

Public Trust Board

To be held online



08/07/2026 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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 ENHPS Hub, Old School of Nursing, Lister Hospital,
on Wednesday, 13 May 2026 at 9.30am**

Present:

Ms Anita Day (AAD)	Trust Chair
Mrs Karen McConnell (KMc)	Deputy Trust Chair
Ms Janet Scotcher (JS)	Non-Executive Director
Ms Gillian Hooper (GH)	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:

Mr Stuart Dalton (SD)	Head of Corporate Governance
Mrs Debbie Okutubo (DO)	Deputy Company Secretary (Board Secretary - minutes)
Mr Moreblessing Zvorwadza (MZ)	Divisional Nursing & Quality Director (26/050)

No	Item	Action
	The Chair, AAD welcomed Board members, attendees and a special guest speaker to narrate the patient story. It was confirmed that the agenda had been published on the website and seen by all Board members.	
26/048	DECLARATIONS OF INTEREST There were no new interests declared.	
26/049	APOLOGIES FOR ABSENCE Apologies for absence were received from Professor Zoe Aslanpour, Non-Executive Director, Dr David Buckle, Non-Executive Director and Ms Diana Skeete, Non-Executive Director.	
26/050	PATIENT STORY The Chief Nurse, TM introduced the patient also known as A, an NHS staff member from another Trust. A described her pre-admission care as 'incompetent' due to lack of system integration, explaining she presented with IBS symptoms and was referred for colonoscopy without advice on escalation if symptoms worsened. A later attended ED with rectal bleeding; her medical notes were not transferred, there was no escalation, and she was told she did not meet criteria to be admitted and was left unsupported. At follow-up, there was no acknowledgement of her rectal bleeding or diarrhoea. She was referred back to her GP instead of being reviewed and was advised to wait for gastroenterology, leading to loss of confidence and concerns about her safety.	

She was eventually admitted to a gastroenterology ward without clarity on why. During ward rounds, she felt unheard, and her fear was not acknowledged, despite her experience managing long-term complex conditions. She reported a lack of dignity and privacy on the ward but praised visiting hours, porters, and the clinical team. She was discharged on a Saturday.

Post-discharge, it took two weeks to confirm her medication, during which symptoms returned. A year passed before she saw a consultant, by which time she had developed a lifelong complex condition.

Board Discussion

The Chair AAD thanked A for her openness and apologised on behalf of the trust.

JD apologised, stating her care should have been better, referrals were too late, and failure to combine records was poor care. He noted structural issues, including ICB referral constraints. A responded that she felt she had failed as an NHS professional in navigating her care.

JD advised a new ICB was in place and discussions would occur regarding referrals. He committed to addressing ward round practice, noting all patients would be scared and this needed recognition.

GH described the story as powerful and raised concerns about unconscious incompetence and whether failure to consider the patient voice was systemic or ward-specific.

TM praised A's courage and confirmed ward-level improvements, including unconscious bias training and ensuring dignity across day and night care. TM committed to ongoing contact with A.

KMc also apologised and praised A's professionalism and questioned how much improvement was within the Trust's control and suggested broader place-based working and sharing the patient story with partners.

LD thanked A and noted the story highlighted multiple risks and improvement areas.

PSM asked what could be done differently in ED.

A highlighted environmental concerns including:

- overcrowding,
- lack of ventilation,
- no natural light,
- no charging points, and
- a noisy mixed environment.

She suggested safer, quieter areas.

ASJ emphasised that not all issues were outside the trust's control, particularly follow-up waiting times, and described A's account as striking from a frontline NHS perspective. He thanked A for her measured approach and stressed the importance of rebuilding her trust.

The Chair, AAD reiterated the impact of the story, noting the implications if an NHS worker experienced such care, and encouraged continued dialogue with executives.

A thanked the Board and agreed to follow up, then left the meeting.

Actions and Reflections

The Chair, AAD requested a report on thematic issues and progress.

JD confirmed actions were underway.

Members noted clinicians were avoiding referrals and that MDT working and confidence needed improvement.

The Board was informed that the violence and aggression group had met, with a focus on ensuring safety for patients and staff.

Actions and next steps

- Report back to Board on thematic issues and progress improvements – JD to action.
- Engagement with ICB regarding referral pathways – JD to action.
- Review:
 - Follow-up delays
 - Ward round practices
 - Patient experience and dignity standards TM and JD.
- Continue dialogue with Patient A - TM.

The Board **NOTED** the patient story.

26/051 MINUTES OF THE PREVIOUS MEETING

The minutes of the meeting held on 11 March 2026 was **APPROVED** as an accurate record of the meeting.

26/052 ACTION LOG

The Board reviewed the action log and noted progress against actions.

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

26/053 QUESTIONS FROM THE PUBLIC

There were no public questions.

26/054 CHAIR'S REPORT

The Chair, AAD provided an update. She commented that the integrated care board (ICB) reconfiguration had taken effect on 1 April 2026, with Hertfordshire & West Essex ICB merging into the Central East ICB.

She further mentioned that this was the last board meeting with the Chief Executive, Adam Sewell-Jones but that it would be discussed in detail under the AOB agenda item.

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

26/054a - Philanthropy Board sub-committee

The Chair sought formal ratification of the Chair's action to establish a Philanthropy Board as a sub-committee of the Hospital Charity. She reported that a local businessman and regular donor, Simon Cox, had agreed to act as chair of the Board, and a £2 million fundraising target had been set. The intention was to use the funding to enhance facilities and patient experience for children and young people in the Trust's new paediatric unit next year.

The Board **RATIFIED** the Chair's action.

26/055 CHIEF EXECUTIVE'S REPORT

The Chief Executive, ASJ presented his report and summarised key updates. He reported that the Trust had been ranked as the highest-rated acute Trust in the East of England and 21 overall nationally within the NHS oversight framework, narrowly missing progression into the highest segment.

He informed the Board that demand across hospital services remained very high and noted the opening of a new audiology hub, which would support reductions in waiting times and contribute to the development of a centre of excellence. He commended both clinical and estates' teams for their contribution to its delivery.

The Chief Executive, ASJ highlighted developments in quality, including the introduction of a "swarm" approach to incident learning, whereby multidisciplinary teams rapidly reviewed incidents in real time. He further reported on successful capital investment in areas such as paediatrics, renal dialysis and diagnostic equipment.

He advised that a Trust-wide transformation programme had been launched, focusing on both fundamental service redesign and improvement in core operational processes.

He also drew attention to the significant national recognition received by trust staff, including multiple NHS excellence awards.

Finally, the Chief Executive informed the Board that this would be his final Board meeting prior to his departure from the Trust and expressed his appreciation to the Board and staff for their support.

The Chair thanked Mr Sewell-Jones for his leadership and contribution to the Trust and reiterated that a farewell would be said at the end of the meeting.

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

26/056 WHISTLE BLOWING POLICY

The Chief People Officer, PSM presented the policy, and explained that the policy had been developed to provide clarity for staff on how to raise concerns and for managers on how to respond appropriately. She stated that the policy outlined the Trust's commitment to supporting staff to raise concerns, including clear guidance through flowcharts. She further provided examples distinguishing whistleblowing from other processes such as grievances.

The Head of Corporate Governance, SD, outlined minor amendments made following further review, including additional provisions regarding conflicts of interest, counter-fraud considerations and clarification on the management of malicious allegations.

RO asked about the arrangements for monitoring. PSM confirmed that information would be captured through a case management system and reported through the People and Culture Committee.

Following further discussion, the Board approved the Whistleblowing Policy.

The Board **APPROVED** the Whistleblowing Policy.

26/057 LEARNING FROM DEATHS REPORT

The Medical Director, JD presented the report and emphasised that while mortality rates remained low compared to expectations, the trust remained committed to learning from deaths where care could have been improved. He noted that delays in urgent and emergency care pathways remained the most significant factor associated with avoidable deaths.

TM asked about care for vulnerable patient groups, particularly those with learning disabilities. JD acknowledged that this required ongoing focus as it was consistent with national challenges.

In response to a question from KMc, JD confirmed that there were no current concerns regarding mortuary capacity, although delays in medical examiner processes could affect families.

RO asked about the upward trend in the last few months and if the Medical Director found this worrying. JD reported that mortality indicators remained stable overall and that no emerging concerning trends had been identified.

NJ asked if health inequality including race data could be measured. JD stated that work to improve ethnicity data capture and understanding of health inequalities was underway, although challenges remained, due to data limitations.

The Chair commented on the SJR tool that was being decommissioned. JD advised that a new mortality review system was being implemented and remained on track, with it having an enhanced capability to analyse and triangulate data compared to the existing tool.

Following further discussion, the Board agreed with the proposed assurance rating of substantial.

The Board **AGREED** to a **SUBSTANTIAL** assurance for the learning from deaths report.

26/058 ANNUAL REVIEW OF STANDING ORDERS, SCHEME OF RESERVATION AND DELEGATION & STANDING FINANCIAL INSTRUCTIONS

The Chief Finance Officer, MA presented the annual review of the Trust's governance documents. He advised that the revisions were minimal and primarily related to tightening financial controls in response to the current financial environment.

RO asked if there was a timeline due to the number of issues raised. MA responded that work was underway to develop an interactive digital tool to improve accessibility and understanding of the documents. It was noted that by September we should have the navigating tool. In the meantime, conversations would continue at the Finance, Performance and Planning Committee (FPPC).

NJ asked how the changes would be assessed and what impact it would have on quality. In response, JD stated that quality impacts would be assessed alongside financial decision-making. Data would also be utilised to measure the impact on quality.

The Chief Executive, ASJ commented that there was now an escalation route which had been included in the document presented.

The Board **RATIFIED** the Standing Orders, Scheme of Reservation and Delegation & Standing Financial Instructions.

26/059 BOARD ASSURANCE FRAMEWORK (BAF) – STRATEGIC RISKS

The Head of Corporate Governance, SD presented the proposed BAF strategic risks for 2026/27. He noted that these had been developed following extensive discussion and horizon scanning.

The Chair endorsed this and commented that the board had been discussing this for a while it should therefore not be a surprise to any board member.

KMc commented that demand capacity and flow was a FPPC risk and asked if the Quality and Safety Committee (QSC) needed to have oversight on this - risk #9 and risk #1, it was noted fell in the same domain.

A discussion ensued on the allocation of risks to committees, and it was agreed that while each risk should have a clear lead committee, there should also be appropriate cross-committee oversight for risks spanning multiple domains.

GH commented that QSC would focus mainly on the clinical governance of the risk presented to them.

The Chair, AAD stated that there needed to be clear governance to ensure cross cutting oversight was carried out smoothly and asked the Head of Corporate Governance to ensure that cross-committee oversight arrangements were appropriately reflected in governance processes with immediate effect.

The Board **APPROVED** the BAF.

26/060 INTEGRATED PERFORMANCE REPORT (IPR)

The Chief Kaizen Officer, KoH presented this item and highlighted key points from all four quadrants:

Quality: He reported that quality indicators remained stable overall, with high levels of patient satisfaction. However, there were issues relating to availability of medical records during transition to digital systems.

Operations: In relation to operational performance, KoH reported that four-hour emergency department performance stood at 74.7%, representing improvement, and that elective performance had exceeded national improvement targets. It was noted that cancer performance remained strong, although diagnostics and community paediatrics continued to present significant risks due to demand and capacity constraints.

Finance: He advised that the Trust had reported a £5 million surplus, however, this was heavily reliant on non-recurrent measures. He stated that productivity and delivery of savings remained significant challenges.

People: Workforce indicators showed improvement in vacancies, but there was continued reliance on bank staffing, and sickness absence was above target levels.

The Board discussed several areas, including sepsis compliance, patient experience, complaints performance and workforce planning. It was noted that actions were underway to address each of these areas, although further improvement was required.

The board requested that the Chief People Officer, PSM strengthen workforce planning arrangements and reduce reliance on bank staff through the transformation programme.

The Chief Nurse, TM commented that progress on sepsis 6 compliance would be reported through the QSC.

The Chair asked about the urgent emergency centre (UEC) and if progress seen to date was part of the transformation project. In response, LD commented that JD, TM and herself (LD) had visited West Hertfordshire Teaching Hospital, Watford and following that visit, Deloitte had been invited to support the trust in taking the project forward.

The Chair requested that a timeline be presented to the board.

Actions:

- The Chief Nurse, TM to provide a clear improvement trajectory for complaints response times at the July Board meeting.
- The Chief Operating Officer, LD to present a timeline on the improvement work in the UEC.

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

26/061 QUALITY AND SAFETY COMMITTEE (QSC) REPORT TO THE BOARD

In the absence of the QSC Chair, DB, GH highlighted the matters of concern to the Board as contained within the report.

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

26/062 FINANCE PERFORMANCE AND PLANNING COMMITTEE (FPPC) REPORT TO THE BOARD

The FPPC Chair, RO highlighted matters of concern to the Board and referred them to the report.

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

26/063 PEOPLE AND CULTURE COMMITTEE (PCC) REPORT TO THE BOARD

The PCC Chair, JS drew attention to matters of concern to the Board reiterating what had been reported.

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

26/064 HEALTH CARE PARTNERSHIP (HCP) REPORT TO THE BOARD

The Chief Executive, ASJ presented to the board. He commented that we were still awaiting final feedback from the new ICB and to date no delegations had been indicated and that new membership had been discussed.

Regarding the HCP performance report, it was noted that it was not available due to the ongoing restructuring in the ICB since the last meeting.

The Audit and Risk Committee (ARC) Chair, KMc requested future discussion of HCP governance at ARC.

The Chair thanked Mr Adam Sewell-Jones, for chairing the HCP in his capacity as Chief Executive and informed the board that Mr Martin Armstrong, Interim Chief Executive would chair the HCP going forward.

She also used the opportunity to thank all committee chairs.

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

26/064a
ENH – HCP committee terms of reference

The Board **APPROVED** the terms of reference

26/065 AUDIT AND RISK COMMITTEE (ARC) REPORT TO THE BOARD

The ARC Chair, KMc presented the committee report as contained within the report. She commented that since providing the report, the Head of Internal Audit (HOIA) opinion had been upgraded to 'reasonable'.

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

26/066 DIGITAL COMMITTEE REPORT TO THE BOARD

The Digital Committee Chair, RO presented the report to the Board.

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

26/067 REMUNERATION & APPOINTMENTS COMMITTEE TERMS OF REFERENCE

The Head of Corporate Governance, SD presented the amendment to the terms of reference.

The Board **APPROVED** the revised terms of reference.

26/068 ANNUAL CYCLE

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

26/069 ANY OTHER BUSINESS

The Chair formally acknowledged that this was the final board meeting for Mr Adam Sewell-Jones as Chief Executive and expressed appreciation for his leadership and contribution to the organisation.

She commented that she had approached several people in the trust asking them to describe Adam in a word/phrase and that the consistent words/phrases included:

- great impact
- continuous improvement
- engagement with partners in the system
- collaborative
- building relationships with primary care
- encouraging openness and people to speak up.

The Chair commented that these were all testaments of his leadership skills.

It was noted that he would be leaving at the end of May. The Chair thanked him on the behalf of the board on his direction and contribution in the Trust over the last four and a half years since taking up the position.

There was no other business.

26/070 DATE OF NEXT MEETING

The date of the next meeting is 8 July 2026 to be held online.

Ms Anita Day
Trust Chair
May 2026

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

Agenda item: 5

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

Meeting Date	Minute ref	Issue	Action	Update	Responsibility	Target Date
11 March 2026	26/044a	Committee terms of reference (ToR)	There should be layout consistency across all Committee ToRs	This will form part of the corporate governance teamwork cycle for 2026	Head of Corporate Governance	December 2026
13 May 2026	26/050	Issues from the patient story	Report back on thematic issues and progress <ul style="list-style-type: none"> Follow-up delays Ward round practices Patient experience and dignity standards 	<ul style="list-style-type: none"> Discussion with gastroenterology CD re specialty ward rounds and what can change. Discussion with ED team – could they improve amenities in ED waiting room. Met with patient to feedback and discuss care. 	Medical Director & Chief Nurse	May 2026 Completed
13 May 2026	26/050	Issues from the patient story	Engagement with ICB regarding referral pathways	Met with ICB medical director and have confirmed inwriting a change to consultant-to-consultant referrals – this has been communicated to teams.	Medical Director	May 2026 Completed

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

Meeting Date	Minute ref	Issue	Action	Update	Responsibility	Target Date
13 May 2026	26/060	Integrated Performance report	To provide a clear improvement trajectory for complaints response times at the July Board meeting	Improvement trajectory attached.	Chief Nurse	June 2026 Completed
13 May 2026	26/060	Integrated Performance report	To present a timeline on the improvement work in the UEC.	In progress via Deloitte-supported transformation workstream.	Chief Operating Officer	September 2026

Chief Executive's Report

July 2026

Chief executive update

I am incredibly honoured to have been appointed as chief executive of East and North Hertfordshire Teaching NHS Trust (ENHT). Having worked within the trust for almost ten years, this organisation, its people and the communities we serve mean a great deal to me personally. To be entrusted with leading ENHT into its next chapter is both a privilege and a responsibility that I take very seriously.

As I begin my tenure as chief executive, my immediate focus is on listening, engaging and working with colleagues, patients, partners and stakeholders. ENHT has many strengths. We have talented staff, committed clinical and operational teams, strong community support and a proud record of service. However, strong foundations alone are not enough. Performance across a number of important areas remains below the standards we aspire to achieve and, in some cases, below the standards our patients, staff and Board rightly expect.

The Board has been clear in its ambition for the organisation and in its expectation that we improve. I share that ambition. The challenge facing all of us is not simply to identify opportunities for improvement, but to execute them effectively and deliver meaningful, measurable and sustained change. The pace of improvement has not always matched the scale of the challenge before us and I believe we must now move with greater urgency, focus and consistency.

Following my appointment, Barry Jenkins has been appointed as interim chief finance officer. Barry brings extensive executive experience supporting organisations through periods of financial recovery, transformation and operational improvement. I am also delighted that Theresa Murphy, our chief nurse, has agreed to undertake the additional responsibilities of deputy chief executive. Theresa is a highly respected clinical leader and I am grateful for the energy, insight and commitment she will bring to the role.

Whilst there is much to be proud of, I believe we have become too comfortable being regarded as a good organisation. My ambition is for ENHT to become a great organisation – recognised not only for its culture and values, but for consistently delivering outstanding outcomes for patients, staff and communities. That ambition will require us to build on our strengths, confront our challenges honestly and relentlessly focus on delivery.

National and regional update

The national NHS landscape continues to evolve at pace, with increasing focus on productivity, financial sustainability, constitutional standards, neighbourhood health services and organisational performance.

The publication of Quarter 4 NHS Oversight Framework ratings provided an opportunity to reflect on the Trust's current position. ENHT maintained its segmentation rating of 2 and remains one of the stronger non-tertiary acute providers within the East of England. This reflects the commitment and hard work of colleagues across the organisation.

However, emerging performance trends demonstrate that maintaining this position through 2026/27 will become increasingly challenging without significant improvement across financial performance, elective recovery, diagnostic access and urgent care standards. Stability alone is not enough. Our focus must now be on delivering the improvements necessary to strengthen performance and improve outcomes for patients.

Regionally, Nick Carver has taken up the role of regional chair for the East of England. His appointment reinforces the importance of collaboration across organisations and systems as we respond to the opportunities and challenges facing the NHS.

National reviews and learning

Two significant national reviews have been published in recent weeks which have important implications for NHS organisations.

The publication of Lord Mann's independent review into antisemitism and other forms of racism in the NHS highlights the continuing importance of tackling discrimination, strengthening accountability and fostering inclusive organisational cultures. The review examines how NHS organisations identify, report and respond to antisemitism and wider forms of racism affecting both staff and patients. The Government has accepted the recommendations and NHS organisations will be expected to consider their implications locally. The trust will review the findings carefully and ensure relevant learning and action is reflected within our governance arrangements and our people, equality, diversity and inclusion programmes.

The publication of Dame Donna Ockenden's independent review into maternity and neonatal services at Nottingham University Hospitals NHS Trust provides a stark and sobering reflection on the consequences of sustained failures in patient safety, leadership, governance and organisational culture. The report identifies significant concerns regarding the quality of care provided to women, babies and families over an extended period and highlights the importance of listening to patients and staff, responding effectively to concerns and maintaining robust clinical governance arrangements.

Whilst the findings relate specifically to Nottingham, the lessons are relevant to maternity services across the NHS. The report will therefore require careful consideration by the trust's maternity, nursing and quality leadership teams. The Board will receive assurance regarding our assessment of the findings and any actions arising at its September meeting.

Together, these reviews reinforce the importance of leadership, culture, inclusion, accountability and a relentless focus on quality and safety.

Performance and improvement

The trust's Transformation Programme remains central to improving organisational performance, supporting financial sustainability and delivering better outcomes for patients.

The programme continues to develop and gain pace, bringing together a broad portfolio of work across clinical, operational and corporate services. Key areas of focus include improving urgent and emergency care flow, reducing waiting times, strengthening outpatient pathways, improving theatre productivity, expanding diagnostic capacity and delivering recurrent efficiency improvements.

A significant development during the period has been the mobilisation of Deloitte to support the trust's agreed transformation and recovery programme. Deloitte are currently undertaking an initial diagnostic phase to validate opportunities, establish baselines and support prioritisation across key areas of focus. This work will move rapidly into mobilisation and delivery across agreed workstreams.

The purpose of this partnership is not simply to generate additional analysis or recommendations. Rather, it is to provide additional capacity, capability and challenge to support the organisation in delivering meaningful and sustainable improvements at pace. Importantly, the programme remains owned and led by the trust, with Deloitte providing support and expertise alongside our own teams.

The next phase of the Patient Hub rollout is also underway, introducing additional digital functionality that will improve patient experience whilst reducing administrative burden and supporting more efficient ways of working.

Mount Vernon Cancer Centre Consultation

The report summarising public and stakeholder feedback on proposals for the future location of Mount Vernon Cancer Centre has now been published. The proposals seek to secure the long-term sustainability of specialist cancer services through the development of a new purpose-built facility at Watford General Hospital alongside enhanced local and community provision.

The programme represents a significant milestone in the future development of specialist cancer services across the region and reflects the need to ensure that patients continue to have access to high-quality cancer care supported by the wider acute services increasingly required for modern cancer treatment.

The proposals also envisage that responsibility for specialist cancer services would ultimately transfer from East and North Hertfordshire Teaching NHS Trust to University College London Hospitals NHS Foundation Trust. The timetable for this transition, together with the business case approvals required to support it, remains subject to further development and agreement.

The trust will continue to work closely with partners, patients, staff and stakeholders as the programme progresses.

Bedford rail incident response

The serious rail incident near Bedford on 19 June provided a reminder of the importance of resilience, preparedness and partnership working.

Whilst the incident occurred outside our immediate geography, ENHT played an important role in supporting the wider NHS response by providing additional capacity and assistance to partner organisations. I was extremely proud of the professionalism, flexibility and commitment demonstrated by colleagues throughout the incident.

The event also highlighted the importance of robust business continuity arrangements, major incident planning and strong partnership working. I would like to place on record my thanks to all colleagues involved in supporting the response.

Quality

Lister Hospital has become the first district general hospital in the country to be recognised as a Sophie's Legacy Approved Hospital.

This important achievement reflects the trust's continued focus on compassionate, family-centred care and demonstrates the commitment of colleagues to improving the experience of children, young people and families receiving care at ENHT.

Estates and capital developments

I am pleased to report that Swift Ward returned to full patient occupancy on 25 June following completion of a comprehensive refurbishment programme.

I would like to thank clinical, operational and support colleagues for the flexibility and resilience they demonstrated throughout the closure period. Alternative arrangements were established at pace and colleagues adapted ways of working whilst continuing to provide safe, high-quality care.

I would also like to recognise the contribution of our estates and facilities teams, whose prompt and professional response enabled the ward to reopen safely and within the planned timescale.

The Children's Big Build campaign has also made an excellent start. Significant charitable funds have already been secured and the response from local communities has been overwhelmingly positive, reflecting the importance and popularity of the project.

New main entrance

As outlined towards the end of last year, major redevelopment works to improve the front entrance at Lister Hospital began in September 2025, and we are now one step closer to completion as works on the concrete structure concludes.

Opening in autumn 2026, the new entrance will provide a better experience for our patients and visitors, with new shops and facilities transforming the existing entrance into a modern, welcoming, accessible and sustainable space. Crucially, the project is commercially funded, meaning no public money will be spent on the build and no money will be taken from any clinical, patient care or staff budgets.

People

Trust teams continue to receive external recognition for their achievements.

Mount Vernon Cancer Centre's Care Closer to Home initiative was recognised through the NHS Excellence Awards, whilst the Carer Experience Service received recognition for its innovative support to carers and families.

The Critical Care Outreach Team has also been shortlisted in the HSJ Patient Safety Awards 2026. These achievements reflect the professionalism, innovation and commitment demonstrated by colleagues across the organisation.

Our forthcoming Time to Shine Awards will provide a further opportunity to celebrate the outstanding contribution of colleagues across the trust. The awards are funded by the Hospitals' Charity, with generous sponsorship.

Chief executive closing remarks

As this is my first report to the Board as chief executive, I would like to conclude by thanking colleagues across the trust for the support I have received since my appointment.

There remains much to do. We face significant challenges in relation to performance, access, finance and delivery. The Board is rightly ambitious for this organisation and expects us to improve. That expectation is both reasonable and necessary.

However, I remain optimistic about the future. We have strong foundations, talented people and a clear opportunity to build something exceptional. My ambition is simple: that ENHT becomes one of the highest-performing and most respected organisations in the NHS, recognised not only for its culture and values, but for consistently delivering outstanding outcomes for patients, staff and communities.

I look forward to working with the Board, our staff and our partners as we translate that ambition into action and that potential into performance.

Martin Armstrong
Chief Executive

Board

Meeting	Public Trust Board		Agenda Item	9	
Report title	Staff survey – review of free text comments		Meeting Date	8 July 2026	
Author	Head of Colleague Development and Experience				
Responsible Director	Chief People Officer				
Purpose	Assurance	<input type="checkbox"/>	Approval/Decision	<input checked="" type="checkbox"/>	
	Discussion	<input type="checkbox"/>	For information only	<input type="checkbox"/>	
Proposed assurance level (<i>only needed for assurance papers</i>)	Substantial assurance	<input type="checkbox"/>	Reasonable assurance	<input type="checkbox"/>	
	Partial assurance	<input type="checkbox"/>	Minimal assurance	<input type="checkbox"/>	
Summary of key issues:					
<p>NHSE has asked all Trusts to consider the free text comments that accompany the Staff Survey and suggest improvement to three areas of dissatisfaction. The text has been analysed for ENHT and the three themes are;</p> <ul style="list-style-type: none"> • Workload and burnout • Leadership, communication and culture • Hygiene factors <p>Suggestions for how to improve these areas are covered in the accompanying paper.</p>					
Impact: <i>tick box if there is any significant impact (positive or negative):</i>					
Patient care quality	<input type="checkbox"/>	Equity for patients	<input type="checkbox"/>	Equity for staff	<input checked="" type="checkbox"/>
				Finance/Resourcing	<input type="checkbox"/>
				System/Partners	<input type="checkbox"/>
				Legal/Regulatory	<input type="checkbox"/>
				Green/Sustainability	<input type="checkbox"/>
<p>Delivery of the recommendations in the paper should lead to an improved colleague experience and ultimately better services for patients.</p>					
Trust strategic objectives: <i>tick which, if any, strategic objective(s) the report relates to:</i>					
Quality Standards	<input type="checkbox"/>	Thriving People	<input checked="" type="checkbox"/>	Seamless services	<input checked="" type="checkbox"/>
				Continuous Improvement	<input type="checkbox"/>
Identified Risk: <i>Please specify any links to the BAF or Risk Register</i>					
<p>This work is tasked to improve the environment within which our colleagues work and is part of the continuous colleague experience programme.</p>					
Report previously considered at & date(s):					
Recommendation	The Board is asked to support the suggestions for immediate action.				

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Staff Survey 2025

Overview and comments

July 2026



East and North
Hertfordshire Teaching
NHS Trust



Context

NHSE have requested that Boards review the free text comments from the most recent Staff Survey, and identify 3 key areas of dissatisfaction, with a view to developing actions to address these areas.

This presentation offers the Trust Board an overview of those comments and identifies 3 areas for consideration and awareness.

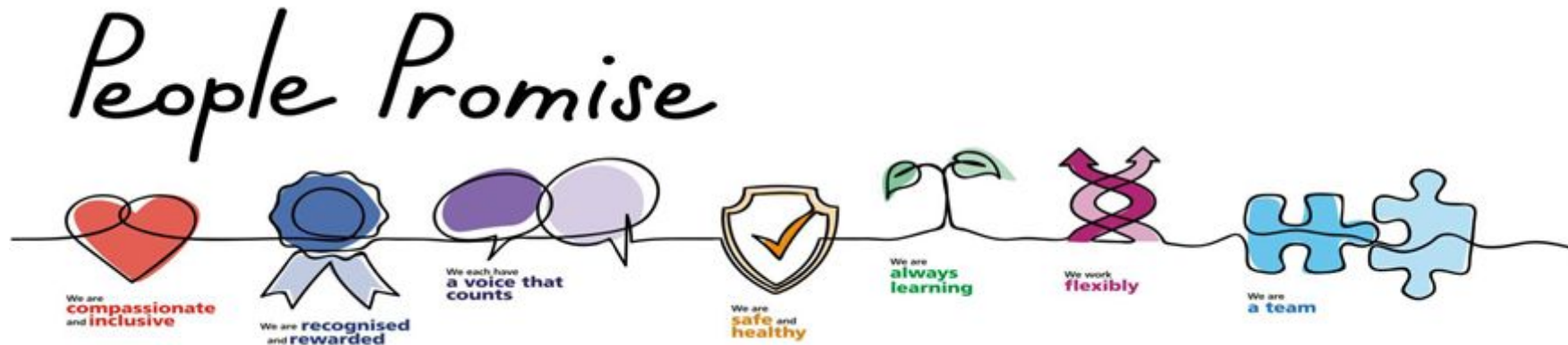
The themes identified are:

- Workload and burnout
- Leadership, communication and culture
- Hygiene factors.

For context, the deck also covers a summary of the survey results overall.

2025 National NHS Staff Survey

- Used by the NHS and CQC to assess Trust performance
- Links have been shown between staff engagement, patient experience and patient outcomes
- The survey aligns to the 7 NHS People Promises, there are also references to engagement and morale
- Our colleagues completed the survey during September and November 2025
- The National results were released in March.



Trust Response Rate & what it means

Response Rate

	Usable Sample	Completed			Total	Response Rate
		Paper	Online	Telephone		
2025 Org.	6,727	40	2,716	0	2,756	40.97%
2025 IQVIA	941,326	22,954	434,056	8	457,018	48.55%
2024 Org.	6,639	14	3,333	0	3,347	50.41%
2024 IQVIA	962,001	30,868	458,721	12	489,601	50.89%

IQVIA is an independent contractor appointed to administer the annual NHS Staff Survey in the UK, ensuring the process is confidential and secure.

- **Fewer people completed the survey in 2025 compared with 2024.** Even though the number of eligible staff increased slightly, the number of responses dropped by almost 600.
- **The response rate has fallen by around 10 percentage points.** That's a noticeable decline and suggests fewer colleagues chose to share their views this year.
- **Lower response rates can affect how representative the results feel.** It doesn't invalidate the findings, but it does mean fewer voices contributed to the overall picture.
- We recognise this reflects how stretched many colleagues have been, and it's understandable that not everyone had the time or capacity to take part. **Nevertheless, the feedback we received offers valuable insight into their experiences.**
- **We remain committed to acting on what they've told us** and to making it easier and more meaningful for everyone to share their views throughout the year.
- Even so, the voices we did hear from **provide important insight into what matters most right now.** We know colleagues engage when they see change, and we are determined to show that your feedback leads to action.
- We have been creating **more opportunities for open, honest conversations** so every colleague feels able to shape improvements within their team and across the Trust.

Ranked Sub Scores from highest to lowest across People Promise Themes

The **highest-scoring areas** cluster around compassion, inclusion, and feeling safe from negative experiences:

Diversity & Equality (8.27) - A standout strength. Colleagues feel the organisation treats people fairly and values diversity.

Negative experiences (7.89) - This suggests fewer colleagues are reporting bullying, harassment, or discrimination.

Compassionate leadership & culture (7.05 / 7.02) - Colleagues feel leaders and teams generally act with kindness and empathy.

Autonomy and control (6.94) - Colleagues feel they have some say in how they do their work.

These strengths paint a picture of a workplace that is fair, respectful, and grounded in positive relationships.

Middle-of-the-pack areas - steady but with room to grow:

Inclusion (6.90)

Line management (6.90)

Team working (6.71)

Work-life balance support (6.44)

Development (6.34)

Raising concerns (6.28)

Flexible working (6.22)

These scores are not low, but they show inconsistency. Some teams experience these things strongly; others less so.

Lowest-scoring areas

The bottom three scores are all linked to safety, wellbeing, and development:

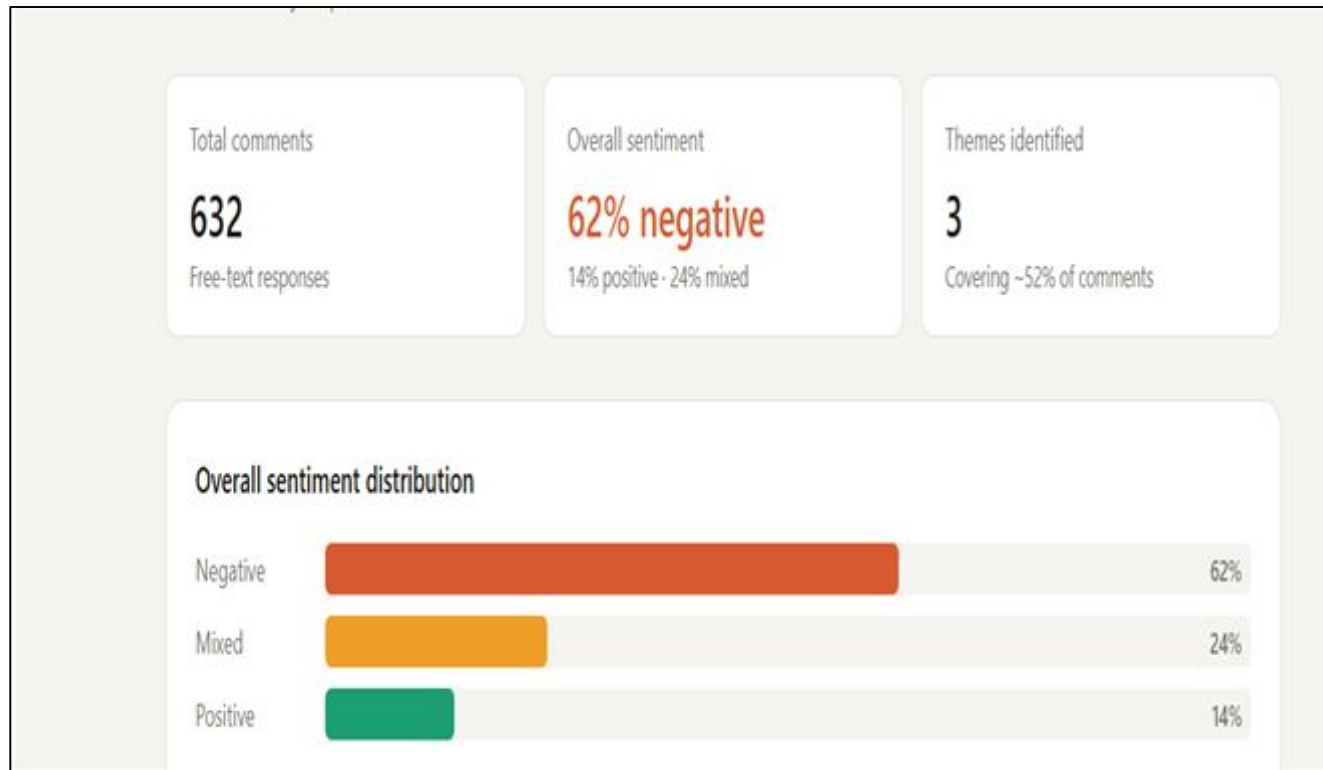
Health & safety climate (5.34) - Colleagues may feel the environment is not consistently safe or well-managed.

Burnout (4.99) - A clear signal of fatigue, workload pressure, and emotional strain.

Appraisals (4.89) - This is the lowest score — suggesting appraisals may feel inconsistent, unhelpful, or not meaningful.

These three areas align closely with the themes that declined in the overall survey results.

Overview of free text comments



23% of the respondents of the staff survey completed free text comments.

In 2025, 41% of colleagues completed the survey

The free text comments were analysed using;

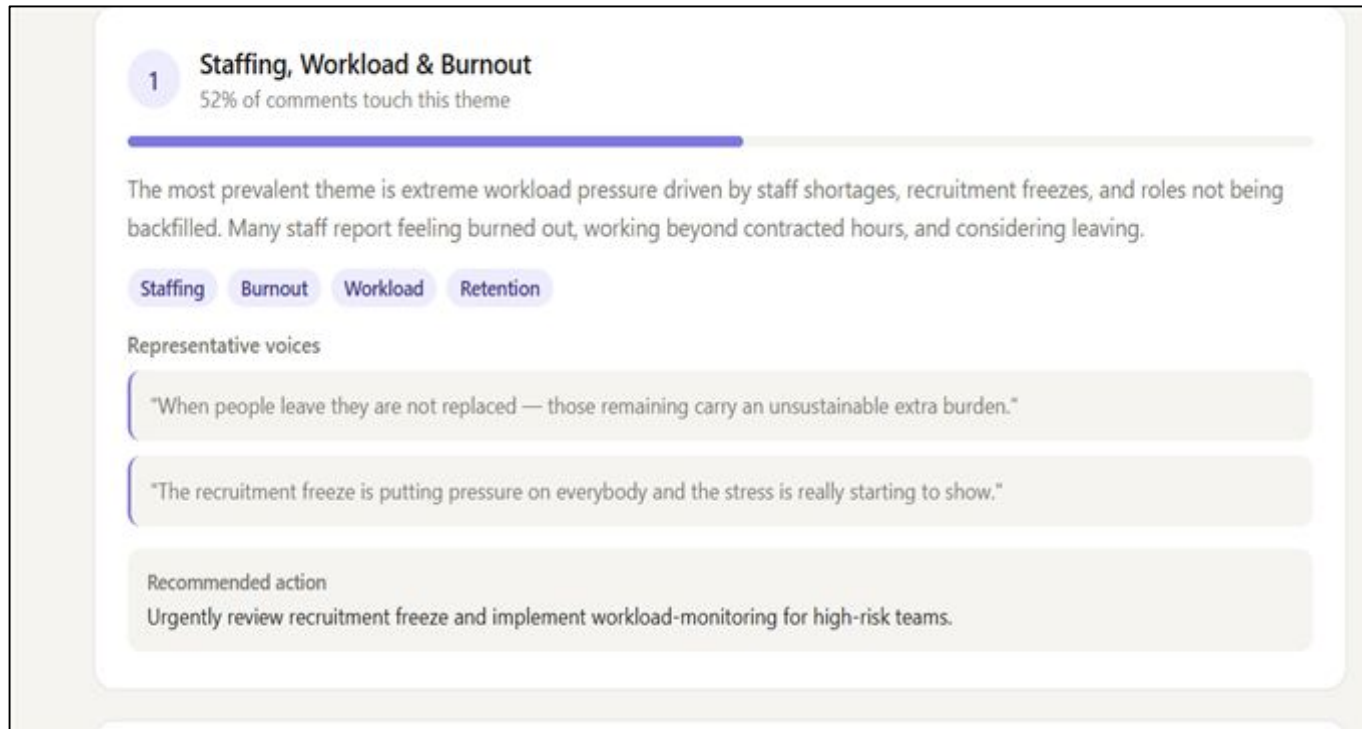
- MS Co-Pilot

- Qualitative review by the Colleague Experience Project Lead

- Python analytics supported by ENH Data Analysts

391/632 of the comments were negative.

Theme 1 - Workload and Burnout



This theme appeared over 328 times within the free text comments. This theme highlights the impact of (perceived) recruitment freezes on colleague wellbeing and morale.

Theme 2 - Leadership, Communication & Culture

Recommended action
Urgently review recruitment freeze and implement workload-monitoring for high-risk teams.

2 Leadership, Communication & Culture
44% of comments touch this theme

Many staff feel disconnected from senior leadership, citing poor communication during organisational changes, lack of transparency, and a culture that enables bullying or favouritism. Decisions feel top-down without meaningful consultation.

Communication
Bullying
Transparency
Leadership

Representative voices

"There is absolutely no communication between higher levels and staff — morale is falling apart."

"Bullying is rife and even when reported it is ignored, always in favour of the bullying manager."

Recommended action
Implement structured communication cascade and strengthen bullying investigation processes.

This theme appeared 278 times and highlights how colleagues believe a lack of communication and transparency from senior leadership has created a negative culture within the trust.

Theme 3 – Hygiene Factors

3 Pay, Parking & Practical Conditions

31% of comments touch this theme

Car parking costs and availability are a persistent daily stressor across all staff groups. Pay adequacy, especially for lower-banded roles, and the high local cost of living are also frequent concerns, with some staff citing these as reasons for considering departure.

Parking **Pay** **Cost of Living** **Facilities**

Representative voices

"Parking costs and the daily stress of finding a space significantly impact mental health."

"The salary is not enough to live here after paying rent, bills and daily expenses."

Recommended action
Review parking provision and subsidy options; benchmark pay against regional cost of living.

This theme occurred 195 times and indicates that cost and access to parking continues to impact colleague morale.

Actions -summary

- **Themes**
- **Workload and burnout**
 - Address perception of 'recruitment freeze'
 - Review priority work areas/ focus on alignment with 4 x strategic goals
 - Promote health and wellbeing interventions
 - Separately we are looking at how we conduct Grow Together Reviews to encourage performance and development conversations to be an ongoing process, rather than an end of year annual event.
- **Leadership, communication and culture**
 - Ensure every colleague has access to a computer to access learning and communication channels.
 - Continue with transformation communications in a diversity of ways including face to face briefings.
 - Encourage open and honest two-way communication through role modelling.
- **Hygiene factors**
 - Raise awareness of existing benefits e.g. money off websites, pension contributions, travel schemes – in one place allowing ease of access.

Board

Meeting	Public Trust Board		Agenda Item	10									
Report title	Responding to the Mann Review		Meeting Date	8 July 2026									
Author	Chief People Officer												
Responsible Director	Chief People Officer												
Purpose	Assurance	<input checked="" type="checkbox"/>	Approval/Decision	<input type="checkbox"/>									
	Discussion	<input type="checkbox"/>	For information only	<input type="checkbox"/>									
Proposed assurance level (<i>only needed for assurance papers</i>)	Substantial assurance	<input checked="" type="checkbox"/>	Reasonable assurance	<input type="checkbox"/>									
	Partial assurance	<input type="checkbox"/>	Minimal assurance	<input type="checkbox"/>									
Executive assurance rationale:													
The report seeks to provide assurance that ENHT has reviewed and begun actioning the recommendations contained within the Mann Review Report.													
Summary of key issues:													
Lord Mann, the Government Independent Adviser on Antisemitism, was asked to review, investigate, expose, and tackle antisemitism and other forms of systemic racism across the National Health Service (NHS) and UK healthcare regulatory systems. He found systemic antisemitism and other forms of racism impacting both NHS colleagues and patients, warning that discrimination forces many to suffer in silence or avoid care. The accompanying slide deck outlines how we are responding to the review including actions already underway.													
Impact: <i>tick box if there is any significant impact (positive or negative):</i>													
Patient care quality	<input checked="" type="checkbox"/>	Equity for patients	<input checked="" type="checkbox"/>	Equity for staff	<input checked="" type="checkbox"/>	Finance/Resourcing	<input type="checkbox"/>	System/Partners	<input type="checkbox"/>	Legal/Regulatory	<input checked="" type="checkbox"/>	Green/Sustainability	<input type="checkbox"/>
Delivery of the recommendations should result in a place of work, and provision of services that values and respects all ethnicities and religions and is open, safe and welcoming to all.													
Report previously considered at & date(s):													
NA													
Recommendation	The Board/Committee is asked to note the paper and agree that it provides substantial assurance of action taken and/or being planned.												

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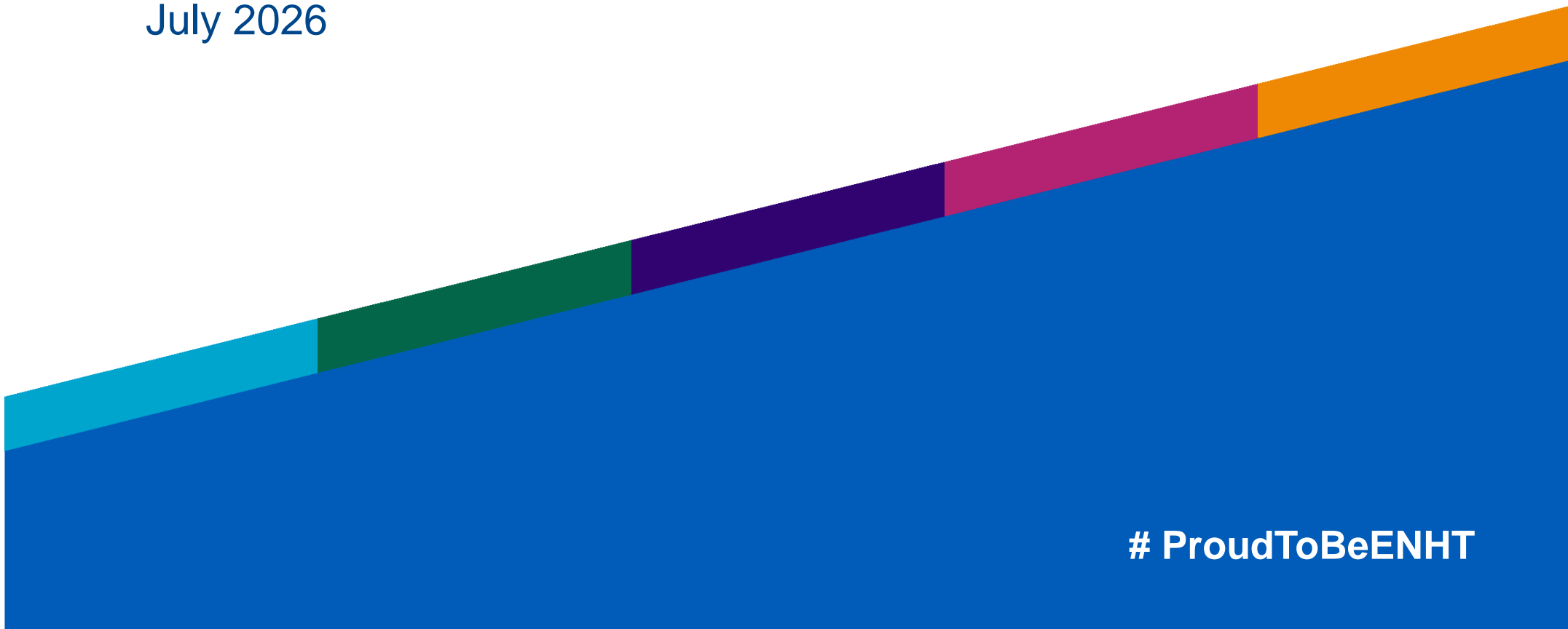
The Mann Review

Trust Board

July 2026



East and North
Hertfordshire Teaching
NHS Trust



Context

- The purpose of the **Lord Mann Review** (officially published in June 2026) was to investigate, expose, and tackle antisemitism and other forms of systemic racism across the National Health Service (NHS) and UK healthcare regulatory systems.
- He found systemic antisemitism and other forms of racism impacting both NHS colleagues and patients, warning that discrimination forces many to suffer in silence or avoid care.
- In response the Government accepted the recommendations and has asked for a greater focus on strengthening leadership accountability, improving reporting mechanisms, and enforcing mandatory anti-racism training.

What are we doing already?

- We have an active EDI Strategy, among other things stipulates;
 - Executive Directors play an active role in Staff Networks
 - They also have EDI objectives in their GTR (Grow Together Review)
- The ENH Appraisal process (Grow Together Review) has already introduced an EDI Objective into its 2026 process – know as the ‘9th Objective’.
- NHS Core Skills framework module on Equality, Diversity and Human Rights is already included in the Trusts Stat/Mand process.
- A new dedicated and specific Inclusion (EDI) learning pack which is well under development and will offer a comprehensive package of learning activities and advice on how to successfully implement EDI.
- As well as our FTSU guardian (freedom to speak up) introduced a Whistleblowing policy enabling another route for colleagues to raise concerns.

Contd.

- A project is underway preparing ENH for the new leadership and management 'Code of Conduct' and 'Competencies' this process will now include the 'NHS Staff Standards' when launched
- The EQIA process for ENH being reviewed with training, policy and practical implications being reviewed ensuring new practices and decisions across the organisation are inclusive

What are we planning?

- An updated review of the 2025 Staff Survey (and other staff experience data) - People Team Dashboard
- Communication– stand alone dedicated website page and intranet space
- The support of colleagues will be reviewed in a joint forum including FTSU, United Networks, Health@Work, People Partners, Colleague Experience – a clear pathway of support options and escalation – including expectations of line managers – will emerge
- Update on the implementation of the ‘Violence, Prevention and Reduction Standard’ is planned by the EDI Steering Group
- The new ‘Bitesize’ modules being prepared nationally will be included in Inclusion (EDI) learning pack and on ENH Academy when they are released

The ask from the Mann Review

- Embed the NHS Race and Health Observatory's seven anti-racism principles
- Adopt the International Holocaust Remembrance Alliance (IHRA) working definition of antisemitism
- Adopt the Government's non-statutory definition of anti-Muslim hostility
- Discussed and agreed at People and Culture Committee.

7 ANTI-RACISM PRINCIPLES



1 DEMONSTRATE LEADERSHIP BY NAMING RACISM

Demonstrate leadership by naming racism, engaging seriously and continuously with the ways in which racism impacts the lives of patients and the public, and actively working to dismantle it.

2 UNDERSTAND & ACKNOWLEDGE

Understand and acknowledge that structural, institutional and interpersonal racism all impact on health and be clear about where accountability lies for improvement and progress. Create transparent pathways for raising concerns and tangible steps for addressing them.

3 MEANINGFULLY INVOLVE RACIALLY MINORITISED INDIVIDUALS & COMMUNITIES

Meaningfully involve racially minoritised individuals and communities in every stage of developing a service or intervention, including ensuring that teams and decision-making structures themselves are racially diverse and fundamentally inclusive.

4 COLLECT & PUBLISH DATA

Collect and publish data on race inequity in its entirety, ensuring it directly informs policy, strategy, and improvement. Where data is not available, change policies to ensure that data is collected.

5 IDENTIFY RACIAL BIAS

Identify racial bias in policies, decision making processes, and other areas within your organisation.

