CQC SAFE DOMAIN

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

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

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

Summary:

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

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

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

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

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

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

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

Corporate Risk ID	Strategic Ambition	Type	Principle Risk:: Violence and aggression against staff	Appetite	Initial Rating	February Rating	March Rating	Target Rating	Target Date
117	An Environment that promotes wellbeing	Operational ; Health & Safety	Organisational risk to compliance with legislative requirements, with the risk of major injuries, fatality or permanent disability to employees due to the failure to manage the risk of staff being subjected to acts of violence and aggression whilst carrying out normal duties, due to lack of suitable control measures and appropriate training.	Minimal	16	12	12	8	July 2025

Key Targets	Current Position	Plans to Improve Control and Risks to Delivery
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.	The organization is facing several challenges related to Violence & Aggression (V&A), Security, and Lone Working: • **Outdated Policies**: Current policies on Violence & Aggression, Security, and Lone Working are outdated and do not reflect the Trust's current structure, services, or resources. • **Generic Risk Assessments**: Available risk assessments are generic and lack clear identification of hazards or control measures. • **Limited Security Presence**: Security coverage is limited, with a security guard in place only in the Emergency Department from 6 PM to 6 AM, and a single Local Security Management Specialist (LSMS) supporting the entire Community footprint. • **Inadequate Training**: Training is limited and not provided on a risk-based approach, with low compliance in Conflict Resolution and Physical Restraint training, particularly before 2024. • **Inconsistent Escalation Procedures**: Procedures for staff response to incidents and patient management are limited and inconsistently applied. • **High Incident Rates**: There are daily reports of violence and aggression against staff, with 20-30 incidents recorded per month, despite the Trust's promotion of a zero-tolerance approach. • **Cultural Issues**: There is an ingrained culture of accepting certain levels of violence and aggression. **Training Updates and Compliance**: • Conflict Resolution Level 1 (mandatory e-learning) was introduced in January 2024, with 83.9% compliance across the Trust and 77.4% compliance in the HIF. • Lone Working training compliance stands at 96.7%. • Pre-2024 compliance for Conflict Resolution Breakaway Skills was 56.2%, with even lower compliance for Physical Restraint training. **Security Review**: • A limited assurance audit on Security has highlighted significant gaps, leading to a decision to separate Security risks from the broader V&A risks. This will include areas such as security policies, physical presence, lockdown procedures, and community support. • **Legislation Impact**: The upcoming Martyn's Law, which is pending due to the election, will likely require significant changes to the Trust's security measures. • **Resource Limitations**: The lack of dedicated security presence, especially at the HDH site, has hindered the ability to reduce the V&A risk score, with notable incidents occurring in hospital corridors and visitor toilets. • **Risk Score**: The risk score remains at 12, reflecting the ongoing challenges and will be reviewed at the August H&S Committee Meeting. The situation is compounded by a recent increase in high-risk incidents, highlighting the insufficient resources available to support both acute and community settings	**Task and Finish Group**: A Task and Finish group, led by the Head of H&S, has been established to review and improve all existing policies and procedures, aligning them with NHSE's Public Health Approach. Monthly meetings will begin in May 2024. **Mental Health Triage and Policy Update**: Changes to mental health triage in the Emergency Department are ongoing and will be incorporated into a new policy for managing patients who may self-harm or have mental health issues. This policy is in the approval process as of April 2024. **Ligature Assessments**: Ligature risk assessments are under review due to ward and therapy area changes. Training provision for ligature risks is also being addressed after delays caused by staffing changes. **Conflict Resolution Training**: A new Conflict Resolution training program is being developed with three levels tailored to staff risk levels. The content will align with the CQC-supported Restraint Reduction Network, with ongoing discussions to ensure appropriate training needs assessments (TNA) across the Trust. A business case is being prepared to expand training provision. **Community Security and Lone Working**: Visits to all community teams and locations are underway to assess current security and lone working procedures. **Domestic Abuse and Sexual Violence**: Meetings are being held to integrate issues of domestic abuse, sexual violence, and workplace sexual safety into the Violence Prevention and Reduction Strategy. A new policy and training package for line managers is in development, with plans for a team talk session by September/October. **Policy Reviews**: New policy and procedure are under delopment for staff safety. The Lockdown Policy and Bomb Alert Policies are under review to ensure they are up-to-date and effective. **New Risk Assessment Process**: A Trust-wide risk assessment has been developed and is now being used to inform team and department-level assessments. This is part of an ongoing effort to implement a new risk assessment process across the Trust.

Corporate Risk ID	Strategic Ambition	Type	Principle Risk:: Physical security provisions, training and support resources	Appetite	Initial Rating	February Rating	March Rating	Target Rating	Target Date
577	An Environment that promotes wellbeing	Operational ; Health & Safety	Organisational risk to compliance with legislative requirements, and the risk of major injuries, fatality or permanent disability to employees, patients, visitors or others due lack of suitable policies and procedures, and the subsequent lack of suitable and sufficient control measures, including physical security provision, training, resources to support implementation.	Minimal	16	16	16	8	April 25

Key Targets

Building Security Assessments completed for all premises used by Trust staff (this will not include patient homes which will be referenced in any relevant patient plan)

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

Risk assessments, policies and control measures actively monitored and reviewed. Reported via Security Forum

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

Security incidents investigated and remedial action taken where identified.

Effective communications to all staff.

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

Current Position

Outdated Security Policies: Policies related to Security, Lockdown, Bomb Alert, Theft, Damage of Trust assets, personal property, and CCTV are outdated and do not reflect the Trust's geographical footprint or current operations.

Generic Risk Assessments: Existing security risk assessments are generic and do not sufficiently identify hazards or provide clear control measures, particularly for building security, individual response, and lone working.

