Public Trust Board

Online

NHS East and North Hertfordshire Teaching NHS Trust

11/03/2026 09:30 - 12:00

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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).

Minutes of the Trust Board meeting held at Mount Vernon Cancer Centre, Rickmansworth Road, Northwood HA6 2RN on Wednesday, 14 January 2026 at 9.30am

Present:

Ms Anita Day (AAD)	Trust Chair
Dr David Buckle (DB)	Non-Executive Director
Ms Janet Scotcher (JS)	Non-Executive Director
Ms Gillian Hooper (GH)	Non-Executive Director
Mr Tichafara Phiri (TP)	NeXT Non-Executive Director
Ms Diana Skeete (DS)	Non-Executive Director
Mr Richard Oosterom (RO)	Associate Non-Executive Director
Ms Nina Janda (NJ)	Associate Non-Executive Director
Mr 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:

Ms Amanda Rowley (AR)	Director of Midwifery (26/010)
Ms Aolat Adisa (AA)	SACT Matron Mount Vernon Cancer Centre (26/013)
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 first meeting of the new year. She noted that introductions would be made as individuals first spoke and 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.

The Chair remarked that it was a busy agenda and that there was a slight change in the order. It was noted that the patient story would be taken later on the agenda when the patient arrived.

26/001 DECLARATIONS OF INTEREST

There were no new interests declared.

26/002 APOLOGIES FOR ABSENCE

Apologies for absence were received from Mrs Karen McConnell (KMc), Deputy Trust Chair and Non-Executive Director, Professor Zoe Aslanpour (ZA), Non-Executive Director and Ms Ivana Chalmers, Chief Executive, Healthwatch Hertfordshire.

26/003 MINUTES OF THE PREVIOUS MEETING

The Chair noted one minor correction from DB

"25/128 - DB commented … but acknowledged the human impact which could have drawbacks for individual members of staff".

No further amendments were raised.

Subject to the correction above, the minutes of the previous meeting held on 19 November 2025 was **APPROVED** as an accurate record of the meeting.

26/004 ACTION LOG

The Head of Corporate Governance provided an update on outstanding actions. It was noted that all actions were down as green. Some were ongoing but could come off the log.

The Board were advised that the Digital Committee Terms of Reference were due in January 2026 but had to go back to the Committee and would be presented to the board at a future meeting.

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

26/005 QUESTIONS FROM THE PUBLIC

There were no public questions.

26/006 CHAIR'S REPORT

The Chair, AAD provided a verbal update she commented on the recently announced imminent public consultation on proposed relocation of Mount Vernon Cancer Centre services. She commented that consultation would start week commencing 19 January and would run until the end of March.

She emphasised on continuity, safety and quality of care during the transition period and encouraged staff and patient engagement.

DB commented that it was good to see a clear way forward after years of uncertainty.

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

26/007 CHIEF EXECUTIVE'S REPORT

The Chief Executive summarised key updates:

- Improving doctors' working lives: He commented that baseline assessment improved from 62% to 87% compliance and that there was strong engagement with the resident doctors' forum.
- HSJ awards: The board was advised that the Trust had been shortlisted for "Trust of the Year" but that West Hertfordshire Teaching Hospitals NHS Trust had won. This Trust congratulated West Herts for winning.
- Performance rankings: It was noted that the Trust remained the highest performing acute trust in the region but nationally we moved from 19th position to 21st.

- Planning: The first financial and operating draft plan for 2026/27 was submitted before Christmas and the final submission was due in February.

Following the presentation, the Chair asked about areas where rankings appeared to drop in relation to the improving doctors' lives programme. The Chief People Officer, PSM clarified that the changed rankings were due to stricter assessments and not a deterioration in performance.

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

26/008 ESTATES AND FACILITIES STRATEGY

The Director of Estates and Facilities, KH presented this item and highlighted that the strategy was a live and evolving document that aligned with the NHS estate long term plan.

Following the presentation, the Chief Nurse, TM asked about dementia-friendly wards, KH confirmed that inclusion was an integral in all new designs with emphasis on dementia-friendly designs in new projects and routine maintenance.

DS asked about inclusion as a 'whole' and asked about the key learnings and how they were being incorporated into the strategy. KH responded that they were including learnings.

The Chief Finance Officer, MA commented that the new clinical spaces would provide opportunities for financial efficiency through space consolidation and agile working. KH confirmed that this was the case and that there would also be energy saving opportunities.

RO asked about the status of the energy saving scheme. KH explained that CHP was at the end-of-life stage and that procurement was underway.

The Chief Kaizen Officer, KoH commented that the ENH Production System (ENHPS) improvement method would be utilised to include other teams alongside the estates and facilities team to ensure involvement early on.

Following the discussion, the Board **NOTED** the Estates and Facilities Strategy.

26/009 LEARNING FROM DEATHS

The Medical Director, JD presented the learning from deaths summary. The board was advised that mortality rates remained stable and lower than expected. However, there had been a recent slight increase in extended perinatal mortality. It was noted that this was being reviewed but that no clear trend was currently apparent. Monitoring would continue.

There were concerns regarding delays to TAVI CT which had been flagged as a risk but work was underway to resolve it.

Chair of Quality and Safety Committee (QSC), DB commented that this was discussed at QSC and they had deemed the assurance level as substantial as it was a reassuring patient safety report.

NJ commented on the perinatal mortality and the reviews that took place- she commended maternity team's rapid response and quality of report.

It was noted that the proposed assurance level was 'reasonable assurance' and a discussion took place. Following the discussion, the board agreed to raise the assurance rating from 'Reasonable' to 'Substantial'.

The Board **AGREED** to a **SUBSTANTIAL** assurance rating on the learning from death report.

26/010 MATERNITY INCENTIVE SCHEME (MIS)

The Director of Midwifery, AR presented this item. She advised the board that the Trust was fully compliant with all MIS Year 7 10 Safety Standards requirements. There was also a robust governance and evidence log in place. The board was informed that the full report with evidence had been reviewed at QSC and following the review, QSC had recommended a substantial assurance rating.

The Chief Nurse commented that it was an excellent in-depth paper and asked for AR's view on safety action 4 'clinical workforce planning'. AR responded that they were fully compliant and continued to make progress against the action plan.

TP asked about the actions the team were currently taking and which ones they would say was the least robust, and if there were contingencies in place. In response, AR commented that the least robust area was Safety Action 2 (Data Quality). She further observed that although EPR went live 18 months ago and progress had been made, there are still concerns about data quality in some parts of the system. AR further stated that they were working with the Trust's Digital Team and K2 to strengthen workflows and improve data robustness, but this remained an ongoing risk.

Another area was Safety Action 8 (Training compliance) which had achieved compliance this year, but that it still required sustained oversight to maintain performance. However, overall, Safety Action 2 presented the greatest challenge due to the complexity of the EPR implementation and the reliance on both internal and external partners to resolve issues.

NJ, commented that over the past year, the team had worked exceptionally hard, with strong leadership and consistent collaboration across services. She continued that after 12 months of using the K2 EPR system, there should be a much clearer understanding of our data-quality challenges, and the improvements needed. AR responded that we were already addressing data quality through:

- continued staff training,
- routine data-quality checks,
- and close work with K2 and the digital team

to make the system easier and more intuitive for staff.

It was suggested that as the Trust became increasingly digital, maternity was positioned to lead by example in demonstrating effective digital adoption.

DB remarked that incentive schemes were there for a reason, so it was great to see the achievement and congratulated the team.

The Chair commented that the board had been asked to do two things:

- agree and approve the assurance level as substantial and
- authorise the Chief Executive to sign the declaration.

It was noted that once this was done the declaration would be submitted to the ICB by the March deadline.

The Board **AGREED** that the Chief Executive to sign the Trust Board declaration form prior to submission to NHS Resolution by 3 March 2026 and **AGREED** to a **SUBSTANTIAL** assurance rating.

26/011 COMPLAINTS, PALS AND PATIENT EXPERIENCE ANNUAL REPORT

The Chief Nurse, TM presented this item and thanked all the volunteers, admiral nurses and carers for their work.

Key points were highlighted:

- the Trust has seen an 18% rise in the number of complaints in 2024-2025
- Friends and Family Test (FFT) responses were largely positive
- there was the plan to launch the Patient Experience Phone Line in April 2026 for real-time resolution
- PALS response times were too long as it was currently 40+ days but that improvements were being planned.

The Chair, AAD asked whether the rise in complaints reflected a national trend. TM confirmed that nationally complaints were also increasing, but organisations offering 7-day patient-contact services were seeing reductions because issues were resolved earlier.

RO asked what was driving the 18% increase. TM stated the main cause was poor communication.

TP asked where compliments were usually submitted. TM explained that most people submit compliments through PALS or the Complaints Team. The Chief Executive added that there was a formal national route for complaints but not for compliments, and in the current climate people were eager to share positive experiences.

DS asked about team capacity. TM confirmed a senior nurse was always allocated to PALS.

DB warned that delays in replying to complaints could generate more complaints. AAD noted that many complaint themes relate to communication and asked how staff could be supported to improve this. TM said customer care training had begun and that it focused on communication skills and accurate documentation.

The Chief Executive highlighted that the data covered 2024/25, and improvements were now being seen since introducing the EPR, which was reducing administrative waste and improving response times. The Chief Executive also reminded the board of the national requirement to reduce admin staffing levels.
The Chief Information Officer, MS confirmed the patient portal went live last year.

JS asked about triangulation. TM confirmed triangulation was undertaken and that specialties were also making the most of digital opportunities.

A discussion ensued on assurance levels.

RO noted that quarterly reports normally include a proposed assurance rating when presented at QSC.
GH commented that the annual report had not been taken to the committee.
The Chief Executive stated that the report provided sufficient assurance.

The Chair, AAD emphasised the need to shift from monitoring to delivering assurance, with a focus on communication and response times.

The Board agreed on assigning a reasonable assurance level.

Action: The QSC Chair requested that the annual report be submitted to QSC.

The Board **AGREED** to a **REASONABLE** assurance rating.

26/012 SAFEGUARDING AND L.D. ANNUAL REPORT (ADULT AND CHILDREN)

The Chief Nurse, TM presented this item. She commented that the report aligned with the Trust's statutory obligations and showed incremental increases in safeguarding activities across children and adults, including complex cases.

She further highlighted domestic violence cases and the support for staff and patients. Lastly, she commended Hampshire Local Authority for partnership support.

GH praised the clarity and professionalism of the report and asked about local standards for Level 4 and 5 safeguarding training. TM explained the different levels: Level 1–2 for all staff; Level 3 for senior clinicians; Level 4–5 for specialised roles (for example child protection leads, FGM specialists). She commented that work was ongoing to improve compliance with Level 3 safeguarding training.

The Medical Director, JD added that there was a very professional team and robust processes, especially in children's ED. JS commented that she had visited the safeguarding team as part of her 'walkaround' and found this to be the case.

TM commented that level 4 and level 5 were externally commissioned.

NJ commended the multi-disciplinary team which allowed for good integration.

TP asked about training compliance and JD commented that there were logistical challenges. JD further suggested hybrid solutions and inclusion of physical health needs for people with learning disabilities.

The Chair, AAD remarked that we need to understand the perspective of people with learning disabilities which would ensure inclusion.

RO asked about the increase in deprivation of liberty safeguards (DoLS) applications which rose to 878. JD responded that it was a national trend.

Following the discussion, the Board **AGREED** to a **SUBSTANTIAL** assurance rating.

26/013 PATIENT STORY

The SACT Matron at Mount Vernon Cancer Centre (MVCC), AA, introduced Mr and Mrs D to the Board.

Mr D, who has a history of prostate cancer, had undergone several lines of systemic anti-cancer therapy (SACT). He expressed his appreciation for the professionalism, expertise and compassion consistently demonstrated by the SACT team. He highlighted in particular the responsive and attentive care he received when a small subcutaneous lump was noted at the cannula site following a saline flush at the end of one of his treatment sessions.

The Medical Director, JD, outlined the clinical reasons why it had been necessary to address the subcutaneous lump promptly.

The Chief Executive informed the Board that consultation regarding the relocation of MVCC services to Watford would shortly commence, and asked what services could continue to be delivered locally.

EM further enquired whether follow-up appointments could also be provided closer to where patients reside.

The Chief Nurse commented that, in cases similar to Mr D's, MVCC patients should not be required to attend A&E, as an appropriate triage pathway ought to be in place to ensure rapid assessment and fast-tracking of such concerns.

The Chair and Chief Executive thanked Mr and Mrs D for attending and for their generous reflections.

Mr and Mrs D in turn expressed their gratitude to the MVCC staff for their professionalism and care.

The Board **NOTED** the patient story including positive engagement and likely future challenges.

26/014 BOARD ASSURANCE FRAMEWORK

The Head of Corporate Governance presented this item and highlighted two alerts:

- Future of cancer services at Mount Vernon Cancer Centre consultation risk.
- FPPC recommendation to increase system instability risk score from 16 to 20.

The Medical Director, JD spotlighted BAF risk 2 – health inequalities. JD spoke about the health equity work and that there were five programs underway. He commented that it was early days but that there was strong enthusiasm.

The Chief Finance Officer, MA spotlighted BAF risk 3 - system and internal financial constraints. He gave an update and commented that break-even was likely but that it was reliant on non-recurrent actions. He also commented that the cost improvement programme (CIP) delivery was behind the planned schedule and finally that the refreshed BAF reflected both gaps and the mitigations.

During discussion, the Board agreed that the assurance level should remain at reasonable for the governance processes.

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

26/015 INTEGRATED PERFORMANCE REPORT (IPR)

The Medical Director, JD presented this item. He summarised the four quadrants and noted that:

- **Quality:** there was high incident reporting with low harm. He also commented on the stroke rating which had improved slightly, and that major obstetric haemorrhage was under review.

- **Operations:** He remarked that the 4-hour ED performance was on trajectory and that cancer targets were met and that following the Siemens national recall of 3T MRI which affected QE2 and Lister that capacity had been restored.

- **Finance:** He observed that the year-to-date deficit was as expected. He commented that as explained by the CFO that CIP achievement was low and that whilst the Trust continued to increase its cohort of permanent staffing it was not reducing premium bank and agency staffing utilisation at a proportionate rate.

- **People:** It was noted that there was a slight increase in turnover and that the flu vaccine uptake was at 45%. Regarding the vacancy rate, it was below target at 5.8%, however, agency usage down but bank was slightly up at 6.7% which was above the target of 5%.

Following the introduction, a discussion ensued, and members asked questions.

GH queried the Patient Treatment List (PTL) growth and if the trend was anticipated to continue and also queried MRI staffing. LD commented that the growth would continue but not at the current rate. LD clarified the reasons for the PTL delays and the outsourcing arrangements. JD also responded that we were working with other trusts who were part of the MRI availability programme.

JS raised questions on bank/agency spend and maternity cover. The Chief People Officer, PSM explained the resource panel scrutiny and recruitment progress and that results would soon be seen.

The Chair, AAD asked if the resource panel identified where there were likely to be higher costs.

Some board members commented that they were not comfortable with the results and were therefore not assured by it.

A discussion ensued. RO commented that the Executives should look into having a suggested assurance rating per quadrant on the IPR summary page as a single assurance rating did not apply. Following further discussion, it was agreed that the Executives should deliberate on this.

Action: Executives to review quadrant-level assurance ratings.

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

26/016 QUALITY AND SAFETY COMMITTEE (QSC) REPORT TO THE BOARD

The QSC Chair, DB highlighted the matters of concern to the board.

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

26/017 FINANCE PERFORMANCE AND PLANNING COMMITTEE (FPPC) REPORT TO THE BOARD

The FPPC Chair, RO confirmed that at the committee meeting, Risk 7 (financial constraints) was increased to a score of 20, reflecting current financial pressures and uncertainty in system, region and national about future arrangements.

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

26/018 ENH PLACE PERFORMANCE REPORT

The Chief Executive introduced the report and commented that it was developmental. It was noted that it included local authority data.

JS commented that it lacked children's social care metrics.

It was also noted that the number of appointments in primary care remained static over the last 12months.

The Chair, AAD commented that she welcomed the progress but flagged the need for broader scope and clarity on accountability.

The Board **NOTED** the ENH Place performance report.

26/019 HEALTH CARE PARTNERSHIP (HCP) REPORT TO THE BOARD

The Chief Executive presented this report and noted capacity pressures in hospital at home and urgent care hubs. It was noted that demand exceeded supply.

The Board discussed need for influencing ICB priorities for community investment.

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

26/020 AUDIT AND RISK COMMITTEE (ARC) REPORT TO THE BOARD

In the absence of the ARC Chair, KMc, GH highlighted to the board the revised internal audit plan and progress on the charity accounts approval.

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

26/021 CHARITY TRUSTEE COMMITTEE (CTC) REPORT TO THE BOARD

The CTC Chair, NJ presented the committee report and commented that the sunshine terrace project was progressing. It was noted that successful fundraising events occurred over the Christmas period.

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

26/022 DIGITAL COMMITTEE

The Digital Committee Chair, RO presented the report to the Board. He commented that outpatient digitisation was progressing well.

He remarked that there was concern over the OneEPR implementation delays and that software delivery was now expected in February.

The Digital committee report to the Board was **NOTED**.

26/022a – Digital Committee terms of reference (ToR)

Regarding the ToR approval, RO confirmed that it would be discussed at the next Committee meeting and brought back to the March Board for sign-off.

26/023 ANNUAL CYCLE

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

26/024 **ANY OTHER BUSINESS**

There was no other business.

26/025 **DATE OF NEXT MEETING**

The date of the next meeting is 11 March 2026 to be held online.

Ms Anita Day
Trust Chair
January 2026

(red)	Action has slipped
(amber)	Action is not yet complete but on track
(green)	Action completed
*	Moved with agreement

Agenda item: 5

EAST AND NORTH HERTFORDSHIRE TEACHING NHS TRUST
TRUST BOARD ACTIONS LOG TO JANUARY 2026

Meeting Date	Minute ref	Issue	Action	Update	Responsibility	Target Date
14 January 2026	26/011	Complaints, PALS and patient experience annual report	The QSC Chair requested that the annual report be submitted to QSC as they had mainly seen the quarterly reports to date.	The annual report was presented at the QSC September 2025 meeting. This was confirmed at the January QSC meeting and will be presented in line with the annual cycle.	Chief Nurse	March 2026 Closed
14 January 2026	26/015	Integrated performance report (IPR)	Executives should look into having a suggested assurance rating per quadrant on the IPR summary page.	Following Executives discussion, it was suggested that each quadrant is a mix of measures it would therefore not be robust. Also, each measure in the statistical process control (SPC) chart has a confidence rating as well as hitting target or not. Hence, each quadrant having an assurance rating is not viable.	All Executives	March 2026 Closed
14 January 2026	26/022a	Digital Committee terms of reference (ToR)	To be brought back to the March board meeting for approval	On the agenda	Chief Information Officer	Completed

Chief Executive's Report

March 2026

Chief Executive Update

As the Trust plans for the challenges and opportunities of 2026/27 a new trust wide transformation programme, Better Care, Better Value is being finalised. This programme has been designed to remove the barriers that make work harder than it needs to be, strengthen the foundations of how we run services, and ensure we can meet rising demand, increasing financial pressures, and our ambition to be consistently outstanding.

Our transformation work will focus on the areas that matter most, such as further reducing waiting lists, improving and simplifying our corporate processes, meeting urgent and emergency care standards, and using our people, time and resources more effectively.

January's activity levels once again highlight both the scale of demand and the dedication of our teams. Over the month, we delivered 359 births, 59,074 outpatient appointments,1,545 planned operations,18,000 emergency attendances, 3,560 inpatient stays, and 486 emergency operations. These numbers reflect the extraordinary work taking place across our hospitals every day.

We continue to strengthen our partnerships within the community through our Neighbourhood Health approach, supporting integrated, local care that helps patients stay well at home and reduces pressure on hospital services, in line with the Government's 10 Year Plan. Working closely with primary care, through ENHGP, Hertfordshire Community NHS Trust (HCT) as well as other NHS, local government and third sector colleagues, activity has taken place to build a clearer vision of the potential of an increasingly strengthened neighbourhood care model. It was good to have the leadership of ENHGP recently attend a board seminar to share their vision and to meet with the board of HCT to discuss our shared agenda.

We were also pleased to welcome Professor Woodman, Chancellor of the University of Hertfordshire, who met staff and toured several of our research and teaching facilities. With the Hertfordshire Medical School opening this September, the visit was an important opportunity to build on our growing partnership with the University, supporting the next generation of clinicians and enhancing the Trust's reputation as a centre for learning, research and innovation.

MVCC Public Consultation

Plans to secure the long-term future of specialist cancer services for over two million people in the East of England have progressed, following agreement on capital funding for a new cancer centre. This has enabled a public consultation (led by NHS England) to run from 19 January to 29 March 2026 on proposals to move Mount Vernon Cancer Centre to a new facility next to the new Watford General Hospital. If approved, the new centre would create a centre of excellence that brings world class cancer services together with the necessary facilities of an acute hospital site. The proposals also include expanding chemotherapy, diagnostics and follow-up care in local hospitals and the option of an additional radiotherapy unit in either Luton or Stevenage to reduce travel times for patients living in the north of the area. This would be in addition to radiotherapy at the new main cancer centre.

Digital

The Trust is delivering outstanding progress in the transition from paper to digital patient letters. Currently, 95% of outpatient clinics have adopted the new digital system, enabling over 70% of

appointments to be managed directly through the NHS App (which is the target set by NHS England).

This strong performance demonstrates the Trust's leadership in digital transformation and is bringing clear benefits for patients, who can easily view, cancel, or rebook appointments on their mobile devices, supported by automated reminders that help reduce missed appointments.

Estates

Plans to redesign and relocate our paediatric services have received national funding support. I'm pleased to say we've now had further confirmation of investment in our estate and equipment – a total of over £27 million.

While final plans will be developed with NHS England, this funding will enable us to move ahead with several significant improvements: a new paediatric area, investment in the Lister Urgent Treatment Centre, the development of home dialysis for renal patients, refurbishment of Ward 11, backlog maintenance, and four new scanners – two MRI and two CT.

People

Our teams have achieved several notable successes this quarter. Firstly, our digital team has been shortlisted for two categories at the Health Service Journal Digital Awards: Digital Transformation Organisation of the Year and Digital Clinical Safety, reflecting the significant progress and innovation achieved across our digital programmes.

In addition, our Security team has won Carlisle Support Services' Q3 Award in recognition of their exceptional response to recent incidents and positive feedback from colleagues. Selected from over 6,000 employees, the team will now progress to the national finals at Carlisle's Innovation Lab, where they have the opportunity to be named overall winners and receive a £1,000 team award.

Four of our student nurses have been shortlisted in the Student Nursing Times Awards 2026, reflecting the strength of our training and development programmes. Congratulations to Kinga Gorko (Apprentice Nurse of the Year), Jasna Lemes Filipovic (Learner of the Year – Post Registration), Chloe Hadley (Student Nursing Associate of the Year), and Liz Ward (Student of the Year – Children). We look forward to supporting our finalists at the awards ceremony in London on Friday 24 April.

And finally, congratulations to urological surgeon, Mr Tim Lane, who has been appointed President of the Royal College of Surgeons of England (RCOS) and starts in July. Mr Lane is the first RCOS president in its history to be directly elected by surgical members and fellows.

Adam Sewell-Jones
Chief Executive

Board

Meeting	Public Trust Board			Agenda Item	9
Report title	Strategic Goals Cascade			**Meeting Date**	11 March 2026
Author	Chief Kaizen Officer				
Responsible Director	Chief Kaizen Officer				
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:

There are an increasing number of areas where strategic cascade is now well-embedded, with correlation strongly linked to the ENHPS for Leaders programme. The process is well understood, aligned, measurable, governed, monitored and delivering intended outcomes. This is particularly evident at divisional and care group level. The rating of "partial assurance" reflects the variation as cascade moves deeper down into the organisation at individual ward and department level and forms part of the ongoing organisational change journey.

Summary of key issues:

This paper provides a Board update regarding the status of the strategic goal cascade for 2026/27. This remains an iterative process and learning from last year evidenced significant improvements at divisional care group and corporate department level. The focus of activity for 2026/27 is to embed alignment amongst leaders and teams at speciality and ward-level. An accelerated roll-out of advanced daily management during quarter one will both improve strategic alignment at local level and provide a sustainable improvement infrastructure going forward that will also support next year's transformation programme.

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 cascade process involves all four strategic themes including quality, thriving people, seamless services and continuous improvement and therefore positively impacts across all listed areas.

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 Risk 11 VMI – getting what the Trust needs, BAF Risk 5 Culture, leadership and engagement and BAF Risk 12 Clinical engagement and change.

Report previously considered at & date(s):

Trust Management Group Seminar 5th March 2026

Recommendation	The Board/Committee is asked to approve this report.

To be trusted to provide consistently outstanding care and exemplary service

1.Introduction

This paper provides an update on the development and organisational cascade of the Trust's 2026/27 strategic goals, describing the rationale for refinement, the alignment approach adopted, and the mechanisms being established to support delivery.

Strategic goals define the few breakthrough priorities that shape culture, leadership behaviour, and long-term system design. They build capability and behaviours that in turn drive operational delivery. Strategic alignment is the systematic connection between the organisation's vision, strategy, goals, and daily work, so that everyone - from the Board to the frontline - understands:

- What the organisation is trying to achieve (strategic intent),
- How their work contributes to it (operational alignment), and
- How to continuously improve toward that goal (method alignment -ENHPS).

Key elements of this lean approach include –

- True North vision: A small set of long-term, breakthrough goals define the ideal future state.
- Environmental scan: A structured process considers internal and external factors that influence future direction.
- Catchball: Goals cascade through dialogue, not instruction - leaders and teams co-produce, so alignment is both top-down and bottom-up.
- Visual management: Alignment is made visible through ENHPS tools and concepts connecting daily improvement work to organisational priorities.
- Leader standard work: Leaders reinforce alignment through structured huddles and coaching.
- Focus on the vital few: Resources are directed only to initiatives that advance strategic goals, preventing diffusion and waste.

Figure 1: Strategic Alignment Process

2. Trust Vision

Every one of us - whether we work on a ward, in a clinic, in estates, finance, digital, pharmacy, portering, cleaning, reception or administration - comes to work because we want to make a difference to someone's life. Our Trust vision, "to be trusted to consistently provide outstanding care and exemplary service," is about one thing. When people come to us - patients, families, colleagues - they should feel safe, valued, listened to and supported, every single time. Trust isn't automatic. It's earned through the thousands of small actions we take every day:

- A clinician noticing a subtle change in a patient's condition.
- A receptionist greeting someone kindly when they're anxious.
- A porter reassuring a patient during transfer.
- A digital, finance or people team colleague fixing a problem that removes staff frustration.
- A scheduler arranging an appointment that fits a person's life.
- A facilities engineer preventing a breakdown before it disrupts care.

All these moments matter. They build trust. They create dignity. They shape experience. They show who we are. Outstanding care is not just about clinical excellence. Exemplary service is not just about customer service. It's about how we make people fee - safe, respected, cared for, and confident that they are in the right hands.

Our vision is an invitation. To take pride in our craft. To support one another. To improve what we can and escalate what we can't. To make today better than yesterday. To leave work knowing we made a real difference. When we each bring our skill, compassion and commitment, we create a space where patients can trust us – not sometimes, but consistently.

2. Strategic Goal Development

A structured series of catch-ball events engaging senior leaders to iteratively test, refine and align the proposed 2026/ 27 strategic goals were undertaken during quarter three as part of the business planning cycle. These workshops considered the environmental scans, emergent executive team priorities whilst also reflecting on the learning and progress made during 2025/ 26. Feedback was then used to inform themes for where the senior leadership group felt prioritisation needed to evolve for each goal in the years ahead.

There was one dominant message evident throughout all feedback, a request for simplicity in the context of a significantly challenging period for the NHS. To reflect this request, we purposefully reduced the number of strategic goals from eight, to the four most purposeful. These were then formally presented to the Trust Board in November as the last formal step in this year's sign-off process. Below is a summary of the rationale behind each new goal -

2.1 Quality

Leaders recognised ENHPS - our quality management method - as becoming "the way we do things here" but at times people didn't always feel they had the freedom to try new things through devolution and accountability. The reframing of this goal simplifies from the two previous ones that focused on zero harm and minimising waits, to acknowledge the emphasis on psychological safety and reducing blame. It promotes a learning culture enabling autonomy, daily improvement, prevention thinking, and leadership behaviours that make processes safer, more reliable, and continuously improved.

2.2 Thriving People

Leaders highlighted waste through either inefficient process, bureaucracy or the volume of meetings limiting time for reflection and action. The reframed goal acknowledges the significant people development undertaken, and shifts focus to enabling systems: simplification, clarity, digital support, local empowerment, inclusion, wellbeing, and creating time for meaningful work and daily kaizen. This intent directly links staff wellbeing to performance, attendance and improved patient outcomes.

2.3 Seamless Services

There was a strong recognition and desire to improve collaboration with external partners and improve services and outcomes for patients. Leaders wanted to act but recognised current fragmentation, silos, and hand-off delays internally and externally hindered speed of adoption for new ways of working. The refreshed goal signals strategic intent and moves from alignment to action: where leaders connect teams, pathways, and information, improve interoperability, reduce duplication, and enable coordinated flow and experience across organisational boundaries.

2.4 Continuous Improvement

The desire to maximise time for, and value of care delivery both for patients and staff was an overwhelming factor in feedback. Leaders linked digital enablement, data and innovation to safety, productivity, and sustainability. The emphasis was on real-time information, improvement-focused measurement, reducing manual burden, removing waste, and fostering curiosity, experimentation, learning, and value creation. Innovation needs to become what we do because organisational culture enables and expects it.

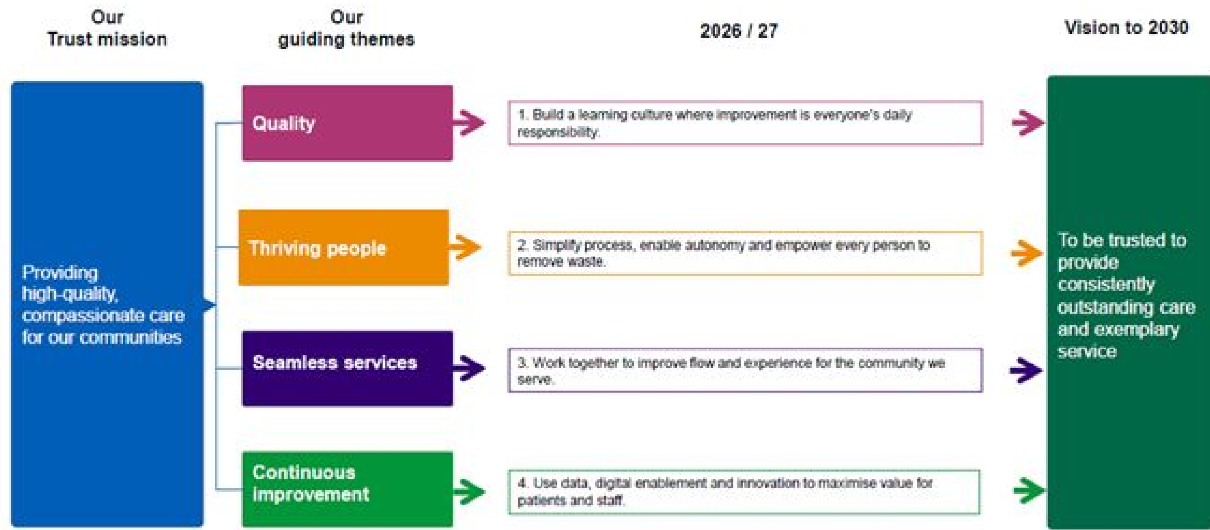


Figure 2: Strategic Goals

It is an important clarification that NHSE planning guidance targets define what must be delivered; strategic goals define how the organisation must operate. Sustainable performance emerges when management systems, behaviours, and environment are deliberately aligned to meet those demands. The Trust, alongside all NHS providers, face significant financial and performance challenges next year. These requirements can only be delivered through genuine transformation of services and ways of working. The goals define the change environment and behaviours that enable that to happen.

3. Strategic Cascade

The strategic cascade is the process for how strategic goals are meaningfully translated down into the organisation leading to agreed annual objectives that are clear, local, practical and relevant to the work teams do every day (Figure 3). The process takes the Trust’s long-term ambitions and makes them real for each ward, department, clinic and support service. The cascade helps every team understand what the goals mean to them, identifies where teams can make improvements and reflects how local ownership contribute to something much bigger. This approach intentionally balances organisational direction (“clarity of what must be achieved”) with local autonomy (“ownership of how this is achieved”).

Catchball is part of cascade, it’s the ongoing two-way feedback process where local leaders share the strategic goals with their teams to test ideas for local aligned objectives back and forth. It happens through simple team conversations, where leaders begin by sharing direction. As teams reflect and respond to what these goals mean, ideas are tested, refined and adjusted until agreement is reached.

It is a leader expectation that four aligned, specific, measurable, achievable, relevant, time-bound objectives are agreed for every department, team and speciality. This includes both the activity and Plan-Do-Study-Act cycles required to deliver the desired change, as well as the metrics that will demonstrate progress and success.

The final stage of strategic cascade follows through to our "Grow Together" annual appraisal process where team objectives are further broken down into individual aligned objectives and personal development plans. This ensures at individual level, there are both operational and strategic objectives agreed. Planned changes to ENH Academy functionality will make this a mandated process for 2026/ 27.

There are a range of supporting materials, resources and facilitation guides to support leaders in this work, all accessible via a dedicated intranet website page. A range of communication stories, case studies and bite-size videos have run through Trust news, leadership events and all-staff briefings across January and February.   These have included exemplar sites from ENHPS for Leaders, where teams have already successfully embedded strategic alignment into daily work demonstrating improvements across a range of meaningful metrics.

Oversight of local delivery will be devolved to clinical and corporate teams, though Positive Leadership Rounds provide senior leaders opportunity to create curiosity, role model strategic alignment and test adoption. Delivery of speciality and corporate department-level activity and metrics will be monitored and reported through the Trust Management Group – the Trust's formal executive governance meeting.

Figure 3: Strategic Cascade

4. Strategic Alignment and ENHPS

ENHPS is both a method for improvement and a management system for running the organisation and is based on the successful adoption of lean principles in healthcare by the Virginia Mason Institute. It is the way the organisation is managed, improvement is therefore not something teams "do in addition to work" – it is how work is designed, monitored and evolved.

Whilst strategic alignment sets direction, daily management tracks movement and provides a structured way for teams to see how work is going every day, spot problems early, and fix them quickly and safely. It is less about meetings and more about making work visible and management in real-time, preventing drift.

Daily management and strategic alignment are layers of the same management system operating at different time zones – with the first focusing on today/ this week, the latter next month/next year. The critical shift for 2026/27 will be to accelerate the adoption of both, moving from a pull change model, to setting explicit leader expectations. A mobilisation plan to support rapid roll-out over the next four

months has been agreed at the February meeting of the Trust Guiding Team – the executive management meeting that oversees ENHPS delivery.

This refinement is expected to deliver several benefits:

- Improved line of sight between strategic priorities and operational activity.
- Reduced fragmentation of improvement and transformation efforts.
- Stronger accountability and decision-making clarity.
- Enhanced organisational focus during a financially constrained period.

5. North Star Metrics

North star metrics express system-level outcomes for strategic goals and long-term direction; locally aligned metrics translate that intent into influenceable team objectives, guiding daily management, problem-solving, and improvement within each service and department. North star metrics need to be strategically critical to patients, staff and sustainability and reflect results over time. There are several NHS staff survey metrics that align closely to our strategic themes, that whilst not a linear relationship, if consistently tracked over time help measure progress (Figure 4).

Strategic Theme	NHS Staff Survey Metric	2021	2022	2023	2024
Quality	We are always learning (People element 5)	5.17	5.15	5.56	5.79
	Care of patients is my organisations priority (Q25a)	75.33%	71.87%	75.43%	77.04%
	My organisation encourages us to report errors (Q19b)	N/A	84.21%	84.6%	85.82%
	I feel safe to speak up about concerns (Q25e)	57.78%	57.36%	58.35%	60.10%
Thriving People	We are safe and healthy (Promise element 4)	5.86	5.77	5.98	6.09
	I am trusted to do my job (Q3B)	90.09%	89.77%	89.02%	89.61%
	I am able to access the right learning/dev (Q24e)	53.50%	54.33%	58.66%	61.00%
	Staff engagement (Theme)	6.83	6.71	6.80	6.90
Seamless Services	We are a team (People element 7)	6.63	6.55	6.65	6.77
	Teams work well together to achieve objectives (Q8a)	51.44%	50.61%	51.14%	54.45%
	I feel my role makes a difference to patients (Q6a)	87.06%	87.96%	86.20%	87.02%
	I would recommend my organisation (Q25c)	56.70%	52.60%	56.51%	61.31%
Continuous Improvement	We each have a voice that counts(Promise element 3)	6.61	6.51	6.57	6.66
	I feel supported to develop my potential (Q24d)	50.62%	52.35%	54.48%	56.50%
	Able to make improvement in my area of work (Q3f)	53.19%	54.10%	54.12%	54.93%
	There are opportunities to show initiative (Q3c)	72.03%	71.79%	72.97%	73.49%

Figure 4: North Star Metrics

6. Conclusion

The 2026/ 27 strategic goals represent an evolution rather than a redesign, focusing on simplification, alignment, and delivery discipline. An accelerated roll-out of daily management and strategic alignment changes how the organisation functions at every level. For patients, it means safer, more reliable care, fewer delays, and quicker responses when problems arise. For staff, it creates clarity, reduces firefighting, and builds confidence that issues are seen, discussed, and resolved rather than absorbed. For the organisation, it strengthens delivery and accountability, exposes risks early, aligns effort to priorities, and converts strategy from intention into daily action. Over time, performance becomes more predictable, improvement becomes routine, and culture shifts from reactive to proactive. In essence, it connects purpose, performance, and people — ensuring that what matters most is visible, manageable, and continuously improving every single day.

