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NHS Foundation Trust

Board Meeting Held in Public
Wednesday 30 July 2025

Title:	Learning from Deaths Quarterly Report Q4: Jan-Mar 2025
Responsible Director:	Executive Medical Director
Author:	Deputy Medical Director for Quality and Safety

Purpose of the report and summary of key issues:	The board is asked to note the surveillance of mortality indices across the trust.	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	
	AIM 2: To work with partners to deliver integrated care	
	BAF2.1 To improve population health and wellbeing, provide integrated care and to support primary care	X
	BAF2.2 To be an active partner in population health and the transformation of health inequalities	
	AIM 3: To deliver high quality care	
	BAF3.1 and 3.4 To provide outstanding care and outstanding patient experience	X
	BAF3.2 To provide a high quality service	X
	BAF3.3 To provide high quality care to children and young people in adults community services	
	BAF3.5 To provide high quality public health 0-19 services	
	AIM 4: To ensure clinical and financial sustainability	
	BAF4.1 To continually improve services we provide to our population in a way that are more efficient	
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	
	BAF4.4 To be financially stable to provide outstanding quality of care	
Corporate Risks	N/A	
Report History:	Paper also submitted to End of Life Group, Patient Safety Forum, Quality Governance Management Group and Quality Committee	
Recommendation:	The board is asked to note the contents of the report, including the metrics and methodology used.	

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Learning from Deaths Quarter 4 Report

Executive Medical Director

1.0 Executive Summary

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

SHMI has risen which is most likely a data accuracy issue due to delays in clinical coding. There are early signs that this situation is improving. Observed number of deaths remains at a stable level.

19 cases have undergone a structured judgement review since the last report. Quality of care in this challenging winter quarter are similar to those throughout the last year. Learning from these reports is shared across the organisation.

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2.0 Introduction

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

3.0 Findings

3.1 Crude Mortality Data

The crude mortality rate for admissions gives a long-term view of trust mortality. In total, 204 deaths were recorded in Q4, up from 199 in the preceding Q3 and also up compared to Q4 in 23/24 which had 183 deaths. A regional increase has been identified by Medical Examiners across the north of England who have estimated an approximate 10% increase in total deaths (hospital and community) compared to last winter. This data is not risk-adjusted so takes no account of the unique characteristics of individual admissions. Comparison with the national mortality rate is also shown where data is available (shown in the darker blue line in Figures 1 and 2). This demonstrates that the peaks and troughs we see in HDFT are often mirrored at the national level. Figure 2 gives a "zoomed in" view of data from the last 2 years. Note that the rise in mortality in HDFT seen in December 2024 is mirrored by a similar rise in national numbers.

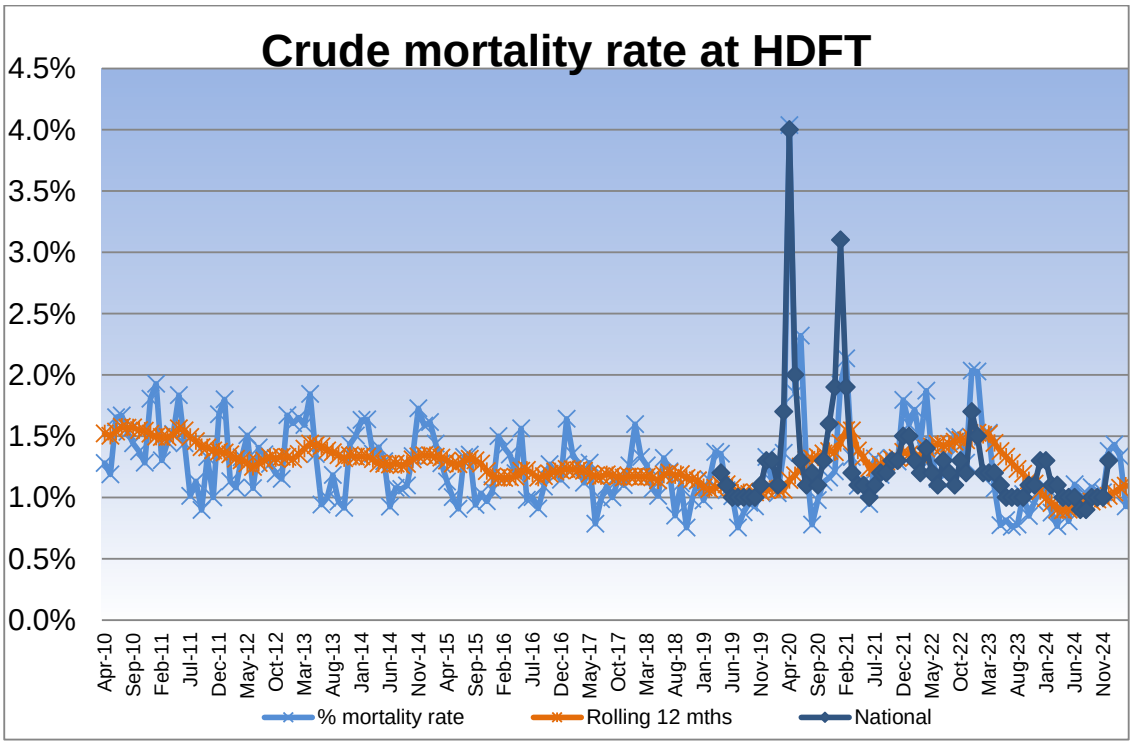

Figure 1: Crude mortality rates over the last 14 years (%deaths per hospital episode)

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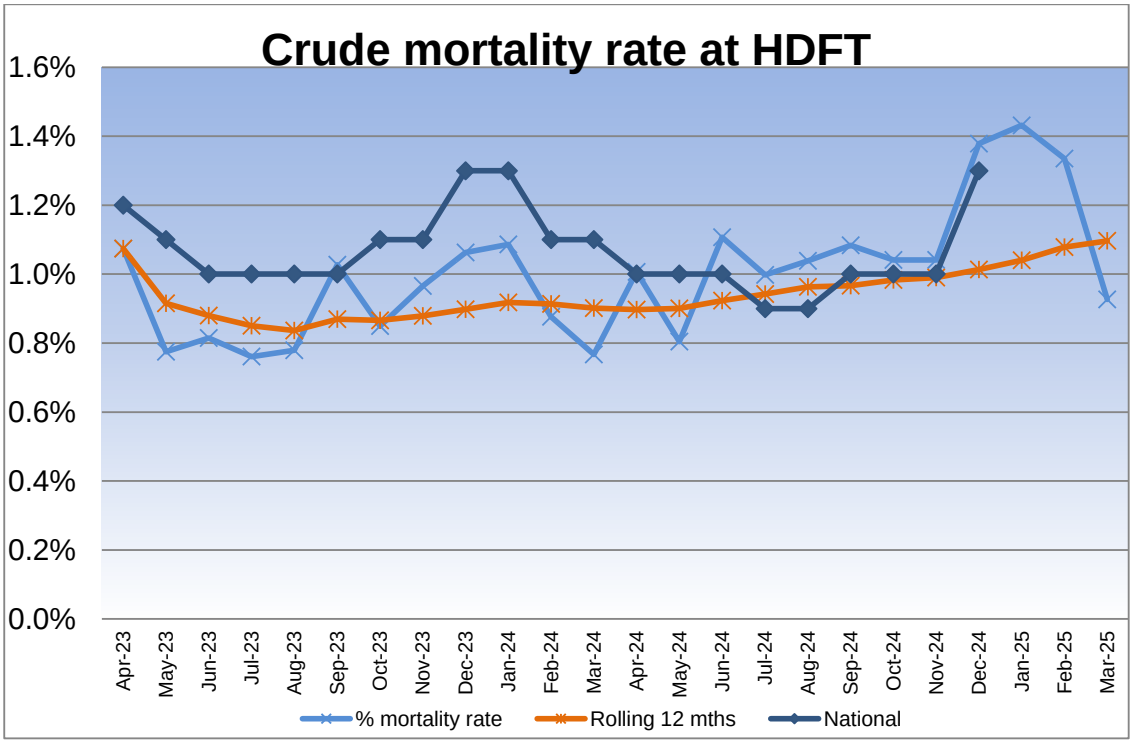

Figure 2: Expanded crude mortality rates over the last 2 years (%deaths per hospital episode)

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3.2 Standardised Hospital Mortality Index (SHMI)

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

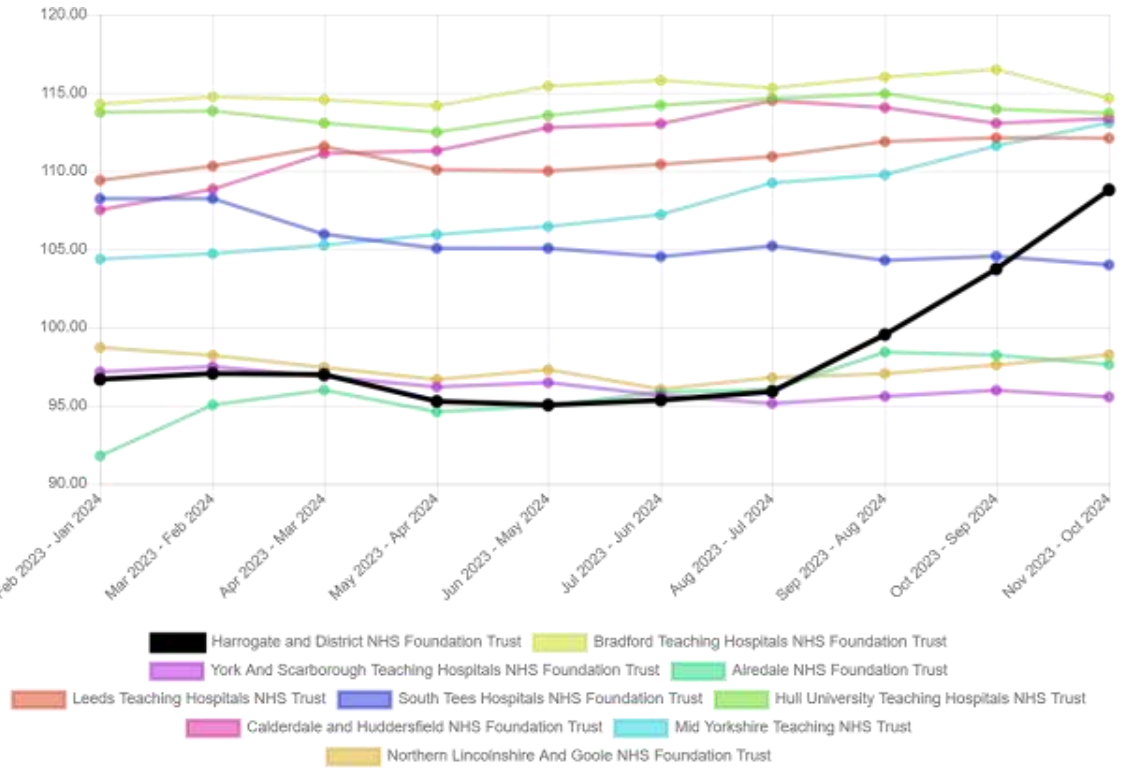

Figure 3: HDFT SHMI since December 2022 versus regional peers

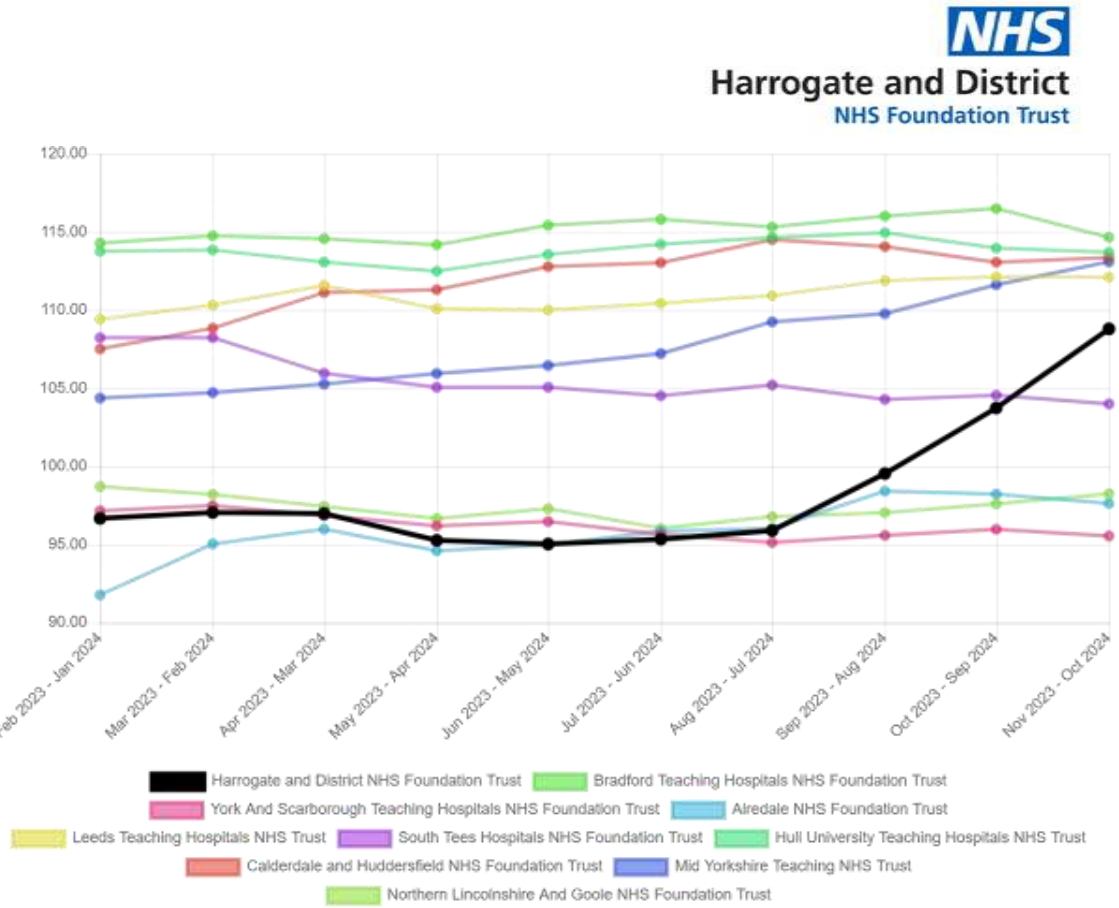

Figure 4: HDFT SHMI since December 2022 versus national peers

As can be seen, our SHMI has been rising since June 2024. Further interrogation of the data shows that the number of deaths has remained fairly constant but the number of expected deaths has declined:

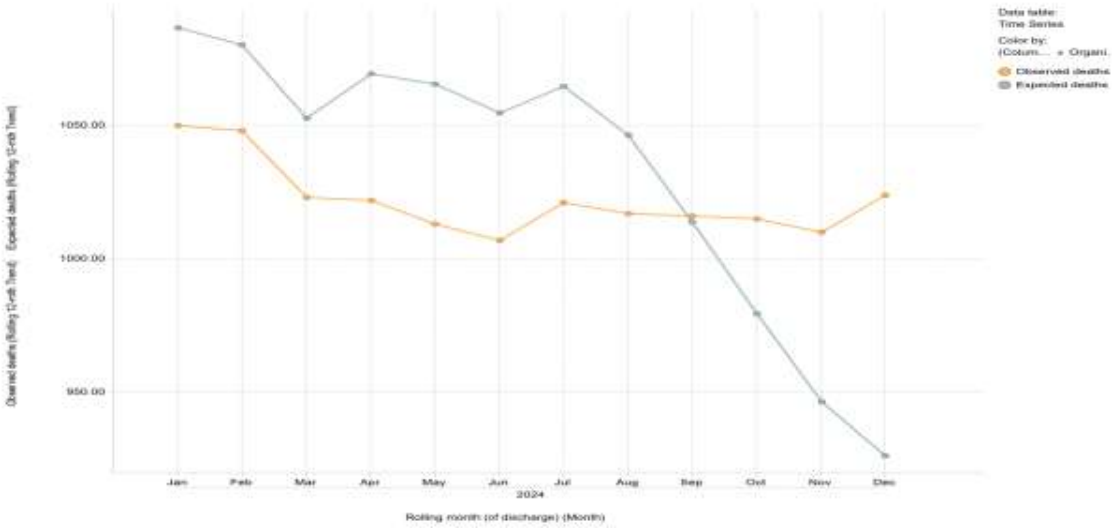

Figure 5: Observed and expected number of deaths (in hospital or within 30 days of discharge – rolling 12 months)

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A significant fall in expected death numbers raises concerns of a data quality issue. Following interrogation of the data, we have identified a recent increase in patients' diagnostic code in the category "Invalid primary diagnosis". As can be shown in Figure 6, we normally have very few spells in this category, but it has sharply risen in 24/25 year to date. The reason behind the rise of this coding category is likely due to incomplete clinical coding by the time of SHMI generation. Working with the data analytics team, an action plan to improve turnaround for clinical coding has been agreed and is now underway, and there are early signs this is improving. We understand from our external data processing provider (HED) that our SHMI data will remain as it is for 24/25 and cannot be retrospectively adjusted.

