CQC SAFE DOMAIN

Safety is a priority for everyone. People should always be safe and protected from bullying, harassment, avoidable harm, neglect, abuse and discrimination. Their liberty is protected where this is in their best interests and in line with legislation.

- **Learning culture -** We have a proactive and positive culture of safety based on openness and honesty, in which concerns about safety are listened to, safety events are investigated and reported thoroughly, and lessons are learned to continually identify and embed good practices.
- **Safe systems, pathways and transitions -** We work with people and our partners to establish and maintain safe systems of care, in which safety is managed, monitored and assured. We ensure continuity of care, including when people move between different services.
- **Safeguarding -** We work with people to understand what being safe means to them as well as with our partners on the best way to achieve this. We concentrate on improving people's lives while protecting their right to live in safety, free from bullying, harassment, abuse, discrimination, avoidable harm and neglect. We make sure we share concerns quickly and appropriately.
- **Involving people to manage risks -** We work with people to understand and manage risks by thinking holistically so that care meets their needs in a way that is safe and supportive and enables them to do the things that matter to them.
- **Safe environments -** We detect and control potential risks in the care environment. We make sure that the equipment, facilities and technology support the delivery of safe care.
- **Safe and effective staffing -** We make sure there are enough qualified, skilled and experienced people, who receive effective support, supervision and development and work together effectively to provide safe care that meets people's individual needs.
- **Infection prevention and control -** We assess and manage the risk of infection. We detect and control the risk of it spreading and share any concerns with appropriate agencies promptly.
- **Medicines optimisation -** We make sure that medicines and treatments are safe and meet people's needs, capacities and preferences by enabling them to be involved in planning, including when changes happen.

Lead Committee	Quality Committee
Executive Committee	Quality Management Group (QGMG)
Initial Date of Assessment	1st July 2022
Last Reviewed	April 2025

Summary:

Aligned with the **CQC SAFE Domain**, the organization is addressing key safety risks to protect staff, patients, and visitors while promoting a culture of continuous improvement.

- **HDH Goods Yard Security (CHS2)**: Temporary security measures are in place to prevent unauthorized access, with permanent improvements targeted by March 2025.
- **Fire Safety (CHS3)**: Fire risk assessments are complete, and infrastructure upgrades are underway to reduce the risk rating by September 2024.
- **Violence and Aggression (CHS5)**: Policy updates, enhanced training, and security reviews are being implemented to safeguard staff and improve safety, including addressing limited security presence and outdated procedures.
- **Health & Safety – Building Security (CRR102)**: Outdated security policies, limited security presence, and inadequate CCTV/access control systems are being addressed through updated risk assessments, infrastructure improvements, and enhanced staff training. Plans include replacing door access systems, expanding CCTV coverage, and preparing for compliance with Martyn's Law by April 2025.
- **Containment Level 3 Microbiology Work (CRR98)**: The unavailability of the onsite CL3 lab has led to outsourcing, posing risks to patient safety and financial sustainability. Plans to recommission the CL3 facility by March 2025 are underway, alongside efforts to improve sample logistics and mitigate delays.

These actions reflect the organization's proactive approach to ensuring safe systems, environments, and staffing, in line with **SAFE Domain** standards.

Risk ID	Strategic Ambition	Type	Principle Risk: HDH Goods yard	Appetite	Initial Rating	April Rating	May Rating	Target Rating	Target Date
CRR75/ ID 115	An Environment that promotes wellbeing	Operational; Health & Safety	Unauthorized access and safety hazards in the HDH Goods Yard may result in major injuries, fatalities, or permanent disability due to inadequate security measures, non-compliance with safety regulations, and improper use of the area, posing a risk to the objective of maintaining a safe and secure environment for employees, patients, and others within the hospital premises.	Minimal	16	12	12	4	~~April 25~~ June 25

Key Target	Current Position	Plans to Improve Control and Risks to Delivery
Board level lead for Health and Safety Annual Audit programme for Health and Safety Health & Safety Committee Suitable and sufficient risk assessments in place Implementation of control measures from assessments Capital programme to implement permanent physical changes to the area Control of unauthorised access	The organisation has taken several steps to address health and safety risks within the goods yard. Risk assessments have been completed, identifying key areas of concern. In response, temporary measures have been implemented to mitigate these risks: • **Access Control**: A temporary Heras fenced walkway has been established to safely guide staff and visitors to the Pharmacy lift and stairwell. • **Staff Communication**: Instructions have been communicated to all Trust staff via email and Team Talk regarding the safety protocols. • **High-Visibility Clothing**: High-visibility clothing is required for personnel who need routine access to the yard. • **Contractor Guidelines**: Contractors have been instructed that the yard area is strictly for delivery drop-offs and collections, and not for parking. • **Security Weakness**: The loading bay entrance remains unsecure 24/7 due to doors that do not close properly, posing a significant security risk, particularly during the night when staff presence is limited, leaving the area open to unauthorized access. • **Safety Improvements**: New pedestrian crossing markings were added at the entrance to the goods yard and car park in July 2023. Despite these measures, the ongoing issue of the unsecured loading bay entrance remains a critical security concern that requires further attention. The target date has been reviewed and updated, logistical challenges with maintaining operational activity have delayed works.	The organization has outlined several key plans and actions aimed at improving safety and security in the goods yard: **Physical Barriers and Controls**: for the protection of the liquid oxygen store, which will be factored into the overall improvement costs for the goods yard. **Waste Management**: A newly formed group is tasked with assessing the impact of changes to waste separation and new waste streams on site, with a report due to the Health & Safety Committee in June. **Contractor Management**: A new Contractor Management Policy is awaiting approval, with written instructions now issued to all delivery drivers and external users of the goods yard. This policy will guide future management and operations. **Security Review**: There will be a review of the current security guard provision in the goods yard to ensure it meets the evolving needs of the area. **Construction Planning**: A programme outline is being developed in collaboration with a contractor to ensure that the goods yard remains operational during upcoming construction activities. **Timeline**: The target date for completing these improvements is set for March 2025, aligning with the organization's 24/25 backlog programme. These actions are designed to enhance the safety, security, and operational efficiency of the goods yard while maintaining confidentiality of specific details.

Risk ID	Strategic Ambition	Type	Principle Risk:: Managing the risk of injury from fire	Appetite	Initial Rating	April Rating	May Rating	Target Rating	Target Date
CRR 75/ ID 116	An Environment that promotes wellbeing	Operational ; Health & Safety	Organisational risk to compliance with legislative requirements, with the risk of major injuries, fatality, or permanent disability to employees, patients and others, and the unauthorised access of persons to restricted areas of the hospital through the loading bay entrance.	Minimal	20	15	15	10	~~April 25~~ Oct 25

Key Risk Indicators	Current Position	Plans to Improve Control and Risks to Delivery
Updated Fire Safety Policy and associated management protocols Completion of fire assessments Appointment of competent Fire Manager and Authorising Engineer Completion of assessments Implementation of fire procedures and policies Communication of fire procedures to all employee Audits and reviews of the above conditions at appropriate intervals.	The Trust has made substantial progress in addressing fire safety concerns, with several key actions and improvements: **Fire Risk Assessments**: Fire risk assessments, which were initially incomplete, have now been completed for all areas of the HDH site. The process is being carried out by Oakleaf and is monitored by the Fire Safety Group with reports to the Health & Safety Committee. However, Oakleaf has been unable to meet the required level of availability, leading to a backlog in reviewing risk assessments, particularly in areas that have recently changed usage due to Block C moves. Addressing this backlog will be a priority for the new Fire Manager. **Communication Improvements**: Communication of fire safety information, which was previously inconsistent, is now regularly disseminated through weekly bulletins by the Fire Manager. **Fire Wardens**: The use of Fire Wardens remains inconsistent, highlighting an area requiring further attention. Fire Manager Recruitment: The position of Fire Manager has been advertised, attracting some interest. The recruitment process is complete, with pre-employment checks currently underway. **Contractor Assessments**: The assessment of contractors and construction work is to be integrated more consistently into Trust fire assessments and evacuation procedures. Construction Phase Plans for all CDM work are under review to include fire risk assessments and shared control measures. **Corridor and Exit Safety**: There has been a significant improvement in keeping corridors, escape routes, and exits clear, with the HIF waste team prioritizing daily clearing. However, issues with fire doors being wedged open on wards still persist. **Fire Policy and Management**: A new Fire Policy and Fire Management Procedures have been established. A Service Level Agreement (SLA) with Leeds Teaching Hospitals NHS Trust (LTHT) has been fully implemented, with regular site attendance to review fire risk assessments, fire strategy in relation to construction work, and provide training. **Ongoing Assessments and Reporting**: The Health & Safety Team continues to report on fire safety assurances for the community estate in fortnightly CC Estates meetings. Additional information is being gathered from all community sites to assess resource needs, including risk assessments and training. **Fire Safety Testing**: Significant Cause and Effect testing, especially in the main theatres, has been completed. **Evacuation Procedures**: Ward changes and the development of updated evacuation procedures are ongoing, with the Fire Safety Manager collaborating with relevant teams. A review of evacuation and alarm sounding is ongoing **SLA Conclusion**: The SLA with LTHT has officially ended, although support for some pre-arranged work, including SMT training, the TIF2 project, and online training is on-going. **Fire Safety Group Establishment**: The Fire Safety Group has been fully established, with its first meeting held on August 31, 2023. Monthly meetings are now in place, with an action being reviewed by the Fire Safety Group and escalated through the Health & Safety Committee as needed.	**Ongoing Fire Safety Support**: The Fire Safety team continues to receive ad hoc requests for support from both the HDH site and Community sites. **Infrastructure Risk Work**: Efforts to separate infrastructure risk items, such as fire alarms, compartmentation, fire doors, and fire dampers, are ongoing and expected to be completed by April 2024. These risks will be added to the Health & Safety Risk Register and escalated where necessary, with updates reported via the Fire Safety Group, Health & Safety Committee, and Environment Board. **Fire Alarm System Costs**: An analysis of the costs for a new fire alarm system is being conducted, comparing the total upfront cost of switching providers versus upgrading the existing system over multiple years. **Basement Corridor Improvements**: Priority work is being planned to improve the compartmentation and fire stopping in the basement corridor between plant rooms as part of the 2024/25 backlog maintenance budget. New drawings have been produced, and cost estimates are being sought. **Evacuation Risk Management**: Remedial actions are being taken to minimize risks associated with the closure of corridors for six weeks. Evacuation aids have been repositioned, and additional training is being provided to both clinical and non-clinical staff, with multiple sessions organized by the Fire Manager. **Monthly Fire Checklist**: A new Monthly Acute and Community Fire Checklist is being developed for completion by all teams, departments, and community locations. **Evacuation Procedures and Training**: Evacuation procedures are being escalated, with training provided to clinical teams, including a simulated exercise at an extended SMT workshop, which has been completed. **Backlog Maintenance for Fire Safety**: A Backlog Maintenance paper for 2024/25 has been submitted to the Environment Board, covering key fire-related works, including basement compartmentation, fire damper remediation, main entrance remedial work, and upgrades to fire doors. The outline proposal has been agreed upon, with detailed costs and a program plan being developed. Costs have now been confirmed, and the work is being scheduled. A schedule is in place to carry out new FRA in all community sites.

Corporate Risk ID	Strategic Ambition	Type	Principle Risk:: Managing the risk of violence and Aggression	Appetite	Initial Rating	April Rating	May Rating	Target Rating	Target Date
117	An Environment that promotes wellbeing	Operational ; Health & Safety	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.	Minimal	16	12	16	8	July 25

Key Targets

Suitable and sufficient assessments of risk Trust / HIF activities.

Supported by up to date policies that reflect the activities carried out by the Trust and the geographical differences created.

Risk assessments, policies and control measures actively monitored and reviewed.

Use of available data sources, such Datix, sickness absence as part of the monitoring and review process.

Provision of appropriate training and information to all Trust staff clinical and non-clinical.

Current Position

The organization is facing several challenges related to Violence & Aggression (V&A), Security, and Lone Working:

- **Outdated Policies**: Current policies on Violence & Aggression, Security, and Lone Working are outdated and do not reflect the Trust's current structure, services, or resources.
- **Generic Risk Assessments**: Available risk assessments are generic and lack clear identification of hazards or control measures.
- **Limited Security Presence**: Security coverage is limited, with a security guard in place only in the Emergency Department from 6 PM to 6 AM, and a single Local Security Management Specialist (LSMS) supporting the entire Community footprint.
- **Inadequate Training**: Training is limited and not provided on a risk-based approach, with low compliance in Conflict Resolution and Physical Restraint training, particularly before 2024.
- **Inconsistent Escalation Procedures**: Procedures for staff response to incidents and patient management are limited and inconsistently applied.
- **High Incident Rates**: There are daily reports of violence and aggression against staff, with 20-30 incidents recorded per month, despite the Trust's promotion of a zero-tolerance approach.
- **Cultural Issues**: There is an ingrained culture of accepting certain levels of violence and aggression.

Training Updates and Compliance:

- Conflict Resolution Level 1 (mandatory e-learning) was introduced in January 2024, with 83.9% compliance across the Trust and 77.4% compliance in the HIF.
- Lone Working training compliance stands at 96.7%.
- Pre-2024 compliance for Conflict Resolution Breakaway Skills was 56.2%, with even lower compliance for Physical Restraint training.

Security Review:

- A limited assurance audit on Security has highlighted significant gaps, leading to a decision to separate Security risks from the broader V&A risks. This will include areas such as security policies, physical presence, lockdown procedures, and community support.
- **Legislation Impact**: The upcoming Martyn's Law, which is pending due to the election, will likely require significant changes to the Trust's security measures.
- **Resource Limitations**: The lack of dedicated security presence, especially at the HDH site, has hindered the ability to reduce the V&A risk score, with notable incidents occurring in hospital corridors and visitor toilets.
- **Risk Score**: The risk score remains at 12, reflecting the ongoing challenges and will be reviewed at the August H&S Committee Meeting.

The situation is compounded by a recent increase in high-risk incidents, highlighting the insufficient resources available to support both acute and community settings

Plans to Improve Control and Risks to Delivery

Task and Finish Group: A Task and Finish group, led by the Head of H&S, has been established to review and improve all existing policies and procedures, aligning them with NHSE's Public Health Approach. Monthly meetings will begin in May 2024.

Mental Health Triage and Policy Update: Changes to mental health triage in the Emergency Department are ongoing and will be incorporated into a new policy for managing patients who may self-harm or have mental health issues. This policy is in the approval process as of April 2024.

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

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

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

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

Policy Reviews: New policy and procedure are under development for staff safety.
The Lockdown Policy and Bomb Alert Policies are under review to ensure they are up-to-date and effective.

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

Corporate Risk ID	Strategic Ambition	Type	Principle Risk:: Physical security provisions, training and support resources	Appetite	Initial Rating	April Rating	May Rating	Target Rating	Target Date
CRR102/ ID 577	An Environment that promotes wellbeing	Operational ; Health & Safety	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.	Minimal	16	16	16	8	~~April 25~~ Sept 25

Key Targets	Current Position	Plans to Improve Control and Risks to Delivery
Building Security Assessments completed for all premises used by Trust staff (this will not include patient homes which will be referenced in any relevant patient plan) Supported by up to date policies that reflect the activities carried out by the Trust and the geographical differences created. Risk assessments, policies and control measures actively monitored and reviewed. Reported via Security Forum Use of available data sources, such Datix, sickness absence as part of the monitoring and review process. Security incidents investigated and remedial action taken where identified. Effective communications to all staff. Provision of appropriate training and information to all Trust staff clinical and non-clinical.	**Outdated Security Policies**: Policies related to Security, Lockdown, Bomb Alert, Theft, Damage of Trust assets, personal property, and CCTV are outdated and do not reflect the Trust's geographical footprint or current operations. **Generic Risk Assessments**: Existing security risk assessments are generic and do not sufficiently identify hazards or provide clear control measures, particularly for building security, individual response, and lone working. **Limited Security Presence**: • **Acute Setting**: Security is present only from 6 PM to 6 AM daily, with additional coverage on Monday, Friday (7 AM – 5:30 PM), and weekends (6 AM – 6 PM). • **Community Hospitals**: No dedicated security presence, such as at Ripon Community Hospital. • **Community Footprint**: A single Local Security Management Specialist (LSMS) covers the entire community setting, limiting response capabilities. **Inconsistent Training**: Staff training is limited and not risk-based. Compliance with escalation procedures during violent incidents is inconsistent, and staff are underprepared to manage security threats, including Violence & Aggression. **CCTV and Access Control Limitations**: • **CCTV**: Current coverage at the HDH site is inadequate, with management delegated to the HIF. • **Access Control**: The swipe card access system is outdated, unsupported, and lacks proper control over keys and lock codes. This has led to poor key management, particularly with contractors and Trust staff. **High Incident Rates**: Recent high-risk incidents, including absconded patients and Violence & Aggression (V&A) incidents in hospital corridors and visitor toilets, underline insufficient resources and response capabilities. **Safeguarding Gaps**: There is no formal communication between the Safeguarding Team, Trust Security management, and Emergency Department management, despite warnings from local law enforcement regarding County Lines gang activity. **Governance Gaps**: • **Security Leadership**: Lack of clarity around executive leadership and accountability for Security within the Trust. • **Security Forum**: The Trust Security Forum has been established and now reports to the Health & Safety (H&S) Committee. A review of membership and terms of reference is underway.	**Policy Updates**: The Health & Safety (H&S) team, in coordination with HIF, is currently updating all relevant security policies, including Lockdown, Bomb Alert, Theft/Damage, and CCTV. These updates aim to align policies with the Trust's current structure, services, and geographical footprint. **Risk Assessments**: Comprehensive security risk assessments are being developed, with a focus on individual sites, lone working, and staff responses. Departmental risk assessments are ongoing at the local HDH level and across the community footprint. **Security Infrastructure Improvements**: • **Door Access Control**: A new door access system has been costed and will be replaced incrementally as part of the Trust's Backlog Maintenance work. • **CCTV Coverage**: A review of CCTV systems is in progress, with updates planned where necessary. • **Security Guards**: HIF is obtaining legal advice regarding the provision and licencing of Security Guards at the HDH site. This will be included in a business case for securing funding for additional security personnel. **Training Improvements**: Training on Violence & Aggression and Security risks is under review and will be updated to ensure staff receive appropriate, risk-based training. A new Conflict Resolution program tailored to various risk levels is in development. **Governance and Responsibility Clarification**: Discussions are ongoing with HIF to clarify security roles and responsibilities. Additionally, the Trust Security Forum's review will strengthen the governance structure by refining its terms of reference and membership. **Compliance with Martyn's Law**: With the impending implementation of the Terrorism (Protection of Premises) Bill (Martyn's Law), the Trust will undergo significant work to ensure compliance, particularly in areas related to terrorism risk management. **Improved Safeguarding Communication**: Efforts are being made to establish formal communication channels between the Safeguarding Team, Trust Security management, and Emergency Department management to address security threats, such as County Lines gang activities.

Corporate Risk ID	Strategic Ambition	Type	Principle Risk: Outsourcing of Hazard Group 3 Microbiology Work Due to CL3 Facility Unavailability	Appetite	Initial Rating	April Rating	May Rating	Target Rating	Target Date
CRR98/ ID 264	An Environment that promotes wellbeing	Operational ; Health & Safety	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.	Cautious	9	15	15	3	Sept 25

Key Targets

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

Current Position

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

These include:

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

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

Plans to Improve Control and Risks to Delivery

A series of plans and actions are being developed to address the risks associated with the outsourcing of Hazard Group 3 microbiology work, including delays, lost samples, and logistical challenges.

These include:

- **Recommissioning of Onsite CL3 Facility:**
  An outline business case to recommission an onsite CL3 facility was presented to the BCRG on 2 July 2024. A full business case will proceed. This business case will detail the lab specification, costs, and implementation timescale, aiming to restore onsite testing capabilities and reduce reliance on external providers.
- **DX Transport Investigation:**
  DX, the transport provider, is conducting an internal investigation to identify potential errors and establish mitigations to prevent future occurrences of lost or delayed samples. The results of the investigation are awaited, with the aim of improving sample tracking, delivery times, and overall reliability.
- **Sourcing Alternative NHS Suppliers:**
  Despite ongoing efforts to find an alternative NHS supplier for Hazard Group 3 work, no viable options have been found due to capacity and facility issues at other trusts within the region. Attempts to identify a suitable alternative will continue alongside the progression of the onsite CL3 facility business case.
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These actions are critical to mitigating current risks and ensuring patient safety, sample integrity, and operational continuity.

Harrogate and District NHS Foundation Trust Corporate Risk Register

CQC CARING DOMAIN	
	*People are always treated with kindness, empathy, and compassion. They are supported to live as independently as possible. Their privacy and dignity are respected. Every effort is made to take their wishes into account and respect their choices, to achieve the best possible outcomes for them.***Kindness, compassion and dignity -** We always treat people with kindness, empathy and compassion and we respect their privacy and dignity. We treat colleagues from other organisations with kindness and respect. • **Treating people as individuals -** We treat people as individuals and make sure their care, support and treatment meets their needs and preferences. We take account of their strengths, abilities, aspirations, culture and unique backgrounds and protected characteristics. • **Independence, choice and control -** We promote people's independence, so they know their rights and have choice and control over their own care, treatment and wellbeing. • **Responding to people's immediate needs -** We listen to and understand people's needs, views and wishes. We respond to these in that moment and will act to minimise any discomfort, concern or distress. • **Workforce wellbeing and enablement -** We care about and promote the wellbeing of our staff, and we support and enable them to always deliver person centred care.

Lead Committee	Quality Committee: People and Culture (Workforce Risk)	**Summary in Month:** In alignment with the CQC CARING Domain, which emphasizes treating people with kindness, empathy, and compassion while supporting staff wellbeing, the organisation has been addressing risks related to patient safety and colleague health due to low staffing levels in the North Yorkshire 0-19 Service (CRR93). CRR93 scoring was reduced in September 2024 and therefore it has been reduced form the CRR. The Trust continues its commitment to maintaining high standards of care, respecting patient choices, and supporting the wellbeing of the workforce, in line with the values of the CARING Domain.
Executive Committee	Quality Management Group (QGMG) (Clinical) Workforce Committee (Workforce)	
Initial Date of Assessment	1st July 2022	
Last Reviewed	April 2025	

Corporate Risk ID	**Strategic Ambition**	**Type**	**Principle Risk:**	**Appetite**	**Initial Rating**	**Rating**	**Rating**	**Target Rating**	**Target Date**

Key Targets	**Current Position**	**Plans to Improve Control and Risks to Delivery**

	CQC RESPONSIVE DOMAIN
	People and communities are at the centre of how care is planned and delivered at all times. Their health and care needs are understood and they are actively involved in planning care that meets these needs. Care, support, and treatment are easily accessible, including physical access. People can access care in ways that meet their circumstances and protected equality characteristics • **Person-centred care -** We make sure people are at the centre of their care and treatment choices and we decide, in partnership with them, how to respond to any relevant changes in their needs. • **Care provision, integration, and continuity -** We understand the diverse health and care needs of people and our local communities, so care is joined-up, flexible and supports choice and continuity. • **Providing information -** We provide appropriate, accurate and up-to-date information in formats that we tailor to individual needs. • **Listening to and involving people -** We make it easy for people to share feedback and ideas or raise complaints about their care, treatment and support. We involve them in decisions about their care and tell them what's changed as a result. • **Equity in access -** We make sure that everyone can access the care, support and treatment they need when they need it. • **Equity in experiences and outcomes -** We actively seek out and listen to information about people who are most likely to experience inequality in experience or outcomes. We tailor the care, support and treatment in response to this. • **Planning for the future -** We support people to plan for important life changes, so they can have enough time to make informed decisions about their future, including at the end of their life.

Lead Committee	Resource Committee
Executive Committee	Operational Management Group (OMG)
Initial Date of Assessment	1st July 2022
Last Reviewed	April 2025

Summary

The organization is facing critical challenges within the CQC Responsive Domain, which emphasizes timely, person-centred care and equitable access to services. The risks include significant delays in autism assessments (CRR34), where waiting times have ballooned to a projected 43 months, preventing children from receiving timely diagnoses and necessary support. Additionally, the Trust is struggling to meet the A&E 4-hour target, with performance dropping below the national standard of 78%, leading to increased 12-hour breaches and ambulance handover delays. These delays compromise patient safety and the quality of care, highlighting the urgent need for improved capacity, streamlined processes, and strategic resource allocation to ensure that care is responsive, accessible, and equitable for all patients.

CRR 257 – Imaging for ED Patients has been reviewed by the Executive Risk Management Group in April 25 and de-escalated from the Corporate Risk Register back to the Directorate Risk register for management and oversight.

Corporate Risk ID	Strategic Ambition	Type	Principle Risk: : Autism Assessment	Appetite	Initial Rating	April Rating	May Rating	Target Rating	Target Date
CRR 34 / ID 1	Great Start in Life	Clinical; Patient Safety	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)	Minimal	12	15	15	9	March 26

Key Targets	Current Position	Plans to Improve Control and Risks to Delivery
Waiting list would have to be reduced to 120 and longest wait to 13 weeks. Baseline capacity would need to meet the referral rate. Numbers on the waiting list 1566 (target 120) Longest wait of CYP having commenced assessment, 82 weeks (target 13) Activity - 31 completed assessments in Aug against ICB plan of 50 (plus 2 military assessment), YTD 255 against plan of 250. ■ To meet the monthly ICB target for number of assessments ■ Meet the annual planned target for assessments	Our commissioned capacity is now lower at 40 assessments per month which means the waiting list will grow more steeply. Non-recurrent funding challenges service management due to lead times for capacity acquisition and staff training, exacerbated by national shortages. Loss of a key clinical team member impacts medium-term assessment capacity. Support provided to the team; commissioners informed. ICB-wide autism and ADHD group supersedes previous locality-based group, aiming to standardize referral criteria. No extra funding available for capacity gaps. Stabilizing waiting lists requires increased capacity, costing £490k annually. Modelling shared at CC Resources Review and escalated to place ICB meeting for executive consideration. No agreed plan for long-term resource provision is currently agreed and in place. The target date has been reviewed and updated to March 2026.	The progress with PLACE based work. Mobilisation of WLI and new pathways In order to stabilise the waiting list we would need to increase the service capacity to approx. 90 assessments per month with the additional staffing costing £490k full year effect. The modelling has been shared at the CC Resources Review Meeting and has been escalated to the place ICB meeting with Execs as it was felt HDFT could no longer carry all the risk of these waits and there is currently no agreed plan to provide the resources required to address this longer term.

Harrogate and District NHS Foundation Trust Corporate Risk Register

Corporate Risk ID	Strategic Ambition	Type	Principle Risk: ED 4-hour Standard	Appetite	Initial Rating	April Rating	May Rating	Target Rating	Target Date
CRR 61 / ID 3	Person centred, integrated care, strong partnership	Clinical; Patient Safety	Failure to Meet A&E 4-Hour Target Due to Inadequate Patient Flow, Leading to Increased 12-Hour Breaches and Ambulance Delays, Resulting in Compromised Patient Safety and Regulatory Non-Compliance	Minimal	12	12	12	8	March 26

Key Targets	Current Position	Plans to Improve Control and Risks to Delivery
4 hour performance A&E 4 hour target to be met, 6 hour breaches <102 per month 0 x 12 hour breaches	**Improved streaming pathways** to HDFT specialties are in place, supported by focused engagement across Medicine, Surgery, Frailty, and Paediatrics. **Assumed acceptance of admissions** into Medicine and ASCOM referrals initiated in Surgery are supporting more efficient patient handover processes. **Significant ED capital works** completed in 2023 have enabled new models of care delivery, including the creation of a Fit2Sit area and Ambulance RIAT bay, aimed at improving performance and reducing congestion. **Direct streaming to Surgical Assessment Unit** (SAU) began w/c 13 January and is currently in the process of being embedded into standard practice. **Nurse staffing is** now in line with SNCT levels, improving workforce assurance and patient safety. **New medical team members**, many of whom are new to the NHS, are being supported through structured 1:1s and clearly defined role expectations. **TES SOP (Transfer and Escalation Suite)** has been implemented to allow decompression of the ED during critical periods of overcrowding. **Point-of-care testing** in the ED enables timely diagnostics and patient placement decisions. **OPEL escalation framework** is in use to manage operational pressures with consistent processes. Three daily bed meetings are in place, coordinated by a designated Manager of the Day to support site-wide flow and escalation. Significant delays to medical beds are a recognised issue; recently mitigated by the opening of a Winter Ward from 6 December (planned through end of February) as a short-term solution. Up to 17% of patients are classified as NCTR (No Criteria to Reside); adoption of OPTICA as the Trust's tool to support discharge and flow is underway, alongside a corporate discharge project launching in early 2025. The target date has been reviewed and updated	To support the Trust's **True North objective** of achieving the **ED 4-hour standard**, the following targeted actions are being implemented: **Focussed Impact Work**: Targeted performance initiatives at the directorate, care group, and ED front-line levels to drive improvement against the 4-hour standard. • **Relaunch of Internal Professional Standards**: A refreshed framework (currently in draft) aims to strengthen internal clinical escalation and handover processes. • **Improved Triage Timeliness**: Work is underway to ensure triage is completed within **15 minutes of arrival** for all patients, enhancing early risk identification and throughput. • **Enhanced Streaming to SDEC and ED2**: More focused operational support is being deployed to improve the consistency and appropriateness of patient streaming. • **Expansion of Non-Headed Beds**: Following initial success, this model will be reviewed for broader integration into flow and capacity plans. Further planned mitigations include: • **Formalisation and audit of direct-to-specialty streaming**, including SAU, with SOPs, monitoring, and outcome evaluation to ensure consistency and reduce ED burden. • **Review and evaluation of ED reconfiguration outcomes**, with refinement of design or process elements based on real-world performance data. • **Structured evaluation of the Winter Ward model** to inform the **longer-term corporate ward reconfiguration project**, with a focus on sustainable medical bed capacity. • **Implementation and embedding of the OPTICA tool** as part of a **Trust-wide corporate discharge project** launching in early 2025 to address high NCTR rates. • **Strengthening of digital infrastructure** to support **bed meetings**, with real-time dashboards, improved flow visibility, and predictive analytics.

Corporate Risk ID	Strategic Ambition	Type	Principle Risk: Stroke Provision	Appetite	Initial Rating	April Rating	May Rating	Target Rating	Target Date
79	Person centred, integrated care, strong partnership	Clinical; Patient Safety	Risk to patient care and safety due to delayed treatment caused by limited HASU capacity, non-adherence to the regional stroke pathway, and delays in assessing self-presenting stroke patients at HDFT ED, impacting timely and effective stroke care delivery.	Minimal	16	16	16	~~8~~ 4	Oct 25

Key Targets

All eligible patients receiving HASU Care

No patients requiring HASU are directly admitted to Harrogate for Emergency Care.

Current Position

- There is limited HASU capacity at LTHT and YTHFT, and aspects of the regional stroke pathway are not being followed.
- 2023/24 SSNAP data indicates that 41.5% of confirmed strokes were directly admitted to HDFT, bypassing HASU care and assessment.
- York cannot accept HDFT patients unless they are directly referred by YAS.
- Due to a lack of accurate and timely data, the trust cannot report all events where patients missed HASU access. The likelihood of risk ranges from possible to likely.
-

Existing controls include:

- Awareness initiatives to ensure stroke events are reported via DCIQ.
- Safety investigations: One SI (18460) and a related inquest are awaiting hearing, with a potential risk of a Prevention of Future Death (PFD) report.
- Access to PPM+ viewing has been granted and is being rolled out to staff.

Plans to Improve Control and Risks to Delivery

To support the Trust's True North objective, several focused actions and plans are being implemented:

1. Executive Support: Secure agreement from WYATT and HNY ICB for future stroke care arrangements across the region.
2. Regional Collaboration: Engage with WYAAT to integrate stroke care pathways and discuss regional stroke care solutions. Restart paused pilot pathways for direct referrals to tertiary centres as part of WYAAT discussions. Liaise with York to develop a sustainable and comprehensive HASU support plan.
3. Consultant Collaboration: Explore shared on-call arrangements with York to enhance consultant cover for ASU.
4. Data Accuracy and Reporting: Conduct a 12-week audit with HDFT and YAS to investigate why stroke patients bypassed HASU care. Improve Datix reporting to ensure accurate and timely data collection for decision-making.
5. Pilot Implementation: Proceed with the pilot project for walk-in and inpatient stroke referrals to York, pending sign-off by YTHFT management.
6. Continue to monitor SSNAP data and datix's raised re direct admissions to Harrogate. Ensure datix reports submitted for all delays and non transfer is robust to understand root causes.

Harrogate and District NHS Foundation Trust Corporate Risk Register

Corporate Risk ID	Strategic Ambition	Type	Principle Risk: Patient harm due to Non Compliance with National KPI's for waiting times and reporting in Imaging Services	Appetite	Initial Rating	April Rating	May Rating	Target Rating	Target Date
ID 379	Person centred, integrated care, strong partnership	Clinical; Patient Safety	Currently, the radiology department at HDFT relies on traditional, manual interpretation of chest x-rays, which has led to a backlog of cases, inconsistent diagnosis times, and variability in diagnostic accuracy. The system's inability to efficiently manage and prioritize urgent cases further exacerbates these issues.	Minimal	16	12	12	3	~~March 25~~

Key Targets	Current Position	Plans to Improve Control and Risks to Delivery
	The primary risk of not implementing the AI solution for chest x-ray interpretation lies in continued reliance on manual processes, which are susceptible to delays and inaccuracies in diagnosis. The current manual methods place a heavy workload on radiologists, prolong diagnosis times, and potentially lead to suboptimal patient outcomes due to delayed treatment. This situation poses a serious risk not only to patient health but also to the operational efficiency and reputation of the healthcare facility. Currently, the radiology department at HDFT relies on traditional, manual interpretation of chest x-rays, which has led to a backlog of cases, inconsistent diagnosis times, and variability in diagnostic accuracy. The system's inability to efficiently manage and prioritize urgent cases further exacerbates these issues. Without the AI solution, the department continues to face challenges in meeting the compliance standards expected for timely and accurate service delivery, directly impacting patient care and throughput in radiological services	Staffing: Service is only budgeted 9-5 Monday through Friday this requires a business case for expansion of staffing provision Reporting: Lack of resilience in sub speciality reporting. Expansion of Trust wide services leading to a shortfall in reporting capacity **Current Controls** Delay in diagnosis: circa 500 patients above 6 week waiting for appointment. Reporting: Circa 200 breaching reporting target, with patients beyond 45 days beyond examination **Gaps in Controls** Limited Scalability: Existing manual interpretation processes lack the scalability necessary to handle increasing volumes of x-ray exams efficiently. Insufficient Real-Time Monitoring: Current systems may not provide real-time analytics or alerts for backlog increases and error rates, which delays the identification and resolution of issues. Inadequate Error Tracking Mechanisms: There is a possible lack of robust mechanisms to track and analyze errors in x-ray interpretations systematically, hindering continuous improvement efforts. Lack of Integration: Current systems may not be fully integrated with other hospital systems, leading to fragmented workflows and information silos. Dependency on Human Resources: Over-reliance on radiologists for interpretations without adequate support tools can lead to inconsistencies and errors due to fatigue and high workload. Treatment Plan: Accelerate AI Integration: Fast-track the deployment of the AI solution for chest x-ray interpretation to reduce dependency on manual processes and enhance diagnostic accuracy and efficiency. Enhance Monitoring Systems: Implement advanced monitoring tools that provide real-time data on key performance indicators, allowing for timely interventions when performance thresholds are breached. Establish Comprehensive Error Analysis Protocols: Develop and implement a robust system for tracking, analyzing, and learning from diagnostic errors to foster continuous improvement. System Integration: Work towards integrating the radiology information systems with other hospital systems to ensure seamless data flow and improve overall workflow efficiency. Support and Training Initiatives: Increase investments in training programs to ensure radiologists and related staff are well-equipped to handle new technologies and workflows. Additionally, consider hiring more staff or adjusting shifts to manage workload effectively.