Board

Meeting	Public Trust Board		**Agenda Item**	10
Report title	Homebirth and Birth Outside of Clinical Guidance: Response to the Coroner's Prevention of Future Deaths Report		**Meeting Date**	11 March 2026
Author	Consultant Midwife Director of Midwifery and Lead Divisional Director			
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:

Appropriate systems, processes, and controls are established and operating effectively. Identified gaps are understood and are being actively addressed through defined workstreams with clear governance oversight.

Summary of key issues:

Purpose:
To provide assurance to the Trust Board and the Chief Midwife for England that robust governance, clinical pathways, and oversight arrangements are in place to support the safe provision of homebirth and birth outside of clinical guidance, in response to the Coroner's Prevention of Future Deaths (PFD) report (November 2025).

Context:
The Coroner's PFD report, following the deaths of Jennifer Cahill and her baby who were under the care of Manchester Foundation Trust, highlighted national and local risks associated with homebirth and out-of-guidance care, including variation in guidance, informed consent processes, workforce capability, equipment readiness, and inter-agency working. This assurance report reflects a comprehensive local review of homebirth and out-of-guidance provision against this national learning. Within maternity services, women have a legal right to make informed choices about their place of birth and to accept or decline elements of their maternity care. Midwives, in accordance with the NMC Code, have a professional and legal responsibility to provide care during labour. This can present operational and clinical challenges in the provision of homebirth services.

Key Highlights for the Trust Board's attention:

- Clear governance and divisional oversight arrangements are in place for homebirth and care outside of clinical guidance.
- 100% compliance has been achieved with planned homebirth risk assessments in 2025.
- A well-established Birth Options Clinic supports informed choice and personalised decision-making.
- Triangulation of incidents, complaints, and feedback has identified no recurring safety themes.
- Robust escalation processes, regional collaboration, and a trauma-informed approach are embedded.

- A Homebirth and Out-of-Guidance Task and Finish Group has been established (March 2026) to oversee delivery of improvement actions arising from the Coroner's report.

Key Risks and Challenges

- Increasing numbers of women declining elements of recommended care or requesting out-of-guidance births.
- Absence of national homebirth guidance contributing to variation in practice.
- Workforce sustainability and maintenance of skills within community settings.
- Cross-boundary and private care arrangements reducing system oversight.
- Limitations in digital interoperability affecting information sharing and documentation.

Improvement actions and workstreams
Six priority workstreams are underway:

1. Workforce models, training, supervision, and on-call provision
2. Equipment maintenance, audit, and assurance
3. Standardised homebirth pathways and SOPs
4. Out-of-guidance care, safeguarding, and MDT birth planning
5. Governance, audit cycle inclusion, and learning from incidents
6. Digital records optimisation and public-facing information on birth choices

Conclusion
The Trust has responded appropriately to the Coroner's Prevention of Future Deaths notice and the Chief Midwife for England's request for assurance. Governance arrangements are in place, there are robust risk assessment and informed choice processes, and no systemic safety concerns have been identified.

Full assurance is dependent on the successful delivery of the identified workstreams and continued national alignment on homebirth guidance.

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	☐

- Safe systems are in place, with recognised variability linked to workforce pressures and service complexity.
- Actions are underway to improve consistency, equity of information and personalised care planning.
- The Trust is responding appropriately to the Prevention of Future Deaths notice, with full assurance contingent on completion of improvement actions and national alignment.

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*
#3114 Risks associated with cross border care.
#1138 Risk of failure of delay / failure in recognising deteriorating women due to not being able to calculate / capture MEOWS on nerve centre).

Report previously considered at & date(s):
N/A

Recommendation	Trust Board are asked to note: • The current level of assurance regarding homebirth and out-of-guidance care.

	• The active management of identified risks through structured improvement programmes. • Ongoing oversight through the Homebirth and Out-of-Guidance Task & Finish Group.

To be trusted to provide consistently outstanding care and exemplary service

Assurance Report on the Safety and Governance of Homebirth and Birth Outside of Clinical Guidance - Service and care provision at ENHTT

Consultant Midwife
Director of Midwifery and Lead Divisional Director.

25.02.26

 # ProudToBeENHT

Context

- Coroner's report published November 2025 showing learning for NHS and requiring action to prevent future deaths.
- Regional level work survey looking at homebirth provision and staffing
- Chief Midwife request letter to trusts asking for assurance to trust board around homebirth and out of guidance care.
- Consider operational running of service (trained equipped staff senior MDT support)
  - ➢ Care planning and risk assessment-personalised care MDT review and communication.
  - ➢ Equipment, homebirth process, staffing, out of guidance counselling and birth planning etc
  - ➢ Governance and oversight- board oversight, audit program, homebirth guidance and SOPs

Classification: Official

NHS England

To: Trust Chief Nurses
Trust Directors of Midwifery

cc: ICB Chief Nurses
ICB Directors of Midwifery

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

26 November 2025

Dear colleagues,

Urgent review of homebirth services following Prevention of Future Deaths report

We are writing to bring to your immediate attention the Prevention of future deaths report issued by the Senior Coroner for Manchester North after the tragic deaths of Jennifer Cahill and her child Agnes Cahill following a homebirth. The report raises a number of concerns and we are asking you to urgently review the safety and quality of your homebirth services.

We would like you to consider the following issues which were highlighted in this case:

The operational running of your service: including how it ensures that prompt midwifery care is available 24 hours a day; that staff are properly equipped, trained, prepared and skilled for providing birth and neonatal care in a home setting; that staff have senior multi-disciplinary support available to them at all times and have sufficient rest periods; and that potential transfer and extraction processes are clear and planned for each birth.

Care planning and risk assessment: including systematic assessment of complexity and risk; how the multidisciplinary team (MDT) ensures a personalised approach to women in planning care in light of any identified issues (particularly when homebirth is not recommended); how the MDT continues to maintain good communication at all stages of care with women and between all teams including ambulance services; and how dynamic risk assessment is managed and responded to throughout pregnancy, birth and the postnatal period.

Publication reference: [illegible]

Case overview

Case overview and circumstances of death:

The conclusion of the Inquest was:

- That Jennifer Rose Cahill and her newborn daughter, Agnes Lily Wren Cahill died as a result of complications of childbirth, contributed to by neglect.

Key Circumstances:

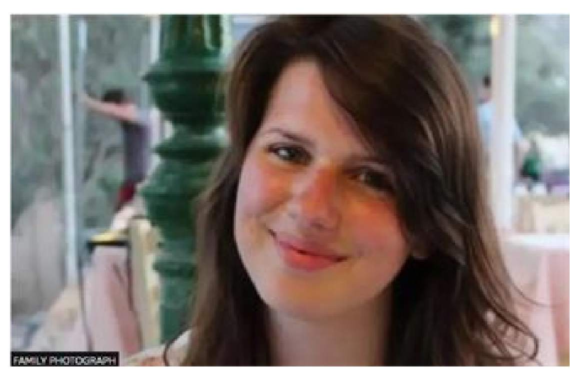
- Jennifer planned a home birth due to trauma from her first birth, which included a post-partum haemorrhage. Her pregnancy was low risk, but birth carried high PPH risk. She was not fully counselled on out-of-guidance birth risks or alternatives.
- Antenatal care gaps: missed obstetric review following risk factor for pre-eclampsia detected on PCR test. In addition, there was lack of continuity and consistency in midwifery contact.

Birth Events:

- Attending midwives unfamiliar with Jennifer; one was junior.
- Equipment failures: Entonox, IT, and resuscitation equipment.
- Labour complications: ineffective pain relief, high maternal blood pressure, inadequate fetal heart monitoring.
- Baby born at 06:44: delayed and initially ineffective resuscitation; transferred by ambulance; Baby died in NICU 3 days later.

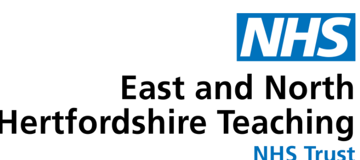
Maternal complications:

- Delay in active management of 3rd stage of labour; 4th-degree tear unrecognised for 40 minutes;
- Lack of clear communication and situational awareness between midwives and paramedics.
- Delay in extrication with full observations/mews scoring not used during this time.
- Jennifer suffered cardiac arrest at 08:01, was transferred to hospital where she sadly died.



https://www.bbc.co.uk/news/articles/c0516207gq2o

Coroners' concerns



During the course of the inquest the evidence revealed matters giving rise to concern.

In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you.

The **MATTERS OF CONCERN** are as follows: –

1. There is no national guidance in respect of home births. Specifically, robust evidenced based guidance on home birth care, similar to that which is in place for intrapartum care in a hospital setting.

2. There is an increase in the number of women with 'high risk pregnancies' requesting home births where required interventions cannot take place or would be significantly delayed and there is no robust framework for midwives supporting home birth care. There is no national guidance to support consistent practice across the country including, for example, details of clinical scenarios where women, following robust assessment, have been considered too high risk to safely receive care in a home-setting.

3. The lack of national guidance means there are differing models of care and unlike other specialities home births are not a specialist commissioned service. There is no national guidance considering the ethical responsibility and proportionality of offering a home birth model under the NHS framework.

4. Even though there is a very small risk of death, this is not something which is discussed with women particularly in relation to maternal death, even if the woman has a recognised risk such as a post-partum haemorrhage. There is no guidance to ensure the risk of death to both mother and baby is discussed with any woman considering a home birth irrespective of being considered high or low risk.

5. NICE guidance on intrapartum care (2023 updated June 2025) Section 1.3.3 only refers to the potential risk of death to a baby. There is no mention in the guidance of risk to the mother.

6. Terminology around pregnancies describes them as 'high' or 'low risk pregnancy' and leads women to consider that pregnancy encompasses all stages through to delivery of a child. Practice does not personalise or individualise risk so women can fully understand what the level of risk is for them in actually being pregnant, or what the level of risk is for them in giving birth.

7. In order to maintain their skills, there is no set number of deliveries a community midwife must conduct following qualification. There is no mandated number of deliveries that any midwife (irrespective of the settings in which they are working) must complete once they have qualified as a midwife in order to maintain their registration. The level of experience of community midwives in conducting deliveries is not information routinely provided to women to inform their decision whether to have a homebirth.

8. No bespoke training needs analysis has been conducted focusing on midwives practicing in home birth teams.

9. The lack of national data collection means there is no data to evidence the number of women who are transferred in during labour or after birth, maternal or neonatal outcomes, number of women who are considered out of guidance.

10. The no national guidance on the model of staffing, training and experience for midwives providing home birth care.

ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe each of you respectively have the power to take such action.

Service assurance - Birth options clinic in place

East and North Hertfordshire Teaching NHS Trust

- Support women to make informed choices by providing clear, evidence-based information, documenting recommendations and decisions, and exploring possible compromise through MDT working and joint appointments
- Run by Consultant Midwives (senior midwives)
- Clear SOP and process in place for birth options service. Clinicians support—but do not approve or own—women's choices, and responsibility remains with the woman.
- Baby has no rights until birth and maternal choices must be supported while providing our staff a safe work environment
- The approach prioritises ongoing engagement, even where care is declined or services are limited, to maintain safety, oversight, and trust.
- Senior clinical support is available for complex cases, alongside staff training and wellbeing support.
- There is an increase in women declining elements of care or choosing unassisted birth, often influenced by non-professional sources and a desire for physiological birth.
- Maintaining strong relationships, multi-agency liaison, and clear communication is essential to keep women and babies as safe as possible
- MDT escalation and virtual reviews utilised when women decline obstetric care
- Work to increase oversight and build relationships when women choose unassisted birth
- Counsel for tokophobia and previous birth trauma

Within maternity services, women have a legal right to make informed choices about their place of birth and to accept or decline elements of their maternity care. Midwives, in accordance with the NMC Code, have a professional and legal responsibility to provide care during labour. This can present operational and clinical challenges in the provision of homebirth services.

Service assurance - Homebirth guidance

Homebirth
Suitability for labour and birth in ANY location
GREEN

- Women on a low risk pathway of care who fit the eligibility criteria for the Midwife Led Unit
- Term gestation between 37-42 weeks of pregnancy
- <100kg at booking
- All maternal observations within normal limits with a MEOW's score of 0
- No concerns in relation to fetal wellbeing
- Singleton pregnancy
- Cephalic presentation
- Normal growth trajectory of baby
- Insignificant meconium stained liquor with no other fetal concerns in labour
- Absence of abnormal bleeding
- Platelets >150
- HB >85 g/dl
- Spontaneous labour < 48 hours SROM with no other risk factors and in the absence of IOL.
- HIV positive with undetectable viral load
- Parity 0-5
- Midwife able to monitor fetal heart rate effectively (IA)
- No evidence of pre-eclampsia or pregnancy induced hypertension;
- Normally sited placenta

Home Birth Checklist	
Suitable for Homebirth Yes	
Mother Meets Criteria for Planned Home Birth	Yes
Support Partner Supportive of Decision	Yes
Environmental Factors Discussed Environmental factors. Heating. Lighting. Access - parking etc. Phones signal for mobiles etc). Ambulance access outside and inside property	Yes
Discussed the Findings of the BirthPlace Study & Provided Written Information	Yes
Arrangement for other Children in the Household	N/A
Social Issues Discussed	N/A
Contraindications to Planning a Home Birth eg Medical. Surgical. Previous Obstetric History. Present Pregnancy. Social	N/A
Waterbirth Information Discussed eg Type of pool to be hired. Public health advice not using pool with heaters and recirculation pumps. Positioning pool for ease of entry/exit	Yes
Staff Safety Requirements Discussed eg Contact arrangements. On-call arrangements between teams. Own midwife not always on duty. Distance / time to hospital. Midwives response time	Yes
Midwifery Arrangements Discussed	Yes
Availability of Medical Assistance Discussed	Yes
Fetal Monitoring during Labour Discussed	Yes
Management of Emergencies Discussed	Yes
Transfer to Hospital Discussed	Yes
Access to Internet Available / Granted if Required	Yes
• Minimum Broadband Speed Met	Yes

Place of birth (MD)

Lister Hospital 01/01/2025 to 31/12/2025

	Pregnancies
BBA	30
Home Birth	86
MLU	511
CLU and Theatre	3788
Other	31

Risk assessment for planned homebirth undertaken at home around 36/40 using template built in to EPR. RAG rating for place of birth in guideline.

Birthplace study should be discussed (slightly different outcomes for first baby at home + higher transfer rates)

Planned homebirth transfers reviewed monthly by matron for learning

YTD homebirth rate 1.96% births

Governance and learning from homebirth related incidents

- In the last year, two DIRM cases involving moderate harm related to homebirth were reviewed. These reviews identified no gaps in homebirth risk assessment, transfer processes, or adherence to guidance, and no specific learning related to homebirth practice.
- Operational learning from one case has been addressed, including ensuring experienced midwife support for preceptors, availability of equipment, and use of Trust-issued phones. Historical issues with equipment oversight have been resolved.
- A separate case involving private midwifery care highlighted risks associated with incomplete antenatal blood testing, prompting consideration of improved signposting for women to complete routine 28 bloods.
- There were two known unassisted births and several births with independent midwives in the area. These cases highlight the ongoing risks when care is declined and have led to, close working to build relationships and welcome to NHS care at any point, there is planned improvement on information for women choosing unassisted birth, and consideration of neonatal rights and safeguarding once baby born which has been highlighted as a concern in two of the cases.
- Overall, no recurring themes of unsafe or out-of-guidance homebirth care were identified. Wider improvement work continues around results follow-up after triage contacts which is relevant. Also, our out of area cross boundary working creates risk around having oversight of women who pick and choose elements of care or who may self-discharge from one hospital but require our input from a community perspective

Audit themes

Risk Identified	Audit Findings / Theme	Mitigation / Controls in Place	Further Actions / Assurance
Risk assessment place of birth decision-making	Risk assessments consistently reviewed on EPR when labour care commenced in all birth areas including the home	Annual intrapartum audit confirms appropriate review of place of birth risk assessments	Ongoing annual intrapartum and homebirth audits
Homebirth equipment not checked consistently	Paper checklists not always completed	Electronic checklist implemented with real-time oversight; standardised paramedic bags; equipment now checked on day of on-call	Monthly audit and review with oversight via fundamentals meeting
Inconsistent fetal heart monitoring at homebirth	Minor non-compliance with exact 5-minute monitoring in second stage	Targeted training delivered at community midwife meetings; annual mandatory fetal monitoring training for all community midwives	Ongoing monthly fetal monitoring audits
Inconsistent reporting of BBA events for oversight	Incomplete incident reporting and data collection	Midwives attend majority of BBAs, cases reviewed for oversight by community matron	Strengthen incident reporting and data capture- communications to teams
Documentation of homebirth/place of birth inconsistent	Inaccurate records of BBA, unassisted birth	Crib sheets to be produced of where documentation needs to be and mandatory fields	Planned training for midwives, consider improvements to EPR
Inconsistent contact process could impact oversight of midwives at homebirth and responsibility for calling staff	Pathway to be developed from triage to CLU to CMW sent out	Pathway reviewed and discussed with teams and information added in triage	SOP to be developed detailing process

Local actions:

Establishment of a Homebirth and out of guidance task and finish group Commencing 9th March 2026 with six workstreams identified:

1) **Workforce and training**

2) **Equipment maintenance and assurance**

3) **Strengthening processes and pathways for homebirth service**

4) **Out of guidance care**

5**) Governance and Assurance**

6) **Digital information and communication**

Summary:

- Supporting women to make informed choices, including out-of-guidance birth, can be challenging and resource-intensive and may impact staff wellbeing. However, it is essential to maintain engagement, provide clear counselling, and work collaboratively with women to ensure care is delivered as safely as possible rather than risk further disengagement from maternity services.
- As maternity care becomes increasingly polarised, with more women declining aspects of antenatal care or planning unassisted births, the need for complex birth planning clinics and consultant midwife support has increased for both women and staff.
- The Cahill case highlights the impact of birth trauma and has reinforced the department's focus on trauma-informed care, staff education, partnership working with specialist services, reflective debriefing, and responsive feedback mechanisms, including birth options clinics.
- Following the Chief Midwife's recommendations, a homebirth audit has been undertaken, a GAP analysis and a homebirth task and finish group set up to ensure guideline compliance and safe working, alongside a review of on-call structures and staffing to support safe practice.

Recommendations:

- Note the assurance that appropriate governance, clinical pathways and oversight are in place for homebirth and birth outside of guidance however further improvement work to address GAPs and strengthen our service is planned
- Consider out of guidance homebirth woman's story to board

Board

<table>
<tr><td>Meeting</td><td colspan="2">Public Trust Board</td><td>Agenda Item</td><td colspan="2">11</td></tr>
<tr><td>Report title</td><td colspan="2">Board Assurance Framework (BAF) – Strategic Risks</td><td>Meeting Date</td><td colspan="2">11 March 2026</td></tr>
<tr><td>Author</td><td colspan="5">Head of Corporate Governance</td></tr>
<tr><td>Responsible Director</td><td colspan="5">Deputy Chief Executive</td></tr>
<tr><td rowspan="2">Purpose</td><td>Assurance</td><td>☒</td><td>Approval/Decision</td><td colspan="2">☐</td></tr>
<tr><td>Discussion</td><td>☐</td><td>For information only</td><td colspan="2">☐</td></tr>
<tr><td rowspan="2">Proposed assurance level (<u>only</u> needed for assurance papers)</td><td>Substantial assurance</td><td>☐</td><td>Reasonable assurance</td><td colspan="2">☒</td></tr>
<tr><td>Partial assurance</td><td>☐</td><td>Minimal assurance</td><td colspan="2">☐</td></tr>
<tr><td colspan="6">Executive assurance rationale:</td></tr>
<tr><td colspan="6">Reflecting the reasonable assurance rating score for the BAF the Board determined at November and January 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.</td></tr>
<tr><td colspan="6">Summary of key issues:</td></tr>
</table>

Key matters to highlight

- All BAF risks having been reviewed by their lead committee in February 2026 and the only two risk score changes proposed are for the two spotlighted risks below.
- The two highest risk scores are 20 for **Risk 3 (Financial constraints)** and **Risk 7 (System instability)**.
- **Risk 9 (Future of cancer services):** Following capital funding agreement, the public consultation on moving from Mount Vernon launched in January 2026. This significantly increases the chances that the future of cancer services will be known shortly and with it a potential risk score reduction.
- The developing for the 2026-27 BAF will take place at April's Board Seminar and is highlighted to give Board members time to start considering if any of the biggest risks to delivering our strategy are missing from the BAF.

Board spotlight on two BAF risks

Spotlighted BAF Risk 4 *(Workforce morale whilst making savings) – Penny St Martin*

- Overall some excellent progress. Therefore, February People & Culture Committee agreed to reduce the risk score from 16 to 12 (reduced likelihood from 4 to 3) given we are making positive progress in our staff survey and in relation to turnover (under threshold by 2.5%).
- Positively, the workforce plan was submitted to the national team December 2025.
- In addition, positively, two gaps are proposed to close: Previous gap 'Inability to recruit to key posts at speed due to CIPS not delivered' and 'Mutually Agreed Resignation Scheme'.
- Instead a new gap has been added of 'Workforce planning and affordability'.
- 'Meetings rationalisation programme' has been added as an action to help address the gap 'capacity of staff to deliver expected improvements and BAU with reduced staff'.
- Some assurances have been removed (visible as tracked changes) because it was concluded these are not critical assurances to the specified risk.

Spotlighted BAF Risk 5 *(Leadership and engagement)* – *Penny St Martin*

- People & Culture Committee on 2 February agreed the risk score increase from 9 to 12, reflecting NED feedback on the importance of difficult decisions being made and seen through.
- The 360 NHSE framework will not be ready until Autumn 2026.
- A revised senior performance meeting approach has been agreed to be trialled from April, which is envisaged to assist with driving performance and holding to account.

Latest on the other BAF risks:

- **Risk 1 (Investment & Estates)**: New control gap added "Capital Envelope Insufficient to Reduce Backlog Risk" with proposed actions for consideration.
- **Risk 3 (Financial constraints)**: is at the forefront of Board and executive discussions given the savings target for 2026-27 with FPPC asking that a control gap be added "Embedding the accountability framework". Actions to address this gap will need to be added.
- **Risk 6 (Compliance culture and accountability):** There has been increased focus on policy compliance, including a TMG discussion in January 2026, and seeing increased policy update compliance rates.
- **Risk 7 (System instability):** Lack of clarity from national team on policy for Integrated Healthcare Organisations and delegation added as a gap in controls. We are intending to invite an NHSE senior leader to a Board Seminar for clarification.
- **Risk 8 (Flow and performance):** Audiology HWE mutual aid discussions are imminent.
- **Risk 10 (Digital transformation):** Reviewed but no control, assurance or action changes.
- **Risk 11 (Change management):** There has been agreement on simplified strategic priorities for 2026-27 to aid manageability and focus.

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 14 January; Digital Committee 9 February; People & Culture Committee (PCC) 2 February; Audit & Risk Committee 10 February; Quality & Safety Committee (QSC) 25 February; Finance, Planning and Performance Committee (FPPC) 23 February.

Recommendation	The Board is asked to • discuss and **NOTE** the BAF; and • agree the assurance rating, with reasonable recommended.

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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 and estates challenges (capital, system allocation and no growth)**	Chief Financial Officer	Finance, Performance and Planning	16	↔
2.	**Health inequalities**	Medical Director	Quality and Safety	12	↔
3.	**System and internal financial constraints**	Chief Financial Officer	Finance, Performance and 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 and Culture	~~16~~12	↓
5.	**Leadership and engagement**	Chief People Officer	People and Culture	~~9~~12	↑
6.	**Compliance culture and accountability**	Chief People Officer	People and Culture	12	↔
Deliver seamless care for patients through effective collaboration and co-ordination of services within the Trust and with our partners					
7.	**System instability**	Deputy Chief Executive (CFO)	Finance, Performance 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 and 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***

Impact						
	5					
	4		8	11; 4 3; 10	1; ~~4;~~ 8; 9 10	3; 7;
	3		11	5 1; 2; 4; 7	2; 5; 6	
	2		5; 6		9	
	1					
	I x L	1	2	3	4	5
		Likelihood				

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 <3 days off work, if staff	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	**Moderate**	Moderate injury requiring professional intervention RIDDOR reportable incident	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
4	**Major**	Major injury leading to long term incapacity requiring significant increased length of stay	Intermittent failures in a critical service Significant underperformance of a range of key targets	National media coverage and increased level of political / public scrutiny. Total loss of public confidence	Loss of between £501,000 and £5m
5	**Extreme**	Incident leading to death Serious incident involving a large number of patients	Permanent closure / loss of a service	Long term or repeated adverse national publicity	Loss of >£5m

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**

Our Trust mission

Providing high-quality, compassionate care for our communities

Our guiding themes

Quality
Consistently deliver quality standards, targeting health inequalities and involving patients in their care.

Thriving people
Support our people to thrive by recruiting and retaining the best, and creating an environment of learning, autonomy, and accountability.

Seamless services
Deliver seamless care for patients through effective collaboration and co-ordination of services within the Trust and with our partners.

Continuous improvement
Continuously improve services by adopting good practice, maximising efficiency and productivity, and exploiting transformation opportunities.

2025 / 26 goals

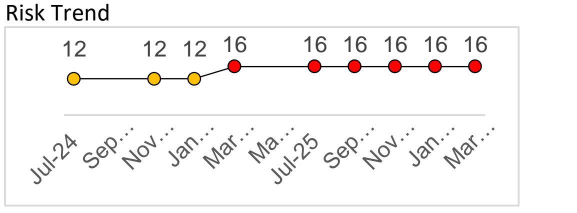
1. Minimise waits by redesigning pathways and processes
2. Aim for Zero Harm/defects by applying and developing research, and utilising improvement methodology
3. Give staff the autonomy, development and necessary tools to succeed
4. Build capability for compassionate and inclusive leadership, sharing clear expectations and accountability
5. Ensure the voices of those we serve are heard in designing and improving services
6. Organise and improve services by collaboration and integration with partners
7. Improve safety and outcomes by redesigning processes and pathways supported by digitisation
8. Improve efficiency by the continuous removal of waste and increasing productivity

Vision to 2030

To be trusted to provide consistently outstanding care and exemplary service

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	Risk Trend
Inherent	4	4	16	4	
Current	4	4	16		
Target	3	3	9		

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
Monthly Investment Group meetings & Critical Infrastructure Weekly meetings	Reports (1) Qtrly Capital Plan Reports to FPPC (2)	6
ICS Directors of Finance meeting	Reports to ICS Directors meeting (1)	4
Investment Group	Report to TMG 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
Alignment of Capital Investment Priorities ~~With~~with Strategic Need	• 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~~Mar 26 [Original: Dec 25]
Capital Envelope Insufficient to Reduce Backlog Risk	• Quantify backlog risk trajectory within LTFM • Prioritisation model focused on risk reduction • Escalation through ICS capital framework	MA	Mar 26
Limited Assurance on ICS-Level Capital Distribution and Place-Based "Fair Share"	• 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~~Complete
Long-Term Capital & Estate Planning Infrastructure Not Fully Embedded	• 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	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
Dependency on ~~System~~ Transformational Capital That Is Not Yet Secured	• Map Trust-dependent system capital into a single risk register for 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 contingency plans in the event that system capital does not materialise.	MA	~~Q3 25/26~~Ongoing
Responsiveness to In-Year Capital Opportunities Limited	• 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 IG cycle
Compliance Gaps: Backlog Maintenance, Fire Safety and Regulatory Standards	• Update the estates compliance risk register and backlog model as part of 26/27 planning. • 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	~~Q2~~Q4 25/26 [original Q2 25/26]

Current Performance – Highlights from the Integrated Performance Report:
• £33m capital programme approved, ~~but several schemes show~~ delivery ~~and slippage~~ risk ~~driven~~being managed by ~~contractor capacity~~CIG and supporting Estates and ~~inflation volatility.~~Finance Teams • Backlog maintenance remains high, with key mechanical and electrical (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. • Some notable successes in respect of bid funding for 26/27, increasing overall capital programme to c£50m • 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	Risk Trend
Inherent	4	4	16	4	12 12 12 12 12 12 12 12 12 12 12 12 12 12 12 Jul-22 Oct-... Jan-... Apr-... Jul-23 Oct-... Jan-... Apr-... Jul-24 Oct-... Jan-... Apr-... Jul-25 Oct-... Jan-...
Current	3	4	12		
Target	3	3	9		

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~~ 23.1.26 - ICB currently undergoing significant change and policy not available	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) 23.1.26 Needs further work as not fully enacted	1~~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 23.1.26 – we hope will go live within the next month	1
Health equity group projects: Homelessness	Status: Initial discussion with partner (23.1.26 – discussions with local authority and pathway, funding discussed with trust charity)	1

Inability to work due to health delays Childhood	Initial discussions with partner - 23.1.26 – discussions have progressed, DWP keen to work with us on a pilot, trust stakeholders involved Review of existing data and discussions with partners – 23.1.26 – discussions with Barnardo's, trust charity and local authority	
Health inequalities workplan	Health equities group progress report (1) Assurance report to QSC (2)	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 – 23.1.26 – EoE national focus to narrow the wait gap – clear mandate to do this locally	COO	See Corporate Risk Register
• Children's wellbeing bill • Tobacco and vape bill • Mental health bill	• Implement actions once legislation enacted	MD	2025
• 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.	• TBC	MD	TBC
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	TBC

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~~paediatrics Update 24.11.25 Good progress on no smoking on site Progress made on paediatric audiology with a clear road map More work to do on community ~~paediatrics~~paediatrics Health inequality group active, self assessment done, 3 potential projects being worked on – cost will be an issue Update 23.1.26 Progress made on homelessness, CYP and unemployment due to illness, close to go live for opt out HIV testing.

Further dedicated resource unlikely. National and regional mandate to work on decreasing inequality in CYP waiting times. Funding received to rebuild paediatric ward

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
3114	Risk to new mothers and babies due to cross-border	16
3550	Sight loss risk for paediatric patients	20
0693	Transition from paediatric to adult care	15

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	Risk Trend
Inherent	5	4	20	4	16 20 20 16 16 12 12 12 12 16 16 16 20 20 20 Jul-22 Nov-... Mar-... Jul-23 Nov-... Mar-... Jul-24 Nov-... Mar-... Jul-25 Nov-... Mar-...
Current	**4**	**5**	**20**		
Target	4	3	12		

Risk Lead	Chief Financial Officer	Assurance committee	FPPC

Controls	Assurances against stated controls, with assurance level *1st line (front line); 2nd (corporate); 3rd (independent)*	Assurance score
Strategies and Plans		
Approved 25/26 Financial Plans	Monthly Finance Update to TMG (2)	4
	Monthly Finance Report / Key Metrics to FPPC (2)	4
	CIP report & productivity report to FPPC (2)	4
	Outturn Reports to TMG, FPPC and Board (2)	4
	Delivery & Progress reports to Finance Recovery Group (2)	4
	25/26 Financial plan submitted to & approved by NHSE (3)	4
Operational Systems and Resources		
Financial Reporting & BI Systems	Monthly financial reporting to NHSE & HWE System (1)	6
Detailed monthly CIP performance reporting	Reports to FPPC and FRG and national reporting (2)	4
Monthly ERF & Productivity Report to FPPC	Internal performance monitoring and Model Hospital / GIRFT / Use of Resources benchmarking (2)	3
Monthly Finance Reports	External / Internal audit review of key financial systems and processes (3)	4
Outturn Forecast report to TMG, FPPC and System	Review at FPPC and TMG (2)	4
Monthly ICS System Transformation and Improvement Board	Facilitated by ICS financial and executive leaders (3)	2
Monthly system finance oversight meeting with NHSE	Regional confirm and challenge of Trust and system financial deliver (3)	3
Biweekly System CEO / CEO finance review meetings	System stakeholder review of financial delivery and planning (3)	3

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

Gaps in Controls and Assurances	Actions and mitigations to address gaps	Lead	Target date
~~Up to Date Finance strategy~~Absence of a Delivered Structural Transformation Programme	~~26/27 & 27/28 financial plan review and approval to December FPPC prior to submission~~• Mobilisation of Trust-wide Transformation Programme • Dedicated PMO, executive SROs, productivity & cost base reset • Multi-year savings and productivity recovery targets	~~CFO~~TD	~~Dec 25 [originally July 25]~~Apr 26
High Structural Cost Base with Workforce Growth Outpacing Activity	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.	Execs / PMO	Q4 25/26
Structural ~~Under-Delivery~~under-delivery of CIP ~~and Over-Reliance on Non-Recurrent Measures~~reflecting historic incremental schemes insufficient to close the underlying deficit	Delivery Board to oversee CIP delivery. Embed Accountability Framework, ~~strengthen PMO, mandate risk-assessed CIP pipeline, and establish multi-year recurrent savings baseline.~~implementation of the agreed Transformation Programme	Execs / ~~PMO~~TD	Q4 & ongoing

Material Productivity Deterioration vs Pre-Pandemic Levels	Deploy revised productivity pack with actionable insights, divisional heatmaps. Scale AI-driven productivity reviews to service lines.	DDOF / PMO	Q3 25/26
ERF & RTT Delivery Misalignment with Financial Plan	Accelerate RTT/ERF Working Group outputs, reset divisional trajectories and align workforce deployment to achievable delivery plans.	DDOP	Q4 25/26
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.	CFO	Q4 25/26
Limited Understanding of Service Line Financial Dynamics	Fully deploy SLR with deep dives and link outputs to CIP, job planning and D&C modelling.	DDOF (FP)	Q4 25/26
Persistent Risk of Expenditure Overspend	Strengthen divisional oversight, enhance controls on temporary staffing, procurement and run-rate monitoring.	DDOF(FM)	Ongoing
Lack of Long-Term Workforce Affordability Plan	Develop multi-year workforce affordability plan aligned to CIP, productivity and digital/capital transformation.	CPO	Q4 25/26
Insufficient Integration of Finance, Workforce, Activity, Digital and Capital Plans	Apply Trust planning schematic to integrate all planning pillars and establish triangulation checkpoints.	CFO	Dec 25
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.~~

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- **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.
- Underlying deficit trajectory for 26/27 indicates a materially higher savings requirement than in 25/26, reinforcing the need for structural transformation rather than incremental controls.

- **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.
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- **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
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~~12
Strategic Risk No.4: **Workforce morale whilst making necessary staffing savings**			
If the Trust does not manage the necessary staffing savings approach well	***Then*** staff morale and motivation could be affected	***Resulting in*** a range of issues arising from a disaffected workforce including reduced patient quality and safety, productivity and increased turnover and difficulty recruiting high calibre staff.	

	Impact	Likelihood	Score	Assurance	Risk Trend
Inherent	4	5	20	4	Jul-25: 16; Aug…: 16; Sep…: 16; Oct…: 16; Nov…: 12; Dec…; Jan…; Feb…; Mar…
Current	4	~~4~~3	~~16~~12		
Target	3	3	9		

Risk Lead	Chief People Officer	Assurance committee	People and Culture Committee

Controls	Assurances against stated controls, with assurance level *1st line (front line); 2nd (corporate); 3rd (independent)*	Assurance score
Strategies and Plans		
People Strategy	People Committee reports (2) Annual report to Board (2)	6
Clinical Strategy 2022-2030	Report to QSC (safer staffing quarterly; Establishment review; Q&S metrics monthly) (2)	6
EDI Strategy	People Committee reports (2) Annual report to Board (2)	4
Annual Divisional demand and capacity modelling, workforce plans and local Skill mix reviews	Planning reports to FPPC and PCC (2)	6
~~Apprenticeship strategy~~	~~People Committee reports (2)~~ ~~Oversight at Education Committee (1)~~	~~5~~
Mechanisms for identifying hotspots and shortfalls	People Committee reports (temp staffing; resourcing; people report; retention deep dive) (2)	6
NHS Workforce long-term plan	Annual People Committee updates on progress (2)	~~5~~6
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)	6~~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	Annual Staff survey annual (2) Both to PCC bi-annual (2)	~~5~~6
Governance & Performance Management Structures		
Medical establishment oversight working group	Held monthly & feeds into People report taken to PCC (2)	~~5~~4
~~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~~6
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

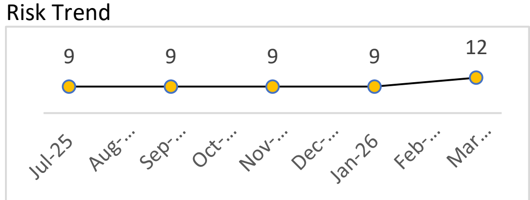
Gaps in Controls and Assurances	Actions and mitigations to address gaps	Lead	Target date
~~Inability to recruit to key posts at speed due to CIPS not delivered~~ The explanation of this gap has moved on – it is not about the ability to recruit to key posts that is necessarily the issue – it has now evolved into a focus on workforce planning and affordability – both have been picked up as a learning point from the RCP noted below.	• ~~We have continued to recruit successfully to key posts; where appropriate people, 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~~Complete – this is an ongoing monthly activity
• Workforce planning and affordability	• A Resource control panel has been established and includes both permanent, temporary and rate uplifts. Meeting 3 x weekly this panel consisting of 5 Executive Directors challenges divisional requests and decisions with some early positive results including: o Reduction in contracted staff by 7.5 (November data) o Overall bank and agency spend 7.9% of total pay bill against an upper limit of 8%. o December predicted to reduce further. o Clearer areas if focus for the medical resourcing roadmap.	• CPO	• This action will become BAU once stabilized when the Executive Directors will be replaced by Deputies – will be reviewed end Jan 2026.
• ~~Mutually Agreed Resignation Scheme~~	• ~~To approve MARS scheme and enact- PHASE 1 HAS BEEN COMPLETED~~	• ~~CPO~~	~~Nov 25~~Complete
• Establishment growth controls	• Consistency of HR and Finance data – a working group has been set up and a pilot area/methodology	• CFO and CPO	• Mar 26

• Better infrastructure for agreeing establishment and funding for posts (planning process)	identified. If the pilot works well, we will roll out across the Trust.		
• Capacity of staff to deliver expected improvements and BAU with reduced staff	• Redesign ways of working • Use AI and digital solutions – currently ~~exploring~~piloting how to automate minutes for meetings (and question why each meeting needs minutes and not decision/action logs) using Teams transcribe and CoPilot – being trialled in meetings to stress test suitability for broader implementation. • Meetings rationalization programme – using the principles and methodology of the ENHPS as a guide, the governance team are running workshops/events to review and evaluate the impact of current ways of working – if reduced this has the ability to reduce workload, and potentially headcount. • 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 Head of Corporate Governance KPO	• In progress now e.g. minute taking January 2026 14 Oct 2025.
• Updated workforce plan	• Develop a workforce plan • Seek Board input at a Board Seminar	• CPO	• ~~July 26~~ • ~~Dec 25 - completed~~Workforce plan delivered and submitted to national team December 2025 • Completed action but outputs will form the basis of further work.

