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 Days Treatment	**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**	
	Ensuring Smart Foundations			**Operational: Cautious**	
	Safe Practice			**Operational: Cautious**	
	Support People			**Operational: Cautious**	
	Empower Citizens			**Operational: Cautious**	
	Improving Care			**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
	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).

November 2025

As per the HDFT protocol on the 12th and 13th November 2025, Directorates, through their Performance Review Meetings (PRM) reviewed the risks rated 9 and above on their Directorate Risk Register. Discussions were held on any risks to escalate or de-escalate from the Corporate Risk Register.

As per the HDFT protocol on the 13th November 2025, Executive Risk Review Group was held, where Executives reviewed all risks currently on the Corporate Risk Register and any risks that had been escalated or de-escalated by Directorates. At the meeting, the following was confirmed:

- 827 – CYPD – Financial impact of the 25/26 pay award in 0-19 services: Following confirmation from 7 of our 11 Local Authorities that they will fund the impact of the 25/26 pay award from the Public Health Grant, this risk has been reduced to 4x2=8. Following discussion at PRM, it was confirmed this risk would be de-escalated from the corporate risk register, back to the directorate risk register for continued oversight.
- 597 – Histopathology (Space and Safety Concern) – risk scoring 15. Discussed at PRM and Exec Risk Review Group and confirmed acceptance to Corporate Risk Register.
- 116 – Managing the risk of injury from fire – Noted scoring change from a 15 to (5x2) 10. Risk to be remain on the Corporate Risk Register with a further review due to take place next month. Risk updated to reflect updates relating to the fire alarm. The target date was amended to December 2025.
- 577 – Governance of security – update of risk noted. Scoring remains unchanged, with amendment to the target date of April 2026
- 816 – Delivery of financial plan 25/26 - Change to score from 15 to 20. Position continues to be closely monitored.
- No further risks were escalated from Directorates in month for inclusion on the Corporate Risk Register
- No further risks were de-escalated from the Corporate Risk Register for management on Directorate Risk Registers

CRR ID: CRR 75 / ID 116 **Strategic Ambition:** An Environment that promotes wellbeing **Type:** Operational; Health & Safety	Target Date: December 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 = 5 L = 2	10									Target Rating		Current Rating		Initial Rating	

Summary:

This risk was reviewed at the Exec risk review group on Thursday 13th November. The risk score was noted to have been reduced from 15 to 10. The risk was updated to reflect elements raised by HIF. Risk score to be reviewed following these updates. The target score remained the same. Risk Team to liaise with HIF colleagues to ensure updates noted within the PRM document are reflected within the risk. Amendment to target date of December 2025 was noted, as is to be reviewed by the risk owner.

Previous rating: October 2025 - 15

Date added to CRR: February 2024

Date reviewed: November 2025

CQC Domain: Safe

Executive Committee: Health & Safety

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.

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: 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.

Fire Alarm:

System past lifecycle with parts becoming obsolete proving difficulty in maintenance and lack of Cause and effect strategy throughout the system.
Multiple activations have incorrectly identified the zone or detector for the fire brigade, leading to delays in their response to the correct area.
The old system is currently not connected to the network and the work associated to get it reconnected involves putting with system into monitor mode which would mean no alarms would trigger on the old system in that instance if there was a fire.

Fire compartmentation:

There is no recent surveys available for the condition of the fire compartmentation. There has been various schemes & projects completed over the years with no assurance provided that fire compartments haven't been breached or if they have there is no fire stopping records.

Fire Doors

Several hundred have failed on critical criteria during the most recent inspections, with some of them being part of the original hospital installation.

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 Audits and reviews of the above conditions at appropriate intervals	**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**: • A capital scheme for the full replacement of the existing fire alarm systems • Create procedure to get the system reconnected and cover the period of it being in monitor mode with manual resource **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. **Fire Doors:** • 6 Monthly inspections of all doors. • Risk assessing most critical doors to undertake minor repairs of critical components.	

CRR ID: ID 117 **Strategic Ambition:** An Environment that promotes wellbeing **Type:** Operational; Health & 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 L = 3	12							Target Rating			Current Rating		Initial Rating		

Summary:

This risk was reviewed at the Exec risk review group on Thursday 13th November , this risk was reviewed, and the scoring and target date remained the same. No other changes to note.

Previous rating: October 2025 - 12

Date added to CRR: February 2024

Date reviewed: November 2025

CQC Domain: Safe

Executive Committee: People & Culture

- **Previous Target date July 25**

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.

Current Position

The organisation 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 - 98% (Trust, 3582 enrolled), 98% (HIF, 343 enrolled)
- Conflict Resolution Breakaway Skills - 60.8% (Trust, 186 enrolled), 61.5% (HIF, 39 enrolled) Conflict Resolution Physical Restraint - 69.5% (Trust, 95 enrolled), N/A (HIF)
- Lone Working - 98.4% (Trust, 1495 enrolled), N/A at this time (HIF) Financial resource now confirmed from Nursing CPD budget and is being transferred to L&D budget to facilitate additional session bookings , which will fund an additional 10 sessions (120 staff) of Breakaway Skills training to be delivered before April 2026.

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.
Health and Safety Watch metrics being developed around violence and aggression. Data available for 25/26 data to date.

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, sickness absence as part of the monitoring and review process. Provision of appropriate training and information to all Trust staff clinical and non-clinical.	**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. Executive led task and finish group met in September and August, and has since been stood down. Issues will be taken through health and safety committee moving forwards. **Mental Health Triage and Policy Update**: Changes to mental health triage in the Emergency Department are ongoing and will be incorporated into a new policy for managing patients who may self-harm or have mental health issues. This policy is in the approval process as of April 2024. **Ligature Assessments**: Ligature risk assessments are under review due to ward and therapy area changes. Training provision for ligature risks is also being addressed after delays caused by staffing changes. **Conflict Resolution Training**: A new Conflict Resolution training program is being developed with three levels tailored to staff risk levels. The content will align with the CQC-supported Restraint Reduction Network, with ongoing discussions to ensure appropriate training needs assessments (TNA) across the Trust. A business case is being prepared to expand training provision. **Community Security and Lone Working**: Visits to all community teams and locations are underway to assess current security and lone working procedures. **Domestic Abuse and Sexual Violence**: Meetings are being held to integrate issues of domestic abuse, sexual violence, and workplace sexual safety into the Violence Prevention and Reduction Strategy. A new policy and training package for line managers is in development, with plans for a team talk session by September/October. **Policy Reviews**: New policy and procedure are under development for staff safety. The Lockdown Policy and Bomb Alert Policies are under review to ensure they are up-to-date and effective. **New Risk Assessment Process**: A Trust-wide risk assessment has been developed and is now being used to inform team and department-level assessments. This is part of an ongoing effort to implement a new risk assessment process across the Trust.	

CRR ID: CRR102 / ID 577 **Strategic Ambition:** An Environment that promotes wellbeing **Type:** Operational; Health & Safety	**Target Date: April 2026** C = 4 L = 4 **16**	**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					Initial Rating Current Rating		

Summary:

This risk was reviewed at the Exec risk review group on Thursday 13th November, this risk was reviewed, and the scoring remained the same. No further changes to note.

Previous rating: October 2025 – 16

Date added to CRR: August 2024

Date reviewed: November 2025

CQC Domain: Effective

Executive Committee: Health and Safety

Principle Risk: Governance of security (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.

Current Position

November 25:

- HIF is progressing the establishment of a 24/7 on-site security team at HDH, with a revised target date of April 2026. Interim cover continues to be provided by Gough & Kelly.
- CCTV weaknesses have been partially addressed; three HIF staff have completed SIA CCTV training to enable internal monitoring.
- Support to community teams continues to rely on a single HIF LSMS, resulting in significant capacity pressures.

Incident Trends

- Violence and aggression incidents have increased in 2025/26 compared with 2024/25.
- Improved joint working between HIF, H&S, and Safeguarding is in progress, though several serious incidents have required substantial staff resource due to the lack of a dedicated security team.

Forward View

- Achieving the current target risk score is unlikely until the security team is fully established. The target date should be revised to align with the April 2026 implementation and related governance structures.

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 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 were identified. Effective communications to all staff. Provision of appropriate training and information to all Trust staff clinical and non-clinical.	**Policy Updates**: The Health & Safety (H&S) team, in coordination with HIF, is currently updating all relevant security policies, including Lockdown, Bomb Alert, Theft/Damage, and CCTV. These updates aim to align policies with the Trust's current structure, services, and geographical footprint. **Risk Assessments**: Comprehensive security risk assessments are being developed, with a focus on individual sites, lone working, and staff responses. Departmental risk assessments are ongoing at the local HDH level and across the community footprint. **Security Infrastructure Improvements**: • **Door Access Control**: A new door access system has been costed and will be replaced incrementally as part of the Trust's Backlog Maintenance work. • **CCTV Coverage**: A review of CCTV systems is in progress, with updates planned where necessary. • **Security Guards**: HIF is obtaining legal advice regarding the provision and licensing 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 / ID 264	**Target Date:** April 2026	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
Strategic Ambition: An Environment that promotes wellbeing		1	2	3	4	5	6	8	9	10	12	15	16	20	25
Type: Operational; Health & Safety	C = 3														
	L = 5	**15**			Target Rating						Initial Rating	Current Rating			

Summary:

This risk was reviewed at the Exec risk review group on Thursday 13th November, this risk was reviewed, and the scoring remained the same. No further changes to note.

Previous Rating: October 2025 – 15

Date added to CRR: November 2022

Date reviewed: November 2025

CQC Domain: Effective

Executive Committee: TBC

- **Previous target date April 2025**

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.

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.	Jan 25- Design plans in the final stages of agreement - required enabling work to move doors approved by Health & Safety and Fire.

CRR ID: CRR34 / ID 1	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	15								Target Rating		Initial Rating	Current Rating			
	L = 5															

Summary:

This risk was reviewed at the Exec risk review group on Thursday 13th November, this risk was reviewed, and the scoring remained the same. No further changes to note.

Previous Rating: October 2025 - 15

Date added to CRR: December 2023

Date reviewed: November 2025

CQC Domain: Responsive

Executive Committee: Resources

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)

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 is 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 ongoing risk has been escalated to HNY ICB executive team. A meeting between HDFT and HNY ICB executives is planned for September to discuss the ongoing capacity and demand challenges and future commissioning intentions.
The Key risk indicators are:

- Numbers on the waiting list: 1560 (target 120)
- Longest wait for completed assessment: 98 weeks (target 13 weeks)
- Activity - Financial Year end position 546 completed assessments against ICB plan of 530 (plus 14 military assessments completed in addition).

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 1560 (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: ID 381	**Target Date:** March 2026	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
Strategic Ambition:		1	2	3	4	5	6	8	9	10	12	15	16	20	25
Type: Patient Safety	C = 4														
	L = 4	**16**				**Target Rating**		**Initial Rating**					**Current Rating**		

Summary:

This risk was reviewed at the Exec risk review group on Thursday 13th November. Target date was outstanding alongwith current position. Risk Owner and directorate urgently chased for review. Position and target date updated.

Previous Rating: October 2025 - 15

Date added to CRR: November 2025

Date reviewed: November 2025

CQC Domain: Well-led

Executive Committee: Resources

Principle Risk: - Risk of harm to patients due to unreliability of aged equipment (CT)

Risk Description:

Deterioration of image quality over time which has now been evidenced in a routine Medical Physics QA report that was dated 11th June 2025. This may now be affecting patient diagnosis and therefore poses a safety risk. Currently all acute and Paediatrics patients are scanned on this scanner as well as colons (screening and symptomatic), biopsies (IP and OP), interventional procedures and some OP cancer. Due to this increased safety concern, we have relocated some types of scanning from the acute scanner to the elective scanner however this will further adversely impact our waiting times.

A CT scanner has been purchased by the Trust for the TIF2 project and is currently in storage. Proposal is to replace the aging acute CT scanner with this one and relocate this into TIF2 when the space is complete. There are currently approximately 1700 patients on the elective OP/GP waiting list which equates to approximately a 37 week wait.

Current Position

Nov 25 - currently working through an SBAR and finance details prior to it being approved

26/09/25 - QUAD review - escalated to Exec register. score 16 as per updates below.

23/09/25 -SBAR regarding Acute CT scanner replacement submitted to Quad for review.

Deterioration of image quality over time which has now been evidenced in a routine Medical Physics QA report that was dated 11th June 2025. This may now be affecting patient diagnosis and therefore poses a safety risk. Currently all acute and Paediatrics patients are scanned on this scanner as well as colons (screening and symptomatic), biopsies (IP and OP), interventional procedures and some OP cancer. Due to this increased safety concern, we have relocated some types of scanning from the acute scanner to the elective scanner, however this will further adversely impact our waiting times.
A CT scanner has been purchased by the Trust for the TIF2 project and is currently in storage. Proposal is to replace the aging acute CT scanner with this one and relocate this into TIF2 when the space is complete. There are currently approximately 1700 patients on the elective OP/GP waiting list which equates to approximately a 37 week wait.
CT scanners were down on 18/09/25. Scanner now back up and running, but concerns could go down again at any point due to age/unreliability. Resulted OPs being cancelled to accommodate urgent/acute CTs.
Score amended to 16 and escalated to Directorate register for review.
27/8/25 Risk score updated due to report from Leeds stating that the equipment is prone to misdiagnosing patients. Datix from Consultant radiologist regarding patient safety concerns around misdiagnosis. Care Group is completing an SBAR to review options to replace the machine imminently

10/07/25: MR pump has been replaced, Plane film equipment has also been replaced
Fluoroscopy equipment room 4 - end of support was 30/06/25. now on 3rd party contract. Siemens no longer make parts for it and if not in stock, then cannot replace. This is our only interventional room. Mitigation could be sent to Leeds/York but unclear if SLA is in place. New dept opens Jan 2027.
Problem with emergency lift impacting ability to get to MRI van in June. Risk assessed.
On static MRI, there was a problem reported with helium. scanner still operational. 1 hrs. downtime to fix.

CT static is beyond the recommended life span. Purchased a second scanner for TIF2 which is in storage. The current CT scanner could be replaced with planning but would impact on services. Breast ultrasound is 5 and half years old. ideal

replacement at 5-7 years.
24/04/2024 Reviewed wording and agreed score
Risk of harm due to delays caused by breakdown and or radiation incidents due to repeated exposures.
Staff harm due to manual handling of some aged equipment, staff morale due to operating in a difficult environment. Evidence in staff survey
Beyond life cycle:
CT Static
MR Van
MR Static
MR Pump
Fluoroscopy Room 4
Plain Film Equipment (Except ED)
Room 3 has new equipment Feb 25
Room 4 Interventional room is no longer under MFR contract

Key Targets	Current controls	Gaps in control
	Number of radiation incidents Datix reports for equipment breakdown Datix of staff injury after moving equipment Fully comprehensive contract cover for equipment Breast scanner-controlled QA annually and serviced. sonographer monitor and escalate if image quality changes.	Plan for new equipment into current room 3. Now completed. Room 4 out of service contract March 2025 Plan for new build and equipment in new department

CRR ID: CRR61 / ID 3	**Target Date:** March 2026		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	12							Target Rating			Initial Rating				
	L = 3											Current Rating				

Summary:

This risk was reviewed at the Exec risk review group on Thursday 13th November, this risk was reviewed, and the scoring remained the same. No further changes to note

Previous Rating: October 2025 - 12

Date added to CRR: December 2023

Date reviewed: November 2025

CQC Domain: Safe

Executive Committee: Resources

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.

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.	Significant delays to medical bed - Recent support with patient flow by opening of winter ward w/c 6 Dec (planned to end of Feb) - longer term ward configuration corporate project Up to 17% NCTR - adoption of OPTICA as Trust tool to support flow and corporate discharge project to launch in early 2025. Direct streaming to SAU commenced w/c 13 Jan - in process of being embedded

	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: ID 642	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	12			Target Rating							Initial Rating				
	L = 4											Current Rating				

Summary: This risk was reviewed at the Exec risk review group on Thursday 13th November, This risk was reviewed and the scoring remained the same.

Previous Rating: September 2025 - 12

Date added to CRR: November 2025

Date reviewed: November 2025

CQC Domain: Safe

Executive Committee: Quality

Principle Risk: Risk to providing DGH urgent and emergency care services due to lack of 24/7 cover (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.

Current Position

- Staffing Shortages:

October 2025 – Locum consultant no longer in post.
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.
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: ID 292	Target Date: November 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
Strategic Ambition: Person-centered, integrated care, strong partnership **Type:** Clinical; Patient Safety	C = 4 L = 3	**12**				**Target Rating**			**Initial Rating**			**Current Rating**				

Summary:

This risk was reviewed at the Exec risk review group on Thursday 13th November, this risk was reviewed, and the scoring remained the same. No further changes to note. Directorate to provide a more up to date position.

Previous Rating: October 2025 - 12

Date added to CRR: November 2022

Date reviewed: November 2025

CQC Domain: Safe

Executive Committee: Resources

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.

Current Position

July 25- Business Case Developed, however waiting for detail from capital planning before submission to business case review group. Aim for re-submission at September's review group, pending outstanding information from capital planning team.

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 it 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: ID 721	**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 = 3	12							Target Rating			Current Rating		Initial Rating		
	L = 4															

Summary:

This risk was reviewed at the Exec risk review group on Thursday 13th November, this risk was reviewed, and the scoring remained the same. No further changes to note

Previous Rating: October 2025 - 12

Date added to CRR: February 2025

Date reviewed: November 2025

CQC Domain: Well-Led

Executive Committee: Resources

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.

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.

The Trust is currently managing cash flow on a week-by-week basis. As of the end of July, there are outstanding payments to suppliers. The Finance Team is prioritising payroll commitments, followed by any urgent payments.

Public Dividend Capital (PDC) funding has begun to be received, which will allow supplier payments to be released. The Trust is also actively pursuing receipt of funding relating to the EPR programme and for the SDEC initiative.

Key Targets	Current controls	Gaps in control
Cash position maintained	WRAP Programme 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.	Aged Debt - Although more focused is still needed, due to supplier payments being delayed it is impacting payments from other Trusts. Balanced financial plan - Financial Plan for 25/26 remains challenging NHSE timeframes for review of capital cases and issuing MOU's.

CRR ID: ID 816	**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 = 4														
	L =5	**20**						**Target Rating**				**Initial Rating**		**Current Rating**	

Summary:

This risk was reviewed at the Exec risk review group on Thursday 13th November, this risk was reviewed, and the scoring was noted to have increased to 20 from a 15. Current position continues to be closely monitored.

Previous Rating: October 2025 - 15

Date added to CRR: June 2025

Date reviewed: November 2025

CQC Domain: Well-Led

Executive Committee: Resources

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.

Current Position

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.

As at the end of October, the Trust reported a £11.7m deficit this is £7.1m away from plan. The plan includes a risk share arrangement of £12m, the £6m HDFT need to identify has been phased into the second half of the year (M12). Deficit funding, £5.2m is at risk if the financial plan is not delivered across the system (secured for Qtr1 and Qtr2)

Key drivers impacting the position include

WRAP (Non Pay Variance)

Prior year £1.3m

Wards £1.2m but does include 0.2m 1:1 247 care(Pay Variance)

Medical Staffing £0.8m A3 being developed to explore drivers

Forecast deficit £20-28m without any mitigating actions.

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. Nonclinical overtime being monitored and escalated to managers 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.	Recurrent delivery of WRAP Contracts agreed (ICB) Managing pay spend within budgeted allocations

	Finance governance escalation – FDOG to commence from June WRAP principles, A3 documentation and governance arrangements in place.	

CRR ID: ID 73	**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 = 3														
	L = 4	**12**						**Target Rating**			**Current Rating**		**Initial Rating**		

Summary:

This risk was reviewed at the Exec risk review group on Thursday 13th November, this risk was reviewed, and the scoring remained the same. No further changes to note.

Previous Rating: October 2025 - 12

Date added to CRR: June 2025

Date reviewed: November 2025

CQC Domain: Well-Led

Executive Committee: Resources

Principle Risk: Recurrent delivery of Efficiency programme (WRAP)

Risk Description:

The Trust has a £14.4m WRAP programme to deliver in 25/26.

Current Position

The Trust has a £14.4m WRAP programme to deliver in 25/26.

As at October 73% has been actioned. £6.2m cost reduction schemes have also been identified.

Risk adjusted plans have improved but still leave a gap to full delivery.

There are a number of high risk schemes that are being worked through via the A3 HDFT impact methodology.

Top 5 unactioned schemes

Theatres Utilisation £500k

Procurement non pay £300k

CYP Non pay saving £264k

Drug savings £263k

LTUC Model Health £208k

Total £1.5m 11% of the target

Governance structure has been developed and PRMs will pick up progress each month.

There is also the £6m risk share to consider how this will be addresses (part of the contract agreement 50/50 risk share)

Key Targets	Current controls	Gaps in control
	Monthly Directorate and Trust reporting. Directorate performance panels. Regional engagement/shared learning.	25/26 plans were underpinned by the opportunity to attract Elective Recovery Funding, HNY have now confirmed a fixed contract, WY is a variable contract but confirming if there is a ceiling in place. Recurrent schemes versus non recurrent schemes.

CRR ID: ID 884	Target Date:	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
Strategic Ambition:	March 2026	1	2	3	4	5	6	8	9	10	12	15	16	20	25
Type: Clinical; Patient Safety	C = 4			Target Rating									Current Rating		
	L = 4	16											Initial Rating		

Summary:

This risk was reviewed at the Exec risk review group on Thursday 13th November, this risk was reviewed, and the scoring remained the same. No further changes to note. Current position documented.

Previous Rating: October 2025 - 16

Date added to CRR: August 2025

Date reviewed: November 2025

CQC Domain: Responsive

Executive Committee: Resources

Principle Risk: Risk to Patient Safety & Experience due to non-compliance with National KPI's for waiting times and reporting in Imaging Services

Risk Description:

Due to the delays in routine diagnostic imaging, there is an unknown risk of patients waiting up to 5.5 months for diagnostics which should be delivered within 6 weeks. This is causing delays in treatment, diagnosis and decision making for care plans for patients. It impacts on RTT performance, organisational reputation and patient experience. There is also a risk due to our non-compliance with National KPI's for waiting times and reporting.

Current Position

12/11/25 departmental update/current wait times as at 03/11/25 (shared with Primary Care):

Appointment Waiting Times

MODALITY	CANCER	URGENT	ROUTINE	NO. OF PTS WTG
CT	1-2 weeks	4-5 weeks	41-42 weeks	1570
DEXA	2 weeks	2-3 weeks	3 weeks	102
MRI	2-3 weeks	1-2 weeks	14-15 weeks	1172
US	2 weeks	2-3 weeks	8-9 weeks	884
MAMMO	2 weeks	2 weeks	2 weeks	0
NUC MED	2 weeks	2-3 weeks	3-4 weeks	1
PLAIN FILM	Walk in Service	Walk in Service	Walk in Service	
FLUORO	-	2-3 weeks	29-30weeks	261

Please note these are dependent on resource availability and exam requested.

Outstanding Reporting (pts)

MODALITY	CANCER	URGENT	ROUTINE	NO. OF PTS WTG REPORT
CT	20	54	63	141
DEXA	3	47	960	1010
MRI	4	190	280	476
US	30	34	27	91

1500 routine patients are awaiting a CT scan.
Impact on RTT:
Neurology

- Patients waiting 5.5 months for routine CT.
- 24 patients over 30 weeks as of end of May 2025 awaiting a scan.

Respiratory

- Patients waiting 4 months for routine CT.

Impact on cancer pathways:
Patients coming to follow up appointments for treatment review having not had requested scan. This results in a poor experience and a wasted clinic appointment.

23/09/24 updated to factor in risk of Non-Implementation of AI CXR Interpretation: Compromised Radiological Service Delivery and Patient Outcomes:
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
	MRI and CT clinical diaries have been reviewed and ringfenced capacity has been provided proportionately to each clinical group (cancer, urgent, planned oncology, routine). Patients are being booked in clinical and the chronological order (chronological from the date imaging received the referral). Clinicians are asking for expedited scan for patients of concern. Cancer clinicians using cancer pathway tag when requesting however this is not always successful in achieving a scan before clinic.	Gaps in capacity. Business case prepared and agreed from resource committee. This will provide the staffing levels required to maintain demand in most specialties, but it will not support backlog reduction). The business case is currently being taken through board by CFO. Once agreed, more radiographers will be recruited. Once individuals are recruited and trained the CT and MRI services will operate for extended hours. Robotic process automation (RPA) worked through and due to be implemented end June/July. This will input RTT start dates into Imaging PAS system and allow patients to be booked in RTT order. Included as key driver metric for care group and directorate. Work ongoing to identify outsourcing providers to support backlog reduction. Work ongoing to identify capital resources to support sites for direct-access patient.

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

Summary:

This risk was reviewed at the Exec risk review group on Thursday 13th November, this risk was reviewed, and the scoring remained the same. No further updates to note.

Previous Rating: October 2025 - 12

Date added to CRR: December 2025

Date reviewed: November 2025

CQC Domain: Responsive

Executive Committee: Resources

Principle Risk: Community Dental

Risk Description:

Risk to Trust performance standards by failing to meet NHS annual planning target of no RTT waiters beyond 52wks by end March 2025. Risk to patient safety due to correlation of long waiting times and increased risk of pain and infection which may impact on quality of life and treatment required, particularly for surveillance patients due to lower capacity than required to meet review timescales.

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.

Procurement tender process has been complete, awaiting assessments and contract sign off. No change to risk scoring until system is implemented.

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 – 1187 patients over 52 weeks, no of overdue continuing care patients. Overdue surveillance patients -1666 (longest overdue by 3 years).	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.	Lack of contract and delivery plan beyond 31st March 26 as procurement exercise for long term contract still not concluded (1yr extension offered in interim). Current extension has additional requirement of delivering Epidemiology survey for public health, which will reduce core service capacity - unfortunately base budget also not fully re-provided which has reduced capacity in the service. Current focus on key areas: 1) Continuing recruitment focus on posts and hard-to-recruit areas - paediatric specialist/consultant capacity 2) Patient IT system procurement to replace SOEL Health which is no longer supported (Procurement exercise in evaluation phase, implementation date for Oct25) 3) Supporting new leadership team development - new clinical lead commenced in post with new Service Manager 4) Focus on GA pathways to try to replicate productivity at York exodontia lists at Harrogate/Northallerton - implemented increase from 4 per list at Northallerton to 5 - further opportunity identified to work with South Tees in September25.

CRR ID: ID 597	**Target Date:** December 2025	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
Strategic Ambition:		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			

Summary:

This risk was reviewed at the Exec risk review group on Thursday 13th November, following escalation at the directorate PRM meeting. The risk was confirmed for acceptance onto the corporate risk register.

Previous Rating:

Date added to CRR: November 2025

Date reviewed: November 2025

CQC Domain:

Executive Committee:

Principle Risk: Histopathology space and safety concern

Risk Description:

The Histopathology laboratory area has limited space due to expansion over the last 10 years. Expansion has been essential to ensure that the service provided to the trust is appropriate to the requirements aligned to cancer pathways. Additional analysers and essential equipment have been installed which has now resulted in the area being extremely cramped. Due to increase in specimen numbers the storage capacity of the laboratory is now critical and imposing a safety concern to both staff and patient specimens. It is a regulatory requirement to store specimens for 42 days post authorisation. This is now resulting in specimens being stacked on top of each other including at height as there are no other options currently. This increases the risk of specimen formalin spillages and higher risk of incorrect disposal or loss of specimens. Increased risk of slips and trips to staff. This has now been raised as a finding by UKAS who we are accredited with. UKAS need to be provided with evidence of how this will be rectified to ensure the safety of both staff and specimens. Due to increased demand from the trust further expansion is required but due to the space constraints this is not currently possible. This will impact the ability to support any further workload increase e.g. TIF2, proposal for women's unit expansion, dermatology expansion. It has also hindered the ability to take on further clinical trials which may have improved the patient pathway and clinical outcome. The inability to expand will also hinder support of cancer targets i.e. ensuring 62 day referral to a cancer pathway, and RTT targets are met.

Current Position

24.07.25 No funding opportunity from cancer alliance. Working through impact plan to approach capital team

31.10.25 Flagged to Jordan McKie as an issue, and will prevent us from taking on any additional work in histopathology eg TIF2. Discussions took place around drawing up proposal for expansion.

Key Targets	Current controls	Gaps in control

	Risk of specimen loss - controlled by specimen disposal performed by x2 staff members with quality control checks in place Risk of spillage due to specimens being stacked and at height - Disposal carried out weekly in order to try and create space and reduce specimens being stacked at height. Wax deliveries (20kg) each are having to be stored under benches in the lab - this poses a health and safety risk to staff having to move the bulk boxes from under benches. Blocks are required to be stored for a minimum of 30 years. Blocks are kept on site for a minimum of 2 years due to additional tests that may be required. They are then transferred to an off site secure facility to store for the remaining 30 years. The capacity for storage has been reached and there are limited options for further storage due to the requirement for a reinforced floor. A significant amount of flammable reagent (alcohol, xylene and formalin) are used daily and more frequently due to additional strainers being required to keep up with the increased demand. Due to limited space majority of this is being stored in the outside flammable store. This results in staff having to make frequent trips to the store and poses a manual handling issue. When receiving a breast mastectomy specimen national standards state that the specimen should be opened within 4 hours. this is not always possible due to a downdraft bench being unavailable. This may lead to degradation of the specimen	Specimens being stacked at height - we ensure that disposal is regular but this is not always sufficient to ensure that specimens are not stacked at height. Risk assessment complete and staff trained in spill procedure, spill kits available if required. Datix completed if a spill occurs Breast mastectomy specimens - in order to meet national standards the team try to reorganise workload to enable a downdraft bench to be freed up. If this is not possible a different bench is used but this requires the movement of all reagents to an area where there is no downdraft ventilation. This poses a health and safety risk Inability to expand the service to support additional workload i.e - expansion of specific services, TIF2 project. Discussion underway with cancer alliance regarding funding opportunity and if this can be used for expansion either additional equipment or capital work. Paper submitted to environment board to highlight space issues

Harrogate and District NHS Foundation Trust

Board Meeting Held in Public

Title:	Learning from Deaths Quarterly Report Q2: July-September 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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Board Meeting Held in Public

Learning from Deaths Quarter 2 Report

Executive Medical Director

1.0 Executive Summary

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

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

21 cases have undergone a structured judgement review since the last report. One case was identified of poor overall care but that was not felt to have significantly affected the sad outcome. The team involved will review the case in their regular Quality and Governance meeting.

We are continuing to use “watch metrics” in keeping with HDFT Impact methodology.

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, 143 deaths were recorded in Q2, down from 168 in the preceding Q1 and down from Q2 in 24/25 which had 175 deaths. This data is not risk-adjusted so takes no account of the unique characteristics of individual admissions. Comparison with the national mortality rate is also shown where data is available (shown in the darker blue line in Figures 1 and 2). This demonstrates that the peaks and troughs we see in HDFT are often mirrored at the national level. Figure 2 gives a "zoomed in" view of data from the last 2 years. Note that the rise in mortality in HDFT seen in December 2024 is mirrored by a similar rise in national numbers.

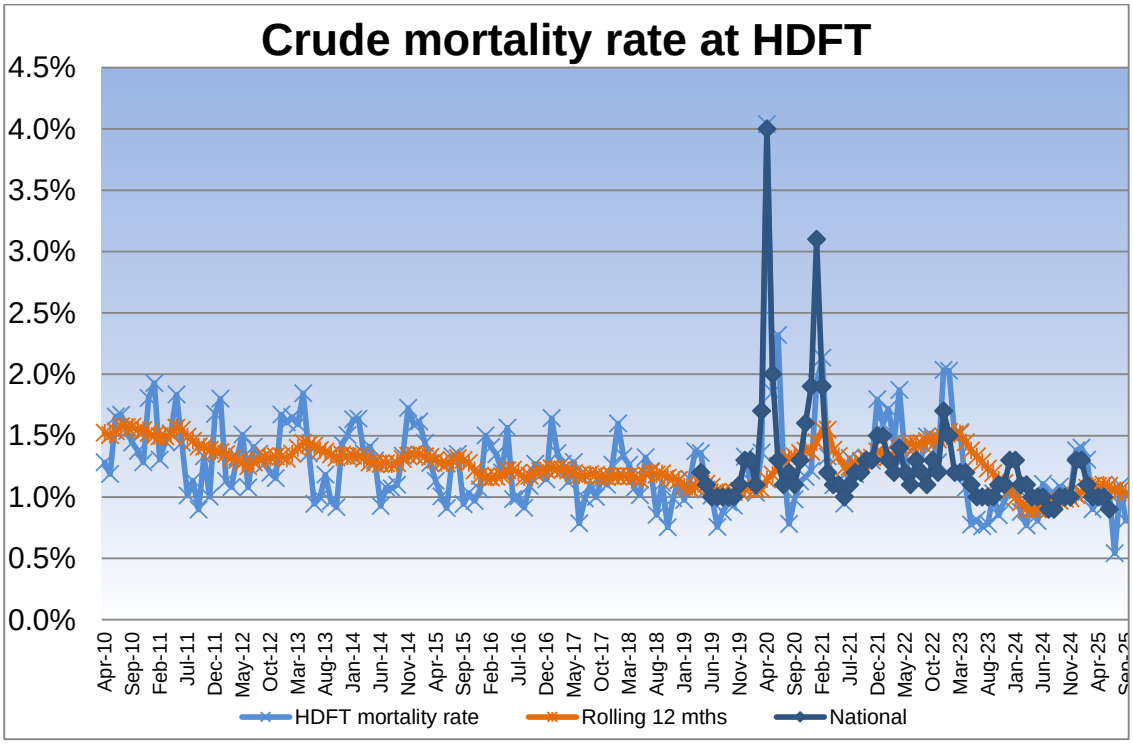

Figure 1: Crude mortality rates over the last 15 years (%deaths per hospital episode)

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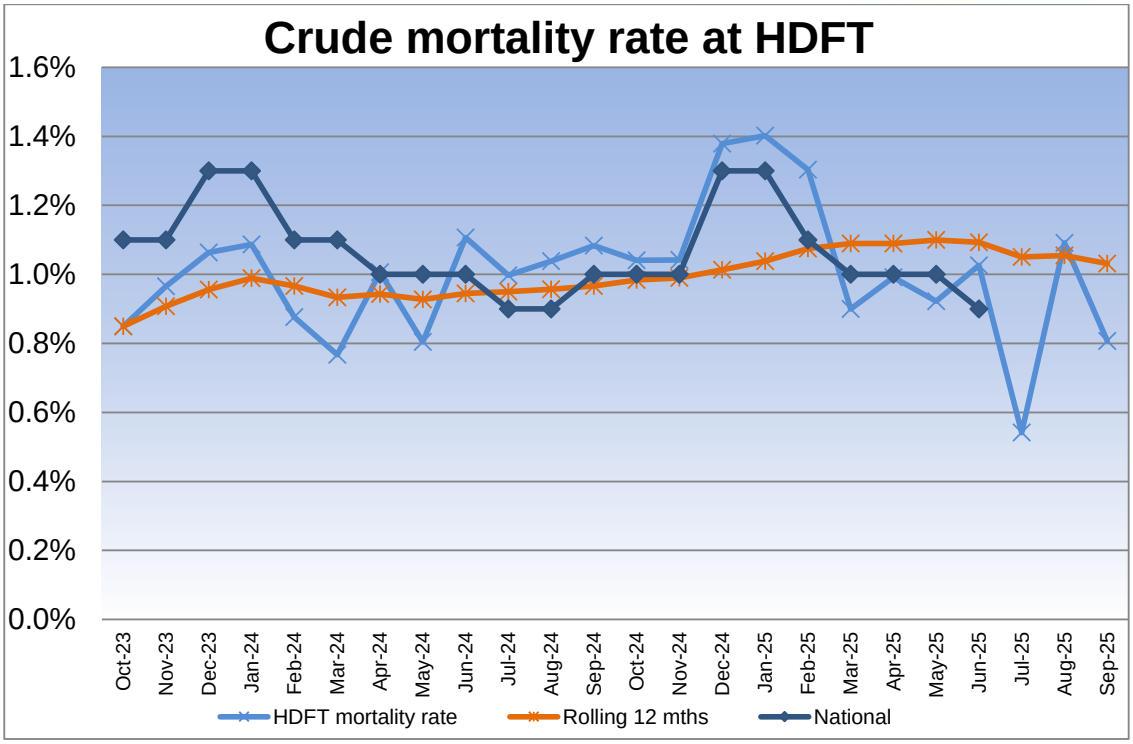

Figure 2: Expanded crude mortality rates over the last 2 years (%deaths per hospital episode)

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3.2 Standardised Hospital Mortality Index (SHMI)

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

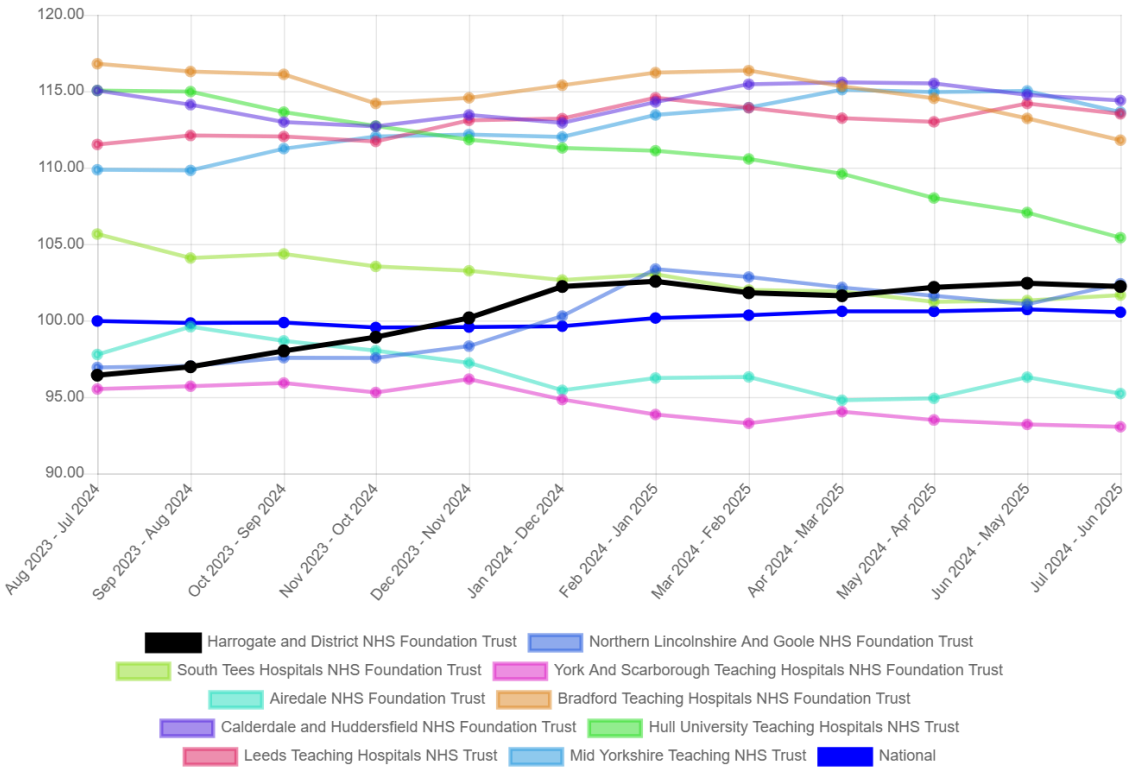

Figure 3: HDFT SHMI since July 2023 versus regional peers

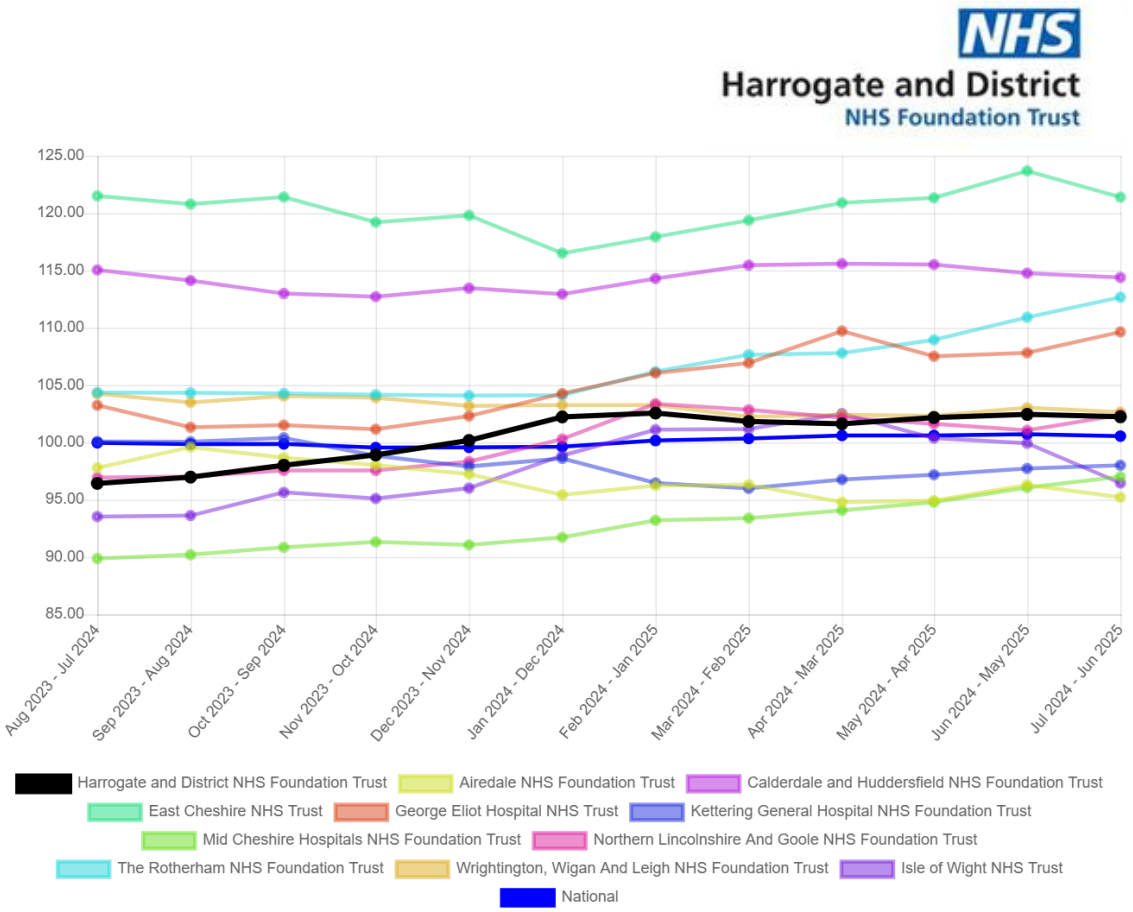

Figure 4: HDFT SHMI since July 2023 versus national peers

As can be seen, our SHMI peaked in the period Feb 2024-Jan 2025 having slowly climbed previously. This rise was primarily driven by a precipitous fall of expected deaths, as shown in figure 5.