Corporate Risk ID	Strategic Ambition	Type	Principle Risk: Cardiology	Appetite	Initial Rating	April Rating	May Rating	Target Rating	Target Date
642	Person centred, integrated care, strong partnership	Operational; Business Continuity	Risk to HDFT's ability to deliver acute DGH services due to the fragility of the cardiology service caused by inadequate staffing, reliance on locum cover, and increasing service demand. A locum consultant and Registrar are now in post, this has provided significant control and reduction in likelihood.	Minimal	12	12	12	3	Dec 2025

Key Targets	Current Position	Plans to Improve Control and Risks to Delivery
Staffing and Workforce KRIs: • Consultant Staffing Levels: Percentage of Consultant PAs filled with substantive staff versus locums. Number of unfilled Consultant posts after each recruitment round. Quality and Outcomes KRIs: • Clinical Outcomes: Mortality rates for acute cardiology patients on CCU. Readmission rates for cardiology patients within 30 days of discharge.	• Staffing Shortages: Consultant staffing is currently 12.5 PAs short, covered by locums, resulting in lack of continuity and associated risks to quality. Cardiology Fellow recruitment is underway to address acute care continuity and safety risks. Existing workforce lacks skill sets for temporary pacing wires and pericardiocentesis; collaboration with LGI provides specialist support. A locum consultant and Registrar are now in post, this has provided significant control. • Service Delivery Challenges: Long outpatient wait times for angiograms (30% waiting over six weeks, down from 50%) and ECHO services (22% waiting over six weeks, improved from 70%). Pacemaker service demand is increasing due to an aging population. No weekend Consultant ward rounds or ECHO provision, failing to meet GIRFT standards. • Current Mitigations: Locum consultants and registrars are in place to maintain minimum service levels. Outsourcing of ECHO workload has reduced backlogs, with a permanent post recruited (starting Jan 2025). Cath lab utilization is under review to further address angio delays. HDFT IMPACT meetings and LTUC Tri-Team updates ensure escalations are reported to the executive team. Due to on-going concerns in likelihood the risk has been increased back to 12.	To support the Trust's True North objective, several focused actions and plans are being implemented: Strategic Planning: Workforce Development: Continue recruitment for a substantive consultant post and Cardiology Fellow. Develop "grow your own" plans for the ECHO team to ensure workforce resilience. Service Improvements: Review Cath lab utilization to further reduce angio waiting times. Evaluate options to provide weekend Consultant ward rounds and ECHO provision to meet GIRFT standards. Collaboration: Strengthen links with LTHT's Clinical Lead for specialty support and shared learning. Demand Management: Explore solutions to manage the increasing demand on the pacemaker service due to the aging population.

Corporate Risk ID	Strategic Ambition	Type	Principle Risk: **Automated medicines supply services**	Appetite	Initial Rating	April Rating	May Rating	Target Rating	Target Date
ID 379	Person centred, integrated care, strong partnership	Clinical; Patient Safety	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.	Minimal	8	12	12	4	Sept 25

Key Targets	Current Position	Plans to Improve Control and Risks to Delivery
	Robot malfunctions monitored via Stores and Distribution and escalated where increasing frequency gives cause for concern. Robot listed on the capital assets register. Staff re-training in progress to ensure correct use. 6 monthly service due 5th July 2023. Detailed reports now obtained from supplier when issues logged. 15/11/23 Robot training completed for all staff. 01.05.24 Weekly robot reboot including log of when this has occurred. 01.05.24 First recovery planning meeting held. Risk score increased due to increase in frequency of failure. 21.5.24 No failure requiring significant downtime for 4 weeks. Recovery plan in progress with completeness by mid-June. Service due 22nd May. 13.05.25 Failure around once a month. Escalated back to capital planning for replacement. To update the business case and resubmit to Business Case Review Group.	**Gaps in control:** Business case to support capital replacement of the robot. 1.5.24 Business continuity plan for robot failure Meeting with supplier to discuss new robot options planned for 27th June.

	USE OF RESOURCES
	Use of resources area Key lines of enquiry (KLOEs) • **Clinical services -** How well is the trust using its resources to provide clinical services that operate as productively as possible and thereby maximise patient benefit? • **People**- How effectively is the trust using its workforce to maximise patient benefit and provide high quality care? • **Clinical support services** - How effectively is the trust using its clinical support services to deliver high quality, sustainable services for patients? • **Corporate services, procurement, estates and facilities** - How effectively is the trust managing its corporate services, procurement, estates and facilities to maximise productivity to the benefit of patients? • **Finance** - How effectively is the trust managing its financial resources to deliver high quality, sustainable services for patients?

Lead Committee	Resource Committee
Executive Committee	Operational Management Committee (OMG)
Initial Date of Assessment	1st July 2022
Last Reviewed	April 2025

Summary in Month:
The Trust is currently addressing significant financial challenges under the CQC Use of Resources domain, which emphasizes the effective management of resources to maximize patient benefit and ensure sustainable, high-quality care. To deliver the 2024/25 plan, which includes a £5.2 million deficit and a 6% efficiency target, the Trust must reduce its current run rate and successfully implement the Waste Reduction and Productivity (WRAP) programme, despite high-risk schemes and ongoing financial pressures. Additionally, the Trust faces potential cost pressures due to the ability of Local Authorities (LAs) to fund the impact of NHS pay awards, which could further strain resources if funding gaps remain unaddressed. The Trust is engaging in continuous discussions with LAs to secure necessary funding and mitigate these risks. To ensure these financial challenges are managed effectively, the Trust has implemented monthly meetings across directorates, contracting, and finance teams, focusing on corporate efficiency, workforce optimization, and financial stability, all of which are critical to maintaining productivity and delivering high-quality, patient-centred care.

CRR69 – Delivery of financial plan 2024-25 has been closed. **A new risk relating to the delivery of the 2025-26 plan is being developed.**
CRR367 – NHS Pay Award has been closed.

Corporate Risk ID	Strategic Ambition	Type	Principle Risk: Group Cash Position 2025-26	Appetite	Initial Rating	April Rating	April Rating	Target Rating	Target Date
721	Overarching Finance	Financial	Due to the underlying financial position of the organisation, cash support is required in March 2025 totalling £18.5m. A cash forecast has been prepared for 2025-26 and this has highlighted cash concerns for the year which will need managing.	**Cautious**	**16**	**12**	**12**	**4**	March 26

Key Targets	Current Position	Plans to Improve Control and Risks to Delivery
Cash position maintained	At the start of the financial year, there is a risk that future cash support will be required. This is currently being monitored on a monthly basis corporately and through directorate performance review meetings.	WRAP Programme £16.4m funding has been received from the ICB. Emergency Case protocol to be developed to prioritise cash payments which factors in cash support not being offered. Regular monitoring of cash position and forecast Review of council payment terms. Cash support request submitted within NHS E timeframes **Gaps in control** Agreed debt due to vacancy / LTS in team – recruitment and fix term cover underway Balanced financial plan – financial plan for 2025-26 remains challenging.

Harrogate and District NHS Foundation Trust Corporate Risk Register

CQC EFFECTIVE DOMAIN

People and communities have the best possible outcomes because their needs are assessed. Their care, support and treatment reflect these needs and any protected equality characteristics. Everyone is supported to see what works well and not so well based on indicators of quality. Continuous improvement is always guided by this insight

- **Assessing needs -** We maximise the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.
- **Delivering evidence-based care and treatment -** We plan and deliver people's care and treatment with them, including what is important and matters to them. We do this in line with legislation and current evidence-based good practice and standards.
- **How staff, teams and services work together -** We work effectively across teams and services to support people. We make sure they only need to tell their story once by sharing their assessment of needs when they move between different services.
- **Supporting people to live healthier lives -** We support people to manage their health and wellbeing so they can maximise their independence, choice and control. We support them to live healthier lives and where possible, reduce their future needs for care and support.
- **Monitoring and improving outcomes -** We routinely monitor people's care and treatment to continuously improve it. We ensure that outcomes are positive and consistent, and that they meet both clinical expectations and the expectations of people themselves.
- **Consent to care and treatment -** We tell people about their rights around consent and respect these when we deliver person-centred care and treatment.

Lead Committee	Quality Committee
Executive Committee	Quality Management Group (QGMG)
Initial Date of Assessment	1st July 2022
Last Reviewed	April 2025

Summary in Month:

The CQC Effective Domain is focused on optimizing patient outcomes by addressing their specific needs and continuously improving care quality. Currently, significant risks include prolonged waiting times, which jeopardize patient safety and Trust performance against NHS targets. An additional £1.5 million investment has been secured to extend the Community Dental Services (CDS) contract, with strategic initiatives underway to manage waiting times and enhance service delivery. Despite challenges in funding alignment, IT system replacement, and recruitment, efforts are progressing, including regional discussions on potential funding increases and service adjustments post-election.

Corporate Risk ID	Strategic Ambition	Type	Principle Risk: Community Dental	Appetite	Initial Rating	April Rating	May Rating	Target Rating	Target Date
6	Provide person centred, integrated services through strong partnerships	Clinical; Patient Safety	Risk to patient safety due to correlation of long waiting times and increased risk of pain and infection, which may affect quality of life and treatment required. Secondary risk to Trust performance standards by failing to meet NHS annual planning target of no RTT waiters beyond 78weeks currently, 65 weeks by end March 2024 and 52wks by end March 2025.	Minimal	12	12	12	6	March 26

Key Targets	Current Position	Plans to Improve Control and Risks to Delivery
Numbers on the patients waiting to start treatment over 52weeks, 65weeks and 78weeks Current position for RTT waiters - 0 patients between 52-64 weeks. Current position for Non RTT waiters – 1053 patients over 52 weeks, No of overdue continuing care patients.	The ICB has agreed to invest an additional £1.5 million into the CDS service at HDFT, extending the contract by 18 months until March 31, 2025. Regional discussions suggest a potential agreement on a 7+3 contract and amended service specification, with a possible increase in the funding envelope, though formal confirmation is pending post-general election. The current funding does not fully align with the submitted business case, so the operational team and service manager have developed a plan to optimize the use of this investment, focusing on managing waiting times for both RTT and non-RTT patients. Key actions for July include recruiting a new clinical lead, continuing IT procurement, and addressing low staff engagement, which has been identified as a significant risk to service delivery. The CDS team is also being encouraged to participate in the HDFT Impact work as part of phase 4 to further support service improvements. The Target Date has been reviewed and updated.	The key plans and actions for the CDS service include ongoing liaison with the ICB and the implementation of a Waiting List Initiative (WLI) to address patient backlogs, with additional GA and clinic sessions planned for the financial year. The replacement of the SOEL Health dental IT system is underway, although the procurement process has faced delays, and a direct award is being sought to meet the April 2024 deadline. Capital kit replacement, including dental chairs and X-ray equipment, is progressing, with 2023/24 equipment being installed and approvals pending for 2024/25 purchases. Recruitment efforts are ongoing, with successful appointments for dentists and dental nurses from the business case, though challenges remain in filling positions in the East and for paediatric specialists. Recruitment for key leavers is also ongoing, with many new staff expected to start in September 2024.

CQC WELL-LED DOMAIN

There is an inclusive and positive culture of continuous learning and improvement. This is based on meeting the needs of people who use services and wider communities. There are effective governance and management systems in place. Leaders proactively support staff and collaborate with partners to deliver care. This care is safe, integrated, person-centred and sustainable care and helps reduce inequalities.

- **Shared direction and culture:** We have a shared vision, strategy and culture. This is based on transparency, equity, equality and human rights, diversity and inclusion, engagement, and understanding challenges and the needs of people and our communities in order to meet these.
- **Capable, compassionate and inclusive leaders:** We have inclusive leaders at all levels who understand the context in which we deliver care, treatment and support and embody the culture and values of their workforce and organisation. They have the skills, knowledge, experience and credibility to lead effectively. They do so with integrity, openness and honesty.
- **Freedom to speak up:** We foster a positive culture where people feel that they can speak up and that their voice will be heard.
- **Governance, management and sustainability:** We have clear responsibilities, roles, systems of accountability and good governance. We use these to manage and deliver good quality, sustainable care, treatment and support. We act on the best information about risk, performance and outcomes, and we share this securely with others when appropriate.
- **Partnerships and communities :**We understand our duty to collaborate and work in partnership, so our services work seamlessly for people. We share information and learning with partners and collaborate for improvement.
- **Learning, improvement and innovation:** We focus on continuous learning, innovation and improvement across our organisation and the local system. We encourage creative ways of delivering equality of experience, outcome and quality of life for people. We actively contribute to safe, effective practice and research.
- **Environmental sustainability – sustainable development:** We understand any negative impact of our activities on the environment and we strive to make a positive contribution in reducing it and support people to do the same.
- **Workforce equality, diversity and inclusion:** We value diversity in our workforce. We work towards an inclusive and fair culture by improving equality and equity for people who work for us."

Lead Committee	Trust Board
Executive Committee	Senior Management Committee (SMT)
Initial Date of Assessment	1st July 2022
Last Reviewed	April 25

Summary in Month:
This area of the Corporate Risk Register is linked to the Well-Led Domain. Currently there is no Corporate Risk within this Domain.

Corporate Risk ID	Strategic Ambition	Type	Principle Risk:	Appetite	Initial Rating	Rating	Rating	Target Rating	Target Date

Key Targets	Current Position	Plans to Improve Control and Risks to Delivery

Trust Board Meeting held in Public

Date: 28 May 2025

Title:	Annual Health & Safety Report
Responsible Director:	Jordan McKie, Director of Finance
Author:	Paul Yeadon, Head of Health & Safety

Purpose of the report and summary of key issues:	Annual Report for 2024. Report provides overview of 2024 H&S data, as well as detailing progress against our HS&S priorities and additional workstreams.	
Trust Strategy and Strategic Ambitions:	**The Patient and Child First** Improving the health and wellbeing of our patients, children and communities	
	Best Quality, Safest Care	x
	Person Centred, Integrated Care; Strong Partnerships	
	Great Start in Life	
	At Our Best: Making HDFT the best place to work	x
	An environment that promotes wellbeing	x
	Digital transformation to integrate care and improve patient, child and staff experience	
	Healthcare innovation to improve quality	
Corporate Risks:	Fire Violence & aggression Security Workplace transport	
Report History:	Health & Safety Committee Quality Governance Management Group (May 2025) Strategy Deployment Room (May 2025) Quality Committee (May 2025)	
Recommendation:	To note as a supplementary paper, for information.	

Freedom of Information:	

Health & Safety Annual Report 2024

Harrogate and District NHS Foundation Trust

Table of Contents

1. INTRODUCING OUR ANNUAL HEALTH & SAFETY REPORT

The Annual Health & Safety Report reviews our performance and progress for the period 1st January 2024 – 31st December 2024, and will set out our key health and safety priorities for 2025.

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

Welcome to the 2024 Annual Health and Safety Report.

During 2024 we have continued to build on the work of the previous 12 months and establish a robust and positive health and safety system that benefits those who come in contact with HDFT as employees, patients, visitors and all others.

Our 2023 report outlined where HDFT stood in terms of legal compliance and the work we had started to begin the reset of how we wish to use health and safety as a tool of improving both staff and patient experience. Once more this report sets out what we have achieved over the last 12 months to build on the foundations we started to lay in 2023 and evidence the further areas of work we have begun as we continue to learn more about how we can best protect and manage our health and safety risk.

The last 12 months have provided us the opportunity to make further improvements to our governance structures and establish new policies and procedures to support the work we are doing. 2024 has also been a period of significant change to our physical environment, providing challenges in delivering this vital work whilst also providing services to our patients.

I can confirm that the Board of Directors has reviewed the 2024 Annual Health and Safety Report and can confirm that to the best of my knowledge, the information contained within this report is an accurate and fair account of our performance.

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

With best wishes

Jordan McKie
Director of Finance
Executive Lead for Health & Safety

2. ABOUT HDFT

HDFT IN NUMBERS

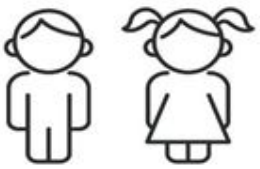
ESTATES & FACILITIES SUBSIDUARY EMPLOYING 380+

3 INTEGRATED CARE SYSTEMS AND 3 CLINICAL DIRECTORATES

C316,000 HOSPITAL CATCHMENT AREA

c621,000 COMMUNITY SERVICES POPULATION

c600,000 CHILDREN SUPPORTED IN 9 LOCAL AUTHORITY AREAS



LARGEST EMPLOYER IN HARROGATE AND DISTRICT

OVER 5000 COLLEAGUES

Our Services

Acute and Community Services for Harrogate and District and wider North Yorkshire:

- Harrogate District Hospital which includes an Emergency Department, comprehensive medical and surgical specialities, an oncology centre, maternity services and extensive outpatient facilities
- Community Services which includes podiatry, district and community nursing, therapy services and community dental services

Children's Public Health (0-25) Services

- 9 local authorities in North East and Yorkshire
- Looking after over 600,000 children
- The largest provider of 0 – 19 services in England

3. OUR HEALTH & SAFETY SYSTEM / GOVERNANCE STRUCTURE

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

After major changes in 2023 to re-establish the key elements of a health and safety system appropriate for an organisation of our type and size, including a new Health & Safety Team, Health & Safety Committee, and clear governance structures for relevant Groups/Forums to report and escalate matters of concern, 2024 has been seen a number of minor changes to support our continuous improvement.

The Health & Safety Team at HDFT is led by the Head of Health & Safety, and supported by a Health & Safety Advisor (Acute) and Health & Safety Advisor (Community), and is now closely linked to the Moving & Handling Co-ordinator, Fire Safety team and Security team.

In addition to this we have:

- Established a new COSHH Steering Group, chaired by our Chief Pharmacist, and reporting to H&S Committee.
- Re-established the Electrical Safety Group through HIF and reporting to H&S Committee.
- Increased membership of the H&S Committee to now include staff representation from the Clinical Directorates, and will be extending this across our Corporate Directorate in 2025.
- Reformed the Radiation Safety Group (now Medical Exposures Group) to provide greater assurances around radiation safety for both staff and patients.

As outlined in the 2023 report we continue to base our legal compliance, and establishing best practice in our H&S system in line with the following Healthcare approved publications:

- HSG65 Managing for Health and Safety (published by Health & Safety Executive) Managing for health and safety (HSG65) (hse.gov.uk)
- Workplace health and safety standards (published by the NHS Staff Council's HSWPG) hswpg_workplace-health-safety-standards_may_2022_final.pdf (nhsemployers.org)

Both publications focus on the principal of Plan, Do, Check, Act, as outlined in the table below.

	Conventional health and safety management	Process safety
PLAN	Determine your policy/Plan for implementation	Define and communicate acceptable performance and resources needed
DO	Profile risks/Organise for health and safety/Implement your plan	Identify and assess risks/Identify controls/Record and maintain process safety knowledge Implement and manage control measures
CHECK	Measure performance (monitor before events, investigate after events)	Measure and review performance/Learn from measurements and findings of investigations
ACT	Review performance/Act on lessons learned	

HEALTH & SAFETY GOVERNANCE STRUCTURE 2024

*new in 2024, reporting to H&S Committee

**previously the Radiation Protection Group

(Both the Water Safety Group and Ventilation Safety Group are also represented at Health & Safety Committee and will provide updates as and when required)

4. HEALTH & SAFETY - THE DATA

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

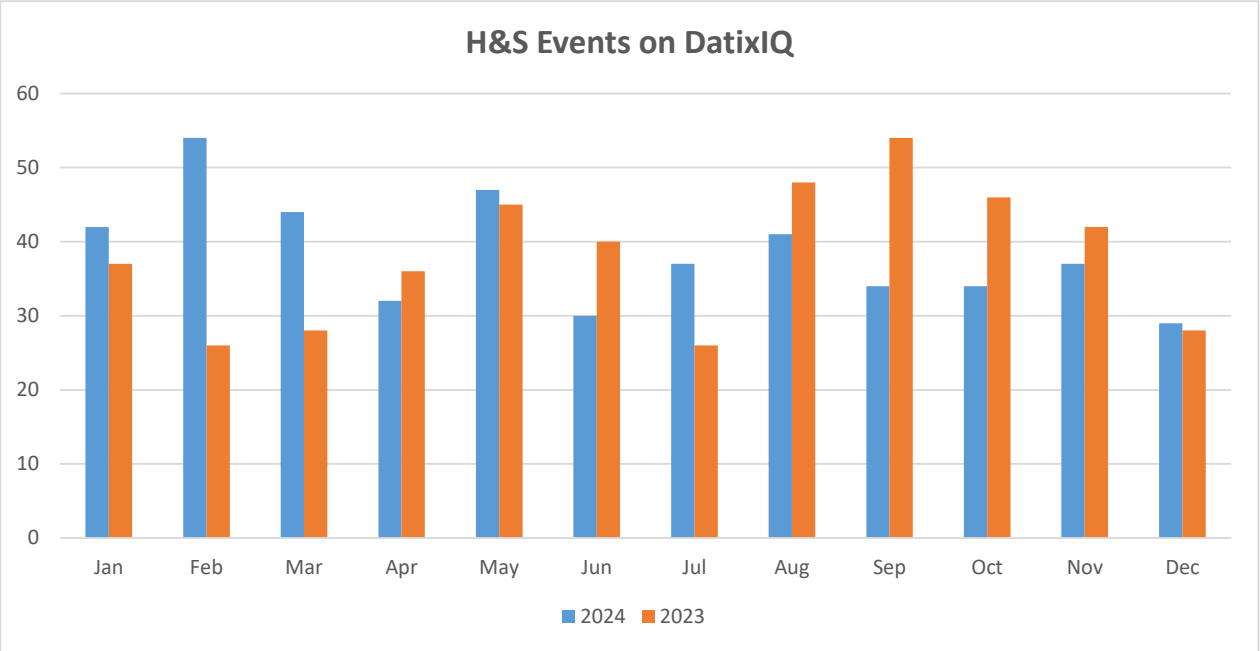
During 2024 HDFT upgraded its incident reporting system to DatixIQ, further supporting the effective reporting of events and provide greater analysis of the data that is generated. As is the case in all industries the effective reporting of incidents and near misses is vital in supporting the identification of hazards, targeting appropriate resources at higher risk areas, or individual teams /areas. This system also supports HDFT, as an employer, in ensuring we comply with our legal duties in relation to the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013.

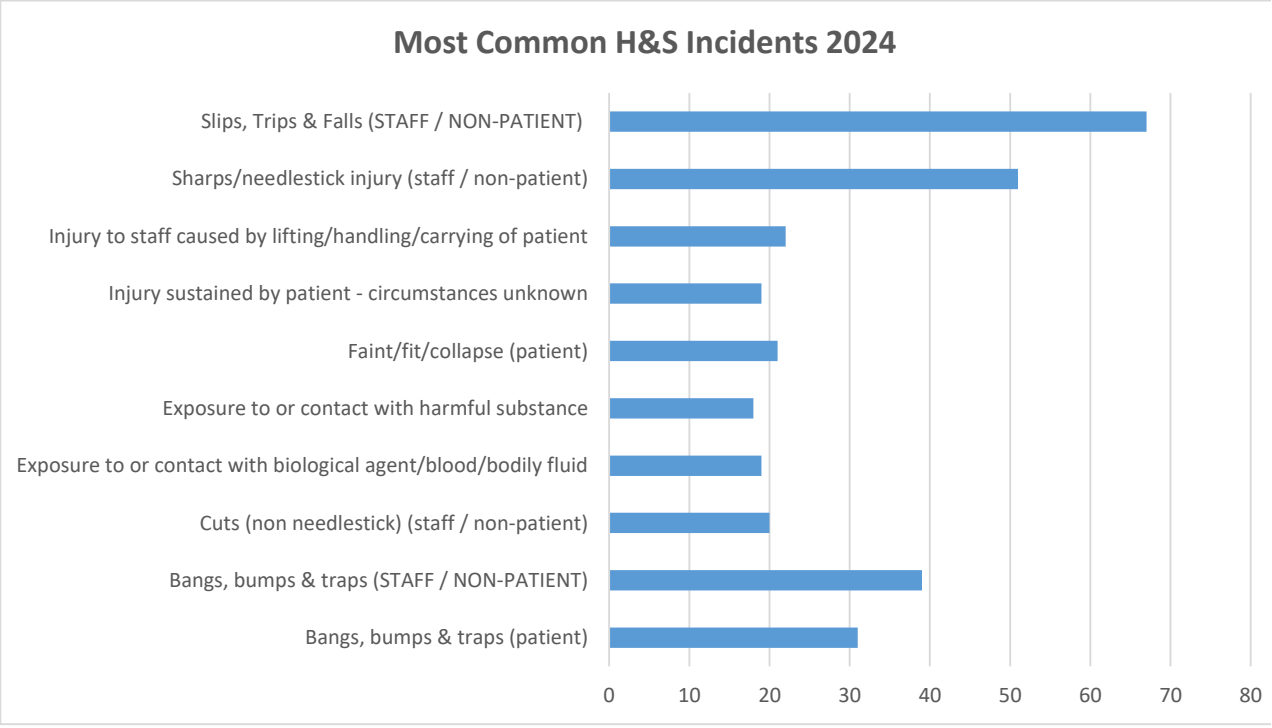
As stated in the 2023 report HDFT has not effectively collected or analysed health and safety data over the previous 5-10 years, and therefore the 2024 data is another step in gathering significant amounts of data to further inform the decisions we make and also evidence that changes made are leading to improvements.

Further analysis of this data will allow us ensure our priorities in Health and Safety align with the Trust's Strategy and True North Ambitions – ***Best Quality, Safest Care***, and ***Making HDFT the Best Place to Work***. In 2025 we will use HDFT Impact methodology to identify metrics that will support improvement in line with these True North Ambitions.

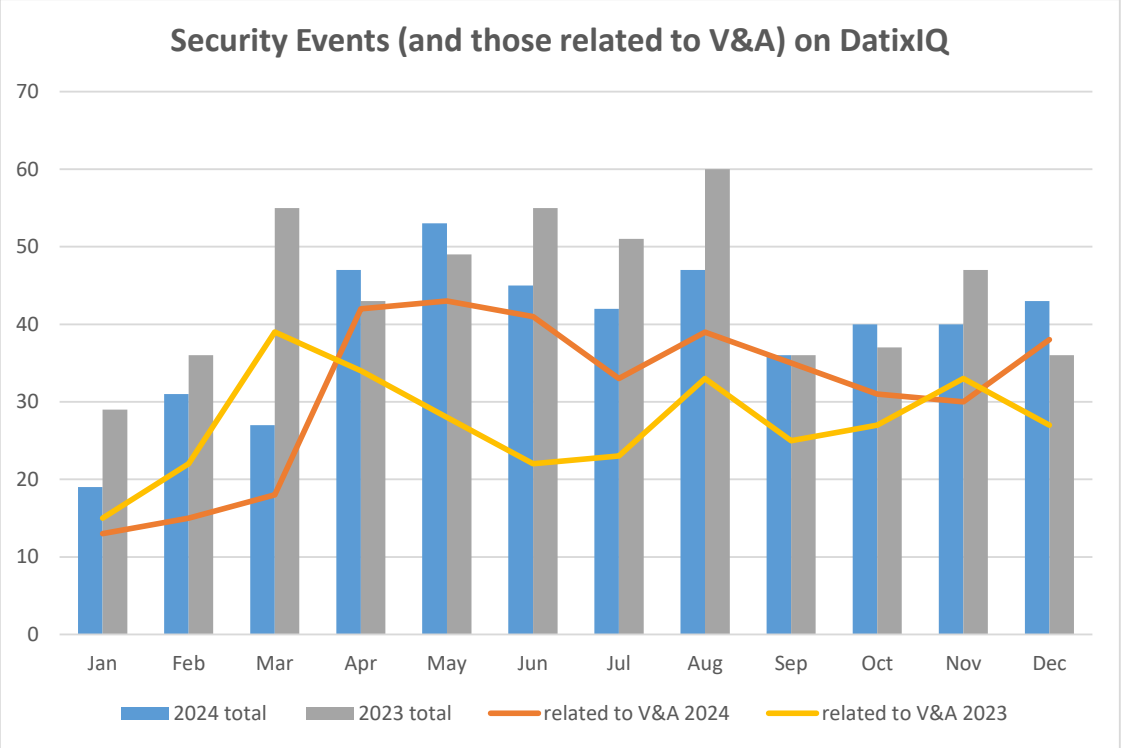
HEALTH & SAFETY INCIDENTS

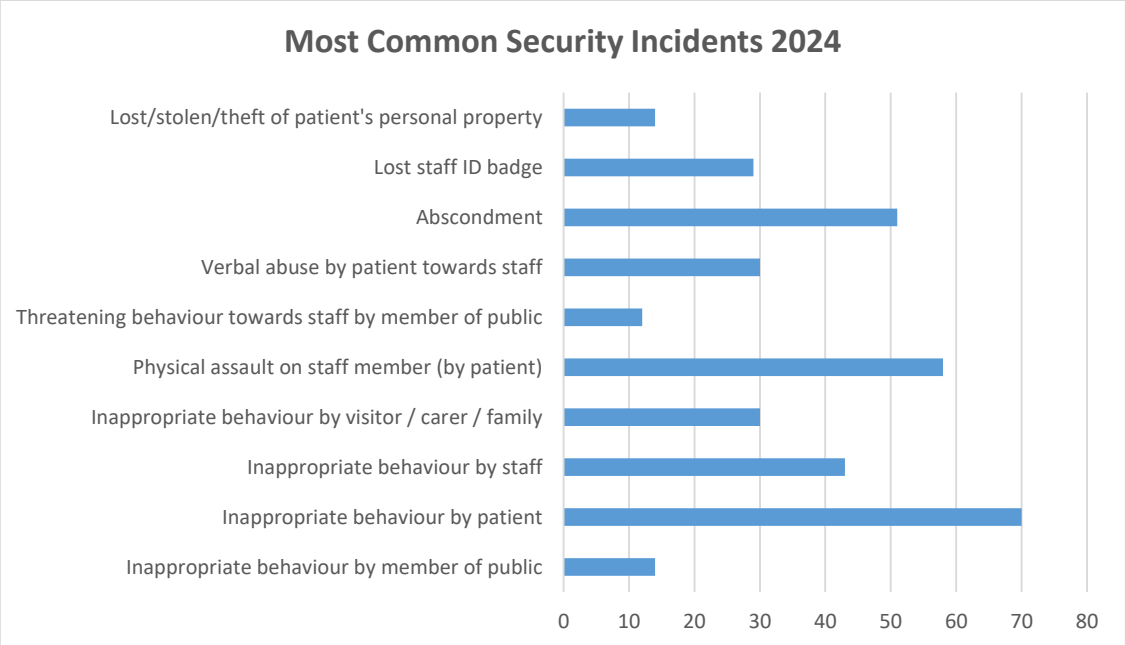
Health & Safety			Security and V&A				
Month	2024	2023	Month	2024 total	related to V&A 2024	2023 total	related to V&A 2023
Jan	42	37	Jan	19	13	29	15
Feb	54	26	Feb	31	15	36	22
Mar	44	28	Mar	27	18	55	39
Apr	32	36	Apr	47	42	43	34
May	47	45	May	53	43	49	28
Jun	30	40	Jun	45	41	55	22
Jul	37	26	Jul	42	33	51	23
Aug	41	48	Aug	47	39	60	33
Sep	34	54	Sep	36	35	36	25
Oct	34	46	Oct	40	31	37	27
Nov	37	42	Nov	40	30	47	33
Dec	29	28	Dec	43	38	36	27
Totals	461	456		470	378	534	328


H&S Events on DatixIQ
60
50
40
30
20
10
0
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
2024
2023

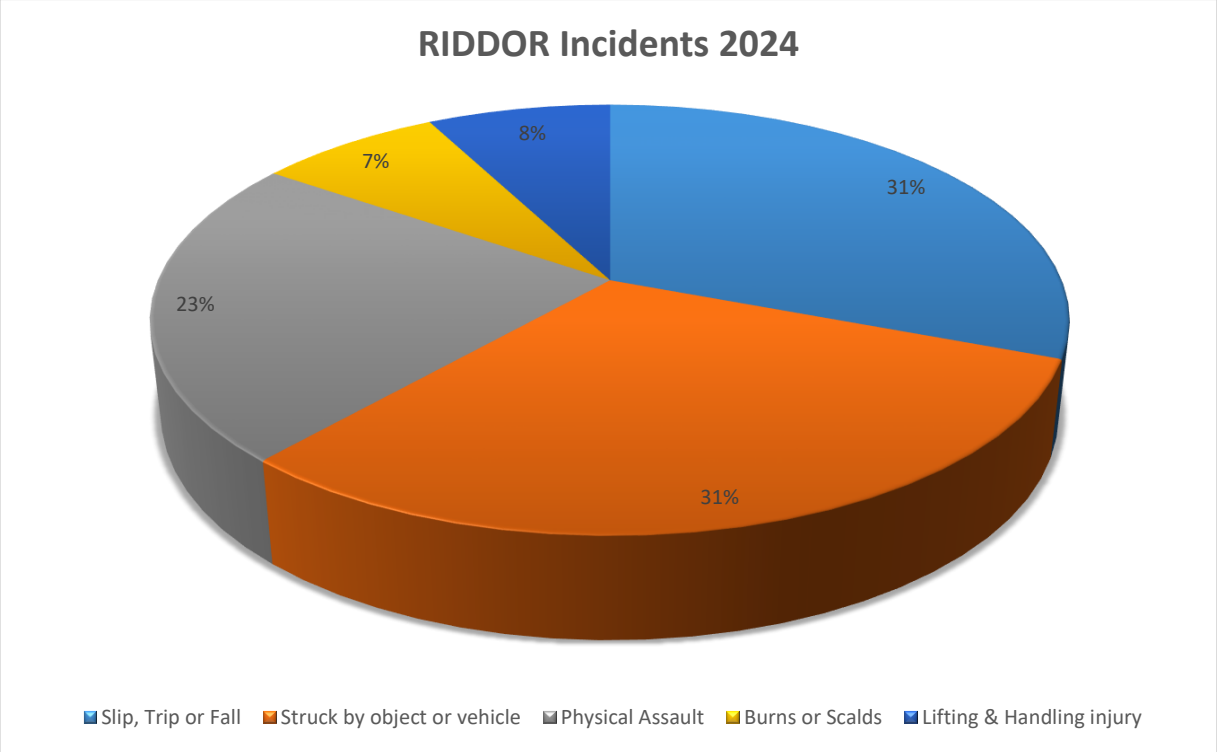

Most Common H&S Incidents 2024
Slips, Trips & Falls (STAFF / NON-PATIENT)
Sharps/needlestick injury (staff / non-patient)
Injury to staff caused by lifting/handling/carrying of patient
Injury sustained by patient - circumstances unknown
Faint/fit/collapse (patient)
Exposure to or contact with harmful substance
Exposure to or contact with biological agent/blood/bodily fluid
Cuts (non needlestick) (staff / non-patient)
Bangs, bumps & traps (STAFF / NON-PATIENT)
Bangs, bumps & traps (patient)
0
10
20
30
40
50
60
70
80

SECURITY / VIOLENCE & AGGRESSION INCIDENTS





RIDDOR INCIDENTS



RIDDORs by CATEGORY

Type of category	Total
Slip, Trip or Fall	4
Struck by object or vehicle	4
Physical Assault	3
Burns or Scalds	1
Lifting & Handling injury	1

Estimated costs (based on HSE 2023 analysis across all industries)

Type of incident	Financial cost (per incident)
Workplace fatal accidents*	£119,200
Non-fatal injuries	
• 7 or more days absence*	£7,800
• Up to 6 days absence	£120
Ill health	
• 7 or more days absence*	£9,200
• Up to 6 days absence	£170

The gathering of Sickness Absence data will provide us with a powerful indicator of health and safety performance, as with our DatixIQ reporting we need to treat this year's collection of data as a continuing development of a baseline from which we can start to assess the impact of improved health and safety performance over the ensuing years.

The following sickness absence reason can be reasonably linked to health and safety performance, although it is not currently possible to identify every instance where work activity is the sole or primary cause of the injury / ill health.

