Public Trust Board

Online

19/11/2025 09:30 - 12:00

Agenda Topic	Presenter	Time	Page
Assurance rating guide			4
STANDING ITEMS			
1. Declarations of interest For noting	Trust Chair	09:30-09:35	
2. Apologies for Absence For noting	Trust Chair		
3. Staff Story For discussion	Chief People Officer	09:35-09:55	
4. Minutes of Previous Meeting held 10 September 2025 For approval	Trust Chair	09:55-10:00	5
5. Action Log For noting	Head of Corporate Governance		17
6. Questions from the Public For noting	Head of Corporate Governance	10:00-10:05	
7. Chair's Report For noting	Trust Chair	10:05-10:10	
7.1 Charity annual accounts and report For delegation to the Audit & Risk Committee	Chair		
8. Chief Executive's Report For discussion	Chief Executive	10:10-10:20	19
PERFORMANCE, ASSURANCE AND GOVERNANCE ITEMS			
9. Nursing and Midwifery Safer Staffing Establishment Review For discussion	Chief Nurse	10:20-10:30	22

10.	Summary learning from deaths report	Medical Director	10:30-10:40	35
For assurance				
11.	Board Assurance Framework (BAF) - Strategic risks	Head of Corporate Governance	10:40-10:50	72
For assurance				
BREAK		Trust Chair	10:50-11:00	
STRATEGY AND CULTURAL ITEMS				
12.	Resident Doctors Working Lives action plan	Chief People Officer	11:00-11:10	107
For assurance				
13.	Integrated Performance Report		11:10-11:35	114
For discussion				
14.	Quality and Safety Committee (QSC) reports to board - 24/9/25 & 29/10/25	Chair of QSC		
For noting				
15.	Finance, Performance and Planning Committee (FPPC) reports to board - 29/9/25 & 27/10/25	Chair of FPPC		166
For noting				
16.	People and Culture Committee report to board - 16/9/25 & 4/11/25	Chair of PCC		
For noting				
17.	System Performance Report	Deputy Chief Executive and Chief Finance Officer	11:35-11:40	167
For noting				
COMMITTEE REPORTS			11:40-11:50	
18.	Health Care Partnership (HCP) report to the board - 17/10/25	Chief Executive		213
For noting				
19.	Audit and Risk Committee (ARC) report to board - 7/10/25	Chair of ARC		215
For noting				
20.	Charity Trust Committee report to the board - 8/9/2025	Chair of CTC		
For noting				
OTHER ITEMS			11:50-11:55	
21.	Annual Cycle	Trust Chair		217
For noting				

22. Any Other Business — Trust Chair

For noting

23. Date of Next Meeting — Trust Chair

Wednesday, 14 January 2026 - Mount Vernon Hospital (Northwood, England, United Kingdom)

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 Lister Hospital on Wednesday, 10 September 2025 at 9.30am

Present:

Mrs Karen McConnell (KMc)	Deputy Trust Chair and Non-Executive Director - in the Chair
Dr David Buckle (DB)	Non-Executive Director (NED)
Mr Richard Oosterom (RO)	Associate Non-Executive Director
Ms Nina Janda (NJ)	Associate Non-Executive Director
Ms Janet Scotcher (JS)	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
Ms Penny St Martin (PSM)	Chief People Officer
Mr Mark Stanton (MS)	Chief Information Officer
Ms Eilidh Murray (EM)	Director of Communications and Engagement

From the Trust:

Mrs Debbie Okutubo (DO)	Deputy Company Secretary (Board Secretary - minutes)
Mr Stuart Dalton (SD)	Head of Corporate Governance
Dr Catherine Bond (CB)	Consultant Physician Interface Geriatrics
Ms Samantha King (SK)	Frailty CNS Lead

In attendance

Ms Ivana Chalmers (IV)	Chief Executive – Healthwatch Hertfordshire
Mr Neil Tester (NT)	Chair – Healthwatch Hertfordshire

No	Item	Action

The Chair, KMc welcomed everyone to the meeting, she commented that this was a live streamed meeting of the Trust Board to ensure transparency to patients, staff and the wider community. She informed the Board that the Chair, Anita Day was unavoidably absent, hence her reason for being the Chair. It was confirmed that the agenda had been published on the website and seen by all Board members.

25/098 DECLARATIONS OF INTEREST

There were no new interests declared.

25/099 APOLOGIES FOR ABSENCE

Apologies for absence were received from Ms Anita Day, Trust Chair; Professor Zoe Aslanpour, Non-Executive Director; Mr Tichafara Phiri, NeXT Non-Executive Director; and Ms Diana Skeete, Non-Executive Director.

East and North Hertfordshire Teaching NHS Trust

25/100 PATIENT STORY

The Chief Nurse, TM introduced CB and SK and commented that they were presenting the patient story. TM remarked on the impact of frailty, and that this patient story was not just about an individual patient's journey but also showed the complexity of the work undertaken by clinical staff involved with frail patients.

SK addressed the meeting, outlining the frailty service and commenting that frailty in older people showed as a diminished physiological response compared to healthy young individuals.

She commented that the team used the Rockwood frailty score which assessed the patient's functional baseline from two weeks prior to attending the clinic and not just when they present in hospital. It was noted that this enabled the clinical team to classify the level of frailty in patients.

SK introduced Mrs A's story, who was described as an 86-year-old woman found on the floor in her home by carers. Following assessment by the ambulance crew she was brought into hospital, and she had a diagnosis of frailty. Mrs A was identified as suitable for a comprehensive geriatric assessment. No significant risk factors were identified but blood tests revealed asymptomatic anaemia. The decision was made with her next of kin to refer her to the hospital at home service for further monitoring.

A plan was established for Mrs A to attend the frailty hot clinic for a blood transfusion. Following the treatment a discussion was held with Mrs A's next of kin who later referenced the positive impact of the conversation and the continuity of care. Mrs A's next of kin commented that although Mrs A could not recall individual staff due to her dementia, she remembered the kindness and engagement demonstrated by the team. This included staff handing her a small stuffed animal which was important to Mrs A as it helped keep her calm and engaged.

CB outlined what might have happened if Mrs A had not been intercepted on arrival in hospital and explained that in that scenario Mrs A would have been reviewed by the emergency department (ED) team; then referred to the medical team for further management of her low haemoglobin, which would have resulted in several ward moves and an extended stay which could have led to a decline in her general health.

During the discussion the Board was advised that for patients requiring a brief hospital stay they were admitted to Ashwell ward which was for short stays. The intention for the ward is to always discharge patients within 48 hours of being admitted. The Board noted that the recruitment of a Clinical Nurse Specialist (CNS) was underway, and that the role would be based in the ambulance bay to focus on the early identification of suitable patients for the frailty pathway.

Following the presentation, the Chair, KMc thanked CB and SK for presenting and asked what needed to be done to get the best results for patients as we headed into the winter period. In response, CB stated that one initiative they were currently working on was to meet patients at the door to intercept them as this provided a safety net. Secondly, as a team they ideally needed ring fenced space in ED as they currently use the hot clinic.

DB observed that the prevalence of frailty was huge, and we could not do this alone. He asked if there was a plan to work with primary care. In response CB noted that we currently work with the Hertfordshire Community Trust (HCT) and we engage with the local neighbourhood teams which enable us to link more patients with the appropriate care. It was also suggested that we need to link in with Palliative care.

KH asked about the flow on Ashwell ward and what was within our gift to speed things up. SK responded that we need to start thinking of what needed to be done to aid the discharge of patients at the beginning of their journey. This would mean when the patient arrives in hospital, they are assessed for what needs to be done to ensure a quick discharge and if it was felt that they were going to be there for longer than 24 hours, they should be moved to another ward which was not a short stay one.

The Chief Executive thanked both CB and SK for bringing the patient story to life and asked if there was scope to increase the number of patient 'turnaround'. CB responded that the current percentage seemed to be the optimal number, as a number of patients who attended had comorbidities. The Chief Executive further asked if hospices could be of more assistance.

RO commented that what had been described above was the ideal path and asked if we knew the number of patients who did not follow this path and if more could be done so that less people were admitted. SK responded that a lot of patients had hospital at home and community care services, but the services did not cover out of hours, as it was not a 24-hour service. Regarding if there was a way of measuring the number of people not following the path, CB commented that with the implementation of the new IT system this would be made possible.

KOH remarked that it was a good thing they were looking into neighbourhood teams and asked what insights they had. CB responded that there was a need to build relationships and work alongside multidisciplinary teams. SK also responded that there was the need to have day-to-day contact with the multidisciplinary teams (MDT) involved in the care which should bring down some of the barriers.

TM commented that for dementia patients, there was the need to find a place to have the conversation with family members.

LD thanked the team and asked how to change the way we understand 'getting better'. CB responded that sometimes people relate more if you talk about maintaining their resilience, as some patients did not like being referred to as 'frail'.

JS asked what the requirements of the team were in terms of the workforce strategy. CB suggested that they did not have that much input into the strategy.

The Chair thanked both CB and SK for the presentation and commented that Mrs A's case highlighted the essential and effective work of the frailty path team and that we needed to investigate how we work with the various teams involved to avoid unnecessary admissions and prolonged hospital stays.

The Board **NOTED** the patient story.

East and North Hertfordshire Teaching NHS Trust

25/101 MINUTES OF THE PREVIOUS MEETING

The minutes of the previous meeting held on 9 July 2025 was **APPROVED** as an accurate record of the meeting.

25/102 ACTION LOG

The Head of Corporate Governance reported that most actions were complete or in progress.

Regarding the renal action this would be presented at the Trust Management Group (TMG) meeting on Thursday, 11 September and would be published on the website thereafter.

Action: Renal action plan to be published on the website.

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

25/103 QUESTIONS FROM THE PUBLIC

There were no public questions.

25/104 CHAIR'S REPORT

The Chair, KMc welcomed NT, Chair Healthwatch Hertfordshire and IC, Chief Executive Healthwatch Hertfordshire to the meeting and commented that they were on the agenda to present their annual report.

She introduced and welcomed the three General Management Trainees observing the Board as part of their induction:

- Emma Mason – Women & Children
- Evangeline Anderson - Corporate
- Myles Hung – Operations.

The Chair reminded the Board that the Baxter Patients Specific service level agreement (SLA) was approved as a Chair's action. The Board was advised that it was reviewed at the Finance, Performance and Planning Committee (FPPC) meeting in May. Following a brief discussion, the Board **RATIFIED** the decision.

The Chair further remarked that the Cath lab refurbishment was also approved as a Chair's action. It was noted that it was reviewed at the July FPPC meeting and recommended to the Board for approval but due to the timing, it had to be signed off as a chair's action. Following a brief discussion, it was **RATIFIED** by the Board.

The Board was advised that Leadership live would take place on 14 October in the afternoon and that all NEDs were invited to it.

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

25/105 CHIEF EXECUTIVE'S REPORT

The Chief Executive summarised key updates:

The Board was reminded that the government's 10-Year Health Plan aimed to transform the NHS into a preventative, community-focused, and digital service.

The Chief Executive commented that the plan was aspirational, but it was being worked through by National teams and the Department of health and social care (DHSC).

It was also noted that there were new ICB formations and the cluster we were under was known as East Central and that it would come into play on 1 April 2026.

The Board was advised that the Trust was shortlisted for the HSJ Trust of the Year Award. It was stated that this was a testament of all the work staff were putting in.

It was also noted that teams and individuals were shortlisted for various national awards across patient safety, experience, and sustainability categories. A congratulatory message was sent to all nominees.

The Chief Executive continued that as a Trust, there was a board-to-board meeting with Hertfordshire Community Trust (HCT) to explore community focused care opportunities. The next meeting would take place in February 2026.

The Board were informed that the Chief Kaizen Officer, KOH would lead on a 3P event on frailty in November 2025.

The Board were updated on the front entrance to the hospital which would be owned by the private partner carrying out the works as a commercially viable model.

The Chief Executive commented that despite being on financial plan, as a Trust we still required further cost-saving schemes. It was noted that there was a week-long event on variable pay which allowed us look at opportunities to reduce costs.

It was asserted that midwifery and nursing students were graduating but not getting jobs. However, the Board was assured that the Trust was carrying out an initiative for them to secure employment if not with us then elsewhere.

It was remarked that we were going into winter and Covid as well as other upper respiratory diseases was on the increase.

25/105a

Provider capability return to NHSE

There is a request from NHS England for us to do a self-assessment which needs to be backed up by evidence and submitted by 22 October 2025.

It was noted that the new segment of providers was published on 9 September. On the new league table we are in segment two out of five. Also, we came 19 out of 134 Trusts nationally. Appreciation was sent to the organisation and staff for all the hard work.

The Board was asked to approve delegating the sign-off of the self-assessment return to NHS England on provider capability on behalf of the Board to the Chief Executive, following review and endorsement by the:

- Trust Board Chair
- Chair of Finance, Performance and Planning Committee
- Chair of Audit & Risk Committee
- Chair of Quality and Safety and
- Chair of People and Culture.

This was **APPROVED** by the Board.

The Chair, KMc echoed her appreciation to everyone in the Trust for the hard work making us Number 19 in the league table.

SD reminded the Board that the annual general meeting (AGM) will take place on Monday, 15 September 2025 at 5:30 PM.

RO commented that the Chief Executive report was a good summary however the management capacity was worrying and asked how this was going to be addressed in the coming months.

JS noted that succession planning was discussed at the Remuneration committee meeting.

25/105b

New main entrance funding

The Director of Estates and Facilities presented this item and reiterated that following on from the Chief Executive report, we were in partnership with the developer who would build a new main entrance.

JD suggested that we could use the site for health promotion including having an outside public gym area as this would provide and/or promote public health.

KH responded that he would investigate this request but that there might be concerns about safety and other logistical barriers.

DB commented that the hospital charity needed to be taken into consideration as there could be projects that the charity might be willing to support and the potential of the charity increasing main door visibility.

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

25/106 HEALTHWATCH HERTFORDSHIRE ANNUAL REPORT

Neil Tester (NT), Chair and Ivana Chalmers (IC), Chief Executive, Healthwatch Hertfordshire presented this item. It was remarked that Healthwatch Hertfordshire provided public information, engaged communities, held services accountable, and championed co-production.

The Board was reminded that the NHS 10-year plan transferred functions to ICBs and local authorities, increasing patient feedback and participation. It was noted that the Dash review recommended combining Healthwatch and ICB engagement for patient input. NT commented that the absence of its inclusion in the forthcoming King's Speech could delay any legislative changes until possibly 2027.

IC provided an overview of Healthwatch's recent work and summarised themes from public feedback over the past 6 to 12 months. The Board was advised that Healthwatch Hertfordshire's signposting service received around 500 enquiries annually which included complex cases.

Following the presentation, TM thanked them for their work to date including the British sign language (BSL) work and asked how the community would continue to gain access to services.

JD commented on a recent board seminar on poverty and that there was a request to produce a paper on the organisation's response. It was agreed that IC's input would be sought before the paper is submitted.

Board members acknowledged challenges in future patient engagement and the need to avoid duplication or overburdening community groups especially considering ongoing structural changes. They noted that there was the need to continue collaboration with Healthwatch and voluntary sector partners to address challenges and support the population effectively.

The Chair thanked IC and NT for their insights and contributions and for attending the meeting.

Following the discussion, the Board **NOTED** the Healthwatch Hertfordshire annual report.

25/107 BOARD ASSURANCE FRAMEWORK (BAF) - STRATEGIC RISKS

The Head of Corporate Governance presented this item. He reported to the Board that the BAF was rated as partial assurance reflecting that there were five new risks out of 11 on the 25/26 BAF and that these would not have been included, if the Board was assured about them.

It was also noted that 7 of the 11 BAF risks were currently red rated.

BAF risk 9 the future of cancer services was spotlighted. The Chief Executive presented this BAF. Reference was made to the oncology service at Watford, with ongoing interviews concerning service strengthening. The Board asked whether the plan was coherent and whether West Herts were engaged as expected.

Following a discussion, the Board acknowledged the need for continued collaboration. MA commented that the service had been under development for over a year and that specific NHS funding had been allocated. He advised that recruitment had taken time, but recent appointments meant significant progress in addressing clinical risk.

BAF Risk 10 Digital Transformation was also spotlighted. The Chief Information Officer, MS presented this BAF. He updated the Board on digital transformation risks and commented that discussions had taken place between RO, Chair, OneEPR committee, The Trust Chair, AAD, and the Chief Information Officer, MS regarding the evolution of the OneEPR committee. It was noted that the committee which currently focused on the OneEPR, was to become a permanent committee with a broader remit covering all digital matters and meet monthly.

Action: The revised terms of reference for the digital committee to be brought to the next board meeting.

It was confirmed that the digital transformation risk retained a score of 16, primarily due to challenges with workforce engagement and training, as well as limited funding from the frontline digitisation programme.

The Board **AGREED** to a **PARTIAL** assurance rating on the BAF, with no objections raised.

East and North Hertfordshire Teaching NHS Trust

25/108 WORKFORCE DISABILITY EQUALITY STANDARD (WDES) AND WORKFORCE RACE EQUALITY STANDARD (WRES)

The Chief People Officer PSM presented this item. She commented that it needed to be published annually and noted that we do not currently have a complete data set. What was set out in the report was all the information we currently hold.

The Board was advised that the WDES data for 2025 had shown improvement in the majority of metrics and continued to show improvements year-on-year for the Trust.

Areas with deterioration related to metrics with small numbers of staff which could skew percentages. It was noted that disability declaration rates had increased, however there remained a 17% gap in declarations.

It was reported that disabled staff were one and a half times more likely than non-disabled staff to experience a formal capability process. The Board heard that 76% of colleagues who had declared a disability had also received reasonable adjustments, but there was a need for further understanding of and support around the types of disabilities present in the workforce. The Board was informed that 32% of disabled staff had reported experiencing harassment and bullying from patients, an increase of four percentage points from the previous year. However, overall staff engagement, as evidenced by the staff survey, had marginally increased and was now on par with the national average.

On the Workforce race equality progress report, the Chief People Officer, PSM commented that the 2025 workforce race equality data showed improvements across most metrics for the Trust. However, shortlisting/appointments of black, minority ethnic (BME) staff, bullying/harassment, and career progression deteriorated. With 6% ethnicity data missing, divisional deep-dives and an equality, diversity and inclusion (EDI) Steering Group session were recommended. The report aimed to provide reasonable assurance on equity for staff and progress towards exemplary service.

PSM commented that they used the term BME as that was what was in the legislation. It was reported that BME staff were less likely to face disciplinary action but more likely to experience harassment (31%) and perceive fewer career opportunities (50.5%). White candidates remained 1.59 times more likely to be appointed after shortlisting.

With recent societal events and the prevalence of certain flags, it was stated that this was making some staff feel less safe.

The Board was told of positive developments, including an increased likelihood of BME staff accessing non-mandatory training but that these gains had not yet translated into improved career progression.

The Board was advised that on the three-year EDI strategy, we were in our second year.

Following the presentation, DB asked if we should and could do more in the area of disability in terms of engagement.

RO asked how our declared percentage of disabled staff compared to our population.

NJ asked about data on abuse from staff and asked if it could be made available. She also spoke about a harassment policy and if it should be developed to cover everyone.

KH commented that there had been a general increase in incivility across the Trust and it would be helpful to focus on how we address this, including through the use of “Civility Saves Lives”.

The Chief Executive commented on the percentage of board member declarations and noted that people believe they do not require anything but that they need to declare.

The Board was reminded that there was an Equality and Diversity Steering board and that there would be a review on the way talent identification work was done.

TM commented that Lorraine Williams, Deputy Director of Infection Prevention and Control was working on a project to address some of the issues raised.

The Board **NOTED** that the report provided a **REASONABLE** level of assurance.

25/109 INTEGRATED PERFORMANCE REPORT (IPR)

The Chief Information Officer, MS presented this item and summarised the IPR across its four quadrants.

During the presentation, the Board discussed a fall in the stroke SNAAP rating to E, it was noted that the fall was due to a reclassification rather than a deterioration in performance and that work was ongoing to address this. The Board was also advised that timely handling of complaints remained an issue.

The QSC Chair, DB reported that many issues raised in the performance discussion also featured in the QSC report to the board, with additional matters such as fire safety scheduled for next month's meeting. It was noted that complaints handling continued to be challenging, with up-and-down trends but no dramatic changes to report. Regarding the stroke downgrade, DB informed the Board that a number of Trusts had also been downgraded following a change in assessment criteria. NJ asked if all Trusts had experienced a drop in their SNAAP rating due to the stroke reclassification. DB responded that more than half had dropped.

During the presentation on People, the Board noted the increase in bank and agency staff utilisation. The Board acknowledged that several workstreams were in play to address this, including targeting variable pay.

It was noted that sickness absence, particularly in mental health, was rising, but early management through occupational health referrals was being encouraged. The Board discussed the importance of promptly filling vacancies with substantive staff and avoiding unnecessary reliance on temporary staff.
The Board was informed that 15 staff members had been approved under the MARS scheme.

RO remarked on the low vacancy rates and low attrition but not low bank/agency staff and asked what the issue was. PSM responded that there was the need for improved job planning and roster robustness. It was also noted that weekly reviews of bank and agency staffing was being considered.

JS raised concern that the process for approving substantive posts could inadvertently be driving-up bank and agency usage.
The Chief Executive commented that retention remained high across the NHS, in part due to fewer external opportunities. He remarked that there was the need to be mindful of potential turnover once the job market reopened.

The Board was informed that the impact of industrial action at the end of July had contributed to an £8.6 million deficit, which remained in line with expectations. The CIP plan assumed £4.3 million pounds at month four.

The FPPC Chair commented that some of our reserves had been used to remain on plan, and that the full size of the CIP had yet to be identified, constituting a significant risk.

On Operations, the Board heard that there had been improvements in urgent and emergency care (UEC). Six-week performance on MRI had been a focus, with increased capacity and additional outsourcing established. Performance in cancer pathways had dipped slightly under the 62-day target, but it was anticipated that the target would be met the following month.
Positive trends were reported, but ongoing focus was required in some diagnostic areas, such as non-obstetric ultrasound.

RO remarked that he was encouraged by the improvements that they had seen.

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

25/110 QUALITY AND SAFETY COMMITTEE (QSC) REPORT TO THE BOARD

The QSC report to the Board was **NOTED.**

25/111 FINANCE PERFORMANCE AND PLANNING COMMITTEE (FPPC) REPORT TO THE BOARD

The FPPC report to the Board was NOTED.

25/112 PEOPLE AND CULTURE COMMITTEE (PCC) REPORT TO THE BOARD

The PCC report to the Board was NOTED.

25/113 SYSTEM PERFORMANCE REPORT

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

25/114 HEALTH CARE PARTNERSHIP (HCP) REPORT TO THE BOARD

The Chief Executive, ASJ advised the Board that significant work was underway in the background, particularly in planning, due diligence, and establishment of good governance. He commented on the importance of behavioural and cultural alignment with the organisational vision and that there were ongoing workshops being held with system partners.

The HCP report to the Board was **NOTED**.

East and North Hertfordshire Teaching NHS Trust

25/115 AUDIT AND RISK COMMITTEE (ARC) REPORT TO THE BOARD

The ARC report to the Board was **NOTED**.

25/116 DIGITAL COMMITTEE REPORT TO THE BOARD

The Committee Chair, RO updated the Board and noted that the report reflected the outcomes of the first meeting held in July, with the subsequent meeting in September.

It was noted that three additional risks had been highlighted, and mitigation strategies were being developed in response to these risks, and that close monitoring would continue.

It was reported that the revised Digital Committee would cover all digital matters at their monthly meetings.

25/117 ANNUAL CYCLE

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

25/118 ANY OTHER BUSINESS

25/118a

WINTER PLANNING BOARD ASSURANCE

The Chief Operating Officer LD presented this item. She emphasised that this was a developing plan which went to the FPPC meeting in July and additional updates have been included since then.

A planning exercise was carried out recently which would be reflected in the plan before it goes to the FPPC committee in September. It was noted that the Trust responses needed to be in by end of September.

RO commented that it was a good piece of work and noted that targets/milestones would be good. He asked a question about Covid vaccinations, in addition to flu. He also raised concern about winter capacity in relation to paediatrics and mental health patients. LD responded that this year we had a better baseline, and we were reasonably well prepared. RO suggested that it would be good to see the data.

JD noted that the flu vaccination would be offered to staff this year and that there was a national decision to not offer the Covid vaccination. In response to a question, it was noted that patients would be offered lateral flow tests which could lead to on the day cancellations. TM commented that a lot of work was being done for surge planning.

KH suggested that flu vaccinations for staff should be extended to non-clinical staff including porters as they come in contact with patients a lot.

Following the discussion, authority was delegated to the FPPC to review the document on behalf of the Board.

East and North Hertfordshire Teaching NHS Trust

25/118b

Chief Executive Adam Sewell-Jones receiving honorary doctorate

The Chair on behalf of the Board, congratulated the Chief Executive who had received an honorary doctorate degree.

There was no other business.

25/119 DATE OF NEXT MEETING

The date of the next meeting is 19 November 2025 online.

Ms Karen McConnell
Deputy Trust Chair
September 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 NOVEMBER 2025

Meeting Date	Minute ref	Issue	Action	Update	Responsibility	Target Date
15/1/25	25/006	Renal services PSII	Progress on the implementation of the improvement plan is reported to the Board.	The main outstanding actions are around the contract with Divaerum which is close to being signed. We also have not resolved the recommendation that large contracts be held centrally rather than in divisions. Updated renal improvement plan has been uploaded to Board papers site.	Medical Director	**Completed**
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.	A review is underway for protected time however due to availability for those undertaking additional duties outside of their day job, progress has been delayed. An update/recommendation will be provided to the November Board	Chief People Officer	November 2025

	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
09/7/25	25/084	Freedom to Speak Up annual report	Explore creation of standard response templates for staff concerns. There was a suggestion that future reports to include statements from executive and NED leads. PSM commented that the People Team would meet with SG for alignment of training and support strategies including integrating the data into the equity, diversity and inclusion (EDI) strategy	This will be linked to a team redesign which is underway A review and redesign of the People Team is underway. EDI, data, training and integration is a key part of the structure and ways of working that is in the design phase now The CPO also meets regularly with the FTSU Group and that role is also part of the Trust Partnership Group.	Chief People Officer (CPO) Chief People Officer (CPO)	January 2026 November 2025
10/9/25	25/107	Board Assurance Framework - Strategic risks	The revised terms of reference for the digital committee to be brought to the next board meeting	This will be brought to the January 26 meeting as it is yet to be presented to the Digital Committee	Chief Information Officer	January 2026

East and North Hertfordshire Teaching NHS Trust

Chief Executive's Report

November 2025

Chief Executive Update

Regional and national update

New NHS performance league tables were recently published and show East and North Hertfordshire Teaching NHS Trust as the highest-ranked acute hospital trust in the East of England.

The new national rankings updated every three months, compare how trusts across England are performing in key services such as urgent and emergency care, planned operations, as well as how efficiently they are run. Each trust is placed into one of four segments – with Segment 1 representing those facing fewer challenges, and Segment 4 those with the greatest challenges. East and North Hertfordshire Teaching NHS Trust has been placed in Segment 2 the trust is ranked 19th of 134 acute and specialist trusts in the country.

As of 1 October 2025, Integrated Care Boards (ICBs) across the East of England will begin to work more closely, forming new clusters that will create more streamlined, sustainable health and care systems. Following this, a new 'Central East' ICB which will cover Hertfordshire, Bedfordshire, Cambridgeshire and Milton Keynes and will formally come into being from 1 April 2026, with Jan Thomas appointed as Chief Executive Officer (CEO).

The new East and North Hertfordshire GP Provider Collaborative (ENHGP) has officially been established. ENHGP brings together Primary Care Networks (PCNs) and GP leadership across East and North Hertfordshire.

ENHGP will work closely with system partners, including East and North Hertfordshire Teaching NHS Trust (ENHT), Hertfordshire Community NHS Trust (HCT), Hertfordshire County Council (HCC), Hertfordshire Partnership University NHS Foundation Trust (HPFT), Primary Care colleagues, and a wide range of state and voluntary sector organisations, to foster strong partnerships and support the delivery of joined-up, person-centred care.

The collaborative aims to transform neighbourhood health services by strengthening integration between primary care and wider providers, playing a pivotal role in delivering high-quality, community-based care for the populations we serve.

On 24 October 2025, the Medium-Term Planning Framework was published by NHSE covering the period 2026/27 to 2028/29. Intended to return the NHS to much better health – with waiting times dramatically reduced, access to local care restored to the level patients and communities expect, and unnecessary bureaucracy slashed so that savings are poured back into frontline services and staff, it sets out a range of ambitious targets to be achieved over each of the next three years.

Organisations are expected to develop 5-year strategic plans that set out how they will deliver the 3 shifts contained in the 10 Year Health Plan and improve productivity of their services. These 5-year plans will need to be supported by 3-year numerical returns that describe what the organisation will deliver from 2026 to 2029.

Plan development has already commenced, and the Board will receive updates at various stages through the remainder of this year.

Estates Update

As part of our commitment to environmental sustainability, we will be installing a solar canopy over the main staff car park at Lister Hospital to provide sustainable solar power to the hospital, reduce our energy costs and lower our carbon footprint. The work will start on 17 November 2025 and is scheduled to finish in March 2026.

The trust has also recently received confirmation of £2.3m of capital funding to expand capacity in the Emergency Department (ED) for the receiving of patients arriving by ambulance. This will both improve the care environment and increase the speed by which ambulance crews can handover patients to the care of staff in ED

People Update

Our annual flu vaccination programme is now underway, with strong engagement across the organisation. Our Medical Director, Dr Justin Daniels, joined colleagues in delivering vaccinations, including to members of the Executive Team, demonstrating our collective commitment to protecting patients and staff as we head into the winter months.

Well done to the UEC Care Group, Site Team and Unplanned Care Leadership Team who recently won a Proud2bOps Annual Congress 2025 Operational Improvement Award for their collaborative work on reducing waiting times for urgent and emergency care, with patient outcomes and experience at the heart of the improvement journey.

Some of our nursing teams attended the Nursing Times Awards on 22 October, where the trust was a finalist in four categories: I am pleased to share that the trust won the Sustainability in Nursing and Midwifery award for our greener emergency response system. The nurse-led innovation impressed judges, with a smart approach to reducing waste, including sharing resources between departments and improving the organisation of resus equipment. Well done to the team!

Congratulations to our teams across Wards 9a, 9b, and Barley who have been formally recognised for their commitment to outstanding end of life care and have achieved Gold Standard Framework (GSF) Accreditation.

GSF is recognised by the Care Quality Commission (CQC) as an excellent provider for end-of-life care. While most patients wish to die at home, only 28% achieve this, highlighting the importance of initiatives like GSF. Wards 9a, 9b, and Barley now join other accredited wards in the trust, including the Respiratory Unit, 11a, Ashwell, Pirton, 5b, and 10b.

Finally, the trust has been reaccredited with a Gold Award status from the Ministry of Defence, under the Defence Employer Recognition Scheme. The award is given to those employers who demonstrate exemplar support to the armed forces community.
We were honoured to welcome Robert Voss, Lord-Lieutenant of Hertfordshire, to Lister Hospital to present the award. Well done to all that made this possible.

Digital update

OneEPR is the trust's largest digital programme this year, as we work towards a fully integrated electronic patient record by the summer of 2026. This will move us towards digital entry into the system rather than the current paper-based process.

Alongside that, we are scanning paper records into a new electronic document management system (EDMS). This allows clinicians to see patients, for example in an outpatient clinic, without the need for paper records and the information available to them digitally.

The first go-live was in paediatrics and has received very positive feedback received. Thank you to all of the teams involved. We will now proceed to further roll out across the trust.

Improvement Update

Two years ago, we began our partnership with the Virginia Mason Institute (VMI), developing the ENH Production System as our way of improving and leading. In August, VMI carried out a health check to assess our progress. In the subsequent report, it was identified that more colleagues are starting to see the benefits of the ENH Production System, particularly those who have taken part in the rapid process improvement workshops (RPIWs).

The RPIWs have led to real improvements, including a 33% reduction in lead time for Ophthalmology patients, saving 12–15 minutes per appointment and allowing 711 extra patients to be seen per year, helping to cut waiting times. In Resourcing, we've achieved a 73% reduction in the number of days to hire, cutting 11 days from the recruitment process and 68% reduction in error rate.
September and October has seen a large volume of activity including improvement events for the induction of labour pathway, variable pay processes, medium locum processes and sterile services and theatres. Report outs from these events are made available to staff from across the trust to watch.

In November we will be leading a large event including partner organisations focussed on urgent and emergency care patients presenting to the hospital.

Adam Sewell-Jones
Chief Executive

Board

East and North Hertfordshire Teaching NHS Trust

Meeting	**Public Trust Board**			**Agenda Item**	**9**
Report title	**Nursing and Midwifery Safer Staffing Establishment Review**			**Meeting Date**	**19 November 2025**
Author	**Strategic Nursing Program Manager Lead Nurse for Workforce Data supplied by - Interim Head of Flexible Workforce and e-Rostering**				
Responsible Director	**Chief Nurse**				
Purpose [See note 7]	**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:

N/A

Summary of key issues:

This report provides the committee with a synopsis of the initial bi-annual Establishment Growth Review of the year which was undertaken in April 2025. This review followed a structured, evidence-based triangulated approach that provides an insight into nurse staffing requisites mapped against clinical requirements. All inpatient wards within Unplanned and Planned Care, which also includes all Emergency and Assessment areas throughout the ED Complex, were included.

This process entailed reviewing actual worked staffing hours, patient insight/dependency data and quality indicators. Birth-rate Plus® (BR+) was not captured during this review, because this will be reported separately through Maternity governance.

The urgent and emergency care establishments (UEC/UTC) have also been refined in line with the Trust's evolving emergency care strategy. This review will provide the groundwork for the subsequent Shift Plan Establishment Review, supporting the Trust's CIP programme. Consequently, the Nursing Directorate met and exceeded financial targets without compromising patient safety or clinical safer staffing levels.

Key findings/impact:

- Most clinical areas were working within their expected shift plan/skill mix
- Senior nursing staff have determined that staffing within the AMU and ED remains constrained. However, ongoing reconfiguration efforts and active recruitment initiatives are being undertaken to address the current high level of vacancies.
- Swift Ward – Findings from this review indicated that an additional CSW was required during the day to address the complexities and care needs of this patient group. As a result, Swift Ward's staffing levels were increased as part of the subsequent shift plan review, while remaining within the established financial parameters.
- The accuracy of data validation for Wards 9A and 9B has been questioned due to the acuity and complexity of the medical ailments of this patient cohort, as well as current recording practices. The Specialising team is advised to document the frequency of support provided to this area on Enhance. This information should be evaluated in the next establishment review.

- 5A/B reported that the additional RN support provided when the ward has Tracheostomy, Flap, or MTOP patients has been effective and only utilized during periods of high acuity. They have requested that this arrangement continue, as it has made a significant contribution to improved patient care.
- Following the review and evaluation of shift plans, 11A/B has been revised for year-round service, as seasonal establishments have proved to be clinically and financially ineffective.
- The Trust is committed to filling vacancies and reducing reliance on costly bank or agency staff, while balancing clinical needs and financial sustainability.
- The bi-annual financial realignment of these nursing establishments enhances the ability to address clinical needs in each area, optimises patient safety, minimises reliance on temporary staffing, and contributes to stabilising sickness rates.
- By utilising the SNCT Establishment review as a foundation for a subsequent Shift Plan Establishment review, we successfully met and surpassed the Trust's financial objectives through the CIP programme. This approach enabled us to achieve safer staffing levels within our clinical areas and secure funding for the forthcoming development of the Paediatric UTC Centre within the emergency complex.

Key recommendations of the review:

- Continue to work with divisions and finance to re-align budgets to the agreed shift plan rosters.
- Continue to duly invest and fund the nursing and midwifery staffing budgets in line with bed base and service demand considering national guidance and safer staffing reviews.
- Continue to review staffing establishments on wards with continual high acuity to ensure the area remains safe for both staff and their patients.
- Obtain the upgraded version of the SafeCare application to support accurate capture of 1c/1d acuity in clinical areas according to the new SNC Tool. There are associated costs for this update; therefore, the organisation should assess the expenses related to licences and RLDatix upgrade implementation before proceeding.
- Continue to review funding for study leave and placement backfill for budget planning 2026/2027.
- Trust to explore investment for staff completing top up degree programmes, with a possible continuing central budget but this should not be a cost pressure on the wards.
- New measures to regulate bank and agency staff usage have been implemented and are currently in progress.

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**	☐

If you have ticked any of the boxes, succinctly explain why. You can include other impacts not named above. This section enables the reader to understand from the start particularly significant implications/impact envisaged. This can be both positive benefits and disbenefits that are crucial for robust decision-making. [See note 10]

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 4 -Workforce
BAF 8 -Improving performance and flow
BAF 12 -Clinical engagement
BAF 2 -Health inequalities

Report previously considered at & date(s):

Quality and Safety Committee, October 2025

Recommendation	The Board is asked to note the report.

Introduction

The National Quality Board Guidance (2016) requires Trust Boards to ensure that there is adequate and sustainable staffing capacity and capability which will continue to provide safe and effective care to patients across all healthcare settings. In addition, boards should ensure that there is an annual strategic staffing review, with evidence that this will be developed using a triangulated approach that takes account of all healthcare professional groups and is in line with financial planning.

The RCN Workforce Standards (updated 2025) highlight that a lack of nursing leadership and relevant support structures within organisations impacts on safety, quality of care and patient mortality, as well as the mental health and general wellbeing of the nursing workforce. It is well documented that having good leadership and sufficient skilled staff will be pivotal to the safe and effective restoration of healthcare services and will support staff wellbeing, recruitment, and retention within the organisation. The recommendations in this review will support current workforce challenges and enhance the development of the new UTC pathway within Emergency care.

Establishment Review methodology

This review triangulated the new Safer Nursing Care Tool (2024 SNCT) for Safer Staffing collected over a 30-day period on all inpatient wards. This data was then analysed using current validated frameworks, professional judgement, quality and safety indicators, benchmarking with other Trusts using NHSI Model Health system and National Guidance for Safer Staffing.

This review is underwritten by a bottom-up approach involving all clinical Divisional Nursing Directors and their Deputies, finance, and senior nurses throughout each area, using a zero-based budget approach. SNCT Safer Staffing data and the latest National Safer Staffing Guidelines of each speciality were used, accompanied by a collaborative professional judgement through a clinical check & challenge of each establishment, matching the clinical needs of a specific area within an agreed financial budget. To undertake the establishment review, various national guidance validation tools were used by the Nursing Directorates to assist with this calculation:

- Current assumptions & validation
- Care Hours Per Patient Day
- Updated Safer Nursing Care Tool
- Professional Judgement
- National Benchmarks

The review consisted of having full clinical engagement with Ward Managers, Matrons, Divisional Nursing and Quality Directors/Deputies, the People Partner Team, and finance colleagues. Thus, ensuring that robust clinical discussions and appropriate context were captured by all of those involved in the undertaking of this review. Appendix 1 shows the summary of proposals for each inpatient area.

Current assumptions – Skill Mix and Registered Nurse to bed ratio

The nurse-to-patient ratio describes the number of patients allocated to each registered nurse. Nurse/patient allocations are based on the perception of patient needs within each ward.
In critical care the ratio may be 1:1 for those patients most at risk or 1:2 or 1:3 for patients who are acutely ill but stable ward able patients. On general wards the nurse-to-patient ratio is higher, for example 1:6 or 1:8 depending on the type of service delivered and patient needs. This type of nurse/patient ratio is based on guidelines from professional organisations and accreditation bodies but also reflects the needs of the individual patients at a given point in time.

A full ward breakdown of the service model skill-mix and an actual worked skill mix for the reference period can be found in Appendix 1.

Care Hours per Patient Day (CHPPD)

At ENHT care hours per patient day (CHPPD) is a productivity model used, congruent with other methods, to setup nursing establishments. The review of NHS productivity, chaired by Lord Carter, highlighted that CHPPD was the preferred metric to provide NHS Trusts with a single consistent way of recording and reporting on the deployment of staff working on inpatient wards.

CHPPD was used to identify the likely care time required for an expected patient type for a service. This was then compared to the required CHPPD for actual patients using the service, and the real time CHPPD provided by staff on the ward to assess if wards were suitably staffed for dealing with actual patients.

Note - the Cancer division comprises of ward 10 and the following tables show that they are over on CHPPD (table 1) and SNCT (table 2). This Clinical Ward is a stand-alone unit at Mount Vernon and requires a minimum staffing level for patient safety. It also has ambulatory ward attenders which could not be encapsulated within the data sets. During the data collection period, the ward was closed due to current estate works being carried out, so the data does not accurately reflect actual need when the ward is fully operational.

Table 1 below shows the average ward recommended SNCT CHPPD (excluding level 1c and 1d patients outlined within the SNCT tool), the planned CHPPD (as per the funded roster template), and the actual worked CHPPD per care group.

Table 1

Care Group	SNCT CHPPD (Ward Recommended)	CHPPD Planned (roster template)	CHPPD Actual Worked
	Apr-25		
1	7.09	7.20	8.16
2	7.42	7.43	7.69
3	6.69	6.22	6.59
4	8.40	7.07	6.37
8	7.81	6.15	16.25
10	-	7.19	12.21

The SNCT calculator for Children and Young People does not include an SNCT CHPPD recommendation, this figure is therefore blank for Care Group 10.

A full ward breakdown of the Care Hours per Patient Day (CHPPD) for the reference period can be found in Appendix 2

Safer Nursing Care Tool (SNCT)

The SNCT is an evidence-based tool developed to help NHS hospitals measure a patient's acuity and dependency to inform decision making on staffing and workforce. The tool enables nurses to assess patient acuity and dependency, incorporating a staffing multiplier to ensure that nursing establishments reflect patient needs in acuity/ dependency terms. SNCT is NICE approved as an effective evidence-based staffing tool.

The process involves using the acuity tool over a period of 30 days on each inpatient ward to establish patient need and dependency. The tool is based on six levels of care, defined by National guidance for safer staffing.

The SNCT multipliers are based on dependency, workload literature and empirical data. The Trust uses licensed software to gain this information. There is now an updated version of this tool with two additional levels of care included. These new levels include 1c & 1d to help identify those patients who require specialist care either by 1:1 or 2:1 staff patient ratio. However, as our current Safe-Care application does not reflect these new levels, for the purpose of this review, paper audits were completed across all the in-patient wards to provide this additional information. In addition, a new ED specific SNCT tool, which looks at data over a 12-day period, has also been developed. Acuity is recorded twice a day 12 hours apart (for example 12:00 & 24:00, 01:00 & 13:00 etc), this ensures a complete 24-hour period is captured within the 12 days. The staffing establishment for these areas was unreliable due to the ongoing vacancy levels and deviations within some of the data collection in capturing the multifaceted needs throughout the emergency complex. A further review on how best to approach this kind of data collection is underway prior to future establishment reviews to identify any further recommendations within this area.

Table 2 below shows the average occupancy information for each care group for the sample period, with the total SNCT recommended establishment per care group (whole time equivalent - WTE), current funded establishment and the variance between the two metrics.

Other factors that should be considered would be.

- Clinical speciality
- Ward size and layout (evidence suggests the tool does not work well in small wards)
- Wards that have a higher number of side rooms
- Staff capacity, skill mix, competence, and leadership
- Organisational support and support roles
- Ward Manager supervisory time
- Additional care hours provided by the Enhanced Nursing Care (Specialling) team.

Table 2

Care Group	Average Occupancy	SNCT Recommended Ward WTE	SNCT 1c and 1d cover	Total SNCT	Funded M1 (QlikView excl. Ancillary)	Variance of Total Funded Est. to SNCT recommended
		Apr-25			Apr-25	
1	88.08%	163.64	12.18	175.83	204.02	40.38
2	98.23%	145.67	9.78	155.44	148.88	3.21
3	96.56%	298.38	37.37	335.75	275.01	-23.37
4	89.75%	220.77	1.50	222.27	233.68	12.91
8	31.63%	24.93	0.00	24.93	36.02	11.09
10	68.32%	26.13	0.00	26.13	28.29	2.16

(see Appendix 4 for Full Breakdown)

Professional Judgement

All Ward Managers, Divisional Nursing and Quality Director/Deputies, Finance, workforce leads, and the e-roster team met with the Deputy Chief Nurse to review all the above data and triangulate relevant quality indicators, incidents, themes and red flag events. The recommended adjustments to some ward establishments are based on the data review and robust discussions with all present. This process added specific clinical context to the discussions and provided an evidence-based bottom-up approach ensuring Ward Managers,

Matrons and Divisional Nursing and Quality Directors were engaged and took ownership of their clinical areas.

National Benchmarks

The latest available April 2025 data was taken as a benchmark which compares similar local peers within the NHSI Model health system. ENHT was rated in the middle quadrant of the lowest quartile for CHPPD for total nursing care given. (Appendix 3).

Data Validation

The following actions were taken to validate the data collection from the updated SNCT specifically for this establishment review:

- SNCT training was delivered throughout March 2025 – this was to ensure that the SNCT data was validated and consistent; inter-rater reliability exercises were undertaken with the nursing teams to ensure the consistent application of the acuity multipliers.
- Comparing recommended establishment of each clinical area with the National guidance for both CHPPD and SNCT
- Senior Nurse Acuity Audits - throughout the data collection period, senior nurses trained and competent in the SNCT, peer audited wards to validate data inputs. Any discrepancies in the acuity data scoring were corrected and senior nurses worked with wards to ensure consistent application of the tool. It should be noted that further training is required with SNCT scoring in areas below 90% accuracy (prior to validation and correction). Ongoing workshops continue and the ward acuity scoring is closely monitored daily through the Safe-Care application.
- External benchmarking with other organisations using the NHS Improvement (NHSI) Model health system.
- Professional Judgement
- Review and discussion at ward board rounds and quality huddles

Nursing and Midwifery Quality Indicators

The Trust uses information and statistical tools to examine quality of care indicators. These indicators include pressure ulcer prevalence, complaints, patient falls, drug administration errors, Clostridium-difficile rates, and MRSA rates. Standardising these metrics by occupancy and length of stay creates a statistical tool that highlights outlying areas in which indicators are higher than anticipated.
Any indicator triggering above established threshold is subject to detailed root cause analysis and an action plan developed, where appropriate, to improve patient safety and experience.

Monitoring and Governance

The Trust has a robust system of reviewing daily staffing utilising the RL Datix Safe Care system and e-roster. Staffing is reviewed 3 times daily and risks are mitigated across the divisions. Due to the need to reduce bank & agency spend, all bank shifts are checked, challenged and doubly approved prior to being sent out to be filled. All current bank shifts booked at short notice and those booked for the following day are reviewed and approved, (where appropriate), within the 8.30,12.30 & 15.30 Safer Staffing review meetings. Releasing Padlocks to go out for Agency are only considered after all avenues has been explored and senior staff have confirmed approval from either the DDDON or DDON from each Division. In addition, each roster and its clinical effectiveness is closely monitored at the daily, weekly staffing review and monthly roster KPI review meetings, which are attended by the ward managers, matrons, deputy divisional directors of nursing, finance, and recruitment, to ensure information is shared and actions put in place for safe staffing and cost effectiveness.

SNCT Establishment Review

Following the SNCT staffing review in September 2024, which involved all inpatient wards and newly formed UEC clinical areas, a second establishment review was completed in April 2025 using the updated version of SNCT Tool. Feedback sessions post this review with the Deputy Chief Nurse, Divisional Directors of Nursing, Matrons, and Ward Managers were held to review the results of this review and discuss any concerns.

Areas of concern raised and discussed within the SNCT feedback sessions within some care groups were:

- **CSW Levels** - Concern around the CSW levels for the acuity level of the wards due to ongoing vacancy rates and delays in recruiting staff. To address this, the recruitment team have been working hard to improve the recruitment process to reduce delays. In addition, the Trust's recruitment team in collaboration with senior nurses throughout the Nursing Directorates introduced an CSW assessment day followed by a series of interviews in September 2025. During this period the resourcing team were able to take ID and confirm reference details with successful candidates on the day, to reduce time to hire. By streamlining the recruitment process in this way, it is likely some will be able to start 6 weeks from offer dates, some will be longer depending on time pre-employment checks take, notice period etc. Quality instability due to Ward Managers having to work clinically on their supervisory days to support their wards due to staffing short falls. Main identified drivers for this are sickness, study day backfill & high levels of parenting leave in some clinical areas.
- **AMU** - continue to work within their new shift plan and this is going well. Full realisation of the establishment review in April 2025, regarding this area at the time of the third SNCT staffing review, has not been realised due to ongoing staff re-alignment. A discussion remains around whether this data can accurately capture the true activity of the chair area within this unit and their remaining vacancy levels, all of which are being addressed.
- **SSU** - SNCT data reflects their clinical activity and staffing skill-mix accurately. However, currently they remain on a reduced bed capacity due to being in the Tower Block while estate works are going on within their own area.
- **11A/B** – Post this SNCT review it has been agreed that on the occasion the band 7 is pulled into the nursing numbers a clinical shift will be pulled on to the roster to reflect this. In addition, 11A/B Staffing has been uplifted in line with their continued acuity/occupancy throughout the year as discussed at Divisional level. This reconfiguration remained within the financial envelop as agreed. This situation will continue to be monitored and reviewed within the next SNCT review.
- In **care groups 3 & 4**, concerns around patient acuity and special needs in the care of the elderly wards were discussed. Indeed, most areas within this care group concurred with Ashwell's comments post that the increase in CSW staffing levels on the late shift were appropriate for the area. Moreover, due to the multifaceted needs of this care group, it was suggested that the best way to address these issues going forward would be to consider whether these wards would be better served by increasing the Enhanced Care Specialist Team to give greater support across the care group or to maintain the level of CSW's throughout the day. Moreover, concerns were raised around the acuity and complexity of the patients being admitted to **9A & 9B**. It was felt that the acuity scoring of these wards needed attention as it was felt that the SNCT data failed to accurately record the acuity/activity of these areas. As a result, evidence to support this will be provided by the HON/Matron for this area prior to the next SNCT review.
- In Wards **10A/10B** the discussion focussed on the fact that, although staffing levels were stable, staff were still required to escort patients being transferred for treatment, and this resulted in a shortfall in ward staffing which was identified as a concern. DDON said they would consider alternative arrangements, and this would be reassessed in the next staffing review.

- Ward **5A** – noted that since the optional RN escalation shift had been added to the night staff template whereby a ward manager could utilise this if the ward had tracheostomy patients, thus staffing was at a much better level, and it was requested they keep the extra staffing support. This shift would only be utilised in such circumstances.
- Within **Swift Ward** it was noted that the side room factor had increased SNCT staffing levels recommended within this review. The SNCT data collection supports the need for an additional CSW on the day shift due to the complexities and care requirements of this patient group. Following this review, and as part of the shift plan establishment review that followed, Swift received an uplift as this remained within the agreed financial envelope.

Nurse and Midwifery Education

Throughout 2025, the Trust has continued to support the preferred 'grow your own' programmes such as the student nurse associate, top up degree and the 4-year degree apprenticeship. It is recognised that our study leave is above the 2% budgeted headroom threshold in most inpatient wards, and this will continue next year to support these initiatives which will push wards and departments over their budgeted headroom allowance.

In line with NHS England guidance, the Trust has made a significant effort to support the recruitment and intake of newly qualified nurses (NQNs), in that currently, all our NQN's will be attending an assessment/recruitment day this month. All successful candidates will be placed to fill several vacancies across the Trust. Following this a robust process will be put in place to streamline this process and initially give priority to our own NQN's prior to going externally to recruit.

Efforts are underway to optimise the processes for study leave and the allocation of supernumerary time. The proposed approach involves introducing a degree of flexibility in the application of percentage headroom designated for training purposes. Departmental managers would then be responsible for setting priorities for staff training and continuing professional development (CPD), as well as managing the current One-EPR training release, according to the specific needs of their departments. For instance, it may not be possible to support all staff members in undertaking courses within the same year or timeframe.

Decreasing the annual leave KPI level within the current Headroom from 17% to 15% will support managers to keep within budgets and exercise flexibility when allocating study leave. In addition, the Trust is currently supporting staff development through financing placement backfill shifts centrally, taking some of the financial burden away from the clinical areas reducing the cost pressure within ward budgets of developing staff further.

Temporary Staffing Controls

The Trust has undertaken a significant drive to reduce vacancies through both International and domestic recruitment. However, Temporary Staffing costs have not reduced in line with this substantive recruitment due to the length of time taken to give start dates to newly recruited staff. Therefore, additional controls regarding roster management and within the e-Rostering System were put in place in December 2024 to restrict the ability of certain staff groups to send shifts through the NHSP interface. All bank shifts now require second level approval from the Senior Nursing & Midwifery team prior to being released from the e-roster to the NHSP booking system. In addition, the removal of agency padlocks now requires approval from the Divisional Heads of Nursing. We have observed a reduction in agency usage across most areas, and this trend is expected to continue as new staff from the recruitment pipeline begin their roles.

We have also increased the use of Flexi Pool shifts submitted to NHSP, while reducing the number of Rapid Response shifts being issued.

During the double approval stage for each roster, only clinical shifts related to parenting leave, long-term sickness, and budget-confirmed vacancies are permitted to be allocated to the staff bank. Authorisation to enter Other Leave (including both paid and unpaid leave under the Special Leave policy) is limited to Band 7 staff and above. Approval for Special Leave requires endorsement from either the Deputy Divisional Director (DDDON) or the Divisional Director of Nursing / Midwifery. Coding changes for certain bank-released shifts have been updated to better reflect required skill mixes, currently implemented in ED and Paediatrics, with plans for wider rollout to all clinical areas. All flexible working agreements undergo review and formal approval as part of ongoing roster assessments. The rationale for using bank or agency staffing now receives a second level of approval to enhance accuracy. When completed, temporary staffing data will continue to be transferred from the e-rostering system to the new BI reporting system on a weekly basis, increasing transparency regarding usage drivers. This process will support timely identification and resolution of issues by the Nursing Directorate and Executive team.

Summary

This establishment review has considered and analysed the data relating to shift plans and actual staffing requirements to continue to deliver safe and effective care to our patients, using evidence-based tools and safer staffing guidance and worked through with the divisional directors of nursing and finance.

Following this Establishment Review, further meetings were held to review shift plans for each in-patient clinical area as part of the CIP (cost improvement Programme). As a result, the Nursing Directorate met and exceeded the Trusts financial targets without compromising patient safety or clinical safer staffing levels.

Recommendations

- Continue to work with divisions and finance to re-align budgets to the agreed shift plan rosters.
- Continue to invest and fund appropriately the nursing and midwifery staffing budgets in line with bed base and service demand considering national guidance and safer staffing reviews.
- Continue to review staffing establishments on wards with continued high acuity to ensure the area remains safe for both staff and their patients.
- Obtain the upgraded version of the SafeCare application to support accurate capture of 1c/1d acuity in clinical areas according to the new SNC Tool. There are associated costs for this update; therefore, the organisation should assess the expenses related to licences and RLDatix upgrade implementation before proceeding.
- Continue to review funding for study leave and placement backfill for budget planning 2026/2027.
- Trust to explore investment for staff completing top up degree programmes, with possible continuing central budget as this should not be a cost pressure on the wards.

Appendix 1 - Full ward breakdown of the service model skill-mix and the actual worked skill mix for the reference period.