Limited Security Presence:

- **Acute Setting**: Security is present only from 6 PM to 6 AM daily, with additional coverage on Monday, Friday (7 AM – 5:30 PM), and weekends (6 AM – 6 PM).
- **Community Hospitals**: No dedicated security presence, such as at Ripon Community Hospital.
- **Community Footprint**: A single Local Security Management Specialist (LSMS) covers the entire community setting, limiting response capabilities.

Inconsistent Training: Staff training is limited and not risk-based. Compliance with escalation procedures during violent incidents is inconsistent, and staff are underprepared to manage security threats, including Violence & Aggression.

CCTV and Access Control Limitations:

- **CCTV**: Current coverage at the HDH site is inadequate, with management delegated to the HIF.
- **Access Control**: The swipe card access system is outdated, unsupported, and lacks proper control over keys and lock codes. This has led to poor key management, particularly with contractors and Trust staff.

High Incident Rates: Recent high-risk incidents, including absconded patients and Violence & Aggression (V&A) incidents in hospital corridors and visitor toilets, underline insufficient resources and response capabilities.

Safeguarding Gaps: There is no formal communication between the Safeguarding Team, Trust Security management, and Emergency Department management, despite warnings from local law enforcement regarding County Lines gang activity.

Governance Gaps:

- **Security Leadership**: Lack of clarity around executive leadership and accountability for Security within the Trust.
- **Security Forum**: The Trust Security Forum has been established and now reports to the Health & Safety (H&S) Committee. A review of membership and terms of reference is underway.

Plans to Improve Control and Risks to Delivery

Policy Updates: The Health & Safety (H&S) team, in coordination with HIF, is currently updating all relevant security policies, including Lockdown, Bomb Alert, Theft/Damage, and CCTV. These updates aim to align policies with the Trust's current structure, services, and geographical footprint.

Risk Assessments: Comprehensive security risk assessments are being developed, with a focus on individual sites, lone working, and staff responses. Departmental risk assessments are ongoing at the local HDH level and across the community footprint.

Security Infrastructure Improvements:

- **Door Access Control**: A new door access system has been costed and will be replaced incrementally as part of the Trust's Backlog Maintenance work.
- **CCTV Coverage**: A review of CCTV systems is in progress, with updates planned where necessary.
- **Security Guards**: HIF is obtaining legal advice regarding the provision and licencing of Security Guards at the HDH site. This will be included in a business case for securing funding for additional security personnel.

Training Improvements: Training on Violence & Aggression and Security risks is under review and will be updated to ensure staff receive appropriate, risk-based training. A new Conflict Resolution program tailored to various risk levels is in development.

Governance and Responsibility Clarification: Discussions are ongoing with HIF to clarify security roles and responsibilities. Additionally, the Trust Security Forum's review will strengthen the governance structure by refining its terms of reference and membership.

Compliance with Martyn's Law: With the impending implementation of the Terrorism (Protection of Premises) Bill (Martyn's Law), the Trust will undergo significant work to ensure compliance, particularly in areas related to terrorism risk management.

Improved Safeguarding Communication: Efforts are being made to establish formal communication channels between the Safeguarding Team, Trust Security management, and Emergency Department management to address security threats, such as County Lines gang activities.

Corporate Risk ID	Strategic Ambition	Type	Principle Risk: Outsourcing of Hazard Group 3 Microbiology Work Due to CL3 Facility Unavailability	Appetite	Initial Rating	February Rating	March Rating	Target Rating	Target Date
264	An Environment that promotes wellbeing	Operational ; Health & Safety	The unavailability of the onsite Containment Level 3 (CL3) laboratory at HDFT, deemed unfit for purpose in November 2022, has led to the outsourcing of Hazard Group 3 microbiology work to external providers. Initially outsourced to NHS Trusts within WYAAT and, since June 2024, to a private laboratory in London, this situation poses risks to quality, safety, and financial sustainability, including potential delays in clinical diagnosis, risk of inappropriate treatment, and significant ongoing cost pressures.	Cautious	9	15	15	6	TBC

Key Targets

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

Current Position

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

These include:

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

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

Plans to Improve Control and Risks to Delivery

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

These include:

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

Harrogate and District NHS Foundation Trust Corporate Risk Register

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

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

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

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

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

Lead Committee	Resource Committee	**Summary** The organization is facing critical challenges within the CQC Responsive Domain, which emphasizes timely, person-centered care and equitable access to services. The risks include significant delays in autism assessments (CRR34), where waiting times have ballooned to a projected 43 months, preventing children from receiving timely diagnoses and necessary support. Additionally, the Trust is struggling to meet the A&E 4-hour target, with performance dropping below the national standard of 78%, leading to increased 12-hour breaches and ambulance handover delays. These delays compromise patient safety and the quality of care, highlighting the urgent need for improved capacity, streamlined processes, and strategic resource allocation to ensure that care is responsive, accessible, and equitable for all patients.
Executive Committee	Operational Management Group (OMG)	
Initial Date of Assessment	1st July 2022	
Last Reviewed	March 2025	

Corporate Risk ID	Strategic Ambition	Type	Principle Risk: : Autism Assessment	Appetite	Initial Rating	February Rating	March Rating	Target Rating	Target Date
1	Great Start in Life	Clinical; Patient Safety	Risk to quality of care by not meeting NICE guidance in relation to the commencement of autism assessment within 3 months of referral. Risk that children may not get access to the right level of support without a formal diagnosis and that this could lead to deterioration in condition. There is a need to reduce the backlog of referrals back to the NICE standard of three months (reduce the waiting list to approximately 120)	Minimal	12	15	15	9	March 25