HDFT's number one sickness absence reason for each month of 2024 was anxiety / stress / depression / other psychiatric illnesses, a repeat of 2023. Back problems and other musculoskeletal ill health continue to be within the top 10 monthly figures

HDFT data

Absence Reason	Average no. of absences per month*	Total FTE Days Lost*	Average % of HDFT sickness absence per month*	Estimated salary cost*
Anxiety/stress/depression/other psychiatric illnesses	**126.25** (116.3)	**22,999.53** (16,433.24)	**28.8%** (31.6)	**£2,576,737** (£1,770,639)
Other Musculoskeletal	**45.9** (37.4)	**5766.05** (3615.57)	**7.2%** **(7%)**	**£644,184** (£392,218)
Back problems	**24.9** (21.1)	**3151.37** (1906.36)	**3.9%** (3.64%)	**£348,933** (£204,218)

(*2023 data in brackets)

It is not currently possible for us to clearly state what percentage of the above sickness absence is work related. At present when recording sickness absence on our internal system (ESR) it is not mandatory to confirm whether the absence was work related or not (although the function is available). The following data was available, highlighting the unreliable nature of the data, however in 2025 we will look to formalise this requirement and look to make use of this information for targeting resources and support of staff and managers.

	% of FTE Days Lost		
Absence Reason	**NOT STATED**	**NOT WORK RELATED**	**WORK RELATED**
Anxiety/stress/depression/other psychiatric illnesses	**57.8%**	**39%**	**2.8%**
Other Musculoskeletal	**39.7%**	**60.2%**	**0.1%**
Back problems	**35.5%**	**62.8%**	**1.7%**

It is common for anxiety/stress to be a combination of personal and work issues, and it is therefore difficult to identify where the individual is absent primarily due to personal or work, and that the other is also contributing.

Likewise MSK or back problems developed during personal activities may be made worse by poor work practices or workstations that have not been assessed to comply with the Display Screen Equipment Regulations.

2024 STAFF SURVEY DATA

Health and Wellbeing Themes from 2024 Quarterly Inpulse Surveys

"What additional Health & Wellbeing support could teamHDFT provide that would be of benefit to you?"

WORKLOAD AND STAFFING (424 responses)

High workload leading to stress and burnout – 210 responses – example "we wouldn't need wellbeing support if things were properly managed."

Unrealistic work expectations – 84 responses – example "additional hours required (to get the job done) is almost seen as expected / the norm."

HEALTH AND WELLBEING RESOURCES (422 responses)

Access to mental health support – 182 responses – example "face to face counselling, more than 6 sessions, ongoing input if needed."

Support for physical health (ergonomic needs) – 95 responses – example "ensure I am able to order a chair I require in a timely manner."

MANAGEMENT AND COMMUNICATION (256 responses)

Lack of management support and understanding – 112 responses – example "my manager shouted at me because I wished to go to the funeral of a family member, the impact on staffing mattered, not how I was feeling."

Clearer communication from leadership – 88 responses – example "management often dictates changes and very little consideration is given to the staff that make those changes happen."

WORK-LIFE BALANCE (155 responses)

Time to take breaks and manage workload – 50 responses – example "time out to take lunch breaks. Time away from the laptop."

Condensed or flexible hours– 25 responses – example "opportunity for working condensed hours as previously declined."

ENVIRONMENTAL AND EQUIPMENT ISSUES (62 responses)

Ergonomics and equipment support – 35 responses – example "better workspaces, better seating, more break spaces with air conditioning."

Improved working environment – 27 responses – example "the physical environment we work in is way below anything we should accept for both staff and patients."

HDFT NHS STAFF SURVEY RESULTS 2024

In the last 12 months have you experienced musculoskeletal problems as a result of work activities? – Yes 27.2%
(2023 – 27.5% / Comparator – 31.1%)

In the last 12 months have you felt unwell as a result of work-related stress? – Yes 40.9%
(2023 – 42.2% / Comparator – 42.2%)

In the last 3 months have you ever come to work despite not feeling well enough to perform your duties? – Yes 52.6%
(2023 – 52.4% / Comparator – 56.1%)

Have you felt pressure from your manager to come to work in the last 12 months? – Yes 15.8%
(2023 – 15.7% / Comparator – 21%)

In the last 12 months have you experienced at least one incident of physical violence at work? – Yes 9%
(2023 – 8.2% / Comparator – 14.1%)

The last time you experienced physical violence did you or a colleague report it? – No 36.8%
(2023 – 37.2% / Comparator – 30%)

In the last 12 months have you experienced at least one incident of harassment, bullying or abuse at work from patients, relatives or MoP's? – Yes 19.5%
2023 – 20.6% / Comparator – 25.2%

The last time you experienced harassment, bullying or abuse did you or a colleague report it? – No 46.6%%
2023 – 47.2% / Comparator – 48.5%

In the last 12 months have you experienced at least one incident of harassment, bullying or abuse at work from managers? – Yes 7.7%
2023 – 8.1% / Comparator – 9.6

In the last 12 months have you experienced at least one incident of harassment, bullying or abuse at work from colleagues? – Yes 14.7%
2023 – 16.3% / Comparator – 18.4%

5. HEALTH & SAFETY WORKSTREAMS 2024

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

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

2024 PRIORITY WORKSTREAM - WORK-RELATED STRESS

Strategic Ambition Making HDFT the Best Place to Work

Aims for 2025

Continue to progress implementation of the HSE Management Standards Approach across the Trust, whilst also reducing the common causes of stress (identified during HSE's recent Stress Project across the NHS in England) violence and aggression and musculoskeletal disorders.

Work-related Stress

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

What action has been taken in 2024

Anxiety, stress and depression continues to be the top sickness absence reason across the Trust in 2024, accounting for 28.8% (monthly average, compared to 31.6% in 2023).

This is supported by HSE statistics for 2023-2024 (across all industries) that show there were 1.7million new and longstanding cases of work-related ill health, of which 776,000 were as a result of stress, anxiety and depression.

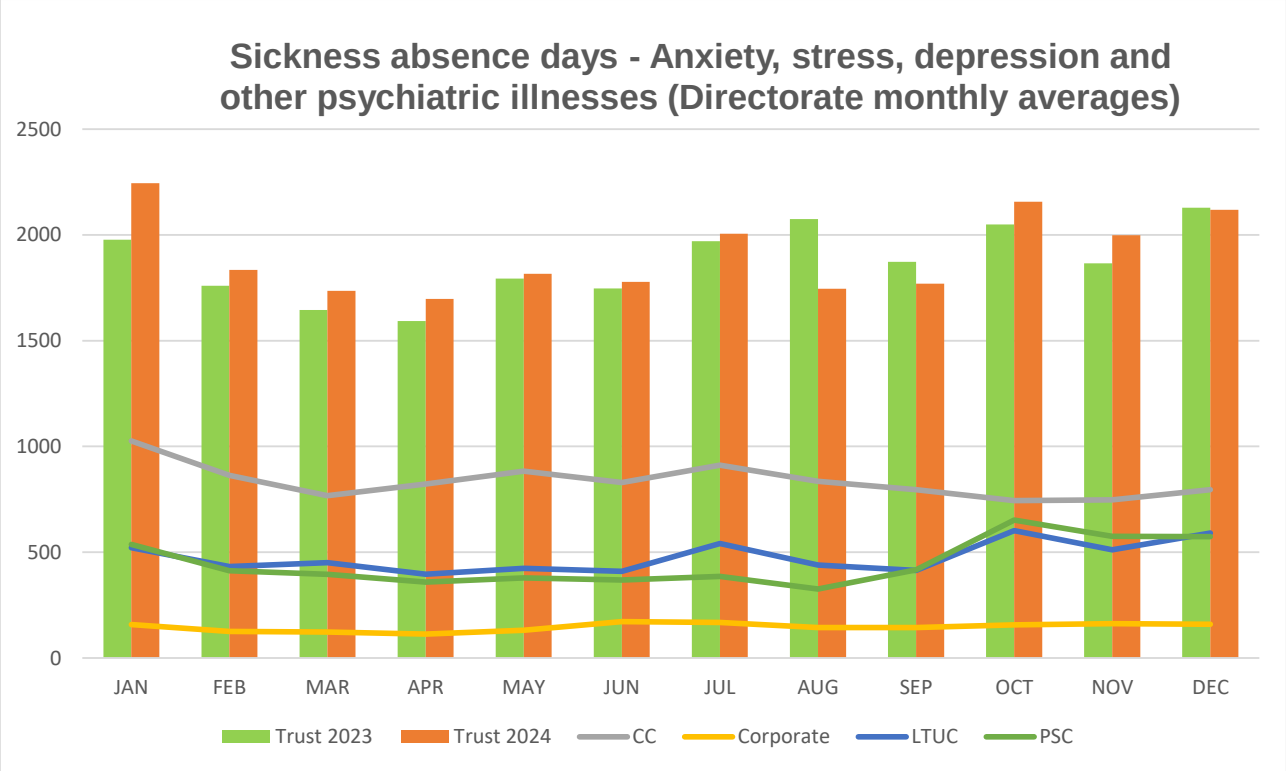
The NHS Staff Survey results for 2024 showed that 40.9% of staff have felt unwell as a result of work-related stress in the last 12 months in comparison to 42.2% in 2023. Phase two of HSEs inspection campaign across the NHS looking at work-related stress, again reinforced that the impact of violence and aggression, and ill health outcomes such as musculoskeletal disorders as key stressors.

During 2024 we have:

- We have completed Trust wide WRS risk assessment and are using this as the basis for completing more localised risk assessments across the Trust.
- The CC Directorate (subsequently CYPPH) has led on this process by incorporating the principles of the Management Standards approach within the Team Charters standard work they have developed for all of their teams, and this work will continue to be supported across all directorates in 2025.
- Team Charter sessions have been supported by the H&S team as well as the Trust Wellbeing manager.
- Focus on two main stressors in healthcare settings – Violence and Aggression and Musculoskeletal Disorders has been targeted. (This work is detailed on pages 16-21)

The table below provides a comparison of sickness absence data in 2024 with previous year, and provides a breakdown by directorate on a monthly basis (it should be noted that October – December directorate numbers will have been affected by organisational changes)

There has been a slight increase in the total number of days lost, as is detailed in section 4 we are unable to attribute definitively how much of this is work-related. In 2025 we will look to improve the use of ESR in identifying when absences have been triggered by work activities.



In 2025 we will continue to:

- Deliver sessions to teams based on the Management Standards Approach – Already booked to be delivered in the first half of 2025 are sessions with teams working in North Yorkshire 0-19, Imaging Services, Research and Innovation, Safeguarding and Children Main Theatres.

- This work is also being reflected within teams who are identifying wellbeing of staff as part of their team metrics using HDFT Impact methodology.
- Create more detailed analysis of sickness data to best target resources at teams / individuals requiring immediate support.
- Work detailed below in other Priority areas of Violence and Aggression and Moving and Handling will continue to support the reduction of work-related stress.
- Work with clinical leads to support the delivery of CRISSP (Critical Incident Staff Support Pathway) training, to help staff manage post incident trauma.

2024 PRIORITY WORKSTREAM - MOVING AND HANDLING

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

Aims for 2025

The aim for 2025 is to continue the work of 2024, focussing on the delivery of tailored training to staff groups, and enabling staff to carry out task specific moving and handling assessments.

Moving & Handling

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

What action has been taken in 2024

Incidents relating to moving and handling remain one of the most reported H&S categories across HDFT (table page 8), with the challenges to the delivery of suitable training and appropriate equipment to all teams across all our geographical locations remaining.

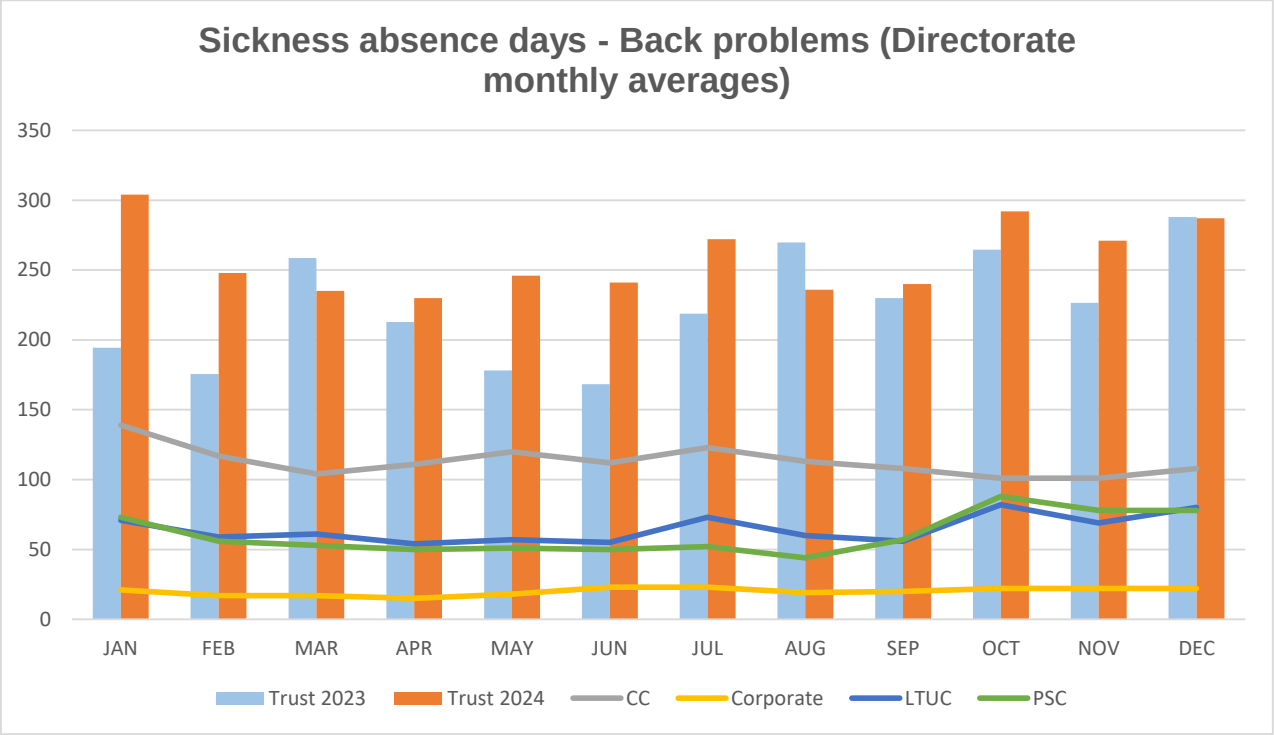
- During 2024 compliance levels for level 2 training compliance have fluctuated between 80% and 85%.This shows no significant change from December 2023and indicates that without additional training resource we will not be able to increase this figure above the Trust standard of 90%.
- Level 1 e-learning training remained over 95% for 2024.
- We have successfully implemented the required changes to our mandatory training to align it with the nationally approved CSTF (Clinical Skills Training Framework) training.
- In reviewing the delivery of level 2 training we have also been able to change the content of training to certain staff groups to provide more tailored / task specific content, resulting in new training being delivered to:
    - ARCH team training in single handed care

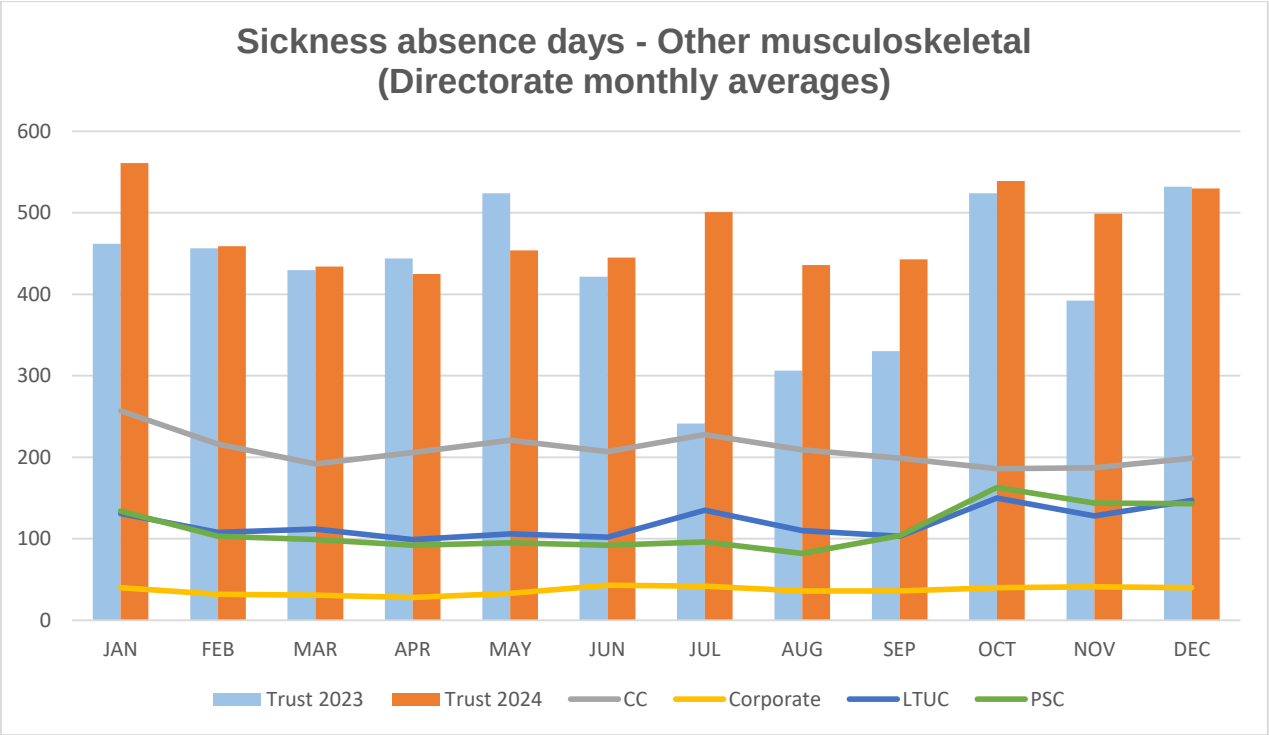
  - Slide sheet drop-in session at Harrogate hospital
  - Porter training
  - Slide sheet training for Ripon Hospital
  - Slide Sheet training for Knaresborough community team
  - Podiatry teams in Scarborough and Selby
  - Cardiology team
  - International nurses' full day induction (new cohort each month)
  - Additional training for all Occupational Therapists.
  - Pharmacy staff.
  - Hornbeam Park medical records teams
  - Radiology staff (x5 sessions)
  - Dental staff located at Monkgate, Northallerton, Malton and Harrogate
  - Maternity drop-in sessions
  - Raizor lift chair training for community education nurses
  - Support for members of staff within main theatres, who will then provide training to theatre colleagues.
  - Palliative care team training
  - Physio team training
  - Silverdale department team training

- In addition to this a training package has been developed relating to the safe handling of bariatric patients.
- In October our Moving and Handling co-ordinator delivered a drop-in training session based on an Escape Room, which has subsequently been praised for its innovation at the National Back Exchange.
- DSE e-learning has been introduced as a mandatory course (one time completion) for all staff to support and improve the completion of DSE assessments.
- Task specific moving and handling risk assessment templates have been created and are now being used by teams across the Trust.
- To support the entire team in SSD, a full moving and handling assessment was carried out reviewing all work practices throughout the department.

Sickness absence days related to back problems and other musculoskeletal injuries continue to be in the top 10 absence reasons on a monthly basis, and there has been a significant increase in total absence days in 2024 compared to 2023 (table page 11).

The following two tables show the absence days on a month by month comparison both for the Trust and by directorate, it should be noted that the directorate figures for October to December will have been impacted by the organisational changes made to the three clinical directorates.





As detailed in section 4, it is currently not possible to identify which absences are due solely or in part to work-related activity, and this will be an objective of 2025 to try to address this challenge.

In 2025 we will continue:

- Tailored changes to training to provide task specific content relevant to the staff being trained.
- To create an increased training resource for delivering moving and handling training, and push training compliance levels above 90%.
- Implement new moving and handling risk assessments to all teams, and implement suitable and sufficient control measures consistently across the Trust.
- Ensure all moving and handling equipment / aids are maintained and safe to use.
- Continuing review of available data to target high risk areas, such as patient handling, and targeting training to address common activities.
- Closely work with clinical leads in relation to the moving and handling of patients post fall, and when carrying out a spinal injury assessment (log rolling etc…).

2024 PRIORITY WORKSTREAM – VIOLENCE & AGGRESSION

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

Aims for 2025

To build on the work started in 2024 in relation to risk assessment, changes to training and implementing a long term strategy for preventing incidents of violence and aggression.

Violence & Aggression, Security & Lone Working

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

What action has been taken / planned

2024 reports via DatixIQ have shown a significant increase from 328 (in 2023) to 378 (in 2024), whilst the overall number of security incidents (including those relating to violence & aggression) has decreased from 534 to 470 over the same period.
Verbal feedback to multiple forums across the Trust indicate that promotion and encouraging staff to report all incidents has impacted this. The table below highlights that whilst the reporting of physical assaults has remained virtually the same, incidents of inappropriate behaviour, verbal abuse and threatening behaviour (incidents more commonly viewed / tolerated as part of the job) have all increased during 2024.

	2023	2024
Total number of Security Incidents	**534**	**470**
Total relating to Violence & Aggression	**328**	**378**
Physical Assault	**59**	**58**
Inappropriate Behaviour	**147**	**157**
Verbal Abuse	**32**	**44**
Threatening Behaviour	**13**	**20**

In December 2024 the Health and Safety Executive wrote to all NHS Trusts in England to inform them of their findings in relation to phase two of an inspection programme looking at causes of ill health in healthcare focussing on musculoskeletal disorders and violence and aggression, which are stressors and major contributory factors to work-related stress.

This reaffirmed the four main categories where management failings have been consistently identified (as in phase one) – Risk Assessment, Training, Roles & Responsibilities and Monitoring & Review. In addition they also highlighted the reluctance to report violence & aggression incidents, conflicting and contradicting guidance within the same organisation, and a lack of collaboration with third parties.
Our work in 2024:

- Trust staff are now actively attending partnership groups to improve joined up working and access to best practice. This has included attendance at the North Yorkshire Right Care, Right Person Group led by North Yorkshire Police. Attendance at the NPAG (National Performance Advisory Group) Violence Reduction & Security Management Network.
- HIF Security Manager and HDFT Head of H&S have both attended training and achieved a Royal Society of Public Health Level 3 Award in Violence Prevention and Reduction for Strategic Specialists.
- North Yorkshire Police attending HDH site on a monthly basis to promote various topics and provide advice to staff and members of the public.
- The Trust Lone Working Policy has been reviewed and updated to reflect all staff groups.
- Level 1 eLearning training was made mandatory for all HDFT staff, compliance already over 90%.
- Lone worker training provided to all Community based staff, compliance in December 2024 over 95%.
- Joint working between our ED team at HDH and our Mental Health Liaison team (Tees, Esk and Wear Valleys NHS Trust) to create a new triage document to ensure patients with mental health issues are supported, and suitable assessments in place to support staff, this has also included training being given to staff on completing this.
- Risk assessments across the Trust have been developed (as detailed in Management of Risk section) to reflect violence & aggression and security risks. Also completed a Trust wide risk assessment for violence & aggression.
- Changes to our physical environment at the HDH site will enhance the security of our site. Improvements to the Goods Yard to be completed in 2025 will include new door installation and swipe access controls for the goods entrance doors and rear estates corridor.

- 2024 also saw the relocation of the GP Out of Hours Service to a new area at the HDH site, to support this new door access controls and cameras were installed to support staff in this area.
- On site security (external contractor) presence increased on site to provide cover 24/7 Friday - Monday and night time cover Tuesday – Thursday.
- Security as a standalone risk has been separated from the overall Violence & Aggression risk register entry. Although the two are intrinsically linked this allows us to focus on the individual elements of each, in particular the environmental infrastructure improvements required.
- HDFT signed up to the NHS Sexual Safety in Healthcare Organisational Charter. Work on this is being led by our Safeguarding team, and has already resulted in new policies being produced in relation to Domestic Abuse (patients) and for Staff experiencing domestic abuse.

Work has started and will continue in 2025 on the following:

- With changes to the NHS Violence Prevention and Reduction Standards being developed in 2024 (published in December 2024) the Trust Strategy has been delayed to 2025 so these changes as well the outcomes of HSE's phase 2 inspection programme can be reflected.
- New Trust Violence & Aggression and Security policies have also been delayed to reflect the above new guidance, and will be implemented in 2025.
- As a Trust we currently provide two levels of Dementia Awareness training, and these are being reviewed to ensure it also provides suitable information in relation to managing V&A risk from patients who have dementia / delirium.
- Although we have developed a training package and trialled its delivery we have needed to delay the wider delivery whilst we review and look to increase our moving and handling training resource to incorporate this new training package.
- All refurbishment or alteration to existing patient facing areas (as well as our new build TIF2) will consider the environmental impact on patients and incorporate best practice installations such as ligature free fittings, doors etc… to create Safe Spaces. This has been reflected in the completed works to ED, ED2 and Wensleydale Ward.
- We have increased the use of lone worker devices to include staff groups at the HDH site, and 2025 will see us extend this use to other appropriate groups within HIF, including out of hours workers and delivery/courier drivers.
- To support our community teams a review of the use and effectiveness of the current lone worker devices is being carried out and will report in 2025.
- Work has also started within HIF to become a licensed security provider, as well as a business case to provide an in-house enhanced security presence at the HDH site.

2024 PRIORITY WORKSTREAM - PHYSICAL WORKING ENVIRONMENT

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

Aims for 2025

The aim for 2025is to continue the work of 2024 to carry out improvements to the physical working environment through addressing the backlog maintenance position as well as identifying and controlling risk associated with fire, water safety and others.

Estates / Backlog Maintenance

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

What action has been taken / planned

As stated in our 2024 Annual Report improvements to our physical environment through addressing the recommendations of the backlog maintenance survey carried out in 2022/23 was made a priority.

(The survey follows the methodology prescribed in NHSE “A Risk based Methodology for Establishing and Managing Backlog” and is in line with the requirements of HBN 00-08 “The Efficient Management of Healthcare Estates and Facilities”.)

The results of the backlog survey, risk assessment and cost profile will continue to inform the urgency of investment decisions as follows:

- Low risk elements can be addressed through agreed maintenance programmes or included in the later years of your estate strategy.
- Moderate risk elements should be addressed by close control and monitoring. They can be effectively managed in the medium term so as not to cause undue concern to statutory enforcement bodies or risk to healthcare delivery or safety.
- Significant risk elements require expenditure in the short term but should be effectively managed as a priority so as not to cause undue concern to statutory enforcement bodies or risk to healthcare delivery or safety.

- High risk elements must be addressed as an urgent priority in order to prevent catastrophic failure, major disruption to clinical services or deficiencies in safety liable to cause serious injury and/or prosecution.

In 2024 we have delivered multiple Capital Projects, including:

- Backlog Maintenance projects were delivered across **6 key workstreams**.
- **Water Safety** – work was started in 2024 to upgrade the domestic hot water supply in Strayside Wing (work will complete in March 2025). This work will directly support improvements to water safety and how we manage the risks associated with Legionella.
- **Patient safety / security** – the Nurse call and door access systems on Bolton Ward were upgraded. The new ASCOM system will be rolled out across the HDH site.
- **Fire Safety** – upgrades to fire stopping and the installation of new fire doors in the x-ray basement commenced in November 2024 and will be complete by February 2025. Improvements made to compartmentation in relation to the Café Bistro (completed in 2024), with additional works to replace fire doors within the main reception area to be completed in early 2025.
- **Workplace Transport** – Design works and logistics plans completed in relation to phase 1 improvements to the Goods Yard, work on site to begin in January 2025 and be completed by April 2025. (see workplace transport section for further detail)
- **Mechanical & Electrical Safety (Fire)** – Replacement of the boiler in Heatherdene complete. Upgrades to key switchboards in ED and the new Silverdale completed in 2024.
- **Environmental upgrades (DSU theatres 1&2)** – Design and logistics work completed in 2024 to provide floors, wall and ceilings upgrades, new surgeon panels, fire doors to theatres 1 & 2, and work to install a new nurse call system throughout DSU. To support operational activity the work will be carried out across March and April 2025

Further Capital Projects started or completed in 2024 include:

- Demolition of Block and the start of the TIF2 build phase, to provide new theatre capacity and Imaging Services Department (work to complete in October 2026).
- Development of the former Medical Records area at HDH site, to form new Outpatient department.
- Transfer of medical records and associated teams to Hornbeam Park site, with upgrade to staff welfare facilities included.
- New Portakabin build and installation of new CT scanner.
- Works to upgrade and install new equipment in Imaging Services x-ray room 3.
- Works to Grove Park site to facilitate the delivery of patient services from new location as well as provide improved staff base.
- Works to refurbish areas of the Briary wing to improve staff and patient areas, including welfare, as part of the Block C relocation.

We have also implemented a Wellbeing Fund, responding to the direct requests of staff across the HDFT footprint, this has included:

- Upgrades to flooring, decoration and new blinds in office spaces.
- Upgrades to staff kitchens, and the provision of new kitchen goods.
- New furniture to improve shared staff areas, as well as individual needs.
- Additional staff lockers.
- Improved external areas, including a seating area at Lascelles and staff POD in the Briary wing courtyard.

In addition we were also able to relocate all staff from 50 Lancaster Park Road (office space), as this was no longer deemed suitable as a staff base. The majority of staff were moved to new office accommodation in the Harrogate area, with other relocated at the HDH site.

Water and Ventilation Safety

In addition to the capitals works outlined above, the Trust has continued to make improvements in the management of water and ventilation safety. Reporting directly to the TRUST IPC Committee, the two groups also provide assurance reports to the H&S Committee. Additional highlights for 2024 include:

- ILM Accredited Responsible Person Training delivered to all member of the Water Safety Group.
- Site flushing records produced and reviewed on a weekly basis by IPC and Facilities teams.
- 6 monthly Authorising Engineers Reports produced for Water and Ventilation, and presented to both Groups.
- Planned Preventative Maintenance and Legionella sampling compliance improved with the use of MICAD. New colour coded system for management and replacement of shower heads and hoses.
- New legionella sampling schedule reviewed and commenced May 2024.
- Individual AHU's have their own digital maintenance record.
- Pseudomonas sampling every 6 months (or as determined by positive samples) reported and reviewed at Water Safety Group / Ventilation Safety Group.
- New Legionella and Pseudomonas risk assessments completed for HDH site and surrounding buildings.
- Annual verification of all critical ventilation systems completed.

Management of RAAC

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

What action has been taken / planned

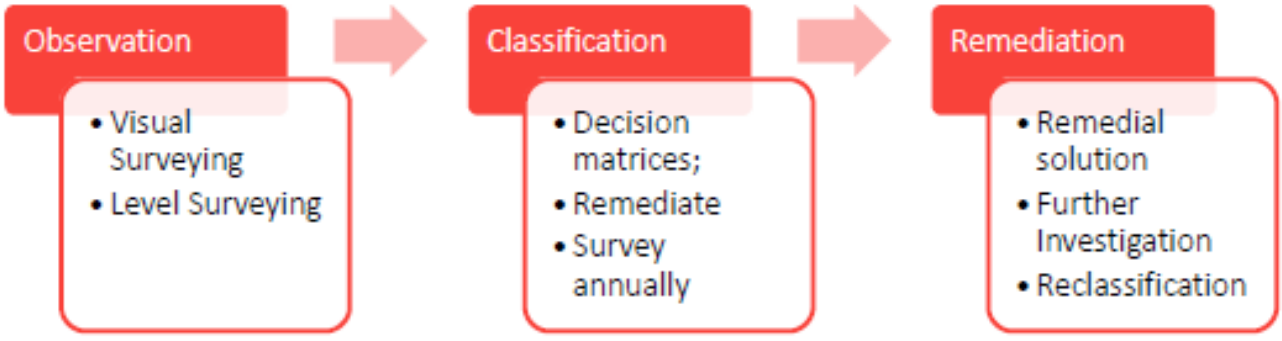
We have continued to carry out remedial work to mitigate against the risk of RAAC panels collapsing, and ultimately the eradication of all RAAC panels from the HDH site.

In 2024 we have delivered:

- Year 2 surveying of the HDH site by a structural engineer was completed, including both visual and deflection surveys.
- Demolition of Block C as part of the TIF2 development, resulting in the eradication of approximately 50% of the RAAC panels at the HDH site.
- Work to install safety netting within the Energy Centre started in November 2024 and will be completed by April 2025.
- Failsafe works throughout the Estates/workshop areas were started in November 2024 and will be completed by March 2025.
- E17 corridor failsafe works – completed in 2024.
- Further remedial to 163 panels designed and will be carried out in early 2025.
- Work to replace the RAAC panel roof of the Kitchen Plantroom began in November 2024 and will be completed by June 2025.
- Design of failsafe works to panels around rooflights agreed, work to be carried out in early 2025.
- Assurance has now been received from ALL Community landlords regarding the RAAC status of these buildings, currently there is no risk to HDFT staff associated with RAAC panel collapse.

In 2025 we will continue to monitor and assess the condition of the RAAC panels, the mitigation measures installed and the carry out any newly identified remedial action with a view to eradicate RAAC from the HDH site by 2030, in line with the process below.

Submissions are being made for additional funding to continue with the progress made to date.



2025 will see HDFT deliver 0-19 services in two new areas (Cumberland, and Westmorland & Furness), as we did previously we will gather assurances in relation to RAAC for all premises inherited through this process.

Workplace Transport – HDH Goods Yard

Standard	Effective arrangements in place to manage the risks from vehicle movements on site.
Rationale	The risk to pedestrians from vehicles at work is a major cause of accidents in the workplace. At HDH the Goods Yard is a high risk of pedestrian injury due to the physical constraints of the yard and the volume of vehicle movement.
Legal reference	Health and Safety at Work etc. Act 1974 Management of Health and Safety at Work Regulations 1999 Workplace (Health, Safety and Welfare) Regulations 1992 Provision and Use of Work Equipment Regulations 1998

What action has been taken / planned

The HDH site is located in the centre of a busy urban area, with high volumes of traffic visiting both the HDH site and surrounding area. The delivery and collection of goods at HDH is serviced primarily by a single Goods Yard area, which also handles the site's main waste storage and collection.

The Goods Yard was identified in 2023 as a high risk area for workplace transport, with the risk added to the H&S Risk Register and escalated to the Executive Risk Group.

In 2024 we delivered the following in relation to workplace transport:

- Risk assessment continued to be reviewed during this period, with further work on correlating the risks faced by the variety of teams requiring access.
- Backlog Maintenance programme was agreed in 2024, with designs and contractor appointment in place by December 2024. The work to be started in January 2025 and completed by financial year end (April 2025).
- The agreed scope of work to include, new security fencing to provide a protected walkway for pedestrians and secure gate entrance to the yard. Resurfacing of entire yard area to also include new concrete pads for waste skips, and new concrete pad adjacent to the oxygen tanks (reduce risk associated with gas storage). New secure doors to the loading bay entrance, and swipe card access controls to the rear estates area from the main hospital corridor.
- The above work will provide us with greater control of those able to access not only the goods yard but also the estates / kitchens area and reduce both of the related workplace transport and security risks.
- Work has also been completed on a number of drop kerbs around the HDH site to improve pedestrian walkways.
- Written instructions have now been given to all regular contractors accessing the Goods Yard, and the presence of the security guard allowed us do provide hard copies to all irregular visitors / couriers etc…

Fire Safety – Assessment, Control Measures & Evacuation

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

What action has been taken / planned

The identification and management of risk associated with fire remains on the H&S Risk Register and escalated to the Executive Risk Group.

In 2023 were able to create an SLA with Leeds Teaching Hospitals to provide the Trust with expert Fire Safety Management, and an external contractor is carrying out new fire risk assessments for all areas at HDH. Unfortunately a lack of capacity at LTHT meant this contract had to be terminated and the Trust sought an alternative solution to this.