Current Performance – Highlights from the Integrated Performance Report:
• Staff turnover rate – current performance (Nov 2025) shows below the 10% threshold @ 7.5% • Staff survey – particularly workload and morale questions – initial performance for survey shows some very minor increases and some very minor decreases (e.g. given below) showing relatively steady results of 2025. 6/8 showing better performance than comparator results. o ~~Recruitment pipeline time to hire~~Staff engagement 2024 6.91; 2025 6.82 o Morale 2024 5.94; 2025 5.86 o Work pressure 2024 5.33; 2025 5.15

Associated Risks on the Corporate Risk Register		
Risk no.	Description	Current score
3421	Nursing levels in critical care	15
3361	Stroke staffing levels	15
1079	Epilepsy staffing	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 ~~9~~12
Strategic Risk No.5: **Leadership and engagement**			
If the Board and Executive do not effectively nurture and model the right leadership behaviours and skills and these standards are not adopted at all levels of the organisation	***Then*** sub-optimal management and behaviours in hotspot areas will occur and staff may not feel psychologically safe to raise concerns	***Resulting in*** being unable to make the transformation changes needed to improve patient services and core performance standards and staff experiencing stress, bullying, harassment and discrimination	

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

Risk Lead	Chief People Officer	Assurance committee	People Committee

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

	Staff survey question on appraisals (3)	
Retention		
Annual staff survey and quarterly pulse surveys	Reported in IPR taken to PCC (2) Twice per year updates to PCC & annual to Trust Board (2)	6
Stay interviews and exit questionnaires	New approach agreed by PCC, assurance report to be presented by Mar 25 (2 once starts)	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	KPO	Reported at TGT monthly
• 360 feedback of leadership behaviours	• ~~This will need to form part of the new People team offer~~ NHSE framework will not be ready for implementation until Autumn 2026 • Until then an interim arrangement is in place and used for NED at EoY	• CPO	• ~~Mar 26~~Ongoing for interim, Autumn 2026 for NHSE application

Current Performance – Highlights from the Integrated Performance Report:
• Numbers of successful staff challenges – grievances and ETs - tbc • Number of staff completed ENHPS leaders – 98 currently signed up (Nov 2025) • % leaders done training – core competencies and clinical ops programme – 4 signed up for ENHPS for Ward Managers • Staff survey re leadership & staff advocating for the Trust – compassionate leadership increased from 6.98 to 7.04, advocacy declined from 6.84 to 6.67 • GROW completion rate – appraisal rate 86% against a target of 90%

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 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
Inherent	4	5	20	4
Current	4	3	12	
Target	4	2	8	

Risk Trend

15 15 12 12 12

Jul-25 Aug… Sep… Oct… Nov… Dec… Jan… Feb… Mar…

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 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)	~~5~~4
Q&S framework	Quality & Safety Committee (2)	4
People Strategy	People Committee reports (2) Annual report to Board (2)	6
ENHT Production System	Reported annually to board (2)	6
EDI Strategy	People Committee reports (2) Annual report to Board (2) EDI Steering Group (1)	6
Governance & Performance		
Revised Scheme of Delegation	ARC and Board review annually (2)	6
Balanced scorecard	Divisional Board reports (1)	4
Well-led review action plan	ARC & TMG progress reports (2)	4
Management Structures		
Divisional operating model – structure and responsibilities	Reviewed as part of Trust Management Group (1)	4
Divisional Performance reviews	Reviewed as part of Trust Management Group (1)	6
Divisional boards	Divisional Performance Reviews (1)	6
Grow together reviews and talent forums	Reported annually to PCC (2)	6

Improvement Partner		
Principles and values related to the ENH Production system to be embedded through training programmes	To be reported to PCC (2 once start)	3
Positive leadership rounds	~~To be reported to PCC (2 once start)~~In progress	~~3~~6
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)~~Now embedded into regular agenda item	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 • MOU for Resident Drs signed allowing for a training passport to follow them around for mandatory training preventing duplication.	Emma Martin	Dec 2025 Complete
• 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	• Mar26
• Values not always understood and demonstrated by all staff	• TBC	• CEO	• Mar 26
• Leadership culture modelling/enabling accountability	• Redefining 'The Trust Way' on the agenda for Board in December 2025	• CPO	• Complete • Dec 2025

Current Performance – Highlights from the Integrated Performance Report:

- CIPs delivery
- Policies: Proactive action in this area has resulted in ~~89~~increase from 89% to 93% 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%~~A Whistleblowing Policy is with the TU for review and hoping to be on the Trust Board agenda for 14 January 2026.
- Further work is required post restructure to review how we capture guidance in policy and SOP form.
- 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	Discharge letters not being completed at the time of discharge	16

Strategic Aim: **Deliver seamless care for patients through effective collaboration and co-ordination of services within the Trust and with our partners**			**Risk score 16**
Strategic Risk No.7: **System instability**			
If significant and rapid changes are made to NHS oversight and delivery structures	***Then*** decision making may be slowed due to increased ambiguity or management capacity	***Resulting in*** important transformation not keeping pace with patient need.	

	Impact	Likelihood	Score	Assurance	Risk Trend
Inherent	4	5	20	**3**	Jul-25: 12; Aug-…: 16; Sep-…; Oct-25; Nov-…: 16; Dec-…; Jan-26: 20; Feb-…; Mar-…: 20
Current	**4**	**5**	**20**		
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 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 until April 2026	• 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 the new ICB that the ICB BAF includes this risk	• CEO	~~Completed but gap remains~~Q4 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 ICB cluster as they develop thinking and strategy	• 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 appointments to key leadership roles made	• NHSE	• Q3 25 [originally June 25]
• Lack of clarity from national team on policy for IHOs and delegation	• None currently	• NHSE	• Q4 25/26

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
- HCP performance dashboard metrics tracking progress against HCP priorities
- Risk increased temporarily due to the current period of change in ICB 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	Risk Trend
Inherent	4	4	16	4	12 16 16 16 16 16 16 16 16 16 16 16 16 16 16 Jul-22 Nov... Mar... Jul-23 Nov... Mar... Jul-24 Nov... Mar... Jul-25 Nov... Mar...
Current	**4**	**4**	**16**		
Target	4	2	8		

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 and ensure focus on non RTT patient cohorts	• 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 25/26 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 • Claire Moore, ~~Interim~~ Deputy COO • •	• March 2026 [Original: Mar 25]

	• Interim funding for Feb and Mar 26 from NHSE being reviewed to maximise opportunity to improve both RTT and 52 week positions • Escalation meetings in place for RTT and diagnostics • IST invited in to review RTT and non RTT PTL and processes • Outpatient Transformation Programme: Centralising all OP booking to the Outpatient Appointment Centre (OPAC)	• • • • • • • • Mark Stanton, CIO	April 2026 May 2026
• 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	• Paul Thorp ~~Claire Gowland, Interim Lead~~ DOD Unplanned Care • Junaid Qazi, Divisional Medical Director • Justin Daniels, Medical Director • Theresa Murphy, Chief Nurse (SRO for 26/7 UEC transformation)	• 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	• 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, opened~~ing~~ October	• Redeemed Mzila, Head of Site • Junaid Qazi • Moreblessing Zvorwadza, Divisional Nursing Director • Heidi Hall,	• March 2026 [Original: Mar 25]

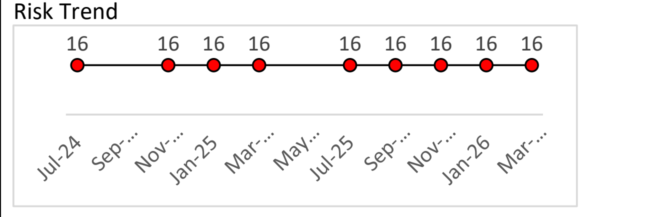
	25 however being used as inpatient area due to demand. • New transport criteria in place	Head of Service HCC	
• Diagnostic wait times – MRI and U/S, Audiology	• Weekly PTL tracking meetings for all modalities now in place. • 25/6 MRI capacity tactical plan agreed. • Robust plan for long term MRI capacity 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 imminent underway	• Claire Moore, Interim Deputy COO • Kate FruinNatasha Simper, Lead Acting a Planned Care • Mark Stanton, diagnostic transformation SRO	• March 2026 [Original: Mar 25]
• Theatre utilisation and pre – tci cancellation rate	• Recruitment plans ongoing. • 'Drumbeat' huddles to manage activity • Theatre Transformation Programme 2026/7	• Kate FruinNatasha Simper, Lead DOD • Lucy Davies COO - theatre tranformation SRO	• March 2026 [Original: Dec 25]

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

Associated Risks on the Board Risk Register

Risk no.	Description	Current score
3634	Ex ward referrals not being booked into clinic	20
3470	The risks associated with flow in ED related to congestion	16
3255	ICU discharge guidelines compliance	15
1722	OOH radiology provision	16
3723	Orthotics demand	15
3137	Gastroenterology capacity	16

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

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

Risk Lead	Chief Operating Officer	Assurance committee	QSC

Controls	Assurances against stated controls, with assurance level *1st line (front line); 2nd (corporate); 3rd (independent)*	Assurance score
Clinical Strategy	• Mount Vernon Programme review with NHSE – quarterly (3) • Cancer peer review (3) that reports to QSC • National annual cancer patient experience survey (3)	5
Cancer divisional risk register (up to date with no overdue risks and all risks have mitigation actions)	• RMG monthly and deep dive (1) • Divisional Performance review (1) • Corporate Risk Register to Board (2)	5
Fabric improvement capital investment to address the sites three year backlog maintenance priorities (partial but not a long-term control) is almost complete but we now need additional review and capital to maintain services to 2034-9	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 J~~joint acute oncology provision and ward at Watford now in place. Funding for this service needs substantive agreement with 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.~~	~~5~~4
Cancer services deep dives to QSC and FPPC	QSC and FPPC reports (2)	~~5~~4
Standing Board updates on progress with the Mount Vernon transfer	Updates to each Board (2)	~~5~~4
Public consultation launched on 19th January and runs to 29th March following agreement on route to capital	Mount Vernon/Watford development board Mount Vernon Programme board	4

Gaps in Controls and Assurances	Actions and mitigations to address gaps	Lead	Target date

• Outcome of ENHT cancer service options to NHSE to enable Trust planning	• Agreement on the route to capital secured, followed by public consultation	• Lucy Davies	• ~~Revised date Jan 26~~ • Consultation launched Jan 26
• Public awareness of the impact of the delay on quality of services	• Proactive communication discussed as part of the NHSE led public consultation ~~plan if gap agreed. Consultation delayed pending agreement on route to capital for new build.~~	• NHSE/ICB	• 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 2034~~2~~. Needs further refinement with detailed site survey to be led by THH.	• Martin Armstrong	• Jan 26~~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
- National Cancer Patient Experience Survey

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.	12~~20~~

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

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

Risk Trend: Jul-23 16; Sep-23 16; Nov-23 16; Jan-24 16; Mar-24; May-…; Jul-24; Sep-24 16; Nov-24 16; Jan-25 16; Mar-25; May-…; Jul-25 16; Sep-25 16; Nov-25 16; Jan-26 16; Mar-26 16

Risk Lead	Chief Information Officer	Assurance committee	Digital Committee

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		
Digital Committee established May 2025	• All reports to the 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 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	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
• If change is not managed effectively	• 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	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
3708	MESH connectivity - discharge letters to GPs	20
0942	Endoscopy paper processing timescales	15

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
Inherent	4	4	16	4
Current	**4**	**3**	**12**	
Target	3	2	6	

Risk Trend

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~~ • Something about the ADM modules?	• 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 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~~ Completed ~~Sept 25~~Completed ~~Mar 26~~Completed
• 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 Completed~~Mar 26~~ ~~Mar 26~~Completed

Current Performance – Highlights from the Integrated Performance Report:
ENHPS for Leaders Cohorts 10,11 and 12 involving a further 33 staff commenced in December. A bespoke Ward Managers version approved via TGT with scheduled dates to commence in March. Several 3P, RPIW, Kaizen Events and Value Stream launches occurred throughout November and December with an additional 2 RPIWs, Kaizen Event and 3P all scheduled over January to March. 2026 27 strategic goal cascade formally launched following Leaders Forum in January. A comprehensive comms plan and supporting materials including a Leaders Toolkit form part of roll-out. KPO have also created a new coaching offer to help establish strategic alignment boards and huddles. Board seminar session held in December to highlight progress and next steps with the ENHPS delivery plan. NHSE Clin Ops training programme now established and over 100 staff have booked and/or attended various modules to support productivity and efficiency initiatives. Health Check action plan signed off and monitored via TGT with all agreed actions either completed or on track. Several PDSA cycles completed, and a staff survey undertaken focusing on ideas to improve attrition rates for ENHPS for All with alternative approaches tested to make it easier for clinical staff to attend. 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	

Integrated Performance Report

Month 10 | 2025-26

	P	?	F
H / L	2	5	4
	8	37	10
H / L	1	2	7

Data correct as at 18/02/2026

Performance Highlights

Quality

- Mortality remains stable - no 3 sd outliers
- Stroke data continues to improve although remains at SNAP D overall - increased thrombolysis rates are an important improvement
- 5 MNSI year to date - very different themes
- Complaints -number stable with increased complaint closures in month
- MOH reflects a national trend but continues to be watched carefully
- VTE and Sepsis - ongoing work
- NEL stay a cause for concern as it impacts flow
- Security incidents remain a concern

Operations

- **Urgent and Emergency Care:** Highest on record UEC attendances and bed closures for continued estates work and IPC drove 4 and 12 hr performance behind trajectory. YTD 4 hrs: 74.4 % vs 69.5 % same period in 24/5. Improvement sprint starts 1/3.
- **Cancer Waits:** Achieved 3/3 targets in Dec and YTD.
- **Referral To Treatment (RTT)** (excluding Community Paeds): Continued on plan. Upper quartile performance nationally for 18 and 52 week waits. Herts COOs leading on acceleration of integrated CYP Neurodiversity pathway.
- **Diagnostics:** Performance improved by 2% to 51.5%. Audiology, MRI & NOUS 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 M10, the Trust has reported an actual YTD deficit of £4.6m. This is in line with phased plan expectations.
- CIP achievement YTD totals £14.5m. 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.
- Elective income performance in the YTD is behind plan.

People

- Staff turnover rate increased to 7.9% but remains below target.
- Overall Bank & Agency spend above target by 0.8%, driven through Bank costs as opposed to Agency which is 2% under target.
- GROW together compliance as well as Appraisal compliance remains static and under target.
- Stat Mand training compliance reducing - improvement paper going to Board early March with assurances around targeted interventions.
- FTE establishment monitoring (plan vs actual) is on plan, levels are aligned and on track for our March 2026 target.
- Sickness target monitoring worsening position, increasing MoM since Oct 25 with M10 highest sickness rate since January 25.
- Vacancy rate remains under target (6.1%).

Month 10 | 2025-26

Integrated Performance Report

How to interpret a Statistical Process Control (SPC) Chart

Common cause variation

A single point above the upper process limit

Consecutive values above the mean

Consecutive values below the mean

Two out of three points close to a process limit

Six or more consecutive points decreasing

3.5
3.0
2.5
2.0
1.5
1.0
0.5

A M J J A S O N D J F M A M J J A S O N D J F M A M J J A S O N D J F M

2019-20 2020-21 2021-22

Orange lower is better
Blue higher is better
Grey neither is better

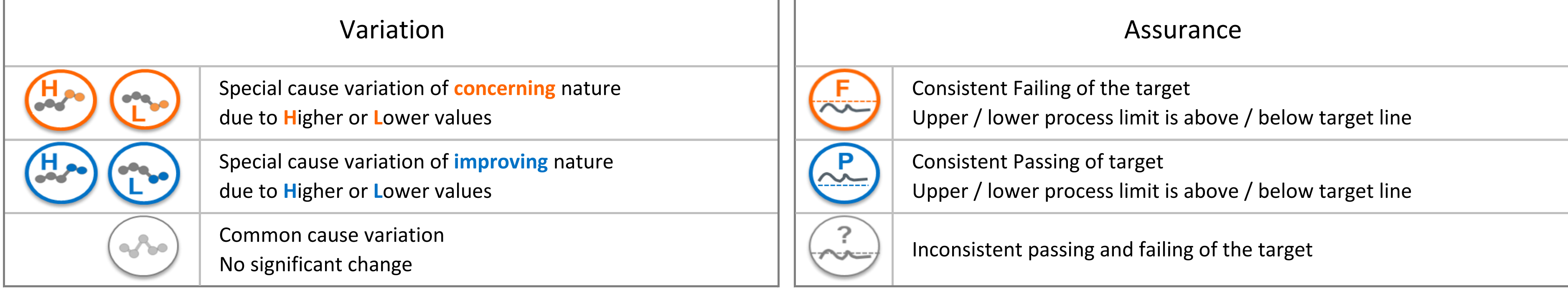
Upper process limit

Mean line

Target line

Lower process limit

Orange higher is better
Blue lower is better
Grey neither is better

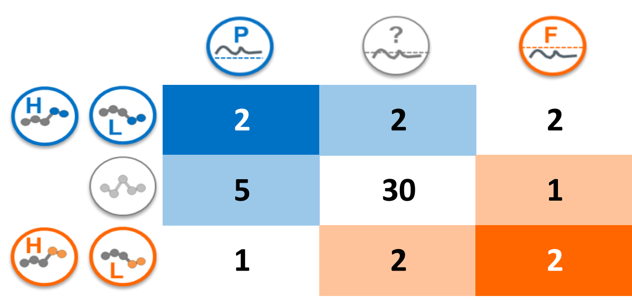


Variation	
H / L (orange)	Special cause variation of concerning nature due to Higher or Lower values
H / L (blue)	Special cause variation of improving nature due to Higher or Lower values
	Common cause variation No significant change

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

Quality

Month 10 | 2025-26



Quality

Summary

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Patient Safety Incidents	Total incidents reported in-month	Jan-26	n/a	1,640	H		16 points above the mean No target
Infection Prevention and Control	Hospital-acquired MRSA Number of incidences in-month	Jan-26	0	2	H	?	1 point above the upper process limit Metric will inconsistently pass and fail the target
	Hospital-acquired c.difficile Number of incidences in-month	Jan-26	0	7		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired MSSA Number of incidences in-month	Jan-26	0	4		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired e.coli Number of incidences in-month	Jan-26	0	2		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired klebsiella Number of incidences in-month	Jan-26	0	2		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired pseudomonas aeruginosa Number of incidences in-month	Jan-26	0	0		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired CPOs Number of incidences in-month	Jan-26	0	0		?	Common cause variation Metric will inconsistently pass and fail the target
	Hand hygiene audit score	Jan-26	80%	93.5%		P	Common cause variation Metric will consistently pass the target
Safer Staffing	Overall fill rate	Jan-26	n/a	86.4%			Common cause variation No target
	Staff shortage incidents	Jan-26	n/a	13			Common cause variation No target

Month 10 | 2025-26

Quality

Summary

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Cardiac Arrests	Number of cardiac arrest calls per 1,000 admissions	Jan-26	n/a	0.66			Common cause variation No target
	Number of deteriorting patient calls per 1,000 admissions	Jan-26	n/a	0.77			Common cause variation No target
Sepsis Screening and Management	Inpatients receiving IVABs within 1-hour of red flag	Jan-26	95%	81.8%	H	?	11 points above the mean Metric will inconsistently pass and fail the target
	Inpatients Sepsis Six bundle compliance	Jan-26	95%	54.5%		F	Common cause variation Metric will consistently fail the target
	ED attendances receiving IVABs within 1-hour of red flag	Jan-26	95%	91.0%	H	?	9 points above the mean Metric will inconsistently pass and fail the target
	ED attendance Sepsis Six bundle compliance	Jan-26	95%	58.2%	L	F	1 point below the lower process limit Metric will consistently fail the target
VTE Risk Assessment	VTE risk assessment stage 1 completed	Jan-26	85%	78.0%		?	Common cause variation Metric will inconsistently pass and fail the target
HATs	Number of HAT RCAs in progress	Jan-26	n/a	215	H		11 points above the upper process limit No target
	Number of HAT RCAs completed	Jan-26	n/a	21			Common cause variation No target
	HATs confirmed potentially preventable	Jan-26	n/a	1			Common cause variation No target
PU	Pressure ulcers All category ≥2	Jan-26	0	7		?	Common cause variation Metric will inconsistently pass and fail the target

Month 10 | 2025-26

Quality

Summary

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Patient Falls	Rate of patient falls per 1,000 overnight stays	Jan-26	n/a	4.6			Common cause variation No target
	Proportion of patient falls resulting in serious harm	Jan-26	n/a	0.0%			Common cause variation No target
Other	National Patient Safety Alerts not completed by deadline	Sep-24	0	0			Metric unsuitable for SPC analysis
Friends and Family Test	Inpatients positive feedback	Jan-26	95%	96.7%		P	Common cause variation Metric will consistently pass the target
	A&E positive feedback	Jan-26	90%	91.0%		?	Common cause variation Metric will inconsistently pass and fail the target
	Maternity Antenatal positive feedback	Jan-26	93%	93.3%		?	Common cause variation Metric will inconsistently pass and fail the target
	Maternity Birth positive feedback	Jan-26	93%	100.0%	H	P	8 points above the upper process limit Metric will consistently pass the target
	Maternity Postnatal positive feedback	Jan-26	93%	100.0%		?	Common cause variation Metric will inconsistently pass and fail the target
Friends and Family Test	Maternity Community positive feedback	Jan-26	93%	100.0%		?	Common cause variation Metric will inconsistently pass and fail the target
	Outpatients FFT positive feedback	Jan-26	95.0%	94.3%		?	Common cause variation Metric will inconsistently pass and fail the target
PALS	Number of PALS referrals received in-month	Jan-26	n/a	431		-	Common cause variation No target

Month 10 | 2025-26

Quality

Summary

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Complaints	Number of written complaints received in-month	Jan-26	n/a	104	H	-	12 points above the mean No target
	Number of complaints closed in-month	Jan-26	n/a	149	H	-	1 point above the upper process limit No target
	Proportion of complaints acknowledged within 3 working days	Jan-26	75%	81.5%	H	P	2 points below the lower process limit Metric will consistently pass the target
	Proportion of complaints responded to within agreed timeframe	Jan-26	80%	32.3%	H	F	8 points below the mean Metric will consistently fail the target
Maternity Safety Metrics	Caesarean section rate Total rate from Robson Groups 1, 2 and 5 combined	Jul-24	60 - 70%	70.4%		?	Common cause variation Metric will inconsistently pass and fail the target
	Massive obstetric haemorrhage >1500ml vaginal	Jan-26	3.3%	5.0%		?	Common cause variation Metric will inconsistently pass and fail the target
	3rd and 4th degree tear vaginal	Jan-26	2.5%	3.4%		?	Common cause variation Metric will inconsistently pass and fail the target
	Massive obstetric haemorrhage >1500ml LSCS	Jan-26	4.5%	2.7%		?	Common cause variation Metric will inconsistently pass and fail the target
	3rd and 4th degree tear instrumental	Jan-26	6.3%	2.3%		?	Common cause variation Metric will inconsistently pass and fail the target
	Term admissions to NICU	Jan-26	6.0%	6.3%		?	Common cause variation Metric will inconsistently pass and fail the target
	ITU admissions	Jan-26	0.7	0		?	Common cause variation Metric will inconsistently pass and fail the target

Month 10 | 2025-26

Quality

Summary

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Maternity Other Metrics	Smoking at time of booking	Jan-26	12.5%	5.6%			Common cause variation Metric will consistenly pass the target
	Smoking at time of delivery	Jan-26	2.3%	5.3%			Common cause variation Metric will inconsistently pass and fail the target
	Bookings completed by 9+6 weeks gestation	Jan-26	50.5%	68.8%			Common cause variation Metric will consistenly pass the target
	Breast feeding initiated	Jan-26	72.7%	72.2%			Common cause variation Metric will inconsistently pass and fail the target
	Number of MNSI PSII	Jan-26	0.5	1			Common cause variation Metric will inconsistently pass and fail the target
Mortality	Crude mortality per 1,000 admissions In-month	Jan-26	12.8	11.2			Common cause variation Metric will inconsistently pass and fail the target
	Crude mortality per 1,000 admissions Rolling 12-months	Jan-26	12.8	9.2			Rolling 12-months - unsuitable for SPC
	HSMR In-month	Nov-25	100	91.9			Common cause variation Metric will inconsistently pass and fail the target
	HSMR Rolling 12-months	Nov-25	100	88.8			Rolling 12-months - unsuitable for SPC
	SHMI In-month	Aug-25	100	83.3			Common cause variation Metric will inconsistently pass and fail the target
	SHMI Rolling 12-months	Aug-25	100	92.1			Rolling 12-months - unsuitable for SPC

Month 10 | 2025-26

Quality

Summary

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Re-admissions	Number of emergency re-admissions within 30 days of discharge	Nov-25	n/a	654	L		2/3 points close to lower process limit No target
	Rate of emergency re-admissions within 30 days of discharge	Nov-25	9.0%	5.6%	L	P	3 points close to lower process limit Metric will consistently pass the target
Length of Stay	Average elective length of stay	Jan-26	2.8	2.4		P	Common cause variation Metric will consistently pass the target
	Average non-elective length of stay	Jan-26	4.6	5.2	H	?	3 points close to upper process limit Metric will inconsistently pass and fail the target
Palliative Care	Proportion of patients with whom their preferred place of death was discussed	Jan-26	n/a	94.9%			Common cause variation No target
	Individualised care pathways	Jan-26	n/a	37	H		9 points above the mean No target
Stroke Services	Trust SSNAP grade	Q3 2024-25	A	D			
	4-hours direct to Stroke unit from ED	Dec-25	63%	51.0%	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)	Dec-25	63%	51.0%	H	F	3 point above the upper process limit Metric will consistently fail the target
	Number of confirmed Strokes in-month on SSNAP	Dec-25	n/a	88			Common cause variation No target
	If applicable at least 90% of patients' stay is spent on a stroke unit	Dec-25	80%	90.0%		?	Common cause variation Metric will inconsistently pass and fail the target
	Urgent brain imaging within 20 minutes of hospital arrival for suspected acute stroke	Dec-25	40%	35.2%			Not enough data for SPC
	Urgent brain imaging within 60 minutes of hospital arrival for suspected acute stroke	Dec-25	50%	65.0%		?	Common cause variation Metric will inconsistently pass and fail the target

Month 10 | 2025-26

Quality

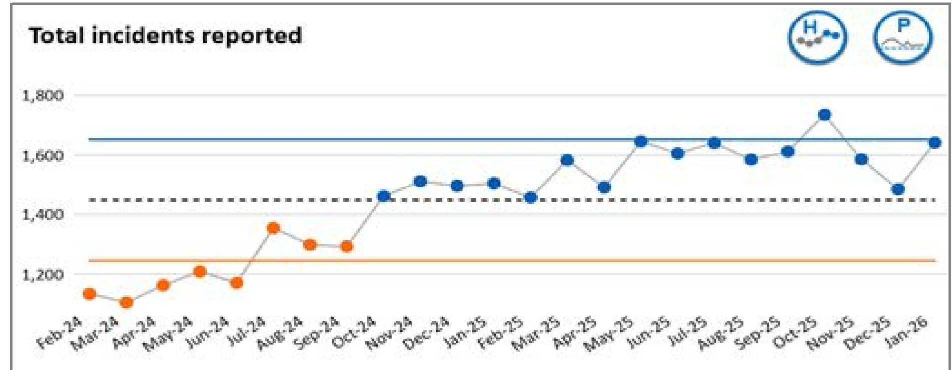
Summary

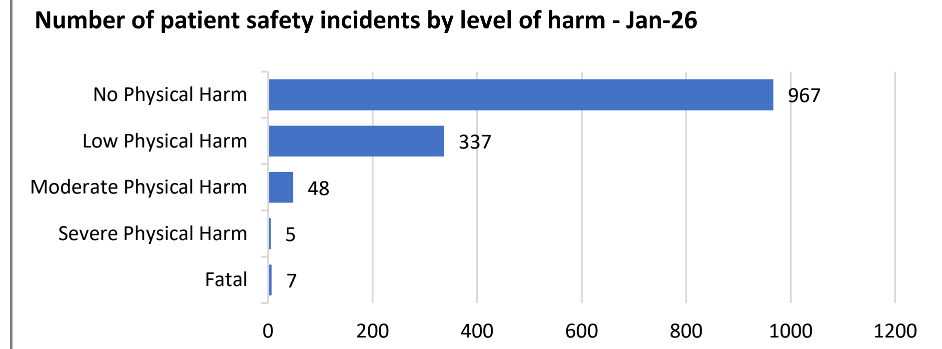
Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
	% of all stroke patients who receive thrombolysis	Dec-25	11%	18.0%		?	Common cause variation Metric will inconsistently pass and fail the target
	Discharged with ESD	Dec-25	50%	46.0%		?	Common cause variation Metric will inconsistently pass and fail the target

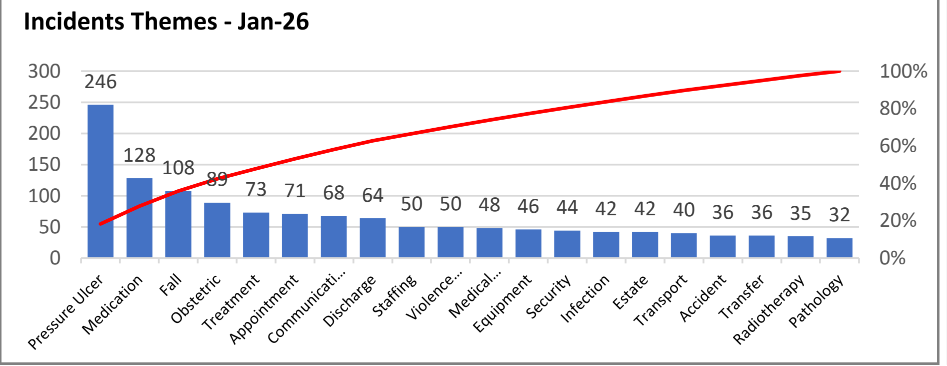
Month 10 | 2025-26

Quality

Patient Safety Incidents

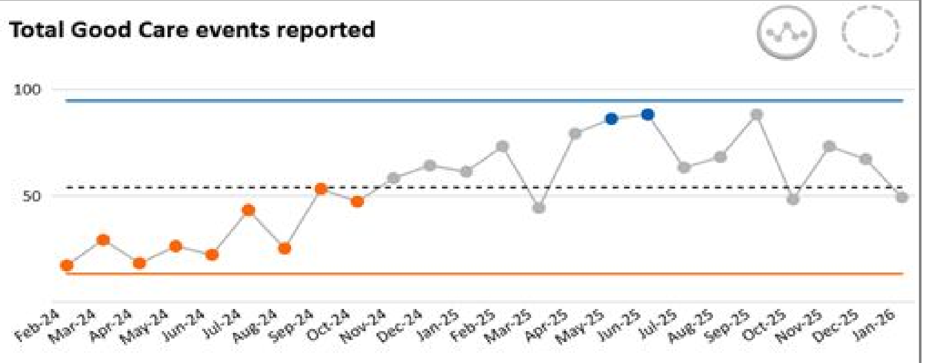






Key Issues and Executive Response

- Continued normal variation in incident reporting.
- 96% of incidents resulting in no harm / low harm, in line with previous months. Reflective of effective daily incident review huddles with prompt harm reviews
- Obstetrics and Emergency Medicine continue to be the highest reporting specialties in line with previous months
- Increase in restraint/violence and aggression incidents within Paediatrics reflecting ongoing challenges with young people awaiting appropriate community placement.
- Acknowledged high number of falls occurring in toilets- under review within falls steering group
- Emerging theme of loss to follow up in Oral Surgery. Clinical harm review process to be agreed. Acknowledged in broader organisational risk regarding non-RTT follow up processes on corporate risk register.
- 1 new PSii regarding delay in diagnosis and referral of an ophthalmic tumour in a young person resulting in permanent loss of vision. Care issues identified so far include incorrect MRI urgency categorisation, multiple incorrectly routed tertiary referrals, lack of pathway between Ophthalmology and Paediatrics and lack of MDT oversight.



Month 10 | 2025-26

Quality

Infection Prevention and Control

Number of hospital-acquired MRSA BSI incidences

Number of hospital-acquired C.difficile incidences

Number of hospital-acquired MSSA incidences

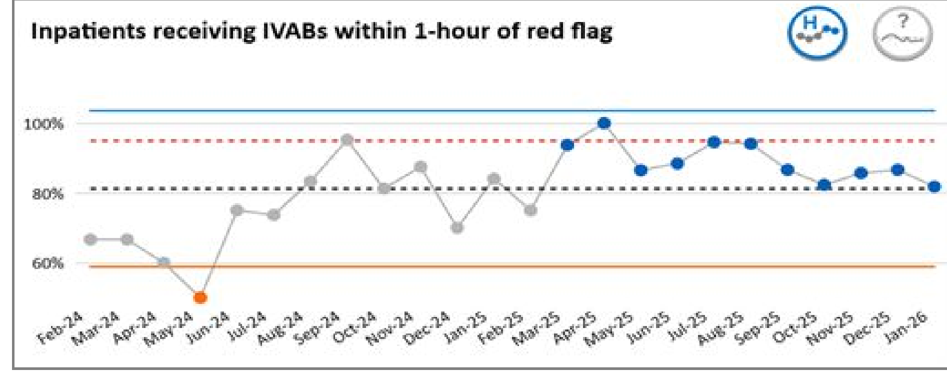
Number of hospital-acquired E.coli BSI incidences

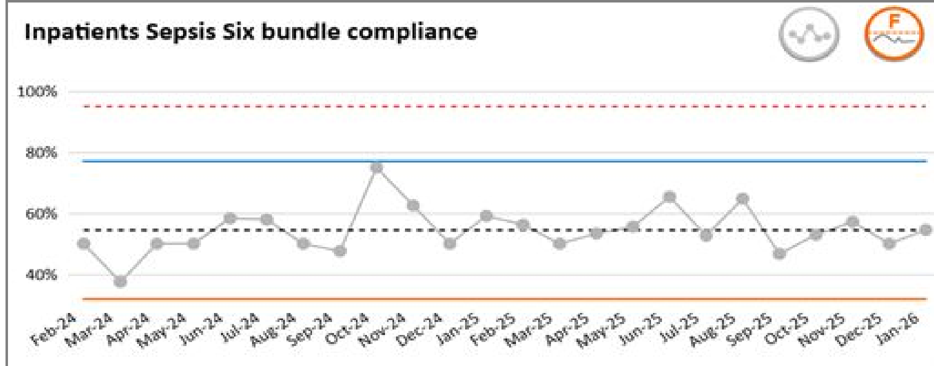
- MRSA BSI - There were two MRSA Bloodstream Infections (BSI) in Jan.'26. Year-to-date (YTD) total is four. Early learning from the first case showed a missed opportunity to screen on admission and identify a recent history of MRSA colonisation. There is ongoing work and a renewed focus on both MRSA and CPE admission screening. The second case involved a vulnerable infant transferred from tertiary care to ENHTT for palliative care. The central line had previously been colonised, but it was determined by the clinical team that the line could not be removed as it served as a vital lifeline. The source of risk remained in place, leading to a subsequent episode of bacteraemia.
- MSSA BSI - In Jan. '26, there were four cases of MSSA BSI. YTD total is 24 cases. There is no threshold.
- *C. difficile (C diff.)* infection (CDI) - seven CDI cases were reported in Jan. '26. The YTD total stands at 57 cases, compared to a total of 71 in the same period in the last financial year (FY) '24/25. The Trust continues to hold once weekly *Cdiff* Multi-Disciplinary Team (MDT) meeting , and insights from each meeting are consistently shared with all the divisions.
- *E.coli* BSI - In Jan.'26, there were two reported cases of E. coli BSI, four cases fewer than last month. The YTD total stands at 48 cases.

Month 10 | 2025-26

Quality

Sepsis Screening and Management | Inpatients





Themes

Sepsis IP	2024-25		2025-26									
	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
Oxygen	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Blood cultures	73%	73%	92%	81%	86%	94%	94%	73%	81%	92%	57%	91%
IV antibiotics	75%	94%	100%	88%	87%	94%	94%	87%	82%	86%	86%	82%
IV fluids	86%	79%	89%	100%	89%	93%	92%	100%	82%	92%	100%	88%
Lactate	73%	81%	57%	81%	73%	71%	76%	50%	81%	64%	71%	82%
Urine measure	81%	88%	93%	89%	93%	68%	88%	80%	82%	93%	75%	73%

Key Issues and Executive Response

Themes

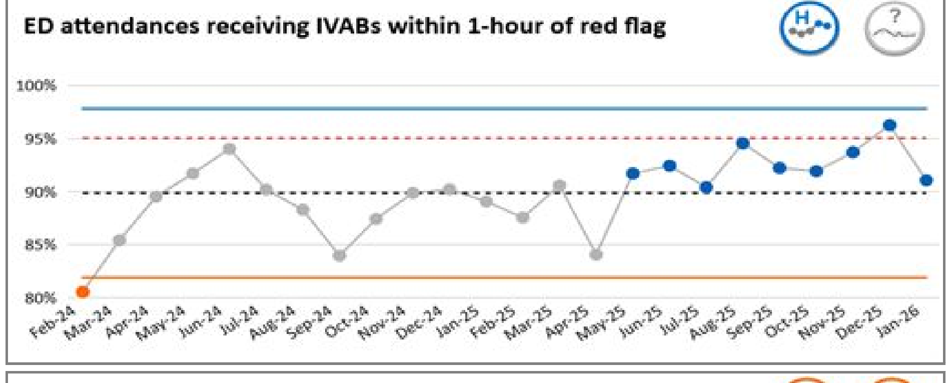
- 6/11 patient audits demonstrated sepsis six compliance, achieving 6/6 elements within the hour.
- IV antibiotic compliance shows normal variation, sitting at 82% in January.
- A slight improvement is noted in lactate measurement compliance, which jumped from 71% to 82% in January.
- Urine output measurement shows normal variation and remains an area for improvement.
- Blood culture compliance has significantly improved, with a rise in compliance from 57% in December, to 91% in January.
- IV fluid administration compliance has dropped from 100% down to 88%; this is the result of one single patient receiving IV fluids 26 minutes outside of the golden hour.