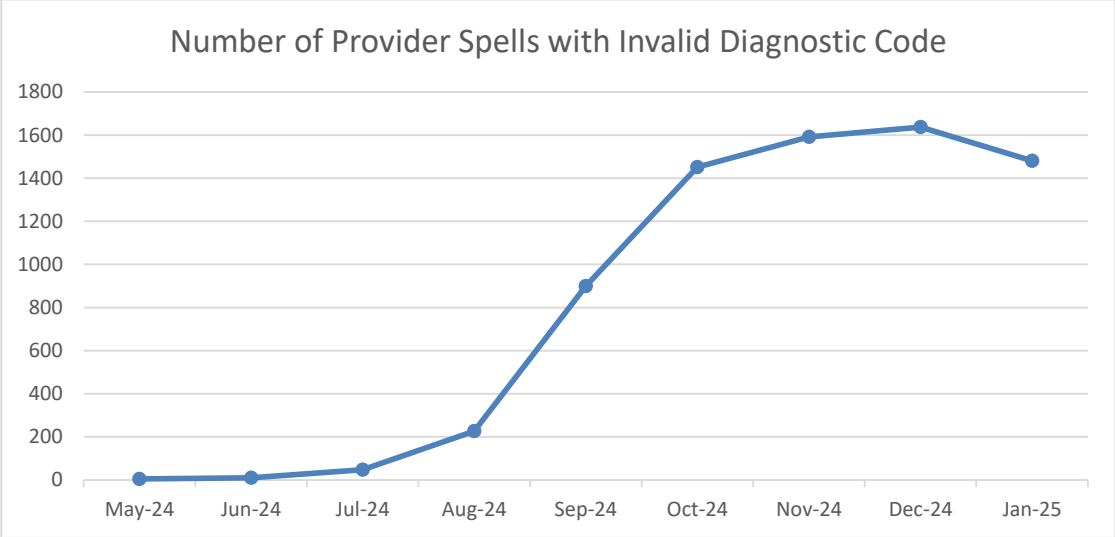

Figure 6: Number of provider spells falling into the SHMI diagnostic category of "Invalid Primary Diagnosis"

Whilst the improvement work around timeliness of our clinical coding is underway, in the interim period our other mortality metrics such as the observed number of deaths, any Medical Examiner concerns and the Structured Judgemental Reviews (SJRs) will continue to provide further assurance of our mortality data.

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3.3 Structured judgement reviews (SJR)

19 cases have been reviewed in this quarter with 16 relating to deaths in this period and 3 from the preceding Q3.

We are now able to interrogate SJRs based on the reason they were chosen for review. 13 of the cases this quarter were selected randomly to give assurance as to the quality of care received. The breakdown of care is shown in Figure 7. The 1 case with "poor" care was subsequently reviewed by the admitting specialty Clinical Lead, and errors were identified in the SJR review. A repeat SJR has since been performed and care upgraded to "adequate".

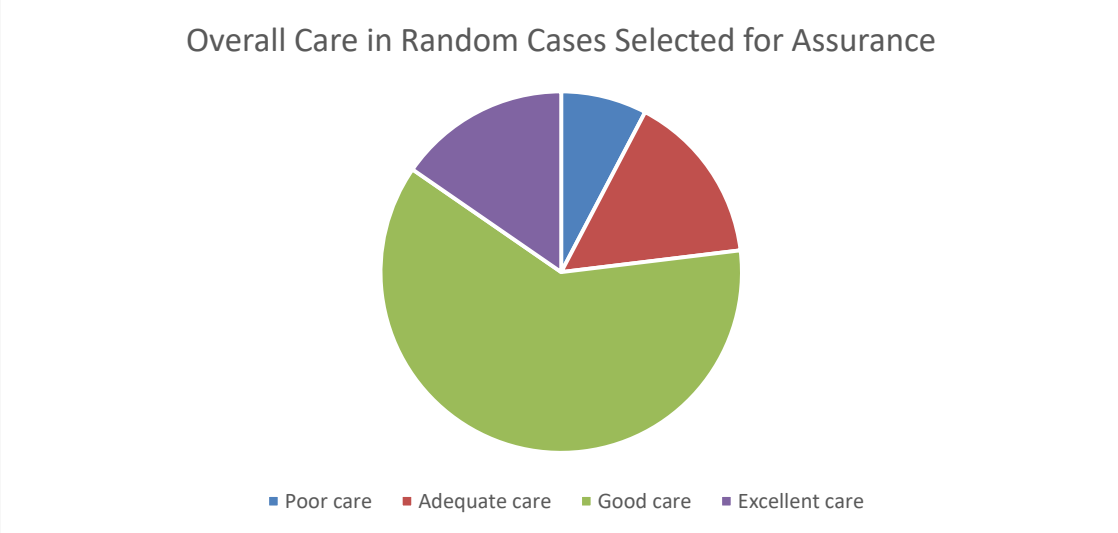

Figure 7: Breakdown of Overall Care rating in randomly selected cases in Q4

In addition to cases chosen at random to provide assurance, some clinical teams select cases that they have already identified as having possible lapses in care and we would therefore expect a higher number of cases with poorer care. Figure 8 shows the breakdown in care categories for all cases reviewed in Q1-4:

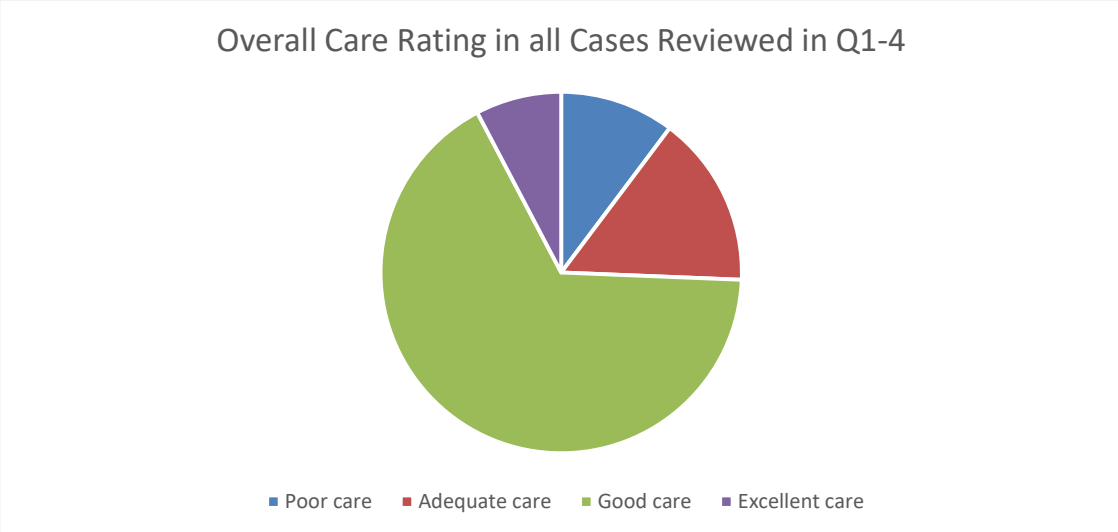

Figure 8: Breakdown of Overall Care rating in all cases reviewed on Q1-4

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4 cases were in patients with a learning disability who will receive a second external review as part of the LeDeR process. No feedback from the external reviewers has been received in Q4.

All cases in this quarter were reviewed using the Datix iCloud SJR module which includes a subjective assessment of the avoidability of death – if this were deemed to be higher than 50:50 then the process to commence a Patient Safety Incident Investigation (PSII) would be triggered. We also record if there were gaps in clinical care, organisational aspects or both. In this quarter, organisational aspects noted continued to be delays in admissions from the Emergency Department and failure to be consistently reviewed by a consultant within 14 hours of admission (predominantly in acute medicine).

The overall assessment of the standard of care of is shown in Table 1:

Month of Admission	Care in First 24 hours	Ongoing Care	Avoidability of Death	Clinical/Organisational score (NCEPOD)	Overall Care
11/2024	Excellent care	Not Applicable	Definitely not avoidable	Good practice	Excellent care
10/2024	Adequate care	Not Applicable	Slight evidence of avoidability	Room for improvement in clinical and organisational care	Adequate care
01/2025	Adequate care	Adequate care	Definitely not avoidable	Room for improvement in clinical care	Adequate care
01/2025	Good care	Good care	Definitely not avoidable	Good practice	Good care
01/2025	Poor care	Not Applicable	Slight evidence of avoidability	Room for improvement in clinical care	Poor care
01/2025	Good care	Not Applicable	Definitely not avoidable	Good practice	Excellent care
01/2025	Adequate care	Excellent care	Definitely not avoidable	Room for improvement in clinical and organisational care	Good care
02/2025	Good care	Good care	Definitely not avoidable	Good practice	Good care

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09/2024	Good care	Adequate care	Definitely not avoidable	Room for improvement in organisational care	Good care
12/2024	Excellent care	Good care	Definitely not avoidable	Good practice	Good care
01/2025	Good care	Good care	Definitely not avoidable	Good practice	Good care
01/2025	Good care	Good care	Definitely not avoidable	Good practice	Good care
02/2025	Adequate care	Adequate care	Slight evidence of avoidability	Room for improvement in clinical and organisational care	Adequate care
02/2025	Adequate care	Good care	Definitely not avoidable	Good practice	Good care
02/2025	Good care	Adequate care	Slight evidence of avoidability	Room for improvement in clinical care	Adequate care
02/2025	Good care	Adequate care	Definitely not avoidable	Room for improvement in clinical care	Good care
02/2025	Excellent care	Excellent care	Definitely not avoidable	Good practice	Excellent care
01/2025	Adequate care	Good care	Definitely not avoidable	Good practice	Good care
12/2024	Good care	Good care	Definitely not avoidable	Good practice	Good care

Table 1: Details of the cases reviewed this quarter

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Tables 2 and 3 show the quality of end-of-life care and record keeping respectively:

Care received by the patient during end of life care rating - LAST Financial Year by Quarter					
	24/25 Q1	24/25 Q2	24/25 Q3	24/25 Q4	Total
Not Applicable	2	3	6	3	14
Poor care	1	1	0	0	2
Adequate care	4	2	1	5	12
Good care	12	11	11	6	40
Excellent care	0	2	3	5	10
Total	19	19	21	19	78

Table 2: End of Life Care provided

Quality of the patient record rating - LAST Financial Year by Quarter					
	24/25 Q1	24/25 Q2	24/25 Q3	24/25 Q4	Total
Poor	0	0	0	1	1
Adequate	5	6	2	1	14
Good	14	12	18	12	56
Excellent	0	1	1	5	7
Total	19	19	21	19	78

Table 3: Quality of Patient Records

Reviewers are able to highlight any positive or negative learning from cases. These are shared with the clinicians via the regular Medical Directorate newsletter. Positive themes this quarter related to early input from senior clinicians and comprehensive record keeping. Negative themes included lack of advanced care planning and timely recognition and action on abnormal investigations. The latter will be included as part of the ongoing thematic review into the deteriorating patient.

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

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4.0 Recommendation

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

INFECTION PREVENTION & CONTROL ANNUAL REPORT

2024/25

Contents

Abbreviations

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

1.0 Introduction

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

This annual report covers the period 1st April 2024 to 31st March 2025 and has been written in line with the ten criteria outlined in the Health and Social Care Act 2008 Code of Practice in the Prevention and Control of infection (updated 2015). The ten criteria outlined in the code are used by the Care Quality Commission to judge a registered provider on how it complies with Cleanliness and Infection Prevention & Control requirements detailed in the legislation.

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

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

2.0 Criterion 1

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

Hospital Infection Prevention and Control Team

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

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

Role	Role holder	Responsibility
Director of Infection Prevention and Control (DIPC)	Dr Jaqueline Andrews (Executive Medical Director)	Executive authority and responsibility for the development and delivery of the Trust's IPC strategy
Deputy DIPC	Jenny Nolan (Deputy Chief Nurse)	Supports and deputises for the DIPC
IPC Matron	Sonya Ashworth	Manages the IPC team
Infection Control Doctor (ICD)	Dr Lauren Heath	Clinical IPC support and leadership
Consultant Medical Microbiologists	Dr Katharine Scott Dr Sarah Drake Dr Alison Muir (from Sept 2024)	Deputises for the ICD
IPC Team Lead	Amanda Gooch	Operational management of the IPC team
IPC Specialist Nurses (3.2 WTE)	Iona Goodwin Jane Cozens Leisa Mark Sheeba Sojan	Provide specialist advice on all aspects of IPC
IPC Support Nurse (0.4 WTE)	Gillian Mitchell	Routine review of patients with transmissible infection
IPC Clinical Support Worker (0.6 WTE)	Dana Fedorockova (From Sept 2024)	IPC audit programme, delivering IPC education to non-registered staff
IPC Admin and Surveillance Officers (2.0 WTE)	Chris Richardson (Left Oct 2024) Karina Hess Jodie Fryer (from Jan 2025)	Data collection, mandatory external data reporting & surveillance of transmissible infection.
Ward Hygienists	James Wightman Rafal Gasiorowski	Carry out specialist cleaning of patient equipment and environment

Changes to the team 2024-25:

Dr Alison Muir – Joined the team in September 2024.

Dana Fedorockova joined the team in September 2024 as an IPC clinical support worker. After more than 10 years service with the IPC team, Chris Richardson left to pursue a new role with the Trust Payroll team. Jodie Fryer has joined the team to replace Chris, providing infection data analysis and surveillance.

External Reviews

- The Regional IPC Team (Led by Janine Patrickson-Daly) undertook an informal external review of the IPC Team and services in January 2025. HDFT is considered to have relatively low rates of HCAI within our region and therefore has a low frequency of Regional IPC team visits. The Regional team were interested to learn more about our processes in order to establish if they may benefit other Trusts within the region.

Infection Prevention and Control Committee

The Trust Infection Prevention and Control Committee (IPCC) is held monthly and is chaired by the DIPC. (Appendix 1 – Terms of Reference for IPCC, Appendix 2 - meeting record for 2024/25).

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

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

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

In addition to the routine work carried out by the IPC team there is an annual plan of work, which describes the quality improvement objectives for the year. The plan of work for 2024-25 can be viewed in Appendix 4.

The work plan consisted of 21 separate pieces of work. Seventeen (81%) have been completed and two items have been rolled over to next year's plan. This is a great achievement, considering the unprecedented demands on the reactive IPC service over this winter.

Trust Board

The Code of Practice requires that the Trust Board have a collective agreement recognising its responsibilities for Infection Prevention and Control. The Chief Executive has overall responsibility for the control of infection at the Trust. The Trust has a designated DIPC and this role is undertaken by the Medical Director who attends Trust Board meetings with detailed updates on IPC performance and matters.

Antimicrobial Prescribing Sub-Group (APSG)

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

Decontamination Committee

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

Water Safety Group

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

Ventilation Safety Group

The Trust has a multi-disciplinary Ventilation Safety Group. It is chaired by the Deputy Director of Estates and meets quarterly. The ICD alongside the IPC Nurse Team Lead represent the IPC team on this group. This group produces a quarterly assurance report for IPCC. The group has been strengthened this year by the addition of Senior Surgical Clinical staff ensuring that operational

concerns and queries can be directly voiced by the staff who are directly using our main specialist ventilation systems.

Harrogate Integrated Facilities (HIF): Cleanliness and Estate Services

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

Infection Prevention and Control Assurance

To demonstrate compliance with the Trust IPC Policies there is an IPC programme of audit in place. The audit strategy has been significantly revised for 2024-25. All areas are now categorised as either High risk or Low risk, see Table 1.0. High risk areas are audited every quarter and low risk areas annually. The audits are undertaken by a member of the IPC team. The audits assess compliance with Standard; Transmission based IPC precautions and Hand Hygiene. Audit data is collected via the Trust digital audit software package, Tendable. Table 1.1 shows the average overall scores for all areas over the last 12 months.

Table 1.0

High Risk	Low Risk
Byland	Antenatal Clinic
Farndale	Cardiology/ Heart Centre
Granby	Dermatology
Jervaulx	Elmwood
Oakdale	Max Fax/Orthodontics
Wensleydale	Medical Day Unit
AFU	OPD Paediatrics
Emergency Dept.	OPC Ophthalmology in Outpatient
Lascelles	Orthopaedics=Silverdale
Ripon MIU	Pre-Assessment Admissions Unit
SDEC	Radiology
SROMC	Ripon Outpatients SA to do
Trinity	Women's Unit (Coverdale)
DSU	Phoenix (eyes)
Delivery Suite	Main Outpatients Zone 1 is CIA
Endoscopy	Main Outpatients Zone 2
Fountains	Main Outpatients Zone 3
ICU/HDU	Main Outpatients Zone 4
Littondale/Bolton	Cardiology/ Heart Centre
Main Theatres	Dermatology
Nidderdale	Elmwood
Pannal	Max Fax/Orthodontics
Rowan	
SCBU	
Woodlands	

Table 1.1

Audit	Completed	Average Overall score April 2024 –March 2025 (all directorates)
High risk area General IPC Inspection	Quarterly	88%
High risk area Hand hygiene	Quarterly	91.7%
Low risk area General IPC Inspection	Annually	92%
Patient Hand hygiene	Bi-annually	82%
Commode	Monthly	98.2%
Cannula Insertion (Sept 24-Mar 25)	Monthly	86.3%

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

Healthcare Associated Infection Surveillance (including mandatory reporting)

The IPC team continues to monitor all alert organisms (defined as organisms of IPC significance). The microbiology department has this year implemented WinPath, a new laboratory information management system (LIMS). This new system has given the laboratory the capability to communicate digitally in real-time; alert organisms to the IPC team. The IPC team can digitally acknowledge receipt of this information. This has strengthened the communication of significant results and removed some of the human error risk.

Clostridioides difficile

Clostridioides difficile (*C.difficile)* is a bacterium found in the gut, which can cause diarrhoea after receiving antibiotics, particularly broad-spectrum antibiotics. It can rarely cause a severe and life-threatening inflammation of the gut called pseudo-membranous colitis. The bacterium is capable of forming spores, which are very resistant and can survive in the environment for prolonged periods. The spores require effective (sporicidal) cleaning products to remove them from the environment and prevent transmission to others.

The Trust reports all cases of *C.difficile* diagnosed in the laboratory to UKHSA via the national Data Capture System (DCS). Every Trust is given a threshold level, which it should not exceed over the course of one year. The Harrogate threshold level for *C.difficile* in 2024/25 was 32.

At the end of March 2025, there were 34 cases of *C.difficile* apportioned to the Trust. This means we exceeded our threshold by two cases.

