Public Trust Board

Online meeting

09/07/2025 09:30 - 12:00

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Wednesday, 10 September 2025 - Lister Hospital,

ASSURANCE RATING GUIDE

Whilst context and individual circumstances should be taken into account, the below descriptions are intended as an aid in applying and interpret ratings in a consistent way. The assurance rating is also intended to help identify where action is needed and level of monitoring required.

Assurance Rating	Description
Substantial	• Taking account of the issues identified, substantial assurance can be taken that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied or effective.
Reasonable	• Taking account the issues identified, reasonable assurance can be taken that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied or effective. • However, issues have been identified that need to be addressed in order to ensure the control framework is effective in managing the identified risk(s).
Partial	• Taking account the issues identified, partial assurance can be taken that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied or effective. • Action is needed to strengthen the control framework to manage the identified risk(s).
Minimal	• Taking account the issues identified, assurance cannot be taken that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied or effective. • Urgent action is needed to strengthen the control framework to manage the identified risk(s).

East and North Hertfordshire Teaching NHS Trust

Minutes of the Trust Board meeting held at Hertford County Hospital, Hertford SG14 1LP on Wednesday, 14 May 2025 at 9.30am

Present:	Ms Anita Day (AD)	Trust Chair
	Mrs Karen McConnell (KMc)	Deputy Trust Chair and Non-Executive Director
	Dr David Buckle (DB)	Non-Executive Director
	Ms Diana Skeete (DS)	Non-Executive Director
	Mr Richard Oosterom (RO)	Associate Non-Executive Director
	Ms Nina Janda (NJ)	Associate Non-Executive Director
	Mr Tichafara Phiri (TP)	NeXT Non-Executive Director
	Ms Gillian Hooper (GH)	Non-Executive Director
	Mr Adam Sewell-Jones (ASJ)	Chief Executive Officer
	Ms Theresa Murphy (TM)	Chief Nurse
	Mr Martin Armstrong (MA)	Chief Finance Officer and Deputy Chief Executive Officer
	Dr Justin Daniels (JD)	Medical Director
	Ms Lucy Davies (LD)	Chief Operating Officer
	Mr Kevin Howell (KH)	Director of Estates and Facilities
	Mr Kevin O'Hart (KOH)	Chief Kaizen Officer
	Mr Thomas Pounds (ThP)	Chief People Officer
	Mr Mark Stanton (MS)	Chief Information Officer
	Ms Eilidh Murray (EM)	Director of Communications and Engagement
	Ms Amanda Harcus (AH)	Interim Chief People Officer
		Quality Director, Can
From the Trust:	Mrs Debbie Okutubo (DO)	Deputy Company Secretary (Board Secretary - minutes)
	Ms Paula Statham	Quality Director, Cancer
Observing	Ms Penny St. Martin	Incoming Chief People Officer

No	Item	Action
	The Chair welcomed everyone to the meeting, in particular she welcomed Ms Paula Statham who was observing the meeting, and Ms Penny St. Martin, the incoming Chief People Officer who would commence employment from July 2025. The Chair commented that this was a live streamed meeting of the Trust Board to ensure transparency to patients, staff and the wider community.	
25/047	**DECLARATIONS OF INTEREST** There were no new interests declared.	
25/048	**APOLOGIES FOR ABSENCE** Apologies for absence were received from Professor Zoe Aslanpour, Non-Executive Director, Ms Janet Scotcher, Non-Executive Director, Mr Stuart Dalton, Head of Corporate Governance and Ms Ivana Chalmers, Chief Executive – Healthwatch Hertfordshire.	

East and North Hertfordshire Teaching NHS Trust

25/049 PATIENT STORY

Ms MN was the patient presenting her story to the Trust Board. MN was supported by the Chief Nurse.
MN is a mum to two children.

Women's health is a subject close to MN's heart as she has had a history of endometriosis and had tried to cope with the condition even though it was debilitating. She experienced high levels of pain, fatigue, irregular periods and on one occasion collapsed in front of her mother, due to the symptoms.

MN believes that there is a lack of knowledge and a "total misunderstanding of the condition ".

MN had surgery at another Trust that did not go well, and it left her with some residual issues. She then had a second procedure at ENHT with Mr Lim, which was much more successful. Unfortunately, she then had a haematoma post operation and struggled initially to get the appropriate support in ED. However, she felt that it was managed effectively by Mr Lim once he was made aware of her situation, although she had further issues regarding her discharge paperwork which was not filled in properly.

Now MN is getting on with her busy and active life and she is a source of knowledge and support for other women, empowering them to ask for specialists like Mr Lim.

The Chief Nurse commented that they were planning to work with MN on an improvement project which would enhance knowledge and access for other women. It was essential that there was consistency in treatment and that the specialist medical staff understood MN's clinical diagnosis and treatment and follow up on her care.

The board were advised that MN was part of a support group for women and was an active participant in seeking good quality information that would help other women. MN felt happy that she had access to a knowledgeable clinical team here at Lister Hospital.

In terms of what could be done better, MN had commented that

- waiting in ED for a long period of time to get a bed
- not getting individualised and accurate discharge information
- not having someone she could contact post operation for help and or advice were areas that needed to be improved.

The Chair apologised to MN for the short comings in care that she experienced. TM thanked MN for sharing her story and informed the board that to ensure joined up working on our improved process, MN had agreed to join the process as they were keen on working with the patient. The Chair thanked MN as she would be supporting the Trust on the improvement process.

GH thanked MN for outlining the issues and asked if the specialty who were meant to deal with discharge summaries had raised any issues. In response, TM commented that the gynaecological team had explained that they were currently unable to have a reliable seven-day working process but that the service was working on finding a solution.

The Chief Executive thanked MN for coming and for being articulate. He commented that the Minister came in on that day and was a great supporter of women issues and had met with MN. The Chief Executive asked the Chief Information Officer MS, why shared care records were not seen at clinician level. In response, MS commented that anything created digitally should be available and accessible but that we need to understand why this did not happen in this case. He further commented that all discharge letters go through to GPs and the patient.

MN commented that every time she attended accident and emergency (A&E), they could never find her records and she could not understand why this was always an issue.

JD commented that it was possible to get shared records, but clinicians were not equipped on how to use all systems therefore work needed to be done to resolve this with clinicians.

The Chair reiterated that as a board they were grateful to have heard the patient's story and that as a Trust we would take forward as actions all issues listed. She commented that she was glad MN was in a better place and wished her all the best.

MN left the meeting.

The Chair commented that as a Trust we need to hear when things are not working well; that was the only way we would learn how to improve.

The Board **NOTED** the patient story.

25/050 MINUTES OF THE PREVIOUS MEETING

The minutes of the previous meeting held on 12 March 2025 were **APPROVED** as an accurate record of the meeting.

25/051 ACTION LOG

It was agreed that action 25/035 relating to non-elective length of stay be sent round to all board members.

The Board **NOTED** the status of the rest of the action log.

25/052 QUESTIONS FROM THE PUBLIC

There was one question from the public on why the Audiology service wait times had become so bad?

TM apologised for the long wait and commented that the Trust has now recruited to the team, and they have invested in equipment and the estate. She informed the board that progress on this would be shared with the Quality and Safety Committee (QSC).

The Chief Executive commented that we had not stopped accepting referrals throughout this period as the ICB had not allowed this to happen.

TP asked when we would cease to have a backlog which would mean no waiting list. In response TM commented that we might have at least two more years as the service was still struggling.

LD commented that from the regional perspective, it had been agreed that all Trusts should pause on non-urgent cases to assist with the long waiting list.

This response was published on our website.

25/053 CHAIR'S REPORT

The Chair commented that Ministers at the Department of Health and Social Care (DHSC) approved our application to include 'Teaching' in our name and that this came into effect on 1 April 2025. Consequently, Professor Zoe Aslanpour, Dean of the Medical School at the University of Hertfordshire had been appointed as a Non-Executive Director to our Trust and Dr Justin Daniels would reciprocate this at the University.

The Board **RECEIVED** and **NOTED** the Chair's report.

25/054 CHIEF EXECUTIVE'S REPORT

The Chief Executive presented his report. He outlined some of the highlights since the last Board meeting.

He shared some national and regional updates, including the NHSE and DHSC merging with a resultant reduction in staff of 50%. In addition, integrated care boards (ICBs) having to reduce costs by approximately 50%.

The Board was advised that in April, the ICB wrote and asked that the local Health and Care Partnership (HCP) complete the necessary work to ensure that the Trust becomes host provider for the HCP from 1 July 2025. The Chief Executive continued that we would bring some formal documentation to this board regarding the governance arrangements which would list the benefits and the risks.

The Board was also advised that NHSE East of England Regional Support Group (RSG) had considered the segmentation score of the Trust and following a review of operational performance for quarter 3, year-to-date financial performance and quality insight, RSG had improved the Trust's segmentation rating from Segment 3 to Segment 2. It was noted that this was positive for the Trust and that areas where we needed to do better were also listed and included 12 hour waits for treatment in A&E remaining high and diagnostic performance being poor.

The Trust became a smoke free trust from 1 April 2025 providing other options like nicotine replacement therapies and expert advice on how to quit smoking.

It was also noted that some ENHT staff were recognised and awarded with national awards.

TP commented that he was pleased with the governance arrangements and asked about the impact on the host provider for the region and what effect that would have on our resources. He also asked if there were case studies of other trusts being host providers.

In response, ASJ commented that South and West Hertfordshire were the best-case study as a lot of work was being done there, but that we would take our own legal advice and that it would come into effect from 1 July 2025.

The Chief Executive continued that regarding resources, NHSE was ensuring funding as and when. At place level, we would work within the parameters, and this would be brought back to the board to ensure we were improving the health of the population.

The Chair commented that these were exciting times and that there was a lot of work to be done.

The Board **RECEIVED** and **NOTED** the Chief Executive's report.

25/055 STRATEGIC GOALS – 2024/25 UPDATE

The Chief Kaizen Officer, KOH presented this item. The annual strategic goal cascade process which provided highlights of the range of activities undertaken during 2024/25, at both organisational and local level, that aligned to delivery was presented.

The Chief Kaizen Officer commented that even though there was an established framework the process was relatively immature which was why a partial level of assurance was being proposed.

He explained the key steps in the strategic planning process and gave a summary of activities aligned to the Trust's strategic goals.

The Board was advised that the revised accountability framework had been drafted by the Chief Finance Officer, MA.

KMc asked how we would take a patient story and ensure joined up working using this type of system. In response KOH responded that the value stream process/development was being worked up. We would look at our priority services that we need to align into our strategic goals, and this would become our programme of improvement.

NJ asked what metrics would be used on cultural change. In response, KOH said that it had been discussed at the Trust Guiding Team (TGT) meetings and gave the example of the staff survey that some specific metrics had been built in to measure cultural changes. KOH also commented that organisational change would also be looked at and that it will go to the People and Culture Committee in July.

RO commented that this was one of the vital things we needed to get right even though it was a difficult process, he asked how:

- the quality of the objective setting process would be ensured
- we would ensure effective performance management of the objective setting process
- would we create SMART objectives for this?

KOH responded that work was ongoing and gave the example of the accountability framework amongst other initiatives and that these would be included in subsequent iterations to the board.

TM asked about the production ward system and how it would work visually. In response KOH suggested that daily management would play a major role in this piece of work. Also, that the Strategic Alignment board would be utilised.

Following the discussion, the Board discussed the strategic goals update and **AGREED** that the paper be assigned **PARTIAL ASSURANCE**.

25/056 ANNUAL NATIONAL STAFF SURVEY RESULTS

The Interim Chief People Officer, AH presented this item. The Board was informed that the results had been shared across the Trust in teams. It was noted that our staff survey results were used by the NHS and CQC to assess the Trust performance and that over 50% of people responded.

The board was advised that the areas where we had most opportunity for improvement was 'voice that counts' and 'safe and healthy'. AH commented that 'focus on inclusion, civility and respect' were essential within these domains.

Areas of key focus based on the staff results were also discussed.

DS asked about racial discrimination as it seemed to be rising and wanted to know that this was being handled and if there could be more regular updates on how it was being tackled. DS further commented that capacity and capability seemed to also be an issue.

AH responded that several programmes were being trialled:

- race discrimination and how it is called out
- managers and staff were being empowered to have difficult conversations in order to change the culture and
- leadership in this area and how it was being embedded.

DS asked if the training was robust enough and gave the example of the equality impact assessments (EIA) if they were theoretical as there was the need to make sure the EIAs were operational rather than just academic.

NJ commented that this was also an issue last year and asked how it would be measured across the Trust and people start feeling comfortable.

AH responded that staff stories was powerful, and that staff reporting was due to psychological safety. Managers confidence and capability levels also needed to be equipped; it therefore required a combination of measures.

The Chair commented that the number of concerns raised had increased and yet none were anonymous as people were willing to put their names to it, so this was an encouraging sign.

RO congratulated the team for the survey response at 50%. He commented that in terms of local action plans, if people believed that there were consequences they would do better and asked when these would be delivered. He further commented that discrimination was a big issue and asked if direct action could be taken where these were prevalent. AH responded that local action plans would come back to the EDI steering group. On the take up rate we would continue to incentivise and encourage people to complete the staff survey.

KMc commented that a year ago there was a video and the learning was from the ground up, she asked what could we do to embed this type of thinking.
In response AH stated that the video still featured during inductions and was on the intranet via ENH Academy.

JD thanked AH for the leadership and commented on the survey results of experiencing discrimination from patients and or their relatives. He noted that there was some improvement but not enough. He stated that on discrimination from patients to staff, we need to give our staff the required support.

TM commented that she would soon be meeting some London teams from other Trusts about the new kindness campaign. She commented that we should be able to gather what we can do proactively.

The Chair commented that we need to do more to help identify precisely where behaviours were not as we would want and suggested that a cultural heat map might be the answer as it would enable us to drill down into specific parts of the organisation.

The Chair further commented that the paper was marked as providing substantial assurance and she agreed that we had made progress but there was still a lot of work to be done. She therefore proposed to the board that it be changed to providing reasonable assurance.

Board members agreed that it should change to a reasonable level of assurance as issues raised were of concern.

The Board **NOTED** the annual staff survey results and agreed that they were **REASONABLY ASSURED** for the reasons listed above.

25/057 DIGITAL STRATEGY 2020 – 2025 UPDATE

The Chief Information Officer MS presented this item. Members were advised that this strategy was developed coming out of Covid. Members were also advised that specialty systems were established and not just the OneEPR.

It was noted there was now movement from using fixed devices to mobile devices and that there were no PCs of more than four years old being used across the Trust. There was a cyber team on site and multi authentication for security reasons was now in operation. In February 2024 the board signed off a self-funding EPR programme.

The achievements over the last five years was explained to the board.

TP asked if the OneEPR system would help resolve issues raised in the patient story. In response, MS explained that we have two EPR systems; the admin EPR system had the shared records, but clinicians tended not to use that system.

RO commented that this was discussed in the Finance, Performance and Planning Committee (FPPC) and that a piece of work was required to be carried out and concluded by the end of the year.

The Chair said that this was a good update and was looking forward to the end of the year to see what had been achieved.

The Board **NOTED** the digital strategy 2020 – 2025 update.

25/057A

ONEEPR Committee Terms of Reference (ToR)

A task and finish OneEPR committee was established by the board and the terms of reference was discussed.

GH asked a question on the effective governance on risk mitigation and wanted to know if quality impact assessments would be taken into account.

She asked who the members of the one EPR committee were. In response, it was noted that RO was the chair, DB as a clinician and JS with her HR specialism were members of the committee.

RO clarified that contrary to the report, the committee did not meet in shadow form on 12 May.

NJ asked about BAF 10 and asked if that included Daedalus as they had not done what they were meant to do. MS responded that there was a risk register where these were listed.

The terms of reference was **APPROVED.**

25/058 INTEGRATED PERFORMANCE REPORT

The Deputy CEO, MA presented this item. The board was advised that this report represented the full year for 2024-2025. It was noted that there had been operational and financial constraints but in all of this there had been positive stories.

Improvement areas were discussed. The board was assured that maternity services had been stable.

It was noted that there had been some significant progress in some of our operational areas including cancer and RTT.

Community paediatric remained a challenge and diagnostics was below target. ED performance was at 73.8% in March and the Trust Stroke SSNAP grade was on a B.

On Finance, the board was reminded that a surplus plan of £1.0m for 24/25 was approved but that the Trust had reported an actual YTD surplus of £1.5m which was marginally better than planned due to the cost improvement programme (CIP).

For People, in terms of vacancy rates, we were at our best to date, recruitable establishment had reduced by 154.

Staff survey results had also improved. It was a challenging environment in 2024/25 but there are strong shoots of improvement, however, it was recognised that there was much more to do.

The CEO commented that various executives were being drawn to do external work. However, board members needed to be aware of the impact of the 5% cost improvement requirements. It was noted that a lot of people were putting their energy into the cost improvement programme and the board needed to be aware of the risk this carried.

The Chair asked if there was clarity on what these risks were. In response, the Chief Executive stated that it was still early but that there were areas that we needed to focus on due to our finite resources.

The Chair recognised this point and requested that as and when the executive had the clarity of the impact of this external work on our day-to-day activities, the board should discuss.

DB thanked the Chief Executive and Chair for clarifying the issues and requested that they understand that we need to prioritise and balance the risks.

The Chair responded that we were all focused on making the Trust the best it could be and to be clear to our staff what the priorities were. She commented that we had a lot to be proud of in the year but that there was more to do. She congratulated everyone on their hard work to get to this point.

The Board **RECEIVED** and **NOTED** the integrated performance report.

25/059 QUALITY AND SAFETY COMMITTEE REPORT TO THE BOARD

The QSC Chair, DB commented that there were clinical concerns around blood clots and that the number of reviews had increased. JD remarked that he was worried about this, but that several changes were being introduced including no patient leaving ED without a VTE assessment.

On complaints, the QSC Chair commented that both complaints and PALS had increased because as a Trust, we were cancelling a lot of operations and asked what could be done about this. LD commented that a lot of these cancellations would have been rescheduled as patient appointments needed to be cancelled if an urgent matter came in. JD also commented that we had one waiting list across the NHS and that pre-operative assessments was what was leading to cancellations.

KOH remarked that a health questionnaire had been introduced, and that teams were operating a text reminder service. Both these initiatives had happened to reduce the rates of cancellation. Digital solutions were also being worked on.

The CEO commented that PALs activity had increased due to people not able to get through the telephones as abandoned rates of calls were high. In response, MS stated that with the reviewed contact centre the abandoned rate of calls had reduced and that there was a date in May where we had zero abandonment rates. The Chair commented that this showed great progress.

25/060 FINANCE PERFORMANCE AND PLANNING COMMITTEE (FPPC) REPORT TO THE BOARD

The FPPC chair, RO commented that we need to keep an eye on the collaboration with HCP. He acknowledged that the executive would be stretched over the next few months due to this collaborative piece of work.

25/061 PEOPLE AND CULTURE COMMITTEE (PCC) REPORT TO THE BOARD

DS presented this and commented that the staff survey had been discussed but that the EDI steering group would be very involved in seeing this through, in particular, the discrimination that staff had brought up in the results.

East and North Hertfordshire Teaching NHS Trust

25/062 2025/26 BOARD ASSURANCE FRAMEWORK (BAF)

It was noted that the BAF had been re-worded following the discussion at the board seminar in April and that there were 11 risks following input from board members.

KMc commented on the risk on change management and noted that there was the need to keep our eye on business as usual. In terms of risk oversight at FPPC and PCC she commented that QSC should have its own oversight of some risks.

RO commented that the iteration of these re-worded BAFs was a good reflection of the conversation. On the digital transformation risk he asked if this needed to move to the One EPR committee.

Action: A discussion ensued, following the discussion, it was agreed that it should move and that the Audit and risk committee should have oversight of it.

The Board **APPROVED** the board assurance framework (BAF) subject to the change above.

25/063 SYSTEM PERFORMANCE REPORT

The Board **NOTED** the System performance report.

25/064 SUMMARY LEARNING FROM DEATHS

The Medical Director, JD presented this item. He stated that the trust seeks to learn from each death that takes place. The report offered reasonable assurance to the board that this was the case. He also advised the board that the in-month data for the last few months had been corrected and that this was due to a lag in the data flow.

KMc asked about the total of in-hospital deaths under the Medical Examiner scrutiny section and why Mount Vernon Cancer Centre (MVCC) was excluded if we had the data. JD explained that any deaths at MVCC were scrutinised by the team at the Hillingdon. He also explained that deaths at MVCC were fairly rare.

The Board **NOTED** the report and agreed that the assurance level was at **REASONABLE ASSURANCE.**

25/065 AUDIT AND RISK COMMITTEE (ARC) REPORT TO THE BOARD

The Committee Chair, KMc asked about the pathology contract and how was it working. RO suggested that it formed part of the audit of effectiveness of estates management. MA confirmed that it would go to the July FPPC meeting and be shared with members.

The Board **RECEIVED** and **NOTED** the summary report from the 1 April 2025 meeting.

East and North Hertfordshire Teaching NHS Trust

25/066 REMUNERATION AND APPOINTMENTS COMMITTEE TERMS OF REFERENCE (ToR)

The Board **NOTED** and **AGREED** the highlighted changes in the terms of reference of the Remuneration and Appointments Committee.

GH asked which members sat on the remuneration committee and what was the intention of other NEDs not attending the committee to influence the discussion.

The Chair confirmed that membership was three NEDs and the Trust Chair. The three NEDs being KMc, DB and JS. She noted that scheduling of meetings was more fluid to get everyone there at short notice and that the quorum should be three out of four at meetings rather than two as stated on the ToR.

Action: Quorum should be three.

On feedback into appraisal of executives, the Chair suggested that feedback could be gathered from all NEDs and fed back to the Chief Executive and vice versa for executives to feedback about the NEDs. It was noted that this was not a role of the committee but it could be taken on board.

The terms of reference was **APPROVED** subject to the change above.

25/067 ANNUAL CYCLE

The Board **RECEIVED** and **NOTED** the latest version of the annual cycle.

25/068 ANY OTHER BUSINESS

There was no other business.

25/069 DATE OF NEXT MEETING

The date of the next meeting is 9 July 2025 and will be held online.

Ms Anita Day
Trust Chair
June 2025

East and North Hertfordshire Teaching NHS Trust

Minutes of the Extraordinary Trust Board meeting held Online on Monday, 30 June 2025 at 2pm

Present:	Ms Anita Day (AD)	Trust Chair
	Mrs Karen McConnell (KMc)	Deputy Trust Chair and Non-Executive Director
	Ms Diana Skeete (DS)	Non-Executive Director
	Ms Janet Scotcher (JS)	Non-Executive Director
	Mr Richard Oosterom (RO)	Associate Non-Executive Director
	Ms Nina Janda (NJ)	Associate Non-Executive Director
	Ms Gillian Hooper (GH)	Non-Executive Director
	Mr Tichafara Phiri (TP)	NeXT Non-Executive Director
	Mr Adam Sewell-Jones (ASJ)	Chief Executive Officer
	Mr Martin Armstrong (MA)	Chief Finance Officer and Deputy Chief Executive Officer
	Ms Lucy Davies (LD)	Chief Operating Officer
	Mr Kevin Howell (KH)	Director of Estates and Facilities
	Mr Kevin O'Hart (KOH)	Chief Kaizen Officer
	Mr Thomas Pounds (ThP)	Chief People Officer
	Mr Mark Stanton (MS)	Chief Information Officer
	Ms Eilidh Murray (EM)	Director of Communications and Engagement
	Ms Amanda Harcus (AH)	Interim Chief People Officer
	Ms Sarah Lucy James (SLJ)	Delivery Director
From the Trust:		
	Ms Mel Gunstone (MG)	Deputy Chief Nurse
	Mr Stuart Dalton (SD)	Head of Corporate Governance
	Mrs Debbie Okutubo (DO)	Deputy Company Secretary (Board Secretary - minutes)

No	Item	Action

The Chair welcomed everyone to the meeting and expressed her gratitude to everyone present for making this extraordinary meeting. She commented that it had to be done at short notice for reasons that would become apparent as the meeting progressed.

The meeting was recorded and would be shared on the Trust website to ensure transparency to patients, staff and the wider community.

25/070 DECLARATIONS OF INTEREST

There were no new interests declared.

25/071 APOLOGIES FOR ABSENCE

Apologies for absence were received from Ms Theresa Murphy (TM), Dr Justin Daniels (JD) and Dr David Buckle (DB).

25/072 HCP COMMITTEE

The Chair invited the Head of Corporate Governance, SD to present this item. Following a brief introduction, he commented that the purpose of the report was to approve the:

- creation of HCP committee of the board,

- proposed terms of reference which had been circulated and discussed by HCP partners and
- changes to the standing orders to enact the HCP committee.

The Chair invited the Chair of Audit and Risk Committee (ARC), KMc to comment if she had anything to add as the paper had been reviewed by ARC at their last meeting.

KMc commented that there was nothing to add as ARC examined the report and was satisfied with the changes as proposed in the report.

The Chief Executive commented that the HCP committee was in shadow form and that it would run as a committee in common with the ICB committees. He noted that by November 2025 all the work on delegation agreements should have been completed and that there was a workshop set up to ensure this.

He further commented that during the month of July, partners would come together to start to shape what it would look like and ensure it has the right representation and that the board would be sighted on all updates.

The Chair asked about feedback that had been received from place partners. In response the Chief Executive remarked that the report reflected the changing arrangements and that he had shared the SRO position with the Chief Executive of Hertfordshire Community Trust (HCT). The Chief Executive informed the board that the membership in the report had been updated to reflect his role and that there was an executive member from the HCT.

He further commented that at the next iteration there would be information on what primary care representation looks like and he believed that at that stage there will be more engagement from place partners.

The board was also advised that as detailed within the report, HCP committee will be in shadow form until the delegation is done and the proposed completion date was the end November 2025.

RO asked what would happen if in November we realised we needed more time. In response the Chief Executive commented that there should be the ability to ask for more time if required. The firm date was the 1 July start date but that the team working on this believed that to reach the delegation agreements, put them all in place and have the right legal advice, November was when they believed the work would have been done.

GH asked that if there was further development during July would it be brought back to the board. The Chief Executive commented that he believed this would be the case and that July would not be the only event as he felt there would be a number of times that the board would have sight of all iterations as there were a number of unknown things.

The board was also advised that the powers of the committee would also change as they now have the right to Co-opt primary care representatives who would also be full members of the committee. This he felt gave them as host provider to shape it as they were the convener.

It was also noted that there would also be non-executive representation from both ENHT and HCT, something which the other Place committees had not done.

The Chair commented that engaging with primary care was one of the advantages and with the 1st of July start date, having the meeting today was important hence, the short notice.

The Chair thanked the team that had been involved in this piece of work and commented that it had taken several unsocial hours to get it to this state as they had extremely tight deadlines imposed on them by the ICB. On behalf of the board, she therefore felt it was important to express heartfelt appreciation.

The Board **APPROVED** the**:**

- creation of an HCP Committee of the Board, with only advisory and no decision-making powers at this stage;
- changes to the Standing Orders, SoRD and SFIs to reflect the creation of the HCP Committee and annual review changes; and
- Terms of Reference for the HCP Committee.

25/073 QUALITY ACCOUNTS 2024 - 2025

The Chair invited the Deputy Chief Nurse, MG to present this item. MG commented that it was a statutory requirement for the quality accounts to be approved by the board before publication and that it had been through the Quality and Safety Committee (QSC) for them to review and give feedback.

MG further commented that this year's quality accounts had improved engagement and highlighted some positive areas including the maternity journey as well as areas of improvement like the complaint responses. She further commented that there were some quality priorities attached to the report and feedback from external partners to evidence the engagement and the journey.

In the absence of the QSC Chair, David Buckle, The Chair invited GH to talk to the item as a member of QSC. GH commented that at the QSC meeting they heard from the team that had put the quality accounts together and that the Committee was very pleased with the rigour that had been given to presenting the story over the last year. The Committee felt that it was a very balanced story and that there was still room for improvement but feedback from three external partners: the HWE ICB, Healthwatch Hertfordshire and Central Bedfordshire Council's Social Care Health and Housing Overview and Scrutiny Committee (HOSC) all had common themes in them, which the team would take forward.

The Chair asked that there was a statement from Bedfordshire HOSC but there was none from Hertfordshire HOSC and asked why this was the case.

The board was advised that Hertfordshire HOSC was an important stakeholder and that we would look to see why the comments were not included and close that gap – **Action**.

The Chair thanked the team for presenting a balanced quality account and commented that she believed that it was a fair summary. She requested that the appreciation from the board be passed on to them.

The Board **APPROVED** the Quality accounts.

25/074 ANY OTHER BUSINESS

There was no other business.

East and North Hertfordshire Teaching NHS Trust

25/075 DATE OF NEXT MEETING

The date of the next meeting is 9 July 2025 to be held online.

Ms Anita Day
Trust Chair
July 2025

	Action has slipped
	Action is not yet complete but on track
	Action completed
*	Moved with agreement

Agenda item: 5

EAST AND NORTH HERTFORDSHIRE NHS TRUST
TRUST BOARD ACTIONS LOG TO JULY 2025

Meeting Date	Minute ref	Issue	Action	Update	Responsibility	Target Date
11/9/24	24/097	Quality account to target our audience	A summary of the Quality Account to be produced for the end user.	Work is underway with stakeholders to combine an easy read handheld version for the Quality strategy, which will encompass quality account objectives. We anticipate this being completed by quarter four.	Chief Nurse	June 2025 Completed
06/11/24	24/122	There is a desire/appetite for a health inequality discussion	Health inequality to be brought to a future Board meeting.	The Board Chair agreed health inequalities moves to the July Board Seminar instead	Medical Director	~~July 25~~ Postponed to Sept meeting
15/1/25	25/006	Renal services PSII	Progress on the implementation of the improvement plan is reported to the Board.	The Medical Director will provide a verbal update at the meeting.	Medical Director	July 25
15/1/25	25/016	Standing orders, SFIs and Scheme of delegation was reviewed prior to it coming to the Board	A number of amendments need to be made. All documents once updated would be made available to all board members, but the documents would not be brought back to a Board meeting as stated in the Standing Orders until all documents are complete	Standing Orders changes approved at 30 June extraordinary Board	Head of Corporate Governance	July 2025 Completed

	Action has slipped
	Action is not yet complete but on track
	Action completed
*	Moved with agreement

Meeting Date	Minute ref	Issue	Action	Update	Responsibility	Target Date
15/1/25	25/019	Freedom To Speak Up (FTSU) Champions, request for consideration of them to have protected time	The Chief People Officer commented that it would be taken through our internal mechanisms and reported back to the board.	This is part of a wider element of work of time release for voluntary roles: FTSu / MHFA/ Staff network chair/co-chair/ Inclusion Ambassador's to review numbers/time spent and cost. Due to resource capacity and competing higher priorities, the work will complete by September.	Interim Chief People Officer	~~July 2025~~ September 2025

East and North Hertfordshire Teaching NHS Trust

Chief Executive's Report

July 2025

Chief Executive Update

Regional and National Update

As you may be aware, in March, we were informed of the ongoing national change process affecting all NHS organisations, including Integrated Care Boards (ICBs).

In summary, NHS England will be abolished, the DHSC itself is expected to reduce in size by around 50%, NHS trusts have been asked to reduce roles that are not patient-facing and ICBs must deliver reductions of around 50% in our running costs (including staffing and programme budgets) by the end of December 2025 – on top of the 30% savings we have been working towards since 2023.

To meet these challenges, ICBs have been asked to form 'clusters' within their regions, to help deliver functions more efficiently by working together across bigger geographies.
In our region, the current proposal would see the Hertfordshire part of our ICB footprint brought together with the Bedfordshire, Luton and Milton Keynes (BLMK) ICB area and the Cambridgeshire and Peterborough (C&P) ICB area, to form a larger single organisation.
A separate 'Greater Essex' ICB would be created (including the west Essex area of our current footprint), alongside a new Norfolk and Suffolk ICB.

We await the next steps in terms of implementing the changes.

We (East and North Hertfordshire Teaching NHS Trust) and Hertfordshire Partnership University NHS Foundation Trust (HPFT) have welcomed the national commitment to fund more mental health crisis centres across the country. The mental health urgent care centre has made a real difference to patients in crisis and is a great example of the NHS working to join up and improve services. It allows patients to receive urgent care away from the emergency department – and to be seen by specialist mental health clinicians at the right time. Since opening, the mental health urgent care centre has supported over 500 patients from the Lister emergency department who have been able to benefit at a time when they are most in need.
For more information about the urgent care centre and other mental health support services in Hertfordshire, visit http://www.hpft.nhs.uk/get-help.

Digital Update

Parents and carers with babies receiving care in our Neonatal Intensive Care Unit (NICU) at Lister Hospital can now benefit from two new digital tools designed to reduce anxiety, provide vital information, and help families stay connected.

The Little Journey app, originally developed to support children preparing for surgery, has been specially adapted to meet the needs of families with babies in neonatal care.

Financial Update

In order to deliver a balanced financial plan for this year, an efficiency programme of 5% is required, which equates to in excess of £35m. In addition, alongside the reductions to posts in NHS England

and the ICBs, all trusts are expected to reverse the growth in non-patient facing roles over recent years.

This presents a significant challenge to the trust, in line with all others. Good progress has been made but there is more to do and due to the valuable role that non-patient facing staff do, redesign of services is necessary to free up roles without simply increasing the burden on other staff.

The implementation of this transition is always difficult, including the temporary freezing of vacant positions and I would like to thank staff for their continued dedication and contribution to designing these changes.

Further detail is provided in the Integrated Performance Report.

ENH Production System

In June we undertook our first 3P event with Children and Young People's Team. 3P is part of the ENH Production System and means Production, Preparation and Process. It' was a week-long workshop that included all stakeholders in an intensive workshop to redesign new processes and spaces.

In just 30 minutes, the team generated 81 ideas, themed under:

- Flow – Ensuring the right patient receives the right care, at the right time, from the right person.
- Efficiency – Enhancing systems through better information flow and digital solutions.
- Environment – Creating spaces that support wellbeing, healing, and productivity.
- Vision – A concept and vision for the next ten years focusing on care that centres around the child, young person and their family - turning vision into action and ensuring a better and brighter future for paediatrics.

What started as a week of passionate, high-energy co-design is already creating momentum across the service. Teams are energised – sharing ideas, already making immediate improvements, and thinking about what is possible. By streamlining processes, reducing waste, and embracing innovation, they are already enhancing care and experience for our patients, families, and staff.

People Update

The last couple of months has seen a range of recognition events where we celebrate various aspects of our workforce.

Activities have taken place to mark occasions including:

Pride Month
Philippines Independence Day
Armed Forces Day
National Healthcare Estates and Facilities Day
Carers week
Windrush Day

And well as other days highlighting particular staff groups and services within the trust.

I would like to highlight Prabin Edayanattubaby, Patient Experience Nurse, who had the honour of attending a garden party at Buckingham Palace, hosted by King Charles. This prestigious event recognises individuals who have made significant contributions to their communities. Prabin was nominated due to her exceptional dedication to the welfare of internationally educated staff, a role she undertakes in her own time. We are incredibly proud of her achievements and her unwavering commitment to our Trust and its values.

In addition, our lead midwife for multiple births, Dionne Thompson, was recognised on the national stage in May as she took part in the prestigious Florence Nightingale Commemoration Service at Westminster Abbey. Dionne was chosen as one of 12 healthcare professionals selected from across the country to walk in the symbolic procession behind the Florence Nightingale Lamp – a role deep in honour. Well done, Dionne.
Lastly, I would like to wish the best of luck to Mr Nikhil Vasdev, a dedicated robotic and urological surgeon, who has been asked to deliver the state-of-the-art lecture at this year's ERUS (European Society of Robotic Surgery). This is the world's largest robotic meeting.

Operational Update

Mount Vernon Cancer Centre are the first cancer centre in the country to treat a patient with an injectable form of immunotherapy. This means patients will spend a significantly less amount of time in hospital as patients will have their fortnightly or monthly treatment in 5 minutes instead of up to an hour via an IV drip.

Adam Sewell-Jones
Chief Executive

Board

East and North Hertfordshire Teaching NHS Trust

Meeting	Public Trust Board		**Agenda Item**	9	
Report title	Annual Freedom to Speak Up Report (2024/ 25)		**Meeting Date**	9 July 2025	
Author	Freedom to Speak Up Guardian				
Responsible Director	Chief Nurse				
Purpose	**Assurance**	☒	**Approval/Decision**	☐	
	Discussion	☐	**For information only**	☐	
Proposed assurance level (*only needed for assurance papers)*	**Substantial assurance**	☐	**Reasonable assurance**	☒	
	Partial assurance	☐	**Minimal assurance**	☐	

Executive assurance rationale:

Reasonable assurance is provided that within the 'Speaking Up' service a just, restorative and learning culture is being supported. Significantly contributing to incremental improvements seen within ENHT staff survey and satisfaction at work results, responsiveness to patient safety incidents. Indirectly reduced levels of complaints and legal cases raised by staff against the Trust.

Summary of key issues:

The purpose of the report is to give the Trust Board the opportunity to hear directly from the Freedom to Speak Up Guardian and to provide assurance of the progress and development of the Speak Up service.

The report highlights a continuous annual increase in speaking up episodes, from 270 2023/24 to 311 episodes 2024/25.Workforce prevalence of staff speaking up is 57% black, brown and minority ethnic group compared with 43% white British and other white ethnicity group. Information to note includes:

- Over the last 12 months 70% of staff have Spoken Up to their line manager or the appropriate manager and contacted Freedom to Speak Up Guardian either because they did not believe they were heard or perceived there was no meaningful response.
- Continued focus on local resolution, responsiveness, and organisational learning from Freedom to Speak Up (FTSU) concerns raised

Themes:

- 47% cases relate to worker safety or wellbeing. Of these:
    1. 30% relate to staff unhappiness regarding office moves i.e. decanting from Wiltron House and the refurbishment of the Old School of Nursing building
    2. 30% relate to the breakdown of relationship between the line managers and the employees.
    3. 17% relate to failure to follow systems and processes,
    4. 10% relate to recruitment process, in particular interview feedback
    5. 8% relate to perceived inequality and discrimination
    6. 5% relate to health and safety including staff experiencing aggression and violence from service users

- 35% concerns relate to inappropriate attitudes or behaviours, primarily incivility and conduct at work

- 12% concerns relate to patient safety and quality
- 6% concerns relate to Bullying and Harassment

Future next steps for improvement include:

- Embed opportunities to promote psychological safety within teams
- Increase the number of trained mediators within our Trust
- Continuous support for all managers to listen and respond to staff when voicing concerns.
- Embed processes to enable Speaking Up learning and improvements to be shared as business as usual
- Embed civility saves lives interventions
- Support the workforce appreciate and manage expectations when raising a concern, and/or responding to a concern

Impact: *tick box if there is any significant impact (positive or negative):*

Patient care quality	☒	**Equity for patients**	☒	**Equity for staff**	☒	**Finance/ Resourc -ing**	☒	**System/ Partners**	☐	**Legal/ Regul- atory**	☒	**Green/ Sustai- nability**	☐

Poor speaking up arrangements and lack of psychological safety is likely to increase risk of patient safety incidents, drop in accepted standards of care, negatively impacting service user and staff experience. Poor staff experience could increase negative staff survey results, increase turnover, sickness absence rates and on-going recruitment costs.

Trust strategic objectives: *tick which, if any, strategic objective(s) the report relates to:*

Quality Standards	☒	**Thriving People**	☒	**Seamless services**	☐	**Continuous Improvement**	☒

Identified Risk: *Please specify any links to the BAF or Risk Register*

BAF 8 -Improving performance and flow.
BAF 5-Culture, leadership and management
BAF 12 -Clinical engagement
BAF 2 -Health inequalities

Report previously considered at & date(s):

People and Culture Committee on 13 May 2025

Recommendation	The Board is asked to discuss and agree if true accuracy of risks presented.

Introduction:

The National Guardian's Office (NGO) and the role of the Freedom to Speak Up Guardian were created in response to recommendations made in Sir Robert Francis QC's report which investigated failures in care at the Mid Staffordshire NHS Foundation Trust. 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 NGO leads, trains and supports Speaking Up strategy within the NHS including monitoring the number and themes of concerns raised by NHS staff.

Background:

This report reflects the third year of increased demand for the Freedom to Speak Up (FTSU) service. The demand has led to improvements in the capacity and structure of the service which has enabled 'Speaking Up' support to be accessible any 5 days per week including weekends. The increased investment in supporting our colleagues to Speak Up demonstrates a positive shift within our Trust to building an open, transparent and psychologically safe work environment.

Our Chief Nurse, Theresa Murphy, and Non-Executive Director (NED) Diana Skeete are responsible for providing Board oversight and guidance to the FTSU service. Governance is provided by the People Committee, offering assurance in relation to process and clear connectivity to the People Priorities and People Promise. Operational delivery of the service is enabled through the Director of Quality, on behalf of the Chief Nurse.

1.0 Operational function of the service includes:

1.1 FTSU Guardian's Role in Supporting and Resolving Issues:

- Being available and responsive to staff is vital part of the FTSU Service. All staff receive a response within 48 hours of contacting the FTSU Guardian. Staff are always offered the choice of where/ how and when they wish to meet the guardian which can be on site or off site/ in person/ on teams or via phone
- As the aim of the service is to make Speaking Up business as usual, staff are always encouraged to speak to their immediate or second tier line manager in the first instance unless there are sound reasons for not doing so. If the staff member feels unable to do this on their own, then, with consent from both parties, the FTSU Guardian can help to facilitate a meeting with their manager, or the individual involved.
- Staff are advised at the start of the discussion that should their concern have elements of patient, staff safety or safeguarding, the concern must be escalated immediately.
- Support is provided by listening, coaching and encouraging staff to raise their concerns directly with their manager. Sometimes listening to understand is all that is required.
- The FTSU Guardian has helped to identify range of options when the staff member has raised concerns. Often staff are unable to see the full picture when they are absorbed in the issue. By exploring options, staff are sometimes able to see a solution to their concerns. This has been reflected in the publication of the Speak Up Policy 2023.
- The FTSU Guardian has played a crucial role in de-escalating issues by supporting local resolution and linking in with the Trust OD team to enable development at a practical level with individuals, teams, and services.

1.2 Raising awareness of Freedom to Speak Up

The Speaking Up service helps improve patient safety, quality of care and has a positive impact on service user and staff experience.

Therefore, the objectives of the FTSU Guardian are to ensure:

1. Staff members who have approached FTSU Guardian with concerns are thanked for Speaking Up and supported in speaking up.
2. Barriers to speaking up are addressed promptly
3. A positive culture of speaking up is role modelled
4. Issues raised are used as opportunities for learning and improvement.
5. Any clinical or immediate safety concerns are escalated appropriately, while supporting staff who have spoken up. Where necessary ensuring incident reporting episodes completed.

1.3 Speak Up Champions:

The last financial year, 12 Speak Up Champions were recruited and trained, bringing the total number of Speak Up Champions to 38. Recruitment has been inclusive, reflecting our diverse workforce and representing variety of staff groups, grades, and ethnicity to include all professional streams (Nurses, Midwives, Doctors, Therapists, Operation Department Practitioners, Radiographers, Health Care Support Workers, Administration and Clerical Staff).

Staff Group	**Numbers**
Additional Professional Scientific & Technical	2
Additional Clinical Services	5
Administrative & Clerical	10
Allied Health Professionals	4
Medical & Dental	6
Nursing & Midwifery Registered	13
Total	**40**

Speak Up Champions help influence the Speak Up culture within their departments, signpost colleagues who wish to speak up and help address barriers to Speaking Up. Speak Up Champions do not have protected time to carry out their work. This is a voluntary role and is dependent on individual managers agreeing the time to be taken to perform the Speak Up function. The Champions meet monthly to network, share learning and generate awareness of issues experienced by our People

Champions access emotional support via Employee Assistance Programme (Vivup).

1.4 Training:

All staff are assigned the Speak Up training module on ENH academy. 88% of staff have completed Speak Up training. All managers are assigned Speak Up and Listen Up training modules. 85% of managers have completed Listen Up training module.

1.5 Freedom to Speak Up Month:

October 2024 was promoted as Speak Up month and used a variety of avenues to share information.

- Each week in October was promoted with the FTSU theme in line with NGO (Listen Up for Safety, Listen Up for Civility, Listen Up for Inclusivity and Speak Up for Everyone)
- Anonymised learning and feedback from Speak Up cases were shared in Trust newsletter and on the FTSU intranet page
- The Trust Civility video was promoted within clinical departments to generate 'Civility Saves Lives' awareness.
- The FTSU Guardian facilitated reflective session at the leadership forum on 'Listening Up'. This session generated discussion on how we listen and respond to our people's voice and leaders made commitments to creating a psychologically safe environment within their teams.
- The FTSU Guardian also delivered talks and presentations on Speaking Up; Psychological Safety, and influencing just, restorative and learning culture at the Leadership Forum, Quality Huddle, departmental governance sessions, divisional meetings, rolling half day audit meetings and team meetings
- The FTSU Guardian attended senior managers meetings, staff network groups, People Committee, Trust Partnership, Quality and Safety meetings to work collaboratively with the wider organisation to create and promote a Speaking Up culture
- Training was delivered to 6 Speak Up Champions including 1 doctor.
- The Speak Up Champions pledges poster was displayed in the staff experience hub to promote the importance of Speaking Up.
- The FTSU Guardian visited departments Trust wide and cross site to introduce 'Speaking Up' and build connections with staff and managers
- The promotion of Speak Up month reflected a rise in staff raising concerns

1.6 Regional and National Networking:

The FTSU Guardian has networked outside the Trust including attending regional meetings and has set up regular meetings with FTSU Guardian at neighbouring Trusts to share learning. The FTSU Guardian attended the annual Speak Up conference hosted by the NGO

The next section of this report provides the statistical data of matters raised to the FTSU Guardian, assessment of the issues and themes, areas where issues are being raised, as well as outlining actions taken or underway.

2.0 Annual review of issues 2023/24

2.1 Assessment of Issues

Speak Up Cases over last 4 years.

Year	**2021/2022**	**2022/2023**	**2023/2024**	**2024/2025**
No. of Speak Up Cases	90	191	270	311

The FTSU Guardian facilitated weekly drop-in sessions within specific departments including Critical Care Unit, Emergency Department, Maternity and Mount Vernon Cancer Centre to increase opportunities for staff to interact with the FTSU Guardian. These drop-in sessions and office moves due to closure of Wiltron House and the refurbishment of Old School of Nursing contributed to a rise in Speak Up cases

Number of Speak Up cases for each quarter (2024/25):

	Q1	Q2	Q3	Q4	Total
Total Cases	74	77	77	83	311
Cases Closed	74	77	72	75	298
Cases Open	0	0	5	8	13

Open cases are actively monitored, and regular contact is maintained by the FTSU Guardian with the staff member.

2.2 Themes over the last 3 years:

This is in line with the NGO's recommended themes. The breakdown is as follows:

Themes	Number 2022/23	Number 2023/24	Number 2024/25
1. Worker Safety or Wellbeing	119	93	148
2. Inappropriate attitudes or behaviours	43	115	109
3. Patient Safety/ Quality	15	49	36
4. Bullying and Harassment	14	13	18
5. Disadvantageous or demeaning treatment because of Speaking Up	0	0	0
Total	191	270	311

Themes April 2024 to March 2025

Themes	Number	Percentage
1. Worker Safety or Wellbeing	148	47%
2. Inappropriate attitudes or behaviours	109	35%
3. Patient Safety/ Quality	36	12%
4. Bullying and Harassment	18	6%
5. Disadvantageous or demeaning treatment because of Speaking Up	0	0
Total	311	100%

2.3 Who is speaking up?

Concerns raised by staff groups (as defined by NGO)

Staff Group	Number of Concerns Raised 2022/23	Number of Concerns Raised 2023/24	Number of Concerns Raised 2024/25
Additional Professional Scientific & Technical	9	10	16
Additional Clinical Services	39	32	29
Administrative & Clerical	39	71	52
Allied Health Professionals	7	14	34
Estates & Ancillary	0	7	7
Healthcare Scientists	0	5	15
Medical & Dental	12	31	62
Nursing & Midwifery Registered	84	92	89
Students	0	3	6
Unknown (anonymous)	1	4	0
Other	0	1	1
Total	191	270	311

Who is Speaking Up by Staff Group April 2024 to March 2025

Staff Group	Number of Concerns Raised	Percentage
Additional Professional Scientific & Technical	16	5%
Additional Clinical Services	29	9%
Administrative & Clerical	52	17%
Allied Health Professionals	34	11%
Estates & Ancillary	7	2%
Healthcare Scientists	15	5%
Medical & Dental	62	20%
Nursing & Midwifery Registered	89	29%
Students	6	1.7%
Unknown (anonymous)	0	0
Other	1	0.3%
Total	311	100%

2.4 Who is speaking up by Ethnicity?

Ethnicity	Number 2022/23	Number 2023/24	Number 2024/25
Asian	45	82	107

Black	42	68	66
Mixed (Asian & White British)	6	2	2
Mixed (Black & White British)	12	3	4
Mixed (other)	3	0	0
White British	70	106	124
White (other)	12	5	8
Unknown	1	4	0
Total	191	270	311

Who is Speaking Up by Ethnicity (April 2024 to March 2025)

Ethnicity	Number	Percentage
Asian	107	34.4%
Black	66	21.2%
Mixed (Asian & White British)	2	0.6%
Mixed (Black & White British)	4	1.2%
White British	124	40%
White (other)	8	2.6%
Total	311	100%

2.5 Themes in more detail:

1. **Worker Safety or Wellbeing:** This relates to cases where there is a risk of adverse impact on worker safety or wellbeing including work related stress. 30% of cases relate to the office moves i.e. decanting from Wiltron House and the refurbishment of the Old School of Nursing building. Staff affected Spoke Up to report gaps in communication and their perception that the needs of the service was not taken into consideration when allocating office space. Review of the process followed in allocation of workspace elicited that the project team had communicated with senior department managers, but this communication did not reach the staff directly affected by the move. 30% of cases related to a breakdown of relationships between line managers and employees. Both managers and employees need to be supported with resolving their issue and moving forward. In some circumstances, early mediation may have stopped issues from escalating to a formal complaint process. 17% of cases related to failure to follow systems and processes relating to pay, approval of annual leave and work schedules. 10% relate to the recruitment process, in particular obtaining meaningful interview feedback. 8% of cases relate to perceived inequality and discrimination and 5% of cases relate to health and safety issues including staff experiencing aggression and violence from service users.

   Action: Managers need support to manage performance and attendance issues to ensure that any action taken is just and restorative. Training is available on ENH academy to help managers

gain skills required to manage people. This is self-directed and does not provide an opportunity for discussions with peers. Training with a group of managers may be more effective and supportive.

Managers need coaching/ training to gain people management skills including skills to have difficult conversations and respond to conflict between team members. As part of learning from Speak Up cases, coaching has commenced for some managers. This needs to be expanded and provided to all managers as part of our people strategy 'help our people thrive and grow.'

Staff in patient/ service user facing areas must complete de-escalation training. A majority of staff in high-risk areas have accessed this training. However, there are concerns that not all staff are attending the required training. Some of this is due in part to line managers unable to back-fill the staff member who needs to attend the training.

Office moves are contentious due to competing priorities and therefore it is crucial that good communication is fostered from the planning stage and a standard operating procedure is developed to confirm governance around decision making processes and to ensure staff affected by office moves have been informed and their voices have been heard.

Recruiting managers must plan and provide meaningful feedback to unsuccessful candidates. This should include examples of model answers to interview questions.

There is a need to continue Cultural Intelligence work that has started within the organisation including training, reverse mentoring, appointment of inclusion ambassadors and staff network streams.

2. **Behavioural / Inappropriate attitudes (Incivility):** 35% concerns raised related to interactions that lacked civility and respect and dignity. This contributed to poor psychological safety within teams. All grades of staff including managers were impacted by this. A majority of staff who experienced incivility reported that it had a negative impact on their well-being and their ability to promote patient safety when working as part of the multidisciplinary team to deliver safe care. Several staff reported they felt anxious and dreaded coming to work.

Actions:

- Healthy Teams action plan in progress to set the cultural tone in line with Trust values and facilitate departmental values and behaviour charter. Almost 60% of teams have participated proactively in sessions to define values and behaviors that underpin these values. More work is needed on how to hold peers and colleagues accountable compassionately for behaviours not in line with Trust values.
- Provision of timely supportive feedback and coaching to staff involved to help them develop communication styles that reflect our Trust values. Conflicting operational pressures have created barriers in provision of timely feedback. There is improved access to coaches within our Trust and over time this should have a positive impact on the standard of communication within our Trust.
- Managers need coaching/ training to gain team management skills to embed psychological safety within their teams.

3. Patient safety concerns:

Patient safety concerns primarily related increased demand and limited resources to meet this demand.

- Staffing shortfall including poor skill mix – predominantly within inpatient areas.
- Insufficient equipment- this included fully functioning equipment needed to deliver clinical care.
- Deviation from agreed clinical standards.
- Patient allocation within wards for nursing team does not include adjustment for dependency and skill mix. This was across inpatient areas within Lister hospital.

Action:

- Support and encourage staff to report instances where care provision was not in line with agreed policy/ standards. This action is aligned with the Patient Safety Incident Response Framework (PSIRF) and a plan to deliver training for clinical staff is in progress.
- Deviation from standards must be reported via the incident reporting system Enhance to initiate due process, review and learning. This action is again aligned with PSIRF and proposed training to all clinical staff.
- Staffing reviews must identify areas that consistently RAG rate as Amber to seek reassurance on patient safety and quality. This action will need to be agreed by the Quality and Safety Committee in line with safe staffing standards. Daily escalations occur through senior nurse site safety review.
- Ward managers and matrons to review patient allocation against shift skill mix to ensure allocation promotes patient safety and quality. To be discussed and agreed at matrons and ward managers meetings.

4. Bullying and Harassment:

18 members of staff raised concerns about bullying and harassment. 6 staff members decided to leave the organisation as they did not trust the investigation process. 12 staff members have raised concerns with Employee Relations Advisory Service (ERAS) via Trust grievance process.

Action:

- Managers need pastoral support when allegations of bullying and harassment are made against them. To be discussed and agreed with the ERAS team
- Managers need coaching/ training to gain people management skills. To be discussed and agreed as part of Grow Together conversations.
- Early interventions including mediation and facilitated conversations can help resolve issues and heal workplace relationships. Therefore, it is essential that managers seek advice and support promptly from the People Team when allegations of bullying/ harassment are made.

3.0 Concerns raised via other avenues:

3.1 Anonymous concerns raised with Care Quality Commission (CQC):

2 concerns were raised anonymously in the year 2024/25

2021/2022 – 2022/2023 Comparison

Year	April 2021 – March 2022	April 2022 – March 2023	April 2023 – March 2024	April 2024 – March 2025
Number of anonymous concerns	4	4	23	2

Of the two cases reported this year, one related to working conditions, leadership dynamics and collaborative culture within provision of neonatal care. The department took steps to re-evaluate the training provided to doctors and made the multidisciplinary team (MDT) aware of routes of escalation in the event of any concerns relating to team working, including human factors. Themes are discussed at governance and speciality meetings with agreed plan of action as an outcome. The department has developed an action plan to support medical staff in training. There is also a dedicated neonatal governance team co-led by medical and nursing leads to improve the service and patient care.

The second letter related to the Critical Care Unit (CCU) and raised concerns around poor staffing, team working and discrimination. Staffing was reviewed in line with patient acuity. This review did not identify unsafe (red) shifts. The CCU leadership team in collaboration with the People team and the FTSU Guardian facilitated listening events for staff. Every concern was logged for appropriate action including support for the wider team. In addition to these changes a critical care improvement group meets fortnightly to discuss staffing, cultural and service issues.

3.2 Ask Adam email inbox: Staff within our organisation can contact our CEO directly to raise concerns by emailing ask.adam@nhs.net.

The concerns raised directly with our CEO fall under the following themes:

- Parking: Availability, maintenance of staff parking, lack of disabled parking
- Recruitment and sponsorships: Changes to certificate of sponsorship cost and visa fees
- Feeling valued: Not being kept informed, changes happening without timely communication.

These issues were addressed on a case-by-case basis.

4.0 Achievements:

- Rise in Speak Up cases from our people, from every staff group, reflecting our diverse workforce and representing breath of grades and seniority
- No anonymous FTSU cases over the last 12 months
- 8 Speak Up Champions recruited and trained.
- Reduction in anonymous CQC whistleblowing concerns. 2 concerns compared with 23 last year and 4 the year before.
- NHS Staff Survey: 3% increase (classed as significant) in staff having confidence that if they Speak Up, the Trust will address their concerns
- Increase in local resolution/ facilitated conversation/ mediation
- 88% of staff have completed the Speak Up training module and 85% of managers have completed the Listen Up training module.

- Speaking Up is part of corporate induction and included in a variety of meetings including Leadership Forum, Quality Huddle, consultant induction, medical trainee induction, local negotiation committee and junior doctor forum
- Sustained increase in cross-site visibility of FTSU Guardian including site specific all staff team briefings and departmental meetings
- FTSU workshop delivered at Mount Vernon Cancer Centre, Lister Hospital, Queen Elizabeth II and Hertford County Hospitals.
- Positive feedback received from the staff members who accessed the service. Staff members reported that they felt supported, were grateful that their voice was heard and thanked the service for helping then Speak Up and resolve their concerns.

5.0 Learning and Improvement:

1. Fear continues to be a barrier to Speaking Up. The need to develop healthy teams and embed psychological safety within teams continues. There are several positive streams of work in play within our organisation including Healthy Teams, Values and Behaviours and What Matters to You. We need to connect these initiatives to ensure effective delivery on Trust strategy. In addition to this, training is available to help staff to gain skills to Speak Up and for managers to Listen Up. It is essential that all staff access this training to promote speaking up within the organisation.
2. Availability of mediators within the Trust: Observations and learnings from the FTSU service have highlighted ongoing gaps in the availability of mediators that could support early de-escalation of interpersonal conflict. The delay in accessing mediation, increases the risk of prolonging the ongoing interpersonal challenges as opportunities for early resolution are missed. This report recommends that we increase the number of trained mediators within our Trust through training
3. Support for leaders/ managers: over the last 12 months, 70% of staff who contacted the FTSU Guardian have Spoken Up to their line manager. The escalation occurred either because staff did not believe they were heard or were not convinced there was a meaningful response. All ward managers and department leadership teams need support to listen and respond to staff voices. This needs to be assessed individually as part of Grow Together conversations to plan individualised support.
4. Recruiting managers should offer to provide meaningful feedback including examples of model answers to interview questions to all unsuccessful applicants.
5. To work towards our goal of making Speaking Up business as usual, managers need to include FTSU within their agenda for team meetings bi-annually and invite either the FTSU Guardian or a Speak Champion to join their meeting.
6. As civility saves lives, it is essential that the Trust video on civility is shared widely across our Trust with teams, followed by a reflective session facilitated by our civility campaign champions or OD/ Cultural team to support shifting our organisational culture to a place where our values of Include, Respect and Improve are lived.
7. More maturity is required for workforce appreciation of expectations when raising a concern or responding to a concern. The FTSU Guardian will continue to contribute to the NGO mission. Part of this work is to submit and support requirements from the NGO. These include quarterly submissions, regional meetings and other surveys.

6.0 2023/24 Recommendations:

1. All staff complete Speak-Up training available via ENH Academy
2. All managers complete Listen Up training in addition to above

3. Grow Together conversations for all line managers should include a plan to support individual managers to listen and respond to Staff Voice
4. Speak up cases are reviewed through the lens of learning and improving, ensuring meaningful actions and sustained improvement.
5. All teams to work in partnership with Trust OD team to draw up a team charter including behaviours that reflect our values with biannual reflections on how team members are encouraged to live our Trust Values.
6. The People Team to undertake some work to identify where mediation can be deployed and implement that at an early stage particularly where they know there has been a breakdown in relationships between staff, particularly between line managers and their direct reports
7. Speak Up Champions have protected time to carry out their work
8. The FTSU service needs to be strategically aligned to the Trust strategy
9. There is formal agreement between FTSU function and People Team to confirm process for responding to staff concerns including expected actions and agreed timeframes. A service level agreement that sets standards on agreed timeframe for response/ action will help manage expectations of staff who Speak Up.
10. FTSU Guardian continues work stream that has started to grow staff confidence in 'Speaking Up'
11. FTSU Guardian continues to link in with OD to enable development at a practical level within individuals, teams and services
12. FTSU Guardian, OD and Governance work collaboratively to embed learning for Speak Up themes
13. FTSU Guardian reports to be discussed at Audit and Risk Committee and Quality and Safety Committee to provide assurance that issues crossing over into their areas are picked up and dealt with appropriately

The Trust Board is asked to:

- Consider and comment on the themes, trends and issues arising from this report
- Support the drive for cultural change, including living our new values (Include, Respect and Improve) by scrutinising the organisations approach to leadership development and people management and seek assurance there are clear plans and resources in place to support this.

Board

NHS
East and North Hertfordshire Teaching NHS Trust

Meeting	Public Trust Board		**Agenda Item**	10	
Report title	Trust Green Plan Refresh		**Meeting Date**	9 July 2025	
Author	Head of Compliance and Sustainability and Trust Green Plan Stakeholders.				
Responsible Director	Medical Director as Chair of the Trust Sustainability Board				
Purpose	**Assurance**	☐	**Approval/Decision**	☒	
	Discussion	☐	**For information only**	☐	
Proposed assurance level (*only needed for assurance papers*)	**Substantial assurance**	☐	**Reasonable assurance**	☐	
	Partial assurance	☐	**Minimal assurance**	☐	

Executive assurance rationale:

Summary of key issues:

In January 2022 Trust formally adopted its Green Plan (2021-24), a live strategy outlining our aims, objectives, and delivery plans for sustainable development. Following government guidance released in February 2025, the Trust has been working on refreshing the Green Plan for the next 3-year cycle.

The refreshing of the Trust Green Plan has involved engagement with a broad range of stakeholders. This engagement period has enabled an honest review and reflection of Green Plan commitments and what as an organisation we have achieved since the launch in January 2022.

The refreshed Green Plan covers the period August 2025 to July 2028.

Impact: *tick box if there is any significant impact (positive or negative):*

Patient care quality	☐	**Equity for patients**	☐	**Equity for staff**	☐	**Finance/ Resourc -ing**	☒	**System/ Partners**	☐	**Legal/ Regul- atory**	☐	**Green/ Sustai- nability**	☒

Financial / resourcing impact as per Risk ID #3628 (below).
Green Plan refresh outlined a high-level roadmap to how the Trust will work towards achieving the NHS Net Zero Target by 2040.

Trust strategic objectives: *tick which, if any, strategic objective(s) the report relates to:*

Quality Standards	☐	**Thriving People**	☒	**Seamless services**	☐	**Continuous Improvement**	☒

Identified Risk: *Please specify any links to the BAF or Risk Register*

Risk ID #3628 'Risk that current financial climate may compromise the Trust ability to be proactive on sustainability agenda'.

Report previously considered at & date(s):

Trust Sustainability Board – 6 June 2025.
Finance Performance and Planning Committee (FPPC) SIGN-OFF APPROVAL at 23 June 2025.

Recommendation	The Board is asked to review and approve Trust Green Plan Refresh.

To be trusted to provide consistently outstanding care and exemplary service

NHS
East and North Hertfordshire Teaching
NHS Trust

Green Plan Refresh 2025 - 2028

#ProudToBeENHT

Content

Foreword

Our greener trust

Welcome to our Green Plan which sets out the next phase of our sustainability strategy (2025 - 2028), the reasons behind our plans and the benefits we think they will bring.

Three years on from the publication of our first Green Plan, which covered the time period 2021 to 2024, we've made some good progress across key areas, working towards greener hospital sites and reducing our environmental impact.

As our largest site, Lister Hospital has been a main focus with LED and solar panel installation and an upgrade to our building management system. Our heat decarbonisation plan is also now complete and sets out how we'll transition to low carbon technologies.

Ongoing work with our digital team on energy saving projects has included switching off non-essential and idle equipment overnight and the introduction of an electronic document management system project which will digitise patient records.

To support a drive to offer sustainable food options, our catering team is working towards SOIL Association accreditation, has made the switch to recycled wooden cutlery and food waste is now sent to a biodigestion tank diverting it from landfill or incineration.

In June 2023, the trust achieved zero waste to landfill. Reusable containers are also now in place for sharps disposal which resulted in a 23.5% reduction in carbon emissions from clinical waste in the first year they were used and by a further 9.6% in year two.

Our electric vehicle charging scheme for staff is established and we now have electric vehicles in our internal transport fleet with tracking software to help more efficient route planning.

Looking at other sites, the team at Mount Vernon Cancer Centre (MVCC) has run trial projects about reusable Personal Protective Equipment (PPE) and reducing carbon footprint on radiotherapy pathways. Funded by the National Lottery, a nature ranger is also now in post to further improve the green spaces at the cancer centre and support on projects at other sites.

Elsewhere in our research team, five studies have been published which highlight the intersection of healthcare and climate change and the environmental impact of medical practices, particularly in asthma care. Lister is also now officially a smoke free hospital site with the removal of smoking shelters making way for improved green spaces.

These are just some of the projects we've been working on and we encourage you to find out more in this plan.

We looked forward to continuing to work with our staff, our patients, our local communities and our partners towards a greener, more sustainable trust.

Justin Daniels
Medical director and
chair of sustainability board

Karen McConnell
Non-executive director and
vice chair of the trust board

Executive Summary

Achieving Net Carbon Zero is the most significant non-clinical policy agenda in the NHS, and the policy and protocols are developing and evolving alongside expected delivery. There are significant opportunities and challenges associated with delivering the Green Plan, despite it being a strategy in its infancy.

In January 2022, the trust formally adopted its Green Plan (2021–2024), a live strategy outlining our aims, objectives, and delivery plans for sustainable development. Following government guidance released in February 2025, the trust has been working on refreshing the Green Plan for the next three year cycle.

The refreshing of the trust's Green Plan has involved engagement with a broad range of stakeholders. This engagement period has enabled an honest review and reflection of Green Plan commitments and what as an organisation we have achieved since the launch in January 2022.

Looking forward, we have taken a pragmatic approach to what we hope to achieve, the most effective way to monitor our progress and to ensure progress is shared and celebrated with our colleagues and community.

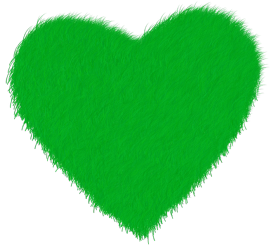
Our trust has identified 11 key areas of focus. Each area has an overarching aim, details the work the trust has carried out to date, details what we will do in the next three years and how we plan to monitor and measure progress against these objectives.

The areas of focus are:

- Workforce and leadership.
- Net zero clinical transformation.
- Digital transformation.
- Medicines.
- Energy and water.
- Travel and transport.
- Food and nutrition.
- Waste.
- Biodiversity.
- Supply chain and procurement.
- Adaptation.

The refreshed Green Plan covers the period August 2025 to July 2028.

Helen O'Keefe
Head of Compliance and Sustainability (Estates & Facilities)



Introduction

Greener NHS

In January 2022, the trust formally adopted its Green Plan (2021–2024), a live strategy document outlining our aims, objectives, and delivery plans for sustainable development. The Green Plan sets out the trust's carbon emissions and resource use reduction targets in line with the Greener NHS programme and the UK Climate Change Act (2008).

Three years on, the trust continues to work towards the NHS Long Term Plan commitment of achieving Net Zero by 2040 by embedding sustainability at the heart of decision-making across the organisation. This includes:

- Achieving Net Zero by 2040 for the emissions we control directly, with an ambition to reach an 80% reduction between 2028 and 2032 (against a 1990 baseline), and
- Achieving net zero by 2045 for the broader emissions we can influence, with an ambition to reach an 80% reduction between 2036 and 2039 (against a 1990 baseline).

Every intervention will aim to:

- Improve health and patient care outcomes.
- Reduce system inefficiencies.
- Address health inequalities.
- Deliver a more resilient healthcare system.

The refreshed Green Plan marks the next phase of our sustainability journey and will guide our actions and ambitions over the next three years.

Our Sustainable Vision

East and North Hertfordshire Teaching NHS Trust's vision is to deliver high-quality, compassionate care to our community. Our strategic priorities are quality, people, pathways, ease of use, and sustainability. Our core aim is to meet CQC well led and Health and Care Act expectations around decision making, considering the environmental impact alongside patient care and finance. This will be achieved by developing and embedding sustainability impact assessments to support decision making.

Environmental sustainability is recognised by the Royal College of Physicians as a key domain of quality care. We will embed sustainability across all aspects of trust operations, contributing to the UN sustainable development goals and achieving Net Zero NHS carbon emissions targets.

We share NHS England's objective of sustainable development:

"We recognise that Sustainable Development is a critical factor in our organisation being able to deliver world class healthcare, both now and in the future. We are therefore dedicated to ensuring we create and embed sustainable models of care throughout our operations and to ensuring our operations, and our estate(s), are as efficient, sustainable and resilient as they possibly can be".

Lister Hospital (including smaller sites), is the largest footprint where we directly manage the estate, upkeep and development of the building and grounds and it will continue to be the main focus of our sustainability work. However, we will be working closely with estates teams and landlords at our other sites (Hertford County Hospital, New QEII and MVCC) to work towards our targets and goals.

Our people

The East and North Hertfordshire Teaching NHS Trust's 2021–2024 Green Plan recognised the steps required to improve the environmental and social performance of our operations. Our strategy focused on carbon reduction, community resilience and social and health outcomes. We have reviewed our performance against our previous strategy, adopted lessons learnt, and developed it into a Green Plan refresh to cover the next three years.

We have continued our trust-wide approach to sustainability, with our Sustainability Board consisting of 15 representatives from across the organisation. Together, we are working to identify opportunities to improve our environmental and social sustainability performance, raise awareness on sustainable healthcare, and support our communities in more sustainable behaviours. This group is led by the medical director, and reports into the Finance Planning and Performance Committee (FPPC).

In addition to the Sustainability Board, we created sub-groups to focus on specific areas within the trust, including an active team of environmental volunteers at MVCC. This team supports MVCC and partner organisations in ensuring strong environmental stewardship and best practice. Specifically for our trust, feedback from engagement with staff has shown that raising awareness and supporting our team and communities is a key opportunity area.

Our Green Plan goals

Our Green Plan is anchored around three key goals that reflect the ambition and need for action within our trust. These goals were developed and approved by our trust's Sustainability Board. Our full action plan covers 12 workstreams which support in achieving these overarching goals.

Priority Area	Objective	Aligned UN Sustainability Development Goal (SDG)	
1. Increase sustainability awareness	Increase staff awareness of sustainability in healthcare, including carbon reduction and climate change adaptation, appropriate to their role.	SDG 13: Climate Action	
2. Support our community	Actively engage all our communities, focusing on reducing health and social inequalities through sustainable actions and behaviours.	SDG 3: Good Health and Well-being SDG 11: Sustainable Cities and Communities	 
3. Improve resource efficiency, reducing emissions and waste	Reduce energy and water consumption year on year, improving resource and looking at waste, retaining the value of things aligning to the circular economy approach. Continue achievement of zero waste to landfill and reach net zero for directly controlled emissions by 2040.	SDG 7: Affordable and Clean Energy SDG 12: Responsible Consumption and Production	 

Table 1 – Our goals which inform our Green Plan are derived from the UN's Sustainable Development Goals

About us

East and North Hertfordshire Teaching NHS Trust

At East and North Hertfordshire Teaching NHS Trust, we provide acute and tertiary care services from four hospitals – Hertford County in Hertford, Lister in Stevenage, MVCC in Northwood and the New QEII in Welwyn Garden City where we have our 6,500 members of staff. The trust was created in April 2000, following the merger of two former NHS trusts serving the east and north Hertfordshire areas.

Since 2014, the Lister has been the trust's main hospital for specialist inpatient and emergency care. The New QEII hospital, commissioned by the East and North Hertfordshire Clinical Commissioning Group, opened in June 2015 and provides outpatient, diagnostic and antenatal services and an urgent treatment centre. Hertford County provides outpatient and diagnostic services, and MVCC provides tertiary radiotherapy and local chemotherapy services.

Acute hospital care by the trust, covers an area of over 600,000 people, covering south, east and north Hertfordshire, as well as parts of Bedfordshire. The MVCC provides specialist cancer services to approximately three million people from across Hertfordshire, Bedfordshire, north-west London and parts of the Thames Valley.

Figure 1: From top left clockwise, Lister Hospital, Hertford County Hospital, New QEII and MVCC

Our Local Authorities

The trust works across several local authority areas, each of which has declared a climate emergency and set out plans to reach Net Zero. Stevenage, Welwyn Hatfield, and Hillingdon are acting on areas such as sustainable transport, renewable energy, energy efficiency in housing, waste reduction, and behaviour change.

Our approach aligns with their priorities by aiming to reduce emissions from our buildings and supply chain, cut waste, promote sustainable travel, and engage our communities and staff in climate action. By working closely with local partners, we are ensuring our efforts compliment the wider regional Net Zero goals and help create healthier, more sustainable communities.

Drivers for change

National policy and legislation

The 2022 Health and Care Act has made the NHS's commitment to Net Zero a legal requirement. Consequently, all NHS organisations must consider carbon reduction in their decision making and demonstrate this using governance, metrics, and embedding sustainability into policies.

The NHS has two main reduction targets:

- **NHS Carbon Footprint**: Net Zero by 2040 for the emissions the NHS controls directly, with an ambition to reach an 80% reduction by 2028 to 2032 (from a 1990 baseline).
- **NHS Carbon Footprint Plus**: Net Zero by 2045 for the broader emissions the NHS can influence, with an ambition to reach an 80% reduction by 2036 to 2039 (from a 1990 baseline).