6 APPLY A RACE-CRITICAL LENS

Apply a race-critical lens to the adoption of any interventions or improvements to be tested, and to the design and delivery of services.

7 EVALUATE & REFLECT

Evaluate and reflect on interventions using metrics that recognise the role of racism as determinant of health. These evaluations should seek to understand the extent to which interventions mitigate the impacts of racism.

NOVEMBER 2024

Additional information

International Holocaust Remembrance Alliance (IHRA) working definition of antisemitism

“Antisemitism is a certain perception of Jews, which may be expressed as hatred toward Jews. Rhetorical and physical manifestations of antisemitism are directed toward Jewish or non-Jewish individuals and/or their property, toward Jewish community institutions and religious facilities”

Non-statutory definition of anti-Muslim hostility

Anti-Muslim hostility is intentionally engaging in, assisting or encouraging criminal acts – including acts of violence, vandalism, harassment, or intimidation, whether physical, verbal, written or electronically communicated – that are directed at Muslims because of their religion or at those who are perceived to be Muslim, including where that perception is based on assumptions about ethnicity, race or appearance”

“It is also the prejudicial stereotyping of Muslims, or people perceived to be Muslim including because of their ethnic or racial backgrounds or their appearance, and treating them as a collective group defined by fixed and negative characteristics, with the intention of encouraging hatred against them, irrespective of their actual opinions, beliefs or actions as individuals”

“It is engaging in unlawful discrimination where the relevant conduct – including the creation or use of practices and biases within institutions – is intended to disadvantage Muslims in public and economic life”

Report Coversheet

Meeting	Public Trust Board		Agenda Item	11
Report title	Board Assurance Framework (BAF) – Strategic Risks		Meeting Date	8 July 2026
Author	Head of Corporate Governance			
Responsible Director	Chief Executive			
Purpose	Assurance	<input checked="" type="checkbox"/>	Approval/Decision	<input type="checkbox"/>
	Discussion	<input type="checkbox"/>	For information only	<input type="checkbox"/>
Proposed assurance level (<i>only needed for assurance papers</i>)	Substantial assurance	<input type="checkbox"/>	Reasonable assurance	<input type="checkbox"/>
	Partial assurance	<input checked="" type="checkbox"/>	Minimal assurance	<input type="checkbox"/>
Executive assurance rationale:				
<p>The BAF and risk management process received a reasonable assurance rating from internal audit. Reflecting the reasonable assurance rating score for the BAF the Board has previously determined. The rationale is the reasonable assurance rating reflects the robustness of the BAF process, such as effective top strategic risk identification and effective completion of the BAF document and committee oversight arrangements rather than being a judgement on specific outcomes covered under each BAF.</p>				
Summary of key issues:				
<p>The BAF is presented for review and feedback.</p> <p>New and revised BAF risks</p> <p>Following May Board approval of the risks and risk descriptions for the 2026/27 BAF, the new and revised BAF risks have been developed with executive leads (controls, assurances, risk and assurance scores, gaps and actions) and reviewed by their respective lead committees for all BAF risks, bar the two digital BAF risks purely because Digital Committee has not met since the last Board.</p> <p>To enable cross-referencing, the BAF summary reflects the significant changes as tracked changes from the 2024-25 BAF to the 2025/26 BAF.</p> <p>Existing BAF risks key updates</p> <ul style="list-style-type: none"> • Risk 2 (Health inequalities): Some good progress - with the new priorities agreed for the health equities group and the audiology service re-opened. • Risk 3 (Financial constraints): New control added: 'Interim Transformation Director and team in place' plus actions have been added to address the gap 'Embedding the accountability framework'. • Risk 10 (Digital transformation): A significant review with a range of tracked changes that will be reviewed by the next Digital Committee. <p>Next steps</p> <ul style="list-style-type: none"> • 13 July Digital Committee will review its 2 BAFs • To fully develop BAF 6 Leadership destabilisation and transition risk – which is currently partially developed, particularly in relation to assurance and gaps in assurance. • BAF risks informing committee annual cycle and agenda - the Board has set the BAF as the biggest strategic risks to the organisation and therefore expecting the lead 				

<p>committees to be prioritising time to ensuring these risks are robustly over-seen. The Committees will be asked to consider are the subjects the BAF risks relate to covered in the committee annual cycle that need revised or enhanced assurance approaches</p> <ul style="list-style-type: none"> Spotlighted BAF risks will re-start at the September Board with BAF risks BAF 7 Accountability and BAF 8 OneEPR the next BAFs due for spotlighted consideration 													
<p>Impact: tick box if there is any significant impact (positive or negative):</p>													
Patient care quality	<input checked="" type="checkbox"/>	Equity for patients	<input checked="" type="checkbox"/>	Equity for staff	<input checked="" type="checkbox"/>	Finance/Resourcing	<input checked="" type="checkbox"/>	System/Partners	<input checked="" type="checkbox"/>	Legal/Regulatory	<input checked="" type="checkbox"/>	Green/Sustainability	<input type="checkbox"/>
<p>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.</p>													
<p>Trust strategic objectives: tick which, if any, strategic objective(s) the report relates to:</p>													
Quality Standards	<input checked="" type="checkbox"/>	Thriving People	<input checked="" type="checkbox"/>	Seamless services	<input checked="" type="checkbox"/>	Continuous Improvement	<input checked="" type="checkbox"/>						
<p>Identified Risk: Please specify any links to the BAF or Risk Register</p>													
<p>The BAF is based on risks to these strategic objectives and the top two-four risks to each strategic objective are included on the BAF.</p>													
<p>Report previously considered at & date(s):</p>													
<p>At 15 April 2026 Board Seminar, Board members carried out a horizon-scanning exercise to help identify the biggest risks to delivering the four strategic objectives which were then presented at 15 May 2026 Board for approval of the 2025/26 BAF. This is the first Board where the full written-up BAFs is presented. The BAF was included in papers to June's FPPC, PCC and QSC meetings for review. Digital Committee in June was cancelled so the first opportunity to review the BAF will be July's Committee.</p>													
Recommendation	<p>The Board is asked to:</p> <ul style="list-style-type: none"> review the BAF and highlight any key feedback; 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 & estates challenges (capital, system allocation and no growth) <u>Estates infrastructure to meet growing demand</u>	Chief Financial Officer	Finance, Performance & Planning	15	
2.	Health inequalities	Medical Director	Quality & Safety	12	↔
3.	System and internal financial constraints	Chief Financial Officer	Finance, Performance & Planning	20	↔
4.	<u>Patient engagement, involvement and public accountability</u>	Director of Comms & Engagement	Quality & Safety	9	
Support our people to thrive by recruiting and retaining the best, and creating an environment of learning, autonomy, and accountability					
5.	Workforce morale whilst making necessary staffing savings <u>Employee relations</u>	Chief People Officer	People & Culture	12	
6.	Leadership and engagement <u>Leadership destabilisation and transition</u>	Chief People Officer	People & Culture	16	
7.	Compliance culture and accountability <u>Accountability, escalation, ownership & effective performance monitoring framework</u>	Chief Executive	People & Culture	16	
Deliver seamless care for patients through effective collaboration and co-ordination of services within the Trust and with our partners					
8.	System instability <u>OneEPR</u>	Deputy Chief Executive (CFO)	Digital Committee	16	
9.	Improving flow and performance <u>Demand, capacity and flow</u>	Chief Operating Officer	Finance, Performance & Planning	16	
	The future of cancer services	Chief Operating Officer	Quality & Safety	16	
Continuously improve services by adopting good practice, maximising efficiency and productivity, and exploiting transformation opportunities					
10.	<u>Digital Transformation & AI</u>	Chief Information Officer	Digital Committee	16	↔
11.	Change management <u>Failure to deliver transformation and achieve financial sustainability</u>	Chief Kaizen Officer	Finance, Performance & Planning	20	

Section 2 Strategic Risk Heat Map

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

The heat made will be updated after July Board once risk scores have been confirmed by Board. Only continued risks from 2025/26 are included below.

I m p a c t	5					
	4			10 <i>3</i>		3
	3		10	2	2	
	2					
	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

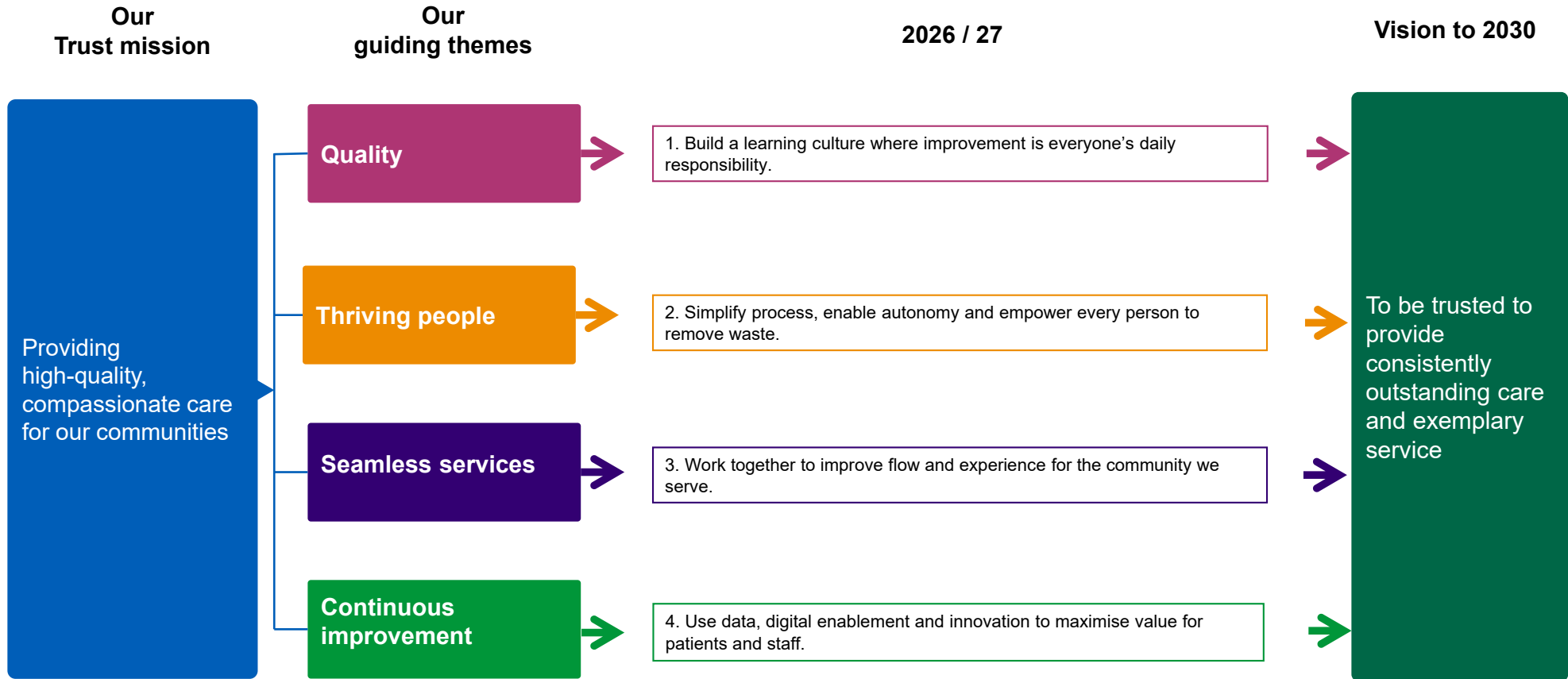
Risks included in the Risk Assurance Framework (RAF) are assessed as extremely high, high, medium and low based on an Impact/Consequence X Likelihood matrix. Impact/Consequence – The descriptors below are used to score the impact or the consequence of the risk occurring. If the risk covers more than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

Trust Strategic Goals



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 15
Strategic Risk No.1: Estates infrastructure to meet growing demand		
If the Trust’s estates and physical infrastructure is not capable of meeting changing patient and staff demand, due to legacy infrastructure and investment constraints	Then the Trust will be unable to deliver safe, effective and timely services at the scale and quality required, and will have limited flexibility to redesign services, increase productivity or respond to system pressures and provide a satisfactory staff environment (including parking and accommodation)	Resulting in non-delivery of clinical and operational objectives, increased risks to patient and staff safety and experience, workforce inefficiencies and turnover, non-compliance with regulatory standards, reputational damage and reduced ability to achieve system priorities and long-term sustainability.

	Impact	Likelihood	Score	Assurance	Risk Trend
Inherent	5	5	25	4	
Current	3	5	15		
Target	2	5	10		

Risk Lead	Director of Estates and Facilities	Assurance committee	FPPC (send to QSC)
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Controls	Assurances against stated controls, with assurance level 1st line (front line); 2nd (corporate); 3rd (independent)	Assurance score
Strategies and Plans		
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
System (ICS) Engagement Control		
Formal ICS capital engagement and escalation framework	Approval of all external PDC capital funding by ICB (3)	4
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
Monthly Investment Group meetings & Critical Infrastructure Weekly meetings	Reports (1) Qtrly Capital Plan Reports to FPPC (2)	6
Investment Group	Report to TMG monthly (1)	4
Compliance & Safety Controls		
Statutory compliance program	All engineering critical function safety group meetings report quarterly into TIPCC and QSC (2)	6

	Health, safety, fire and security group meetings report into QSC (2)	6
Backlog maintenance management framework	Critical infrastructure risk register (reviewed monthly at critical infrastructure group) and used to inform the annual capital BLM allocation (1)	6
Estates risk register	Estates risk register (reviewed monthly at critical infrastructure group) and used to inform the annual capital BLM allocation (1)	6
Capital Delivery & Programme Controls		
Formal capital programme governance framework with project controls (RIBA, milestones, risk logs)	Weekly critical infrastructure group reporting into TMG and FPPC (2) Monthly capital program review with CEO (1)	6 4
Benefits realisation framework incl post-implementation reviews, tracking productivity & service impact	Critical infrastructure group weekly meeting providing project debrief and productivity/benefits realisation (from FY 26/27) report annually to FPPC (2)	4
Workforce & Capacity Control		
Estates, digital and PMO workforce capacity model Skills gap identification	2026/27 estates and facilities (including capital) staffing consultation based on Estates workforce capacity model and skill mix requirements (1)	4
Appointment of skilled technical contractors where skill mix mitigation is not adequately managing risk.	Critical engineering safety meetings report into QSC (2)	6

Gaps in Controls and Assurances	Actions and mitigations to address gaps	Lead	Target date
Alignment of Capital Investment Priorities with Strategic Need	<ul style="list-style-type: none"> Strengthen triangulation between the estates strategy, the Integrated Business Plan and long-term capital requirements. 	CFO	Dec 26 [Original: Dec 25]
Capital Envelope Insufficient to Reduce Backlog Risk	<ul style="list-style-type: none"> Escalation through ICS capital framework Escalation through NHSE funding groups 	CFO	Ongoing – March annually
Long-Term Capital & Estate Planning Infrastructure Not Fully Embedded	<ul style="list-style-type: none"> Present capital lifecycle modelling and 10-year infrastructure scenarios to FPPC. 	CFO	Q4 26/27
Dependency on Transformational Capital That Is Not Yet Secured	<ul style="list-style-type: none"> Map Trust-dependent system capital into a single risk register for FPPC oversight. Work with NHSE transformation leads to ensure ENHT’s priorities are reflected in system submissions (including RtCS-linked allocations and diagnostics programs). Develop local contingency plans in the event that system capital does not materialise. 	CFO	Ongoing
Compliance Gaps: Backlog Maintenance, Fire Safety and Regulatory Standards	<ul style="list-style-type: none"> Provide strengthened reporting to TMG and FPPC on backlog trajectory and residual high-risk items. 	Dir of Estates	Q4 26/27 [original Q2 25/26]
Alignment of Capital Investment with Strategic Need	<ul style="list-style-type: none"> Formal scoring framework for prioritisation Annual Board approval of methodology Mandatory link to IBP in all business cases 	CFO	Q4 26/27

Insufficient Capital to Reduce Backlog Risk	<ul style="list-style-type: none"> Develop multi-year backlog trajectory model 	Dir of Estates	Q4 26/27
Long-Term Planning Not Embedded	<ul style="list-style-type: none"> Integrated model: estates + digital + finance Annual "State of the Estate" Board session 	Dir of Estates	Q4 26/27
Development areas (Backlog, Fire, Regulatory)	<ul style="list-style-type: none"> Produce full compliance dashboard Define risk thresholds & escalation triggers Agree independent validation process with Audit Committee (audit / external review) Prioritise compliance as non-discretionary capital 	Dir of Estates	Q3 26/27
Legacy refurbishments/building projects issues needing clear derogation sign-off	<ul style="list-style-type: none"> Approval of all projects involving critical engineering systems by relevant authorising engineers. All derogation from new/refurbished compliant estate to have CEO formal sign off. Suitable and sufficient register of derogation to be held by the capital projects team. Create a capital and minor works policy with standardization equipment document and derogation form template. 	Dir of Estates	Q1 26/27
Lack of S106 and CIL monies in prior years	<ul style="list-style-type: none"> Open dialogue with planning authority and directly with constructors to secure funding for new/refurbished areas to suit relevant required expansion. 	Dir of Estates	Q1 26/27

Current Performance – Highlights from the Integrated Performance Report:

Financial performance – capital projects and backlog maintenance – Quarterly FPPC report
 Authorising engineer audits:
 HTM01 Decontamination – Reasonable assurance
 HTM02 Medical gases – Limited assurance
 HTM03 HVAC – Reasonable assurance
 HTM04 Water systems – Reasonable assurance
 HTM05 Fire safety – Reasonable assurance
 HTM06 – Electrical systems HV and LV – Reasonable assurance
 PSSR – Pressure systems – Reasonable assurance
 HTM08 – Lifts and lifting systems – Reasonable assurance

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
3079	Risk to the safety of children, young people, staff and visitors and risk to the reputation of East and North Herts NHS Trust due to the significant and visible disrepair of the building Fabric and unmet electrical needs and mechanical requirements relating to Bluebell Ward, Bramble Day Services and Children's Outpatient services including the Hub.	20
3441	HTM 05 Fire - If known fire safety deficiencies in the external facade and window assemblies of the main ward block are not addressed, then the Trust remains exposed to significant fire risk, resulting in potential large scale patient harm, fatalities, and regulatory non-compliance.	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		
<i>If we do not address health inequalities in line with mandated NHS expectations and ICB priorities including neighbourhood models</i>	<i>Then avoidable variation in access, experience and outcomes will widen, particularly for our most deprived communities</i>	<i>Resulting in in avoidable excess mortality and morbidity, rising non-elective activity, loss of public confidence and heightened regulatory scrutiny, constraining our capacity to deliver planned care and system flow.</i>

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

Risk Lead	Chief Medical Officer	Assurance committee	Quality & Safety Committee
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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)	<u>7</u> 1
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	<u>1</u> 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;	<u>5</u> 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 1.4.26 – went live for HIV 1.6.26 – now working on widening to include hepatitis B and C	<u>6</u> 1

<p>2025-6 Health equity group projects:</p> <ul style="list-style-type: none"> • Homelessness • Inability to work due to health delays • Childhood • Smoking – see above • Blood born viruses – see above 	<p>Status:</p> <p>Initial discussion with partner (23.1.26 – discussions with local authority and pathway, funding discussed with trust charity)</p> <p>1.6.26 – paused as expenditure to be justified based on data</p> <p>Initial discussions with partner - 23.1.26 – discussions have progressed, DWP keen to work with us on a pilot, trust stakeholders involved</p> <p>1.6.26 – continuing to work on – data sharing problematic</p> <p>Review of existing data and discussions with partners – 23.1.26 – discussions with Barnardo’s, trust charity and local authority</p> <p>1.6.26 – revised plan for CED</p>	<p>31</p>
<p>Health inequalities workplan</p>	<p>Health equities group progress report (1) Assurance report to QSC (2)</p>	<p>32</p>
<p>2026-7 health inequalities workplan</p> <p>Based on core20+5</p>	<p>Health equity group has identified 2 adult and 2 paediatric priorities for work over the course of the year</p>	<p>1</p>

Gaps in Controls and Assurances	Actions and mitigations to address gaps	Lead	Target date
<ul style="list-style-type: none"> • Large PTLs with associated risk post pandemic 	<ul style="list-style-type: none"> • Increasing service awareness 	<p>COO</p>	<p>Individual national targets</p>
<ul style="list-style-type: none"> • Paediatric audiology 	<ul style="list-style-type: none"> • 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 	<p>DON</p>	<p>See Corporate Risk Register</p>
<ul style="list-style-type: none"> • Community paediatric long waits for assessment 	<ul style="list-style-type: none"> • 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 • 1.6.26 – 9 box model agreed with partners and being piloted with first cohort. Small decreases in waiting list seen. 	<p>COO</p>	<p>See Corporate Risk Register</p>
<ul style="list-style-type: none"> • Childrens wellbeing bill • Tobacco and vape bill • Mental health bill 	<ul style="list-style-type: none"> • Implement actions once legislation enacted 	<p>MD</p>	<p>TBC once enacted</p>
<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • TBC 	<p>MD</p>	<p>unclear TBC</p>

Transition from paediatric to adult care	<ul style="list-style-type: none"> • 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 • 1.6.26 – hospital wide transition group now set up with nursing and medical leads 	MD	FBC2026
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Current Performance – Highlights from the Integrated Performance Report:
<ul style="list-style-type: none"> • ED 4 hour standard, 12 hour performance • 28 day faster diagnosis standards • DMO1 – audiology • 65 week waits for community Paediatrics <p> Update 1.6.26 Audiology service now fully reopened 9 box model agreed for neurodiversity and being piloted New priorities agreed for health inequality group for 26-27 based on core 20+5 for adults and children </p>

Associated Risks on the Corporate Risk Register		
Risk no.	Description	Current score
3027	Risk of Regulatory non-compliance within Audiology Service	168
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
3502	Paeds Mental Health restrictive practices	12

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	
Current	4	5	20		
Target	4	3	12		

Risk Lead	Chief Financial Officer	Assurance committee	FPPC
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Controls	Assurances against stated controls, with assurance level 1st line (front line); 2nd (corporate); 3rd (independent)	Assurance score
Strategies and Plans		
Approved 25/26 / 27/26 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
	26/27 / 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	\$
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
<u>Interim Transformation Director and team in place</u>	<u>Transformation Board monthly (1)</u>	<u>3</u>

Gaps in Controls and Assurances	Actions and mitigations to address gaps	Lead	Target date
Absence of a Delivered Structural Transformation Programme	 <ul style="list-style-type: none"> ▲ Mobilisation of Trust wide Transformation Programme ▲ Dedicated PMO, executive SROs, productivity & cost base reset ▲ Multi-year savings and productivity recovery targets 	TD	Apr 26 Complete
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 of CIP reflecting historic incremental schemes insufficient to close the underlying deficit	Delivery Board to oversee CIP delivery. Embed Accountability Framework, implementation of the agreed Transformation Programme	Execs / 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	<ul style="list-style-type: none"> Paper to Board 13 May 26 Senates followed by TMG Performance to progress consequences 	<ul style="list-style-type: none"> CFO 	<ul style="list-style-type: none"> May 25 31 June 26

Current Performance – Highlights from the Integrated Performance Report:

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Associated Risks on the Board Risk Register

Risk no.	Description	Current score
1834	Renal service demand versus operational capacity	20
3751	Endoscopy capacity linked to histology	15
3501	Diabetes service for CYP	16

Strategic Priority: Consistently deliver quality standards, targeting health inequalities and involving patients in their care		Risk score 9
Strategic Risk No.2: Patient engagement, involvement and public accountability		
If patient, carer and public engagement is disconnected from decision-making or is inconsistent or perceived as tokenistic and we fail to demonstrate transparency and accountability to our communities	Then Trust decisions may lack legitimacy, fail to reflect lived experience, and attract increased scrutiny and challenge from patients, Healthwatch, local partners and regulators	Resulting in regulatory action taken in response to inadequate patient / public responsiveness when concerns have been raised, erosion of public trust, increased complaints and judicial or media challenge, reduced engagement from seldom-heard groups, and constraints on our ability to transform services to meet the needs of the patients we serve and demonstrate effective Well-Led governance.

	Impact	Likelihood	Score	Assurance	Risk Trend
Inherent	4	4	16	4	
Current	3	3	9		
Target	3	2	6		

Risk Lead	Director of Communications and Engagement	Assurance committee	Quality & Safety Committee
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Controls	Assurances against stated controls, with assurance level 1st line (front line); 2nd (corporate); 3rd (independent)	Assurance score
Strategies & plans		
Public & Engagement strategy aligned with Trust strategy (due to be updated before 2027)	Report to Board (2) annually	4
Frameworks for co-production, involvement and engagement in service development & improvement	Report to new Patient sub-committee (2)	3
Governance		
Board level lead	Annual Report (2)	6
Committee oversight	New Patient sub-committee (2)	1
Inclusion of engagement in decision-making coversheets & business cases	Minutes of stakeholder meetings (1)	2
Accountable lead for ensuring formal engagement and consultation duties are met for service changes	Appraisal (1)	6
Structures		
Existing patient and VCSFE groups plus structured forums: <ul style="list-style-type: none"> • Patient panels (being created) • Carer forums • Community listening events • Equality / seldom-heard group engagement mechanisms 	Minutes and reports to Trust groups (1)	3

Functioning patient experience team	Appraisals (1)	4
Feedback Capture & Triangulation		
Systems to capture Complaints, PALS, compliments; Friends and Family Test; and surveys (local and national)	Regular triangulated reports to QSC (2) IPR to Board (2) Patient experience annual report to Board (2)	6
Mechanisms to triangulate patient feedback with Safety data; Quality metrics; and Workforce insight	IPR to Board (2) Reports to QSC (2)	6
Demonstrating Impact		
“You said, we did”	LAKPA/MVP examples – meeting minutes (1) Accountability wall (1)	3
Inclusion & Equality		
Targeted engagement strategies for seldom-heard groups	Health Equity Group (1) EDI steering Group (2)	2
EDI integration into engagement approach	Engagement strategy approval via Board (2)	4
Transparency & Public Accountability		
Published engagement outcomes	Report to TMG two years ago (2) Media and stakeholder sentiment monitoring to Board members weekly (2) Comms and engagement monthly report (1)	4
Accessible communication formats	Silktime index monthly assessment of Trust monthly (3) – ranked 45 out of all UK NHS organisations & Trusts (May 26) Mini-readers panel responses (1)	6
Active relationship with: Healthwatch; Local authorities; VCSE sector; CQC	HCP Board meetings with Trust engagement representative (3) Meetings with Healthwatch (3)	6
Regulatory alignment		
Alignment to CQC Well-Led domain	Meetings with CQC (3) CQC inspection findings (3)	6
Government Digital Service (inspection of digital communications and Trust website)	Ad hoc unannounced GDS inspection & report (3)	6

Gaps in Controls and Assurances	Actions and mitigations to address gaps	Lead	Target date
GAPS IN CONTROLS			
Over-Reliance on Quantitative Feedback / Insufficient qualitative insight / lived experience	<ul style="list-style-type: none"> Create and report to new PACE on engagement sentiment framework. 	Director of Comms	March 2027
Seldom-Heard Groups Underrepresented	<ul style="list-style-type: none"> Work with Healthwatch to engage the community assembly attendees to increase the voice of seldom heard groups into our decision-making. 	Director of Comms	March 2027
Limited Evidence of “Sharing impact on outcomes of engagement activity”	<ul style="list-style-type: none"> Create a web page on trust website collating evidence of patient engagement impact Create section in stakeholder briefings – eg MPs on public engagement 	Director of Comms	March 2027

Clarifying ICS engagement priorities	<ul style="list-style-type: none"> Work with ICS engagement lead to understand approach 	Director of Comms	September 2026
Engagement strategy to be renewed by 2027	<ul style="list-style-type: none"> Refresh and renew engagement strategy 	Director of Comms	April 2027
Limited engagement team capacity	<ul style="list-style-type: none"> Review capacity required in communications and engagement team to deliver activity 	Director of Comms	December 2026
Systematic inclusion of patient voice in: Business cases; Service change proposals & Transformation programmes	<ul style="list-style-type: none"> Discussion with executive colleagues to develop a framework for systematic patient voice Audit of patient voice inclusion – robustness of evidence in and informing decision-making 	Director of Comms	December 2026 December 2027
GAPS IN ASSURANCE			
Committee and NED oversight	<ul style="list-style-type: none"> Creation of new PACE sub-committee to QSC 	Chief Nurse	December 2026
Peer review of membership and engagement services (how we make sure patient voice is systematically fed through from ward to Board) and run proposed changes via Healthwatch.	<ul style="list-style-type: none"> Work with Healthwatch and ICB to facilitate an external review 	Director of Comms	November 2026
Inclusion of engagement in decision-making coversheets & business cases	<ul style="list-style-type: none"> Annual audit/sample review of Board and Committee papers covering % with completed engagement sections & % with evidence-based content – report to QSC Develop a scoring approach, e.g.: 0 = not completed 1 = generic statement 2 = evidence of engagement 3 = clear impact on decision Produce guidance wording on what “good” engagement evidence looks like with examples Training or reminders for committee chairs on actively challenging absence or weakness of engagement evidence / asking “What was the patient/public voice in this?” Introduce requirement all major programmes to report engagement outcomes as part of programme reporting 	Director of Comms	August 2027
Director of comms not aware of all proposed service changes and therefore able to advise on consultation and engagement	<ul style="list-style-type: none"> Education in trust on importance of including comms and engagement team early on proposed services changes 	Director of Comms	March 2027
Patient Panel to report to HCP Board	<ul style="list-style-type: none"> Monthly patient panel report to HCP Board and new PACE sub committee 	Director of Comms	December 2026
Reports from patient & community groups to new engagement sub-committee	<ul style="list-style-type: none"> Monthly report to new PACE 	Director of Comms	December 2026

Targeted engagement strategies for seldom-heard groups	<ul style="list-style-type: none"> • Included in trust comms on importance of engagement for service change • Engagement with ENH Community Assembly to co-create specific engagement strategies 	Director of Comms	March 2027
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Current Performance – Highlights from the Integrated Performance Report:

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

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.5: Employee relations		
If the Trust is unable to maintain positive employee relations during periods of financial constraint and cost improvement and transformation delivery	Then workforce morale, engagement and stability may deteriorate, leading to reduced productivity, increased absence and disruption to service delivery. It could also lead to increased collective action such as working to rule, and/or collective grievance action	Resulting in compromised patient safety and experience, failure to maintain safe staffing levels, adverse impacts on staff wellbeing, recruitment and retention, deterioration in quality and performance standards, and reputational and financial damage to the Trust.

	Impact	Likelihood	Score	Assurance	Risk Trend
Inherent	5	4	20	4	
Current	4	3	12		
Target	2	2	4		

Risk Lead	Chief People Officer	Assurance committee	People and Culture Committee
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Controls	Assurances against stated controls, with assurance level 1st line (front line); 2nd (corporate); 3rd (independent)	Assurance score
Strategies and Plans		
People Strategy with outcome measures	People Committee reports (2) Annual report to Board (2)	6
Redesign HR team	People Committee report (2)	4
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
Employee Relations Strategy, with risk appetite and gap analysis of manager capability standards for handling ER issues	Reported and signed off at PCC (2) Monitoring through People Dashboard monthly (1)	1
Annual Divisional demand and capacity modelling, workforce plans and local Skill mix reviews	Planning reports to FPPC and PCC (2)	6
Mechanisms for identifying hotspots and trend data over time & rapid response process	People Committee reports (hot spot identified in People Dashboard) (2) FTSU internal audit 26-27 (3) FTSU annual report to Board (2)	6
NHS Workforce long-term plan	Annual People Committee updates on progress (2)	6
Staff Survey comments plan & Trust-wide action planning framework	Reported to PCC annually (2)	1
Resourcing		
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

Transformation delivery plan for medical workforce	Reported to PCC – frequency tbc with Chair (2)	1
Change		
Change Management framework, including minimum standards for staff engagement during change	Reported to PCC – frequency tbc with Chair (2)	3
Delivery of wellbeing strategy	Reported annually to PCC (2) Wellbeing questions part of annual staff survey Included in monthly IPR (3) Sickness rates monitored in Divisional Performance Reviews (1)	6
Delivery of leadership and management competency development 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)	6
Governance & Performance Management Structures		
Medical establishment oversight working group	Held monthly & feeds into People report taken to PCC (2)	4
Trust Partnership	Held monthly & feeds into People report taken to PCC (2)	6
Business Partners	Intelligence feeds into PCC reports (2)	4

Gaps in Controls and Assurances	Actions and mitigations to address gaps	Lead	Target date
<ul style="list-style-type: none"> Development of an ER plan 	<ul style="list-style-type: none"> Workshop with Trust Staff Side, FTSU and ER consultant to agree roles and responsibilities including ways of working 	<ul style="list-style-type: none"> Director of People 	<ul style="list-style-type: none"> July 2026
<ul style="list-style-type: none"> Signed off refreshed People Strategy 	<ul style="list-style-type: none"> Finalise slides and agree with Chair PCC Agenda item at PCC 	<ul style="list-style-type: none"> CPO 	<ul style="list-style-type: none"> June 2026 July 26
<ul style="list-style-type: none"> Staff survey comments plan 	<ul style="list-style-type: none"> Agreement with PCC Agreement at Trust Board 	<ul style="list-style-type: none"> Head of Colleague Development and Experience CPO 	<ul style="list-style-type: none"> June 2026 9 September 2026
<ul style="list-style-type: none"> Medical workforce transformation delivery plan 	<ul style="list-style-type: none"> Agree the medical workforce plan and delivery model 	<ul style="list-style-type: none"> CPO & Transformation Director 	<ul style="list-style-type: none"> July 2026
Inconsistent management capability in handling ER issues	<ul style="list-style-type: none"> Gap analysis as part of ER strategy 	<ul style="list-style-type: none"> CPO 	<ul style="list-style-type: none"> Dec 26
No real-time workforce intelligence dashboard at team level	<ul style="list-style-type: none"> Develop Power BI dashboard Confirm priority level of BI workforce dashboard to confirm date (Dec 26 date may need to change if there are higher other priorities) 	<ul style="list-style-type: none"> CFO 	<ul style="list-style-type: none"> Dec 26
Heatmap / scorecard to PCC	<ul style="list-style-type: none"> Produce Heatmap/scorecard to PCC 	<ul style="list-style-type: none"> CPO 	<ul style="list-style-type: none"> Nov 26
Strategic workforce implementation plan	<ul style="list-style-type: none"> Strategic workforce implementation plan 	<ul style="list-style-type: none"> CPO 	<ul style="list-style-type: none"> Mar 27

Communications plan in relation to employee relations	<ul style="list-style-type: none"> • Develop comms plan for employee relations 	<ul style="list-style-type: none"> • CPO with Dir of Comms 	<ul style="list-style-type: none"> • Jan 27
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Current Performance – Highlights from the Integrated Performance Report:

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

Strategic Priority: Support our people to thrive by recruiting and retaining the best, and creating an environment of learning, autonomy, and accountability		Risk score 16
Strategic Risk No.6: Leadership destabilisation and transition		
If the Trust does not effectively manage the Chief Executive leaving and NEDs retirement transition effectively including maintaining leadership stability, cohesion and clarity of authority	Then there is a risk of wider leadership turnover, fragmented relationships within the leadership team and reduced strategic focus	Resulting in derailing delivery of our strategy and impaired decision-making and loss of confidence from the workforce and stakeholders.

	Impact	Likelihood	Score	Assurance	Risk Trend
Inherent					
Current	4	4	16		
Target					

Risk Lead	Chief Executive	Assurance committee	People & Culture Committee
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Controls	Assurances against stated controls, with assurance level 1st line (front line); 2nd (corporate); 3rd (independent)	Assurance score
Leadership Transition & Succession Planning		
CEO transition plan		
NED succession and recruitment plan (interviews scheduled for Sept 26 for two replacement NEDs)		
Identified interim leadership arrangements	Report to Board (2)	
Executive and senior leadership succession pipeline / plan	RemCo report annually (2)	
Talent management approach and programmes	VSM and future leaders' remuneration committee annual report (2) Annual talent review executive team meeting (1)	4
Governance		
Scheme of Delegation (sets out decision-making authority during transition)	Annual Board review (2)	
Committee structure stability with Named Chairs / deputies & contingency plans for turnover		
Leadership Cohesion & Culture		
Board Seminar: Regular Executive/NED development sessions	Board Seminar plan (2)	
Structured Executive Team development and support to maintain alignment & team cohesion (external)		
Stakeholder & System Relationship Management		
Clear transition comms plan - Engagement & clear messaging with ICS, NHSE, CQC, partner Trusts & Healthwatch		
Workforce Confidence & Engagement		

Regular CEO / Executive communications (Meet Martin)	Feedback from regulators & partners (3)	
Visibility of leadership (walkarounds, briefings)		
Monitoring (staff survey, Pulse checks; FTSU themes)	Reports to PCC (2)	
Performance & Strategic Delivery Controls		
IPR; transformation programme and strategic priorities delivery tracking	Reports to Board (2)	
Board Effectiveness & Capability		
Board and Committee effectiveness reviews	Board Seminar annually and Annual Report (2)	
Induction and development for new NEDs	ASSURANCE GAP – Introduce an induction effectiveness survey for new NEDs	
Skills gap analysis	Provided to Chair to help inform focus of NED recruitment (1)	
<i>Leadership competency framework</i>	<i>NHSE submission annually (3)</i>	6
<i>Board Values and behaviour charter</i>	<i>Aligned to CEO objectives (1)</i> <i>Positive leadership rounds (1)</i>	4

Gaps in Controls and Assurances	Actions and mitigations to address gaps	Lead	Target date
Lack of documented CEO/NED transition plan	<ul style="list-style-type: none"> Produce and approve transition plans 	•	•
Limited Board / Executive Cohesion Assurance & risks of fragmented behaviours	<ul style="list-style-type: none"> A structured assessment of team dynamics & alignment post-transition? Conduct Board/executive team development session? 	•	•
Stakeholder Confidence Not Actively Managed / tracked	<ul style="list-style-type: none"> Stakeholder comms and engagement plan for transition? 	•	•
Absence of agreed transition risk metrics & insufficient real-time intelligence for early warning/action	<ul style="list-style-type: none"> Agree transition KPIs/real-time workforce sentiment monitoring such e.g. Leadership turnover rate; Time to fill roles; Board attendance / stability; Stakeholder sentiment 	•	•
<ul style="list-style-type: none"> <i>Capacity to undertake support and development in identified areas to improve leadership practice and engagement</i> 	<ul style="list-style-type: none"> <i>Targeting where to focus management competency framework due to limitation on capacity</i> <i>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</i> <i>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.</i> 	• CPO	• Mar 26
<ul style="list-style-type: none"> <i>360 feedback of leadership behaviours</i> 	<ul style="list-style-type: none"> <i>NHSE framework will not be ready for implementation until Autumn 2026</i> <i>Until then an interim arrangement is in place and used for NED at EoY</i> 	• CPO	• Ongoing for interim, Autumn 2026 for

			<i>NHSE applicati on</i>
Lack of verification of efficacy of new NED induction	<ul style="list-style-type: none"> Introduce an induction effectiveness survey for new NEDs 	<ul style="list-style-type: none"> Head of Corp Gov 	<ul style="list-style-type: none"> July 27
External perspective on NED interview panel	<ul style="list-style-type: none"> Determine if an external perspective would help 	<ul style="list-style-type: none"> CPO 	<ul style="list-style-type: none"> Sept 26

Current Performance – Highlights from the Integrated Performance Report:
<ul style="list-style-type: none">

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 16
Strategic Risk No.7: Accountability, escalation, ownership & effective performance monitoring framework			
If the Trust is unable to successfully implement the improvements to accountability, ownership and organisational culture, including embedding a clear and effective accountability framework with consequences	Then performance and financial delivery and compliance with core standards will remain inconsistent	Resulting in the Trust struggling to deliver key operational and financial outcomes (including cost improvement programmes), failure to consistently meet mandatory and statutory requirements (such as statutory and mandatory training), and reduced capacity to deliver the wider cultural, transformational and service improvements required to achieve the Trust’s strategic objectives.	

	Impact	Likelihood	Score	Assurance	Risk Trend
Inherent	5	5	25	3	
Current	4	4	16		
Target	3	2	6		

Risk Lead	Chief People Officer	Assurance committee	People & Culture Committee
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Controls	Assurances against stated controls, with assurance level <i>1st line (front line); 2nd (corporate); 3rd (independent)</i>	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
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
Transformation delivery plan	Reports to Transformation Board (2) Reports Trust Private Board (2)	1
Governance & Performance		
Revised Scheme of Delegation	ARC and Board review annually (2)	6
Well-led review action plan	ARC & TMG progress reports (2)	4
Day of the Senates	Escalation matters to Trust Management Group (2) & Trust Board (2) – most commonly in the IPR	1
Management Structures		
Divisional operating model – structure and	Reviewed as part of Trust Management Group (1)	4

responsibilities		
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	Report by exception to PCC if matters arising (2)	6
Core skill and knowledge output from Leadership and Management Competency Development Framework	Reported annually to PCC (2)	4

Gaps in Controls and Assurances	Actions and mitigations to address gaps	Lead	Target date
<ul style="list-style-type: none"> Organisation goals affectively cascaded to all divisions and teams 	<ul style="list-style-type: none"> Focus on driving up Grow Together Review compliance rates Assessment of dissemination and understanding of goals as part of Positive Leadership Rounds Reviewed in day of the senates Identify mechanism to monitor impact 	<ul style="list-style-type: none"> Exec and Divisional Directors CPO 	<ul style="list-style-type: none"> Mar27
<ul style="list-style-type: none"> Transformation delivery plan 	<ul style="list-style-type: none"> In development following discovery phase by Deloitte 	<ul style="list-style-type: none"> CEO 	<ul style="list-style-type: none"> July 2026
<ul style="list-style-type: none"> People Dashboard remedial action plan 	<ul style="list-style-type: none"> Develop proposal for dealing with non compliance of statman training 	<ul style="list-style-type: none"> Director of People 	<ul style="list-style-type: none"> Sept 2026
Accountability framework embedded into: <ul style="list-style-type: none"> Objectives and appraisal system Job descriptions and Scheme of Delegation Leadership behaviours framework linked to consequences in GROWS 	<ul style="list-style-type: none"> Commission internal audit of accountability framework in 2027-28. Amend GROW process to include leadership behaviours linked to consequences 	<ul style="list-style-type: none"> CFO/CPO CPO 	<ul style="list-style-type: none"> May 2027 Mar 2027
Performance management framework with consequences (moving from activity to tracking impact): <ul style="list-style-type: none"> Defined escalation routes Consistent application across divisions and Corporate Directorates 	<ul style="list-style-type: none"> Introduce monthly accountability reporting dashboard 	<ul style="list-style-type: none"> CFO 	<ul style="list-style-type: none"> Dec 2026
Statutory & mandatory training & appraisal enforcement mechanism	<ul style="list-style-type: none"> Agree Trust position on non-compliance – paper to agree position at People Senate 	<ul style="list-style-type: none"> CPO 	<ul style="list-style-type: none"> Oct 2026
Heatmap/dashboard Report to PCC with trend data, hotspots	<ul style="list-style-type: none"> Develop heatmap/dashboard Report to PCC with trend data, hotspots including qualitative intelligence from Business Partners 	<ul style="list-style-type: none"> CPO 	<ul style="list-style-type: none"> Jan 2027
ASSURANCE GAPS			
Independent assessment and assurance of leadership accountability culture	<ul style="list-style-type: none"> Well-led developmental review 	Head of Corporate Governance	<ul style="list-style-type: none"> Dec 2027

Current Performance – Highlights from the Integrated Performance Report:

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Associated Risks on the Corporate Risk Register

Risk no.	Description	Current score

Strategic Aim: Deliver seamless care for patients through effective collaboration and co-ordination of services within the Trust and with our partners		Risk score 16
Strategic Risk No.8: Demand, capacity and flow		
<i>If</i> we do not achieve further improvements to clinical pathways, matching capacity to demand, and flow within the Trust and wider system, including left shift	<i>Then</i> patients will experience prolonged waits, delays in treatment and fragmented care pathways; pressures will continue to escalate across ENHTT and partner organisations; and the Trust's key (NOF) performance metrics will not be achieved	<i>Resulting in poor patient experience, poor quality care and adverse outcomes, wider health improvements not being delivered; increased scrutiny or intervention from regulators and commissioners and reputational damage</i>

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

Risk Lead	Chief Operating Officer	Assurance committee	FPPC (sent to QSC too)
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Controls	Assurances against stated controls, with assurance level 1st line (front line); 2nd (corporate); 3rd (independent)	Assurance score (from 7 levels)
Integrated Demand & Capacity Planning Framework <ul style="list-style-type: none"> Trust-wide modelling aligned to RTT, cancer, diagnostics (by Specialty) Rolling 12 month capacity plans aligned to demand forecasts Workforce plans aligned to activity modelling 	<ul style="list-style-type: none"> Board IPR; transformation reports; escalation reports (2) FPPC: IPR & deep dives papers (2) Performance Senate; monthly review including gap analysis, recovery trajectories and improvement plans 1) Access Board reports (1) Accountability Framework (1) 	6
Patient Tracking & Validation Controls <ul style="list-style-type: none"> Weekly PTL validation standard operating procedure (SOP) Risk stratification rules for prioritisation (clinical & waiting time) Mandatory clinical validation thresholds (e.g. >52 weeks, harm review) Audit of data quality / pathway integrity Cancer timed pathway analysis work and associated action plan 	<ul style="list-style-type: none"> Board IPR; transformation reports; escalation reports (2) FPPC: IPR & deep dives papers (2) Performance Senate; monthly review including gap analysis, recovery trajectories and improvement plans 1 Cancer Board reports (1) Access Board reports (1) Accountability Framework (1) 	4
Operational Flow Controls (UEC + Inpatient) <ul style="list-style-type: none"> Full Capacity Protocol with clear triggers and compliance monitoring Daily Gold/Silver/Bronze command structure Site management control processes (bed meetings, discharge huddles) SDEC utilisation standards UEC Transformation Programme 	<ul style="list-style-type: none"> Board IPR; transformation reports; escalation reports (2) FPPC: IPR & deep dives papers (2) Performance Senate; monthly review including gap analysis, recovery trajectories and improvement plans 1 Access Board report (2) UEC Board minutes (2) GIRFT GEMI score (3) Accountability Framework (2) 	4
Discharge & Length of Stay Controls	<ul style="list-style-type: none"> Board IPR (2) 	4

<ul style="list-style-type: none"> • Daily discharge planning from admission • Estimated Date of Discharge compliance standards • System-wide DTOC/criteria-to-reside monitoring • Hospital at Home / virtual ward utilisation thresholds • Escalation for >14/21 day length of stay 	<ul style="list-style-type: none"> • TOCH reports (1) • Power BI info suite (1) • Performance Senate; improvement plans (2) • Performance Senate; monthly review including gap analysis, recovery trajectories and improvement plans 1) 	
<p>Theatre & Productivity Management Controls</p> <ul style="list-style-type: none"> • Utilisation and cancellation thresholds • Weekly review with divisional escalation • Theatre Transformation Programme 	<ul style="list-style-type: none"> • Board IPR (2) • Power BI info suite (1) • Performance Senate; monthly review including gap analysis, recovery trajectories and improvement plans 1) 	4
<p>Diagnostic Capacity & Demand Controls</p> <ul style="list-style-type: none"> • Modality-level demand/capacity tracking • Weekly PTL reviews for diagnostics • Diagnostic Transformation Programme 	<ul style="list-style-type: none"> • Board IPR (2) • Power BI info suite (1) • Performance Senate; monthly review including gap analysis, recovery trajectories and improvement plans 1) 	4
<p>System Flow & Ambulance Interface Controls</p> <ul style="list-style-type: none"> • Handover escalation protocols • Call-before-convey compliance oversight 	<ul style="list-style-type: none"> • Board IPR (2) • Power BI info suite (1) • Regional weekly ambulance handover report (3) 	4

Gaps in Controls and Assurances	Actions and mitigations to address gaps	Lead	Target date
<ul style="list-style-type: none"> • Need for a consistent weekly PTL validation process across specialties • Inconsistent application of prioritisation criteria • Limited visibility of demand vs capacity mismatch by specialty 	<ul style="list-style-type: none"> • Reverse engineered RTT trajectories developed based on detailed demand and capacity analysis. • Increase validation volume • Deploy and regular review of validation strategy • IPR updated to include 26/7 RTT targets • Escalation meetings in place for RTT and diagnostics • GIRFT reviewed RTT and non RTT PTL and processes Feb 2026; work programme in development • Outpatient Transformation Programme • Theatre Transformation Programme • Community Waits: pilots of new ways of working • CYP Neurodiversity shared service for Hertfordshire 	<ul style="list-style-type: none"> • Laura Moore, Associate Director of Planning and Information • Claire Moore, Deputy COO • Mark Stanton, CCIO • Lucy Davies, COO 	<ul style="list-style-type: none"> • March 2027
<ul style="list-style-type: none"> • Inconsistent compliance with Full Capacity Protocol triggers • Limited streaming effectiveness from ED to UTC • Variation in SDEC utilisation across specialties • Lack of capacity for mental health patients in local system • Limitations of existing ward estate, leading to regular but unplanned IP bed closures to resolve urgent estates issues 	<ul style="list-style-type: none"> • UEC Transformation Programme (Flow Is Safety) • Embedding of EPIC and APIC roles • Improve streaming to UTC • 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) • Refreshed implementation of Principles of Safe & Effective Emergency Care • Working with system partners on winter planning 	<ul style="list-style-type: none"> • Paul Thorp DOD Unplanned Care • Junaid Qazi, Divisional Medical Director UPC • Justin Daniels, Medical Director • Theresa Murphy, 	<ul style="list-style-type: none"> • March 2027

	<ul style="list-style-type: none"> 7-day band 7 nursing in place in paediatric ED Corridor Care Elimination Plan Pilot of Acute Medics in Urgent Care Coordination Hub (June 2026) EEMAC implementation Use of patient stories Regular liaison between ENHT and HPFT wrt shared pathways Estates work to SSU, Renal, Swift 	<p>Chief Nurse (SRO for 26/7 UEC transformation)</p> <ul style="list-style-type: none"> Lucy Davies, COO Claire Moore, Deputy COO 	
<p>Ambulance Handover</p> <ul style="list-style-type: none"> Limited control over conveyance decision-making Inconsistent use of call-before-convey protocols 	<ul style="list-style-type: none"> EEAST: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 Central East System Coordination Centre <i>Handover @ 45</i> Lister ED new Ambulance handover process May 2025 National UEC capital allocation for extended Ambulance Handover Bay, work completed Apr 2026 Pilot of Acute Medics in Urgent Care Coordination Hub (June 2026) 	<ul style="list-style-type: none"> Lucy Davies, COO EEAST Central East SCC 	<ul style="list-style-type: none"> March 2027
<p>Inpatient Flow</p> <ul style="list-style-type: none"> Lack of social care and community capacity to support more timely discharge Underfunded ICB Patient Transport contract (CE ICB) Limitations of existing ward estate, leading to regular but unplanned IP bed closures to resolve urgent estates issues 	<ul style="list-style-type: none"> 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 October 25 however being used as inpatient area due to demand. New transport criteria in place Robust pathway oversight and earlier discharge planning for medical and surgical specialties Ward reconfiguration plan 	<ul style="list-style-type: none"> Redeemed Mzila, Head of Site Junaid Qazi Moreblessing Zvorwadza, Divisional Nursing Director Heidi Hall, Head of Service HCC 	<ul style="list-style-type: none"> March 2027
<p>Diagnostic wait times – MRI and U/S, Audiology</p> <ul style="list-style-type: none"> Insufficient MRI capacity vs demand baseline Reliance on outsourcing without long-term sustainability Variability in modality-level productivity Unfunded backlog in adult audiology (CE ICB) 	<ul style="list-style-type: none"> Changeology support for Imaging Transformation Programme Detailed trajectories at modality level Weekly PTL tracking meetings for all modalities now in place. MRI capacity tactical plan agreed. Robust plan for long term MRI capacity to bridge gap in demand including replacement of 2 x scanners by March 27- recovery trajectory being developed to reflect updated activity. Optimise use of community diagnostic capacity MRI outsourcing in place with commercial provider. Audiology capital at Lister site completed and operational – May 2026 with recovery trajectory in place 	<ul style="list-style-type: none"> Claire Moore, Deputy COO Kate Fruin, Acting DOD Planned Care Mark Stanton, diagnostic transformation SRO 	<ul style="list-style-type: none"> March 2027
<ul style="list-style-type: none"> Theatre utilisation below benchmark 	<ul style="list-style-type: none"> Recruitment plans ongoing. 'Drumbeat' huddles to manage activity 	<ul style="list-style-type: none"> Kate Fruin DOD 	<ul style="list-style-type: none"> March 2027

<ul style="list-style-type: none"> • High late cancellation rates due to HSSD and casenote delivery constraints • Workforce gaps impacting list delivery • Lack of digital POA • Limitations of current physical theatre estate 	<ul style="list-style-type: none"> • Theatre Transformation Programme 2026/7 including review of theatre timetable • POA Kaizen workstream • Estates work to Theatres, Swift 	<ul style="list-style-type: none"> • Lucy Davies COO - theatre transformation SRO 	
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Current Performance – Highlights from the Integrated Performance Report:
<ul style="list-style-type: none"> • % of 62-day PTL over 62 days • 28-day faster diagnosis • Cancer 31 day waits • RTT performance • 65 and % 52 weeks RTT • Ambulance handovers • ED 4 and 12 hour performance • Corridor Care breaches • Diagnostic waits / DM01 • Patients not meeting the criteria to reside • Length of Stay

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
<u>3708</u>	<u>Timely clinical communications to primary care</u>	<u>16</u>

Strategic Aim: Deliver seamless care for patients through effective collaboration and co-ordination of services within the Trust and with our partners		Risk score 16
Strategic Risk No.9: OneEPR programme		
If the OneEPR programme is further delayed or fails without an effective mitigation or contingency approach	Then the Trust’s digital capability will be insufficient to support modern healthcare delivery	Resulting in not being able to mitigate for patient safety and information governance risks, significant inefficiencies in clinical and administrative workflows, failure to realise planned benefits and CIPs, and loss of credibility with regulators and system partners.