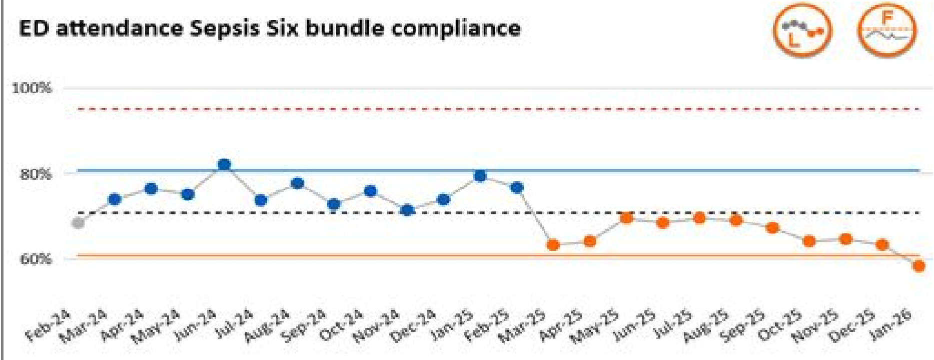
Response

- All delays have been ENHanced and sent to relevant teams and ward managers to investigate as appropriate. This includes the single case of delayed IV fluids too.
- 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 Sepsis Team continue to promote fluid balance in ward areas.
- The team are utilising formal and bedside education, alongside working with practice educators to push for sustainability in compliance.
- Sepsis simulation delivered in January and ALERT course (sepsis teaching) being delivered in February to nursing staff from across clinical areas.

Quality

Sepsis Screening and Management | Emergency Department





Themes

Sepsis ED	2024-25		2025-26									
	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
Oxygen	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Blood cultures	94%	96%	88%	96%	92%	96%	95%	92%	97%	94%	95%	96%
IV antibiotics	88%	91%	84%	92%	92%	90%	95%	92%	92%	94%	96%	91%
IV fluids	93%	90%	89%	91%	99%	93%	94%	93%	94%	98%	100%	97%
Lactate	95%	97%	96%	99%	99%	100%	97%	100%	99%	97%	100%	99%
Urine measure	81%	68%	73%	75%	77%	73%	73%	70%	68%	66%	67%	62%

Key Issues and Executive Response

Themes

- 46/79 ED patient audits demonstrated sepsis compliance, with 58% having all six elements completed within an hour in January.
- Urine output measurement shows normal variation at 62% compliance and remains an area of improvement.
- Lactate and blood culture collection have maintained compliance and remain above target.
- IV antibiotic compliance sits at 91% with 71/78 patients receiving antibiotics within 1 hour.
- IV fluid administration compliance remains above target at 97%.
- Oxygen administration remains above target at 100%.

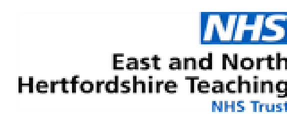
Response

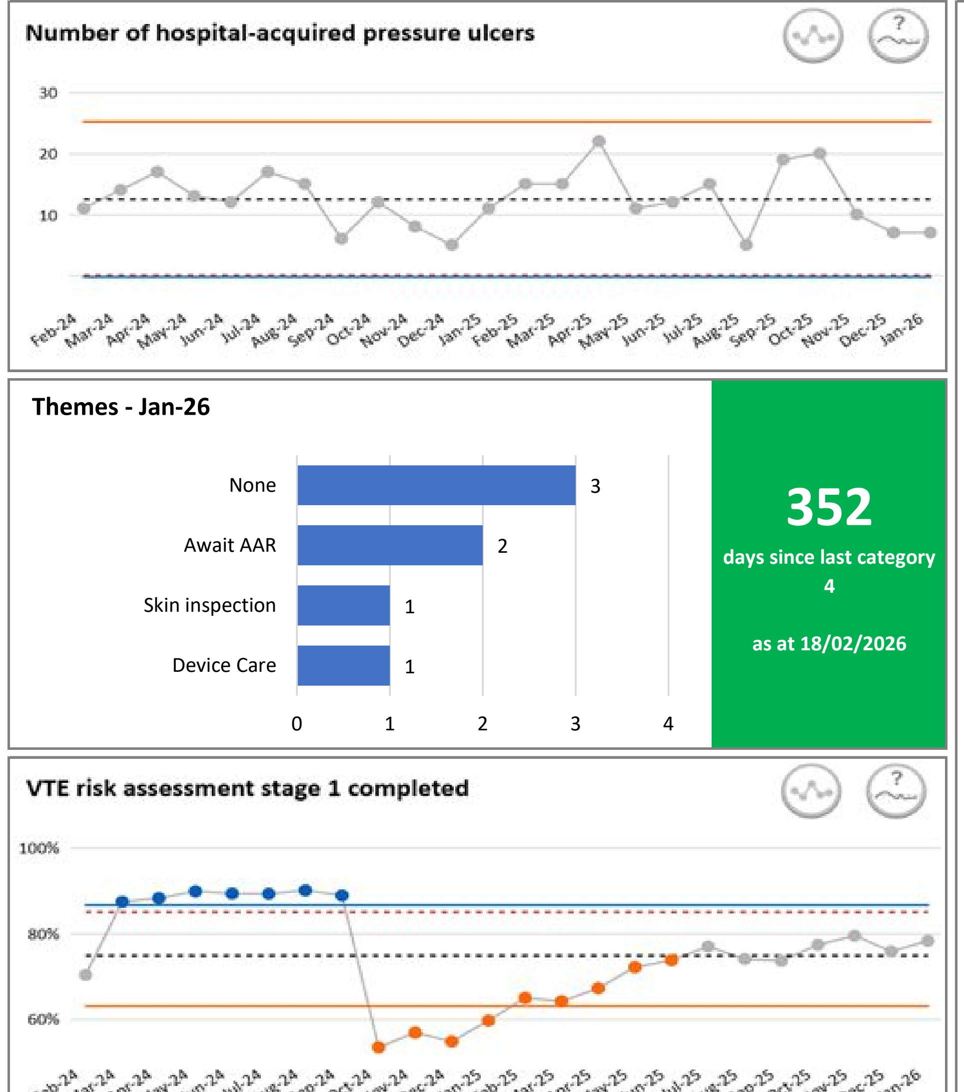
- The Sepsis Team continue to attend patients in ED and going through the Sepsis Screening Tool in real time. ENHance reports are submitted to ED matrons for non-compliance to be reviewed. Meeting held with ED matron to discuss improvement strategies for urine output measurement which is the main area for improvement in ED. ED will plan to order more digital devices and promote fluid balance in the department.
- Poster flow charts surrounding IV fluid administration and fluid balance monitoring in sepsis management have been produced and disseminated around the department.
- The team are working with the practice development team to focus on sustaining good sepsis compliance.
- Opportunities for MDT teaching made available via Academy with some uptake from ED staff, and some ED staff also attended the sepsis simulation study day in January.

Month 10 | 2025-26

Quality

Pressure Ulcers | VTE





Key Issues and Executive Response

Pressure Ulcers

- A steady decline in HA PU figures is noted from Oct 2025.
- From end of August 2025, selected wards have submitted data for pressure ulcer audits, focusing on NICE CG179 and NICE QS89. Results have identified learning gaps which link nurses providing peer education. The audit will run up to end of March 2026.
- 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.

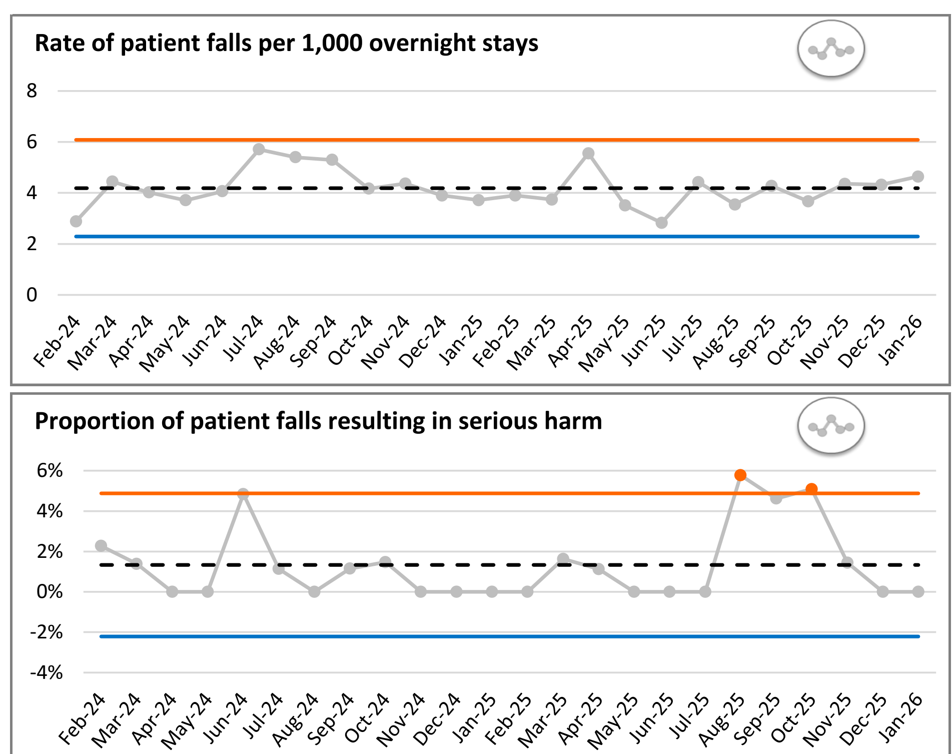
VTE

- In October 2024, the Trust adopted a 14-hour timeframe for the completion of VTE risk assessments, in accordance with NHSE requirements. This change resulted in an anticipated reduction in reported compliance due to the application of more stringent reporting parameters.
- The decline in compliance with VTE risk-assessment completion observed from July 2025 is likely attributable to industrial strike action occurring toward the end of July, compounded by the significant influx of new staff across the Trust during August.
- A further reduction in compliance is noted in December 2025, coinciding with an additional period of industrial action.

Month 10 | 2025-26

Quality

Patient Falls



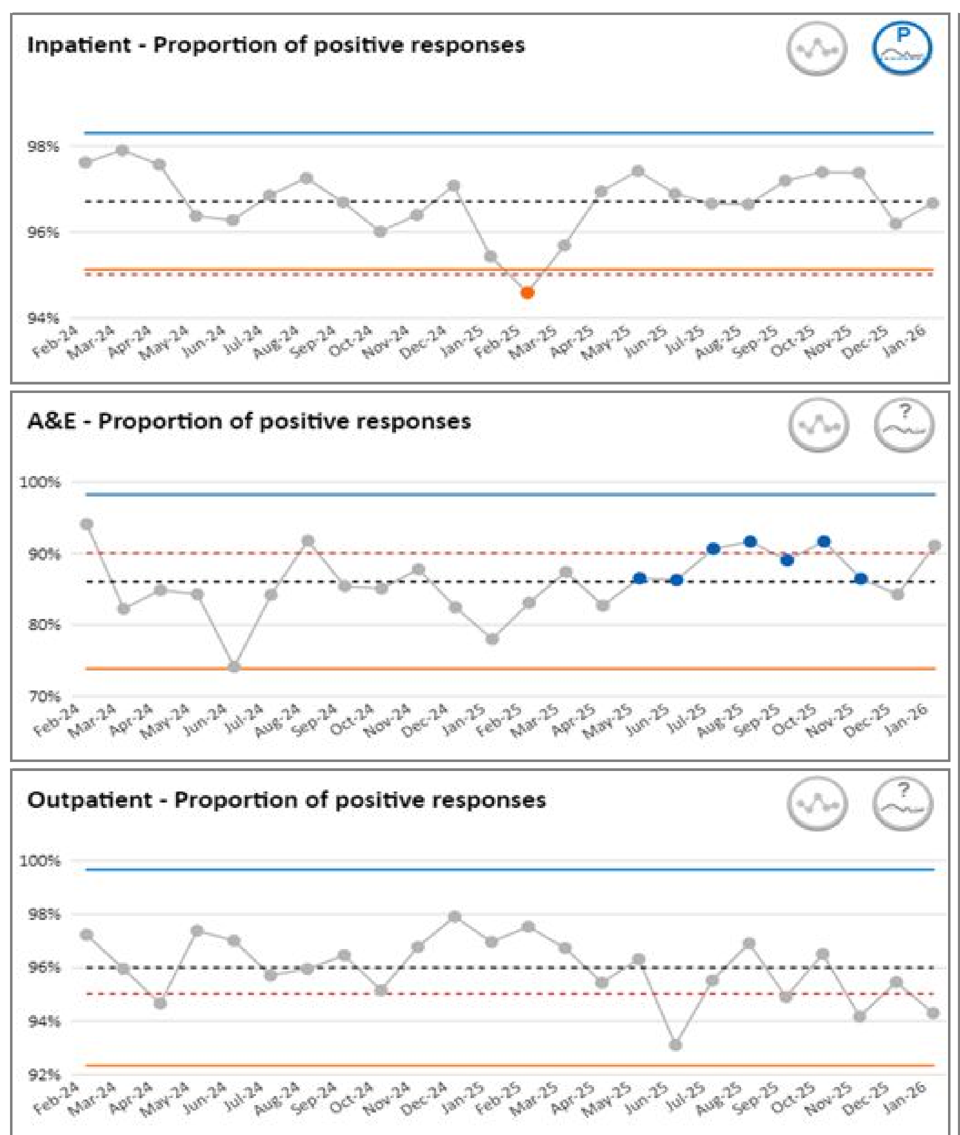
Key Issues and Executive Response

- Inpatient falls data continues to show common cause variation, with an average of 4 per month per 1000 bed days.
- 3 falls with moderate or serious harm recorded for the month of January. (1) Patient had unwitnessed fall and sustained fracture dislocation of left shoulder. Falls risk and post fall assessment were updated at the time of incident. This incident will be presented at the divisional incident review panel on 13 February and learnings identified will be shared across division. (2) Patient had unwitnessed fall in ED and sustained subdural haemorrhage. Latest CT head states resolution of subdural haemorrhage. No evidence of falls risk assessment in ED completed nor post fall assessment following the fall. The incident will be presented in the divisional incident safety huddle where gaps in falls documentation will be discussed and learnings to be shared. (3) Patient fell off the hospital wheel chair on the way to x-ray dept. following assessment in UTC. Patient sustained right hip fracture. Falls risk assessment had not been completed at this point in time. Patient was admitted to orthopaedic ward and was discharged a week later after the incident.

Month 10 | 2025-26

Quality

Friends and Family Test



Key Issues and Executive Response

Friends and Family Test

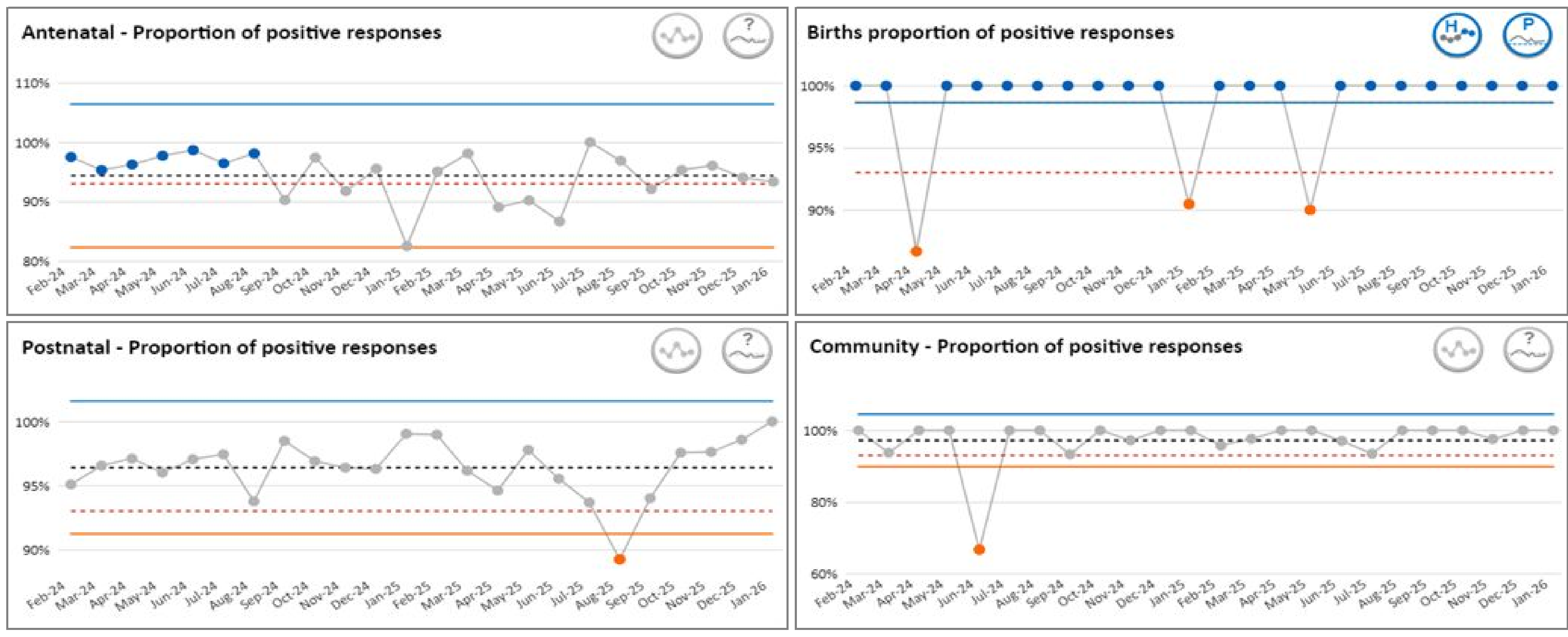
- There was a slight decrease again this month for number of responses received across the Trust for January compared to the previous month. Whilst the overall Trust score remained almost the same for % good/very good at 95.23% (95.22% Dec), the % poor/very poor increased slightly at 1.62% (1.43% Dec).
- The number of discharges for inpatient/Day Case increased although the overall response rate decreased to 17.32% (19.79% Dec). The score for % very good/good had a minimal increase.
- ED-UCC saw a recovery in the proportion of positive responses received compared to the previous two months, together with an increase in the response rate 0.53% (0.44% Dec). The score for % very good/good increased to 91.03% (84.17% Dec), and the % poor/very poor decreased to 6.90% compared to 9.17% (Dec).
- The number of responses for both antenatal and postnatal were about half from the previous month. Although the proportion of positive responses for the postnatal element improved to 100% (98.57% Dec), the antenatal service decreased slightly to 93.33% (94.03% Dec) and % poor/very poor increased to 3.33% (1.49% Dec). Community midwifery was consistent with 100% of positive responses again this month.
- Unplanned care division exploring how to ensure elderly patients are also able to feedback during there stay as there have been a decrease on certain wards due to this.
- Postnatal feedback showed themes of feeding information issues, tongue-tie delays and ward environment and noise levels which are being addressed within the Woman and Children's division currently.

Month 10 | 2025-26

Quality

Friends and Family Test

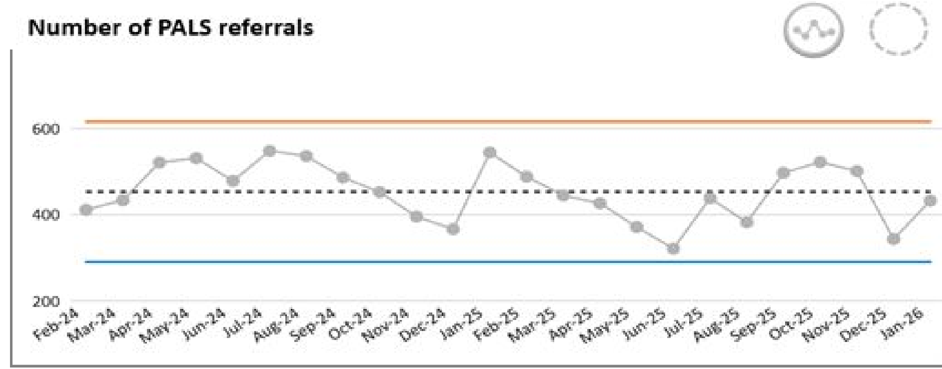
East and North Hertfordshire Teaching NHS Trust

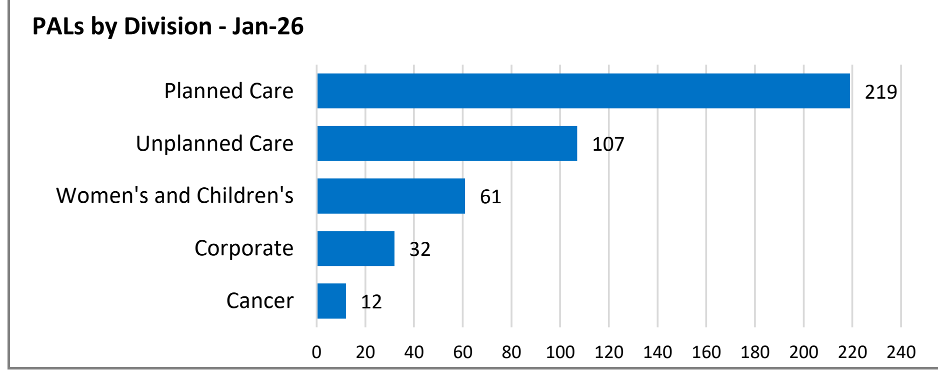


Month 10 | 2025-26

Quality

Patient Advice and Liaison Service

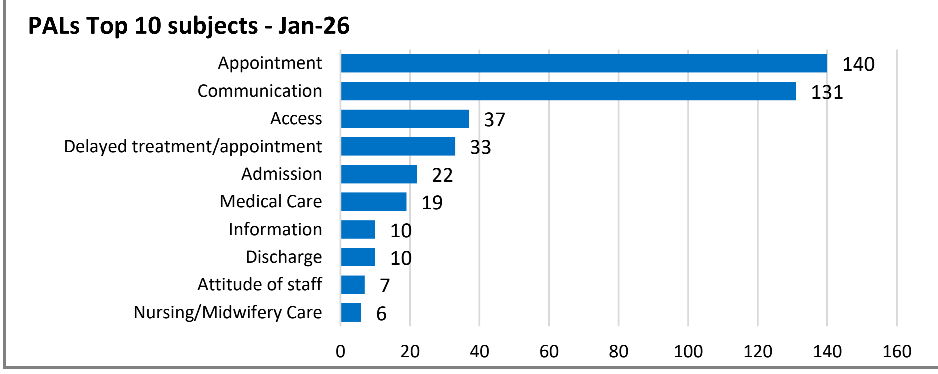


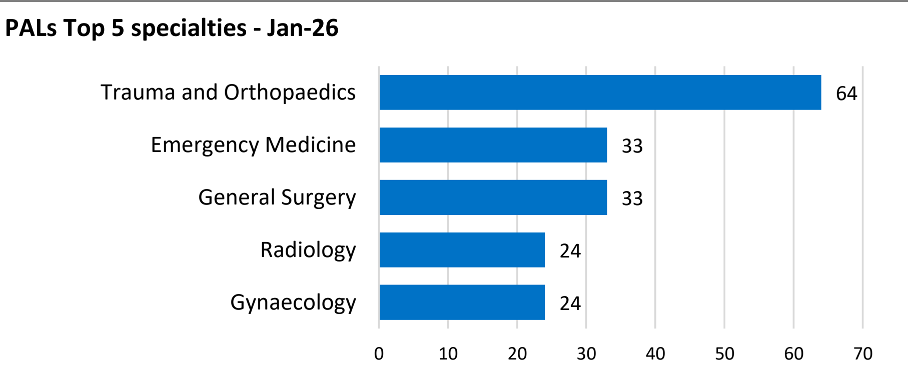


Key Issues and Executive Response

Patient Advice Liaison Service

- The category appointments received the highest amount of PALS . On further review the themes are - delay in appointment, cancelled appointments without getting a new appointment and multiple cancellations of appointments.
- Trauma and Orthopaedics concerns relate to: waiting list times, delay in appointments, cancellation of appointments. Action: T&O have added an out of office to advise patients they will return a call within 3-5 days.
- An increase in PALS in January - in line with the previous years drop in December and large increase in January.
- Continued improvements with PALS response timeframes for non-urgent enquiries
- Weekly escalations of overdue PALS are now being sent to the HoN's to ensure timely responses.





Month 10 | 2025-26

Quality

Complaints

Number of written complaints received

Number of complaints closed in-month

Key Issues and Executive Response

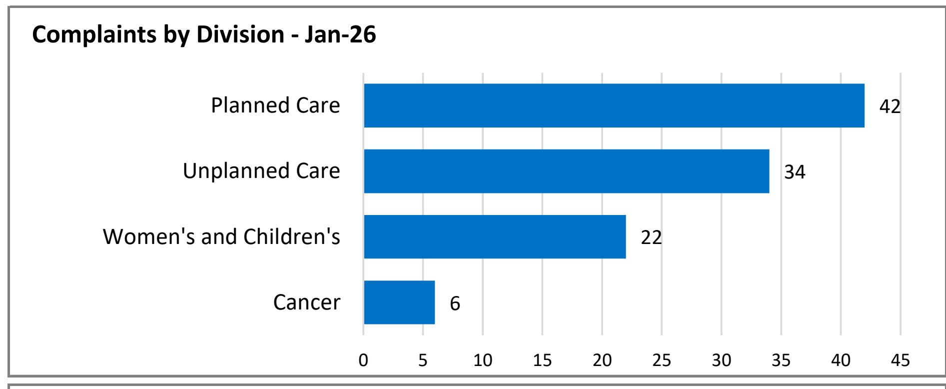
- A significant increase in the amount of complaints closed within January from additional drafting support. A very positive outcome.
- Acknowledgments also increasing within the timeframe due to the decrease in open complaints from October 2025.
- Continued phone calls from Senior Leads within the divisions to provide early resolution to complaints, such as appointments and inpatient care well have been received by complainants.
- A 6 month trial within Unplanned Care of a new complaints processes has started January 2026, this is being closely monitored and regular updates provided to PACE.
- Continued work within the team on responding within allocated timeframe and ensuring acknowledgments are completed in time.

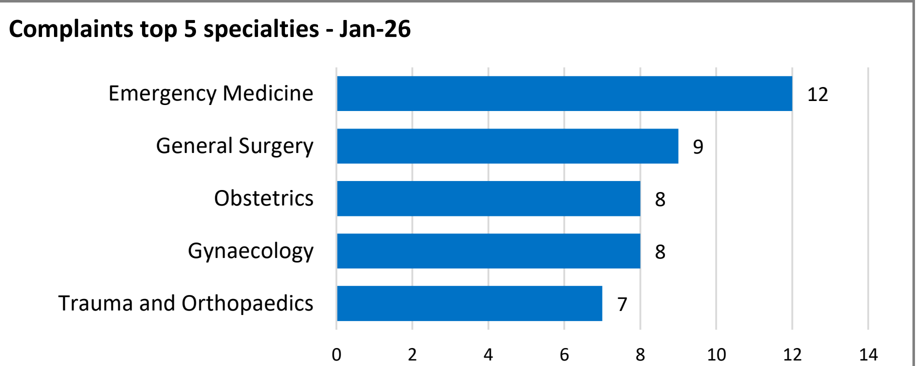
Proportion of complaints acknowledged within three working day

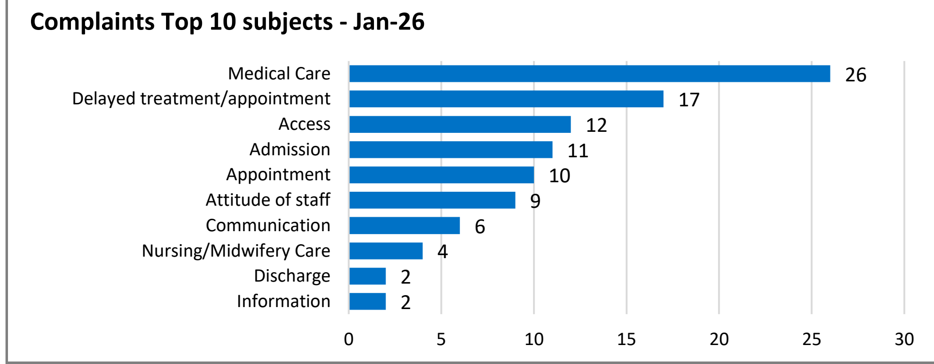
Proportion of complaints responded to within agreed timeframe

Month 10 | 2025-26

Quality
Complaints Themes







Month 10 | 2025-26

Operations
Stroke Services

4-hours direct to stroke unit from ED

At least 90% of patients stay is spent on a stroke unit

Key Issues and Executive Response

- **Thrombolysis/Thrombectomy -** Door to needle time increased to 1 hr from 44 mins in previous month. 18.2% of patients receiving thrombolysis against bespoke 14% target. CTP now live with increase month on month across October-Dec. Thrombectomy at 6.8% with 10% target - (16 referred, 7 sent, 5 performed).
- **4 hr performance 50.6%** for confirmed strokes. On trajectory to meet 60% by end of March 2026. Median time decreased to 4hr8. SPC chart displays significant upward trend. Influencing factors; SOP, SPR 7/7 2200 working, CTP, ward & CNS processes, weekly breach meetings/validation from data & clinical perspective.
- **Length of stay:** 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:** Significant improvement to 35.2% (national target of 40%). Implementation of Stroke Video Triage will improve rapid diagnosis with go live in house est. Feb 2026.
- **TIA performance**: 24hr standard at 1.5 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. Slight delay due to strikes/sickness over Dec.

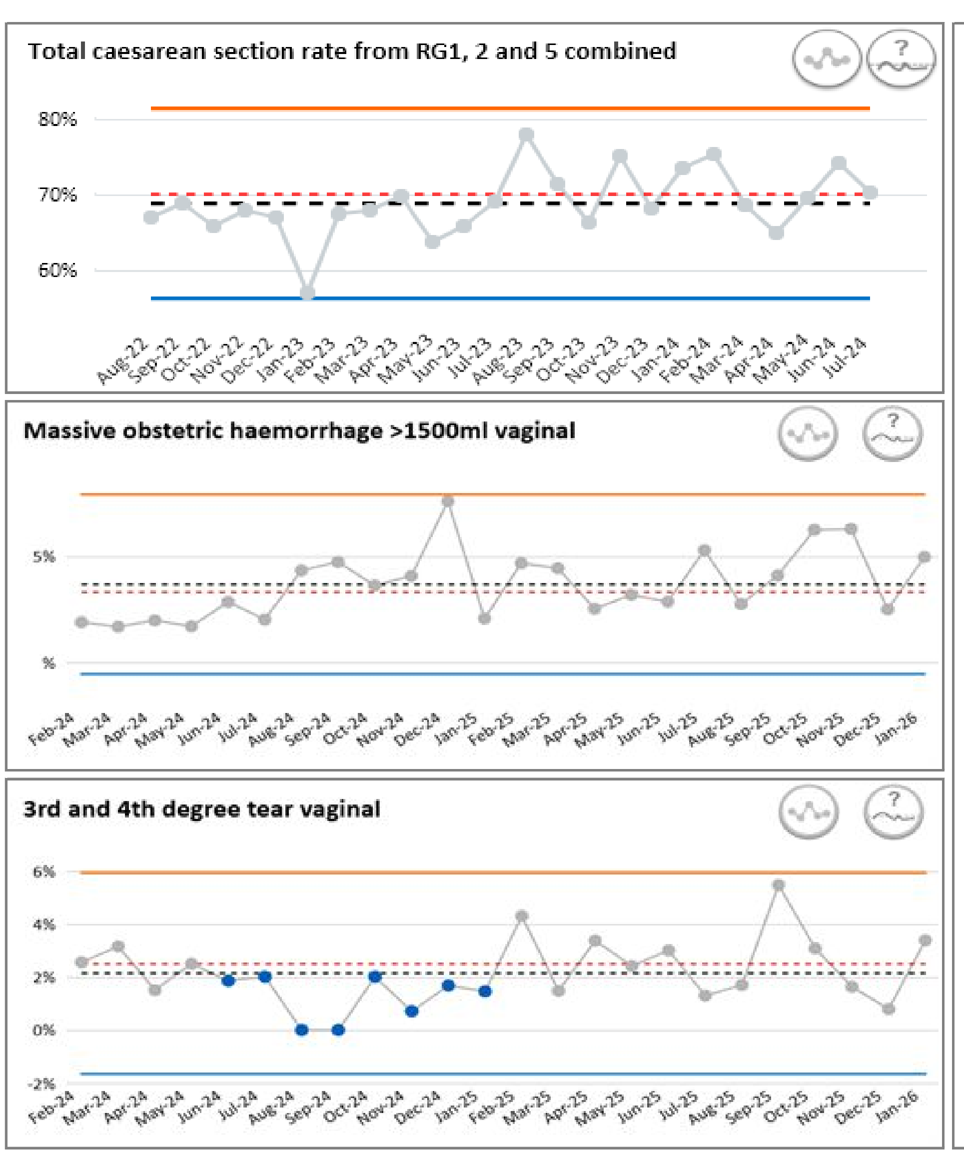
Urgent brain imaging within 60-mins for suspected acute stroke

Proportion of all stroke patients who receive thrombolysis

Month 10 | 2025-26

Quality

Maternity | Safety Metrics



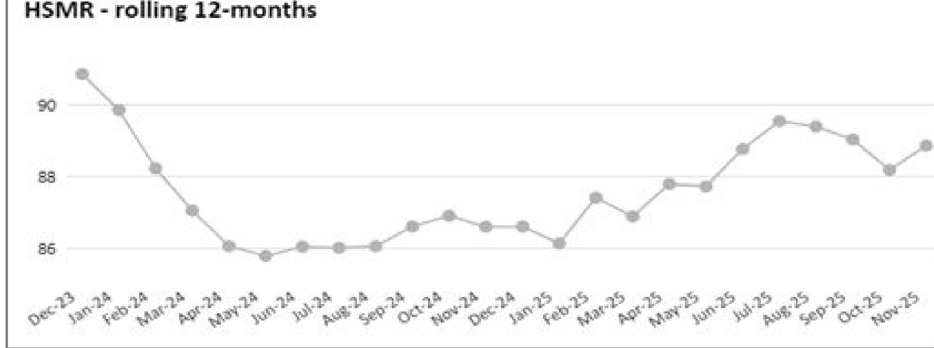
Key issues and executive response

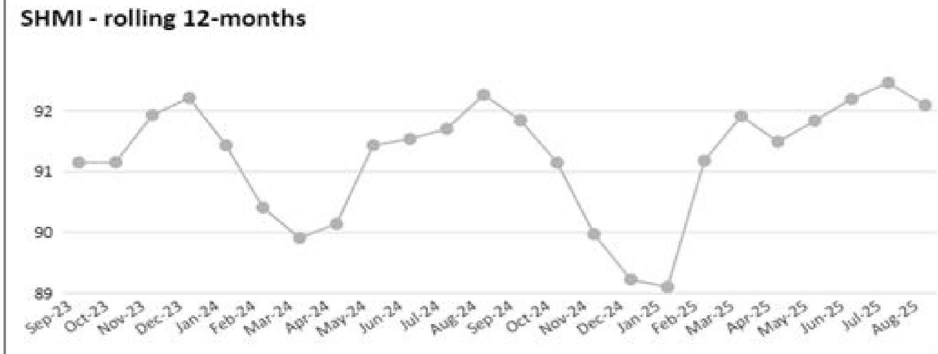
- There were two cases accepted for investigation by MNSI, qualifying as a PSII (1. admission at 41/40 with reduced foetal movements, cat 2 LSCS, poor apgars, seizures, hypoglycaemic encephalopathy , 2. IOL for LGA & PIH, septic screen, poor CTG, sequential instruments, shoulder dystocia, transfer out for therapeutic cooling). All cases presented to PSERP. Awaiting MNSI ToR for January 2026 cases. Four cases referred in six months, prompting local review for themes.
- There were three cases of moderate physical harm (2% of 216 incidents reported), consistent with previous months. Two MNSI cases. One EMLSCS for chorioamniotis, difficult IV access, main theatres in attendance, transverse/breech lie, challenging delivery, fractured neonatal femur and admission to NICU).
- There were no cases of stillbirth and one case of neonatal deaths >20/40. No cases of maternal death.
- Rates of 3rd/4th degree perineal trauma at instrumental births were significantly reduced from previous months (9.68% Nov 2025, 3.23% Dec 2025, 2.33% Jan 2026). Perineal trauma at vaginal births had increased (up from 0.79% Dec 2025 to 3.39% Jan 2026) but both were within process limits.
- MOH >1500mls had increased at vaginal births (8 cases, 4.97%) but remained a consistent rate at caesarean section births (4 cases, 2.68%). MOH >1500mls overall was 2.27% and >2000mls was 0.65%, both well within process limits. The NHSE maternal care bundle launch looks to support QI work in relation to MOH due to high incidence nationally. Due for full implementation by March 2027.
- Total LSCS= 171 (50.00%), Total Cat 1-3 (Emergency) = 95 (27.78%), Total Cat 4 (Elective) = 76 (22.22%) reflective of an increasing LSCS birth rate nationally. Emergency rate may be reported higher than actual as elective cases moved to cat 3 lists due to capacity. Robson Group Criteria RC1 = 20.0%, RC2 = 57.61%, RC5 = 86.27%.