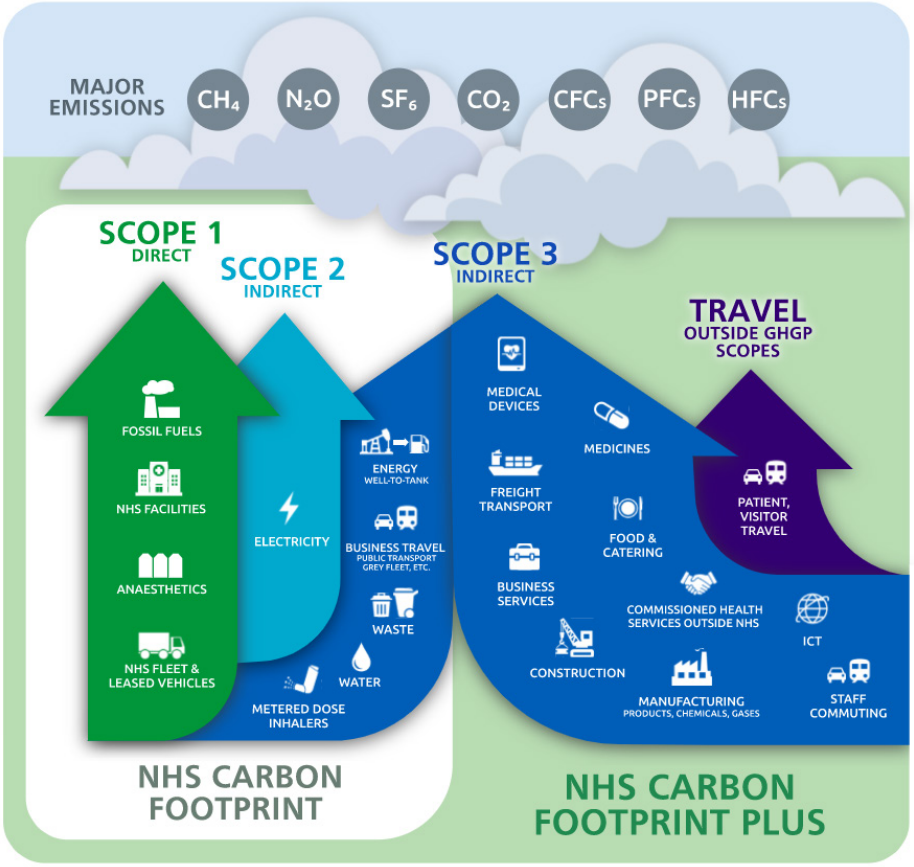


Figure 2: Sources of carbon emissions by proportion of NHS Carbon Footprint and NHS Carbon Footprint Plus

The NHS long term plan includes several commitments related to health and the environment, including efforts to tackle climate change, reduce single-use plastics, improve air quality, and minimise waste and water use. We want sustainability to be embedded across the trust, enabling strategies and operations so that we can effectively deliver on these commitments.

United Nations Sustainable Development Goals

United Nations member states adopted the 17 Sustainable Development Goals (SDGs) in 2015. These goals are a call to action for members, in addressing the needs of people in both developed and developing countries and are a blueprint in sustainable development for all. The trust is starting to contribute to these 17 goals, shown in Figure 3, at a local level and this Green Plan has been developed to enhance our contributions over the coming years, using these to guide our overall strategy.

Figure 3: United Nations Sustainable Development Goals

Energy consumption and carbon

We continue to improve our understanding and calculation of our NHS carbon footprint and have begun tracking our current carbon emissions resulting from energy (scope 1 and 2). As a trust, most of these emissions are derived from our energy consumption, and we have focused our efforts on producing actionable plans to mitigate this.

Energy Consumption

In Figure 4 below, our ERIC reported energy consumption has been mapped out since our previous Green Plan in 2021. ERIC is a methodology used by trusts to monitor the costs of looking after the estate such as maintaining and equipping hospitals and managing services such as cleaning and food. Most of our energy usage is associated with the combustion of gas, due to the operation of a Combined Heat and Power system (CHP) at Lister Hospital, providing both heat and electricity to the site. This means that while our gas consumption is high, our electricity consumption is comparatively low. The biggest challenge that we will face when reducing our NHS carbon footprint, will be a reduction in gas consumption, as degassing will be an expensive process in terms of designing and installing new infrastructure.

Our Energy Consumption

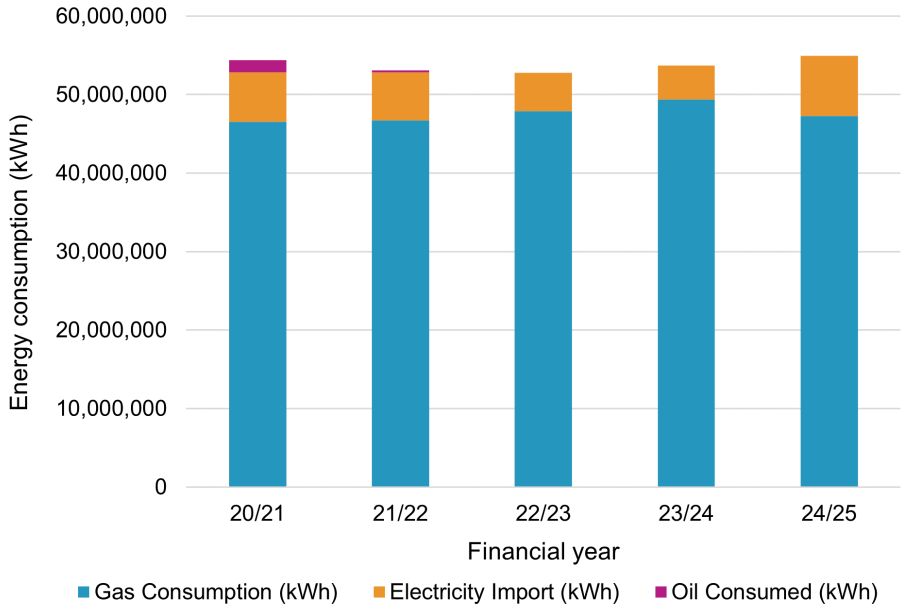


Figure 4 – Energy consumption across all trust sites based on the past five years of ERIC data. We are in the process of quantifying our fleet and business travel.

Energy Related Carbon Emissions

Using the energy data above, we have calculated our carbon emissions associated with energy use. Most of our energy related carbon emissions (91%) arise from the combustion of gas, with approximately 50% of our gas consumption arising from our CHP at the Lister Hospital. To support with this, the trust now has a heat decarbonisation plan for the Lister hospital site, focusing on how to deliver the trust's ambition in the most cost-effective way.

Our Location-Based Emissions

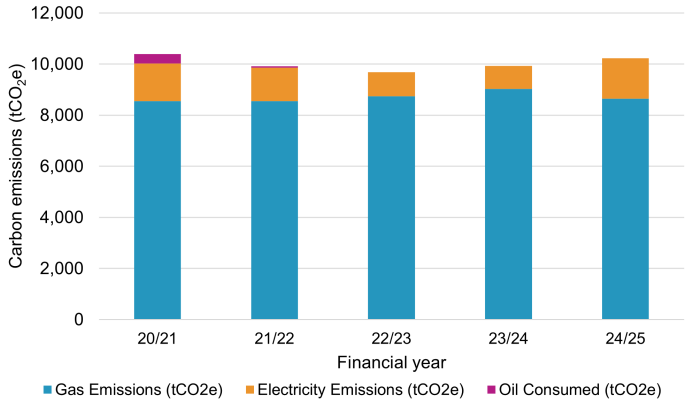


Figure 5 – Our emissions across all trust sites based on the past five years of ERIC data.

How have our emissions changed?

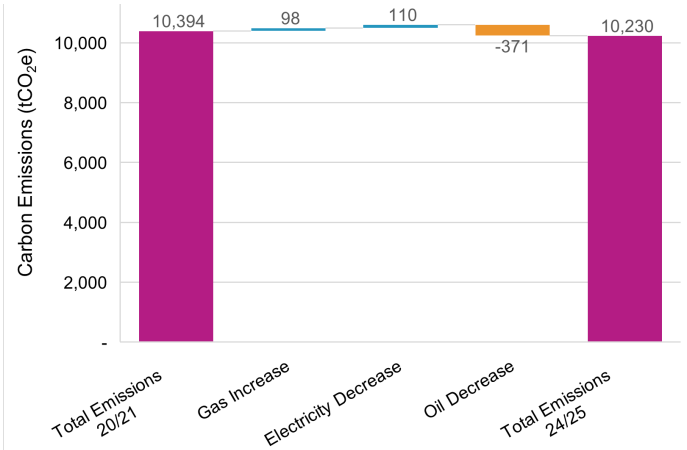


Figure 6 – How our energy related carbon emissions have changed since the trust's previous green plan.

Since the previous Green Plan, the trust's emissions associated with energy consumption have reduced by 4%, primarily by reducing our oil consumption (-3.6%) and a reduction in the emission intensity of the UK electricity grid. This has, however, been offset by a slight increase in our gas consumption (1%) and electricity consumption (7%).

Focus Areas

Our trust has identified 11 key areas of focus. Each area has an overarching aim, details the work the trust have carried out to date, details what we will work towards in the next three years and how we will measure our progress against these objectives.

The areas of focus are:

- Workforce and leadership
- Net zero clinical transformation
- Digital transformation
- Medicines
- Energy and water
- Travel and transport
- Food and nutrition
- Waste
- Biodiversity
- Supply chain and procurement
- Adaptation

Graphic credit: Greener NHS

The actions across these areas address the social, environmental and economic aspects of sustainability. As a trust, we are prioritising interventions which simultaneously improve patient care and community well-being while tackling climate change and broader sustainability issues. We have also based our forward focus and targets for each focus area on the NHS Key Milestones for the next two years (Figure 7) and considered what additional steps are necessary for the NHS Key Milestones for the next four to eight years (Figure 8 and Figure 9).

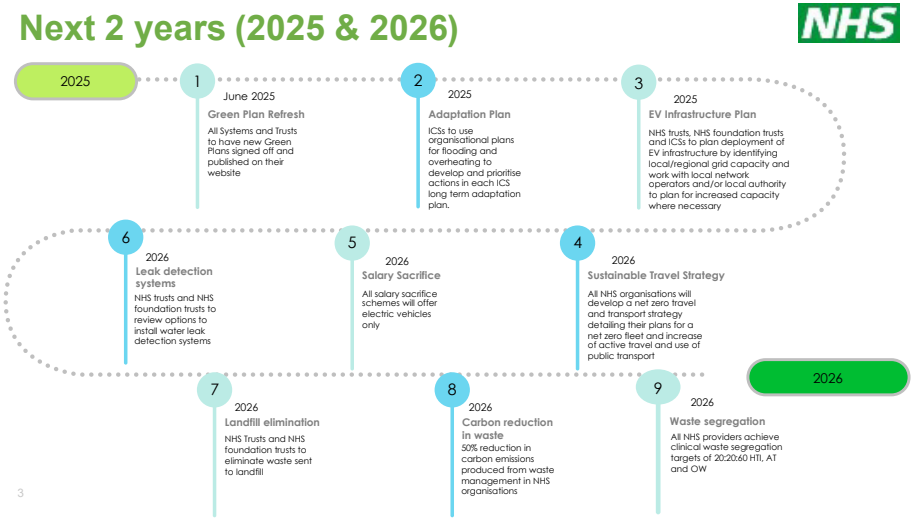


Figure 7: NHS Key Milestones for the next two years

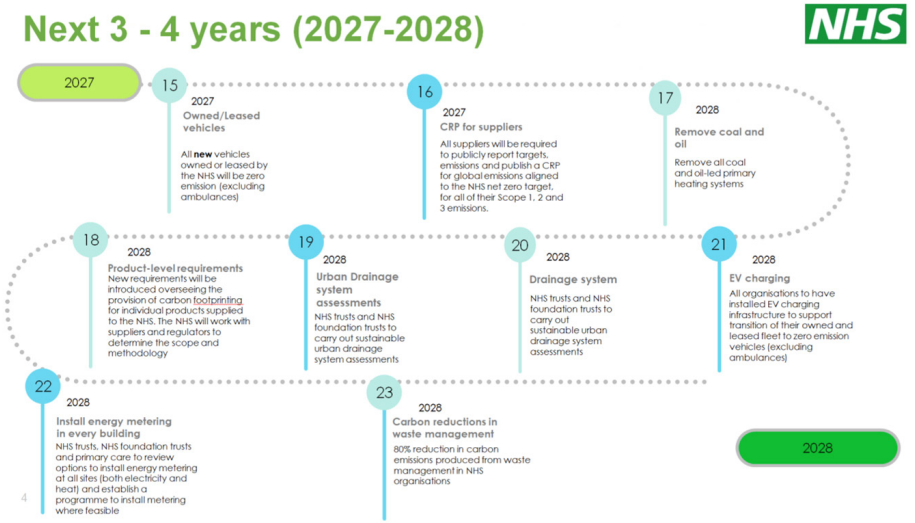


Figure 8: NHS Key Milestones for the next three to four years

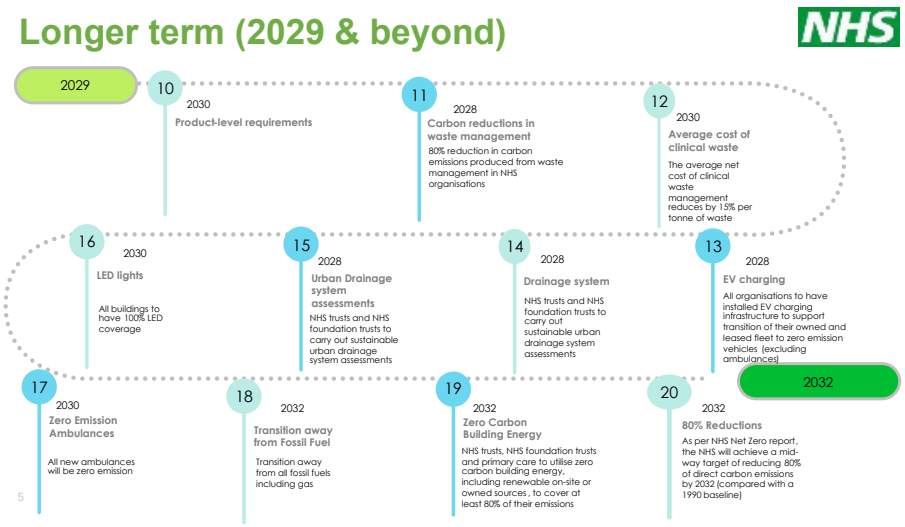


Figure 9: NHS Key Milestones for the longer term (2029 and beyond)

Workforce and Leadership

A skilled and engaged workforce is essential to delivering the Green Plan and achieving the NHS's Net Zero commitments. Developing skillsets through training and embedding sustainability in roles, as well as supporting staff-led initiatives at all levels will be a key focus over the next three years.

Our aim: Empower and equip our workforce with the knowledge, skills, and support needed to embed sustainability into everyday practice.

What have we achieved?

- Appointed Net Zero Board Lead and Non-Executive Director.
- Bi-annual Trust Sustainability Board with Chair and Deputy Chair.
- Established Green Ambassadors Group (informal monthly meeting).
- Ongoing communications led promotion of green initiatives (local and national).
- Trust Green Plan features on Trust Corporate Induction Programme.
- Sustainability Plans – Audit Review undertaken (March 2025).
- Appointed one WTE Energy and Sustainability Manager.

Future Focus

Target Area	Our Commitment
Trust-wide commitment to Net Zero	We will continue to ensure our legal obligation under the Health and Care Act 2022 to achieve Net Zero is reflected in our trust's published values, mission statement, and guiding principles.
Staff engagement and benefits	We will promote and expand sustainability-focused staff benefits such as the cycle-to-work scheme and access to EV salary sacrifice schemes. These actions intend to support staff well-being and extend the trust's sustainability impact into the community.
Sharing and collaboration	Collaboration and knowledge sharing internally and across partner organisations, is an integral element for achieving our net zero goals. To encourage staff engagement and highlight best practice, we will showcase at least one sustainability case study from within the trust each month, aiming to celebrate staff-led initiatives, inspire others, and promote a culture of continuous improvement.
Green roles across the workforce	We will continue building sustainability skillsets across clinical and non-clinical teams. We will explore integrating green apprenticeships, internships, and fellowships to support entry and progression into sustainability-focused careers.
Training	To strengthen trust-wide understanding of sustainability, we will broaden access to environmental training across all staff levels. This includes further incorporating sustainability into staff inductions and training.

What we will do next

- Publish trust progress against the Green Plan refresh, celebrate staff initiatives and success stories on a monthly basis.
- Provide a variety of staff development and training opportunities that support our Green Plan refresh and drive behaviour change. To support day-to-day staff engagement, sustainability training will be promoted through channels such as screensavers to raise awareness.
- Promote Carbon Literacy Project.
- Carry out an annual sustainability awareness staff survey in 2025-2026.
- Develop a Sustainability Impact Assessment (SIA), embed in Project Initiation (PID) and Business Case (BC) documentation.

Net Zero Clinical Transformation

The NHS is committed to moving to out-of-hospital and digitally enabled care where clinically appropriate, improving prevention of ill health and reducing health inequalities. These changes also underpin our commitment to Net Zero. Net Zero clinical transformation should ensure high-quality, preventative, low-carbon care is provided to patients at every stage.

Our trust is fully committed to embedding and delivering Net Zero clinical transformation, creating better and more efficient experiences for our patients.

Our aim: Take a whole systems approach to deliver the best quality of care whilst being mindful of the social, environmental and economic impacts.

What have we achieved?

- Our Net Zero clinical transformation team carried out a carbon footprint study of UK brachytherapy (a type of radiotherapy where the radiation dose is given internally) to help us identify the main sources of emissions across the pathway. The biggest contributors were time spent in wards and theatres, as well as patient travel. These results will serve as a foundation for developing targeted reduction strategies and will also be used as a pilot example for a broader ESTRO brachytherapy study.
- From our carbon footprint of our molecular imaging process, we found that the primary sources of emissions were patient travel, scanner power usage, and radiotracer consumption. One carbon reduction measure we identified was the overnight power-down of PET scanners, which could save around 7,280 kWh of electricity per year. Based on 2024 UK grid factors, this would reduce emissions by approximately 1.5 tCO_2e per annum.
- As part of a Green Scholar project, we looked at the head and neck cancer treatment pathway and found that enteral feeding equipment (a way of giving patients food and drink with a tube) was often over-prescribed.
- We are currently implementing a Gloves Off campaign to reduce the number of plastic gloves used across sites.
- A successful pilot was conducted at MVCC, trialling the use of reusable Type IIR surgical facemasks (the type that are fluid resistant and have a high bacteria filter). An external cleaning company laundered these masks to maintain compliance with the Type IIR classification. While the pilot demonstrated the environmental benefit of reusable PPE, it did incur significant laundry costs, resulting in low cost-effectiveness. Consequently, reusable PPE is not currently considered viable, unless it is able to be adopted on a larger scale beyond trust level.

Future Focus

Target Area	Our Commitment
Net Zero clinical transformation lead	We are committed to embedding Net Zero principles into everyday clinical practice through a clear and evidence based approach. To lead this work, we will appoint a dedicated senior lead who will oversee our Net Zero clinical transformation efforts and maintain engagement with trust board-level leadership and the governance framework.
Sharing and collaboration	To complete quality improvement project(s) in the clinical area(s) that focus on a measurable reduction in emissions, with co-benefits for outcomes and quality of care, efficiency and reducing healthcare inequalities. Sharing learning and outcomes, for example, through clinical networks, the Integrated Care Board (ICB) and NHS England.
Reducing emissions for in clinical care	Our focus will be on reducing emissions and improving quality of care within designated areas of clinical services. This will include an assessment for all clinical services to help us identify a priority area where changes could have the greatest impact.

What we will do next

- Identify a clinical lead with oversight of Net Zero clinical transformation.
- Applying the Sustainability in Quality Improvement (SusQI) framework when reconfiguring services and pathways to ensure a sustainable approach.
- Identify carbon hotspots in clinical services (proposed high carbon intensity or volume areas include urgent and emergency care/diagnostic tests and procedures/medical pathways with a focus on acute or long-term conditions such as renal disease, diabetes or cardiovascular disease).
- Achieve a 10% emissions reduction in a designated clinical carbon hotspot.
- Work towards Greener Emergency Department (ED) accreditation (bronze by 2026, silver by 2027).
- Achieve a 10% reduction in non-sterile glove use.

Digital Transformation

Digital technology plays a key role in helping the NHS become more efficient, resilient, and environmentally sustainable. By embracing smarter ways of working, we can reduce our environmental impact while improving patient care and streamlining services.

Our aim: To use digital systems to reduce carbon emissions and support more efficient service delivery.

What have we achieved?

- In 2023/2024, the new eConsent platform was rolled out amongst the trust, digitising the process for signing patient consent forms. This has reduced the need for approximately 60,000 pieces of paper per annum from consent forms alone.
- Launched in late 2023, the Patient Engagement Portal (PEP) continues to be rolled out across the trust's wards. Patients are given the option to replace postal appointment letters with digital link, allowing patients to view, confirm, or cancel appointments online. This system is helping to reduce 'Did Not Attend' (DNA) rates and supports a reduction in emissions from postal services and unnecessary hospital visits.
- The Electronic Document Management System (EDMS) project has started with the aim of digitising the trust's patient records. Currently, two off-site warehouses store paper records, with up to 25,000 files transported to and from the hospital each week. Transitioning to a digital records system will help reduce weekly transport between sites, and lower the associated carbon emissions from mileage.

Future Focus

Target Area	Our Commitment
Digital optimisation	We aim to maximise the benefits of digital transformation to reduce emissions and enhance patient care. This includes reducing paper use and offering virtual pathways where appropriate. A Digital Maturity Assessment will support this work by helping us identify and target areas for improvement in our digital readiness, capabilities, and infrastructure.
	Across all digital commissioning cycles and relevant polices, we will embed the principles and guidance of the Technology Code of Practice with a focus on procuring low-power, energy-efficient equipment. Additionally, we will implement a holistic circular device strategy, integrating refurbishment, leasing, education, and community reuse to maximise hardware lifespan, support digital inclusion, and minimise waste.
ICT carbon footprint	We will establish a carbon baseline for our ICT department to serve as a reference point for measuring progress in carbon reduction. This will align with the guidance provided in the UK Government's Sustainable Technology Advice & Reporting (STAR) framework.
Power down software	A 'power down' software will be trialled with a view to being rolled out across Lister Hospital. This software will automatically turn off unnecessary computer hardware when idle, leading to energy, carbon and cost savings.
Data storage	To reduce the energy intensity of our data storage, we will prioritise the hosting of data in energy-efficient low-carbon local or cloud-based data centres.

What we will do next

- Roll out eConsent and PEP to all departments to achieve annual reductions in DNA.
- Digitalisation of patient records to reduce annual mileage between off-site record storage and hospital sites.
- To reduce energy consumption and carbon emissions, we plan to replace 800 end-user devices over ten years old with more energy-efficient devices and pilot removal of dual screens that are not in use in one department.

Medicines

We are committed to reducing the environmental impact of the medicines and medical products we use. This includes looking at how we prescribe and store medicines, and finding lower carbon alternatives where possible. As part of this, we will focus on key areas like inhalers and anaesthetic gases, in line with NHS priorities.

Our aim: Reduce the carbon impact of medicines and medical products through better use, less waste, and choosing lower carbon options where appropriate.

What have we achieved?

- We have made great progress in reducing the environmental impact of medical gases. The use of desflurane (a type of general anaesthesia used in surgery) has been ceased across the trust in line with national guidance, with any exceptional use aligned to Neuro Anaesthesia and Critical Care Society recommendations (completed 2024). Similarly, nitrous oxide manifolds were turned off in 2024, and we are now only using portable cylinders to reduce waste and leakage risk.
- We are working with primary care to support reductions in the use of salbutamol, a type of inhaler used for symptoms of asthma and chronic obstructive pulmonary disease (COPD) such as coughing, wheezing and feeling breathless. These inhalers are usually blue and have high levels of propellents, which are potent greenhouse gases for the environment.
- Medicines were previously delivered to wards in single use plastic bags. We have since updated this system to deliver medicines in reusable bags.
- We are educating patients being treated for diabetes to use the PenCycle program by Novo Nordisk. This is a free recycling scheme which enables patients to return their empty insulin pens so the manufacturer can recycle them.

Future Focus

Target Area	Our Commitment
Inhaler emission reductions	We are also embedding sustainable respiratory care across secondary care. This includes, supporting patient-informed choices of lower carbon inhalers in line with clinical guidelines, conducting inhaler technique checks during reviews, and promoting correct inhaler disposal practices across care settings.
Nitrous oxide waste	In support of national objectives, we will continue to reduce nitrous oxide waste by implementing further actions from the updated Nitrous Oxide Waste Mitigation Toolkit. This work complements our wider efforts to reduce emissions from all medical gases.

What we will do next

- Provide education for clinical staff on cleaner prescribing. For example, the decision of what inhaler type to prescribe to patients or prescribing medication in tablet form rather than liquids.
- Track prescriptions of Metered Dose Inhalers (MDIs) and Short-Acting Bronchodilator medicines (SABAs) with the aim of reducing prescription of higher carbon footprint inhalers where appropriate.

Energy and Water (Estates and Facilities)

There are significant opportunities across the NHS estate to reduce emissions and lower costs, while improving energy resilience and patient care. We are committed to reducing the environmental impact of our buildings by improving how we use energy and water across our sites. This includes making our buildings more efficient, using less energy and water, and moving away from fossil fuels where possible.

Our aim: Reduce the carbon emissions of our energy and water use through various energy efficiency and reduction measures.

What have we achieved?

- Since the baseline year of 2019/20, the trust has made meaningful progress in reducing environmental impact across key estates and energy areas. Energy consumption has fallen by 565,000 kWh, of which saving 163 tCO_2e. Water consumption has also dropped 44% since the 2022/23 baseline, contributing to an estimated 20 tCO_2e reduction.
- The trust has secured the following funding to support:
  - £748k: Installation of solar PV panels on the Treatment Centre, maternity, and endoscopy buildings at Lister Hospital.
  - £1.1m: LED lighting upgrades, bringing our LED coverage at Lister to 90%.
  - £25k: Building management system (BMS) improvements, and heat meter installations at Lister Hospital.
  - £100k: Additional electrical and heat metering.
- An additional £2.1 million in NEEF funding has been awarded to deliver a 726 kWp solar carport array at the Lister site, further supporting the trust's long-term decarbonisation goals. The expected delivery for this project is FY25/26.
- A Heat Decarbonisation Plan (HDP) has also been completed in partnership with Veolia for both the Lister main site and the Treatment Centre, providing a strategic roadmap for future low-carbon heating

Future Focus

Target Area	Our Commitment
Heat decarbonisation plans	Work with estate teams and landlords on our other hospital sites to develop a strategy for heat decarbonisation at Hertford County Hospital, MVCC and New QEII Hospital. This strategy will cover all major buildings, including a prioritised roadmap to phase out all fossil-fuel primary heating systems by 2032 and eliminate oil-based heating systems by 2028. Develop business cases to deliver the measures outlined in the Lister/ Treatment Centre heat decarbonisation plan as well as accompanying energy efficiency and renewable energy interventions, with a view to submitting a funding application through the Public Sector Decarbonisation Scheme if projects cannot be financed through internal budgets.
Energy consumption and emissions	Create a site-specific strategy for reducing emissions in line with the UK Emissions Trading Scheme (UK ETS) regulatory targets for the CHP plant at Lister Hospital.
	We will install energy metering at all sites (where possible and in partnership with estates teams and our landlords) to establish a programme to install metering where feasible by 2028.
Net Zero building standards	Ensure all applicable new building and major refurbishment projects are compliant with the NHS Net Zero Building Standard.

What we will do next

- Achieve all reduction targets in UK ETS small emitter scheme.
- 100% LED coverage across Lister Hospital and at our other sites (where possible and in partnership with estates teams and our landlords).
- Further upgrade of the Business Management System (BMS) and heat meter installations at our Lister site.
- Completed solar panel rollout on the main multi storey hospital car park roof at Lister.
- Complete installation of solar carport at Lister.
- Undertake options appraisal of water leak detection systems.

Travel and Transport

Approximately 3.5% (9.5 billion miles) of all road travel in England relates to patients, visitors, staff and suppliers to the NHS, contributing around 14% of the system's total emissions. Providing and promoting sustainable transport options will reduce emissions and improve air quality in our local area. This includes staff commuting and business travel, logistics and patient travel.

Our aim: Minimise the environmental and health impacts associated with our supply chain and to encourage sustainable and active travel wherever possible.

We are committed to reducing travel-related emissions and promoting more sustainable travel choices across the trust.

What have we achieved?

- A target has been set for 20% of the trust's vehicle fleet to be electric or hybrid by 2025, and progress is already underway with five fully electric vehicles now embedded within the non-patient transport fleet. Our 'non patient' transport fleet is used to move and deliver medical records, pharmaceuticals, consumables and equipment between our sites.
- To support this transition, a fleet optimisation system (Stream) has been installed in vehicles to help identify more efficient routes and reduce overall emissions from business travel.
- The trust has made a significant investment in electric vehicle charging infrastructure, with seven new EV charging points now operational for staff and two additional points available for visitors in the main car park. Further support for staff is provided through the NHS Fleet workplace charging scheme.
- Flexible and remote working arrangements have been strengthened through the provision of VDI and VPN access for staff, with ongoing monitoring in place to assess uptake and the potential for reducing business mileage.

Future Focus

Target Area	Our Commitment
Travel and transport strategy	The trust will develop a Net Zero travel and transport strategy detailing their plans for a 100% Net Zero fleet and increase of active travel and use of public transport by 2026.
Electric and zero emission vehicles	We will ensure 100% of new leased or purchased trust vehicles are zero-emission from December 2027, in line with national guidance (ambulances excluded).

What we will do next

- Develop a Net Zero Travel and Transport Strategy by 2026.
- Carry out a review of bike shelters and storage areas across Lister Hospital and other sites where possible.
- 100% of new leased/purchased vehicles to be zero-emission (excluding ambulances).
- Pending external funding being awarded, planned roll out of additional EV charging points for both staff and patients at the Lister site. Our funding application to NHS England for £100,000 is currently awaiting confirmation on whether it has been successful.
- Raise further awareness and encourage uptake of salary sacrifice schemes to purchase electric vehicles and/or cycles.

Food and Nutrition

The food we buy, prepare, and serve has a direct impact on both human health and the environment. As part of our commitment to delivering sustainable healthcare, we are taking steps to reduce the carbon footprint of food across the trust while supporting healthier diets for patients, staff, and visitors.

Our aim: To provide nutritious, sustainable, and responsibly sourced food that supports health and well-being, reduces carbon emissions, and minimises waste.

What have we achieved?

Our collaboration with the procurement team has been key in reducing carbon emissions and improving the sustainability of our food supply chains.

- We continue to align with the Government Buying Standards for Food and Catering Services, ensuring that all catering providers meet minimum mandatory standards and comply with UK food production legislation.
- Introduced crockery and china on wards, which has reduced single-use items and supported both sustainability and a better patient experience.
- We are actively working towards bronze accreditation with the Soil Association, intending to achieve Food for Life awards for our staff catering services.
- We are in the process of switching to a single main supplier for food procurement to help improve supply chain transparency and reduce emissions.

Future Focus

The trust is committed to delivering healthier, more sustainable food options for patients, staff, and visitors, while reducing the environmental impact of catering services.

Target Area	Our Commitment
Soil Association certification	We will work towards accreditation for the Soil Association's Food for Life Bronze Award by September 2025. This ensures the food we serve is fresh, locally sourced where possible, environmentally sustainable, and supportive of healthy eating. Soil Association certification also promotes the use of seasonal menus that prioritise fruit, vegetables, pulses, and whole grains, and reduce reliance on ultra-processed and high-emission ingredients.
Reducing food waste	Reduce food and drink waste generated within Lister Hospital. Reducing the amount of food that we waste decreases the environmental footprint as well as leading to cost savings for the trust. The trust will measure food waste in key areas from production, plate, unserved meals, and spoilage.
Low carbon menu	We will introduce one clearly labelled low-carbon meal per day across patient and staff menus by June 2026, that uses seasonal produce and requires minimal processing, and is in line with the NHS England Low Carbon Menu Bank.

What we will do next

- Continue to work towards becoming Soil Association accredited (aim for Q3 2026).
- Measure food waste in key areas from production, plate, unserved meals and spoilage.
- Roll out electronic meal ordering to all ward areas in Lister Hospital.
- Offer one low carbon meal daily on all menus in Lister Hospital.

Waste

Our trust is committed to reducing the environmental impact of waste by decreasing the amount of waste produced, improving how we sort and dispose of it, and supporting a more circular approach to materials across the trust.

Our aim: Reduce waste by raising awareness and supporting more sustainable choices across all areas of the trust.

What have we achieved?

The trust has taken several key steps to improve waste management and sustainability:

- Food waste is now sent to a biodigestion tank (a sealed container that uses microorganisms to break down organic waste) diverting it from landfill or incineration.
- Reusable containers are now in place for sharps disposal, significantly reducing the amount of single-use plastic incinerated. In the first year of this project, we reduced carbon emissions from clinical waste by 23.5% and by a further 9.6% in year two.
- As of June 2023, the trust achieved zero waste to landfill.
- Following on from the stand-down of Covid measures, the re-introduction of the offensive (non-infectious) healthcare waste stream and associated staff engagement has improved clinical waste segregation ensuring that clinical and healthcare waste is not over-treated, thereby reducing the CO_2 emissions from clinical and healthcare waste disposal. The NHS England 20/20/60 target (by 2026) for clinical waste segregation was achieved in May 2024.
- A national target to reduce carbon emissions from waste disposal by 50% by 2026 was set. The chart below shows the trust is well on its way to achieving this target.

Trajectory to reduce carbon emissions from waste by 50% by 2026

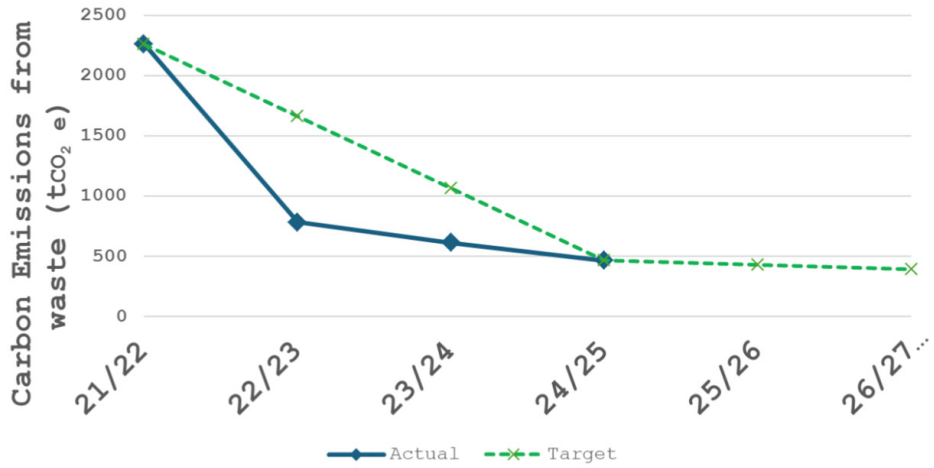


Figure 10: Carbon Emissions from waste

Future Focus

Target Area	Our Commitment
Waste reduction	We are committed to supporting our colleagues throughout the trust to minimise waste disposal from all trust sites and ensuring where waste is produced, its disposal is managed responsibly, following the waste hierarchy. We will continue to measure all waste streams to ensure accuracy of data and set clear targets to achieve year on year reductions in line with NHS England targets.

What we will do next

- Maintain clinical waste segregation target of 60/20/20.
- Expand current Linen Recycling Scheme. Hospital linen includes items such as blankets, sheets, and scrubs.
- Explore Linen Wastage schemes including colouring coding scrubs and tagging blankets.
- Continue to closely monitor food waste reporting (key action with ERIC return) and support initiatives to reduce food waste.

Biodiversity

Biodiversity is of great value not only in terms of its environmental benefits, but also socially, improving our health, patient recovery rates and patient experience. Improving and maintaining green infrastructure across our estate is key to creating a sustainable environment.

Our aim: Enhance the quality of our green spaces and reduce biodiversity loss by protecting and enhancing natural assets.

What have we achieved?

- Funding has been secured through the National Lottery for a two year Nature Recovery Ranger post (0.8 WTE), based at MVCC. The new ranger started in June 2025 and will be focused on projects to develop and further enhance green spaces primarily at the cancer centre as well as offering support and guidance for similar projects at our other sites.
- The Lister has formally become a smoke-free hospital site, and the removal of the former smoking shelter has created an opportunity to develop a new, accessible landscaped garden. Works are scheduled to begin in July 2025, providing a healthier and more inviting environment.

Future focus

Target Area	Our Commitment
Biodiversity	Ensure Biodiversity Net Gain on any developments from 2024. Play an active role in Local Authority biodiversity initiatives, providing valuable input to relevant nature recovery strategies and programmes, distributing opportunities throughout our healthcare networks. Actively encourage healthcare providers to develop and enhance incidental green spaces and implement small biodiversity measures such as tree planting, pocket parks, bat/bird boxes and pollinator programmes, identifying relevant funding pots wherever possible. Advocate for and actively participate in the Centre for Sustainable Healthcare's NHS Forest project. This alliance aims to transform the green spaces of healthcare sites to maximise their contribution to health, wellbeing, and biodiversity, as well as to foster engagement with nature.

What we will do next

- Redevelop/landscape green space next to the trust management office at Lister Hospital. This is one of the main walk-through areas on site and a large green space will be seen and enjoyed by many staff, patients and visitors.
- Redevelop/landscape green space at the Front Door Civic entrance at Lister Hospital to increase biodiversity.
- Ensure new capital builds prioritise and maximise rewilding and biodiversity wherever possible and take thoughtful person-centric design principles into account.

Supply Chain and Procurement

The NHS supply chain accounts for approximately 62% of total carbon emissions and is a clear priority area for the trust. We are committed to working with our suppliers and contractors to reduce our environmental impact of the goods and services we use.

Our aim: Support decarbonisation of the supply chain through responsible and sustainable procurement practices.

What have we achieved?

- We have aligned our procurement processes with the NHS England Road Supplier Map, helping us embed sustainability more consistently across our supply chains.
- Our aim is to make more informed, sustainable purchasing decisions. We've made progress by using tools like the Evergreen Assessment and Maturity Dashboard to evaluate and track the sustainability performance of our procurement activities and suppliers. This helps us assess the maturity of suppliers across key environmental and social criteria, identify areas for development, and prioritise actions that support continuous improvement and alignment with our green procurement goals.
- Procurement has played an active role in supporting wider Green Plan priorities, including:
  - Working with Net Zero clinical transformation workstream on the reusable milk bottles initiative in the maternity department at Lister and the Gloves Off campaign.
  - Supporting the Food and Nutrition workstream in sourcing suppliers that meet Soil Association accreditation standards.

Future Focus

Update with trust specific focuses and targets based on the following:

Target Area	Our Commitment
Supplier engagement	Our suppliers will be encouraged to go beyond minimum requirements and engage with the Evergreen Sustainable Supplier Assessment to support a single conversation between the NHS and our suppliers on sustainability priorities.
Net Zero roadmap	We will ensure the NHS Net Zero supplier roadmap requirements are embedded into all relevant procurements. Implementation will be monitored via Key Performance Indicators (KPIs). This approach supports our commitment to reducing emissions across our supply chain and driving sustainable procurement practices.
Reducing single-use products	We aim to reduce reliance on single-use products by integrating safe and sustainable alternatives into clinical improvement projects (see Net Zero clinical transformation and Annex B of the Green Plan Guidance: selected resources for additional support tools) such as reusable tourniquets (a medical device used to restrict blood flow), Gloves Off initiative, electrophysiology (EP) catheters (a type of tube used to assess and treat heart rhythms) and any others.
Training and education	All finance and procurement teams will participate in training in the application and development of meaningful social value criteria, as per PPN 06/20 and PPN 02/25.
Sustainable supply chain lead	To align our procurement governance with the NHS Net Zero Supplier Roadmap and incorporate sustainability into the core of our delivery approach, we will appoint a lead for sustainable supply chain and procurement.

What we will do next

Prioritise suppliers that demonstrate environmental stewardship, verified sustainability reports, or use of renewable materials.

- Assess products and services across their full lifecycle, prioritising those that support circular economy principles- such as reuse, repairability, recyclability, and use of recycled materials. We favour suppliers offering closed-loop solutions, take-back schemes, and products designed to minimise waste and resource use.
- Implement environmental criteria into vendor selection and maintain regular sustainability audits to ensure compliance with green standards.

Adaptation

As the impacts of climate change become more frequent and severe, it is essential that the trust takes steps to protect its patients, staff, services, and buildings from associated risks. This includes being prepared for extreme weather events such as heatwaves, flooding, and storms, which can affect service delivery, infrastructure, and the health of vulnerable people.

Our aim: To prepare for and reduce the risks that climate change and extreme weather events pose to our patients, staff, services, and infrastructure.

What have we achieved?

All climate related risks (and strategy) continue to be identified and added to the trust's risk register and included in the trust Critical Infrastructure risk register as required. These risks are reviewed on a monthly basis via the trust Risk Management Group and reported up to the trust Quality and Safety Committee.

Future Focus

Target Area	Our Commitment
Resilience standards	We will ensure all our providers and commissioners of NHS-funded services continue to comply with the adaptation provisions within the NHS Core Standards for Emergency Preparedness, Resilience and Response (EPRR) and the NHS Standard Contract to support business continuity during adverse weather events. Additionally, we will implement the Climate Adaptation Framework to strengthen climate resilience across our sites.
Infrastructure resilience	The impact of climate change will be factored in when making infrastructure decisions and designing new facilities, incorporating features such as green spaces, improved drainage, and passive cooling to enhance resilience.
Business continuity planning	Clear actions will be formalised and distributed across the organisation to prepare for severe weather events and improve climate resilience of local sites and services, including digital services (see Annex B of the Green Plan Guidance: selected resources for a supporting Climate Change Risk Assessment Tool).
Emergency communication channels	We will ensure the adequate cascading of weather health alerts and relevant messaging across the organisation, in line with the government's Adverse Weather and Health Plan.
Training and education	Our staff will participate in Adaptation training programs addressing extreme weather events, such as heatwaves and flooding, to raise awareness about climate resilience across the workforce.

What we will do next

- Work with our ICS colleagues to undertake the Climate Change Risk Assessment as the first step of our Climate Change Adaptation Plan.
- Identify members of the trust to be involved in the Climate Change Adaptation Group: Estates – Building infrastructure, Emergency Planning, Fire Remediation.

Governance

Governance Structure

Governance is key to the effective implementation of the actions and commitments made in this Green Plan. Everyone within the trust has a responsibility to ensure the objectives defined in this Green Plan are met.

The trust's sustainability governance structure has changed to better reflect the work required for delivering our Green Plan. The previous eight workstreams have been consolidated and structured into three workstreams: Estates, Clinical, and ICS, however the third external workstream remains subject to change. Each workstream is responsible for the relevant focus areas within their domain, as detailed below.

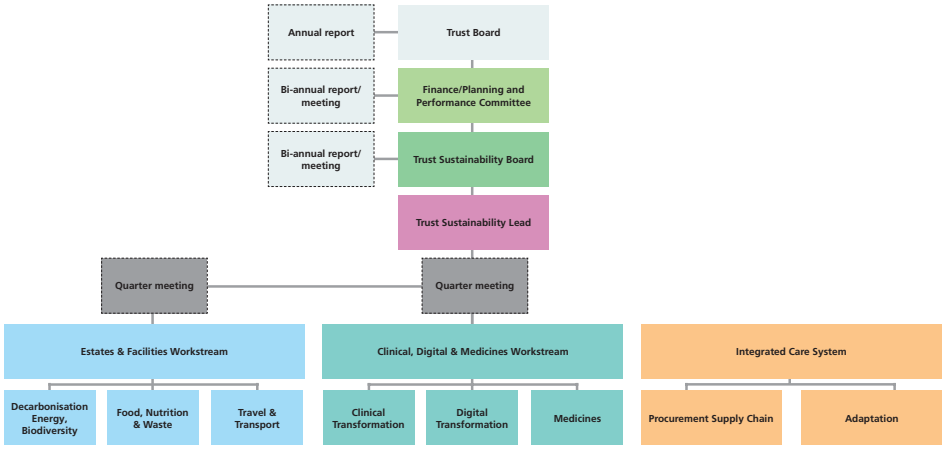


Figure 11: East and North Hertfordshire Teaching NHS Trust Governance Structure

These workstreams will develop action plans with KPI's and will meet quarterly to monitor progress and support delivery of the trust's sustainability goals. Representatives from all three workstreams come together on a quarterly basis to align efforts, review performance, and escalate issues or opportunities to the bi-annual Sustainability Board.

The workstreams will report on progress against the action plans and escalate issues or risk items as appropriate to the trust Finance/Planning and Performance Committee (FPPC) and through this forum to the trust Board. The FPPC Committee will have oversight of the implementation of the Green Plan. It will ensure that a detailed Sustainable Development update is included in the trust Annual Report.

The trust board will consider and approve the Green Plan and associated monitoring and reviewing of performance against targets and approve any changes to the plan over the course of its duration.

Risk and Mitigation

In order to successfully deliver our Green Plan, we will need to proactively identify, manage and mitigate any risk. Any risks identified will be logged, mitigated and reported to Sustainability Board and up to Finance, Planning and Performance Committee.

The following risk has now been entered onto the trust Enhance reporting system – *Risk ID #3628 'Risk that current financial climate may compromise the trust ability to be proactive on sustainability agenda'*. The risk score is still pending approval, and whether the risk should be entered onto the trust Corporate Risk Register.

Our Green Plan is supported by performance indicators and tracking these is the responsibility of the Sustainability Board on a bi-annual basis.

Tracking Progress and Reporting

As part of aligning with the Task Force on Climate-related Financial Disclosures (TCFD) framework, the trust is strengthening its approach across the Governance, Risk Management, and Metrics and Targets pillars. While full carbon footprinting remains at a national level, we will continue to track key metrics and targets related to emissions reduction and sustainability performance. To support this, we will develop action plans within each workstream and agree KPI's to help guide delivery of our Green Plan. Progress against the action plans will be shared at the Sustainability Board.

We will also be undertaking a review of our baseline carbon emissions as well as aligning our data collection with the existing ERIC reporting, Sustainability Reporting Portal (SRP) and the new Greener NHS reporting requirements. These will together inform the sustainability section of the trust's Annual Report and calculate the trust's carbon emissions (Scope 1, 2 and 3). The following table summarises our reporting plan.

Annual	Bi-Annually	Quarterly
• Sustainability section in Annual Report. • Board-level progress report on annual Green Plan. • ERIC. • Greener NHS Sustainability Reporting Portal –format to be agreed with the regional greener NHS team. • TCFD. • Annual Fleet Return.	• Progress reports to Sustainability Board. • Progress reports up to Finance, Planning and Performance Committee.	• Data collection – including utilities, waste data and other data required for KPIs. • Workstream updates, performance tracker and action plan. • Greener NHS Data Collections.

Table : Trust reporting frequency

The goals and objectives listed in this Green Plan are for the duration of the strategy, with some specific measures having a set target date. The reporting and measuring of targets are ongoing. This Green Plan will be refreshed after three years and reviewed in detail at least once in the interim.

Thank you and acknowledgments

Catherine Cadzow (Carbon Architecture)
Stella Cockerill (Regional Net Zero Programme Lead, NHS England)

East and North Hertfordshire Teaching NHS Trust
Debbie Cockcroft (Waste Manager)
Justin Daniels (Medical Director)
Emily Human (Clinical Sustainable Procurement Lead)
Gerry Lowe (Clinical Scientist, Radiotherapy, MVCC)
Karen McConnell (Non-Executive Director and Vice Chair, Trust Board)
Preeti Mehta (Head of Portfolio Management, Digital Delivery)
Sarah Peterson (Communications Team)
Nikki Ross (Head of Facilities)
Bridget Sanders (Medical Programme Director)
Phil Smith (Associate Director of Research)
Tasia Somers (Advanced Pharmacist)
Sam Woods (Energy & Sustainability Manager)
Design: Clinical Photography and Illustration

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Board

East and North Hertfordshire Teaching NHS Trust

Meeting	Public Trust Board		**Agenda Item**	11	
Report title	Summary Learning from Deaths Report		**Meeting Date**	9 July 2025	
Author	Mortality Improvement Lead				
Responsible Director	Medical Director				
Purpose	**Assurance**	☒	**Approval/Decision**	☐	
	Discussion	☐	**For information only**	☐	
Proposed assurance level (*only needed for assurance papers*)	**Substantial assurance**	☐	**Reasonable assurance**	☒	
	Partial assurance	☐	**Minimal assurance**	☐	

Executive assurance rationale:

East and North Hertfordshire Teaching NHS Trust seeks to learn from every death that occurs.
This paper provides assurance to the Board that:

- Our rates of death remain lower than would be expected
- That we learn from scenarios when care does not meet the standard that we and our patients and carers set
- That we interrogate data to ensure we understand its meaning
- That we innovate to reduce mortality.

Summary of key issues:

Mortality improvement work is a continual on-going process within the Trust. This quarterly report provides a summary of the detailed Learning from Deaths report provided to the Board, which outlines key results of this work, including the regular monitoring of mortality rates, together with outputs from our Q4 learning from deaths work. It also incorporates information and data mandated under the National Learning from Deaths Programme.

Prior to submission to the board, both reports were approved by the Mortality Surveillance Committee and the Quality and Safety Committee, which agreed that they appropriately highlight current topics and activity of particular relevance in providing assurance to the Executive regarding this workstream.

Points of note this quarter include:

- Mortality rates remain stable and well positioned against national and Model Hospital Peer, with HSMR and SHMI in the 'as expected'/mid-range bands. For several months there has been an in-month spike in HSMR, which on the subsequent refresh has reduced. Discussion with our statistical suppliers suggests this is due to an initial incomplete data submission and then corrects itself once our HES data refreshes. It will continue to be closely monitored.
- No 3SD HSMR alerts; 1 SHMI 3SD alert – with work in progress to understand this and clear evidence this is not related to thromboprophylaxis prescribing rates.
- Following previous increases to the volume of readmissions, recent months have shown decreases both to the volume and rate of readmissions.
- Sustained increases in community deaths requiring scrutiny have continued to place stress on the Medical Examiner service, with concerns that the new funding regime

coupled with the Trust's current financial constraints may represent a significant challenge to the service.

- Learning from SJRs continues to be promoted by asking all clinical governance leads to ensure they are discussed at specialty Mortality and Morbidity meetings.
- To date there have been two Q4 deaths where the preliminary SJR review has judged the deaths to be more likely than not due to a problem in healthcare. Both these cases are currently being further reviewed by the patient safety team, where the question of preventability will be more rigorously interrogated.
- To date four Q4 deaths receiving an SJR have been assessed as evidencing poor care – these have also been escalated as patient safety incidents ensuring further review at specialty/division level.
- NELA (National Emergency Laparotomy Audit) case ascertainment remains a challenge. This is exacerbated by funding constraints affecting capacity for a NELA data coordinator. Pressures on emergency theatre capacity also represent another challenge for the service where a lack of funding/resources mean there are no current expansion plans. Finally, the lack of Level 1+ beds continue to have a negative impact on the management of acute abdomen.
- Cardiology basket alerts: while the elements originally alerting have settled, other elements have subsequently alerted. Collaborative work between Coding and Cardiology remains ongoing to understand the dynamics underpinning these alerts.
- The mortality team is starting to consider how we could incorporate health inequality data into future versions of this report.

Impact: *tick box if there is any significant impact (positive or negative):*

Patient care quality	☒	**Equity for patients**	☒	**Equity for staff**	☐	**Finance/ Resourc -ing**	☐	**System/ Partners**	☐	**Legal/ Regul-atory**	☒	**Green/ Sustai-nability**	☐

Ongoing focus on the areas detailed in this report are vital for the following reasons:

Equality:

- To constantly target health inequalities and involve patients in their care.
- To identify and reduce unwarranted variation through the creation of an environment of learning, autonomy, and accountability.

Patients' benefit/detriment:

- To continuously strive to improve services for the living by identifying good practice and suboptimal care in our reviews of those who have died in our care, both sharing this learning and using themes and trends identified to shape forward planning and quality improvement strategies.
- To promote seamless care for patients by identifying opportunities for more effective collaboration and co-ordination of services within the Trust and with our partners.

Legal/Regulatory:
To ensure compliance with the requirements stipulated in the National Guidance on Learning from Deaths (NQB 2017).

Trust strategic objectives: *tick which, if any, strategic objective(s) the report relates to:*

Quality Standards	☒	**Thriving People**	☒	**Seamless services**	☒	**Continuous Improvement**	☒

Identified Risk: *Please specify any links to the BAF or Risk Register*

Please refer to page 4 of the report.

Report previously considered at & date(s):

Mortality Surveillance Committee: 11 June 2025: Full report & Summary discussed/approved.
Quality and Safety Committee: 25 June 2025: Full report presented with no significant comments or challenges made.

Recommendation	The Board is invited to note the contents of this report.

To be trusted to provide consistently outstanding care and exemplary service

1. Executive Summary

1.1 Summary
Reducing mortality remains one of the Trust's key objectives. This quarterly report summarises the results of mortality improvement work, including the regular monitoring of mortality rates, together with outputs from our learning from deaths work that are continual on-going processes throughout the Trust.

It also incorporates information and data mandated under the National Learning from Deaths Programme.

1.2 Impact
1.2.1 Strategic ambitions
The Trust has developed a framework of strategic objectives to support and drive continuous improvement. These are listed on the front cover of this report. Additionally, a set of mortality focussed objectives have been developed to echo and support the overarching Trust's strategic ambitions. A new iteration of the strategy is currently being developed to provide focus through 2025-27.

1.2.2 Compliance with Learning from Deaths NQB Guidance
The national Learning from Deaths guidance states that trusts must collect and publish certain key data and information regarding deaths in their care via a quarterly public board paper. This paper provides this information for Q4 2024-25. An in-depth Learning from Deaths Report covering the same period was provided to both the Quality & Safety Committee, and Mortality Surveillance Committee in June 2025.

1.2.3 Potential impact in all five CQC domains
At the heart of our learning from deaths work are the questions posed by the CQC's five domains of care, whether through the conduct of structured judgement reviews and clinical thematic reviews, through the monitoring and analysis of mortality metrics and alerts or invited service review. Whatever the approach taken, in all domains of care we seek to identify and reduce unwarranted variation in the care we provide and the associated outcomes for our patients.

Figure 1: Learning from deaths and CQC domains of care

1.3 Risks

The following represent areas identified where there is currently an element of concern. Only the first of these (ref 3398) constitutes a formal risk on the Trust's risk register.

Table 1: Current risks

Risks	Red/amber rating
SJRPlus review tool Following transfer of the SJRPlus review tool from NHSE to Aqua, it took some time to gain the data protection assurances required by our Executive. An element of risk has remained, as to date, Aqua has not conducted a pen Test, on the basis that the App has moved from one part of the Azure platform to another. Our Chief Information Officer approved our use of the tool, on the basis that we logged this as a tolerated risk on the Risk Register. Aqua has confirmed that pen testing has now been scheduled for July 2025.	Ref: 3398
Medical Examiner Service: Funding/capacity Changes to the way the service is funded from 2025-26, combined with the current financial austerity measures introduced at the Trust, have the potential to jeopardise the efficiency and effectiveness of the service. This would be to the detriment of bereaved families; the wellbeing of staff working within the service; our performance against mandated standards; and the Trust's reputation, especially with the Coroner Service. Additionally, it would put pressure on the mortuary.	
Cardiology: recurrent SHMI alerts to various elements of the cardiology basket of diagnosis groups Following recurrent mortality alerts across the cardiology diagnosis basket, and a report by the Cardiology Clinical Director, a joint initiative between Cardiology and Coding was agreed. This has remained ongoing. Initially the groups alerting were myocardial infarction, congestive heart failure and coronary atherosclerosis and other heart disease. Following significant work, none of these are currently 3 standard deviation outliers, although coronary atherosclerosis has intermittently still alerted. However, as these alerts have settled others have arisen, such as cardiac dysrhythmias, heart valve disorders and pulmonary heart disease. Preliminary coding and clinical reviews have shown similar challenges regarding accurate allocation of deaths across the various diagnosis groups. Further work will continue between coding and cardiology with regular updates to Mortality Surveillance Committee (the next is scheduled for July 2025). To date no concerns have been raised regarding quality of care.	
Ovarian Cancer SACT 30 Day Mortality: External review findings In the 2017-20 national Systemic Anti-Cancer Therapy (SACT) audit, the Trust was identified as an outlier for 30 Day Mortality. Following discussion at Mortality Surveillance an external peer review was commissioned. This identified a lack of integrated care at MVCC. Following completion of the review of patient care, a formal SI report has been completed. A small number of associated actions remain outstanding. This risk will be maintained until these are confirmed as complete. This is anticipated to be the end of 2025.	

	Low risk		Medium risk		High risk

2. Context

Rich learning from deaths requires the triangulation of information from multiple sources, including mortality metrics, medical examiner scrutiny, structured judgement reviews, patient safety incident investigation outcomes, together with detail from other Trust quality and governance processes. This quarterly report provides a summary of key relevant activity, which has been reported in full to the Quality and Safety Committee.

2.1 Headline mortality metrics

Table 2 below provides headline information on the Trust's current mortality performance.

Table 2: Key mortality metrics

Metric	Headline detail
Crude mortality	Crude mortality is 0.88% for the 12-month period to Mar 2025 compared to 1.00% for the latest 3 years.
HSMR: (data period Mar25 –Feb25)	HSMR for the 12-month period is **84.22, *'Mid-range'*.**
SHMI: (data period Dec23 – Nov24)	SHMI for the 12-month period is **90.15, 'as expected' band 2.**
HSMR – Peer comparison	ENHT ranked 2nd (of 10) within the Model Hospital list* of peers.

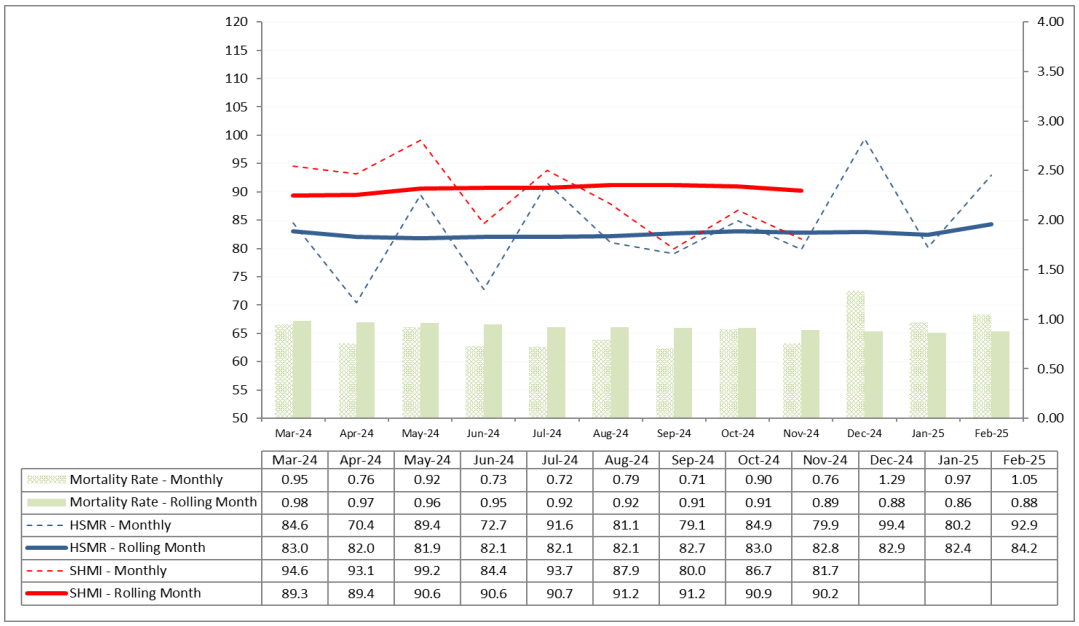
* We are comparing our performance against the recommended peer group indicated for ENHT in the Model Hospital (updated in November 2022). Further detail is provided in 2.1.3.

Figure 2 below shows the Trust's latest in-month and rolling 12-month trend for the three key mortality metrics: Crude mortality, HSMR and SHMI, as reported by CHKS. Following a prolonged downward trend since March 2023, rolling 12-month HSMR plateaued, then showed slight increases over the last 2 months.

We are aware that the most recent in-month HSMR may be adversely affected as the HES data used is not always complete for the latest month. Apparent increases in the most recent in-month HSMR are being monitored.

Rolling 12-month SHMI reported by CHKS stands at **90.15** to Nov 2024.This represents a decrease from the last reported **92.05** for the12 months to Aug 2024.

Figure 2: Trust key mortality metrics: Latest position



	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
Mortality Rate - Monthly	0.95	0.76	0.92	0.73	0.72	0.79	0.71	0.90	0.76	1.29	0.97	1.05
Mortality Rate - Rolling Month	0.98	0.97	0.96	0.95	0.92	0.92	0.91	0.91	0.89	0.88	0.86	0.88
HSMR - Monthly	84.6	70.4	89.4	72.7	91.6	81.1	79.1	84.9	79.9	99.4	80.2	92.9
HSMR - Rolling Month	83.0	82.0	81.9	82.1	82.1	82.1	82.7	83.0	82.8	82.9	82.4	84.2
SHMI - Monthly	94.6	93.1	99.2	84.4	93.7	87.9	80.0	86.7	81.7			
SHMI - Rolling Month	89.3	89.4	90.6	90.6	90.7	91.2	91.2	90.9	90.2			

2.2 Mortality alerts

2.3.1 CQC CUSUM alerts
There have been no CQC alerts in Q4.

2.2.2 HSMR CUSUM alerts
There are no HSMR CUSUM red alerts which constituted a rolling 12-month 3 standard deviation outlier, for the year to February 2025.

2.2.3 SHMI CUSUM alerts
CHKS report indicated one SHMI CUSUM red alert for the period to November 2024 which constituted a rolling 12-month 3 standard deviation outlier, as detailed in the table below.

Table 3: SHMI Outlier Alerts December 2023 to November 2024

	SHMI	Observed Deaths	Expected Deaths	"Excess" Deaths✦	Included Spells
60 - 103: Pulmonary heart disease	108.23	323	298	24.6	2072

✦ Excess deaths are defined as the number of deaths above what would be expected in a given period based on historical data. Excess deaths are derived from a statistical model. They do not represent actual deaths. They are, however, an important indicator for further review, particularly where the number of excess deaths is significant. In such situations it is important that the actual deaths underpinning a mortality rate alert are reviewed to ensure there are no clinical or operational factors negatively impacting on patient outcomes.

Pulmonary heart disease is a new alert discussed at May Mortality Surveillance Committee, where it was agreed that a preliminary coding review should be undertaken. This revealed that a small number of cases had been incorrectly coded (4/36). 9/36 cases related to a diagnosis of secondary pulmonary hypertension. A review of these will be included in the Cardiology update due at July Mortality Surveillance. The remaining 27/36 cases related to a diagnosis of pulmonary embolism, with 8/27 involving a hospital acquired thrombosis. To date 7 of these have been reviewed as part of the Trust's HAT oversight programme, with an assessment that the HAT was not potentially preventable. One is awaiting a stage 2 review. Once all the clinical review outcomes are known an assessment will be made as to whether any further review/action is required.

2.2.4 Other external alerts
There are no current active external alerts.

2.2.5 Key Learning from Deaths Data

2.2.5.1 Mandated mortality information

The Learning from Deaths framework states that trusts must collect and publish certain key data and information regarding deaths in their care via a quarterly public board paper. This mandated information is provided below for Q4 2024-25.

Table 4: Q4 2024-25: Learning from deaths data

	Jan-25	Feb-25	Mar-25
Total in-hospital deaths (ED & inpatient)	131	121	121
SJRs completed on in-month deaths (at 15.04.25)	37	28	7
Patient safety incident escalation from SJR (by month of death) (at 15.04.25)	11	11	1
SJR outcome: Deaths more likely than not due to problem in care (≥50%) (at 15.04.25)	1	1	0
Learning disability deaths	0	2	0
Mental illness deaths	1	2	2
Stillbirths	0	0	1

Child deaths (including neonates/CED**)	1	2	0
Maternity deaths	0	0	0
PSIIs reported regarding deceased patient	1	0	1
PSIIs approved regarding deceased patient	0	0	2
Complaints received in month regarding deceased patient	9	3	2
Requests received in month for a Report to the Coroner	7	12	9
Regulation 28 (Prevention of Future Deaths)	0	0	0

* *Medical termination of pregnancies where the baby is born with signs of life are not included in these figures

2.2.5.2 Learning from deaths dashboard

The National Quality Board provided a suggested dashboard for the reporting of core mandated information. This dashboard is provided at Appendix 1.

3.0 Scrutiny to SJR

3.1 Medical Examiner Scrutiny

Table 5: Medical Examiner scrutiny data: Q4 2024-25

Scrutiny detail	Jan	Feb	Mar	Q4 Total
Total in-hospital deaths (excluding MVCC)*	132	132	123	387
ENHT deaths scrutinised by ME	132	132	123	387
MCCDs not completed within 3 calendar days of death	15	20	10	45
ME referrals to Coroner	20	27	20	67
Deaths where significant concern re quality of care raised by bereaved families/carers	1	0	1	2
Patient safety incidents notified by ME office as a result of scrutiny	0	1	0	1
ME referrals for SJR	36	42	35	113
Community deaths reviewed	253	191	217	661
Deaths referred by the Coroner to ME office to review	71	60	64	195
Total deaths reviewed				1243

**MVCC deaths are excluded as these deaths are not scrutinised by our Trust, they are instead scrutinised by Hillingdon.*

The Medical Examiner office continues to be extremely busy, with large numbers of hospital and in particular community deaths to be reviewed.

Funding for the service has changed for 2025-2026. Trusts are now permitted to determine how the service is funded within their budgets, rather than the funding being ring-fenced. There is real concern within the service that given current financial constraints, this change will make the approval of the additional resource considered necessary to cope with the increased volume of scrutiny required, unlikely.

This brings into question the sustainability of service, especially looking ahead to winter pressures, where the increased work demands on staff are likely to have a negative impact on their wellbeing. The concern is that current capacity is too lean to ensure the service remains robust.

Given both the regulatory and emotional pressure to ensure timely cause of death certification, allowing families to move forward with funeral plans, the likely impact will be that the quality of both our processes and our Medical Examiner scrutiny may be compromised. With regard to hospital deaths, such a situation would also place additional pressure on mortuary capacity.

3.2 Structured Judgement Reviews

3.2.1 SJR process and methodology

Adoption of the FutureNHS/Better Tomorrow SJR Plus mortality review format and e-review tool successfully went ahead from July 2022, with supporting standard operating procedure, Qlik Sense mortality report and Mortality Support intranet page.

As previously reported, from the end of April 2024, the SJRPlus review tool transferred from NHSE to Aqua (Advancing Quality Alliance), an NHS health and care quality improvement organisation working across the NHS, care providers and local authorities.

3.2.2 SJR and deaths YTD headline data

Table 6: Headline Year to date SJR and deaths data

Data count	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Total in-patient deaths	89	112	85	92	98	87	122	96	150	121	117	111	1280
Total ED deaths	11	7	11	3	16	11	9	7	8	10	12	10	115
SJRs completed on in-month deaths (at 15.04.2025)	16	10	7	15	36	41	41	36	29	37	28	7	296

The above table shows that by mid-April, 21% of 2024-25 hospital deaths have received a formal structured judgement review. This is an improvement on the Q3 figure of 18%.

Since these figures were taken, by the end of April, (our cut-off date for review of 2024-25 deaths for performance purposes) the percentage of deaths reviews has reached 26%. This means that by year-end, we have not only met the 15-20% review target suggested by the Better Tomorrow team (now part of Aqua) as being needed to provide robust learning/assurance, but also our internal target of 25%.

3.2.3 Learning beyond SJR

3.2.3.1 SJR patient safety incident escalations

Table 7: Year to end of Q4 Patient Safety Incidents reported following SJR

Escalations for deaths in month (at 15.04.25)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Patient Safety Incident Escalations from SJRs	4	5	2	3	6	7	16	13	10	11	11	1	89

For deaths in the current year which have been subject to an SJR, 89 cases have been escalated as a patient safety incident. When we adopted the SJR format and revisited our internal quality and governance processes, it was agreed with our patient safety team, that there are three triggers in the SJR which should result in the case being logged and investigated as a patient safety incident: (i) Where overall care is considered poor/very poor, (ii) Where a problem in care led to harm/probably led to harm, (iii) where the reviewer considered there was any evidence that the death may have been preventable. This approach ensures further scrutiny of these cases at specialty/divisional level.

These criteria for further review are broader than those historically used to identify areas of concern which means more cases may be identified for further scrutiny, but some will involve a lower level of concern, but still provide valuable opportunities to learn.

Learning from concluded patient safety incident investigations relating to deaths will be collated and added to themes and trends identified in SJRs to inform future quality and improvement work. This quarterly report will detail outcomes of incidents escalated from SJRs where the reviewer judged the death to be more than 50:50 likely preventable and/or the quality of care to have been very poor. Additionally, incidents relating to deaths which are subject to PSII under PSIRF will be included, which will often not have received an SJR. The report will cover cases concluded in the current quarter, irrespective of the date of death of the patient.

In Q4 one case matching these criteria was concluded and discussed at Mortality Surveillance.

Table 8: Q4 2024-25: Concluded Escalated Cases Summary

SJR/ SI/PSII	Death Preventability (Final MSC decision)	Incident category	Learning themes
SJR	Possibly preventable, less than 50-50	Decision Making	• Treatment/Management Plan • Clinical Monitoring/ observations/planning • Management Complex Patients

As the Patient Safety Incident Response Framework (PSIRF) becomes fully embedded in the Trust, it is vital that internal pathways for review and investigation continue to be revisited and clarified to ensure a seamless fit that ensures effective processes that combine to maximise learning potential.

3.24. Learning and themes from concluded mortality reviews
Historically, throughout the year emerging themes have been collated and shared across the Trust via governance and performance sessions and specialist working groups. The information has also been used to inform broad quality improvement initiatives.

With the introduction of the ENHance platform for patient safety incident monitoring; together with the new PSIRF approach to learning from incidents, we are continuing to look for new ways in which learning can be shared and regarding the methods to be used for assessing its impact and effectiveness.

A quarterly ‘Food for Thought’ presentation is now created, each iteration focussing on a particular aspect of SJR outputs. These presentations are shared in forums such as Mortality Surveillance Committee, Divisional Quality & Safety meetings and with the ICB. A condensed version of these presentations is now also shared in Rolling Half Day documentation packs.

Additionally, from February 2025 Clinical Governance Leads have also been asked to ensure that all SJRs are discussed in their specialty Mortality & Morbidity meetings, or other appropriate governance forums. Prior to this date, while many SJRs were already being discussed in these forums, the practice had not been standardised. This initiative forms part of the ongoing drive to encourage the sharing of learning identified in these reviews.

4.0 Improvement activity

4.1 Focus areas for improvement/monitoring

Table 9: Focus Areas for Improvement

Diagnosis group	Summary update
Ovarian Cancer	In the 2017-20 national Systemic Anti-Cancer Therapy (SACT) audit, the Trust was identified as an outlier for 30 Day Mortality. Following discussion at Mortality Surveillance an external peer review was commissioned. This identified a lack of integrated care at MVCC. Following completion of the review of patient care, a formal SI report has been completed. A small number of associated actions remain outstanding. This risk will be maintained until these are confirmed as complete.
Cardiology diagnoses	Following recurrent mortality alerts across the cardiology diagnoses basket, and a report by the Cardiology Clinical Director, a joint initiative between Cardiology and Coding was agreed. This has remained ongoing. Following significant work, the diagnosis groups originally alerting (myocardial infarction, congestive heart failure and coronary atherosclerosis and other heart disease) are no longer alerting. However, as these alerts have settled others have arisen, such as cardiac dysrhythmias, heart valve disorders and pulmonary heart disease. Preliminary coding and clinical reviews have shown similar challenges regarding accurate allocation of deaths across the various diagnosis groups. Further work will continue with regular updates to Mortality Surveillance Committee, the next of which is scheduled for July. To date no concerns have been raised regarding the quality of care.
Sepsis	While HSMR performance relative to national peer remains extremely well placed, achievement of sepsis targets remains variable. The sepsis team continues to develop multiple initiatives aimed at improving compliance.
Stroke	After a long delay, SSNAP finally provided an updated risk adjusted mortality report covering the 2-year period April 2021 to March 2023. While this indicated that the Trust was not an outlier for mortality, it also showed no improvement since the last reported risk adjusted metric for 2019-20. Over the same period HSMR had shown a significant improvement. SSNAP has recently published risk adjusted mortality for the year to March 2024. This indicated that the Trust's stroke risk-adjusted SSNAP mortality has improved dramatically, now standing at 105 (previous 117). While there has been clear improvement, at Mortality Surveillance Committee in May, it was agreed that performance should continue to be monitored and reported on until there is assurance that the improvement has been sustained. Current key updates include: • In the latest published SSNAP report covering the period Oct-Dec 2024 no letter ratings were included as per the new SSNAP processes. This will return in future reports. In the interim our SSNAP data analyst has maintained reports to allow continued work on improvement • Thrombolysis percentages remain improved following the TASC project completion. Weekly case reviews have been continued to maintain this work and are now embedded as business as usual • The focus on engagement with teams such as ED, emergency medicine and radiology has been maintained with the aim of continuing to improve overall

	performance • Collaborative work at a regional level with the East of England Integrated Stroke Delivery Network (ISDN) has also continued. The team has almost completed the implementation of CT perfusion and the rollout of Tenecteplase for Thrombolysis in line with new national /NICE guidance, all of which will improve Thrombolysis and Thrombectomy pathways • Finally, the team continues to work on all aspects of performance with a particular focus on the 4-hour to stroke unit performance and have a trajectory mapped out for significant improvement by 2026 which will be aided by the increase in out of hours stroke registrar cover.
Emergency Laparotomy	The NoLap Audit commenced in April 2024. This will show how the case selection is affecting the mortality of those not operated on. Additional support and funding will be required if the Trust is to ensure sufficient focus is placed on the audit. There will be no outlier policy for the first year, however, this will change from the second year and will likely be based on case ascertainment. Work has commenced on a strategy to improve the front door to theatre time. ED and Radiology are crucial in this work which will expand the Emergency Laparotomy pathway into ED. A number of ongoing challenges remain: • NELA (National Emergency Laparotomy Audit) case ascertainment remains a challenge. This has been further exacerbated by funding constraints affecting capacity for a NELA data coordinator • Pressures on emergency theatre capacity also represent another challenge for the service where a lack of funding/resources mean there are no current expansion plans • Finally, the lack of a level 1+/Surgical HDU in the Trust remains a serious risk to acute abdomen patients, a fact that continues to be raised at Clinical Director and Clinical Governance meetings.

5.0 Preventable deaths

Currently we are here referring to those deaths that have been judged more likely than not to have been preventable on the basis of an SJR. It must be remembered that the question of the preventability of a death is the subjective assessment of an individual reviewer on the basis of a SJR desktop review. While not definitive, the assessment by them that the death was more likely than not due to a problem in healthcare (more than 50:50% preventable) provides an invaluable, powerful indication that further in-depth investigation of the case is required using the Trust's Patient Safety Incident processes.

The table below provides year to end of Q4 deaths/SJR/Preventability data (detailing SJRs conducted up to 15 April 2025). The outcome of investigations and actions relating to deaths judged more than 50:50 preventable are discussed by the Mortality Surveillance Committee. To date there have been two Q4 deaths where the preliminary SJR review has judged the death to be more likely than not due to a problem in healthcare. Both these cases are currently being further reviewed by the patient safety team, where the question of preventability will be more rigorously interrogated.