Key Targets	Current Position	Plans to Improve Control and Risks to Delivery
Waiting list would have to be reduced to 120 and longest wait to 13 weeks. Baseline capacity would need to meet the referral rate. Numbers on the waiting list 1566 (target 120) Longest wait of CYP having commenced assessment, 82 weeks (target 13) Activity - 31 completed assessments in Aug against ICB plan of 50 (plus 2 military assessment), YTD 255 against plan of 250. ■ To meet the monthly ICB target for number of assessments ■ Meet the annual planned target for assessments	We have modelled the impact of the funded Waiting List Initiative (WLI) which ended on 31st Aug 24. The projected wait for assessment for a new referral added to the waiting list today is 39 months. Our commissioned capacity is now lower at 40 assessments per month which means the waiting list will grow more steeply. Non-recurrent funding challenges service management due to lead times for capacity acquisition and staff training, exacerbated by national shortages. Loss of a key clinical team member impacts medium-term assessment capacity. Support provided to the team; commissioners informed. ICB-wide autism and ADHD group supersedes previous locality-based group, aiming to standardize referral criteria. No extra funding available for capacity gaps. Stabilizing waiting lists requires increased capacity, costing £490k annually. Modeling 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 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.

Corporate Risk ID	Strategic Ambition	Type	Principle Risk: ED 4-hour Standard	Appetite	Initial Rating	February Rating	March Rating	Target Rating	Target Date
3	Person centred, integrated care, strong partnership	Clinical; Patient Safety	Failure to Meet A&E 4-Hour Target Due to Inadequate Patient Flow, Leading to Increased 12-Hour Breaches and Ambulance Delays, Resulting in Compromised Patient Safety and Regulatory Non-Compliance	Minimal	12	12	12	8	March 25

Key Targets

A&E 4 hour target to be met, 6 hour breaches <102 per month and 0 x 12 hour breaches

4 hour performance

The new national target for 24-25 is 78%. The average performance decreased during the winter months.

Current Position

4 hour performance

The new national target for 24-25 is 78%. Performance:

TOTAL ED PERFORMANCE INCL RIPON	Year	Month	Day	Non admitted breaches	Admitted Breach Number	TOTAL ED ATTENDANCE WITH RIPON	MAX ED Attendances	MIN ED attendance	AVERAGE ED attendance	Ripon MIU Attendance
64.27%	2022	September	30	669	544	3395	181	123	150	544
68.22%	2022	October	31	857	814	5258	169	122	144	785
66.22%	2022	November	30	875	857	5128	168	112	146	748
63.65%	2022	December	31	943	959	5235	187	114	145	735
77.82%	2023	January	31	385	643	4635	154	93	126	742
80.79%	2023	February	28	329	551	4580	181	102	138	721
78.45%	2023	March	31	461	688	5337	167	109	146	810
83.48%	2023	April	30	360	501	5219	169	121	147	806
81.56%	2023	May	31	461	610	5815	182	134	157	952
80.54%	2023	June	30	536	617	5926	188	133	165	988
81.95%	2023	July	31	522	532	5838	189	129	157	979
72.89%	2023	August	31	784	736	5607	177	130	152	902
65.56%	2023	September	30	1157	840	5799	185	123	161	982
69.87%	2023	October	31	809	890	5656	195	125	155	851
68.91%	2023	November	30	854	838	5443	194	131	157	734
67.10%	2023	December	31	920	931	5626	205	120	158	724
71.21%	2024	January	31	767	889	5751	187	125	161	775
71.97%	2024	February	29	778	713	5320	209	128	158	727
78.15%	2024	March	31	576	670	5702	195	128	160	750
72.51%	2024	April	30	725	815	5606	193	129	158	858
73.40%	2024	May	31	864	790	6219	197	137	167	1038
72.88%	2024	June	30	873	787	6121	202	143	170	1010
74.25%	2024	July	31	816	772	6168	196	127	165	1058
79.23%	2024	August	31	636	592	5913	181	120	156	1079
75.44%	2024	September	30	831	668	6103	202	142	169	1044
72.29%	2024	October	31	839	824	5987	209	133	164	915

Plans to Improve Control and Risks to Delivery

To support the Trust's True North objective of meeting the ED 4-hour standard, several focused actions and plans are being implemented:

- **Focussed Impact Work**: Targeted efforts are being made at the directorate, care group, and ED front line levels to improve performance against the 4-hour standard.
- **Internal Professional Standards**: These are being relaunched, with a draft prepared following a workshop, to enhance escalation processes.
- **Triage Efficiency**: Efforts are underway to ensure all patients receive an initial triage within 15 minutes of arrival, improving patient flow and safety.
- **Effective Streaming**: More focused support is being provided to improve the effectiveness of patient streaming to Same Day Emergency Care (SDEC) and ED2.
- **Non-Headed Beds**: These have been implemented with measurable success, contributing to better patient management and care outcomes.

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

Key Targets

All eligible patients receiving HASU Care

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

Current Position

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

Existing controls include:

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

Plans to Improve Control and Risks to Delivery

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

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

Harrogate and District NHS Foundation Trust Corporate Risk Register

Corporate Risk ID	Strategic Ambition	Type	Principle Risk: Cardiology	Appetite	Initial Rating	February Rating	March Rating	Target Rating	Target Date
642	Person centred, integrated care, strong partnership	Operational; Business Continuity	Risk to HDFT's ability to deliver acute DGH services due to the fragility of the cardiology service caused by inadequate staffing, reliance on locum cover, and increasing service demand. A locum consultant and Registrar are now in post, this has provided significant control and reduction in likelihood.	Minimal	12	9	9	3	Dec 2025