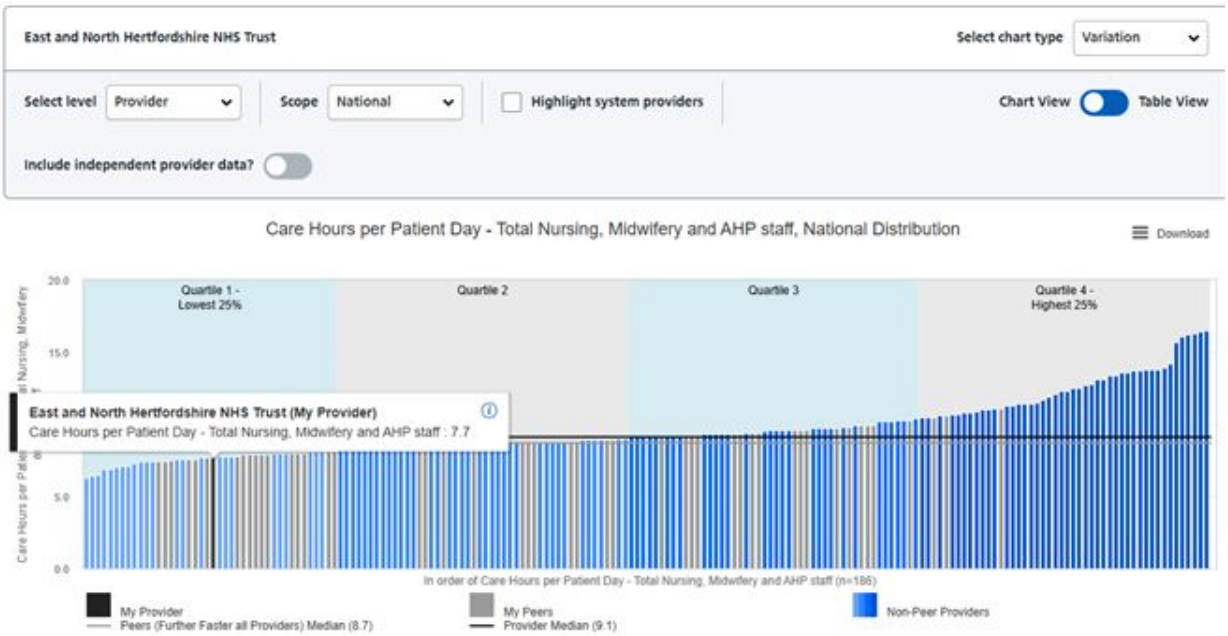
Care Group	Ward/Unit Name	Bed Numbers	Early		Late		Night		Registered staff to bed ratio			Actual Registered to patient ratio per 24 hours
			Reg	Unreg	Reg	Unreg	Reg	Unreg	Early	Late	Night	
1	AMU1	40	9	8	9	9	11	9	2/9	2/9	2/7	1:4.37
1	SSU	20	4	3	4	3	3	2	1/5	1/5	1/7	1:5.88
1	Barley	24	4	4	4	3	3	3	1/6	1/6	1/8	1:6.57
1	Pirton	22	5	2	5	2	3	2	2/9	2/9	1/7	1:4.73
2	11A	29	4	4	4	4	4	3	1/7	1/7	1/7	1:7.42
2	11B RSU	10	3	2	3	2	3	2	2/7	2/7	2/7	1:3.95
2	8A	30	5	4	4	4	4	2	1/6	1/7	1/7	1:7.47
2	ACU	22	4	3	4	3	4	3	1/5	1/5	1/5	1:5.06
3	10A	24	4	4	4	4	4	2	1/6	1/6	1/6	1:6.14
3	10B	30	5	5	4	5	4	3	1/6	1/7	1/7	1:7.48
3	6A	30	5	4	4	4	4	2	1/6	1/7	1/7	1:7.07
3	6B	24	5	4	5	3	4	1	1/5	1/5	1/6	1:5.33
3	9A	30	4	5	4	5	4	3	1/7	1/7	1/7	1:8.05
3	9B	30	4	5	4	5	4	3	1/7	1/7	1/7	1:7.88
3	Ashwell	24	4	4	4	3	3	3	1/6	1/6	1/8	1:6.74
4	7A	29	6	4	6	4	6	2	1/5	1/5	1/5	1:6.52
4	7B	30	4	4	4	4	4	2	1/7	1/7	1/7	1:7.54
4	5A	30	5	3	5	3	4	2	1/6	1/6	1/7	1:6.81
4	5B	30	4	5	4	5	4	2	1/7	1/7	1/7	1:7.54
4	Swift	26	4	3	4	3	4	3	1/6	1/6	1/6	1:6.23
4	SAU	22	5	3	5	3	3	2	2/9	2/9	1/7	1:4.70
5	Critical Care	18	13	2	13	2	13	1	5/7	5/7	5/7	1:1.39
8	Ward 10	22	4	3	4	3	3	2	1/5	1/5	1/7	1:2.28
10	Bluebell	16	4	1	4	1	4	1	1/4	1/4	1/4	1:2.63

Appendix 2 - Care Hours per Patient Day (CHPPD)

Care Group	Ward/Unit Name	Occupancy	SNCT CHPPD (Ward Recommended)	CHPPD Planned (roster template)	CHPPD Actual Worked
		Apr-25			
1	AMU1	89.34%	7.22	9.54	11.23
1	SSU	99.42%	5.77	6.77	6.89
1	Barley	90.54%	7.15	6.29	6.87
1	Pirton	73.04%	8.23	6.19	7.66
2	11A	97.15%	5.95	5.84	6.23
2	11B RSU	113.19%	7.83	11.29	10.16
2	8A	97.87%	5.94	5.42	5.59
2	ACU	84.72%	9.94	7.18	8.77
3	10A	96.47%	5.88	6.56	7.02
3	10B	97.08%	6.16	6.22	6.45
3	6A	93.57%	6.16	6.21	6.31
3	6B	94.02%	8.16	5.93	6.75
3	9A	99.03%	6.86	6.03	6.57
3	9B	99.03%	6.97	6.01	6.16
3	Ashwell	96.74%	6.61	6.59	6.9
4	7A	94.95%	4.62	7.00	6.16
4	7B	94.44%	5.25	5.25	5.82
4	5A	94.40%	5.46	5.25	5.5
4	5B	94.54%	7.54	5.64	6.03
4	Swift	87.19%	8.27	6.46	6.74
4	SAU	72.99%	19.28	12.84	7.99
5	Critical Care	77.38%		18.53	18
8	Ward 10	31.63%	7.81	6.15	16.25
10	Bluebell	68.32%		7.19	12.21

Appendix 3 - NHSI Model Health system

Modern Hospital Care Hours per Patient Day - Total Nursing, Midwifery and AHP staff (April 2025)



Appendix 4 - Average occupancy information for each care ward/unit for the sample period, SNCT recommended establishment per care group (whole time equivalent - WTE), M1 funded establishment and the variance between the two metrics.

Care Group	Ward/Unit Name	Average Occupancy	SNCT Recommended Ward WTE	SNCT 1c and 1d cover	Total SNCT	Funded M1 (QlikView excl. Ancillary)	Variance of Total Funded Est. to SNCT recommended
			Apr-25			Apr-25	
1	AMU1	89.34%	63.79	4.80	68.59	**106.28**	**42.49**
1	SSU	99.42%	27.42	0.54	27.96	**31.31**	**3.89**
1	Barley	90.54%	37.50	5.67	43.17	**34.72**	**-2.78**
1	Pirton	73.04%	34.93	1.18	36.11	**31.71**	**-3.22**
2	11A	97.15%	39.85	4.66	44.51	**74.65**	**13.49**
2	11B RSU	113.19%	21.31	1.97	23.28		
2	8A	97.87%	42.01	3.04	45.05	**37.42**	**-4.59**
2	ACU	84.72%	42.50	0.11	42.61	**36.81**	**-5.69**
3	10A	96.47%	33.23	2.78	36.02	**36.77**	**3.54**
3	10B	97.08%	42.81	3.00	45.81	**42.84**	**0.03**
3	6A	93.57%	42.32	6.64	48.96	**40.70**	**-1.62**
3	6B	94.02%	45.02	0.43	45.45	**35.37**	**-9.65**
3	9A	99.03%	48.83	14.03	62.86	**41.53**	**-7.30**
3	9B	99.03%	49.90	5.46	55.36	**41.37**	**-8.53**
3	Ashwell	96.74%	36.26	5.03	41.30	**36.43**	**0.17**
4	7A	94.95%	31.15	0.54	31.69	**46.55**	**15.40**
4	7B	94.44%	35.42	0.00	35.42	**36.85**	**1.43**
4	5A	94.40%	37.31	0.75	38.06	**36.26**	**-1.05**
4	5B	94.54%	51.03	0.00	51.03	**38.94**	**-12.09**
4	Swift	87.19%	46.58	0.00	46.58	**35.63**	**-10.95**
4	SAU	72.99%	19.28	0.21	19.49	**39.45**	**20.17**
5	Critical Care	77.38%	-	-	-	**96.98**	
8	Ward 10	31.63%	24.93	0.00	24.93	**36.02**	**11.09**
10	Bluebell	68.32%	26.13	0.00	26.13	**28.29**	**2.16**

Board

East and North Hertfordshire Teaching NHS Trust

Meeting	Public Trust Board		**Agenda Item**	10	
Report title	Summary Learning from Deaths Report		**Meeting Date**	19 November 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 Q1 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.
- Following previous increases to the volume of readmissions, recent months have shown decreases both to the volume and rate of readmissions.
- Initial consideration of how health inequality/deprivation data can be used in our learning from deaths work.
- 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 funding available 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 one Q1 death receiving an SJR has been judged by the reviewer to have been more likely than not due to a problem in healthcare. In this case the concerns related to care provided prior to admission. The detail of this case has been shared with the ICB to ensure learning in the Community. The in-hospital care was considered to be of a good standard.
- To date three Q1 deaths receiving an SJR have been assessed as evidencing poor care – these have been escalated as patient safety incidents ensuring further review at specialty/division level.
- NELA (National Emergency Laparotomy Audit) case ascertainment remains a challenge. 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+ bed continues to have a negative impact on the management of acute abdomen. At the same time a new Emergency Laparotomy pathway, aimed at improving time to theatre, is under discussion, with implementation targeted for September/October.
- 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.

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: 10 September 2025: Full report & Summary discussed/approved.
Quality and Safety Committee: 24 September 2025: Full report presented. The Chair and Non-Executive colleagues commented positively on the breadth and detail of the report and indicated that the report provided significant assurance.

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, developed to provide focus through 2025-27 was approved by the Mortality Surveillance Committee in June 2025.

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 Q1 2025.-26 An in-depth Learning from Deaths Report covering the same period was provided to both the Quality & Safety Committee, and Mortality Surveillance Committee in September 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, but with it being logged as a tolerated risk on the Risk Register. Aqua has confirmed that pen testing planned for July 2025, has been postponed to the end of the year.	Ref: 3398
Medical Examiner Service: Funding/capacity Changes to the way the service is funded from 2025-26, combined with the current funding available to 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 has been implemented and remains 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 is continuing between coding and cardiology with regular updates to Mortality Surveillance Committee, the next is scheduled for September. To date concerns have not 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 0.91% for the 12-month period to Jun 2025 compared to 0.99% for the latest 3 years.
HSMR: (data period Jun24 – May25)	HSMR for the 12-month period is **88.08, *'Mid-range'*.**
SHMI: (data period Mar24 – Feb25)	SHMI for the 12-month period is **90.95, 'as expected' band 2.**
HSMR – Peer comparison	ENHT ranked 3rd (of 10) within the Model Hospital list* of peers.

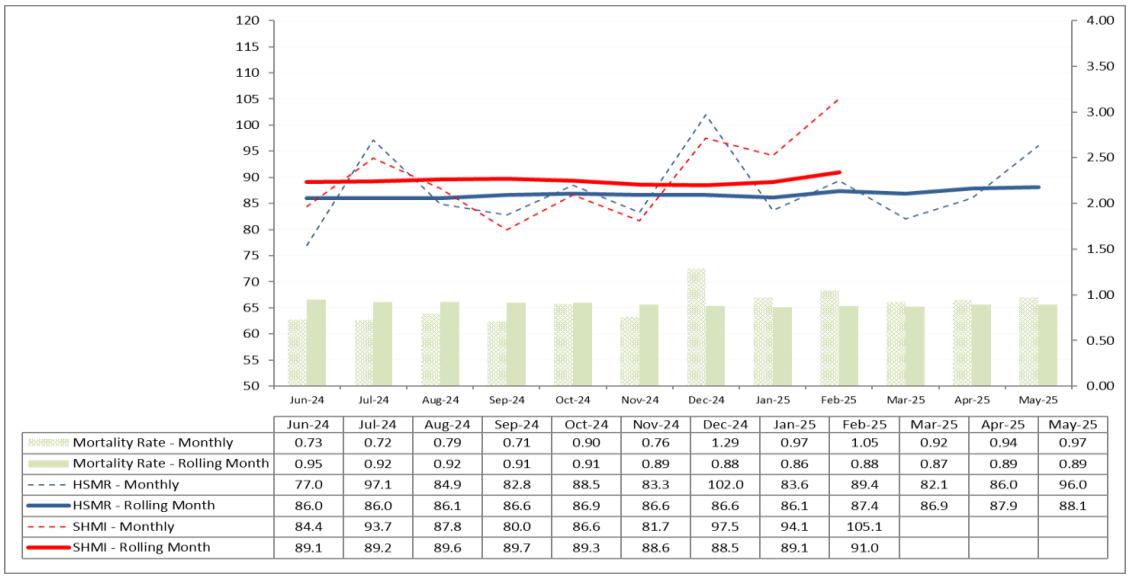
* We are comparing our performance against the recommended peer group indicated for ENHT in the Model Hospital (updated in November 2022).

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 4 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 **90.95** to Feb 2025.This represents a increase from the last reported **90.15** for the12 months to Nov 2024.

Figure 2: Trust key mortality metrics: Latest position



	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
Mortality Rate - Monthly	0.73	0.72	0.79	0.71	0.90	0.76	1.29	0.97	1.05	0.92	0.94	0.97
Mortality Rate - Rolling Month	0.95	0.92	0.92	0.91	0.91	0.89	0.88	0.86	0.88	0.87	0.89	0.89
HSMR - Monthly	77.0	97.1	84.9	82.8	88.5	83.3	102.0	83.6	89.4	82.1	86.0	96.0
HSMR - Rolling Month	86.0	86.0	86.1	86.6	86.9	86.6	86.6	86.1	87.4	86.9	87.9	88.1
SHMI - Monthly	84.4	93.7	87.8	80.0	86.6	81.7	97.5	94.1	105.1			
SHMI - Rolling Month	89.1	89.2	89.6	89.7	89.3	88.6	88.5	89.1	91.0			

2.2 Mortality alerts

2.3.1 CQC CUSUM alerts
There have been no CQC alerts in Q1.

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 May 2025.

2.2.3 SHMI CUSUM alerts
CHKS report indicated one SHMI CUSUM red alert for the period to February 2025 which constituted a rolling 12-month 3 standard deviation outlier, as detailed in the table below.

Table 3: SHMI Outlier Alerts March 2024 to February 2024

	SHMI	Observed Deaths	Expected Deaths	"Excess" Deaths	Included Spells
Heart valve disorders	279.50	8	3	5	60

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.

A preliminary coding review of the heart valve disorders death has been undertaken. While most of the coding was correct, 2 deaths required clinical clarification and will be included in the forthcoming cardiology update, scheduled for September.

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

2.3 Health inequalities and deprivation

The reduction of health inequalities is a stated priority in the latest NHSE priorities and operational guidance, both for ICBs and acute providers. Trusts are urged to consider health inequalities in their assessments of quality in an attempt to ensure fair access, outcomes, and experiences across all sectors of the population. Health inequalities are seen as avoidable, systemic injustices that lead to poorer health, increased costs, and lost productivity.

While the subject of health inequalities is relevant across the whole spectrum of our care for patients, we are keen to start to consider it from the perspective of our learning from deaths work.

SHMI Contextual Indicator for deprivation
The SHMI methodology does not make an adjustment for deprivation. This is because adjusting for deprivation might create the impression that a higher death rate for those who are more deprived is acceptable.

However, deprivation is the subject of one of its Contextual Indicators, designed to accompany the core SHMI publication, providing additional information about the context in which a hospital operates, helping to understand SHMI results. Patient records are assigned to one of five deprivation groups (quintiles) using the Index of Multiple Deprivation (IMD).

The following charts detail the percentage of provider spells and percentage of deaths reported in SHMI by deprivation quintile taken from the most recent SHMI release, including

deaths up to February 2025. Interpretation of this data is difficult without adjusting for further confounders such as age.

What is known and is clear from this data is that our Trust has a significantly higher percentage of activity relating to those in quintile 5 (least deprived) and significantly less activity relating to those in quintile 1 (most deprived) than the national average and that this is mirrored by the percentage of deaths in those quintiles.

Figure 3: Percentage of provider spells belonging to each deprivation quintile

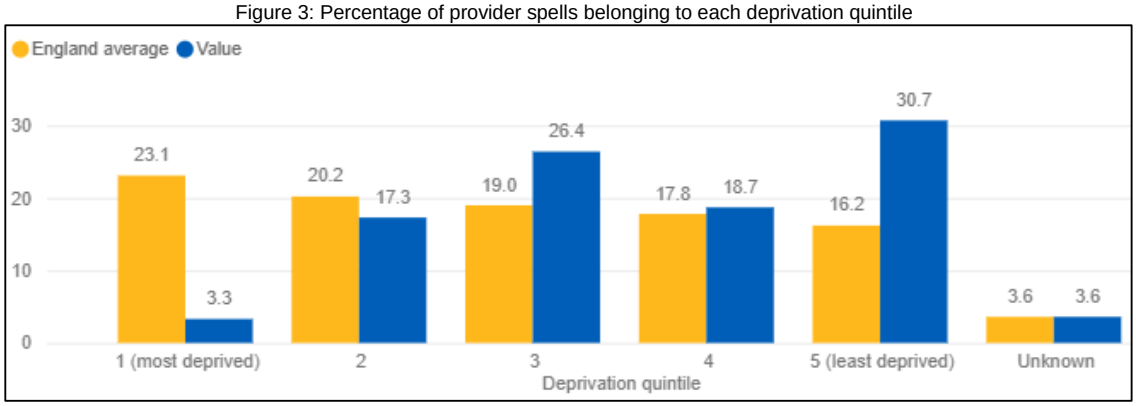
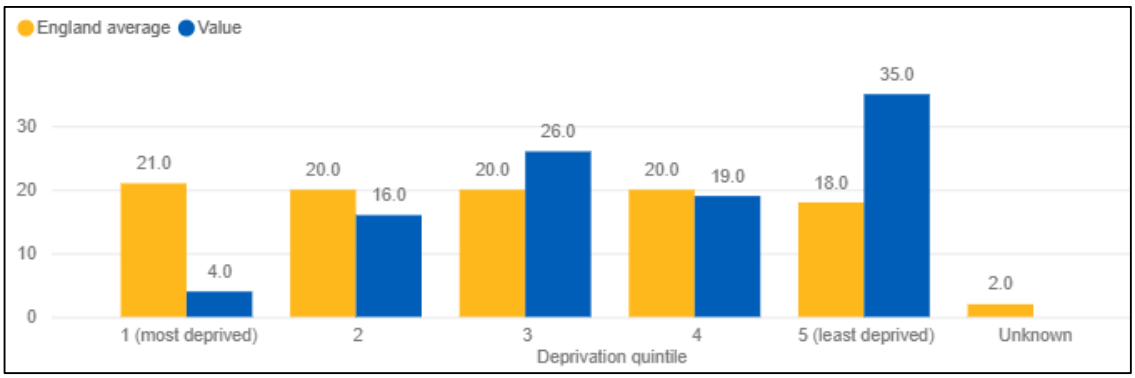


Figure 4: Percentage of deaths reported in SHMI belonging to each deprivation quintile: R12M to February 2025

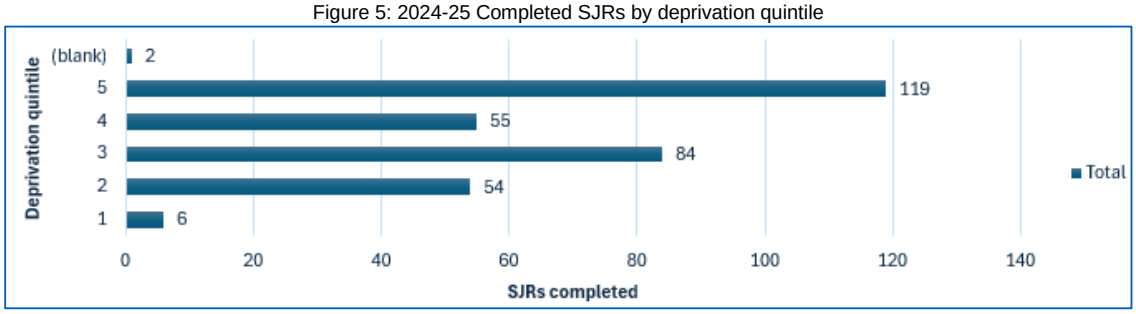


Deprivation quintiles classify small geographic areas, using postcodes, into five groups based on their relative level of disadvantage, with Quintile 1 representing the most deprived areas and Quintile 5 the least deprived. We are working with our business intelligence colleagues to improve the accessibility of this deprivation information, with the aim of routinely including deaths of patients from lower quintiles in deaths selected for structured judgement review.

While we have recognised above that in comparison to the national picture, we have relatively low levels of deprivation in our geographical area, this will enable us to identify specific learning or themes that may help us to address potential health inequalities for this small, but vulnerable cohort of patients in our geographical area.

2024-25 SJR deprivation quintile data
As an initial exercise we checked the deprivation quintile data for the 320 deceased patients whose deaths were subject to a structured judgement review for the 2024-25 year.

Figure 5: 2024-25 Completed SJRs by deprivation quintile



What was immediately apparent was the close correlation seen between the ratio of deaths by quintile seen in the SHMI indicator and in the deaths which received an SJR.

Table 4: SHMI indicator/SJR deprivation quintile comparison

Deprivation Quintile	% of deaths reported in SHMI	% of deaths (SJR reviews)
1	4	2
2	16	17
3	26	26
4	19	17
5	35	37
Not known		1

Focussing on the six deaths reviewed matched to quintile 1: minor concerns regarding problems in care in 2 cases resulted in escalation as patient safety incidents; in 5/6 cases the death was assessed to have been definitely not preventable, and in the remaining one, there was slight evidence of preventability; 5/6 deaths was expected and the other was due to an un-survivable event; finally, in 3/6 cases the care was judged as adequate and in 3/6 it was judged to have been of a good standard. In summary, this initial high-level review, did not flag any significant themes or concerns.

This report has included all the health inequalities detail from the full report to Q&SC. Future reports may include a reduced extract, subject to initial feedback from the Board as to the usefulness of this level of detail.

2.4 Key Learning from Deaths Data

2.4.1 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 Q1 2025-26.

Table 5: Q1 2025-26: Learning from deaths data

	Apr	May	Jun
Total in-hospital deaths (ED & inpatient)	117	122	104
SJRs completed on in-month deaths (at 23.07.25)	24	20	16
Patient safety incident escalation from SJR (by month of death) (at 23.07.25)	7	3	2
SJR outcome: Deaths more likely than not due to problem in care (≥50%) (at 23.07.25)	0	1*	0
Learning disability deaths	1	0	2

Mental illness deaths	3	2	2
Stillbirths	0	0	1
Child deaths (including neonates/CED**)	1	0	0
Maternity deaths	0	0	0
PSIIs reported regarding deceased patient	1 ***	0	0
PSIIs approved regarding deceased patient	0	1	0
Complaints received in month regarding deceased patient	2	2	5
Requests received in month for a Report to the Coroner	3	8	10
Regulation 28 (Prevention of Future Deaths)	0	0	0

Notes:

* *In this case the concerns related to care provided prior to admission. The patient had been discharged from PAH with 1 week supply of anticoagulants with instruction for repeat prescription by GP. This did not happen. The reviewer did not consider that the care provided in-hospital by the Trust contributed to the outcome.*

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

*** *Following detailed MDT review, the incident was downgraded with agreement that the appropriate learning response was a corporate roundtable.*

2.4.2 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 6: Medical Examiner scrutiny data: Q1 2025-26

Scrutiny detail	Apr	May	Jun	Q1 Total
Total in-hospital deaths (excluding MVCC)*	118	123	104	345
ENHT deaths scrutinised by ME	118	123	104	345
MCCDs not completed within 3 calendar days of death	15	18	8	41
ME referrals to Coroner	21	13	19	53**
Deaths where significant concern re quality of care raised by bereaved families/carers	1	1	3	5
Patient safety incidents notified by ME office as a result of scrutiny	0	0	2	2
ME referrals for SJR	34	34	28	96
Community deaths reviewed	174	198	214	586
Deaths referred by the Coroner to ME office to review	58	38	16	112
Total deaths reviewed				1043

Notes:

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

** *Please note that of the 53 coroner referrals made for Qtr 1, 27 were either for a post mortem or an inquest. The remaining 26 were deaths that the Coroner did not take for investigation, and we were able to issue the MCCD to the registration office.*

Due to a change in Hertfordshire Constabulary processes relating to notification of deaths, the number of deaths being referred by them to the Coroner is decreasing. Now, if a death meets certain criteria, the Police no longer need to attend, and the death will not be referred to the Coroner. Rather than these being referred to our ME office by the Coroner, we will receive them as a community death referral from the GP surgery when they are notified of the death.

Recent Regional Data comparisons received for the East of England show that our turnaround times are above the regional average. We consistently work hard as a team to ensure the bereaved are supported and that delays to the cause of death paperwork are minimised.

While at the beginning of the Q1 the service was still struggling to get doctors to attend on time to complete the MCCD; there have since been signs of improvement.

The volume of Community deaths has remained consistently high. Additional staffing, to both the Medical Examiner and Medical Examiner Office teams would be beneficial in order for the team to continue to provide a robust, effective service.

3.2 Structured Judgement Reviews

3.2.1 SJR process and methodology

In July 2022, the FutureNHS/Better Tomorrow SJR*Plus* mortality review format and e-review tool was adopted. From the end of April 2024, the 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 7: Headline 2025-26 Year-to-date SJR and deaths data

Data count	Apr	May	Jun	Q1 Total
Total in-patient deaths	109	116	96	321
Total ED deaths	8	6	8	22
SJRs completed on in-month deaths (at 23.07.2025)	24	20	16	60

The above table shows that by 23 July 2025, 17% of 2025-26 hospital deaths have received a formal structured judgement review. While this matches the 15-20% review target suggested by the Better Tomorrow team (now part of Aqua), as being needed to provide robust learning/assurance, it is currently below our internal target of 25%.

3.2.3 Learning beyond SJR

3.2.3.1 SJR patient safety incident escalations

Table 8: Year to end of Q4 Patient Safety Incidents reported following SJR

Escalations for deaths in month (at 23.07.25)	Apr	May	Jun	Total
Patient Safety Incident Escalations from SJRs	7	3	2	12

For deaths in the current year which have been subject to an SJR, 12 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.

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 Q1 one case matching these criteria was concluded and discussed at Mortality Surveillance.

Table 9: Q1 2025-26: Concluded Escalated Cases Summary

SJR/ SI/PSII	Death Preventability (Final MSC decision)	Incident category	Learning themes
SJR & SI	Slight Evidence of Preventability	Clinical Monitoring	Clinical Monitoring/Observations/Planning
SJR	Slight Evidence of Preventability	Delay in Treatment	Readmission, Assessment, Investigation or Diagnosis

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.

A presentation outlining key findings from our learning from deaths work for 2024-25 has been produced and will be shared across the Trust. A copy has been attached at Appendix 2 for information.

4.0 Improvement activity

4.1 Focus areas for improvement/monitoring

Table 10: 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 September. 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: • The latest published SSNAP report covered the period Jan-Mar 2025 and was the first full report following the introduction of the new SSNAP data set. In this report the Trust's rating has dropped from a B to an E. This had been anticipated by the team in light of the changes introduced to the dataset. The significant fall in rating has been experienced by many other trusts, with changes in the parameters, particularly regarding staffing levels, resulting in many trusts reporting deficits against the new indicators, although there has been no decline in performance.

	• Thrombolysis percentages dipped in this quarter but have improved again in recent months, with the team continuing to maintain their weekly case review meetings, implemented as part of the TASC project. • 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 and the team is currently taking part in a regional audit of Mechanical Thrombectomy patients to help improve that key indicator regionally in line with National requirements. • The team has also completed preparatory work with the pharmacy team in readiness for implementation of Tenecteplase for Thrombolysis (in line with new national /NICE guidance), which will improve Thrombolysis and Thrombectomy pathways. Implementation is scheduled for September, once supplies are obtained. • In addition, the team has continued to work with radiology on the implementation of CT perfusion scanning which will improve the pathway for wake-up stroke patients with a start day to be confirmed soon. • The Stroke Standard Operating Procedure and Ring Fencing of Beds Policy have been implemented, both benefiting from increased management support. The team is continuing to monitor progress against its target trajectory for improvement against the 4-hour to stroke unit target, which will be supported by extended registrar cover from September 2025. • Finally, the whole multidisciplinary team continues to work on all aspects of performance which is reflected in the service's overall action plan, discussed at regular performance meetings.
Emergency Laparotomy	In the 2019 National Laparotomy Audit Report, the Trust's risk adjusted mortality for emergency laparotomy stood at 13%, with the Trust ranked in the bottom 20% of reporting Trusts nationally. Since this time the NELA Lead and team have worked tirelessly to improve performance. 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 continued on a strategy to improve the front door to theatre time. A new Emergency Laparotomy pathway is being proposed and has been presented in General Surgery, Anaesthesia/ITU and ED departmental meetings. When implemented this will extend the pathway into ED and should reduce time to theatre. It is hoped that this could become operational in Sept/Oct 2025. The following ongoing challenges persist: • 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 Q1 deaths/SJR/Preventability data (detailing SJRs conducted up to 23 July 2025). The outcome of investigations and actions relating to deaths judged more than 50:50 preventable are discussed by the Mortality Surveillance Committee.

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 used 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 11: 2025-26 SJR preventable deaths data Year to the end of Q1

Data count (at 23.07.2025)	**A**pr	May	**J**un	**Total**
Hospital deaths (ED & inpatient)	117	122	104	343
SJRs completed on in-month deaths	24	20	16	60
% of deaths subject to SJR to date	22%	17%	17%	17%
Deaths judged more likely than not to be due to a problem in healthcare	0	1*	0	1
% SJRs assessed ≥50:50 preventable	0%	5%	0%	2%

Note:
**In this case the concerns related to care provided prior to admission. The patient had been discharged from PAH with 1 week supply of anticoagulants with instruction for repeat prescription by GP. This did not happen. The reviewer did not consider that the care provided in-hospital by the Trust contributed to the outcome*.

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 - June 2025-26

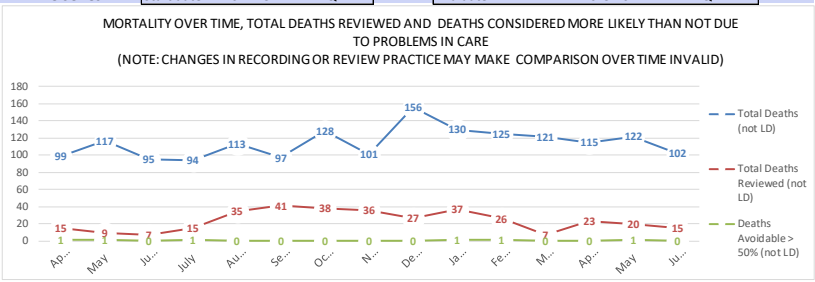
Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

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
102	122	15	20	0	1
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
339	376	58	70	1	2
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
339	1376	58	293	1	5

Time Series: Start date 2024-25 Q1 End date 2025-26 Q1



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

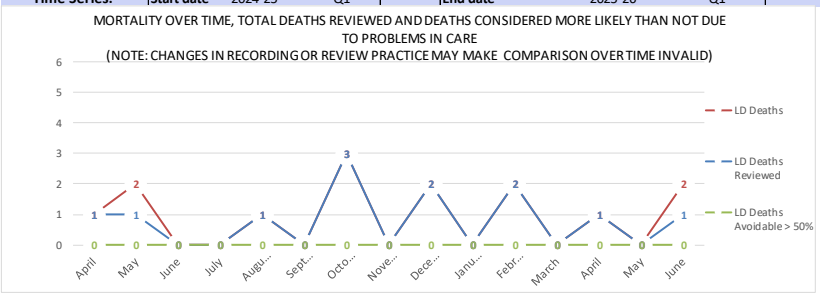
Score 1 Definitely preventable			Score 2 Strong evidence of preventability			Score 3 Probablypreventable (more than 50:50)			Score 4 Probably preventable but not very likely			Score 5 Slight evidence of preventability			Score 6 Definitely not preventable		
This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	15	100.0%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	1	1.8%	This Quarter (QTD)	1	1.8%	This Quarter (QTD)	3	5.3%	This Quarter (QTD	52	91.2%
This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	1	1.8%	This Year (YTD)	1	1.8%	This Year (YTD)	3	5.3%	This Year (YTD)	52	91.2%

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
2	0	1	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
3	2	2	2	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
3	11	2	10	0	0

Time Series: Start date 2024-25 Q1 End date 2025-26 Q1



Appendix 2: Learning from Deaths: 2024-25 Summary

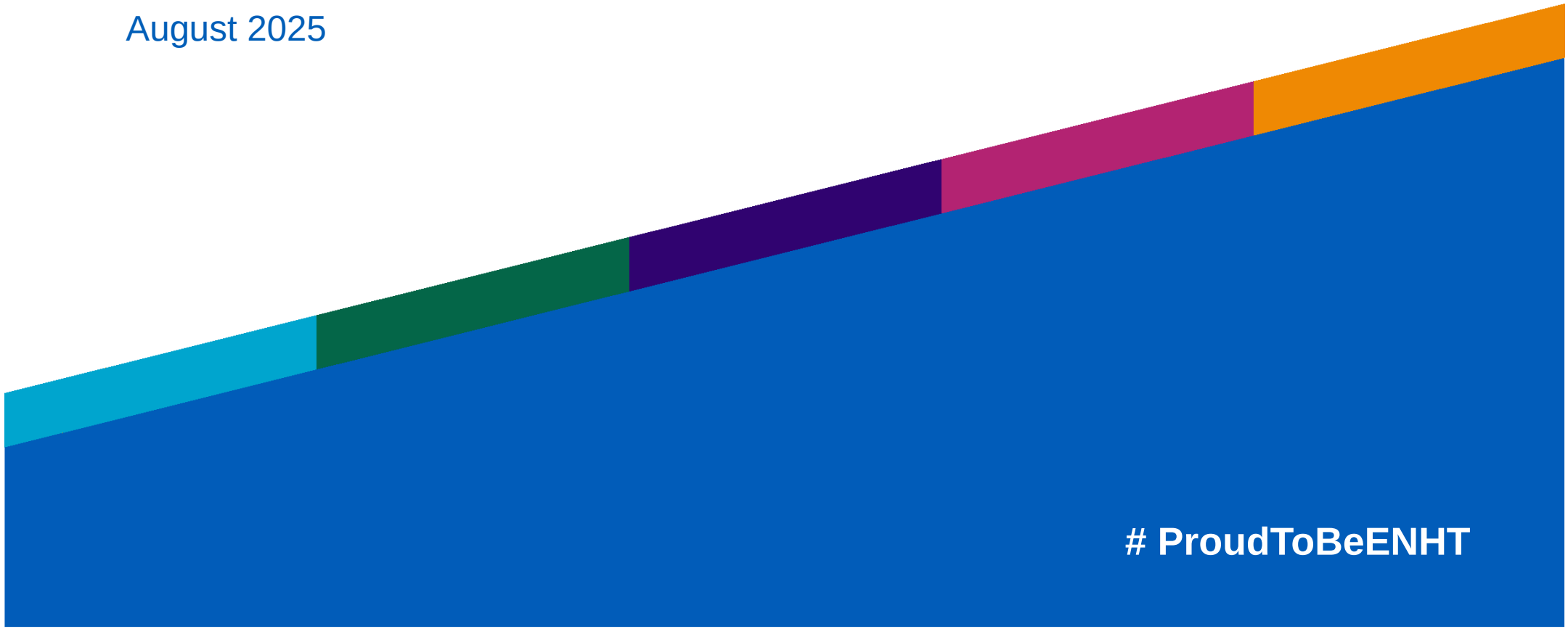
Learning from Deaths 2024-25 Sum

Learning from Deaths: 2024-25 Summary

Sarah El Sharnoubi

August 2025

East and North Hertfordshire Teaching NHS Trust



In hospital deaths

East and North Hertfordshire Teaching NHS Trust

2024-25 in-hospital deaths data													
	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**
Total in-hospital deaths	100	119	96	95	114	98	131	103	158	131	129	121	**1395**

Headline SJR data: 2024-25 deaths

East and North Hertfordshire Teaching NHS Trust

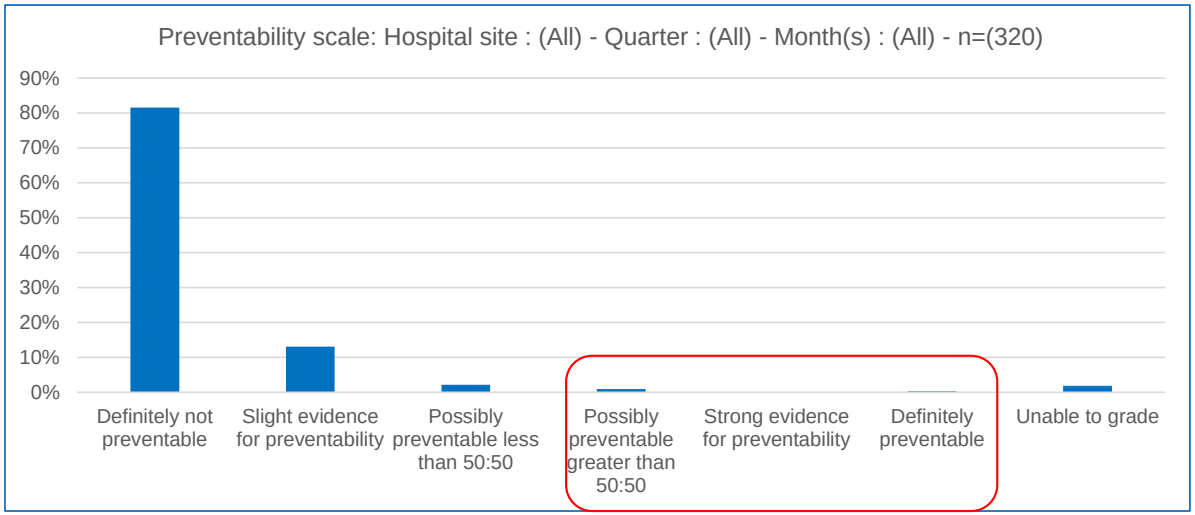
Total in-patient deaths	1280	
Number of deaths reviewed (by 30 April 2025)	320	(25%) *vs 25% target*
SJR assessment that death >50:50 preventable	4	(1.25%) *(Hogan/PRISM study 2009-10 estimated preventable deaths ≈ 5% nationally)*
>50:50 preventable cases downgraded following further patient safety review/investigation	1 3	Concluded tbc

East and North Hertfordshire Teaching NHS Trust

Key SJR findings…

Preventability

East and North Hertfordshire Teaching NHS Trust



Definitely not preventable	261	81.6%
Slight evidence for preventability	42	13.1%
Possibly preventable less than 50:50	7	2.2%
Possibly preventable greater than 50:50	3	0.9%
Strong evidence for preventability	0	0.0%
Definitely preventable	1	0.3%
Unable to grade	6	1.9%
Grand Total	**320**	**100.0%**

Deaths more likely than not due to a problem with healthcare

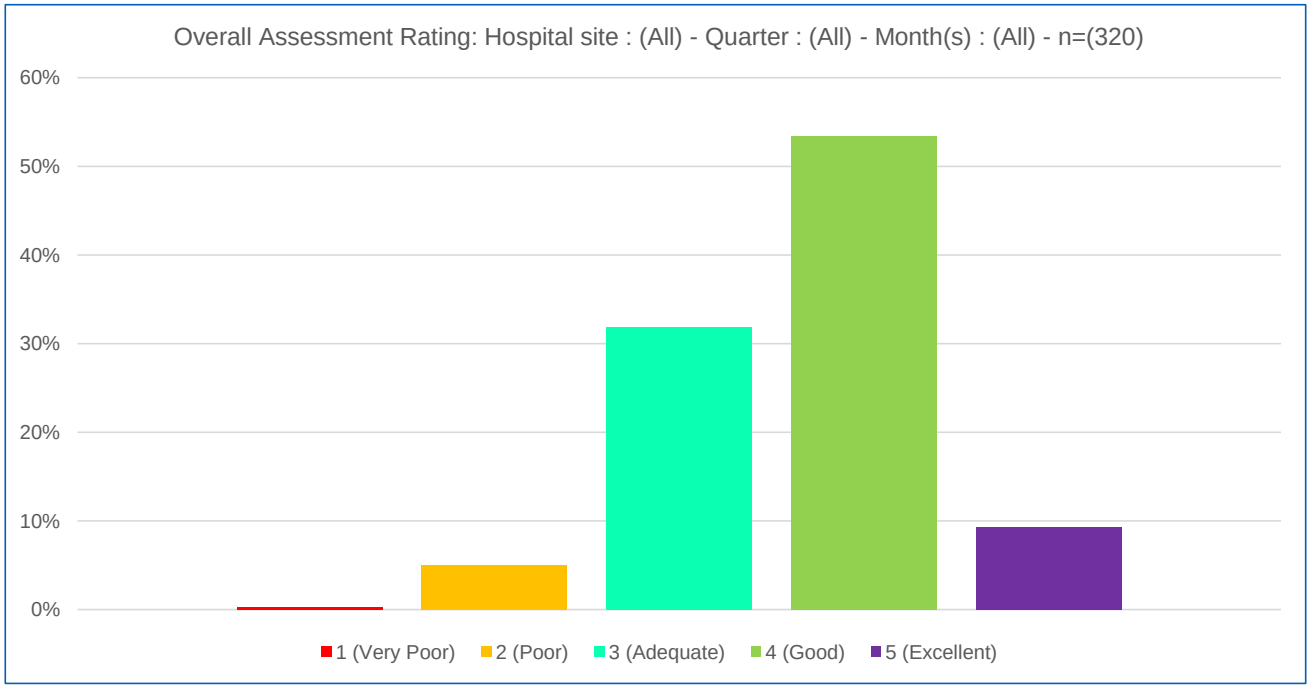
NHS
East and North Hertfordshire Teaching NHS Trust

Possibly preventable greater than 50:50	3	0.9%
Strong evidence for preventability	0	0.0%
Definitely preventable	1	0.3%

Specialty	Count	Summary of concern	Outcome
Vascular Surgery	1	Delay in decision making	Downgraded at PSERP to possibly preventable, less than 50-50 Discussed at MSC March 2025 who agreed with PSERP
ED	1	Query - missed stroke	Awaiting Discussion
Respiratory	1	Failure to address AKI	Discussed at DISH, they disagree with preventability score and are escalating to PSERP
Acute Medicine	1	Opioid related constipation – COD 1a) Ischaemic bowel disease 1b) Large bowel perforation with sigmoid diverticulitis	Corporate Round Table report to go to PSERP

Quality of Care ratings

East and North Hertfordshire Teaching NHS Trust

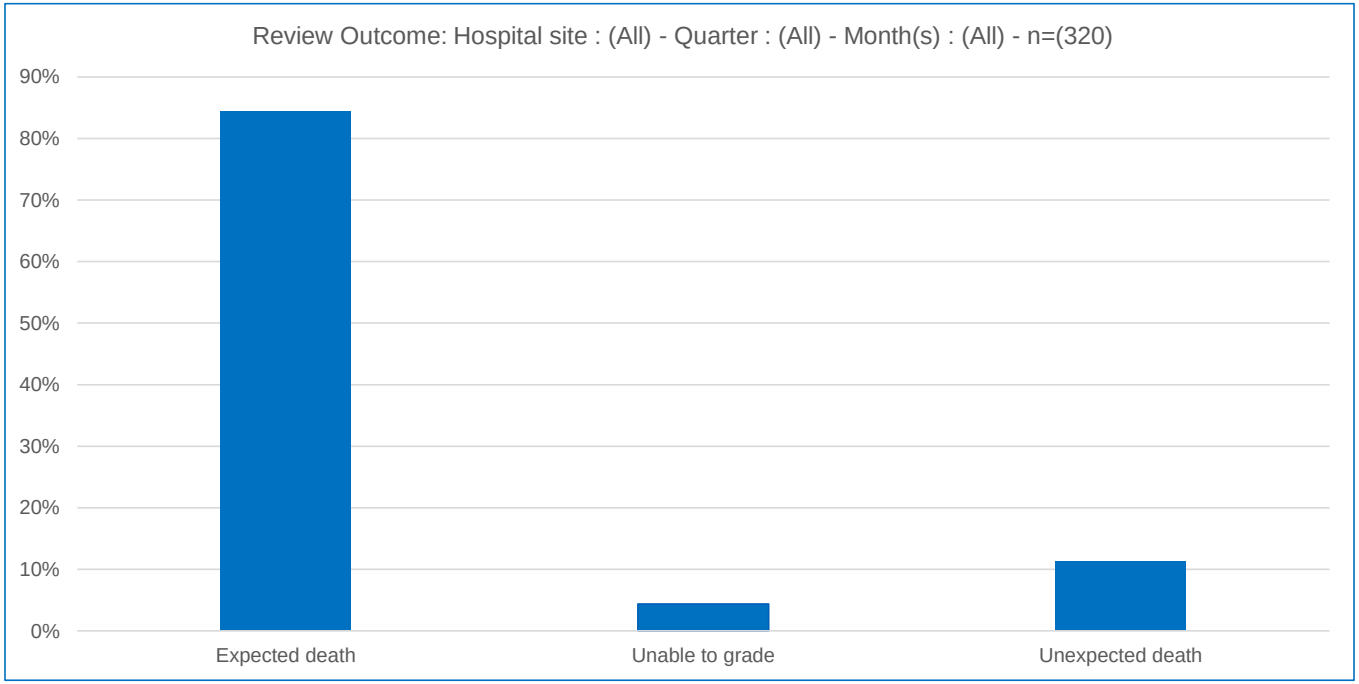


	n.	%
1 (Very Poor)	1	0.3%
2 (Poor)	16	5.0%
3 (Adequate)	102	31.9%
4 (Good)	171	53.4%
5 (Excellent)	30	9.4%
Grand Total	**320**	**100%**

number of not applicable records 0

Expected/unexpected deaths

East and North Hertfordshire Teaching NHS Trust

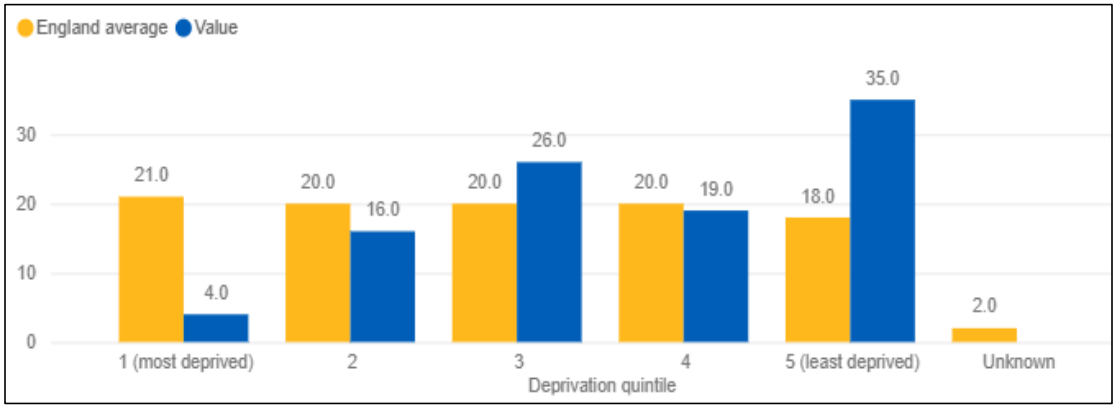


Review outcome	n.	%
Expected death	270	84.4%
Unable to grade	14	4.4%
Unexpected death	36	11.3%
Grand total	**320**	**100.0%**

Health inequalities – what SHMI tell us

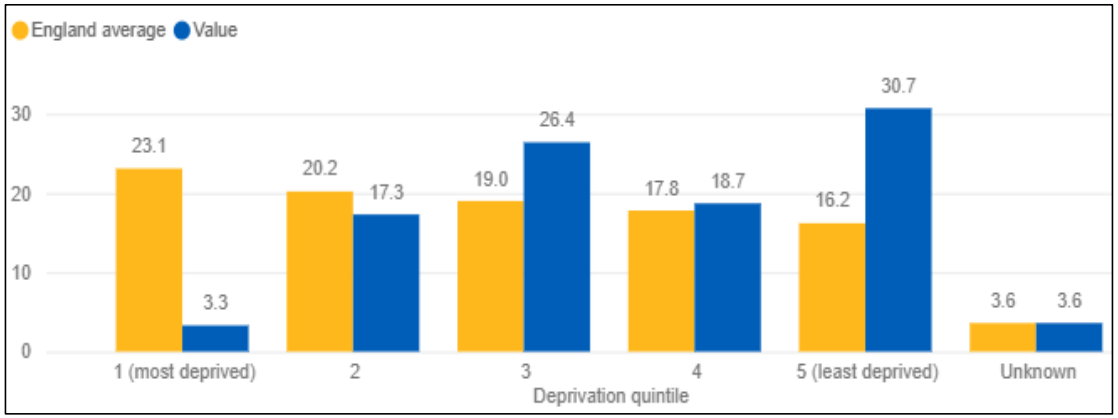
East and North Hertfordshire Teaching NHS Trust

Percentage of deaths reported in SHMI belonging to each deprivation quintile: R12M to February 2025



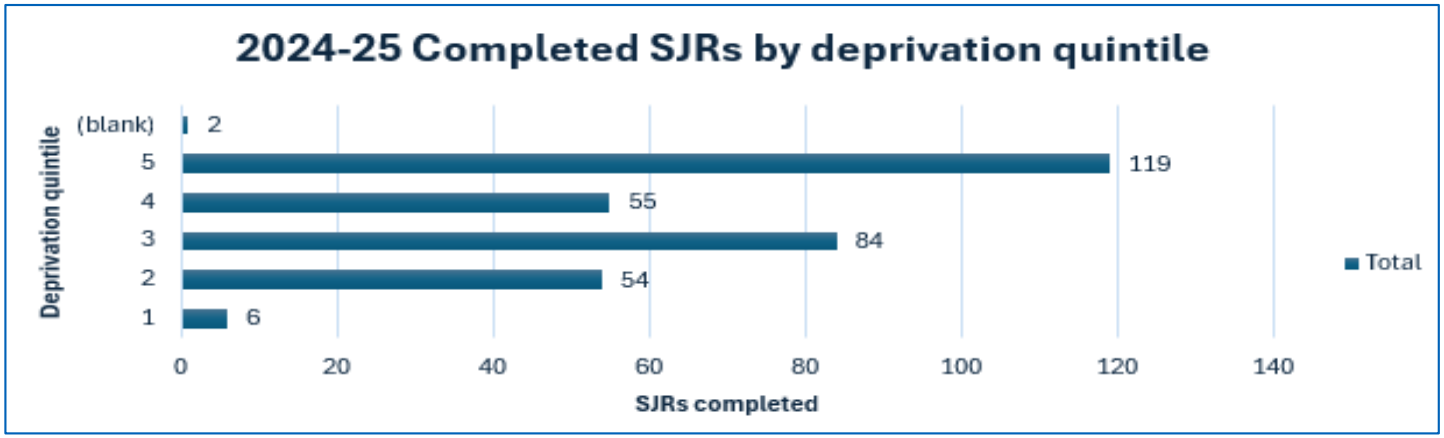
What is known and is clear from this data is that our Trust has a significantly higher percentage of activity relating to those in quintile 5 (least deprived) and significantly less activity relating to those in quintile 1 (most deprived) than the national average and that this is mirrored by the percentage of deaths in those quintiles.

Percentage of provider spells belonging to each deprivation quintile



Health inequalities – what SJRs tell us

East and North Hertfordshire Teaching NHS Trust



A close correlation was seen in the ratio of deaths by quintile seen in the SHMI indicator and in the deaths which received an SJR

Deprivation Quintile	% of deaths reported in SHMI	% of deaths (SJR reviews)
1	4	2
2	16	17
3	26	26
4	19	17
5	35	37
Not known		1

Focussing on the six deaths reviewed matched to quintile 1: minor concerns regarding problems in care in 2 cases resulted in escalation as patient safety incidents; in 5/6 cases the death was assessed to have been definitely not preventable, and in the remaining one, there was slight evidence of preventability; 5/6 deaths was expected and the other was due to an un-survivable event; finally, in 3/6 cases the care was judged as adequate and in 3/6 it was judged to have been of a good standard. In summary, this initial high-level review, did not flag any significant themes or concerns.

Positive lessons learned

NHS
East and North Hertfordshire Teaching NHS Trust

1. **Communication and Documentation**: Consistently good communication with families and patients, sensitive discussions about end-of-life care, and clear documentation of care priorities and decisions
2. **Multidisciplinary Team (MDT) Involvement**: Strong collaboration across specialties, including ITU, Gastroenterology, Oncology, and Palliative Care, ensuring comprehensive care
3. **End-of-Life Care**: Excellent palliative care provided, with involvement of families and timely recognition of patients nearing the end of life
4. **Clinical Management**: Timely interventions, such as early administration of antibiotics, optimal treatment planning, and proactive management in emergency settings
5. **Coordination of Care**: Effective handovers, senior reviews, and tailored care plans to address complex medical needs
6. **Patient-Centred Care**: Respect for patient wishes, including facilitating leave from the ward and providing full information about treatment options
7. **Technical Excellence**: Examples of excellent surgical and ITU care, including during procedures and thorough investigations
8. **Proactive Identification**: Early recognition of deteriorating patients and timely escalation of care

Note: These two summaries highlighting areas of excellence in patient care and systemic and procedural gaps that require improvement were compiled from review narrative using AI

Negative lessons learned

NHS
East and North Hertfordshire Teaching NHS Trust

1. **Delays in Care**: Delays in ED assessment, bed allocation, investigations, and procedures (eg, NG tube insertion, sepsis management, and palliative care referrals)
2. **Documentation Issues**: Poor or incomplete documentation, including TEP/DNACPR forms, nutritional assessments, fluid balance charts, and clinical reasoning during deterioration
3. **Communication Gaps**: Lack of clarity in communication with families, primary care, and between medical teams, leading to missed opportunities for advanced care planning
4. **Medication Errors**: Omissions, duplications, and delays in prescribing essential medications, including anticoagulants and pain relief
5. **Missed Opportunities**: Failure to initiate timely palliative care, advanced care planning, or Gold Standard Framework, and missed recognition of conditions like sepsis or stroke symptoms
6. **Systemic Issues**: Bed pressures, equipment failures, and lack of emergency services (e.g., colonic stenting) negatively impacting patient care
7. **Inappropriate Management**: Patients managed under the wrong specialty, lack of continuity in care, and insufficient monitoring during transfers or deterioration
8. **End-of-Life Care Deficiencies**: Delayed symptom control, poor management of hydration/nutrition, and inadequate preparation for end-of-life care

Note: These two summaries highlighting areas of excellence in patient care and systemic and procedural gaps that require improvement were compiled from review narrative using AI

How we can improve our SJRs

NHS
East and North Hertfordshire Teaching NHS Trust

- Improve timeliness of review
- Preventability rating:
  - Encourage consistency of approach to assessing preventability
  - Include rationale re preventability ratings to provide clarity to further review
- Continue to reduce clinical narrative content
- Continue to sharpen structured judgements made regarding the quality of care
- Encourage reviewers to consider and include suggestions for where learning should be shared

East and North Hertfordshire Teaching NHS Trust

Beyond SJR…

Maternity, Neonatal, Child deaths

NHS
East and North Hertfordshire Teaching NHS Trust

Category	2024-25 Total	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Maternity	0	0	0	0	0	0	0	0	0	0	0	0	0
Children - ED	4	0	0	0	1	0	1	1	1	1	1	0	0
Children - IP	2	0	0	0	0	0	0	0	2	0	0	0	0
Stillbirths	7	1	0	1	2	2	0	0	0	0	0	0	1
Medical Termination (born alive)	2	0	0	0	1	0	0	1	1	0	0	0	0
Neonatal (Pre-term: non-viable ≤ 22 wks)	3	0	0	1	0	0	0	0	0	0	0	2	0
Neonatal (Pre-term: viable ≥ 22 wks)	0	0	0	0	0	0	0	0	0	0	0	0	0
Full term birth neonatal death within 28 days	0	0	0	0	0	0	0	0	0	0	0	0	0

- Maternity, neonatal and child deaths are all subject to strict national review and learning processes
- Key information is included in the quarterly Learning from Death report provided to the Mortality Surveillance Committee, Quality & Safety Committee, with a summary going to Board

SJR/PSIRF: Patient Safety escalations

East and North Hertfordshire Teaching NHS Trust

Trigger	Total	Specialty	Specialty Total	Summary of Concern	Outcome
SI/PS II	6	Emergency Department	3	**Drug allergy**	PSII - awaiting presentation at QSC
				Thematic – handover and communication	PSII ongoing
				Absconsion – MH patient	Joint PSII ongoing
		General Surgery	1	**Clinical management: LD patient**	PSII ongoing
		Gastroenterology	1	**Misplaced NG tube**	PSII ongoing
		Trauma and Orthopaedics	1	**VTE assessment**	PSII ongoing
> 50% preventable	4	Vascular Surgery	1	**Delay in decision making**	Downgraded at PSERP to possibly preventable, less than 50-50 Discussed at MSC March 2025 who agreed with PSERP
		Emergency Department	1	**Query - missed stroke**	Awaiting Discussion
		Respiratory	1	**Failure to address AKI**	Discussed at DISH, they disagree with preventability score and are escalating to PSERP
		Acute Medicine	1	**Opioid related constipation – COD** **1a) Ischaemic bowel disease** **1b) Large bowel perforation with sigmoid diverticulitis**	Corporate Round Table report to go to PSERP
Very poor care	1	Acute Medicine	1	**Opioid related constipation – cause of death** **1a) Ischaemic bowel disease** **1b) Large bowel perforation with sigmoid diverticulitis**	Opiod related constipation – cause of death 1a) Ischaemic bowel disease 1b) Large bowel perforation with sigmoid diverticulitis
Local learning	93				9 Closed as local learning

Medical Examiner

NHS
East and North Hertfordshire Teaching NHS Trust

Medical Examiner scrutiny data: 2024-25					
Scrutiny detail	**Q1**	**Q2**	**Q3**	**Q4**	**Total**
Total in-hospital deaths (excluding MVCC)*	316	306	405	387	1414
ENHT deaths scrutinised by ME	290	302	405	387	1384
MCCDs not completed within 3 calendar days of death	25	17	55	45	142
ME referrals to Coroner	55	45	75	67	242
Deaths where significant concern re quality of care raised by bereaved families/carers	3	0	2	2	7
Patient safety incidents notified by ME office as a result of scrutiny	2	2	0	1	5
ME referrals for SJR	73	66	96	113	348
Community deaths reviewed	457	492	607	661	2217
Deaths referred by the Coroner to ME office to review	107	133	162	195	597
Total deaths reviewed	855	927	1174	1243	**4198**

ME referrals for further action

NHS
East and North Hertfordshire Teaching NHS Trust

Reason given for referral *	Count
Readmission	281
Clinical/medication/care concern	56
Family concern	28
LEDER	8
Patient safety concern	6
Mental Health	5
Multiple admissions	3
Safeguarding	1

* *More than 1 reason may attach to a referral*

Coroner

NHS
East and North Hertfordshire Teaching NHS Trust

Number of deaths resulting in an Inquest being opened and statements requested from ENHT	111
Number of SJRs shared with Coroner	6
Number of Regulation 28: Report to Prevent Future Deaths	0

Key challenges and opportunities

NHS
East and North Hertfordshire Teaching NHS Trust

- We need to continue to focus on maximising the quality of our SJR content
- We need to continue to focus on making the interfaces between our learning, quality improvement and governance processes as seamless and thereby as effective as possible
- We need to work to triangulate SJR findings with outputs from other systems eg, M&M meetings, PSIRF work, complaints, audit…
- We need to explore and maximise the potential for systems integration and IT technology to support not only the triangulation of outputs but to link Trust-wide improvement strategy and activity and to demonstrate improvement:
    - ENHance reporting/linkages
    - Power BI reporting/linkages/accessibility/communication
    - AI – How do we harness the power of AI to improve our analysis/triangulation of data?
- We need to find ways to make it easier for clinical staff to undertake quality assurance/governance work

Focused action

NHS
East and North Hertfordshire Teaching NHS Trust

- Continue to improve the quality of our SJR reviews (including the introduction of some form of QA/peer review)
- Continue to improve the timeliness of SJR completion
- Improve how we use SJR content:
  - M&M/RHD specialty discussions and improvement initiatives
  - Improve our identification of themes and trends (potential for using AI tools to improve analysis?)
  - Improve access to information: development of Power BI dashboards
  - Improve our triangulation with other system outputs
    - Development of SJR mortality module on ENHance
    - Development of Medical Examiner and M&M meeting modules on ENHance???
    - Development of ENHance ‘consolidated’ reporting
- Use the above to strengthen:
  - The quality and clarity of the assurance we provide to Board
  - The sharing of learning across the Trust
  - Our ability to triangulate information to support our quality improvement strategy

Board

East and North Hertfordshire Teaching NHS Trust

Meeting	Public Trust Board		**Agenda Item**	11	
Report title	Board Assurance Framework (BAF) – Strategic Risks		**Meeting Date**	19 November 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 25/26 BAF and these would not have been added by the Board, if the Board was assured about them. Plus 7 of the 11 BAF risks are currently red-rated.