In 2024 we delivered the following:

- Through HIF we have recruited a permanent Fire Safety Manager, providing a single point of contact for all Fire related matters.
- With completion of the Oakleaf fire risk assessments (FRAs) at the end of 2023 (approx. 150 assessments), in 2024 we were able to share the findings of these assessments with all the relevant areas, and allow for identified remedial action to commence.
- Since the appointment of the new Fire Safety Manager we have also been able to start the review of the new FRAs and create a new template tailored specifically to our needs. BY the end of 2024 we had carried out reviews of all patient sleeping areas, and transferred the results to the new template.
- These reviews carried out by the new Fire Safety manager has also allowed us to identify and remedy gaps in training, and has resulted in multiple additional training sessions being given to staff, including evacuation and use of fire extinguishers.
- Backlog Maintenance work agreed in 2024 has also included a number of fire improvements across the HDH site including:
    - Upgrades to fire stopping and the installation of new fire doors in the x-ray basement (commenced in November 2024 and will be complete by February 2025.)
    - Improvements made to compartmentation in relation to the Café Bistro (completed in 2024).
    - Additional works to replace fire doors within the main reception area to be completed in early 2025.
    - Mechanical and electrical upgrades in Heatherdene, and to key switchboards in ED and the new Silverdale (all reducing related fire risks, completed in 2024).

  - Environmental upgrades (including the completion of Wensleydale Ward, Silverdale and works to be completed in DSU theatres 1&2 all incorporated fire upgrades, including doors and compartmentation.

- 2024 also allowed our estates team to complete a detailed assessment of all fire doors across the HDH site, and begin the process of carrying out identified remedial action, or identify those that require full replacement. This work will be ongoing in 2025.
- With the creation of the new FRA template to be used at the HDH site work has also been completed on a new FRA template to be completed at all of our community settings.
- 2025 will see a new FRA being completed for every community setting used by our staff, this work will be prioritised based on risk across the four quarters of 2025 (approx. 120 properties).

2024 ADDITIONAL WORKSTREAMS

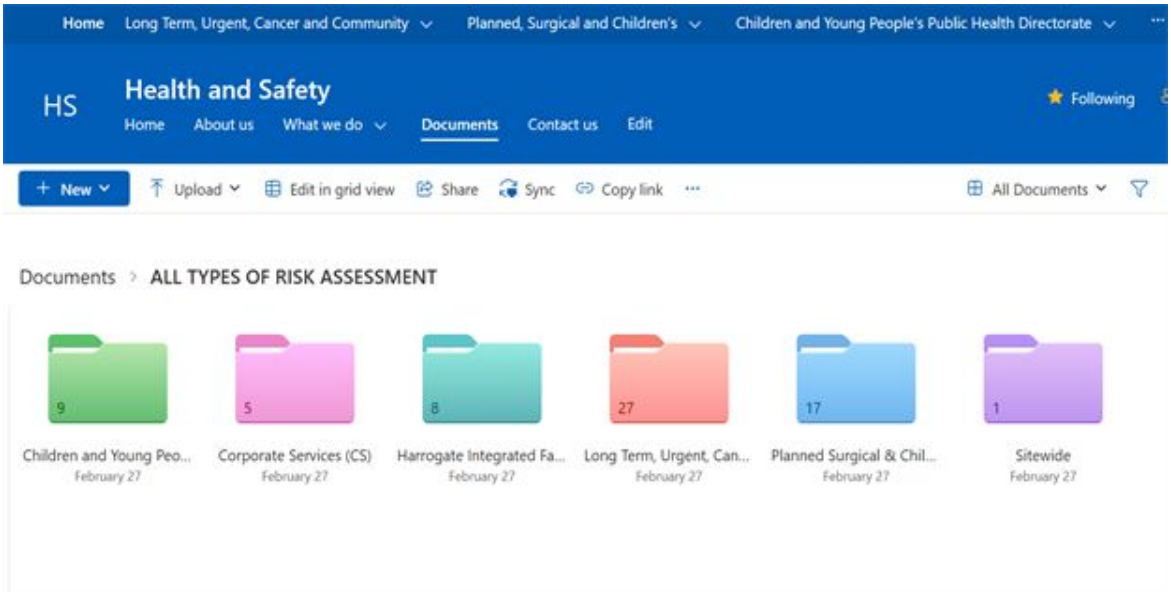
Identification and Management of Risk – Risk Assessment

Standard	The carrying out of suitable and sufficient assessments of the risks to which employees and others might be exposed.
Rationale	To allow the Trust to identify and implement reasonably practicable measures to control significant risks.
Legal reference	Health and Safety at Work etc. Act 1974 Management of Health and Safety at Work Regulations 1999

What action has been taken / planned

The creation of new risk assessments across the entire Trust continues with phase 1 now nearing completion in December 2024.

- The H&S team has met with all teams across HDFT and HIF and completed initial risk assessments in the majority of areas, supporting teams / departments in identifying hazards across their areas, and identifying suitable control measures to eliminate or reduce the level of risk.
- In a number of areas, phase 2 work has commenced in creating standalone assessments for higher risk activities, providing a more detailed assessment, such as Moving & Handling or use of specific work equipment.
- Development of the new Trust Intranet through SharePoint has allowed the team to create a new H&S page which is now being populated with all relevant documentation, including risk assessments, COSHH assessments, fire assessments and relevant guidance and is accessible by all staff. The page is structured to allow each team/department to have its own dedicated area to enhance accessibility and allow local review where appropriate.



- New Display Screen Equipment eLearning has been made available to all staff to assist in the carrying out of individual DES workstation assessments.
- Trust wide risk assessments have been produced in relation to work-related stress and violence & aggression which will be used by teams/departments to inform local assessments.

Management of Contractors

Standard	Effective arrangements in place to manage, coordinate and supervise contractors working on behalf of HDFT
Rationale	Poorly managed contractors on site can result in fatalities, major injuries and ill health to staff, patients and visitors.
Legal reference	Health and Safety at Work etc. Act 1974 sections 2 & 3 Management of Health and Safety at Work Regulations 1999 Construction (Design and Management) Regulations 2015

What action has been taken / planned

To support changes to this:

- A new Contractors Policy has been implemented across the Trust.
- Reset Compliance System (competence-verification product) has gone live at the HDH site (initially being applied to contractors appointed by HIF), this is used for signing in/out contractors to site and monitoring work.
- The Reset system requires all contractor employees to complete a Trust approved induction package before they are allowed to work on site. An adapted version of this induction is provided to all major project contractors (CDM projects) so that it can be included in their induction processes.
- In 2025 we will begin to expand the contractor process more fully to the smaller number of contractors not appointed by HIF.

Extensive work and support continues to be carried out by the Estates and Health & Safety teams to robustly monitor all capital works projects, including reviewing contractor procedures and health and safety site audits of the work.

Community Assurance & Support

Standard	Effective arrangements are in place to ensure the risks to which community based teams / staff are exposed are adequately controlled.
Rationale	The geographical footprint of the community based services provided by HDFT mean that staff are exposed to a wide range of hazards in varied environments including buildings not owned/managed by HDFT and patient homes.
Legal reference	Health and Safety at Work etc. Act 1974 Management of Health and Safety at Work Regulations 1999 Workplace (Health, Safety and Welfare) Regulations 1992 Control of Substances Hazardous to Health Regulations 2002

What action has been taken in 2024

- H&S Advisor (Community) has completed initial visits to all community locations in 2024, carrying out building and environment checks for all these locations. This has allowed us to start identifying gaps in our assurances / controls, and allow us to focus our work in 2025. (types of assurances being collected, and expected frequency

Item check - frequency
Asbestos re-inspection check 1Y
Electrical Installation Condition Report 5Y
Emergency Lighting - Various Types - 1M
Fire Door Inspection and Test Process 6M
Fire Extinguishers - various types - 12M
Hot and Cold Water Systems Temperature Process 12M
TMV Failsafe Check Process 12M
Car Parks - Multi-Storey and Underground - 12M
Swing Doors - 6M
Fire Alarm System - 6M
Fire Alarm Systems - Weekly Test
Sewage or Drainage Pumps Submersible - 12M
Secondary Hot Water Circulating Pumps - 12M
Inspection of Closed Water System Expansion Vessels 12M
Inspection of Pressurisation Units - Chilled Water, Condenser Water and LTHW Types 12M

- All community teams continue to finalise / complete / review their new risk assessments in conjunction with the H&S team.
- Security assessments have continued to be progressed, led by our LSMS (HIF)

- A review of lone working procedures has been completed by the Community Local Security Management Specialist, including the use of lone worker devices, this will feed in to a security review across the Trust in 2025.
- Continuing in 2025 we will be implementing task specific / high risk assessments, as well as focussing on new Fire Risk Assessments for all community locations which will be used in conjunction with wider landlord building assessments.

Control of Substances Hazardous to Health (COSHH)

Standard	Effective arrangements in place to manage the risks from substances hazardous to health.
Rationale	Hazardous substances including both chemical and biological agents can cause significant ill health to employees, patients, and others. Examples include: • Exposure to blood borne viruses, such as HIV, Hep B and C, from handling bloods • Exposure to wet work, causing skin diseases such as dermatitis • Handling of chemicals such as formaldehyde and cytotoxic drugs • Handling of cleaning and maintenance products. • Exposure to infectious diseases such as SARs
Legal reference	Health and Safety at Work etc. Act 1974 sections 2 & 3 Management of Health and Safety at Work Regulations 1999 Control of Substances Hazardous to Health Regulations 2002 Personal Protective Equipment at Work Regulations 1992

What action has been taken / planned

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

As such we need to ensure that the use / exposure to any of these substances is suitably risk assessed and that where we are unable to stop the use of or substitute for a lees harmful product, that we implement control measures that will prevent ill health.

To achieve this we have taken the following action in 2024 which will then be expanded on in 2025:

- Established a new COSHH Steering Group which is chaired by our Chief Pharmacist, reflecting the high number of potentially harmful drugs staff are required to handle. The Group has representation from all areas of HDFT and HIF, and will provide assurance to the Trust H&S Committee.
- Representatives from the Group have liaised with counterparts at other NHS Trusts to gain best practice knowledge to inform the terms of reference for the group and also inform changes to our COSHH Policy and how we carry out COSHH assessments.

- A new COSHH Policy has been written and approved outlining 5 key areas of work that will be focussed on in 2025, these are:

    1. **COSHH Risk Assessments**, details what needs to be taken into consideration when completing COSHH Risk Assessment including, the scope of the COSHH regulations, how to assess the risks, deciding if any additional measures are required and documenting the risks.
    2. **Selection, Use, Maintenance, Examination and Testing of control measures**, covers when a COSHH assessment concludes that the control of exposure to hazardous substances is inadequate, or where a new process or substance is introduced, the steps to be taken to introduce measures which will give adequate control.
    3. **Exposure Monitoring,** states that exposure to substances hazardous to health should be prevented, or at least controlled. Where substances with Workplace Exposure Limits (WELs) are used, control measures such as engineering controls are required to prevent or control exposure. These include a variety of systems e.g. fume cupboards. The purpose of exposure monitoring is to provide assurance that these engineering controls are controlling exposure to the hazardous substance.
    4. **Health Surveillance** may be needed to protect the health of staff exposed to a substance hazardous to health. The ward or departmental manager must carry out COSHH risk assessments and work with the Occupational Health Service (OHS) to ensure health surveillance is in place where necessary, the objectives of health surveillance include protecting the health of staff and ensuring measures taken to control exposure are adequate in the event of a member of staff requires it, for example in a latex allergic member of staff.
    5. **Storage, Spillage & Disposal,** covers what needs to be taken into consideration when storing substances hazardous to health, and the actions that need to be taken in the result of a spillage. It links to other Trust procedures that deal with the disposal of hazardous substances.

- In relation to training we have developed and delivered new COSHH Awareness training to our Domestic teams in HIF, which will now be extended to further staff groups in 2025 (training has been adapted in to an online training module to facilitate easy access).
- An additional training package is being developed to provide training to staff required to carry out COSHH risk assessments and will go live in 2025.
- Flammable and oxidising substances will be risk assessed and managed using the arrangements for hazardous substances as detailed in this COSHH Policy. To support this we have reviewed and amended the policy for Safe Handling of Flammable and Oxidising Substances (completed in 2024).

Where contractors are working with hazardous substances in shared areas they will provide their own COSHH risk assessments and share their findings with relevant Trust staff, this is supported by information included in the induction provided to all contractors.

The Occupational Health team are leading on work to support staff who are exposed to needlestick injuries:

- In 2024 this has included reviewing the process for ensuring staff are instructed on the immediate actions that need to be taken when a needlestick injury occurs, developing promotional material to inform all staff groups.
- Reviewing DatixIQ report to ensure any staff members who initially do not access Occupational Health support are contacted ASAP.
- 2025 will see a full review and amendments to the existing Blood Bourne Viruses Policy to reflect a wider approach covering all Body Fluid Exposure.

Health and Safety Risk Register Entries - December 2024

CHS1 – Identification and Management of Risk	Organisational risk to compliance with legislative requirements due to a failure to make a suitable and sufficient assessment of the risks to the health and safety of employees, patients and others. COMPLETE - TARGET SCORE MET
CHS2 – HDH Goods Yard*	Organisational risk to compliance with legislative requirements, with the risk of major injuries, fatality, or permanent disability to employees, patients and others, and the unauthorised access of persons to restricted areas of the hospital through the loading bay entrance. TARGET SCORE TO BE MET APRIL 2025
CHS3 - Managing the risk of injury from fire*	Organisational risk to compliance with legislative requirements, with the risk of major injuries, fatality, or permanent disability to employees, patients and others due to the failure to ensure that suitable and sufficient assessment of the risk from fire has been carried out, and that the necessary control measures are in place. TARGET SCORE TO BE MET BY JUNE 2025
CHS4 – Control of contractors / construction work	Organisational risk to compliance with legislative requirements, with the risk of major injuries, fatalities, or permanent disability to employees, patients and others, due to the failure to manage the impact of contractors, and construction work at Trust premises. COMPLETE – TARGET SCORE MET
CHS5 - Violence and Aggression*	Organisational risk to compliance with legislative requirements, with the risk of major injuries, fatality or permanent disability to employees due to the failure to manage the risk of staff being subjected to acts of violence and aggression whilst carrying out normal duties, due to lack of suitable control measures and appropriate training. TARGET SCORE TO BE MET 2025
CHS6 – Moving & Handling	Organisational risk to compliance with legislative requirements, with the risk of major injuries, fatalities, or permanent disability to employees, patients and others due to failure to provide suitable and sufficient training for moving and handling. ONGOING – RISK TO BE COMBINED WITH L&D RESOURCE RISK
CHS7 – Community Services	Organisational risk to compliance with legislative requirements, with the risk of major injuries, fatalities, or permanent disability to employees, patients and others due to the failure to ensure H&S standards, procedures and control measures are in place for Community based staff/services. COMPLETE – RISK BEING REVISED TO REFLECT SEPARATE RISKS INCLUDING FIRE, SECURITY, WATER SAFETY ETC…
CHS8 – RAAC Roofing	Organisational risk to compliance with legislative and NHSE requirements, with the risk of major injuries, fatalities, or permanent disability to employees, patients and others, due to the failure to manage the risk associated with RAAC roofing. RISK SCORE REDUCED – ONGOING WORK CONTINUES AS DESCRIBED ABOVE
CHS10 - Security*	Organisational risk to compliance with legislative requirements, and the risk of major injuries, fatality or permanent disability to employees, patients, visitors or others due lack of suitable policies and procedures, and the subsequent lack of suitable and sufficient control measures, including physical security provision, training, resources to support implementation. RISK ADDED SEPTEMBER 2024

*** currently escalated to Corporate Risk Register**

6. HEALTH & SAFTEY PRIORITIES FOR 2025

Commitment to a Culture of Continuous Improvement

2025 will see us continue at HDFT to ensure health and safety standards are raised to acceptable levels, achieving legal compliance and matching industry best practice, whilst also striving for Continuous Improvement that will ultimately lead to HDFT being an exemplar for health and safety management within the NHS and beyond. As an organisation we are implementing HDFT Impact which will provide the standard Continuous Improvement methodology to support all staff to take action at the right level to make improvements.

Our priorities in 2024 focussed on four key areas that would support us in improving the health, safety and wellbeing of our staff, patients and others, whilst also contributing to HDFTs strategic ambitions **Making HDFT the Best Place to Work** and **Best Quality & Safest Care**. These choices were also supported by the limited data we have started to gather at Trust level, as well as general evidence from recognised healthcare guidance (HSE and CQC) and wider NHS staff survey results.

Based on the continued need to make improvements in Work-Related Stress, Moving and Handling, and Violence and Aggression, these will continue to remain priorities for 2025. We also continue to make improvements to our physical environment both at the HDH site and at our other locations, and this work will continue. However, our incident data as well as RIDDOR accidents indicate our priority with regards our physical working environment should be focussed on the prevention of Slips, Trips and Falls.

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

- Work-Related Stress
- Moving and Handling
- Violence and Aggression
- Physical Working Environment – reduction in Slips, Trips and Falls

WORK-RELATED STRESS

Strategic Ambition Making HDFT the Best Place to Work

Aims for 2025

Continue to progress implementation of the HSE Management Standards Approach across the Trust, whilst also reducing the common causes of stress (identified during HSE's recent Stress Project across the NHS in England) violence and aggression and musculoskeletal disorders.

Objectives

The objectives for 2025 include:

- Continued delivery of Work-related stress workshops.
- Risk assessments and action plans produced locally for each team.
- Changes to the recording of sickness absence to identify work-related absence.

- Workshop held with Senior Management Team to promote and support senior participation in the process and to embed change where appropriate.
- Collection and analysis of team feedback to identify common issues and to evidence wider organisational changes.
- Continued review of relevant policies / procedures / risk assessments.

Performance measures

- Sickness Absence Days and associated salary costs
- Impulse staff surveys
- NHS Staff Survey
- Datix incidents associated with trauma or known stressors such as violence and aggression

MOVING AND HANDLING

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

Aims for 2025

The aim for 2025 is to continue the work of 2024, focussing on the delivery of tailored training to staff groups, and enabling staff to carry out task specific moving and handling assessments.

Objectives

The objectives for 2025 include:

- Continued changes to the delivery of the training to reflect the diversity of the Trust, both in the types of services delivered and the geographical setting.
- Tailored changes to training to provide task specific content relevant to the staff being trained.
- To create an increased training resource for delivering moving and handling training, and push training compliance levels above 90%.
- Implement new moving and handling risk assessments to all teams, and implement suitable and sufficient control measures consistently across the Trust.
- Ensure all moving and handling equipment / aids are maintained and safe to use.
- Continuing review of available data to target high risk areas, such as patient handling, and targeting training to address common activities.
- Closely work with clinical leads in relation to the moving and handling of patients post fall, and when carrying out a spinal injury assessment (log rolling etc…).

Performance measures

- Sickness Absence Days and associated salary costs
- Datix incidents
- Moving and handling training compliance
- Staff / Patient harm incidents
- RIDDOR reportable injuries

VIOLENCE AND AGGRESSION

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

Aims for 2025

To build on the work started in 2024 in relation to risk assessment, changes to training and implementing a long term strategy for preventing incidents of violence and aggression.

Objectives

The objectives for 2025 include:

- Review and update of all relevant policies in line with the recently updated (December 2024) NHS Violence Prevention and Reduction Standards.
- Build on the mental health triage process being used in ED to support staff and patients across the Trust.
- Build on the successful implementation of Level 1 Conflict Resolution training to increase the delivery of Level 2 Conflict Resolution – Breakaway Skills training to more frontline staff.
- Work with clinical leads to support the delivery of CRISSP (Critical Incident Staff Support Pathway) training, to help staff manage post incident trauma.
- Support a Trust review of security provision across HDFT, including the use of physical security guards, lone working devices and upgrades to security infrastructure (CCTV, Door Access systems).
- Implementation and promotion of a new HDFT Violence Prevention and Reduction Strategy (3-5 year strategy, including collaboration with external partners / stakeholders)
- Continue to generate, review and implement the outcomes of risk assessments relating to violence and aggression.

Performance measures

- Sickness Absence Days and associated salary costs
- Datix incidents
- Violence & Aggression related training compliance
- Staff / Patient harm incidents
- RIDDOR reportable injuries

SLIPS, TRIPS & FALLS (Maintaining our Physical Working Environment)

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

Aims for 2025

The aim for 2025 is to build on the significant amount of improvements we have made to our physical environment and focus this on the wider context of preventing slips, trips and falls through maintaining, repairing and refurbishing our working environment to reduce / eliminate the physical causes of slips, trips and falls.

Standard	Effective arrangements are in place to ensure the risks of slips, trips and falls are manage.
Rationale	Slips, Trips and Falls are the largest cause of health and safety incidents at HDFT (excluding incidents relating to violence and aggression), affecting staff, patients and others.
Legal reference	Health and Safety at Work etc. Act 1974 Management of Health and Safety at Work Regulations 1999 Workplace (Health, Safety and Welfare) Regulations 1992 Personal Protective Equipment at Work Regulations 1992

Objectives

The objectives for 2025 include:

- Identify areas (and resources) to continue refurbishment work carried out in 2024, such as the wellbeing works, ward upgrades.
- Ensure systems are in place to maintain and repair existing environment through Estates teams, and facilities teams within community locations.
- Review existing related policies and procedures, including Slips, Trips and Falls Policy, response to extreme weather, cleaning procedures.
- Ensure suitable and sufficient risk assessments are in place for all areas that consider:
    - Environment risks
    - Processes, such as cleaning of floors.
    - Response to adverse weather conditions.
    - Use of appropriate footwear (PPE).

Performance measures

- Datix incidents
- RIDDOR incidents
- Health and safety audits

Board Meeting held in public

May 2025

Title:	Adult Inpatient, Emergency Department and Children and Young People Inpatient Ward, Safer Nursing Care Tool (SNCT) Bi-annual Safer Staffing Review
Responsible Director:	Alison Smith
Author:	Brenda Mckenzie

Purpose of the report and summary of key issues:	The purpose of this paper is to provide the Board of Directors with assurance of the January 2025 Safer Nursing Care Tool (SNCT) for the Adult Inpatient ward, Emergency Department and Children and Young People (C&YP) Inpatient Nurse staffing levels at Harrogate District NHS Foundation Trust, as recommended by the Developing Workforce Safeguards (NHSI 2018) which builds on the National Quality Board (NQB) standards (2016). The Developing Workforce Safeguards, reinforces the requirement for Trusts to adopt a triangulated approach in relation to the use of evidence-based tools, professional judgement and patient outcomes to provide assurance of safe, sustainable and effective staffing. Compliance with the principles outlined in the document is to be assessed bi-annually	
Trust Strategy and Strategic Ambitions:	**SNCT Safer Staffing**	
	Best Quality, Safest Care	
	Person Centred, Integrated Care; Strong Partnerships	
	Great Start in Life	
	At Our Best: Making HDFT the best place to work	
	An environment that promotes wellbeing	
	Digital transformation to integrate care and improve patient, child and staff experience	
	Healthcare innovation to improve quality	
Corporate Risks:	Safer Staffing Levels; triangulated approach in relation to the use of evidence-based tools, professional judgement and patient outcomes to provide assurance of safe, sustainable and effective staffing.	
Report History:	Strategy Deployment Room (May 2025) Quality Committee (May 2025)	
Recommendation:	The Strategy Deployment Room and Board Sub-Committees have accepted the SNCT review of the Adult inpatient, Emergency Department and C&YP inpatient ward safer staffing review. This is included in the Board Supplementary Papers for information.	

	Adult Inpatient Wards PSCC: The SNCT outputs (data, quality metrics and professional judgement) indicate no changes to the current budgeted establishment as a result of this review. LTUCC: The SNCT outputs (data, quality metrics and professional judgement) indicate minor changes to the establishment as a result of this review. These changes are within the current budgeted establishment and no additional funding is required. These recommended changes are being presented to the Establishment review panel on 20th May 2025. **Emergency Department** The SNCT review has given us assurance that the Emergency Department, establishment and skill mix, achieves optimal safe staffing requirements. However the data shows a requirement to alter the shift patterns to meet the changes in demand for the service. These shift adjustments are within the current budgeted establishment and no additional funding is required. The recommended changes are being presented to the Establishment review panel on 20th May 2025. **C&YP (Woodlands Ward)** The SNCT outputs (data, quality metrics and professional judgement) indicate an accurate nursing establishment for the current Woodlands Ward requirements and that no changes are proposed as a result of this review. However, the Children's Assessment Unit (CAU) service review and redesign may influence additional changes in the future. The next bi-annual safer staffing review will be undertaken in May 2025 for ED and June 2025 for the Adult and C&YP inpatient wards.

Freedom of Information:	

SAFER STAFFING REPORT MAY 2025

Adult Inpatient, Emergency Department and Children and Young People Inpatient Ward, Safer Nursing Care Tool (SNCT) Bi-annual Safer Staffing Review.

Brenda McKenzie: Workforce Lead

Harrogate and District NHS Foundation Trust

Contents

Harrogate and District NHS Foundation Trust

Safer Nursing Care Tool (SNCT) Adult Inpatient Wards

Date of SNCT data collection: January 2025

SNCT review meetings: March/April 2025

Author: Brenda Mckenzie (Workforce Lead)

Situation

The Board of Directors are required to receive a Nurse Establishment Review twice a year. This requirement is underpinned by the direction of NHS Improvement (2018) who, in conjunction with the National Quality Board (NQB) (2016), provide a guidance framework containing the key components that should be considered as part of safe staffing review and analysis and in turn enable their nationally endorsed expectations to be met.

HDFT undertook its bi annual adult inpatient safer staffing review using the updated licenced SNCT during the month of January 2025.

Background

The NQB guidance framework (2016) is central in supporting us to develop a workforce that is fit for purpose in the context of it being safe, sustainable and productive. It comprises of a principle document which is supplemented by a suite of additional publications that collectively act as improvement resources.

The principle structure of the NQB expectations are illustrated below and together form a framework that facilitates and supports care to be underpinned by;

• delivery of the right care, first time in the right place

• minimising avoidable harm

• maximising the value of available resources

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

The scope for this Safer Nursing Care Tool (SNCT) data collection encompasses the adult in patient wards. This is the third set of data that has been collected using the updated SNCT which encompasses the new levels of care for patients with an increased dependency in relation to enhanced care requirements.

Teams are reporting increasing levels of enhanced care requirements on a daily basis. Enhanced care relates to; *patients who require an increased level of care to prevent them harming themselves, others or absconding.* NHSE together with the Shelford Group, have made adaptations to the SNCT tool to incorporate this level of dependency within our patients.

The new levels of care will breakdown the 'Enhanced Care' requirements, which will enable us to better monitor and manage how we care for these patients, in addition to aligning establishments to allow for this level of care. At least two data collections will need to be undertaken before the data can be used to triangulate and apply professional judgment to make changes to the ward establishments, in respect of the enhanced care requirements.

Ward budgets were increased to match the outputs of the SNCT in April 2023 and recruitment in to these registered nurse vacancies was extremely successful with many wards now recruiting to turnover. This new establishment aligns HDFT to a 60/40 skill mix ratio and has increased our Care Hours Per Patient Day (CHPPD) to above the national average when compared on Model Hospital.

The January data collection ran for the full month. Prior to these collections, the Workforce Lead facilitated an extensive training programme; an hour training session, that was conducted via MS Teams. All attendees were assessed and were required to pass the inter-rater scoring pass levels. This information is stored on the corporate nursing 'shared drive'. It is essential that all scorers are trained to ensure that high quality, reliable data is collected. All the data was peer reviewed by the Matrons to validate and add assurance that the data was an accurate reflection of the patients on the ward and activity during the time of the audit.

The SNCT was used with a 60:40 ratio Registered Nurse (RN) to Care Support Worker (CSW) for all wards with exception of Farndale and Wensleydale, our medical admissions ward and Cardiology and Respiratory ward. For these wards a ratio of 70:30 was used to take into account the additional registered nurse input required to manage the acutely unwell patients, which is recommended by the tool with regards to these areas.

Assessment

All wards have daily safety huddles where all staff, including medical and AHP colleagues come together on the ward at a set time to discuss any patient safety risks; for example patients who are risk of falls and consider preventative measures to be put in place.

A detailed description of each ward and specific staffing, agency and quality indicators were available at the review meetings. As recommended by the SNCT; data collected must be triangulated with quality indicators and professional judgement before any changes to establishments are agreed.

The SNCT recommendation is to review the required staffing establishment for each ward bi annually at differing periods/times of the year.

As part of the SNCT process, the Deputy Director of Nursing, Midwifery and AHP's, Associate Director of Nursing (ADoN) for Planned and Surgical Care and Long Term and Unscheduled Care, Matron and Ward Manager from each ward and the Lead for Workforce Assurance and Compliance met to review the SNCT results, quality data, patient flow information, environmental factors (including PLACE inspection results), and apply professional judgement.

The discussions have been found to be useful in identifying support roles that enhance patient care and improve the working lives of each team. Mainly, Nutritional Assistant roles and Ward Clerk hours. Complaints and concerns in relation to poor hydration and nutrition have reduced. However, most wards have highlighted the need for their Ward Clerk hours to be reviewed to meet the needs of the patients and staff. These administration requirements are being looked in to be the Directorates.

Acuity and dependency data was provided via the ward managers and all other supportive data was provided by analytics, sitereps, Tendable, finance, NHSP and ESR

All clinical areas recognised the challenges and understood the results. Where there were perceived anomalies, these were discussed and professional judgement applied. This was pertinent to some smaller wards, wards with more than 50% side rooms, those with assessment areas and those that require non-invasive ventilation (NIV) as not all patients requiring NIV are admitted to a high observation/critical care environment at HDFT.

Headroom for each ward is calculated at an overall 21% with the following breakdown:

- 14.96% Annual leave
- 1.92% Study leave
- 3.9% Sickness.

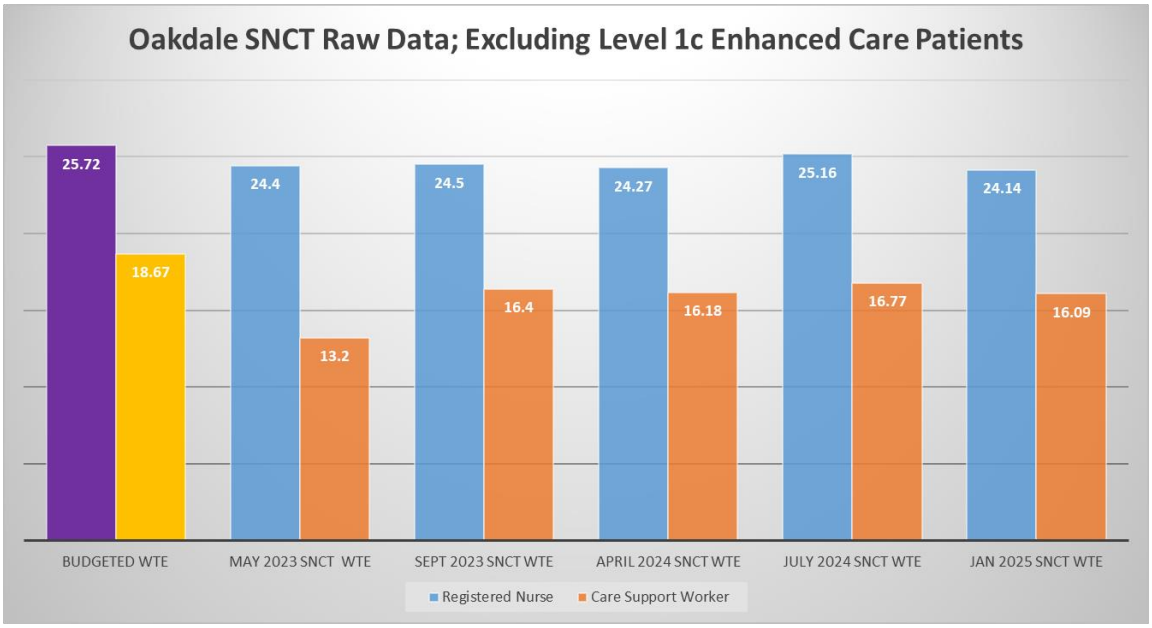
Harrogate and District NHS Foundation Trust

LTUCC Results by Ward

Oakdale

Oakdale is a 30 bedded General Medical, Oncology, Haematology & Endocrine ward.

SNCT Data since establishment uplift in April 2023



The current staffing template for Oakdale:

	Early	Late	Night
RN	**5**	**5**	**4**
CSW	**4**	**3**	**3**
Nutritional Assistant	**7 days 1.4 WTE**		
MD	**22.5 hours (0.6 WTE)**		

Budgeted Skill Mix

Band	WTE
7	1.0
6	4.0
5	20.72
3	0
2	18.67
2 Nutritional Assistant	1.4
2 Ward Clerk	1.0

Discussions and data pack

See appendix 1

Recommendations

The SNCT outputs (data, quality metrics and professional judgement) **indicate an accurate nursing establishment.**

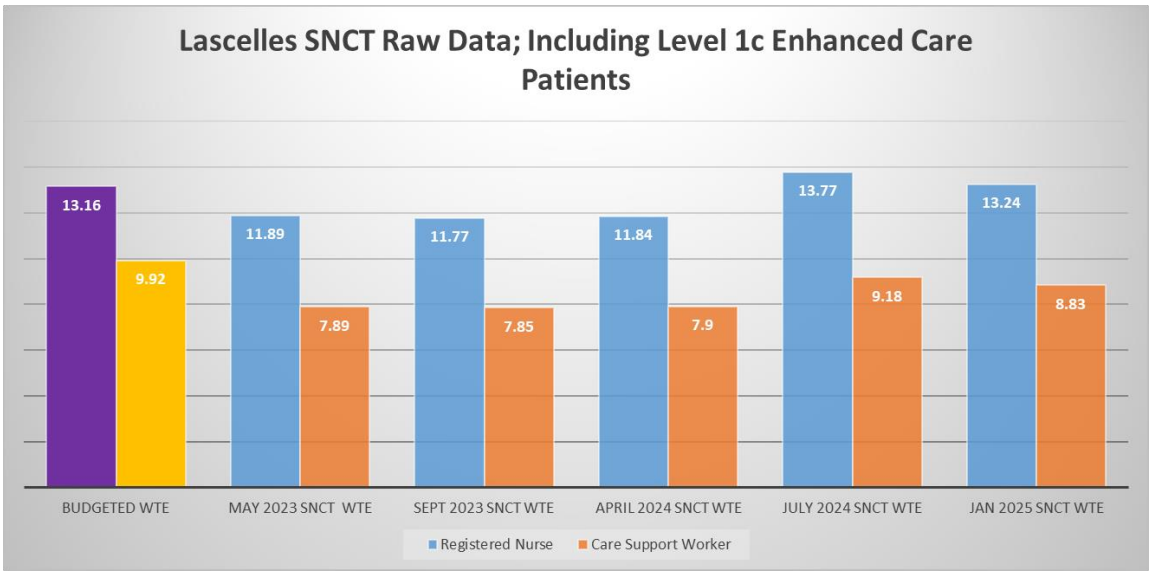
Any enhanced care requirements or unfilled shifts should be reviewed as part of the new safer staffing meetings using SafeCare. This is a safer staffing tool which measures the actual acuity and dependency of the patients on each ward against the availability of staff to ensure that we are deploying the right staff with the right skills at the right place and time. Once the acuity and dependency levels have been peer reviewed by the Matron and professional judgement has been applied to the information within the system, a decision is made as to whether a staff redeployment should be undertaken or additional temporary workforce is required.

Continue to collect twice yearly SNCT data, using the new levels of care SNCT tool. The next data collection will be in June 2025.

Lascelles

Lascelles is a 12 bedded Rehab ward, that is based off the main HDFT site.