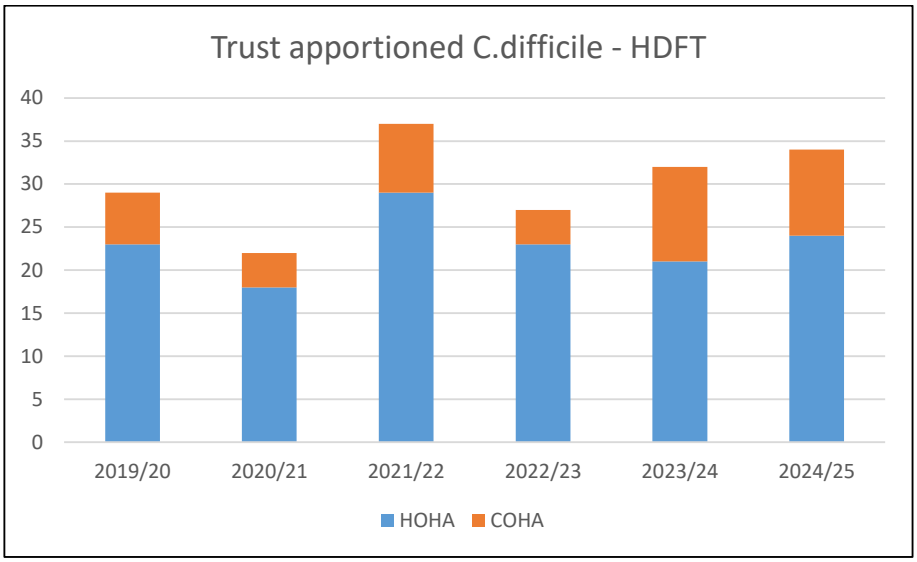
The ICB has changed its HCAI review process this year, the monthly ICB/Trust HCAI review meetings have been replaced with a bi-monthly regional HCAI and AMS collaborative meeting. The focus of this group is to share learning and good practice rather than review individual HCAI cases. Cases are no longer defined as avoidable/unavoidable by the ICB.

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

Table 2.0

Learning themes (all COHA+ HOHA cases)	Number (%) 2024-25
Inappropriate antibiotic prescribing	6 (17.6%)
Delay in stool sampling	7 (20.5%)
Delay in isolation	5 (14.7%)
Delay in starting C.diffiicle treatment	1 (2.9%)

Figure 1.0



Characteristics of our *C.difficile* patients:

Gender:

- COHA 50% male. HOHA 58% male

Average age:

- COHA 69 years. HOHA 68 years

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

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

MRSA bacteraemia

In 2043/25, there has been one trust apportioned MRSA bacteraemia. This was a COHA case. No lapses in care were identified from the post-infection review.

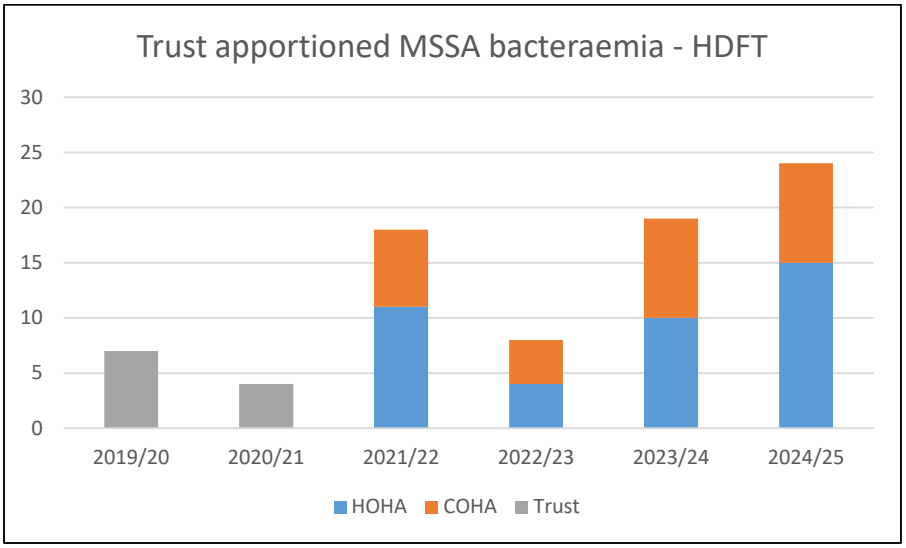
MSSA bacteraemia

MSSA (methicillin sensitive *Staphylococcus aureus*) is the much more common and antibiotic sensitive version of Staphylococcus aureus. 24 MSSA bacteraemia's were apportioned to the Trust in

2024/25; this is a significant increase on the previous year, a phenomenon that has been observed nationally.

All of our HOHA MSSA bacteraemia's have a detailed post infection review. One MSSA bacteraemia case was secondary to an intravascular device (peripheral cannula) which could have been removed at an earlier date. See Table 2 for the trend analysis of our HOHA bacteraemia's.

Figure 2.0



Gram negative bloodstream infections

There are three Gram negative organisms that are monitored. *E.coli, Klebsiella sp* and *Pseudomonas aeruginosa*. In keeping with the rise in MSSA bacteraemia, a rise has been seen in all trust-apportioned Gram negative bacteraemia' s this year except for *Pseudomonas aeruginosa.*

The HDFT annual thresholds for each of the Gram negative bacteraemia's are as follows, *E.coli* =41, *Klebsiella species* = 16 and *Pseudomonas aeruginosa* = 6. HDFT have breached these thresholds for all but *Pseudomonas aeruginosa*. *E.coli* = 51 and *Klebsiella species* = 20. Nationally Humber and North Yorkshire ICB are an outlier for *E.coli* bacteraemia, in the final quarter of 2024/25 the national average for *E.coli* COCA was 12.0 cases per 100,000 population. Humber and North Yorkshire reported an incidence of 14.0 cases per 100,000 population.

Figure 3.0

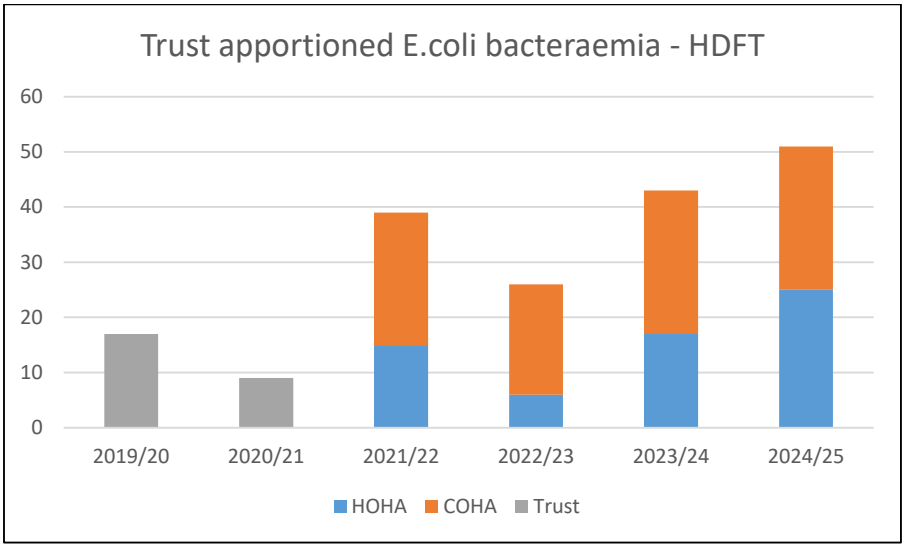


Figure 4.0

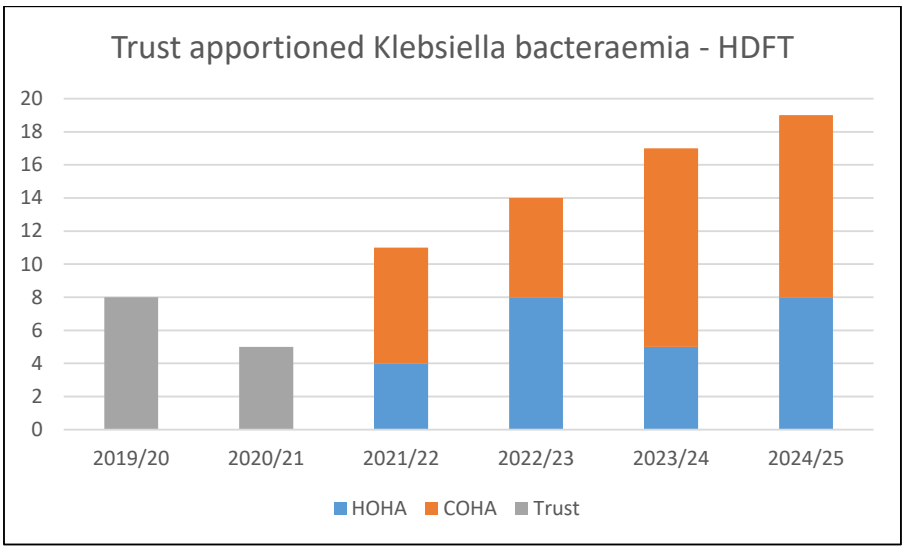


Figure 5.0

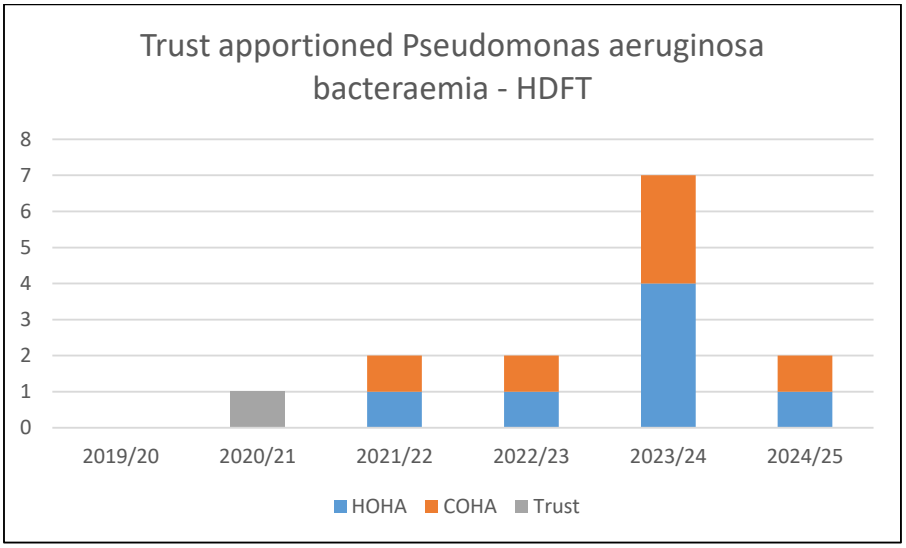


Table 2.0 – HOHA cases summary

Infection		**MSSA**	***E.coli***	***Klebsiella sp.***	***Pseudomonas aeruginosa***
Trend in cases	24-25	15^	25^	8^	1
	23-24	10	17	4	4
	22-23	4	6	8	1
	21-22	11	15	4	1
Gender	Male	78%	58%	44%	80-year-old male who had been an inpatient for 3 days.
	Female	22%	42%	56%	
Age (mean)		79 years	76 years	75 years	
Average time since admission to positive blood cultures		12 days	12 days	10 days	

Carbapenemase producing Enterobacteriaceae (CPE) cases

CPE are Gram-negative bacteria, which are so resistant to antibiotics that even our last line of defence, carbapenem antibiotics are ineffective. It is therefore extremely important to detect patients carrying these bacteria and prevent spread through isolation and cleaning. The Trust has a policy on the screening and management of patients with CPE, which reflects the guidance produced by UKHSA. HDFT has a very low incidence of CPE (<0.1%) with only two cases identified in 2024/25.

3.0 Criterion 2

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

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

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

Cleanliness assurance

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

Deep Cleans

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

4.0 Criterion 3

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

Antimicrobial Prescribing Sub-Group (APSG)

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

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

Annual Report of the Antimicrobial Prescribing Subgroup 2024-25

Annual Report of the Antimicrobial Prescribing Subgroup 2024-25

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

Remit of the Group

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

Meetings held, membership and attendance

Title	May 2024	July 2024	Sept 2024	Nov 2024	Jan 2025	Mar 2025
Consultant Microbiologist (Chair)	✓	✓	✓	✓	✓	✓
Director/Deputy Director of Pharmacy (Deputy Chair)	Apologies (KW)	Apologies (KW)	✓ (SM)	✓ (SM)	✓ (SM)	✓ (SM)
Director of Infection Prevention & Control						
Lead Antimicrobial Pharmacist	✓	✓	✓	✓	✓	✓
Specialist Antimicrobial Pharmacist						✓
ICB Pharmacist	✓	✓	Apologies	✓	✓	✓
ICB Lead General Practitioner	Unable to attend					
Lay Representative	Technical issues	✓	Apologies	Apologies	✓	Technical issues
Directorate Antimicrobial Link Physicians	Playne Ebai Rick Mayers	Playne Ebai Rick Mayers	Apologies (RM)	Chris Mahon Rick Mayers	Ian Cannings Rick Mayers	Rick Mayers
Junior Doctor(s)				Minhee Kim Ollie Croft		Minhee Kim

				Cynthia Ise		
Nursing Representative	Apologies	Apologies			Apologies	Apologies
Lead Pharmacist - Medicines Quality & Safety	✓	✓	Apologies			✓

Terms of Reference

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

Key Areas of Responsibility

1. Development and implementation of evidence-based guidelines for antimicrobial use.
2. Monitoring antimicrobial use and compliance with guidelines within the Trust through a programme of audit.
3. Development of education and training resources for antimicrobial stewardship (AMS) and the means to deliver them.
4. Identification of antimicrobial agents for restricted use only and monitoring to ensure there is compliance with restriction policies.
5. Review of root cause analyses following cases of *Clostridioides difficile* infection.
6. Reviewing trends in local antimicrobial resistance patterns as well as data on prevalence of selected multi-resistant bacteria.
7. Encouraging and, wherever possible, supporting good antimicrobial prescribing in primary care settings.
8. Align local practice with UK AMR National Action Plan goals using AMR tools and resources, such as AMR local indicators produced by UKHSA.

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

Summary of Work during 2024/25

1. <u>Development and implementation of evidence-based guidelines for antimicrobial use.</u>

Revisions to antimicrobial guidelines:

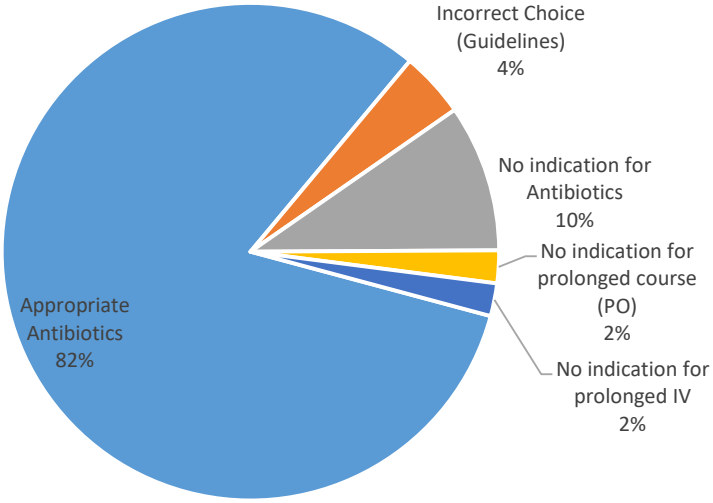
- MicroGuide, which hosted our Trust antimicrobial guidelines, has been taken over by Eolas. All guidelines transitioned to the Eolas platform in September 2024.
- Endocarditis guidelines were updated to reflect the gentamicin regimen recommended by the European Society of Cardiology Guidelines.
- Over summer 2024, an aztreonam shortage prompted a change to several guidelines. Fortunately the shortage was resolved more quickly than expected.
- Antibiotic course length was updated for mycoplasma pneumonia, according to severity of infection.
- Recently published UK-Paediatric Antimicrobial Stewardship (UK-PAS) guidelines were reviewed and a gap analysis undertaken. Minor changes to Trust paediatric antimicrobial guidelines were made and new categories of infection added.
- Doxycycline dosing recommendations for various infections were reviewed. For certain indications including CAP, HAP and cellulitis, the recommended maintenance dose was halved. This will support our ambition to reduce total antimicrobial consumption.
- Maximum gentamicin course length in general surgery was reduced from five days to three as part of a pilot to address concerns over monitoring levels and prescribing.
- A new mastitis guideline was created
- Spontaneous bacterial peritonitis prophylaxis guidelines were amended to include co-trimoxazole as an alternative to ciprofloxacin
- Meningitis guidelines were update to reflect NICE guidelines, with a recommendation for ceftriaxone as an alternative to cefotaxime.
- Leg ulcer guideline expanded to give recommendations for antibiotic therapy when infection is present, in line with NICE guideline NG152
- Screening for and treatment of asymptomatic bacteriuria in pregnancy now recommended for women at intermediate and high risk of pre-term labour. Treatment of asymptomatic bacteriuria in all pregnant women recommended if diagnosed incidentally

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

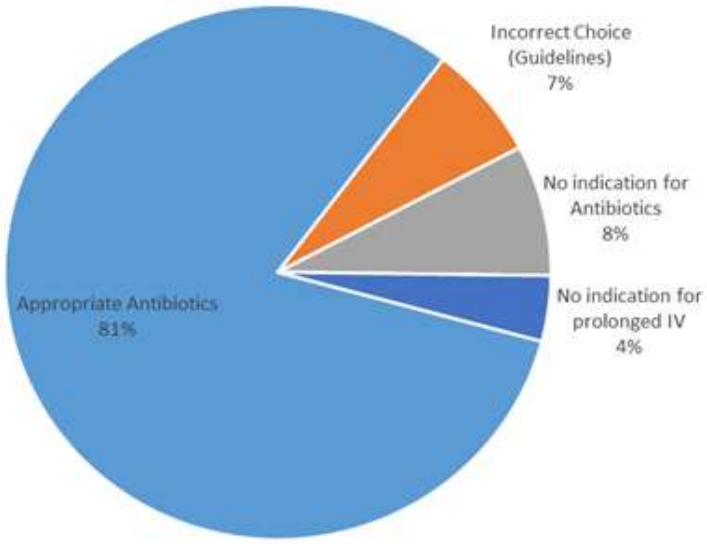
Trust-wide antibiotic point prevalence audit, April and October 2024 (Antimicrobial Stewardship Team)

All inpatient antibiotic prescriptions were reviewed on a given day. The results demonstrate appropriate prescribing in over 80% of cases; similar to previous audits.

Antibiotic Point Prevalence Audit April 2024



Antibiotic Point Prevalence Audit October 2024



Key successes

- As a result of the April audit results, a section for antibiotic prescribing decision was built into WebV ward round templates. As a result, at the October audit daily antibiotic review was happening in nearly all cases (98%), around 96% of which were good quality.
- There was a further increase in the number of prescriptions with a stop date on the prescription, up to 95%.