Summary of key issues:

Key updates

- There is one risk score increase: **Risk 3** (System and internal financial constraints): September FPPC agreed to increase the risk score from 16 to 20, reflecting the over-reliance on non-recurrent savings to keep to plan and the implications this has for next year.
- Reviewing and updating the risk appetite for the Trust is on the agenda for the December Board Seminar.
- Proposed performance measures for each BAF risks have been agreed by lead Committees and reviewed by the October's Audit & Risk Committee. TMG are considering the best way of updating on BAF risk performance in an efficient, consistent way.

Board spotlight on two BAF risks

Spotlighted BAF Risk 1 *(*Investment & Estates*) – Martin Armstrong*

- No risk score or assurance score changes are proposed.
- NHSE's recently published medium-term financial planning requirements should support longer term investment planning and with it, it is envisaged, an increase from the current assurance score of 2. The productivity assurance framework score remains at 3.
- Fire safety investment works progress reports go to TMG monthly.

Spotlighted BAF Risk 11 *(*Change management*) – Kevin O'Hart*

- Risk 11 remains appropriately scored at 12 – high impact and possible likelihood.
- The controls are comprehensive and maturing, with improving strategic alignment but variable depth and engagement across the organisation. This is consistent with a system moving from "early adopter" to "early majority" stage on the adoption curve.
- Mitigation actions demonstrate steady progress, especially in leadership development and daily management systems, signalling a downward risk trajectory over the next 12 months as actions further mature and embed.
- These findings correlate with the VMI Health Check (2025) where the Trust has made strong progress across all ten domains of the Transformation Continuum and where

senior leadership are recognising ENHPS as “the way we do things round here”, both in terms of the method and culture change.

Latest on the other BAF risks:

- **Risk 2** (Health inequalities): A Health equity group has been formed to progress and build on the ways forward identified at July’s and September’s Board Seminar.
- **Risk 4** (Workforce morale whilst making necessary staffing savings): PCC requested that Workforce Plan be added as a gap in controls, which can be seen on the updated BAF. A Resourcing Panel has been introduced. It was agreed at PCC to review any assurance scores of 5.
- **Risk 5** (Leadership and engagement): All actions are in date and no assurance scores are below 4, reflected in the lowest risk score of 9 for any BAF risk.
- **Risk 6** (Compliance culture and accountability): The accountability framework has now launched. The Board Seminar in October considered compliance culture and concluded the challenge was not a legal/statutory/regulation compliance one but more an agreed internal standards compliance one.
- **Risk 7** (System instability): The risk score increased in September from 12 to 16. Appointments have now been made for all the executive posts for the new Central East ICB, which will help reduce this risk as the new structure and relationships embed.
- **Risk 8** (Flow and performance): No risk score or assurance score changes are proposed. The IPR demonstrates progress on A&E performance.
- **Risk 9** (The future of cancer services): There has been good progress with gaps in control addressed by identified actions being completed for four gaps. Most critically, a business continuity plan is now in place should acute Mount Vernon services need to close at short notice.
- **Risk 10** (Digital transformation): Although the One-EPR rollout is taking longer, the recommendation to the Digital Committee is not to increase the risk score beyond 16. With the Digital Committee meeting on 14 November after Board papers finalisation, if there are any crucial updates these will be updated at the Board meeting. The Digital Committee moving to monthly and becoming permanent is intended to assist Board assurance assessment.

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*

N/A

Report previously considered at & date(s):

Board on 10 September; Digital Committee 14 November; People & Culture Committee 4 November; Audit & Risk Committee 7 October; Quality & Safety Committee 24 September; Finance, Planning and Performance Committee 29 September.

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

To be trusted to provide consistently outstanding care and exemplary service

NHS
East and North Hertfordshire Teaching NHS Trust

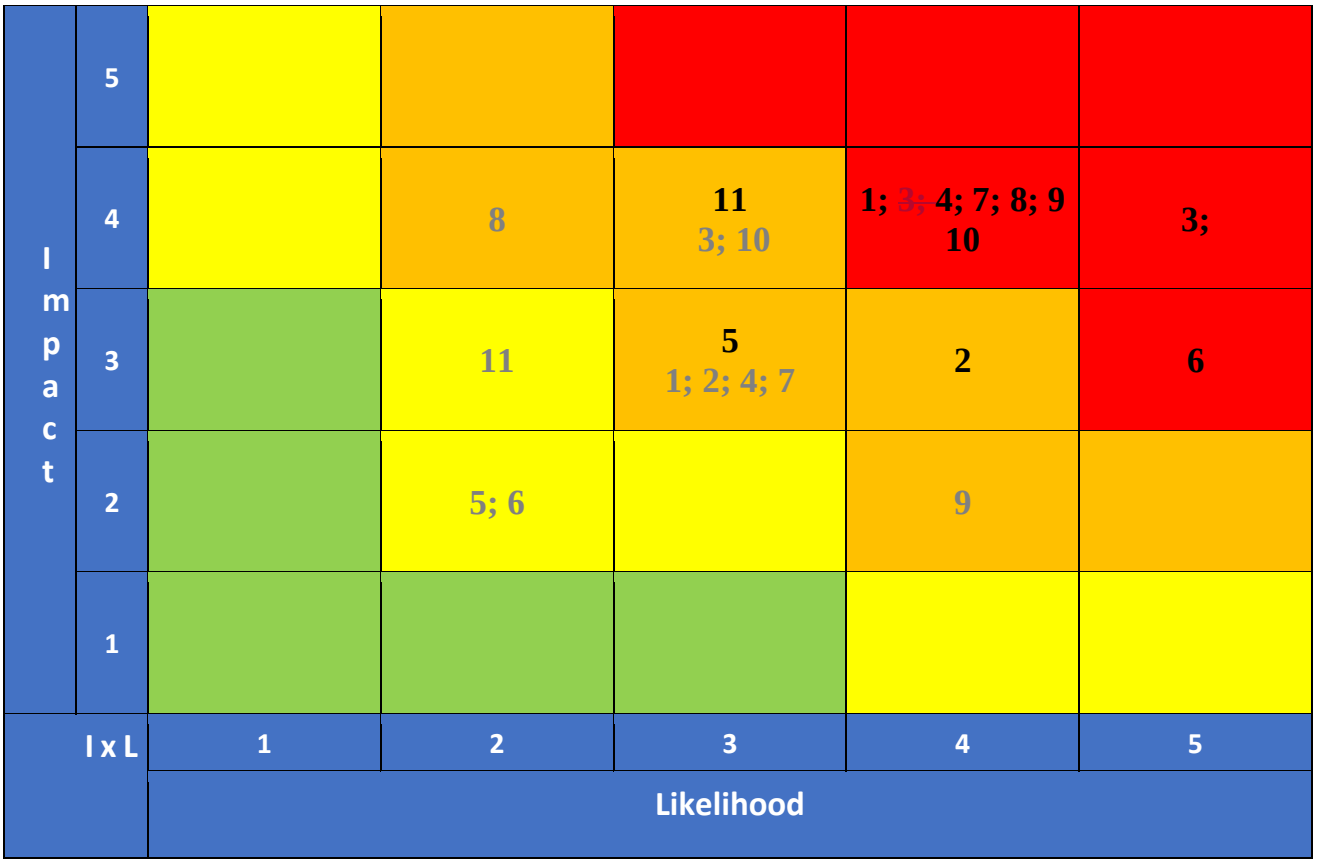
BOARD ASSURANCE FRAMEWORK REPORT

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~~20	↑
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 instability**	Deputy Chief Executive (CFO)	Finance, Performance & Planning	16	⟷
8.	**Improving 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	OneEPR Committee	16	⟷
11.	**Change management**	Chief Kaizen Officer	People & Culture	12	⟷

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**

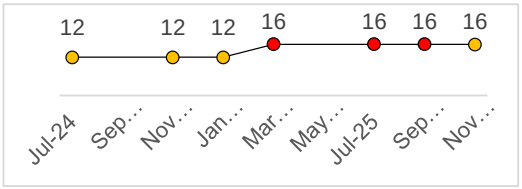
NHS East and North Hertfordshire NHS Trust

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 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	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	Annual Capital Plan reviewed and approved by FPPC (2)	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)	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)	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~~Dec 25 Board Seminar combined with supplementary development of revised long-term financial model	MA	~~Sept~~Dec 25 [originally Sept 25]
• Transformational solutions to address the system financial gap	• 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	~~Q1~~Q2 25/26 [originally 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.	MA	25/26 – ICB Place reconfiguration 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. • Preliminary Outputs coming to FPPC in Oct 25	MA	~~Oct~~Q3 25/26 [originally 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
• Medium term financial plan	• FPPC review of medium term financial plan refreshed ~~post 25/~~as part of 26/27 planning round • Integrate Trust LTFM output into revised system medium term plan informed by comprehensive spending revie output and system transformation strategy	MA	Oct 25

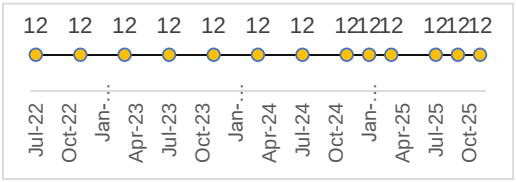
Current Performance – Highlights from the Integrated Performance Report:
• The Trust workforce has expanded significantly since COVID. This represents a significant financial investment, although activity delivery and productivity has declined. • Underlying in year financial performance is at significant variance to plan. • The Trust has agreed a £~~15m~~33m capital investment plan for ~~24/~~25~~-~~/26. • ~~Profile~~The profile of capital spend delivery in year is planned and monitored by the Capital Infrastructure Group (CIG) • H&S compliance assurance ratings. Fire Safety investment works reported on a monthly basis to TMG • ~~Headcount tracker~~HWE ICS overall financial performance whilst on plan year to date, forecasts a significant shortfall at 25/26 year end

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**		
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)		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 national smoke free pledge	Signed off by board (2), smoking shelter removed, ongoing work with HPFT around their patients smoking, signage changes,	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
• 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], waiting list has dropped by 2,000 (August 25) but still needs further infrastructure change	DON	See Corporate Risk Register
• Community paediatric long waits for assessment	• Ongoing ICB working group, national and regional focus on improvement	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	MD	
• No dedicated work plan	• Lack of resource makes this challenging • ~~For November Board spotlight discussion~~ • Health inequality self-assessment undertaken • Health equity group in formation	MD	

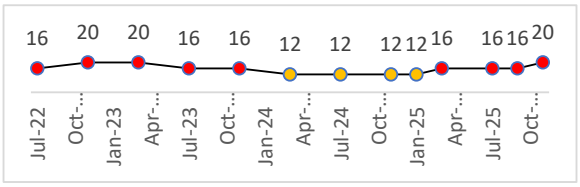
Current Performance – Highlights from the Integrated Performance Report:
• ED 4 hour standard, 12 hour performance • 28 day faster diagnosis standards • DMO1 – audiology • 65 week waits for community paediatrics update 6.8.25: further work to do with HPFT re smoking and their patients and staff on site. good progress on audiology waiting lists limited progress on paediatric community waits health inequality self-assessment completed health equity group being formed 3P for future state of paediatric infrastructure and services undertaken

Associated Risks on the Corporate Risk Register		
Risk no.	Description	Current score
3027	Risk of Regulatory non-compliance within Audiology Service	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~~12
3114	Risk to new mothers and babies due to cross-border	16

Strategic Priority: **Consistently deliver quality standards, targeting health inequalities and involving patients in their care**			**Risk score** ~~16~~20
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~~5	~~16~~20	
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 25/26 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
	25/26 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)	6
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 System 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~~December Board Seminar	• MA	• ~~July~~Dec 25 [originally 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~~SJ • S~~D~~J • All Execs	• Q2 25/26 • Q2 25/26 • Oct 25
• Delivery of Trust RTT Plan and impact on Trust financial plan	• 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~~LD	• Q2 25/26
• Risk of non delivery of CIP / Savings Targets	• ~~Regular review of CIP and Recovery plan delivery through FPPC and Delivery Board~~	• MA • MA • All Execs	• In place • In place • Sep-25

	• ~~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	• ~~Embedding regular hotspot reporting to track expenditure at variance to budget plans~~	• MA	• In place~~Q2 25/26~~
• Understanding of financial dynamics underpinning service line performance	• Implementation of SLR model – now in go-live • Service Line productivity line production • Revised and summarised productivity report to TMG focusing on actionable insights metrics and levers – revised productivity report to FPPC • – complete with Accountability Framework	• DP / LL • Divisions • DP • MA	• Q2 25/26 • ~~Q1~~Q2 25/26 [originally Q1 25/26] • Sept 25 • Sept 25
• 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~~is required to refresh its medium ~~terms~~term financial plan ~~based upon agreed national and local assumptions.~~. To be used to frame the ~~development of the 25/~~26/27 financial plan • Development of long-term financial model to report to FPPC in Oct and integration with system medium-term financial plan incorporating ~~CSR~~national planning and 10Y plan assumptions ~~and system transformation plan~~.	• MA	• 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.	• Productivity report, with an emphasis on insight and actionable activity to be implemented and presented to committee ~~from Sept~~in 25 ~~onwards the development~~/26. A series of ~~a 'Productivity Index, to FPPC. Productivity QV app deployed~~AI generated productivity assessments are being developed 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	• DP • SJ	• Q3 25/26 • Q2 25/26

Current Performance – Highlights from the Integrated Performance Report:
• The Trust reports a YTD deficit of £~~8.2m @ M2~~9.6m @ M5, this is in line with the plan • As at Month ~~2~~5 the Trust ERF plans are significantly behind plan. ~~Some~~A range of pay pressures have also emerged • The Trust CIP plan for 25/26 is £35.8m. To date ~~£16~~only £21.5m has been fully identified and agreed against that target • 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

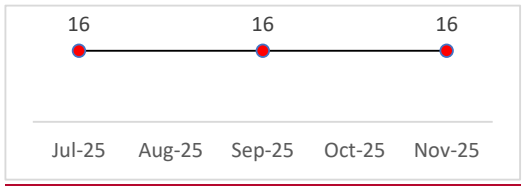
- ~~Year on year overspend on Directorate budgets~~An outturn forecast exercise during Q2 has highlighted a significant anticipated gap to plan unless corrective action is undertaken. The TMG and Delivery Board have reviewed a range of mitigating actions to bridge this gap. The position and associated actions have been reviewed and considered by FPPC and Trust Board.
- September FPPC to review credible route to financial plan delivery. Overall BAF risk score to be reviewed at this point.

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
Inherent	4	5	20	4
Current	**4**	**4**	**16**	
Target	3	3	9	

Risk Trend



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)	6

	Wellbeing questions part of annual staff survey 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

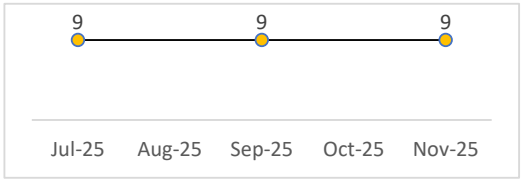
Gaps in Controls and Assurances	Actions and mitigations to address gaps	Lead	Target date
• Inability to recruit to key posts at speed due to CIPS not delivered	• We have continued to recruit successfully to key posts; where appropriate people Partners are supporting business areas with redesign of work and accountability to address skill/people gaps • We are also in the process of introducing a Resourcing Panel, designed to replace the Vacancy Control Panel with a broader remit than just vacancies and will look at setting and controlling the right type of resourcing for the Trust.	• CPO	• In progress already First meeting 24 October 2025
• Mutually Agreed Resignation Scheme	• To approve MARS scheme and enact- PHASE 1 HAS BEEN COMPLETED	• CPO	• Nov 25
• Establishment growth controls • Better infrastructure for agreeing establishment and funding for posts (planning process)	• Consistency of HR and Finance data – a working group has been set up and a pilot area/methodology identified. If the pilot works well we will roll out across the Trust.	• CFO and CPO	• Mar 26
• Capacity of staff to deliver expected improvements and BAU with reduced staff	• Redesign ways of working • ~~Use AI and digital solutions~~Use AI and digital solutions – currently exploring how to automate minutes for meetings (and question why each meeting needs minutes and not decision/action logs) using Teams transcribe and CoPilot. • Use a prioritisation methodology such as MoSCoW to identify real priorities and consider stopping some work. • Work with leadership population on reducing the strategic objectives from 8 to 4	• Executive Directors • CPO KPO	• In progress now e.g. minute taking 14 Oct 2025.
• Workforce Plan	• Develop a workforce plan • Seek Board input at a Board Seminar	• CPO	• July 26 • Dec 25

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	
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)	6

	Staff survey question on appraisals (3)	
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~~4
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

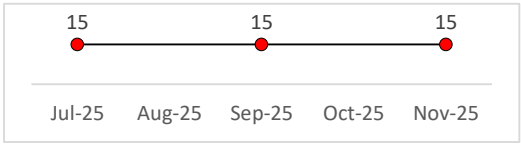
Gaps in Controls and Assurances	Actions and mitigations to address gaps	Lead	Target date
• Capacity to undertake support and development in identified areas to improve leadership practice and engagement • Challenges in the level of organisational engagement across ENHT to make things happen and embed 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 development alongside day-	• Creative delivery and support to enable release and participation. Pilots with local events, bitesize and development coaching in order to use time effectively. Use	• CPO	• Mar 26

to-day priorities	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	• This will need to form part of the new People team offer	• CPO	• Mar 26

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 **12**
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	
Current	4	3	12		
Target	~~2~~4	2	~~4~~8		

Risk Lead	Chief People 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		
Accountability Framework	Accountability framework ~~set to launch in next few weeks~~ progress report to FPPC (2)	6
Policies	Scheduled reports to PCC (2) (since introduced in July 25)	7
Stat Mand training	Report to PCC (2)	~~7~~5
Q&S framework	~~TBC~~ Quality & Safety Committee (2)	4
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)	6
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 • Current required mandatory and statutory training being reviewed to determine options for reducing demand	Emma Martin	Dec 2025
• 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~~Mar26
• Values not always understood and demonstrated by all staff	• TBC	• CEO	• Mar ~~25~~26
• Leadership culture modelling/enabling accountability	• ~~Launch of accountability framework~~ • Redefining 'The Trust Way' on the agenda for Board in December 2025	• ~~CFO~~ • CPO	• ~~Oct 2025~~Complete • Dec 2025

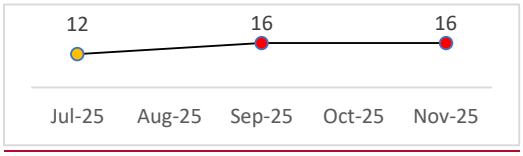
Current Performance – Highlights from the Integrated Performance Report:
• CIPs delivery • Policies: Proactive action in this area has resulted in 89% policy compliance with a comprehensive and timed plan in place to ensure review and refresh of all outstanding policies. A further 2 policies agreed at LNC now waiting sign off at TMG so likely to be >90% • Stand/Mand training: Current performance 88.6% with a focus for People Partners to raise at management team meetings to get over the line of >90% • GROW • Updated risks • Referrals to professional/regulatory bodies e.g. NMC/CQC

Associated Risks on the Corporate Risk Register		
Risk no.	Description	Current score
0048	~~N/A~~Discharge letters not being completed at the time of discharge	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.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
Inherent	4	4	16	**3**
Current	**4**	**4**	**16**	
Target	3	3	9	

Risk Trend



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 (3)	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
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		
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~~ • ~~HCP Committee report to Board from Sept 25~~	• ~~CEO~~	• ~~July 25~~ Complete • ~~Sept 25~~ Complete
• ~~Trust objectives linking and helping deliver the ICB strategy~~	• ~~When 25-26 priorities ICB/HCP priorities will be explicitly referenced.~~	• ~~CEO~~	• ~~Q1 25~~ Complete
• 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~~ Q4 25 [originally Q1 25]
• Embedding the effectiveness of the HCP	• Carry out HCP Board effectiveness review	• CEO	• Q4 25/26
• 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~~New clustering now announced and awaiting appointments to key leadership roles with whom to engage	• NHSE	• ~~June~~ Q3 25 [originally June 25]

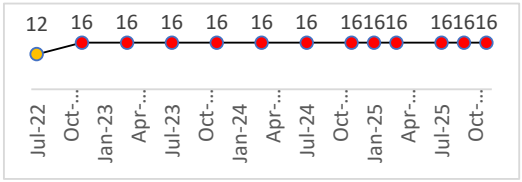
Current Performance – Highlights from the Integrated Performance Report:
• The over-arching system financial break-even plan 2025-26 • NHSE oversight framework assessment of ICB and the Trust • ICB/HCP performance dashboard metrics tracking progress against HCP priorities • Risk increased temporarily due to the current period of change in leadership and rapid development of changes included within the 10 year plan

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

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 **performance**		
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, 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 trajectories (Elective, cancer, diagnostics), 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 [Original: Mar 25]

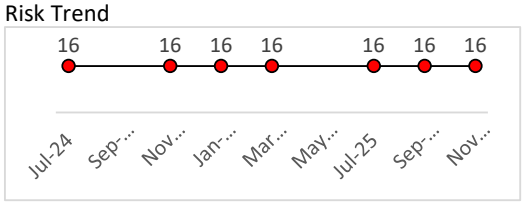
	weeks by 3/26; Reduce to max of 1% the % of patients waiting 52 weeks+ • Escalation meetings in place for RTT and diagnostics		
• Improve UEC pathways	• Sharpen ED processes. • Optimise SDEC pathway. • Optimise Frailty pathway. • Redesign of specialty pathways • Full Capacity Protocol refreshed and in use. • Mental Health Urgent Care Centre at Lister • National UEC Plan (June 2025) • Refresh implementation of Principles of Safe & Effective Emergency Care • Working with system partners on winter planning • 7-day band 7 nursing in place in paediatric ED	• Claire Gowland, Interim Lead DD • Junaid Qazi, Divisional Medical Director • Justin Daniels, Medical Director	• March 2026 [Original: June 25]
• Ambulance Handover	• 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~~Bay, Feb / March 2026 [originally Apr 25]	• Lucy Davies, COO • EEAST • HWE SCC	• March 2026 [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. Weekend working within the transfer of care team and focused resources on long length of stay patients. • Regular MADE weeks. • Further work required to prevent admission for frailty patients includes a frailty assessment unit in ED - trialed in MADE week, opening October 25 • New transport criteria in place	• Redeemed Mzila, Head of Site • Junaid Qazi • Moreblessing Zvorwadza, Divisional Nursing Director • Heidi Hall, Head of Service HCC	• March 2026 [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 - recovery trajectory being developed to reflect updated activity. • Optimise use of community diagnostic capacity • MRI outsourcing now in place with commercial provider.	• ~~Sarah James~~ • Alison Gibson, Deputy COO • Claire Moore, Lead DD	• March 2026 [Original: Mar 25]

	• ~~Audiology capital~~ at Lister ~~underway @June 25~~ • ~~Audiology capital Hertford County~~site allocated @~~June~~Sept 25 [originally June 25] • Audiology HWE mutual aid discussions underway		
• Theatre utilisation and pre – tci cancellation rate	• Recruitment plans ongoing. • 'Drumbeat' huddles to manage activity	• Claire Moore, Lead DD	• March 2026 [Original: Dec 25]

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
3634	Ex ward referrals not being booked into clinic	20
3534	ERS referrals waiting longer than 180 days with no activity against their UBRN will drop off live worklists	8
3663	Risk of the Trust failure to meet to meet its contractual RTT targets and subsequent financial impact	15
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**
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~~three 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	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~~at interview stage with good applicants 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
• Public awareness of the impact of the delay on quality of services	• Proactive communication plan if gap agreed. Consultation ~~planned in autumn 25~~delayed pending agreement on route to capital for new build.	• NHSE/ICB	• Nov 2025

• Outcome of service options to NHSE to enable Trust planning	• ~~Obtaining answer from NHSE/ICB about capital and revenue plans to sustain current services~~[Commercially confidential – update to Private Board]	• Lucy Davies	• ~~April~~August 2025
• 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~~ Preliminary capital ask submitted to NHSE/ICB to sustain current services on site up to 2032. Needs further refinement with detailed site survey to be led by THH.	• Martin Armstrong	• Dec 2025
• 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

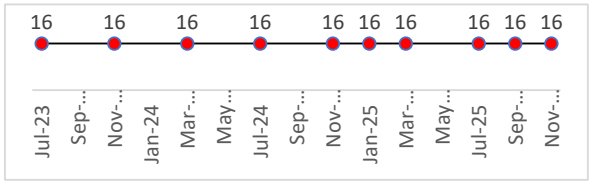
Current Performance – Highlights from the Integrated Performance Report:
• 62 and 31 day cancer performance standards • Faster diagnosis standard • 30 day SACT mortality data • COSD cancer data

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
Inherent	4	4	16	4
Current	**4**	**4**	**16**	
Target	4	3	12	

Risk Trend



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 OneEPR committee (2)	5
Clinical Digital Design Authority (Clinical Decision Committee) with clinical safety review signed off by clinical directors.	• Programme update monthly report to OneEPR Committee (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)	3
Learning events, safety huddles and debriefs	Reports to Divisional Boards (1)	3

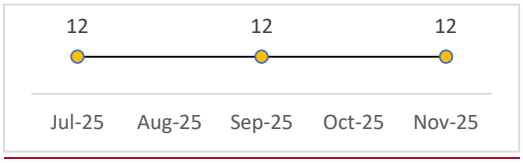
Gaps in Controls and Assurances	Actions and mitigations to address gaps	Lead	Target date
Control gaps • Market movement from Perpetual licensing to Software as a Service (SaaS) is preventing the capitalisation of Software licenses and deployment	**Control treatments** • Review Vendor licensing models 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 ENH production system 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 • Outline Plan approved by Steering group • Compliance to be monitored and reported to divisional leads	MS	~~Feb 26~~ June 26 [original date: Feb 26]
• 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 • Trust financial position could impact Digital Resources which is being closely monitored	MS	Ongoing
• Performance data indicates issues with sustaining changes & embedding culture of improvement & learning	• ~~Cultural changes via ENH production System~~ *[OneEPR Committee 1 Sept agreed this action needed reviewing/replacing]* • ENHPS is now the agreed change methodology	TGT	~~Dec 25~~ Proposing this gap is removed.
• 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

Current Performance – Highlights from the Integrated Performance Report:
• OneEPR project milestones delivered on time – Update: Orbis product delivery date has been delayed with knock-on effects on go-live date and re-phasing planning is underway. • 85% of staff trained on OneEPR prior to go live – Update: postponed due to Orbis delay • Records management: papers records are no longer needed – Update: on track Future agreed performance measures: • Outpatients: 90% of patient calls are answered • Outpatients: Increase PIFU • Outpatients: Reduce DNAs

Associated Risks on the Board Risk Register		
Risk no.	Description	Current score
3486	Risk of Cyber Attack	20
3399	Risk of inaccurate allergy documentation	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	
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 ~~Completed~~ Mar 26

	~~• Establish ENHPS learning network~~ • ~~Health check assessment process~~	~~• KOH~~ • ~~KOH~~	~~Completed~~ ~~Completed~~
• 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 Completed ~~Oct 25~~ Completed 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~~ Complete 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~~	Ongoing Mar 26 Mar 26 Completed ~~Sept 25~~Completed
• 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:
• Variable Pay Event completed week commencing 25 August with initial outputs built into the forecast outturn projections. • Joint expression of interest with Hertfordshire Community Healthcare NHS Trust submitted as part of a national NHS Impact Board development programme focusing on improvement. • Rapid Process Improvement Workshops (RPIWs) for induction of labour and temporary medical staffing completed in October, with an additional kaizen event, RPIW and 3P event scheduled in November. • VMI Health Check report received and cascaded across the organisation via leadership briefings with paper and action plan scheduled for People and Culture Committee 4 November. Review highlights progress in each of the ten domains of the transformation continuum assessment matrix. • Leadership Live event 14 October commenced the annual strategic alignment process with proposals for 2026/27 strategic goals due to be discussed at Board on 19 November. • ENHPS Skills Builder course launched in September and now an integral regular training offer that acts as a bridge between Intro to ENHPS and ENHPS for Leaders for all staff bookable via ENH Academy. • Positive Leadership Rounds (PLRs) expanded with 3 or more PLRs as a minimum occurring weekly involving TGT members, with access now opened to NEDs. Next steps are to increase the number of areas involved and expend to all satellite sites. • New format for divisional performance reviews and accountability framework launched September. • Cohorts of new staff through both Intro and Leaders offers now on a rolling programme with increasing evidence of daily management infrastructure established across a range of areas as a consequence. • Communications plans reflect increased frequency and channels for sharing stories across the wider organisation to promote successes and learning. Agreed performance measures: • ENHPS training target numbers • Organisational impact measured via staff survey, health check transformation continuum and Model Hospital NHS Impact metrics.

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

Board

East and North Hertfordshire Teaching NHS Trust

Meeting	Public Trust Board		**Agenda Item**	12	
Report title	Resident doctor 10-point plan		**Meeting Date**	19 November 2025	
Author	Chief People Officer				
Responsible Director	Chief People Officer				
Purpose [See note 7]	**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:

Action against the Resident doctor 10-point plan has been underway since the Summer. ENHT has completed an initial baseline assessment which showed a completion/progress rate of 62%.

Since that date we have introduced a Resident doctor 10-point plan multi-disciplinary working group, allocated a Board sponsor as well as a Resident doctor nominee and continue to engage with the Resident doctor forum.

We have made considerable progress over the last few months and as a result, would expect a subsequent follow up assessment to improve considerably on the initial 62%.
As a result, I have suggested a reasonable assurance level – we are actively working on moving key areas forward with nominated and named individuals.

We have also confirmed the governance arrangements for monitoring progress of this plan, and this is now a standing agenda item on the People and Culture Committee meeting before being shared with Board (first PCC meeting 4 Nov 2025).

Summary of key issues:

This paper is shared with Board to meet the requirements of necessary governance; and to provide assurance that progress is being made to address the issues outlined in the plan.

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**	☐

If you have ticked any of the boxes, succinctly explain why. You can include other impacts not named above. This section enables the reader to understand from the start particularly significant implications/impact envisaged. This can be both positive benefits and disbenefits that are crucial for robust decision-making. [See note 10]

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*

There are no new risks associated with this paper however we continue to experience industrial action as a result of the discontent felt by Resident Drs; nationally there is work to be done.

Report previously considered at & date(s):	
N/A	
Recommendation	The Board is asked to discuss the report.

To be trusted to provide consistently outstanding care and exemplary service

Resident Doctor 10 point plan

Progress update

Penny St Martin

October 2025

East and North Hertfordshire NHS Trust

ProudToBeENHT

Classification : Confidential

Summary of performance – 10 point plan (1)

East and North Hertfordshire Teaching NHS Trust

The ask	Current position
Workplace wellbeing Within the next 12 weeks, trusts should: undertake an audit into the feasibility of improving priority areas like rest areas, parking when on call, mess facilities and 24/7 hot meals, as well as allowing resident doctors autonomy to complete portfolio and self-directed learning from an appropriate location for them. The audit and subsequent plans should be approved by people committees and reported nationally	• We do have rest facilities for Resident Drs but are assessing demand v supply to ensure that there are enough • Taxis offered where rooms not available • Access to multi storey parking provided to registrar and resus team (medicine). Work ongoing to ensure access to permits from day 1 of rotation. • Eating facilities for cold food is available now, and we do have healthy snacks and a microwave available for heating food. • Enhance is used to recognise and promote positive feedback • A Facilities sub group is being set up to ensure areas of focus are delivered. • Pulling all this information together for Resident Drs in one place
Rota and schedule transparency From now, trusts should: issue work schedules at least 8 weeks in advance and detailed rotas no later than 6 weeks before rotations. Performance data should be submitted and monitored nationally	We aim to provide work schedules within 8 weeks notice now with performance at 78.5% in October. Work in underway with the rostering team to meet the 6 week requirement. Separately we are also working through an issue with Resident Drs being allocated less than full time shifts which can be challenging full time cover.
Annual leave reform Within the next 12 weeks NHS England will: conduct and publish a review of how annual leave allocation is managed. Recommendations will follow to ensure fair and consistent practices.	We encourage good practice in the Resident Dr induction and are working on a local policy which explicitly references Resident Drs – within 6 months. Currently we do not allow Resident Drs to carry over AL

Summary of performance – 10 point plan (2)

East and North Hertfordshire Teaching NHS Trust

Theme	Current position
Board level leadership Within the next 6 weeks, trusts should: appoint a senior named lead for resident doctors' issues (where one is not already in place), and a resident doctor peer representative, to report to the board. In September 2025, NHS England will: publish a national role specification for the board lead. Each board should also ensure the executive team engages with resident doctors to understand and address local issues.	There is a named Board SRO, a Programme Director and a named Resident Dr nominated. In addition we have a Resident Dr forum.
Payroll accuracy Within the next 12 weeks, trusts should: participate in the national payroll improvement programme. By March 2026: rotation-related payroll errors should be reduced by at least 90%. Trusts should establish board-level governance and begin national reporting.	ENHT were involved in the payroll improvement programme and continue to be part of ongoing meetings for improvements. We have local SLAs for payroll, a report showing all payroll errors and also have a payroll working group within the People Team to enable trouble shooting.
Eliminating mandatory training duplication Within the next 12 weeks, trusts should: comply with the May 2025 Statutory and Mandatory Staff Movement MoU to accept prior mandatory training, where this is not already the case. By April 2026, NHS England will: introduce a reformed national framework for statutory and mandatory training.	We already comply with the Statutory and Mandatory training MOU which allows the training completion to follow the individual preventing duplication.

Summary of performance – 10 point plan (3)

NHS East and North Hertfordshire Teaching NHS Trust

Theme	Current position
Exception reporting NHS England will: work with the BMA, NHS Employers and DHSC to continue with preparations for the implementation of the new national framework for exception reporting, to enable and encourage resident doctors to engage with this process	Exception report framework is on the agenda for the Resident Dr forum in November and has also been shared with LNC – in progress.
Course related expenses reimbursement Within the next 12 weeks, trusts should: review their current reimbursement processes to ensure they can reimburse resident doctors upon submission of valid receipts for all approved study leave-related expenses, including travel and subsidence – not evidence of attendance/completion – so that reimbursement can take place within 4 to 6 weeks of claims being submitted.	Expenses are reimbursed through the next available payroll date and therefore will be within the 4/6 week timeframe
Rotation reform Within the next 12 weeks: Department of Health and Social Care and NHS England will develop and launch pilot rotational schemes and continue to look at wider reform.	Action for NHSE to mobilise a pilot scheme.
Lead model expansion In October 2025: NHS England will produce a roadmap for extending the Lead Employer model to cover all resident doctors and dentists.	In October NHSE will produce a roadmap for extending the lead model approach. Separately we are looking at whether we submit a bid to become a lead provider for Medical and Dental Resident Drs.

Submission to NHSE September 2025

East and North Hertfordshire Teaching NHS Trust

Improving Doctors Working Lives Programme - The 10 Point Plan

Provider: **EAST AND NORTH HERTFORDSHIRE NHS TRUST**

Amenities

Access to Lockers	Yes, but not all
Rest facilities	Yes
Designated on-call parking access	Yes, but not all
Access to hot and cold food 24/7	No, but plan to in 3 months
Access to cold food 24/7	Yes
Access to inductions specifically designed to meet the needs of Resident Doctors	Yes
Beds/sleeping pods available free of charge	Yes, but not all
Are Resident doctors able to work from home for portfolio and self-directed learning?	Yes
Is there access to free psychological support treatment?	Yes
Are there positive feedback mechanisms in place to reward and promote staff?	No, but plan to in 3 months
Are there protected breaks?	Yes, but not all
Do you promote the Safe Learning Environment Charter?	No, but plan to in 3 months
Offer sexual safety/harassment training and awareness?	No, but plan to in 3 months

Appointing senior leads to take action on Resident Doctor issues

Has your Trust Board appointed a senior named, accountable Resident Doctor Lead?	No
If yes, please provide their name and role.	
Do you have a peer representative Resident Doctor who your Board consults with on local issues relating to Resident Doctors?	Yes
At what levels of your organisation have you reviewed and discussed the following surveys? (Executive team, Trust Board, People Committee or All)	
GMC Training survey	People Committee
NETS survey	People Committee

Annual Leave

Do you have a local policy to encourage good annual leave management which explicitly includes reference to resident doctors?	Planning to introduce (6 months)
Is good annual leave practice covered at resident doctor induction?	Yes
Do you allow resident doctors to carry over annual leave between rotations?	No
How much leave can Resident Doctors carry over?	
Do your rostering systems for Resident Doctors allow for self/preferential rostering?	No

Payroll and Expenses

Have you implemented local SLAs and introduced board-level governance for tracking/reporting payroll errors?	Yes
Have there been changes in payroll errors over the last 12 months?	Decrease in errors
How do you process course related expenses?	After course attendance

Mandatory Training & Learning

Do you accept mandatory training completed by resident doctors elsewhere, in line with the Recognition of Statutory and Mandatory Training Memorandum of Training AND do you adhere to the People Policy Framework for Mandatory Learning agreed on 1 May 2025?	Yes, both

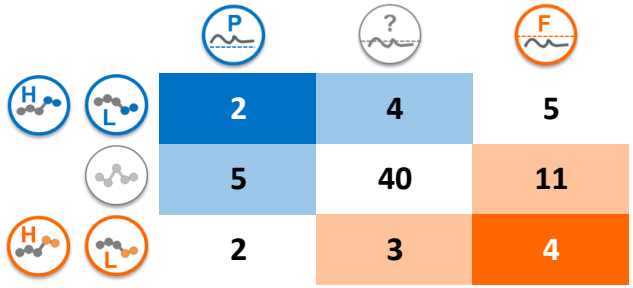
* Baseline assessment score **62%**

* The Baseline Assessment score is calculated by averaging the percentage scores of each scored question. Please refer to the points scheme for specific scoring criteria.

NHS
East and North Hertfordshire Teaching
NHS Trust

Integrated Performance Report

Month 06 | 2025-26



Data correct as at 29/10/2025

Performance Highlights

NHS East and North Hertfordshire Teaching NHS Trust

Quality

- Infection / Sepsis - hospital acquired infections remain as expected, improvement in time to antibiotics has been maintained.
- VTE assessment - still more to do to prevent avoidable blood clots.
- Complaints - remain higher than previously with delays in response.
- Stroke - more to do in all metrics.
- Maternity - no significant changes, metrics as expected.
- Mortality - no significant changes, compare well to peers.

Operations

- **Urgent and Emergency Care**: Sept: slight deterioration in 4 hr, 12 hr and ambulance handover, linked to higher need for admission amongst UEC presentations & beds closed for Estates work & IPC. Trust rank however improved by 2 places to 39/122 nationally.
- **Cancer Waits:** Achieved 3/3 targets in August.
- **Referral To Treatment (RTT)** (excluding Community Paeds): Continued on plan. 63.2% of patients waiting under 18 weeks, just 1% away from 3/26 target. Refreshed RTT Delivery Plan at specialty level; Herts COOs leading on acceleration of integrated CYP Neurodiversity pathway.
- **Diagnostics**: The % of patients waiting over 6 weeks improved to 54% with Audiology and MRI remaining the concern. MRI capacity increased from the beginning of August with the switchover of CT van to MRI and outsourcing. Audiology actions continue.

Finance

- The Trust approved a breakeven plan for 25/26. This plan assumes that a £35.8m cost improvement programme will be delivered.
- At M6, the Trust has reported an actual YTD deficit of £9.4m. This is in line with phased plan expectations.
- The CIP plan phasing assumes only £8.6m of delivery at Month 6, so a significant step up in savings needs to be realised in Q3 and Q4.
- The Trust has experienced a range of unanticipated cost pressures in the year to date, including high CSW and maternity bank spend, and overspends relating to medical locum and agency use in the Unplanned Care division.
- Whilst the Trust continues to increase its cohort of permanent staffing it is not reducing premium staffing utilisation at a proportionate rate.
- Elective income performance in the YTD is behind plan.

People

- Staff turnover rates remain static (7.3%).
- Overall Bank & Agency spend only 0.5% above target of 8%. Deep dives commenced in Top 4 areas of Bank spend in N&M (ED, AMU1, Theatres and Renal).
- GROW together compliance continues to improve (81.2%).
- Stat Mand compliance reduced (88.5%), proactive action includes review of role essential training & focused support for low compliance areas.
- FTE establishment monitoring (plan vs actual) is on plan, levels are aligned and on track for our March 2026 target.
- Sickness target monitoring remained consistent with the previous month (5%), stress and mental health issues remain majority reasons impacting attendance. Flu vaccine uptake at 23.8%.
- Vacancy rate remains under target (7.4%)

Month 06 | 2025-26

NHS Oversight Framework

Last updated 11/12/2025

Average Metric Score	Unadjusted Segment	Adjusted Segment	Financial Override	Recovery Support Programme
2.15	2	2	No	No

Average metric score

Average Domain Scores

Domain Name	Domain Score
Access to services	2.18
Effectiveness and experience of care	2.08
Finance and productivity	1.32
Patient safety	2.81
People and workforce	2.24

Metrics for Attention / Monitoring

Metric Name	Trust NOF	Trust Performance	Peer Median	Provider Median
Percentage of patients waiting over 52 weeks for community services	3.97	66%	4.24%	0.58%
CQC safe inspection score	3.00	3	3	3
NHS staff survey - raising concerns sub-score	2.68	6.38	6.24	6.42
Number of MRSA bacteraemia cases	2.60	3	3.5	3
Patients spending more than 12 hours in the department	2.52	8.91%	8.74%	8.82%

NHS Oversight Framework

Last updated 11/12/2025

This replication of the NHS Oversight Framework is **indicative**. It is designed to be used as an early heads-up on performance measures that may be going off-target, as well as providing an estimate of what the next published Segment score might look like. The NHS England-published NHS Oversight Framework can be found on the Model Hospital.

The data presented here is the latest available nationally-published data, the dates for which vary from metric to metric. See each metric individually for the time period it pertains to.

Methodology

Full methodology can be found here but the general process is described below.

- For each metric, Trust performance is ranked in ascending / descending order depending on whether higher or lower is better.
- If there is a target:
  - Trusts that have achieved that target are automatically given a NOF Score of 1.
  - The remaining Trusts are then given a NOF Score between 2 and 4 depending on where each Trust is ranked.
  - Note that only one Trust will score a 4 (worst performing) using this methodology.

- If there is no target:
  - Trusts receive a NOF Score between 1 and 4 depending on where each Trust is ranked.
  - Note that only one Trust will score a 4 (worst performing) using this methodology.

- Special instances:
  - CQC inpatient survey satisfaction rate | Based on banded score for overall experience (1.00 for a band >= 6, 2.00 for a band between 4 and 5, 3.00 for a band = 3, 4.00 for a band <= 2).
  - CQC safe inspection score | CQC rating is translated to a score (1.00 = outstanding, 2.00 = good, 3.00 = requires improvement, 4.00 = inadequate).
  - SHMI |Based on SHMI band (1.00 = lower than expected mortality, 2.00 = as expected mortality, 3.00 = higher than expected mortality).
  - Combined finance score | The combined finance score is based on a combination of two individual financial scores.

Final Scoring

The overall score is the average of the NOF scores for all metrics. Trusts are then ranked and split into quartiles to determine the **unadjusted** segment score.
If the Financial override is **Yes** and the unadjusted segement score is 1 or 2, the **adjusted** segment score is 3; otherwise the adjusted segment is directly inherited from the unadjusted segment.

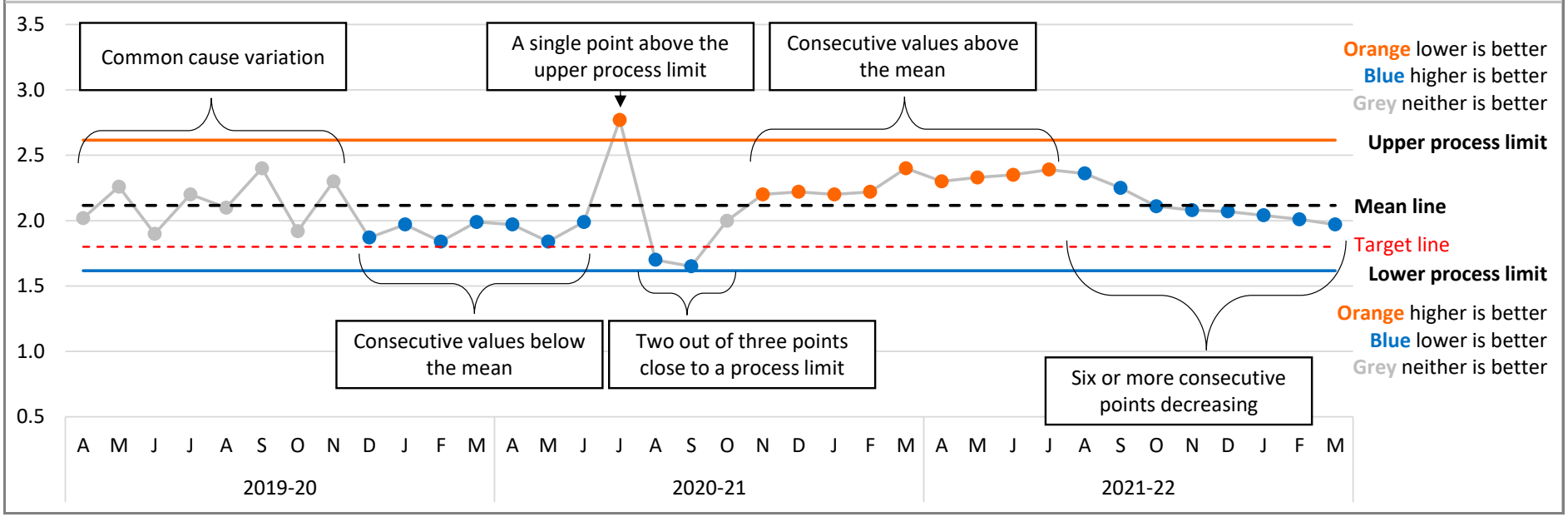
The scores for each Domain are simply the average of the scores within each Domain.

Please note that the three infection prevention and control measures (MRSA, c.difficile and e.coli) are **one third-weighted** both for the Domain score and the Overall score.
Furthermore, the **combined finance score** is based on a combination of the two individual financial scores (planned surplus/deficit score and variance year-to-date score). As such, **only** the combined finance score contributes to the Domain and Overall score, while the planned surplus/deficit and variance year-to-date are **zero-weighted**.

Integrated Performance Report

NHS East and North Hertfordshire Teaching 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

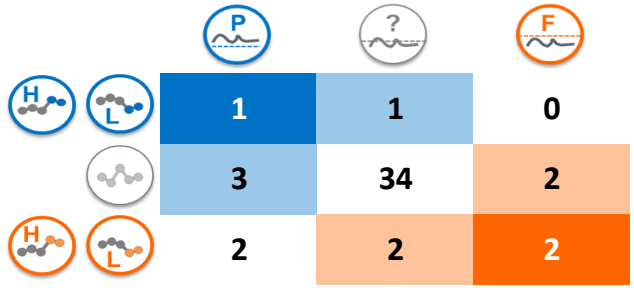
Assurance

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

NHS
East and North Hertfordshire Teaching
NHS Trust

Quality

Month 06 | 2025-26



Quality

Summary

NHS East and North Hertfordshire Teaching NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Patient Safety Incidents	Total incidents reported in-month	Sep-25	n/a	1,619			5 points above the upper process limit No target
Infection Prevention and Control	Hospital-acquired MRSA Number of incidences in-month	Sep-25	0	0			Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired c.difficile Number of incidences in-month	Sep-25	0	5			Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired MSSA Number of incidences in-month	Sep-25	0	3			Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired e.coli Number of incidences in-month	Sep-25	0	5			Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired klebsiella Number of incidences in-month	Sep-25	0	0			Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired pseudomonas aeruginosa Number of incidences in-month	Sep-25	0	0			Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired CPOs Number of incidences in-month	Sep-25	0	1			Common cause variation Metric will inconsistently pass and fail the target
	Hand hygiene audit score	Sep-25	80%	88.0%			1 point below the lower process limit Metric will consistently pass the target
Safer Staffing	Overall fill rate	Sep-25	n/a	86.1%			7 points above the mean No target
	Staff shortage incidents	Sep-25	n/a	66			1 point above the upper process limit No target

Month 06 | 2025-26

Quality

Summary

NHS East and North Hertfordshire Teaching NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Cardiac Arrests	Number of cardiac arrest calls per 1,000 admissions	Sep-25	n/a	0.55			Common cause variation No target
	Number of deteriorting patient calls per 1,000 admissions	Sep-25	n/a	1.75			Common cause variation No target
Sepsis Screening and Management	Inpatients receiving IVABs within 1-hour of red flag	Sep-25	95%	86.7%	H	?	7 points above the mean Metric will inconsistently pass and fail the target
	Inpatients Sepsis Six bundle compliance	Sep-25	95%	46.7%		?	Common cause variation Metric will inconsistently pass and fail the target
	ED attendances receiving IVABs within 1-hour of red flag	Sep-25	95%	92.2%		?	Common cause variation Metric will inconsistently pass and fail the target
	ED attendance Sepsis Six bundle compliance	Sep-25	95%	67.2%	L	F	7 points below the mean Metric will consistently fail the target
VTE Risk Assessment	VTE risk assessment stage 1 completed	Sep-25	85%	73.0%		?	Common cause variation Metric will inconsistently pass and fail the target
HATs	Number of HAT RCAs in progress	Sep-25	n/a	254	H		7 points above the upper process limit No target
	Number of HAT RCAs completed	Sep-25	n/a	7			Common cause variation No target
	HATs confirmed potentially preventable	Sep-25	n/a	1			Common cause variation No target
PU	Pressure ulcers All category ≥2	Sep-25	0	19		?	Common cause variation Metric will inconsistently pass and fail the target

Month 06 | 2025-26

Quality

Summary

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Patient Falls	Rate of patient falls per 1,000 overnight stays	Sep-25	n/a	4.3			Common cause variation No target
	Proportion of patient falls resulting in serious harm	Sep-25	n/a	4.6%			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	Sep-25	95%	97.2%			Common cause variation Metric will inconsistently pass and fail the target
	A&E positive feedback	Sep-25	90%	89.0%			Common cause variation Metric will inconsistently pass and fail the target
	Maternity Antenatal positive feedback	Sep-25	93%	92.1%			Common cause variation Metric will inconsistently pass and fail the target
	Maternity Birth positive feedback	Sep-25	93%	100.0%			Common cause variation Metric will inconsistently pass and fail the target
	Maternity Postnatal positive feedback	Sep-25	93%	94.0%			Common cause variation Metric will inconsistently pass and fail the target
Friends and Family Test	Maternity Community positive feedback	Sep-25	93%	100.0%			Common cause variation Metric will inconsistently pass and fail the target
	Outpatients FFT positive feedback	Sep-25	95.0%	94.9%			Common cause variation Metric will inconsistently pass and fail the target
PALS	Number of PALS referrals received in-month	Sep-25	n/a	404		-	Common cause variation No target

Month 06 | 2025-26

Quality

Summary

NHS East and North Hertfordshire Teaching NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Complaints	Number of written complaints received in-month	Sep-25	n/a	105	H	-	9 points above the mean No target
	Number of complaints closed in-month	Sep-25	n/a	99		-	Common cause variation No target
	Proportion of complaints acknowledged within 3 working days	Sep-25	75%	68.3%	L	P	3 points below the lower process limit Metric will consistently pass the target
	Proportion of complaints responded to within agreed timeframe	Sep-25	80%	17.7%	L	F	2 points below the lower process limit Metric will consistently 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	Sep-25	3.3%	4.1%		?	Common cause variation Metric will inconsistently pass and fail the target
	3rd and 4th degree tear vaginal	Sep-25	2.5%	5.5%	H	?	1 point above the upper process limit Metric will inconsistently pass and fail the target
	Massive obstetric haemorrhage >1500ml LSCS	Sep-25	4.5%	5.1%	H	?	7 points above the mean Metric will inconsistently pass and fail the target
	3rd and 4th degree tear instrumental	Sep-25	6.3%	6.5%		?	Common cause variation Metric will inconsistently pass and fail the target
	Term admissions to NICU	Sep-25	6.0%	8.3%		?	Common cause variation Metric will inconsistently pass and fail the target
	ITU admissions	Sep-25	0.7	2		?	Common cause variation Metric will inconsistently pass and fail the target

Month 06 | 2025-26

Quality

Summary

East and North Hertfordshire Teaching NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Maternity Other Metrics	Smoking at time of booking	Sep-25	12.5%	6.1%			Common cause variation Metric will consistenly pass the target
	Smoking at time of delivery	Sep-25	2.3%	4.5%			Common cause variation Metric will inconsistently pass and fail the target
	Bookings completed by 9+6 weeks gestation	Sep-25	50.5%	76.2%			Common cause variation Metric will consistenly pass the target
	Breast feeding initiated	Sep-25	72.7%	74.8%			Common cause variation Metric will inconsistently pass and fail the target
	Number of MNSI PSII	Sep-25	0.5	1			Common cause variation Metric will inconsistently pass and fail the target
Mortality	Crude mortality per 1,000 admissions In-month	Sep-25	12.8	7.2			Common cause variation Metric will inconsistently pass and fail the target
	Crude mortality per 1,000 admissions Rolling 12-months	Sep-25	12.8	9.1			Rolling 12-months - unsuitable for SPC
	HSMR In-month	Jul-25	100	108.0			Common cause variation Metric will inconsistently pass and fail the target
	HSMR Rolling 12-months	Jul-25	100	89.7			Rolling 12-months - unsuitable for SPC
	SHMI In-month	Apr-25	100	89.4			Common cause variation Metric will inconsistently pass and fail the target
	SHMI Rolling 12-months	Apr-25	100	91.2			Rolling 12-months - unsuitable for SPC

Month 06 | 2025-26

Quality

Summary

NHS East and North Hertfordshire Teaching NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Re-admissions	Number of emergency re-admissions within 30 days of discharge	Jul-25	n/a	719			Common cause variation No target
	Rate of emergency re-admissions within 30 days of discharge	Jul-25	9.0%	5.7%	L	P	8 points below the mean Metric will consistently pass the target
Length of Stay	Average elective length of stay	Sep-25	2.8	1.9		P	Common cause variation Metric will consistently pass the target
	Average non-elective length of stay	Sep-25	4.6	4.8		?	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	Sep-25	n/a	94.4%			Common cause variation No target
	Individualised care pathways	Sep-25	n/a	38			Common cause variation No target
Stroke Services	Trust SSNAP grade	Q2 2024-25	A	E			
	4-hours direct to Stroke unit from ED	Sep-25	63%	37.0%		F	Common cause variation Metric will consistently fail the target
	4-hours direct to Stroke unit from ED with Exclusions (removed Interhospital transfers and inpatient Strokes)	Sep-25	63%	39.0%		F	Common cause variation Metric will consistently fail the target
	Number of confirmed Strokes in-month on SSNAP	Sep-25	n/a	72			Common cause variation No target
	If applicable at least 90% of patients' stay is spent on a stroke unit	Sep-25	80%	86.0%		?	Common cause variation Metric will inconsistently pass and fail the target
	Urgent brain imaging within 20 minutes of hospital arrival for suspected acute stroke	Sep-25	40%	24.0%			Not enough data for SPC
	Urgent brain imaging within 60 minutes of hospital arrival for suspected acute stroke	Sep-25	50%	65.0%		?	Common cause variation Metric will inconsistently pass and fail the target

Month 06 | 2025-26

Quality

Summary

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
	% of all stroke patients who receive thrombolysis	Sep-25	11%	11.0%			Common cause variation Metric will inconsistently pass and fail the target
	Discharged with ESD	Sep-25	50%	53.0%			Common cause variation Metric will inconsistently pass and fail the target

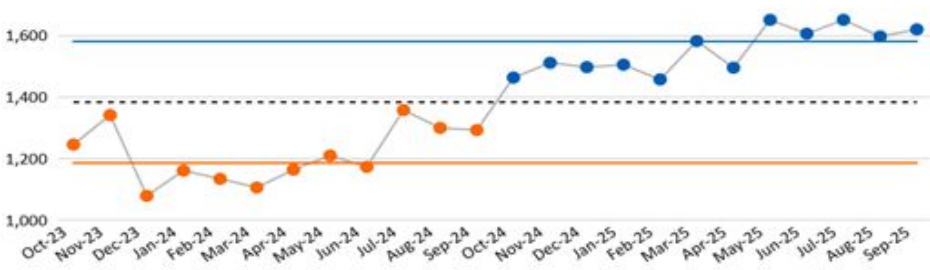
Month 06 | 2025-26

Quality

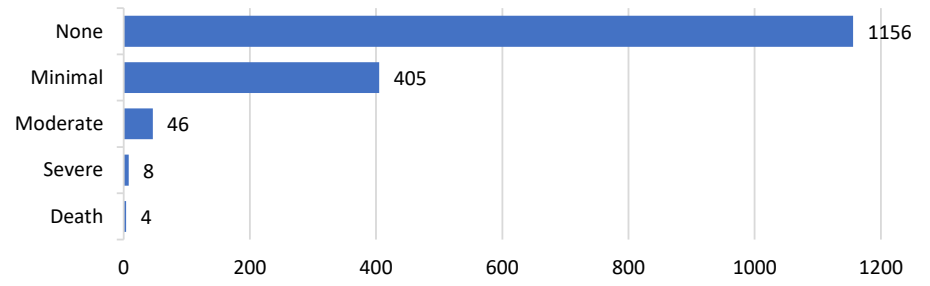
Patient Safety Incidents

East and North Hertfordshire Teaching NHS Trust

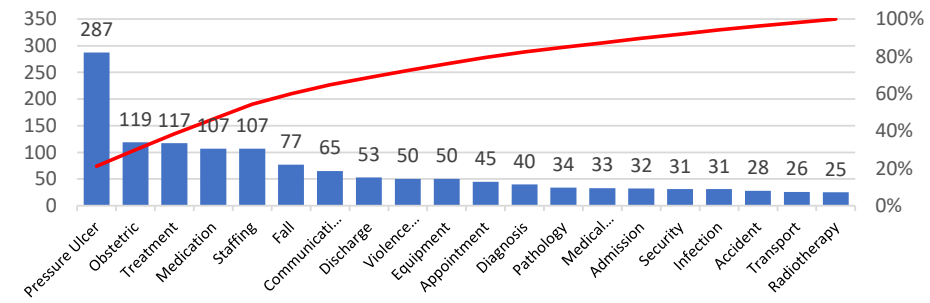
Total incidents reported



Number of patient safety incidents by level of harm - Sep-25



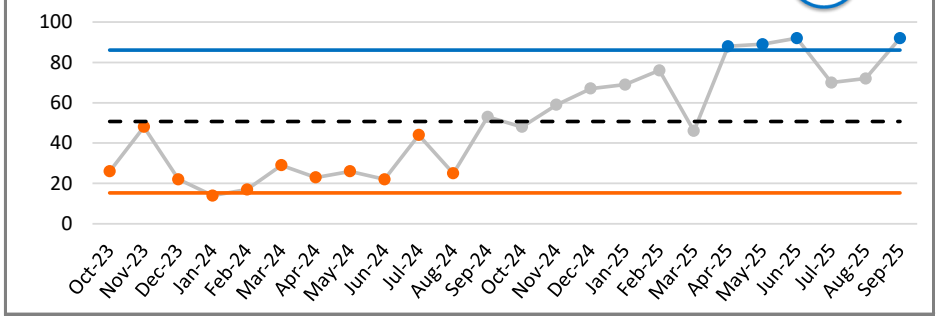
Incidents Themes - Sep-25



Key Issues and Executive Response

- Continued special cause variation in incident reporting. Influenced by active promotion of reporting and the emerging use of daily incident review huddles across all Care Groups.
- 97% of incidents resulting in no harm / low harm, in line with previous months
- Obstetrics and Emergency Medicine continue to be the highest reporting specialty in line with previous months
- Reduction in discharge related incidents and violence and aggression incidents compared to previous month.
- 38% increase in staffing related incidents compared to last month, of these 31% were in Renal service
- 1 new PSii agreed relating to delays in Cardiology follow up pathways. Learning to be reviewed as part of wider thematic review across services, terms of reference drafted in collaboration with service leads and subject matter experts. Learning response team agreed.
- Ongoing review of all incidents reported with level of harm as 'death' through local incident management process with escalation to PSERP as required.