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

Corporate Risk ID	Strategic Ambition	Type	Principle Risk: Imaging for ED Patients	Appetite	Initial Rating	February Rating	March Rating	Target Rating	Target Date
257	Person centred, integrated care, strong partnership	Clinical; Patient Safety	Risk to patient safety due to potential delays in diagnostic imaging for ED patients caused by intermittent CT scanner breakdowns, lack of MRI access out of hours, and delays in CT reporting for trauma cases due to unclear job planning and Medica processes. These issues could lead to delayed diagnoses, compromised patient outcomes, and increased treatment times, impacting the organisation's ability to provide timely and effective emergency care.	Minimal	12	12	12	3	TBC

Key Targets

- Reduction in incidents breakdown of CT scanner
- Access to MRI out of hours
- Reduction in Delays for CT reporting out of hours for trauma

Current Position

HDFT faces a significant risk to patient safety due to delays in diagnostic imaging caused by:

- **Equipment and Access Issues:**
  - Intermittent breakdowns of the CT scanner, requiring reliance on temporary solutions like a dismountable Canon CT scanner and mobile CT scanner.
  - Lack of access to MRI services out of hours, resulting in non-compliance with GIRFT recommendations for 24/7 access (compliance deadline June 2024).
  -
- **Operational and Reporting Delays:**
  - Delays in CT reporting for trauma cases caused by unclear job planning and Medica processes.
  - Delays to scans due to the unavailability of a 24/7 transfer team.

Short-term mitigation includes a Standard Operating Procedure (SOP) for diverting patients to Leeds when the CT scanner is down and the use of temporary CT scanner facilities. Longer-term plans involve permanent infrastructure improvements to house a new CT scanner within the hospital building.

Equipment and Infrastructure:

- A dismountable Canon CT scanner and mobile CT scanner are operational on-site to maintain service continuity.
- An SOP is in place to divert patients to Leeds when the CT scanner is non-functional.

Reporting and Escalation:

- Continued escalation and updates through operational teams to address Medica delays and job planning gaps for CT reporting.

Plans to Improve Control and Risks to Delivery

Plans for Improvement:

1. **Infrastructure Development:**
   - Complete works for installing a permanent CT scanner within the hospital building to ensure reliable imaging services.
2. **MRI Access and Compliance:**
   - Develop and implement a plan to achieve 24/7 MRI access by June 2024 to meet GIRFT requirements. This includes exploring partnerships, additional staffing, or equipment procurement.
3. **Operational Efficiency:**
   - Address delays in CT reporting by revising job planning and ensuring clear processes with Medica.
   - Review and enhance transfer team availability to support 24/7 imaging needs.
4. **Monitoring and Review:**
   - Conduct regular reviews of imaging service delays, including equipment downtime, reporting timeframes, and transfer delays, to track improvements.
   - Evaluate the effectiveness of temporary CT solutions and escalate any gaps to the executive team.

This approach prioritises patient safety by ensuring continuous access to diagnostic imaging services while addressing equipment, staffing, and operational challenges.

USE OF RESOURCES

Use of resources area Key lines of enquiry (KLOEs)

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

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

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

Corporate Risk ID	Strategic Ambition	Type	Principle Risk: Delivery of financial plan	Appetite	Initial Rating	February Rating	March Rating	Target Rating	Target Date
69	Overarching Finance	Financial	The Trust achieved a breakeven plan in 23/24 however for the Trust to deliver the 24/25 plan, £5.2m deficit, it will require a reduction to current run rate and delivery of the waste reduction and productivity program	**Cautious**	9	16	16	8	March 25

Key Targets	Current Position	Plans to Improve Control and Risks to Delivery
1. Monthly financial reporting **2. NHSE productivity analysis** **3. Agency Expenditure** **4. Cash position**	The Trust has reviewed and established the underlying pressure moving into 24/25, £20.1m. Following further scrutiny across the wider system, the system agreed to a higher efficiency % target and an allocation of further funding. This has resulted in a £5.2m deficit plan for 24/25 which includes a 6% efficiency target. There are a number of risks contained within this plan including • Continued ED boundary divert • Inflation above the levels included in planning • Recurrent delivery of the efficiency programme • ERF Funding is achieved/over delivered The Directorate highlighted a number of issues when signing budget plans for 24/25. A number of mitigations are being reviewed to manage these. As at December the Trust are £8.6m away from plan, £12.5m deficit YTD however the current forecast suggests this will worsen and is likely to be between a £18m to £20m deficit, there are a number of areas contributing to this. An area which continues to show improvement is agency spend which is now 1.3% against a 3.2% NHSE target. The current run rate is having a detrimental impact on the cash balance. Cash support will be required throughout the year if the reduction in run rate is not delivered. Current cash forecast highlights that this will be required in March 25.	1. Continued discussions with ICB. 2. Efficiency becoming a Corporate programme. Targeted Directorate training and support have been delivered to all Directorates. 3. WRAP Champions to be developed across the Trust.

Corporate Risk ID	Strategic Ambition	Type	Principle Risk: NHS Pay awards	Appetite	Initial Rating	February Rating	March Rating	Target Rating	Target Date
367	Overarching Finance	Financial	Ability of Local Authorities to fund the impact of NHS pay award could result in a cost pressure for HDFT. The Public Health Grant for 2024/25 varies by Local Authority. While NHS national guidance suggests that the Public Health Grant has been uplifted to cover both the ICB non recurrently funded 2.9% from the 2023/24 pay award and the 2.1% proposed pay award for 2024/25 this appears not to be the case for all the Local Authorities we have contract with. Where there is a gap between LA public health grant and the cost of pay award there is a risk HDFT could be left with a financial pressure	**Cautious**	12	12	12	4	March 25