SNCT Data since establishment uplift in April 2023



The current staffing template for Lascelles:

	Early	Late	Night
RN	**3**	**2**	**2**
CSW	**2**	**2**	**1**
Nutritional Assistant	**5 days 1.0 WTE**		
MD	**22.5 hours (0.6 WTE)**		

Budgeted Skill Mix

Band	WTE
7	1
6	2
5	10.16
3	0
2	8.92
2 Nutritional Assistant	1.0
2 Ward Clerk	0.53

Discussion and data pack

See appendix 2

Recommendations

The SNCT outputs (data, quality metrics and professional judgement) **indicate an accurate nursing establishment.**

Ward Clerk hours were identified as a concern. Additional Ward clerk hours would assist with the administrative tasks that are currently being picked up by clinical staff. This is being picked up by the directorate as part of a wider admin support review.

Any enhanced care requirements or unfilled shifts should be reviewed as part of the new safer staffing meetings using SafeCare. This is a safer staffing tool which measures the actual acuity and dependency of the patients on each ward against the availability of staff to ensure that we are deploying the right staff with the right skills at the right place and time. Once the acuity and dependency levels have been peer reviewed by the Matron and professional judgement has been applied to the information within the system, a decision is made as to whether a staff redeployment should be undertaken or additional temporary workforce is required.

It was acknowledged that Lascelles requires additional Nutritional Assistant hours at the weekend. Currently Lascelles are only funded for a Nutritional Assistant Monday to Friday.

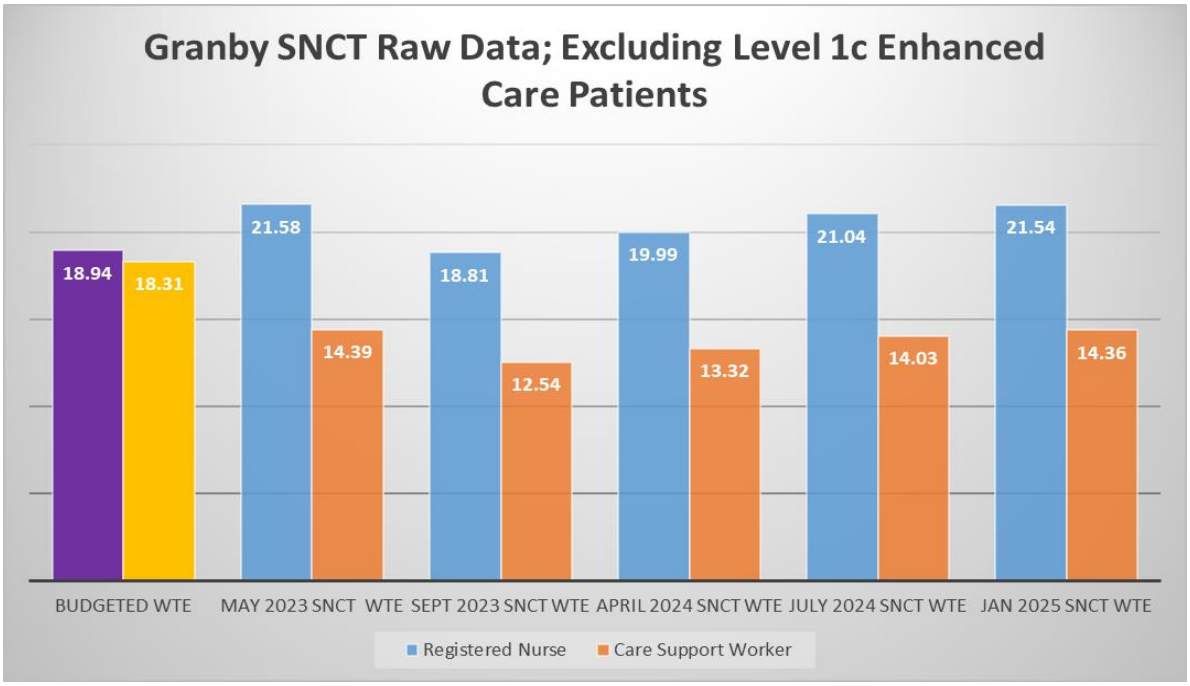
This will be looked at as part of the overall reduction in Early/Late factors across the LTUCC wards to accommodate this additional resource.

Continue to collect twice yearly SNCT data, using the new levels of care SNCT tool. The next data collection will be in June 2025

Granby

Granby is a 22 bedded Stroke & Neurology ward.

SNCT Data since establishment uplift in April 2023



The current staffing template for Granby:

	Early	Late	Night
RN	**3**	**3**	**3**
CSW	**3**	**3**	**3**
RN	**Early on Mon Thurs & Fri**		
Nutritional Assistant	**7 days 1.4 WTE**		
MD	**22.5 hours (0.6 WTE)**		

Budgeted Skill Mix

Band	WTE
7	1.0
6	3.70

5	14.24
3	0.0
2	16.91
2 Nutritional Assistant	1.4
4 Ward Clerk	0.73
2 ward Clerk	0.92
7 Specialist Nurse	1.0

Discussion and data pack

See appendix 3

Recommendations

The SNCT outputs (data, quality metrics and professional judgement) **indicate an accurate nursing establishment** no changes are required.

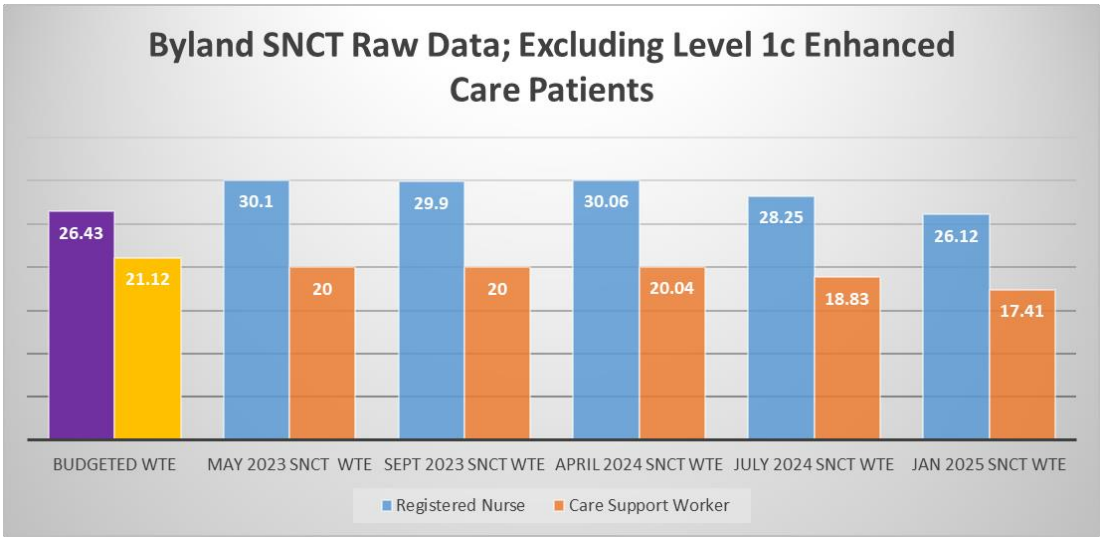
Any enhanced care requirements or unfilled shifts should be reviewed as part of the new safer staffing meetings using SafeCare. This is a safer staffing tool which measures the actual acuity and dependency of the patients on each ward against the availability of staff to ensure that we are deploying the right staff with the right skills at the right place and time. Once the acuity and dependency levels have been peer reviewed by the Matron and professional judgement has been applied to the information within the system, a decision is made as to whether a staff redeployment should be undertaken or additional temporary workforce is required.

Continue to collect twice yearly SNCT data, using the new levels of care SNCT tool. The next data collection will be in June 2025.

Byland

Byland is a 30 bedded Frailty ward.

SNCT Data since establishment uplift in April 2023



The current staffing template for Byland:

	Early	Late	Night
RN	**5**	**5**	**4**
CSW	**4**	**4**	**3**
Nutritional Assistant	**7 days 1.4 WTE**		
MD	**22.5 hours (0.6 WTE)**		

Budgeted Skill Mix

Band	WTE
7	1.0
6	4.0
5	21.43
3	0.0
2	19.72
2 Nutritional Assistant	1.4
2 Ward Clerk	1.0

Discussion and data pack

See appendix 4

Recommendations

The SNCT outputs (data, quality metrics and professional judgement) **indicate an accurate nursing establishment** for the baseline requirements. However, the data shows that this frailty ward has been using an additional CSW on a Night shift for the past 12 months. The requirement was reported essential due to the Enhanced Care needs of the patients, which was not able to be mitigated through other means.

Any enhanced care requirements or unfilled shifts should be reviewed as part of the new safer staffing meetings using SafeCare. This is a safer staffing tool which measures the actual acuity and dependency of the patients on each ward against the availability of staff to ensure that we are deploying the right staff with the right skills at the right place and time. Once the acuity and dependency levels have been peer reviewed by the Matron and professional judgement has been applied to the information within the system, a decision is made as to whether a staff redeployment should be undertaken or additional temporary workforce is required.

It has been agreed that the overall SNCT changes within LTUCC will be taken to the Establishment Review Panel with a QIA. These changes will be within the Directorates financial envelope, using reductions in staffing within areas where the SNCT shows that

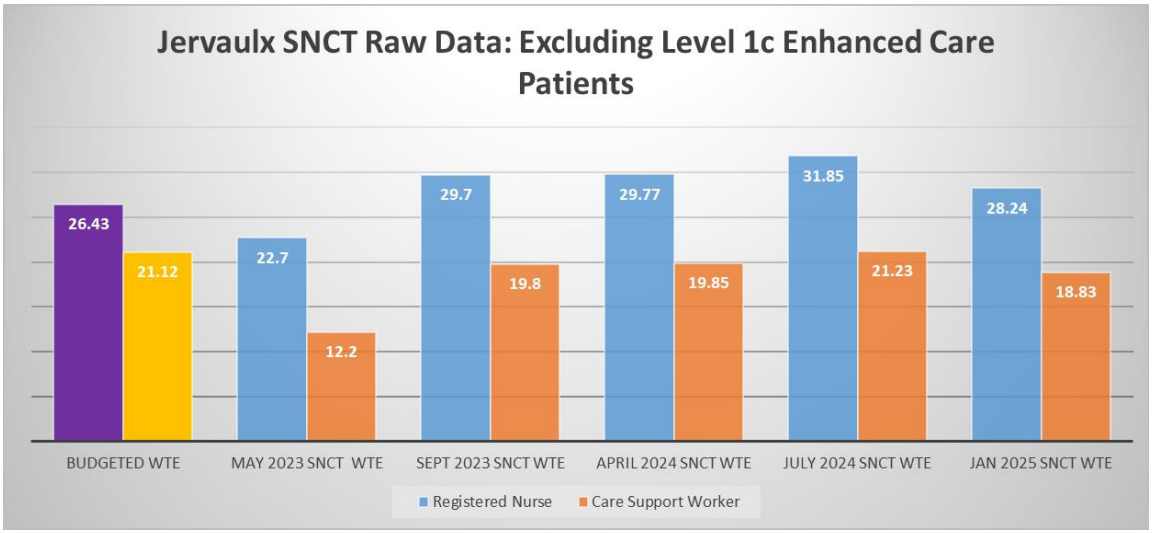
the acuity and dependency is lower and moving to the areas that have highlighted additional requirements.

Continue to collect twice yearly SNCT data, using the new levels of care SNCT tool. The next data collection will be in June 2025.

Jervaulx

Jervaulx is a 30 bedded Frailty ward.

SNCT Data since establishment uplift in April 2023



The current staffing template for Jervaulx:

	Early	Late	Night
RN	**5**	**5**	**4**
CSW	**4**	**4**	**3**
Nutritional Assistant	**7 days 1.4 WTE**		
MD	**22.5 hours (0.6 WTE)**		

Budgeted Skill Mix

Band	WTE
7	1.0
6	4.0
5	21.43

3	0.0
2	19.72
2 Nutritional Assistant	1.4
2 Ward Clerk	0.6

Discussion and data pack

See appendix 5

Recommendations

The SNCT outputs (data, quality metrics and professional judgement) **indicate an accurate nursing establishment** for the baseline requirements. However, the data shows that this frailty ward has been using an additional CSW on a Night shift for the past 12 months. The requirement was reported essential due to the Enhanced Care needs of the patients, which was not able to be mitigated through other means.

Any enhanced care requirements or unfilled shifts should be reviewed as part of the new safer staffing meetings using SafeCare. This is a safer staffing tool which measures the actual acuity and dependency of the patients on each ward against the availability of staff to ensure that we are deploying the right staff with the right skills at the right place and time. Once the acuity and dependency levels have been peer reviewed by the Matron and professional judgement has been applied to the information within the system, a decision is made as to whether a staff redeployment should be undertaken or additional temporary workforce is required.

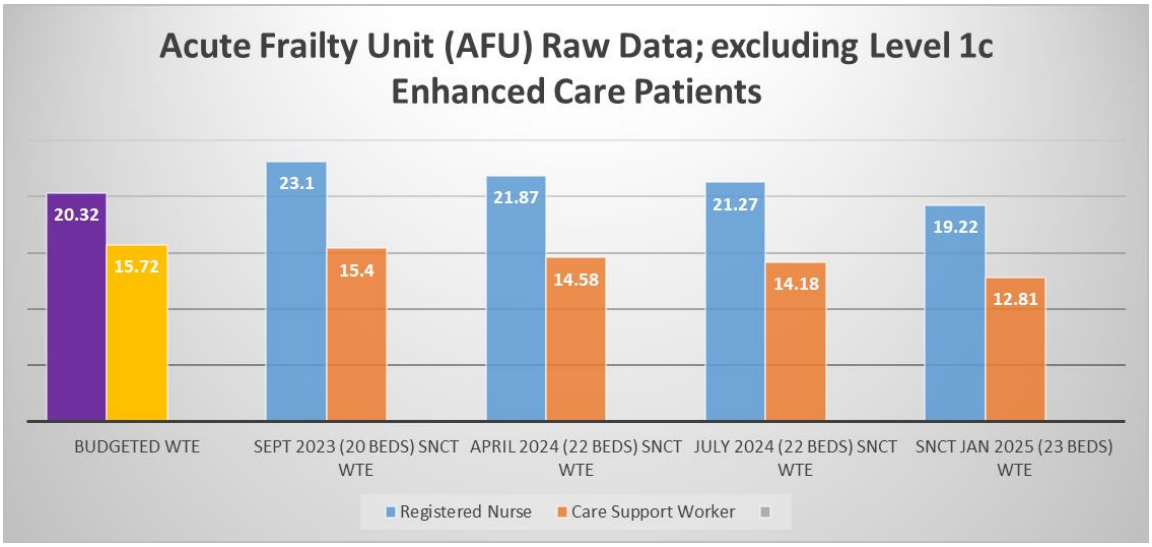
It has been agreed that the overall SNCT changes within LTUCC will be taken to the Establishment Review Panel with a QIA. These changes will be within the Directorates financial envelope, using reductions in staffing within areas where the SNCT shows that the acuity and dependency is lower and moving to the areas that have highlighted additional requirements.

Continue to collect twice yearly SNCT data, using the new levels of care SNCT tool. The next data collection will be in June 2025.

Acute Frailty Unit (AFU)

AFU is an 18 Frailty Admissions Ward with 2 assessment beds. However, due to the demand on Frailty beds the ward has been open at escalation since winter 23/24 at a total of 23 beds.

SNCT Data since establishment uplift in April 2023



The current staffing template for AFU (not including escalation beds):

	Early	Late	Night
RN	**4**	**4**	**3**
CSW	**3**	**3**	**2**
Nutritional Assistant	**7 days 1.4 WTE**		
MD	**22.5 hours (0.6 WTE)**		

Budgeted Skill Mix

Band	WTE
7	1.0
6	4.38
5	14.94
3	1.76
2	12.56
2 Nutritional Assistant	1.4
2 Ward Clerk	0.60

Discussion and data pack

See appendix 6

The SNCT outputs (data, quality metrics and professional judgement) indicate an accurate nursing establishment for the funded baseline beds (18+2). However, when open at 23 beds an additional RN and CSW is required on a night shift and CSW on the early shift.

Recommendations

The SNCT outputs (data, quality metrics and professional judgement) **indicate no changes to the establishment as a result of this data collection.**

The directorate should build a business case to encompass all of the wards, Ward Clerk requirements.

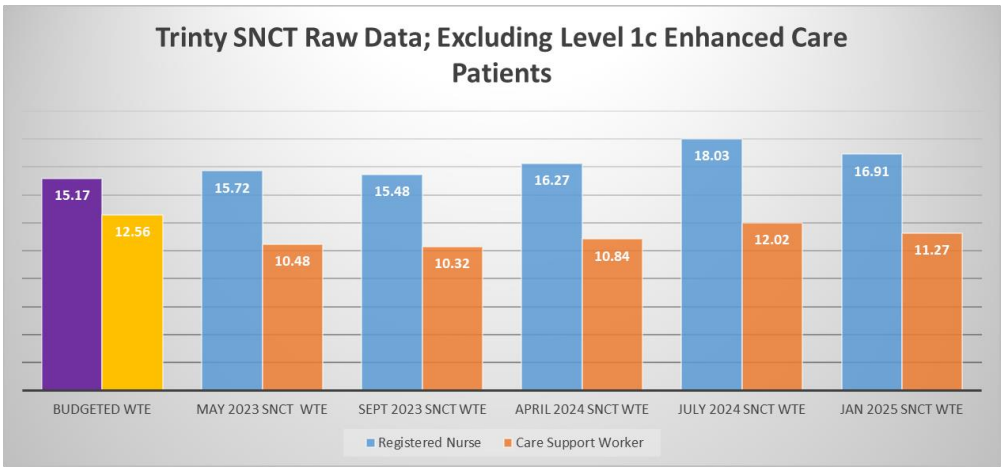
Any enhanced care requirements or unfilled shifts should be reviewed as part of the new safer staffing meetings using SafeCare. This is a safer staffing tool which measures the actual acuity and dependency of the patients on each ward against the availability of staff to ensure that we are deploying the right staff with the right skills at the right place and time. Once the acuity and dependency levels have been peer reviewed by the Matron and professional judgement has been applied to the information within the system, a decision is made as to whether a staff redeployment should be undertaken or additional temporary workforce is required.

Continue to collect twice yearly SNCT data, using the new levels of care SNCT tool. The next data collection will be in June 2025.

Trinity

Trinity is a 19 bedded Rehab Ward, based within Ripon Hospital (off the main HDFT Hospital site).

SNCT Data since establishment uplift in April 2023



The current staffing template for Trinity

	Early	Late	Night
RN	**3**	**3**	**2**
CSW	**3**	**2**	**2**
RN	**Early RN every Monday (MDT)**		
MD	**22.5 hours (0.6 WTE)**		

Budgeted Skill Mix

Band	WTE
7	1.0
6	2.64
5	11.53
3	0.0
2	12.56
2 Nutritional Assistant	0.0
2 Ward Clerk	1.92

Discussion

See appendix 7

Recommendations

The SNCT outputs (data, quality metrics and professional judgement) **indicate an accurate nursing establishment.**

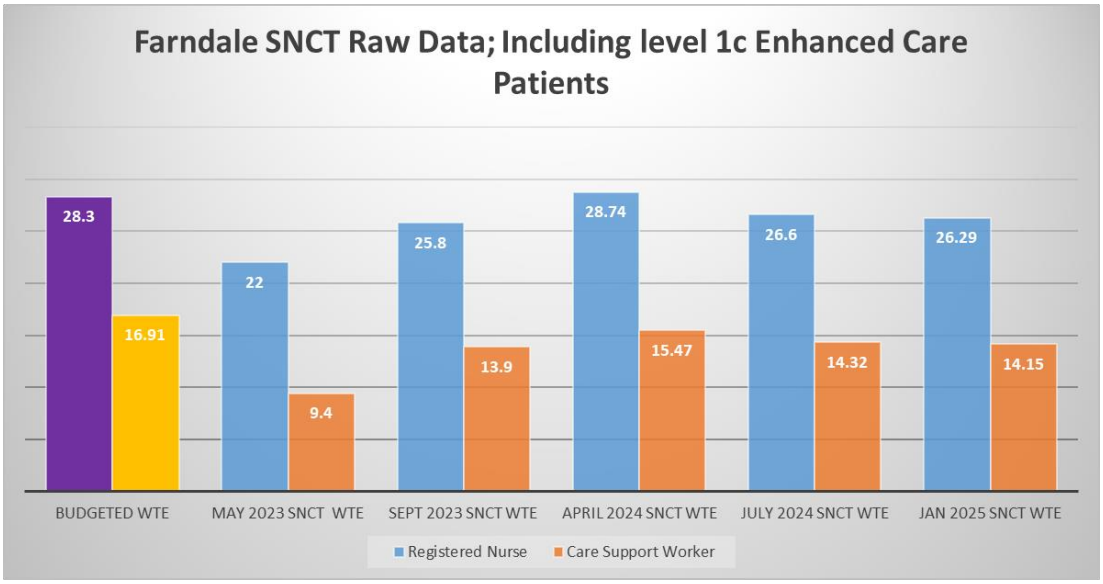
Any unfilled shifts should be reviewed as part of the new safer staffing meetings using SafeCare. This is a safer staffing tool which measures the actual acuity and dependency of the patients on each ward against the availability of staff to ensure that we are deploying the right staff with the right skills at the right place and time. Once the acuity and dependency levels have been peer reviewed by the Matron and professional judgement has been applied to the information within the system, a decision is made as to whether a staff redeployment should be undertaken or additional temporary workforce is required.

Continue to collect twice yearly SNCT data, using the new levels of care SNCT tool. The next data collection will be in June 2025.

Farndale

Farndale is a 23 bedded Medical Admissions ward.

SNCT Data and Changes in Nursing Establishment



The current staffing template for Farndale:

	Early	Late	Night
RN	**5**	**5**	**5**
CSW	**3**	**3**	**3**
Nutritional Assistant	**7 days 1.4 WTE**		
MD	**22.5 hours (0.6 WTE)**		

Budgeted Skill Mix

Band	WTE
7	1.0
6	6.44
5	20.86
3	0.0
2	16.91
2 Nutritional Assistant	1.4
2 Ward Clerk	2.07

Discussion and data pack

See appendix 8

Recommendations

The SNCT outputs (data, quality metrics and professional judgement) **indicate an accurate nursing establishment.**

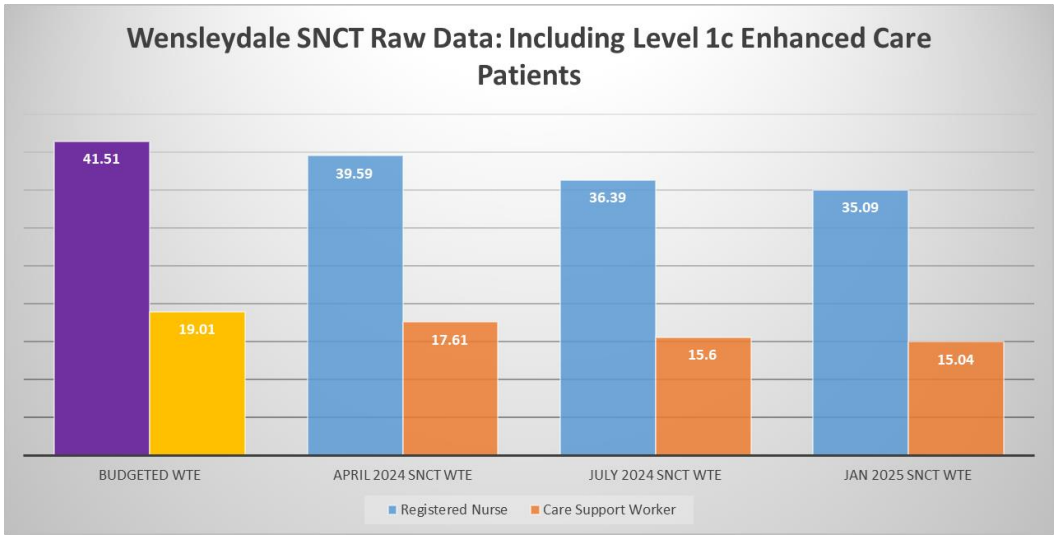
Any enhanced care requirements or unfilled shifts should be reviewed as part of the new safer staffing meetings using SafeCare. This is a safer staffing tool which measures the actual acuity and dependency of the patients on each ward against the availability of staff to ensure that we are deploying the right staff with the right skills at the right place and time. Once the acuity and dependency levels have been peer reviewed by the Matron and professional judgement has been applied to the information within the system, a decision is made as to whether a staff redeployment should be undertaken or additional temporary workforce is required.

Continue to collect twice yearly SNCT data, using the new levels of care SNCT tool. The next data collection will be in June 2025.

Wensleydale

This is a new Cardio-respiratory ward with MECU beds. This is the second SNCT data collection since the ward opened.

SNCT Data since New Ward Budget Set in April 2023



The current staffing template for Wensleydale:

	Early	Late	Night
RN	**7**	**7**	**7**
CSW	**3**	**3**	**3**
Nutritional Assistant	**7 days 1.4 WTE**		

MD	**22.5 hours (0.6 WTE)**

Budgeted Skill Mix

Band	WTE
7	1
6	12.51
5	28.0
3	0.0
2	17.61
2 Nutritional Assistant	1.4
2 Ward Clerk	1.4

Discussion

See appendix 9

Recommendations

The SNCT outputs (data, quality metrics and professional judgement) **indicate a safe nursing establishment.** However, the three data collections since the establishment was set suggests that there could be a reduction in Early/Late factors without a negative impact on quality, safety or performance. This will be factored as part of the LTUCC review that will be taken to the Establishment Review Panel.

Any unfilled shifts should be reviewed as part of the new safer staffing meetings using SafeCare. This is a safer staffing tool which measures the actual acuity and dependency of the patients on each ward against the availability of staff to ensure that we are deploying the right staff with the right skills at the right place and time. Once the acuity and dependency levels have been peer reviewed by the Matron and professional judgement has been applied to the information within the system, a decision is made as to whether a staff redeployment should be undertaken or additional temporary workforce is required.

Continue to collect twice yearly SNCT data, using the new levels of care SNCT tool. The next data collection will be in June 2025.

LTUCC Summary and Overall Requirements

Possible reductions in establishment are mainly due to a required reduction in the Early/Late factor, which is not being utilised during the rostering process and causing issues with assignment of shifts and accurate monitoring of key performance indicators.

Ward	Reductions	Increases
Oakdale	No Reductions	No Increases
Granby	• Remove 1 X RN Early/Late Factor (3 hours)	No Increases
Farndale	No Reductions	No Increases
Wensleydale	• Remove 2 X RN (Band 5) Early/Late Factors (6 hours) • Remove 1 X CSW (Band 3) Early/Late Factors (3 hours)	No Increases
Byland	• Remove 1 X RN Early/Late Factor (3 hours)	Increase 1 X CSW 11 hour Night shift
Jervaulx	• Remove 1 X RN Early/Late Factor (3 hours)	Increase 1 X CSW 11 hour Night shift
Acute Frailty Unit	No Reductions	No Increases
Trinity	No Reductions	No Increases
Lascelles	No Reductions	Increase Nutritional Assistant hours to include provision for Sat and Sun (7.5 hours shifts) Increase Ward Clerk Hours by 15 hours per week (0.4 WTE)

The changes recommended by the outputs of the review meetings are minor establishment changes, within the existing budgetary allocation. These changes are being presented to the establishment review panel on the 20th May 2025. The financial details are demonstrated below.

NHS
Harrogate and District
NHS Foundation Trust

SNCT Review - May 2025 ~ LTUCC

Ward	Reductions	Increases	RN WTE Roster/A/L & Study	RN WTE Sickness/NHSP	RN WTE TOTAL	RN £ Roster/A/L & Study	RN £ Sickness/NHSP	RN £ k TOTAL	CSW WTE Roster/A/L & Study	CSW WTE Sickness/NHSP	CSW WTE TOTAL	CSW £ Roster/A/L & Study	CSW £ Sickness/NHSP	CSW £ k TOTAL	Nutritional Assistant WTE TOTAL	Nutritional Assistant £ k TOTAL	Ward Clerk WTE TOTAL	Ward Clerk £ k TOTAL	WTE TOTAL	£ k TOTAL
Oakdale	No Reductions	No Increases	-	-	0.00	-	-	0.0	-	-	0.00	-	-	0.0					0.00	0.0
Granby	• Remove 1 X RN (Band 5) Early/Late Factor (3 hours)	No Increases	0.66	0.03	0.68	30.9	1.7	32.6	-	-	0.00	-	-	0.0					0.68	32.6
Farndale	No Reductions	No Increases	-	-	0.00	-	-	0.0	-	-	0.00	-	-	0.0					0.00	0.0
Wensleydale	• Remove 2 X RN (Band 5) Early/Late Factors (6 hours)	No Increases	1.31	0.05	1.36	66.9	3.3	70.3											1.36	70.3
	• Remove 1 X CSW (Band 3) Early/Late Factors (3 hours)								0.66	0.03	0.68	19.6	1.2	20.8					0.68	20.8
Byland	• Remove 1 X RN (Band 5) Early/Late Factor (3 hours)	Increase 1 X CSW 11 hour Night shift	0.66	0.03	0.68	33.5	1.7	35.2	-2.41	-0.09	-2.50	-70.0	-4.5	-74.5					-1.82	-39.3
Jervaulx	• Remove 1 X RN (Band 5) Early/Late Factor (3 hours)	Increase 1 X CSW 11 hour Night shift	0.66	0.03	0.68	33.7	1.7	35.3	-2.41	-0.09	-2.50	-71.7	-4.5	-76.2					-1.82	-40.9
Acute Frailty Unit	No Reductions	No Increases	-	-	0.00	-	-	0.0	-	-	0.00	-	-	0.0					0.00	0.0
Trinity	No Reductions	No Increases	-	-	0.00	-	-	0.0	-	-	0.00	-	-	0.0					0.00	0.0
Lascelles	No Reductions	Increase Nutritional Assistant hours to include provision for Sat and Sun (7.5 hours shifts)	-	-	0.00	-	-	0.0			0.00	-	-	0.0	-0.40	-14.2			-0.40	-14.2
	No Reductions	Increase Ward Clerk 15hpw (Band 2)	-	-	0.00	-	-	0.0			0.00	-	-	0.0			-0.40	-12.0	-0.40	-12.0
Total			3.28	0.13	3.41	165.1	8.27	173.3	-4.16	-0.16	-4.32	-122.1	-7.72	-129.9	-0.40	-14.2	-0.40	-12.0	-1.71	17.3

Notes
WTE figures include roster requirement with allowance for A/L and study; sickness funded separately at NHSP rates
CSW costs based on B2 - B3 re-banding to be implemented as separate exercise
CSW B2 costs do not inlude Living Wage uplift - to be funded through annual planning once 25/26 pay award announced
Impact on enhancement % changes to be addressed in annual pay budget setting exercise
Financial impact assessment excludes compounded adj (headroom on headroom)

SUMMARY	WTE	£ k
Reduction/Saving	4.09	194.1
Increase/Cost	-5.80	-176.8
Total Reduction/(Increase)	**-1.71**	**17.3**

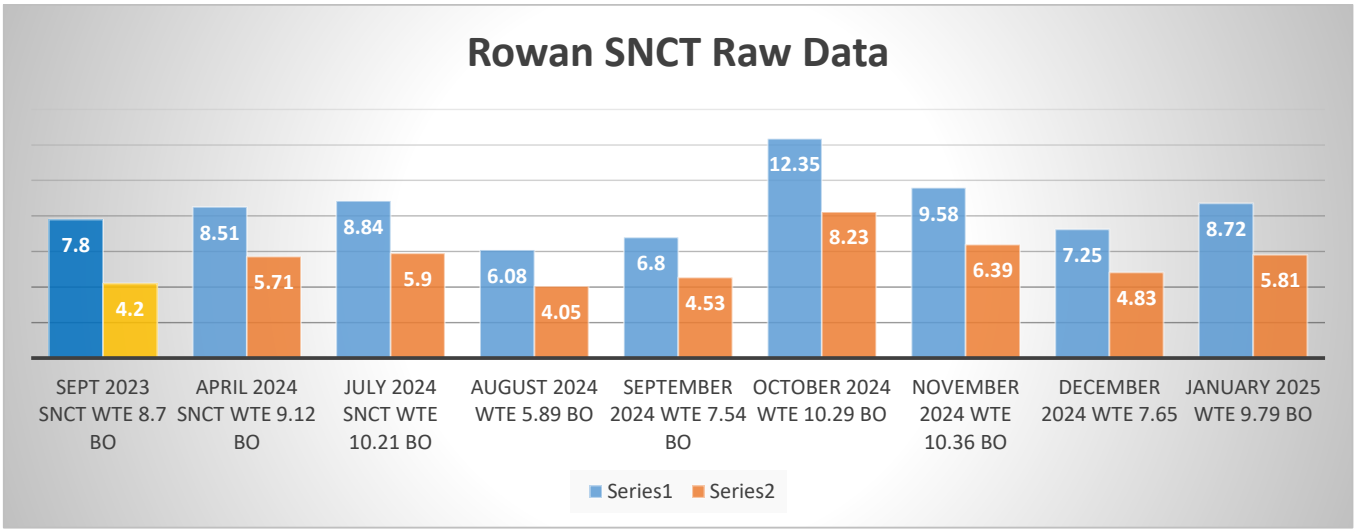
Breakdown of staff		
Substantive	-1.67	16.7
Bank (sickness backfill)	-0.03	0.6

PSCC Results by Ward

Rowan

Rowan is an Elective Orthopaedic ward with 16 beds. As highlighted by the SNCT results, the full bed capacity is not yet being utilised. However, each data collection indicates greater usage. There is a minimum baseline staffing requirement to maintain quality, safety and performance. Therefore the Budgeted establishment in not able to be changed, but can be flexed, using professional judgement by senior nursing colleagues as part of the daily safer staffing professional judgement redeployment.

SNCT Data since New Ward Budget Set in April 2023



The current staffing template for Rowan:

	Early	Late	Night
RN	**2**	**2**	**2**
CSW	**2**	**2**	**1**
MD	**22.5 hours (0.6 WTE)**		

Budgeted Skill Mix

Band	WTE
7	1.0
6	3.0
5	8.1
3	0.0
2	8.92

2 Nutritional Assistant	0.0
2 Ward Clerk	1.19

Discussion

See appendix 10

Recommendations

The SNCT outputs (data, quality metrics and professional judgement) **indicate an accurate nursing establishment.**

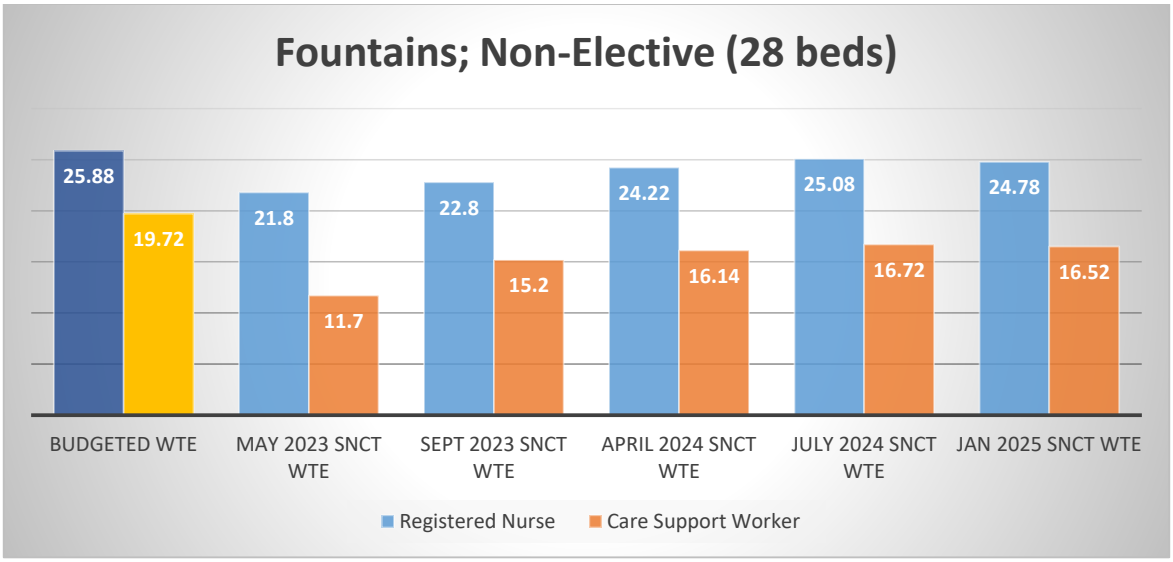
Any unfilled shifts should be reviewed as part of the new safer staffing meetings using SafeCare. This is a safer staffing tool which measures the actual acuity and dependency of the patients on each ward against the availability of staff to ensure that we are deploying the right staff with the right skills at the right place and time. Once the acuity and dependency levels have been peer reviewed by the Matron and professional judgement has been applied to the information within the system, a decision is made as to whether a staff redeployment should be undertaken or additional temporary workforce is required. It was agreed that Rowan would not recruit in to the remaining 2 WTE care support worker positions until activity increases. However, the budget and staffing template would remain the same.