As stated above, the preventability of death data provided in this report is taken from mortality reviewers' assessment in their structured judgement reviews. Where cases are escalated for further patient safety review/investigation, the additional rigour employed may bring to light detail which results in a downgrading (or increase) to the level of harm deemed to have been caused. The results of these more in-depth reviews are taken into consideration when estimating the number of deaths judged to be more likely than not due to a problem in healthcare reported in the annual Quality Account.

Table 10: 2024-25 SJR preventable deaths data Year to the end of Q4

Data count (at 15.04.2025)	**A**pr	May	**J**un	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Total**
Hospital deaths (ED & inpatient)	100	119	96	95	114	98	131	103	158	131	129	121	1395
SJRs completed on in-month deaths	16	10	7	15	36	41	41	36	29	37	28	7	296
% of deaths subject to SJR to date	16%	8%	7%	16%	32%	42%	31%	35%	18%	28%	22%	6%	21%
Deaths judged more likely than not to be due to a problem in healthcare	1	1	0	1	0	0	0	0	0	1	1	0	5
% SJRs assessed ≥50:50 preventable	6%	10%	0%	7%	0%	0%	0%	0%	0%	3%	4%	0%	2%

6.0 Options/recommendations

The Board is invited to note the contents of this Report.

Appendix 1: Learning from Deaths Dashboard

East and North Hertfordshire Trust: Learning from Deaths Dashboard - March 2024-25

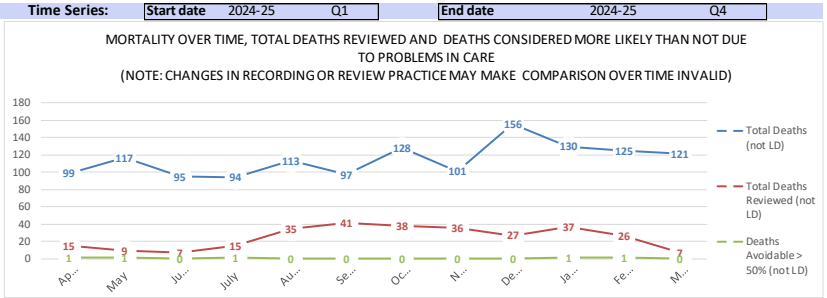
Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

Summary of total number of deaths and total number of cases reviewed under the Structured Judgement Review Methodology (SJRPlus)

Total Number of Deaths, Deaths Reviewed and Deaths Deemed more likely than not due to problems in care (does not include patients with identified learning disabilities)

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered more likely than not due to problems in care PRISM Score<=3 or equivalent measure	
This Month	Last Month	This Month	Last Month	This Month	Last Month
121	125	7	26	0	1
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
376	385	70	101	2	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
1376	1358	293	352	5	4

Time Series: Start date 2024-25 Q1 End date 2024-25 Q4



Total Deaths Reviewed, categorised by PRISM Score/SJRPlus preventability score

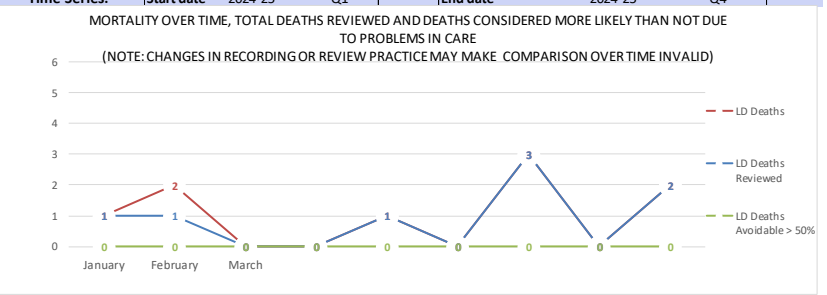
Score 1 Definitely preventable			Score 2 Strong evidence of preventability			Score 3 Probablypreventable (more than 50:50)			Score 4 Probably preventable but not very likely			Score 5 Slight evidence of preventability			Score 6 Definitely not preventable		
This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	7	100.0%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	2	2.9%	This Quarter (QTD)	1	1.4%	This Quarter (QTD)	9	12.9%	This Quarter (QTD	58	82.9%
This Year (YTD)	1	0.3%	This Year (YTD)	0	0.0%	This Year (YTD)	4	1.4%	This Year (YTD)	6	2.0%	This Year (YTD)	39	13.3%	This Year (YTD)	243	82.9%

Summary of total number of learning disability deaths and total number reviewed using the SJR methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed more likely than not due to problems in care for patients with identified learning disabilities

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered more likely than not due to problems in care	
This Month	Last Month	This Month	Last Month	This Month	Last Month
0	2	0	2	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
2	5	2	5	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
11	15	10	14	0	1

Time Series: Start date 2024-25 Q1 End date 2024-25 Q4



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13

Board

East and North Hertfordshire Teaching NHS Trust

Meeting	Public Trust Board		**Agenda Item**	12	
Report title	Board Assurance Framework (BAF) – Strategic Risks		**Meeting Date**	9 July 2025	
Author	Head of Corporate Governance				
Responsible Director	Deputy Chief Executive				
Purpose	**Assurance**	☒	**Approval/Decision**	☐	
	Discussion	☐	**For information only**	☐	
Proposed assurance level (*only needed for assurance papers*)	**Substantial assurance**	☐	**Reasonable assurance**	☐	
	Partial assurance	☒	**Minimal assurance**	☐	

Executive assurance rationale:

Rated as partial assurance reflecting that there are five new risks out of 11 on the BAF and these would not have been added by the Board, if the Board was assured about them.

Summary of key issues:

The 2025/26 BAF

- Following May Board approval of the risks for the 2025/26 BAF, the agreed changes have been progressed and BAF risks are presented. The Board agreed five new or significantly amended risks to the BAF:
  - Risk 4: "Workforce morale whilst making necessary staffing savings"
  - Risk 5: "Leadership and engagement"
  - Risk 6: "Compliance culture and accountability"
  - Risk 7: "System instability" replaces "System inertia"
  - Risk 11: "Change management"

- Whilst QSC and FPPC have reviewed the BAF risks they are the lead committee for, due to committee timings, People and Culture Committee does not meet until 15 July and therefore the risk and assurance scores have not been validated by the committee and may be amended following lead committee input.

Board spotlight on two BAF risks

The two risks below are the spotlighted risks for this Board and were reviewed at 23 June FPPC:

Spotlighted BAF Risk 7 *(*System instability*) – Adam Sewell-Jones*

- The Board changed the risk description focus from system inertia to system instability reflecting agreement that the Trust take on hosting of the ENH HCP meaning inertia is less of an issue. Meaning, the instability arising from changes to NHSE and the ICS is now the larger concern. Therefore, the risk has been fundamentally re-written so is not presented as tracked changes.
- FPPC asked for changes to the BAF, which have been added, to reflect the resourcing challenges that come from taking on the host provider role for the HCP and FPPC's desire to make sure that core Trust services do not suffer as a result of officer time devoted to the HCP work.
- Assurance is rated as a 3 overall given the uncertain landscape.

Spotlighted BAF Risk 8 *(*Flow and Performance*) – Lucy Davies*

- The Board agreed to change the risk summary from 'Improving performance and flow' to 'Improving flow and performance' given flow is the real focus of this risk and not all performance.
- The accountability framework is the most significant new control.
- Originally identified delivery dates for actions have been amended to later delivery dates to address control or assurance gaps. Therefore, the original as well as revised action delivery dates are included to denote more time is needed to deliver the improvements than originally envisaged.

Other key updates

- Key changes are presented as tracked changes.
- **Risk 1:** estates challenges has been explicitly added to the investment risk description for the first time, reflecting Board and QSC input.
- **Risk 2:** Health inequalities will be an item for discussion at July's Board Seminar.

Impact: *tick box if there is any significant impact (positive or negative):*

Patient care quality	☒	**Equity for patients**	☒	**Equity for staff**	☒	**Finance/ Resourc -ing**	☒	**System/ Partners**	☒	**Legal/ Regul- atory**	☒	**Green/ Sustai- nability**	☐

The BAF risks present potentially significant negative impacts relating to inequality, patients, finances, the system and regulatory compliance should the risks materialise which is why they are top risks on the BAF.

Trust strategic objectives: *tick which, if any, strategic objective(s) the report relates to:*

Quality Standards	☒	**Thriving People**	☒	**Seamless services**	☒	**Continuous Improvement**	☒

Identified Risk: *Please specify any links to the BAF or Risk Register*

The BAF is based on risks to these strategic objectives and the top two/three risks to each strategic objective are included on the BAF.

Report previously considered at & date(s):

At 9 April 2025 Board Seminar, Board members carried out a horizon-scanning exercise to help identify the biggest risks to delivering the four strategic objectives which were then presented at 14 May 2025 Board for approval of the 2025/26 BAF. This is the first Board where the full written-up BAFs is presented. FPPC and QSC has met and reviewed the BAF risks they are lead committee for. People and Culture Committee and OneEPR Committees are due to meet in July, after Bard paper finalisation, to review their BAF risks.

Recommendation	The Board is asked to discuss and **NOTE** the BAF.

To be trusted to provide consistently outstanding care and exemplary service

East and North Hertfordshire Teaching NHS Trust

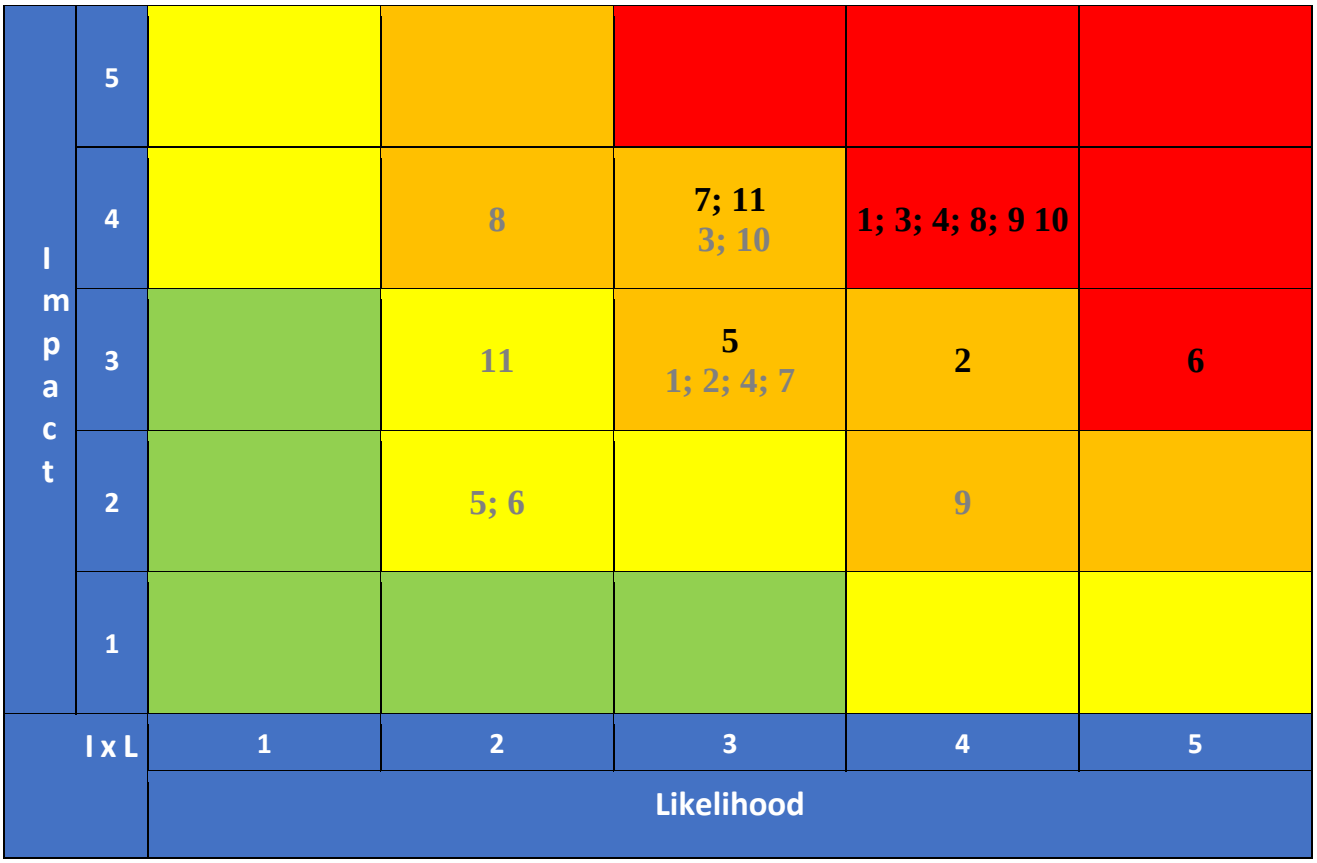
BOARD ASSURANCE FRAMEWORK REPORT

Section 1 - Summary

Risk no	Strategic Risk	Lead(s) for this risk	Assurance committee(s)	Current score	Trajectory
Consistently deliver quality standards, targeting health inequalities and involving patients in their care					
1.	**Investment & estates challenges (capital, system allocation and no growth)**	Chief Financial Officer	Finance, Performance & Planning	16	⟷
2.	**Health inequalities**	Medical Director	Quality & Safety	12	⟷
3.	**System and internal financial constraints**	Chief Financial Officer	Finance, Performance & Planning	16	⟷
Support our people to thrive by recruiting and retaining the best, and creating an environment of learning, autonomy, and accountability					
4.	Workforce morale whilst making necessary staffing savings	Chief People Officer	People & Culture	16	
5.	Compliance culture and accountability	Chief People Officer	People & Culture	15	
6.	Leadership and engagement	Chief People Officer	People & Culture	9	
Deliver seamless care for patients through effective collaboration and co-ordination of services within the Trust and with our partners					
7.	System ~~inertia~~instability	Chief Executive	Finance, Performance & Planning	12	
8.	**Improving ~~performance and~~ flow** and performance	Chief Operating Officer	Finance, Performance & Planning	16	⟷
9.	**The future of cancer services**	Chief Operating Officer	Quality & Safety	16	⟷
Continuously improve services by adopting good practice, maximising efficiency and productivity, and exploiting transformation opportunities					
10.	**Digital Transformation**	Chief Information Officer	~~Finance, Performance & Planning~~OneEPR Committee	16	⟷
11.	Change management	Chief Kaizen Officer	People & Culture	TBC	

Section 2 Strategic Risk Heat Map

Current risk scores in **black**
Target risk scores in ***grey***



Section 3 Risk Appetite

Risk level	0 - Avoid Avoidance of risk and uncertainty is a Key Organisational objective	1 - Minimal (as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	2 - Cautious Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.	3 - Open Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)	4 - Seek Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).	5 - Mature Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust
APPETITE	**NONE**	**LOW**	**MODERATE**	**HIGH**	**SIGNIFICANT**	
Quality			✓			
Financial				✓		
Regulatory				✓		
People					✓	
Reputational					✓	

Section 4 Risk Scoring Guide

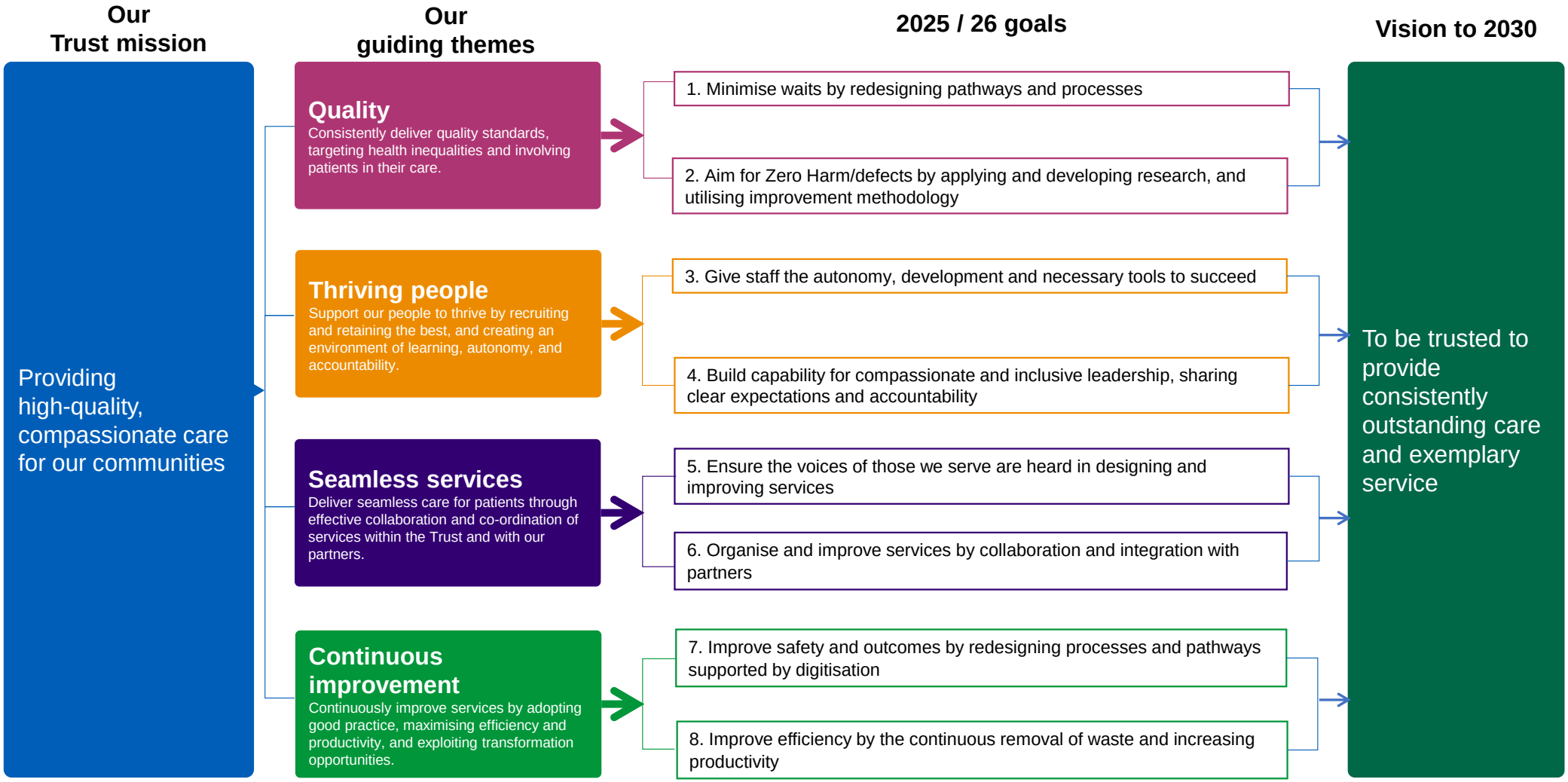
Risks included in the Risk Assurance Framework (RAF) are assessed as extremely high, high, medium and low based on an Impact/Consequence X Likelihood matrix. Impact/Consequence – The descriptors below are used to score the impact or the consequence of the risk occurring. If the risk covers more than one column, the highest scoring column is used to grade the risk.

Impact Level	Impact Description	Safe	Effective	Well-led/Reputation	Financial
1	**Negligible**	No injuries or injury requiring no treatment or intervention	Service Disruption that does not affect patient care	Rumours	Less than £10,000
2	**Minor**	Minor injury or illness requiring minor intervention	Short disruption to services affecting patient care or intermittent breach of key target	Local media coverage	Loss of between £10,000 and £100,000
		<3 days off work, if staff			
3	**Moderate**	Moderate injury requiring professional intervention	Sustained period of disruption to services / sustained breach key target	Local media coverage with reduction of public confidence	Loss of between £101,000 and £500,000
		RIDDOR reportable incident			
4	**Major**	Major injury leading to long term incapacity requiring significant increased length of stay	Intermittent failures in a critical service	National media coverage and increased level of political / public scrutiny. Total loss of public confidence	Loss of between £501,000 and £5m
			Significant underperformance of a range of key targets		
5	**Extreme**	Incident leading to death	Permanent closure / loss of a service	Long term or repeated adverse national publicity	Loss of >£5m
		Serious incident involving a large number of patients			

Likelihood	**1 Rare (Annual)**	**2 Unlikely (Quarterly)**	**3 Possible (Monthly)**	**4 Likely (Weekly)**	**5 Certain (Daily)**
Death / Catastrophe 5	5	10	15	20	25
Major 4	4	8	12	16	20
Moderate 3	3	6	9	12	15
Minor 2	2	4	6	8	10
None /Insignificant 1	1	2	3	4	5

Risk Assessment	**Grading**
15 – 25	**Extreme**
8 – 12	**High**
4 – 6	**Medium**
1 – 3	**Low**

NHS East and North Hertfordshire NHS Trust

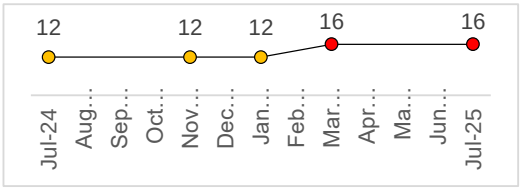


Assurance Rating	ACTIONS	OUTCOMES
Level 7	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systematic causes/reasons for performance variation.	Evidence of delivery of the majority or all of the agreed actions, with clear evidence of the achievement of desired outcomes over a defined period of time i.e. 3 months.
Level 6	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systematic causes/reasons for performance variation.	Evidence of delivery of the majority or all of the agreed actions, with clear evidence of the achievement of desired outcomes.
Level 5	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systematic causes/reasons for performance variation.	Evidence of delivery of the majority or all of the agreed actions, with little or no evidence of the achievement of desired outcomes.
Level 4	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systematic causes/reasons for performance variation.	Evidence of several agreed actions being delivered, with little or no evidence of the achievement of desired outcomes.
Level 3	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systematic causes/reasons for performance variation.	Some measurable impact evident from actions initially taken AND an emerging clarity of outcomes sought to determine sustainability with agreed measures to evidence improvements.
Level 2	Comprehensive actions identified and agreed upon to address specific performance concerns.	Some measurable impact evident from actions initially taken.
Level 1	Initial actions agreed upon, these focused upon directly addressing specific performance concerns.	Outcomes sought being defined. No improvements yet evident.
Level 0	Emerging action not yet agreed with all relevant parties.	No improvements evident.

Strategic Priority: **Consistently deliver quality standards, targeting health inequalities and involving patients in their care**			**Risk score 16**
Strategic Risk No.1: **Investment & estates challenges (capital, system allocation and no growth)**			
If there is insufficient investment (capital, system allocation and no growth) to address rising costs~~, demand~~ and aging infrastructure	***Then*** difficult choices will need to be made where to reduce costs or not to invest	***Resulting in*** services and infrastructure in those areas suffering and potential negative quality and safety impacts on patients and staff and increased risks to health and safety compliance.	

	Impact	Likelihood	Score	Assurance
Inherent	4	4	16	~~5~~4
Current	4	4	16	
Target	3	3	9	

Risk Trend



Risk Lead	Chief Financial Officer	Assurance committee	FPPC

Controls	Assurances against stated controls, with assurance level 1st line (front line); 2nd (corporate); 3rd (independent)	Assurance score
Strategies and Plans		
Digital Strategy	Strategy approval by Board & annual progress report (2)	6
Estates Strategy	Strategy approval by Board & annual progress report (2)	3
Approved Financial & Capital Plans ~~24/25~~	Annual Capital Plan reviewed and approved by FPPC (2)	~~5~~6
Integrated Business Plan and supporting strategies inform investment priorities	Strategy approval by Board & annual progress report (2)	4
Productivity Framework	Monthly report to FPPC defining a productivity framework and change at the Trust (2)	3
Operational Systems and Resources		
HWE ICS annual operating plan	ICB approval (3)	4
Trust LTFM & System Medium Term Financial Plan (MTFP)	System CEOs review (1) Reports to FPPC bi-annually (2) Regional and national NHSE review (3)	2
Governance & Performance Management Structures		
Finance People and Performance Committee	Monthly finance and performance reports to Committee Scheduled annual planning briefings to Committee (2)	3
Board seminar sessions (include strategy review)	Annual Board Seminar review (2)	4
Financial Recovery Group (FRG)	Co-ordination of financial improvement activity to support in year delivery of financial plan (2)	4
Monthly Capital Review Group meetings & Critical Infrastructure Weekly meetings	Reports (1) Qtrly Capital Plan Reports to FPPC (2)	~~5~~6
ICS Directors of Finance meeting	Reports to ICS Directors meeting (1)	4
Investment Group	Report to TMG (1)	4

Trust Management Group ratification of investment decisions	Quarterly reports to TMG (1)	~~5~~6

Gaps in Controls and Assurances	Actions and mitigations to address gaps	Lead	Target date
• Finance strategy	• 25-26 refresh of strategy reviewed at July 25 Board Seminar combined with supplementary development of revised long-term financial model	MA	Sept 25
• Transformational solutions to address the system financial gap	• ~~The System is evaluating options to structure transformation programmes across the system, and the potential commissioning of consultancy resource to pump prime delivery~~ - COMPLETED • The system has agreed six transformational workstreams that will be developed in 25-26 to assist embedding financial sustainability across the ICS. Individual CEOs and CFOs are mapped to individual workstreams.	MA	~~Q4 24/25~~ Q1 25/26
• Confidence in the appropriate deployment of resources across place and providers	• The system has invested in a PHM system that can generate data to support analysis of the distribution of system resources. Consultancy deployment may be required. ~~Timeline TBC~~	MA	25/26 – ICB Place reconfiguration timetable~~planning timetable~~
• Long Term Financial Planning Infrastructure	• Trust to refresh its LTFM (linking to system MFTP) to clearly set out options for resource utilisation within the context of national and local drivers and strategies. Complete during 2024. • Outputs coming to FPPC in Oct 25	MA	~~25/26 planning timetable~~Oct 25
• Responding to in year investment opportunities	• In addition to the annual planning process, the Trust will establish a monthly 'Investment Group'. This will provide a forum to consider in year opportunities for affordable investment as they arise	DDOF	Monthly investment group meeting
• ~~ICS capital prioritisation framework and associated investment plan~~	• ~~Plan being produced by ICS Estates Director (reliant on ICS for the timescale to be met)~~	~~MA (internally)~~	~~25/26 planning timetable~~Complete - reflected in 25-26 allocations
• ~~Absence of a clear space utilization baseline and strategy limits the effectiveness of estate investment~~	• ~~Space Utilisation survey commissioned as part of the 24/25 capital programme to inform 25/26 and long term capital planning~~	~~AM~~	~~Mar-25~~Complete
• Medium term financial plan	• FPPC review of medium term financial plan refreshed post 25/26 planning round • Integrate Trust LTFM output into revised system medium term plan informed by comprehensive spending revie output and system transformation strategy	MA	~~Jun-25~~Oct 25
• ~~Consistent process/oversight of business case approval and post project evaluation~~	• ~~Capital review group oversight of business cases to produce recommendations and undertake post implementation evaluation~~	~~MA~~	~~Dec 24~~Complete

Current Performance – Highlights from the Integrated Performance Report:

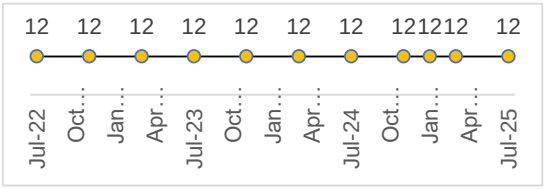
- The Trust workforce has expanded significantly since COVID. This represents a significant financial investment, although activity delivery and productivity has declined.
- Underlying in year financial performance is at significant variance to plan.
- The Trust has agreed a £15m capital investment plan for 24/25.
- Profile of capital spend delivery
- H&S compliance assurance ratings
- Headcount tracker

Associated Risks on the Board Risk Register		
Risk no.	Description	Current score
	N/A	

Strategic Priority: **Consistently deliver quality standards, targeting health inequalities and involving patients in their care**		**Risk score 12**
Strategic Risk No.2: **Health inequalities ~~& patient expectations~~**		
If we do not address health inequalities nor meet the expectations of patients and other stakeholders	***Then*** population/stakeholder health outcomes will suffer	***Resulting in*** poorer public health, loss of trust, loss of funding opportunities and regulatory censure and knock-on impacts on our ability to regulate front-door demand for non-elective services.

	Impact	Likelihood	Score	Assurance
Inherent	4	4	16	4
Current	3	4	12	
Target	3	3	9	

Risk Trend



Risk Lead	Chief Medical Officer	Assurance committee	Quality & Safety Committee

Controls	Assurances against stated controls, with assurance level *1st line (front line); 2nd (corporate); 3rd (independent)*	Assurance score
National Strategies		
Core 20 plus 5	National reporting (3)	7
System Plans		
ICS EDI Policy and Strategy 23-27	No current report on delivery of the Trust's elements	1
Trust Plans		
EDI strategy – which includes health inequalities	Report to People Committee and Board (2)	3
Appointment of deputy MD with responsibility for health inequalities (Started 1.11.24)	~~N/A~~	2
Changes to waiting lists for patients with learning disability	Report to QSC on LD annually (2)	4
Targeted lung health checks	National policy, enacted locally, assured via SQAS – (3)	7
Workforce health strategy	Brought to board, one off (2)	2
Smoking policy agreed by board and implemented	Signed off by board (2), smoking shelter removed	2
DH mandate to do opt out testing for blood borne viruses in ED	Process being worked through	1

Gaps in Controls and Assurances	Actions and mitigations to address gaps	Lead	Target date
~~• Lack of a unified smoking cessation policy~~	~~• Developing a site policy~~	~~MD~~	~~• Complete~~
• Large PTLs with associated risk post pandemic	• Increasing service awareness	COO	Individual national targets

• Paediatric audiology	• Weekly meetings with ICB and region whilst the service restarts [21 Jan 25 update: parts of the service have re-opened]	DON	See Corporate Risk Register
• Community paediatric long waits for assessment	• Ongoing ICB working group	COO	See Corporate Risk Register
• Childrens wellbeing bill • Tobacco and vape bill • Mental health bill	• Implement actions once legislation enacted	MD	2025
• An ICS delivery plan is needed for its Patient EDI Strategy	• Requesting ICS to produce a delivery plan	ICB	Apr 25
• Dedicated resource for health inequalities	• ~~MD / deputy MD and MD ops lead spend a limited amount of time, in addition there is a small amount of support from the business planning team~~ • ~~For November Board spotlight discussion~~	MD	
• No dedicated work plan	• Lack of resource makes this challenging • For November Board spotlight discussion	MD	

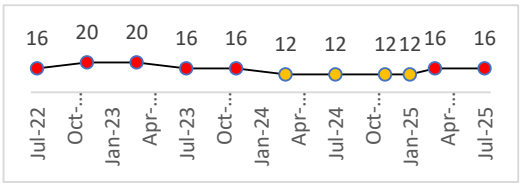
Current Performance – Highlights from the Integrated Performance Report:
• ED 4 hour standard • 28 day faster diagnosis standards • DMO1 – audiology • 65 week waits for community paediatrics Update 06.06.2025 • No smoking policy approved by board and smoking shelter removed • Opt-out blood born virus testing to be implemented in ED • Concerns about lack of school nursing for special schools preventing school attendance for some

Associated Risks on the Corporate Risk Register		
Risk no.	Description	Current score
3027	Risk of Regulatory non-compliance within Audiology Service	~~20~~16
3079	Disrepair of the Building Fabric and unmet electrical needs and mechanical requirements relating to Bluebell Ward & Bramble Day Services.	20
3420	Risk of increased waiting times for initial and subsequent appointments within Community Paediatrics	20
3269	Bereavement care following pregnancy loss	16

Strategic Priority: **Consistently deliver quality standards, targeting health inequalities and involving patients in their care**			**Risk score 16**
Strategic Risk No.3: System and internal **financial constraints**			
If far-reaching financial savings are required (either due to system financial instability or internal pressures), and we do not deliver greater efficiencies	***Then*** we will need to make difficult decisions that could have a negative impact on quality and delivery of our strategy	***Resulting in*** poorer patient outcomes, longer waiting times; reduced staff morale, reputational damage and not delivering all of our strategy.	

	Impact	Likelihood	Score	Assurance
Inherent	5	4	20	4
Current	**4**	**4**	**16**	
Target	4	3	12	

Risk Trend



Risk Lead	Chief Financial Officer	Assurance committee	FPPC

Controls	Assurances against stated controls, with assurance level *1st line (front line); 2nd (corporate); 3rd (independent)*	Assurance score
Strategies and Plans		
Approved 25/264/25 Financial Plans	Monthly Finance Update to TMG (2)	4
	Monthly Finance Report / Key Metrics to FPPC (2)	4
	CIP report & productivity report to FPPC (2)	4
	Outturn Reports to TMG, FPPC and Board (2)	4
	Delivery & Progress reports to Finance Recovery Group (2)	4
	24/2525/26 Financial plan submitted to & approved by NHSE (3)	4
Operational Systems and Resources		
Financial Reporting & BI Systems	Monthly financial reporting to NHSE & HWE System (1)	56
Detailed monthly CIP performance reporting	Reports to FPPC and FRG and national reporting (2)	4
Monthly ERF & Productivity Report to FPPC	Internal performance monitoring and Model Hospital / GIRFT / Use of Resources benchmarking (2)	3
Monthly Finance Reports	External / Internal audit review of key financial systems and processes (3)	4
Outturn Forecast report to TMG, FPPC and System	Review at FPPC and TMG (2)	4
Monthly ICS Financial Recovery BoardSystem Transformation and Improvement Board	Facilitated by ICS financial and executive leaders (3)	2
Monthly system finance oversight meeting with NHSE	Regional confirm and challenge of Trust and system financial deliver (3)	3
Biweekly System CEO / CEO finance review meetings	System stakeholder review of financial delivery and planning (3)	3

Vacancy Review Panel & Non-Pay controls	Daily / Weekly executive led mechanisms to review and challenge the application of recruitment and spending request relative to tightened criteria (1)	3
Rostering & Job Planning system	Variety of Rota and rostering tools to regulate workforce deployment (2)	2
Ratified SFI's and SO's, Counter Fraud Policy	Annual review and ratification by Board and Audit Committee. Deployment in Trust finance, workforce and governance systems. Annual audit review of effectiveness (3)	4
Governance & Performance Management Structures		
Accountability framework	Monthly FPPC and bi-monthly Board reports (2)	3
FPPC, FRG & TMG Reporting	Monthly meetings Exec/ NED chaired – agreed agenda (2)	4
Divisional Finance Boards meetings	Monthly meetings Exec chaired – finance delivery review (2)	4
Monthly Capital Review Group	Monthly meeting DDOF chaired – capital plan review (2)	4
Weekly D&C / ERF delivery meetings	Weekly session – Info led / divisional attendance – review of ERF plans and delivery (2)	4
Monthly cost-centre / budget holder meetings	Scheduled review of CC performance with budget holders and finance managers. Frequency determined by performance (2)	4
Bi-weekly ICS Director of Finance meetings	System stakeholder review of financial delivery and planning (3)	3
Bi-weekly Income Recovery Group	Internal corporate review of counting and coding effectiveness and accuracy	4
Monthly Workforce Utilisation & Deployment Group & MEOG medical staffing group	Monthly workforce groups (exec chaired) to review temporary staffing deployment across key workforce groups (2)	2
Procurement Governance Board	Monthly meeting of procurement service stakeholders to review delivery against workplan (3)	4

Gaps in Controls and Assurances	Actions and mitigations to address gaps	Lead	Target date
• Finance strategy	• To July Board Seminar	• MA	• July 25
• Medium Term Financial Plan	• To produce MTFP	• MA	• Oct 25
• Establishment Growth controls	• Corporate services recruitment freeze • Approved CIP Plan establishment reduction • Temporary staffing regulation versus permanent recruitment	• MA	• Q2 25/26
• ~~Delivery of levels of planned ERF activity~~ • Delivery of of Trust RTT Plan and impact on Trust financial plan	• ~~recruitment of additional ERF capacity – progress now tracked through FRB and FPPC~~ • Working Group set up by TMG to review activity delivery , validation strategy and associated access governance arrangements to provide assurance of RTT delivery strategy	• CO	• ~~Q4 24/25~~ • Q2 25/26
• Risk of non delivery of CIP / Savings Targets	• ~~Review and Implementation of PWC CIP actions~~ completed • ~~Internal Audit Review of CIP effectiveness arrangement commissioned~~ completed	• MA • MA • All Execs	• ~~Nov 24~~ • ~~April 25~~ • ~~Q4 24/25~~

	• Regular review of CIP and Recovery plan delivery through FPPC and Delivery Board~~FRB~~ • ~~Enhanced PMO arrangements now implemented led by dedicated delivery director and associated resources~~ • Accountability framework approved by May Board Seminar		
• Risk of significant overspend against Trust expenditure budgets	• ~~Go Live of 'No PO – No Pay' system~~ • ~~Tightened Vacancy Control Panel~~ • ~~UEC and Establishment Growth Review Work steams~~ • ~~Pathology activity and cost control workstream~~ • Embedding regular hotspot reporting to track expenditure at variance to budget plans	• ~~MA~~ • ~~MA~~ • ~~SJ / KOH~~ • ~~CM~~	• ~~Jan 25~~ • ~~Ongoing~~ • ~~Q4 24/25~~ • ~~Q4 24/25~~ • Complete • Q2 25/26
• Understanding of financial dynamics underpinning service line performance	• Implementation ~~and testing~~ of SLR model – now in go-live • Service Line ~~review and validation~~productivity line production • Revised and summarised~~Link of output to~~ productivity report to TMG focusing on actionable insights metrics and levers – revised productivity report to FPPC • ~~Development of supporting incentivization mechanisms~~– complete with Accountability Framework	• DP / LL • Divisions • DP • MA	• Q2~~4~~ 2~~4/~~25/26 • Q1 25/26~~3/Q4~~ • ~~April 25~~Sept 25 • ~~Business Planning 25/26~~
• Risk around absence of a short and long-term financial strategy for the system and stakeholders to address underlying deficit	• The Trust has generated a medium terms financial plan based upon agreed national and local assumptions. To be used to frame the development of the 25/26 financial plan • Development of long-term financial model to report to FPPC in Oct and integration with system medium-term financial plan incorporating CSR assumptions and system transformation plan	• MA	• ~~Q1 25~~Q3 25/26
• Absence of effective job planning framework	• Trust to develop a programme of activity to review (1) review historic additional duties allocations (2) benchmarking job planning principles and assumptions (3) link team job plans to demand and capacity modelling • Implementing consultant job planning framework approved in Jan 25 FPPC mtg – this is embedded within CIP programme for 25/26	• MA / JD / TP	• Q4 24/25 • Until year end for review
• Significant reductions in Trust productivity vs pre-pandemic levels. Significant increases in staff volumes and costs not related to activity change.	• ~~This has framed areas for review and restatement. This is formalized in 'Establishment Growth' workstream,~~ • Productivity report, with an emphasis on insight and actionable activity to be implemented and presented to committee from Sept 25 onwards the development of a 'Productivity Index, to FPPC. Productivity QV app deployed to assist service line level productivity reviews. • Headcount reduction plan to be incorporated within final CP plan for 25/26 covering both directed NHSE reductions and local schemes	• ~~KOH~~ • DP	• ~~Q4 24/25~~ • ~~April 25~~Q3 25/26

Current Performance – Highlights from the Integrated Performance Report:
• The Trust reports a YTD ~~surplus~~ deficit of £~~8~~0.2m @ M2~~8~~, this is in line with the plan~~adverse to plan by £0.7m~~ • ~~As at Month 28 the Trust ERF plans are significantly behind plan. Significant~~ Some pay pressures have emerged ~~and non-pay hotspots have emerged.~~ • ~~The utilisation of significant reserves funding has been required to support YTD achievement of the financial plan.~~ • The Trust CIP plan for 25/26 is £35.8m. To date £16.5m has been fully identified and agreed against that target • ~~All Divisions have been requested to develop and implement run rate recovery plans.~~ • ~~Additional Financial Recovery Workstreams have been developed and mobilized to bridge remaining gaps to plan.~~ • CIP delivery – revised PMO and delivery Board structure in place to ID savings identification and delivery • Headcount reductions schemes covering corporate services and non-patient saving roles have been identified as part of 25/26 savings plans • Tracking arrangements in place to monitor run rate variation in divisional expenditure levels with a link through to corresponding hotspots and remedial review where necessary • Year on year overspend on Directorate budgets

Associated Risks on the Board Risk Register		
Risk no.	Description	Current score
3300	Lack of special school nursing staff	20

Strategic Priority: **Support our people to thrive by recruiting and retaining the best, and creating an environment of learning, autonomy, and accountability**			Risk score **16**
Strategic Risk No.4: **Workforce morale whilst making necessary staffing savings**			
If the Trust does not manage the necessary staffing savings approach well	***Then*** staff morale and motivation could be affected	***Resulting in*** a range of issues arising from a disaffected workforce including reduced patient quality and safety, productivity and increased turnover and difficulty recruiting high calibre staff.	

	Impact	Likelihood	Score	Assurance	Risk Trend
Inherent	4	5	20	4 TBC	
Current	**4**	**4**	**16**		
Target	3	3	9		

Risk Lead	Chief People Officer	Assurance committee	People and Culture Committee

Controls	Assurances against stated controls, with assurance level *1st line (front line); 2nd (corporate); 3rd (independent)*	Assurance score
Strategies and Plans		
People Strategy	People Committee reports (2) Annual report to Board (2)	6
Clinical Strategy 2022-2030	Report to QSC (safer staffing quarterly; Establishment review; Q&S metrics monthly) (2)	6
EDI Strategy	People Committee reports (2) Annual report to Board (2)	4
Annual Divisional demand and capacity modelling, workforce plans and local Skill mix reviews	Planning reports to FPPC and PCC (2)	6
Apprenticeship strategy	People Committee reports (2) Oversight at Education Committee (1)	5
Mechanisms for identifying hotspots and shortfalls	People Committee reports (temp staffing; resourcing; people report; retention deep dive) (2)	6
NHS Workforce long-term plan	Annual People Committee updates on progress (2)	5
Recruitment and attraction		
Workforce Plans aligned with Financial budgets and agreed establishments	Reported annually to PCC (2) Reported to ICB and monitored at ICB People Board (3)	5
Engagement with schools and colleges as part of the widening participation programme as well as offering work experience	Reported annually to PCC (2) ICS sustainable workforce supply committee (3)	5
Retention		
Improvement to induction and onboarding, including coaching and mentoring support	Reported annually to PCC (2) Retention steering group (1)	4
Delivery of wellbeing strategy – Care Support Pyramid	Reported annually to PCC (2) Wellbeing questions part of annual staff survey	6

	Included in monthly IPR (3) Sickness rates monitored in Divisional Performance Reviews (1)	
Delivery of management competency framework	Reported annually to PCC (2)	6
Annual Staff survey and quarterly pulse surveys team talks and action plan		5
Governance & Performance Management Structures		
Medical establishment oversight working group	Held monthly & feeds into People report taken to PCC (2)	5
Clinical oversight working group	Held monthly & feeds into People report taken to PCC (2)	5
Recruitment and retention group	Held monthly & feeds into People report taken to PCC (2)	5
Workforce reports – time to hire, pipeline reports	Figures incorporated into the IPR which are taken to PCC and Trust Board (2)	6
Education committee	Held bi-monthly and feeds into People report taken to PCC (2)	6

Gaps in Controls and Assurances	Actions and mitigations to address gaps	Lead	Target date
• Inability to recruit to key posts at speed due to CIPS not delivered	• TBC	•	•
• Mutually Agreed Resignation Scheme	• To approve MARS scheme and enact	• CPO	• Nov 25
• Establishment growth controls • Better infrastructure for agreeing establishment and funding for posts (planning process)	• Consistency of HR and Finance data	•	•
• Capacity of staff to deliver expected improvements and BAU with reduced staff	• Redesign ways of working • Use AI	•	•

Current Performance – Highlights from the Integrated Performance Report:
• Staff turnover rate • Staff survey – particularly workload and morale questions • Recruitment pipeline time to hire

Associated Risks on the Corporate Risk Register		
Risk no.	Description	Current score
	N/A	

Strategic Priority: **Support our people to thrive by recruiting and retaining the best, and creating an environment of learning, autonomy, and accountability**			Risk score **9**
Strategic Risk No.5: **Leadership and engagement**			
If the Board and Executive do not effectively nurture and model the right leadership behaviours and skills and these standards are not adopted at all levels of the organisation	***Then*** sub-optimal management and behaviours in hotspot areas will occur and staff may not feel psychologically safe to raise concerns	***Resulting in*** being unable to make the transformation changes needed to improve patient services and core performance standards and staff experiencing stress, bullying, harassment and discrimination	

	Impact	Likelihood	Score	Assurance	Risk Trend
Inherent	4	3	12	4 TBC	
Current	**3**	**3**	**9**		
Target	2	2	4		

Risk Lead	Chief People Officer	Assurance committee	People Committee

Controls	Assurances against stated controls, with assurance level *1st line (front line); 2nd (corporate); 3rd (independent)*	Assurance score
Strategies and Plans		
People Strategy	People & Culture Committee reports (2) Annual report to Board (2)	4
Freedom to speak up strategy	Twice per year at PCC & annual report to Trust board (2)	6
EDI Strategy	People & Culture Committee reports (2) Annual report to Board (2)	4
People development plans – including education, learning and development	Annually to PCC (2) Education committee reports (1)	6
Leadership competency framework	NHSE submission annually (3)	6
Learning and Development		
Healthy culture and healthy teams' framework	Reported annually to PCC (2) Divisional performance reviews (1) Divisional updates to PCC (2)	6
ENHT Values and behaviour charter	Aligned to CEO objectives (1) Positive leadership rounds (1)	4
Core Management Skills & Knowledge	Reported annually to PCC (2)	4
Delivery of wellbeing strategy – Care Support Pyramid	Reported annually to PCC (2)	4
Mentoring and coaching programmes	Reported annually to PCC (2)	4
Talent management approach and programmes	VSM and future leaders' remuneration committee annual report (2) Annual talent review executive team meeting (1)	4
Grow Together Reviews training and support	Grow Together Reviews embedded within organisation and reported to PCC (2) Staff survey question on appraisals (3)	6

Retention		
Annual staff survey and quarterly pulse surveys	Reported in IPR taken to PCC (2) Twice per year updates to PCC & annual to Trust Board (2)	6
Stay interviews and exit questionnaires	New approach agreed by PCC, assurance report to be presented by Mar 25 (2 once starts)	3
Staff survey team talks and action plan	Divisional update provided to each PCC (2)	6
Staff Engagement and Wellbeing		
Delivery of wellbeing being strategy – Care Support Pyramid	Reported annually to PCC (2) Wellbeing questions part of annual staff survey (2) Included in monthly IPR (2) Sickness rates monitored in Divisional Performance Reviews (1)	6
Core offer of support available linked to financial, physical, mental, spiritual and social wellbeing for all staff	Reported annually to PCC (2)	6
Annual engagement events and days to raise awareness of specific topics	Reported annually to PCC as well as monthly updates (2)	6
Staff networks /Freedom To Speak Up/ Meet the Chief Executive/ Positive Leadership Rounds	Voice of our people featured at PCC (2) Staff story featured at Trust board (2)	6
Internal communications - all staff briefing, in brief and newsletter	Reported through CEO report and IPR (2)	6
Governance & Performance Management Structures		
Divisional boards	Monthly and report through to Divisional Performance Review (1)	6
Recruitment and retention group	Held monthly and feeds into People report taken to PCC (2)	6
Staff networks	7 core networks held monthly and report to PCC (2)	6

Gaps in Controls and Assurances	Actions and mitigations to address gaps	Lead	Target date
• Capacity to undertake support and development in identified areas to improve leadership practice and engagement • Challenges in the level of organisational engagement across ENHT to make things happen and embed sustainable change	• Targeting where to focus management competency framework due to limitation on capacity • Healthy Teams work is being implemented in Gynae, Maternity, Theatres, paediatrics, ITU and ED. to support leaders and teams develop a good leadership rhythm and build healthy culture • Staff survey action plans support improvements happening locally and results are used to identify priority areas and specific support to low score areas - Team talks on staff survey and on values charters remain active within divisions. These are now based on the Care Support Pyramid (4 dimensions that make a difference to staff experience) this makes the intervention organisationally consistent but locally owned and accountable.	• CPO	• Mar 26
• Capacity to release staff and leaders to participate in	• Creative delivery and support to enable release and participation. Pilots with local events, bitesize and development coaching in order to use time effectively.	• CPO	• Mar 26

development alongside day-to-day priorities	Use of rolling half day and leadership forum as an opportunity for development. • Introduction to ENH Production System and ENH Production System for leaders now launched with participants supported to attend		
• 360 feedback of leadership behaviours	• Needs agreement - TBC	•	•

Current Performance – Highlights from the Integrated Performance Report:
• Numbers of successful staff challenges – grievances and ETs • Number of staff completed ENHPS leaders • % leaders done training – core competencies and clinical ops programme • Staff survey re leadership & staff advocating for the Trust • GROW completion rate

Associated Risks on the Corporate Risk Register		
Risk no.	Description	Current score
0048	Discharge letters not being completed at the time of discharge	16

Strategic Priority: **Support our people to thrive by recruiting and retaining the best, and creating an environment of learning, autonomy, and accountability**		Risk score **15**
Strategic Risk No.6: **Compliance culture and accountability**		
If the desired accountability approach and framework changes are not achieved	***Then*** compliance and appropriate action and consequences will remain sub-optimal	***Resulting in*** the Trust struggling to deliver key outcomes such as CIPs, mandatory requirements such as statutory and mandatory training, as well as wider needed changes and improvements.

	Impact	Likelihood	Score	Assurance	Risk Trend
Inherent	4	5	20	4 TBC	
Current	**3**	**5**	**15**		
Target	2	2	4		

Risk Lead	Chief People Officer	Assurance committee	People

Controls	Assurances against stated controls, with assurance level *1st line (front line); 2nd (corporate); 3rd (independent)*	Assurance score
Strategies and Plans		
Accountability Framework	TBC	
Policies	TBC	
Stat Mand training	TBC	
Q&S framework	TBC	
People Strategy	People Committee reports (2) Annual report to Board (2)	6
ENHT Production System	Reported annually to board (2)	6
EDI Strategy	People Committee reports (2) Annual report to Board (2) EDI Steering Group (1)	
Governance & Performance		
Revised Scheme of Delegation	ARC and Board review annually (2)	6
Balanced scorecard	Divisional Board reports (1)	4
Well-led review action plan	ARC & TMG progress reports (2)	4
Management Structures		
Divisional operating model – structure and responsibilities	Reviewed as part of Trust Management Group (1)	4
Divisional Performance reviews	Reviewed as part of Trust Management Group (1)	6
Divisional boards	Divisional Performance Reviews (1)	6
Grow together reviews and talent forums	Reported annually to PCC (2)	6
Improvement Partner		

Principles and values related to the ENH Production system to be embedded through training programmes	To be reported to PCC (2 once start)	3
Positive leadership rounds	To be reported to PCC (2 once start)	3
Core skill and knowledge programmes (management and Leadership)	Reported annually to PCC (2)	4
Staff Engagement and Involvement		
Staff networks /Freedom To Speak Up/ Meet the Chief Executive (Ask Adam)	Voice of our people featured at PCC (2) Staff story featured at Trust Board (2)	6
Internal communications - all staff briefing, In Brief and newsletter, leadership briefings	Reported through CEO report and IPR (2)	6
Reciprocal mentorship programme	Update provided to PCC (2)	6

Gaps in Controls and Assurances	Actions and mitigations to address gaps	Lead	Target date
• Time to complete all required training without protected time	• Reviewing stat/mand to basic minimums & core priorities	•	•
• Organisation goals affectively cascaded to all divisions and teams	• Focus on driving up Grow Together Review compliance rates • Assessment of dissemination and understanding of goals as part of Positive Leadership Rounds • Reviewed in divisional performance review meetings	• Exec and Divisional Directors • TP	• Mar 25
• Values not always understood and demonstrated by all staff	• TBC	• CEO	• Mar 25
• Leadership culture modelling/enabling accountability	• TBC	•	•

Current Performance – Highlights from the Integrated Performance Report:
• CIPs delivery • Stand/Mand training • GROW • Updated risks • Referrals to professional/regulatory bodies e.g. NMC/CQC

Associated Risks on the Corporate Risk Register		
Risk no.	Description	Current score
	N/A	

Strategic Aim: **Deliver seamless care for patients through effective collaboration and co-ordination of services within the Trust and with our partners**			**Risk score 12**
Strategic Risk No.7: **System instability**			
If significant and rapid changes are made to NHS oversight and delivery structures	***Then*** decision making may be slowed due to increased ambiguity or management capacity	***Resulting in*** important transformation not keeping pace with patient need.	

	Impact	Likelihood	Score	Assurance	Risk Trend
Inherent	4	4	16	**3**	
Current	**4**	**3**	**12**		
Target	3	3	9		

Risk Lead	Chief Executive	Assurance committee	FPPC

Controls	Assurances against stated controls, with assurance level *1st line (front line); 2nd (corporate); 3rd (independent)*	Assurance score
Strategies and Plans		
Trust Strategy and Trust objectives·linking and helping deliver the ICB strategy	• Annual Board approval of new strategic priorities (2) • Annual Board review of Strategy delivery (2) • CEO update to Board includes system developments (2)	6
ICB strategy includes creation of HCPs as multi-agency delivery vehicles	• Approved by ICB (3) • ICB Chair & CEO walks the Board through ICB priorities at least annually • Formal letter from ICB establishing the Trust as a host provider	6
HCP Strategy pillar covers ways of working	• ToRs HCP Partnership Board & committees approved by ICB (3) – but lacks Trust Board oversight beyond minutes of HCP	4
Leadership of the HCP Delivery Unit	• Regular meetings and correspondence with the Director of Development of the HCP	5
Allocate senior level resource to system working	• Dedicated time allocated to Chief Kaizen Officer to work on HCP based activity	5
Financial Controls		
System finances reviewed monthly	• DoFs bi-weekly meeting (1) • CEOs monthly meeting (1) • ICB Board & Finance Committee (3) review system finances • Report to Trust Board includes the system financial position (2)	6
Governance & Performance Management Structures		
NHSE East of England oversight of ICS	• Letter of assessment from NHSE Director to ICB (3)	N/A
ICS Directors of Finance bi-weekly meeting	• Reports/updates to FPPC (2)	6
Relational		

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Provider Trust Chairs Forum	• Chair's update to Board where relevant (2)	N/A
Trust CEOs group weekly meetings	• CEO's update to Board where relevant (2)	N/A
Trust CEO now a member on the ICB	• Minutes from meetings (3)	6
Trust CEO is the SRO for the HCP	• Minutes from HCP go to the Trust Board (3)	6

Gaps in Controls and Assurances	Actions and mitigations to address gaps	Lead	Target date
• Improving how is the Board currently assured/updated on progress with system working	• HCP Committee terms of reference approval by Trust Board, with NED representation	• CEO	• July 25
• Trust objectives linking and helping deliver the ICB strategy	• When 25-26 priorities ICB/HCP priorities will be explicitly referenced.	• CEO	• Q1 25
• Does the ICB BAF cover the risk of impact of major change	• Propose to ICB that the ICB BAF includes this risk	• CEO	• End of Q1 25/26
• Lack of a shared view across Providers and ICB on optimal structuring to create a sustainable financial and operational delivery model	• CEOs developing the delivery strategy for the ICB	• CEO	• Q1 25
• Embedding the effectiveness of the HCP	• Carry out HCP Board effectiveness review	• CEO	• Q4 25
• Uncertainty about the new ICB regional landscape and the potential implications for the Trust depending on the preferred model	• Model ICB being produced nationally – ICB plans expected by end of May 25	• NHSE	• June 25
• Anticipated resource allocation from ICB not yet agreed limiting the ability to expand dedicated resource	• Regularly discussed in ICB CEO meetings • Transformation programme timetable will make resource allocations clear shortly	• CEO • ICB	• Q2 25

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Current Performance – Highlights from the Integrated Performance Report:
• The over-arching system financial break-even plan 2025-26 • NHSE oversight framework assessment of ICB and the Trust • ICB performance dashboard metrics tracking progress against HCP priorities

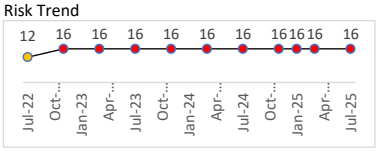
Associated Risks on the Corporate Risk Register		
Risk no.	Description	Current score
~~1923~~	~~Emergency Department pressures~~	~~16~~

Strategic Aim: **Deliver seamless care for patients through effective collaboration and co-ordination of services within the Trust and with our partners**	Risk score **16**
Strategic Risk No.8: Improving flow and p~~P~~**erformance ~~and flow~~**	

If we do not achieve the improvements in flow within the Trust and wider system	***Then*** the Trust's key performance targets will not be met	***Resulting in*** poor quality care and adverse outcomes~~increased avoidable Serious Incidents~~, wider health improvements not being delivered and regulatory censure

	Impact	Likelihood	Score	Assurance
Inherent	4	4	16	4
Current	**4**	**4**	**16**	
Target	4	2	8	

Risk Trend



Risk Lead	Chief Operating Officer	Assurance committee	FPPC

Controls	Assurances against stated controls, with assurance level *1st line (front line); 2nd (corporate); 3rd (independent)*	Assurance score (from 7 levels)
Strategies and Plans		
Performance~~Recovery~~ trajectories (Elective, cancer, diagnostics), ~~refreshed for 24/25 and being~~ refreshed for 25/26	• Board IPR; transformation reports; escalation reports (2) • FPPC (IPR & deep dives papers (2) • Access Board reports (2) • Accountability Framework (2)	6
Cancer timed pathway analysis work and associated action plan	• Herts & West Essex Cancer Board reports (3) • Cancer Board reports (1) • Access Board reports (2) • Accountability Framework (2)	6
UEC Phase 2 Improvement Plan	• Board report (2) • FPPC reports (2) • Access Board report (2) • UEC Board minutes (2) • GIRFT GEMI score (3) • Accountability Framework (2)	6

Gaps in Controls and Assurances	Actions and mitigations to address gaps	Lead	Target date
• Impact of ERF cap and requirement to improve RTT by 5% in 2025/6	• Reverse engineered RTT trajectories being developed based on detailed demand and capacity analysis • Increase validation volume via Validation Sprint activity • Validation strategy in development • IPR updated to include 25/6 RTT targets: 5% improvement in RTT and 1st appt within 18	• Laura Moore, Head of Performance & Planning • Alison Gibson, Deputy COO	• March 2026~~5~~ [Original: Mar 25]

	weeks by 3/26; Reduce to max of 1% the % of patients waiting 52 weeks+		
• Improve UEC pathways	• Sharpen ED processes • Optimise SDEC pathway • Optimise Frailty pathway • Redesign of specialty pathways • Full Capacity Protocol refreshed and in use • Mental Health Urgent Care Centre at Lister • National UEC Plan (June 2025) • Refresh implementation of Principles of Safe & Effective Emergency Care	• Claire Gowland, Interim Lead DD • Junaid Qazi, Divisional Medical Director • Justin Daniels, Medical Director	• March 2026~~June 2025~~ [Original: June 25]
• Ambulance Handover ~~intelligent conveyancing - improving~~	• System solution to intelligent conveyancing/ambulance intelligence will improve, but not fully address the challenge – ongoing • EEAST trialing call before convey and access to the stack to identify those patients who would be best cared for by alternative providers • EEAST Local Operations Cell participation in HWE System Coordination Centre • *Handover @ 45* launched Nov 2024 • Lister ED new Ambulance handover process May 2025 • National UEC capital allocation for extended Ambulance Handover bay, April 2025	• Lucy Davies, COO • EEAST • HWE SCC	• March 2026~~Jan 2025~~ [Original: Jan 25]
• Robust pathway oversight and earlier discharge planning for medical specialties • Lack of social care and community capacity to support discharge • Utilisation of Hospital at Home not yet optimal	• Work being undertaken to increase uptake of Hospital at Home • Work ongoing with system partners on discharge processes • Regular MADE weeks • Further work required to prevent admission for frailty patients includes a frailty assessment unit in ED	• Redeemed Mzila, Head of Site • Junaid Qazi • Moreblessing Zvorwadza, Divisional Nursing Director	• March 2026~~March 2025~~ [Original: Mar 25]
• Diagnostic wait times – MRI and U/S, Audiology	• Weekly PTL tracking meetings for all modalities now in place. • Clear recovery trajectories created with action plans to deliver compliance by March 25 (excluding MRI, Audiology) – achieved • 25/6 MRI capacity tactical plan agreed • Robust plan for long term MRI capacity to bridge gap in demand • Optimise use of community diagnostic capacity • MRI outsourcing now in place with commercial provider • Audiology capital Lister underway @June 25 • Audiology capital Hertford County allocated @June 25 • Audiology HWE mutual aid discussions underway	• Sarah James • Claire Moore, Lead DD	• March 2026~~March 2025~~ [Original: Mar 25]

• Theatre utilisation and pre – tci cancellation rate	• Recruitment plans ongoing. • 'Drumbeat' huddles to manage activity	• Claire Moore, Lead DD	• March 2026~~Dec 2025~~ [Original: Dec 25]

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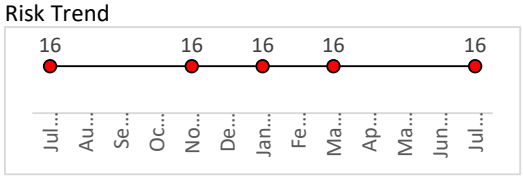
Current Performance – Highlights from the Integrated Performance Report:
• % of 62 day PTL over 62 days • 28 day faster diagnosis • Cancer 31 day waits • RTT performance • 65 and % 52 weeks RTT • % of elective patients 1st appt within 18 weeks • Ambulance handovers • ED 4 and 12 hour performance • Diagnostic waits / DM01 • Patients not meeting the criteria to reside

Associated Risks on the Board Risk Register		
Risk no.	Description	Current score
~~0064~~	~~Risk to staff and patients' wellbeing and quality of care delivered due to an increase in mental health patient admissions and attendances and reduced admission spaces/beds~~	~~20~~
~~0051~~	~~Ophthalmology service recovery~~	~~16~~
3470	The risks associated with flow in ED related to congestion	16

Strategic Aim: **Deliver seamless care for patients through effective collaboration and co-ordination of services within the Trust and with our partners**		**Risk score** ~~16~~20
Strategic Risk No.9: **Future of cancer services**		
If the future of cancer services at Mount Vernon and Lister is not resolved promptly by strategic partners	***Then*** there is a risk of unplanned reconfiguration of cancer services and the inability of the Trust to undertake long-term strategic planning that is financially viable	***Resulting in*** fragmented clinical care with the inability to optimise clinical outcomes; material financial destabilisation; the inability of the Trust to deliver its legal duties; and reputational damage.

	Impact	Likelihood	Score	Assurance	Risk Trend
Inherent	4	4	16	4	
Current	**4**	**4**	**16**		
Target	2	4	8		

Risk Lead	Chief Operating Officer	Assurance committee	QSC

Controls	Assurances against stated controls, with assurance level *1st line (front line); 2nd (corporate); 3rd (independent)*	Assurance score
Clinical Strategy	• Mount Vernon Programme review with NHSE – quarterly (3) • Cancer peer review (3) that reports to QSC • National annual cancer patient experience survey (3)	5
Cancer divisional risk register (up to date with no overdue risks and all risks have mitigation actions)	• RMG monthly and deep dive (1) • Divisional Performance review (1) • Corporate Risk Register to Board (2)	5
Fabric improvement capital investment to address the sites two year backlog maintenance priorities (partial but not a long-term control)	Q&S Committee reports as required (2) NHSE sustainability group (3) – quarterly	4
New Q&S governance structure Mortality and morbidity meeting oversight of risk (Q&S meetings)	Trust Mortality Committee (1) with 30 day SACT mortality data	~~3~~5
Business Plan approved for joint acute oncology provision and ward at Watford	Mount Vernon Programme Board (3) AOS Steering Group with NHSE and ICB reps (3~~)~~). AOS consultants out to advert and 2/3 ACP post at Watford appointed into.	4
Cancer services deep dives to QSC and FPPC	QSC and FPPC reports (2)	4
Standing Board updates on progress with the Mount Vernon transfer	Updates to each Board (2)	4

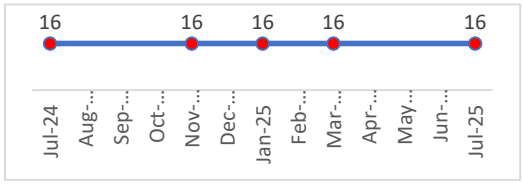
Gaps in Controls and Assurances	Actions and mitigations to address gaps	Lead	Target date
• ~~Clear ownership and roles and responsibilities for making decisions on the future of the current~~	• ~~Add to agenda/ensure continued visibility on joint ICB/NHSE cancer contract meetings to push for prompt decision-making~~	• ~~NHSE~~ENHT MVCC Programme Director	• April 2025 - complete

~~service and ENHT's role in this~~ • ~~Fragmented decision-making between ICB and NHSE which could make decision-making more challenging~~			
• Public awareness of the impact of the delay on quality of services	• Proactive communication plan if gap agreed. Consultation planned in autumn 25.	• NHSE/ICB	• Nov 2025
• ~~Access to specialist oncology advice at local DGH sites for those that cannot access Mount Vernon~~	• ~~Need a clinical oncology strategy for Lister once Mount Vernon transfers~~	• ~~Sarah James~~	• ~~April 2025~~ • Complete
• ~~Business continuity plan should acute MV services need to close suddenly~~	• ~~Business continuity/evacuation plan pre-agreed with other cancer providers (UCLH, Circle, Watford, Hillingdon etc)~~This is now complete and sustainability multi-stakeholder panel now in situ with UCLH, NHSE, Watford and Hillingdon	• ~~Paula Statham~~	• ~~Dec 2025~~Complete
• Outcome of service options to NHSE to enable Trust planning	• Obtaining answer from NHSE/ICB about capital and revenue plans to sustain current services	• Lucy Davies	• April 2025 – flag to FPPC
• Lack of a financial mitigation plan for sudden loss of services or significant interim costs whilst awaiting a decision	• Work with NHSE to identify interim funding opportunities that address investment above and beyond NHS contract negotiations	• Martin Armstrong	• Dec 2025
• ~~Assurance gap: Improving QSC oversight of the Mount Vernon strategic plans/patient pathways~~	• ~~Introduce regular assurance/progress reports to QSC until this risk is resolved~~	• ~~Justin Daniels~~	• ~~Nov 2025~~ • Complete
• Even if the building is fully equipped it does not fully resolve the issue of fragmented care	• Services need to move to an acute site	• NHSE	• April 2026

Current Performance – Highlights from the Integrated Performance Report:
• 62 and 31 day cancer performance standards • Faster diagnosis standard • 30 day SACT mortality data • COSD cancer data

Associated Risks on the Board Risk Register		
Risk no.	Description	Current score
3028	Risk of delay in transfer of deteriorating patients [from Mount Vernon] with co- morbidities as a result of inadequate onsite acute facilities to support patient care.	20

Strategic Aim: **Continuously improve services by adopting good practice, maximising efficiency and productivity, and exploiting transformation opportunities**		Risk score **16**
Strategic Risk No.10: **Digital transformation**		
If the necessary digital transformation improvements are not prioritised, funded or delivered	***Then*** the Trust will lack the digital means to deliver its plans including using obsolete legacy systems that are unsupportable	***Resulting in*** 1) not delivering transformation plans that are crucial to improving efficacy and productivity 2) not achieving the nationally mandated minimum digital foundations and 3) a failure to optimize patient experience and quality of care

	Impact	Likelihood	Score	Assurance	Risk Trend
Inherent	4	4	16	4	
Current	**4**	**4**	**16**		
Target	4	3	12		

Risk Lead	Chief Information Officer	Assurance committee	OneEPR

Controls	Assurances against stated controls, with assurance level *1st line (front line); 2nd (corporate); 3rd (independent)*	Assurance score
Strategies and Plans		
Board approved 23/24 Strategic Objectives	• Annual Board review (2)	4
23/24 Digital Strategy and Roadmap	• Digital programme boards (1) • Assurance submissions to NHSE for front line digitization (3) • National benchmarking reports (3)	5
Governance & Performance Management Structures		
OneEPR Committee established May 2025	• All reports to the committee (2)	TBC
Clinical Digital Design Authority (Clinical Decision Committee) with clinical safety review signed off by clinical directors.	• Programme update monthly report to FPPC (2) • Report to Programme Board (1) • Report to Clinical Safety Committee (1)	6
Training and Adoption		
Training and development programme	KPI reporting to Programme Board (1)	2
Learning events, safety huddles and debriefs	Reports to Divisional Boards (1)	2

Gaps in Controls and Assurances	Actions and mitigations to address gaps	Lead	Target date
Control gaps • Market movement from Perpetual licensing to Software as a Service (SaaS) is preventing the capitalisation of Software licenses and deployment	**Control treatments** • Review Vendor licensing models 1/8/23 • Identify NHS E revenue funding models (not capital) 1/8/23 • Identify Blended Capital/revenue models 1/8/23 • Trust funds identified to fund EPR programme. • Fully mitigated for EPR	Mark Stanton	June 26
• Variation in business-as-usual systems and processes	• Adoption of lean thinking in pathway redesign model as part of the ENHPS for later phases of the project	Mark Stanton	Jan 26

• Improvement training compliance is variable across staff groups and levels of seniority	• Develop a robust training program to include classroom and f2f and communicate requirements with notice via the programme board. Senior stakeholder to share responsibility • Date realigned with plan	MS	June 25
• ~~Digital Solutions and Delivery team has been historically funded through Capital using contract resource, but new Capitalisation rules mean a move towards revenue, this could significantly reduce the size of the team for Road map deliveries~~	• ~~Move towards a substantive team to reduce spend~~ • ~~Seek NHS E revenue funding streams~~ • ~~This is now funded through an agreed Benefits case through Trust Revenue~~	~~MS~~	CLOSED
• Training delivery	• Recruitment of a training lead as per the programme plan • Date realigned with plan	MS	~~Feb 25~~ July 25 [Originally Feb 25]
• Engagement with the divisions to embed digital as part of learning events, safety huddles and debriefs	• Engagement at appropriate forums to raise awareness and understanding – has started an ongoing • Embedded into programme delivery and governed by Clinical and Operations group (Chaired by Deputy COO)	MS	Closed
Assurance gaps • Performance data indicates issues with sustaining changes & embedding culture of improvement & learning	**Assurance treatments** • Cultural changes via ENH production System	TGT	~~Dec 25~~ Ongoing {Originally Dec 25]
• ~~Programme milestones and KPIs reflect compliance issues with Trust project management principles~~	• ~~New strategic project management governance framework project Management established. Ext audit scheduled~~ • ~~Project Management model in place~~	~~MS~~	CLOSED
• Engagement in the design and adoption of digital systems	• Review of mechanisms to ensure stakeholders have adequate time to engage in design and transformation. • Executive Programme Board to provide oversight and leadership regarding alignment resourcing and decisions	MS	Ongoing
• ~~Alignment of new transformation portfolio digital requirements with overarching Digital Roadmap~~	• ~~Executive Programme Board to provide oversight and leadership regarding alignment resourcing and decisions~~ • ~~Full governance model in place and aligned with Outpatients transformation under a board sub commitee~~	~~MS~~	CLOSED

Current Performance – Highlights from the Integrated Performance Report:
• Dedalus initiated a region wide workshop to ensure they met the Delivery timescales and have presented a new delivery model for the Trust. • All position in the OneEPR team now filled

Associated Risks on the Board Risk Register		
Risk no.	Description	Current score
3486	Risk of Cyber Attack	~~20~~16

Strategic Aim: **Continuously improve services by adopting good practice, maximising efficiency and productivity, and exploiting transformation opportunities**		**Risk score** 12
Strategic Risk No.11: Change management		
If the Trust does not develop the change management capacity and capability required to transform its operations and performance	***Then*** the Trust will not increase its agility and adaptiveness and will continue to observe evidence a non sub-optimal hierarchical culture which is resistant to change	***Resulting in*** not seizing opportunities to further our wider goals, improve productivity and morale and reduce waste

	Impact	Likelihood	Score	Assurance	Risk Trend
Inherent	4	4	16	4 TBC	
Current	**4**	**3**	**12**		
Target	3	2	6		

Risk Lead	Chief Kaizen Officer	Assurance committee	People & Culture

Controls	Assurances against stated controls, with assurance level *1st line (front line); 2nd (corporate); 3rd (independent)*	Assurance score
Strategies and Plans		
Trust Strategy, Vision and Annual Goal cascade	Board report – annual progress (2)	4
People Strategy	Board report – annual progress (2) People and Culture Committee reports (2)	6
EDI Strategy	Board report – annual progress (2) People and Culture Committee reports (2)	4
Freedom to Speak Up Strategy	Board report – annual progress (2)	6
Demand and capacity modelling and workforce plan	Finance, Performance and Planning Committee	2
Operational Systems and Resources		
PSIRF	Quality and Safety Committee quarterly updates (2)	4
Governance & Performance Management Structures		
TGT oversight of ENH Production System programme	Trust Guiding Team - monthly (2)	6
Staff survey	Board report – annual (3)	4
Improvement Partnership contract management	Trust Guiding Team - monthly (2)	6
Executive Value Stream Guiding Teams	Trust Guiding Team - monthly (2)	2
Divisional operating model – structure and responsibilities	Reviewed as part of Trust Management Group (1)	4
Core skill and knowledge programmes (management and leadership)	People and Culture Committee reports (2)	4

Gaps in Controls and Assurances	Actions and mitigations to address gaps	Lead	Target date
• ENHPS roll-out remains targeted at innovators and early majority of the adoption curve	• ENHPS 2025/26 work plan approved via TGT. • Intro to ENHPS Plus training programme launch. • Divisional and corporate training target trajectories.	• KOH • KOH • KOH	Mar 26 Jul 25 Mar 26

	• Establish ENHPS learning network • Development of production board for comms stories • Health check assessment process	• KOH • KOH • KOH	Jun 25 Complete Aug 25
• Limited capability in managing change and leaders learning to coach and become problem framers, not fixers	• ENHT KPO Leaders Certification. • Expansion of ENHPS for Leaders cohorts. • Increase frequency of positive leadership rounds. • Expansion of transformational/ visioning events i.e. RIPW and 3P	• KOH • KOH • KOH • KOH	Sept 25 Mar 25 Oct 25 Mar 26
• Managers understanding their duties and responding to resolve issues and concerns raised by staff (i.e. Freedom to Speak Up framework)	• 2025/26 management competencies training programme. • Freedom to speak up training included in required learning for all staff on ENH Academy. • Coaching and mentoring framework and guideline implementation • Grow Together reviews and 1-1 conversations. • NHSE ClinOps programme launch.	• RC • AH • AH • TP • KOH	Mar 26 Mar 26 Oct 25 Sept 25 Mar 26
• Strategic goal alignment and deployment process	• Annual strategic goal cascade process. • Value stream development process • Roll-out of advanced daily management including strategic alignment boards • 'Team Talk - setting our team objectives' roll out • New accountability framework launch.	• KOH • KOH • KOH • KOH • MA	Aug 25 Mar 26 Mar 26 Aug 25 Sept 25
• Organisation development capacity to undertake support and development in identified areas to improve leadership practice and engagement	• Targeted focus of management competency framework • Healthy Teams roll-out • Staff survey team talks and action plans • Local values charters development • Care Support Pyramid	• AH • AH • AH • AH • AH	Mar 26 Mar 26 Mar 26 Mar 26 Mar 26

Current Performance – Highlights from the Integrated Performance Report:
• Leadership live event involving top 100 leaders held 1 May to formally launch 2025/26 strategic goal cascade. • ENHT KPO-led ENHPS for Leader's cohorts launched week commencing 2 June. • Divisional and corporate trajectories agreed for Intro to ENHPS 20% target. • New accountability framework signed-off at Board Seminar 4 June. • Confirmation and launch of NHSE ClinOps programme with ENHT 'accelerator site' status confirmed for EoE 9 June. • 3P strategy and visioning event for acute paediatric services completed week commencing 9 June. • Launch of ENHPS Network event 17 June. • Launch of Planned Care Value Stream 18 June.