Total number of Good Care events

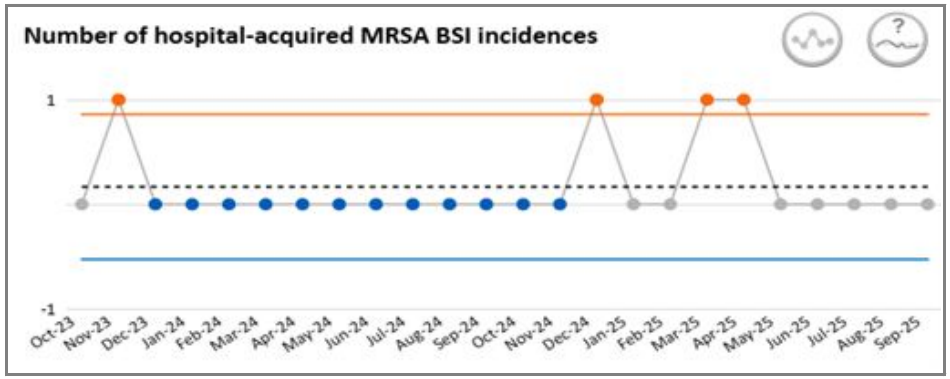


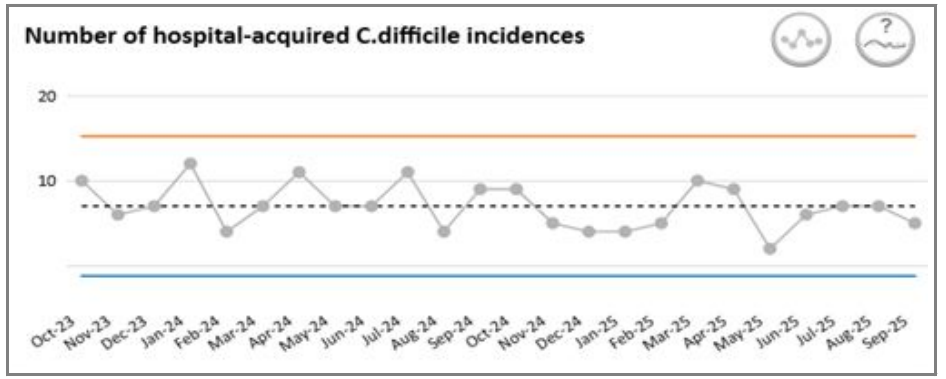
Month 06 | 2025-26

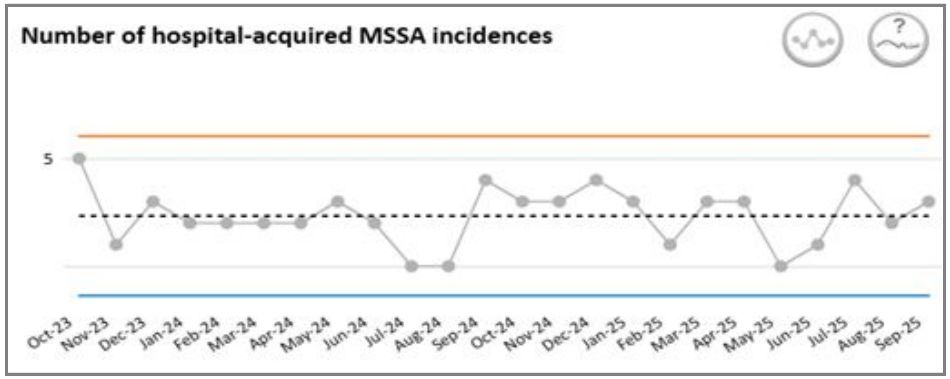
Quality

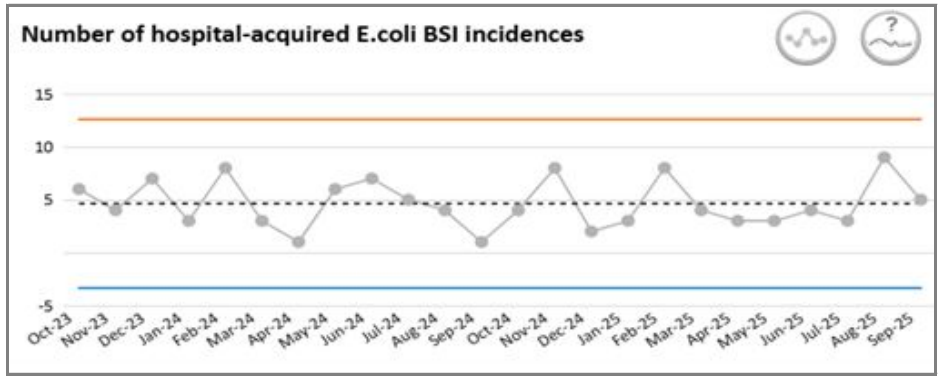
Infection Prevention and Control

NHS East and North Hertfordshire Teaching NHS Trust









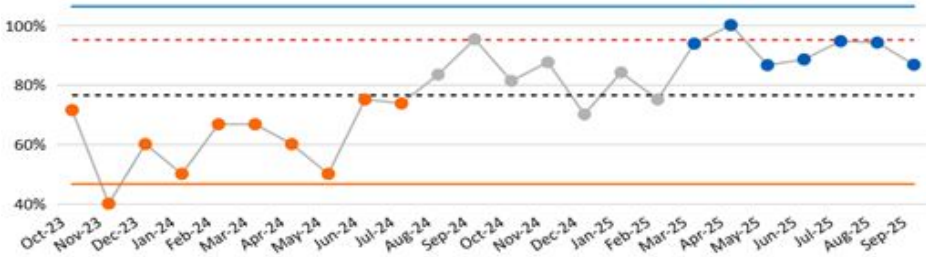
- MRSA BSI - there were zero MRSA Bloodstream Infections (BSI) in Sept.'25.
- MSSA BSI - there were two MSSA BSIs in Sept.'25. This is equivalent to the previous month. The year to date (YTD) total is 12 cases which is one case above the same period in the last financial year (FY) (2024/25).
- C. difficile (C diff.) infection (CDI) - there were five CDI cases in the month of Sept.'25, two cases fewer than the previous month, and four cases below the same period in FY 2024/25. The financial YTD total is 36, which is significantly lower than 49 cases in the same period last year. The weekly C. diff multidisciplinary team (MDT) meeting continues, however, a slight decrease in attendance has been noted and escalated.
- E.coli BSI - there were five cases in Sept.'25. This is four cases fewer than last month. The YTD total is 27, which is above trajectory.

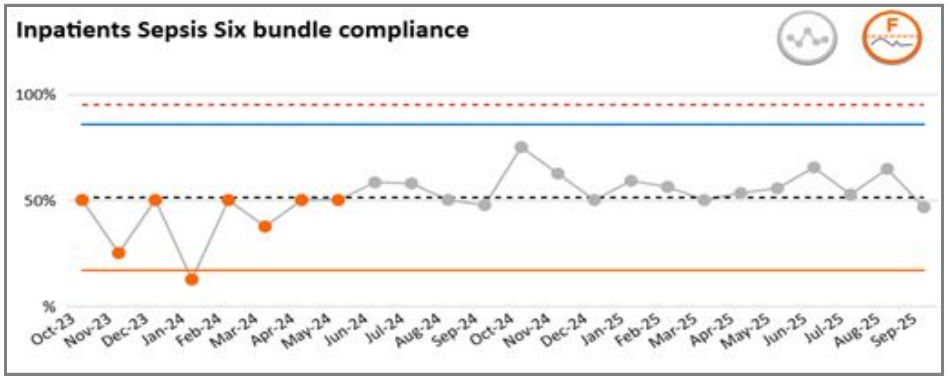
Month 06 | 2025-26

Quality

Sepsis Screening and Management | Inpatients

NHS East and North Hertfordshire Teaching NHS Trust





Themes

Sepsis IP	2024-25							2025-26				
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Oxygen	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Blood cultures	88%	93%	90%	84%	73%	73%	92%	81%	86%	94%	94%	73%
IV antibiotics	81%	89%	70%	86%	75%	94%	100%	88%	87%	94%	94%	87%
IV fluids	83%	93%	64%	93%	86%	79%	89%	100%	89%	93%	92%	100%
Lactate	88%	78%	68%	73%	73%	81%	57%	81%	73%	71%	76%	50%
Urine measure	94%	95%	84%	95%	81%	88%	93%	89%	93%	68%	88%	80%

Key Issues and Executive Response

Themes

- 7/15 patients audited across September showed sepsis six compliance, achieving 6/6 elements within the hour.
- IV antibiotic compliance dropped from 94% to 87% in August, with two prolonged delays of 2:27 hours and 3:34 hours respectively. Both ENHanced.
- Lactate measurement declined, with only 50% of patients audited having a lactate level checked within one hour - most delays sat around the three hour mark, and two longer delays - all ENHanced.
- Urine measurement showed normal variation at 80% compliance, with previous months sitting at 68% and 88% respectively.
- Blood culture compliance declined with a drop of around 20%.

Response

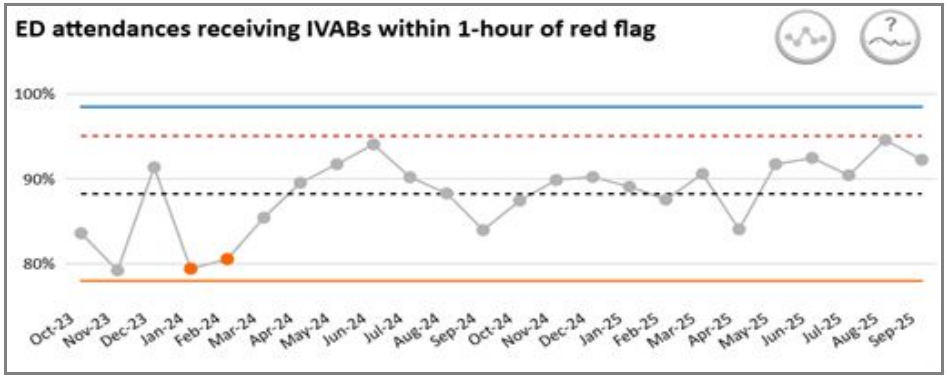
- Sepsis Grab boxes continue to be utilised as a time saving measure for Sepsis management - these have been promoted again throughout September, especially during World Sepsis Day (midway through the month).
- We have tailored our education with a focus and big push on lactate and blood culture collection - particularly on 10A (bitesize sessions) and AMU (team time) as well as educating ward staff when visiting wards on weekdays. Will be sending a lactate/blood culture memo to doctors too.
- All delays have been ENHanced and sent to relevant teams and ward managers to investigate as appropriate.
- The team are working closely with Orbis to ensure the new EPR system reflects the need for sepsis screening and fluid balance charts.
- The team are utilising formal and bedside education, alongside working with practice educators to push for sustainability in compliance.
- BEACH and ALERT course sepsis education provided this month.

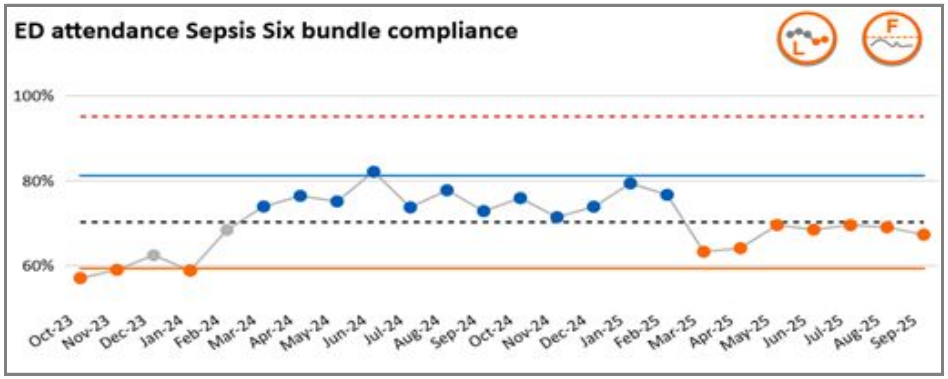
Month 06 | 2025-26

Quality

Sepsis Screening and Management | Emergency Department

East and North Hertfordshire Teaching NHS Trust





Themes

Sepsis ED	2024-25							2025-26				
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Oxygen	100%	100%	99%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Blood cultures	97%	90%	93%	95%	94%	96%	88%	96%	92%	96%	95%	92%
IV antibiotics	87%	90%	90%	89%	88%	91%	84%	92%	92%	90%	95%	92%
IV fluids	93%	95%	91%	92%	93%	90%	89%	91%	99%	93%	94%	93%
Lactate	99%	97%	94%	99%	95%	97%	96%	99%	99%	100%	97%	100%
Urine measure	80%	81%	80%	88%	81%	68%	73%	75%	77%	73%	73%	70%

Key Issues and Executive Response

Themes

- 43/64 patients audited across September showed sepsis six compliance with all 6/6 elements being completed within the hour.
- Urine output measurement shows normal variation at 70% and remains below target.
- Lactate compliance sits at 100%. Blood culture collection shows normal variation at 92%.
- IV antibiotic compliance shows normal variation, sitting at 92%.

Response

- The Sepsis Team continue to attend 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 completed a 3-month block of weekly teaching where we are seeing small improvements in the use of digital fluid balance charts.
- Mandatory e-learning updated and now live on ENH Academy for all staff to refresh their sepsis knowledge and review the updated guidance.
- The team are working with the practice development team to focus on sustaining good sepsis compliance.
- The team have worked with ED to book the new sepsis Links onto upcoming sepsis training so they can continue to promote timely sepsis recognition and management in ED.
- Good sepsis care is being reinforced - the first sepsis star awards have been given out in September - with the first recipient being an ED nurse - well done!

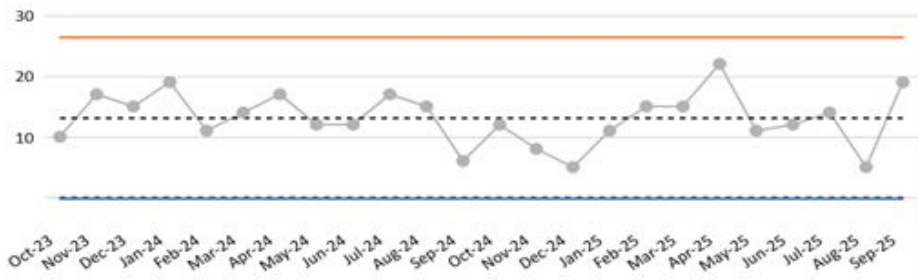
Month 06 | 2025-26

Quality

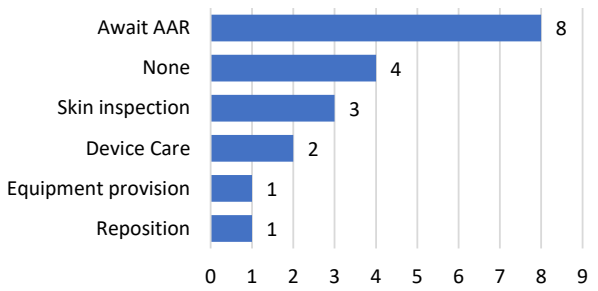
Pressure Ulcers | VTE

NHS East and North Hertfordshire Teaching NHS Trust

Number of hospital-acquired pressure ulcers



Themes - Sep-25

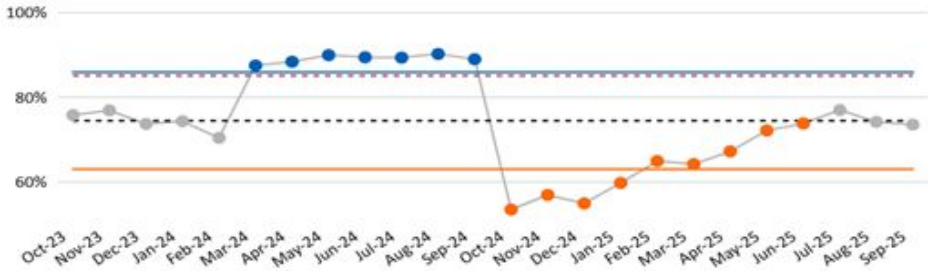


233

days since last category 4

as at 22/10/2025

VTE risk assessment stage 1 completed



Key Issues and Executive Response

Pressure Ulcers

- From end of August 2025, some selected wards will be involved in pressure audits, focusing on NICE CG179 and NICE QS89. The audit will run up to end of March 2026.
- 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.

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.
- From June 2025 patients can no longer leave ED/Recovery without a VTE risk assessment.
- In July 2025, the Trusts new VTE Pharmacist was appointed after several month period of vacancy.
- The observed drop in compliance to completing a VTE risk assessment from July 2025 may be linked to the volume of new staff across the Trust.

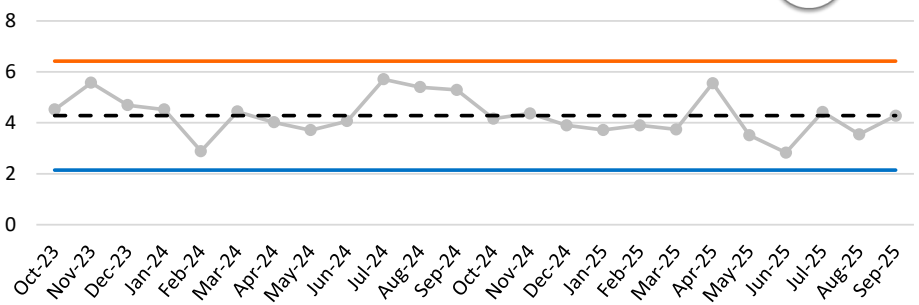
Month 06 | 2025-26

Quality

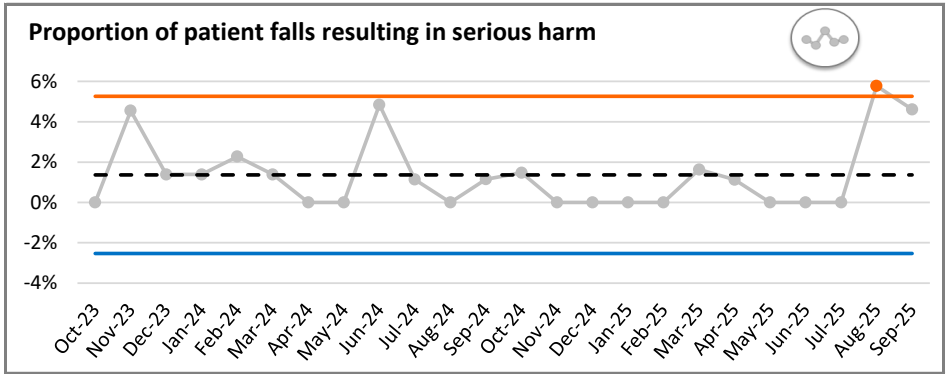
Patient Falls

East and North Hertfordshire Teaching NHS Trust

Rate of patient falls per 1,000 overnight stays



Proportion of patient falls resulting in serious harm



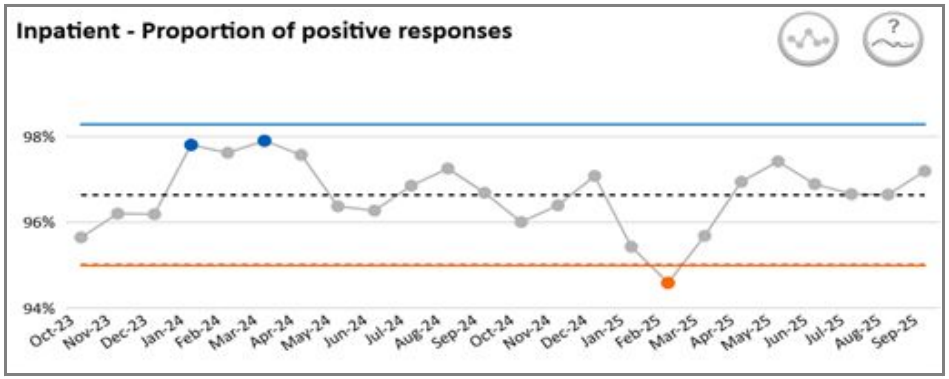
Key Issues and Executive Response

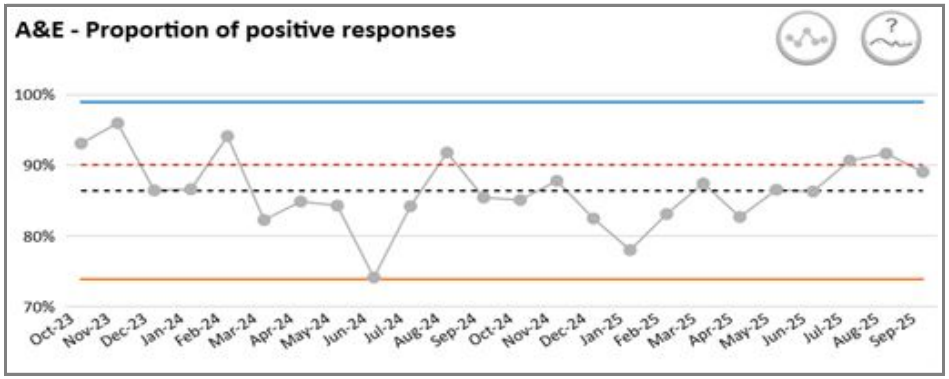
- Inpatient falls data continues to show common cause variation, with an average of 4 per month per 1000 bed days.
- 3 falls with harm recorded for September. 2 patients has capacity and 1 patient lacked capacity. 2 falls happened in stroke unit. One of which is a witnessed fall and patient has capacity patient tripped whilst trying to mobilise and sustained a small brain bleed, not requiring intervention. The other patient fell whilst trying to reach cardigan on chair, sustaining a shoulder dislocation. The 3rd patient fall occurred in elderly care - a witnessed fall where patient trying to mobilise with a frame and lost his balance. Patient sustained neck of femur fracture. These incidents will be discussed in the divisional incident safety huddle in unplanned care and learnings identified will be shared across divisions.
- Falls Lead to attend the next ward managers meeting to highlight falls incidence in the division, baywatch compliance, and timely completion of risk assessments and care plans.
- Questions added to "Falls Section" in Enhance to capture capacity and enhance care support at the time of the incident.

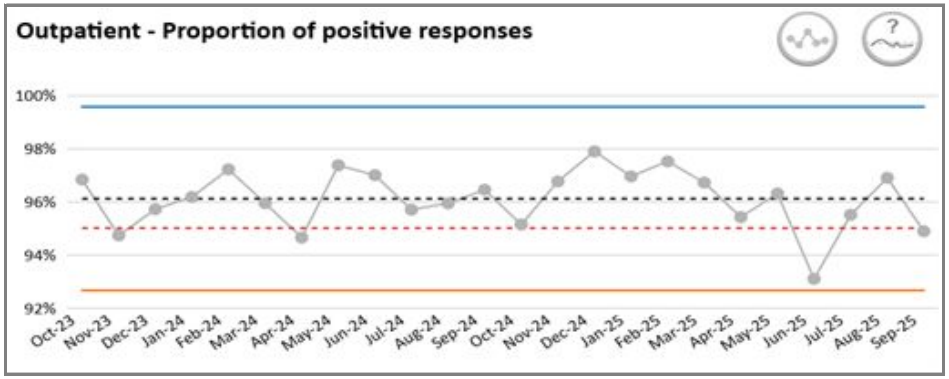
Month 06 | 2025-26

Quality

Friends and Family Test







Key Issues and Executive Response

Friends and Family Test

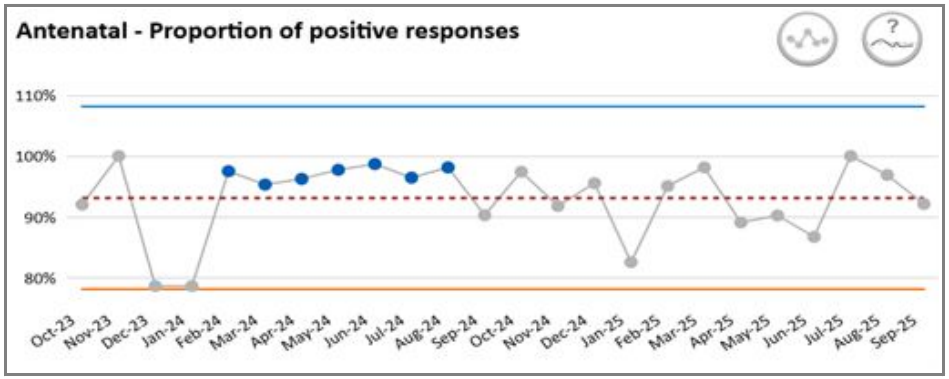
- The overall number of responses for maternity decreased this month across all four elements (Antenatal, Birth, Postnatal and Community Midwifery) from 172 in August to 122 in September.
- The overall outpatient response shows an increase this month. This was mainly due to Mount Vernon CC services and the satellite dialysis units gaining the higher number of surveys completed, which also show an increase in being completed by smartphone/tablet and via QR code.
- The inpatient responses increased as did the % very good/good from last month. In addition, the same three questions on the inpatient satisfaction survey scored highest again: Staff support family & friends to visit; Respect & dignity; Treated with kindness & compassion.

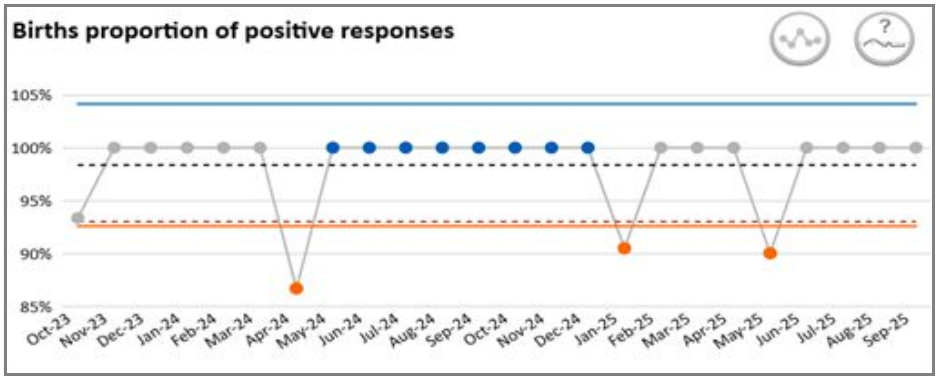
Month 06 | 2025-26

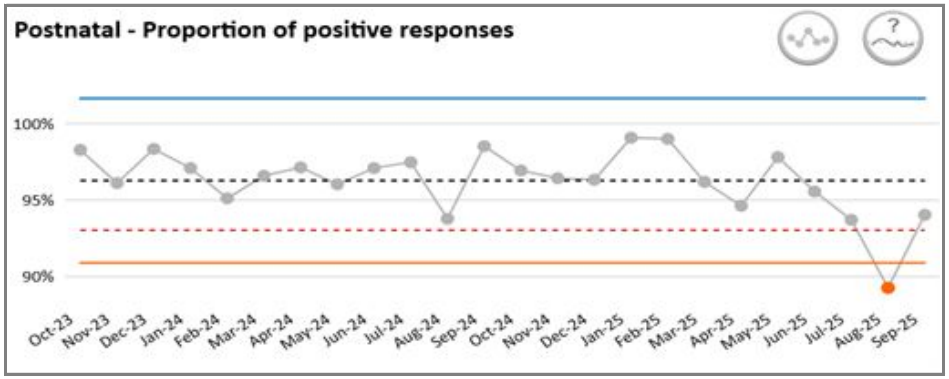
Quality

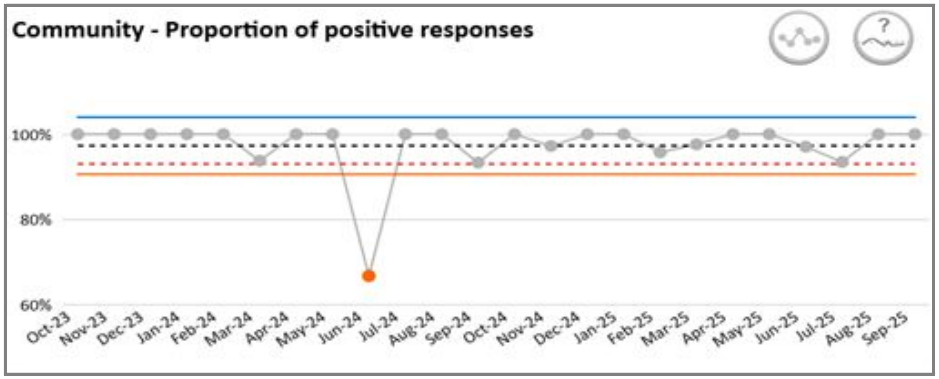
Friends and Family Test

East and North Hertfordshire Teaching NHS Trust









Month 06 | 2025-26

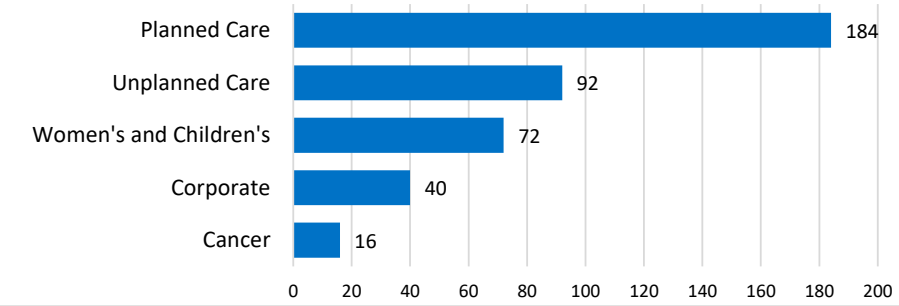
Quality

Patient Advice and Liaison Service

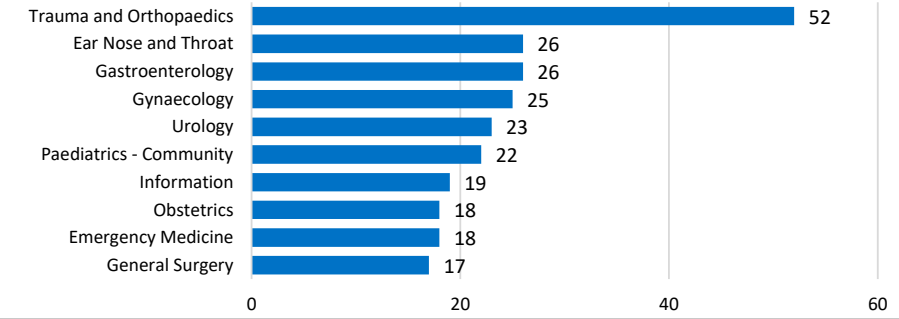
East and North Hertfordshire Teaching NHS Trust

Number of PALS referrals

PALs by Division - Sep-25



PALs Top 10 subjects - Sep-25

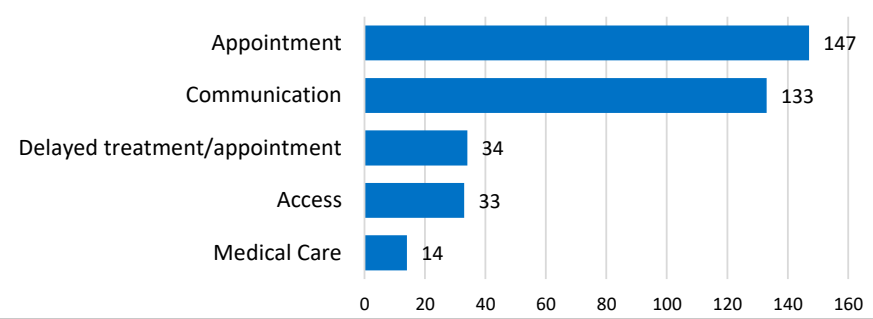


Key Issues and Executive Response

Patient Advice Liaison Service

- At this time the PALS team are able to respond within a 21 working day timeframe for non-urgent concerns.
- A member of staff on the bank is now supporting the team for 2/3 days per week.
- Consideration is being made to have senior nursing staff visit the PALS team to support and engage in patient engagement and escalate the challenges being faced.
- Themes: Appointments, lack of communication, delays in treatment and receiving an appointment.
- Planned care continue to receive the highest number of concerns raised and this is reflected in the volume of complaints received.

PALs Top 5 specialties - Sep-25



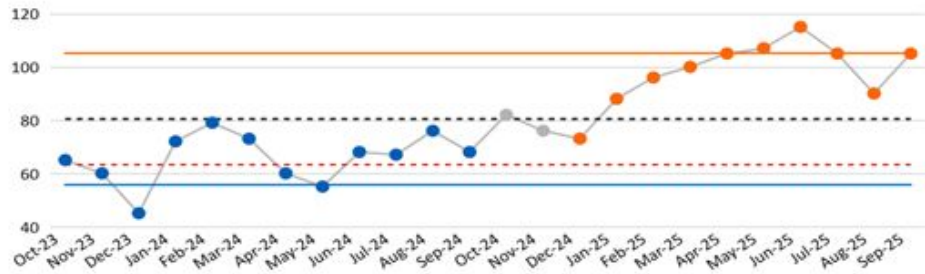
Month 06 | 2025-26

Quality

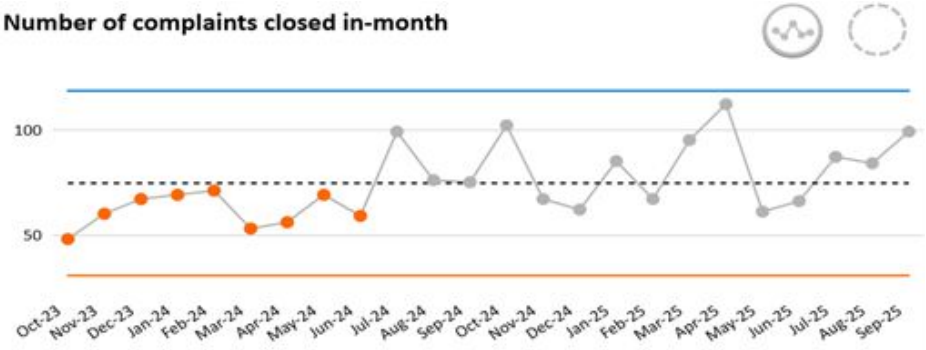
Complaints

NHS East and North Hertfordshire Teaching NHS Trust

Number of written complaints received



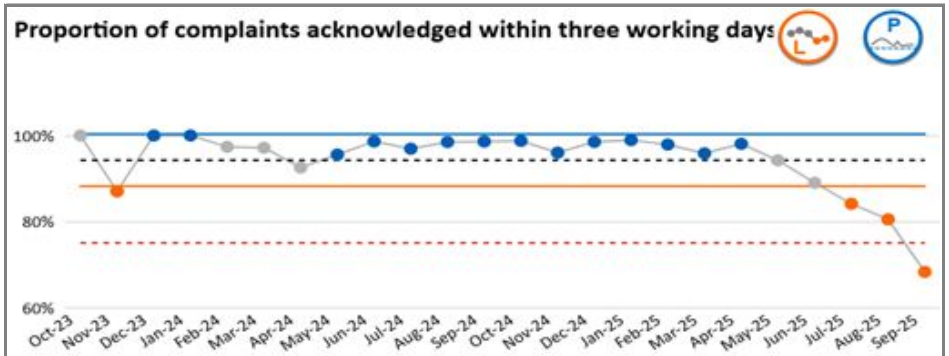
Number of complaints closed in-month



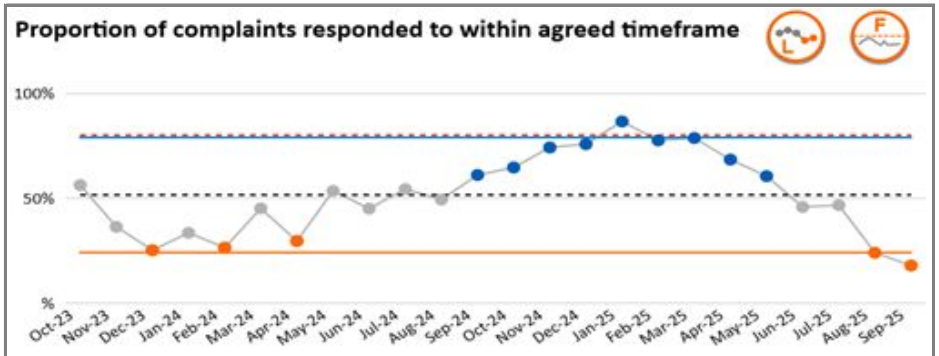
Key Issues and Executive Response

- There has been an increase in the number of complaints received in September 2025.
- A pilot for Complaints Handlers to triage the complaint at the first point and request services to call patients/carers to offer early resolution whenever possible, in relation to cancelled appointments/surgery, delays, communication and staff attitude. This has been successful with Cancer Services and Women and Childrens Services and is now being trialled with Planned care.
- Planned Care continue to receive the highest amount of complaints month on month since January 2025. Planned Care currently has 156 open complaints. The Trusts open complaints total was 297 at the end of September 2025.
- The complaints team continue to struggle with the volume of formal complaints being received. The acknowledgement timeframe has dropped due to the impact of the volume being received.

Proportion of complaints acknowledged within three working days



Proportion of complaints responded to within agreed timeframe



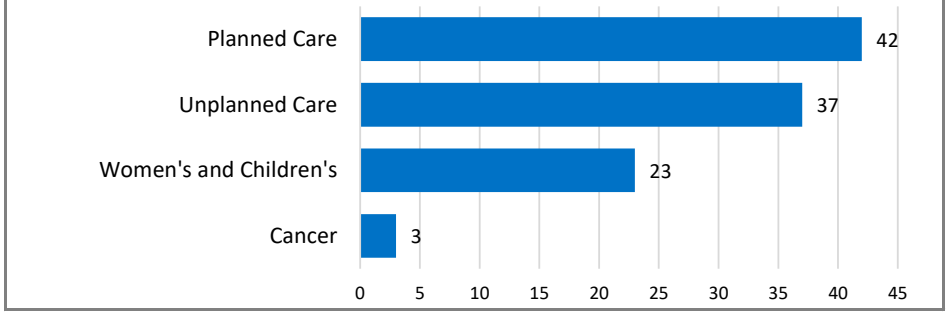
Month 06 | 2025-26

Quality

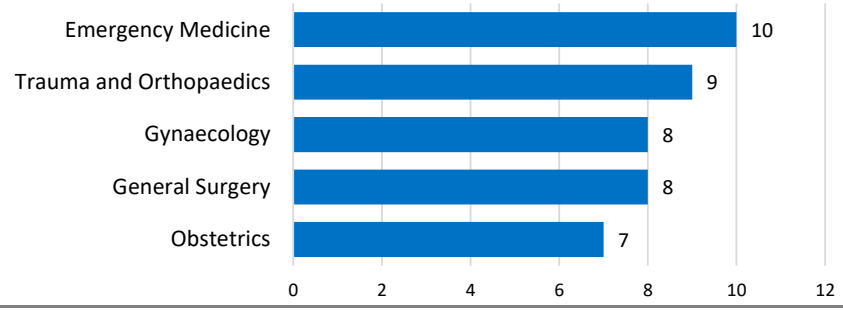
Complaints Themes

East and North Hertfordshire Teaching NHS Trust

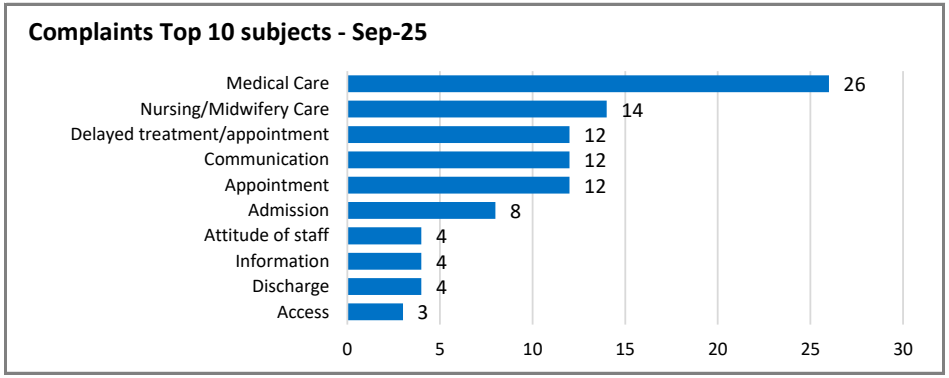
Complaints by Division - Sep-25



Complaints top 5 specialties - Sep-25



Complaints Top 10 subjects - Sep-25

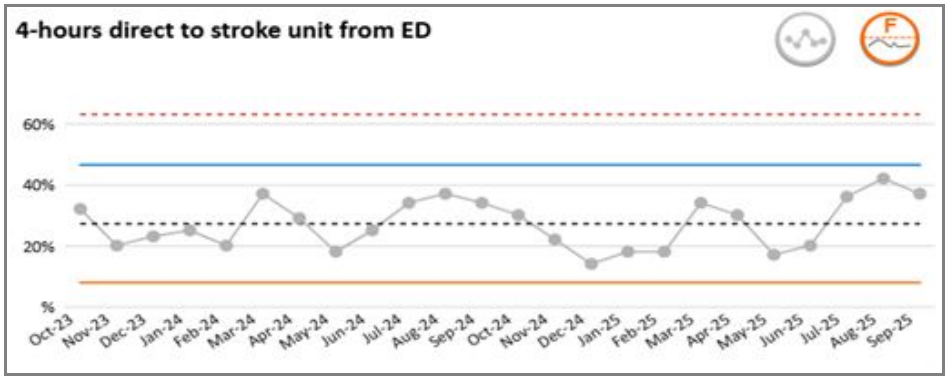


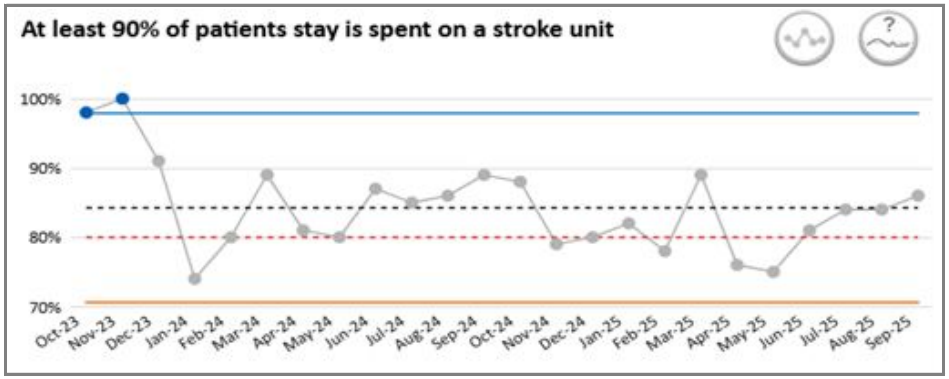
Month 06 | 2025-26

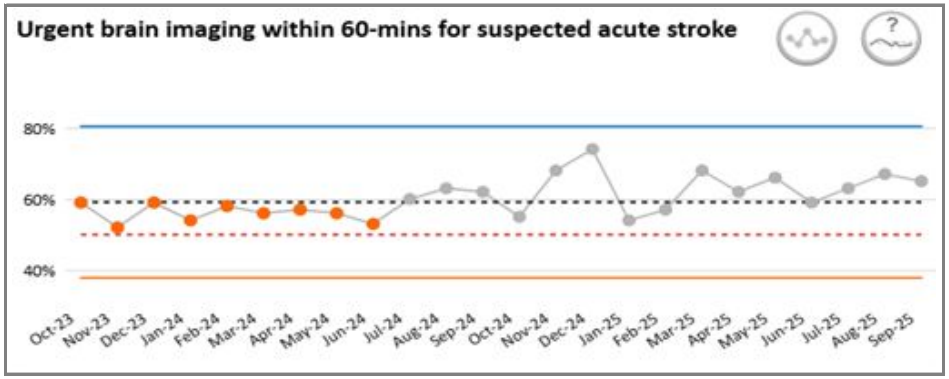
Operations

Stroke Services

East and North Hertfordshire Teaching NHS Trust

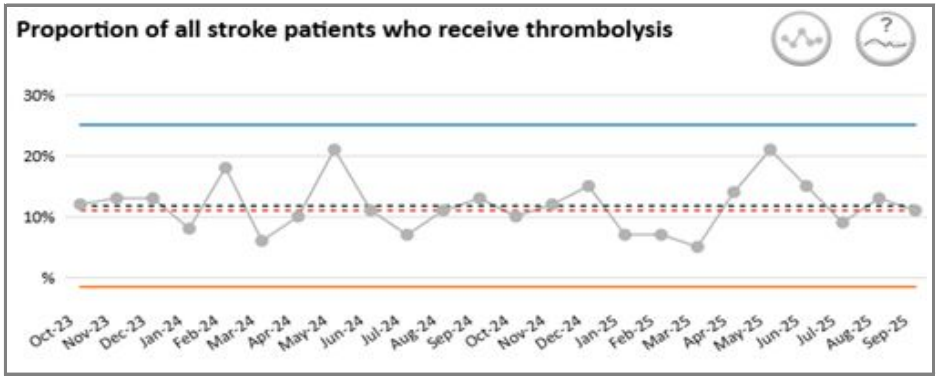






Key Issues and Executive Response

- **Thrombolysis/Thrombectomy** - Door to needle time is 49 minutes, 5 minutes increase from previous month. 10.7% of patients receiving thrombolysis. CTP go live is 20th Oct and expected benefits include Increase in eligible patients for thrombolysis and thrombectomy. 4% Thrombectomy rate in month, 7.2% for Q2 rating. ICB/NHSE visit to discuss actions for improving Thromb/throm. Weekly case reviews of Thrombos/Thromb patients continuing.
- **4 hr performance 37.3%** SOP in place to ring fence stroke beds and meet trajectory of 60% by March 2026. SPR 7/7 22:00 commenced from 1st Sept. Seeing significant improvement in 4-hour performance in daily audit (IPR data based on SSNAP data which is based on patients who discharged in the month of Sept, so data varies).
- **Length of stay:** Continued focus on MDT LOS reviews conducted weekly. An increase in level 1 beds required which is impacting LOS. Ongoing discussions with ICS and region addressing capacity and longer term plans and processes.
- **CT within 20 minutes** (new standard) : 24% which sees a dip from previous month; focus on improving to meet SSNAP target of 40%. 65.3% were scanned within an hour. Implementation of Stroke Video Triage will improve rapid diagnosis.

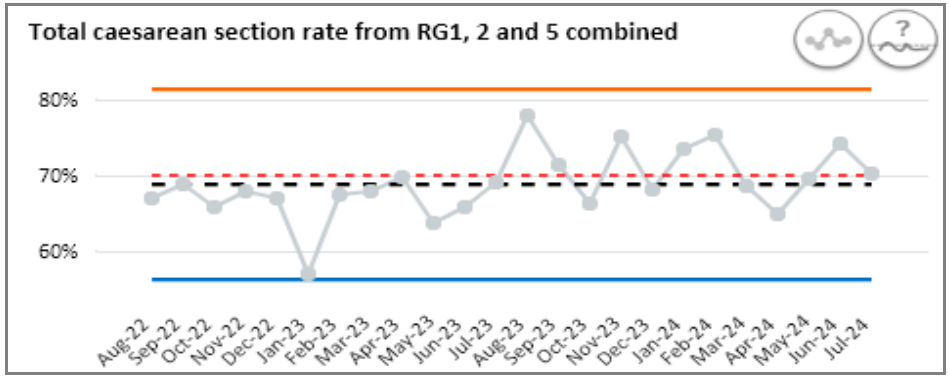


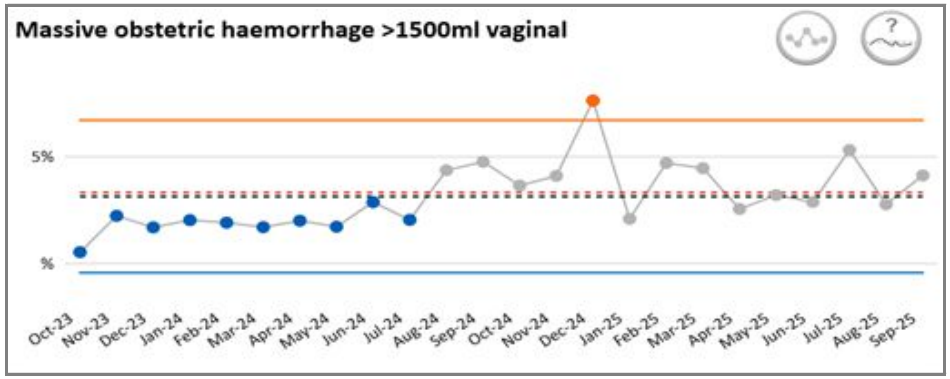
Month 06 | 2025-26

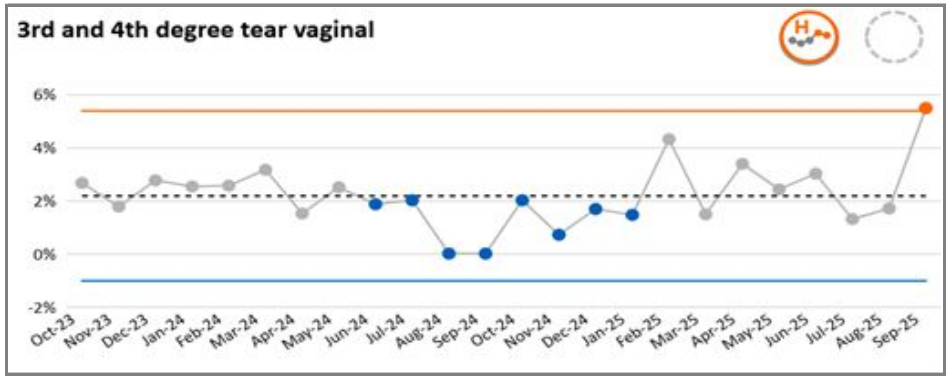
Quality

Maternity | Safety Metrics

East and North Hertfordshire Teaching NHS Trust







Key issues and executive response

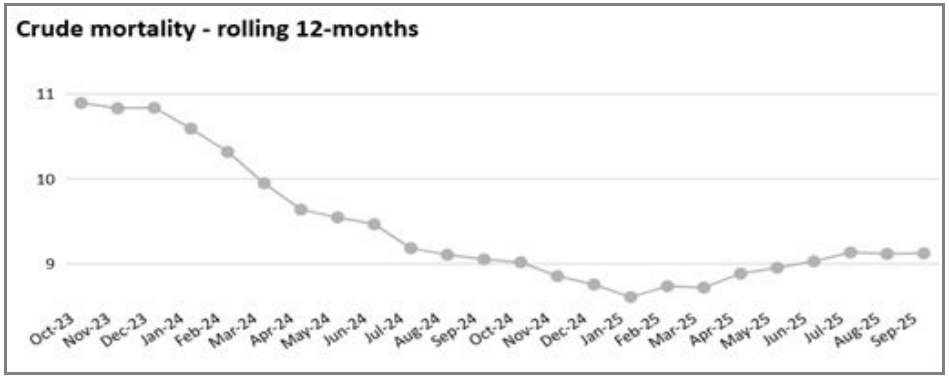
- There was one case qualifying as PSII and accepted for investigation by MNSI (planned homebirth, thick meconium, transferred tertiary unit for therapeutic cooling for acute HIE. No care and service delivery issues. GBS confirmed placental histopathology). There were 3 cases of moderate physical harm, consistent with previous months. One (an MOH 1.9L) to be brought to PSERP for consideration as PSII following learning from closure of obstetric theatre 1. No cases of serious harm.
- There have been no stillbirths >24/40 and no cases of maternal death.
- There were 3 cases of 3rd/4th degree perineal trauma at instrumental births, supported by a high episitomy rate (97.92%) and 8 cases at vaginal births. This is outside of process limits but episiotomy rates at vaginal birth remain consistent with previous months (5.03%). An increased number of women birthing on CLU (89.92%) may have had impact. OASI training has been prioritised for all clinicians.
- There was an increase in MOH >1500mls (4.56%). Total 17 and of those, 3 (0.80%) were >2000mls. 8 (4.10%) MOH at vaginal births, and 9 (5.06%) MOH at LSCS. Weekly thematic review of MOH ongoing. LMNS collaboration on learning and actions.
- There was an increase in separation of mothers and babies demonstrated by NICU admissions of 33 (8.25%) rising above national standards (<6%). One avoidable case where baby could have been transferred to TC sooner. Weekly review and actions ongoing.
- Smoking at delivery (4.2%) remains below national standard (<6%).
- Breastfeeding initiation (74.75%) has returned above national standard (>72%) but work is ongoing by Infant Feeding leads to ensure digital documentation is reflective of practice (33 missing).
- Total LSCS = 190 (47.86%), Total Cat 1-3 (Emergency) = 98 (24.69%). Total Cat 4 (Elective) = 92 (23.17%) relative to previous months. Robson Group Criteria RC1 = 18.0%, RC2 = 64.76%, RC5 = 84.06%. Incomplete denominator data remains an area of focus. Figures are proportionate representation of actual cases for the month.

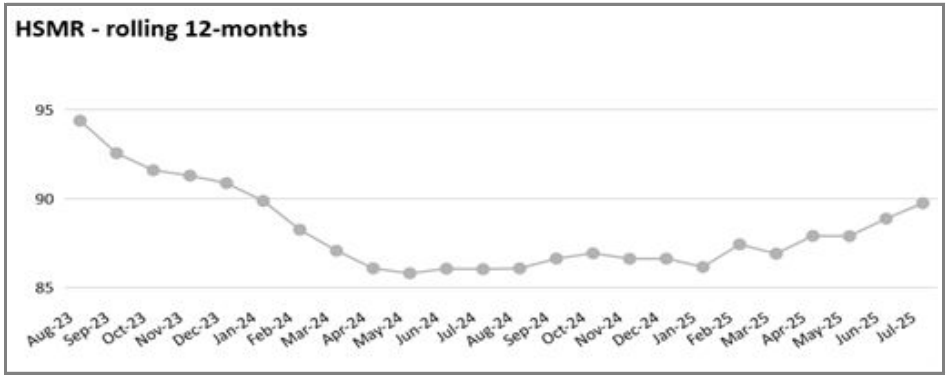
Month 06 | 2025-26

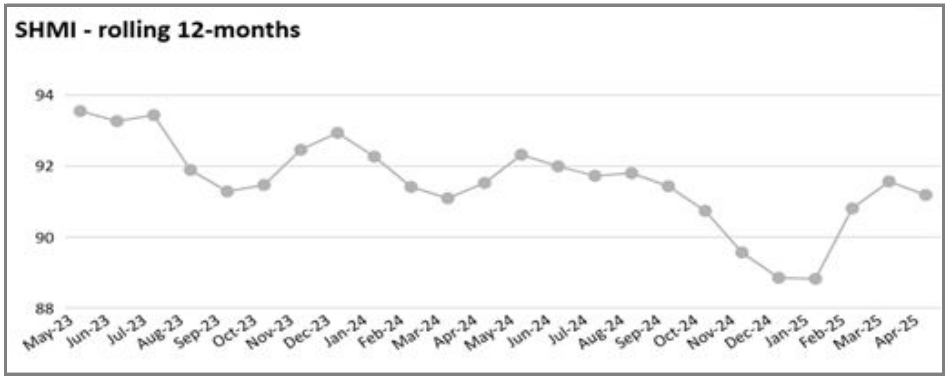
Quality

Mortality

East and North Hertfordshire Teaching NHS Trust







Key Issues and Executive Response

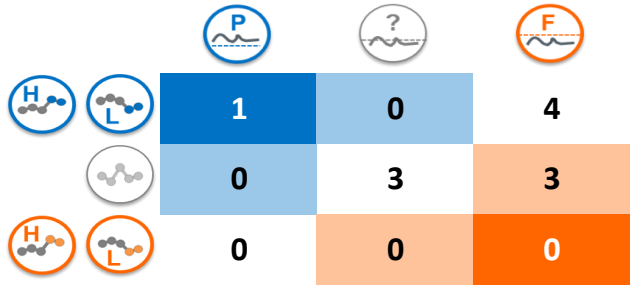
- Crude mortality is the factor which usually has the most significant impact on HSMR. The exception was during the COVID pandemic, when the usual correlation was weakened by the partial exclusion of COVID-19 patients from the HSMR metric. This partial exclusion continues for the CHKS HSMR metric that the Trust uses.
- The general improvements in mortality (excluding the COVID-19 period) seen over recent years 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.
- Significant downward trend in rolling 12-month HSMR from Mar-23 to Apr-24, when the metric plateaued and has been on an upward trend since Jan-25. The latest rolling 12-month HSMR to Jul-25, reported by CHKS, stands at 89.7 positioning us in the mid-range of trusts nationally.
- The latest in-month figure to Jun-25 stands at 108.0, a significant increase from the previous month's figure of 90.7. We are waiting for next months' refresh to see if this figure adjusts downwards (which would indicate it was initially due to incomplete data) or whether there is a 'real' increase requiring further review.
- Latest NHSD published rolling 12-month SHMI available to May 2025, stands at 91.44, an increase from last month's 91.17. This positions us in the first quartile of trusts nationally and well below the national average within the 'as expected' band.
- Our position relative to other trusts has remained relatively stable. Over the last 12 months our most favourable position has been 18/118 and least favourable 23/118 acute trusts.
- The latest figures provided by CHKS for Apr-25 are 89.4 in-month and 91.2 for rolling 12-month. While there had been a recent upward trend to our in-month position, April saw a marked decrease, resulting in the overall annual SHMI figure remaining broadly the same.