Key Concerns

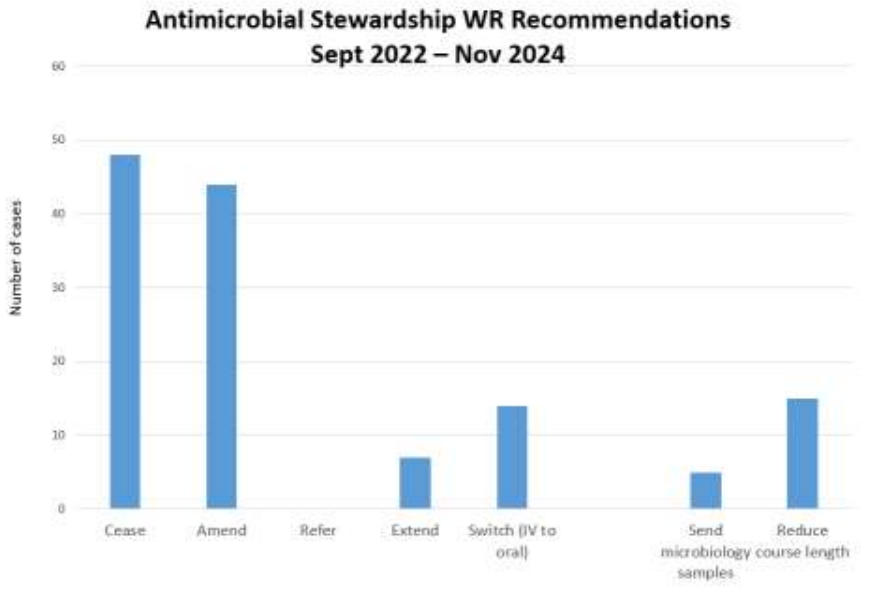
- There is a stubborn proportion of prescriptions (around 10%) in successive audits where the reviewers judge antibiotic therapy is not indicated, either because of lack of evidence of bacterial infection, inappropriately long course length or prolongation of IV antibiotics despite meeting oral switch criteria
- Surgical specialties continue to perform least well overall

Recommendations

- Results were shared across the Trust via an Antibiotic Bulletin, including highlighting the 'CARES' antibiotic review outcomes.
- Results were incorporated into teaching sessions and audit meetings for medical and pharmacy staff.
- Weekly antimicrobial stewardship ward rounds continue with the resident doctors in surgical specialties.

Surgical Antimicrobial Stewardship Ward Round Prescribing Review

A review was conducted to assess the impact of the surgical antimicrobial stewardship ward round.



Key successes

- Over 100 patients benefited from an intervention based on specialist microbiologist advice over a two year period.
- The ward round provides the opportunity for education and relationship-building between the resident doctors and Consultant Microbiologist

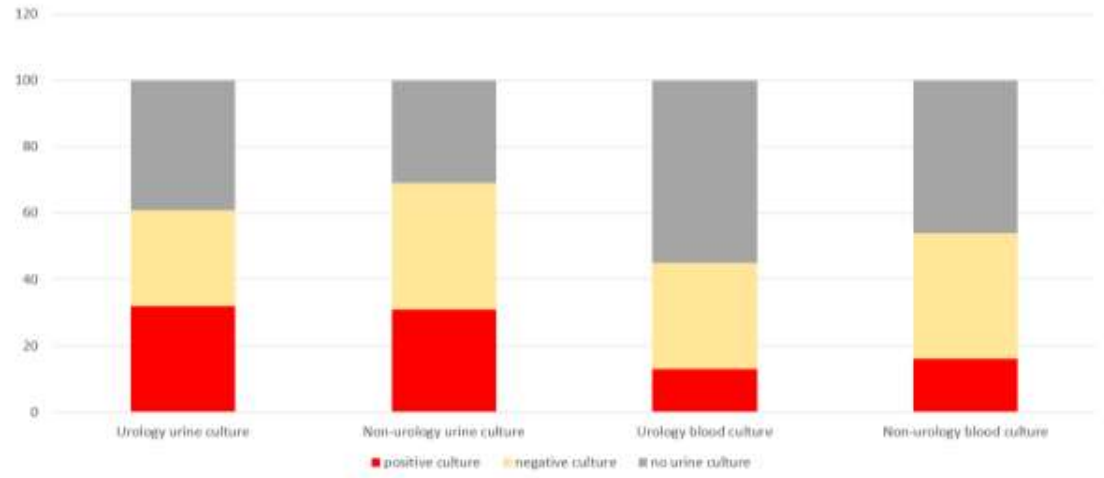
Key concerns

- Denominator data was not available for this audit, but will be collected for future audits
- Antibiotic therapy being started/continued where there is no clear clinical evidence of infection
- Antibiotic therapy not being modified on the basis of impaired renal function (i.e. using alternative to gentamicin)

Audit of Microbiological Sampling in Patients with Urinary Sepsis/Pyelonephritis

Review of appropriate microbiological sampling in patients being treated for urinary sepsis and pyelonephritis, according to prescription on ePMA (samples dated Jan-March 2024). Comparing patients under the care of urology with other specialties.

Graph to show proportion of patients in whom urine and blood cultures were sent in urology and non-urology specialties



Key Successes

- Urine culture was positive in almost half of samples sent, allowing targeted rather than empirical therapy to be prescribed.

Key Concerns

- Urine samples were obtained for culture in only around two thirds of patients being treated for severe urinary tract infection. Sampling was undertaken less frequently in Urology patients than those cared for by other specialties.

Recommendations

- Results presented at Urology Audit Meeting

Audit of Antimicrobial Prophylaxis in General Surgery

Data was collected for 30 patients who had undergone acute or elective breast, upper GI and lower GI surgery.

Key Successes

- 100% of patients received antibiotics where indicated and at the correct dose.
- 100% of patients did not receive antibiotic prophylaxis where it was not indicated.

Key Concerns

- Two patients received antibiotics which were not in line with HDFT guidance.
- Four patients did not have their antibiotic prophylaxis prescribed on ePMA.

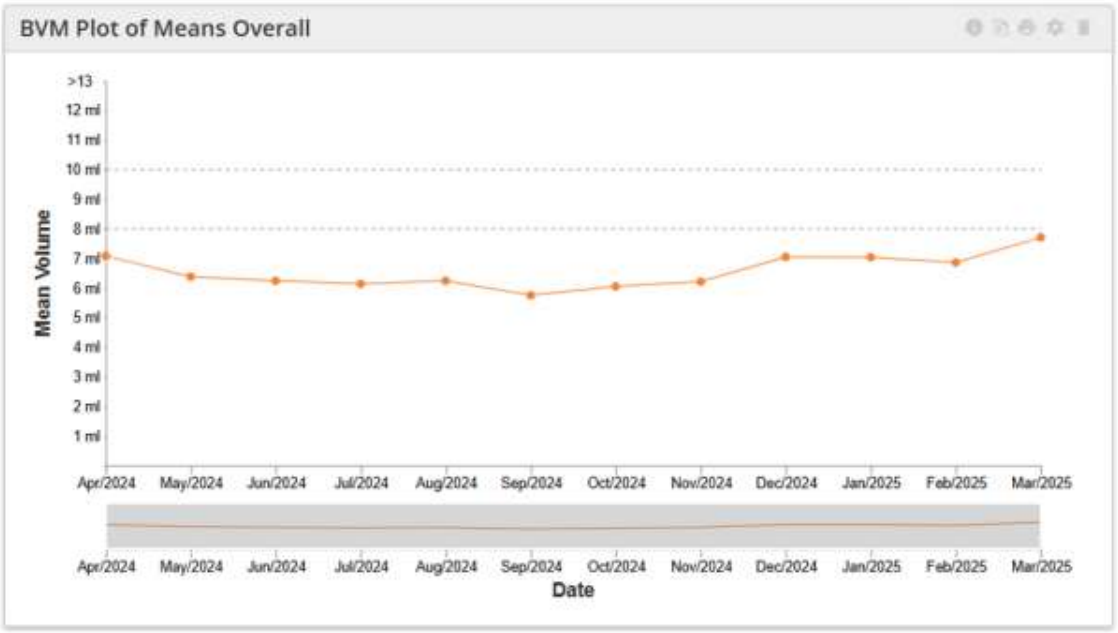
Recommendations

- Present audit and findings at general surgery audit meeting
- Print a poster including all the points of concern with compliance percentage in DSU, discharge lounge, main theatres, and surgical wards
- Email the key concerns to the General Surgery team
- Re- audit as per trust antibiotic prophylaxis policy (yearly)

Improving the Blood Culture Pathway

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

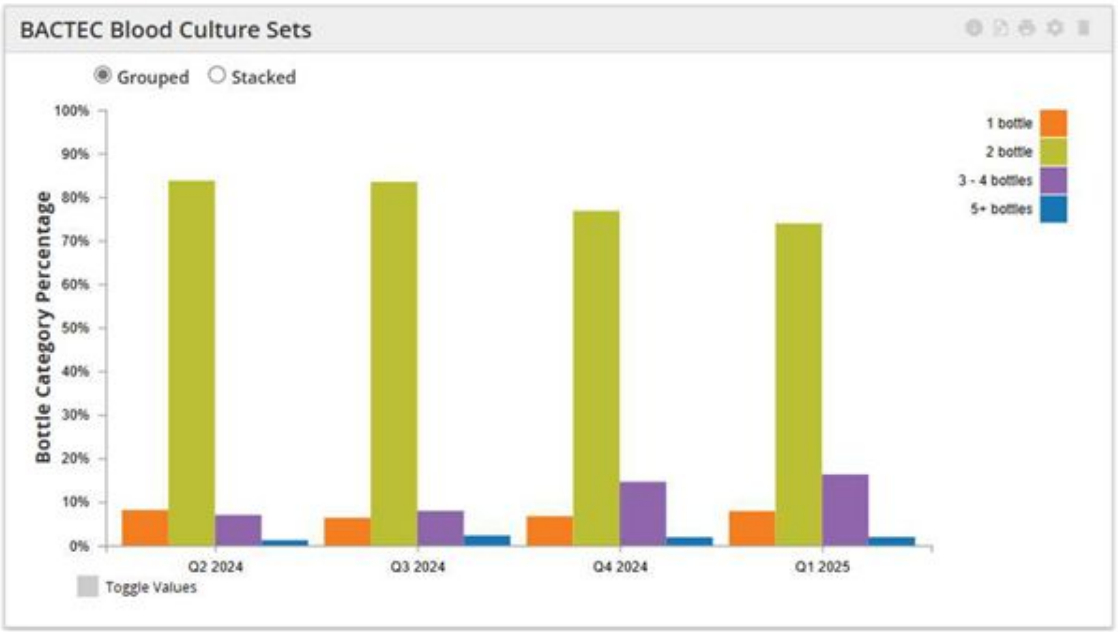
Graph to show average blood culture volume previous 12 months – all wards and departments



Average blood culture volume per bottle has increased across the Trust but falls below the recommended 8-10mL in nearly all wards/departments.

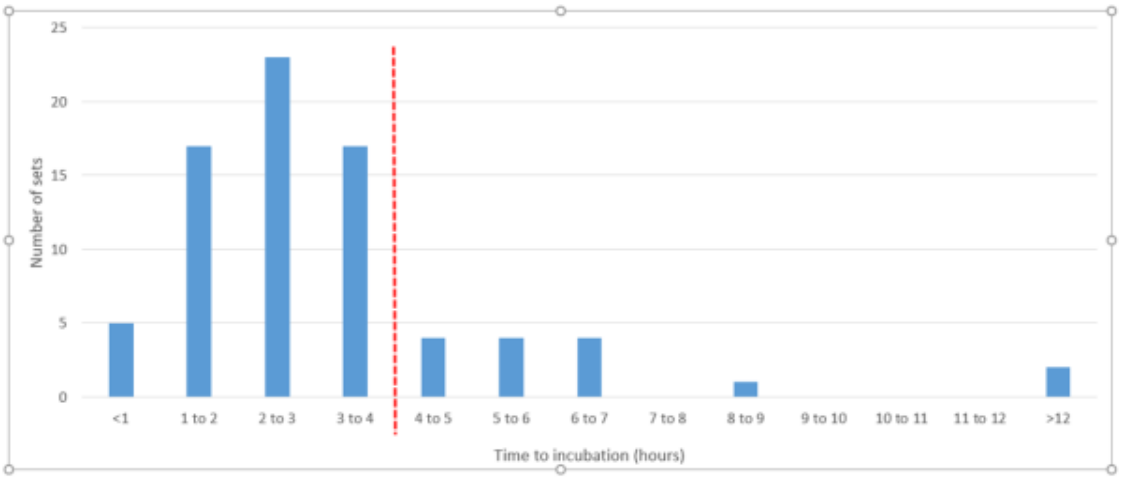
There was a doubling in the proportion of patients for whom two sets of blood cultures were received over this 12 month period (7%->16%).

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



More than 80% of blood cultures were incubated on the blood culture analyser within 4 hours of collection (increasing to 96% within 7 hours).

Blood Culture Time to Incubation: Data collection from a 7 day period in March 2025



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

Alongside the antimicrobial stewardship training already provided for F1 doctors, enhanced training in prescribing and monitoring of gentamicin continues to be provided. An interactive teaching session was given to final year medical students on the Post Finals Assistantship (PFA) programme in May 2024 and this was repeated for all F1s in November 2024.

Antimicrobial stewardship teaching was given to the following groups:

- Non-medical prescribers (November 2024)
- VTS training for GPs (December 2024)
- ED doctors (March 2025)

'UTI in Older Adults' teaching given at Care Home Leads meeting January 2025 and Elderly Medicine Departmental meeting March 2025.

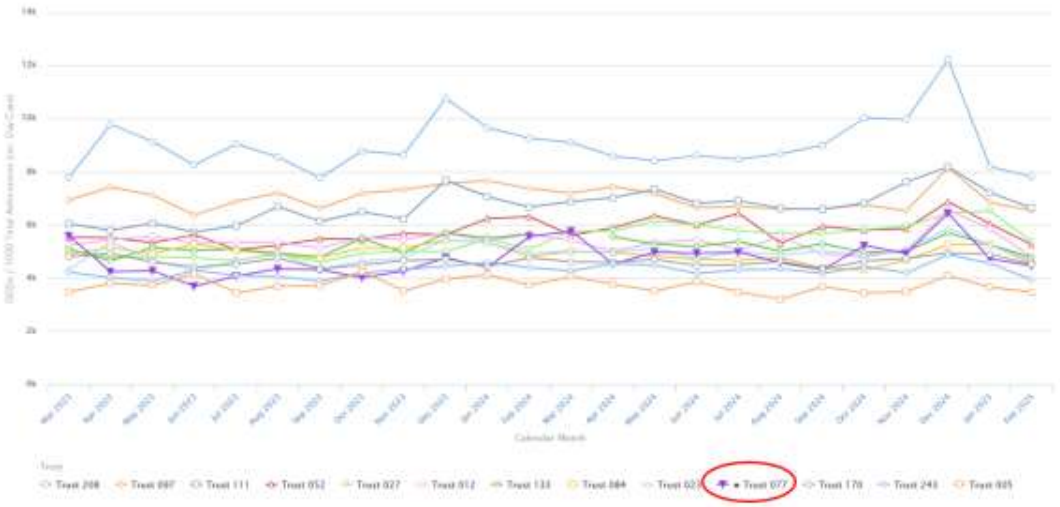
Weekly antimicrobial stewardship ward rounds were introduced with the surgical junior doctors in September 2022. These focus on duration of antibiotics, timing of iv to oral switch, restriction of gentamicin course length to 5 days, review of microbiology culture results and discussion of complex cases.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

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

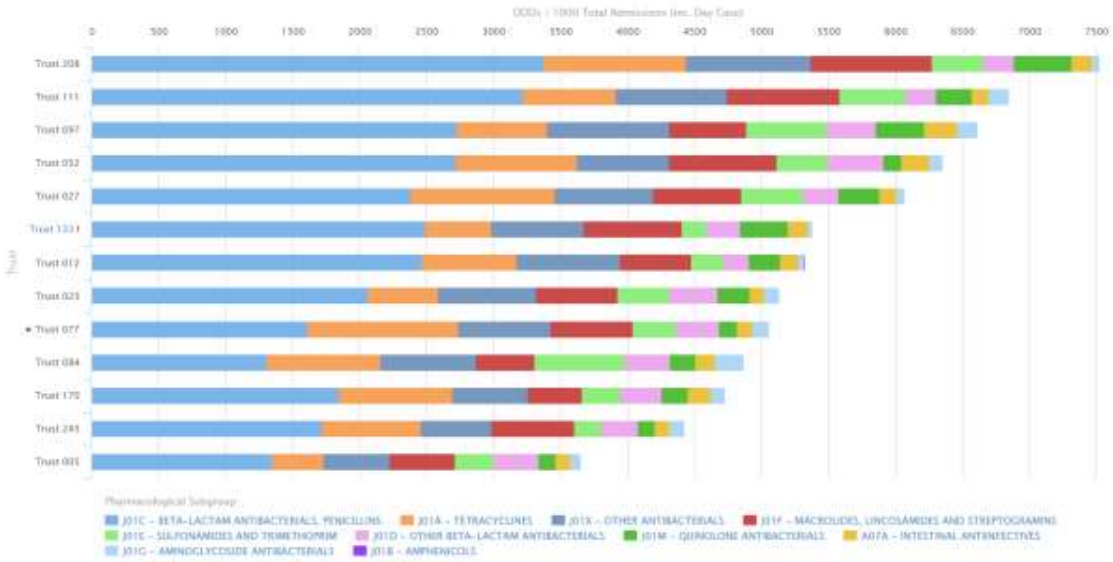
The following charts compare antibiotic consumption at HDFT with other Trusts in the region. HDFT is Trust 077.