Continue to collect continuous SNCT data, using the new levels of care SNCT tool. The next data review of this data will be in June 2025.

Fountains

Fountains is a 28 bedded Trauma and Orthopaedics ward (Non elective).

SNCT Data since New Ward Budget Set in April 2023



The current staffing template for Fountains:

	Early	Late	Night
RN	**5**	**5**	**4**
CSW	**4**	**¾**	**3**
Nutritional Assistant	**7 days 1.0 WTE**		
MD	**22.5 hours (0.6 WTE)**		

Budgeted Skill Mix

Band	WTE
7	1.0
6	3.0
5	21.88
3 Patient Liaison	1.0
3 CSW	0.0
2	18.45
2 Nutritional Assistant	1.0
2 Ward Clerk	1.0

Discussion and data pack

See appendix 11

Recommendations

The SNCT data and triangulation **supports the current funded nursing establishment and skill mix.**

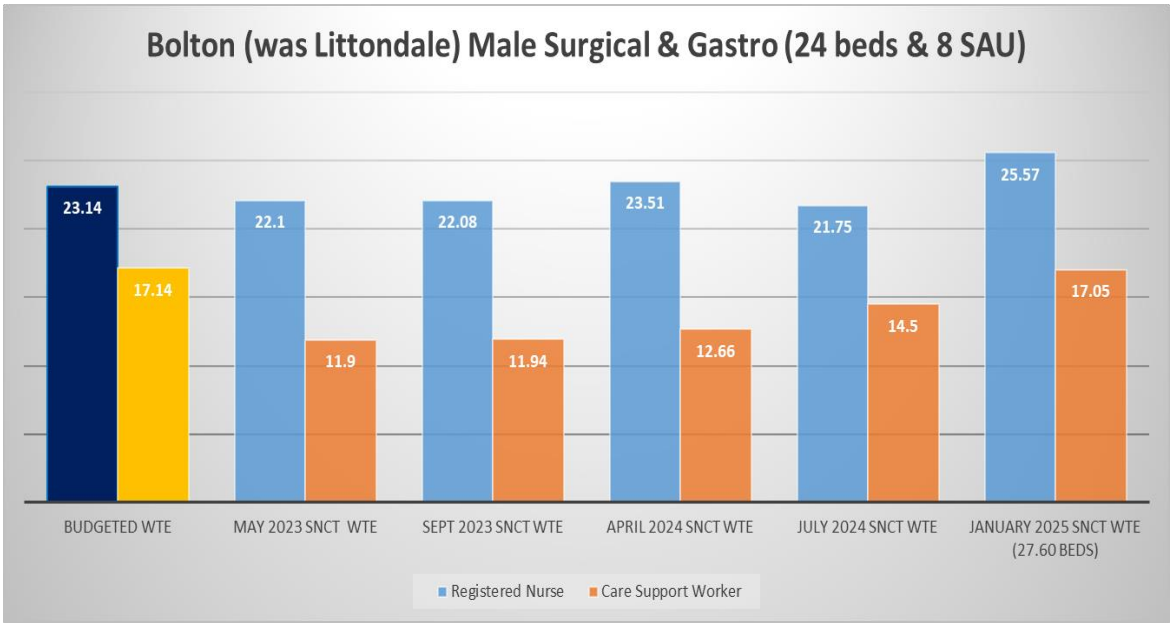
Any unfilled shifts should be reviewed as part of the new safer staffing meetings using SafeCare. This is a safer staffing tool which measures the actual acuity and dependency of the patients on each ward against the availability of staff to ensure that we are deploying the right staff with the right skills at the right place and time. Once the acuity and dependency levels have been peer reviewed by the Matron and professional judgement has been applied to the information within the system, a decision is made as to whether a staff redeployment should be undertaken or additional temporary workforce is required.

Continue to collect bi annual SNCT data, using the new levels of care SNCT tool. The next data collection will be in June 2025.

Littondale now Bolton

Littondale is a 24 bedded, male surgical and gastroenterology ward with a 8 bedded Surgical Assessment Unit.

SNCT Data since New Ward Budget Set in April 2023



The current staffing template for Littondale. This staffing model is for the 24 beds and the 8 beds in the Surgical Assessment Unit:

	Early	Late	Night
RN	**5**	**5**	**3**
CSW	**4**	**4**	**3**
Nutritional Assistant	**7 days 1.0 WTE**		
MD	**22.5 hours (0.6 WTE)**		

Budgeted Skill Mix

Band	WTE
7	1.0
6	3.15
5	18.99
3 CSW	8.92
2	10.80
2 Nutritional Assistant	1.0
2 Ward Clerk	1.0

Discussion and data pack

See appendix 12

Recommendations

The SNCT data and triangulation **supports the current funded nursing establishment and skill mix.**

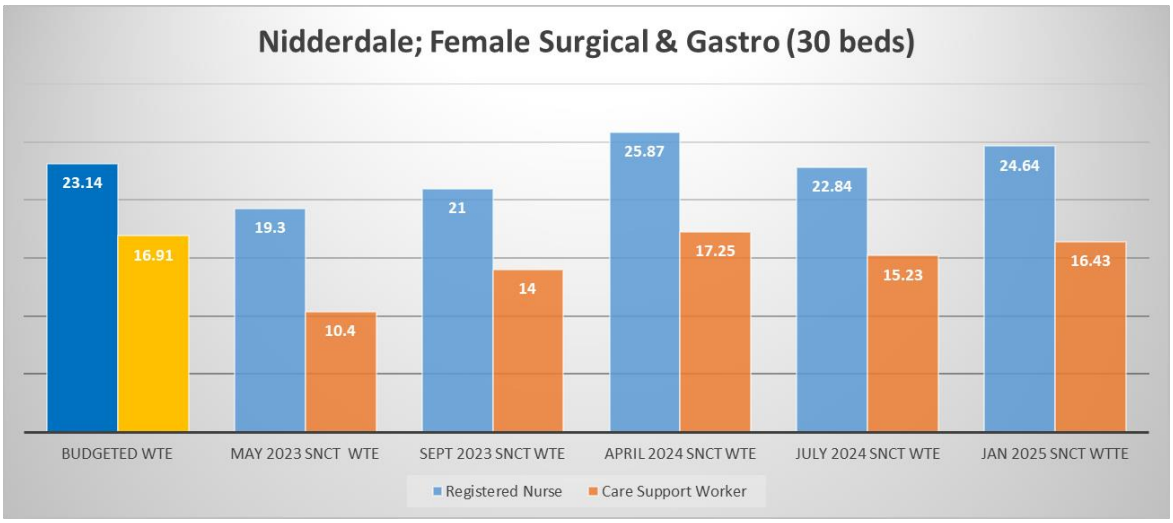
Any unfilled shifts should be reviewed as part of the new safer staffing meetings using SafeCare. This is a safer staffing tool which measures the actual acuity and dependency of the patients on each ward against the availability of staff to ensure that we are deploying the right staff with the right skills at the right place and time. Once the acuity and dependency levels have been peer reviewed by the Matron and professional judgement has been applied to the information within the system, a decision is made as to whether a staff redeployment should be undertaken or additional temporary workforce is required.

Continue to collect bi annual SNCT data, using the new levels of care SNCT tool. The next data collection will be in June 2025.

Nidderdale

Nidderdale is a 30 bedded female, multi specialist surgical ward.

SNCT Data since New Ward Budget Set in April 2023



The current staffing template for Nidderdale:

	Early	Late	Night
RN	**5**	**5**	**4**
CSW	**3**	**3**	**3**
Nutritional Assistant	**7 days 1.0 WTE**		
MD	**22.5 hours (0.6 WTE)**		

Budgeted Skill Mix

Band	WTE
7	1.0
6	4.0
5	18.14
3	0.0
2	14.32
2 Nutritional Assistant	1.0
2 Ward Clerk	1.0

Discussion

See appendix 13

Recommendations

The SNCT data and triangulation **supports the current funded nursing establishment and skill mix.**

Any enhanced care requirements or unfilled shifts should be reviewed as part of the new safer staffing meetings using SafeCare. This is a safer staffing tool which measures the actual acuity and dependency of the patients on each ward against the availability of staff to ensure that we are deploying the right staff with the right skills at the right place and time. Once the acuity and dependency levels have been peer reviewed by the Matron and professional judgement has been applied to the information within the system, a decision is made as to whether a staff redeployment should be undertaken or additional temporary workforce is required.

Continue to collect bi annual SNCT data, using the new levels of care SNCT tool. The next data collection will be in June 2025.

PSCC Summary and Overall Requirements

No Changes are required to the PSCC establishment from the outputs of this bi-annual review. Safe staffing assurance has been demonstrated.

Emergency Department

Background

Following a National Institute of Clinical Excellence (NICE) endorsed Safer Nursing Care Tool (SNCT) review in 2023, significant investment supported the recommended nurse staffing establishments within the Emergency Department. Therefore ensuring that HDFT are delivering “the right staff, with the right skills, in the right place at the right time” The National Quality Board (NQB) (2018) and addressing the quality, safety and performance issues and align to the overall trust strategy; best quality, safest care and great start in life.

The latest SNCT data collection took place in January 2025 with triangulation of the results with quality data and professional judgement in February 2025.

Department Description

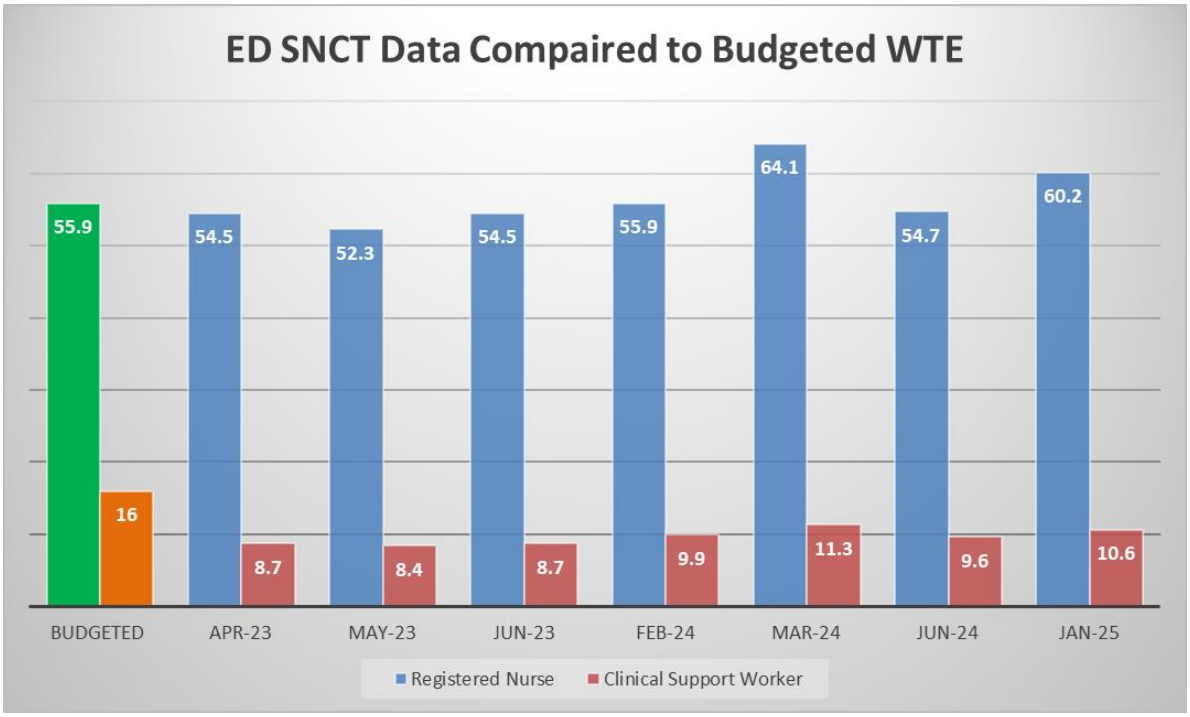
The Emergency Department (ED) is open 24 hours a day, 7 days a week delivering unscheduled care for acutely ill/injured adults and children. The department consists of two areas (ED1 and ED2). ED1 manages those patients presenting with major medical conditions, ED2 manages patients presenting with Minor Illness and injuries.

Management structure: The ED is led by a Triumvirate leadership structure consisting of a Clinical Lead, Service Manager and Matron. The matron is supported by 2 WTE Band 7 Department Managers who have 45 hours management time allocated per week. The workforce model ensures that there will be a band 7 Registered Nurse ‘in charge’ of each shift.

The NIC will consider staff experience, skill and competence when allocating staff to work areas, considering skill mix, workload, clinical priorities and patient dependency. The NIC is responsible for overseeing the team of Registered Nurses and Care Support Workers, ED reception clerks, patient flow in and out of the department (supported by a non-clinical patient flow coordinator and ED senior doctor: EPIC), and having an overview of patient acuity within the department. The NIC works closely with the EPIC and can escalate any concerns regarding prioritisation of patients to be seen. The NIC of each shift allocates staff to patient care areas on a shift basis:

- Streaming
- Triage
- Resuscitation room (2 enclosed cubicles and 1 curtained cubicle)
- Cubicle areas 1 -15 & ED2
- Fit 2 Sit
- YAS Rapid Initial Assessment Treatment

SNCT Raw Data



The current staffing template for the Emergency Department:

	Early	Late	LD	Night	Twilight
RN	3	3	7	10	0
CSW	2	2	1	3	0
Management Days	45 hours a week (1.2WTE)				
Practice Education	67.5 hours a week (1.8 WTE)				

Budgeted Skill Mix

Band	WTE
Band 7 Manager	2.0
Band 7 Clinical	5.35
Band 6 Clinical	12.4
Band 6 Practice Educator	1.8
Band 5 Clinical	34.35
Band 3 Support Staff	16

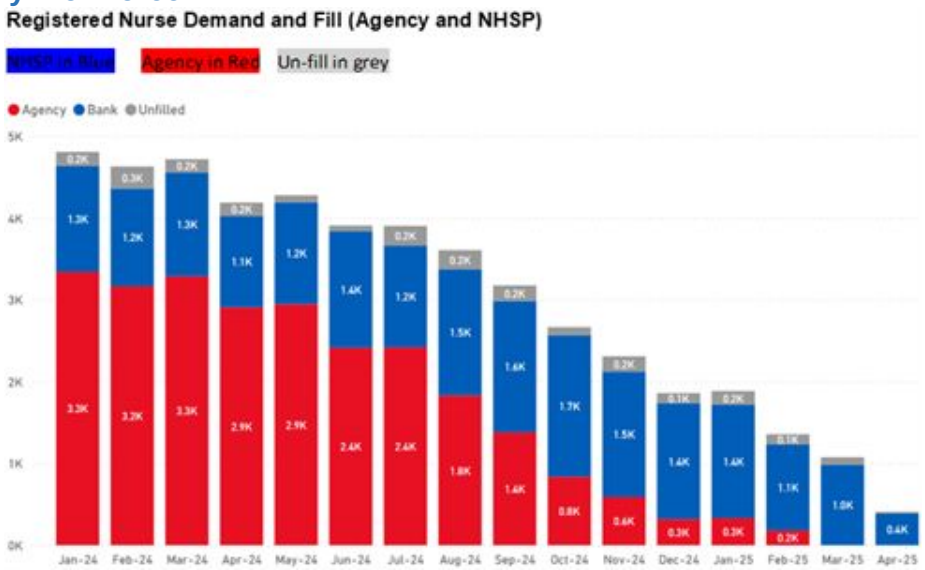
Recruitment and Vacancies

Band	Budgeted	In Post	Vacancies
Band 7 Manager	2.0	2.0	0
Band 7 Clinical	5.35	5.35	0
Band 6 Clinical	12.6	12.4	0.52
Band 6 Practice Educator	1.8	1.6	0
Band 5	34.35	35.35	Over 0.7
Band 3	16	11	5 (out to advert)

There has been some excellent work within the ED to ensure that the right people are recruited in to the vacant positions. This has assisted the reduction in temporary workforce usage and for the first time in March 2025 ED has reached a zero usage position for Agency.

The Band 2 CSW's underwent a re-banding review and are now Band 3 CSW's. The focus is now to recruit in to these remaining vacant Band 3 positions.

Temporary Workforce



Discussion, Quality and Performance Data

See appendix 14

Recommendations

The SNCT data and triangulation **supports the current funded nursing establishment and skill mix. However, the data has suggested that the ED requires a different**

distribution of shift times. It is recommended that One Long Day Band 5 Registered Nurse is changed to a Twilight shift. The Twilight shift would cover from 14:00hrs – 02:00hrs. This change does **not** incur any financial impact and is **affordable within the existing ED workforce budget.**

Recommended Staffing Model

	Early	Late	LD	Night	Twilight
RN	3	3	6	10	1
CSW	2	2	1	3	0
Management Days	45 hours a week (1.2WTE)				
Practice Education	67.5 hours a week (1.8 WTE)				

These changes should be presented to the Establishment review panel on 20th May along with a Quality Impact Assessment.

Continue to collect bi annual SNCT data, using the SNCT tool. The next data collection will be in May 2025.

Ensure effective rostering to meet the Key Performance Indicators and workforce model outlined in the Business Case.

Children and Young People; Woodlands Ward

Background

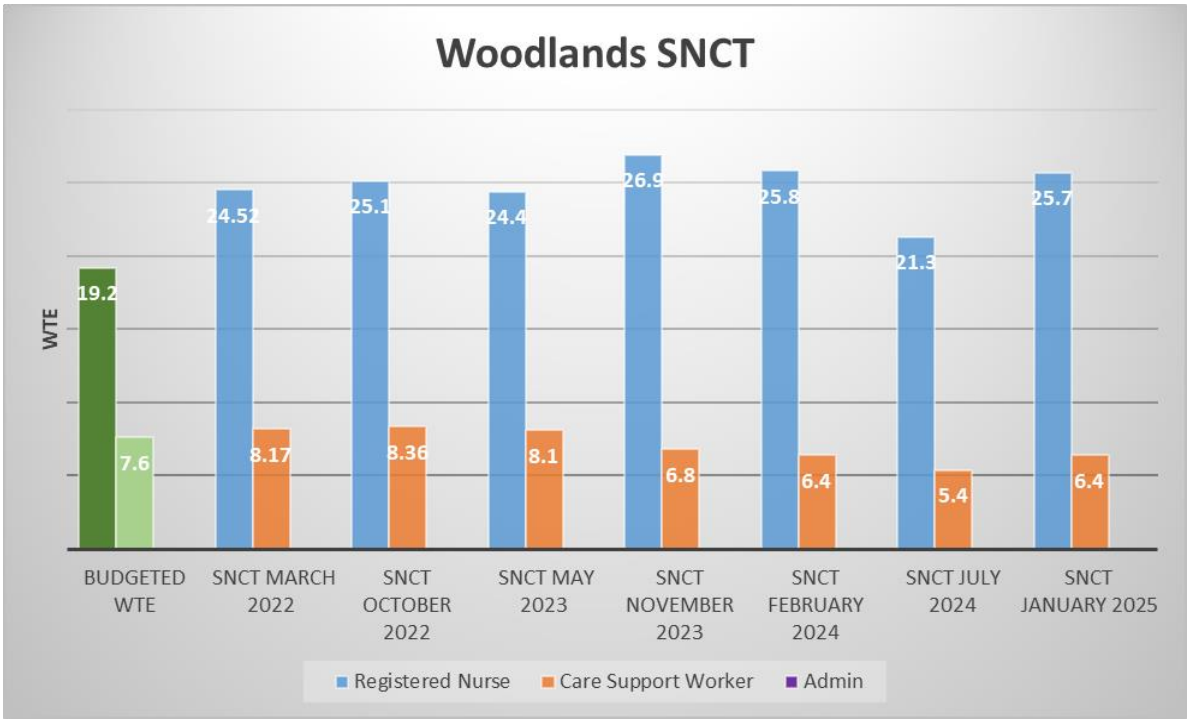
Following a National Institute of Clinical Excellence (NICE) endorsed Safer Nursing Care Tool (SNCT) (2021) review, undertaken biannually. The scope for this SNCT data collection encompasses the Children and Young People inpatient ward. To note, there is another review of Children's and Young People inpatient services and pathways with the Emergency Department (ED). Specifically in relation to delivering "the right staff, with the right skills, in the right place at the right time" The National Quality Board (NQB) (2018). Therefore, the results of this review are awaiting triangulation with this additional piece of work.

Data was collected in January 2025 with triangulation of the results with quality data and professional judgement in February 2025.

Ward Description

Woodlands ward is a 16 bedded general paediatric ward admitting acute and elective medical and surgical patients. A Children's Assessment Unit (CAU) is situated within the ward which can flex the ward to a 22 bedded unit. The ward admits children and young people (CYP) from birth to 17 years old from various referral routes, general practice, emergency department, health visitors, outpatients, midwifes etc. The ward has 3 bays of 4 beds but one is the CAU and 10 side rooms, one of which acts as a high dependency unit (HDU).

SNCT Raw Data



The current staffing template for Woodlands

Play Specialist	1.0 wte
Practice Education	0.2 wte
Admin	1.0 wte
Management Time	0.8 wte

Monday to Friday

	Early	Late	Night
RN	4	3	3
CSW	1	1	1

Saturday to Sunday

	Early	Late	Night
RN	3	3	3
CSW	1	1	1

Budgeted Skill Mix

	Budgeted WTE
Band 7	1.0
Band 6	6.13
Band 5	12.14
Band 4	1.0
Band 3	0
Band 2	5.65
Band 2 ward clerk	1.0

The Band 2 CSW's are in the process of being re banded to Band 3 CSW's. This was a part of the national Band 2 to Band 3 review.

Discussion

See appendix 15

Recommendations

The SNCT data and triangulation supports a slight increase in establishment. However, this requirement relates to the provision to support the Children's Assessment Unit (CAU) which is still being worked through by the PSCC directorate.

The SNCT outputs (data, quality metrics and professional judgement) **indicate an accurate nursing establishment for the current Woodlands Ward requirements and that no changes are proposed as a result of this review.**

A separate business case is being worked up by the Ward Manager and Matron for C&YP to support the increase in Practice Education provision, in line with regional and national recommendations and an options appraisal is being undertaken regarding the most appropriate model to run the CAU in the future.

Continue to collect bi annual SNCT data, using the SNCT tool. The next data collection will be in June 2025.

Ensure effective rostering to meet the Key Performance Indicators.

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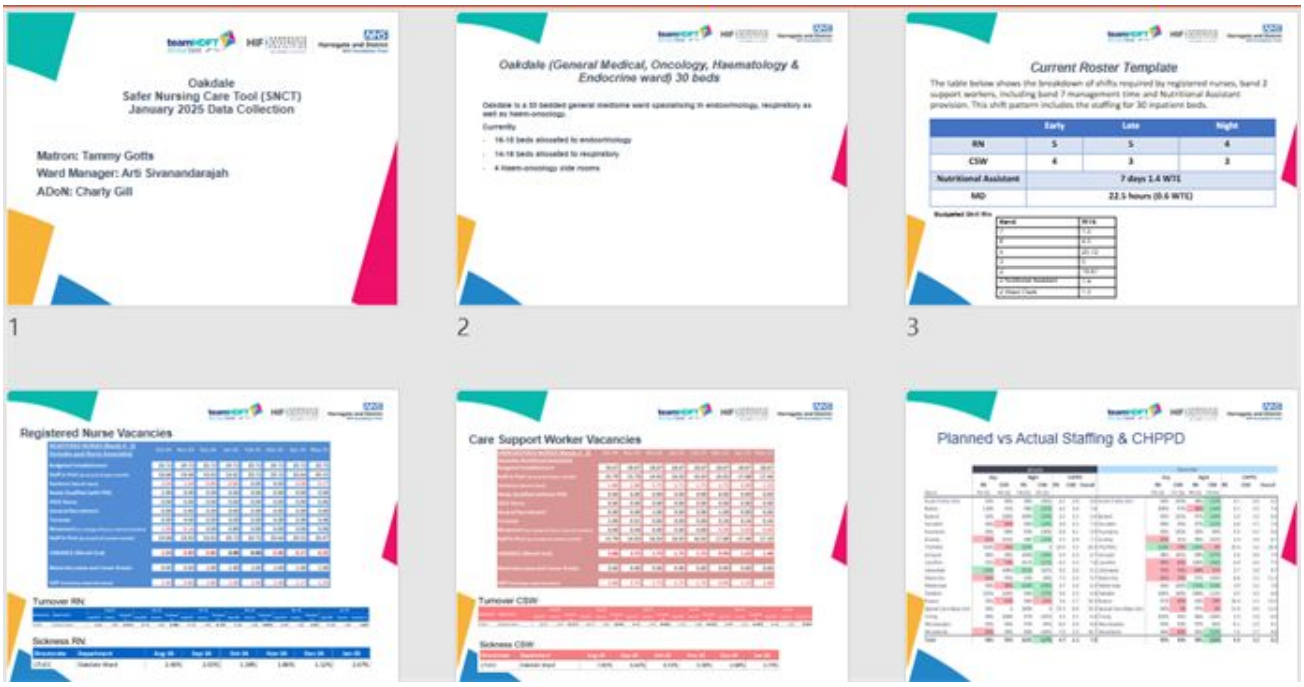
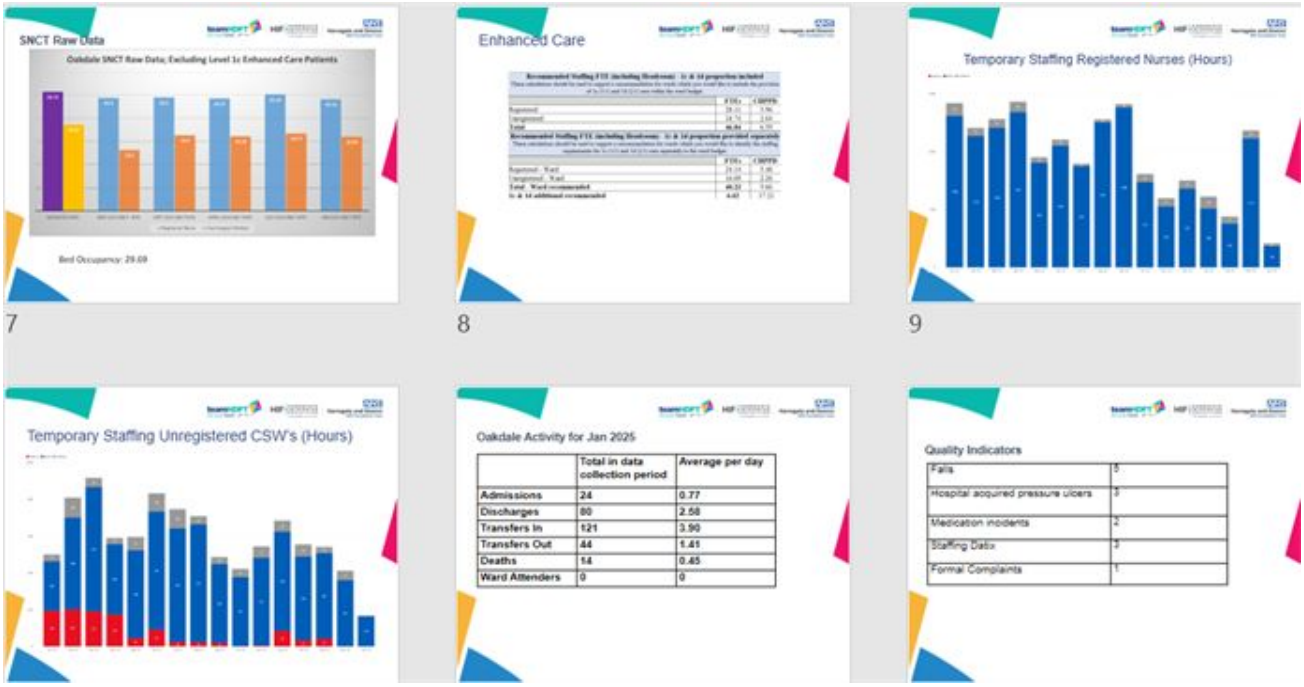
Appendix 1





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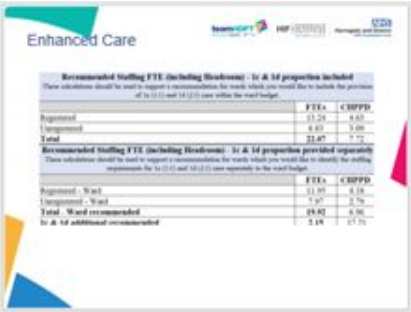

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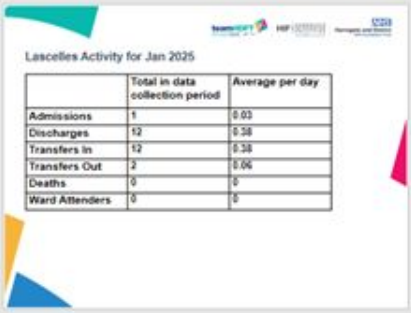

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Appendix 3

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Appendix 8

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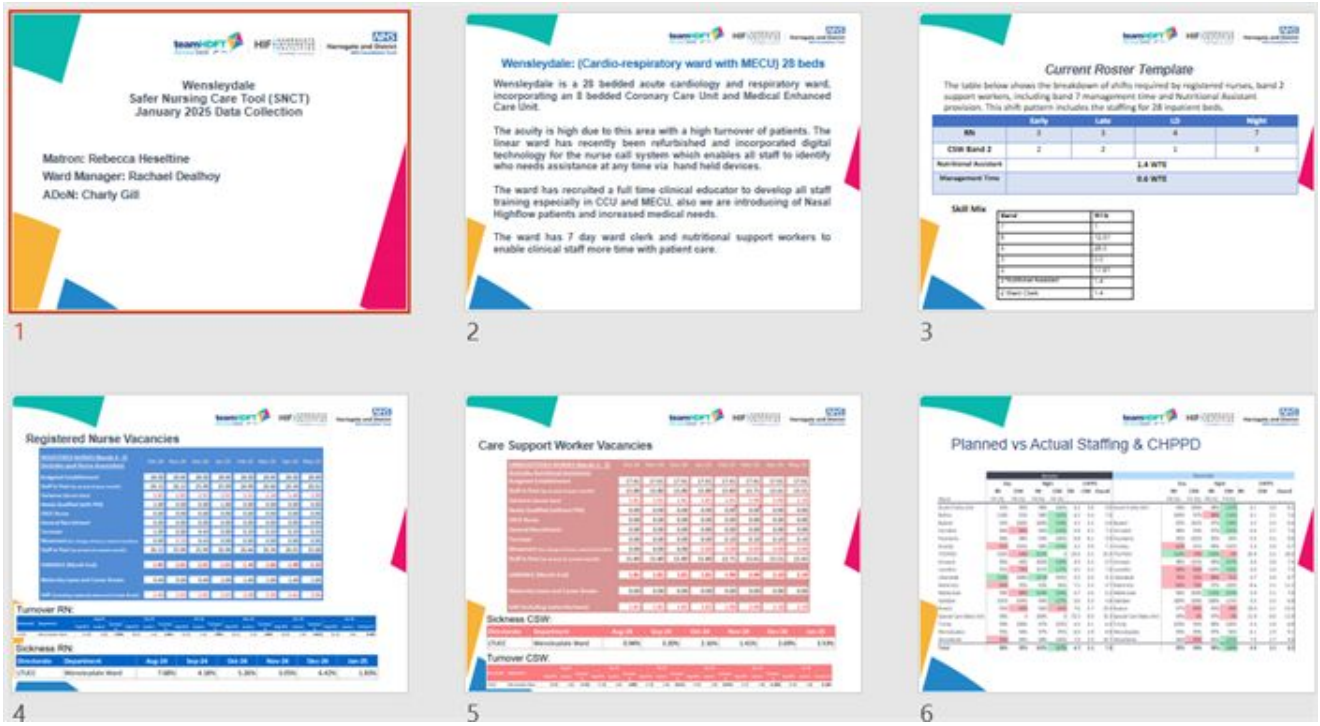
Appendix 9



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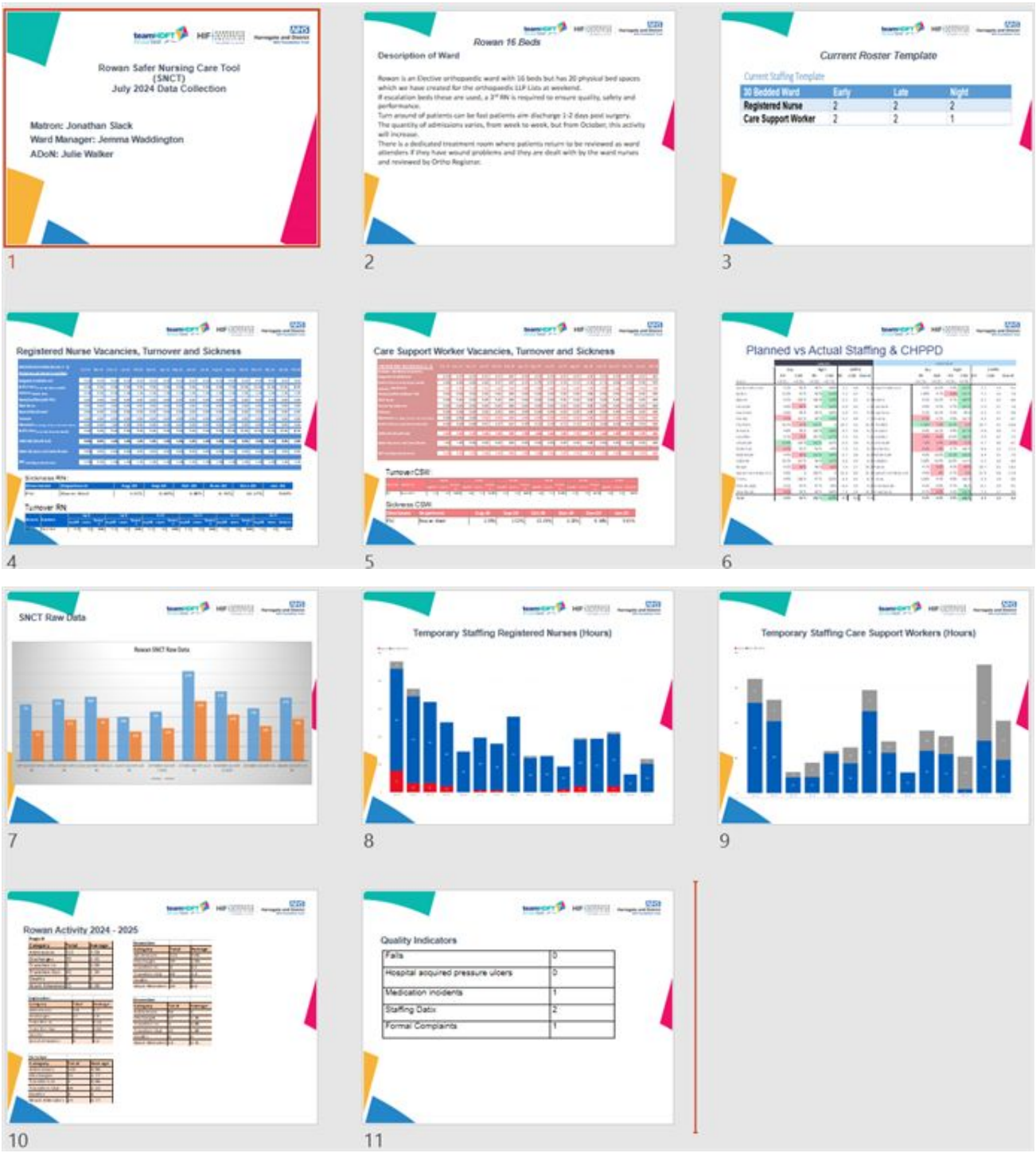
Appendix 10



