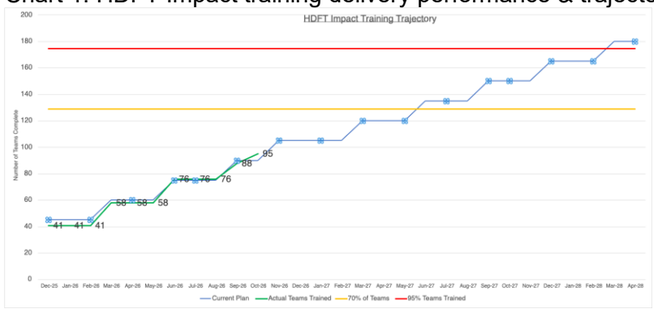
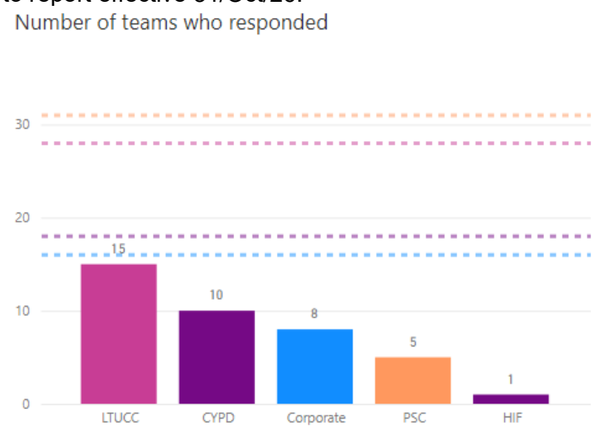
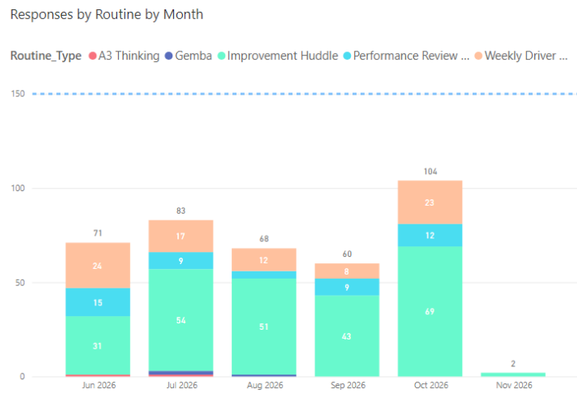
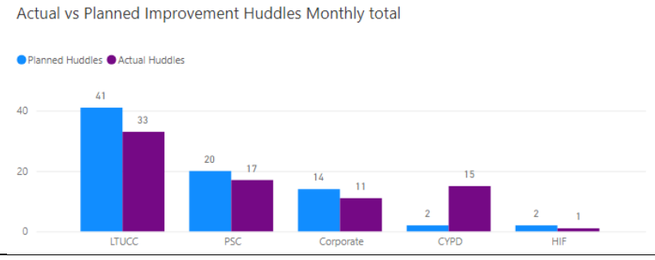
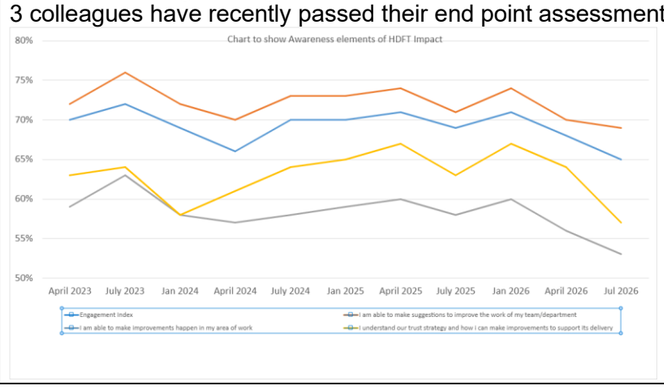
				and Westmoreland & Furness Service areas. Feedback was predominantly positive from those involved. • The first countermeasure to address the problem of trainee doctor participation in Impact have begun. Chart 1: HDFT Impact training delivery performance & trajectory 	Continue to test and develop the countermeasures for medical colleagues in Impact routines.		
			Sustainability: 65% of those who have completed training will have embedded the routines and processes of the Improvement Operating Model after 4 months.	There are 5 months of data (Jun-Oct'26) for the self-assessment of Impact routines: https://app.powerbi.com/groups/01a88572-f02f-46fc-8f40-4aabac707bbd?experience=power-bi Highlights of the Oct 2026 data: • A total of 104 responses this month were received from 39 different teams. As 86 of the teams who have completed training are expected to report, this number indicates 42% of teams are meeting this sustainability target, a 12% improvement from September. • The number of different teams with a response in month per directorate is illustrated in chart 1 below; LTUCC: 15 / Corporate: 8 / PSCC: 5 / CYPPH: 10. • 79 Improvement Huddles were planned with 64 taking place (81%). The average quality score was 2.6 / 3. • 12 PRMS were reported in month, an increase of 2 from the last report with an average quality score of 2.8 / 3. • 17 Weekly Driver Meetings took place and increase of 9 since September. Data from the 'health check' to determine the level of support teams may need to strengthen the sustainability of their Impact routines has been used to begin the planned interventions. Interventions thus far have been very well received, and credit should be given to leaders within directorates for their commitment to support this plan. Conversations to support the integration of HDFT Impact routines and behaviours into the local offer for the new Leadership & Management framework and self-assessment have taken place.	Improvement in the reporting and engagement with sustainability activities is indicative that current strategies are having a positive effect. The focus will be on effective deliver of the existing plan as well as warranted adaptation and timely escalation to navigate challenges linked with operational pressures. The sustainability dashboard is proving useful to support targeted interventions. Consideration is being given to selective focus on teams within PSCC. The Weekly Driver Meeting routine is also emerging as a distinct opportunity as it provides a critical bridge between frontline improvement huddles and PRMs. Building on positive progress with the integrated approach of EPR benefits realisation coupled with effective impact routines will be a new area to explore this month so the key learning can support transferability. An agreement to support workforce pressures in the emergency department will reduce Improvement Academy team capacity over the		

				Chart 1. Monthly reporting of Impact routines by different teams. (NB: dotted line indicates 100% compliance based on no. Teams expected to report effective 31/Oct/26.  Chart 2. Cumulative monthly Impact routines: Jun-Oct '26.  Chart 3. Directorate Huddle Activity: planned vs. happened. 	next 2-months which is expected to impact sustainability performance		

