Public Trust Board

Mount Vernon Cancer Centre, Rickmansworth Road, Northwood HA6 2RN

NHS East and North Hertfordshire Teaching NHS Trust

14/01/2026 09:30 - 12:00

PERFORMANCE, ASSURANCE AND GOVERNANCE ITEMS

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For noting			
25.	Date of Next Meeting	Trust Chair	
Wednesday, 11 March 2026 - Online			

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 online on Wednesday, 19 November 2025 at 9.30am

Present:

Ms Anita Day (AAD)	Trust Chair
Mrs Karen McConnell (KMc)	Deputy Trust Chair and Non-Executive Director
Dr David Buckle (DB)	Non-Executive Director
Ms Janet Scotcher (JS)	Non-Executive Director
Ms Gillian Hooper (GH)	Non-Executive Director
Ms Diana Skeete (DS)	Non-Executive Director
Professor Zoe Aslanpour (ZA)	Non-Executive Director
Mr Adam Sewell-Jones (ASJ)	Chief Executive Officer
Ms Theresa Murphy (TM)	Chief Nurse
Ms Penny St Martin (PSM)	Chief People Officer
Mr Martin Armstrong (MA)	Chief Finance Officer and Deputy Chief Executive Officer
Dr Justin Daniels (JD)	Medical Director
Ms Lucy Davies (LD)	Chief Operating Officer
Mr Kevin Howell (KH)	Director of Estates and Facilities
Mr Kevin O'Hart (KOH)	Chief Kaizen Officer
Mr 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

No	Item	Action
	The Chair, AAD 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. It was confirmed that the agenda had been published on the website and seen by all Board members.	
25/120	**DECLARATIONS OF INTEREST** There were no new interests declared.	
25/121	**APOLOGIES FOR ABSENCE** Apologies for absence were received from Mr Richard Oosterom, Associate Non-Executive Director, Nina Janda, Associate Non-Executive Director and Tichafara Phiri, NeXT Non-Executive Director.	
25/122	**STAFF STORY** The Chief People Officer, PSM introduced the staff story, highlighting the inspirational journey of T. She was an internationally educated nurse who joined the Trust during the Covid-19 pandemic. T shared her experience of resilience, from failing her initial OSCE exam to becoming a Practice Development Nurse and supporting over 200 internationally educated nurses. Her story highlighted her experience and wellbeing initiatives by describing her progression to Band 6, her recognition at Buckingham Palace, and her recent	

nomination for the Nursing Times Workforce Award. T was now in a leadership role.

Following T's presentation, board members expressed admiration for her achievements.

The Chair AAD, commended her courage and asked whether her initial OSCE failure had informed her current training approach. T explained that cultural adjustment, workload, and pandemic pressures contributed to her not being successful at her first attempt, but the experience strengthened her ability to support others.

KMc asked whether more could be done to support overseas' recruits. T responded that the Trust already provided excellent support and should continue empowering staff at all levels to help one another.

TM and KOH echoed appreciation for T's role-model behaviour and resilience.

The Chair concluded by thanking T and encouraging her to keep sharing her story and enthusiasm.

Action: Chief People Officer to continue embedding empowerment initiatives and report progress through People and Culture Committee.

The Board **NOTED** the staff story including positive engagement and ongoing challenges.

25/123 MINUTES OF THE PREVIOUS MEETING

The minutes of the previous meeting held on 10 September 2025 was **APPROVED** as an accurate record of the meeting.

25/124 ACTION LOG

The Head of Corporate Governance provided an update on outstanding actions.

- The Renal Services Action Plan had been uploaded to the website.
- Revised terms of reference for the Digital Committee would be presented at the January 2026 Trust Board meeting.
- The Board was advised that Freedom to Speak Up actions were progressing, including alignment with the EDI strategy.

PSM reported that a business case for protected time for Freedom to Speak Up Guardians was being developed and that it would propose one hour per week per guardian.

Board members supported this approach and stressed the importance of psychological safety and engagement.

The Chair, AAD requested that PSM to let the board know the outcome of these discussions in due course as our increased focus on FTSU seemed to be having a significant impact on our progress with staff engagement, but equally the Board

recognised that our current financial constraints were likely to be a factor in the decision.

Action: Business case for protected time to be finalised and outcome brought to the Board.

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

25/125 QUESTIONS FROM THE PUBLIC

There were no public questions.

25/126 CHAIR'S REPORT

The Chair, AAD paid tribute to staff for their commitment during a challenging period, including recent industrial action by resident doctors. She acknowledged the impact on services and thanked all who worked flexibly to maintain patient safety.

The Chair also noted the successful submission of the capability self-assessment to NHS England.

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

25/126a
The Chair commented that the Charity accounts would be presented at the Charity Trustee Committee meeting in December and that the Board needed to delegate approval to the Audit and Risk Committee who would also be meeting in December to sign-off the accounts.

The Audit and Risk Committee Chair, KMc confirmed that the charity audit was progressing smoothly.

Board **AGREED** to delegate **APPROVAL** of the charity accounts to the Audit and Risk Committee.

25/127 CHIEF EXECUTIVE'S REPORT

The Chief Executive, ASJ summarised key updates:

He highlighted that the Trust ranked 19th acute trust nationally, and first in the East of England in NHS performance segmentation.

The Trust was second for cancer performance and received positive coverage from the BBC.

The Chief Executive, ASJ gave an estates update, which included the installation of solar canopy in the staff car park necessitating off-site parking with shuttle service for staff who had volunteered or earmarked to park off-site. It was noted that this was all part of our sustainability programme.

Funding of £2.3m had been received for ambulance handover expansion.

The Chief Executive ASJ stated that confirmation of funding to support developing our Audiology department was received and that this would enable us to create a great environment for paediatric audiology.

It was noted that flu vaccination uptake for staff was over 40%.

Action: The Chief People Officer, PSM and the Medical Director, JD to continue the flu vaccination campaign to all staff.

The Board was reminded of the structural changes in the NHS with Integrated Care Boards (ICBs) merging. It was noted that there was now emphasis on Place based working, and we were the lead for East and North Hertfordshire with primary care involved. The CE commented that we would build stronger partnerships with primary care.

The Strategic planning guidance had been received early, and the Chief Finance Officer and his team were working on it. It was noted that we were moving away from the annual submission to a five-year strategic narrative with a three-year detailed plan behind it.

On digital transformation, the rollout of electronic document management and progress on OneEPR was noted.

Finally, the board was advised that the Trust and individuals in the Trust had been nominated for various national awards.

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

25/128 NURSING & MIDWIFERY SAFER STAFFING ESTABLISHMENT REVIEW

The Chief Nurse, TM presented the safer staffing review confirming compliance with national standards and dynamic daily monitoring. It was noted that the report had gone to the Quality and Safety Committee (QSC).

Seasonal pressures and rising patient acuity were noted, particularly in respiratory and maternity services.

The Board was advised that recruitment of care support workers had improved significantly.

DB commented that safer staffing was an ongoing process with daily meetings which gave a high level of assurance and acknowledged the human impact of redeployments which could have drawbacks. He concluded by reminding the board that safety needed to be maintained.

The Chief Nurse responded that conversations around daily redeployments were managed and that individuals in such positions were supported.

The Chair, AAD asked if establishment numbers had been rising because of the association with acuity and asked if the Chief Nurse agreed with that assertion. In response, the Chief Nurse observed that a higher number of patients now required non-invasive intervention which meant higher levels of acuity. However, more beds were now back in use and thanked the Director of Estates and Facilities and his team for making this possible.

Following the discussion, the Board **NOTED** the Nursing & Midwifery Safer Staffing establishment review.

East and North Hertfordshire Teaching NHS Trust

25/129 LEARNING FROM DEATHS

The Medical Director, JD presented the learning from deaths summary and winter risk outlook. He stated that mortality was lower than expected overall but that there were concerns about flow during the winter months. JD also remarked that communication with families remained a key learning theme.

Following his introduction, KMc commented that it was a helpful paper and that she got a lot of assurance from it. She remarked that we receive a lot of complaints from patients and their families and asked if the new EPR would help. In response JD commented that patients had stated that they want to be involved in discussions around their care but that this is not consistent. We need to get it right every time and involve patients in their care plan. Regarding EPR, JD stated that he was hopeful around what was being implemented.

DB commented that the report was fundamental and important. Regarding NELA, he suggested that theoretically our performance improved but at walk-arounds this was not what was being said. JD responded that there was the need to strike a balance around prioritisation of pathways but that discussions would continue to take place.

DS observed that it was an excellent paper especially for non-clinical people and asked about the health inequalities and deprivation section in the report, and asked how the learning would be shared across all sections in the Trust. JD responded that the number of deaths had not increased in any of the vulnerable groups. On the other hand, healthy life expectancy had increased but there was homelessness which had its drawbacks. There was also an ageing population in the community.

The Chair, AAD commented that we were fortunate in this region that we do not have high numbers of patients experiencing socio-economic deprivation and asked about the medium risk around the Medical Examiner issue. JD responded that we had taken on the medical examiner role for community deaths but that we need to make sure that we have the resources to do this. Discussions were being held to see what more we could do.

Following for the discussion the board endorsed the substantial assurance rating.

Action: Medical Director to review medical examiner resourcing and report back to the board.

The Board **AGREED** to a **SUBSTANTIAL** assurance rating on the learning from death report, with no objections raised.

25/130 BOARD ASSURANCE FRAMEWORK (BAF) - STRATEGIC RISKS

The Head of Corporate Governance presented this item. He reported on the financial risk score increase and system instability.

The Chief Kaizen Officer, KOH spoke to BAF risk 11 – Change management and the Chief Finance Officer, MA updated on BAF risk 1 – Investment and Estates.

KMc suggested that the assurance level may be higher as it was a living document that was reviewed at all committees.

The Board discussed the maturity of risk processes and agreed to raise the assurance level from partial to reasonable.

It was noted that the risk appetite discussion was scheduled for the December seminar.

The Chair thanked the Head of Corporate Governance and the committees.

The Board **AGREED** to a **REASONABLE** assurance rating on the BAF.

25/131 RESIDENT DOCTORS WORKING LIVES ACTION PLAN

The Chief People Officer, PSM presented this item. PSM updated on the progress of the 10-point plan, including improvements in facilities, rota compliance, and mandatory training passporting. It was noted that the baseline score of 62% was expected to rise following recent actions.

GH commented that it was discussed at the People and Culture Committee and asked if the Executive had seen any unintended consequences from other groups.

PSM commented that some improvements were likely to benefit other colleagues TM stated that locally there had not been many pushbacks but nationally some people had asked about nurses. JD mentioned that with resident doctors they tend to move across hospitals within the region and therefore had unique challenges.

The assurance level was confirmed as reasonable.

Following discussion, it was **agreed** that the implementation of the 10-point plan would continue and the People & Culture Committee would have oversight of progress.

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

25/132 INTEGRATED PERFORMANCE REPORT (IPR)

The Chief Nurse, TM presented this item. The NHS oversight framework summary was shared with the board and members commented that the slide was good.

TM went on to summarise the IPR across its four quadrants.

Following the presentation, JS asked about the overspend relating to medical locums. In response, JD commented that rostering was a significant issue, and work was ongoing to resolve some of the issues related to less than full time working.

Action: JS asked if this had been looked through a creative and a more flexible approach and further suggested that it could be discussed outside of the meeting with the Chief People Officer, Medical Director and herself as Chair of People and Culture Committee.

KMc asked about the overall bank and agency spend of 0.5% above target of 8% and asked why the target was 8%. In response PSM commented that we could strive for better but now we were at 8% and that we were looking at bringing in a single rostering function.

Action: During discussion, it was suggested that PSM and JD will meet to address some of the unintended consequences.

The Chair commented that there were lots of positivity in the IPR but raised concern about the relative likelihood of a white applicant being shortlisted and appointed compared to a BAME applicant. In response PSM commented that there were actions being taken and gave the example of the Trust having Inclusion ambassadors. She also commented that we were looking at how recruitment was taking place and having discussions at staff network groups with conversations addressing the various barriers and how these could be eliminated.

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

25/133 QUALITY AND SAFETY COMMITTEE (QSC) REPORT TO THE BOARD

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

The Committee Chair, DB commented that going forward meeting frequency was being increased to 11 meetings a year and all authors were being invited to the meetings for feedback.

25/134 FINANCE PERFORMANCE AND PLANNING COMMITTEE (FPPC) REPORT TO THE BOARD

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

In the absence of the Committee Chair RO, KMC stated that there was a significant planning workload, and financial risks.

She continued that the challenges were clear, and we were still overly reliant on non-recurrent savings despite the Trust having a comprehensive CIP programme.

The Chair, AAD commented that we really have to get everyone to understand that the issue is not only a Finance one but everyone's issue.

25/135 PEOPLE AND CULTURE COMMITTEE (PCC) REPORT TO THE BOARD

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

The Committee Chair, JS commented that the Strategic workforce planning needed to align with transformation and the whistleblowing policy was under review.

25/136 SYSTEM PERFORMANCE REPORT

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

The Chief Executive, ASJ advised the board that he was the Hertfordshire representative on the ICB, and the Trust's major focus is on what happens at place.

25/137 HEALTH CARE PARTNERSHIP (HCP) REPORT TO THE BOARD

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

KMc asked the Chief Executive about pressures on hospices and the Garden House hospice. In response, the Chief Executive commented that the challenges hospices were facing was attracting fundraising campaigns.

In response to another question, it was noted that partners received the minutes of the meetings and this report to board was as a direct consequence of it being a sub-committee of the board.

25/138 AUDIT AND RISK COMMITTEE (ARC) REPORT TO THE BOARD

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

25/139 CHARITY TRUSTEE COMMITTEE (CTC) REPORT TO THE BOARD

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

In the absence of the Committee Chair NJ, DS presented the report and commented that there were delays to the Sunshine Terrace delays due to Grenfell-related regulations.

It was noted that the Estates team were due to finalise Sunshine Terrace plan and report to Charity Trust Committee at their meeting in December.

The Chair noted that it was a complex project.

GH asked about the maintain energy therapy service and what it was. **Action:** DS promised to find out about it and respond to GH.

25/140 ANNUAL CYCLE

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

25/141 ANY OTHER BUSINESS

25/141a

Christmas events: The Chief Executive stated that there was a Christmas carol service on 13 December at St. Mary's Church in Hitchin

There was no other business.

25/142 DATE OF NEXT MEETING

The date of the next meeting is 14 January 2026 at Mount Vernon hospital.

Ms Anita Day
Trust Chair
November 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
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 Completed November 2025 Completed
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.	Chief Information Officer	Completed January 2026

	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
19/11/25	25/122	Staff story	Chief People Officer to continue embedding empowerment initiatives and report progress through People & Culture Committee	This is an ongoing action and can be closed.	Chief People Officer	December 2025 Close
19/11/25	25/127	Flu vaccination for staff	The Chief People Officer, PSM and the Medical Director, JD to continue the flu vaccination campaign to all staff.	Campaigns continue to encourage staff to have vaccinations	Chief People Officer and Medical Director	Completed
19/11/25	25/129	Learning from deaths	Medical Director to review medical examiner resourcing and report back to the board.	We have 1.8 wte medical examiners and 5 officers. in 2024 we had 1342 hospital deaths, 535 people brought in dead to the mortuary and 1957 community deaths making a total of 3834 deaths. We therefore have the right number of medical examiners per death.	Medical Director	January 2026

	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
19/11/25	25/132	Re: overspend on rostering	During discussion, it was suggested that the Chief People Officer, Medical Director will discuss how rostering could be improved	There have been a number of discussions with medical HR and there is now work to ensure that when new, less than full time, resident doctors join the organisation that rostering takes into account both individual and organisational needs.	Chief People Officer and Medical Director	Completed
19/11/25	25/132	Overall bank and agency spend of 0.5% above target of 8%.	CPO and MD meet to discuss/address some of the unintended consequences	As above.	Chief People Officer and Medical Director	Completed

East and North Hertfordshire Teaching NHS Trust

Chief Executive's Report

January 2026

Chief Executive Update

In August 2025, NHS England launched a strategic initiative - the 10-Point Plan - to address core working conditions for resident doctors across England. This plan focuses on improving working conditions for resident doctors, focusing on wellbeing, governance, administration, training, and workload management. The plan aims to create a fair, supportive, and efficient environment by ensuring better annual leave practices, appointing named leads, reducing payroll errors, streamlining mandatory training, and minimising disruption from rotations.

Over the 12-week period, we achieved significant progress under the Improving Doctors' Working Lives Programme, reaching an overall score of 87%, an improvement of 25 percentage points from the baseline survey. Key achievements include improved amenities such as rest facilities, lockers, psychological support, and 24/7 food access; strengthened governance with appointed leads; reduced payroll errors and faster expense reimbursements; and streamlined mandatory training acceptance. Annual leave policy development continues, but induction now covers best practice, and self-rostering is in place. These improvements reflect a clear commitment to enhancing the working lives of resident doctors. I have attached a screenshot which can be found in appendix A.

In November 2025, I attended the Health Service Journal Awards, where the Trust was shortlisted for Trust of the Year. A central theme of our submission was our commitment to fostering a culture where colleagues feel able to speak up. It was wonderful to be joined by Sylvia Gomes, our Freedom to Speak Up Guardian, alongside colleagues Faith Lukwago and Shella Sandoval, who also supported the awards as a judge. I'd like to congratulate colleagues at West Hertfordshire Teaching Hospitals NHS Trust for winning the award. It is a real positive for the population of Hertfordshire that both its acute trusts were shortlisted in this category.

In December NHS England published its second quarterly segmentation and league tables. The Trust has again been placed in segment 2, the highest ranked of all acute trusts across the East of England and 21st among acute trusts nationally.

Planning 2026/2027

Trusts were required to submit their first draft financial and operating plans for next year during December. As part of this process a new Board Assurance template had to be submitted. This can be found in Appendix B. Triangulation with commissioning intentions has not yet taken place and an updated set of statements will be required when a final plan submission is made in February 2026.

People Update

Between 1st January 2025 and 31st December 2025, the Trust received over 650 compliments from patients, families, and colleagues, reflecting the dedication and professionalism of our staff. These compliments highlight the positive impact our teams have on patient care and experience and demonstrate how staff consistently embody the trust's core values of include, respect, and improve in everything they do. Our values describe what matters to us at the Trust, and they are a promise of how we will carry out our work – how we will treat our patients, our staff and our partners.

The Trust has continued to deliver a successful year of VIP Awards, which recognise colleagues demonstrate our core values of *Include, Respect, and Improve*. Since transitioning to a quarterly nomination process in April 2025, the programme has celebrated nine outstanding winners,

alongside numerous nominated colleagues. Winners are selected by the Chair and myself and receive a £250 award, generously sponsored by Walter Cooper through our hospitals' charity. This initiative reflects our ongoing commitment to acknowledging exceptional contributions and reinforcing the values that underpin our culture.

Winter Preparedness Update

As flu cases continue to rise both nationally and locally, the Trust is taking every possible step to protect staff, patients, and visitors. Vaccination remains one of the most effective measures to reduce the risk of serious illness, supported by the appropriate use of personal protective equipment (PPE) to prevent the spread of infection. Evidence from the previous flu season across Hertfordshire and West Essex shows that individuals with underlying conditions such as heart disease, lung disease, liver disease, or diabetes who were not vaccinated were approximately twice as likely to be hospitalised with a serious respiratory illness compared to those who received the flu vaccine. By choosing vaccination, we collectively play a vital role in protecting the most vulnerable and ensuring the resilience of our workforce throughout the winter months.

Digital Update

Paper records across Women's and Children's services are being replaced with digital records following the successful launch of MediViewer within Obstetrics and Gynaecology.
This builds on the October go-live in Paediatrics and represents a key milestone in the Trust's wider digital transformation towards full Electronic Patient Records (EPR). The progress achieved reflects months of close collaboration between Health Records, Digital, Women's and Children's teams, and system partner Mizaic. Chronic Conditions and Ophthalmology services are scheduled to adopt MediViewer in January 2026.

Finally, during last month's leadership forum, we spent time reflecting on the Trust's key highlights and achievements throughout 2025. These achievements demonstrate the collective efforts and commitments of our teams across the organisation. A summary of these highlights has been included in Appendix C.

Adam Sewell-Jones
Chief Executive

Appendix A – CEO Report Jan 26

Improving Doctors Working Lives Programme - The 10 Point Plan

Provider: EAST AND NORTH HERTFORDSHIRE TEACHING NHS TRUST

Amenities	Baseline survey	12-week progress
Access to Lockers	Yes, <50%	Yes, <50%
Rest facilities	Yes	Yes, <50%
Designated on-call parking access	Yes, <50%	Yes, <50%
Access to hot and cold food 24/7	Plan to	Yes
Access to cold food 24/7	Yes	Yes
Inductions specifically designed to meet the needs of Resident Doctors	Yes	Yes
Beds/sleeping pods available free of charge	Yes, <50%	Yes, <50%
Are Resident doctors able to work from home for portfolio and self-directed learning?	Yes	Yes
Access to free psychological support treatment?	Yes	Yes
Positive feedback mechanisms in place to reward and promote staff?	Plan to	Yes
Protected breaks?	Yes, <50%	Yes, >50%
Do you promote the Safe Learning Environment Charter?	Plan to	Yes
Sexual safety/harassment training and awareness?	Plan to	Yes

Appointing senior leads to take action on Resident Doctor issues	Baseline survey	12-week progress
Has your Trust Board appointed a senior named, accountable Resident Doctor Lead?	No	Yes
Has your Trust Board appointed a Resident Doctor Peer Lead?	Yes	Yes
At what levels of your organisation have you reviewed and discussed the following surveys? (None, Executive team, Trust Board, People Committee, Two out of Three, or All)		
GMC Training survey	People Committee	Two of the Three
NETS survey	People Committee	Two of the Three
National Staff Survey		Two of the Three
National Student Survey		Two of the Three

Annual Leave	Baseline survey	12-week progress
Is there a local policy to encourage good annual leave management which references resident doctors?	Plan to	Yes
Good annual leave practice covered at resident doctor induction?	Yes	Yes
Allow resident doctors to carry over annual leave between rotations?	No	Yes (internal rotations)
Do rostering systems for Resident Doctors allow for self/preferential rostering?	No	No

Payroll and Expenses	Baseline survey	12-week progress
Implemented local SLAs and introduced board-level governance for tracking/reporting payroll errors?	Yes	Yes
Changes in payroll errors over the last 12 months?	Decrease in errors	Decrease in errors
Processing of course related expenses?	After course attendance	When course is booked

Mandatory Training & Learning	Baseline survey	12-week progress
Do you accept resident doctors' mandatory training from other sites and follow the People Policy Framework (May 2025)?	Yes, both	Yes, MOU only

Does the Resident Doctor Peer Lead support the findings as set out in this survey?	Fully supports

* 12-week progress survey | 87% | (Improvement of 25pp)

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

Board Assurance Statements

Boards should review the assurance statements and apply the maturity assessment 1-4 which best reflects the level in which the assurance statement has been embedded within the organisation. See Maturity assessment key below.
If boards select a maturity assessment of 2-4, i.e. signalling an activity is not embedded, supporting commentary must be provided. This should include a brief description (cells are limited to 500 characters / approx 80 words) of any exceptions that you want to note. Full details of gaps in assurance will be covered in the final submission.
Board approval must be confirmed and all statements require a response.
Validations have been included which will signal an error if guidance has not been followed correctly. Organisations will be unable to submit their template until these validations are cleared.

Board Approval		Name	Date
Sign Off Required	CEO	Adam Sewell-Jones	15/12/2025
Sign Off Required	Chair	Anita Day	15/12/2025

Maturity Assessment Key	
1. Embedded [Full Assurance]	The action is fully integrated into normal operations. It is standardised, sustainable, and reinforced by policy, leadership, systems, and culture. Continuous improvement is an established norm, and outcomes are consistently positive.
2. Maturing	The action is becoming routine. There are documented processes, growing staff awareness, and increasing consistency across teams. Evaluation and improvement mechanisms may be in place but are not yet fully optimised.
3. Developing	Steps have been taken to introduce and implement this action. There may be informal processes, or isolated examples of good practice, but they lack consistency, coordination, or broad awareness.
4. Not Embedded [No Assurance]	There is little to no evidence that this action has started. If it has, it's ad hoc, inconsistent, or heavily reliant on individuals rather than being supported by systems or structures.

Reference	Category / Area For Assurance	Statement	Response (1-4 see key above)	Commentary (required against a response of 2-4. Provide a brief description of any exceptions you want to note - limited to 500 characters)
1	Foundational activities	The board has reviewed the outputs from the foundational work undertaken as part of phase one of planning. This includes reviewing demand and capacity analysis.	1. Embedded [Full Assurance]	Foundational analyses, including demand and capacity, have been regularly reviewed through Executive, FPPC and Board processes. Work is detailed and iterative, though further triangulation with ICB assumptions are now required follwing the ICB sharing planning allocations late on 12th Dec 2025 which were too late for the December submission.
2	Governance and leadership	The board can confirm strong clinical leadership is involved in the development of plans.	2. Maturing	Strong clinical engagement has underpinned our plan development over recent years. The December plan is based on assumptions using top-down methods with expert testing due to time constraints; these now need full bottom-up validation and triangulation. Further detailed work is planned ahead of February's submission once system assumptions are known.
3	Governance and leadership	The board can confirm processes are in place to take into consideration the assessment of population needs, underserved communities and inequalities when developing plans.	2. Maturing	The Trust has modelled demographic growth across different population groups and has reflected this in its demand forecasts and activity plans. Through the place Health and Care Partnership (HCP), we have considered population needs and identified shared clinical priorities, including frailty, hypertension, diabetes and chronic kidney disease, and are working with partners to reflect service developments in these areas in our plans.
4	Governance and leadership	Robust quality and equality impact assessments (QEIA) are underway or are planned to be undertaken and reviewed by the board to inform development of the organisation's plan.	2. Maturing	QEIA/EIA processes were updated and embedded as part of the 2025/26 planning process and integrated into CIP and transformation proposals. These will not be completed for the December draft but will inform final plans once full detail and system assumptions are available.
5	Governance and leadership	The board is playing an active role in setting direction, reviewing drafts, and constructively challenging assumptions during the plan's development.	1. Embedded [Full Assurance]	The Board is actively engaged in reviewing drafts, testing assumptions and shaping plan development. Governance forums receive regular updates. Full triangulation with system assumptions will be strengthened during January as the ICB provided initial planning assumptions and allocations on 12 Dec 2025.
6	Governance and leadership	The board is confident that there is a data-driven and clinically-led continuous improvement approach in place. The organisation has a systematic approach to building improvement capacity and capability.	3. Developing	The Trust is embedding a production system improvement methodology based on Virginia Mason. The plan draws on detailed modelling and a coherent improvement approach, but the scale of required CIP and transformational change over the coming years demands strengthened improvement capacity. Options to enhance capability are being developed and will be incorporated into the February submission.
7	Governance and leadership	The board confirms that the organisation has established structures to work effectively with commissioners and system partners, ensuring that system working is constructive and efficient.	3. Developing	As Host Provider for the East & North Herts Care Partnership, we have established a strong joint planning infrastructure with partners and are coordinating activity across organisations. However, limited ICB planning information prevents full triangulation, so further alignment work is required ahead of February.
8	Plan development	The board can confirm that the plan is evidence-based, robust and deliverable. The board is content that the phasing of the plan across **two** years is realistic.	3. Developing	Planning is grounded in evidence, guidance and run-rate analysis with scenario modelling. However, deliverability depends on commissioner allocations, which have only been shared on 12 Dece 2025. Assumptions used for December may not align with eventual ICB positons. Internal matching of top-down assumptions and bottom-up delivery refinement continues.
9	Plan development	The board can confirm that plans have been triangulated across finance, workforce and performance, ensuring each element of the plan reinforces the others, making the plan internally consistent.	3. Developing	Internal triangulation across finance, workforce and performance is strong, but alignment with ICB assumptions has not been possible as only received initial allocations and planning assumptions on 12 Dec 2025. Further reconciliation will be required ahead of February.
10	Productivity	The board can guarantee that the organisation is fully considering and reflecting productivity opportunities in plans. This should include those identified in national data packs as well as any local opportunities to improve productivity.	2. Maturing	Productivity opportunities are understood, including national and local areas, but realisation depends on confirming delivery mechanisms and system assumptions. Further work is underway to define achievable trajectories for the final plan.
11	Risk	The board can confirm that the organisation has a robust approach to risk management in place including the ability to demonstrate a comprehensive understanding of financial risk and an agreed approach to managing and mitigating risks in year.	2. Maturing	Key risks are understood and managed, but lack of clarity on the ICB position limited the Trust's ability to confirm the full financial risk profile. Further assessment is now required as discussions on system assumptions are negotiated and refined.
12	NHS standard contract and commissioning	The board can confirm work is underway to ensure contract values used in planning submissions are aligned across (commissioner and provider) activity and financial plans.	4. Not Embedded [No Assurance]	No ICB information was shared in time to inform the December submission, preventing triangulation of activity and value assumptions before finalising the internal plan. Contract values therefore diverge from ICB expectations, requiring resolution in early 2025.
13	NHS standard contract and commissioning	The board can confirm that there is an effective process in place to manage the sign-off of contracts.	2. Maturing	Contract sign-off processes are well established internally, and initial 26/27 contract information and negotiation timetable from Commissioners has now been received but needs to be fully worked through. Further clarity will be required to ensure completion by March 2026.
14	NHS standard contract and commissioning	The board can confirm that there is a timetable in place to ensure that the board will be updated on the sign-off of contracts and any delays to signing contracts will be reviewed by the board.	2. Maturing	A timetable will be put in place and the Board will be updated regularly. Ability to assure delivery is dependent on timely negotiation between the Trust and ICB in relation to planning assumptions and contract information.
15	Workforce	The board can confirm the impact of the 10 Year Health Plan on the workforce is being considered in the development of plans. This includes the impact of productivity gains and how staff are deployed including the three shifts - from hospital to community, from analogue to digital, from sickness to prevention.	3. Developing	A five-year strategic workforce plan is being developed to align with the emerging 10-year view, supporting shifts to prevention, community delivery and digital. Further work is needed to finalise neighbourhood-level assumptions and the workforce implications of this are being worked through with system partners as part of the development of neighbourhood plans.
16	Ambulance trusts only	The board, supported by the lead ambulance commissioner, can confirm that there is alignment of hospital handover trajectories in both ambulance and acute trust plans within their footprint.		Not applicable

Nursing Highlights 2025

East and North Hertfordshire Teaching NHS Trust

Nursing Quality Fundamentals

- Resus team – NT awards
- Dementia nurses- NT awards
- Patient safety team of the year HSJ Short list
- Ward to board oversight of quality and safety- ENHance Quality Management System (safeguarding, FTSU. 20206 plans for Martha's rule, CAE, Mortality)
- Safeguarding innovations – international adoption of digital risk tool
- IPC achievement – 50% reduction of C.diff- ongoing winter plans to sustain

Learning and Improving

- Sustained increase in incident reporting from an average of 1200 to 1600 per month
- Over 900 good care events reported
- Ox star – Human Factor masterclass CPD Accredited course started
- AAR, Debrief and PSIRF training plan
- Patient safety Learning symposium & PSIRF responses
- Improved Risk management systems and processes
- In situ High Fidelity Human factors Simulation Programme (IsSafe)

Patient Centred Care

- Transitioning complex children
- Patient centred discharge passports – adult and SEND
- Improving processes for vulnerable adult
- Safer staffing establishment reviews- all areas
- Strengthened E-roster ground rules- fundamental of care at forefront

Digital Highlights 2025

NHS
East and North Hertfordshire Teaching NHS Trust

• **Digital Records (Mizaic Mediviewer)** successfully launched in Womens and Children across all services to replace paper medical notes with digitised versions – helping to support patient safety, clinical outcomes, and an efficient health records service for the Trust. Rollout across all divisions and services planned and on track to complete by end June 2026.

• **Patient Experience Portal (Patient Hub)** now rolled out across all outpatient services allowing patients to see their appointment details and correspondence via the NHS App – delivered four months ahead of NHS England deadline. Next step is to enhance the integration between our Patient Hub and Lorenzo so that we can switch off the need to print outpatient appointment letters and move to a completely digital first approach.

• **Outpatients Target Operating Model becoming a reality.** Contact Centre performance has improved dramatically with less than 15% of calls being missed (down from 70%). Womens and Children and Lister Cancer have transitioned to the new operating model, with Planned Care going live in December, and Unplanned Care in February. This follows the staff consultation which involved 180 staff members, and sets out to support the Trust in achieving better RTT outcomes, reducing waiting lists, reducing DNA's, and improving patient experience.

• **AI deliveries.** Our AI programme is advancing at pace. Copilot is now live Trust-wide for personal productivity, and enterprise AI capability has been established in Imaging via AI reporting on the DeepC platform. This foundation will allow us to extend AI support to additional clinical specialties over the coming months.

• **Alertive.** A smartphone solution designed to replace traditional bleeps, has been implemented to manage all messaging workflows, including time-critical crash calls.

• **Infrastructure**. We have replaced a 30-year-old telephony system with a modern cloud-based solution. We have also begun the rollout of Windows 11 across the Trust with 2,000 PCs already upgraded and the remaining devices scheduled for completion next year improving reliability and security

People Team Highlights 2025

NHS
East and North Hertfordshire Teaching NHS Trust

- **Enquire** (our people team virtual assistant) has had over 45,000 self service questions this year with a recognition rate of 96%
- **10 Point Plan –** We are the leaders on the region for the new resident doctors 10 point plan
- **Temporary Staffing** - Improvement in reducing our temp staffing reliance (7.9%) – more than half from a year ago
- Achievement in meeting vacancy rate target (under 8%)
- Resourcing team were flagship workstream for **East and North Herts Production System**
- **Employee Turnover** - Improvement in turnover to 8.3%
- Recognised in both **HPMA and Nursing Times awards** categories in 2025
- Awarded as pilot site for new **national ESR system replacement project**
- Workforce submission against FTE plan remains on target for submitted numbers to NHSE
- 95% of AfC staff are on Healthroster
- SLA agreed with HCT to provide Library Services across their organisation.

Kaizen Promotion Office Highlights 2025

NHS
East and North Hertfordshire Teaching
NHS Trust

• **The new Kaizen Promotion Office** was established in 2024 and over the last 12 months all staff have successfully completed their Advanced Process Improvement Training (APIT) . It is delivered by the Virginia Mason Institute and is designed to build deep, practical understanding of the management system that sits behind the ENHPS tools and concepts. This has provided the foundational learning that turns improvement from an activity into a management system. Over the next 12 months with further coaching and certification the KPO will become fully independent and have the internal capability and capacity to deliver all our own training programmes and kaizen events in the future.

• **East and North Herts Production System** introductory training – ENHPS for All – has now been delivered to over 1470 staff or 21% of the workforce with the ambition to reach over 30% early next year. Wide coverage of ENHPS is critical to managing change because it creates a shared foundation for how the organisation thinks, talks and acts. In addition another 55 senior leaders have started their ENHPS for Leaders programme , building on the 35 senior leaders who joined the initial cohorts in 2024. This training builds the capability leaders need to establish the foundations of daily management so Trust strategy is translated into safe, everyday, reliable practice. In addition to the new ENHPS Skills Builder offer, various new modular programmes will be launched in the next 12 months to support the ENHPS change journey.

• **Kaizen activity** has accelerated in recent months with a range of kaizen events, value stream launches, rapid process improvement workshops and a Place-based 3P event all occurring over the last 6 months. This activity is not simply about the improvements they deliver; they play a key role in building organisational capability, belief, and momentum within a management system. They create visible proof to staff improvement is possible, they offer powerful leaning opportunities, they model the desired behaviours the organisation wants to demonstrate, and they create cultural shift. We hold the ambition to run at least one major kaizen event (RPIW or 3P) every month next year.

Cancer Services Highlights 2025

NHS
East and North Hertfordshire Teaching NHS Trust

- **Top ranking annual cancer performance;** The Trust was one of three hospitals nationally who delivered all three cancer operational standards (62day 85.1% against an 85% target; 31day subsequent treatment 96.4% against a 96% target; FDS 77.2% against a 75% target).

- **First Trust in the UK and Europe to deliver subcutaneous Nivolumab immunotherapy;** The SACT team continues to lead innovation in cancer treatment delivery. By introducing subcutaneous Nivolumab immunotherapy, patients benefit from shorter appointments and less time spent in the hospital, while also increasing capacity for additional treatments. This advancement also opens the door for patients to potentially administer their immunotherapy at home.

- **SABR transition to a Linac platform;** the strategic decision to decommission Cyberknife as part of the linac replacement programme has provided increase capacity across the radiotherapy department for both SABR and the increasing number of fractions being delivered. This transition to linac based SABR has also seen a reduction in treatment time and increased access to patients in terms of technical delivery.

- **Development of in-house extravasation and arm port insertion pathways for SACT patients at MVCC;** The new approach to the in-house management of SACT extravasations has strengthened patient safety, reduced treatment delays and delivered cost savings. Similarly, the introduction of an in-house arm-port insertion service offers a cost saving alternative to radiology inserted chest ports.

Medical Director Highlights 2025

NHS
East and North Hertfordshire Teaching NHS Trust

- **Smoking policy** – agreed policy, smoking shelter removed, ongoing work to support colleagues and staff who smoke
- **Health equity group founded** – As part of our work to address health inequalities, a new smoke free site policy was introduced in April, when the smoking shelter by the Trust management offices was taken down. A "swop to stop" initiative was run during Stoptober. Next steps include recruiting ward and department-based smoke free champions.
- **Transfer of pathology to HSL** – MD as ICB wide SRO
- **Agreement from GMC for UH to open Medical School** – MD as member of UH board
- **Alertive** – clinical SRO for successful role out
- **UCL visit** – University College London visit – identifies ENHTT as 'best DGH' Medical School works with
- **Job Planning Project –** The job planning project has made progress throughout 2025, with meetings held with 68% of specialties and 54% now having a team activity plan template in place at varying stages of alignment with demand. Overall, 79.96% of high-quality job plans are now signed off as of November 2025, an increase of 6% since May 2025, reflecting substantial improvement and engagement in the job planning process. The job planning project has identified and begun to realise substantial financial opportunities through more accurate, consistent, and demand-aligned use of PAs. Key areas of impact include the revision of on-call PAs and availability supplements, where reviews have already delivered savings in excess of £200,000—alongside identifying and assisting with the implementation of strengthened leave management and comprehensive rota reviews that support efficiencies around clinical capacity. Further opportunities have arisen from reducing reliance on Waiting List Initiative (WLI) spend, equitably aligning administrative PAs and Supporting Professional Activity (SPA) and ensuring that External Duties and Additional NHS Responsibilities are appropriately aligned to Trust tariffs.
- **Martha's Rule –** This year has seen significant developments, with CCOT now active across all clinical in-patient areas, including paediatrics, with NICU being included from the new year. We have received 115 calls since January and are seeing a month on month increase in calls as awareness continues to be raised. Five patients have been admitted to Critical Care following calls from relatives about them under Martha's Rule preceding their admission. Our newest development has been the virtual daily review of patients with learning disabilities, ensuring that the softer signs of deterioration are being identified and acted on, these sometimes lead to " in person" reviews and have resulted in escalations to higher levels of care.

Finance Highlights 2025

East and North Hertfordshire Teaching NHS Trust

- **Payroll: Transformation, Digitalisation and Compliance Excellence –** Throughout 2025, the team delivered several significant improvements to payroll and compliance processes. We successfully transitioned Trust payroll to Benefits in Kind (BIK), fully removing reliance on paper P11Ds and modernising reporting processes. Alongside this, the team delivered Auto Enrolment activity accurately and on schedule, ensuring continued compliance. We also digitalised a number of payroll forms, improving consistency of documentation, reducing manual handling, and enabling smoother, more efficient processing across payroll and pensions functions.
- **Management Accounts –** Continued development of staff and trainees which has resulted in several internal promotions. Promotion of NHS finance careers through introducing a group week experience week and attending two county wide career fairs
- **Financial Accounts –** Implemented the No PO, No Pay policy, driving sustained improvements in purchase order compliance. The Trust increased PO usage from 82.35% in March 2025 to 85.67% in November 2025, exceeding the peer average of 81.53%.
- **Commercial Investment –** During 2025, the finance and estates teams led on the high-impact and commercially complex New Main Entrance project. In 2026, this project will deliver a new modern main entrance for the Trust at Lister Hospital, introduce high street brands into our new front door, as well as two new floors of office accommodation.
- **Clinical Coding –** 100% coding by flex dates despite a reduction in 3 wte staff
- **Payroll: Sustained High-Quality Delivery Amid Staffing Challenges –** The team consistently delivered payroll on time and accurately, without compromising quality or compliance. During this period, multiple payrolls were restructured and realigned, yet service standards were fully maintained. This was achieved through exceptional teamwork, flexibility, and a strong collective commitment to delivery.
- **Financial Planning -** Income team managing to pull together a coherent Indicative Activity Plan for 25-26 despite the moving goalposts.

Communications and Engagement Highlights 2025

NHS
East and North Hertfordshire Teaching NHS Trust

•**Public engagement in Trust Board** 1,800 views of our public Trust Board meetings this year on YouTube, and 294 viewed our Trust Annual General Meeting online.

•**Staff and ViP awards** Delivered staff awards event for 350 staff – from start to finish including nominations, judging, delegate management, logistics and marketing. With thanks to the charity team for sourcing the generous sponsorship. Relaunched Values into Practice ViP Awards in April, with increased staff nominations and generous sponsorship from Walter Cooper.

•**Teaching Trust status** Achieved Teaching Trust status in April 2025, through showcasing our excellence in education and university partnerships.

•**GP liaison** Answered over 1,700 GP queries in the last 12 months and increased the use of Consultant Connect by 78% increase in total calls, and 650% rise in use for Same Day Emergency Care queries.

•**Clinical Photography** Our department of clinical photography and illustration photographed 1,560 patients, taking 18,200 clinical photographs, and 2,450 non clinical photographs. Additionally, they processed 17,900 photos taken via the clinical app, of almost 7,000 patients.

•**Media engagement** Continued monthly clinical column with The Comet, providing trusted health advice. Hosted BBC national team on cancer targets including surgery access, patient and staff interviews across broadcast, online and social media.

•**Social media engagement** Increased social media engagement – ensuring audience attention when we need it most for service updates and emergencies: Reactions increased by 58% (18,000); clicks by 119% (235,000) and comments by 72% (1,724)

Estates & Facilities Highlights 2025

NHS
East and North Hertfordshire Teaching NHS Trust

- **Catering –** The Catering Service were awarded 5* by Environmental Health Food Standards Agency. The restaurant has a new “Around the World” Menu, incorporating demographics of staff and patients with home cooked foods. The service has built a menu and information booklet for younger patients, bringing back favorite foods and giving allowance to parents and carer meals. The department has introduced finger foods for dementia and elderly patients and an alternative menu for dysphagia and cultural meals

- **Transport** – Increase in EVs within the service making up 30% of fleet with further increase in 2026. Fuel/mileage decrease from 2024

- **Cleaning** – Reduction in consumable waste. Trained >400 nursing staff on cleaning responsibilities and have surpassed last years audit figures

- **Portering** – Working with clinical teams and adding zones has increased patient flow within our UEC service. Overall, the portering teams have had a reduction in average response times per task, driving productivity for our patient's pathway

- **Origin Housing –** Remedial works to accommodation and offices to complete February 2026, with discussions on long term development

- **New Main Entrance -** Commercially funded project to improve facilities for users. Build commenced and due to open Autumn 2026

- **Medical Gas** – Filters have been changed, and we are adding to a new oxygen manifold to site which will result in more oxygen resilience

- **Level 3 Entrance Upgrades –** Ceiling and lighting upgrades, along with new hygiene boards and redecorating

- **Green plan** – Trust has secured funding for Solar Panels, LED Lighting, BMS and additional electrical and heating metering. £2.1m in NEEF funding awarded to deliver solar car port

- **Reduction of Carbon Emissions** – Meaningful progress made with the reduction of energy consumption, saving 163 tCO2e. Water consumption has also dropped 44%, contributing to an estimated 20 tCO2e reduction.

Board

East and North Hertfordshire Teaching NHS Trust

Meeting	Public Trust Board		**Agenda Item**	9	
Report title	Estates and Facilities Strategy Update		**Meeting Date**	14 January 2026	
Author	Director of Estates and Facilities and Infrastructure Development Programme Manager				
Responsible Director	Director of Estates and Facilities				
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:

N/A

Summary of key issues:

The paper is to provide an information update on the Estates and Facilities Strategy – highlighting the "Left Shift" principles and how the Quality and Estates Strategies need to work together, not in isolation. There is also an Estates and Facilities progress to date update.

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**	☒

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*

Risks linked to Estates and Facilities.

Report previously considered at & date(s):

Recommendation	The Board is asked to review for information and discussion only.

To be trusted to provide consistently outstanding care and exemplary service

January 2026

East and North Hertfordshire Teaching NHS Trust

Estates and Facilities Strategy

Public Board 14 January 2026

Kevin Howell, Director of Estates and Facilities V5

1. Estates and Facilities Strategy and Quality Strategy – “Left Shift” and integration with the NHS 10-year plan

- “Left Shift” and why it matters for the NHS Estate:

(Reference “Left Shift and the Future NHS Estate: Why the next decade will redefine how and where care is delivered” by Marc Wilson, 2025)

“Left Shift” refers to transforming the NHS from a reactive, hospital-focused system toward one that prevents illness and delivers care earlier, closer to home and in the community and supports the NHS Long Term Plan.

There is an emphasis on prevention, early intervention, proactive support and integrated care.

Left shift cannot success without a fundamental change in how NHS property and facilities are planned and used. The built environment must support the delivery of community-based, digitally enabled and flexible services.

Key considerations:

- Estate is a strategic asset, not a passive backdrop – physical buildings must shape care delivery, not just respond to it.
- Integrated estates and clinical planning – estates teams should be involved at the earliest stages of service design
- Without the right estate strategy, Left Shift ambitions risk being unimplementable at scale.

In summary, Left Shift is not just a clinical or organisational idea, it is an estate transformation challenge.

To succeed, the NHS must reimagine its buildings and spaces so that care is delivered proactively, closer to where people live and supported by digital and community-centred infrastructure.

This requires integrated planning between the quality strategy and the estates strategy together, not in isolation.

An estates strategy is a dynamic and evolving document which must adapt and survive external changes, which sometimes happen with surprising speed and finality. The estates strategy, shared with the board previously, we believe encompasses the ethos of “left shift” within the principles of “clinical space for clinical need”, led by our clinical/nursing teams and shaped by our users and partnership organisations

2. Our Estates and Facilities Strategy

"Clinical Space for Clinical Need"

Sustainable	Fit for purpose	A positive environment
• We are able to expand to meet demand • We have flexibility to embrace technology • We work towards as being as green as possible	• Our building are kept up to date and we address issues quickly • Were proactive and ready to respond • Better use of all of our estate	• Patients feel supported and their needs are met by the space around them • Staff have the right environment to support them to do a great job.

Examples of work undertaken (led or in collaborative partnership)

1. Management of the Estate

Space Utilisation Review

- Space Utilisation assessments underway to utilise the estate better and make efficiencies were possible.
- Desk booking pilot system implemented on one site to maximise use and value for money

Commercial Contracts, PFI and leased Estates

- Active contract and performance management continues across all commercial contracts and leased estates.
- The commercial team has implemented a new digital contract management system, providing greater transparency, compliance tracking, and lifecycle monitoring across all service contracts. This is improving assurance, supplier performance management, and audit readiness in line with the Trust's strategy.
- The team has introduced a contracts management governance framework, which will include process standardisation, risk and tiering, a contract playbook, and alignment with the new Procurement Act 2023 to strengthen governance, compliance, and commercial assurance across the Estates and Facilities contracts portfolio.
- Full property terrier scoping started October 2025.
- PFI expiry and transition programme for HCH to ensure a safe, compliant, financially sustainable handover in 2033

2. Improving the Estate

Origin Housing

- Refurbishment works complete to the Old School of Nursing building and due to complete for the remainder of site by early 2026.
- Developing the next stages of Origin Housing re-generation plans

New Main Entrance Build

- Project funded by commercial partnership
- Improving facilities for staff, patients and visitors

Renal

- New Renal Modular Unit complete. Patients are being cared for in the unit, accessing care directly or via Strathmore Day Hospital entrance. Works to modernise Level 3 Renal Outpatient Facility have begun, completing in January 2026.

Renal HD

- The design has undergone further review by the clinical team and the authorising engineers for Fire and Ventilation.

UEC

- The Modular stage 4 is complete. Works have commenced on site and is on programme and within allocated budget.

Green Plan

- Since the baseline year of 2019/20, the trust has made meaningful progress in reducing environmental impact across key estates and energy areas. Energy consumption has fallen by 565,000 kWh, of which saving 163 tCO2 e. Water consumption has also dropped 44% since the 2022/23 baseline, contributing to an estimated 20 tCO2 e reduction.

- The Trust has secured the following funding to support:

  » Installation of solar PV panels on the Treatment Centre, maternity, and endoscopy buildings at Lister Hospital.

  » LED lighting upgrades, bringing our LED coverage at Lister to 90%.

  » Building management system (BMS) improvements, and heat meter installations at Lister Hospital.

  » Additional electrical and heat metering.

• Additional NEEF funding has been awarded to deliver a 726 kWp solar carport array at the Lister site, further supporting the trust's long-term decarbonisation goals. Commencement date 17th November, with expected completion date 31st March.

• Funding has been secured through the National Lottery for a two-year Nature Recovery Ranger post (0.8 WTE), based at MVCC. The new ranger started in June 2025 and will be focused on projects to develop and further enhance green spaces primarily at the cancer centre as well as offering support and guidance for similar projects at our other sites.

• The Lister has formally become a smoke-free hospital site, and the removal of the former smoking shelter has created an opportunity to develop a new, accessible landscaped garden.

3. Facilities

Catering

- Introduction of a new food management system, installing a systematic approach to controlling hazards and ensuring the safety and quality of food throughout the supply chain, from production to consumption. In addition, new compliance records implemented to ensure all food safety and hygiene standards are consistently met.
- Regular compliance monitoring and internal audits to maintain high standards and identify areas for continuous improvement.
- Understanding patient needs and demographics have resulted in developing new menus, enhancing nutritional quality, patient satisfaction, and dietary choice.
- There has been a strong focus on food safety training for staff training to reinforce best practices and accountability, however further focus is required at ward level to ensure we meet our legal obligations and maintain patient safety.
- The Trust has achieved five star rating for food hygiene.

Domestic services

- Domestic services are meeting national standards performance targets. Work is in place to further enhance and strengthen service quality within the hospital environment. Collaborative work with the domestic contractor is ongoing to drive improvements in service delivery. Additionally, the importance of clinical support and targeted clinical staff training on cleaning elements have been highlighted and has been implemented.

Portering/Nonclinical Transport/Linen

- A review of services was conducted to realign operations, improve performance. Following this work is underway to enhance efficiency, increase oversight to improve patient pathways.
- Key priorities include across all services –
    - Service realignment. Optimising scheduling, workflow, and resource use to improve responsiveness and reliability.
    - Leadership development. Reinforcing the skills of supervisors/team leaders to provide consistent staff support and operational oversight.
    - Training and development. Expanding training programmes to continuously improve staff capability, engagement and retention.

4. Governance Arrangements

- Review Strategy on a quarterly basis with a formal agenda item on the Estates and Facilities Divisional Board.
- Update the Strategy yearly as developments emerge.
- Current review of Estates and Facilities Structure is in line with the emerging Estates and Facilities Strategy

5. Next Steps for Estates and Facilities

- Clear principles agreed to drive our approach to development
- Ongoing collaborative stakeholder engagement – develop joint clinical and estate masterplans (to create investment cases aligned with Left Shift outcomes)
- Partnership with community, local providers, universities and council.
- Priorities for capital allocation based on critical infrastructure risk and recommendations from Critical Infrastructure Group to Board.
- Continue development of processes, document management and systems to improve efficiency and planning and reduce risk

Board

East and North Hertfordshire Teaching NHS Trust

Meeting	Public Trust Board		**Agenda Item**	10	
Report title	Summary Learning from Deaths		**Meeting Date**	14 January 2026	
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 instances 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 Q&SC. That report outlines key results of this work, including the regular monitoring of mortality rates, together with outputs from our Q2 learning from deaths work. It also incorporates information and data mandated under the National Learning from Deaths Programme.

Prior to submission of the summary report to the board, the full report was approved by the Mortality Surveillance Committee and the Quality and Safety Committee, which agreed it appropriately highlighted 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 – heart valve disorders (a diagnosis group with very small numbers). Review and monitoring of this has been subsumed into the ongoing Cardiology/Coding collaborative improvement work.
- Our neonatal service has given an early indication that extended perinatal mortality for 2025 may be above the national average when reported by MBRRACE in 2027. An in-depth review, including external peer review, has been completed to ensure robust learning and governance.

- 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 financial constraints, may represent a significant challenge to the service.
- Learning from SJRs continues to be promoted by asking all clinical governance leads to ensure they are discussed at specialty Mortality and Morbidity meetings.
- To date two Q2 deaths receiving an SJR have been judged by the reviewer to have been more likely than not due to a problem in healthcare.
- To date four Q2 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): as case ascertainment has remained a challenge, the lead is working with the Head of Coding and BI team to produce a script to identify these. Latest reported risk adjusted mortality stands at 3.5%.
- Cardiology basket alerts: while the elements originally alerting have settled, other elements have subsequently alerted. Collaborative work between Coding and Cardiology remains ongoing to understand the dynamics underpinning these alerts.
- The Cardiology service has raised concerns regarding delays to TAVI CT which are being caused by current capacity issues in radiology.

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 5 of the report.

Report previously considered at & date(s):

Mortality Surveillance Committee: 10 December 2025: Full report presented
Quality and Safety Committee: 16 December 2025: Full report presented.

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 detailed on the front cover of this report. Additionally, a set of mortality focussed objectives has 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 Q2 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 December 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, an element of risk has remained, as to date, Aqua has not conducted a pen test. Our Chief Information Officer approved our use of the tool, but with it being logged as a tolerated risk on the Risk Register.	Ref: 3398
Extended neonatal mortality Our neonatal service has given an early indication that extended perinatal mortality for 2025 may be above the national average when reported by MBRRACE in 2027. An in-depth review, including external peer review is underway to ensure robust learning and governance. While initial review detail has not given rise to concern, emerging outputs will be closely monitored and reported on.	
Medical Examiner Service: Funding/capacity Changes to the way the service is funded from 2025-26, combined with the current financial constraints at the Trust, have the potential to jeopardise the efficiency and effectiveness of the service. This would be to the detriment of bereaved families; the wellbeing of staff working within the service; our performance against mandated standards; and the Trust's reputation, especially with the Coroner Service. Additionally, it would put pressure on the mortuary.	
Cardiology: recurrent SHMI alerts to various elements of the cardiology basket of diagnosis groups Following recurrent mortality alerts across the cardiology diagnosis basket, and a report by the Cardiology Clinical Director, a joint initiative between Cardiology and Coding was implemented and remains ongoing. Following significant work, none of the original alerting diagnosis groups are currently outliers. However, as these alerts have settled others have arisen. Preliminary coding and clinical reviews have shown similar challenges regarding accurate allocation of deaths across the various diagnosis groups. At September Mortality Surveillance it was agreed the collaborative work should continue with a further update in 12 months' time. The service has raised a concern regarding current delays to TAVI CT caused by capacity issues in radiology.	
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. The subsequently commissioned external peer review 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.	

	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 Sep 2025 compared to 0.97% for the latest 3 years.
HSMR: (data period Aug24 – Jul25)	HSMR for the 12-month period is **89.71, *'Mid-range'*.**
SHMI: (data period Jun24 – May25)	SHMI for the 12-month period is **91.44, 'as expected' band 2.**
HSMR – Peer comparison	ENHT ranked 4th (of 10) within the Model Hospital list* of peers.

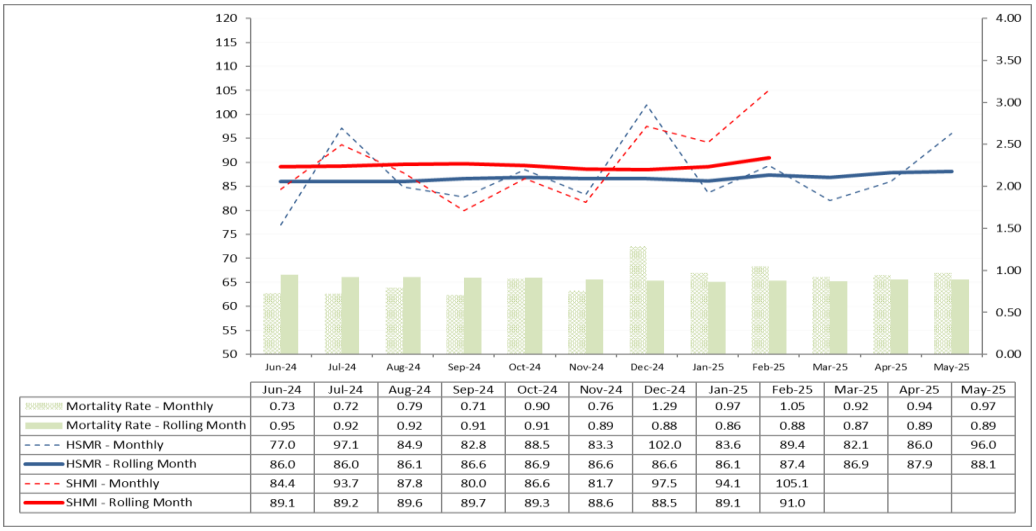
* We are comparing our performance against the recommended peer group indicated for ENHT in the Model Hospital (updated in November 2022).

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 has shown a gradual increase over the last 6 months.

We are aware that the most recent in-month HSMR may be adversely affected as the HES data used is sometimes incomplete. The apparent increase in the most recent in-month HSMR is being monitored, with a preliminary coding review of certain elements being undertaken.

Rolling 12-month SHMI reported by CHKS stands at **91.44** to May 2025.This represents an increase from the last reported **90.95** for the12 months to February 2025.

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

2.2.1 CQC CUSUM alerts
There have been no CQC alerts in Q2.

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 July 2025.

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

Table 3: SHMI Outlier Alerts May 2024 to April 2025

	SHMI	Observed Deaths	Expected Deaths	"Excess" Deaths*	Included Spells
54 - 96: Heart valve disorders	313.65	8	3	5	55

* 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.

Following a preliminary coding review of the heart valve disorder deaths a clinical review was undertaken as part of the ongoing cardiology coding/clinician collaborative work. This revealed that a significant percentage of this small group of patients would have been more appropriately coded either as AMI or HF. Monitoring of the coding and subsequent impact on HSMR will be included in the group's ongoing work.

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).

We are now routinely monitoring this indicator. To date this has shown 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.

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 locale.

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 Q2 2025-26.

Table 4: Q2 2025-26: Learning from deaths data

	Jul	Aug	Sep
Total in-hospital deaths (ED & inpatient)	109	96	92
SJRs completed on in-month deaths (at 22.10.25)	39	29	24
Patient safety incident escalation from SJR (by month of death) (at 22.10.25)	8	6	6
SJR outcome: Deaths more likely than not due to problem in care (≥50%) (at 22.10.25)	1	0	1
Learning disability deaths	1	0	0
Mental illness deaths	2	1	2
Stillbirths	0	1	0
Child deaths (including neonates/CED*) **	0	0	0
Maternity deaths	0	0	0
PSIIs reported regarding deceased patient	1	1	1
PSIIs approved regarding deceased patient***	0	0	5
Complaints received in month regarding deceased patient	1	3	3
Requests received in month for a Report to the Coroner	7	13	4
Inquests attended	2	2	5
Regulation 28 (Prevention of Future Deaths)	0	0	0

Notes:

**Medical termination of pregnancies where the baby is born with signs of life are not included in these figures. Pre-term non-viable births early neonatal deaths (born at ≤ 22 weeks) are also not included. Early neonatal deaths born after 22 weeks are included*

***The number of child/neonatal deaths reported in the table above relate to deaths which occurred in-hospital, which aligns with the 2017 Learning from Deaths guidance*

****The reports approved do not necessarily relate to the incidents reported*

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 5: Medical Examiner scrutiny data: Q2 2025-26

Scrutiny detail	Jul	Aug	Sep	Q2 Total
Total in-hospital deaths (excluding MVCC)*	111	95	94	300
ENHT deaths scrutinised by ME	111	95	94	300
MCCDs not completed within 3 calendar days of death	15	7	5	27
ME referrals to Coroner	15	15	20	50
Deaths where significant concern re quality of care raised by bereaved families/carers	3	3	0	6
Patient safety incidents notified by ME office following scrutiny	1	2	2	5
ME referrals for SJR	24	14	11	49
Community deaths reviewed	181	207	182	570
Deaths referred by the Coroner to ME office to review	21	19	25	65
Total deaths reviewed				935

Notes:

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

3.2 Structured Judgement Reviews

3.2.1 SJR and deaths YTD headline data

Table 6: Headline 2025-26 Year-to-date SJR and deaths data

Data count	Apr	May	Jun	Jul	Aug	Sep	Q1/2 Total
Total in-patient deaths	109	116	96	106	88	84	599
Total ED deaths	8	6	8	3	8	8	41
SJRs completed on in-month deaths (at 22.10.2025)	29	29	35	39	29	24	185

The above table shows that by 22 October 2025, 31% of 2025-26 hospital deaths have received a formal structured judgement review against an internal target of 25%.

3.2.2 Learning beyond SJR

3.2.2.1 SJR patient safety incident escalations

Table 7: Year to end of Q2 Patient Safety Incidents reported following SJR

Escalations for deaths in month (at 22.10.25)	Apr	May	Jun	Jul	Aug	Sep	Total
SJR Patient Safety Incident Escalations	10	5	6	8	6	6	41

For deaths in the current year which have been subject to an SJR, 41 cases have been escalated as a patient safety incident.

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 Q2 no cases matching these criteria were concluded/discussed at Mortality Surveillance.

3.2.3. Learning and themes from concluded mortality reviews
A quarterly 'Food for Thought' presentation is 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 QISS documentation packs.

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.

4.0 Improvement activity

Table 8: 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. The subsequently commissioned external peer review identified a lack of integrated care at MVCC. Following completion of the review of patient care, a formal SI report was 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 and remains 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	The latest published SSNAP report covered the period April-June 2025. While the Trust's rating has stayed at an E rating, there were improvements across 3 domains and our overall score improved from 33.2 to 38 (only 3 points away from a D rating). This demonstrates an overall trajectory of improvement. As previously stated, the rating drop had been anticipated by the team in light of the changes introduced to the dataset. A 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. There is a multidisciplinary team which continues to work on all aspects of performance which is reflected in the service's overall action plan and is discussed at their regular performance meetings. Recent improvements include: • In the latest quarter there was a sustained improvement in the 4 hours to stroke unit domain demonstrated with 42% achieved in August • Thrombolysis has also improved in this quarter with a score of 15.1% and was above the bespoke Trust target of 14%
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 service has worked tirelessly to improve

	performance, with mortality currently standing at 6% crude, 3.5% risk adjusted. • In collaboration with Coding/Business Intelligence the service is working to create a script to identify all NELA cases. This should significantly increase case ascertainment. In the meantime, a focus on manually checking theatre activity has already resulted in a significant improvement to case ascertainment. • Once the case ascertainment script is functioning, work with the BI team is proposed to enable more real time access to data. • Significant improvement to the service by virtue of 80% of NELA patients now being seen by a consultant geriatrician. • Strategic focus is maintained via a regular NELA meetings. The current focus is on time from front door to theatre, including ED assessment and CT scan. • Establishing a dedicated radiology request on ICE for NELA CT remains a challenge.

5.0 Preventable deaths

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 Q2 deaths/SJR/Preventability data (detailing SJRs conducted up to 22 October 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 9: 2025-26 SJR preventable deaths data Year to the end of Q2

Data count (at 22.10.2025)	Apr	May	Jun	Jul	Aug	Sep	Total
Hospital deaths (ED & inpatient)	117	122	104	109	96	92	640
SJRs completed on in-month deaths	29	29	35	39	29	24	185
% of deaths subject to SJR to date	25%	24%	34%	36%	30%	26%	29%
Deaths judged more likely than not to be due to a problem in healthcare	0	1*	0	1	0	1	3
% SJRs assessed ≥50:50 preventable	0%	3%	0%	3%	0%	4%	2%

**In this case the concerns related to care provided prior to admission. The patient had been discharged from another trust 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

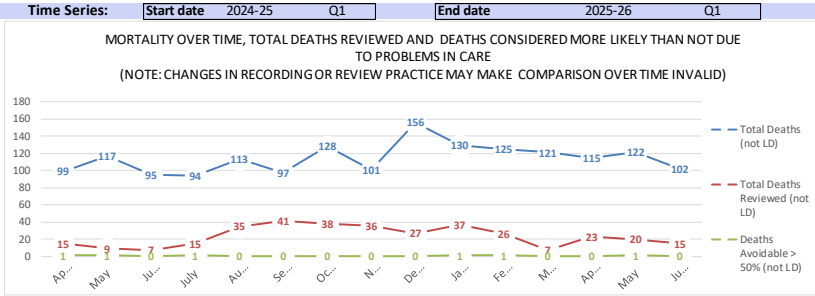
Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

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

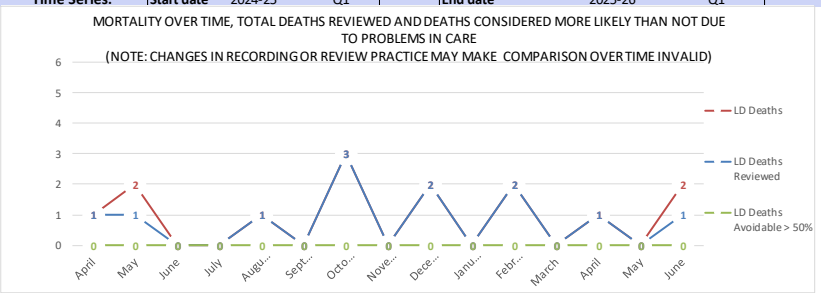
Score 1 Definitely preventable			Score 2 Strong evidence of preventability			Score 3 Probablypreventable (more than 50:50)			Score 4 Probably preventable but not very likely			Score 5 Slight evidence of preventability			Score 6 Definitely not preventable		
This Month	0	0.0%	This Month	0	0.0%	This Month	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



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Board

East and North Hertfordshire Teaching NHS Trust

Meeting	Public Trust Board		**Agenda Item**	11	
Report title	Maternity Incentive Scheme Year 7 – Final Trust position		**Meeting Date**	14 January 2026	
Author	Director of Midwifery Head of Governance and Assurance for women's services Obstetric Group lead for Women's Services				
Responsible Director	Chief Nurse				
Purpose	**Assurance**	☒	**Approval/Decision**	☒	
	Discussion	☐	**For information only**	☐	
Proposed assurance level (*only needed for assurance papers*)	**Substantial assurance**	☒	**Reasonable assurance**	☐	
	Partial assurance	☐	**Minimal assurance**	☐	

Executive assurance rationale:

The evidence demonstrates that East and North Hertfordshire NHS teaching (ENHTT) is fully compliant with all MIS Year 7 requirements. The Board's endorsement will enable submission of the Board Declaration form to NHS Resolution ahead of the submission deadline of 3 March 2025.

Summary of key issues:

NHS Resolution is operating year seven of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) to continue to support the delivery of safer maternity care.

To be eligible for payment under the scheme, Trusts must submit their completed Board. declaration form to NHS Resolution by 12 noon on 3 March 2026.
https://resolution.nhs.uk/wp-content/uploads/2025/04/MIS-Year-7-guidance.pdf

The purpose of this report is to provide assurance to the Trust Board that the Trust is fully compliant with all ten standards of MIS year 7.

Executive Summary

This report provides assurance to the Trust Board that ENHTT has achieved full compliance with all ten safety actions required for Year 7 of the NHS Resolution Maternity Incentive Scheme (MIS)**,** part of the Clinical Negligence Scheme for Trusts (CNST).

The relevant reporting period for MIS Year 7 was 2 April 2025 to 30 November 2025**.** Compliance has been evidenced across all ten safety actions, with robust governance, oversight, and assurance processes in place through the women's and children's divisional governance structure and the Trust Quality and Safety Committee (QSC).

All required evidence has been collated by designated accountable leads, reviewed through monthly MIS meetings, and formally scrutinised and approved by the women's and children's divisional quadrumvirate and the Quality and Safety Committee (December 2025).

Achievement of all ten safety actions enables the Trust to recover the additional 10% CNST maternity contribution, subject to timely submission of the Board Declaration to NHS Resolution by 12 noon on 3 March 2026**.**

Key Points for the Boards attention

- The Trust is fully compliant with all ten MIS Year 7 safety actions.
- Strong governance and assurance processes are in place, including regular reporting to QSC.
- Evidence demonstrates compliance across perinatal mortality review, workforce standards, training, data quality, safety culture, and early notification requirements.
- Submission of the signed Board Declaration is required to secure the associated CNST financial recovery.
- The declaration requires sign-off by the Chief Executive Officer and the Senior Responsible Officer for the Integrated Care Board (ICB), following Trust Board confirmation.

Main Report

1. **Purpose**

   In line with regulatory requirements and the maternity transformation programme, maternity services engage with a series of externally mandated quality improvement programmes including the CNST Maternity Incentive Scheme (MIS) operated by NHS Resolution. As part of the latter, the Trust must demonstrate compliance with all ten maternity safety actions in year 7.

2. **Background**

   CNST is a scheme for handling clinical negligence claims against NHS trusts. The Trust pays an annual premium to the CNST scheme, plus an additional 10% towards the MIS. Trusts that can demonstrate that they have achieved all ten safety actions in full, recover the additional maternity contribution charged under the scheme.

   Trusts that are not compliant with all ten safety actions will not recover their contribution to the CNST MIS but may be eligible for a small discretionary payment from the scheme to help them make progress against actions they have not achieved.

3. **Discussion**

   Evidence to support compliance with each aspect of the maternity safety actions has been collated by designated accountable leads for each safety action and progress has been monitored through monthly MIS meetings chaired by the Head of Governance, Compliance and Quality improvement for Women's services, with oversight from the Director of Midwifery and the Divisional Quadumvirate.

   Assurance of compliance with the requirements for each standard has been achieved through the divisional governance structure with required evidence and progress reports submitted to the Trust Quality and Safety Committee in line with MIS requirements.

   Assurance of compliance against the evidence of each standard is summarised below with examples of evidence included for the committee's reference in **appendix 1** to the report.

Safety Action 1: National Perinatal Mortality Review

This refers to the use of Perinatal Mortality Review Tool (PMRT) to review and report perinatal deaths. The Trust Quality and Safety Committee have received quarterly reports from the PMRT leads throughout this reporting period.

In the MIS year 7 reporting period, the Trust notified all perinatal deaths to MBRRACE-UK *(**M**others and **B**abies: **R**educing **R**isk through **A**udits and **C**onfidential **E**nquiries across the UK)* within seven working days. The trust has a local process of monitoring evidence of compliance with all elements of this standard.

Safety Action 2: Maternity Services Data Set

The Trust has submitted data to the Maternity Services Data Set (MSDS) to the required standard and is therefore complaint all requirements for this safety standard.

The scorecard for July 2025 was published in November 2025 evidencing full compliance with this standard.

Safety Action 3: Avoidable Term Admission in Neonatal Unit (ATAIN) / Transitional care

The service is compliant with all evidence requirements for this safety action. The service continues to focus on reducing mother–baby separation while maintaining safe, high-quality transitional care as evidenced in the ATAIN action plan which has been updated and shared with the Trust QSC during this reporting period.

The service has made progress with actions from the quality improvement plan which was developed from collation of data and trends identified in the weekly ATAIN reviews. Subsequently bedside IV cannulation has been implemented across all postnatal areas, supporting bonding and reducing avoidable transfers to neonatal unit.

Regular progress updates have been presented to the Local Maternity and Neonatal System Quality and Safety forums and discussed with the Safety Champions.

Safety Action 4 - Clinical Workforce planning

Obstetric Medical Workforce
The Trust is fully compliant with the requirements a1, 2 & 4 in the technical guidance document and partially compliant with standard 3 (compensatory rest).

Compensatory Rest:
The Service has a guideline and standard operational policy (SOP) in place for provision of compensatory rest following out of hours on call and an action plan to address any non-compliance. This meets the requirements outlined within the technical guidance document.

Compliance with RCOG workforce document:
A three-month audit period between Feb 2025 and 30 Nov 2025 demonstrated no reported incidents where a consultant was unable to attend for clinical situations listed in the RCOG document. The Labour ward lead exception reports have demonstrated 100% compliance for the audit period.

Anaesthetic medical workforce
There is a duty anaesthetist available on the labour ward 24 hours per day as demonstrated in the rota data (available on request).

Neonatal medical Workforce
Previous non-compliance with latest 2022 BAPM *(British Association of Perinatal Medicine)* standards at consultant grade related to the requirement for a 7th Consultant. As evidenced within the related action plan, substantive funding has since been approved. Following two attempts at substantive recruitment a locum has been appointed who commenced is post in November 2025.

Neonatal Nursing Workforce
Over 70% of our nursing team are Qualified in Speciality (QIS). Workforce data is collected quarterly to ensure on-going monitoring of our skill mix and compliance and this information is routinely shared with the East of England network.

The Trust is therefore compliant with all evidence requirements for this safety action.