	Impact	Likelihood	Score	Assurance	↗ Deteriorating Programme remains RED with unresolved supplier delivery commitments and dependencies
Inherent	4	4	16	4	
Current	4	4	16		
Target	4	2	8		

Risk Lead	Chief Information Officer	Assurance committee	Digital Committee
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Controls	Assurances against stated controls, with assurance level <i>1st line (front line); 2nd (corporate); 3rd (independent)</i>	Assurance score
Strategies and Plans		
Board approved OneEPR Business case (2/24)	<ul style="list-style-type: none"> Annual Board review (2) 	4
2026 Digital Strategy and Roadmap	Digital programme boards (1) Assurance submissions to NHSE for frontline digitisation (3) National benchmarking reports (3) Weekly programme highlight reporting and integrated programme plan review (1)	4
Governance & Performance Management Structures		
Digital Committee established May 2025	All reports to the Digital Committee (2) Executive Programme Board oversight and escalation (2)	5
Clinical and Operations Group (CaOG) with clinical safety review signed off by clinical directors.	<ul style="list-style-type: none"> Programme update monthly report to Digital Committee (2) Report to Clinical Safety Committee (1) 	5
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
<ul style="list-style-type: none"> Variation in business-as-usual systems and processes 	<ul style="list-style-type: none"> Adoption of lean thinking in pathway redesign model as part of the ENH production system for later phases of the project 	<ul style="list-style-type: none"> Mark Stanton 	<ul style="list-style-type: none"> Optimisation phase (2028)
<ul style="list-style-type: none"> Improvement training compliance is variable 	<ul style="list-style-type: none"> Develop a robust training program to include classroom and f2f and communicate requirements 	<ul style="list-style-type: none"> MS 	December 26

across staff groups and levels of seniority	<p>with notice via the programme board. Senior stakeholder to share responsibility</p> <ul style="list-style-type: none"> • Date realigned with plan • Outline Plan approved by Steering group • Compliance to be monitored and reported to divisional leads 		
<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • MS 	<ul style="list-style-type: none"> • Ongoing
<ul style="list-style-type: none"> • If change is not managed effectively 	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • TGT 	<ul style="list-style-type: none"> • ongoing
<ul style="list-style-type: none"> • Engagement in the design and adoption of digital systems 	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • MS 	<ul style="list-style-type: none"> • Ongoing
<ul style="list-style-type: none"> • OneEPR does not progress (e.g. running out of funding/supplier issues/not delivering agreed specification etc) 	<ul style="list-style-type: none"> • 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. • Full legal review of contract position 	<ul style="list-style-type: none"> • MS 	<ul style="list-style-type: none"> • Controls in place
<ul style="list-style-type: none"> • Current System become unsupported 	<ul style="list-style-type: none"> • Contractual arrangements in place with Nerve until July 2028 	<ul style="list-style-type: none"> • MS 	<ul style="list-style-type: none"> • COMPLETE
<ul style="list-style-type: none"> • Clinical risks requiring mitigation through EPR are ongoing 	<ul style="list-style-type: none"> • 22 risks that's require a new EPR 	<ul style="list-style-type: none"> • MS 	<ul style="list-style-type: none"> • October 2026

	<ul style="list-style-type: none"> • Full mitigation of all controls with 3 risks (Gastro ORM, Diabetes, Post operative assessment identified as needing a standalone system. Approval to proceed agreed. 		
Supplier delivery commitments and product roadmap dependencies remain unresolved	Secure delivery dates for all outstanding Full EPR, MVP and Core requirements. Strengthen contractual performance management and escalation with Dedalus. Monthly review of supplier commitments through Executive Programme Board and Digital Committee. Maintain contingency planning for delayed functionality.	MS	September 2026

Current Performance – Highlights from the Integrated Performance Report:

- Programme status remains RED.
- Outstanding delivery commitments for Full EPR, MVP and Core requirements.
- Multiple workstreams remain RED including Integration, User Experience, CPOE, Pathways, ED/IP, Outpatients and Comms.
- Positive engagement with Dedalus continues but key delivery dates remain outstanding.
- Testing and design activities continue across programme workstreams.
- Governance arrangements remain active through Executive Programme Board and Digital Committee.

Associated Risks on the Board Risk Register

Risk no.	Description	Current score

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 & AI		
If the necessary digital transformation and AI 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	<p>The Risk Trend chart shows a constant score of 16 across all dates from Jul-23 to Jul-26. The data points are: Jul-23 (16), Oct-23 (16), Jan-24 (16), Apr-24 (16), Jul-24 (16), Oct-24 (16), Jan-25 (16), Apr-25 (16), Jul-25 (16), Oct-25 (16), Jan-26 (16), Apr-26 (16), Jul-26 (16).</p>
Current	4	4	16		
Target	4	3	12		

Risk Lead	Chief Information Officer	Assurance committee	Digital Committee
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Controls	Assurances against stated controls, with assurance level 1st line (front line); 2nd (corporate); 3rd (independent)	Assurance score
Strategies and Plans		
Board approved Strategic Objectives One EPR Business case (2/24)	<ul style="list-style-type: none"> Annual Board review (2) 	4
23/24/2026 Digital Strategy and Roadmap	<ul style="list-style-type: none"> Digital programme boards (1) Assurance submissions to NHSE for front line digitization frontline digitisation (3) National benchmarking reports (3) Weekly programme highlight reporting and integrated programme plan review (1) 	<u>54</u>
Governance & Performance Management Structures		
Digital Committee established May 2025	<ul style="list-style-type: none"> All reports to the Digital committee Committee (2) Executive Programme Board oversight and escalation (2) 	5
Clinical Digital Design Authority (Clinical Decision Committee and Operations Group (CaOG)) with clinical safety review signed off by clinical directors.	<ul style="list-style-type: none"> Programme update monthly report to Digital Committee (2) Report to Programme Board (1) Report to Clinical Safety Committee (1) 	<u>65</u>
Cyber Security & Resilience	<ul style="list-style-type: none"> Controls: Annual cyber maturity assessment, MFA and privileged access reviews, DR testing. Assurances: Cyber audit reports (3), DSPT compliance returns (2), Cyber committee reporting (2). 	<u>4</u>
AI Governance and Assurance	<ul style="list-style-type: none"> Controls: AI governance framework, model approval process, clinical safety assessment, AI use register. Assurances: AI governance reports (2), clinical safety sign-off (2), internal audit review (3). 	<u>4</u>

<u>Data Quality & Interoperability</u>	<ul style="list-style-type: none"> <u>Controls: Data quality programme, master data governance, interoperability standards. Assurances: Data quality dashboards (1), integration reporting (1), benchmarking/audit (3).</u> 	<u>4</u>
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
<p>Control gaps</p> <ul style="list-style-type: none"> Market movement from Perpetual licensing to Software as a Service (SaaS) is preventing the capitalisation of Software licenses and deployment 	<p>Control treatments</p> <ul style="list-style-type: none"> 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. <ul style="list-style-type: none"> Fully mitigated for EPR 	Mark Stanton	<ul style="list-style-type: none"> June 26
<ul style="list-style-type: none"> Variation in business-as-usual systems and processes 	<ul style="list-style-type: none"> Adoption of lean thinking in pathway redesign model as part of the ENH production system for later phases of the project 	Mark Stanton MS	<ul style="list-style-type: none"> Jan 26 ongoing
<ul style="list-style-type: none"> Improvement training compliance is variable across staff groups and levels of seniority 	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> June 26 original date: Feb 26
<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Ongoing
<ul style="list-style-type: none"> If change is not managed effectively 	<ul style="list-style-type: none"> 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. 	TG/TMG	<ul style="list-style-type: none"> TBC ongoing
Engagement in the design and adoption of digital systems	<ul style="list-style-type: none"> Review of mechanisms to ensure stakeholders have adequate time to engage in design and transformation. 	MS	<ul style="list-style-type: none"> Ongoing

<ul style="list-style-type: none"> Executive Programme Board to provide oversight and leadership regarding alignment resourcing and decisions <u>Board education in AI</u> 			
<p><u>Appropriate skills within the Digital team to deliver Digital solutions specifically AI</u></p>	<ul style="list-style-type: none"> <u>Identify appropriate training</u> <u>Consideration of AI skillsets within all recruitment</u> 	MS	<ul style="list-style-type: none"> <u>Ongoing</u>
<p><u>AI governance, ethics and regulatory compliance</u></p>	<ul style="list-style-type: none"> <u>Implement Trust-wide AI policy, AI review panel, AI inventory and DPIA/clinical safety assessments before deployment</u> 	MS	<ul style="list-style-type: none"> <u>June 2027</u>
<p><u>Cyber resilience and legacy technology risk</u></p>	<ul style="list-style-type: none"> <u>Develop legacy system retirement roadmap, resilience testing and annual recovery exercises</u> 	MS	<ul style="list-style-type: none"> <u>March 2027</u>
<ul style="list-style-type: none"> <u>OneEPR does not progress (e.g. running out of funding/supplier issues/not delivering agreed specification etc)</u> <u>Data quality and benefits realisation</u> 	<ul style="list-style-type: none"> <u>Maintain robust programme governance through the Executive Programme Board and Digital Committee, with clear escalation routes for delivery, financial, and supplier risks.</u> <u>Secure and regularly review programme funding and affordability, including contingency planning within Trust revenue and alignment to agreed benefits realisation.</u> <u>Implement active supplier management, including contractual performance monitoring, milestone assurance, and formal issue escalation to address delivery delays or specification risk.</u> <u>Define benefits framework with KPI ownership, baselines and quarterly benefits tracking</u> 	MS	<ul style="list-style-type: none"> <u>Mar 26 December 2026</u>

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~~
- Current AI programmes including Ambient voice technology (AVT) scoped as a pilot
- OP AI within the plan such as digital PIFU

Associated Risks on the Board Risk Register

Risk no.	Description	Current score
3486	Risk of Cyber Attack	20 16
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 20
Strategic Risk No.11: Failure to deliver transformation and achieve financial sustainability		
If the Trust is unable to deliver its transformation programmes at the required pace and scale and is unable to reduce running costs and deliver sustainable financial improvement	Then existing services and operating models will remain inefficient and unaffordable, financial balance will not be achieved, and productivity and quality improvements will not be realised	Resulting in the risk of compromising safe, effective and high-quality care; continued operational pressure; failure to deliver cost improvement and financial recovery plans; reduced ability to improve patient outcomes and quality of care; increased risk of regulatory intervention and censure; and an inability to deliver key elements of the Trust’s strategic objectives.

	Impact	Likelihood	Score	Assurance	Risk Trend
Inherent	5	5	25	3	
Current	5	4	20		
Target	4	3	12		

Risk Lead	Chief Kaizen Officer	Assurance committee	FPPC
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Controls	Assurances against stated controls, with assurance level <i>1st line (front line); 2nd (corporate); 3rd (independent)</i>	Assurance score
Strategies and Plans		
Trust strategy, vision and goal cascade	Board report (2)	4
Strategic delivery plan 2026 - 2031	Finance, Performance and Planning Committee (2)	3
Annual business planning process	Finance, Performance and Planning Committee (2)	6
Transformation delivery plan	External consultancy diagnostic reviews (3)	3
Accountability framework	Finance, Performance and Planning Committee (2)	2
Governance & Performance Management Structures		
Transformation Programme Board	Finance, Performance and Planning Committee (2)	3
Day of the Senates	Finance, Performance and Planning Committee (2)	1
Trust Guiding Team	People and Culture Committee reports (2)	6
Operational Systems and Resources		
Transformation programme governance	Monthly progress reports to TMG/TGT (1)	6
Divisional operating model	Internal audit report of Divisional governance (3)	3
Core skill and knowledge programmes	People and Culture Committee reports (2)	3
Advanced daily management	Trust Guiding Team (1)	2
Divisional governance	Integrated performance reports (2)	3

Gaps in Controls	Actions and mitigations to address gaps	Lead	Target date
<ul style="list-style-type: none"> Variable ENHPS adoption and daily management maturity limits organisational discipline and delivery pace. 	<ul style="list-style-type: none"> 2026/ 27 ENHPS work plan approved via TGT. Mandate minimum daily management standards monitored and escalated through TGT. Divisional and corporate targets and trajectories. 	<ul style="list-style-type: none"> CKO CKO CKO 	<p>Mar 2027 Sept 2026 Mar 2027</p>
<ul style="list-style-type: none"> Inconsistent accountability and escalation arrangements restrict timely intervention and reduce delivery assurance. 	<ul style="list-style-type: none"> Embed accountability and escalation framework into performance review process. Amend GROW process to include leadership behaviours linked to consequences. Link transformation programme to accountability and escalation framework. 	<ul style="list-style-type: none"> Interim CEO CPO Interim TD 	<p>Sept 2026 Mar 2027 Sept 2026</p>
<ul style="list-style-type: none"> Inconsistent strategic cascade weakens alignment between organisational priorities and operational delivery. 	<ul style="list-style-type: none"> Mandate minimum specialty-level cascade standards monitored and escalated through TMG. ENHPS training and coaching resources. Structured executive visibility and escalation walkarounds with tracking and accountability 	<ul style="list-style-type: none"> CKO CKO Execs 	<p>Jul 2027 Mar 2027 Nov 2026</p>
<ul style="list-style-type: none"> Current leadership capacity and capability limit the pace, scale and effectiveness of transformation delivery. 	<ul style="list-style-type: none"> Mandated standards for ENHPS for Leaders Programme. Leadership and Management Competency Development framework. Targeted executive-led intervention support for high-risk transformation priorities. 	<ul style="list-style-type: none"> CKO CPO Execs 	<p>Sept 2026 Mar 2027 Sept 2026</p>
<ul style="list-style-type: none"> Immature benefits realisation arrangements limit evidence of transformation impact and value. 	<ul style="list-style-type: none"> Introduce a mandated benefits realisation framework for all transformation programmes. 	<ul style="list-style-type: none"> CKO 	<p>Dec 2027</p>
<ul style="list-style-type: none"> Current business partnering and governance arrangements lack sufficient proactive challenge, intervention and delivery support. 	<ul style="list-style-type: none"> Redesign business partnering model. 	<ul style="list-style-type: none"> CPO/ Interim CEO 	<p>Dec 2027</p>
<ul style="list-style-type: none"> Multiple internal/external partners create complexity, reducing clarity of ownership and accountability. 	<ul style="list-style-type: none"> Implement a single integrated transformation governance structure and operating model. Establish robust consultancy oversight and contract management process. 	<ul style="list-style-type: none"> Interim CEO Interim TD 	<p>Jun 2026 May 2026</p>
<ul style="list-style-type: none"> Inconsistent cultural and leadership behaviors limit psychological safety, transparency, escalation and organisational learning. 	<ul style="list-style-type: none"> Freedom to speak up framework. Whistle-blowing policy. Positive leadership rounds. Accountability and escalation framework 	<ul style="list-style-type: none"> CPO CPO CKO Interim CEO 	<p>Apr 2026 June 2026 Apr 2026 Jun 2026</p>
<ul style="list-style-type: none"> Insufficient integration of workforce and financial planning and clinical redesign. 	<ul style="list-style-type: none"> Introduce new integrated workforce , financial and clinical redesign planning as a mandatory component of annual planning processes. 	<ul style="list-style-type: none"> CPO/ Interim CEO 	<p>Mar 2027</p>
Gaps in Assurance	Actions and mitigations to address gaps	Lead	Target date
<ul style="list-style-type: none"> Independent assessment and assurance of leadership accountability culture. 	<ul style="list-style-type: none"> Well-led developmental review. ENHPS Health Check processes 	<ul style="list-style-type: none"> Head of Corporate Governance CKO 	<p>Dec 2027</p>

<ul style="list-style-type: none"> • Strong data availability and benchmarking is not consistently translated into action. 	<ul style="list-style-type: none"> • Introduce specialty-level productivity review and action process. 	<ul style="list-style-type: none"> • Head of PMO 	Oct 2026
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Current Performance – Highlights from the Integrated Performance Report:

- ENHPS work plan approved via TGT with KPO resource now fully aligned with transformation programme.
- External consultancy partners Deloitte and Changeology are now on site and first diagnostics outputs and workstream values signed off via May Transformation Programme Board.
- Brilliant basics launched during early quarter one with 2-day-per-week SME on-site support provided through VMI.
- New Day of the Senate planning underway with initial meeting scheduled week commencing 8 June. This will integrate accountability and escalate framework and decision-making processes explicitly into the new approach to performance review.
- A new formal quarterly exception reporting process for strategic cascade was agreed via TMG in May and will commence from July.
- A series of focused executive sessions have begun to target and describe intervention support for high-risk transformation priorities.
- A proposal for a review and redesign of the corporate business partnering model was discussed and agreed at TMG in May.
- The new whistle blowing policy was signed off in May Board meeting following extensive consultation.

Associated Risks on the Board Risk Register

Risk no.	Description	Current score
<u>3676</u>	<u>Administrative staffing savings</u>	<u>16</u>

Board



**East and North
Hertfordshire Teaching**
NHS Trust

Meeting	Public Trust Board	Agenda Item	12	
Report title	Summary Learning from Deaths	Meeting Date	8 July 2026	
Author	Mortality Improvement Lead			
Responsible Director	Medical Director			
Purpose	Assurance	<input checked="" type="checkbox"/>	Approval/Decision	<input type="checkbox"/>
	Discussion	<input type="checkbox"/>	For information only	<input type="checkbox"/>
Proposed assurance level (<i>only needed for assurance papers</i>)	Substantial assurance	<input checked="" type="checkbox"/>	Reasonable assurance	<input type="checkbox"/>
	Partial assurance	<input type="checkbox"/>	Minimal assurance	<input type="checkbox"/>
Executive assurance rationale:				
<p>East and North Hertfordshire Teaching NHS trust seeks to learn from every death that occurs. This paper provides assurance to the Board that:</p> <ul style="list-style-type: none"> • Our rates of death remain lower than would be expected • That we learn from scenarios when care does not meet the standard that we and our patients and carers set • That we interrogate data to ensure we understand its meaning • That we innovate to reduce mortality. 				
Summary of key issues:				
<p>Mortality improvement work is a continual on-going process within the Trust. This quarterly report provides a summary of the detailed Learning from Deaths report provided to the Quality and Safety Committee. That report outlines key results of this work, including the regular monitoring of mortality rates, together with outputs from our Q4 learning from deaths work. It also incorporates information and data mandated under the National Learning from Deaths Programme.</p> <p>Prior to submission of the summary report to the board, the full report was approved by the Mortality Surveillance Committee and the Quality and Safety Committee, which agreed it appropriately highlighted current topics and activity of particular relevance in providing assurance to the Executive regarding this workstream.</p> <p>Points of note this quarter include:</p> <ul style="list-style-type: none"> • Mortality rates remain stable and well positioned against national and Model Hospital Peer, with HSMR in the first quintile and SHMI in the 'as expected' band 2. • One 3SD HSMR alert. Three 3SD SHMI alerts. • Our neonatal service had indicated that extended perinatal mortality for 2025 may be above the national average when reported by MBRRACE in 2027. An in-depth review, including external peer review, has been undertaken to ensure robust learning and governance, the associated report will be presented to Mortality Surveillance Committee. • Following initial consideration of how health inequality/deprivation data can be used in our learning from deaths work, further investigation is in progress as to metrics that might support our understanding. • Following Aqua's decision to decommission their online SJRPlus review tool at the end of March 2026, development of a mortality module on ENHance is nearing 				

completion, with a 'go-live' date of 9 June 2026.

- Learning from SJRs continues to be promoted by asking all clinical governance leads to ensure they are discussed at specialty Mortality and Morbidity meetings.
- To date no Q4 deaths receiving an SJR has been judged by the reviewer to have been more likely than not due to a problem in healthcare.
- To date no Q4 deaths receiving an SJR have been assessed as evidencing poor care or very poor care thereby requiring escalation as a patient safety incident.
- Cardiology basket: collaborative work between Coding and Cardiology remains ongoing, with one element of the cardiology basket currently alerting (coronary atherosclerosis).
- The Cardiology service has raised a concern regarding current delays to TAVI CT caused by capacity issues in radiology. The issue was highlighted by a recent patient safety incident and focussed work is in progress to improve the situation.

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

Patient care quality	<input checked="" type="checkbox"/>	Equity for patients	<input checked="" type="checkbox"/>	Equity for staff	<input type="checkbox"/>	Finance/Resourcing	<input type="checkbox"/>	System/Partners	<input type="checkbox"/>	Legal/Regulatory	<input checked="" type="checkbox"/>	Green/Sustainability	<input type="checkbox"/>
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Ongoing focus on the areas detailed in this report are vital for the following reasons:

Equality:

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

Patients' benefit/detriment:

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

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

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

Quality Standards	<input checked="" type="checkbox"/>	Thriving People	<input checked="" type="checkbox"/>	Seamless services	<input checked="" type="checkbox"/>	Continuous Improvement	<input checked="" type="checkbox"/>
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Identified Risk: Please specify any links to the BAF or Risk Register

Please refer to page 4 of the report.

Report previously considered at & date(s):

Mortality Surveillance Committee: 10 June 2026: Full report presented.
Quality and Safety Committee: 24 June 2026: Full report presented.

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

To be trusted to provide consistently outstanding care and exemplary service

1. Executive Summary

1.1 Summary

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

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

1.2 Impact

1.2.1 Strategic ambitions

The Trust has developed a framework of strategic objectives to support and drive continuous improvement. These are detailed on the front cover of this report. Additionally, a set of mortality focussed objectives has been developed to echo and support the overarching Trust’s strategic ambitions. A new iteration of the strategy, developed to provide focus through 2025-27 was approved by the Mortality Surveillance Committee in June 2025.

1.2.2 Compliance with Learning from Deaths NQB Guidance

The national Learning from Deaths guidance states that trusts must collect and publish certain key data and information regarding deaths in their care via a quarterly public board paper. This paper provides this information for Q4 2025-26. An in-depth Learning from Deaths Report covering the same period was provided to both the Quality & Safety Committee, and Mortality Surveillance Committee in June 2026.

1.2.3 Potential impact in all five CQC domains

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

Figure 1: Learning from deaths and CQC domains of care



1.3 Risks

The following represent areas identified where there is currently an element of concern. One of these (ref 3491) constitutes a formal risk on the Trust’s risk register.

Table 1: Current risks

Risks	Red/amber rating	
<p>SJR review tool</p> <p>A mortality module is being developed on ENHance to replace the Aqua App which has been decommissioned.</p> <p>As it has been necessary to fit in with the continuing roll-out of other ENHance modules, there has been a short gap between the closure of the Aqua App and go-live on ENHance. This will be in the region of 8 weeks. During this period deaths are continuing to be monitored, and where any element of concern arises, cases are being raised as a patient safety incident to mitigate any risk and ensure appropriate learning. Development of the ENHance module is nearing completion with go-live scheduled for 9 June.</p>		
<p>Extended neonatal mortality</p> <p>Our neonatal service gave an early indication that extended perinatal mortality for 2025 may be above the national average when reported by MBRRACE in 2027. An in-depth review, including external peer review has been undertaken to ensure robust learning and governance. Once this report has been presented to Mortality Surveillance Committee final detail will be provided in this report.</p>		
<p>Cardiology: recurrent SHMI alerts to various elements of the cardiology basket of diagnosis groups</p> <p>Following recurrent mortality alerts across the cardiology diagnosis basket, and a report by the Cardiology Clinical Director, a joint initiative between Cardiology and Coding was implemented and remains ongoing.</p> <p>The latest update was at September Mortality Surveillance when it was agreed the collaborative work should continue with a further update in 12 months’ time.</p> <p>One element of the cardiology basket of diagnosis groups is currently alerting: coronary atherosclerosis. The small number of deaths in this group makes it particularly susceptible to alerting. A review has indicated that inappropriate coding has underpinned this alert.</p>		
<p>Cardiology: Delays to TAVI CT scans</p> <p>The service has raised a concern regarding current delays to TAVI CT caused by capacity issues in radiology. The issue was highlighted by a recent patient safety incident and focussed work is in progress to improve the situation.</p>	Risk register ref: 3491	
<p>Ovarian Cancer SACT 30 Day Mortality: External review findings</p> <p>In the 2017-20 national Systemic Anti-Cancer Therapy (SACT) audit, the Trust was identified as an outlier for 30 Day Mortality. Following discussion at Mortality Surveillance an external peer review was commissioned. This identified a lack of integrated care at MVCC.</p> <p>Following completion of the review of patient care, a formal SI report has been completed. A small number of associated actions remain outstanding. This risk will be maintained until these are confirmed as complete. This is now anticipated to be in late-2026.</p>		
Low risk	Medium risk	High risk

2. Context

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

2.1 Headline mortality metrics

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

Table 2: Key mortality metrics

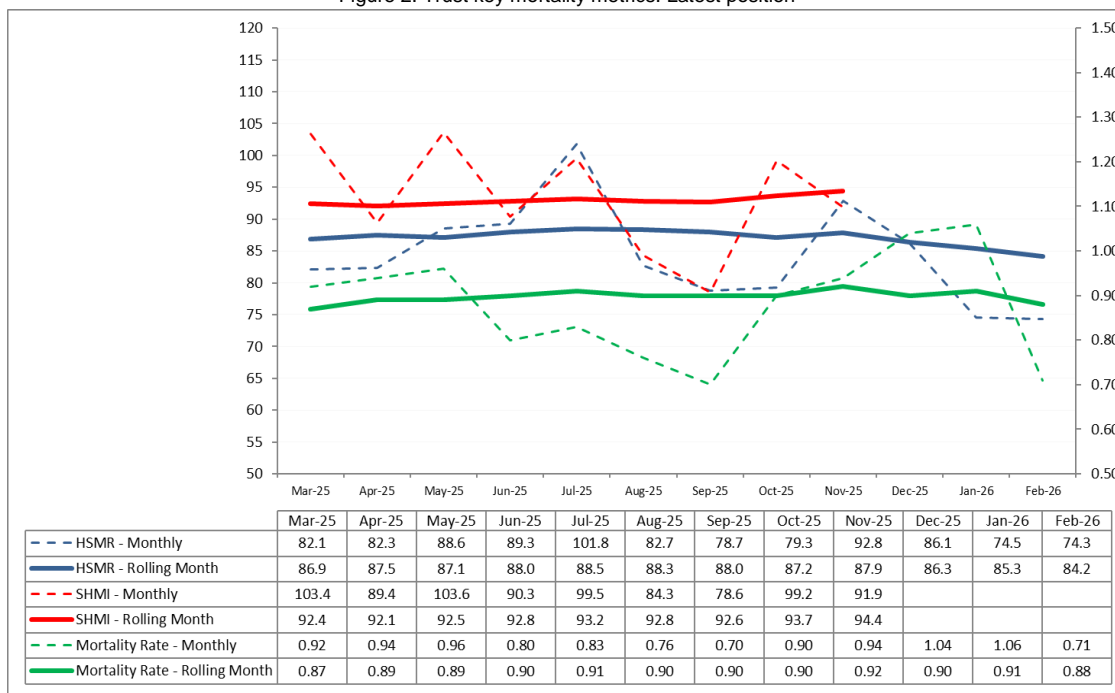
Metric	Headline detail
Crude mortality	Crude mortality is 0.89% for the 12-month period to Feb 2026 compared to 0.93% for the latest 3 years.
HSMR: (data period Mar25 – Feb26)	HSMR for the 12-month period is 84.17 , <i>'First quartile'</i> .
SHMI: (data period Dec24 – Nov25)	SHMI for the 12-month period is 94.99 , <i>'as expected' band 2</i> .
HSMR – Peer comparison	ENHT ranked 3 rd (of 11) within the Model Hospital list* of peers.

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

Figure 2 below shows the Trust’s latest in-month and rolling 12-month trend for the three key mortality metrics: Crude mortality, HSMR and SHMI, as reported by CHKS. Following a prolonged downward trend since March 2023, rolling 12-month HSMR plateaued, then has shown slight increases to November 2025, since when it has been on a downward trend again.

Rolling 12-month SHMI reported by CHKS stands at **94.99** to Nov 2025. This represents a slight increase from the last reported **92.09** for the 12 months to Aug 2025.

Figure 2: Trust key mortality metrics: Latest position



2.2 Mortality alerts

2.2.1 CQC CUSUM alerts

There have been no CQC alerts in Q4.

2.2.2 HSMR CUSUM alerts

There is one HSMR CUSUM red alert which constituted a rolling 12-month 3 standard deviation outlier, for the year to February 2026.

	Relative Risk	Observed Deaths	Expected Deaths	“Excess” Deaths	Included Spells
101 - Coronary atherosclerosis and other heart disease	278.40	11	4	7	228

2.2.3 SHMI CUSUM alerts

CHKS also reported three SHMI CUSUM red alerts constituting a rolling 12-month 3 standard deviation outlier for the latest period to November 2025.

	SHMI	Observed Deaths	Expected Deaths	“Excess” Deaths	Included Spells
142 - 38: Non-Hodgkin's lymphoma	216.27	22	10	12	50
100 - 156, 158: Nephritis; nephrosis; renal sclerosis, Chronic renal failure	215.54	15	7	8	388
58 - 101: Coronary atherosclerosis and other heart disease	267.06	9	3	6	221

2.2.4 Other external alerts

There are no current active external alerts.

2.3 Health inequalities and deprivation

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

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

SHMI Contextual Indicator for deprivation

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

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

We are now routinely monitoring this indicator. To date this has shown that our Trust has a significantly higher percentage of activity relating to those in quintile 5 (least deprived) and

significantly less activity relating to those in quintile 1 (most deprived) than the national average and that this is mirrored by the percentage of deaths in those quintiles.

We are working with our business intelligence colleagues to improve the accessibility of this deprivation information, with the aim of routinely including deaths of patients from lower quintiles in deaths selected for structured judgement review.

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

We have accepted that looking at the comparison of the number of deaths in each socioeconomic quintile with the population proportion in that quintile is not providing much information about health service performance based on socioeconomic status. We are investigating whether there are better measures of the impact of deprivation on mortality.

2.4 Key Learning from Deaths Data

2.4.1 Mandated mortality information

The Learning from Deaths framework states that trusts must collect and publish certain key data and information regarding deaths in their care via a quarterly public board paper. This mandated information is provided below for Q4 2025-26.

Table 3: Q4 2025-26: Learning from deaths data

	Jan	Feb	Mar
Total in-hospital deaths (ED & inpatient)	140	97	85
SJRs completed on in-month deaths (at 31.03.26)	21	4	0
Patient safety incident escalation from SJR (by month of death) (at 31.03.26)	6	0	0
SJR outcome: Deaths more likely than not due to problem in care (≥50%) (at 31.03.26)	0	0	0
Learning disability deaths	1	2	0
Mental illness deaths	1	0	2
Stillbirths	0	2	1
Child deaths (including neonates/CED) **	0	1*	1***
Maternity deaths	0	0	0
PSIs reported regarding deceased patient	1	1	1
PSIs approved regarding deceased patient****	0	2	0
Complaints received in month regarding deceased patient	5	14	8
Requests received in month for a Report to the Coroner	7	11	7
Inquests attended	5	2	1
Regulation 28 (Prevention of Future Deaths)	0	0	0

Notes:

* Sadly, this was an expected death of a child with complex cardiac condition

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

*** While the baby was born at 23+0, an immediate decision was made with the family to redirect the focus to comfort care.

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

2.4.2 Learning from deaths dashboard

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

3.0 Scrutiny to SJR

3.1 Medical Examiner Scrutiny

Table 4: Medical Examiner scrutiny data: Q4 2025-26

Scrutiny detail	Jan	Feb	Mar	Q4 Total
Total in-hospital deaths (excluding MVCC)*	140	101	88	329
ENHT deaths scrutinised by ME	140	101	88	329
MCCDs not completed within 3 calendar days of death	23	10	10	43
ME referrals to Coroner	27	25	17	69
Deaths where significant concern re quality of care raised by bereaved families/carers	0	0	0	0
Patient safety incidents notified by ME office as a result of scrutiny	2	3	3	8
ME referrals for SJR	18	16	11	45
Community deaths reviewed	273	237	216	726
Deaths referred by the Coroner to ME office to review	38	24	33	95
Total deaths reviewed				1150

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

3.2 Structured Judgement Reviews

3.2.1 SJR and deaths YTD headline data

Table 5: Headline 2025-26 Q1-4 SJR and deaths data

Data count	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Year Total
Total in-patient deaths	109	116	96	106	88	84	115	112	120	128	81	81	1236
Total ED deaths	8	6	8	8	8	8	8	7	7	12	16	4	100
SJR completed on in-month deaths (at 31.03.2026)	32	30	42	47	36	41	41	38	37	21	4	0	369

The above table shows that by 31 March 2026, 28% of 2025-26 hospital deaths have received a formal structured judgement review. This is currently above our internal target of 25%.

3.2.2 Learning beyond SJR

3.2.2.1 SJR patient safety incident escalations

Table 6: Year to end of Q4 Patient Safety Incidents reported following SJR

Escalations for deaths in month (at 31.03.2026)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Patient Safety Incident Escalations from SJRs	12	5	8	9	8	9	14	10	10	6	0	0	91

For deaths in the current year which have been subject to an SJR, 91 cases have been escalated as a patient safety incident.

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

In Q4, six cases matching these criteria were concluded and discussed at Mortality Surveillance.

Table 7: Q4 2025-26: Concluded Escalated Cases Summary

SJR/ SI/PSII	Death Preventability (Final MSC decision)	Incident category	Learning themes
SJR	Possibly preventable less than 50:50	Prescribing	Medication
SJR	Possibly preventable less than 50:50	Bowel Management in LD patients	Fundamentals of Care/Treatment Management Plan
PSII	Possibly preventable greater than 50-50	VTE	Fundamentals of Care/Treatment Management Plan
SJR	Possibly preventable less than 50:50	Missed Stroke	Assessment, investigation or diagnosis
PSII	Possibly preventable greater than 50-50	Failure to act on abnormal results	Assessment, investigation or diagnosis/ Treatment/Management Plan/ Clinical Monitoring/Obs/planning/ Communication with patient, relatives and carers/ Deteriorating Patie
PSII	Possibly preventable greater than 50-50	VTE	Fundamentals of Care/Treatment Management Plan

The three deaths judged to have been more likely than not due to a problem in healthcare have been through the rigours of a PSII, with attendant remedial action plans aimed at learning and guarding against the potential for future reoccurrence.

3.2.3. Learning and themes from concluded mortality reviews

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

From February 2025 Clinical Governance Leads have also been asked to ensure that all SJRs are discussed in their specialty Mortality & Morbidity meetings, or other appropriate governance forums.

4.0 Improvement activity

Table 8: Focus Areas for Improvement

Diagnosis group	Summary update
Ovarian Cancer	In the 2017-20 national Systemic Anti-Cancer Therapy (SACT) audit, the Trust was identified as an outlier for 30 Day Mortality. The subsequently commissioned external peer review identified a lack of integrated care at MVCC. Following completion of the review of patient care, a formal SI report was completed. A small number of associated actions remain outstanding. This risk will be maintained until these are confirmed as complete. Revised anticipated completion is September 2026.
Cardiology	Following recurrent mortality alerts across the cardiology diagnosis basket, and a report by

diagnoses	<p>the Cardiology Clinical Director, a joint initiative between Cardiology and Coding was implemented and remains ongoing.</p> <p>The latest update was at September Mortality Surveillance when it was agreed the collaborative work should continue with a further update in 12 months' time.</p>
Sepsis	<p>While HSMR performance relative to national peer remains extremely well placed, achievement of sepsis targets remains variable. The sepsis team continues to develop multiple initiatives aimed at improving compliance.</p>
Stroke	<p>The latest published SSNAP report covered the period Oct-Dec 2025. The Trust had maintained the D rating with improvements in two domains and a drop in only one. Our overall score (rounded up) improved from 44-50.</p> <p>There is a multidisciplinary team which continues to work on all aspects of performance which is reflected in the service's overall action plan and is discussed at their regular performance meetings.</p>
Emergency Laparotomy	<p>In the 2019 National Laparotomy Audit Report, the Trust's risk adjusted mortality for emergency laparotomy stood at 13%, with the Trust ranked in the bottom 20% of reporting Trusts nationally. Since this time the NELA service has worked tirelessly to improve performance.</p> <p>In collaboration with Coding/Business Intelligence the service is working to create a script to identify all NELA cases. This should significantly increase case ascertainment. In the meantime, a focus on manually checking theatre activity has already resulted in a significant improvement to case ascertainment, which is currently close to 100%.</p> <ul style="list-style-type: none"> • Once the case ascertainment script is functioning, work with the BI team is proposed to enable more real time access to data • Significant improvement to the service by virtue of 80% of NELA patients now being seen by a consultant geriatrician • Strategic focus is maintained via a regular NELA meetings. The current focus is on time from front door to theatre, including ED assessment and CT scan • Establishing a dedicated radiology request on ICE for NELA CT remains a challenge.

5.0 Preventable deaths

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

The table below provides year to end of Q4 deaths/SJR/Preventability data (detailing SJRs conducted up to 31 March 2026). The outcome of investigations and actions relating to deaths judged more than 50:50 preventable are discussed by the Mortality Surveillance Committee.

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

Table 9: 2025-26 SJR preventable deaths data Year to the end of Q4

Data count (at 31.03.2026)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Hospital deaths (ED & inpatient)	117	122	104	114	96	92	123	119	127	140	97	85	1336
SJR's completed on in-month deaths	32	30	42	47	36	41	41	38	37	21	4	0	369
% of deaths subject to SJR to date	27%	25%	40%	41%	38%	45%	33%	32%	29%	15%	4%	0%	28%
Deaths judged more likely than not to be due to a problem in healthcare	0	1*	0	1	0	1	1**	0	0	0	0	0	4
% SJRs assessed ≥50:50 preventable	0%	3%	0%	2%	0%	2%	2%	0%	0%	0%	0%	0%	1%

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

** In this case the concerns related to care provided prior to admission. The concerns related to Catheter Care in the community (Perforated bladder due incorrectly sited catheter), the concerns were shared with HCT who are investigating. The reviewer did not consider that the care provided in-hospital by the Trust contributed to the outcome.

6.0 Options/recommendations

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

Appendix 1: Learning from Deaths Dashboard

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

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

Total Number of Deaths, Deaths Reviewed and Deaths Deemed more likely than not due to problems in care (does not include patients with identified learning disabilities)					
Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered more likely than not due to problems in care PRISM Score<=3 or equivalent measure	
This Month	Last Month	This Month	Last Month	This Month	Last Month
84	94	0	2	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
316	366	23	113	0	1
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
1317	1376	364	293	5	5

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

Score 1 Definitely preventable	Score 2 Strong evidence of preventability	Score 3 Probably preventable (more than 50:50)	Score 4 Probably preventable but not very likely	Score 5 Slight evidence of preventability	Score 6 Definitely not preventable
This Month 0 -	This Month 0 -	This Month 0 -	This Month 0 -	This Month 0 -	This Month 0 -
This Quarter (QTD) 0 0.0%	This Quarter (QTD) 0 0.0%	This Quarter (QTD) 0 0.0%	This Quarter (QTD) 0 0.0%	This Quarter (QTD) 3 13.0%	This Quarter (QTD) 20 87.0%
This Year (YTD) 0 0.0%	This Year (YTD) 1 0.3%	This Year (YTD) 4 1.1%	This Year (YTD) 10 2.8%	This Year (YTD) 33 9.3%	This Year (YTD) 305 86.4%

Time Series: Start date 2024-25 Q4 End date 2025-26 Q4

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

Total Number of Deaths, Deaths Reviewed and Deaths Deemed more likely than not due to problems in care for patients with identified learning disabilities					
Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered more likely than not due to problems in care	
This Month	Last Month	This Month	Last Month	This Month	Last Month
0	2	0	2	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
3	2	2	2	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
9	11	8	10	0	0

Time Series: Start date 2024-25 Q4 End date 2025-26 Q4

Board

Meeting	Public Trust Board		Agenda Item	13
Report title	Annual Freedom to Speak Up Report (2025/ 26)		Meeting Date	8 July 2026
Author	Sylvia Gomes, Freedom to Speak Up Guardian			
Responsible Director	Chief Nurse			
Purpose [See note 7]	Assurance	<input checked="" type="checkbox"/>	Approval/Decision	<input type="checkbox"/>
	Discussion	<input type="checkbox"/>	For information only	<input type="checkbox"/>
Proposed assurance level <i>(only needed for assurance papers)</i>	Substantial assurance	<input type="checkbox"/>	Reasonable assurance	<input checked="" type="checkbox"/>
	Partial assurance	<input type="checkbox"/>	Minimal assurance	<input type="checkbox"/>
Executive assurance rationale:				
<p>As agreed with the People and Culture Committee on 16th June 2026, this annual report demonstrates reasonable assurance of the provision of Freedom to Speaking Up (FTSU) service within our organisation.</p> <ul style="list-style-type: none"> • A just, restorative and learning culture is being supported. • The service is contributing to incremental improvements seen within ENHT staff survey and satisfaction at work results and responsiveness to patient safety incidents. • Reduction in direct escalation of staff concerns to CEO via 'ask.adam' in box. • A more diverse and inclusive engagement with FTSU service established across all staff groups. 				
Summary of key issues:				
<p>The report highlights a consistent annual increase in speaking up episodes, from 270 episodes in 2023/24, 311 episodes in 2024/25 to 326 episodes in 2025/26.</p> <p>Workforce prevalence of staff speaking up is 50% black, brown and minority ethnic make-up compared with 48% white British and other white ethnicity make-up, with a small proportion (2%) of other ethnicities.</p> <p>Themes:</p> <ul style="list-style-type: none"> • 55% of cases relate to worker safety or wellbeing. • 31% of concerns relate to inappropriate attitudes or behaviours, primarily incivility and conduct at work. • 9% of concerns relate to patient safety and quality. • 5% of concerns relate to bullying and harassment <p>Future next steps for improvement include:</p> <ul style="list-style-type: none"> • Improve strategic alignment across FTSU and other organisational domains that improve staff experience and reduce clinical risk. • Embed opportunities to promote psychological safety within teams • Increase the number of trained mediators across all staff groups within our Trust • Continuous support for all managers to listen and respond to staff when voicing concerns. • Embed processes to enable Speaking Up learning and improvements to be shared as business as usual 				

<ul style="list-style-type: none"> • Embed civility saves lives interventions • Support the workforce to appreciate and manage expectations when raising a concern, and/or responding to a concern 													
Impact: tick box if there is any significant impact (positive or negative):													
Patient care quality	<input checked="" type="checkbox"/>	Equity for patients	<input checked="" type="checkbox"/>	Equity for staff	<input checked="" type="checkbox"/>	Finance/Resourcing	<input checked="" type="checkbox"/>	System/Partners	<input type="checkbox"/>	Legal/Regulatory	<input checked="" type="checkbox"/>	Green/Sustainability	<input type="checkbox"/>
Strategic and organisational issues requiring Board-level oversight include: <ul style="list-style-type: none"> • Poor speaking up arrangements and lack of psychological safety is likely to increase risk of patient safety incidents, drop in accepted standards of care, negatively impacting service user and staff experience. • Poor staff experience could increase negative staff survey results, increase turnover, sickness absence rates and on-going recruitment costs. 													
Trust strategic objectives: tick which, if any, strategic objective(s) the report relates to:													
Quality Standards	<input checked="" type="checkbox"/>	Thriving People	<input checked="" type="checkbox"/>	Seamless services	<input type="checkbox"/>	Continuous Improvement	<input checked="" type="checkbox"/>						
Identified Risk: Please specify any links to the BAF or Risk Register													
Key risks for board to note include: <ul style="list-style-type: none"> • Over the last 12 months 70% of staff have first Spoken Up to their line manager or the appropriate manager and contacted the FTSU Guardian either because they did not believe they were heard or perceived there was no meaningful response. • The current organisational response to enabling Listening Up and Following Up culture requires maturity to deliver a timely and meaningful response to colleagues who Speak Up • The absence of protected time for Speak Up champions, in the context of rising FTSU cases, and a very lean FTSU office structure, increases the risk to sustainably deliver a FTSU service required for required culture change. BAF 2 -Health Inequalities BAF 4 -Workforce BAF 5-Culture, Leadership and Management BAF 6 Leadership and Engagement													
Report previously considered at & date(s):													
People and Culture Committee, 16/6/26													
Recommendation	The Trust Board is asked to <ol style="list-style-type: none"> 1. Discuss the findings and thematic analysis of the annual report. 2. Agree if a true accuracy of risks is presented. 3. Consider the strategic and organisational issues detailed as a consequence of the on-going risks that have been identified. 												

Foreword

Theresa Murphy, Chief Nurse and Executive Lead for FTSU

Our Trust is committed to enabling and supporting our staff to Speak Up and it is encouraging to see the consistent rise in the number of colleagues using the FTSU service to speak up. We want to deliver consistently outstanding care to our community and an absolute pre-requisite to this is cultivating a culture where people feel safe and empowered to Speak Up. Every concern raised is a valuable opportunity to learn, reflect and improve and we are committed to translating these lessons into meaningful, systemic change.

I welcome the opportunity to evolve and grow the FTSU service so that we can build a workplace where openness is celebrated and every voice is heard.

I also want to commend the findings of the Trust's recent Freedom to Speak Up audit, which provided a Reasonable Assurance rating and would like to extend my sincere gratitude to the FTSU service for providing a safe, confidential space for our colleagues to Speak Up and for working tirelessly to ensure a meaningful response.

Whilst we celebrate the many achievements outlined in this report, we must continue to do better at Listening Up and Following Up

Diana Skeete, FTSU Non Executive Director

I was particularly encouraged by the findings of the Trust's recent Freedom to Speak Up audit, which provided a Reasonable Assurance rating. The audit recognised many of the strengths already in place within the Trust's arrangements and acknowledged that work was already underway to address a number of the areas identified for further development.

It is also encouraging to see in the annual report that colleagues are continuing to make use of the Freedom to Speak Up service. Whilst an increase in speaking up activity should always be considered alongside wider organisational intelligence, it can be a positive indicator that staff are aware of the support available to them and feel able to raise concerns, share ideas and seek advice when needed. This is a vital element of a healthy organisational culture and an important mechanism through which organisations can identify concerns, learn from experiences and improve both staff and patient outcomes.

While the audit provided Reasonable Assurance and recognised improvements already underway, it also highlighted opportunities to further strengthen the service. As we look ahead, discussions are continuing regarding how Freedom to Speak Up can be more effectively aligned with the Trust's wider culture, workforce and improvement agendas. This has the potential to strengthen organisational learning, improve visibility of emerging themes and support a more integrated approach to staff experience and organisational culture.

The continued success of Freedom to Speak Up will depend not only on the commitment of those involved, but also on ensuring that the service has the capacity, capability and organisational support required to deliver its role effectively and sustainably. At a time when national Freedom to Speak Up arrangements are evolving, including changes to the National Guardian's Office, it is important that we remain focused on what matters most: ensuring that every colleague feels safe and supported to raise concerns, share ideas and contribute to improving the care we provide. Regardless of changes to national structures, creating an environment where people can speak up without fear remains fundamental to patient safety, staff wellbeing and organisational learning.

Introduction:

The role of the Freedom to Speak Up Guardian was created in response to recommendations made in Sir Robert Francis QC's report which investigated failures in care at the Mid Staffordshire NHS Foundation Trust. These recommendations were made as Sir Robert found that NHS culture did not always encourage or support workers to speak up, and that patients and workers suffered as a result.

The National Guardian's Office (NGO) previously trained Freedom to Speak Up Guardians, collated data on Speak Up themes and shared learning. The NGO is closing in June 2026 with Speak Up roles and responsibilities moving to NHS England and eventually to Department of Health when NHS England ceases to operate.