			75% of HDFT staff will answer positively to the question: 'I understand our trust strategy and how I can make improvements to support its delivery' by Mar 2026.	The results of the July Inpulse survey provide the most recent data to inform performance for this metric. These scores show consistent deterioration of 3-7 percentage points across all domains as summarised below: • **Engagement index**: 65% (-3 % points) • "I am able to **make suggestions** to improve the work of my team" 69% (-1% point) • "I understand our **trust strategy** and how I can make **improvements to support its delivery**": 57% (-7 % points) • "I am able to **make improvements happen** in my area": 53% (-3% points) The deterioration in the scores takes the Impact programme further from the original goal (75% positive responses by March '26). The gap remains 22 percentage points. Cohort 3 of The Data Skills for Impact digital apprenticeship offer via Multiverse has begun with 11 colleagues with 2 learners beginning level 5 (Data Engineering) qualifications. 3 colleagues have recently passed their end point assessments. 	New impact video content showcasing teams from the Medical Day Unit and Trinity Ward is complete and will be published this month. The revised A3 to identify and prioritise new countermeasures for the Awareness workstream has been drafted with novel countermeasure discussed at programme board. This work can now move into action over the next 2-months with the expectation of improved performance in the January survey. Making explicit the strategic alignment of the 'financial sustainability' enabling ambition will continue throughout Q3. The proposal to launch a new breakthrough objective targeted at finance is expected to be agreed by the board this month. Formative work is in process exploring how leveraging copilot functionality can integrate with HDFT Impact methodology such that the improvement academy can facilitate uptake as part of training and sustainability activities.		

Breakthrough Objective:

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

Related Corporate Risks

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

Related External Risks

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

ENABLING AMIBITION: AN ENVIRONMENT THAT PROMOTES WELLBEING 2026-27

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

GOALS:

Wellbeing

A patient and staff environment that promotes wellbeing

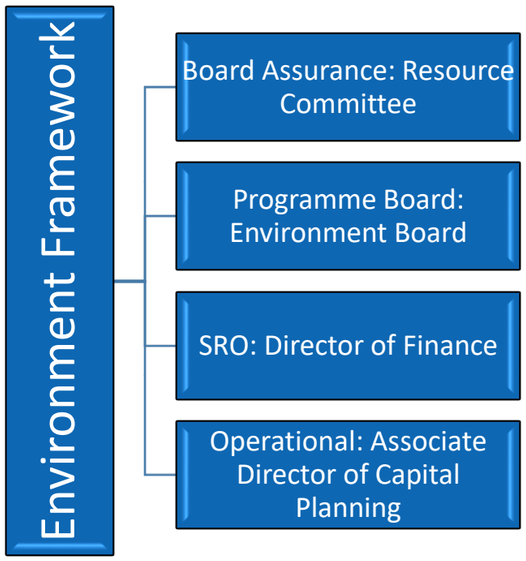
Quality & Safety

An environment and equipment that promotes best quality, safest care

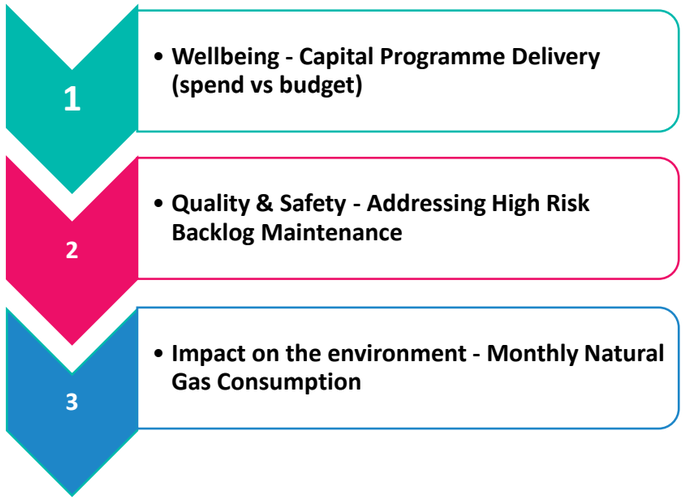
Environmental Impact

Minimise our impact on the environment

GOVERNANCE:



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



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

Overarching Risk Summary:

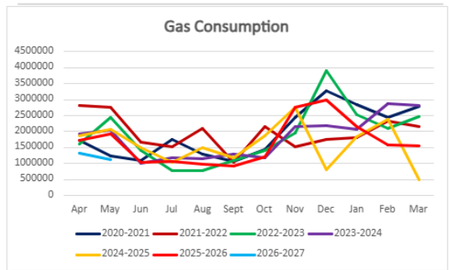
Ambition	Workstream	True North Metric	Risk Appetite	Level of Risk to Achieve Metric – Linked to Risk Appetite
				1 – 3 | 4 – 6 | 8 – 9 | 10 | 12 | 15 | 16 | >20
An Environment that promotes wellbeing	Wellbeing	Capital Programme Delivery (Spend vs Budget)	Operational: Cautious	
	Quality & Safety	High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

Enabling Ambitions Metrics Summary:

Enabling Ambition Metric	Vision	Goal	Countermeasures	Current State	Level of Risk to Achieving Goal	Level of Risk for progressing actions
Wellbeing	A patient and staff environment that promotes wellbeing	To improve the environment for patients and staff Capital spends vs budget – to ensure delivery against allocated budget.	• Deliver 2026/27 Capital Programme • Develop Capital Priorities for future years. • Deliver Block C Theatres & Imaging build. • Develop plans for Imaging Corporate Project • Deliver Harrogate Estates Plan	2026/27 Capital Programme - £35.3m Predicted spend forecast – 100%. • Block C build – On track. • Community Diagnostic Centre – Programme timescales to be confirmed, awaiting confirmation of funding from NHS England before being able to schedule updated case for Board of Directors. • Harrogate Estates Plan – A3 developed		

Quality & Safety	An environment and equipment that promotes best quality, safest care	To reduce high risk backlog maintenance risks and improve the Trust's premises infrastructure.
		
		2023/24 PAM
		• 37 Moderate Improvement SAQs
		2024/25 PAM
		• 28 Moderate Improvement SAQs
			• Premises Assurance Model
			  ○ Deliver 25/26 PAM action plan.
			  ○ Assess Trust against 26/27 standards.
			
			• Deliver £1.8m Estates Safety Fund monies.
			
			• RAAC Eradication – Cost submission due from Contractors in September 2026. Initial forecast circa £28m plus sizable costed risk register, which will require additional NHSE funding.
			