Month 10 | 2025-26

Quality

Mortality



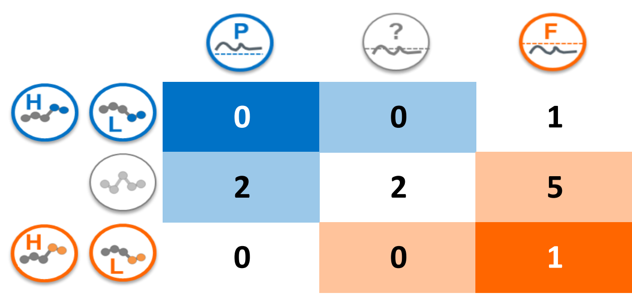


Key Issues and Executive Response

- 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 had then been on an upward trend since January 2025
- The latest rolling 12-month HSMR to Nov-25, reported by CHKS, stands at 88.2. This positions us in the mid-range of trusts nationally.
- Since the Jul-25 spike in in-month HSMR of 108.67, levels have reduced. The latest in-month figure for November stands at 91.9.
- Latest NHSD published rolling 12-month SHMI available to August 2025, stands at 92.38 a marginal increase from the last month's 92.09. This positions in the first quartile of trusts nationally and within the 'as expected' band 2.
- While we remain well positioned vs other acute trusts (21/118) over the last 12 months there has been a slight downward shift (best position 18/118).
- The latest figures provided by CHKS for Aug-25 are 83.3 in-month and 92.1 for rolling 12-month. CHKS has reported that the recent increases have been largely driven by increases to out-of-hospital SHMI deaths rather than in-hospital deaths.

NHS
East and North
Hertfordshire Teaching
NHS Trust

Operations
Month 10 | 2025-26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Urgent and Emergency Care
Summary

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Emergency Department	Patients waiting no more than four hours from arrival to admission, transfer or discharge	Jan-26	95%	68.6%		F	Common cause variation Metric will consistently fail the target
	Patients waiting more than 12 hours from arrival to admission, transfer or discharge	Jan-26	5%	16.4%		F	Common cause variation Metric will consistently fail the target
	Percentage of ambulance handovers within 15-minutes	Jan-26	65%	14.9%		F	Common cause variation Metric will consistently fail the target
	Time to initial assessment - percentage within 15-minutes	Jan-26	80%	48.6%		F	Common cause variation Metric will consistently fail the target
	Average (mean) time in department - non-admitted patients	Jan-26	240	209		P	Common cause variation Metric will consistently pass the target
	Average (mean) time in department - admitted patients	Jan-26	tbc	710			Common cause variation No Target
	Average minutes from clinically ready to proceed to departure	Jan-26	tbc	191	L		8 points below the mean No target
RTT & Diagnostics	Patients on incomplete pathways waiting no more than 18 weeks from referral	Jan-26	92%	67.0%	H	F	4 points above the upper process limit Metric will consistently fail the target
	Patients waiting more than six weeks for diagnostics	Jan-26	0%	51.5%		F	Common cause variation Metric will consistently fail the target

Month 10 | 2025-26

Urgent and Emergency Care

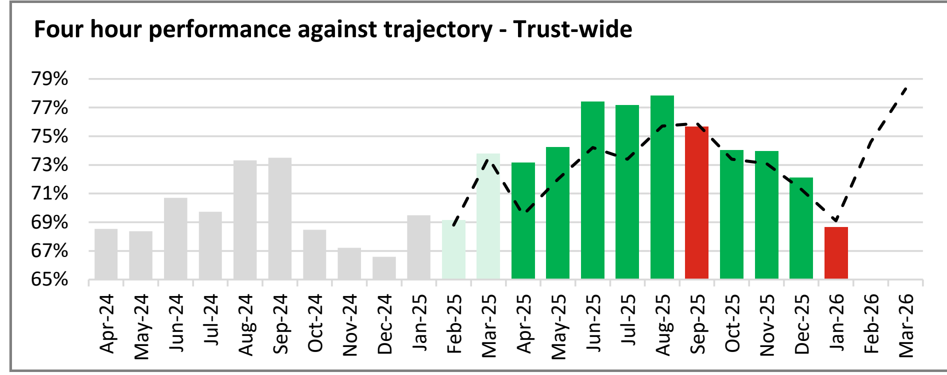
Summary

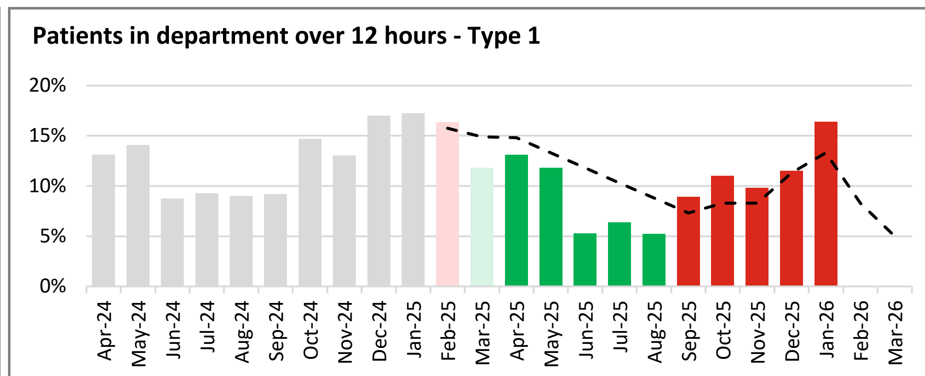
Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Cancer Waiting Times	62-day referral to treatment standard	Dec-25	85%	86.4%		P	Common cause variation Metric will consistently pass the target
	31-day decision to treat to treatment standard	Dec-25	96%	97.8%		?	Common cause variation Metric will inconsistently pass and fail the target
	28-day Faster Diagnosis standard	Dec-25	75%	77.7%		?	Common cause variation Metric will inconsistently pass and fail the target
	Proportion of cancer PTL waiting more than 62 days	Jan-26	7%	18.9%	H	F	7 points above the mean Metric will consistently fail the target

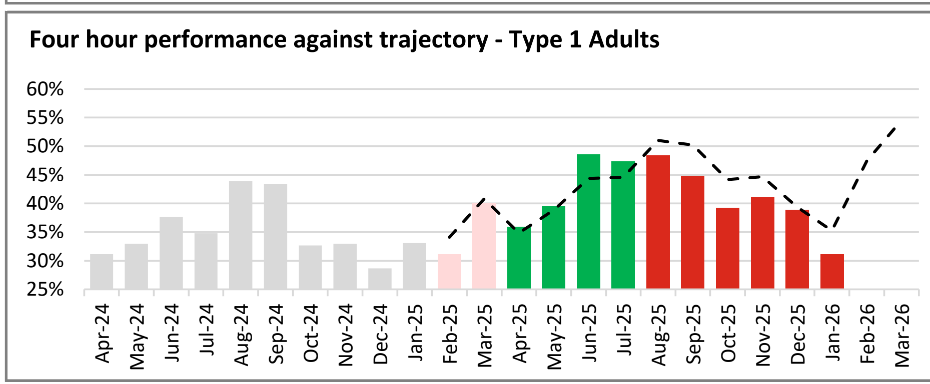
Month 10 | 2025-26

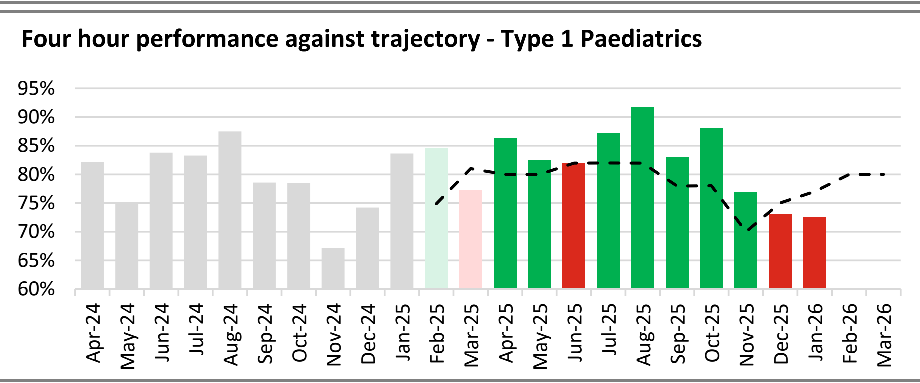
Urgent Emergency Care

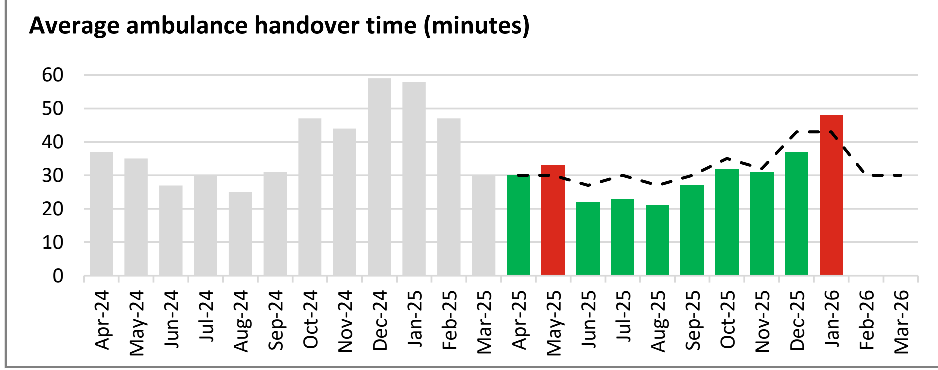
Trajectory Monitoring 2025-26











Month 10 | 2025-26

Cancer Waiting Times | RTT 18 weeks

Trajectory Monitoring 2025-26

Incomplete pathways within 18 weeks | 65% trajectory

70%
65%
60%
55%
50%

Apr-24 May-24 Jun-24 Jul-24 Aug-24 Sep-24 Oct-24 Nov-24 Dec-24 Jan-25 Feb-25 Mar-25 Apr-25 May-25 Jun-25 Jul-25 Aug-25 Sep-25 Oct-25 Nov-25 Dec-25 Jan-26 Feb-26 Mar-26

First appointments within 18 weeks | 72% trajectory

80%
75%
70%
65%
60%

Apr-24 May-24 Jun-24 Jul-24 Aug-24 Sep-24 Oct-24 Nov-24 Dec-24 Jan-25 Feb-25 Mar-25 Apr-25 May-25 Jun-25 Jul-25 Aug-25 Sep-25 Oct-25 Nov-25 Dec-25 Jan-26 Feb-26 Mar-26

Incomplete pathways over 52 weeks | 1% trajectory

5%
4%
3%
2%
1%
0%

Apr-24 May-24 Jun-24 Jul-24 Aug-24 Sep-24 Oct-24 Nov-24 Dec-24 Jan-25 Feb-25 Mar-25 Apr-25 May-25 Jun-25 Jul-25 Aug-25 Sep-25 Oct-25 Nov-25 Dec-25 Jan-26 Feb-26 Mar-26

Cancer Waiting Times | 28-day Faster Diagnosis

82%
80%
78%
76%
74%
72%
70%
68%
66%

Apr-24 May-24 Jun-24 Jul-24 Aug-24 Sep-24 Oct-24 Nov-24 Dec-24 Jan-25 Feb-25 Mar-25 Apr-25 May-25 Jun-25 Jul-25 Aug-25 Sep-25 Oct-25 Nov-25 Dec-25 Jan-26 Feb-26 Mar-26

Cancer Waiting Times | 31-day standard

99%
98%
97%
96%
95%
94%

Apr-24 May-24 Jun-24 Jul-24 Aug-24 Sep-24 Oct-24 Nov-24 Dec-24 Jan-25 Feb-25 Mar-25 Apr-25 May-25 Jun-25 Jul-25 Aug-25 Sep-25 Oct-25 Nov-25 Dec-25 Jan-26 Feb-26 Mar-26

Cancer Waiting Times | 62-day standard

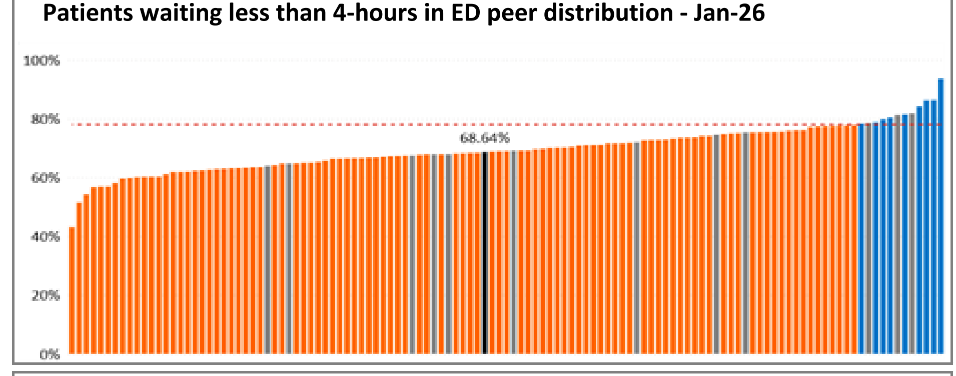
90%
88%
86%
84%
82%
80%
78%
76%
74%

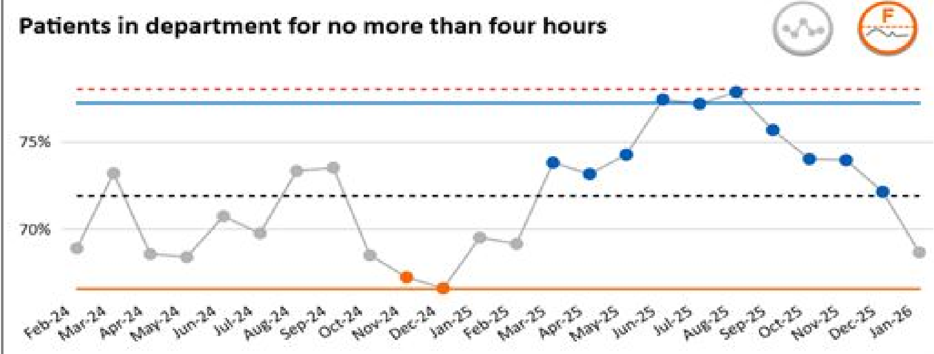
Apr-24 May-24 Jun-24 Jul-24 Aug-24 Sep-24 Oct-24 Nov-24 Dec-24 Jan-25 Feb-25 Mar-25 Apr-25 May-25 Jun-25 Jul-25 Aug-25 Sep-25 Oct-25 Nov-25 Dec-25 Jan-26 Feb-26 Mar-26

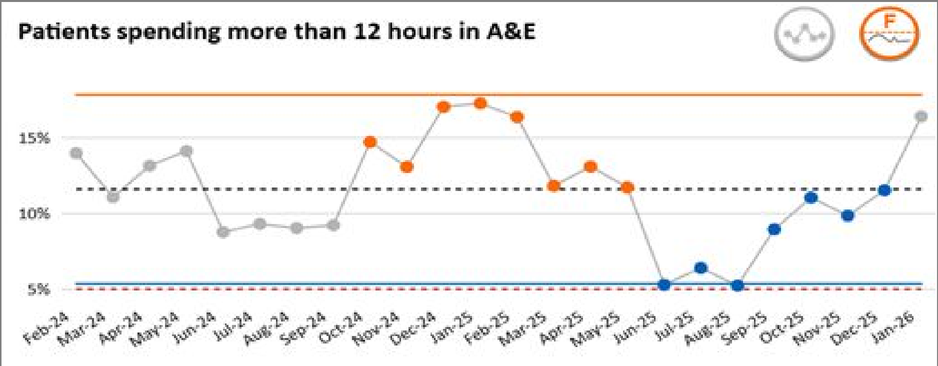
Month 10 | 2025-26

Operations

Urgent and Emergency Care New Standards

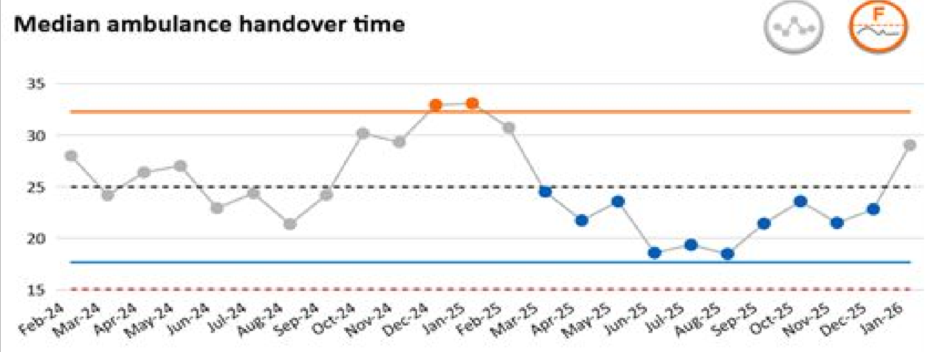






Key Issues and Executive Response

- Jan-26: highest ever UEC attendances - 13% higher than Jan-25, with T1 paeds 26% up, T1 adults 6% up and adults overall 11% up (+1372).
- Admitted performance impacted by the 5 beds closed due to SSU estates work and, on average, 13 beds were closed each day due to IPC vs 6 per day in Jan-25.
- We are initiating a UEC Improvement sprint from 1st March focusing on streaming, SDEC and SAU flow and workforce reconfiguration. Beneficial learning visit to West Herts by COO, CMO, UPC Medical and Nursing Directors on 10 Feb.
- 4-hour performance was 68.64%, slightly below trajectory of 69.1% following a challenging month in terms of demand & flow across all types of UEC.
- Adult T1 non-admitted performance was 39%, down from 46% in Dec. Adult T1 admitted performance was 10%, down from 19% in Dec.
- ED 12-hour waits stood at 16.4% vs a trajectory of 13.3%, reflecting an increase in time from DTA to admission by 69 minutes.
- Although mean ambulance handover times increased to 48 mins, ambulance handover performance improved by 10 mins vs Jan 25.
- EEAST Rapid release protocol implemented for offloads over 30 mins has seen daily overcrowding and corridor care within ED.



Month 10 | 2025-26

Operations

Urgent and Emergency Care | Supporting Metrics

Percentage of ambulance handovers within 15 minutes

30%
20%
10%

Feb-24 Mar-24 Apr-24 May-24 Jun-24 Jul-24 Aug-24 Sep-24 Oct-24 Nov-24 Dec-24 Jan-25 Feb-25 Mar-25 Apr-25 May-25 Jun-25 Jul-25 Aug-25 Sep-25 Oct-25 Nov-25 Dec-25 Jan-26

Percentage of ambulance handovers within 30 minutes

80%
60%
40%

Feb-24 Mar-24 Apr-24 May-24 Jun-24 Jul-24 Aug-24 Sep-24 Oct-24 Nov-24 Dec-24 Jan-25 Feb-25 Mar-25 Apr-25 May-25 Jun-25 Jul-25 Aug-25 Sep-25 Oct-25 Nov-25 Dec-25 Jan-26

Average acuity

2.8
2.7
2.6

Feb-24 Mar-24 Apr-24 May-24 Jun-24 Jul-24 Aug-24 Sep-24 Oct-24 Nov-24 Dec-24 Jan-25 Feb-25 Mar-25 Apr-25 May-25 Jun-25 Jul-25 Aug-25 Sep-25 Oct-25 Nov-25 Dec-25 Jan-26

Patients Not Meeting the Criteria to Reside

1,400
1,200
1,000

Feb-24 Mar-24 Apr-24 May-24 Jun-24 Jul-24 Aug-24 Sep-24 Oct-24 Nov-24 Dec-24 Jan-25 Feb-25 Mar-25 Apr-25 May-25 Jun-25 Jul-25 Aug-25 Sep-25 Oct-25 Nov-25 Dec-25 Jan-26

G&A bed occupancy

90%
85%

Feb-24 Mar-24 Apr-24 May-24 Jun-24 Jul-24 Aug-24 Sep-24 Oct-24 Nov-24 Dec-24 Jan-25 Feb-25 Mar-25 Apr-25 May-25 Jun-25 Jul-25 Aug-25 Sep-25 Oct-25 Nov-25 Dec-25 Jan-26

Total average G&A beds open

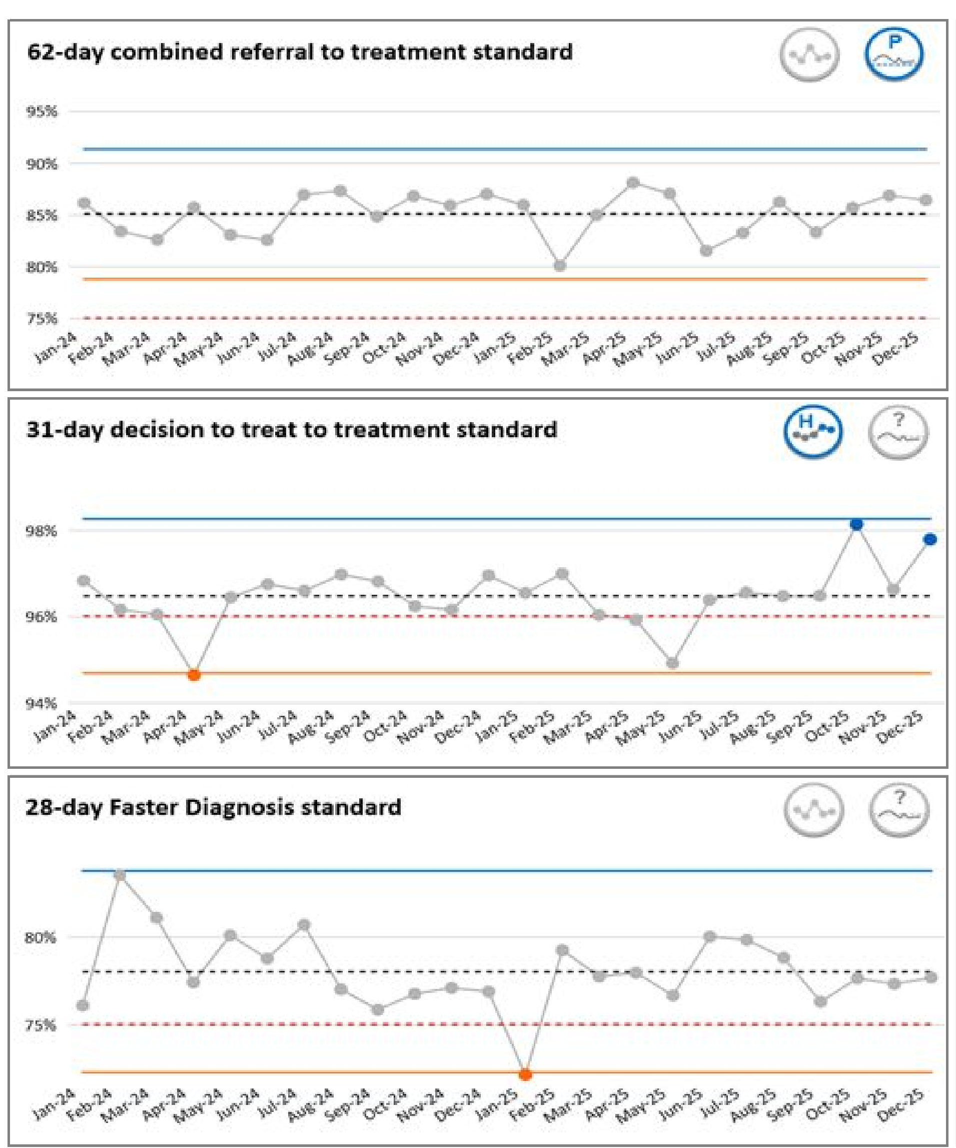
590
580
570

Feb-24 Mar-24 Apr-24 May-24 Jun-24 Jul-24 Aug-24 Sep-24 Oct-24 Nov-24 Dec-24 Jan-25 Feb-25 Mar-25 Apr-25 May-25 Jun-25 Jul-25 Aug-25 Sep-25 Oct-25 Nov-25 Dec-25 Jan-26

Month 10 | 2025-26

Operations

Cancer Waiting Times | Supporting Metrics



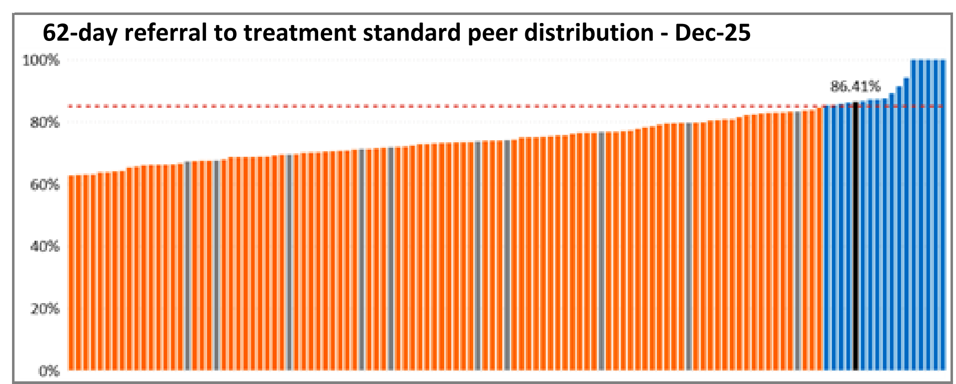
Key Issues and Executive Response

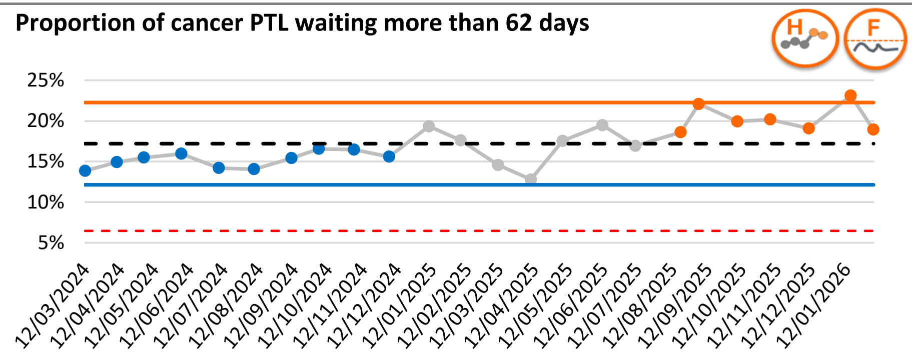
- We achieved 3 of the 3 national standards in December 25: 28 day Faster Diagnosis, 31 day decision to treat standards and 62 day referral to treatment general standard.
- The 62 day referral to treatment standard performance was 86.4% in December 25, YTD aggregate performance is 85.3%.
- The 62-day performance in December ranked 7th nationally out of 119 NHS providers. This exceeded both regional and national averages by approximately 20%, making us the top-performing hospital in the East of England region.
- The proportion of patients on the waitlist for over 62 days has started to improve compared to previous months and the operational teams are working to reduce it further.
- 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 10 | 2025-26

Operations

Cancer Waiting Times | Supporting Metrics



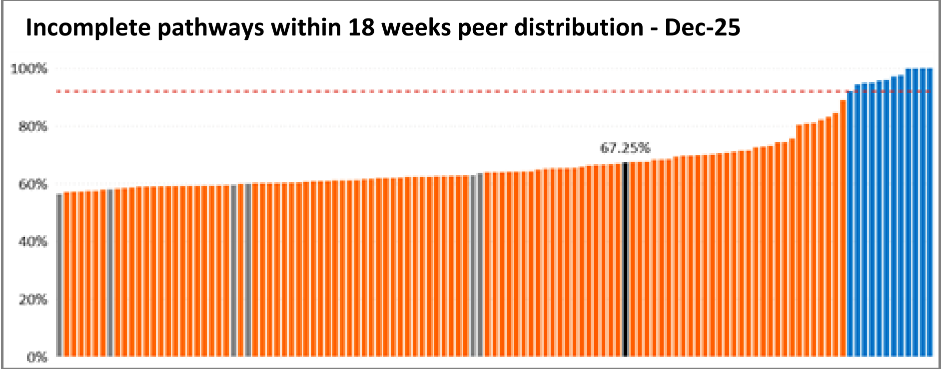


Month 10 | 2025-26

Operations

RTT 18 Weeks

Incomplete pathways within 18 weeks peer distribution - Dec-25



Key Issues and Executive Response

Community Paediatrics

- Community Paediatrics is now reported via the Community Data Set. Referrals stil exceed core capacity but are stabilising.
- Internal pathway improvements are starting to deliver additional capacity, with several 1-stop pathway pilots now underway at different stages of PDSA review. The service also secured additional Sprint funding for a further 300 ASD pathways to be outsourced to OWL before 31st March.
- Ongoing meetings with 3 COOs (ENHT, HPFT, HCT) from 20/10/2025 are driving 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 researched amongst the team, alongside improved signposting.
- **78 Weeks** - There were 3882 patients waiting over 78 weeks at the end of December, compared to 3,847 the previous month.
- **65 Weeks** - There were 4,336 Community Paediatric patients waiting over 65 weeks at the end of January.

Key Issues and Executive Response

Excluding community paediatrics

- **National Performance** ENHT is ranked 27 out of 134 Trusts for percentage of patients waiting within 18 weeks for elective treatment and 32 out of 134 Trusts for percentage of patients waiting more than 52 weeks for elective treatment.
- **Q4 sprint -** agreement with regional colleagues to take part in Q4 sprint to deliver 69% RTT by end of March. Focused around ENT, T&O, Oral and targeted validation.
- **18 Week Performance** - 67.2% of patients were waiting under 18 weeks in January, remaining ahead of the March 2026 5% improvement target of 64.2%.
- The Patient Treatment List (PTL) decreased by 501 patients.
- **52w proportion of PTL** - 475 patients / 0.9% waiting over 52 weeks in January, an improvement from last month and against the target of no more than 0.7% patients in March 2026. This remains ahead of trajectory.
- **Awaiting First Event < 18 weeks** - 72.1% of patients are waiting less than 18 weeks for their first activity, against the March 2026 improvement target of 72.2%. This reflects an improvement from last month's position of 70.8%. Targeted improvement work continues, with services below 72% reviewing processes, identifying additional capacity, and working to book patients in strict waiting-time order.
- **65 Weeks** - As of the end of January, 12 patients were waiting over 65 weeks: 8 in Trauma & Orthopaedics (T&O), and 3 in Oral Surgery and 1 in Ophthalmology. The breaches were due to clinical complexity, patient choice and patient fitness.

Month 10 | 2025-26

Operations

RTT 18 Weeks - excl. Community Paediatrics

Number of patients waiting over 65 weeks

400
200
0
Feb-24 Mar-24 Apr-24 May-24 Jun-24 Jul-24 Aug-24 Sep-24 Oct-24 Nov-24 Dec-24 Jan-25 Feb-25 Mar-25 Apr-25 May-25 Jun-25 Jul-25 Aug-25 Sep-25 Oct-25 Nov-25 Dec-25 Jan-26

Number of patients waiting over 52 weeks

3,000
2,000
1,000
0
Feb-24 Mar-24 Apr-24 May-24 Jun-24 Jul-24 Aug-24 Sep-24 Oct-24 Nov-24 Dec-24 Jan-25 Feb-25 Mar-25 Apr-25 May-25 Jun-25 Jul-25 Aug-25 Sep-25 Oct-25 Nov-25 Dec-25 Jan-26

Incomplete pathways within 18 weeks

65%
60%
55%
Feb-24 Mar-24 Apr-24 May-24 Jun-24 Jul-24 Aug-24 Sep-24 Oct-24 Nov-24 Dec-24 Jan-25 Feb-25 Mar-25 Apr-25 May-25 Jun-25 Jul-25 Aug-25 Sep-25 Oct-25 Nov-25 Dec-25 Jan-26

Total patients waiting at month-end

60,000
55,000
50,000
Feb-24 Mar-24 Apr-24 May-24 Jun-24 Jul-24 Aug-24 Sep-24 Oct-24 Nov-24 Dec-24 Jan-25 Feb-25 Mar-25 Apr-25 May-25 Jun-25 Jul-25 Aug-25 Sep-25 Oct-25 Nov-25 Dec-25 Jan-26

Month 10 | 2025-26

Operations

RTT 18 Weeks - Community Paediatrics ONLY

Number of patients waiting over 104 weeks | Community Paediat

Number of patients waiting over 78 weeks | Community Paediatri

Number of patients waiting over 65 weeks | Community Paediatri

Number of patients waiting over 52 weeks | Community Paediatri

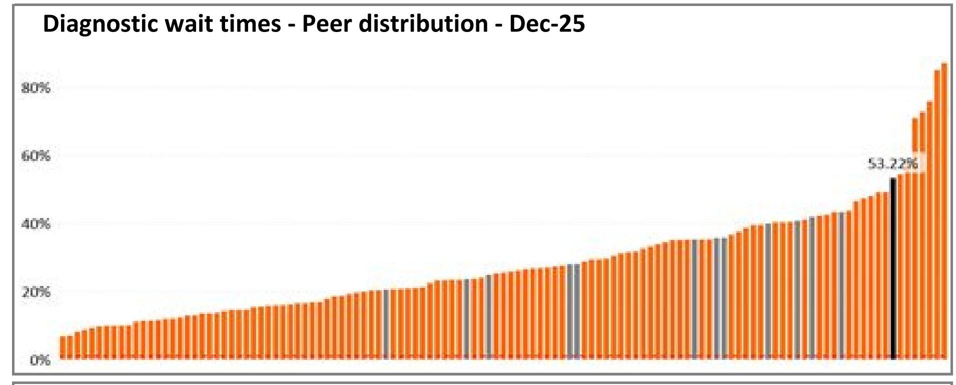
Incomplete pathways within 18 weeks | Community Paediatrics

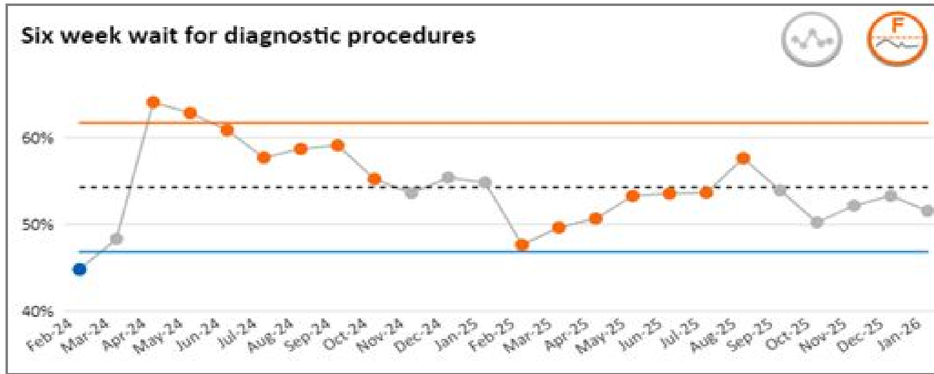
Total patients waiting at month-end | Community Paediatrics

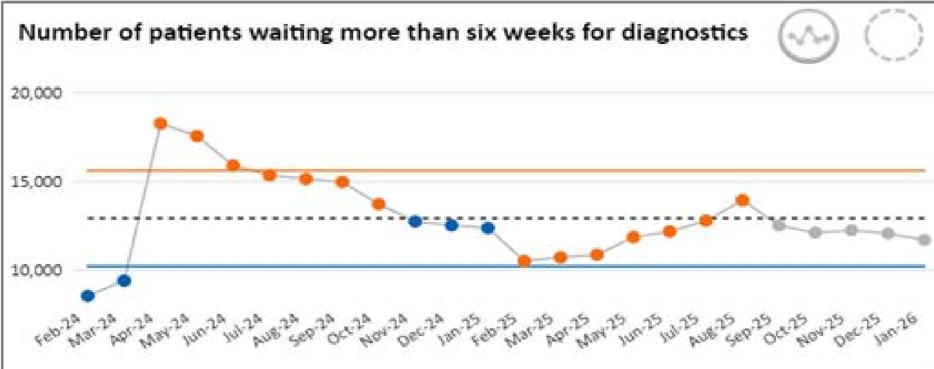
Month 10 | 2025-26

Operations

Diagnostics Waiting Times







Key Issues and Executive Response

- In January, DM01 performance (the % of patients waiting over six weeks for diagnostics) improved from 53.23% to 51.50%.
- For DM01 excluding Audiology, there are 5,640 patients waiting >6 weeks; with 453 patients (improved by 173 from December) 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.