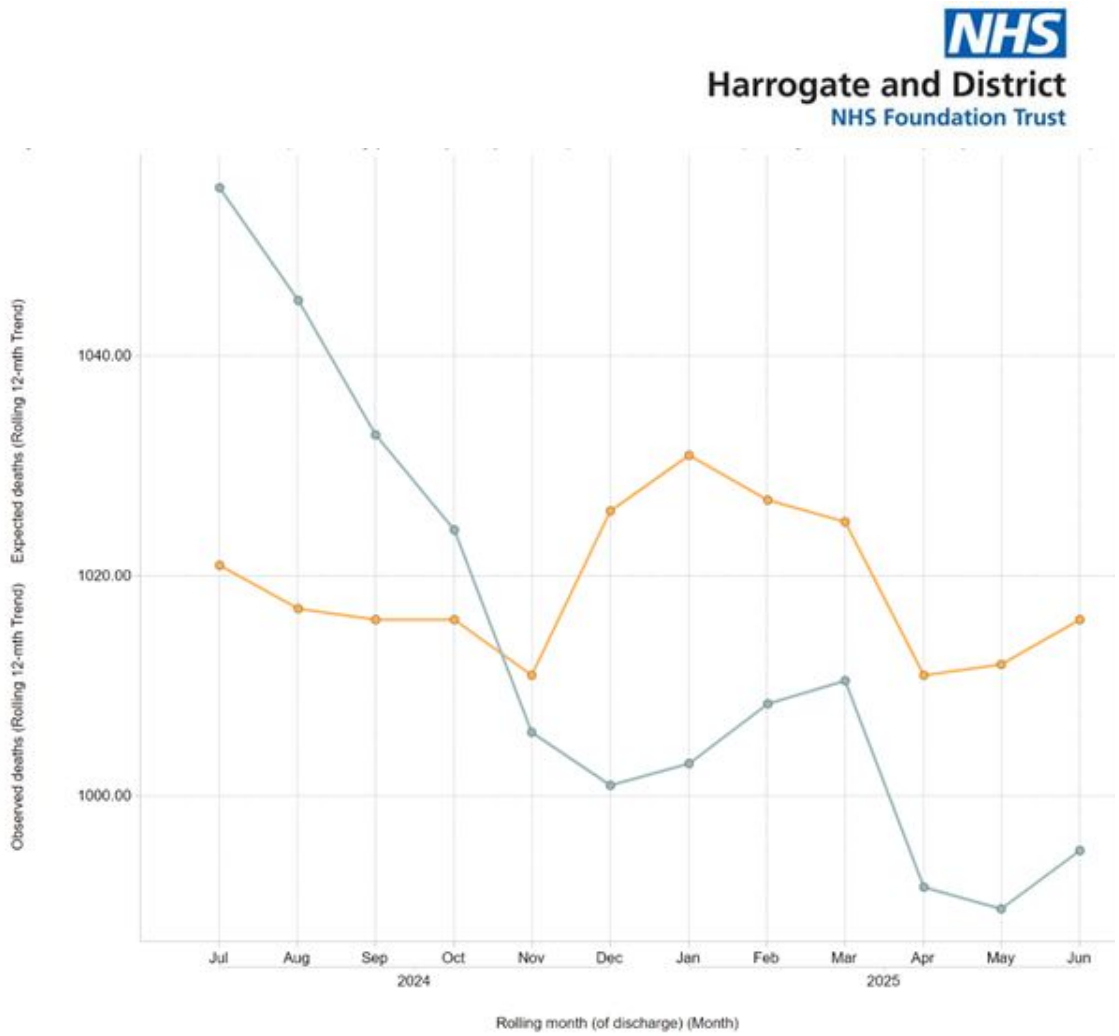

Figure 5: Observed (orange) and expected (grey) number of deaths (in hospital or within 30 days of discharge – rolling 12 months)

A sudden fall in expected death numbers, as seen from July to December 2024, raises concerns of a data quality issue. We identified an increase in patients' diagnostic code in the category "Invalid primary diagnosis". We normally have very few spells in this category, but it sharply rose in 24/25 year. The reason behind the rise of this category is likely due to incomplete clinical coding by the time of SHMI generation. The number of cases with "invalid primary diagnosis" has now fallen significantly:

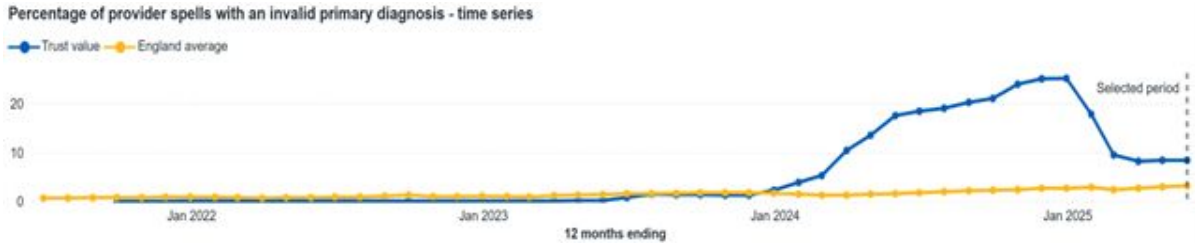

Figure 6: Spells with a "Invalid primary diagnosis" coding. Note how the number had fallen but not fully returned to baseline

3.3 Structured judgement reviews (SJR)

21 cases have been reviewed in this quarter with 6 relating to deaths in this period and the remainder from earlier admissions.

No triggers were reached in our agreed mortality “watch metrics” and therefore targeted selection of specific diagnoses was not undertaken this quarter (see Appendix 1)

Table 1 shows how the cases in this financial year have been selected for review.

	Poor care	Adequate care	Good care	Excellent care	Total
Diagnostic category	0	1	9	0	10
Learning Disability/Mental Health	0	0	7	4	11
Medical Examiner	1	1	1	0	3
Quality Team/Trust concern	0	0	1	0	1
Random selection	0	5	7	4	16
Specialty concern	0	3	1	0	4
Other	0	1	0	0	1
Total	1	11	26	8	46

Table 1: Breakdown of Overall Care rating in randomly selected cases in Q1&2

6 cases were in patients with a learning disability who will receive a second external review as part of the LeDeR process. We have received updated information on the LeDeR review process. Currently, Xyla Health and Wellbeing Services are commissioned by the ICB to undertake the reviews. They pool their reports for both the ICB and for the national annual LeDeR report. Ideally their reviews take place within 12 months, but they may fall outside this target, in cases involving the Coroner or Safeguarding concerns. HDFT may occasionally be given specific feedback where appropriate, both positively and negatively. In the last 2 years, only positive feedback has been received in relation to Palliative Care and Learning Disabilities Liaison. This has been shared with the relevant teams.

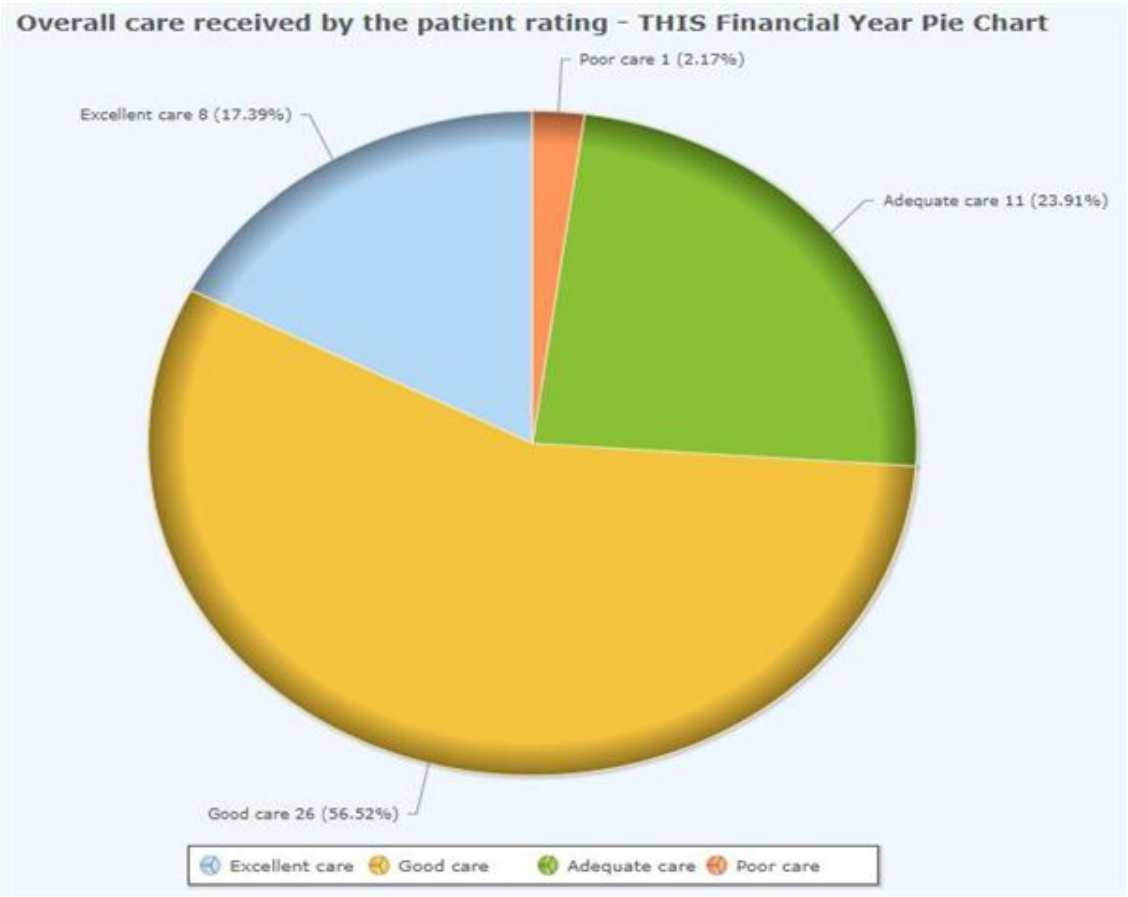

Figure 7: Breakdown of Overall Care rating in all cases reviewed this financial year

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, no deaths were identified with a significant chance of avoidability.

One case was described as poor overall care. This related to avoidable delays in arranging a procedure done at a neighbouring trust. It is not felt to have affected the outcome however. It has been referred to the lead specialty for them to discuss at their Quality and Governance meeting.

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The overall assessment of the standard of care for each case of is shown in Table 2:

Date of admission	Care in First 24 hours	Ongoing Care	Avoidability of Death	Clinical/Organisational score (NCEPOD)	Overall Care
09/03/2025	Poor care	Good care	Definitely not avoidable	Not Scored	Adequate care
09/03/2025	Adequate care	Good care	Definitely not avoidable	Good practice	Good care
02/04/2025	Excellent care	Good care	Definitely not avoidable	Good practice	Excellent care
01/05/2025	Good care	Not Applicable	Definitely not avoidable	Good practice	Good care
20/05/2025	Excellent care	Excellent care	Definitely not avoidable	Not Scored	Excellent care
21/03/2025	Excellent care	Good care	Definitely not avoidable	Good practice	Excellent care
31/05/2025	Good care	Adequate care	Definitely not avoidable	Good practice	Good care
30/06/2024	Good care	Good care	Definitely not avoidable	Room for improvement in clinical care	Adequate care
23/06/2025	Excellent care	Not Applicable	Definitely not avoidable	Good practice	Excellent care
26/06/2025	Excellent care	Not Applicable	Definitely not avoidable	Good practice	Good care
27/06/2025	Poor care	Adequate care	Definitely not avoidable	Room for improvement in organisational care	Adequate care
21/06/2025	Good care	Good care	Definitely not avoidable	Good practice	Good care
10/08/2025	Adequate care	Adequate care	Definitely not avoidable	Room for improvement in clinical care	Adequate care
22/04/2025	Good care	Good care	Definitely not avoidable	Good practice	Good care

23/07/2025	Excellent care	Excellent care	Definitely not avoidable	Good practice	Excellent care
16/09/2025	Excellent care	Excellent care	Definitely not avoidable	Good practice	Excellent care
03/08/2025	Adequate care	Good care	Definitely not avoidable	Room for improvement in organisational care	Good care
11/08/2025	Adequate care	Good care	Slight evidence of avoidability	Good practice	Good care
26/08/2025	Good care	Good care	Definitely not avoidable	Good practice	Good care
22/06/2025	Good care	Adequate care	Slight evidence of avoidability	Room for improvement in clinical care	Adequate care
23/05/2025	Adequate care	Poor care	Slight evidence of avoidability	Room for improvement in clinical care	Poor care

Table 2: Details of the cases reviewed this quarter

Table 3 shows the quality of end-of-life care received. Note this is recorded as “not applicable” in the case of a sudden death.

End of Life Care Rating			
	25/26 Q1	25/26 Q2	Total
Not Applicable	7	7	14
Poor care	2	1	3
Adequate care	3	5	8
Good care	11	4	15
Excellent care	2	4	6
Total	25	21	46

Table 3: End of Life Care provided

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 early recognition of when palliation would be appropriate. Negative themes included lack of timely, detailed management plans and failure to identify the whole clinical picture rather than focussing on one specific symptom.

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

4.0 Recommendation

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

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Appendix 1

"Watch Metrics"

	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Aggregated CUSUM (HSMR)							
108-Heart failure							
109-Acute cerebrovascular							
122-Pneumonia							
127-COPD and bronchiectasis							
129-Aspiration pneumonia				prev red			
2-Septicaemia			X				
226-#NOF							
55-Fluid and electrolytes							
100-AcuteMI			X				
107-Cardiac arrest							
150-Liver disease, alcohol related							
68-Senility and organic mental disorders							
157- Acute and unspecified renal failure					prev red		
231- Other fractures							
159 - UTI							
153 - GI haemorrhage							
SHMI (monthly SHMI - use last month in period)							
111:205-Spondylosis							
58:101-Coronary atherosclerosis			X				
110:204 Other nontraumatic joint disorders							
SHMI (VLAD) HES							
75::COPD and bronchiectasis							
73:122-Pneumonia							
2:2 Septicaemia							
110:204 Other nontraumatic joint disorders							

3

Safeguarding Annual Report (2024-25)

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

Purpose of the report and summary of key issues:	The purpose of this report is to provide assurance of Safeguarding activity within Harrogate and District NHS Foundation Trust (HDFT) and identify how this meets our statutory safeguarding responsibilities under the Children Act 1989/2004; the Care Act 2014 and the Mental Capacity Act 2005. The report is aligned to the six safeguarding principles and Section 11 of the Children Act (2004). As part of our multi-agency commitment to Safeguarding Adults and Children, HDFT is represented on North Yorkshire Safeguarding Executive and Adult Board arrangements and is represented by Executive Director of Nursing or Deputy Director of Nursing and AHPs. HDFT are represented in North Yorkshire adult and children`s partnership arrangements by Named Professionals. Named Nurses working across 0-19 localities represent HDFT in respective safeguarding children`s partnership arrangements. Through existing Governance arrangements, The Trust Safeguarding Governance Forum reports to and links directly into the Quality Governance Management Group (QGMG). The Safeguarding Committee, with external partners, reports directly into Quality Committee on behalf of the Trust Board	
	The Patient and Child First Improving the health and wellbeing of our patients, children and communities	x
	Best Quality, Safest Care	x
	Person Centred, Integrated Care; Strong Partnerships	x
	Great Start in Life	x
	At Our Best: Making HDFT the best place to work	x
	An environment that promotes wellbeing	x
	Digital transformation to integrate care and improve patient, child and staff experience	x
	Healthcare innovation to improve quality	x
Corporate Risks		
Report History:	Safeguarding Senior Management Team (SMT) – 17.09.25 Safeguarding Governance Forum – 23.09.25 Safeguarding Committee – 17.10.25 QGMG – 09/09/25	
Recommendation:	The Board are asked to receive this report and note the content, activity and progress in safeguarding delivery, governance and leadership improvements over the last 12 months	

INTRODUCTION

This report is the Safeguarding Annual Report for the reporting period 1st August 2024 – 31st July 2025.

The report provides an overview of activity and outlines key achievements and developments on HDFT safeguarding priorities. It has been structured around the key principles of safeguarding, which are central within our *All Age Safeguarding Strategy* (2024-2027), which underpins all our safeguarding work. It also aligns to our progress and compliance with Section 11 of the Children Act (2004). Our Safeguarding Strategy aligns with the Safeguarding Adults Board and Safeguarding Children's Partnerships` priorities.

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

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

The safeguarding diagnostic completed at the end of 2023 identified a number of areas that needed to be addressed and strengthened. These areas were reported on in the 2024 annual report, and an update to these areas is presented below:

Area of Development	**Achieved**	**How? / Plan to Address**
Strengthened safeguarding strategic leadership to provide oversight and strategic direction with increased visibility within acute services	Y	Head of Safeguarding commenced in post Sep 2024. Full-time acute Named Nurse commenced July 2025.
Strategic leadership underpinned by a safeguarding strategy	Ongoing	Strategy completed. Delivery plan in progress.
Trust wide Safeguarding processes	Ongoing	Addressed through Safeguarding SMT work streams.
Increased focus on safeguarding within the acute setting – child and adults	Y	Key roles recruited to. Now fully linked into directorate governance processes.
Clarity of roles/responsibilities across safeguarding teams/functions	Y	Clarified through individual teamwork streams.
Increased focus on learning disability and autism	Ongoing	Lack of autism lead remains on safeguarding risk register.
Development of a strategic safeguarding risk register	Y	In place.

Clear escalation/communication processes	Y	Escalation process updated.
Consistency in processes and reporting of mandatory training figures being reported	Y	All safeguarding training is now centrally recorded.
Increased engagement and involvement with the safeguarding adults team in the wider safeguarding strategy and Trust strategies	Y	Adults team represented in all safeguarding work streams.
Strengthened team working in acute safeguarding function	Y	Adults and children team now co-located and moving towards all age service. Recruitment completed to key posts.
Strengthened support/communication and engagement with acute clinical teams to improve relationships, increase ownership and accountability	Y	Safeguarding representation at all relevant meetings. Increased presence on wards.
A focused safeguarding annual audit plan	N	Working towards.
Identification of clear outcomes and impact	N	Part of audit plan.
Consistency in representation at CYP partnership meetings – North Yorkshire	Y	Recruitment to full time acute Named Nurse post.
Robust governance processes to provide assurance	Y	New governance arrangements embedded.
Clear line of accountability within the organisation for work on safeguarding and promoting the welfare of children and adults	Y	Achieved through revised governance and leadership processes.
Revision of Safeguarding Strategic Governance Committee	Y	Revised during reporting period.
Robust processes in Tees Children in Care contracts	Y	Pathways and audits all now in place.

SECTION A: Principles of Safeguarding

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

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

1.1 Voice of the Individual:

The Voice of the Child is a golden thread that runs through safeguarding in HDFT. Regular training is provided to staff to ensure that the voice of the child is captured. Monthly record audits evidence compliance with the verbal and non-verbal messages of children and young people. Some areas of the HDFT footprint have Child Lived Experience practitioners, whose

primary role is to capture the voice of the child in all stages of HDFT involvement. Risk assessment tools are used, and practitioners are trained to identify vulnerabilities. Record keeping audits, safeguarding supervision and thematic reviews ensure learning and good practice is disseminated.

During February 2025, North Yorkshire Safeguarding Children's Partnership was subject to a Joint Targeted Area Inspection (JTAI) on arrangements to protect children under 7 who are experiencing domestic abuse. A summary of the findings of the report can be found in Section 3.1 of this report. Although good practice was identified, there were also gaps in practice identified around how the voice of the child is heard in Harrogate Emergency Department (ED) and how children who may be exposed to domestic abuse are responded to and protected. A working group and action plan has been developed in response to this. As of July 2025, there is a plan in place to roll out routine enquiry in ED at the point of triage. Training will be provided by the Independent Domestic Abuse Service (IDAS) in November and the department will adopt a train the trainer approach.

The adult voice is captured through applying the principles of Making Safeguarding Personal (MSP). A core element of safeguarding adults training is the focus on asking the adult what they want to happen when a concern is identified. This also forms the focus of the safeguarding adults' team direct work with wards and teams. A further MSP audit is planned for this year.

During this reporting period, the HDFT Safeguarding Children policy was revised in line with the updated Working Together to Safeguard Children guidance. The policy emphasises that the voice of the child is paramount and at the centre of the practitioners' risk assessments and decision making.

1.2 Mental Capacity Act (MCA):

HDFT now have an MCA Lead in post (the role being combined with the Named Professional – Safeguarding Adults). Work is being carried out to establish the key priorities of focus. One area already identified is the requirement to update Trust documentation on mental capacity assessments and best interests decisions in line with case law and government guidelines. This will be implemented on the different digital systems used by HDFT.

During this reporting period, 260 Deprivation of Liberty Safeguard (DoLS) applications were made by the Trust. This compares to 240 applications made in the previous year. More detail can be found in the data section of this report. There were two standard authorisations approved by the Supervisory Body during this period. It is likely that the true number of applications is higher but due to applications being submitted directly through to North Yorkshire Council, it is possible that the adult safeguarding team are not made aware of every application made.

A review of the DoLS audit completed in 23/24 is being finalised. This is one of the Trust's priority audits. Emerging outcomes show that although some good practice was identified (in relation to applications meeting the "acid test"), there were some concerns in relation to: the evidence base and documentation of capacity assessments; limited evidence of less restrictive options being considered; and evidence that nearest relatives were not always informed of the requirement for a DoLS. Once finalised, the audit will be disseminated to directorates through the established governance processes.

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

2.1 Learning and Improvement Framework

During 2023/24, as part of the safeguarding diagnostic, it was identified that there needed to be a more consistent mechanism in place for capturing learning from safeguarding reviews across the HDFT footprint; with the ability to identify trends and patterns of learning; and how these would be communicated through governance processes, using the learning to inform training requirements. During 2025, the Safeguarding Learning and Improvement framework was developed, which meets the above objectives. A copy of this framework can be found in appendix three of this report. The next stage of work is to continue to embed the Framework across all safeguarding teams.

An area highlighted in the diagnostic that remains in development is the creation of a footprint wide safeguarding audit programme. The learning and improvement framework will help to identify the areas of focus for such audits by enabling themes of learning to be more clearly identified.

2.2 Prevent

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

Trust wide Prevent training compliance, as of the end of Q1 25/26, is 97% for Basic Prevent Awareness and 94% for Awareness of Prevent – level 3. Compliance is reported on a quarterly basis through NHS England's national safeguarding data collection framework and during this reporting period, HDFT were compliant on each submission. During the reporting period, HDFT did not make any referrals into Prevent.

2.3 Safeguarding and Discharge from Acute Hospital

Safeguarding is being considered as part of Trust wide work on discharge. The Named Professional – Safeguarding Adults is being consulted as part Corporate Discharge Project and has supported in the review of the Criteria for Discharge Standard Operating Procedure (SOP).

Work with North Yorkshire Council has taken place to try to improve the timeliness of feedback in safeguarding cases to avoid delays in transfers of care. Some improvements have been seen, with feedback being given in many cases now at the point of triage.

2.4 Children in Care (CIC):

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

Area	Number of CIC	Performance
North Yorkshire	1,171	IHAs YTD 37% completed within timescales; this is an increase from 25% year prior.

		RHAs YTD 84.5% were completed within timescales. Slight decrease from last year's figures.
Tees Valley	2335	IHAs completed within statutory timeframes across the Tees Valley increased to 57.3% from 48% from the previous year. RHAs completed within statutory timeframes across the Tees Valley was 86.4% which was a slight increase from 85.8%.
Durham	1771 (Durham children placed in Durham)	RHAs completed within statutory timeframes for Durham Local Authority children living in Durham was 83.9%. This is a decrease from 91% the previous year.

2.4.2. Developments / Improvements

During this reporting period, there has been continued work in relation to improving the compliance of the IHAs which have to be completed within 20 working days of the child/young person coming into care. North Yorkshire has IHAs completed by 5 different providers all with different pressures, however improvements have continued throughout the year.

The 12-month fixed term North Yorkshire Specialist Nurse Children in Care post has been extended for another 12 months.

Within the Tees Valley Children in Care (CIC) service, a full time Service Manager was appointed to ensure operational management of staff was in accordance with the 0-19 (25) contract areas. This has ensured equitable distribution of work and sustainability for our children and young people.

Within Durham CIC team, the staff have worked closely with County Durham and Darlington Foundation Trust (CDDFT), the commissioned service, to ensure that pathways and processes align between the two provisions. This has provided timely intervention and the correct support for our children and young people in care and also care leavers.

2.4.3. Key successes

North Yorkshire have been successful in implementing a virtual movement in clinic when a child is new into care or new into the area, there is a criteria for this clinic and feedback has been positive; it is working well for our carers, children and young people and has also helped support team capacity.

The Specialist Nurse for Children in Care arranged a very successful teaching session for the operational safeguarding team and social care, which included updates from the Specialist Hepatology nurse and a member of the TB Team. The purpose of this session was to raise awareness of the differing needs of our Unaccompanied Asylum-Seeking Children and ensuring that they are referred to the right services in a timely manner and, dependant on results, have access the right support.

A number of staff from the Tees Valley Children in Care service supported 'The Christmas Dinner' on Christmas Eve. The Christmas Dinner is a charity that provides a Christmas Lunch for care leavers; those young people who may ordinarily spend Christmas Day alone. Members of the team volunteered on Christmas Eve to support with dressing lunch tables, gift wrapping and decoration of the room.

https://www.youtube.com/watch?v=MPlhSjoXH-E

2.4.4. Care Leavers

A Care Leaver is a young person who has been "looked after" for at least 13 weeks since the age of 14 years and who was in care on their 16th birthday. Local authorities are expected to stay in touch with care leavers and provide statutory support to help their transition to independent living. Health passports are a national initiative which provide a health record for the young person.

There has been some work completed in North Yorkshire in relation to young people's health passport. A new version has been developed in line with listening to their voice as to what they want/need as they move into adulthood. There is also ongoing work with the ICB in relation to how health summaries/passports will look in the future.

Tees Valley Children in Care had 200 young people leave their service as care leavers and 100% of young people had a health passport completed on their behalf by the team. There has been 59% of young people provided their consent for their health passport to be shared with them and their social worker on their behalf which supports pathway planning.

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

3.1 Domestic Abuse

A domestic abuse action plan, initiated during 2024, is ongoing. This centres on the support staff require to be able to effectively identify and respond to disclosures of domestic abuse, including disclosures from colleagues. A domestic abuse champions' network is now in place in the acute Trust, with meetings being held quarterly. During North Yorkshire safeguarding week in June, HDFT held a study day for maternity staff on domestic abuse, with external speakers from the police and from survivor organisations.

North Yorkshire JTAI (Joint Targeted Area Inspection):
During January-February 2025, North Yorkshire Safeguarding Children Partnership was subject to a JTAI on domestic abuse (see section 1.1.). Overall, findings were generally very positive. A summary of the report is as follows: "*Unborn children, and those aged 0-7 who are victims of domestic abuse in North Yorkshire, are seen, understood and safeguarded by professionals and key people in their own communities. The response to domestic abuse in a place of this scale is consistent with its localism, informed by clear and decisive strategic intent and delivered by skilled practitioners who understand the impact of domestic abuse on young children. For a very small number of children, there are areas for further improvement and key partnerships have co-produced plans in place to drive any necessary change".*

Development actions are being taken forward across services, which feed into a Partnership action plan.

All safeguarding teams across the footprint continue to contribute to local area Multi-Agency Risk Assessment Conference (MARAC) meetings through the submission of information gathering and the acute safeguarding team now attend the weekly Harrogate/Craven MARAC meeting in order to support the multi-agency risk assessment and management of high risk cases.

In Northumberland, there has been a Safeguarding Children Partnership task and finish group in relation to domestic abuse in young people. Learning from a recent Rapid Review identified the need to promote and raise awareness of the recognition of harmful behaviour in relations, and how to support individuals. Scrutiny of police (and other) data highlighted an increase in domestic abuse in teenage relationships (16- and 17-year-olds), with a gap identified in provision and intervention work. Young people themselves voiced that there is a lack of support. It was agreed that this would be a key area of work for the Partnership, linking to the "risks outside of the home" thematic priority. The outcomes of the task and finish work was to agree a pilot for "teenage relationship harm"; which includes a specific referral path; the creation of a "serious harm" pathway; and the launch of a "teenage relationship harm" delivery group.

3.2 Sexual Safety Charter

On 4 September 2023, NHS England launched its first ever sexual safety charter in collaboration with key partners across the healthcare system. Signatories to this charter commit to taking and enforcing a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours within the workplace, and to ten core principles and actions to help achieve this. HDFT as an organisation has signed up to the Charter. The safeguarding service is supporting internal work to demonstrate HDFT's commitment to meeting the charter's principles.

3.3 Emergency Department (ED)

The acute safeguarding team have jointly developed an action plan with ED, based on the Facing the Future urgent care standards, adapted to include adults. Key lines of enquiry include: supporting ED to meet safeguarding training and supervision compliance; appropriate escalation; and ensuring access to safeguarding policies, procedures and guidelines. The action plan forms the basis of discussion in monthly meetings with the ED matron where progress can be tracked.

The safeguarding team attend the daily ED safety huddle, giving key messages to staff and ensuring visibility into the department and continue to offer bespoke training and support to staff, based on the principles of trauma informed practice.

There is now safeguarding representation on both the North Yorkshire strategic and operational Right Care Right Person groups.

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

4.1 CPIS

The Child Protection – Information Sharing System (CPIS) is well embedded and identifies to staff, children and young people with a Child Protection flag/Looked after Children flag as part of gold standard information sharing practices. CPIS Phase 2 will be rolled out during early 2026. Phase 2 focuses on health visitor and school nursing services, community dental services and community paediatric services. At the time of writing, work will shortly be starting with IT to roll this out with mandated timescales.

4.2 Managing Allegations against People in Positions of Trust

At the time of writing, the revised HDFT *Managing Allegations* Policy was going through the ratification process. This policy incorporates PiPoT (Persons in a Position of Trust) into

existing LADO (Local Area Designated Officer) processes and clarifies roles and responsibilities of employees' dependent on role. A roll out of the policy is planned through line manager webinars and other staff briefing sessions. During the reporting period, briefings on PiPoT and LADO were provided to key staff, including the HR team, both by the acute safeguarding team and by the North Yorkshire LADO manager.

Over the reporting period, four PiPoT referrals were received into HDFT and two referrals were made by HDFT. Eight LADO referrals were made involving HDFT staff members.

5. PARTNERSHIP – *collaboration with partner agencies and communities.*

As part of our multi-agency responsibilities to safeguarding adults/children and children looked after, HDFT is represented at North Yorkshire Safeguarding Adults Board (NYSAB), ICB Safeguarding and Executive arrangements. The Named Nurses/ Professionals represent the Trust on the sub-groups of Adults Boards/Partnerships and across all Children`s Boards/Partnerships across HDFT footprint.

5.1 Work across partnerships 2025/26

5.1.1. Community

Safeguarding colleagues embedded within 0-19 locality teams work closely with multiagency stakeholders across all footprints. Quality assurance reports to commissioners across all localities from Named Nurses continue to be shared to outline the findings of the safeguarding children team activity undertaken and any changes in practice that impact and/or improve quality of practice within the 0-19 Service and safeguarding children team. The reports outline any learning from Inspections/Child Safeguarding Practice Reviews and/or Learning Lesson Reviews and also highlight evidence of good practice. Reports are provided to assure commissioners that key performance indicators are being achieved which will include safeguarding supervision and training compliance.

Some examples of Partnership work are as follows:

Cumbria, Westmoreland and Furness:
JTAI preparatory work is being undertaken for domestic abuse and transitional safeguarding in the form of case audits. The Cumbria Safeguarding Children Partnership Neglect Strategy (2023-2026) remains a key priority, alongside domestic abuse and child exploitation.

Gateshead:
Gateshead Safeguarding Children Partnership and Newcastle Safeguarding Children Partnership are working with the National Society for the Prevention of Cruelty to Children (NSPCC) to review local responses to child sexual abuse. This work will help to identify strengths, areas for improvement and ensure local response is fit for purpose.

Gateshead Partnership are developing a local model for Harm outside the Home (HOtH) Conferencing, scheduled to begin in September. A new report format to be used in HOtH conferences has been shared and agreed.

Darlington:
In March 2025, Darlington Partnership developed its new multi-agency safeguarding arrangements to align to changes set out in the revised Working Together guidance. The aims are: clarifying responsibilities of partners; emphasising the role of education;

strengthening accountability by clarifying responsibilities for information sharing, independent scrutiny, funding and reporting; and introducing a Partnership Chair role.