			• Develop business case for Fire Alarm upgrade (circa £9m)
				• Premises Assurance Model 26/27 submission – On track
				
				• Estates Safety Fund (Fire & Main Theatres design) – On track
				
				• Business case being submitted to NHS England for Estates RAAC Eradication Phases 1-4 (£12m). Additional business case for Phases 5-10 will be developed in due course and allow additional options appraisal for Energy Centre.
				
				• Design and Quote from supplier to undertake upgrade received, business case under development. Case anticipated for Board Q2 2026/27. No funding or timescale agreed.		

Environmental Impact	Minimise our impact on the environment	HDFT to be carbon net zero by 2040.
		
		Achieve 1,700 tCO2e reduction in Scope 1 and 2 emissions by 2028.
			• Refreshed Green Plan developed and approved.
			• Carbon accounting process implemented.
			• Estates & Facilities
			  ○ Replacement of CHP with more modern, efficient system
			  ○ Investigate geothermal energy.
			  ○ Investigate onsite waste to energy system.
			  ○ PSDS 4 Works
			
			Medicines- Complete nitrous oxide removal and develop Entonox reduction plan.
				• Complete
				• On Track
				• TBC depending on funding.
				
				PLOI agreed between HIF and Trust – will update next month.
				
				External funding received for trolleys to house localised canisters. Piped network will be capped off. Entonox project to be initiated.		

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

	2020-2021	2021-2022	2022-2023	2023-2024	2024-2025	2025-2026	2026-2027
Apr	1718953	2807111	1620648	1926041	1877301	1737574	1317132
May	1232831	2750971	2443531	2034675	2084214	1929807	1127613
Jun	1094369	1656464	1402540	1011927	1492894	1032859	
Jul	1768353	1525916	790138	1185096	1047118	1067681	
Aug	1300459	2099000	766496	1155382	1496099	979048	
Sept	1069875	1025624	1080973	1305695	1188302	924195	
Oct	1442709	2162393	1401301	1175095	1883559	1213951	
Nov	2457444	1530057	1960470	2150621	2749748	2746209	
Dec	3283299	1757298	3922392	2185757	812495	2977290	
Jan	2851890	1826197	2528074	2064552	1840643	2169588	
Feb	2438526	2334727	2093447	2879211	2380436	1573496	
Mar	2792297	2159283	2468989	2827828	489749	1550420	

Trust wide Project: Harrogate Estates Plan

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

Strategic Programme:

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

Breakthrough Objective:

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

Related Corporate Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
ID 117	Violence and aggression against staff	Organisational risk to compliance with legislative requirements, with the risk of major injuries, fatality, or permanent disability to employees due to the failure to manage the risk of staff being subjected to acts of violence and aggression whilst carrying out normal duties, due to lack of suitable control measures and appropriate training. Multiple clinical and non- clinical changes being made.	4 x 3 = 12	4 x 2 = 8 March 2027	Operational: Health & Safety	Minimal
ID 264	Containment Level 3 Laboratory	The unavailability of the onsite Containment Level 3 (CL3) laboratory at HDFT, deemed unfit for purpose in November 2022, has led to the outsourcing of Hazard Group 3 microbiology work to external providers. Initially outsourced to NHS Trusts within WYAAT and, since June 2024, to a private laboratory in London, this situation poses risks to quality, safety, and financial sustainability, including potential delays in clinical diagnosis, risk of inappropriate treatment, and significant ongoing cost pressures.	3 x 5 = 15	3 x 1 = 3 ~~June 2026~~ ~~Sept 2026~~ April 2027	Operational: Health & Safety	Minimal
ID 577	Physical security provisions, training, and support resources	Organisational risk to compliance with legislative requirements, and the risk of major injuries, fatality or permanent disability to employees, patients, visitors or others due lack of suitable policies and procedures, and the subsequent lack of suitable and sufficient control measures, including physical security provision, training, resources to support implementation. Current rating reduced to reflect implementation of security team, but remains on Corporate Risk Register whilst work is completed on assurance processes around the team, and completed review of Martyn's Law position	4 x 3 = 12	4 X 2 = 8 ~~September 2026~~	Operational: Health & Safety	Minimal
ID 597	Histopathology space and safety concern	The Histopathology laboratory is facing significant space constraints due to sustained service expansion over the past decade, resulting in overcrowded working conditions, insufficient storage capacity, and increasing safety risks to both staff and patient specimens. The need to retain specimens for 42 days has led to unsafe storage practices, including stacking at height, raising the likelihood of formalin spills, specimen loss or misidentification, and staff slips or trips. This issue has been highlighted by UKAS, requiring demonstrable action to maintain accreditation. Despite recognition at organisational level and submission of capital funding proposals, no immediate solution has been implemented, and space limitations continue to worsen due to equipment failures and contingency working. The inability to expand laboratory capacity restricts service growth, prevents participation in additional clinical work and trials, and risks failure to meet key cancer and RTT targets, with further pressure anticipated from planned service expansions.	3 x 5 =15	3 x 1 December 2026	Clinical: patient Safety	
ID 959	Risk to Theatre utilisation and scheduling due to aged condition of estates	Risk to Theatre utilisation and scheduling due to aged condition of estates. • Air handling system needs renewing. • General theatre area need refurbishment. • New doors that meet current standard • Theatre panels need renewing. • Inbuilt IT equipment. • Cancellation of theatre lists • Short notice cancellation of patients Increased risk of infection, Impact on acute services	3 x 5 = 15	2 x 2 = 4 ~~Sept 2026~~ Sept 2027	Operational: Business Continuity	
1392	Fire Safety Compliance and Life Safety Risk Across the HDH Estate	Harrogate District Hospital (HDH) faces a significant and ongoing fire safety risk due to a combination of ageing fire alarm infrastructure, unreliable alarm zoning and location identification, unassured compartmentation, and widespread fire door compliance issues. Together, these weaknesses limit the Trust's ability to reliably detect, locate, contain and respond to fire incidents and support safe progressive horizontal evacuation across the estate. The risk is particularly acute within a live hospital environment where patients may be sleeping, clinically vulnerable, immobile, cognitively impaired, dependent on medical equipment, or otherwise reliant on staff-assisted evacuation. Failure of fire safety systems or barriers could lead to delayed emergency response, inappropriate evacuation decisions, fire and smoke spread, harm to patients, staff and visitors, service disruption, regulatory enforcement action, reputational damage and significant financial consequences.	4 x 5 = 20	1 x 5 = 5 Target date TBC	Operational	

Related External Risks

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

Trust Board

25th November 2026

Title:	Emergency Preparedness, Resilience & Response Report 2026
Responsible Director:	Julia Nixon, Accountable Emergency Officer Chief Operating Officer
Author:	*Roseanne Kirkham, Clinical Operations Manager and EPRR Lead*