Month 06 | 2025-26

NHS
East and North Hertfordshire Teaching
NHS Trust

Operations

Month 06 | 2025-26



Urgent and Emergency Care

Summary

NHS East and North Hertfordshire Teaching 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	Sep-25	95%	75.7%	H	F	7 points above the mean Metric will consistently fail the target
	Patients waiting more than 12 hours from arrival to admission, transfer or discharge	Sep-25	5%	8.9%		F	Common cause variation Metric will consistently fail the target
	Percentage of ambulance handovers within 15-minutes	Sep-25	65%	20.7%	H	F	7 points above the mean Metric will consistently fail the target
	Time to initial assessment - percentage within 15-minutes	Sep-25	80%	55.5%	H	F	9 points above the mean Metric will consistently fail the target
	Average (mean) time in department - non-admitted patients	Sep-25	240	174	L	P	7 points below the mean Metric will consistently pass the target
	Average (mean) time in department - admitted patients	Sep-25	tbc	472	L		7 points below the mean No Target
	Average minutes from clinically ready to proceed to departure	Sep-25	tbc	184	L		8 points above the mean No target
RTT & Diagnostics	Patients on incomplete pathways waiting no more than 18 weeks from referral	Sep-25	92%	56.9%	H	F	10 points above the mean Metric will consistently fail the target
	Patients waiting more than six weeks for diagnostics	Sep-25	0%	53.9%		F	Common cause variation Metric will consistently fail the target

Month 06 | 2025-26

Urgent and Emergency Care

Summary

NHS East and North Hertfordshire Teaching NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Cancer Waiting Times	62-day referral to treatment standard	Aug-25	85%	86.1%			Common cause variation Metric will inconsistently pass and fail the target
	31-day decision to treat to treatment standard	Aug-25	96%	96.8%			Common cause variation Metric will inconsistently pass and fail the target
	28-day Faster Diagnosis standard	Aug-25	75%	78.9%			Common cause variation Metric will inconsistently pass and fail the target
	Proportion of cancer PTL waiting more than 62 days	Aug-25	7%	19.9%			Common cause variation Metric will consistently fail the target

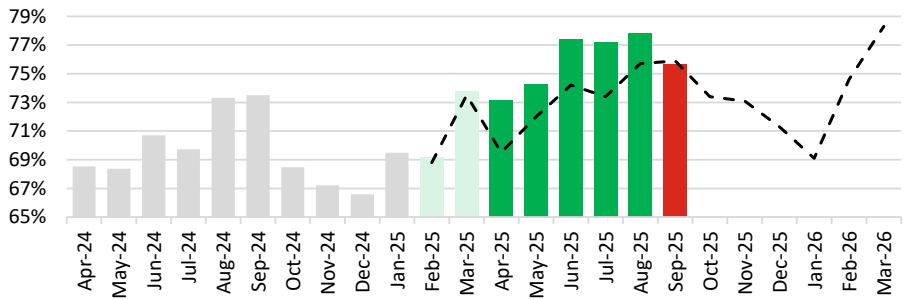
Month 06 | 2025-26

Urgent Emergency Care

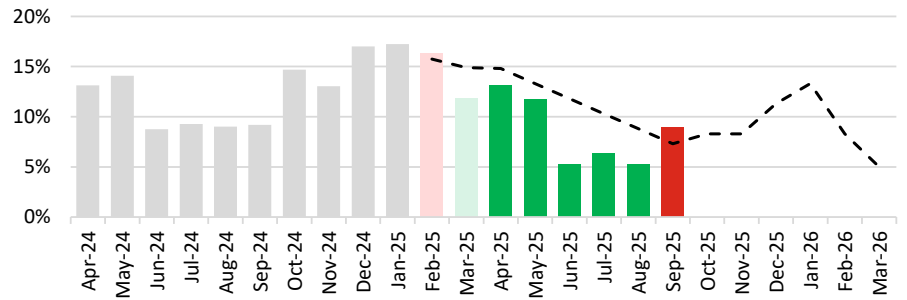
Trajectory Monitoring 2025-26

NHS East and North Hertfordshire Teaching NHS Trust

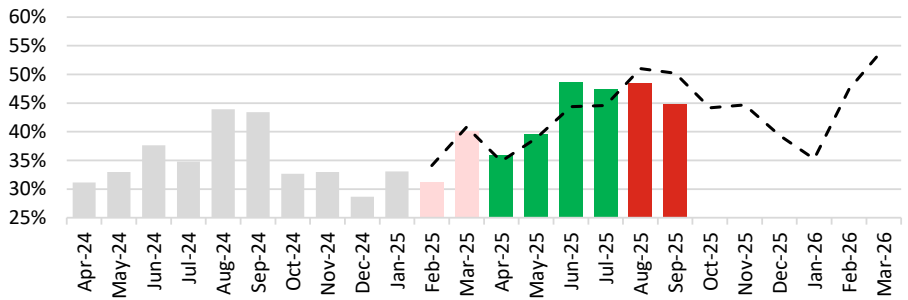
Four hour performance against trajectory - Trust-wide



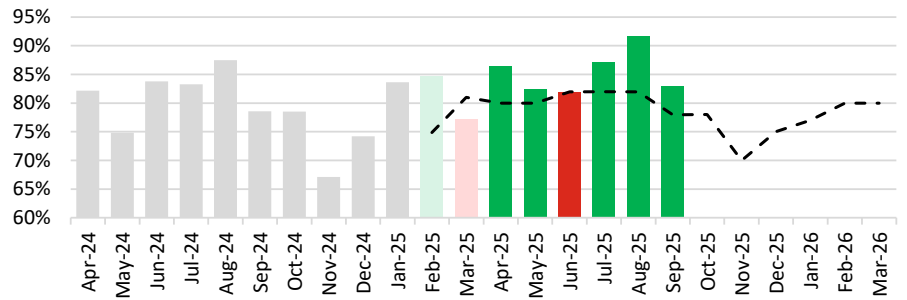
Patients in department over 12 hours - Type 1



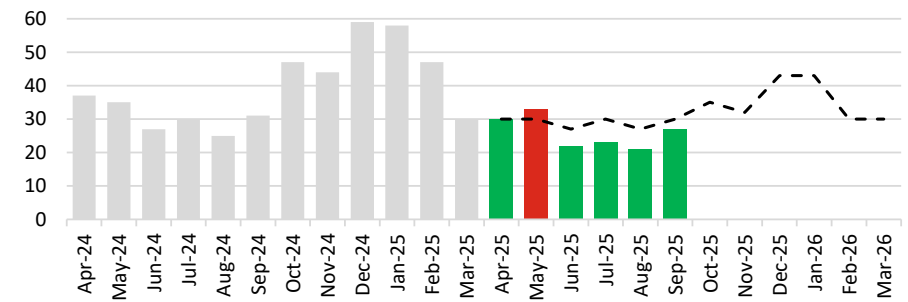
Four hour performance against trajectory - Type 1 Adults



Four hour performance against trajectory - Type 1 Paediatrics



Average ambulance handover time (minutes)

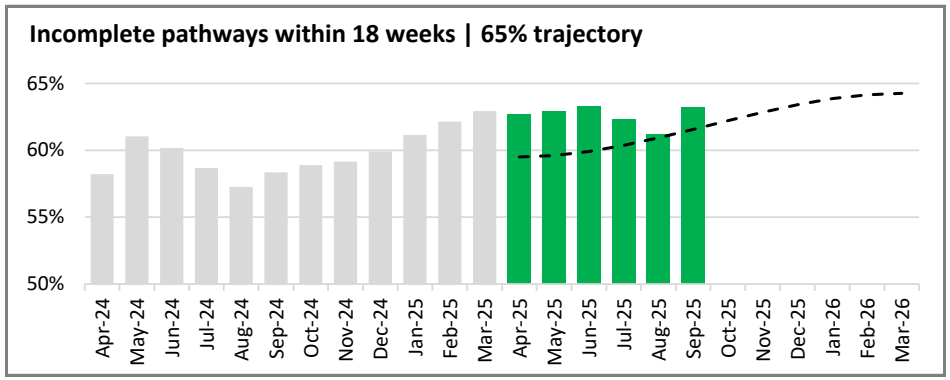


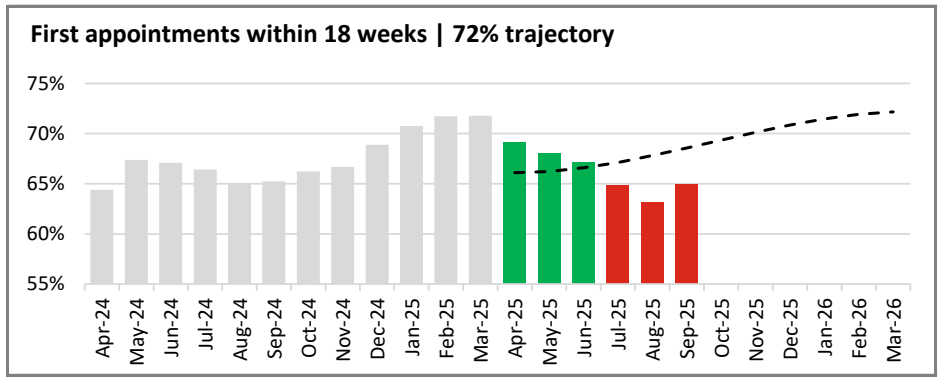
Month 06 | 2025-26

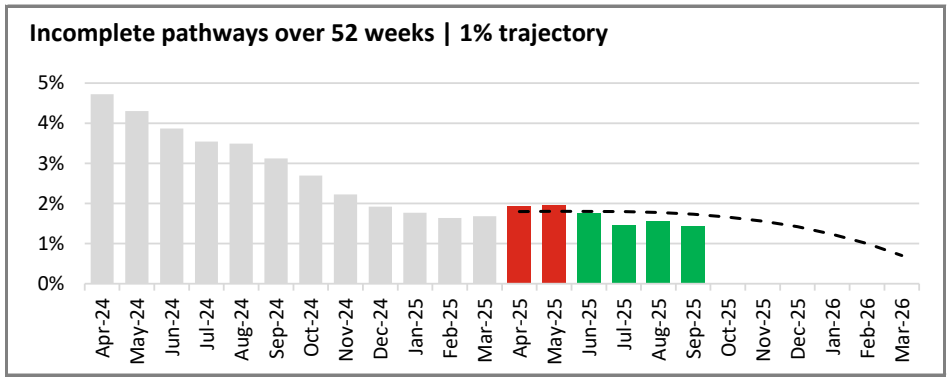
Cancer Waiting Times | RTT 18 weeks

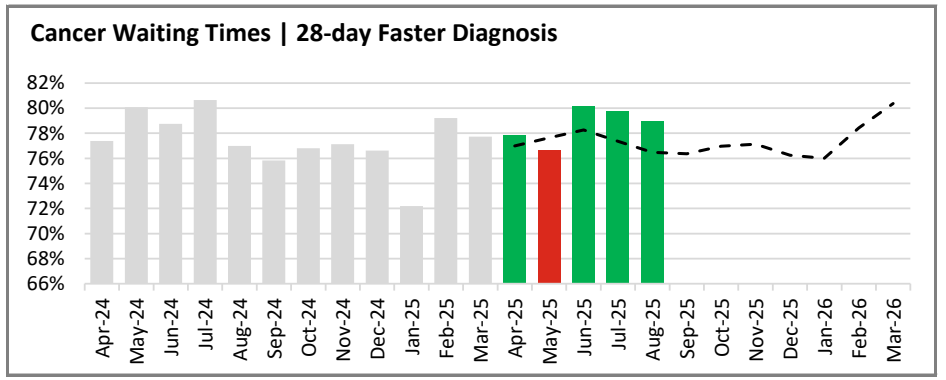
Trajectory Monitoring 2025-26

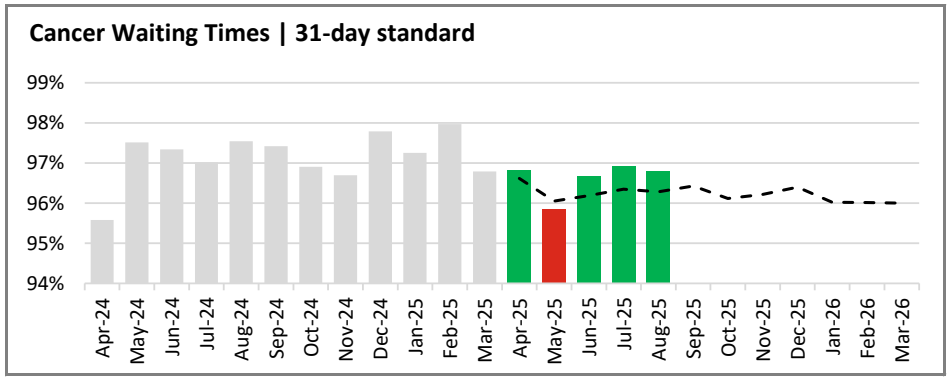
NHS East and North Hertfordshire Teaching NHS Trust

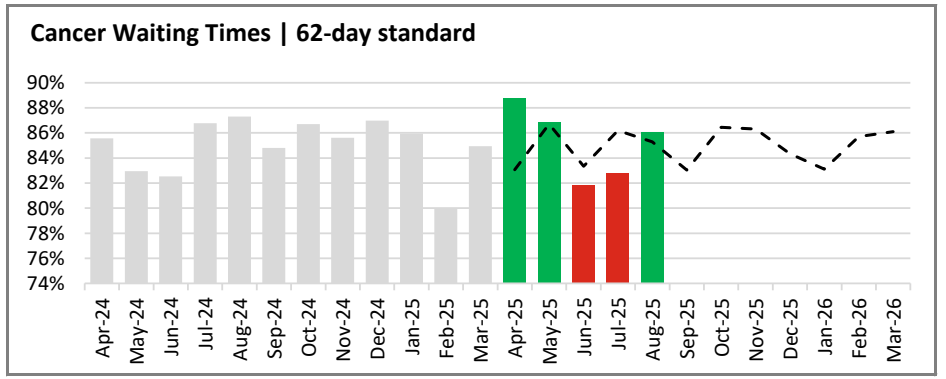












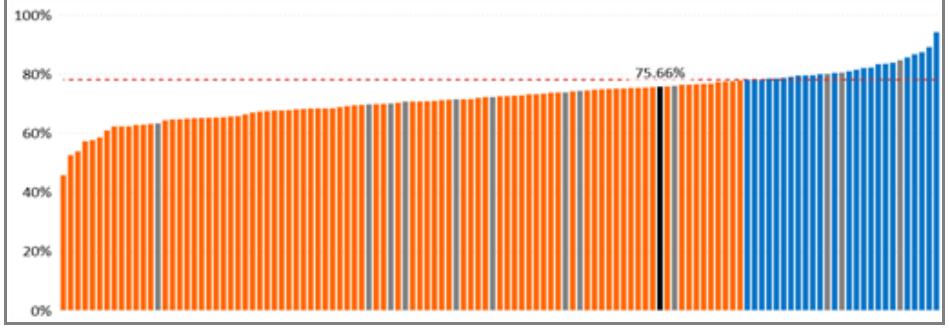
Month 06 | 2025-26

Operations

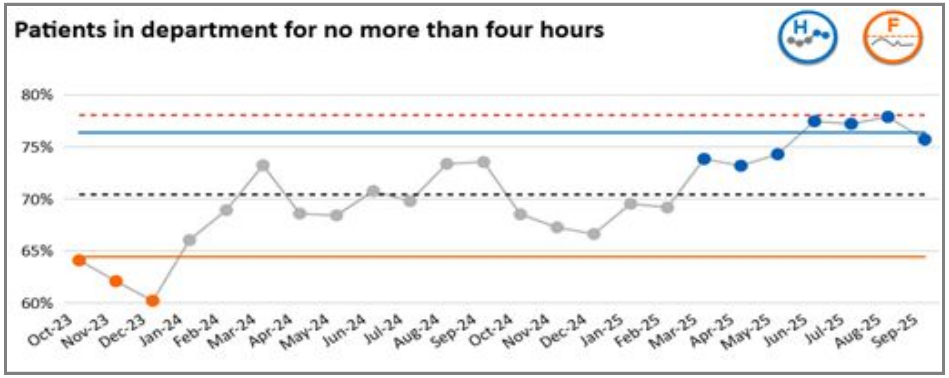
Urgent and Emergency Care New Standards

NHS East and North Hertfordshire Teaching NHS Trust

Patients waiting less than 4-hours in ED peer distribution - Sep-25



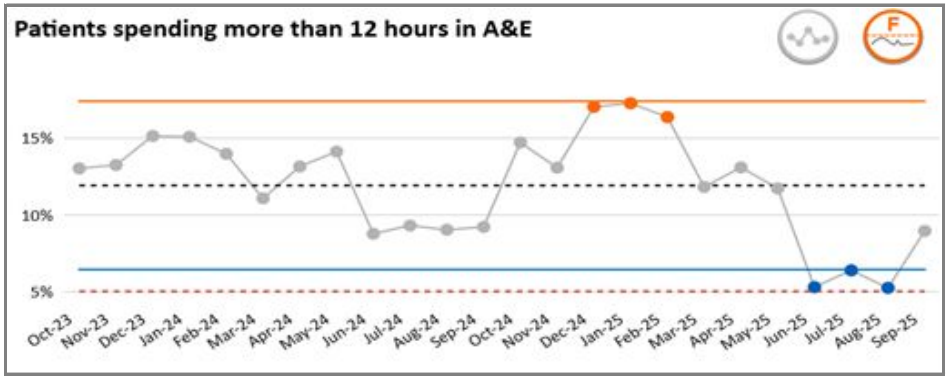
Patients in department for no more than four hours



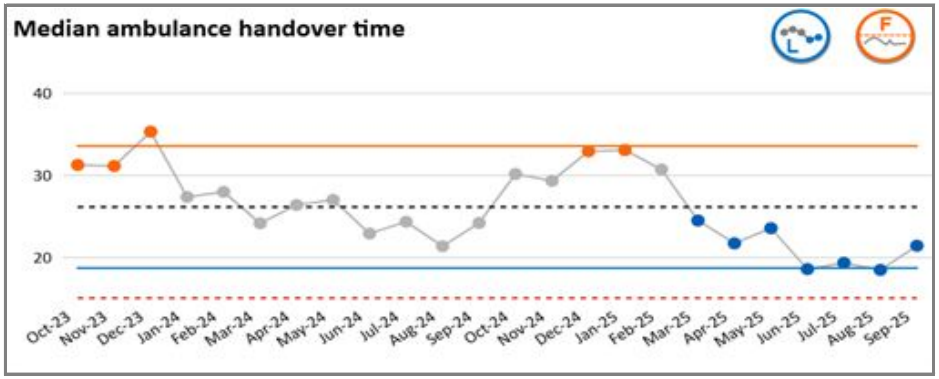
Key Issues and Executive Response

- In September, 4-hour performance stood at 75.66%, slightly below trajectory. Performance for Adult Type 1 non-admitted was maintained at 52.5%; however, admitted performance saw a significant decline from 32.8% to 22.9% in the wake of increased adult admitted demand, IP beds closed for Estates work and increasing LOS for discharge ready patients. Paeds type 1 performance stayed ahead of trajectory.
- 12 hour waits in ED increased to 8.93%, slightly behind our improvement plan for the first time this year; but still materially improved on 2024/5.
- Median ambulance handover times increased slightly to 27 mins, attributed to reduced patient flow within the department and mutual aid for PAH. A new SOP and infrastructure changes starting in Dec will increase capacity, improve flow & patient experience.
- Mean ED doctor waiting times and referral to specialty wait times have been maintained, showing consistent month-on-month improvements since April 2025.
- Efforts continue to be concentrated across all working groups, including Resus, Main Wait, Clinical Decision Unit, and Ambulance Handover.

Patients spending more than 12 hours in A&E



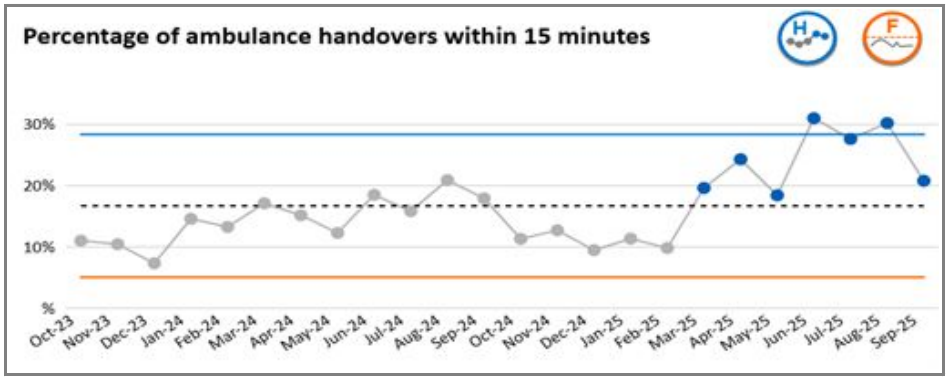
Median ambulance handover time

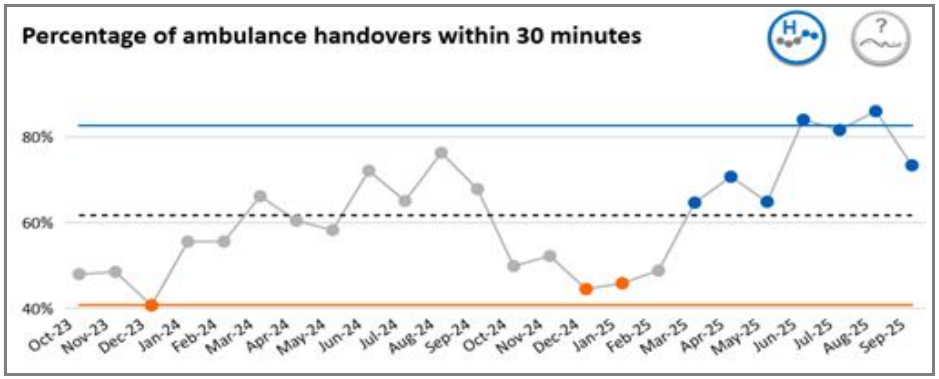


Month 06 | 2025-26

Operations

Urgent and Emergency Care | Supporting Metrics



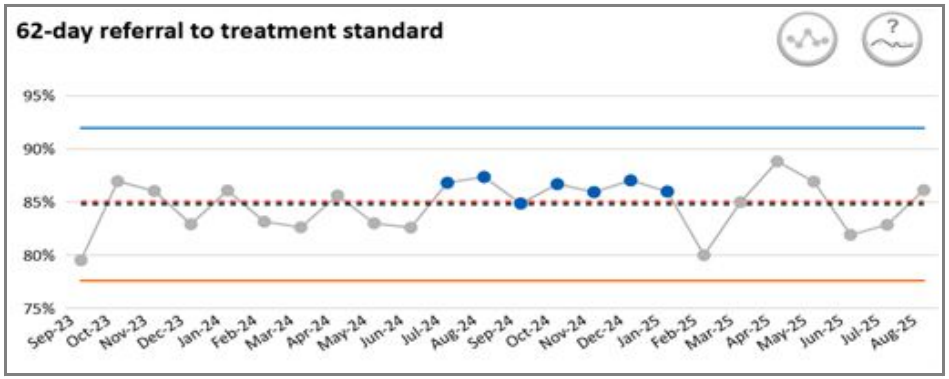


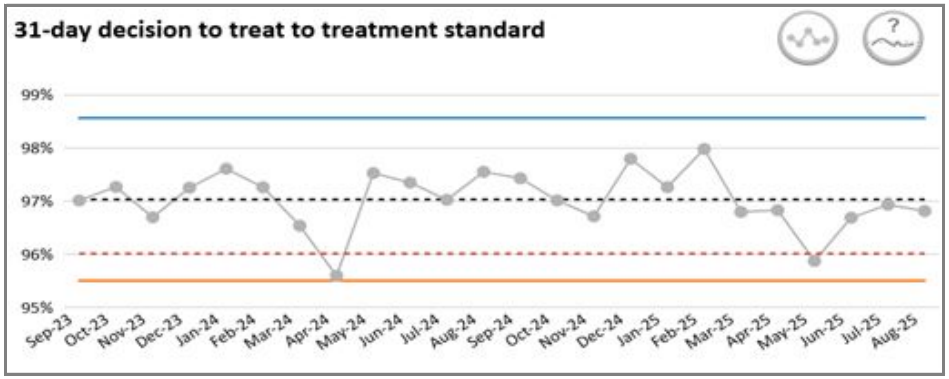
Month 06 | 2025-26

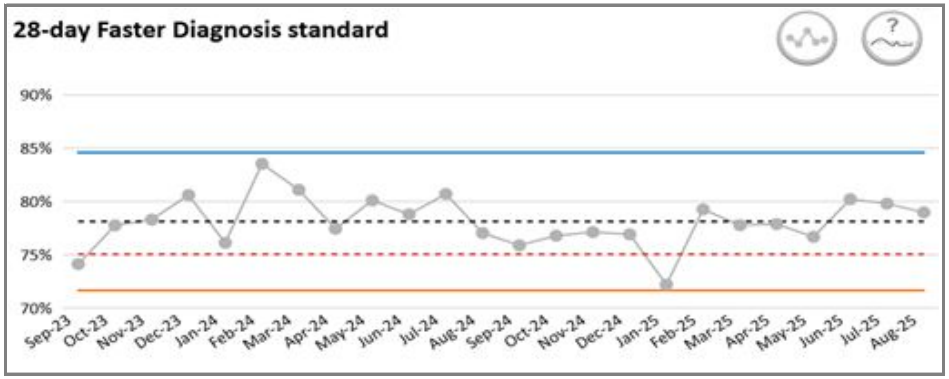
Operations

Cancer Waiting Times | Supporting Metrics

NHS East and North Hertfordshire Teaching NHS Trust







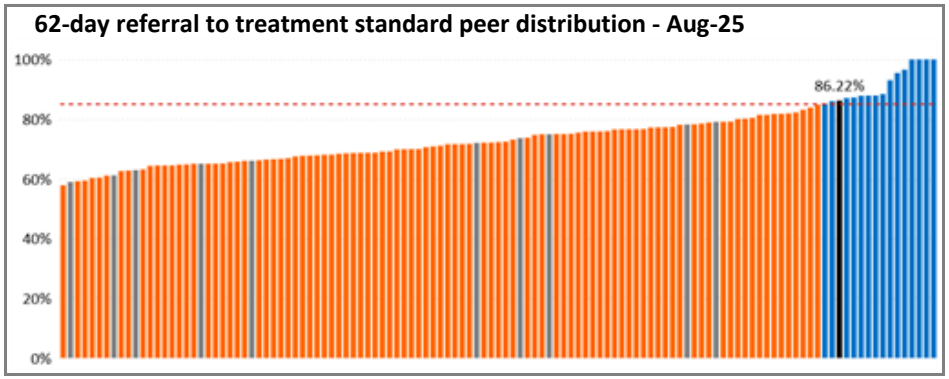
Key Issues and Executive Response

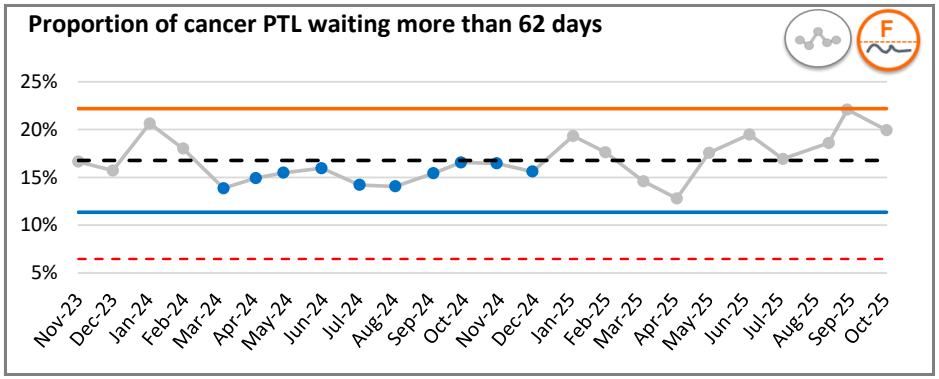
- We achieved 3 of the 3 national targets in August 25 with compliance in the 28 day Faster Diagnosis, 31 Day decision to treat standards and 62 Day referral to treatment standard.
- The 62-day performance in August returned to compliance as expected and ranked 5th nationally out of 118 NHS providers. This exceeded both regional and national averages by approximately 20%, making us the top-performing hospital in the East of England region.
- 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.
- Job planning is taking place to reduce dependence on WLIs and help sustain 28 FDS compliance this year at the increased target of 80%.
- Breach analysis continues for all patients against all standards to influence pathway redesign and learning with MDT teams.

Month 06 | 2025-26

Operations

Cancer Waiting Times | Supporting Metrics





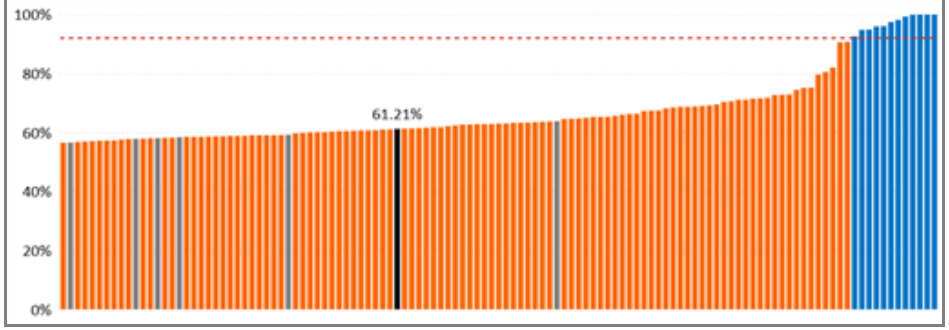
Month 06 | 2025-26

Operations

RTT 18 Weeks

East and North Hertfordshire Teaching NHS Trust

Incomplete pathways within 18 weeks peer distribution - Aug-25



Key Issues and Executive Response

Community Paediatrics

- Community Paediatrics is now reported via the Community Data Set. Referrals have started to stabilise since spring 2024, albeit at approx. 90 referrals per month higher than core capacity, so the waiting list continues to increase, with high numbers tipping across 104ww.
- Internal pathway improvements are starting to deliver additional capacity, with 3 pathway improvement pilots starting from November.
- Meeting with 3 COOs (ENHT, HPFT, HCT) 20/10/25 to agree next steps on system work.
- Single point of referral for neurodiversity hosted at HCT is now live, improving completeness of information ahead of triage
- Further improvements and the use of technology are being discussed amongst the team, alongside improved signposting whilst waiting.
- **78 Weeks** - There were 3,536 patients waiting over 78 weeks at the end of September, compared to 3,429 the previous month.
- **65 Weeks** - There were 4,114 Community Paediatric patients waiting over 65 weeks at the end of September.

Key Issues and Executive Response

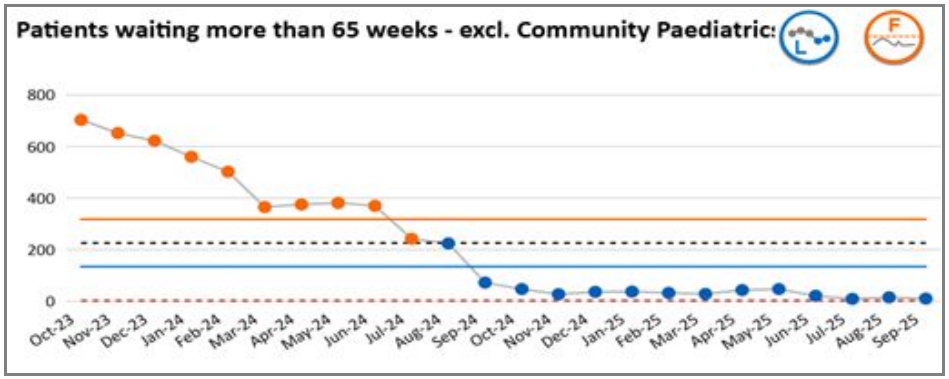
Excluding community paediatrics

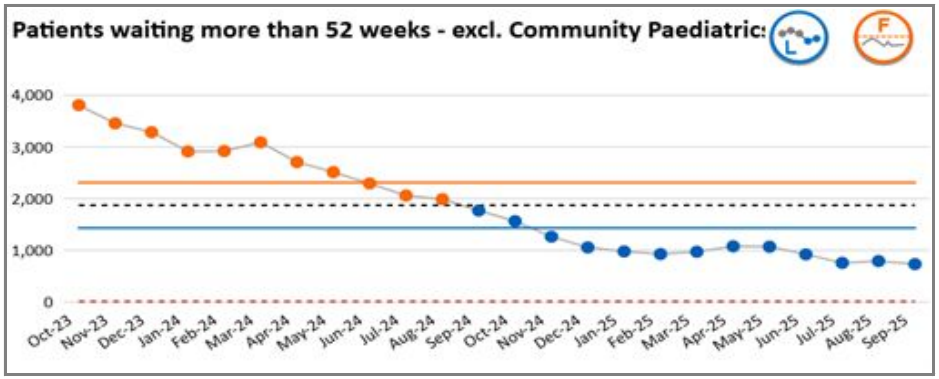
- **18 Week Performance** - 63.2% of patients were waiting under 18 weeks in September, compared to 61.2% at the end of August, 1% away from the March 2026 5% improvement target of 64.2% and ahead of trajectory.
- The Patient Treatment List (PTL) slightly increased by 158 patients, but remained within trajectory.
- **52w proportion of PTL** - 723 patients / 1.4% waiting over 52 weeks in September, against target of no more than 0.7% patients in March 2026. This is ahead of trajectory and a continued improvement on last month.
- **Awaiting First Event < 18 weeks** - 66.9% of patients waiting for first activity within 18 weeks against March 2026 improvement target of 72.2%, was the only target off trajectory. Focussed improvement work taking place with services below 72% to review processes and ensure patients are booked in waiting time order. Additional capacity is being identified to bring waiting times down for first events.
- **65 Weeks** - As of the end of September, 8 patients waiting over 65 weeks: 5 in Trauma & Orthopaedics (T&O), 1 in Ophthalmology, and 2 in Colorectal Surgery. In accordance with NHSE guidance, all patients projected to be waiting longer than 65-weeks in December are scheduled to receive their first outpatient appointment by the end of October. A targeted escalation plan is in place for every patient expected to breach by 21st December, ensuring that no one remains on the waiting list beyond 65 weeks by the end of the year.

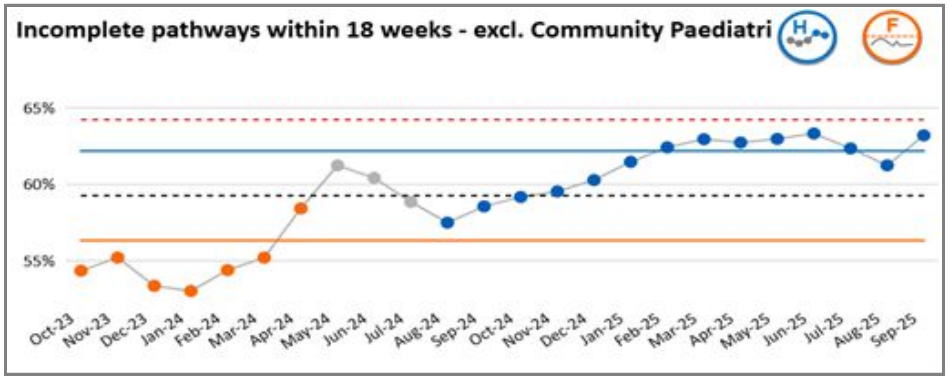
Month 06 | 2025-26

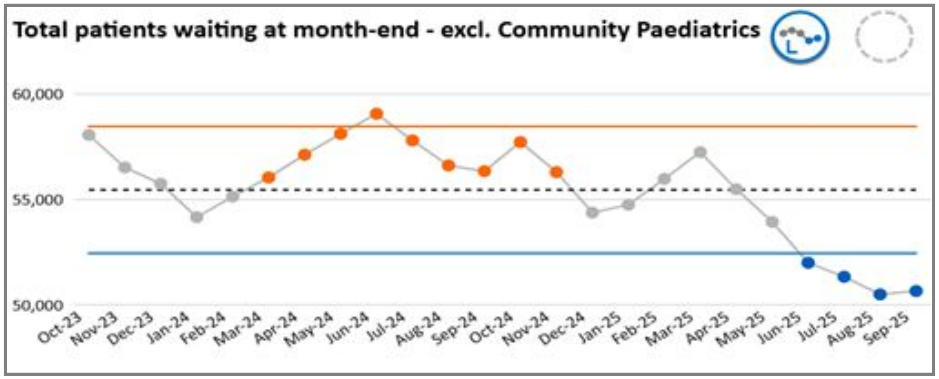
Operations

RTT 18 Weeks - excl. Community Paediatrics







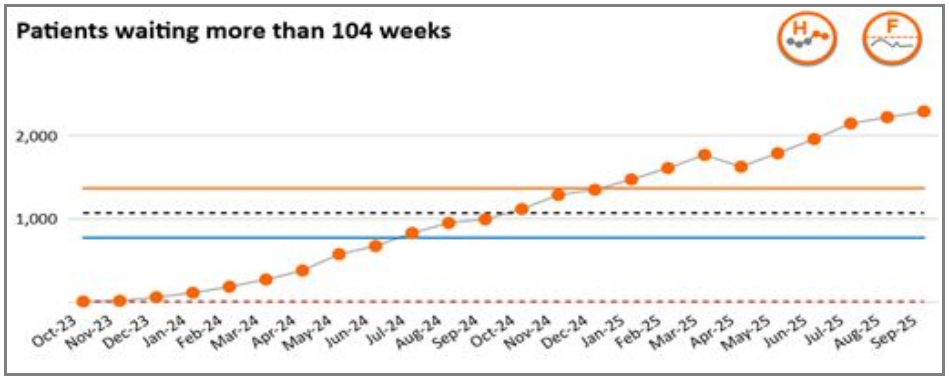


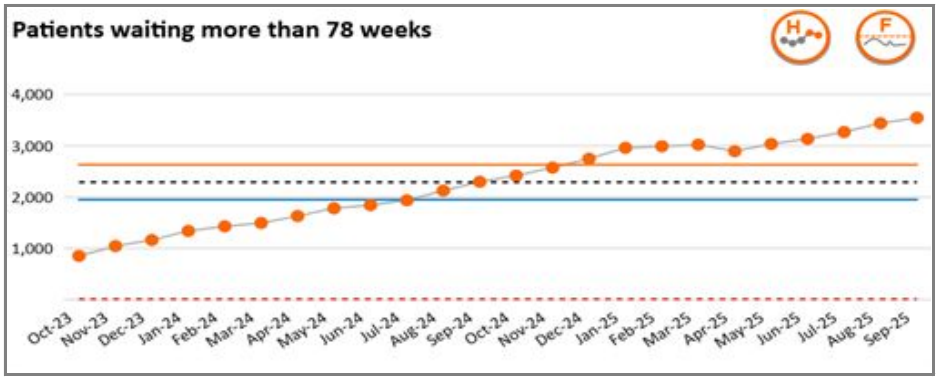
Month 06 | 2025-26

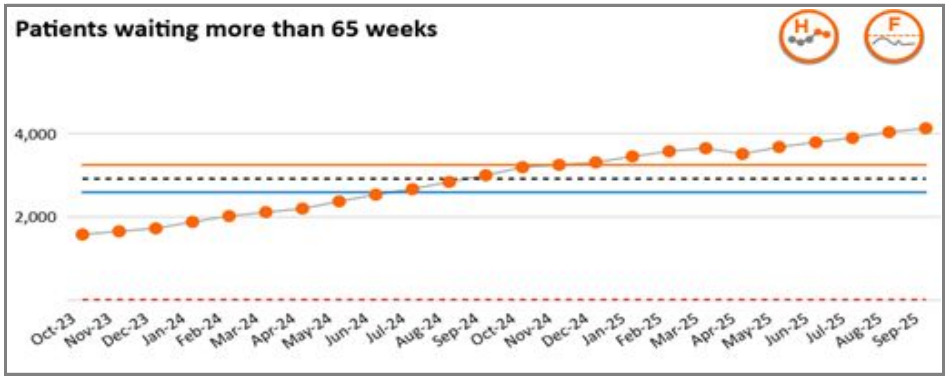
Operations

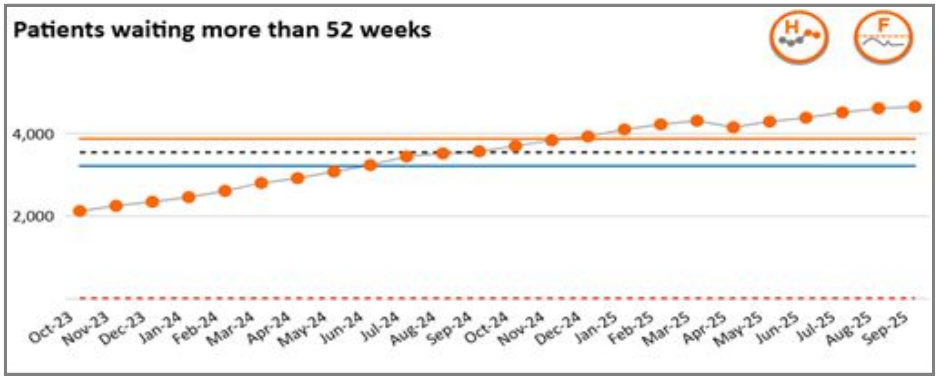
RTT 18 Weeks - Community Paediatrics ONLY

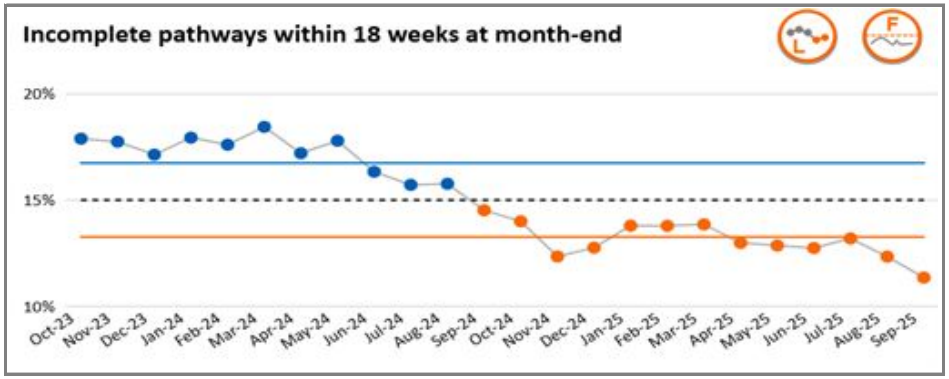
NHS East and North Hertfordshire Teaching NHS Trust

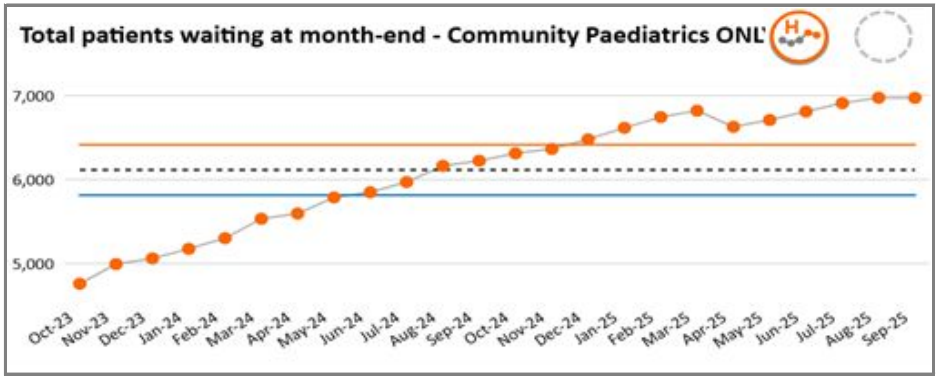








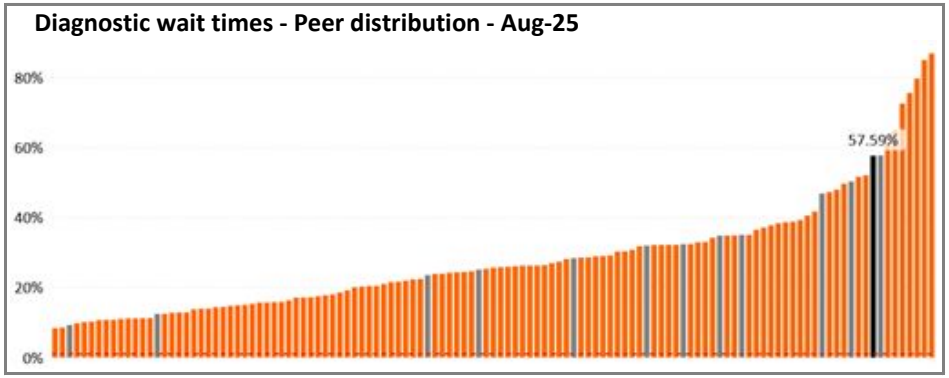


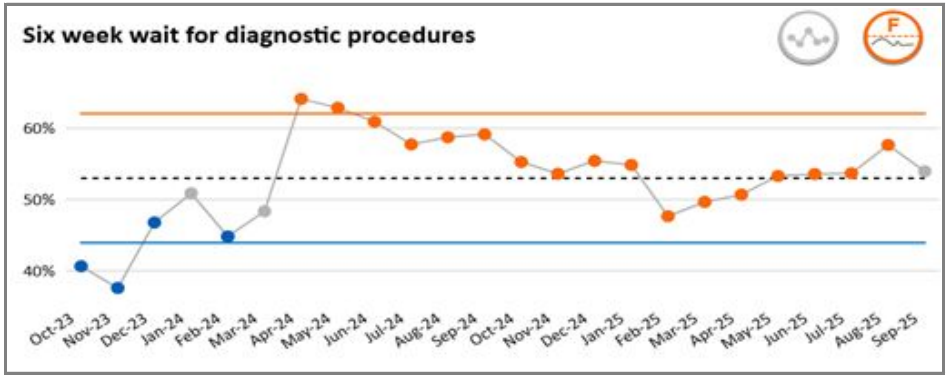


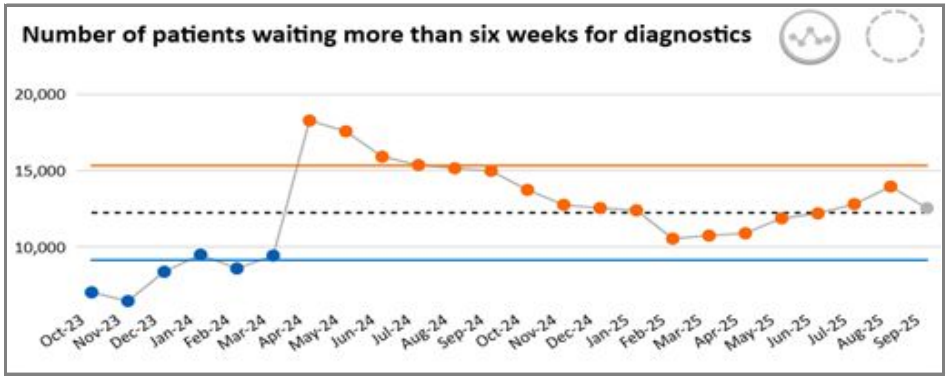
Month 06 | 2025-26

Operations

Diagnostics Waiting Times







Key Issues and Executive Response

- In **September DM01 performance (% of patients waiting over 6 weeks for diagnostics) has improved** from 58% to 54%.
- For DM01 excluding Audiology, there are 5,948 (improved by 12% vs Aug 6,775) patients waiting >6 weeks; with 998 (improved by 40% vs Aug 1,656) patients waiting >13 weeks, the majority waiting for MRI and US.
- Weekly escalation meetings are in place with services who are not compliant which follow the same rigour as RTT meetings.

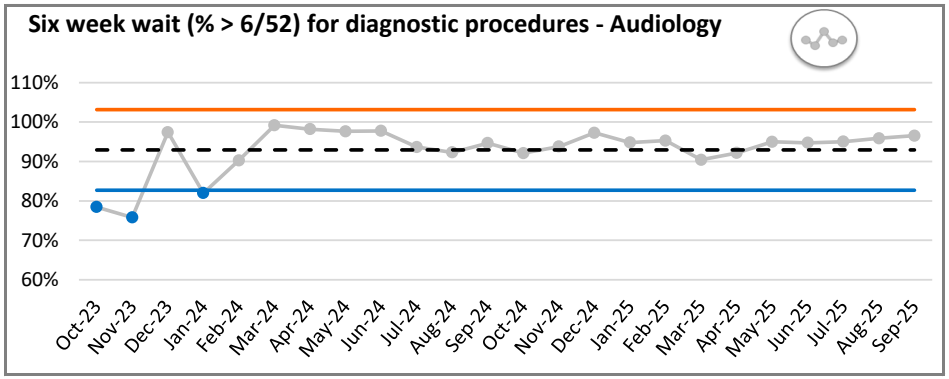
Challenges / Actions

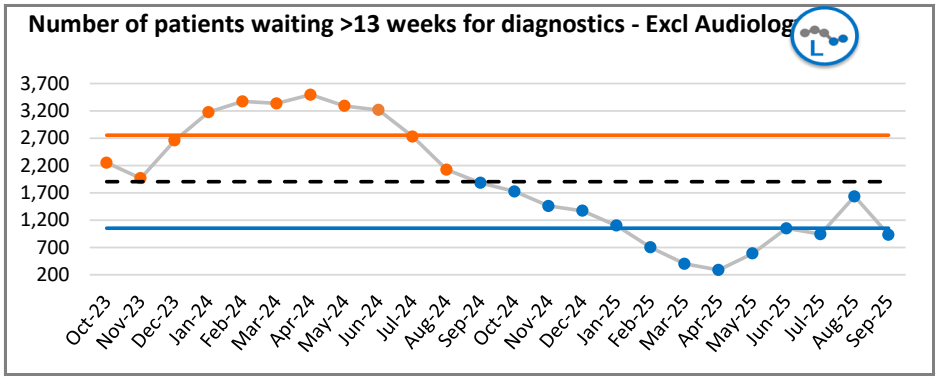
- **Non-Obstetric ultrasound** has been impacted by staffing gaps (20% vacancy). Extension of insourcing has been agreed, therefore the trajectory for compliance needs to be re forecast. Current performance improved from 49% to 45% (4,169 breaches); mean wait 5.37 weeks.
- Outsourcing for **MRI** to Pinehill has started, and CT van capacity switched to MRI for 4 lists per month. An MRI accelerator has been installed at QE2. Following staff training, expected to support an additional 30 scans per month from Oct. Improvements have also been made to slot utilisation. Current performance has improved from 47% to 40% (1,123 breaches); mean wait is 5.04 weeks. Trajectory for compliance is end of the financial year, but subject to additional staff being in post by November.
- Estate has been identified on the Lister site for paeds **audiology,** with plan to open by Mar 2026. Adult audiology currently 96.95% (4,825 breaches) with mean wait of 60 weeks. Paeds audiology currently 95.53% (1,732 breaches) with mean wait of 61 weeks.
- **Sleep studies** - the team is reviewing options to improve capacity, inc alternative clinic locations and additional equipment.

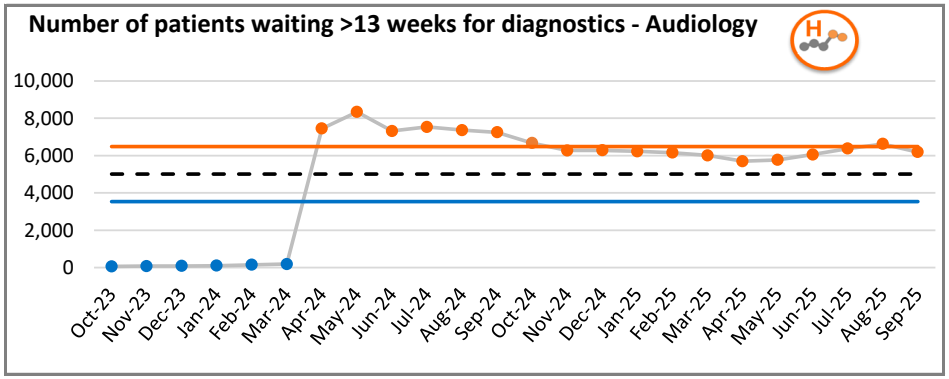
Month 06 | 2025-26

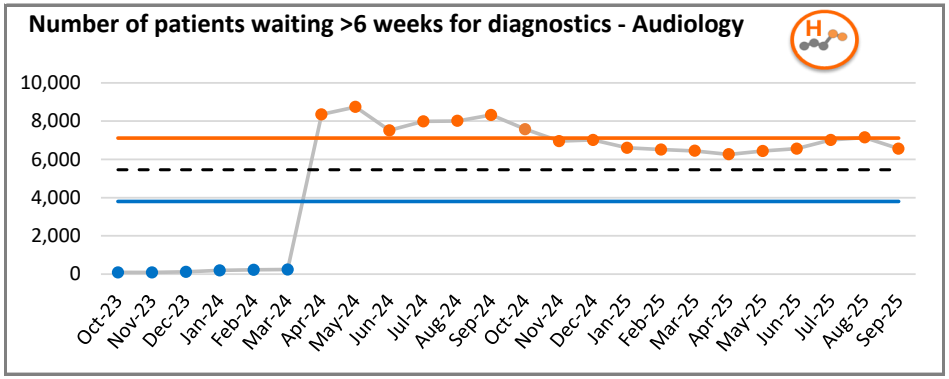
Operations

Diagnostics Waiting Times - Audiology







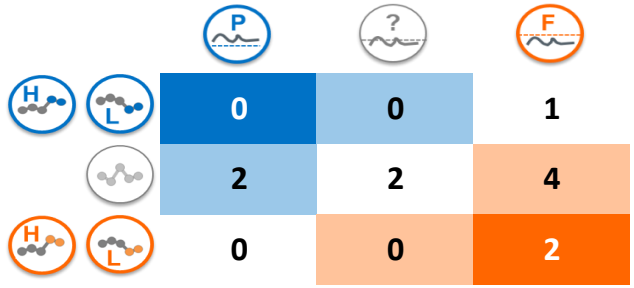


Month 06 | 2025-26

NHS
East and North Hertfordshire Teaching
NHS Trust

Finance

Month 06 | 2025-26



Finance

Summary

East and North Hertfordshire Teaching NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Summary Financial Position	Surplus / deficit	Sep-25	-2.4	0.25		?	Common cause variation Metric will inconsistently pass and fail the target
	CIPS achieved	Sep-25	1,245	1,602			Common cause variation No target
	Cash balance	Sep-25	77.9	26.5	L	F	1 point below the lower process limit Metric will consistently fail the target
Key Financial Drivers	Income earned	Sep-25	45.3	60.1		P	Common cause variation Metric will consistently pass the target
	Pay costs	Sep-25	29.5	37.2		F	Common cause variation Metric will consistently fail the target
	Non-pay costs (including financing)	Sep-25	15.5	22.6	H	F	12 points above the mean Metric will consistently fail the target

Month 06 | 2025-26

Finance

Summary

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Key Payroll Metrics	Substantive pay costs	Sep-25	24.9	33.8		F	Common cause variation Metric consistently fail the target
	Average monthly substantive pay costs (000s)	Sep-25	0.9	5.6		F	Common cause variation Metric will consistently fail the target
	Agency costs	Sep-25		0.6	L		10 points below the mean No target
	Unit cost of agency staff	Sep-25		12.5			Common cause variation No target
	Bank costs	Sep-25	3.7	2.8		?	Common cause variation Metric will inconsistently pass and fail the target
	Overtime and WLI costs	Sep-25	0.5	0.5	L	F	2 point below the lower process limit Metric will consistently fail the target
Other Financial Metrics	Private patients income earned	Sep-25	0.4	0.6		P	Common cause variation Metric will consistently pass the target
	Drugs and consumable spend	Sep-25	2.8	4.5		F	Common cause variation Metric will consistently fail the target

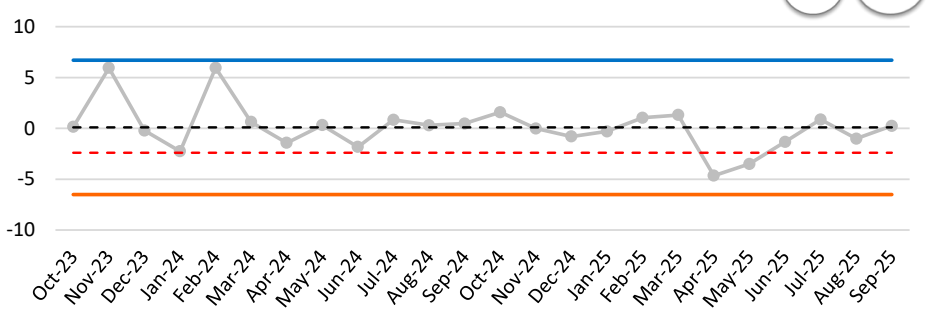
Month 06 | 2025-26

Finance

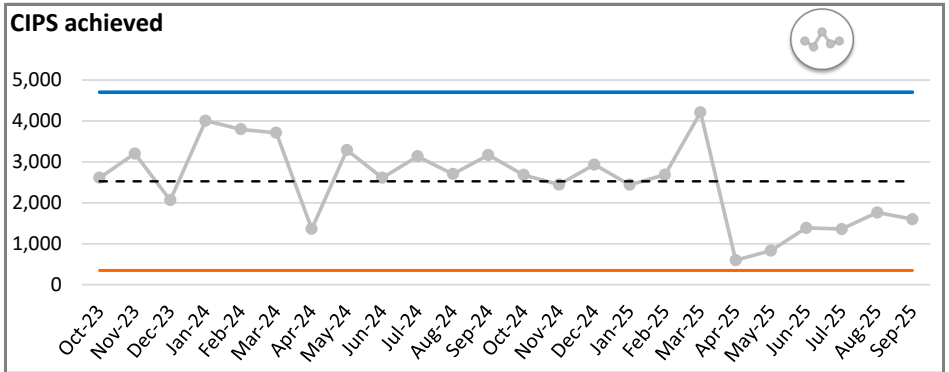
Summary Financial Position

East and North Hertfordshire Teaching NHS Trust

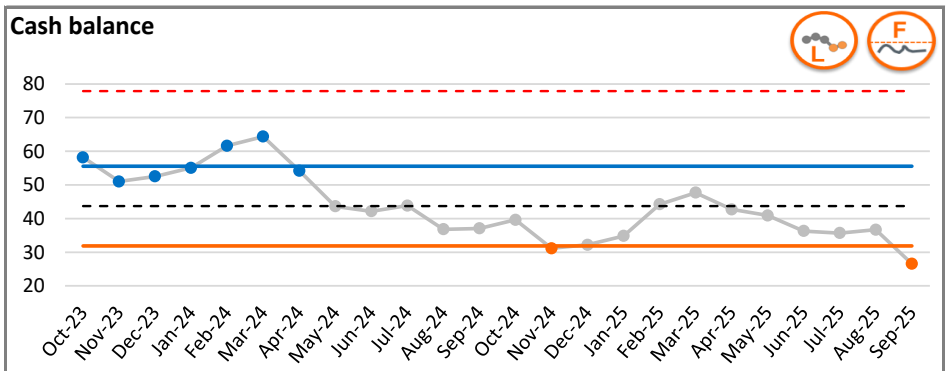
Surplus / deficit



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 6, the Trust has reported an actual YTD deficit of £9.4m. This is in line with phased plan expectations.
- The CIP plan assumes only 25% of delivery at the half way point of the year, so a significant step up in savings needs to be realised in Q3 and Q4.
- The Trust has experienced a range of unanticipated cost pressures in the year to date, including high CSW bank spend as a product of recruitment delays, high levels of maternity bank spend and overspends relating to medical locum and agency use in the Unplanned Care division.
- Whilst the Trust continues to increase is cohort of permanent staffing it is not reducing premium staffing utilisation at a proportionate rate.
- Elective income performance in the YTD is significantly behind plan.
- The Trust estimates the impact of Industrial Action in July at over £0.5m.