Safety Action 5 – Midwifery Workforce

The Trust is fully compliant with all the requirement of this standard. The Trust QSC received the first biannual midwifery staffing report for this reporting period in July 2026, meeting MIS requirements. The second report is scheduled for presentation to QSC in January 2026.

Safety Action 6 – Saving babies lives care bundle.

Evidence to support the current level of implementation of each element has been updated on the national implementation tool on the NHS futures platform to track compliance.

Table 1 below evidences our self-assessed and LMNS validated compliance which meets the minimum evidential requirements needed for this standard.

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)
Element 1	Smoking in pregnancy	Partially implemented	90%	Partially implemented	80%
Element 2	Fetal growth restriction	Fully implemented	100%	Fully implemented	100%
Element 3	Reduced fetal movements	Fully implemented	100%	Fully implemented	100%
Element 4	Fetal monitoring in labour	Fully implemented	100%	Partially implemented	80%
Element 5	Preterm birth	Fully implemented	100%	Fully implemented	100%
Element 6	Diabetes	Partially implemented	83%	Partially implemented	83%
All Elements	TOTAL	Partially implemented	97%	Partially implemented	94%

Table 1. Saving babies lives care bundle self-assessed and validated compliance with implementation.

Safety Action 7 - Maternity and Neonatal Voices Partnership (MNVP)

ENHTT has a funded service user MNVP *(Maternity and neonatal Voice Partnership)* lead in place as per the required standard. However, it is recognised that although commissioned there is not currently sufficient funding to ensure adequate infrastructure to effectively carry out all requirements of the role (including vacancy backfill of the neonatal lead role). The associated risk is held on the ICB risk register, and an action plan has been developed between the LMNS and the Trust.

The MNVP have held board meetings as required within this reporting period and work to provide regular feedback. The Trust meet all requirements for this standard.

Safety Action 8 – Multi-professional Training

Monthly training compliance is reported through the monthly divisional governance and via the perinatal assurance report to the Trust QSC. The Trust can evidence compliance with undertaking the required number of emergency skills/drills in a clinical area within the reporting timeframe. Training compliance as of 24 November 2025 is included within **appendix 1** evidencing compliance with all requirements for this safety action.

Safety Action 9 – Board Assurance on maternity and neonatal safety and quality.

The Perinatal assurance report is submitted monthly to the Trust QSC for oversight, discussion, and scrutiny. This includes maternity and neonatal quality metrics within the Perinatal Quality Surveillance Model (PQSM) and Trust Integrated Performance Report (IPR). All agendas and minutes are available for evidence review.

Progress with cultural improvement across perinatal services including actions in response to the staff survey results was presented to the People and Culture Committee on 4 November 2025.

Quarterly reports triangulating incident and complaints data with the Trust CNST Score Card have been presented at the women's care group Governance and safety Champions meetings during this reporting period.

The Board level safety champions undertake clinical walk arounds and attend monthly divisional safety champion meetings which also have representation from our Maternity and Neonatal; Voice Partnership (MNVP), with escalations to the women's and children's board and QSC.

The Trust is compliant with all evidence requirements for this safety action.

Safety Action 10: Reporting to Early Notification Scheme.

ENHTT has had two qualifying MNSI (*Maternity and Newborn Safety Investigation)* cases in this reporting period which have been appropriately referred to the NHS resolutions early notification scheme.

The trust can evidence 100% compliance with Duty of Candour (DOC) for eligible cases in line with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The families involved have received information on the role of MNSI and NHS Resolution's Early Notification Scheme.

All MNSI and PSII *(Patient safety Incident Investigation)* reports have been shared with PSERP *(Patient Safety Escalation and Review Panel)* and QSC for oversight as per Ockenden and MIS year 7 requirements.

4. Submission to NHSR

To be eligible for payment under the scheme, Trusts must submit their completed Board declaration form to NHS Resolution by 12 noon on Monday 3 March 2026.

The ENHT Board declaration form requires sign of by the Trust CEO and the SRO for the ICB. The service therefore request that the Trust Board confirm that they are satisfied that evidence has been provided to meet the specified requirements for all safety actions.

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**	☐

- **Patient care quality and equity:** Positive assurance regarding maternity and neonatal safety and quality
- **Finance / Resourcing:** Recovery of CNST maternity contribution dependent on timely Board approval and submission.
- **Legal / Regulatory:** Demonstrates compliance with national maternity safety and assurance requirements.
- **System / Partners:** MIS delivery has strengthened collaboration with LMNS partners through shared oversight of data, training, PMRT, MNVP involvement and safety-champion engagement which supports consistency and shared learning across the system.

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):

Quality and Safety Committee 17/12/25
LMNS Partnership Board 27/11/2025

Recommendation	Trust Board is asked to: • Review and note the content of the report.

	• Note that all evidence is available on request. • Note that all required evidence has been reviewed and accepted by the Women's and Children's Divisional quadrumvirate demonstrating achievement of the ten maternity safety actions as set out in the safety actions and technical guidance document. • Note that assurance and associated evidence was reviewed and approved by the Quality and Safety Committee at its meeting on 17 December 2025. • Confirm that it is satisfied that the evidence has been provided to meet all ten safety standards and give their permission to the Chief Executive Officer to sign the Trust Board Declaration form prior to submission to NHS Resolution by 3 March 2026.

To be trusted to provide consistently outstanding care and exemplary service

Maternity Incentive Scheme Year 7

LMNS and Board Reporting Requirement November 2025

East and North Hertfordshire Teaching NHS Trust

Amanda Rowley: Director of Midwifery

 # ProudToBeENHT

Contents

East and North Hertfordshire Teaching NHS Trust

Purpose of the Report

- To provide the committee/Board of the progress being made by the Maternity service against the ten safety actions outlined in Year 7 of the Maternity Incentive Scheme (MIS) for the reporting period from 1 December 2024 to 30 November 2025.
- To provide assurance of compliance through evidence.
- To update the committee/Board of current compliance against the ten safety actions and outline the next steps where indicated.

Executive Summary

East and North Hertfordshire Teaching NHS Trust

Successes

- The Maternity service has achieved compliance against all safety standards outlined in Year 7 of the Maternity Incentive Scheme (MIS).
- The service has led several quality improvement projects including the bedside cannulation, related to Saving Babies Lives care bundle (v3.2).

Key Themes

- Evidence has been reviewed by the Trust Quality and safety Committee (QSC), Maternity Safety Champions and the Integrated care Board (ICB) to support assurance of compliance.

Recommendations

- The Trust Board is required to confirm that it is satisfied with the evidence of compliance at Public Trust board on 14 January 2026.
- The Trust Board is required to approve the Board Declaration Form for submission ahead of the submission deadline of midday on 3 March 2026.

This report includes confirmation of compliance and examples of available evidence. All evidence is available on request.

Safety Action 1

National Perinatal Mortality Review Tool (PMRT)

East and North Hertfordshire Teaching NHS Trust

ProudToBeENHT

Safety Action 1: PMRT

	Requirement	Actions/progress	Compliance status	Supporting evidence
1.1	Have all eligible perinatal deaths from 1 December 2024 onwards been notified to MBRRACE-UK within seven working days?	This has been achieved for the reporting period and failsafe process is in place between the governance and bereavement teams.		1. Quarterly Perinatal Bereavement Reports Q3 and Q4 2024/25, Q1 and Q2 2025/26 (Q3 2025/26 not yet published/outside of reporting period/due Jan 2026). 2. PMRT reports, MBRRACE-UK. 3. PMRT process tracker - held by Patient Safety Midwife.
1.2	For at least 95% of all deaths of babies who died in your Trust from 1 December 2024, were parents' perspectives of care sought and were they given the opportunity to raise questions?	Patient engagement following pregnancy and baby loss is managed by the bereavement midwives. A phone call or face to face intercations and phone calls are followed up in writing, explaining the PMRT process and family questions to include as part fo the review. A postnatal debrief appointment is held with the Consultant Obstetrician for bereavement and bereavement midwives once the review is complete, placental histopathology/cytology results confirmed and/or coroners report received.		1. Local bereavement cases tracker - held by bereavement midwives. 2. PMRT/patient engagement/letter to families template. 3. Postnatal debrief letters from Consultant Obstetrician.
1.3	Has a review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 1 December 2024 been started within two months of each death? This includes deaths after home births where care was provided by your Trust.	This has been achieved for the reporting period and failsafe process is in place between the governance and bereavement teams.		1. Quarterly Perinatal Bereavement Reports Q3 and Q4 2024/25, Q1 and Q2 2025/26 (Q3 2025/26 not yet published/outside of reporting period/due Jan 2026). 2. PMRT reports, MBRRACE-UK. 3. PMRT process tracker - held by Patient Safety Midwife.
1.4	Were 75% of all reports completed and published within 6 months of death?	This has been achieved for the reporting period and failsafe process is in place between the governance and bereavement teams.		1. Quarterly Perinatal Bereavement Reports Q3 and Q4 2024/25, Q1 and Q2 2025/26 (Q3 2025/26 not yet published/outside of reporting period/due Jan 2026). 2. PMRT reports, MBRRACE-UK. 3. PMRT process tracker - held by Patient Safety Midwife.
1.5	For a minimum of 50% of the deaths reviewed, was an external member present at the multi-disciplinary review panel meeting and was this documented within the PMRT?	This has been achieved for the reporting period and failsafe process is in place between the governance and bereavement teams.		1. Quarterly Perinatal Bereavement Reports Q3 and Q4 2024/25, Q1 and Q2 2025/26 (Q3 2025/26 not yet published/outside of reporting period/due Jan 2026). 2. PMRT reports, MBRRACE-UK. 3. PMRT review presentations - held by Patient Safety Midwife.
1.6 1.7	Have you submitted quarterly reports to the Trust Executive Board on an ongoing basis? These must include details of all deaths from 1 December 2024 including reviews and consequent action plans. Were quarterly reports discussed with the Trust Maternity Safety and Board level Safety Champions?	Quarterly Perinatal Bereavement reports are presented to Divisional Governance meetings and Maternity & Neonatal Safety Champions meetings, then to Trust Mortality Surveillance Committee and Trust Quality & Safety Committtee by the Head of Governance for Women's Services and Lead Consultant Obstetrician for Bereavement.		1. Quarterly Perinatal Bereavement Reports Q3 and Q4 2024/25, Q1 and Q2 2025/26 (Q3 2025/26 not yet published/outside of reporting period/due Jan 2026). 2. Minutes Divisional Governance meetings. 3. Minutes Maternity & Neonatal Safety Champions meetings. 4. Quarterly Perinatal Bereavement report presentations taken to Mortality Surveillance Committee. 5. Minutes Mortality Surveillance Committee meetings. 6. Minutes Trust Quality & Safety Committee meetings.

NHS
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Report Coversheet

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Meeting	Care Group 9 Meeting 18/11/2025 Maternity and Neonatal Safety Champions 25/11/2025 MSG 10/12/2025 QSC 17/12/2025	**Agenda Item**	
Report title	Q2 2025/26 Perinatal Bereavement Report	**Meeting Date**	18/11/2025
Presenters	Rachel Wooldridge, Consultant Obstetrician Josie Reynolds, Lead Midwife for Quality Assurance, Governance & Compliance		
Authors	Rachel Wooldridge, Consultant Obstetrician Josie Reynolds, Lead Midwife for Quality Assurance, Governance & Compliance		
Responsible Director	Director of Midwifery	**Approval Date**	Care Group 9 Meeting 18/11/2025

Purpose *(tick one box only)* [See note 8]				
	To Note	☐	Approval	☒
	Discussion	☒	Decision	☐

Report Summary:

MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK is the collaboration appointed by the Healthcare Quality Improvement Partnership (HQIP) to run the national Maternal, Newborn and Infant clinical Outcome Review Programme which continues the national programme of work conducting surveillance and investigating the causes of maternal deaths, stillbirths and infant deaths. The aim is to provide robust national information to support the delivery of safe, equitable, high quality, patient-centred maternal, new-born and infant health services.
The MBRRACE–UK programme of work comprises national surveillance of late fetal losses (22 – 23+6 weeks gestation), stillbirths and infant deaths and the provision of confidential enquiries into stillbirths, infant deaths and cases of serious infant morbidity on a rolling basis This report provides the assurance that the maternity services are contemporaneously and continuously monitoring the Stillbirth and Neonatal death rates, by means of the PMRT (perinatal mortality review tool) and provides a summary of the outcomes and actions for the second quarter of 2025/2026 (Jul-Sept). Figures were obtained from the Bereavement Midwife records, Maternity Information System (CMIS) and MBRRACE / PMRT documentation.

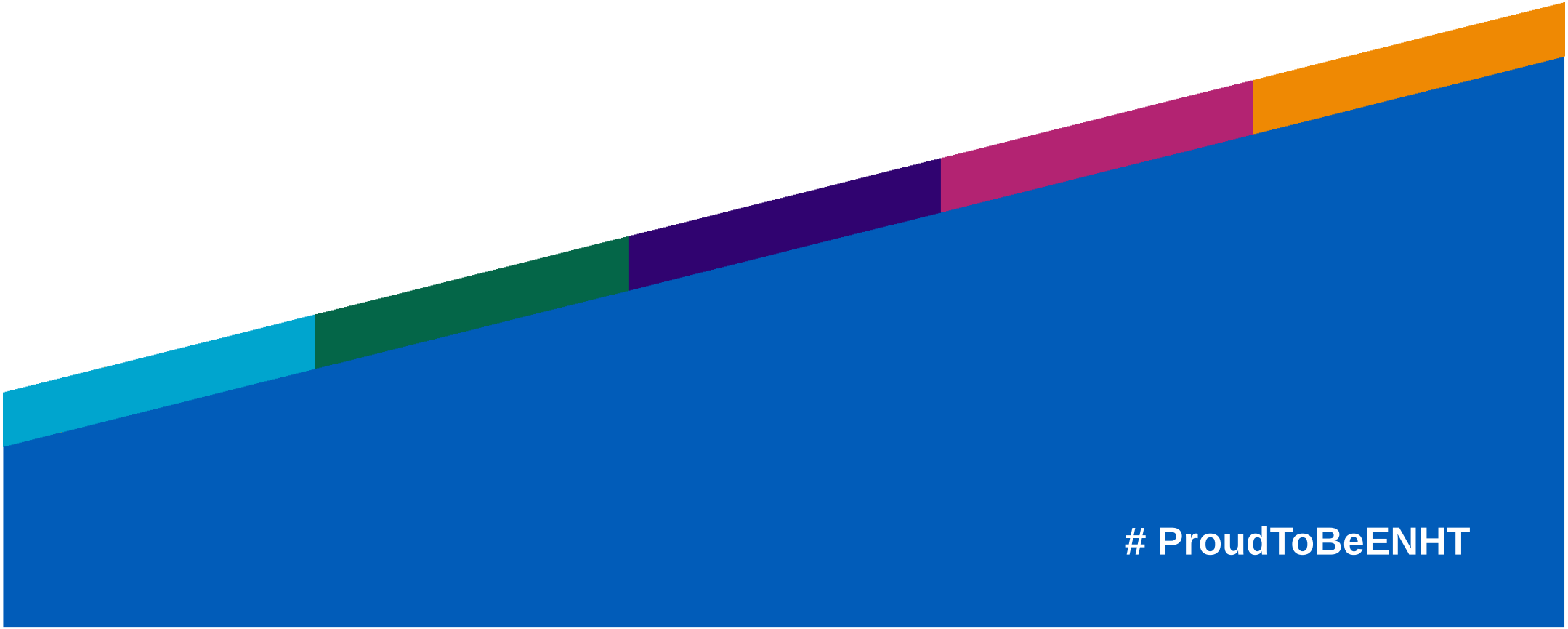
In the second quarter of 2025/2026 (Jul-Sept) there were 1197 babies born.

- **1 antenatal stillbirth occurred**
- **0 neonatal deaths occurred**
- **0 late fetal loss occurred**
- **0 late medical terminations**
- **2 babies born at East & North Hertfordshire Trust, and who was transferred out ex-utero and died at another Trust**
- **1 baby transferred out inutero and was stillborn during the intraprtum period at**

Safety Action 2

Maternity Services Data Set (MSDS)

East and North Hertfordshire Teaching NHS Trust



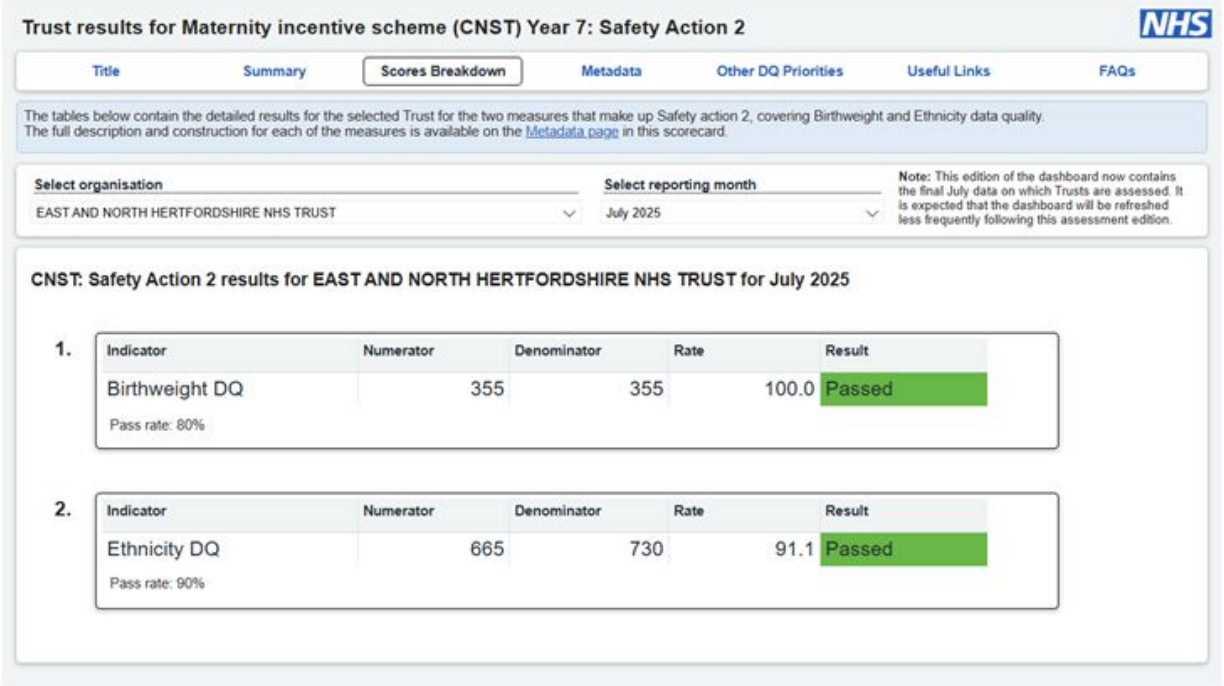
Requirements of Safety Action 2: MSDS

East and North Hertfordshire Teaching NHS Trust

Reporting period: 2 April 2025 until 30 November 2025

	Requirement	Actions/ progress	Compliance status
2.1	Did July 2025's data contain valid birthweight information for at least 80% of babies born in the month. This requires the recorded weight to be accompanied by a valid unit entry. (Relevant data tables include MSD401; MSD405)	ENHT July 2025 Scorecard result for Birthweight DQ = 100% Passed (pass rate 80%).	
2.2	Did July's 2025's data contain a valid ethnic category (Mother) for at least 90% of women booked in the month? Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001)	ENHT July 2025 Scorecard result for Ethnicity DQ = 91.1% Passed (pass rate 90%).	

Extract from July 2025 Scorecard (NHS Dashboard)



Trust results for Maternity incentive scheme (CNST) Year 7: Safety Action 2

Title | Summary | Scores Breakdown | Metadata | Other DQ Priorities | Useful Links | FAQs

The tables below contain the detailed results for the selected Trust for the two measures that make up Safety action 2, covering Birthweight and Ethnicity data quality.
The full description and construction for each of the measures is available on the Metadata page in this scorecard.

Select organisation: EAST AND NORTH HERTFORDSHIRE NHS TRUST

Select reporting month: July 2025

Note: This edition of the dashboard now contains the final July data on which Trusts are assessed. It is expected that the dashboard will be refreshed less frequently following this assessment edition.

CNST: Safety Action 2 results for EAST AND NORTH HERTFORDSHIRE NHS TRUST for July 2025

1.

Indicator	Numerator	Denominator	Rate	Result
Birthweight DQ	355	355	100.0	Passed
Pass rate: 80%				

2.

Indicator	Numerator	Denominator	Rate	Result
Ethnicity DQ	665	730	91.1	Passed
Pass rate: 90%				

Recommend that compliance with this safety action has been achieved.

Safety Action 3

Avoiding Term Admissions Into the Neonatal unit (ATAIN)

East and North Hertfordshire Teaching NHS Trust

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Requirements of Safety Action 3: ATAIN

East and North Hertfordshire Teaching NHS Trust

	Requirement	Actions/progress	Compliance status	Supporting evidence
3.1	Are pathway(s) of care into transitional care in place which includes babies between 34+0 and 35+6 in alignment with the BAPM Transitional Care Framework for Practice?	Yes, We have implemented a new pathway for babies born at 34 weeks to be admitted to TC.		Admission pathway for 34-34+6
Drawing on insights from themes identified from any term or late preterm admissions to the neonatal unit, undertake or contir admissions and/or length of infant/mother separation.				
Or For units continuing a QI project from the previous year				
3.5	Demonstrate progress from the previous year within the first 6 months of the MIS reporting period, and present an update to the LMNS and Safety Champions.	QIP and action plan commenced in 2024. Aims to reduce seperation for IV cannulation, introduce TC huddles to improve communication and review staffing model.		1. QIP. 2. Action Plan. 3. Bedside IV cannulation pathway. 4. Stages of change.
3.6	By 30 November 2025, present a further update to the LMNS and Safety Champions regarding development and any progress at the end of the MIS reporting period	Presented to Maternity & Neonatal Safety Champions Sept 2025. Update to ODN and LMNS also provided.		1. MNSC meeting minutes. 2. LMNS meeting minutes.

Recommend that compliance with this safety action has been achieved.

Term Admissions to the Neonatal Unit -
Discussion of findings and recommendations

East and North Hertfordshire Teaching NHS Trust

There were 222 cases of term admissions reviewed by the ATAIN group between 1 January 2025 – 31 October 2025.

Mode of Birth:

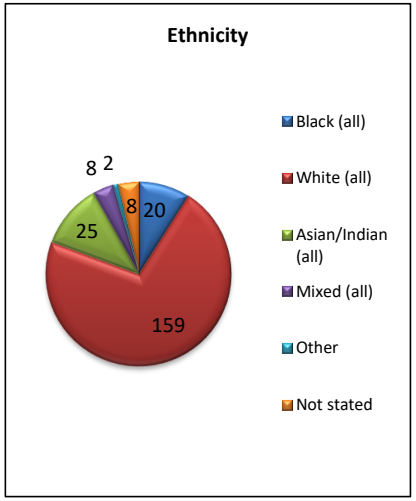
- Instrumental births represented 18% of TC admissions despite accounting for 11% of term births during this period.
- Elective LSCS (Cat 4) births = 20%. Emergency LSCS = 33%. SVD= 29% (44% term births).

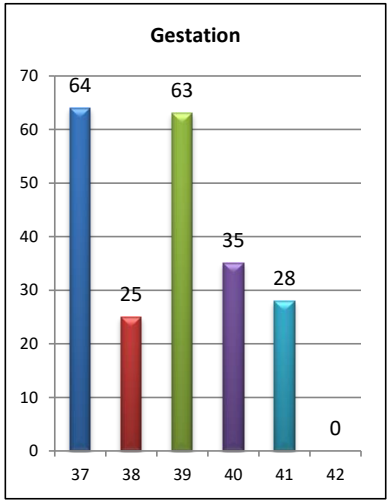
Reason for Admission:

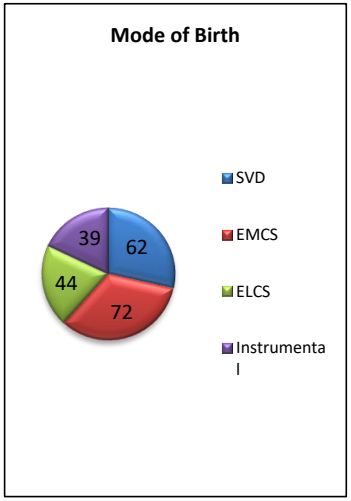
- The highest at 65% was respiratory.

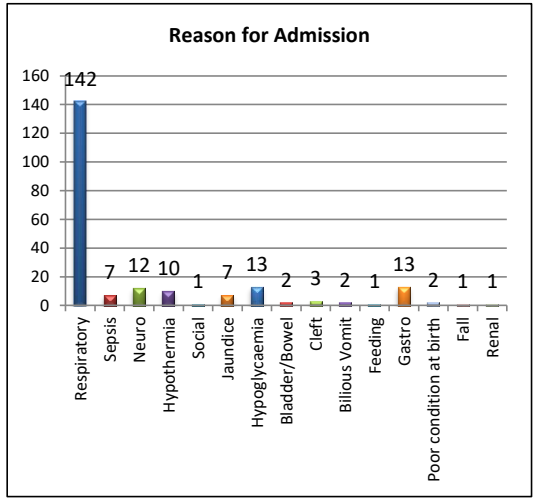
Avoidable Admissions:

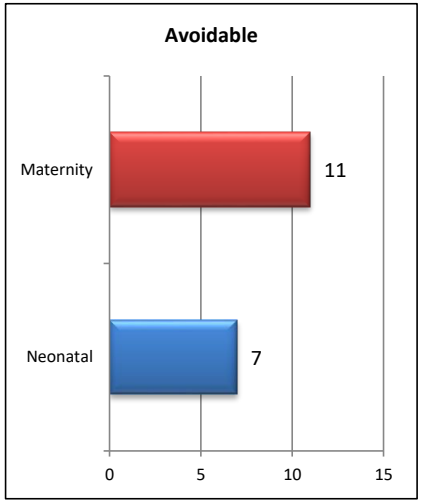
- Separation for cannulation, assessment or screening/ temperature management/ identification of cleft palate/ availability of second theatre/ TC capacity/ earlier intervention or escalation/ feeding support. There were no babies admitted that applied to the abandoned or relinquished category.









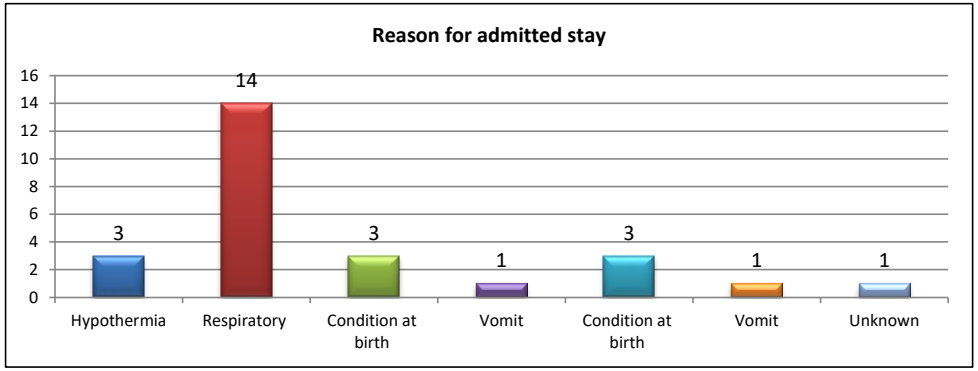


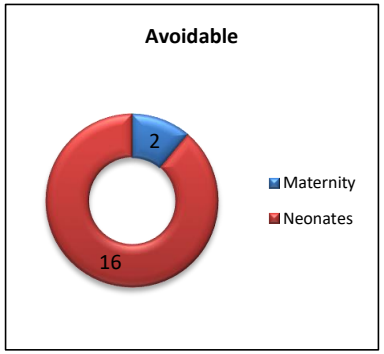
Short Stay Admissions – A Quality Improvement Project

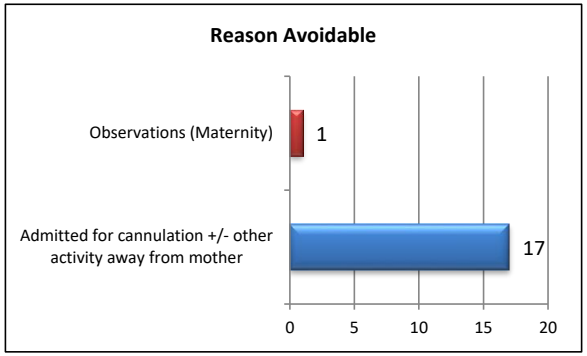
Discussion of findings & recommendations

NHS East and North Hertfordshire Teaching

The ATAIN QIP audit for MISY7 shows there were 17 avoidable cases of short-stay admissions between 1st January – 31st October 2025 representing a small but ongoing proportion of cases where bedside cannulation was not possible.







Interventions Implemented:

1. **Reconfigured the Transitional Care (TC) Bay**
   - Optimised the layout to support bedside procedures and reduce movement of babies between areas.
   - Created space to safely carry out cannulation and observations within the postnatal environment.
2. **Introduced Essential Equipment to Enable Bedside Care**
   - Heated cot obtained to support safe observation and cannulation at the bedside.
   - IV trolley sourced to store and organise cannulation equipment and antibiotics, ensuring rapid access.
   - Monitoring device installed for vital signs observations, improving safety and reducing need for neonatal unit transfers.
3. **Strengthened Multidisciplinary Communication**
   - Ongoing communication with medical, midwifery and nursing teams to agree processes, responsibilities, and escalation pathways.
   - Ensured all teams understood the aim of minimising mother–baby separation and how bedside cannulation supports this.
   - Promoted collaboration to support smooth implementation across all postnatal areas.

Challenges with staffing transitions:

- Peaks in transfers following the induction of new resident doctors who were not yet fully familiar with the new procedures.
- These challenges are being addressed by providing targeted support and training for new staff to ensure they are comfortable with the new protocols.

Significant Improvements:
Improved bedside cannulation: There has been significant improvement in babies receiving cannulation next to their mothers, either in CLU, recovery or TC. The new process has drastically reduced unnecessary mother-baby separations, allowing for better maternal-infant bonding and more efficient care delivery.

Safety Action 4

Clinical Workforce

East and North Hertfordshire Teaching NHS Trust

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Requirements of Safety Action 4: Obstetric Workforce

East and North Hertfordshire Teaching NHS Trust

	Requirement	Lead	Actions/progress	Compliance status	Supporting evidence
Obstetric Workforce					
Has the Trust ensured that the following criteria are met for employing all short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology, demonstrated through audit of any 6-month period from February 2025 and before submission to Trust Board:					
4.1	Locum currently workr in their unit an the tier 2 ar 3 rata?	Douglar Salveren (Medical Director), Mana Madi (Clinical Service Lead), Ini Oranqun (Clinical Director Obstetrics)	The Trust ir fully compliant uith the RCOG requirementr.		Audit fram temparary medical staffing department, Feb-Aug 2025
Has the Trust ensured that the following criteria are met for employing long-term locum doctors in Obstetrics and Gynaecology, demonstrated through audit of any 6-month period from February 2025 to 30 November 2025:					
4.4	Har the Trust implemented the RCOG quidance an engagement af lang-term lacumr in full? Trustr should demanstrate full compliance thraugh audit af any 6-manth period fram February 2025 ta 30 Navember 2025.	Douglar Salveren (Medical Director), Mana Madi (Clinical Service Lead), Ini Oranqun (Clinical Director Obstetrics)	the Trust ir fully compliant uith the RCOG requirementr.		Audit fram temparary medical staffing department, Feb-Aug 2025
RCOG compensatory rest (not reportable in MIS year 7)					
4.5	Have you met, ar are warking taward full implementatian af the RCOG guidance an compensatary rest uhere Canrultantr and Seniar Speciality, Arsaciate Specialirt and Specialirt (SAS) dactarr are warking ar nan-resident an-call aut af haurr and da nat have sufficient rest ta undertake their narmal warking dutier the fallauing day.	Douglar Salveren (Medical Director), Mana Madi (Clinical Service Lead), Ini Oranqun (Clinical Director Obstetrics)	Warking taward. Guideline and SOP in place. Actian Plan in place and updated for 2025.		Guideline, SOP, Staff Surevy, Audit, Actian Plan.
Consultant Attendance					
4.6	Ir the Trust compliant uith Canrultant attendance in parsan ta the clinical rituatianr lirted in the RCOG uarkforce dacument: 'Raler and Rarpanribilitier af the Canrultant praviding acute care in abrtetrics and gynaecalaqy' inta their service. Trustr should demanstrate a minimum af 80% campliance thraugh audit af any 2-manth period fram February 2025 ta 30 November 2025.	Douglar Salveren (Medical Director), Mana Madi (Clinical Service Lead), Ini Oranqun (Clinical Director Obstetrics)	Raler and rarpanribilties included in quideline and fully compliant thraughaut 2025.		Guideline in place. Manthly exceptian repart fram Labaur Ward lead. MOH Audit. Triagnulatian uith camplaintr and incidentr.
4.7	Da you have evidence that the Trust paritian uith the abave har beenshared uith Trust Board?	Douglar Salveren (Medical Director), Mana Madi (Clinical Service Lead), Ini Oranqun (Clinical Director Obstetrics)	Obstetric Medical Warkforce MISY7 Campliance Paper 2025 rchedulef for Trust QSC Dec 2025 and Trust Baard Jan 2026.		Obrtetric Medical Warkforce MIS Campliance Paper 2025
4.8	Da you have evidence that the Trust paritian uith the abave har beenshared uith Baard level Safety Champianr?	Douglar Salveren (Medical Director), Mana Madi (Clinical Service Lead), Ini Oranqun (Clinical Director Obstetrics)	Obstetric Medical Warkforce MISY7 Campliance Paper 2025 rchedulef for Trust QSC Dec 2025 and Trust Baard Jan 2026. Paper alrata be rent ta all Safety Champianr far reviaw and chairr actianr.		Obrtetric Medical Warkforce MISY7 Campliance Paper 2025
4.9	Da you have evidence that the Trust paritian uith the abave har beenshared uith the LMNS?	Douglar Salveren (Medical Director), Mana Madi (Clinical Service Lead), Ini Oranqun (Clinical Director Obstetrics)	LMNS Partnership Baard rchedulef far 27/11/2025.		Obrtetric Medical Warkforce MISY7 Campliance Paper 2025
Anaesthetic Workforce					
4.10	Is there evidence that the duty anaesthetist is immediately available for the obstetric unit 24 hours a day and they have clear lines of communication to the supervising anaesthetic consultant at all times? In order to declare compliance, where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1)	Derek Brunnen (Consultant Anaesthetist)	Anaesthetic Medical Warkforce MISY7 Campliance Paper 2025 rchedulef for Trust QSC Dec 2025 and Trust Baard Jan 2026.		1. Anaesthetic medical uarkforce MISY7 compliance paper 2025 2. Anaesthetic clinical rostersr Feb-May 2025
Neonatal Medical Workforce					
4.11	Daer the neanatal unit meet the Britirh Arrociatian af Perinatal Medicine (BAPM) natianal standardr af medical staffing?	Ather Ahmed (Clinical Director Neonatology)	Nat fully compliant at Canrultant level. Currently six Canrultantr. Funding for 7th approved. Seventh canrultant appointed ar lacum and due tar tart within three manth. Will then be fully compliant. Have made progrerr an actian plan.		Neanatal medical uarkforce MISY7 compliance paper
4.12	Ir thir farmally recarded in Trust Baard minutes?	Douglar Salveren (Medical Director)	Neanatal Medical Warkforce MISY7 Campliance Paper 2025 rchedulef for Trust QSC Dec 2025 and Trust Baard Jan 2026.		Neanatal medical uarkforce MISY7 compliance paper
4.13	If the requirementr are nat met, Trust Baardrhauld agree an actian plan uith updater an pragrerr against any previaurly developed actian planr. Thir rhauld be manitared via a rirk regirter.	Douglar Salveren (Medical Director)	Actian plan rubmitted ar part af the Neanatal medical uarkforce compliance paper. Pragrerr evident.		Neanatal medical uarkforce MISY7 compliance paper
4.14	War the abave actian plan rhared uith the LMNS?	Ather Ahmed (Clinical Director Neonatology)	LMNS Partnership Baard rchedulef far 27/11/2025.		Neanatal medical uarkforce MISY7 compliance paper
4.15	War the abave actian plan rhared uith the Neanatal ODN?	Ather Ahmed (Clinical Director Neonatology)	Actian plan ar part af uarkforce repartrent ta ODN by DS (MD).		
Neonatal Nursing Workforce					
4.16	Daer the neanatal unit meet the Britirh Arrociatian af Perinatal Medicine (BAPM) natianal standardr af nurring rtaffing?	Laura Kelly (Neonatal Matran)	Yer, The QIS compleince ir canrirtently >70%, currently at 74% uith 2 marerstaff pragrerring thraugh their QIS training.		Quarterly repart an neanatal nurring uarkforce datarent ta EoE. Daily nurring numberr recarded daily an BadgerNet.
4.17	Ir thir farmally recarded in Trust Baard minutes?	Laura Kelly (Neonatal Matran)	Thir ir rhared in aur divirianal baard repartr and care graup gavernance repartr.		

Recommend that compliance with this safety action has been achieved.

Obstetric Workforce

East and North Hertfordshire Teaching NHS Trust

QSC Assurance Report December 2025

Report Coversheet

East and North Hertfordshire Teaching NHS Trust

Meeting	Quality and Safety Committee		**Agenda Item**		
Report title	Obstetric Medical Workforce MIS year 7 compliance paper 2025		**Meeting Date**	17/12/2025	
Author	Inibiokun Orangun, Clinical Director				
Responsible Director	Chief Nurse and Medical Director				
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:

As part of the NHS Resolution 10 steps to safety MIS year 7 compliance standards, NHS organisations are required to provide assurance to their Boards that we are demonstrating an effective system of clinical workforce planning to the required standard.

For Obstetric Medical Workforce, there are 4 criteria the organisation are required to fulfil.

1) NHS Trusts/organisations should ensure that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas:

a. currently work in their unit on the tier 2 or 3 rota
or
b. have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP)
or
c. hold a certificate of eligibility (CEL) to undertake short-term locums.

2) Trusts/organisations should implement the RCOG guidance on engagement of long-term locums and provide assurance that they have evidence of compliance to the Trust Board, Trust Board level safety champions and LMNS meetings.

3) Trusts/organisations should be working towards implementation of the RCOG guidance on compensatory rest where consultants and senior Speciality, Associate Specialist and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day. While this will not be measured in Safety Action 4 this year, it remains important for services to develop action plans to address this guidance.

4) Trusts/organisations should monitor their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service roles-responsibilities-consultant-report.pdf when a consultant is required to attend in person. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further nonattendance.

Compensatory Rest Action plan excerpt

ACTION PLAN - SAFETY ACTION 4 Compensatory Rest: Action plan 2025/26

	Action	Owner	Due Date	Progress	RAG 2023/24	RAG 2024/25	RAG 2025/26
1	Carry out review of current job plans to understand current position on supporting compensatory rest.	D Salvesen	Jun-23	Current position reviewed, department is non complaint with the RCOG guidance, included in new guideline and added to narrative for Q&S board report 08/09/2023. Job plans adjusted and on call rota adjusted to support compensatory rest April 2024. Review of current position completed April 2024. Revised job plans in April 24 and Nov 24 to work towards compliance. RAG rated green as job plan review has occured. 10/07/2025 Team and individual job planning has occured in 2025/26. On call freq now 1 in 13. Timetables updated. Frequency of on call is low compared to other units. Also have resident consultants 4 nights per week. Team job planning is currently underway for the year April 2026/27 and this will include review of sessions after Sunday night on call. On call frequency has reduced sine last year and is currently 1 in 13.			
2	Guideline and SOP to be written and taken through internal governance process and revised as need be.	D Salvesen	Aug-23	Guideline and SOP ratified and on knowledge centre 08/09/2023. April 2024 guideline in place and in date and reviewed April 2024. April 2024 minor editing made to SOP to support progress towards compliance . Shared with all consultants again in April 24. Rated green as guideline updated and circulated to all consultants. 10/07/2025 guideline and SOP remain in place and			
3	Escalations to be shared monthly as part of Labour Ward Lead report.	K McNamee	Sep-23	Agreed as part of LWL monthly escalations 10/07/2023. April 2024 LWL providing escalations by exception reporting. ENHANCE to be reviewed. Rated Green as Exception reporting continues and no ENHANCE reports between Feb and July 2024. 10/07/2025: monthly exception reports received from labour ward lead. No ENHANCE realted to compensatory rest between Feb and August 2025. LWL continues to complete exception report monthly.			
4	Staff survey to be undertaken	K McNamee	Jul-23	Survey undertaken 10/7/2023.Results have fed into the guideline details and SOP and will then feed into job planning 24/25 and onwards and business cases for additional staff.Job plans adjusted to help support compensatory rest. Repeat survey undertaken in April 2024. Rated green as survey completed and added to NHSR evidence. Repeat staff survey undertaken 2025. Will feed into job planning 2026/27. Requires significant consultant expansion to ensure 100% compliance. Need 3-4 more consultants . Added this detail to the divisional workforce planning document for 2026/27			
5	Consultant Staff expansion	D Salvesen	Apr-27	Agreed to be part of budget setting and cost pressure discussions 10/07/23 in guideline. Require x2 current locums to be substantive and then additional x3 consultants. Nov 23: PID submitted for additional staff for 24/25. If agreed will need to advertise, appoint and then adjust job plans. April 2024: Two locums appointed as substantive posts. Two additional Obs & Gynae consultants approved. Appointments made. Moving to 1 in 13 obstetrics on call rota to help facilitate compensatory rest. Additional x1 /wte required to move to 1 in 14 on call rota and fully implement compensatory rest with split weekends. Case for x1 WTE obstetrician will be considered for planning for 2025/26. Amber as rota improving from Nov 24 to 1 in 13. On call rota in 2025/26 now 1 in 13. Further expansion unlikely to occur without specific additional funding. The need for additional staff has been added to the divisional workforce document for 2026/27. Continue to review consultant staffing on an annual basis.			

Anaesthetic Workforce

Report Coversheet

NHS East and North Hertfordshire Teaching NHS Trust

Meeting	Quality and Safety Committee		**Agenda Item**		
Report title	Anaesthetic Medical Workforce MIS year 7 compliance paper 2025		**Meeting Date**	17/12/2025	
Author	Douglas Salvesen, Divisional Medical Director Women's and Children's				
Responsible Director	Divisional Medical Director Women's and Children's				
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:

As per the requirements of CNST Maternity Incentives Scheme year 7, The Trust is required to formally record in their Board minutes, the compliance status against Anaesthetics Clinical Services Accreditation (ACSA) standard 1.7.2.1. The requirement stipulates that a duty anaesthetist is available, 24 hours a day within obstetrics. Maternity services at East & North Hertfordshire NHS Trust are fully compliant with this standard. Evidence provided by a three month rota audit undertaken during the period Feb 2025 - 30th November 2025.

Summary of key issues:

The purpose of this paper is to provide the Board with the information on the provision of Anaesthetic Clinical Services against the required standard as set out in Maternity Incentive Scheme Year 7, Safety Action 4.

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	
	☒		☐		☐		☐		☐		☐		☐

Risk to patient safety if not sustained.

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

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

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

Risk 7463

Report previously considered at & date(s):

Update on the report from MIS compliance year 6 in 2024 and previous years.

Recommendation	The Committee is asked to approve compliance with the ACSA recommendation in preparation for sign-off submission the NHS Resolution.

To be trusted to provide consistently outstanding care and exemplary service

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Neonatal Medical Workforce

NHS East and North Hertfordshire Teaching NHS Trust

Report Coversheet

NHS East and North Hertfordshire Teaching NHS Trust

Meeting	Quality and Safety Committee		**Agenda Item**		
Report title	Neonatal Medical Workforce MIS year 7 compliance 2025		**Meeting Date**	17/12/2025	
Author	Douglas Salvesen, Divisional Medical Director Women's and Children's				
Responsible Director	Chief Nurse and Medical Director				
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:

As part of the NHS Resolution 10 steps to safety MIS year 7 compliance standards, NHS organisations are required to provide assurance to their Boards that the neonatal unit meets the British Association of Perinatal Medicine (BAPM) national standards 2022 for medical staffing. Where the standards are not met, the Trust Board is required to agree an action plan and outline progress against any previously agreed action plans. NHS resolutions also require the reason for non-compliance to be specified. The audit of staffing covered 1st April 2025 to 30th November 2025.

The Neonatal unit at East and North Hertfordshire does not meet all the MIS national medical staffing standards for a local neonatal unit as assessed between 1st April 2025 and 30th November 2025. Actions are required in order to fully comply with the requirements relating to the Tier three rota– Consultant staffing. The Consultant staffing is non complaint as they work on a 1 in 6 rota and the frequency of the consultant rota needs to be no more onerous than 1 in 7 (BAPM 2022).

Current Y7 action plan and progress on the action plan from year 6 are as follows:

1) Current non-compliance with latest 2022 BAPM standards at consultant grade relates to the requirement for a 7th Consultant. Funding approved, appointment made with plan for 7th consultant due to start in Nov 2025. ODN informed of progress. However, on 14/07/2025 appointee declined post. Post was then readvertised, and a locum has been appointed and due to start within the next 3 months.

Included for the board:

- BAPM compliance action plan edited for Y7
- BAPM 2022 standards: https://hubble-live-assets.s3.eu-west-1.amazonaws.com/bapm/file_asset/file/1494/BAPM_Service_Quality_Standards_FINAL.pdf

Summary of key issues:

Patient Safety & Quality of Care
Non compliance with all BAPM 2022 recommendations related to neonatal medical staffing as well as CQC safe staffing requirements.

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	
	☒		☐		☐		☐		☐		☐		☐

Neonatal Nursing Workforce Summary 2024/25

East and North Hertfordshire Teaching NHS Trust

We remain compliant with BAPM nursing workforce standards, with over 70% of our nursing team holding QIS qualifications.

September 2024- September 2025

September	October	November	December	January	February	March	April	May	June	July	August	September
74%	73%	73%	73%	75%	75%	75%	75%	74%	74%	74%	74%	74%

Workforce data is collected quarterly to ensure on-going monitoring of our skill mix and compliance, and this information is routinely shared with the East of England network. This approach supports transparency, maintains high standards of neonatal care, and ensures our service continues to meet national requirements.

DIRECT PATIENT CARE - *DO NOT INCLUDE ANY NON-DIRECT PATIENT CARE WTE*				
Role Title	**Band**	**WTE Budget**	**WTE in post**	**Head Count in post**
Sister / Charge Nurse	7	3.22	3.22	5
Deputy Sister / Charge Nurse or Senior Staff Nurse	6	16.5	16.5	20
Staff Nurse QIS	5 QIS	11.3	11.3	13
Subtotal QIS Nurses		**31.02**	**31.02**	**38**
Staff Nurse NON QIS	5 NON QIS	12.6	9.85	11
Subtotal Non QIS Nurses		**12.6**	**9.85**	**11**
Subtotal - Registered Nurses		**43.62**	**40.87**	**49**
Nursing Associate	4	1	1	1
Trainee Nursing Associate	3	1	1	1
Nursery Nurse	4	7.53	7.53	8
Healthcare Support Worker	3	2.87	2	2
Subtotal - Other direct patient care staff		**11.4**	**10.53**	**11**
TOTAL DIRECT PATIENT CARE		**55.02**	**51.4**	**60**

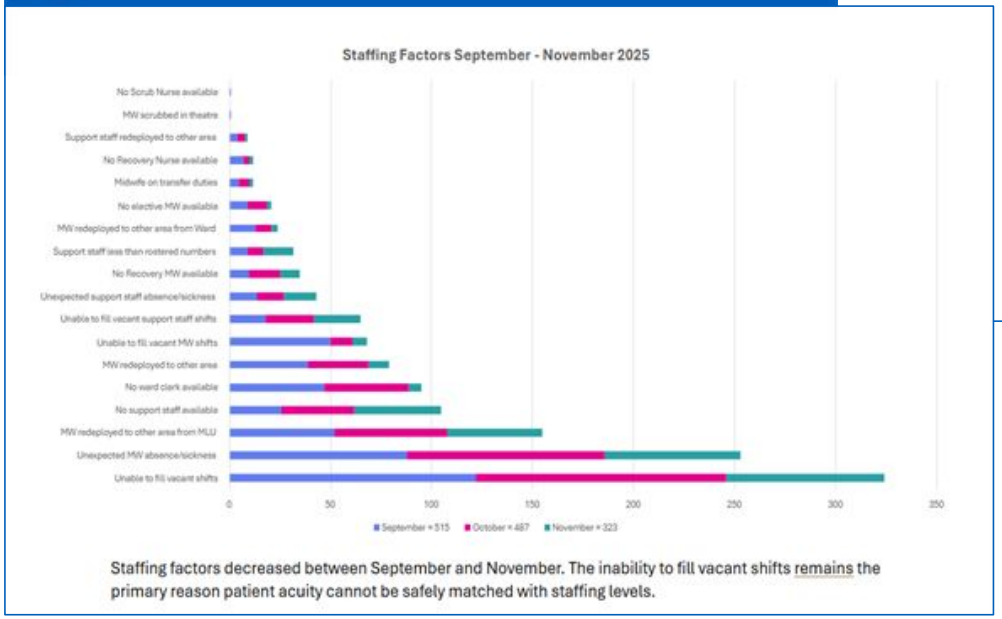
Safety Action 5

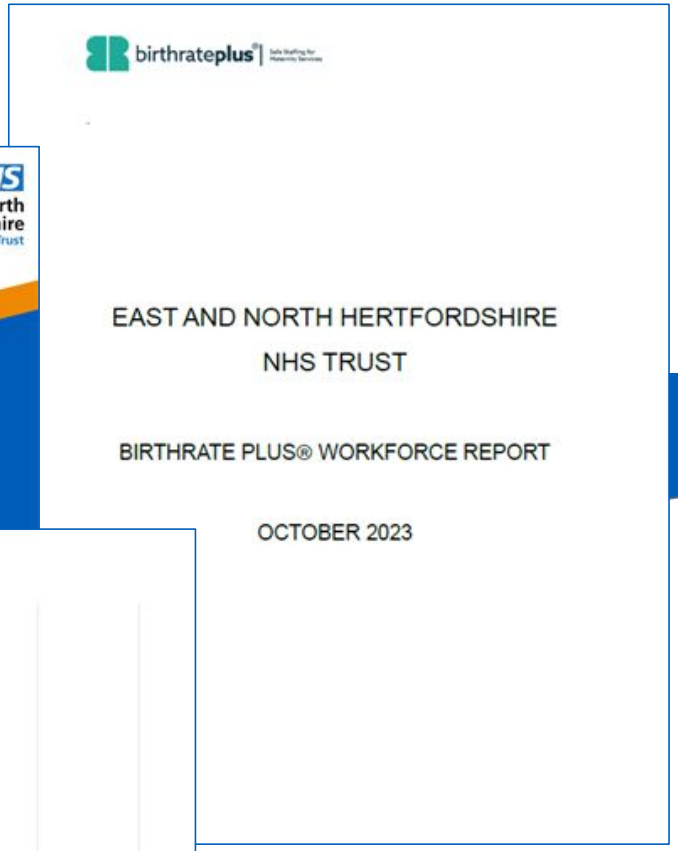
Midwifery Workforce

East and North Hertfordshire Teaching NHS Trust

ProudToBeENHT

Midwifery Workforce –
Examples of evidence





DOC ID: 673

NHS
East and North Hertfordshire Teaching
NHS Trust

NHS
East and North Hertfordshire
NHS Trust

Escalation and diversion policy for maternity

About this document	
Document ID	673 Version: 12
Full review due before	01 November 2027
Document type	Policy
Version type	Full review of document
Usage & applicability	For use Locally by clinical roles only at Lister Hospital

Summary

This policy is to support:

- Early identification and appropriate escalation of capacity and/or staffing concerns which have the potential to impact on the delivery of a safe maternity service
- A proactive rather than reactive response
- Concise and clear actions when:
  - Staffing levels and/or skill mix are insufficient to provide safe care to the people within the service
  - Midwifery Red Flags are triggered including but not exhaustive to:

1. Any instance of the CLU coordinator NOT being able to maintain supernumerary status at the start of each shift and/or at any time throughout the shift due to the need to provide one to one care. This is an immediate trigger for escalation to Maternity Matrons in the first instance and Senior Midwife on Call overnight and at weekends.
2. Any instance of a woman not being able to receive one to one care in labour
3. Local Capacity is insufficient to meet the demands of activity within the service
4. The ongoing management of any elective procedures (for example elective CS/ induction of labour (IOL)) is compromised by any of the above

Defined responsibilities, ensuring an appropriate response from key staff members to contribute to a reduction in escalation status

To be read in collaboration with Maternity Key Guideline: 826 Manager of the Day SoP

What you need to know about this version

Midwifery Workforce – Staffing Red Flag Report.

East and North Hertfordshire Teaching NHS Trust

September	CLU	MLU	Glouc	Dacre	Totals
Total	**19**	**8**	**16**	**48**	**91**
Delayed in activity	19	3	16	48	**86**
Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour		5			**5**
Coordinator unable to maintain supernumerary status - NOT providing 1:1 care					**0**
Coordinator unable to maintain supernumerary status - providing 1:1 care					0

October	CLU	MLU	Glouc	Dacre	Totals
Total	**25**	**6**	**11**	**38**	**80**
Delayed in activity	25		11	38	**74**
Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	5	1			**6**
Coordinator unable to maintain supernumerary status - NOT providing 1:1 care					**0**
Coordinator unable to maintain supernumerary status - providing 1:1 care					**0**

November	CLU	MLU	Glouc	Dacre	Totals
Total	**17**	**3**	**3**	**38**	**61**
Delayed in activity	17	3	3	38	**61**
Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour					**0**
Coordinator unable to maintain supernumerary status - NOT providing 1:1 care					**0**
Coordinator unable to maintain supernumerary status - providing 1:1 care					0

Delay in activity was the most significant red flag identified. All incidents relating to occasions where "Any occasion when 1 midwife is not able to provide continuous one- to-one care and support to a woman during established labour" were appropriately recognised, mitigated and enhanced with escalation actions undertaken. No red flags were raised in relation to the coordinator being unable to maintain supernumerary status. The reduction in red flags correlates with the improvement in staffing levels relative to acuity observed in November.

Safety Action 6

East and North Hertfordshire Teaching NHS Trust

Saving Babies Lives Care Bundle, Version 3.2 (SBLCBv3.2)

ProudToBeENHT

Requirements of Safety Action 6: SBLCBv3.2

East and North Hertfordshire Teaching NHS Trust

	Requirement	Lead	Actions/progress	Compliance status	Supporting evidence
6.1	Have you agreed with the ICB that Saving Babies' Lives Care Bundle, Version 3 is fully in place or will be in place, and can you evidence that the Trust Board have oversight of this assessment? **Where full implementation is not in place, compliance can still be achieved if the ICB confirms it is assured that all best endeavours – and sufficient progress – have been made towards full implementation, in line with the locally agreed improvement trajectory.**	Josie Reynolds (Head of Governance), Alessandro Sironi (Quality & Safety Manager)	25/11/2025: Planned Q2 review with LMNS Quality, Safety & Governance Lead. Expected evidence of full compliance and assurance to be taken to Trust QSC, December 2025 and Trust Board, January 2026. ENHT Board notification document to be sent between 17/02/2026 and 03/03/2026.		1. National SBLCBv3.2 live tool 2. Local SBLCBv3.2 spreadsheet 3. January 2026 Board presentation 4. Board Notification form
6.2	Have you continued the quarterly QI discussions between the Trust and the LMNS/ICB (as commissioner) from Year 6, and more specifically be able to demonstrate that at least two quarterly discussions have been held in Year 7 to track compliance with the care bundle? **These meetings must include:**	Josie Reynolds (Head of Governance), Alessandro Sironi (Quality & Safety Manager)	28/10/2025: Q1 review with LMNS Quality, Safety & Governance Lead (81% compliance confirmed by LMNS). 25/11/2025: Planned Q2 review with LMNS Quality, Safety & Governance Lead.		1. National SBLCBv3.2 live tool
	▪ **Initial agreement of a local improvement trajectory against these metrics for 25/26**, and subsequently reviews of progress against the agreed trajectory.	Josie Reynolds (Head of Governance), Alessandro Sironi (Quality & Safety Manager)	23/05/2025: Trajectory setting meeting with LMNS Quality, Safety & Governance Lead.		1. National SBLCBv3.2 live tool
	▪ Details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element.	Josie Reynolds (Head of Governance), Alessandro Sironi (Quality & Safety Manager)	Locally designed SBLCBv3.2 spreadsheet created to assist specialists in documenting compliance data to formulate trackers and graphical representation of performance. Opportunities for improvement represented visually enabling element leads to focus action planning. QI work evidenced to SBL SRO monthly.		1. Local SBLCBv3.2 spreadsheet
	▪ Evidence of sustained improvement where high levels of reliability have already been achieved.	Josie Reynolds (Head of Governance), Alessandro Sironi (Quality & Safety Manager)	Locally designed SBLCBv3.2 spreadsheet created to assist specialists in documenting compliance data to formulate trackers and graphical representation of performance. Sustainability evidenced through process charts demonstrating consistent compliance.		1. Local SBLCBv3.2 spreadsheet
	▪ Regular review of local themes and trends with regard to potential harms in each of the six elements.	Josie Reynolds (Head of Governance), Alessandro Sironi (Quality & Safety Manager)	Locally designed SBLCBv3.2 spreadsheet created to assist specialists in documenting compliance data to formulate trackers and graphical representation of performance. Themes and trends captured by charts and traingulated with dashboard variances and incidents were targets for QI work and where necessary escalated to the divisional risk register.		1. Local SBLCBv3.2 spreadsheet
	▪ Sharing of examples and evidence of continuous learning by individual Trusts with their local ICB, neighbouring Trusts and NHS Futures where appropriate.	Josie Reynolds (Head of Governance), Alessandro Sironi (Quality & Safety	Governance reporting via monthly Trust QSC, LMNS Quality & Safety (Q&S) and Shared Learning Forums.		1. LMNS Q&S Forum ENHT presentations 2. LMNS Shared Learning Forum ENHT presentations
6.3	**Following these meetings, has the LMNS determined that sufficient progress has been made towards implementing SBLCBv3, in line with the locally agreed improvement trajectory?**	Josie Reynolds (Head of Governance), Alessandro Sironi (Quality & Safety Manager)	28/10/2025: Q1 review with LMNS Quality, Safety & Governance Lead (81% compliance confirmed by LMNS). 25/11/2025: Planned Q2 review with LMNS Quality, Safety & Governance Lead		1. National SBLCBv3.2 live tool 2. Local SBLCBv3.2 spreadsheet 3. January 2026 Board presentation 4. Board Notification form

Recommend that compliance with this safety action has been achieved.

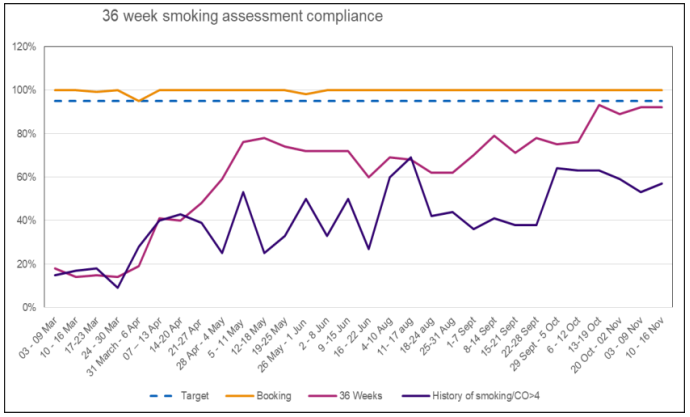
Evidence of Safety Action 6: LMNS Dashboard Review SBLCBv3.2 Implementation Progress

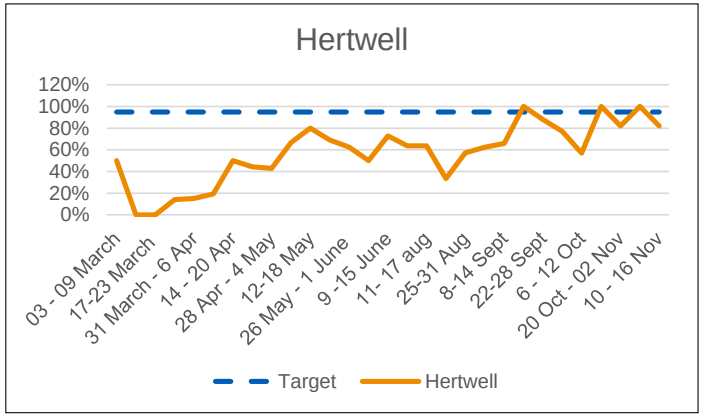
NHS East and North Hertfordshire Teaching NHS Trust

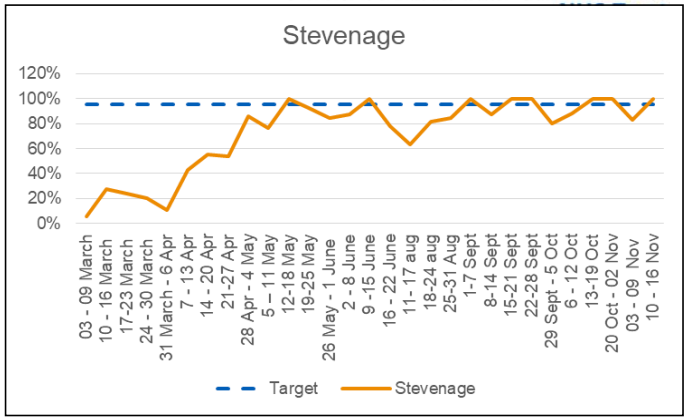
Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)
Element 1	Smoking in pregnancy	Partially implemented	90%	Partially implemented	80%
Element 2	Fetal growth restriction	Fully implemented	100%	Fully implemented	100%
Element 3	Reduced fetal movements	Fully implemented	100%	Fully implemented	100%
Element 4	Fetal monitoring in labour	Fully implemented	100%	Partially implemented	80%
Element 5	Preterm birth	Fully implemented	100%	Fully implemented	100%
Element 6	Diabetes	Partially implemented	83%	Partially implemented	83%
All Elements	TOTAL	Partially implemented	97%	Partially implemented	94%

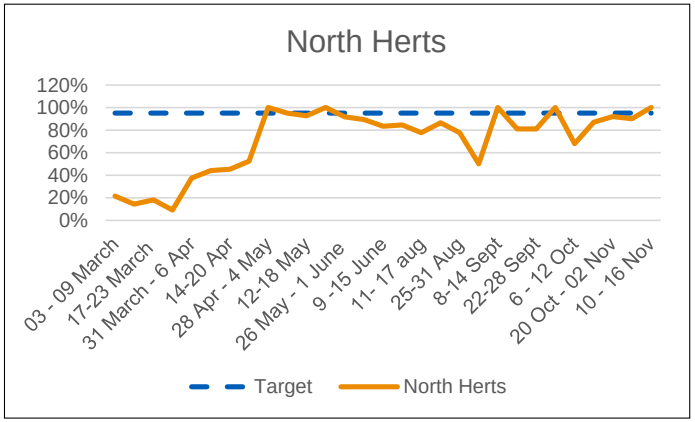
Element 1: Carbon Monoxide Screening QIP

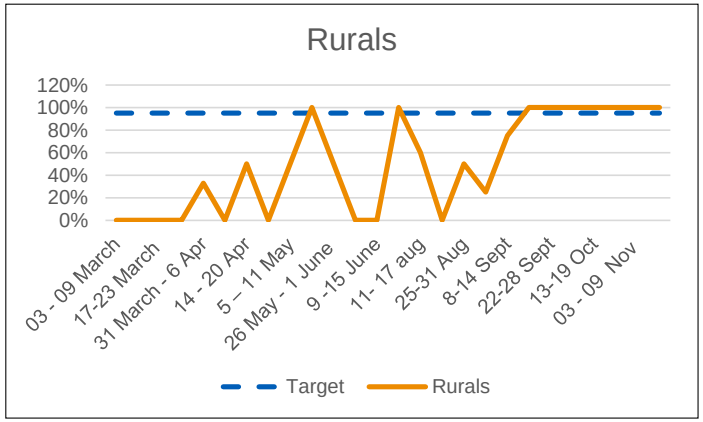
East and North Hertfordshire Teaching

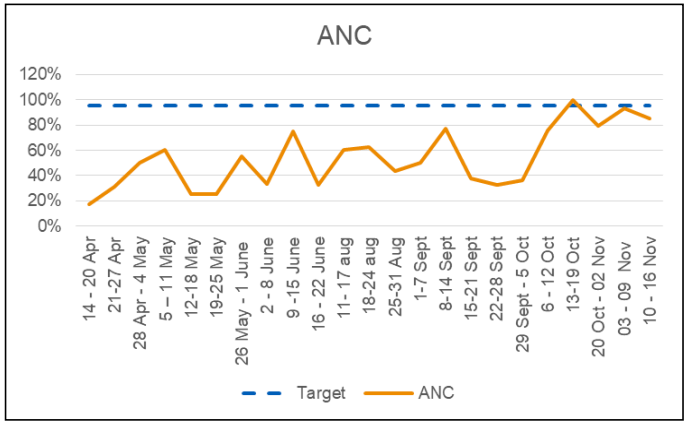












A Quality Improvement Project with Community and ANC midwives ran from March 2025 (ongoing) targeting barriers to carbon monoxide screening at 36/40 by staff training, digital support, weekly team meetings, progress reports and escalation pathways. A gradual and sustained improvement in compliance >90% was achieved by November 2025. Phase 2 of the project continues with focus on history of smoking/smoking status and screening at all antenatal appointments.

Element 2: Assessment of Fetal Growth Restriction (FGR)/the Small for Gestational Age (SGA) fetus

NHS East and North Hertfordshire Teaching NHS Trust

EAST AND NORTH HERTFORDSHIRE NHS TRUST - Expected Births: 5226

SGA/FGR Referral and Detection Rates

Definitions - see here

Birthweight centile: 10th 3rd Trust/Hospital

ALL RECORDS		Q1 Jan-Mar	Q2 Apr-Jun	Q3 Jul-Sep	Q4 Oct-Dec
1. Completed records	N	1,021	1,126	1,163	
	%	78.1	86.2	89.0	
2a. SGA at birth	n	44	36	39	
	%	4.3	3.2	3.4	
2b. SGA at birth, no AN EFW	n	4	6	3	
	%	9.1	16.7	7.7	
3a. AN detection of SGA < 3rd by EFW < 3rd	n	19	12	11	
	%	43.2	33.3	28.2	
3b. FP AN detection of SGA	n	12	12	13	
	%	1.2	1.1	1.2	
4. AN detection of SGA < 3rd by EFW < 10th	n	27	14	19	
	%	61.4	38.9	48.7	
5a. EFW < 3rd	n	31	24	24	
	%	3.0	2.1	2.1	
5b. EFW < 3rd and birth by 37+6	n	25	20	20	
	%	80.6	83.3	83.3	

24 |

Risk assessment algorithm for FGR/SGA and preterm birth

Hospital No: _____
Surname: _____
Forename: _____
Date of Birth: _____

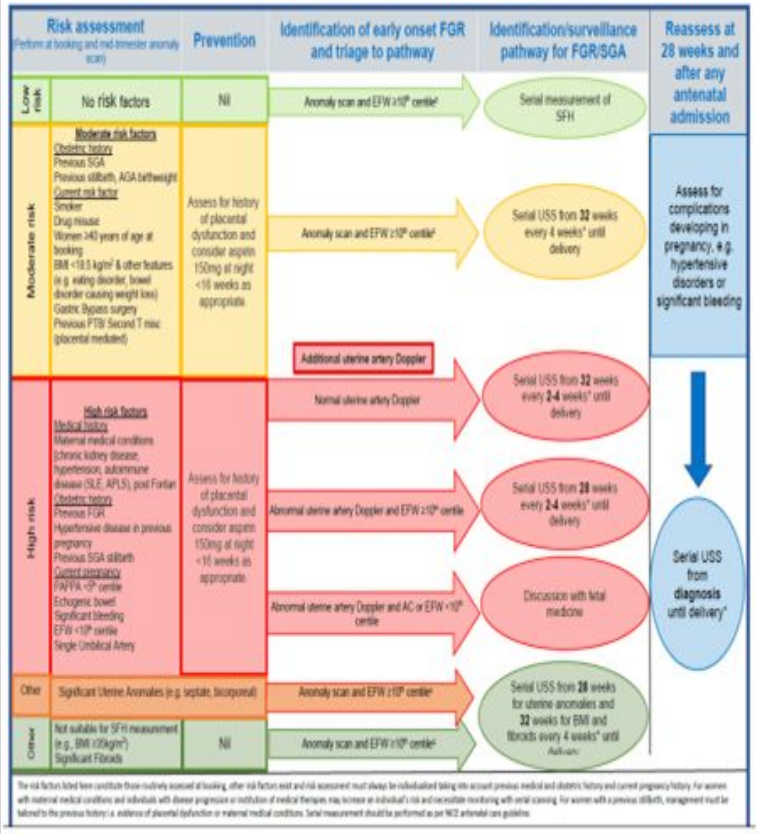
Comments

	Condition	Pathway	Signdat e	Gestation at scan	Pre-term birth pathway	CI & viability only
	Tick relevant referral and sign				Conditions requiring referral to PTB clinic	
Low Risk	No risk factors identified at booking ☐ FGR risk factors reviewed at each AN contact as cases can occur in women with no identifiable risk factors	SFH only Refer to algorithm, for low risk		NA	☐ Previous LLETZ (>1 LLETZ or LLETZ >10mm) ☐ Previous fully dilated Caesarean section	Single scan 18-22
Moderate Risk	Current risk factors for FGR identified ☐ Current smoker ☐ Drug misuse ☐ Women ≥ 40 at booking ☐ BMI <18.5 with other features (eating/bowel disorder) ☐ Gastric bypass surgery Obstetric History ☐ Previous SGA (3-10 centile) ☐ Previous AGA stillbirth ☐ Prev PTB/2nd trimester miscarriage(placental mediated)	Screening /surveillance pathway for FGR/SGA Refer to algorithm for moderate risk		32, 36, 40	☐ Uterine variant eg: unicornuate, bicornuate, septum, Asherman's syndrome ☐ Previous trachelectomy for cervical cancer	16, 20, 24 Bespoke plan
	Women unsuitable for SFH measurements ☐ BMI ≥ 35kg/m3 ☐ Fibroids ≥ 5cm interfering with SFH measurements			28,32,36,40		
High Risk	Medical History ☐ Diabetes ☐ Maternal medical indication CKD, HTN, Autoimmune conditions (SLE, APLS) Post fontan surgery			28,32,36,40	☐ Previous late miscarriage 16+0-23+6 (Spontaneous birth not IUD which is induced with misfi and miso)	16, 18, 20, 22, 24
	Obstetric History ☐ Previous FGR (< 3rd centile or SGA/AGA with abnormal dopplers) ☐ Previous SGA Stillbirth ☐ Previous PIH/PET ☐ Previous uterine rupture Current Pregnancy ☐ Echogenic Bowel ☐ Significant bleeding ☐ EFW <10th centile ☐ Low PAPP A ☐ Single umbilical artery	MUAD screening for early onset FGR and triage to pathway Refer to algorithm for screen +ve/-ve		(28) 32, 36, 40	☐ Spontaneous preterm birth 24+0-27+6 ☐ Previous spontaneous preterm birth 28+0-33+6 ☐ Previous rupture of membranes < 34+0 ☐ Previous use of cervical cerclage	16, 20, 24 Bespoke plan

Guideline: 2.21 The Assessment of Fetal Growth version 10.

Algorithm for using uterine artery Doppler

Guideline: 2.21 The Assessment of Fetal Growth, version 10.



Element 3: Reduced Fetal Movements leaflet and proforma

East and North Hertfordshire Teaching NHS Trust

Tommy's
The pregnancy and baby charity
NHS
English

Feeling your baby move is a sign that they are well

Most women and birthing people usually begin to feel their baby move between 16 and 24 weeks of pregnancy.

How often should my baby move?
There is no set number of normal movements.
From 16-24 weeks on you should feel the baby move more and more up until 32 weeks then stay roughly the same until you give birth.

If you think your baby's movements have slowed down, stopped or changed call your maternity unit or midwife immediately

The maternity unit is open 24 hours a day 7 days a week. Even at night. Don't wait.

Get to know your baby's movements
It is NOT TRUE that babies move less towards the end of pregnancy or in labo
You should CONTINUE to feel your baby move righ up to the time you into labour and whi you are in labour too

Why are my baby's movements important?
A reduction or change in a baby's movements can be an important warning sign that a baby is unwell.
Around half of women who had a stillbirth noticed their baby's movements had slowed down or stopped.