Associated Risks on the Board Risk Register		
Risk no.	Description	Current score
	N/A	

East and North Hertfordshire NHS Trust

Integrated Performance Report

Month 02 | 2025-26

	P	?	F
H, L	3	8	2
	6	43	14
H, L	0	6	2

Data correct as at 18/06/2025

Performance Highlights

East and North Hertfordshire NHS Trust

Quality

- *C difficile (C diff.)* infection (CDI) - the number of CDI cases for the month of May-25 is 2.
- VTE assessment completion has continued to improve.
- The rolling 12-month crude mortality rate continued to decrease, HSMR remained below 100 and SHMI is same as previous month in their latest respective publications.
- There is a single 3SD outlier - pulmonary cardiac - work has been done to check this is not related to failure to prescribe thromboprophylaxis.
- Complaints have increased over the last 6 months - work has been done to understand the clinical areas and the reasons for these complaints.

Operations

- **Urgent and Emergency Care**: Improvements continue, both 4 hour (74.25%) and ambulance handover. Focus is to reduce long length of stay within ED. The Trust continues to improve ranking and is now 50/122 nationally and 4/13 within the region (May data).
- **Cancer Waits**: The Trust achieved all three national targets in April, with the 62 day performance the best in the last two years.
- **Referral To Treatment (RTT)** (excluding Community Paeds): 18 week performance continues to improve with 62.9% of patients waiting under 18 weeks, 1.3% away from the March 2026 target.
- **Diagnostics**: The % of patients waiting over 6 weeks has deteriorated from 50.6% to 53.2% due to vacancies and absences. Audiology and MRI remain the concern, with plans to address shortfalls in capacity. Trust executives are supporting with paediatric audiology.

Finance

- The Trust approved a breakeven plan for 25/26. This plan assumes that a £35.8m cost improvement programme will be delivered.
- At Month 2, the Trust has reported an actual YTD deficit of £8.2m. This is in line with phased plan expectations.
- The Trust has seen improvement in a number of the run rate hotspot areas that had consistently defined pay performance during the previous year.
- Overspends against medical staffing and CSW budgets are a key feature of the pay position in the opening months of 25/26.
- The CIP plan for month is only £1.3m, so there will need to be a significant step up in financial performance in the coming months of the year.
- Elective income performance in the YTD has been below plan across inpatient and daycase points of delivery.

People

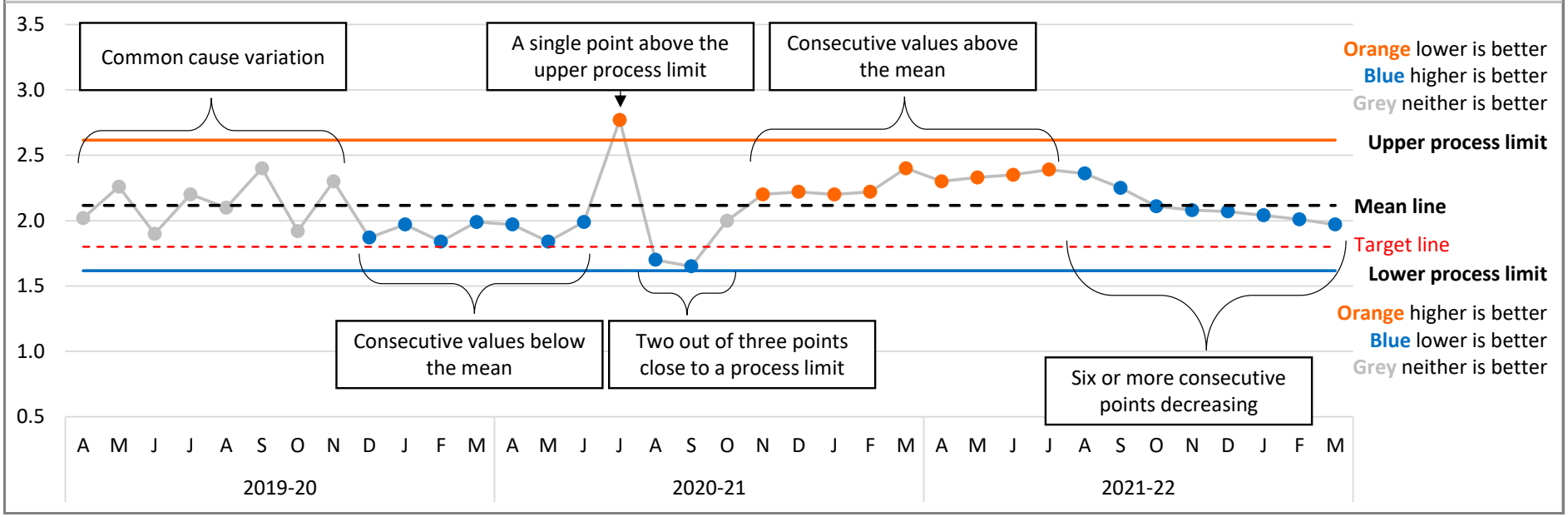
- Turnover rates continue to reduce and are now below 8%
- Bank and Agency spend continue to reduce and total FTE usage is below 25/26 targets
- On-going Grow Together communications shared via the Trust News with monthly open online support for managers now in place until August.
- There were increased sickness absence levels in May, in particular due to stress and mental health issues. Referrals from managers for occupational health advice have also increased, stress and mental health issues are currently the most common reason for referral.
- The last of the Band 2/3 CSW/MSW extended scope payments have been processed and final payments will be made to remaining handful of staff in July.

Month 02 | 2025-26

Integrated Performance Report

East and North Hertfordshire NHS Trust

How to interpret a Statistical Process Control (SPC) Chart



Variation

H L	Special cause variation of **concerning** nature due to **H**igher or **L**ower values
H L	Special cause variation of **improving** nature due to **H**igher or **L**ower values
	Common cause variation No significant change

Assurance

F	Consistent Failing of the target Upper / lower process limit is above / below target line
P	Consistent Passing of target Upper / lower process limit is above / below target line
?	Inconsistent passing and failing of the target

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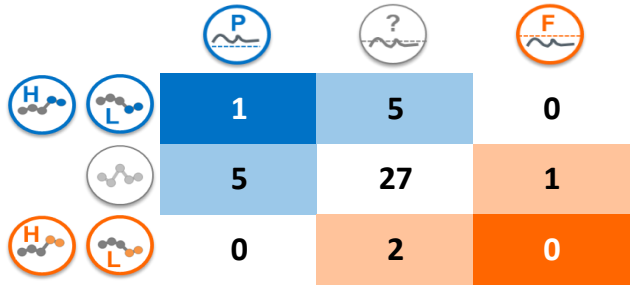
NHS Trust

Quality

Month 02 | 2025-26



Quality

East and North Hertfordshire NHS Trust

Summary

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Patient Safety Incidents	Total incidents reported in-month	May-25	n/a	1,660	H		8 points above the Mean No target
Infection Prevention and Control	Hospital-acquired MRSA Number of incidences in-month	May-25	0	0		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired c.difficile Number of incidences in-month	May-25	0	2		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired MSSA Number of incidences in-month	May-25	0	0		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired e.coli Number of incidences in-month	May-25	0	3		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired klebsiella Number of incidences in-month	May-25	0	1		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired pseudomonas aeruginosa Number of incidences in-month	May-25	0	1	L	?	7 points below the mean Metric will inconsistently pass and fail the target
	Hospital-acquired CPOs Number of incidences in-month	May-25	0	0	L	?	24 points below the mean Metric will inconsistently pass and fail the target
	Hand hygiene audit score	May-25	80%	93.8%		P	Common cause variation Metric will consistently pass the target
Safer Staffing	Overall fill rate	May-25	n/a	87.0%	H		3/3 points closer to upper process limit No target
	Staff shortage incidents	May-25	n/a	39			Common cause variation No target

Month 02 | 2025-26

Quality

Summary

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Cardiac Arrests	Number of cardiac arrest calls per 1,000 admissions	May-25	n/a	0.87			Common cause variation No target
	Number of deteriorting patient calls per 1,000 admissions	May-25	n/a	1.19			Common cause variation No target
Sepsis Screening and Management	Inpatients receiving IVABs within 1-hour of red flag	May-25	95%	86.5%		?	Common cause variation Metric will inconsistently pass and fail the target
	Inpatients Sepsis Six bundle compliance	May-25	95%	55.6%	H	?	8 points above the mean Metric will inconsistently pass and fail the target
	ED attendances receiving IVABs within 1-hour of red flag	May-25	95%	91.7%		?	Common cause variation Metric will inconsistently pass and fail the target
	ED attendance Sepsis Six bundle compliance	May-25	95%	69.4%		F	Common cause variation Metric will consistently fail the target
VTE Risk Assessment	VTE risk assessment stage 1 completed	May-25	85%	72.1%	L	?	8 points below the mean Metric will inconsistently pass and fail the target
HATs	Number of HAT RCAs in progress	May-25	n/a	209	H		4 points above the upper process limit No target
	Number of HAT RCAs completed	May-25	n/a	0			Common cause variation No target
	HATs confirmed potentially preventable	May-25	n/a	0	L		7 points below the mean No target
PU	Pressure ulcers All category ≥2	May-25	0	11		?	Common cause variation Metric will inconsistently pass and fail the target

Month 02 | 2025-26

Quality

Summary

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Patient Falls	Rate of patient falls per 1,000 overnight stays	May-25	n/a	3.5			Common cause variation No target
	Proportion of patient falls resulting in serious harm	May-25	n/a	0.0%			Common cause variation No target
Other	National Patient Safety Alerts not completed by deadline	Sep-24	0	0			Metric unsuitable for SPC analysis
Friends and Family Test	Inpatients positive feedback	May-25	95%	97.4%			Common cause variation Metric will inconsistently pass and fail the target
	A&E positive feedback	May-25	90%	86.5%			Common cause variation Metric will inconsistently pass and fail the target
	Maternity Antenatal positive feedback	May-25	93%	90.2%			Common cause variation Metric will inconsistently pass and fail the target
	Maternity Birth positive feedback	May-25	93%	90.0%			1 point below the lower process limit Metric will inconsistently pass and fail the target
	Maternity Postnatal positive feedback	May-25	93%	100.0%			11 points above the upper process limit Metric will inconsistently pass and fail the target
Friends and Family Test	Maternity Community positive feedback	May-25	93%	97.8%			Common cause variation Metric will inconsistently pass and fail the target
	Outpatients FFT positive feedback	May-25	95.0%	96.3%			Common cause variation Metric will inconsistently pass and fail the target
PALS	Number of PALS referrals received in-month	May-25	n/a	351		-	Common cause variation No target

Month 02 | 2025-26

Quality

Summary

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Complaints	Number of written complaints received in-month	May-25	n/a	107	H	-	3 points above the upper process limit No target
	Number of complaints closed in-month	May-25	n/a	64		-	Common cause variation No target
	Proportion of complaints acknowledged within 3 working days	May-25	75%	96.1%		P	Common cause variation Metric will consistently pass the target
	Proportion of complaints responded to within agreed timeframe	May-25	80%	60.4%	H	?	9 points above the mean Metric will inconsistently pass and fail the target
Maternity Safety Metrics	Caesarean section rate Total rate from Robson Groups 1, 2 and 5 combined	Jul-24	60 - 70%	70.4%		?	Common cause variation Metric will inconsistently pass and fail the target
	Massive obstetric haemorrhage >1500ml vaginal	May-25	3.3%	3.2%		?	Common cause variation Metric will inconsistenly pass and fail the target
	3rd and 4th degree tear vaginal	May-25	2.5%	2.4%		?	Common cause variation Metric will inconsistenly pass and fail the target
	Massive obstetric haemorrhage >1500ml LSCS	May-25	4.5%	5.3%		?	Common cause variation Metric will inconsistenly pass and fail the target
	3rd and 4th degree tear instrumental	May-25	6.3%	2.3%		?	Common cause variation Metric will inconsistently pass and fail the target
	Term admissions to NICU	May-25	6.0%	7.2%		?	Common cause variation Metric will inconsistently pass and fail the target
	ITU admissions	May-25	0.7	0		?	Common cause variation Metric will inconsistently pass and fail the target

Month 02 | 2025-26

Quality

East and North Hertfordshire NHS Trust

Summary

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Maternity Other Metrics	Smoking at time of booking	May-25	12.5%	3.5%			Common cause variation Metric will consistenly pass the target
	Smoking at time of delivery	May-25	2.3%	3.5%			Common cause variation Metric will inconsistently pass and fail the target
	Bookings completed by 9+6 weeks gestation	May-25	50.5%	69.8%			Common cause variation Metric will consistenly pass the target
	Breast feeding initiated	May-25	72.7%	76.3%			Common cause variation Metric will inconsistently pass and fail the target
	Number of MNSI PSII	May-25	0.5	0			Common cause variation Metric will inconsistently pass and fail the target
Mortality	Crude mortality per 1,000 admissions In-month	May-25	12.8	9.9			Common cause variation Metric will inconsistently pass and fail the target
	Crude mortality per 1,000 admissions Rolling 12-months	May-25	12.8	8.8			Rolling 12-months - unsuitable for SPC
	HSMR In-month	Feb-25	100	92.9			Common cause variation Metric will inconsistently pass and fail the target
	HSMR Rolling 12-months	Feb-25	100	84.2			Rolling 12-months - unsuitable for SPC
	SHMI In-month	Nov-24	100	81.7			Common cause variation Metric will inconsistently pass and fail the target
	SHMI Rolling 12-months	Nov-24	100	90.2			Rolling 12-months - unsuitable for SPC

Month 02 | 2025-26

Quality

Summary

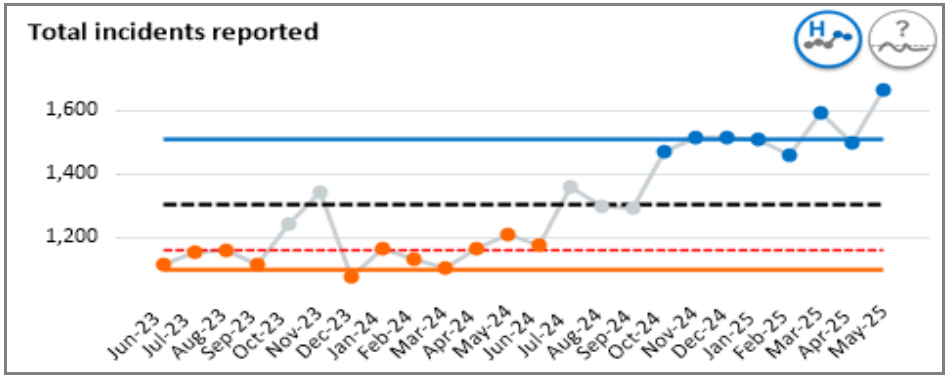
Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Re-admissions	Number of emergency re-admissions within 30 days of discharge	Mar-25	n/a	667			1 point below the lower process limit No target
	Rate of emergency re-admissions within 30 days of discharge	Mar-25	9.0%	5.6%			1 point below the lower process limit Metric will consistently pass the target
Length of Stay	Average elective length of stay	May-25	2.8	2.4			Common cause variation Metric will consistently pass the target
	Average non-elective length of stay	May-25	4.6	5.2			Common cause variation Metric will inconsistently pass and fail the target
Palliative Care	Proportion of patients with whom their preferred place of death was discussed	May-25	n/a	97.8%			Common cause variation No target
	Individualised care pathways	May-25	n/a	50			Common cause variation No target

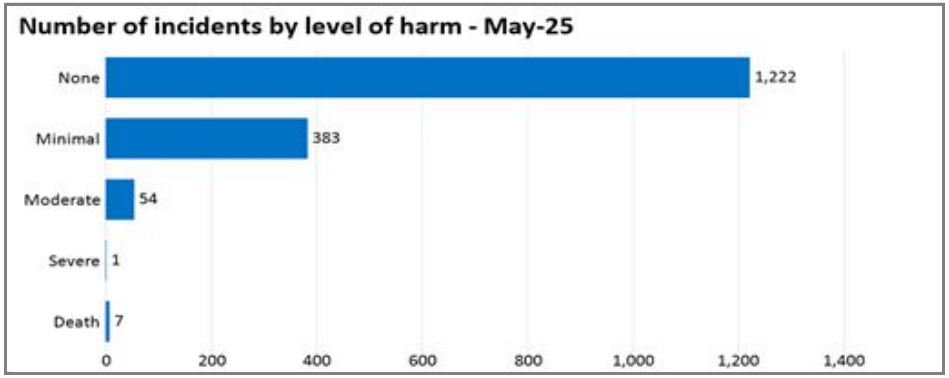
Month 02 | 2025-26

Quality

Patient Safety Incidents

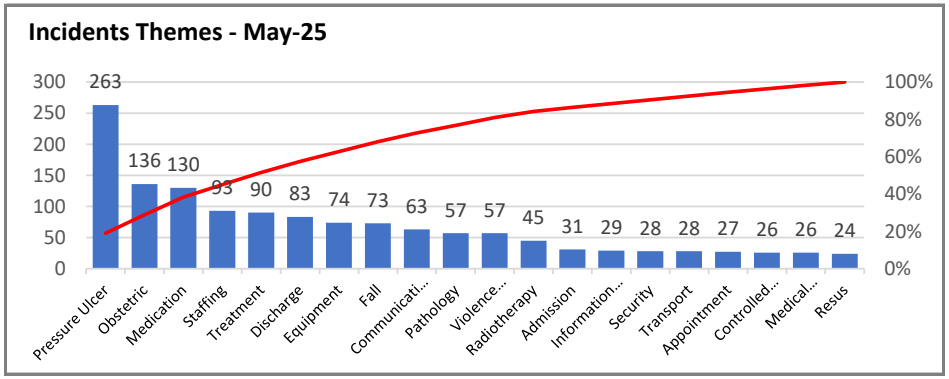
East and North Hertfordshire NHS Trust

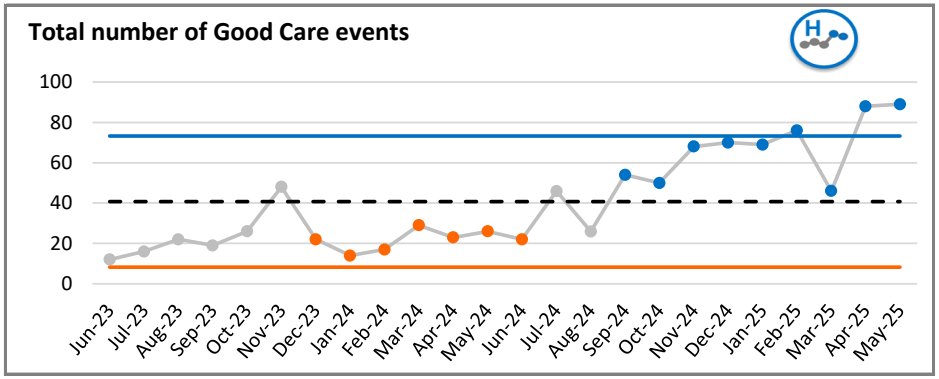




Key Issues and Executive Response

- Continued special cause variation in incident reporting and also of good care. Influenced by active promotion of reporting and the emerging use of daily incident review huddles across all Care Groups.
- 96% of incidents resulting in no harm / low harm, in line with previous.
- Obstetrics continues to be the highest reporting specialty , ahead of Emergency Medicine for the second consecutive month.
- Increased incidents reported in Obstetrics month on month since January 2025 following a campaign within the service to actively promote incident reporting. 98% of Obstetrics incidents were low/no harm, themes seen are delays in second stage of labour, delays in induction and increased neonatal admissions.
- Increase in medication related incidents-being reviewed through Medication Forum.
- Reduction in inpatient falls (58) compared to April; 2 staff falls noted at MV site - ongoing liaison with Hillingdon Health and Safety team.
- Ongoing review of all incidents reported with level of harm as 'death' through local incident management process with escalation to PSERP as required, some early learning relates to out of hospital cardiac arrests.
- 4 x serious incidents (Paeds Audiology) approved by May QSC.



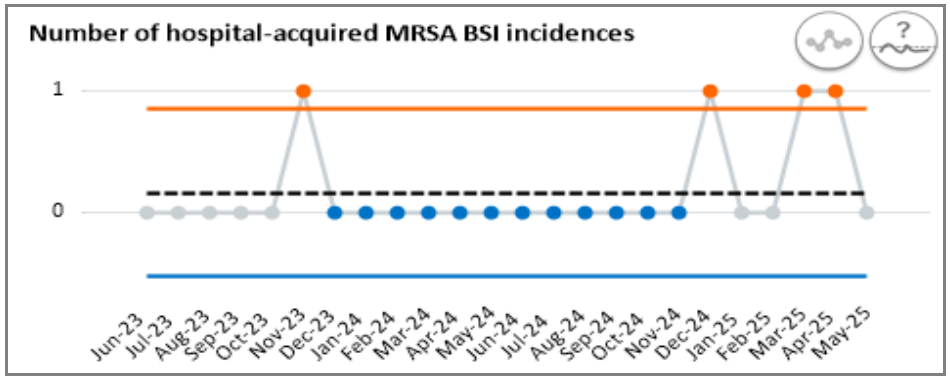


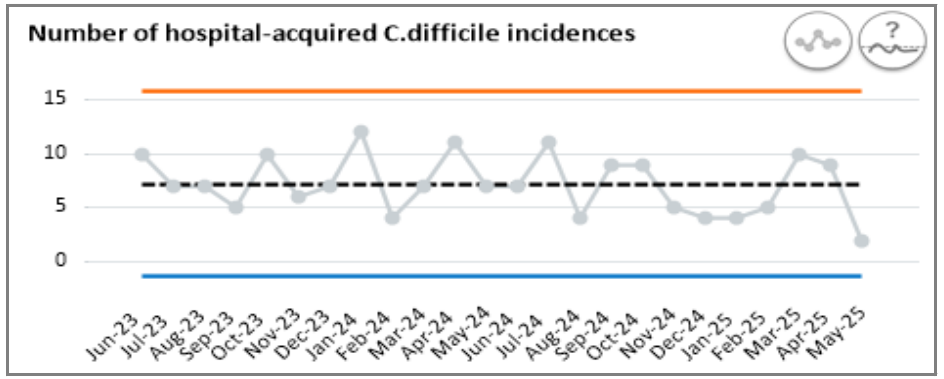
Month 02 | 2025-26

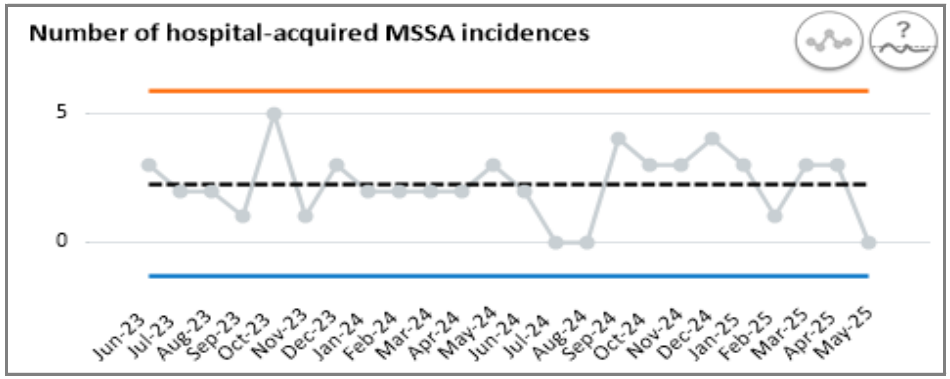
Quality

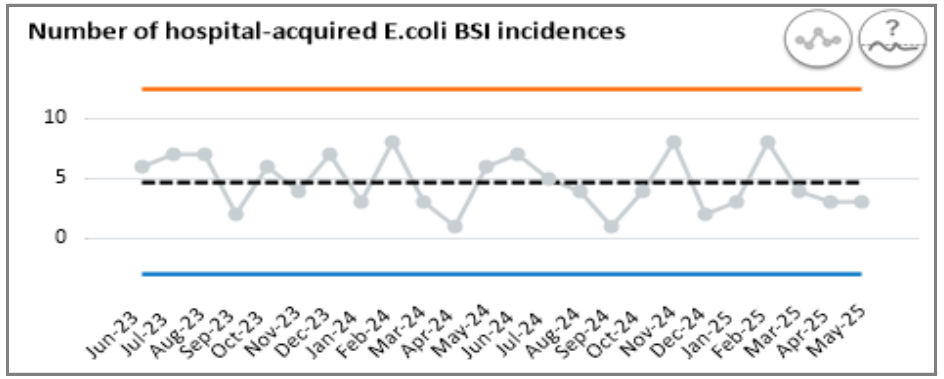
Infection Prevention and Control

East and North Hertfordshire NHS Trust









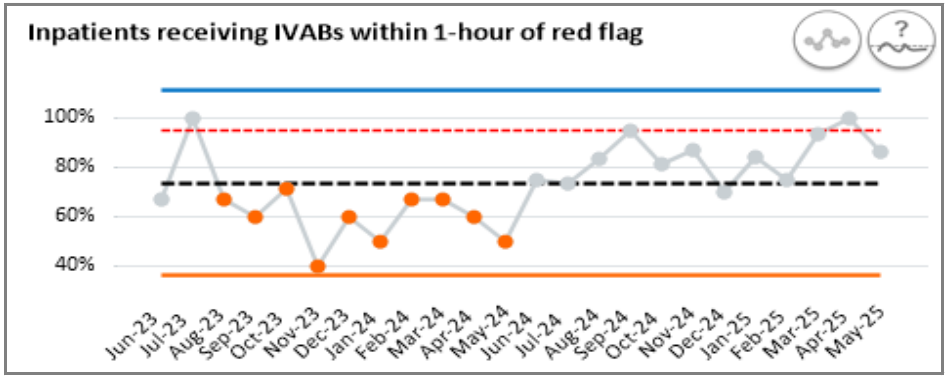
- MRSA BSI - there were zero MRSA BSI in May '25.
- MSSA BSI - there were zero MSSA BSI in May '25.
- C difficile (C diff.) infection (CDI) - there were two CDI cases in the month of May '25, which is below both the trust monthly threshold. Both cases were in the Unplanned Care Division. Post infection reviews (PIRs) concluded that these cases were unavoidable. The IPC team continues to disseminate learning to the divisions.
- E.coli BSI - there were three cases of healthcare-associated infection in May '25. One case under the Planned Care division and two cases under the Unplanned Care division. PIR action plan are ongoing.

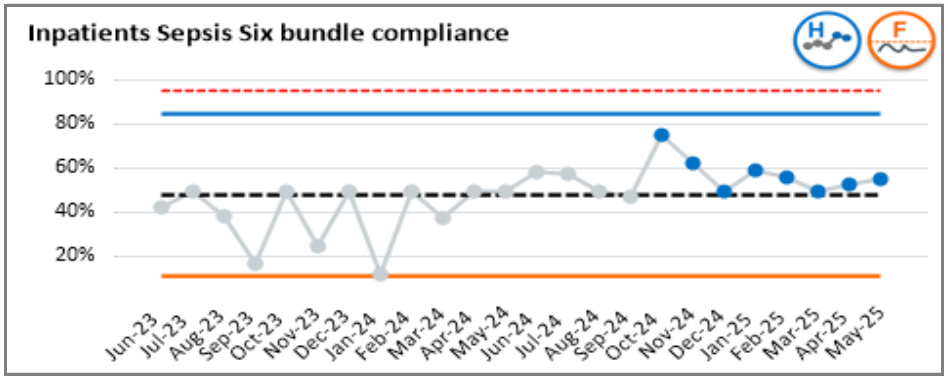
Month 02 | 2025-26

Quality

Sepsis Screening and Management | Inpatients

East and North Hertfordshire NHS Trust





Themes

Sepsis IP	2024-25										2025-26	
	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
Oxygen	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Blood cultures	75%	95%	65%	67%	88%	93%	90%	84%	73%	73%	92%	81%
IV antibiotics	75%	74%	83%	95%	81%	89%	70%	86%	75%	94%	100%	88%
IV fluids	67%	77%	83%	80%	83%	93%	64%	93%	86%	79%	89%	100%
Lactate	75%	89%	59%	81%	88%	78%	68%	73%	73%	81%	57%	81%
Urine measure	92%	74%	94%	76%	94%	95%	84%	95%	81%	88%	93%	89%

Key Issues and Executive Response

Themes

- 15/27 patients audited across May showed 6/6 compliance within the hour.
- IV antibiotic compliance dropped slightly to 88% in May with 23/26 patients receiving it within the hour.
- Lactate measurement improved to 81% in May and has shown fluctuating compliance over the last few months.
- Compliance for oxygen administration remains at 100%.
- Blood culture compliance sits at 81% with 22/27 patients having the taken within the hour.

Response

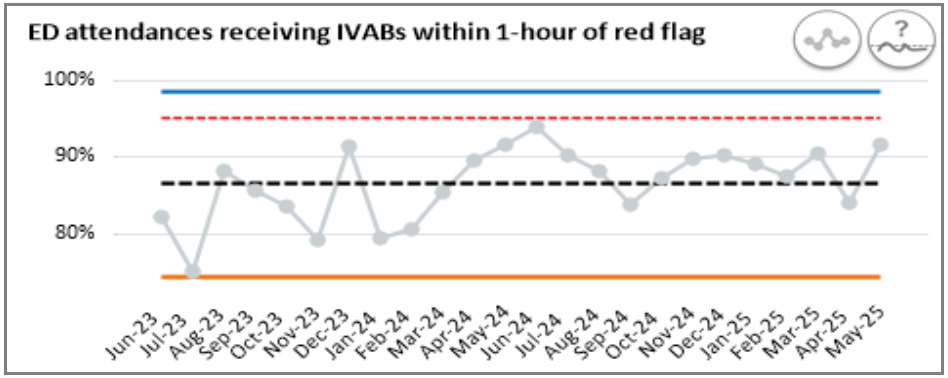
- 27 patients were audited across IP in May, a big jump from 15 in April and can be accountable for some of the variation in compliance.
- Blood bottles and checklists for Sepsis Grab Boxes have been updated with the change in lab ensuring accurate equipment being readily available with the new equipment.
- The team continue to respond to unwell septic patients across the trust, reviewing them and assisting to implement the sepsis six.
- Remembering to obtain a lactate result has been a focus on recent training with sessions for the FY1 and FY2 medical doctors. There are further sessions for frailty and surgical doctors currently being arranged
- The sepsis team are arranging further study and simulation sessions for later in the year and have started planning for world sepsis day in September.
- A deteriorating patient week is in the initial staged of being planned, with sepsis being one of the focus points for a day during that week.
- The team are meeting regularly with sepsis teams from across East of England to share learning and best practices.
- The team are working closely with Orbis to ensure the new EPR system reflects the need for sepsis screening and fluid balance charts.

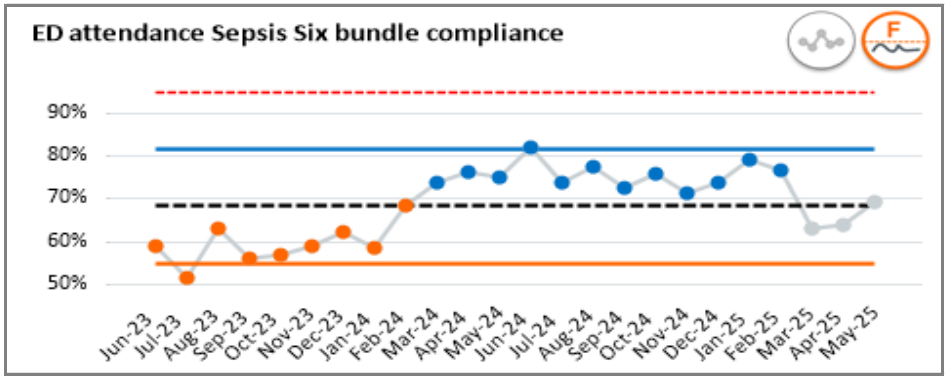
Month 02 | 2025-26

Quality

Sepsis Screening and Management | Emergency Department

East and North Hertfordshire NHS Trust





Themes

Sepsis ED	2024-25										2025-26	
	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
Oxygen	100%	100%	100%	100%	100%	100%	99%	100%	100%	100%	100%	100%
Blood cultures	100%	99%	93%	97%	97%	90%	93%	95%	94%	96%	88%	96%
IV antibiotics	94%	90%	88%	84%	87%	90%	90%	89%	88%	91%	84%	92%
IV fluids	94%	92%	90%	87%	93%	95%	91%	92%	93%	90%	89%	91%
Lactate	100%	100%	96%	98%	99%	97%	94%	99%	95%	97%	96%	99%
Urine measure	86%	74%	79%	81%	80%	81%	80%	88%	81%	68%	73%	75%

Key Issues and Executive Response

Themes

- 50/72 patients audited across May showed 6/6 compliance within the hour.
- Urine output measurement has seen a marginally improvement in April sitting at 75% but still remains the areas of concern.
- Lactate and blood culture measurements sit above the Trusts target percentage at 99% and 96%.
- Digital Fluid balance and its documentation remains a focus for the ED department.
- IV antibiotic compliance has remained in the 80-90% percentage range over the last couple of months showing consistency and reflecting the high demands of the department. It sits at 92% across May, edging closer to the target of 95%.

Response

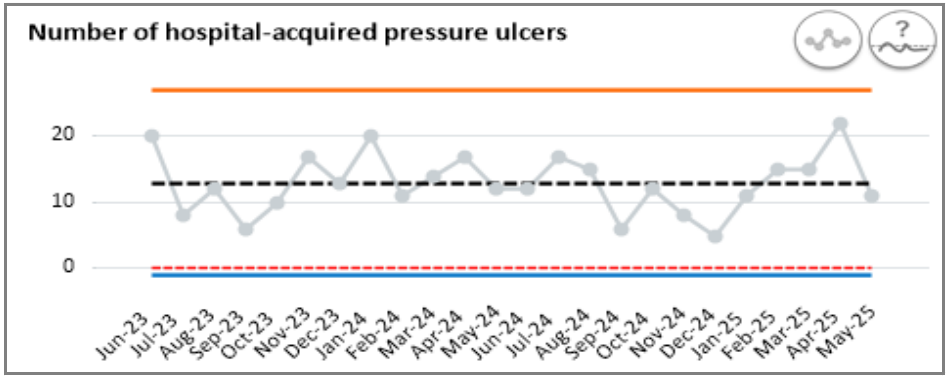
- The Sepsis Team continue to provide bedside education to staff, often attending patients in ED and going through the Sepsis Screening Tool in real time. ENHance reports are submitted to ED matrons for non-compliance to be reviewed and set a plan for continuous improvement.
- The team have started to deliver their 12 week ED team time block in May, delivering sepsis sessions to the ED department, particularly focusing on fluid balance and how the team can assist in improving compliance.
- Mandatory e-learning updated and now live on ENH Academy for all staff to refresh their sepsis knowledge and review the updated guidance.
- A sepsis notice board has been utilised in the ED to act as a visual prompt for good sepsis management.
- The team are going down to the ED in order to prompt use of timely digital fluid balance and sepsis screening.

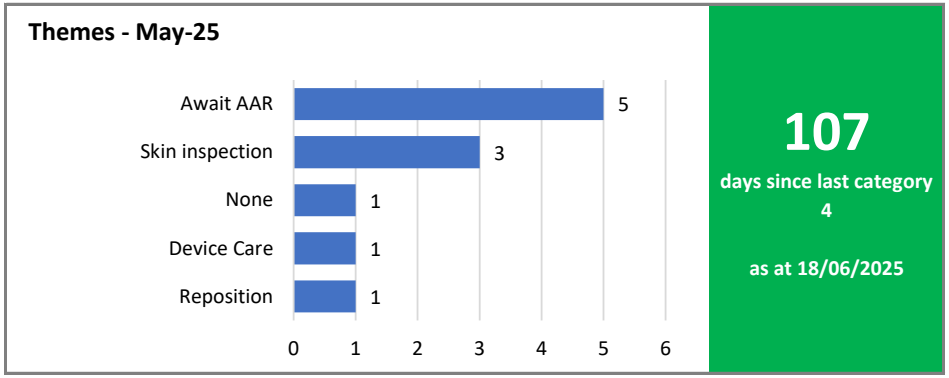
Month 02 | 2025-26

Quality

Pressure Ulcers | VTE

East and North Hertfordshire NHS Trust

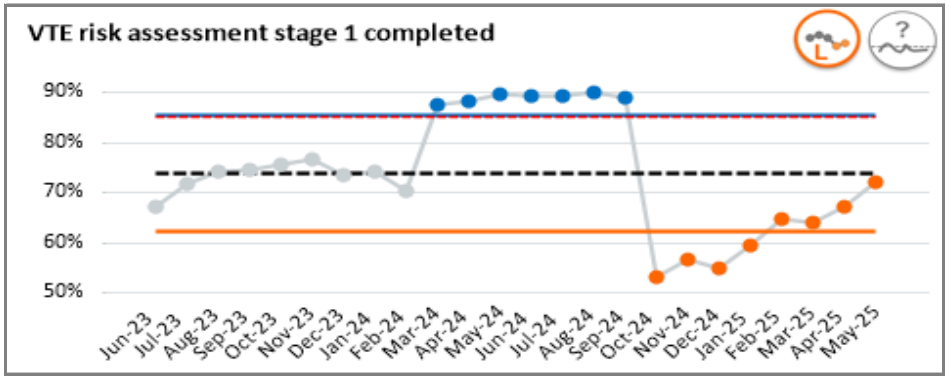




107

days since last category 4

as as at 18/06/2025



Key Issues and Executive Response

Pressure Ulcers

- Pressure Ulcer Prevention (PUP) Improvement plan is being implemented with focus on embedding PUP processes trust wide to all clinical staff.
- Heel pressure ulcers continue to be among the leading cause of pressure ulcers in the trust. Heads of Nursing retain oversight of this and there is an improvement work aimed at heel pressure ulcer reduction by ensuring that equipment is available for use where required to prevent heel PU development.
- Ongoing weekly Division Pressure Ulcer Safety Huddle (DPUSH) aimed at addressing HA PU concerns and providing early interventions, support/immediate actions.
- The plan to adopt PURPOSE-T PU prevention risk assessment tool is in progress. This will be implemented in 2026, due to new EPR system rollout delays.
- A Link Nurse form one ward has completed a 4th quarter audit regarding pressure ulcer prevention. The findings will be shared on the NMAHP audit meeting this month.

VTE

- In October, Trust agreed to adopt 14-hour timescale to complete VTE risk assessments in line with NHSE requirements. This led to an anticipated drop due to a stricter reporting parameters.
- VTE Lead has left the Trust and the post has been offered and accepted, just completing the onboarding process.
- Trust wide pilot of digital 'welcome pack' to improve patient awareness of VTE, VTE risk assessments and VTE prevention.
- Overview of detailed actions provided in Integrated Performance Report for June 2025. Also see details action plan in compliance report.

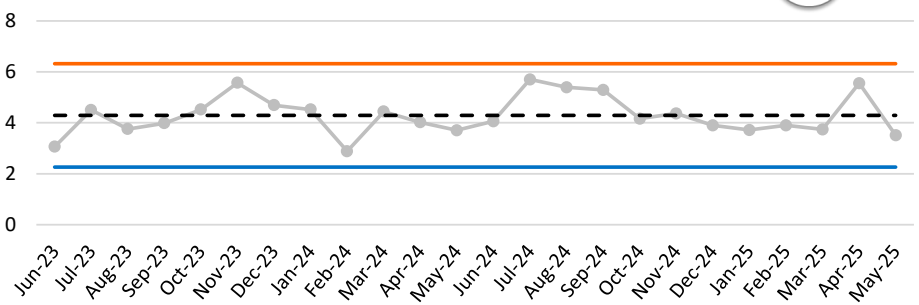
Month 02 | 2025-26

Quality

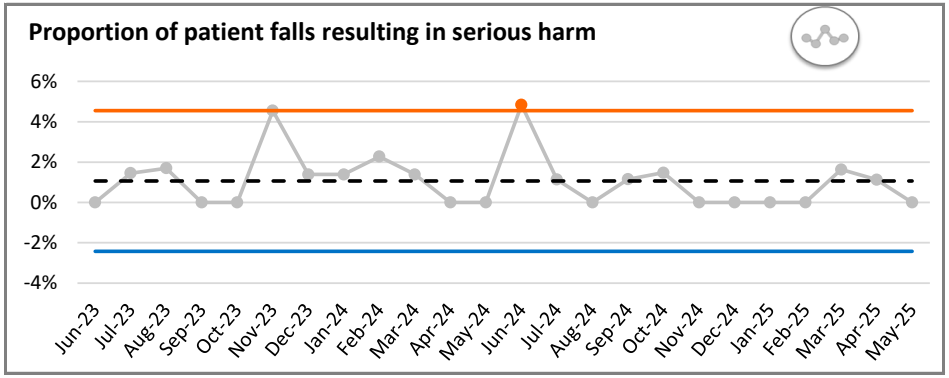
Patient Falls

East and North Hertfordshire NHS Trust

Rate of patient falls per 1,000 overnight stays



Proportion of patient falls resulting in serious harm



Key Issues and Executive Response

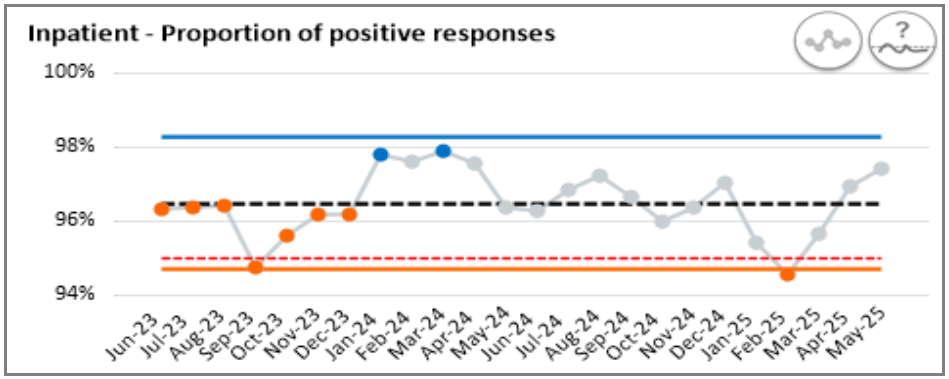
- Inpatient falls data continues to show common cause variation, with an average of 4 per month per 1000 bed days.
- Inpatient falls for the month of May is lower compared to previous month.
- We will continue to monitor falls rate and escalate any concerns to the patient safety team.
- No inpatient fall with serious harm recorded for the month of May.
- Falls lead to continue to engage with team leaders and managers to look at ways in effectively and safely supporting our high risk of falls patients. We are continuously focusing in improving baywatch compliance and ensuring that the appropriate acuity is recorded on safecare so targeted support can be provided on our most highest risk patients.
- Falls steering group will happen in July after a long pause due to unavailability and lacking of quorum.

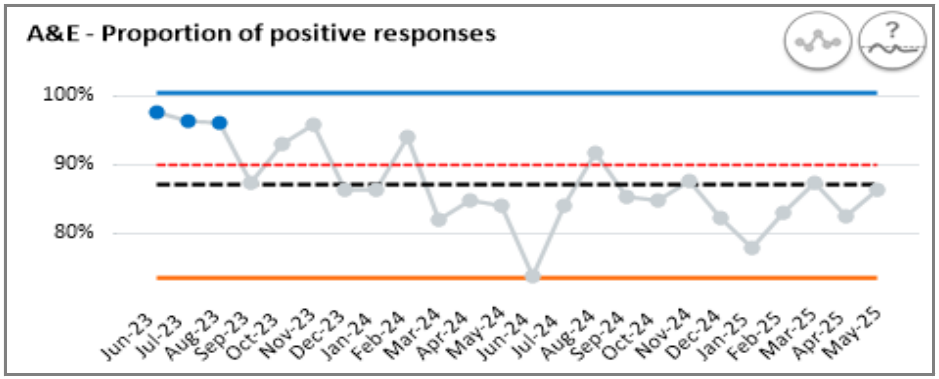
Month 02 | 2025-26

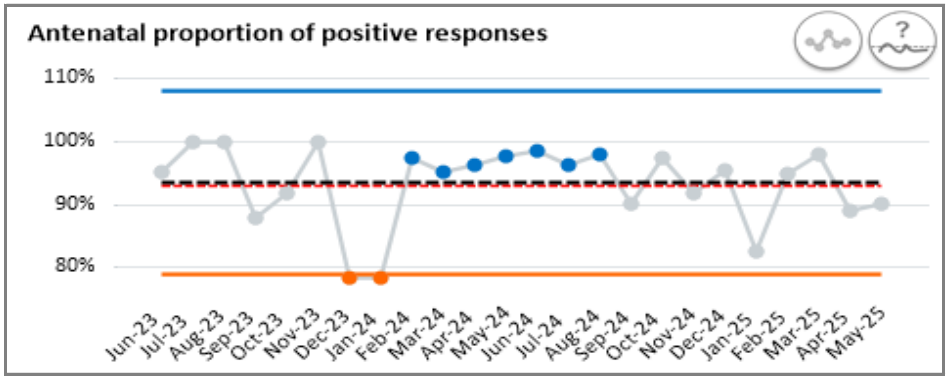
Quality

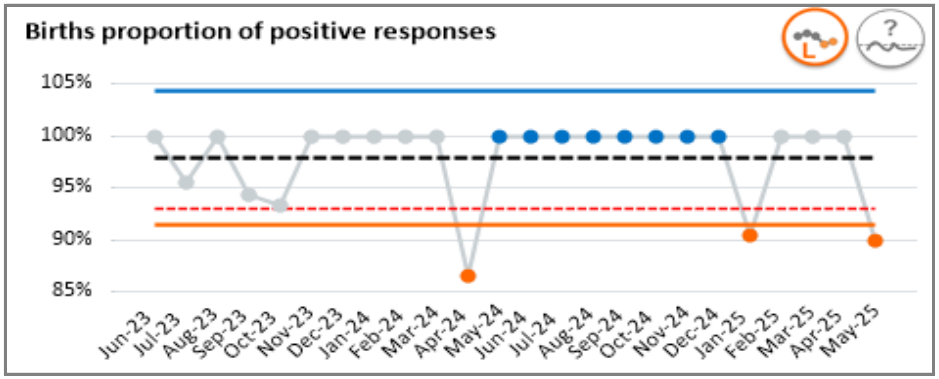
Friends and Family Test

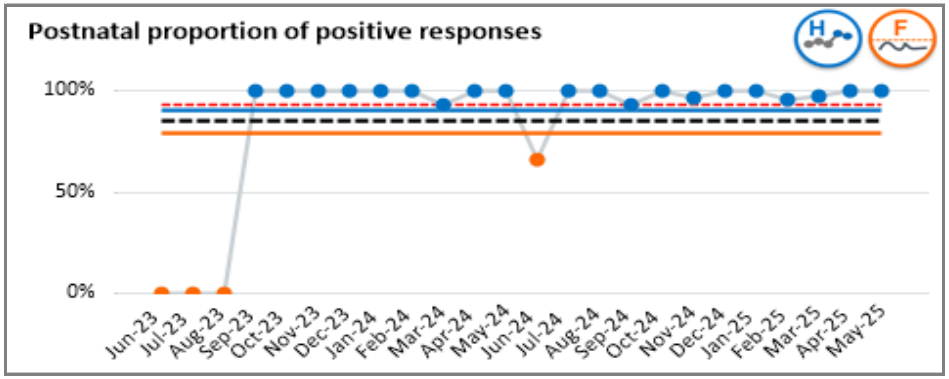
East and North Hertfordshire NHS Trust

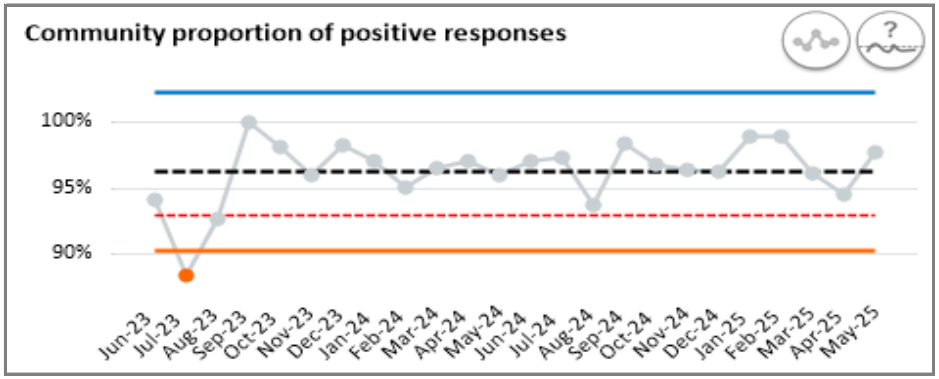










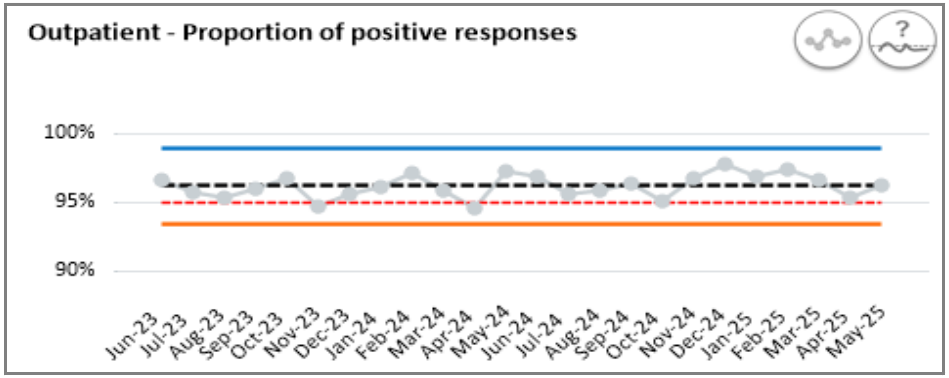


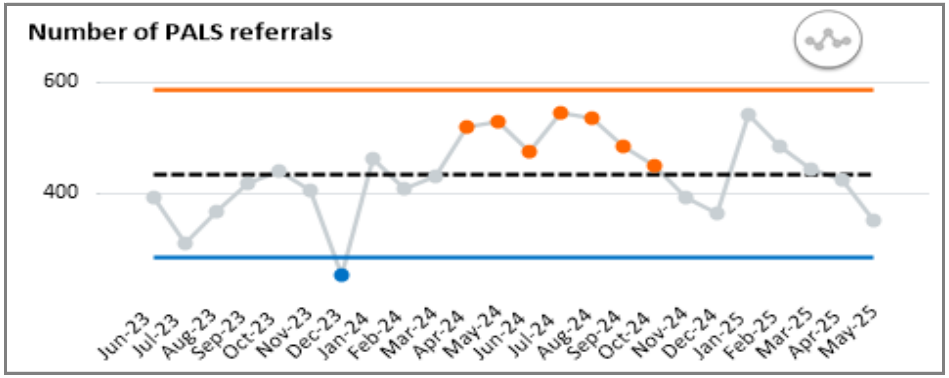
Month 02 | 2025-26

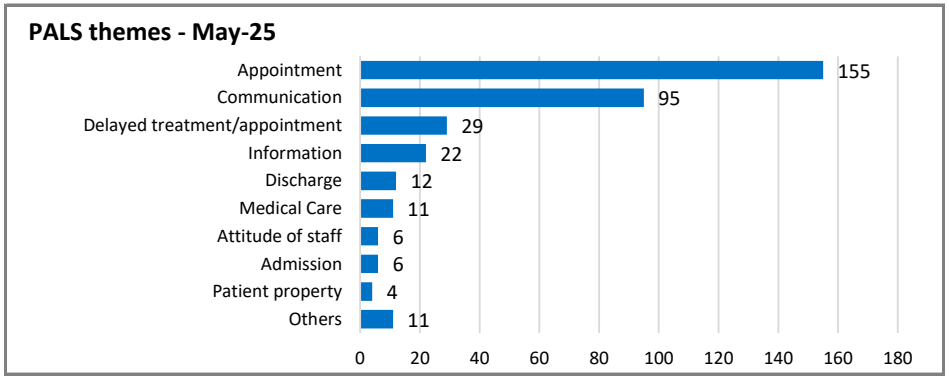
Quality

Friends and Family Test | Patient Advice and Liaison Service

East and North Hertfordshire NHS Trust







Key Issues and Executive Response

Friends and Family Test

- Continued increase in the number of inpatient satisfaction surveys completed.
- Current review of outpatient survey questions.
- Continued promotion of QR codes within inpatient and outpatient areas to minimise manual inputting.
- Focused work within ED and CAU underway to collect more data due to low submission.

Patient Advice Liaison Service

- Due to sickness and annual leave in the team, PALS response times have increased for all non urgent enquiries.
- Continued contacts relate to outpatient appointments and call lines, with calls being passed to the division / service.
- Currently reviewing logging processes of contact made within the service to ensure improved efficiency.
- Quick resolution on inpatient concerns with the assistance of Ward Mangers, Matrons and Heads of Nursing.
- Around 100 emails from May to still be reviewed.
- Top 5 services receiving highest number of concerns - T&O (50), Urology (29), ENT (28), Oral Surgery (24), Gynae (20).
- Continued concerns over time taken to get appointments and cancellations with no instant rebooking.

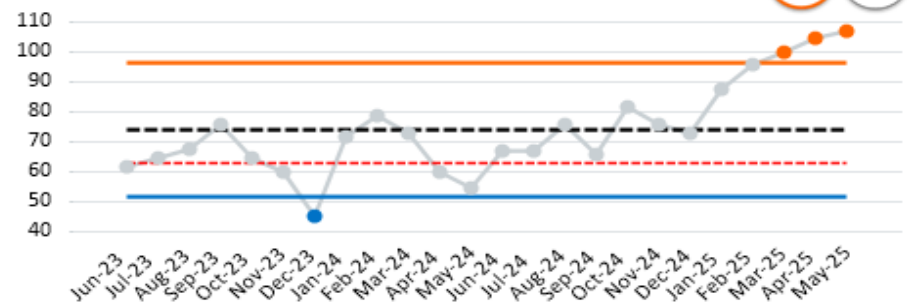
Month 02 | 2025-26

Quality

Complaints

East and North Hertfordshire NHS Trust

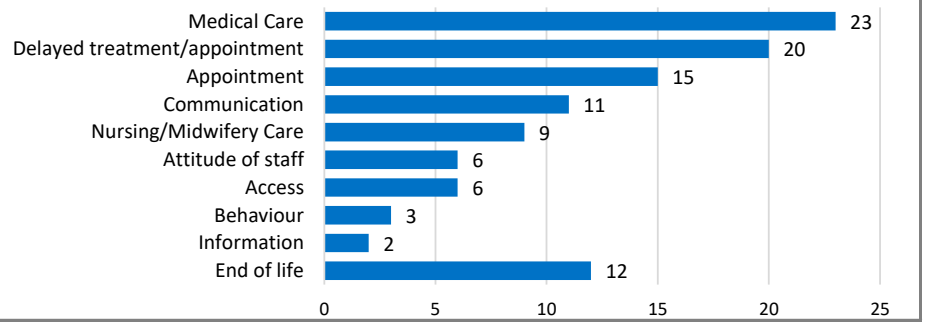
Number of written complaints received



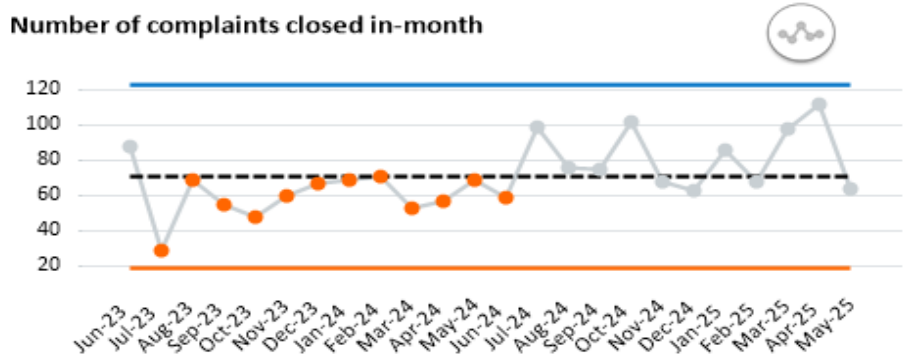
Key Issues and Executive Response

- Continued rise in formal complaints in May with 107 being raised.
- T &O (10), ED (9) Radiology (9), Gynaecology (8), Community Pead's (8) are the top directorates to receive complaints in May 2025.
- Escalations sent to Triumvirates around Radiology spike - division investigating.
- Significant rise in complaints within Planned Care - 18 additional this month (50 complaints compared with previous month of 36).
- Currently 243 open complaints, with 37 in scoping phase.
- Large increase in complaints received from November 2024.

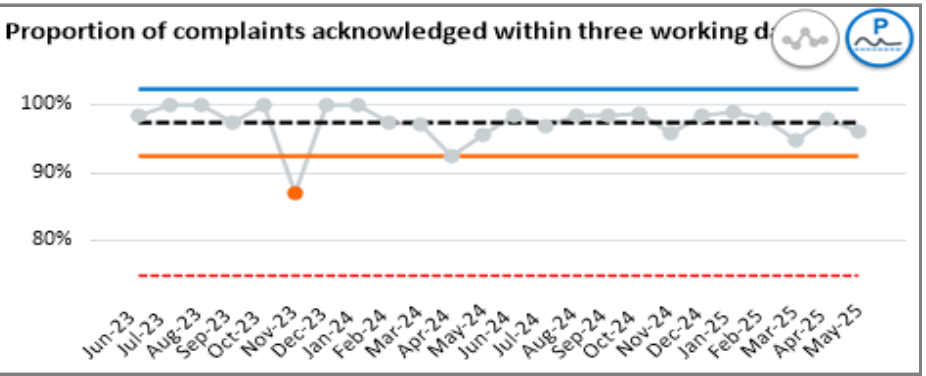
Complaints themes - May-25



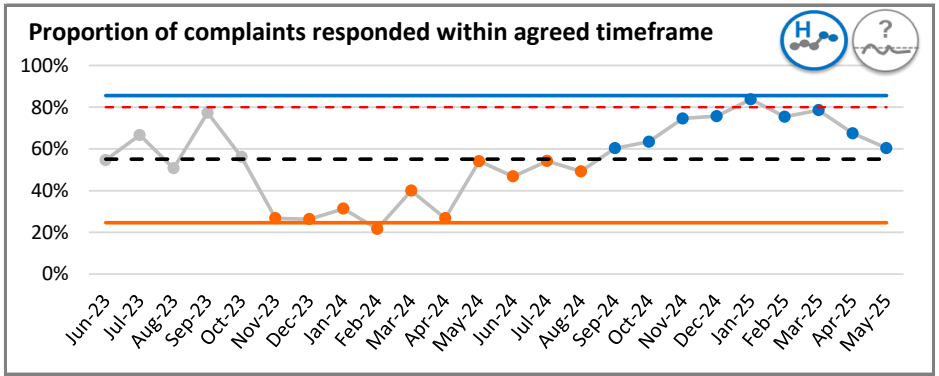
Number of complaints closed in-month



Proportion of complaints acknowledged within three working d



Proportion of complaints responded within agreed timeframe



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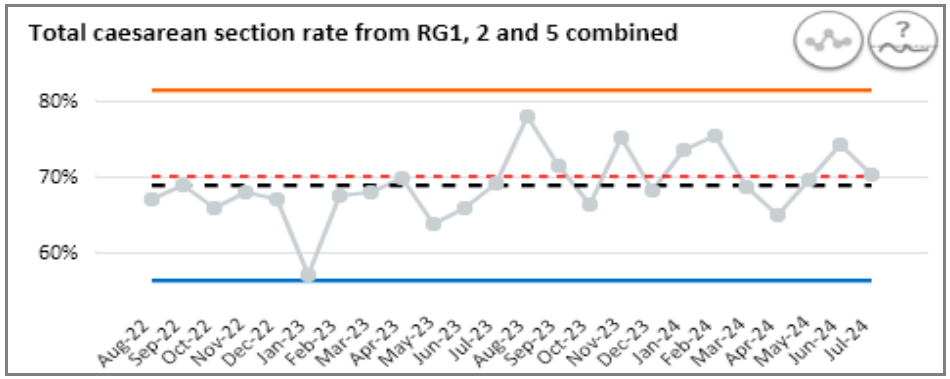
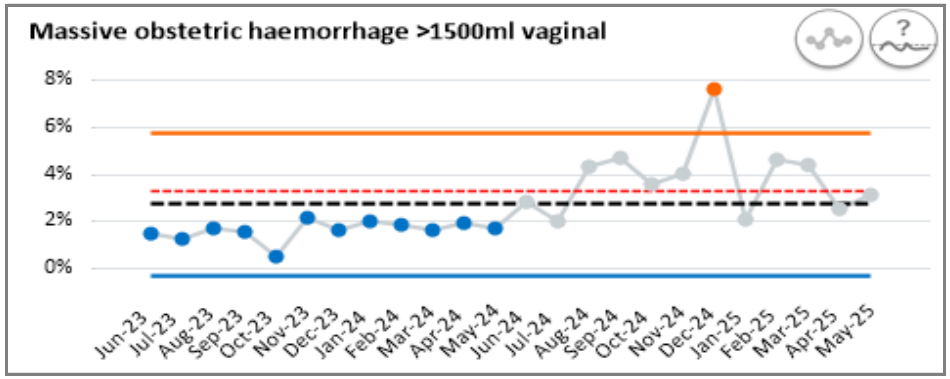
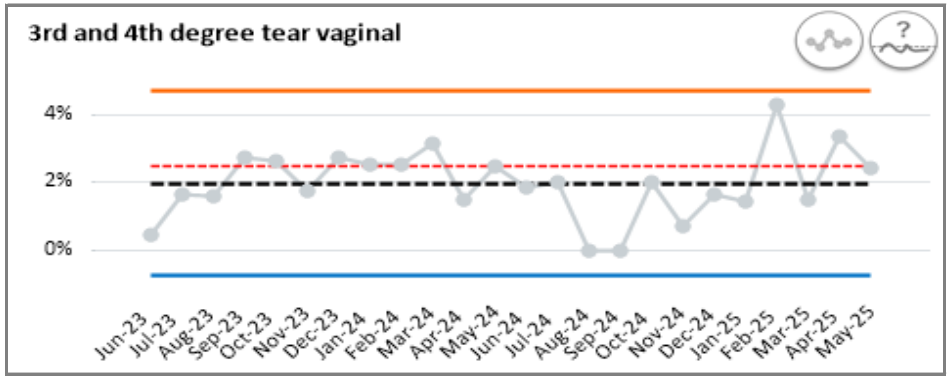
Quality

Maternity | Safety Metrics

East and North Hertfordshire NHS Trust







Key issues and executive response

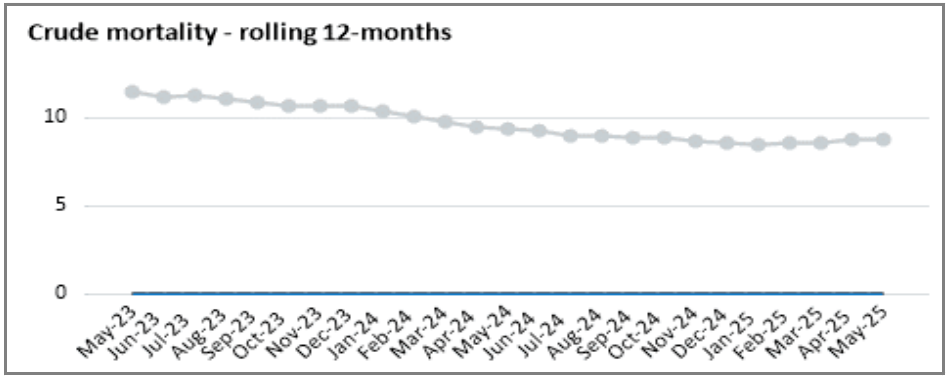
- There were no incidents meeting criteria for MNSI referral and no divisional incidents qualifying as Patient Safety Incident Investigations. There were 6 cases of moderate physical harm, consistent with previous months. These are all being followed up through the Divisional Incident Review meetings. No cases of serious harm.
- There were 4 cases of 3rd/ 4th degree perineal trauma at vaginal births and 1 case at instrumental births. This is within process limits.
- MOH >1500mls at vaginal births within process limits. There were 8 (5.33%) MOH > 1500mls at LSCS births, which is a notable increase on previous months. Obstetric escalation and management of cases appropriate. Early tranexamic acid use noted. Poor documentation on PPH scribe tool - for learning and dissemination. Delays in transfer to obstetric theatres overnight due to lack of anaesthetic and ODP cover needed to open a second theatre. This and a new theatres staffing model are being considered as contributing factors to MOH rates. Of the 15 total MOH's in April 2025, 2 were >2000mls. Weekly thematic review of all MOH ongoing. Collaboration across the LMNS on MOH learning and actions.
- ATAIN rate (7.23%) continues to be above goal limit since inclusion of short-stay admissions in line with national requirements from 2025. Babies requiring cannulation in NICU is one emerging theme. Clinicians are being encouraged to cannulate at the bedside or facilitate mother to accompany transfer to avoid separation.
- Pregnancy referrals are now triaged by a midwife and booking bloods facilitated prior to booking appointment in order to facilitate target of booking by 10 weeks (69.75%).
- Total LSCS= 168 (42.21%), Total Cat 1-3 (Emergency) = 90 (22.61%), Total Cat 4 (Elective) = 78 (19.60%). Robson Group Criteria RC1 = 11.32%, RC2 = 37.10%, RC5 = 80.00%. Incomplete denominator data remains an area of focus (mandated fields requested from digital provider April 2025).

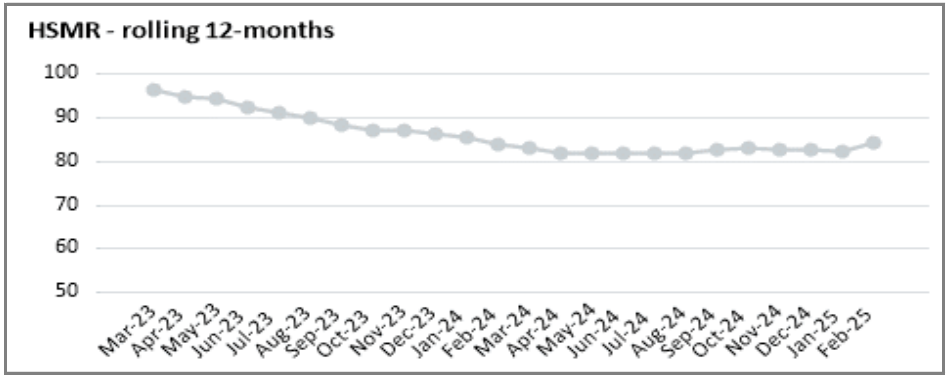
Month 02 | 2025-26

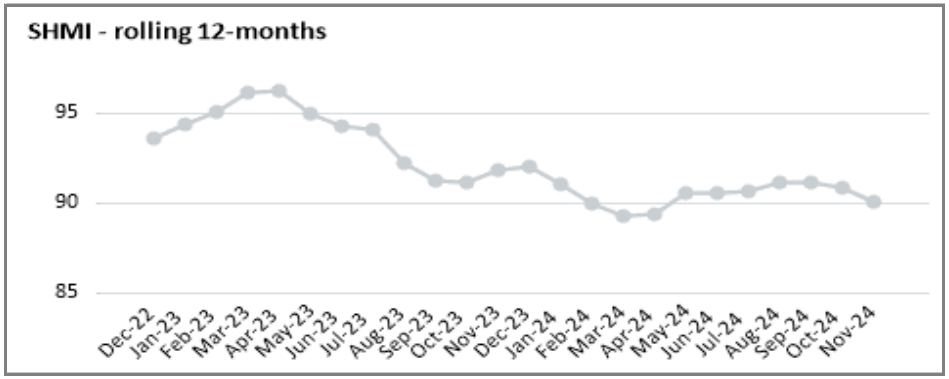
Quality

Mortality

East and North Hertfordshire NHS Trust







Key Issues and Executive Response

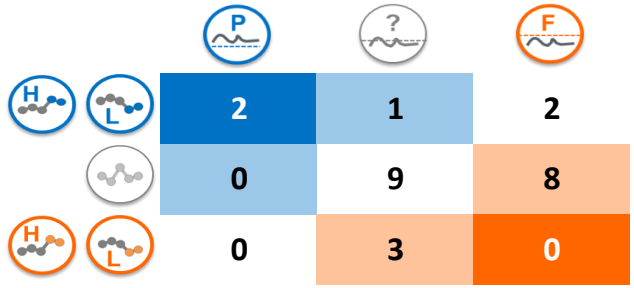
- Crude mortality is the factor which usually has the most significant impact on HSMR. The exception was during the COVID pandemic, when the usual correlation was weakened by the partial exclusion of COVID-19 patients from the HSMR metric. This partial exclusion continues for the CHKS HSMR metric that the Trust uses.
- The general improvements in mortality (excluding the COVID-19 period) have resulted from corporate level initiatives such as the learning from deaths process and focussed clinical improvement work. Of particular importance has been the continued drive to maintain a high standard of clinical coding.
- There was a significant downward trend in rolling 12-month HSMR from March 2023 to April 2024, when the metric plateaued and has since risen slightly.
- The latest rolling 12-month HSMR to Feb-25, reported by CHKS, stands at 84.2. This positions us in the mid-range of trusts nationally. It should be noted that national peer currently stands well below 100 at 89.5. CHKS has confirmed that a rebase of their HSMR is due imminently. These figures have not refreshed since the last IPR, since CHKS has experienced an issue with their HES/HSMR/SHMI data.
- Latest NHSD published rolling 12-month SHMI available to January 2025, stands at 88.86, a reduction from last month's 89.35. This positions us in the first quartile of trusts nationally and well below the national average within the 'as expected' band.
- The latest figures provided by CHKS are for Nov-24 and are 81.7 in-month and 90.2 for rolling 12-month, both well below the national average.
- For the period to Nov-24, CHKS reported one 3SD outlier alerts: Pulmonary heart disease.