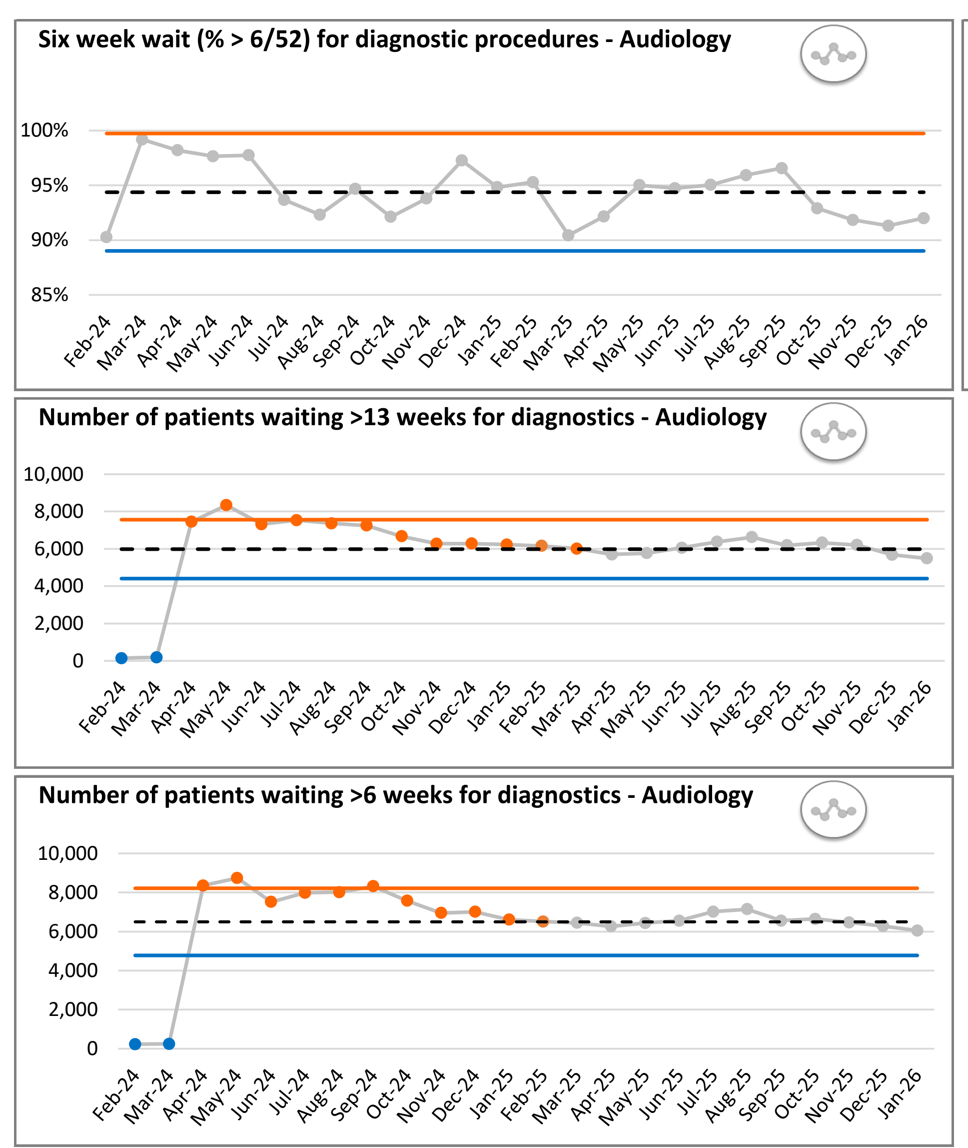
Challenges / Actions

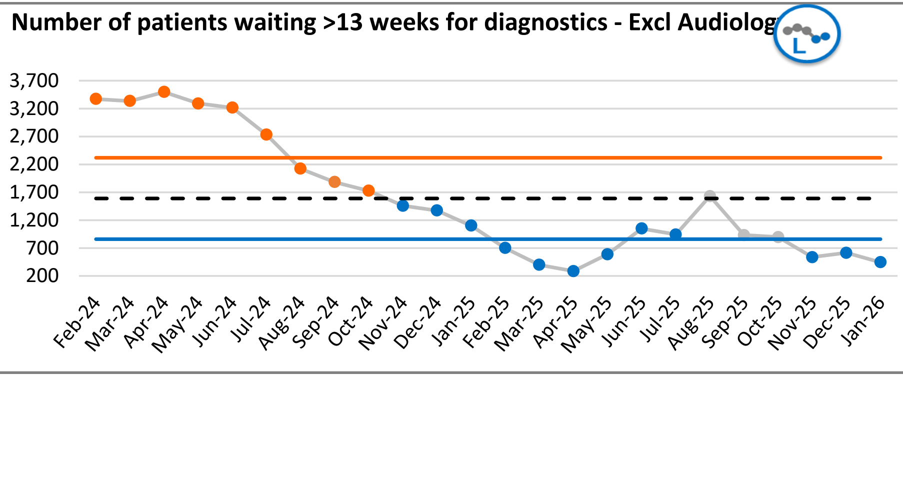
- **Non-Obstetric ultrasound** has been impacted by staffing gaps (20% vacancy, 5 wte out to advert); appointed 2 in November, 1 started 09/02 and 1 to start in March. Extended insourcing has been agreed to continue until end of March. Current performance improved from 43.6% to 39.95%, breaches reduced from 3,870 in December to 3,340; mean wait improved to 4.5 weeks in January.
- Outsourced **MRI** activity to Pinehill has ceased due to capacity constraints. One Stop Health Care have offered 65 scans per week; Contract Team progressing contractual arrangements. CT van switched to MRI for 4 lists per month until end March. Consultation on the 7-day MRI service complete, with implementation from 5 April. 6.4 wte out to advert for recruitment. There are 1356 patients over 6 weeks; mean wait is 5.1 weeks. Capital funds have been allocated by EoE for the replacement of two MRI and two CT scanners.
- Estate build at Lister for paeds **audiology**, planned to open in April 2026. Adult audiology currently 89.68% (4,328 breaches) with mean wait of 49.98 weeks. Paeds currently 98.4% (1,717 breaches) with mean wait of 60.63 weeks.
- **Sleep studies** - New clinic locations in use at Lister; DNA % reduced.

Month 10 | 2025-26

Operations

Diagnostics Waiting Times - Audiology





Month 10 | 2025-26

NHS
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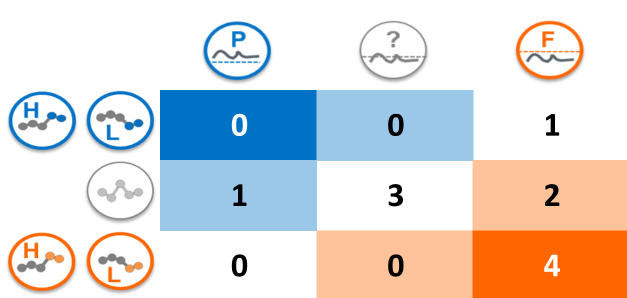
Hertfordshire Teaching
NHS Trust

Finance
Month 10 | 2025-26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Finance

Summary

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Summary Financial Position	Surplus / deficit	Jan-26	2.0	2.0			Common cause variation Metric will consistently pass the target
	CIPs achieved	Jan-26	3.3	2.1			10 points below the mean No target
	Cash balance	Jan-26	77.9	31.5			8 points below the mean Metric will consistently fail the target
Key Financial Drivers	Income earned	Jan-26	58.8	61.6			Common cause variation Metric will consistently pass the target
	Pay costs	Jan-26	-37.0	-37.3			10 points above the mean Metric will consistently fail the target
	Non-pay costs (including financing)	Jan-26	-19.8	-22.4			Common cause variation Metric will consistently fail the target

Month 10 | 2025-26

Finance

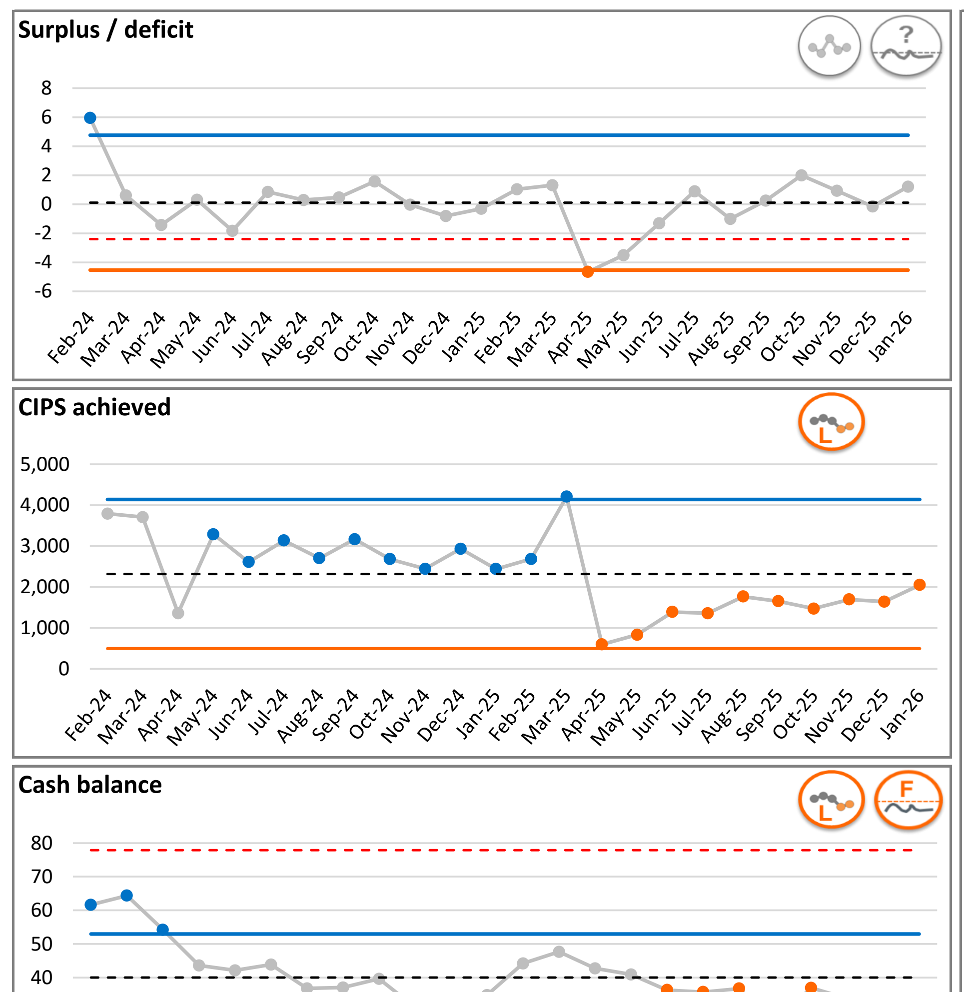
Summary

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Key Payroll Metrics	Substantive pay costs	Jan-26	-36.0	-34.1			Common cause variation Metric will consistently pass the target
	Average monthly substantive pay costs (000s)	Jan-26	-5.5	-5.7			10 points above the mean Metric will consistently fail the target
	Agency costs	Jan-26	-0.1	-0.4			10 points above the mean Metric will consistently fail the target
	Unit cost of agency staff	Jan-26	23.1	-10.4			Common cause variation Metric will consistently pass the target
	Bank costs	Jan-26	-0.9	-2.8			Common cause variation Metric will inconsistently pass and fail the target
	Overtime and WLI costs	Jan-26	-0.3	-0.4			9 points below the mean Metric will consistently fail the target
Other Financial Metrics	Private patients income earned	Jan-26	0.7	0.6			Common cause variation Metric will inconsistently pass and fail the target
	Drugs and consumable spend	Jan-26	-8.1	-8.4			Common cause variation Metric will consistently fail the target

Month 10 | 2025-26

Finance

Summary Financial Position



Key Issues and Executive Response

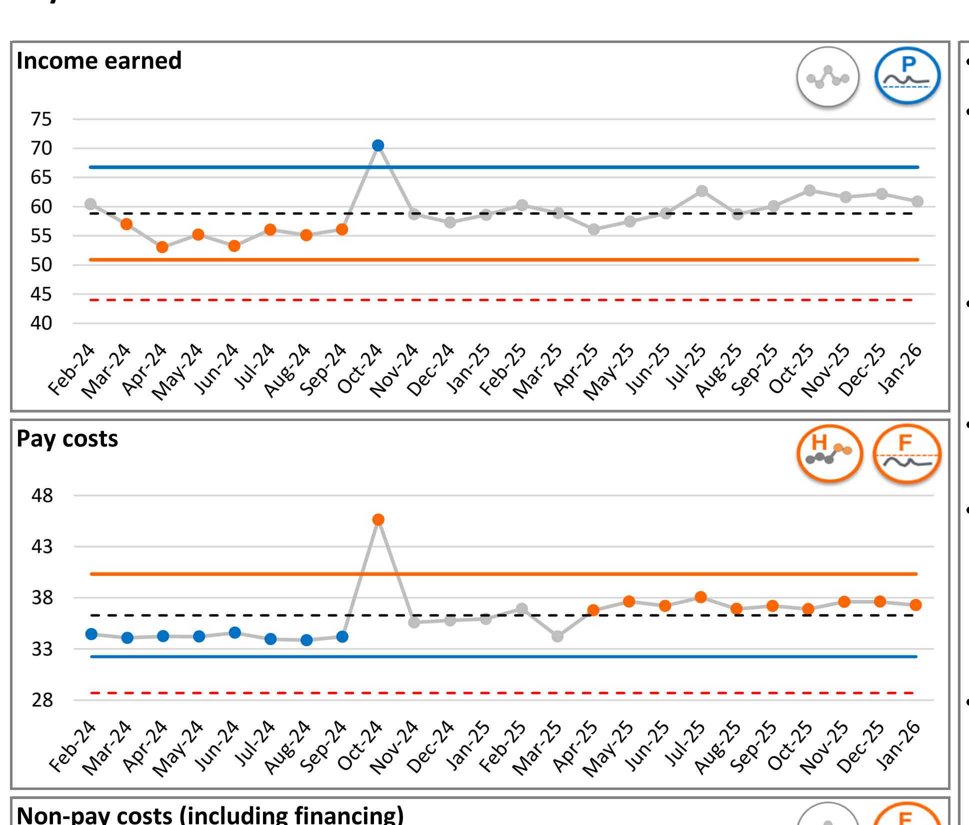
- The Trust agreed a breakeven plan for 25/26. This plan assumes that a £35.8m cost improvement programme will be delivered.
- At Month 10, the Trust has reported an actual YTD deficit of £4.6m. This is in line with phased plan expectations.
- The Trust reports significant slippage against its CIP plan at M10.
- 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 it's cohort of permanent staffing it is not reducing premium staffing utilisation at a proportionate rate.
- Elective income performance YTD is significantly behind plan.

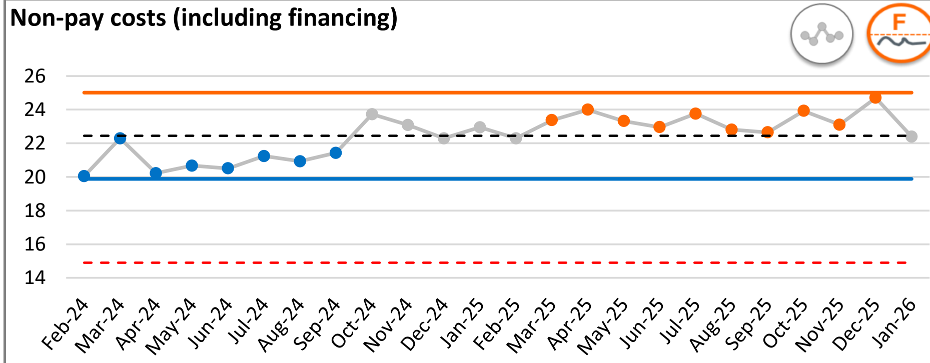
	Annual Budget £m	Budget YTD £m	Actual YTD £m	Variance YTD £m
Income	705.0	587.0	602.2	15.2
Pay	-444.6	-370.9	-373.1	-2.3
Non Pay	-222.9	-189.5	-203.2	-13.7
EBITDA	**37.5**	**26.6**	**25.9**	**-0.8**
Financing Costs	-37.5	-31.3	-30.5	0.8
Retained Deficit exc. PSF	**-0.0**	**-4.6**	**-4.6**	**0.0**
Surplus / Deficit (excl Fin Adj's)	**-0.0**	**-4.6**	**-4.6**	**0.0**

Month 10 | 2025-26

Finance

Key Financial Drivers





- The Trust is reporting a £4.6m deficit at the end of M10, which is on plan.
- The reported position includes the estimated impact of cover of industrial action and the loss of ERF activity as a result. The month 10 position includes £0.6m of funding to cover the December industrial action only. However, the net year to date industrial action impact has resulted in a £1.1m adverse variance.
- Although the year to date position is on plan, this is due to the release of significant non recurrent provisions to offset slippage in CIP delivery and BAU pressures.
- Year to date CIP delivery is £14.5m, which is just 40% of the annual CIP target, despite being 10 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 £1.2m above the YTD plan, which indicates that not all of the agreed productivity targets have been met.
- The under performance on ERF activity, has largely been mitigated as the Trust has agreed a fixed payment for all ERF activity for Herts and West Essex ICB. However, this is expected to be a non recurrent benefit, and RTT targets will still need to be met. There is a significant financial risk if RTT targets are not met.
- In month, there was an actual £2.0m surplus compared with a £2.0m surplus plan. The reported position includes £0.6m of industrial action funding, to offset the costs of the December strike.
- There continues 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, which was partially due to increased occupancy within Critical Care and Respiratory units.

Month 10 | 2025-26

Finance

Other Financial Indicators

Substantive pay costs

45
40
35
30
25
20
Feb-24 Mar-24 Apr-24 May-24 Jun-24 Jul-24 Aug-24 Sep-24 Oct-24 Nov-24 Dec-24 Jan-25 Feb-25 Mar-25 Apr-25 May-25 Jun-25 Jul-25 Aug-25 Sep-25 Oct-25 Nov-25 Dec-25 Jan-26

Average monthly substantive pay costs

7.0
6.5
6.0
5.5
5.0
4.5
4.0
Feb-24 Mar-24 Apr-24 May-24 Jun-24 Jul-24 Aug-24 Sep-24 Oct-24 Nov-24 Dec-24 Jan-25 Feb-25 Mar-25 Apr-25 May-25 Jun-25 Jul-25 Aug-25 Sep-25 Oct-25 Nov-25 Dec-25 Jan-26

Agency costs

1.4
1.2
1.0
0.8
0.6
0.4
0.2
0.0
Feb-24 Mar-24 Apr-24 May-24 Jun-24 Jul-24 Aug-24 Sep-24 Oct-24 Nov-24 Dec-24 Jan-25 Feb-25 Mar-25 Apr-25 May-25 Jun-25 Jul-25 Aug-25 Sep-25 Oct-25 Nov-25 Dec-25 Jan-26

Unit cost of agency staff

19
17
15
13
11
9
7
5
Feb-24 Mar-24 Apr-24 May-24 Jun-24 Jul-24 Aug-24 Sep-24 Oct-24 Nov-24 Dec-24 Jan-25 Feb-25 Mar-25 Apr-25 May-25 Jun-25 Jul-25 Aug-25 Sep-25 Oct-25 Nov-25 Dec-25 Jan-26

Bank costs

4.5
4.0
3.5
3.0
2.5
2.0
Feb-24 Mar-24 Apr-24 May-24 Jun-24 Jul-24 Aug-24 Sep-24 Oct-24 Nov-24 Dec-24 Jan-25 Feb-25 Mar-25 Apr-25 May-25 Jun-25 Jul-25 Aug-25 Sep-25 Oct-25 Nov-25 Dec-25 Jan-26

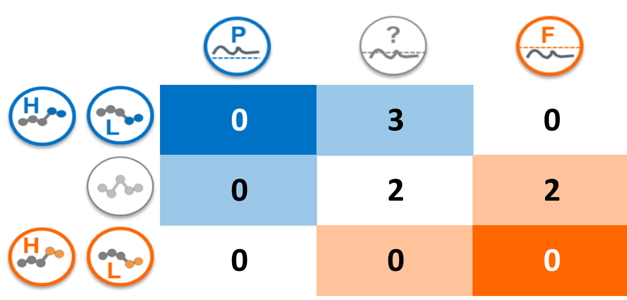
Overtime and WLI costs

1.1
1.0
0.9
0.8
0.7
0.6
0.5
0.4
Feb-24 Mar-24 Apr-24 May-24 Jun-24 Jul-24 Aug-24 Sep-24 Oct-24 Nov-24 Dec-24 Jan-25 Feb-25 Mar-25 Apr-25 May-25 Jun-25 Jul-25 Aug-25 Sep-25 Oct-25 Nov-25 Dec-25 Jan-26

Month 10 | 2025-26

People

Month 10 | 2025-26



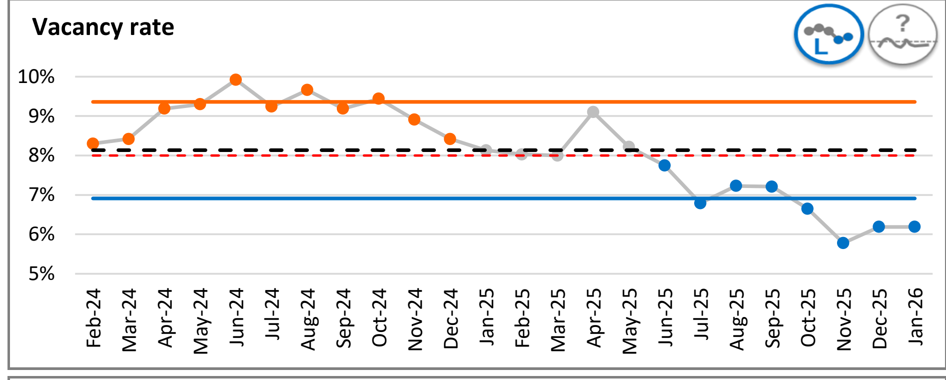
People
Summary

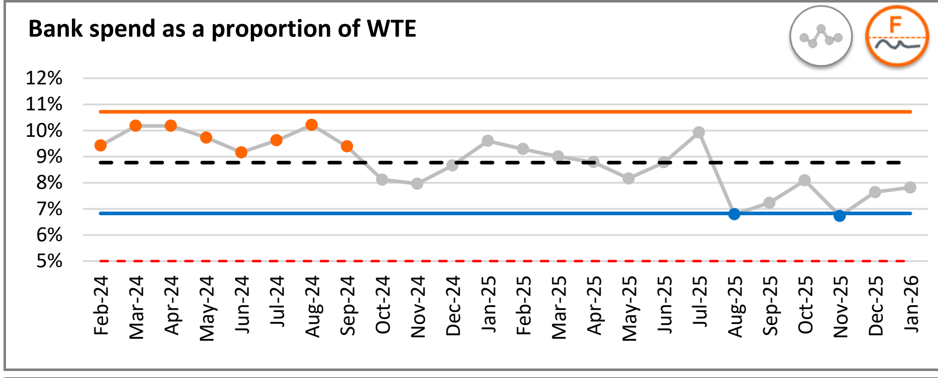
Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Work	Vacancy rate	Jan-26	8%	6.2%			8 points below the mean Metric will inconsistently pass and fail the target
	Bank spend as a proportion of WTE	Jan-26	5%	7.8%			Commn cause variation Metric will consistently fail the target
	Agency spend as a proportion of WTE	Jan-26	3%	1.0%			5 points below the lower process limit Metric will inconsistently pass and fail the target
Grow	Statutory and mandatory training compliance rate	Jan-26	90%	88.0%			Commn cause variation Metric will inconsistently pass and fail the target
	Appraisal rate	Jan-26	90%	85.8%			Common cause variation Metric will consistently fail the target
Thrive	Turnover rate	Jan-26	10.5%	7.9%			11 points below the mean Metric will inconsistently pass and fail the target
Care	Sickness rate	Jan-26	4.0%	5.3%			Common cause variation Metric will inconsistently pass and fail the target

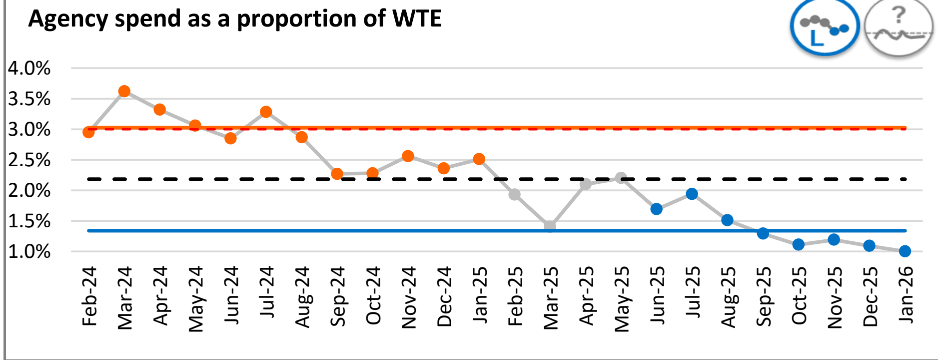
Month 10 | 2025-26

People

Work Together







Key Issues and Executive Response

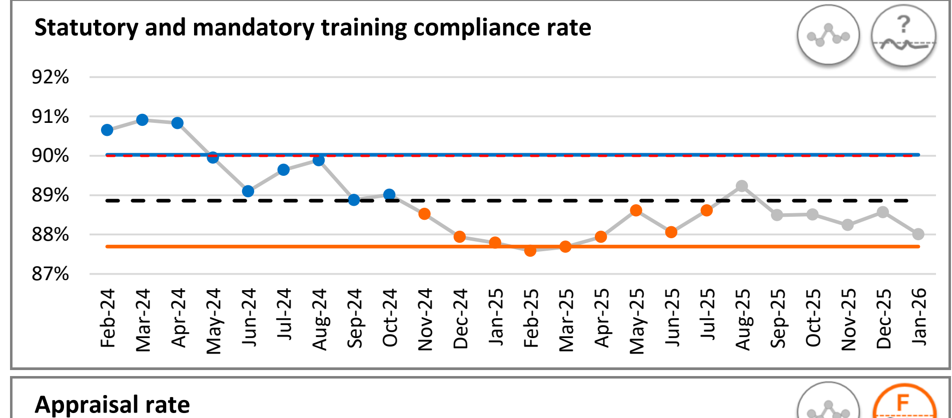
- Vacancy rate remained stable at 6.19% (408.15 FTE) in January. BI recruitment pipeline dashboard created to provide clear picture of vacancy hotspots to enable targeted support. Current areas of focus are Estates and CSWs.
- Average time to hire increased across all staff groups. Weekly check-ins with team established pre rotations, designed to reduce knowledge gaps, provide continuity and sharing of key updates, learning and progress.
- CSW recruitment remains a priority. Reductions of 5.2wte bank usage across ED and AMU1 following to substantive recruitment
- Assessment-based approach for Registered Nurses to continue, following previous success. Next assessment day will focus on vacancies within Stroke, Swift, 5A, 6A, and Outpatients
- Recruitment and Selection, and Job Matching Policies signed off, providing greater clarity and consistency of processes. Guidance being created to support consistent application of policies across Trust
- Paper approved at TMG relating BAU job planned delivery model as default. Additional elective activity exceptional, time-limited and affordable. Remuneration aligned to standard bank rates. This represents a shift to planned, governed and financially sustainable
- Medical Locum retrospective bookings remain. Analysis ongoing to understand causes. TSOD using Patchwork classification fields to capture reasons (e.g., RCP not followed, short-notice requests). Exploratory meeting on-going to determine retrospective costs, particularly within Planned Care
- Newly digital RCP request platform created by People Digital, pilot to commence with UEC, replacing existing Trac workflow. Expected to significantly reduce admin burden
- Agency spend as a proportion of WTE remains below target. Bank is above target. Proactive review continues of usage against vacancies.

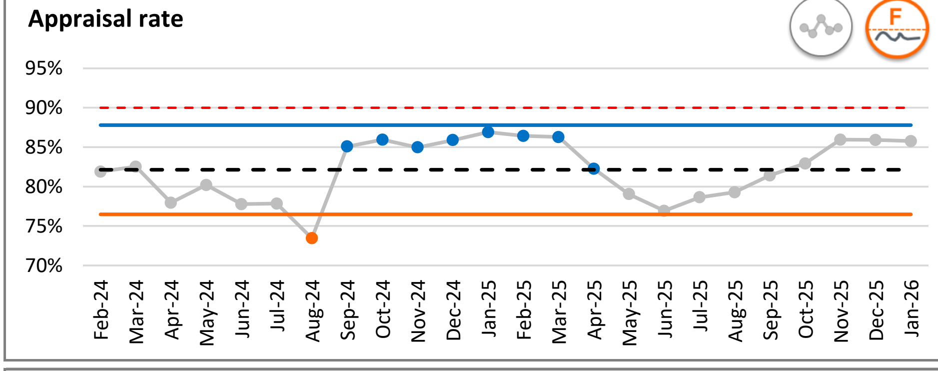
Month 10 | 2025-26

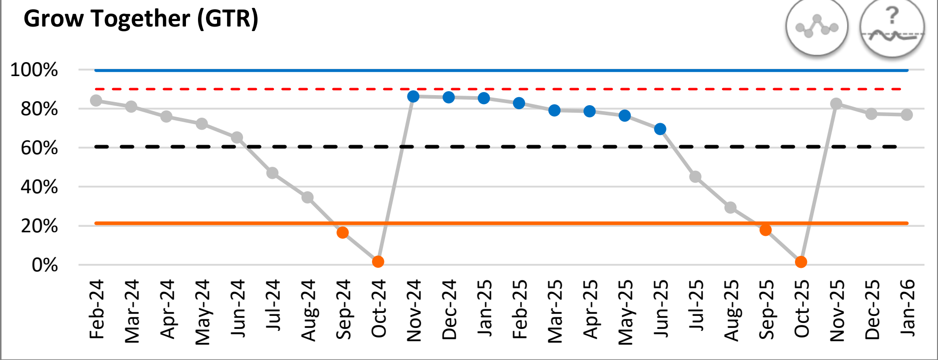
People

Grow Together

NHS East and North Hertfordshire Teaching NHS Trust







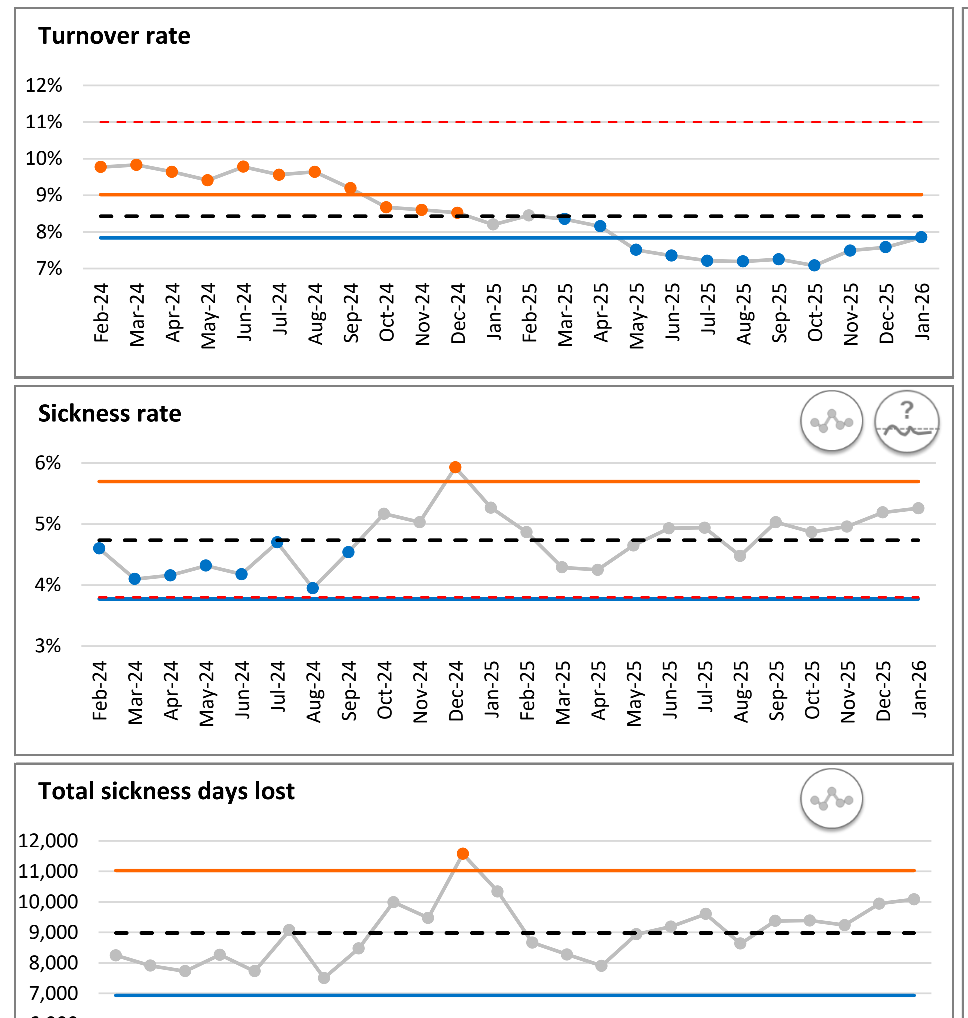
Key Issues and Executive Response

- **GTR compliance** for Jan is 84.4%. Virtual monthly support sessions increased to two sessions monthly from March onwards are all set upon ENH Academy as we prepare for the 2026; April - August window. Collaborative working with Business Partners is on-going, highlighting at Divisional Leadership meetings the importance of advance planning and strategic team goal setting for the 2026/27 aligned to Trust goals and objectives.
- **UCL & UoH Education Risks**: Wi-Fi and accommodation issues pose immediate risk to UCL student placements; Uni of Hertfordshire September 2026 cohort planning is underway but dependent on confirming funding for the new Clinical Link Tutor role.
- **Regulatory & Operational Pressures**: GMC action plan requires further evidence to avoid escalation; ongoing vacancies are impacting capacity despite recent successful recruitment.
- **Infrastructure & Process Changes**: AV failures at Lister Education Centre require expedited repairs; transition to new study leave/expenses systems in April 2026 will need careful rollout to avoid disruption.
- **Moving & Handling**: Introducing MS Forms for competencies (awaiting approval) and reviewing bariatric equipment processes to reduce delays and overspend.
- **CPD Team**: Piloting Microsoft digital training; early courses show strong positive impact.
- **Pre-Reg Team**: Supporting new students and preparing 45 Educational Audits with UH. Also guiding staff on alternatives after the Nursing Associate programme pause and working with Resourcing on RNDA/top-up recruitment.

Month 10 | 2025-26

People

Thrive Together | Care Together



Key Issues and Executive Response

Thrive Together

- Long standing suspension case has been heard, outcome to be sent shortly. Lessons learnt on delays to be shared with wider audience when appropriate.
- Average duration of disciplinary cases and Staff concerns have both increased due to long standing complex matters.
- Vast majority of cases relate to either failure to follow policies and procedures or bullying and harassment concerns. Work to share themes with divisional management has commenced to address any hot spot areas.
- Health Records Consultation - 45 day consultation launched 19 January 2026. 102 members of staff in scope (all members of staff in the Health Records team, members of the Medico Legal team, plus two members staff from Unplanned Care).

Care Together

- Health and wellbeing promotion in January has included the launch of an updated policy to reduce stress and promote mental wellbeing. The policy provides clearer guidance on proactive stress management strategies and includes easy to follow risk assessment tools.
- Encouragement and support has been given to make healthier lifestyle choices by promoting dry January, stop smoking support, menopause support, mindfulness and talking therapies. The Health at Work Service have collaborated with the library and Trust charity on Bookfest, a new event which promotes the wellbeing benefits of reading.
- Flu vaccines continue to be available and strongly encouraged, uptake in frontline staff is 47.6%.

Month 10 | 2025-26

Meeting	Public Trust Board			Agenda Item	13
Report title	Quality and Safety Committee report to Board meeting held 28 January 2026			Meeting Date	11 March 2026
Chair	Dr David Buckle – Non-Executive Director - East and North Herts NHS Trust				
Author	Governance Business Administrator				
Quorate	Yes	☒	No		☐

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

- **Workforce pressures in maternity and neonatal services:** Sustained workforce gaps, including high maternity leave rates and pressures on the on-call rota, continue to pose practical problems and resilience risks.

Assurances provided to the Board:

- **Integrated compliance report:** Incident reporting remains strong, Duty of Candour performance is showing early signs of recovery, but needs to stay a focus of attention for some time
- **Monitoring of Martha's Rule:** The Committee was assured that an implementation process is in place which will monitor outcomes and support safe implementation as demand grows.
- **Complaints and PALS improvements:** PALS turnaround improved to 8–12 days despite staffing challenges, supported by ongoing process redesign. We had reasonable confidence that complaint-handling performance is stabilising, but it will remain a significant challenge for some time.
- **Nursing strategy:** Improvements were reported in recruitment, retention, digital support, leadership visibility and practice development. KPIs are being developed to strengthen measurable assurance going forward.
- **Maternity and perinatal services:** Improvement actions following a Never Event, including enhanced training, strengthened governance, and exploration of digital verification solutions, providing reasonable assurance of learning and response.
- **Ex-ward appointments:** QSC receives and scrutinises a monthly detailed report which is presented by the COO. Harm reviews in several clinical areas are being undertaken

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

- **Thematic review of CQC concerns:** A detailed thematic analysis of CQC concerns - including patterns, mitigations and assurance levels - has been commissioned and is due in February QSC

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

- **Birthrate plus workforce review:** A new Birthrate Plus review has been commissioned to ensure maternity workforce modelling reflects rising acuity, staffing pressures and changed community service nee
- **Strengthening Duty of Candour compliance:** Weekly Duty of Candour review panels are in place to address overdue cases, prioritise severe harm incidents and support divisions in improving completion rates.

Any actions recommended to improve effectiveness of the meeting:	
• Discussions should prioritise assurance over operational detail, reinforcing a cultural shift toward more effective meetings. • Clearer, more structured reporting of new, closed, and escalated risks to support better Committee oversight.	
Recommendation	The Board is asked to **DISCUSS** the report from the Committee.

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Board

Meeting	Public Trust Board	Agenda Item	13.1
Report title	NHSE call to action Antimicrobial (AMR)	Meeting Date	11 March 2026
Author	Head of Clinical Services, Diagnostics, and Ambulatory Care Principal Pharmacist – Patient Safety		
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:

ENHT is currently performing well across the East of England for IV antibiotic usage, however further work is required as outlined below for the use of 'Access' antibiotics and diagnostics. Therefore, suggests partial assurance.

Summary of key issues:

To brief the Board on the Trust's current position in relation to antimicrobial resistance (AMR) and antimicrobial stewardship (AMS), following a letter from NHS England requesting:

- A joint presentation from AMS teams and Infection Prevention and Control (IPC) at QSC
- Benchmarking of Trust performance
- Identification of key risks
- A forward plan to progress the national AMR improvement agenda.

This summary provides an overview of current performance, identified priority areas, and governance arrangements in place. A Trust working group has been established to respond to these requirements, comprising:

- Head of Clinical Services, Diagnostics and Ambulatory Care
- Lead Consultant Microbiologist
- Advanced Pharmacist – Antimicrobials
- Deputy Director of Infection Prevention & Control and Lead Nurse

Key Areas of Focus

Clinical Engagement

The Trust demonstrates strong performance in intravenous (IV) to oral antibiotic switching.

- 20% of all antibiotics used are IV, compared with a regional mean of 25%, making ENHT the best-performing Trust in the region.
- However, compliance with the national requirement to increase use of Access category antibiotics (the least resistance driving category) requires improvement.

- Current position: 46% (regional mean 43%)
- National target: 70% by 2029

Diagnostics

Appropriate blood culture sampling and timely incubation are critical to accurate diagnosis and reduction of unnecessary antibiotic use.
Recent audit findings show:

- 45% compliance with the requirement for blood culture bottles to be loaded into an analyser within four hours
- 20% compliance with the requirement to obtain 8–10 ml of blood per bottle.

The Trust is working with Health Sciences Laboratories to seamline the blood culture pathway and this is reflected in the action plan.

Infection Prevention and Control (IPC)

Strong IPC systems directly reduce infection burden and associated antibiotic use, thereby supporting AMR reduction. Key areas for strengthening include:

- Behaviour and culture change across clinical teams
- Improvements to the physical environment
- Enhanced data quality, accessibility and utilisation
- Ensuring adequate staffing and appropriate resource allocation

Action plans for each work stream have been developed and will be overseen via existing Trust governance structures:

- Trust Infection Prevention and Control Operational Group (TIPCOG)
- Trust Antimicrobial Forum (TAF)
- Trust Infection Prevention and Control Committee (TIPCC)

These groups will monitor progress, risk, performance metrics, and impact on patient outcomes.