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Appendix 11

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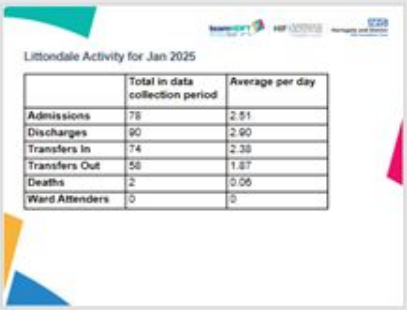

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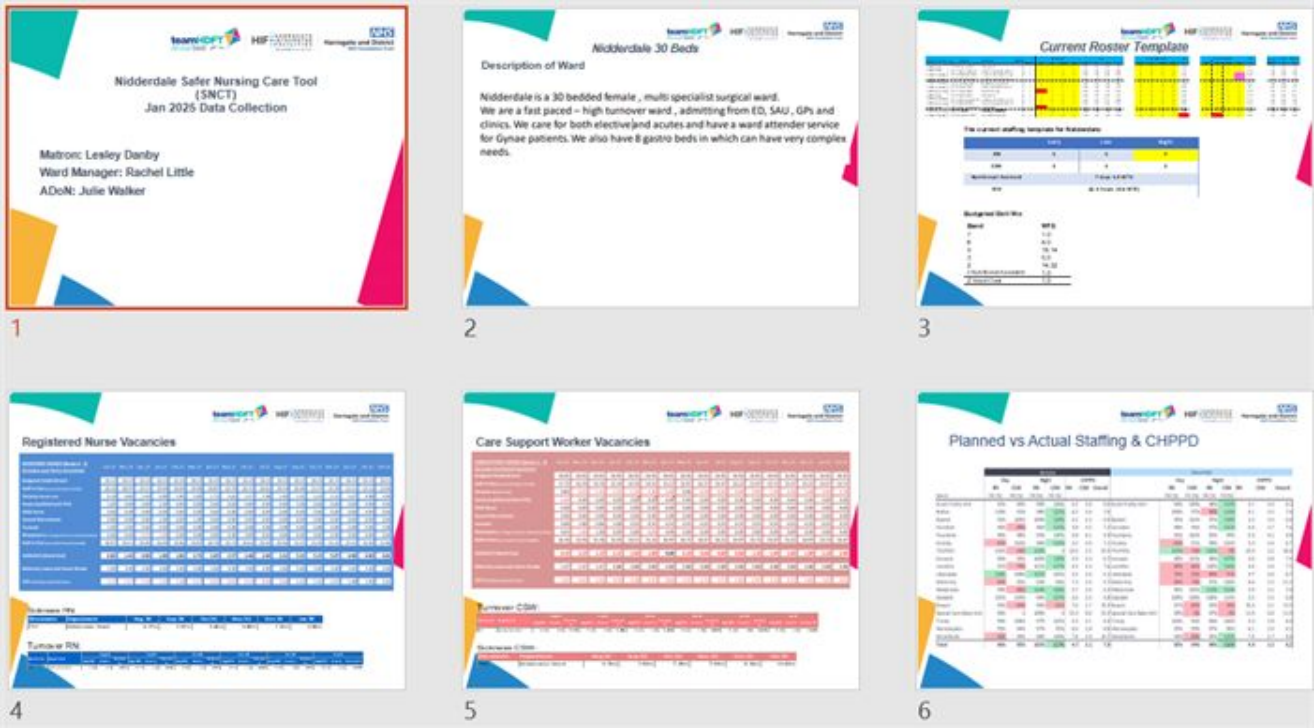
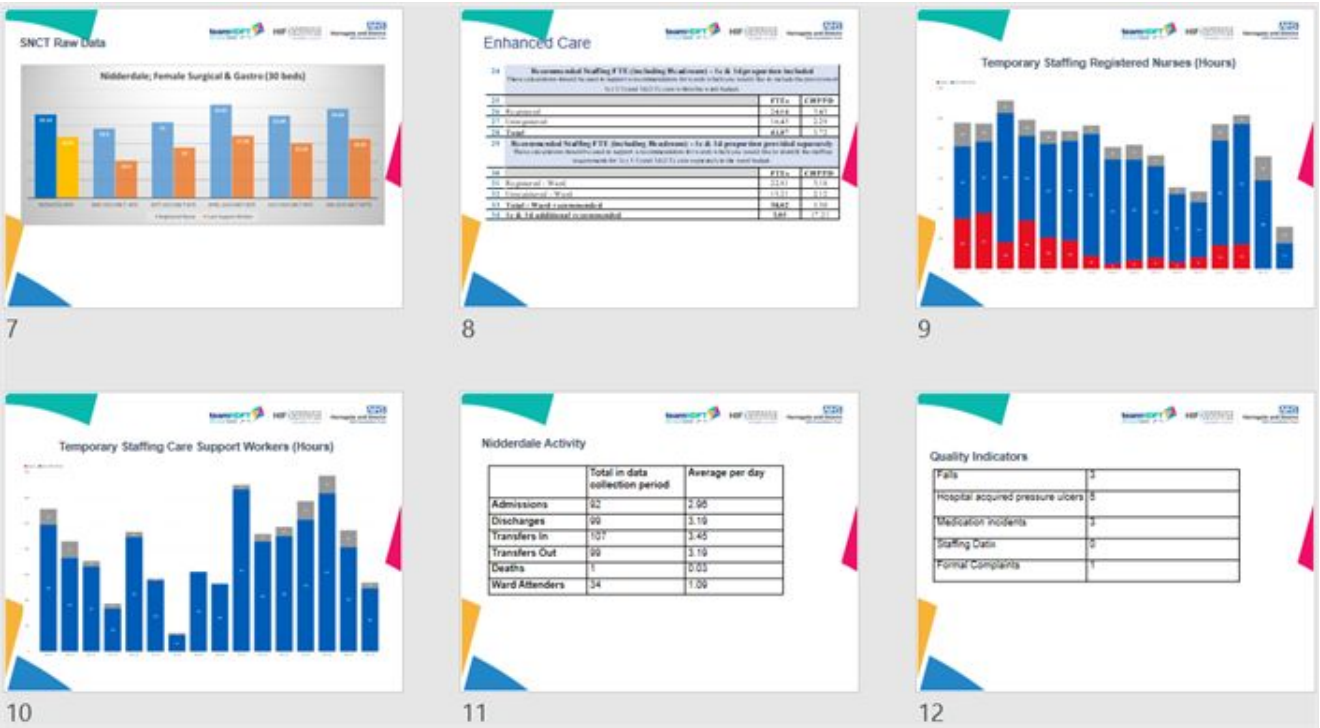
Appendix 13





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Appendix 14

Data Pack for ED SNCT Jan 2025

Matron: Amy Carr
Department Managers: Elvira Obrinja and Rachael Worton

Dates of SNCT data collections:
January 2025

1

Description of ED

- The Emergency Department (ED) is open 24 hours a day, 7 days a week delivering unscheduled care for acutely ill/injured adults and children.
- The department consists of two areas (ED1 and ED2).
- ED1 manages those patients presenting with major medical conditions, ED2 manages patients presenting with Minor Illness and injuries.
- ED1 consists of :

15 Majors Cubicles
3 X Resus Bays
3 X YAS RIAT Bays (Ambulance off load area)
Relatives room – often used for mental health patients
Fit 2 Sit – up to 8 Patient capacity
Triage Room
Streaming Room

2

Description of ED

- ED2 Consists of:

3 Minors Cubicles
5 Majors Cubicles
1 Mental Health Assessment room.

Management structure: The ED is led by a Triumvirate leadership structure consisting of a Clinical Lead, Service Manager and Matron.

The matron is supported by 2 WTE Band 7 Lead Nurses (managerial roles). The Lead Nurses take on the management and supporting role of 64 WTE nursing staff (from Band 7 – Band 2)

3

Description of ED

4

Current Roster Template

Area	Band	Early	Late	LD	Night
Nurse in Charge/Staff Base	7	0	0	1	1
Streaming	6	1	1	0	1
Streaming	6/5	0	0	1	1
Resus	6	0	0	1	1
Fit to Sit	5	0	0	1	1
Cubicles	5	1	1	2	3
Gynae & MH Room	5	1	1	0	1
YA S RIAT	5	0	0	1	1
YA S RIAT	3	0	0	1	1
Waiting Room RIAT	3/2	1	1	0	1
Cubicles	2	1	1	0	1

5

Current Workforce

Band	Budgeted	In Post	Vacancies
Band 7 Manager	2.0	2.0	0
Band 7 Clinical	5.35	5.35	0
Band 6 Clinical	12.6	12.4	0.52
Band 6 Practice Educator	1.8	1.6	0
Band 5	34.35	35.35	Over 0.7
Band 3	16	11	5 (out to advert)

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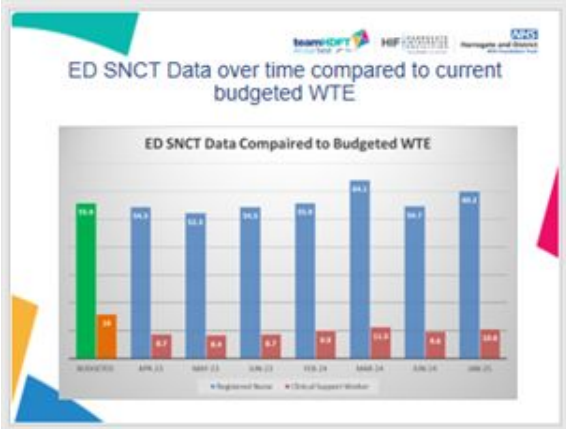

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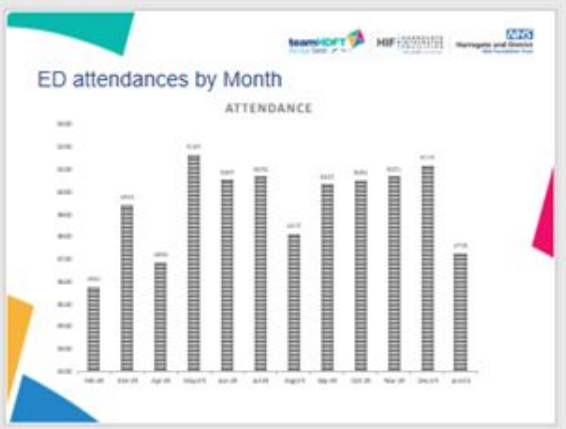

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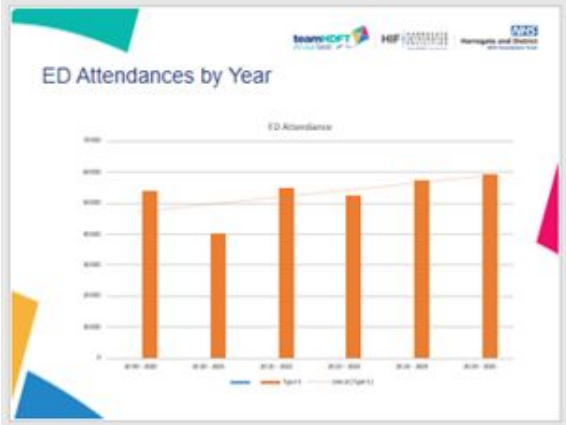

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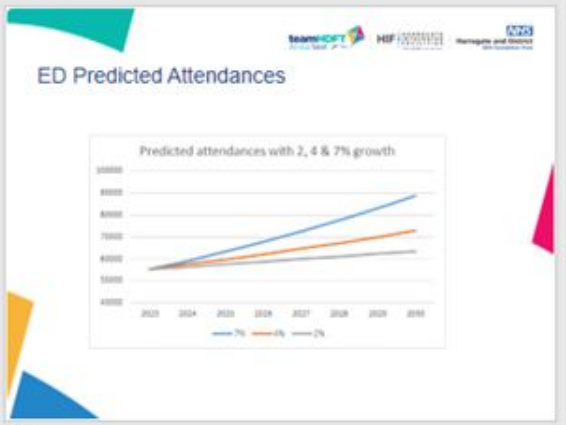

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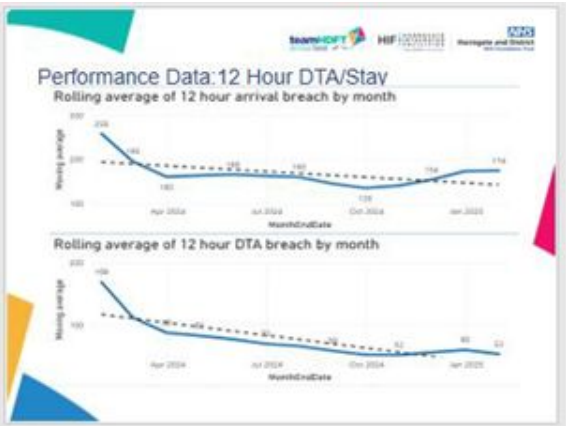

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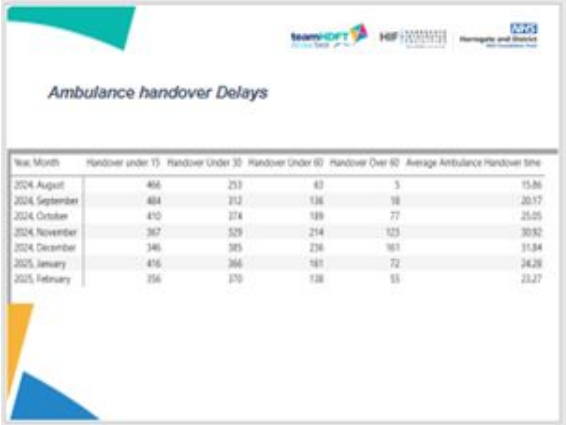

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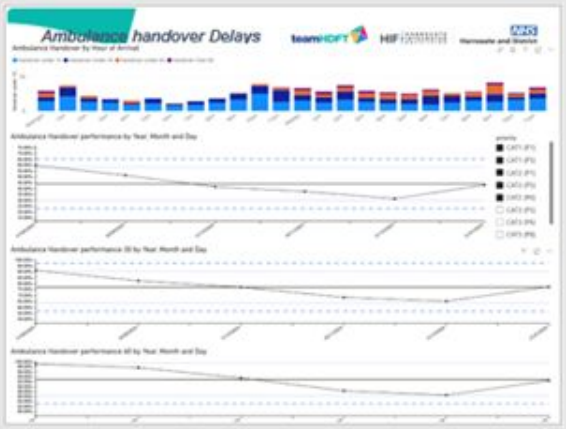

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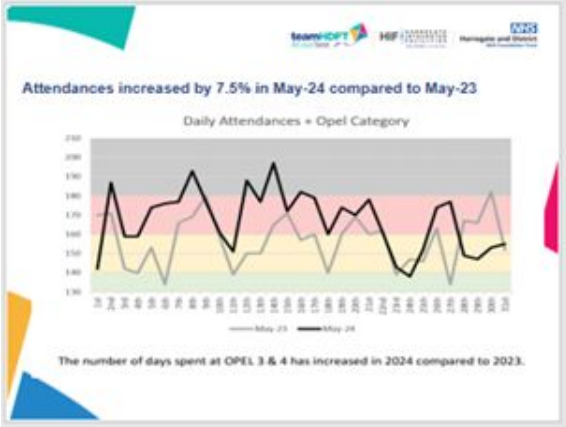

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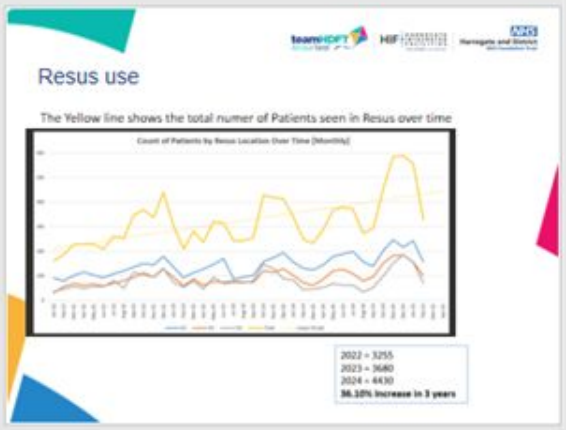

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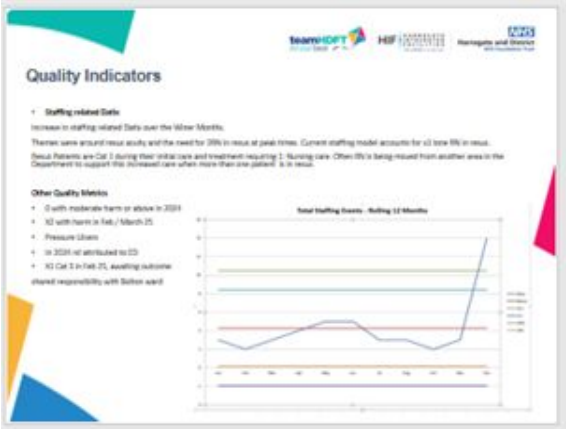

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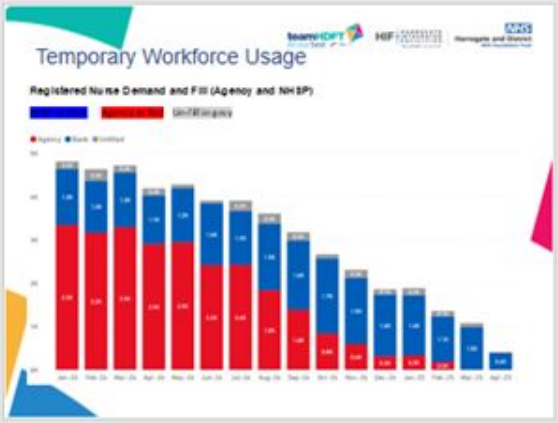
Harrogate and District
NHS Foundation Trust



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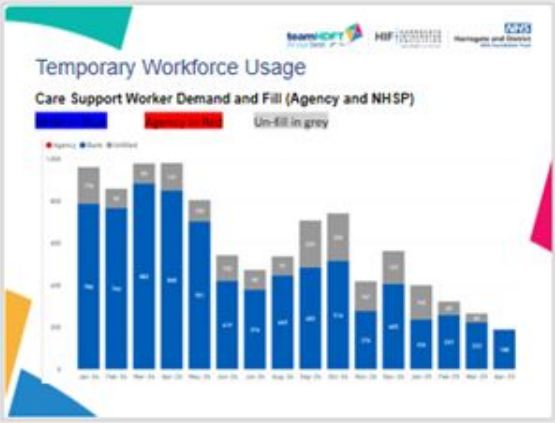

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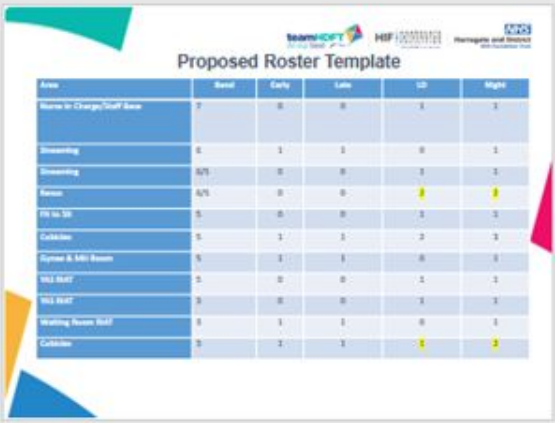

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Appendix 15

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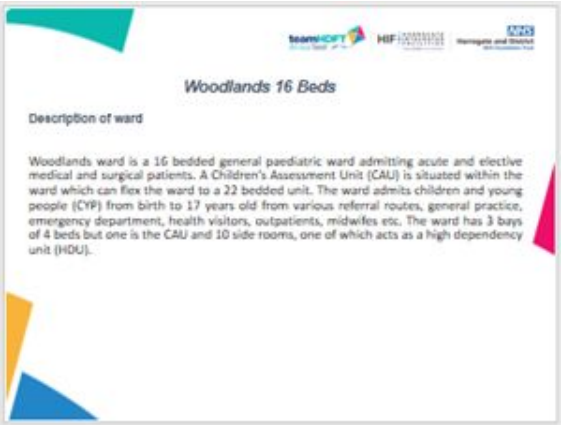

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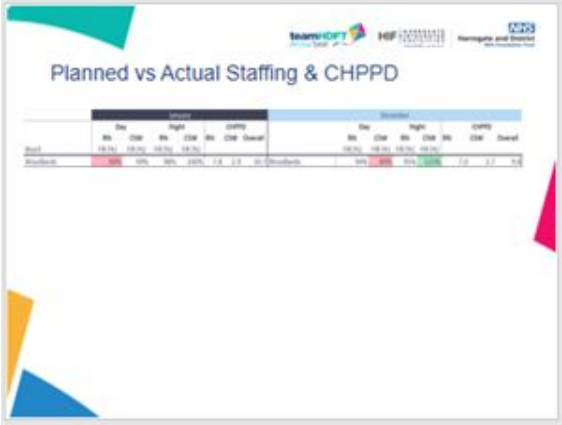

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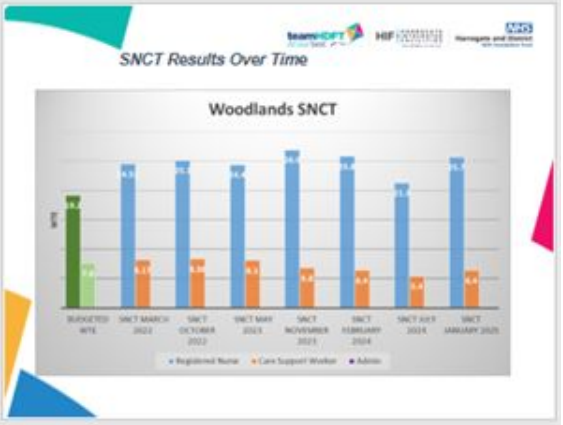

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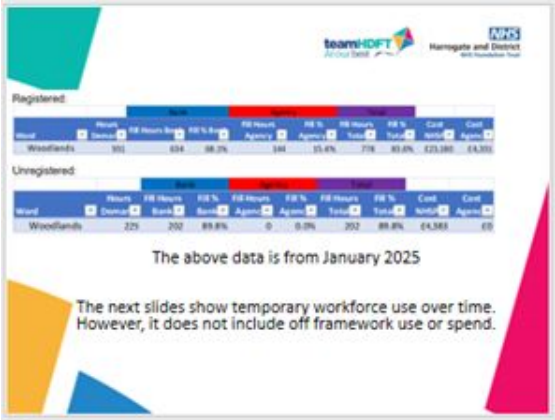

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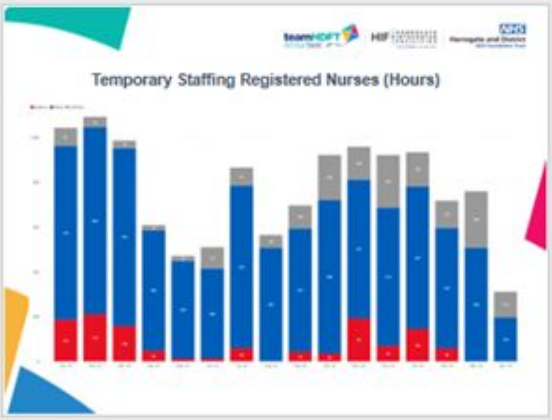

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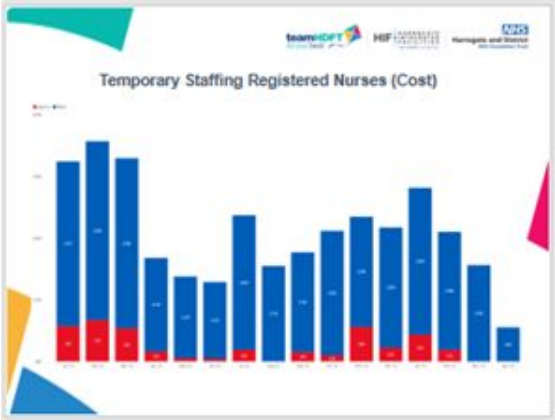

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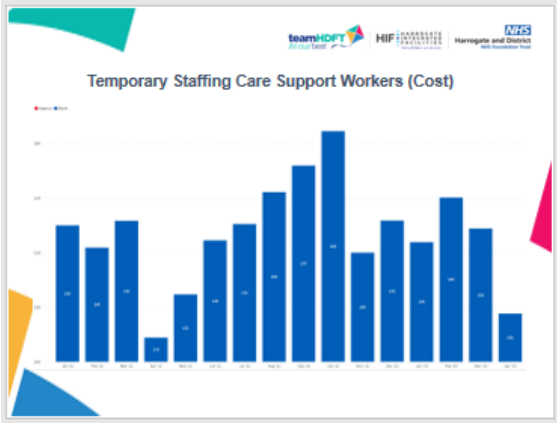

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Woodlands Activity for January 2025

	Total in data collection period	Average per day
Admissions	290	9.35
Discharges	286	9.22
Transfers In	2	0.06
Transfers Out	2	0.06
Deaths	0	0
Ward Attenders	29	0.93

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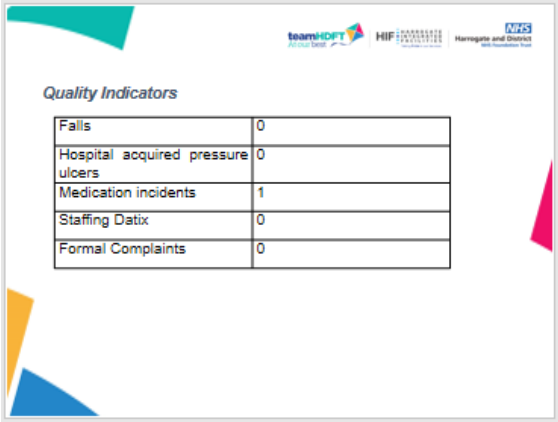

Quality Indicators

Falls	0
Hospital acquired pressure ulcers	0
Medication incidents	1
Staffing Datix	0
Formal Complaints	0

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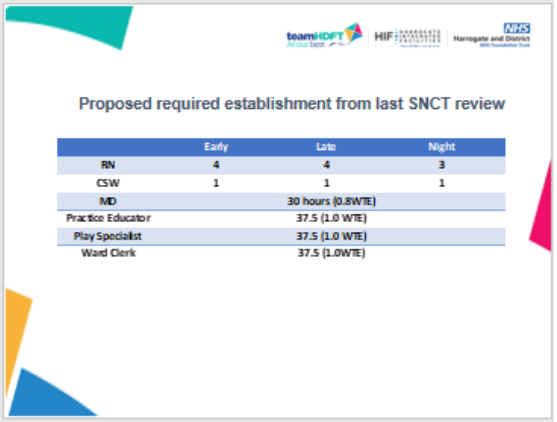

Proposed required establishment from last SNCT review

	Early	Late	Night
RN	4	4	3
CSW	1	1	1
MD	30 hours (0.8WTE)		
Practice Educator	37.5 (1.0 WTE)		
Play Specialist	37.5 (1.0 WTE)		
Ward Clerk	37.5 (1.0WTE)		

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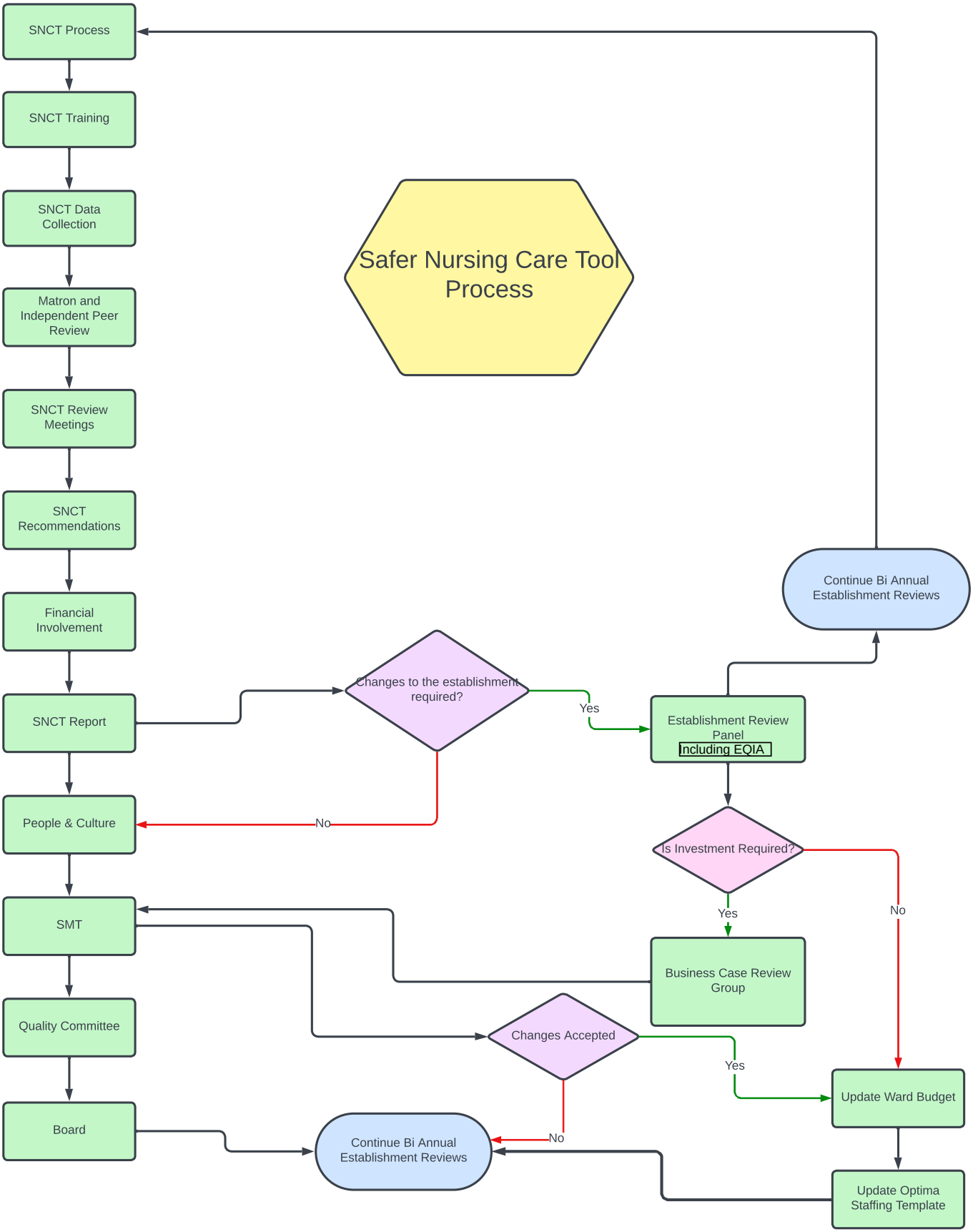

Safer Nursing Care Tool Process
SNCT Process
SNCT Training
SNCT Data Collection
Matron and Independent Peer Review
SNCT Review Meetings
SNCT Recommendations
Financial Involvement
SNCT Report
People & Culture
SMT
Quality Committee
Board
Changes to the establishment required?
Yes
No
Establishment Review Panel Including EQIA
Is Investment Required?
Yes
No
Business Case Review Group
Changes Accepted
Yes
No
Continue Bi Annual Establishment Reviews
Update Ward Budget
Update Optima Staffing Template
Continue Bi Annual Establishment Reviews

Public Sector Equality Duty Report
April 2024– March 2025

Title:	Public Sector Equality Duty Report 2024 - 2025
Responsible Director:	Director of People and Culture
Author:	Head of Education, Learning and Development Equality, Diversity, and Inclusion Manager

Purpose of the report and summary of key issues:	The purpose of this report is to provide assurance of compliance with the Public Sector Equality Duty (PSED) for the period of April 2024 – March 2025. The Trust is required to comply with both the general duties and the specific duties of the PSED and is mandated to publish the results of activities in relation to the Equality Delivery System (EDS) 22, Workforce Equality Standards and Gender Pay Gap (GPG) Report. This report is an aggregation of all Equality, Diversity, and Inclusion (EDI) work to provide assurance that Harrogate District NHS Foundation Trust (HDFT) is compliant with PSED. Key themes include: - Improvements in staff engagement and diversity - Notable increases in BME representation - Notable increases in disclosures of disability and sexual orientation. The National Staff Survey (NSS) results indicate that HDFT falls below the national average concerning discrimination across various protected characteristics: - Gender - Sexual Orientation - Disability

<table>
<tr><td></td><td colspan="2">- Age
- Other

Efforts to address disparities in career progression and harassment are highlighted, along with initiatives such as Reciprocal Mentoring programs and reasonable adjustment support. Recommendations include implementing action plans derived from Workforce Equality Standards to inform future diversity and inclusion strategies.

The report is for noting prior to its publication.</td></tr>
<tr><td rowspan="9">BAF Risk:</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></td></tr>
<tr><td>Person Centred, Integrated Care; Strong Partnerships</td><td></td></tr>
<tr><td>Great Start in Life</td><td></td></tr>
<tr><td>At Our Best: Making HDFT the best place to work</td><td>√</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">None</td></tr>
<tr><td>Report History:</td><td colspan="2">The report has been discussed at the May 2025 Strategy Deployment Room.</td></tr>
<tr><td>Recommendation:</td><td colspan="2">It is recommended that this report is noted prior to publication on the Trust’s external website.</td></tr>
</table>

Contents Page

1. Purpose

The Equality Act 2010 sets out the Public Sector Equality Duty (PSED) in three key areas of compliance, in which the general duty requires the Trust to exercise their functions having due regard to the need to:

- Advance equality of opportunity between people who share and people who do not share a relevant protected characteristic.
- Foster good relations between people who share and people who do not share a relevant protected characteristic.
- Eliminate unlawful discrimination, harassment, victimisation, and any other unlawful conduct prohibited by The Act.

The purpose of the report is to provide assurance of Harrogate District NHS Foundation Trust's (HDFT) compliance with the Public Sector Equality Duty (PSED) under the Equality Act 2010, focusing on advancing equality of opportunity, fostering good relations, and eliminating unlawful discrimination.

2. Background

The first two aims of the PSED (advancing equality and fostering good relations) applies to the first eight of the nine protected characteristics (age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex, sexual orientation and marriage or civil partnership status). Although marriage and civil partnership is a protected characteristic, it is not relevant to the first two aims and only needs to be considered in relation to eliminating unlawful behaviour, which applies to all nine protected characteristics.

HDFT strives to create a culture of inclusivity through the People Plan 2024 and beyond. The delivery of this is through a governance structure which includes the Belonging subgroup. This group facilitates the organisations EDI ambitions:

- Everyone will demonstrate HDFT KITE (Kindness, Integrity, Teamwork and Equality) behaviours to care for our patients, children and communities.
- HDFT will build strong teams who support each other.
- HDFT will promote equality and diversity.
- HDFT will increase diversity in leaders and decision makers.

Alongside the use of the PSED, HDFT also works in line with the NHS's first National EDI improvement plan, published on June 8th, 2023. This improvement plan sets out targeted actions to address prejudice and discrimination – direct and indirect – that exists through behaviour, policies, practices and cultures against certain groups and individuals across the NHS workforce.

The NHS EDI improvement plan includes six high impact actions (HIA):

1. Chief executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable.
2. Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity.
3. Develop and implement an improvement plan to eliminate pay gaps.
4. Develop and implement an improvement plan to address health inequalities within the workforce.
5. Implement a comprehensive induction, on boarding and development programme for internationally recruited staff.
6. Create an environment that eliminates the conditions in which bullying, discrimination, harassment, and physical violence at work occur.