Background:

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

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

1.0 Operational function of the service includes:

1.1 FTSU Guardian's role in supporting and resolving issues:

- Being available and responsive to colleagues is a vital part of the FTSU service. 95% colleagues receive a response within 48 hours of contacting the FTSU Guardian. Colleagues are always offered the choice of where/ how and when they wish to meet the guardian which can be on site or off site/ in person/ on teams or via phone
- As the aim is to make Speaking Up business as usual, colleagues are always encouraged to speak to their immediate or second tier line manager in the first instance unless there are sound reasons for not doing so. If a colleague feels unable to do this on their own, then, with consent from both parties, the FTSU Guardian has helped facilitate a meeting with their manager, or the individual involved.
- Colleagues are advised at the start of the discussion that should their concern have elements of patient safety, colleague safety or safeguarding, the concern cannot be kept confidential and must be escalated immediately.
- Support is provided by listening, coaching and encouraging colleagues to raise their concerns directly with their manager. Sometimes listening to understand is all that was required.
- The FTSU Guardian has helped identify a range of options when colleagues have raised concerns. Often colleagues are unable to see the full picture when they are absorbed in the issue. By exploring options, colleagues are sometimes able to see a solution to their concerns. This has been reflected in the publication of the Speak Up policy in 2023.
- The FTSU Guardian has played a crucial role in de-escalating issues by supporting local resolution and linking in with the Trust OD team to enable development at a practical level with individuals, teams, and services.

1.2 Raising awareness of Freedom to Speak Up

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

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

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

1.3 Speak Up Champions:

In the last financial year, 14 Speak Up Champions were recruited and trained, bringing the total number of Speak Up Champions to 45. We now have Speak Up Champions across all 4 hospital sites. Recruitment has been inclusive, reflecting our diverse workforce and representing a variety of staff groups, grades, and ethnicity to include all professional groups (Nurses, Midwives, Doctors, Therapists, Operation Department Practitioners, Radiographers, Health Care Support Workers, Administration and Clerical Staff).

Staff Group	Numbers
Additional Professional Scientific & Technical	2
Additional Clinical Services	2
Administrative & Clerical	10
Allied Health Professionals	5
Medical & Dental	6
Nursing & Midwifery Registered	20
Total	45

Speak Up Champions help influence the Speak Up culture within their departments, signpost colleagues who wish to speak up and help address barriers to Speaking Up. Speak Up Champions do not have protected time to carry out their work. This is a voluntary role and is dependent on individual managers agreeing time for the Speak Up function. The Champions meet monthly to network, share learning and generate awareness to issues experienced by our People. This report recommends that Speak Up Champions are given protected time of 1 hour per week to address barriers to Speaking Up and to support colleagues who wish to Speak Up.

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

1.4 Training:

All colleagues are assigned the Speak Up training module on ENH academy. 89% of colleagues have completed Speak Up training. All managers are assigned Speak Up and Listen Up training modules. 87% of managers have completed Listen Up training module.

1.5 Freedom to Speak Up Week:

13th to 17th of October 2025 was promoted as Speak Up week and key messages on the theme ‘Follow Up in Action’ was shared with support from our Trust communications team.

- A variety of events took place on each working day that week. It included FTSU workshops, Speak Up champions visits across all sites and presentations at various departmental meetings.
- Anonymised learning and feedback from Speak Up cases were shared in the Trust newsletter and FTSU intranet page
- The Trust Civility video was promoted within clinical departments to generate ‘Civility Saves Lives’ awareness.
- The FTSU Guardian facilitated reflective session at the leadership forum on ‘Listening Up’. This session generated discussion on how we listen and respond to our people’s voice and leaders made commitments to creating a psychologically safe environment within their team
- The FTSU Guardian also delivered talks and presentations on Speaking Up; Psychological Safety, and influencing just, restorative and learning culture at the Leadership Forum, Quality Huddle, departmental governance sessions, divisional meetings, rolling half day audit meetings and team meetings
- The FTSU Guardian attended senior managers meetings, staff network groups, People and Culture Committee, Trust Partnership, Quality and Safety meetings to work collaboratively with the wider organisation to create and promote a Speaking Up culture
- Training delivered to 6 Speak Up Champions including 1 resident doctor, 3 nurses and 2 admin clerical colleagues that week.
- A Speak Up Champions pledges poster was displayed in staff experience hub to promote the importance of Speaking Up.
- The FTSU Guardian visited departments Trust wide and cross site to introduce ‘Listening Up’ and build connections with staff and managers
- Speak Up Champions working in pairs visited departments across all sites to promote Speaking Up

1.6 Regional and National Networking:

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

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

2.0 Annual review of issues 2025/26

2.1 Assessment of Issues

Speak Up Cases over last 5 years.

Year	2021/2022	2022/2023	2023/2024	2024/2025	2025/2026
No. of Speak Up Cases	90	191	270	311	326

Number of Speak Up cases for each quarter (2025/26):

	Q1	Q2	Q3	Q4	Total
Total Cases	88	72	82	84	326

2.2 Themes:

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

Themes	Number 2022/23	Number 2023/24	Number 2024/25	Number 2025/26
1. Worker Safety or Wellbeing	119	93	148	178
2. Inappropriate attitudes or behaviours	43	115	109	102
3. Patient Safety/ Quality	15	49	36	31
4. Bullying and Harassment	14	13	18	15
5. Disadvantageous or demeaning treatment because of Speaking Up	0	0	0	0
Total	191	270	311	326

Themes April 2025 to March 2026

Themes	Number	Percentage
1. Worker Safety or Wellbeing	178	55%
2. Inappropriate attitudes or behaviours	102	31%
3. Patient Safety/ Quality	31	9%
4. Bullying and Harassment	15	5%
5. Disadvantageous or demeaning treatment because of Speaking Up	0	0
Total	326	100%

2.3 Who is speaking up?

Concerns raised by staff groups (as defined by NGO)

Staff Group	Number of Concerns Raised 2022/23	Number of Concerns Raised 2023/24	Number of Concerns Raised 2024/25	Number of Concerns Raised 2025/26
Additional Professional Scientific & Technical	9	10	16	6
Additional Clinical Services	39	32	29	29
Administrative & Clerical	39	71	52	82
Allied Health Professionals	7	14	34	17
Estates & Ancillary	0	7	7	5
Healthcare Scientists	0	5	15	7
Medical & Dental	12	31	62	63
Nursing & Midwifery Registered	84	92	89	108
Students	0	3	6	5
Unknown (anonymous)	1	4	0	2
Other	0	1	1	2
Total	191	270	311	326

Who is Speaking Up by Staff Group April 2025 to March 2026

Staff Group	Number of Concerns Raised	Percentage
Additional Professional Scientific & Technical	6	2%
Additional Clinical Services	29	9%
Administrative & Clerical	82	26%
Allied Health Professionals	17	5%
Estates & Ancillary	5	1.5%
Healthcare Scientists	7	2%
Medical & Dental	63	19%
Nursing & Midwifery Registered	108	33%
Students	5	1.5%
Unknown (anonymous)	2	0.5%
Other	2	0.5%
Total	326	100%

2.4 Who is speaking up by Ethnicity?

Ethnicity	Number 2022/23	Number 2023/24	Number 2024/25	Number 2025/26
Asian	45	82	107	115
Black	42	68	66	37
Mixed (Asian & White British)	6	2	2	1
Mixed (Black & White British)	12	3	4	7
Mixed (other)	3	0	0	1
White British	70	106	124	156
White (other)	12	5	8	7
Unknown	1	4	0	2
Total	191	270	311	326

Who is Speaking Up by Ethnicity (April 2025 to March 2026)

Ethnicity	Number	Percentage
Asian	115	35.4%
Black	37	11.4%
Mixed (Asian & White British)	1	0.3%
Mixed (Black & White British)	7	2.0%
Mixed (other)	1	0.3%
White British	156	48%
White (other)	7	2.0%
Unknown	2	0.6%
Total	326	100%

Speak Up Episodes by site (2025/26)

Site	Lister Hospital	MVCC	QE2	Luton Renal Unit	Gunnels Wood Park	St Albans Renal Unit	Bedford Renal Unit	Avnet House	Harlow Renal Unit	HCH
No of Concerns	244	28	17	16	8	7	2	2	1	1

2.5 Themes in more detail:

1. **Worker Safety or Wellbeing:** This relates to cases where there is a risk of adverse impact on worker safety or wellbeing including work related stress.

20% of cases relate to the consultation and this is reflected in an increased number of Speak Up cases from administration and clerical staff group. Colleagues affected by the process Spoke Up to report lack of support and clarity from the team leading the consultation and gaps in communication. They also perceived that the consultation process was not open and transparent as many questions were left unanswered, their job titles and job description were incorrect, and colleagues reported feeling a sense of confusion around the redeployment process and relevant job opportunities within the organisation. Colleagues reported that it would have been beneficial to have had access to pastoral care/ support on-site which would have significantly reduced the stress and anxiety they experienced whilst going through this process.

15% of cases relate to the breakdown of relationship between line managers and employees. Both managers and employees needed to be supported with resolving the issues they encountered and with moving forward. In some circumstances, early mediation may have stopped issues from escalating to a formal complaint process.

6% of cases related to perceived inequality and discrimination including lack of opportunity for training, flexible working and support with career progression.

5% of cases relate to health and safety including staff experiencing aggression and violence from service users.

5% relate to organisational response to parking concerns raised by colleagues. They reported that they perceived the response from the organisation to lack compassion and understanding.

4% relate to recruitment process, including the need to provide meaningful interview feedback.

Suggested Actions:

- 1) Pastoral care/ support that can be accessed on site and in person must be arranged prior to launching any consultation.
- 2) Electronic Staff Record (ESR) which is an integrated Human Resource (HR) and payroll system should be checked and updated to reflect every colleague's current job role and job description as this will provide accurate information on our workforce and the resource required to meet the needs of the service.
- 3) Managers need support to manage performance and attendance issues to ensure that any action taken is just and restorative. Training is available via ENH academy to help managers gain skills required to manage people. This is self-directed and does not provide opportunity for discussions with peers. Training with a group of managers may be more effective and supportive as it would allow for peer-to-peer support, shared learning including practical scenario based learning
- 4) Managers need coaching/ training to gain people management skills including skills to have difficult conversations with compassion and skills to respond to conflict between team members. As part of learning from Speak Up cases, coaching has commenced for some managers. This needs to be expanded and provided to all managers as part of our people strategy 'help our people thrive and grow.'

- 5) All colleagues working in patient/ service-user facing areas should be encouraged to complete de-escalation training. Majority of staff in high-risk areas such as emergency department have accessed this training.
- 6) Initiation of a 'Critical Infrastructure Group' that provides an MDT approach involving estates and facilities, to co-design moves that are needed to mitigate wider organisation risk. This provides a clear, planned picture to move requests and the opportunity to co-design and consider options prior to moves happening. Through East and North Herts Production system, adoption of '3-P' improvement events, where internal and external partners co-design environmental changes in partnership with services users and offer rationale and value to office moves when requested.
- 7) To continue the Cultural Intelligence work that has started within the organisation including training, reverse mentoring, inclusive talent management and staff network streams.

2. Behavioural / Inappropriate attitudes (Incivility): 31% of concerns raised related to interactions that lacked civility and respect and dignity. This contributed to poor psychological safety within teams. Colleagues across all grades including managers were impacted by this. Most colleagues who experienced incivility reported that it had a negative impact on their well-being and their ability to promote patient safety when working as part of the multidisciplinary team to deliver safe care. Several colleagues reported they felt anxious and dreaded coming to work.

Suggested Actions:

- 1) A Healthy Teams action plan is in progress to set the cultural tone in line with Trust values and to facilitate the development of departmental values and behavior charter. Almost 60% of teams have participated proactively in sessions to define values and behaviors that underpin these values. More work is needed to help colleagues to hold their peers compassionately accountable for behaviors not in line with Trust values.
- 2) Provision of timely supportive feedback and coaching is needed for colleagues involved in incidents of incivility to help them develop a communication style that reflects our Trust values. Conflicting operational pressures have created barriers in provision of timely feedback. There is improved access to coaches within our Trust and over time this should have a positive impact on the standard of communication within our Trust.
- 3) While some interventions are in place through leadership development, improvement methodology and patient safety processes to actively promote and improve psychological safety, there remains a gap. Leaders need support and coaching to gain skills needed to embed psychological safety within their team.

3. Patient safety concerns:

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

- Staffing shortfall including poor skill mix – predominantly within inpatient areas.
- Insufficient equipment- this included fully functioning equipment needed to deliver clinical care.
- Deviation from agreed clinical standards.
- Patient allocation within wards for nursing team did not include adjustment for dependency and skill mix. This was across inpatient areas within the Lister hospital. These concerns are also noted and discussed through the Trust Risk management processes.

Suggested Actions:

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

4. Bullying and Harassment:

15 colleagues in total raised concerns about bullying and harassment. 5 colleagues decided to leave the organisation as they did not trust the investigation process. 10 colleagues raised concerns with Employee Relations Advisory Service (ERAS) via the Trust grievance process.

Suggested Actions:

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

3.0 Concerns raised via other avenues

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

42 concerns were raised in the year 2025/26

Type of Concern

Care related	28
Pathways & Processes	6
Whistleblowing	3
Environmental	2
Treatment/ Diagnosis delay	1
Medication	1
Other	1

Whilst there was no overall theme, there were mini trends across the year in line with areas of concern raised internally such as incident reporting



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

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

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

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

4.0 FTSU Internal Audit:

A review of the FTSU arrangements was undertaken as part of the 2026/27 internal audit plan. The aim was to allow the Trust to take assurance over the robustness of processes and compliance with the Freedom to Speak Up Policy including:

- 1) Whether there are systems in place to allow individuals to raise matters of broad concern.
- 2) If these concerns are addressed in a timely manner and with a comprehensive and effective response, allowing for a culture of openness and transparency.
- 3) If the concerns are reported accurately

FTSU service was audited in April 2026.

Auditors confirmed that the FTSU service has a well-designed control framework that is generally operating effectively.

Specifically, the Trust can evidence that it has a Freedom to Speak Up (FTSU) framework in place that includes the key elements expected in line with NHS national policy and guidance. The framework is supported by an up-to-date, Board-approved policy, clear routes for staff to raise concerns, effective operational case management arrangements, and established reporting to the Trust Board.

Auditors also noted that individuals involved in the FTSU process, including the Guardian and Champions, demonstrated an appropriate understanding of their roles and responsibilities, and that systems are in place to record, manage, and resolve concerns raised.

Reasonable Assurance grading achieved with 4 low priority actions.

5.0 Achievements:

- Rise in Speak Up cases from our people, from every staff group, reflecting our diverse workforce and representing breath of grades and seniority
- Only 2 anonymous FTSU cases over the last 12 months, especially when we consider that we had a large group of colleagues were going through consultation and frightened of losing their jobs.
- 14 Speak Up Champions recruited and trained.
- Increase in local resolution/ facilitated conversation/ mediation
- 89% staff have completed Speak Up training, and 87% managers have completed Listen Up training module.
- Speaking Up is part of corporate induction and included in a variety of meetings including Leadership Forum, Quality Huddle, consultant induction, medical trainee induction, local negotiation committee and junior doctor forum
- Sustained increase in cross-site visibility of FTSU Guardian including site specific all staff team briefings and departmental meetings

- FTSU workshop delivered at Mount Vernon Cancer Centre, Lister Hospital, Queen Elizabeth II and Hertford County Hospitals.
- Internal FTSU Audit: Reasonable Assurance grading achieved

6.0 Learning and Improvement:

1. Strategic alignment of FTSU and other organisational drivers

The overall improvement ambition from the FTSU office is to align more effectively across wider organisational priorities, specifically priorities that impact thriving people and staff experience.

2. Fear continues to be a barrier to Speaking Up

Many colleagues continue to feel fearful of the consequences of Speaking Up and therefore the need to develop healthy teams and embed psychological safety within teams continues. There are several positive streams of work in play within our organisation including Healthy Teams, Values and Behaviours and What Matters to You. We need to connect these initiatives to ensure effective delivery on Trust strategy. In addition to this, training is available to help colleagues gain skills to Speak Up and for managers to Listen Up. It is essential that all colleagues access this training to promote speaking up within the organisation.

3. Duty of Care towards colleagues who have come to harm due to actions within the organisation

The organisation needs to consider formally acknowledging harm caused, share learning and offer an apology to colleagues who have suffered harm to promote restorative healing.

4. Accessing Mediators early:

Observation and learning from FTSU service has highlighted ongoing gaps in deploying mediation early to ensure timely de-escalation of interpersonal conflict. The delay in accessing mediation increases the risk of prolonging the ongoing interpersonal challenges as opportunities for early resolution are missed. This report recommends that our leaders consider mediation as part of initial response to interpersonal conflict. We have 8 trained mediators within the organisation, all based within the People Team. It would be beneficial to have a more diverse pool of trained mediators across all staff groups.

5. Support for leaders/ managers

Over the last 12 months, 70% of colleagues who contacted FTSU Guardian had historically Spoken Up to their line manager. The escalation to FTSU occurred either because colleagues did not believe they were heard or were not convinced there was a meaningful response. All ward managers and department leadership teams need support to listen and respond to staff voice. This needs to be assessed individually as part of Grow Together conversations to plan individualised support.

6. To work towards our goal of making Speaking Up business as usual

Managers need to include FTSU within their agenda for team meetings biannually and invite either FTSU Guardian or Speak Champion to join their meeting. We need to create more opportunities for the FTSU guardian to work more closely with the business partners to help facilitate this improvement.

7. Civility saves lives

It is essential that the Trust campaign and video on civility is shared widely across our Trust with teams, followed by a reflective session facilitated by our civility campaign champions or

OD/ Cultural team to support shifting our organisational culture to a place where our values of Include, Respect and Improve are lived

8. Listen up Culture

More maturity is required for workforce appreciation of expectations when raising a concern, or responding to a concern

9. Changes to NGO Office

The National Guardian's Office (NGO) is closing in June 2026 with the FTSU roles and responsibilities moving over to NHS England. The FTSU Guardian will continue to contribute to the national FTSU mission. Part of this work is to submit and support requirements from the NHS England. These include quarterly submissions, regional meetings and other surveys.

7.0 2026/27 Recommendations:

1. 95% of colleagues complete Speak-Up training available via ENH Academy; this will be recommended role essential training.
2. 95% of managers complete Listen Up training in addition to the above
3. Grow Together conversations for all line managers should include a plan to support individual managers to listen and respond to staff voice
4. Speak up cases are reviewed through the lens of learning and improving, ensuring meaningful actions and sustained improvement in partnership with people team, EDI and staff experience priorities.
5. All teams continue to work in partnership with Trust OD team to draw up a team charter including behaviours that reflect our values with biannual reflections on how team members are encouraged to live our Trust Values.
6. People team to undertake some work to identify where mediation can be deployed and implement that at an early stage particularly where they know there has been a breakdown in relationships between staff, particularly between line managers and their direct reports.
7. Speak Up Champions have locally agreed time to carry out their FTSU champion work. While limitation exists to provide protected time across the workforce, the current model of negotiated balance of time commitment provides a more equitable approach to staff engaging with the Speak up Champion roles and responsibilities.
8. There is formal agreement between the FTSU function and the People Team to confirm a process for responding to staff concerns including expected actions, responsibilities and agreed timeframes.
9. FTSU Guardian continues work stream that has started to grow staff confidence in 'Speaking Up' and grow to encompass 'Listening Up'
10. FTSU Guardian continues to link in with OD to enable development at a practical level within individuals, teams and services
11. FTSU Guardian, OD and Governance work collaboratively to embed learning for Speak Up themes
12. FTSU internal audit assurance actions are reported through the Audit and Risk Committee and any learning related to potential clinical risk are discussed within the Patient Safety Sub Committee.

The Trust Board is asked to:

- Consider and comment on the themes, trends and issues arising from this report
- Support the drive for cultural change, including living our values (Include, Respect and Improve) by scrutinising the organisations approach to leadership development and people

management and seek assurance there are clear plans and resources in place to support this.

- To review the recommendations detailed within this report and discuss FTSU themes and learnings at People and Culture Committee on a regular basis in line with internal audit report recommendation

Integrated Performance Report

Month 02 | 2026-27



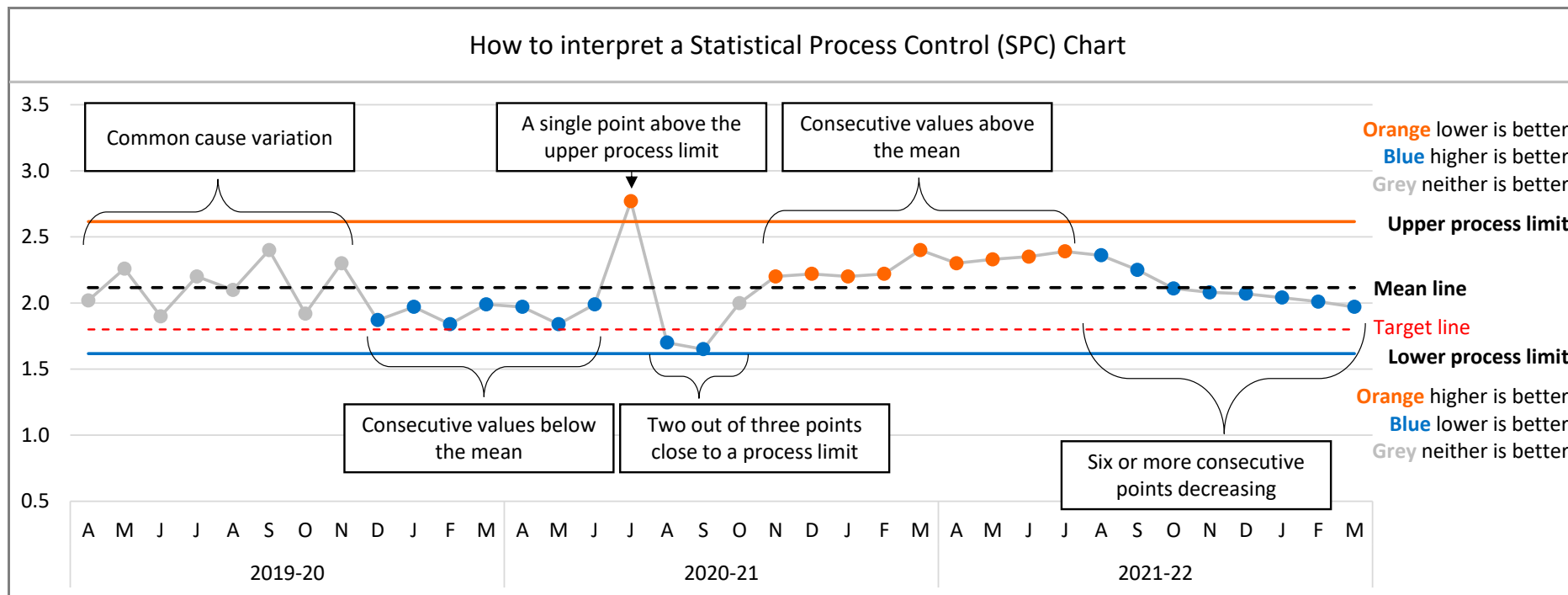
		3	4	3
		9	30	10
		0	5	7

Data correct as at 24/06/2026

Performance Highlights

Quality	Operations
<ul style="list-style-type: none"> • An extraordinary number of new PSII's were commissioned in May (5). • Increased reporting of incidents related to access of medical records and Obstetrics have been noted in May. • Mortality, LOS and readmission rates stable. • Stroke thrombolysis rate improving. • VTE risk assessment successfully achieved 80% compliance. • Sepsis compliance has a targeted improvement plan for fluid balance completion. • IPC and MDT speciality oversight of surgical site infections is underway. 	<ul style="list-style-type: none"> • Cancer Waits: 14/119 nationally in April. Faster Diagnosis Standard short term drop (71%) - back to 79% in May. • Diagnostics: Best monthly improvement in DM01 performance in over a year (50.2% -> 45.2%) with improvements across all modalities in May. Audiology capital works now complete and operational. • Referral To Treatment (RTT) (excl Community Paeds): Adverse impact (1%) of 8 wk closure of Swift Ward & strengthened financial controls. Remains above trajectory. Recovery plan being worked on. • Community waits: Proof of Concept underway for Herts integrated CYP Neurodiversity pathway. • UEC: Below trajectory, impacted by Swift ward closure. June: collaborative work with primary care, EEAST & HCT: Call before Convey and front door redirection. Acute Physician In Charge (APIC) role now in place. Team development and national clinical lead visit planned.
Finance	People
<ul style="list-style-type: none"> • £6.1m YTD deficit against a £5.3m deficit plan • YTD actual CIP delivery is £2.8m. The CIP plan is phased to deliver in latter months of years so monthly run rate needs to significantly improve. • Variance from plan mainly driven by April industrial action (£0.5m) and workforce pressures • Nursing and Medical workforce cost pressures and divisional overspends persist. Elective performance and productivity gaps are masked by block. • 2026/27 position needs to continue to focus on transformation programme savings, strengthening financial controls and improvements in productivity. 	<ul style="list-style-type: none"> • Staff turnover rate at 7.3% and remains below target. • Overall Bank & Agency spend under by 0.5%, Bank spend remains the priority for reducing (currently 1.8% above plan). • GROW together compliance as well as Appraisal compliance remains static and under target, Medical appraisals now included. • Stat Mand training compliance static - improvement paper provided at People Senate with assurances around targeted interventions. • Sickness target monitoring improving position vs previous month, stress & mental health conditions continue to be a leading cause of sickness absence. • Vacancy rate remains under target (2.2%)

Integrated Performance Report











Variation		Assurance	
	Special cause variation of concerning nature due to H igher or L ower values		Consistent Failing of the target Upper / lower process limit is above / below target line
	Special cause variation of improving nature due to H igher or L ower values		Consistent Passing of target Upper / lower process limit is above / below target line
	Common cause variation No significant change		Inconsistent passing and failing of the target



Quality

Month 02 | 2026-27

				
		2	1	1
		5	25	1
		0	4	2

Quality Summary

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment																																																								
Patient Safety Incidents	Total incidents reported in-month	May-26	n/a	1,598			Common cause variation No target																																																								
	<table border="1"> <tr> <td rowspan="8">Infection Prevention and Control</td> <td>Hospital-acquired MRSA Number of incidences in-month</td> <td>May-26</td> <td>0</td> <td>0</td> <td></td> <td></td> <td>Common cause variation Metric will inconsistently pass and fail the target</td> </tr> <tr> <td>Hospital-acquired c.difficile Number of incidences in-month</td> <td>May-26</td> <td>0</td> <td>2</td> <td></td> <td></td> <td>Common cause variation Metric will inconsistently pass and fail the target</td> </tr> <tr> <td>Hospital-acquired MSSA Number of incidences in-month</td> <td>May-26</td> <td>0</td> <td>4</td> <td></td> <td></td> <td>Common cause variation Metric will inconsistently pass and fail the target</td> </tr> <tr> <td>Hospital-acquired e.coli Number of incidences in-month</td> <td>May-26</td> <td>0</td> <td>3</td> <td></td> <td></td> <td>Common cause variation Metric will inconsistently pass and fail the target</td> </tr> <tr> <td>Hospital-acquired klebsiella Number of incidences in-month</td> <td>May-26</td> <td>0</td> <td>1</td> <td></td> <td></td> <td>Common cause variation Metric will inconsistently pass and fail the target</td> </tr> <tr> <td>Hospital-acquired pseudomonas aeruginosa Number of incidences in-month</td> <td>May-26</td> <td>0</td> <td>1</td> <td></td> <td></td> <td>Common cause variation Metric will inconsistently pass and fail the target</td> </tr> <tr> <td>Hospital-acquired CPOs Number of incidences in-month</td> <td>May-26</td> <td>0</td> <td>5</td> <td></td> <td></td> <td>1 point above the upper process limit Metric will inconsistently pass and fail the target</td> </tr> <tr> <td>Hand hygiene audit score</td> <td>May-26</td> <td>80%</td> <td>92.3%</td> <td></td> <td></td> <td>Common cause variation Metric will consistently pass the target</td> </tr> </table>							Infection Prevention and Control	Hospital-acquired MRSA Number of incidences in-month	May-26	0	0			Common cause variation Metric will inconsistently pass and fail the target	Hospital-acquired c.difficile Number of incidences in-month	May-26	0	2			Common cause variation Metric will inconsistently pass and fail the target	Hospital-acquired MSSA Number of incidences in-month	May-26	0	4			Common cause variation Metric will inconsistently pass and fail the target	Hospital-acquired e.coli Number of incidences in-month	May-26	0	3			Common cause variation Metric will inconsistently pass and fail the target	Hospital-acquired klebsiella Number of incidences in-month	May-26	0	1			Common cause variation Metric will inconsistently pass and fail the target	Hospital-acquired pseudomonas aeruginosa Number of incidences in-month	May-26	0	1			Common cause variation Metric will inconsistently pass and fail the target	Hospital-acquired CPOs Number of incidences in-month	May-26	0	5			1 point above the upper process limit Metric will inconsistently pass and fail the target	Hand hygiene audit score	May-26	80%	92.3%		
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Safer Staffing	Overall fill rate	May-26	n/a	87.5%			Common cause variation No target																																																								
	Staff shortage incidents	May-26	n/a	43			Common cause variation No target																																																								

Month 02 | 2026-27

Quality Summary

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Cardiac Arrests	Number of cardiac arrest calls per 1,000 admissions	May-26	n/a	0.92			Common cause variation No target
	Number of deteriorating patient calls per 1,000 admissions	May-26	n/a	1.15			Common cause variation No target
Sepsis Screening and Management	Inpatients receiving IVABs within 1-hour of red flag	May-26	95%	66.7%			Common cause variation Metric will inconsistently pass and fail the target
	Inpatients Sepsis Six bundle compliance	May-26	95%	41.7%			Common cause variation Metric will consistently fail the target
	ED attendances receiving IVABs within 1-hour of red flag	May-26	95%	87.7%			Common cause variation Metric will inconsistently pass and fail the target
	ED attendance Sepsis Six bundle compliance	May-26	95%	63.6%			14 points below the mean Metric will consistently fail the target
VTE Risk Assessment	VTE risk assessment stage 1 completed	May-26	85%	80.0%			8 points above the mean Metric will consistently fail the target
HATs	Number of HAT RCAs in progress	May-26	n/a	170			Common cause variation No target
	Number of HAT RCAs completed	May-26	n/a	38			1 point above the upper process limit No target
	HATs confirmed potentially preventable	May-26	n/a	1			Common cause variation No target
PU	Pressure ulcers All category ≥2	May-26	0	8			7 points below the mean Metric will inconsistently pass and fail the target

Quality Summary

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Patient Falls	Rate of patient falls per 1,000 overnight stays	May-26	n/a	4.3			Common cause variation No target
	Proportion of patient falls resulting in serious harm	May-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	May-26	95%	97.1%			Common cause variation Metric will inconsistently pass and fail the target
	A&E positive feedback	May-26	90%	91.9%			Common cause variation Metric will inconsistently pass and fail the target
	Maternity Antenatal positive feedback	May-26	93%	96.9%			Common cause variation Metric will inconsistently pass and fail the target
	Maternity Birth positive feedback	May-26	93%	100.0%			12 points above the upper process limit Metric will consistently pass the target
	Maternity Postnatal positive feedback	May-26	93%	93.2%			Common cause variation Metric will inconsistently pass and fail the target
Friends and Family Test	Maternity Community positive feedback	May-26	93%	96.8%			Common cause variation Metric will inconsistently pass and fail the target
	Outpatients FFT positive feedback	May-26	95.0%	95.3%			7 points below the mean Metric will inconsistently pass and fail the target
PALS	Number of PALS referrals received in-month	May-26	n/a	412		-	Common cause variation No target

Month 02 | 2026-27

Quality Summary

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Complaints	Number of written complaints received in-month	May-26	n/a	98		-	Common cause variation No target
	Number of complaints closed in-month	May-26	n/a	80		-	Common cause variation No target
	Proportion of complaints acknowledged within 3 working days	May-26	75%	93.6%			Common cause variation Metric will consistently pass the target
	Proportion of complaints responded to within agreed timeframe	May-26	80%	35.5%			12 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	70.0%	70.4%			Common cause variation Metric will inconsistently pass and fail the target
	Massive obstetric haemorrhage >1500ml vaginal	May-26	3.3%	4.7%			Common cause variation Metric will inconsistently pass and fail the target
	3rd and 4th degree tear vaginal	May-26	2.5%	2.0%			Common cause variation Metric will inconsistently pass and fail the target
	Massive obstetric haemorrhage >1500ml LSCS	May-26	4.5%	3.1%			Common cause variation Metric will inconsistently pass and fail the target
	3rd and 4th degree tear instrumental	May-26	6.3%	13.8%			Common cause variation Metric will inconsistently pass and fail the target
	Term admissions to NICU	May-26	6.0%	5.5%			Common cause variation Metric will inconsistently pass and fail the target
	ITU admissions	May-26	0.7	0			Common cause variation Metric will inconsistently pass and fail the target

Quality Summary

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Maternity Other Metrics	Smoking at time of booking	May-26	12.5%	4.1%			Common cause variation Metric will consistently pass the target
	Smoking at time of delivery	May-26	2.3%	2.9%			Common cause variation Metric will inconsistently pass and fail the target
	Bookings completed by 9+6 weeks gestation	May-26	50.5%	70.8%			Common cause variation Metric will consistently pass the target
	Breast feeding initiated	May-26	72.7%	75.7%			Common cause variation Metric will inconsistently pass and fail the target
	Number of MNSI PSII	May-26	0.5	2			1 point above the upper process limit Metric will inconsistently pass and fail the target
Mortality	Crude mortality per 1,000 admissions In-month	May-26	12.8	8.0			Common cause variation Metric will inconsistently pass and fail the target
	Crude mortality per 1,000 admissions Rolling 12-months	May-26	12.8	8.3			Rolling 12-months - unsuitable for SPC
	HSMR In-month	Mar-26	100	68.6			Common cause variation Metric will inconsistently pass and fail the target
	HSMR Rolling 12-months	Mar-26	100	83.2			Rolling 12-months - unsuitable for SPC
	SHMI In-month	Dec-25	100	98.0			Common cause variation Metric will inconsistently pass and fail the target
	SHMI Rolling 12-months	Dec-25	100	95.0			Rolling 12-months - unsuitable for SPC





Month 02 | 2026-27

Quality Summary

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Re-admissions	Number of emergency re-admissions within 30 days of discharge	Mar-26	n/a	658			7 points below the mean No target
	Rate of emergency re-admissions within 30 days of discharge	Mar-26	9.0%	5.2%			3 point below the lower process limit Metric will consistently pass the target
Length of Stay	Average elective length of stay	May-26	2.8	2.2			Common cause variation Metric will consistently pass the target
	Average non-elective length of stay	May-26	4.6	4.8			7 points above the mean Metric will inconsistently pass and fail the target
Palliative Care	Proportion of patients with whom their preferred place of death was discussed	May-26	n/a	95.5%			Common cause variation No target
	Individualised care pathways	May-26	n/a	28			Common cause variation No target
Stroke Services	Trust SSNAP grade	Q4 2024-25	A	D			
	4-hours direct to Stroke unit from ED	Apr-26	63%	33.0%			9 points above the mean Metric will consistently fail the target
	4-hours direct to Stroke unit from ED with Exclusions (removed Interhospital transfers and inpatient Strokes)	Apr-26	63%	37.0%			9 points above the mean Metric will consistently fail the target
	Number of confirmed Strokes in-month on SSNAP	Apr-26	n/a	78			Common cause variation No target
	If applicable at least 90% of patients' stay is spent on a stroke unit	Apr-26	80%	75.0%			Common cause variation Metric will inconsistently pass and fail the target
	Urgent brain imaging within 20 minutes of hospital arrival for suspected acute stroke	Apr-26	40%	38.0%			Not enough data for SPC
	Urgent brain imaging within 60 minutes of hospital arrival for suspected acute stroke	Apr-26	50%	65.0%			Common cause variation Metric will inconsistently pass and fail the target

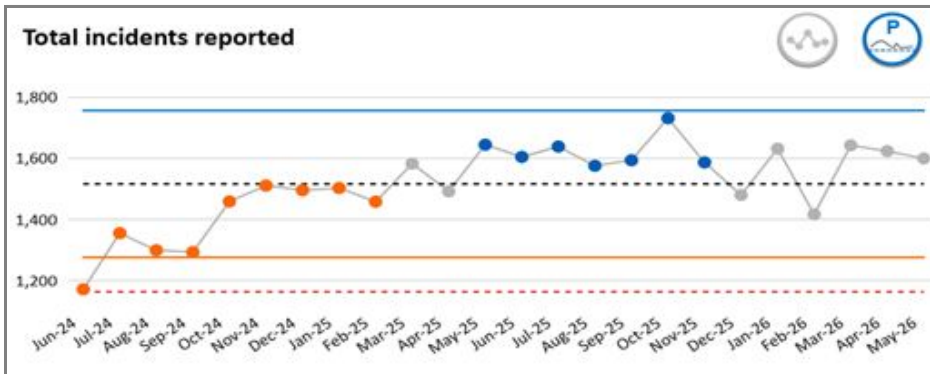
Month 02 | 2026-27

Quality Summary

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
	% of all stroke patients who receive thrombolysis	Apr-26	11%	20.0%			Common cause variation Metric will inconsistently pass and fail the target
	Discharged with ESD	Apr-26	50%	66.0%			Common cause variation Metric will inconsistently pass and fail the target

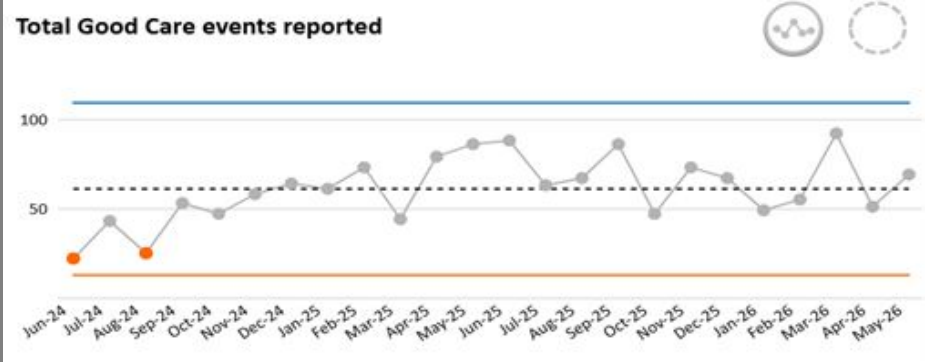
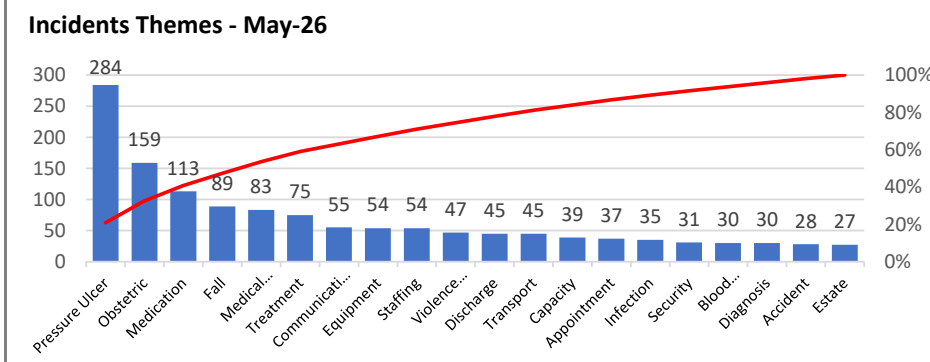
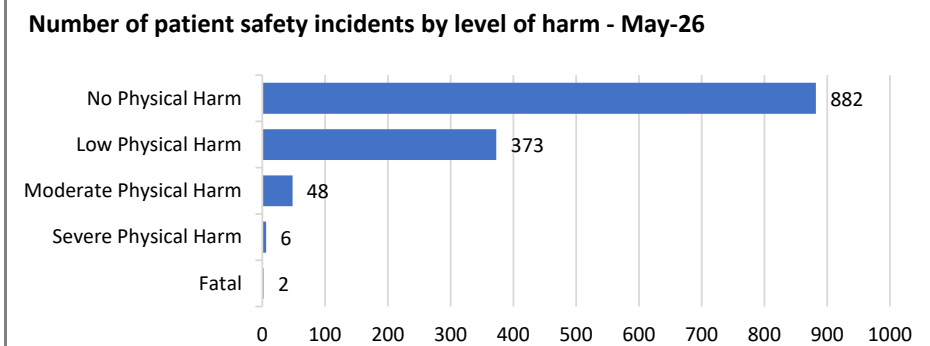
Quality

Patient Safety Incidents



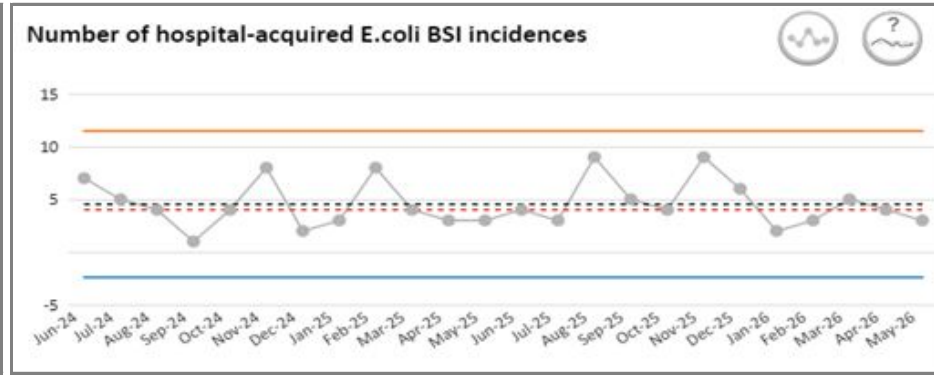
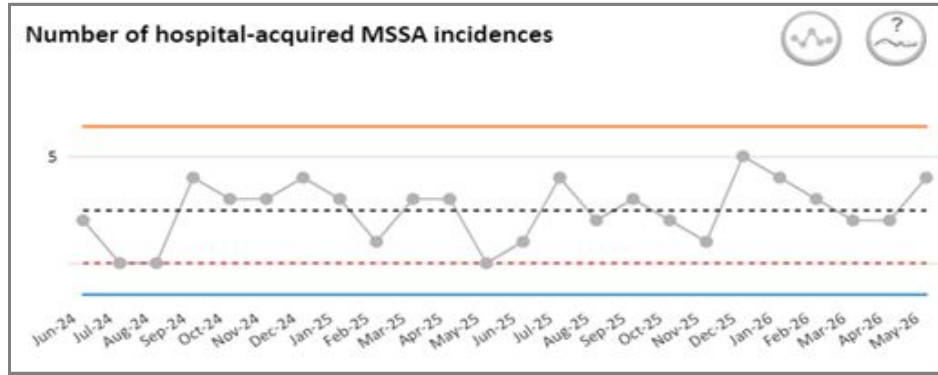
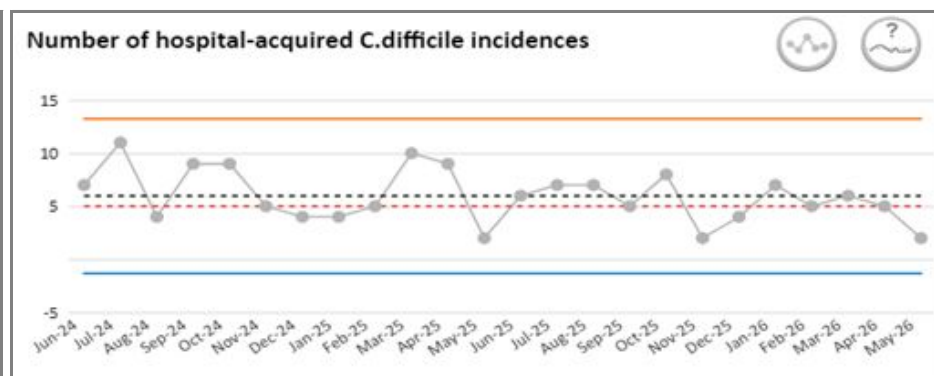
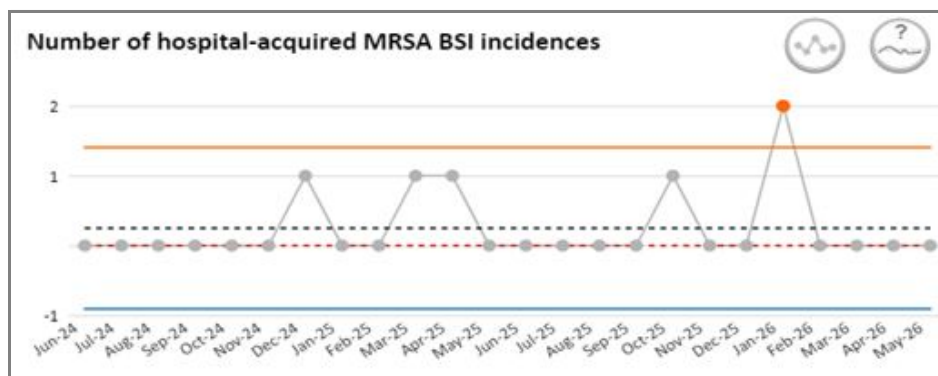
Key Issues and Executive Response

- 96% of patient safety incidents reported resulted in no harm / low harm.
- Obstetrics and Emergency Medicine continue to be the highest reporting specialties in line with previous months
- Increase in incidents reported in Acute Paediatrics, top 3 categories are medical records (16), staffing (15) and medication (12). Increase in staffing incidents being reported following weekly performance meetings and weekly escalations of breaches.
- Continued high reporting of incidents regarding medical records (83) due to ongoing issues with availability of medical records and roll out of Medviewer system. Associated risk recorded on risk register with mitigations and plan in place.
- Within Obstetrics, increase in incidents regarding delayed transfer to CLU for ongoing induction over 24 hours (53). No harm caused. All women with delays in their IOL pathway are reviewed daily by on-call Consultant with monitoring to ensure well-being. Ongoing QI work to improve flow in the department.
- 5 new PSIs commissioned; 3 related to unexpected deaths, 1 consent error and 1x maternity case of baby born in poor condition requiring cooling. All learning response teams in progress of agreeing ToR.



Quality

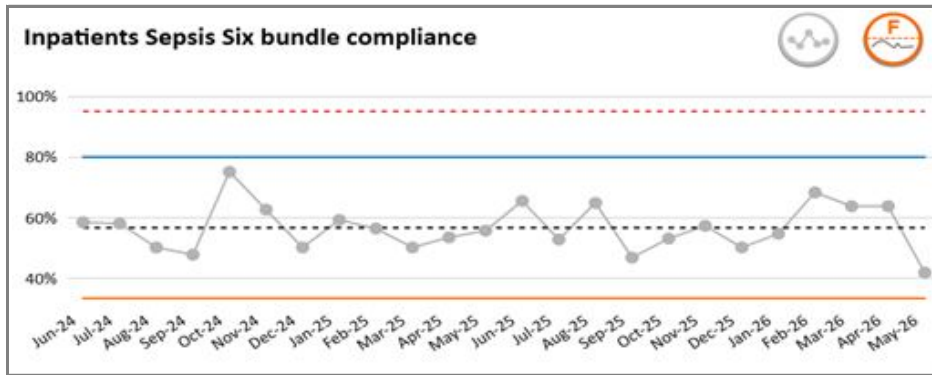
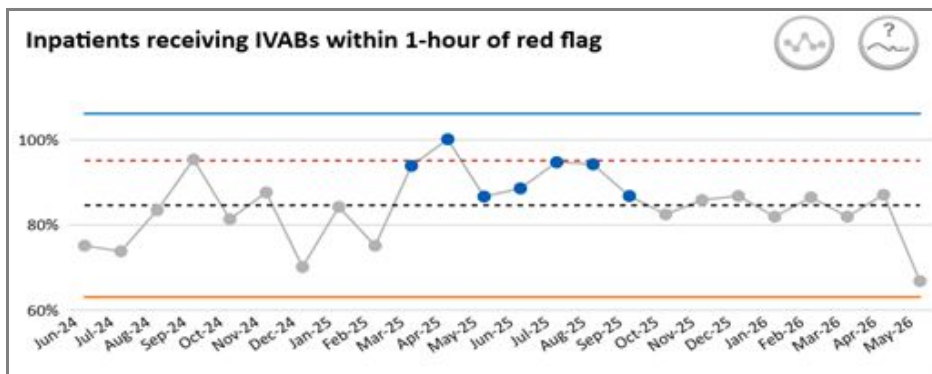
Infection Prevention and Control



- MRSA BSI - there were zero MRSA Bloodstream Infections (BSI) reported during May-26. Year to date (YTD), there are zero cases at this stage.
- MSSA BSI - a total of four MSSA BSI were identified in May-26, compared to no cases in May-25. There have been six cases YTD compared to three cases during the same period (Apr-May) last year. Identified learning, including the likely source, has been shared via the divisional monthly IPC meeting and fed back to the clinical teams involved.
- *C. difficile* (*C diff.*) infection (CDI) - two cases of hospital associated CDI were reported during May-26. The YTD total is seven compared to 11 cases in the same period last year.
- *E.coli* BSI - there were three reported cases in May-26, and seven cases YTD. Primary source of BSI in two of the cases were urinary tract infections and one was most likely related to intravascular device. Documentation and catheter care bundles remain an area for improvement. Learning has been shared with the relevant clinical teams. During TIPCC a request was made to the ICB to continue the collaboration around the area of *E.coli* carriage and BSI.

Quality

Sepsis Screening and Management | Inpatients



Key Issues and Executive Response

Themes

- 5/12 patient audits demonstrated sepsis six compliance - 6/12 patients deteriorated OOH.
- IV antibiotic compliance has declined in May with 8/12 receiving within the hour, with a longest time to of 2hr51min with a combination of delay in prescription and administration. ENHance completed for each delay to highlight for local learning.
- IV fluid sits at 86% with 6/7 patients having a appropriate fluid bolus within an hour.
- Lactate measurement remains an ongoing challenge at 64% with 7/11 patients. Two being delayed and two non compliance. One patient was documented to be difficult to bleed, therefore this patient was recorded as an N/A so not included in compliance within the hour.
- Urine output measurement remained static at 83% compliance in May. Blood culture compliance sits at 89% with 8/9 patients. Reflecting a continued need to focus on prompt blood taking.