Month 02 | 2025-26

NHS
East and North Hertfordshire
NHS Trust

Operations

Month 02 | 2025-26



Urgent and Emergency Care

Summary

East and North Hertfordshire NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Emergency Department	Patients waiting no more than four hours from arrival to admission, transfer or discharge	May-25	95%	74.3%	H	F	3/3 points close to upper process limit Metric will consistently fail the target
	Patients waiting more than 12 hours from arrival to admission, transfer or discharge	May-25	5%	11.7%		F	Common cause variation Metric will consistently fail the target
	Percentage of ambulance handovers within 15-minutes	May-25	65%	18.4%		F	Common cause variation Metric will consistently fail the target
	Time to initial assessment - percentage within 15-minutes	May-25	80%	57.0%		F	Common cause variation Metric will consistently fail the target
	Average (mean) time in department - non-admitted patients	May-25	240	180	L	P	3/3 points close to lower process limit Metric will consistently pass the target
	Average (mean) time in department - admitted patients	May-25	tbc	533			Common cause variation No Target
	Average minutes from clinically ready to proceed to departure	May-25	tbc	205			Common cause variation No target
RTT & Diagnostics	Patients on incomplete pathways waiting no more than 18 weeks from referral	May-25	92%	57.4%	H	F	10 points above the mean Metric will consistently fail the target
	Patients waiting more than six weeks for diagnostics	May-25	0%	53.2%		F	Common cause variation Metric will consistently fail the target

Month 02 | 2025-26

Urgent and Emergency Care

Summary

East and North Hertfordshire NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Cancer Waiting Times	62-day referral to treatment standard	Apr-25	85%	88.8%		?	Common cause variation Metric will inconsistently pass and fail the target
	31-day decision to treat to treatment standard	Apr-25	96%	96.8%	H	?	12 points above the mean Metric will inconsistently pass and fail the target
	28-day Faster Diagnosis standard	Apr-25	75%	77.8%		?	Common cause variation Metric will inconsistently pass and fail the target
	Proportion of cancer PTL waiting more than 62 days	Apr-25	7%	19.5%		F	Common cause variation Metric will consistently fail the target
	Number of cancer PTL waiting more than 104 days	Apr-25	16	139		F	Common cause variation Metric will consistently fail the target
	Patients waiting more than 104-days from urgent GP referral to first definitive treatment	Apr-25	0	9		?	Common cause variation Metric will inconsistently pass and fail the target
	Two week waits for suspected cancer	Apr-25	93%	65.6%	L	?	2 points below the lower process limit Metric will inconsistently pass and fail the target
	Two week waits for breast symptoms	Apr-25	93%	30.6%	L	?	1 point below the lower process limit Metric will inconsistently pass and fail the target

Month 02 | 2025-26

Urgent and Emergency Care

Summary

East and North Hertfordshire NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Stroke Services	Trust SSNAP grade	Q3 2024-25	A	B			
	4-hours direct to Stroke unit from ED	Apr-25	63%	30.0%		F	Common cause variation Metric will consistently fail the target
	% of patients discharged with a diagnosis of Atrial Fibrillation and commenced on anticoagulants	Sep-24	80%	100.0%	H	P	7 points above the mean Metric will consistently pass the target
	4-hours direct to Stroke unit from ED with Exclusions (removed Interhospital transfers and inpatient Strokes)	Apr-25	63%	31.0%		F	Common cause variation Metric will consistently fail the target
	Number of confirmed Strokes in-month on SSNAP	Apr-25	n/a	63			Common cause variation No target
	If applicable at least 90% of patients' stay is spent on a stroke unit	Apr-25	80%	76.0%		?	Common cause variation Metric will inconsistently pass and fail the target
	Urgent brain imaging within 60 minutes of hospital arrival for suspected acute stroke	Apr-25	50%	62.0%		?	Common cause variation Metric will inconsistently pass and fail the target
	Scanned within 12-hours - all Strokes	Sep-24	100%	97.0%		?	Common cause variation Metric will inconsistently pass and fail the target
	% of all stroke patients who receive thrombolysis	Apr-25	11%	14.0%		?	Common cause variation Metric will inconsistently pass and fail the target
	% of patients eligible for thrombolysis to receive the intervention within 60 minutes of arrival at A&E (door to needle time)	Sep-24	70%	29.0%		?	Common cause variation Metric will inconsistently pass and fail the target
	Discharged with JCP	Sep-24	80%	91.0%		?	Common cause variation Metric will inconsistently pass and fail the target
	Discharged with ESD	Apr-25	50%	54.0%	L	?	7 points below the mean Metric will inconsistently pass and fail the target

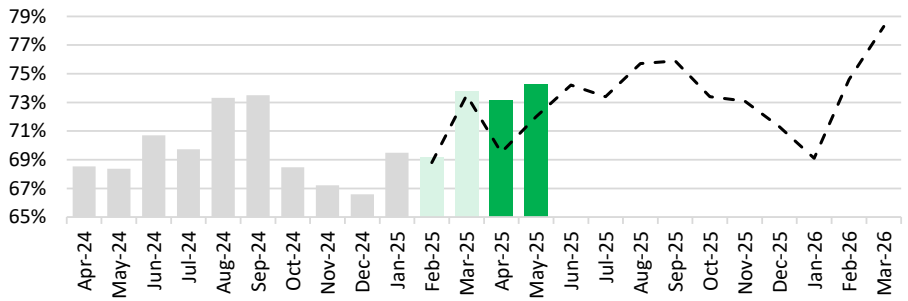
Month 02 | 2025-26

Urgent Emergency Care

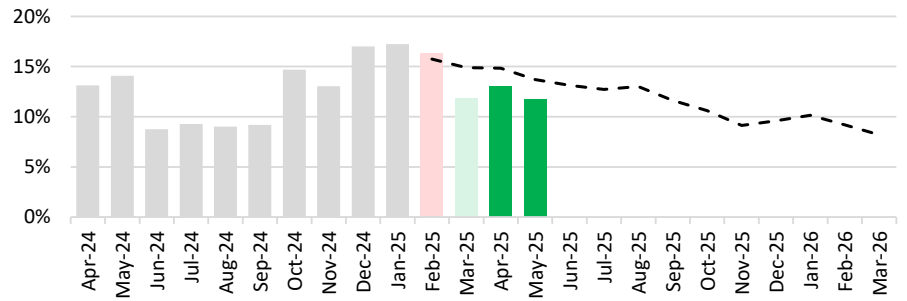
Trajectory Monitoring 2025-26

East and North Hertfordshire NHS Trust

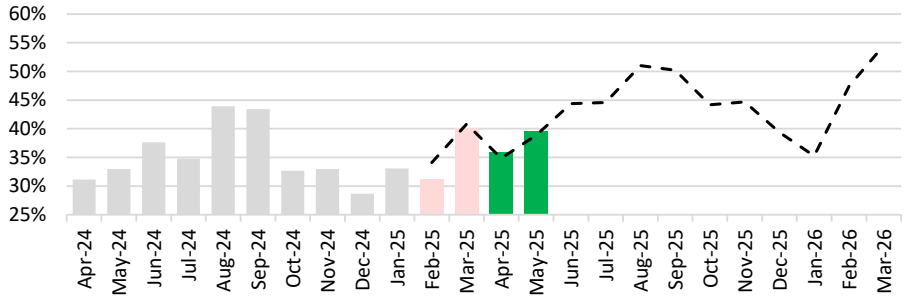
Four hour performance against trajectory - Trust-wide



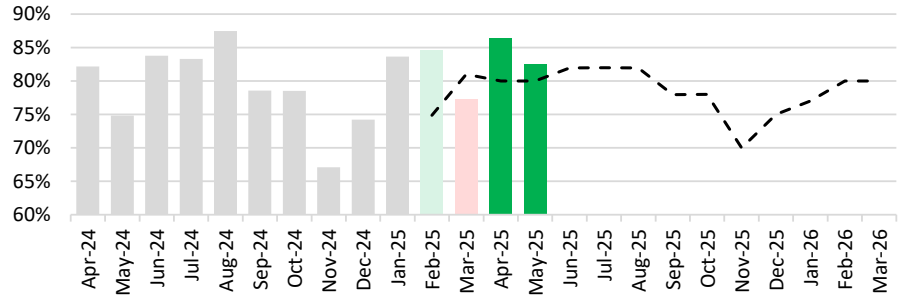
Patients in department over 12 hours - Type 1



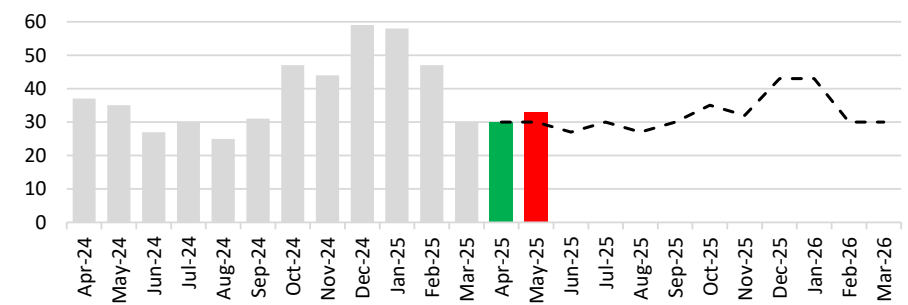
Four hour performance against trajectory - Type 1 Adults



Four hour performance against trajectory - Type 1 Paediatrics



Average ambulance handover time (minutes)

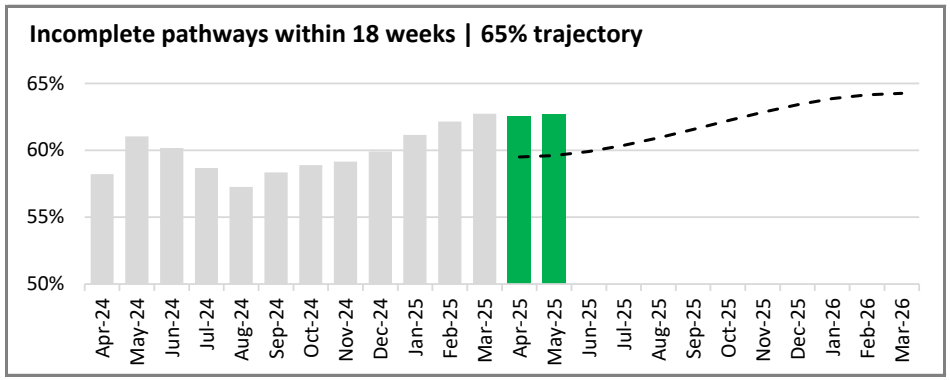


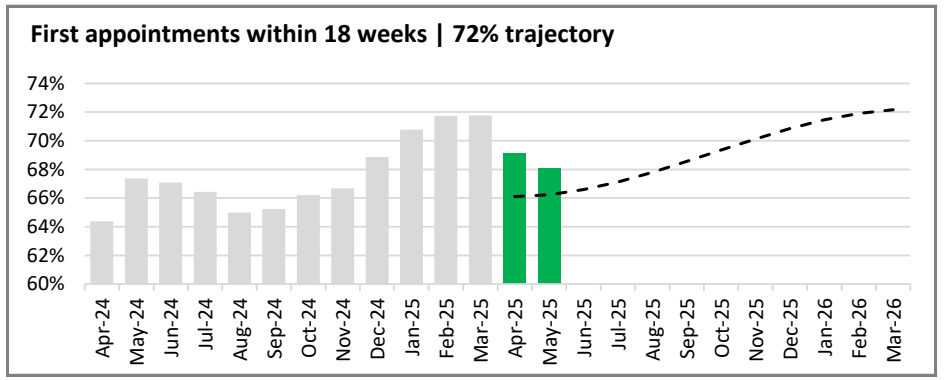
Month 02 | 2025-26

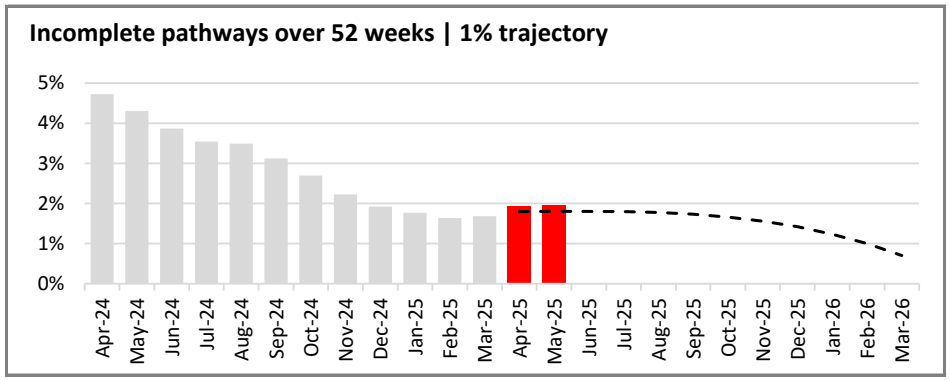
Cancer Waiting Times | RTT 18 weeks

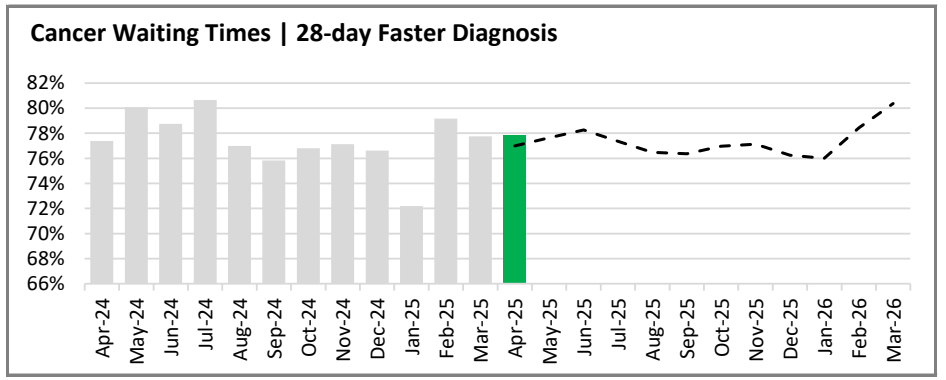
Trajectory Monitoring 2025-26

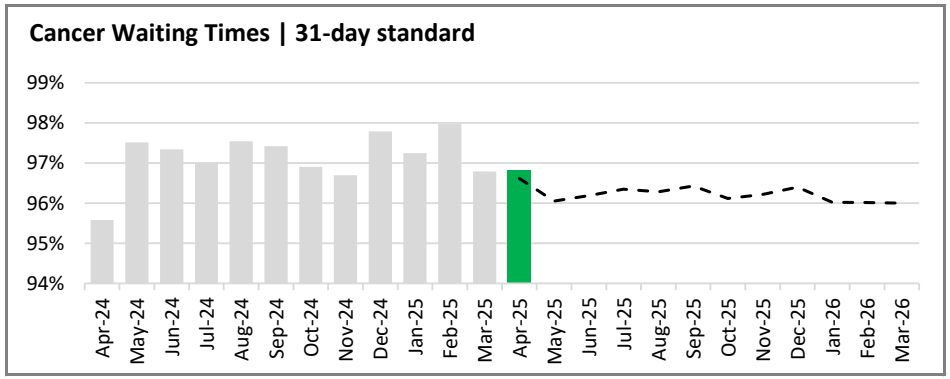
East and North Hertfordshire NHS Trust

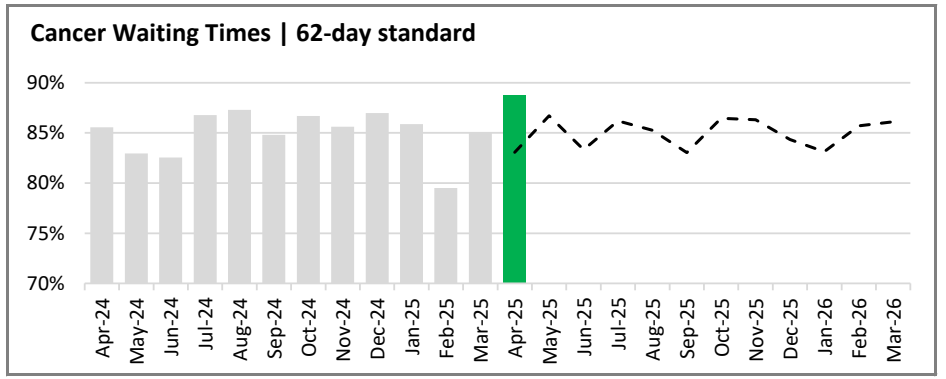










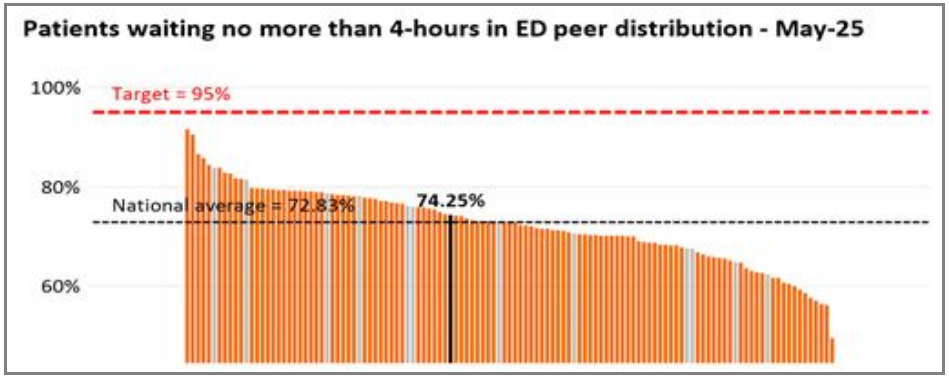


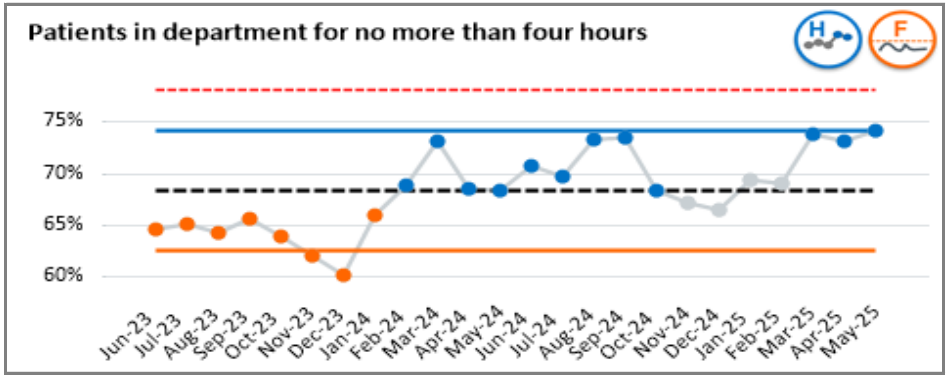
Month 02 | 2025-26

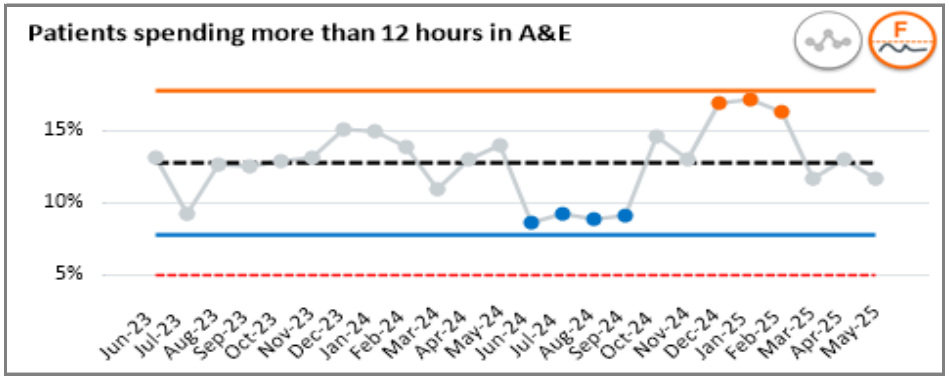
Operations

Urgent and Emergency Care New Standards

East and North Hertfordshire NHS Trust

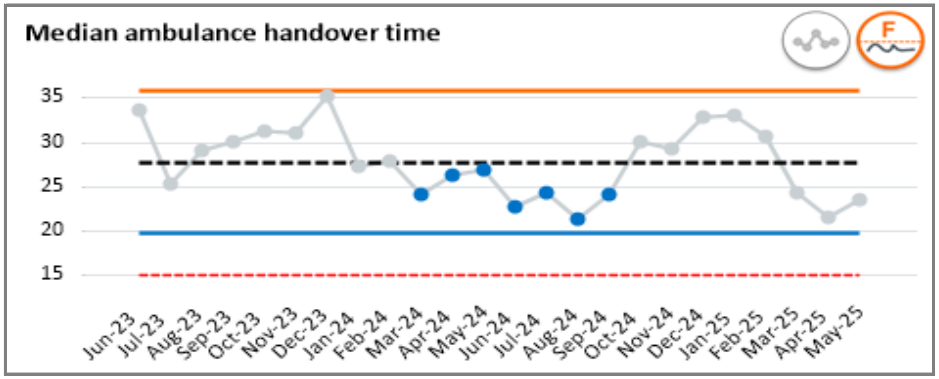






Key Issues and Executive Response

- 4 hr performance improved by 1% to 74.2% for May. Sustained performance of 73% + for Q1 25/6 - this has not been achieved in the last 3 years. 4 hr performance in June continues to improve: 77.3% MTD at 12/6 - ranked 3rd in region.
- Continued improvement in Adult type 1 performance - at 3 year high of 46%; attendances largely stable.
- Increasing focus on 12 hr waits. Ranked 4th in region YTD.
- Overall reduction in time to triage, waits to be seen, referrals to specialities; however increase in time to decision to admit and admission.
- The focus for June is on the main waiting area, using ENHPS to trial changes to triage and darting processes, and utilising the Majors 2 area to enhance department flow. Plans to monitor overnight productivity for impact on wait times.
- Ambulance handover: median handover remains under 25 mins. Volumes reducing as Urgent Care Coordination Hub supports diversion to community services.
- Ward manager increasing engagement in flow => early signs of small improvement in % discharges before midday.
- Sustained reduction in patients not meeting criteria to reside in Q1.

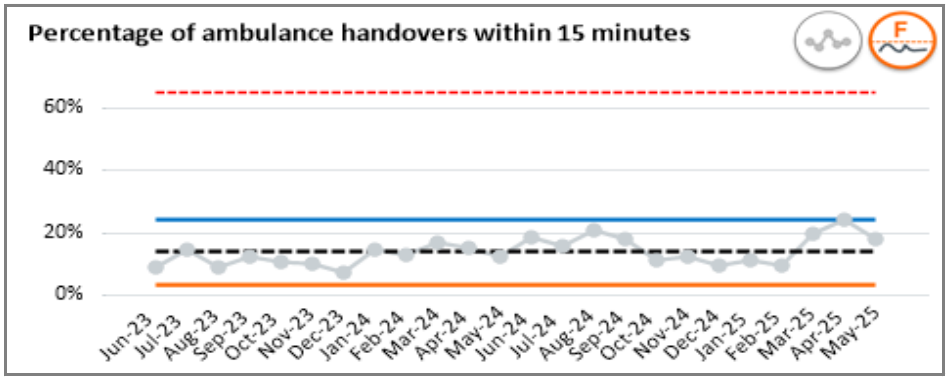


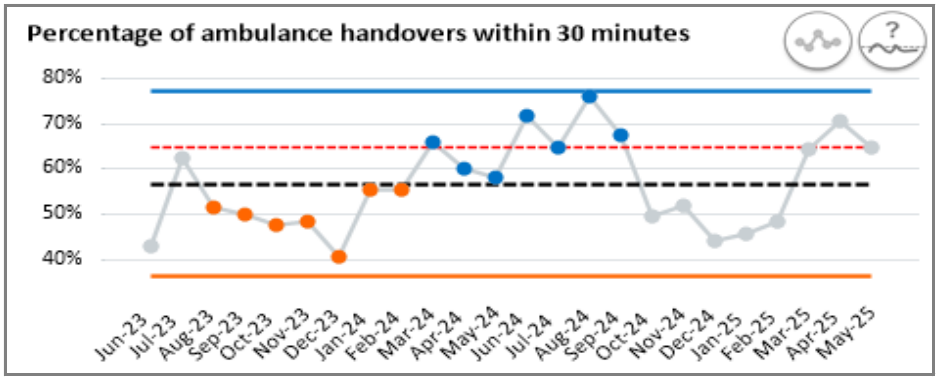
Month 02 | 2025-26

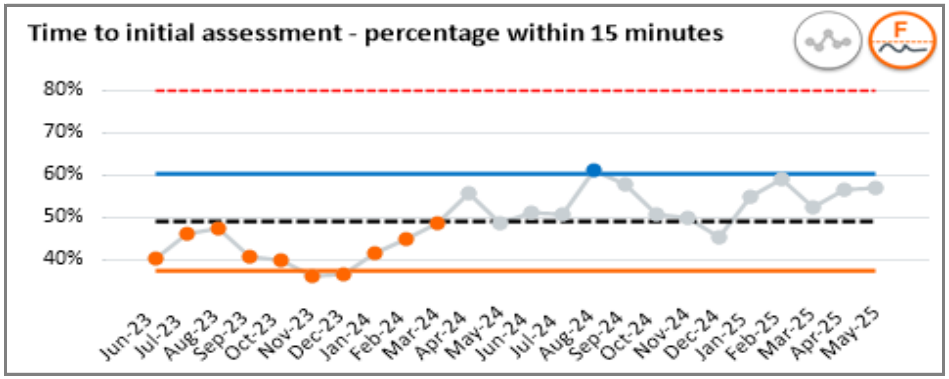
Operations

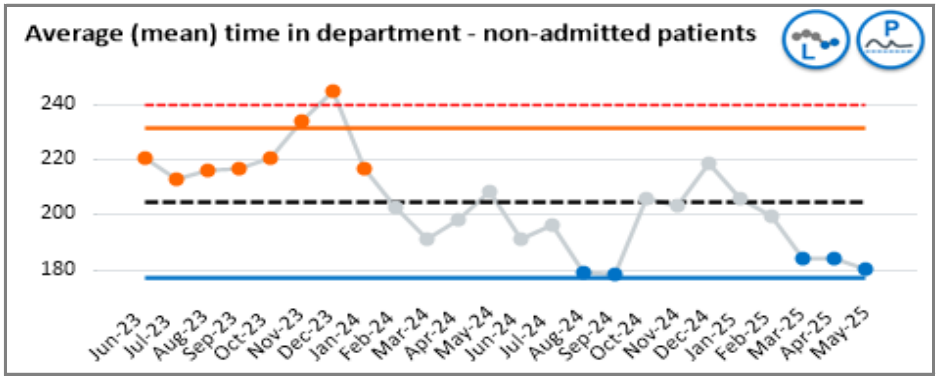
Urgent and Emergency Care | Supporting Metrics

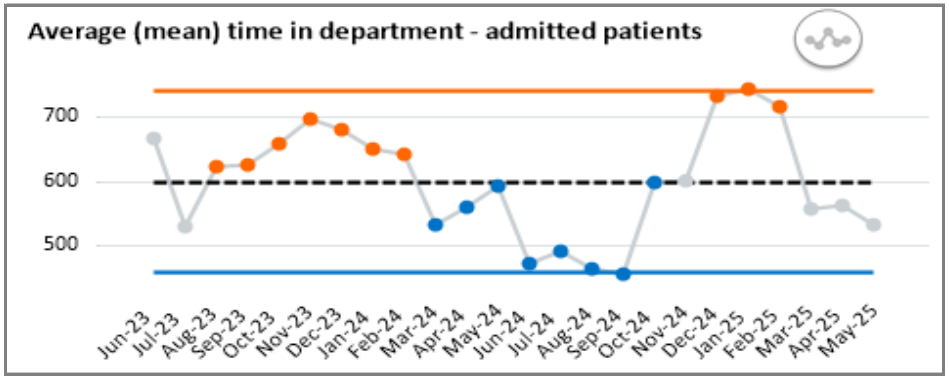
East and North Hertfordshire NHS Trust

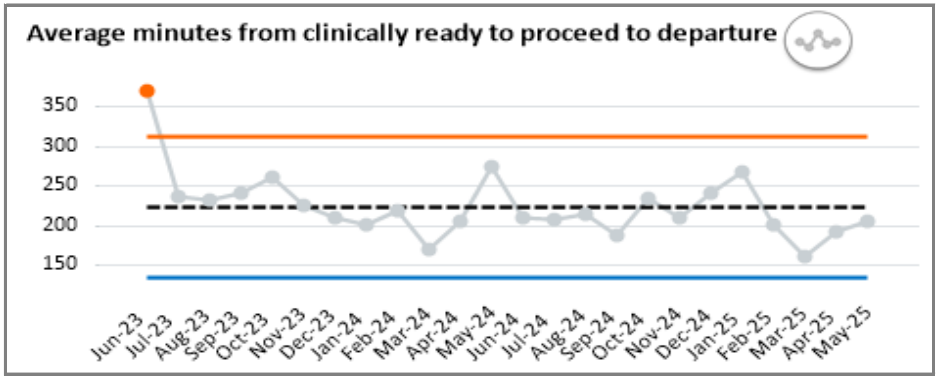








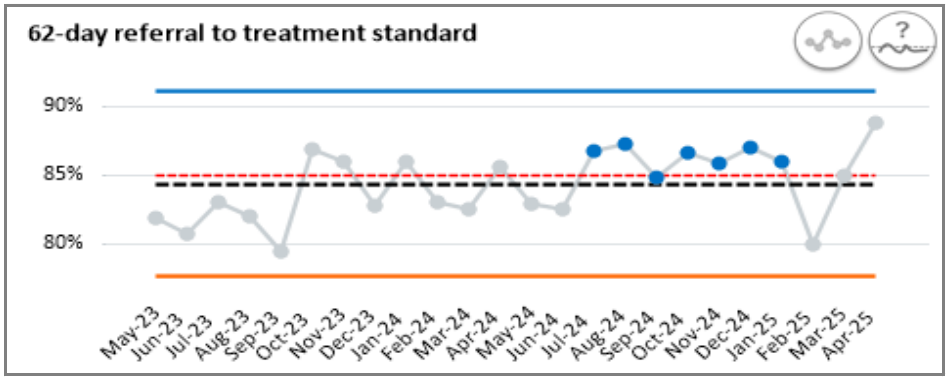


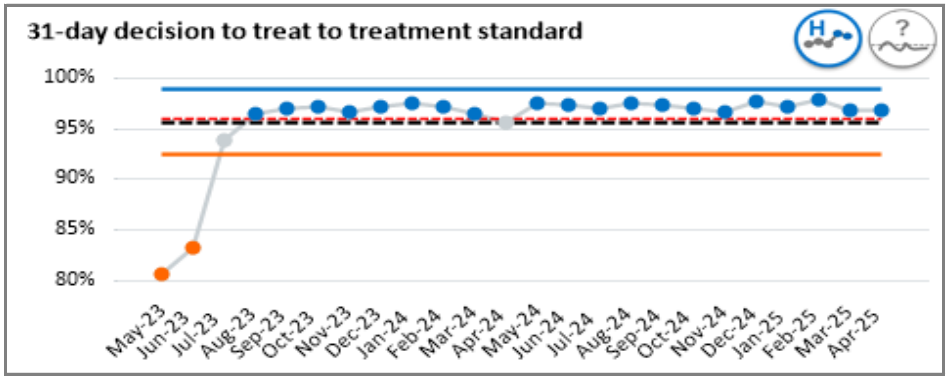


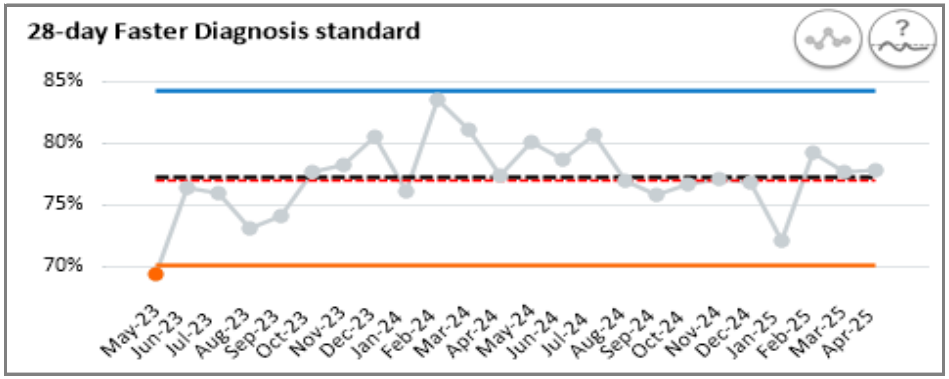
Month 02 | 2025-26

Operations

Cancer Waiting Times | Supporting Metrics







Key Issues and Executive Response

- We achieved 3 out of the 3 national targets in April 25 with compliance in the 28 day Faster Diagnosis, 62 Day general treatment standard, and 31-Day General treatment standard.
- 62 day performance in April was the best in last 2 years. Despite seasonal dips in performance the aggregate 62 day performance for the 24/5 year is compliant at 85.11% and has shifted positively compared to 23/4. This exceeds regional and national performance levels by around 20% and is within the 10 best performing hospitals in the country.
- All 3 standards met in 24/5. Work continues to sustain and improve CWT performance for the Trust: more focus on pathway analysis for challenged specialities to identify constraints and minimise delays; robust PTL management with clear escalations; and Demand and Capacity work to identify gaps in services.
- 2WW performance dropped in March and April due in part to high referrals in March which drove outpatient capacity challenges across all tumour sites; additional capacity is now in place. Staffing issues in breast radiology caused delays in the 1-stop service; the radiology team has arranged additional lists in June and July with one of the locums, and recruited two radiologists - starting in July and September.
- Job planning is taking place to reduce dependence on WLIs and help us to deliver 28 FDS compliance this year; target has increased to 80% from March 2025.
- Breach analysis continues for all patients against all standards to influence pathway redesign and learning with MDT teams.

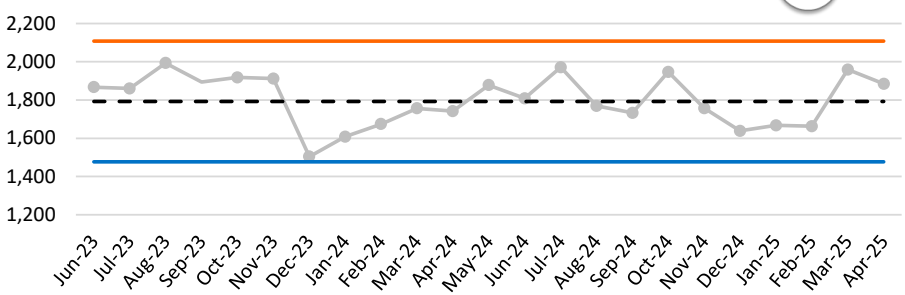
Month 02 | 2025-26

Operations

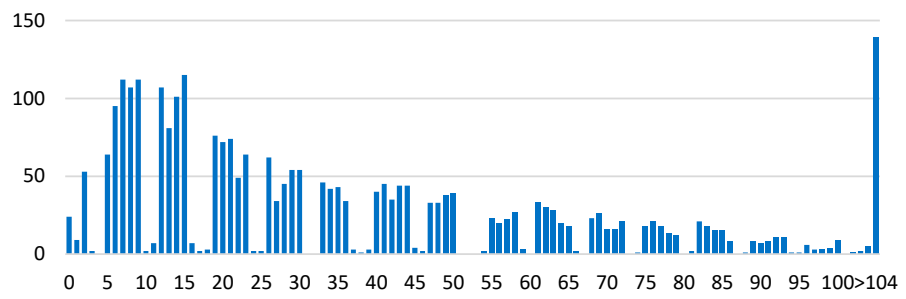
Cancer Waiting Times | Supporting Metrics

East and North Hertfordshire NHS Trust

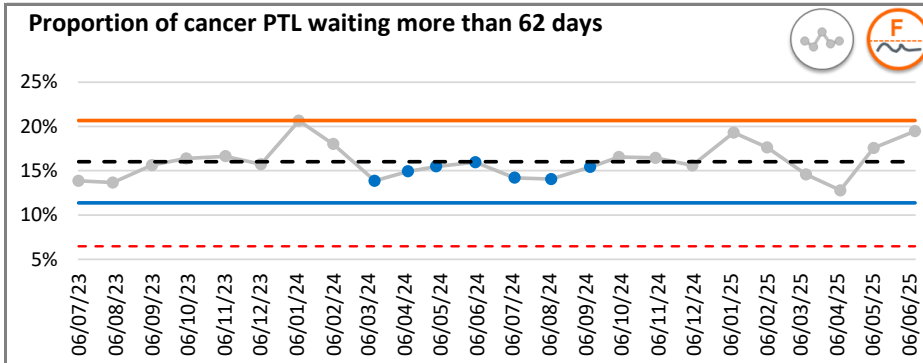
Suspected cancer referrals



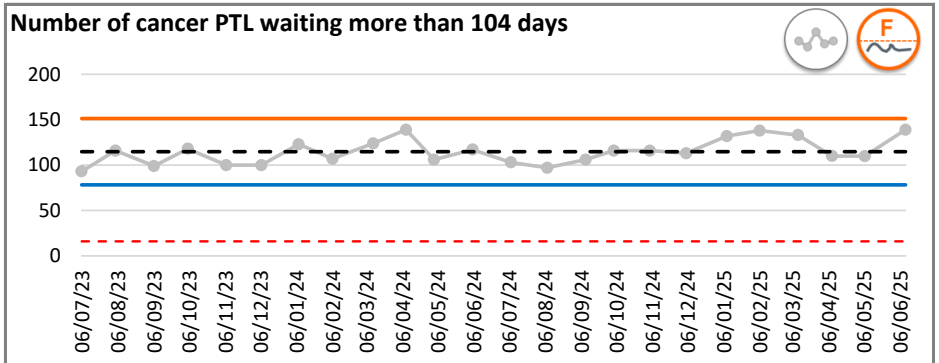
62-day PTL as at 11/06/2025



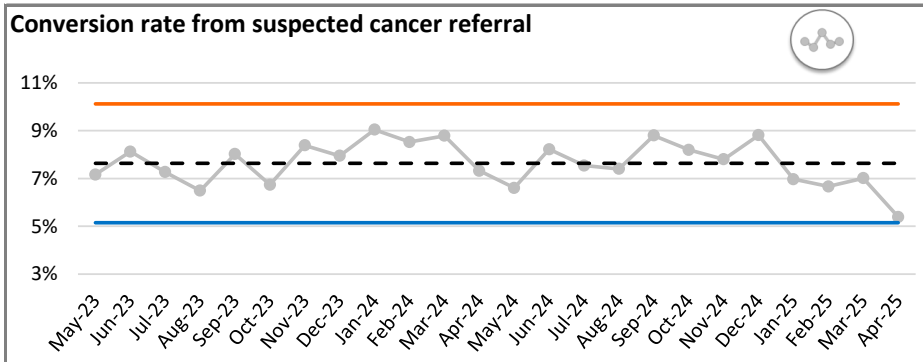
Proportion of cancer PTL waiting more than 62 days



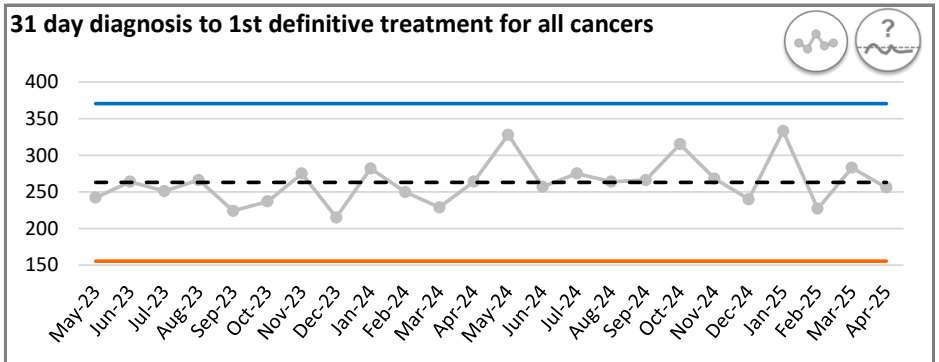
Number of cancer PTL waiting more than 104 days



Conversion rate from suspected cancer referral



31 day diagnosis to 1st definitive treatment for all cancers

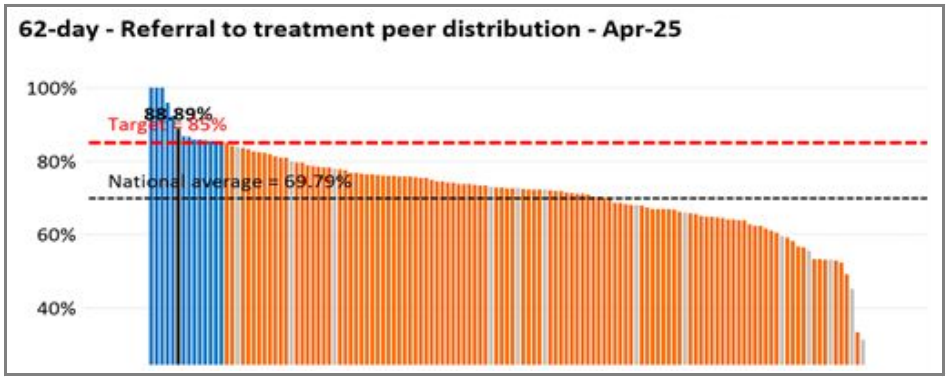


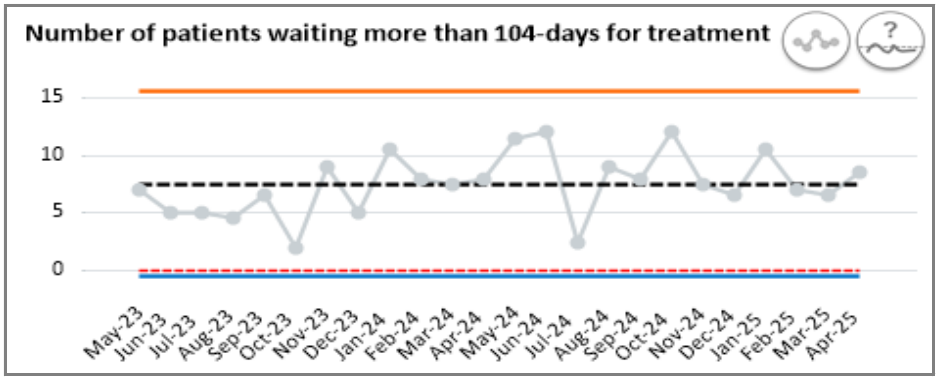
Month 02 | 2025-26

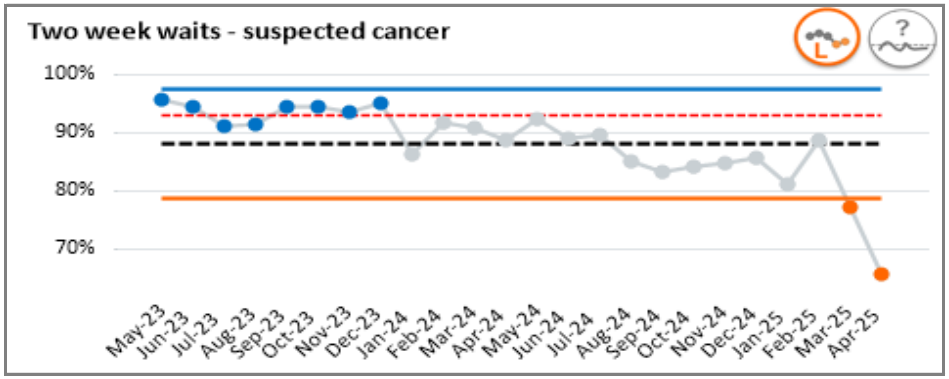
Operations

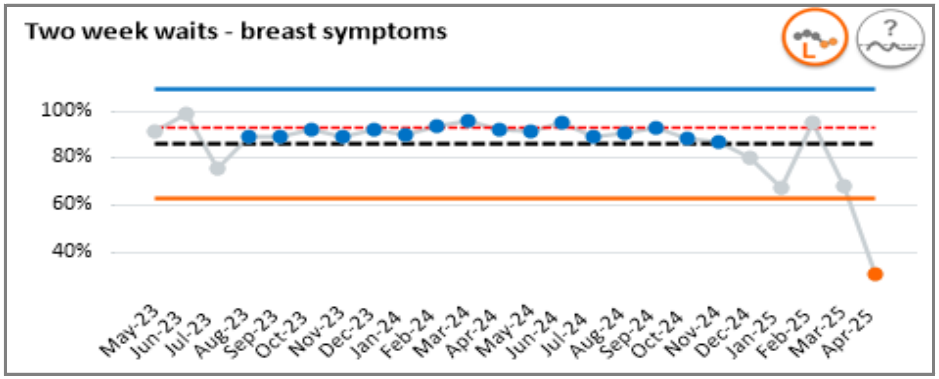
Cancer Waiting Times | Supporting Metrics

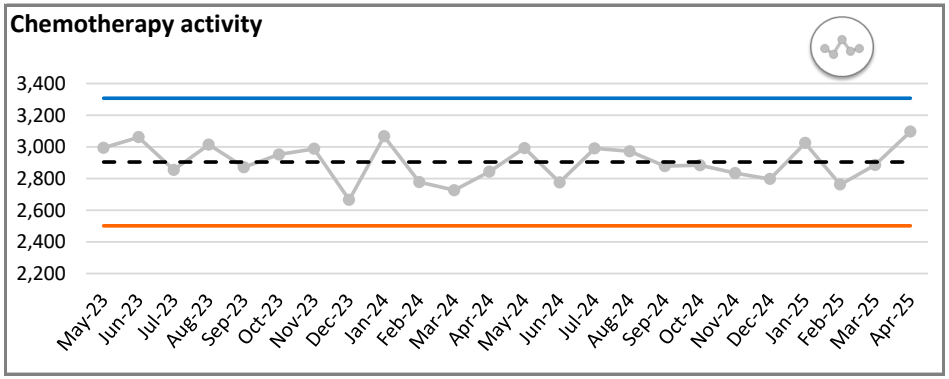
East and North Hertfordshire NHS Trust

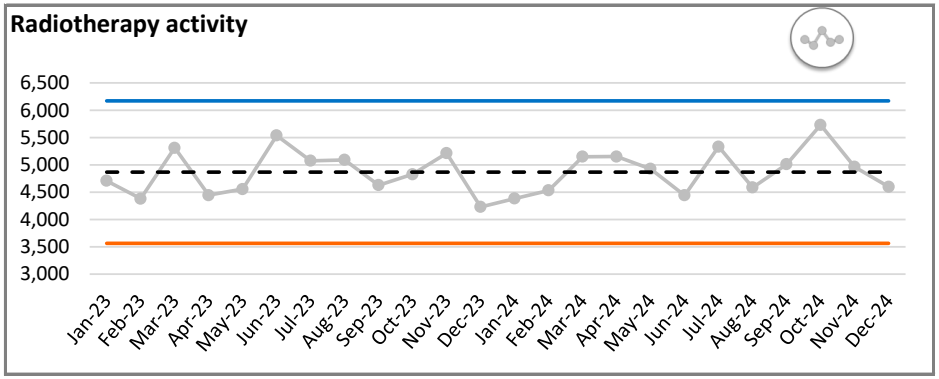










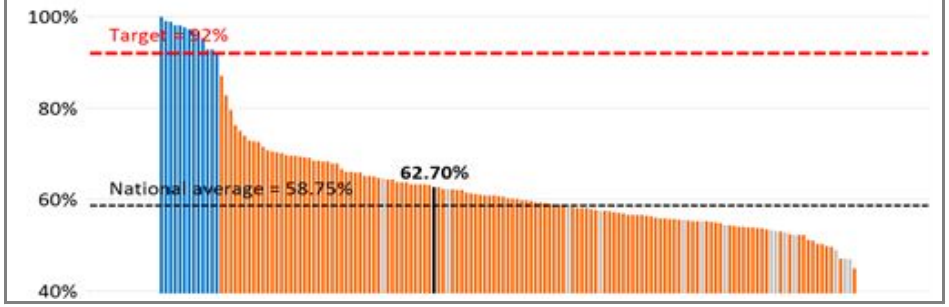


Month 02 | 2025-26

Operations

RTT 18 Weeks

East and North Hertfordshire NHS Trust



Key Issues and Executive Response

Community Paediatrics

- Community Paediatrics is now reported via the Community Data Set.
- Referrals have started to stabilise since April 2024, albeit at a level higher than capacity, so the waiting list continues to increase, but at a slower rate.
- Internal pathway improvements are starting to deliver additional capacity, with the system business case due later this year.
- With support from HWE ICB the Trust has outsourced 300 assessments, the impact of which is now starting to be seen in the reduction of CYP waiting over 78 weeks.
- Single point of referral for neurodiversity hosted at HCT implementation is delayed from April to September 2025, due to digital build issues.
- **78 Weeks** - There were 3,024 patients waiting over 78 weeks at the end of March, compared to 2,883 the previous month.
- **65 Weeks** - There were 3,667 Community Paediatric patients waiting over 65 weeks at the end of May.

Key Issues and Executive Response

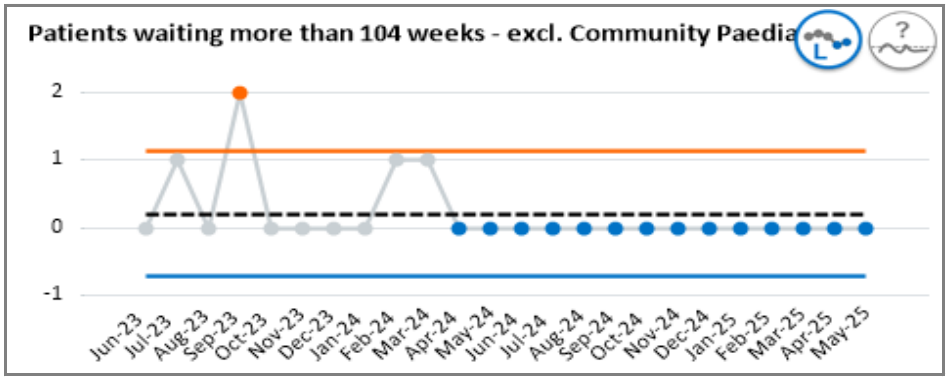
Excluding Community Paediatrics

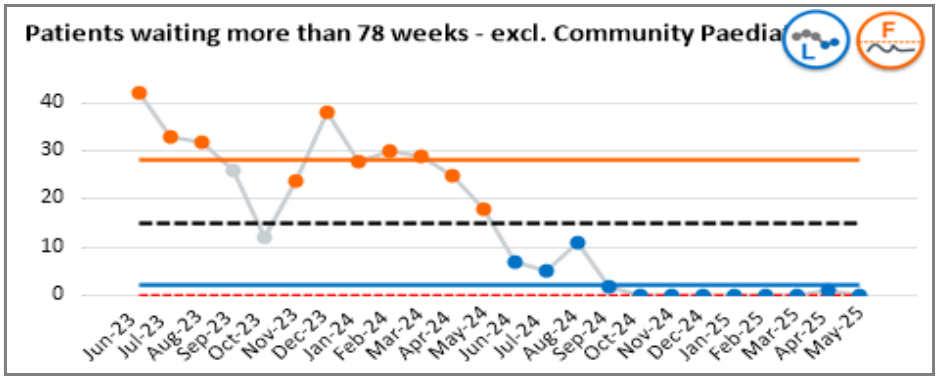
- **18 Week Performance** - Improved performance of 62.9% of patients waiting under 18 weeks in May, remaining above last month's national average of 58.75%. This is just 1.3% way from the March 2026 5% improvement target of 64.2% and ahead of trajectory.
- **52w proportion of PTL** - 1,059 patients / 1.96% waiting over 52 weeks in May, against the improvement target of no more than 0.7% patients in March 2026. This is very slightly behind trajectory. The no. of 52 week + patients reduced from April to May, but % performance deteriorated as the total PTL (denominator) reduced by a greater margin due to validation.
- **Awaiting First Event < 18 weeks** - 70.9% of patients waiting for first activity within 18 weeks against a March 2026 improvement target of 72.2%.
- We perform well on these 3 key targets vs peer Trusts.
- **65 Weeks** - 45 patients waiting more than 65 weeks at the end of May. 28 T&O, 40% of these either patient choice or clinical complexity. The remaining breaches from ENT, Gastro, Ophthalmology, Oral Surgery, Pain Management, and Urology.
- We anticipate approx. 30 patients waiting over 65 weeks at the end of June. Specialties of risk are T&O, Oral Surgery — as the new Cone Beam Computed Tomography (CBCT) service is embedded— and Pain. Targeted weekly patient-level management interventions continue to mitigate these risks.
- **Validation Sprint** - In early April, we started a 12-week Validation Sprint, an NHSE initiative to maximise pathways closed through validation. By end May, an additional 4,711 patient pathways above plan had been closed, potentially generating additional income of £155K. There has been a decrease of 1,404 in the overall RTT waiting list from last month.

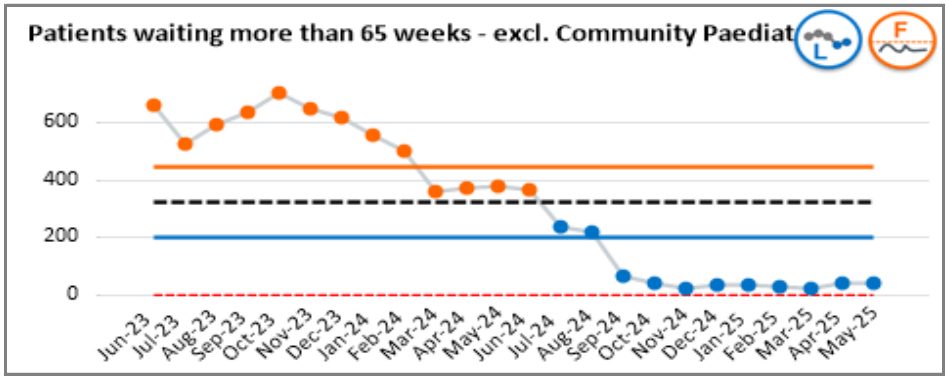
Operations

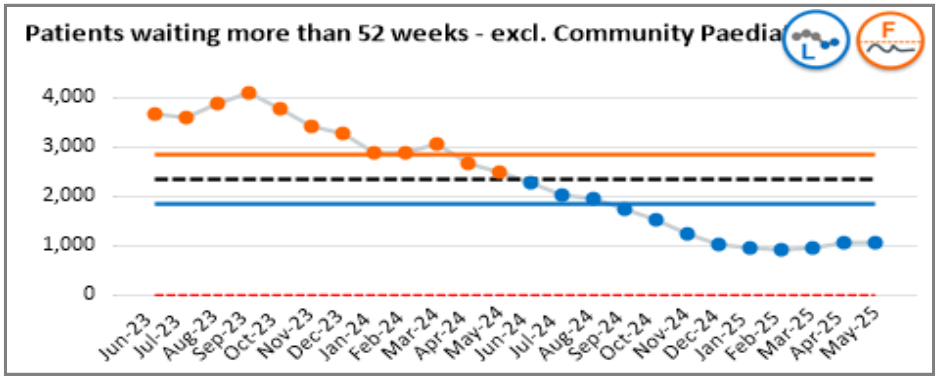
RTT 18 Weeks

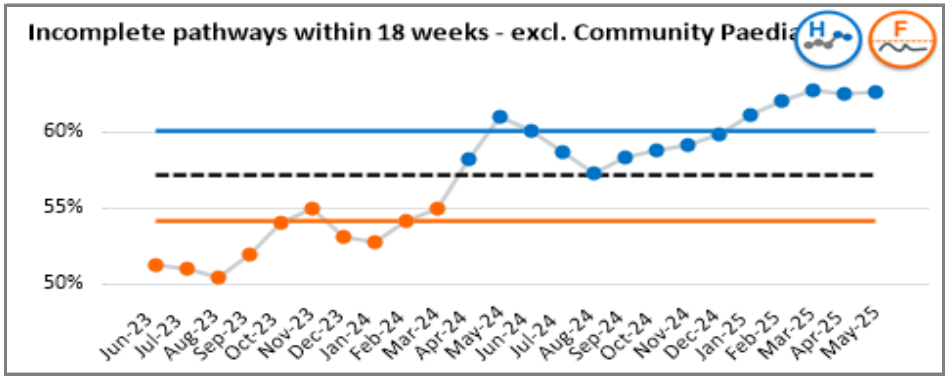
East and North Hertfordshire NHS Trust

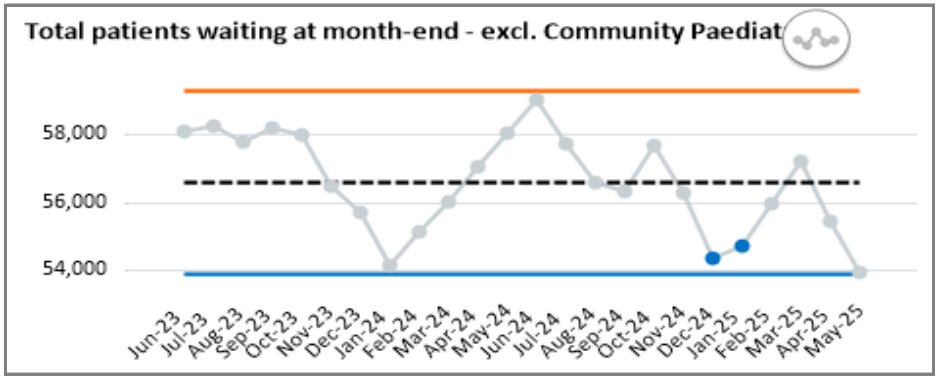










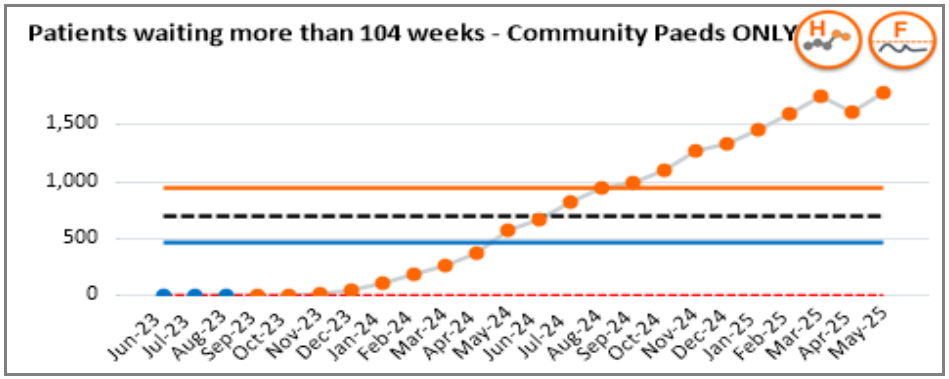


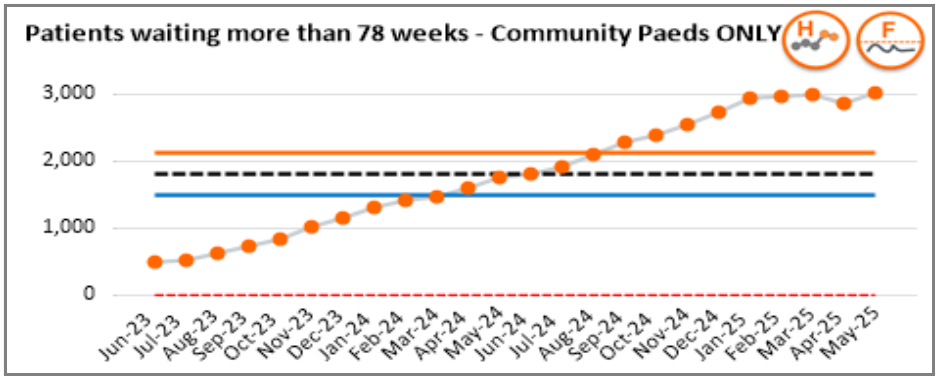
Month 02 | 2025-26

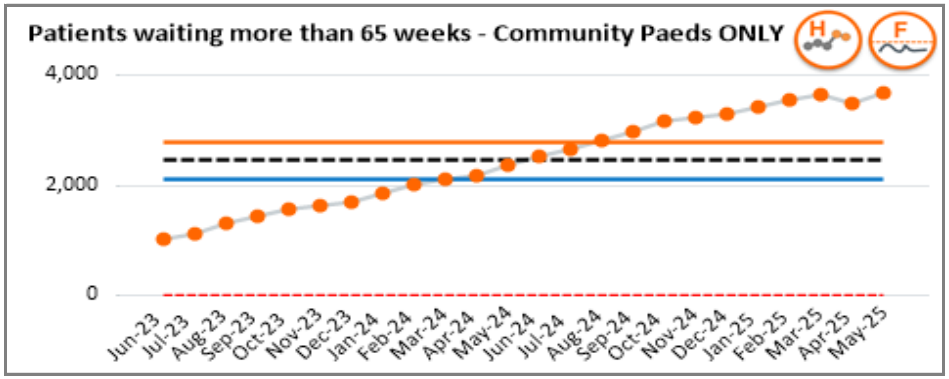
Operations

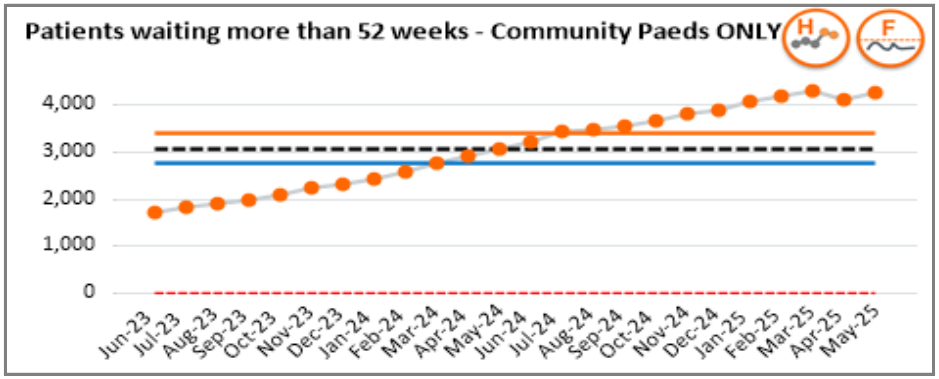
RTT 18 Weeks

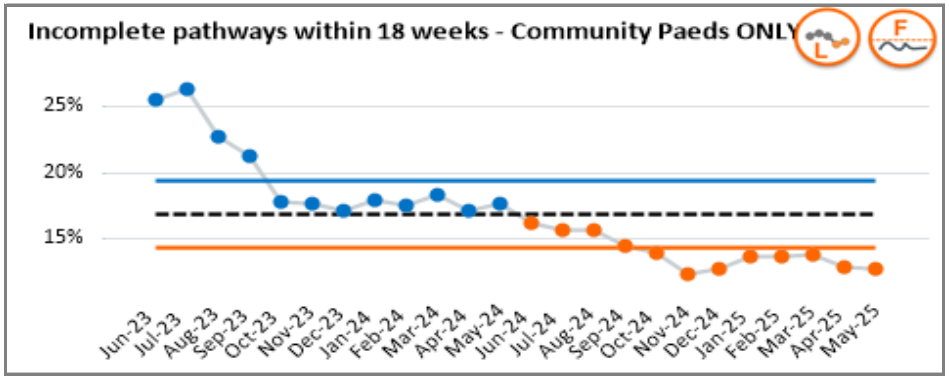
East and North Hertfordshire NHS Trust

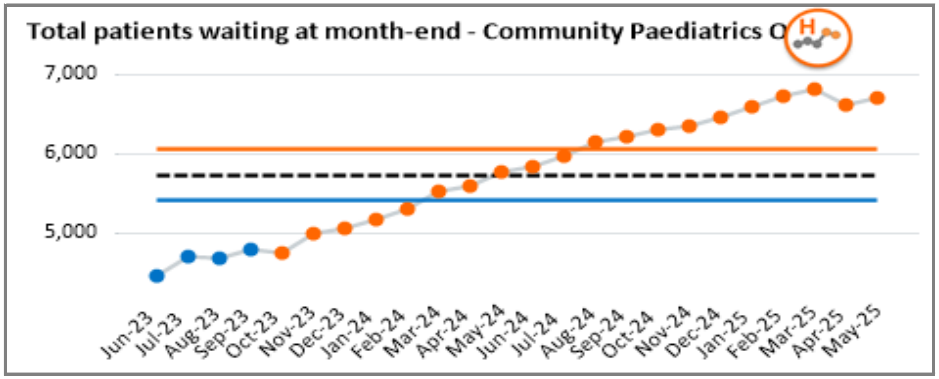










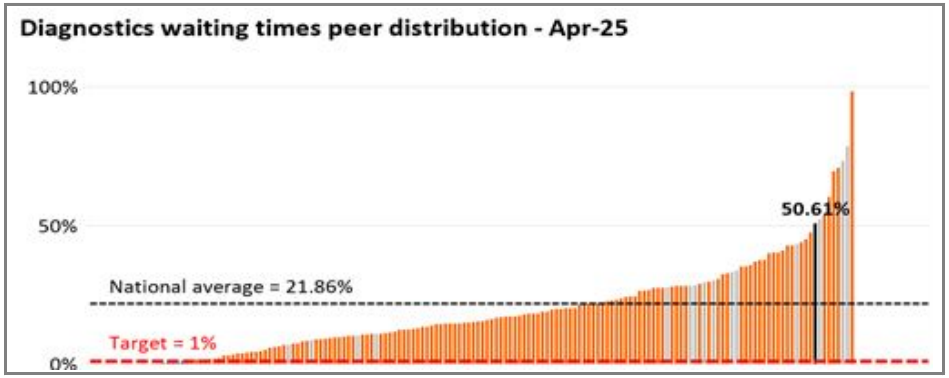


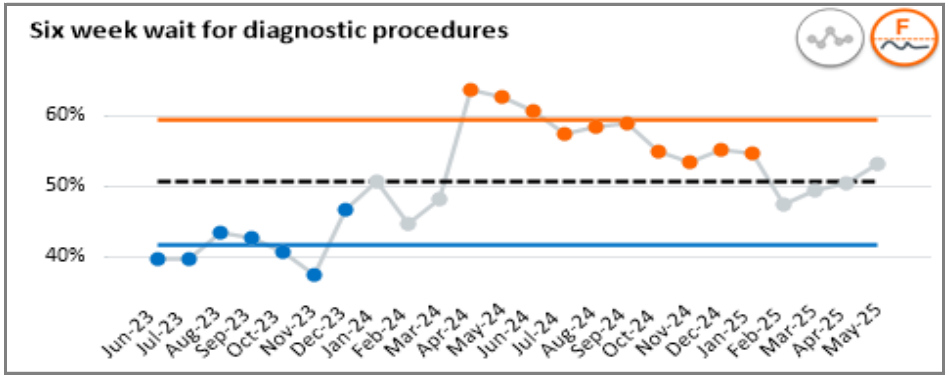
Month 02 | 2025-26

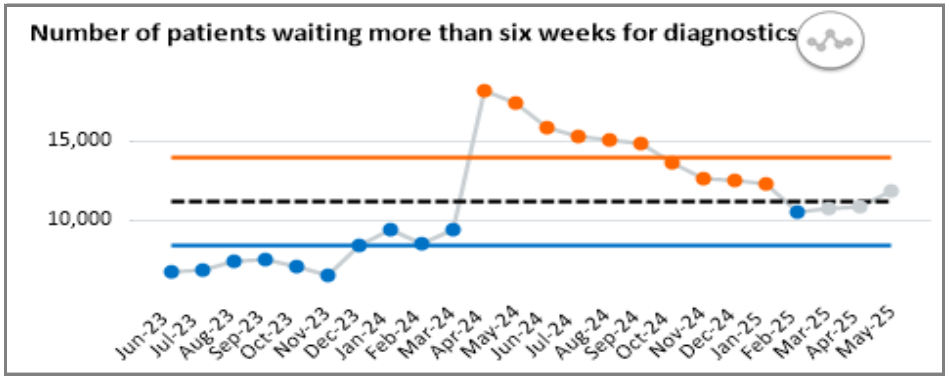
Operations

Diagnostics Waiting Times

East and North Hertfordshire NHS Trust







Key Issues and Executive Response

- May DM01 (% of patients waiting over 6 weeks for diagnostics) has deteriorated from 50.6 % to 53.2% due to vacancies and increased absence during May 25.
- For DM01 excluding Audiology, there are 5,388 patients waiting >6 weeks (46% reduction since April 24) and 598 patients waiting >13 weeks, 83% reduction since April 24.
- Excluding Audiology, average wait is down from 6.9 to 4.5 weeks, April 24 - May 25.

Challenges / Actions

- Refreshed capacity and demand modelling for MRI has been completed: significant gap (140 scans/wk) in capacity to meet demand and backlog clearance. There is an Imaging outsourcing plan for 25/26 to address this gap, use Inhealth for cancer MRI VAN days and to implement a 7 day service.
- D&C plan shows gaps in MR and NOUS; but we have mitigations (service redesign & ENHPS) in place to deliver DM01 compliance by Mar 2026.
- Adult Audiology booths have reopened; the investment growth business case has been submitted for external funding to support backlog clearance but has been declined; internal budget realignment has taken place and posts are out to advert.
- Paeds audiology remains challenged, but with some progress on mutual aid and capital funding allocated for estate infrastructure. Exec meetings to support with load levelling across HWE.
- Specialist US MSK and cardiology CT scans remain a challenge for capacity. Active recruitment is underway to address gap in capacity, with 2 WTE sonographers in pipeline, offering overtime and insourcing US model is been scoped.

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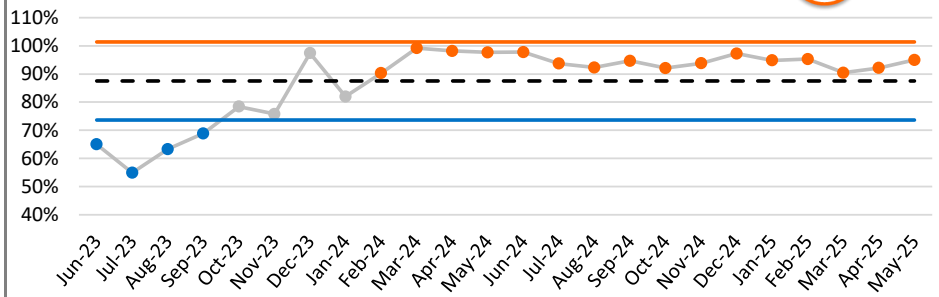
Operations

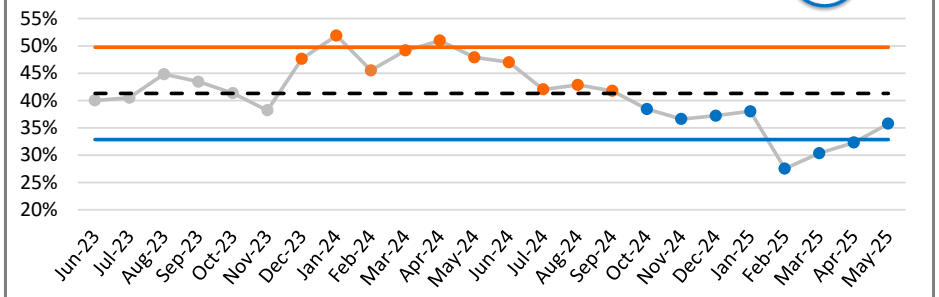
Diagnostics Waiting Times - Audiology

East and North Hertfordshire NHS Trust

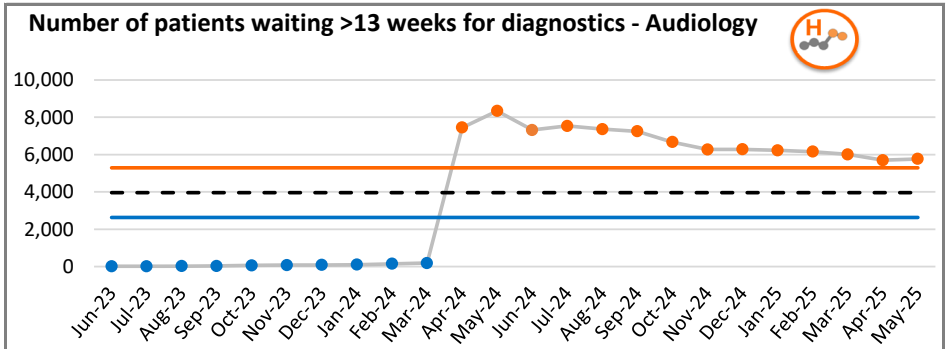
Six week wait (% > 6/52) for diagnostic procedures - Audiology



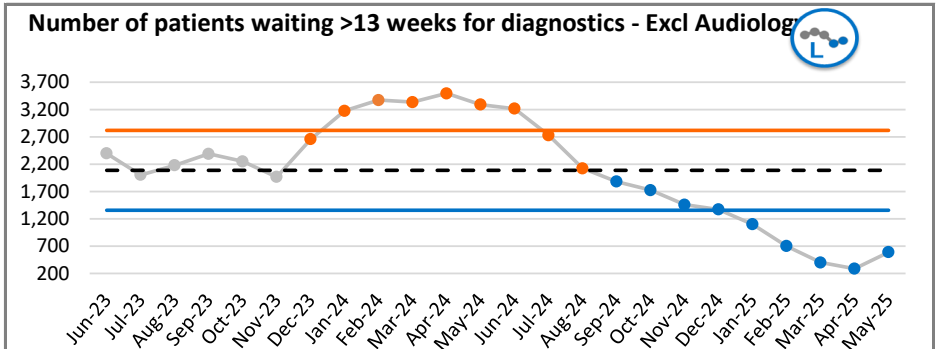
Six week wait (% > 6/52) for diagnostic procedures - Excl Audiology



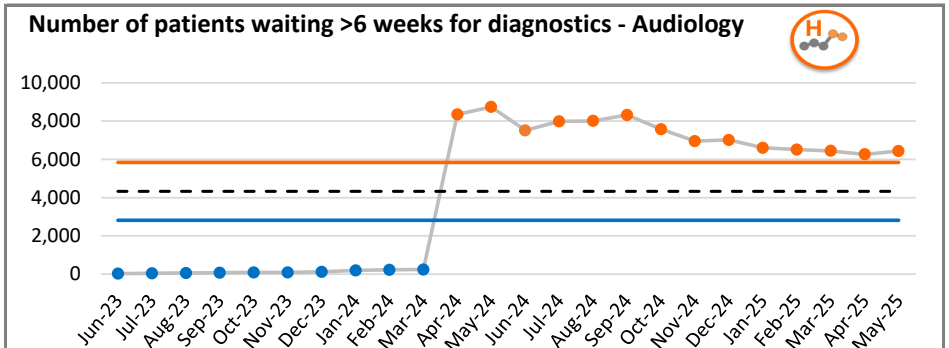
Number of patients waiting >13 weeks for diagnostics - Audiology



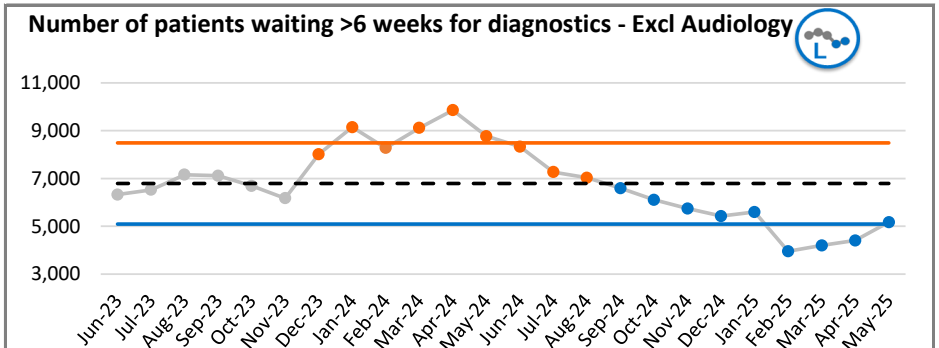
Number of patients waiting >13 weeks for diagnostics - Excl Audiology



Number of patients waiting >6 weeks for diagnostics - Audiology



Number of patients waiting >6 weeks for diagnostics - Excl Audiology

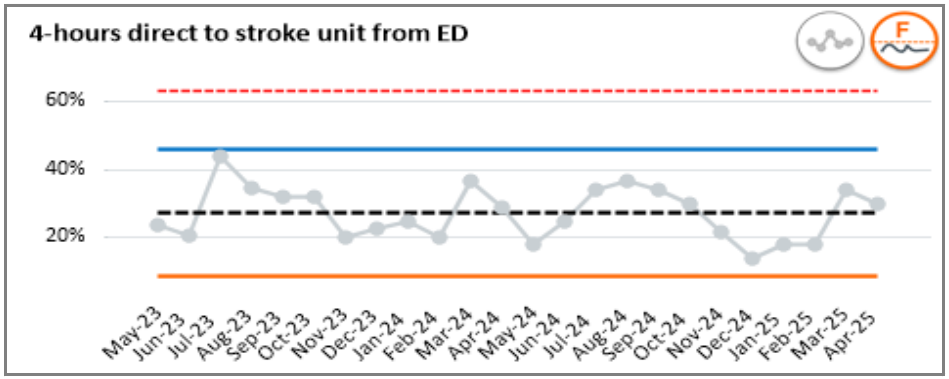


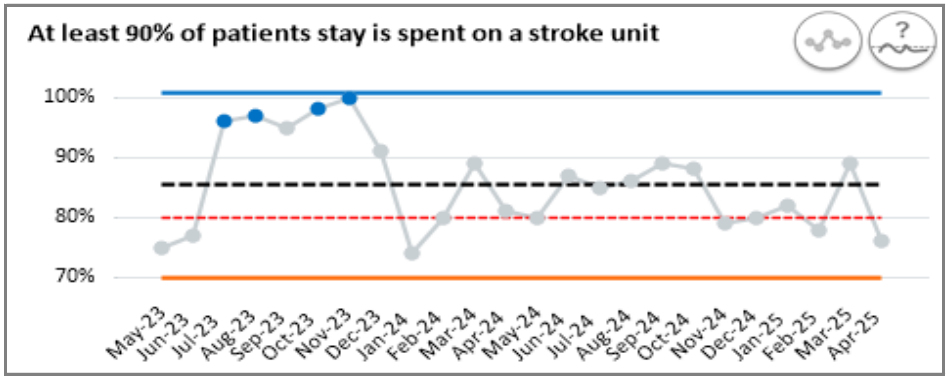
Month 02 | 2025-26

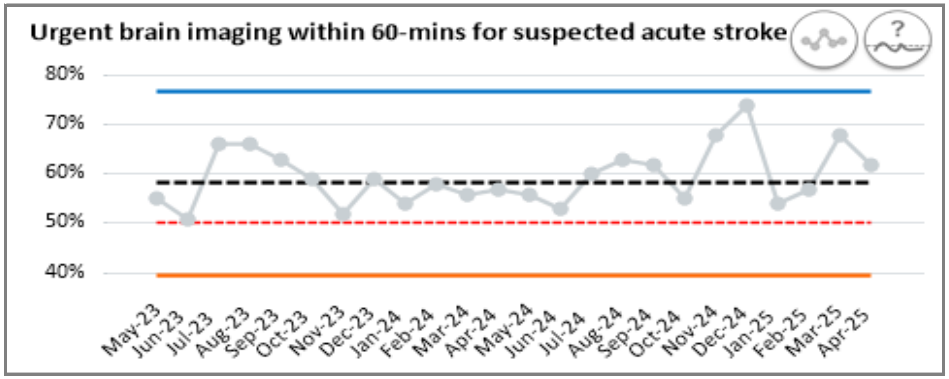
Operations

Stroke Services

East and North Hertfordshire NHS Trust

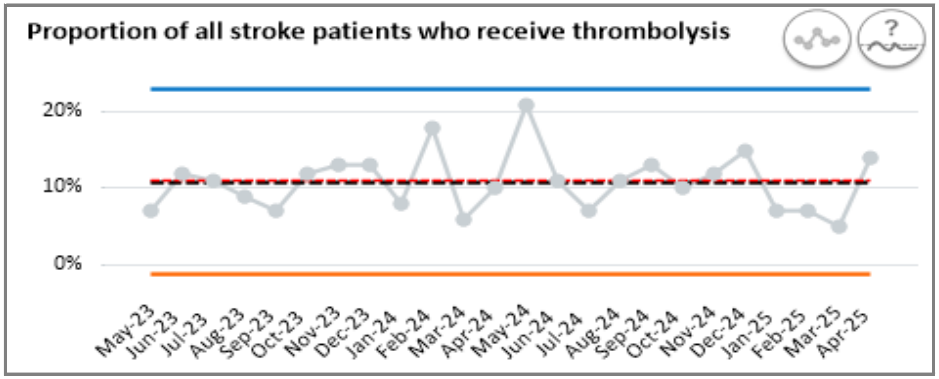






Key Issues and Executive Response

- **Thrombolysis** 14% with increase seen in patients presenting in ED. Projects targeting pre-alert systems and ED pathways aim to improve the efficiency of ED-stroke processes. Performance has been maintained, with ongoing weekly thrombolysis meetings forecasting a continued B rating for the second quarter.
- **4 hr admission** performance 30.5%, a decrease from the previous month, yet aligning with 25/26 improvement trajectory and first quarter achieved. The impact was primarily caused by outlier medical patients experiencing extended stays within ED.
- **Length of stay**: MDT LOS reviews conducted weekly, with escalation processes established for >14 days LOS. As a result, LOS has significantly decreased compared to the previous month.
- **CT within 20 minutes** (new standard) : 34%: a 4% improvement from previous month.
- **TIA performance**: Continuous improvements underway, including audits. A recent audit was shared as a learning resource across EoE. New discharge guidelines are being implemented to achieve the 24-hour target.