Success metrics for the National Improvement Plan include NSS results, WRES and WDES, National Education and Training Survey (NETS) and Board Assurance Framework. The implementation of the national EDI improvement plan will strengthen the progress of the PSED within HDFT, leading to better outcomes for patients and a more inclusive work environment for staff. The success metrics for the NHS Improvement Plan are largely encompassed within this PSED.

This report will now set out HDFT data under the three key areas of the PSED for the period of April 2024 to March 2025. Please be aware that there may be variations in headcount figures between the 2023 – 2024 and 2024 – 2025 periods throughout the report, as the data is sourced from multiple channels at different points in time.

3. To advance equality of opportunity

3.1 Staff Survey Results

HDFT saw a rise in the NSS response rate, with 48.7% (2463 employees) of the workforce taking part, a 3% increase on the previous year.

Between September and November 2024, the National Staff Survey was undertaken by IQVIA for 126 organisations, including HDFT. 65 of these Organisations are Acute and Acute & Community Trusts, which make up the comparator group displayed across the HDFT NSS results.

The seven NHS People Promises and themes of Engagement and Morale have not changed significantly from 2023.

Two questions from the NSS can demonstrate improvements in the advancement of opportunity:

1. Staff who agree or strongly agree that the organisation respects individual differences (e.g. cultures, working styles, backgrounds, ideas, etc.).

There is a 1.7% decline in respondents agreeing that the organisation respects individual difference, as illustrated below.

HDFT 2023	HDFT 2024	Difference	Comparator
75.7%	74%	1.7%	69.8%

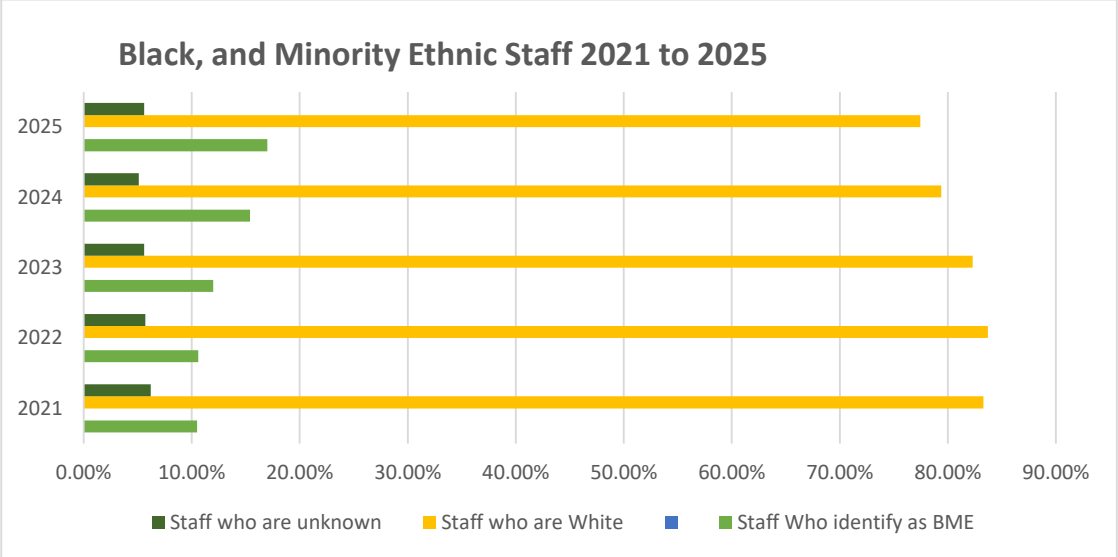
2. Staff who agree that the organisation acts fairly concerning career progression/promotion, regardless of ethnic background, gender, religion, sexual orientation, disability, or age.

As illustrated below, there is a 2.2% decrease in respondents agreeing that the organisation acts fairly concerning career progression/promotion, regardless of ethnic background, gender, religion, sexual orientation, disability, or age.

HDFT 2023	HDFT 2024	Difference	Comparator
60.9%	58.7%	2.2%	54.5%

3.2 Workforce Ethnicity

The proportion of Black and Minority Ethnic Staff (BME) has increased year on year, as illustrated below.



The table below shows the total number of BME staff on 31 March 2025

Out of the 5263 employees who declared their racial identity on ESR, 864 disclosed their ethnicity under the umbrella category of "BME."

Ethnic Origin	Headcount
D Mixed - White & Black Caribbean	8
E Mixed - White & Black African	14
F Mixed - White & Asian	17
G Mixed - Any other mixed background	12
GA Mixed - Black & Asian	1
GC Mixed - Black & White	1
GD Mixed - Chinese & White	3
GE Mixed - Asian & Chinese	2
GF Mixed - Other/Unspecified	5
H Asian or Asian British - Indian	289
J Asian or Asian British - Pakistani	71
K Asian or Asian British - Bangladeshi	9
L Asian or Asian British - Any other Asian background	43
LA Asian Mixed	1
LB Asian Punjabi	2
LE Asian Sri Lankan	8
LG Asian Sinhalese	1
LH Asian British	8

LK Asian Unspecified	7
M Black or Black British - Caribbean	14
N Black or Black British - African	185
P Black or Black British - Any other Black background	5
PB Black Mixed	2
PC Black Nigerian	42
PD Black British	2
R Chinese	18
S Any Other Ethnic Group	43
SC Filipino	42
SD Malaysian	2
SE Other Specified	7
Total	**864**

3.3 Seniority and Ethnicity

Using three broad pay bandings across all staff groups, it is evident that there is an increase in the number of staff disclosing their ethnicity from 2024 to 2025. The overall growth is largely driven by the increase of BME staff and reduction of White staff within Medical and Dental.

HDFT remains committed to taking positive action to address underrepresentation or disadvantage faced by certain groups and over this reporting cycle has:

- Encouraged disclosure of protected characteristics on employment records
- Implemented cohort two of a Reciprocal Mentoring programme.
- Maintained the BME and Ally Staff Network (now known as REACH network)

A comparison table showing the pay bandings of BME staff, including categories for White and Not Stated, is available on the next page.

31st Mar 2024				
Banding	**BME**	**White**	**Not Stated**	**TOTAL**
Bands 2 -7	604	3,562	242	**4,408**
Bands 8 - VSM	12	262	8	**282**
Medical and Dental	191	333	38	**562**
TOTAL	**807**	**4,157**	**288**	**5,252**
Total %	**15%**	**79%**	**5%**	
31st Mar 2025				
Banding	**BME**	**White**	**Not Stated**	**Total**
Bands 2 -7	661	3513	248	4422
Bands 8 - VSM	15	277	8	300
Medical and Dental	188	312	41	541
TOTAL	864	4102	297	**5263**
Total %	**16%**	**78%**	**6%**	

3.4 Workforce Race Equality Standard (WRES) Data

HDFT can demonstrate improvements in the advancement of equality of opportunity through WRES data (reporting period to 31 March 2024):

- Metric 1: The total percentage of BME employees in HDFT (excluding Board members) has increased by 3.6% since 2023.
- Metric 5: 3.4% reduction in staff experiencing harassment, bullying or abuse from patients, relatives, or the public in the last 12 months. 1.3% improvement against the national average.
- Metric 6: 8.1% reduction in staff experiencing harassment, bullying or abuse from staff in the last 12 months.
- Metric 8: 7.0% reduction in staff experiencing harassment, bullying or abuse from their manager, team leader or other colleague in the last 12 months.
- Metric 9: An overall 3.4% reduction in Board of Directors' representation, compared to the overall workforce from 22% in 2023, and now 18.6% in 2024.

The Trust regularly holds its REACH (Race, Ethnicity and Cultural Heritage) staff network group (previously known as BME and Allies network), a well-established network with approximately 111 members. Activities undertaken during this reporting cycle include:

- Workforce celebrations and awareness raising, i.e., ethnicity, religious festivals such as Ramadan, Eid and the Festival of Light, health inequalities, and Black History Month, as well as workshops to support BME colleagues.
- Information through Facebook pages and Team Talk – our Chief Executive leads live MS Teams Trust-wide communication sessions each week, including invited speakers to raise awareness of EDI, health, long-term conditions, and many other topics.
- The Executive sponsor, Russell Nightingale, and Non-Executive Director Wallace Sampson have attended some of the network meetings, providing high-level support and commitment to its members.

See Appendix 1 WRES Data 2024 for more information

3.5 Gender

The workforce remains predominantly female with little movement in percentage terms (86% in March 2022, 85% in March 2023, 83% in March 2024 and 84% in 2025). The Trust demonstrates a steady increase in female staff at higher bands and in Medical and Dental.

	31 Mar 2022			31 Mar 2023			31 March 2024			31 March 2025		
	Employees	Female	Male	Employees	Female	Male	Employees	Female	Male	Employees	Female	Male
Bands 2-7	3,791	3,412	379	3,983	3,545	438	4,408	3,887	521	4422	3901	521
Band 8 to VSM	219	175	44	242	190	52	282	219	63	300	231	69
Medical and Dental	433	235	198	470	244	226	562	277	285	541	296	245

The data tells us:

1 There are more women in roles band 2-7 – 88% Female, 12% Male

2 There are more women in roles band 8 – VSM: 77% Female, 23% Male

3 The representation between men and women within Medical and Dental: 55% Female, 45% Male

Across the whole of the NHS, 77% women make up the NHS workforce but are under-represented at senior level.

3.6 Gender Pay Gap

In 2018, it became mandatory for all public sector employers with more than 250 employees to measure and publish their gender pay gap (GPG) information. The GPG is a measure of the percentage difference in pay between all male and female workers. Closing the gender pay gap is about more than just the numbers, it is about increasing support for female staff.

At HDFT, females earn on average £19.65 hour compared to £25.99 for males. This means that females earn £6.34 less per hour, which equates to a £6.34 gender pay difference or 'gap' this equates to a 24.4% pay gap. Last year this was 26%, which means that the gap has marginally reduced since the previous year by 1.6%

3.7 Age

The majority of Trust staff are aged between 31 and 60. More than 32% of staff are aged over 51, highlighting the importance of age inclusion. The Organisation has seen a rise in the headcount, but not percentage, of staff aged 51 and over.

	2023/2024		2024/2025	
Age Band	**Headcount**	**% of Workforce**	**Headcount**	**% of Workforce**
16-20 Years	17	0.3%	17	0.3%
21-30 Years	757	15.0%	847	16.1%
31-40 Years	1,312	26.0%	1392	26.5%
41-50 Years	1,286	25.5%	1310	24.9%
51-60 Years	1,290	25.6%	1283	24.4%
60+ Years	377	7.5%	410	7.8%
TOTAL	**5,039**		**5259**	

3.8 Disability

The number of staff who have disclosed their disability on the Electronic Staff Record (ESR) has risen by 62 employees but remains as 6.3% of the workforce. There is a 1% increase in colleagues choosing to declare their disability or long-term condition.

The ability to report on who has, or has not, verified their information has only been available from March 2024. Most ESR data is provided at the start of employment, however, it should be considered that disabilities can be acquired during employment, and therefore may not be disclosed.

The National Staff Survey for 2024 shows 665 employees disclosing a disability or long-term condition, which is 27% of respondents or approximately 12% of the workforce. Data collection on ESR continues to be improved in several ways, including by regular communications in our all-staff weekly bulletin, promoting step-by-step guides to complete ESR and highlighting what the data is used for on the Intranet.

Disability Status	Headcount 31 March 2024	Headcount 31 March 2025
Yes	315	377
No	4,402	4396
Not Declared	525	473
Prefer not to answer	10	11
TOTAL	**5,252**	**5257**

Significant amounts of work continue to take place in the organisation regarding disability and long-term conditions, including:

- Within the Disability and Long –Term Condition staff network:
    - The membership has more than doubled, to approximately 75 people.
    - Examples of discussion topics include WDES data, staff policies and specific conditions to raise awareness.
    - The Reasonable Adjustments Passport
    - Executive Sponsor involvement - the Director of Strategy and a Non-Executive Director both attend network meetings to offer support.

- Within the Neurodiversity Staff network:
    - The membership has increased to over 55 people.
    - Topics of discussion are usually based on people's lived experiences.
    - Colleagues who are neurodivergent or parents to neurodivergent children attend, to gain understanding and learn from others.
    - Communication includes E-updates and intranet articles.
    - Equality, Diversity, and Inclusion training is delivered during Corporate induction.
    - Furthermore, the Trust is recognised under the Disability Confident Scheme (level II). The scheme is a best practice standard to ensure that those people who identify as being disabled or having a long-term condition can be offered an interview where they can demonstrate they meet the minimum requirements of the role. Work continues to embed the scheme into the recruitment and selection process, ensuring that people who identify as having a disability are not disadvantaged and is reviewed annually.
    - The Trust has several initiatives or points of contact in place to prevent the development of long-term mental health conditions, including burnout:
        - Mental Health First Aiders
        - Health and Wellbeing Manager
        - Referral links between the Employee Assistance Programme and Occupational Health Department.
        - Annual health and wellbeing events
        - Health promotions, such as the Blue Light Card
        - Staff rest areas within the hospital.

3.9 Reasonable Adjustments

Significant work has been carried out to enable colleagues to feel more empowered to request reasonable adjustments from their manager. The annual National Staff Survey asks the question, "Has your employer made adequate adjustment(s) to enable you to carry out your work?"

78.1% of colleagues received their reasonable adjustment and 21.9% did not. Compared to 2023, there is a 2.1% increase in staff accessing required reasonable adjustments, which runs simultaneously with a decrease in those not receiving or not requiring them, as illustrated below.

	HDFT 2023		HDFT 2024	
Yes	243	75.9%	310	78.1%
No	77	24.1%	87	21.9%
No adjustment required	259	44.7%	264	39.9%

3.10 Workforce Disability Equality Standard (WDES) Data

Harrogate District Hospital Foundation Trust can demonstrate improvements in the advancement of equality of opportunity at the Trust, through the use of WDES data (reporting period to 31 March 2024):

- Metric 1: There continues to be year on year increases of staff declaring their disability or long-term condition. HDFT had more staff declaring this protected characteristic than the national average.
- Metric 3: One employee with a disability or long-term condition entered the capability process in 2023 / 2024.
- Metric 4a – d: Since the last WDES, disabled staff have reported fewer incidents of bullying and harassment from managers, colleagues, and patients/service users. For the incidents that did occur, more were reported in 2023 in comparison to the previous year. HDFT disabled staff experience less incidences of bullying and harassment which is better than the national average.
    - Metric 4a: Harassment, bullying or abuse from patients, relatives or the public in the last 12 months reduced from 29.7% to 26.7% and is 3.1% better than the national average.
    - Metric 4b: Harassment, bullying or abuse from line managers in the last 12 months reduced from 14.5 % to 11.0 % and is 4.3 % lower than the national average.

- Metric 4c: Harassment, bullying or abuse from other colleagues in the last 12 months reduced from 21.2% to 21.1% and is 3.2% lower than the national average.

- Metric 4d: The last time you experienced harassment, bullying or abuse, did you report it? The data has improved from 49.3% to 56.1% and is better than the national average of 50.6%.

Please see Appendix 2 WDES data for more information

3.11 Sexual Orientation

The table below shows the number of LGBTQ+ people who have disclosed their sexuality on ESR.

Sexual Orientation	2024		2025	
	Headcount	%	Headcount	%
Bisexual person	43	0.8%	52	0.99%
Gay or Lesbian	71	1.4%	74	1.41%
Heterosexual or straight	4,107	78.2%	4265	81.07%
Not stated (person asked but declined to respond)	1,024	19.5%	789	15%
Other sexual orientation not listed	4	0.1%	2	0.04%
Undecided	3	0.1%	8	0.15%
TOTAL	**5252**		**5190**	

The number of staff who have disclosed their sexual orientation has increased by 0.19%. The number of people on ESR who identify within the umbrella of “LGBTQ+” (Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, the plus stands for all other identities not captured within the acronym) has increased from 121 employees to 136 employees. This figure only includes sexual orientation within LGBTQ+, as gender is referred to in other sections of the report.

The number of people who have ‘not stated’ their sexual orientation remains high, at 15%; however, it is 4.5% lower than the previous year and 2.1% lower than 2022.

The network membership stands at almost 60 colleagues and is active with its awareness and inclusion events throughout the year.

3.12 Gender Reassignment and Transgender

Records of non-binary colleagues are limited, as currently the ESR system is programmed to only record male or female. Colleagues may disclose themselves as non-binary or transgender, or to identify as “Mx” (gender-neutral title) in the title category.

Staff are encouraged to have their ID badge updated, use their pronouns, and use them alongside their name on their email signature. (Examples include: “he, him, his”, “she, her, hers” or “they, them, theirs”).

3.13 Religion

Compared to 2024, the proportional split of religious groups is similar to 2025 in that over 50% of employees disclose Christianity as their religious belief.19.64% of the workforce have not disclosed their religion on ESR, which is less than 23.2% in 2023.

Religious Belief	2024		2025	
	Headcount	%	Headcount	%
Atheism	828	15.8%	913	17.35%
Buddhism	30	0.6%	32	0.61%
Christianity	2,674	50.9%	2685	51.04%
Hinduism	84	1.6%	98	1.86%
I do not wish to disclose my religion/belief	1,220	23.2%	1033	19.64%
Islam	130	2.5%	140	2.66%
Jainism	1	0.0%	1	0.02%
Judaism	13	0.2%	7	0.13%
Other	258	4.9%	258	4.90%
Sikhism	14	0.3%	16	0.30%
Unspecified	-	-	78	1.48%

The Trust’s Multi-faith Centre offers emotional, spiritual, and religious support to people of all faiths, beliefs, and religions and those who do not observe any belief system. Chaplains provide a confidential ‘listening ear’ to people for staff and

patients at ward level. The Chaplains are also available for prayers, communion and confession for patients and employees.

The Chaplaincy Service collaborates closely with the Wellbeing Manager, Freedom to Speak Up and the Equality, Diversity, and Inclusion Manager to exchange strategies and identify areas where the workforce would benefit from enhanced awareness of their collective pastoral efforts.

3.14 Pregnancy & Maternity and Part-Time Working

The number of pregnant employees totalled 151 in the period to 31 March 2025. This figure excludes employees who TUPE transferred during their Maternity Leave. The Trust does not have the ability to collate data on TUPE staff transfers.

Metric	2023/24 Headcount	2024/25 Headcount
Number of staff who went off on maternity leave between Apr 24 and Mar 25	235	151
How many returned during this period	107	177
How many left the Trust during this period	17	16
How many returned part-time	76	97
How many returned full-time	31	80

Of the 151 colleagues who had Maternity Leave in 2024/25, 177 returned within this period. This equates to 11% leaving, which is 4% higher than the 2023/24 turnover.

Of the colleagues who returned from maternity leave and stayed with the organisation, 55% returned part-time and 45% returned full time which was a significant increase from the previous year.

All pregnant staff have a risk assessment, which considers the pregnant worker's physical and mental health and may involve an Occupational Health referral.

4. Fostering good relations between those who share protected characteristics and those who do not.

There are regular events run by all the staff networks to improve all colleagues understanding of underrepresented groups. The Trust uses the staff networks to inform which inclusion calendar days should be recognised across the Trust, by

following the NHS Employers calendar of inclusion events, which include the Lunar New Year, Ramadan, Eid, Christmas, Transgender Awareness Week and Black History Month. Examples of initiatives to recognise these events include Trust-wide communication, social media posts, guest speakers, charity funded snack bags and face to face meetings and social meetings.

Education and training to support fostering good relations include the commencement of Cohort 3 in 2025, Reciprocal Mentoring, targeted for colleagues with a disability or long term condition and pairing them with senior leaders in the organisation. This helps influence policy change, improve opportunities for career progression, further inclusion and provide increased understanding by non-disabled colleagues of the daily 'lived experience' of being a person of colour. Candidates who attended cohort one of Reciprocal Mentoring were invited to participate in a BME Leadership and Development Programme in this reporting cycle. In total, 20 BME colleagues have accessed Reciprocal Mentoring and 12 followed onto BAME Leadership Development Programme. According to the Trust's WRES report, people of colour are more likely to access continuing professional development than their White peers.

5. To eliminate unlawful discrimination, harassment, and victimisation

5.1 National Staff Survey

The NSS asks questions regarding discrimination at work. HDFT data for the 2024 survey shows that some staff with protected characteristics are experiencing more discrimination than the national average. This is evident across the following protected characteristics:

- Gender
- Ethnicity
- Sexual Orientation
- Disability
- Age
- Other

- There is only one protected characteristic group experiencing less discrimination than the national average, which is Religion.

The work carried out by the Trust to eliminate unlawful discrimination, harassment and victimisation includes the development of appropriate policies, processes, and networks to support staff:

- Further work has been carried out to support colleagues with disabilities and long-term conditions.
- During 2024, presentations were made by network groups, raising awareness to the workforce via TeamTalk.
- Cultural Competency Training was delivered face to face six times in 2024.
- The Trust remains a Disability Confident Employer level II.
- The Trust was awarded Bronze for the Stonewall Rainbow Badge Accreditation Scheme in April 2023 and is working towards the silver award.

5.2 Equality Delivery System 22

5.3 The Equality Delivery System (EDS) aims to help NHS organisations improve service quality for their communities and create discrimination-free workplaces for NHS employees, in line with the Equality Act 2010. The implementation of EDS22 is a mandatory assessment NHS services.

5.4 EDS22, introduced in 2023, is the latest version of the EDS. It aligns with NHS England's Long Term Plan and its commitment to an inclusive, fair, and accessible NHS. This version is the basis for HDFT's most recent assessment, detailed below.

The overall assessment was ‘Achieving’ and remains the same as the previous year.

Outcome:	Description:	Rating: / (Score)	
1. A	*Patients (service users) have the required levels of access to the service.*	●	**Achieving (2)**
1. B	*Individual patients (service users) health needs are met.*	●	**Achieving (2)**
1. C	*When patients (service users) use the service, they are free from harm.*	●●	**Excelling (3)**
1.D	*Patients (service users) report positive experiences of the service.*	●	**Achieving (2)**
2. A	*When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD, and mental health conditions.*	●	**Achieving (2)**
2. B	*When at work, staff are free from abuse, harassment, bullying and physical violence from any source.*	●	**Achieving (2)**
2. C	*Staff have access to independent support/advice when suffering from stress, abuse, bullying harassment, and physical violence from any source.*	●●	**Excelling (3)**
2. D	Staff recommend the organisation as a place to work and receive treatment.	●	**Developing (1)**
3. A	*Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities.*	●	**Achieving (2)**
3. B	*Board/Committee papers (including minutes) identify equality and health inequalities-related impacts/risks and how they will be mitigated & managed.*	●	**Achieving (2)**

3. C	*Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients.*	●	**Achieving (2)**

6. Health Inequalities

HDH's patient groups and data on inequalities is attached in Appendix 3. This is being used within the Local Care Partnership to look at how we can work across social care, primary and secondary care and mental health providers to reduce inequalities and improve outcomes for patients across Harrogate.

Our community based 0-19 services, cover a large footprint across the North, North East and North West of England and have roles that are dedicated to reducing inequalities depending on the population health demographics of the areas. For example, our community anchor works with local communities to develop relationships and target interventions, and some localities have specialist roles such as a health visitor for asylum seekers, as part of the skill mix to specifically target groups that need more support and/or intervention. We also deliver social value through our contracts and use the Great Start in Life Foundation to fund some of the opportunities e.g., we supported families with food, beds and blankets in Wakefield. One of the Healthy Child Programmes key roles is to identify children with high risk and low protective factors, and to ensure that these families receive a personalised service. Poverty is one of the biggest risk factors linked to poorer health outcomes. Poorer children are less likely to be breastfed, more likely to be exposed to tobacco smoke, and more likely to be injured at home and on the roads.

Inequalities in early learning and achievement begin to become apparent in early childhood, with a gap opening between the abilities of poor and prosperous children at as early as two or three years of age. Children who come from families with multiple risk factors (e.g. mental illness, substance misuse, debt, poor housing, and domestic violence) are more likely to experience a range of poor health and social outcomes. These might include developmental and behavioural problems, mental illness, substance misuse, teenage parenthood, low educational attainment, and offending behaviour.

The wide range of issues covered by our 0-19 Services are difficult to quantify due to the diverse needs of individuals, families, and communities. Taken together, the High Impact Areas describe areas where Health Visitors and School Nurses can have a significant impact on health and wellbeing, improving outcomes for children, young people, families, and communities.

the 6 high impact areas for early years and relate to the 4 overarching aims:

- focusing on preconceptual care and continuity of carer
- reducing vulnerability and inequalities
- improving resilience and promoting health literacy
- ensuring children are ready to learn at 2 and ready for school at 5

The 6 high impact areas relate to 4 aims for school age children and young people, namely to:

- reduce inequalities and risk
- ensure readiness for school at 5 and for life from 11 to 24
- support autonomy and independence
- increase life chances and opportunity

Our place-based and community-centred, approach supports development of local solutions drawing on all the assets and resources of an area, integrating services and building resilience in communities so that people can take control of their health.

7. Conclusions

The National EDI Improvement Plan emphasises that a diverse workforce, supported by inclusion, enhances staff engagement, retention, innovation, and productivity, ultimately benefiting patient care and outcomes. The EDS22 report underpins HDFT’s dedication to EDI, maintaining an 'Achieving' rating during this reporting period. For detailed actions, refer to Appendix 4.

Staff surveys and workforce data reveal that HDFT, like the broader NHS, must continue to advance workplace inclusivity. Notably, women constitute 84% of the HDFT workforce but are underrepresented in senior roles.

Despite some areas of decline, the report shows progress compared to 2023/24, such as increased staff disclosure of ethnicity, sexual orientation, or disability/long-term conditions. It is recommended that the Trust fully implements the EDS22 action plan and leverages the NHS EDI Improvement Plan, WRES, and WDES to shape its future EDI agenda. This approach will aid in benchmarking, measuring, monitoring, and developing future initiatives.

The Trust remains committed to enhancing diversity and reducing discrimination through ongoing actions. HDFT has earned the Bronze Award in the Stonewall Rainbow Badge accreditation scheme and holds Level II in the Disability Confidence Scheme and is working towards reaccreditation of the HenPicked Menopause Friendly accreditation reflecting its commitment to fostering an inclusive culture.

8. Recommendations

The Board of Directors are asked to:

- Review the enclosed paper and note how the Trust is meeting the Public Sector Equality Duty requirements.
- Approve the report for publication on the Trust's website.

8. Appendices

Appendix 1: Workforce Race Equality Standard 2024

Points to note:

- **Point 2** - A figure below 1.00 indicates that BME staff are more likely than White staff to be appointed from shortlisting.
- **Point 3** - It is 0.00 for 2023 as no BME colleagues entered the formal disciplinary process in 2022/23, whereas White colleagues did.
- **Point 4** - A figure below 1.00 indicates that BME staff are more likely than White staff to access non-mandatory training and CPD.

			March 2023	March 2024	
1	Percentage of BME staff	Overall	11.8%	15.4%	↑
2	Relative likelihood of White applicants being appointed from shortlisting across all posts compared to BME applicants		2.19	2.44	↑
3	Relative likelihood of BME staff entering the formal disciplinary process compared to White staff		0.00	0.49	↑
4	Relative likelihood of White staff accessing non-mandatory training and continuous professional development (CPD) compared to BME staff		0.63	0.71	↑
5	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives, or the public in last 12 months	BME	29.4%	26.5%	↓
		White	28.1%	19.9%	↓

6	Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	BME	32.9%	24.8%	↓
		White	23.4%	19.5%	↓
7	Percentage of staff believing that their Trust provides equal opportunities for career progression or promotion	BME	40.2%	53.9%	↑
		White	57.2%	61.9%	↑
8	Percentage of staff personally experiencing discrimination at work from a manager/team leader or other colleagues	BME	22.6%	15.6%	↓
		White	5.9%	6.1%	↑
9	BME board membership	BME	22.2%	18.7%	↓
		White	77.8%	81.3%	↑
	Difference (total Board – Overall Workforce)		10.4%	3%	↓

Appendix 2: Workforce Disability Equality Standard 2024

(Workforce Disability Equality Standard)

			March 2023			March 2024		
1	Percentage of staff in AfC pay-bands or medical and dental subgroups and very senior managers (including Executive Board members but excluding Non-Executive Board members) compared with the percentage of staff in the overall workforce.		Disabled (number)	Disabled (%)	RAG	Disabled (number)	Disabled (%)	RAG
	Cluster 1 (up to Band 4)		89	5.65%	↑		6.9%	↑
	Cluster 2 (Bands 5-7)		142	5.58%	↑		6.5%	↑
	Cluster 3 (Bands 8a-8b)		15	6.88%	↓		8.5%	↑
	Cluster 4 (Bands 8c-9 and VSM)		1	3.70%	↓		0%	↓
	Cluster 5 (Medical/dental consultants)		4	2.47%	↑		2.4%	↓
	Cluster 6 (Medical/dental, non-consultants)		0	0.00%	↔		0.7%	↑
	Cluster 7 (Medical/dental, trainees)		6	4.03%	↓		4.67%	↑
			257	**5.34%**	↑		**6.3%**	↑
2	Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts.		1.09		↑		1.15	↑
3	Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.		0.00		↔		3.33	↑

			March 2023			March 2024		
			Disabled	Non-Disabled		Disabled (number)	Disabled (%)	
4a	Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from Patients or other members of the public		32.3%	27.8%	↓		26.7%	↓
4b	Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from Managers		18.5%	9.6%	↓		11.0%	↓
4c	Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from Other Colleagues		26.0%	18.4%	↑		22.1%	↑
4d	Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it		50.0%	46.1%	↑		56.1%	↑
5	Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.		48.2%	55.8%	↑		57.9%	↑
6	Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.		29.6%	22.7%	↓		18.4%	↓

			March 2023			March 2024		
7	Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.		35.0%	45.5%	↑		42.9%	↑
8	Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.		n/a	n/a	↑		75.9%	↑
9a	The staff engagement score for Disabled staff, compared to non-disabled staff.		6.3	6.9	↓		6.8	↑
9b	Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard?		Yes		↔		Y	↔
10a	Percentage difference between the organisation's Board voting membership and its organisation's overall workforce (voting membership of the Board)		-5%		↔		-6.0%	↑
10b	Percentage difference between the organisation's Board voting membership and its organisation's overall workforce (Executive membership of the Board)		-5%		↔		-6.0%	↑

Code:

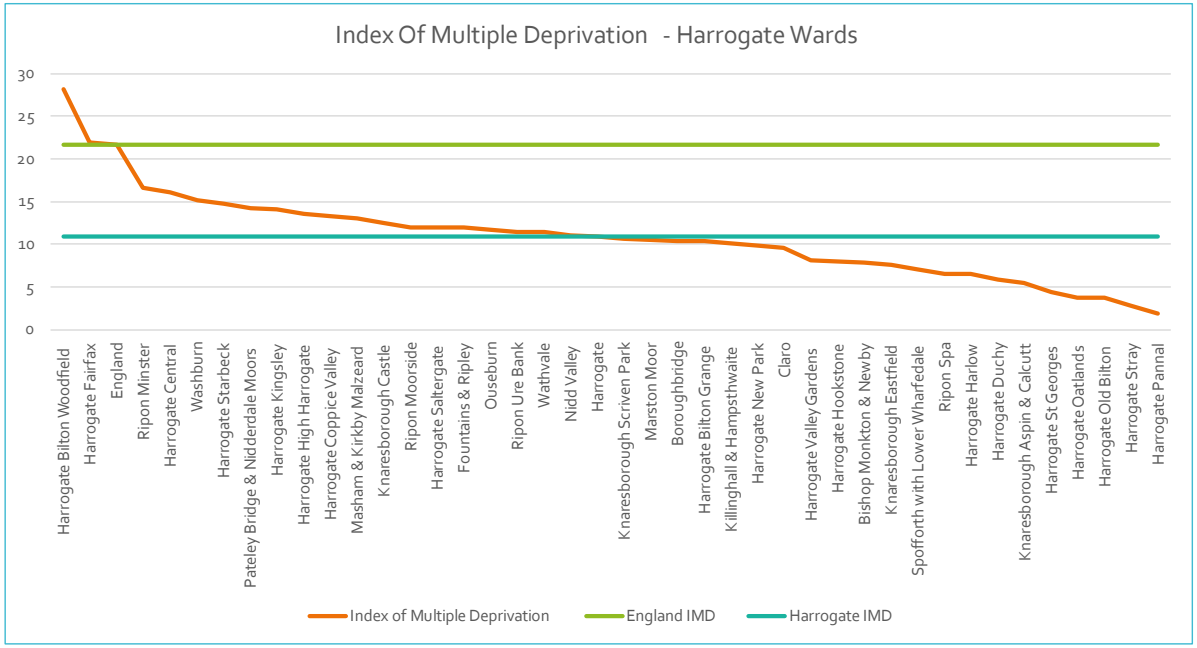
	The score has worsened

	The score has remained at the same or similar level as the previous year
	The score has improved

Appendix 3: Health Inequalities

Harrogate– Index of Multiple Deprivation 2019

Harrogate has low levels of deprivation. It is generally affluent and healthy, but with pockets of deprivation and worse health



- Only 2 wards more deprived than the England average:
  - Harrogate Fairfax: three LSOAs, IMD deciles 3, 5,6
  - Harrogate Bilton Woodfield: five LSOAs, IMD deciles 1, 6, 6, 6, 7

Appendix 4: EDS22 Action Plan

EDS Action Plan	
EDS Lead	***Year(s) active***
Richard Dunston Brady (Equality, Diversity and Inclusion Manager)	*Three*
EDS Sponsor	***Authorisation date***
Angela Wilkinson (Director of People and Culture) Wallace Sampson (NED EDI Champion)	

Domain	Outcome	Objective	Action	Completion date
Domain 1: Commissioned or provided services	1A: Patients (service users) have required levels of access to the service	Develop a system for the additional collection/reporting of waiting times by *Disability* status and *Disability* type and further information and analysis to be included in 2025 from LTUCC and PSC directorates.	Directorates to discuss with planning teams how they can extract data to help them to develop their service.	
	1B: Individual patients (service users) health needs are met	Further engagement of patient's community groups and the public in commissioned services	Clinical Directorates to lead on their own specialisms	

	1C: When patients (service users) use the service, they are free from harm	Outcome 1C: N/A as the Trust has reached 'Excelling' in 2025		
	1D: Patients (service users) report positive experiences of the service	Further evidence is required regarding patient health inequalities and how this is identified and managed as part of the service development, which includes the voices of the service users.	Clinical Directorates/ PET team to consider how they can include all protected characteristics in their feedback mechanisms.	
Domain	**Outcome**	**Objective**	**Action**	**Completion date**
Domain 2: Workforce health and well-being	2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions	Improved sickness absence monitoring data of staff considering all protected characteristics.	People and Culture Directorate to consider additional support for staff with long- covid conditions (2A) and the monitoring of them to provide improved staff support	

	2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	Year-on-year improvements of WRES and WDES data. Continue to deliver Cultural Competency Training to staff. Recording and analysis of themes from the Freedom to Speak Up Guardian	Equality, Diversity, and Inclusion Manager to report on these metrics annually. In place. Freedom to Speak Up Guardian to collate date where available and report on analysis	
	2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source	N/A as the Trust has reached 'Excelling' in 2025		
	2D: Staff recommend the organisation as a place to work and receive treatment	Year-on-year improvements of WRES, WDES and Impulse survey.	Equality, Diversity, and Inclusion Manager to report on these metrics annually.	

Domain	Outcome	Objective	Action	Completion date
Domain 3: Inclusive leadership	3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities	Health inequalities are to be a standing item on the agenda at all board meetings. Improved attendance at staff networks by Exec Sponsors Board to hold services to account and demonstrate their commitment to health inequalities.	All directorates to action this and include the EDI Manager in quarterly meetings for updates	
	3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed	Directorate business plans should shape the needs of their population in terms of health inequalities.	All directorates to work with planning teams as per 1A	
	3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients	Year-on-year improvements of WRES, WDES, Gender Pay Gap and Impulse survey.	Equality, Diversity, and Inclusion Manager to report on these metrics annually.	