Response

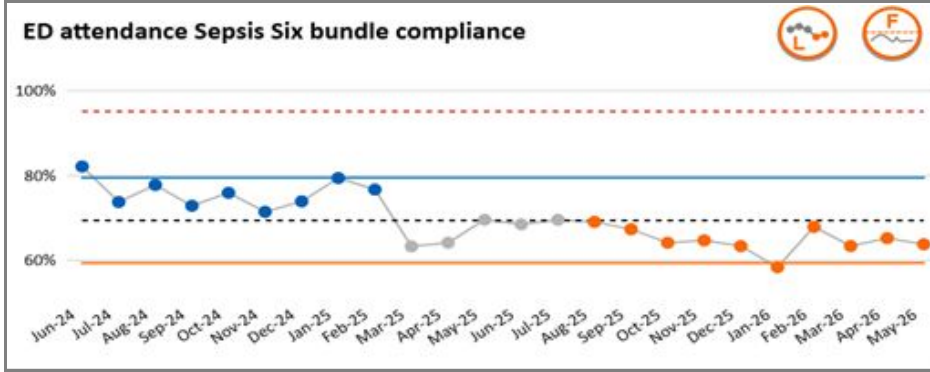
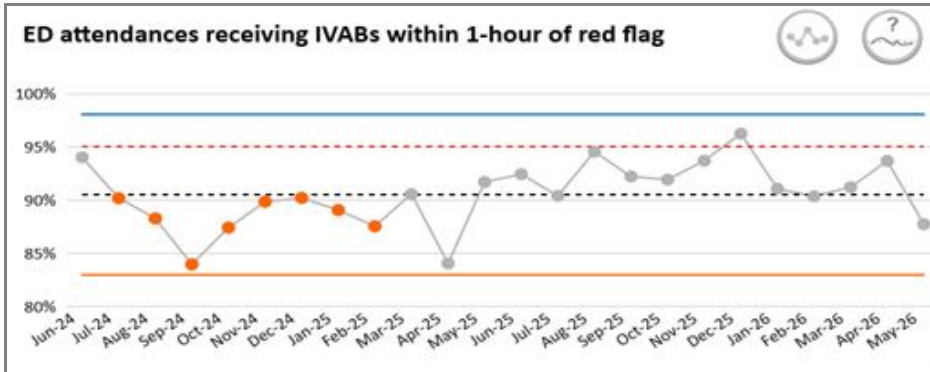
- The team are utilising formal and bedside education, alongside working with practice educators to push for sustainability in compliance.
- The team are trying to intercept unwell septic patients and assist in the delivery of the sepsis six in a timely manner.
- The team are organising further Sepsis/AKI study days for later in the year.
- Education with the FY1 & 2 doctors has focused on prompt blood taking and stat antibiotic prescribing - we are arranging a FY1 simulation session in July with a focus in these areas.

Themes

Sepsis IP	2025-26											2026-27		
	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul
Oxygen	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Blood cultures	81%	86%	94%	94%	73%	81%	92%	57%	91%	73%	74%	89%		
IV antibiotics	88%	87%	94%	94%	87%	82%	86%	86%	82%	82%	88%	67%		
IV fluids	100%	89%	93%	92%	100%	82%	92%	100%	88%	82%	83%	86%		
Lactate	81%	73%	71%	76%	50%	81%	64%	71%	82%	64%	87%	64%		
Urine measure	89%	93%	68%	88%	80%	82%	93%	75%	73%	73%	83%	83%		
Sepsis Six bundle	65%	53%	65%	47%	53%	57%	50%	55%	68%	64%	64%	42%		

Quality

Sepsis Screening and Management | Emergency Department



Sepsis ED	2025-26											2026-27		
	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul
Oxygen	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	98%	100%		
Blood cultures	96%	92%	96%	95%	92%	97%	94%	95%	96%	96%	95%	97%		
IV antibiotics	92%	92%	90%	95%	92%	92%	94%	96%	91%	91%	94%	88%		
IV fluids	91%	99%	93%	94%	93%	94%	98%	100%	97%	90%	98%	88%		
Lactate	99%	99%	100%	97%	100%	99%	97%	100%	99%	100%	98%	97%		
Urine measure	75%	77%	73%	73%	70%	68%	66%	67%	62%	68%	75%	73%		
Sepsis Six bundle	68%	69%	69%	67%	64%	65%	63%	58%	68%	63%	65%	64%		

Key Issues and Executive Response

Themes

- 42/66 ED patient audits demonstrated sepsis compliance, with 64% having all six elements completed within an hour in May.
- Urine output sits at 73% with 48/66 patients having fluid balance completed within the hour and remains the element of sepsis management that reflects lowest compliance.
- Lactate and blood culture collection have maintained compliance and remain above target across May.
- IV antibiotic compliance has seen a dip in compliance to 88% with 57/66 red flag sepsis patients receiving antibiotics within 1 hour with the longest time to being 3hr20mins.
- IV fluid administration has dropped in compliance to 88% with 53/60 patients who required IVF receiving it within an hour.

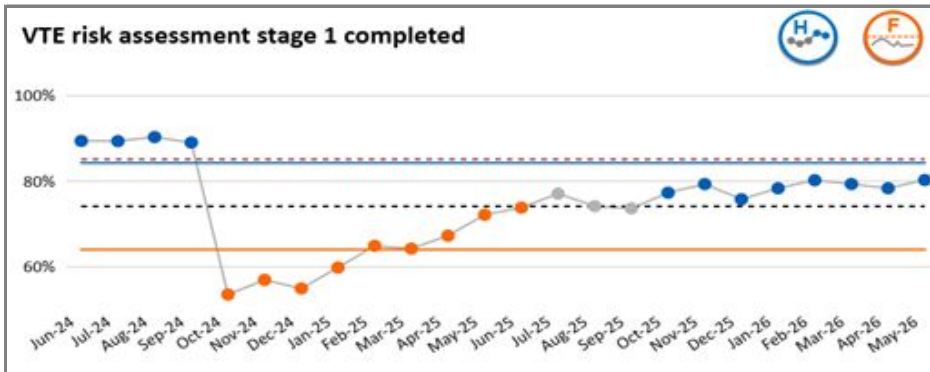
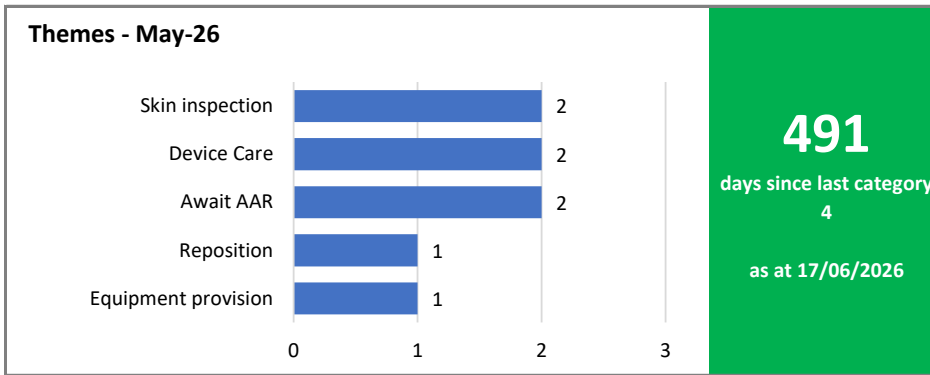
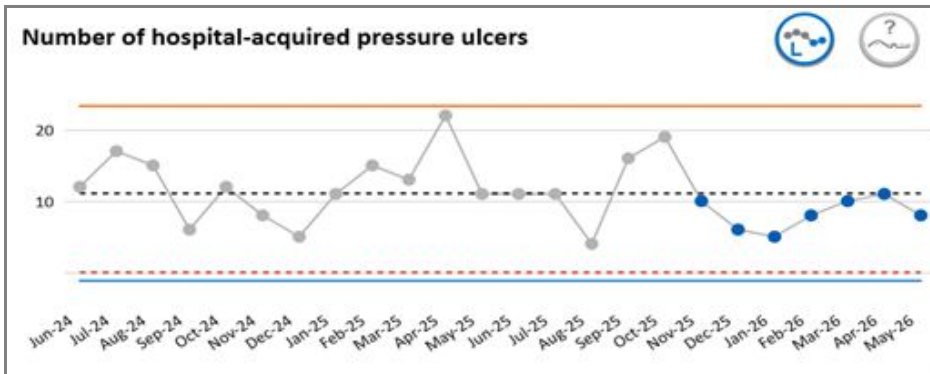
Response

- The Sepsis Team continue to attend patients in ED assessing and going through the Sepsis Screening Tool in real time. Whilst in the department the team utilises this as an education opportunity and works with the team to improve sepsis management.
- ED team time has started in April for 14 weeks, with the sepsis team delivering weekly sepsis simulation sessions with a focus on fluid balance.
- ED have updated and improved a sepsis education/notice board for reference in the department and a fluid balance poster is awaiting confirmation by clinical photography for reference.
- The team remains available on Alertive for referrals, queries and support for staff in ED.
- The senior team in ED are focusing on supporting the team to complete accurate fluid balance daily during huddles.

Month 02 | 2026-27

Quality

Pressure Ulcers | VTE



Key Issues and Executive Response

Pressure Ulcers

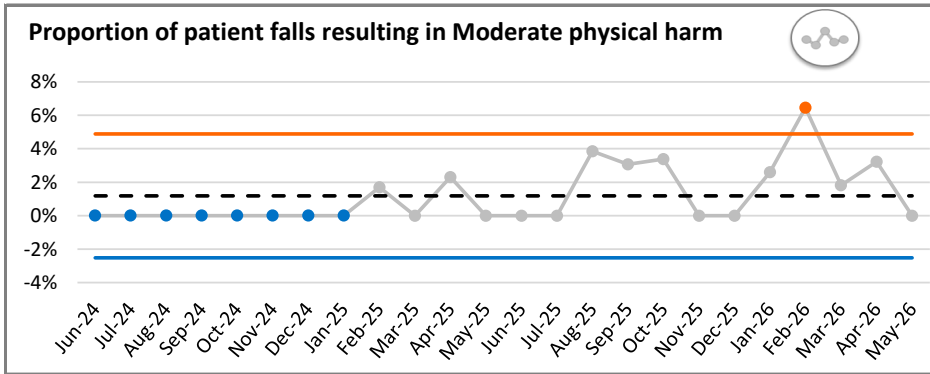
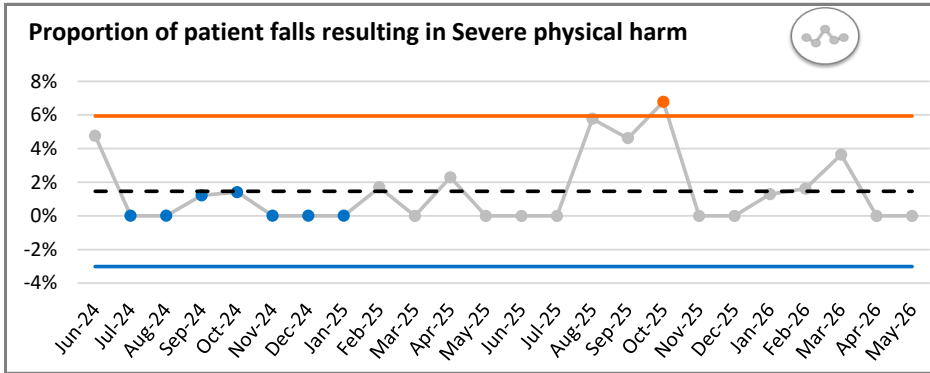
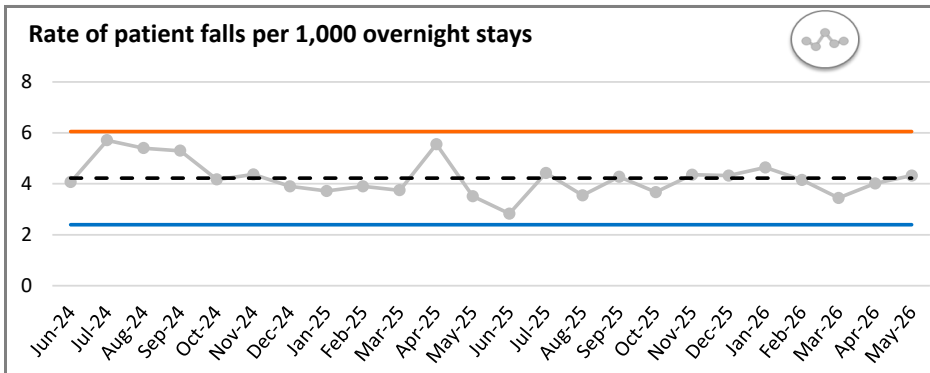
- Division Pressure Ulcer Safety Huddle (DPUSH) aimed at addressing HA PU concerns and providing early interventions, support/immediate actions is ongoing led by the Heads of Nursing, and TVN support
- Heel PUs continue to be the leading cause of PUs in the trust. Targeted improvement work using one of the ENH PS tools 5Ss, heel protection stock has been standardised to ensure availability when required.
- Plan to adopt PURPOSE-T PU prevention risk assessment tool is in progress. This will be implemented in 2026, when the new EPR system is rolled out.

VTE

- In October 2024, in accordance with NHSE requirements the Trust adopted a 14-hour timeframe for the completion of VTE risk assessments. This change resulted in an anticipated reduction in reported compliance due to the application of more stringent reporting parameters.
- February '26 was the first time since the change in NHSE requirements that the Trust reached 80%
- Good care reports have been logged for individual specialties - and there is focus on mirroring this within other areas.
- A key current priority is to ensure VTE risk assessment of day-case patients (both medical and surgical day-case, even if patients are present <14hours).

Quality

Patient Falls

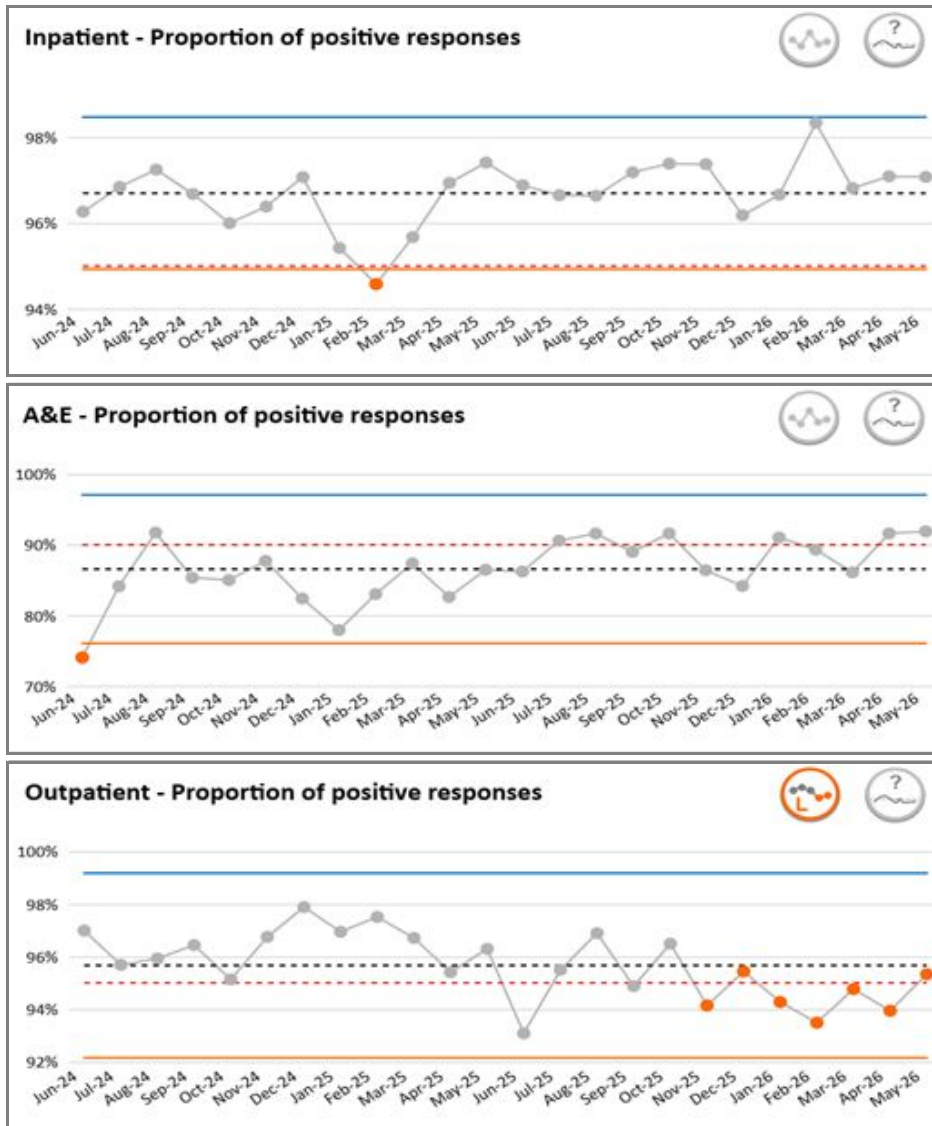


Key Issues and Executive Response

- Inpatient falls data continues to show common cause variation, with an average of 4 per month per 1000 bed days.
- There were no recorded inpatient or ED falls with moderate-to-serious harm in May.
- Falls Champion meetings and training have commenced. This initiative is designed to support clinical areas in achieving Gold Standard falls prevention practices, while improving compliance with falls risk assessments and associated care plans. The sessions are run every other week.
- Falls Training – Getting the Basics Right, has been initiated for all clinical staff. This programme is designed to support and refresh staff knowledge and skills in the prevention of inpatient falls, reinforcing best-practice approaches to falls risk assessment, care planning, and preventative interventions. The sessions run weekly.

Quality

Friends and Family Test

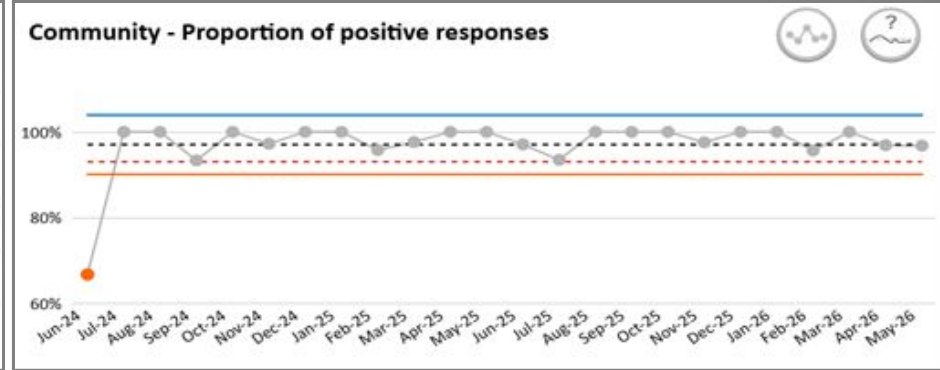
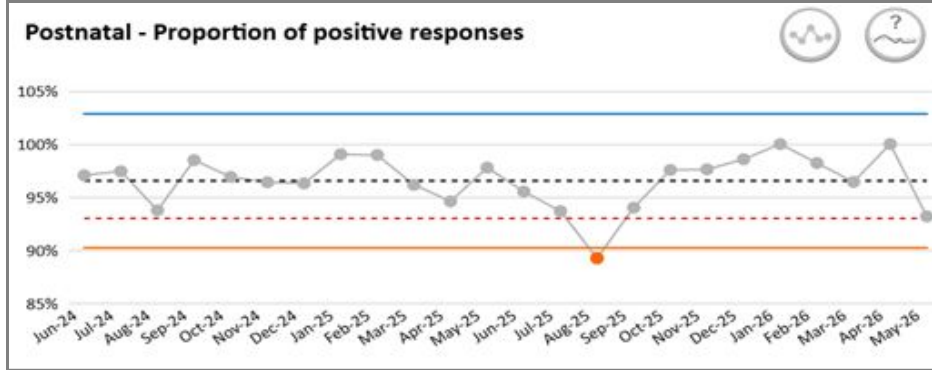
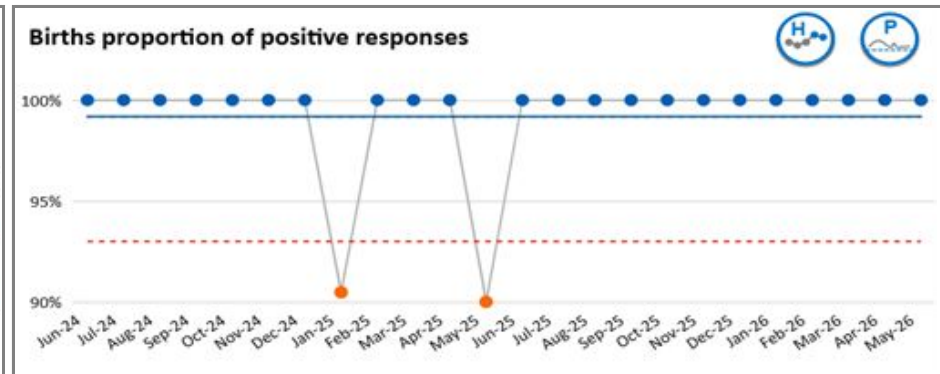
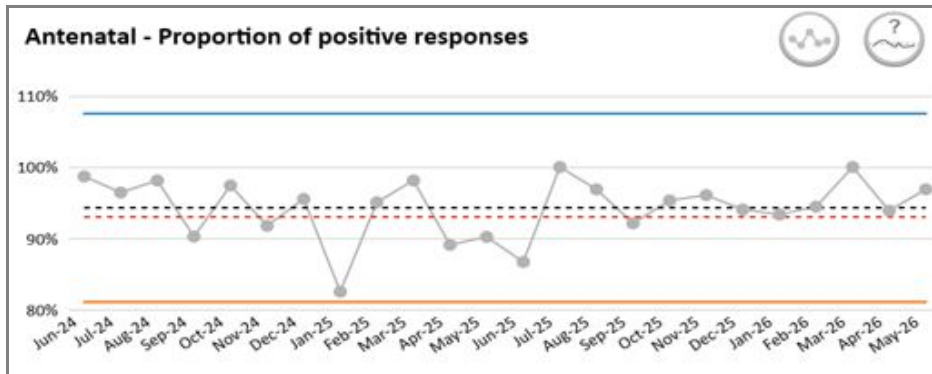


Key Issues and Executive Response

- Significant decrease in Emergency Care service surveys (AMU1, CAU, CED, ED, SDEC, SAU, UTC) completed for May - 48 compared with 222 in April, between all departments. The division has been made aware of the significant reduction, and a response of actions has been requested.
- Outpatients in total (across all sites) had an overall increase in the total number of responses received, 1019 compared to 860 in April. The overall proportion of positive responses remaining about the same but the % poor/very poor increased slightly to 2.36% (1.86% previous month). There are larger dissatisfaction scores for a number of individual clinics in the Yellow Zone at Lister with negative feedback from patients about the change in the arrival process and not being able to check in at the specific clinic they are attending.
- Decrease in the number of responses for the antenatal element of 14 this month (32 in April). However, there was an increase in the proportion of positive responses.
- The overall Trust score remained around the same as last month.
- Divisions to report back on actions regarding FFT response rates and results as part of PACE monthly updates.

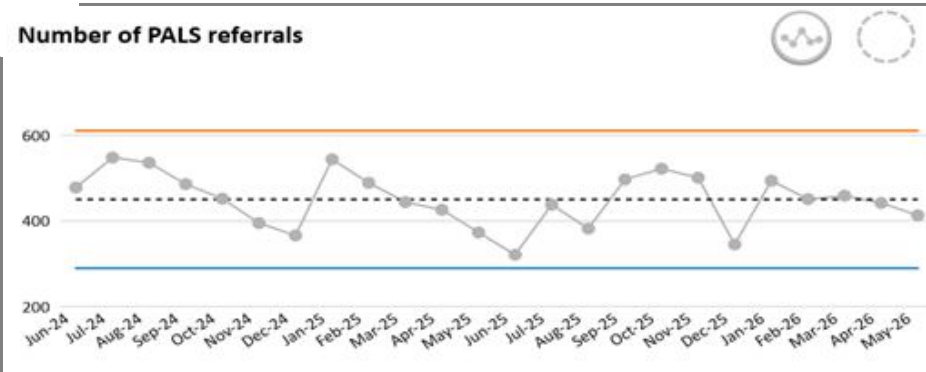
Quality

Friends and Family Test



Quality

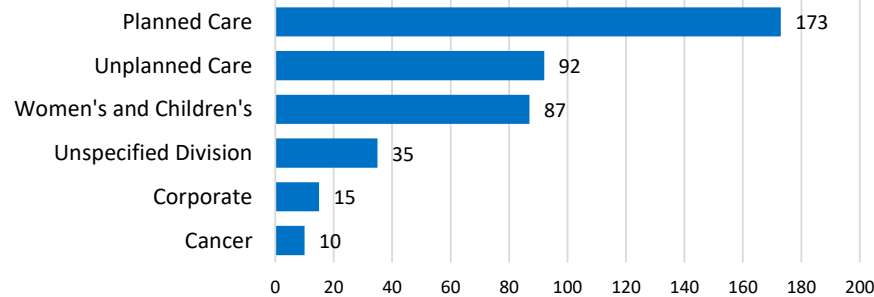
Patient Advice and Liaison Service



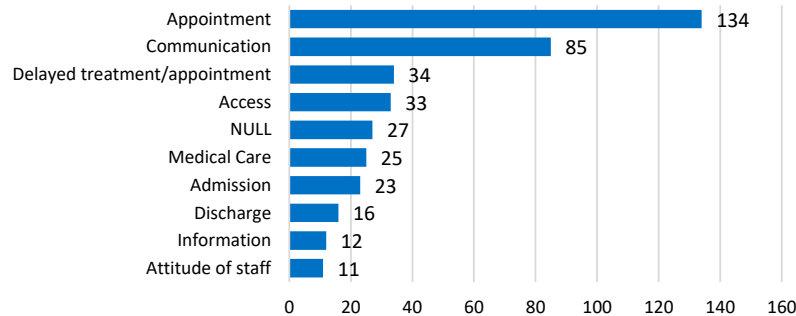
Key Issues and Executive Response

- Successful first month of the PALS online form in place. Decrease in administration time.
- 422 PALS cases were logged in May 2026 an increase from the 372 that were raised in May 2025.
- PALS new monthly numbers now averaging about 400 each month
- Key PALS concerns relate to ongoing problems with appointment delays, delay in follow up appointments, waiting list times and not being able to speak to the services directly.
- Swift ward concerns still ongoing - general response being provided
- Gynaecology received the highest number of concerns in May, with 57 concerns. This is a large increase from the previous months. On further investigation this relates to waiting times and not being able to speak to the services directly about appointment queries.
- Dermatology concerns remain high due to lack of ability patients are having to book appointments for medication, with no current appointments available. Many are now being escalated to formal complaints as requested by patients.

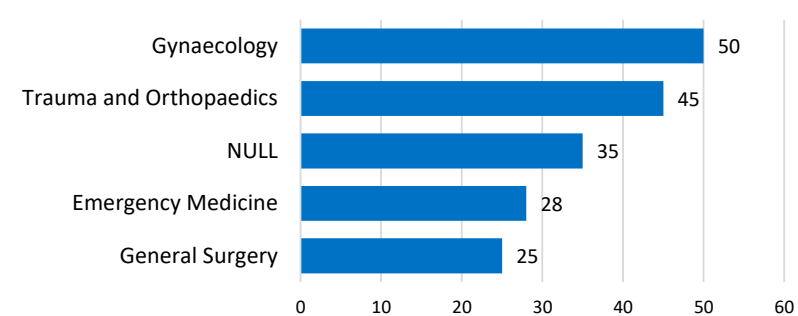
PALs by Division - May-26



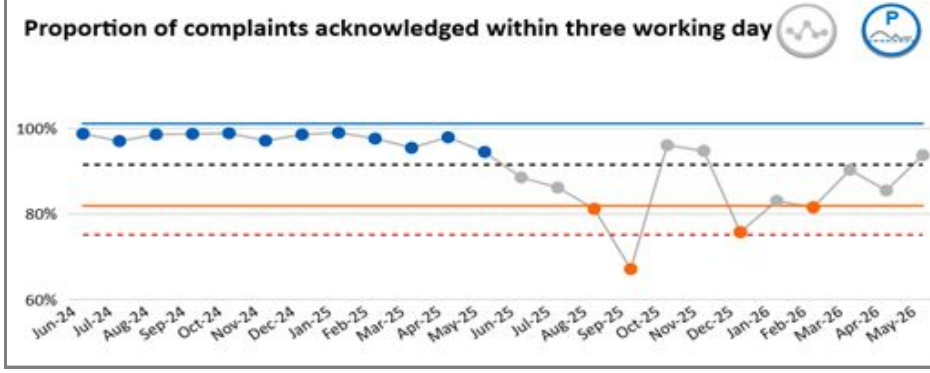
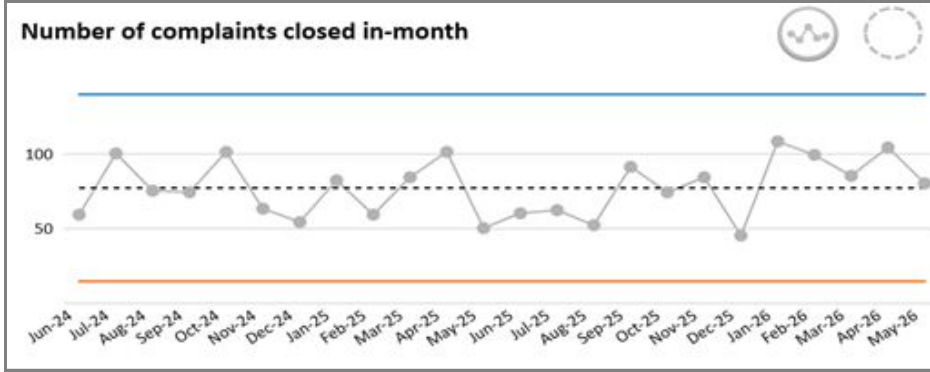
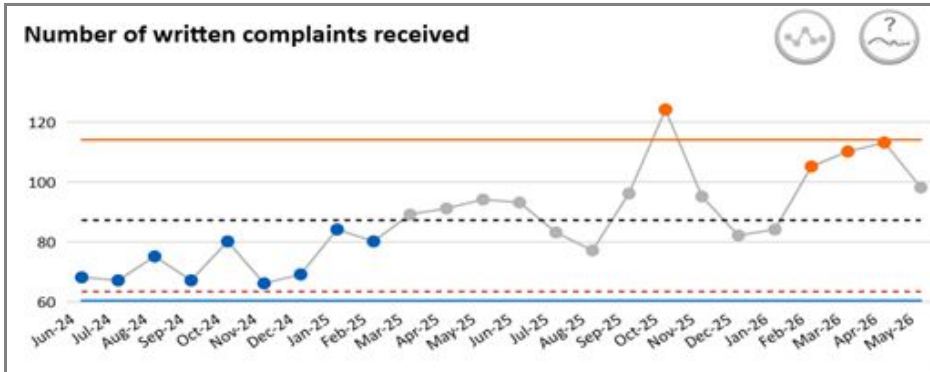
PALs Top 10 subjects - May-26



PALs Top 5 specialties - May-26

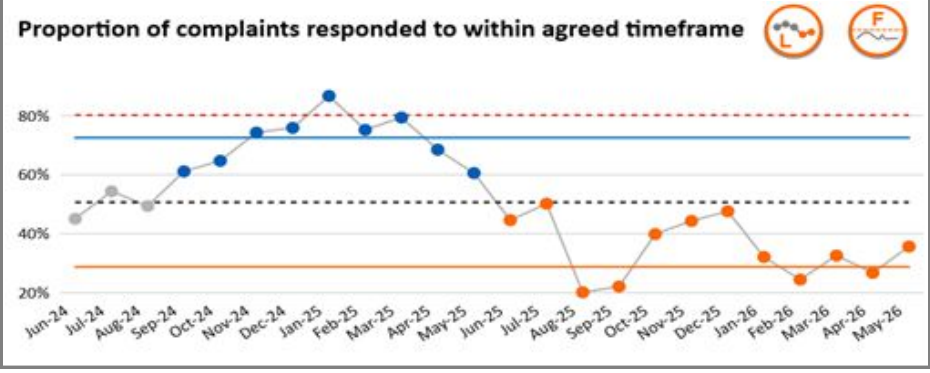


Quality Complaints



Key Issues and Executive Response

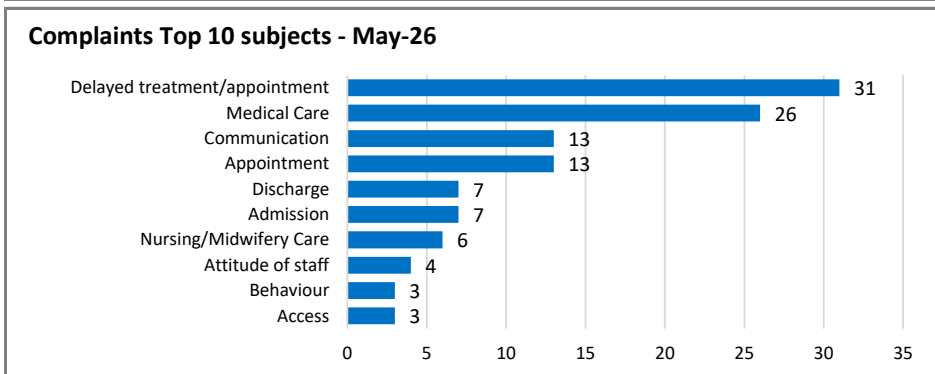
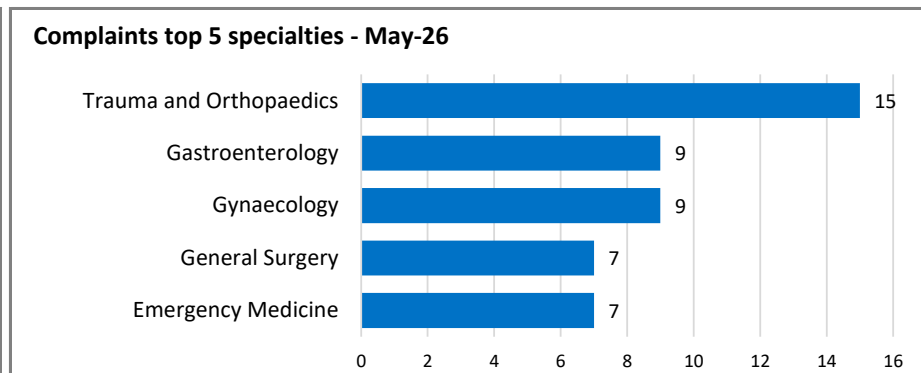
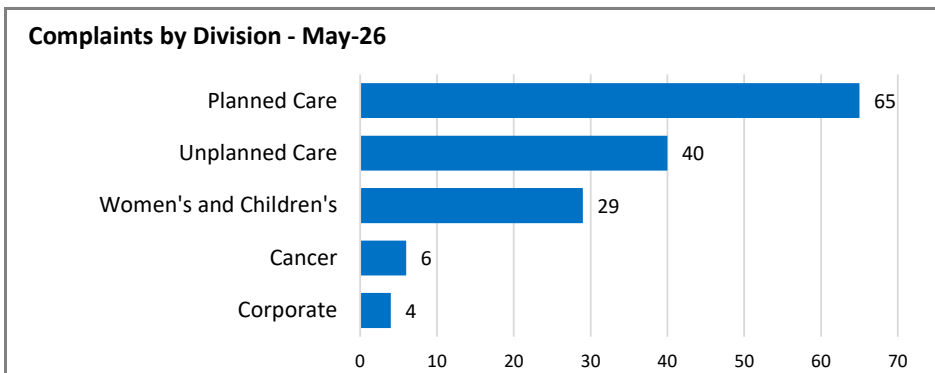
- The Trust has seen an increase in the number of complaints being raised. The Trust received 161 formal complaints in May 2026 with 98 of these currently under investigation. This is the highest volume of complaints received in a month.
- Trauma and Orthopaedics received 24 complaints followed by 15 for the Emergency Department and 15 for Obstetrics.
- The top three themes being raised in May 2026 relate to medical care, delayed treatment/appointments and medical communication
- The number of open complaints at the end of May 2026 was 373.
- The Complaints team triage each new complaint to identify any concerns that could potentially be addressed by divisions making a phone call to the complainant - this is working well.
- Divisional staff and the Complaints team are working collaboratively to reduce the volume of open complaints and to respond to complaint in a timely manner. In the month of May 2026, 39.8% of complaints were responded to within the agreed timeframe because of the significant increase of new complaints received, all requiring processing / scoping.



Month 02 | 2026-27

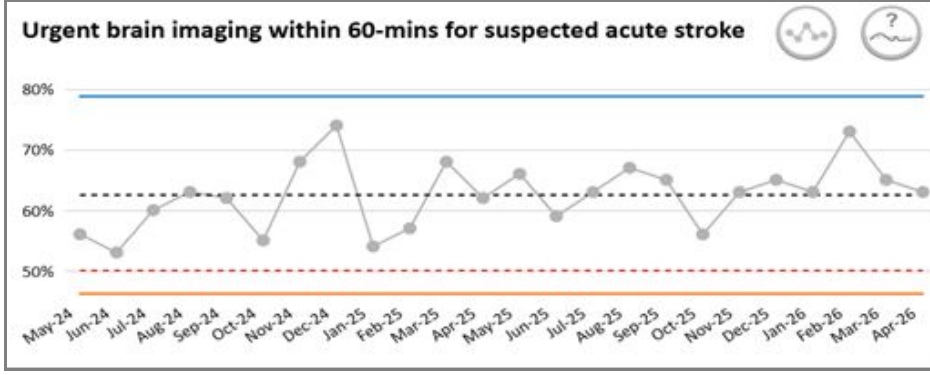
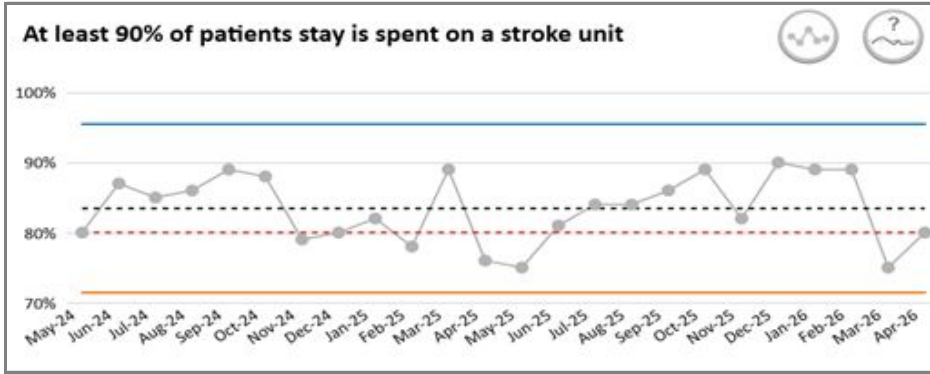
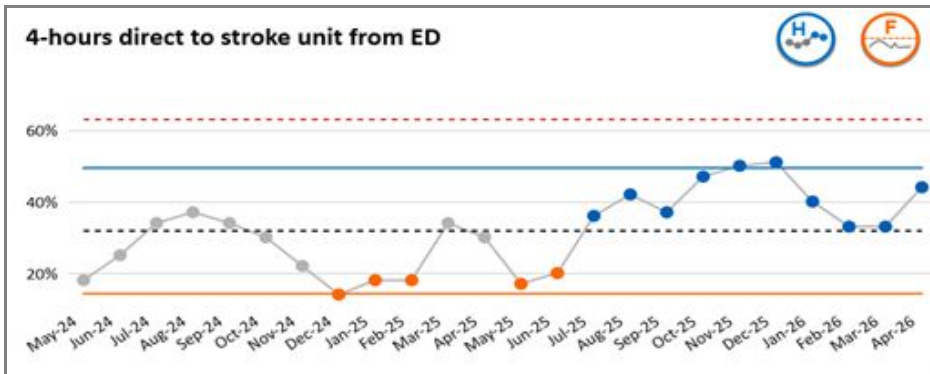
Quality

Complaints Themes



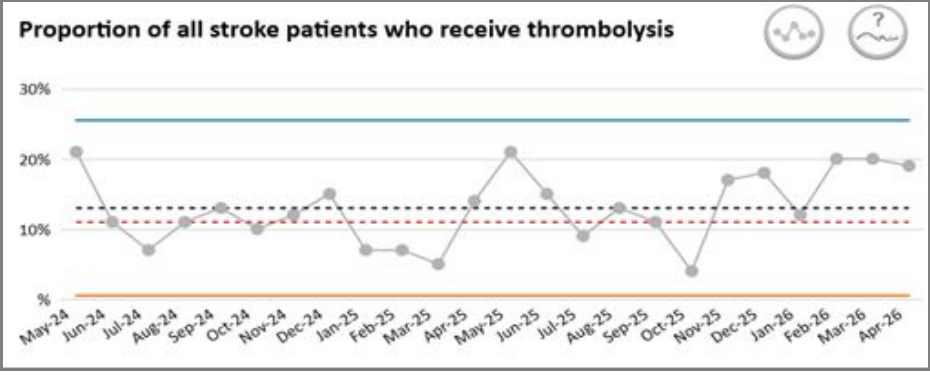
Operations

Stroke Services



Key Issues and Executive Response

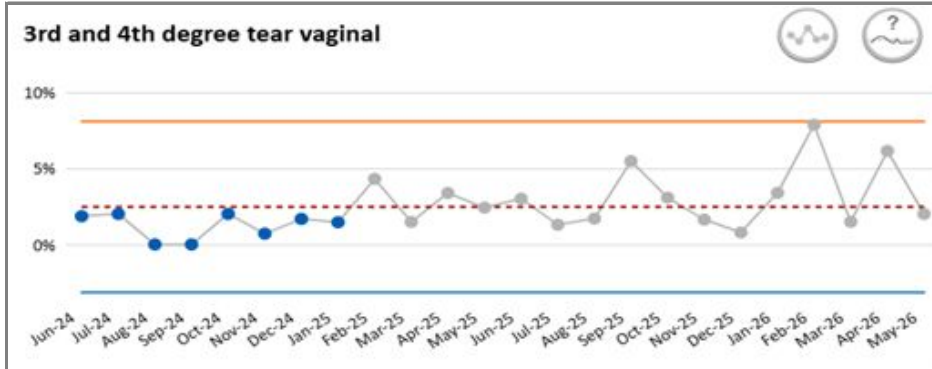
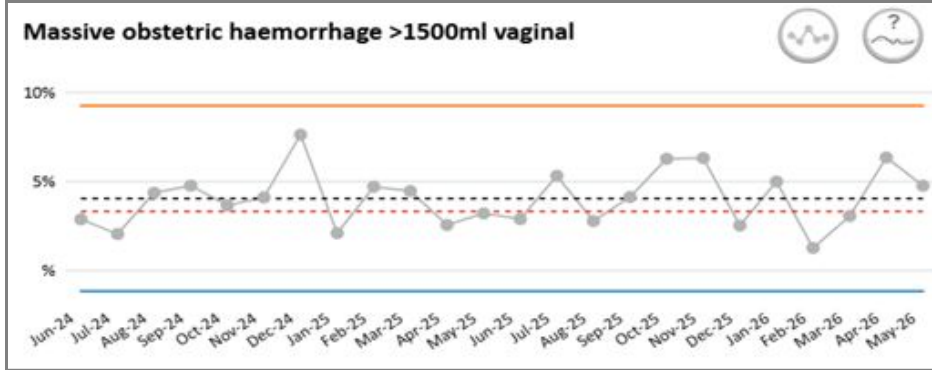
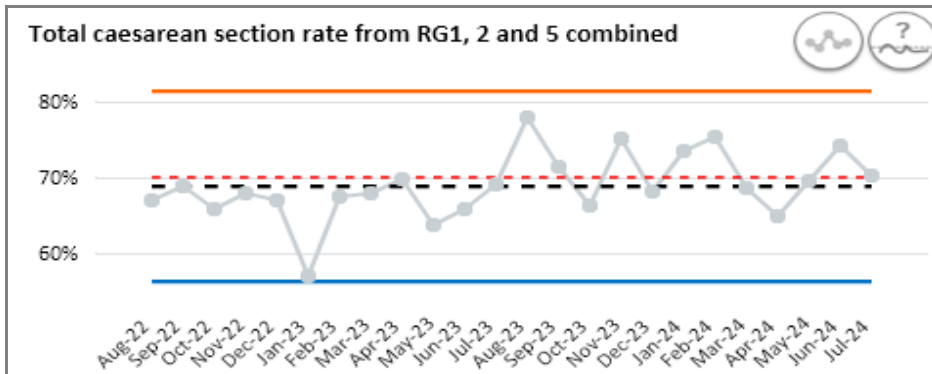
- Thrombolysis/Thrombectomy** - Door to needle time 1:14hr. Sustained performance of 19% of patients receiving thrombolysis against bespoke 14% target. CTP 24/7 go live planned for June 22nd post IA. Thrombectomy at 3.8% with 10% target - (11 referred, 7 sent, 3 performed).
- 4 hr performance 43.8%** for confirmed strokes. For all admissions to SU = 63.48%! SPC chart displays positive upward trend. Influencing factors; SOP, SPR 7/7 2200 working, CTP, ward & CNS processes, weekly breach meetings/validation & stroke ward flow improvements.
- Length of stay:** Increase in level 1 beds required which is impacting LOS. Ongoing discussions with ICS and region addressing capacity plans long term. MRI delays & repeat out processes required to support flow. Radiology long-term plan to be implemented this year will have significant impact on imaging delays for inpatients & TIA.
- CT within 20 minutes:** Dropped from 38% in march to 24% in April (national target of 40%). This was due to high volume and late referrals. Stroke Video Triage will improve rapid diagnosis with go live in house planned for July 13th.



Month 02 | 2026-27

Quality

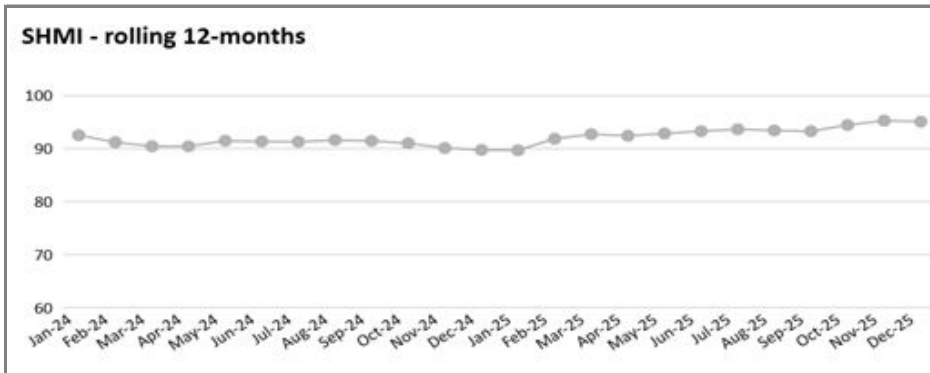
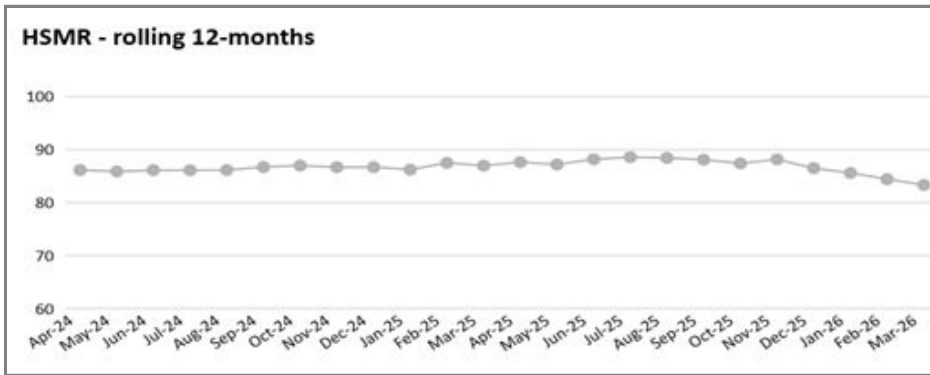
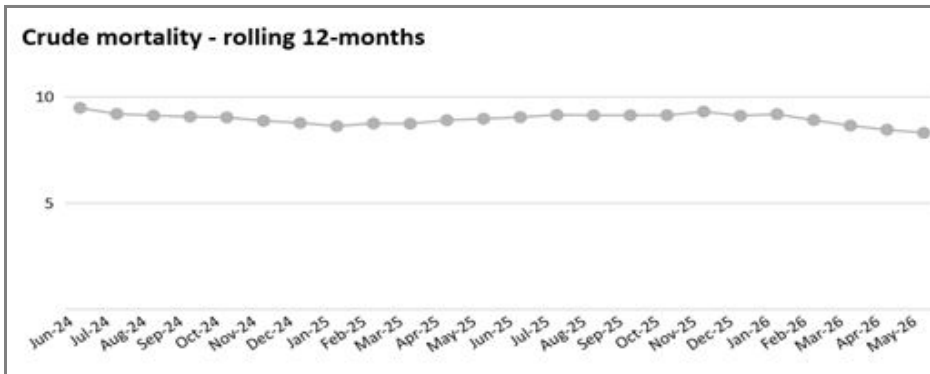
Maternity | Safety Metrics



Key issues and executive response

- Two cases referred to the MNSI and qualify as PSII: one homebirth, neonatal resuscitation and transfer to tertiary unit for cooling (HIE3), one EMLSCS during IOL (IVF), transfer to tertiary unit for cooling, died at 36hrs. Immediate learning response and engagement with families.
- Six cases of moderate harm (3%). Two ATAIN (MNSI cases above), one needle 'lost' during perineal repair, one epidural catheter tip absent on removal - both managed appropriately, one postnatal readmission for nine days for LSCS wound infection, one missed referral to pre-term clinic: inaccurate risk assessment at booking, no access to previous obstetric notes. Transfer out at 25/40 in TPTL. Harm may require adjustment to severe and/or death dependent on outcome.
- MOH>1500ml remain higher than target, 3.91% overall, but low at LSCS with acceptable variance. Reduced to 4.74% at vaginal births (6.32% April 2026). Rates>2000ml remain consistently low. Maternal care bundle element 5 action plan underway and monitored.
- 3rd/4th degree perineal trauma at vaginal births reduced from 6.25% to 2.01% (3 of 149 deliveries) and from 18.18% to 13.79% at instrumental births (4 of 29 deliveries). Overall rates reduced to 3.93% from 8.59% April 2026. Limited assurance of impact of improvement work due to fluctuations in data. MDT working party, clinical 'drop-in sessions' and mandatory training therefore ongoing. Blunt scissors incident reported. Exploring procurement of 'epi-scissors'.
- One case of intra-uterine death >22/40, one early neonatal death >20/40 (MNSI case above). No cases of maternal death.
- ATAIN rate consistently below national target of <6% for four months.
- Total LSCS= 212 (51.33%), Total Cat 1-3 (Emergency) = 129 (31.23%), Total Cat 4 (Elective) = 83 (20.10%) reflective of increasing national rate. Emergency rate may be reported higher than actual as elective cases moved to cat 3 lists due to capacity. Robson Group Criteria RC1 = 27.45%, RC2 = 61.64%, RC5 = 89.47%.

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, with a slight upward trend. Recent months have seen a downward shift.
- The latest rolling 12-month HSMR to Mar-26, reported by CHKS, stands at 83.23. 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 March stands at 68.61.
- Latest NHSD published rolling 12-month SHMI available to December 2025, stands at 95.00, a slight increase from the last month's 94.44. This positions us within the 'as expected' band 2.
- There has been a gradual negative shift in our position nationally, with currently positioned 407/118 vs other acute trusts.
- The latest figures provided by CHKS for Nov-25 are 91.9 in-month and 94.4 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.