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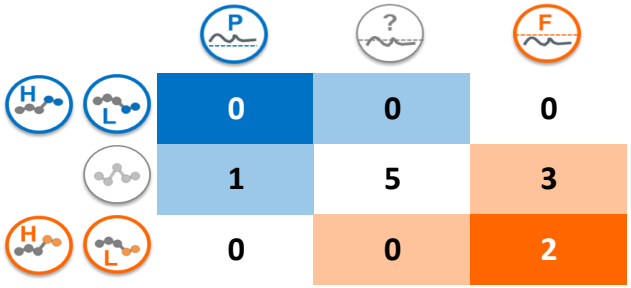
East and North Hertfordshire NHS Trust

Finance

Month 02 | 2025-26



Finance

Summary

East and North Hertfordshire NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Summary Financial Position	Surplus / deficit	May-25	-2.4	-3.50		?	Common cause variation Metric will inconsistently pass and fail the target
	CIPS achieved	May-25	1,245	819			Common cause variation No target
	Cash balance	May-25	77.9	40.9	L	F	13 points below the mean Metric will consistently fail the target
Key Financial Drivers	Income earned	May-25	45.3	57.4		P	Common cause variation Metric will consistently pass the target
	Pay costs	May-25	29.5	37.6		F	Common cause variation Metric will consistently fail the target
	Non-pay costs (including financing)	May-25	15.5	23.3	H	F	9 points above the mean Metric will consistently fail the target

Month 02 | 2025-26

Finance

Summary

East and North Hertfordshire NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Key Payroll Metrics	Substantive pay costs	May-25	24.9	33.7		F	Common cause variation Metric consistently fail the target
	Average monthly substantive pay costs (000s)	May-25	0.9	5.7		F	Common cause variation Metric will consistently fail the target
	Agency costs	May-25		0.9	L		9 points below the mean No target
	Unit cost of agency staff	May-25		16.1	H		1 point above the upper process limit No target
	Bank costs	May-25	3.7	3.1		?	Common cause variation Metric will inconsistently pass and fail the target
	Overtime and WLI costs	Mar-25	0.5	0.9		?	Common cause variation Metric will inconsistently pass and fail the target
Other Financial Metrics	Private patients income earned	May-25	0.4	0.6		?	Common cause variation Metric will inconsistently pass and fail the target
	Drugs and consumable spend	May-25	2.8	4.6		?	Common cause variation Metric will inconsistently pass and fail the target

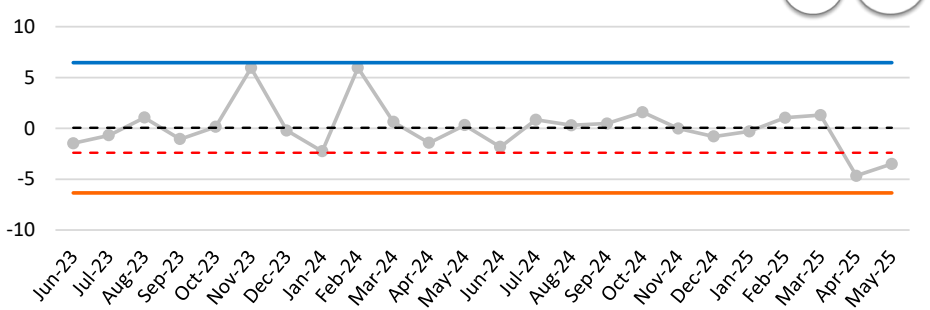
Month 02 | 2025-26

Finance

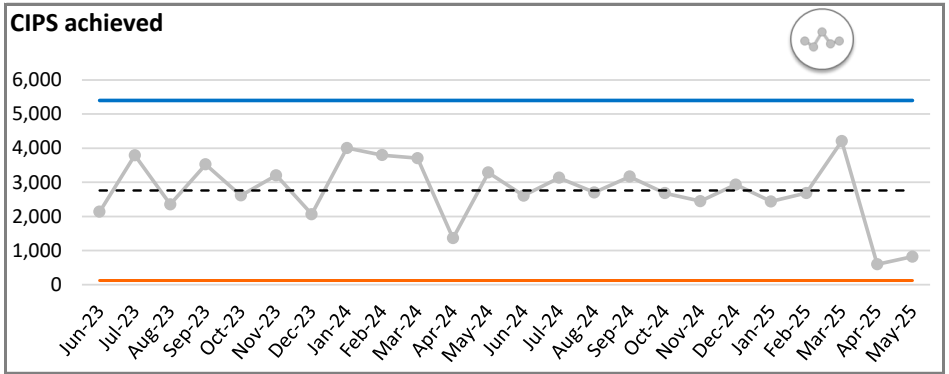
Summary Financial Position

East and North Hertfordshire NHS Trust

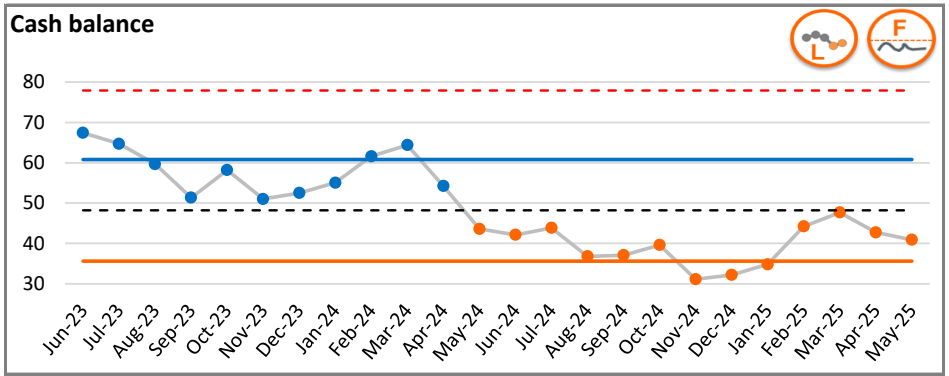
Surplus / deficit



CIPS achieved



Cash balance



Key Issues and Executive Response

- The Trust approved a breakeven plan for 25/26. This plan assumes that a £35.8m cost improvement programme will be delivered.
- At Month 2, the Trust has reported an actual YTD deficit of £8.2m. This is in line with phased plan expectations.
- The Trust has seen improvement in a number of the run rate hotspot areas that had consistently defined pay performance during the previous year. These areas will continued to be monitored closely to ensure that improvements are sustained.
- The CIP plan for month is only £1.3m, so there will need to be a significant step up in financial performance in the latter months of the year.
- Elective income performance in the YTD has been poor across inpatient and daycase points of delivery.

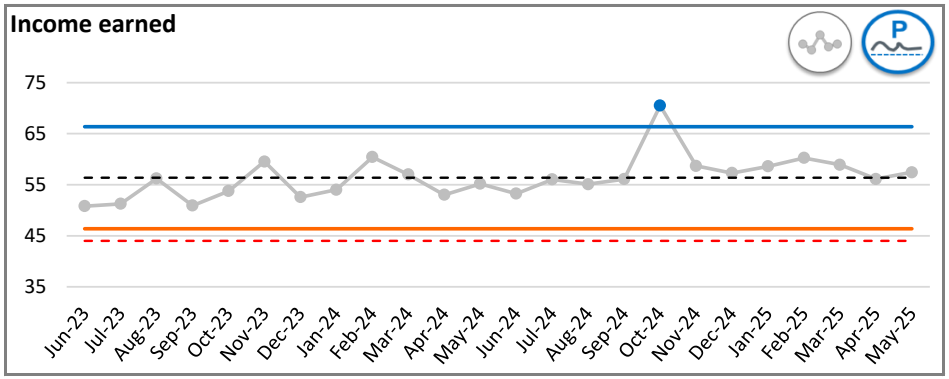
	Annual Budget £m	Budget YTD £m	Actual YTD £m	Variance YTD £m
Income	700.6	113.1	113.6	0.5
Pay	-424.7	-74.1	-74.4	-0.3
Non Pay	-238.4	-41.0	-41.3	-0.3
EBITDA	**37.5**	**-2.0**	**-2.1**	**-0.1**
Financing Costs	-37.5	-6.3	-6.1	0.2
Retained Deficit exc. PSF	**0.0**	**-8.2**	**-8.2**	**0.1**
Surplus / Deficit (excl Fin Adj's)	**0.0**	**-8.2**	**-8.2**	**0.1**

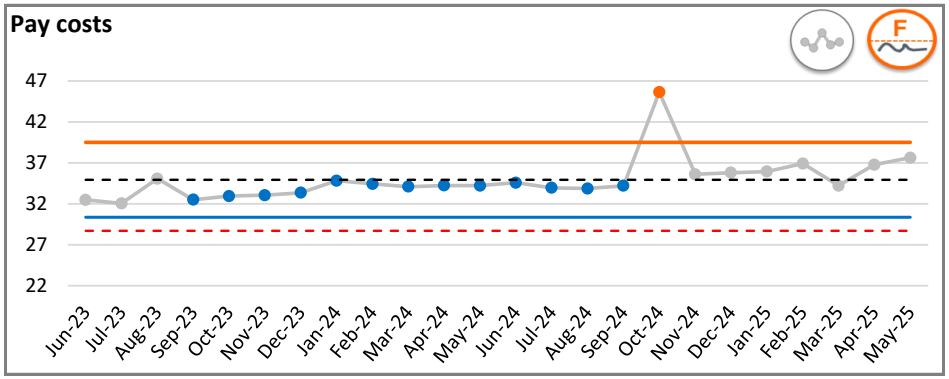
Month 02 | 2025-26

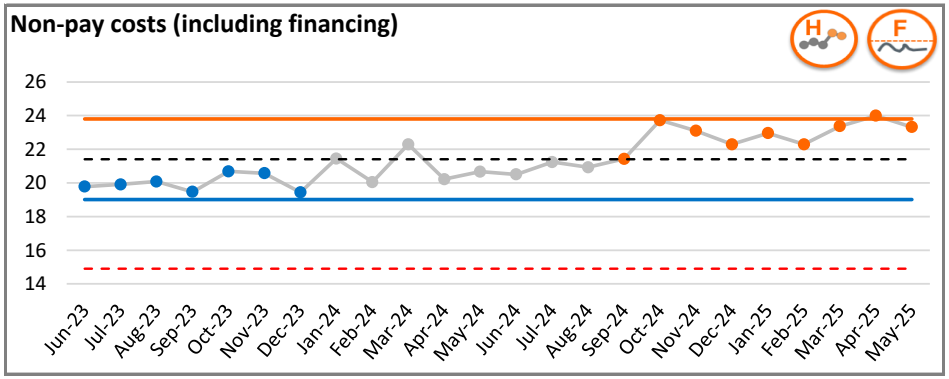
Finance

Key Financial Drivers

East and North Hertfordshire NHS Trust







- The Trust is reporting a £8.2m deficit at the end of Month 2, which is in line with plan.
- The CIP plan phasing assumes just £1.25m (3.5%) CIP delivery against the £35.8m target, so there will need to be a significant step up in CIP delivery and financial performance in the latter months of the year.
- ERF activity YTD was below Divisional phased capacity plans in both Planned and Unplanned Care. However, waiting list payments have significantly increased in May and are now £0.2m above the YTD plan.
- The under performance on ERF activity, has largely been mitigated as the Trust has agreed a fixed payment for all ERF activity for Herts and West Essex ICB. However, this is expected to be a non recurrent benefit, and RTT targets will still need to be met. There is a significant financial risk if RTT targets are not met.
- There are significant pressures within ward areas across the Trust where there is a year to date overspend of £0.6m.
- Although April and May have seen absolute reductions in WTE headcount, there continues to be a pattern whereby substantive workforce is growing but temporary staffing reductions are not falling at the same pace.
- Although bank and agency expenditure is just within the targets agreed within our financial plan, the target significantly reduces in the second half of the year.
- There has also been improvement in most of the pay 'hot spot' areas for 2024/25 which had a significant focus in quarter 4. There are still ongoing pressures within maternity and Unplanned Care medical staffing.
- Non pay reported a £0.7m adverse variance, of which £0.5m related to high cost drugs and devices. There was a £0.2m adverse variance YTD on drugs, particularly within Gastroenterology.

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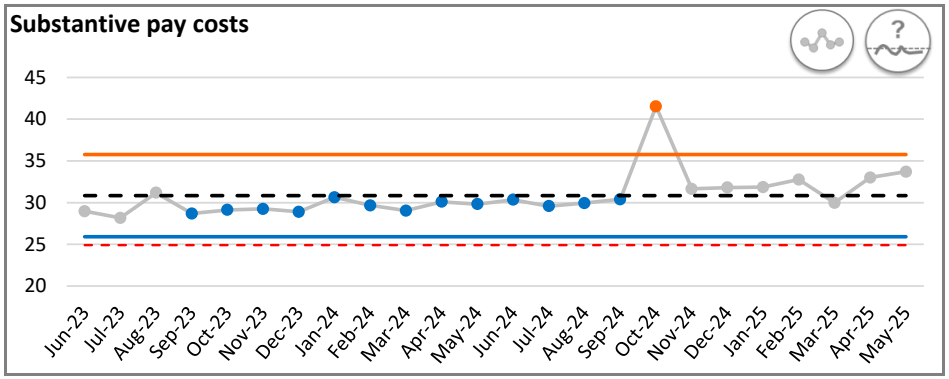
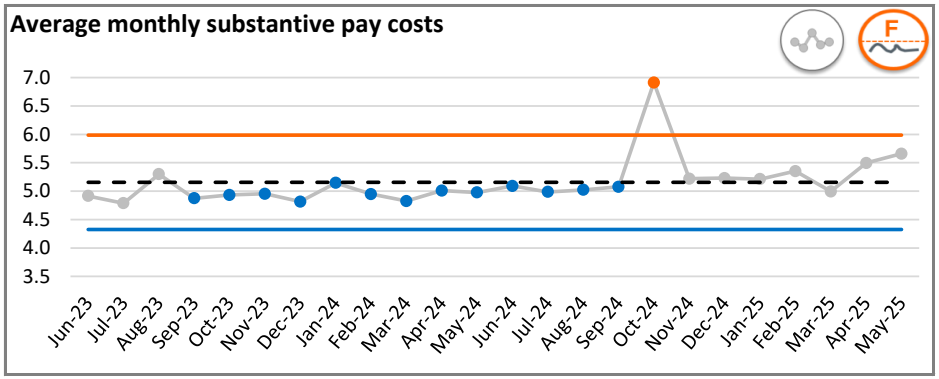
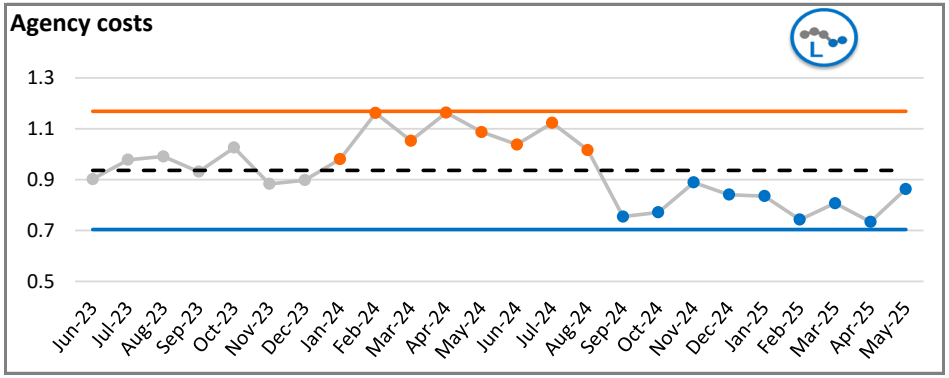
Finance

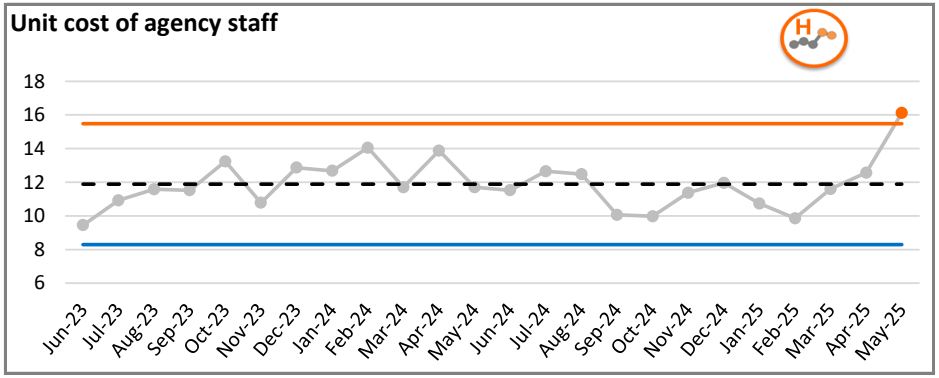
Other Financial Indicators

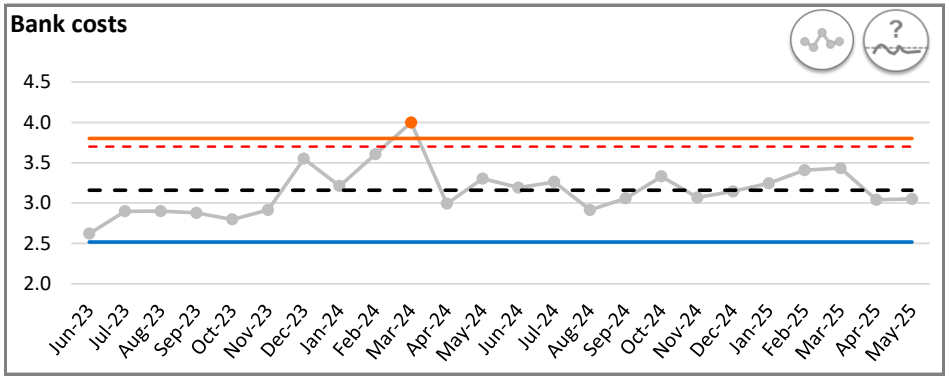
East and North Hertfordshire NHS Trust

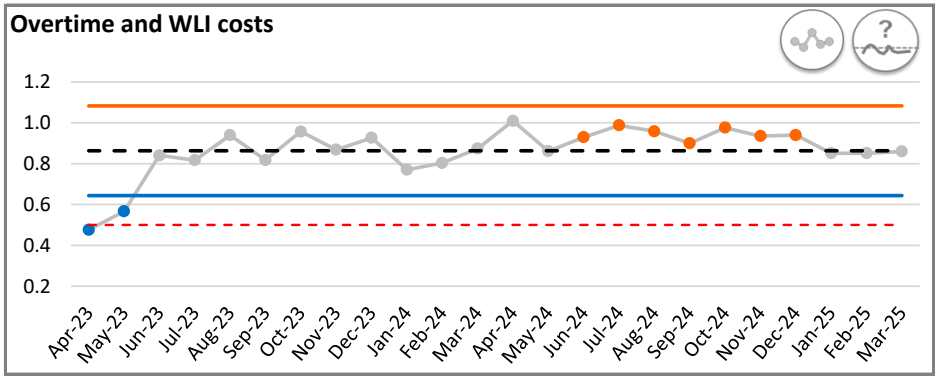












Month 02 | 2025-26

NHS
East and North Hertfordshire
NHS Trust

People

Month 02 | 2025-26

	P	?	F
H / L	0	2	0
	0	2	2
H / L	0	1	0

People

Summary

East and North Hertfordshire NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Work	Vacancy rate	May-25	8%	8.2%		?	Common cause variation Metric will inconsistently pass and fail the target
	Bank spend as a proportion of WTE	May-25	5%	8.2%		F	Common cause variation Metric will consistently fail the target
	Agency spend as a proportion of WTE	May-25	3%	2.2%	L	?	8 points below the mean Metric will inconsistently pass and fail the target
Grow	Statutory and mandatory training compliance rate	May-25	90%	88.6%	L	?	9 points below the mean Metric will inconsistently pass and fail the target
	Appraisal rate	May-25	90%	79.1%		F	Common cause variation Metric will consistently fail the target
Thrive	Turnover rate	May-25	10.5%	7.5%	L	?	8 points below the lower process limit Metric will inconsistently pass and fail the target
Care	Sickness rate	May-25	4.0%	4.7%		?	Common cause variation Metric will inconsistently pass and fail the target

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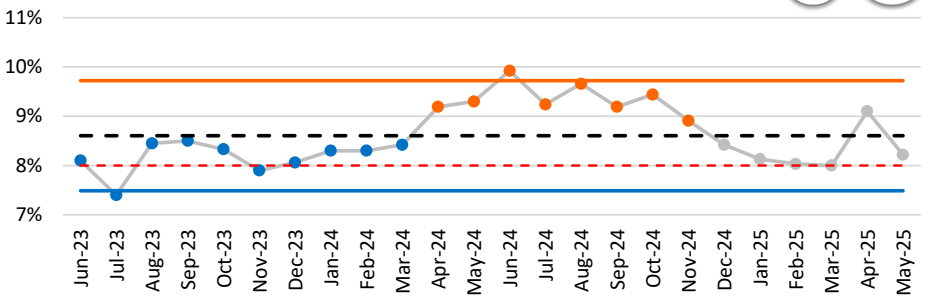
People

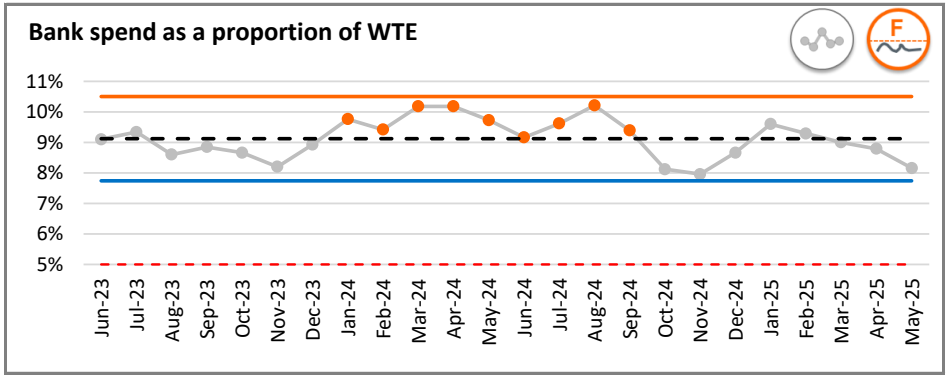
Work Together

East and North Hertfordshire NHS Trust

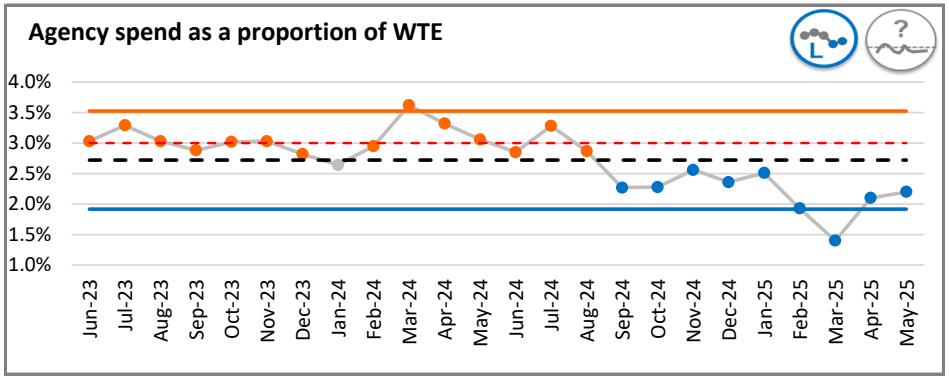
Vacancy rate



Bank spend as a proportion of WTE



Agency spend as a proportion of WTE



Key Issues and Executive Response

- The overall vacancy rate decreased to 8.2% (555 vacancies) from 9.1%. FTE in post increased and recruitable FTE decreased.
- Nursing and midwifery vacancy rate decreased to 11.93% from 12.15%, and recruitment establishment also decreased by 4 WTE.
- High volumes of interest from band 5 newly qualified nurses. Support from the senior nursing team required to place them.
- 249 people in the recruitment pipeline, consisting of 40 doctors, 91 nurses/midwives, 25 CSW/MSW, and 34 allied health professionals.
- Recruitment experience dropped from 4.6 to 4.2, but remains ahead of target of 5.
- Bank and Agency spend continue to reduce and total FTE usage is below 25/26 targets
- Band 5 nursing rate alignment to AfC implemented in June, with run rate savings of £800k in year.
- Bank and agency pay reviews continue for medical locum pay rates, with financial savings opportunities of up to £900k. Review against vacancies continues.
- Admin Temporary staff approvals granted only where patient safety impact or income generation exists.
- Continued increase in % of Clinical staff on a roster from 95% to 97%, including increase in Medical staff (96% to 98%)
- % of roster approved 6 weeks in advance has also increased.

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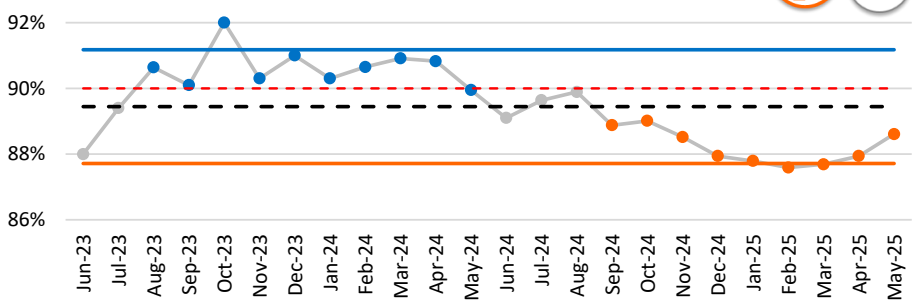
People

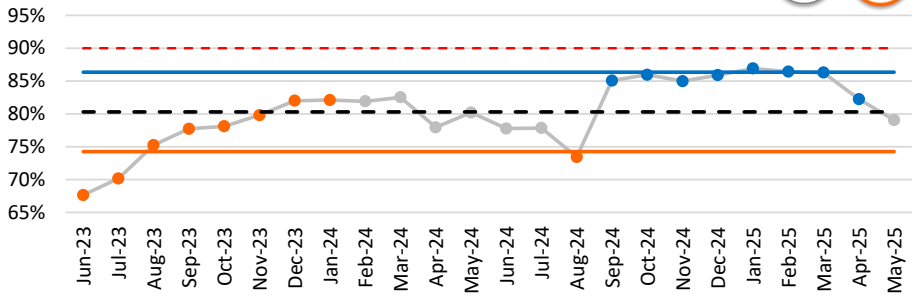
Grow Together

East and North Hertfordshire NHS Trust

Statutory and mandatory training compliance rate



Appraisal rate



Key Issues and Executive Response

- On-going Grow Together communications shared via the Trust News with acknowledged limited level of support available. Monthly open online support for managers now in place till Aug.
- Reviewing compliance data as presented via Power BI. All GTR compliance must zero on 1 April, inline with the Trust GTR window (April - Aug).
- Statutory and Mandatory training requirements are subject to a national review, it is expected national on-line standards modules will be introduced in due course
- At ENHT an internal review is underway to agree core mandatory topics and then role related specifics identified. any new requests are subject to panel review and approval to ensure we manage levels of time 'v' productivity in this space.
- A national Memorandum Of Understanding (MOU) is now agreed and is expected to be live in early May, this enables staff to carry their mandatory training between organisations to improve and support productivity levels in the NHS.
- Pre/Post Registration - currently 203 students on site across all programmes. 116 staff currently on preceptorship including 27 newly enrolled preceptees.
- Moving & Handling compliance (level one): 92.1%, (level two) 80.2%
- CPD - confirmation received from NHSE re funding allocation for 25/26, agreement with Finance to 'front load' for Q1 so staff do not miss out on opportunities between April and June.
- GMC Survey is now closed, all comments and responses actioned -full report will be available early August.

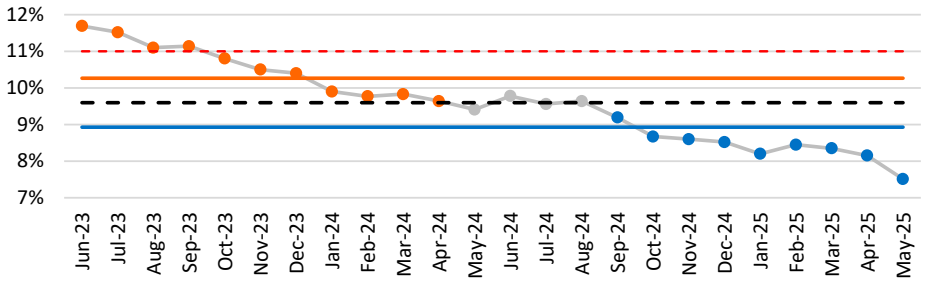
Month 02 | 2025-26

People

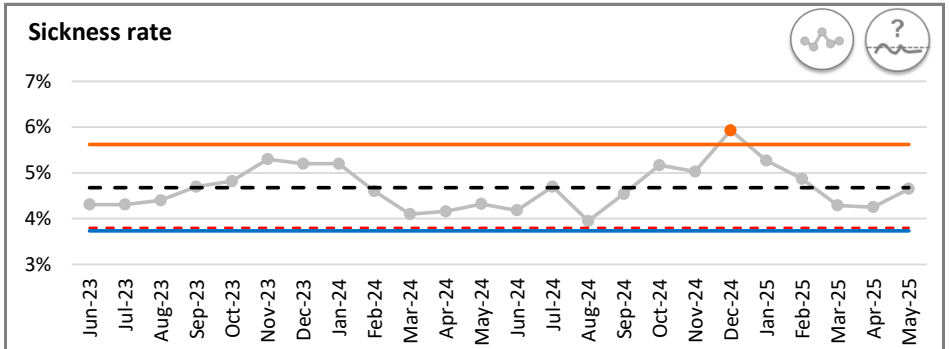
Thrive Together | Care Together

East and North Hertfordshire NHS Trust

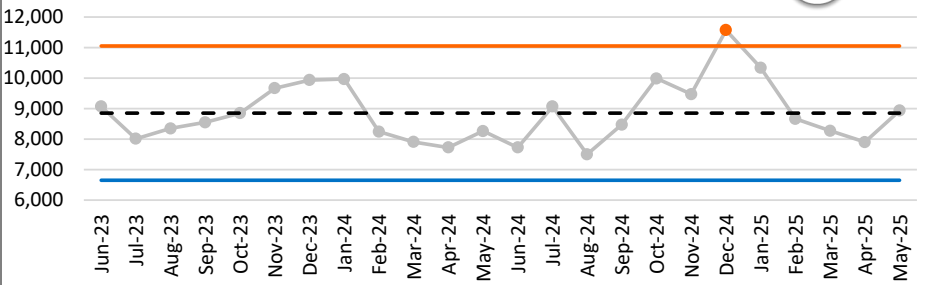
Turnover rate



Sickness rate



Total sickness days lost



Key Issues and Executive Response

Thrive Together

- There is 1 suspension with a duration of 39 days the hearing remains scheduled for June 2025. Disciplinary durations have increased due to the involvement of external bodies such as counter fraud.
- the average duration of grievances has reduced this month due to the closure of 7 cases.
- Negotiations continue with staff side to launch the workplace mediation service .
- The last of the Band 2/3 CSW/MSW extended scope payments are now going through for June main payroll and supplementary run.

Care Together

- There has been an increase in sickness absence levels in May, in particular sickness absence due to stress and mental health issues is raised. Referrals from managers for occupational health advice have also increased, stress and mental health issues are currently the most common reason for referral.
- 'Here for You' which provides staff support and team reflection sessions facilitated by a psychologist has commenced in June. This offers a proactive approach to reducing stress at work and preventing colleagues from becoming unwell.
- Sickness absence activity continues with LTS and STS review meetings. Managers are being supported to progress cases to stage three where appropriate.

Month 02 | 2025-26

Board committee report

NHS East and North Hertfordshire Teaching NHS Trust

Meeting	Public Trust Board			**Agenda Item**	14
Report title	Quality and safety (QSC) reports to the board For 28 May 2025 & 25 June 2025			**Meeting Date**	9 July 2025
Chair	Dr David Buckle				
Author	Deputy Trust Secretary				
Quorate	**Yes**	☒	**No**		☐

Alert (Matters of concern or key risks to escalate to the Board):

- QSC commissioned an update on the Fire risk assessments. We have been advised that they are complete for all in-patient areas but for some outpatient areas further work is required. All risk assessments are due to be completed by end July 2025.
- Maternity Services use the K2 digital platform but there are ongoing digital and data challenges since the transition to the K2 system. As a consequence, there are gaps in assurance regarding data quality. This will be one of the issues we will be asking the OneEPR committee to look into.
- There are a number of ongoing Patient Safety Incident Investigations (PSIIs) and the committee discussed the team's capacity to support all the open PSIIs. We were advised that there is sector external assistance, but this is a safety priority for the Trust, and we will monitor team capacity and all delivery elements closely.

Assurances provided to the Board:

- At the May meeting we looked at a PSII Audiology serious incident and agreed that the report provided a reasonable assurance of the rigour of the investigation undertaken and learning identified.
- Complaints are increasing and therefore, we have asked for a brief summary on the root cause and lessons learned from the analysis on the complaints received.
- At the June meeting, we looked at a PSII relating to ED Anaphylaxis, the summary of the areas of improvement and safety were discussed. QSC advised the team that communication with the affected families was of critical importance and should be clear, sensitive and transparent. We heard that this is not always as good as we would expect due to a number of practical issues.
- QSC continues to closely monitor all aspects of hospital acquired thrombosis. We were pleased to hear that a venous thromboembolism (VTE) practitioner will join the Trust in September to strengthen clinical leadership.

Advise (Matters the Board should be aware of not covered above e.g. on-going monitoring, new developments etc):

Decisions made by the committee or major actions commissioned and work under way:

- The Committee continues to closely monitor fire safety standards particularly those related to external cladding. Work is ongoing with this.

• The Committee will have additional meetings in July and possibly in September to ensure that there is enough level of scrutiny on the number of PSIIs that we currently have. There are 11 open PSIIs in June.
Any actions recommended to improve effectiveness of the meeting:
This remains ongoing and will take some months to embed.

Recommendation	The Board is asked to **DISCUSS** the report from the Committee.

To be trusted to provide consistently outstanding care and exemplary service

Board committee report

NHS East and North Hertfordshire Teaching NHS Trust

Meeting	Public Trust Board	**Agenda Item**	15
Report title	Finance, Planning and Performance Committee – May and June	**Meeting Date**	9 July 2025
Chair	Richard Oosterom		
Author	Committee Secretary		
Quorate	**Yes** ☐	**No** ☐	

Alert (Matters of concern or key risks to escalate to the Board):

May:

- In relation to the Finance Report, there was continued concern around a number of hotspot areas that were overspending with no clear mitigation actions. It was highlighted that when the committee reviewed and approved the 25/26 plan there was a clear understanding that if changes were not made then further issues would ensue.
- The major concern in month 1 was around activity levels that were below plan, and how this could affect RTT performance. The reasons and corrective actions were not yet clearly identified.
- Concerns remain regarding some diagnostics areas; a plan for tactically increasing MRI capacity was mentioned and regarding Audiology a System plan was in development

June:

- A significant gap remained within CIP; out of 36M target, ca. 20M was identified and planned, leaving a significant gap and risk to I&EThe chair emphasized the need for contingency planning to address the identified financial gaps and risks.
-

Assurances provided to the Board:

May:

- The Performance report outlined that cancer had achieved 62 days which exceeded both regional and national standards.

- UEC had broadly maintained 4 and 12 hour performance, and in May 4 hour performance further improved to nearly 76% at month to date.

- The OneEPR programme remained on track for completion by June 2026, although phasing might change. The idea would be to go live with Theatres and ITU in October/November 2025 and the remaining areas (ED, Inpatient, Outpatient, CPOE and ePMA) in June 2026. The committee expressed a preference for this model, to maintain momentum in the Trust.

June:

- Sustained improvement in urgent care performance, achieving mid-70s for three consecutive months.
- Cancer performance met all national targets
- T&O performance and financial improvements were encouraging

Advise (Matters the Board should be aware of not covered above e.g. on-going monitoring, new developments etc):

May:

- The CIP report outlined that there had been £23m of £35.8m identified, of which £14.4m are validated CIP programmes which had been through the panel and approved; an acceleration of identification and validation is required to achieve our CIP target for 25/26.

- The PMO team felt they were spending too much time on PIDs with low value, rather than focusing on high impact schemes with higher value. It was suggested that the "difficult decisions" should be revisited to help close the gap.

June:

- RTT targets set for March 2026, requiring careful monitoring.

Decisions made by the committee or major actions commissioned and work under way:

May:

- The Committee approved the Baxter Patients Specific SLA contract. It was requested that for future meetings the cover sheet with a summary and a contract term sheet, summarising the key terms in the contract, would suffice.

June:

- The committee endorsed the introduction of an Accountability Framework and requested regular updates on the implementation.

- The updated Green Plan is recommended for approval by the board

- The Pharmacy Business Case was not approved and needs to be discussed in the Investment committee first.

Any actions recommended to improve effectiveness of the meeting:

Recommendation	The Board is asked to **DISCUSS** the report from the Committee.

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Board committee report

NHS East and North Hertfordshire Teaching NHS Trust

Meeting	Public Trust Board			**Agenda Item**	16
Report title	People and Culture Committee – 13 May 2025			**Meeting Date**	9 June 2025
Chair	Janet Scotcher				
Author	Committee Secretary				
Quorate	**Yes**	☐	**No**		☐

Alert (Matters of concern or key risks to escalate to the Board):

- Impact and Equality impact assessments remain an aspect of assurance the committee was interested in. The Board is asked to consider this committee providing scrutiny and assurance, particularly with the pressures of CIP targets felt at present.

Assurances provided to the Board:

- A single workbook of all the EDI related actions is now in place and will be tracked through the EDI steering group.
- It was highlighted the people related workstreams had been discussed at FPPC and quality and equality assessments had been conducted.

Advise (Matters the Board should be aware of not covered above e.g. on-going monitoring, new developments etc):

- There was also focus on cost improvement works in relation to trust wide People priorities. There were currently executive led workstreams eight of which link in with the people team, a number of workstreams had already commenced with others requiring further review and planning.
- The Committee remained concerned about how we were seeking to shift the dial on staff reporting experiencing racism. This would continue to be an area of scrutiny and support.
- Data on staff being appointed with a disability was a challenge and the committee had asked to be kept updated on the level of disability disclosure in order that this would be more accurately measured.

Decisions made by the committee or major actions commissioned and work under way:

N/A

Any actions recommended to improve effectiveness of the meeting:

- JS stated that a chairs meeting had been held where it was advised that a senior member of the finance team was required to attend People and Culture Committee and that a senior member of the People team was required to attend FPPC to have a clear overview of the workstreams.

Recommendation	The Board is asked to **DISCUSS** the report from the Committee.

To be trusted to provide consistently outstanding care and exemplary service

Hertfordshire and West Essex Integrated Care System

HWE ICS Performance Report

May 2025

Working together
for a healthier future

Executive Summary: KPI Risk Summary

Further information regarding high level risks can be found within the accompanying Risk Report

Highest Risk	Programme
Community Waits (Children)	Community
Autism Spectrum Disorder (ASD)	Community

Lowest Risk	Programme
Learning Disability (LD) Health Checks	Primary Care
CHC Assessments in Acute	Community

Low Risk	Programme
2 Hour UCR	UEC
NHS 111 Calls Abandoned	UEC
No Criteria to Reside (NCTR)	UEC
Community Waits (Adults)	Community
% of on the day GP Appointments	Primary Care
ED 4 Hour Standard	UEC
31 Day Standard	Cancer
62 Day Standard	Cancer
CHC Assessments < 28 Days	Community

Variable Risk	Programme
28 Day Faster Diagnosis	Cancer
% of <14-day GP Appointments	Primary Care
Dementia Diagnosis	Primary Care
Patients discharged before Noon	UEC
Talking Therapies	Mental Health
Severe Mental Illness (SMI) Health Checks	Mental Health
62 Day Backlog	Cancer
RTT 65 Week Waits	Elective
RTT 52 Week Waits	Elective
Community MH - Adult Waits for 2nd Appt	Mental Health

High Risk	Programme
Ambulance Handovers	UEC
18 Week RTT	Elective
6 Week Waits	Diagnostics
Ambulance Response Times	UEC
Out of Area Placements	Mental Health
CAMHS 28 Day Standard	Mental Health
Community MH - CYP Waits for 1st Appt	Mental Health
ADHD	Community

Moved to lower risk category | Moved to higher risk category | No change to risk category

Executive Summary

URGENT CARE	**4 Hour Performance**	**Region: HWE better than average**	**National: HWE better than average**

- NHS 111 abandoned call performance continues on an improved trend with performance meeting standard;
- Cat 2 ambulance response times continue to reduce and reached 34 minutes in March; although the best performance since June 21, times remain outside the national 30-min std and are longer than regional average;
- Hours lost to handover has improved significantly since January; performance is on a variable trend, close to the fair shares handover target and has moved from highest to high risk category;
- 4 hour ED performance continues on a variable trend and improved to 77% in March; this is the best since June 21 and better than national and regional average, moving from variable to low risk. Improvements have been made across all 3 places with the biggest improvement seen in West Essex.

PLANNED CARE	**18 Week RTT**	**Region: HWE better than average**	**National: HWE worse than average**

- The overall elective PTL size remains high; a significant increase was seen in January with deferred referrals being added to the PAH PTL.
- 65 wk waits have continued to reduce to 89 in February; clearance is currently forecast for May 25. 52 wk waits have continued on a trend of improvement although increases were seen in Jan and Feb;
- The 18 wk position has plateaued at around 55% with common cause variation; this remains significantly below national standard and an area of high risk.

DIAGNOSTICS	**6 Week Waits**	**Region: HWE worse than average**	**National: HWE worse than average**

- The overall PTL continues to increase and is far higher than the historic mean. Excluding paediatric audiology, diagnostic performance continues on an improved trajectory although has declined since Dec. There remains significant challenges to paediatric audiology with variation by Trust; a return to reporting of the challenged service at ENHT in June 24 saw a step change decline in performance. Overall diagnostic performance has improved however moving from a declining to variable trend and from highest to high risk.

CANCER	**28 Day FDS / 31 Day / 62 Day**	**Region: HWE better than average**	**National: HWE better than average**

- 28-day Faster Diagnosis Standard (FDS) performance continues to meet this year's ambition of 77% although has moved from an improving to variable trend and moved from a low to variable risk. 31-day performance also continues to meet the national standard of 96%. 62-day performance continues to meet the 70% planning target but there remains notable variation by Trust with PAH the most challenged (moved up to low risk).

MENTAL HEALTH / LD	**Community MH (2nd Appt)**	**National: HWE better than average (Adult)**

- Learning Disability Annual Health Check (LDAHC) performance remains strong with all Places exceeding their equivalent 23/24 positions; the 75% target was met in 23/24 and remains on track to deliver in 24/25;
- Overall increase in number of HWE Out of Areas Placements at 37 against plan of 6. Winter pressures resulted in an increase in out of area bed placements in Herts with plan in place to reduce to 0 by end of June;
- Community Adult MH median waits for a 2nd contact decreased in February at 50 days, which benchmarks well against the national average and moves from high to variable risk.

CHILDREN	**Various**	**Community 18 Week %: HWE worse than national**	**Community MH 1st Appts: HWE better than national**

- The number of children on community waiting lists remains very high with children's community waits continuing as an area of highest risk. Waits over 52 weeks increased in Feb to 4,396.
- 18 week % for children's community waits remains largely the same at c37% which is below the national average of c50%. The main pressures continue to be Community Paeds, Therapies and Audiology;
- Autism Spectrum Disorder (ASD) waiting lists and times continue to grow as funding/investment remains unresolved continuing as an area of highest risk. ADHD services are also high risk due to rising demand & waits;
- The 28-day CAMHS access standard in Hertfordshire has not been achieved since 2021. Performance has seen some recovery to 61% in March 2025 moving to a variable trend. Vacancy rates continue to impact;
- Children's waits for a Community MH 1st appointment decreased to 125 days in Feb and continue to better the national average (253 days); there remains variation across the system.

COMMUNITY (Adults)	**% <18 Weeks**	**National: HWE better than average**	**Adult waiting times better than CYP**

- The % of adults waiting <18 weeks remains comparatively strong at 91.8% compared to the national average of 85%;

PRIMARY CARE & CHC	**CHC Assessments Within 28 Days:**	**HWE better than regional and national average**

- There has been sustained improvement in the % of gp appts seen on same day, remaining at low risk. The % seen within 14 days continues along the mean and is marginally below this year's plan of 89%;
- CHC assessments <28 days have continued to see significant improvements and met the 80% standard for the first time in Feb. Moving from variable to low risk, performance is better than regional & national average.

Executive Summary: Performance Benchmarking by Provider / Place

February 2025 — **Hertfordshire and West Essex ICB (PROVIDERS)**

Area	Activity	Data Published	East and North Herts Trust	Trend Aagainst Last Month	Position Against National	Position Against Region	Provider Ranking	West Herts Teaching Hospital Trust	Trend Aagainst Last Month	Position Against National	Position Against Region	Provider Ranking	The Princess Alexandra Hospital Trust	Trend Aagainst Last Month	Position Against National	Position Against Region	Provider Ranking
A&E	% Seen Within 4 Hours (with additional mapped activity)	March 25	76.28%	✓ 5.23%			50	81.88%	✓ 2.505%			18	72.04%	✓ 9.163%			80
	% >12hr Waits in ED From Arrival	March 25	11.76%	✓ -39.15%			74	8.51%	✓ -10.92%			49	7.61%	✓ -21.42%			45
Cancer	28 Days Faster Diagnosis	February 25	79.16%	✓ 8.796%			89	87.10%	✓ 9.94%			18	75.18%	✓ 11.63%			123
	31 Days Standard	February 25	96.99%	✗ 0.47%			46	97.44%	✓ 0.01%			41	90.63%	✓ 3.74%			111
	62 Days Standard	February 25	79.62%	✗ -7.87%			30	79.88%	✓ 2.35%			29	54.11%	✓ 7.60%			131
RTT	Incomplete Pathways <18 weeks	February 25	62.38%	✓ 1.98%			57	61.07%	✓ 0.46%			65	44.49%	✓ 0.40%			151
	52+ Weeks as % of Total PTL	February 25	1.63%	✓ -8.63%			81	2.03%	✗ 0.20%			82	4.70%	✗ 11.52%			137
	65+ Weeks as % of Total PTL	February 25	0.05%	✓ -20.57%			78	0.00%	– 0.00%			27	0.09%	✓ -89.57%			91
	78+ Weeks as % of Total PTL	February 25	0.00%	– 0.00%			54	0.00%	– 0.00%			27	0.00%	– 0.00%			62
Diagnostics	% Waiting 6+ Weeks	February 25	47.58%	✓ -15.13%			149	8.22%	✓ -48.61%			58	32.58%	✓ -14.47%			136
	Activity	**Data Published**	**East and North Herts (06K)**	**Trend Against Last Month**	**Position Against National**	**Position Against Region**	**Provider Ranking**	**South and West Herts (06N)**	**Trend Against Last Month**	**Position Against National**	**Position Against Region**	**Provider Ranking**	**West Essex (07H)**	**Trend Against Last Month**	**Position Against National**	**Position Against Region**	**Provider Ranking**
Mental Health	Dementia Diagnosis Rate	February 25	62.5%	– 0.00%			78	62.8%	✗ -0.16%			75	73.8%	✗ -0.41%			14
	Out of Area Placements	February 25	26	✗ 23.08%	n/a	n/a	n/a	26	✗ 23.08%	n/a	n/a	n/a	11	✓ -36.36%	n/a	n/a	n/a
CHC*	% of Eligibility Decisions Made Within 28 Days	February 25	78.6%	✓ 12.12%	72.47%	72.47%	76	90.6%	✓ 22.24%	84.48%	84.48%	51	75.0%	✓ 4.76%	69.51%	69.51%	80
	% of Assessments Carried Out in Acute Settings	February 25	0.0%	– 0.00%	0.00%	0.00%	61	0.0%	– 0.00%	0.70%	0.70%	94	0.0%	– 0.00%	0.00%	0.00%	64

LEGEND

- **Performance against National/Regional**
  - Better
  - Worse
- **Performance against previous month**
  - ✓ Improvement
  - ✗ Deterioration
  - – No change
- **Provider Ranking**
  - First quartile
  - Middle quartile
  - Lowest quartile

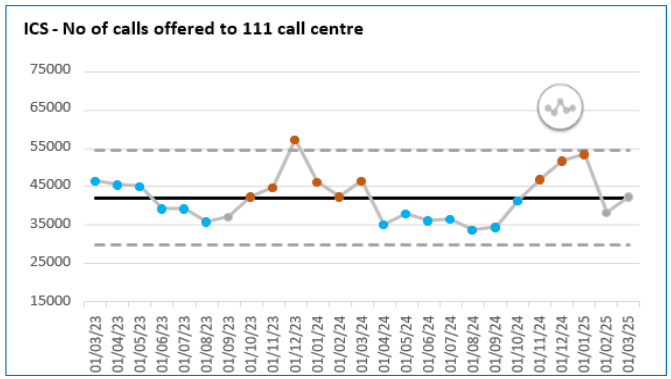
Note: this summary will be updated in the next report to reflect the priorities in the 25/26 planning guidance. Review of primary care and community data also underway to include in future reports.

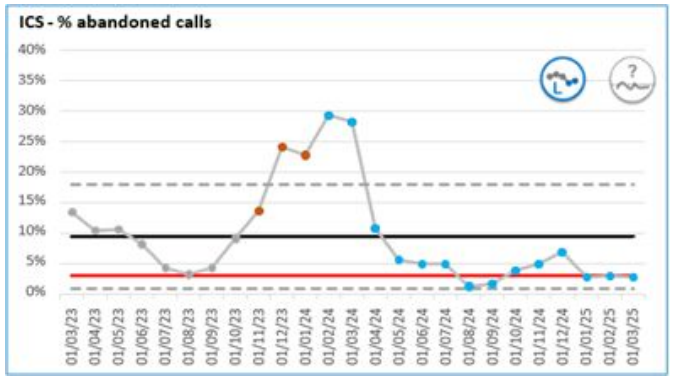
Performance by Work Programme

Click link to relevant slides:

Hertfordshire and West Essex Integrated Care System

NHS 111

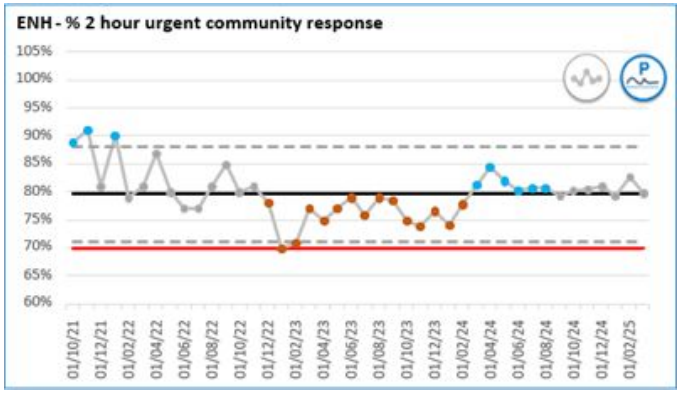


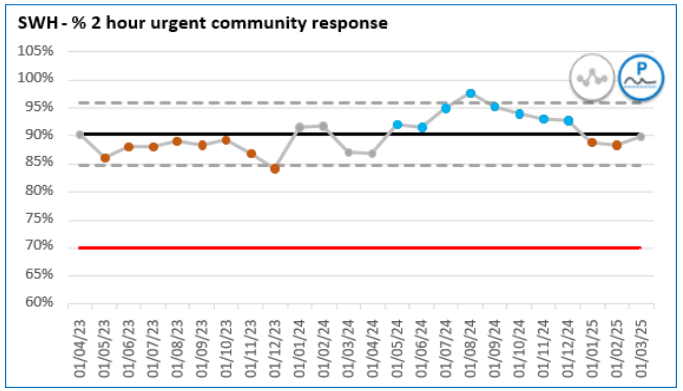


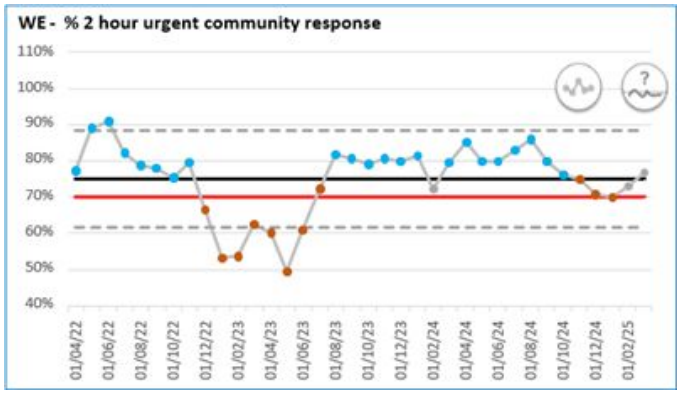
ICB Area	What the charts tell us	Issues	Actions
HUC	• Call volumes have reduced from the peaks seen in winter and are within expected common cause variation limits • Abandoned call rates are consistently achieving the <3% standard	• Occasional intermittent telephony issues delaying staff availability to accept calls during February – business continuity and national contingency measures enacted • Average handing time impacted, with longer average hold times for clinical advice	• New Operational Delivery Manager (ODM) role proactively managing all elements of the 111 service, challenging AHT and productivity in real time • Non-Clinical Floor Walkers (NCFWs) continue to be directly accessible for all pathways queries before clinical input • Workshops for all Health Advisors to support improvement of individual performance, which overall improves KPI performance • HUC-wide rota patterns under review due to address continued issues with weekend rota fill. Project plan in place with senior management and workforce planning teams to agree next steps

Hertfordshire and West Essex Integrated Care System

Urgent 2 Hour Community Response (UCR)







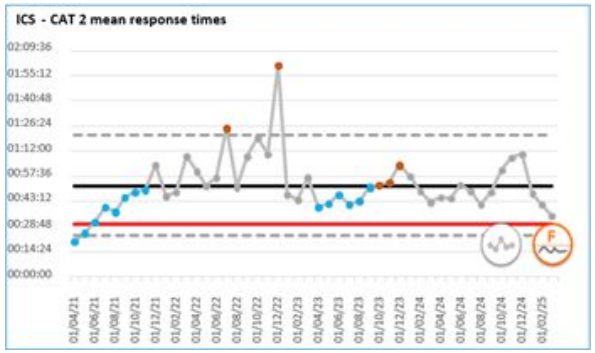
Referrals	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
West Essex	412	397	416	391	461	386	454	511	483	558	724	629	636
East & North Herts	707	736	691	621	659	676	657	678	717	688	763	583	671
South & West Herts	400	417	423	442	363	352	319	370	414	340	376	506	508

ICB Issues, escalation and next steps

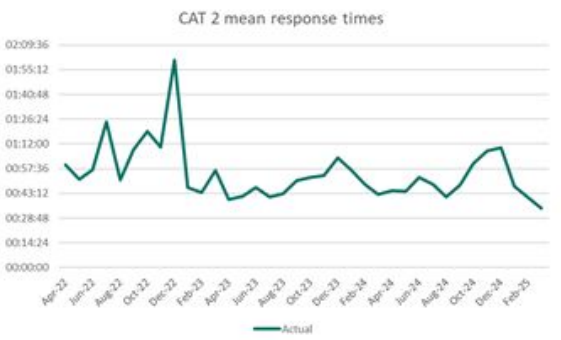
- The ICS and all three places achieved the 70% national standard
- West Essex performance has returned to compliance with improvement seen in each of the last two months
- Notable increase in SWH activity following inclusion of the HAARC vehicle numbers

Hertfordshire and West Essex Integrated Care System

Urgent & Emergency Care (UEC) - Ambulance Response and Handover



Recovery Trajectories



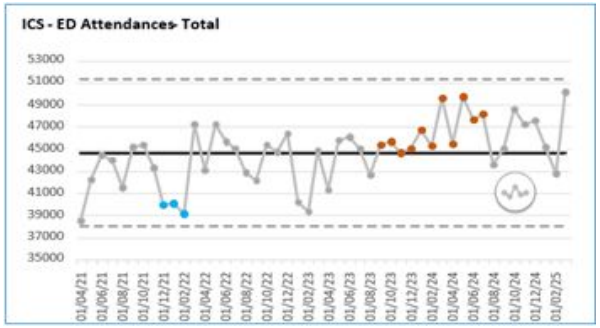
What the charts tell us

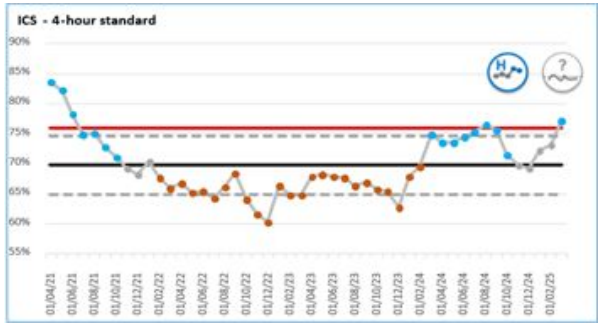
- The mean Category 2 ambulance response time has been reducing over the last four months and reached 34 minutes in March. This remains above the 30 minute target, but is the best performance since Jun-21
- However, mean C2 response times in HWE remain longer than the regional average (Mar-25 = 32 mins) and were the second longest in the region
- Hours lost to handover >15 mins have reduced significantly since January. In Mar-25, 1525 hours were lost over 15 minutes which is close to the fair-shares target for the system (1515 hours)

ICB Issues and actions

- The number of ambulance incidents (A7) in HWE remain high. The number of incidents in Mar-25 was 6.2% higher than in Mar-24
- However, the number of conveyances in HWE was 1.5% lower in Mar-25 compared to Mar-24 as a result of the reduced conveyance rate
- During Q4 of FY2425, EEAST put in place a number of initiatives aimed at increasing staffing hours in HWE to improve C2 response times. These included: HWE crews that have gone out-of-area only booking on once they're back in HWE; internal transfer incentive; moving 5 EEAST ambulance resources into HWE each day from neighbouring sectors; weekend over-time incentives
- Analysis suggested that the impact of these initiatives was to reduce C2 response times by 8 minutes, with the other reductions coming as a result of improvements in factors such as hours lost to handover.
- Hours lost to handover have improved following a number of initiatives at the acute front doors, including: senior clinical reviews of ambulance patients; continued focus on fit-to-sit patients; and increased nursing establishment

UEC – Emergency Department

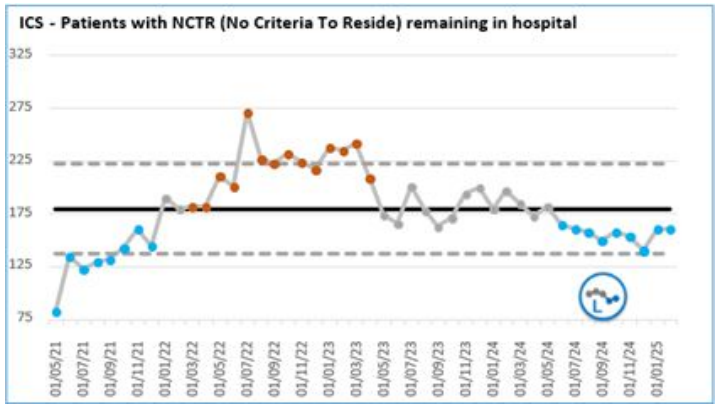


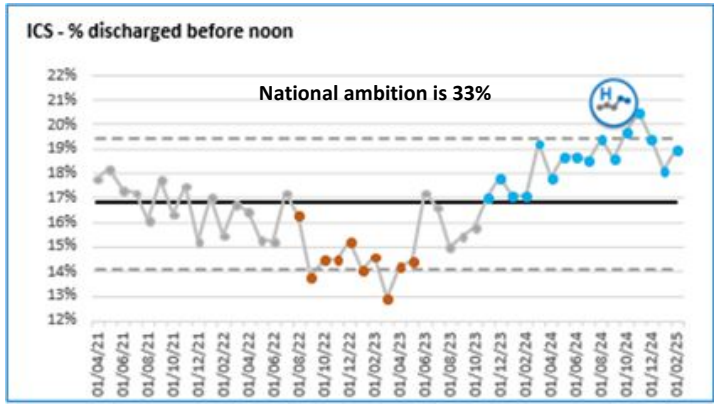


What the charts tell us	Issues	Actions

• In January and February, ED attendances across the system were relatively low, however they were the highest for four years in March. This was mainly driven by increases in type 3 activity at ENHT and WHHT
• ED performance also improved to 77.1% in March. This is slightly below plan, but is the best performance since Jun-21
• There was an improvement for all three places in March
	• There remains significant variation at place level with PAH the most challenged. In March:
	  ○ SWH = 81.9%
	  ○ ENH = 76.3%
	  ○ WE = 72%
	• However, West Essex has observed the greatest improvements in performance over Q4 of FY2425
	• There remains continued high demand. ED attendances were 3.5% higher during FY2425 compared to FY2324. This rise in demand has come from walk-in patients rather than ambulance conveyances
	• There is some evidence that there has been a general increase in acuity in ED presentations over the past two years
	• Mental Health (MH) presentations at ED remain high
		System
		• The Unscheduled Care and Coordination Hub (UCCH) has been effective at reducing the % of C2-C5 conveyances to ED during the day-time which has helped to mitigate the increased ED demand from walk-in patients
		• Front-door audits completed at each acute site during March
		East and North Herts
		• Additional paediatric registrar added to the rota in January (2pm-10pm shift)
		• CDU changed to a non-admitted area in Feb 2025 to support with non-admitted performance and ED flow
		• A new UEC programme with four separate workstreams established in Mar-25. The focus of one of the workstreams is on improving 4-hour performance through improving triage and senior decision making
		West Essex
		• MADE event w/c 17th March with a focus on frailty. 4-hour performance in West Essex in March was the highest since Jun-21
		• NHSE clinical support package now agreed. Focus on behaviours / culture and non-admitted ED
		• UEC capital bids to improve children's ED environment (inc. CYP MH Room), and UEC Corridor
		South and West Herts
		• Trial of having an ED Consultant in the care coordination centre is now complete and decision taken to stand-down following the trial
		• Final amendments being made to falls management pathway before roll-out
		• HAARC and CLCH to agree process for HAARC to link with CLCH urgent community response

UEC – Discharge & Flow

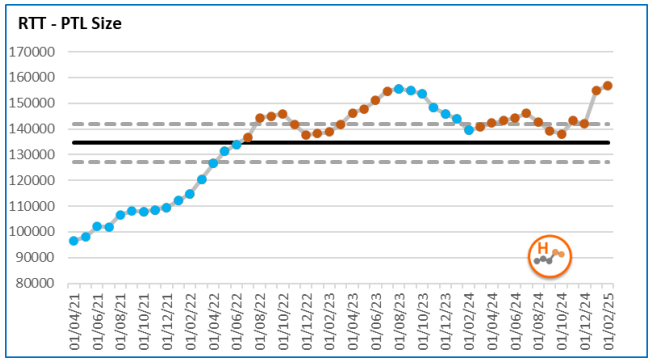


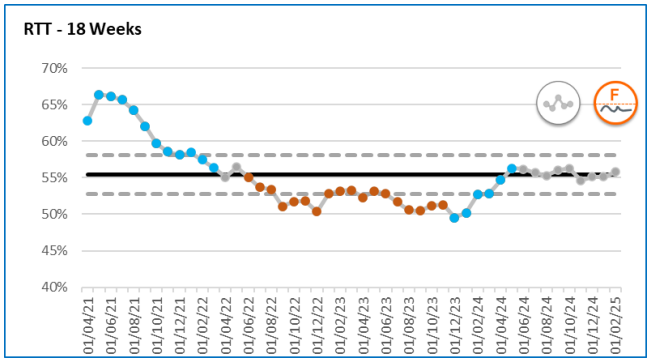


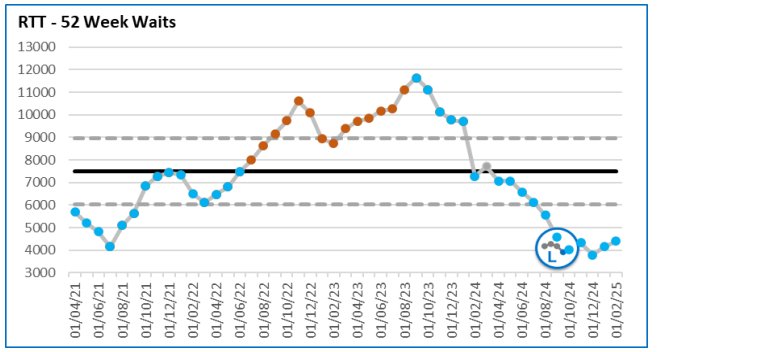
What the charts tell us	Issues	Actions
• The system-level daily average number of patients with no criteria to reside remaining in hospital has consistently been below average for the last nine months and planning targets have been met • The % of patients discharged before noon remains above the historical mean, but is currently not as high between Nov-24 and Jan-25	• There remains significant variation across the three HWE acute trusts for the % of patients discharged before Noon. In Mar-25: ○ ENHT – 17% ○ WHTH – 27.1% ○ PAH – 12.3% • The issues are typical discharge challenges, including: ○ Availability of care home / community capacity ○ Complex discharges ○ Internal process challenges	**East and North Herts** • MADE event took place during the first week of April at ENHT • Change to site management meetings to increase ward ownership and focus on earlier, safer and more effective discharges has been in place since the end of Feb **West Essex** • Discharge Improvement Programme re-launched in January and trajectories agreed to increase pre-Noon discharges and Discharge Lounge utilisation • Weekend discharge processes refreshed resulting in increased weekend discharges **South and West Herts** • Transfer of Care Hub soft launch on 3rd March • Pathway 1 discharge-to-assess at home support work ongoing

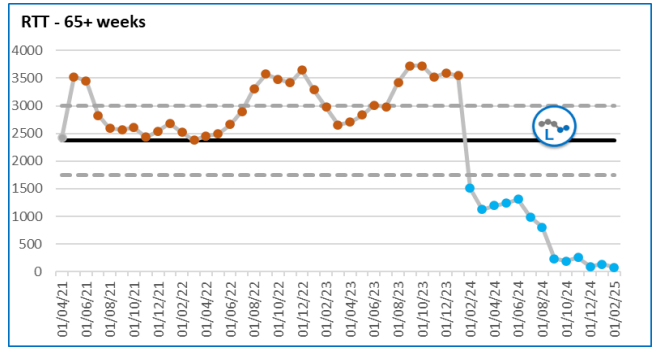
Hertfordshire and West Essex Integrated Care System

Planned Care – PTL Size and Long Waits









Community Paediatrics patients have been excluded from RTT reporting from February 2024 in line with national guidance
Waiting lists therefore show significant reductions

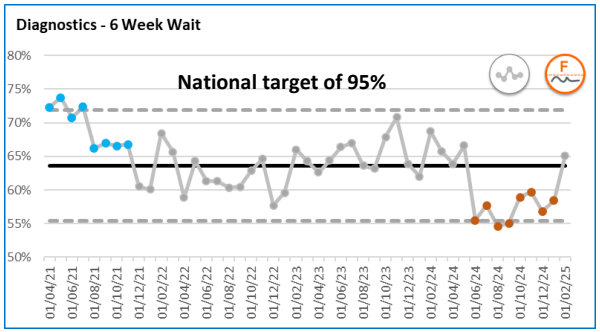
Planned Care – PTL Size and Long Waits

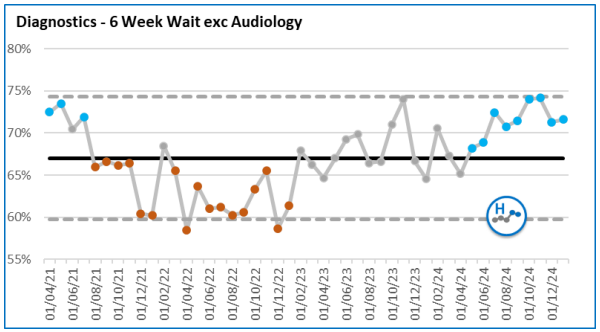
ICB Area	What the charts tell us	Issues	Actions

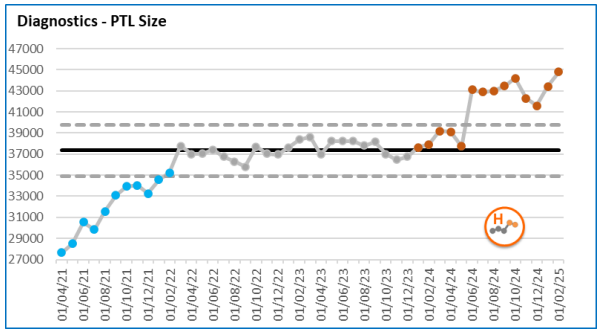
HWE	• The overall PTL size remains high with a significant increase in January and further increase in February. The ASIs were added to the PAH PTL in January which accounts for c.10k patients
	• The overall number of patients waiting >65 weeks has decreased significantly, although the December zero target was not achieved. There remains variation at place level but the ICB overall number of breaches at the end of February was 89
	• The number of patients waiting >52 weeks had been consistently improving since summer 2023 although January & February saw increases
	• The number of patients waiting 18 weeks remains static
	• Due to the change in national guidance, Community Paediatric patients have been excluded from RTT reporting from February 2024. Waiting lists therefore show significant reductions from February 2024. These waits are included within the Community section of this report
		• The end of February 65ww was 89:
		  • ENHT: 30
		  • WHTH: 0
		  • PAH: 51
		  • ISP: 8
		• The 65ww forecast for end of April is 47
		• Trauma and Orthopaedics (T&O) remains the main specialty under pressure, with ENT also a notable risk
		• Staffing remains a challenge
		• There will be increased focus on patients waiting longer than 52 weeks in 2025/26 currently there are c.4k patients across the system
			• Princess Alexandra Hospital is in Tier 2 of the national oversight and support infrastructure for Elective (including Diagnostics) recovery. Fortnightly tiering meetings with the NHSE EOE regional team remain in place
			Management of waiting lists
			• System focus on reducing number of patients waiting >65 weeks, with regional and national oversight
			• Demand, capacity & recovery plans are in place to monitor RTT
			• Weekly KLOEs in place with NHSE to track 65-week positions
			• Fortnightly performance meetings with each of the three acute Trusts are in place with NHSE support
			• Validation and robust PTL management in place
			Increasing capacity and improving productivity
			• Pro-active identification of pressured specialties with mutual aid sought via local, regional & national processes
			• Outpatients has a full programme of work to increase productivity including PIFU (patient initiated follow up), reducing follow ups including discharging where appropriate, and increasing take up of Advice & Guidance
			• Maximising use of ISP capacity and WLIs where possible
			• ICB wide GIRFT programme to improve productivity: Theatre Utilisation, Ophthalmology, MSK, Urology, Gynae and ENT

Hertfordshire and West Essex Integrated Care System

Planned Care – Diagnostics

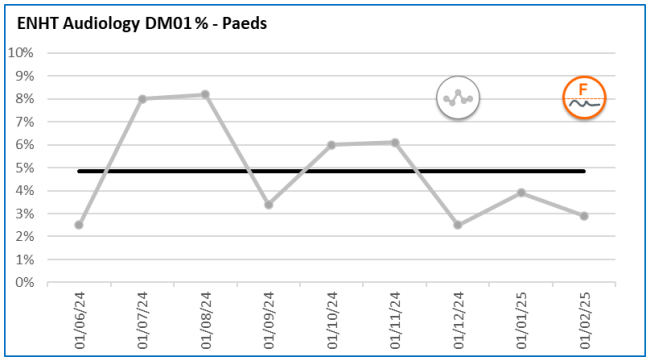


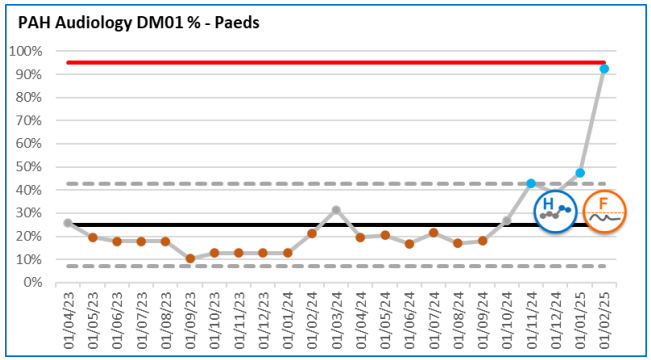


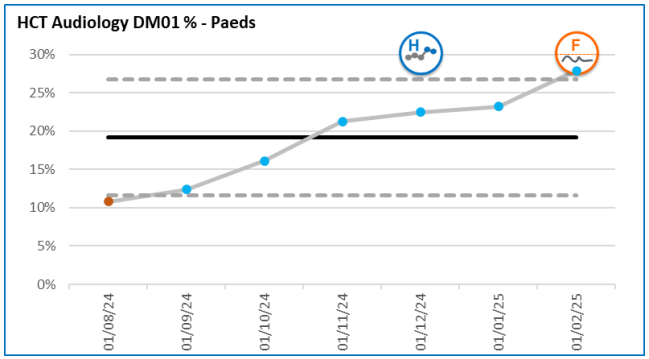


What the charts tell us	Issues	Actions
• Performance significantly improved at each of the four providers during February. There is significant variation in Trust performance: ENHT – 52.4%, WHTH – 91.8%, PAH – 67.4% and HCT 27.9% (Note: HCT only provides Paediatric Audiology Diagnostics – see next slide) • 6-week wait performance across the ICS improved to 65.1% • Decline since May 2024 driven by the inclusion of ENHT Audiology • Excluding audiology, performance continues on an improving trajectory although has declined since December • Step change increase to PTL in June 24 due to return to reporting of Paediatric Audiology at ENHT with HCT also commencing reporting in August 24. Excluding Paediatric Audiology, the diagnostic PTL has remained fairly steady since March 22	**ENHT** • The most significant long waiters remain in Audiology. The 0-3 years and complex paediatric pathways remain paused • There remain significant challenges in the MRI service with demand currently greater than capacity **PAH** • Continued issues in accurately report DM01 backlog for multiple modalities, primarily Endoscopy, following Alex Health launch • Non-Obstetric Ultrasound (NOUS), Echocardiography and Audiology are the key challenges at PAH **WHTH** • In February modalities not reaching the 95% target were MRI, colonoscopy, flexi-sig, gastro and audiology	**ENHT** • Paediatric Audiology: hearing aid pathway went live in Mar-25 and the ABR pathway due to open on 28th April. Estates work ongoing to enable re-opening of 0-3 years and complex pathways. Discussions in relation to further mutual aid ongoing. • Adult audiology: Lister estates work commenced; ongoing discussions regarding outsourcing as currently there is insufficient capacity to clear backlog and meet recurrent demand; business case completed for system growth funding • MRI outsourcing and mobile van have improved waiting times **PAH** • Reporting issues being progressed as part of Alex Health data quality improvement programme. Projected to be resolved in June data reported in July • NOUS: Ongoing recruitment to increase capacity • Echos: Additional NHSP staffing and capacity in place – notable backlog improvement in latest local data • Audiology: Paediatric backlog nearing clearance and focus has switched to adults. Need to recruit 3 x WTE between June and September **WHTH** • There has been a loss of capacity associated with the Surgical Centre works which has impacted cystoscopy in particular and the pause in activity at SACH has further impacted delivery. SACH reopened at the end of February • Recovery actions are in place with insourcing of endoscopy activity, an increase in additional sessions, business case approved for Cardiac MRI expansion, process reviews and re-establishment of lost capacity where possible.