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

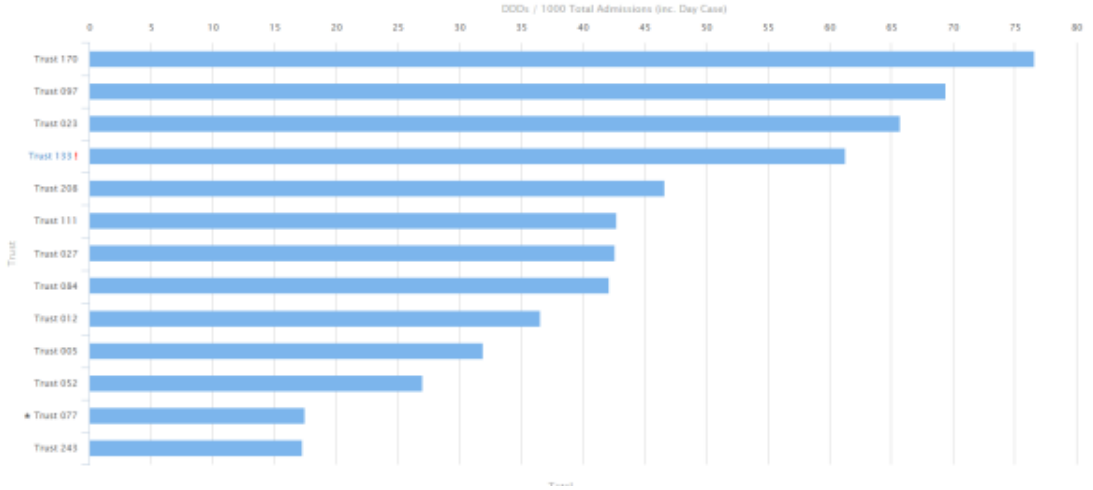
Total Antimicrobial Use in DDD/1000 Admissions



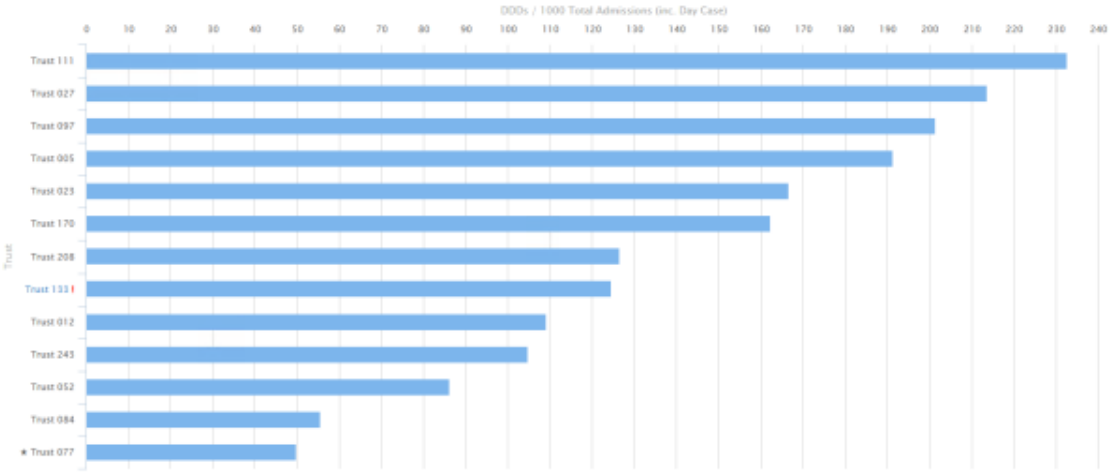
Breakdown of Antimicrobial Consumption into Antimicrobial Classes



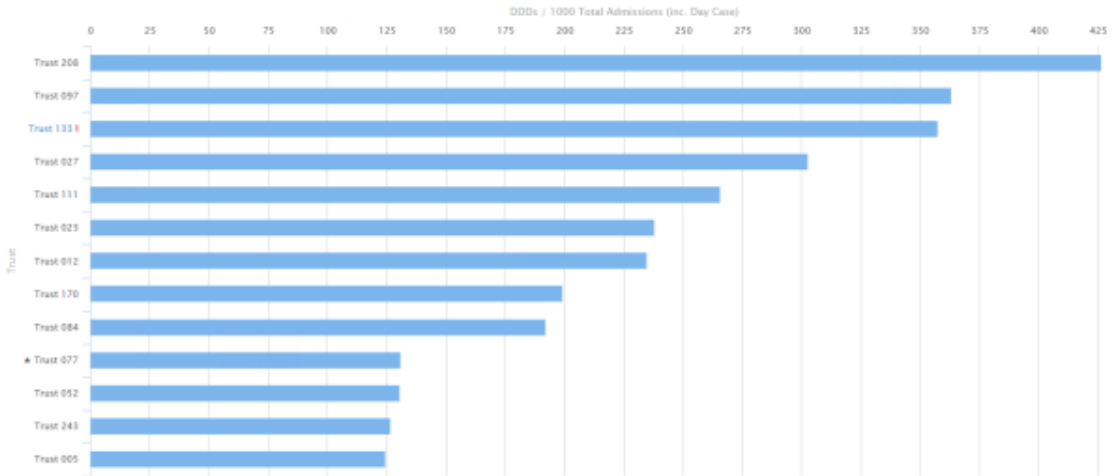
Meropenem



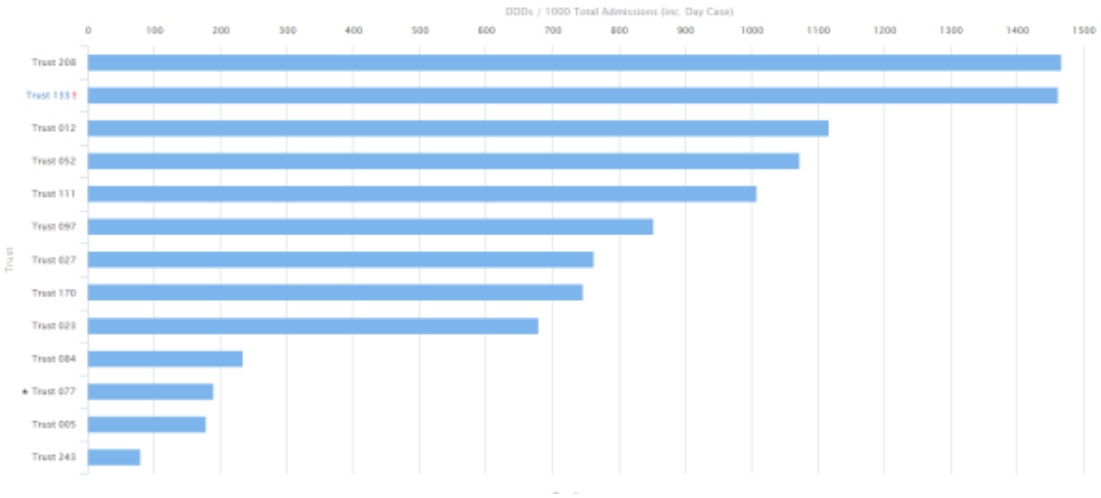
Piperacillin/tazobactam



Fluoroquinolones



Co-amoxiclav



AWaRe Categories

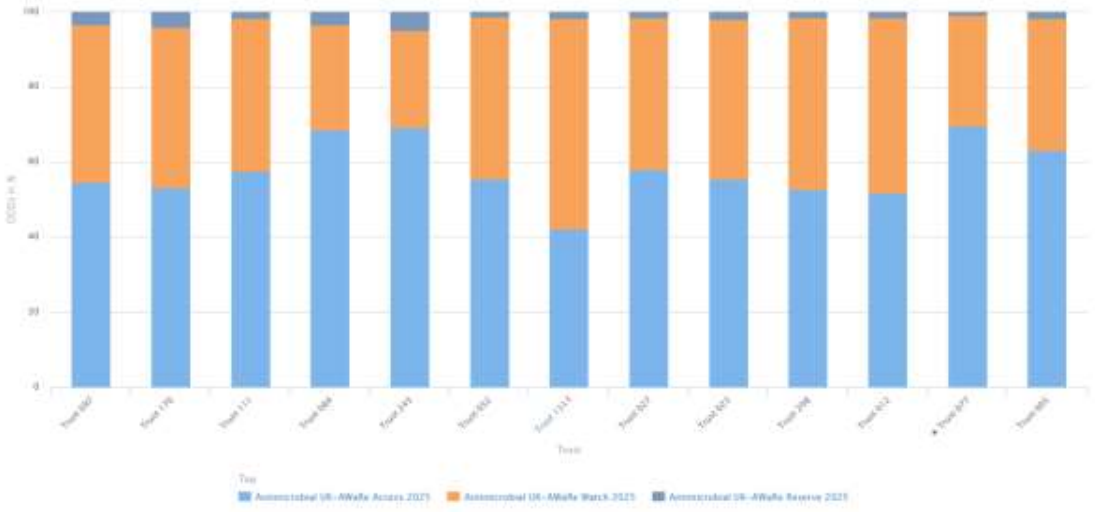
The AWaRe Classification of antibiotics was developed in 2017 by the WHO Expert Committee on Selection and Use of Essential Medicines as a tool to support antibiotic stewardship efforts at local, national and global levels. Antibiotics are classified into three groups, Access, Watch and Reserve, taking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

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

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

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

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



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

Since January 2022, antimicrobial prescribing lessons learnt from the CDI post-infection reviews have been formally fed back to the AMS team for discussion at APSG. Inappropriate antibiotic prescribing was implicated in only 4 of 34 Trust-apportioned cases.

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

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

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

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

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

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

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

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

Progress Towards Proposed Objectives for 2024/25

Objective	Progress
Continue weekly targeted antimicrobial stewardship ward round with junior doctors in general surgery/urology	These have continued and a review of outcomes was performed in November 2024
Support of antimicrobial audit in clinical specialties	Ongoing
Support ACPs in AMS	AMS teaching session given to non-medical prescribers November 2024
Promote and support Trust adherence to Improving the Blood Culture Pathway	Updated blood culture taking SOP Reintroduction of blood culture packs Presentation at Wednesday CPD teaching Presentation at LTUCC and PSCC Quality boards Presentation at urology and general surgery audit meeting Presentation at LTUCC governance meeting MDT set up Ongoing programme of audit
Paediatric guidelines UK-PAS	Gap analysis performed and changes to paediatric guidelines published August 2024
Provide guidance on the use of antimicrobials for the Hospital at Home service	No input required by the service in this time period
Proactive focus on IVOS	Focus at surgical AMS ward rounds
Penicillin allergy delabelling	Expression of interest made for national study Mike Wakefield is leading on a delabelling service for elective orthopaedic patients.

Dr Katharine Scott, Consultant Microbiologist, July 2025

5.0 Criterion 4

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

Communication

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

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

6.0 Criterion 5

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

Alert organism system

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

Surgical Site Infection Surveillance (SSIS)

The Trust's mandatory Orthopaedic SSI for 2024/25 was carried out between October and December 2024. Hip replacements were selected for this year's data submission. There were a total number of 109 hip replacement operations performed during the surveillance period. One SSI's requiring readmission was identified, an infection rate of 0.9%. One patient reported SSI was identified, an infection rate of 0.9%. Total identified SSI's = two, infection rate of 1.8%. An impressive 73% of patients returned a completed patient questionnaire allowing us to calculate meaningful data.

Outbreak Management

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

In 2024/25 we had no *C.difficile* transmission events.

In 2024/25, we have had a relatively low number of hospital respiratory virus outbreaks. With regards to COVID-19, outbreaks have predominantly been limited to a single bay and whole ward closures have not been necessary. We have had one significant Influenza A outbreak on Granby ward, which did necessitate ward closure for a short period. It is thought that the introduction of the rapid respiratory virus point of care test in ED (*see later in the report*) has had a significant impact on respiratory virus transmission within the hospital.

Corynebacterium ulcerans

In January 2025, we identified an inpatient colonised with a toxigenic strain of *Corynebacterium ulcerans.* This organism is capable of patient-to-patient transmission and can cause Diphtheria. A multi-disciplinary incident management team was formed involving both Trust and external partners (Health Protection Team, National Diphtheria reference unit). Unfortunately, the patient had been with us for 3 weeks and we identified 30 significant contacts for post-exposure prophylaxis, many of whom had already been discharged from our care. Through teamwork and collaboration, the GP out of hours service was commissioned to follow up individual contacts and offer them chemoprophylaxis and vaccination. Thankfully, no evidence of onward transmission was identified.

CPE:

This year we experienced our first hospital CPE transmission event. A patient colonised with CPE was identified on Granby ward following repatriation from another local hospital. Unfortunately, the patient was not isolated in a side room as is trust protocol for patients transferred from other hospitals pending CPE screening results. Having spent 18 hours in a multi-bed bay, we identified five significant patient contacts, one of whom was found to be colonised with an identical strain of the CPE producing organism. This means it is likely that a transmission event occurred between the two patients. An outbreak control group was formed to ensure all relevant actions were assigned and completed. The major learning cascaded from the event was to remind all staff of the importance of adhering to the Trust procedure for “bed management and transfer of patients”.

7.0 Criterion 6

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

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

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

Staff Induction

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

Staff Training and Education

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

Table 3.0 – figures as of 31/3/25.

	Level 1	**Level 2**
Corporate	98	98
HiF	93	94
LTUCC	94	92
PSCC	97	97
CYPPH	99	99
Total Average Compliance	96.2%	96%

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

- WHO hand hygiene awareness day (29th April)
- International IPC week (week commencing 13th October)
- World AMR awareness week (week commencing 18th November)

The IPC team hold IPC Champions and interest study sessions, recent presentations have included updates on MRSA and "gloves-off" campaign. The IPC team have effectively used posters to spread the message "*it might be gloves, it's always hand hygiene"* throughout the Trust.

The IPC team hosted a stand at the Doctors in Training Showcase event in July.

The team have this year facilitated specific water safety training for ward managers via external expert partners.

FIT testing Service

Members of the IPC team have attended a HSE accredited training programme and can undertake Fit testing for the HDFT staff who may be required to wear an FFP3 mask as part of their role. Sonya Ashworth has been successful in ensuring Fit testing is now a mandatory role-based training requirement, which means we can monitor compliance and alert staff as to when they are due for re-testing.

HCID preparedness

This year has seen several UKHSA alerts regarding preparedness for the management of patients presenting with suspected HCID. The IPC team have worked hard to implement the UKHSA PPE Addendum. ED now have a fully stocked "HCID box" and a program of PPE training delivered by their local education practitioners. IPC have supported this training by producing video's on the correct don/doff procedures. Working with the Emergency Planning Team, a new Trust-wide HCID protocol has been developed to ensure staff have a central point of reference to consult should a patient present with a suspected HCID.

8.0 Criterion 7

Provide or secure adequate isolation facilities

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

This can, at times of high demand, significantly impact the ability to isolate all patients who should be isolated according to national guidance. When demand exceeds single room occupancy, a risk assessment is carried out to ensure the most appropriate patient is allocated a single room. The IPC Team work closely with the Clinical Site Team to support the risk assessment and decision-making. A priority isolation list is available to help the Clinical Site Team out of hours and ensure that practice is consistent.

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

Use of Point of care testing (POCT) to prioritise most infectious patients for side room placement

The IPC team have been an integral part of the multi-disciplinary team responsible for the implementation of respiratory virus point of care testing in ED this year. The aim of the project was to use an inexpensive, rapid, next-to-patient test to screen for four respiratory viruses, Influenza A, B, RSV and COVID-19. Alongside a clinical pathway, the test results allow clinical site managers to prioritise patients with the highest risk of virus transmission for side rooms. This has resulted in unblocking flow from ED to medical admission wards, reducing the time taken to off-load ambulances, minimised hospital outbreaks of infection and reduced the amount of staff sickness in ED.

This has been a truly cross-departmental collaborative project and is a great example of how working with an industry partner can result in increased quality of care for our patient.

The project was short-listed as one of three finalists for a Medipex NHS Innovation award. We celebrated our success alongside our industry partner, Sterilab at the Medipex, Healthcare Innovation Hub showcase event on Wednesday 25th June 2025.

Strengthened IPC precautions around ESBL/AmpC positive patients:

The IPC team have this year focused on strengthening the risk assessment and placement of patients colonised with ESBL/AmpC producing organisms. Our single room capacity means that we are unable to isolate every patient colonised with ESBL/AmpC producing organisms. The IPC team have now implemented a formal risk assessed approach. An electronic IPC alert is sent to the team via the Laboratory Information Management System (LIMS) when a new inpatient is identified as carrying ESBL/AmpC producing organisms. The IPC team risk assess the individual patient and can prioritise them for single room placement if they have factors, which increase the risk of transmission to other patients. Risk mitigation is undertaken where single room placement is desired but not achievable due to single room capacity (i.e. isolation in a bay bed space, enhanced cleaning procedures).

9.0 Criterion 8

Secure adequate access to laboratory support as appropriate

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

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

The Laboratory department have continued to work flexibly with the Trust and have maintained an extended working hour's rota to provide on-site respiratory virus testing until 9pm seven days per week. This has been key to maximising safe patient flow.

10.0 Criterion 9

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

The IPC Policy and all of the supporting procedure documents are located on PolicyStat. The IPC team is committed to the continuous updating of IPC procedures, the IPC Matron has been given

special permission to enable us to update policies in between the formal review dates when appropriate.

Couch roll reduction project:

Project Lead – Sheeba Sojan, Infection Prevention and Control Nurse.

Couch roll paper is used to cover examination couches to protect them from contamination and is changed in between patients. From an infection prevention and control, perspective couches should be physically cleaned thoroughly between each use, regardless of whether couch roll paper is used.

There are concerns regarding sustainability and environmental impact of unnecessary use/waste of paper. There is also a financial implication to using products, which are not essential.

The IPC team noted that another Trust had successfully reduced the amount of couch roll paper used without compromising infection prevention and control principles and decided to implement the learning at HDFT.

In 2024/23 HDFT ordered over 10,000 couch rolls, (each roll is 40m long). This totals over 250 miles, an equivalent distance from Harrogate to the South Coast.

The IPC team conducted a comprehensive assessment across the departments using couch roll paper. By engaging with staff and providing education the amount of couch roll has been significantly reduced and is now only used for specific indications (e.g. when undertaking invasive procedures). It was even possible to phase out couch roll use in some departments where its use was non-essential.

This is a great example of the IPC team implementing innovative ideas and learning from others.

11.0 Criterion 10

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

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

A new Staff Pre-Placement Policy has been in use this year and a major review of the Body Fluids Exposure policy is underway.

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

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

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

12.0 New Infection Control Doctor for 2025/26

Dr Sarah Drake (Consultant Microbiologist) takes over from Dr Lauren Heath as Infection Control Doctor on 3rd April 2025. A comprehensive handover has taken place and Lauren Heath will continue to represent IPC/Microbiology on the Water Safety Group and Ventilation Safety Group.