Darlington local authority have introduced a “re-think formulation”, which is a form of multi-agency supervision to be used when a case needs to be challenged or when a case is “stuck”. The Named Nurse for Darlington has initiated two of these sessions in order to challenge high level cases, both with excellent outcomes for the children involved.

North Yorkshire:
Both the acute safeguarding team and 0-19 Safeguarding Team have consistent representation at North Yorkshire partnership meetings to drive forward learning and strategic actions. Learning from Safeguarding Practice Reviews is clearly disseminated across the partnership, with HDFT actions shared through internal processes to ensure implementation and embedding into practice. Thematic review #ask me campaign has been pertinent in ensuring professional curiosity and tailored messages around ICON (infant crying) and Safe Sleep are delivered to parents and carers. Professional curiosity guidance developed with partnership has also been promoted to the 0-19 service. The development of Harmful Sexual Behaviour Toolkit following on from harmful sexual behaviour audit was completed by NSPCC across North Yorkshire.

Tees – Stockton and Middlesbrough:
All professionals in the Hartlepool and Stockton-On-Tees children’s workforces were invited to attend a conference in October 2024, dedicated to enhancing the workforce’s collective ability to recognise and address neglect. With 70% of child protection plans in Hartlepool and Stockton Safeguarding Children Partnership (HSSCP) area primarily citing neglect and every serious case review since 2019 involving neglect, it was imperative that we came together to strengthen approaches and share best practices.

The two Tees Safeguarding Children Partnerships, alongside Cleveland police and multiagency partners, have collaborated on implementing a unified Tees HOtH strategy.
The Partnership’s strategy briefing was launched to all multiagency partners in December 2024. Since the introduction of the screening tool Hartlepool and Stockton Safeguarding Children Partnership have reported an increase in referrals and earlier identification of cases. Thus, this has resulted in greater intervention at an earlier age leading to early help and support to children, Young People and families. HDFT continue to support and work in collaboration with Tees HOtH partnership via the HOtH subgroups, as well as operational representation on the weekly screening meetings.

HDFT works with the Partnerships in understanding the effectiveness of safeguarding arrangements and services across the wider Tees footprint. The purpose of the group is to review information available – including data, reviews, and audits. The Tees Performance and Quality group review the information and set questions/hypotheses based on the presenting information. Pieces of work are commissioned to seek assurance about the effectiveness of our partnership working.

HDFT contribute to the work of HSSCP and STSCP by providing and reporting on performance information, this is to assure the organisation that they are fulfilling their responsibilities outlining what they are doing, how much they are doing and how well they are doing it. The Performance and Quality group functions as a hub of intelligence and quality assurance; therefore, providing assurance reporting to the Partnerships’ Executives and to HDFT management team.

Audit
The HSSCP Engine Room conducted two multi-agency audits in 2024-25 as per their agreed audit cycle. Each of these audits trialled a new audit process, neither of which were deemed

to be optimal in terms of output. A third proposal was suggested in which the multi-agency audit process would mirror that of the JTAI audit process. Two cases were selected, one from each Local Authority. The Domestic Abuse JTAI evaluation criteria were used as the basis of the audit questions. Involved agencies undertook an audit of their own involvement and submitted responses to the audit questions. Agencies reflected upon the combined submissions and came together for a reflective discussion.

'I wanted them to notice'
In response to this report from The Child Safeguarding Practice Review Panel, HSSCP have completed a thematic deep dive on Child Sexual Abuse.

'It's silent; race, racism and safeguarding children'
HSSCP have reviewed this report from The Child Safeguarding Practice Review Panel and have asked partners to review their own internal training within their own agencies to ensure it includes racial, ethnic and cultural themes. HSSCP Engine Room made a recommendation to include 'It's silent: race, racism and safeguarding children' with Section 11 to cover all aspects.

Wakefield: Wakefield 0-19 remains actively involved and contributing to three Domestic Homicide Reviews which are reaching the final completion of the Individual Management Review (IMR) Overview reports. Two now referred to as Domestic Abuse Related Death Reviews (DARDR) following the introduction of the recent guidance.

DHR 7 'HDFT Wakefield 01-9 Development and Delivery of the DASH training to include the Young Persons DASH'

The Joint Overview Report and Executive Summary and Learning Briefing were reviewed by the panel members and the executive responsible for sign of within all agencies and submitted to the Home Office Quality Assurance Group January 2025.

Following the presentation of cases consideration though the Domestic Homicide Review (DHR) Steering Group and DHR Standing Panel three further requests for scoping were received following reported adult death as a result of abuse, violence or neglect by a relative, intimate partner or member of the same household.

The DHR Steering group concluded that one of the cases considered did not meet the statutory basis for a DHR, acknowledging that the deceased had experienced domestic abuse, the Steering Group were not able to demonstrate that there was a likely causal link between domestic abuse and the adult death.

Only one progressed to a DARDR for the Wakefield 0-19 as the deceased and the alleged perpetrator had children open to and receiving 5-19 services and the chronology and scoping request was received in July 2025. An IMR for DARDR 8 was requested and has been submitted following the progression of the DARDR Panel meetings.

There are no identified actions for the Wakefield 0-19 Service however the Named Nurse remains on and contributes to the DARDR Panel.

Child Safeguarding Practice Review (CSPR)

In December 2024, following the referral from DHR Steering Group the case for consideration was presented. Given the range of adverse childhood experiences the

children were exposed to for a sustained period, most notably the frequent and significant incidents of domestic abuse between parents, the Child Safeguarding Practice Review Group (CSPRG) agreed to undertake a Practice Learning Circle to understand how services responded to children living with domestic abuse and additional risks posed by parents.

There was no direct learning identified for Wakefield 0-19 but two generic actions for all agencies to progress which were managed through the CSPRG and devolved to the WSCP Integrated Learning and Development (L&D) Group both of which the Named Nurse Child Protection represents on and contributes to.

In May 2025 the Wakefield 0-19 Safeguarding Team referred a case in to the CSPRG for consideration as we had received the information pertaining to a 14-year-old as following the 14-year-old finding their parent deceased a further incident ensued where it is believed they attempted to end their own life. The 14-year-old had a diagnosis of Autistic Spectrum Disorder (ASD) and had been known to services since 2022 following several presenting behaviours and needs which include exhibiting harmful sexual behaviours, threatening another child with a knife, bringing a screwdriver into school, support for their mental health, and being a victim of domestic abuse between their parents.

The CSPRG agreed it would be valuable to undertake a Practice Learning Circle review to consider how services responded and supported them and their family's needs in the three-years prior.

Again, there was no direct learning for Wakefield 0-19 but two generic actions for all agencies to 'ensure that the role of Forensic Child and Mental health Services (FCAMHS) is promoted with staff as deemed appropriate to do so periodically, referring to the Understanding Sexual Behaviour page and resources to support in maintaining an understanding as to what the service provides and its distinction to Child and Adolescent Mental Health Services (CAMHS) and to '*Refer to the professional curiosity and challenge resources on the Wakefield Safeguarding Children Partnership (WSCP) website and consider the use of these within learning offers for respective workforces, with specific emphasis on the requirement to recognise environmental factors a child may be exposed to at home alongside having Special Educational Needs and Disabilities (SEND) as contributing to the behaviours a child presents with'*

Sunderland:
In January 2025, Sunderland local authority Together for Children children's services was subject to inspection. The outcome of the inspection was:

The impact of leaders on social work practice with children and families: Outstanding
The experiences and progress of children who need help and protection: Outstanding
The experiences and progress of children in care: Outstanding
The experiences and progress of care leavers: Good
Overall effectiveness: Outstanding

"Since the last ILACS judgement inspection in 2021, senior leaders in Sunderland…have not only sustained the outstanding practice and leadership seen at the last inspection, but they have also been relentless in driving further progress and improvements. This is bringing about profound and

positive changes for children, families and carers. The workforce is motivated and inspired by leaders and managers to continually improve their practice and children's outcomes".

Acute:

Maternity:
There is representation from maternity services through the Named Midwife role at North Yorkshire Children Safeguarding Children Partnership quarterly meetings. The Named Midwife works closely with other Named Midwives in region through Local Maternity and Neonatal Systems (LMNS).

Development of guidance for Hold on Pain Eases (HOPE) boxes and birth response plans with social care has been taken forward in 2024/25, supporting women separated from their baby close to birth due to safeguarding concerns.

Children:
Children`s acute safeguarding team continue to work collaboratively with partners with increased and strengthened engagement in 2024/25 and remain actively involved in a number of key North Yorkshire partnership meetings identified below:

Multi-Agency Child Exploitation (MACE) level 2 meetings; MACE operational group; Practice and Learning Subgroup; Child Death Overview Panel; Safeguarding Children Health Professionals Network meeting; subject specific meetings (e.g. protected addresses, notification of death of care leavers), High Risk case meetings.

Adults:
The North Yorkshire Safeguarding Adults Boad (NYSAB) sub-groups have been revised and there are now five groups: Safeguarding Adult Reviews (SARs); Audit, Assurance and Quality; Connection and Involvement; Prevention; and Confident Practice and Learning. The Named Professional – Safeguarding Adults attends all sub-groups. At each Audit, Assurance and Quality Improvement sub-group, data is shared from all providers in relation to safeguarding adult activity and audit updates, to identify themes, trends and areas of concern. This allows HDFT activity to be benchmarked against other acute Trusts, which supports prioritisation of focused activity.

There are 4 SARs currently open in North Yorkshire with HDFT involvement (three are statutory SARs and one is "discretionary"). Learning from SARs is disseminated through the newly established Safeguarding Learning and Improvement Framework (see Prevention section of this report). One SAR referral was made by HDFT, which will be considered by the SAR sub-group at its next meeting.

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

6.1 Safeguarding Training

HDFT has a strategic and operational safeguarding training group, both of whose ToRs have been revised during this reporting period. The Operational Training Steering group have developed a training plan for 2025/26.

Training has been established as the watch metric for the HDFT safeguarding service. The Strategic Training Steering group is focusing on four key priorities for adults and children's safeguarding training, including MCA:

1. Conducting a Trust-wide Training Needs Analysis and developing a comprehensive Safeguarding Training Strategy
2. Reviewing all training packages to ensure compliance with Intercollegiate Guidance
3. Providing oversight and assurance of safeguarding mandatory training compliance
4. Strengthening governance within the Trust-wide Training Group

Using Continuous Professional Development (CPD) funding, the Training Steering Groups have sourced, purchased, and scheduled a series of specialist training sessions delivered by nationally recognized external speakers. These sessions aim to deepen staff knowledge and skills in key safeguarding areas:

- **'Out of the Shadows'** – This session focuses on amplifying the voice of the child and helps professionals better understand issues such as county lines, exploitation, and gang involvement.
- **Dr. Emma Katz on Domestic Abuse** – Dr. Katz's training highlights the impact of domestic abuse on women and children, with a particular focus on how domestic abuse affects babies.
- **Zoe Loderick on Vicarious Trauma** – Zoe's session addresses the effects of vicarious trauma on human behaviour and provides insight on how to care for and support trauma workers effectively.

These targeted training opportunities are part of our ongoing commitment to ensuring that staff are equipped to respond effectively to complex safeguarding challenges.

6.2 Training Compliance:

Safeguarding children and adults' level 3 training continues to be delivered through face to face or Teams sessions. Level 1 and 2 training is delivered through e-learning. This ensures compliance with the Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff (2019); the Looked after Children: Roles and Competencies for Healthcare Staff (2020) and the Safeguarding Adults: Roles and Competencies for Healthcare Staff (2024).

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

Below are the training compliance figures as of August 2025. When compared to August 2024, there is an overall increase in compliance (evidenced in the final column).

Category	Certification Name	Required	Not Achieved	Compliance %	Increased/Decreased since August 2024
Mandatory Training	Safeguarding Adults Level 1	1057	15	99%	Increased 3%
Mandatory Training	Safeguarding Adults Level 2	2663	107	96%	Increased 5%
Mandatory Training	Safeguarding Adults Level 3	1106	99	91%	Increased 9%
Mandatory Training	Safeguarding Adults Level 4	2	0	100%	Remains the same

Category	Certification Name	Required	Not Achieved	Compliance %	Increased/Decreased since August 2024
Mandatory Training	Safeguarding Children Level 1	1172	28	98%	Increased 4%
Mandatory Training	Safeguarding Children Level 2	1890	67	97%	Increased 3%
Mandatory Training	Safeguarding Children Level 3	1751	221	87%	Increased 6%
Mandatory Training	Safeguarding Children Level 4	18	1	94%	Same

Category	Certification Name	Required	Not Achieved	Compliance %	Increased/Decreased since previous month
Mandatory Training	Mental Capacity Act (Including DOLs Awareness) Level 1	2582	112	95%	Increased 1%
Mandatory Training	Mental Capacity Act - Level 2	1202	160	87%	Increased 1%

6.3 Safeguarding Supervision

The two Named Nurses who are the thematic leads for safeguarding supervision have led the collaborative process of drafting a Trust wide all age Safeguarding Supervision policy. The policy serves as an essential frame of reference for all HDFT staff groups who require formal safeguarding supervision within their role, staff are enabled to clearly understand the frequency of attending safeguarding supervision and they are align to a suitable qualified safeguarding supervisor. At the time of writing, the policy was going through the final process of ratification.

Having a robust data collection method to provide assurance regarding compliance in relation to attending a safeguarding supervision meeting has proved more challenging. Staff complete a self-declaration of attendance following each supervision session; however, compliance figures are affected if staff do not complete self-declaration on the date they attended the supervision. Various solutions have been investigated, but currently, the mitigation in place is for supervisors to remind staff to self-declare immediately after completing the supervision session. Due to these difficulties, safeguarding compliance reporting has currently been paused while a solution is sought.

The training of new safeguarding supervisors is fundamental to the quality of supervision provided across the organisation. Peer supervisors have to date been offered a two-day training course delivered by a Safeguarding Specialist Nurse. The training has provided safeguarding supervisors with a robust knowledge of the role and an in depth understanding of the Tony Morrison 4x4x4 Model (Morrison T, 2005), which is the primary model to deliver Safeguarding Supervision across HDFT.

This year, three additional safeguarding supervision trainers have been identified, which will both provide resilience across services but also provide the opportunity to review the current two-day training package. The Named Nurses who lead safeguarding supervision have taken staff feedback from new contract areas who have transferred across into HDFT. Many of staff transferring into HDFT have experience of the safeguarding supervisors' role and have undertaken an accredited safeguarding supervision course. The thematic lead Named

Nurses have reviewed the content of prior training courses, mapped this against the current in house two-day course and will provide a refresh update as part of the staff induction process.

The next steps will be for 2025 will be the pool of safeguarding supervisor trainers to offer an update for staff who are experienced supervisors and a condensed one-day course for new supervisors with the introduction of an observed practice element. The quality and compliance with the established 4x4x4 model process require clinical oversight managed at a local level by the Specialist Nurse Child Protection (SNCP) within the local contract area. The audit of the quality of 0-19 peer group supervision should be reported through the Quality-of-Care Business meeting as a form of observed practice standards.

Having addressed the oversight of the 0-19 peer supervision groups the next step for the supervision thematic leads is the audit of the quality of supervision provided to the SNCP. Through the SMT all Named Nurse supervision groups were reviewed to ensure the groups were fully inclusive of all SNCP or the equivalent band 7 roles. The next steps for 2025/2026 will be a case review audit of SNCP supervision.

6.4 Supervision in the Acute Trust:

Children:

- Safeguarding supervision is provided to staff on a six-monthly basis. Case holders (for example, paediatric nurse specialists, physios, and OTs; paediatric Speech and Language Therapists), receive quarterly supervision. Supervision is delivered in groups face to face or over Teams.

Adults:

- Adult safeguarding supervision commenced in January 2025 and is delivered to matrons, ward managers and community nursing team leaders, with discretionary sessions planned for doctors.

Maternity:

- Acute staff attend bi-annual supervision. Case holding midwives attend quarterly supervision. Managers have separate supervision.

6.5 Audit

The development of a footprint wide audit programme remains a key priority. An all-age safeguarding audit programme has been developed in the acute Trust. A number of local safeguarding audits have taken place across the Trust over the last 12 months. Some examples are shared below:

Section 11 Audit:

Improving the way key people and bodies safeguard and promote the welfare of children is crucial to improving outcomes for children and young people. Section 11 of the Children Act 2004 places a statutory duty on key organisations to make arrangements to ensure that in discharging their functions they have regard to the need to safeguard and promote the welfare of children. The request for completion for the North Yorkshire Section 11 audit was received in July 2025, with a submission date in September 2025. Organisations are required to demonstrate compliance in nine domains. The report builds on the baseline self-

assessment that was completed in 2024. The report is split into areas of full compliance, partial compliance and non-compliance.

At the time of writing, the Section 11 audit is in draft. Emerging findings are that this year's report does not identify any areas of non-compliance (the only area from last year where there was non-compliance was in the lack of an MCA role in the Trust - this position has now been recruited to).

HDFT can demonstrate full compliance in the following domains:

The accountability in the commissioning, contracting and commissioning of safeguarding services:

- There are safer working practices for all staff and all contractors to the organisation who work with children and who are delivering statutory services. Contracts require the organisation to achieve Safeguarding Standards.
- Safeguarding is integrated into the contracting, commissioning and provision of services.

Senior Board level lead and effective reporting mechanisms:

- HDFT can demonstrate clear lines of accountability in its safeguarding arrangements, both through leadership and governance.

Information Sharing:

- There is a good understanding of information sharing and multi-agency practices, with the relevant training and policies in place to support staff.
- Records are stored in line with organisational policies and legislation.

Designated safeguarding leadership roles:

- There are safeguarding leads across the HDFT footprint.
- Staff know where to go to when they require support.

Safe recruitment practices:

- HDFT adheres to national safer recruitment standards.
- There is a robust DBS clearance process in place.

Partial compliance is demonstrated in the following areas:

Voice of the child, adult, family, staff and community:

- The voice of the child has been embedded throughout maternity and 0-19 services.
- The most recent MSP audit showed that in the majority of cases, the adult was asked what their objectives were.

Actions identified:

- Implement improvements in hearing the voice of the child in ED, as described in Section 1.1. of this report
- Capture more evidence that MSP has been embedded through repeat audits, as described in Section 1.1. of this report

Whistleblowing processes, including LADO/PiPoT

- HDFT have the required whistleblowing policies in place, including Freedom to Speak Up.
- There is a clear escalation process in place.
- The culture of the organisation enables safeguarding concerns/concerns about the welfare of a child or an adult to be raised.

Action identified:

- There is the need to continue to raise awareness of and embed LADO/PiPoT processes, particularly across the acute Trust.

Supervision and training

- Safeguarding training and supervision is provided to staff, in line with their role.
- There is a robust process of developing and reviewing training packages, including a quality assurance process.
- Safeguarding training is in line with Safeguarding Adult Board and Safeguarding Children Partnership principles and processes.

Actions required:

- Review of acute safeguarding training needs analysis
- Implement local area safeguarding information on staff induction (acute team)
- Continue role out of adult safeguarding supervision with appropriate reporting mechanisms.
- Ensure accuracy of the recording of supervision compliance.
- Developing a footprint wide audit programme.
- Working with the Learning and Development team to ensure robust supervision compliance data.
- Continue the roll out of adult safeguarding supervision.

Creating a culture of safety, equality and protection

- HDFT fosters a culture of safer working practices, equality and ensures that everyone has an equal right to protection.

Action required:

- A review of safeguarding information to ensure that it is accessible to all.
- Develop more robust processes in the acute safeguarding team for young people transitioning into adulthood.

Where only partial compliance is demonstrated, an action plan has been developed.

Section B: Data

The following table shows key safeguarding activity across the 0-19 integrated safeguarding team. Where areas are not shown, or data is not available, this is due to the different recording processes in place, as well as identified inaccuracies in batch reports. This is being addressed through relevant work streams.

	Stockton	NY	Middlebro	Durham	Darlingtn	Gatesh'd	Wakefield	Northumb'land	Cumberland/Westmorland
Children on a CP plan	276	311	399	576	N/A	214	N/A	N/A	495
Safeguarding referrals made by 0-19 teams	59	46	99	181	N/A		74	359	N/A
Reviews: **- Rapid review** **-Learning reviews** **-DHR/DARDR** **-CSPRs**	1 2	6 1	2 3	3 4 1	2 2	2 3	2 3	1	 1 21
Strategy meetings	883	2916	1431	2535	505	N/A	N/A	1452	N/A
MARAC numbers	227	338	716	2035	132	N/A	N/A	N/A	N/A
Prevent referrals	0	0	0	0	0	0	0	0	0
Open actions for HDFT	1	1	0	0	3	1	1		

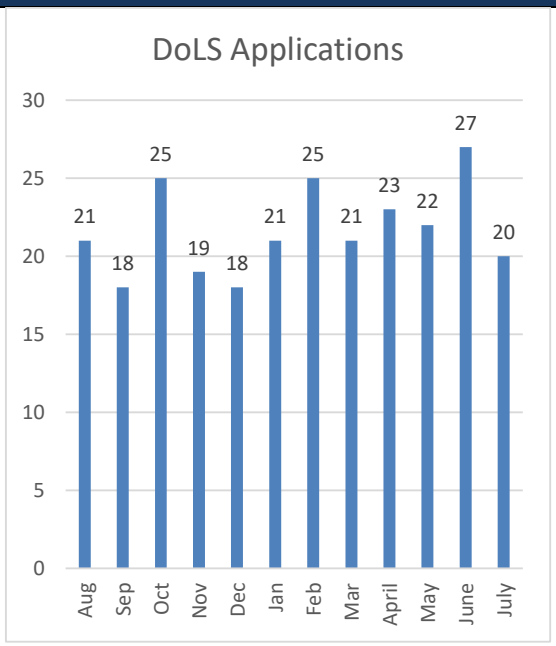
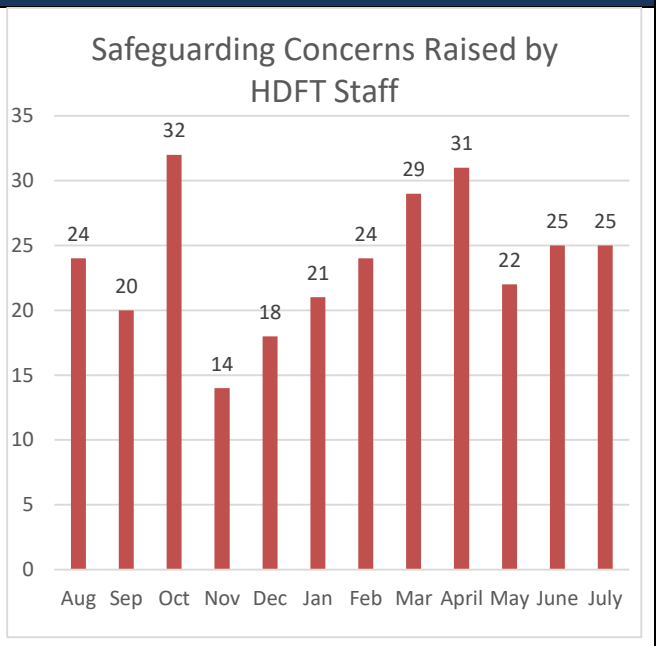
Acute Activity

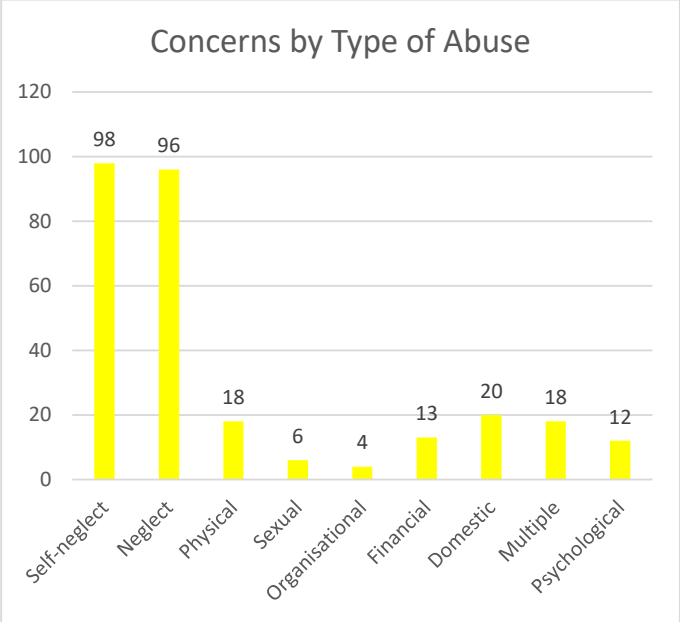
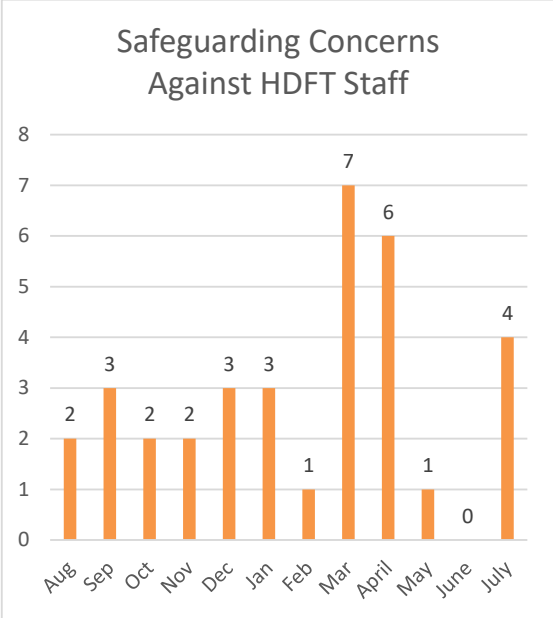
1/ Children

	AUG 2024 – JUL 2025		
NUMBER OF REFERRALS RECEIVED	**272**		
		NUMBER	**PERCENTAGE**
REFERRAL REASON	**CSE / CCE**	**5**	**1.8%**
	DELAYED PRESENTATION	**1**	**0.4%**
	DIED	**0**	**0%**
	DIRECT SELF HARM	**61**	**22.4%**
	FREQUENT ATTENDER / WEB V PLAN TO REFER TO CSCS	**0**	**0%**

	INJURIES TO NON-MOBILE CHILDREN	**3**	**1.1%**
	MENTAL HEALTH	**15**	**5.5%**
	NAI	**4**	**1.5%**
	NEGLECT / SUPERVISION ISSUES	**19**	**7%**
	NO SG CONCERNS / INAPPROPRIATE REFERRAL	**7**	**2.6%**
	PARENTAL BEHAVIOUR	**72**	**26.5%**
	PHYSICAL INJURY	**28**	**10.3%**
	RISKY BEHAVIOUR	**35**	**12.9%**
	SUPPORT	**7**	**2.6%**
	SEXUAL ASSAULT	**1**	**0.4%**
	UNEXPLAINED MOI	**0**	**0%**
	ANY OTHER	**14**	**5.1%**
REFERRAL SOURCE	**ED**	**243**	**89.3%**
	WOODLANDS	**7**	**2.6%**
	SCBU	**1**	**0.4%**
	RIPON MIU	**6**	**2.2%**
	PAEDIATRICIANS	**4**	**1.5%**
	OTHER	**11**	**4%**

Safeguarding Adults data

DoLS Applications Made	Safeguarding Concerns Raised by HDFT Staff
	
Type of data – quality & outcomes To monitor compliance against the Mental Capacity Act 2005	**Type of data** – quality & outcomes To monitor the numbers of safeguarding referrals submitted by HDFT.
Commentary: A total of 260 DoLS applications were made during the reporting period. This compares to 240 applications made during the previous period. The actual number of applications submitted will likely be higher as it is known that copies of applications have not been sent to the HDFT DoLS team. **Highlights: Actions/Outcomes**: • Reminders have been given to staff to send a copy of submitted applications to the HDFT safeguarding team. • Safeguarding adult team now administrate the DoLS process.	**Commentary:** 285 adult safeguarding concerns were submitted by HDFT staff during the reporting period. This compares to 315 applications during the previous reporting period. The actual number of concerns raised will by higher as it is known that staff do not always remember to send copies of concerns to the HDFT safeguarding team. This has been raised as a risk on multiple occasions through safeguarding and directorate governance meetings. **Highlights: Actions/Outcomes**: • Communications with wards and departments around the importance of ensuring the safeguarding team are sent copies of referrals continues.

Breakdown of referrals raised by Trust staff	Safeguarding Concerns Raised Against HDFT
	
Type of data – quality & outcomes This demonstrates that neglect and self-neglect remain the highest types of abuse reported by HDFT. The Adult Safeguarding Team attend the emergency department frequent attenders meeting to ensure safeguarding referrals are submitted where appropriate	**Type of data** – quality & outcomes To investigate and provide assurance following safeguarding referrals raised against HDFT. Safeguarding referrals against HDFT enable shared learning of outcomes and monitoring of any themes.
Commentary: Self-neglect and neglect remain the highest categories of abuse identified by HDFT staff. This is consistent with previous years. The high number of self-neglect referrals is likely to be reflective of the significant work that has gone in to supporting all wards and departments, but particularly ED, to identify, and appropriately respond to, self-neglect concerns following learning from SARs and non-statutory reviews. One of the key operational priorities for the adult safeguarding team for 2025/26 is to strengthen the Trust's response to concerns/disclosures around domestic abuse. **Highlights: Actions/Outcomes**: • Domestic abuse action plan is in place.	**Commentary:** There were 34 safeguarding concerns raised against HDFT in 25/26, raised either by HDFT staff or by other organisations. This is a significant fall from the previous reporting period, when 59 concerns were raised. Numbers will be monitored by the Named Professional – Safeguarding Adults – to ensure that all DATIX where safeguarding concerns are being highlighted are being referred appropriately. The majority of concerns raised are in relation to neglect/acts of omission; and many of these are either pressure ulcers or falls. **Highlights: Actions/Outcomes**: • The safeguarding team are now fully embedded into the PSIRF process. During the reporting period, the Safeguarding Adults Specialist Nurse attended 38 RROSE reviews and 5 After Action Reviews.

Section C: Supporting service users with a Learning Disability / Autism

HDFT has an Acute Liaison Nurse for patients with Learning Disabilities. The post is 0.9 WTE. The post holder sits within the corporate safeguarding team and provides specialist advice and guidance across adult services in addition to providing direct care to service users. Opportunities to increase resilience in the service are being considered.

HDFT also has specialist roles within children`s services providing care and support to children with a learning disability. HDFT does not currently have a dedicated specialist nurse / role for service users with autism. Clinical teams work collaboratively to meet the needs of our service users with a diagnosis of autism and are supported by corporate colleagues within our Patient Experience team as required.

HDFT continue to work alongside colleague across the ICB to deliver the Oliver McGowan Mandatory Training in LD and Autism. This training is being delivered through a three year plan, prioritising key areas, which began in April 2025. York Teaching Hospitals NHSFT has been commissioned to act as the anchor organisation and is co-delivering the package with experts by experience.

Bespoke training has also been provided to targeted areas including the Emergency Department, Pharmacy, Cardiology and Elderly Medicine. These sessions were delivered in response to reviews, incidents and learning themes identified within the speciality.

The Learning Disability Mortality Review (LeDeR) Steering Group has established a working group to explore the introduction of an ICB wide hospital passport. Learning Disability week was utilised in June to engage with staff around Hospital Passports and seek views on the design and content of the updated document.

HDFT continue to participate in the Learning Disability Improvement Standards benchmarking exercise. The report for year 7 has highlighted some areas where the Trust is performing well, these include, flagging systems, appropriate use of DNACPR, engagement with LeDeR and the provision of reasonable adjustments. Areas for improvement include a restraint policy, the availability of support from LD liaison and board level engagement and service planning with patients with learning disabilities and those who support them.

11 LeDeR notifications were submitted to the ICB during the period – no learning for HDFT was identified.

There were 11 safeguarding concerns raised during the reporting period where the individual had a learning disability.

Section D: Priorities and Next Steps

The Safeguarding Strategic Delivery Plan has been updated for 2025/26, with some priorities carried over from the 24/25 plan, as well as new areas identified. The priorities are as follows:

Governance

1) Continue to embed safeguarding governance arrangements across HDFT.
2) Acute safeguarding operational governance to be developed through the Supporting Vulnerabilities Steering Group
3) Regular reviews of safeguarding risk register to be undertaken.
4) Develop and implement MCA work plan.
5) Develop and implement HDFT Safeguarding Strategy to achieve our ambition to deliver safeguarding excellence
6) Review of / implementation of clear robust safeguarding audit programme.
7) Self-assessment against CQC safeguarding standards and expectations working closely with Quality team
8) Delivery of outcomes of Section 11 Audits / Internal Audit report and other key audits / recommendations for HDFT
9) Successful delivery of Safeguarding work plan across 2025/26 – delivered through Safeguarding Governance arrangements
10) Development and delivery of a robust safeguarding training plan

Leadership

1) Review of / evaluation of current workforce models in line with Safe Staffing leadership arrangements
2) Establish focused work to deliver improvements for service users with learning disabilities and autism
3) Review and provide assurance re compliance with accepted national guidance on staff training, skills and competencies in line with their role
4) Review of induction / preceptorship programmes for all staff working in safeguarding roles
5) Provide safeguarding leadership to newly transferred Ripon GP practice.

Policies/Procedures and Processes:

1) Develop an MCA improvement plan following initial scoping, drawing on findings from DoLS audit.
2) Implement e-rostering system Trust wide for safeguarding teams to ensure a safe and effective use of resources across the footprint.
3) Review current recording standards to ensure they are consistent across the HDFT footprint and are in line with national guidelines.
4) Implement actions arising out of NY JTAI, with the focus on A&E (routine enquiry; the voice of the child and professional curiosity)
5) Develop Trust wide Female Genital Mutilation (FGM) policy.
6) Continue to embed the Learning and Improvement framework.
7) Continue to embed PiPoT/LADO processes across the Trust following dissemination of the revised *Managing Allegations* policy.

Data:

1) Develop the use of Power BI across safeguarding teams so that consistent, reliable data is provided.
2) Acute safeguarding team to continue to work with Nervecentre project leads to ensure safeguarding requirements are met.
3) Work with Learning and Development to develop a solution to supervision recording.

Summary and Conclusion

This report has provided an overview of HDFT safeguarding work, including detailed activity and information with regard to focused improvement work across 2024/25, up to July 2025. The report has highlighted areas of good practice and has updated on areas previously requiring development, in addition to new areas of focus. Through ongoing emphasis on robust leadership and embedding governance processes, progress continues towards safeguarding excellence.

Additional Appendices

Appendix 1 - Safeguarding Corporate Structure	HDFT Corporate Safeguarding Structur
Appendix 2 - Governance Structure	Safeguarding Annual Report Governance In
Appendix 3 - Learning and Improvement Framework	Safeguarding Practice Review Qualit
Appendix 4 - Case Studies	CIC Case Study Annual Report.docx

References

Safeguarding Accountability and Assurance Framework (2024)
Version 4. NHS England
https://www.england.nhs.uk

Working Together to Safeguard Children (2023)
A guide to multi-agency working to help, protect and promote the welfare of children
HM Government

Morrison T (2005)
Staff Supervision in Social Care: Making a Real Difference to Staff and Service Users
(3rd Edition). Pavilion, Brighton.

Board of Directors Meeting Held in Public

26 November 2025

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

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

	Adult Inpatient Wards PSCC: The SNCT outputs (data, quality metrics and professional judgement) indicate no changes to the current budgeted establishment as a result of this review. LTUCC: The SNCT outputs (data, quality metrics and professional judgement) indicate no changes to the current budgeted establishment as a result of this review. **Emergency Department** The SNCT review has given us assurance that the Emergency Department, establishment and skill mix, achieves optimal safe staffing requirements. **C&YP (Woodlands Ward)** The SNCT outputs (data, quality metrics and professional judgement) indicates that there is more work required within the Directorate to understand the Children's Assessment Unit (CAU) requirements. The staffing of this area relies on the ward bed occupancy, to be lower, to allow the workforce to provide care in the CAU patients. The next bi-annual safer staffing review will be undertaken in March 2026 for ED, the Adult and C&YP inpatient wards.

Freedom of Information:	

SAFER STAFFING REPORT NOVEMBER 2025

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

Brenda McKenzie: Workforce Lead

Harrogate and District NHS Foundation Trust

Contents

Harrogate and District NHS Foundation Trust

4.1

Safer Nursing Care Tool (SNCT) Adult Inpatient Wards

Date of SNCT data collection: June 2025

SNCT review meetings: July/August 2025

Author: Brenda Mckenzie (Workforce Lead)

Situation

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

HDFT undertook its bi annual safer staffing review using the evidence based, licenced Safer Nursing Care Tool (SNCT) during the month of June 2025.

Background

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

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

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

• minimising avoidable harm

• maximising the value of available resources

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

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

Enhanced Care relates to; *patients who require an increased level of care to prevent them harming themselves, others or absconding.* NHSE together with the Shelford Group, have made adaptations to the SNCT tool to incorporate levels of dependency for Enhanced Care within our inpatient wards. These new levels of care will breakdown the 'Enhanced Care' requirements, which will enable us to better monitor and manage how we care for these patients.

Following a business case, investment was made to align the workforce requirements to the outputs of the SNCT in April 2023 and recruitment in to these additional registered nurse vacancies was extremely successful with many wards now recruiting to turnover. This new establishment aligns HDFT to a 60/40 skill mix ratio and has increased our Care Hours Per Patient Day (CHPPD) to above the national average, for peer hospitals, when compared on Model Hospital.

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

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

Assessment

The SNCT recommendation is to review the required staffing establishment for each ward bi annually at differing periods/times of the year. A detailed description of each ward and specific staffing, agency and quality indicators were available at the review meetings. As recommended by the SNCT; data collected must be triangulated with quality indicators and professional judgement before any changes to establishments are agreed.