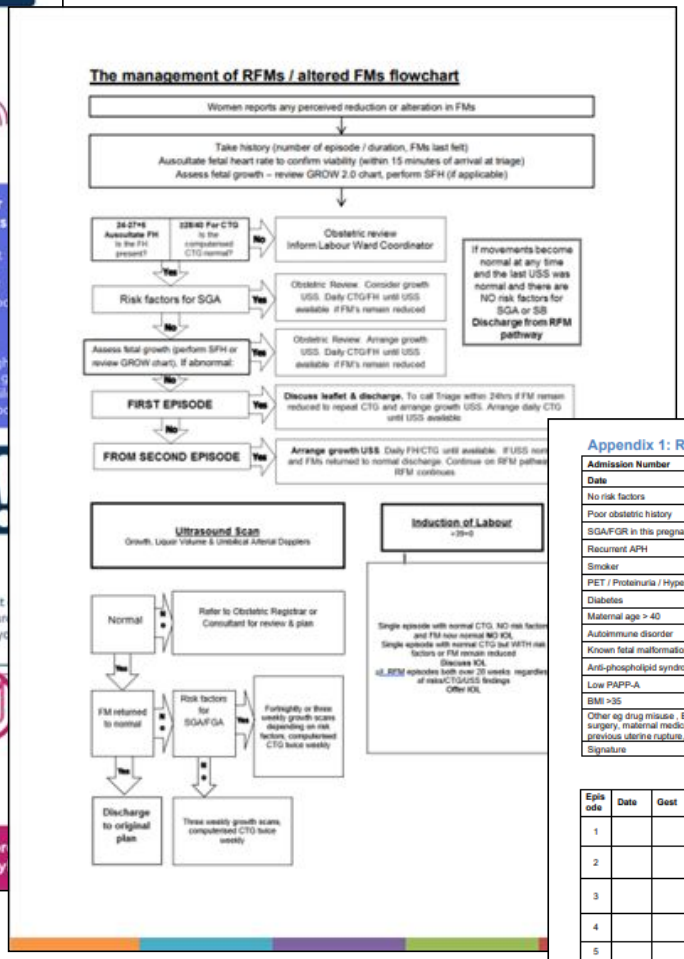
DO NOT WAIT
until the next day to get advice if you are worried about your baby's movements

- **Do not** put off getting in touch with a midwife or your maternity unit.
- **Do not worry about phoning.** It is important you talk to your maternity unit midwife for advice even if you are not sur It is very likely that they will want to see yo straight away.

What if my baby's movements reduce again after check up?
If, after your check up, you are still not happy with your baby's movements, you must contact either your maternity unit or midwife straight away, even if everything was normal last time.
NEVER HESITATE to contact your maternity unit or midwife for advice, no matter how many times this happens.

DO NOT USE HOME DOPPLERS
Do not use hand-held monitors, Dopplers or phone apps to check your baby's health.
Even if you hear a heartbeat, this does not mean your baby is well.

This leaflet is available in other languages: tommys.org/pregnancyresources
Find out mor tommys.org/pregnancy



The management of RFMs / altered FMs flowchart

Women reports any perceived reduction or alteration in FMs

Take history (number of episode / duration, FMs last felt)
Auscultate fetal heart rate to confirm viability (within 15 minutes of arrival at triage)
Assess fetal growth – review GROW 2.0 chart, perform SFH (if applicable)

Auscultate FH present? — No: Obstetric review Inform Labour Ward Coordinator
36/40 For CTG is the computerised CTG normal? — Yes

Risk factors for SGA — Yes: Obstetric Review Consider growth USS. Daily CTG/FH until USS available if FM's remain reduced
No

Assess fetal growth (perform SFH or review GROW chart). If abnormal: — Yes: Obstetric Review Arrange growth USS. Daily CTG/FH until USS available if FM's remain reduced
No

FIRST EPISODE — Yes: **Discuss leaflet & discharge.** To call Triage within 24hrs if FM remain reduced to repeat CTG and arrange growth USS. Arrange daily CTG until USS available
No

FROM SECOND EPISODE — Yes: **Arrange growth USS.** Daily FH/CTG until available. If USS norm and FMs returned to normal discharge. Continue on RFM pathwa RFM continues

If movements become normal at any time and the last USS was normal and there are NO risk factors for SGA or SB **Discharge from RFM pathway**

Ultrasound Scan
Growth, Liquor Volume & Umbilical Arterial Dopplers

Induction of Labour
>39+0

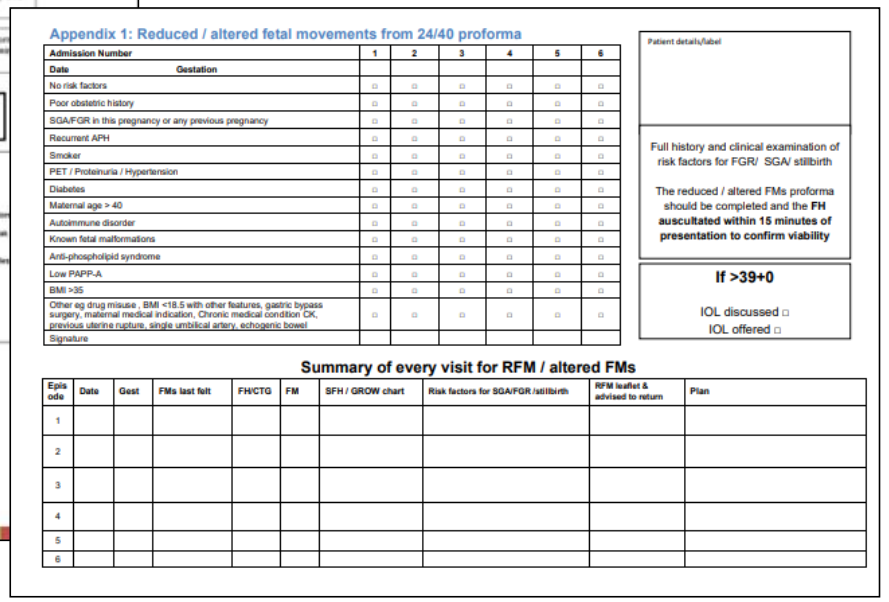
Normal — Refer to Obstetric Registrar or Consultant for review & plan

FM returned to normal — Risk factors for SGA/FGA — Fortnightly or three weekly growth scans depending on risk factors, computerised CTG twice weekly

Discharge to original plan

Three weekly growth scans, computerised CTG twice weekly

Single episode with normal CTG, NO risk factors and FM now normal NO IOL
Single episode with normal CTG but WITH risk factors or FM remain reduced
Discuss IOL
≥2 RFM episodes both over 20 weeks regardless of risks/CTG/USS findings
Offer IOL



Appendix 1: Reduced / altered fetal movements from 24/40 proforma

Admission Number	1	2	3	4	5	6
Date Gestation						
No risk factors	□	□	□	□	□	□
Poor obstetric history	□	□	□	□	□	□
SGA/FGR in this pregnancy or any previous pregnancy	□	□	□	□	□	□
Recurrent APH	□	□	□	□	□	□
Smoker	□	□	□	□	□	□
PET / Proteinuria / Hypertension	□	□	□	□	□	□
Diabetes	□	□	□	□	□	□
Maternal age > 40	□	□	□	□	□	□
Autoimmune disorder	□	□	□	□	□	□
Known fetal malformations	□	□	□	□	□	□
Anti-phospholipid syndrome	□	□	□	□	□	□
Low PAPP-A	□	□	□	□	□	□
BMI >35	□	□	□	□	□	□
Other eg drug misuse , BMI <18.5 with other features, gastric bypass surgery, maternal medical indication, Chronic medical condition CK, previous uterine rupture, single umbilical artery, echogenic bowel	□	□	□	□	□	□
Signature						

Patient details/label

Full history and clinical examination of risk factors for FGR/ SGA/ stillbirth

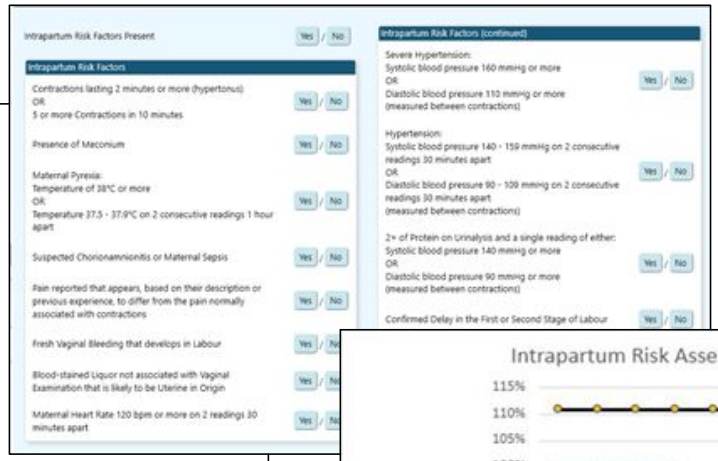
The reduced / altered FMs proforma should be completed and the **FH auscultated within 15 minutes of presentation to confirm viability**

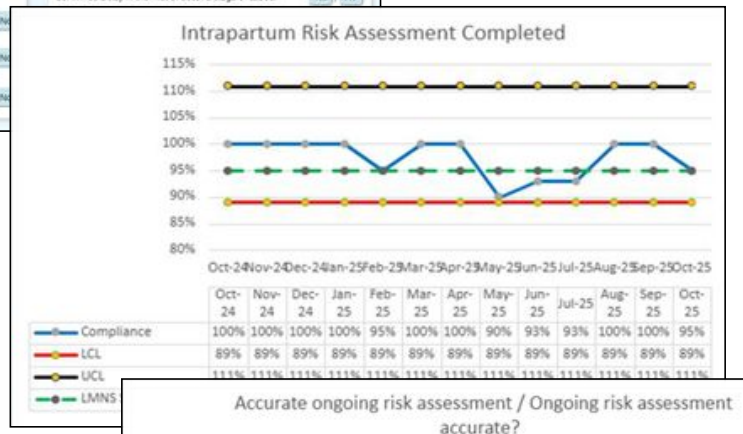
If >39+0
IOL discussed □
IOL offered □

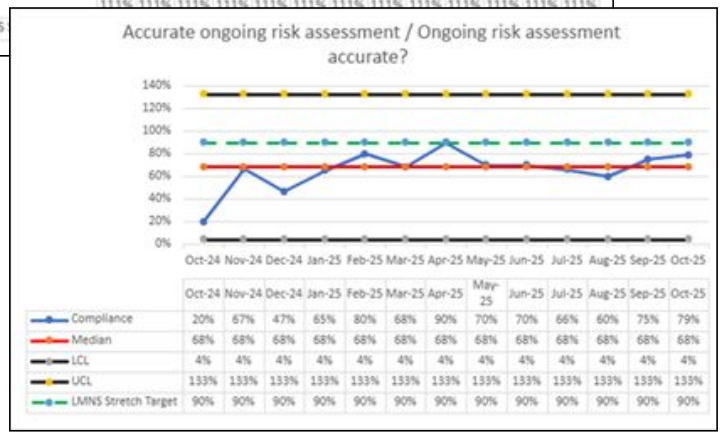
Summary of every visit for RFM / altered FMs

Episode	Date	Gest	FMs last felt	FH/CTG	FM	SFH / GROW chart	Risk factors for SGA/FGR /stillbirth	RFM leaflet & advised to return	Plan
1									
2									
3									
4									
5									
6									

Element 4: Fetal Monitoring







Initial Intrapartum Risk Assessment

Missed Risk Factors:

- Abnormal Dopplers were not identified during the initial intrapartum risk assessment on two occasions (May and July).
- VBAC was missed once in May's audit during the initial assessment but was correctly added in subsequent assessments.

Common Reasons for Non-Compliance in Ongoing Risk Assessment:

- Presence of an epidural
- Administration of oxytocin
- Delay in the first or second stage of labour

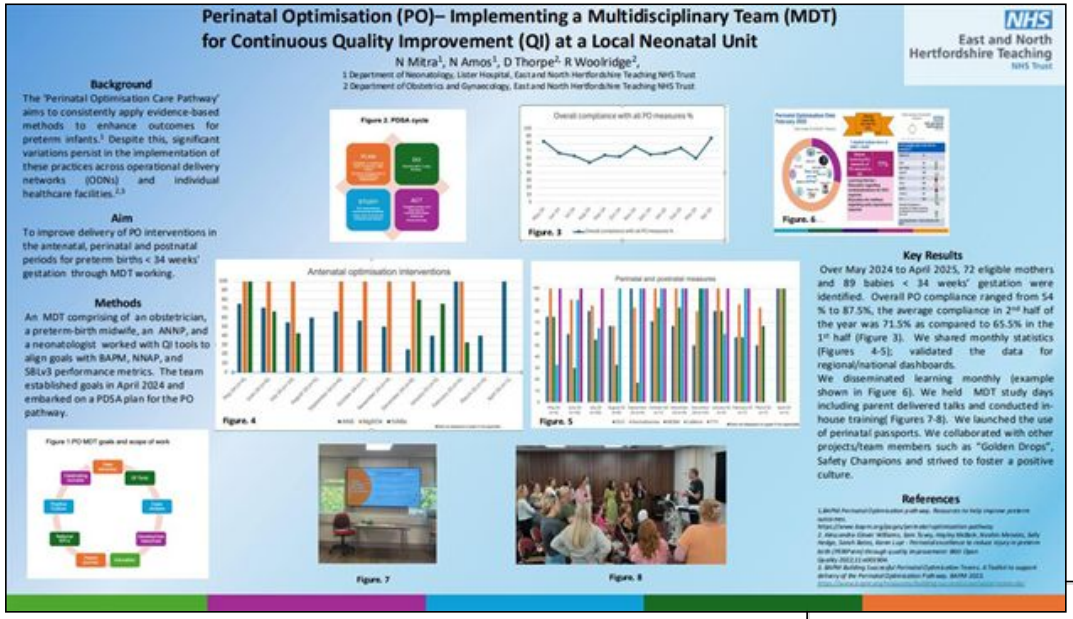
Actions Implemented:

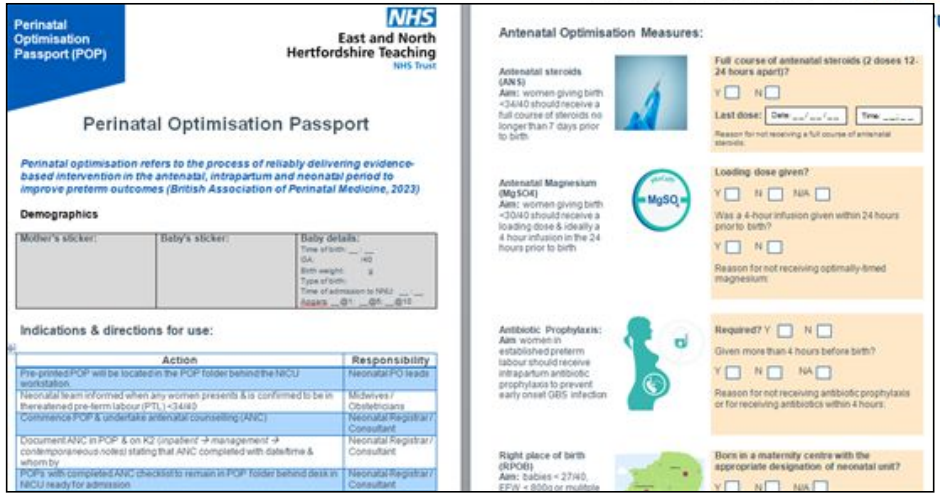
- Monthly audit findings are presented at the fetal monitoring study day.
- When recurring themes are identified, targeted interventions are introduced, including:
  - **Fetal Monitoring Focus Week** dedicated to improving risk assessment.
  - **Safety Bulletin** issued during CLU handover.
  - **Newsletter** reminders on completing risk assessments.
  - **One-to-One Support** for midwives returning from leave or commencing a new CLU rotation.
  - **Individual Feedback** for midwives identified through audit as not meeting compliance standards.

Assurance:

- Although initial intrapartum risk assessments did not achieve full compliance in all months, **100% of women received the correct method of fetal monitoring**.

Element 5: Pre-term Birth





Key
On target to stretch
between baseline & stretch
Below base line
No data- system wide

LMNS/ODN Q2 Optimisation Compliance Meeting data 30.7.25

			2025							
ENHT	LMNS target	Stretch Target	Jan	Feb	March	April	May	June	Mean @ 6 months	Rag rating
RPB	70	85	0	0	0	0	0	0	0	
AN steroids	40	55	40	86	33	100	75	86	70	
Mag sulph	80	90	X	100	X	X	X	X	100	
IV AB - RPQOG	TBC	TBC	X	X	X	X	X	X	X	
DCC	50	75	80	57	50	100	100	71	76	
<34 normothermia	65	85	100	86	80	100	100	100	94	
Early EBM	80	90	80	100	100	100	50	86	86	
Caff	80	95	X	100	X	X	X	X	100	

Element 6: Diabetes

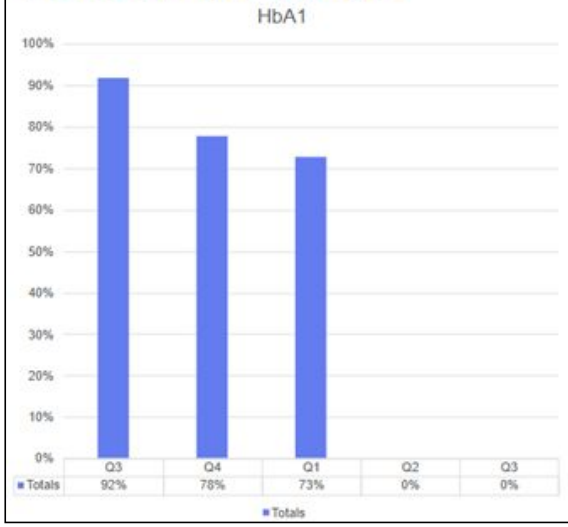
Divisional Risk #1154 (12) *risk to the safe care of women with Type 1 Diabetes due to the lack of access to their Specialist Diabetes Nurse Service and one-stop multi-disciplinary clinic during pregnancy* – **closed 19/12/2025.**

E6.2 = 100% of women were offered pregnancy specific HCL.

East and North Hertfordshire Teaching NHS Trust

A **Diabetes One-Stop Clinic** was launched on 13th November 2025 facilitating a multi-disciplinary approach to diabetes care with the attendance of a diabetes midwife, nurse, dietician, endocrinologist and obstetric consultant.

Element 6.4 - HBa1C



Q4 (Jan – Mar 2025)

Type 1:
78% (4/4) had HBa1c completed correctly.
Type 2:
77.8% (7/9) type 2 completed correctly.
1 woman had HBa1c testing at 22/40 and 36/40 weeks gestation. 1 woman had it done at 31/40 weeks gestation.

Q1 (Apr – June 2025)
73% (7/11) women HBa1c done correctly.
2 women miscarried; 1 woman had the testing at 31/40 weeks.
There was a gap in the woman's care between 13/01/25 and 26/03/25 (between 19-31/40). During this time, appointments were scheduled but the woman did not attend. The woman did not want to attend QEII Hospital (distance), but we were unaware of this. Appointments were sent out by post. The Diabetes lead midwife made referrals to Safeguarding, Mental Health and Autism Specialist in this time period, on 25/02/2025.
The Autism Specialist Midwife had x2 contacts in this time, but the woman declined this service.
This was escalated to the matron for Community and ANC to support in this time period.

DOC ID: 678

East and North Hertfordshire NHS Trust

Diabetes in Pregnancy- Preconception, Antenatal, Birth and Postnatal Management

About this document	
Document ID	678 **Version:** 19
Full review due before	01 January 2028
Document type	Guideline
Version type	Full review of document - various amendments/ complete re-write
Usage & applicability	For use clinical cross speciality by clinical roles only at (Lister Hospital)
Policy governing this document	DOC ID: 694, 685, 642 Policy title: Antenatal Care, Care in labour, Postnatal Care

Summary

This guideline is to ensure that clear evidence-based pathways for staff are available for the management of women with Diabetes in Pregnancy across all clinical settings at East and North Herts NHS Trust, in order to promote patient safety and optimise good outcomes for parents and baby.

What you need to know about this version

- Change to hourly BGL in labour for all women with diabetes (pre-existing or GDM) including those that birth on MLU
- Change to VRIII and substrate fluid in pregnancy
- Change to management of blood sugars in steroid administration
- Change to target blood glucose in labour
- Postnatal Referral to NHS Diabetes Prevention programme for women with Gestational diabetes
- Change to Blood Sugar targets with use of CGM

Safety Action 7

Maternity and Neonatal Voices Partnerships - MNVP

East and North Hertfordshire Teaching NHS Trust

ProudToBeENHT

Requirements of Safety Action 7: MNVP

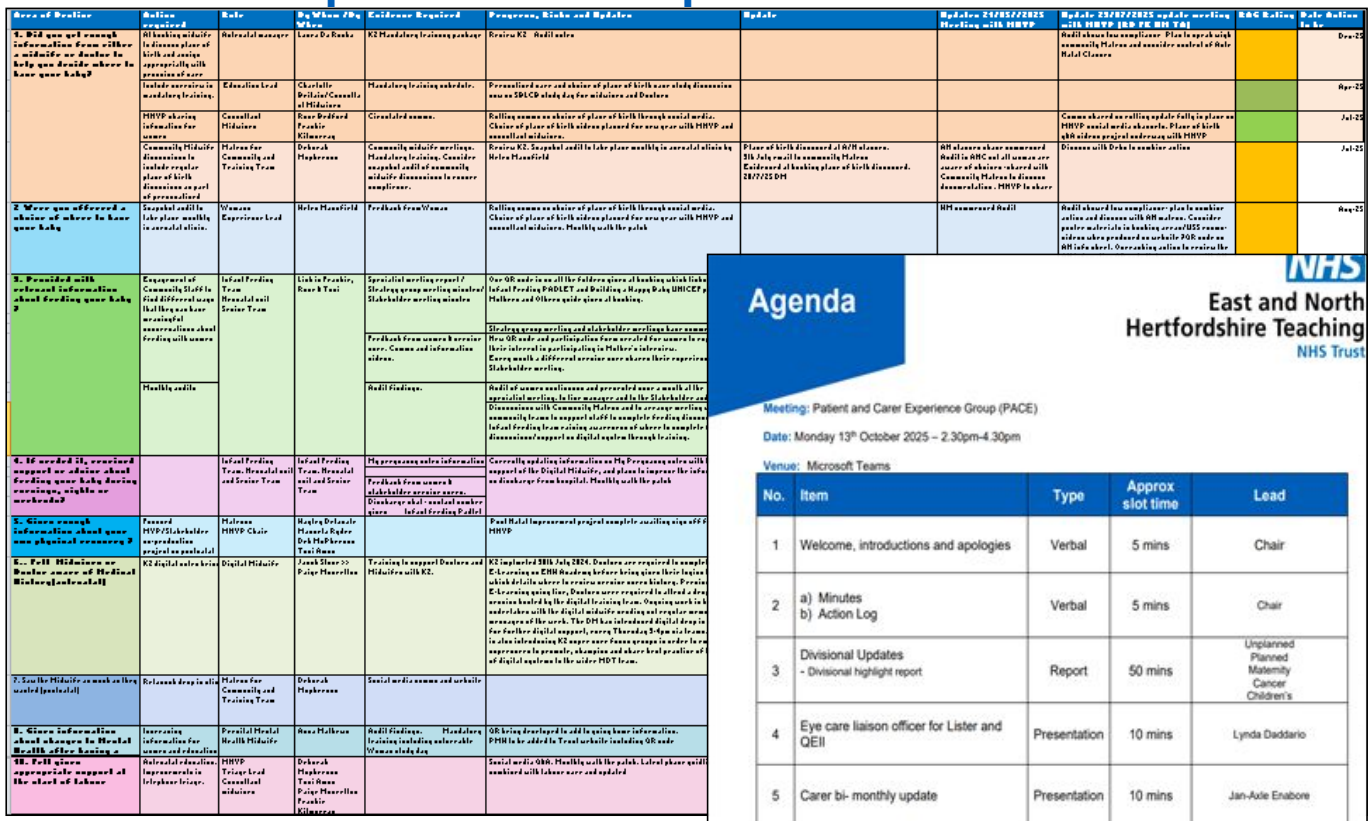
East and North Hertfordshire Teaching NHS Trust

	Requirement	Lead	Actions/progress	Update due	Compliance status	Supporting evidence
7.1	Evidence of an action plan coproduced following joint review of the annual CQC Maternity Survey free text data which CQC have confirmed is available to all trusts free of charge	Frankie Kilmurray (Consultant Midwife)	A CQC women's survey Improvement Plan has been coproduced with the MNVP and actions monitored throughout 2025.	01/04/26		1. CQC Women's Survey Improvement Plan 2025.
	• Has progress on the coproduced action above been shared with Safety Champions?	Frankie Kilmurray (Consultant Midwife), Josie Reynolds (Head of Governance)	A CQC women's survey Improvement Plan has been coproduced with the MNVP and actions monitored throughout 2025.	01/04/26		1. PACE Agenda. 2. PACE Meeting minutes. 3. MNVP Meeting minutes.
	• Has progress on the coproduced action above been shared with the LMNS?	Frankie Kilmurray (Consultant Midwife), Josie Reynolds (Head of Governance)	A CQC women's survey Improvement Plan has been coproduced with the MNVP and actions monitored throughout 2025.	01/04/26		1. PACE Agenda. 2. PACE Meeting minutes. 3. MNVP Meeting minutes. 4. Maternity & Neonatal Safety
7.2	Evidence of MNVP infrastructure being in place from your LMNS/ICB, including all of the following: •Job description for MNVP Lead •Contracts for service or grant agreements •Budget with allocated funds for IT, comms, engagement, training and administrative support •Local service user volunteer expenses policy including out of pocket expenses and childcare cost	Frankie Kilmurray (Consultant Midwife)	MNVP infrastructure contracts, policy agreements and budgets held by HWE LMNS. Accessible via Consultant Midwife.	01/04/26		1. LMNS Evidence of infrastructure
7.3	If the above evidence of an MNVP, commissioned and functioning as per national guidance, is unobtainable, there should be evidence that this has been escalated via the Perinatal Quality Surveillance Model (PQSM) at trust, ICB and regional level. If evidence for 7.2 cannot be provided, then the escalation route must be followed as stated above. Evidence requirements for 7.4 and 7.5 are only required if evidence has been provided for 7.2 **In this event, as long as this escalation has taken place the Trust will not be required to provide any further evidence as detailed below in 7.4 & 7.5 to meet compliance for MIS**	Josie Reynolds (Head of Governance)	Limited funding for MNVP representation. Maternity representation throughout 2025. Parent volunteers supporting neonatal representation (unfunded). Challenges in capacity and full representation as per national guidance escalated, via 'Route 1', through Divisional Governance to Trust Quality Surveillance Committee and Trust Board via the Perinatal Quality Surveillance Model (PQSM) tool and to the LMNS Quality & Safety Forum and to the ICB. October 2025 Update: an additional 6 hours per week funded for Maternity representative.	01/04/26		1. Perinatal Quality Surveillance Model (PQSM) tool as part of the monthly Perinatal Quality Assurance reports. 2. MNVP Route 1 Action Plan.
7.4	showing the MNVP Lead as a quorate member of trust governance, quality, and safety meetings at speciality/divisional/directorate level including all of the following: •Safety champion meetings •Maternity business and governance •Neonatal business and governance •PMRT review meeting •Patient safety meeting •Guideline committee	Frankie Kilmurray (Consultant Midwife), Josie Reynolds (Head of Governance)	MNVP invited to join Maternity & Neonatal Safety Champions June 2025. MNVP invited to Care Group 9 Governance meetings August 2025. Awaiting training materials from LMNS for supportive induction prior to attendance at local PMRT meetings.	01/04/26		1. Maternity & Neonatal Safety Champions meeting ToR. 2. Maternity & Neonatal Safety Champions poster. 2. Care Group 9/Speciality meeting ToR.
7.5	Evidence of MNVP engagement with local community groups and charities prioritising hearing from those experiencing the worst outcomes, as per the LMNS Equity & Equality plan.	Frankie Kilmurray (Consultant Midwife)	Women's and neonatal engagement throughout 2025.	01/04/26		1. Evidence of MNVP engagement folder > walk the patch > 15 steps > Lister MNVP monthly meetings.

Recommend that compliance with this safety action has been achieved.

Evidence for Safety Action 7:
CQC Women's Survey Action Plan, Presentation to PACE & Fifteen Steps Neonatal Report 2025

NHS
East and North Hertfordshire Teaching NHS Trust



Agenda

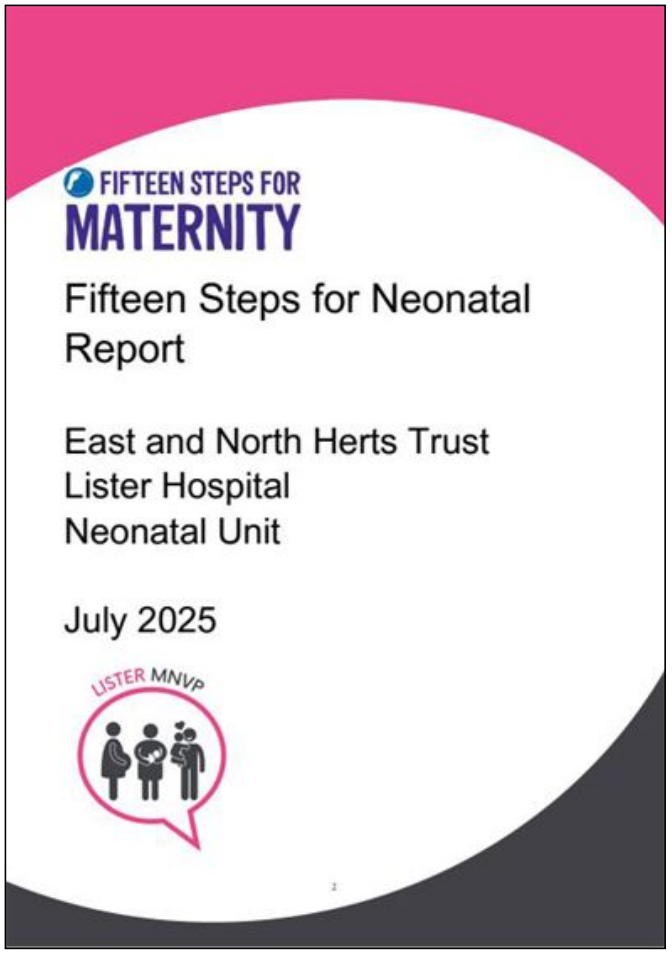
NHS East and North Hertfordshire Teaching NHS Trust

Meeting: Patient and Carer Experience Group (PACE)

Date: Monday 13th October 2025 – 2.30pm-4.30pm

Venue: Microsoft Teams

No.	Item	Type	Approx slot time	Lead
1	Welcome, introductions and apologies	Verbal	5 mins	Chair
2	a) Minutes b) Action Log	Verbal	5 mins	Chair
3	Divisional Updates - Divisional highlight report	Report	50 mins	Unplanned Planned Maternity Cancer Children's
4	Eye care liaison officer for Lister and QEII	Presentation	10 mins	Lynda Daddario
5	Carer bi- monthly update	Presentation	10 mins	Jan-Axle Enabore
6	Unplanned Care – Patient Story	Story	10 mins	Unplanned Care representative
7	CQC National survey action plan updates - Maternity service	Action Plan	10 mins	Helen Mansfield



Safety Action 8

Education, Training and Development

East and North Hertfordshire Teaching NHS Trust

ProudToBeENHT

Requirements of Safety Action 8: Education

East and North Hertfordshire Teaching NHS Trust

	Requirement	Actions/progress	Compliance status
Can you demonstrate the following attendance at the end of the 12 month period 1 December 2023 to 30th November 2024:			
Fetal monitoring and surveillance (in the antenatal and intrapartum period) training			
8.1	90% of obstetric consultants	>90% compliance has been achieved for the reporting period.	
8.2	90% of all other obstetric doctors (commencing with the organisation prior to 1 July 2025) contributing to the obstetric rota (without the continuous presence of an additional resident tier obstetric doctor)	>90% compliance has been achieved for the reporting period.	
8.3	For rotational medical staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	>90% compliance has been achieved for the reporting period.	
8.4	90% of midwives (including midwifery managers and matrons), community midwives, birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives) and maternity theatre midwives who also work outside of theatres	>90% compliance has been achieved for the reporting period.	
Maternity emergencies and multiprofessional training			
8.5	90% of obstetric consultants	>90% compliance has been achieved for the reporting period.	
8.6	90% of all other obstetric doctors (commencing with the organisation prior to 1 July 2025) including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows,foundation year doctors and GP trainees contributing to the obstetric rota	>90% compliance has been achieved for the reporting period.	
8.7	For rotational obstetric staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	>90% compliance has been achieved for the reporting period.	
8.8	90% of midwives (including midwifery managers and matrons), community midwives, birth centre midwives (working in co-located and standalone birth centres) and bank/agency midwives	>90% compliance has been achieved for the reporting period.	
8.9	90% of maternity support workers and health care assistants (to be included in the maternity skill drills as a minimum).	>90% compliance has been achieved for the reporting period.	
8.10	90% of obstetric anaesthetic consultants and autonomously practising obstetric anaesthetic doctors	>90% compliance has been achieved for the reporting period.	
8.11	90% of all other obstetric anaesthetic doctors (commencing with the organisation prior to 1 July 2025) including any anaesthetists in training, SAS and LED doctors who contribute to the obstetric anaesthetic on-call rota. This requirement is supported by the RCoA and OAA.	>90% compliance has been achieved for the reporting period.	
8.12	For rotational anaesthetic staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	>90% compliance has been achieved for the reporting period.	
8.13	Can you demonstrate that at least one multidisciplinary emergency scenario is conducted in any clinical area or at point of care during the whole MIS reporting period? This should not be a simulation suite.	There is an in-situ skills and drills rotational programme in place.	
Neonatal resuscitation training			
8.15	90% of neonatal Consultants or Paediatric consultants covering neonatal units	>90% compliance has been achieved for the reporting period.	
8.16	90% of neonatal junior doctors (commencing with the organisation prior to 1 July 2025) who attend any births	>90% compliance has been achieved for the reporting period.	
8.17	For rotational medical staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	>90% compliance has been achieved for the reporting period.	

Recommend that compliance with this safety action has been achieved.

Final Training Compliance:
As of 24 November 2025

East and North Hertfordshire Teaching NHS Trust

Staff group	PROMPT	Fetal Monitoring	NBLS	SBL
Obstetric Consultants	95.8%	95.8%		95.7%
Gynae Consultants				
Obstetric Doctors (ST2+)	95.5%	95.5%		90.9%
FYs / GP rotation	90.9%			100%
Obstetric Anaesthetic Consultants	95.5%			
Obstetric Anaesthetic Doctors	100%			
Midwives	93.2%	95.4%	93.2%	94.1%
Maternity Support Workers	97.7%			
Neonatal Nurses			98%	
Neonatal Doctors			100%	
Average	**95.5%**	**95.6%**	**97.1%**	**95.2%**

Safety Action 9

Safety Champions

East and North Hertfordshire Teaching NHS Trust

ProudToBeENHT

Requirements of Safety Action 9: Safety Champions

East and North Hertfordshire Teaching NHS Trust

	Requirement	Lead	Actions/progress	Update due	Compliance status	Supporting evidence
9.1	Are all Trust requirements of the Perinatal Quality Surveillance Model (PQSM) fully embedded with evidence of working towards the revised Perinatal Quality Oversight Model (PQOM) when published in 2025? (including the following)	Josie Reynolds, Head of Governance	The Perinatal Quality Surveillance Model (PQSM) tool is presented as part of the Perinatal Quality Assurance report on a monthly basis to Trust QSC and Trust Board. A review of Divisional, Trust and regional-level reporting is taking place to capture all elements of the Perinatal Quality Oversight Model (PQOM) as published, August 2025.	Q3 January 2026		1. Perinatal Quality Assurance reports, Dec 2024 - Nov 2025.
9.2	Has a non-executive director (NED) has been appointed and is visibly working with the Board safety champion (BSC)?	Amanda Rowley, Director of Midwifery	A Maternity Non-executive director (NED) has been appointed and works closely with the Maternity and Neonatal Safety Champions as well as the Board-level Safety Champions.	Q3 January 2026		1. Perinatal Quality Assurance reports, Dec 2024 - Nov 2025. 2. Maternity & Neonatal Safety Champions (MNSC) meetings minutes July 2025 - Nov 2025. 3. MNSC Poster with inclusion of MNVP.
9.3	Is a review of maternity and neonatal quality and safety undertaken by the Trust Board (or an appropriate trust committee with delegated responsibility) using a minimum data set as outlined in the PQSM at least quarterly, and presented by a	Amanda Rowley, Director of Midwifery	The Perinatal Quality Surveillance Model (PQSM) tool is presented alongside the maternity dashboard and Integrated Performance Review (IPR) as part of the Perinatal Quality Assurance report on a monthly basis to Trust QSC and Trust Board.	Q3 January 2026		1. Perinatal Quality Assurance reports, Dec 2024 - Nov 2025.
9.4	Does the regular review include a review of thematic learning informed by PSIRF, training compliance, minimum staffing in maternity and neonatal units, and service user voice and staff feedback and review of the culture survey or equivalent?	Amanda Rowley, Director of Midwifery	The Perinatal Quality Surveillance Model (PQSM) tool, including maternity and neonatal staffing, service user and staff feedback and culture survey results, maternity dashboard and Integrated Performance Review (IPR) are presented as part of the Perinatal Quality Assurance report on a monthly basis to Trust QSC and Trust Board. Thematic learning from incidents in line with the Patient Safety Incident Repsonse Framework (PSIRF) is shared at the Patient Safety Escalation and Review Panel (PSERP) Oversight meetings, in the presence of the	Q3 January 2026		1. Perinatal Quality Assurance reports, Dec 2024 - Nov 2025. 2. PSERP Oversight reports Dec 2024 - Nov 2025.
9.5	Do you have evidence of collaboration with the local maternity and neonatal system LMNS/ODN/ICB lead, showing evidence of shared learning and how Trust-level intelligence is being escalated to ensure early action and support for areas of concern or need, in line with the PQSM.	Josie Reynolds, Head of Governance, Amanda Rowley, Director of Midwifery	The Perinatal Quality Surveillance Model (PQSM) tool, Regional Perinatal Oversight Group (RPOG) and learning from incidents (including MNSI/PSII) are shared at LMNS Quality & Safety and Shared Learning Forums.	Q3 January 2026		1. Perinatal Quality Assurance reports, Dec 2024 - Nov 2025. 2. Regional Perinatal Oversight Group (RPOG) report with outcome measures, Dec 2024 - Nov 2025. 3. PSERP Oversight reports Dec 2024 - Nov 2025.
9.7	Is the Trust's claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level Safety Champions at a Trust level (Board or directorate) meeting quarterly (at least twice in the MIS reporting period)?	Josie Reynolds, Head of Governance, Amanda Rowley, Director of Midwifery	The Q3 & Q4 2024/25 and Q1 & Q2 2025/26 Claims Incidents and Compliants Triangulation (Scorecard) Report were discussed at the Maternity & Neonatal Safety Champions meetings and presented to the Trust Quality & Safety Committee during the reporting period.	Q3 January 2026		1. Quarterly Claims, Incidents & Complaints (CIC) Report (Q3 & Q4 2024, Q1 & 2 2025).
9.8	Evidence in the Trust Board minutes that Board Safety Champion(s) and the MNVP lead (where infrastructure is in place as per SA7) are meeting with the Perinatal leadership team at a minimum of bi-monthly (a minimum of three in the reporting period) and that any support required of the Trust Board has been identified and is being implemented.	Amanda Rowley, Director of Midwifery	The MNVP representative was welcomed as a member of the Maternity & Neonatal Safety Champions and has been an active member of the monthly meetings with the perinatal leadership team during the reporting period. Members of the perinatal leadership have also attended MNVP monthly meetings during the reporting period.	Q3 January 2026		1. Maternity & Neonatal Safety Champions (MNSC) meetings minutes July 2025 - Nov 2025. 2. MNSC Poster with inclusion of MNVP. 3. MNVP monthly meetings minutes.
9.9	Evidence in the Trust Board (or an appropriate Trust committee with delegated responsibility) minutes that progress with the maternity and neonatal culture improvement plan is being monitored and any identified support being considered and implemented.	Kate Fruin, Operational Lead, Amanda Rowley, Director of Midwifery	The Cultural Improvement plan, learning and actions have been shared with the MDT and at Trust level. A divisional EDI board took place monthly during the reporting period.	Q3 January 2026		1. Divisional Cutlural Improvement Plan 2. Divisional EDI Group meeting minutes. 2. Perinatal Cultural Improvement Plan.

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Recommend that compliance with this safety action has been achieved.

Evidence of Safety Action 9: Safety Champions

East and North Hertfordshire Teaching NHS Trust

Safety Champions attending:	Josie Reynolds, Vanessa Tingey, Nina Janda, Inibiokun Orangun, Debbie Collins. Theresa Murphy carried out her own visit - see comments below.	Safety Champion walkabout on 02/10/2025
Area visited	**Concerns escalated with actions in progress / yet to be resolved**	**Actions in place or to be completed**
Gloucester Ward	Well staffed today because they had been provided with help from Infant Feeding midwife.	This is the second occasion where Victoria Hollyman has been praised for her willingness to help out.
Gloucester Ward	There have been ward trransfers without appropriate handover.	
Gloucester Ward	Midwife - Cannot always receive help within short staffed. She wanted to ensure the service was safe when admitting and discharging. One midwife is sometimes having to admit 2 women at once. Women are sometimes being admitted at the same time from different areas and those areas are not aware of each other needing to admit women - who has oversight of this. When NIPE midwife on leave there is no-one to cover.	Suggestion that one person should have oversight of all women being admitted from a variety of areas (MLU, CLU, recovery). Gloucester midwife suggested one person should be responsible for discharging to allow midwives to do other work. This would improve flow by avoiding bed blocking by women being discharged in a timely manner, allowing women to be admitted sooner. Irene suggested a dedicated MSW to do discharges. Better planning needed for NIPE midwife when on leave.
Gloucester Ward	A student and an SHO - There are a lot of patients for one doctor to see (15-16). Some extra help for flow would be useful.	Inibiokun Orangun suggested to the doctors that they should attend the ward for 30 minutes after huddle each morning for 30 minutes. This would help improve flow.
Gloucester Ward	Midwife 2 - talked about staffing issues. She said that her last 3 shifts last week only had 2 midwives on duty. She explained it is unsettling to go onto a shift knowing there is low staff and that she worries about not being able to provide good caare becaue of this. She also mentioned the difficulties when women are being admitted at the same time from a variety of areas. Some of her days, she finds herself doing admissions and discharges all day and very little time to care for the women and their babies. Midwife 2 [illegible] might be n[illegible] always rec[illegible] Midwife 2 [illegible]	Suggestion that women are not admitted during handovers where possible. Consider a dedicated midwife for discharges only.
Gloucester Ward	MSW - Co[illegible] She felt ba[illegible] sometimes[illegible] She felt pe[illegible]	
Theatres	Both Theat[illegible] always agr[illegible] There is qu[illegible] Concern th[illegible] midwives r[illegible] safety and[illegible] It was comm[illegible] RHD.	
Theatres	Cons Anae[illegible] how to mak[illegible] communic[illegible]	
Additional observations		
Two people mentioned that it would be useful[illegible] in women being admitted		

NHS East and North Hertfordshire NHS Trust

Maternity and Neonatal Safety Champions Meeting (MS Teams)
Terms of Reference

Duration: 1 hr **Time:** Regular for staff familiarity and on the second or fourth Tuesday of the month to ensure attendance by the Non-Executive Director

Chair: Josie Reynolds, Lead Midwife for Quality Assurance, Governance & Compliance (Maternity Safety Champion)

*Chair can be any member of the Maternity and Neonatal Safety Champions

Quorum: Chair and two other Safety Champions which must include a member of the MDT.

Frequency: Monthly **Venue:** Remote, MS Teams

Attendees:
- Vanessa Harris, Neonatal Governance and Health & Safety Lead (Neonatal Safety Champion)
- Nipa Mitra, Consultant Neonatologist (Neonatal Safety Champion)
- Nina Janda, Non-Executive Director (Non-Executive Safety Champion)
- Mona Modi, Consultant Obstetrician and Gynaecologist and Service Lead (Obstetric Safety Champion)
- Representative from the Maternity and Neonatal Voices Partnership
- Theresa Murphy, Chief Nurse
- Head of Midwifery / Deputy Head of Midwifery
- Representative from the Risk, Quality and Governance Team
- Representative from the Education, Training and Development Team
- Consultant Midwife
- Professional Midwifery Advocate
- Obstetric Representative
- Anaesthetic Representative

Key Objectives:
- To provide an alternative forum to the monthly Safety Champion walkabouts for staff and service-user group(s) to raise patient safety concerns
- Communicate and share knowledge, safety updates, ideas or learning
- Identify opportunities for improvement
- Escalate concerns, challenges and barriers in implementing improvements
- Evidence good governance structure for accessibility to raise patient and staff safety concerns and feed in to governance forums at Divisional and Trust level, as per safety action 9 of the Maternity Incentive Scheme

Inputs:
- Monthly Maternity and Neonatal Safety Champion walkabout updates
- Escalation updates from various governance forums, divisional and Trust level
- Action Log
- Incident, Audit and Quality Improvement Following Up Learning Feedback
- Feedback from stakeholders, staff and service-user group(s)

Outputs:
- Not to be minuted, as it will be an open forum for all staff to speak up in a psychologically safe environment
- Updated action log
- Escalate operational / resource issues or any risks identified
- Monthly update to Women's and Children's Directorate Board
- Monthly update to Divisional Speciality meeting
- Update to QSC and TWNSQC

Evidence of Safety Action 9: Claims Scorecard

NHS
East and North Hertfordshire Teaching
NHS Trust

Obstetric Claims, Incidents and Complaints Triangulation report: Q1 and Q2 2025/26

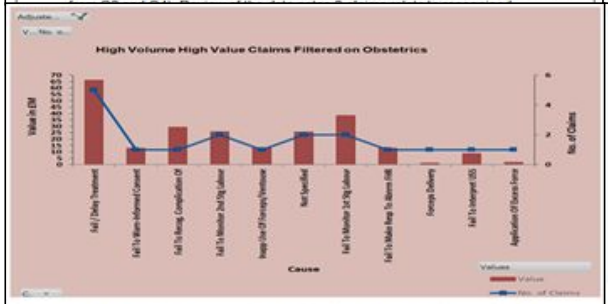
Summary of Obstetric Claims, Incidents and Complaints for Q1 and 2:

Incidents, claims and complaints activity; (pages 2 – 4):

- High levels of incident reporting seen across Obstetrics (and Trust-wide), 98% of Obstetrics incidents reported were low / no harm
- Marginal increase in new complaints received compared to previous reporting period. Of the 25 received, 7 were dealt with at a local level (an increase from previous).
- Reduction in PALS concerns received. All of the concerns received are now closed and 48% of them were resolved with a call directly from the service.
- Increase in new clinical claims received (14). Nine of the new claims had previously been subject to Trust investigation as patient safety incidents.
- NHS Resolution benchmarking data shows that in 2024/25, ENHT received more new clinical claims relating to Obstetrics than the average acute Trust with a maternity unit.
- One new Early Notification claim reported to NHSR (also PSii / MNSI case).
- No new Obstetrics related Inquests.

Incidents, claims and complaint's themes; (pages 5 – 9):

- Reduction in IOL incidents reported
- Increase in staff shortage incidents reported
- Medical care and nursing/midwifery care remain highest category of formal complaint received in line with previous months
- Reduction in new complaints received relating to communication with medical staff/nursing staff.
- Failure or delay in diagnosis and 'failure or 'delay in treatment' are consistently the most common causes of new claims, in line with previous reports.
- 3 of the claims concerned missed diagnosis during pregnancy - GBS, polymicrogyria and extensive PE
- A number of claims are linked to theme 'recognised complication of surgical procedure and/or recognised complication of treatment' (which is a continued theme



The above graph provides more details analysis of the scorecard, with specific focus on the red zone. It highlights that the top themes for obstetric claims by value are *fail/delay treatment* followed by *failure to monitor 1st stage of labour* and *failure to recognise complication of treatment*. The theme of Delay and complications of treatment is aligned with local ENHTT data.

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East and North Hertfordshire Teaching
NHS Trust

Claims and Complaints closed (pages 12 – 13):

- 25 complaints closed; 8 of which were upheld, 8 not upheld and 9 partially upheld
- 5 claims closed, of which 4 were settled (increase from previous reporting period).
- Total damages paid £106,941 (reduction from previous report)
- 2 of the settled claims relate to delay in diagnosing and removing RPOC.

Good care and compliments

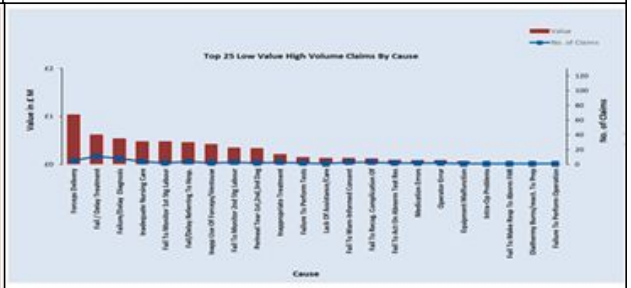
- W&C division accounts for highest proportion of good care events reported
- Increasing number of compliments received

Triangulation report: Q1 and Q2 2025/26

1. **Monthly reporting**

The focus of this report is Q1 and Q2 (2025/26) data however some of the graphs show data from previous rolling 12 months for context. Figure 1 below shows incidents reported within the Obstetrics specialty over the previous rolling 12 months. Of the 1,760 obstetric incidents reported across Q1 and Q2, 98.9% of them were low or no harm levels. There were no incidents graded severe harm or death. This is both in line with Trust-wide reporting levels and consistent with previous reports. It reflects the positive shift that has been seen with improved incident reporting but that harm levels have not also increased. There were on average 293 incidents reported each month across Q1 and Q2, an increase on the previous year.

Figure 1



Further review of the blue zone as seen in the graph above shows that the top themes by volume are *fail/delay treatment* followed by *fail/delay diagnosis* and *forceps delivery*. The Theme of Delay is aligned with local ENHTT data. However, it is important to acknowledge that *forceps delivery* as a cause for claim has not continued – it spiked in 2021/22 with 4 cases and since 2023, ENHTT have only had 2 claims linked to this cause code.

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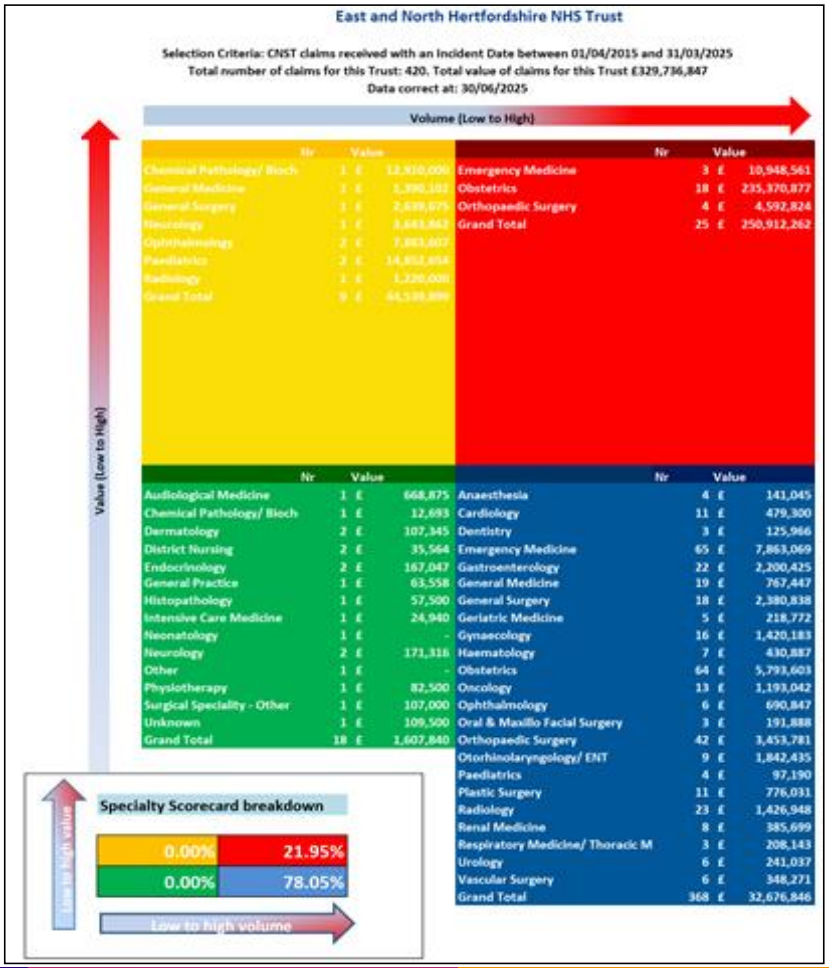


Safety Action 10

East and North Hertfordshire Teaching NHS Trust

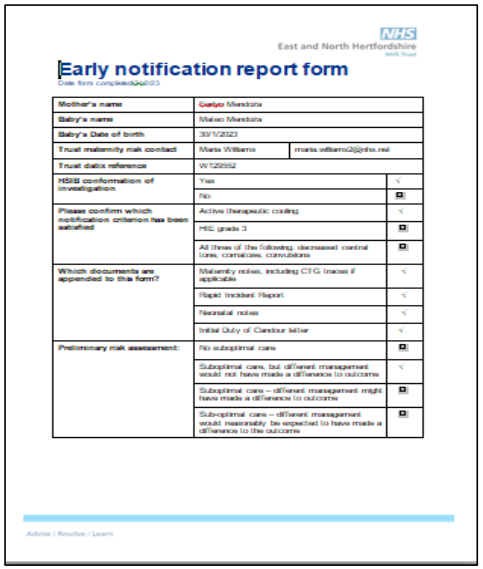
Maternity and Neonatal Safety Investigations (MNSI - formerly HSIB)

ProudToBeENHT

Requirements of Safety Action 10: MNSI

East and North Hertfordshire Teaching NHS Trust

	Requirement	Actions/progress	Compliance status	Supporting evidence
10.1	Have you reported of all qualifying cases to MNSI from 1 December 2024 until 30 November 2025.	This has been achieved for all cases meeting referral criteria throughout the reporting period. A failsafe process is in place between the maternity governance, neonatal, bereavement, ED and corporate patient safety and legal teams.		1. MNSI Case Referral Spreadsheet. 2. MNSI (PSII) report slides.
10.2	Have you reported of all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 1 December 2024 until 30 November 2025.	This has been achieved for all cases that have been accepted by MNSI for investigation throughout the reporting period.		1. MNSI Case Referral Spreadsheet. 2. Completed EN Report Form (MI-039128). 3. Completed EN Report Form (MI -04515).
10.3	Have all eligible families received information on the role of MNSI and NHS Resolution's EN scheme in a format that is accessible to them?	This has been achieved for all cases meeting referral criteria throughout the reporting period. Where there are cases of care transferred to another Trust, liaison with families is managed between our maternity governance, neonatal family support and repatriation lead nurse and neonatal units and governance teams at other Trusts.		1. MNSI Case Referral Spreadsheet. 2. Completed Duty of Candour (DoC) letter to family (MI-039128). 3. Completed Duty of Candour (DoC) letter to family (MI -04515). 4. Patient Information Leaflet.
10.5	Has there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.	This has been achieved for all cases meeting referral criteria throughout the reporting period.		1. MNSI Case Referral Spreadsheet. 2. Completed Duty of Candour (DoC) letter to family (MI-039128). 2. Completed Duty of Candour (DoC) letter to family (MI -04515).
10.9	Have you completed the field on the Claims reporting wizard (CMS), whether families have been informed of NHS Resolution's involvement, completion of this will also be monitored, and externally validated.	The CMS wizard has been completed for every MNSI case during the reporting period and this has been externally validated. A quarterly Claims, Incidents and Compliants triangulation report is also presented through maternity governance structures and up to Trust QSC and Trust Board.		1. Quarterly Claims, Incidents & Complaints (CIC) Report (Q3 & Q4 2024, Q1 & 2 2025).


East and North Hertfordshire NHS Trust

Early notification report form

Mother's name	Carlyn Mankuna	
Baby's name	Mateo Mankuna	
Baby's Date of birth	30/1/2023	
Trust maternity risk contact	Maria Williams	maria.williams2@nhs.net
Trust datix reference	W129892	
HSIB confirmation of investigation	Yes	√
	No	☐
Please confirm which notification criterion has been satisfied	Active therapeutic cooling	√
	HIE grade 3	☐
	All three of the following: decreased cardiac tone, comatose, convulsions	☐
Which documents are appended to this form?	Maternity notes, including CTG traces if applicable	√
	Rapid Incident Report	√
	Neonatal notes	√
	Initial Duty of Candour letter	√
Preliminary risk assessment:	No suboptimal care	☐
	Suboptimal care, but different management would not have made a difference to outcome	√
	Suboptimal care – different management might have made a difference to outcome	☐
	Sub-optimal care – different management would reasonably be expected to have made a difference to the outcome	☐

Advise / Resolve / Learn

MNSI Maternity & Newborn Safety Investigations

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Recommend that compliance with this safety action has been achieved.

Board Declaration

MIS Year 7

East and North Hertfordshire Teaching NHS Trust

ProudToBeENHT

Board Declaration Form – Safety action summary sheet

East and North Hertfordshire Teaching NHS Trust

Action No.	Maternity safety action	Action met? (Y/N)
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	Yes
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	Yes
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?	Yes
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	Yes
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Yes
6	Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?	Yes
7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users	Yes
8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?	Yes
9	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?	Yes
10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) (known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023) and to NHS Resolution's Early Notification (EN) Scheme?	Yes

Completed Board Declaration Form

East and North Hertfordshire Teaching NHS Trust

Maternity Incentive Scheme - Year 7 Board declaration form

Trust name	East and North Hertfordshire NHS Trust
Trust code	T569

All electronic signatures must also be uploaded. Documents which have not been signed will not be accepted.

	Safety actions	Action plan	Funds requested	Validations
Q1 NPMRT	Yes		-	
Q2 MSDS	Yes		-	
Q3 Transitional care	Yes		-	
Q4 Clinical workforce planning	Yes		-	
Q5 Midwifery workforce planning	Yes		-	
Q6 SBL care bundle	Yes		-	
Q7 Patient feedback	Yes		-	
Q8 In-house training	Yes		-	
Q9 Safety Champions	Yes		-	
Q10 EN scheme	Yes		-	
Total safety actions	**10**	**-**		

Board

East and North Hertfordshire Teaching NHS Trust

Meeting	Trust Board		**Agenda Item**	12	
Report title	Patient Experience Annual Report 2024/25		**Meeting Date**	14 January 2026	
Author	Complaints Manager, Patient Experience Team				
Responsible Director	Chief Nurse				
Purpose	**Assurance**	☐	**Approval/Decision**	☐	
	Discussion	☐	**For information only**	☒	
Proposed assurance level (*only needed for assurance papers*)	**Substantial assurance**	☐	**Reasonable assurance**	☐	
	Partial assurance	☐	**Minimal assurance**	☐	

Executive assurance rationale:

Summary of key issues:

To inform the Committee of the Trust's annual position with regards to patient experience feedback, complaints and PALS activity, alongside the work of the Volunteers, Admiral Nurse and Carers work.

The report highlight's themes from patient feedback and Friends and Family Test (FFT) surveys, alongside complaints, Patient Advice and Liaison Service (PALS) and compliments, highlighting any areas of best practice and concern.

Key highlights:

- An increase in the number of volunteers and volunteer activities to support patients
- Development of the Forget-Me-Not dementia volunteer service
- Development and growth in the Carer Experience Service volunteer programme
- PALS – a significant rise in the number of enquiries from the previous year
- Complaints - the Trust has seen an 18% rise in the number of complaints in 2024-2025

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**	☐

CQC domains: Caring, Effective, Responsiveness

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*

Team capacity still remains on the risk register for the Complaints Department and PALS department

Report previously considered at & date(s):

PACE - August 2025

Recommendation	The Board/Committee is asked to note the report

To be trusted to provide consistently outstanding care and exemplary service

Introduction

This annual report provides high level assurance that service users and their families are effectively listened to, and staff are supported to respond to feedback in a timely, effective manner. 2024-25 has seen a continuation of the strengthening and improvement of the arrangements in place within the Trust to respond to feedback and engage and involve people who access our all services provided by the Trust.

1. Volunteers supporting improvements in patient and carer experience

Over the past 12 months, the voluntary services team have received increasing numbers of new volunteer applications. We currently have over 400 active volunteers, with a further 50 in process undergoing their on-boarding checks. With this high demand for our service, we have made some changes to the application and onboarding process for new volunteers that have streamlined the way we work, made information clearer and more accessible for our volunteers and reduced the admin load on the team. Volunteers are now being inducted more quickly and matched to the best role for them and for the Trust. To better manage the volunteers we have, as well as our annual budget, we are taking a new approach to applications. We are instigating 2 recruitment rounds per year, in line with other trusts this year. We will have our open application periods in September and March each year. This will enable us to plan our uniform budget, focus on the applications during these periods and focus on volunteer retention for the rest of the year. Volunteer retention is hugely important for us to retain the best people and provide consistent support for staff, patients and carers.

FFT Surveys
This year we have created a new role to support the collection of patient feedback across the Trust. We have been trialling a volunteer undertaking FFT surveys with patients in the Urgent Treatment Centre (UTC) and the Emergency Department to reach their 20-survey target each month. We are hoping to roll this out across the Trust with more volunteers. We have kindly received funding from the Hospitals' Charity for 4 tablet devices so that we can directly input the surveys and alleviate the administrative task for staff members who input the survey data.

Wheelchair training
We are currently exploring the possibility of having our front of house volunteers (Hospital Guides) getting trained to push patients in wheelchairs to their outpatient appointments. With increasing demand for the portering service each day, we have received feedback from our volunteers that patients waiting at reception for a porter can often be waiting for long periods and worry about missing their appointments. We have undertaken risk assessments, written the standard operating procedure (SOP) and are awaiting approval before arranging training with the moving and handling team. We hope that this will greatly improve the patient experience and provide a valuable service for those that need it.

Therapy dogs
Our therapy dog team has been growing this year, enabling us to provide a unique companionship service to more patients. We are also receiving more referrals from departments requesting a therapy dog to visit patients who would benefit. During the week of Halloween, our dog team and their human owners, raised over £170 for the Hospitals' Charity. We now have 16 therapy dogs, with 3 more that have enquired.

Volunteering for Health
This year (and for the next year), we have been part of a national project funded by NHS England to provide volunteer 'passports' whereby volunteers from one organisation would be able to come and volunteer with us without going through the lengthy recruitment process, as the 'passport' would prove that they

have already fulfilled the necessary requirements at their previous trust. This project looks to standardise the recruitment process across organisations both with the NHS and local community volunteering services. The project is in the early stages, and updates with be provided as the year progresses.

Community volunteers
Our **Sew Dementia** and **Knit and Natter** groups continue to provide us with donated blankets, fiddle mats (for patients with dementia), dolls, frailty cushions, baby hats and gowns for the mortuary, and many other handmade items to benefit our patients.
Over the festive period, we booked a variety of **musical groups** to sing to patients and visitors on the wards and at the main reception area. These included gospel choirs, school groups, individual musicians, bands and many more that brought joy and festive spirit to Lister.
During the Easter period, we invited a **mobile farm** to Lister where staff, patients, visitors and volunteers got to cuddle various animals (miniature chickens, pygmy goats, rabbits and guinea pigs). We received some really good feedback for this event and were thrilled to bring such a positive experience to all those who visited.

Upcoming projects for 2025/2026
There are some exciting projects in the pipeline that are currently in discussion with various stakeholders that we hope will provide value to our patients and help staff to improve the wellbeing of their patients through referrals. These projects pose some logistical challenges that are currently being worked through.

Craft club – The team are in talks with some local artists who are keen to provide crafting sessions to our patients who are in care for long periods of time or who may be struggling to adjust to hospital life. These sessions will enable staff to refer patients who they feel would benefit from these activities, to get away from the ward for an hour and socialise with other patients whilst also making something to take away with them.

Hairdresser – The team have been asked throughout the year by staff if there are any hairdressers that could attend the wards and provide haircuts to our patients who may need some extra support, or who have been a patient for a long time and would really benefit from a trim. Unfortunately, this has not been possible to provide but discussions are in place with a hairdresser who would be willing to provide services at a discounted rate, and the logistics of this are being considered. This is likely to be a popular service due to the number of enquiries received and would greatly improve patient wellbeing during their time of admission.

Children's services volunteers – The trust has been approached by the Children's team to request volunteers to support staff in Children's ED and on the wards. It is hoped this role will be up and running in the coming weeks/months following the recent recruitment round. The volunteers will provide valuable assistance to patients and staff by providing comfort breaks for parents, guiding patients to X-ray/other departments as needed, keeping play areas tidy and any other errands that will help the staff.

3. Admiral Nurse

The Admiral Nurse, the Forget me Not Dementia Volunteer Service Coordinator, and the Elderly Care Consultant Clinician for dementia and delirium, collectively lead the dementia service for the Trust. A wide range of support is available to people living with dementia and their families during a hospital stay. This includes direct patient and carer contact with the team, advice, training, role modelling best practice and continual dementia awareness raising for staff in all roles.

Forget Me Not Dementia volunteer team has continued to grow from a team of 23 to 30 offering support to people living with dementia during a hospital stay 5 days a week. The service is supported by health and social care students from North Herts College. One of our student volunteers has gone on to gaining employment at Lister as a Clinical Support worker.

"The service is highly valued by patients and their families.
Thank you so much, it was a really big help for my dad, it meant it took away that bit of the clinical side of hospital. Chris was lovely and made such a difference"

Additional activities for patients
Funding from ENHT charity means that we are able to provide a music for memory dance session once a week for a year. This brings so much joy to patients, their families and staff as well as an excellent way to enable bed or chair-based exercise.

Dementia Best Practice award
The dementia team continue to notice and reward best practice. Staff across 7 wards were recognised for kind and compassionate care, communication with family members, achieving best practice standards in clinical excellence audit, implementing recommended changes, and role modelling best practice and proactively seeking to meet the specific needs.

Dementia Grab Packs

Provided to wards to make sure they have all the information they need, easily available to enable easy referral, to dementia service and to enable delivery of best practice, person centred dementia care.

Plates and cutlery to improve mealtime experience
Research shows that providing coloured plates and adapted cutely enable people with dementia to maintain independence for

longer with eating and drinking. These have been introduced initially to our elderly care and stroke wards with a plan for roll out.

Person Centred Care

To help ensure that we really get know people with dementia with their own unique needs, we have introduced an easy to use poster which means that all staff caring for the patient will, for example, call them by their preferred name or know how they like to drink their tea or coffee.

4. Carers

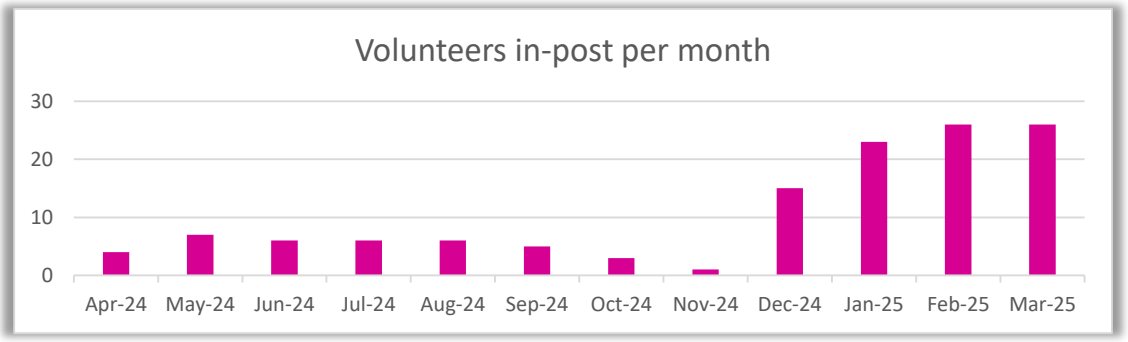
Over the past year, our commitment to enhancing carer engagement has yielded significant progress and valuable outcomes. We are excited to share the highlights of our carer-focused initiatives for this year.

Carer Experience Volunteers

This financial year (April 2024 – March 2025), we are proud to report a significant resurgence in our Carer Experience Service volunteer programme, growing to 26 active volunteers by March 2025.

Despite a challenging period in summer 2024, during which volunteer activity was significantly reduced, we successfully rebuilt our volunteer base through strong partnerships with North Hertfordshire College and Oaklands College. This strategic collaboration enabled a robust recruitment campaign throughout autumn and winter 2024, resulting in a vibrant new cohort of volunteers who began their roles in January 2025.

Number of volunteers

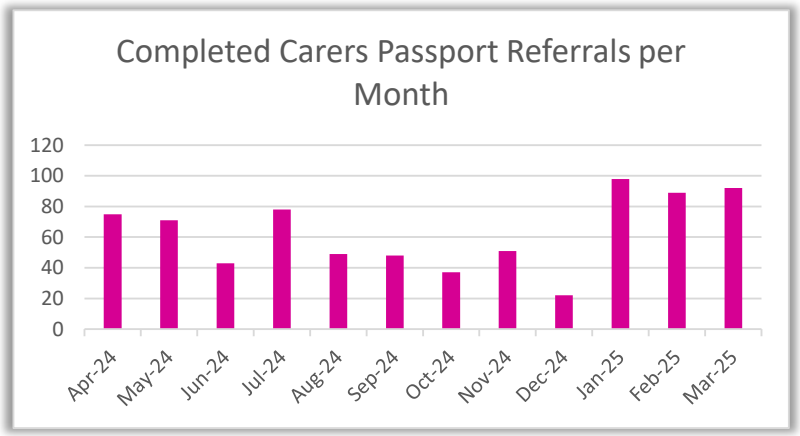


Our current volunteer team includes:

- 21 Carer Support Volunteers, 3 of whom also contribute as Carer Companion Volunteers
- 7 Carer Admin Volunteers, all of whom also serve as Carer In-reach Volunteers

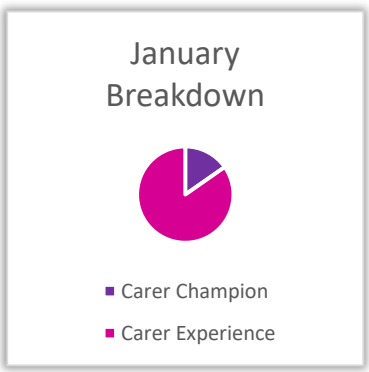
Number of referrals

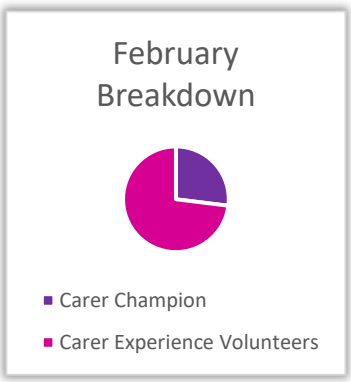
With this renewed capacity, we have not only recovered our previous levels of monthly referrals, but have surpassed them, reflecting both the dedication of our volunteers and the improved processes for identifying carers across the Trust.

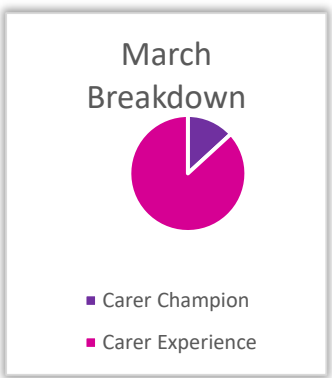


Working with Champions Our now meeting the providing support, and **Carer in Each Area** volunteers are consistently growing demand, timely, meaningful working closely with Carer Champions in each clinical area to ensure no carer is left unsupported.

From January to March 2025, we began tracking volunteer interactions to better understand and evaluate their impact. Early indicators show a strong and growing contribution that continues to enhance the overall carer experience.







Carer champions – help carers complete carer passport referrals locally.

Carer experience volunteers - all of our volunteers that support our patient's families both in person and from a distance through in reach calls.

Themes from Carer Surveys
Introduced in July 2024, carer surveys became mandatory for inpatient areas in November 2024, with a minimum requirement of 10 surveys per ward. Compliance is steadily improving across all ward areas, with a focus on continuous improvement in capturing valuable feedback from carers. Since the increase in volunteer capacity, our volunteers have played an integral role in gathering feedback through the carer surveys, enhancing our ability to accurately assess and address carer needs.

Top 3 Focus Areas Identified from Survey Responses:

1. **Carer Support**
   Ensuring carers are provided with essential support such as breaks, parking concessions, snack bags, and/or a carer's bed.
2. **Supportive Tools**
   Promoting the use of the **Carer's Passport** and the pink **"Supporting Carer"** lanyards to enhance carer recognition and support.
3. **Care Updates**
   Ensuring that carers receive regular and timely updates on the care and treatment plans of the person they are supporting.

Quarterly Carers Forum
In our first full year of hosting quarterly Carer Forums, we experienced amazing engagement from carers. These forums have been consistently well-received, with strong participation and valuable feedback. We are grateful for the ongoing support from Carers in Hertfordshire, which has been instrumental in facilitating these sessions.

As part of our commitment to transparency and improvement, we continue to work on a "You Said, We Did" table on the carer's public page, highlighting the top 3 themes from each hospital site. This will showcase the key areas of feedback and the actions we have taken in response.

Comfort for Carers Appeal
With support from our hospital charity, we launched the Comfort for Carers Appeal in March 2025. A bed testing day invited carers to bring and test beds, with input gathered from clinical staff and the public on the most suitable options for unexpected hospital stays.

This collaborative effort is guiding our plans to ensure every clinical area is equipped with a dedicated carer bed, enhancing comfort and support across the Trust. We are currently raising money for new beds to be added to the trust's small selection of existing ones.