13.0 Conclusion

The IPC team continue to provide a dynamic and responsive service. This has been strengthened by the new laboratory information management system (WinPath) which allows dynamic reporting

(and acknowledgment) of alert organisms. The team continue to embrace new digital ways of working with their advice documented in the electronic patient record and are continue to expand their expertise in the IPC aspects of the built environment by being involved in capital projects right from the start of the design phase.

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

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

14.0 Reference

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

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

13.0 Appendices

1.0 Terms of reference IPCC
2.0 IPCC meeting attendance record 2024/25
3.0 IPC Board Assurance Framework
4.0 IPC annual plan of work 2024/25

Appendix 1 – IPCC Terms of Reference:

Terms of Reference

Infection Prevention and Control Committee (IPCC)

1. **Accountable to:**
   - Quality Committee (QC)
   - Board of Directors

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

   Specifically to include the following:

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

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

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

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

The key standards for this group are:

- The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance (UKHSA 2015)
- Mandatory enhanced MRSA, MSSA, and Gram negative bacteraemia, and Clostridium difficile infection surveillance. (PHE 2016)
- HM Government (2019): Tackling antimicrobial resistance 2019-2904: The UK's 5 years National Action Plan

4. Membership

The core membership comprises:

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

Ad hoc attendance may be by invitation of the Chair.

5. Quorum

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

6. **Administrative support**
   Secretary to the Consultant Microbiologist's

7. **Subgroups**
   Hospital and Community Infection Prevention and Control Team

   - Group responsible for implementation of the IPC APW, acute and community IPC services

   Antimicrobial Prescribing Sub-Group (APSG)

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

   Water Safety Group

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

   Ventilation Safety Group

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

   Decontamination Committee

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

8. **External relationships**
   ICB

   North East and Yorkshire IPC Team

9. **Frequency of meetings**
   Monthly

10. **Communication**
    Minutes and action log to be produced for each meeting by the administration support.
    Escalation of issues to Quality Committee.

11. **Review**
    Annually (April)

12. **Date**
    23/5/24

Appendix 2 – IPCC Meeting Record 2024/25

Meeting	1	2	3	4	5	6	7	8	9	10	11	12
Date	22/4		10/6	22/7	22/8	23/9	28/10	25/11		27/1	3/3	31/3
DIPC										R	R	
Executive Director of Nursing, Midwifery and AHP's			R		R			R		R	R	A
Matron IPC												R
ICD												
Deputy Chief Operating Officer	A			A	A	A	A					
LTUCC HoN			R							R	R	R
PSCC HoN										R	R	A
CC HoN	R		R			A		R			A	
Matron for Paediatric Services				A	A		A					
Head of Occupational Health and Wellbeing						A	A	A		R	A	R
Deputy Director of Estates and Facilities (HiF)					R					R		
Head of Health and Safety										A		

Key:

R – Representative sent

A – Apologies received

Appendix 3: IPC Board Assurance Framework:

Infection Prevention and Control Board Assurance Framework – 2024-2025

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

Health and Social Care Act 2008: code of practice on the prevention and control of infections - GOV.UK (www.gov.uk)

NIPC BAF - HDH 2024-25 (31.3.25).xls:

Appendix 4: IPC Annual Work Plan 2024-25

The HIPCT Work Plan describes the IPC improvement work to be undertaken in 2024-2025. The plan is ratified at the Infection Prevention and Control Committee (IPCC). The IPCC review progress against the plan on a quarterly basis.

Item	Task	Task Lead	Target Date	Progress
	Policy and Guidelines			
	Section 003: Procedure for individual diseases – **redraft**	LH	31/3/25	Complete
	Section 017: Communicable diseases in staff and exclusion policy - **redraft**	IG	31/3/25	Complete
	Section 031: Principles of asepsis – **redraft**	IG	31/3/25	In progress
	Section 027: Procedure for Hospital Outbreak – routine review	LH	30/06/24	Complete
	Section 002: Procedure for Isolation- routine review	SA	31/07/24	In date
	Section 009: Procedure for C.difficile- routine review	SA	30/09/24	In date
	Section 012: Procedure for MRSA - **redraft**	LH	31/3/25	For 25-26 and SD
	Section 029: Handling bodies after death – routine review	SA	31/08/24	Complete
	Quality Improvement and Audit			
	Embed the quarterly IPC and Hand Hygiene audit of High risk areas	SA	31/10/24	Complete
	Embed the annual IPC and Hand Hygiene audit of Low risk areas	SA	31/3/25	Complete
	Review of Staph aureus (MSSA/MRSA) infection prevention strategy	LH	31/3/25	For 25-26 and SD
	Education and Training			
	"Gloves off" campaign	SA/AG	30/09/24	Complete
	IPC champions study event	SA	31/3/25	Complete

	New items to be added throughout the year			
	Couch roll reduction plan	SS	30/09/24	Complete
	Annual review of training resources (NICE guideline requirement)	SA	31/03/25	Complete
	Roll out HCID PPE training to high risk areas	SA	31/10/24	Partial – Needs to be added as role based mandatory requirement (like FFP3 FiT testing)
	Contribute to multi-disciplinary Trust HCID procedure	LH	31/10/24	Complete
	Implement CoreTest lateral flow for detection of respiratory viruses into the acute admissions pathway	LH	31/10/24	Complete
	Roll out Fit testing to relevant staff groups	SA	31/3/25	Complete
	Assess potential impact of in-house Norovirus PCR by collecting real-time data	LH	31/3/25	Complete for 24/25, will need continued review each winter.
	Spectricept trial	SA	31/3/25	Complete – for business case

Harrogate and District NHS Foundation Trust

Gender Pay Gap Report
As at 31 March 2024

1. Gender pay gap reporting

Government departments are covered by the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017, which came into force on the 31 March 2017. Legislation has made it statutory for organisations with 250 or more employees to report annually on their gender pay gap. These regulations underpin the Public Sector Equality Duty and require the relevant organisations to publish their gender pay gap data, including:

- Mean gender pay gap in hourly pay.
- Median gender pay gap in hourly pay.
- Mean bonus gender pay gap.
- Median bonus gender pay gap.
- Proportion of men and women receiving a bonus payment.
- Proportion of men and women in each pay quartile.

The gender pay gap is different to equal pay. Equal pay means that men and women in the same employment who are performing equal work must receive equal pay, as set out in the Equality Act 2010. It is unlawful to pay people unequally because of their gender.

The Trust pays most employees, excepting some medical and dental staff, on the Agenda for Change pay system, and this framework provides assurance that equal pay for equal work is recognised i.e. someone entering the Band 5 scale with the same level of qualifications and experience would be paid the same irrespective of gender; they would then have the opportunity to progress up the pay scale annually in the same way as their peers.

2. Harrogate and District NHS Foundation Trust

Harrogate and District NHS Foundation Trust (the Trust) employs more than 5,000 members of staff to provide essential hospital treatment, as well as community health services, to the population of Harrogate and the local area, across North Yorkshire and Leeds. In addition, it provides children's services, stretching from Berwick upon Tweed in the North to Wakefield in the South, and across the whole of North Yorkshire, from Settle in the West to Scarborough in the East.

The total number of staff eligible for inclusion in this report was 4,910.

	31 March 2024		**31 March 2023**	
	Headcount	**%**	**Headcount**	**%**
Female	4,110	84%	3,979	85%
Male	800	16%	718	15%
TOTAL	**4,910**		**4,697**	

Figure 1 illustrates the gender distribution within the Trust at 31 March 2024.

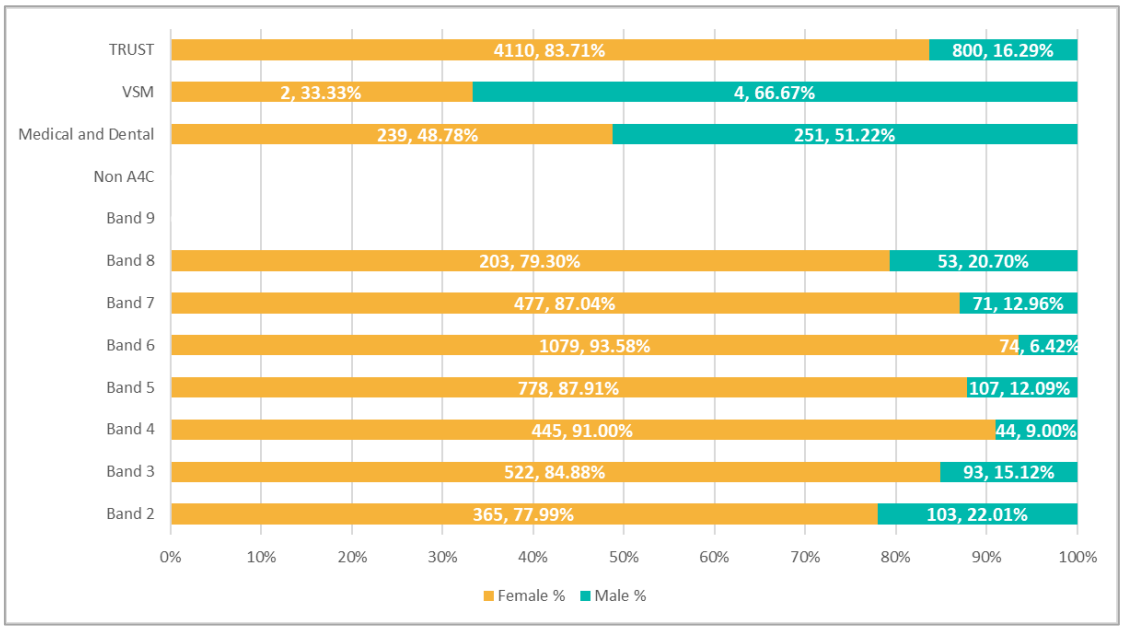
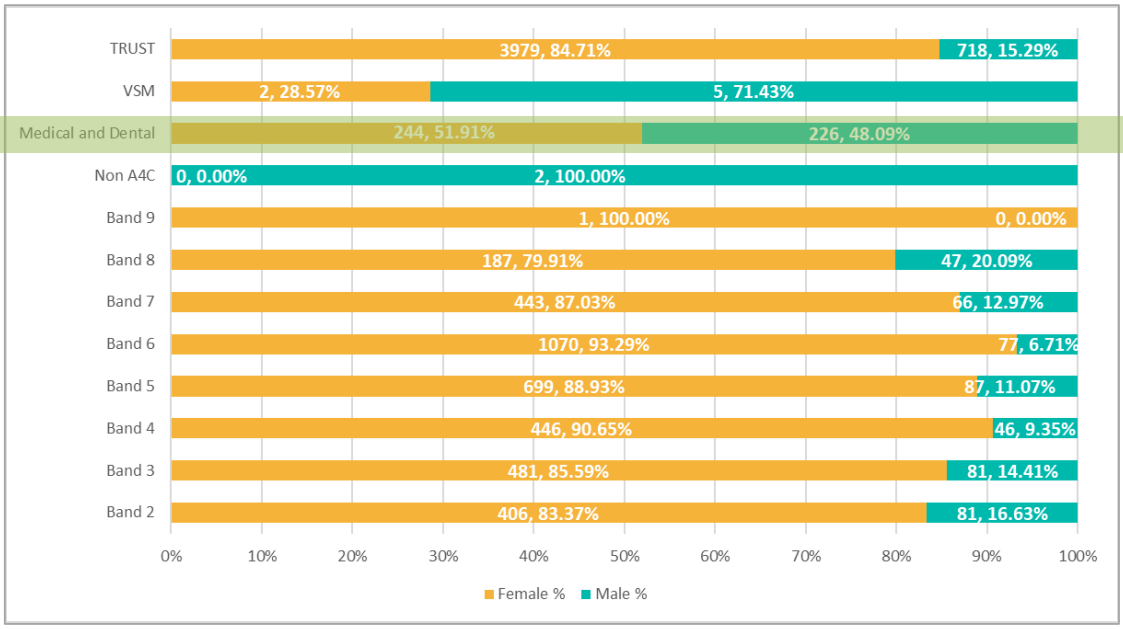


Figure 2 illustrates the gender distribution within the Trust at 31 March 2023



Note - As part of the 2018 pay deal, Band 1 closed to new entrants with effect from 1 December 2018 and from April 2019, all existing staff on a Band 1 contract at the Trust transitioned to Band 2.

Definitions and scope

The gender pay gap is a measure that shows the difference in average earnings between men and women across an organisation.

The gender pay gap is described in two terms. Firstly, the difference between the mean of hourly rates of men and those of women, and secondly as the difference between the median hourly rates of men and women

Mean and Median

- The "mean" is an average of all hourly rates of pay.
- The "median" is the middle value in a complete list of all hourly rates of pay.

The report is based on rates of pay for the financial year 2023/24. It includes all workers in scope at 31 March 2024.

Employees in scope are those who received their usual full basic pay during the pay period. Employees out of scope are those who did not receive their usual full basic pay during the pay period, including staff who had reduced pay due to maternity leave, sickness and unpaid leave.

A positive figure indicates a gender pay gap disadvantageous to women; a negative figure indicates the gender pay gap disadvantageous to men:

3. Mean and median gender pay gap in hourly pay

Gender	Mean Hourly Rate 2024	Median Hourly Rate 2024	Mean Hourly Rate 2023	Median Hourly Rate 2023
Male (£)	25.99	21.06	25.43	19.73
Female (£)	19.65	18.10	18.82	17.24
Difference (£)	6.34	2.96	6.61	2.50
Pay Gap %	24.40	14.07	26.00	12.65

* rounded up to 2 d.p.

- As highlighted in Figure 1, the proportion of female to male staff is higher in lower bands when compared to the senior bandings, (i.e. Band 8, Medical and Dental and VSM), which would explain why there is a gender pay gap. For these senior bandings the proportion of females is lower than the overall Trust average.
- As shown, the Trust is reporting a 24.40% gender pay gap, meaning that based on an average hourly rate, men are paid 24.40% more than women.
- The figures also demonstrate that the Trust has a 14.07% median gender pay gap, which is an increase from 12.65 % for 2023.

The Influence of Medical and Dental Staff

Medical and Dental staff have a substantial impact on the Trust's gender pay gap, as the data shows that individuals in this staff group tend to be paid higher wages than other Trust employees.

Included within this report are 82 male Consultants and 80 female Consultants. As the Trust employs fewer men overall, at 10.3%, the number of male Consultants is higher than that of female Consultants (1.9%) as a proportion of the overall workforce.

To evidence the influence of medical and dental staff driving the percentage gap, the table below shows that removing these staff from the calculations, in 2024, the pay gap percentage for the mean hourly rate is reduced from 24.40% to 1.67%. In this instance, the median hourly rate pay gap percentage becomes favourable to females, changing from 14.07% to -5.53%.

The data shows a small decrease in the gender pay gap percentage for the mean hourly rate of non-medical staff in 2024, dropping from 3.48% to 1.67% when compared to 2023.

Gender	**Mean Hourly Rate 2024**	**Median Hourly Rate 2024**	**Mean Hourly Rate 2023**	**Median Hourly Rate 2023**
Male (£)	18.48	16.76	17.94	16.38
Female (£)	18.17	17.69	17.32	16.87
Difference (£)	0.31	-0.93	0.62	-0.49
Pay Gap %	1.67	-5.53	3.48	-3.01

4. Mean and median bonus gender pay gap

The Trust pays two types of bonuses; Clinical Excellence Awards (CEA) and Long Service Awards. The latter takes the shape of a £40 bonus paid to both males and females, in recognition of 25, 30, 35, 40 and 50 years' service at the Trust. As this bonus is paid out at an equal level to all employees, it has no influence on the figures.

In 2023/2024 there were two types of CEA's that were awarded to the Trust's Consultants. One of these was a lifetime CEA Award, and that was paid to 80 Consultants. The other type of CEA paid was a non-pensionable, non-consolidated award.

The figures below reflect the two CEA payments for Consultant medical staff. The bonus pay gap calculations includes the bonus pay over the previous 12 month period for all Consultant medical staff employed as at 31st March 2024.

The Trust currently employs 171 Consultants, of whom 87 are male and 84 are female (as at 31.03.24). 70 of the 87 male Consultants received a CEA payment in 2023/24 (80.5% of male Consultants) and 77 of the 84 female Consultants received a CEA payment in 2023/24 (91.7% of female Consultants).

Gender	**Mean Bonus 2024 (£)**	**Median Bonus 2024 (£)**	**Mean Bonus 2023 (£)**	**Median Bonus 2023 (£)**
Male	9,030.94	7,277.16	9,287.97	6,781.43
Female	9,137.20	4,316.00	8,819.99	5,725.91
Difference	-106.26	2,961.16	467.98	1,055.52
Pay Gap %	-1.18	40.69	5.04	15.56

- The data shows a 6.22% decrease in the mean gender bonus gap differential from 2023 to 2024. The mean gender bonus gap is favourable to females in 2024 compared to the previous year, when it was favourable to males.
- The figures demonstrate that the Trust has a 40.69% median gender bonus gap. This is an increase from 15.56% in 2023 and in contrast to the mean gender bonus gap, is favourable to males.

5. Proportion of men and women receiving a bonus payment

In addition to the above, the Trust issues Long Service Awards; a £40 bonus paid to both men and women in recognition of 25, 30, 35, 40 and 50 years' service at the Trust. As this

bonus is paid out equally to both men and women, it would have no influence on the figures.

146 Long Service Awards were issued to staff still employed as at 31st March 2024. 89.0% were issued to females, with the remaining 11.0% being issued to males. All long service awards carry the same financial value of £40, meaning that the gender bonus gap would be zero.

Taking both Clinical Excellence Awards and Long Service Awards into account, in 2024 5.0% of females received a bonus compared to 10.8% of males. This is again influenced by the ratio of males in receipt of a bonus. .