	Annual Budget £m	Budget YTD £m	Actual YTD £m	Variance YTD £m
Income	706.2	352.0	353.9	1.9
Pay	-427.4	-222.4	-223.8	-1.4
Non Pay	-241.3	-120.3	-121.3	-1.0
EBITDA	37.5	9.3	8.8	-0.5
Financing Costs	-37.5	-18.8	-18.2	0.6
Retained Deficit exc. PSF	-0.0	-9.5	-9.4	0.1
Surplus / Deficit (excl Fin Adj's)	-0.0	-9.5	-9.4	0.1
Adj Financial Performance	0.1	0.1	-0.1	-0.2
Deficit (Incl Fin Adj's)	0.1	-9.4	-9.4	-0.1

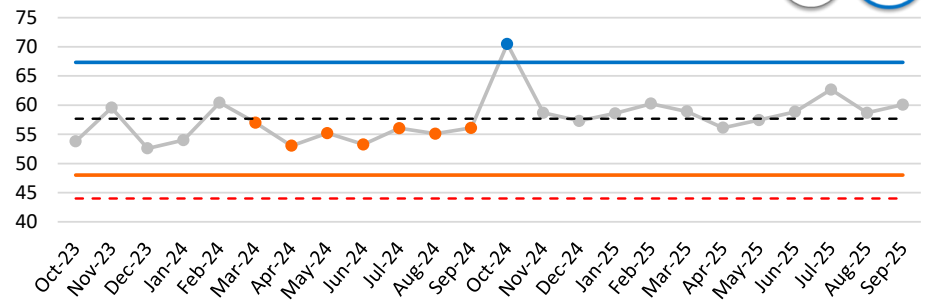
Month 06 | 2025-26

Finance

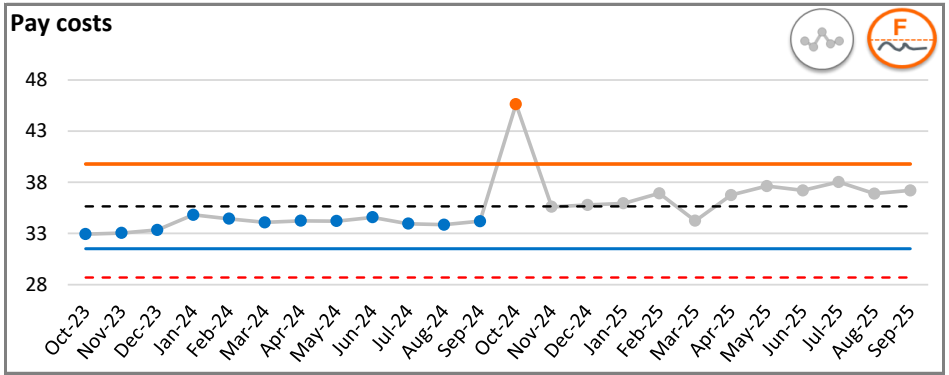
Key Financial Drivers

NHS East and North Hertfordshire Teaching NHS Trust

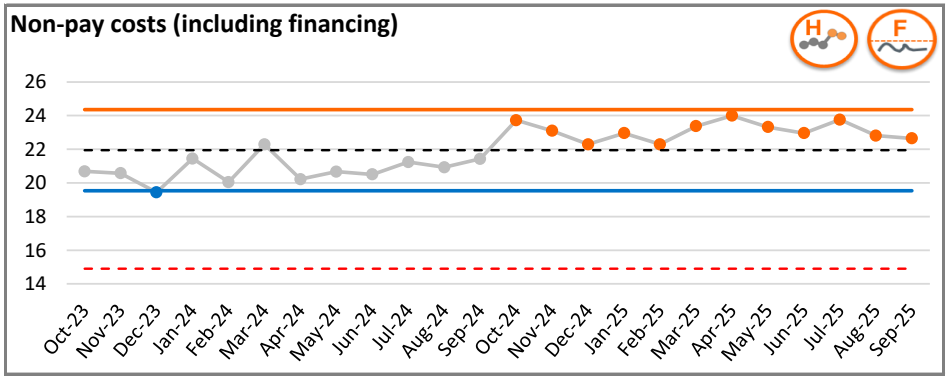
Income earned



Pay costs



Non-pay costs (including financing)



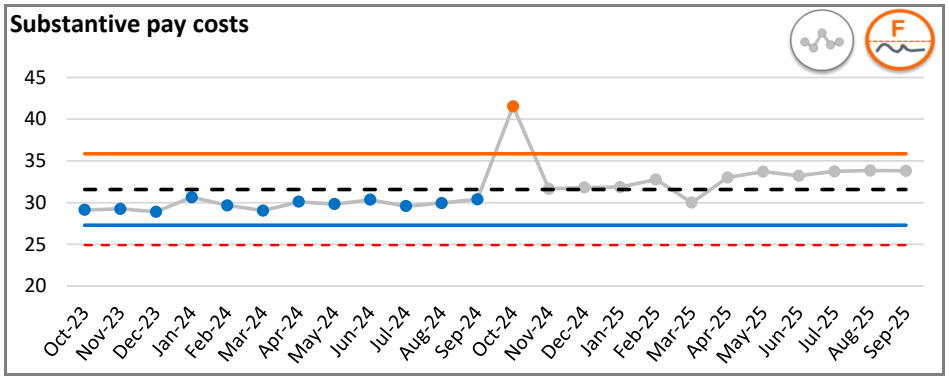
- The Trust is reporting a £9.4m deficit at the end of month 6, which is £0.1m favourable to plan.
- In month, there was an actual £0.2m surplus compared with a £0.2m surplus plan.
- The CIP plan phasing assumes just £8.6m (25%) CIP delivery against the £35.8m target, so there will need to be a significant step up in CIP delivery and/or improvement in the run rate in the latter months of the year.
- ERF activity in month YTD was below Divisional phased capacity plans, particularly within the Unplanned Care, Planned Care and Women and Children's Division. However, waiting list payments are £0.9m above the YTD plan, which indicates that not all of the agreed productivity targets have been met.
- 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 impact, and RTT targets will still need to be met.
- There continued to be pay pressures in month within nursing and clinical support workers. Nursing pay, in particular, was impacted in month by the high number of nursing staff who were 'auto-enrolled' back into the pension. This may reduce in future months as staff 'opt out' of pension again.
- Although agency expenditure is £0.5m YTD lower than the target agreed within our financial plan, bank expenditure is £1.2m above plan. The target significantly reduces in the second half of the year.
- Non pay reported a £0.2m adverse variance in month, excluding the impact of reserves and high cost drugs and devices. This variance was due to a new drugs which was used within the Neonatal unit, as well as a legal fees for the hospital entrance project.

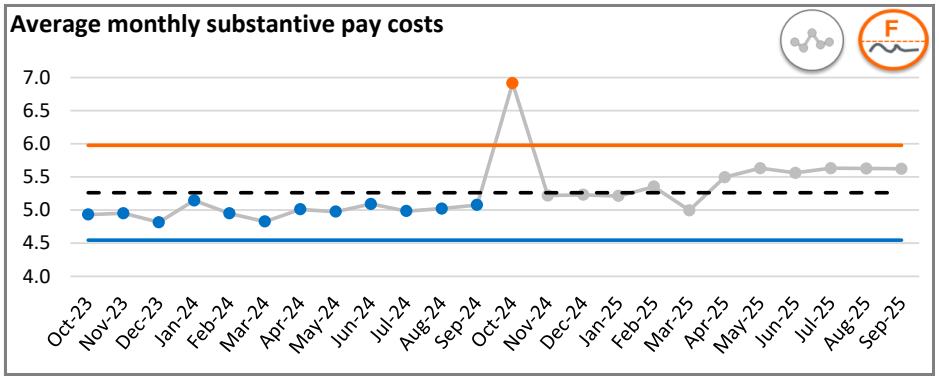
Month 06 | 2025-26

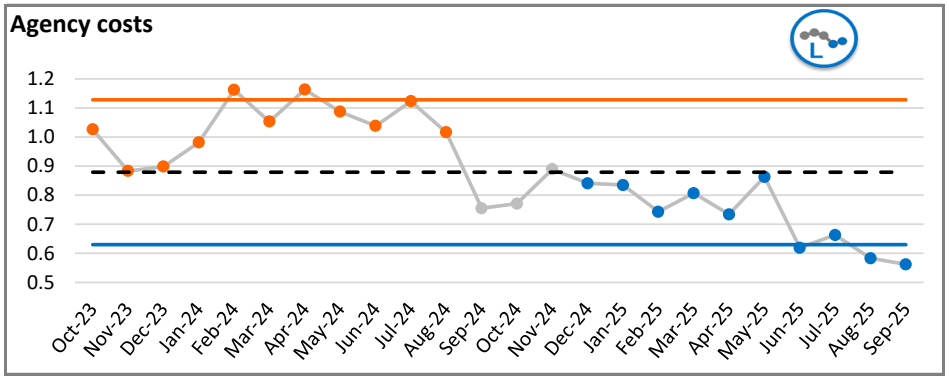
Finance

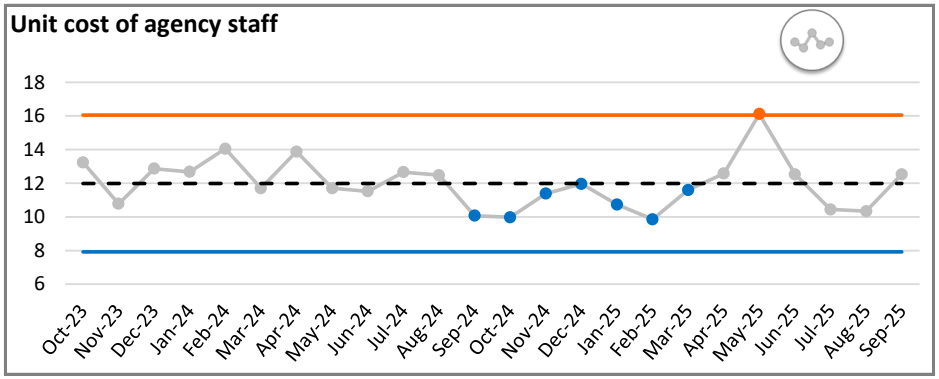
Other Financial Indicators

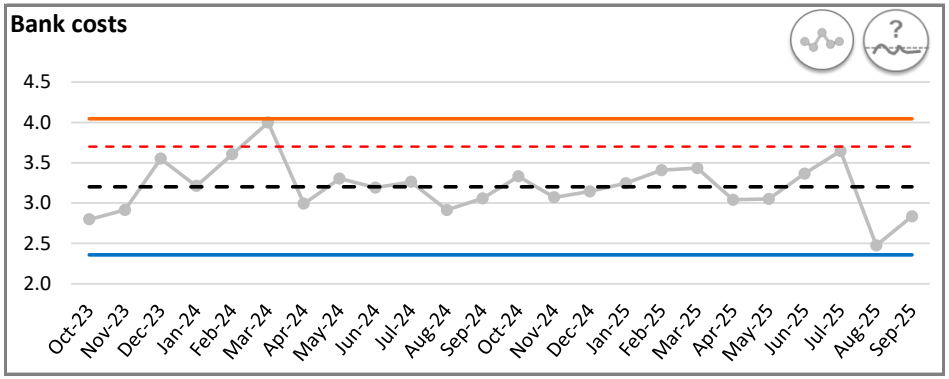
NHS East and North Hertfordshire Teaching NHS Trust

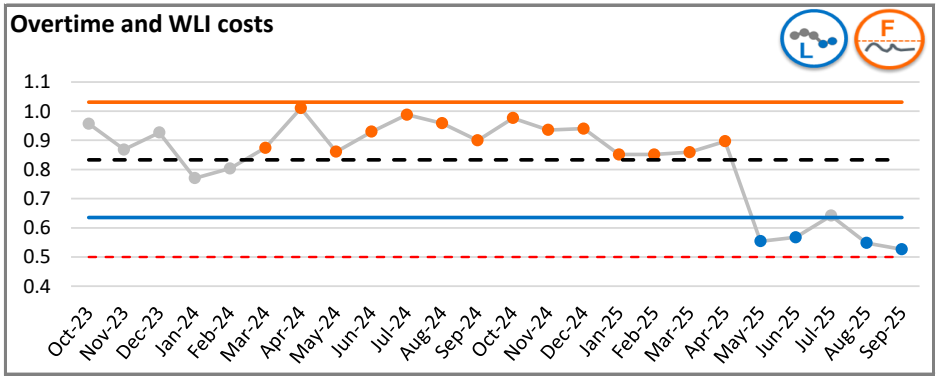










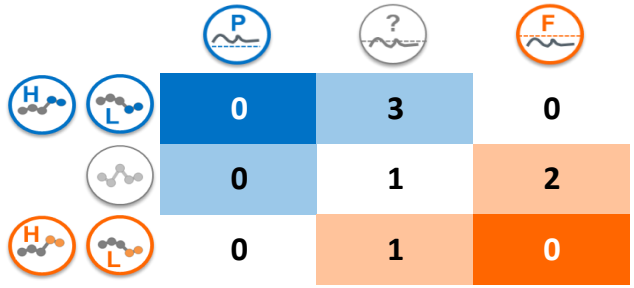


Month 06 | 2025-26

NHS
East and North Hertfordshire Teaching
NHS Trust

People

Month 06 | 2025-26



People

Summary

NHS East and North Hertfordshire Teaching NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Work	Vacancy rate	Sep-25	8%	7.2%	L	?	3 points below the lower process limit Metric will inconsistently pass and fail the target
	Bank spend as a proportion of WTE	Sep-25	5%	7.2%		F	Commn cause variation Metric will consistently fail the target
	Agency spend as a proportion of WTE	Sep-25	3%	1.3%	L	?	8 points below the mean Metric will inconsistently pass and fail the target
Grow	Statutory and mandatory training compliance rate	Sep-25	90%	88.5%	L	?	13 points below the mean Metric will inconsistently pass and fail the target
	Appraisal rate	Sep-25	90%	81.4%		F	Common cause variation Metric will consistently fail the target
Thrive	Turnover rate	Sep-25	10.5%	7.3%	L	?	6 points below the lower process limit Metric will inconsistently pass and fail the target
Care	Sickness rate	Sep-25	4.0%	5.0%		?	Common cause variation Metric will inconsistently pass and fail the target

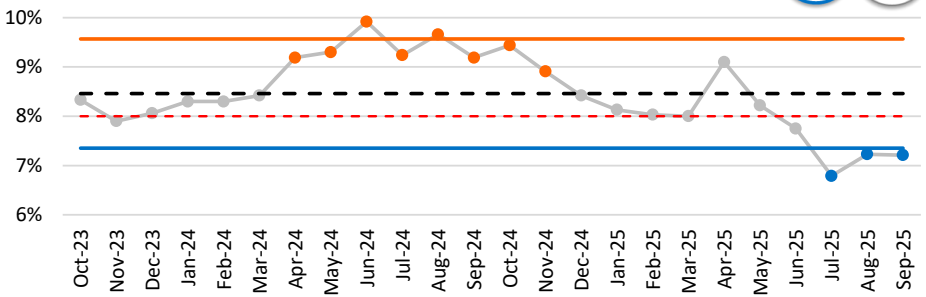
Month 06 | 2025-26

People

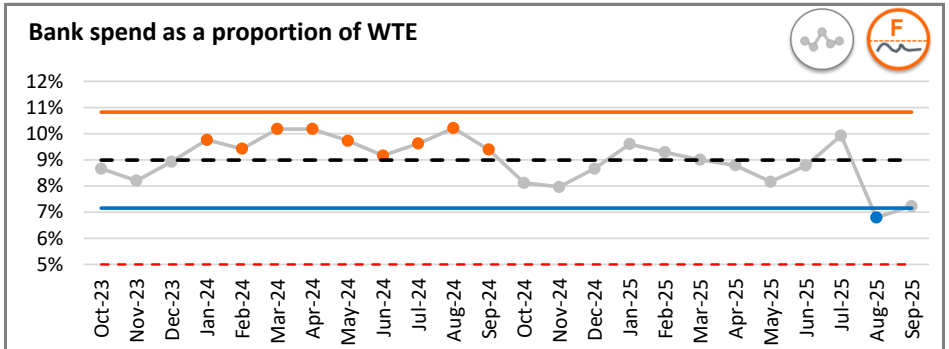
Work Together

NHS East and North Hertfordshire Teaching NHS Trust

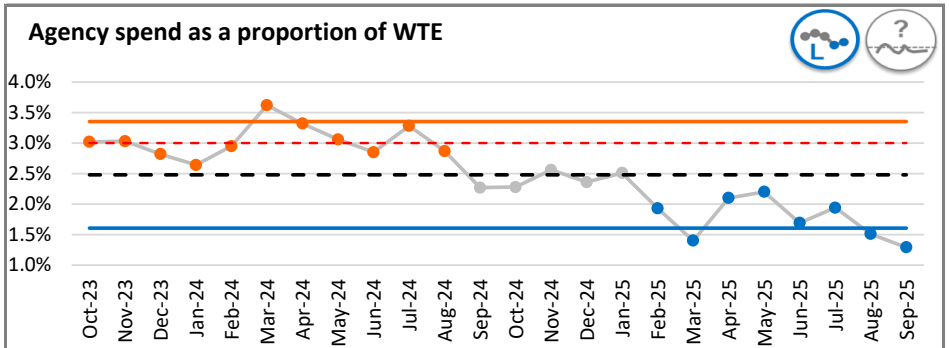
Vacancy rate



Bank spend as a proportion of WTE



Agency spend as a proportion of WTE



Key Issues and Executive Response

- Overall vacancy rate remained at 7.4%.
- Qualified N&M WTE (1914) in post at it's highest.
- 13 NQN commenced employment, 23 candidates in pipeline and 25 applicants invited to attend further October assessment day.
- CSW recruitment - 38 successful candidates, 6 candidates cleared within 10 working days of receiving offer. 60 applicants scheduled to attend further October assessment day.
- Time to Hire (TTH) increased to 17 weeks impacted by A&C reviews, vacancies held for redeployment, and newly qualified staff awaiting registration or qualifications who are now starting in post. This challenge is expected to continue in the coming months. Reduction in contract issue time after checks from 11 days in August to 6 days in September.
- Candidate experience increased to 5 out of 5 stars for the first time.
- The relative likelihood of a White applicant being shortlisted and appointed compared to a BAME applicant increased to 2.44 in the last quarter, up from 1.69, against a target of 1. The Resourcing Team remains focused on reducing bias within the recruitment process.
- Increase of £10k in bank spend, despite 48.85 WTE reduction. Increase in spend largely seen in N&M (£145k increase). Deep dives commenced on top 4 areas of bank spend in N&M (ED Nursing, AMU1, Theatres, Renal).
- Agency remains within plan. Spend reduced by £21k and WTE worked reduced by 11.61 WTE.
- Overall bank and agency spend only 0.5% above target of 8%.
- Reduction in N&M & STT agency price cap breaches from 207 and 64 in April to 10 and 0 in September, respectively.
- Roster implementation to AfC Clinical staff increased from 97% to 98%.

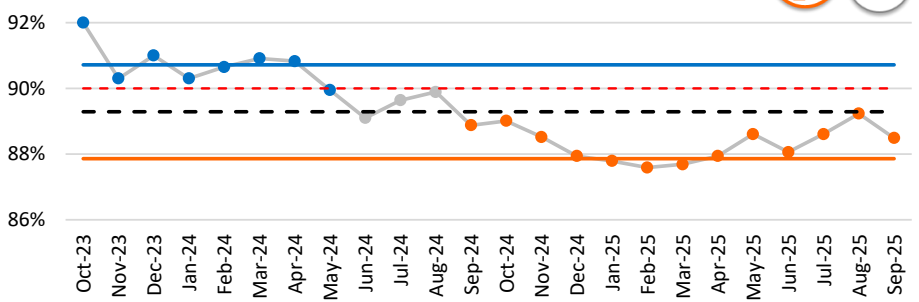
Month 06 | 2025-26

People

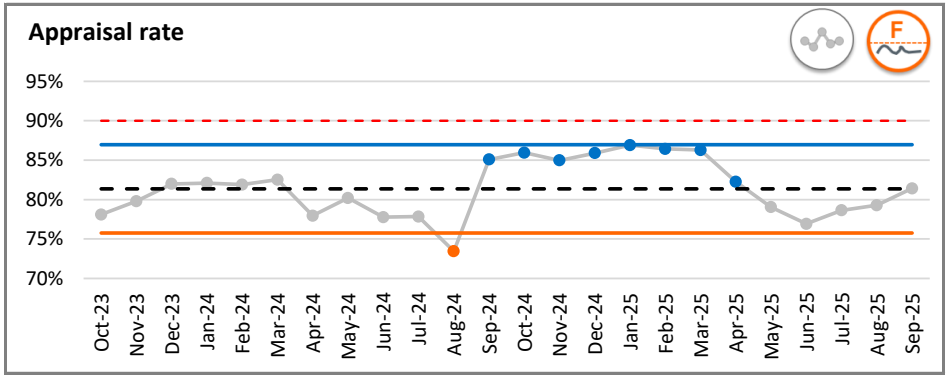
Grow Together

East and North Hertfordshire Teaching NHS Trust

Statutory and mandatory training compliance rate



Appraisal rate



Key Issues and Executive Response

- Moving & Handling level 1 compliance at 93%.
- 71 students on site across all placements, including 6 apprentices, 3 elective placement and 3 return to practice.
- 95 staff engaged in the preceptorship programme.
- Purple Flag Iniative (designed to improve support for leaners) will be launched in November.
- Work remains underway with Resourcing promoting new role opportunities (Top Up, SNA and RNDA courses) to ensure posts are avaliable once registration achieved.
- CPD - 2 shortened Midwifery, 3 non-medical prescibers made avaliable. NHSE confirmed investment of £747,725 with increased scrutiny - met with NHSE to agree approved investment plan.
- GTR compliance had a 10 percentage point increase from 62% in August (*summer holidays effect*) to 72% for Sept. Business Partners are highlighting GTR compliance data at Divisional Leadership Team meetings. Power BI makes it possible for all line managers to drill-down non-compliance GTR team data.
- Cyclical annual appraisal completion data is at 81%.
- Ongoing work to improve Statutory and Mandatory training compliance includes targeted communication campaigns, regular compliance reporting to managers through BI, improved access to e-learning platforms, and focused support for low-compliance areas.

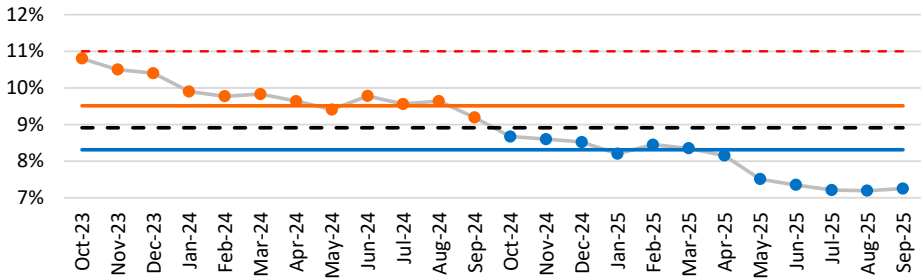
Month 06 | 2025-26

People

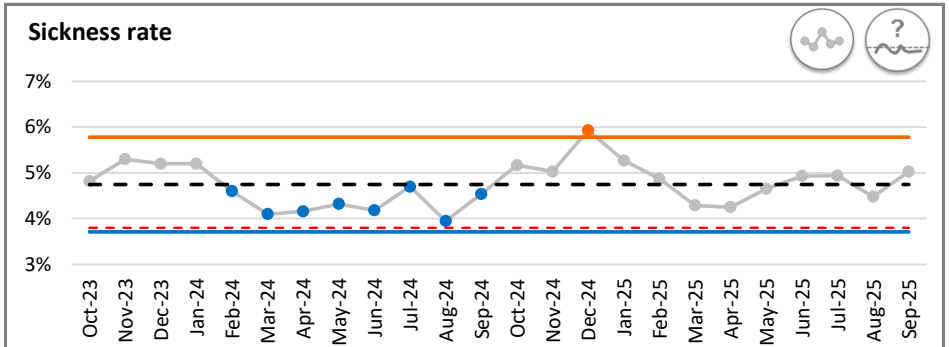
Thrive Together | Care Together

NHS East and North Hertfordshire Teaching NHS Trust

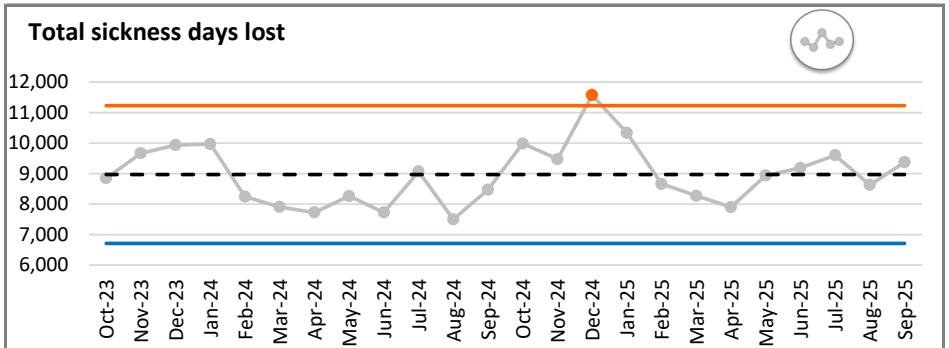
Turnover rate



Sickness rate



Total sickness days lost



Key Issues and Executive Response

Thrive Together

- Single suspension delayed as awaiting external information, decision to proceed internally to mitigate impact on individual and service.
- Average duration of disciplinary cases significantly reduced with the closure of two long standing cases, both resulted in summary dismissal.
- Average duration of Staff concerns remains the same with 4 cases closed, 3 upheld and 4 new cases opened in month.
- Management of sickness absence continues with support provided to managers. 24 cases have been closed in month with 1 dismissal, 3 resignations and 19 cases where the confirmation of sufficient improvement in attendance.
- Over 90% of people policies in date, outstanding policies are reviewed and awaiting endorsements.

Care Together

- The Health at Work Team have been focusing on promoting winter wellness. A winter wellbeing webinar was held to share self-care strategies and techniques to boost health this winter.
- On world mental health day-10 October the Talking Therapies service promoted support services and provided an online training session.
- Flu vaccines have been offered to all colleagues from 1 October. Flu vaccines protect ourselves, our colleagues our loved ones and patients from severe illness from flu. The current uptake is 23.4%.
- The latest reviewed staff menopause guidelines have been published, these offer information and guidance on how to create working environments that support the wellbeing of colleagues experiencing menopause issues.
- There is a continued focus on supporting prevention and reduction of sickness absence.

Month 06 | 2025-26

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 – September			**Meeting Date**	19 November 2025
Chair	Richard Oosterom, FPPC Chair				
Author	Committee Secretary				
Quorate	**Yes**	☒	**No**		☐

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

- Delivery of the CIP and financial break-even remains at risk; whilst a recovery plan is in place, the trend of the last two months hasn't shown a significant improvement yet
- Delivery of RTT is crucial for patients and to meet our financial targets; a plan was presented and extra WLIs will be needed; this will be tracked monthly
- The work on the long term and 26/27 plan is progressing, but deadlines are very tight

Assurances provided to the Board:

- Whilst performance assurance ratings have not changed, the overall performance in UEC had slightly deteriorated due to higher admissions and bed closures.
- Cancer performance is back on track for the three key metrics
- Whilst diagnostic performance in particular in MRI and obstetric ultrasound is still far below target, actions are now progressing; an improvement trajectory is requested
- The theatre transformation programme for T&O is delivering some positive benefits in terms of WLI reduction and Length of Stay improvement
- Winter planning is progressing well

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

- To prevent CIP under-delivery in the future, a multi-year more transformational approach needs to be taken, so that by the start of a financial year the plan is ready for execution
- A Finance Playbook is being developed and will be implemented in November to support consistent financial controls.

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

- The linen contract was approved.
- NWL Pathology SLA was referred to email approval once contract details are provided.

Any actions recommended to improve effectiveness of the meeting:

- Updates of action list to be provided in writing ahead of the meeting rather than verbal during the meeting.

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

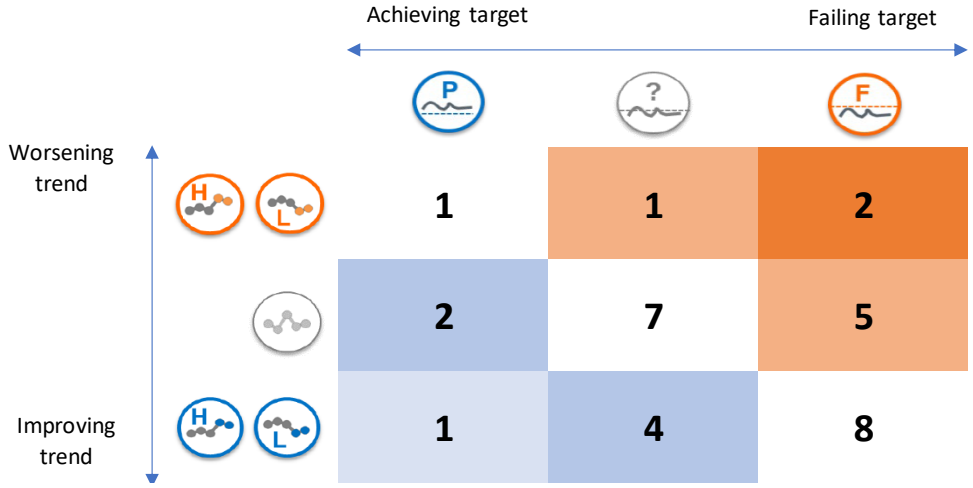
HWE ICS Performance Report

September 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

Low Risk	Programme
2 Hour UCR	UEC
NHS 111 Calls Abandoned	UEC
% of on the day GP Appointments	Primary Care
ED 4 Hour Standard	UEC
31 Day Standard	Cancer
62 Day Standard	Cancer

Variable Risk	Programme
28 Day Faster Diagnosis	Cancer
CHC Assessments in Acute	Community
Discharge Ready Date	UEC
Community Waits (Adults)	Community
% of <14 day GP Appointments	Primary Care
Dementia Diagnosis	Primary Care
Ambulance Handovers	UEC
Patients discharged before Noon	UEC
Talking Therapies	Mental Health
Severe Mental Illness (SMI) Health Checks	Mental Health
62 Day Backlog	Cancer
18 Week RTT	Elective
RTT 65 Week Waits	Elective
RTT 52 Week Waits	Elective
Ambulance Response Times	UEC
Community MH - Adult Waits for 2nd Appt	Mental Health

High Risk	Programme
CHC Assessments < 28 Days	Community
6 Week Waits	Diagnostics
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

Please note that data is to July 25 for UEC and June 25 for all other areas

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, however performance remains slightly adrift of the 3% target, at 3.6% in July;
- Cat 2 ambulance response times continue at improved levels in July at just over 35 mins. Performance remains outside the 30-minute standard however and longer than the regional average of 32 mins 36 seconds;
- Mean ambulance handover times have reduced significantly since January; performance has now moved to a trend of improvement and is ahead of system plan reducing the indicator risk from high to variable;
- 4-hour ED performance continues on a trend of improvement reaching just over 79% in July and remains ahead of the system plan and of low risk.

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

- The overall elective PTL size remains high following a significant increase in January with deferred referrals being added to the PAH PTL, however levels have started to see a significant reduction;
- 65 wk waits have continued to reduce to low levels; 32 remain at ENHT and PAH. 52 wks continue on a trend of improvement; the % of 52 wk waits is just behind system plan but is being met by ENH and SWH.
- The 18 wk position continues on a trend of improvement. Although behind national standard, June performance is ahead of system plan and has moved from high to variable 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 overall trend of improvement however has seen a decline in recent months. 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 moved back to a variable trend and remains behind system plan, however performance is at similar levels to April 2024, before ENHT Audiology was reported.

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

- 28-day FDS performance improved in June but remains just below system plan; ENH and SWH are meeting plan. 31-day performance continues on an improved trend and met national standard in June. Performance against the 62-day standard has deteriorated moving from lowest to low risk; June performance dipped under the 75% National Planning Std and below our planning trajectory; PAH remains the most challenged Trust.

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

- Similar numbers of HWE Out of Areas Placements in June at 30 against a plan of 15 with both West Essex and Herts continuing on a trend of variable performance; plans to reduce OOA placements commenced in April;
- Community Adult MH waits for a 2nd contact continue on a trend of improvement. The median wait decreased in June but continues on a variable trend; indicators continue to benchmark well against national average.

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, continuing as an area of highest risk. Waits over 52 wks remain on a deteriorating trend, increasing further over the last two months.
- 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;
- Although not achieving standard, the 28-day CAMHS access standard in Herts had been improving since Nov 24 however has now returned to a variable trend moving the indicator back to high risk;
- Children's waits for a Community MH 1st appointment remain on a deteriorating trend however do continue to better the national average; there remains variation across the system.

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

- % of adults waiting <18 weeks saw a step decline in March with the inclusion of Circle data; performance has seen notable recovery since April however and moved back from high to variable risk. Plans are in place for Circle to deliver 18 weeks by the September reporting period.

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

- There has been sustained improvement in the % of gp appts seen on the 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 28-day performance has declined significantly, not achieving target in the last 4 months. Performance has moved back to high risk, with most notable decline at SWH. Revised quarterly targets have been agreed.

Executive Summary: Performance Benchmarking by Provider / Place

June 2025

Hertfordshire and West Essex ICB (PROVIDERS)

	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)	July 25	79.38%	✗ -0.28%			34	84.37%	✗ -1.457%			11	71.70%	✓ 0.840%			98
	% >12hr Waits in ED From Arrival	July 25	[no data]	– 0.00%	no data	no data	no data	5.88%	✗ 1.28%			41	8.37%	✗ 23.53%			59
Cancer	28 Days Faster Diagnosis	June 25	80.17%	✓ 4.416%			51	85.39%	✓ 1.58%			21	72.50%	✓ 1.60%			120
	31 Days Standard	June 25	96.38%	✗ 1.54%			56	98.72%	✓ 0.93%			23	93.87%	✓ 4.64%			79
	62 Days Standard	June 25	81.86%	✗ -6.20%			20	78.85%	✓ 1.88%			27	41.79%	✗ -18.74%			141
RTT	Incomplete Pathways <18 weeks	June 25	63.30%	✓ 0.56%			69	64.50%	✓ 1.32%			59	51.14%	✓ 0.66%			144
	52+ Weeks as % of Total PTL	June 25	1.73%	✓ -12.24%			63	1.83%	✓ -1.22%			69	4.68%	✗ 6.16%			140
	65+ Weeks as % of Total PTL	June 25	0.04%	✓ -128.68%			81	0.00%	– 0.00%			29	0.02%	✗ 75.58%			71
	78+ Weeks as % of Total PTL	June 25	0.00%	– 0.00%			73	0.00%	– 0.00%			29	0.00%	– 0.00%			65
Diagnostics	% Waiting 6+ Weeks	June 25	53.49%	✗ 0.51%			148	14.35%	✗ 17.68%			67	33.74%	✓ -3.19%			130
	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	July 25	62.9%	✓ 0.79%			80	64.0%	✓ 0.47%			75	74.9%	✓ 0.93%			16
	Out of Area Placements	June 25	15	✓ -6.67%	n/a	n/a	n/a	15	✓ -6.67%	n/a	n/a	n/a	15	✗ 40.00%	n/a	n/a	n/a
CHC*	% of Eligibility Decisions Made Within 28 Days	June 25	54.7%	✗ -6.90%	55.90%	55.90%	96	24.6%	✗ -171.11%	50.79%	50.79%	101	60.0%	✗ -1.45%	65.79%	65.79%	81
	% of Assessments Carried Out in Acute Settings	June 25	1.9%	✗ 100.00%	0.85%	0.85%	90	0.0%	– 0.00%	4.82%	4.82%	103	0.0%	– 0.00%	0.00%	0.00%	66

Performance Benchmarking (ICB)

June 2025

Hertfordshire and West Essex ICB

Area	Activity	Latest Published Data	Data Published	Trend Aagainst Last Month	NATIONAL Position National vs (ICB)	REGIONAL Position EoE Region vs (ICB)	ICB Ranking
111	Proportion of Calls Answered < 60 secs	76.4%	July 25	✓ 1.48%	85.94% (Worse)	85.08% (Worse)	23
	Proportion of Calls Abandoned	3.6%	July 25	✓ -6.09%	2.53% (Worse)	2.54% (Worse)	19
A&E	% Seen Within 4 Hours (with additional mapped activity)	79.1%	July 25	✗ -0.566%	76.40% (Better)	77.00% (Better)	10
	% >12hr Waits in ED From Arrival	7.2%	July 25	✗ 19.78%	8.33% (Better)	6.99% (Worse)	15
Cancer	28 Days Faster Diagnosis	78.8%	June 25	✓ 1.88%	76.83% (Better)	72.04% (Better)	16
	31 Days Standard	94.7%	June 25	✓ 2.04%	91.74% (Better)	89.16% (Better)	12
	62 Days Standard	69.8%	June 25	✗ -2.76%	67.09% (Better)	62.04% (Better)	13
RTT	Incomplete Pathways <18 weeks	60.4%	June 25	✓ 0.85%	61.5% (Worse)	57.0% (Better)	27
	52+ Weeks as % of Total PTL	2.73%	June 25	✓ -0.22%	2.60% (Worse)	3.92% (Better)	27
	65+ Weeks as % of Total PTL	0.07%	June 25	✓ -5.92%	0.14% (Better)	0.23% (Better)	15
	78+ Weeks as % of Total PTL	0.00%	June 25	✓ -31.56%	0.01% (Better)	0.02% (Better)	15
Diagnostics	% Waiting 6+ Weeks	33.7%	June 25	✗ 0.79%	21.32% (Worse)	29.21% (Worse)	41
Mental Health	Dementia Diagnosis Rate	65.9%	July 25	✓ 0.61%	66.10% (Worse)	64.70% (Better)	21
	Out of Area Placements	30	June 25	✗ 16.67%	n/a	n/a	n/a
CHC *	% of Eligibility Decisions Made Within 28 Days	42.4%	June 25	✗ -46.30%	75.61% (Worse, at 55.40%)	75.10% (Worse, at 55.40%)	36
	% of Assessments Carried Out in Acute Settings	0.7%	June 25	✓ -12.10%	0.69% (Worse, at 2.73%)	0.62% (Worse, at 2.73%)	39

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 Q1 for 2025/25 (covering Apr - Jun 2025).

Executive Summary: Performance against Operational Plan M3

RTT performance vs 18 week standard — **March 2026 Target: 5% improvement**

		M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12
ICB	OP Plan	55.34%	55.96%	56.27%	57.31%	57.93%	58.65%	59.58%	59.68%	60.00%	60.57%	60.56%	60.89%
	OP Actuals	58.50%	59.88%	60.39%									
E&NH	OP Plan	59.50%	59.61%	59.92%	60.38%	60.94%	61.57%	62.22%	62.84%	63.41%	63.86%	64.16%	64.26%
	OP Actuals	62.70%	62.94%	63.29%									
WE	OP Plan	47.66%	49.46%	50.66%	51.86%	53.66%	54.36%	55.06%	56.46%	56.96%	57.66%	59.06%	60.01%
	OP Actuals	48.78%	50.80%	51.14%									
S&WH	OP Plan	59.63%	60.18%	60.73%	61.28%	61.83%	62.38%	62.93%	63.48%	64.03%	64.58%	65.13%	65.68%
	OP Actuals	62.20%	63.65%	64.50%									

Number of patients waiting 52 weeks as percentage of total PTL — **March 2026 Target: <1%**

		M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12
ICB	OP Plan	2.36%	2.31%	2.22%	2.12%	2.02%	1.83%	1.69%	1.58%	1.47%	1.34%	1.13%	0.99%
	OP Actuals	2.80%	2.74%	2.73%									
E&NH	OP Plan	1.80%	1.80%	1.80%	1.79%	1.77%	1.73%	1.66%	1.56%	1.42%	1.24%	1.00%	0.70%
	OP Actuals	1.91%	1.95%	1.73%									
WE	OP Plan	5.00%	4.64%	4.28%	3.92%	3.56%	3.20%	2.84%	2.48%	2.12%	1.76%	1.40%	1.00%
	OP Actuals	4.68%	4.39%	4.68%									
S&WH	OP Plan	2.07%	1.98%	1.88%	1.79%	1.69%	1.60%	1.50%	1.40%	1.30%	1.20%	1.10%	1.00%
	OP Actuals	2.02%	1.85%	1.83%									

EB28 **Diagnostic test waiting list - % over 6 weeks** — **Target: TBC**

Included modalities are: MRI, CT, NOUS, Audiology, DEXA, ECHO, Gastroscopy, Colonoscopy, Flexi-sig

		M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12
ICB	OP Plan	30.41%	30.26%	28.97%	28.08%	27.01%	26.01%	25.23%	24.00%	23.98%	22.60%	21.73%	20.61%
	OP Actuals	31.43%	33.28%	33.51%									
E&NH	OP Plan	54.68%	54.40%	51.92%	50.89%	49.87%	48.80%	47.76%	46.41%	47.15%	46.53%	45.14%	43.88%
	OP Actuals	51.90%	54.34%	54.39%									
WE	OP Plan	33.17%	33.76%	33.18%	32.30%	29.64%	27.12%	25.77%	22.69%	21.12%	17.26%	14.33%	10.04%
	OP Actuals	33.03%	34.22%	33.23%									
S&WH	OP Plan	5.86%	5.44%	5.22%	4.97%	4.74%	4.50%	4.21%	3.96%	3.71%	3.43%	3.13%	2.85%
	OP Actuals	9.80%	10.72%	13.50%									

EB35 **Cancer 62-day standard.** — **March 2026 Target: 75%**

		M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12
ICB	OP Plan	76.98%	79.01%	78.80%	79.58%	80.32%	79.69%	81.09%	81.29%	81.28%	81.34%	82.40%	82.54%
	OP Actuals	72.53%	71.69%	69.77%									
E&NH	OP Plan	83.74%	85.89%	84.38%	85.71%	85.79%	84.05%	85.66%	85.38%	84.34%	84.13%	85.71%	85.56%
	OP Actuals	88.89%	86.94%	81.86%									
WE	OP Plan	65.29%	66.94%	71.09%	70.71%	71.90%	71.97%	72.86%	72.73%	74.22%	74.22%	74.38%	75.00%
	OP Actuals	53.05%	49.62%	41.79%									
S&WH	OP Plan	77.22%	77.78%	78.33%	79.44%	80.00%	80.56%	81.11%	82.22%	82.78%	83.33%	84.44%	85.00%
	OP Actuals	79.84%	77.36%	78.85%									

EB27 **Cancer 28 day waits (faster diagnosis standard)** — **March 2026 Target: 80%**

		M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12
ICB	OP Plan	78.58%	78.77%	79.09%	78.86%	79.16%	79.12%	79.19%	79.55%	79.63%	79.81%	81.29%	81.95%
	OP Actuals	77.98%	77.28%	78.76%									
E&NH	OP Plan	77.32%	77.63%	78.27%	77.37%	77.44%	77.02%	77.26%	77.44%	77.26%	77.84%	78.42%	80.37%
	OP Actuals	77.83%	76.63%	80.17%									
WE	OP Plan	77.00%	77.00%	77.02%	76.98%	77.00%	77.02%	76.98%	77.00%	77.02%	77.02%	79.98%	80.03%
	OP Actuals	72.19%	71.34%	72.50%									
S&WH	OP Plan	80.98%	81.34%	81.75%	82.11%	82.46%	82.82%	83.18%	83.54%	83.90%	84.25%	84.61%	85.02%
	OP Actuals	84.68%	84.04%	85.39%									

EM13 **Percentage of attendances at Type 1, 2, 3 A&E departments, departing in less than 4 hours** — **Target by March 2026: 78%**

MIU not included

		M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12
ICB	OP Plan	72.80%	74.88%	76.32%	76.09%	77.52%	78.05%	77.16%	76.76%	74.51%	73.80%	77.87%	80.75%
	OP Actuals	76.17%	75.49%	78.24%									
E&NH	OP Plan	69.46%	72.04%	74.17%	73.36%	75.70%	75.92%	73.39%	73.14%	71.28%	69.08%	74.65%	78.34%
	OP Actuals	73.14%	74.25%	77.42%									
WE	OP Plan	67.00%	69.00%	70.00%	71.00%	71.00%	73.00%	73.00%	72.00%	71.00%	72.00%	74.00%	78.00%
	OP Actuals	68.14%	64.78%	68.29%									
S&WH	OP Plan	79.69%	81.68%	82.57%	81.99%	83.09%	83.36%	83.62%	83.61%	80.06%	79.40%	83.60%	85.00%
	OP Actuals	84.34%	83.72%	85.62%									

EB42 **Mean handover time (minutes)** — **Target: <= 15 mins**

		M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12
ICB	OP Plan	00:30:09	00:30:12	00:28:08	00:29:05	00:27:59	00:29:54	00:32:39	00:32:50	00:36:44	00:37:16	00:32:10	00:28:30
	OP Actuals	00:25:44	00:27:35	00:22:06									
E&NH	OP Plan	00:30:00	00:30:00	00:27:00	00:30:00	00:27:00	00:30:00	00:35:00	00:32:00	00:43:00	00:42:59	00:30:00	00:30:00
	OP Actuals	00:29:43	00:32:35	00:21:41									
WE	OP Plan	00:35:00	00:35:00	00:35:00	00:35:00	00:35:00	00:35:00	00:37:00	00:39:00	00:41:00	00:43:00	00:44:00	00:30:00
	OP Actuals	00:25:38	00:28:36	00:25:42									
S&WH	OP Plan	00:27:15	00:27:22	00:24:44	00:24:38	00:24:19	00:26:38	00:28:05	00:29:36	00:29:20	00:29:11	00:26:24	00:26:24
	OP Actuals	00:22:39	00:23:04	00:19:51									

Hertfordshire and West Essex Integrated Care System

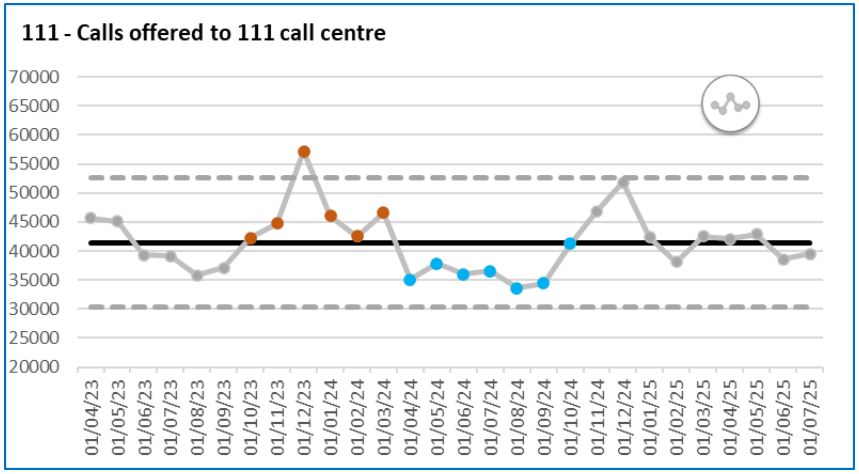
Performance by Work Programme

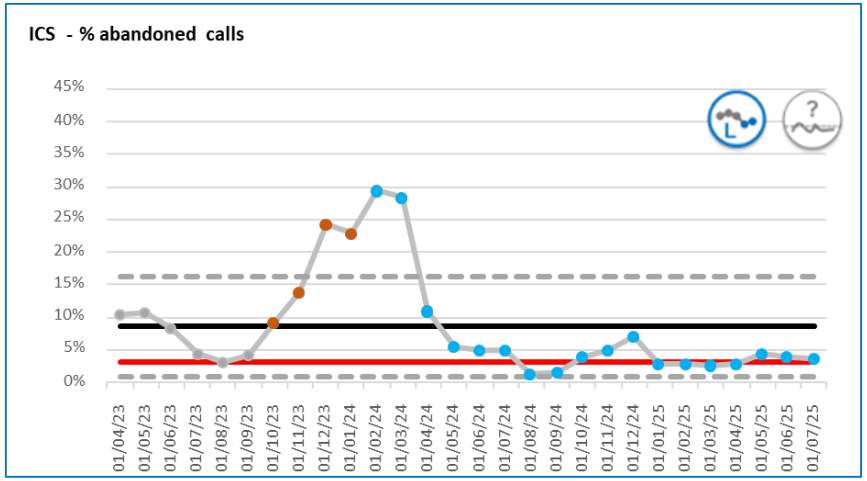
Click link to relevant slides:

Slide 8: NHS 111
Slide 9: Urgent 2 Hour Community Response
Slide 10: Ambulance Response & Handover
Slide 11: Emergency Department
Slide 12: UEC Discharge & Flow
Slide 13: Planned Care
Slide 15: Diagnostics
Slide 17: Cancer
Slide 19: Mental Health
Slide 28: Autism Spectrum Disorder (ASD)
Slide 31: Attention Deficit Hyperactivity Disorder (ADHD)
Slide 33: Community Wait Times
Slide 37: Community Beds
Slide 39: Integrated Care Teams
Slide 41: Continuing Health Care
Slide 42: Primary Care
Slide 44: Appendix B, Statistical Process Control (SPC) Interpretation
Slide 45: Appendix C, Glossary of Acronyms

Hertfordshire and West Essex Integrated Care System

NHS 111

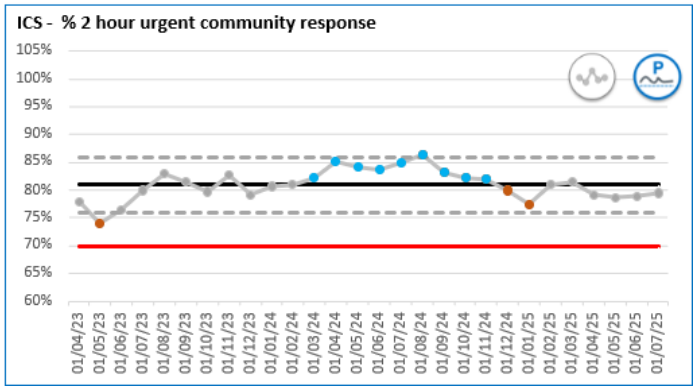


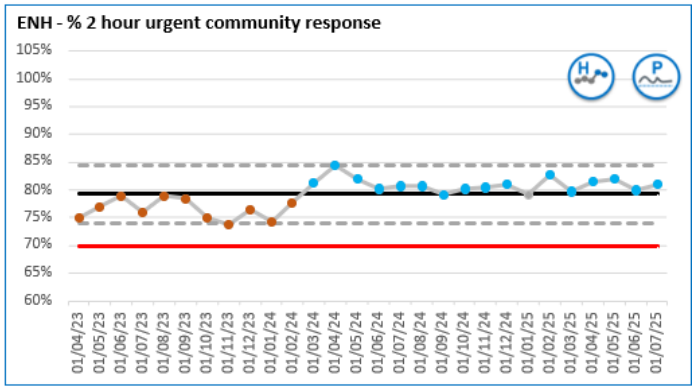


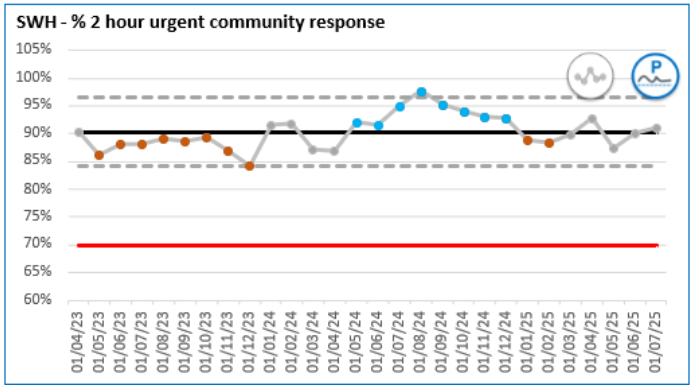
ICB Area	What the charts tell us	Issues	Actions
HUC	• Call volumes have reduced from the peaks seen in winter and are within expected common cause variation limits • The % of 111 calls abandoned improved from 3.9% in June to 3.6% in July. This is slightly worse than the target of 3% but remains better than the historical average	• Call volumes in Jul-25 were 8% higher than in Jul-24 • Rotas remain a challenge despite continued efforts to align the workforce with the PAN HUC rota patterns • Performance was impacted in July by technical issues with the directory of services system on two separate days	• Recruitment priorities have been reassessed, with current efforts directed towards addressing the most pressured parts of the service at evenings and weekends • Continue to monitor productivity and Average Handling Time (AHT) closely to maintain operational efficiency • Preparations for the expected Winter pressures to ensure resources are in place to meet demand

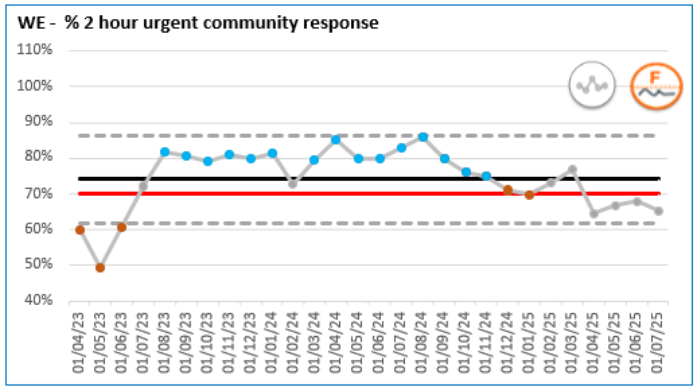
Hertfordshire and West Essex Integrated Care System

Urgent 2 Hour Community Response (UCR)









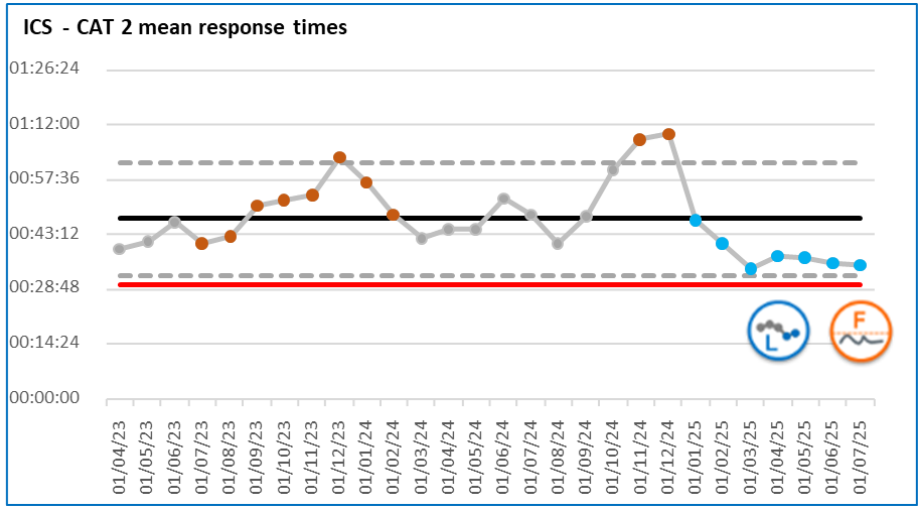
Referrals	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
West Essex	461	386	454	511	483	558	724	629	636	636	608	627	537
East & North Herts	659	676	657	678	717	688	763	583	671	608	627	634	593
South & West Herts	363	352	319	370	414	340	376	506	508	576	590	544	586