Planned Care - Paediatric Audiology Diagnostics

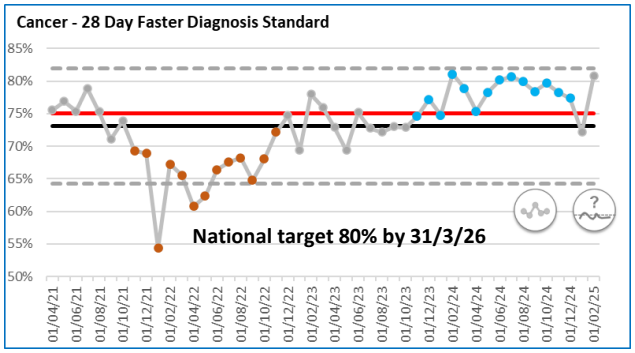


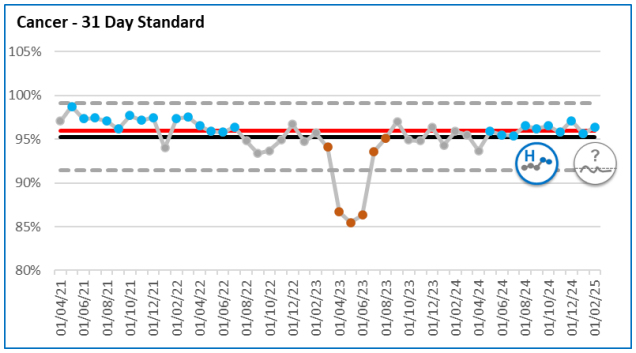


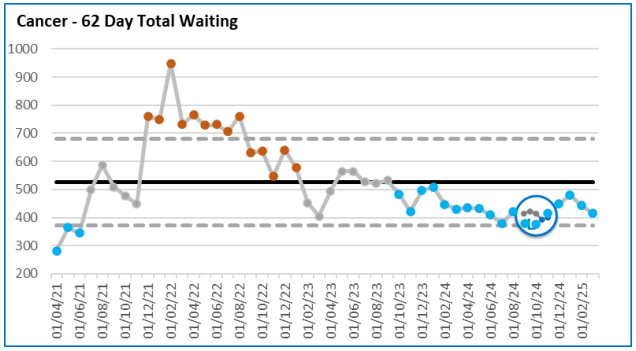


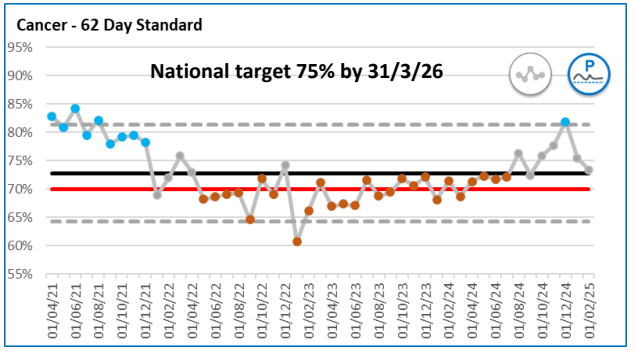
What the charts tell us	Issues	Action
• All providers are below the performance target of 95% with significant variance by provider • PAH are on an improved trend having seen a significant improvement in 2025 to achieve just under the 95% standard in February • ENHT continues on a variable trend, with significantly lower performance levels averaging c.5% • HCT are on an improving trend, with performance increasing in each of the last 6 months to reach 28% in February	• Ongoing support for mutual aid, particularly for 0-3 cohort and hearing aids. Mutual aid request has been submitted by ENHT for specific cohorts of children, system discussions taking place to understand any support available within the ICS. Discussions also taking place with NHSE regional and national teams. • Support requested to obtain SME support from the national register, following submission of request. National MOU for SMEs not yet signed for HWE system, query from providers sent to national team 12th March, awaiting response. • Largest area of risk remains estates for 0–3-year-olds and VRA. Capital bid has been submitted with request for NHSE to expedite review based on current risk within HWE system.	• System wide paediatric audiology oversight group in place and ICB escalation team • Mutual aid discussions in place with all providers to agree levelling up process; comms agreed and sent by NHSE regarding identification of workforce to support extra clinics. Letter also sent to HWE provider Medical Directors requesting support with levelling up across the system. • Data task and finish group progressing consistent local reporting of PTL and DM01 data, demand and capacity modelling and mapping of clinics to support mutual aid. New report has been produced which enables a view of waiting times / referral trends split by provider / age cohort / patient pathway. • Clear timelines for estates work across providers; current work being undertaken is on track including Peace Children's Centre and Lister Hospital. Awaiting outcome of capital bid submitted for required estates work at Hertford County Hospital. • Workforce mapping completed to seek assurance regarding competencies as well as understand available workforce to support mutual aid. Next steps link to system level scientific leadership, awaiting guidance from NHSE.

Cancer









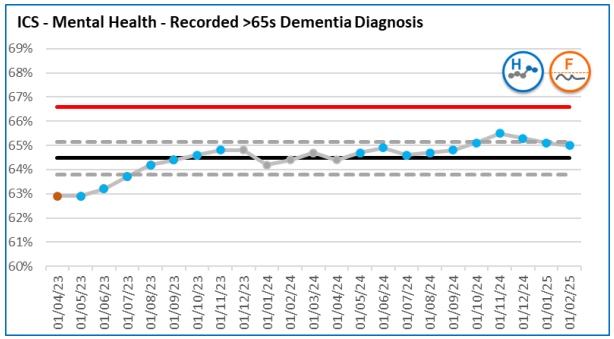
Hertfordshire and West Essex Integrated Care System

Cancer

What the charts tell us	Issues	Actions

• 28-day Faster Diagnosis Standard (FDS) performance improved sharply in February reaching 80.8% which is slightly above target. However, both PAH and ENHT are under target although both showed large improvements.
• The 31-day target was chieved, reaching 96.4% in February
• Performance against the 62-day standard declined over the last two months and although remaining below the national target, it is surpassing the 70% standard expected in the 24/25 National Planning Guidance
• There has been variable performance at each Trust with significant 62-day variation currently:
  ○ ENHT 79.6%
  ○ WHTH 79.9%
  ○ PAH 54.1%
  ○ ICB overall 73.4%
• The 62-day backlog is variable and has decreased over the last two months
	ENHT
	• The 28-day FDS and 31-day treatment were both met in February. However, the 85% target for the 62-day treatment standard was not met.
	• Urology remains the most challenged of the high-volume pathways. For Urology, the Trust is dealing with increased demand: in M1-11 of 24/25, demand for Urology diagnosis was 6.7% higher than M1-11 23/24
	• There has been a reduction in the >62 day backlog over the past few months and there were 164 patients on the >62 backlog as of 13th April
	
	WHTH
	• 28-day FDS challenges remain in Haematology, Head and Neck and Urology.
	• 31-day performance standard has been met across all specialities, except Head and Neck and Urology
	• 62-day, Haematology, Head and Neck, Upper GI and Urology pathways continue to have challenges. Pathway complexity, patient choice and surgical and out-patient capacity issues sited as main reasons for delays.
	
	PAH
	• Lower GI (40.0%) and Urology (43.9%) were the biggest FDS challenges in February. Overall March performance is expected to fall, but the Trust is confident of achieving their 77% plan for April
	• Overall, 62-day performance fell to 54.1% in February, but this is reflective of the continued push to reduce >62-day backlogs
	• Urology, Skin and Head & Neck are the key challenges in terms of the greater than 62-day waits, collectively accounting for 69% of the overall patient backlog
		ENHT
		• ENHT has been putting in place pathway changes / additional capacity in Urology. These include; MRI van at the Lister; one-stop flexi-cystoscopy pathway and additional TP biopsy capacity. However, the impact of these interventions has been limited so far on performance. Partly due to the increase in demand outlined opposite
		• Head & Neck - agreed with Oral Surgery/MaxFax consultant to review all reports at MDT and introduced 2 negative templates one for PIFU and one for FU
		• Haematology – to introduce bloods clinic at Lister McMillan Cancer Centre to start in September
		
		WHTH
		• Cancer Improvement Programme Board continues to oversee service level plans and service developments. Weekly long wait meetings continue and 2/3 times weekly breach validation reviews in place.
		• Gynae Clinical Fellow now supporting with results clinics and MDTs
		• One-stop diagnostic pathway for Prostate (Urology), started in February 2025, following the successful appointment of a CNS and New Registrar to support the pathway using Cancer Alliance funding. Cancer Alliance funded cystoscopy outsourcing in place to support the bladder pathway while a one-stop pathway is developed.
		• Breast Pain pathway to continue for another year as part of regular breast service delivery
		• Work underway to move haematology appointment booking to the Outpatients Booking Team, which is expected to reduce time to first appointments
		
		PAH
		• Princess Alexandra Hospital remains in Tier 2 of the national oversight and support infrastructure for Cancer recovery. Focussed bi-weekly escalation meetings and NHSE clinical support are in place
		• The >62-day backlog spiked following Alex Health launch (clinic build issues and OP capacity). Now steady week on week improvement - currently 151 (at 13/4/25) v. the Trust's fair shares target of 112
		• LGI FDS performance has been impacted by Endoscopy staffing gaps. Recruitment has now been completed with improvement expected from June
		• Programme to improve the oversight of patients transferred to tertiary centres in progress – more frequent contact with the tertiary centres and additional reporting to monitor activity and improve 62-day performance

Mental Health – Dementia Diagnosis in Primary Care



ICB Area	What the charts tell us	Issues	Actions
Dementia Diagnosis in Primary Care	• National data for Feb 2025 shows the ICS dementia diagnosis rate decreasing slightly against the national target (66.7%) at 65.0% for the ICB with continued variance at Place: • South and West Herts: 62.8%. • East and North Herts: 62.5%. • West Essex: 73.8%	• Hertfordshire – Demand for memory assessment via HPFT EMDASS remains high. • Hertfordshire - Actions required in primary care including a coding exercise but currently not prioritised due to GP capacity, not mandated as part of ECF, and key targets dropped from new GP contract.	**Herts** • Commissioners will continue to monitor and disseminate Dementia Diagnosis Rates data despite target being dropped from national planning guidance. • Monthly performance report continues to monitor HPFT EMDASS progress in Hertfordshire. • A new and improved EMDASS referral form has been coproduced with partners, is now live on GP systems and has been positively received by system. • Hertfordshire memory service is currently reducing waiting lists through increased capacity with waiting time for diagnosis currently within the 80% target and waited time at 74% in March 2025.

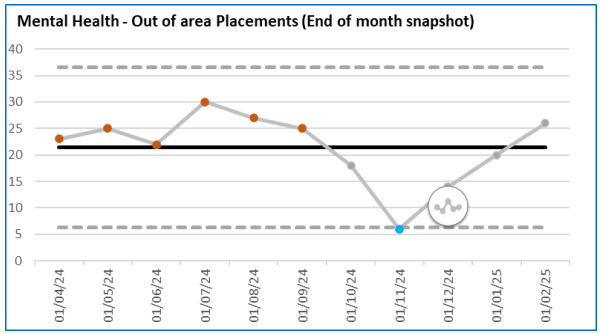
Hertfordshire and West Essex Integrated Care System

Mental Health – Out of Area Placements (OAPs)

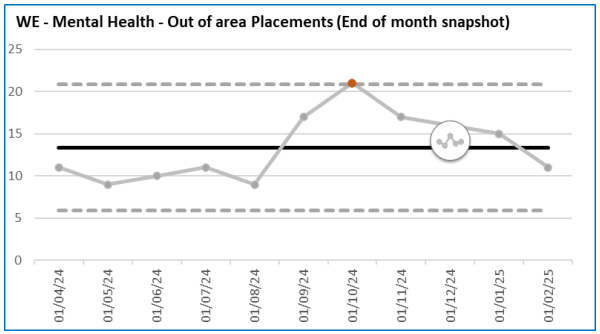
- The basis for measurement of OAPs has changed for 24/25
- Previous reporting was based on the number of out of area bed days in the month
- From April 24, reporting is based on the number of active OAPs at month end

HWE February total out of area placements: 37 vs. 6 plan

Hertfordshire



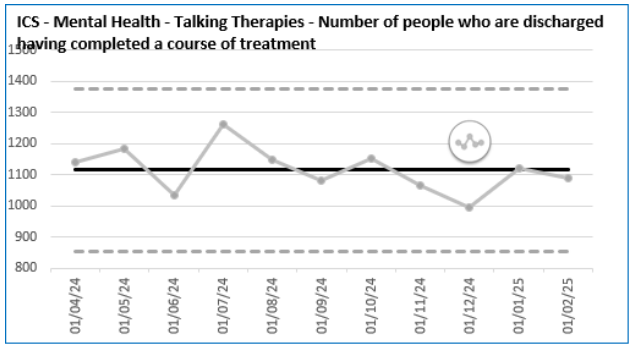
West Essex



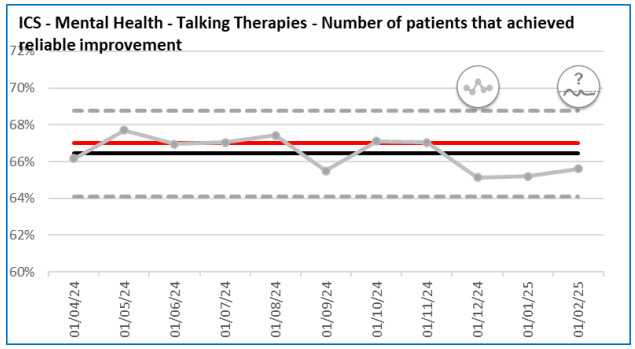
ICB Area	What the charts tell us	Issues	Actions
West Essex	• End of March: 7 people reported out of area (-9 compared to Dec) for west Essex with a total number of 193 bed days (-159 compared to Dec).	• National shortage of MH beds continues • Length of stay OOA and repatriation to place – Longest stay 193 days, although within the 6-month guidance it remains crucial that people are repatriated as soon as they are able • Reduction of local beds due to an increased numbers of SNEE patients placed in EPUT beds • London COMPACT agreement is seeing local beds taken up by London residents, this has an effect on number of local beds available being reduced pushing WE and Herts patients OOA	• Essex wide review of all inpatient beds as well as at place (West Essex) continues. Planning and guidance released in February 2025 identifies capital funding to be ringfenced to reduced out of area placements. This will support this programme • NHSE reported in April that capital funding to be released for MSE and West Essex • Review and remodel of weekly system DTOC calls with stronger governance and responsibilities – follow up MADE calls with provider following December event, including NHSE representatives • Discussions with Trusts to come together with NHSE to review the London COMPACT
Herts	• Winter pressures resulted in an increase in out of area bed placements to 26 (as measured on the last day of the month).	• Reduced capacity last year due to closure of Aston Ward until 7/10/24 and the position improved in Nov but has since increased due to winter pressures. • Hertfordshire has a low number of beds per population and there is ongoing support by provision of additional block beds • National shortage of MH beds, high occupancy rates and use of OOA beds has continued, particularly over the winter period • Placement challenges for service users with complex needs who are ready for discharge • Inpatient recruitment - 13% vacancy on adult acute and urgent care services, which will impact flow.	• Alternatives to admission continue to be developed, including a crisis house, and MHUCC • Wider Executive led work at system level to support placement of longer term DTOCs. • Bed management system continues to be developed and implementing plan to include OAPs. • Enhanced Discharge team fully recruited (addition of Senior Social Worker, Occupational Therapist & Discharge Co-Ordinator) - ways of working developed including input to service users in OOA beds. • Holding ongoing daily Bed Management meetings (3 x a day) to explore all alternatives to admission. • Senior, clinically led team attending providers ward rounds in person to unblock and support discharge • Twice weekly clinical review meetings, led by Medical Lead, involving crisis teams and community services, focusing on barriers to discharge, facilitating early discharges with crisis support. • Collaborative working with HCC reviewed to support service users requiring HCC involvement for discharge. • Plan in place to reduce number of OAPs to 0 by end of June 2025. • Perfect week in April; to prioritise service user and carer experience through effective flow.

Talking Therapies

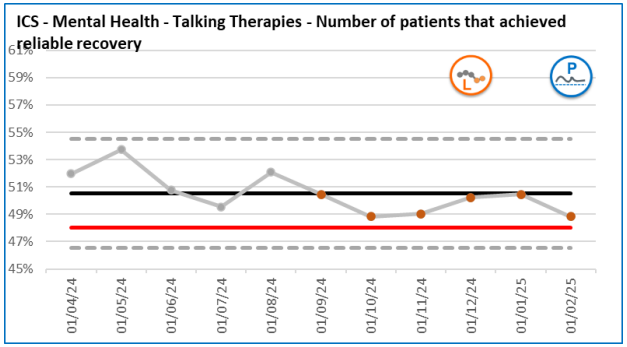
Number of people who are discharged having completed a course of treatment
Percentage of patients that achieved reliable recovery
Percentage of patients that achieved reliable improvement



Adults receiving treatment	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
Hertfordshire	930	875	925	956	837	1039	947	909	970	879	802	926	909
WECCG	170	184	214	225	198	222	200	173	184	186	193	193	179
ICS	1100	1059	1,139	1181	1035	1261	1147	1082	1154	1065	995	1119	1088



Reliable improvement rate	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
Hertfordshire - Actual	65.30%	63.70%	64.80%	66.80%	65.47%	66.06%	66.25%	64.53%	65.77%	66.89%	64.46%	63.50%	65.34%
West Essex - Actual	68.82%	71.30%	72.90%	70.50%	73.23%	73.62%	73.06%	70.52%	73.37%	67.34%	68.91%	73.58%	67.60%
ICS - Actual	65.82%	64.97%	66.29%	67.50%	66.96%	67.04%	67.42%	65.49%	66.98%	67.04%	65.33%	65.24%	65.63%

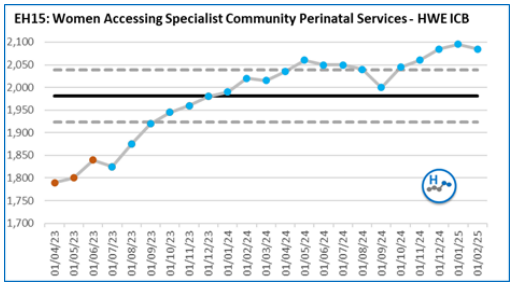


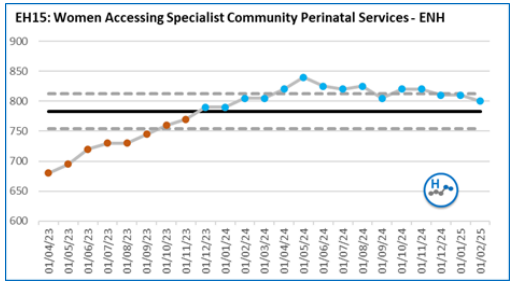
Reliable recovery rate	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
Hertfordshire - Actual	53.90%	54.00%	50.80%	52.60%	50.41%	48.66%	51.23%	49.13%	47.90%	48.48%	51.58%	49.81%	47.77%
West Essex - Actual	56.00%	57.10%	57.00%	57.50%	52.06%	53.24%	55.61%	56.35%	52.81%	51.37%	46.67%	53.13%	53.76%
ICS Actual	54.00%	54.10%	52.10%	53.60%	50.76%	49.55%	52.08%	50.41%	48.75%	49.02%	50.39%	50.45%	48.83%

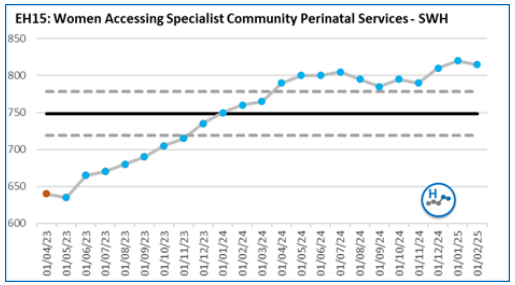
ICB Area	What the charts tell us	Issues	Actions
Hertfordshire & West Essex	**West Essex Year End** *(Note: narrative includes March 25 data)* • Referrals; data for Q4 shows 1,996 referrals which is increase from previous quarters • Recovery; 55% on average and 72% for Reliable Improvement **Hertfordshire** • Similar levels of completed treatments in Jan and February 2025 which have increased since December. • 65% reliable improvement rate in Feb 2025. • 47% reliable recovery rate in Feb 2025.	• Measurement now relates to completion of a course, with at least two appointments. Previously access / first appointments • Consistency of data collection and quality across the system continues to be monitored due to changes in the MHSDS. • Continuing focus on addressing attrition and drop-out rates following the change in counting for 24/25 • West Essex overall DNA rate is 10% & patient cancellation rate approx. 14%. Drop out rate, approx. 30% for referral to assessment & 50% for assess to treatment. • Potential risk in Hertfordshire if procurement process is not successful for building capacity to support 'counselling for depression'. • In Hertfordshire the pressure remains at Step 3; more assessments required and a greater need for step 3 treatment.	• NHSE advise that positive practice guide being drafted to support services reducing dropouts. • NHS England system wide planning calls scheduled to support ICBs throughout 25/26 • NHS England representation embedded within West Essex contract meetings • Increased access to funded training posts via NHSE • NHSE Autumn trainee funding support for 100% paid salary until 2028 *opportunity* that will support HPFT step 3 waits/ reasonable growth ambition , HWE meeting in place with NHSE to discuss 28th April. • Procurement of counselling providers in Hertfordshire by May 2025, leading to an improvement of pathways and ensuring right modality in place for service users. Announcement of tender process outcome following standstill period 24th April 2025. HPFT Actions: • Choose & Book has been rolled out to all Herts team to increase flow of patients from referral to initial appointment; to be reviewed for efficiency and improvements • The Time to Change group-based initiative is being rolled out across Herts to improve the engagement in treatment at Step 3. • All teams are required to offer clients further resources and support whilst waiting, such as the webinars and online self-help information. • Workforce, productivity and adjusted caseloads are under regular review.

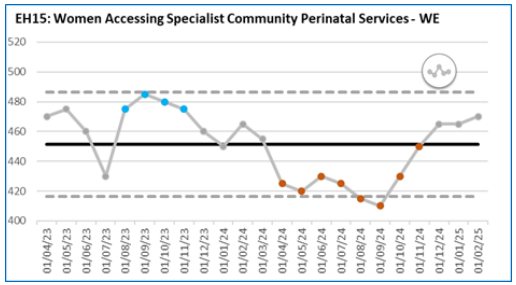
Community Perinatal Mental Health

Number of women accessing (1+ contact) specialist community PMH and MMHS services in the previous 12 months









HWE 24/25 year-end plan: 2,089

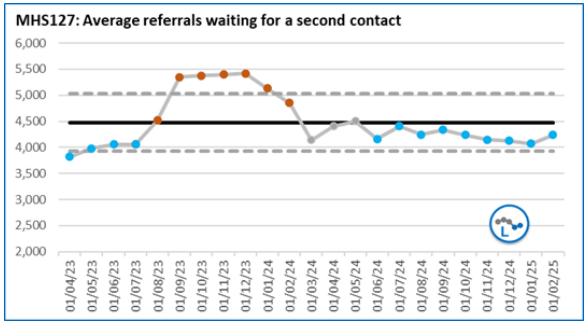
ICB Area	What the charts tell us	Issues	Actions
Hertfordshire & West Essex	**West Essex** • To achieve the cumulative 10% national target West Essex services are required to see 444 births Rolling 12 months). Local data is currently showing that at the end of Feb that a cumulative % of 9.92 and a rolling 12 month of 10.76% **Hertfordshire** • Consistently exceeding national target.	**West Essex** • There are 2 reporting methods being used; local data relates to specific time in the contract year whereas national data monitors on a 12-month rolling access report. **Hertfordshire** • Contractual reporting has been changed to reflect national 12 month rolling measure.	**West Essex** • Continually monitor local services on the 12-month access target to ensure services remain on track • Review of contract reporting schedules and DQIP meetings with EPUT **Hertfordshire** • Continued monitoring to ensure that we remain on track

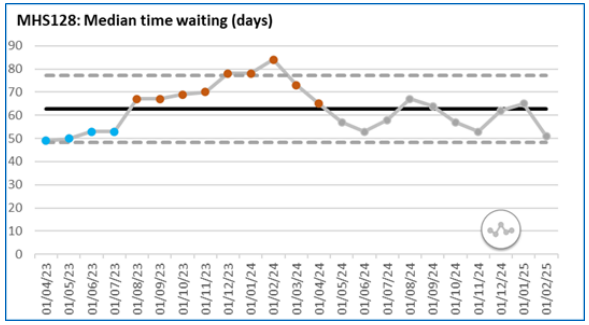
Hertfordshire and West Essex Integrated Care System

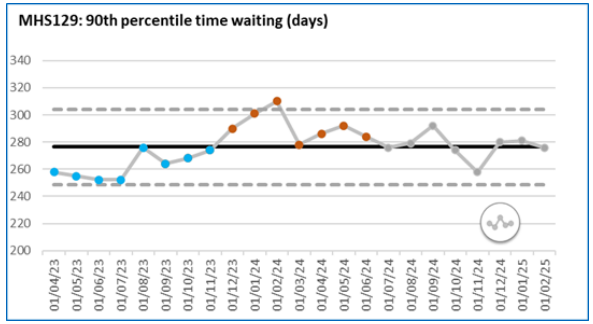
Mental Health – Community Waits

Adults and Older Adults – time still waiting for second contact*

* Please note NHS community MH dashboard waiting times front page states experimental waiting times and this section is being reported to support data quality improvement. Therefore, the data should not be used at this point to assess local activity and performance.



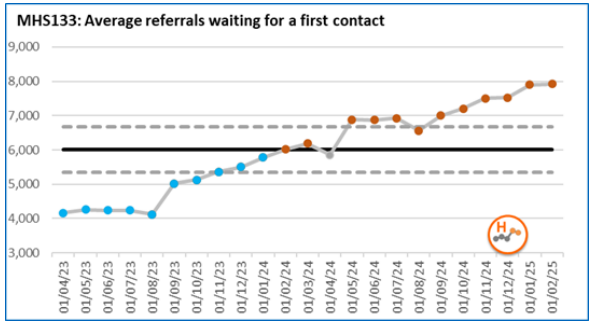


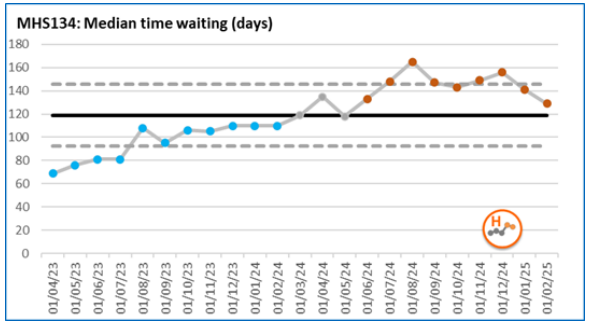


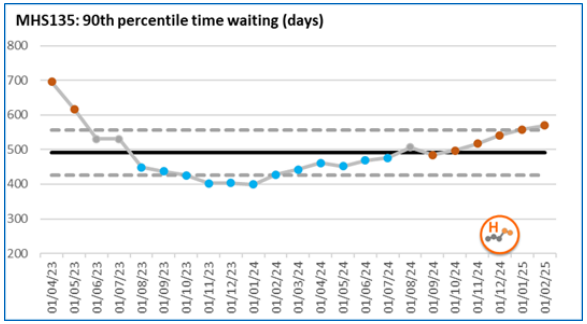
ICB Area	What the charts tell us	Issues	Actions
Hertfordshire & West Essex	**West Essex** • As of Jan 2025, 105 referrals of which 35 (9.1%) are still waiting for a second contact in 4 weeks. • 7.2% (25) have been waiting two to four weeks for second contact. 20 of those have been waiting less than one week. **Hertfordshire** • As of January, there were 43.3% of referrals with 2 plus contacts in 4 weeks compared to the national average of 30.6%. • Referrals with 2 plus contacts and a baseline outcome measure were at 88.9% compared to the national position of 49.1% (latest data June 2024).	• There remains gaps in the datasets with sporadic data month on month on the NHS England platform. Unclear if missing data is included as a rolling month or if accumulative data is included. • Although EPUT open referrals remain consistent month by month, the last 6 months the case loads have increased by 10% • In Hertfordshire, the data flow from Primary Care and VCSFE providers to MHSDS or the GP equivalent has not been worked through. This relates to the transformed PCN areas that have ARRS workers and Enhanced Primary Care. The data collection from these new services is recorded locally on System one or EMIS but this is not a shared system with the MH Trust (West Essex VSCE data flow is via a shared system with MH trust)	• Essex wide meetings scheduled to discuss the community mental health transformation, with a focus on the medium term plan, safety and improved access and better integration of services • ICBs and providers continue to engage with NHSE regarding data platforms • In Hertfordshire, a Trust-wide waiting times steering group is in place to ensure the care and safety of all people waiting for services. • HPFT Service lines are incorporating the new waiting times into their transformation work. SNOMED codes have been re-mapped on the HPFT EPR, PARIS, and continue to be reviewed as changes are made at National level. Internal reporting has been developed and key areas for action are being determined. • Hertfordshire is also working with NHSE and Voluntary Community, Faith and Social Enterprise (VCFSE) providers to look at the data flow from them to MHSDS, to include as part of the second contact information • All ICBs and providers of services continue to engage with NHSE with regional discussions being held regarding the MH data platform and progress is being made to capture accurate data for all pathways

Mental Health – Community Waits

Children – time still waiting for a first contact* *Please note NHS community MH dashboard waiting times front page states experimental waiting times and this section is being reported to support data quality improvement. Therefore, the data should not be used at this point to assess local activity and performance.



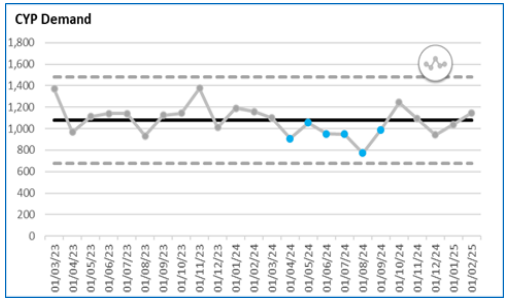


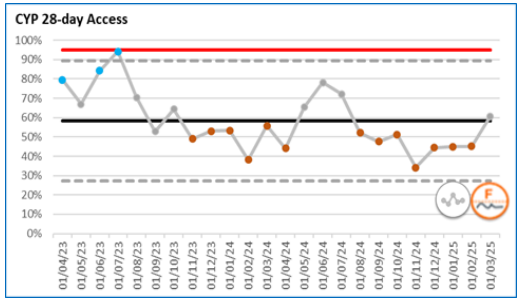


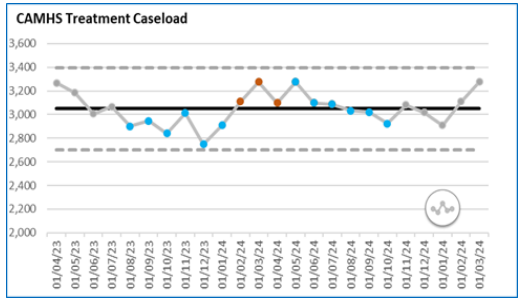
ICB Area	What the charts tell us	Issues	Actions

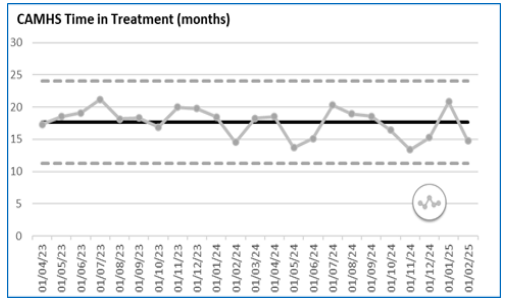
Hertfordshire & West Essex	• Median waiting times continue to drop to 125 days, which benchmarks well against the national average of 253 days
	• Within the system there is variation :
	  • East & North Herts - 35 days in February (down from 77 in December 24)
	  • South & West Herts - 143 days (down from 182 in December 2024) (this is due to ASD/ADHD diagnostic pathways data flowing into MHSDS)
	  • West Essex - 38 days at end of February 2025 down from 72 days in December 2024
	• 90th percentile waiting times for the quarter to February were tracking above 541 days, but continues to benchmark well against the national average of 821 days (as at Feb 25)
	• Within the system there is variation:
	  • East & North Herts – 284 days (down from 330 days in December 2024)
	  • South & West Herts – 459 day (down from 564 days in December 2024) same as above; this is due toASD/ADHD pathway data flowing via MHSDS. For E&N Herts it flows via CSDS which is not used for these metrics)
	  • West Essex – 266 days at end February 2025, down from 309 days in December 2024
		• The biggest impact on the Hertfordshire waiting list and long waiters is Autism & ADHD backlogs / waiting lists for diagnostic pathways
		• South & West Hertfordshire data is reflective of the historically longer waiting times in the patch, due to ASD / ADHD backlogs (for East & North these services are delivered by ENHT not HPFT/HCT)
			• CYP services in Herts are incorporating the new waiting times in their transformation work and service design. SNOMED coding has been re-mapped on the HPFT EPR, PARIS and internal reporting is under development with first draft produced in March 2025.
			• An HPFT Trust-wide waiting times steering group is in place to ensure the care and safety of all people waiting for services
			• Local provider dashboards are in place for assessment & treatment activity, caseloads and waiting times. Average waits not always reflective of challenges experienced by service, but recovery action plans in place where applicable and closely monitored by commissioning leads
			• Commissioners, HPFT and now an HCT representative are linked into EOE waiting times standards group. Long waiters in HPFT all relate to ADHD backlog
			• Across NELFT Team Managers review their waiting list monthly, and >18-week waiters on a weekly basis. All waiters >18 weeks have a clinical harm review in place and the team will be working towards seeing all longest waiters as soon as possible.

Mental Health – CAMHS Services









What the charts tell us	Issues	Actions
West Essex • West Essex does not have a formal KPI for 28 days; the cohort of YP seen <4 weeks is monitored at monthly provider meetings • There has been a rise in demand during Q4 • Numbers on caseload remain consistent with those as @ end of Q3 • Time in treatment has increased but reflects acuity and complexity of caseload **Herts – HPFT only** • Demand into the service is, as expected, tracking around the historic mean • 28-day performance has been falling since May-24 reaching a low of 34% in November 24 but seeing some recovery to 61% in March 2025 • Caseloads have reduced by 12% over the last 12 months. • Time in treatment is variable and close to the historic mean	**West Essex** • The SPA continues to see a steady increase in demand for referrals and work is ongoing to continue to stream line the referral process • The rise of acuity / complexity of referrals continues, this is monitored via RAG systems for triage • Team manager CAMHS hub team on long term sickness • Clinical lead role will become vacant due to promotion internally. **Herts – HPFT only** • Clinicians have reported increased acuity / complexity of referrals • Active issue regarding recruitment to vacancies impacting on capacity and performance, cover provided by agency staff to mitigate • Acquiring highly skilled CYP clinicians remains difficult. Non-health support roles being used to bolster teams • All underperforming quadrants now have trajectories for recovery in place. • Transfers of care for >18 years from CYP are impacting on flow	**West Essex** • Strong team in West Essex with additional support provided by the clinical lead and Head of Service across Essex. Clinical lead role out for recruitment. **Herts – HPFT only** • CYP Community waiting times remain at Level 3 business continuity with the Divisional Director leading & monitoring recovery • SLT professional leads overseeing performance in their quadrant teams • Recovery trajectories have been updated to reflect vacancies and recruitment to show impact on waiting lists. • Number of assessments undertaken has increased over the last quarter and backlog is now decreasing. • Recruitment gaps are being addressed through active recruitment and bank and agency cover. • Clear patient safety focused plan in situ and held at weekly Quadrant Safety Group • Care of Waiters protocol is in place with longest waiters regularly reviewed. • Caseload management tool developed and in active use across the quadrants. Improvements in recording are underway to facilitate reporting of treatment waits. • CYP programme of work to improve transition experience and outcomes

Mental Health – Learning Disability (LD) Health Checks

LD Health Checks January 2025	Total LD Register (age 14+)	Completed health checks	Health Checks Declined	Patients NOT had a health check	% Completed health checks *	Comparison to January 2024
NHS Hertfordshire and West Essex ICB	**7,774**	**4,836**	**138**	**2,800**	**62.2%**	**55.6%**
East & North Hertfordshire	3,220	1,951	69	1,200	**60.6%**	**55.6%**
South & West Hertfordshire	3,394	2,191	38	1,165	**64.6%**	**58.6%**
West Essex	1,160	694	31	435	**59.8%**	**43.3%**

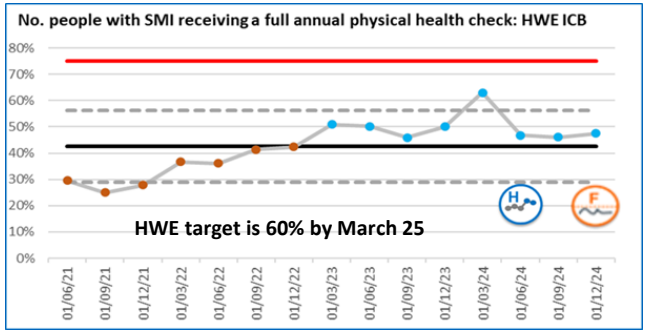
*** 75% Year End Target**

ICB Area	What the charts tell us	Issues	Actions
Hertfordshire & West Essex	• All three places achieved the 75% standard in 23/24 • January 25 data shows the ICB and each place notably ahead of the equivalent 23/24 position at this point in the year	• It is challenging to forecast end of year performance against the 75% LD Health Checks standard, as a large proportion of health checks are carried out towards the end of the year, and particularly in Quarter 4	• Ongoing work between HWE Team and NHSE to cross check local data against national systems

Hertfordshire and West Essex Integrated Care System

Severe Mental Illness (SMI) Health Checks

Number of people with severe mental illness (SMI) receiving a full annual physical health check – percentage achievement in the 12 months to the end of the period

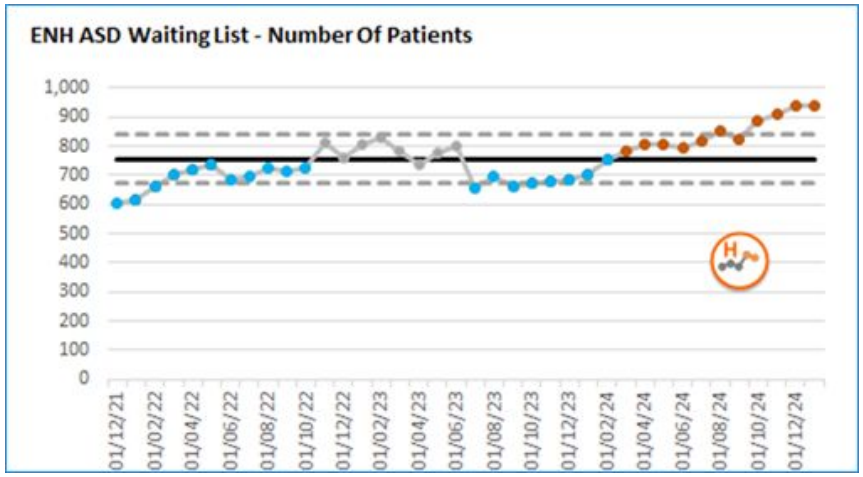


	2021/22				2022/23				2023/24				2024/25		
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3
East and North Herts Place	19.6%	11.9%	15.1%	25.8%	24.0%	36.3%	40.4%	45.9%	49.7%	47.7%	49.4%	60.5%	52.3%	52.7%	53.6%
South West Herts Place	39.4%	38.2%	39.5%	47.5%	44.6%	46.4%	43.6%	55.9%	51.0%	44.8%	52.2%	66.9%	38.9%	36.8%	38.1%
West Essex Place	28.9%	24.5%	30.6%	36.5%	38.5%	38.9%	44.0%	50.4%	49.4%	44.8%	46.4%	59.2%	52.1%	52.4%	55.3%
NHS Herts & West Essex ICB	**29.6%**	**25.1%**	**27.9%**	**36.7%**	**36.1%**	**41.3%**	**42.4%**	**51.0%**	**50.2%**	**45.9%**	**50.0%**	**63.0%**	**46.8%**	**46.1%**	**47.5%**

- The systems for submitting and reporting of SMI Health Checks data has changed for 24/25
- Health Checks undertaken in Secondary Mental Health Services may not currently be fully captured, and therefore a direct comparison to last year's data is not possible at present. This is a known national issue

What the charts tell us	Issues	Actions
• Current data is not capturing all health checks undertaken in secondary care MH services • Despite the data quality position, South & West Hertfordshire is notably performing lower at 38.1% than East & North at 53.6% • ICB data pulled from Ardens however shows the following performance for quarter 3 - East and north Herts at 54% - Southwest Herts at 59%* - West Essex at 54% **National data for SWH only showing 4125 people on SMI register with only 1570 PHC completed , however local data at 5045 people with 2967 PHC completed*	• Data quality issues as per NHSE disclaimer. The data presented here are considered experimental owing to the fact that they are known to be incomplete both in terms of the number of Practices who have not supplied information, and that some of those that have supplied information have supplied partial data. The experimental label of these statistics will be reviewed and removed once data completeness improves sufficiently.	• The data is being extracted from General Practice Extraction Service (GPES), an alternative system this year in Primary Care. There is a piece of work that needs to take place in order that the GPs are recording the data for health checks undertaken in primary care, as well as those carried out when a person is under the care of the MH Trust. This is a known national issue • Data by practice in place showing those practices current performance against target to be shared with practices : ongoing • Work with ICB BI leads and Provider leads to understand reporting requirements of secondary mental health services and primary care QOF data to ensure clear guidance and responsibilities, in line with the NHSE reporting procedures • Standardise record checking process agreed as an action for the Data Subgroup of the contract meeting • HCP place meetings in SW and ENH attended to present current support offer to GPs and identify further actions to support programme of work • Support the improvement of interoperability and provider electronic care records and information systems to enable monitoring of performance against equity of access to care • Working with Regional MH Team to look at shared care protocols to detail who is responsible for the physical health check, and how support for people who only engage with secondary care and not primary care will be captured, awaiting response • Review and development of a potential business case an ICB wide primary care outreach support on hold due to current financial position

Autism Spectrum Disorder (ASD) – East & North Hertfordshire



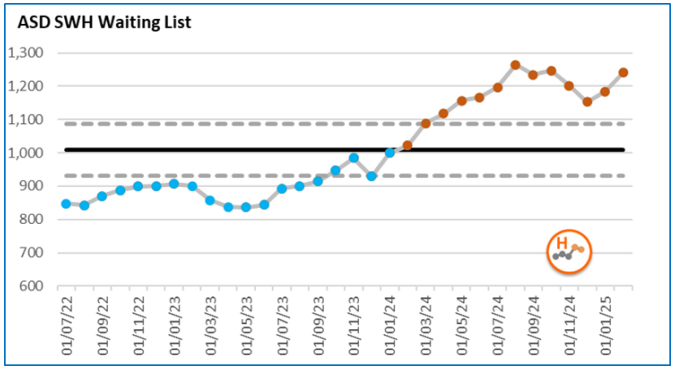
- In ENH, patients have a first appointment with Community Paediatrics. If the clinician, then considers that the patient requires an ASD assessment then they are added to the ASD waiting list
- Data is available on the waiting times for the first community paediatrics appointments and also for ASD assessments once a patient has been added to the ASD assessment waiting list. However, data is not available for both pathways combined
- The chart opposite shows the trend in the number of patients waiting for an ASD assessment once they have been referred by a community paediatrician
- The table below summarises how long patients on the ASD waiting list have been waiting (as of Jun-24):

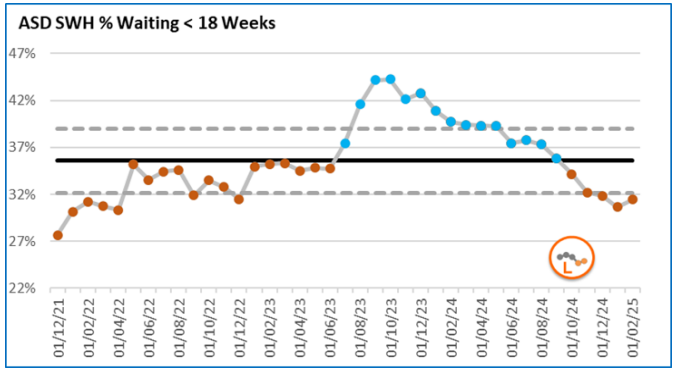
Waiting list bucket	Number of patients (Dec-24)	Number of patients (Jan-25)
<18 weeks	91	71
18 – 65 weeks	508	505
66 – 78 weeks	100	106
>78 weeks	242	257

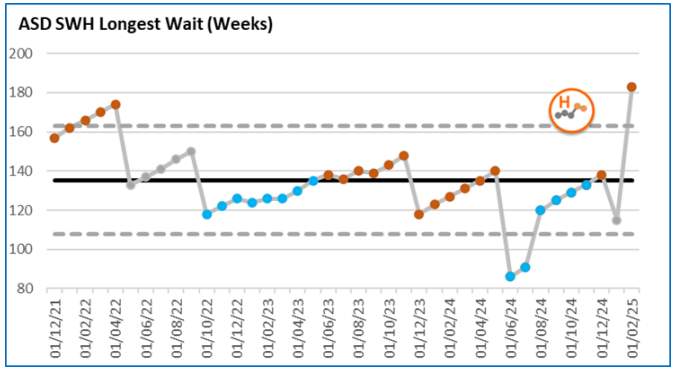
ICB Area	What the charts tell us	Issues	Actions
East & North Herts	• The ASD waiting backlog waiting list continues to increase and reached 939 patients in Jan-25 which is the highest recorded level • The number of patients waiting >78 weeks for an ASD assessment has risen from 86 in Dec-23 to 257 in Jan-25 • The waiting list shown above does not include patients waiting for their first Community Paediatrics appointment, even if they have been referred by their GP as query ASD. It only shows patients who have been assessed by a community paediatrician and referred for a detailed ASD assessment	• Data not currently reportable on the same basis as the other two ICB Places • Backlog funding ended December 2023 and waiting lists are increasing. In addition to this, further increases in demand predicted • Awaiting confirmation of investment into the service	• Procurement process to outsource assessments for autism completed – currently in stand-still period. New provider in place from 11th September • Learning Disabilities, Mental Health and Autism HCP continuing to develop support offer for parents, carers, families and CYP with behaviours and / or needs associated with Autism and / or ADHD • Funding approved for Neurodiversity Support Centre for the next 3 years • Understanding My Autism funding ends July 2025, not currently extended. • The MHLDA HCP and providers continue to scope implementation of new pathway • Hertfordshire wide single point of referral logging for all ASD and ADHD referrals is progressing with providers working together to plan implementation in autumn 2025

Autism Spectrum Disorder (ASD) – South & West Hertfordshire

			Patients Waiting			% waiting < 18 weeks			Longest wait (weeks)			
Place	Provider	Age	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
SWH	HCT	Children	1184	1241	↑	30.64%	31.46%	↑	115	183	↑	February



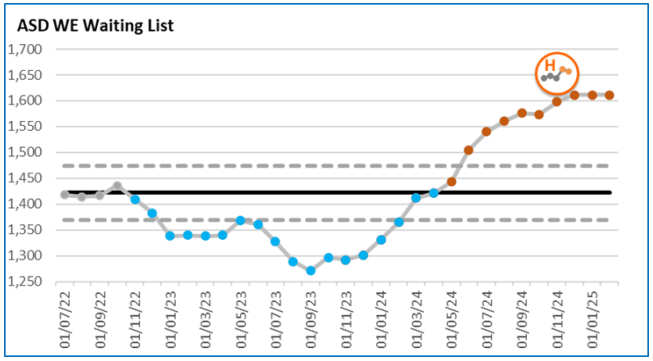


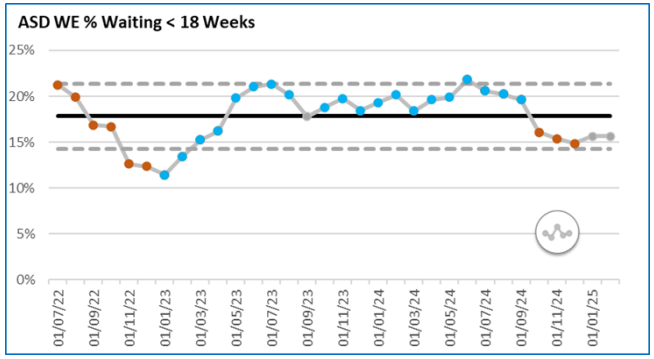


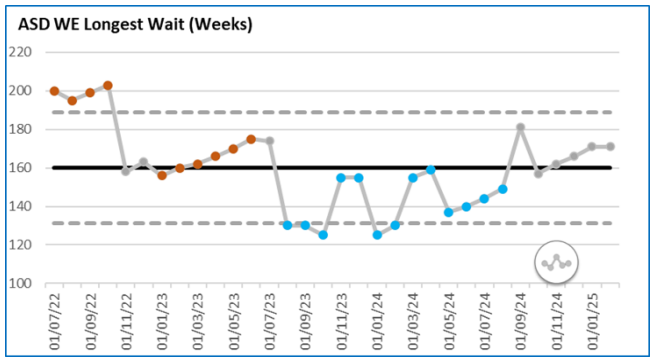
ICB Area	What the charts tell us	Issues	Actions
South & West Herts	• The ASD waiting list has increased for the last two months and remains consistently above the historic average • The % of ASD waiters <18 weeks remains low but increased slightly in February • The increase in longest wait is likely a single patient and will quickly recover	• Capacity in existing services does not meet demand • Further increases in demand predicted • Awaiting confirmation of investment into the service for 2025/26	• As a result of a focus on the long waits in Comm Paeds. (first wait), the waiting list in ASD (second wait) is increasing as expected • Procurement process to outsource assessments for autism completed – currently in stand-still period. New provider in place from 11th September • Learning Disabilities, Mental Health and Autism HCP continuing to develop support offer for parents, carers, families and CYP with behaviours and / or needs associated with Autism and / or ADHD • Funding approved for Neurodiversity Support Centre for the next 3 years • Understanding My Autism funding ends July 2025, not currently extended • The MHLDA HCP and providers continue to scope implementation of new pathway • Hertfordshire wide single point of referral logging for all ASD and ADHD referrals is progressing with providers working together to plan implementation in autumn 2025

Autism Spectrum Disorder (ASD) – West Essex

			Patients Waiting			% waiting < 18 weeks			Longest wait (weeks)			
Place	Provider	Age	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
WE	HCRG	Children	1611	1611	→	15.64%	15.64%	→	171	171	→	February



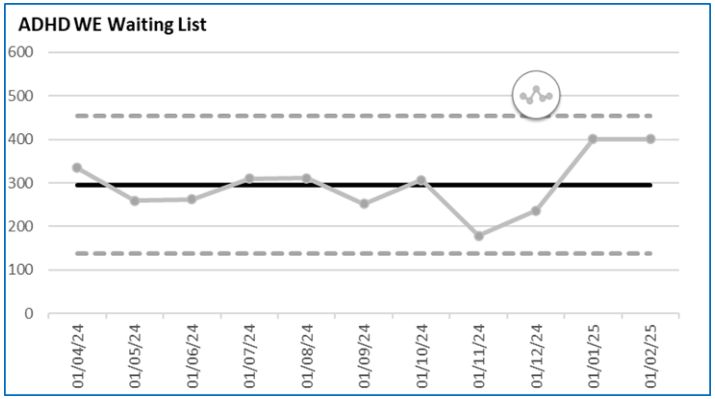


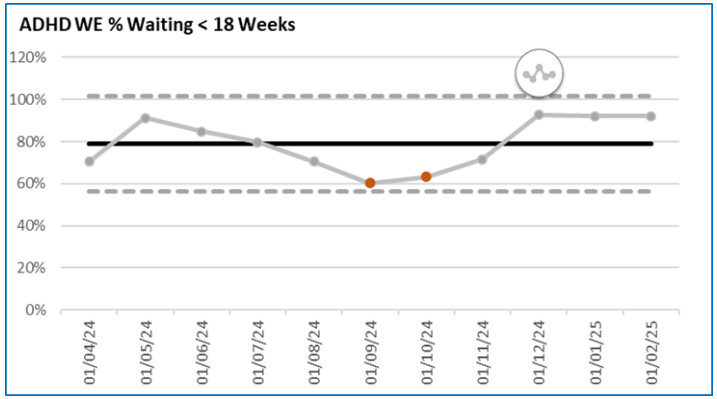


ICB Area	What the charts tell us	Issues	Actions
West Essex	• To note data has been copied over from January in the absence of February data being available • The ASD waiting list remains very high • The % of waiters <18 weeks remains low and fell in each of the six months leading up to January • The longest wait has been steadily increasing but remains within common cause variation limits	• No February data received from HCRG following cyber incident All issues are ongoing in the absence of additional resource: • Average monthly referral rate continues to be >70% greater than commissioned capacity • Demand and capacity analysis forecasts continued waiting list growth • Imminent CQC / Ofsted SEND Inspection for Essex. ASD waiting times and progress with improvement since last inspections in 2019 and 2022 expected to be highlighted	• Once access to data platforms have been reopened, HCRG will provide back-dated performance data which will be reflected on this report • Business case submitted to increase core capacity for sustainable delivery – remains outstanding. Potential to be considered as part of recommissioning of the contract • Seven additional team members undergoing ADOS training. Two paediatricians being trained in A3DI to support JADES team during absences • 'Waiting well' workstream continues with local partners at Place, led by trainee psychologist at HCRG • Continuing to explore use of the ND Profiling Tool

Attention Deficit Hyperactivity Disorder (ADHD)
West Essex & East & North Hertfordshire

			Patients Waiting			% waiting < 18 weeks			Longest wait (weeks)			
Place	Provider	Age	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
WE	HCRG	Children	401	401	→	92.02%	92.02%	→	40	40	→	February

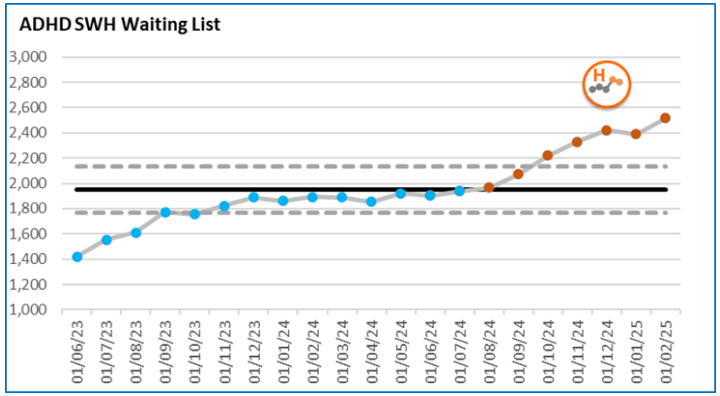


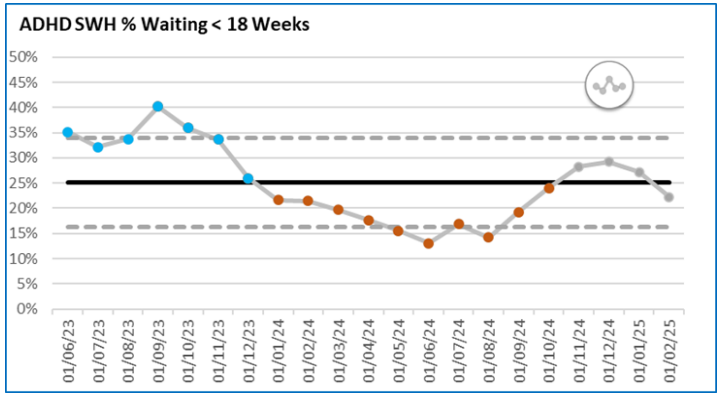


ICB Area	What the charts tell us	Issues	Actions
West Essex	• West Essex data has been copied over from January in the absence of February data being available • West Essex waiting lists continue to fluctuate at historic average levels • The % of children waiting <18 weeks are also within common cause variation limits	• ENHT is not currently able to report on waiting times / waiting list sizes for patients waiting for an ADHD assessment • No February data received from HCRG for West Essex following cyber incident • Referral rates for WE have increased by 250% by the end of Q3 • WE Adult services are limiting the number of young people transitioning to adult care, resulting in Paediatrics holding an increasing caseload of >18yrs • Referral rates continues to rise, resulting in risk to maintaining waiting list performance	• Once access to data platforms have been reopened, HCRG will provide back-dated performance data which will be reflected on this report • WE pathway redesign complete, incorporating ASD and ADHD into a single referral pathway route • WE Adult transition issues have been raised, however the number of referrals accepted is limited under contract activity plans. There is no resource in the system to increase capacity for adult transition

Attention Deficit Hyperactivity Disorder (ADHD) – South & West Hertfordshire

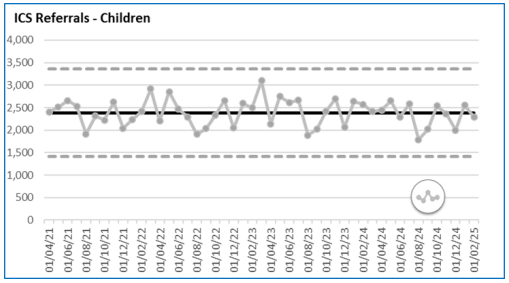
			Patients Waiting			% waiting < 18 weeks			Longest wait (weeks)			
Place	Provider	Age	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
SWH	HPFT	Children	2391	2518	↑	27.19%	22.28%	↓	186	191	↑	February

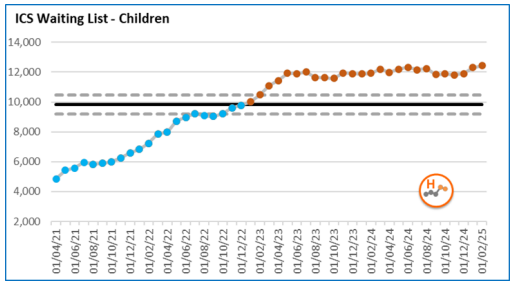


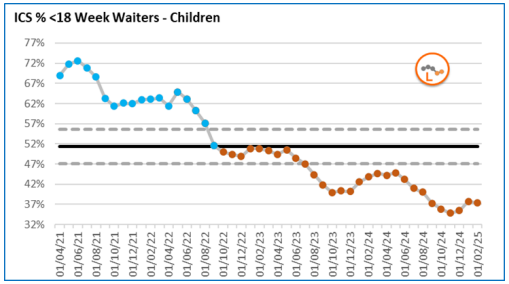


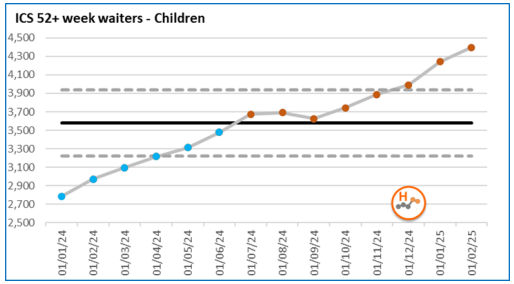
ICB Area	What the charts tell us	Issues	Actions
West Essex	• Overall waiting list was relatively stable but has notably increased over the last six months • The % of ADHD patients waiting <18 weeks has declined in recent months but remains within common cause variation limits	• Awaiting confirmation of investment into the service for 2025/26	• Learning Disabilities, Mental Health and Autism HCP continuing to develop support offer for parents, carers, families and CYP with behaviours and / or needs associated with Autism and / or ADHD • Funding approved for Neurodiversity Support Centre for the next 3 years • The MHLDA HCP and providers continue to scope implementation of new pathway • Hertfordshire wide single point of referral logging for all ASD and ADHD referrals is progressing with providers working together to plan implementation in autumn 2025

Community Waiting Times (Children)









		Referrals			Patients Waiting			% Waiting <18 weeks			Patients Waiting >52 Weeks			
Place	Age	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
ICS	Children	2551	2292	↓	12309	12422	↑	37.75%	37.35%	↓	4241	4396	↑	February

Place	Provider	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
ENH	HCT	356	328	↓	565	548	↓	87.43%	83.94%	↓	0	0	→	February
ENH	AJM (W/Chairs)	34	14	↓	137	132	↓	62.04%	61.36%	↓	0	0	→	February
ENH	ENHT Community Paeds.	254	191	↓	6608	6735	↑	13.77%	13.76%	↓	4085	4208	↑	February
ENH	**All**	**644**	**533**	↓	**7310**	**7415**	↑	**20.37%**	**19.80%**	↓	**4085**	**4208**	↑	**February**

Place	Provider	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
SWH	HCT	1337	1199	↓	3649	3663	↑	55.39%	55.36%	↓	153	188	↑	February
SWH	AJM (W/Chairs)	31	23	↓	132	126	↓	62.12%	70.63%	↑	3	0	↓	February
SWH	Communitas (ENT)	NO DATA	NO DATA	-	NO DATA	NO DATA	-	NO DATA	NO DATA	-	NO DATA	NO DATA	-	February
SWH	**All**	**1368**	**1222**	↓	**3781**	**3789**	↑	**55.62%**	**55.87%**	↑	**156**	**188**	↑	**February**

Place	Provider	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
WE	EPUT (W/Chairs)	20	18	↓	38	38	→	94.74%	92.11%	↓	0	0	→	February
WE	HCRG	519	519	→	1180	1180	→	86.36%	86.36%	→	0	0	→	February
WE	**All**	**539**	**537**	↓	**1218**	**1218**	→	**86.62%**	**86.54%**	↓	**0**	**0**	→	**February**

NOTE: **Work underway with all Community Providers currently not providing accurate community waiting list data**
No HCRG February 25 data received. January numbers carried forward ti ensure consistency of overall system reporting

Hertfordshire and West Essex Integrated Care System

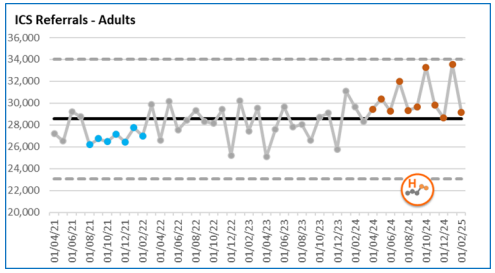
Community Waiting Times (Children)

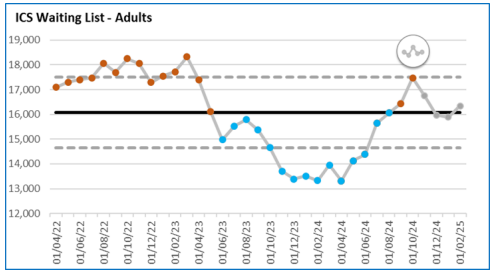
The NHS 18-week Referral to Treatment (RTT) standard only applies to consultant led services. For Children's community services this include Community Paediatrics (ICS wide) and Children's Audiology (SWH). Other services have locally agreed waiting times standards which may be 18 weeks or less. All services are shown compared to an 18-week target for an overall view of waiting time performance.

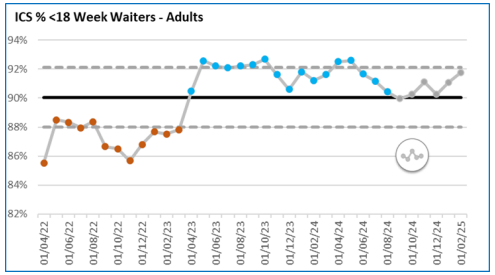
ICB Area	What the charts tell us	Issues	Actions
ICB	• The total number of children on waiting lists remains very high, but has plateaued at c.12,000 • The % of children waiting less than 18 weeks is broadly unchanged at c.37%, compared to the national average of c.50% • The longest waits are within the ENHT Community Paediatrics Service where there are now 4,208 x 52 week waits • There are additionally 188 x 52 week waits within HCT services in South & West Hertfordshire – a notable increase over the last 2 months • Consultant led 18-week RTT performance: SWH Community Paediatrics – 38.0% SWH Children's Audiology – 40.4% ENH Community Paediatrics – 13.8% WE Community Paediatrics – NO DATA	**Hertfordshire** • Most HCT children's specialist services are seeing a marked increase in demand • Waiting times in the SWH HCT Community Paediatrics service are stable but there is an increase in long waits • There are continued waiting time pressures in Paediatric Audiology in SWH, but there has been improvement with a 59% decrease in total waiters since a high point in June 2023. The service has supported ENHT newborn hearing pathways • Improvement in waiting times across Hertfordshire for children's therapies (OT, Speech & Language and Physiotherapy) although they remain under pressure, EHCP performance and workforce position is improving **West Essex (WE)** • No February data received from HCRG following cyber incident	**Hertfordshire** • Waiting list initiatives in place to limit the risk of 65+ week waiters • Community Paediatrics in SWH is continuing to receive non-recurrent extra investment to increase workforce capacity and introduce new specialist nursing posts. Service working at full establishment • Paediatric Audiology in SWH is focusing on higher priority appointments, especially follow ups, and signposting to interim advice whilst awaiting assessment. Implementing patient self-booking to reduce NBIs. Demand and capacity analysis completed and identified required staffing model to reduce the waiting list • Focus on reducing DNA / NBI rates for children living in relatively more deprived neighbourhoods • Children's Therapies – increasing capacity through successful recruitment, waiting list initiatives and outsourcing. Pilot for self-booking in one locality has reduced NBI, now being rolled out to other localities • EHCP dashboard developed to improve waiting list management **West Essex (WE)** • Increases in places at Harlow Fields special school will increase demand a pressure on therapies, community paediatric and special school nursing provisions. Currently looking at mitigations in the absence of additional resource being available to increase capacity inline • New Designated Clinical Officer for SEND in post and proactively working with both Essex and Herts DCOs • Care Closer to Home workstream restarted with PAHT • Dietician vacancy filled • Still awaiting release of identified CYP funding to close the gap between demand and capacity • Preparation for recommissioning of HCRG contract ongoing

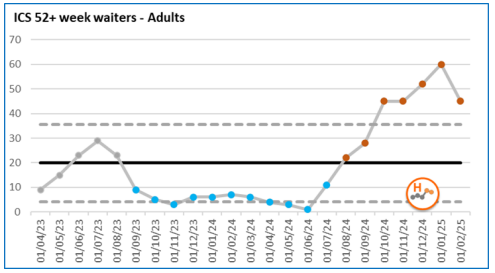
Hertfordshire and West Essex Integrated Care System

Community Waiting Times (Adults)









		Referrals			Patients Waiting			% Waiting <18 weeks			Patients Waiting >52 Weeks			
Place	Age	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
ICS	Adults	33567	29179	↓	15881	16347	↑	91.10%	91.77%	↑	60	45	↓	February

Place	Provider	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
ENH	HCT	10176	7742	↓	9695	9835	↑	90.14%	90.34%	↑	46	33	↓	February
ENH	AJM (W/Chairs)	130	105	↓	515	481	↓	60.00%	64.24%	↑	6	3	↓	February
ENH	**All**	**10306**	**7847**	↓	**10210**	**10316**	↑	**88.62%**	**89.12%**	↑	**52**	**36**	↓	**February**

Place	Provider	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
SWH	CLCH	7942	7931	↓	1439	1597	↑	99.72%	99.62%	↓	0	0	→	February
SWH	CHEC (Ophthalmology)	NO DATA	NO DATA	-	NO DATA	NO DATA	-	NO DATA	NO DATA	-	NO DATA	NO DATA	-	February
SWH	Circle Health (MSK)	NO DATA	NO DATA	-	NO DATA	NO DATA	-	NO DATA	NO DATA	-	NO DATA	NO DATA	-	February
SWH	Communitas (ENT)	NO DATA	NO DATA	-	NO DATA	NO DATA	-	NO DATA	NO DATA	-	NO DATA	NO DATA	-	February
SWH	The Gynaecology P/Ship	NO DATA	NO DATA	-	NO DATA	NO DATA	-	NO DATA	NO DATA	-	NO DATA	NO DATA	-	February
SWH	HCT	903	969	↑	937	997	↑	96.58%	97.99%	↑	0	0	→	February
SWH	AJM (W/Chairs)	125	100	↓	579	562	↓	63.21%	67.79%	↑	8	9	↑	February
SWH	**All**	**8970**	**9000**	↑	**2955**	**3156**	↑	**91.57%**	**93.44%**	↑	**8**	**9**	↑	**February**

Place	Provider	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
WE	EPUT	14178	12251	↓	2609	2759	↑	100.00%	99.42%	↓	0	0	→	February
WE	EPUT (W/Chairs)	113	81	↓	107	116	↑	97.20%	100.00%	↑	0	0	→	February
WE	Mayflower	NO DATA	NO DATA	-	NO DATA	NO DATA	-	NO DATA	NO DATA		NO DATA	NO DATA	-	February
WE	**All**	**14291**	**12332**	↓	**2716**	**2875**	↑	**99.89%**	**99.44%**	↓	**0**	**0**	→	**February**

NOTE: **Work underway with all Community Providers currently not providing accurate community waiting list data**

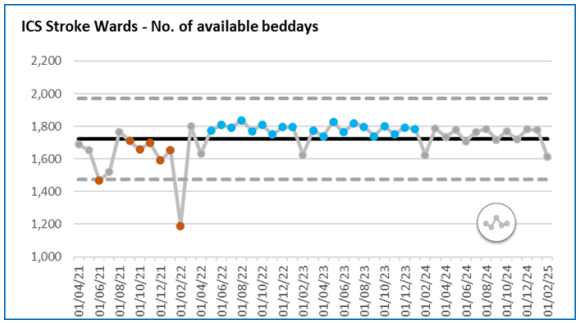
Hertfordshire and West Essex Integrated Care System

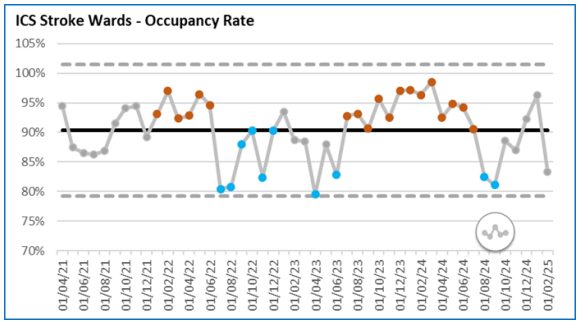
Community Waiting Times (Adults)

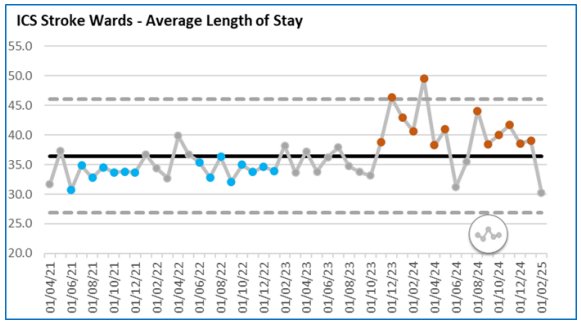
The NHS 18-week Referral to Treatment (RTT) standard only applies to consultant led services. For Adult community services this include Skin Health (ENH), Respiratory (S&W), and Podiatric Surgery (WE). Other services have locally agreed waiting times standards which may be 18 weeks or less. All services are shown compared to an 18-week target for an overall view of waiting time performance.