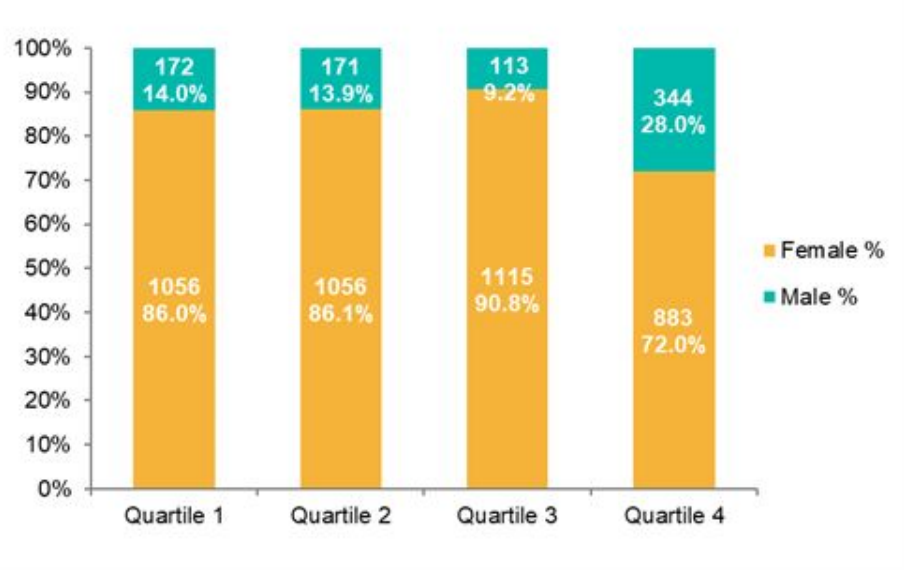
6. Proportion of men and women in each pay quartile

A quartile is where you take the range of data and divide it up. In this case it would be the range of hourly earners, divided into four groups. Therefore, Quartile 1 is the lower 25% of staff hourly wages.

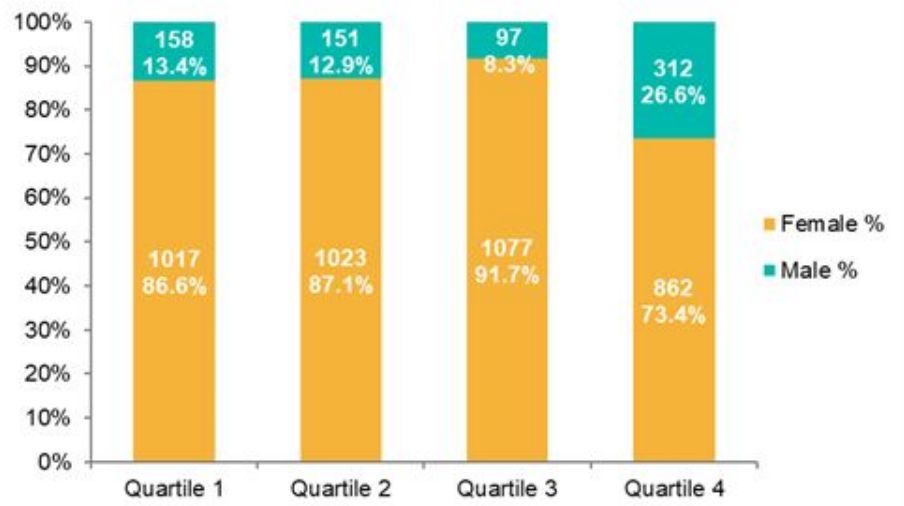
- Quartile 2 – lower middle
- Quartile 3 – upper middle
- Quartile 4 – upper

The graph below shows that the highest proportion of males and lowest proportion of females is found in the upper quartile when compared with other quartiles. This is influenced by the large proportion of male doctors and dentists within the Trust. The percentage of females has decreased across all quartiles compared to the 2023 figures, however this is due to an increase in the male workforce, which now accounts for 16% of the overall workforce, compared to 15% in the previous year.

Proportion of male to female staff allocated to quartiles, 31st March 2024



Proportion male to female staff allocated to quartiles, 31st March 2023



7. Summary and next steps in reducing the gender pay gap

Based on the data at 31 March 2024, when comparing median hourly wages, women working in HDFT earn 85p for every £1 that men earn. Their median hourly wage is 14.07% lower than men's.

When comparing mean hourly wages, women's mean hourly wage is 24.40% lower than men's.

Women occupy 72.0% of the highest paid jobs and 86.0% of the lowest paid jobs and account for 83.7% of the total workforce.

In the ‘Medical and Dental’ category, the number of female Consultants eligible to be included in this report decreased slightly from 81 in 2023, to 80 in 2024. Male Consultants increased from 76 in 2023 to 82 in 2024.

When comparing the gender bonus pay gap, men’s mean bonus pay is 1.18% lower than women’s, however in contrast, the median bonus pay is favourable to males and has a gap of 40.69%.

It can be seen from the data in the report that the influence of medical and dental staff is driving the percentage gap. Removing medical and dental staff from the calculations, in 2024, the pay gap percentage for the mean hourly rate is reduced from 24.40% to 1.67%. In this instance, the median hourly rate pay gap percentage is 5.53% greater for females, meaning that men earn 94p for every £1 that women earn, when comparing median hourly wages.

The gender pay gap report has been shared with the Trust Board to make informed decisions on actions that are required to improve the gender pay gap. These will include

- Promoting awareness of opportunities and policies, including flexible and agile working arrangements, which encourage women to return to careers following maternity and other life events.
- Promoting training in equality issues as part of the First Line Leaders’ programme and Pathway to Management.
- Progressing the Working Carers Passport initiative and providing/initiating welfare discussions for all colleagues.

There is no significant risk associated with the identified pay gap.

Harrogate and District NHS Foundation Trust

4

Ethnicity Pay Gap Report
As at 31 March 2024

1. Ethnicity pay gap reporting

Diversity and inclusion are fundamental to the success of an organisation both in the service it provides, and in creating a fair, diverse and inclusive environment for its workforce.

Research shows that organisations with diverse workforces and inclusive cultures perform better because they benefit from having a range of lived experiences and experience a deeper understanding and viewpoints in the room. This in turn promotes diverse, creative and innovative decision-making.

The culture of an organisation also depends on these values; a place where people are proud to work, where they feel valued, recognised and supported to develop their true potential.

While there is currently no legal requirement to publish ethnicity pay gap data in the UK, in line with our commitment to close gaps in workplace inequalities between our Black, and Minority Ethnic (BME) staff and White staff, and as an example of good practice, we are reviewing this data alongside our mandated Gender Pay Gap data.

The disclosure of diversity data, such as ethnicity, is optional for staff. The data used in this report is based on a snapshot of data from 31 March 2024 for colleagues who have chosen to disclose their ethnicity.

Our mean ethnicity pay gap shows the difference in average pay between BME colleagues and White colleagues and takes into account all roles at all levels within Harrogate and District NHS Foundation Trust (HDFT). This is different to the concept of equal pay i.e. the

comparison in pay received by BME and White colleagues performing the same roles at the same grade.

HDFT pays most employees, except some medical and dental staff, on the Agenda for Change pay system, and this framework provides assurance that equal pay for equal work is recognised i.e. someone entering the band 5 scale with the same level of qualifications and experience would be paid the same irrespective of ethnicity; they would then have the opportunity to progress up the pay scale annually in the same way as their peers

The report will provide a breakdown of:

- Mean ethnicity pay gap in hourly pay.
- Median ethnicity pay gap in hourly pay.
- Mean bonus ethnicity pay gap.
- Median bonus ethnicity pay gap.
- Proportion of White and BME colleagues receiving a bonus payment.
- Proportion of White and BME colleagues in each pay quartile.

2. Harrogate and District NHS Foundation Trust

Harrogate and District NHS Foundation Trust (the Trust) employs more than 5,000 members of staff to provide essential hospital treatment as well as community health services to the population of Harrogate and the local area, across North Yorkshire and Leeds. It also provides children's services, stretching from Berwick upon Tweed in the North to Wakefield in the South, and across the whole of North Yorkshire, from Settle in the West to Scarborough in the East.

The total number of staff eligible for inclusion in this report was 4,679 from a workforce of 4,910. The data in this report is based on those who have chosen to disclose their ethnicity, which accounts for 95.3% of the workforce.

	31 March 2024		**31 March 2023**	
	Headcount	**%**	**Headcount**	**%**
BME	747	16.0%	555	12.5%

White	3,932	84.0%	3,884	87.5%
TOTAL	**4,679**		**4,439**	

We must continue to encourage staff to declare their ethnicity. The disclosure rate is important as it reflects how comfortable, or not, people are about sharing these details with us and more broadly, whether we are creating an environment where people can truly be themselves.

Figure 1 illustrates the ethnicity distribution within HDFT at 31 March 2024

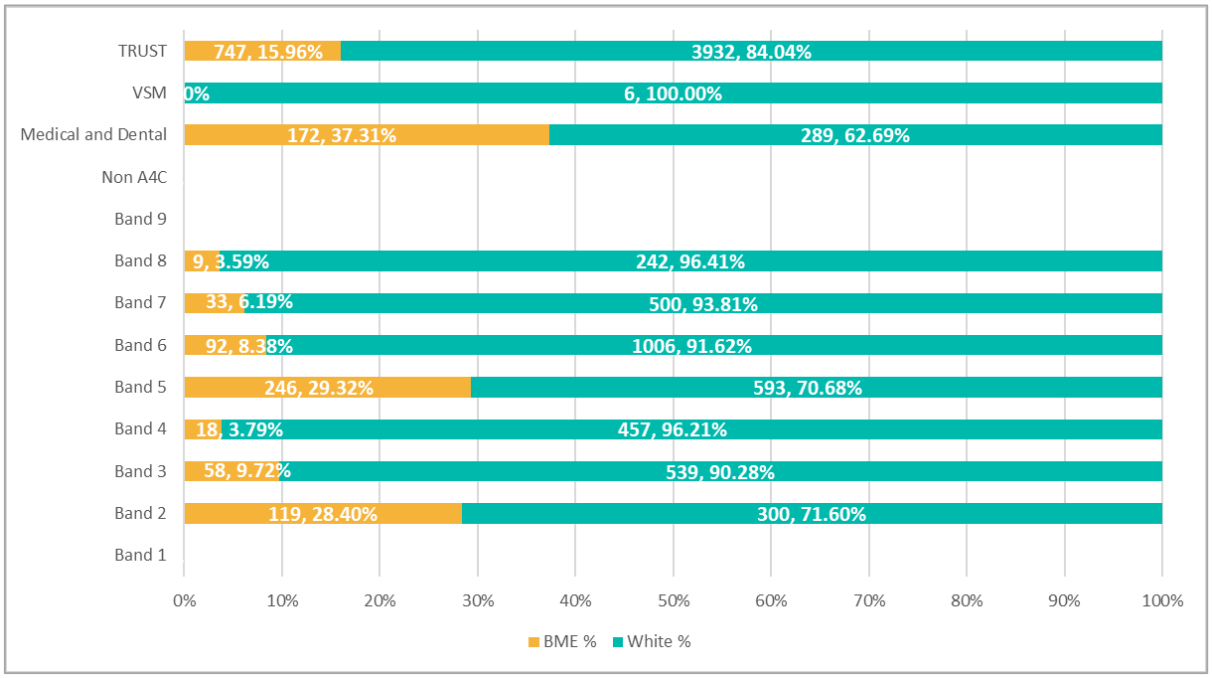
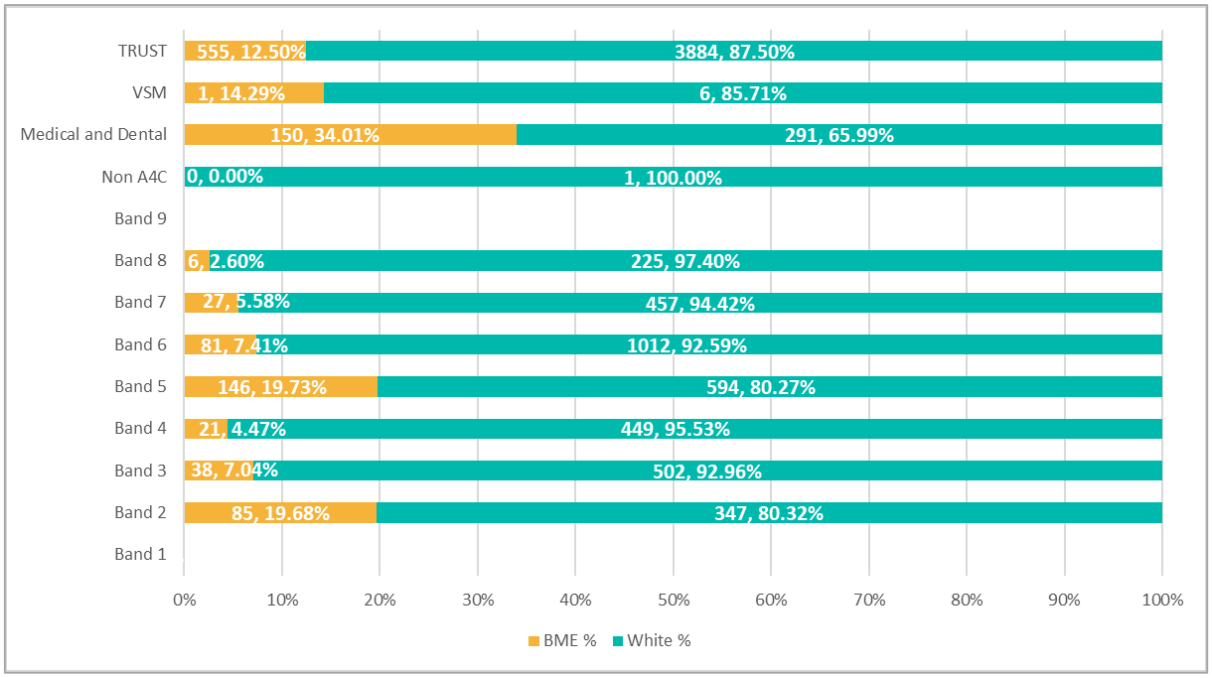


Figure 2 illustrates the ethnicity distribution within HDFT at 31 March 2023



Note - As part of the 2018 pay deal, Band 1 closed to new entrants with effect from 1 December 2018, and all existing staff on a Band 1 contract at HDFT transitioned over to Band 2 from April 2019.

3. Definitions and scope

The Ethnicity Pay Gap is a measure which shows the difference in average earnings between BME colleagues and White colleagues across the organisation.

The report is based on rates of pay for the financial year 2023/24. It includes all workers in scope at 31 March 2024. A figure above zero indicates an Ethnicity Pay Gap disadvantageous to BME colleagues; a minus figure indicates the ethnicity pay gap disadvantageous to White colleagues.

The Ethnicity Pay Gap is described in two terms. Firstly, the difference between the mean of hourly rates of White colleagues and their BME colleagues and secondly, the difference between the median hourly rates of White colleagues and those of BME colleagues.

Mean and Median

• The "mean" is an average of all hourly rates of pay.
• The "median" is the middle value in a complete list of all hourly rates of pay.

4. Mean and median ethnicity pay gap in hourly pay

Ethnicity	Mean Hourly Rate 2024	Median Hourly Rate 2024	Mean Hourly Rate 2023	Median Hourly Rate 2023
White (£)	20.49	18.10	19.54	17.24
BME (£)	22.03	18.28	22.44	18.19
Difference (£)	-1.54	-0.18	-2.91	-0.95
Pay Gap %	-7.52	-0.99	-14.87	-5.54

- As highlighted in Figure 1, the proportion of BME staff is higher in the medical and dental staff group than in any other pay band.
- As shown above, HDFT is reporting a minus ethnicity pay gap of -7.52%, meaning that, based on an average hourly rate, BME employees are paid 7.52% more than white employees. This is a decrease from -14.87% on the 2023 figure.
- The figures also demonstrates that HDFT has a minus median ethnicity pay gap of -0.99%, a decrease from -5.54% in 2023.
- In 2024, both the mean and median pay gap percentages have seen a shift towards 0%, indicating that the pay gap by ethnicity has narrowed in comparison to the previous year.

<u>The Influence of Medical and Dental Staff</u>

Medical and Dental staff have a substantial impact on HDFT's Ethnicity Pay Gap, as the data suggests that individuals in this staff group tend to be paid higher wages than other HDFT employees.

Included within this report are 123 White Consultants and 36 BME Consultants. As the Trust employs fewer BME colleagues overall, as a proportion of the overall BME workforce,

at 4.82%, the number of BME Consultants is higher than that of White Consultants (3.13% of the overall White workforce).

To evidence the influence of medical and dental staff driving the percentage gap, the table below shows that in removing the medical and dental staff from the calculations, the ethnicity pay gap percentage for the average mean hourly rate in 2024 increases from -7.52% to 6.47% and becomes favourable to White colleagues. The median hourly rate pay gap percentage increases from -0.99% to 3.42% also changes to become more favourable to White colleagues when you take out the medical and dental staff data.

The data shows a small increase in the ethnicity pay gap percentage for the mean hourly rate of non-medical staff in 2024 when compared to 2023, from 4.95% to 6.47%.

Ethnicity	Mean Hourly Rate 2024	Median Hourly Rate 2024	Mean Hourly Rate 2023	Median Hourly Rate 2023
White (£)	18.42	17.69	17.52	16.87
BME (£)	17.23	17.08	16.66	16.75
Difference (£)	1.19	0.60	0.87	0.11
Pay Gap %	6.47	3.42	4.95	0.66

5. Mean and median bonus ethnicity pay gap

The Trust pays out two types of bonuses, Clinical Excellence Awards (CEA) and Long Service Awards. The latter takes the shape of a £40 bonus paid to both White and BME colleagues in recognition of 25, 30, 35, 40 and 50 years' service at the Trust. As this bonus is paid out at an equal level to all employees, it has no influence on the figures.

In 2023/2024 there were two types of CEA's that were awarded to the Trust's Consultants. One of these CEA's was a lifetime CEA Award and that was paid to 79 Consultants. The other type of CEA paid was a non-pensionable, non-consolidated award.

The figures below reflect the two CEA payments for Consultant medical staff. The bonus pay gap calculations include all Consultant medical staff employed as at 31st March 2024 and their bonus pay over the 12 month period to this date.

As of 31.03.24, the Trust employs 167 Consultants who are therefore eligible for inclusion in this report, of whom 130 are White and 37 are BME. Of the 130 White Consultants, 112 Consultants received a CEA payment in 2023/24 (86.2% of White Consultants). Of the 37 BME Consultants, 32 Consultants received a CEA payment in 2023/24 (86.5% of BME Consultants).