Quality and Safety Committee (QSC) received an initial update on 25 February 2025. An annual report will be submitted to QSC in 2027, detailing progress against the AMR improvement agenda, achievements, and further actions required.

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*	
This section helps the reader understand any new risks related to the paper or if the paper relates to an existing significant known risk(s) [See note 12]	
Report previously considered at & date(s):	
Report considered at QSC on the 25 February 2026.	
Recommendation	The Board is asked to: 1. Note the Trust's current position and key risks regarding AMR and AMS. 2. Endorse the ongoing work of the AMS and IPC teams. 3. Support continued cross-organisational engagement to meet national AMR targets.

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Board

Meeting	Finance, Performance and Planning Committee	Agenda Item	14.1
Report title	Finance, Performance and Planning Committee Terms of Reference	Meeting Date	11 March 2026
Author	Committee Secretary		
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:

N/A

Summary of key issues:

The enclosed revised committee terms of reference for Finance, Performance and Planning Committee (FPPC) are enclosed for approval, having been reviewed and endorsed by the committee on 26 January 2026.

Key proposed change

- Removal of Stroke from the National Performance Standards.

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*

Report previously considered at & date(s):

26 January 2026 FPPC meeting.

Recommendation	The Board is asked to **APPROVE** the terms of reference for the Finance, Performance and Planning Committee.

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FINANCE, PERFORMANCE AND PLANNING COMMITTEE

TERMS OF REFERENCE

1. Purpose

The purpose of the Finance, Performance and Planning Committee is to provide assurance to the Board that appropriate arrangements are in place to support the delivery of the financial, operational and other short term planning objectives which contribute to the delivery of the Trust Strategy. Through this work, the Committee will play a key role in ensuring the sustainability of the Trust.

The Committee's work will include:

- maintaining an overview of the development and maintenance of the Trust's medium and long term financial strategy;
- providing scrutiny of operational performance;
- providing scrutiny of the implementation of the business plans to deliver the Trust's long-term strategy;
- overseeing risk management for the duties of the Committee.

The Committee shall be kept informed of any developments relating to the Hertfordshire and West Essex Integrated Care System that may impact on the work of the Committee.

2. Status and Authority

The Committee is constituted as a formal Committee of the Trust Board and is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

3. Membership

Three Non-Executive Directors, one of whom will be nominated as Chair

Core Attendees:

- Chief Executive
- Director of Finance
- Chief Operating Officer
- Chief People Officer (bi-monthly for workforce agenda items)
- Chief Information Officer
- Director of Improvement

Commented [DO1]: CEO not a core member of any committee

Attendees:

- Chief Nurse
- Medical Director
- Director of Estates
- Deputy Director of Finance Financial Management
- Deputy Director of Finance Financial Planning
- Deputy Director of Workforce and OD
- Deputy Chief Operating Officer
- Digital Director -solutions and delivery

All other Non-Executive Directors/Directors are welcome to attend.

Other staff will be invited to attend to present an item to the Committee or to support their personal development with the prior agreement of the Committee Chair.

If a conflict of interests is established, the above member/attendee concerned should declare this and withdraw from the meeting and play no part in the relevant discussion or decision.

4. Quorum

The Committee will be quorate if two non-executive members are present, and two core attendees; one of which must be the Director of Finance and the other must be the Chief Operating Officer or their nominated Representative.

5. Frequency of meetings

The Committee will meet every month (with the exception of August) and prior to Trust Board meetings. The Chair of the Committee may convene additional meetings if required to consider business that requires urgent attention.

6. Duties

6.1 Financial Planning

Act as an Assurance Committee of the Trust's business and finance risks through the following activities:

To approve:

- Individual investment decisions including a review of Outline and Full Business Cases between £500k and £1 million.

To approve and recommend to the Board:

- The Trust's Business Plan, including the approved financial framework to support the delivery of the Trust's strategic objectives;
- The Medium Term Financial Strategy including the Long Term Financial Model;

- Proposals for the reinvestment of any surpluses generated by the Trust in undertaking its operational activities;
- Adoption of the annual plan and budgets for revenue and capital;
- For investment decisions or schemes in excess of £1 million, the Committee will make a recommendation to the Trust Board, who will ultimately make a decision on the proposal;
- The Cost Improvement Programme. Any potential concerns on quality are to be referred to the Quality and Safety Committee (QSC).

To monitor and review:

- Financial impacts relating to enabling strategies (specifically the digital, estates and capital strategies);
- The capital programme and work of the Capital Review Group;
- The development of the annual Cost Improvement Programme and oversee development of the rolling programme that is to be incorporated into the Long Term Financial Model and monitor in-year delivery;
- Value for money and efficiency issues as required to ensure problem areas are addressed and action taken as appropriate;
- Financial implications relating to the system collaboration framework;
- The development of financial forecasts and measures taken to promote financial sustainability.

6.3 Financial Performance

Regularly review the performance of the Trust against financial performance targets as described in the NHS Performance Management Framework (NHS Trust). This review should include:

To monitor and review:

- Financial performance in relation to both the capital and revenue budgets;
- Financial performance in relation to activity and Service Level Agreements;
- Financial performance in relation to sensitivity analysis and the risk environment;
- To commission and receive the results of in depth reviews of key financial issues affecting the Trust;
- To monitor the progress of the Trust's strategic projects;
- To monitor the benefits realisation of major projects.

6.4 Operational Performance

To monitor and review the Trust's operational performance, including consideration of issues such as winter preparedness and bed planning, significant operational service developments and compliance with national performance standards.

The Committee will receive regular updates regarding the national performance standards, currently:

- A&E,
- Cancer waiting times,
- Referral to treatment,
- Diagnostics,

To work closely with the QSC to understand any quality and safety implications associated with operational performance.

To be kept appraised of operational performance matters relating to system collaboration.

To receive an agreed programme of deep dives relating to significant operational issues.

6.5 Workforce

To monitor and review risk areas that relate to Trust's workforce metrics impacting on our operational performance and financial planning including but not limited to: temporary staffing, recruitment and establishments.

6.6 Planning

To act as the lead assurance committee for the implementation of short-term business plans to deliver the Trust's long-term strategy.

To gain assurance on the design and delivery of transformation in support of the Trust's strategy.

To monitor and review at a strategic level:

- annual business plans to deliver the Trust's strategy, providing assurance and exception reporting to the Board on strategy delivery progress;
- delivery of the major strategic programmes within the business plans;
- oversee development of the integrated performance report measures for delivery of the strategy.
- financial planning to deliver the Trust's strategy and where relevant develop proposals for discussion/agreement by Trust Board;
- the Trust's strategic plans for IT/Digital, Estates and the Green Plan.

Updated January 2026

6.7 Other duties

To monitor and review:

- Procurement activities, progress against savings targets, and key strategic tenders.
- Major change projects which may impact on the core areas of the Committee's work.
- Review elements of the Trust's workforce metrics impacting on our operational performance including but not limited to: temporary staffing, recruitment, establishments.

6.8 Risk Reporting

The Committee will regularly receive risk register reports for the areas relevant to its duties for review and consider with the appropriate escalation to the Trust Board and for incorporation within the Board Assurance Framework.

7. Reporting arrangements

The Committee will identify and report the key issues requiring Board consideration to the Trust Board after each meeting. It will make recommendations to the Board, Executive Committee and Executive Directors for these groups/individuals to take appropriate action.

8. Process for review of Committee's work including compliance with terms of reference

The Committee will monitor and review its compliance through the following:

- The Committee report to Trust Board;
- FPPC annual evaluation and review of its terms of reference.

9. Support

The Trust Secretary will ensure the Committee is supported administratively and advise the Committee on pertinent areas.

Updated January 2026

Board committee report

Meeting	Public Trust Board		Agenda Item	15
Report title	People and Culture Committee February		Meeting Date	11 March 2026
Chair	Janet Scotcher – People and Culture Committee Chair			
Author	Committee Secretary			
Quorate	Yes	☒	No	☐

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

- fluctuating training compliance rates.
- disparity between attraction and appointment rates for colleagues from white and BAME background.

Assurances provided to the Board:

- Noted progress on SAR and eRoster policies, with the annual leave policy gaining traction.

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

- A response to the Gynaecology grievance had been completed, and the service had made some progress, although the cultural improvement work remained ongoing.
- March 2025 Gender Pay Gap data. It was confirmed that the action plan would focus on Doctors and Dental staff, estates colleagues and Very Senior Managers. Ethnicity Pay Gap reporting would also be considered in future years.
- Issues with reminder emails being directed to incorrect recipients and discussed the possibility of scheduling rolling half day sessions to improve training completion.

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

-

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

Meeting	People and Culture Committee			Agenda Item	15.1
Report title	People and Culture Committee Terms of Reference			Meeting Date	11 March 2026
Author	Committee Secretary				
Responsible Director	Chief People Officer				
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 enclosed revised updated committee terms of reference are presented for approval, having being reviewed and endorsed by the committee at the 2 February 2026 meeting. **Key proposed changes** - Change to core members job titles - Add the phrase '***as required'*** to the attendee list for people presenting but not core members - Removal of the staff network chairs from attendees list as this is now covered within the EDI steering group.

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*

Report previously considered at & date(s):

2 February 2026 People and Culture Committee.

Recommendation	The Board is asked to **APPROVE** the terms of reference for the People and Culture Committee.

To be trusted to provide consistently outstanding care and exemplary service

EAST AND NORTH HERTFORDSHIRE NHS TRUST
PEOPLE AND CULTURE COMMITTEE
TERMS OF REFERENCE

1. Authority

1.1 The People and Culture Committee is constituted as a standing committee of the Trust Board and has no executive powers, other than those specifically delegated in these terms of reference. Its constitution and terms of reference are set out below and can only be amended with the approval of the Trust Board.

1.2 The People and Culture Committee is directly accountable to the Trust Board and is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee or contractor of the Trust and all employees and contractors are directed to cooperate with any request made by the Committee.

2 Purpose

2.1 The People and Culture Committee will provide assurance to the Trust Board on all aspects of the development and delivery of the Trust's People strategy and plans to ensure and deliver a sustainable workforce that is engaged, motivated and well supported.

2.2 The People and Culture Committee will ensure the Trust's strategic ambitions in relation to the workforce are delivered in an affordable manner and any corporate risks identified and managed.

2.3 To provide assurance to the Trust Board on all aspects of workforce, capability and OD supporting the provision of safe, high quality, patient-centred care;

3 Membership

3.1 The members of the People and Culture Committee shall be appointed by the Trust Board and comprise:

Members
- Three Non-Executive Directors

Core attendees
- Chief People Officer (named as the lead Executive Director)
- Chief Nurse
- Medical Director
- Director of Estates and Facilities
- People Director
- Deputy Director of Finance
- Chief Operating Officer
- Chief Kaizen Officer

Attendees
- Equality, Diversity and inclusion Lead
- Executive Network sponsors

- ~~Staff Network Chairs~~
- Trades Unions as required
- FTSU lead role
- Associate Directors of People Function as required
- ~~Assistant Director –~~ Director of Communications and Engagement
- Divisional Directors as required

3.2 One Non-Executive Director will be appointed as the Chair of the People and Culture Committee by the Trust Board. In the absence of the Committee Chair a deputy will be appointed to Chair.

3.3 Only members of the People and Culture Committee have the right to attend Committee meetings. However, other post-holders and external advisors may be invited to attend all or part of any meeting, as and when required.

3.4 Each member of the People and Culture Committee shall disclose to the Committee:

- Any conflict of interest
- Any personal financial interest in any matter to be decided by the Committee

Any such member shall refrain from discussions concerning such matter and, if requested by the Committee Chair, will leave the meeting for the duration of the discussion.

4. Quorum

4.1 A quorum shall be three members comprising two Non-Executive Directors and one Executive Director.

5. Attendance

5.1 Members should make every effort to attend all meetings of the People and Culture Committee and will be required to provide an explanation to the Chair of the Committee if they fail to attend more than two meetings in a financial year. If a member fails to attend more than three meetings in a financial year, the Chair of the Committee will consider with the Chair of the Trust the appropriate action to be taken. The Committee Secretary will monitor attendance by members and report this to the Chair of the Committee on a regular basis.

5.2 Other Executive Directors and other Trust staff will be invited to attend for specific agenda items with the agreement of the Chair of the Committee.

6. Frequency of Meetings

6.1 Meetings will be held six times a year.

6.2 The Chair of the People and Culture Committee may convene additional meetings if required to consider specific business that requires urgent attention.

7. Duties

STRATEGY

7.1 Shape and drive the Trust's People and Organisational Development Strategy and its implementation to ensure appropriate impact;

CULTURE and ORGANISATIONAL DEVELOPMENT

7.2 Shape, approve and drive improvements arising from the triangulation of feedback from staff surveys, exit interviews, Freedom to Speak Up Guardians and other

sources of intelligence; to continually develop and shape the workforce to deliver service needs

7.3 Oversee the development of an inclusive culture where people feel safe and able to raise concerns and that concerns raised are suitably and consistently addressed;

7.4 Monitor the Trust's activities designed to enable colleagues to feel supported in their work, and consistently experience civil and respectful behaviours;

7.5 Oversee the Trust's approach to enhancing the health and wellbeing of staff and integrating health and well-being consideration into organisational decision-making.

EQUALITY, DIVERSITY and INCLUSION

7.5 Oversee the development and delivery of the Trust's inclusion, equality and diversity strategy for our people, particularly ensuring a representative and supported workforce with inclusive leadership;

7.6 Oversee the development of effective data collection and KPIs to enable effective scrutiny of delivery against the equality, diversity and inclusion priorities;

7.7 Receive a regular report on inclusion, equality and diversity in the Trust and specifically review the inclusion, equality and diversity strategy;

WORKFORCE PLANNING and REPORTING

7.9 Review the development and delivery of the Trust's workforce planning with a focus on:

- Strategic workforce information and planning
- Recruitment and retention
- Education, learning and organisation and leadership development
- Inclusion, equality and diversity
- Staff experience and engagement, reward, recognition, health and wellbeing
- Staff benefits, recognition and rewards

7.10 Receive a report at each meeting from the Executive lead for the People and Culture Committee covering issues escalated from relevant executive groups and compliance with statutory and regulatory workforce standards, workforce performance indicators and provide assurance that any necessary corrective plans and actions are in place. Provide assurance that legal and regulatory requirements relating to the workforce are met;

7.11 Advise the Board on remuneration proposals changes for Trust employees (excluding senior staff covered by the Remuneration Committee);

7.12 Consider any proposed significant changes in the terms of employment of Trust employees, including national directives requirements;

7.13 Receive annual workforce planning briefs of proposed and major workforce changes taking place in the following year

STAFF ENGAGEMENT

7.13 Oversee the development of the Trust's staff engagement and communications strategies and related programmes of work, and review the effectiveness of internal communications and engagement;

7.14 Ensure engagement and consultation processes with staff reflect the ambition and values of the Trust and also meet statutory requirements;

AUDIT and RISK

7.15 Receive and review at each meeting those entries on the Board Assurance Framework (BAF) which are to be overseen by the People and Culture Committee and ensure they are appropriately reflected on the Committee's work programme to enable the Committee to gain assurance on the effective controls in place and address gaps in controls and assurance.

7.16 Review the proposed Internal Audit Plan and make recommendations to the Audit Committee on the internal Audit work programme as relevant to the remit of the People and Culture Committee.

7.17 Review on behalf of the Audit Committee the findings of Internal and External Audit reports covering matters within the remit of the People and Culture Committee, seeking assurance that appropriate actions are identified and implements in response to recommendations and that learning is shared across the organisation.

7.18 Receive and review reports of significant concern or adverse findings highlighted by Regulators, peer review exercises, surveys and other external bodies in relation to areas under the remit of the People and Culture Committee. Seek assurance that appropriate action is being taken to address these.

7.19 Review any People issues referred to the committee by the Trust Board.

COMMITTEE EFFECTIVENESS

7.20 Develop an annual work programme agreed by the People and Culture Committee to discharge duties as set out above.

7.21 Undertake an annual review of the effectiveness of the Committee to inform the Committee's annual report to the Trust Board and the following year's work programme.

8. Reporting Arrangements

8.1 The People and Culture Committee will identify and report the key issues requiring Board consideration to the Trust Board after each meeting. It will make recommendations to the Board and Executive Team to take appropriate action.

8.2 The People and Culture Committee will work closely with other Trust Board sub-committees as required.

9. Committee Review

9.1 The People and Culture Committee will monitor and review its performance and compliance through the following:

- The Committee's report to Trust Board
- An annual evaluation of the People and Culture Committee
- An annual review of the People and Culture Committee Terms of Reference

10. Support

10.1 Administrative support will be provided by the Trust Secretariat alongside advice to the People and Culture Committee on pertinent areas.

Updated February 2026

Board committee report

Meeting	Public Trust Board			Agenda Item	16
Report title	ENH Health Care Partnership Committee report to Board			**Meeting Date**	11 March 2026
Chair	Chief Executive - East and North Herts NHS Trust				
Author	Governance Business Administrator				
Quorate	**Yes**	☒	**No**		☐

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

Urology Demand Growing (7% Increase)

- The Board noted increasing pressure within urology services, with demand rising by approximately 7%, leading to growing concerns about pathway capacity. In response, a deep-dive review has been commissioned to understand the drivers of this demand, assess capacity constraints, and identify potential mitigation measures.

Assurances provided to the Board:

ENH Development Directors Update

- ENH neighbourhood priorities were confirmed to be broadly aligned with the ICB's emerging five priority areas i.e. (cancer, MSK, CVD, advanced illness & end-of-life, mental-health crisis)., with further detailed mapping planned to ensure full consistency across programmes.

ENH Performance Review

- Despite rising A&E attendances, six of eight urgent and emergency care targets were still being met.
- Category 2 ambulance response times had improved substantially to around 34 minutes, better than both plan and last year's levels.
- Handover delays have also improved overall, with continued close monitoring in place to track and respond to the early indications of slippage seen in January.

Primary Care Update

- All but one practice meet online consultation and GP Connect requirements.
- Orthodontic procurement is complete, with 5-to-10-year contracts proposed for approval ready for approval.
- GP training practices and trainee numbers had increased by 28%.

Planning Update

- Funding of £11m has been secured for ENHT paediatric ward refurbishment. Further capital for neighbourhood and mental health infrastructure is anticipated, and HCPs will lead on location and design decisions.

PB Forward Plan & Governance

- The approved membership model ensures inclusive representation, covering primary care, CYP, care providers, housing and health inequalities.

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

National Priority

- ''Strengthening integration between health and social care services" has been named as one of the 3 national priorities for Adult Social Care.

ENH Performance Area (UEC)

- Early January slippage in handover delays requires close and ongoing monitoring to prevent deterioration.
- Diagnostics remain pressured across MRI, ultrasound and audiology.

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

Action Log and Oversight

- The Board agreed that the previously omitted action relating to the creation of a place-level risk register must be added back into the action log to ensure visibility and follow-through

Governance Structure & Membership Decisions

- The Board approved the proposed PB meeting rhythm and structure for 2026, comprising:
  - a Formal PB Board
  - an Informal PB Board
  - a Place Leadership Forum meeting every four months

Outputs from 3P Event

- The Board requested that the outputs from the Neighbourhood Stakeholder Workshop and the 3P event be embedded into the Neighbourhood PIDs, capital funding submissions, and broader programme development.

Any actions recommended to improve effectiveness of the meeting:

Improving Clarity and Conciseness of Meeting Papers

- Members to ensure papers are concise and focused on assurance, and that operational detail is routed through appropriate subcommittees rather than escalated to the Board unnecessarily.

Governance Structure and Voting

- The revised Terms of Reference and voting arrangements to be presented at the next meeting in April, to ensure governance clarity and improve the effectiveness and consistency of decision-making

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 HCP performance report

28 January 2026

Working together
for a healthier future

Place

East and North Herts Place UEC Performance Summary

Place	Indicator	Previous Month	Current Month	Latest Month	Month Change	Current month trajectory	Variance to target	12 month trend
ENH	% abandoned calls	2.7%	2.5%	Dec-25	↓	3.0%	-0.5%	
ENH	CAT 2 mean response times	00:35:57	00:34:43	Dec-25	↓	00:45:30	-10.78	
ENH	UCCH activity: A2S patients passed + CB4C incidents per day	17.1	19.9	Dec-25	↑	na	na	
ENH	% 2 hour urgent community response	82.8%	81.1%	Dec-25	↓	70.0%	11.1%	
ENH	Mean handover time	00:30:01	00:34:38	Dec-25	↑	00:43:00	-8.37	
ENH Place	4-hour standard	76.2%	74.6%	Dec-25	↓	74.4%	0.2%	
ENH	% of type 1 patients spending more than 12 hours in ED	5.2%	5.9%	Dec-25	↑	11.3%	-5.4%	
ENH	Bed occupancy (G&A)	93.2%	89.9%	Dec-25	↓	92.1%	-2.2%	
ENH	% patients discharged on discharge ready date	76.0%	76.9%	Nov-25	↑	78.4%	-1.5%	
ENH	% discharged before noon	16.1%	14.7%	Dec-25	↓	33.0%	-18.3%	
ENH	Virtual ward occupancy	113.2%	110.8%	Dec-25	↓	na	na	

- Where trajectories have been agreed, 6 out of 8 targets were met in December
- The 111 % abandoned calls continued to improve and reached 2.5% in December which is better than the national target. This is despite December being the busiest month so far for 111 calls in FY2526
- Mean Cat 2 response times improved to 34m 43s in December which is better than the EEAST target of 45m 30s. Performance in HWE is now typically better than the regional average.
- The volume of activity going through the UCCH (access-to-stack calls passed + call-before-convey incidents handled) increased to 19.9 per day in December.
- The % of urgent community responses within 2 hours is consistently above the 70% target in East and North Hertfordshire. In Dec-25 , 81% of urgent community responses were reached within 2 hours.
- In November, the mean handover time at ENHT was 34m. This is ahead of the plan outlined in the FY2526 planning submission (43m for December)
- Performance against the 4-hour standard deteriorated to 74.6% in December but this remains ahead of plan (74.4% for December)
- % of type 1 patients waiting over 12 hours improved was 5.9% in December which is 5.4 percentage points better than plan
- The % of patients discharged on their discharge ready date was 76.9% in November which is 1.5 percentage points below plan
- The % of patients discharged before noon reduced to 14.7% in December. There hasn't been any sustained improvement in this metric over the last 12 months
- Virtual ward occupancy in East and North Hertfordshire remained very high at 110.8% in December. Referrals remain high but below their peak from Jan-25

East and North Herts
Health and Care
Partnership

Place

UEC performance benchmarking

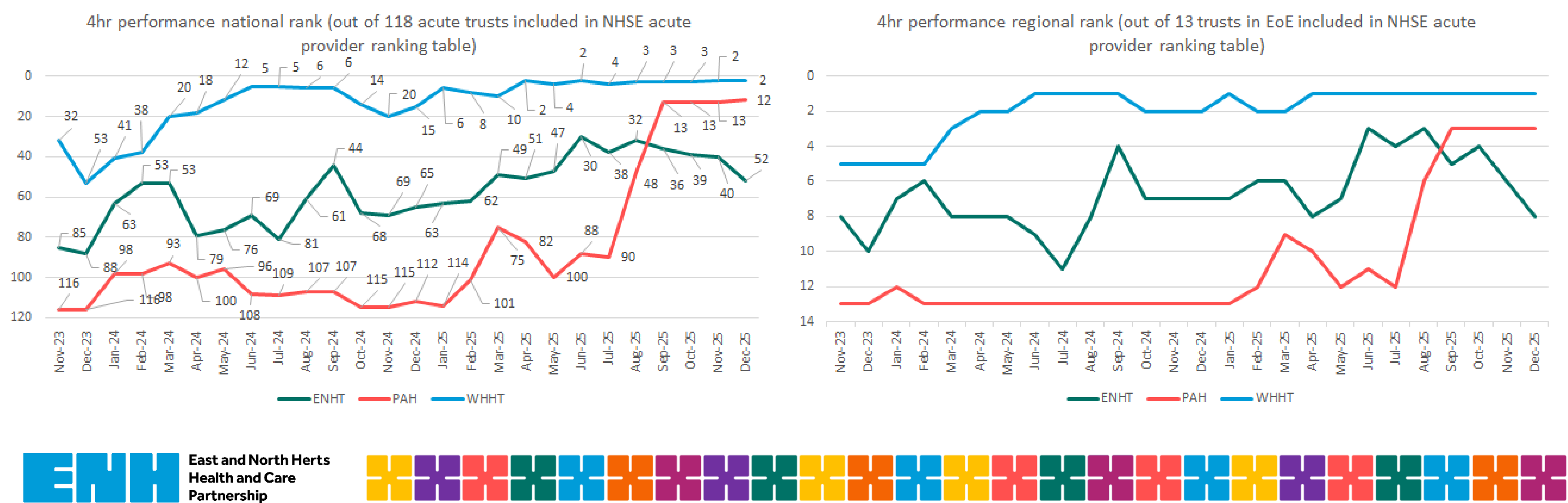
- There are currently four metrics where ENH place is performing better than regional and national average: % abandoned calls; 12-hours in ED; discharges before 5pm; average NEL LOS
- There are four metrics where ENH place is performing between the national and regional averages: C2 mean response times; ambulance conveyance rate; mean handover time; 4-hour standard; and the GEMI score
- The only metric where ENH is performing below both the national and regional mean is the % of discharges before noon

	ICS	ENH	SWH	WE	National	Regional	
% abandoned calls	2.5%	2.5%	2.5%	2.4%	4.8%	4.3%	Red = Above national and regional average Amber = Between national and regional average Green = Below national and regional average
CAT 2 mean response times	00:33:30	00:34:43	00:28:57	00:38:59	00:32:43	00:36:43	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	48.8%	48.3%	50.1%	47.3%	51.9%	47.6%	Red = Below national and regional average Amber = Between national and regional average Green = Above national and regional average
Mean handover time	00:30:51	00:34:38	00:22:47	00:38:31	00:30:43	00:39:35	Red = Above national and regional average Amber = Between national and regional average Green = Below national and regional average
4-hour standard	79.2%	74.6%	83.8%	80.2%	73.8%	74.9%	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	5.6%	5.9%	3.5%	9.2%	7.5%	6.8%	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)		101	43	150			Red =Bottom third of trusts nationally Amber = Middle third of trusts nationally Green = Top third of trusts nationally
% discharged before noon	20.4%	14.7%	30.4%	12.9%		15.3%	Red = Below regional average Green = Above regional average
% discharged before 5pm	61.5%	60.0%	69.9%	51.0%		55.0%	Red = Below regional average Green = Above regional average
Average NEL LOS (excl 0 and 1 day spells)	8.70	8.30	9.10	8.70	10.2	9.5	Red = Above national and regional average Amber = Between national and regional average Green = Below national and regional average

Provider

4-hour A&E waits performance benchmarking

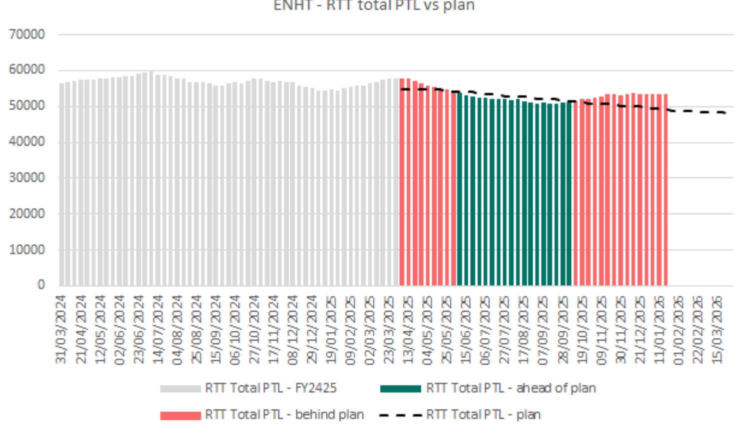
- Between Nov-23 and Jun-25 there was a general improvement in the national ranking of ENHT for the 4-hour standard and in Jun-25 the Trust was ranked 30th nationally. However, since Jun-25, there has been a slight deterioration in the trust's national ranking meaning that the dip in performance this winter has been slightly more significant than the national average
- There was a significant improvement in the ranking of PAH between July and September. This was primarily due to a recording change in relation to SDEC patients. In Dec-25, PAH was ranked 12th nationally out of 118 acute trusts. However, there are some inconsistencies between the PAH ECDS data and its A&E sitrep data which mean that this improvement in A&E performance may not be real

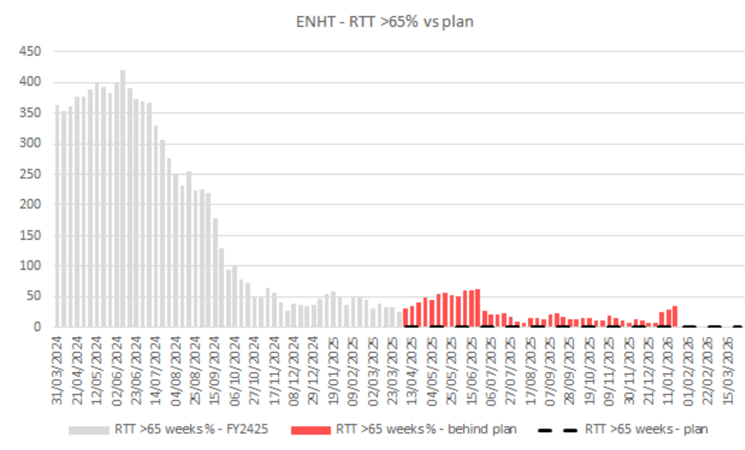


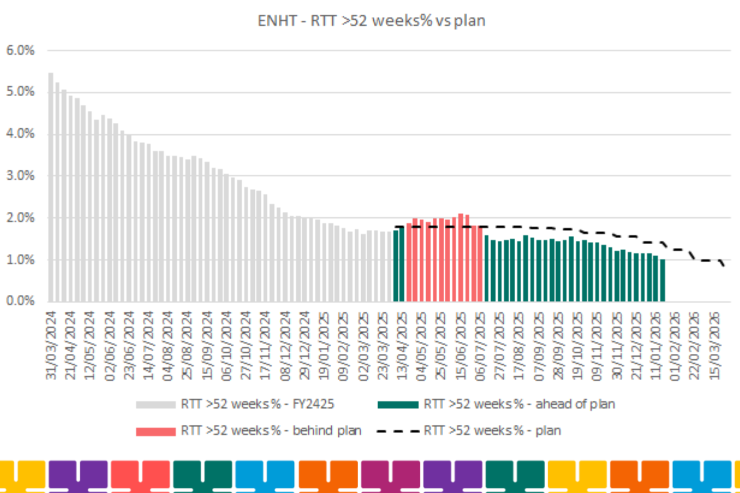
East and North Herts Health and Care Partnership

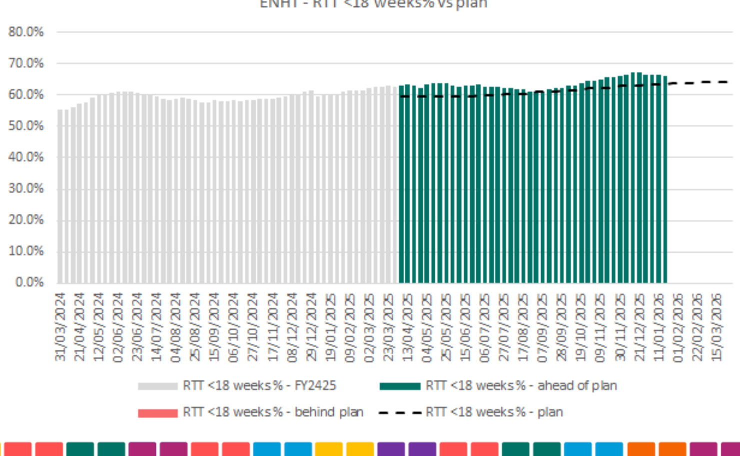
Acute planned care – RTT and long waiters ENHT

- As at 18th January, ENHT had 35 patients waiting >65 weeks. This figure has increased from 8 on 28th December. It isn't unusual to get an increase in long-waiters at this time of year. In the same weeks last year there was an increase from 38 to 59 patients. This is partly due to the reduced capacity over the holiday period.
- The biggest increases in >65ww have been in Oral Surgery / Orthodontics (15 patients on 18th Jan) and Trauma & Orthopaedics (13 patients on 18th Jan).
- Some issues in Oral Surgery relate to the CBCT scanner capacity / reporting capacity. An external company has now been brought in to do the reporting. There has also been some Consultant sickness in Oral Surgery and a high number of patients cancelling the day before procedures
- The Trust is ahead of plan for the % of patients waiting >52 weeks and the % of patients waiting <18 weeks
- However, the trust is below plan for the overall PTL size





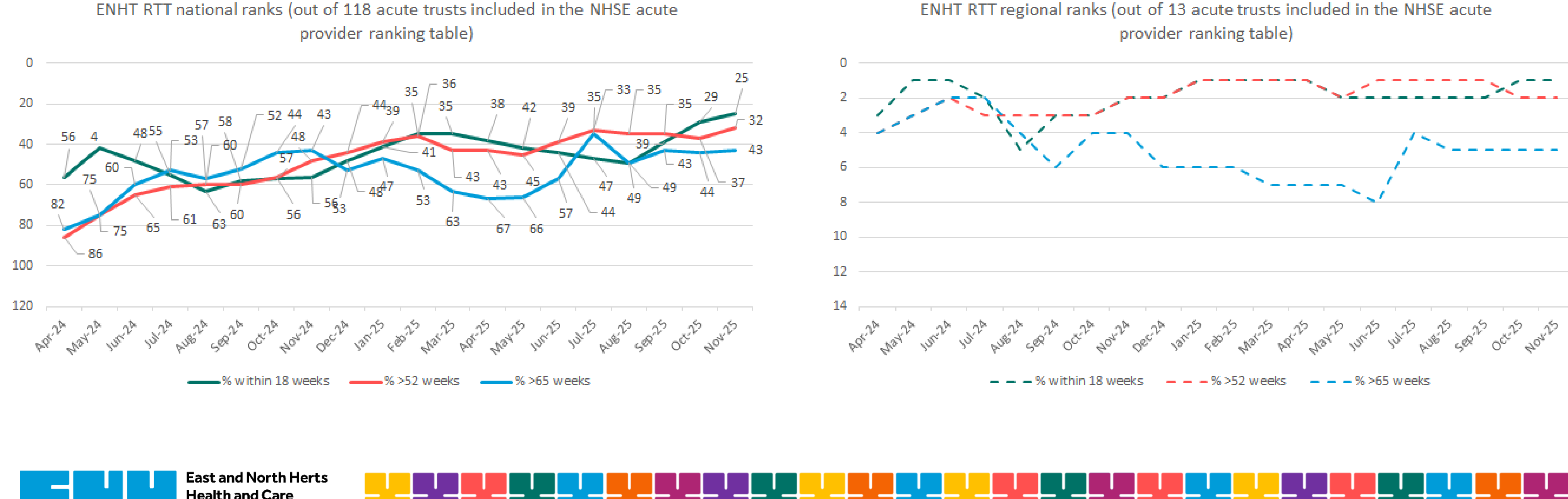




Provider

RTT performance benchmarking

- Using the latest published data from Nov-25, ENHT ranks in the 2nd quartile nationally for the % patients waiting >52 weeks and % patients waiting >65 weeks. ENHT ranks in the top quartile nationally for the % of patients waiting <18 weeks (25th out of 118 Trusts)
- Regionally, the Trust is in the top / 2nd quartile for all of the three main RTT performance metrics

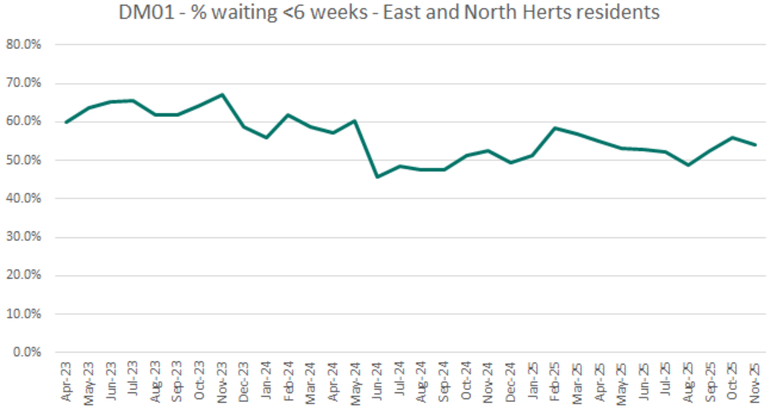


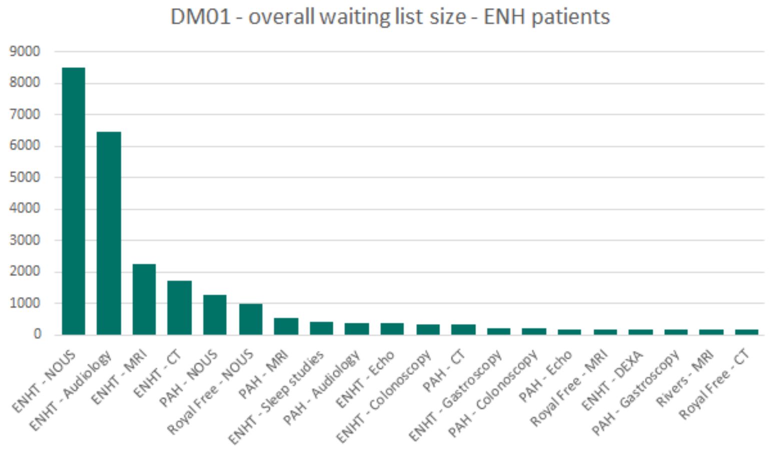
East and North Herts Health and Care Partnership