ICB Area	What the charts tell us	Issues	Actions
ICB	• **Data for five community providers is currently excluded from the overall HWE system position as noted on the previous slide. Work is ongoing to resolve reporting from April 25** • The % of patients waiting less than 18 weeks remains comparatively strong at 91.8%, compared to the national average of c.85% • Overall waiting lists remain close to the historic 16k average • 52 week waits reduced at both HCT and AJM wheelchairs – down from 60 to 45 in month • Consultant led 18-week RTT performance: ENH Skin Health – 92.7% SWH Respiratory – 100% WE Podiatric Surgery – 70.7%	**East & North Hertfordshire (ENH)** • Increase in referrals compared to 2023/24 • Slight reduction in the 'waiting within target' performance in recent months when compared to the pre-pandemic baseline and last year **South & West Hertfordshire (SWH)** • MSK services previously delivered by Connect have been reprocured with Circle. Work continues to resolve data quality issues before incorporation into this report • Four other Providers currently with reporting issues • CLCH – Slight decrease in number of referrals received in month and increase in total number of patients waiting on caseload. However, no patients waiting more than 52 weeks **AJM (Wheelchairs)** • 12 x 52 week waits reported in the February position, which is an improvement from 16 in the December position. Commissioners continue to work with AJM to oversee improvement plans and it should be noted that quoted waiting times are from referral to chair handover, and patients will have had multiple appointments in the interim with plans in place **West Essex (WE)** • SLT, Podiatry and Bio-Mechanics breaches of waiting times due to vacancies / capacity / long-term sickness. Maximum wait of 10 weeks v. 8-week target • MSK breaches and increased PTL following transfer of iMSK patients from Stellar Healthcare on contract termination. Also impacted by long-term sickness	**East & North Hertfordshire (ENH)** • All waits, especially longer waits, are closely monitored and subject to robust internal governance • Service productivity initiatives continue • Comprehensive health inequalities metrics in place and analysis has allowed the Trust to compare waiting times and DNA rates for those living in relative deprivation versus those that do not. Targets have been set to address discrepancies • Extensive focus on digital initiatives to support and improve patient access • Forecasting suggests a generally stable trend over the next 12 months **South & West Hertfordshire (SWH)** • Working with Circle and ICB contract leads to resolve reporting issues following re-tender of SWH MSK contract from 1st April • Contract teams also working with the other four providers not currently reporting to resolve for 25/26 • Daily and weekly monitoring remain in place. Additional external support sourced for services where there are waiting times concerns. These include Neuro, Bladder and Bowel, Planned Care Therapy, and Respiratory services **West Essex (WE)** • SLT breaches continue to improve month on month – recovery expected from March • Podiatry / Bio-Mechanics – band 6 post out to advert. Locum support from 14th April • iMSK recovery plan agreed and continued month on month improvement

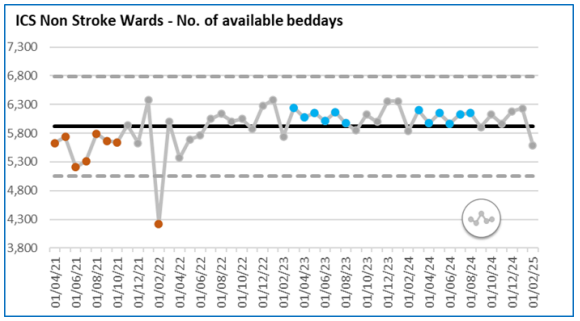
Community Beds (Stroke & Non-Stroke)

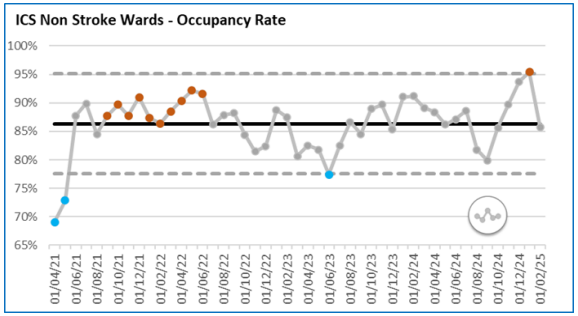


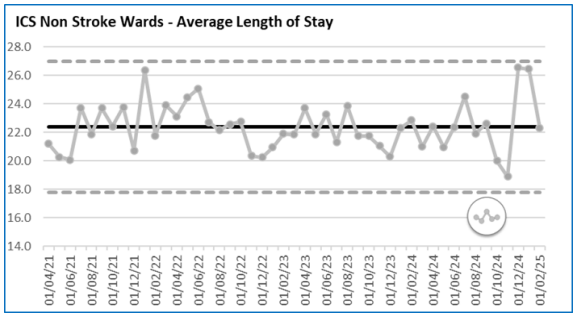




Stroke Wards		Number of available beddays			Occupancy Rate			Average length of stay (days)			
Place	Provider	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
ENH	HCT	744	672	↓	95.30%	88.10%	↓	37.8	26.5	↓	February
SWH	CLCH	600	550	↓	99.83%	92.73%	↓	39.8	29.6	↓	February
WE	EPUT	434	392	↓	92.86%	61.99%	↓	40.0	41.0	↑	February
ICS	**All**	**1778**	**1614**	↓	**96.23%**	**83.33%**	↓	**39.0**	**30.3**	↓	**February**







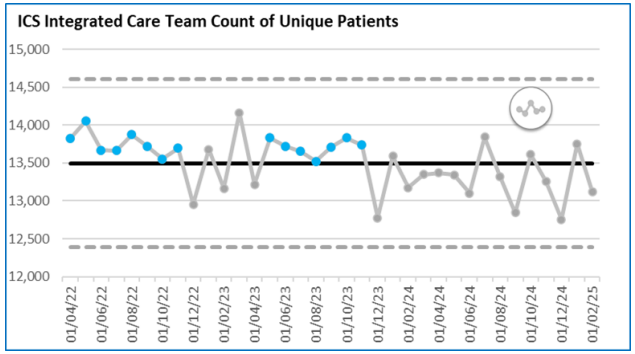
Non-Stroke Wards		Number of available beddays			Occupancy Rate			Average length of stay (days)			
Place	Provider	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
ENH	HCT	1739	1484	↓	91.78%	84.23%	↓	23.7	20.2	↓	February
SWH	CLCH	2232	2060	↓	98.84%	95.68%	↓	25.8	23.9	↓	February
WE	EPUT	2263	2044	↓	94.92%	76.81%	↓	29.1	22.0	↓	February
ICS	**All**	**6234**	**5588**	↓	**95.44%**	**85.74%**	↓	**26.4**	**22.3**	↓	**February**

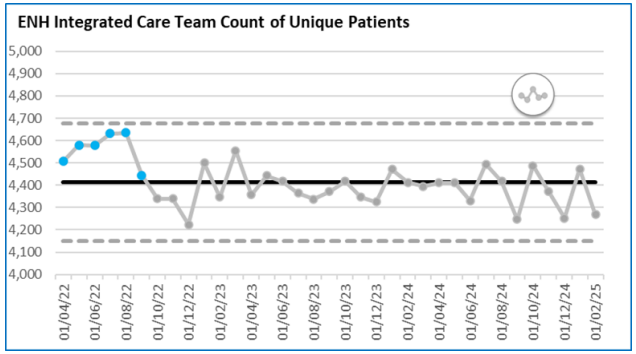
Community Beds (Stroke & Non-Stroke)

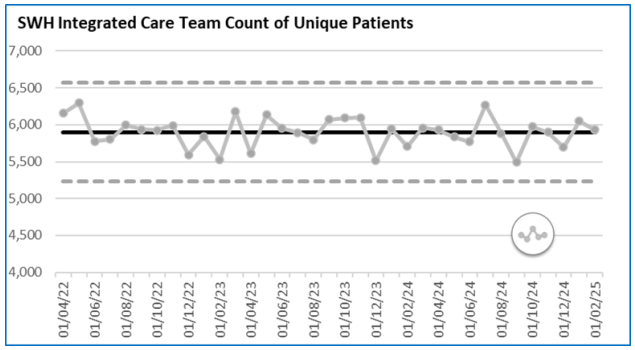
ICB Area	What the charts tell us	Issues	Actions
ICB	**Stroke Beds** • Available stroke bed days remain stable • Overall stroke bed occupancy rates dropped to 83.3%, driven primarily by a reduction at EPUT to 62.0% • CLCH occupancy remains high at 92.7% • Overall length of stay is within common cause variation limits, but is highest within EPUT at 41 days **Non-Stroke Beds** • Available non-stroke bed days reduced due to lower number of days in February • Overall non-stroke bed occupancy rates reduced at all providers, returning to the historic average of c.85% • Overall length of stay reduced at all providers, returning to the average of c.22 days	**East & North Hertfordshire (ENH)** • Bed occupancy remains the highest at Danesbury with an average of 90% over the past 12 months. Herts & Essex and QVM both have a 12-month average occupancy of 82 • Average length of stay over the past 12 months for Herts & Essex averaged 24 days, and 27 days at QVM. At Danesbury, there is now normal variation with an average of 37 days. Admissions into community hospitals show no significant change in trend at Herts and Essex and QVM • Danesbury has the least admissions with an average of 17 a month, with QVM averaging 18, and Herts & Essex averaging 32 **South & West Hertfordshire (SWH)** • Although reduction in occupancy rates from previous month, this remains high • Reduction in average length of stay **West Essex (WE)** • Length of stay on stroke ward increased by 1 day, but has reduced from 49 days in November, as the longest stay patients have been discharged • Non-stroke bed occupancy and length of stay have seen positive improvements and both decreasing. This is reflective of the D2A ward opening, and despite increased acuity of patients. Continuous improvement work ongoing	**East & North Hertfordshire (ENH)** • New process regarding criteria to reside in place to support discharge • Step up as well as step down in place **South & West Hertfordshire (SWH)** • Daily assurance calls remain in place with HCC, with clear escalation process • TOCH has now gone live • Deep Dive into all units currently underway. Focus is on referral numbers, admissions & discharges and average length of stay **West Essex (WE)** • Daily escalation calls in place to support all delayed discharges • Discharge to Assess (D2A) – 22 dedicated beds now in place to support system

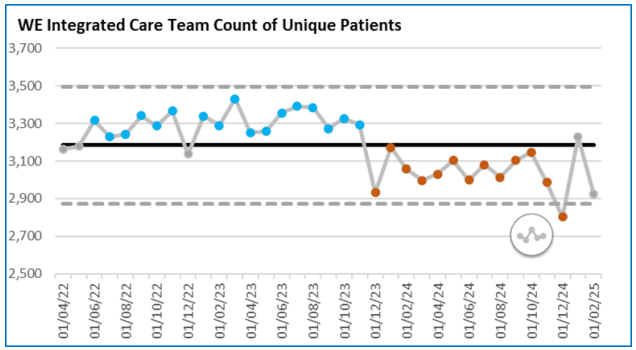
Hertfordshire and West Essex Integrated Care System

Integrated Care Teams (ICT)









			Contacts (unique patients)			Contacts (unique patients) per 1000 population			
Place	Provider	Age	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
ENH	HCT	All	4473	4269	↓	7.1	6.8	↓	February
SWH	CLCH	All	6051	5932	↓	8.7	8.6	↓	February
WE	EPUT	All	3228	2923	↓	9.6	8.7	↓	February
ICS	**All**	**All**	**13752**	**13124**	↓	**8.3**	**7.9**	↓	**February**

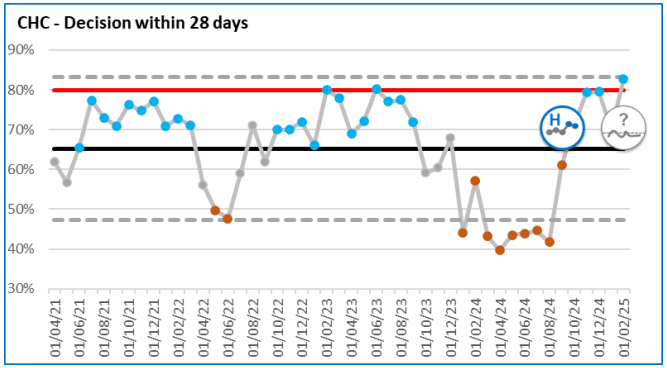
Hertfordshire and West Essex Integrated Care System

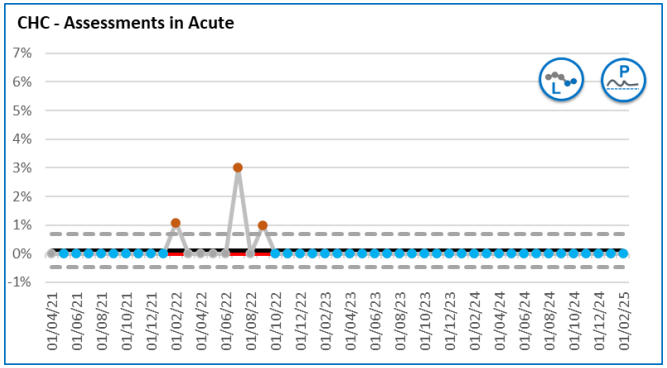
Integrated Care Teams (ICT)

ICB Area	What the charts tell us	Issues	Actions
ICB	• Unique contacts across the ICS and within each place are within common cause variation limits • However, other than in one-month, contacts in West Essex have trended below the historic average during 24/25	**East & North Hertfordshire (ENH)** • The number of individuals rereferred to the ICT is similar to pre-pandemic • There is an increase in the first-to-follow-up appointment ratio linked to increased acuity • The overall caseload is much higher than in 2019/20 across all localities • Patient complexity is increasing, with more intensive treatments required. e.g. numbers of intravenous antibiotics (IV) and End of Life (EOL) patients **South & West Hertfordshire (SWH)** • Slight reduction in contacts. This is due to planned and unexpected leave **West Essex (WE)** • Since April 2021 ICTs have seen a reduction in referrals. Contacts per patient however have increased, suggesting an increase in acuity of patients receiving care in the community • Contacts reduced in month, but are still up compared to the 2803 for December position	• Care Closer to Home programme underway across HWE to reduce variation and shift to reporting outcomes and impact, to compliment the activity driven data that exists **East & North Hertfordshire (ENH)** • A comprehensive transformation programme in place focused on workforce, wound care and diabetes management with the ICT • Model being developed to improve capacity, agility and consistency across ICTs • Comprehensive SystmOne optimisation project continues roll out - aiming to streamline use of clinical systems with a prospective productivity gain • The Hospital at Home services appear to be effectively supporting reduced Acute demand **West Essex (WE)** • Work progressing to support development of Integrated Neighbourhood Teams of which the ICTs are integral, alongside socialisation of the new HWE Care Closer to Home model of care • Proactive care model for segments 4 & 5 to support a 25% reduction in NELs • Proposal to accelerate support in Harlow with an additional matron submitted to BCF

Hertfordshire and West Essex Integrated Care System

Continuing Health Care (CHC)



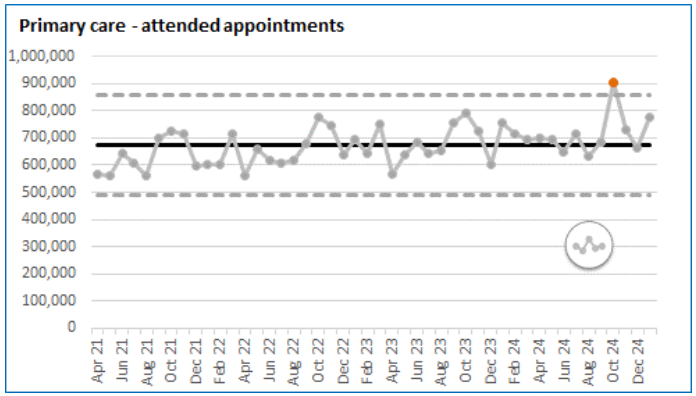


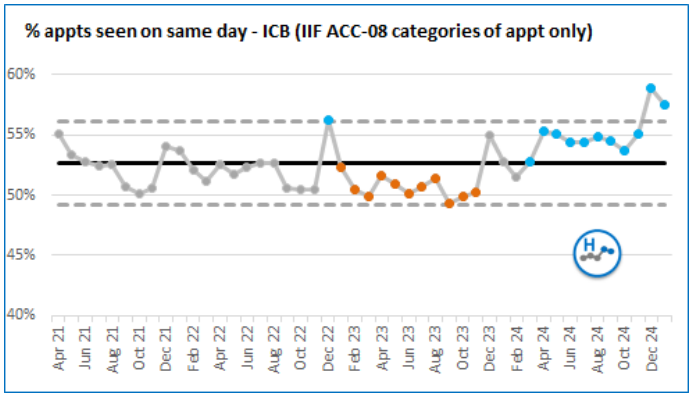
	What the charts tell us	Issues	Actions

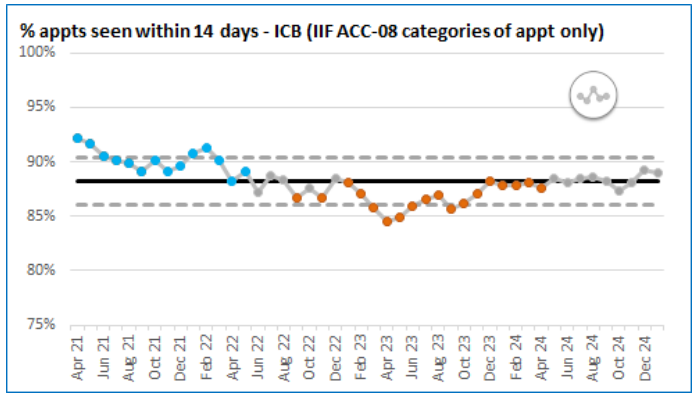
HWEICB	• The 28-day standard has notably improved over the last two months, most significantly in South & West Hertfordshire
	• February overall performance significantly improved and the ICB has achieved the national target (>=80%) for the first time since its formation:
	  ○ Overall ICB – 82.7%
	  ○ West Essex – 75%
	  ○ ENH – 78.6%
	  ○ SWH – 90.6%
	• The recovery of the 28-day standard was forecast to be achieved by Q4 24/25 and is on track
	• The assessments in an acute setting <15% standard continues to be routinely achieved
		• The newly recruited starters do not have previous CHC experience and therefore require robust training and development, this is an ongoing concern.
		• Continued concerns around Social Worker availability across all areas is predicted to have a negative impact on the 28-day KPI.
		• Both East & North Herts and West Essex remain short of the target due to a lack of nursing capacity within the team, this continues to be addressed where possible given current system limitations.
			• Weekly meetings are in place across all areas to monitor performance. Additional assurance meetings are being held with NHSE
			• A further comprehensive layer of management control and support is being implemented across the East & North Herts and West Essex service to significantly improve work allocation, daily analysis of completed work, case status and risk identification. This approach is similar to that which has improved the service in South & West Herts
			• More robust induction and training packs are being developed for new starters to ensure they can become as productive as possible with day-to-day operations as quickly as possible

Hertfordshire and West Essex Integrated Care System

Primary Care







NOTE: %s in the above charts are based on appointments made, not requests received

What the charts tell us

- Although the number of primary care attended appointments continues to show standard normal variation, there is a continued slight upward trend in the number of attended appointments. For example, the number of appointments attended in M1-10 of FY2425 have been 5% higher than M1-10 of FY2324.
- The % of appointments seen on the same day of booking has been above the long-term mean for the last eleven months, suggesting that there has been a sustained improvement in this metric. The chart above now shows the % of same day appointments for a subset of appointment types where the patient would typically want the first available appointment, rather than reviews / check-ups (IIF ACC-08 categories of appointment)
- The % of appointments which were seen within 14 days of booking has returned towards the mean over the last nine months, and performance is only marginally below this year's plan of 89%. The chart above now shows the % of same day attendances for a subset of appointment types where the patient would typically want the first available appointment, rather than reviews / check-ups (IIF ACC-08 categories of appointment)

Hertfordshire and West Essex Integrated Care System

Primary Care

Issues	Actions
• National contract for 24/25 imposed without agreement and Collective Action in Primary Care added to the risk register – new contract for 25/26 agreed however while formal collective action stood down the principle of not undertaking unfunded work remains • General Practice continues to see increases in demand against a backdrop of working through the backlog, workforce pressures and negative media portrayal • 24/25 focus on cutting bureaucracy, helping practices with cash flow and increase financial flexibilities and continue to improve patient experience of access • 25/26 greater emphasis on performance management with launch of new Primary Care General practice dashboard and supporting elective recovery through Advice and Guidance Local Enhanced Service, reducing bureaucracy continues with reduction in QOF indicators, and new contract requirement for access to online consultations • 25/26 contract changes for Dental and Community Pharmacy	**Engagement with the National Access Recovery Plan** • Logging local intelligence on practices taking part in collective action and ongoing work with HETCG and liaison with LMC to identify and mitigate any issues arising • Annual GP Patient Survey (GPPS) was published in July (data collected Jan –Mar 24). Overall slight improvement and PCCC and Primary Care Board oversight of results. Action plan developed through the Access MDT Group Triangulation with other data held does not show any strong correlation e.g. number of appointments, digital telephony etc. • GPPS 2024 Dental Access results shows HWE as best performing in East of England • National Monthly Health Insights survey Wave 7 (published March 25) shows 12.7 point improvement in % of patients rating their overall experience of general practice as good. • Many practices transitioning to Modern General Practice (MGP) through demand / capacity analysis, use of cloud-based telephony, roll out NHS app, online GP registration, development of GP and PCN websites and testing triage models. Audit undertaken of the latest position for all practices for 24/25 year-end update. • Local CAIP - 29 of 35 PCNs have submitted their self-declaration based on the PCN's progress in implementing the Modern General Practice Access (MGPA) model and specifically in delivering against three priority domains. Specifically, these are Better Digital Telephony – 29 PCNs; Simpler Online Requests – 24 PCNs; Faster Care Navigation, Assessment and Response – 26 PCNs. PCNs can submit their self-declaration up to 31 March 25 • Transition Cover – All practices supported with further funding to implement modern general practice • All practices now have Cloud Based Telephony of some level. Looking at options for improving services at the circa 25 practices who are on the lowest level of CBT • National GP Improvement Programme - 43 practices & 4 PCNs participated in this nationally supported facilitated programme • Support Level Framework (SLF): Self-assessment tool to support practice teams in understanding what they do well, what they might wish to do better, and where they might benefit from development support. Roll-out of SLF facilitated sessions for practices at increased pace in 24/25 • The majority of practices have progressed towards full enablement of prospective records access; over 725k patients across HWE have access to their records; 60% of practices have 90%+ of patients with online access + records access enabled; over 80% of practices with 80%+ • Partnership working to increase self-referrals in high volume services: Physio, IAPT, Podiatry etc. • Communications to support ICB and practice websites, media statements and patient comms re the Delivery Plan • Inclusion of newly qualified GPs in the ARR scheme from Oct 24, with 21 of 35 PCNs claimed by end of Jan-25. Workforce Leads engaging with PCNs to support further recruitment • Review of newly launched national CATS GP Performance Dashboard, noting negative variation identified in Access and Patient Experience for 21 practices, Workforce 4 practices have negative variation, Clinical Outcomes and Quality negative variation in 4 practices and for Vaccs and Imms there are 17 practices identified. Further analysis planned through conversation with BI, monthly Access MDT and Risk and information sharing groups. The CATs tool will feed in to local contract monitoring noting limitations of using bottom decile and take as a starting point for discussion with practices to understand if variation is unwarranted. • Planning for June submission of GP practice plans focussed on access and unwarranted variation and identify practices suitable for GPIP and PLS • Work in progress on implementation of the Advice and Guidance LES **Other** • Active engagement with LMCs to refine Enhanced Commissioning Framework (ECF) for 25/26, including specific activity-based payment for Wound Care activity. • Trend analysis to identify practices with poor access via complaints and patient contacts • Initiatives for Primary Care Workforce to support recruitment and retention, supported by the HSE ICB Training Hub • Daily review of OPEL reporting by practices and follow up by place Primary Care Teams with individual practices • Pharmacy First now live, work with Community Pharmacy leads and practices to promote service • Approval of extension of Urgent Dental Access pilot to support Operating Plan submission to ensure delivery of our required additional dental appointments • Child Focused Dental pilot agreed

Appendix A: Performance Benchmarking (ICB)

February 2025 — Hertfordshire and West Essex ICB

Area	Activity	Latest Published Data	Data Published	Trend Against Last Month	NATIONAL Position National vs (ICB)	REGIONAL Position EoE Region vs (ICB)	ICB Ranking
111	Proportion of Calls Answered < 60 secs	80.9%	March 25	✗ -0.33%	82.07% (Worse)	84.93% (Worse)	20
	Proportion of Calls Abandoned	2.7%	March 25	✓ -5.63%	3.16% (Better)	2.37% (Worse)	18
A&E	% Seen Within 4 Hours (with additional mapped activity)	78.4%	March 25	✓ 4.634%	74.98% (Better)	74.80% (Better)	11
	% >12hr Waits in ED From Arrival	9.2%	March 25	✓ -25.68%	9.71% (Better)	9.17% (Worse)	16
Cancer	28 Days Faster Diagnosis	80.3%	February 25	✓ 10.21%	80.21% (Better)	77.65% (Better)	21
	31 Days Standard	94.6%	February 25	✓ 4.27%	91.75% (Better)	89.80% (Better)	12
	62 Days Standard	70.0%	February 25	✗ -1.54%	66.96% (Better)	61.99% (Better)	13
RTT	Incomplete Pathways <18 weeks	57.0%	February 25	✓ 0.73%	59.2% (Worse)	54.9% (Better)	15
	52+ Weeks as % of Total PTL	2.66%	February 25	✗ 3.69%	2.61% (Worse)	3.71% (Better)	28
	65+ Weeks as % of Total PTL	0.08%	February 25	✓ -30.14%	0.18% (Better)	0.27% (Better)	11
	78+ Weeks as % of Total PTL	0.00%	February 25	✓ -31.17%	0.02% (Better)	0.03% (Better)	10
Diagnostics	% Waiting 6+ Weeks	28.8%	February 25	✓ -21.58%	17.46% (Worse)	24.69% (Worse)	40
Mental Health	Dementia Diagnosis Rate	65.0%	February 25	✗ -0.15%	65.40% (Worse)	64.00% (Better)	21
	Out of Area Placements	37	February 25	✗ 5.41%	n/a	n/a	n/a
CHC *	% of Eligibility Decisions Made Within 28 Days	82.7%	February 25	✓ 15.18%	75.53% (Better, at 76.73%)	76.17% (Better, at 76.73%)	26
	% of Assessments Carried Out in Acute Settings	0.0%	February 25	– 0.00%	0.40% (Better, at 0.31%)	0.13% (Worse, at 0.31%)	27

LEGEND

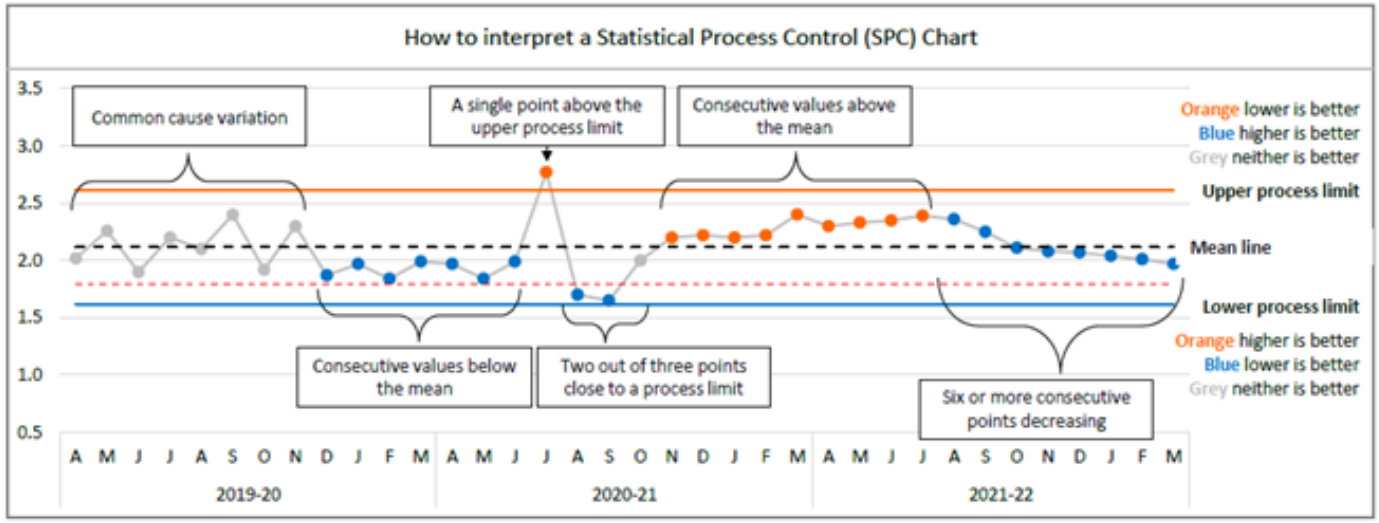
Performance against National/Regional
- Better
- Worse

Performance against previous month
- ✓ Improvement
- ✗ Deterioration
- – No change

Provider Ranking
- First quartile
- Middle quartile
- Lowest quartile

* CHC benchmarking and ranking is based on quarterly data only.
The latest data is Q3 for 2024/25 (covering Oct - Dec 2024).

Appendix B: Statistical Process Control (SPC) Interpretation



Variation	
H L	Special cause variation of concerning nature due to Higher or Lower values
H L	Special cause variation of improving nature due to Higher or Lower values
	Common cause variation No significant change

Assurance	
F	Consistent Failing of the target Upper / lower process limit is above / below target line
P	Consistent Passing of target Upper / lower process limit is above / below target line
?	Inconsistent passing and failing of the target

Hertfordshire and West Essex Integrated Care System

Appendix C: Glossary of acronyms (1 of 2)

A&E	Accident & Emergency
AAU	Ambulatory Assessment Unit
ADHD	Attention Deficit Hyperactivity Disorder
AHC	Annual Health Check
ASD	Autism Spectrum Disorder
BAME	Black Asian & Minority Ethnic
BAU	Business As Usual
CAMHS	Children & Adolescent Mental Health Service
CCATT	Children Crisis Assessment & Treatment Team
CCC	Care Coordination Centre
CDC	Community Diagnostic Centre
CDU	Clinical Decision Unit
CHAWS	Child Health and Women's Service
CHC	Continuing Healthcare
CISS	Community Intensive Support Service
CLCH	Central London Community Healthcare NHS Trust
CPCS	Community Pharmacy Consultation Service
CQI	Continuous Quality Improvement
CQC	Care Quality Commission
CT	Computerised Tomography (scan)
CYP	Children & Young People
D2A	Discharge to Assess
DEXA	Dual Energy X-ray Absorptiometry (bone density scan)
DMAS	Digital Mutual Aid System
DQ	Data Quality
DST	Decision Support Tool
DTA	Decision To Admit
DTOC	Delayed Transfer of Care
DWP	Department for Work & Pensions
EAU	Emergency Assessment Unit
ECAT	Emergency Clinical Advice and Triage

ECHO	Echocardiogram
ED	Emergency Department
EEAST	East of England Ambulance Service NHS Trust
EIP	Early Intervention in Psychosis
EMDASS	Early Memory Diagnosis and Support Service
EMIS	Supplier of GP Practice systems and software
ENHT	East & North Herts NHS Trust
EPR	Electronic Patient Record
EPUT	Essex Partnership University NHS Foundation Trust
F2F	Face-to-Face
FDS	Cancer 28 day Faster Diagnosis Standard
FHAU	Forest House Adelescent Unit
FNC	Funded Nursing Care
GIRFT	Getting It Right First Time
GP	General Practice
GPPS	GP Patient Survey
HALO	Hospital Ambulance Liaison Officer
HCA	HealthCare Assistant
HCT	Hertfordshire Community Trust
HEG	Hospital Efficiency Group
HPFT	Hertfordshire Partnership NHS Foundation Trust
HCRG	Health Care Resourcing Group
HUC	Hertfordshire Urgent Care
ICB	Integrated Care Board
ICP	Integrated Care Partnership
ICS	Integrated Care System
IPC	Infection prevention and control
IS	Independent Sector
IUC	Integrated Urgent Care
IUATC	Integrated Urgent Assessment and Treatment Centre

Hertfordshire and West Essex Integrated Care System

Glossary of acronyms (2 of 2)

LA	Local Authority
LD	Learning Disability
LDAHC	Learning Disability Annual Health Checks
LMNS	Local Maternity Neonatal System
LMS	Local Maternity System
LoS	Length of Stay
MADE	Multi Agency Discharge Event
MDT	Multi Disciplinary Teams
MH	Mental Health
MHSOP	Mental Health Service for Older People
MOU	Memorandum Of Understanding
MRI	Magnetic Resonance Imaging
MSK	Musculoskeletal
NHSE	NHS England
NICE	The National Institute for Health & Care Excellence
NMCTR	Not Meeings Criteria To Reside
NOK	Next Of Kin
NOUS	Non-Obstrtric Ultrasound
OOAP	Out of Area Placements
OPEL	Operational Pressures Escalation Levels
OT	Occupational Therapy
PAH / PAHT	The Princess Alexandra Hospital NHS Trust
PCN	Primary Care Network
PEoLC	Palliative & End of Life Care
PIFU	Patient Initiated Follow-Up
PMO	Project Management Office

PRISM	Primary Integrated Service for Mental Health
PTL	Patient Tracking List
RCA	Root Cause Analysis
REAP	Resource Escalation Action Plan
RESUS	Resuscitation
RTT	Referral to Treatment (18-week elective target)
SACH	St Albans City Hospital
SAFER	Tool to reduce patient flow delays on inpatient wards
SDEC	Same Day Emergency Care
SLT	Speech & Language Therapist
SMART	Surge Management and Resilience Toolset
SMI	Severe Mental Illness
SRG/LDB	System Resilience Group / Local Delivery Board
SSNAP	Sentinel Stroke National Audit Programme
SVCC	Single Virtual Call Centre
T&O	Trauma and Orthopaedic
TOCH	Transfer of Care Hub
TTA	Take Home Medication (To Take Away)
UEC	Urgent Emergency Care
US	Ultrasound Scan
UTC	Urgent Treatment Centre
VCSFE	Voluntary, Community, Faith and Social Enterprise
WAF	Winter Access Fund
WGH	Watford General Hospital
WHHT	West Herts Hospital Trust
WW	Week Waits

Hertfordshire and West Essex Integrated Care System

Board committee report

-

NHS
East and North Hertfordshire Teaching
NHS Trust

Meeting	Public Trust Board			**Agenda Item**	18
Report title	Audit and Risk Committee report to the Board			**Meeting Date**	9 July 2025
Chair	Mrs Karen McConnell				
Author	Deputy Trust Secretary				
Quorate	**Yes**	☒	**No**		☐

Alert (Matters of concern or key risks to escalate to the Board):

- The draft external auditor's Annual Report and Value for Money (VFM) Commentary for the year ended 31st March 2025 was reviewed by the Committee. The report identified a significant weakness in relation to the Trust's Financial Sustainability arrangements. This related to the Trust's ability to manage and close budget gaps given the significant proportion of savings in the CIP plan which were not identified or not identified in sufficient detail. Action taken by the Trust to improve processes during 24/25 and into 25/26 were also discussed.
- The Annual Report also included a recommendation on improving processes to track assets.
- We were advised that a matter would be referred to the Secretary of State under s30 of the Local Audit and Accountability Act 2014 in relation to the Trusts cumulative deficit as at 31March 2025.

The Final Annual Report from the external auditors (BDO) is attached as an appendix to this report.

Assurances provided to the Board:

- BDO anticipated issuing an unqualified opinion on the Trust's financial statements in accordance with the deadline of 30 June.
- We reviewed the audit completion report and areas where further discussion was required including control deficiencies identified in relation to key IT systems.
- The Committee approved the Internal Audit Progress Report and Annual Report.
- As part of the audit programme, internal audit undertook a review of the Trust's cost improvement programme (CIP) governance and delivery and also of Financial Sustainability. Both reports were given partial assurance opinions. The Committee also considered a report from the CFO. This report noted that many of the issues and requirements for improvements were recognised by the Trust during 24/25 and included a summary of improvement action undertaken including remedial actions and governance reforms. The aim of all the changes is to move from a fragmented and reactive exercise to a rigorously governed, centrally coordinated and data driven programme of work. The Committee noted that there is ongoing scrutiny of the recommendations by FPPC.
- The Committee discussed the Local Counter Fraud Specialist Annual Report. This included the Counter Fraud Functional Standard Return which had been submitted to the NHS Counter Fraud Authority and had an overall rating of green.

Advise (Matters the Board should be aware of not covered above e.g. on-going monitoring, new developments etc):	
• The External Auditors Annual Report has been shared with all Board members and is appended to this document. Key recommendations will be discussed by the Committee Chairs to ensure items are addressed appropriately. • The Internal Auditors reports on Financial Sustainability and CIP have been shared with the Chair of FPPC. • The remaining internal audit reports for 24/25 will be discussed at ARC on 8 July and shared with Committee Chairs as appropriate	
Decisions made by the committee or major actions commissioned and work under way:	
• The Internal Audit Progress report and Annual Report was approved. • The Local Counter Fraud Specialist (LCFS) Annual Report was discussed and noted. • The Committee approved the Annual Report and Accounts (including the Annual Governance Statement) and given the audit was not yet complete delegated final Approval of the Annual Report and Accounts to the Committee Chair subject to their being no material changes.	
Any actions recommended to improve effectiveness of the meeting:	
• N/A at this meeting.	
Recommendation	The Board is asked to **DISCUSS** the report from the Committee.

To be trusted to provide consistently outstanding care and exemplary service

Auditor's Annual Report for the year ended 31 March 2025

East and North Hertfordshire NHS Trust*

Report to Audit and Risk Committee FINAL

* East and North Hertfordshire Teaching NHS Trust from 1 April 2025

Contents

Welcome

Executive summary

We have pleasure in presenting our Auditor's Annual Report to the Audit and Risk Committee. This Auditor's Annual Report provides a summary of the key issues arising from our audit of East and North Hertfordshire NHS Trust (the 'Trust') for the year ended 31 March 2025. It is addressed to the Trust but is also intended to communicate the key findings we have identified to key external stakeholders and members of the public.

Financial statements

We issued an unqualified opinion on the Trust's financial statements on 29 June 2025. This means that we consider that the financial statements give a true and fair view of the Trust's financial position and its expenditure and income for the year ended 31 March 2025.

Value for money

We identified significant weaknesses in respect of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources. These significant weaknesses are detailed in the 'Value for money' section of this report, along with our commentary on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources.

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Key Audit Partner

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Welcome

Executive summary

Additional reporting responsibilities

We have referred a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014. This is explained further in the 'Additional reporting responsibilities' section of this report.

We are aware that, effective 1st April 2025, the Trust's name changed from East and North Hertfordshire NHS Trust to East and North Hertfordshire Teaching NHS Trust. As the Trust's name had not changed in the year under audit, we have used the original name throughout the report.

We would also like to take this opportunity to thank the Management and staff of East and North Hertfordshire NHS Trust for the co-operation and assistance provided during the audit.

CIARAN MCLAUGHLIN

Key Audit Partner

29 June 2025

Financial statements

Summary of findings

Responsibility of the Trust

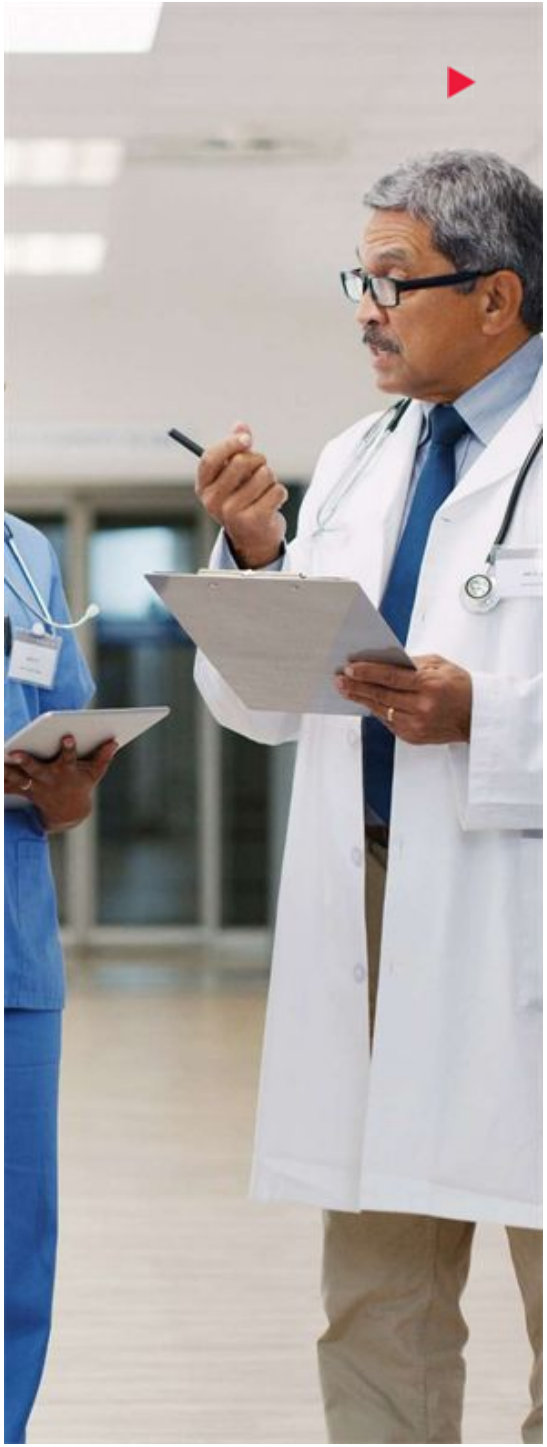
Under the National Health Service Act 2006 (as amended), NHS England has directed each NHS Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. In preparing the accounts, the Trust's Accountable Officer is required to comply with the requirements of the Government Financial Reporting Manual and, amongst other things, to confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

Responsibility of the auditor

Our responsibility is to report on whether the financial statements give a true and fair view of the Trust's financial position and of its income and expenditure for the year. Our audit of the financial statements does not relieve the Accountable Officer, nor those charged with governance, of their responsibilities for the preparation of the Annual Report and Accounts.

Outcome of the audit of the financial statements

We issued an unqualified opinion on the Trust's financial statements on 29 June 2025 in accordance with the deadline. This means that we consider that the financial statements give a true and fair view of the Trust's financial position and its expenditure and income for the year ended 31 March 2025.



Financial statements

Summary of findings

We reported our detailed findings in our Audit Completion Report, which we presented to the Audit and Risk Committee on 26 June 2025 and circulated an updated version on 29 June 2025 at the point of completing our audit. The key findings from our audit are as follows:

- Corrected misstatements - four adjusted misstatements were corrected for. These all related to classification. None of these adjustments are material and none impacted the surplus for the year.
- Uncorrected misstatements - fourteen unadjusted misstatements were identified. These are not material either individually or in combination; if the adjustments were posted they would reduce the surplus for the year of £1.686m into a surplus of £0.918m. Management did not adjust the financial statements to correct these misstatements as they are not considered material.
- Significant deficiencies in controls were identified in relation to IT General Controls. These primarily related to privileged access roles, absence of audit trails for one system in particular and the presence of a qualified audit report in respect of the Oracle application.

Whole of Government Accounts

The Trust is required to produce returns to facilitate the preparation of Consolidated NHS Provider Accounts by NHS England. We have complied with the group audit instructions prepared by the NAO on behalf of the Comptroller and Auditor General, which require us to examine and report on the consistency of these returns with the body's audited financial statements for 2024/25.

This work has not identified any significant findings.

Value for money

Summary of findings

Scope of our work

We are required to review and report on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources. Where we identify significant weaknesses in these arrangements, we are required to report these to the Trust and to make recommendations for improvement.

Specified criteria

The NAO has issued guidance to auditors which requires us to report our value for money work against three specified reporting criteria:

- **Financial sustainability** - how the Trust plans and manages its resources to ensure it can continue to deliver its services
- **Governance** - how the Trust ensures that it makes informed decisions and properly manages its risks
- **Improving economy, efficiency and effectiveness** - how the Trust uses information about its costs and performance to improve the way it manages and delivers its services.

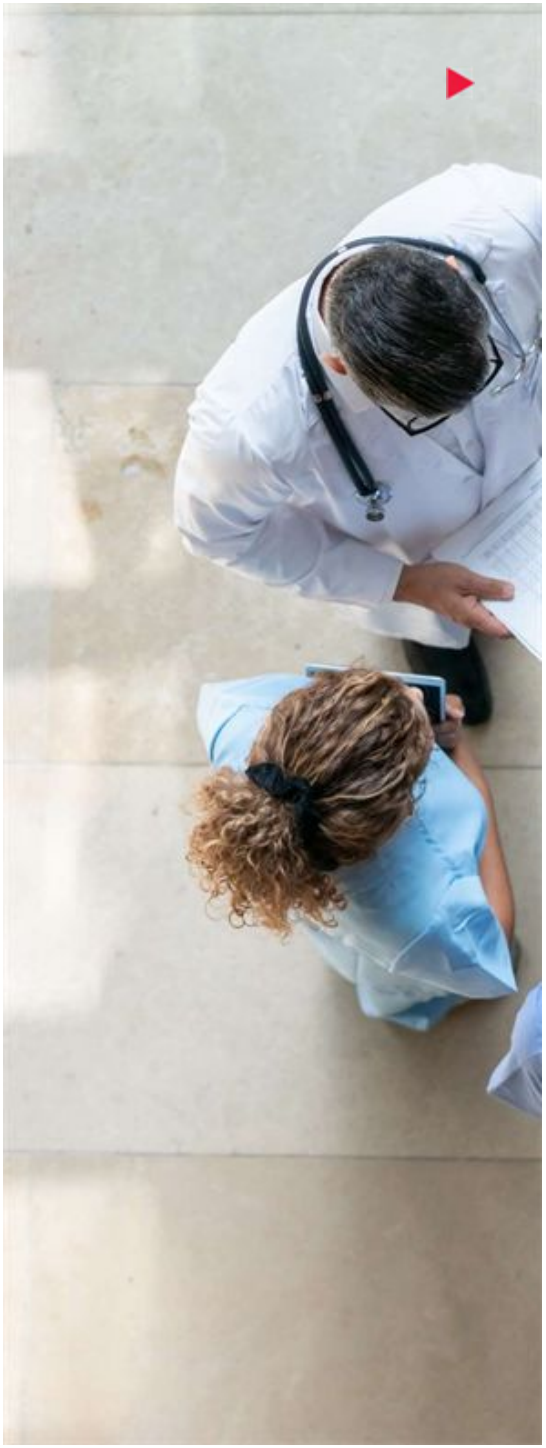
Output from our work

The key output from our work is a commentary on the Trust's arrangements to secure value for money. This commentary is set out in the following pages of this report.

We are also required to:

- report any significant weaknesses we have identified in the Trust's arrangements to secure value for money, and
- make recommendations for improvement in respect of any such significant weaknesses.

We identified a significant weakness in respect of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources. This significant weakness was in respect of financial sustainability and the Trust's ability to manage their medium-term budget gaps. Our detailed findings in respect of this significant weakness are set out on page 8 of this report.



Value for money

Summary of findings

Risk of significant weakness	Findings of our work	Reference
We have identified a risk of significant weakness with regards to the financial sustainability arrangements on how the Trust plans and manages its resources to ensure it can continue to deliver its services.	We identified a significant weakness in the Trust's arrangements to secure value for money in respect of this risk	Our commentary on the Trust's arrangements in respect of this risk is set out on page 8 of this report

Financial sustainability

Commentary on VFM arrangements

Areas reviewed

- How significant financial pressures relevant to short and medium-term plans are identified and built into plans;
- Plans to bridge funding gaps and to identify achievable savings;
- How financial plans support the sustainable delivery of services in accordance with strategic priorities;
- The consistency of financial plans with other plans such as workforce, capital, investment, and other operational planning which may include working with other local public bodies as part of a wider system; and
- Identification and management of risks to financial resilience e.g. unplanned changes in demand, including challenge of assumptions underlying its plans.

Commentary

The Healthcare Financial Management Association (HFMA) is emphasising a renewed focus on enhancing financial sustainability within the NHS. NHS bodies are being tasked with regaining financial control while managing operational activities, workforce demands, and pandemic recovery. The Trust prepares a monthly Finance Report which monitors performance against budget for the period as well as year to date.

The reports contains activity levels, year on year comparisons, paybill analysis, divisional financial performance, capital programme summary and balance sheet performance, with supporting detailed reporting. This report is presented to the Finance, Performance and People Committee (FPPC) at each meeting; the Committee discuss and challenge the contents. The discussion typically covers the risks and challenges faced to meet the budget requirements and observed unexpected performance/trends. Financial performance reports go to every Board meeting.

This budget process is guided by the ICB's and NHS England through the NHS productivity packs whose objective is to assist trusts in achieving their financial targets, enhance service delivery and support strategic planning through data-driven insights. Trusts used the ICB allocation and their own planning to set individual budgets, taking into account local priorities and service needs.

The Trust financial performance for 2024/25 was expected to have a break-even position at year end of 31 March 2025.

Financial sustainability

Commentary on VFM arrangements

Despite the HWE system planning for a £20m deficit for the year, the Trust planned a small surplus in 2024/25 (£1m). The Trust recognised that delivering the agreed position for 2024/25 would be a significant challenge created several Financial Recovery workstreams to address this and identify additional headroom.

The Trust has performed well within a challenging financial, performance and delivery environment throughout 2024/25. Further increases in elective activity performance over 2023/24 and the delivery of a challenging £33.6m savings programme allowed the Trust to deliver on its financial targets for the year. It must be noted that the Trust delivered it's Cost Improvement Programme through higher use of unplanned non-recurrent support which was 32% of the overall savings planned. Which increases the pressure on future financial years as without recurring savings costs return going forwards.

Within the ICS, the Trust is actively collaborating with colleagues in other health and care organisations through being an active partner in the east and north Hertfordshire Health and Care Partnership (HCP).

Through the work of the HCP, the Trust is involved in projects to ensure that services and care are co-ordinated and integrated for our local population, which includes the development of a Hospital at Home service to support people to be cared for safely at home.

The Trust developed a model which will support their five-year financial planning across income, expenditure, capital and workforce. It strengthens the Trust's position on financial sustainability and responsiveness and supports Board-level decision-making through improved forecasting and visualisation. Alignment with NHSE and ICB expectations on long-term planning is also a key benefit.

Financial sustainability

Commentary on VFM arrangements

For the financial year 2025/26, the Trust's CIP target has increased from £33m in 2024/25 to £35m in 2025/26 which is a 6% increase. Recognising the extent of the challenge it faced the Trust took a number of steps to strengthen its CIP progresses, enhancing the governance arrangements and ensuring central capacity to focus on working up appropriate CIP plans and monitoring delivery during the year. A new PMO team has been established to assist with this led by a new Delivery Director, reporting to the Board and responsible for CIP development and ensuring effective delivery. The Trust has also implemented reporting of CIP identification and deliver through Power BI and established board level assurance meetings to provide strategic oversight and leadership (Delivery Programme Board).

In the May 2025 report to FPPC, reflecting the month 1 position, the Trust had identified and approved savings schemes worth £16m which accounts for roughly 45% of the total savings. From this £16m approved schemes, only £550k relates to non-recurrent savings which demonstrates that the Trust are working on having more recurrent savings plans going forward.

However, the CIP reporting to FPPC in May 2025 indicated that the Trust had not yet identified detailed savings plans for £12m of the total savings target for the year.

These unidentified schemes results in a 35% gap, representing a significant portion of the savings plan and also highlights the need for strategic action to ensure financial sustainability going forward.

This could hamper the Trust's ability to achieve their forecasted financial outturn for the year. This is not uncommon among the NHS organisations we audit, reflecting the significant financial and productivity challenges facing the NHS in 2025/26, however it does reflect a significant weakness in the Trust's arrangements.

Conclusion

Our assessment has identified a significant weakness in the Trust's financial sustainability arrangements, primarily concerning its ability to effectively manage and close budget gaps. This is primarily derived from the significant proportion of the Trust's savings plans for the year not yet identified or not identified in sufficient detail to date. We recommend that the Trust ensures its efficiency programmes and cost-saving measures are robust, effective to mitigate these risks and identified early enough for implementation. Failure to address these issues could adversely affect the Trust's long-term financial health and its capacity to deliver services.

Governance

Commentary on VFM arrangements

Areas reviewed

- how the body monitors and assesses risk and how the body gains assurance over the effective operation of internal controls, including arrangements to prevent and detect fraud;
- how the body approaches and carries out its annual budget setting process;
- how the body ensures it makes properly informed decisions, supported by appropriate evidence and allowing for challenge and transparency. This includes arrangements for effective challenge from those charged with governance/audit committee; and
- how the body monitors and ensures appropriate standards, such as meeting legislative/regulatory requirements and standards in terms of officer or member behaviour (such as gifts and hospitality or declarations/conflicts of interests), and for example where it procures or commissions services.

Commentary

The Trust's Internal Audit function is outsourced to a third party and was changed in year from TIAA Ltd to RSM. This function is headed by the Head of Internal Audit whose approach is to develop the internal audit processes by analysing the corporate objectives, risk profile as well as assurance framework.

The draft Head of IA opinion for the 2024/25 financial year confirms that 'The organisation has an adequate and effective framework for risk management, governance and internal control. However, they noted that their work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective.

For 2024/25, Internal Audit carried out eight reviews. Four audit reviews produced a reasonable assurance rating; four produced a partial assurance rating and none produced a limited assurance rating.

We note that Internal Audit raised a finding regarding the Key Financial Controls in particular the fixed asset verification. The last full verification was performed in 2019. Throughout the external audit work performed, various challenges were faced with confirming the existence of these assets, although no material findings were noted. We therefore recommend that management implement processes which will enhance the tracking of assets and a more accurate fixed asset register.

Governance

Commentary on VFM arrangements

We note through our review of various Audit and Risk committee minutes that the Internal audit function engage frequently with the Trust management on the status of management actions through progress reports. These reports include overdue actions, management actions closed and not yet due.

Risk management is supported by the Risk Management Strategy. Arrangements include monthly meetings to identify and discuss risks and related controls for inclusion on local/divisional risk registers; Corporate Directorate meetings/Divisional Boards for monitoring risk management and approving escalation/de escalation of risks to a corporate risk register; identification of Risk Leads and Approving Managers to manage and approve risks operationally; identification of divisional Governance/Audit Leads and Quality Managers with responsibilities for facilitating risk management a divisional level. Risks are escalated to a Corporate Risk Register and BAF based on assessed risk scores and relevance to the Trust's strategic priorities.

The BAF is considered at other Board Committees including Finance, Performance and People Committee.

The Trust has an anti-fraud and bribery policy in place approved by Board. It has an accredited Local Counter Fraud Specialist (LCFS), provided by RSM in addition to internal audit services, with a programme of proactive counter fraud and corruption work which is risk based. The LCFS reports to the Audit and Risk Committee.

We have not noted any specific review performed in year by Care Quality Commission(CQC). We have however reviewed the Trust's CQC Well Led and Core Service Action Plan which came from the unannounced CQC and well-led inspection in 2023 and we confirmed that the Trust actively was tracking their progress against the recommendations made by CQC.

We noted that all outstanding recommendations were listed as completed.

Budgetary control is principally monitored through monthly Finance reporting and Integrated Performance reports (inclusive of performance data for financial plans in addition to nonfinancial performance).

Governance

Commentary on VFM arrangements

A role of the Board is to ensure the Trust has appropriate arrangements for ensuring it exercises its functions effectively, efficiently and economically and complies with generally accepted principles of good governance as are relevant to it. We know from our review of Board and committee papers, minutes for these meetings and attendance at Audit and Risk Committee meetings, that the Board and its committees meet regularly and that key issues are addressed with effective challenge from members. We have also observed evidence of good arrangements in place regarding tracking and responding to the recommendations made by Internal Audit and that management has been held to account throughout the year regarding progress on recommended actions.

Responsibility for ensuring appropriate standards such as meeting legislative/regulatory requirements in terms of member behaviour sits primarily with the Audit and Risk Committee. Review of the effectiveness and compliance with key policies such as gifts and hospitality, declarations/conflicts of interest are confirmed to be covered by the Counter Fraud programme.

In our previous Auditor's Annual Report (2023/24), we highlighted several recommendations concerning Single Tender Waivers, contracts not signed promptly, Cyber Security assessment and Budget Setting and Financial Reporting (Monitoring of training). We have actively followed up with management on these points and found that all recommendations were fully implemented in the 2024/25 financial year. These are reported on page 18.

Front Entrance Project

The Trust is seeking to enter into a contract in relation to the redevelopment of the Front Entrance at Lister Hospital. Under this arrangement, a private sector developer would help to build, develop and manage a revamped building with space for retail tenants, paid for by the retail tenants over a forty-year period, with the Trust providing a guarantee in respect of rentals due to the developer.

Governance

Commentary on VFM arrangements

Where any new or unusual capital development or project is considered, there is a risk of bodies not adequately considering all potential sources of risk, particularly where there may be a strong institutional will to pursue a particular action.

We are satisfied that the proposal has been reported to the Board and FPPC regularly during the year and that management have waited until similar schemes have been signed off by other NHS Trusts before deciding whether to proceed or not.

Ensuring the Trust has carried out appropriate sensitivity analysis on the financial implications of the proposal, before committing is an important part of demonstrating value for money as is the need to obtain independent financial accounting advice, separate from the developer. We will conclude our consideration of proposed accounting treatment for the development, in early July once this year's audit is concluded.

Conclusion

The Trust had sufficient arrangements in place to make informed decisions and properly manage its risks.

Improving economy, efficiency and effectiveness

Commentary on VFM arrangements

Areas reviewed

- how financial and performance information has been used to assess performance to identify areas for improvement;
- how the body evaluates the services it provides to assess performance and identify areas for improvement;
- how the body ensures it delivers its role within significant partnerships and engages with stakeholders it has identified, in order to assess whether it is meeting its objectives; and
- where the body commissions or procures services, how it assesses whether it is realising the expected benefits.

Commentary

The Board is provided with both financial and non-financial performance information on a regular basis, principally through the Integrated Performance Report and highlight reporting from the FPPC. The Board and committee members can challenge management regarding departures from plans or expectations.

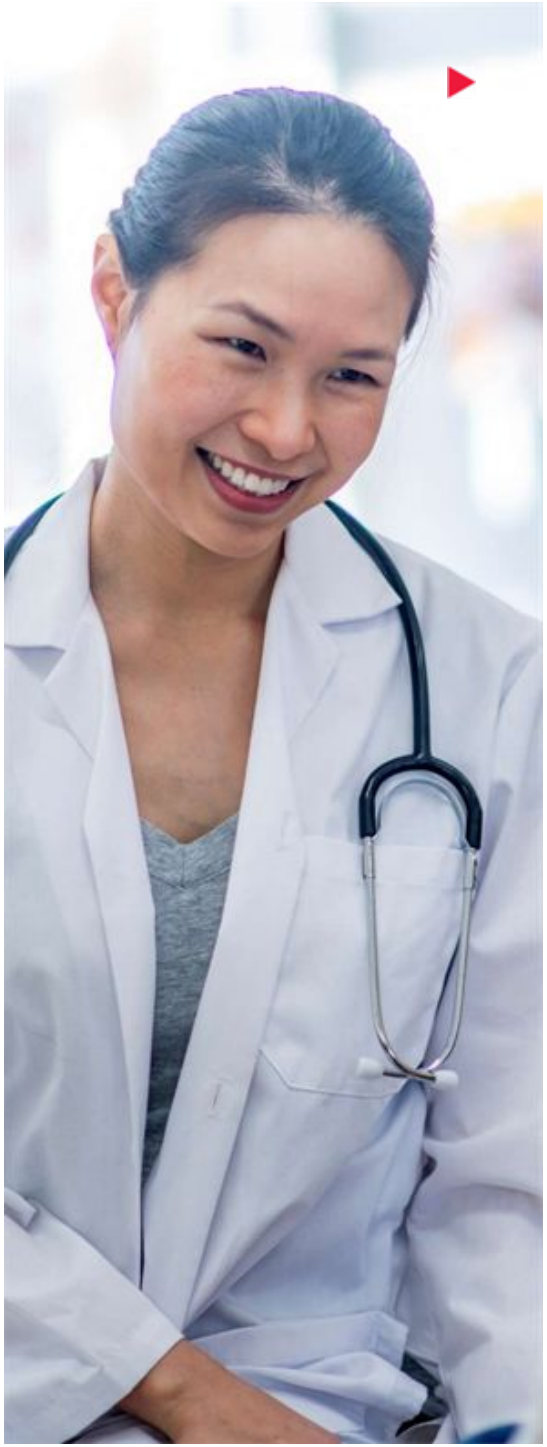
Within these reports, commentary is provided on the reasons for variances and executive responses, for the Board and relevant committees to identify and drive forward areas for improvement.

The Trust carries out an annual review of the effectiveness of its Board and committees. The review identified FPPC as an effective and high-performing committee overall.

The yearly internal audit programmes are designed to review all areas of the Trust and the 2024/25 plan supports this.

The Trust is required to report on the quality of its services against performance indicator targets throughout the year, resulting in an annual quality account report.

Quality indicators against which performance is measured for reporting are wide ranging and between them require numerous systems of processes and controls and IT applications to record and report accurate data. Performance against a wide range of indicators was monitored through the Board's Quality and Safety Committee (QSC) and reported to the Board through regular Integrated Performance Reports.



Improving economy, efficiency and effectiveness

Commentary on VFM arrangements

Integrated Performance reporting provided graphical dashboards for clear illustration of performance trends and also provided commentary on key issues identified and executive responses to aid Board scrutiny. Monitoring the Integrated Performance report at public Board level demonstrated clear accountability for improvement and arrangements in place to secure these improvements.

The Trust set four broad priorities for improvement linked to its "vision and values to 2030" and it has a programme of measures for progress across themes within its priorities for improvement. The four Strategic Themes are used to underpin other key frameworks in use at the Trust, for example, the Board Assurance Framework.

The annual clinical audit programme is reviewed and approved through the Clinical Effectiveness Committee and progress is monitored through the Divisions and QSC. The Audit and Risk Committee receives the annual self-assessment against the assurance framework.

The Trust is part of the Hertfordshire and West Essex Integrated Care System (ICS). The ICS took on statutory responsibilities for the strategic commissioning of healthcare in the area from July 2022.

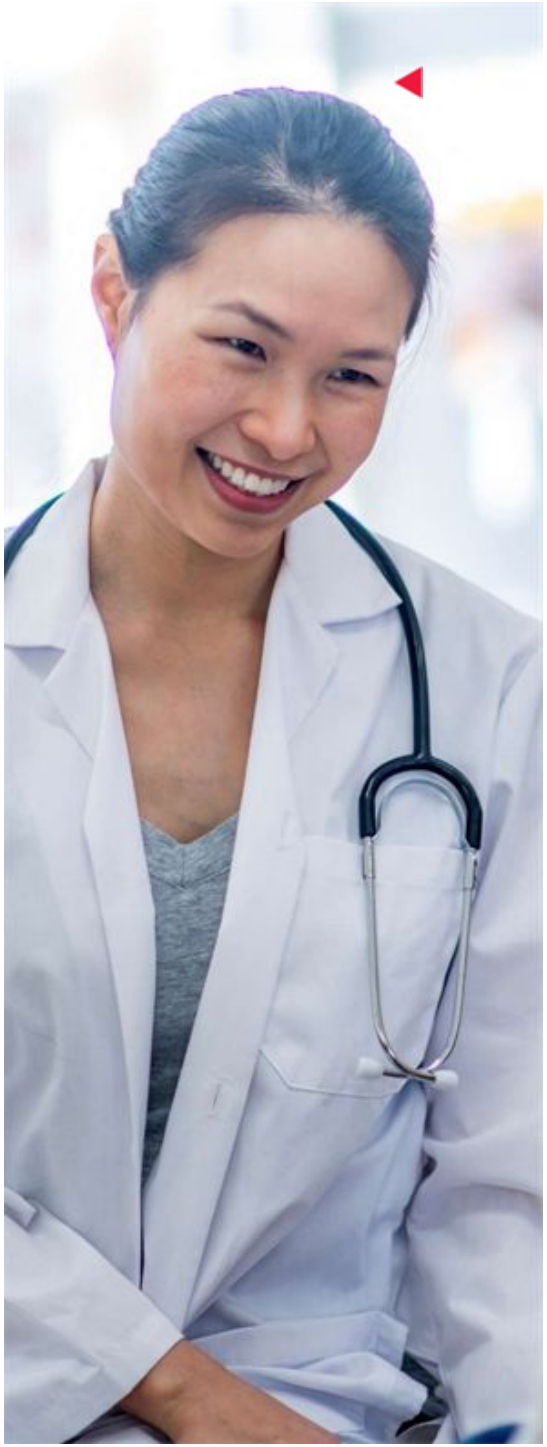
Through the Hertfordshire Health and Care Partnership the Trust has almost completed the build of a 'vascular hub' at Lister Hospital.

The Trust has also continued to work with system partners through the East & North Hertfordshire Integrated Care Partnership (ICP). The ICS Monthly performance report produced by Hertfordshire and West Essex integrated care system and sets out performance against a range of access dimensions across the system and its constituent organisations.

The ICS Procurement Service provides procurement services to the 5 Provider Trusts of the Hertfordshire and West Essex ICS. The FPPC receives periodic updates on Procurement Delivery.

Conclusion

We have not identified any significant weaknesses in arrangements to ensure the Trust improves economy, efficiency and effectiveness. The Trust makes use of performance and financial information in order to review and improve its processes and services. The Trust continues to work collaboratively with key partners across the ICP and ICS.



Recommendations

Value for money arrangements

	VFM criteria	Matter identified	Significant weakness identified?	Recommendation	Type	Management Response
1	Financial sustainability	The Trust set itself a target of making £35 million of cost savings in 2025/26. By May 2025 the Trust had not identified detailed plans for how it will make £12 million (34%) of these savings. This matter is evidence of a significant weakness in the Trust's arrangements for financial sustainability, in that the Trust did not have adequate arrangements in place to bridge its funding gaps and identify achievable savings	Yes	We recommended that the Trust ensure its efficiency programmes and cost-saving measures are robust, effective to mitigate these risks and identified early enough for implementation.	Significant	The Trust has had a clear and decisive response to address the challenges of delivering the CIP target for 2025/26 These include: 1. Commissioning IA to undertake a review of CIP governance/delivery for 24/25 and implementing actions on the findings/recommendations 2.Implemented a robust CIP project governance and delivery framework emphasising strong governance, clear accountability, structured project management and rigorous financial oversight 3. Learned from and put in processes that address limitations in previous CIP delivery periods. 4. Invested in a PMO team with a remit to ensure effect governance, coordination and tracking of CIP schemes 5. Employed a senior delivery director for drive and oversight 6. Implemented robust reporting of CIP identification and deliver through Power BI 7. Implemented monthly board level assurance meetings to provide strategic oversight and leadership (Delivery Programme Board)

Recommendations

Value for money arrangements

	VFM criteria	Matter identified	Significant weakness identified?	Recommendation	Type	Management Response
2	Governance	Physical assets verification – some assets could not be easily traced back to the fixed assets register	No	We recommend that management implement processes which will enhance the tracking of assets and a more accurate fixed asset register.	Other	Management acknowledges that during the physical verification process, some assets could not be easily traced back to the fixed asset register. We recognise that this issue highlights weaknesses in the current asset tracking and reconciliation processes. To address this, the Trust will: 1. Reconcile Records: Undertake a full reconciliation between the fixed asset register and physical assets to ensure all items are properly recorded and identifiable. This already started towards the end of Q4 25/25 2. Improve Asset Tagging: Introduce or enhance the use of asset tags with unique identifiers to improve traceability between physical assets and the register. This will allow linkage between the EBME database and the Finance CARS system. (continued overleaf)

Recommendations

Value for money arrangements

	VFM criteria	Matter identified	Significant weakness identified?	Recommendation	Type	Management Response
2	Governance	Physical assets verification – some assets could not be easily traced back to the fixed assets register	No	We recommend that management implement processes which will enhance the tracking of assets and a more accurate fixed asset register.	Other	3. Strengthen Processes: Review and update asset management procedures to ensure all new assets are recorded accurately at the point of acquisition, with supporting location and identification data, together with the EBME department. 4. Conduct Periodic Verifications: Implement regular internal asset verification checks to maintain accuracy and address any discrepancies proactively. We plan to verify the whole asset register by 31.03.26. 5. Training and Oversight: Provide training to responsible teams on the importance of accurate asset recording and verification, and ensure clear accountability for maintaining asset records via monthly capital calls with Divisions. These actions will improve the reliability of the fixed asset register and support effective management and audit of the Trust's physical assets.

Prior year recommendations

Value for money arrangements

	VFM criteria	Matter identified	Significant weakness identified?	Recommendation made in prior year	Type of recommendation	Our view as to whether recommendation has been implemented satisfactorily
1	Governance	Procurement Policy	No	For the Procurement policy to be updated to include a framework/methodology for selection of service providers as that is currently not in the policy, this will ensure that there is consistency in the process to follow to select service providers in certain circumstances.	Other	Satisfactory
2	Governance	Cyber Security assessment	No	We recommend that management monitor and set aside clear instructions on roles and responsibilities with regards to implementation of the National Cyber Security assessment framework to avoid future non-compliance and implement effective internal controls.	Other	Satisfactory

Prior year recommendations

Value for money arrangements

	VFM criteria	Matter identified	Significant weakness identified?	Recommendation made in prior year	Type of recommendation	Our view as to whether recommendation has been implemented satisfactorily
3	Governance	Budget Setting and Financial Reporting	No	We recommend that the Trust closely monitor budget managers compliance with their training to address all budget statements and management accounts in a timely manner.	Other	Satisfactory
4	Governance	Contracts not signed in a timely manner	No	The Trust should ensure that contracts are signed in a timely manner going forward to improve monitoring and financial management and improve the Trust's ability in making informed and timely decisions in their financial reporting. We note however that this is not solely dependent on the Trust.	Other	We note that counter signing of contracts is dependent on other parties meeting the same deadlines and therefore not fully in the control of the Trust. This will be continuously monitored.

Additional reporting responsibilities

Summary of action taken

	Additional reporting responsibility	Action taken
1	We are required to report if we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which would, if followed to its conclusion, be unlawful and likely to cause a loss or deficiency.	On 27 June 2025 we referred a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 in relation to Trust's cumulative deficit as at 31 March 2025.
2	We are required to report on whether those disclosures subject to audit within the Remuneration and Staff Report have been properly prepared in accordance with the requirements of the Department of Health and Social Care's Group Accounting Manual 2024/25.	We are satisfied that the auditable parts of the Remuneration and Staff report had been properly prepared.
3	We are required to report by exception if the Trust's Governance Statement is materially inconsistent with the financial statements, or our knowledge obtained in the course of the audit or otherwise appears to be materially misstated	In our opinion, the Trust's Governance Statement is not materially inconsistent with the financial statements, or our knowledge obtained in the course of the audit or otherwise appears to be materially misstated

Additional reporting responsibilities

Summary of action taken

	Matter	Comments
4	We are required to report on whether the financial and non-financial information in the Annual Report not subject to audit is consistent with the financial statements and the knowledge acquired by us in the course of our audit.	We are satisfied that the other information in the Annual Report not subject to audit is consistent with the financial statements and our knowledge.
5	We are required to report by exception if we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014	We did not issue a report in the public interest
6	We are required to report by exception if we make a written recommendation to the Trust under section 24 of the Local Audit and Accountability Act 2014	We did not make a written recommendation to the Trust
7	We are required to certify the completion of the audit. The effect of the certificate is to close the audit. This marks the point when the auditor's responsibilities in respect of the audit of the period covered by the certificate have been discharged. There may be occasions when the auditor is able to issue the audit report on the financial statements but cannot certify completion of the audit.	We cannot formally conclude the audit and issue an audit certificate until we have received confirmation from the National Audit Office that the Department of Health and Social Care group audit has been certified by the Comptroller & Auditor General and therefore no further work is required to be undertaken in order to discharge the auditor's duties in relation to consolidation returns under the Code.

FOR MORE INFORMATION:

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Board Annual Cycle 2025-26

Notes regarding the annual cycle:

The Board Annual Cycle will continue to be reviewed in-year in line with best practice and any changes to national scheduling.

Items	April 2025	May 2025	June 2025	July 2025	Aug 2025	Sept 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026
Standing Items												
Chief Executive's Report		X		X		X		X		X		X
Integrated Performance Report		X		X		X		X		X		X
Board Assurance Framework				X		X		X		X		X
Corporate Risk Register				X				X				X
Patient/Staff Story (Part 1 where possible)		X		X		X		X		X		X
Employee relations (Part 2)		X		X		X		X		X		X
Board Committee Summary Reports												
Audit Committee Report		X		X		X		X		X		X
Charity Trustee Committee Report				X		X		X		X		X
Finance, Performance and Planning Committee Report		X		X		X		X		X		X
Quality and Safety Committee Report		X		X		X		X		X		X
People Committee		X		X		X		X		X		X
Strategic reports												
Planning guidance										X		
One EPR Digital update												X
Smoke free sites												
Trust Strategy refresh and annual objectives												X

Board Annual Cycle 2025-26

Items	April 2025	May 2025	June 2025	July 2025	Aug 2025	Sept 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026
Strategy delivery report		X								X		
Strategic transformation & digital update		X						X				
Integrated Business Plan								X				
Annual budget/financial plan												
System Working & Provider Collaboration (ICS and HCP) Updates		X		X		X		X		X		X
Mount Vernon Cancer Centre Transfer Update (Part 2)		X		X		X		X		X		X
Estates and Green Plan												
Workforce Race Equality Standard										X		
Workforce Disability Equality Standard										X		
People Strategy										X		
Enabling Strategies												
Estates and Facilities Strategy								X				
Green Strategy				X								
Quality& Clinical Strategy						X						X
Equality, Diversity and Inclusion Strategy												X
Digital Strategy		X										
Engagement Strategy						X						
Other Items												
Audit Committee												
Audit Committee TOR and Annual Report (if required)												

Board Annual Cycle 2025-26

Items	April 2025	May 2025	June 2025	July 2025	Aug 2025	Sept 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026
Review of Trust Standing Orders and Standing Financial Instructions (if required)												
Charity Trustee Committee												
Charity Annual Accounts and Report								X				
Charity Trust TOR and Annual Committee Review										X		
Finance, Performance and Planning Committee												
FPPC TOR and Annual Report										X		
Quality and Safety Committee												
Complaints, PALS and Patient Experience Annual Report						X						
Safeguarding and L.D. Annual Report (Adult and Children)								X				
Staff Survey Results		X										
Learning from Deaths		X		X				X		X		
Nursing Establishment Review								X				
Patient Safety and Incident Report (Part 2)		X						X				
Teaching Status Report		X										
QSC TOR and Annual Review (if required)												
People Committee & Culture												
Workforce Plan												
Trust Values refresh		X										

Board Annual Cycle 2025-26

Items	April 2025	May 2025	June 2025	July 2025	Aug 2025	Sept 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026
Freedom to Speak Up Annual Report				X								
Equality and Diversity Annual Report and WRES						X						
Gender Pay Gap Report		X										
Healthwatch Hertfordshire annual report/presentation on key findings and recommendations						X						
Shareholder / Formal Contracts												
ENH Pharma (Part 2) shareholder report to Board				X								