Key Targets	Current Position	Plans to Improve Control and Risks to Delivery
Written confirmation of funding for pay awards received from LA. Revised workforce model agreed and signed off by LA and HDFT	The Trust has communicated with all Local Authorities (LAs) regarding the need for them to fund the 2.9% pay award and the proposed 2.1% increase for 2024/25. Finance has provided the LAs with the associated costs, and ongoing meetings are being held to discuss funding arrangements, particularly in relation to Public Health Grant allocations and the cost of NHS pay awards. To ensure progress, monthly meetings have been established with the Directorate, Contracting, and Finance teams to track feedback from the LAs and determine the next steps. The situation is being closely monitored as discussions continue. The financial impact of NHS pay awards on Local Authority (LA) Commissioned Services remains a significant risk, with varying positions across LAs for 2024/25. **Pay Award Coverage and Challenges:** The Public Health Grant for 2024/25 is insufficient in some areas to fully cover the 2.9% pay award from 2023/24 (previously funded by the ICB on a non-recurrent basis) and the proposed 2.1% pay award for 2024/25. ○ Where there are funding gaps, service models may need adjustment to align with available budgets, introducing potential risks to service delivery. **Local Authority Funding Positions:** ○ **Middlesbrough:** Public Health Grant uplift does not cover the 2.9% or 2.1% pay awards; discussions are ongoing. ○ **North Yorkshire:** Grant uplift covers the 2.9% but not the 2.1%; awaiting final pay award confirmation. ○ **Wakefield:** Currently not funding due to contract underspend; discussions ongoing on using the 23/24 underspend to fund future pay awards. ○ **Durham, Darlington, and Northumberland:** Public Health Grant is sufficient to cover both pay awards. ○ **Gateshead, Stockton, and Sunderland:** Awaiting further confirmation or budget adjustments; discussions are ongoing. ○ .	The Trust is actively engaging with Local Authorities (LAs) to address the funding required for the 2.9% pay award and the proposed 2.1% increase for 2024/25. Finance has provided detailed cost estimates to the LAs, and ongoing meetings are being held to negotiate the funding, particularly concerning Public Health Grant allocations. To manage and monitor progress, the Trust has established monthly meetings with the Directorate, Contracting, and Finance teams to review feedback from LAs and determine the appropriate next steps. These actions are part of a coordinated effort to secure the necessary funding and ensure financial stability for the upcoming fiscal year. **Escalation and Mitigation Efforts:** ○ Finance and contracting teams have informed LAs about the funding requirements and provided cost details. ○ Monthly meetings are in place between the Directorate, Contracting, and Finance to monitor LA feedback and plan next steps. ○ Contracting has escalated unresolved issues, such as in Wakefield, to the Deputy Director of Finance. • **Potential Service Implications:** Where funding gaps persist, service models may require adjustments. If these adjustments pose risks, they will be reviewed by the CC Board and escalated as needed

CQC EFFECTIVE DOMAIN

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

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

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

Summary in Month:

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

Corporate Risk ID	Strategic Ambition	Type	Principle Risk: Community Dental	Appetite	Initial Rating	February Rating	March Rating	Target Rating	Target Date
6	Provide person centred, integrated services through strong partnerships	Clinical; Patient Safety	Risk to patient safety due to correlation of long waiting times and increased risk of pain and infection, which may affect quality of life and treatment required. Secondary risk to Trust performance standards by failing to meet NHS annual planning target of no RTT waiters beyond 78weeks currently, 65 weeks by end March 2024 and 52wks by end March 2025.	Minimal	12	12	12	6	Aug 25

Key Targets	Current Position	Plans to Improve Control and Risks to Delivery
Numbers on the patients waiting to start treatment over 52weeks, 65weeks and 78weeks **Current position for RTT waiters –3 patients between 52-64 weeks. Current position for Non RTT waiters -– 125 patients over 78 weeks, 199 patients between 65-77 weeks, 366 patients between 52-64 weeks.** No of overdue continuing care patients. **Current position – 2169 patients overdue. Longest waiter - 4 years overdue.**	The ICB has agreed to invest an additional £1.5 million into the CDS service at HDFT, extending the contract by 18 months until March 31, 2025. Regional discussions suggest a potential agreement on a 7+3 contract and amended service specification, with a possible increase in the funding envelope, though formal confirmation is pending post-general election. The current funding does not fully align with the submitted business case, so the operational team and service manager have developed a plan to optimize the use of this investment, focusing on managing waiting times for both RTT and non-RTT patients. Key actions for July include recruiting a new clinical lead, continuing IT procurement, and addressing low staff engagement, which has been identified as a significant risk to service delivery. The CDS team is also being encouraged to participate in the HDFT Impact work as part of phase 4 to further support service improvements.	The key plans and actions for the CDS service include ongoing liaison with the ICB and the implementation of a Waiting List Initiative (WLI) to address patient backlogs, with additional GA and clinic sessions planned for the financial year. The replacement of the SOEL Health dental IT system is underway, although the procurement process has faced delays, and a direct award is being sought to meet the April 2024 deadline. Capital kit replacement, including dental chairs and X-ray equipment, is progressing, with 2023/24 equipment being installed and approvals pending for 2024/25 purchases. Recruitment efforts are ongoing, with successful appointments for dentists and dental nurses from the business case, though challenges remain in filling positions in the East and for paediatric specialists. Recruitment for key leavers is also ongoing, with many new staff expected to start in September 2024.

CQC WELL-LED DOMAIN

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

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

Lead Committee	Trust Board	**Summary in Month:** This area of the Corporate Risk Register is linked to the Well-Led Domain. Currently there is no Corporate Risk within this Domain.
Executive Committee	Senior Management Committee (SMT)	
Initial Date of Assessment	1st July 2022	
Last Reviewed	March 25	

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

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

Harrogate and District NHS Foundation Trust

Board Meeting Held in Public
Wednesday 26th March 2025

Title:	Learning from Deaths Quarterly Report Q3: Oct-Dec 2024
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.	