Purpose of the report and summary of key issues:	*The Civil Contingencies Act 2004 identifies NHS Acute Trusts as Category 1 responders, giving them legal responsibility to plan for and respond to emergencies, working in co-operation with other responders and communicating with the public.* *This report updates the Board on the range of actions undertaken this year as part of the Emergency Preparedness, Resilience and Response ("EPRR") agenda by the Trust.* *The NHS EPRR Framework identifies that NHS funded services must show they can effectively respond to major, critical and business continuity incidents whilst maintaining services to patients. It also provides a set of core standards for all NHS funded organisations in England to help with meeting the legislative requirements.* *The report outlines key activities undertaken since the last report in November 2025 by the Trust's EPRR Team and the wider health emergency planning community in Humber and North Yorkshire.* *The report also outlines the capacity versus demand of the Emergency Preparedness, Resilience & Response team as outlined in Appendix C.* *The Trust has been assessed against the 10 domains containing 62 applicable core standards.* • *This year, the Trust has been determined to have:* *41 Fully-Compliant Standards* *21 Partially-Compliant Standards* *0 Non-Compliant Standards* *The Trust's overall compliance rating against the NHSE Core Standards is therefore categorised as 'non-compliant' (<76% of standards fully compliant). Despite the compliance rating of the Trust*

<table>
<tr><td></td><td colspan="2">remaining as non-compliant, the percentage of compliance has still risen.

The process usually involves an additional assessment of a separate domain which is a deep dive investigation into a particular area that isn't included in the main assurance process. This year, NHS England did not include a deep dive in the assurance process.

Appendix A – Statement of Compliance

Appendix B – EPRR Financial Forecast

Appendix C – Emergency Preparedness, Resilience & Response Capacity vs Demand Analysis</td></tr>
<tr><td rowspan="8">Trust Strategy and Strategic Ambitions</td><td colspan="2">The Patient and Child First
Improving the health and wellbeing of our patients, children and communities</td></tr>
<tr><td>Best Quality, Safest Care</td><td>X</td></tr>
<tr><td>Person Centred, Integrated Care; Strong Partnerships</td><td>X</td></tr>
<tr><td>Great Start in Life</td><td></td></tr>
<tr><td>At Our Best: Making HDFT the best place to work</td><td>X</td></tr>
<tr><td>An environment that promotes wellbeing</td><td></td></tr>
<tr><td>Digital transformation to integrate care and improve patient, child and staff experience</td><td></td></tr>
<tr><td>Healthcare innovation to improve quality</td><td></td></tr>
<tr><td>Corporate Risks</td><td colspan="2">Risk 951 – Not meeting EPRR Core Standards (9)</td></tr>
<tr><td>Report History:</td><td colspan="2">HDFT's previous EPRR Core Standards Assurance ratings:

2023 10% Non-compliant
2024 45% Non-compliant
2025 53% Non-compliant
2026 66% Non-compliant</td></tr>
<tr><td>Recommendation:</td><td colspan="2">The Board is asked to:

• Consider the compliance self-assessment, rating and associated guidance and provide feedback accordingly.
• Formally approve the self-assessment, overall compliance rating that has been agreed by the organisation's EPRR Team and Accountable Emergency Officer.
• Approve the recommendation to bring additional paper in May outlining progress towards compliance in 2027
• Recognise the capacity versus demand analysis and consider the requirement for additional staffing resource for the Emergency Preparedness, Resilience & Response Team.</td></tr>
</table>

1. INTRODUCTION

This report updates the Board on the range of actions undertaken this year as part of the Emergency Preparedness, Resilience and Response ("EPRR") agenda by the Trust. Acute Trusts are identified as Category 1 (Cat 1) responders which are those organisations deemed to be at the core of emergency response. This puts them on equal response footing with the ICB, ambulance services and local authorities, as well as Police and Fire and Rescue Services.

The report outlines key activities undertaken since the last report in November 2024 by the Trust's EPRR Team and the wider health emergency planning community in Humber and North Yorkshire.

2. BACKGROUND

The NHS needs to be able to plan for and respond to a wide range of emergencies and business continuity incidents that could affect health or patient safety. Under the Civil Contingencies Act (2004) and Health and Social Care Act 2012, NHS organisations and providers of NHS-funded care must show that they can effectively respond to emergencies and business continuity incidents while maintaining services to patients. This work is referred to in the health service as 'Emergency Preparedness, Resilience and Response' (EPRR).

One of the requirements of the EPRR Core Standards is that organisations report annually to their board on the results of their self-assessment against the standards, the incidents they have responded to, the outputs of training and exercising, and the lessons identified.

The Trust's EPRR agenda is delivered by the EPRR Team (currently made up of one subject matter expert) and the Accountable Emergency Officer (the Trust's Chief Operating Officer and Deputy Chief Executive) who are supported in the execution of these duties by the Deputy Chief Operating Officer.

The Trust's on-call rota ensures that a Tactical Commander and Strategic Commander are available to support in responding to incidents and emergencies at all times.

3. ASSESSMENT

As part of preparing for incidents, the Trust, along with other NHS providers, has undertaken the following:

3.1. Risk Assessment

The top risks assessed by the Local Health Resilience Forum on behalf of the whole ICB/ICS are:

- Denial of Access to Systems
- Adverse Weather
- Infectious Diseases & Pandemics
- Loss of Utilities (including energy & telecommunications)
- COMAH Site Release, Explosion or Malicious Attack (contaminated bodies)

The LHRP selected these risks as priorities from the North East and Yorkshire NHS Risk Register, which is derived from the national and community risk registers, taking account of the local context and geography.

4. RESPONSE TO INCIDENTS

Since the last report, the Trust has had to respond to a variety of Incidents, including:

- High Consequence Infectious Diseases
- IT/ Systems Outages
- Power Outages

5. TRAINING

A significant range of work has been undertaken to align the Trust's EPRR training plan with the Minimum Occupational Standards for EPRR. In April 2024, personal development portfolios were rolled out to all ICB commanders and EPRR advisors, with supportive 'drop-in' style sessions in January and February 2026 teaching commanders how to use the portfolios and access the required training. Due to the absence of an EPRR officer, these meetings have not been as frequent, but they have been relaunched with a plan for collaborative working and internal tabletop exercises to support completion.

The On-call Managers and Directors Portfolio Team has been expanded to include the training needs analysis and training log. Work is still being undertaken to add the requirements to LearningLab, but the set-up on Microsoft Teams has proven to be the best way to organise the PDPs, with work ongoing to report compliance to LearningLab for inclusion in commanders' accounts. This is planned to be live by November 2026. Commanders have their own portfolios to log training attendance and complete reflective practice on their experiences. Portfolios need to be reviewed once in a three-year cycle, and the EPRR team is working through the practicalities and governance surrounding this.