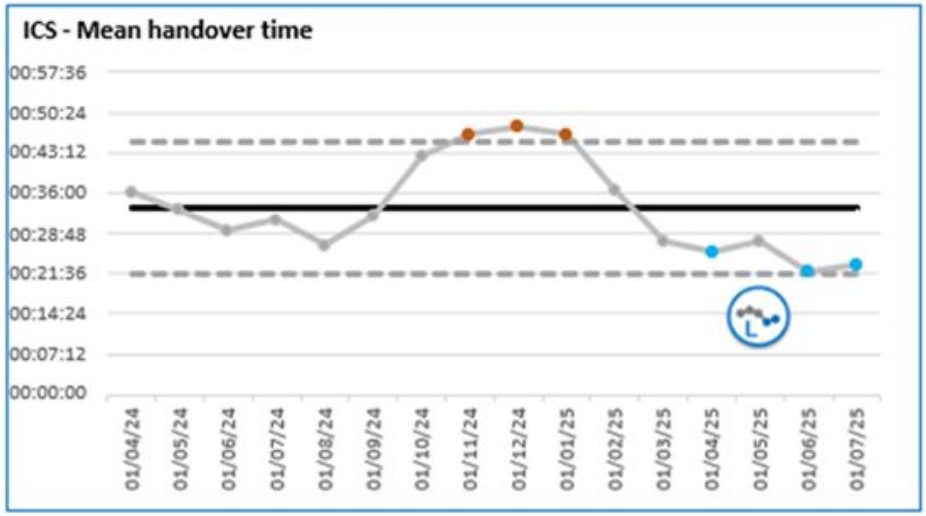
ICB Issues, escalation and next steps

- The ICS achieved the 70% national standard, with ENH and SWH achieving at Place
- West Essex performance continues on a variable trend dropping just below standard over the last four months. Demand is regularly exceeding capacity, with referrals exceeding 500 per month appearing to be the trigger for failing the national standard> Referrals in June were the lowest in 2025 to date however still reached 540.
- 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





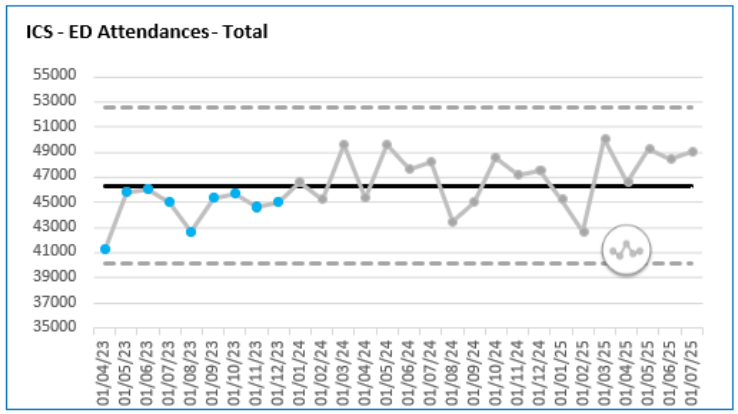
What the charts tell us

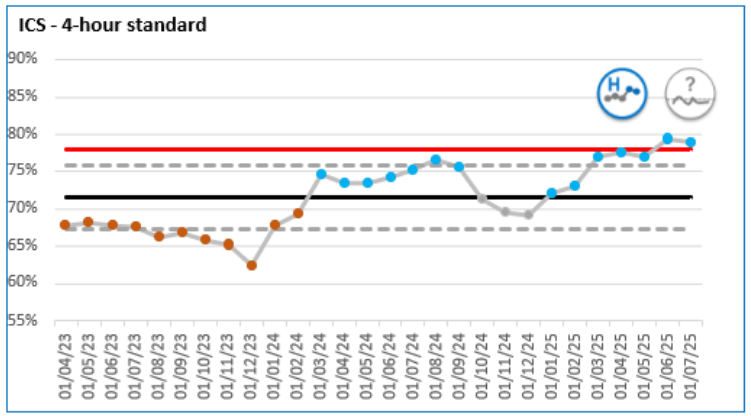
- In Jul-25 the mean Category 2 ambulance response time was 35m 12s. This remains worse than the 30 minute target but is lower than the long-term average for the system
- In Jul-25, mean Category 2 response times in HWE remained longer than the regional average (32m 36s) and were the second longest in the region
- The mean handover times have reduced significantly since January and were 23m 28s at a system level in July. This is better than the plan of 29m 5s from the FY2526 planning submission

ICB Issues and actions

- The overall number of ambulance incidents in HWE remain high. The number of incidents in M1-4 FY2526 was 5% higher than during M1-4 FY2425
- However, across the system, the number of conveyances to ED has been 3.5% lower in M1-4 FY2526 compared to M1-4 FY2425. This has been driven by factors including: the impact of the unscheduled care hub / alternatives to conveyance + an increase in hear-and-treat rates
- EEAST has a detailed operational performance improvement plan in place for FY2526. In HWE, in July six out of eight productivity metrics from this plan were being met
- There have been notable improvements in on-scene times for crews through FY2526 so far. There have also been notable improvements in the number of vehicles out-of-service
- Significant numbers of newly qualified paramedics are starting in Herts and West and Essex in Q3
- Hours lost to handover have continued to improve following a number of initiatives at the acute front doors, including: straight to Assessment Unit/SDEC pathways; continued focus on fit-to-sit patients; clarifications and standardisation of HALO role; senior clinical reviews of ambulance patients; front-door process redesign focusing on rapid assessment and treatment
- Capital work at ENHT for 8 designated handover cubicles to start in Dec-25

UEC – Emergency Department

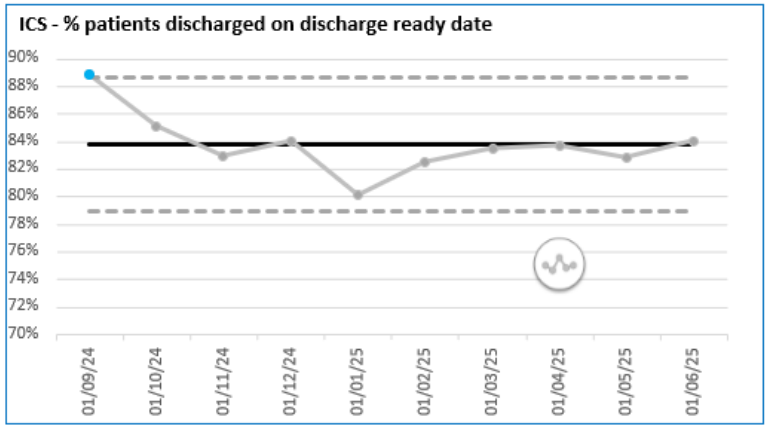


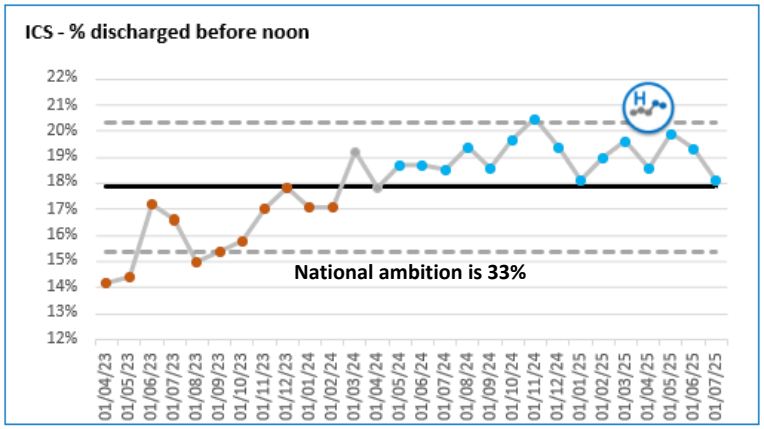


What the charts tell us	Issues	Actions

• ED attendances have been high in recent months and there have been five consecutive months where ED attendances have been above the long-term mean
• These high levels of attendances have mainly been driven by increases in type 3 activity at ENHT and type 1 activity at WHHT
• ED performance has improved noticeably over the last three months and reached 79.1% in Jul-25. This is ahead of the combined system plan of 77.9% for July
	• There remains significant variation at place level with West Essex continuing to be the most challenged. Performance against the 4-hour standard in July for each place was:
	  ○ SWH = 84.4%
	  ○ ENH = 79.4%
	  ○ WE = 71.7%
	• There remains continued high demand. However, the rate of growth may have slowed as ED attendances in M1-4 of FY2526 were only 1% higher than M1-4 of FY2425
	• Type 1 ED attendances appear to be reducing marginally and were 1% lower in M1-4 of FY2526 compared to M1-4 of FY2425
	• There is some evidence that there has been a general increase in acuity in ED presentations over the past two years
		System
		• The % of C3-C5 patients being conveyed to ED has reduced following the expansion of call-before-convey and initiatives at EEAST which have focused on improving hear-and-treat rates. E.g. the ITK link between EEAST and HUC is now live meaning that patients can be passed from the stack to HUC more efficiently. These initiatives have helped to mitigate the increased ED demand from walk-in patients.
		• The seven priority initiatives of the ICB frailty programme are ongoing and indications are that there have been fewer frailty admissions / ED attendances in FY2526 so far
		East and North Herts
		• During the MADE week, there was a trial of a different way of working for the frailty assessment unit which was successful. From Oct-25, Frailty Assessment Unit to manage all of CDU. 7 cubicles and 10 chairs
		• Focus in ED has been on reducing time to triage and wait-to-be-seen. Working group established reviewing overnight processes; protection of assessment spaces within ED and re-enforcing the 1pm huddle
		West Essex
		• Improvement work focussed around 4 key workstreams: optimising use of UTC; non-admitted patients (inc. SDEC optimisation / expansion); admitted patients (inc. Discharge Improvement Programme / H@H optimisation); paediatrics
		• Optimisation of alternative pathways and consistent use of escalation tool at peak times
		• Review / refresh of Full Capacity Protocol (FCP)
		South and West Herts
		• Work on the Transfer of Care Hub (previously SPOC) continues with the leadership structure agreed. The aim is to ensure the ToCH operates as one single function regardless of organisational boundaries.
		• Implementation of OPTICA has made significant progress. This is a Federated Data Platform app which provides a live workflow-based dashboard for ToCH

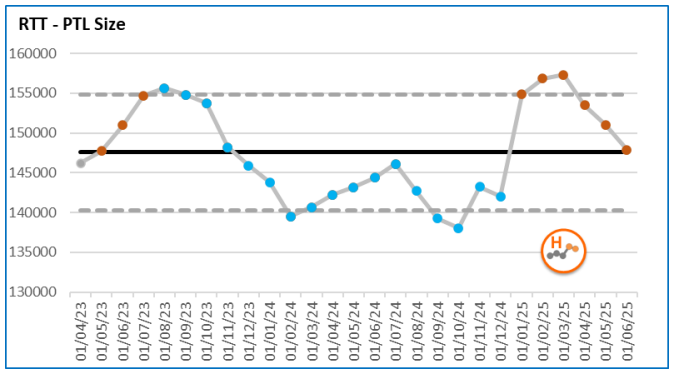
UEC – Discharge & Flow

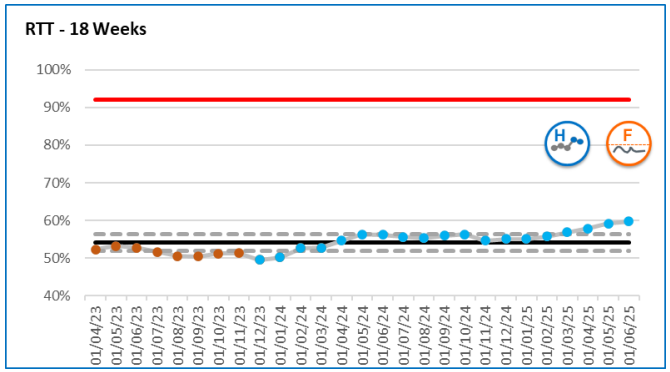


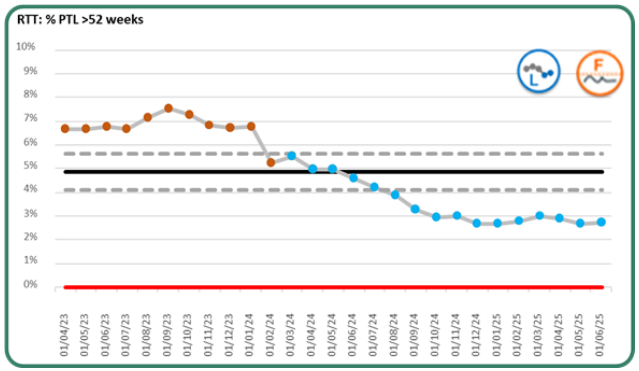


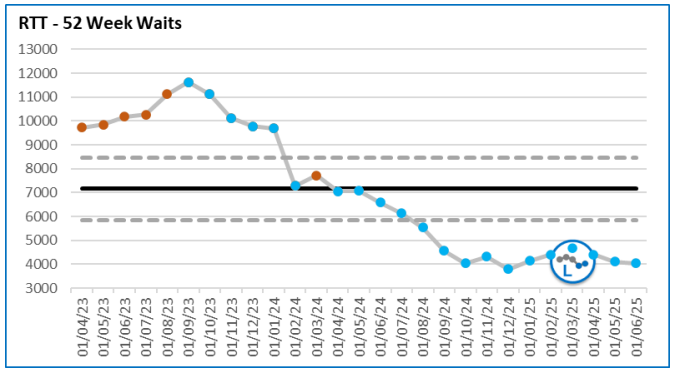
What the charts tell us	Issues	Actions
• At a system level, 84.1% of patients were discharged on their discharge ready date in Jun-25. This is better than the system target of 83% for Jun-25. However, this data does not include data from PAH as the data quality is not sufficiently high to be published • The % of patients discharged before noon was 18.1% in July. This is above the historical mean, but below the national target of 33%	• There remains significant variation across the three HWE acute trusts for the % of patients discharged before Noon. In Jul-25: ○ ENHT – 13.2% ○ WHTH – 25.8% ○ PAH – 13.6% • The issues are typical discharge challenges, including: ○ Availability of care home / community capacity ○ Complex discharges ○ Internal process challenges	**East and North Herts** • MADE week took place in Jul-25 with a focus on frailty • The Trust is currently investigating how pre-noon discharges are reported when the patient uses the discharge lounge prior to discharge • New acquired brain injury level 1 rehab waiter pathway **West Essex** • Work underway with Fleming Ward & Surgical teams on criteria-led discharge. • Alex Health now captures criteria-to-reside, pathways codes and real-time updates. • Improve flow of medically optimised patients out of PAH. Working with transfer of care team and allocated team member for ED / OPAL referrals **South and West Herts** • A review of pathway 0 processes has begun in the Division of Surgery with support from the QI team. This aims to bring forward the time of discharge • The referral process for the Virtual Urgent Case Review is now in place for ED with a plan to roll out across inpatient wards

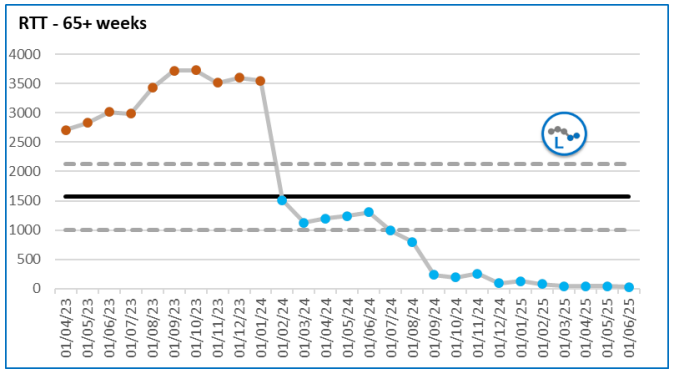
Planned Care – PTL Size and Long Waits

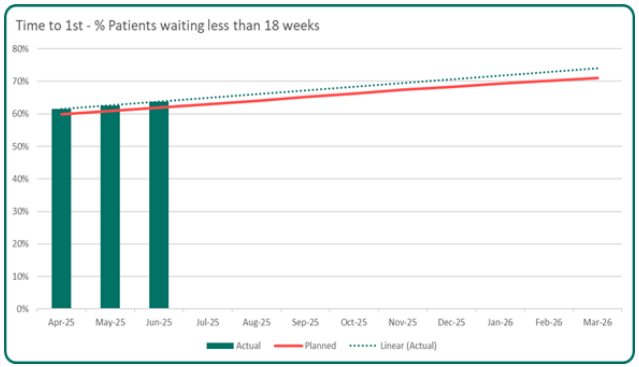












Community Paediatrics patients have been excluded from RTT reporting from February 2024 in line with national guidance
Waiting lists therefore show significant reductions

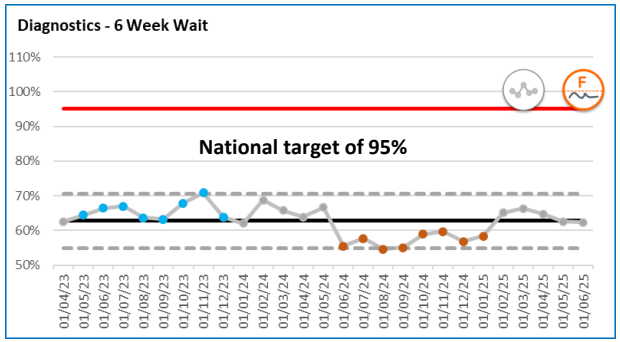
Planned Care – PTL Size and Long Waits

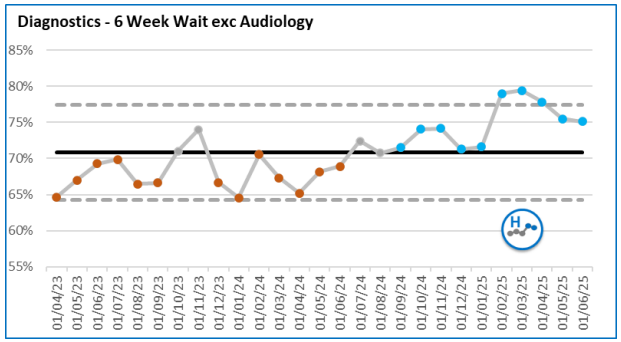
ICB Area	What the charts tell us	Issues	Actions

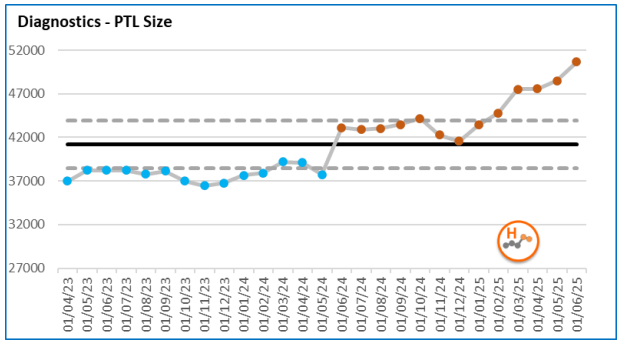
HWE	• The overall PTL size remains high although there have been significant reductions since the highest level in March 2025 of c.156000 to c.147900 in June 2025 which is 2% better than plan.
	• The overall number of patients waiting >65 weeks was minimal and remained static. There remains variation at place level but the ICB overall number of breaches at the end of June was 32
	  • ENHT: 19
	  • WHTH: 0
	  • PAH: 12
	  • ISP: 1
	• The number of patients waiting over 52 weeks reduced in May and remained static in June with the new metric of the number of patients who are waiting over 52 weeks as a % of the PTL reaching 2.7% for June. Therefore reaching just under the system plan for month 3 with a target of 1% by March 2026.
	• The number of patients waiting 18 weeks has been on an improving trend since November 2024 and is above planned trajectory for June 60.4% against a plan of 56.3%
		• The 65ww breaches forecast for end of August is 62 although the national expectation is zero. The increase comes from PAH which has an expectation of 50 breaches
		• Trauma and Orthopaedics (T&O) remains the main specialty under pressure across the system
		• Gynaecology is an emerging area of risk at PAH
		• Oral and pain management are areas of pressure at ENHT
		• Staffing remains a challenge across the system
		• There remain a number of planned care related Data Quality (DQ) issues at PAH following launch of Alex Health which are included with the Trust's improvement plan
			• There is a system focus on reducing the number of patients facing long waits, particularly those waiting over 65 and 52 weeks. Alongside regular performance meetings with the ICB and each Trust, there is both regional and national oversight
			• Demand, capacity & recovery plans are in place to monitor RTT
			• Weekly KLOEs in place with NHSE to track the 65-week and 52-week positions
			• The Q1 validation sprint is almost completed with positive results from each of the three trusts
			• 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
			• In July, Princess Alexandra Hospital were moved from Tier 1 of the national oversight and support infrastructure to Tier 2 for Elective recovery, however remain in Tier 1 for Diagnostics recovery. Fortnightly tiering meetings with the NHSE EOE regional team are in place
			• At WHTH, the Elective Care improvement programme for 2025/26 has been finalised and is aligned to delivery of the national planning guidance target of 65.5% for RTT
			• WHTH have identified priority projects have been identified at each point of the pathway milestones and specialty improvement projects have been agreed following analysis of waiting list data and an assessment of issues and root causes
			• At ENHT, the delays with the rollout of the CBCT scanner for Oral surgery have now been resolved and the Trust is hoping to recover the position quickly
			• ENHT have recruited a new surgeon who can support the knee osteotomy which has been a particular area of challenge in T&O

Hertfordshire and West Essex Integrated Care System

Planned Care – Diagnostics



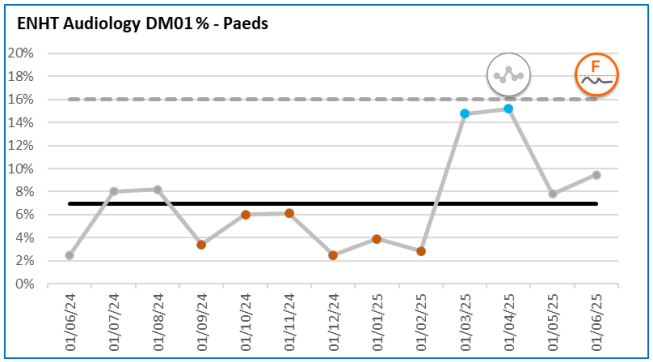


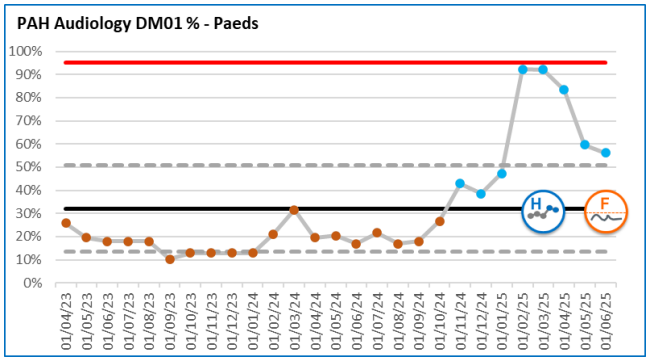


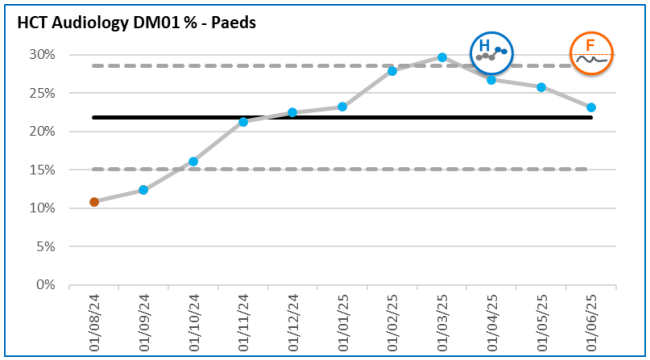
What the charts tell us	Issues	Actions

• Although performance deteriorated slightly from April, May and June have remained static with performance at similar levels to April 2024, before Audiology was added to the data. There are also continued issues inaccurately reporting DM01 backlog for multiple modalities, primarily Endoscopy, following Alex Health launch at PAH
 	
• There is significant variation in Trust performance:
  • ENHT – 46.5%
  • WHTH – 85.6%
  • PAH – 66.3%
• Excluding audiology, performance has declined over the last three months however remains on a trend of improvement overall.
• The primary drivers for PTL growth ENHT audiology and WHTH NOUS
	ENHT
	• The most significant long waiters remain in Audiology. In adult audiology only 2% of patients are waiting <6 weeks
	• In paediatric audiology 9.4% of patients are waiting <6 weeks
	• Outside of audiology, MRI and Ultrasound remain the most challenged modalities
	PAH
	• Continued issues in accurately reporting DM01 backlog for multiple modalities, primarily Endoscopy, following Alex Health launch
	• The most challenged tests in June were Audiology (18.6%), Gastroscopy (20.3%), Colonoscopy (24.0%) & Flexi Sig (26.6%)
	WHTH
	• The most challenged modalities in June were NOUS, Cystoscopy and cardiac MRI
		ENHT
		• Further detail on paediatric audiology is outlined on the following slide
		• Adult audiology: Lister estates work has finished on three booths which opened on 10 June; successful recruitment, where there are 4 new band 6s and 1 new band 8a due to start in the coming months
		• MRI – Pinehill contract has now been agreed and patients being booked. InHealth van being utilised for two days per week; approval has been granted to convert temporary spend to substantive post that will support the provision of 7-day service
		• Ultrasound – hoping to start insourcing from September; two new sonographers recently recruited; using booking production boards to ensure full utilisation; additional head and neck lists; some sonographers increasing their hours
		PAH
		• Reporting issues being progressed as part of Alex Health data quality improvement programme. New data extraction processes expected to be live in August have been delayed until September
		• Additional 75 Audiology assessments per week once CDC at full capacity
		• 2 x Diagnostic Imaging capital bids nearing completion
		• Continued Paediatric Audiology support to the wider system is impacting recovery of Adult services. Additional recruitment underway with revised trajectory expected in September
		WHTH
		• There has been challenges in cardiac MRI which has been a 3 day service due to capacity issues. From July, the service has moved to a 5 day service which will aid recovery
		• Recovery actions are in place for cystoscopy which are longer term and focus on resource
		• As increase in number of referrals in NOUS has added pressure for the service and extra capacity is being reviewed

Planned Care - Paediatric Audiology Diagnostics

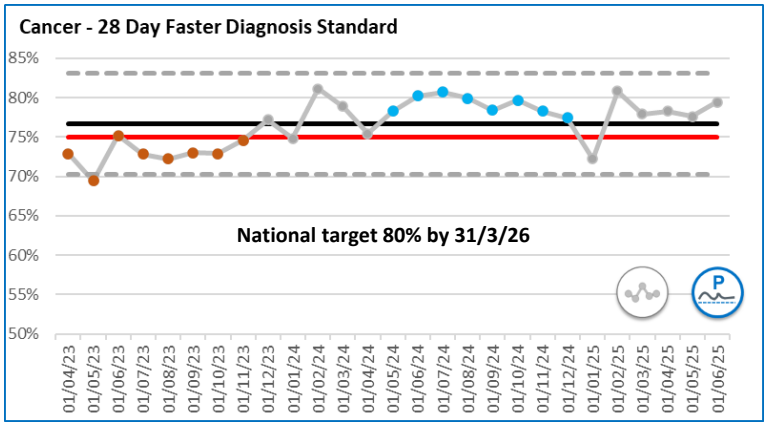


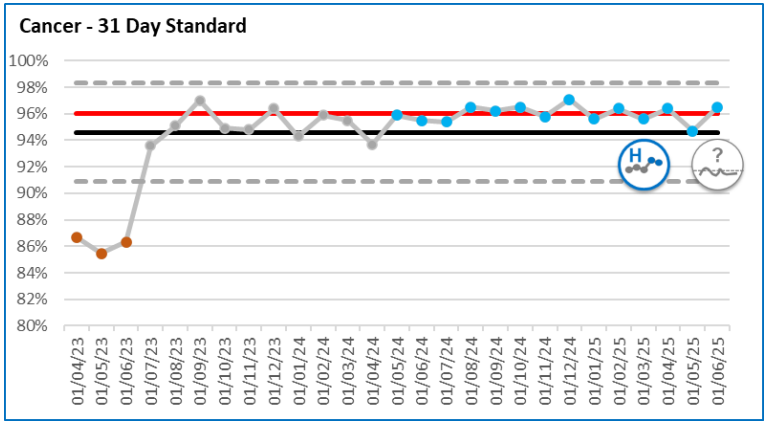


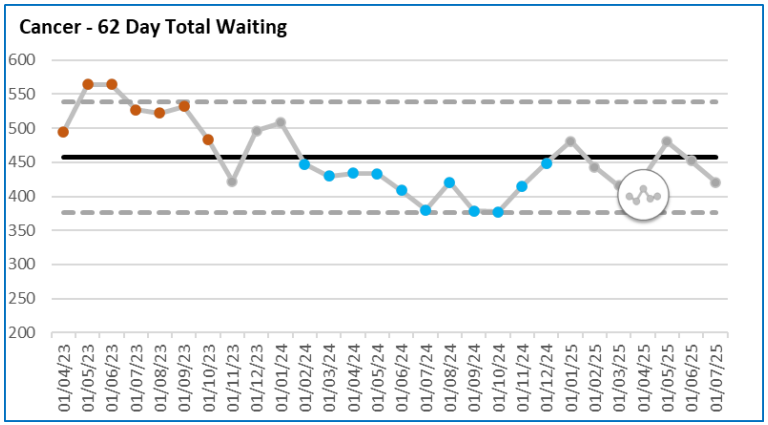


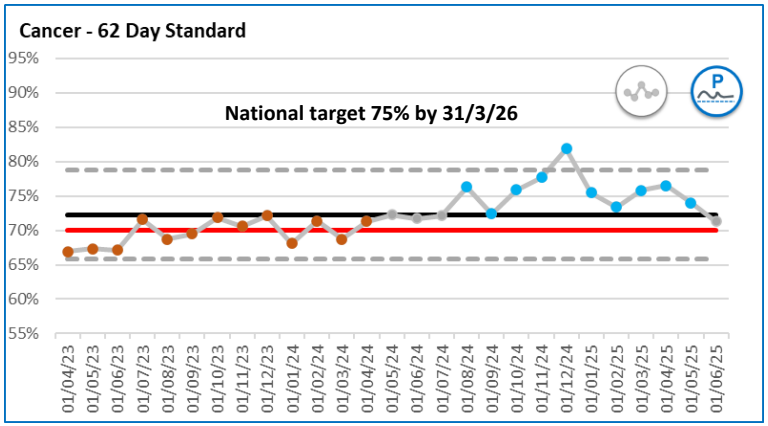
What the charts tell us	Issues	Action
• All providers are significantly below the DM01 performance target of 95%, however with the exception of ENHT, continue on improved trajectories. There is a large variance in performance by provider: • After a significant improvement seen in the early part of 2025, PAH performance has dropped over the last few months to 56% in June. • HCT has also seen a drop in performance over the last couple of months to 23% in June. • With significantly lower performance levels that have averaged c7% over the last 6 months, ENHT performance continues on a variable trend, at 9% in June.	• ENHT remains significantly challenged with paused pathways for 0–3-year-olds and complex patients. Key issue relates to estates for this patient cohort. • Limited mutual aid available within the Herts and west Essex system, in part due to estates challenges and workforce capacity. There is also limited mutual aid available externally to the system. • Site visits to HCT and PAH as part of the National Paediatric Audiology Improvement Programme have confirmed HCT and PAH to be delivering safe services. However, HCT have triggered a full 5 year look back for their auditory brainstem response (ABRs). PAH may also trigger the 5 year look back for ABRs, awaiting confirmation from NHS England. • Workforce is relatively fragile across all paediatric audiology services; this is a similar picture regionally and nationally.	• System wide paediatric audiology oversight group in place with monthly meetings to oversee key actions at system level and progress required improvements. ICB escalation team in place with weekly meetings. • Working with system partners to identify any possible mutual aid within the local system and review of potential levelling up. ENHT in direct conversation with BLMK regarding repatriation of patients. NHSE supporting with mutual aid options outside of local system. Ongoing review of PTLs by pathway to help manage children waiting as safely as possible, looking to ensure they are seen appropriately based on clinical need. • ENHT estates work completed at Lister site. Plans for Hertford County in progress, linked to national capital bid funding. Required estates work completed at HCT and on track at PAH. Also looking at sharing of estates e.g. HCT offering facilities one day per week to ENHT. • Work has been undertaken to map all audiology workforce across HWE, including bandings, skills and competencies. Focused recruitment where vacancies remain. Seeking external workforce to assist with mutual aid. • Data task and finish group delivering consistent local datasets and a new report which enables a view of paediatric audiology waiting time and referral trends split by provider, age cohort and patient pathway.

Cancer







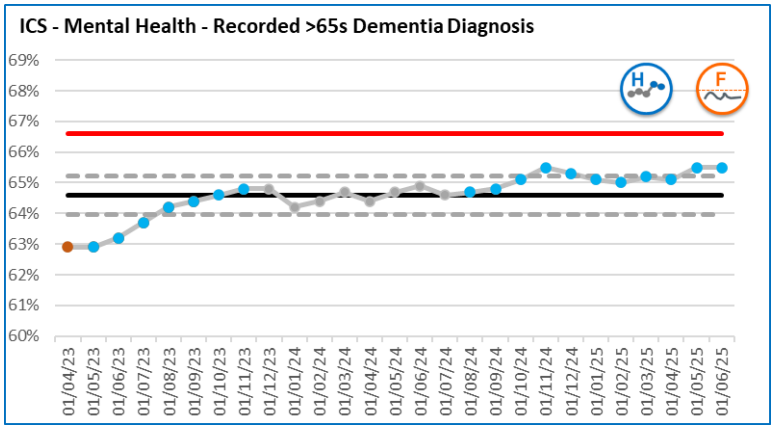


Hertfordshire and West Essex Integrated Care System

Cancer

What the charts tell us	Issues	Actions
• The 28-day Faster Diagnosis Standard (FDS) performance improved in June after three months of static performance reaching 78.7% against a M3 plan of 79%. However, there is variation across the system: | | Plan | Actual | |---|---|---| | ENHT | 78.3% | 80.2% | | WHTH | 81.7% | 85.4% | | PAH | 77.0% | 72.5% | • The 31-day target was achieved, reaching over 96% in June • Performance against the 62-day standard deteriorated in both May and June dipping under the 75% standard expected in the National Planning Guidance and below our planning trajectory for June • The 62-day backlog is variable but deteriorating over both May and June	**ENHT** • ENHT met two out of three standards in June. The 62 day standard was not met but ENHT was the 9th best performing trust nationally • Urology remains the most challenged of the high-volume pathways. For Urology, the Trust is dealing with increased demand of c.7% year-on-year • There has been a deterioration in the lung faster diagnosis standard in May and June. This is primarily because lung cancer screening hasn't been reported in these months. Reporting due to start again in July. **WHTH** • 28-day FDS performance maintained although particular challenges remain in the Haematology and Urology pathways • 31-day performance standard has been met across all specialities, except for Gynae and Urology. The 96% target was missed by 2.7% in Gynae and 1.1 % in Urology. • 62-day- Haematology, Head and Neck and Urology have continued to have challenges in meeting the 62-day target. Pathway complexity, late pathway transfers, out-patient capacity and histology delays, cited as the main reasons for delays. **PAH** • Urology (31.8%), Lower GI (46.5%) and Head & Neck (64.0%) were the biggest FDS challenges in June. Endoscopy staffing and Urology prostate triage, MRI and MDT clinic capacity are the key issues • Overall, 62-day performance fell to 41.8% in June, but this was largely driven by the progress made in reducing the >62-day backlog • 62-day performance is forecast to improve to c.54% in July • Greater than 62-day waits are continuing to improve with the Trust now achieving their fair shares target. As of 10/8 the latest backlog was 109 patients	**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 due to the increases in demand. • Breast performance recovered in June to 80.26% and the locum breast radiologist has now started with a new permanent staff member starting in September • 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. • Haematology USC referral booking transferred to Cancer Scheduling Team and new USC appointments ringfenced. Service demand and capacity modelling in progress • Post Advertised for a new H&N consultant, unfortunately no applications received and therefore exploring alternative solutions. Daily cancer outpatient appointments now available for H&N USC referrals. • Recruitment almost completed for Bladder one-stop pathway. Planned move of clinics to SACH in October to create additional clinic capacity. CDC bid submitted for additional U/S machine to support the cystoscopy service • One Stop Prostate service to restart, registrar appointed to start in September 2025. • Exploring digital solutions for PSA monitoring. **PAH** • PAH remains in Tier 1 of the national oversight and support infrastructure for Cancer recovery • Cancer improvement funding bids approved totalling £660k • Weekly meetings to review recovery trajectories and improvement plans are being led by the Deputy COO for Urology, Upper GI and Lower GI • Lower GI: Endoscopy insourcing in place from August and performance is improving; Audit of the Bowel Prep / Low Residual Diet pathway complete with changes now in development; More efficient process for removing benign patients being implemented in August • Urology: Prostate triage now fully embedded by day 3 of the pathway; Additional MRI capacity now in place and being fully utilised; Programme to improve turnaround times for pathology and to introduce mpMRI which should reduce the need for some patients to have a biopsy • Stretch trajectory agreed to further reduce >62-day backlog to 80

Mental Health – Dementia Diagnosis in Primary Care



ICB Area	What the charts tell us	Issues	Actions
Dementia Diagnosis in Primary Care	• National data for end of July 2025 shows the ICS dementia diagnosis rate continuing on an improved trend at 65.9% for the ICB against the national target of 66.7%. There is continued variance at Place: • South and West Herts: 64.0% • East and North Herts: 62.9% • West Essex: 74.9% July 2025	**Herts** • Dementia prevalence rate rises every month • Demand for memory clinic assessments via HPFT EMDASS remains very high **West Essex** • No concerns identified	**Herts** • Hertfordshire memory service continues to reduce its backlog, with the lowest waiting list so far this year. • In June, 73.46% of people were diagnosed within 12 weeks of being referred.

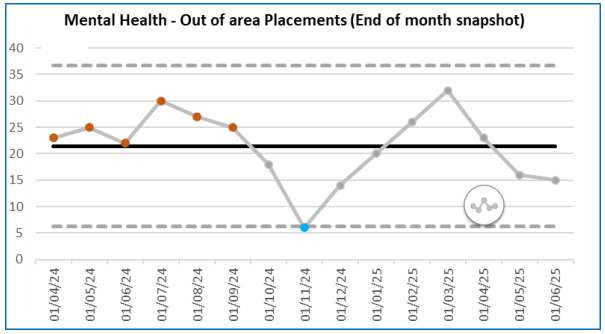
Hertfordshire and West Essex Integrated Care System

Mental Health – Inappropriate Out of Area Placements (OAPs)

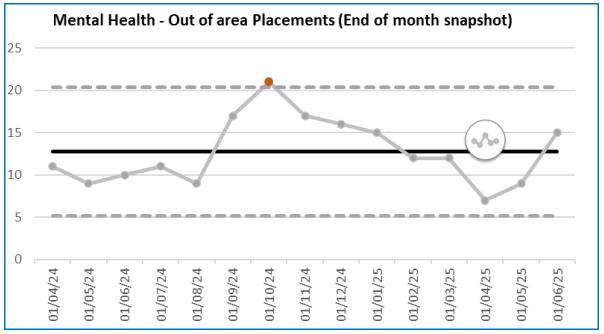
- The basis for measurement of OAPs has changed for 24/25
- Previous reporting was based on the number of out of area bed days in the month
- From April 24, reporting is based on the number of active OAPs at month end

HWE end of June total out of area placements: 30 vs. 15 plan

Hertfordshire



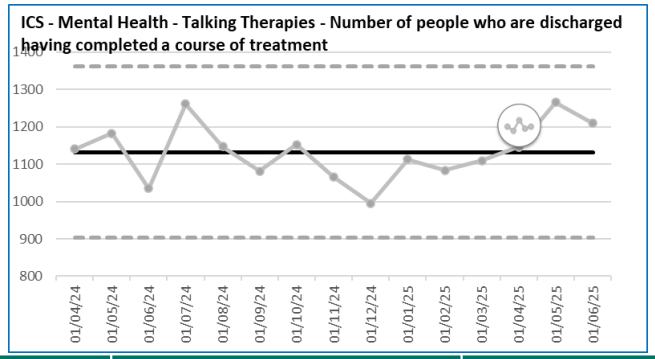
West Essex

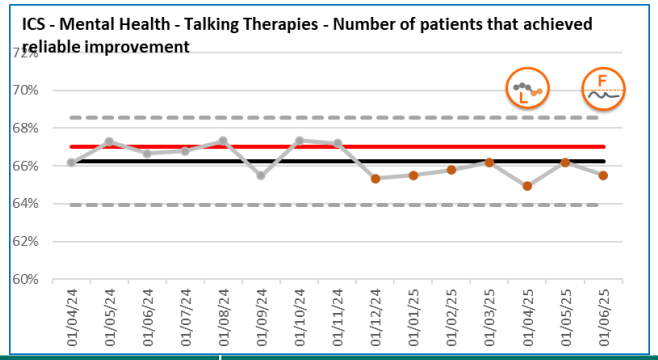


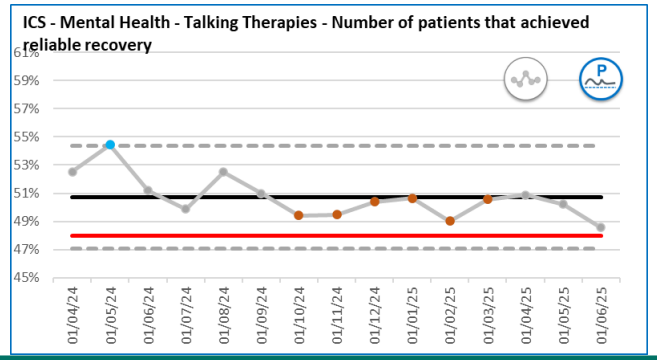
ICB Area	What the charts tell us	Issues	Actions
West Essex	An increase in numbers has been seen in west Essex across the last two months with 15 out of area placements reported at the end of June.	Previous concerns continue to place pressure on the system such as increased bed demand.	• Essex wide review has seen a new bed model being introduced to free up capacity and repatriate people back closer to home – example being; West Essex beds occupied by NE Essex residents being repatriated to the north of County into a NEE bed. • Although west Essex remain within planned OOA bed numbers there has been a contract performance notice served and meeting held with wider Essex leads and EPUT to agree an action plan.
Herts	June saw a further decline in numbers to 15 from a peak in March of 32 (as measured on the last day of the month)	• Hertfordshire has a low number of beds per population and there is ongoing support for provision of additional block beds • National shortage of MH beds, high occupancy rates and use of OOA beds is likely to continue • Placement challenges for service users with complex needs who are ready for discharge • There is a Trust Wide plan across divisions to reduce the OOA placements which commenced in April	• Alternatives to admission continue to be developed, including HPFT complex need crisis house, and MHUCC • Wider Executive led work at system level to support placement of longer term CRFDs. • Bed management system continues to be developed and implementing plan to include OAPs. • Continue to strengthen relationships with contracted bed providers emphasising LoS management, to reduce the number of inappropriate beds and to ensure all Service Users are within Hertfordshire boundaries. • Conducting clinical visits to contracted bed providers to support discharge planning. • Holding ongoing daily Bed Management meetings (3 x a day) to explore all alternatives to admission. • Senior, clinically led team attending independent providers ward rounds in person to unblock and support discharge • Collaborative working with HCC reviewed support service users requiring HCC involvement for discharge.

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



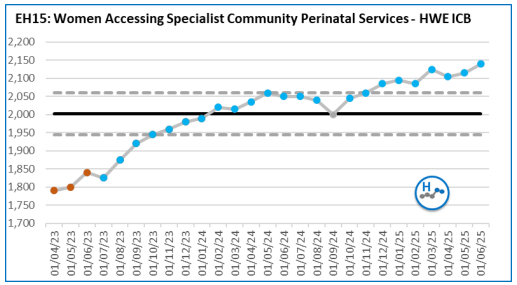


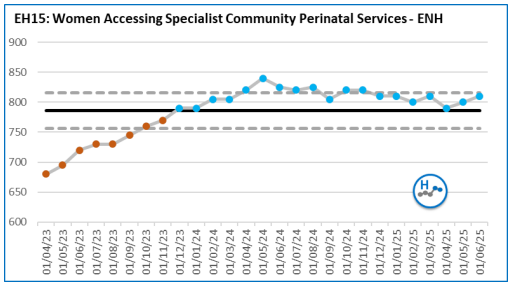


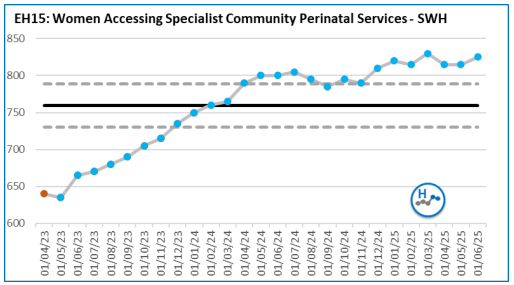
ICB Area	What the charts tell us	Issues	Actions
Hertfordshire & West Essex	**West Essex (JULY)** • Referrals (689) increased during July from previous month (+97) • Reliable Recovery rate is 46.4% in July and Reliable Improvement 64.6%. **Hertfordshire** • Increase in completed treatments since February 2025 • 63% reliable improvement rate in July 2025 • 48% reliable recovery rate in July 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 • CFD procurement complete, implementation period for new providers will limit capacity until training complete. • 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 • SDF funding now in place for Herts that will increase HIT workforce with immediate support to Step 3 pressures. • 6 providers In place to support 'Counselling for depression pathway' training places allocated for counsellors with training commencing September onwards. **Service Improvements and Limbic System:** The Limbic system was introduced to enhance referral quality by collecting more information before assessment. The service also emphasized the stepped care model, with new clinical lead roles at both step 2 and step 3, and a focus on recovery training and appropriate referrals. **HPFT Actions:** • Choose & Book has been rolled out to all Herts team to increase the flow of patients from referral to initial appointment. This is to be reviewed for efficiency and improvements now that it is established in all teams. We are looking to expand this to include choose and book for treatment sessions. This will be piloted in SW. • The Time to Change group-based initiative continues to be rolled out across Herts to improve the engagement in treatment at Step 3. There is now an additional offer of a single session to improve accessibility. • All teams are required to offer clients further resources and support whilst waiting, such as the webinars and online self-help information. • Workforce, productivity, adjusted caseloads are under regular review.

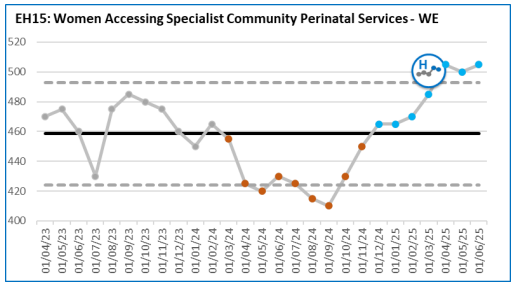
Community Perinatal Mental Health

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









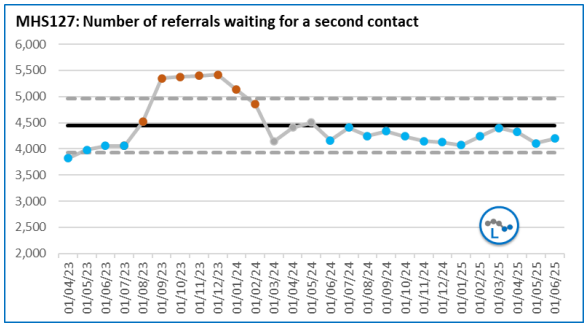
ICB Area	What the charts tell us	Issues	Actions
Hertfordshire & West Essex	**West Essex** • Consistently exceeding national target at 10.44% • Accessing service (new clients) 138 to date this financial year. July saw 29 referrals of which 22 were seen within 4 weeks and 419 contacts with new patients. **Hertfordshire** • Consistently exceeding national target	**West Essex** • No concerns identified **Hertfordshire** • Contractual reporting has been changed to reflect national 12 month rolling measure	**Hertfordshire West Essex** • Continually monitor local services on the 12-month access target to ensure services remain on track

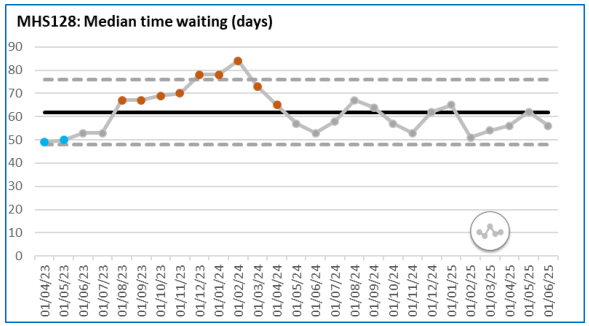
Hertfordshire and West Essex Integrated Care System

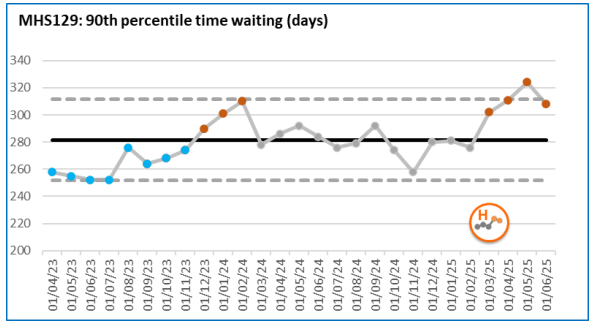
Mental Health – Community Waits

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.



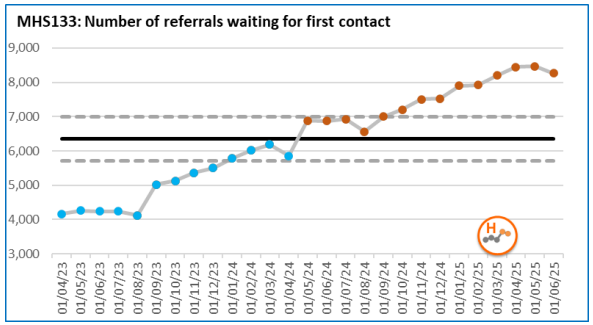


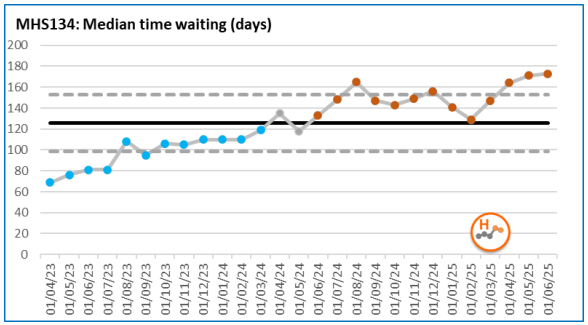


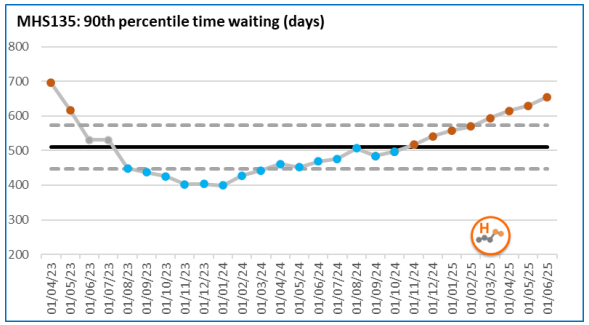
ICB Area	What the charts tell us	Issues	Actions
Hertfordshire & West Essex	**West Essex** • Referrals spells started June 2025 – 315, previous month % change is 290.0 (+8.6%). • Referrals spells closed in June – 340 • Referrals spells open in June – 1,725 • Referrals spells still waiting for second contact 265 (previous month change -3.6%). **Hertfordshire** • As of June, there were 71.4% of referrals with 2 plus contacts and a SNOMED assessment compared to the national average of 41.5%. • Referrals with 2 plus contacts and a baseline outcome measure were at 87.6% compared to the national position of 45.9% (latest data June 2025).	**West Essex** • Although there has been an increase in referrals (8.6%) patients waiting for a second contact reduced by 3.6% however there is local recognition that second contact remains high. • 249 patients DNA'd in June 2025. **Hertfordshire** • The data flow from Primary Care and VCSFE providers to MHSDS or the GP equivalent continues to be a challenge. 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).	• Community First steering group established across Essex. This is a strategic initiative to review and redesign community mental health teams, establishing a standardised, equitable, and sustainable model of care. • 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 Power BI reporting has been developed and key areas for action are being determined. • 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.

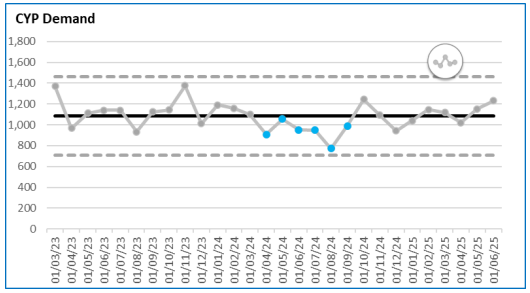


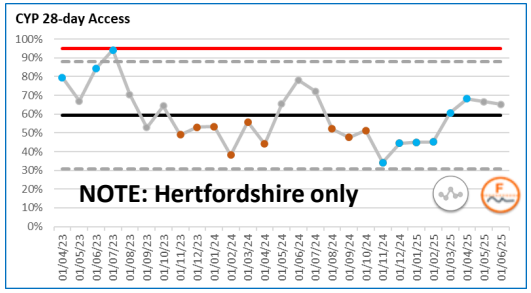


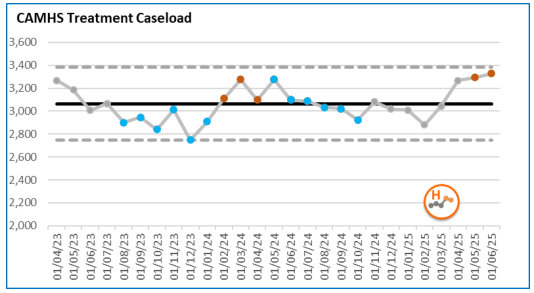


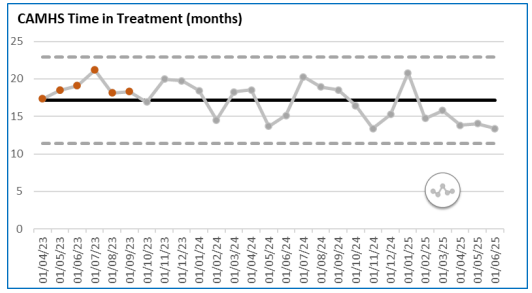
ICB Area	What the charts tell us	Issues	Actions
Hertfordshire & West Essex	• The number of referrals waiting for first contact continues on a trajectory of deterioration, remaining high at 8,265 across the ICS. • There remains significant variance by place with 6,385 waiting at SWH, 1,580 at ENH and 300 at WE. • The median and 90th percentile time waiting also continue to increase at 173 and 655 in June respectively across the ICS. • Again there is significant variance at place with the longest time waiting at SWH (204 day median time), followed by ENH (82 day median time) and WE (26 day median time).	• 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 available for Teams to review elements of the waiting time standard • 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 all teams have systems in place to review treatment waiters in their MDT's and team managers review patterns of data errors to ensure that training is delivered to staff if needed

Mental Health – CAMHS Services





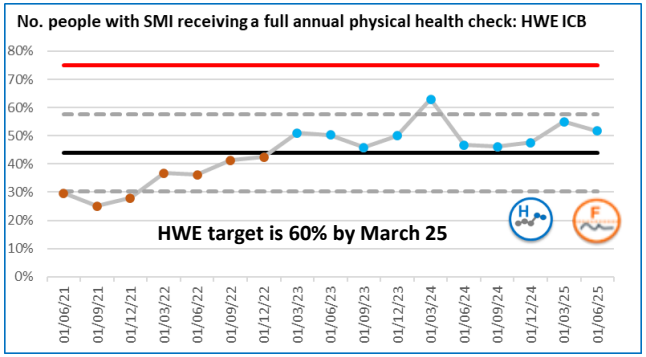




What the charts tell us	Issues	Actions
West Essex • West Essex does not have a formal KPI for 28 days; the cohort of YP seen <4 weeks is monitored at monthly provider meetings • There has been a slight decrease in demand during Q1 2025 • Numbers on caseload remain consistent with those as at the end of Q4 2025 • Time in treatment has increased but reflects acuity and complexity of caseload **Herts – HPFT only** • Demand into the service has seen a slight increase in June • 28-day performance has been improving since November 2024 however has moved to a variable trend over the last couple of months, achieving 65% in June • Caseloads have risen in the last 3 months • Time in treatment has been reducing for the last 4 months	**West Essex** • The SPA continues to see a steady demand in referrals but following review clinical triage is back on track and throughput is swifter. • The rise of acuity / complexity of referrals continues, this is monitored via RAG systems for triage • Team manager CAMHS hub team has returned from long term sickness • Clinical lead role remains vacant. **Herts – HPFT only** • 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	**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** • Service has been improved to level 2 of trust escalation framework • P1s are prioritised with more robust processes & oversight • Recovery trajectories have been updated and are on track • 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.