Harrogate and District NHS Foundation Trust

Board Meeting Held in Public

Wednesday 26h March 2025

Learning from Deaths Quarter 3 Report

Executive Medical Director

1.0 Executive Summary

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

SHMI has risen which is most likely a data accuracy issue due to delays in clinical coding. Observed number of death remains at a stable level.

21 cases have undergone a structured judgement review since the last report. Learning from these reports is shared within and across the organisation.

NHS
Harrogate and District
NHS Foundation Trust

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, 199 deaths were recorded in Q3, up from 175 in the preceding Q2 and also up compared to Q3 in 23/24 which had 189 deaths. A regional increase has been identified by Medical Examiners across the north of England who have estimated an approximate 20% increase in total deaths (hospital and community) compared to last winter. This data is not risk-adjusted so takes no account of the unique characteristics of individual admissions. Comparison with the national mortality rate is also shown where data is available (shown in the darker blue line in Figures 1 and 2). This demonstrates that the peaks and troughs we see in HDFT are often mirrored at the national level. Figure 2 gives a "zoomed in" view of data from the last 2 years. Note that the 12 month rolling mortality has generally declined since 2010 (apart from the impact of the Covid pandemic). It should be remembered that the denominator for this data is the number of hospital episodes, so as we increase elective work (including endoscopies), the percentage of deaths would be expected to fall.

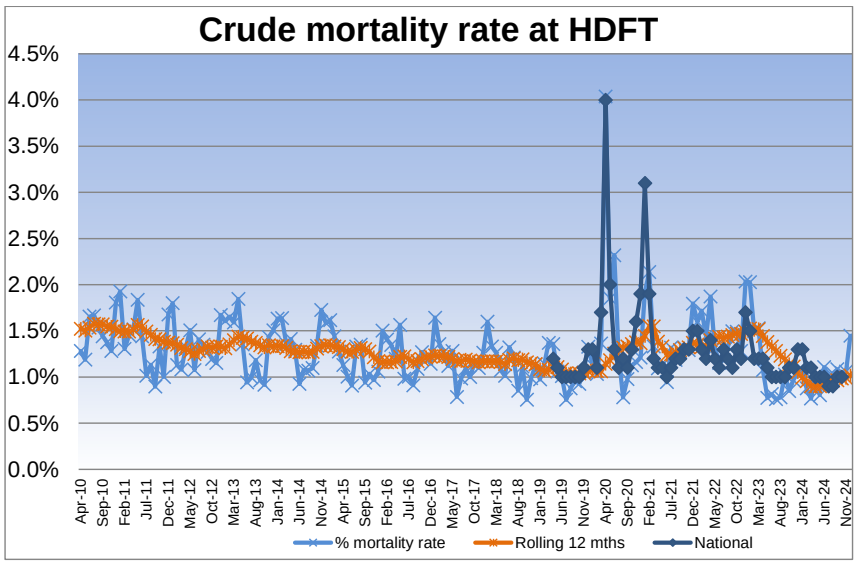

Figure 1: Crude mortality rates over the last 14 years (%deaths per hospital episode)

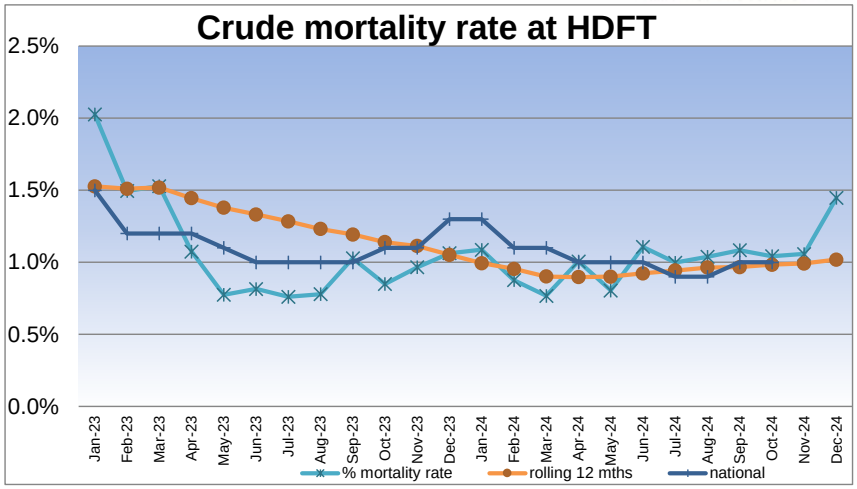

Figure 2: Expanded crude mortality rates over the last 2 years (%deaths per hospital episode)