All health organisations that are members of the LHRP are also using the same portfolios and system to allow portability of the portfolios and collaborative delivery and design. Compliance with the courses listed in the portfolios is reported quarterly through LHRP and up to the Regional Health Resilience Partnership. Portfolio completion is seen below:

Overall Compliance Against the Portfolio					
Number of Strategic Health Commanders	17		29.81%		
Number of Tactical Health Commanders	17				
Number of EPRR specialists/advisors	3				
Compliance against the relevant portfolio	0-24%	25-49%	50-74%	75-99%	100%
Strategic compliance against Health Commander Portfolios	6	6	4	1	0
Tactical compliance against Health Commander Portfolios	9	5	3	0	0
EPRR compliance against Health Commander Portfolios	1	0	2	0	0

With support from the Corporate Affairs team and through planning future commander training sessions and exercises, we aim for commanders either to have achieved 75% compliance or to be booked onto training that would take them to 75% compliance by April 2027, excluding training sessions that cannot be provided in-house.

The regional NHS England EPRR Team has collectively developed short courses to improve access and relevance, enabling the Trust to provide some of the training for commanders. Not all sessions are currently available, and further dates are awaited. The remaining 'experience elements' will be covered in future commander training sessions and exercises.

6. EXERCISING

The Trust is required to complete a communications exercise every six months, a tabletop exercise annually, and command-post and live exercises every three years. The Trust has responded to incidents such as industrial action and power outages, which have negated the need for a full live exercise. However, we have recently completed a live, no-notice exercise of the Trust's Chemical, Biological, Radiological and Nuclear (CBRN) plan to ensure that lessons were learnt from last year's exercise. A full list of exercises can be seen below. Those in red were hosted by other providers:

Communications Test		Sep 2024
Border Terrier (Mass Casualty)	Table top	Nov 2024
Golden Retriever (Mass Casualty)	Table top	Nov 2024
Evacuation Workshop (York District Hospital)	Table top	Dec 2024
Communications Test		Apr 2025
Exercise Flanders (CBRN)	Live	Nov 2025
Power Outage	Table Top	April 2026
Business continuity exercises 1 per directorate	Table Top	monthly
Emergo mass casualty	Table top	October 2026

CBRN	Live	Nov 2026

Future scheduled exercises:

BCP Exercises	Table top	2 per month
Command-Post Exercise	Table Top	December 2026

7. LESSONS IDENTIFIED

The Trust is required to ensure it commits to a continuous cycle of learning and improvement as a result of any incidents, training sessions or exercises. The table below summarises some of the high-level lessons identified since the last report. The resulting actions are monitored by the EPRR Team on the single Master Action Tracker.

Exercise or Incident	**Lessons Identified**	**Resulting Actions**
Generator Failure	UPS locations. Knowledge of where each generator covers	HIF centralising information
CT scanner failure	Escalation process to the ICB	Educating teams of the escalation process of a business continuity incident
All systems downtime	ASCOMS can access nervecentre without WIFI	To include in the BCP
Mass casualty exercise		

8. BUSINESS CONTINUITY

The Trust has a Business Continuity Management Strategy which outlines our Business Continuity Management System (BCMS). The key performance indicators have been developed for inclusion in the board report every year to provide assurance to the board on the effectiveness of the BCMS.

All directorates to have completed a BIA	To be completed by December 2027
Strategic BIA has been reviewed	Completed Sep 2026
Exercise(s) have been completed to test all aspects of business continuity arrangements.	Completed September 2026

Any business continuity incidents have been entered onto the EPRR Team Incident Log	Completed - work ongoing to ensure staff are aware this needs to be communicated to EPRR staff.
Any business continuity exercises have been entered onto the EPRR Team Exercise Log	Completed – work ongoing to ensure staff are aware this needs to be communicated to EPRR staff.
Any lessons identified from incidents and exercises and their resultant actions have been captured on the Master Action Tracker	Yes
Business continuity plans have been reviewed, incorporating any changes to BIAs and/or changes due to lessons identified through incidents or exercising	This is a continuous process and is reported via the Business Continuity Working Group.

The Emergency Planning Steering Group (EPSG) has recently established a Business Continuity Working Group (BCWG) in order to better coordinate the business continuity requirements of the organisation. Membership is required across directorates and Business Continuity Leads have been appointed.

The Trust will need to be externally audited in 20207 as per the EPRR core standards assurance.

9. NHSE EPRR CORE STANDARDS ASSURANCE PROCESS

The NHS EPRR Core Standards were introduced to clearly set out the minimum standards expected of NHS organisations and providers of NHS-funded care with respect to emergency preparedness, resilience, and response.

The NHSE EPRR Core Standards enable agencies across the country to share a common purpose and to coordinate EPRR activities in proportion to the organisation's size and scope. In addition, they provide a consistent cohesive framework for self-assessment, peer review and assurance processes.

These standards will be reviewed and updated as lessons are identified from testing, as national legislation and guidance change, and/or as part of the rolling NHSE EPRR governance programme.

The assurance process changed in 2023 to include evidence submission against each core standard, formal peer-review and subsequently a check and challenge. In the wake of lessons identified from recent incidents such as the Manchester Arena,

Grenfell and COVID-19, it is clear that the standard which organisations must achieve is one which requires a dedicated robust assurance process which can ensure our collective system resilience.

Organisations were asked to provide evidence only against standards whose ratings have increased from non-compliant or partially compliant to fully compliant.

The process continues to be an open, honest and transparent review of evidence associated with the core standards with the objective of improving our collective resilience for our patients and communities.

Assurance Rating Thresholds

- Fully Compliant = 100%
- Substantially Compliant =99-89%
- Partially Compliant = 88-77%
- Non-Compliant = 76% or less

Calculated using the number of FULLY COMPLIANT EPRR Core Standards

9.1. PREVIOUS YEAR'S POSITION (2025)

In the 2025-26 NHSE Core standards assurance process, the Trust was determined to have a compliance rating of 53% - 'Non-Compliant.'

Percentage Compliance	**53%**
Overall Assessment	**Non-Compliant**

9.1.1. Domains

A breakdown of the 10 domains is seen below:

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non-compliant
Governance	6	4	2	0
Duty to risk assess	2	1	1	0
Duty to maintain plans	11	6	5	0
Command and control	2	2	0	0
Training and exercising	4	2	1	1
Response	7	6	1	0
Warning and informing	4	4	0	0
Cooperation	4	4	0	0
Business Continuity	10	4	6	0
Hazmat/CBRN	12	0	11	1
CBRN Support to acute Trusts	0	0	0	0
Total	62	33	27	2

9.2. CURRENT POSITION

This year, the EPRR team have self-assessed the Trust against the 62 applicable core standards.