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

The discussions have been found to be useful in identifying support roles that enhance patient care and improve the working lives of each team. Mainly, Nutritional Assistant roles and Ward Clerk hours. Complaints and concerns in relation to poor hydration and nutrition have reduced. Some inatient wards have highlighted the need for their Ward Clerk hours to be reviewed to meet the needs of the patients and staff. These administration requirements are being reviewed alongside the implementation of NERVE centre (the trusts new electronic patient record) to understand the impact on administrative workload and predicted future requirements.

Acuity and dependency data was provided via the ward managers and all other supportive data was provided by analytics, sitereps, Tendable, finance, electronic roster, NHS Professionals (temporary workforce provider) and Electronic Staff Record (ESR).

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

Headroom for each ward is calculated at an overall 25.76% with the following breakdown:

- 14.96% Annual leave
- 1.92% Study leave
- 3.9% Sickness.
- 4.98% Compound adjustment

Maternity leave is backfilled using a ‘Maternity’ cover fund and is allocated/moved by finance to ensure that recruitment is funded ‘like for like’ without cost pressure.

On a daily basis. any enhanced care requirements or unfilled shifts should be reviewed as part of the new safer staffing meetings using SafeCare. This is a safer staffing tool which measures the actual acuity and dependency of the patients on each ward against the availability of staff to ensure that we are deploying the right staff with the right skills at the right place and time. Once the acuity and dependency levels have been peer reviewed by the Matron, the appropriate therapeutic interventions and mitigations are considered and were possible implemented in line with the Safer Staffing Policy.

Harrogate and District NHS Foundation Trust

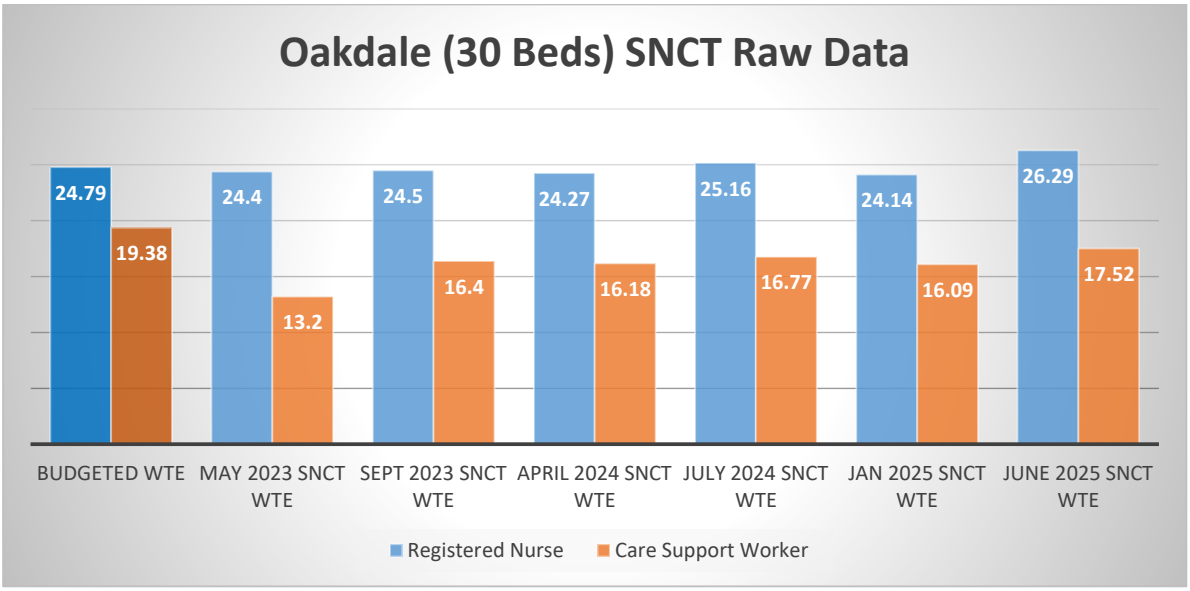
LTUCC Results by Ward

Oakdale

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

SNCT Raw Data

The data in the table below includes Enhanced Care, levels of care and is based on a full bed occupancy



The current staffing template for Oakdale:

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

Budgeted Skill Mix

Band	WTE
7	1.0
6	4.0
5	19.79
3	17.98

2 Nutritional Assistant	1.4
2 Ward Clerk	1.0

Discussions and data pack

See appendix 1

Recommendations

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

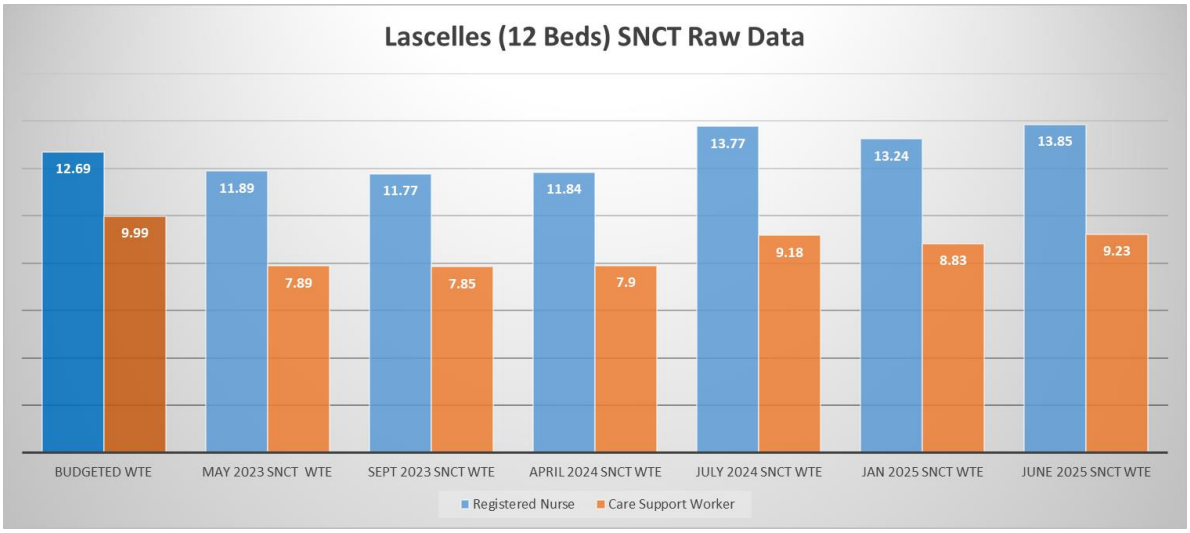
Continue to collect twice yearly SNCT data, using the new levels of care SNCT tool. The next data collection will be in March 2026.

Lascelles

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

SNCT Raw Data

The data in the table below includes Enhanced Care, levels of care and is based on a full bed occupancy.



The current staffing template for Lascelles:

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

Budgeted Skill Mix

Band	WTE
7	1
6	2
5	9.69
3	8.59
2 Nutritional Assistant	1.4
2 Ward Clerk	0.93

Discussion and data pack

See appendix 2

Recommendations

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

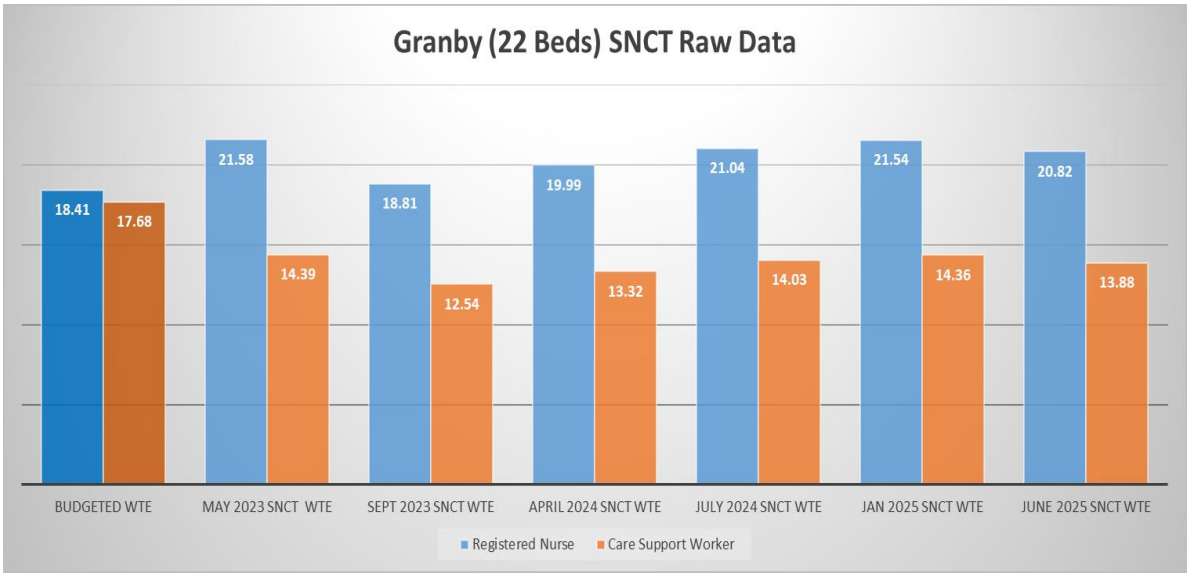
Continue to collect twice yearly SNCT data, using the new levels of care SNCT tool. The next data collection will be in March 2026

Granby

Granby is a 22 bedded Stroke & Neurology ward.

SNCT Raw Data

The data in the table below includes Enhanced Care, levels of care and is based on a full bed occupancy.



The current staffing template for Granby:

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

Budgeted Skill Mix

Band	WTE
7	1.0
6	3.70
5	12.91
3	16.28
2 Nutritional Assistant	1.4
4 Ward Clerk	0.73
2 ward Clerk	1.07
7 Specialist Nurse	0.8

Discussion and data pack

See appendix 3

Recommendations

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

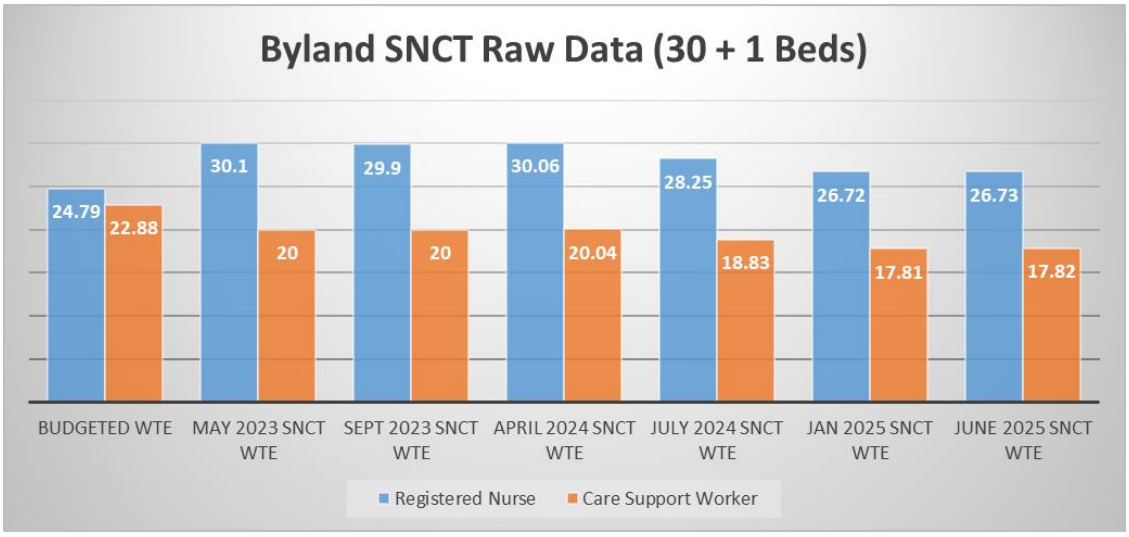
Continue to collect twice yearly SNCT data, using the new levels of care SNCT tool. The next data collection will be in March 2026

Byland

Byland is a 30 bedded Frailty ward with one escalation bed.

SNCT Raw Data

The data in the table below includes Enhanced Care, levels of care and is based on a full bed occupancy.



The current staffing template for Byland:

	Early	Late	LD	Night
RN	1	1	4	4
CSW Band 2	1	1	3	4
MD	22.5 hours (0.6 WTE)			
Nutritional Assistant	45 hours (1.4 WTE)			

Budgeted Skill Mix

Band	WTE
7	1.0
6	4.0
5	19.79
3	21.48
2 Nutritional Assistant	1.4
2 Ward Clerk	0.6

Discussion and data pack

See appendix 4

Recommendations

The outputs of the last SNCT data collection saw the increase in 1 CSW on a night shift.

The SNCT outputs from June (data, quality metrics and professional judgement) **indicate an accurate nursing establishment.** No further changes required.

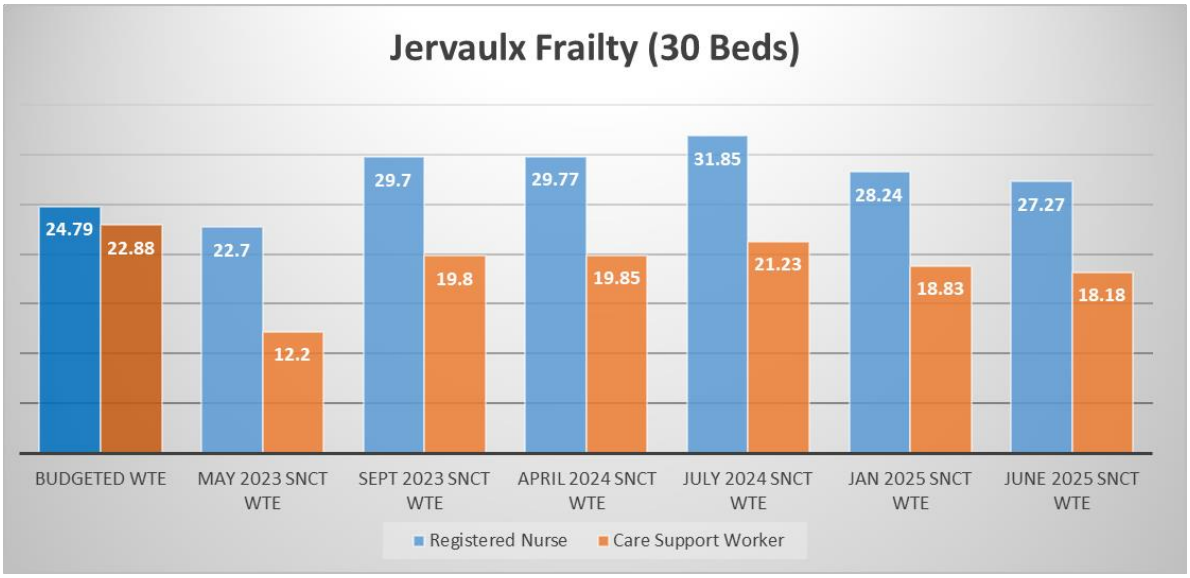
Continue to collect twice yearly SNCT data, using the new levels of care SNCT tool. The next data collection will be in March 2026

Jervaulx

Jervaulx is a 30 bedded Frailty ward.

SNCT Raw Data

The data in the table below includes Enhanced Care, levels of care and is based on a full bed occupancy. The July 2024 data was peer reviewed as inaccurate and therefore excluded from the review process.



The current staffing template for Jervaulx:

	Early	Late	LD	Night
RN	1	1	4	4
CSW Band 2	1	1	3	4
MD	22.5 hours (0.6 WTE)			
Nutritional Assistant	45 hours (1.4 WTE)			

Budgeted Skill Mix

Band	WTE
7	1.0
6	4.0
5	19.79
3	21.48
2 Nutritional Assistant	1.4
2 Ward Clerk	1.0

Discussion and data pack

See appendix 5

Recommendations

The outputs of the last SNCT data collection saw the increase in 1 CSW on a night shift.

The SNCT outputs from June (data, quality metrics and professional judgement) **indicate an accurate nursing establishment.** No further changes required.

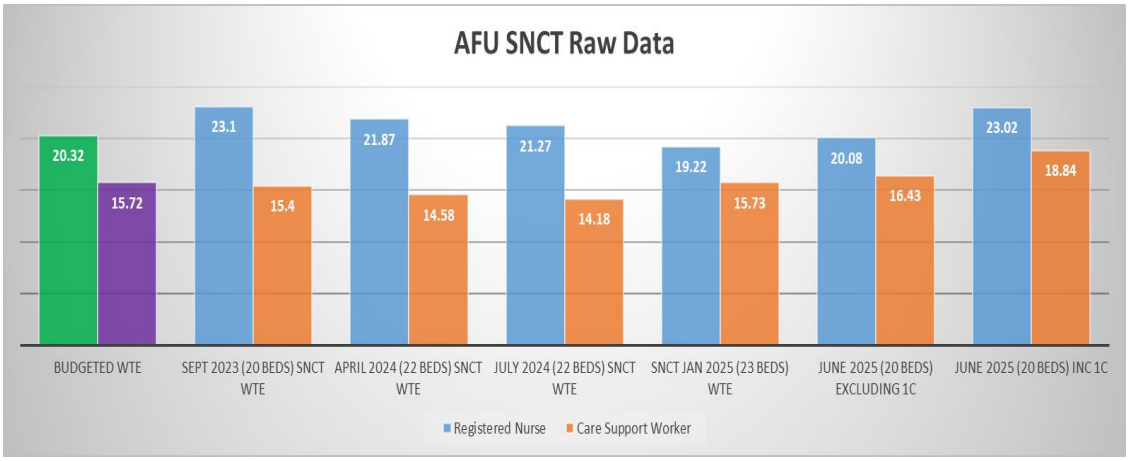
Continue to collect twice yearly SNCT data, using the new levels of care SNCT tool. The next data collection will be in March 2026

Acute Frailty Unit (AFU)

AFU is an 18 Frailty Admissions Ward with 2 assessment beds. However, due to the demand on Frailty beds the ward opens escalation beds (up to 23).

SNCT Raw Data

The data in the table below includes Enhanced Care, levels of care and is based on a full bed occupancy.



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

	Early	Late	LD	Night
RN	1	1	3	3
CSW Band 2	0	1	2	2
CSW Band 3	1	0	0	0
MD	22.5 hours (0.6 WTE)			
Nutritional Assistant	45 hours (1.4 WTE)			

Budgeted Skill Mix

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

Discussion and data pack

See appendix 6

Recommendations

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

There is ongoing review of the skill mix requirements on this Frailty admissions ward. This is to be picked back up at the next SNCT review meeting to determine if an increase in Band 6 workforce is required to provide 24/7 cover.

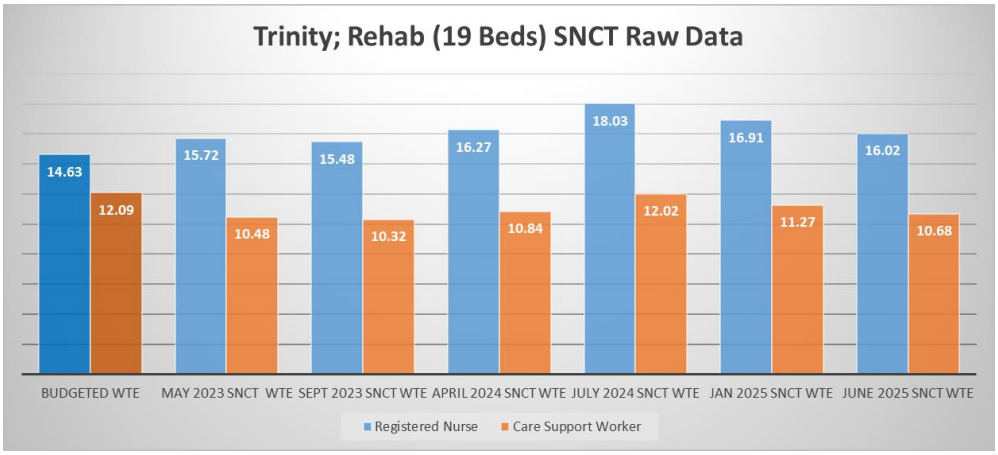
Continue to collect twice yearly SNCT data, using the new levels of care SNCT tool. The next data collection will be in March 2026

Trinity

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

SNCT Raw Data

The data in the table below includes Enhanced Care, levels of care and is based on a full bed occupancy. The July 2024 data was peer reviewed as inaccurate and therefore excluded from the review process.



The current staffing template for Trinity

	Early	Late	LD	Night
RN	1	1	2	2
CSW Band 2	1	0	2	2
RN	**Additional Early RN every Wednesday (MDT)**			
Management Time	**22.5 hours (0.6 WTE)**			

Budgeted Skill Mix

Band	WTE
7	1.0
6	2.64
5	10.99
3	12.09
2 Nutritional Assistant	0.0
2 Ward Clerk	1.92

Discussion

See appendix 7

Recommendations

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

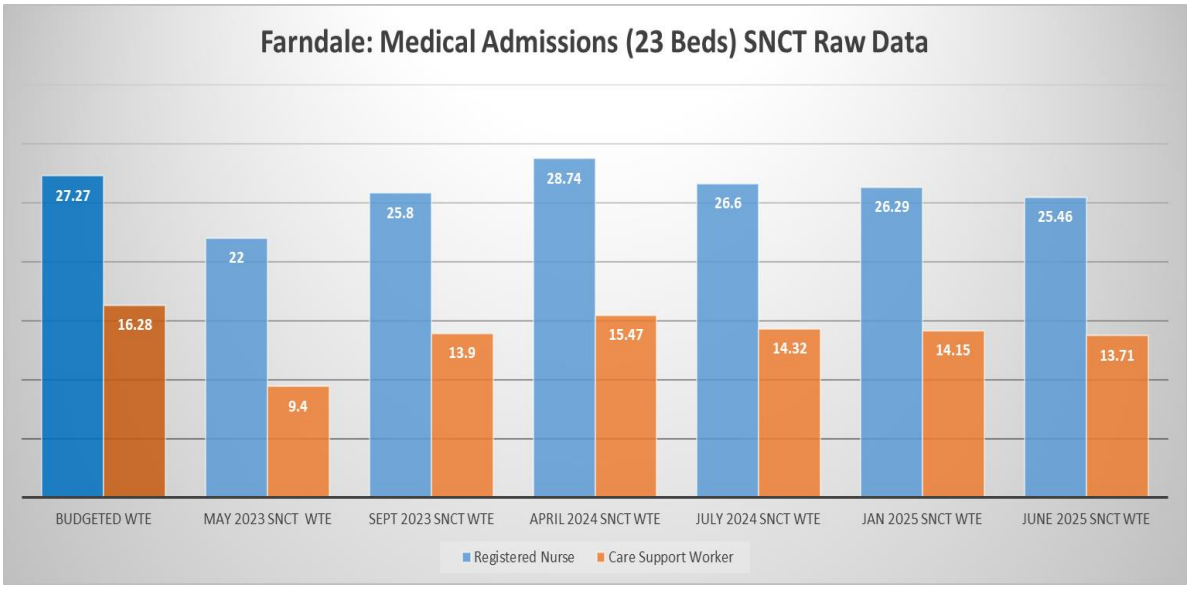
Continue to collect twice yearly SNCT data, using the new levels of care SNCT tool. The next data collection will be in March 2026.

Farndale

Farndale is a 23 bedded Medical Admissions ward.

SNCT Raw Data

The data in the table below includes Enhanced Care, levels of care and is based on a full bed occupancy.



The current staffing template for Farndale:

	Early	Late	LD	Night
RN	1	1	4	5
CSW Band 2	1	1	2	3
Nutritional Assistant	**1.4 WTE**			
Management Time	**2.07 WTE**			

Budgeted Skill Mix

Band	WTE
7	1.0
6	6.44
5	19.83
3	16.28
2 Nutritional Assistant	1.4
2 Ward Clerk	2.07

Discussion and data pack

See appendix 8

Recommendations

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

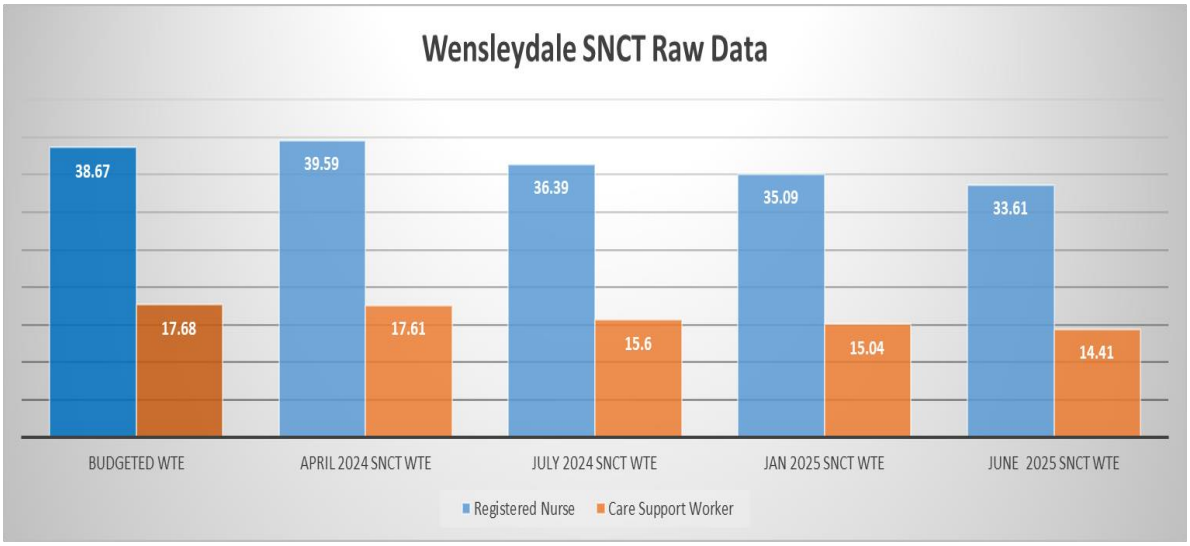
There are plans to move this ward to a different location. When this occurs we have agreed to collect three months of SNCT data in the new environment, to provide assurance that the workforce requirements are accurate or make the necessary changes.

Wensleydale

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

SNCT Raw Data

The data in the table below includes Enhanced Care, levels of care and is based on a full bed occupancy.



The current staffing template for Wensleydale:

	Early	Late	LD	Night
RN	1	1	6	7
CSW Band 2	1	1	2	3
Nutritional Assistant	**1.4 WTE**			
Management Time	**0.6 WTE**			

Budgeted Skill Mix

Band	WTE
7	1
6	12.51
5	25.16
3	16.28
2 Nutritional Assistant	1.4
2 Ward Clerk	1.4

Discussion

See appendix 9

Recommendations

The SNCT outputs from June (data, quality metrics and professional judgement) **indicate an that Wensleydale have optimal workforce and skill mix.**

When 3 MECU beds open on Littondale, the new Medical Admission Unit, Wensleydale will reduce by one RN on a night shift and the budget will be moved to Littondale.

Continue to collect twice yearly SNCT data, using the new levels of care SNCT tool. The next data collection will be in March 2026.

LTUCC Summary and Overall Requirements

There were minor changes made to the establishments from the last SNCT review, which were funded using the Early/Late factors that were no longer required. This SNCT review has seen a stabilisation of our requirements within LTUCC and no workforce changes have been recommended from this review. The next SNCT review will commence in March 2026.

Ward	Reductions	Increases
Oakdale	No Reductions	No Increases
Granby	No Reductions	No Increases
Farndale	No Reductions	No Increases
Wensleydale	No Reductions	No Increases
Byland	No Reductions	No Increases
Jervaulx	No Reductions	No Increases
Acute Frailty Unit	No Reductions	No Increases
Trinity	No Reductions	No Increases
Lascelles	No Reductions	No Increases

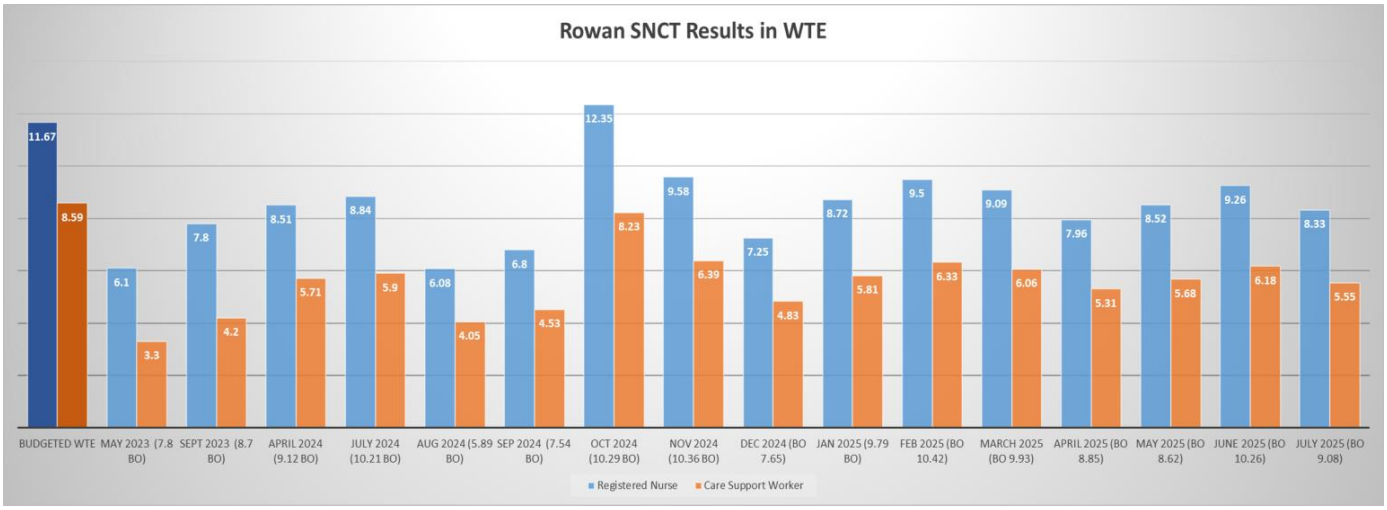
PSCC Results by Ward

Rowan

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

SNCT Raw Data

The data in the table below includes Enhanced Care, levels of care.



The current staffing template for Rowan:

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

Budgeted Skill Mix

Band	WTE
7	1.0
6	3.0

5	7.67
3	8.59
2 Nutritional Assistant	0
2 Ward Clerk	1.19

Discussion

See appendix 10

Recommendations

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

It was agreed that Rowan would not recruit in to the remaining 2 WTE care support worker positions until activity increases. However, the budget and staffing template would remain the same.

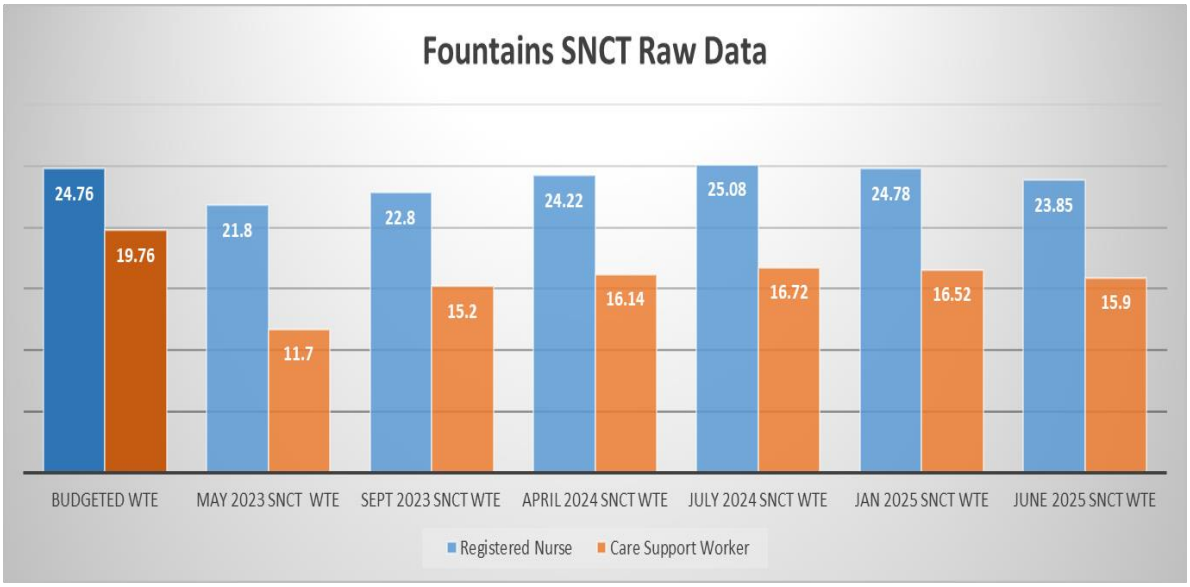
Continue to collect continuous SNCT data, using the new levels of care SNCT tool. The next review of this data will be in March 2026.

Fountains

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

SNCT Raw Data

The data in the table below includes Enhanced Care, levels of care and is based on a full bed occupancy.



The current staffing template for Fountains:

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

Budgeted Skill Mix

Band	WTE
7	1.0
6	3.0
5	20.76
3 Patient Liaison	1.0
3 CSW	0.0
2	17.76
2 Nutritional Assistant	1.0
2 Ward Clerk	1.0

Discussion and data pack

See appendix 11

Recommendations

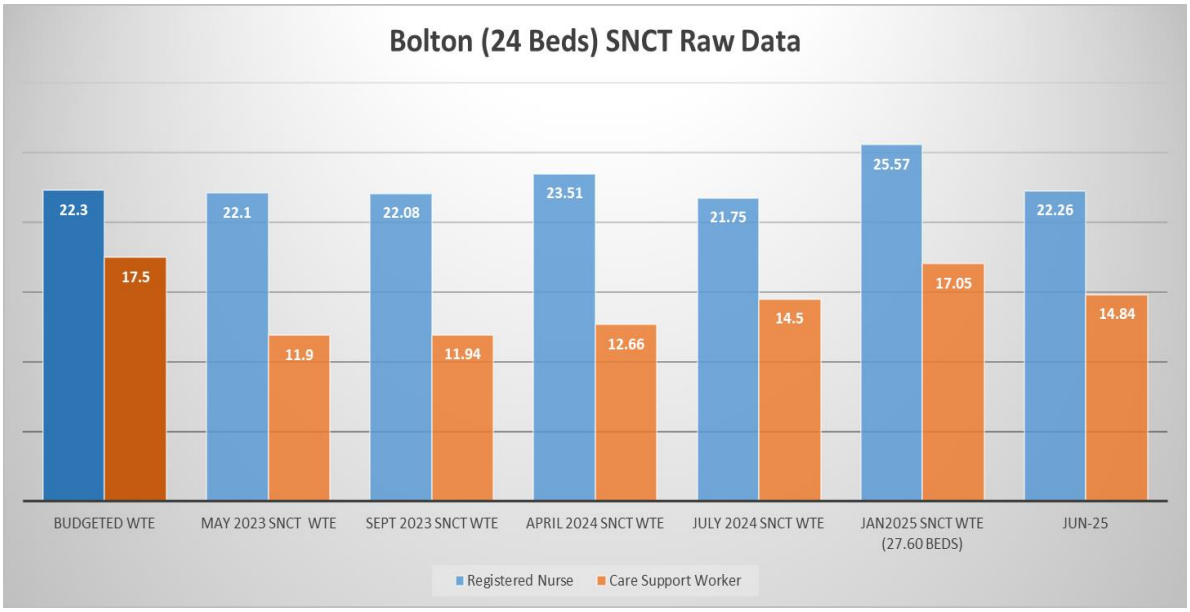
The SNCT data and triangulation **supports the current funded nursing establishment and skill mix.**

Continue to collect bi annual SNCT data, using the new levels of care SNCT tool. The next data collection will be in March 2026.

Bolton (was Littondale)

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

The data in the table below includes Enhanced Care, levels of care and is based on a full bed occupancy.



The current staffing template for Bolton.

This staffing model is for the 24 beds and the 8 beds in the Surgical Assessment Unit:

	Early	Late	Night
RN	**5**	**5**	**3**
CSW	**4**	**4**	**2**
Nutritional Assistant	**7 days 1.0 WTE**		
MD	**22.5 hours (0.6 WTE)**		

Budgeted Skill Mix

Band	WTE
7	1.0
6	3.15
5	18.15
3 CSW	5.2

2	11.3
2 Nutritional Assistant	1.0
2 Ward Clerk	1.0

Discussion and data pack

See appendix 12

Recommendations

The SNCT data and triangulation **supports the current funded nursing establishment and skill mix** for the inpatient beds. The Surgical Assessment Unit, is starting to increase in activity. The Matron for this ward will collect activity data to review at the next SNCT review meeting. Additionally it was decided that The Bolton team will collect SNCT acuity and dependency data in November in addition to the standard bi annual SNCT data collection, due in March 2026.

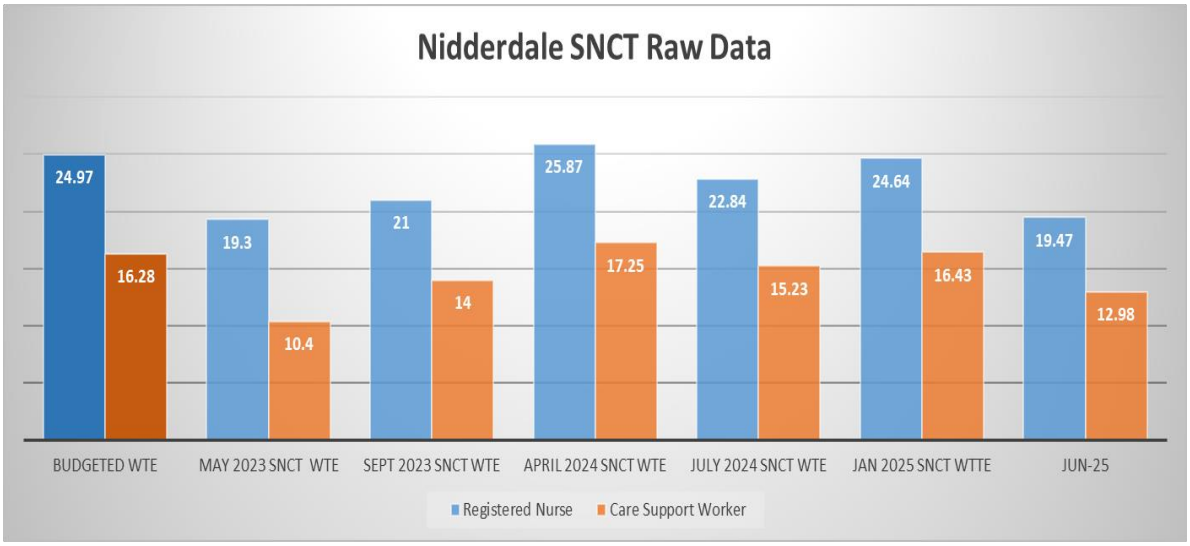
It was acknowledged that additional staffing would be required on Bolton if there were any 1c Enhanced Care requirements on a night, as CSW staffing drops to 2 on a night. This CSW establishment was previously 3; however, the requirement was moved to Littondale in 2024 following a staffing review and EQIA panel.