Next Steps for 2025-2026

- Update Carers Public Page - Refresh the content on the carers public page to ensure it provides up-to-date information and resources for carers
- Expand Support to Outpatient Areas and Increase Service Capacity - Extend carer support services to outpatient areas and increase service capacity to cover the New QEII Hospital and Hertford County Hospital, with Mount Vernon Hospital already supported by Lynda Jackson
- Revamp Carer Corner in Lister - Redesign and enhance the Carer Corner at Lister Hospital to provide a more welcoming and supportive space for carers
- Fundraise for Carer Beds - Continue fundraising efforts to ensure that all clinical areas are equipped with dedicated carer beds, enhancing comfort and support for carers

5. Compliments

503 compliments were raised over the last year, a rise compared to previous year of 295.

Compliments continue to be promoted within governance meetings, divisional updates to PACE, and reported to the staff member involved and reporting manager to ensure that praise is given.

6. Complaint and PALS annual overview

This report provides a summary of formal complaints received in 2024-25 in accordance with the NHS Complaints Regulations (2009).

The trust is committed to improving the experience of our patients, and complaints and concerns provide valuable information to ensure that learning is identified, and changes made to ensure that our patients, carers and relatives have a positive experience.

The Patient Advice and Liaison Service (PALS) provide 'on the spot advice and support' with the aim of timely resolution. In the event that this has not been achieved, PALS discuss with patients and relatives how their concerns can be appropriately resolved and where appropriate, provide advice to them on the formal complaints process. The PALS role has unfortunately not met the expectation of the service provision due to capacity issues within the team. As such, there has been a 48 day turn around on non-urgent concerns.

On closure of complaints, any action plans are now logged and tracked on ENHance to ensure that continuous improvements are happening within the Trust. This also helps identify areas that that are still having the same consistent concerns raised in their areas, and for shared learning.

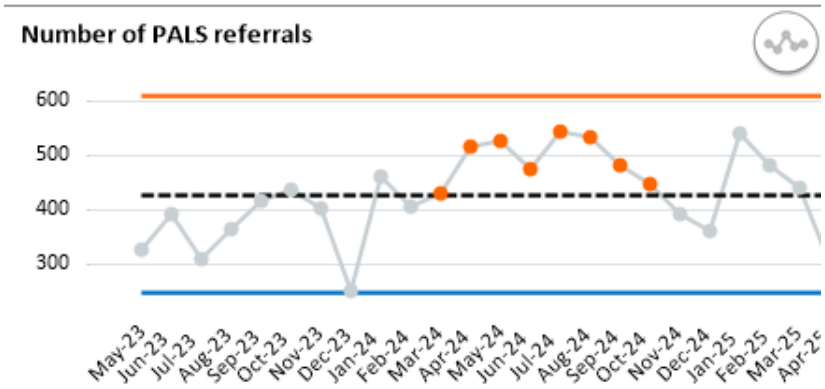
Formal complaints training is also conducted by the Complaints Department twice a month via Microsoft Teams. This has been very successful and due to this, staff are now able to book online to attend so that we are able to keep a log of all that have been trained.

New dashboards have also been set up for Divisional use on reviewing themes and trends of complaints, concerns and compliments to enable cascade of learning and support improvements.

PALS Enquiries – Concerns

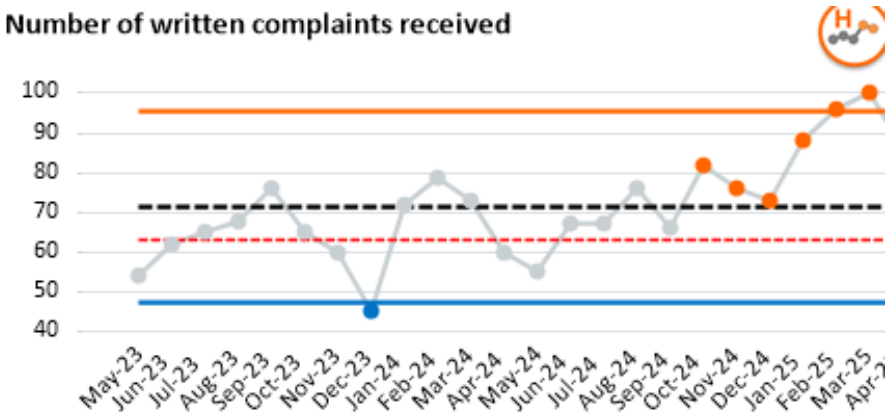
There was a total of 4,657 PALS enquiries received in 2024-25, a significant increase from 3,496 the previous year. Turnaround of up to 48 days for non-urgent enquires. The generic inbox and voicemail service is reviewed daily and all urgent/safeguarding and inpatient concerns are triaged to be actioned that day.

Key themes from our Patient Advisory Liaison Service (PALS) are related to delays in appointments, poor communication and delayed/poor care/treatment.



Formal complaints activity

In 2024-25, 904 formal complaints were received, an 18% increase from the 763 formal complaints received in 2023/24 across all services.



The top five trust complaint categories:

- Medical care
- Communication
- Delayed appointment/treatment
- Nursing/Midwifery Care
- Attitude of staff

These top five categories remain in line with previous years. Communication this year pertains to the communication around care, family being updated, appointments and waiting times.

Unplanned Care have received the highest number of complaints during 2024-25, in line with the previous annual report. The Emergency Department receives the most complaints per month and sits within the unplanned care division, increasing the overall number of complaints received for the division.

There are continuous improvement works within the Emergency Department, including redeveloping the department's environment and also reviewing shift patterns for staff to cover the higher numbers of people within the waiting area.

Top 5 five services receiving highest number of complaints:

- Emergency Medicine
- Gynaecology
- Trauma and Orthopaedics
- General Surgery
- Paediatric Acute

7. Acknowledgement of formal complaints

There is a mandatory requirement to acknowledge all formal complaints within three working days of receipt. In 2024-25 98% of complaints were acknowledged within this timeframe. This has increased from the 97% the previous year. The team continue to strive towards 100% compliant in 2025-26. The current Trust target is set at 90% and as such we have been exceeding this target.

8. Outcomes of formal complaints

During 2024-25, 929 formal complaints were closed, of those closed 69% were closed in the allocated timeframe.

7. Parliamentary and Health Service Ombudsman Outcomes

Q1 2024-2025

The PHSO requested three sets of patients records and complaints files in Q1, April – June 2024. And provided outcomes to the three cases below.

1. The PHSO provided a final report regarding a family that was dissatisfied with communication.
2. The family had sought a private consultation and scans and requested full recompense from the trust. The PHSO rejected the request for recompense after reviewing this case but recommended that the Trust write a letter of apology surrounding the poor communication.
3. The trust wrote to the family and offered an apology for the poor communication.

The PHSO contacted the trust regarding a proposal for early resolution for a patient who had suffered a miscarriage and was dissatisfied with the waiting times.

Early resolution: A meeting was offered for the patient and her husband to meet with senior staff from the maternity team to discuss their experience and to learn of the planned quality improvements and timeframes. The meeting was arranged and attended and as a result the PHSO closed the case.

Q2 2024-2025

The PHSO requested one set of patients records and complaints file in Q2, July – September 2024.

The PHSO reviewed a complaint in relation to a patient who had been under the care of Cancer services. The PHSO reviewed the medical records and complaint file and have advised that they were not investigating.

The PHSO contacted the Trust regarding a proposal for early resolution for a patient relative who raised concerns around the patient's previous labour.

Early resolution: Staff offered to meet with the patient to discuss any concerns and offer ongoing support. The patient contacted the Trust and said it was her father who had raised concerns, however she did not feel the need for a meeting and was happy with the care she was receiving. The PHSO closed the case.

The PHSO shared provisional findings for two complaints they had investigated and asked staff to review and provide comment. This was for a patient who received care under Cancer Services and a patient who had received care under Planned Care. Comments were sought from staff and shared with the PHSO.

Q3 2024 -2025

The PHSO requested one set of patients records and complaints file in Q3, October – December 2024.

The PHSO ceased the investigation into the Cancer Services complaint they had requested further information on and advised no further action would be taken and the case was closed.

The PHSO carried out a primary investigation into the care provided to a patient who was end of life with no further action and the case was closed.

The PHSO shared provisional views upon completing an investigation about a patient who had deteriorated whilst an inpatient at the Trust. The PHSO report was shared with senior staff who were given the opportunity to review and provide comment, which was shared with the PHSO.

1. The PHSO shared a final report on the complaint which was initially raised with the Trust by the family on 14 September 2021 regarding the care provided to a patient. The family were dissatisfied with the care and discharge arrangements.
2. The PHSO recommended that a letter of apology be made to the family. The PHSO did not award the family any recompense.
3. A letter of apology was drafted and sent to the family and staff were able to evidence that learning had taken place regarding communication with relatives around the delivery of equipment on discharge.

Q4 2024-2025

The PHSO requested two sets of patients records and complaints files in Q4, January – March 2025

The PHSO made a recommendation for early resolution regarding a patient who was bed bound. The patient was dissatisfied with staff communication. Senior staff were contacted to consider the concerns raised and provided information to the PHSO for review.

The PHSO had a total of seven cases under review at the end of March 2025.

8. Local Surveys

The Trust continually monitors feedback from patients and uses this feedback to make changes and improvements to the services it provides. An electronic patient survey system is in place called 'ENHance'.

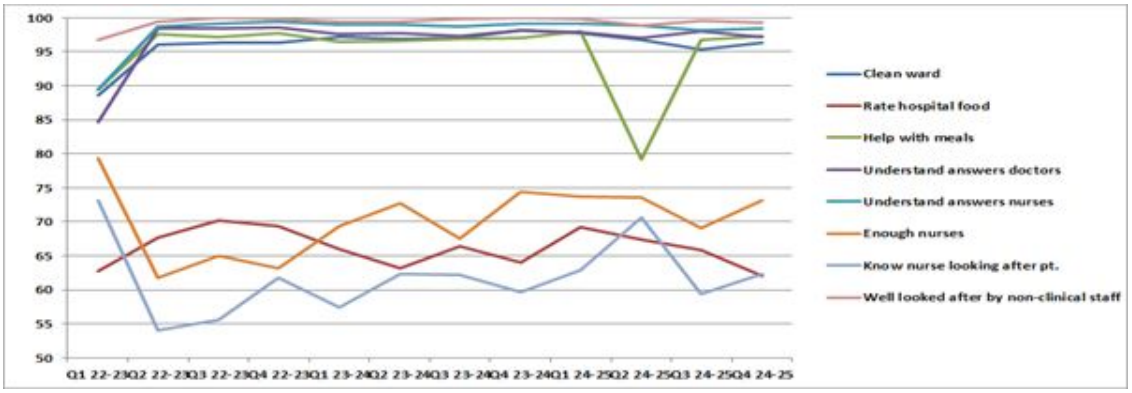
In 2024-25, 14,394 patient experience surveys were completed compared to 12,972 surveys in 2023-24 (this excludes the single question Friends and Family Test survey).

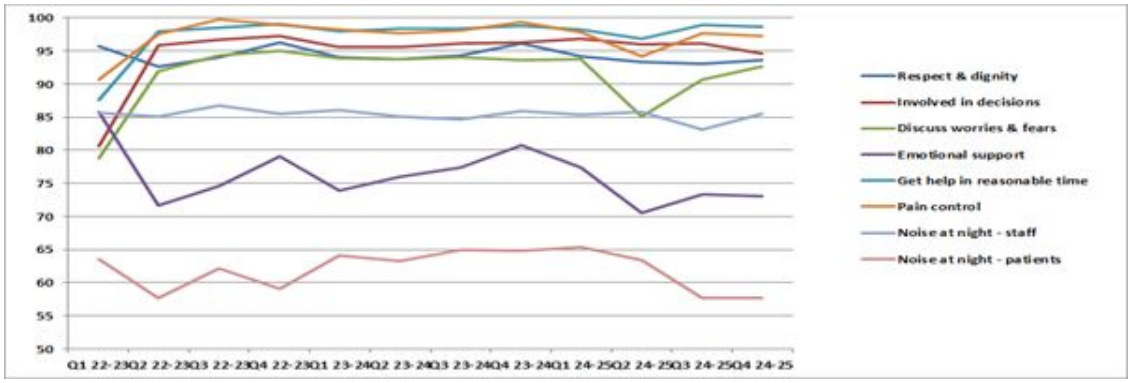
ENHance Local Patient Experience Surveys	No of responses 2022-23	No of responses 2023-24	No of responses 2024-25
Day Case	498	569	1180
Critical Care	67	169	106
Emergency Department / UCC	191	457	421
Discharge	N/A	N/A	N/A
Renal Dialysis	908	1027	1028
Outpatient Department	3,241	4,692	4,952
Neonatal	169	116	121
Maternity	330	247	135
Inpatient	4,207	5,412	6,005
Assessment Area	109	69	308
Community Respiratory	204	163	116
Experience of EoL Care	11	48	22
Total	**10,012**	**12,972**	**14,394**

The compliance scoring for the Inpatient Survey questions was reviewed and updated in early 2024. This had an impact on the historical data since the Inphase platform ENHance has been used in the Trust (July 2022).

Divisional action plans on findings continue to be presented during the monthly PACE Group which provides ongoing evidence of what is being done about the consistent themes raised within the FFT surveys.

The charts below show a comparison of the inpatient survey results between April 2022 - March 2025.





Friends and Family Test

The Friends and Family Test (FFT) asks **'Overall, how was your experience of our service?'** There are six response options ranging from 'very good' to 'very poor'.

We continue to collect feedback from patients completing a survey on their own device via displayed QR codes, by using a ward iPad or completing a paper survey whilst they are in the hospital. The FFT surveys are also available on the Trust website. We are resuming post-discharge telephone calls to patients asking for feedback regarding their experience of their most recent visit to hospital.

An easy read version of the FFT survey is offered to people (with appropriate support if needed) who have dementia, learning disability, are profoundly deaf, deafblind, blind/vision loss, have little or no English or low levels of literacy. Guidance is available for staff offering the FFT survey to patients with dementia or a learning disability.

Summary of Trust FFT results and response rates (2024-25):

In 2024-25, 26,436 patients responded to the Friends and Family Test (FFT) question (compared to 23,144 in the previous year).

	Inpatients/ Day Case	ED-UCC	Outpatients	Maternity				TOTAL
				Antenatal	Birth	Postnatal	Community	
Q1 2024-25	2610	391	3246	248	35	246	14	**6790**
Q2 2024-25	2689	416	3119	374	31	208	38	**6875**
Q3 2024-25	2752	526	2565	280	30	321	104	**6578**
Q4 2024-25	2446	434	2672	194	51	279	117	**6193**
Total	**10497**	**1767**	**11602**	**1096**	**147**	**1054**	**273**	**26436**

Trust wide improvements following FFT results:

- Coat hooks added to the new area in MV Cancer Centre following the refurbishment
- Nutrition and Hydration steering group formed within the Trust
- Sleep masks and ear plugs available on all inpatient wards
- Signs and site maps continue to be reviewed and updated

Board

East and North Hertfordshire Teaching NHS Trust

Meeting	Public Trust Board		**Agenda Item**	13	
Report title	Safeguarding Annual Report		**Meeting Date**	14 January 2026	
Author/s	Lead Nurse for Adult Safeguarding Head of Children's and Maternity Safeguarding Named Doctor for Adults and Children's Safeguarding Named Midwife for Safeguarding				
Responsible Director	Chief Nurse				
Purpose	**Assurance**	☒	**Approval/Decision**	☐	
	Discussion	☐	**For information only**	☐	
Proposed assurance level (*only needed for assurance papers)*	**Substantial assurance**	☒	**Reasonable assurance**	☐	
	Partial assurance	☐	**Minimal assurance**	☐	

Executive assurance rationale:

The report provides assurance regarding all aspects of safeguarding for ENHT in line with statutory duties.

Summary of key issues:

The Safeguarding Annual Report 2024/2025 outlines the work undertaken by the Trust during the past year. Safeguarding is the term used for protecting children and adults from abuse or neglect.

The report provides assurance and illustrates the strong procedures and systems established within the Trust to guarantee the appropriate safeguarding of both children and adults. The primary indicators reveal that the Trust consistently fulfils and upholds all statutory responsibilities concerning the protection of unborn babies, children, young individuals, and adults.

The Trust safeguarding team remains committed to responding to national emerging issues within safeguarding such as the National Child Safeguarding Practices review panel's report.

Safeguarding is a whole systems approach, and the Trust is a partner agency of the Hertfordshire Children's Safeguarding Partnership (HCSP) and the Hertfordshire Safeguarding Adult Board (HSAB). The safeguarding team has worked with the partnership in response to local identified need, including work to reduce sudden unexpected death in infancy, transitional safeguarding, multi-agency supervision pilot, and working with fathers and partners.

The Trust's safeguarding team model employs an integrated approach that emphasises safeguarding throughout the lifespan, with daily team supervision conducted collaboratively across the specialties of Children's, Adults, and Maternity Services.

Key highlights of 2024/2025 include:

- CSE risk assessment tool adopted nationally - finalist for the Nursing Times Awards 2025
- National recognition for safeguarding clinical audits (RCPCH)
- The 'Was not Brought' initiative launched in 2024 to oversee attendance of individuals with an LD at outpatient appointments
- Domestic and Sexual Abuse Team (DSAT) provided support to over 600 service users of all ages during 2024/25 (PCC funded)

- Focus on full digitalisation of s42 and DoLS applications – DoLS applications rose to 878, the highest since MCA introduced
- Key involvement in multi-agency practice audits
- Enhanced integration between Perinatal Mental Health (PNMH) and Maternity Safeguarding services through creation of risk assessment tool
- Successful launch of the maternity Electronic Patient Record (EPR) supported through the adaptation of safeguarding pathways and processes.

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 Committee is asked to receive the report for information and assurance that the Trust is compliant with its duties under the Children Act (2004), Mental Capacity Act (2005) and Care Act (2014)

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*

Report previously considered at & date(s):

Safeguarding Committee – November 2025

Recommendation	The Board is asked to note the report.

To be trusted to provide consistently outstanding care and exemplary service

Introduction

Welcome to the combined East and North Hertfordshire Teaching NHS Trust (ENHT) safeguarding annual report 2024-2025. ENHT continues to be committed to safeguarding all patients, their families and our staff, and safeguarding is a fundamental component of our Trust values. Safeguarding is everyone's responsibility, and we all have a duty to protect our patients from abuse and harm.

This report reflects the arrangements to safeguard and promote the welfare of children, young people, and adults at risk within East and North Hertfordshire Teaching NHS Trust. In doing so, the Trust discharges part of its responsibility for Board-level assurance, scrutiny and challenge of safeguarding practice within the Trust, as outlined in the statutory requirements of section 11 of the Children's Act (2004), Working Together to Safeguard Children (2018), the Mental Capacity Act (2015) and the Care Act (2014).

In addition to the above requirements, the Trust as a registered provider with the Care Quality Commission (CQC), must have regard for the Regulations as established under the Health and Social Care Act (2008), including but not limited to, Regulation 13 and Regulation 17, relating to protecting service users from abuse and good governance.

The Trust regularly reports to the Hertfordshire and West Essex ICB, Hertfordshire Safeguarding Children's Partnership and Hertfordshire Safeguarding Adults.

Safeguarding governance and team structure

Safeguarding Governance and Oversight

The Safeguarding Committee continues to meet bimonthly, chaired by the Chief Nurse. The Committee provides strategic oversight of all safeguarding activity across the Trust. Membership includes the Head and Leads for Safeguarding (including the Named Midwife) and representation from all clinical divisions, each of which provides divisional safeguarding reports.

The Committee is also attended by the local Integrated Care Board (ICB) Adults' and Children's Safeguarding Leads, Learning Disability Nurses from Hertfordshire County Council, and a Trust Board Non-Executive Director. The Safeguarding Committee reports safeguarding activity, risks and outcomes to the Quality and Safety Committee, providing assurance on compliance and performance.

The Learning Disability Working Group, a sub-group of the Safeguarding Committee, meets bimonthly to oversee safeguarding matters relating to patients with learning disabilities.

Safeguarding Structure and Statutory Roles

The Trust continues to meet all statutory safeguarding requirements and has maintained the necessary posts and roles throughout the reporting period.

The safeguarding leadership structure includes:

- Head of Children's and Maternity Safeguarding / Named Nurse for Safeguarding Children (Band 8B)
- Lead Nurse for Adult Safeguarding / Mental Capacity Act/ Prevent / Learning disabilities (Band 8A)
- Lead Safeguarding Midwife (Band 8A)
- Named Consultant for Safeguarding

The team reports directly to the Deputy Chief Nurse. The Chief Nurse is the Executive Lead for Safeguarding and represents the Trust at both the Hertfordshire Safeguarding Adults Board and the Hertfordshire Safeguarding Children's Partnership, supported by the Deputy Chief Nurse.

Demand and Capacity

During the reporting period, the safeguarding team experienced increased demand due to:

- Higher levels of safeguarding activity
- Increased training and supervision requirements (key performance indicators)
- Rising patient acuity and complexity
- Growing multi-agency and partnership working requirements.

ENHT is one of few acute Trusts commissioned to provide safeguarding services to Community Paediatrics, which includes a weekday on-call child protection rota and supervision for caseload holders. This additional responsibility requires significant training and oversight. Additional staffing would strengthen the team's capacity to meet current and emerging safeguarding priorities.

Performance Monitoring

Safeguarding performance is monitored through a comprehensive dashboard, which informs the safeguarding work plan and supports assurance reporting to relevant boards and committees. The Trust ENHTelligence - Business analytics hub host data on safeguarding team activity which can be accessed by the divisions.

Embedding Safeguarding across the Trust

Safeguarding is embedded in everyday practice across all divisions. Divisional Directors, Heads of Nursing and Senior Managers remain responsible for compliance with safeguarding policies and for maintaining high standards of care.

The safeguarding team continues to support staff in understanding their safeguarding duties, promoting professional curiosity, and improving outcomes for vulnerable adults, children, and young people.

Trust safeguarding policies and procedures

The safeguarding policies and procedures are regularly updated to reflect any changes in practice, learning from case reviews and national guidance and recommendations. Any updates or new policies continue to be approved by the Safeguarding Committee.

During the reporting year, the following Trust policies and standard operating procedures (SOP) have been updated and/or introduced:

- Maternity Safeguarding Policy
- Trust Wide FGM Policy
- Was Not Brought in Policy
- The Management of acute mental health in Maternity SOP
- Women who misuse substances in pregnancy guideline
- Women who do not attend (DNA) maternity appointments in the community / hospital setting
- The Care of Adult patients with a learning disability or autism
- LeDeR programme notification, in the event of the death of inpatients who have a learning disability or autism (SOP)

In addition, the safeguarding team have been involved in the update of the following Hertfordshire wide Policies and Procedures (HSCP/HSAB):

- HSCP FGM Pathway
- HSCP Bruising Protocol

Assurance Visits

Arrangements to Safeguard Children under Section 11 of the Children Act 2004 and Adult Safeguarding Assurance Visit

A combined Adult Safeguarding Assurance visit, and Section 11 audit visit was carried out in October 2023 by Hertfordshire and West Essex ICB to ensure compliance with our responsibilities under the Children's Act and the Care Act. Notable practice and recommendations were discussed during the visit.

Joint Targeted Area Inspection (JTAI) - Domestic Abuse – Children

In 2024, ENHT were involved with the partnership wide JTAI inspection into Domestic Abuse, examining professional responses to safeguarding children who live in the context of domestic abuse. The focus for this inspection was children under the age of 7. As part of the inspection, ENHT were involved in case audits following the lived experience of unborn babies and children and an onsite CQC inspection. Formal feedback from the audits & onsite inspection were positive and reflected a trust wide commitment to safeguarding children from domestic abuse and appropriate safeguarding arrangements in place to support both children and survivors of Domestic Abuse. The report notably recognised the Trust Domestic and Sexual Abuse Team. Partnership learning opportunities were collated into a ENHT Trust action plan. The report can be found here.

Data Reporting

The Trust confirmed key performance indicators with the ICB to ensure compliance with statutory safeguarding requirements. A quarterly safeguarding adults and children's dashboard continues to be submitted to the ICB to demonstrate progress. Matters are escalated via the Trust Safeguarding Committee who have responsibility for monitoring the implementation of any action plans.

Metrics for attendance at strategy discussions shows a continued improvement resulting in an end of year position 100% attendance.

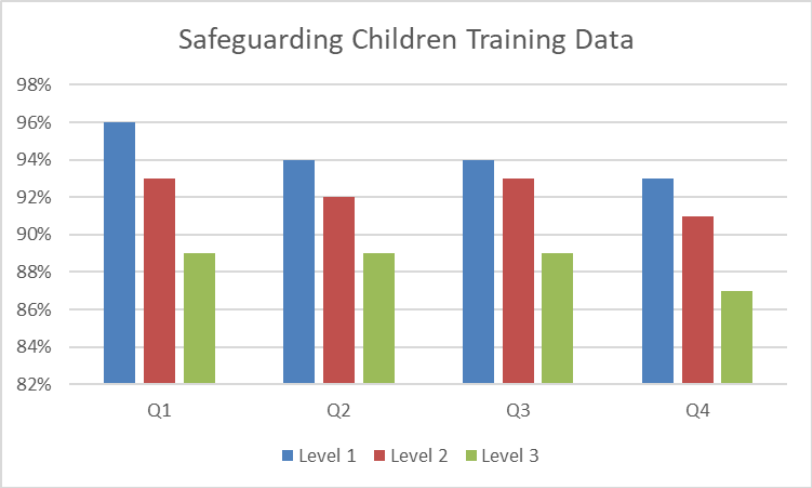
We are now able to collect and collate data which identifies the number of children affected by domestic abuse, through referrals to children's social care and cases heard at Multi Agency Risk Assessment Conference (MARAC). During the reporting period, the Maternity Safeguarding team attended 32 MARACs, relating to unborn babies or infants under six months of age, directly contributing to the risk management and safety planning of high-risk domestic abuse cases.

Knife crime data is shared for all child and adult attendances to the organisation.

Safeguarding children's supervision targets continue to not be met. This is partly due to several factors including staff availability to attend the planned sessions due to acuity of work, staff shortages and sickness within teams. The safeguarding team continue to provide sessions to meet the requirements; however, they do not have the capacity to provide additional sessions to support the teams working at the point of care.

Children and Maternity Safeguarding

Safeguarding Children Training Compliance 2024 - 2025



Over the past year, there has been a strong and sustained focus on improving safeguarding children training compliance across all levels within the organisation.

Our Key Performance Indicator for safeguarding training is set at 90% compliance for all levels. As shown in the chart, Level 1 has consistently exceeded this target across all four quarters, demonstrating excellent engagement. Level 2 training has remained close to, or above the KPI, reflecting steady and positive performance. While Level 3 training has shown slightly lower compliance rates, performance has remained stable throughout the year.

Continued efforts will focus on closing the gap for Level 3 to ensure all training levels consistently meet or exceed the 90% target.

An enhanced level of safeguarding training offer is in place for all staff across the organisation, with a targeted approach to managing staff who are not compliant with training (relevant for their role), including a full review of the audience list for staff who are required to complete Level 3 Safeguarding Children Training. All speciality registrar level and above medical staff are now required to complete Level 3 training which supports the safeguarding agenda across all departments within the organisation, including the management and support of 16 and 17 year olds within the adult areas across the Trust. The Level 3 training specifically highlights transitional safeguarding topics and discussion with an added lens of assessing vulnerability and needs for SEND children.

Child Exploitation Tool

The safeguarding team have developed and launched a bespoke digital tool to help identify child exploitation in unscheduled care settings within the Trust. The risk assessment tool has been launched in conjunction with the National Working Group and supported by NHSE Safeguarding Lead. This tool has been audited and reflected excellent compliance rates and an increase of recognition of child exploitation, resulting in a 70% increase in referrals across the Trust from 2022. This work has been published within the British Journal of Nursing and currently a finalist for the Nursing Times Awards 2025.

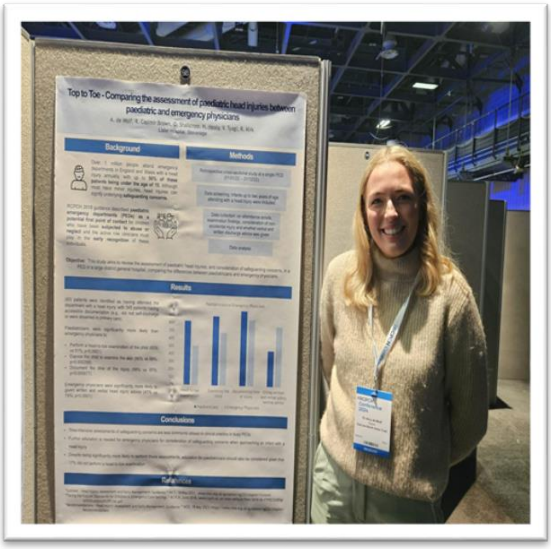
The risk assessment tool has been replicated within 14 other NHS Trusts so far and following evaluation, NHSE are committed to roll this out across GP surgeries, pharmacies and wider health partners to support the incoming mandatory reporting for child sexual abuse and compliance with the the Serious Violence Duty (2022). The Children's Safeguarding Team are working closely with the HSCP/ICB in sharing these outcomes and intelligence across the Safeguarding Partnership.

Clinical Audits

Two clinical audits were recognised for excellence at the RCPCH Conference in 2024:

- Top to Toe - comparing the assessment of Paediatric head injuries between paediatric and emergency physicians
- Recognising Abusive Fractures in children under age 2

We were proud to be winners of the Trust Wide Clinical Poster Presentation for the Audit examining recognising abusive fractures in children under the age 2.



Quality Improvements for Children and Young People with Special Educational Needs and Disabilities

Fortnightly Quality Improvement Working Group with MDT input from ENHT, HCC, HCT and HWE supported by monthly service user attendance for co-design and coproduction. This specifically looks at improving outpatient pathways for children with SEN and Disabilities, introduction and roll out of my Health Care Passport, and improving ED pathways and sedation pathways to support safe, effective and compassionate care for all children with additional needs. Funding has been approved for a clinical nurse specialist for Children's Learning Disability and Autism which will continue to drive trust wide improvements throughout 2025/2026.

Local partnership working

ENHT has a responsibility to cooperate with the operation of the Hertfordshire Safeguarding Children's Partnership and Hertfordshire Adults Safeguarding Board as a statutory partner. We share responsibility for the effective discharge of its functions in safeguarding and promoting the welfare of children and adults by ensuring representation at Board meetings and subgroups.

The safeguarding team continue to work closely and collaboratively with the Independent Domestic Violence Advisors (Refuge), Local Authority Safeguarding teams, ICB safeguarding teams and other Health safeguarding teams in Hertfordshire, and Police Specialist and safeguarding teams.

Currently, the Trust is a key partner agency for safeguarding and is involved in the following groups:

- HSCP/HSAB Board Meetings
- Practice Policies and Procedures – subgroups for adults and children's
- Active contribution to Safeguarding Adult Reviews (SARs), Rapid Reviews, care leavers reviews and local learning reviews
- Active contribution to Hertfordshire's Improving health care outcomes groups for individuals with an LD
- Active members of the Trust's frequent attender's panel, violence and aggression panel and PSIR forums, mental health operational group and discharge steering group
- Active Members of HSAB's policy and procedures subgroup.
- Active contribution to Domestic Homicide Reviews (DHR'S)
- Active members of the HSAB domestic homicide review sub-group
- Active participation at complex safeguarding meetings
- Attendance and sharing information at the Multi-Agency Risk Assessment Conference (MARAC)
- Sharing information for section 17 and 47 requests, strategy meetings, Multi-Agency Safeguarding Hub (Bedfordshire and Hertfordshire), and Multi Agency Child Exploitation (MACE)

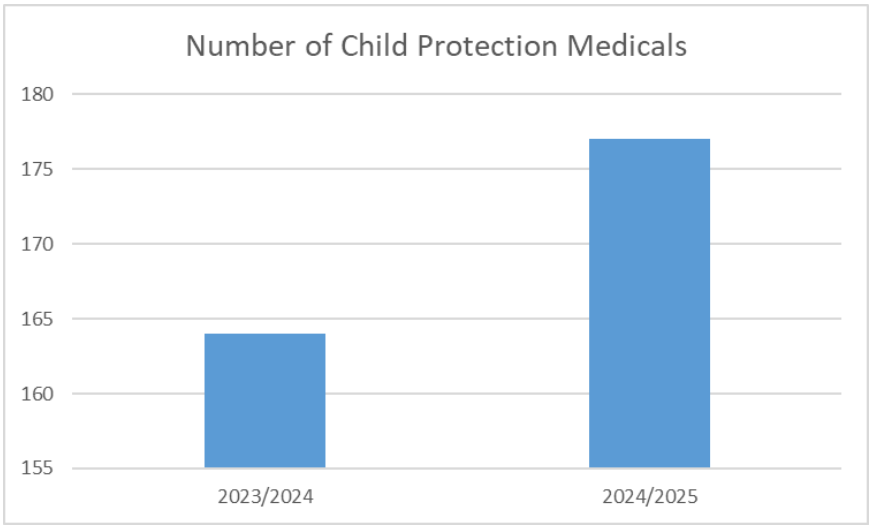
The Trust safeguarding team have also been involved in the following areas of partnership work:

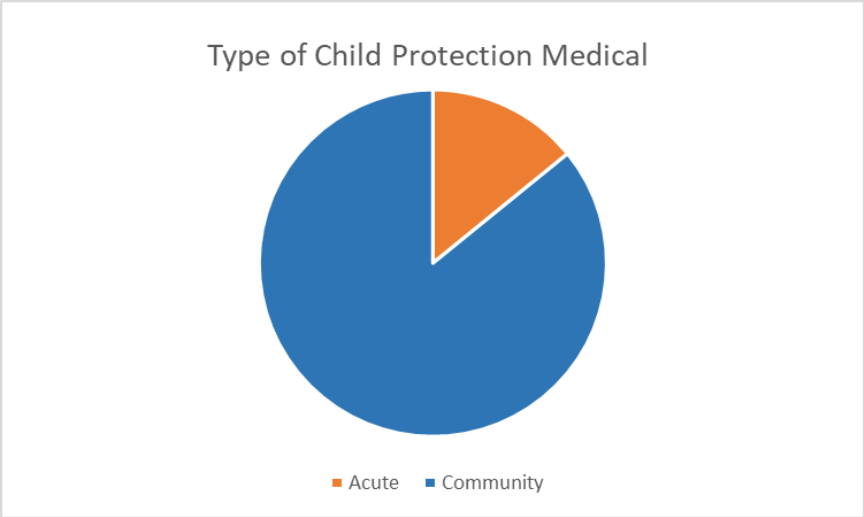
- Task and Finish Group – FGM pathway review
- Task and Finish Group – Consent: Children's Social Care Portal
- Multi-Agency Audit – Bruising in Babies

Key Achievement – High level of commitment to partnership working and participation in specific work streams driving forward improvements in practices policies and procedures and ultimately better outcomes for families across the communities served by ENHT

Safeguarding Activity

Child Protection Medicals 2023-24/2024-25

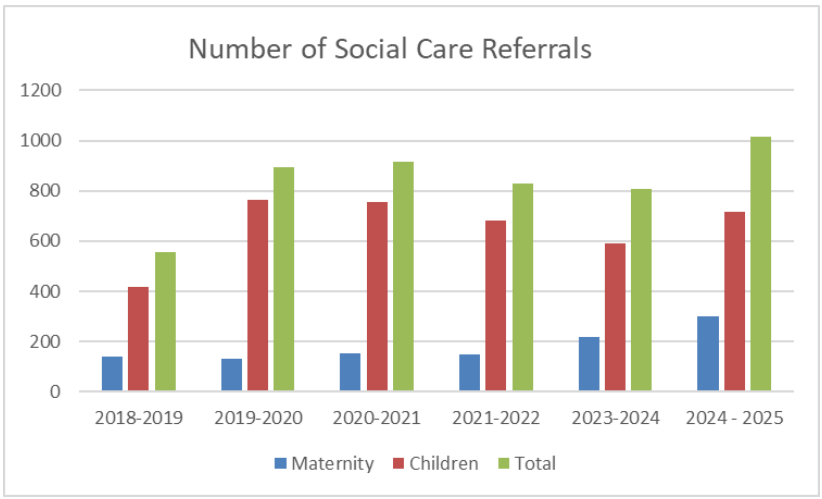




ENHT conducts Child Protection Medicals for children where there are concerns surrounding physical abuse and/or neglect. This is a detailed, holistic medical examination which can be referred via two pathways into the service, through the acute trust, or through the ENHT provided Community Child Protection Medical Service, which is staffed by an on-call Consultant Paediatrician and Safeguarding Specialist Nurse. The service provides a holistic and comprehensive assessment of the child, capturing voices and wishes of children, and both clinicians are involved in information sharing and ongoing multiagency plans to safeguard the child.

Children who attend the acute hospital with concerns relating to injuries or significant neglect will also be offered a child protection medical for a detailed and holistic assessment of any injuries of concern. This service is covered by the Acute Paediatric Team and Safeguarding Nurse Specialists are involved in oversight and coordinating professionals to support safe discharge arrangements. The chart above details an increase from 164 Child Protection Medicals Conducted in 2023/2024 to 177 in 2024/2025. This upward trend may reflect improved awareness and recognition of safeguarding concerns, enhanced referral pathways, or increased reporting of suspected abuse and neglect. The data highlights the continued demand for the Trust's Community Child Protection Medical Service, which provides a holistic and multidisciplinary approach to safeguarding children, ensuring that both medical and emotional needs are thoroughly assessed. The second chart reflects a significantly higher amount of Child Protection medicals remain via the community route, which supports avoiding prolonged hospital admissions and distress for children and their families. A total of 152 Child Protection medicals took place via the Community Route and 25 where children were found to have injuries of concern during their attendance to unscheduled care settings.

Referrals to Social Care

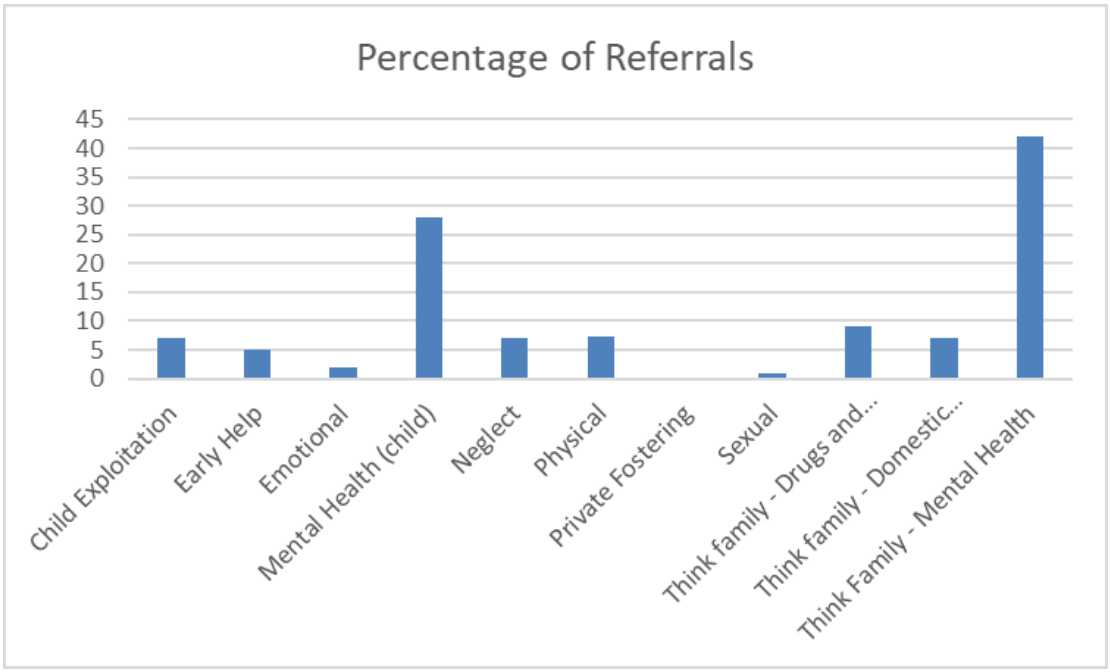


Recognising and referring vulnerable children and families is a key role and responsibility of all staff working for ENHT.

The chart illustrates the number of social care referrals made between 2018–2019 and 2024–2025, categorised by Maternity, Children, and total referrals. Across the reporting period, there has been a sustained upward trajectory in overall referrals, indicating a continued and growing focus on safeguarding within the organisation. Maternity referrals have shown a gradual but consistent increase, particularly evident from 2021–2022 onwards. This suggests heightened professional awareness and proactive identification of safeguarding concerns relating to unborn and newborn babies. During this year, the team have had heightened focus on improving recognition and response to safeguarding concerns for unborn babies (UBB), with the introduction of the Maternity Rag Rating Tool, to support safeguarding risk assessments at the point of booking. This innovation and practice development, alongside an increase in training activity and strengthening of policies, has supported this increase and drive for safeguarding vulnerable women and UBBs.

Referrals concerning children constitute the largest proportion of total referrals each year. While some year-on-year fluctuation is evident, the overall trend remains stable at a high level, demonstrating the ongoing need for vigilance in identifying children at risk of harm. The Adult Emergency Department remain the highest department who make referrals, based on increasing presentations of parental mental health, domestic abuse and substance misuse.

Nature of concerns referred to Children's Social Care – 2024/2025:



The chart presents the percentage breakdown of the primary concerns leading to referrals made to Children's Social Care during 2024–2025.

The most frequently recorded concerns relate to children's mental health and parental or family mental health, which together account for a significant proportion of referrals. This reflects the continuing impact of mental health challenges on children and families, particularly in the context of post-pandemic recovery and wider social pressures.

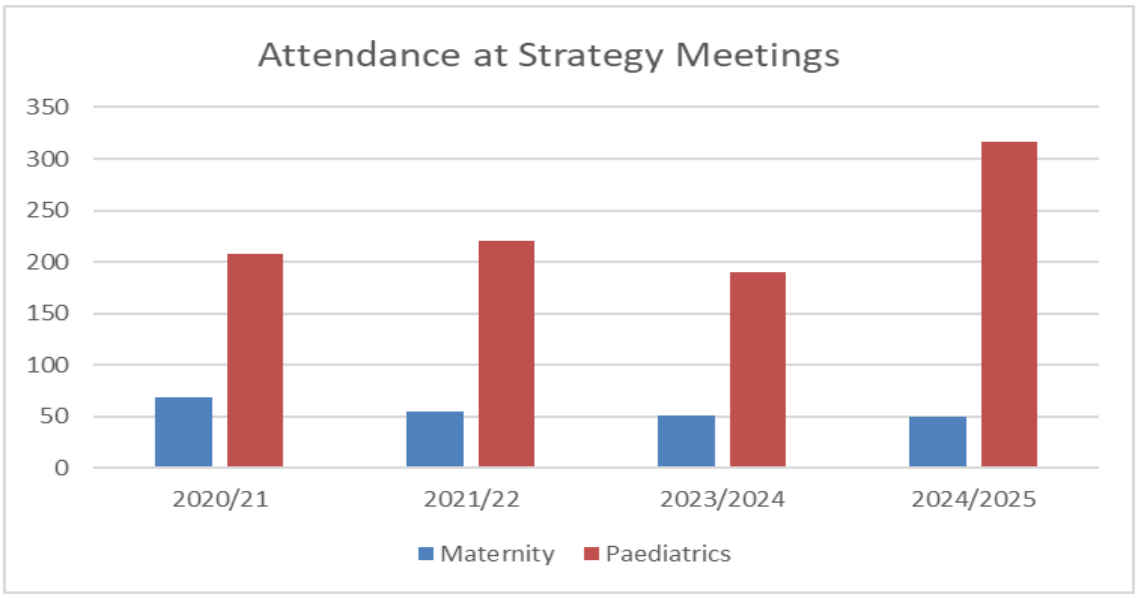
Neglect and domestic abuse also feature prominently among referral categories, indicating persistent concerns regarding the safety and wellbeing of children in the home environment. These categories remain consistent with national safeguarding trends, where neglect and exposure to domestic abuse are among the leading causes for statutory intervention.

Smaller but notable proportions of referrals relate to physical harm, sexual abuse, and parental substance misuse (Think Family – Drugs and Alcohol), underscoring the importance of a multi-agency approach in assessing and managing complex family situations.

Referrals under Child Exploitation, Early Help, and Private Fostering represent lower overall percentages, though each continues to form a critical part of the safeguarding landscape. The presence of these categories demonstrates ongoing vigilance in identifying a broad spectrum of risks beyond immediate harm and notably, an increase in Child Exploitation referrals from the previous year of a much smaller percentage.

Overall, the data highlights a sustained pattern of complex, interrelated safeguarding concerns, particularly those linked to family mental health, neglect, and domestic abuse, reinforcing the need for continued multidisciplinary collaboration to ensure timely and effective intervention.

Strategy Discussions



A key assurance surrounding the efficacy of safeguarding children is partnership and multiagency working, ensuring there is good engagement, timely information sharing and collective multiagency plans in place to safeguard children. Strategy meetings are pivotal in determining the child's welfare and planning rapid action to safeguarding the child/ young person. This involves ensuring the child's health is an integral aspect of this plan.

At ENHT, we have been committed to working with our partner agencies to improve our attendance and participation at strategy meetings. There has been a clear year-on-year increase in the amount of strategy meetings which are attended by both the safeguarding team and paediatric team, enabling the development of effective rapid action plans with an effective health focus. In 2024/2025, the safeguarding team attended 316 strategy meetings which are in keeping with the increased referral and recognition across the partnership for children requiring child protection medical assessments for concerns of physical abuse and neglect. A reflection on complexity of safeguarding children concerns for children attending the acute trust, also accounts for a significant number of these meetings.

Maternity Risk Assessment

Between 1 April 2024 and 31 March 2025, a total of 4,329 births were recorded, compared to 5,132 births in the previous reporting period, representing an 18% decrease in birth rate. This aligns with the

national trend of declining birth rates; however, it is important to note the increasing complexity and comorbidities observed within the current caseload.

Risk assessment continues to be undertaken through the review of Information Sharing Forms (ISFs) completed by midwives and other professionals. These forms are triaged by the Maternity Safeguarding Team using community safeguarding records and shared care systems to ensure comprehensive assessment.

Unborn babies (UBBs) continue to be discussed at the monthly Vulnerable Women's Information Sharing Meeting, where further information sharing and multidisciplinary decision-making occur. These discussions support the identification of appropriate intervention levels, from universal service provision to targeted support for families with heightened vulnerability or safeguarding needs.

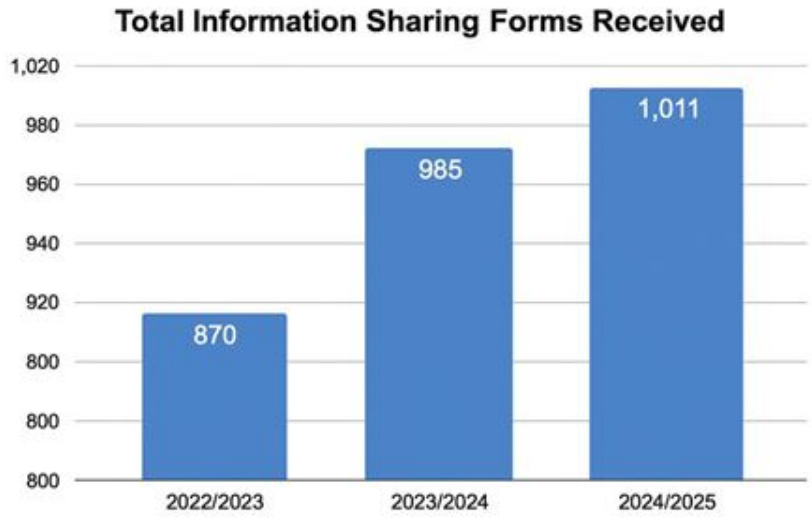
Since October 2024, Children's Social Care has ceased attending these multi-agency meetings. Despite ongoing efforts with the Integrated Care Board (ICB) and Hertfordshire Children's Social Care to re-establish their participation, attendance has not yet been reinstated. To mitigate this risk, three-weekly meetings have been established with a representative from Children's Social Care to review and discuss any referral rejections, thereby maintaining oversight and safeguarding continuity.

All safeguarding teams continue to collaborate with the overarching aim of promoting timely referrals, robust follow-up of outcomes, and the provision of trauma-informed, family-centred support for all cases.

The following chart illustrates the number of Information Sharing Forms (ISFs) received during the reporting period, which shows a 3% increase compared to the previous year. This rise is reflective of the positive impact of enhanced maternity safeguarding training, policy development, and a stronger organisational focus on early identification and response to vulnerability and safeguarding concerns.

All ISFs are screened and appropriately shared with Public Health Nursing services, including Health Visiting, General Practice, and the Community Midwifery Team, to ensure effective information flow and coordinated support for families.

Total number of information sharing forms received (Maternity Safeguarding).



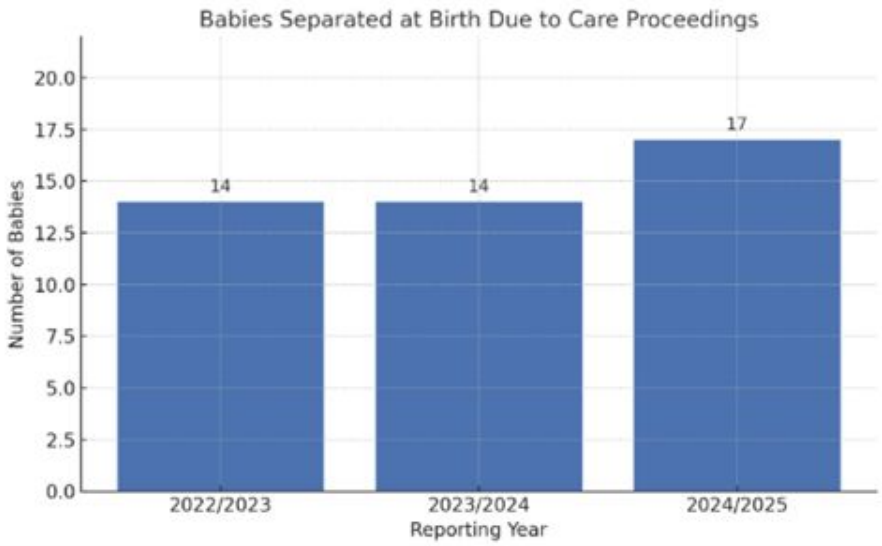
New cases continue to be risk assessed through the Maternity Vulnerable Women's Information Sharing Meetings, with actions clearly recorded and monitored. During this reporting year, a Terms of Reference was developed and published to strengthen governance, accountability, and the structure of these multi-agency meetings.

Cases are tracked and reviewed at each meeting, with information shared regarding the outcomes of assessments, Child in Need plans, Child Protection plans, and thresholds for legal planning, ensuring coordinated and effective safeguarding oversight.

During 2024/2025, there were 42 Initial Child Protection Case Conferences relating to maternity cases. This figure remains consistent with the previous reporting year, during which 41 conferences were attended. Notably, 100% of Child Protection Conferences were attended by maternity safeguarding representatives, demonstrating the team's continued commitment to comprehensive engagement in safeguarding processes and multi-agency decision-making.

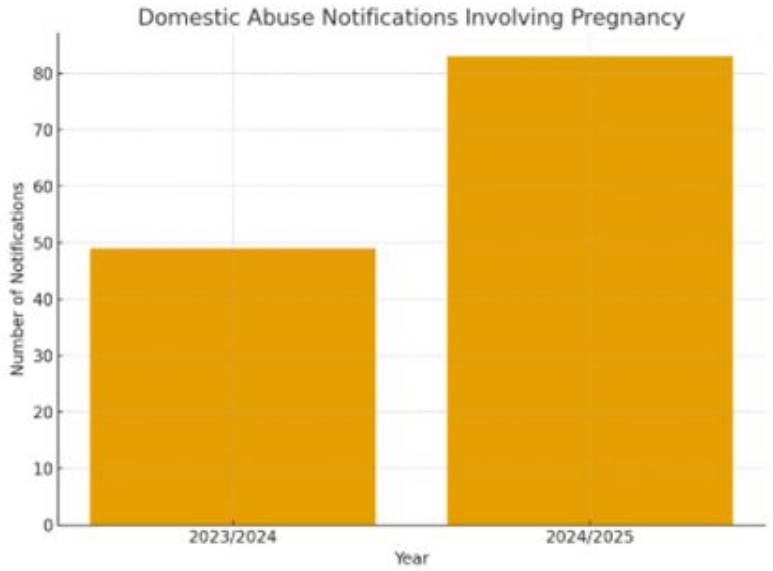
Maternity Cases Involving Initiation of Care Proceedings

In previous reporting periods, there were 14 cases in which care proceedings were initiated at birth, resulting in separation of babies from their mothers. During the 2024–2025 reporting year, this number increased to 17 cases, representing a 21% rise compared with the previous year. This rise will need to be monitored, and some thematic analysis required to further understand this if the rise is sustained, or further increases.



Domestic Abuse Notifications

Throughout this reporting period processes for Domestic Abuse (DA) notifications involving pregnancy have been improved through strengthened working relationships and enhanced information sharing with the Police. As a result, all DA notifications involving pregnancy are now received, where previously notifications were limited to women over 28 weeks' gestation. This has led to a 69% increase of domestic abuse notifications involving pregnancy.



Female Genital Mutilation (FGM)

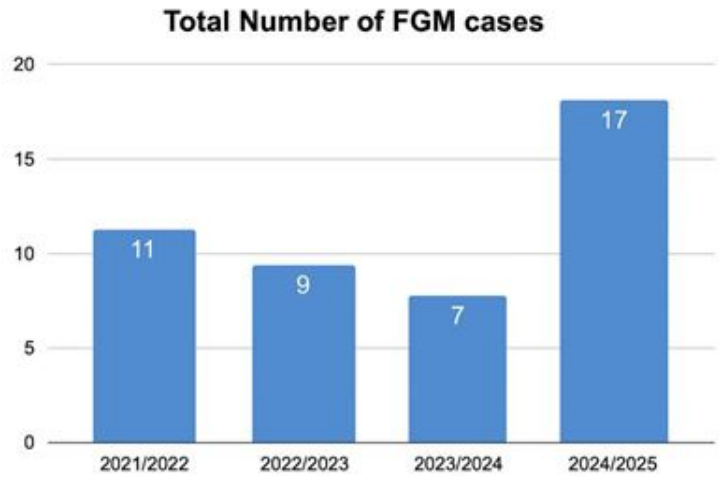
The number of women booked for maternity care within ENHT who have undergone Female Genital Mutilation (FGM) remains low. However, during the 2024–2025 reporting year, there has been a 143% increase in reported cases, rising from 7 cases in the previous year to 17 cases in this period.

The chart below illustrates the number of women identified with FGM at booking over the past three reporting years. In all cases, a comprehensive risk assessment is undertaken, and referrals are made to Children's Social Care in line with the Hertfordshire Safeguarding Children Partnership policy. Additionally, the General Practitioner and Health Visitor are notified to ensure coordinated support and ongoing safeguarding oversight.

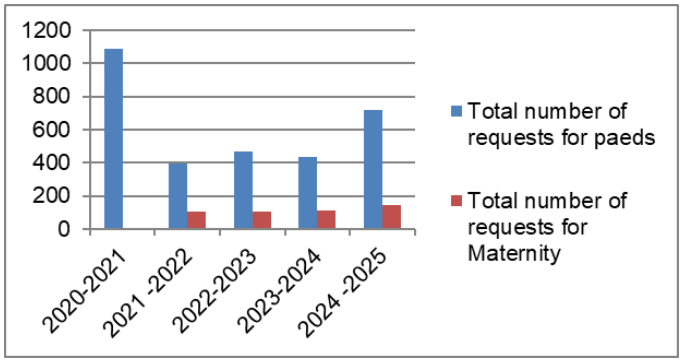
The Safeguarding Midwives continue to add an FGM alert to the National Spine record for every female child born to a mother who has sustained FGM. This ensures that relevant information is accessible to frontline and unscheduled care providers within ENHT to facilitate further risk assessment when required.

FGM data and outcomes are reported nationally on a quarterly basis, contributing to the broader understanding of prevalence and safeguarding response.

Total number of FGM cases managed by ENHT maternity services.



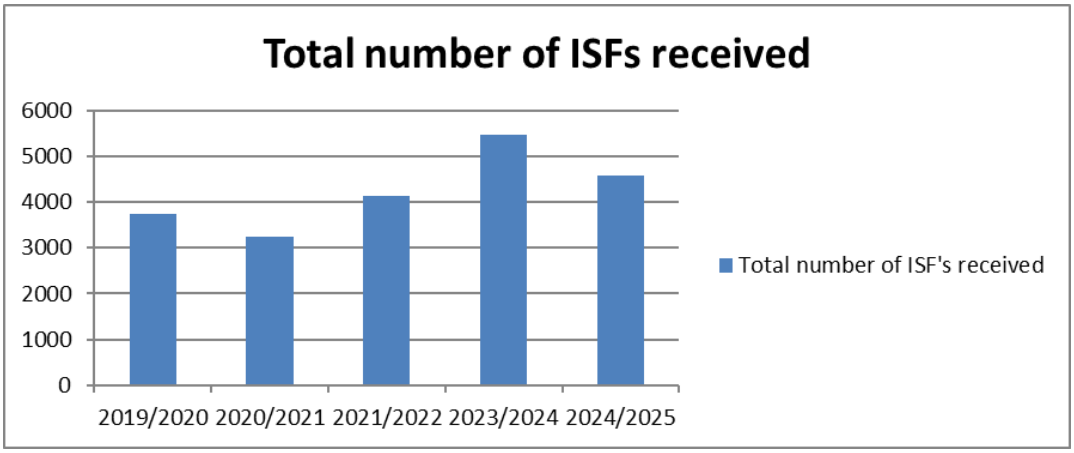
Requests for Information – S17 and 47 requests



Where requested to do so by local authority children's social care, practitioners have a duty to co-operate under section 27 of the Children Act 1989 by assisting the local authority in carrying out its children's social care functions, including information sharing.

In previous years, it was identified that all S17/47 and MASH requests were directly being requested to ENHT safeguarding team, in instances where children were not known, and no information was held by ENHT about the child or family. There has been effective partnership working over the last 2 years looking at streamlining requests for information for children who are known to our service, therefore supporting an appropriate and proportionate information sharing process which is tailored to the child and their family. Notably an increase from 2023-2024, which also reflects and aligns with the increase in Safeguarding activity seen across the Trust.

Paediatric Liaison



The Paediatric Liaison Service has experienced a significant increase in activity over the past year and continues to be a highly pressured area of work.

The bulk upload system remains in operation alongside the existing service, supporting the timely sharing of key safeguarding and wellbeing information. In addition, the information sharing criteria continue to guide the identification of children and young people attending the organisation who present with additional concerns. This ensures that relevant information is shared with health visitors, school nurses, and other partner agencies involved in the child's care and wellbeing.

To further enhance this process, the service introduced an electronic referral form, embedded within the Nervecentre patient record. A daily report is generated by the Paediatric Liaison Service, allowing staff to submit Information Sharing Forms (ISFs) directly from patient records. This development has improved access, increased staff engagement in information sharing, and enhanced the team's ability to risk assess and action concerns promptly. As a result, partner agencies receive timely, accurate, and detailed information.

The shared information includes attendance details, clinical findings, actions taken, outcomes, and any additional support required. This enables more meaningful risk analysis, providing a fuller picture of each child's presentation. Early intervention at this stage helps prevent escalation and reduces the need for more specialist interventions later.

There has been a year-on-year increase in recognition and information sharing from the Trust to partner agencies. Frontline staff are more frequently identifying children and young people who require further support or follow-up from community health services such as Health Visiting and School Nursing. The safety netting process, screening all discharge summaries for children and young people under 18, remains a crucial part of the service. It ensures that all attendances meeting information sharing criteria are reviewed by the Paediatric Liaison Team.

Where missed opportunities are identified, the system enables rapid learning and supports ongoing safeguarding education across the Emergency Department (ED) and Paediatrics. The team plays an active role in staff development, contributing to monthly supervision for ED doctors and nurses, leading paediatric and neonatal psychosocial meetings, and delivering daily teaching sessions within the Child Assessment Unit and Children's Emergency Department.

The Paediatric Liaison Service continues to prioritise strong partnerships. It chairs and leads liaison meetings with Hertfordshire Community NHS Trust and maintains consistent multi-agency engagement in weekly psychosocial meetings. Regular attendance from partner agencies, including the DSAT team, Children's Services, and CGL, strengthens joint working to safeguard children and promote their wellbeing.

Despite these developments and the rising volume of activity, it is important to note that permanent nursing staffing hours have not increased. This highlights the ongoing pressure on the service and the need for continued investment to sustain and build on the improvements achieved.

Looked-After Children (LAC) Health Assessments ENHT 2024-2025

Looked-After Children (LAC) continue to receive statutory Health Assessments. Initial Health Assessments (IHAs) are completed within 28 days of a child coming into care, followed by Review Health Assessments (RHAs) every six months for those under five, and annually for those aged five and above. Paediatricians remain responsible for all LAC IHAs for children under ten, and for RHAs for children where adoption is part of the care plan. Health assessments are requested by the child's social worker and coordinated through the LAC team.

Following agreement with commissioners and the LAC health team, children in special schools have their LAC health reviews integrated with their annual school health review. This means some assessments take place outside statutory timescales but ensures a child-centred approach and is considered in their best interests.

Where there are breaches of statutory timescales, these are reviewed, and where appropriate, covered by exception reporting (for example, last minute 'was not brought' or carers not presenting the child).

The target for completion of both IHAs and RHAs within timescales remains at 90%. Performance data is reported quarterly to the Safeguarding Committee and also provided to the Health of Looked After Children Leadership Group.

Staffing remains a key challenge. The Trust now has a consultant paediatrician in place as the adoption lead, who also delivers LAC reviews as part of their job plan. This new arrangement has improved the stability of the service, although overall capacity is still impacted by the consultant's broader clinical commitments. The Trust continues to operate without a named doctor for LAC, but the adoption lead consultant's expanded remit ensures oversight of both adoption and LAC Review processes.

Child Death

ENHT have a child death lead who is a Consultant Paediatrician who has responsibility and oversight for the involvement of ENHT in all child deaths.

In addition, the paediatric liaison/safeguarding children's team, along with the divisional quality manager, also supports and continues to be the link between professionals for CDOP, Hertfordshire Community NHS Trust (HCT) and ENHT. The link professionals represent the Trust at rapid response meetings quarterly and share agency summary reports.

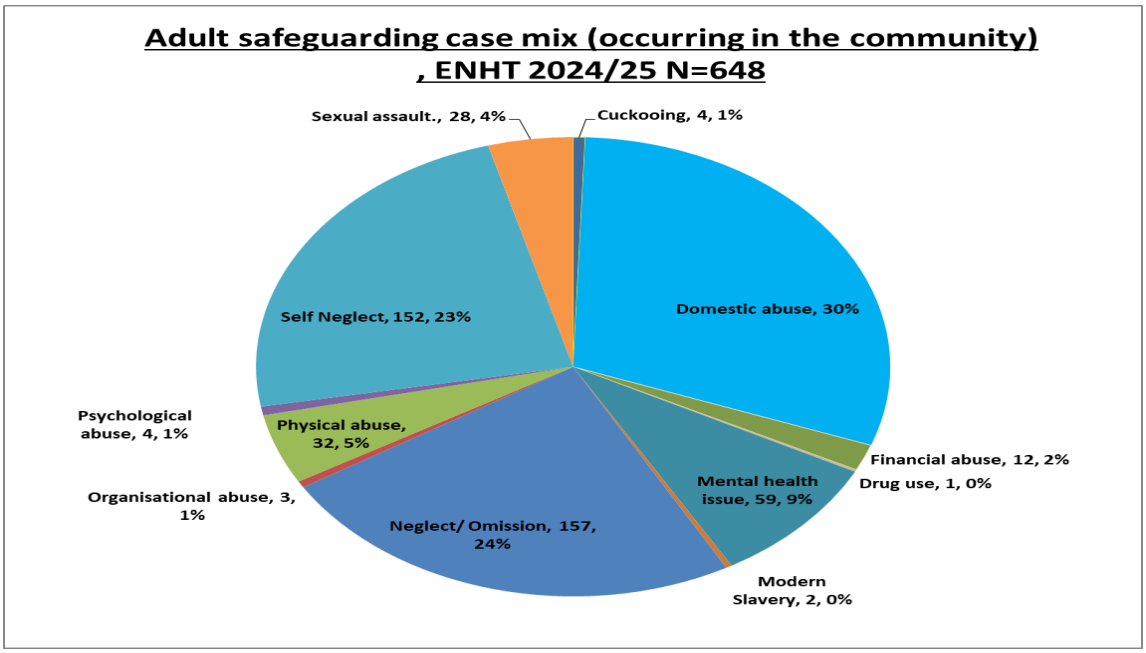
All child deaths continue to be reported on the Trust risk management and incident reporting system ENhance and are reviewed at divisional incident review meetings which take place weekly in Paediatrics. This incorporates the PSIRF which supports the decision-making process if further investigation is required. In all cases a Rapid Incident Review/Child Death Review is completed and taken to panel for further decision making on any further investigation required.

ENHT continue to be an active member of the rapid Response to Child Death steering group and have trust wide paediatric mortality review meetings, which examine the dissemination of learning and good practice across the division and Trust.

Safeguarding Adults

Activity

In the year 2024/25, the safeguarding team of the Trust received a total of 648 safeguarding concerns regarding vulnerable adults. These concerns were reported by Trust staff on behalf of service users and related to instances of abuse occurring within the community. The pie chart displayed below highlights the mix of adult safeguarding cases for the year 2024/25. The primary categories of abuse reported by Trust staff encompass issues related to individuals who are self-neglecting, cases of complex domestic abuse necessitating S42 level support, and concerns regarding vulnerable individuals affected by neglect and acts of omission whilst lodged with another care provider or in their own homes.

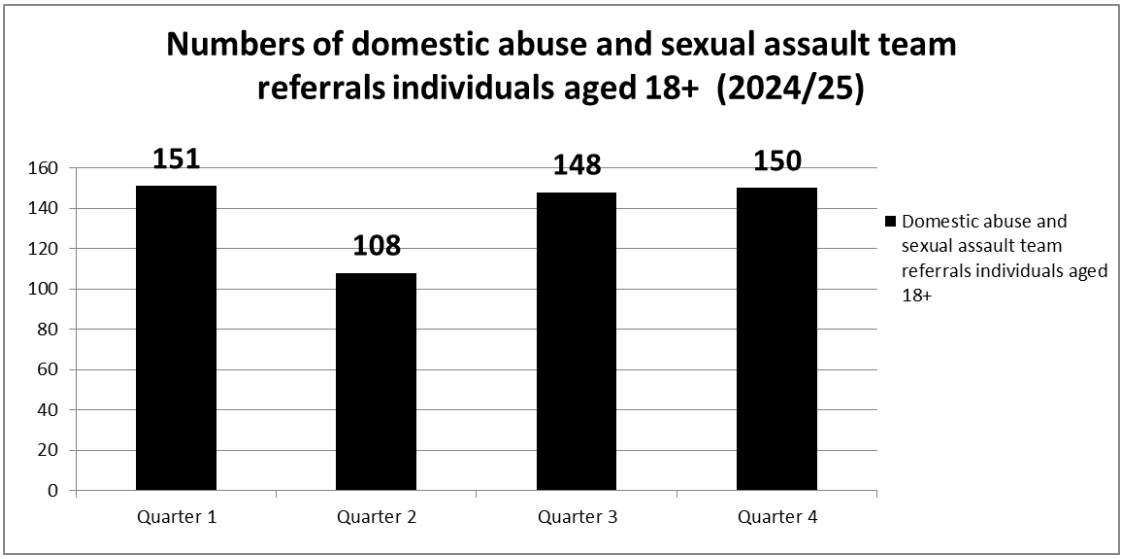


Domestic and Sexual Abuse

The graph below highlights the total number of adult domestic abuse concerns managed by our domestic abuse and sexual assault team (DSAT) per quarter amongst individuals who did not meet the Care Act 2014 definition of a vulnerable adult. The Trust currently employs three full-time staff members in the team who collaborate with the trust's safeguarding team in specialised roles focused on supporting victims of both domestic and sexual abuse. The team offers personalised, victim-centred support to individuals affected by sexual or domestic violence or abuse, including both staff members and children/adults accessing trust services. The team provides impartial advice and support for adults aged 18 years and over, with specialist expertise provided by a team member with a focus on children and young people (CYP) under the age of 18. Support is delivered in a manner that prioritises the needs of victim, offering them various options open to them following a disclosure of abuse. This includes guidance on reporting the crime to the police, accessing a sexual assault referral centre (SARC), and connecting with other specialised support organisations. DSAT work in collaboration with a broader multidisciplinary team (MDT) to effectively address the risks and requirements of individuals referred to them. Support services encompass helping individuals navigate health and social care resources, securing safe and appropriate housing, and providing advice on how to report assaults to the police. A key objective for the safeguarding teams is to ensure that the DSAT is easily accessible to both staff and patients, allowing for a prompt response to victims and facilitating timely access to supportive services.

Benefits of onsite domestic violence and sexual violence advisors in ENHT include:

- Same day face to face support offered to victim in a safe space
- Additional services available to support (LD, Language Line, MH services)
- Live staff support and supervision in case management
- The team routinely provide domestic abuse training for our patient facing practitioners in the Trust
- The team also represents victims and the Trust during MARAC proceedings
- Support can be offered in scheduled appointments (outpatients/maternity), immediate action on non-disclosed DA but with high risk factors (MH, substance abuse, frequent attender)



A total of 60, S42 safeguarding concerns were escalated to the organisation by the local authority regarding care delivered by a Trust service, representing a 19% decrease compared to the previous year. The predominant theme of these concerns was linked to the development of hospital acquired pressure ulcers during an episode of care. Our tissue viability team, in collaboration with the relevant ward teams and practice standard matrons, examined each incident, which were also subjected to divisional governance processes. These reviews aimed to formulate mitigative action plans that could be implemented in the care plans of future patients moving forward.

The second most common reason for a S42 concern being raised against the Trust related to omissions in the discharge process involving failures such as not making district nurse referrals when indicated

or missing discharge medications. In 2024, the Trust developed a discharge pathway aimed at minimising the risk of omissions during the patient discharge process. This proforma was created through the analysis of incident forms and through its introduction, the number of discharge related S42 decreased when compared to 2023/24. Currently, the Trust's discharge steering group is working on additional pathways to further mitigate omissions at the point of discharge, including the creation of safer discharge procedures that will eventually be integrated into our Trust's electronic records system.

One case was reported to the police who concluded that no further action to be taken upon completion of their investigation. An internal investigation could not identify a member of staff who's reported name could not be linked to a member of staff working on the unit where the assault was reported to have taken place. The second report of sexual assault was submitted by a service user concerning an incident of care within the Trust, which they indicated occurred 9 years previously. The individual was contacted for support and advised a safeguarding practitioner not to report the matter to the police as they were receiving ongoing support from another psychological well-being service and believed that their involvement in a police investigation would result in psychological harm to them. This individual was encouraged to report the issue to the police or to connect with the Trust's safeguarding team in the future when they felt prepared to participate in an investigation and was signposted to specialist sexual abuse services. The individual could not recall a sufficient description or name for the alleged perpetrator. A trauma informed approach was taken in considering the management of this concern as escalation to the police without consent would have been disproportionately psychologically harmful to the individual in the context of the passage of time. Routinely the Trust position is to report such matters to the police for criminal investigation as a local safeguarding investigation do not meet the required thresholds.

In managing safeguarding issues associated with a care episode, the safeguarding team collaborates closely with relevant specialties through established patient safety governance processes. This collaboration aims to identify and implement responsive learning strategies to reduce the risk of similar incidents occurring in the future.

In 2024/25, the local authority revised their S42 management strategy and discontinued the practice of either substantiating or not substantiating concerns raised against an organisation. Instead, they opted to implement a process for obtaining learning assurance from providers based on the theme's trends and root causes of S42 referrals. The Trust safeguarding team in conjunction with clinical specialities including the patient safety team co-produce learning actions for clinical areas with practice standard matrons overseeing the implementation of the learning in clinical areas.

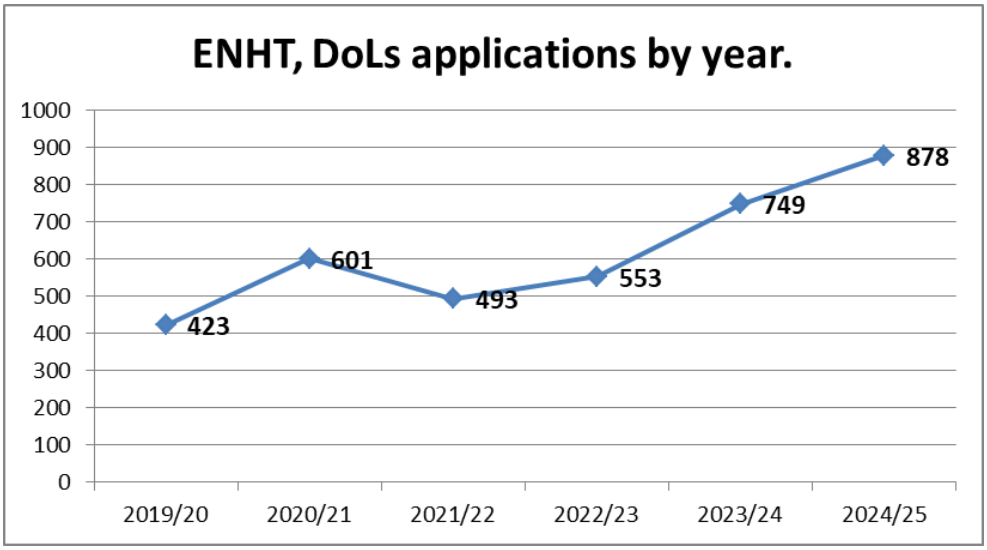
Prevent – referrals to Channel Panel

Two referrals were submitted by the Trust to channel panel who ultimately determined that no further action was required. All Trust staff are required to complete the home office WRAP prevent level 3 training. Currently, 91% of Trust staff have completed Level 3 training.