The overall position for this year has therefore been determined as non-compliant. Our total percentage of compliance for 2025 is 66%, being fully compliant with 41 of the 62 core standards.

Any standard that has been rated as partially compliant or non-compliant has been automatically transferred into an action plan that will form part of the Trust's EPRR Work plan for the following 12 months.

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation is compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plan will be monitored on a quarterly basis to demonstrate progress towards compliance.

9.3. Summary of compliance with Core Standards for 2026

A breakdown of the 10 domains can be seen below:

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	5	1	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	11	8	3	0
Command and control	2	2	0	0
Training and exercising	4	2	2	0
Response	7	6	1	0
Warning and informing	4	4	0	0
Cooperation	4	4	0	0
Business Continuity	10	6	4	0
Hazmat/CBRN	12	2	10	0
CBRN Support to acute Trusts	0	0	0	0
Total	62	41	21	0

9.3.1. Deep Dive

There was no deep dive in the 2026 Core Standards Assurance Process.

9.3.2. Overall position

Percentage Compliance	**66%**
Overall Assessment	**Non-compliant**

9.4. This year

Over the course of this year, the EPRR team has experienced considerable staffing constraints for the second year running, primarily resulting from the agreement to release the Trust's EPRR Officer on secondment to support York and Scarborough Teaching Hospitals NHS Foundation Trust. This decision has significantly reduced the team's operational capacity and directly limited the volume of improvements able to be implemented. This has impacted our ability to deliver the planned 85% compliance. However over the year we have moved 10 number of core standards from non- compliant into partial or fully. We were commended by the ICB EPRR lead for this.

Plans to mitigate this gap within the EPRR team through advertising a secondment post were not successful as no one waws appointable at the interview process and

then the plan to readvertise was paused due to the Trusts vacancy advertising hold for three months.

The EPRR officer will return from secondment in March 2027.

9.5. Resource benchmarking

Other Trusts in North and West Yorkshire have been asked to provide us with the numbers and grades of their Trusts' EPRR Workforce for benchmarking purposes. Results can be seen below:

Harrogate & District	8A	6
York & Scarborough	8A	7
Humber Health Partnership	8D	3
	8A	5
	8A	5
Airedale Teaching Hospitals	8A*	
Mid Yorkshire	8A	3
Bradford Teaching Hospitals	8A	7
	= Non-dedicated EPRR workforce	
	= Dedicated EPRR workforce	

*Heavily supported by various specialists and leads, e.g. infection prevention on infectious diseases, IT on cyber, etc.

10. ACTIONS

Actions identified from the Core Standards process have been compiled into an action plan contained within the EPRR Core Standards Self-Assessment Tool and then transferred into the EPRR Action Tracker, which is reviewed regularly at meetings of the Emergency Planning Steering Group (EPSG) or the relevant sub-groups.

Any outstanding actions will continue to form the basis for the 2027 EPRR Work Programme.

The Trust will establish structured, ongoing engagement with the ICB EPRR Team to obtain feedback and insights, identify areas for improvement and reinforce best practice. Integrating these perspectives into HDFT's planning and review cycles will support improved compliance outcomes and continuous improvement throughout the next assurance process.

11. CONCLUSION

Whilst the summary position for the EPRR Core Standards Assurance Process has remained the same, significant work has been completed to raise the Trust's percentage of compliance from the previous year. A breakdown of the changes can be seen below:

	Standards		
	Fully Compliant	**Partially Compliant**	**Non-Compliant**
2024	28	30	4
2025	33	27	2
2026	41	21	0
Difference	**+8**	**-6**	**-2**

2024 Compliance	45.16%
2025 Compliance	53.22%
2026 Compliance	66.13%
Difference	**+12.91%**

There has been a visible improvement in compliance compared to last year's position, notwithstanding the considerable staffing constraints faced by the EPRR team.

To support improved compliance in 2027, EPSG meetings have increased from bi-monthly to monthly. In addition, the Emergency Preparedness, Resilience and Response (EPRR) Lead is implementing a structured work programme with the ED CBRN Lead, supported by weekly progress meetings.

A capacity versus demand analysis has been undertaken to assess the requirements of the EPRR work programme against the team's current establishment. This identified planned workload demand at approximately 140% of available establishment capacity, indicating a significant capacity shortfall. This is further compounded by both members of the EPRR team being non-dedicated resources, with responsibilities extending beyond the EPRR work programme.

The analysis considers planned activity only and does not account for unplanned demands, including incident response, which can require immediate reprioritisation of resources and further reduce capacity to deliver scheduled EPRR activity.

Given that the Trust has been non-compliant for the previous three Core Standards assurance processes, the EPRR Team will bring an additional paper to the Board in six months' time with an update on the actions in the tracker.

12. RECOMMENDATIONS

The Trust Board is asked to:

- Consider the compliance self-assessment, rating and associated guidance and provide feedback accordingly.
- Formally approve the self-assessment, overall compliance rating that has been agreed by the organisation's EPRR Team and Accountable Emergency Officer.
- Approve the recommendation to bring additional paper in May outlining progress towards compliance in 2027
- Recognise the capacity versus demand analysis and consider the requirement for additional staffing resource for the Emergency Preparedness, Resilience & Response Team.

13. APPENDICES

Appendix A – Statement of Compliance

Appendix B – EPRR Financial Forecast

Appendix C – Emergency Preparedness, Resilience & Response Capacity vs Demand Analysis

Appendix A – Statement of Compliance 2026-27 (double-click to view)

Appendix B – EPRR Financial Forecast

EPRR FINANCIAL FORECAST

YEAR	2027

ITEM/SERVICE	DATE	COST
Legal Awareness Training x4 Directors	2027	£1,490
Media Training x6 Directors	2027	£860
TOTAL		**£2,350.00**

Other considerations:

- Staff training to complete PDPs.
- Staff to participate in exercises.

YEAR	2026-27

ITEM/SERVICE	DATE	COST
PRPS Suit Servicing (x7 suits)	Nov/ Dec 2026	£1,953.21.00
Decontamination Unit Servicing	November 2026	£990.00
Single New PRPS Suit including: • 1 Training suit • Life servicing upfront	November 2026	£4,633.14
TOTAL		**£7,576.35**

Other considerations:

- Staff to participate in exercises.