Monthly planned vs actual data will reviewed at the next SNCT review meeting to assist with ensuring accurate establishment requirements.

Nidderdale

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

The data in the table below includes Enhanced Care, levels of care and is based on a full bed occupancy.



The current staffing template for Nidderdale:

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

Budgeted Skill Mix

Band	WTE
7	1.0
6	4.0
5	19.79
3	0.0
2	16.28
2 Nutritional Assistant	1.0
2 Ward Clerk	1.0

Discussion

See appendix 13

Recommendations

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

Continue to collect twice yearly SNCT data, using the new levels of care SNCT tool. The next data collection will be in March 2026.

PSCC Summary and Overall Requirements

No workforce changes are required to the PSCC ward establishments from the outputs of this bi-annual SNCT review.

Ward	Reductions	Increases
Rowan	No Reductions	No Increases
Fountains	No Reductions	No Increases
Bolton	No Reductions	No Increases
Nidderdale	No Reductions	No Increases

Emergency Department

Background

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

The latest SNCT data collection took place in May 2025 with triangulation of the results with quality data and professional judgement in July/August 2025.

Department Description

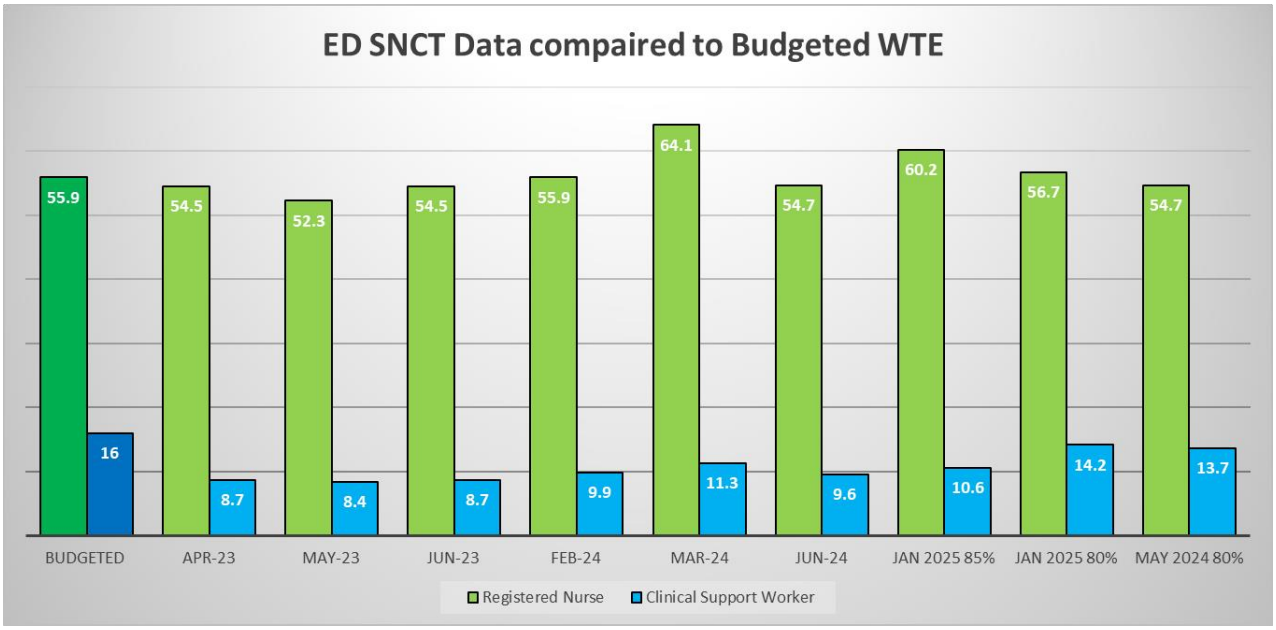
The Emergency Department (ED) is open 24 hours a day, 7 days a week delivering unscheduled care for acutely ill/injured adults and children. The department consists of two areas (ED1 and ED2). ED1 manages those patients presenting with major medical conditions, ED2 manages patients presenting with Minor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

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

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

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

SNCT Raw Data



The current staffing template for the Emergency Department:

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

Budgeted Skill Mix

SUMMARY BY BAND - ED Roster NOTES	Bavnd	Mgt Day Total Hours per week	Nursing shifts					WTE establishment requirement	*WTE Sickness backfill*
			Early	Late	Long Day	Twilight	Night		
Includes Childrens and Young Peoples Lead Nurse Time	B7 Management	45						2.00	-
	B7 Clinical				1		1	5.20	*0.20*
	B6 Clinical		1	1	1		2	11.19	*0.43*
	B6 Practice Educator							1.60	-
	B5 Clinical		2	2	4	1	7	37.23	*1.49*
	B3 CSW		1	1	2	0	3	16.00	*0.63*
							TOTAL	**73.22**	**2.75**

Recruitment and Vacancies

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

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

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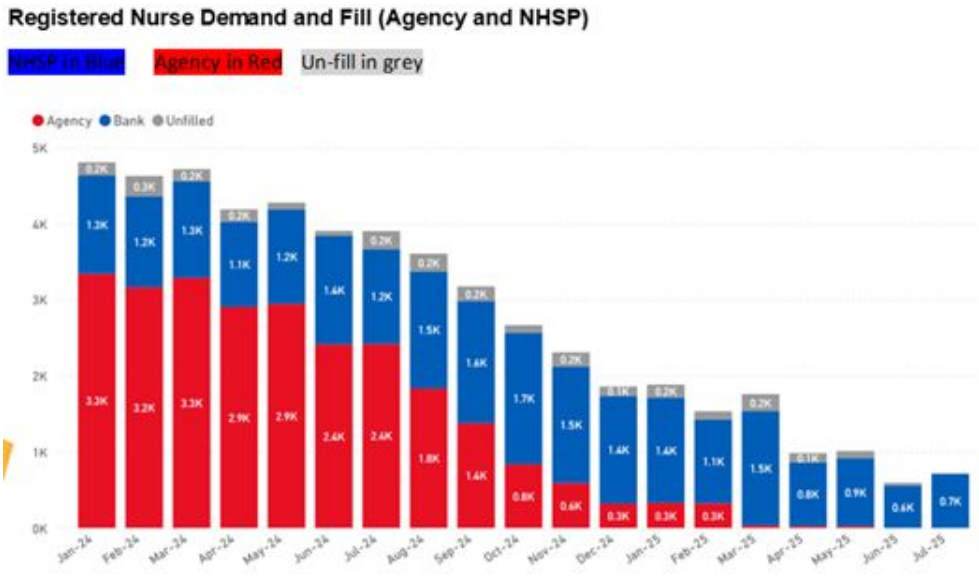
4.1

Temporary Workforce

Temporary workforce dependency is reducing month on month. In addition reliance on agency staff has reduced to a zero use position.



Discussion, Quality and Performance Data

See appendix 14

Recommendations

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

The change in shift patterns that were made since the last SNCT data collection need further data and review to provide assurance that optimal use of the workforce establishment is being used. Therefore it has been agreed that ED will collect an additional 12 days data in preparation for the next SNCT review meeting.

It was discussed that the Matron would organise to shadow one of the CSW's to review if support staff could work differently to improve efficiency. Additionally, the Matron should link with other NHS Organisations to see how they manage pressures within the CSW workforce. Are we assigning appropriate tasks to the CSW's?

ED should continue to ensure effective rostering to meet the Key Performance Indicators and workforce model outlined in the Business Case.

Farndale will be going to Littondale; an increase of 9 beds. This should make the situation more manageable in ED, especially over the coming winter.

Continue to keep on top of recruitment to vacancies.

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4.1

Children and Young People; Woodlands Ward

Background

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

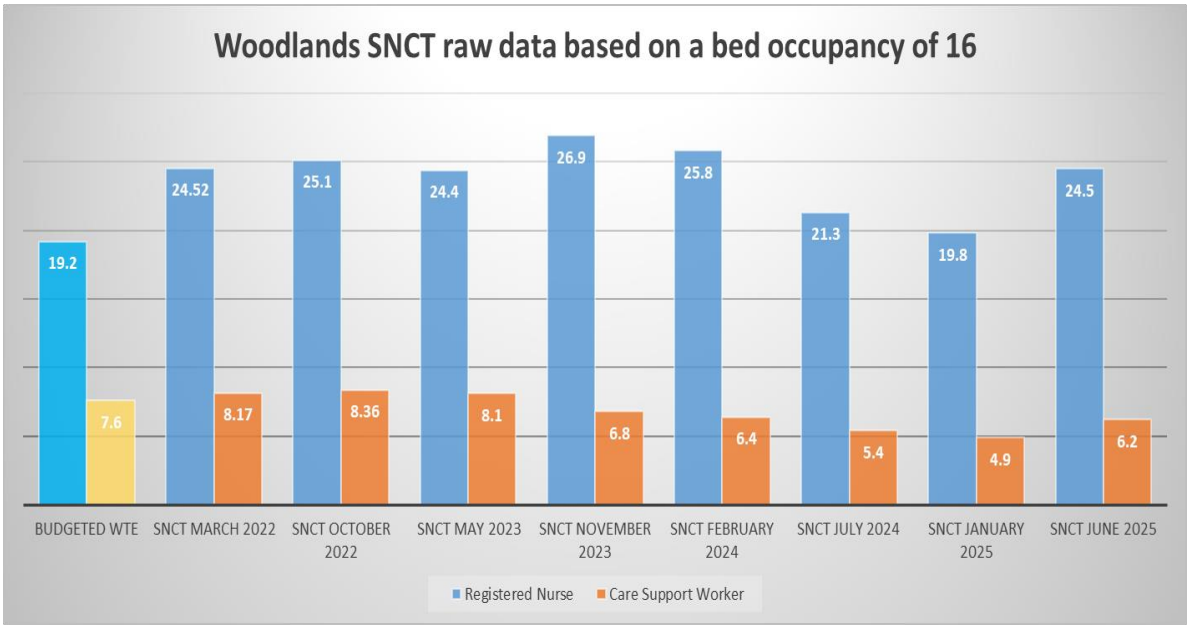
Data was collected in June 2025 with triangulation of the results with quality data and professional judgement in September 2025.

Ward Description

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

SNCT Raw Data

The data in the table below is based on a full bed occupancy.



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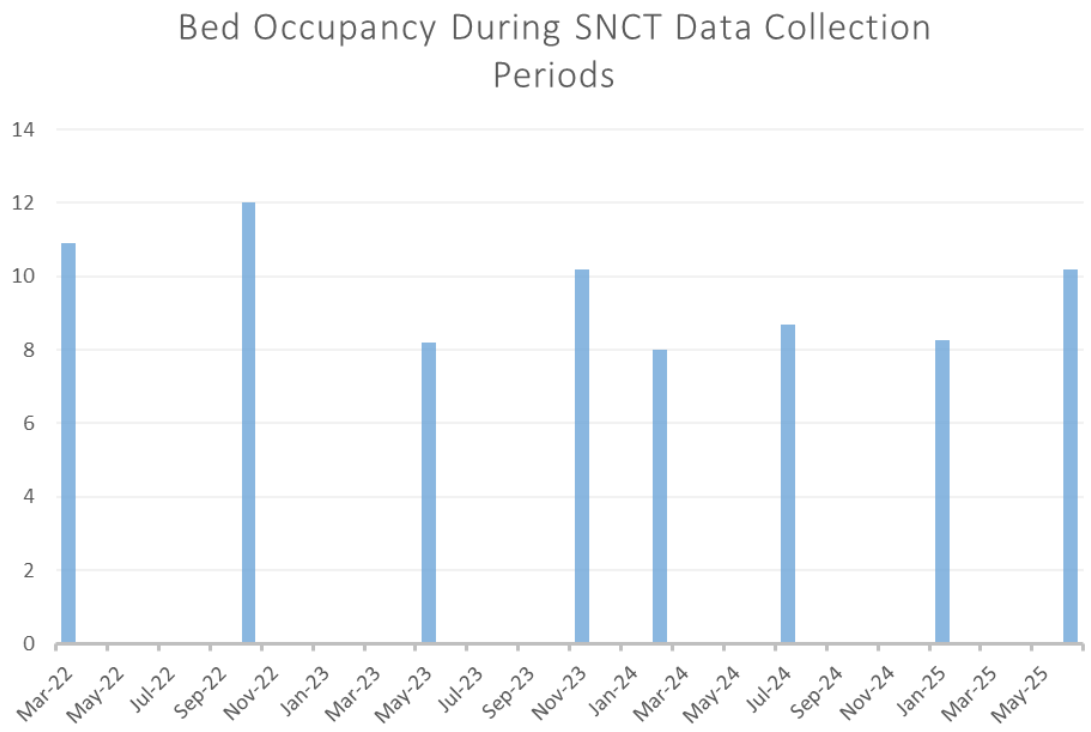
Actual Bed Occupancy During the SNCT Data Collections

Month/Year	Bed Occupancy
Mar-22	10.9
Oct-22	12
May-23	8.2
Nov-23	10.2
Feb-24	8
Jul-24	8.7
Jan-25	8.25
Jun-25	10.2



The current staffing template for Woodlands

Play Specialist	1.0 wte
Practice Education	0.6 wte
Admin	1.0 wte
Management Time	0.8 wte (0.6 funded)

Monday to Friday

	Early	Late	Night
RN	4	3	3
CSW	1	1	1

Saturday to Sunday

	Early	Late	Night
RN	3	3	3
CSW	1	1	1

Budgeted Skill Mix

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

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

Discussion

See appendix 15

Recommendations

The SNCT outputs (data, quality metrics and professional judgement) indicate an accurate nursing establishment for the current Woodlands Inpatient Ward requirements and that no changes are proposed as a result of this review. However, there is more work required within the Directorate to understand the CAU requirements. The staffing of this area relies on the ward bed occupancy, to be lower, to allow the workforce to provide care to the CAU patients. Therefore, we do not have assurance that the workforce model accurately reflects

this additional workload. Any unmitigated ‘Red’ shifts should be escalated to the Director of Nursing, Midwifery and AHP’s in line with the Safer Staffing policy.

Continue to collect bi annual SNCT data, using the SNCT tool. The next data collection will be in March 2026.

Ensure effective rostering to meet the Key Performance Indicators.

Directorate Quad should to continue working on the CAU ‘paper’ development. Acknowledgement that there is a need to increase medical staffing.

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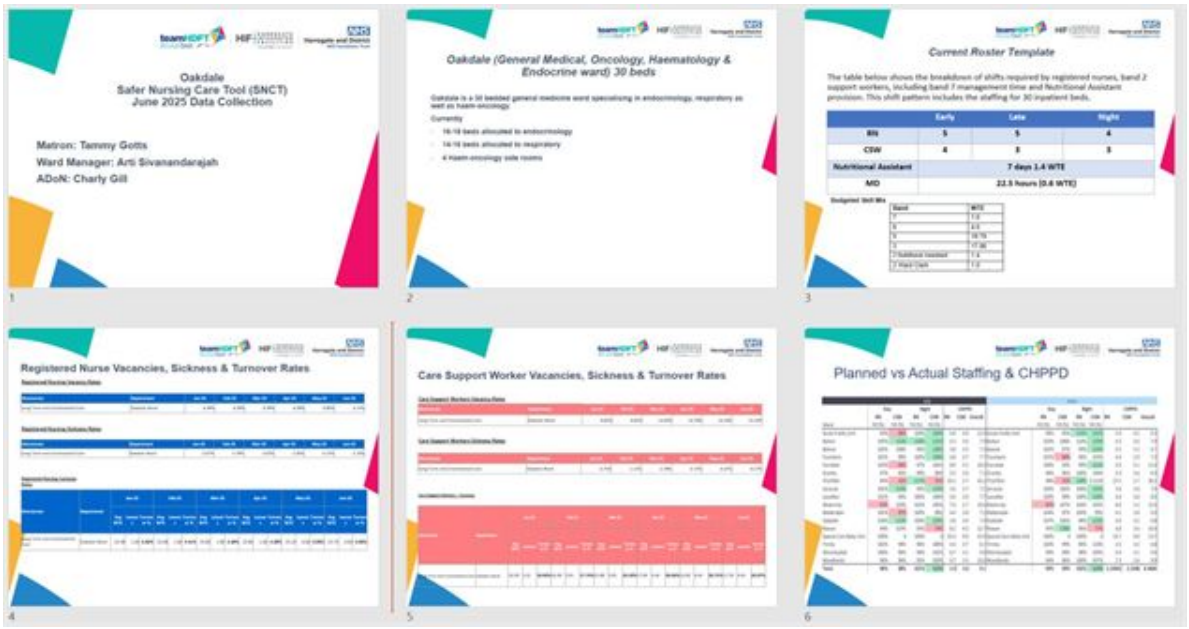
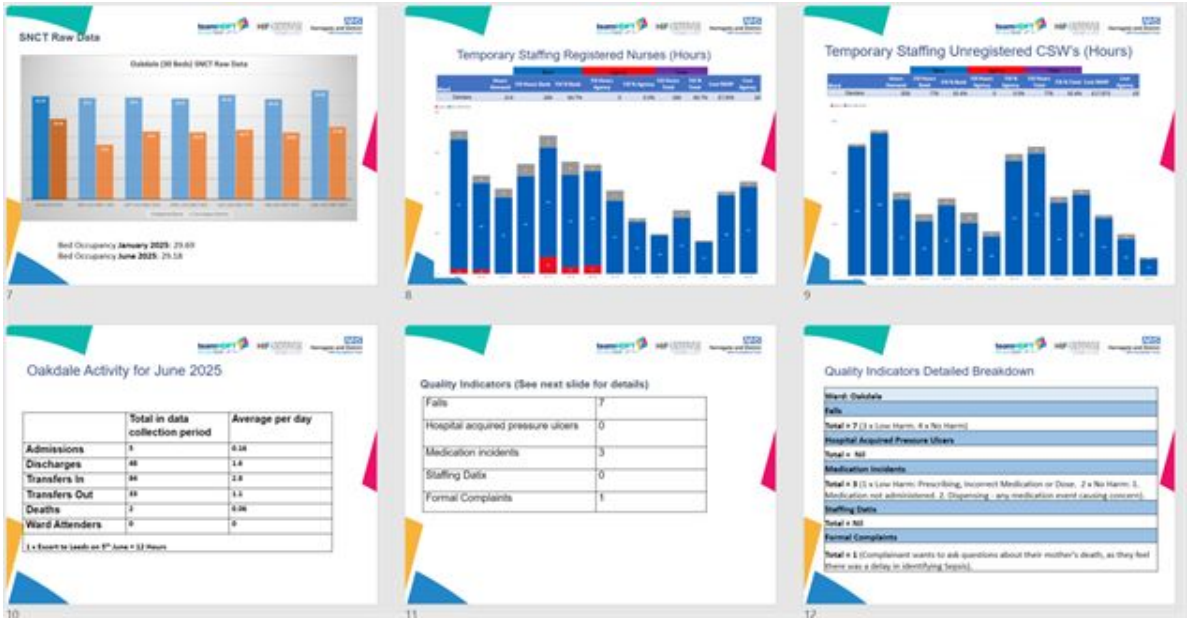
Appendix 1





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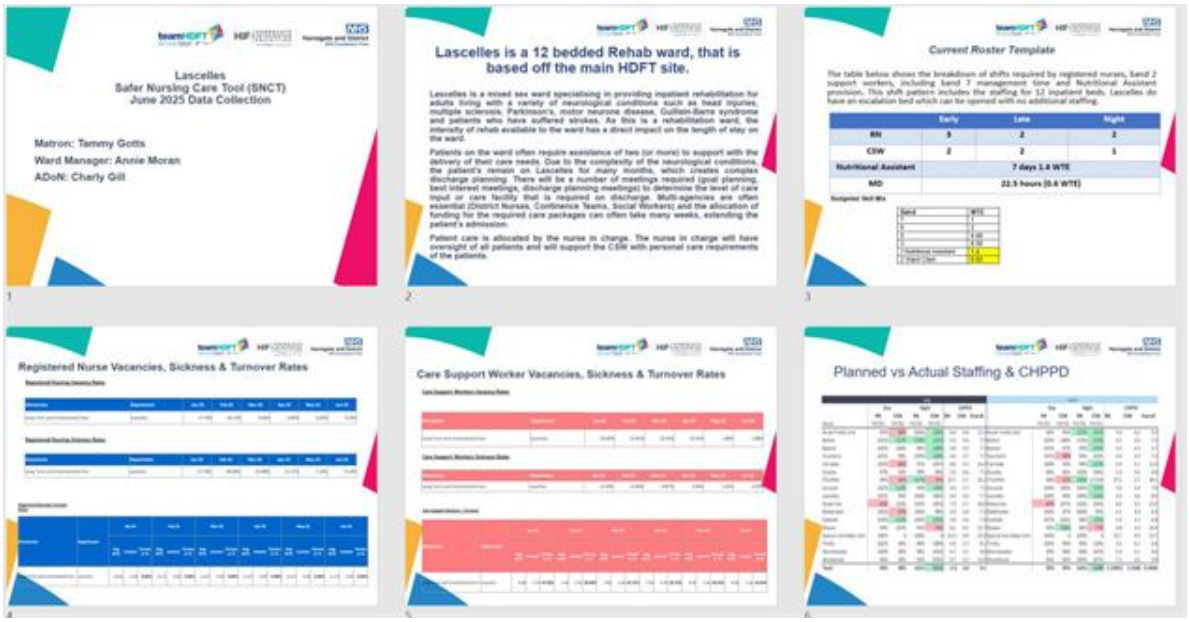
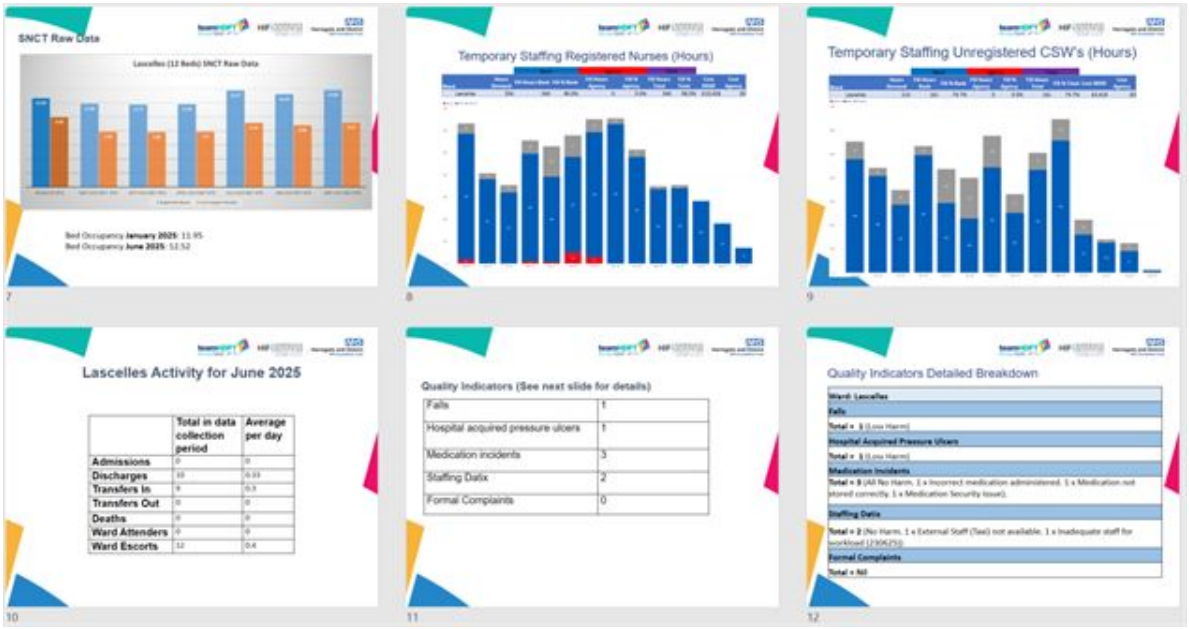
Appendix 2





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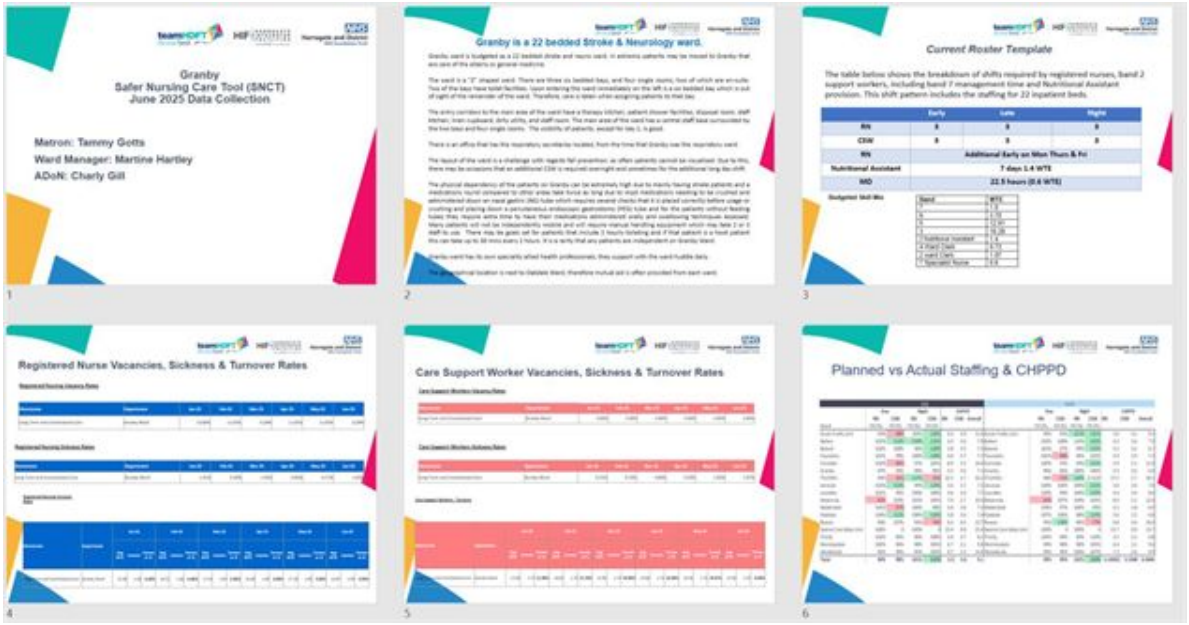
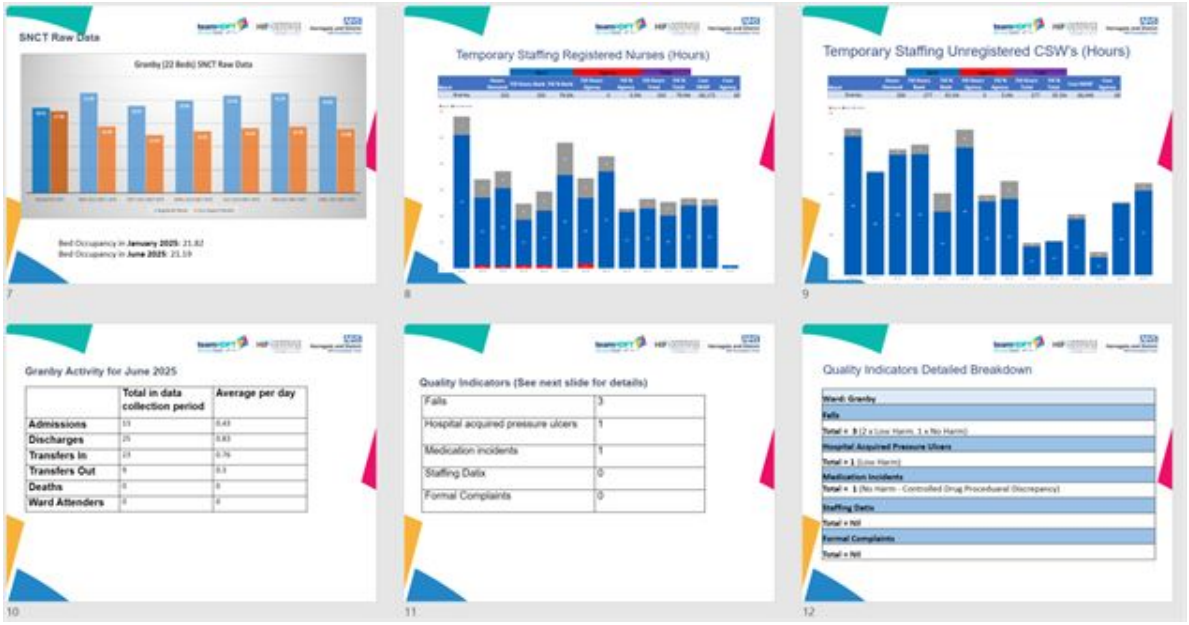
Appendix 3





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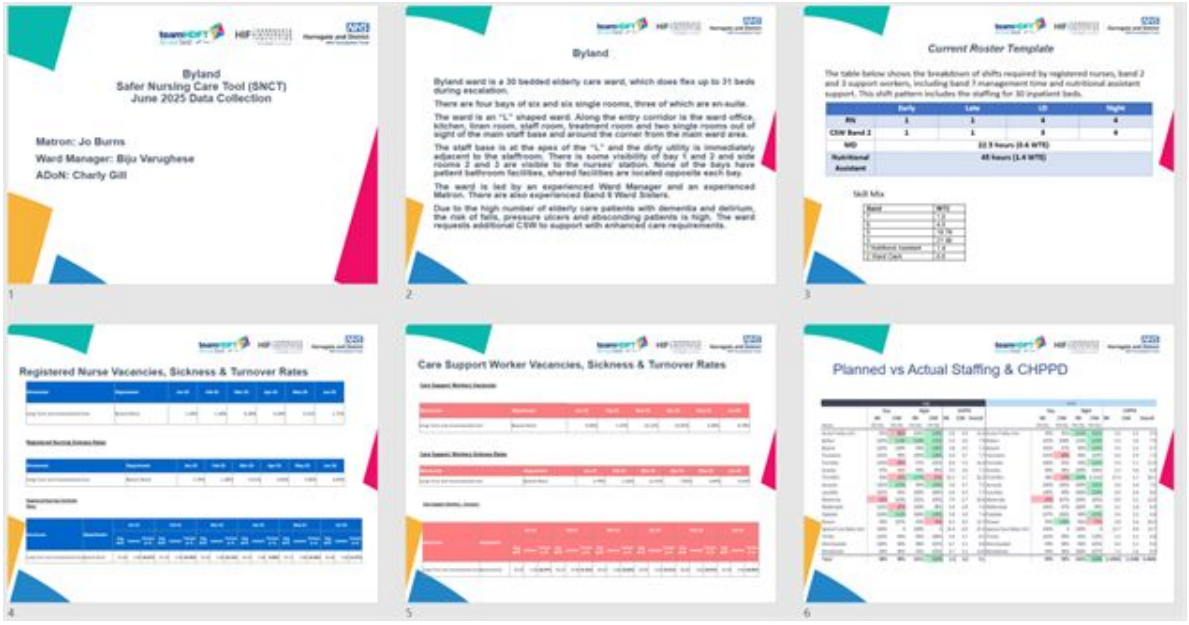
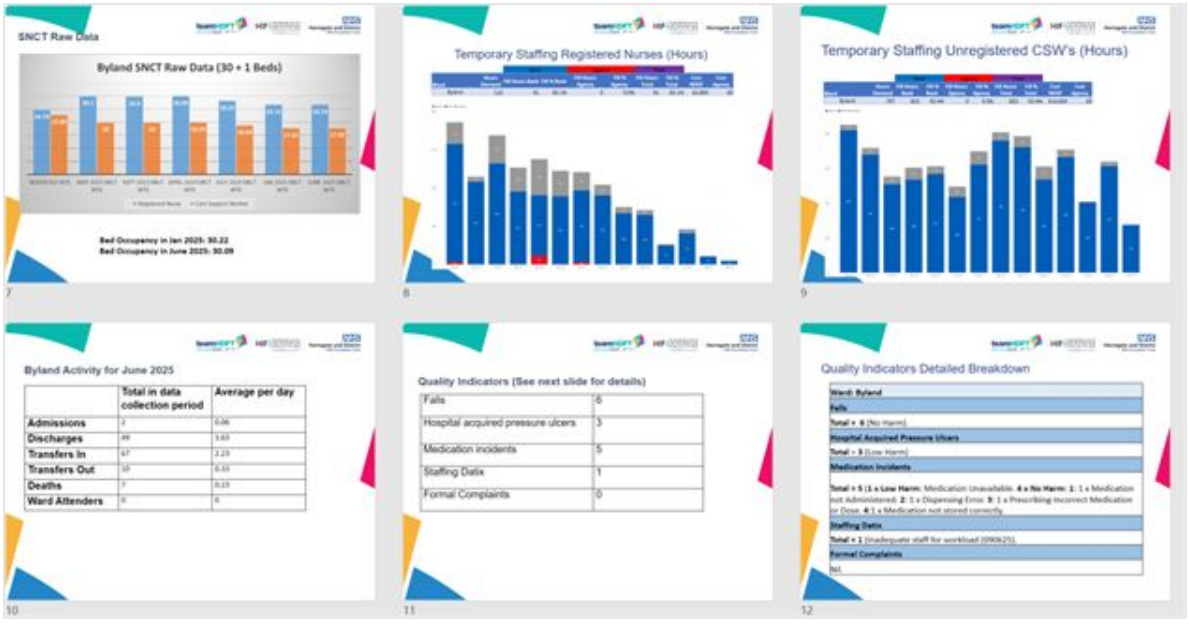
Appendix 4





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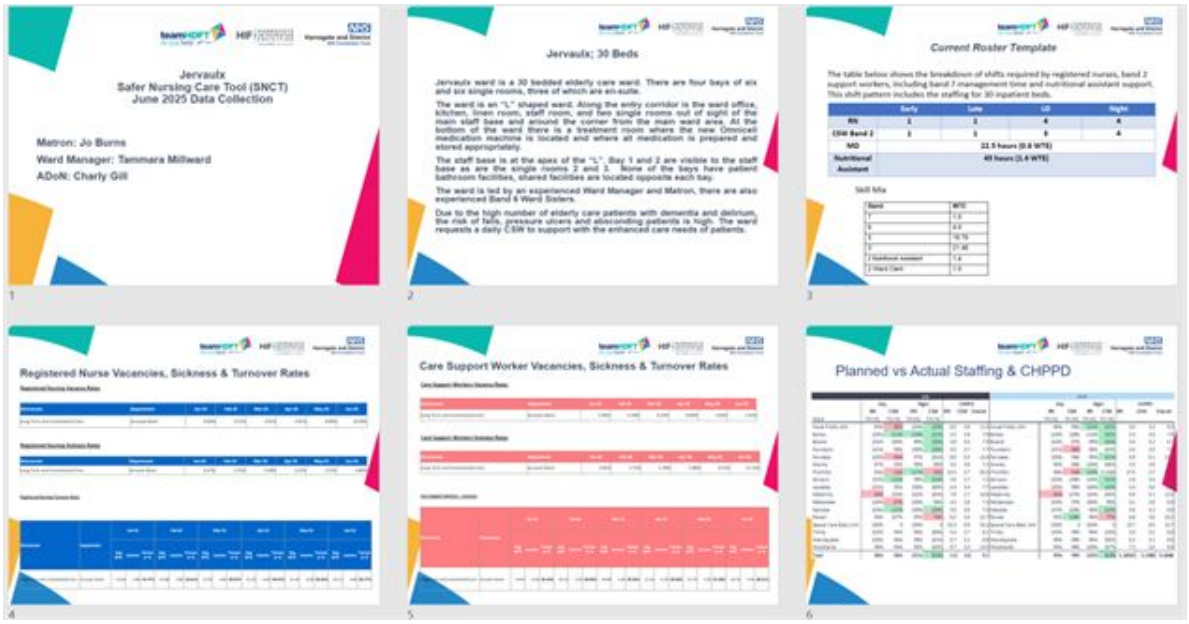
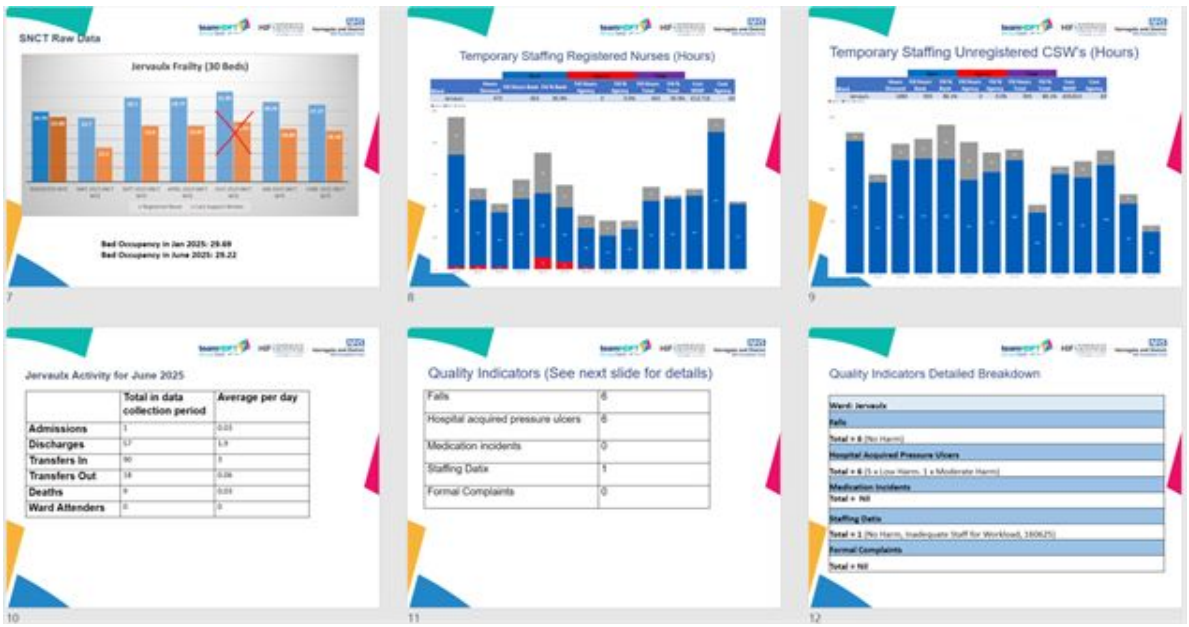
Appendix 5