Operations

Month 02 | 2026-27

				
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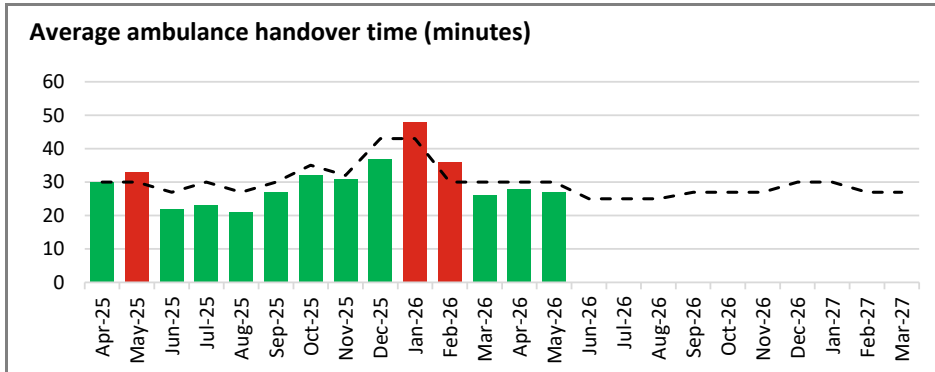
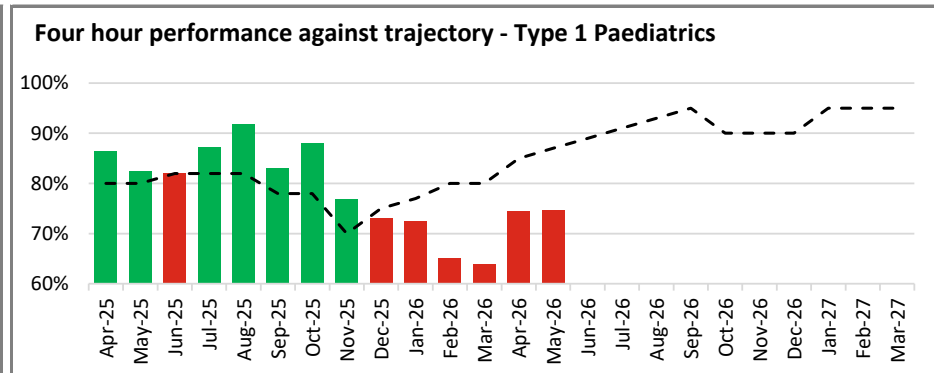
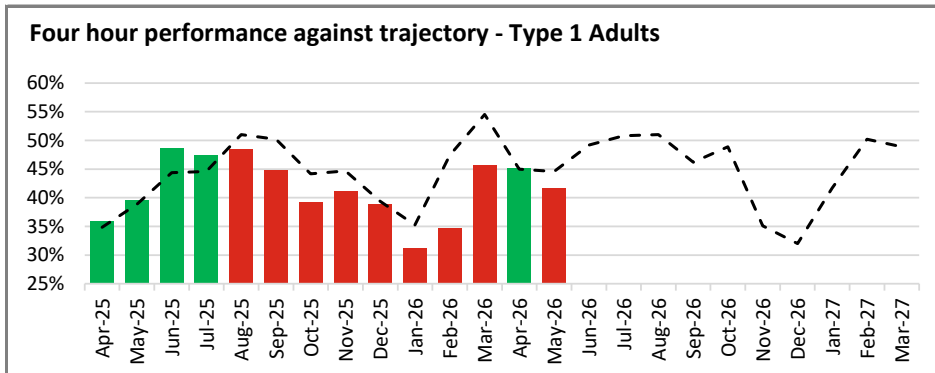
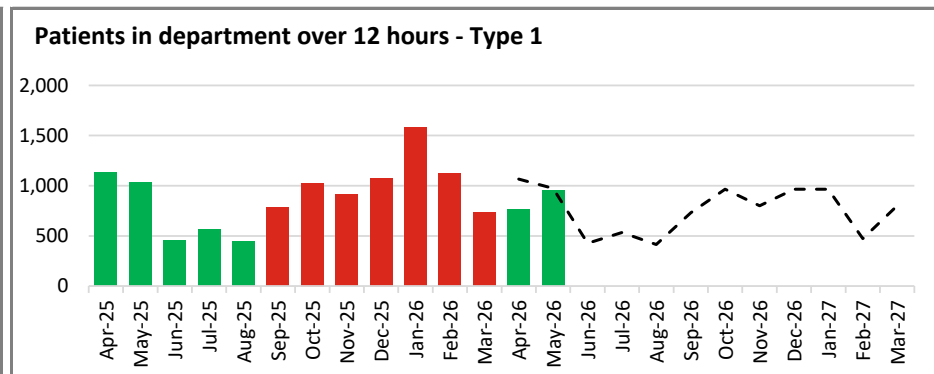
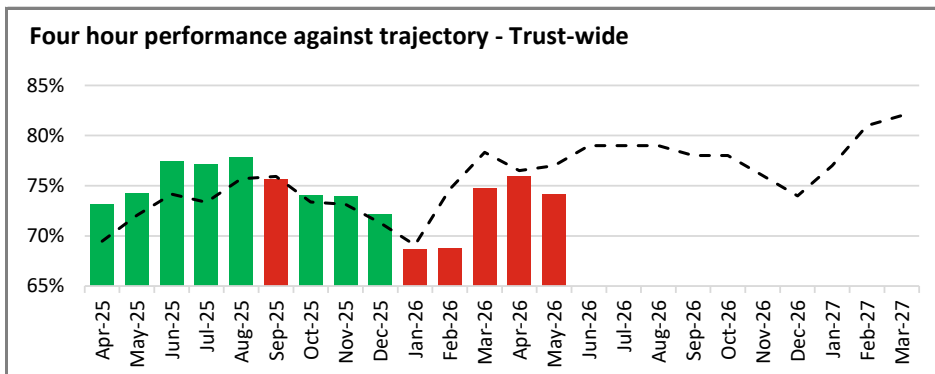
Urgent and Emergency Care Summary

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Emergency Department	Patients waiting no more than four hours from arrival to admission, transfer or discharge	May-26	95%	74.1%			Common cause variation Metric will consistently fail the target
	Patients waiting more than 12 hours from arrival to admission, transfer or discharge	May-26	5%	10.3%			Common cause variation Metric will inconsistently pass and fail the target
	Percentage of ambulance handovers within 15-minutes	May-26	65%	25.6%			Common cause variation Metric will consistently fail the target
	Time to initial assessment - percentage within 15-minutes	May-26	80%	50.7%			7 points below the mean Metric will consistently fail the target
	Average (mean) time in department - non-admitted patients	May-26	240	186			Common cause variation Metric will consistently pass the target
	Average (mean) time in department - admitted patients	May-26	tbc	502			Common cause variation No Target
	Median ambulance handover time	May-26	15	21			Common cause variation Metric will consistently fail the target
RTT & Diagnostics	Patients on incomplete pathways waiting no more than 18 weeks from referral	May-26	92%	66.1%			7 points above the upper process limit Metric will consistently fail the target
	Patients waiting more than six weeks for diagnostics	May-26	0%	45.2%			1 point below the lower process limit Metric will consistently fail the target

Urgent and Emergency Care Summary

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Cancer Waiting Times	62-day referral to treatment standard	Apr-26	85%	83.7%			Common cause variation Metric will consistently pass the target
	31-day decision to treat to treatment standard	Apr-26	96%	96.3%			Common cause variation Metric will inconsistently pass and fail the target
	28-day Faster Diagnosis standard	Apr-26	80%	71.2%			1 point below the lower process limit Metric will inconsistently pass and fail the target
	Proportion of cancer PTL waiting more than 62 days	May-26	7%	24.3%			1 point above the upper process limit Metric will consistently fail the target

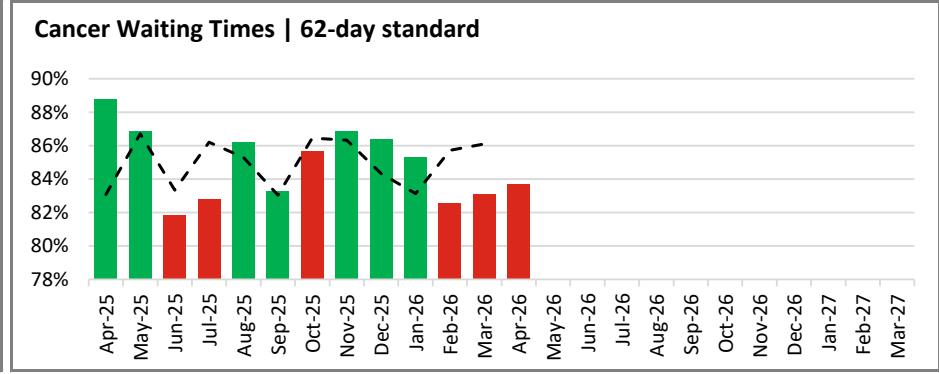
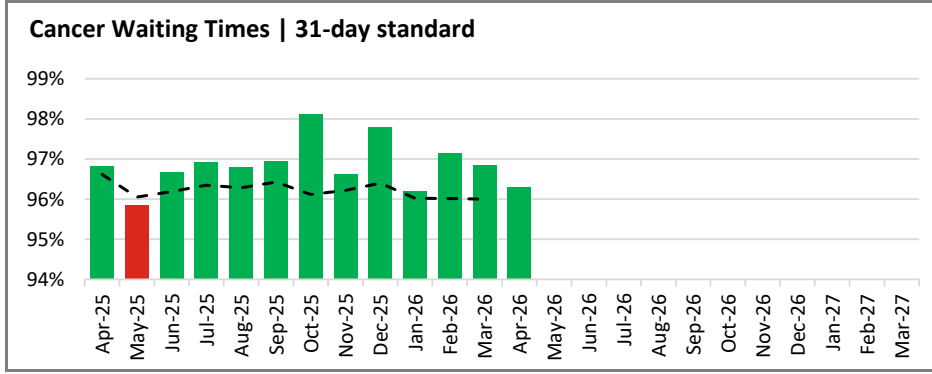
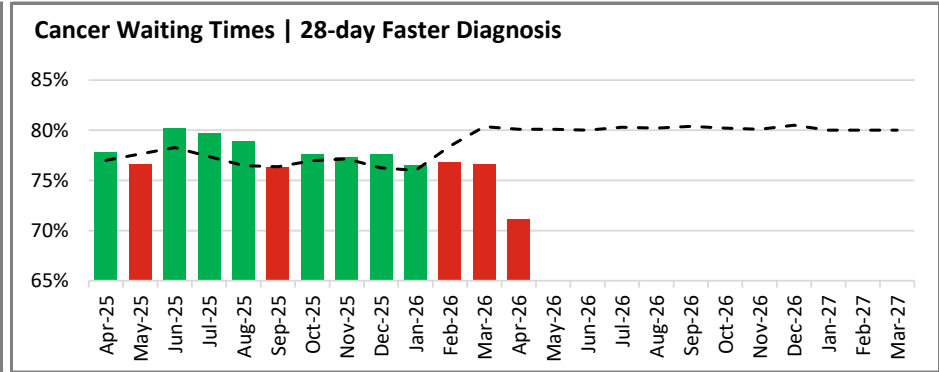
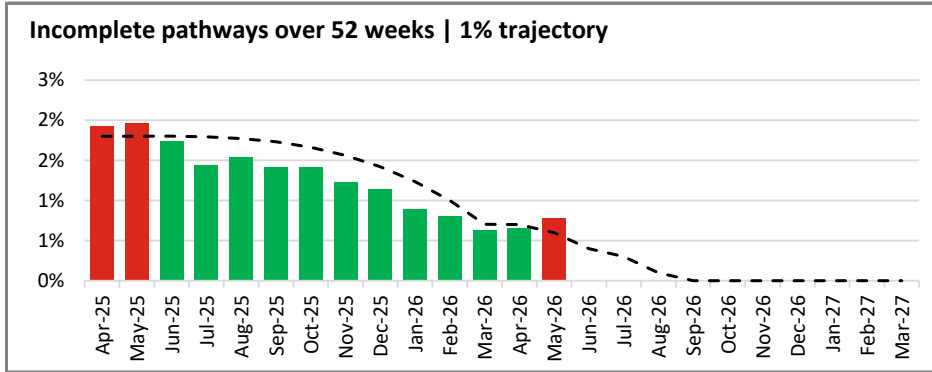
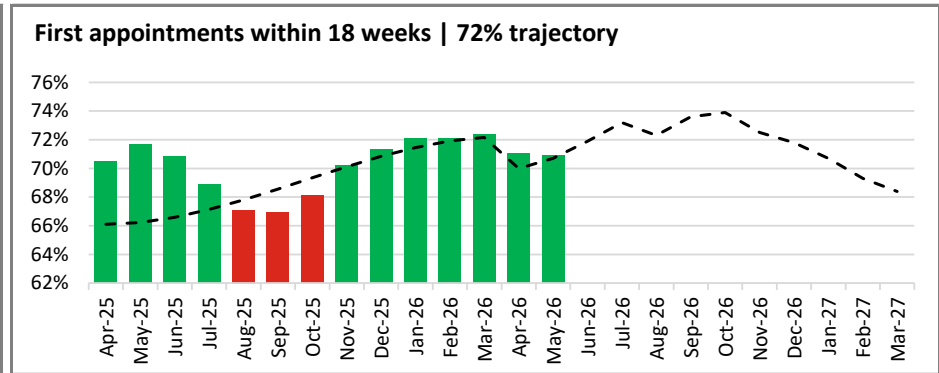
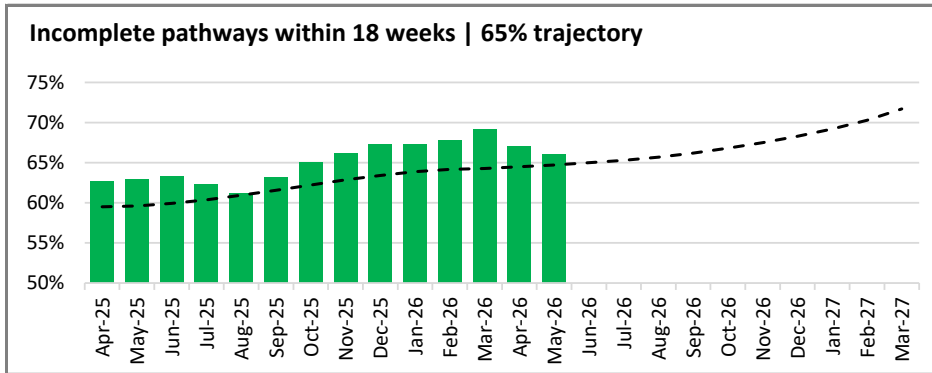
Urgent Emergency Care Trajectory Monitoring 2026-27



Month 02 | 2026-27

Cancer Waiting Times | RTT 18 weeks

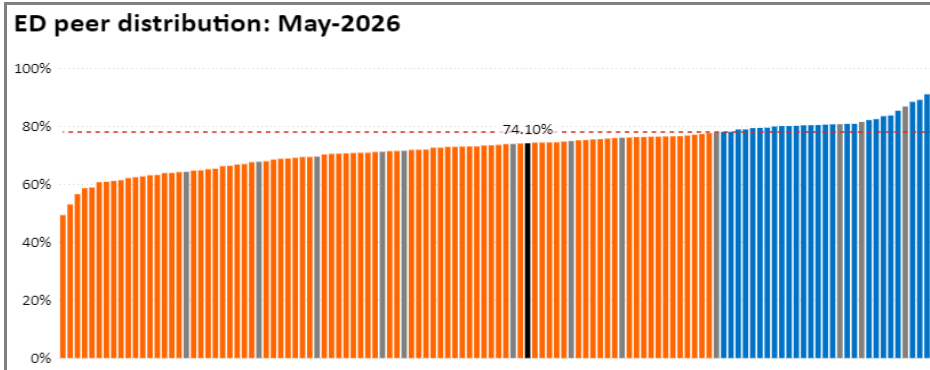
Trajectory Monitoring 2026-27



Month 02 | 2026-27

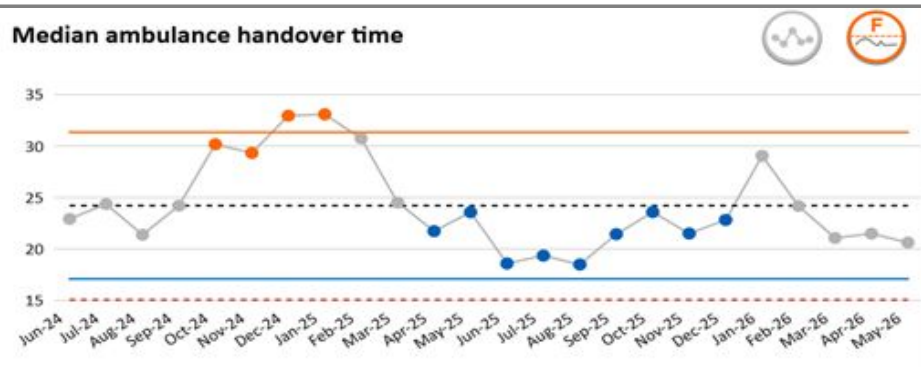
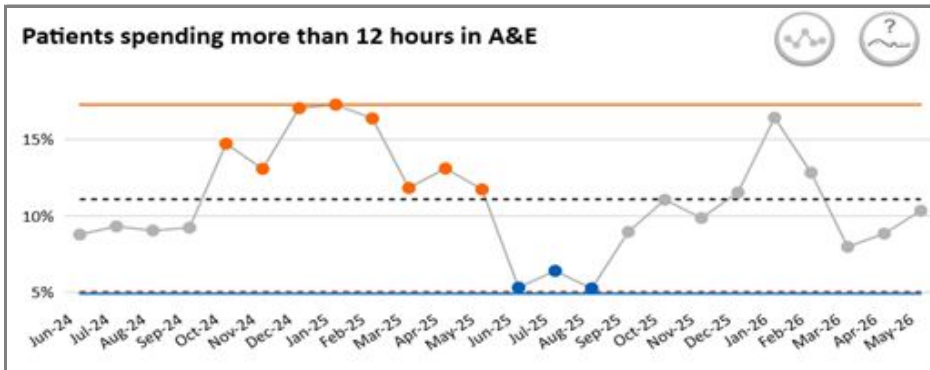
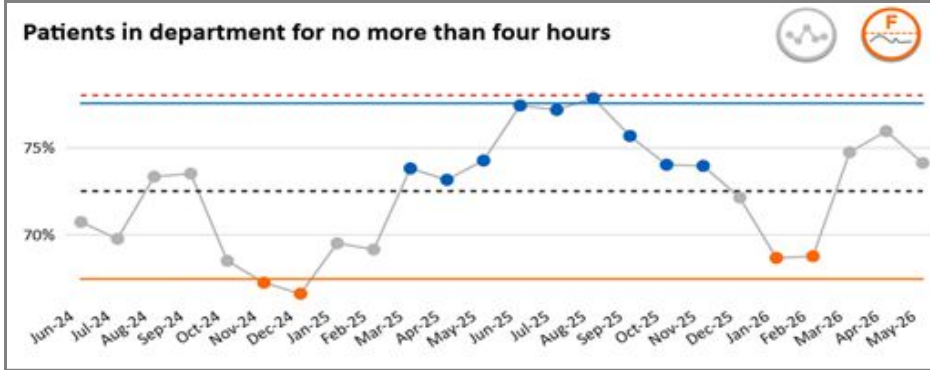
Operations

Urgent and Emergency Care New Standards



Key Issues and Executive Response

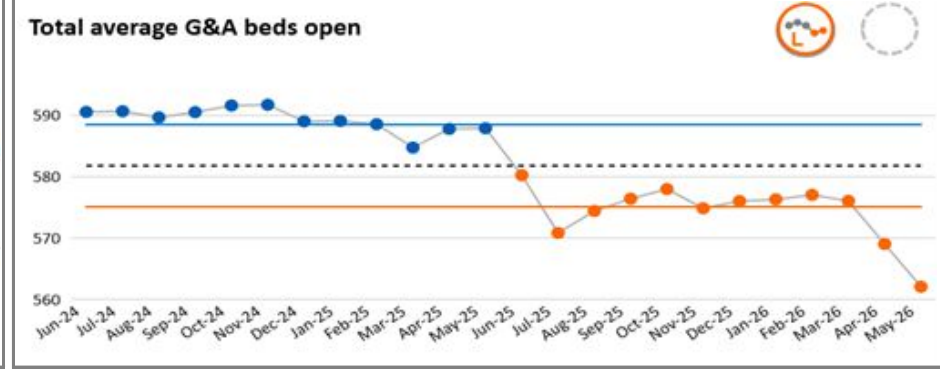
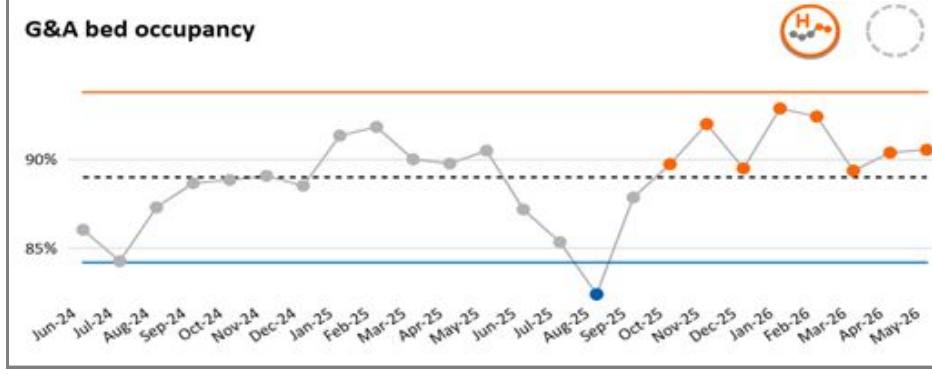
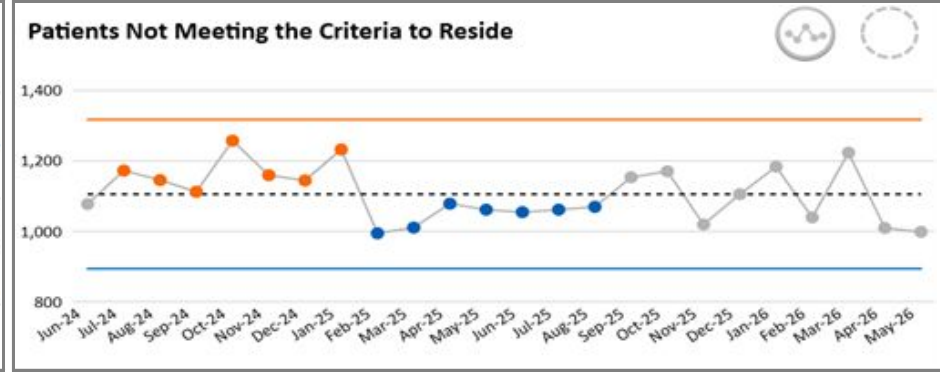
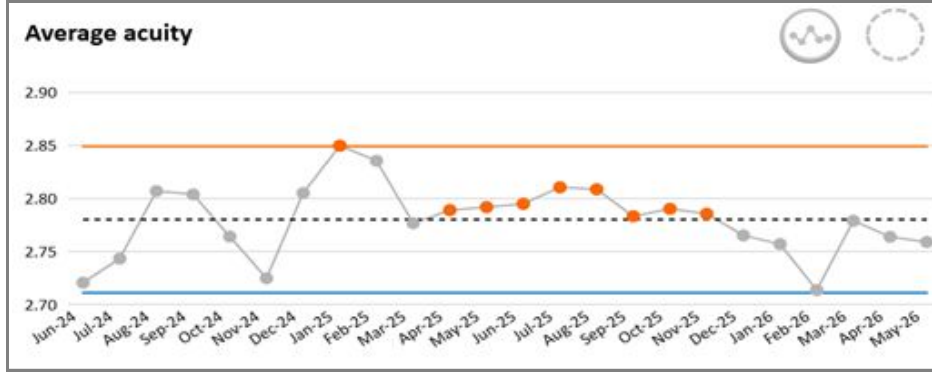
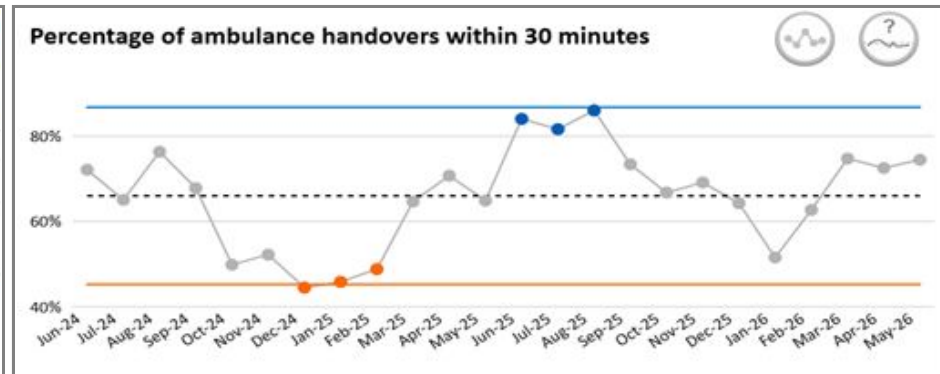
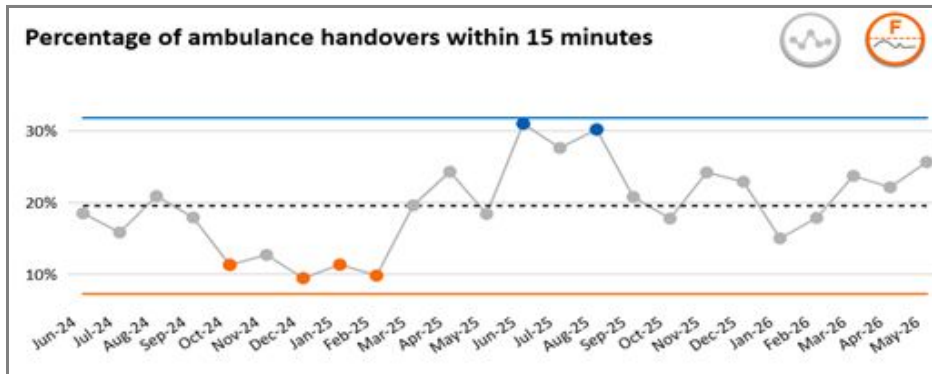
- In May-26, 4-hour performance was 74.1%, below trajectory of 77% impacted due by the urgent estates work required within a surgical ward that saw a closure of 26 beds and only partial reprovision including reallocation of 15 medical beds to Planned Care. Consequently, there was an increase in DTA to admitted and a significant rise in the number of patients remaining in the department for over 12 hours.
- Adult Type 1 performance was 41.6%, an improvement of 2.1% in comparison to May 25. Non admitted performance was 49.3% vs 48.3% May 25. Admitted pathway performance 18.2% remains unchanged to May 25. Type 1 ED 12-hour waits stood at 10.3%, a small improvement on 12 months ago.
- Average ambulance handover time was 27 mins, a 6 min improvement from May 25.
- June focus: collaborative work with Primary Care, EEAST and HCT. Agreed priorities include Call before Convey, Front Door Streaming with HCT and Primary Care based within ED / admission avoidance.
- UEC Transformation programme: streaming to UTC, Medical SDEC, Pull to SAU and Surgical SDEC.



Month 02 | 2026-27

Operations

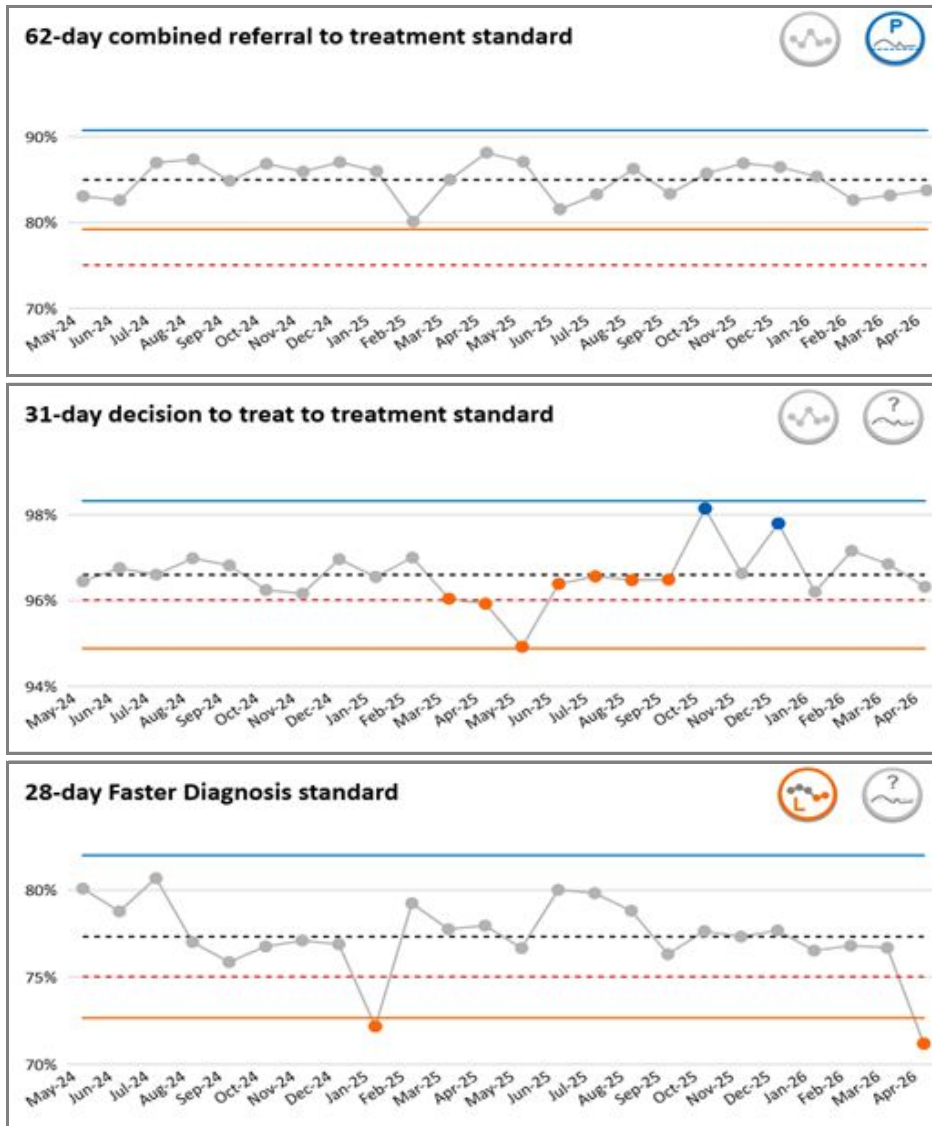
Urgent and Emergency Care | Supporting Metrics



Month 02 | 2026-27

Operations

Cancer Waiting Times | Supporting Metrics



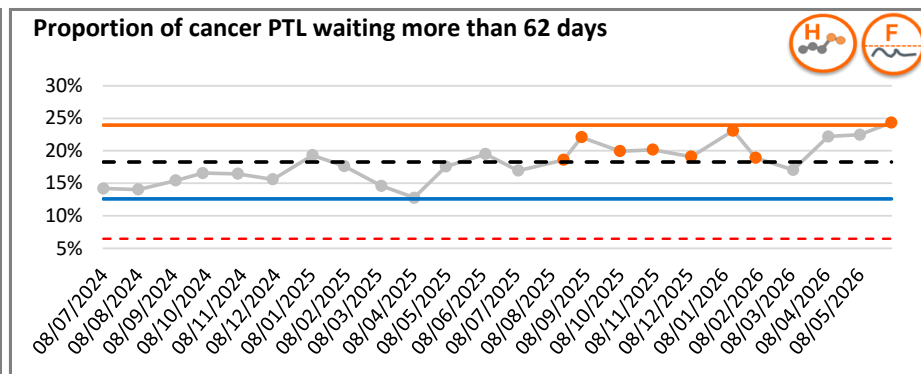
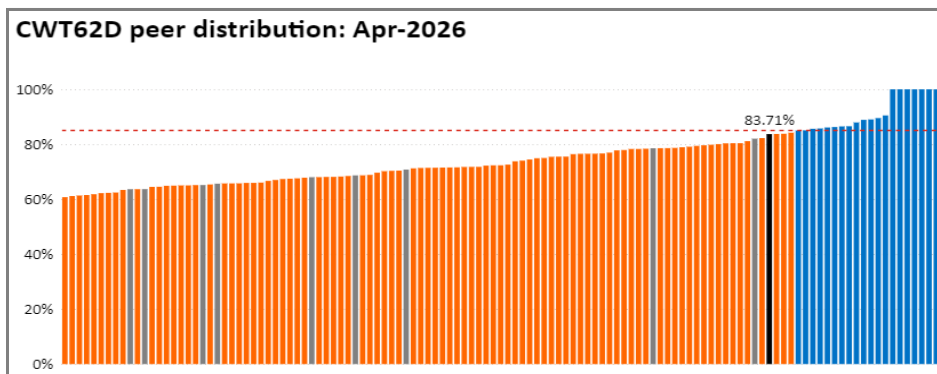
Key Issues and Executive Response

- We achieved 1 of the 3 national standards in April '26 with compliance in the 31 day decision to treat standard. The 28 day Faster Diagnosis standard (FDS) target has increased from 75% to 80% from April 26. FDS for May is 78.9% from 71.2% in April and 62 days is compliant at 87%.
- We are working closely with radiology and operational teams to reduce delays across MRI, CT colon, colonoscopy, Oral Surgery outpatient capacity, improving the triaging of referrals and addressing radiology reporting delays. These actions aim to enhance our 28-day FDS performance and achieve the 80% target.
- The 62-day referral-to-treatment standard (85%) was almost met in April, with performance at 83.70% improved from March.
- Five pathways mainly driving the non compliance: Lower GI due to CT colon and colonoscopy capacity, partially mitigated with additional lists; Upper GI due to delays in triaging of 2ww referrals, mitigating with the implementation of a new triage rota from July; Urology due to MRI capacity and reporting delays, partially mitigated by using One Stop Health Care, and MRI VAN at Lister. An enhanced escalation process has been put in place to ensure prioritised reporting of cancer patients. Gynae delays are driven by slow referral triage and inpatient hysteroscopy capacity, mitigating by converting routine slots for 2WW patients and additional lists.
- The 62-day performance in March ranked 14th nationally out of 119 NHS providers. This exceeded both regional and national averages by approximately 15%, and we maintain the top-performing hospital in the East of England region.

Month 02 | 2026-27

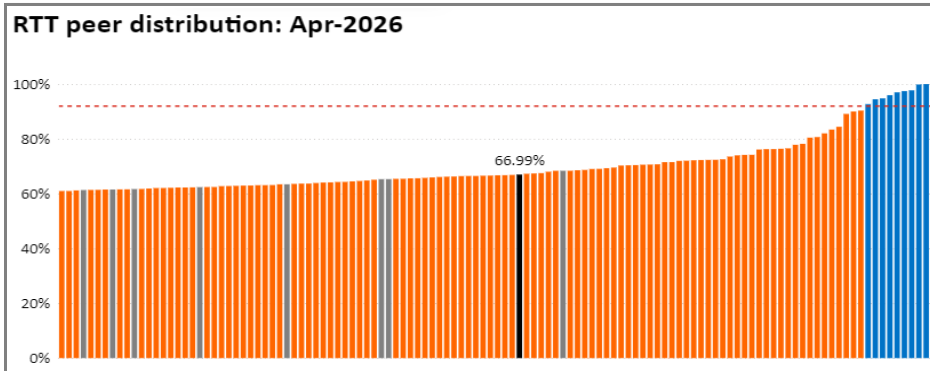
Operations

Cancer Waiting Times | Supporting Metrics



Operations

RTT 18 Weeks



Key Issues and Executive Response

Community Paediatrics

- Community Paediatrics is now reported via the Community Data Set. Referrals have started to stabilise since spring 2024, albeit at approx. 90 referrals per month higher than core capacity, so the waiting list continues to increase, with high numbers tipping across 104ww.
- Internal pathway pilots concluded in March 2026; during Nov - Mar 283 children were seen, reducing waiting list size by 12%. Embedding into BAU once all staff in post and Herts system Proof of Concept pilot has been completed - one single system pathway pilot commenced on 9/6/2026.
- System workstreams continue with oversight via 3 COOs (ENHT, HPFT, HCT); the Proof of Concept started on 9th June to test a single pathway with 50 patients.
- Single point of referral for neurodiversity hosted at HCT is live, improving completeness of information ahead of triage, alongside improved signposting whilst waiting.
- **78 Weeks** - There were 3765 patients waiting over 78 weeks at the end of May, an increase compared to 3,658 the previous month.
- **65 Weeks** - There were 4258 Community Paediatric patients waiting over 65 weeks, an increase from 4,172 at the end of April.

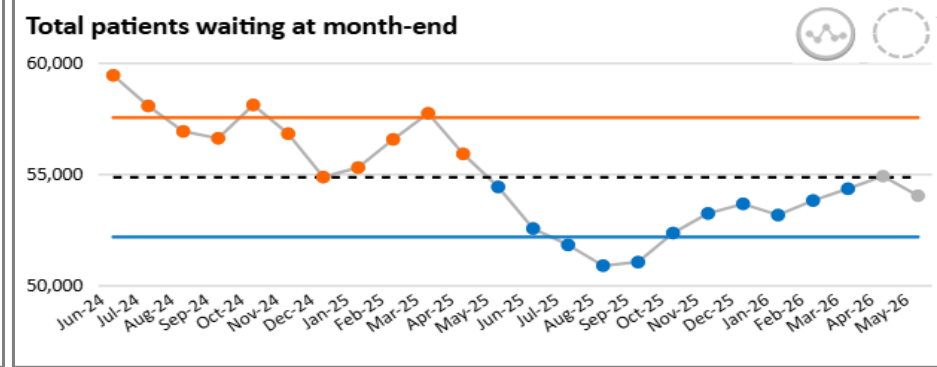
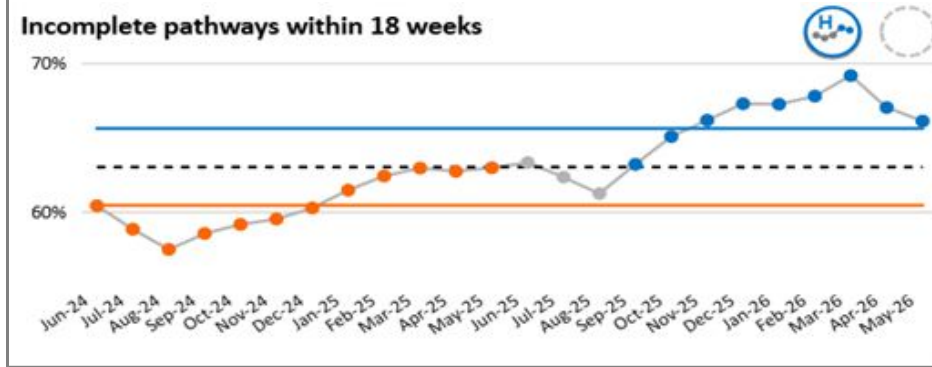
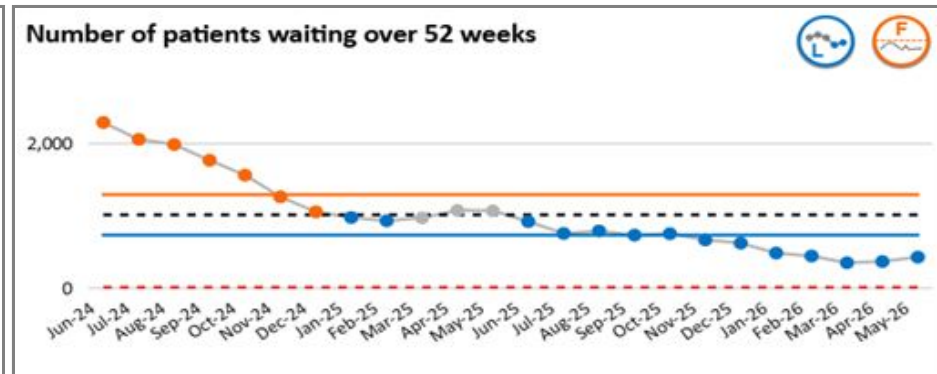
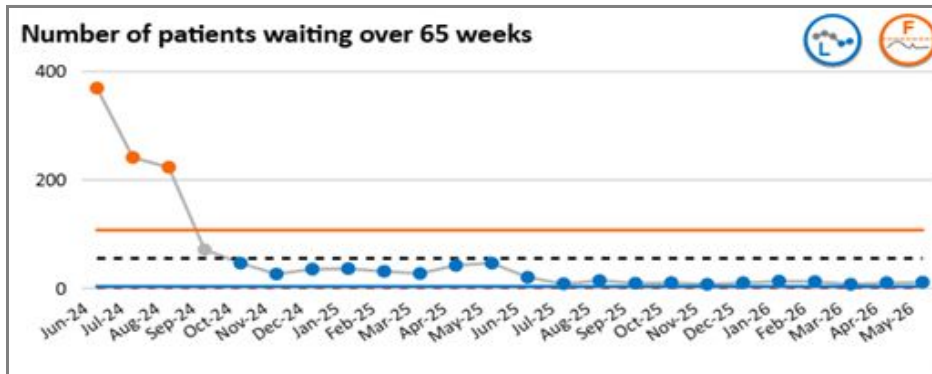
Key Issues and Executive Response

Excluding community paediatrics

- **18 Week Performance** - At the end of May, 66.1% of patients were waiting under 18 weeks, remaining above plan despite a decline in performance. The reduction was driven by operational pressures during the month, most notably the impact of business continuity measures in place for Swift Ward (including the loss of Trauma and Orthopaedic ring fenced capacity) along with strengthened controls in relation to additional waiting list activity.
- **52w proportion of PTL** - At the end of May, 418 (0.77%) patients were waiting above 52 weeks. This represents a slight deterioration from the previous month, largely attributable to the operational pressures described above. The position was further impacted by the business continuity measures that were in place throughout the May, which led to the closure of our Orthopaedic ring-fenced beds.
- **Awaiting First Event < 18 weeks** - We delivered 70.5% of patients waiting less than 18 weeks for their first activity, ahead of plan.
- The Patient Treatment List (PTL) has decreased by 880 patients to 54,018.
- **65 Weeks** - At end of May, 10 patients were waiting over 65 weeks: 9 in Trauma & Orthopaedics (T&O), and 1 in Dermatology due to patient choice.
- RTT and 52 week forums are in place with service managers to monitor and track patient through these pathways, including a weekly escalation meeting with divisional leaders.

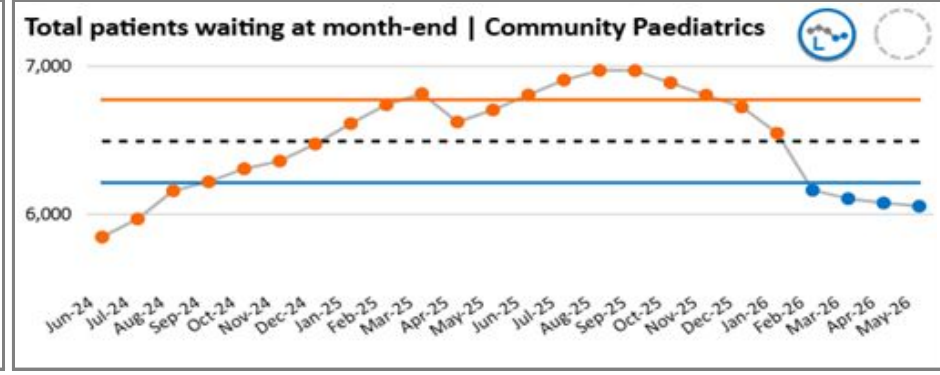
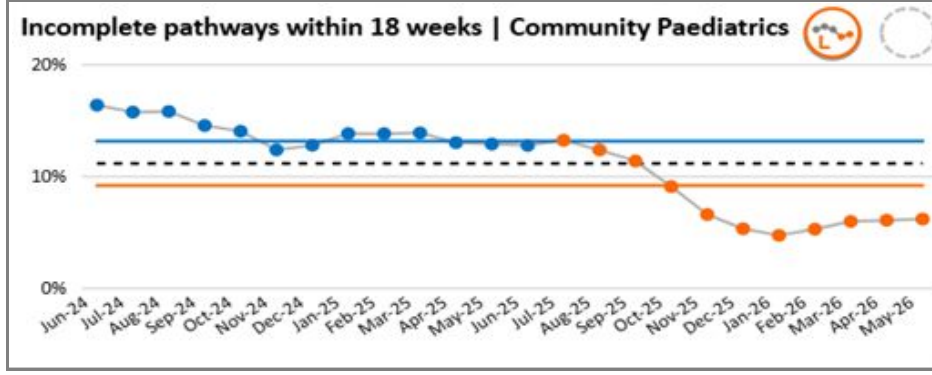
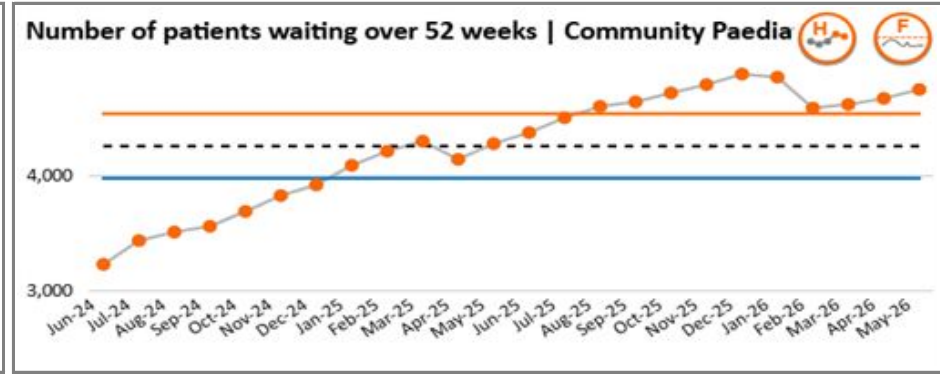
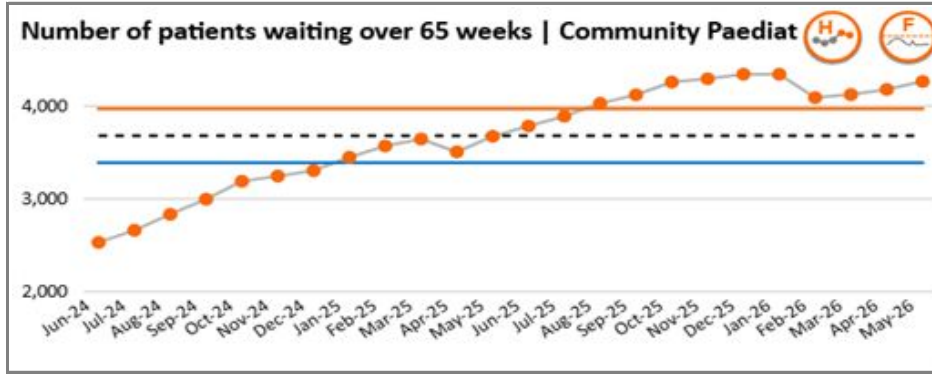
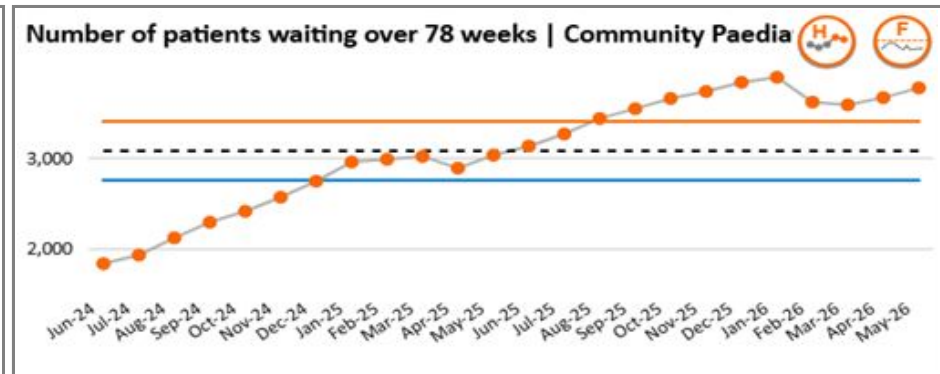
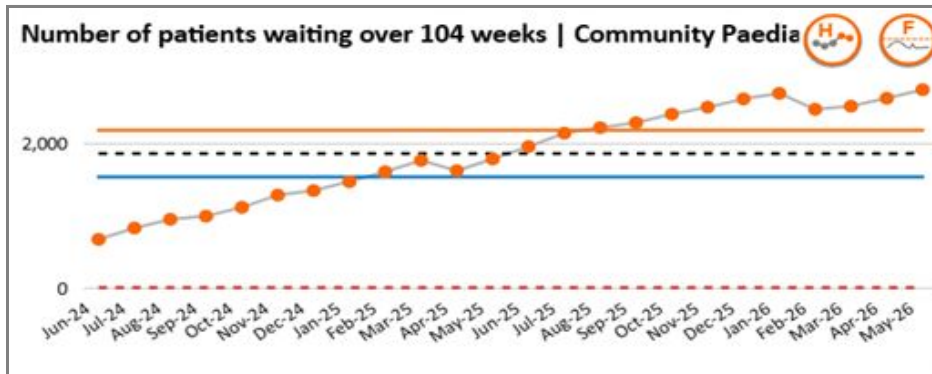
Operations