Appendix C – Emergency Preparedness, Resilience & Response Capacity vs Demand Analysis

B8b

B8b Total days - 261
AL - 33
BH - 8

EPRR codes	Plan areas	April Days	May Days	June Days	July Days	August Days	Sept Days	October Days	Nov Days	Dec Days	January Days	February Days	March Days	Total Days	
	Governance														46
	EPSG	1	1	1	1	1	1	1	1	1	1	1	1	12	
	BCWG	0.5	0.5	0.5		0.5	0.5		0.5	0.5	0.5		0.5	4.5	
	Regional meetings	1			1		0.5	0.5			0.5			3.5	
	Other governance groups/ BoD	0.5			0.5				0.5				0.5	2	
Domain 1	EPRR Resource assurance	1			0.5	0.5		1		1				4	
	Core standards submission		0.5	0.5	0.5	2	1.5	1	1	2	0.5	0.5	0.5	10.5	
	EPRR and BC policy													0	
	EPRR Work Programme	0.5		0.5		0.5		0.5	0.5	0.5		0.5		3.5	
	Continuous Improvement/ Lessons Learned	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	6	
	EPRR Board Reporting													0	
	Duty to assess risks														3
	Risk register maintenance	0.5		0.5		0.5		0.5		0.5		0.5		3	
Domain 2	Risk procedure													0	
	EPRR risk assessments													0	
	Reporting													0	
	Duty to maintain Plans														30.5
	On call procedure					0.5				4			1	5.5	
	Adverse Weather		1	0.5				1	0.5					3	
	Incident response			0.5								0.5		1	
	New and emerging pandemics	1	0.5						1	0.5				3	
	Infectious disease/ outbreak and countermeasures		1	0.5					1	0.5				3	
Domain 3	Evacuation and Shelter incl Regional plans									1				1	
	Excess fatalities/ Mass casualties			0.5						2				2.5	
	Protected individuals					0.5								0.5	
	Lockdown			0.5								1	0.5	2	
	Collaborative Planning/ Consultation		0.5		0.5		0.5		0.5					2	
	Countermeasures		0.5							0.5				1	
	Other plans as required			2	1			2	1					6	
	Command and control														11
	On call mechanism			1	0.5					1	0.5			3	
Domain 4	on call rotas and procedure note	0.5			1			0.5			0.5		1	3.5	
	Training/ Training needs assessment									1				1	
	Training development			0.5		1			1			1		3.5	
	Training and exercising														31.5
	EPRR training	2			2	0.5	2	1				0.5		8	
	EPRR exercising and testing programme		2		2	2		2	2	2	2		1	15	
Domain 5	Staff Awareness & Training													0	
	Responder training	1	1	0.5	0.5	0.5	0.5	0.5	0.5	1	0.5	0.5	0.5	7.5	
	PHC portfolio portal development and testing		0.5	0.5										1	
	Portfolio admin													0	
	Response														0
	Incident Co-ordination Centre (ICC)													0	
	Access to planning arrangements													0	
Domain 6	Management of business continuity incidents													0	
	Decision Logging and Loggist engagement													0	
	Situation Reports incl SITRep local procedure note													0	
	EPRR equipment checks, maintenance and re-supply													0	
	Warning and informing														2
	Warning and informing			0.5										0.5	
Domain 7	Incident Communication Plan				0.5									0.5	
	Communication with partners and stakeholders					0.5								0.5	
	Media strategy						0.5							0.5	
	Communications tests													0	
	Cooperation														10
	LHRP Engagement		0.5			0.5			0.5			0.5		2	
	LRF / BRF Engagement													0	
Domain 8	Mutual aid arrangements				1			1			1			3	
	Information sharing	1					1							2	
	Regional plan coordination	0.5			0.5			0.5				0.5		2	
	Other regional evacuation work		0.5					0.5						1	
	Business Continuity														0
	BC policy statement													0	
	Business Continuity Management Systems (BCMS)													0	
	Business Impact Analysis/Assessment (BIA)													0	
Domain 9	Business Continuity Plans (BCP)													0	
	Testing and Exercising													0	
	Data Protection and Security Toolkit													0	
	BCMS monitoring and evaluation													0	
	BC audit													0	
	BCMS continuous improvement process													0	
	Assurance of commissioned providers / suppliers BCPs includes procedure development													0	
	Hazmat/CBRN														19
	Governance	1	1	1	1	1	1	1	1	1	1	1	1	12	
	Hazmat/CBRN risk assessments													0	
	Specialist advice for Hazmat/CBRN exposure													0	
	Hazmat/CBRN planning arrangements													0	
Domain 10	Equipment and supplies													0	
	Equipment - Preventative Programme of Maintenance													0	
	Hazmat/CBRN training resource													0	
	Staff training - recognition and decontamination													0	
	PPE Access													0	
	Exercising					1	1	1	1			1	1	6	
	YAS audit liaison					1								1	
	EPRR team														67
11	Admin includes team meetings/ attending meetings/ Service meetings	5	5	5	5	5	5	5	5	5	5	5	5	60	
	Training incl mandatory											2	2	4	
	Sickness							3						3	
	Incident response/ Contingency														14.5
	Industrial action NHS Staff	1		1					1.5					3.5	
	Winter plan work	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	6	
	Supply Disruption					0.5		0.5						1	
12	Heatwave			2	0.5	0.5								3	
	Hantavirus		0.5	0.5										1	
	BH Planning													0	
	Other													0	
														234.5	
	TOTAL	19	17.5	21	20.5	21	16	25	21	26	14	17	16.5	234.5	
	Actual days	22	22	21	23	21	22	23	20	23	22	20	22	261	
	Match														