Deprivation of Liberty Safeguards (DoLS) and new Liberty Protection Safeguards (LPS)

DoLS provide legal protection for those people aged 18 years and over who lack the mental capacity to consent to the arrangements for their care or treatment in a hospital, or care home, and in whom, within the meaning of Article 5 of the European Convention of Human Rights (ECHR), are deprived of their liberty, in their best interests, to protect them from harm.

Over the past six years, the Trust has experienced a significant rise in the number of DoLS applications. Prior to formal submission to a supervisory body, each application is audited by the adult safeguarding team to confirm compliance with the legal criteria set out in the Mental Capacity Act 2005. The increase in applications can be primarily attributed to enhanced staff awareness of the relevant legislation, which has been fostered through educational initiatives and increased oversight provided to clinical teams by members of the safeguarding team. The graph below highlights the number of DoLS applications made by the Trust over the course of the past 6 years.



The rollout of Liberty Protection Safeguards (LPS) which received Royal assent in 2019, is intended to replace the current Deprivation of Liberty Safeguards (DoLS) framework. Its introduction has been postponed at national level, with no clear timeline for its launch yet communicated by the department of health and social care.

Rapid Reviews (RRs) Safeguarding Adults Reviews (SAR), Partnership Case reviews (PCR) Domestic Homicide Reviews (DHRs)

The Trust are members of the HSAB SAR's subgroup and regularly provide input into review processes incorporating learning into training provided to staff, with learning also reflected in the review of relevant Trust policies. Identification of self-neglect and its management, along with suicide prevention and house fires was a particular risk factor noted in reviews undertaken in Hertfordshire during 2024/25.

In the period of 2024/25, the Trust presented two formal referrals to a safeguarding board for a request regarding the SAR review process. One case pertained to persistent self-neglect exhibited by a young adult suffering from a long-standing chronic illness. This individual had been in contact with various services across several counties over the last five years of their life. Ultimately, the SAR review group in central Bedfordshire decided not to conduct a formal review.

The second for an individual who sadly committed suicide in early 2025 remains under consideration; no decision has been made by HSAB on whether to commission a SAR review. This individual is currently subject to a joint ENHTT and HPFT Patient Safety Incident Investigation (PSII) with the Trusts adult safeguarding team providing input.

The Trust is currently involved in an ongoing SAR review relating to the death of an adult with a learning disability with a bowel obstruction. Preliminary actions have been identified which have been incorporated into the Trust's revised policy for management of individuals with an LD. Examples of learning include the use of call 4 concern for carers of individuals with an LD, the rollout of the Bolton pain scoring tool, a revised Bristol stool charting system which will benefit service users with multiple cognitive vulnerabilities. The safeguarding team is collaborating with the ORBIS development team to implement improvements to the Trust's electronic patient record system, aiming to enhance the care of individuals with learning disabilities in the future. This incident took place before the official launch of Tier 2 Oliver McGowan training, and it has been identified that there is a high possibility that had this training been available at the time of the incident, it would have fostered greater staff awareness regarding this patient's needs during their episode of care.

The Trust continues to engage with two Domestic Homicide Reviews (DHRs). Issues such as the co-dependence on alcohol or illegal substances within abusive relationships, and the impact of caregiver stress on families were themes identified in DHR's conducted by HSAB during 2024/25. We actively

participate in DHR reviews, and the insights gained are routinely incorporated into future revisions of our domestic abuse policy. Additionally, our Trust's domestic abuse training, facilitated by our Domestic Abuse Support and Training (DSAT) team, has incorporated the practice identification and management of the key issues highlighted in these reviews.

Adult Safeguarding Training

In order to protect children and adults from harm, all healthcare staff must be competent to recognise safeguarding concerns across the life span and be able to effectively action as appropriate within their role. Safeguarding training is a fundamental part of the Trust's duty to safeguard our most vulnerable people.

All Trust safeguarding training packages are based on recommendations outlined in the intercollegiate documents for both adults and children's safeguarding competencies for health care staff (2024 and 2019 respectively). The safeguarding learning and development and training needs analysis is commensurate with this guidance.

The safeguarding training packages are continuously reviewed and are delivered predominately through eLearning modules. Additional safeguarding adults and children's safeguarding training is offered in a classroom-based format for Level 3 compliance purposes.

MCA/DoLS training was previously delivered alongside adult safeguarding L2, however due to the move to eLearning, staff are now required to complete MCA/DoLS as a separate module uploaded to the staff academy. Staff are also offered the opportunity to top up MCA/DoLS training by attending face to face or MS teams-based training sessions provided by the adult safeguarding team.

A WRAP prevent level 3 module for health care developed by the home office was also uploaded to ESR for all staff to complete. Currently 91% of Trust staff have completed this eLearning module in the past 3 years.

The Trust target is for 90% of Trust staff to complete the training outlined in the table below. Staff are required to complete eLearning modules via the Staff Academy which was introduced in April 2021.

Module	Trust Compliance % (Current position on Power BI)	Target
Adult safeguarding L1 (All Trust staff)	92%	90%
Adult safeguarding L2 (safeguarding training strategy for staff inclusion criteria)	89%	90%
WRAP prevent L3 (All Trust staff) (NHS digital target for Trusts 85%)	91%	85%
Adult safeguarding L3	TBC (Added to corporate risk register ID 6893	90%
MCA/DoLS (Patient facing health care professionals)	75%	90%
Oliver McGowan Tier 1 e-Learning plus interactive (all Trust staff)	42%	85%
Oliver McGowan Tier 2	37%	90%

Compliance is monitored by the divisions (Power BI) and reported bi-monthly to the Safeguarding Committee along with actions to address non-compliance.

Staffing groups that continue to have low compliance with training are medical and dental staff. This has been escalated to the Trust Medical Director and actions to increase compliance are under

development. Lower attainment amongst this group is a significant factor in the lower MCA Trust compliance percentage.

Staff are also routinely encouraged to attend external training events provided by Hertfordshire Safeguarding Children's Partnership and Hertfordshire adult safeguarding board.

The safeguarding team has created a training passport for staff to complete as part of adult safeguarding level 3. This initiative aims to assist staff in demonstrating compliance with the level 3 requirements outlined in the intercollegiate document. A target audience of 3,500 staff members must show that they have completed 4 hours of safeguarding training and engaged in 4 hours of safeguarding-related practice over a three-year period. Given the large number of staff required to evidence level 3 compliance and the limited resource available within the safeguarding team, it is unfeasible for the team to individually validate each passport. Consequently, a digital solution has been proposed to the Trust Academy and education teams, which would enable line managers in clinical settings to electronically validate their own staff passports. This proposed system would function similarly to the revalidation systems used by various professional bodies, allowing for the electronic tracking of overall trust compliance levels for reporting purposes. The delay in implementing this system is outside the safeguarding team's control and has been raised with the Trust's safeguarding committee and the STAT/MAN steering group and has been added to the Trusts corporate risk register.

Oliver McGowan training began at the Trust in April 2024, with the Tier 1 module primarily delivered through eLearning. The Tier 2 module consists of a 7-hour in-person training session conducted by a provider commissioned by the ICB. Initially, only a limited number of Tier 2 sessions were offered, which did not satisfy the demand. Over the course of the year, the frequency of Tier 2 training sessions has increased at both the Lister and Mount Vernon sites which we anticipate will positively reflect on training compliance rates toward the end of 2025/26.

Safeguarding Audit Activity

During the reporting period, a comprehensive audit programme was undertaken, with action plans developed to address the recommendations. The table below highlights the audits undertaken and learning identified.

Safeguarding Audit or Quality Assurance Activity undertaken by Topic/Title	Methodology i.e. Employee Survey, dip sample, case file audit, Customer Survey etc.	Outcome (Summary of key findings / learning)	Has the learning and actions been implemented?
HSCP Multi-Agency Audit of Physical Abuse Pathways	Case file audit	Primarily practice was in line with the policy, the quality off referrals was good	Evidence of practice which was highlighted as good/outstanding in cases identified and managed by ENHT.
Paediatric Liaison Audit	Audit of Psychosocial records	Improvements noted to the number of cases where additional concerns were being identified by the Paed liaison service which reflects a heightened awareness of vulnerability for children at the point of care. Increase in paediatric liaison activity.	Action plan in place.
Children's Social Care Referral Audit	Audit of Children's Social Care Referrals	Improvements have been made to the overall quality of children's social care referrals from ENHT. Identification for pockets of improvements – including improving narration of risk in respect of parental mental ill health and impact upon children and YP.	Action plan in place
Recognising Abusive Fractures in Children	Audit of Clinical Assessment for children under age 2 who present with fractures	Training and education in place, alongside action plan in improving consistently the clinical assessment of children and safeguarding considerations for non-accidental injury.	Action plan in place
Head Injuries	Audit of Clinical Assessment for children under age 2 who present with head injuries.	Training and education in place, alongside action plan in improving consistently the clinical assessment of children and safeguarding considerations for non-accidental injury.	Action plan in place
Children's Social Care – Multiagency Referral Audit	Audit of Children's Social Care Referrals and Multiagency outcomes	Highlighted need for training and support for practitioners in improving quality of referrals, key areas also highlighted challenges with Children's Social Care portal and referral rejections – leading to escalations to ICB and onward mitigations by ENHT	Learning for Trust, implemented.

Safeguarding Audit or Quality Assurance Activity undertaken by Topic/Title	Methodology i.e. Employee Survey, dip sample, case file audit, Customer Survey etc.	Outcome (Summary of key findings / learning)	Has the learning and actions been implemented?
Child Protection Medical Audit	Case file audit	Improvements have been seen across key indicators, recognition of changes to be made to the child protection medicals and improvements in documentation of chaperone name and position details	Learning implemented
RCPCH National Child Protection Medical Benchmarking	Audit of Safeguarding Arrangements	Reflected robust compliance with CPM good practice quality standards	Completed
MCA audit	Multiple case file audit undertaken by the adult safeguarding team	Quality of mental capacity assessments and best interest decisions. Findings: Clarification is needed regarding the purpose of the decision for which the patient's mental capacity is being evaluated. Audit noted ambiguity in completed capacity assessments which would not satisfy legal threshold, pockets of good practice noted	Action: (1) Re-audit 2025/26. (2) MCA E-Learning package replaced with an alternative health education England approved module, which is better directed towards secondary care (3) To continue to deliver face to face training at various education forums and to provide staff with the opportunity to attend MS teams-based training to supplement E-Learning. (4) To improve medical staffs completion rates for MCA which is currently sitting at 54%.

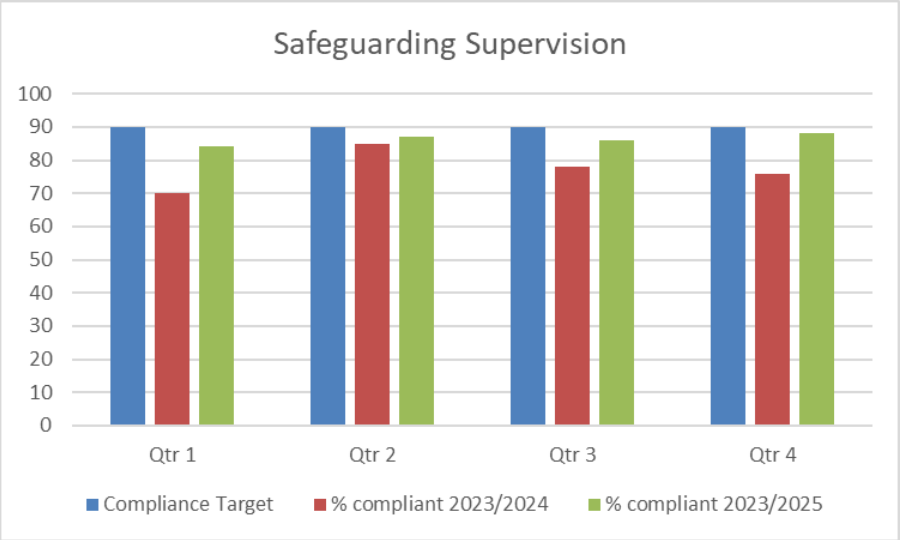
Safeguarding Audit or Quality Assurance Activity undertaken by Topic/Title	Methodology i.e. Employee Survey, dip sample, case file audit, Customer Survey etc.	Outcome (Summary of key findings / learning)	Has the learning and actions been implemented?
Annual National LD Standards benchmarking audit.	Gap analysis undertaken on established Trust practices in comparison to NHS I/E LD standards. Staff survey on Trust LD infrastructure and practice awareness undertaken. Audit undertaken on the hospital experience of individuals with an LD who received care during 2023/24.	The Trusts year 7 report was shared at the learning disabilities working group and safeguarding committee in September 2025. The introduction of 'Ask, Listen, and Do'. Is a priority.	In the third and fourth quarters of 2025/26, the patient experience team, in collaboration with the health liaisons team, will be developing a process for 'Ask, Listen, Do' within the organisation.
National LeDeR report Trust activity comparison.	Comparative audit conducted based on Trust outcomes.	SJR's for LD patients reviewed against a cohort of 300 patients who died in the Trust who did not have an LD. Monitoring for inequities. Audit was presented at the Trust LeDeR working group and at the Trusts mortality review committee.	The mean age of death for individuals with an LD where higher than the national average but lower than the Trusts average. Individuals with an LD were more likely to have their care rated as adequate in comparison to the general patient population in the Trust. The mortality lead in the Trust now sends SJRs to the HLT and safeguarding teams to review SJRs for individuals with a learning disability rated adequate or below for analysis on whether issues found in the individuals care warrant escalation to PSIRF.

Safeguarding Audit or Quality Assurance Activity undertaken by Topic/Title	Methodology i.e. Employee Survey, dip sample, case file audit, Customer Survey etc.	Outcome (Summary of key findings / learning)	Has the learning and actions been implemented?
'Was not brought' (LD)	This audit is conducted on a monthly basis.	This audit is undertaken, and results actioned on a monthly basis to promote improved attendance amongst individuals with LD at outpatient appointments.	We have noted a month on month decrease in missed appointments amongst the target patient group. Due to the success of the 'Was not brought, action audit process the safeguarding team will continue to undertake this audit on the monthly basis as a routine activity.
Maternity safeguarding, domestic abuse audit.	This audit is conducted bi-annually.	This audit is conducted bi-annually, however there are plans to increase to quarterly based on the audit findings.	Recommendations included consideration of auditing cross border cases, improved training specific to domestic abuse and communications to be sent to staff with Trust Wide DA Policy attached.
FGM audit.	Annual audit of all FGM cases booked within the reporting period.	This audit is conducted annually to consider current pathways and processes and seek to improve and strengthen service provision and pathways in respect of FGM.	Recommendations included FGM questions to be embedded within the maternity digital system. Communications were sent across maternity with regards to process once a woman who has undergone FGM has been identified.
Community midwife attendance at ICPC	Annual audit of all Initial Child Protection Conferences we are invited to.	This audit is conducted annually to ensure we are meeting the statutory requirements by providing a report and attending Initial Child Protection Conferences for all unborn babies.	Recommendations included training regarding incorporating voice of the child into ICPC reports for UBBs.

Supervision and peer Review

Supervision – Children's safeguarding

The safeguarding team continue to provide formal and informal safeguarding supervision to all frontline clinical staff working in paediatrics. The Trust target for compliance as set by the ICB is 90% for Band 6 and 7 staff and caseload holders working within community setting.



The above chart demonstrates a clear upward trend in compliance performance across the reporting period. The compliance target remains set at 90% each quarter.

For 2023/2024, compliance began notably below target in Quarter 1 but improved steadily across subsequent quarters, closing the gap significantly by year-end. In comparison, 2023/2025 performance has remained consistently strong, aligning closely with or meeting the target from Quarter 2 onward.

This trajectory reflects strengthened safeguarding supervision processes, improved adherence to standards, and the positive impact of targeted interventions. Sustaining this level of compliance will be key to maintaining assurance and minimising safeguarding risks moving forward.

The safeguarding team prioritised areas of supervision to ED, paediatrics and community services. In addition, the team have provided weekly supervision time for ED nursing staff, monthly supervision to medical staff working in the ED, alongside the usual safeguarding supervision offer to paediatrics and the Trust as a whole.

This has supported safeguarding practice during the height of Trust operational pressures, and offered a space for staff to reflect on some of the complex safeguarding cases which have frequently presented to our high risk areas. A priority for 2024/2025 has been to standarise the oversight of staff supervision, giving great accountability to department managers and staff in mainatining their safeguarding supervision expectations.

Supervision – Maternity Safeguarding

During 2024/2025, the maternity safeguarding service experienced significant staffing challenges. This is the second period reported on whereby the service has been faced with significant staffing challenges. This has contribued towards a recognised drop in maternity staff accessing safeguarding supervision.

The safeguarding team have continued to offer safeguarding sessions for all identified staff, plus extra sessions for ward based staff and leaders. A plan is in place to not only increase the number of midwives who access safeguaring supervision but the way we showcase the value. The agreed action is to hold weekly safeguarding supervision which community midwives will be rostered to attend. This has been agreed by both the maternity safeguarding team and the community team leaders. This will put a safety net in planning in advance and a commitment to engagement.

All specialist midwives will be offered safeguarding supervision to not only support them in experiencial learning but to offer guidance to the team when requiring advice and support . All leadership teams will have the opportunity to engage with an aim to support the smooth running of active cases that require acute and pre planning of cases.

The focus of the monthly safeguarding meeting with matrons will be to discuss pending cases for that month with an aim to assure the team that planning is in place and to offer scope around how the team can meet the family approach.

The local directive is that all community midwives are offered safeguarding supervision due to the nature of managing high risk cases and the work carried out with the wider teams. The recommended uptake is set at 90% engagement every 3 months, and with careful planning and commitment from the maternity safeguarding team, we aim to meet this expectation.

Supervision – Adult Safeguarding

The Trust's adult safeguarding team provide education to staff on national and local safeguarding process and raise awareness on the recognition of abuse and its causes. The safeguarding team routinely provides direct supervision, advice and support to frontline staff that are actively managing and reporting concerns on a case-by-case basis. The current supervision pathway offers line managers an opportunity to supervise staff on safeguarding matters outside of situations where direct case supervision is offered by adult safeguarding practitioners. This function also serves as an opportunity for staff to validate that they are meeting L3 adult safeguarding compliance, our supervision SOP is published on the Trust intranet.

Peer Review

Peer review is fundamental to our commitment to ongoing professional growth. It fosters a collaborative environment, reducing professional isolation and promoting the consistent adoption of best practices across our services. Our aim is to achieve uniform practice through a proactive approach that includes shared learning, robust supervision, and continuous education and training, all designed to improve both our direct service provision and multi-agency collaboration.

We monitor attendance closely, with a minimum expectation for individual consultants to participate in peer review at least once every 12 weeks. While we actively encourage all consultants and junior doctors to attend, direct feedback is provided to consultants and associate specialists who have missed more than three months of meetings.

These sessions are highly effective as a training forum, utilising detailed case discussions, and consistently see strong attendance from our acute and community paediatricians and junior medical teams. Particularly for children's safeguarding, peer review is invaluable. It provides a structured space to analyse complex situations, identify systemic improvements, and ensure our multi-agency responses are as effective and protective as possible. We regularly incorporate learning points from national Serious Case Reviews (SCRs) and any local Serious Incidents (SIs) or learning reviews,

continually strengthening our safeguarding practice. We also encourage the specialist child protection nursing team to attend as well.

Health Liaison Team

The Acute Liaison Learning Disability Nurses at Hertfordshire Health and Community Services remain dedicated to assisting patients with Learning Disabilities (LD) and their caregivers in navigating hospital services. They collaborate with Trust staff to implement necessary reasonable adjustments for patients, offering guidance on potential adjustments, utilising suitable communication methods for individuals with LD, facilitating appropriate discharge care packages, and supporting end-of-life care. Additionally, they provide training to staff regarding the specific needs of patients with learning disabilities.

The Trust has an LD alert function inbuilt in our electronic patient records system, which can be accessed through both Nervecentre and Lorenzo. As of January 2025, there were almost 4,000 individuals identified in our electronic records with an LD alert flag, with the majority of these individuals being residents of Hertfordshire.

The alerts on the Nervecentre continue to produce a daily report which is emailed to the LD nurses and matrons so that they are aware of the patients who are in hospital. At the daily site safety huddle on the acute site (Lister Hospital) all inpatients with LD are discussed to ensure that issues or concerns escalated by the health liaison team practitioners are resolved promptly.

Learning disability working group and improvement action plan

During 2024/25 there has continued to be focused work on improving care for patients with learning disability. Learning from LeDeR reviews was cascaded to clinical teams including learning from the national LeDeR program report which will be included in our revised management of individuals with an LD or Autism policy. A particular focus of education this year related to the completion of RESPECT documents, the introduction of ‘Ask, Listen, Do’, and the importance of incorporating reasonable adjustments into the care of individuals with an LD.

The Trust engaged in the National Learning Disability Audit in Q4 of 2024/2025 to evaluate its performance in relation to NHSE standards for the care of individuals with learning disabilities. Identified deficiencies are included in the action plan of our Trust’s learning disability working group. Additionally, the Trust remains active in Hertfordshire’s working group focused on improving healthcare outcomes for individuals with an LD or autism.

Priorities for 2025/2026

In considering the progress made against the priorities of the previous year, along with the current national priorities and agenda for safeguarding, the priorities below will continue to underpin the Trust safeguarding strategy and forward plan for the safeguarding team:

Training & Supervision:

- Achieve and maintain safeguarding supervision and all levels of Safeguarding training compliance at 90%
- Create tailored, introductory bitesize learning packages to enhance staff understanding and confidence
- Strengthen the Safeguarding Champions initiative to strengthen local leadership, promote best practice, and enhance safeguarding awareness and accountability across all teams

- Review digital solutions for improving recording and oversight of staff safeguarding supervision via our current digital platforms to improve accountability, and enhanced access to training and professional development resources
- Introducing use of debriefs post separation of mother & child to support reflective learning and staff wellbeing
- Enhance obstetric staff engagement - increase participation and collaboration from obstetric teams through the development and delivery of a dedicated training package
- Continued provision of Face: Face or MS teams hoisted MCA/DoLS training for staff
- There is a need for the people team and educational team to add a staff L3 compliance capturing system for adults onto the staff academy

Capturing the Voice of the Vulnerable People and embedding this into our future services:

- Conduct audits in children's services - reviewing current practice in capturing the child's voice within assessments and involvement of medical treatments
- Amplify patient voice, working towards co-production of service improvement - the Patient Experience Midwife to gather feedback from RED RAG–rated women, ensuring that the "voice of the unheard" is obtained and can be utilised to inform and support service improvement and a trauma informed approach to practice

Digital transformation for Safeguarding

- Creating a robust and efficient method for raising Safeguarding and Information Sharing requests, further integrating our maternity safeguarding and perinatal mental health teams, whilst also integrating our Community Services
- Strengthen the datasets for Safeguarding Children and Maternity activity and creating an enhanced oversight of Community Children's Service safeguarding activity
- Strengthen oversight of IHA datasets and ensure reporting is accurate in view of mitigations
- Digitalise internal adult safeguarding referral and case management mechanisms through the Trusts ENHance software (Expected delivery Q3)
- Digitalise the internal process for submitting DoLS applications internally via the Trust ENHance software.
- For the safeguarding team to work closely with the ORBIS implementation team to ensure software at launch is fit for safeguarding purposes.

Improving ongoing partnership work and strengthening risk assessments for aspects related to safeguarding such as:

- children not in school
- Individuals who pose potential risks to children and staff
- domestic abuse
- standardising cross border pathways of care for vulnerable own and unborn babies
- identifying medical neglect

Board

East and North Hertfordshire Teaching NHS Trust

Meeting	Public Trust Board		**Agenda Item**	14	
Report title	Board Assurance Framework (BAF) – Strategic Risks		**Meeting Date**	14 January 2026	
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:

Reflecting the reasonable assurance rating score for the BAF the Board determined at November's Board. The rationale is the reasonable assurance rating reflects the robustness of the BAF process rather than being a judgement on outcomes which can be outside the gift of the Trust such as a decision on the future of cancer services or system instability with ICB changes.

Summary of key issues:

Key matters to highlight

- **Risk 9 (Future of cancer services):** Hugely positive progress with the national team confirming in writing the capital funding, meaning the consultation can launch in January 2026.
- There is one risk score increase: **Risk 7 (System instability)** increasing further from 16 to 20 due to rapid development of changes included within the 10 year plan, ICB distraction with restructuring coupled with lost local East and North Hertfordshire memory with limited East Central ICB senior leadership coming from the existing ICB. The score was already increased at September's Committee from 12 to 16. December FPPC supported the increase. A mitigation is the Trust's Chief Executive has been asked to be one of the provider representatives on the Central East ICB. System CEO meetings have been increased from monthly to weekly meetings. Most mitigation actions that are within the Trust's gift have already been completed.

Board spotlight on two BAF risks

Spotlighted BAF Risk 2 *(Health inequalities) – Justin Daniels*

- Really positive progress with the newly formed Health equity group and health inequalities workplan added as new important controls and drivers. Assurance scores have been rated as prudently low for these new controls but are expected to increase as these controls develop and embed to demonstrate improving outcomes.
- The Board Seminar considered health inequalities in both July and October 2025, with agreement on particularly trying to tackle child poverty health inequalities.
- Equally, there is still much work to do in the health inequalities space in the context two of the five areas in the NHSE capability self-assessment marked as partially compliant related to health inequalities.
- "An ICS delivery plan is needed for its Patient EDI Strategy" has been closed as a gap given the ICS have fed back no separate EDI delivery plan is planned because health inequalities is weaved across ICS approaches.
- Transition from paediatric to adult care has been added as a gap.
- Progress is being made on paediatric audiology with a clear road map.

- However, there is more work to do on community paediatrics.

Spotlighted BAF Risk 3 *(System and internal financial constraints) Martin Armstrong*

- The Chief Finance Officer has put considerable effort into updating the risk with a fundamental re-write of the Gaps and Actions section with either new or amended gaps identified and proposed actions to address these gaps, shown by tracked changes. December FPPC supported the changes but asked that embedding the new accountability framework be retained as a gap.
- The risk score remains high at 20 reflecting the challenging financial position set out in the performance section update.
- Monthly Delivery Board, chaired by the Chief Executive, has been added as a control.

Latest on the other BAF risks:

- **Risk 1 (Investment and Estates)**: Significant updates to the Gaps and Actions section shown as tracked changes, though risk and assurance scores remain unchanged.
- **Risk 4 (Workforce morale whilst making necessary staffing savings):** A Resourcing Panel was introduced in October, designed to replace the Vacancy Control Panel with a broader remit than just vacancies, covering setting and controlling the right type of resourcing for the Trust. November PCC requested that Workforce Plan added as a gap in controls with Workforce Planning discussed at December's Board Seminar.
- **Risk 5 (Leadership and engagement):** All actions are in date and no assurance scores are below 4, reflecting in the lowest risk score of 9 for any BAF risk.
- **Risk 6 (Compliance culture and accountability):** The accountability framework is embedding. The Board Seminar in October considered compliance culture and concluded the issue was less legal/statutory/regulation compliance and more agreed standards compliance.
- **Risk 8 (Flow and performance):** One substantive change: Work has commenced on the extended Ambulance Handover Bay, which is due to complete by April 2026.
- **Risk 10 (Digital transformation):** Although the One-EPR rollout is taking longer, the December Digital Committee agreed the risk score should not increase beyond 16.
- **Risk 11 (Change management):** 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.

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*

See linked corporate risks on individual BAF risks.

Report previously considered at & date(s):

Board on 19 November; Digital Committee 8 December; People & Culture Committee (PCC) 4 November; Audit & Risk Committee 7 October; Quality & Safety Committee (QSC) 17 December; Finance, Planning and Performance Committee (FPPC) 15 December.

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

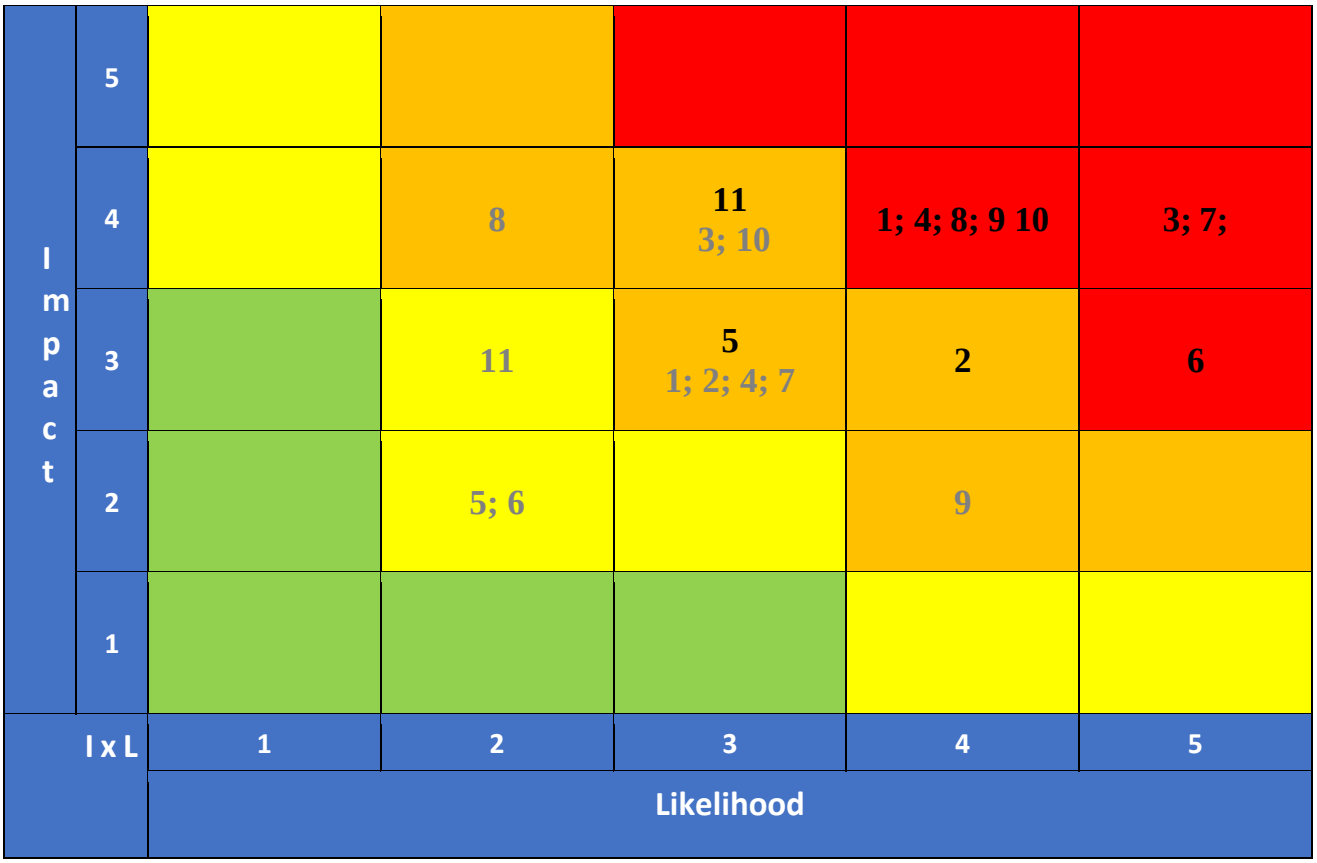
BOARD ASSURANCE FRAMEWORK REPORT

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	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**	Chief Executive	Finance, Performance and Planning	20	↑
8.	**Improving flow and performance**	Chief Operating Officer	Finance, Performance and 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 and 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**

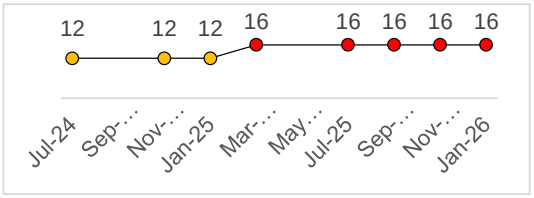
NHS East and North Hertfordshire NHS Trust

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)~~ Monthly Delivery Board	~~Co-ordination of financial improvement activity to support in year delivery of financial plan (2)~~ Chaired by the CEO (2)	~~4~~
Monthly ~~Capital Review~~Investment Group meetings and 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 monthly (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~~Alignment of Capital Investment Priorities With Strategic Need	• ~~25-26 refresh of strategy reviewed at Dec 25 Board Seminar combined with supplementary development of revised long-term financial model~~ Strengthen triangulation between the estates strategy, the Integrated Business Plan and the refreshed long-term capital requirements. • Implement revised Investment Group criteria giving clearer weighting to statutory compliance, backlog risk, digital infrastructure and productivity gains. • Use the 26/27 planning round to set out a three-year forward capital envelope reflecting minimum safety, compliance and replacement needs.	MA	Dec 25 ~~[originally Sept 25]~~
~~Transformational solutions to address the system financial gap~~Limited Assurance on ICS-Level Capital Distribution and Place-Based "Fair Share"	• ~~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.~~ Work with ICS CFOs to secure an agreed fair-shares model for major capital and backlog risk. • Ensure ENHT's core statutory and compliance risks are clearly articulated through the ICS capital prioritisation framework. • Strengthen documentation of ENHT's critical infrastructure risk position through CIG and FPPC.	MA	Q2 25/26 ~~[originally Q1 25/26]~~
~~Confidence in the appropriate deployment of resources across place and providers~~Long-Term Capital & Estate Planning Infrastructure Not Fully Embedded	• ~~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.~~ Complete capital-specific modules of the refreshed LTFM, linked to ICS MTFP assumptions. • Present capital lifecycle modelling and 10-year infrastructure scenarios to FPPC. • Ensure alignment with CE ICB's reconfiguration of Place and provider portfolios.	MA	~~25/26 – ICB Place reconfiguration timetable~~Q3 25/26
Limited Assurance Over Delivery of Approved Capital Schemes	• Continue strengthening CIG reporting with a focus on milestones, risk scoring, slippage forecasting, and cashflow profiling. • Introduce quarterly deep dives to FPPC for high-risk schemes. • Ensure the monthly Investment Group focuses explicitly on scheme delivery grip, not just new bids.	DDOF	Ongoing
~~• Long Term Financial Planning Infrastructure~~ Dependency on System Transformational Capital That Is Not Yet Secured	• Map Trust ~~to refresh its LTFM (linking to~~ dependent system ~~MFTP) to clearly set out options~~capital into a single risk register for ~~resource utilisation within the context of national~~FPPC oversight. • Work with ICS transformation leads to ensure ENHT's priorities are reflected in system submissions (including CSR-linked allocations and diagnostics programmes). ~~•~~ Develop local ~~drivers and strategies. Complete during 2024.~~ • ~~Preliminary Outputs coming to FPPC in Oct 25~~contingency plans in the event that system capital does not materialise.	MA	Q3 25/26 ~~[originally Oct 25]~~

~~Responding to in-year investment opportunities~~Responsiveness to In-Year Capital Opportunities Limited	• ~~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~~Maintain and routinely update a list of ready-to-mobilise capital schemes. • Formalise rapid-assessment processes for in-year NHS capital opportunities. • Strengthen link between digital/estates teams and PMO to ensure schemes are scoped, costed and ready for submission.	DDOF	Monthly ~~investment group meeting~~IG cycle
~~Medium term financial plan~~Compliance Gaps: Backlog Maintenance, Fire Safety and Regulatory Standards	• ~~FPPC review of medium term financial plan refreshed~~Update the estates compliance risk register and backlog model 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~~Prioritise statutory and regulatory risks within capital allocations before discretionary schemes. • Provide strengthened reporting to TMG and FPPC on backlog trajectory and residual high-risk items.	MA	~~Oct~~Q2 25/26

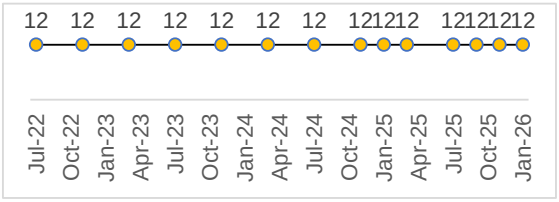
Current Performance – Highlights from the Integrated Performance Report:
• £33m capital programme approved, but several schemes show delivery and slippage risk driven by contractor capacity and inflation volatility. • Backlog maintenance remains high, with key M&E and estates infrastructure beyond lifecycle and carrying material safety and resilience risk. • Fire safety compliance improving, but full assurance won't be achieved until remaining high-risk works are completed. • Digital technical debt growing; multiple systems require upgrade/replacement and cyber resilience gaps remain without further capital. • ICS capital envelope flat and highly constrained, limiting ability to progress key replacements and strategic schemes. • Trust transformation plans increasingly dependent on system-funded capital (diagnostics, elective), with delays creating operational risk. • Internal delivery capacity stretched across estates, digital and PMO, increasing risk to delivery of multiple concurrent schemes. • Market conditions remain challenging: inflation, procurement delays and supply chain fragility impacting cost and timing certainty.

Associated Risks on the Board Risk Register		
Risk no.	Description	Current score
3666	Patient/staff harm & operational disruption due to prolonged MH patients in sub-optimal environments.	16

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
Health equity group projects: Homelessness Inability to work due to health delays Childhood	Status: Initial discussion with partner Initial discussions with partner Review of existing data and discussions with partners	1
Health inequalities workplan	Health equities group progress report (1)	2

	Assurance report to QSC (2)	

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
• Children's 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~~ [Proposed to close: Feedback from the ICS no delivery plan is planned because health inequalities is weaved across ICS approaches]	~~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~~ • ~~Health inequality self-assessment undertaken~~ • ~~Health equity group in formation~~ [Work plan formulated and work starting]	MD	Complete
Transition from paediatric to adult care	• Good work in individual disease groups eg sickle cell disease and diabetes, and complexity - work to do in epilepsy and a number of other disease areas	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~~ Update 24.11.25 Good progress on smoking on site Progress made on paediatric audiology with a clear road map More work to do on community paediatrics

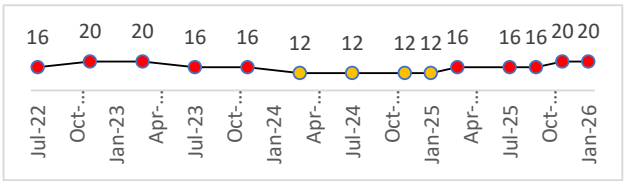
Health inequality group active, self assessment done, 3 potential projects being worked on – cost will be an issue

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~~	~~12~~
3114	Risk to new mothers and babies due to cross-border	16
	Transition from paediatric to adult care (details TBC)	

Strategic Priority: **Consistently deliver quality standards, targeting health inequalities and involving patients in their care**			**Risk score 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**	**5**	**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 and 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~~Investment Group	Monthly meeting DDOF chaired – capital plan review (2)	4
Monthly Delivery Board	Monthly meeting CEO chaired – CIP delivery reviewed	~~5~~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 and~~&~~ 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
Up to Date Finance strategy	~~To December Board Seminar~~26/27 & 27/28 financial plan review and approval to December FPPC prior to submission	~~MA~~CFO	Dec 25 [originally July 25]
~~Medium Term Financial Plan~~High Structural Cost Base with Workforce Growth Outpacing Activity	~~To produce MTFP~~Resource Control Panel meeting X3 per week. Implement workforce cost reduction programme, establishment controls, corporate reductions and workforce redesign. Use job planning and D&C modelling to align deployment.	~~MA~~Execs / PMO	~~Oct~~Q4 25/26
~~Establishment Growth controls~~Structural Under-Delivery of CIP and Over-Reliance on Non-Recurrent Measures	~~• Corporate services recruitment freeze~~ ~~• Approved CIP Plan establishment reduction~~ ~~Temporary staffing regulation versus permanent recruitment~~Delivery Board to oversee CIP delivery. Embed Accountability Framework, strengthen PMO, mandate risk-assessed CIP pipeline, and establish multi-year recurrent savings baseline.	~~• SJ~~ ~~• SJ~~ ~~All~~ Execs / PMO	~~• Q2 25/26~~ ~~• Q2 25/26~~ ~~Oct 25~~Q4 & ongoing

~~Delivery of Trust RTT Plan and impact on Trust financial plan~~ Material Productivity Deterioration vs Pre-Pandemic Levels	~~Working Group set up by TMG to review activity delivery, validation strategy and associated access governance arrangements to provide assurance of RTT delivery strategy~~Deploy revised productivity pack with actionable insights, divisional heatmaps. Scale AI-driven productivity reviews to service lines.	~~LD~~DDOF / PMO	~~Q2~~Q3 25/26
~~Risk of non delivery of CIP / Savings Targets~~ERF & RTT Delivery Misalignment with Financial Plan	~~Accountability framework approved by May Board Seminar~~Accelerate RTT/ERF Working Group outputs, reset divisional trajectories and align workforce deployment to achievable delivery plans.	• ~~MA~~ • ~~MA All Execs~~DDOP	• ~~In place~~ • ~~In place Sep~~ Q4 25/26
~~Risk of significant overspend against Trust expenditure budgets~~Weak System Financial Stability and No Agreed ICS Financial Strategy	Align Trust MTFP with ICS assumptions and push for system-wide financial strategy and recovery alignment.	~~MA~~CFO	~~In place~~Q4 25/26
• Limited u~~U~~nderstanding of ~~financial dynamics underpinning service line performance~~ Service Line Financial Dynamics	• ~~Implementation of~~Fully deploy SLR ~~model – now in go-live~~ • ~~Service Line productivity line production~~ • ~~Revised~~with deep dives and ~~summarised productivity report~~link outputs to ~~TMG focusing on actionable insights metrics~~CIP, job planning and ~~levers – revised productivity report to FPPC~~ ~~– complete with Accountability Framework~~D&C modelling.	• ~~DP / LL~~ • ~~Divisions~~ • ~~DP~~ ~~MA~~DDOF (FP)	• ~~Q2~~Q4 25/26 • ~~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~~Persistent Risk of Expenditure Overspend	• ~~The Trust is required to refresh its medium term financial plan. To be used to frame the 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 national planning and 10Y plan assumptions.~~Strengthen divisional oversight, enhance controls on temporary staffing, procurement and run-rate monitoring.	~~MA~~DDOF(FM)	~~Q3 25/26~~Ongoing
~~Absence of effective job planning framework~~Lack of Long-Term Workforce Affordability Plan	• ~~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 – this is embedded within CIP programme for 25/26~~Develop multi-year workforce affordability plan aligned to CIP, productivity and digital/capital transformation.	~~JD~~ CPO	~~Until year end for review~~Q4 25/26
~~Significant reductions in Trust productivity vs pre-pandemic levels. Significant increases in staff volumes and costs not related to activity change.~~Insufficient Integration of Finance, Workforce, Activity, Digital and Capital Plans	• ~~Productivity report, with an emphasis on insight and actionable activity to be implemented and presented to committee in 25/26. A series of AI generated productivity assessments are being developed to assist service line level reviews.~~ ~~Headcount reduction plan to be incorporated within final CP plan for 25/26 covering both directed NHSE reductions and local schemes~~Apply Trust planning schematic to integrate all planning pillars and establish triangulation checkpoints.	• ~~DP~~ ~~SJ~~CFO	• ~~Q3~~Dec 25~~/26~~ ~~Q2 25/26~~

Embedding the accountability framework	• [Dec 25 FPPC requested added. Actions TBC]	•	•

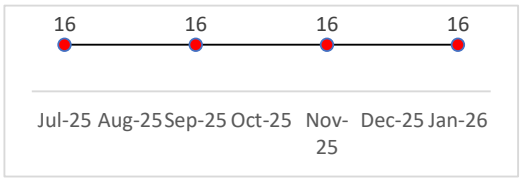
Current Performance – Highlights from the Integrated Performance Report:
• **YTD financial position has materially deteriorated**, with run-rate pressures widening the in-year gap and increasing the likelihood of a significant year-end variance unless further action is taken. • **CIP delivery remains significantly behind trajectory**: only around **53%** of the £35.8m target is forecast as deliverable, with a continued over-reliance on non-recurrent measures and insufficient depth in divisional pipelines. • **Productivity has worsened year-on-year**, with multiple service lines reporting activity below plan despite higher workforce costs; system benchmarking confirms a widening gap vs peers. • **Workforce costs continue to rise**: WTE growth and premium pay spend remain misaligned to activity delivery, with notable pressure in medical and nursing temporary staffing. • **ERF activity is materially behind plan**, reducing income expectations and placing additional pressure on the Trust's underlying deficit position. • **Outturn forecasts now indicate a sizeable financial risk**, with a requirement for additional grip and pace actions to prevent an adverse year-end position. • **Divisional expenditure run-rates remain unstable**, with hotspots in urgent care, theatres and diagnostics requiring intensified performance oversight. • **Validation, RTT and activity governance weaknesses** are contributing to both delivery risk and financial volatility. • **Accountability Framework embedded**, but inconsistent impact at divisional level, with variable evidence of grip on cost drivers and workforce utilisation. • **System position remains fragile**, with HWE ICS forecasting a significant year-end deficit, limiting system flexibilities and increasing the likelihood of further in-year constraints.

Associated Risks on the Board Risk Register		
Risk no.	Description	Current score
~~3300~~	~~Lack of special school nursing staff~~	~~20~~
1834	Renal service demand versus operational capacity	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.
• Updated workforce plan	• Develop a workforce plan • Seek Board input at a Board Seminar	• CPO	• July 26 • Dec 25 - completed

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

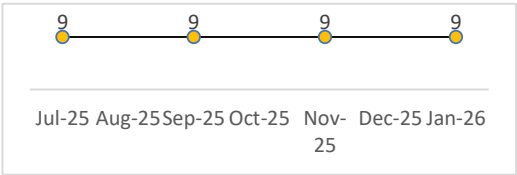
Associated Risks on the Corporate Risk Register		
Risk no.	Description	Current score
	N/A	

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
Inherent	4	3	12
Current	**3**	**3**	**9**
Target	2	2	4

Assurance: 4

Risk Trend



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

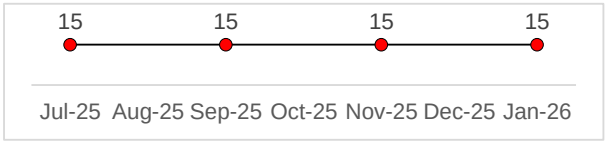
Gaps in Controls and Assurances	Actions and mitigations to address gaps	Lead	Target date
• Capacity to undertake support and development in identified areas to improve leadership practice and engagement • Challenges in the level of organisational engagement across ENHT to make things happen and embed 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 and 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

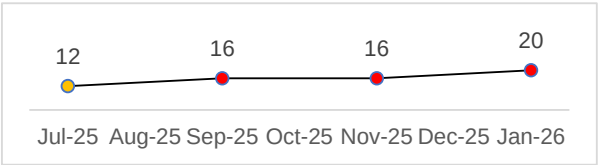
Gaps in Controls and Assurances	Actions and mitigations to address gaps	Lead	Target date
• Time to complete all required training without protected time	• Reviewing stat/mand to basic minimums & core priorities • Current required mandatory and statutory training being reviewed to determine options for 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 20**
Strategic Risk No.7: **System instability**		
If significant and rapid changes are made to NHS oversight and delivery structures	***Then*** decision making may be slowed due to increased ambiguity or management capacity	***Resulting in*** important transformation not keeping pace with patient need.

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



Risk Lead	Chief Executive	Assurance committee	FPPC

Controls	Assurances against stated controls, with assurance level *1st line (front line); 2nd (corporate); 3rd (independent)*	Assurance score
Strategies and Plans		
Trust Strategy and Trust objectives·linking and helping deliver the ICB strategy	• Annual Board approval of new strategic priorities (2) • Annual Board review of Strategy delivery (2) • CEO update to Board includes system developments (2)	6
ICB strategy includes creation of HCPs as multi-agency delivery vehicles	• Approved by ICB (3) • ICB Chair & CEO walks the Board through ICB priorities at least annually • Formal letter from ICB establishing the Trust as a host provider (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~~ weekly 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
• Does the ICB BAF cover the risk of impact of major change	• Propose to ICB that the ICB BAF includes this risk	• CEO	Completed but gap remains~~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	• Influence new ~~I~~ICB cluster as they develop thinking and strategy~~CEOs developing the delivery strategy for the ICB~~	• CEO	• 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	• New clustering now announced and ~~awaiting~~ appointments to key leadership roles made~~with whom to engage~~	• NHSE	• Q3 25 [originally June 25]

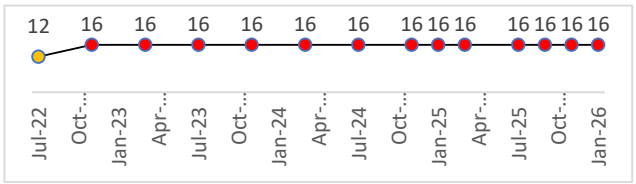
Current Performance – Highlights from the Integrated Performance Report:
• The over-arching system financial break-even plan 2025-26 • NHSE oversight framework assessment of ICB and the Trust • ~~ICB/~~HCP performance dashboard metrics tracking progress against HCP priorities • Risk increased temporarily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

Strategic Aim: **Deliver seamless care for patients through effective collaboration and co-ordination of services within the Trust and with our partners**		Risk score **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 weeks by 3/26; Reduce to max of 1% the % of patients waiting 52 weeks+	• Laura Moore, Head of Performance & Planning • ~~Alison Gibson~~Claire Moore, Interim Deputy COO	• March 2026 [Original: Mar 25]

	• 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, work commenced and due for completion Apr 2026~~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. • 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. • Audiology capital at Lister site allocated @Sept 25 [originally June 25] • Audiology HWE mutual aid discussions underway	• ~~Alison Gibson~~Claire Moore, Interim Deputy COO • ~~Claire Moore~~Natasha Simper, Lead DD	• March 2026 [Original: Mar 25]
• Theatre utilisation and pre – tci	• Recruitment plans ongoing.	• ~~Claire~~	• March

cancellation rate	• 'Drumbeat' huddles to manage activity	~~Moore~~Natasha Simper, Lead DD	2026 [Original: Dec 25]

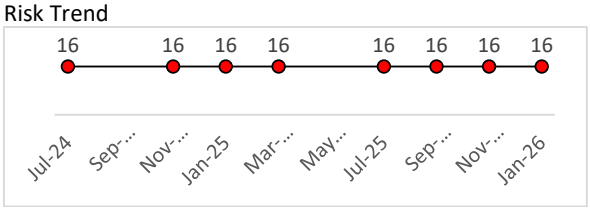
Current Performance – Highlights from the Integrated Performance Report:
• % of 62-day PTL over 62 days • 28-day faster diagnosis • Cancer 31 day waits • RTT performance • 65 and % 52 weeks RTT • % of elective patients 1st appt within 18 weeks • Ambulance handovers • ED 4 and 12 hour performance • Diagnostic 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
Inherent	4	4	16	4
Current	**4**	**4**	**16**	
Target	2	4	8	

Risk Trend



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 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 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
•	•	•	•

• Outcome of service options to NHSE to enable Trust planning	• [Commercially confidential – update to Private Board]	• Lucy Davies	• ~~August 2025~~ • Revised date Jan 26
•	•	•	•
• Public awareness of the impact of the delay on quality of services	• Proactive communication plan if gap agreed. Consultation delayed pending agreement on route to capital for new build.	• NHSE/ICB	• ~~Nov 2025~~Revised Mar 2026
• Lack of a financial mitigation plan for sudden loss of services or significant interim costs whilst awaiting a decision	• 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. Joint Acute oncology service up and running with Watford hospital	• NHSE	• April 2026

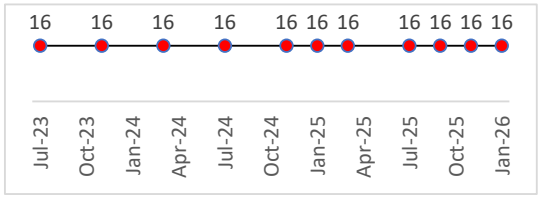
Current Performance – Highlights from the Integrated Performance Report:
• 62 and 31 day cancer performance standards • Faster diagnosis standard • 30 day SACT mortality data • COSD cancer data

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~~Digital

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~~ Digital Committee established May 2025	• All reports to the ~~OneEPR~~ Digital 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~~ Digital 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

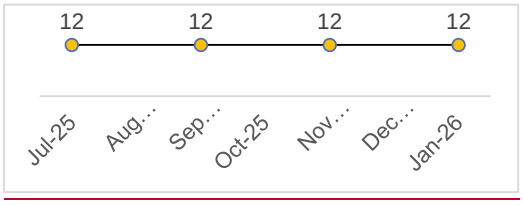
Gaps in Controls and Assurances	Actions and mitigations to address gaps	Lead	Target date
Control gaps • Market movement from Perpetual licensing to Software as a Service (SaaS) is preventing the capitalisation of software licenses and deployment	**Control treatments** • Review Vendor licensing models 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~~ If change is not managed effectively	• ~~Cultural changes via ENH production System~~ • Strengthen executive sponsorship and leadership visibility through the Digital Committee to reinforce accountability for change outcomes, prioritisation, and resourcing. • Ensure early and sustained clinical and operational engagement in system design, pathway redesign, and implementation, with protected time for staff participation. • Embed change impact assessments into programme governance to identify readiness gaps, capacity constraints, and risks to adoption at divisional and service levels.	TGT	~~Dec 25~~ TBC
• 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
• OneEPR does not progress (e.g. running out of funding/supplier issues/not delivering agreed specification etc)	• Maintain robust programme governance through the Executive Programme Board and Digital Committee, with clear escalation routes for delivery, financial, and supplier risks. • Secure and regularly review programme funding and affordability, including contingency planning within Trust revenue and alignment to agreed benefits realisation. • Implement active supplier management, including contractual performance monitoring, milestone assurance, and formal issue escalation to address delivery delays or specification risk.	MS	Mar 26

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: paper records are no longer needed – Update: on track

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. • ~~Establish ENHPS learning network~~ • ~~Health check assessment process~~	• KOH • ~~KOH~~ • KOH • ~~KOH~~ • ~~KOH~~	Mar 26 ~~Completed~~ Mar 26 ~~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	

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Integrated Performance Report

Month 08 | 2025-26

	P	?	F
H / L	3	7	6
L	9	34	8
H / L	0	2	7

Data correct as at 18/12/2025

Performance Highlights

NHS East and North Hertfordshire Teaching NHS Trust

Quality

- Sepsis - InPatient improvements are targeted against lactate measurements and fluid balance measurements within ED .
- VTE assessment - compliance improving within unplanned care pathways, weekly actions are in progress with surgical specialties, and change ideas being tested in recovery.
- One open Psii in progress related to the associated clinical risk of follow up process across the Trust.
- Complaints and PALS - appointments, admissions and communication remain highest reported themes, with delays in response.
- Stroke - now rated D, time to CT and MRI under review
- Maternity - massive obstetric haemorrhage remains under review for any emerging clinical risk and/or learning themes.

Operations

- **Urgent and Emergency Care**: 4 hours on trajectory; 12 hrs improved vs Oct. Median ambulance handover materially down since 2024.
- **Cancer Waits**: Achieved 3/3 targets in October.
- **Referral To Treatment (RTT)** (excluding Community Paeds): Continued on plan. Herts COOs leading on acceleration of integrated CYP Neurodiversity pathway.
- **Diagnostics**: Siemens national recall of 3T MRI affected QE2 and Lister scanners in early December. 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 M8, the Trust has reported an actual YTD deficit of £6.4m. This is in line with phased plan expectations.
- CIP achievement at M8 totals £10.3m. This is significantly short of required delivery
- 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

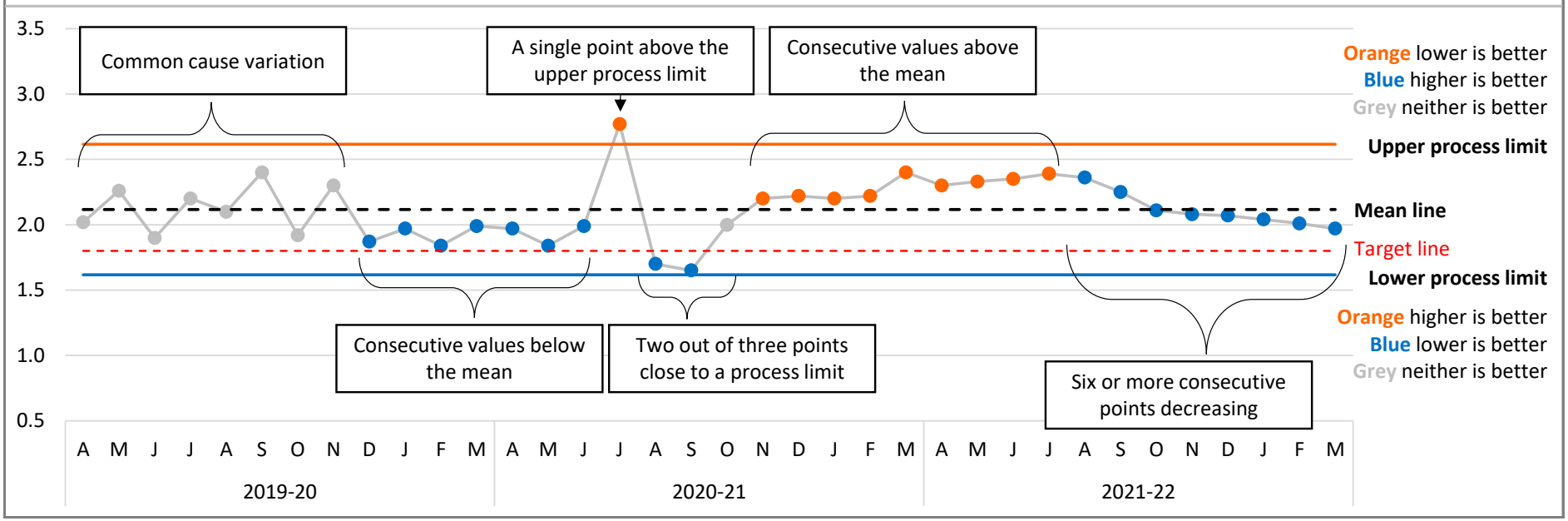
- Staff turnover rate increased to 7.6% but remains below target.
- Overall Bank & Agency spend below target for the first time (8%).
- GROW together compliance continues to improve (87.1%).
- Stat Mand compliance reduced (88.5%), proactive action includes review of role essential training & focused 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 45%.
- Vacancy rate remains under target (5.8%).

Month 08 | 2025-26

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

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Quality

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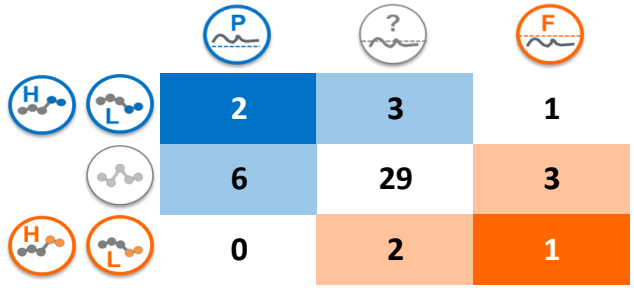

Quality

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	Nov-25	n/a	1,578			14 points above the mean No target
Infection Prevention and Control	Hospital-acquired MRSA Number of incidences in-month	Nov-25	0	0			Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired c.difficile Number of incidences in-month	Nov-25	0	2			Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired MSSA Number of incidences in-month	Nov-25	0	1			Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired e.coli Number of incidences in-month	Nov-25	0	9			Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired klebsiella Number of incidences in-month	Nov-25	0	3			Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired pseudomonas aeruginosa Number of incidences in-month	Nov-25	0	0			Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired CPOs Number of incidences in-month	Nov-25	0	4			1 point above the upper process limit Metric will inconsistently pass and fail the target
	Hand hygiene audit score	Nov-25	80%	94.0%			Common cause variation Metric will consistently pass the target
Safer Staffing	Overall fill rate	Nov-25	n/a	85.9%			9 points above the mean No target
	Staff shortage incidents	Nov-25	n/a	22			Common cause variation No target

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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	Nov-25	n/a	0.66			Common cause variation No target
	Number of deteriorting patient calls per 1,000 admissions	Nov-25	n/a	1.44			Common cause variation No target
Sepsis Screening and Management	Inpatients receiving IVABs within 1-hour of red flag	Nov-25	95%	85.7%	H	?	9 points above the mean Metric will inconsistently pass and fail the target
	Inpatients Sepsis Six bundle compliance	Nov-25	95%	57.1%		F	Common cause variation Metric will consistently fail the target
	ED attendances receiving IVABs within 1-hour of red flag	Nov-25	95%	93.7%	H	?	7 points above the mean Metric will inconsistently pass and fail the target
	ED attendance Sepsis Six bundle compliance	Nov-25	95%	64.6%	L	F	9 points below the mean Metric will consistently fail the target
VTE Risk Assessment	VTE risk assessment stage 1 completed	Nov-25	85%	79.0%		?	Common cause variation Metric will inconsistently pass and fail the target
HATs	Number of HAT RCAs in progress	Nov-25	n/a	265	H		8 points above the upper process limit No target
	Number of HAT RCAs completed	Nov-25	n/a	15			Common cause variation No target
	HATs confirmed potentially preventable	Nov-25	n/a	4			Common cause variation No target
PU	Pressure ulcers All category ≥2	Nov-25	0	10		?	Common cause variation Metric will inconsistently pass and fail the target

Month 08 | 2025-26

Quality

Summary

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Patient Falls	Rate of patient falls per 1,000 overnight stays	Nov-25	n/a	4.4			Common cause variation No target
	Proportion of patient falls resulting in serious harm	Nov-25	n/a	1.4%			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	Nov-25	95%	97.4%		P	Common cause variation Metric will consistently pass the target
	A&E positive feedback	Nov-25	90%	86.4%	H	?	7 points above the upper process limit Metric will inconsistently pass and fail the target
	Maternity Antenatal positive feedback	Nov-25	93%	96.1%		?	Common cause variation Metric will inconsistently pass and fail the target
	Maternity Birth positive feedback	Nov-25	93%	100.0%	H	P	6 points above the upper process limit Metric will consistently pass the target
	Maternity Postnatal positive feedback	Nov-25	93%	97.6%		?	Common cause variation Metric will inconsistently pass and fail the target
Friends and Family Test	Maternity Community positive feedback	Nov-25	93%	97.6%		?	Common cause variation Metric will inconsistently pass and fail the target
	Outpatients FFT positive feedback	Nov-25	95.0%	94.1%		?	Common cause variation Metric will inconsistently pass and fail the target
PALS	Number of PALS referrals received in-month	Nov-25	n/a	476		-	Common cause variation No target

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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	Nov-25	n/a	108		-	11 points above the mean No target
	Number of complaints closed in-month	Nov-25	n/a	70		-	Common cause variation No target
	Proportion of complaints acknowledged within 3 working days	Nov-25	75%	93.0%			Common cause variation Metric will consistently pass the target
	Proportion of complaints responded to within agreed timeframe	Nov-25	80%	29.8%			Common cause variation 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 inconsistenly pass and fail the target
	Massive obstetric haemorrhage >1500ml vaginal	Nov-25	3.3%	6.3%			2/3 points close to upper process limit Metric will inconsistenly pass and fail the target
	3rd and 4th degree tear vaginal	Nov-25	2.5%	1.6%			Common cause variation Metric will inconsistenly pass and fail the target
	Massive obstetric haemorrhage >1500ml LSCS	Nov-25	4.5%	2.1%			Common cause variation Metric will inconsistenly pass and fail the target
	3rd and 4th degree tear instrumental	Nov-25	6.3%	9.7%			Common cause variation Metric will inconsistently pass and fail the target
	Term admissions to NICU	Nov-25	6.0%	5.6%			Common cause variation Metric will inconsistently pass and fail the target
	ITU admissions	Nov-25	0.7	1			Common cause variation Metric will inconsistently pass and fail the target

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Quality

Summary

NHS East and North Hertfordshire Teaching NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Maternity Other Metrics	Smoking at time of booking	Nov-25	12.5%	3.0%			Common cause variation Metric will consistenly pass the target
	Smoking at time of delivery	Nov-25	2.3%	1.2%			Common cause variation Metric will inconsistently pass and fail the target
	Bookings completed by 9+6 weeks gestation	Nov-25	50.5%	72.3%			Common cause variation Metric will consistenly pass the target
	Breast feeding initiated	Nov-25	72.7%	72.4%			Common cause variation Metric will inconsistently pass and fail the target
	Number of MNSI PSII	Nov-25	0.5	0			Common cause variation Metric will inconsistently pass and fail the target
Mortality	Crude mortality per 1,000 admissions In-month	Nov-25	12.8	9.6			Common cause variation Metric will inconsistently pass and fail the target
	Crude mortality per 1,000 admissions Rolling 12-months	Nov-25	12.8	9.3			Rolling 12-months - unsuitable for SPC
	HSMR In-month	Sep-25	100	82.5			Common cause variation Metric will inconsistently pass and fail the target
	HSMR Rolling 12-months	Sep-25	100	89.8			Rolling 12-months - unsuitable for SPC
	SHMI In-month	Jun-25	100	88.8			Common cause variation Metric will inconsistently pass and fail the target
	SHMI Rolling 12-months	Jun-25	100	92.1			Rolling 12-months - unsuitable for SPC

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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	Aug-25	n/a	632			Common cause variation No target
	Rate of emergency re-admissions within 30 days of discharge	Aug-25	9.0%	5.3%	L	P	1 point below the lower process limit Metric will consistently pass the target
Length of Stay	Average elective length of stay	Oct-25	2.8	2.1		P	Common cause variation Metric will consistently pass the target
	Average non-elective length of stay	Oct-25	4.6	5.2		?	Common cause variation Metric will inconsistently pass and fail the target
Palliative Care	Proportion of patients with whom their preferred place of death was discussed	Oct-25	n/a	98.6%			Common cause variation No target
	Individualised care pathways	Oct-25	n/a	37	H		7 points above the mean No target
Stroke Services	Trust SSNAP grade	Q3 2024-25	A	D			
	4-hours direct to Stroke unit from ED	Nov-25	63%	50.0%	H	F	2 point above the upper process limit Metric will consistently fail the target
	4-hours direct to Stroke unit from ED with Exclusions (removed Interhospital transfers and inpatient Strokes)	Nov-25	63%	51.0%		F	2 point above the upper process limit Metric will consistently fail the target
	Number of confirmed Strokes in-month on SSNAP	Nov-25	n/a	75			Common cause variation No target
	If applicable at least 90% of patients' stay is spent on a stroke unit	Nov-25	80%	82.0%		?	Common cause variation Metric will inconsistently pass and fail the target
	Urgent brain imaging within 20 minutes of hospital arrival for suspected acute stroke	Nov-25	40%	39.4%			Not enough data for SPC
	Urgent brain imaging within 60 minutes of hospital arrival for suspected acute stroke	Nov-25	50%	63.0%		?	Common cause variation Metric will inconsistently pass and fail the target

Month 08 | 2025-26

Quality

Summary

East and North Hertfordshire Teaching NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
	% of all stroke patients who receive thrombolysis	Nov-25	11%	17.0%			Common cause variation Metric will inconsistently pass and fail the target
	Discharged with ESD	Nov-25	50%	43.0%			Common cause variation Metric will inconsistently pass and fail the target

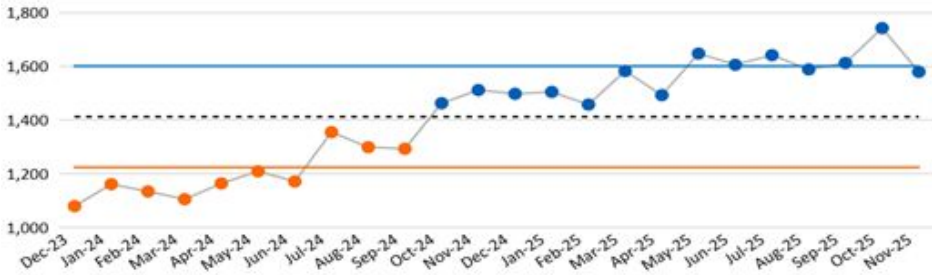
Month 08 | 2025-26

Quality

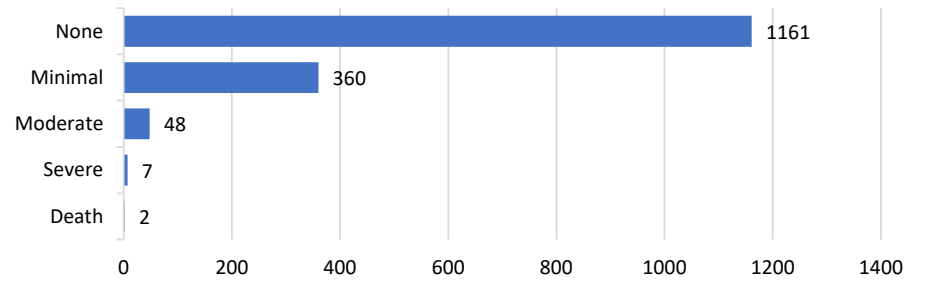
Patient Safety Incidents

NHS East and North Hertfordshire Teaching NHS Trust

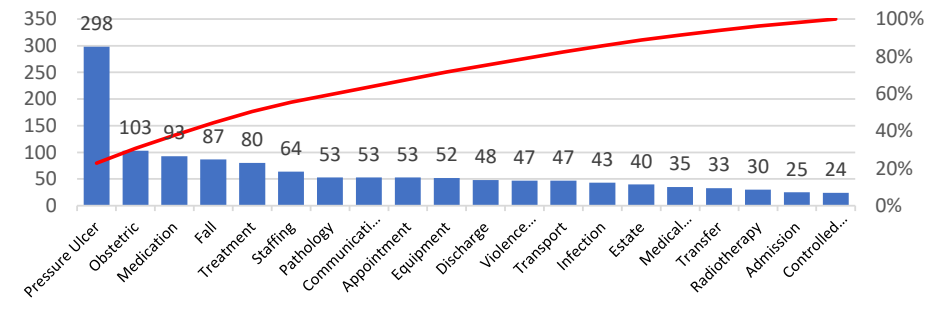
Total incidents reported



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



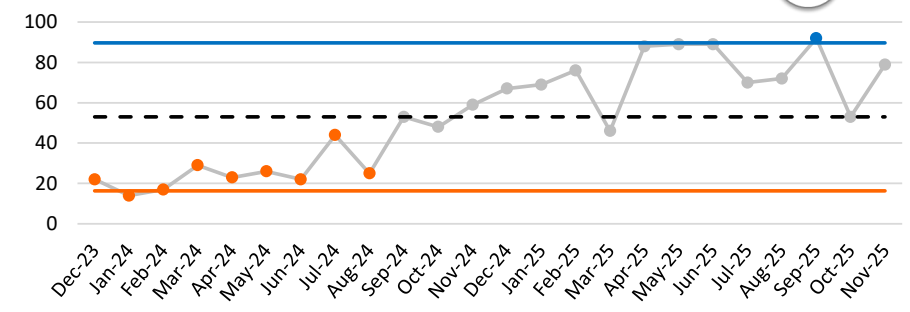
Incidents Themes - Nov-25



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.
- 96% of incidents resulting in no harm / low harm in line with previous months
- Obstetrics and Emergency Medicine continue to be the highest reporting specialties in line with previous months
- Reduction in staffing related incidents reported and reduction in treatment related incidents
- Increase in transport related incidents reported - ENHTT to join ICB operational group to share themes and learning
- After action review undertaken into major haemorrhage process related incidents. Learning including Sim-training commenced, crib sheets for staff, review of protocol. Equipment update to be added to risk register and ongoing training and education.
- On-going PSii learning review into ex-ward referral processes within Gastroenterology, Cardiology and Ophthalmology (specifically medical retina pathway).