3.2 Standardised Hospital Mortality Index (SHMI)

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

Figure 3: HDFT SHMI since December 2022 versus regional peers

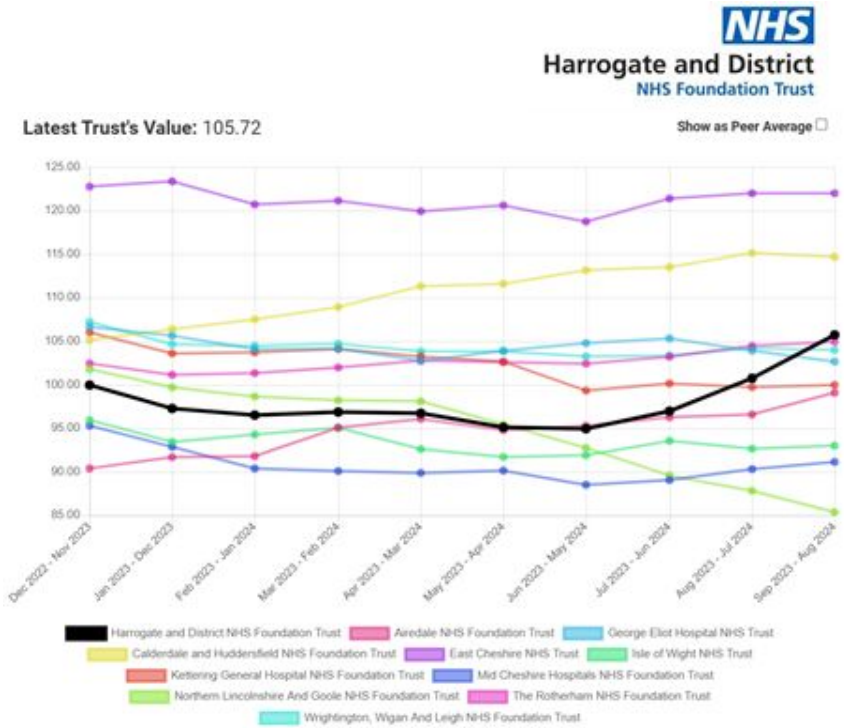

Figure 4: HDFT SHMI since December 2022 versus national peers

As can be seen, our SHMI has been rising since June 2024. Further interrogation of the data shows that the number of deaths has remained fairly constant (Figure 5), but the number of expected deaths has almost halved (Figure 6):

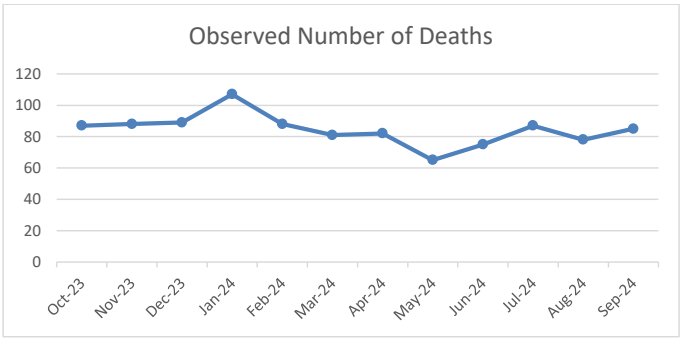

Figure 5: Observed number of deaths (in hospital or within 30 days of discharge)

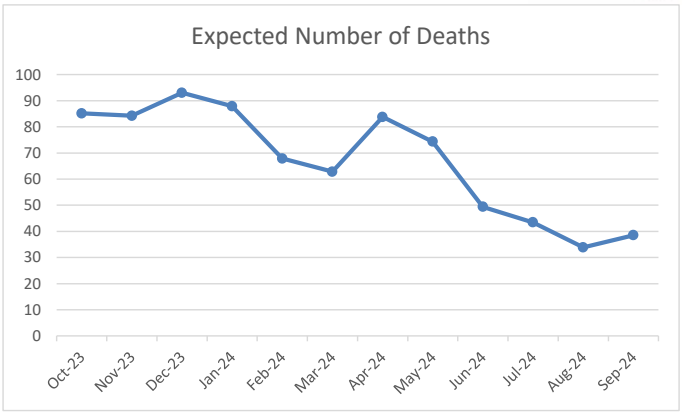

Figure 6: Expected number of deaths (in hospital or within 30 days of discharge)

A significant fall in expected death numbers raises concerns of a data quality issue. Following interrogation of the data, we have identified a recent increase in patients' diagnostic code in the category "Invalid primary diagnosis". As can be shown in Figure 7, we normally have very few spells in this category, but it has sharply risen in 24/25 year to date. The reason behind the rise of this coding category is likely due to incomplete clinical coding by the time of SHMI generation. Working with the data analytics team, an action plan to improve turnaround for clinical coding has been agreed and is now underway. We understand from our external data processing provider (HED) that our SHMI data will remain as it is for 24/25 and cannot be retrospectively adjusted.

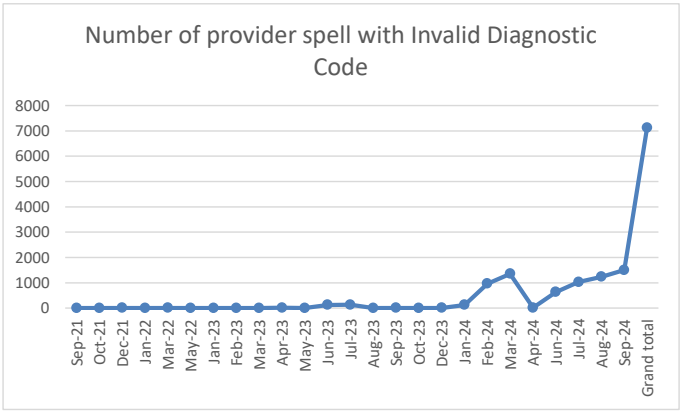

Figure 7: Number of provider spells falling into the SHMI diagnostic category of "Invalid Primary Diagnosis"

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

3.3 Structured judgement reviews (SJR)

21 cases have been reviewed in this quarter with 18 relating to deaths in this period and 3 from the preceding Q2.

We received 1 "red alert" for a diagnostic category with possible excess mortality in this quarter – deaths categorised as being due to "acute cerebrovascular disease". This related to the cumulative number of deaths up to and including August 2024. By September, this had fallen to an "amber alert". In the next quarter, the cases from this category with the lowest predicted mortality during the red alert period will be chosen for an SJR. This is a diagnostic area which has previously between explored with no concerns identified. We are currently finalising "business rules" as to when such intermittent alerts would trigger a more in-depth exploration of clinical cases.

In addition to cases chosen at random to provide assurance, some clinical teams select cases that they have already identified as having possible lapses in care and this therefore generates a higher number of episodes of poor care than previously (where a higher proportion of cases for review were selected at random). We are looking to add an extra field to our SJR tool so we can identify why the case was chosen for review and get a clearer picture of the incidence of each quality-of-care category.