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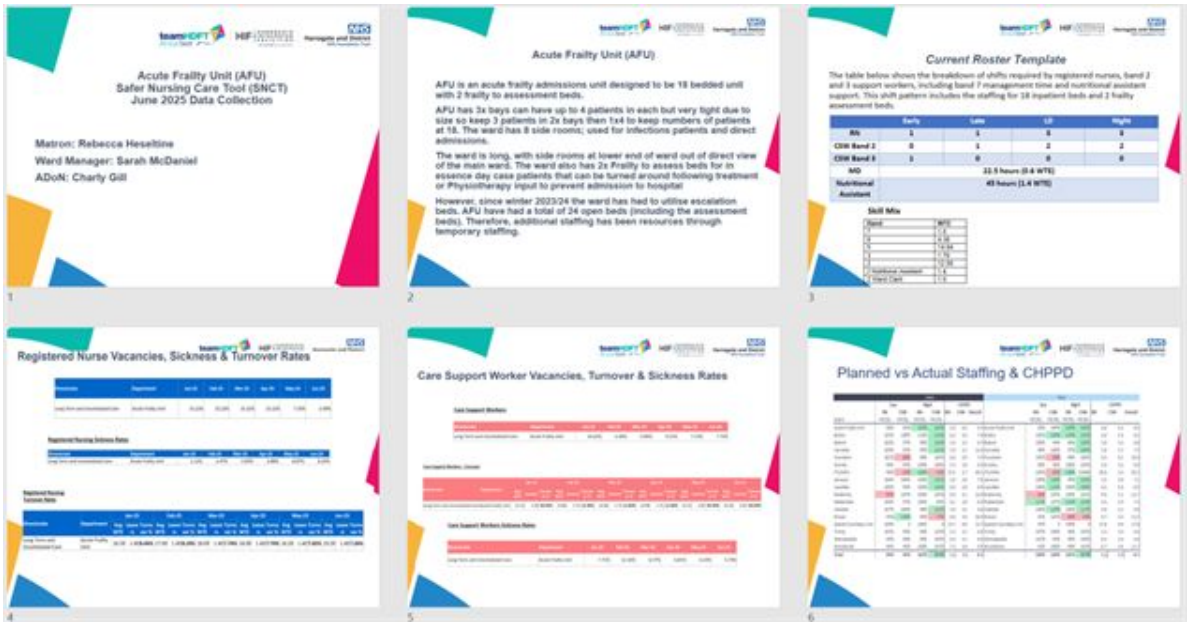
Appendix 6



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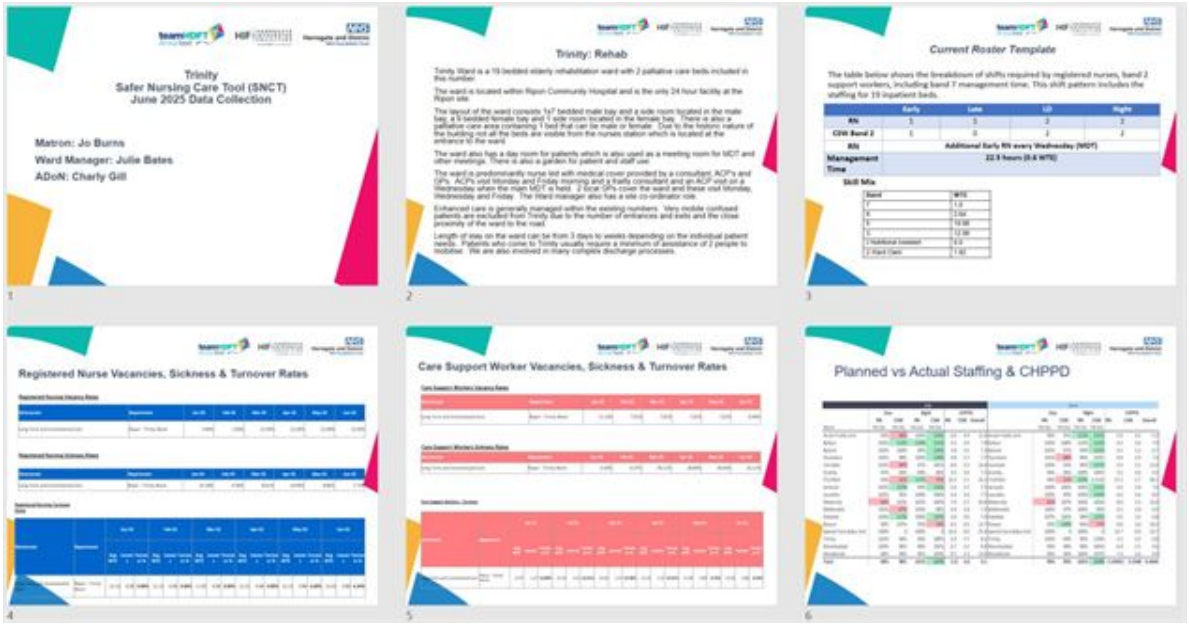
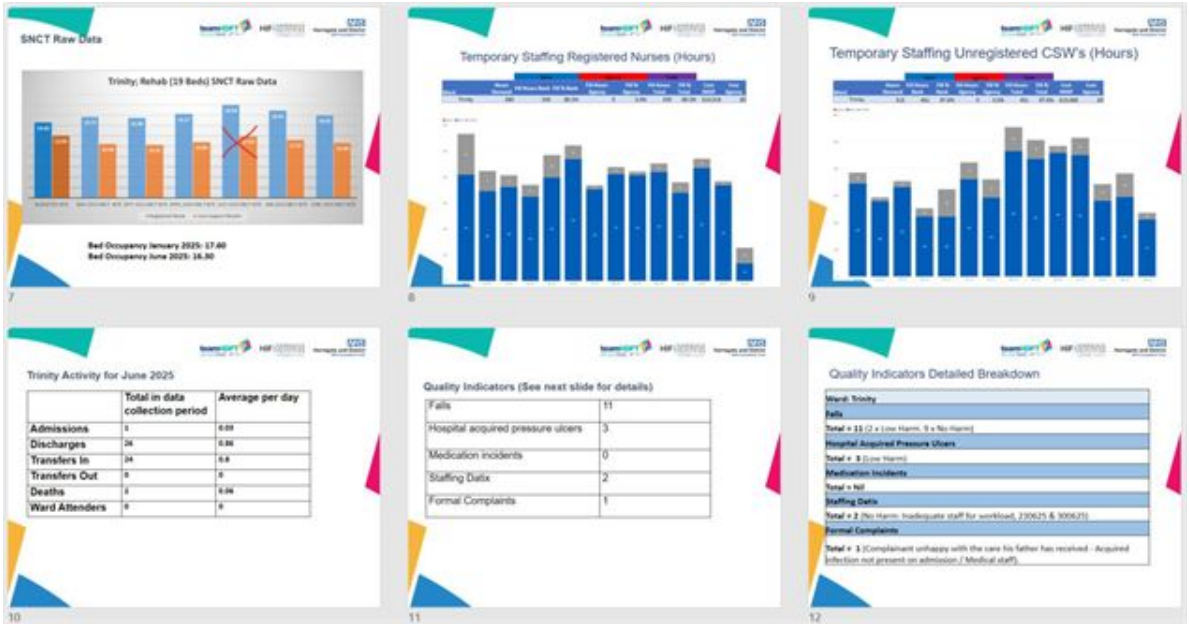
Appendix 7





	Total in data collection period	Average per day
Admissions	1	0.03
Discharges	26	0.86
Transfers In	24	0.8
Transfers Out	0	0
Deaths	1	0.04
Ward Attenders	0	0

Falls	11
Hospital acquired pressure ulcers	3
Medication incidents	0
Staffing Datix	2
Formal Complaints	1

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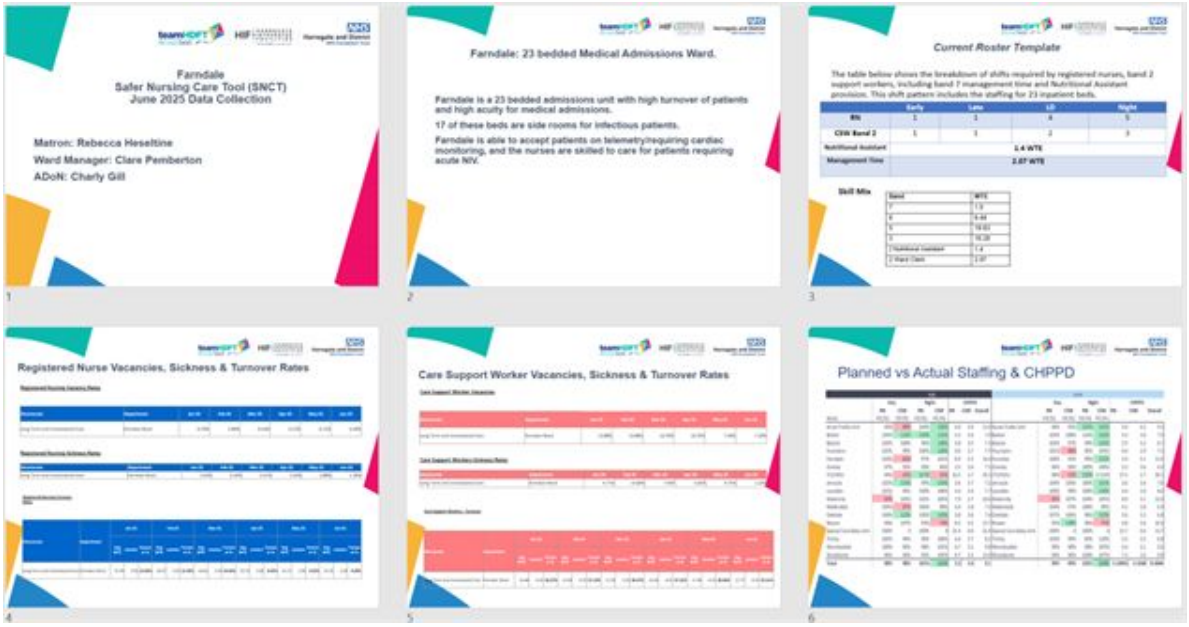
Appendix 8



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Harrogate and District
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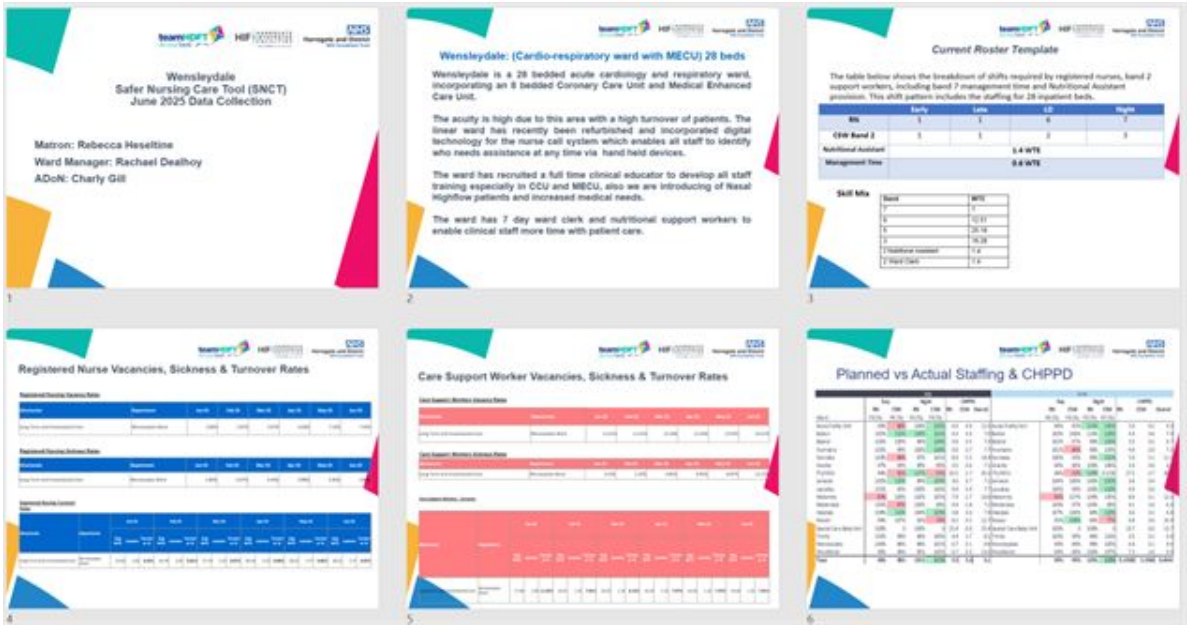
Appendix 9



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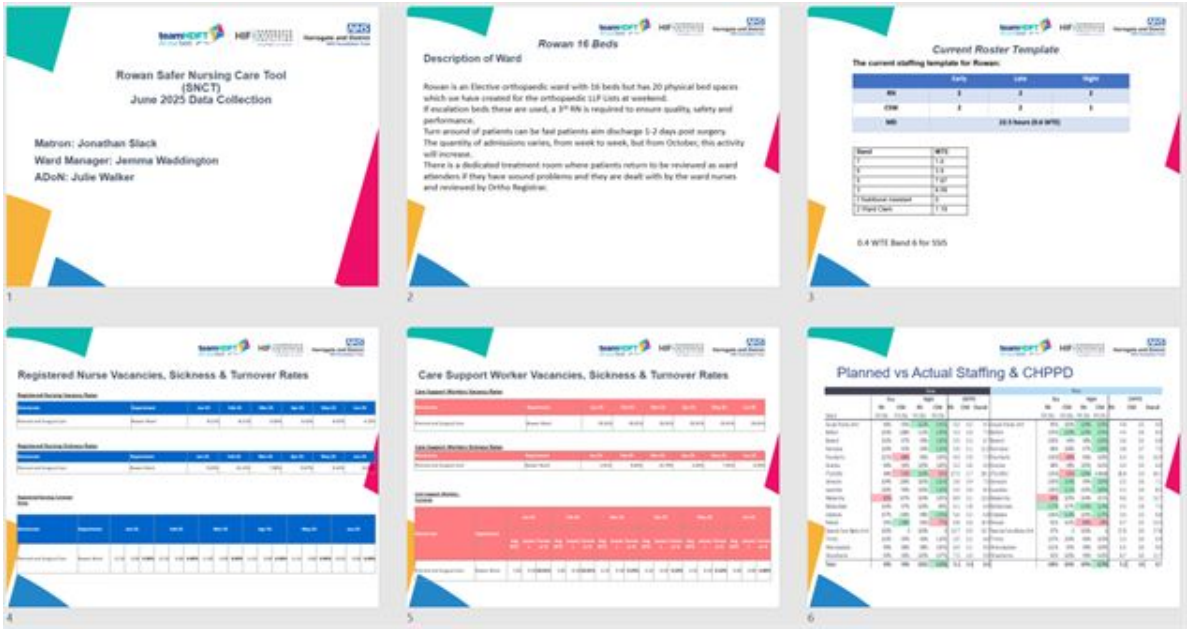
Appendix 10



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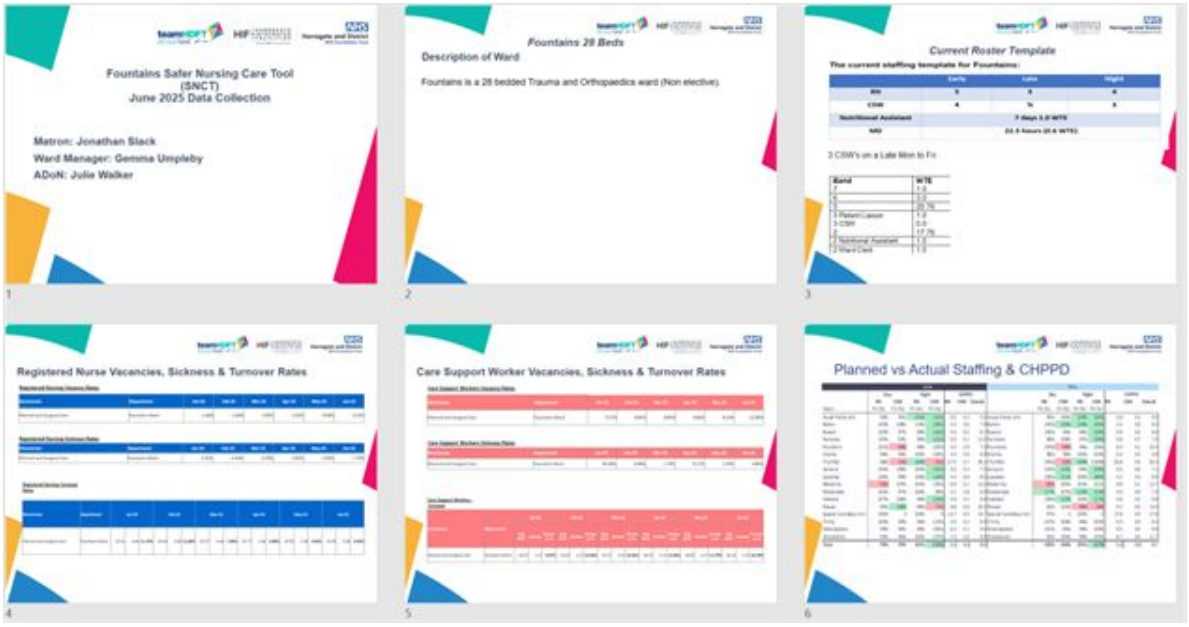
Appendix 11



	Total in data collection period	Average per day
Admissions	77	2.56
Discharges	42	1.4
Transfers In	21	0.7
Transfers Out	49	1.63
Deaths	2	0.06
Ward Attenders	0	0

Falls	2
Hospital acquired pressure ulcers	4
Medication incidents	1
Staffing Data	0
Formal Complaints	2

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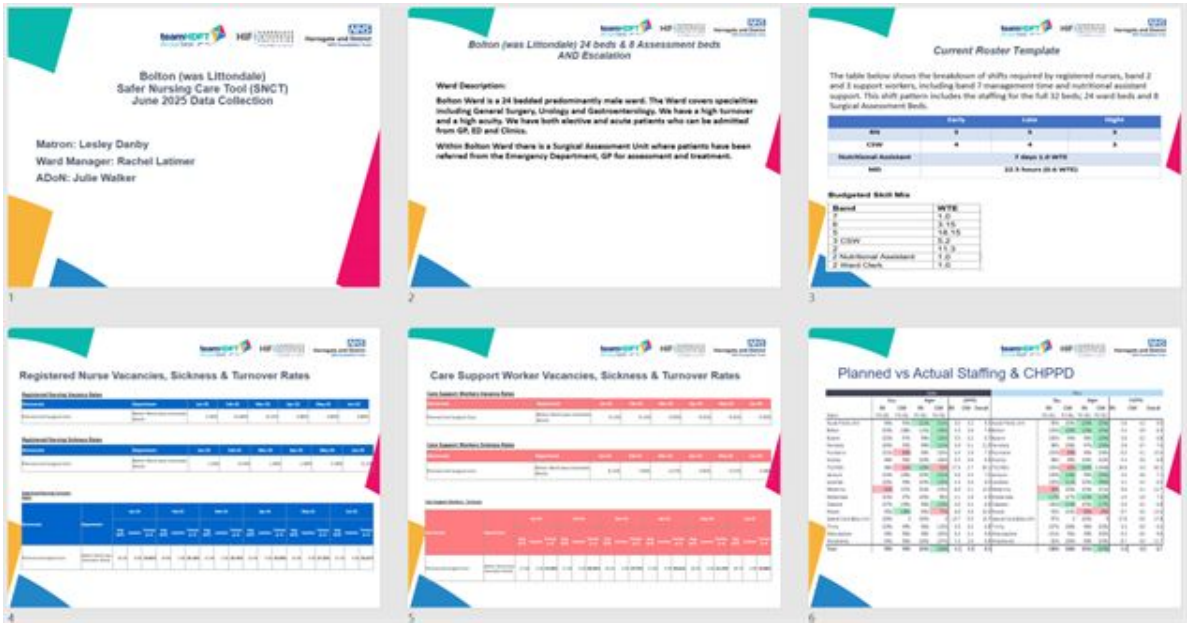
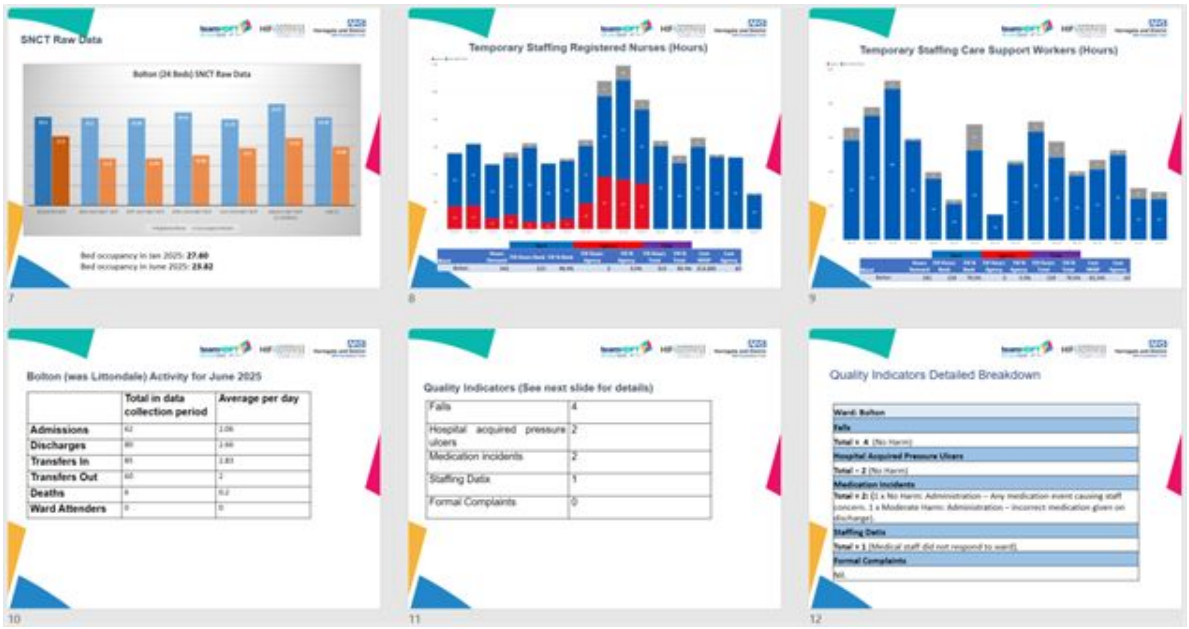
Appendix 13





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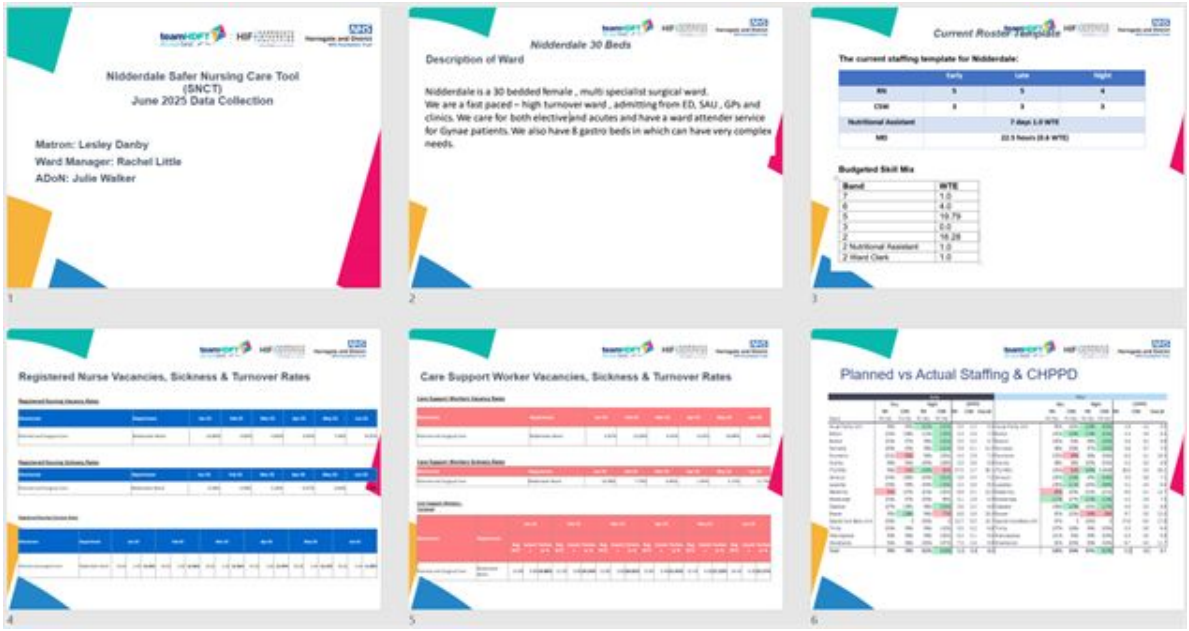
Appendix 13



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Appendix 14

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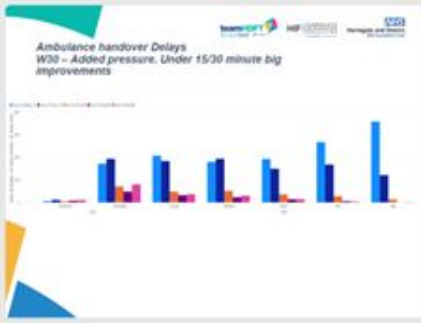

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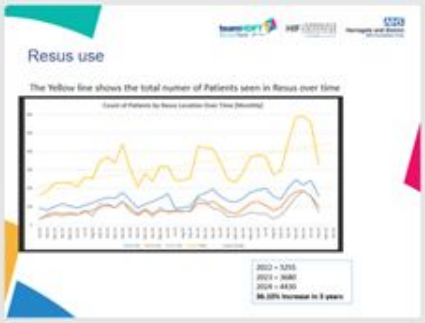

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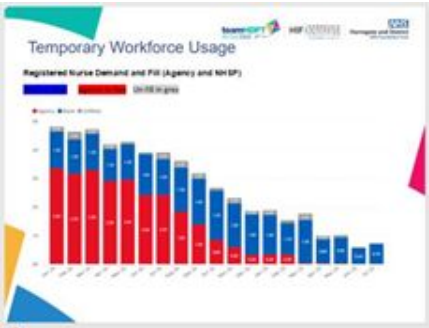

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Appendix 15

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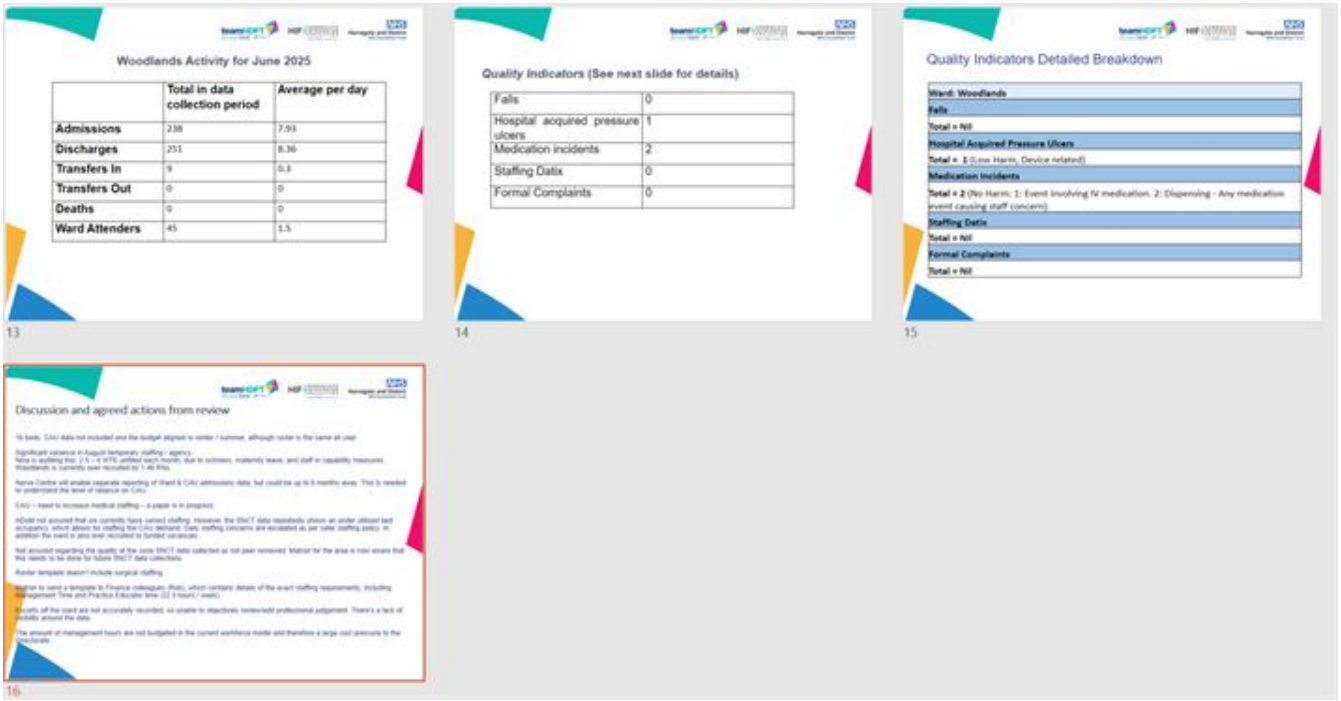

Woodlands Activity for June 2025

	Total in data collection period	Average per day
Admissions	238	7.93
Discharges	251	8.36
Transfers In	9	0.3
Transfers Out	0	0
Deaths	0	0
Ward Attenders	45	1.5

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Quality Indicators **(See next slide for details)**

Falls	0
Hospital acquired pressure ulcers	1
Medication incidents	2
Staffing Datix	0
Formal Complaints	0

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Quality Indicators Detailed Breakdown

Ward: Woodlands

Falls

Total = Nil

Hospital Acquired Pressure Ulcers

Total = 1 (Low Harm, Device related)

Medication Incidents

Total = 2 (No Harm: 1: Event involving IV medication. 2: Dispensing - Any medication event causing staff concern)

Staffing Datix

Total = Nil

Formal Complaints

Total = Nil

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Discussion and agreed actions from review

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Quality Committee November 2025

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

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

Freedom of Information:	Paper can be made available under the Freedom of Information Act once published on the HDFT website.

HARROGATE AND DISTRICT NHS FOUNDATION TRUST

QUALITY COMMITTEE

Nursing and Midwifery Quality and Safe Staffing Report

1.0 Introduction

The purpose of the report is to provide assurance on key patient safety, quality and workforce data.

Data in this report is provided for August and September 2025.

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

As per the Safer Staffing Policy, the threshold for enhanced monitoring of performance is where nursing establishment levels have fallen below the 90% threshold in month.

Further information on all in-patient nurse staffing levels is present to NHS England on a monthly basis to provide assurance that the Trust is responding to National Quality Board (NQB) 2016 guidance in relation to: *Safe, Sustainable and Productive Staffing.*

2.0 Hard Truths Data

HDFT reports nursing and midwifery staffing numbers including registered, unregistered, substantive and temporary to NHS England via a monthly Nurse Staffing Return (Hard Truths).

HDFT have set a threshold of 90% with regards to achieving its planned nursing numbers by shift. Any ward / in patient area, that falls below 90% will be reviewed in line with several quality metrics to see if patient care and outcomes has been affected due to planned establishment not being fully met. It has been identified that planned hours that fall below 90% in August and September are due to a reduction in bed occupancy. This is reflected and evidenced in the higher Care Hours Per Patient Day (CHPPD). Care Hours Per Patient Day, is a metric used in healthcare to measure the amount of direct care provided to patients by registered nurses, midwives, and healthcare support workers over a 24-hour period.

The Hard Truths report reviews inpatient areas. Wards that were closed during the reporting period, have not been included in the submission. Wards that are opened on a temporary basis to create temporary capacity are not required to form part of the national submission. If a temporary ward was opened for more than one roster period (4 weeks) the detail would be included where necessary in this report.

The table below shows all wards and the percentage fill rate for days and nights, split by registered (RN) and unregistered (CSW).

	September							August							
	Day		Night		CHPPD				Day		Night		CHPPD		
	RN	CSW	RN	CSW	RN	CSW	Overall		RN	CSW	RN	CSW	RN	CSW	Overall
Ward	Fill (%)	Fill (%)	Fill (%)	Fill (%)					Fill (%)	Fill (%)	Fill (%)	Fill (%)			
Acute Frailty Unit	87%	84%	97%	99%	7.1	5.7	12.8	Acute Frailty Unit	94%	79%	99%	97%	7.5	5.5	13.0
Bolton	94%	105%	98%	105%	4.3	3.6	7.8	Bolton	98%	110%	101%	110%	4.4	3.7	8.2
Byland	97%	80%	94%	93%	3.9	3.4	7.2	Byland	98%	87%	100%	100%	4.0	3.6	7.7
Fountains	91%	91%	91%	100%	4.5	3.9	8.3	Fountains	101%	86%	97%	97%	7.1	4.4	11.5
Farndale	95%	90%	93%	90%	6.7	4.4	11.1	Farndale	91%	87%	97%	106%	4.6	3.8	8.4
Granby	94%	88%	94%	89%	3.7	3.7	7.4	Granby	97%	87%	100%	99%	3.9	3.8	7.7
ITU/HDU	96%	44%	116%	37%	23.8	1.6	25.4	ITU/HDU	105%	50%	125%	55%	25.8	2.1	27.9
Jervaulx	98%	96%	95%	93%	3.7	3.5	7.2	Jervaulx	101%	101%	100%	99%	3.9	3.7	7.6
Lascelles	96%	86%	97%	97%	4.3	3.2	7.5	Lascelles	100%	102%	100%	103%	4.5	3.7	8.1
Maternity	80%	91%	91%	94%	6.7	2.2	9.0	Maternity	51%	64%	68%	52%	4.6	1.4	6.0
Nidderdale	100%	88%	94%	89%	4.7	3.0	7.7	Nidderdale	102%	91%	97%	106%	4.8	3.3	8.1
Oakdale	101%	102%	95%	105%	3.6	3.1	6.7	Oakdale	105%	107%	99%	116%	3.8	3.3	7.1
Rowan	93%	72%	93%	55%	9.5	3.6	13.2	Rowan	95%	87%	93%	61%	9.7	4.3	14.0
Special Care Baby Unit	99%	0	100%	0	16.4	0.0	16.4	Special Care Baby Unit	97%	0	100%	0	16.8	0.0	16.8
Trinity	89%	87%	93%	105%	3.6	3.4	7.0	Trinity	100%	95%	96%	110%	4.0	3.6	7.6
Wensleydale	96%	91%	95%	92%	6.4	2.9	9.3	Wensleydale	101%	98%	99%	103%	6.7	3.2	9.8
Woodlands	100%	99%	98%	100%	8.7	2.9	11.6	Woodlands	96%	112%	97%	125%	8.8	3.6	12.5
Total	**94%**	**90%**	**96%**	**93%**	**5.4**	**3.3**	**8.8**		**98%**	**98%**	**101%**	**111%**	**5.5**	**3.5**	**8.9**

3.0 August and September 2025 Results

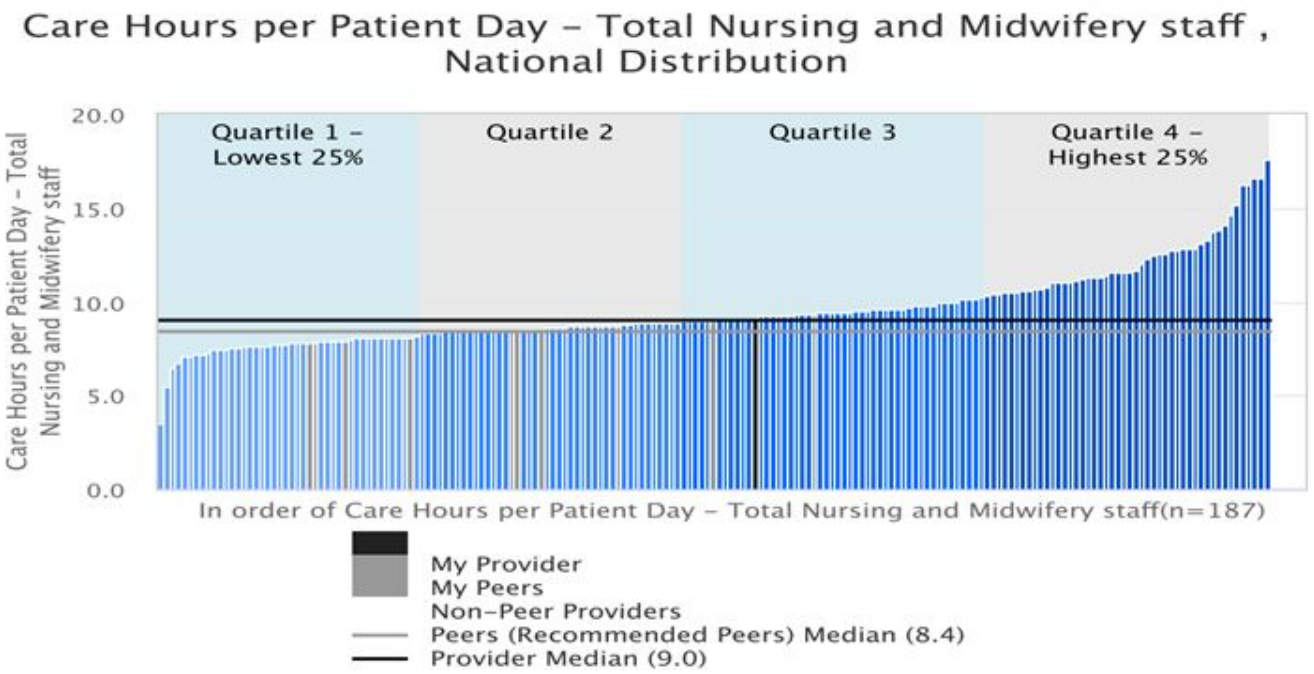
In August and September 2025, 17 eligible inpatient areas were reviewed.