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



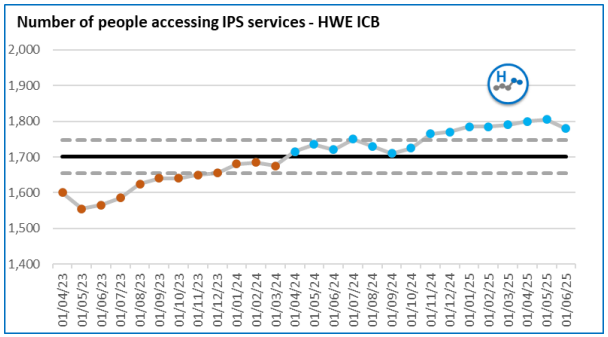
	2021/22				2022/23				2023/24				2024/25				2025/26
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1
East and North Herts Place	19.6%	11.9%	15.1%	25.8%	24.0%	36.3%	40.4%	45.9%	49.7%	47.7%	49.4%	60.5%	52.3%	52.7%	53.6%	61.9%	57.3%
South West Herts Place	39.4%	38.2%	39.5%	47.5%	44.6%	46.4%	43.6%	55.9%	51.0%	44.8%	52.2%	66.9%	38.9%	36.8%	38.1%	42.9%	43.0%
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%	66.4%	59.4%
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%**	**54.9%**	**51.7%**

- 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 • National data indicates South & West Hertfordshire is notably performing lower at 43% than East & North at 57.3% • ICB data pulled from Ardens however shows the following performance for quarter 1 - East and north Herts at 58% - Southwest Herts at 58% - West Essex at 58%	• Data quality issues as per NHSE disclaimer. The data presented here is considered 'experimental' due to known issues of incompleteness both in terms of the number of Practices who have not supplied information, and that some 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 • SW primary care outreach support has stopped due to financial position • Support via a proof of concept with HPFT for those who attend the Clozapine clinics to work with MiMH to assertively outreach and support tests in clinics DATA SHARING PERMITTING • Investment into Physical health professionals in the trust has made it possible to work in partnership with clinical and data governance and honorary contracts to be in place

Individual Placement and Support Access

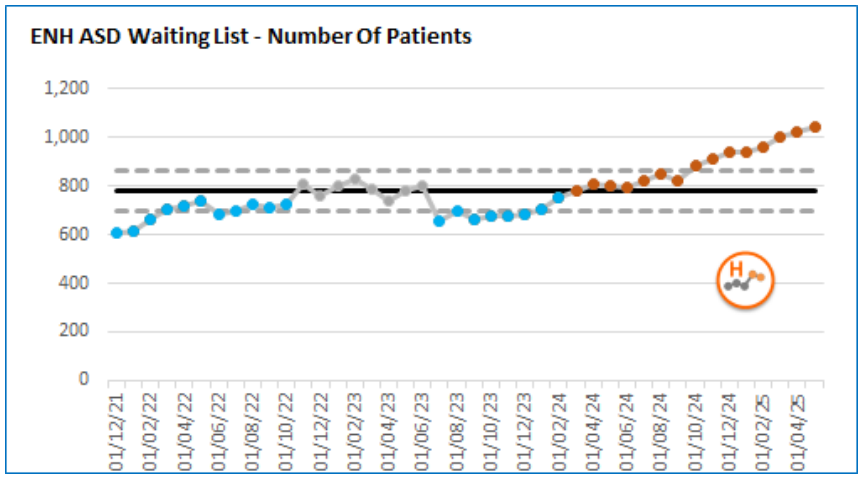
E.H.34 Number of people accessing Individual Placement and Support



	2023/24												2024/25												2025/26		
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	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	Mar-25	Apr-25	May-25	Jun-25
NHS HERTFORDSHIRE AND WEST ESSEX ICB - 06K	525	495	515	535	545	540	525	535	540	550	530	505	535	550	520	525	510	505	500	520	525	535	530	550	560	575	565
NHS HERTFORDSHIRE AND WEST ESSEX ICB - 06N	675	675	680	695	715	725	745	725	720	715	745	755	745	735	730	715	695	695	685	675	660	640	615	575	555	540	525
NHS HERTFORDSHIRE AND WEST ESSEX ICB - 07H	400	385	370	355	365	375	370	390	395	415	410	415	435	450	470	510	525	510	540	570	585	610	640	665	685	690	690
HWE ICB	**1600**	**1555**	**1565**	**1585**	**1625**	**1640**	**1640**	**1650**	**1655**	**1680**	**1685**	**1675**	**1715**	**1735**	**1720**	**1750**	**1730**	**1710**	**1725**	**1765**	**1770**	**1785**	**1785**	**1790**	**1800**	**1805**	**1780**

	Issues	Actions
• The number of people accessing individual placement and support remains on an improved trajectory, however fell slightly in June to 1,780 for the ICS. • Variation at Place: - ENH: 565 - SWH: 525 - WE: 690	• No concerns identified with current provision as service commissioned above the national ask. • Transition to new service following procurement may result in drop in referral rates • The currently commissioned service is not at the full IPS Grow recommended rate. • The recording of data needs to be confirmed with NHSE and IPS grow.	**West Essex** • Ongoing conversations with NHSE and system partners regarding Essex wide services to ensure transition to new services **Herts** • A business model on numbers of people supported and the gap in finance and workforce will be advised, this will be reported through Hertfordshire Contract Review Meeting. • A meeting has been arranged for the data to be discussed with NHSE data leads IPS grow and HPFT leads. • Regular regional meetings to discuss this is being attended • A regular local meeting to discuss employment across Hertfordshire has been taking place with HCC and HPFT and commissioning to seek support from the HCP on wider employment strategies. Programme plan in place with HCP • Meeting has taken place with NHSE and IPS grow, relevant measures are being taken to ensure the data on those who are actively taking up this service is corrected. • Meeting with HPFT and data leads to agree the action plan to re establish the service, move into the Primary Care space and mobilise the new team members • The data will fall below the trajectory, an action plan to monitor this is under development

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 Mar-25):

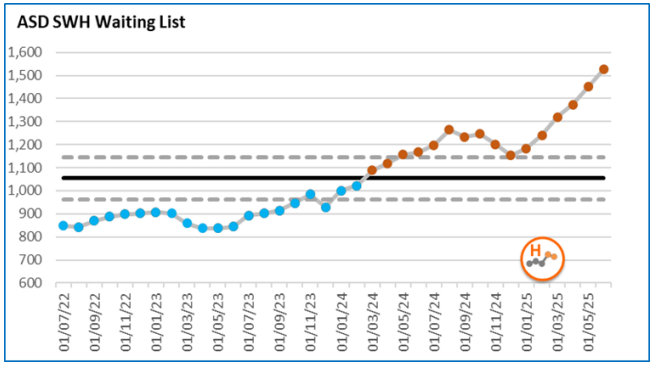
Waiting list bucket	Number of patients (Mar-25)	Number of patients (May-25)
<18 weeks	118	167
18 – 65 weeks	487	476
66 – 78 weeks	100	102
>78 weeks	295	300

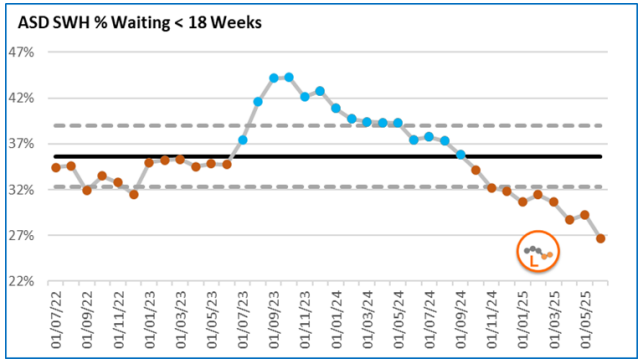
ICB Area	What the charts tell us	Issues	Actions
East & North Herts	• The ASD waiting backlog waiting list continues to increase and reached 1045 patients in May-25 which is the highest recorded level • The number of patients waiting >78 weeks for an ASD assessment has risen from 86 in Dec-23 to 300 in May-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	• Demand continues to far exceed capacity.	• Ongoing Hertfordshire wide ASD/ADHD transformation programme led by MHLDN HCP. • Support whilst waiting initiatives continue to be promoted and developed. • Additional recurrent funding agreed to support growth in capacity.

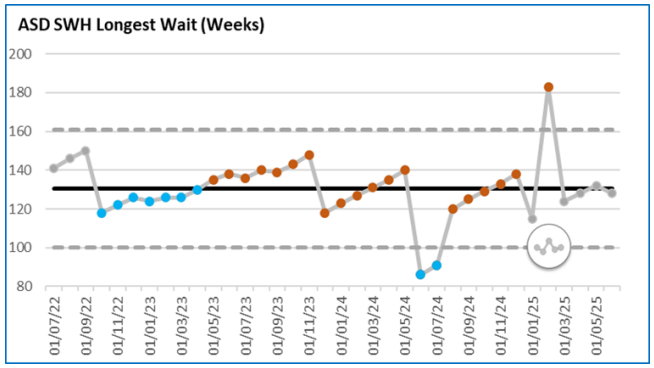
Hertfordshire and West Essex Integrated Care System

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	1450	1526	↑	29.24%	26.70%	↓	132	128	↓	June





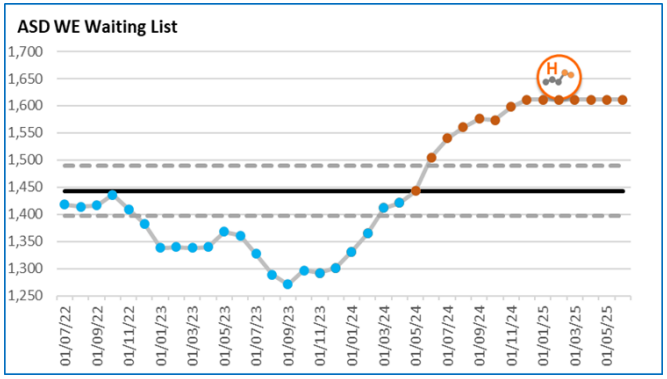


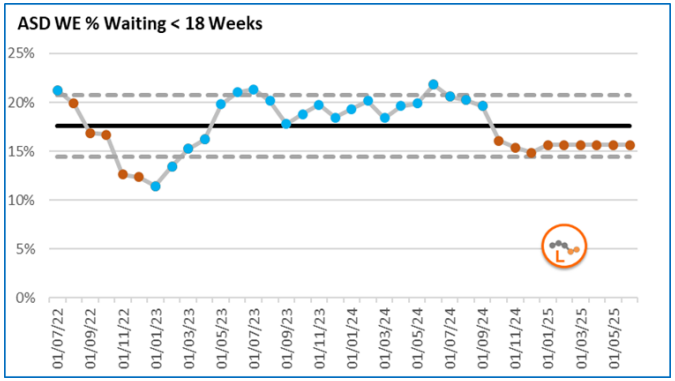
ICB Area	What the charts tell us	Issues	Actions
South & West Herts	• The ASD waiting list has continued to increase and remains consistently above the historic average • The % of ASD waiters <18 weeks remains low declining further in June. • The longest wait has returned to mean levels over the last few months, at 128 weeks in June	• Demand continues to far exceed capacity.	• Ongoing Hertfordshire wide ASD/ADHD transformation programme led by MHLDN HCP. • Support whilst waiting initiatives continue to be promoted and developed. • Additional recurrent funding agreed to support growth in capacity.

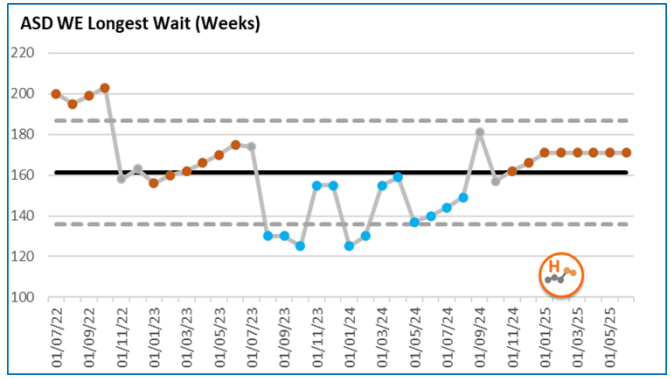
Hertfordshire and West Essex Integrated Care System

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	→	June





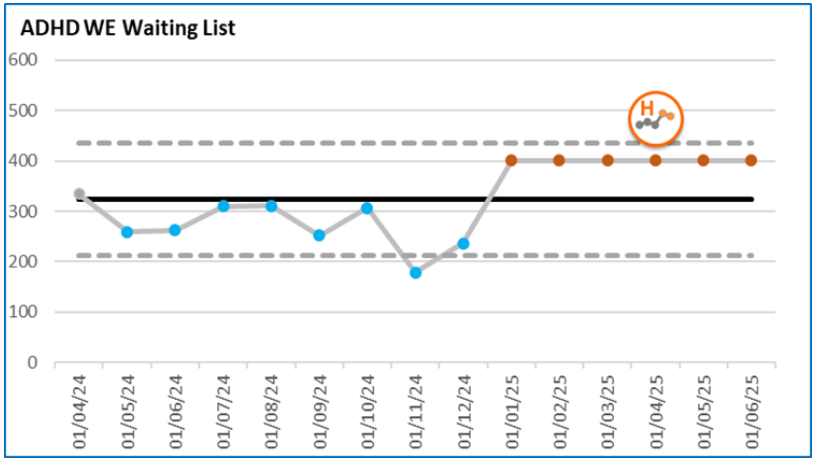


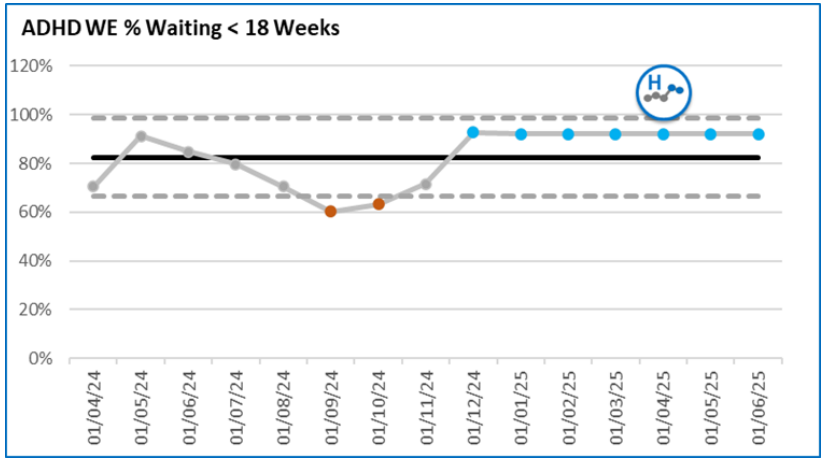
ICB Area	What the charts tell us	Issues	Actions
West Essex	• To note, data has been copied over from January in the absence of any new data being available to April • The ASD waiting list remains very high • The % of waiters <18 weeks remains low and fell in each of the six months leading up to January • The longest wait has been steadily increasing but remains within common cause variation limits	• Awaiting data reporting to resume following cyber incident. • No change: demand continues to far exceed capacity.	• Once access to data platforms have been reopened, HCRG will provide back-dated performance data which will be reflected on this report • 'Waiting well' workstream continues with local partners at Place, led by trainee psychologist at HCRG • Additional recurrent funding agreed to support growth in capacity.

Hertfordshire and West Essex Integrated Care System

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	→	June

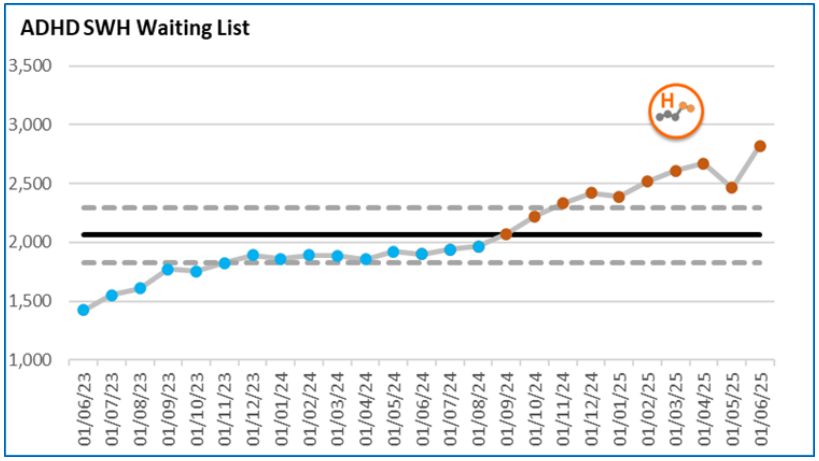


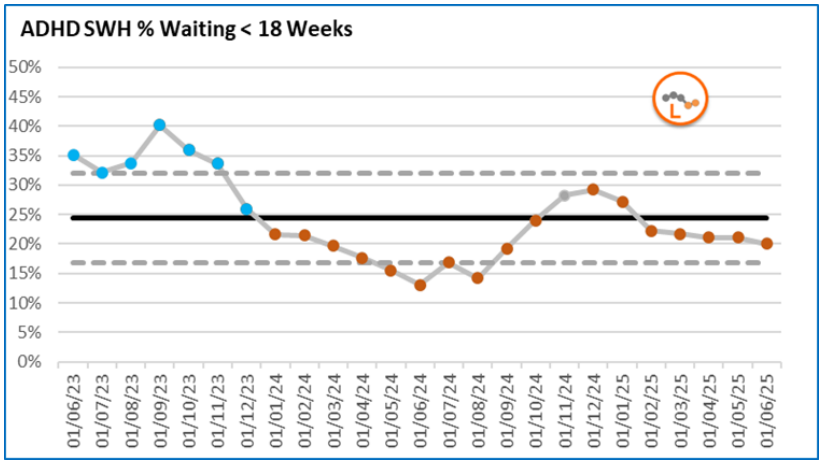


ICB Area	What the charts tell us	Issues	Actions
West Essex	• West Essex data has been copied over from January in the absence of any new data being available to April • West Essex waiting lists continue to fluctuate at historic average levels • The % of children waiting <18 weeks are also within common cause variation limits	• No change: demand continues to far exceed capacity. • ENHT is not currently able to report on waiting times / waiting list sizes for patients waiting for an ADHD assessment • Awaiting WE data reporting to resume following cyber incident. • WE Adult services continue to limit the number of young people transitioning to adult care, resulting in Paediatrics holding an increasing caseload of >18yrs	• Once access to data platforms have been reopened, HCRG will provide back-dated performance data which will be reflected on this report • 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 • Additional recurrent funding agreed to support growth in capacity.

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

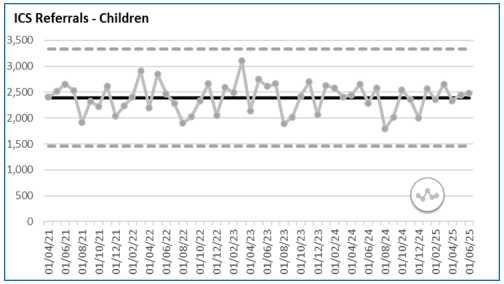
			Patients Waiting			% waiting < 18 weeks			Longest wait (weeks)			
Place	Provider	Age	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
SWH	HPFT	Children	2463	2821	↑	21.07%	19.99%	↓	203	209	↑	June

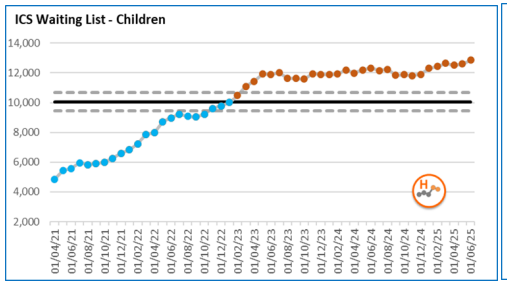


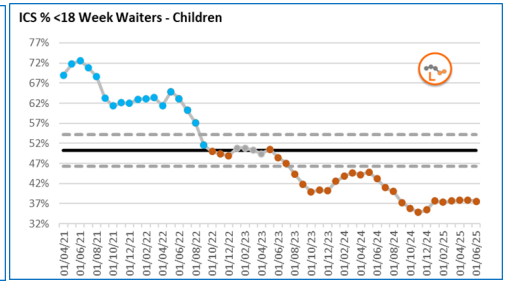


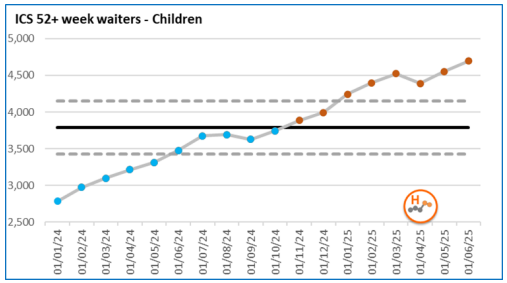
ICB Area	What the charts tell us	Issues	Actions
West Essex	• Overall waiting list was relatively stable but has notably increased over the last ten months • The % of ADHD patients waiting <18 weeks has declined in recent months and is now on a deteriorating trend.	• No change: demand continues to far exceed capacity.	• Ongoing Hertfordshire wide ASD/ADHD transformation programme led by MHLDN HCP. • Support whilst waiting initiatives continue to be promoted and developed. • Additional recurrent funding agreed to support growth in capacity.

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	2447	2476	↑	12594	12847	↑	37.89%	37.57%	↓	4553	4694	↑	June

		Referrals			Patients Waiting			% waiting < 18 weeks			Patients Waiting >52 weeks			
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	338	381	↑	605	655	↑	83.97%	82.60%	↓	0	1	↑	June
ENH	AJM/Millbrook	22	20	↓	100	104	↑	92.00%	93.27%	↑	0	0	→	June
ENH	ENHT Community Paeds.	193	238	↑	6700	6802	↑	12.84%	12.72%	↓	4274	4371	↑	June
ENH	**All**	**553**	**639**	↑	**7405**	**7561**	↑	**19.72%**	**19.88%**	↑	**4274**	**4372**	↑	**June**

		Referrals			Patients Waiting			% waiting < 18 weeks			Patients Waiting >52 weeks			
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	1340	1285	↓	3884	3981	↑	55.97%	55.04%	↓	279	322	↑	June
SWH	AJM/Millbrook	21	15	↓	101	100	↓	96.04%	91.00%	↓	0	0	→	June
SWH	Communitas ENT													
SWH	**All**	**1361**	**1300**	↓	**3985**	**4081**	↑	**56.99%**	**55.92%**	↓	**279**	**322**	↑	**June**

		Referrals			Patients Waiting			% waiting < 18 weeks			Patients Waiting >52 weeks			
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 - Wheelchairs	14	18	↑	24	25	↑	91.67%	92.00%	↑	0	0	→	June
WE	HCRG/Virgin	519	519	→	1180	1180	→	86.36%	86.36%	→	0	0	→	June
WE	**All**	**533**	**537**	↑	**1204**	**1205**	↑	**86.46%**	**86.47%**	↑	**0**	**0**	→	**June**

Hertfordshire and West Essex Integrated Care System

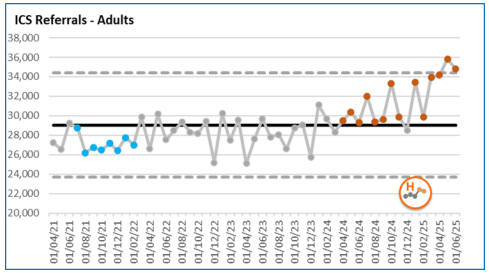
Community Waiting Times (Children)

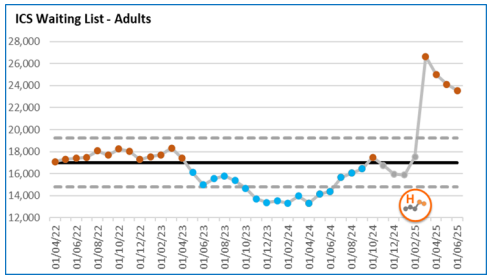
The NHS 18-week Referral to Treatment (RTT) standard only applies to consultant led services. For Children's community services this include Community Paediatrics (ICS wide) and Children's Audiology (SWH). Other services have locally agreed waiting times standards which may be 18 weeks or less. All services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

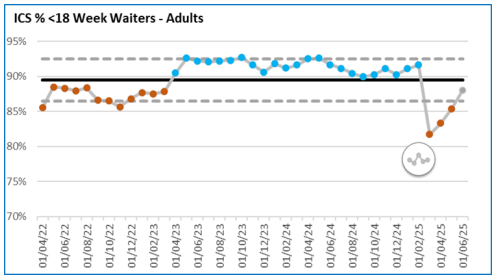
ICB Area	What the charts tell us	Issues	Actions
ICB	• The total number of children on waiting lists remains very high, but has plateaued at c.12,000 • The % of children waiting less than 18 weeks is broadly unchanged at c.37%, compared to the national average of c.50% • The number of waits over 52 weeks has seen in an increase in both the last two months. The longest waits are within the ENHT Community Paediatrics Service where there are now 4,371 x 52 week waits • There are additionally 322 x 52 week waits within HCT services in South & West Hertfordshire which has continued to increase • Consultant led 18-week RTT performance: SWH Community Paediatrics HCT 35.1% SWH Children's Audiology HCT 40.4% ENH Community Paediatrics ENHT 12.7% WE Community Paediatrics HCRG – no data received	**ICS Wide:** • No change in specialist services continuing to experience a marked increase in demand impacting on waiting times for both first and follow-up appointments. • Special School Nursing, Therapies and Comm Paeds are not able in the current format to meet demand for any projected increases in special school places and complexity. • ASD/ADHD assessment continues to be a significant pressure with increase in requests for assessments rising at 24% per year. **Hertfordshire** • Most significant pressures in Audiology (ENH) and Children's Community Nursing (ENH). • Significant pressures in Physiotherapy demonstrated through business case which could not be supported through contract negotiation. • Struggling to find theatre space for tooth extraction with paed anaesthetist. **West Essex (WE)** • Still waiting for HCRG performance reporting to resume following cyber incident	• Audiology action plan in place with ENHT and HCT, including recruitment and capital build. • Load Levelling requested across the ICS to support Audiology pressures, although puts relatively good performance in WE and SWH at risk. • Director level engagement around special school place projections continues. • Theatre space for Tooth Extraction to be raised via HCP governance.

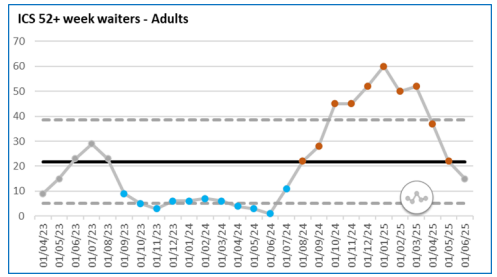
Hertfordshire and West Essex Integrated Care System

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	35826	34787	↓	24127	23563	↓	85.40%	88.05%	↑	22	15	↓	June

		Referrals			Patients Waiting			% waiting < 18 weeks			Patients Waiting >52 weeks			
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	9621	9106	↓	10880	11361	↑	87.14%	87.33%	↑	21	14	↓	June
ENH	AJM/Millbrook	139	114	↓	401	417	↑	92.77%	92.09%	↓	0	0	→	June
ENH	**All**	**9760**	**9220**	↓	**11281**	**11778**	↑	**87.34%**	**87.49%**	↑	**21**	**14**	↓	**June**

		Referrals			Patients Waiting			% waiting < 18 weeks			Patients Waiting >52 weeks			
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	7753	7854	↑	1526	1672	↑	99.93%	100.00%	↑	0	0	→	June
SWH	HCT	892	893	↑	1012	1022	↑	99.31%	98.34%	↓	0	0	→	June
SWH	AJM/Millbrook	122	135	↑	408	438	↑	94.36%	93.84%	↓	0	1	↑	June
SWH	Circle Health MSK	3564	3394	↓	6639	5641	↓	70.33%	78.62%	↑	0	0	→	June
SWH	Communitas ENT													
SWH	The Gynaecology Partnership													
SWH	**All**	**12331**	**12276**	↓	**9585**	**8773**	↓	**79.12%**	**85.75%**	↑	**0**	**1**	↑	**June**

		Referrals			Patients Waiting			% waiting < 18 weeks			Patients Waiting >52 weeks			
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	13620	13190	↓	2520	2290	↓	99.68%	99.87%	↑	0	0	→	June
WE	EPUT - Wheelchairs	115	101	↓	134	137	↑	97.01%	95.62%	↓	0	0	→	June
WE	Mayflower				607	585	↓	86.49%	85.64%	↓	1	0	↓	June
WE	**All**	**13735**	**13291**	↓	**3261**	**3012**	↓	**97.12%**	**96.91%**	↓	**1**	**0**	↓	**June**

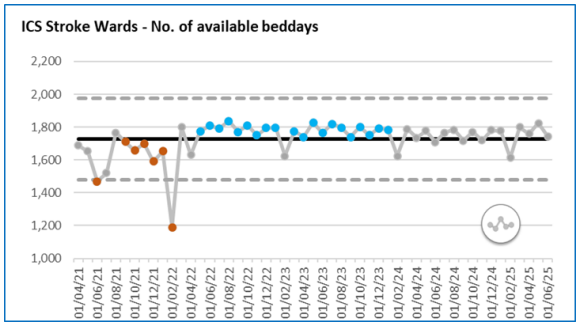
Hertfordshire and West Essex Integrated Care System

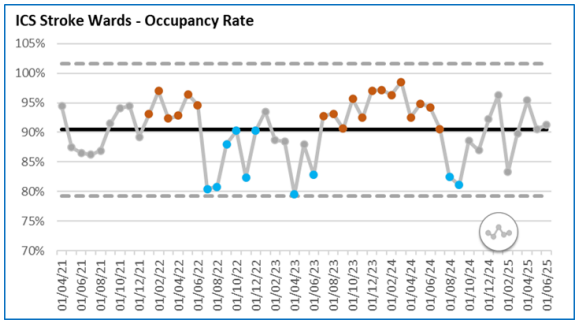
Community Waiting Times (Adults)

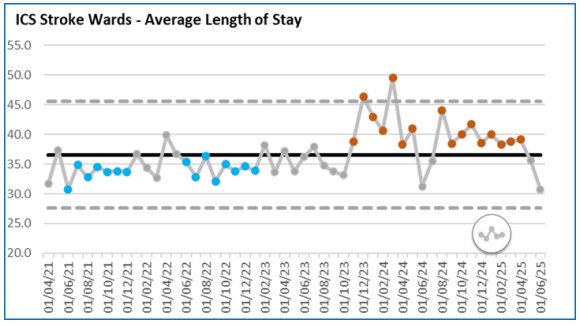
The NHS 18-week Referral to Treatment (RTT) standard only applies to consultant led services. For Adult community services this include Skin Health (ENH), Respiratory (S&W), and Podiatric Surgery (WE). Other services have locally agreed waiting times standards which may be 18 weeks or less. All services 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 two community providers is currently excluded from the overall HWE system position as noted on the previous slide and work is ongoing to resolve reporting. Please note that Circle data has been included from March 25 which has resulted in step changes in reporting** • The % of patients waiting less than 18 weeks declined in March with the inclusion of Circle data, however started to recover from April • Overall waiting lists saw an increase in March with the inclusion of Circle data but again have been decreasing since. • 52 week waits continues to reduce overall. • Consultant led 18-week RTT performance: ENH Skin Health HCT 88.1% SWH Respiratory CLCH 100.0% WE Podiatric Surgery EPUT 100.0%	**East & North Hertfordshire (ENH)** • Increase in referrals compared to 2024/25 • 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)** • Community MSK services delivered by Circle from 1 April 2024 with significant backlog of 22,000 cases transferred from previous service. • July community MSK data shows a similar trend to the previous months in that the provider is seeing a lot more patients/activity to try and reduce the waiting list as soon as possible. There are plans in place to achieve 0 waits over 18 weeks by September reporting period. • Community Gynae and ENT services have been recommissioned under new contracts from 1 April 2025. Commissioners are working with providers to submit data in line with new contract requirements to enable reporting of community waiting times. • CLCH – Slight decrease in number of referrals received in month and decrease in total number of patients waiting on caseload. There are no patients waiting more than 18 weeks. **AJM (Hertfordshire wide wheelchair service)** • 0 over 52 weeks and 79 over 18 weeks. Initial reason for the delays is due to the time it is taken the national procurement team to process the orders. This has now been brought in house in the Hertfordshire service and CS team will order equipment going forward. Provider to share an exception report on the equipment HO status of the over 18 week patients. **West Essex (WE)** • Parkinsons's longest wait 19 weeks due to vacancy • Wheelchair services longest wait 25 week all pts have chairs awaiting parts from supplier • Mayflower longest waiters are in Dermatology	**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)** • ICB working with Circle to achieve target of 0 over 18 week waits by September reporting period • Contract and BI teams working with the other community providers to achieve new reporting requirements for 25/26 • CLCH - daily and weekly monitoring remain in place. Additional external support sourced for services to try and reduce waiting times as much as possible. **West Essex (WE)** • Community neurology specialist nurse will commence July 2025 joint post with PAH • Mayflower longest waiters and overall PTL now improving following recovery discussions at last SPQRG meeting

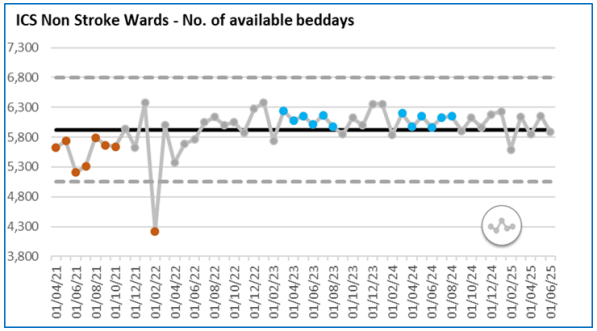
Community Beds (Stroke & Non-Stroke)

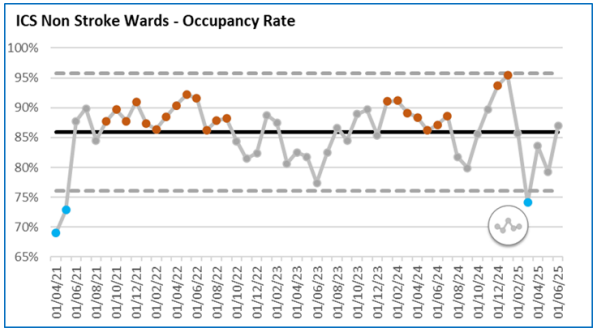


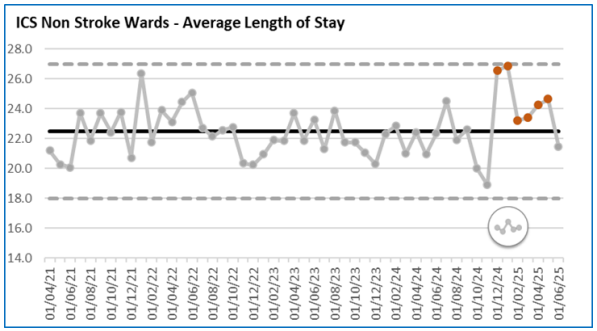




Stroke Wards			Number of available beddays			Occupancy Rate			Average length of stay (days)			
Place	Provider	Age	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
ENH	HCT	All	744	720	↓	92.61%	91.53%	↓	37.9	27.9	↓	June
SWH	CLCH	All	646	603	↓	97.83%	96.52%	↓	24.7	29.5	↑	June
WE	EPUT	All	434	420	↓	76.27%	83.10%	↑	52.0	38.0	↓	June
ICS	**All**	**All**	**1824**	**1743**	↓	**90.57%**	**91.22%**	↑	**35.7**	**30.7**	↓	**June**







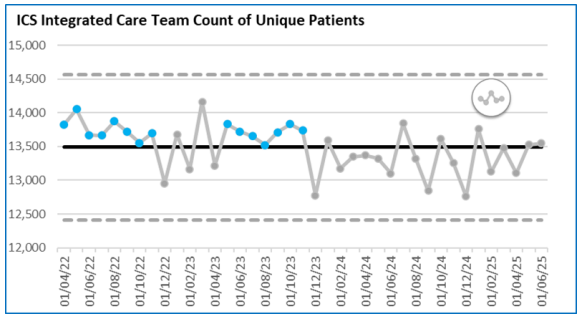
Non Stroke Wards			Number of available beddays			Occupancy Rate			Average length of stay (days)			
Place	Provider	Age	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
ENH	HCT	All	1643	1498	↓	78.03%	83.85%	↑	22.5	21.4	↓	June
SWH	CLCH	All	2248	2195	↓	87.86%	88.93%	↑	24.6	22.3	↓	June
WE	EPUT	All	2263	2190	↓	71.54%	87.03%	↑	26.4	20.7	↓	June
ICS	**All**	**All**	**6154**	**5883**	↓	**79.23%**	**86.93%**	↑	**24.7**	**21.5**	↓	**June**

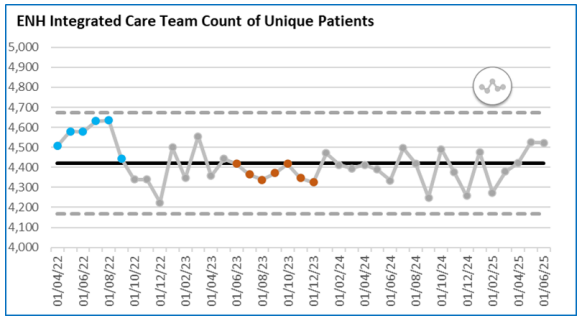
Community Beds (Stroke & Non-Stroke)

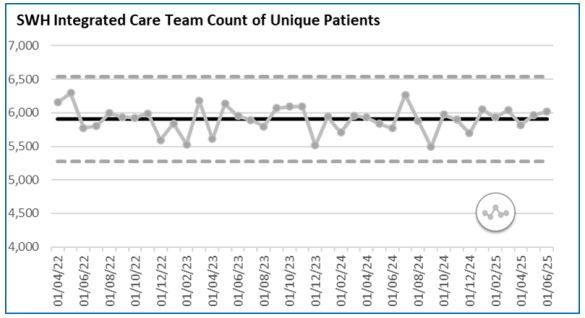
ICB Area	What the charts tell us	Issues	Actions
ICB	**Stroke Beds** • Available stroke bed days remain stable • Overall stroke bed occupancy rates have continued on a variable trend, close to the mean for the last two months • CLCH occupancy remains the highest at 96.52% in June • Overall length of stay has continued to reduce over the last couple of months across the system and at all providers with the exception of CLCH. The longest average length of stay remains EPUT. **Non-Stroke Beds** • Available non-stroke bed days continues on a variable trend close to the mean • Non-stroke bed occupancy rates have also returned to the mean in June at just under 87% • Overall length of stay continues along the average of c.22 days	**East & North Hertfordshire (ENH)** • Bed occupancy remains the highest at Danesbury with an average of 88% over the past 12 months. Herts & Essex and QVM have a 12-month average occupancy of 84% and 78% respectively • Average length of stay over the past 12 months for Herts & Essex averaged 22 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 37 **South & West Hertfordshire (SWH)** • Further reduction in occupancy rates from previous month, this remains high • Increase in average length of stay but within target for stroke beds **West Essex (WE)** • Stroke/neuro bed occupancy increased in June and LOS reduced • Non-stroke bed occupancy has increased in June from May 2025 and Length of stay reduced from 26.4 in May to 20.7 in June 2025	**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)** • Beds model work for the future provision of community beds in SWH underway • TOCH has now gone live and further development taking place **West Essex (WE)** • WECHP are undertaking a review of the community hospitals in West Essex with system partners – report expected July 2025 this has been delayed until September 2025

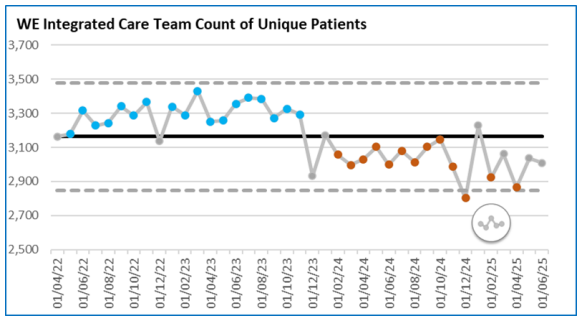
Hertfordshire and West Essex Integrated Care System

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	4524	4522	↓	7.2	7.2	↓	June
SWH	CLCH	All	5966	6018	↑	8.6	8.7	↑	June
WE	EPUT	All	3037	3010	↓	9.0	9.0	↓	June
ICS	**All**	**All**	**13527**	**13550**	↑	**8.1**	**8.2**	↑	**June**

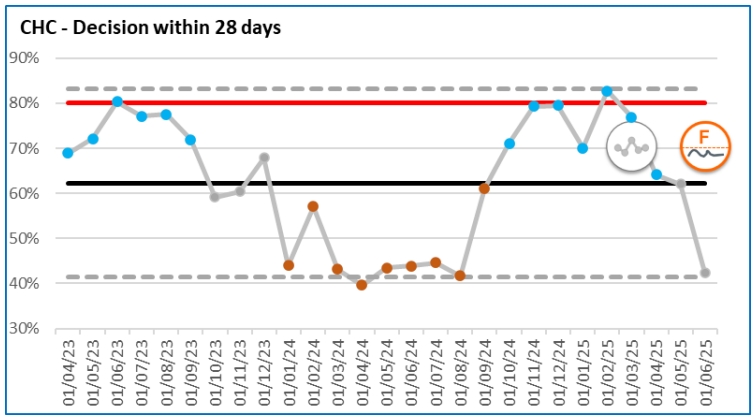
Hertfordshire and West Essex Integrated Care System

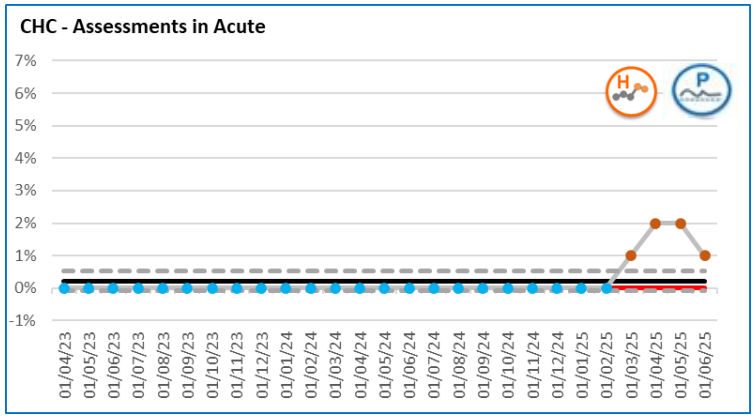
Integrated Care Teams (ICT)

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, all on a variable trend.	**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; continue to monitor month on month **West Essex (WE)** • Slight reduction in contacts from May, 2025 unique contacts per 1000 population stable.	• 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 **South and West Hertfordshire (SWH)** • Work underway to improve vacancy rate for district nursing services • Alignment with INTs already in place, but discussions regarding embedding services further underway at place **West Essex (WE)** • Harlow South PCN – 169 patients consented to proactive care, 153 desktop reviews completed with 64 F2F a further 41 patients identified total will be 194 , expansion to North Harlow PCN in October 2025 • Community Matron and TL away day to progress delivery of the “care closer to home” model

Hertfordshire and West Essex Integrated Care System

Continuing Health Care (CHC)



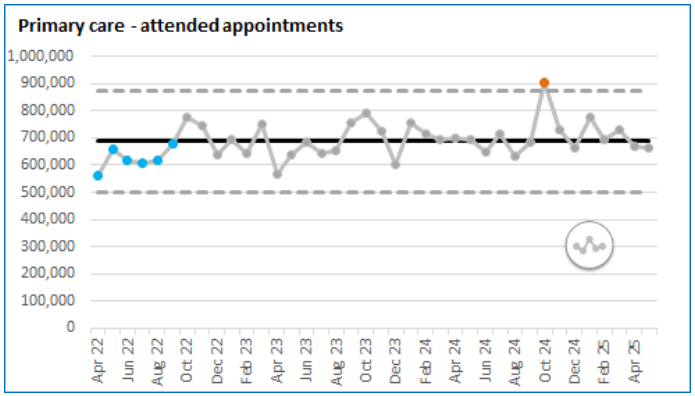


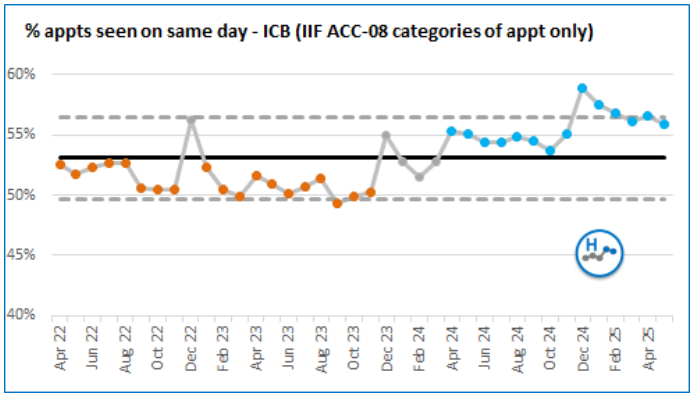
	What the charts tell us	Issues	Actions

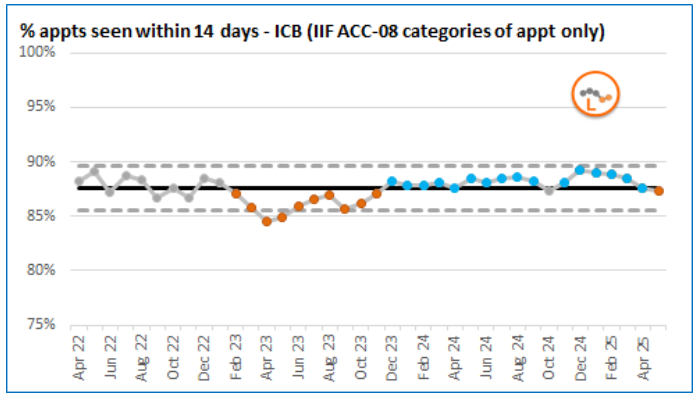
HWEICB	• The 28-day standard declined significantly in June across the ICB, most notably in SWH.
	• As a result, the ICB has not achieved the national target (>=80%) since February and are currently working towards revised quarterly targets agreed with NHSE of Q1 – 50%, Q2 – 65%, Q3 – 75% and Q4 – 80% :
	  ○ Overall ICB – 42.45%
	  ○ West Essex – 60.00%
	  ○ ENH – 54.72%
	  ○ SWH – 24.59%
	• The assessments in an acute setting <15% standard continues to be achieved although there was a 2% increase over the last two months - these cases were by exception
		• Continued staff capacity across all areas is predicted to have a negative impact on the 28-day KPI.
		• Two assessments in acutes were due to be undertaken however, one has since been withdrawn and one is being taken forward due to health needs.
			• Recovery plans are being drafted with locality leads to provide assurance that the 28-day standard is achieved and remains on track going forward
			• Frequent meetings are currently in place across all areas to monitor performance and provide assurance, in addition to assurance meetings held with NHSE.
			• Ongoing training sessions have been implemented to assist both current and new staff to ensure day-to-day operational tasks are carried out both effectively and efficiently

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, there were 4.2% more appointments attended in FY2425 compared to FY2324.
- The % of appointments seen on the same day of booking has been above the long-term mean for the last twelve 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 typically been above the long-term mean over the last 18 months. However, more recently, the % seen within 14 days has decreased for five consecutive months which is worth monitoring going forward. 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)

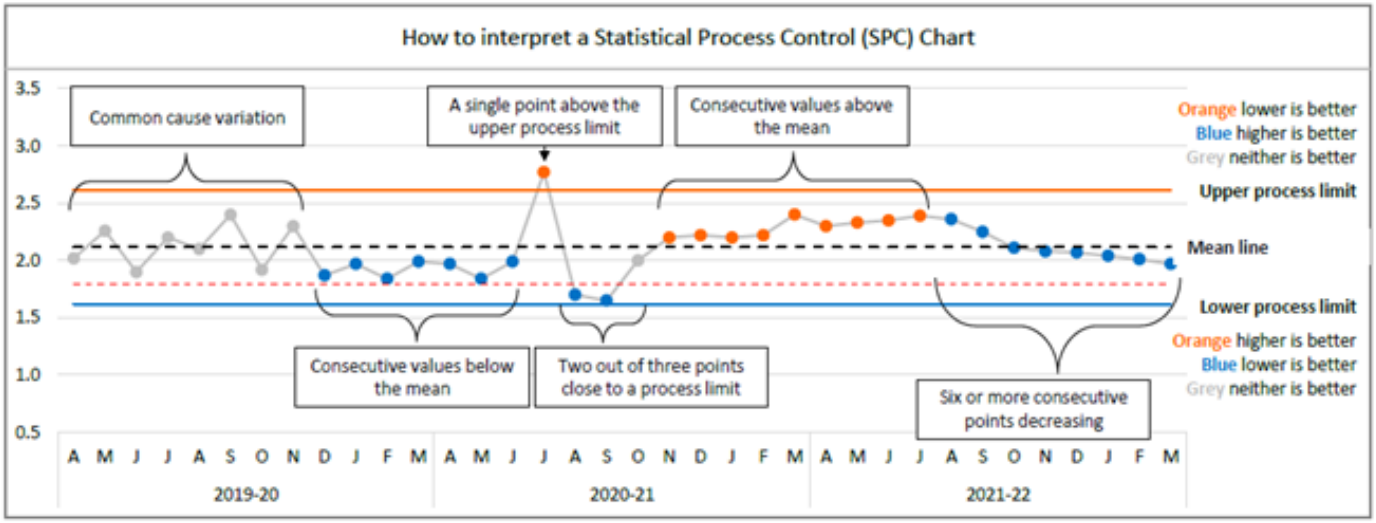
Hertfordshire and West Essex Integrated Care System

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
• Changes to GP contract from October 1st requiring practices to have all access channels open throughout core hours. Note possibility of further industrial action as BMA considers response.
• 25/26 contract changes for Dental and Community Pharmacy
	Engagement with the National Access Recovery Plan
	• Annual GP Patient Survey (GPPS) was published in July 2025. Positive improvement for HWE across GP, Dental and Pharmacy Metrics.
	  • 75% of patients expressed overall satisfaction with their GP practice, compared with 72% last year – in line with the national average of 75%
	  • 91% of patients expressed overall satisfaction with local pharmacy services, compared with 89% last year. This is higher than the national average which is 88%
	  • 77% of patients expressed overall satisfaction with local NHS dental services, compared with 75% last year. This is higher than the national average which is 71%
	• National Monthly Health Insights survey Wave 13 (published Aug25) shows 68% of patients rated their overall experience of general practice as good, the percentage satisfied with NHS dental care received, for those who had an NHS dental appointment in the last 28 days was 86.4%
	• 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 – new scheme for 2025/26 launched with 2/3 of funding set against implementation of Modern General Practice and the final 1/3 on a new indictor looking at risk stratification and continuity of care.
	• 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
	• 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 and further practice identified to take part in the Practice Level Support programme in 2025/26
	• 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 initially negative variation identified in Access and Patient Experience for 21 practices, however this is reduced to 11 in the July data refresh. Further analysis planned through conversation with BI, monthly Access MDT and Risk and information sharing groups. The CATs tool will feed into 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. High level plan discussed at Primary Care Commissioning Committee and submission 30th June. Detailed practice level plans developed which will be reviewed via monthly MDT and though PCCC and the private session of Primary Care Transformation Committee. Feedback on this plan from National/Regional was very positive. Targeted plans for each practice showing negative variation on the CATS tool for access have been developed.
	• Advice and Guidance DES now live and active monitoring of activity in place.
	Other
	• All practices signed up to the Enhanced Commissioning Framework (ECF) for 25/26, active monitoring of new elements.
	• 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. New Workforce Dashboard developed.
	• 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 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

East and North Hertfordshire Teaching NHS Trust

Meeting	Public Trust Board			**Agenda Item**	18
Report title	ENH Health Care Partnership Committee report to Board			**Meeting Date**	17 October 2025
Chair	Adam Sewell-Jones, Chief Executive - East and North Herts NHS Trust				
Author	Reni Tomori, Business Administrator				
Quorate	**Yes**	☒	**No**		☐

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

Urgent and Emergency Care

- Recent performance is showing some downward movement across key UEC indicators. This will continue to be monitored closely with partners.

Diagnostics Capacity

- Diagnostics remain under pressure, particularly MRI, ultrasound, adult audiology and endoscopy. Insourcing is underway, though the impact is not yet visible in performance data.

Paediatric Community Waits

- Paediatric waiting times continue to be challenging. Additional funding has been approved, and improvement actions prioritised.

System Financial Position

- The ICS is currently not on plan and the route to year-end break-even continues to require close oversight. ENH organisations are working actively to mitigate remaining gaps.

Host Provider Delegation Timeline

- Delegation timelines are being adjusted to allow for further work on due diligence and information sharing. Engagement with the ICB remains positive.

Assurances provided to the Board:

Performance

- Performance trends were reviewed and understood.

Finance

- All partners are developing routes to break-even and working actively to close remaining gaps. The disaggregation paper will go through executive approval and will be presented at the ENH HCP Board meeting in December.

Transformation

- Delivery capacity and clarity of risk ownership are being strengthened. A refreshed risk log will be presented at the next meeting.

Host Provider Model

- The proposed adjustment to the delegation timeline has been discussed with the ICB and is supported.

VCFSE / Hospice Sector

- Discussions are ongoing regarding hospice sustainability. The VCFSE Alliance will provide a further update on future arrangements at the next meeting.

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

Neighbourhood Development

- Work continues to strengthen neighbourhood / locality arrangements, including mapping of roles, support functions and leadership links. Engagement activity is underway ahead of proposed sign-off later in the year.

National Programme Positioning

- The partnership was not included in Wave One of the National Health Implementation Programme. Members noted this offers a learning opportunity before participation in Wave Two.

Management Programme Funding Bid

- A coordinated bid focusing on severe mental illness, learning disabilities, children and young people is being developed across the Central East area ahead of the national deadline.

Social Care Data

- The introduction of social care data into the performance report is a positive step.

Care Closer to Home / Vaccination Planning

- A system-wide locality workshop is scheduled to support planning for flu vaccination delivery, with all partners contributing to a consistent neighbourhood approach.

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

Strengthen Risk Ownership and Reporting

- The meeting agreed that each risk should have a clearly identified lead to support more focused discussion and to enable more effective escalation and resolution.

Any actions recommended to improve effectiveness of the meeting:

Clarify Meeting Purpose and Rhythm

- It was noted that further clarity on the purpose and expectations of informal versus formal Partnership Board meetings would support more focused discussion and clearer decision-making.

Provide Clearer Progress Summaries in Future Papers

- Reports that show what has been achieved, what is in progress, and what remains outstanding would enable more efficient Board conversation.

Support Consistent Messaging Across System Partners

- Continuing to reduce terminology differences will help avoid misunderstandings and save meeting time.

Recommendation	The Board is asked to **NOTE** 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**	19
Report title	Audit and Risk Committee report to the Board for meeting held on 7 October 2025			**Meeting Date**	19 November 2025
Chair	Karen McConnell, Audit and Risk Committee Chair				
Author	Deputy Company Secretary				
Quorate	**Yes**	☒	**No**		☐

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

- This is the first year that the Trust has participated in the single tender waiver (STW) benchmarking activity. We have asked for a deep dive due to the comparatively high volume and high value.

Assurances provided to the Board:

- No final reports from the 2025/26 internal audit plan since the Audit Committee meeting in July 2025 were issued.
    - One report in draft has been issued to management on Appraisals (Medical)
    - With five audits in progress (1) Water and Electric – Health and Safety (2) Payroll (3) Key Financial Controls (4) PSIRF (5) Fire – Health and Safety. Fieldwork has commenced on all five audits and results should be reported to Audit Committee in February 2026.

  Internal audit is currently on track to complete the audits planned for this year.

- The External Auditor presented their Audit Plan. They identified four areas to review as part of their VFM work:
    - Financial sustainability in respect of ongoing financial pressures and uncertainties
    - Governance in respect of fixed asset verification particularly the length of time anticipated to address known issues
    - The Front entrance project as a significant capital investment outside of the Trust's usual activities
    - Improving economy, efficiency and effectiveness in respect of the Trust's continuing operation of the Mount Vernon Cancer Centre in the context of further anticipated delays in any transfer of this service to another provider.

- The External Auditor also noted that additional work this year would be undertaken in relation to the full revaluation of land and buildings including potential changes in our approach to Modern Equivalent Asset assessment of the estate.

- The External auditors presented an audit debrief report summarising improved processes which enabled a timely sign off and reporting for the 24/25 audit. The Committee took assurance from this, noting steps to be taken to further improve the accounts and audit processes for 2025/26.

- The Deputy Director of Estates and Facilities presented a report providing an overview of the highest risk categories identified for estates and facilities. The report noted that

although a recent audit carried out by RSM highlighted several areas that required attention, the actions had been identified as part of the critical engineering deep dive process. The risk areas and actions were noted and ARC will maintain oversight of this area.
Advise (Matters the Board should be aware of not covered above e.g. on-going monitoring, new developments etc):
• The Charity audit plan was approved by the Committee. FOI performance remains sub optimal and will be reviewed by TMG
Decisions made by the committee or major actions commissioned and work under way:
• The Corporate Risk Register Escalation policy was approved in principle and will be re-presented to the next Committee meeting for formal ratification. ARC will continue to maintain active oversight. • The adoption of the Modern Equivalent Asset (MEA) methodology as part of the Trust's 2025/26 quinquennial revaluation was endorsed. • The revised Cash and Treasury Management Policy was approved.
Any actions recommended to improve effectiveness of the meeting:
None at this meeting.

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

To be trusted to provide consistently outstanding care and exemplary service

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	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	April 2026	May 2026	June 2026	July 2026	Aug 2026	Sept 2026	Oct 2026	Nov 2026
Standing Items													
Chief Executive's Report	X		X		X		X		X		X		X
Integrated Performance Report	X		X		X		X		X		X		X
Board Assurance Framework	X		X		X				X		X		X
Corporate Risk Register (Part 2)	X				X				X				X
Patient/Staff Story (Part 1 where possible)	X		X		X		X		X		X		X
Employee relations (Part 2)	X		X		X		X		X		X		X
Board Committee Summary Reports													
Audit Committee Report	X		X		X		X		X		X		X
Charity Trustee Committee Report	X		X		X				X		X		X
Finance, Performance and Planning Committee Report	X		X		X		X		X		X		X
Quality and Safety Committee Report	X		X		X		X		X		X		X
People Committee	X		X		X		X		X		X		X
Digital Committee	X		X		X		X		X		X		X
Strategic reports													
Planning guidance			X										
Winter Planning (annual)											x		
Digital update							X						

Board Annual Cycle 2025-26

Items	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	April 2026	May 2026	June 2026	July 2026	Aug 2026	Sept 2026	Oct 2026	Nov 2026
Trust Strategy refresh and annual objectives					X								
Strategy delivery report			X				X						
Strategic transformation & digital update	X						X						X
Integrated Business Plan	X												X
Annual budget/financial plan													
System Working & Provider Collaboration (ICS and HCP) Updates	X		X		X		X		X		X		X
Mount Vernon Cancer Centre Transfer Update (Part 2)	X		X		X		X		X		X		X
Estates and Green Plan													
Workforce Race Equality Standard			X										
Workforce Disability Equality Standard			X										
People Strategy			X										
NHS England capability self-assessment							X						
Enabling Strategies													
Estates and Facilities Strategy			X										X
Green Strategy									X				
Quality& Clinical Strategy					X								
Equality, Diversity and Inclusion Strategy					X								
Digital Strategy							X						
Engagement Strategy											X		
Other Items													
Audit Committee													

Board Annual Cycle 2025-26

Items	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	April 2026	May 2026	June 2026	July 2026	Aug 2026	Sept 2026	Oct 2026	Nov 2026
Review of Trust Standing Orders and Standing Financial Instructions (if required)													
Charity Trustee Committee													
Charity Annual Accounts and Report	X												X
Charity Trust TOR and Annual Committee Review			X										
Finance, Performance and Planning Committee													
FPPC TOR and Annual Report			X										
Quality and Safety Committee													
Maternity Incentive Scheme for sign-off			x										
Complaints, PALS and Patient Experience Annual Report			X										X
Safeguarding and L.D. Annual Report (Adult and Children)	X												X
Staff Survey Results							X						
Learning from Deaths	X		X				X		X				X
Nursing Establishment Review	X												X
Patient Safety and Incident Report (Part 2)	X						X						X
Teaching Status Report													
QSC TOR and Annual Review (if required)													

Board Annual Cycle 2025-26

Items	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	April 2026	May 2026	June 2026	July 2026	Aug 2026	Sept 2026	Oct 2026	Nov 2026
Quality account (delegate sign off to QSC at their June meeting)							X						
People Committee & Culture													
Workforce Plan													
Trust Values refresh							**X**						
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**				