Total number of Good Care events



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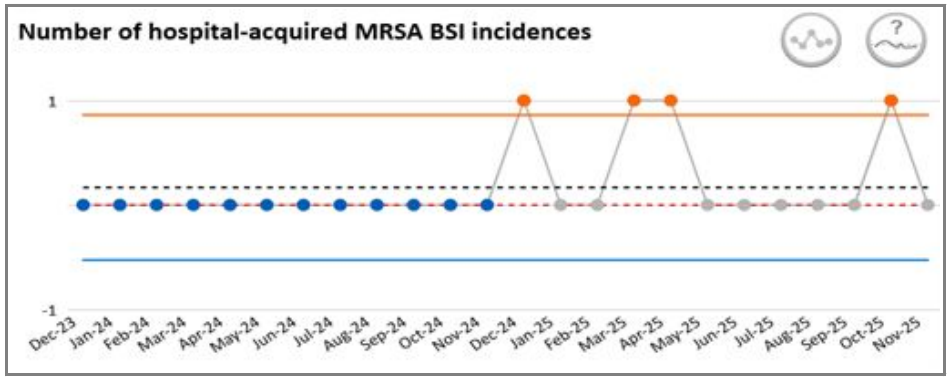
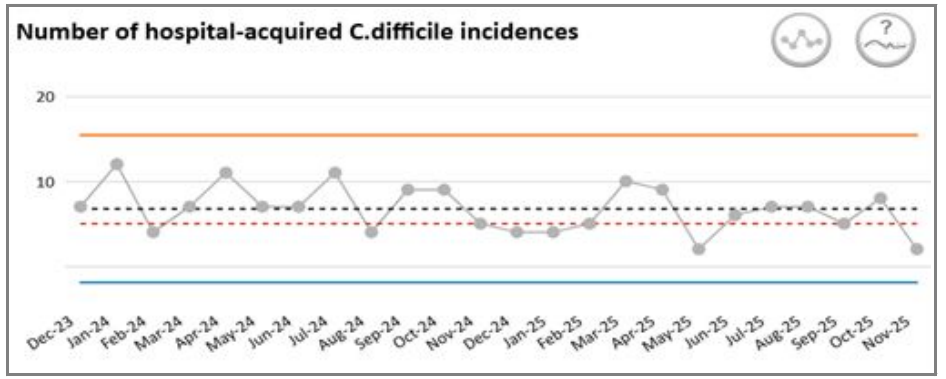
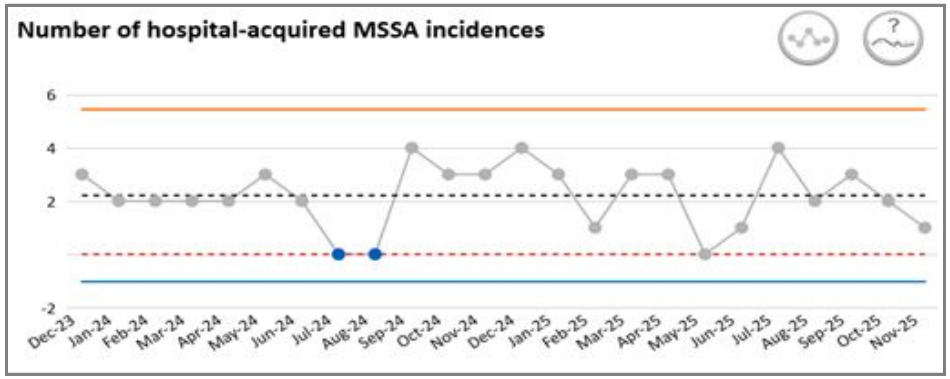
Quality

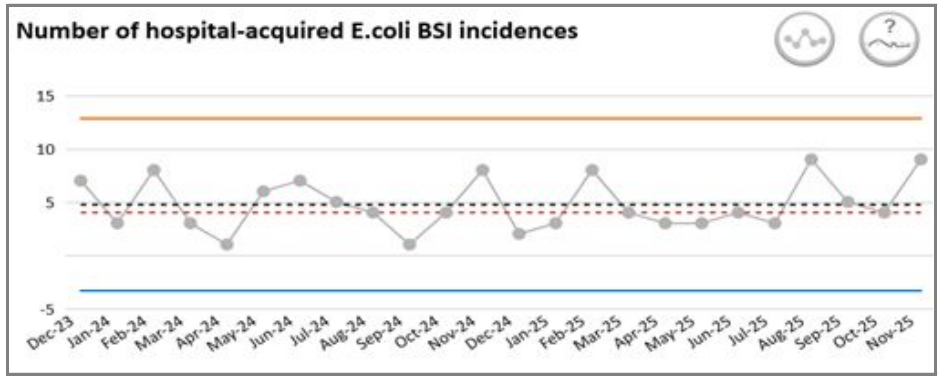
Infection Prevention and Control

NHS East and North Hertfordshire Teaching NHS Trust









- MRSA BSI - There were no MRSA Bloodstream Infections (BSI) in Nov.'25. Year-to-date (YTD) total is two.
- MSSA BSI - In Nov. '25, there was one case of MSSA BSI, a decrease of one compared to the previous month, and two cases lower compared to the same period last year. YTD total is 15 cases.
- C. difficile (C diff.) infection (CDI) - two CDI cases were reported in Nov. '25. This represents a reduction of six cases compared to the previous month and 17 cases fewer than the same period last year. The YTD total stands at 46 cases. Weekly multidisciplinary team (MDT) meetings focused on C diff management continue as part of ongoing improvement efforts.
- E.coli BSI - In Nov.'25, there were nine reported cases of E. coli bloodstream infections (BSI). The YTD total stands at 40 cases, which remains above the expected trajectory. Analysis indicates that these were primarily community-onset, healthcare-associated infections linked to long-term device use or wound care. A gap has been identified regarding incomplete documentation, including in external services, however, care bundle compliance continues to show improvement.

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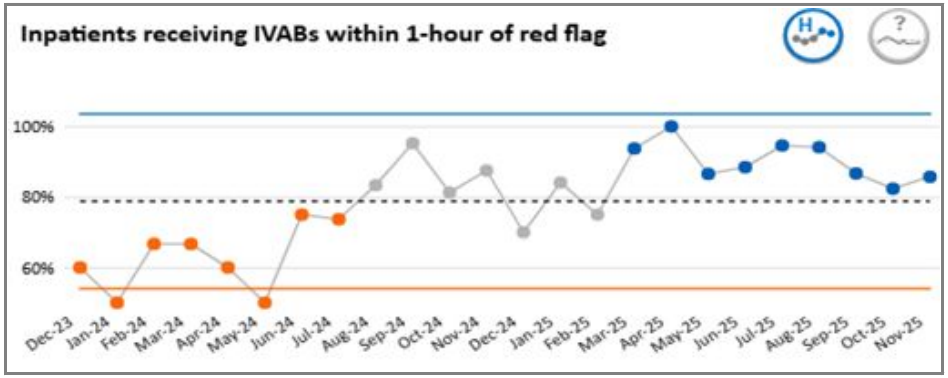
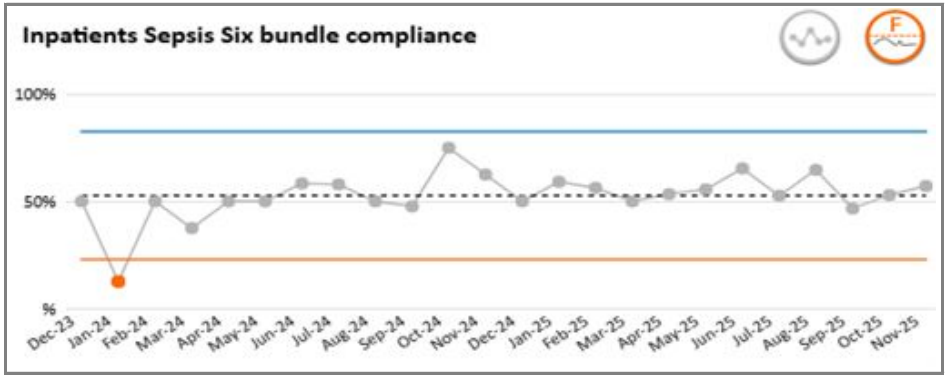
Quality

Sepsis Screening and Management | Inpatients

NHS East and North Hertfordshire Teaching NHS Trust





Themes

Sepsis IP	2024-25				2025-26							
	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Oxygen	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Blood cultures	90%	84%	73%	73%	92%	81%	86%	94%	94%	73%	81%	92%
IV antibiotics	70%	86%	75%	94%	100%	88%	87%	94%	94%	87%	82%	86%
IV fluids	64%	93%	86%	79%	89%	100%	89%	93%	92%	100%	82%	92%
Lactate	68%	73%	73%	81%	57%	81%	73%	71%	76%	50%	81%	64%
Urine measure	84%	95%	81%	88%	93%	89%	93%	68%	88%	80%	82%	93%

Key Issues and Executive Response

Themes

- 8/14 patients audited across November showed sepsis six compliance, achieving 6/6 elements within the hour.
- IV antibiotic compliance has shown natural variation in comparison to October at 86%.
- Lactate measurement continues to be an area of concern with the inpatient wards with a decrease shown in November.
- Urine measurement has improved within the month of November which is positive to be aware of with it hopefully becoming a sustained improvement.
- Blood culture compliance has continued to improve to 92% for November in comparison to 81% for the previous month.

Response

- All delays have been ENHanced and sent to relevant teams and ward managers to investigate as appropriate.
- Lactate measurement is one of the focusses for a quality improvement project lead by a medical colleague with sepsis team input. We are in the process of gaining baseline data from multiple sources so training can be optimised.
- The team are working closely with Orbis to ensure the new EPR system reflects the need for sepsis screening and fluid balance charts.
- A fluid balance monitoring flowchart and IV fluid resuscitation guidance has been produced and disseminated amongst key inpatient areas.
- The team are utilising formal and bedside education, alongside working with practice educators to push for sustainability in compliance.
- BEACH, ALERT and induction sepsis education provided this month.

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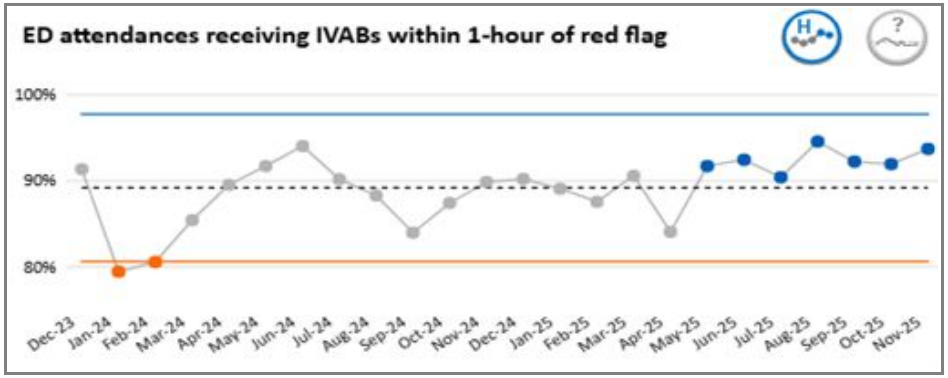
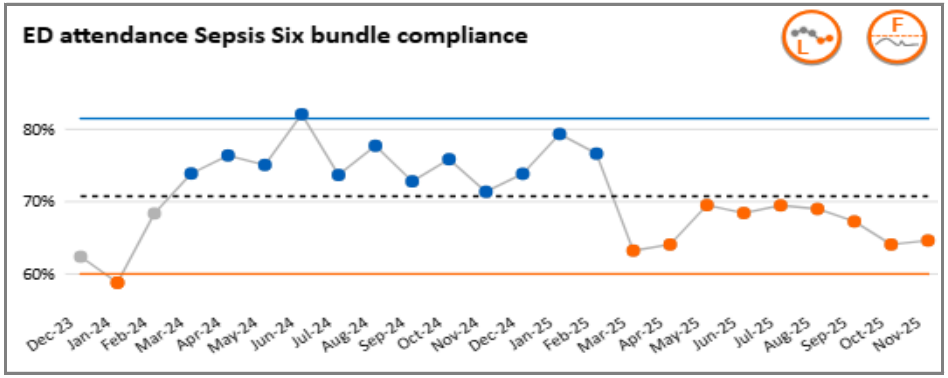
Quality

Sepsis Screening and Management | Emergency Department

East and North Hertfordshire Teaching NHS Trust





Themes

Sepsis ED	2024-25				2025-26							
	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Oxygen	99%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Blood cultures	93%	95%	94%	96%	88%	96%	92%	96%	95%	92%	97%	94%
IV antibiotics	90%	89%	88%	91%	84%	92%	92%	90%	95%	92%	92%	94%
IV fluids	91%	92%	93%	90%	89%	91%	99%	93%	94%	93%	94%	98%
Lactate	94%	99%	95%	97%	96%	99%	99%	100%	97%	100%	99%	97%
Urine measure	80%	88%	81%	68%	73%	75%	77%	73%	73%	70%	68%	66%

Key Issues and Executive Response

Themes

- 51/79 patients audited across November showed sepsis six compliance with all 6/6 elements being completed within the hour.
- Urine output measurement shows normal variation at 66% and remains below target.
- Lactate compliance sits at 97%. Blood culture collection has maintained its high compliance at 94% falling just below target.
- IV antibiotic compliance continues to show natural variation at 94% and IV fluids now sit above target at 98%.

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.
- Poster flow charts surrounding IV fluid administration and fluid balance monitoring in sepsis management have been produced and disseminated around the department.
- Meetings held with key stakeholders and explanations given for non compliance alongside key improvement strategies.
- Mandatory e-learning updated and now live on ENH Academy for all staff to refresh their sepsis knowledge and review the updated guidance - TEL team have provide us with compliance figures
- The team are working with the practice development team to focus on sustaining good sepsis compliance.
- Good sepsis care is being reinforced - the sepsis star awards continue with members of the ED becoming recipients.

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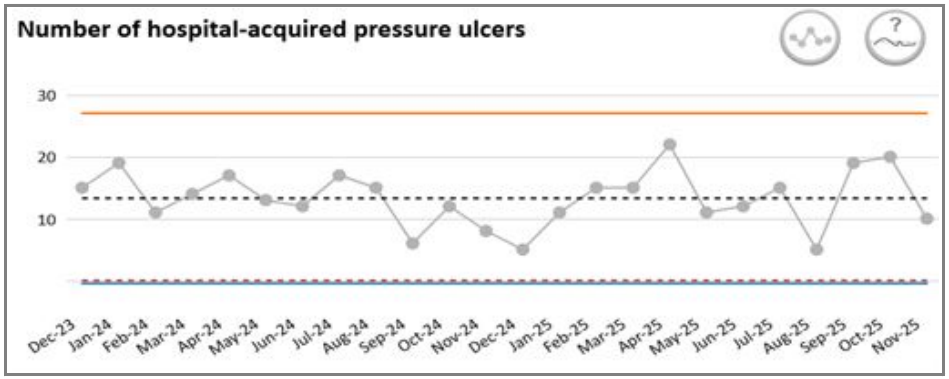
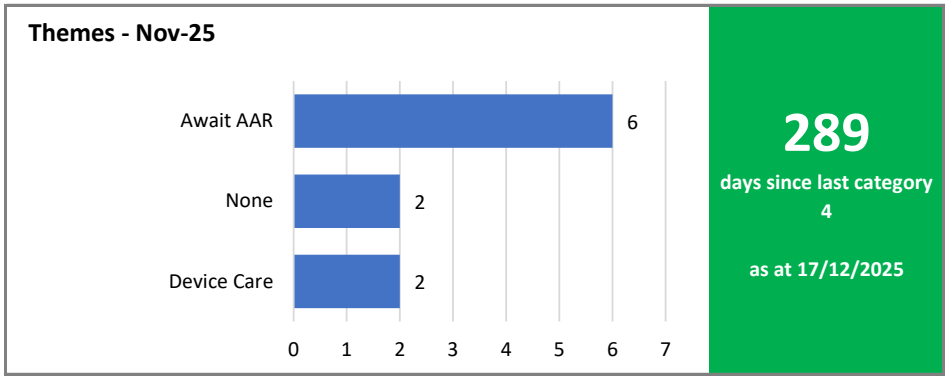
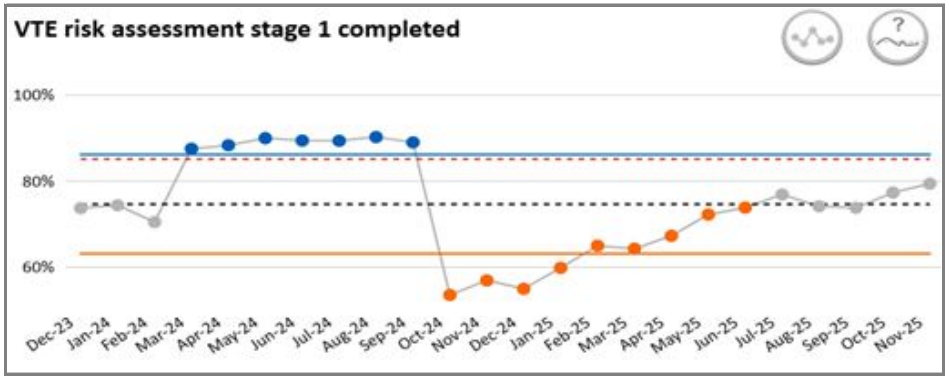
Quality

Pressure Ulcers | VTE

NHS East and North Hertfordshire Teaching NHS Trust







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 2024, 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.
- 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 - however this is improving.
- Areas for quality improvement have been identified to further improve Trust compliance to VTE risk assessment.

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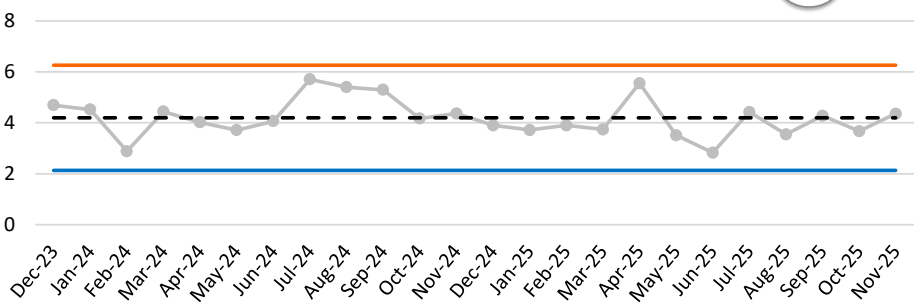
Quality

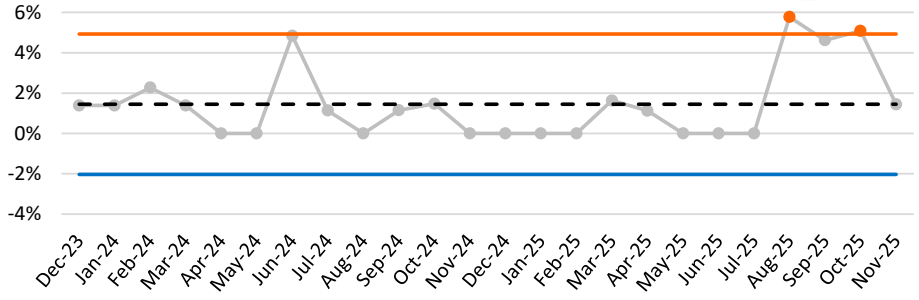
Patient Falls

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.
- One inpatient unwitnessed fall with moderate harm recorded for the month of November. The patient slipped on the way back from the bathroom - witnessed by other patients. Falls risk assessments in date at the time of incident. The patient sustained intracranial haemorrhage, advised conservative management. CT repeated with an improve outcome. Patient repatriated back to PAH for other medical management. Incident to be discuss at the Planned Care Divisional Incident Review Meeting.
- Falls Lead and medical lead working to complete falls audit focusing on the quality of falls risk assessment completion then will feed this back to the falls steering group. Audits to be completed once a week for 6-8 weeks to obtain baseline for future work.

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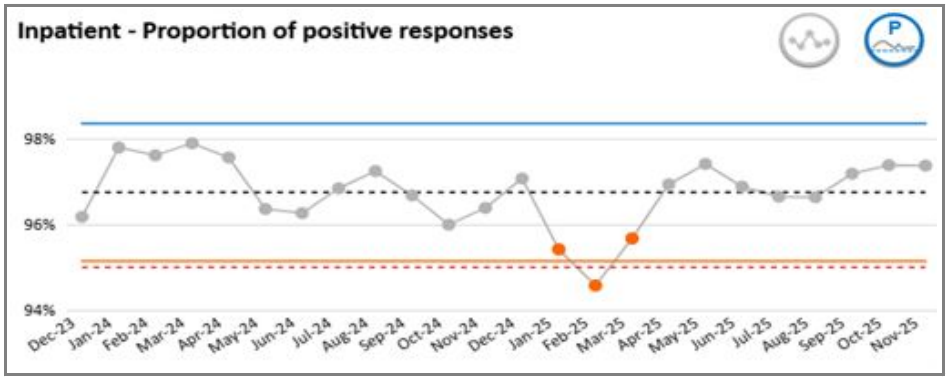
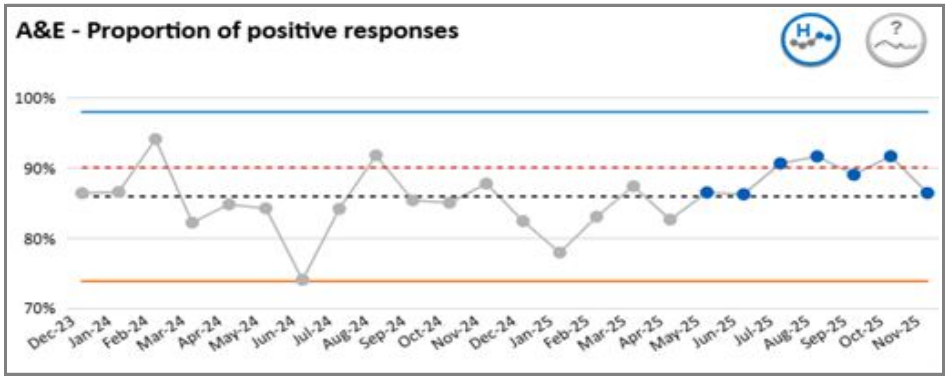
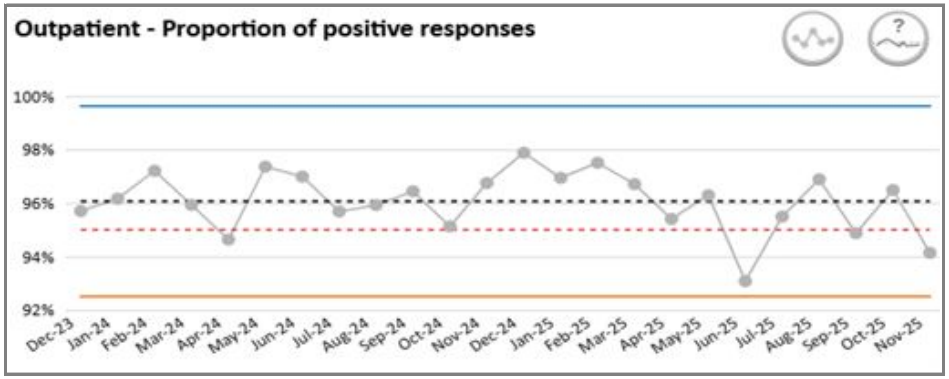
Quality

Friends and Family Test







Key Issues and Executive Response

Friends and Family Test

- The response rate to the inpatient survey was about the same this month with the satisfaction score for % very good/good also remaining steady (97.37% compared to 97.38% in October).
- The total response rate for ED-UCC improved very slightly but the score for % very good/good decreased to 86.39% compared to 91.61% in October.
- Whilst the proportion of positive responses for the maternity birth element shows a consistent 100%, the actual number of maternity surveys completed continue to be at extremely low numbers. The majority of the responses regarding the postnatal element are FFT surveys with 67% of those submitted by smartphone/tablet via QR codes.
- Due to an increase of admin support given to the PALS team, contacting patients by telephone after discharge for FFT feedback has not been possible recently. However, in addition to paper surveys, there is a continued promotion of QR codes within inpatient and outpatient areas to minimise manual inputting.

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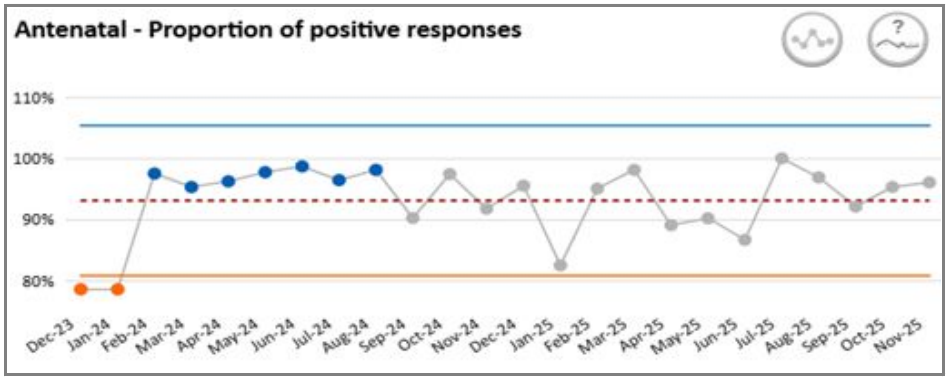
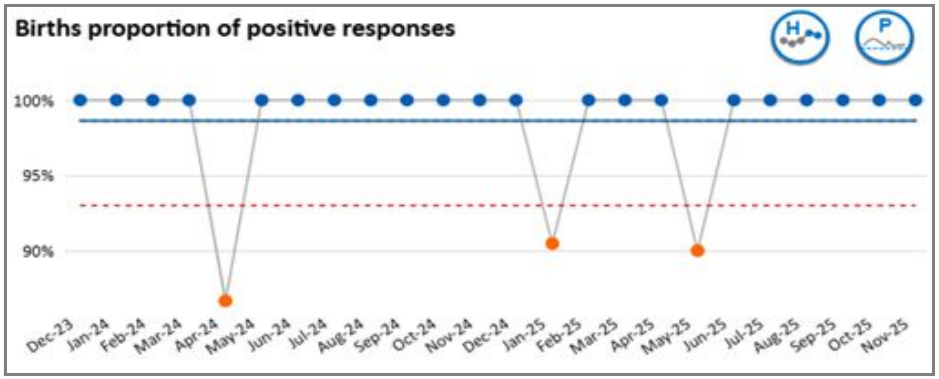
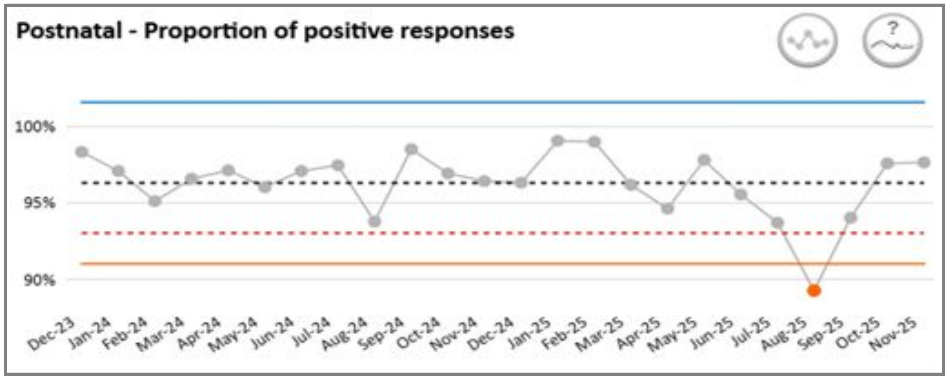
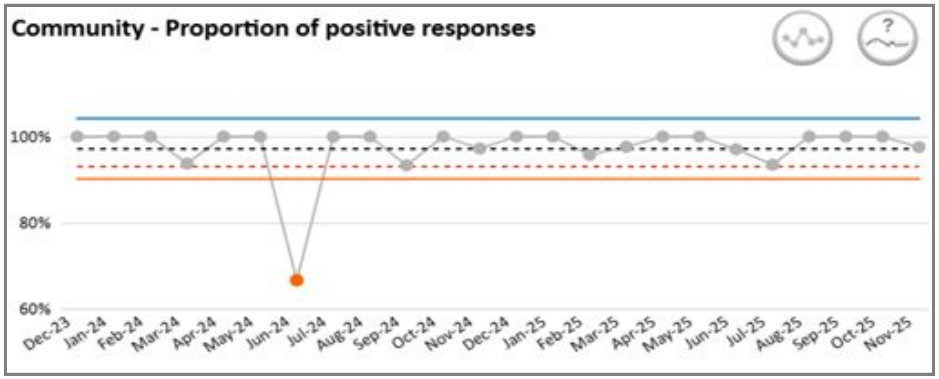
Quality

Friends and Family Test









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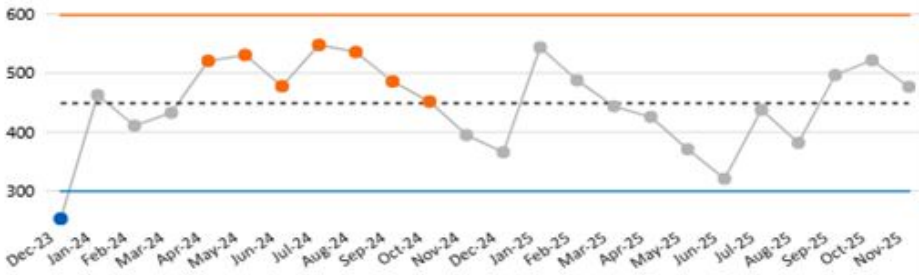
Quality

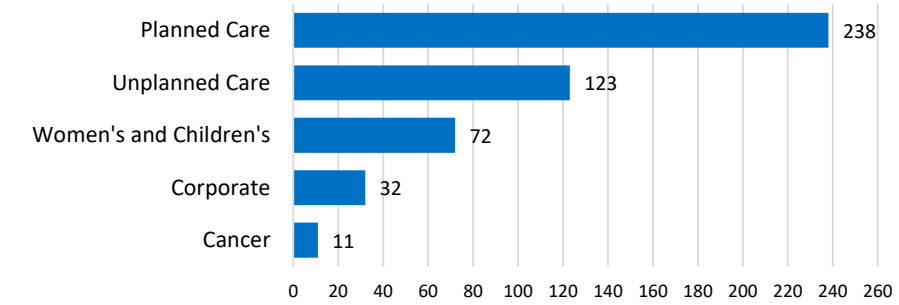
Patient Advice and Liaison Service

NHS East and North Hertfordshire Teaching NHS Trust

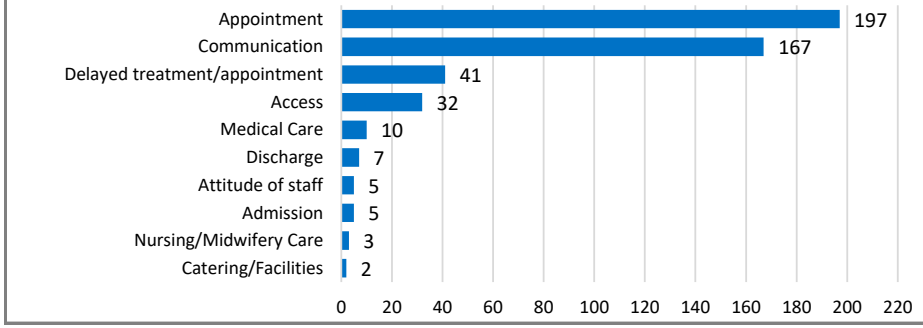
Number of PALS referrals



PALs by Division - Nov-25



PALs Top 10 subjects - Nov-25

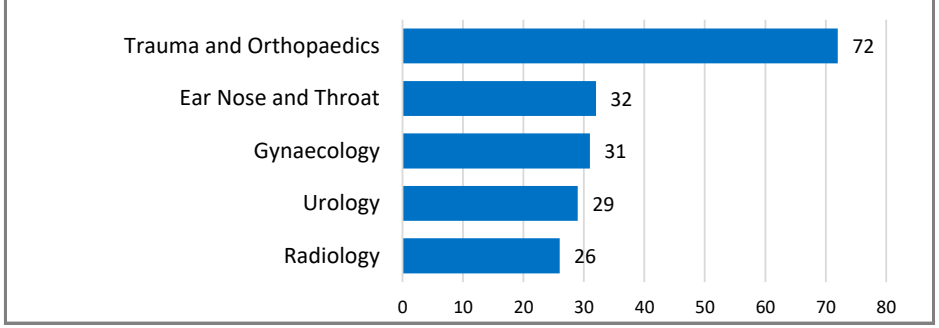


Key Issues and Executive Response

Patient Advice Liaison Service

- A restructure of the PALS team to support the walk-in patients has resulted in the PALS Officers having more time to focus on triaging and responding the email commuincation. The response is an 8 working day timeframe for non-urgent concerns.
- All concerns / enquiries continue to be triaged on the day / next working day.
- Consistent bank staff support remains in place which has had a positive effect in supporting the workload.
- Themes: Appointments, lack of communication, delays in treatment and receiving an appointment.
- Planned care continues to receive the highest number of concerns raised and this is reflected in the volume of complaints received.

PALs Top 5 specialties - Nov-25



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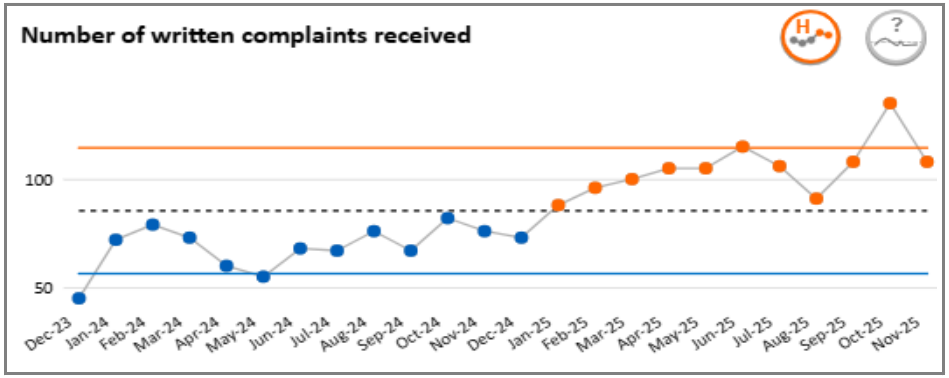
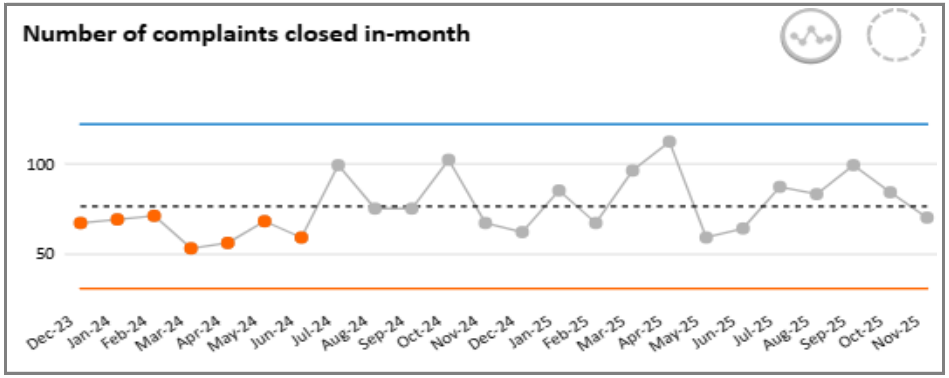
Quality

Complaints

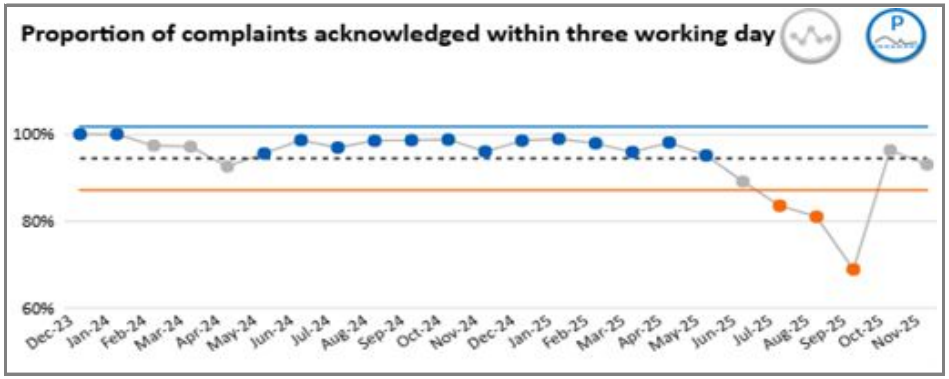
NHS East and North Hertfordshire Teaching NHS Trust

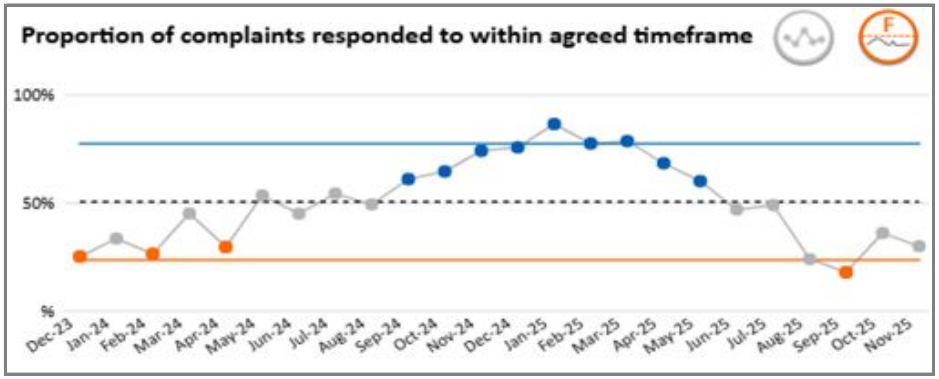




Key Issues and Executive Response

- The Complaints Manager has been engaging with Senior staff within Planned and Unplanned care divisions to understand the challenges being faced preventing staff from investigating the complaints within the agreed 11 working day deadline.
- The Chief Nurse has requested a review of processes.
- Planned care are carrying out a review of the appointment processes to determine how these can be managed more effectively and this report is to be shared at Trust board.
- Planned care continue to receive the highest volume of complaints month on month.
- At the end of April 2025 the Trust had 190 open complaints.
- By comparison the Trust now has 423 open complaints. This is due to a combination of the rise in formal complaints being received and a lack of responsiveness from divisional staff.
- Cancer Services are an exception and strive to resolve concerns before they become complaints. Will call patients/relatives and are swift to respond to any concerns that become formal.
- Divisions are being encouraged to call patients/carers to offer early resolution whenever possible.





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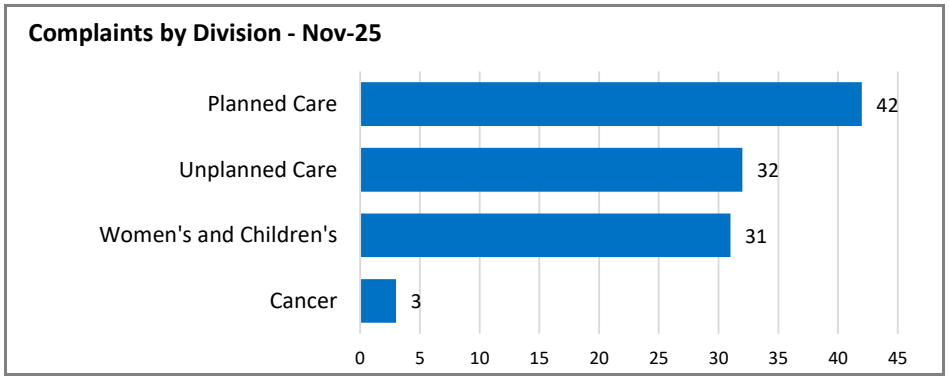
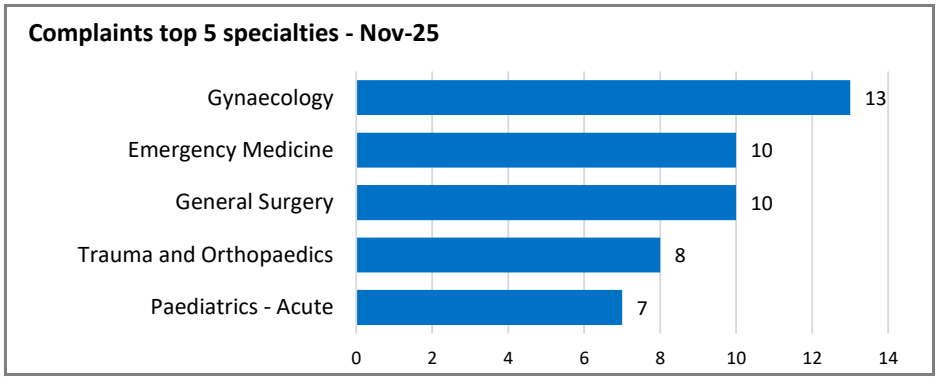
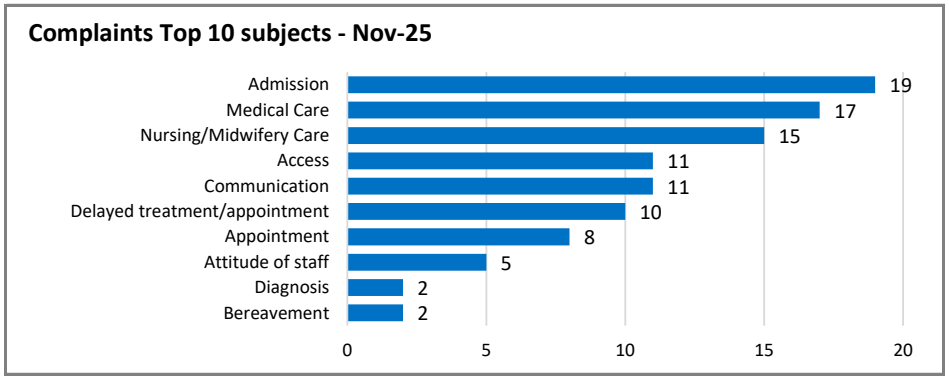
Quality

Complaints Themes







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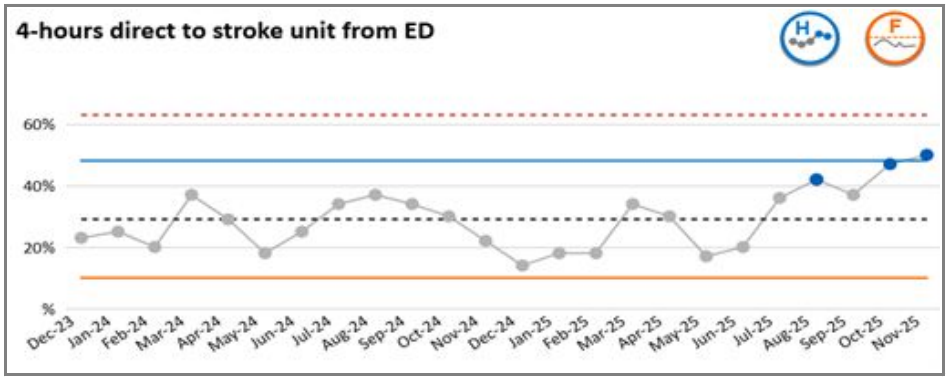
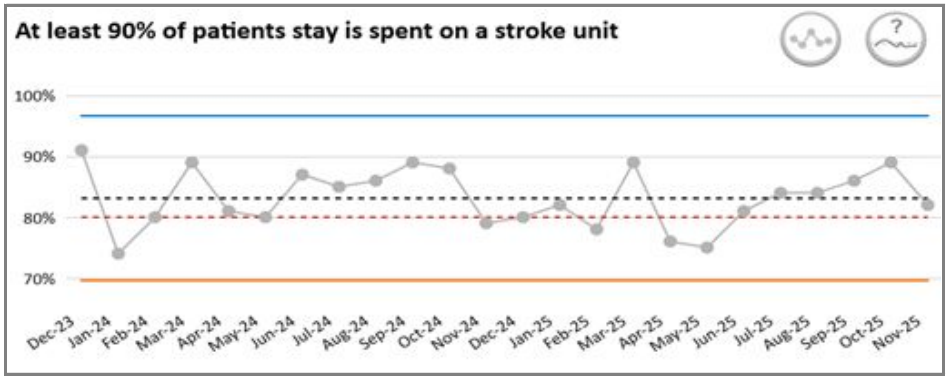
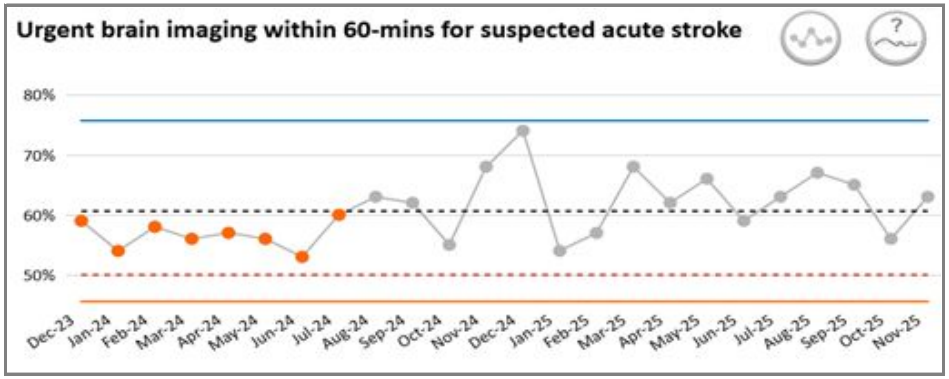
Operations

Stroke Services

East and North Hertfordshire Teaching NHS Trust

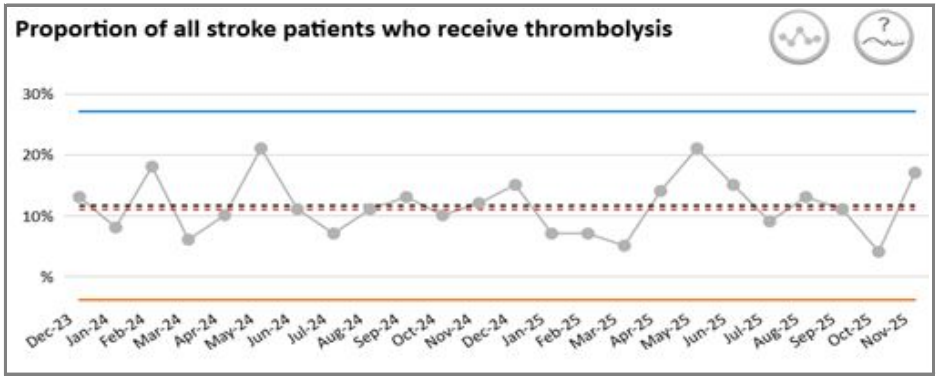






Key Issues and Executive Response

- **Thrombolysis/Thrombectomy** - Door to needle time decreased to 44 minutes from 58 mins in previous month. 16.9% of patients receiving thrombolysis against bespoke 14% target. CTP now live with increase month on month across October and November. Thrombectomy at 2.8% with 10% target - not through lack of referrals to MTC.
- **4 hr performance 37.3%** for confirmed strokes and pts discharged in October. On trajectory to meet 60% by end of March 2026. Median time is 4hrs 39 minutes.
- **Length of stay:** Continued improvement within HASU however increase in level 1 beds required which is impacting LOS. Ongoing discussions with ICS and region addressing capacity plans long term.
- **CT within 20 minutes** (new standard) : Significant improvement to 39.4% from 27.1% in prev. month. Continued focus on improving to meet SSNAP target of 40%. Implementation of Stroke Video Triage will improve rapid diagnosis with go live in house January 2026.
- **TIA performance**: Meeting national target with urgent patients seen within 1.2 days. Improvements due to in-house process changes, collaborative working with radiology with increase in Doppler slots plus pathway changes in referral process from GP's into TIA.

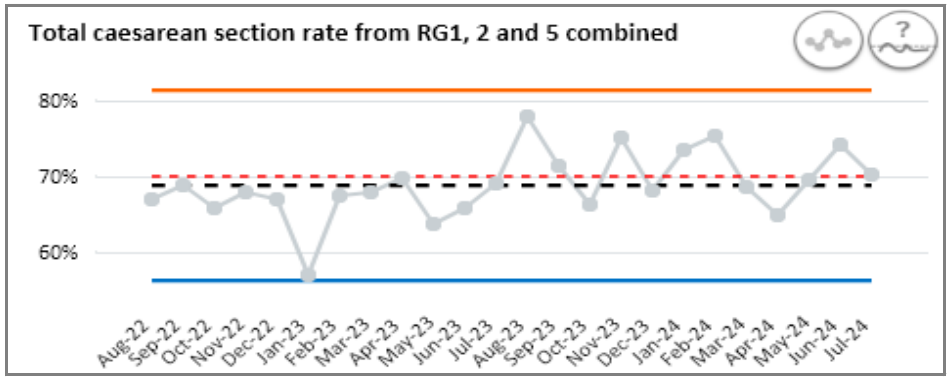


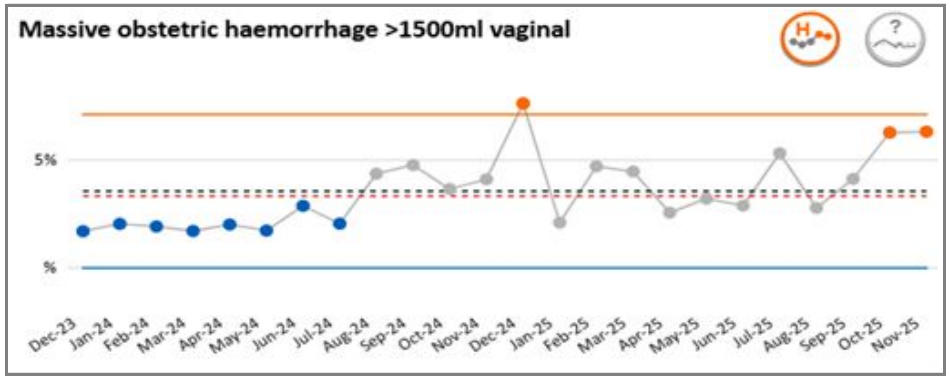
Month 08 | 2025-26

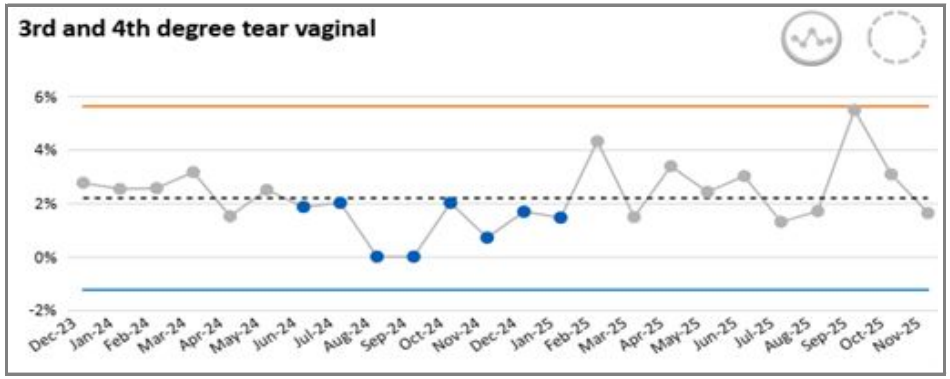
Quality

Maternity | Safety Metrics

East and North Hertfordshire Teaching NHS Trust







Key issues and executive response

- There were no cases qualifying as PSII or accepted for investigation by MNSI. There were six cases (2% of 242 incidents reported) of moderate physical harm, consistent with previous months. One exposure to influenza positive patient on antenatal ward. One readmission for abdominal wall defect post LSCS requiring repair in main theatres. One admission to ITU (transfer from Harlow as their NICU closed. Admitted to ITU with PET and HELLP syndrome). One admission at fully dilated with thick meconium, admission to NICU and transfer to L&D for seizures. One admission to Triage with RFM's, CTG concerns, cat 2 LSCS and transferred to tertiary unit (mother and baby reported). Awaiting acceptance by MNSI. No serious harm.
- Two stillbirths >22/40 (One at 28+5/40 under UCLH foetal medicine, one transfer from PAH at 38/40). No neonatal deaths. External review of increased neonatal mortality rate for the year 20/11/25. Action to meet and review infection rate with IPC 06/01/26. For report back to QSC. One maternal death 9/12 postnatal LSCS sepsis and ITU, known cardiac issues. Reported to MBRRACE. Await details.
- Increased rate of 3rd/4th degree perineal trauma at instrumental births (9.68%), though within process limits. For thematic review to consider reduction in episiotomy (93.94%) as factor. OASI ongoing.
- MOH >1500mls (4.33%) remains above process limits. 13 total MOH and of those 2 (0.67%) were >2000mls. 10 (6.29%) cases of MOH at vaginal births and 3 (2.13%) MOH at LSCS. Weekly thematic review ongoing. LMNS collaboration on learning and actions.
- Total LSCS= 163 (48.80%). Total Cat 1-3 (Emergency) = 93 (27.84%). Total Cat 4 (Elective) = 70 (20.96%) reflective of an increasing LSCS birth rate nationally. Robson Group Criteria RC1 = 27.66%, RC2 = 58.82%, RC5 = 90.38%. Incomplete denominator data remains an area of focus.

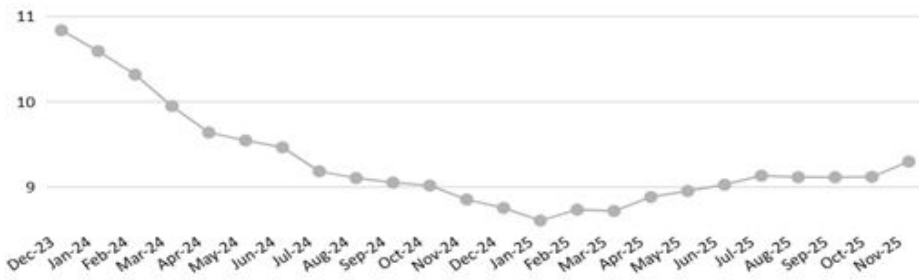
Month 08 | 2025-26

Quality

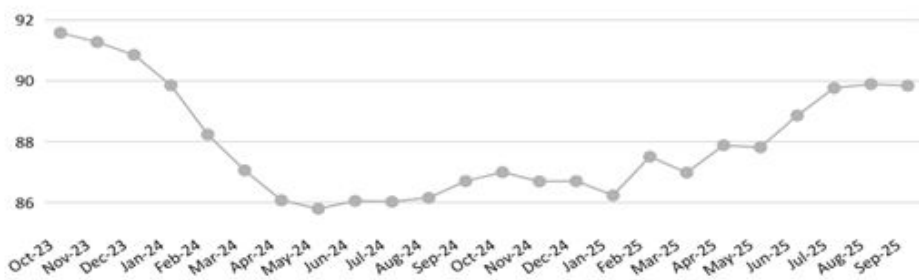
Mortality

East and North Hertfordshire Teaching NHS Trust

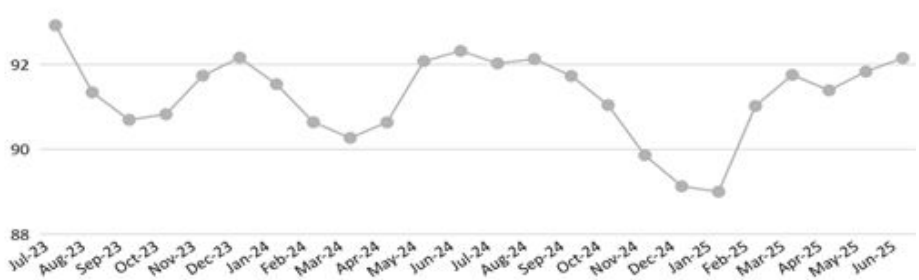
Crude mortality - rolling 12-months



HSMR - rolling 12-months



SHMI - rolling 12-months



Key Issues and Executive Response

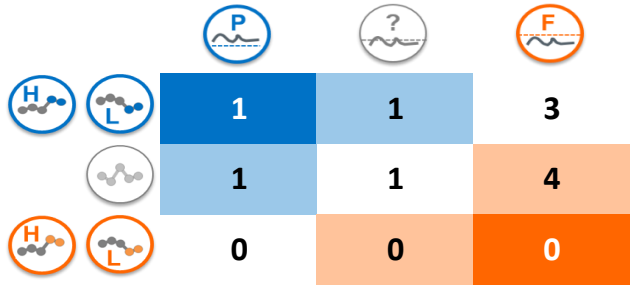
- Crude mortality is the factor which usually has the most significant impact on HSMR. The exception was during the COVID pandemic, when the usual correlation was weakened by the partial exclusion of COVID-19 patients from the HSMR metric. This partial exclusion continues for the CHKS HSMR metric that 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.
- There was a significant downward trend in rolling 12-month HSMR from March 2023 to April 2024, when the metric plateaued and has been on an upward trend since January 2025.
- The latest rolling 12-month HSMR to Aug-25, reported by CHKS, stands at 89.8. This positions us in the mid-range of trusts nationally.
- The in-month figure for Jul-25 spiked at 108.67. As this figure did not reduce on the next refresh, it appears unlikely to be due to incomplete data. A high-level review with CHKS, while not identifying any obvious cause for concern did show some changes to palliative care coding and slight increases to pneumonia and aspiration pneumonia. The Head of Coding is reviewing these.
- Latest NHSD published rolling 12-month SHMI available to July 2025, stands at 92.36, an increase from last month's 92.14. This position is just outside the first quartile of trusts nationally, within the 'as expected' band.
- While we remain well positioned vs other acute trusts (31/118), over last 12 months has been a gradual downward shift (best position 18/118).
- The latest figures provided by CHKS for Jun-25 are 88.8 in-month and 92.1 for rolling 12-month. CHKS has reported that the recent increases have been largely driven by increased out-of-hospital SHMI deaths rather than in-hospital deaths.

Month 08 | 2025-26

East and North Hertfordshire Teaching NHS Trust

Operations

Month 08 | 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	Nov-25	95%	73.9%	H	F	9 points above the mean Metric will consistently fail the target
	Patients waiting more than 12 hours from arrival to admission, transfer or discharge	Nov-25	5%	9.8%		F	Common cause variation Metric will consistently fail the target
	Percentage of ambulance handovers within 15-minutes	Nov-25	65%	24.1%	H	F	9 points above the mean Metric will consistently fail the target
	Time to initial assessment - percentage within 15-minutes	Nov-25	80%	49.4%		F	Common cause variation Metric will consistently fail the target
	Average (mean) time in department - non-admitted patients	Nov-25	240	184	L	P	9 points below the mean Metric will consistently pass the target
	Average (mean) time in department - admitted patients	Nov-25	tbc	531	L		7 points below the mean No Target
	Average minutes from clinically ready to proceed to departure	Nov-25	tbc	136			Common cause variation No target
RTT & Diagnostics	Patients on incomplete pathways waiting no more than 18 weeks from referral	Nov-25	92%	66.1%	H	F	11 points above the mean Metric will consistently fail the target
	Patients waiting more than six weeks for diagnostics	Nov-25	0%	52.1%		F	Common cause variation Metric will consistently fail the target

Month 08 | 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	Oct-25	85%	85.7%		P	Common cause variation Metric will consistently pass the target
	31-day decision to treat to treatment standard	Oct-25	96%	98.1%	H	?	1 point above the upper process limit Metric will inconsistently pass and fail the target
	28-day Faster Diagnosis standard	Oct-25	75%	77.6%		?	Common cause variation Metric will inconsistently pass and fail the target
	Proportion of cancer PTL waiting more than 62 days	Nov-25	7%	19.1%		F	Common cause variation Metric will consistently fail the target

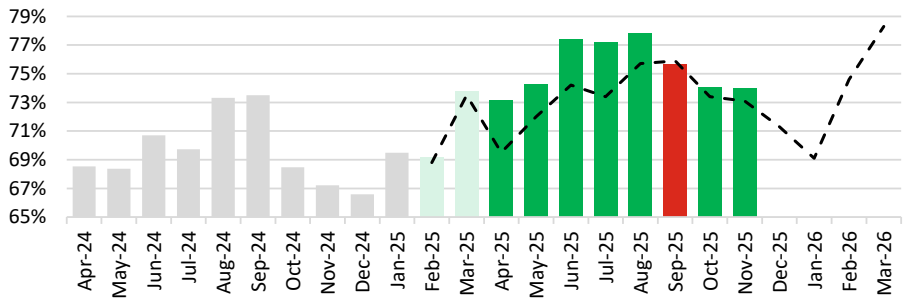
Month 08 | 2025-26

Urgent Emergency Care

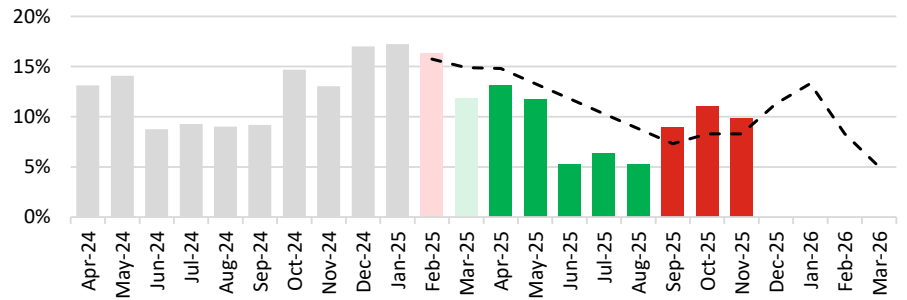
Trajectory Monitoring 2025-26

NHS East and North Hertfordshire Teaching NHS Trust

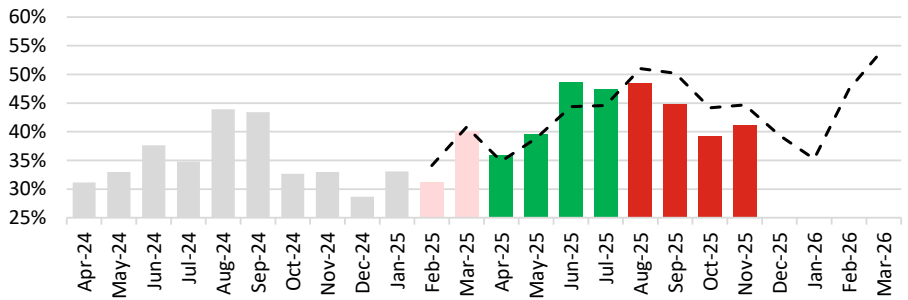
Four hour performance against trajectory - Trust-wide



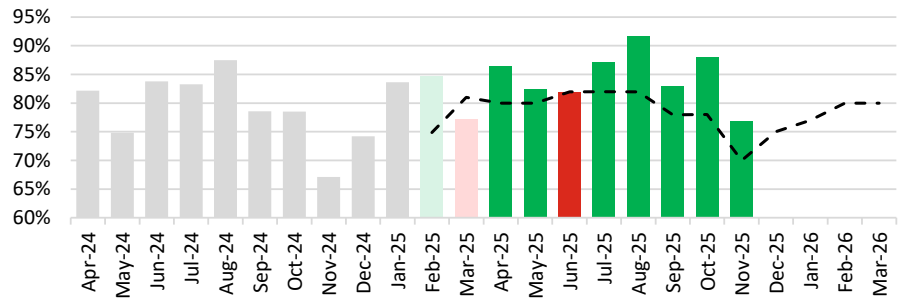
Patients in department over 12 hours - Type 1



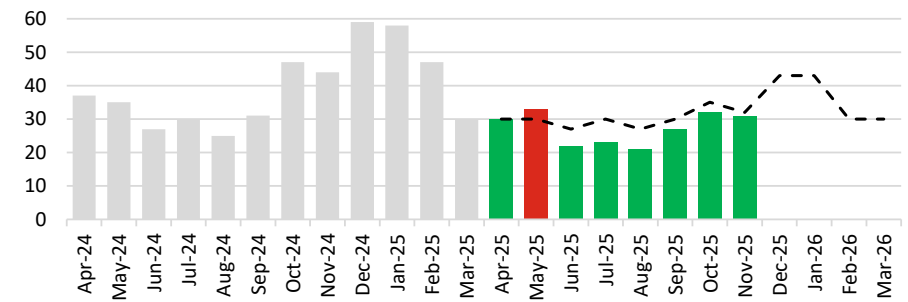
Four hour performance against trajectory - Type 1 Adults



Four hour performance against trajectory - Type 1 Paediatrics



Average ambulance handover time (minutes)

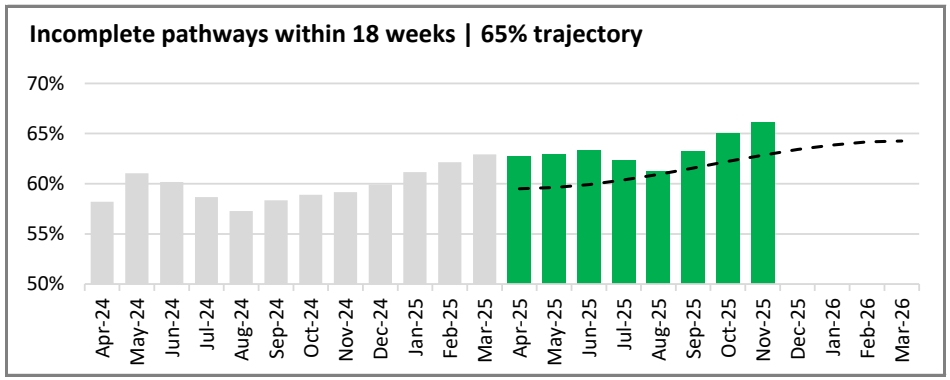


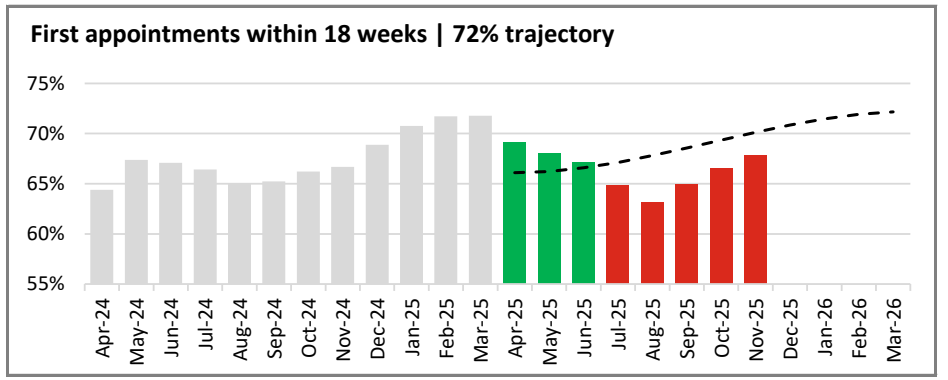
Month 08 | 2025-26

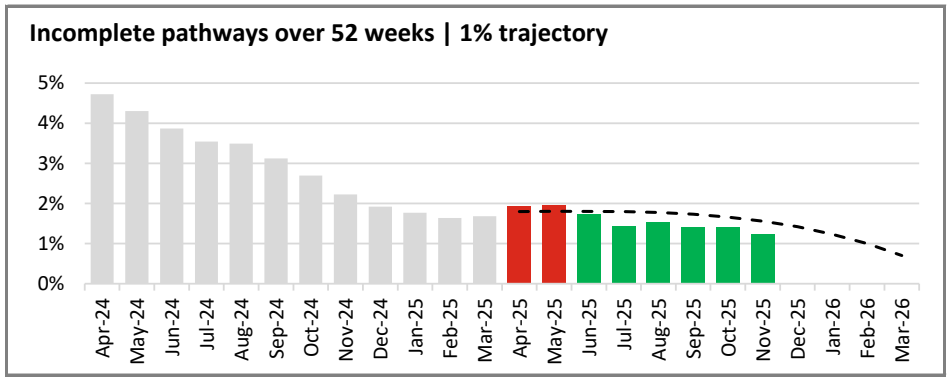
Cancer Waiting Times | RTT 18 weeks

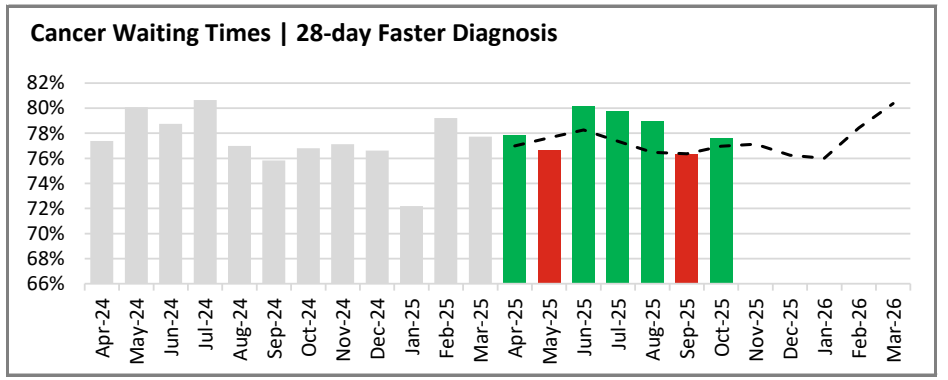
Trajectory Monitoring 2025-26

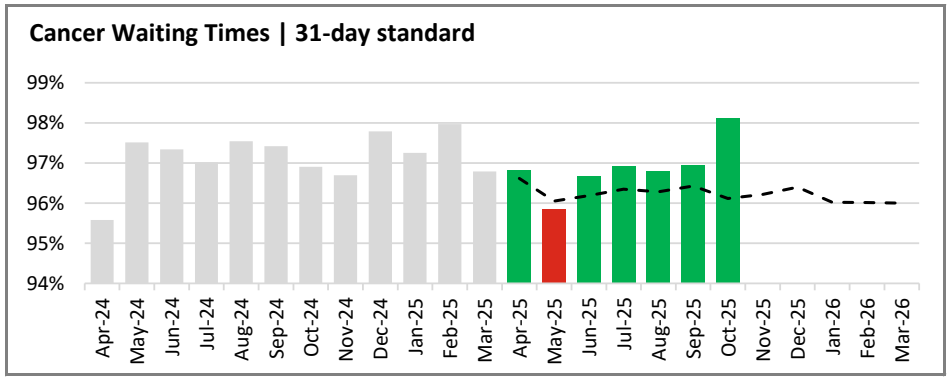
NHS East and North Hertfordshire Teaching NHS Trust

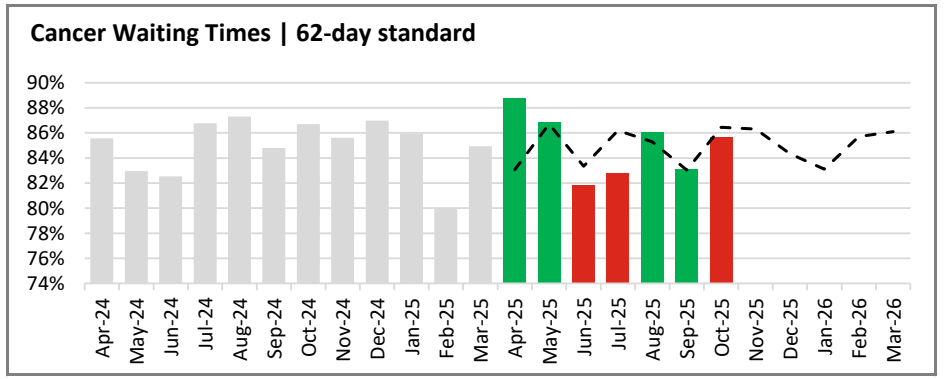












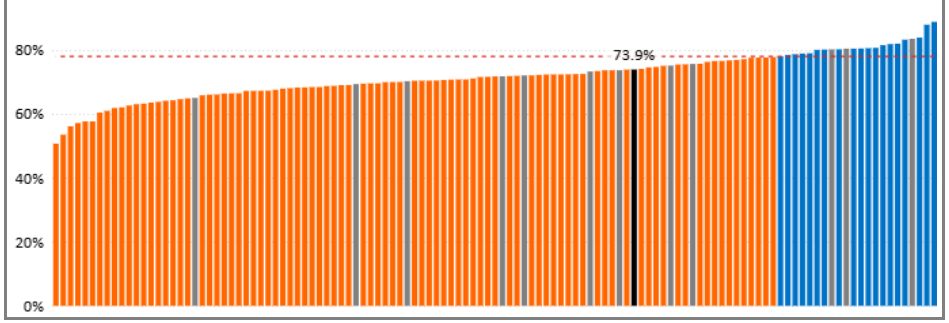
Month 08 | 2025-26

Operations

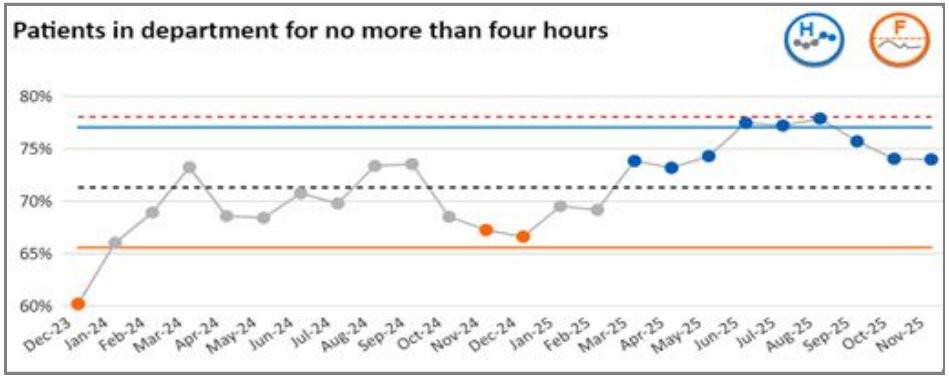
Urgent and Emergency Care New Standards

NHS East and North Hertfordshire Teaching NHS Trust

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



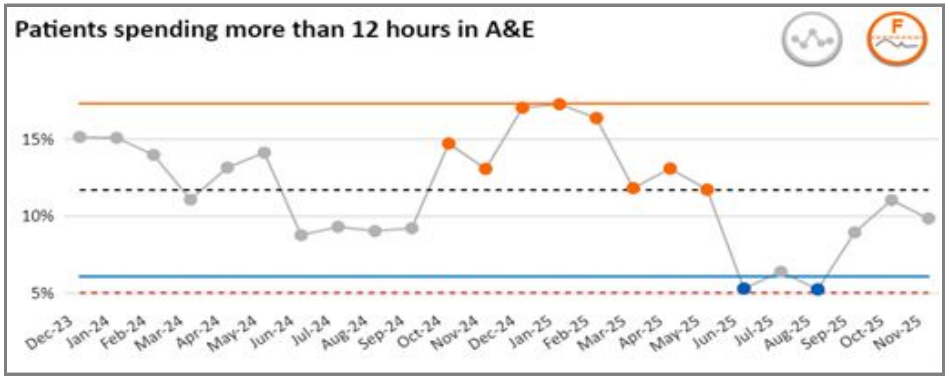
Patients in department for no more than four hours



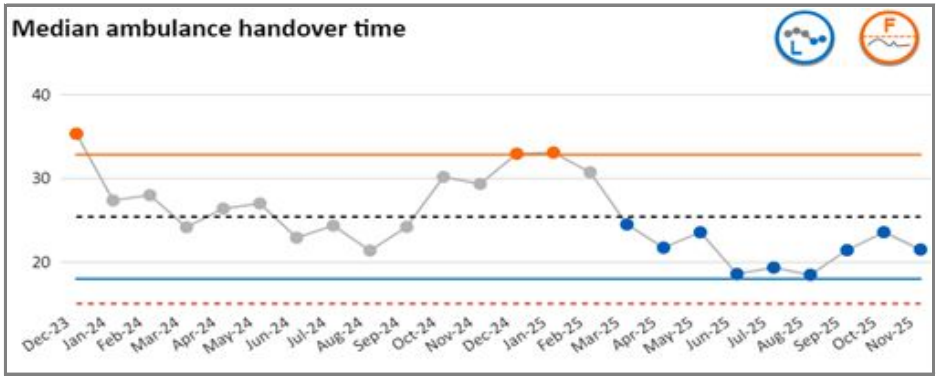
Key Issues and Executive Response

- In November, 4-hour performance remains on trajectory at 73.9%. Performance for Adult Type 1 was 41.1% which was 8.1% better than November 2024.
- 4 hour performance has shown continuous improvement for 2 consecutive years.
- 12 hour waits in ED improved to 9.85%, 1.5% behind trajectory, but 3.7% improved compared to November 2024.
- Median ambulance handover times were 31 mins with reduced patient flow from ED to wards. this is a 13 minute improvement in comparison to November2024.
- Paediatric Type 1 performance improvement remains above trajectory, 9% better than November 2024.
- Following our ENHT 3P event and development of system 5 year strategy, we have submitted a capital bid for a new integrated triage hub to support reduce walk ins to adult and paediatric ED.
- Continuing improvement work:
- Focus on earlier discharges from wards.
- AMU to manage flow from ED, to reduce delays to allocate.