Planned vs actual fill rate data shows that nine of the Nursing wards and departments fell below the 90% threshold for Registered Nurses and Care Support Workers. This was due to a lower bed occupancy during these months, which meant that planned staffing was not required. This is reflected in the healthy CHPPD rates, which are above the National 'peer' hospital CHPPD median and places us in quartile 3 nationally.

For Midwifery and Neonate staffing, further detail is provided in the monthly Maternity and Neonatal Safety Report. Midwifery workforce is detailed in the Perinatal Assurance Report and should be read in conjunction with this.

Maternity services had a midwifery vacancy of 6.73 WTE (8%) in August and September due to waiting for midwives to qualify, and also due to an increased budget and some turnover. Sickness was also impacting on service fill rates with sickness in August at 5.12WTE (6.1%) which is significantly higher than usual and the majority of the sickness was long term sickness. Shifts were released to NHSP and Agency but fill rates were insufficient via NHSP and there was no pick up of shifts via Agency. An incentive was added to the shifts in September to improve NHSP fill.

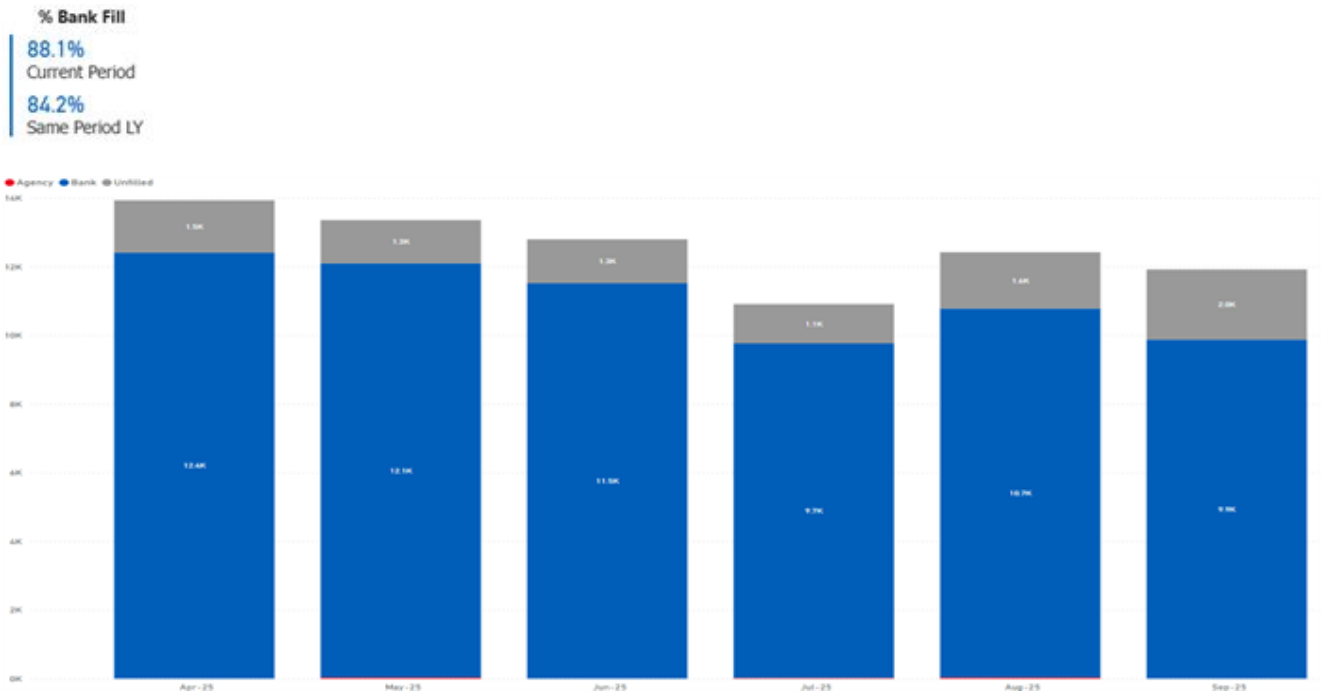
The table below demonstrates that HDFT CHPPD is in the third quartile, which places us above our peers and equal to the national median. This data is taken from Model Health System on 27th October 2025.



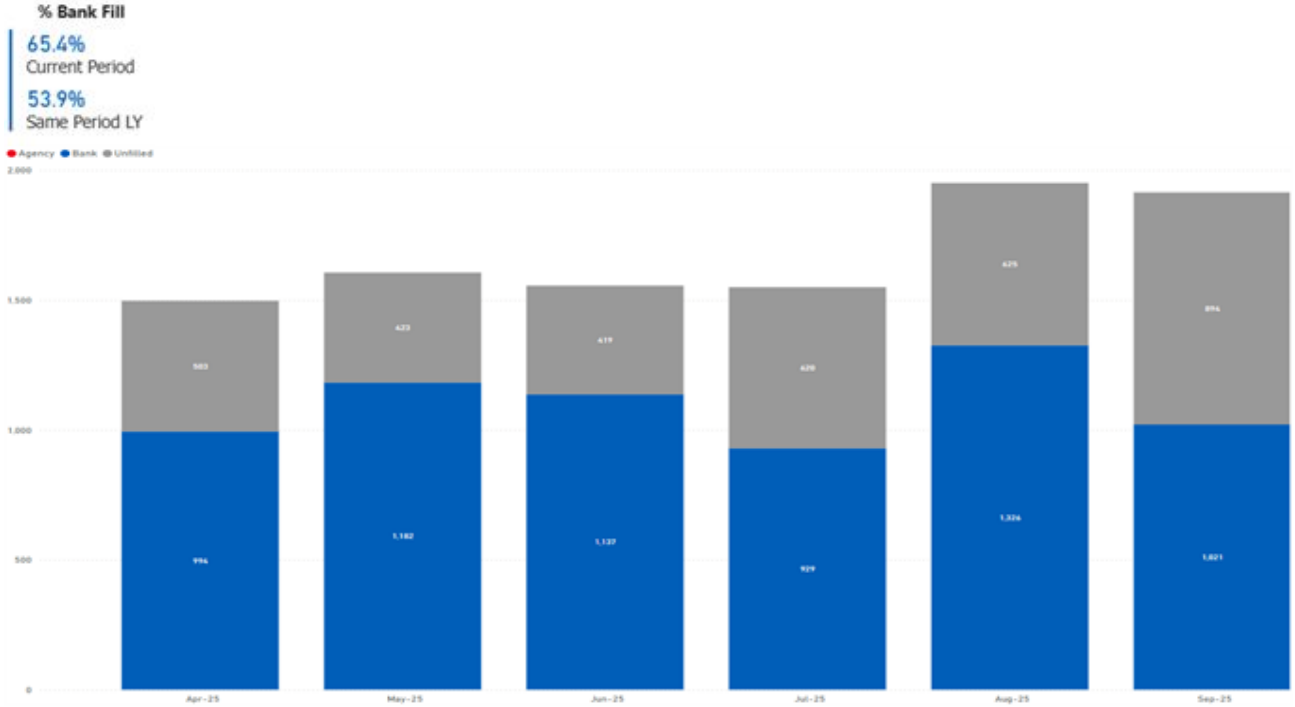
4.0 Temporary Workforce Usage

There has been no agency use in the Emergency Department or the Adult Inpatient wards since May 2025. There has been a small amount of agency use on the Children's Inpatient ward and Special Care Baby unit on authorisation of the Associate Director of Midwifery (ADoM). Improved processes are now in place to assess Enhanced Therapeutic Observational Care on the Adult Inpatient wards, resulting in a large reduction in temporary workforce requirements. Overall, temporary workforce use is reducing month on month and year on year. This is due to these areas being fully recruited to RN vacancies, giving us assurance that we have the right staff with the right skills at the right time and place.

Registered and Unregistered Nursing Temporary Workforce (April – September 2025)



Midwifery Temporary Workforce (April – September 2025)



5.0 Key Performance Indicators

Between August and September 2025, there were 23 moderate and above events reported 1 occurred in August and 13 in September occurring across 6 clinical areas.

Due to the small numbers, these remain within threshold.

Falls:
August: 2 x Moderate falls - No omissions found following investigation at Quality Oversight panel so reclassified as low harm.
Sept: 0 x Moderate or above falls.

Pressure ulcers:
August: 4 moderate harm pressure ulcers – 1 with omissions in care identified, 3 awaiting final investigation.

September: 1 moderate harm pressure ulcer with omissions in care identified.

The events occurred across 5 categories: pressure ulcers, falls, diagnosis, treatment, procedure and tests, equipment and medication.

6.0 Assurance Report

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

- no areas have fallen below the 90% threshold for three consecutive months for staffing
- no areas have fallen below the expected range for key quality indicators for three consecutive months

Of note, the Trust is in the process of developing an SOP for a revised safe staffing escalation and monitoring process. A bespoke dashboard is also in development to support the monitoring of this.

Rapid reviews are undertaken at the request of the Executive Director of Nursing, Midwifery and AHPs, the Deputy Director of Nursing, Midwifery and AHPs, the Associate Director of Quality and Corporate Affairs or Associate Directors of Nursing/Midwifery in response to any concerns which may have been raised through a variety of means (patient experience,

freedom to speak up concerns, Patient Safety Incident Investigations, After Action Reviews). During the reporting period no areas had issues escalated for rapid review.

7.0 Escalation and Reporting Nurse and Midwifery staffing concerns

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

The Nurse in Charge on each adult inpatient ward is responsible for scoring the acuity and dependency of every patient using SNCT levels of care. The patients must be assessed at the start of the early shift (before 10am) and the start of the night shift, and the scores entered into the SafeCare census. Concerns about patient need exceeding available nursing care hours, must be escalated in a timely manner to the matron or designated deputy for that area. Patients will receive a care score level between 0 and 3, with four sub sections of level 1 (a-d).

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

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

After discussion with the nurse in charge/unit manager, the matron will add professional judgement to SafeCare, documenting any mitigation they have made.
Once any moves, mitigations and professional judgement have been added, all matrons and deputies join the 10.30 safe staffing meeting. During this meeting, the lead matron will complete a systematic review of each area, asking for any concerns or safety risks to be raised. Each matron or deputy will highlight any areas where there is still a staffing risk or other concerns, and where they have been unable to mitigate this risk from within their own care group.

The matron leading the meeting will then review the enhanced care requirements, all supernumerary staff on duty and areas where there is no identified risk, to mitigate in other areas. In the meeting, staffing moves will be agreed, staff will be redeployed on SafeCare and any additional professional judgements added. A rating of a 'red' shift in SafeCare indicates unmitigated safety concerns.

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

If the ADoN for their directorate is not available, this should be escalated to another ADoN or ADoM.

In the absence of an ADoN staffing concerns should be escalated to the Deputy Director of Nursing, Midwifery and AHP's.

If staffing safety issues cannot be mitigated at this level, they must be escalated to the Director of Nursing, Midwifery and AHP's.

8.0 August and September 2025 SafeCare Red Shifts

There were no Red shifts during the months of August and September.

9.0 Recommendations

The Quality Committee is asked to:

- Note the safety, quality and staffing information detailed for August and September 2025,
- Note assurance of the daily process for monitoring and managing nurse and midwifery staffing levels at inpatient level through the SafeCare system.
- Note that actions are ongoing to monitor the standards of nursing care given within the Trust and support any identified areas with reduced performance.

Kate Southgate, Associate Director of Quality and Corporate Affairs
Jenny Nolan, Deputy Director of Nursing, Midwifery and AHPs
Brenda Mckenzie, Workforce Assurance Lead

November 2025

Trust Board

November 2025

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

Purpose of the report and summary of key issues:	To provide The Trust Board with a Bi-annual update on Freedom to Speak Up (FTSU) at Harrogate and District Foundation Trust (HDFT)	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	√
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	√
	AIM 2: To work with partners to deliver integrated care	
	BAF2.1 To improve population health and wellbeing, provide integrated care and to support primary care	
	BAF2.2 To be an active partner in population health and the transformation of health inequalities	
	AIM 3: To deliver high quality care	
	BAF3.1 and 3.4 To provide outstanding care and outstanding patient experience	√
	BAF3.2 To provide a high quality service	√
	BAF3.3 To provide high quality care to children and young people in adults community services	√
	BAF3.5 To provide high quality public health 0-19 services	√
	AIM 4: To ensure clinical and financial sustainability	
	BAF4.1 To continually improve services we provide to our population in a way that are more efficient	
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	
	BAF4.4 To be financially stable to provide outstanding quality of care	
Corporate Risks		
Report History:	Previous update provided to People & Culture Committee 27/11/24	
Recommendation:	Trust Board members are asked to receive this report for information.	

Board of Directors Meeting

Freedom to Speak Up Guardian update

1.0 Executive Summary

1.1 Freedom to Speak Up (FTSU) Guardians provide regular, comprehensive reports to their Trust Board so that barriers to speaking up are identified and addressed. This report outlines current work nationally, data and themes relating to local contacts to the Guardians and Fairness Champions, progress with local work and further work to be undertaken.

2.0 Background

2.1 This Board Report follows previous Board Reports, presented by past guardians, which have outlined barriers to speaking up, how they are identified and addressed. This report is presented for information outlining current work being undertaken, data and themes relating to local Guardians progress with local work and further work to be undertaken.

3.0 Introduction

3.1 All National Health Service (NHS) trusts are required to appoint a Freedom to Speak Up Guardian and an assessment of speaking up is at the heart of the well led domain of Care Quality Commission (CQC) inspections of NHS trusts. Recent recruitment by Harrogate and District Foundation trust has resulted in two new guardians being appointed to fill a full-time role.

4.0 Quality Implications and Clinical Input

4.1 There is a risk that poor standards of care can proliferate unless patients and staff are listened to and their concerns welcomed and acted upon.

5.0 Equality Analysis

5.1 This work aims to impact positively on all staff but particularly on staff who might be more vulnerable to speaking up.

6.0 Risks and Mitigating Actions

6.1 Previously the minimal time allocated to Guardian role was viewed as a risk. However, the Trust recruited to a full-time guardian position with two staff starting in role in August 2025.

7.0 Consultation with Partner Organisations

7.1 This Board Report was created without consulting with partner organisations.

8.0 Monitoring Performance

8.1 HDFT is keen to ensure it has robust FTSU arrangements in place and will continue to report on national and local actions, at least bi-annually to the Board, in relation to developing a culture of speaking up about concerns.

9.0 Recommendation

9.1 The Board is asked to review and comment on the content of this Board Report to evaluate the work in relation to embedding a culture of speaking up.

10.0 Supporting Information

10.1 The following paper appended makes up this report:

Report: Freedom to Speak Up Guardian update report to Board of Directors

Date: November 2025

Introduction

The National Guardian's Office and the role of the Freedom to Speak Up Guardian were created in response to recommendations made in Sir Robert Francis' report "The Freedom to Speak Up" (2015). These recommendations were made as Sir Robert found that NHS culture did not always encourage or support workers to speak up, and that patients and workers suffered as a result.

The ambition across the NHS is to affect the cultural change that ensures speaking up becomes business as usual.

Workplace culture is the character and personality of an organisation. It is made up of the organisation's leadership, values, traditions, beliefs, and the behaviours and attitudes of the people working within it. We know that:

"If leaders and managers create positive, supportive environments for staff, they in turn create caring, supportive environments and deliver high-quality care for patients. Such leadership cultures encourage staff engagement".

(The King's Fund: Improving NHS culture)

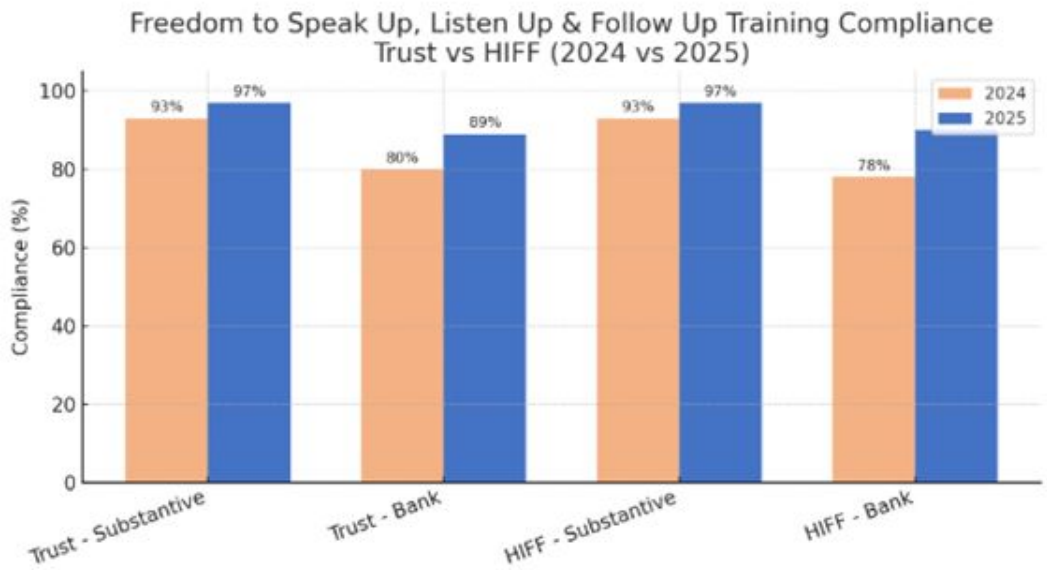
National Guidelines on Speaking Up training in the health Sector in England

Freedom to Speak Up e-learning, has been developed in association with Health Education England and is freely available for everyone who works in healthcare. 'Speak Up, Listen Up, Follow Up' is divided into three modules, it helps learners understand the vital role they can play in a healthy speaking up culture which protects patient safety and enhances worker experience.

It is mandated that all members of Harrogate Integrated Facilities (HIF) and HDFT are required to complete "Speak Up" and all people in a Line Management or Leadership position are required to complete "Listen Up". The final module, "Follow Up" is undertaken by members of the Senior Management Team. This is to raise the profile and awareness of FTSU across the organisation and provide staff with the opportunity to reflect on and consider how they can support and promote a Just Culture.

Engagement and completion of training continues to increase:-

The overall compliance for Trust and HIF staff to date.				
Group	Workforce Type	Required	Not achieved	Compliance %
Trust staff	Substantive	4,864	137	97%
Trust staff	Bank	126	14	89%
HIFF staff	Substantive	342	9	97%
HIFF staff	Bank	40	4	90%



Insights:

Both Trust and HIF substantive staff improved from 93% → 97% (+4%).

Trust bank staff rose sharply from 80% → 89% (+9%).

HIF bank staff had the biggest improvement, 78% → 90% (+12%).

The Freedom to Speak Up Guardian role update

The allocation for the Guardian role is now 37.5 hours per week as a full-time role shared across 2 Guardians at Band 8a.

This is comparable to organisations across the region. The role will now look to be more proactive as well as reactive due to the increase in the capacity of the FTSU role.

The Guardians are part of the Regional Guardian Network and, time allowing, attend network meetings and opportunities to share best practice.

The guardians have been working on a communication plan to ensure reach across all our directorates so we have assurance that teams across the trust understand how freedom to speak up can support them.

Communication plan			
Directorate	Number of divisions in directorate	% Engaged Aug-Sept 2025	% Engaged Oct-Nov 2025
Harrogate Integrated Facilities (HIF)	23	39%	43%
CORPORATE	29	41%	55%
Long Term, Urgent, Cancer & Community (LTUCC)	22	22%	40%
Children & Young People's Public Health Directorate (CYPPHD)	16	100%	100%
Planned, Surgical & Children's (PSCC)	32	1%	15%
Average reach across organisation		40%	50%

Next steps / Action Plan:

- To clarify and establish clear reporting structures.
- Meeting attendance with Nursing and Quality Director team.
- Meeting attendance with the People and Culture Committee.
- Continue to raise awareness of and promote the Guardian role across all directorates.
- A focus on fairness champion engagement and training in 2026.
- To continue to include the FTSU Guardian role in the current work on the organisational culture, values and behaviours –
    - Presented on Team Talk
    - Attended multiple staff engagement meetings, staff network meetings and more planned.
        - Just and learning culture
        - Speak Up, Listen Up, Follow Up training modules.
        - Supporting FTSU Champions
        - Facilitating Corporate Induction training
        - Facilitating Pathway to Management training
        - Presenting at Line Manager Webinar
        - Preceptorship training sessions for midwifes, nursing and AHP colleagues
- To continue the rebrand of FTSU at HDFT 'Listening at Our Best' to embed FTSU into the #teamHDFT values and 'At our Best' programme.
- Focus on FTSU reactive and proactive cases in line with new full-time role.
- Linking with HDFT IMPACT.
- Further define the FTSU model within HDFT, with particular consideration towards Fairness Champion roles.
- The Fairness Champion Directory has been updated. Applications to become a champion and new recruits to be trained will be a focus of Quarter 1 and Quarter 2 of 2026.

Action Required	Lead	Date for completion
To formalise and agree roles/ responsibilities and training for the Fairness Champion role. To promote the fairness champion role and increase membership by 50%	FTSU Leads	Ongoing

Continue with the communication plan to reach 100% of the organisation. Continue to promote and reach teams across all directorates using the communication plan and FTSU material provided by the National Guardian Office (NGO).	FTSU leads, Communication & Marketing Team	Ongoing
Review the NGO Gap Analysis and Just Culture Gap Analysis	FTSU Leads, Board & Human Resources (HR) / Organisational Development (OD)	Ongoing
Update of Fairness Champions directory	FTSU Leads	Ongoing
Regional scoping of comparative FTSU models for collection and data analysis	FTSU Leads via Regional Network	Ongoing
To gain feedback from completed cases and use this to inform FTSU process moving forward.	FTSU Leads	Ongoing
Review the Freedom To Speak Up policy	FTSU Leads	Ongoing

The following table captures the numbers of cases received by the Freedom to Speak Up Guardian, between August 14th 2025 and October 31st 2025:

Numbers of cases brought by professional level	Student	5
	Worker	7
	Manager	1
	Leader	2
	Senior leader	0
	Not disclosed	1
	TOTAL	**16**

Numbers of cases brought by professional group	Medical Registered Nurses, Midwives & Allied Health Professionals (AHPS) Administration, Clerical & Maintenance/Ancillary Non-registered clinical support staff Undisclosed **TOTAL**	4 1 2 8 1 **16**
Number of cases raised anonymously		0
Number of cases with an element of bullying or harassment		6

In Summary: -

What were we aiming to achieve?

At HDFT we aim to make it as easy as possible for every colleague to speak up safely when they want to raise a concern that they do not feel they can do through the usual methods of speaking to their line manager. We aim for speaking up to be business as usual at HDFT and aim to have Fairness Champions in each clinical and non-clinical area to support with signposting and championing speaking up. We aim for colleagues and ex-colleagues, whether employed directly or as contractors, students or volunteers, to be able to speak up about anything that gets in the way of doing a good job. We encourage colleagues to be aware of the different ways within the Trust, Freedom to Speak Up being one of them.

What have we done?

We have continued to embed the Freedom to Speak Up values of courage, impartiality, empathy and learning into our shared understanding of the key elements of a fair, just and safe culture, which are:

1. Fairness, compassion and psychological safety: ensuring each individual knows they will be treated fairly and compassionately by the group if things go wrong, or they speak up to stop problems occurring.
2. Diversity, inclusivity, trust and respect: ensuring people are treated fairly regardless of ethnicity, gender, disability or other characteristics.
3. Speaking up and listening: ensuring speaking up about concerns, events, errors or poor behaviour is welcomed, and seen not just as safe, but the right thing to do.
4. Leadership and teamwork: ensuring supportive, effective and ideally multidisciplinary teamwork alongside compassionate and collective leadership to reinforce a sense of care and belonging, a culture of honesty, authenticity and safe conflict.

5. Trust Values and behaviours: ensuring we promote and expect positive behaviours that improve patient safety and colleague experience, and that behaviour which is at odds with our values is called out and challenged.
6. Open to learning and improvement: ensuring that when things go wrong there is focus on no blame, a just culture, an understanding of human factors, supporting staff, and learning.

What are the results?

- Currently, the Freedom to Speak Up team includes:
  - 2 x Freedom to Speak Up Guardians
  - 17 x Fairness Champions across the organisation

- 2026 will be a focus to support and train further Fairness Champions across the organisation

- Speak Up Month – Listen Up – October 2025, was marked with a presentation on Team Talk and awareness raising across the Trust.

- Collaborative work and constructive signposting, within the Trust established and continuing, including with:
  - Union Representatives
  - The Wellbeing Team
  - Occupational Health
  - Human Resources
  - Equality, Diversity & Inclusion Team

- Regular facilitating within Trust Induction

- Regular facilitating within Pathway to Management training

- Regular facilitating preceptorship for midwives, nurses and AHP's

- Attendance as a presenter on Team Talk

- Regular attendance and updates provided to the People & Culture Committee.

- Fulfilling requests to attend team meetings / huddles including within SROMC; Matrons; SDEC teams and ensuring this offer is given when in communication with managers and their teams

- Attendance at Wellbeing days alongside Wellbeing Lead

- Speaker at the Professional Nurse Advocate Timeout Day

- FTSU Guardian, Satty Ali to sit on the interview panel alongside Director of People and Culture, Angela Wilkinson and Equality, Diversity and Inclusion Lead, Richard Dunston-Brady for interviews for Independent Panel Members (IPM's). This process will assist with a fair and inclusive recruitment decision making process at HDFT.

Summary

A culture that inhibits speaking up because of recrimination and blame acts as a significant barrier to staff wellbeing and patient safety. The work to promote a fair, just and safe culture is focused on ensuring our leaders and managers create positive, supportive environments for all colleagues, knowing that they will then create caring, supportive environments and deliver high quality care for patients. We must promote and expect positive behaviours that improve patient safety and staff experience, constructively challenging behaviour that is at odds with our values to enable people to learn about the impact of their words or actions. All colleagues need to be confident that they will be treated fairly and compassionately, and that speaking up about concerns, events, errors or poor behaviour is welcomed, the right thing to do and an opportunity to learn. We must continue to train colleagues to be positive and compassionate leaders and effective members of teams, where they can reinforce a culture of honesty, authenticity and safe conflict.
We continue a journey towards ensuring all our staff work in positive and supportive environments that enable them to deliver the highest quality of care for our patients.

Guardian of Safe Working Hours Quarterly Report

Quarter 2 of 2025-2026

12th November 2025

Dr Megan Atkinson – Guardian of Safe Working Hours

Executive Summary

This report of the Guardian of Safe Working Hours covers quarter 2 of 2025/2026, 1st July 2025 – 30th Sept 2025. The purpose of this report is to assure the Board of Directors of the state of safe working of resident and LED doctors in the trust.

I, Dr Megan Atkinson am the Guardian of Safe Working Hours (GoSWH) for HDFT. I would like to extend my thanks to Dr Andrews and Kerry Kidd, who covered the role of Guardian during a period of sick leave earlier in the year. I also hold the role of educational supervisor to one geriatric higher specialty trainee and clinical supervisor to one foundation year 1 trainee. I declare this as a potential conflict of interest in both roles. Nationally, other GoSWHs also act as supervisors. I am making this potential conflict of interests known to the board as well as explaining my role to supervisees. If at any point there is concern of a conflict, this will be escalated to Dr Jackie Andrews.

Introduction

Harrogate Hospital currently employs 212 LED/Resident doctors. Resident doctor (RD) refers to doctors currently enrolled in a training programme. LED refers to "locally employed doctors," doctors directly employed by the trust and not otherwise engaged in a training programme. Fellows are LEDs employed by the trust and facilitated to have a portion of their time dedicated to research/quality improvement or education. For the purposes of this report, they are grouped with LEDs.

Harrogate hospital employs the following (accurate November 2025):

- Resident doctors = 171
- Locally employed doctors = 26
- Fellows = 15

An exception report (ER) is raised by a RD/LED when they are required to work outside their work schedule. This is most commonly because of additional time worked but can also pertain to missed breaks and educational opportunities, loss of rest during non-residential on calls and difference in available support. HDFT uses software called Allocate to manage the exception reporting process.

ERs should be reviewed by RD/LED's clinical supervisors (within 7 days), and a determination made whether this is compensated financially or with time owing in lieu (TOIL) in line with the RD/LED's preference. When necessary, a work schedule review can be requested. As Guardian of Safe Working Hours, I have oversight of all ERs and liaise with residents and departments to highlight any trends of

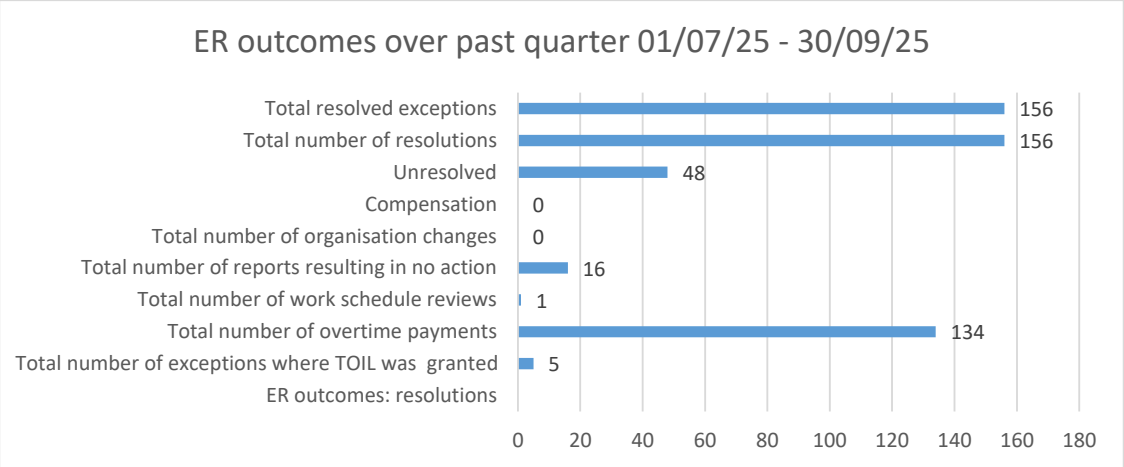
concern. In certain situations, fines are levied against departments for specific breaches of the 2016 T+Cs of service.

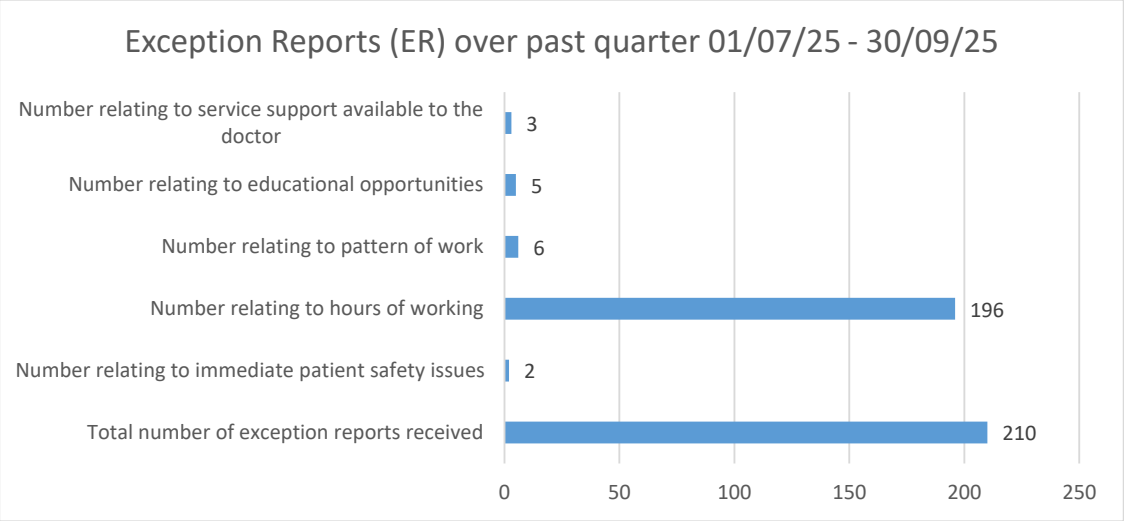
High-level data for Harrogate

a) Exception reports

Explanatory notes:

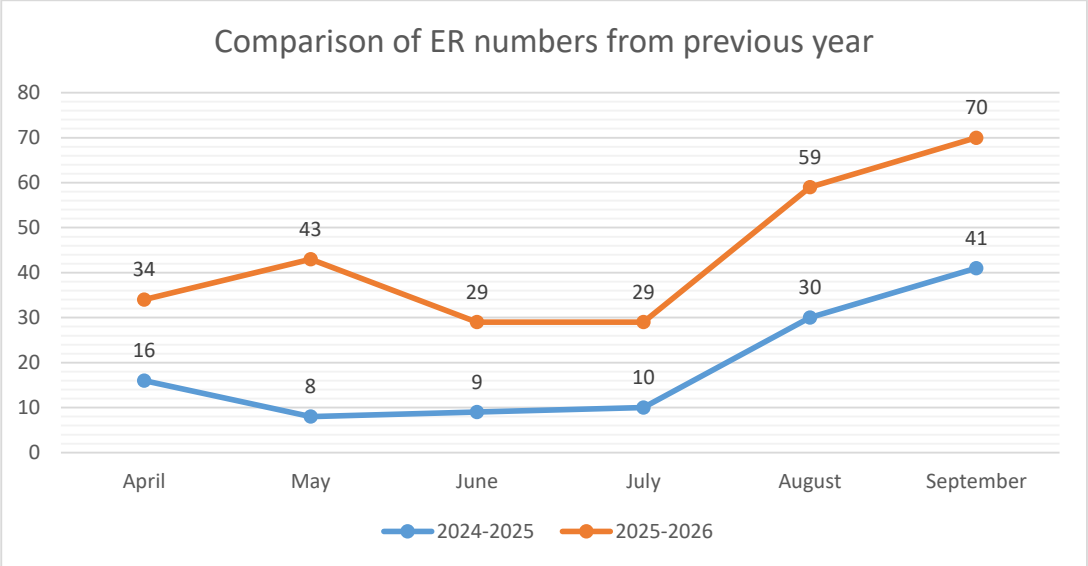
- Within the system, an exception relating to hours of work, pattern of work, educational opportunities and service support has the option of specifying if it is an Immediate Safety Concern (ISC). ISC is not an exception type by itself.
- Compensation covers obsolete outcomes such as 'Compensation or time off in lieu' and 'Compensation & work schedule review'.
- Some exceptions may have more than 1 resolution i.e. TOIL and Work schedule review.
- Unresolved is the total number of exception where either no outcome has been recorded or where the outcome has been recorded but the doctor has not responded.