2 cases were in patients with a learning disability who will receive a second external review as part of the LeDeR process. Feedback on their findings will be provided in subsequent papers when the reports are received.

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

Commented [JA1]: Is that all admission or just medical?

Commented [DE2R1]: Comments relate to medical

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

Date of admission	Care in First 24 hours	Ongoing Care	Avoidability of Death	Clinical/ Organisation score (NCEPOD)	Overall Care
04/10/2024	Good care	Good care	Definitely not avoidable	Good practice	Good care
04/10/2024	Adequate care	Not Applicable	Definitely not avoidable	Room for improvement in clinical care	Good care

NHS
Harrogate and District
NHS Foundation Trust

01/10/2024	Poor care	Poor care	Slight evidence of avoidability	Room for improvement in clinical and organisational care	Poor care
11/10/2024	Good care	Good care	Definitely not avoidable	Good practice	Good care
27/09/2024	Adequate care	Not Applicable	Slight evidence of avoidability	Room for improvement in clinical care	Adequate care
15/10/2024	Excellent care	Excellent care	Definitely not avoidable	Good practice	Excellent care
07/10/2024	Good care	Poor care	Slight evidence of avoidability	Room for improvement in clinical care	Poor care
25/11/2024	Adequate care	Good care	Definitely not avoidable	Room for improvement in clinical care	Good care
24/10/2024	Adequate care	Not Applicable	Definitely not avoidable	Room for improvement in organisational care	Adequate care
31/10/2024	Good care	Not Applicable	Definitely not avoidable	Good practice	Excellent care
10/10/2024	Adequate care	Not Applicable	Definitely not avoidable	Room for improvement in clinical and organisational care	Good care
14/11/2024	Good care	Good care	Definitely not avoidable	Room for improvement in organisational care	Good care
12/06/2024	Adequate care	Adequate care	Slight evidence of avoidability	Room for improvement in organisational care	Adequate care
19/11/2024	Good care	Good care	Definitely not avoidable	Good practice	Good care
31/10/2024	Good care	Good care	Definitely not avoidable	Good practice	Good care
29/11/2024	Good care	Good care	Definitely not avoidable	Good practice	Good care
26/11/2024	Good care	Good care	Definitely not avoidable	Room for improvement in	Good care

				organisational care	
30/11/2024	Good care	Good care	Definitely not avoidable	Good practice	Good care
18/09/2024	Poor care	Excellent care	Slight evidence of avoidability	Good practice	Good care
03/09/2024	Excellent care	Good care	Definitely not avoidable	Good practice	Good care
30/11/2024	Poor care	Poor care	Slight evidence of avoidability	Room for improvement in clinical and organisational care	Poor care

Table 1: Cored details of the cases reviewed this quarter

Three cases had overall care described as “poor”. All have been highlighted for a second review by a different clinician. In all cases where poor care has been identified, the treating team will review the case in the Morbidity & Mortality review section of their regular governance meetings, with learning shared with the required colleagues.

Figure 8 below shows the breakdown of overall care this financial year:

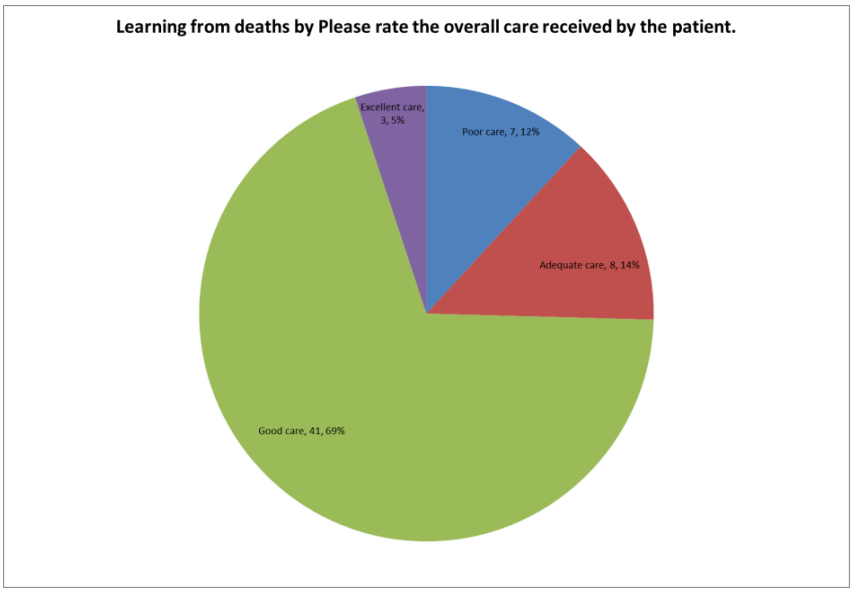

Figure 8: Overall care in all cases reviewed this financial year

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

End of Life Care			
	24/25 Q1	24/25 Q2	24/25 Q3
Good care	12	11	11
Adequate care	4	2	1
Not Applicable	2	3	6
Poor care	1	1	0
Excellent care	0	2	3

Tables 2: End of Life Care provided

Patient Record Quality			
	24/25 Q1	24/25 Q2	24/25 Q3
Good	14	12	18
Adequate	5	6	2
Excellent	0	1	1

Tables 3: Quality of Patient Records

Another new section of the Datix SJR is the ability for the review to identify any positive or negative learning points from the cases. These are shared with the clinicians via the regular Medical Directorate newsletter. Positive themes this quarter related to wider use of the whole multi-disciplinary team to enhance care, the impact of advanced care planning and the contribution from the Palliative Care Team even when a patient is not in the last days of life. Negative themes include ensuring documentation of clinical encounters is thorough and ensuring sepsis care is optimised. The latter is being addresses by the Deteriorating Patient Group.

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.