Ethnicity	**Mean Bonus 2024 (£)**	**Median Bonus 2024 (£)**	**Mean Bonus 2023 (£)**	**Median Bonus 2023 (£)**
White	10,142.01	7,289.29	9,894.44	6,781.43
BME	5,791.31	4,316.00	6,115.35	3,765.47
Difference	4,350.71	2,973.29	3,779.08	3,015.96
Pay Gap %	42.90	40.79	38.19	44.47

- This shows an increase of 4.71% in the mean ethnicity bonus gap differential and a decrease in the median bonus gap differential of 3.68% respectively, from 2023 to 2024.
- The mean pay gap remains significantly high in the favour of White Consultants.

6. Proportion of white and BME colleagues receiving a bonus payment

In addition to the above, the Trust issues Long Service Awards. Long Service Awards include a £40 bonus paid to both White and BME colleagues in recognition of 25, 30, 35, 40 and 50 years' service at the Trust. As this bonus is paid out equally to all ethnicities it would have no influence on the figures.

140 Long Service Awards were issued to staff still employed as at 31st March 2024, who had a recorded ethnicity and are therefore included within this report. 97.1% were issued to White colleagues, with the remaining 2.9% being issued to BME colleagues. All long service awards carry the same financial value of £40, meaning that the ethnicity bonus gap would be zero.

Taking both Clinical Excellence Awards and Long Service Awards into account, 6.3% of white colleagues received a bonus, compared to 4.8% of BME colleagues.

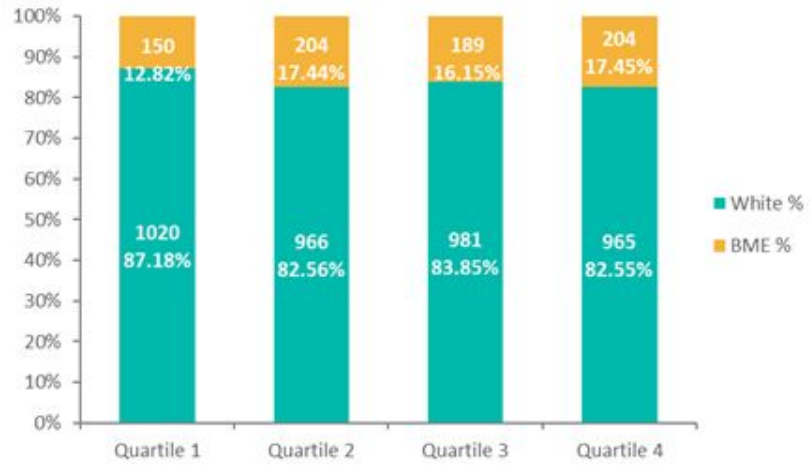
7. Proportion of White and BME colleagues in each pay quartile

A quartile is where you take the range of data and divide it up. In this case it would be the range of hourly earners divided into four groups. Therefore, Quartile 1 is the lower 25% of staff hourly wages.

- Quartile 2 – lower middle
- Quartile 3 – upper middle
- Quartile 4 – upper

The graph on the following page shows that the highest proportion of White colleagues is found in the lower middle quartile and lowest quartile. Compared with the lower quartiles, the highest proportion of BME colleagues is found in the two upper quartiles. This is influenced by the large proportion of BME doctors and dentists within HDFT. Compared to the 2023 figures, the percentage of BME in the upper quartiles has decreased.

2024



2023

8. Summary and next steps in reducing the ethnicity pay gap

The data in this report is based on those who have chosen to disclose their ethnicity.

We acknowledge there is a lot more to do to continue making improvements and bring positive changes for our BME colleagues, and to welcome a more diverse workforce to HDFT. In line with our Workforce Race Equality Standard (WRES) Action Plan and our Recruitment and EDI work streams, and as part of the 'At our Best' programme, HDFT is committed to increase the ethnic diversity of both our overall and senior workforces, putting a greater focus on recruiting and developing BME staff and driving initiatives that will demonstrate that we are serious about real cultural change.

It can be seen from the data in the report that the influence of medical and dental staff is driving the percentage gap. Removing medical and dental staff from the calculations (9.8% of the overall workforce), the pay gap percentage for the average mean hourly rate and median rate in 2024 changes in favour of White staff, providing a reflection of the larger proportion of the workforce.

To continue efforts in reducing the ethnicity pay gap actions will be taken forward in 25/26 including:

- Progressing strategies to make recruitment and progression more equitable
- Continuing to listen to the lived experiences of the REACH Staff Network, engaging with and valuing their expertise.
- Encouraging staff to feel confident in disclosing their ethnicity status on ESR.
- Continuing work in relation to encouraging more applications for CEA from BME consultants and providing support for individuals who have submitted unsuccessful applications in the past.

There is no significant risk associated with this pay gap.

Harrogate Hospital & Community Charity | teamHDFT At our best | HIF HARROGATE INTEGRATED FACILITIES Taking Pride in our Services | NHS Harrogate and District NHS Foundation Trust

CORPORATE

RISK REGISTER.

Summary Corporate Risk Register.

Ambition	Workstream		True North Metric	Risk Appetite	Level of Risk to Achieve Metric – Linked to Risk Appetite
					1 – 3 | 4 – 6 | 8 – 9 | 10 | 12 | 15 | 16 | >20
Best Quality, Safest Care	Ever Safer Care		Moderate & Above Harm	Clinical: Minimal	
	Excellent Outcomes				
	A positive experience		Patient Experience	Clinical: Minimal	
Person Centred, Integrated Care, Strong Partnerships	The best place for person centred , integrated care		4 hour ED standard	Operational: Cautious	
	An exemplar system for the care of the elderly		Length of Stay – Patients with Frailty	Operational: Cautious	
	Equitable, Timely Access to Best Quality Planned Care		Elective Recovery RTT – 18 Weeks	Operational: Cautious	
			Cancer 62 Day Standard – 62 DaysTreatment	Operational: Cautious	
Great Start in Life	National Leader for Children & Young People's Public Health Services		Children at Risk of Vulnerability	Clinical: Minimal	
	Hopes for Healthcare		Children's Patient Experience	Clinical: Minimal	
At Our Best – Making HDFT the Best Place to Work	Looking After our people		Staff Engagement	Workforce: Cautious	
	Belonging				
	Growing for the future		Staff Availability	Workforce: Cautious	
	New ways of working				
Finance	Financial Sustainability		Annual Breakeven	Financial: Cautious	
			System Oversight Framework Rating	Financial: Cautious	
An Environment that promotes wellbeing	Wellbeing	All	Capital Programme Delivery (Spend vs Budget)	Operational: Cautious	
	Quality & Safety		PAM >moderate improvement	Operational: Cautious	
	Environmental Impact		Natural gas consumption	Operational: Cautious	
Digital Transformation	Well Led		Achieve a score of 5/5 across all seven What Good Looks like (WGLL) pillars	Operational: Cautious	

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

Risk Score.

Initial Score	The score before any controls (mitigating actions) are put in place.
Current Score	The score after the risk has been mitigated (by controls) but with gaps in controls (things we are not able to do) identified.
Target Score	The score at which the risk management committee would be comfortable in removing the risk from the corporate risk register (CSU or corporate function).

CRR ID: CRR 75 / ID 115	Target Date:	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
Strategic Ambition: An Environment that promotes wellbeing	October 2025	1	2	3	4	5	6	8	9	10	12	15	16	20	25
Type: Operational; Health & Safety	C = 4				Target rating						Current Rating		Initial Rating		
	L = 3 **12**														

CQC Domain:	Executive Committee:	Committee reviewed at:	Previous rating:	June 2025 - 12

Principle Risk: HDH Goods yard

Risk Description:
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.

Date added to CRR: July 2022

Date reviewed: July 2025

Current Position

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.

Key Targets	Current controls	Gaps in control
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 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.	

CRR ID: CRR 75 / ID 116	Target Date:	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
	October 2025	1	2	3	4	5	6	8	9	10	12	15	16	20	25
Strategic Ambition: An Environment that promotes wellbeing	C = 5									Target Rating		Current Rating		Initial Rating	
Type: Operational; Health & Safety	L = 3 **15**														

CQC Domain:	Executive Committee:	Committee reviewed at:	Previous rating:	June 2025 - 15

Principle Risk: Managing the risk of injury from fire

Risk Description:
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.

Date added to CRR: February 2024

Date reviewed: July 2025

Current Position

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.

Key Targets	Current controls	Gaps in control
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	**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.	

Audits and reviews of the above conditions at appropriate intervals	**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.	

CRR ID: ID 117 **Strategic Ambition:** An Environment that promotes wellbeing **Type:** Operational; Health & Safety	**Target Date:** July 2025 C = 4 L = 3 **12**	**Very Low Risk**			**Low Risk**			**Medium Risk**		**High Risk**		**Significant Risk**			
		1	2	3	4	5	6	8	9	10	12	15	16	20	25
								Target Rating			Current Rating		Initial Rating		

CQC Domain:	**Executive Committee:**	**Committee reviewed at:**	**Previous rating:** June 2025 - 12

Principle Risk: Managing the risk of violence and Aggression

Risk Description:
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.

Date added to CRR: February 2024

Date reviewed: July 2025

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

Key Targets	Current controls	Gaps in control
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,	**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	

sickness absence as part of the monitoring and review process. Provision of appropriate training and information to all Trust staff clinical and non-clinical.	(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.	

CRR ID: CRR102/ID577 **Strategic Ambition:** An Environment that promotes wellbeing **Type:** Operational; Health & Safety	Target Date: September 2025	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
		1	2	3	4	5	6	8	9	10	12	15	16	20	25
	C = 4 L = 4 16							Target Rating					Initial Rating Current Rating		

CQC Domain:	Executive Committee:	Committee reviewed at:	Previous rating:	June 2025 - 16

Principle Risk: Physical security provisions, training and support resources

Risk Description:
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.

Date added to CRR: August 2024

Date reviewed: July 2025

Current Position

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.

Key Targets	Current controls	Gaps in control
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	**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 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.	• **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.	

CRR ID: CRR98/ID264	Target Date:	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
	September 2025	1	2	3	4	5	6	8	9	10	12	15	16	20	25
Strategic Ambition: An Environment that promotes wellbeing **Type:** Operational; Health & Safety	C = 3 L = 5 **15**			Target Rating							Initial Rating	Current Rating			

CQC Domain:	Executive Committee:	Committee reviewed at:	Previous Rating:	June 2025 - 15

Principle Risk: : Outsourcing of Hazard Group 3 Microbiology Work Due to CL3 Facility Unavailability

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

Date added to CRR: November 2022

Date reviewed: July 2025

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.

Key Targets	Current controls	Gaps in control
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	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. These actions are critical to mitigating current risks and ensuring patient safety, sample integrity, and operational continuity.	

CRR ID: CRR34/ID1	Target Date: March 2026	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
Strategic Ambition: Great Start in Life		1	2	3	4	5	6	8	9	10	12	15	16	20	25
Type: Clinical; Patient Safety	C = 3 L = 5 — 15								Target Rating		Initial Rating	Current Rating			

CQC Domain:	Executive Committee:	Committee reviewed at:	Previous Rating:	June 2025 - 15

Principle Risk: **Autism Assessment**

Risk Description:
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)

Date added to CRR: December 2023

Date reviewed: July 2025

Current Position

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.

Key Targets	Current controls	Gaps in control
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	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.	

CRR ID: CRR61/ID3 **Strategic Ambition:** Person centered, integrated care, strong partnership **Type:** Clinical; Patient Safety	Target Date: March 2026		Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
	C = 4	12							Target Rating			Initial Rating				
	L = 3											Current Rating				

CQC Domain:	Executive Committee:	Committee reviewed at:	Previous Rating:	June 2025 - 12

Principle Risk: ED 4-hour Standard

Risk Description:
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

Date added to CRR: December 2023

Date reviewed: July 2025

Current Position

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

Key Targets	Current controls	Gaps in control
4 hour performance A&E 4 hour target to be met, 6 hour breaches <102 per month 0 x 12 hour breaches	To support the Trust's **True North objective** of achieving the **ED 4-hour standard**, the following targeted actions are being implemented: **Focused 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.	

CRR ID: CRR96/ID79	Target Date:	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
Strategic Ambition: Person centred, integrated care, strong partnership	October 2025	1	2	3	4	5	6	8	9	10	12	15	16	20	25
Type: Clinical; Patient Safety	C = 4				Target Rating								Initial Rating		
	L = 4 16												Current Rating		

CQC Domain:	Executive Committee:	Committee reviewed at:	Previous Rating:	June 2025 - 16

Principle Risk: **Stroke Provision**

Risk Description:
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.

Date added to CRR: February 2024

Date reviewed: July 2025

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.

Key Targets	Current controls	Gaps in control
All eligible patients receiving HASU Care No patients requiring HASU are directly admitted to Harrogate for Emergency Care.	To support the Trust's True North objective, several focused actions and plans are being implemented: Executive Support: Secure agreement from WYATT and HNY ICB for future stroke care arrangements across the region. 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. Consultant Collaboration: Explore shared on-call arrangements with York to enhance consultant cover for ASU. 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. Pilot Implementation: Proceed with the pilot project for walk-in and inpatient stroke referrals to York, pending sign-off by YTHFT management. 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.	

CRR ID: ID379	Target Date: August 2025	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
Strategic Ambition: Person centered, integrated care, strong partnership		1	2	3	4	5	6	8	9	10	12	15	16	20	25
Type: Clinical; Patient Safety	C = 4 / L = 4 — 16			Target Rating									Initial Rating / Current Rating		

CQC Domain:	Executive Committee:	Committee reviewed at:	Previous Rating:	June 2025 - 12

Principle Risk: **Patient harm due to Non Compliance with National KPI's for waiting times and reporting in Imaging Services**

Risk Description:
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.

Date added to CRR: January 2021

Date reviewed: July 2025

Current Position

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

Key Targets	Current controls	Gaps in control
	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 specialty 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	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.

CRR ID: ID642	Target Date: December 2025	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
Strategic Ambition: Person centered, integrated care, strong partnership		1	2	3	4	5	6	8	9	10	12	15	16	20	25
Type: Clinical; Patient Safety	C = 3			Target Rating							Initial Rating				
	L = 4	12									Current Rating				

CQC Domain:	Executive Committee:	Committee reviewed at:	Previous Rating:	June 2025 - 12

Principle Risk: Cardiology

Risk Description:
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.

Date added to CRR: November 2025

Date reviewed: July 2025

Current Position

- 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.

Key Targets	Current controls	Gaps in control
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.	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.	

CRR ID: ID292	Target Date:	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
Strategic Ambition: Person centered, integrated care, strong partnership	September 2025	1	2	3	4	5	6	8	9	10	12	15	16	20	25
Type: Clinical; Patient Safety	C = / L = **12**				Target Rating			Initial Rating			Current Rating				

CQC Domain:	Executive Committee:	Committee reviewed at:	Previous Rating:	June 2025 - 12

Principle Risk: Automated medicines supply services

Risk Description:

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.

Date added to CRR: November 2022

Date reviewed: July 2025

Current Position

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.

Key Targets	Current controls	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.

CRR ID: ID721	Target Date: July 2025	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
Strategic Ambition: Overarching Finance		1	2	3	4	5	6	8	9	10	12	15	16	20	25
Type: Financial	C = 3 L = 4 **12**							Target Rating			Current Rating		Initial Rating		

CQC Domain:	Executive Committee:	Committee reviewed at:	Previous Rating:	June 2025 - 12

Principle Risk: Group Cash Position 2025-26

Risk Description:

Due to the underlying financial position of the organisation, cash support is required in March 2025 totaling £18.5m. A cash forecast has been prepared for 2025-26 and this has highlighted cash concerns for the year which will need managing.

Date added to CRR: February 2025

Date reviewed: July 2025

Current Position

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.

Key Targets	Current controls	Gaps in control
Cash position maintained	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.

CRR ID: ID816	Target Date: March 2026		Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
Strategic Ambition: Overarching Finance			1	2	3	4	5	6	8	9	10	12	15	16	20	25
Type: Financial	C= 5	15							Target Rating				Initial Rating			
	L= 3												Current Rating			

CQC Domain:	Executive Committee:	Committee reviewed at:	Previous Rating:	June 2025 - 15

Principle Risk: Delivery of Financial Plan 25/26

Risk Description:
The trust has submitted a breakeven plan for 25/26 however there are a number of risks still to be mitigated including full delivery of WRAP programme, mitigating unfunded cost pressures and how the risk share with the ICB will be managed.

Date added to CRR: June 2025

Date reviewed: July 2025

Current Position

As at the end of May, the Trust reported a £3.2m deficit this is £2.2m away from plan. The plan includes a risk share arrangement of £12m that is still to be worked through with the ICB, the £6m HDFT need to identify has been phased into the second half of the year. Deficit funding, £5.2m is at risk if the financial plan is not delivered.

Key drivers impacting the position include
WRAP £1.6m
Prior year £0.8m
Wards £0.5m

Key Targets	Current controls	Gaps in control
Financial Variance to plan WRAP delivery Cash position	Vacancy Panels to review all TRACS following finance review Requisitions are in place before any spend is committed. No PO no Pay Discretionary spend controls remain in place, moved onto an online form for secondary approvals and panel available to pick up any themes/queries. NHS Supply Chain restrictions in place. All spend over £10k is authorised by the Finance Director. EASY expenses is restricted for specific spend requests including Travel/Eye Test/Course Fees/Vaccination/Blue Light Card/Telephone Calls. Non clinical overtime being monitored and escalated to mangers to review arrangements and approval. Off Framework agency monitoring. Agency requests to be recorded via the online form, confirming Exec sign off if over cap or off framework. All minor works requests approved by Trust prior to HIF undertaking. Finance governance escalation – FDOG to commence from June	Recurrent delivery of WRAP Contracts agreed (ICB)

CRR ID: ID6	Target Date: March 2026		Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
Strategic Ambition: Provide person centered, integrated services through strong partnerships	C = 3	12				Target Rating						Initial Rating				
Type: Clinical; Patient Safety	L = 4											Current Rating				

CQC Domain:	Executive Committee:	Committee reviewed at:	Previous Rating:	June 2025 - 12

Principle Risk: Community Dental

Risk Description:
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

Date added to CRR: December 2025

Date reviewed: July 2025

Current Position

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.

Key Targets	Current controls	Gaps in control
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 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.	