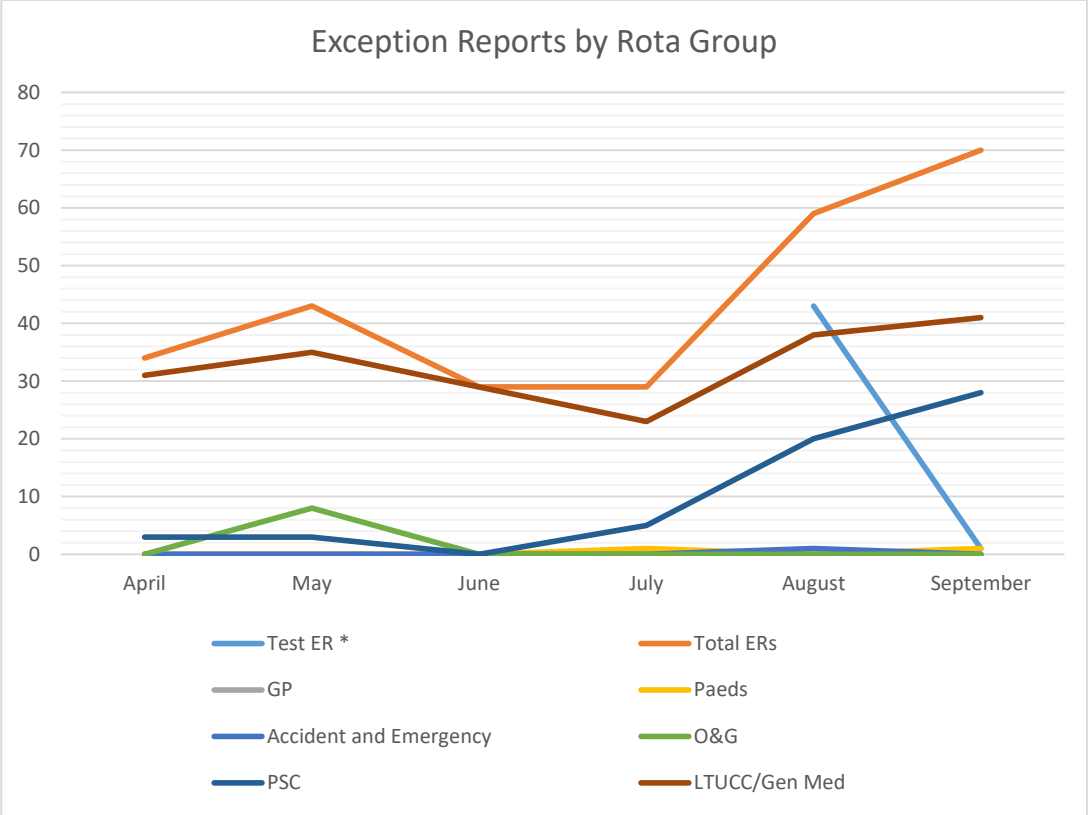




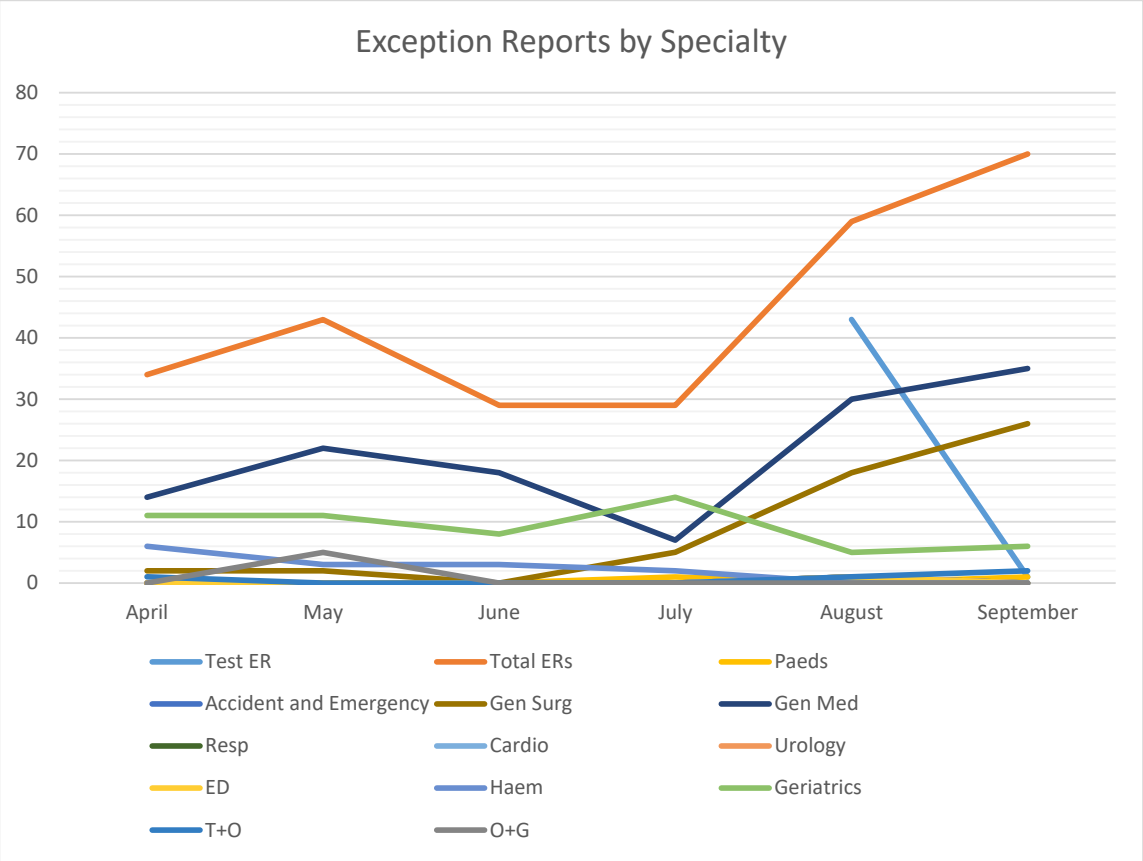
Reasons for ER over last quarter by specialty & grade

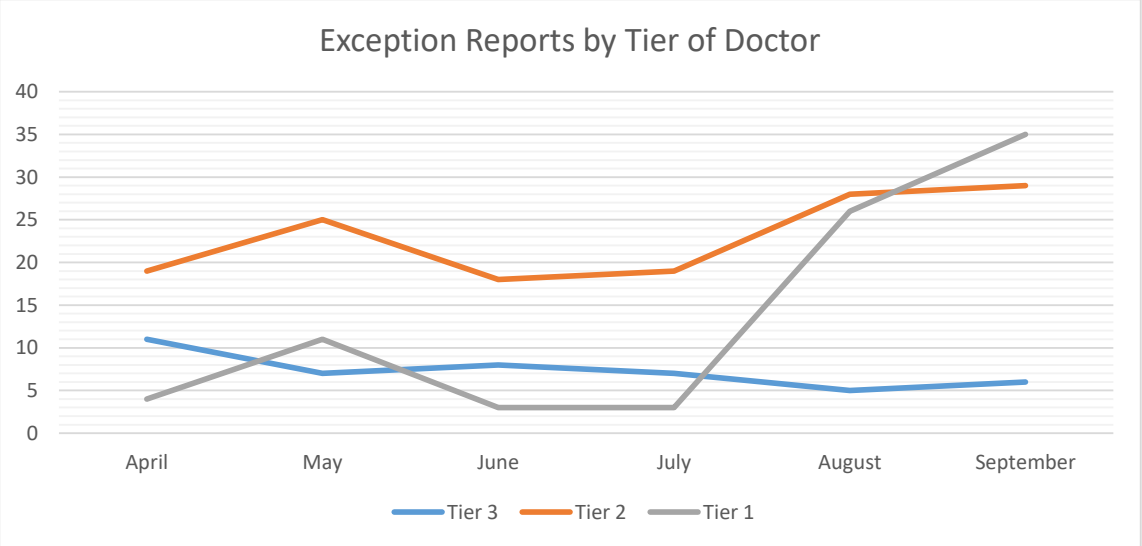
ER relating to:	Specialty	Grade	No. ERs carried over from last report	No. ERs raised	No. ERs closed	No. ERs outstanding
Immediate patient safety	General practice	FY2	0	1	0	0
	General surgery	FY1	1	1	0	2
Total			**1**	**2**	**0**	**2**
No. relating to hours/pattern	Accident and emergency	FY2	0	1	0	0
	Accident and emergency	ST1	0	2	1	0
	Acute Medicine	FY1	0	2	0	0
	Acute Medicine	ST3 *	0	1	1	0
	Anaesthetics	CT2	0	1	0	0
	Anaesthetics	CT3	0	1	0	0
	Anaesthetics	CT4 *	0	1	0	0
	Anaesthetics	FY1	0	2	0	0
	Cardiology	FY1	0	1	1	0
	General medicine	CT1	0	2	1	0
	General medicine	FY1	1	21	17	1
	General medicine	FY2	8	28	30	3
	General medicine	FY2 *	0	7	7	0
	General medicine	Pre-registration house officer *	0	9	0	9
	General medicine	ST1	9	25	25	11
	General medicine	ST1 *	0	2	2	1
	General medicine	ST1 Chronologically *	0	1	0	0
	General medicine	ST5	0	1	1	0
	General medicine	ST7	0	1	0	0
	General practice	FY2	0	2	1	0
	General practice	ST1	0	1	0	0
	General surgery	FY1	1	35	25	10
	General surgery	FY2	0	19	8	9
	Geriatric medicine	ST1	0	1	1	0
	Geriatric medicine	ST5	8	17	25	0
	Haematology	FY1	0	2	2	0
	Haematology	ST1	1	0	1	0
	Haematology	ST4	0	1	0	0
	Obstetrics and gynaecology	FY2	0	1	0	0
	Obstetrics and gynaecology	ST1	2	0	2	0
	Paediatrics	FY1	0	1	0	0
	Paediatrics	FY2	0	3	1	1
	Respiratory Medicine	FY1	0	2	1	0
	Respiratory Medicine	FY2	0	1	0	0
	Trauma & Orthopaedic Surgery	FY1	0	1	0	0
	Trauma & Orthopaedic Surgery	FY2	0	4	1	2
	Urology	FY1	0	2	1	0
Total			**30**	**202**	**155**	**47**
No. relating to educational opportunities	General medicine	CT1	0	1	0	0
	General medicine	ST1	0	1	0	1
	General surgery	FY2	0	1	0	0
	Paediatrics	FY1	0	1	0	0
	Urology	FY1	0	1	0	0
Total			**0**	**5**	**0**	**1**
No. relating to service support	Accident and emergency	ST1	0	1	0	0
	Anaesthetics	CT3	0	1	0	0
	Anaesthetics	ST3	0	1	1	0
Total			**0**	**3**	**1**	**0**





*Explained below

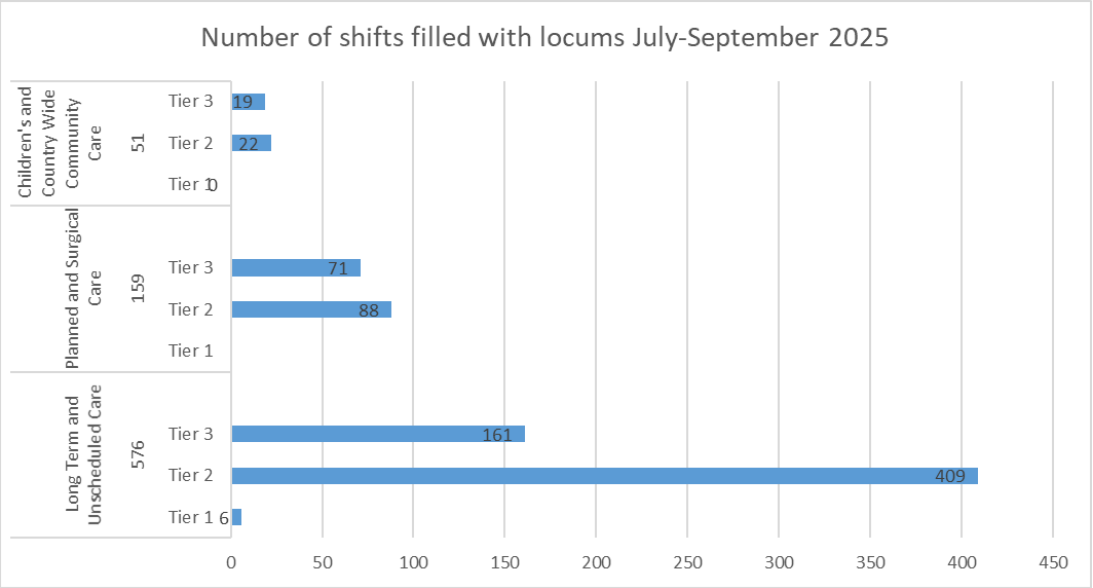

Exception Reports by Specialty
80
70
60
50
40
30
20
10
0
April
May
June
July
August
September
Test ER
Total ERs
Paeds
Accident and Emergency
Gen Surg
Gen Med
Resp
Cardio
Urology
ED
Haem
Geriatrics
T+O
O+G

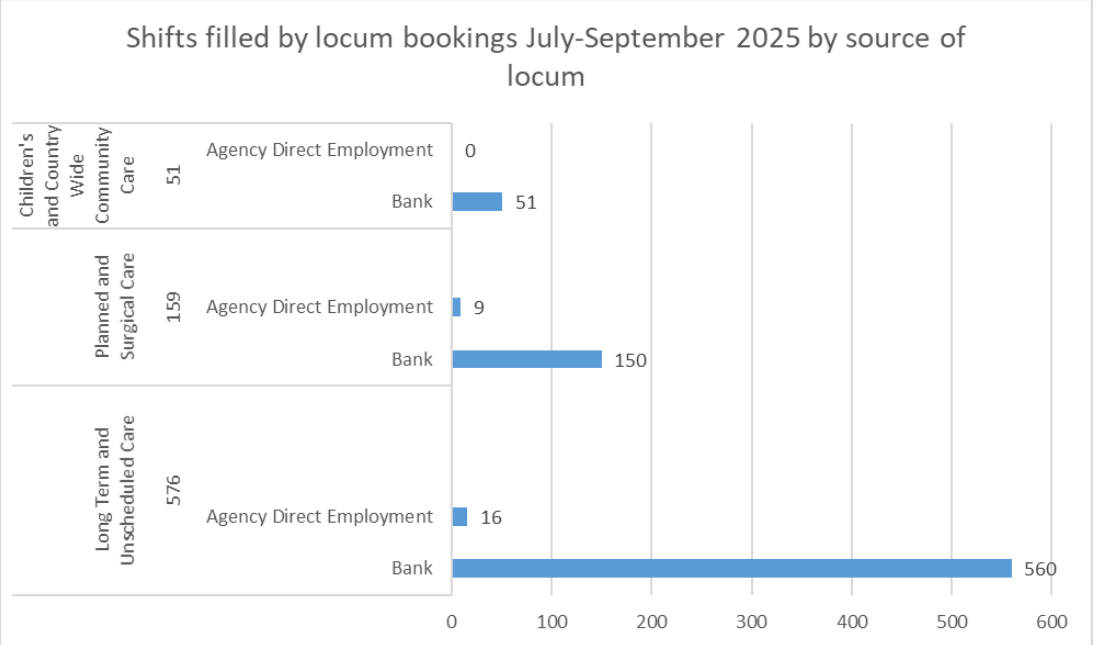

Exception Reports by Tier of Doctor
40
35
30
25
20
15
10
5
0
April
May
June
July
August
September
Tier 3
Tier 2
Tier 1

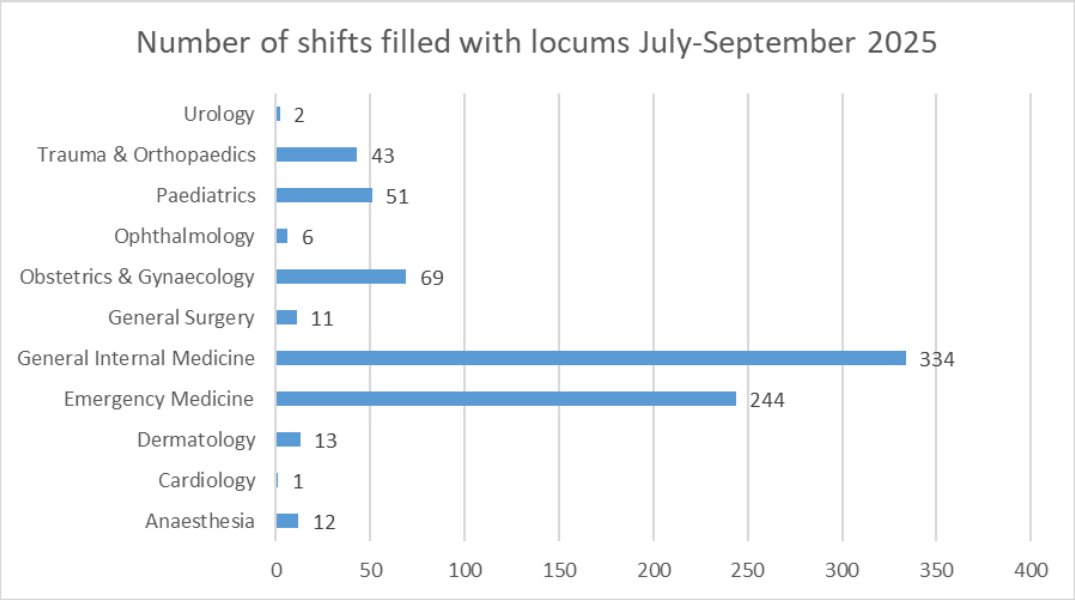
b) Work schedule reviews

ER outcomes - work schedule reviews				
Date	**Specialty**	**Grade**	**Reference No.**	**Review meeting notes**
18/07/25	General medicine	FY2	tplant150725_1	.

c) The following data is derived from TempRE reports for the relevant time.
Specialties not shown had no resident/LED locum bookings for the periods described.







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d) Below is a table supplied from Medical Workforce showing the relevant rota gaps across HDFT for quarter two and the current recruitment actions.

Directorate	Department	ROTATES	Grade	Deanery or Trust	WTE	Notes	Recruitment
LTUCC	Elderly Medicine/Acute Fra	Aug/Feb	GPST1	Deanery	1	Full-time deanery gap	Successfully recruited LED ST1 from Aug 25 to Feb 26
LTUCC	Elderly Medicine	Aug/Feb	GPST1	Deanery	1	Full-time deanery gap	Successfully recruited LED ST1 from Aug 25 to Feb 26
LTUCC	Acute Medicine (ACCS)	Aug/Feb	CT1	Deanery	1	Full-time deanery gap	Successfully recruited LED ST1 from Aug 25 to Aug 26 (LTFT 80%)
LTUCC	Emergency Medicine (ACCS	Aug/Feb	CT1	Deanery	1	Full-time deanery gap	Successfully recruited LED ST1 from Aug 25 to Feb 26
LTUCC	Emergency Medicine (HST)	Mar/Sep	ST4+	Deanery	2	2 x Full-time deanery gap	Successfully recruited 1 x LED from Sep 25 to Mar 26. Department have carried the remaining gap.
LTUCC	Psychiatry	Aug	FY1	Deanery	2	2 x Full-time deanery gap	No supervisors available for this placement, so doctors were reallocated to other specialties.
LTUCC	Respiratory	Aug/Feb	IM3	Deanery	1	Full-time deanery gap	Department did not wish to recruit
LTUCC	Stroke/Neuro	Aug	FY2	Deanery	1	Full-time deanery gap	Delayed start date due to FY1 extension
PSC	Orthogeriatrics	Aug/Feb	GPST1	Deanery	1	Full-time deanery gap	Consistent gap
PSC	General Surgery	Aug	FY2	Deanery	1	Full-time deanery gap	4 month gap fro Aug-Dec, did not recruit

e) Fines

Some backdated fine data is shown from previous quarters. There was a delay in these fines being issued due to leave of the GoSWH.

Numb	ER Submission Date	Doctor Grad	Director ate	Specialty	Rota Tier	Reson for fine	Hours: 0700-210	Hours: 2100-0700	Fine Tota	Payable to Docto	Payable to GOSW Fund
53	19/05/2025	LED	LTUCC	General Medicine	Tier 2	B	0	1	£100.75	£37.78	£62.97
54	29/05/2025	ST1	PSCC	Obs and Gynae	Tier 2	B	0	0.75	£89.44	£33.54	£55.90
55	12/08/2025	ST5	LTUCC	General medicine	Tier 3	B	0	0.58	£87.66	£32.87	£54.80
56	20/28/2025	FY2	PSCC	General Surgery	Tier 2	B	0	0.5	£50.39	£18.89	£31.50
57	23/08/2025	ST1	LTUCC	General Medicine	Tier 2	B	0	0.5	£59.63	£22.35	£37.27
58	28/08/2025	FY1	PSCC	General surgery	Tier 1	B	0	0.25	£21.77	£8.16	£13.61
59	28/08/2025	FY2	PSCC	General surgery	Tier 1	B	0	0.25	£21.77	£8.16	£13.61
60	23/08/2025	ST1	LTUCC	General Medicine	Tier 2	B	0	0.25	£29.81	£11.18	£18.64
61	23/08/2025	ST1	LTUCC	General Medicine	Tier 2	B	0	0.25	£29.81	£11.18	£18.64
62	28/08/2025	FY1	PSCC	General surgery	Tier 1	B	0	0.75	£65.31	£24.49	£40.82
63	03/09/2025	FY1	LTUCC	General Medicine	Tier 1	B	0	0.58	£50.51	£18.94	£31.57
64	13/09/2025	FY1	PSCC	General surgery	Tier 2	B	0	1.5	£151.13	£56.66	£94.47
65	23/09/2025	FY1	PSCC	General Surgery	Tier 1	B	0	1	£87.08	£32.65	£54.43
66	23/09/2025	FY2	PSCC	General Surgery	Tier 2	B	0	1	£87.08	£32.65	£54.43
67	29/09/2025	FY1	PSCC	General surgery	Tier 1	B	0	1.5	£130.62	£48.97	£81.65

Reason for fine	
A	A breach of the 48-hour average working week (across the reference period agreed for that placement in the work schedule)
B	A breach of the maximum 13 hour shift length
C	A breach of maximum of 72 hours worked across any consecutive 168 hour period
D	where 11 hours rest in a 24 hour period has not been achieved (excluding on-call shifts)
E	where five hours of continuous rest between 22:00 and 07:00 during a non-resident on-call shift has not been achieved
F	where 8 hours of total rest per 24 hour non-resident on-call shift has not been achieved
G	breaks have been missed on at least 25% of occasions across a four week reference period

Expenditure of GoSWH Funds			
Claim number	Expenditure Date	Justification	Amount
1	05/07/2025	Pizza for Redsident Doctor Forum	£ 156.12
2	23/07/2025	Ticket price to attend Society of Radiologist in Training Conference to present an oral presentation	£ 143.76

Current GoSWH Fund Total	£ 8,778.36

Qualitative information and summary

This quarter saw a significant increase in total numbers of exception reports compared with the same period last year. This was most marked in the Tier one (FY1) doctors across General Medicine and General Surgery. This most likely reflects an increase in reporting rather than a significant change in working practices among our Residents and LEDs.

In addition, the new framework for exception reporting will require RDs and LEDs to submit a “test” exception report within 7 days of starting work, which should be verified by the GoSWH. This was implemented in August by Medical Workforce and saw a proportion of the RD/LED body respond. These were manually filtered from the numbers shown in the above graphs where shown separately.

Themes and areas of concern

Frailty medicine

> *Moved to Byland ward in the afternoon. Ward round still happening at 3pm.*

Within LTUCC most exception reports are related to working on the frailty wards, most often from doctors rostered to work on the frailty base wards (Jervalux and Byland) or moved from AFU to support the base wards. On the base wards, complexity of patients, frequent complex discussion and junior skill mix are often referenced as reasons for remaining beyond 4pm. On AFU the reports are

> *…we have a very junior workforce which does not meet the need for Byland ward's complexity…*

often due to admissions, post take reviews and patient acuity late in the afternoon, requiring LEDs and RDs to remain after their 4pm finish. Frailty accounts for over half of the total reports placed for LTUCC each month and made up 71% of LTUCC exceptions in September. This data has been fed back to the directorate for review. I recommend staffing and skill mix of resident doctors is reviewed in these areas.

Breaks and Educational opportunities

There is an increasing number of reports placed for missed breaks and educational opportunities. Rather than representing a new problem, I believe this represents increase in reporting.

> *We all missed our breaks to meet the demands.*

Surgical Assessment Unit

> *When driving to work for an SAU shift, I think: "maybe if I just bump my car into this tree, I'd have less of my shift to do."*

The Tier 1 doctors working on SAU raised significant concerns, both via exception reports and during face-to-face meetings. They also completed a survey of all FY1s working on SAU that was shared with me.

They were very concerned about the workload on SAU, the level of responsibility they had and inconsistent senior support. There reported being asked to document for remote colleagues and of discharge letters piling up. Again, the PSCC escalation SOP for late finishes was raised as a source of anxiety.

> *…there was already a significant number of discharge letters that had not been completed from the previous week and I did not want to add too much to this if possible*

Most worryingly was that some FY1s had become fearful and reluctant to place exception reports. They felt that there was pressure from supervisors not to raise a report and that they would "sour" the relationship with their consultants if they continue. This was fed back to PSCC and received very a prompt response from Ms Rachel Morrison (Group Clinical Lead for PSCC group 2), Alex Kirk (Service Manager PSCC group 2) and Ms Kirstie Laughlan (Deputy Group Clinical Lead PSCC group 2). The following action plan has been created (thanks to Alex Kirk for sharing it for this report) to address the areas of concern. Exception reports form General Surgery and SAU have subsequently decreased. Early feedback from an FY1 doctor working on SAU reports that anecdotally they have "noticed a decent improvement and I have not left late on any of my recent shifts. I have been appreciative of the response from you and the surgical consultant team".

Some of the comments made by the residents were very emotive. I have reached out to those who expressed concerning ideas while driving to work and myself and Alex have made them aware of the range of support available to them. I am confident they have the information they need to seek further support if needed.

Subject	Description	Actions	Owner	Evidence	Status	Target Completion Date
Resident Engagement, Wellbeing and Feedback	Following serious concerns raised regarding FY1 wellbeing, immediate measures have been agreed to improve support and ensure staff are aware of the full range of wellbeing services available. Ongoing engagement between the directorate, education team, and GOSW is central to monitoring progress and sustaining improvement.	• Maintain regular meetings between resident doctors, ward sisters, service managers, and GOSW to discuss issues and progress.	Alexandra Kirk/ Lesley Danby / Rachel Morrison	Minutes of Meetings	Ongoing - Further SAU Feedback Session 12/11/25	Nov-25
		• Continue open communication with resident doctors, ensuring feedback can be shared directly with senior staff or through the GOSW.	Alexandra Kirk/ Lesley Danby / Rachel Morrison	Email, Minutes of Meetings	Ongoing - Further SAU Feedback Session 12/11/25	Nov-25
		• Deliver a Wellbeing Update Session led by Mel Kavanagh, outlining the support services available at the Trust.	Alexandra Kirk/ Katy Hodgson	Minutes of Meetings	Not yet started	
		• Conduct a Departmental Stress Risk Assessment, facilitated by Paul Yeadon and Mel Kavanagh.	Alexandra Kirk/ Katy Hodgson	Stress Risk Assessments	Not yet started	
		• Ensure all SAU managers complete the Trust e-learning "Suicide Awareness for Managers" if not already done.	Alexandra Kirk/ Katy Hodgson	Learning Lab	Not yet started	Nov-25
		• Managers to consider offering Thrive Conversations with staff where appropriate to support wellbeing discussions.	Alexandra Kirk/ Katy Hodgson	THRIVE Documentation	Not yet started	Nov-25

Subject	Description	Actions	Owner	Evidence	Status	Target Completion Date
Exception Reporting and Timely Support	Feedback from resident doctors (FY1s) and exception reports have highlighted issues with late finishes, delayed documentation, and variability in senior support on SAU. While exception reporting remains essential, proactive steps are being taken to address underlying causes and ensure a culture of openness and timely support.	• Reinforce expectations to all consultants and clinical supervisors that exception reports must be supported and responded to constructively.	Rachel Morrison	Email	Complete	Oct-25
		• Promote early escalation to senior staff when workloads become unmanageable, ensuring timely senior input.	Rachel Morrison / Alexandra Kirk	Email & Resident Doctor Escalation Policy	Complete	Oct-25
		• Reinforce the importance of real-time documentation, with senior staff supporting resident doctors to complete clinical records, discharge summaries, and letters contemporaneously.	Rachel Morrison	Email ?Could we do more for this		Oct-25
		• Encourage early identification of TTOs during ward rounds to reduce end-of-day backlogs.	Rachel Morrison	Email	Complete	Oct-25
		• Maintain a positive culture of exception reporting, ensuring that all reports trigger appropriate escalation and discussion with senior staff.	Rachel Morrison / Medical Education Team	Email	Complete	Oct-25
SAU SAS Grade Support	Although a dedicated SAS grade doctor has been assigned to SAU Monday to Friday, feedback has highlighted that senior presence and responsiveness have been inconsistent. Actions have been agreed to ensure robust oversight and consistent support for resident doctors.	• SAS grade cover has now been expanded to include weekends, ensuring consistent senior support across the week. Weekend shifts are currently being filled by offering additional paid sessions to SAS-grade doctors, with escalation to consultants where SAS cover cannot be secured.	Alexandra Kirk	Rota (Filled Shifts)	Ongoing - o/s shifts to fill 27&28 December 2025	Oct-25
		• Continue the audit of SAS presence and responsiveness on SAU, covering both General Surgery and Urology.	Victoria Franklin/ Alexandra Kirk	Audit documentation	Ongoing	Nov-25
		• SAS doctors rostered to SAU to remain resident and available on site during their shifts.	Alexandra Kirk	Email	Complete	Oct-25
		• Where SAS cover cannot be secured, consultants will provide direct support to maintain safe cover.	Alexandra Kirk	Rota (Filled Shifts)	Ongoing - o/s shifts to fill 27&28 December 2025	Oct-25
		• Reinforce that referral acceptance and bed allocation are the responsibility of the SAS grade doctor, not the FY1s.	Rachel Morrison/ Alexandra Kirk	Email from GOSW reinforced via the directorate.	Complete	Oct-25
		• Resident doctors encouraged to provide feedback directly to the directorate or GOSW if support is lacking, so that individual issues can be addressed promptly	Rachel Morrison/ Alexandra Kirk	GOSW reinforced via the directorate. Email also sent to SAS grades	Complete	Oct-25
SAU Staffing	SAU staffing remains a known challenge. Eight LED posts have been recruited to in order to strengthen supervision, provide mentoring, and improve rota resilience across the resident doctor rota. SCP roles are also being reviewed to ensure consistent daytime presence on SAU.	• Complete on boarding and induction of all eight new LEDs. Assign LED presence to SAU during weekday daytime hours.	Alexandra Kirk	Recruitment data	Ongoing - pre-employment check stage	Dec-25
		• Deploy LEDs to fill rota gaps and improve continuity for resident doctors.	Alexandra Kirk	Rota (Filled Shifts)	Ongoing - pre-employment check stage	Dec-25
		• Ensure SCPs are rostered to SAU when not required in theatre	Alexandra Kirk	Rota (Filled Shifts)	Complete	Oct-25
		• SCPs Job Plan Review	Alexandra Kirk/ Lesley Danby	Job Plans	Not yet started	Dec-25
		• SCPs rostered to SAU to remain resident and available on site during their shifts.	Alexandra Kirk/ Lesley Danby	Email & Audit	Ongoing - emails sent, Audit TBC	Nov-25
		• Maintain SAU staffing as a standing risk on the directorate risk register, reviewed at each PRM meeting.	Alexandra Kirk/ Lesley Danby / Rachel Morrison	Datix	Complete	Oct-25
		• Conduct a nurse staffing review supported by the Workforce Matron to ensure appropriate establishment and skill mix on SAU, aligned with patient demand and acuity.	Lesley Danby		Ongoing	
SAU Space and Environment	The SAU environment continues to experience high patient volumes and physical constraints, affecting staff workflow and patient safety. The issue has been escalated to the risk register for directorate.	• Space and environment issues to be discussed at the next PRM to explore short- and long-term solutions.	Alexandra Kirk/ Lesley Danby / Rachel Morrison	PRM Minutes	Ongoing - PRM 05/11/25	Oct-25
		• workstations to be ordered for ease of access for doctors	Alexandra Kirk/ Lesley Danby / Rachel Morrison		Ongoing - order submitted	Nov-25

Work Schedule Reviews

One work schedule review was requested on allocate during this period, of which I did not receive feedback. Currently we do not have a robust process for what a work schedule review should entail, or how this should be fed back. Final guidance on this process is awaited for version 13 of the T+Cs, and Medical Workforce and I will review this process when this is available.

Immediate Safety Concerns

Two Exception reports in Q2 flagged as immediate safety concerns. One was an error on a test report. The second report was from an FY1 doctor, relating to a very busy day on SAU. This fed into the conversations about SAU, as documented above. I continue to ask all residents flagging ISCs to raise these in DATIX to allow robust investigation.

Fines and Disbursement

There were 14 individual fines in Q2, although these were backdated to May 2025. They were all for exceeding shift length of 13 hours during residential long days/nights on call. This appears to be a pinch point for fines, as these is little leeway when the shift is already 12.5 hours long. The common causes for these in Q2 were acute deterioration in patients, requiring urgent intervention, and being new to the trust and needing time to learn how systems work. Several were related to FY1s working on SAU, which has already been addressed separately.

The Board should be aware, that current fine identification and calculation is a manual process undertaken by the GoSWH from individual exception reports. Some are more readily identifiable (rest and shift length), but the absence of fines for average hours worked, breaks and those relating to non-residential on calls does not give assurance of compliance. Rather this reflects a lack of robust method for monitoring and under reporting.

The money held in the GoSWH funds is for disbursement, by the resident doctors, to benefit their education and working lives. There are some contractual limitation on what the money can be used for, but little guidance on suggested uses. Version 13 of the T+Cs emphases the use of funds for wellbeing initiatives. Expenditure has historically been very low and to improve this I have created a group of resident doctors, led by Dr Matt Smith and Dr Sam Jackson (two of our registrars), to try and increase use of these funds and also to approve applications as a panel.

To support this I have created an application process for access to these monies and some principles to guide use, which has been presented and approved at RDF. I will retain oversight of applications and expenditure and it will be shared in my reports. Please see attached the process for attention.

Resident doctor forums

These continue on quarterly bases, no specific concerns were raised relevant to the GoSWH in September. The next meeting is planned for December 2025.

New Framework for exception reporting – February 2026

Version 13 of the Terms and Conditions of Service were published in September, with an implementation date of 4th February 2026.

They can be accessed in full using the following link: NHS Doctors and Dentists in Training England TCS 2016 VERSION 13 Final.pdf

This includes large reforms in how exception reporting will work. The largest change will be in how Exception reports are handled. Below I have highlighted some of the key changes to the process of which the Board should be aware.

- Exception reports <2 hours will be signed off by Medical Workforce within 10 calendar days with the doctors preference of time owing in lieu or payment (except where contractual limitations dictate time owing), subject to a 3 level checking process.

- Medical Workforce must complete the following process within 10 days for each exception report:-
    - Level 0 – Confirm category of exception and duration. Review evidence of additional hours (time, date and location), review the roster and cross check everything for accuracy. If correct, send to payroll for processing or approve TOIL.
    - Level 1 – If errors or concerns are identified, contract the Doctor and discuss. If not resolved, move to level 2
    - Level 2 – Contact the GoSWH to discuss

- The organisation should seek only to establish if the hours were worked, not the merit of the need to work beyond a work schedule. The GoSWH retains oversight of all report and can investigate if there are concerns about validity from Medical Workforce, including contacting the resident doctor to verify. If there are concerns about financial abuse, the GoSWH can raise this for investigation through local channels.

- Exception reports must be treated as strictly anonymous and only visible to named members of Medical Workforce, payroll, the GoSWH and their deputies and, in the case of educational ERs, the DME. A list of identified individuals must be shared with RD at induction, and an updated list shared if there are any changes. A proven breach of confidentiality will result in a £500 fine.

- Exception reports of >2 hours should be subject to a locally determined process, investigating safe staffing is maintained. This process must be agreed with the LNC.

- The employer must provide access to exception reporting for a doctor within 7 calendar days of them starting employment or work. The doctor must submit a test report for cross-validation with the GoSWH. The trust will have seven calendar days to resolve problems with access to exception reporting before a recurring weekly fine of £250 is levied, ongoing until access is established (£500/week from 3rd August 2026).

- Money in the GoSWH funds should be held in distinct pots to aid equitable distribution across the trust.

- The GoSWH will conduct a quarterly survey on fear of detriment from exception reporting in the trust and report to the board. I intend to combine this with a wider survey of working hours. Further details of the content of this survey is outstanding.

- GoSWH reports must be shared with the JLNC, LNC chair, at least one nominated LNC representative and an RDF representative. They must be publically available online within a month of completion.

- Reporting will be made according to a standardised national template (not yet available).

- Consolidated annual report on rota gaps and the plan for improvement to reduce these shall be included in the Trusts Quality Account, which must be signed off by chief executive and supplied to the JLNC.

- Any unresolved issues identified by the GoSWH must be raised in exceptional reports to the Board at the next meeting.

At the time of writing, there is a lack in robust guidance from NHSE regarding many elements of implementation. I have several concerns relating to these reforms detailed below:

- A predicted significant increase in the number of exception reports placed. Early adopting Trusts have unofficially advised of an 100% increase in numbers. This will significantly increase the administrative burden for Medical Workforce, particularly in relation to setting up immediate access to ER system and reviewing each exception report, and the GoSWH, in particular relating to the monitoring and levying of fines. The stated timeframes also give concern as there is only one GoSWH in role, and planned or unexpected leave could disrupt workflows. There will also be an increase in expenditure. Dedicated administrative support is available to GoSWHs in multiple other Trusts to great benefit. Primarily this is used for screening of exception reports, identifying, calculating and issuing fines and maintain and producing data for GoSWH and reports, freeing the GoSWH to investigate and support when there are issues. It would also be sensible to establish a deputy GoSWH who could assist with investigating concerns as well as cross-covering periods of leave.

- Currently we use Allocate as the platform for our exception reports. At a recent GoSWH conference, they were unable to give assurances the changes to the Allocate software would be ready in time for the February launch date. The software is disliked by residents as being cumbersome and time consuming and does not fulfil several areas that would be of benefit, such as asking residents to flag possible fines (or indeed automatically identifying these).

- Geolocation technology has been suggested as a means for providing assurance of financial scrutiny for exception reports. Although robust guidance on this is outstanding, I anticipate the feasibility and acceptability of this as a process being difficult. It would also not be immune to abuse if there were mal intent in raising reports. It has been stated that the Trust can determine what level of information they would require for financial assurance. I would suggest that a declaration of truth should be sufficient and the fact that any abuse of the ER system would be grounds for referral to the GMC. I ask the board to consider this question, so we can establish for February the level of scrutiny required, before taking this to the LNC/RDF for approval.

Recommendations for consideration

1. A formal process for work schedule review, based on the version 13 of T+Cs, should be designed to aid this process. This would allow robust feedback on these occurrences and I would the be able to offer assurance of this process.

2. Consideration of dedicated admin support for the GoSWH role.

3. Consideration of additional resource for the Medical Workforce Team to support additional work.

4. Consideration of a deputy GoSWH.

5. Determination of what assurance from exception reports is needed by HDFT to satisfy financial assurance.

6. Maintain awareness that due to limitations in time, software and reporting, it is not possible to wholly give assurance of RD/LED maintaining safe working hours in the trust.