RTT 18 Weeks - excl. Community Paediatrics



Operations

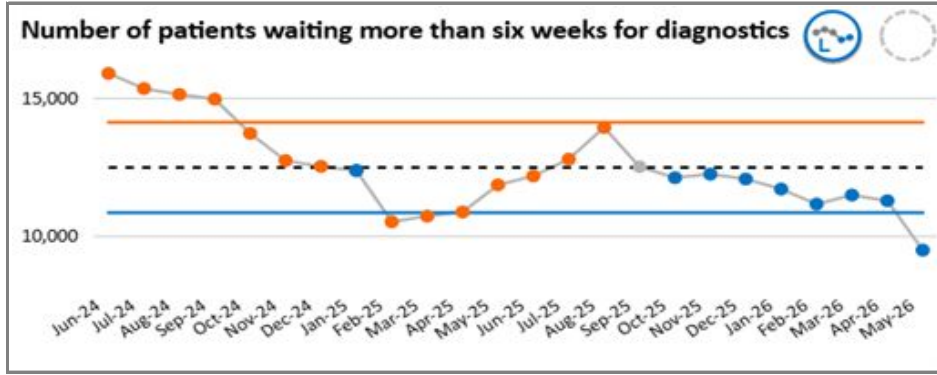
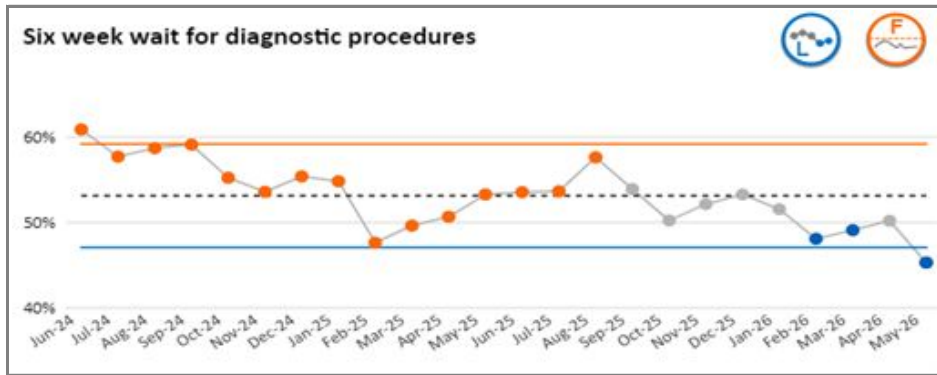
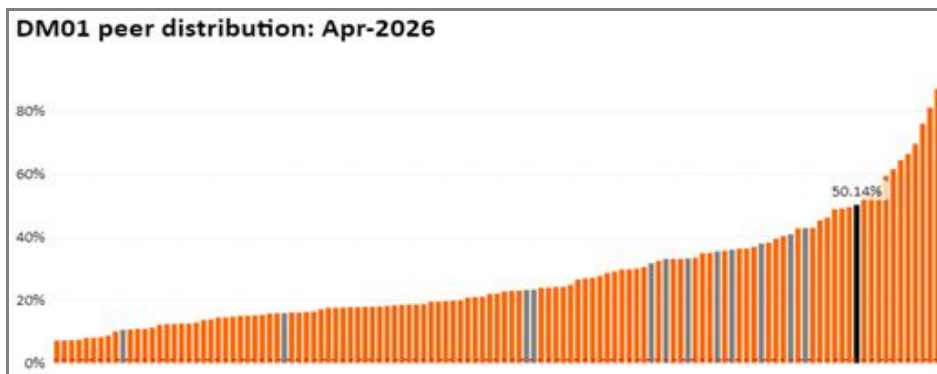
RTT 18 Weeks - Community Paediatrics ONLY



Month 02 | 2026-27

Operations

Diagnostics Waiting Times



Key Issues and Executive Response

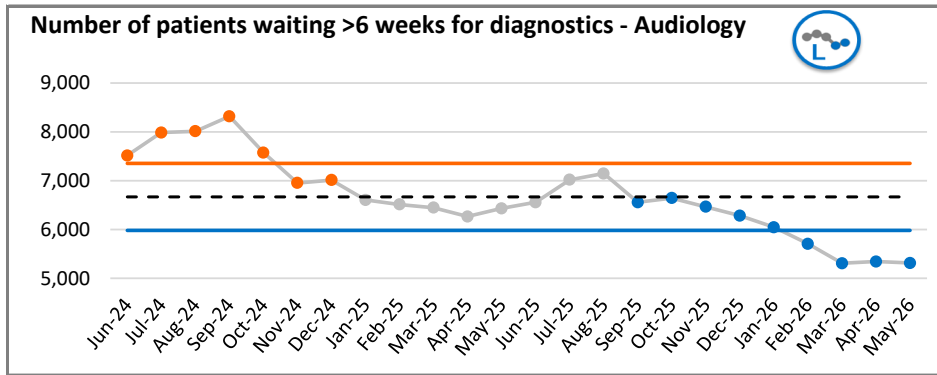
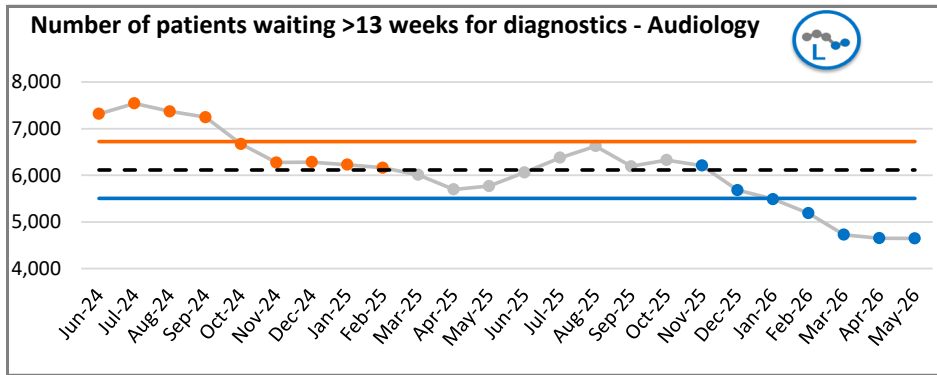
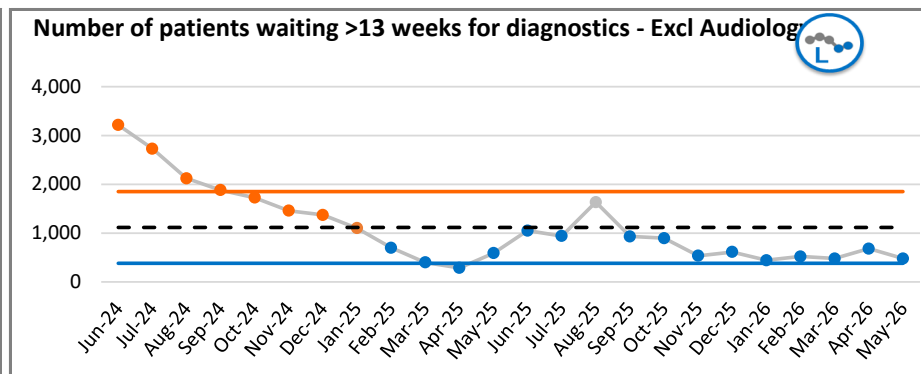
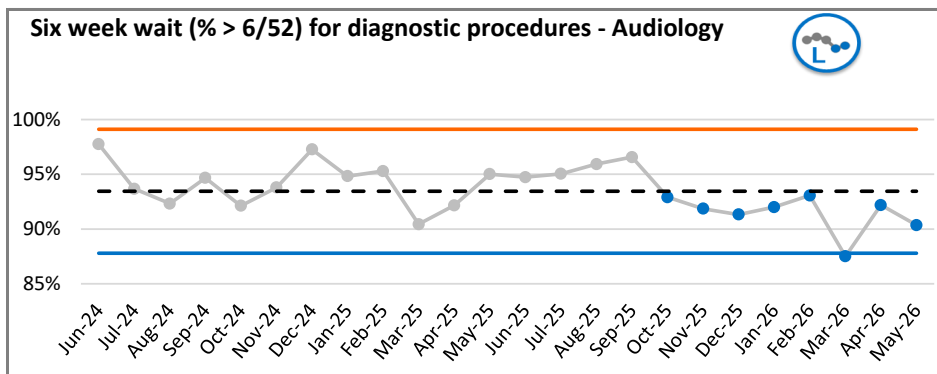
- Last 6 months we have driven a positive shift in diagnostic waits over 6 weeks, both volume and percentage.
- In May, DM01 performance (% waiting over 6 weeks for diagnostics) improved from 50.2% to 45.2%, best monthly improvement in over a year.
- Excluding Audiology position has improved, there are 4,157 patients waiting >6 weeks; with 486 patients waiting >13 weeks, most waiting for MRI or 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** impacted by staffing gaps (20% vacancy, 3.56 wte out to ad); two appointed and started. Extension of insourcing agreed until end of June, awaiting approval for July. Launch of consultation for standardised shifts to deliver 6-day; 9-hour service started 27/4. Current performance improved from 40.52% to 31.26%, with breaches reduced from 3,410 to 2,347; mean wait improved to 4.23 weeks in May.
- Outsourcing of **MRI** activity to One Stop Health Care started 16/3: 65 scans per week. MRI van has been signed for 4 lists(16-20 per list) per week until Oct '26. Consultation on 7-day MRI service completed, and partial started from 5 April due to vacancies. All B7 recruited to start in August, 1 B6 out to ad., 1249 patients over 6 weeks; mean wait 5.6 weeks. Replace two MRI scanners in 26/27.
- Capital works for paed **audiology** completed, operational from May 26. We anticipate being DM01 compliant by the end of 26/27, with a 5-10% improvement in performance each month throughout this year. Adult audiology currently 92.01% (3,927 breaches) with mean wait of 47.1 weeks. Paeds currently 85.17% (1,246 breaches) with mean wait of 39.96 weeks.

Operations

Diagnostics Waiting Times - Audiology



Month 02 | 2026-27



Finance

Month 02 | 2026-27

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		2	2	3
		0	0	3

Finance

Summary

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Summary Financial Position	Surplus / deficit	May-26	-2.8	-2.78			Common cause variation Metric will inconsistently pass and fail the target
	CIPS achieved	May-26	2.1	2.0			Common cause variation Metric will inconsistently pass and fail the target
	Cash balance	May-26	36.2	43.5			Common cause variation Metric will inconsistently pass and fail the target
Key Financial Drivers	Income earned	May-26	59.7	59.3			Common cause variation Metric will consistently pass the target
	Pay costs	May-26	36.9	38.1			7 points above the mean Metric will consistently fail the target
	Non-pay costs (including financing)	May-26	25.5	23.9			Common cause variation Metric will consistently fail the target

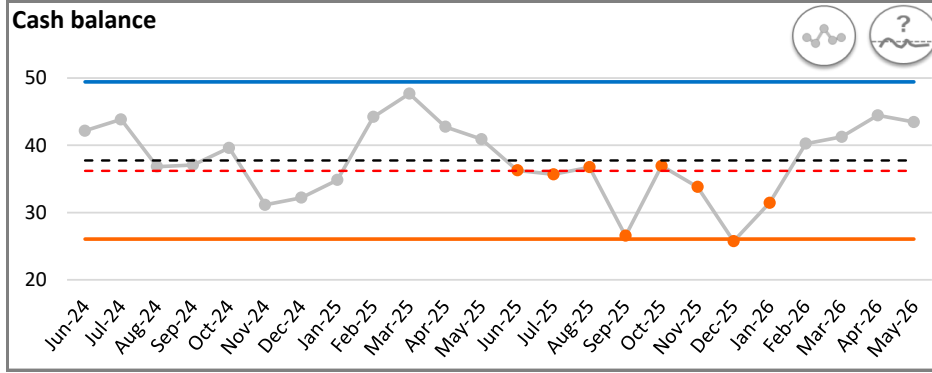
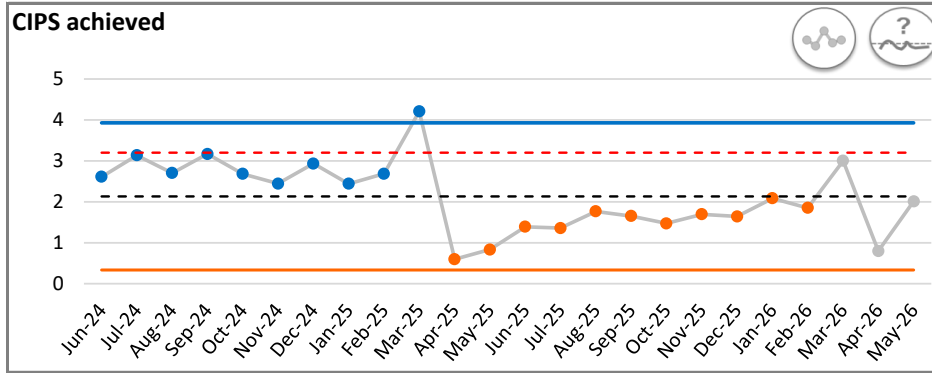
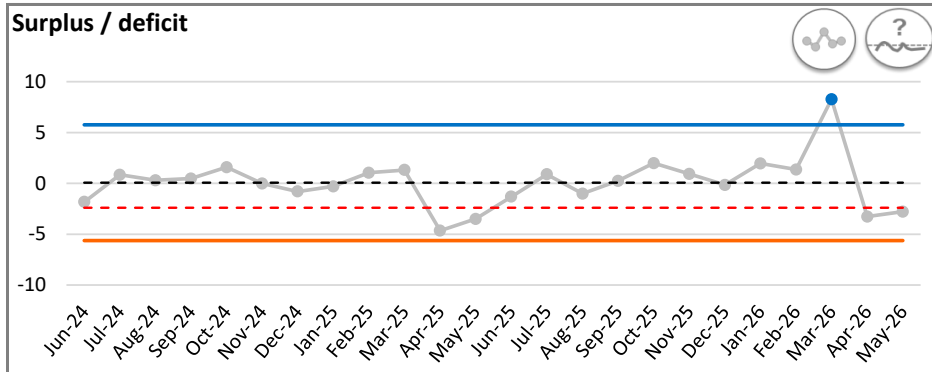
Finance

Summary

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Key Payroll Metrics	Substantive pay costs	May-26	36.1	35.4			11 points above the mean Metric consistently fail the target
	Average monthly substantive pay costs (000s)	May-26	5.8	5.8			13 points above the mean Metric will consistently fail the target
	Agency costs	May-26	0.1	0.3			10 points below the mean No target
	Unit cost of agency staff	May-26		11.4			Common cause variation No target
	Bank costs	May-26	0.7	2.5			Common cause variation Metric will inconsistently pass and fail the target
	Overtime and WLI costs	May-26	0.5	0.4			1 point below the lower process limit Metric will inconsistently pass and fail the target
Other Financial Metrics	Private patients income earned	May-26	0.6	0.6			Common cause variation Metric will consistently pass the target
	Drugs and consumable spend	May-26	4.6	4.5			Common cause variation Metric will consistently fail the target

Finance

Summary Financial Position



Key Issues and Executive Response

Executive Overview

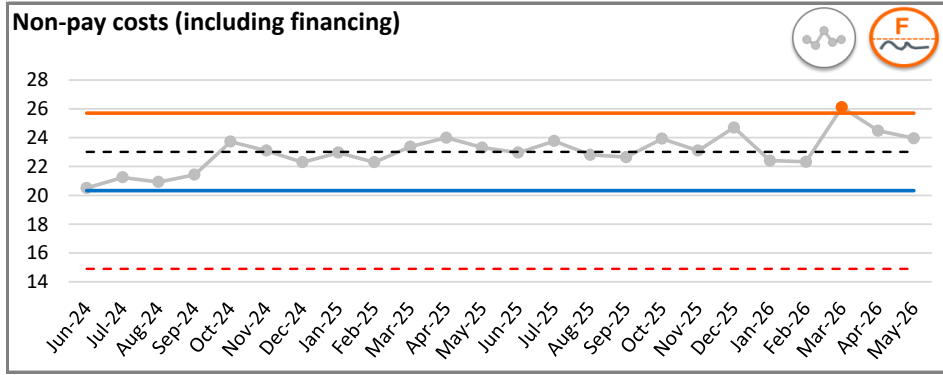
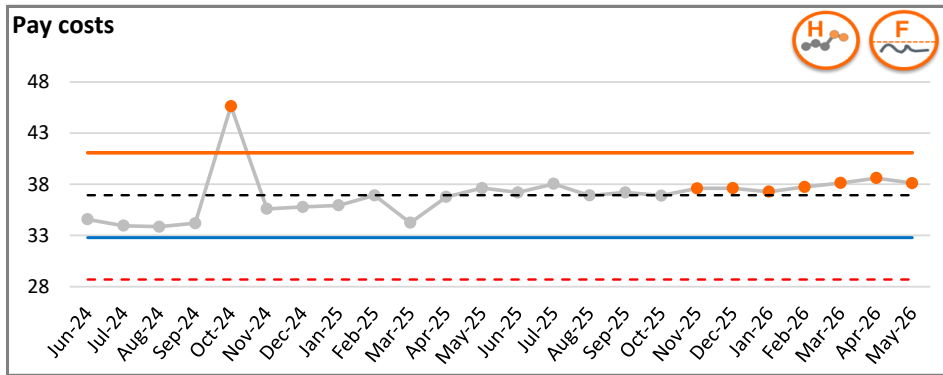
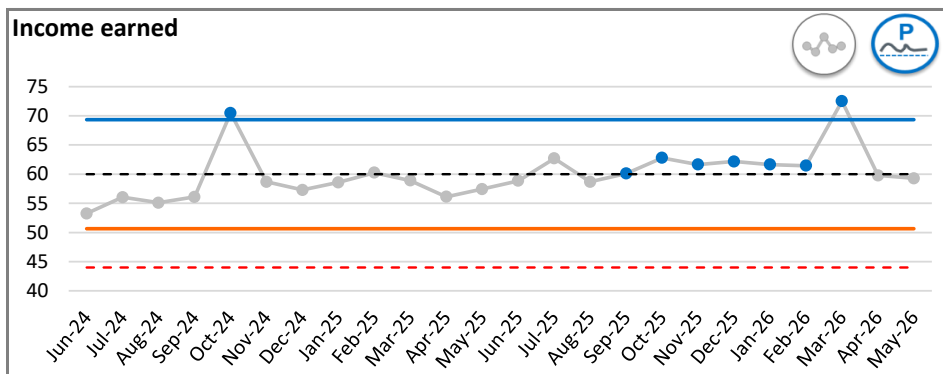
- The Trust reported a £6.1m YTD deficit at Month 2 YTD against a plan of £5.3m.
- The primary drivers of this position are industrial action (£0.5m), sustained workforce pressures within nursing and premium capacity solutions within radiology and an adverse variance against the external CIP plan phasing (£1m).
- The above pressures have been partially mitigated by £800k favourable variances on consumables and prosthesis due to low elective activity.
- Elective performance remains materially challenged due to industrial action and temporary ward closures. This is mainly mitigated by the block contract agreed with Central East ICB.
- Divisional overspends persist in Planned Care, Unplanned Care and Women's and Children's, driven by unidentified savings, low activity and workforce pressures.

Executive Response

- Significant reduction in run and rate and step up in recurrent CIP delivery is required for latter months of the year.
- Implementation of transformation schemes
- Strengthening financial controls for both workforce and temporary staffing
- Driving productivity performance within theatres, outpatients and bed utilisation.

Finance

Key Financial Drivers



Income Performance

- Month 2 income performance has improved since month 1 due to the industrial action impact. It was, however, below plan across a number of SLA and elective income lines, reflecting lower than planned activity delivery.

Pay Position

- Pay expenditure remains above plan due to:
 - Unidentified pay CIP (£3.1m)
 - Industrial action (£0.5m)
 - Sickness absence & high temporary staffing usage for nursing.
- The above pressures have been partially mitigated by £0.3m favourable variance for WLI payments due to low activity

Non-Pay Position

- Underspent in month of £0.8m on medical consumables and prosthesis due to low elective activity, particularly for Trauma and Orthopaedics.

Productivity & Operational Delivery

- Operational productivity remains variable across theatres, outpatient delivery and elective throughput.

2026/27 Focus Areas

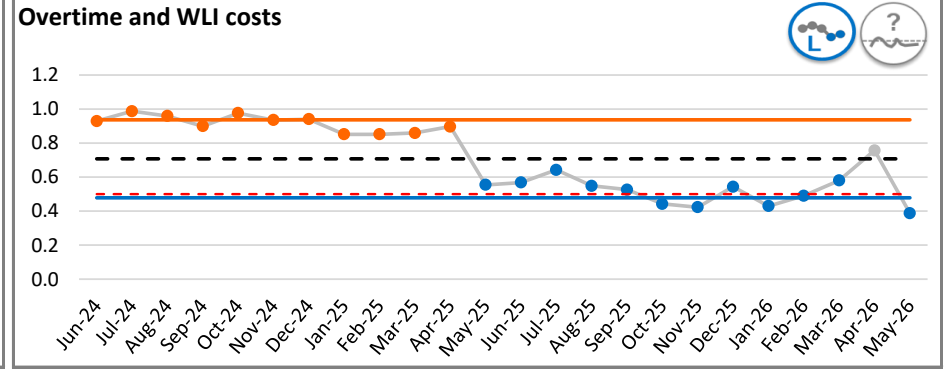
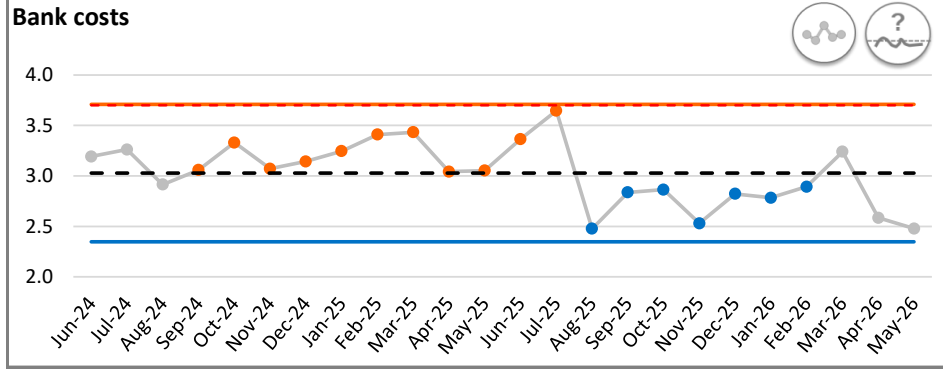
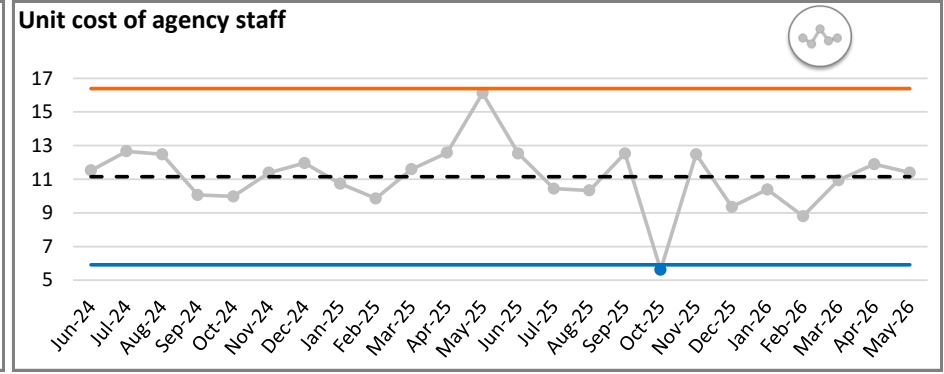
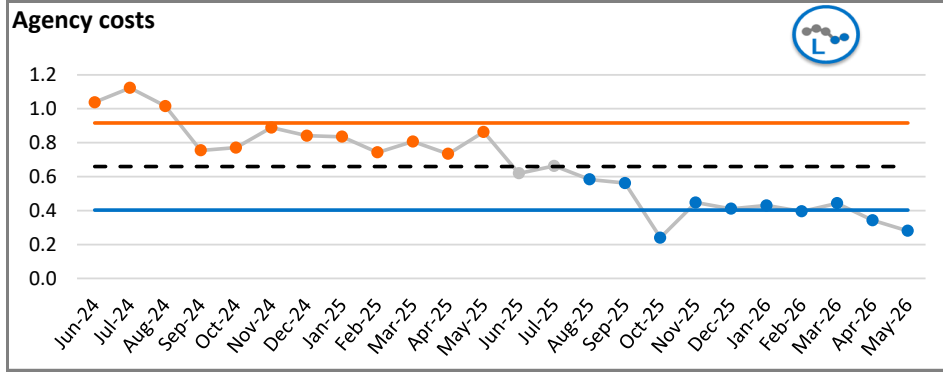
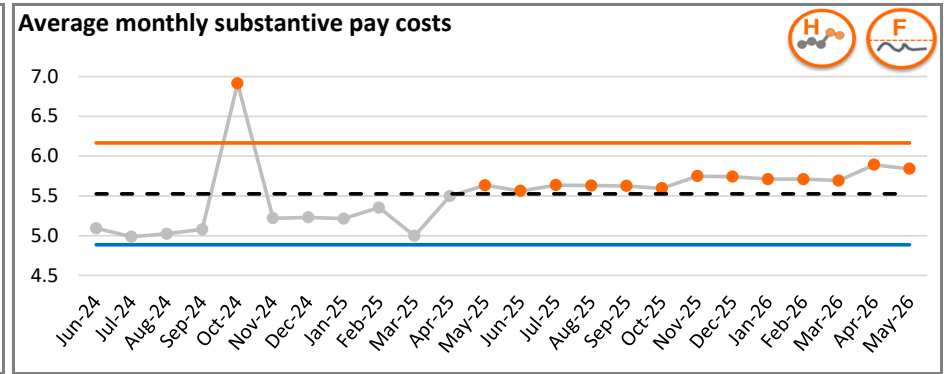
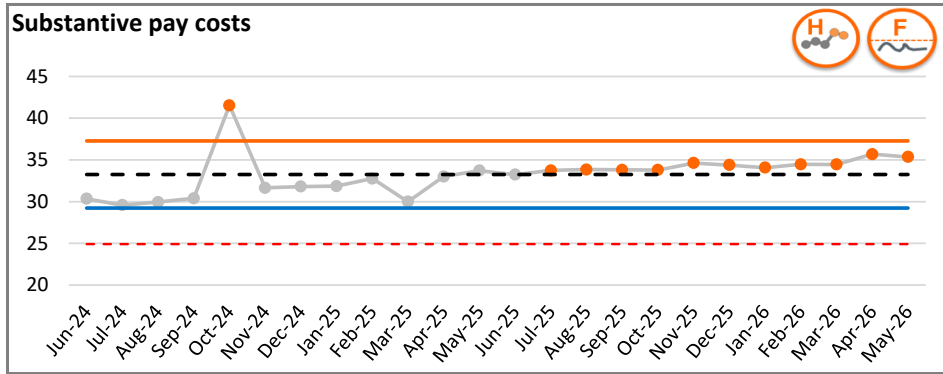
- Deliver recurrent CIP and transformational schemes
- Reduce premium pay expenditure
- Improve theatre and outpatient productivity
- Strengthen pay and non-pay controls

Key Message

- Sustained operational improvement and recurrent productivity delivery will be required to improve the run rate during 2026/27.

Finance

Other Financial Indicators











Month 02 | 2026-27



People

Month 02 | 2026-27

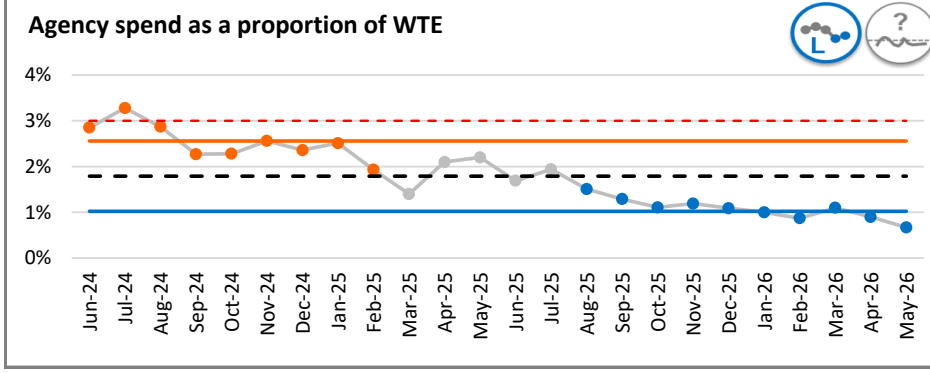
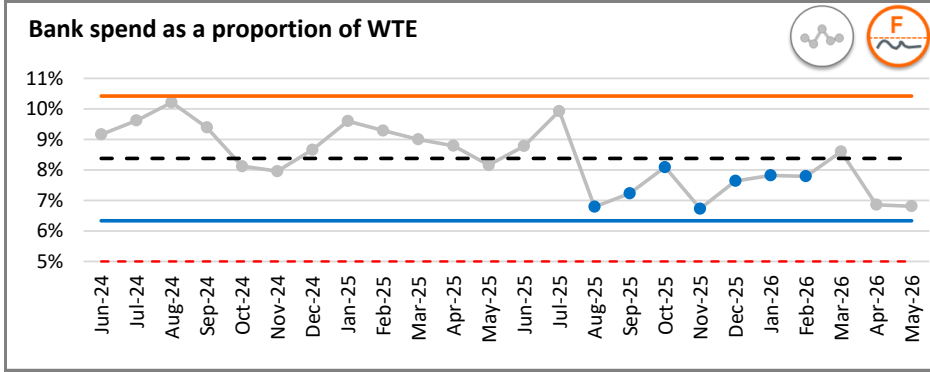
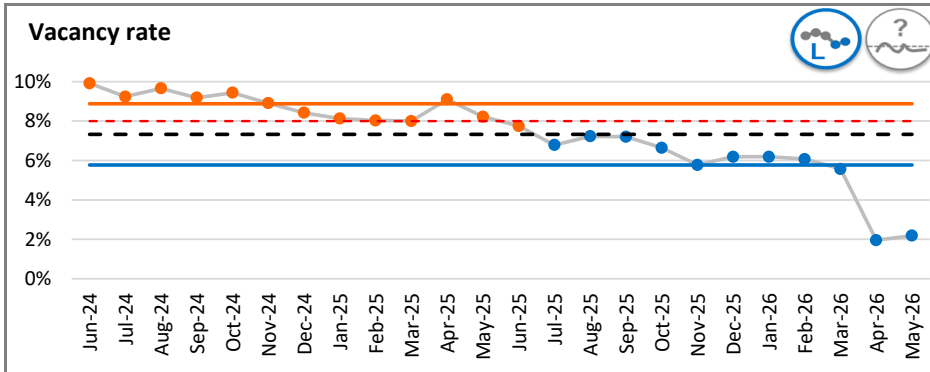
				
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People Summary

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Work	Vacancy rate	May-26	8%	2.2%			3 points below the lower process limit Metric will inconsistently pass and fail the target
	Bank spend as a proportion of WTE	May-26	5%	6.8%			Common cause variation Metric will consistently fail the target
	Agency spend as a proportion of WTE	May-26	3%	0.7%			10 points below the mean Metric will inconsistently pass and fail the target
Grow	Statutory and mandatory training compliance rate	May-26	90%	88.7%			Common cause variation Metric will inconsistently pass and fail the target
	Appraisal rate	May-26	90%	81.1%			Common cause variation Metric will consistently fail the target
Thrive	Turnover rate	May-26	10.5%	7.3%			13 points below the mean Metric will consistently pass the target
Care	Sickness rate	May-26	4.0%	4.4%			Common cause variation Metric will consistently fail the target

People

Work Together

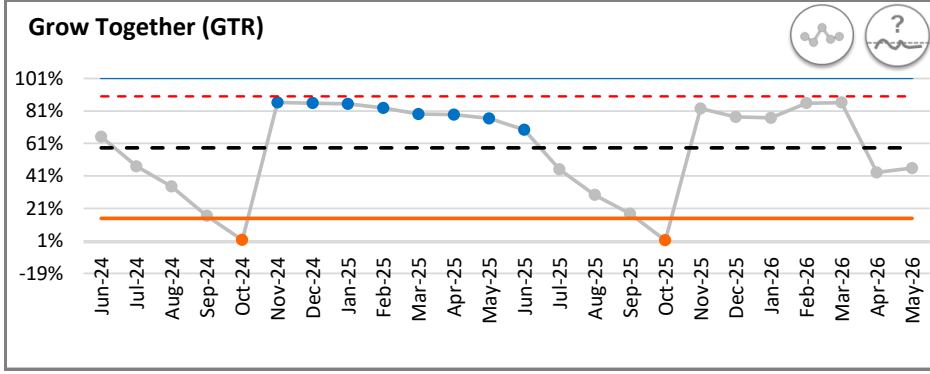
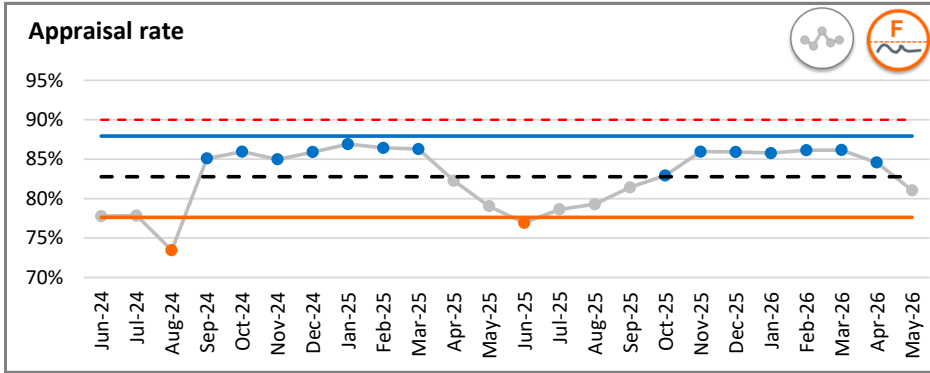
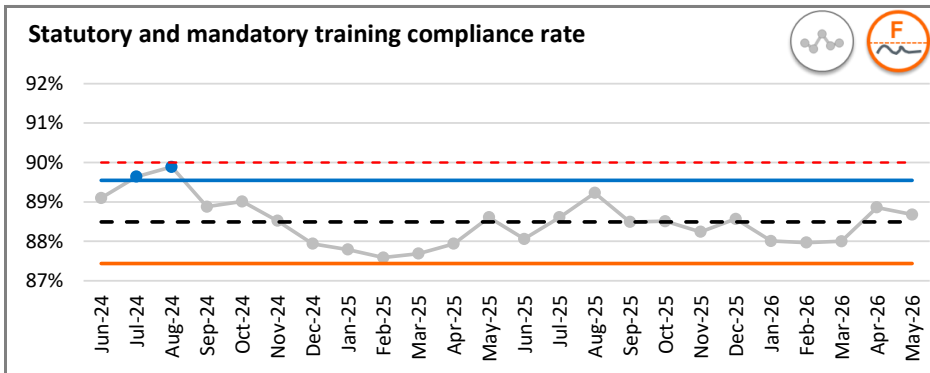


Key Issues and Executive Response

- Vacancy rates rose slightly in May to 2.2% from 2%. There were 34 starters and 44 leavers (net -10), with over 50 new starters expected in June.
- Continued focus remains on reducing long-term bank usage. Proposal paper presented to RCP outlining transiting process of long-term bank roles to fixed-term contracts, supporting high bank spend areas such as digital.
- Time to hire improved to 13 weeks in May. Reflective of process improvements enabling better oversight and quicker issue resolution.
- Recruitment experience remained strong in May, maintaining a 5-star rating, with 100% of candidates saying they would recommend applying.
- Face-to-face Trust Welcome sessions will resume from 1 June, focusing on a values-based introduction and day one mandatory training.
- Nurse recruitment plans remain unclear pending vacancy review (meeting planned); paediatrics plan to recruit externally, CSW pipeline progressing and maternity recruitment being reviewed, including Band 5–6 transition and September qualifiers.
- Agency price breaches and agency spend continues to show an improving position, following on-going proactive measures to reduce temporary staffing spend.
- Work underway to implement NHSP and Roster Controls to significantly improve governance and oversight.
- Temporary staffing spend is 0.5% below the 8% target, Agency spend as a proportion of WTE remains below target. Bank is above target.
- M2 Nursing and CSW bank use reduced from M1 despite an increase in annual leave and sickness. 7.9 WTE reduction in hours attributed to supernumerary and student shifts demonstrating that staff are now working in the numbers.

People

Grow Together

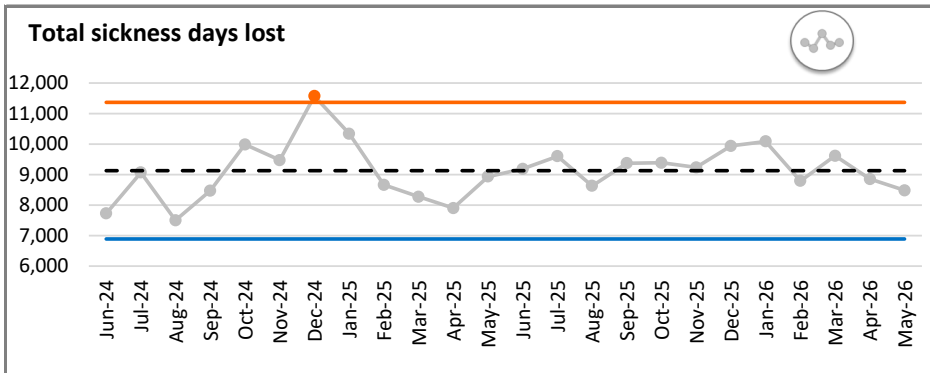
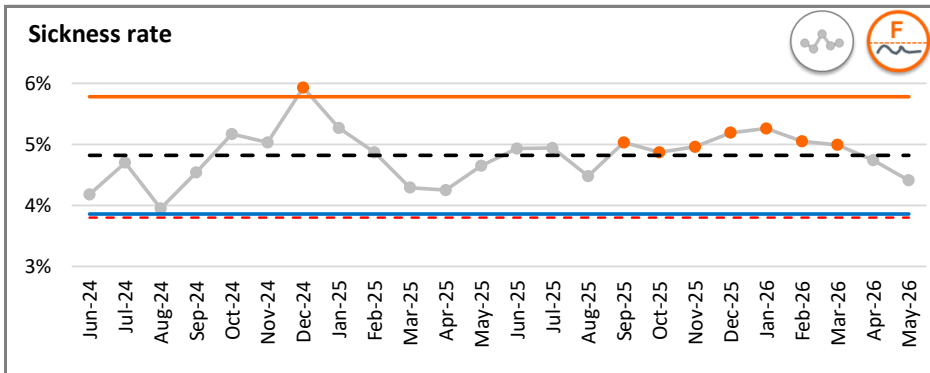
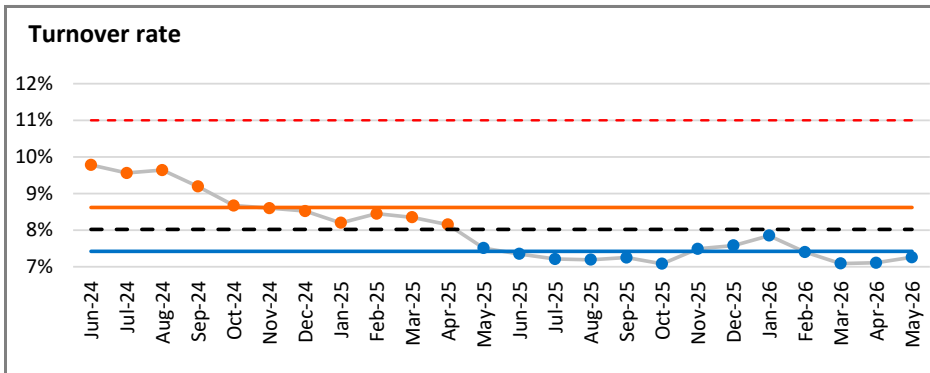


Key Issues and Executive Response

- **GTR compliance** for May is at 46% for those at AfC band 7 and above. Across the Trust we have an additional 8% at AfC band 6 and below that have already completed the GTRs. This is evidence of good team planning. Fortnightly GTR system and quality conversation support sessions are available to book via ENH Academy with great impact feedback.
- **StatMand** - Compliance continues to remain below target at 88.5% and is 'perstiently red'. Significant efforts are required to ensure compliance for all staff, especially Medics and those in Estates and Facilities. Discussions are planned for StatMand Steering Group to seek support from service managers on improving compliance

People

Thrive Together | Care Together



Key Issues and Executive Response

Thrive Together

- One current suspension which is taking longer than expected due to emergency bereavement leave and workload of IO. Plan in place to resolve asap.
- Average duration for disciplinary and staff concerns have minimal change. Work continues with communications team and managers to highlight the need to seek early informal resolution prior to escalation to formal stages of all case types.
- A concerning trend is coming to light where an increasing number of current employees are going against their union advice and raising early conciliation claims prior to the resolution of internal processes. This is putting additional pressure on all concerned and this adversarial approach is unlikely to assist in reaching a meaningful resolution to all involved.
- Policy development continues with compliance for people team policies reaching 93% this month. Outstanding policies being prioritised with medical colleagues to move forward.

Care Together

- In May there have been reductions in long term sickness absence which has reduced the sickness rate to 4.4%. Targeted support and occupational health advice has been given to managers to enable sickness absence to be prevented where possible and to plan return to work after absence that is safe and sustained.
- Proactive approaches to enhancing wellbeing and reducing sickness absence included peer support provided at the Menopause Staff Support Group, promotion of the Vivup staff support service and a health promotion stall at Lister supported by Hertfordshire Talking Therapies Service for Mental Health awareness Week.

Board committee report

Meeting	Public Trust Board		Agenda Item	15
Report title	Audit and Risk Committee Report to the Board 23 June 2026		Meeting Date	8 July 2026
Chair	Karen McConnell, Committee Chair			
Author	Deputy Trust Secretary			
Quorate	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>
Alert (Matters of concern or key risks to escalate to the Board):				
<ul style="list-style-type: none"> The draft Auditor's Annual Report and Value for Money (VFM) commentary was reviewed by the committee. The external auditors identified a significant weakness in the Trust's financial sustainability arrangements, primarily in the ability to effectively manage and close budget gaps. They recommended strengthening efficiency programmes and cost saving initiatives and that these measures should be ongoing, enabling the identification and development of savings, efficiency and transformational plans on a rolling basis. They also included a governance recommendation on the front entrance project to ensure ongoing monitoring of the commercial viability and risk associated with the project including associated accounting treatment. We were advised that a matter would be referred to the Secretary of State under s30 of the Local Audit and Accountability Act 2014 in relation to the Trust's cumulative deficit as of 31 March 2026. The Audit Completion Report included two recurring significant control deficiencies: <ul style="list-style-type: none"> Deficiencies in user access controls and system permissions weaknesses in privileged access controls requiring clearer mitigation and assurance. The Final Annual Report from the external auditors (BDO) is attached as an Appendix to this report. This report will be published on the Trust's website. 				
Assurances provided to the Board:				
<ul style="list-style-type: none"> Head of Internal Audit Opinion for 25/26 amber-green, indicating an adequate and effective framework for risk management, governance and internal control. BDO anticipated issuing an unqualified audit opinion on the Trusts financial statements in accordance with the deadline of 26 June 2026. We reviewed the Audit Completion Report, including unadjusted audit differences, recommendations arising from the audit and management responses. The Annual Report and Annual Governance Statement was fair and balanced and aligned with audit findings and was approved. 				
Advise (Matters the Board should be aware of not covered above e.g. on-going monitoring, new developments etc):				
<ul style="list-style-type: none"> Other control deficiencies were noted from the Audit Completion Report these included strengthening the drugs accrual methodology through strengthening of reconciliation processes. 				

<ul style="list-style-type: none"> • Continued focus on translating transformation programmes into measurable impact for 2027/28 will be discussed with Chair of FPPC. • The remaining internal report for 25/26 Emergency Planning, Preparedness and Resilience will be discussed at ARC on 21 July. 	
Decisions made by the committee or major actions commissioned and work under way:	
<ul style="list-style-type: none"> • Approved the Annual Accounts, subject to any material amendments being referred to the Committee Chair. • Approved the Annual Report and Annual Governance Statement, with Chair oversight on any material amendments. • Actions commissioned include: <ul style="list-style-type: none"> ○ Report on stock reconciliation and system alignment ○ Comprehensive report on IT access controls and mitigation ○ Action plan addressing audit recommendations ○ Update on waiver reduction and procurement process improvements ○ Reminder to directors regarding declarations of interest requirements. 	
Any actions recommended to improve effectiveness of the meeting:	
<ul style="list-style-type: none"> • Reinforce timely implementation of audit recommendations • Improve clarity and follow-up of control weaknesses and mitigation plans. • Strengthen transparency in declarations of interest. 	
Recommendation	The Board is asked to DISCUSS the assurances provided by the Audit and Risk Committee.

To be trusted to provide consistently outstanding care and exemplary service



IDEAS | PEOPLE | TRUST

Auditor's Annual Report for the year ended
31 March 2026

East and North Hertfordshire Teaching NHS Trust

Final report to Audit and Risk Committee

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Welcome

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We have pleasure in presenting our Auditor's Annual Report to the Audit and Risk Committee. This Auditor's Annual Report provides a summary of the key issues arising from our audit of East and North Hertfordshire Teaching NHS Trust (the 'Trust') for the year ended 31 March 2026. It is addressed to the Trust but is also intended to communicate the key findings we have identified to key external stakeholders and members of the public.

Financial statements

We issued an unqualified opinion on the Trust's financial statements on 26 June 2026. This means that we consider that the financial statements give a true and fair view of the Trust's financial position and its expenditure and income for the year ended 31 March 2026.

Value for money

We identified a significant weakness in respect of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources. This significant weakness is detailed in the 'Value for money' section of this report, along with our commentary on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources.



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Additional reporting responsibilities

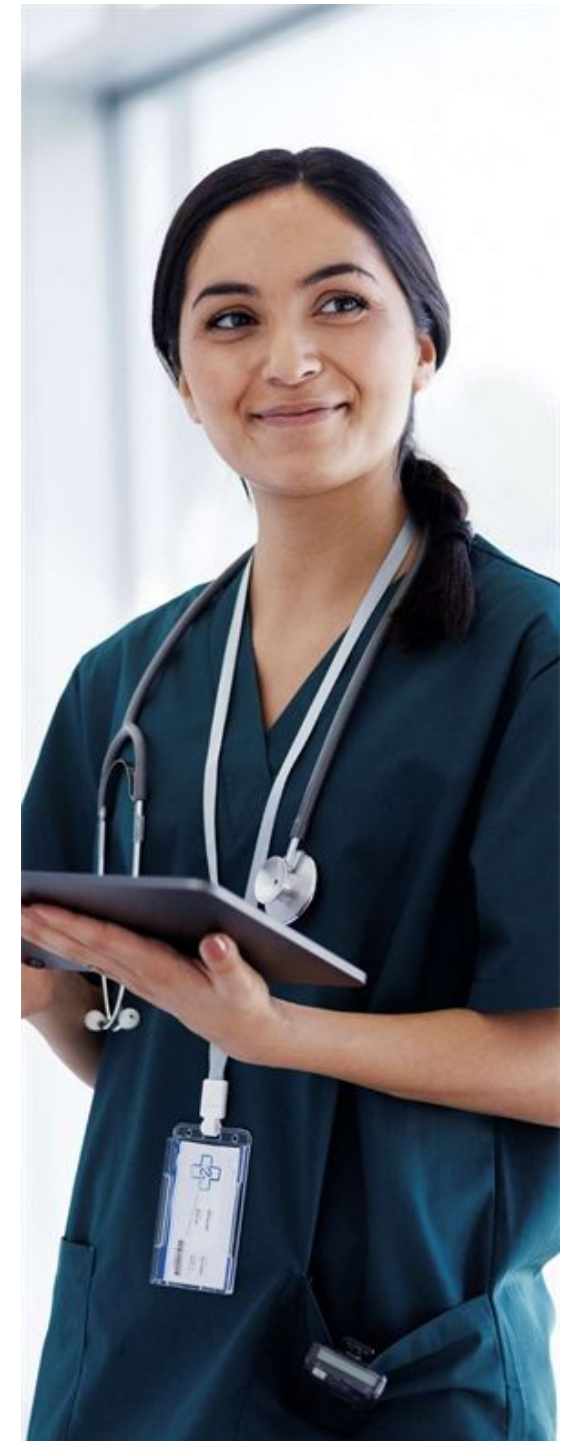
We have referred a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014. This is explained further in the 'Additional reporting responsibilities' section of this report.

We would also like to take this opportunity to thank the Management and staff of East and North Hertfordshire Teaching NHS Trust for the co-operation and assistance provided during the audit.

Ciaran McLaughlin

Key Audit Partner

26 June 2026



Financial statements

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Responsibility of the Trust

Under the National Health Service Act 2006 NHS England has directed each NHS Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. In preparing the accounts, the Trust's Accountable Officer is required to comply with the requirements of the Government Financial Reporting Manual and, amongst other things, to confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

Responsibility of the auditor

Our responsibility is to report on whether the financial statements give a true and fair view of the Trust's financial position and of its income and expenditure for the year. Our audit of the financial statements does not relieve the Accountable Officer, nor those charged with governance, of their responsibilities for the preparation of the Annual Report and Accounts.

Outcome of the audit of the financial statements

We issued an unqualified opinion on the Trust's financial statements on 26 June 2026. This means that we consider that the financial statements give a true and fair view of the Trust's financial position and its expenditure and income for the year ended 31 March 2026. We are unable to issue the completion certificate until the NAO has completed its audit of the Consolidated NHS Provider Accounts.



Financial statements

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We reported our detailed findings in our Audit Completion Report, which we presented to the Audit and Risk Committee on 23 June 2026 and circulated an updated version of on 26 June 2026 at the point of completing our audit. The key findings from our audit are as follows:

- ▶ Corrected misstatements four adjusted misstatements were corrected for. These all related to classification. None of these adjustments are material and none impacted the surplus for the year.
- ▶ Uncorrected misstatements - seven unadjusted misstatements were identified. These are not material either individually or in combination.
- ▶ We identified cut-off audit differences relating to the prior year that have been recognised in the current year (2025/26). While these differences impact the reported surplus for the current year, we have not requested a prior period adjustment on the basis that the overall impact is not material. The cumulative effect of rolling forward these prior year differences is an overstatement of the Group's 2025/26 surplus by of £0.808 million
- ▶ Significant deficiencies in controls were identified in relation to IT General Controls. These primarily related to privileged access roles, absence of audit trails for one system.

Whole of Government Accounts

The Trust is required to produce returns to facilitate the preparation of Consolidated NHS Provider Accounts by NHS England. We have complied with the group audit instructions prepared by the NAO on behalf of the Comptroller and Auditor General, which require us to examine and report on the consistency of these returns with the body's audited financial statements for 2025/26. Our audit work to ensure that the NHS Provider Accounts Template (used in the preparation of the Consolidated NHS Provider Accounts) is consistent with the financial statement is due to be reported to the National Audit Office by 3 July 2026. We are undertaking the work at present to meet that reporting timeline.



Value for money

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Scope of our work

We are required to review and report on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources. Where we identify significant weaknesses in these arrangements, we are required to report these to the Trust and to make recommendations for improvement.

Specified criteria

The NAO has issued guidance to auditors which requires us to report our value for money work against three specified reporting criteria:

- ▶ **Financial sustainability** - how the Trust plans and manages its resources to ensure it can continue to deliver its services
- ▶ **Governance** - how the Trust ensures that it makes informed decisions and properly manages its risks
- ▶ **Improving economy, efficiency and effectiveness** - how the Trust uses information about its costs and performance to improve the way it manages and delivers its services.

Output from our work

The key output from our work is a commentary on the Trust's arrangements to secure value for money. This commentary is set out in the following pages of this report.

We are also required to:

- ▶ report any significant weaknesses we have identified in the Trust's arrangements to secure value for money, and
- ▶ make recommendations for improvement in respect of any such significant weaknesses.

We identified a significant weakness in respect of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources. This significant weakness was in respect of financial sustainability and the Trust's ability to manage their medium-term budget gaps. Our detailed findings in respect of this significant weakness are set out on page 8 of this report.