B6

B6 Total days - 261
AL - 29
BH - 8

EPRR codes	Plan areas	April Days	May Days	June Days	July Days	August Days	Sept Days	October Days	Nov Days	Dec Days	January Days	February Days	March Days	Total Days	
Domain 1	**Governance**														53
	EPSG	1	1	1	1	1	1	1	1	1	1	1	1	12	
	BCWG	0.5	0.5	0.5		0.5	0.5		0.5	0.5	0.5		0.5	4.5	
	Regional meetings	1			1		0.5	0.5			0.5			3.5	
	Other governance groups/ BoD	0.5			0.5				0.5				0.5	2	
	EPRR Resource assurance	1			0.5	0.5		1		1				4	
	Core standards submission		0.5	0.5	0.5	2	1.5	1	1	2	0.5	0.5	0.5	10.5	
	EPRR and BC policy	1			1		1			1			0.5	4.5	
	EPRR Work Programme	0.5		0.5		0.5		0.5	0.5	0.5		0.5		3.5	
	Continuous Improvement/ Lessons Learned	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	6	
	EPRR Board Reporting		0.5			0.5			1			0.5		2.5	
Domain 2	**Duty to assess risks**														14.5
	Risk register maintenance		1			1			1		1			4	
	Risk procedure			1							1			2	
	EPRR risk assessments	0.5	1	1		0.5		0.5	0.5		1		0.5	5.5	
	Reporting	0.5			0.5			0.5		0.5		0.5	0.5	3	
Domain 3	**Duty to maintain Plans**														46.5
	On call procedure			0.5									1	1.5	
	Adverse Weather		1	0.5				1	0.5					3	
	Incident response	2	1	0.5						2	1	0.5		7	
	New and emerging pandemics	1	0.5						1	0.5				3	
	Infectious disease/ outbreak and countermeasures		1	0.5					1	0.5				3	
	Evacuation and Shelter incl Regional plans	1	1					1.5	1					4.5	
	Excess fatalities/ Mass casualties	2	0.5	0.5			2	1						6	
	Protected individuals				1	0.5								1.5	
	Lockdown		1	0.5								1	0.5	3	
	Collaborative Planning/ Consultation	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5			0.5	5	
	Countermeasures	1	0.5			1	0.5							3	
	Other plans as required			2	1			2	1					6	
Domain 4	**Command and control**														11
	On call mechanism			1	0.5					1	0.5			3	
	on call rotas and procedure note	0.5			1			0.5			0.5		1	3.5	
	Training/ Training needs assessment									1				1	
	Training development			0.5		1			1			1		3.5	
Domain 5	**Training and exercising**														51.5
	EPRR training	2			2	0.5	2	1				0.5		8	
	EPRR exercising and testing programme	2	2	2	2	2	2	2	2	2	2	2	2	24	
	Staff Awareness & Training				0.5		2				1.5			4	
	Responder training	1	1	0.5	0.5	0.5	0.5	0.5	0.5	1	0.5	0.5	0.5	7.5	
	PHC portfolio portal development and testing	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	6	
	Portfolio admin		0.5			0.5			0.5			0.5		2	
Domain 6	**Response**														20
	Incident Co-ordination Centre (ICC)		1			1			1			1		4	
	Access to planning arrangements		0.5											0.5	
	Management of business continuity incidents				2		2							4	
	Decision Logging and Loggist engagement	0.5	0.5	0.5	1	0.5	1	0.5	0.5	0.5	1	0.5	0.5	7.5	
	Situation Reports incl SITRep local procedure note	0.5	0.5							0.5	0.5			2	
	EPRR equipment checks, maintenance and re-supply		0.5			0.5			0.5			0.5		2	
Domain 7	**Warning and informing**														8
	Warning and informing		1	0.5										1.5	
	Incident Communication Plan			1	0.5									1.5	
	Communication with partners and stakeholders				1	0.5								1.5	
	Media strategy					1	0.5							1.5	
	Communications tests	1						1						2	
Domain 8	**Cooperation**														11
	LHRP Engagement		0.5			0.5			0.5			0.5		2	
	LRF / BRF Engagement		0.5			0.5			0.5			0.5		2	
	Mutual aid arrangements				1			1			1			3	
	Information sharing	1					1							2	
	Regional plan coordination	0.5			0.5			0.5				0.5		2	
	Other regional evacuation work													0	
Domain 9	**Business Continuity**														72
	BC policy statement		2	1	1		0.5							4.5	
	Business Continuity Management Systems (BCMS)		2	1	1		0.5						1	5.5	
	Business Impact Analysis/Assessment (BIA)	1	1	1	1	1	1	1	1		1	1	1	11	
	Business Continuity Plans (BCP)	2	2	2	2	2	2	2	2		2	2	2	22	
	Testing and Exercising	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	2.5	8	
	Data Protection and Security Toolkit					1								1	
	BCMS monitoring and evaluation		1			1			1			1		4	
	BC audit	1			1			1			1			4	
	BCMS continuous improvement process		1			1			1			1		4	
	Assurance of commissioned providers / suppliers BCPs includes procedure development	2		2		2				2				8	
Domain 10	**Hazmat/CBRN**														52.5
	Governance		1									1		2	
	Hazmat/CBRN risk assessments	0.5				0.5				0.5				1.5	
	Specialist advice for Hazmat/CBRN exposure	0.5								0.5				1	
	Hazmat/CBRN planning arrangements	2	1					2	1	0.5				6.5	
	Equipment and supplies	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	6	
	Equipment - Preventative Programme of Maintenance		2	1							2	1		6	
	Hazmat/CBRN training resource	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	6	
	Staff training - recognition and decontamination	1	1	1	1		1	1	1		1	1	1	10	
	PPE Access									0.5				0.5	
	Exercising	0.5	0.5	0.5	0.5	1.5	1.5	1.5	1.5	0.5	0.5	1.5	0.5	11	
	YAS audit liaison		1							1				2	
11	EPRR team														66
	Admin includes team meetings/ attending meetings/ Service meetings	5	5	5	5	5	5	5	5	5	5	5	5	60	
	Training incl mandatory											2	2	4	
	Sickness						2							2	
12	**Incident response/ Contingency**														18
	Industrial action NHS Staff	1		1					1.5					3.5	
	Winter plan work													0	
	Supply Disruption					0.5		0.5						1	
	Heatwave			2	0.5	0.5								3	
	Hantavirus		0.5	0.5										1	
	BH Planning	1.5	2			1				1.5		1.5	2	9.5	
	Other													0	
														424	
	TOTAL	43.5	45.5	36.5	35.5	37	34.5	34.5	35.5	30.5	29	33	29	424	
	Actual days	22	22	21	23	21	22	23	20	23	22	20	22	261	
	Match														

Totals and Percentages

Staff	Total Days	Annual Leave	Bank Holidays	Available Days
(B8A)	261	33	8	236
(B6)	261	29	8	240
	522	62	16	**476**

Plan areas	Days	Percent
1. Governance	99	20.80%
2. Duty to risk assess,	17.5	3.68%
3. Duty to maintain plans,	77	16.18%
4. Command and control,	22	4.62%
5. Training and exercising,	83	17.44%
6. Response,	20	4.20%
7. Warning and informing,	10	2.10%
8. Co-operation,	21	4.41%
9. Business continuity,	72	15.13%
10. Chemical biological radiological nuclear (CBRN) and hazardous material (HAZMAT).	71.5	15.02%
EPRR team (adminl, training, sickness etc.)	133	27.94%
Contingency/ incident response	32.5	6.83%
	658.5	**138.34%**