Patients spending more than 12 hours in A&E



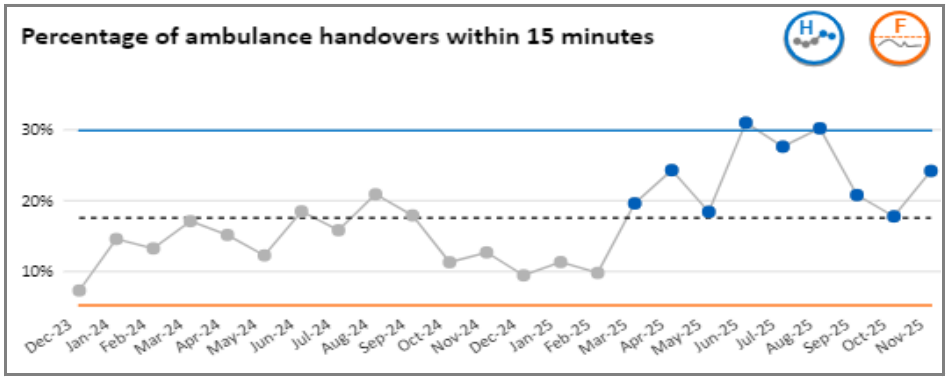
Median ambulance handover time

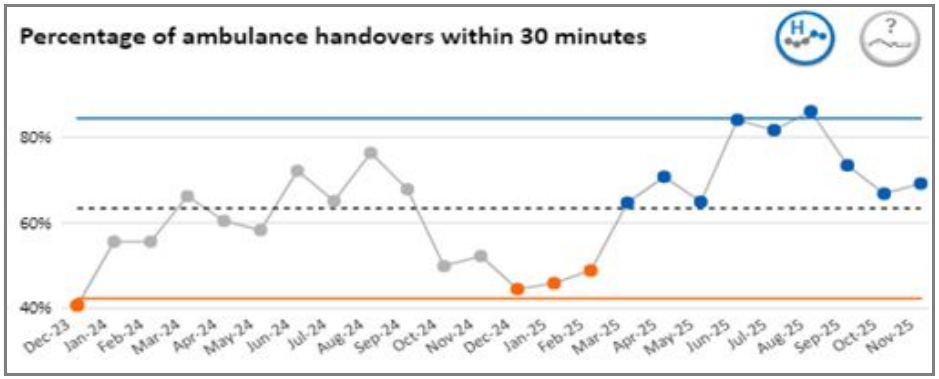


Month 08 | 2025-26

Operations

Urgent and Emergency Care | Supporting Metrics



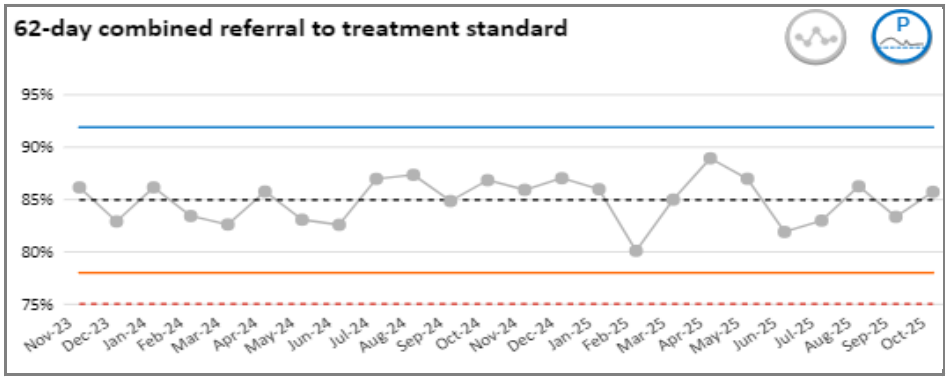


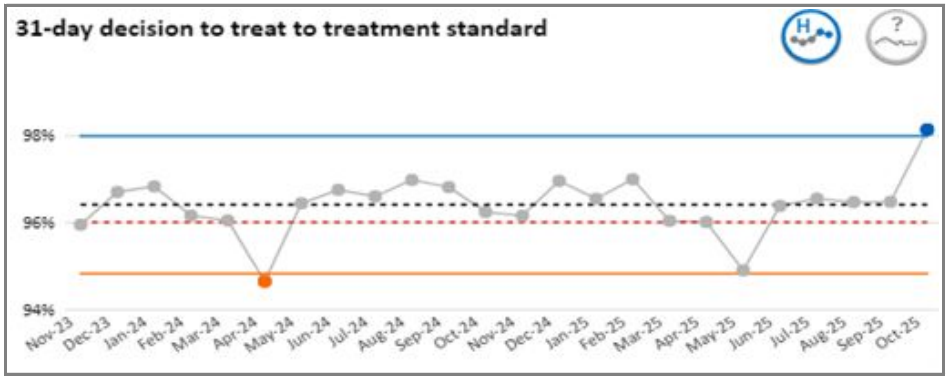
Month 08 | 2025-26

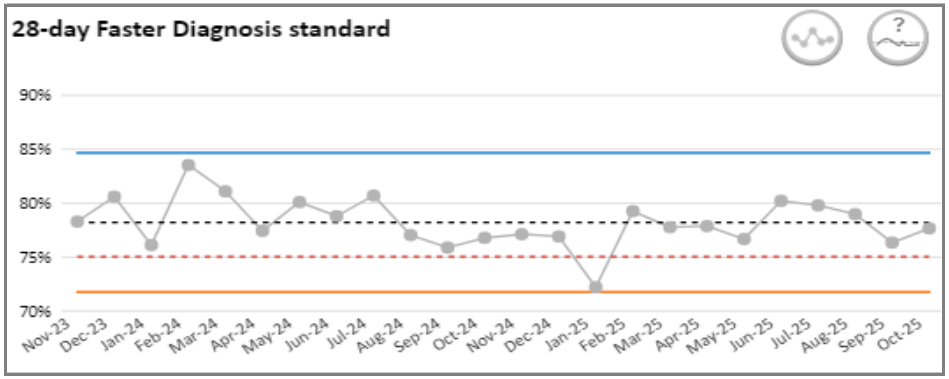
Operations

Cancer Waiting Times | Supporting Metrics

NHS East and North Hertfordshire Teaching NHS Trust







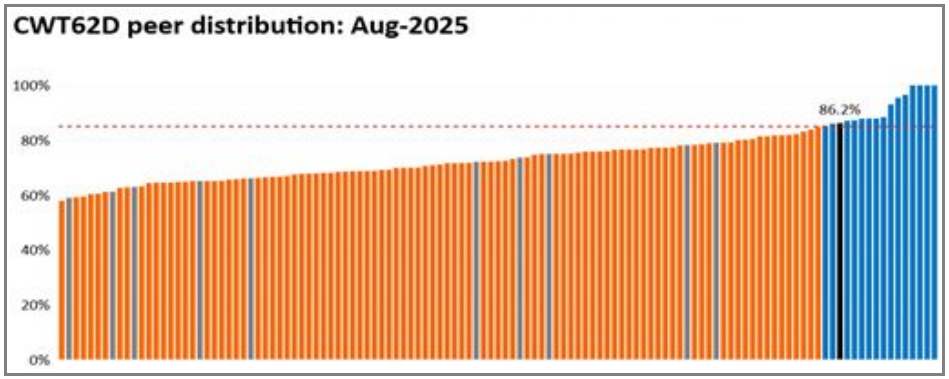
Key Issues and Executive Response

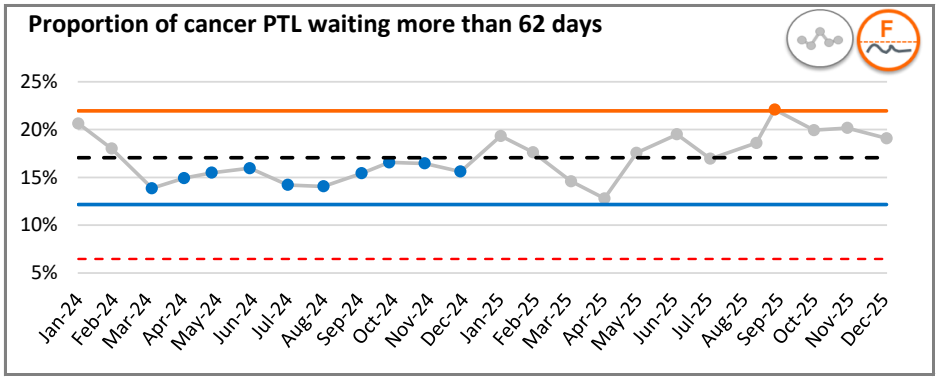
- We achieved 3 of the 3 national standards in October 25: 28 day Faster Diagnosis, 31 day decision to treat standards and 62 day referral to treatment general standard.
- The 62 day referral to treatment standard performance was 85.7% in October 25, YTD aggregate performance is 85.00%.
- The 62-day performance in October ranked 4th 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: pathway and breach analysis 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% after March 26.
- Breach analysis continues for all patients against all standards to influence pathway redesign and learning with MDT teams.

Month 08 | 2025-26

Operations

Cancer Waiting Times | Supporting Metrics





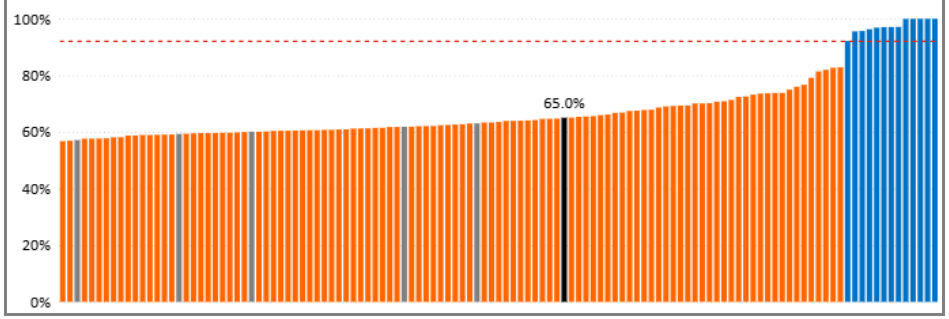
Month 08 | 2025-26

Operations

RTT 18 Weeks

East and North Hertfordshire Teaching NHS Trust

Incomplete pathways within 18 weeks peer distribution - Oct-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 started in November, with further pathway changes to be implemented from January.
- Ongoing meetings with 3 COOs (ENHT, HPFT, HCT) from 20/10/2025 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 3,725 patients waiting over 78 weeks at the end of November, compared to 3,702 the previous month.
- **65 Weeks** - There were 4,287 Community Paediatric patients waiting over 65 weeks at the end of November.

Key Issues and Executive Response

Excluding community paediatrics

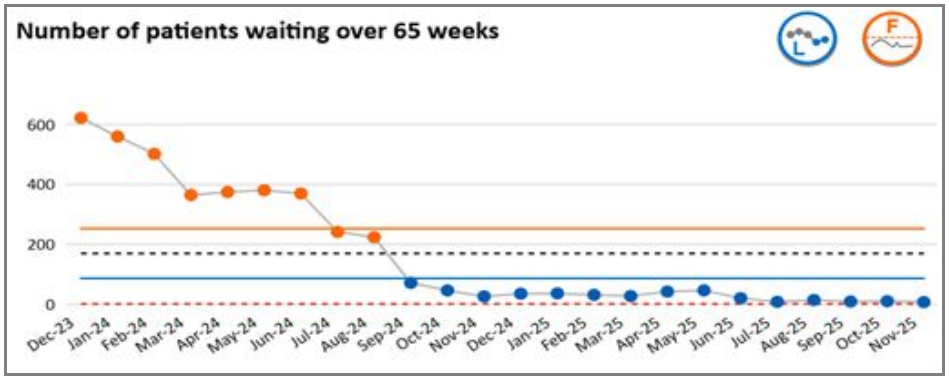
- **18 Week Performance** - 66.1% of patients were waiting under 18 weeks in November, compared to 64.5% at the end of October, ahead of the March 2026 5% improvement target of 64.2%.
- The Patient Treatment List (PTL) has grown by 800 patients due to a temporary reduction in resources and continued focus on long waiters and performance targets. The validation team has reviewed and flexed resources to mitigate the impact.
- **52w proportion of PTL** - 656 patients / 1.2% waiting over 52 weeks in November, against target of no more than 0.7% patients in March 2026. This remains ahead of trajectory.
- **Awaiting First Event < 18 weeks** - 70.2% of patients waiting for first activity within 18 weeks against March 2026 improvement target of 72.2%. This is an improvement from last months 68.1% and is now within trajectory. Focussed improvement work taking place with services below 72% to review processes, additional capacity and ensure patients are booked in waiting time order.
- **65 Weeks** - As of the end of November, 6 patients waiting over 65 weeks: 5 in Trauma & Orthopaedics (T&O), and 1 in Oral Surgery.
- There are currently 108 patients who will have been waiting more than 52 weeks for a first outpatient by the of January 2026. Every service has confirmed there is capacity available for all of these patients to have an appointment before the end of January and they are currently being booked.

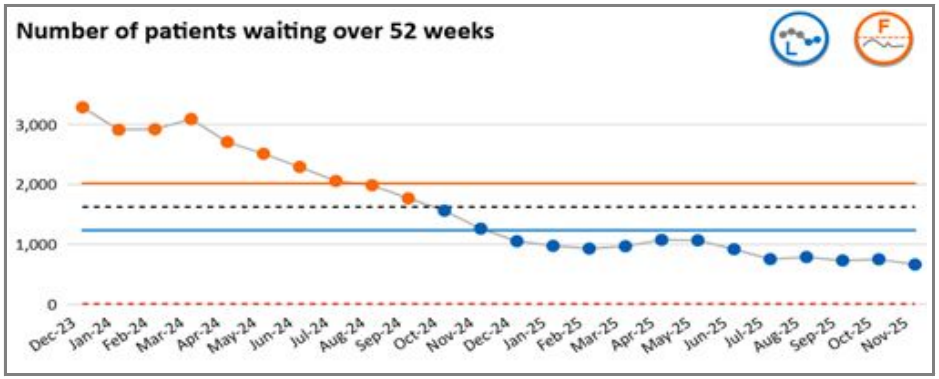
Month 08 | 2025-26

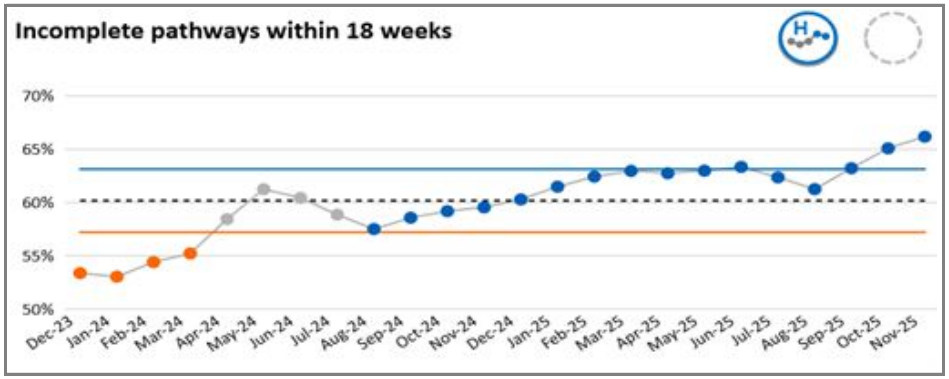
Operations

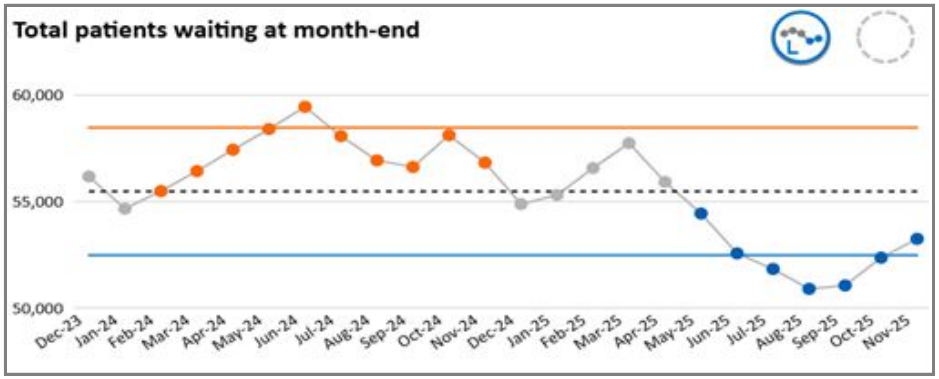
RTT 18 Weeks - excl. Community Paediatrics

NHS East and North Hertfordshire Teaching NHS Trust







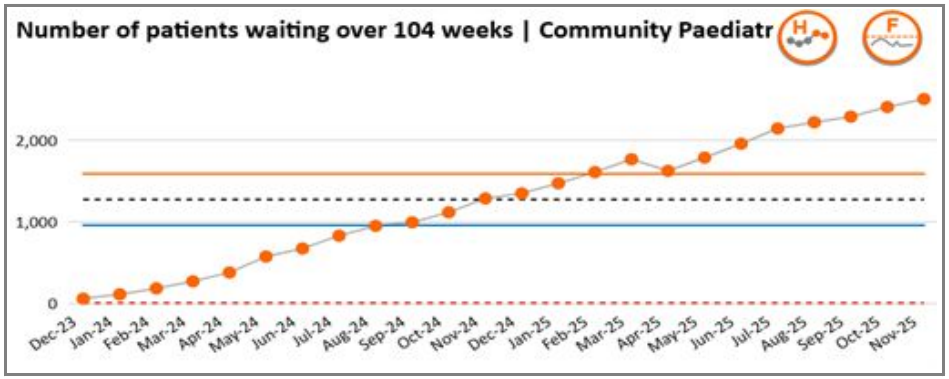


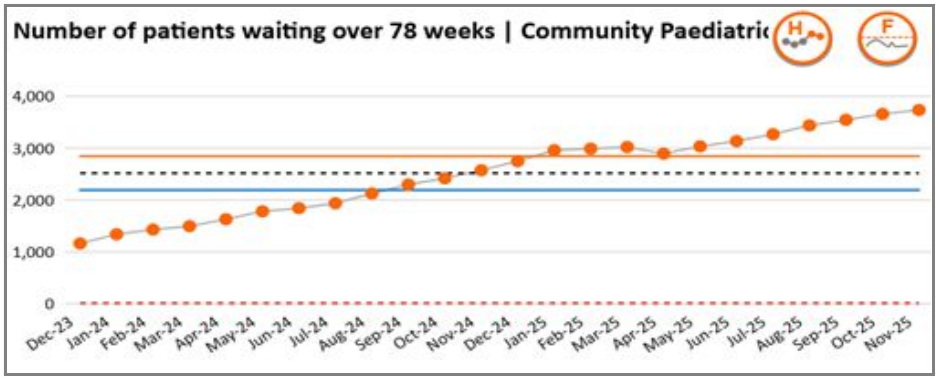
Month 08 | 2025-26

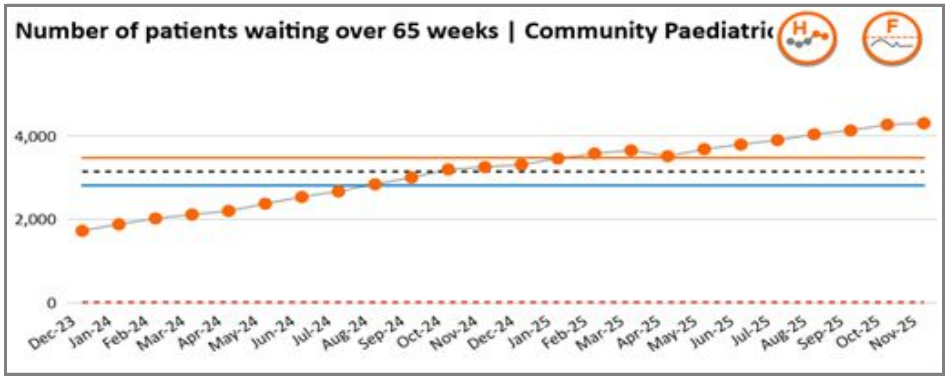
Operations

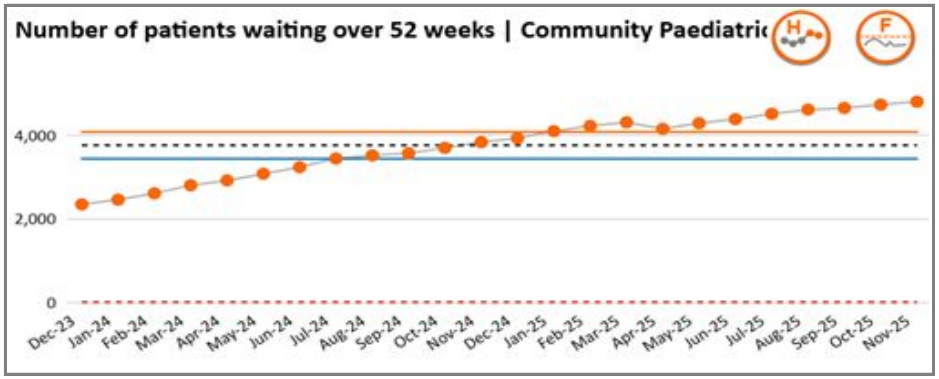
RTT 18 Weeks - Community Paediatrics ONLY

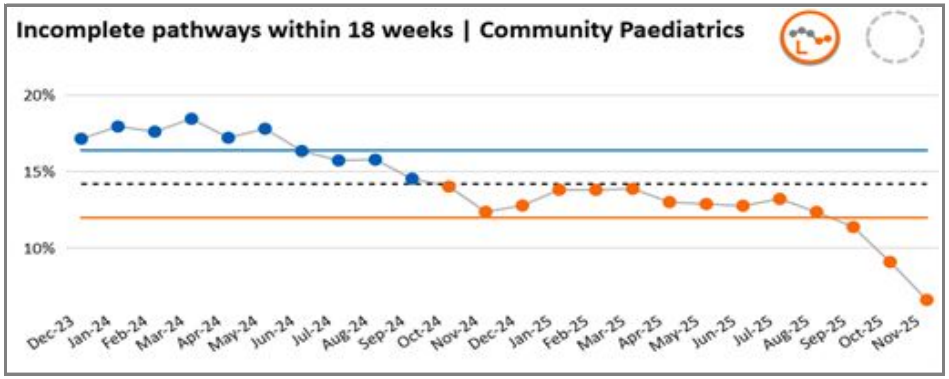
NHS East and North Hertfordshire Teaching NHS Trust

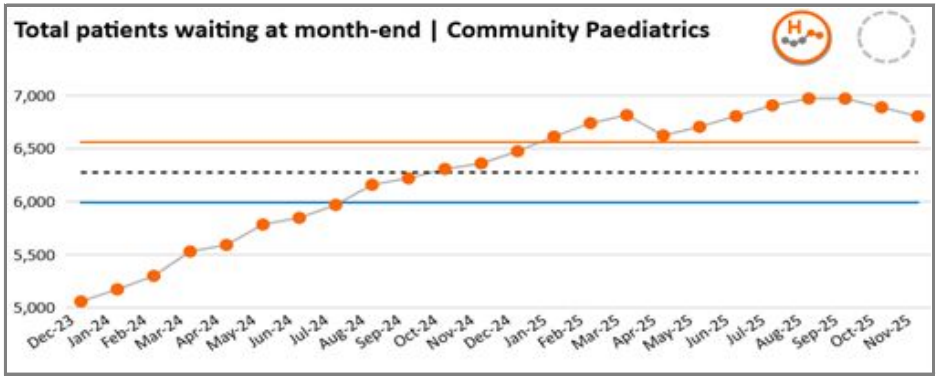








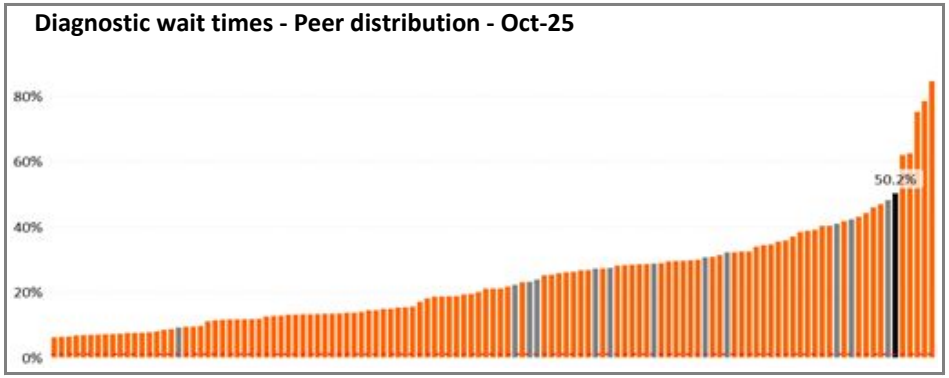


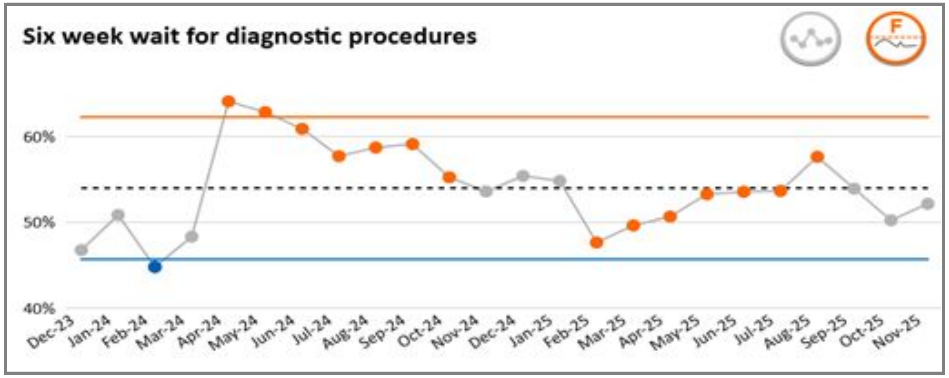


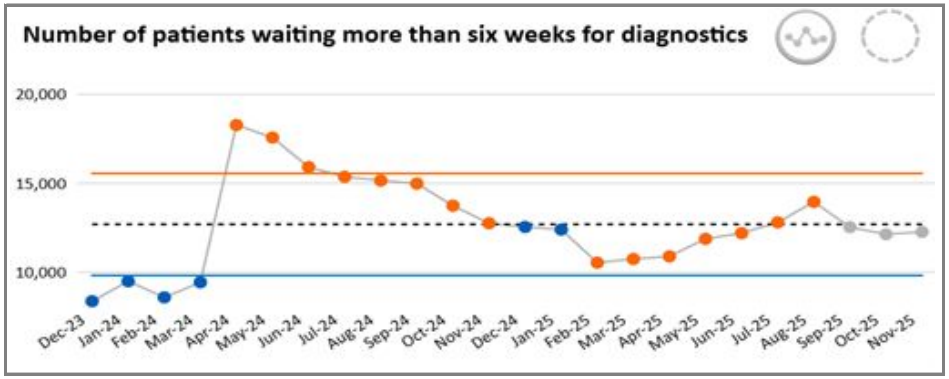
Month 08 | 2025-26

Operations

Diagnostics Waiting Times







Key Issues and Executive Response

- In November DM01 performance (% of patients waiting over 6 weeks for diagnostics) has deteriorated from 50.2% to 52.1%.
- For DM01 excluding Audiology, there are 5,762 patients waiting >6 weeks; with 551 patients (improved by 40% vs 914 in October) 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.

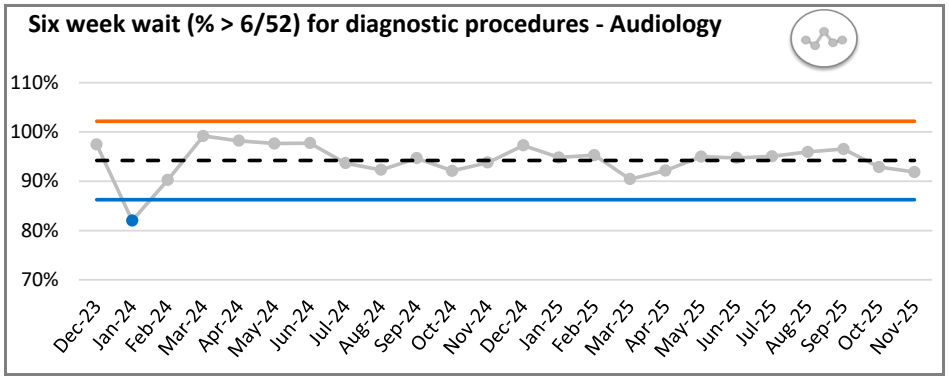
Challenges / Actions

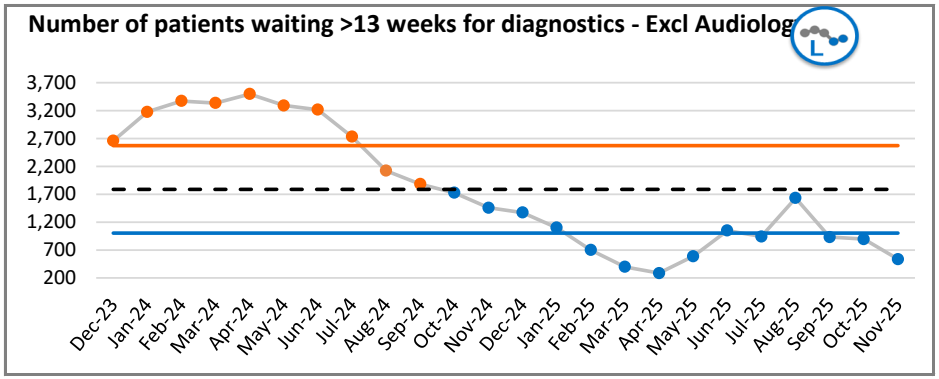
- **Non-Obstetric ultrasound** has been impacted by staffing gaps (20% vacancy 6 wte) appointed 2 in November awaiting starting dates. Extension of insourcing has been agreed to continue until end of March. Current performance deteriorated from 39.5% to 43.2% (4,098 breaches) due to high number of planned patients; mean wait remains 5.1weeks.
- Outsourcing for **MRI** to Pinehill continues, & CT van switched to MRI for 4 lists per month. An MRI accelerator installed at QE2. Following staff training, expected to support an additional 30 scans per month in a phased approach from October. Consultation for 7 day service ended in December with a starting date end of February : additional 4.89 wte recruitment interviews in November. There are 894 patients over 6 weeks vs 903 in October; mean wait is 4.3 weeks. Based on the above, trajectory for compliance to be reforecast.
- Estate identified at Lister & regional capital signed off for paeds **audiology**, planned to open by 3/26. Adult audiology currently 91.7% (4,878breaches) with mean wait of 57 weeks. Paeds currently 92.24% (1,677breaches) with mean wait of 62 weeks.
- **Sleep studies** - In November new clinic locations has started at Lister to reduce DNAs and improve attendance.

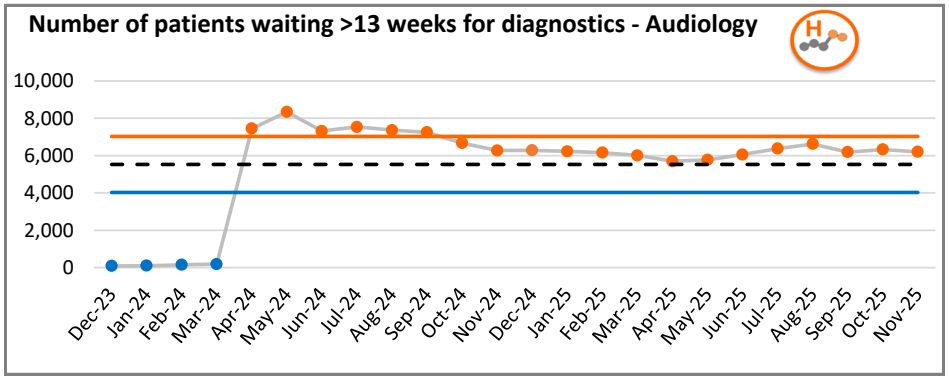
Month 08 | 2025-26

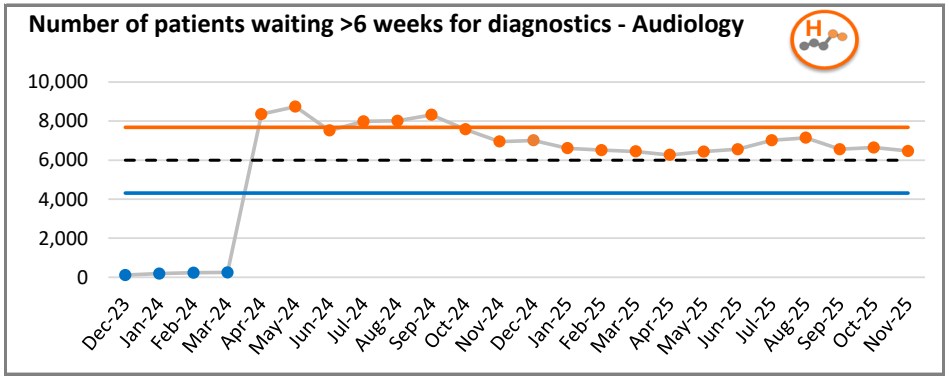
Operations

Diagnostics Waiting Times - Audiology









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NHS
East and North Hertfordshire Teaching
NHS Trust

Finance

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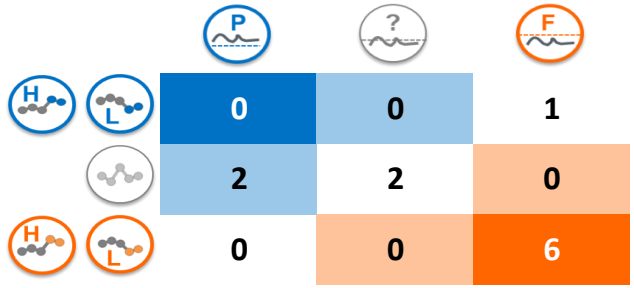

Finance

Summary

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Summary Financial Position	Surplus / deficit	Nov-25	-2.4	0.94		?	Common cause variation Metric will inconsistently pass and fail the target
	CIPS achieved	Nov-25	1,245	1,681	L		8 points below the mean No target
	Cash balance	Nov-25	77.9	33.8	L	F	7 points below the mean Metric will consistently fail the target
Key Financial Drivers	Income earned	Nov-25	45.3	61.6		P	Common cause variation Metric will consistently pass the target
	Pay costs	Nov-25	29.5	37.6	H	F	8 points above the mean Metric will consistently fail the target
	Non-pay costs (including financing)	Nov-25	15.5	23.1	H	F	14 points above the mean Metric will consistently fail the target

Month 08 | 2025-26

Finance

Summary

NHS East and North Hertfordshire Teaching NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Key Payroll Metrics	Substantive pay costs	Nov-25	24.9	34.6			8 points above the mean Metric consistently fail the target
	Average monthly substantive pay costs (000s)	Nov-25	0.9	5.7			8 points above the mean Metric will consistently fail the target
	Agency costs	Nov-25		0.4			2 points below the lower process limit No target
	Unit cost of agency staff	Nov-25		12.5			Common cause variation No target
	Bank costs	Nov-25	3.7	2.5			Common cause variation Metric will inconsistently pass and fail the target
	Overtime and WLI costs	Nov-25	0.5	0.4			4 points below the lower process limit Metric will consistently fail the target
Other Financial Metrics	Private patients income earned	Nov-25	0.4	0.5			Common cause variation Metric will consistently pass the target
	Drugs and consumable spend	Nov-25	2.8	4.5			9 points above the mean Metric will consistently fail the target

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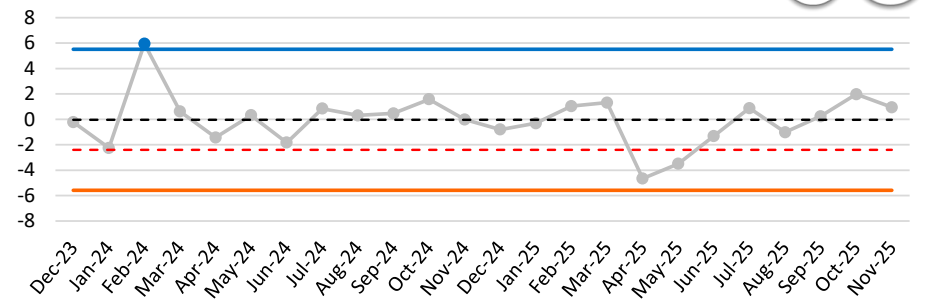
Finance

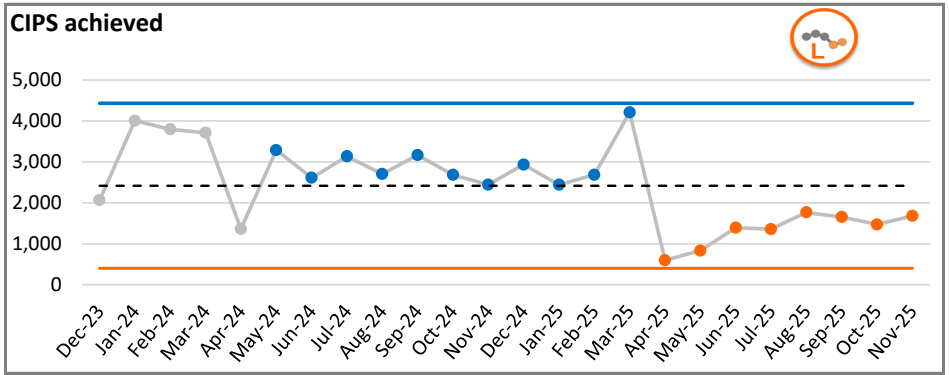
Summary Financial Position

NHS East and North Hertfordshire Teaching NHS Trust

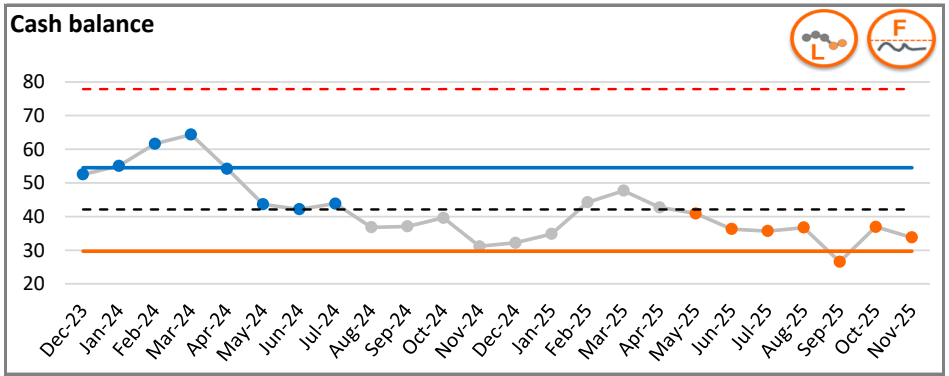
Surplus / deficit



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 8, the Trust has reported an actual YTD deficit of £6.4m. This is in line with phased plan expectations.
- The CIP plan assumes only 30% of delivery at M8, 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 and November at over £1.0m.

	Annual Budget £m	Budget YTD £m	Actual YTD £m	Variance YTD £m
Income	704.7	470.8	478.4	7.5
Pay	-444.3	-296.8	-298.3	-1.5
Non Pay	-223.0	-155.6	-162.3	-6.7
EBITDA	**37.5**	**18.5**	**17.8**	**-0.7**
Financing Costs	-37.5	-25.0	-24.3	0.8
Retained Deficit exc. PSF	**-0.0**	**-6.5**	**-6.4**	**0.1**
Surplus / Deficit (excl Fin Adj's)	**-0.0**	**-6.5**	**-6.4**	**0.1**
Adj Financial Performance	0.1	0.1	0.1	0.1
Deficit (Incl Fin Adj's)	**0.1**	**-6.4**	**-6.3**	**0.1**

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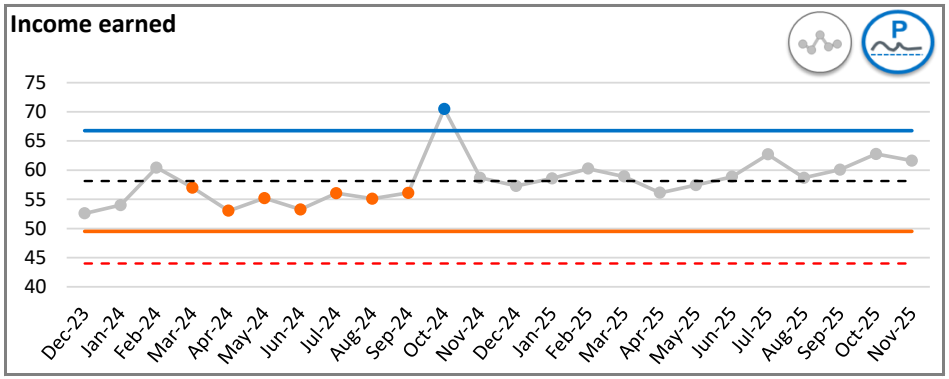
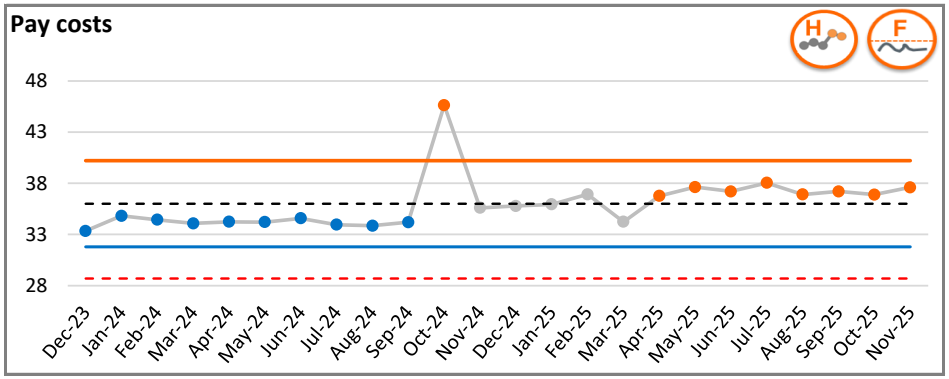
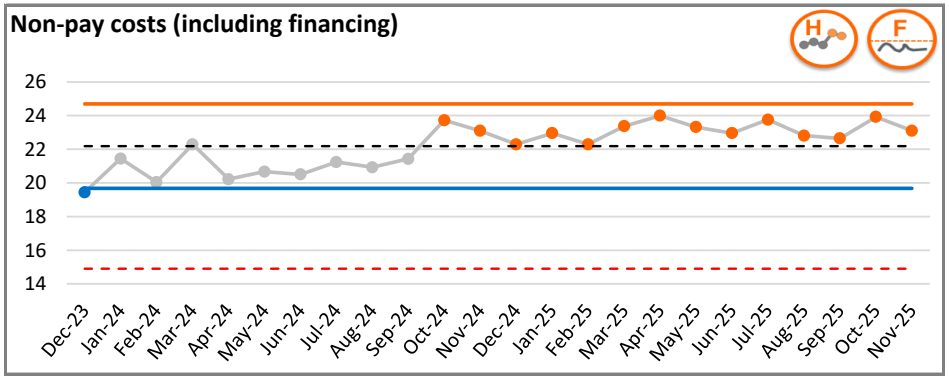
Finance

Key Financial Drivers

NHS East and North Hertfordshire Teaching NHS Trust







- The Trust is reporting a £6.4m deficit at the end of month 8, which is £0.1m favourable to plan.
- In month, there was an actual £0.9m surplus compared with a £0.9m surplus plan.
- The reported position includes the estimated impact of cover of industrial action and the loss of ERF activity as a result. This has resulted in a £1.1m pressure in the year to date.
- Although the year to date position is on plan, this is due to the release of £10.6m non recurrent reserves to offset slippage in CIP delivery and BAU pressures.
- Year to date CIP delivery is £10.7m, which is just 30% of the annual CIP target, despite being 8 months through the financial year.
- ERF activity YTD is below Divisional phased capacity plans, particularly within the Unplanned Care, Planned Care and Women and Children's Division. However, waiting list payments are £1.0m above the YTD plan, which indicates that not all of 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 support, and RTT targets will still need to be met. There is a significant financial risk if RTT targets are not met.
- There continued to be pay pressures in month within nursing and clinical support workers. Nursing pay, in particular, had a high level of bank expenditure in the month.
- Non pay reported a significant adverse variance in month, excluding the impact of reserves and high cost drugs and devices. This was partially offset by local income, however, there was also a number of non recurrent expenditure items in month.

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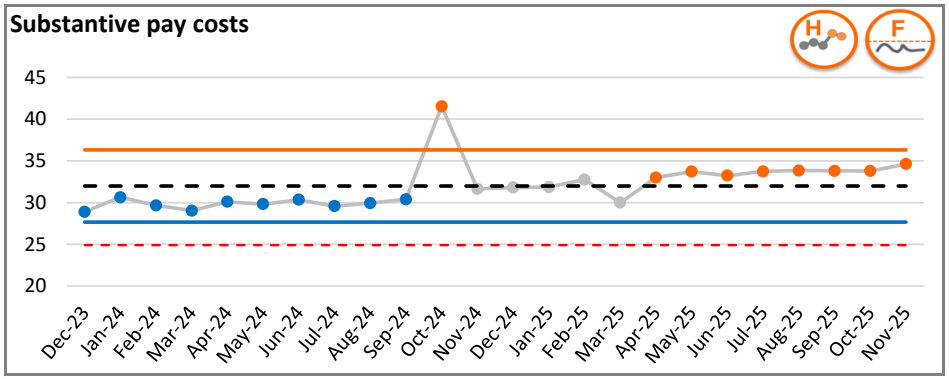
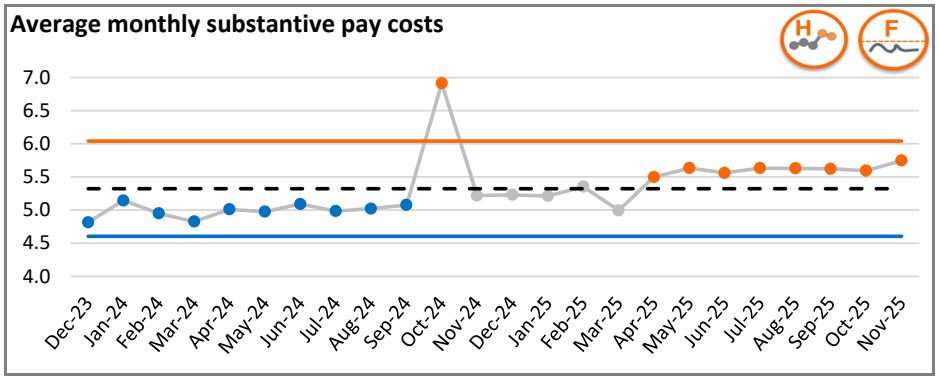
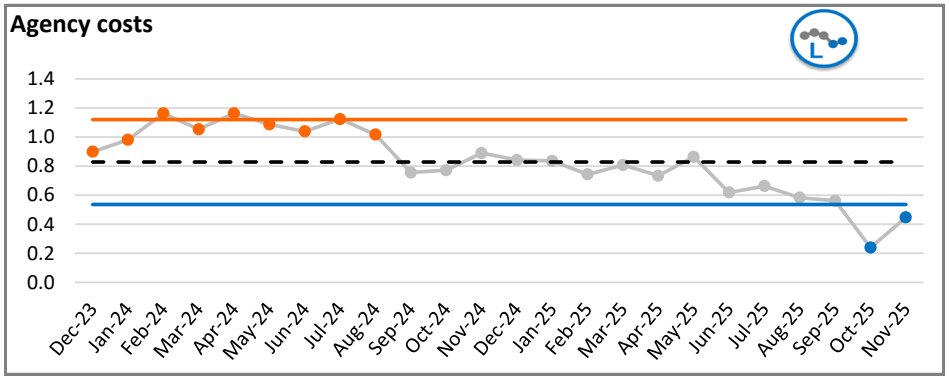
Finance

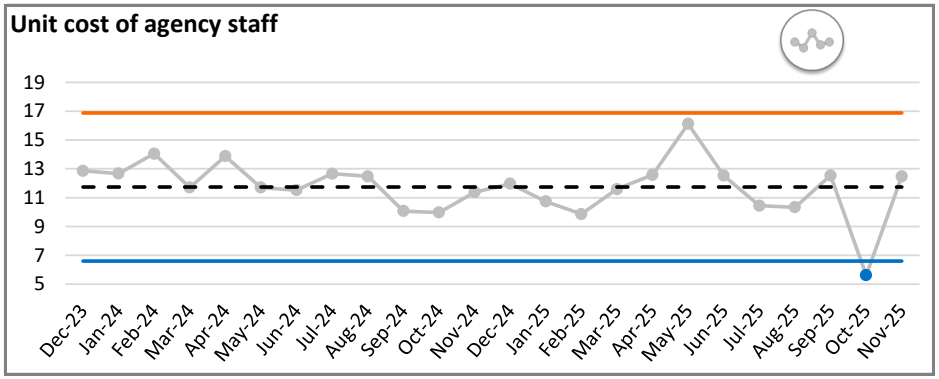
Other Financial Indicators

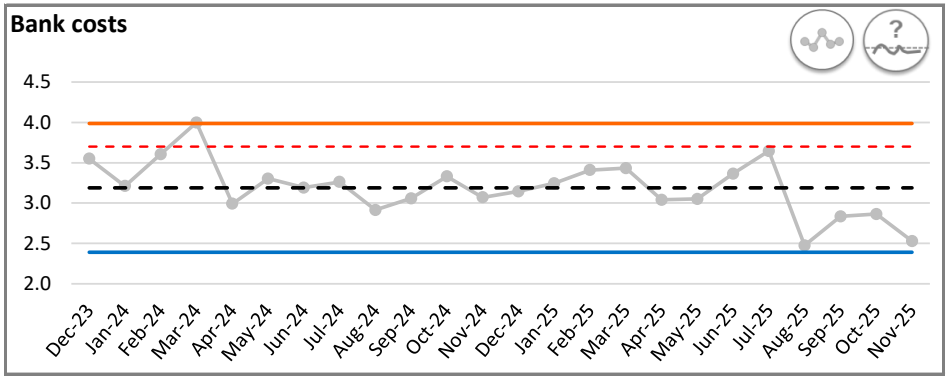
NHS East and North Hertfordshire Teaching NHS Trust

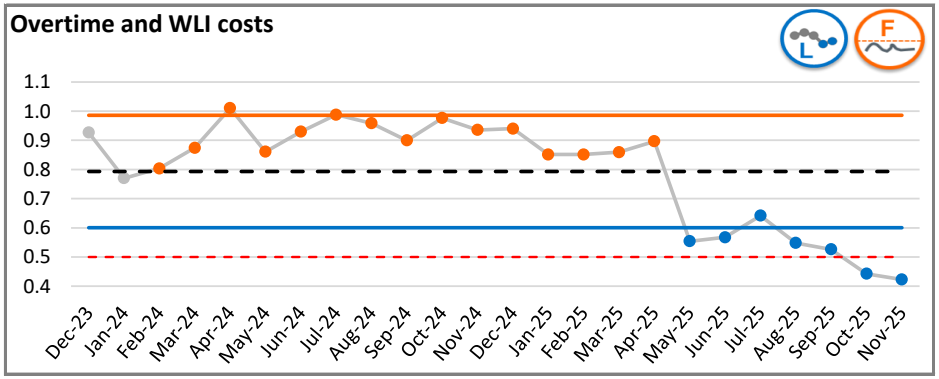












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NHS
East and North Hertfordshire Teaching
NHS Trust

People

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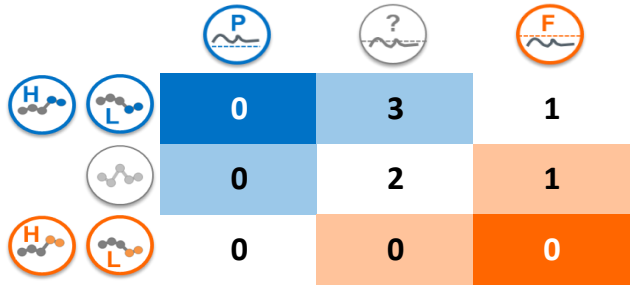

People

Summary

NHS East and North Hertfordshire Teaching NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Work	Vacancy rate	Nov-25	8%	5.8%			7 points below the mean Metric will inconsistently pass and fail the target
	Bank spend as a proportion of WTE	Nov-25	5%	6.7%			1 point below the lower process limit Metric will consistently fail the target
	Agency spend as a proportion of WTE	Nov-25	3%	1.2%			10 points below the mean Metric will inconsistently pass and fail the target
Grow	Statutory and mandatory training compliance rate	Nov-25	90%	88.2%			Commn cause variation Metric will inconsistently pass and fail the target
	Appraisal rate	Nov-25	90%	86.0%			Common cause variation Metric will consistently fail the target
Thrive	Turnover rate	Nov-25	10.5%	7.5%			7 points below the lower process limit Metric will inconsistently pass and fail the target
Care	Sickness rate	Nov-25	4.0%	5.0%			Common cause variation Metric will inconsistently pass and fail the target

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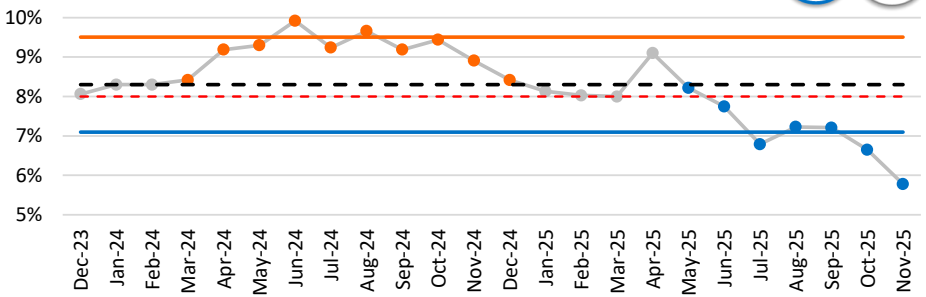
People

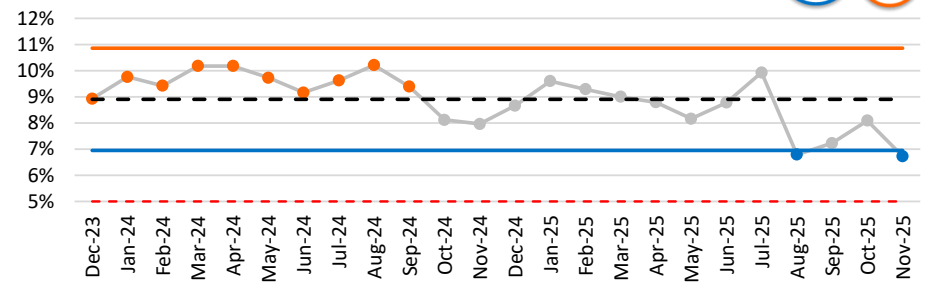
Work Together

East and North Hertfordshire Teaching NHS Trust

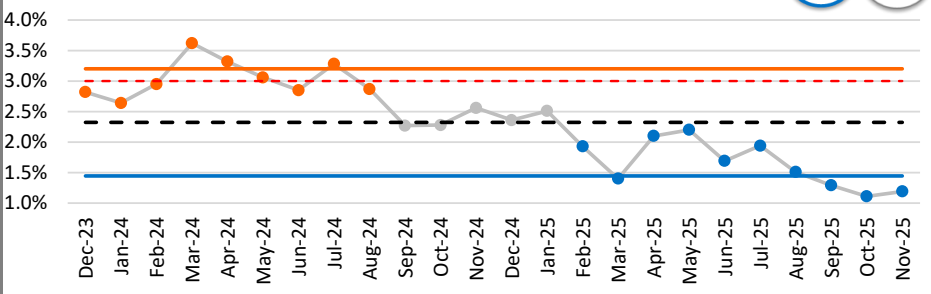
Vacancy rate



Bank spend as a proportion of WTE



Agency spend as a proportion of WTE



Key Issues and Executive Response

- Overall vacancy rate reduced to 5.8%
- Qualified N&M WTE (1940) in post continues to increase and is at its highest. Total WTE in post also increased to 6214.
- 236 candidates in recruitment pipeline. 67 nurses/midwives, 30medical, 11 AHPs and 14 HCS.
- Time to Hire (TTH) reduced to 14 weeks for all staff groups. General resourcing TTH remained at 15, 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.
- Candidate experience improved to 5 out of 5 stars, exceeding target of 4.
- Implementation of Resource Control Panel to support Governance, Scrutiny and Oversight of all recruitment and Resourcing activity – including bank and agency.
- Triangulation into nursing shows bank usage generally aligns with existing vacancies with strong recruitment pipelines in place. Review identified vacant posts not always listed on Trac. Resourcing team actively addressing this with managers.
- The total Bank and Agency spend below target 8% Trust target for the first time.
- Agency remains within plan. Spend increased due to circa £160 of accrual reversals form previous month.
- Agency spend as a proportion of WTE remains below target. Bank is above target.
- Agency price cap breaches increased slightly, however spend remain significantly below ceiling target.
- Reduction of £1k in bank spend when reserves are excluded. Bank 5.93 WTE above target. 13.84 WTE Medical Locum FTE incorrectly coded to a bank subjective code. To be corrected in M9.

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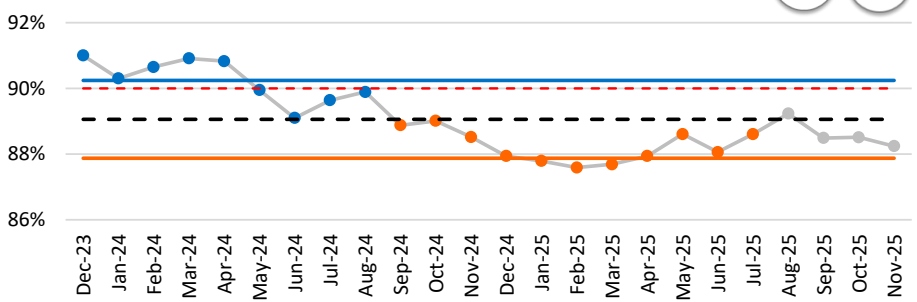
People

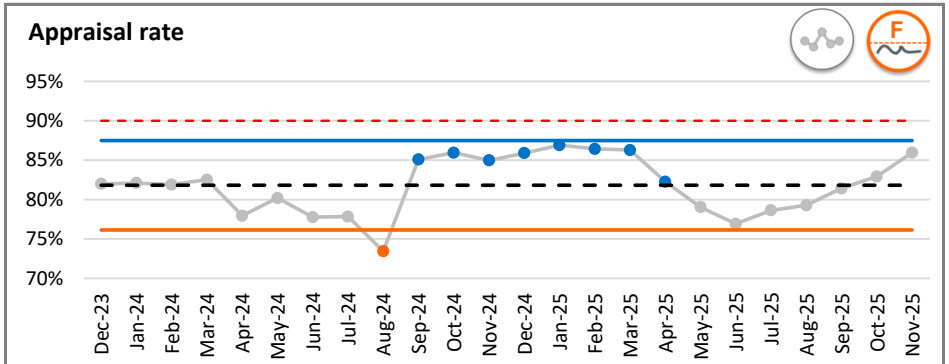
Grow Together

East and North Hertfordshire Teaching NHS Trust

Statutory and mandatory training compliance rate



Appraisal rate



Key Issues and Executive Response

- October GTR compliance is now 87.1%. Planning for monthly virtual support sessions in the new year subject to capacity.
- Moving & Handling level 1 compliance at 92%.
- 147 students on site across all placements, including 22 apprentices, 5 elective placement and 4 return to practice.
- Purple Flag Initiative (designed to improve support for learners) launched for Nursing students with a plan to rollout to other staff groups in the new year.
- Additional practical induction spaces for CSW increased to 36 per month (previously 24).
- Moving and Handling update session changing from 6 to 8 capacity in accordance with CSTF.
- 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.
- As part of the Resident Doctors 10 point improvement plan, Medical Education will fund lockers for Doctor colleagues.
- A one off Grand Round has been approved for February 2026, giving Trust colleagues an opportunity to meet with University of Hertfordshire to discuss ways to get involved with the new medical school (expected Autumn 2026)
- Conversations are progressing with NHSE/Deanery regarding the Trust becoming a pilot site for Medical Lead Employer Services in the East of England region (none of which exist currently).

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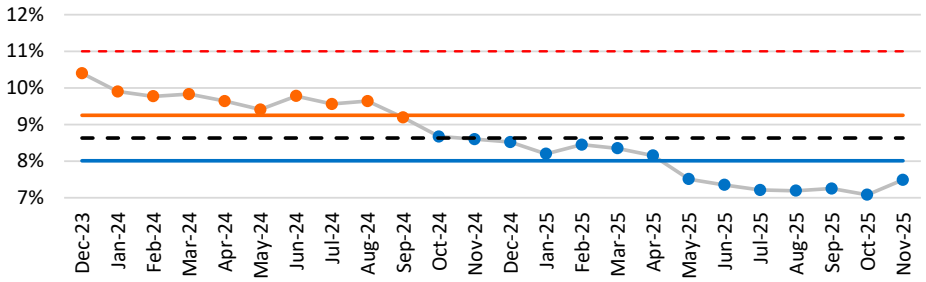
People

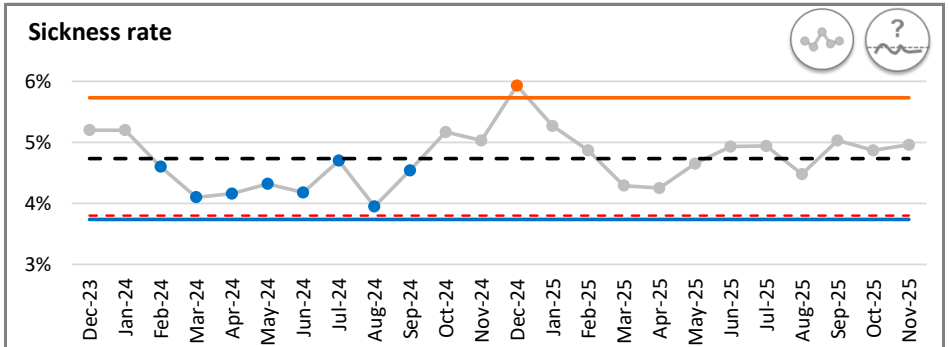
Thrive Together | Care Together

NHS East and North Hertfordshire Teaching NHS Trust

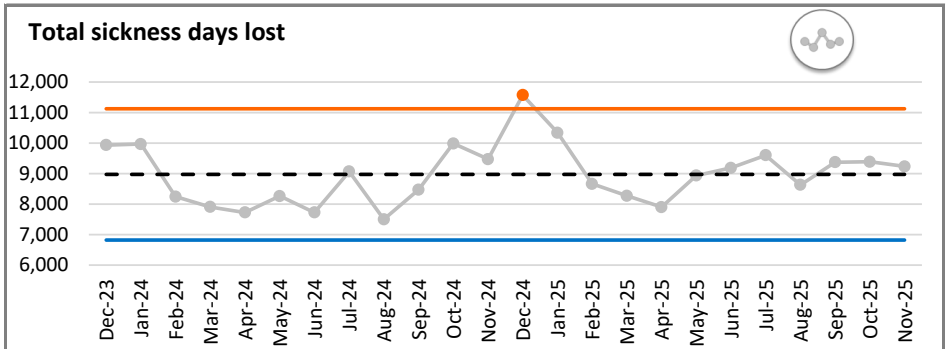
Turnover rate



Sickness rate



Total sickness days lost



Key Issues and Executive Response

Thrive Together

- Single suspension duration is over target due to involvement of external agency and due to staff side availability to attend a disciplinary hearing.
- Average duration of disciplinary cases reduced for the third month in a row following closure of a long standing MHPS concern.
- Average duration of Staff concerns has increased slightly due to one case taking a significant period to establish the issues and reach a conclusion.
- Management of sickness absence continues with support provided to managers. W&C pilot commenced to provide support in early management and escalate support options where necessary.

Care Together

- Flu vaccines have continued to be offered throughout November. Flu vaccines protect ourselves, our colleagues our loved ones and patients from severe illness from flu. Vaccines continue to be available in booked appointments and pop up clinics in clinical areas. Flu vaccine uptake in frontline employees has exceeded the 45% target, The current uptake in frontline employees is 46.9%.
- Occupational health advice continues to offered to support the prevention of sickness absence and to enable safe and sustained return to work following ill health.
- In November wellbeing events have focused on men's health awareness. Stevenage Healthy hub visited Lister to promote men's fitness and wellbeing workshops and Hertfordshire and Mid Essex Talking Therapies Service launched a webinar on men's mental health.

Month 08 | 2025-26

Board committee report

NHS East and North Hertfordshire Teaching NHS Trust

Meeting	Public Trust Board			**Agenda Item**	16
Report title	Quality and Safety Committee reports to Board for meetings held 12 November and 17 December 2025			**Meeting Date**	14 January 2026
Chair	Dr. David Buckle – Committee Chair				
Author	Governance Business Administrator				
Quorate	**Yes**	☒	**No**		☐

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

- **GIRFT Programme**
  Continued engagement with the national GIRFT programme is supporting improvements in clinical practice, with work ongoing to strengthen consistency across specialties.
- **Women and Children's Services**
  Improvement work is progressing across the division, including estate upgrades, enhanced community support, and strengthened care pathways for children and young people.
- **Seven Day Standards**
  The latest review identified areas for improvement in seven day standards, and actions are underway to address workforce and operational challenges.
- **Adult inpatient survey**
  The inpatient survey showed several positive results while highlighting areas (particularly communication and discharge support) that are being targeted for further improvement.
- **IPR – Infection prevention and control; Neonatal E. coli review**
  Local clusters of neonatal and maternal infections (including E. coli) and increasing regional antimicrobial resistance patterns require strengthened IPC controls and cross-division coordination.
- **Risk management framework maturity – corporate risk register gaps**
  The Trust's maturing risk management processes continue to reveal gaps, including inconsistent action planning across several high scoring corporate risks.
- **Maternity – home birth, screening pressures and workforce model**
  A recent homebirth incident with minimal harm, screening pathway pressures, and ongoing workforce constraints require continued senior monitoring.

Assurances provided to the Board:

- **MNSI Case**
  Actions from an MNSI case are being progressed, including improved CTG training, strengthened intrapartum risk assessment, and family engagement.
- **Never Event**
  Improvement actions following a Never Event, including enhanced training, strengthened governance, and exploration of digital verification solutions, providing *reasonable assurance* of learning and response.

- **Estates and Facilities**
  Estates planning, space utilisation work, and prioritised safety improvements (especially paediatrics) are progressing.

- **VTE Action Plan**
  - Significant improvement work is underway to strengthen VTE assessment and re-assessment processes.
  - Digital transformation teams, clinical leaders, and divisional teams are collectively addressing long-standing system limitations.
- **Complaints performance – improved responsiveness and C**
- **clear ownership**
  - Significant reductions in complaints backlog were achieved through coordinated divisional and corporate efforts.
  - Planned Care and Unplanned Care divisions demonstrated strong leadership and operational ownership.
  - Targeted staff redeployment and closer consultant engagement have resulted in faster, high-quality responses.
- **Maternity assurance – full compliance with national safety actions**
  - The Trust is compliant with all maternity safety actions required for the national Maternity Incentive Scheme.
  - Leadership in maternity and neonatal services demonstrated strong governance and learning mechanisms.
  - A recent neonatal safety event demonstrated effective response, escalation, and system resilience.

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

- **Patient safety and experience (back to the floor, adult inpatient survey)**
  Clear improvement actions are progressing and agreed monitoring mechanisms are in place.
- **Ongoing oversight of improvement programmes**
  Several quality improvement programmes and divisional transformation plans will require continued monitoring to ensure sustained progress over the coming months.
- **Focus on workforce and operational resilience**
  Workforce pressures and rota challenges continue to influence service delivery in key areas. Mitigation plans are in progress.

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

- **MNSI Case**
  Executive team to consider an external peer review of the MNSI investigation and report back to Quality and Safety Committee.
- **Women and Children's Division**
  Business case for a paediatric hospital at home service to be progressed and presented by February 2026. Estate refurbishment (Bluebell Ward) to be prioritised, with an update due January 2026.
- **Learning Disability PSII**
  A Trust-wide Learning Disability Improvement Plan will be developed and presented by March 2026.
- **Committee Effectiveness Review**
  - The committee approved moving to a new governance model
  - Implementation planning (including Terms of References (ToRs), reporting flows, and meeting rationalisation) to begin in early 2026.
  - Non-Executive Directors membership on committees to be reduced to three per committee from January 2026.

Any actions recommended to improve effectiveness of the meeting:

- Strengthen use of executive summaries, particularly for complex reports, to aid clarity and improve committee decision making.
- Encourage consistent attendance from key clinical and operational leads, supporting more robust and informed discussions.
- Prioritise agenda time for deep dives on complex topics to be prioritised. Certain issues require focused time for quality assurance level discussion that cannot be achieved in congested agendas.

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

To be trusted to provide consistently outstanding care and exemplary service

Board committee report

NHS East and North Hertfordshire Teaching NHS Trust

Meeting	Public Trust Board			**Agenda Item**	17
Report title	Finance, Planning and Performance Committee – November and December			**Meeting Date**	14 January 2026
Chair	Richard Oosterom, FPPC Chair				
Author	Committee Secretary				
Quorate	**Yes**	☒	**No**		☐

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

- Risk 7 (financial constraints) increased to a score of 20, reflecting current financial pressures and uncertainty in system, region, national about future arrangements.
- Tight RTT management required, not only to achieve RTT targets, but to secure block payment
- Break-even position for the year at risk due to lack of defined CIP programmes, under delivery against agreed CIP programmes and ongoing run rate pressures in particular in Unplanned Care and Women and Children. Mitigation measures taken but require utmost attention.