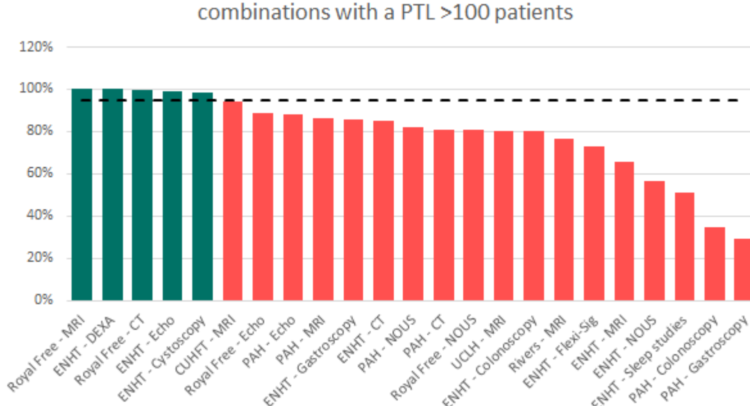
Place

Acute planned care – diagnostics waits ENH Place

- This analysis is now focused on East and North Herts residents rather than just ENHT as a provider
- Of the 27,744 East and North Herts residents who are currently waiting for a diagnostic, 75% are on an ENHT waiting list, 11% are on a PAH waiting list and 6% 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.
- There was some disruption to the MRI scanners at ENHT during December; the impact of this is not yet included in the charts on this slide
- There are also other pockets of long waiters for ENH patients (see chart below right), including PAH Audiology (adult mainly), PAH Colonoscopy and PAH Gastroscopy



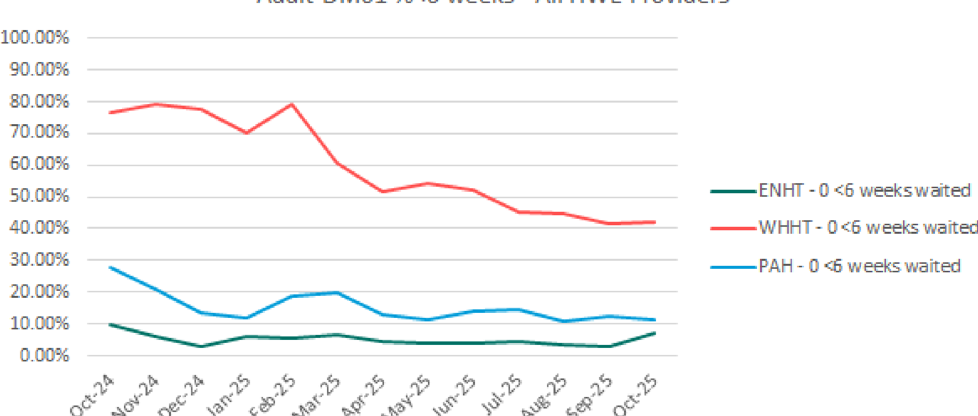


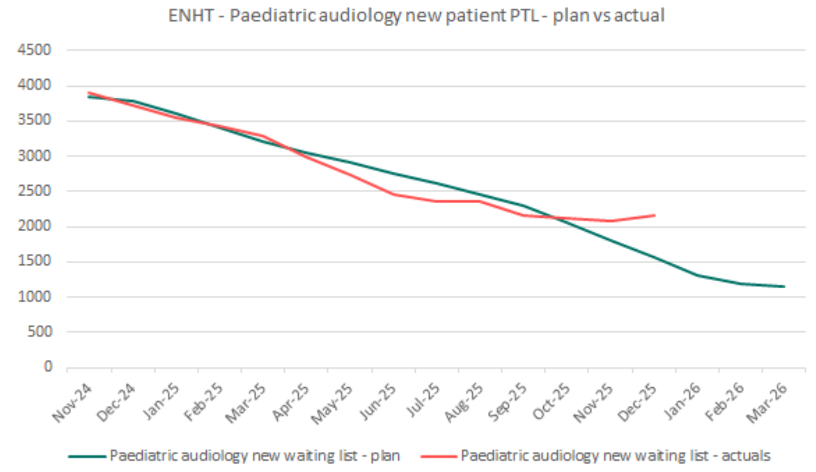


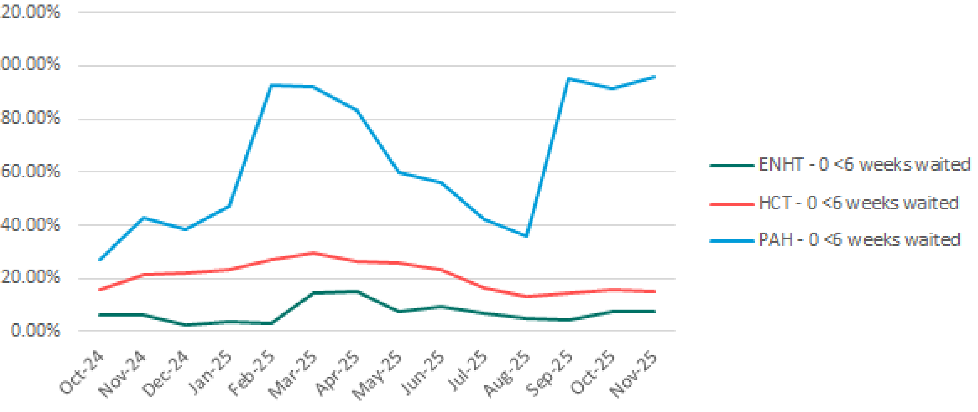
Provider

Audiology waiting times

- The ENHT paediatric audiology new patient waiting list increased in December. This is the first month-on-month increase since at least Nov-24. The increase was primarily for 0-2 year olds and 5+ year olds
- The % of patients waiting <6 weeks has not improved (see chart below right). However, there has been a significant improvement in PAH paediatric audiology waits since Sep-25
- The *adult* audiology waiting times continue to be challenged across all three HWE providers (see chart above right)
- ENHT paediatric workforce update: 2 year Fixed Term Band 7 appointed and started 1-Dec. One returning from mat leave in Feb-26
- Hertfordshire County building work started on 01/12/25. Hoping to be complete by Apr-26
- ENHT adult workforce update: 1x Band 7 starting 16th Feb







Acute planned care – cancer ENHT

- In Nov-25, ENHT met its target for the 31-day treatment standard and the 62-day treatment standard. The Trust was fractionally below plan for its faster diagnosis standard
- The Trust remains one of the leading performers for cancer performance nationally. In Nov-25, ENHT was ranked 3rd out of 118 nationally for the 62-day treatment standard and 64th out of 118 nationally for the 28-day faster diagnosis standard
- The faster diagnosis standard plan for Nov-25 was 77.4% for ENHT. This target was met for four 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:
    - Jul-25 – additional MRI vans, increased TP biopsy capacity, increased flexi-cystoscopy capacity
    - Aug-25 – outsourcing 140 MRI scans per week to Pinehill
    - Oct-25 – Imaging team are prioritising prostate patients and dating within 10 days
    - Nov-25 – four new scopes
- Haematology – to introduce bloods clinic at Lister McMillan Cancer Centre to start in Jan-26
- Head and neck – in process to remap the 2ww pathway for oral surgery and allocate dedicated 2ww clinics and triage process to start in November

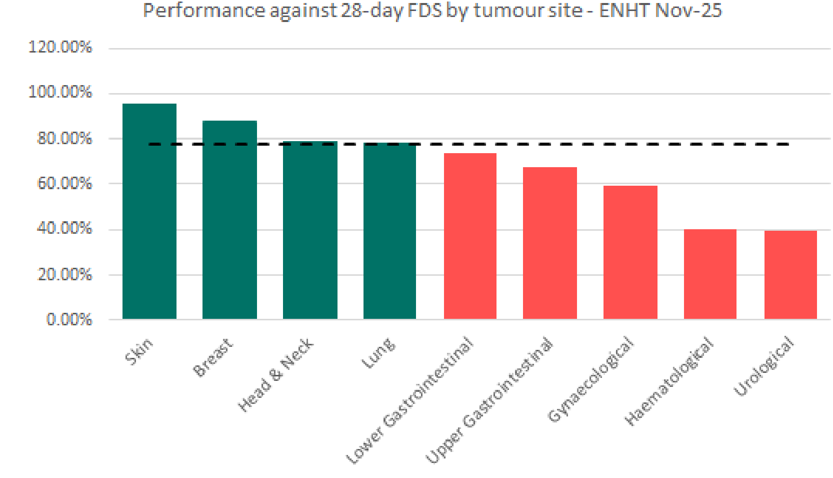


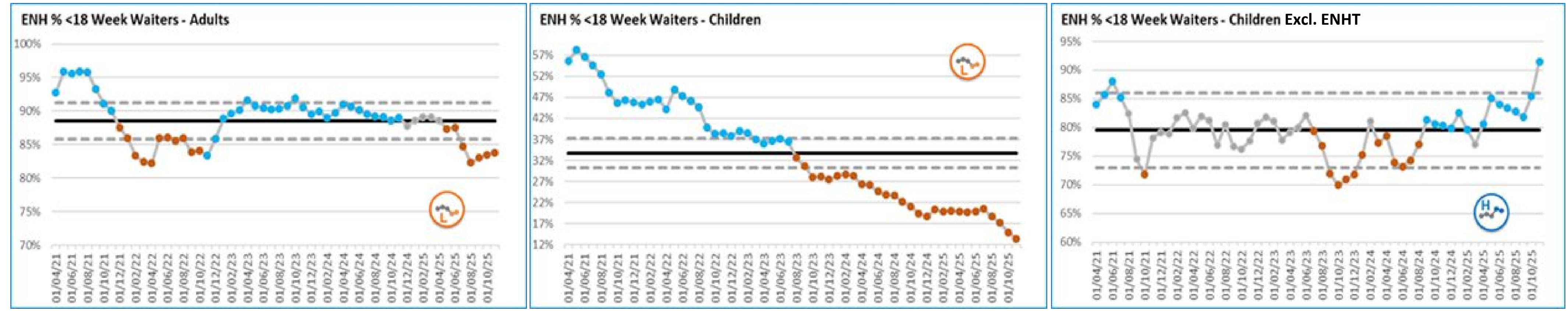
Table below shows performance vs ENHT plans from the national planning submissions

Standard	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
28 General FDS Referral	76.60%	72.20%	79.20%	77.70%	77.80%	76.60%	80.17%	79.75%	78.90%	76.30%	77.60%	77.30%
31 Day General Treatment Standard	97.00%	96.50%	97.00%	96.00%	96.00%	94.90%	96.38%	96.54%	96.50%	96.47%	98.10%	96.60%
62 Day General Treatment Standard	87.00%	85.90%	79.60%	85.10%	88.90%	86.90%	81.86%	82.94%	85.36%	83.30%	85.70%	86.90%

Targets – ENHT plan

Nov-25
77.4%
96.0%
85.4%

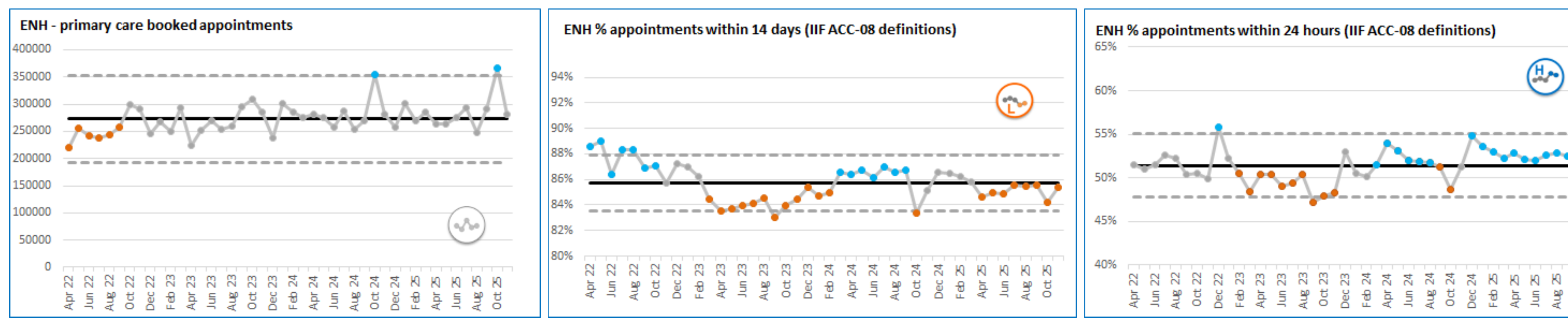
ENH Place community waits



- Community waiting times for adults in East and North Hertfordshire been below average for the last seven consecutive months. The services at HCT which are primarily driving this trend are:
    - MSK Triage
    - Hand therapy
- In particular, the MSK triage service has seen the number of patients waiting over 18 weeks go from 657 in June to 1022 in December. 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 hand therapy service has seen the number of patients waiting over 18 weeks go from 66 in June to 187 in December. There hasn't been an increase in referrals to hand therapy, but there appears to have been a reduction in monthly contacts. There has been successful recruitment to vacancies recently and the service is forecasting an improvement in waiting times before the end of FY2526. The service is also considering a group-session pathway following a successful pilot.
- The Community Paediatrics service at ENHT continues to be the biggest driver of long paediatrics waits. However, there has been a reduction in referrals in recent months.
- The MHLDA HCP and providers continue to scope implementation of new pathway across Hertfordshire for community paediatrics.
- 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) and in November, over 90% of patients were waiting <18 weeks. In particular, waits for paediatric OT and CYP continence service at HCT have been improving

Place

Primary care

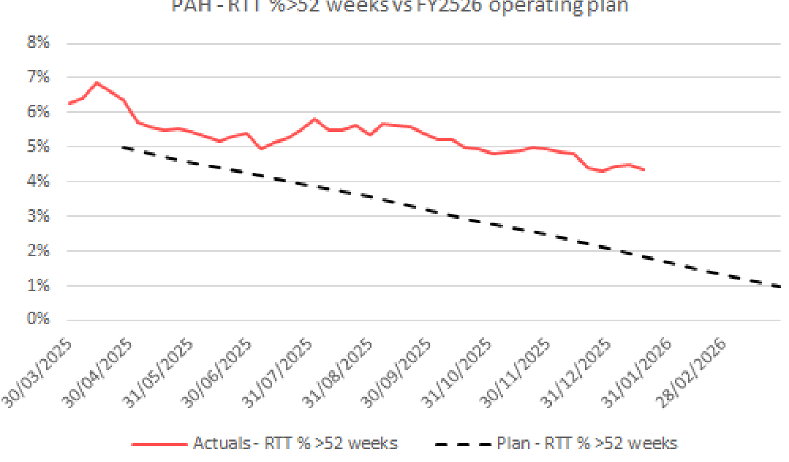


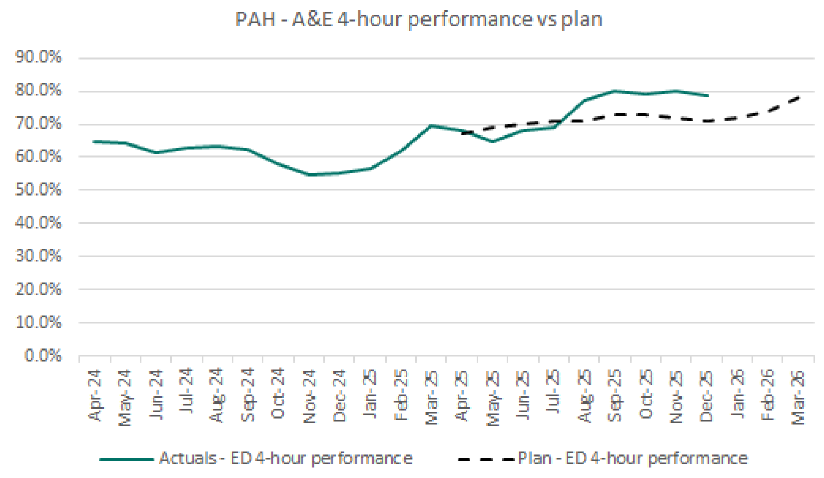
- The number of GP appointments booked in East and North Hertfordshire was gradually increasing between 2022 and 2024. However, over the last 12 months there hasn't been any growth in appointments booked. There was significant growth in Oct-25, but this was due to winter vaccinations
- The % of attendances 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)
- For the % of appointments seen within 14 days, there have been eight 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 twelve months.
- The latest data in the above charts is from November and therefore is the second month with the GP contract changes. There doesn't appear to have been an obvious impact of these contract changes on the % same day appointments or % of appointments within 14 days.
- 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

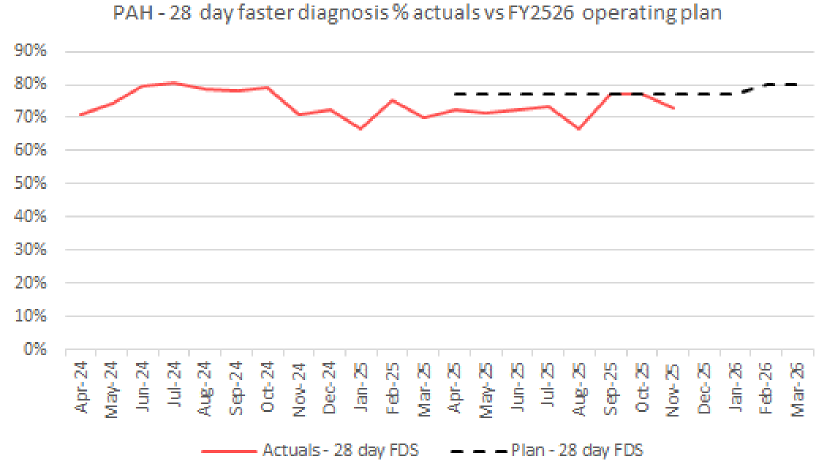
Provider

PAH performance summary

- Approximately 10% of East and North Hertfordshire patients use PAH for acute services
- PAH is currently performing worse than its FY2526 operating plan for the % of patients waiting over 52 weeks (see chart top right). However, performance is steadily improving
- PAH was slightly below plan for the 28-day faster diagnosis standard in November with performance of 72.7% vs a plan of 77%
- PAH has been ahead of plan for 4-hour A&E performance for the last five months, but there are some data quality concerns relating to the consistency of A&E sitrep and ECDS data







East and North Herts Health and Care Partnership

Board committee report

-

Meeting	Public Trust Board	Agenda Item	17
Report title	Audit and Risk Committee held on 10 February 2026	Meeting Date	11 March 2026
Chair	Karen McConnell, Audit and Risk Committee Chair		
Author	Deputy Trust Secretary		
Quorate	Yes ☒	No ☐	

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

- **Internal Audit Progress:** Six reports were presented: Minimal Assurance was reported for Medical Appraisals and Partial Assurance was reported on a further 4 reports. These included reports relating to Fire Safety and to Water and Electrical Safety audits. The reports contain critical/high priority actions that must be addressed promptly. Further updates will be considered at the March and April Audit Committees.

Assurances provided to the Board:

- **Internal Audit Plan 2026/27:** The Committee discussed the plan. Audit areas include Data Quality/PTL, Staff Rostering, Patient Experience/ Learning from Complaints, Productivity/ Theatre utilisation, Discharge management and FTSU.
- **Risk Oversight:** Open risks continue to reduce, and governance processes have strengthened; huddles are in place to improve the quality of risk actions and documentation.
- **External Audit:** Interim work is progressing with no new risks identified. The audit remains on track.
- **LCFS:** A progress report was presented, work was on track.
- **Cyber security and FOI performance concerns**: The digital update was deferred, and the Chair expressed concern at lack of progress and FOI delays, with a full report required at the next meeting.
- **Tender and Waiver report**
- **Accounting Standards and Policies**: The Committee considered changes in accounting standards and regulatory reporting requirements and noted relevant changes relating to the Trust, Trusts Charity and to Trust subsidiaries

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

- **Patient Safety Audit Considerations:** Committee queried need for an audit of ENHance incident and risk system due to ongoing challenges with incident analysis and action tracking. PSIRF audit report to be brought to the March Committee.
- **Corporate Risk Register:** Governance maturing but persistent delays noted in completing risk actions; cross cutting themes include digital, flow and workforce.
- **ARC Effectiveness:** Positive overall feedback; improvements needed in paper length, timeliness and strengthening the executive contribution. ToR updates to go to March Board.
- **ENH Pharma**: KPMG review in progress. Draft report received and discussed. External audit nearing completion.

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

- The Committee reviewed and approved the write off of bad debts
- Internal Audit Report Actions:
  - Revised action due dates must include rationale.

<table>
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<li style="list-style:none">o Internal escalation process to address late/absent updates to be implemented.

ENH Pharma:
o Action plan including areas relating to SLA, transfer pricing and oversight arrangements to be finalised and reported back to the Committee.
Digital/Cyber Update:
o Digital team to provide full cyber security and FOI improvement report at next meeting.

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<tr><td colspan="2">Any actions recommended to improve effectiveness of the meeting:</td></tr>
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Encourage production of shorter, more concise papers.
Earlier Committee involvement in internal audit planning and earlier sight of scopes.

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<tr><td>Recommendation</td><td>The Board is asked to DISCUSS the report.</td></tr>
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Board

Meeting	Public Trust Board			**Agenda Item**	17.1	
Report title	Audit and Risk Committee (ARC) Terms of Reference approval			**Meeting Date**	11 March 2026	
Author	Deputy Trust Secretary					
Responsible Director	Chief Finance Officer					
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 enclosed revised committee terms of reference for Audit and Risk Committee are enclosed for approval, having been reviewed and endorsed by the committee on 10 February 2026.

Key proposed changes

- UK public sector internal audit teams transitioned from Public Sector internal audit standards (PSIAS) to the new Global internal audit standards (GIAS which became effective from April 2025. This change is reflected in the terms of reference.
- It was agreed the Audit and Risk Committee remained the appropriate committee for Information Governance compliance oversight which has now been made explicit in the terms of reference.
- The committee to maintain oversight of the HCP governance arrangements.

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*

N/A.

Report previously considered at & date(s):

10 February 2026 Audit and Risk Committee.

Recommendation	The Board is asked to **APPROVE** the terms of reference for the Audit and Risk Committee.

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AUDIT AND RISK COMMITTEE TERMS OF REFERENCE

Purpose

The purpose of the Audit and Risk Committee is to provide an independent and objective review of the Trust's system of internal control including its financial systems, financial information, assurance arrangements including clinical governance, risk management and compliance with legislation.

Status and Authority

The Audit and Risk Committee is established as a formal committee of the Board. It is a non-executive committee and has no executive powers other than those specifically delegated in these terms of reference.

The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is also authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

Membership

Three Non-Executive Directors (excluding the Chair of the Trust Board), one of whom shall be appointed Chair by the Board. At least one member will have recent and relevant financial experience.

Quorum

Any two members of the Committee are required to be present.

Attendance

The Director of Finance, the Head of Corporate Governance, and appropriate internal and external audit representatives shall normally attend meetings. At least once a year the Committee will meet privately with the external and internal auditors.

The Chief Executive should be invited to attend, at least annually, to discuss with the Audit and Risk Committee the process for assurance that supports the Annual Governance Statement (AGS). He or she should also attend when the Committee considers the draft internal audit plan and the annual accounts. Other executive directors should be invited to attend, particularly when the Committee is discussing the areas of risk or operation that are their responsibility. Other senior managers may be required to attend as needed.

Frequency of Meetings

The Committee will consider the appropriate frequency and timing of meetings to allow it to discharge all its responsibilities, but it will not meet less than five times during the year. The External Auditors or Head of Internal Audit may request a meeting if they consider that one is necessary.

Duties

The duties of the Committee can be categorised as follows:

Governance, Risk Management and Internal Control

The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.

In particular, the Committee will review the adequacy of:

- the strategic approach to risk management across the Trust, the policies and processes for preparing the Board Assurance Framework and Corporate Risk, including the quality of the evidence for assurance provided by Internal and External Audit, management and other sources
- to review and monitor the Board Assurance Framework and Corporate Risk Register and the effectiveness of the management of principal risks, including carrying out a robust assessment of the Trust's emerging and principal risks.
- assurances relating to the management of risk, including assurance that Divisional and corporate risk registers are maintained and updated appropriately and that the Trust can demonstrate effective controls and assurances are in place to mitigate risk.
- all risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board
- the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements
- the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification
- the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud Authority.

In carrying out this work the Committee will primarily utilise the work of internal audit, external audit and other assurance functions to test the effectiveness of the framework, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

This will be evidenced through the Committee's use of an effective Board Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

Internal Audit

The Committee shall ensure that there is an effective internal audit function that meets mandatory ~~Public Sector~~ global Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board. This will be achieved by:

- consideration of the provision of the internal audit service, the cost of the audit and any questions of resignation and dismissal
- review and approval of the internal audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Board Assurance Framework
- consideration of the major findings of internal audit work (and management's response), and ensuring co-ordination between the internal and external auditors to optimise audit resources
- ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation
- an annual review of the effectiveness of internal audit

External Audit

The Committee shall review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:

- consideration of the appointment and performance of the external auditors, as far as the rules governing the appointment permit, including the effectiveness of the external audit process and the external auditor's independence and objectivity
- discussion and agreement with the external auditors, before the audit commences, of the nature and scope of the audit as set out in the annual plan, and ensuring co-ordination, as appropriate, with other external auditors in the local health economy
- discussion with the external auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee
- review of all external audit reports, including the report to those charged with governance, agreement of the Auditor's Annual Report (including Value for Money Report) before submission to the Board and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.

Other Assurance Functions

The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation.

These will include, but will not be limited to, any reviews by Department of Health arm's length bodies or regulators/inspectors (eg the Care Quality Commission, etc) and professional bodies with responsibility for the performance of staff or functions (eg Royal Colleges, accreditation bodies, etc).

The Committee will also undertake the following additional duties:

- **Oversee information governance compliance**, ensuring adherence to all relevant legislation, standards, and internal policies.

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- Approve the Data Quality Strategy and monitor performance against agreed indicators.
- Review and oversee any non-compliance with the Standing Orders (SO) or Standing Financial Instructions (SFI), receiving reports and ensuring appropriate action is taken.
- **Maintain oversight of governance arrangements** for the East and North Hertfordshire Health and Care Partnership (HCP).

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In addition, the Committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the Audit Committee's own scope of work.

In reviewing the work of the Quality and Safety Committee, and issues around clinical risk management, the Audit Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function.

Counter Fraud

The Committee shall satisfy itself that the organisation has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work.

Management

The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

The Committee may also request specific reports from individual functions within the organisation (eg clinical audit) as they may be appropriate to the overall arrangements.

Financial Reporting

The Audit Committee shall review the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance. The Committee should ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

The Audit Committee shall review the annual report and financial statements before submission to the Board, focusing particularly on:

- the wording in the AGS and other disclosures relevant to the terms of reference of the Committee
- changes in, and compliance with, accounting policies, practices and estimation techniques
- unadjusted mis-statements in the financial statements
- significant judgements in preparation of the financial statements
- significant adjustments resulting from the audit
- letter of representation
- qualitative aspects of financial reporting.

Reporting Arrangements

Following each meeting, the Audit Committee will submit a report to the Board on how it has discharged its responsibilities. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board, or require executive action.

The Committee will report to the Board at least annually on its work in support of the AGS, specifically commenting on the fitness for purpose of the Board Assurance Framework, the completeness and embeddedness of risk management in the organisation, the integration of governance arrangements, the appropriateness of the evidence compiled to demonstrate fitness to register with the CQC and the robustness of the processes behind the Quality Account.

Process for Review

The Committee will complete an annual review of its terms of reference and conduct a self-assessment of its effectiveness on an annual basis, in line with the requirements of the Audit Committee Handbook.

Support

The Trust Secretary and Deputy Trust Secretary will ensure the Committee is supported administratively and advise the Committee on pertinent issues/areas.

Board committee report

Meeting	Public Trust Board	Agenda Item	19
Report title	Digital Committee Report to the Board for 16 January and 9 February 2026	Meeting Date	16 January and 9 February 2026
Chair	Richard Oosterom – Chair, Finance Performance and Planning Committee		
Author	Governance Business Administrator		
Quorate	Yes ☒	No ☐	

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

- **Continued Slippage in OneEPR Delivery and Associated Operational Risk:**
  - The Minimal Viable Product (SU4) delivered on 9 February is incomplete and missing required core functionality
  - 58 Priority-1 defects remain unresolved, posing a major risk to clinical safety and operational readiness.
  - Confidence in supplier delivery is low, and revised delivery date of 27 March 2026 is not considered credible by the Committee.

Assurances provided to the Board:

- **Strengthened Governance and Clarity of Committee Responsibilities:**
  - The Committee approved the updated Terms of Reference, confirming governance alignment
- **Progress in Digital Outpatients and Contact Centre Performance:**
  - There have been significant drops in missed calls and call volumes; and a cumulative 1.29% DNA reduction, equating to £636k YTD benefit.
  - Digital Outpatients is making measurable progress, including:
    - 65–70% clinic onboarding to Patient Hub.
    - Positive patient engagement (70–75% digital uptake).
    - Pre-assessment digital questionnaires preventing 383 appointments to date.
- **Committee-Directed Strengthening of Risk Management:** The Committee has instructed the programme team to produce a dedicated OneEPR Risk Register, including a full risk review, clear articulation of clinical and operational risks, and a defined "Plan B" pathway. This register will support traceability, early identification of deteriorating risk positions, and visibility for the Board.
- **Strengthened Oversight and External Assurance:** The Trust is undergoing an NHS England First of Type Review, which will provide an additional level of independent scrutiny to support the assurance required before any go-live approvals. This process is expected to strengthen the robustness of decision-making and provide evidence on whether the Trust's plans are credible and safe.

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

- **Outpatient Transformation Delivery Risk Due to Workforce Capacity:** Current vacancy approval controls may be slowing recruitment at a time when timely resourcing is essential.
- **Continued Withholding of NHSE Funding:** NHSE is currently withholding approximately **£1.4m** linked to procurement concerns.

- **Ongoing Monitoring of Supplier Delivery (Dedalus):** Continued scrutiny will be needed as the supplier attempts to meet the revised 27 March 2026 milestone for missing MVP components.

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

- **Terms of Reference:** The Committee approved the updated Terms of Reference, including revised governance responsibilities and updated standing attendees, for submission to the Board for formal ratification.
- **Cancer Services**: The Committee noted the upcoming go-live of the Somerset Cancer Register (SCR) and accepted the underlying risk related to equipment upgrades and Windows 11 compatibility.
- **Diagnostics Connect**: The Committee agreed to further explore whether Diagnostics Connect functionality should be incorporated into OneEPR in future.
- **K2 Review:** Given performance concerns and limited supplier viability, the Committee agreed that a formal review of the K2 maternity system is required.

Any actions recommended to improve effectiveness of the meeting:

N/A

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

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Board

Meeting	Public Board	**Agenda Item**	19.1
Report title	Digital Committee Terms of Reference approval	**Meeting Date**	11 March 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 and 16 January 2026 OneEPR Committee.	
Recommendation	The Board is asked to **APPROVE** the terms of reference for the Digital Committee.

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DIGITAL COMMITTEE

TERMS OF REFERENCE

1. Purpose

The Committee provides assurance, scrutiny, and oversight of all major digital transformation programmes (including OneEPR and Outpatient Transformation (OPD), ensuring alignment with the Trust's strategic objectives.

2. Scope

The Committee's work will include all digital matters specifically:

Digital Strategy & Sustainability:
- Overseeing the Trust's digital and technology strategy, ensuring alignment with national NHS priorities and the Trust's business plan.
- Identifying emerging technologies and opportunities to improve patient care and operational efficiency.

Digitally-led Major Programme Performance & Delivery:
- Assurance on delivery of major programmes (e.g., Electronic Patient Record (EPR), interoperability initiatives, cyber security improvements).
- Scrutinising programme performance, delivery milestones, and key performance indicators (KPIs).
- Ensuring effective governance, decision-making, and risk mitigation.
- Benefits realisation and ensuring financial sustainability and value for money relating to the digital programmes.

Digital Business Planning & Risk Management:
- Review and approval (or recommendation) of significant digital capital/revenue business cases within delegated authority.
- Reviewing business plan implementation and strategic alignment.
- Overseeing financial, operational, workforce, and reputational risks, ensuring effective mitigation.
- Digital Business continuity/disaster recovery assurance
- Assurance relating to effective cyber-security controls.

Digitally-led Major Programme Workforce & Organisational Readiness:
- Monitoring workforce transformation, change management, and service delivery impacts.

Digital Procurement & Commercial Oversight:
- Reviewing digital procurement, strategic contracts, and efficiency savings.

Policy and Governance:
- Oversight of digital policies, cyber security, and compliance with NHS standards.

3. Status & Authority

The Committee is a formal Committee of the Trust Board. The Committee is authorised by the Board to investigate any activity within its terms of reference.

It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

4. Membership

Three Non-Executive Directors, one of whom will be nominated as Chair.

Core Attendees:

- Chief Information Officer
- Chief People Officer
- Medical Director
- Deputy Director of Finance Financial Planning
- Deputy Chief Information Officer
- Chief Clinical Information Officer
- Chief Operating Officer
- Chief Kaizen Officer
- Deputy Chief Nurse

Attendees:

- EPR Programme Director
- Programme Director – Outpatients Transformation
- Chief Nursing Information Officer
- Deputy COO
- Director of Communications and Engagement

All other Non-Executive Directors/Directors are welcome to attend.

Other staff will be invited to attend to present an item to the Committee or to support their personal development with the prior agreement of the Committee Chair.

If a conflict of interest is established, the above member/attendee concerned should declare this and withdraw from the meeting and play no part in the relevant discussion or decision.

Deputies are permitted for attendees as an exception, with the Chair's agreement.

5. Quorum

The Committee will be quorate if two non-executive members are present, the Chief Information Officer or their deputy and the Medical Director or their Deputy.

6. Frequency of meetings

The Committee will aim to meet monthly. The Chair of the Committee may convene additional meetings if required to consider business that requires urgent attention.

Whilst not binding, the meeting is intended to alternate between face-to-face meetings and on Teams.

7. Duties

7.1 Digital Strategy & sustainability

- Scrutinise and approve the Trust's digital strategy and plans.
- Monitor progress against agreed milestones and benefits realisation.

- Stakeholder Engagement: Work collaboratively with system partners (ICS, NHS England) to align digital initiatives.

7.2 Digitally-led Major Programme Financial and Resource Assurance

- Regularly review the programme's financial performance against the approved relevant budget and benefits case.
- Provide oversight and assurance on financial management, ensuring alignment with the Trust's strategic objectives.
- Financial and resource assurance: Review significant digital investment proposals and ensure value for money.
- Regularly review the programme's financial performance against the approved relevant budget and benefits case

7.3 Performance and Planning

- Monitor and evaluate the programme's performance against the agreed project plan, ensuring delivery milestones are met.
- Review and approve any proposed deviations from the plan that:
    - Have a significant financial impact on the Trust (exceeding £250k).
    - Materially affect the expected benefits case or return on investment.
- Ensure that risks to programme delivery are identified, assessed, and mitigated appropriately.

7.4 Workforce and Resourcing

- Provide oversight of workforce planning in relation to the digital programmes, ensuring that staffing levels, skills, and structures align with the programme's objectives.
- Identify and monitor programme workforce-related risks, including the impact of staffing changes on service delivery and financial sustainability.
- Oversight to Support workforce transformation by leveraging digital solutions to streamline workflows, enhance collaboration and improve patient safety.
- Support Successful Adoption of Digital Solutions: Drive engagement, training, and cultural change initiatives to ensure the workforce fully embraces and successfully adopts new digital tools and ways of working, and benefits to patient care are identified and measured.
- Support Engagement in Digital Deployment: Foster active involvement and engagement of the workforce during the deployment of digital solutions, ensuring clear communication, ongoing support and feedback loops to drive adoption and address concerns, particularly where these concerns may impact successful adoption and resultant patient care benefits.
- Ensure organisational change plans are in place to support digital adoption.

7.4 Procurement Oversight

- Review procurement activities for strategic digital contracts, ensuring alignment with the Trust's financial strategy and value-for-money principles in relation to the digital programmes.
- Monitor progress against efficiency and cost savings.
- Oversee major change initiatives that have implications for procurement, financial performance, or operational effectiveness.

7.5 Workforce Metrics and Operational Performance

- Review workforce metrics that impact operational performance in relation to Digitally-led Major programmes, including but not limited to:
    - Temporary staffing utilisation and expenditure
    - Establishment controls and workforce planning
    - Provide assurance to the Board on workforce sustainability and efficiency.

11 December 2025

7.6 Governance and Compliance

- Ensure that all programme-related activities comply with relevant regulatory, financial, and governance frameworks.
- Oversight of digital policies.
- Ensure compliance with NHS digital standards.

7.7 Risk Reporting

- Review programme and corporate risks allocated to the committee.
- Escalate significant risks to the Board and for incorporation within the Corporate Risk Register or Board Assurance Framework.
- Seek assurance that programmes have effective governance, risk management, and resource planning.

7.8 Cyber Security

- Cyber security strategy.
- Confirm robust cyber security and disaster recovery frameworks are maintained.
- *[Note: Information Governance compliance is overseen by the Audit & Risk Committee rather than the Digital Committee]*

8. Reporting arrangements

The Committee will identify and report the key issues, risks and performance trends requiring Board consideration to the Trust Board after each meeting. It will make recommendations to the Board, Trust Management Group and Executive Directors for these groups/individuals to take appropriate action. The Committee will maintain transparency on progress, risks, and decisions.

9. Process for review of Committee's work including compliance with terms of reference

The Committee will monitor and review its compliance through the following:

- The Committee report to Trust Board;
- Annual evaluation and review of its terms of reference;
- Where relevant a workplan will be developed to capture improvement actions as part of the annual review and progress reported back to the Committee.

10. Support

The Corporate Governance department will ensure the Committee is supported administratively and advise the Committee on pertinent areas.

11 December 2025

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													

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
Planning guidance	X												X
Winter Planning (annual)									x				
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				
Whistle blowing			X										
NHS England capability self-assessment					X								
Enabling Strategies													
Estates and Facilities Strategy	X										X		X
People Strategy					X								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**
Green Strategy							X						
Quality& Clinical Strategy			X										
Equality, Diversity and Inclusion Strategy			X										
Digital Strategy					X								
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

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**
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													
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													

East and North Hertfordshire Teaching NHS Trust

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
ENH Pharma (Part 2) shareholder report to Board							X						