Assurances provided to the Board:

- Cancer performance: Strong recovery after September dip; all key metrics on target.
- RTT Improved from 59.5% last year to 66.1%; 52-week waits reduced from 2.2% to 1.2%.
- Diagnostics improving (although MRI will be impacted by supplier call back)

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

- The 26/27 3-year plan development is well underway for a first draft submission done on 17 December; This submission will contain top-down assumptions and will be refined bottom-up for the February submission.
- Delivery of a break-even position for 26/27 currently requires a £51.5m CIP
- To have a chance to deliver this size of CIP requires difficult decisions, urgent prioritisation, and a significant cultural shift as well as external support to be in place in Q4 25/26

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

- Off-line approval of the Audiology business case

Any actions recommended to improve effectiveness of 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

East and North Herts Health and Care Partnership

East and North Herts HCP performance report

27 November 2025

Working together
for a healthier future

Healthcare performance

East and North Herts Health and Care Partnership

Place

East and North Herts Place UEC Performance Summary

		Validated data							Unvalidated data	
Place	Indicator	Previous Month	Current Month	Latest Month	Month Change	Current month trajectory	Variance to target	12 month trend	Latest weekly performance	
ENH	% abandoned calls	3.9%	3.8%	Oct-25	↓	3.0%	0.8%		1.4%	↓
ENH	CAT 2 mean response times	00:36:52	00:38:58	Oct-25	↑	00:37:04	1.90		na	
ENH	UCCH activity: A2S patients passed + CB4C incidents per day	17.5	15.2	Oct-25	↓	na	na		na	
ENH	% 2 hour urgent community response	79.7%	87.7%	Sep-25	↑	70.0%	17.7%		na	
ENH	Mean handover time	00:27:04	00:31:59	Oct-25	↑	00:35:00	-3.02		00:20:46	↓
ENH Place	4-hour standard	77.4%	76.4%	Oct-25	↓	76.5%	-0.1%		77.8%	↑
ENH	% of type 1 patients spending more than 12 hours in ED	8.9%	11.0%	Oct-25	↑	8.3%	2.7%		na	
ENH	Bed occupancy (G&A)	88.4%	90.5%	Oct-25	↑	92.1%	-1.6%		91.2%	↑
ENH	% patients discharged on discharge ready date	76.9%	77.4%	Sep-25	↑	77.5%	-0.1%		na	
ENH	% discharged before noon	14.6%	15.1%	Oct-25	↑	33.0%	-17.9%		na	
ENH	Virtual ward occupancy	103.9%	116.7%	Oct-25	↑	na	na		na	

- There was a slight improvement in the % abandoned calls to 3.8% in October. This is above the national target of 3% but better than the long-term average
- Mean Cat 2 response times deteriorated from 36m 52s in September to 38m 58s in October. This performance is slightly worse than the EEAST target of 37m 4s but remains better than the long-term average. System performance so far in November has improved to 33m
- The volume of activity going through the UCCH (access-to-stack calls passed + call-before-convey incidents handled) has been reducing since the peak in Jan-25.
- The % of urgent community responses within 2 hours is consistently above the 70% target in East and North Hertfordshire. In Sep-25, 88% of urgent community responses were reached within 2 hours. Data not available for October due to system changes at HCT
- In October, the mean handover time at ENHT was 32m. This is ahead of the plan outlined in the FY2526 planning submission (35m for October)
- % of type 1 patients waiting over 12 hours increased to 11% in Oct-25 which is 2.7 percentage points worse than plan. However, performance remains marginally better than the long-term average
- The % of patients discharged on their discharge ready date was 77.4% in September which is just below plan
- The % of patients discharged before noon reduced to 15.1% in October. There hasn't been any sustained improvement in this metric.
- Virtual ward occupancy in East and North Hertfordshire remained very high at 116.7% in October. Referrals remain high but below their peak from Jan-25

East and North Herts Health and Care Partnership

Place

UEC performance benchmarking

- There are three metrics where ENH place is performing better than regional and national average: 4-hour standard; discharges before 5pm; average NEL LOS
- There are three metrics where ENH place is performing below both regional and national average: 111 abandonment rate; % of type 1 patients spending more than 12 hours in ED; % discharges before noon
- There are four metrics where ENH place is performing between the national and regional averages: C2 mean response times; ambulance conveyance rate; mean handover time; and the GEMI score

	ICS	ENH	SWH	WE	National	Regional	
% abandoned calls	3.8%	3.8%	3.8%	3.9%	3.1%	2.6%	Red = Above national and regional average Amber = Between national and regional average Green = Below national and regional average
CAT 2 mean response times	00:38:30	00:38:58	00:35:32	00:42:48	00:32:37	00:40:41	Red = Longer than national and regional average Amber = Between national and regional average Green = Shorter than national and regional average
EEAST deployed staff hours per face-to-face incident	4.1					4.8	Red = Below regional average Green = Above regional average
Ambulance conveyance rate (A53 + A54)/A7	53.2%	52.4%	55.0%	51.6%	53.2%	49.6%	Red = Below national and regional average Amber = Between national and regional average Green = Above national and regional average
Mean handover time	00:30:33	00:31:59	00:23:08	00:39:29	00:31:19	00:39:11	Red = Above national and regional average Amber = Between national and regional average Green = Below national and regional average
4-hour standard	78.9%	76.4%	83.2%	80.5%	74.1%	74.6%	Red = Below national and regional average Amber = Between national and regional average Green = Above national and regional average
% of type 1 patients spending more than 12 hours in ED	10.4%	11.0%	8.9%	11.3%	10.8%	10.1%	Red = Above national and regional average Amber = Between national and regional average Green = Below national and regional average
National GEMI score rank (low = good, out of 169 sites)		91	30	129			Red =Bottom third of trusts nationally Amber = Middle third of trusts nationally Green = Top third of trusts nationally
% discharged before noon	18.9%	15.1%	27.1%	12.2%		17.4%	Red = Below regional average Green = Above regional average
% discharged before 5pm	60.8%	60.8%	67.8%	50.9%		60.0%	Red = Below regional average Green = Above regional average
Average NEL LOS (excl 0 and 1 day spells)	9.10	8.80	9.20	9.20	10.5	9.7	Red = Above national and regional average Amber = Between national and regional average Green = Below national and regional average

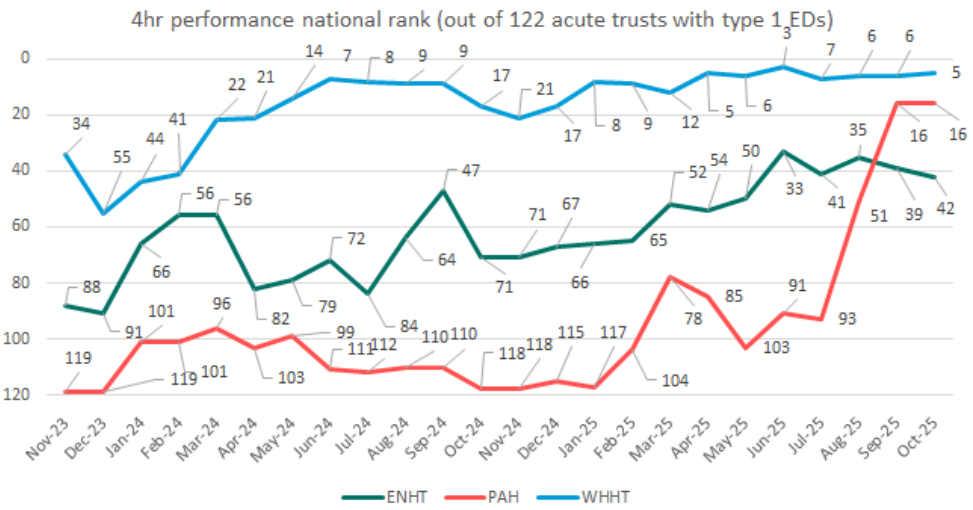
East and North Herts Health and Care Partnership

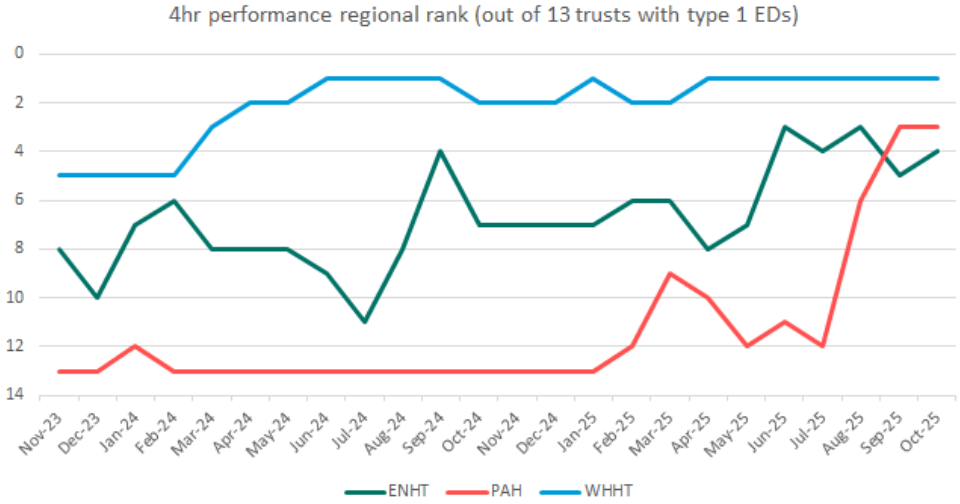
Provider

4-hour A&E waits performance benchmarking

- Over the last two years, there has been a general improvement in the national ranking of ENHT for the ED 4-hour standard. In Oct-25, ENHT was ranked 42nd nationally out of 122 acute trusts with a type 1 ED. Regionally, ENHT was ranked 4th out of 13 trusts with a type 1 ED

- There was a significant improvement in the ranking of PAH since July. This was primarily due to a recording change in relation to SDEC patients. In Oct-25, PAH was ranked 16th nationally out of 122 acute trusts with a type 1 ED. However, there are some inconsistencies between the PAH ECDS data and its A&E sitrep data which calls into question whether this improvement in A&E performance is real

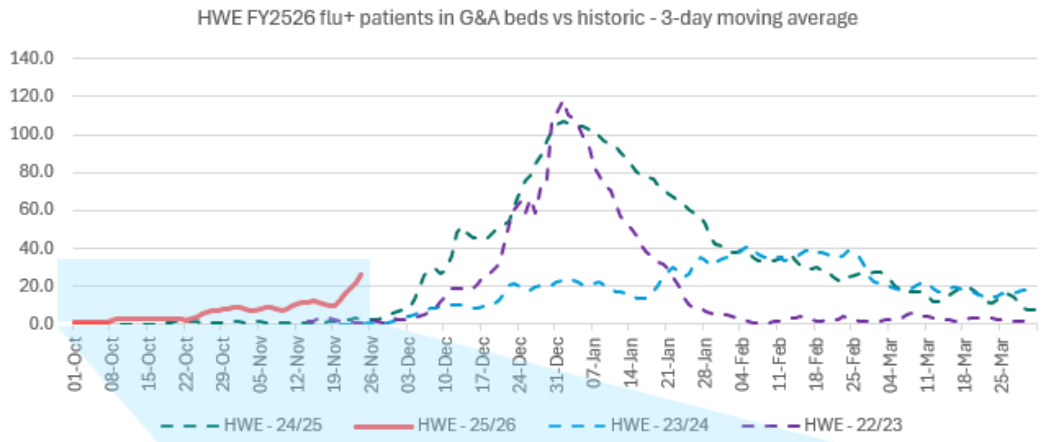


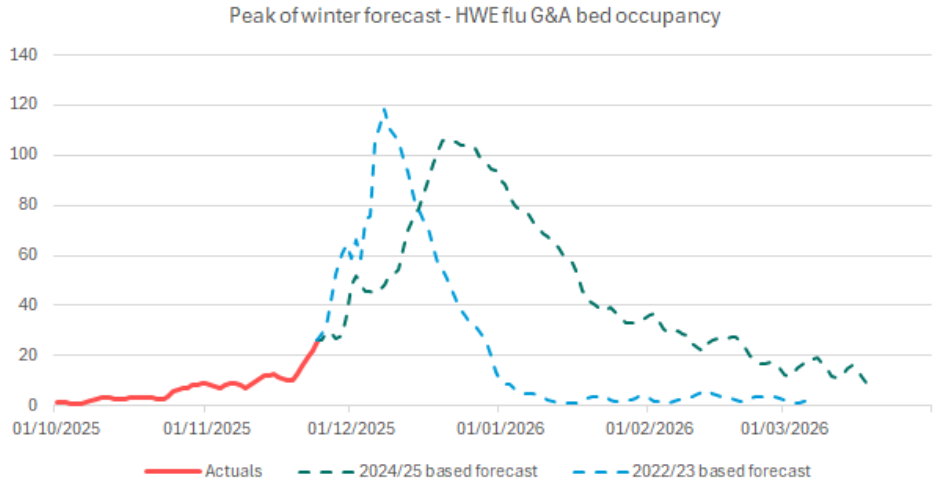


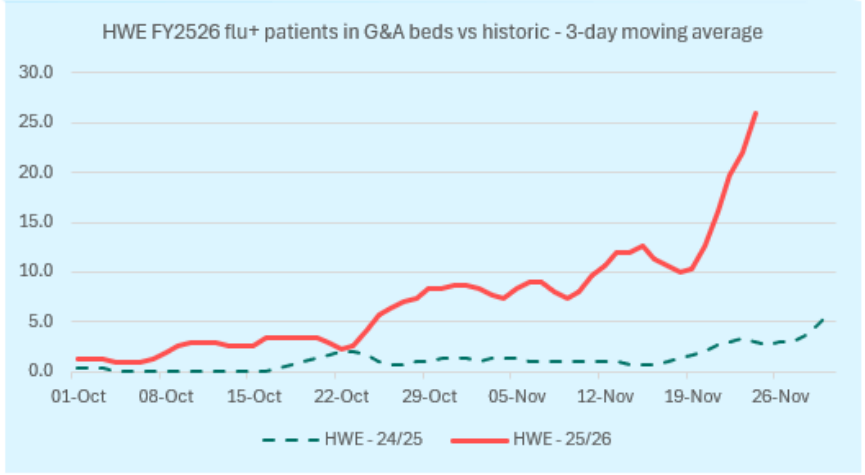
East and North Herts Health and Care Partnership

Peak of winter forecasting

- Flu bed occupancy in the East of England is about 9 days ahead of FY2425
- HWE is about 12 days ahead of FY2425
- For HWE, our modelling suggests a flu occupancy peak between 8th Dec and 21st Dec
- Peak flu occupancy typically correlates with the most challenging period for performance / access during the winter





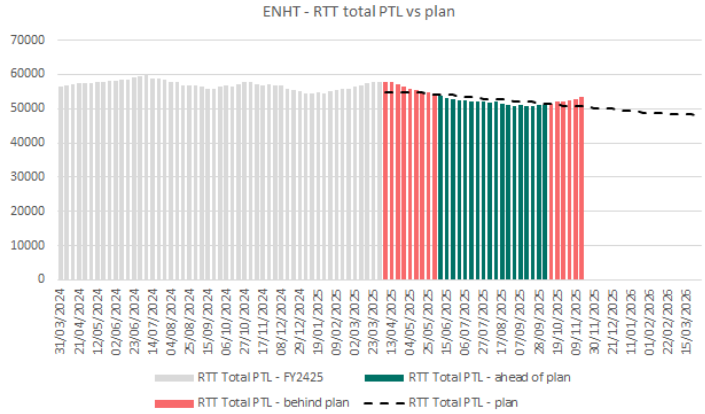


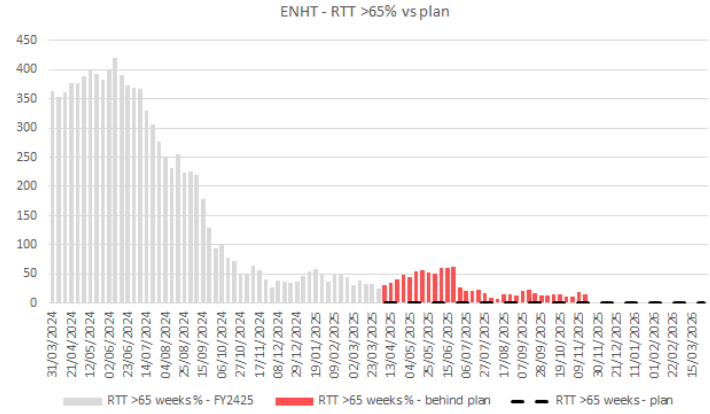
East and North Herts Health and Care Partnership

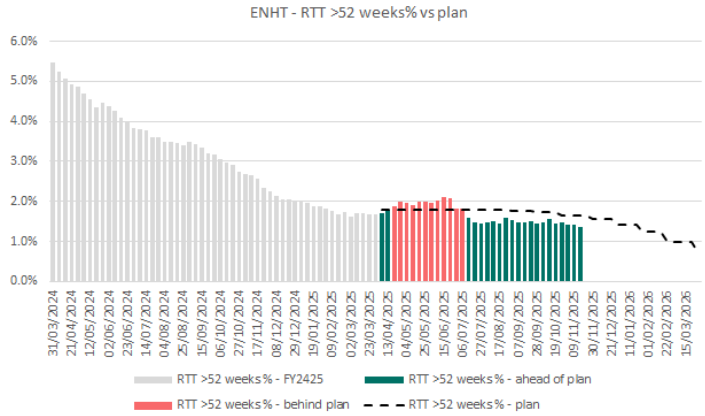
Provider

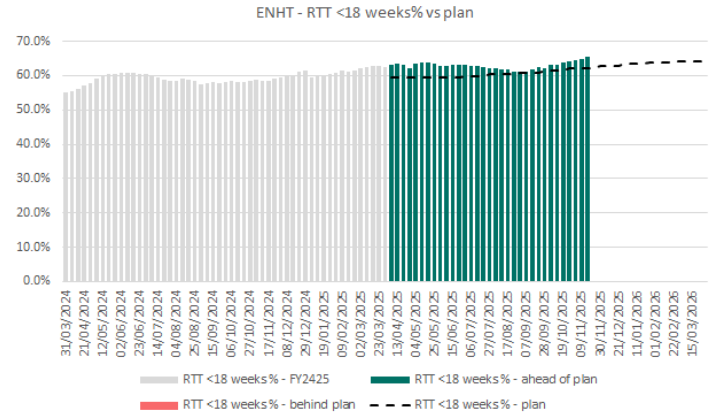
Acute planned care – RTT and long waiters ENHT

- As at 16th November, ENHT had 15 patients waiting over 65 weeks. This figure has been relatively static over the last four months. 8 of these 15 patients are T&O patients
- The Trust is forecasting to have zero >65ww by 21-Dec
- The Trust is ahead of plan for the % of patients waiting >52 weeks and the % of patients waiting <18 weeks
- However, the trust is now behind plan for the overall PTL size following some increases over the last few weeks







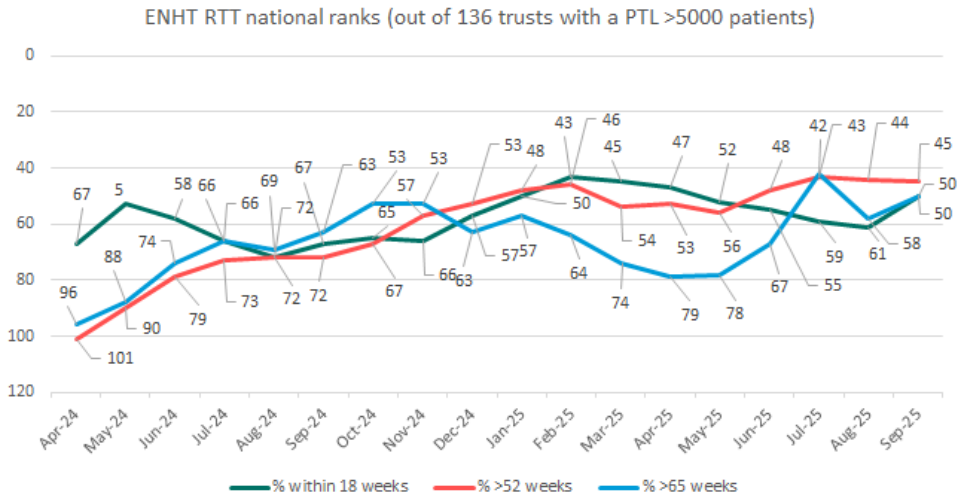


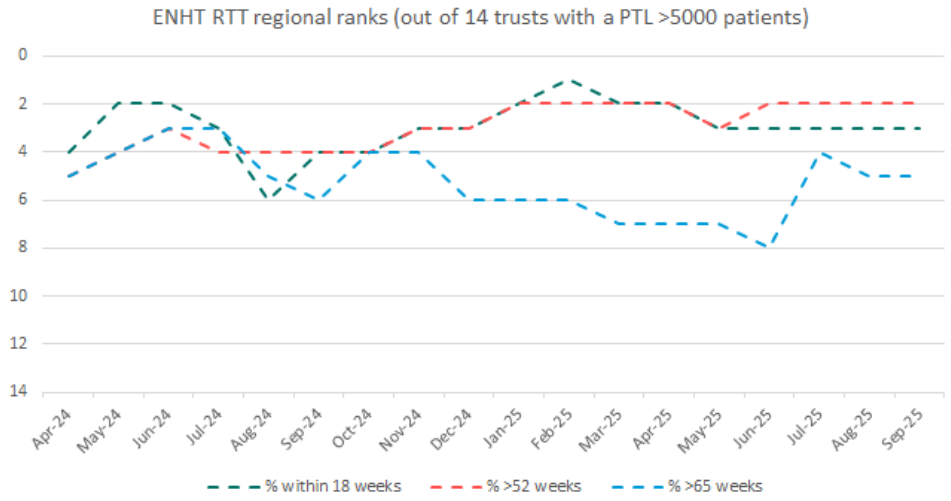
East and North Herts Health and Care Partnership

Provider

RTT performance benchmarking

- Using the latest published data from Sep-25, ENHT ranks in the 2nd quartile nationally for all of the three main RTT performance metrics
- The Trust's relative ranking for %<18 weeks has improved in September as the validation focus has reverted back to focusing on the longest waiters
- Regionally, the Trust is in the top / 2nd quartile for all of the three main RTT performance metrics



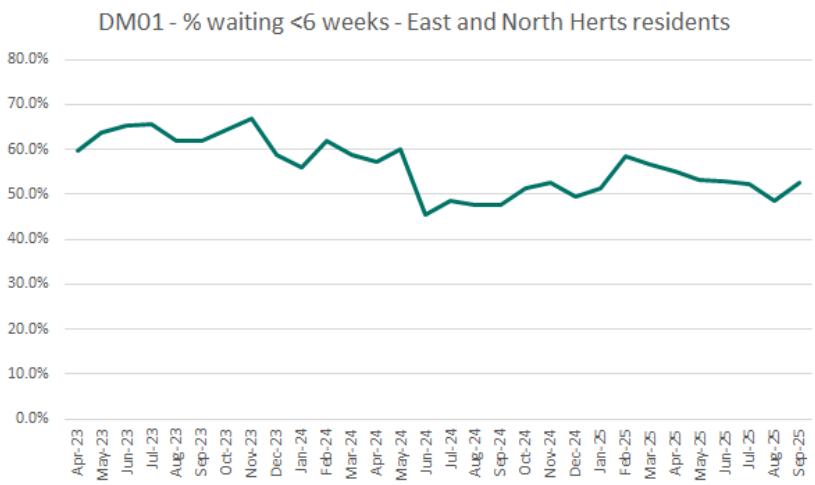


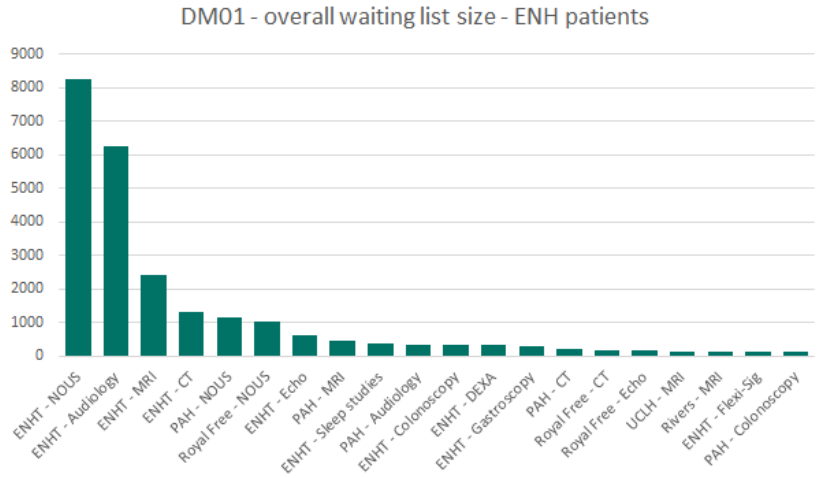
East and North Herts Health and Care Partnership

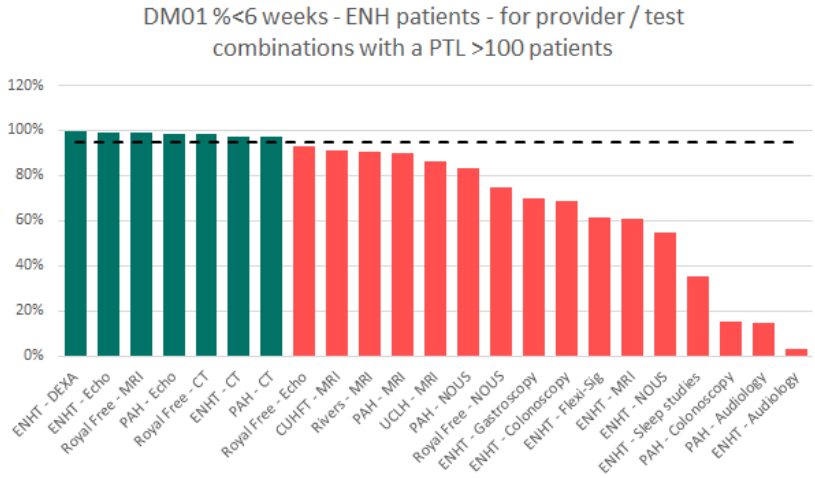
Place

Acute planned care – diagnostics waits ENH Place

- Following discussion at the last HCP board, this analysis is now focused on East and North Herts residents rather than just ENHT as a provider
- Of the 26,800 East and North Herts residents who are currently waiting for a diagnostic, 76% are on an ENHT waiting list, 9.5% are on a PAH waiting list and 6.5% are on a Royal Free waiting list
- Since Apr-23 there has been a gradual deterioration in the % of patients waiting <6 weeks for a diagnostic. This has predominantly been driven by ENHT Audiology, ENHT MRI and ENHT NOUS. However, there have been improvements in the MRI and Ultrasound position over the last two months
- There are also other pockets of long waiters for ENH patients (see chart below right), including PAH Audiology (adult mainly) and PAH Colonoscopy





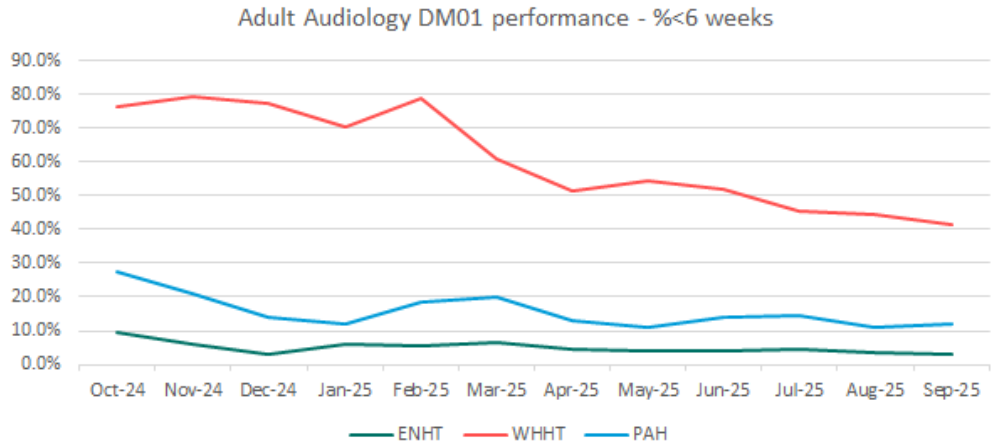


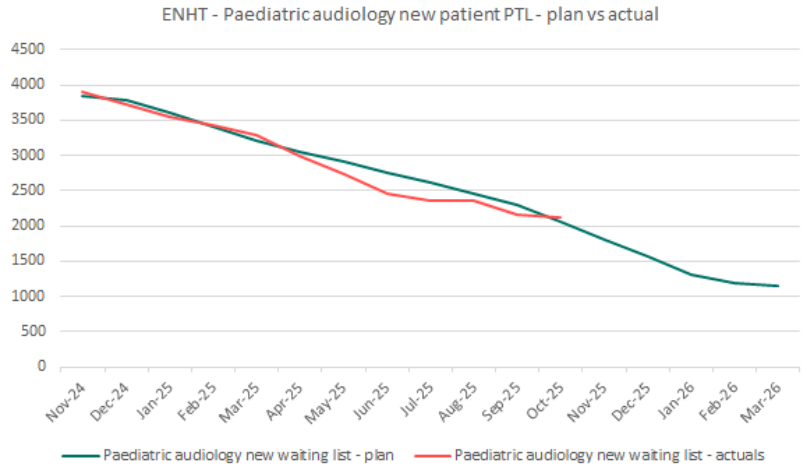
East and North Herts Health and Care Partnership

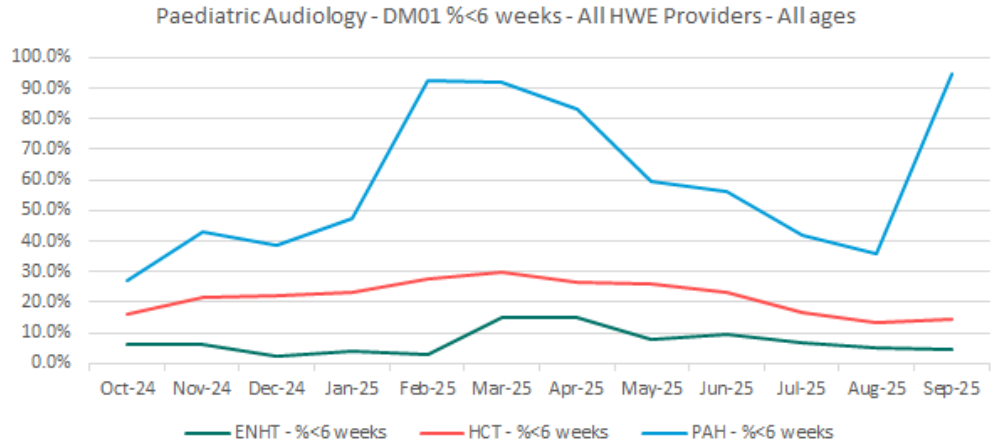
Provider

Audiology waiting times

- Overall ENHT paediatric audiology new patient waiting list continuing to reduce. Most of this reduction has been >5 year old pathways
- ENHT is currently meeting plan for paediatric audiology patients waiting for a new appointment (see chart below). However, number of patients waiting for a follow-up appointment is increasing.
- Despite reduction in the ENHT paediatric audiology new patient PTL, the % of patients waiting <6 weeks has not improved (see chart below opposite). However, there has been a significant improvement in PAH paediatric audiology waits in Sep-25
- The *adult* audiology waiting times continue to be challenged across all three HWE providers
- ENHT paediatric workforce update: 2 year Fixed Term Band 7 appointed and starting 1-Dec. One returning from mat leave in Feb-26
- ENHT adult workforce update: 4x B6,1x B6 mat leave, 1x B7, 1x B8a have all recently started or are due to start soon







East and North Herts Health and Care Partnership

Provider

Acute planned care – cancer ENHT

- In Sep-25, ENHT met its target for the 31-day treatment standard but did not meet its target for the 28-day faster diagnosis standard or the 62-day treatment standard
- The Trust remains one of the leading performers for cancer performance nationally. In Sep-25, ENHT was ranked 11th out of 118 nationally for the 62-day treatment standard and 53rd out of 118 nationally for the 28 day faster diagnosis standard
- The faster diagnosis standard plan for Sep-25 was 77.0% for ENHT. This target was met for three out of nine tumour sites – see chart opposite.
- Urology remains the most challenged high-volume pathway and performance remains significantly below target despite a number of pathway changes over the past few years. There has been a notable increase in referrals for urology compared to other tumour sites: c.7% year-on-year increase in referrals
- ENHT has been putting in place additional capacity in Urology. Including:
  - 01/07/25 – two additional MRI vans per week
  - 05/07/25 – increased TP biopsies from 5 to 6 patients per list + started nurse-led TP biopsy capacity
  - 05/07/25 – increased flexi-cystoscopy capacity from 10 to 11 per list
  - 06/08/25 – outsourcing 140 MRI scans per week to Pinehill
  - 13/10/25 – Imaging team are prioritising prostate patients and dating within 10 days
  - Nov-25 – four new scopes arriving
- Haematology – to introduce bloods clinic at Lister McMillan Cancer Centre to start in October
- Gynae – additional hysteroscopy lists in place for 2ww patients

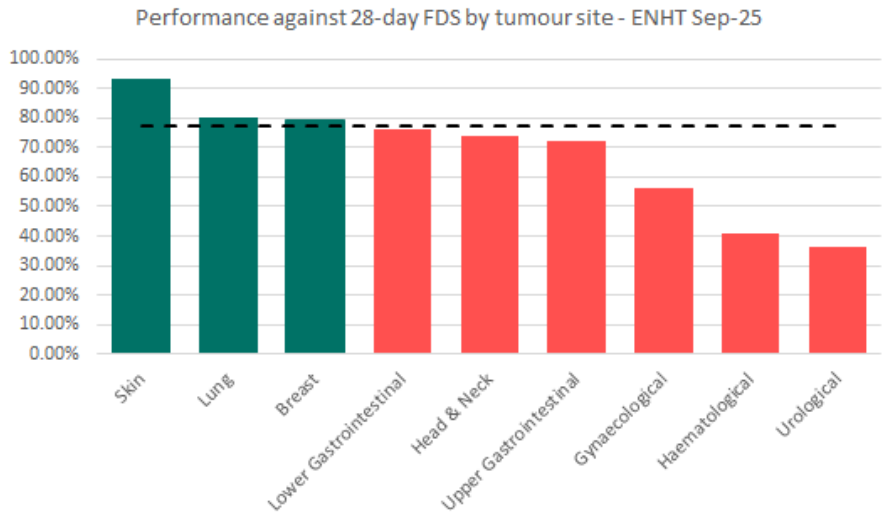


Table below shows performance vs ENHT plans from the national planning submissions

Standard	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
28 General FDS Referral	76.80%	77.10%	76.60%	72.20%	79.20%	77.70%	77.80%	76.60%	80.17%	79.75%	78.90%	76.30%
31 Day General Treatment Standard	96.10%	96.10%	97.00%	96.50%	97.00%	96.00%	96.00%	94.90%	96.38%	96.54%	96.50%	96.47%
62 Day General Treatment Standard	86.90%	85.60%	87.00%	85.90%	79.60%	85.10%	88.90%	86.90%	81.86%	82.94%	85.36%	83.30%

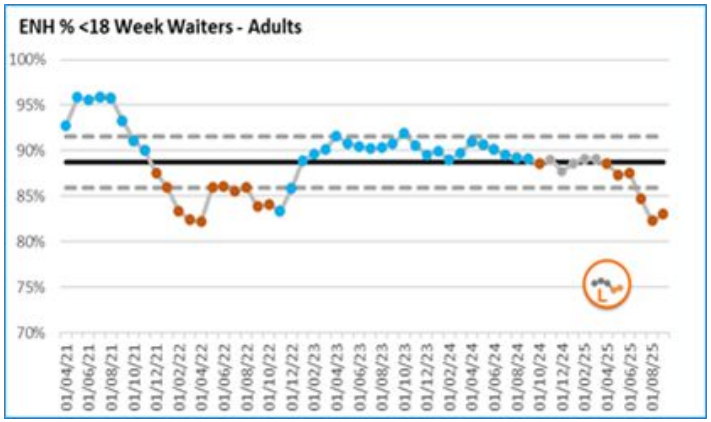
Targets – ENHT plan

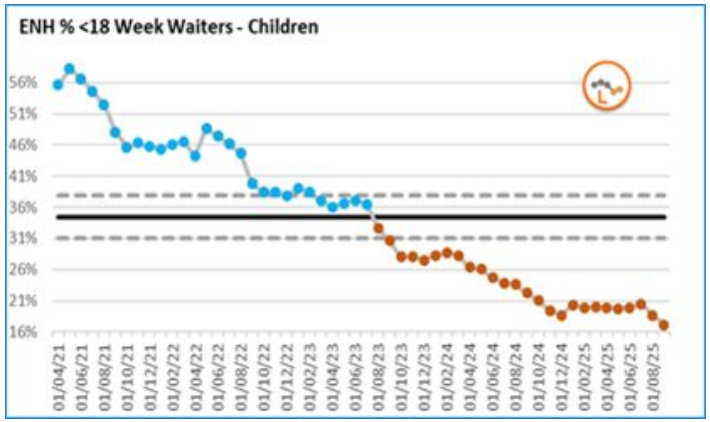
Sep-25
77.0%
96.0%
84.1%

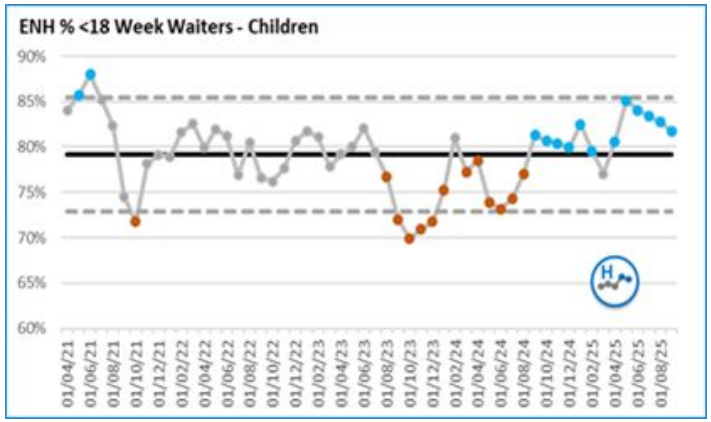
East and North Herts Health and Care Partnership

Place

ENH Place community waits





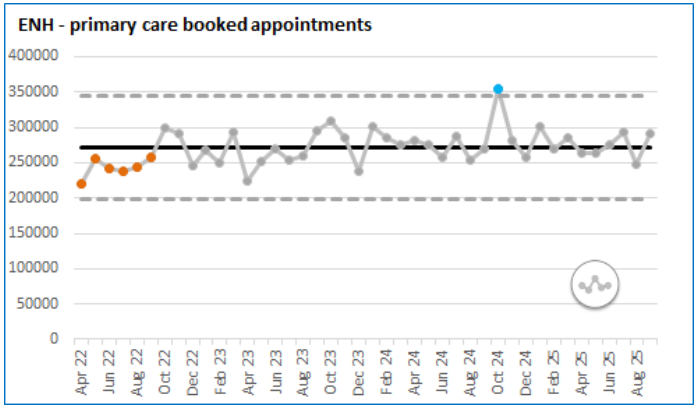


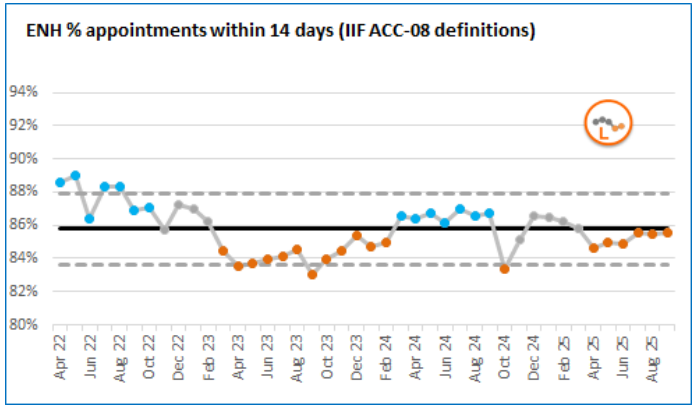
- Community waiting times for adults in East and North Hertfordshire have deteriorated in the most recent two months. The services which appear to be driving this trend at HCT are:
  - MSK Triage
  - MSK Physio
  - Occupational Therapy
  - Skin Health
- In particular, the MSK triage service has seen the number of patients waiting over 18 weeks go from 657 in June to 1052 in October. There has been a general sustained increase in the number of referrals to this service over the past two years. Referrals have grown by 14% over the last two years but capacity has remained largely stable.
- The Community Paediatrics service at ENHT continues to be the biggest driver of long paediatrics waits.
- If community paediatrics at ENHT is excluded from the data, the overall waiting times for children have been improving over the last two years (see chart above right). Waits for paediatric OT and CYP continence service at HCT have been improving
- Hertfordshire wide single point of referral logging for all ASD and ADHD referrals is progressing with providers working together to plan implementation in autumn 2025 (an additional £200k per annum has been approved for this service). The MHLDA HCP and providers continue to scope implementation of new pathway across Hertfordshire for community paediatrics

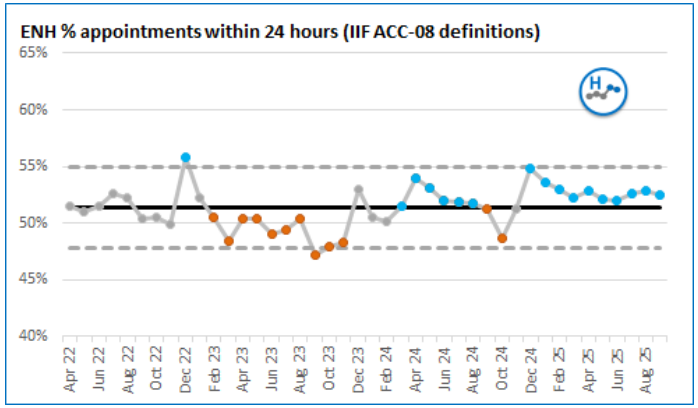
East and North Herts Health and Care Partnership

Place

Primary care







- The % of attendances within 14 days and % attendances within 24 hours should exclude certain categories of appointment based on national definitions aimed at excluding appointments that would not be expected to be seen within 2 weeks (e.g flu vaccine bookings)
- The number of GP appointments booked in East and North Hertfordshire was gradually increasing between 2022 and 2024. However, over the last 12 months there hasn't been any growth in appointments booked.
- For the % of appointments seen within 14 days, there have been six consecutive points below the mean which is why the chart is now showing special cause variation which will be worth monitoring in the coming months
- The % of appointments seen on the same day has been above the long-term average for the last ten months and was 52% in Sep-25
- The latest data in the above charts is from September and is therefore prior to the online all-day access initiative
- The data above is based on appointments which took place and therefore would exclude, for example, patients who called their practice and were told there were no appointments available and to try again the following day

East and North Herts Health and Care Partnership

Social care performance

East and North Herts Health and Care Partnership

Performance Highlights

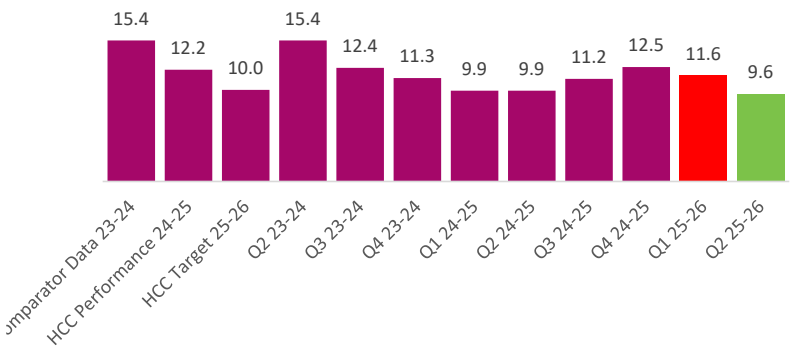
"We will reduce the number of people aged 18-64 whose needs are met by admission to residential or nursing care" (Rate per 100k)

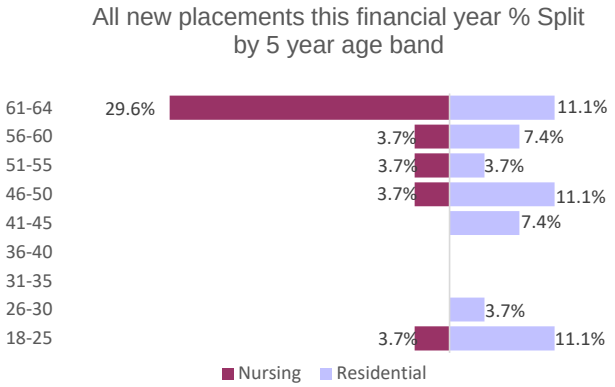
9.6

Data ⬇

Performance ⬆

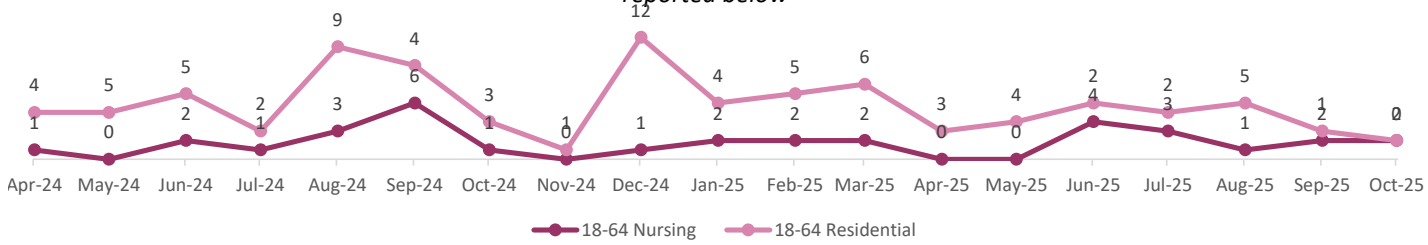
Hertfordshire are currently set to achieve an admission rate of 9.6 per 100,000 population for 25-26. Of our comparative local authorities in 2022-23, Cambridgeshire reported the lowest admission rate at **6.3 (per 100k)** with Nottinghamshire highest at **21.2** Hertfordshire sat **52nd (out of 152)** nationally in 2023-24 **Good to be low**





Monthly Placement Trends

(Actual placements between Apr 2024 end of Oct 2025) ***Please note*** *that the last three months are likely to settle higher than reported below*



Indicator Overview:

Admissions rate is 9.6 per 100,000 population, below the 10 per 100,000 target.

What's Gone Well:

- Reduction in placements and provider failures indicates improved market stability.
- Supported living and Shared Lives placements are prioritised over residential care.
- Strategic planning with Special Educational Needs and commissioning teams supports early intervention.

What's Been a Challenge:

- Limited provision for younger adults with physical disabilities restricts options.
- Accessibility constraints in housing stock affect placement suitability.
- Complex needs such as acquired brain injury and early-onset dementia require specialist solutions.

Actions to Improve Performance:

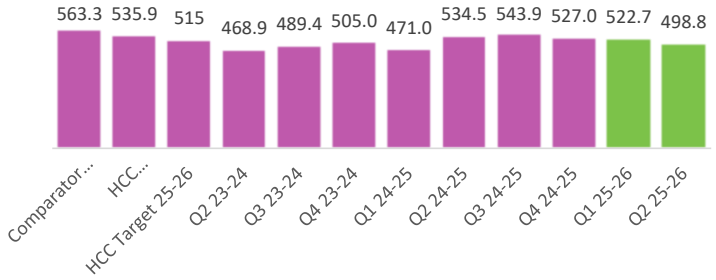
- Reopening the Supported Living framework to attract providers with relevant expertise.
- Development of supported accommodation specifications to meet accessibility needs.
- Expansion of overnight Short Breaks services to delay or prevent residential admissions.
- Continued collaboration with housing providers and commissioning teams.

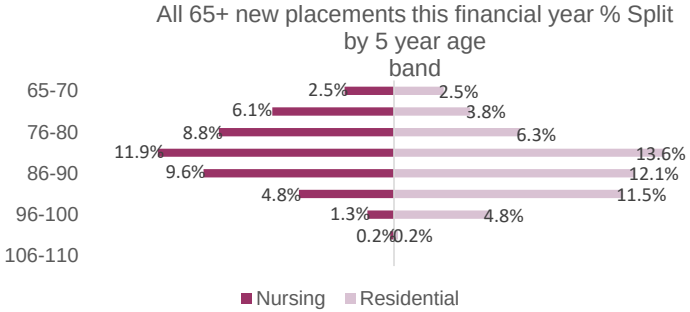
Performance Highlights

"We will reduce the number of people aged 65+ whose needs are met by admission to residential or nursing care" (Rate per 100k)

Data **498.8** ⬇ Performance ⬆

Hertfordshire are currently set to achieve an admission rate of 502.5 per 100,000 population for 25-26.
Of our comparative local authorities in 2023-24, Essex reported the lowest admission rate at **334.7 (per 100k)** with Warwickshire highest at **838.1.** Hertfordshire sat 59th (out of 152) nationally in 2023-24. **Good to be low**

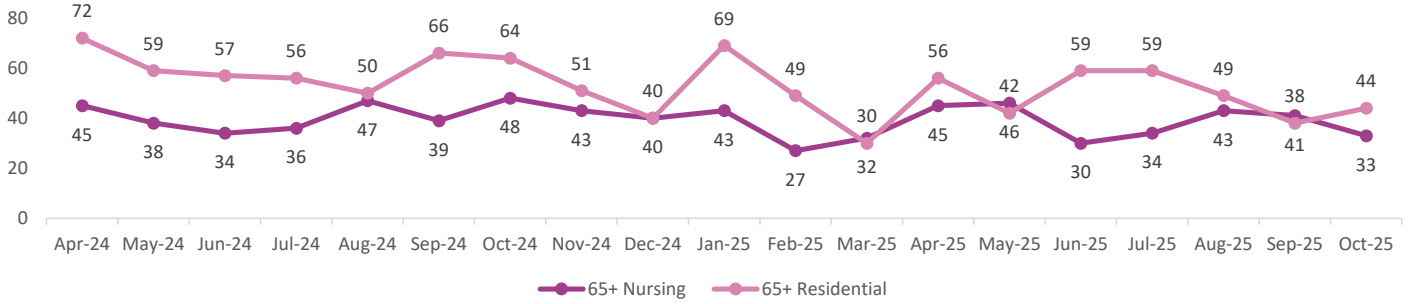




Monthly Placement Trends

(Actual placements between April 2024-end of Oct 25)

***Please note** that the last three months are likely to settle higher than reported below*



Indicator Overview:

Admissions rate is 498.8 per 100,000 population, slightly below the 515 per 100,000 target.

What's Gone Well:

- Decrease in placements reflects improved care planning and use of community-based alternatives.
- Better use of Quantum Care beds and flexicare services supports independence.
- Strong application of Continuing Health Care funding and home-first principles.

What's Been a Challenge:

- Admissions of self-funders and out-of-county placements complicate oversight and planning.
- Rising costs and increasing complexity of cases require close budget management.
- Limited wrap-around services for individuals with dementia and mental health needs.

Actions to Improve Performance:

- Clear guidance and oversight tools to support consistent decision-making.
- Partnership working with Finance and Integrated Discharge Teams to manage backdated funding.
- Use of the Prevention of Admission Service and rapid response models to support community care.
- Negotiation with providers to manage fee rates and ensure value for money.

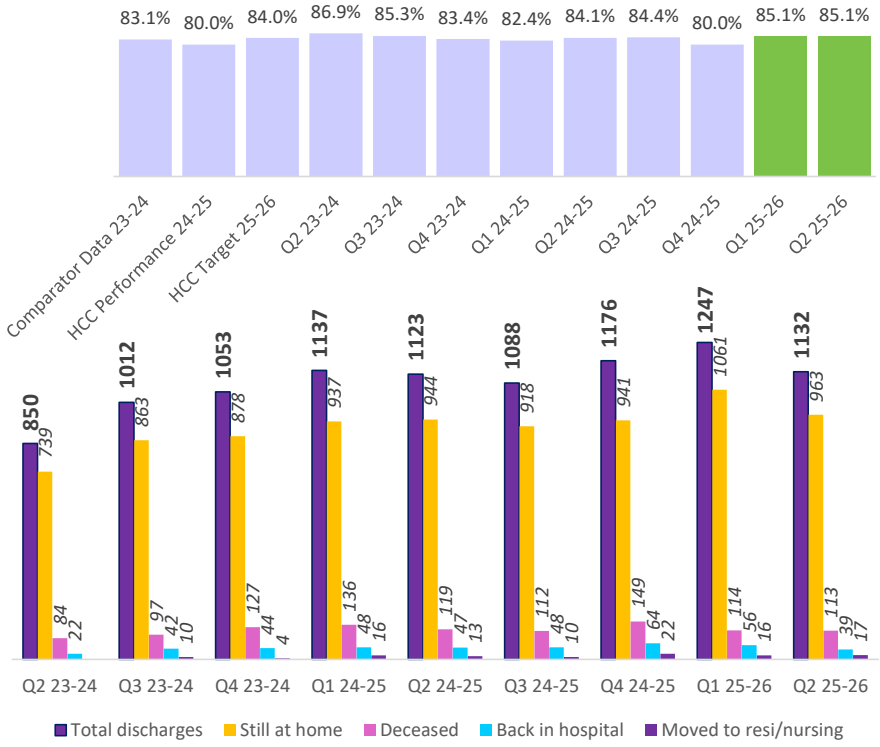
Performance Highlights

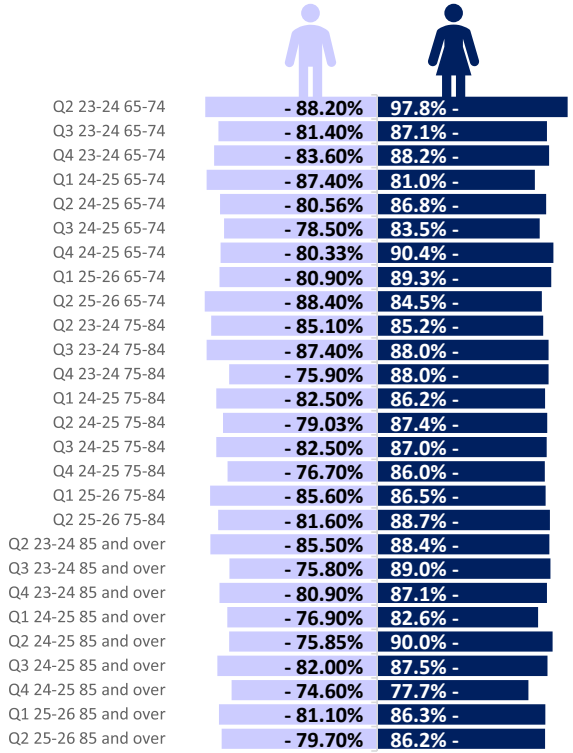
"We will increase the proportion of older people still at home 91 days after leaving hospital with enabling style care"

85.1%

Data ↑ Performance ↑

Performance has increased from the 80.0% reported in quarter 4 of 24-25 to 85.1% in Q2 25-26. Of our comparative local authorities in 2023-24, Warwickshire reported the best performance with **93.8%**. West Sussex reported the lowest at **67.6%**. Hertfordshire sat **84th** nationally in 2023-24.





Indicator Overview:

Performance is 85.1%, exceeding the 84% target.

What's Gone Well:

- Expanded enabling pathways and strong discharge processes ensure timely transitions.
- Reablement and mainstream home care services have sufficient capacity, with minimal delays.
- High utilisation of reablement services reflects effective recovery and independence support.

What's Been a Challenge:

- Limited access to comprehensive community health services affects continuity of care.

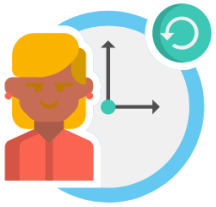
Actions to Improve Performance:

- Holistic discharge planning to address broader health and social care needs.
- Enhanced post-discharge support to reduce re-admissions and promote sustained independence.
- Connect and Prevent project improving referrals, provider collaboration, and outcome tracking.

Performance Highlights

"Adults & Carers waiting for 'First' needs assessment"

Adults



Total waiting **633**

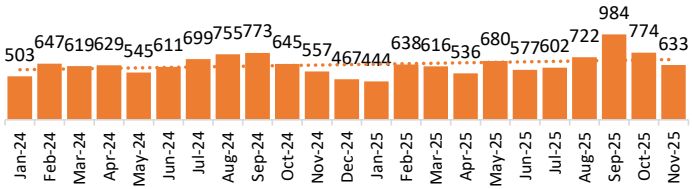
Median Wait **14 Days**

Carers

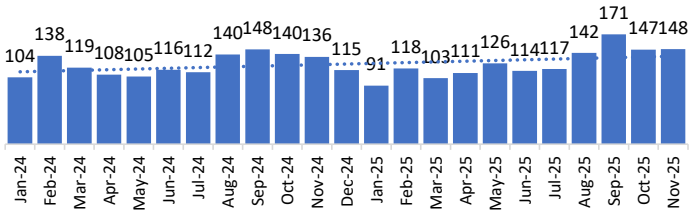
Total waiting **148**

Median Wait **22 Days**

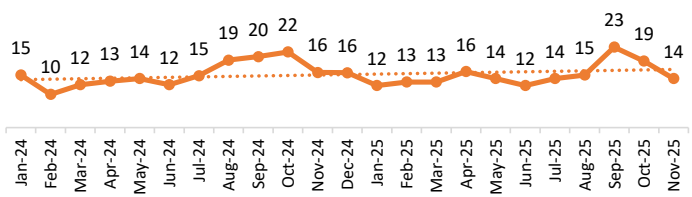
Adutls waiting for first Care Act Needs Assessment (Monthly Average)



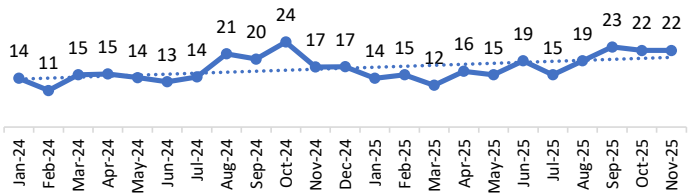
Carers waiting for first Care Act Needs Assessment (Monthly Average)



Adutls MEDIAN waiting for first Care Act Needs Assessment (Monthly Average)



Carers MEDIAN waiting for first Care Act Needs Assessment (Monthly Average)



Indicator Overview:

Wait times remain low and consistent despite increased demand.

What's Gone Well:

- Weekly oversight and triage training have improved responsiveness.
- Recruitment and retention strategies have stabilised workforce capacity.
- Enhanced triaging and performance reporting support timely allocation.

What's Been a Challenge:

- Rising referrals, safeguarding alerts, and complex cases increase pressure on assessment capacity.
- Administrative burdens from dual systems and new frameworks add complexity.
- Staff morale affected by reorganisation and high volumes of crisis-driven reviews.

Actions to Improve Performance:

- Embedding triage practices and training across all teams.
- Reviewing and improving the duty system to support timely responses.
- Utilisation of the Prevention of Admission Service to manage waiting lists and support early intervention.
- Development of guidance and training to ensure consistent allocation and risk management.

Board committee report

NHS
East and North Hertfordshire Teaching NHS Trust

Meeting	Public Trust Board		**Agenda Item**	19
Report title	ENH Health Care Partnership Committee report to Board		**Meeting Date**	14 January 2026
Chair	Adam Sewell-Jones, Chief Executive			
Author	Governance Business Administrator			
Quorate	**Yes**	☒	**No**	☐

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

- **Hospital at Home**
  Hospital at Home continue to experience sustained operational pressure. Activity remains high and capacity constrained.
- **Finance**
  System-level financial pressures persist, and ISFE transition issues are currently limiting the ability to produce Place level financial reporting.
- **Workforce and capacity pressures across system partners**
  Capacity constraints across neighbourhoods, primary care and community services may affect delivery timelines for transformation and Year 1 plans. These pressures are being compounded by wider organisational changes within the ICB and the associated role uncertainties.
- **UCCH**
  The UCCH remains lightly staffed with variable demand and funding limited to 31 March. A detailed paper has been requested to assess its capacity, activity levels and longer-term sustainability.

Assurances provided to the Board:

- **VCFSE/Hospice Sector**
  Immediate hospice funding risks have been stabilised, with contractual arrangements in place to support safe continuity of care.
- **Performance improvement in urgent and emergency care**
  UEC performance shows improvement, giving assurance that winter resilience measures are having a positive impact.
- **Diagnostics and cancer performance**
  Diagnostics reporting is more comprehensive, and cancer performance remains comparatively strong.
- **Primary care digital compliance**
  Primary care leaders confirmed that only one practice remains non-compliant with online consultation requirements, with full compliance expected by 31 December, strengthening access and visibility of demand.
- **Enhanced Commissioning Framework**
  The ECF continues to show strong outcomes across long-term condition management, including improved diagnosis, frailty care, prevention (NDPP referrals), and end of life planning.
- **Transformation reporting**
  Work is progressing to embed meaningful outcome measures (respiratory, diabetes, heart failure), giving the Board clearer oversight of transformation impact.
- **Planning process**
  Planning work across partners is aligned and progressing despite wider system uncertainty.

• **SEND** SEND services show recognised progress, supported by the wider rollout of the Healthcare Passport. • **ENH HCP governance and membership transition** Governance development is progressing, with strong support for the preferred future model and further work underway on representation.
Advise (Matters the Board should be aware of not covered above eg on-going monitoring, new developments etc):
• **Neighbourhood health** Continued monitoring will be required as system pressures increase through winter, particularly across urgent care, community services, and neighbourhood delivery teams. • **Transformation overview** Development of outcome-focused transformation reporting will continue, enabling clearer visibility of impact across programmes in the coming months.
Decisions made by the committee or major actions commissioned and work under way:
• **Place-level risk log to be developed** Risk leads will convene in the new year to establish a shared place-level risk log, responding to concerns about system risks and governance. • **Neighbourhood health programme – PID development under way** Project Initiation Documents (PIDs) are being developed, aligned with transformation priorities, and mapped over a five-year delivery trajectory.
Any actions recommended to improve effectiveness of the meeting:
• **Prioritise headline items for discussion** Detailed papers to be taken as read where appropriate, to ensure sufficient time for strategic issues. • **Maintain focused updates from workstreams** Decision relevant changes to be highlighted, rather than operational detail, to support more strategic debate.
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

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NHS
East and North Hertfordshire Teaching
NHS Trust

Meeting	Public Trust Board			**Agenda Item**	20
Report title	Audit and Risk Committee report to the Board (Charity Annual Report and Accounts)			**Meeting Date**	14 January 2026
Chair	Karen McConnell, Committee Chair				
Author	Deputy Trust Secretary				
Quorate	**Yes**	☒	**No**		☐

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

CHARITY ACCOUNTS

- The external audit of the accounts had been concluded.

Material Adjustment

- £192k legacy income reallocated to 2024/25 after reassessment.
- Risk identified: Potential year-end issues if significant legacies are not addressed early.

Internal Control Gaps

- Overhead/staff cost recharge policy last updated in 2019; requires regular review cycle.
- Banking transaction discrepancy (£525) noted; reconciliation routines need strengthening.

Regulatory Change

- Charity SORP (FRS 102) changes effective 1 January 2026; impact expected mainly on disclosures.

Cyber Risk

- Auditors reminded Trust of responsibilities to avoid cyber-crime; training in place but vigilance required.

Gift/Donation Acceptance Policy

- No formal policy currently; Financial Controller tasked to develop and report back.

Assurances provided to the Board:

Charity annual accounts approved as delegated by the Board at the November 2025 meeting.

- Unqualified Audit Opinion Expected: No going concern issues or materiality concerns identified.
- Key Risks tested and concluded satisfactorily.
- Legacy tracker to be implemented, to ensure evidence for significant legacies is available before the next audit.

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

1. Ensure early engagement with auditors for significant legacies in 2025/26.
2. Prepare for Charity SORP changes by reviewing disclosure requirements.
3. Support implementation of regular review cycles for overhead/staff cost recharges.
4. Maintain cybersecurity vigilance and training.

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

- The Committee **Approved** the Charity Annual Report and Accounts 2024/25.
- The Committee **Agreed**:
  - Escalation of any material changes in staff cost recharges to FPPC.
  - Walkthrough of draft charity accounts 25/26 for ARC and CTC members before committee presentation.
  - Letter of Representation to reflect committee approvals of adjusted/unadjusted items.

Any actions recommended to improve effectiveness of the meeting:

1. Implement regular review cycle for overhead/staff cost recharges.
2. Enhance month-end and year-end reconciliation routines to prevent timing discrepancies.
3. Develop gift/donation acceptance policy and report back to ARC.
4. Schedule a walkthrough session for draft charity accounts for ARC and CTC members.
5. MKS to liaise with management on ARC and CTC dates around year-end for audit planning alignment.

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

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Board committee report

NHS East and North Hertfordshire Teaching NHS Trust

Meeting	Public Trust Board	**Agenda Item**	21
Report title	Charity Trustee Committee	**Meeting Date**	14 January 2026
Chair	Nina Janda, Committee Chair		
Author	Committee Secretary		
Quorate	**Yes** ☒	**No** ☐	

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

Sunshine terrace is still in the planning stages. Kevin to submit revised plan for approval and hoping to start building around June.

Assurances provided to the Board:

- External auditors confirmed an unqualified audit opinion with no significant issues. Key areas reviewed included income recognition, management override of controls, grant commitments, investments, and fund classifications.
- Successful fundraising event, the Hertfordshire Residential Development Awards, which raised an impressive £89,000.
- Potential £798,000 legacy for cancer research and a further estimated £350,000 gift, which will significantly impact future income.

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

The committee approved the following proposals:

- Gastroenterology symposium support, subject to clear charitable benefit and financial transparency.
- Relocation of procedure rooms at Mount Vernon Cancer Centre.
- Continuation of complementary therapy supplies at Linda Jackson Centre.
- Garden restoration project at Mount Vernon, with assurances on sustainability.
- Reinvigorating the Art Life project in-house, with Beth managing delivery.
- Christmas presents and activities funded from dedicated donations.

As discussed at previous Board seminars, the charity team put together a successful Christmas event for staff on 22 December.

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

- N/A

Any actions recommended to improve effectiveness of the meeting:

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

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Board committee report

NHS East and North Hertfordshire Teaching NHS Trust

Meeting	Public Trust Board			**Agenda Item**	22
Report title	Digital Committee Report to the Board for 8 December 2025			**Meeting Date**	14 January 2026
Chair	Richard Oosterom, Committee Chair				
Author	Governance Business Administrator				
Quorate	**Yes**	☒	**No**		☐

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

- **Significant Ongoing Risk in OneEPR Programme (Strategic Risk Score Remains 16):**
  - Digital transformation risk remains high (score 16) due to continuing delays in the OneEPR programme.
  - Full programme assurance is not possible until testing of SU4 is complete.
- **Loss of Programme Manager:**
  - The departure of the OneEPR Programme Manager represents a major risk to delivery.
  - Recruitment is ongoing but not yet resolved.
  - Committee stressed the urgency and high-risk impact of this leadership gap on a complex programme.
- **Supplier Risk – Dedalus Performance and Contractual Concerns:**
  - Despite positive engagement from Dedalus UK leadership, confidence remains low because assurances are not yet backed by deliverables.
  - This indicates a high impact supplier related risk affecting strategic programme delivery.

Assurances provided to the Board:

- **No Blocker Level Defects Identified in SU4 Release:**
  - Early testing of SU4 by Dedalus identified some defects, but none were considered blockers, offering assurance that progress could continue once validation is complete.
- **Improved Dedalus Engagement and Strengthened Supplier Relationship:**
  - Dedalus UK leadership restructuring has led to improved engagement and renewed commitment, with the new Managing Director personally overseeing delivery. This offered assurance that supplier responsiveness and accountability have increased.
- **Legal Assurance on the Dedalus Contract:** External advice about the contractual situation has been sought and received and confirms our strong position.
- **Outpatient Transformation:** The Committee received multiple positive updates providing operational assurance:
  - **Successful Transitions to the New Target Operating Model:** Women & Children and Cancer Services transitioned successfully. Planned Care was on track for go live the week of 15 December.
  - **Patient Hub Rollout Exceeded National Target:** Patient Hub deployment reached the NHS England 70% target ahead of schedule. This is a strong indicator of digital adoption.

- **Major Improvements in Telephony Service:** A large reduction in missed calls was reported, showing measurable service improvement.
- **Digitisation Programme on Track:** Trust-wide patient records digitisation remains on schedule for June 2026, with a contingency month included. Early adopter areas (paediatrics, women's services) reported successful uptake.

- **Programme Controls and Governance Actions Are Underway:** The Committee directed that the Board Assurance Framework (BAF) be updated to strengthen controls relating to OneEPR, including clearer articulation of supplier dependency and change readiness issues. This demonstrates assurance that risks are being actively managed and escalated appropriately.

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

- **Outpatient Transformation:**
  - Unplanned Care transitions have been rescheduled (Care Group 2 is scheduled for later in Q4 with a more integrated redesign, Care Group 3 to progress in February 2026).
- **Upcoming Detailed Paper for 2026/27 Planning:**
  - A detailed paper covering scope, dependencies, workforce implications**,** digital enablers, and benefits will be brought to a future Committee meeting. This will align with CIP planning cycle.

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

- **Terms of Reference:** The Committee agreed changes to the Terms of Reference, including:
  - Information Governance to move to the Audit Committee.
  - Cyber security to remain a strategic responsibility of the Digital Committee (with compliance functions aligned with Audit).
  - Communications and Engagement to gain permanent representation on the Committee.
  - Membership refined to reduce unnecessary duplication.

Any actions recommended to improve effectiveness of the meeting:

The Committee agreed that the updated Terms of Reference will be brought back and formally approved at the next Digital Committee meeting, to strengthen clarity of roles, streamline membership, and improve overall Committee effectiveness

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

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Board

East and North Hertfordshire Teaching NHS Trust

Meeting	Public Board		**Agenda Item**	22.1	
Report title	Digital Committee Terms of Reference approval		**Meeting Date**	14 January 2026	
Author	Head of Corporate Governance				
Responsible Director	Chief Information 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:

N/A

Summary of key issues:

The enclosed revised committee terms of reference for the OneEPR Committee to become the Digital Committee are enclosed for approval, having been reviewed and endorsed by the committee on 8 December.

Key proposed changes

- Digital Committee to supersede the existing OneEPR task and finish Committee, to become a permanent committee.
- The purpose and scope sections amended for the committee to have expanded responsibility for providing oversight across all major digital initiatives. The committee's remit will still encompass the OneEPR project as well as the outpatient transformation programme.
- Amending the duties section to reflect the broadened scope.
- Meeting monthly.
- The Corporate Governance team will take over meeting administration given it is becoming a permanent committee of the Board.
- The Director of Communications and Engagement added as an attendee.

Point of note – Information Governance

- The Chair of the Audit Committee joined the Digital Committee review of the terms of reference changes for a discussion on the most appropriate committee for oversight of Information Governance. It was agreed the Audit and Risk Committee remained the appropriate committee for Information Governance compliance oversight.

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	☐

Digital projects represent essential pillars within the Trust's improvement journey. These initiatives demand significant financial investment, and the dedicated commitment of resources. As such, its success is crucial to the progress of the Trust.

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 10: Digital Transformation.

Report previously considered at & date(s):	
8 December 2025 OneEPR Committee.	
Recommendation	The Board is asked to **APPROVE** the terms of reference for the Digital Committee.

To be trusted to provide consistently outstanding care and exemplary service

Board Annual Cycle 2026-27

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	Jan 2026	Feb 2026	Mar 2026	April 2026	May 2026	June 2026	July 2026	Aug 2026	Sept 2026	Oct 2026	Nov 2026	Dec 2026	Jan 2027
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		
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
Digital Committee ToR	X												X
Strategic reports													
Planning guidance	X												X
Winter Planning (annual)									X				

Board Annual Cycle 2026-27

Items	Jan 2026	Feb 2026	Mar 2026	April 2026	May 2026	June 2026	July 2026	Aug 2026	Sept 2026	Oct 2026	Nov 2026	Dec 2026	Jan 2027
Digital update					X								
Trust Strategy refresh and annual objectives			X										
Antimicrobial resistance			X										
Strategy delivery report	X				X								X
Strategic transformation & digital update					X						X		
Integrated Business Plan											X		
Annual budget/financial plan													
System Working & Provider Collaboration (ICS and HCP) Updates	X		X		X		X		X		X		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				
NHS England capability self-assessment					X								
Enabling Strategies													
Estates and Facilities Strategy	X										X		X
People Strategy	X												X
Green Strategy							X						
Quality& Clinical Strategy			X										
Equality, Diversity and Inclusion Strategy			X										
Digital Strategy					X								

Board Annual Cycle 2026-27

Items	Jan 2026	Feb 2026	Mar 2026	April 2026	May 2026	June 2026	July 2026	Aug 2026	Sept 2026	Oct 2026	Nov 2026	Dec 2026	Jan 2027
Engagement Strategy									X				
Other Items													
Audit Committee													
Review of Trust Standing Orders and Standing Financial Instructions (if required)													
Charity Trustee Committee													
Charity Annual Accounts and Report											X		
Charity Trust TOR and Annual Committee Review	X												X
Finance, Performance and Planning Committee													
FPPC TOR and Annual Report	X												X
Quality and Safety Committee													
Maternity Incentive Scheme for sign-off	x												
Complaints, PALS and Patient Experience Annual Report	X										X		X
Safeguarding and L.D. Annual Report (Adult and Children)											X		
Staff Survey Results					X								
Learning from Deaths	X				X		X				X		X
Nursing Establishment Review											X		
Patient Safety and Incident Report (Part 2)					X						X		
Teaching Status Report													

Board Annual Cycle 2026-27

Items	Jan 2026	Feb 2026	Mar 2026	April 2026	May 2026	June 2026	July 2026	Aug 2026	Sept 2026	Oct 2026	Nov 2026	Dec 2026	Jan 2027
QSC TOR and Annual Review (if required)													
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**						