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Risk of significant weakness	Findings of our work
<p>Financial plans (Financial Sustainability)</p> <p>We have identified a risk of significant weakness with regards to the financial sustainability arrangements on how the Trust plans and manages its resources to ensure it can continue to deliver its services.</p>	<p>We identified a significant weakness in the Trust's arrangements to secure value for money in respect of this risk.</p> <p>Our commentary on the Trust's arrangements in respect of this risk is set out on page 12 of this report.</p>
<p>Fixed Asset Register verification process (Governance)</p> <p>The Trust faces a risk of significant weakness due to the lack of a timely and robust fixed asset verification processes. Limitations in the ability to track assets exposes the Trust to risks of loss and misreporting.</p> <p>This matter has previously been reported by external and internal audit, and discussions with management indicate that implementing an effective solution will take time with a residual risk remaining in the interim.</p>	<p>We did not identify a significant weakness in the Trust's arrangements to secure value for money in respect of this risk.</p> <p>Our commentary on the Trust's arrangements in respect of this risk is set out on page 18 of this report.</p>



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Risk of significant weakness

Impact of ENH Pharma stock findings (Governance)

At the 10 February Audit and Risk Committee, a report was received summarising stock accounting issues that were identified through the audit of ENH Pharma (year ended 31 March 2025) and the subsequent actions taken by the Trust and Pharma over underlying control issues, including through engagement of external advisors.

From an external audit VFM perspective, where significant control issues exist at a subsidiary there is a need to understand the potential impact on the wider group control environment and governance.

Findings of our work

We did not identify a significant weakness in the Trust's arrangements to secure value for money in respect of this risk.

Our commentary on the Trust's arrangements in respect of this risk is set out on page 18 of this report.



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Risk of significant weakness

Medical Appraisals nil assurance report

At the 10 February Audit and Risk Committee, internal audit reported a Minimal Assurance opinion in respect of Appraisals (Medical). The report included five high priority recommendations. From an external audit VFM perspective, National Audit Office guidance requires us to consider internal audit report outcomes as indicators of potential significant weakness. Therefore, as part of our work we will seek to gain more understanding of the findings, recommendation implementation progress and also seek to understand any potential wider implications of the findings (where applicable) based on our wider experience and knowledge of the Trust.

Findings of our work

We did not identify a significant weakness in the Trust's arrangements to secure value for money in respect of this risk.

Our commentary on the Trust's arrangements in respect of this risk is set out on page 18 of this report.



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Risk of significant weakness

Front Entrance Project (Governance)

The Trust is entering into a major redevelopment project to improve the front entrance of Lister Hospital, with construction expected to commence in October 2025. This represents a significant capital investment outside of the Trust's usual activities. The structure and financial accounting for the transaction are relatively new and innovative, involving a range of third-party organisations. The project spans a 40-year period and ensuring that financial risks are appropriately understood as well as ensuring the project is accounted for correctly are important issues. We therefore identified a risk of significant weakness regarding how the Trust ensure it makes properly informed decisions, supported by appropriate evidence and allowing for challenge and transparency. This includes arrangements for taking independent financial advice and ensuring effective challenge from the board and relevant sub committees.

Findings of our work

We did not identify a significant weakness in the Trust's arrangements to secure value for money in respect of this risk. However, we have included some recommendations for the trust, please refer to page 25.

Our commentary on the Trust's arrangements in respect of this risk is set out on page 19 of this report.



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Risk of significant weakness	Findings of our work
<p>Mount Vernon Cancer Centre (Improving 3Es)</p> <p>The risk of significant weakness at Mount Vernon Cancer Centre stems from the uncertainty in timeframe of transferring the cancer services to University College London Hospital (UCLH). Initially expected within a rolling twelve-month period since 2021, the timeline has now become indefinite with a minimum expected period of at least three years. This extension requires the Trust to ensure safe and effective cancer services at a site with ageing infrastructure, which could impact service continuity and patient safety, and ensure this is appropriately financed. This therefore creates a risk of significant weakness regarding the Trust's ability to continue to safely deliver the services it provides and assess performance and identify funding for future improvement to the buildings.</p>	<p>We did not identify a significant weakness in the Trust's arrangements to secure value for money in respect of this risk.</p> <p>Our commentary on the Trust's arrangements in respect of this risk is set out on page 22 of this report.</p>



Financial sustainability

Commentary on VFM arrangements

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Areas reviewed

- How significant financial pressures relevant to short and medium-term plans are identified and built into plans;
- Plans to bridge funding gaps and to identify achievable savings;
- How financial plans support the sustainable delivery of services in accordance with strategic priorities;
- The consistency of financial plans with other plans such as workforce, capital, investment, and other operational planning which may include working with other local public bodies as part of a wider system; and
- Identification and management of risks to financial resilience e.g. unplanned changes in demand, including challenge of assumptions underlying its plans.

Commentary

The Trust operates a structured medium-term financial planning framework which identifies financial pressures through activity modelling, workforce planning, inflation assumptions, tariff and income analysis, and scenario modelling.

The Trust produces a monthly Finance Report, which monitors performance against budget for both the reporting period and year-to-date.

These reports highlight expected key cost pressures and demonstrate how identified financial challenges are embedded within planning assumptions and financial models.

The report includes detailed analysis of activity levels, year-on-year comparisons, pay bill performance, divisional financial results, capital programme delivery, and balance sheet position, supported by additional reporting where required.

The Finance, Performance and People Committee (FPPC) receives these reports at each meeting and provide scrutiny and challenge. Discussions focus on risks and challenges associated with delivering the financial plan, including any unexpected performance trends or variances. In addition, financial performance is reported to each Board meeting. FPPC membership includes Non-Executive Directors with financial expertise and assurance experience.

The Trust has set a Cost Improvement Programme (CIP) target of approximately £37.9m (5.2%) for 2026/27, representing an increase from the £35.8m target in 2025/26. The 2026/27 CIP has been designed as a transformation-led programme rather than a standalone cost reduction exercise.



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Key design principles include embedding CIP within a Trust-wide Transformation Programme, focusing on recurrent and sustainable savings, and promoting continuous improvement rather than annual cost-cutting.

The Trust-wide Transformation Programme is structured as a coordinated, organisation-wide initiative, supported by a programme-managed approach with PMO oversight. This includes weekly performance dashboards, clear accountability across divisions, named leads for each programme and workstream, and a strong focus on execution and delivery discipline, with defined phasing and trajectory tracking. The programme aims to deliver recurrent financial savings, improve productivity and operational performance, and address the Trust's underlying structural financial deficit.

To support effective delivery, a structured Project Initiation Document (PID) governance process has been established, ensuring that all schemes are appropriately developed, reviewed, validated, and approved prior to implementation.

As at the end of May 2026, management reported that £21.2m of savings schemes had been identified and approved against the £37.9m target, representing approximately 56% of the total.

Of the identified schemes, £8.5m (40%) relates to non-recurrent savings. While this indicates an ongoing effort to increase the proportion of recurrent and sustainable savings, this remains a challenge. This leaves an outstanding gap of £16.5m.

In addition, pipeline opportunities of £4.9m have been identified. If fully realised, this would reduce the unidentified gap to £11.7m. However, this still represents a 31% shortfall against the overall target, which is a significant proportion of the savings requirement two months into the financial year.

This gap highlights the need for continued strategic focus to identify and deliver further savings to ensure financial sustainability. It may also impact the Trust's ability to achieve its planned financial outturn for the year. While such challenges are not uncommon across NHS organisations, given the wider financial and productivity pressures in 2026/27, the scale of the gap does reflect a significant weakness in the Trust's arrangements.

Financial planning is integrated with the Trust's strategic objectives and operational priorities. Investment decisions are supported by business cases demonstrating affordability, strategic alignment, and expected benefits.



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The Trust ensures resources are prioritised toward core services, quality improvement, and statutory requirements.

Financial plans are developed alongside workforce, operational, digital, and capital strategies to ensure alignment across organisational priorities. Cross-functional planning groups and governance committees (i.e. FPPC and Trust Board) provide oversight to ensure plans are realistic and deliverable within available resources.

Financial risks are captured within the Board Assurance Framework and risk register and reviewed through established governance structures. The Trust uses sensitivity analysis and scenario planning to assess risks relating to demand, workforce availability, and funding assumptions. Mitigating actions are monitored through executive oversight.

Conclusion

Our assessment has identified a significant weakness in the Trust's financial sustainability arrangements, primarily concerning its ability to effectively manage and close budget gaps.

We recommend that the Trust strengthens its efficiency programmes and cost-saving initiatives to ensure they are robust, effective, and capable of mitigating identified financial risks. These measures should be an ongoing process, enabling the identification and development of savings, efficiency and transformational plans on a rolling basis. Failure to address these issues may adversely impact the Trust's long-term financial sustainability and, ultimately, its ability to deliver services effectively.



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Areas reviewed

- how the body monitors and assesses risk and how the body gains assurance over the effective operation of internal controls, including arrangements to prevent and detect fraud;
- how the body approaches and carries out its annual budget setting process;
- how the body ensures it makes properly informed decisions, supported by appropriate evidence and allowing for challenge and transparency. This includes arrangements for effective challenge from those charged with governance/audit committee; and
- how the body monitors and ensures appropriate standards, such as meeting legislative/regulatory requirements and standards in terms of officer or member behaviour (such as gifts and hospitality or declarations/conflicts of interests), and for example where it procures or commissions services.

Commentary

The Trust's Internal Audit function is outsourced to RSM, with oversight provided by the Head of Internal Audit. The audit approach is risk-based and informed by the Trust's strategic objectives, risk profile, and assurance framework.

The Trust maintains a system of internal control, supported by risk management processes, internal audit, counter-fraud arrangements, and compliance monitoring. The Audit and Risk Committee provides independent oversight and receives regular assurance on governance, risk management, and the effectiveness of internal controls.

The Head of Internal Audit opinion for 2025/26 confirms that 'The organisation has an adequate and effective framework for risk management, governance and internal control. However, they noted that their work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective.'

For 2025/26, Internal Audit carried out eleven reviews. Four audit reviews produced a reasonable assurance rating; five produced partial assurance rating, one produced a limited assurance rating, and the review of the Cyber Assessment Framework rating was High Risk (ie between 2 and 4 outcomes not meeting the minimum achievement levels) with a High Confidence rating (low level of no deviation) between the self assessment and the review findings).



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One area of note relates to medical appraisal processes, where limited assurance was reported. Key issues included weaknesses in training of appraisers, data integrity, record-keeping, and governance arrangements. Progress has been made to address these findings, with most actions implemented and only one remaining in progress. Therefore, no significant weakness is reported from our end concerning this issue.

The Audit and Risk Committee provides independent oversight and receives regular assurance on governance, risk management, and control effectiveness. We note through our review of various Audit and Risk committee minutes that the Internal audit function engage frequently with the Trust management on the status of management actions through progress reports. These reports include overdue actions, management actions closed and not yet due.

Risk management is supported by the Risk Management Strategy. Arrangements include monthly meetings to identify and discuss risks and related controls for inclusion on local/divisional risk registers; Corporate Directorate meetings/Divisional Boards for monitoring risk management and approving escalation/de escalation of risks to a corporate risk register; identification of Risk Leads and Approving Managers to manage and approve risks operationally; identification of divisional Governance/Audit Leads and Quality Managers with responsibilities for facilitating risk management a divisional level. Risks are escalated to a Corporate Risk Register and BAF based on assessed risk scores and relevance to the Trust's strategic priorities.

The BAF is considered at other Board Committees including Finance, Performance and People Committee.

The Trust has an anti-fraud and bribery policy in place approved by Board. It has an accredited Local Counter Fraud Specialist (LCFS), provided by RSM in addition to internal audit services, with a programme of proactive counter fraud and corruption work which is risk based. The LCFS reports to the Audit and Risk Committee.



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We have not noted any specific review performed in year by Care Quality Commission (CQC). We have however reviewed the Trust's CQC Well Led and Core Service Action Plan which came from the unannounced CQC and well-led inspection in 2023 and we confirmed that the Trust actively was tracking their progress against the recommendations made by CQC.

We noted that all outstanding recommendations were listed as completed.

Monthly financial reporting provides timely, accurate management information to budget holders and governance committees. Integrated performance reports combine financial, operational, and quality metrics to support informed decision-making. Variances are investigated promptly, with corrective actions monitored through performance management processes.

Budgetary control is primarily exercised through monthly finance reporting and Integrated Performance Reports, which incorporate both financial delivery against plan and wider non-financial performance indicators.

Decision-making is supported by structured governance processes requiring business cases with financial analysis, risk assessment, and expected benefits. Committees provide independent scrutiny and challenge to ensure decisions demonstrate value for money and alignment with strategic objectives.

A role of the Board is to ensure the Trust has appropriate arrangements for ensuring it exercises its functions effectively, efficiently and economically and complies with generally accepted relevant principles of good governance. We know from our review of Board and committee papers, minutes for these meetings and our attendance at Audit and Risk Committee meetings, that the Board and its committees meet regularly and that key issues are addressed with effective challenge from members. We have also observed evidence of good arrangements in place regarding tracking and responding to the recommendations made by Internal Audit and that management has been held to account throughout the year regarding progress on recommended actions.



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The Trust promotes high standards of governance through policies covering procurement, conflicts of interest, standards of conduct, and regulatory compliance. Compliance is monitored through governance reporting and internal audit assurance.

Responsibility for ensuring appropriate standards such as meeting legislative/regulatory requirements in terms of member behaviour sits primarily with the Audit and Risk Committee. Review of the effectiveness and compliance with key policies such as gifts and hospitality, declarations/conflicts of interest are confirmed to be covered by the Counter Fraud programme.

The Trust has taken steps to respond to the new corporate offence for "failure to prevent fraud" in Economic Crime and Corporate Transparency Act 2023, including delivering "failure to prevent fraud" training for management. A fraud and bribery risk assessment has also been undertaken and continues to be monitored against identified risks. These are reported to the Audit Committee through the LCFS progress report. However, it is noted that the Trust has not yet updated its fraud and bribery policy, nor all procurement policies and procedures. Updating these documents is essential to ensure full compliance.

Our review of compliance reports highlighted that The Medicines and Healthcare products Regulatory Agency (MHRA) inspection identified serious deficiencies within the Lister Hospital Quality Control Laboratory, including a critical failure to ensure analytical methods were properly validated, meaning test results cannot be reliably assured.

MHRA raised a number of other matters in relation to investigating deviations, incomplete equipment validation, data integrity, ineffective implementation of previously agreed corrective actions, as well as gaps in the self-inspection programme. Management promptly addressed all identified issues. Following the inspection, management worked quickly to address all of the matters raised resulting in MHRA closing the inspection process as at 19 March 2026 and concluding that the Trust's arrangements were in line with the GMP requirements.

Fixed Asset Verification

In the prior year, Internal Audit raised a finding regarding the Key Financial Controls in particular, the fixed asset verification. The last full verification was performed in 2019. There was a risk that the Trust was lacking effective arrangements to maintain an accurate fixed asset register.



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At year end, we confirmed with management of the audited entity and through the inspection of the Internal Audit reports in April, that the Trust had completed a physical verification exercise to confirm the existence and location of its assets. Management also provided evidence that a formal process had been documented for undertaking regular future physical verification exercise.

ENH Pharma Ltd stock discrepancy:

We confirmed that ENH Pharma employees were not receiving the Combo CC report that indicates the drug issued which is used for invoicing purposes. Instead, these reports were received by Trust employees, who manually adjusted drug issue pricing in the Combo CC report to reflect reimbursable contract prices rather than actual purchase costs. This was particularly relevant for branded drugs purchased when generic alternatives were unavailable.

The Trust commissioned KPMG to review the design of controls and processes and to recommend improvements. The BDO audit team confirmed that the mailing list for the drug issue reports had been updated to include ENH Pharma employees. The KPMG report was finalised close to year end on 24 March 2026, and an action plan was drafted by the Trust to address the deficiencies identified.

The Trust has not, as noted in our Audit Completion Report, undertaken a similarly detailed piece of work to reconcile its own drugs expenditure to the pharmacy stock system.

Medical Appraisals:

Based on our reviews and internal audit reports report and management's actions, appropriate arrangements are now in place to mitigate the risks associated with medical appraisals. Management has implemented the majority of the agreed actions, with only limited items remaining in progress. Overall, this demonstrates significant improvement in the control framework and oversight of the medical appraisal process.

Front Entrance Project:

Based on our review, the Trust have now demonstrated in in-depth consideration of the accounting and financing considerations associated with the project.

However, while some of this was done at the preparatory stages, as was the overall evaluation of the feasibility of the project, much of the accounting and financing considerations were based on information from financial advisors introduced to the Trust by the Developer, rather than being independently procured to challenge the proposed accounting treatment and protect the Trust's interests.



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In discussion during the audit Management were able to provide us with a range of documents and assessments which supported the proposed treatment.

Any arrangement which is based on a 40-year horizon ultimately carries significant uncertainty. As at the time of this memo the Front Entrance is still being physically built. The accounting treatment rests upon the Trust having no liability for payment of the fees due to the Developer over the life of the scheme and while the documents reviewed indicate that the parties involved have signed leases enabling the to occupy premises for the full 40 years, there are break clauses after 15 years. Therefore, it is imperative that the Trust is able to monitor the financial performance on the site regularly to understand the relative risk of it having to step into the arrangement during its lifetime. There are a number of examples in local government where organisations have entered into long term capital developments, which have, as a result of changes in the economic environment, become financial liabilities.

The Trust will need to ensure that robust project management arrangements for the development are in place, and for monitoring ongoing commercial viability and risk associated with the project, including ensuring the associated accounting treatment, remains up-to-date.

Conclusion

The Trust had sufficient arrangements in place to make informed decisions and properly manage its risks.



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Areas reviewed

- how financial and performance information has been used to assess performance to identify areas for improvement;
- how the body evaluates the services it provides to assess performance and identify areas for improvement;
- how the body ensures it delivers its role within significant partnerships and engages with stakeholders it has identified, in order to assess whether it is meeting its objectives; and
- where the body commissions or procures services, how it assesses whether it is realising the expected benefits.

Commentary

The Trust utilises integrated dashboards that combine financial, operational, and quality indicators to monitor performance and support the identification of improvement opportunities. Benchmarking and trend analysis are used to inform service redesign and efficiency initiatives where appropriate.

The Board receives regular financial and non-financial performance information, primarily through the Integrated Performance Report and highlight reporting from the Finance, Performance and Planning Committee (FPPC).

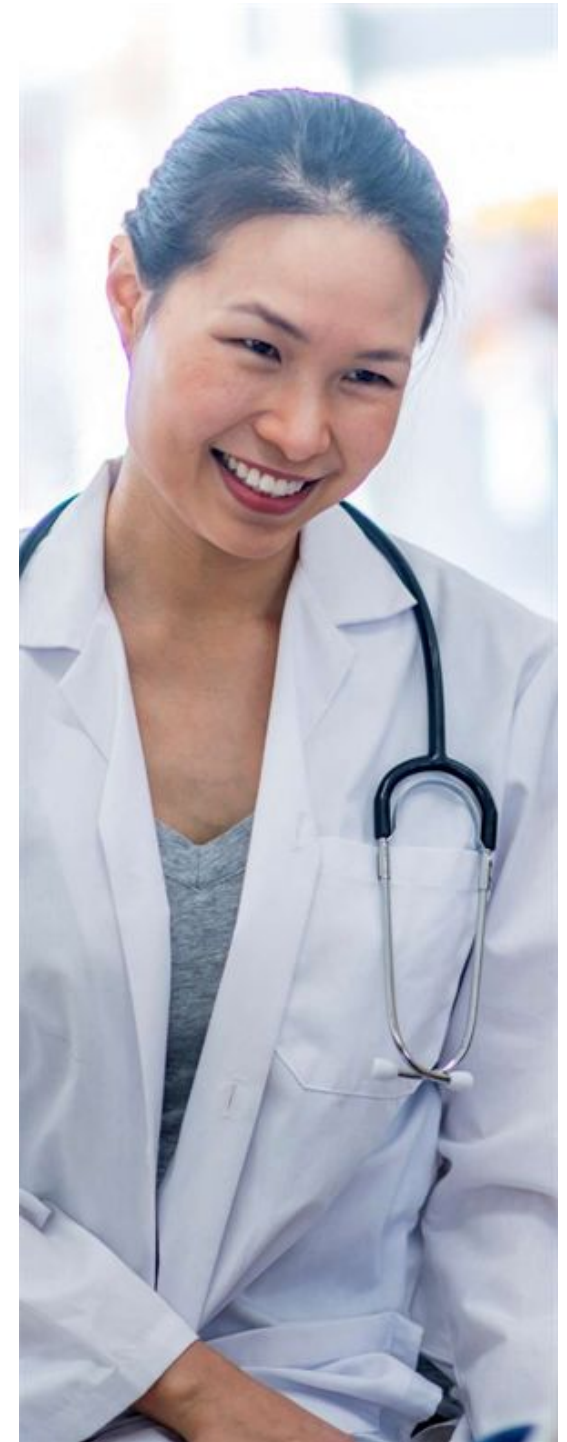
These reports enable the Board and its committees to scrutinise performance and challenge management where there are variances from plan or expected outcomes. Supporting narrative is included to explain material variances and outline management actions, allowing the Board to monitor progress and identify areas requiring further attention.

The internal audit programme is designed to provide coverage across the Trust's key functions on a cyclical basis. The 2025/26 plan reflects this approach, supporting independent review of controls and processes across a range of operational and financial areas.

Service performance is evaluated through audit, outcome measures, benchmarking, and patient feedback. Findings inform continuous improvement, transformation programmes, and investment decisions.

The Trust is required to report on the quality of its services against performance indicator targets throughout the year, resulting in an annual quality account report.

Quality indicators against which performance is measured for reporting are wide ranging and between them require numerous systems of processes and controls



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and IT applications to record and report accurate data. Performance against a wide range of indicators was monitored through the Board's Quality and Safety Committee (QSC) and reported to the Board through regular Integrated Performance Reports.

Integrated Performance reporting provided graphical dashboards for clear illustration of performance trends and also provided commentary on key issues identified and executive responses to aid Board scrutiny. Monitoring the Integrated Performance report at public Board level demonstrated clear accountability for improvement and arrangements in place to secure these improvements.

The Trust set four broad priorities for improvement linked to its "vision and values to 2030" and it has a programme of measures for progress across themes within its priorities for improvement. The four Strategic Themes are used to underpin other key frameworks in use at the Trust, for example, the Board Assurance Framework.

Procurement processes are aligned with established regulatory frameworks and supported by clear business cases, defined outcomes, and appropriate performance monitoring arrangements. Post-implementation reviews are undertaken where relevant to assess the delivery of expected benefits and value for money.

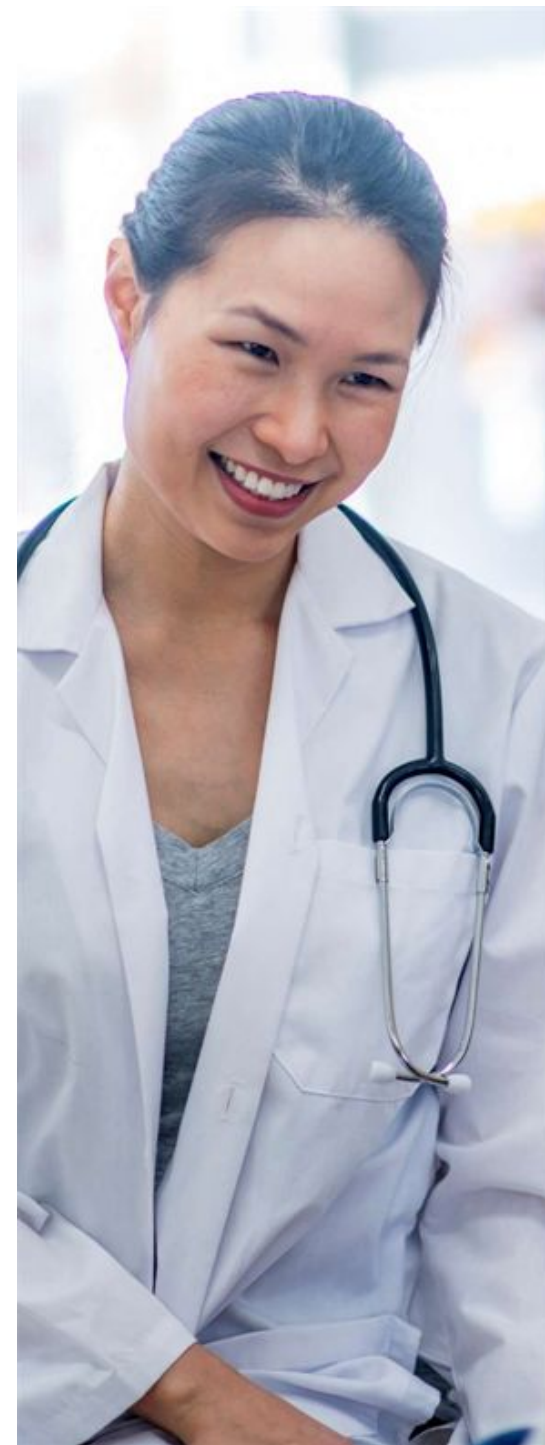
The ICS Procurement Service provides procurement support to the five Provider Trusts within the Hertfordshire and West Essex Integrated Care System. The Finance, Performance and Planning Committee (FPPC) receives periodic updates on procurement activity and delivery, supporting oversight and accountability.

The internal audit programme is designed to provide coverage across the Trust's key functions on a cyclical basis. The 2025/26 plan reflects this approach, supporting independent review of controls and processes across a range of operational and financial areas.

Mount Vernon Cancer Centre

Our review confirmed that there remains uncertainty regarding the transfer of cancer services to UCLH.

The preferred option—reprovision of services at Watford, was identified as the only option that is clinically viable, sustainable, and acceptable to various stakeholders. This option has been presented for public consultation alongside alternatives involving additional networked radiotherapy provision at either Lister Hospital (Stevenage) or Luton and Dunstable Hospital (Luton).



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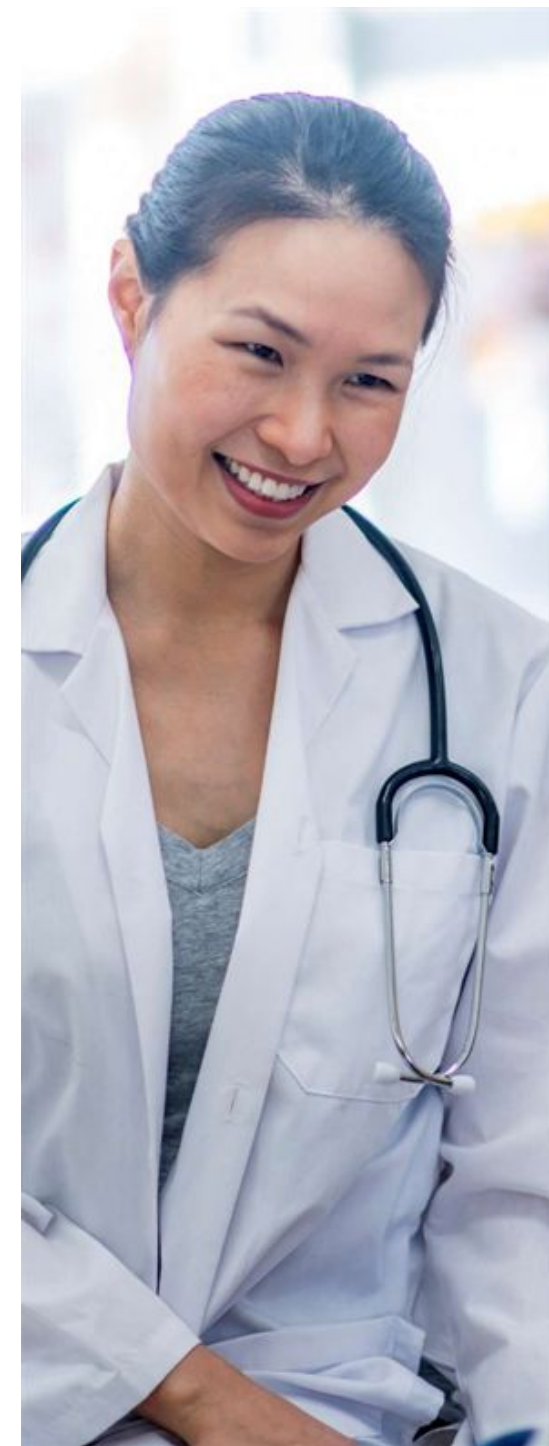
Commissioners of MVCC services, under the oversight of the Programme Board, will develop the Decision-Making Business Case (DMBC) in collaboration with key stakeholders. The DMBC is expected to be reviewed by the end of September 2026.

In the interim, planning concerning the move remains short-term, with a year-to-year approach and no defined long-term position beyond the forthcoming decision point. The Trust is progressing the next phase of the Fabric Improvement Programme, expected to require £5m-£6m investment to maintain the current facility. This is subject to approval from NHSE/DHSC.

We therefore conclude that there is no significant weakness.

Conclusion

We have not identified any significant weaknesses in arrangements to ensure the Trust improves economy, efficiency and effectiveness. The Trust makes use of performance and financial information in order to review and improve its processes and services. The Trust continues to work collaboratively with key partners across the ICP and ICS.



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VFM criteria	Matter identified	Significant weakness identified?	Recommendation	Type of recommendation	Management response
1 Financial sustainability	<p>The Trust has identified a £37.9 million savings target for 2026/27. As at May 2026, the Trust had not identified detailed plans for how it will make £16.6 million (44%) of these savings.</p> <p>This matter is evidence of a significant weakness in the Trust’s arrangements for financial sustainability, in that the Trust did not have adequate arrangements in place to bridge its funding gaps and identify achievable savings</p>	Yes	We recommend that the Trust strengthens its efficiency programmes and cost-saving initiatives to ensure they are robust, effective, and capable of mitigating identified financial risks. These measures should be identified and developed at an early stage to allow sufficient time for implementation. .	Significant	<p>Management agrees with the recommendation and recognises the importance of delivering a robust and sustainable efficiency programme to support the Trust's financial position.</p> <p>At the start of the financial year, a significant proportion of the savings target had already been identified and approved, with further opportunities under development. Management acknowledges the remaining gap and continues to work closely with clinical and corporate divisions to identify, validate and deliver additional recurrent efficiencies.</p> <p>The Trust has established governance arrangements to oversee the development, approval and monitoring of efficiency schemes, including regular review through divisional performance meetings, executive oversight groups and Board reporting.</p> <p>(continued overleaf)</p>

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VFM criteria	Matter identified	Significant weakness identified?	Recommendation	Type of recommendation	Management response
1 Financial sustainability	<p>The Trust has identified a £37.9 million savings target for 2026/27. As at May 2026, the Trust had not identified detailed plans for how it will make £16.6 million (44%) of these savings.</p> <p>This matter is evidence of a significant weakness in the Trust's arrangements for financial sustainability, in that the Trust did not have adequate arrangements in place to bridge its funding gaps and identify achievable savings</p>	Yes	We recommend that the Trust strengthens its efficiency programmes and cost-saving initiatives to ensure they are robust, effective, and capable of mitigating identified financial risks. These measures should be identified and developed at an early stage to allow sufficient time for implementation.	Significant	<p>Savings opportunities are subject to assessment to ensure that they are achievable, sustainable and do not adversely impact patient safety, quality of care or operational performance.</p> <p>Work will continue throughout the year to strengthen the pipeline of opportunities, accelerate the identification of schemes at an earlier stage of the planning cycle and improve forecasting and delivery monitoring. The Trust remains committed to reducing the unidentified gap and maintaining financial sustainability whilst continuing to deliver high-quality services for patient.</p>

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VFM criteria	Matter identified	Significant weakness identified?	Recommendation	Type of recommendation	Management response
1 Governance	Front Entrance Project	No	The Trust will need to ensure that robust project management arrangements for the ongoing construction is in place, and for monitoring ongoing commercial viability and risk associated with the project, including associated accounting treatment, remains up-to-date.	Other	<p>Management agrees with the recommendation. The Front Entrance Project is subject to established project governance arrangements, including regular oversight of project delivery, costs, risks and programme milestones. The Trust recognises the importance of maintaining robust controls throughout the remaining construction phase and ensuring that any emerging risks are identified and managed promptly.</p> <p>The project will continue to be monitored through the appropriate governance structure, with regular reporting to senior management and relevant committees. Commercial viability, contractual commitments and project risks will be reviewed on an ongoing basis to ensure that appropriate mitigating actions are implemented where required.</p> <p>Finance will continue to work closely with the project team and external advisors, as appropriate, to ensure that the accounting treatment of project costs remains accurate, supported and compliant with relevant accounting standards and NHS guidance. This will provide ongoing assurance over both the delivery and financial management of the project.</p>

Prior year recommendations

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VFM criteria	Matter identified	Significant weakness identified?	Recommendation made in prior year	Type of recommendation	Our view as to whether recommendation has been implemented satisfactorily
1 Financial sustainability	<p>The Trust set itself a target of making £35 million of cost savings in 2025/26. By May 2025 the Trust had not identified detailed plans for how it will make £12 million (34%) of these savings.</p> <p>This matter is evidence of a significant weakness in the Trust's arrangements for financial sustainability, in that the Trust did not have adequate arrangements in place to bridge its funding gaps and identify achievable savings.</p>	Yes	We recommended that the Trust ensure its efficiency programmes and cost-saving measures are robust, effective to mitigate these risks and identified early enough for implementation.	Significant	Unsatisfactory

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VFM criteria	Matter identified	Significant weakness identified?	Recommendation made in prior year	Type of recommendation	Our view as to whether recommendation has been implemented satisfactorily
2 Governance	Physical assets verification - some assets could not be easily traced back to the fixed assets register.	No	We recommend that management implement processes which will enhance the tracking of assets and a more accurate fixed asset register.	Other	Satisfactory

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Additional reporting responsibility	Action taken
<p>1 We are required to report if we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which would, if followed to its conclusion, be unlawful and likely to cause a loss or deficiency.</p>	<p>We referred a matter on 25 June 2026, to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 in relation to Trust's cumulative deficit as at 31 March 2026, and because Trust does not have credible plans that would enable it to return to a breakeven position by 31 March 2029.</p>
<p>2 We are required to report on whether those disclosures subject to audit within the Remuneration and Staff Report have been properly prepared in accordance with the requirements of the Department of Health and Social Care's Group Accounting Manual 2025/26.</p>	<p>In our opinion, the auditable parts of the Remuneration and Staff report had been properly prepared.</p>
<p>3 We are required to report by exception if the Trust's Governance Statement is materially inconsistent with the financial statements, or our knowledge obtained in the course of the audit or otherwise appears to be materially misstated.</p>	<p>In our opinion, the Trust's Governance Statement is not materially inconsistent with the financial statements, or our knowledge obtained in the course of the audit or otherwise appears to be materially misstated.</p>

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<p>4 We are required to report on whether the financial and non-financial information in the Annual Report not subject to audit is consistent with the financial statements and the knowledge acquired by us in the course of our audit.</p>	<p>We are satisfied that the other information in the Annual Report not subject to audit is consistent with the financial statements and our knowledge.</p>
<p>5 We are required to report by exception if we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014.</p>	<p>We did not issue a report in the public interest.</p>
<p>6 We are required to report by exception if we make a written recommendation to the Trust under section 24 of the Local Audit and Accountability Act 2014.</p>	<p>We did not make a written recommendation to the Trust.</p>
<p>7 We are required to certify the completion of the audit. The effect of the certificate is to close the audit. This marks the point when the auditor's responsibilities in respect of the audit of the period covered by the certificate have been discharged. There may be occasions when the auditor is able to issue the audit report on the financial statements but cannot certify completion of the audit.</p>	<p>We cannot formally conclude the audit and issue an audit certificate until we have received confirmation from the National Audit Office that the Department of Health and Social Care group audit has been certified by the Comptroller & Auditor General and therefore no further work is required to be undertaken in order to discharge the auditor's duties in relation to consolidation returns under the Code.</p>

FOR MORE INFORMATION:

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The matters raised in our report prepared in connection with the audit are those we believe should be brought to your attention. They do not purport to be a complete record of all matters arising. This report is prepared solely for the use of the company and may not be quoted nor copied without our prior written consent. No responsibility to any third party is accepted.

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Board committee report

Meeting	Public Trust Board			Agenda Item	16
Report title	Quality and Safety Committee report to Board 27 May 2026 and 24 June 2026			Meeting Date	8 July 2026
Chair	Dr. David Buckle – Non-Executive Director - East and North Herts NHS Trust				
Author	Corporate Governance Officer/ David Buckle, Chair, QSC				
Quorate	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	
Alert (Matters of concern or key risks to escalate to the Board):					
<ul style="list-style-type: none"> • Complaints: The Committee reported an increase in both the number (50% over 2 years) and complexity of complaints, alongside ongoing challenges in meeting response times. (Proportion of responses within agreed time a low at 30%) It was noted that staffing capacity and delays in clinical input were contributory factors. This was recognised as an area requiring continued attention to support improvements in patient experience. • The following 3 were provided by PSSC: <ul style="list-style-type: none"> ○ Assurance rating: An assurance rating was not given to the comprehensive PSII/MNSI status report, reflecting the need for additional information to significantly improve the timeliness of undertaking, completing and reporting on PSII's to evidence reliable organisational learning & improvement. A detailed summary table will continue to form part of regular assurance papers to monitor impact of improvements. ○ Corporate risk register: The CRR, was recognised as presenting multiple outstanding significant risks to patient safety with to date no decisions had been taken to address. Recognition was given to the sustained progress being made to refine the detail within the CRR and the commitment to a single register of high scoring risks. ○ Unplanned care: We were unable to assess the effectiveness of Unplanned Care Division Safety Fora due to the lack of evidence available. Support will be provided to the Director of Nursing – Unplanned Care, to enable a detailed assurance report to be presented at the next meeting. ○ 					
Assurances provided to the Board:					
<ul style="list-style-type: none"> • Environmental Cleanliness and Estate Standards: The Committee was assured that the recent external review (2nd April) had been broadly positive, with strong staff engagement and clear commitment to improvement. It was reported that a range of actions were in progress, including enhanced auditing, training, and strengthened cleaning processes, and that this area would remain subject to ongoing review. (Note- cleanliness was originally noted to be worse than average in a 2024 review). • Governance and PSII Oversight: The Committee was assured that governance systems remained operational and that oversight of PSII investigations continued across the organisation. It was reported that, whilst pressures were emerging, mechanisms were in place to manage cases and that further monitoring would ensure continued effectiveness. • The Patient Safety Sub Committee (PSSC) met on two occasions and provided the Board with detailed and comprehensive reports. The individual minutes and a chairs escalation report providing assurance. The resulting 4 PSII's will be considered at the next Trust Private Board along with a highlight report provided by the subcommittee chair. 					

- 27 May extract of PSSC escalation report (Agreements and actions held back until after Board discussion)
 - Assurances provided to the Board from PSSC:
 - The Chief Nurse offered a transparent and timely update of all emerging patient safety concerns not otherwise captured in reports.
 - Reasonable Assurance ratings were given to the Divisions of W&C & Cancer regarding the effectiveness of Safety Forum and wider governance arrangements. It was agreed that all papers evidenced significant assurance of process, with overall assurance levels modified due to the absence/limitation of actions taken to address longstanding risks recorded on the CRR.
 - A high quality and insightful intelligence report was received from Safeguarding.
 - FTSU intelligence indicated that staff were using established mechanisms for escalating concerns regarding patient safety issues rather than needing to use FTSU routes.
 - Observations arising from a range of NED clinical visits aligned with evidence available from formal assurance reports.

- 8th June the papers summarising the death of a patient with peritonitis will go to the Trust Board for discussion and learning. However, a thorough review by PSSC was provided to QSC and the findings and recommendations are to be discussed at private Board without any alteration by QSC. Assurance was also provided as regards two more investigations.
 - Assurances provided to the Board from PSSC:
 - The PSSC scrutinised the MNSI investigation into the death of a baby and was Substantially Assured by the findings which concluded that antenatal care, homebirth planning, escalation following identification of meconium, transfer arrangements, intrapartum management, neonatal resuscitation and initiation of therapeutic cooling were broadly consistent with national and local guidance. No single clinical error was identified as causative of the outcome. The PSSC concluded that the principal learning related to organisational systems supporting clinical care rather than individual clinical performance.
 - The PSSC scrutinised the MNSI investigation into the death of baby and was Significantly Assured that the investigation had been undertaken swiftly and that the majority of direct clinical care was found to be appropriate. PSSC concluded that the principal learning arises from organisational and system factors, particularly the governance of cross-boundary maternity pathways.

- Maternity Services – Oversight and Improvement: The Committee was assured that maternity services were subject to robust oversight, with actions in place to address workforce, capacity and clinical challenges. It was reported that learning from recent incidents was being actively progressed, alongside engagement with external review processes where appropriate.
- Gynaecology review of quality and patient experience. The service has been experiencing significant pressures and that's been reflected in the patient experience. QSC found the work programs and review very helpful but there is more to be done and therefore rated this partial assurance.
- Variation in Care, Including Out-of-Hours: The Committee was advised that variation in care delivery had been recognised and was being addressed through ongoing work to improve oversight and consistency. It was reported that this would form part of continued improvement activity across services.
- Violence and Aggression: The Committee noted that a structured programme of work had been established, including a multidisciplinary steering group, targeted training and hotspot analysis. (It was noted that face to face de-escalation training had started.) It was reported that further detailed work was planned ;-see below
- Maintaining quality with financial pressures and digital frailty: QSC welcomed the CEO and CIO who presented a paper on One EPR delay risk mitigation. The balance of

<p>money(cost) and quality was discussed and the seeking of opportunities when efficiency could improve outcomes. The committee was also assured that the clinical risks as a result of the delay in One EPR had been reviewed and where possible responded to in a prioritised approach.</p> <ul style="list-style-type: none"> • A transformation update was discussed. QSC found the plans clear and comprehensive but remained concerned about progress • Community Paediatric update was welcomed by QSC. It gave good assurance that the present initiatives were making a difference to the service. However, it was recognised that the long-standing high level of demand was not likely to change, and the committee was concerned that waits would still be a problem in a few years time. • QSC gained substantial assurance from the learning from death report
<p>Advise (Matters the Board should be aware of not covered above e.g. on-going monitoring, new developments etc):</p> <ul style="list-style-type: none"> • Quality Reporting and Performance Framework: The Committee noted that the Safe and Effective Care report continued to provide a comprehensive source of assurance. It was advised that further development was planned to strengthen the report through the introduction of trajectories and benchmarking, to support more forward-looking oversight. • Stroke Service Improvements: The Committee noted ongoing improvements within stroke services, particularly in thrombolysis performance. The rate has been around 20% on the last 3 occasions this year which is excellent. It was reported that further developments, including MRI capacity expansion and participation in regional initiatives, were in progress, although benefits would take time to be fully realised. • Digital Developments in Women’s Services: The Committee noted progress towards a digital options paper for Women’s and Children’s services. It was reported that, whilst some improvements had been made, certain system issues remained under review and would require continued monitoring. • QSC noted the good work undertaken by our Organ donation team • QSC noted the value to patients and the Trust of our significant research work involving over 4,000 patients. • The following were provided by PSSC: <ul style="list-style-type: none"> ○ A formal Patient Safety Strategy has not yet been published, with the intent that this form part of the Quality Strategy to be considered by the board in October 2026, with the PSSC being actively engaged in the development of the Quality Strategy. ○ The report of the PSII Waiting List Thematic Review was considered alongside additionally requested information to clarify aspects of the timeline and clarification on the delays in escalation. Further discussions are scheduled in June prior to assurance being confirmed. ○ Variation across Divisions indicated potentially inconsistent implementation of safety systems across the trust. Generally, safety training compliance was improving, with further information requested from planned and unplanned care divisions. ○ Multiple sources of assurance evidenced that risks to patient safety are well understood but not consistently mitigated or reduced. Intelligence from safety walkabouts/audits aligned with other sources.
<p>Decisions made by the committee or major actions commissioned and work under way:</p> <ul style="list-style-type: none"> ○ Violence and Aggression – Deep Dive Commissioned: The Committee requested that a detailed deep dive be undertaken within four to six months, with clear linkage to equality, diversity and inclusion work, and interim updates provided to the Chair. The committee was also keen to understand the relationship (if any) between the consistent drop in security related incidents and reports of violence and aggression (steady reported levels). ○ Patient Engagement Follow-Up: The Committee requested a follow-up report regarding a patient’s story previously presented at Board, in order to provide assurance on actions taken. ○ Orthotics Service – Further Assurance Requested: The Committee agreed that a

<p>clear summary update should be brought back in July and include timelines, escalation pathways and progress on patient prioritisation and triage. QSC was concerned as the complete clinical picture was not yet evident due to limited service capacity and backlog complexities.</p>	
<p>Any actions recommended to improve effectiveness of the meeting:</p>	
<ul style="list-style-type: none"> • Clarity and Usability of Reporting: The Committee noted that, whilst reports were comprehensive, further development could improve clarity and usability, particularly through the inclusion of trajectories and benchmarking. It was considered that this would support more effective discussion and decision-making. • Depth of Assurance in Key Risk Areas: The Committee reflected that in some areas, particularly those with limited assurance, clearer articulation of timelines, risks and mitigation plans would support more effective scrutiny. It was suggested that concise summary updates may improve the Committee’s ability to provide oversight. 	
<p>Recommendation</p>	<p>The Board is asked to NOTE the report from the Committee.</p>

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Board committee report

Meeting	Finance, Performance and Planning Committee.		Agenda Item	17
Report title	Finance, Performance and Planning Committee Board report May 2026		Meeting Date	8 July 2026
Chair	Richard Oosterom – Non-Executive Director			
Author	Committee Secretary			
Quorate	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>
Alert (Matters of concern or key risks to escalate to the Board):				
<ul style="list-style-type: none"> • Risk of structural financial deterioration and weak recovery plan credibility. • £0.8m adverse variance vs plan and £27.5m unidentified CIP gap • Diagnostics bottlenecks (MRI capacity, workforce gaps) • Cancer performance dipped, recovery expected in June • Community midwifery digital gaps affecting patient safety and data quality. 				
Assurances provided to the Board:				
National Cost Collection:				
<ul style="list-style-type: none"> • Submission on track with governance (CFO delegated approval) 				
Procurement:				
<ul style="list-style-type: none"> • Savings exceeding target and costs below budget 				
Capital Programmes:				
<ul style="list-style-type: none"> • Good pro-active approach of portfolio management and resource management. 				
Advise (Matters the Board should be aware of not covered above e.g. on-going monitoring, new developments etc):				
<ul style="list-style-type: none"> • Industrial action and operational disruption affecting performance. <p>Increasing reliance on diagnostics outsourcing</p> <ul style="list-style-type: none"> • Accelerate CIP identification and financial recovery actions • Strengthen PTL validation and performance recovery 				
Decisions made by the committee or major actions commissioned and work under way:				
<ul style="list-style-type: none"> • Baxter SLA approved despite late paper • Establish sickness taskforce and targeted interventions; governed by People Committee. 				
Any actions recommended to improve effectiveness of the meeting:				
<ul style="list-style-type: none"> • Increase focus on delivery progress, clarity on trajectories and measurable impact • Maintain strong scrutiny on key risks 				
Recommendation	The Board is asked to DISCUSS the report from the Committee.			

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Board committee report

Meeting	Public Trust Board		Agenda Item	18
Report title	People and Culture Committee Board Report June		Meeting Date	8 July 2026
Chair	Janet Scotcher – Non-Executive Director/Committee Chair			
Author	Committee Secretary			
Quorate	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>
Alert (Matters of concern or key risks to escalate to the Board):				
<ul style="list-style-type: none"> Ongoing organisational risk relating to workforce sickness absence, which remains above target and continues to impact operational performance and financial sustainability. Delivery of the 'Return Well programme' is in place; however, sustained focus and manager capability improvement are required to ensure impact. <p>Risk identified regarding the effectiveness and consistency of the business partnering model, including:</p> <ul style="list-style-type: none"> Variation in delivery across divisions Lack of clarity in role expectations Reduced visibility linked to agile working. <p>Strategic risk associated with implementation of the Mann Review recommendations, including:</p> <ul style="list-style-type: none"> Complexity in applying definitions of antisemitism and anti-Muslim hostility Potential inconsistency in interpretation Data capture and monitoring limitations Balancing staff inclusion with patient experience and external scrutiny 				
Assurances provided to the Board:				
<ul style="list-style-type: none"> Policy compliance has improved to 93%, demonstrating strengthened governance and oversight. Return well programme is in place with a clear governance structure which provides reasonable assurance of progress to reduce sickness absence levels. Inclusive recruitment programme progressing, with improved shortlisting guidance and an ongoing audit of interview and selection practices Freedom to speak up arrangements provide reasonable assurance with an increase in speaking up activity and established governance and reporting Whistleblowing implementation plan is robust supported by comprehensive communications and training roll-out and clear success measures and monitoring arrangements in place. 				
Advise (Matters the Board should be aware of not covered above e.g. on-going monitoring, new developments etc):				
<ul style="list-style-type: none"> Requirement for a cultural shift in business partnering, including: Moving from reactive “reporting” to proactive, real-time engagement Strengthening relationships with frontline services 				

<ul style="list-style-type: none"> • Designing services based on organisational need rather than role structures. <p>Impact of agile working remains a key consideration:</p> <ul style="list-style-type: none"> • Benefits recognised, but challenges identified in visibility, collaboration, and team cohesion • Need to achieve a better balance between flexibility and presence • Continued development required in relation to equality, diversity and inclusion, including: • Implementation of Mann Review recommendations • Measurement of impact and outcomes • Ensuring consistent and fair application across the organisation • Staff survey feedback highlights ongoing workforce concerns relating to workload and burnout, leadership and communication with a need to shift towards continuous engagement and improved communication approaches. 	
<p>Decisions made by the committee or major actions commissioned and work under way:</p>	
<ul style="list-style-type: none"> • Support to progress development of a strengthened business partnering model, including: • Support for continued rollout of the Return Well programme, including further evaluation and monitoring • Support in principle for Mann Review recommendations, with further work required prior to formal Board approval • Agreement to continue policy compliance improvements and incorporate lessons learned into reporting • Endorsement of ongoing inclusive recruitment improvements, including strengthening governance and accountability • Approval and support for Whistleblowing implementation plan and associated training programme • Support for strengthening Freedom to speak up culture, including earlier use of mediation and increased support for speak up champions. 	
<p>Any actions recommended to improve effectiveness of the meeting:</p>	
<ul style="list-style-type: none"> • Reinforce requirement for all papers to include coversheets to ensure clarity, consistency, and effective governance • Improve visibility of forward plans and policy updates to ensure all members are aware of upcoming changes • Continue to enhance quality and consistency of reporting, including: • Clear articulation of impact and outcomes • Inclusion of lessons learned where appropriate. 	
<p>Recommendation</p>	<p>The Board is asked to DISCUSS the report from the Committee.</p>

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Board committee report

Meeting	Public Trust Board		Agenda Item	19
Report title	ENH Health Care Partnership Committee report to Board - 5 June 2026		Meeting Date	8 July 2026
Chair	Martin Armstrong, Chief Executive			
Author	Corporate Governance Officer			
Quorate	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>
Alert (Matters of concern or key risks to escalate to the Board):				
<ul style="list-style-type: none"> Financial Reporting and Data Visibility: The Board identified a significant gap in financial oversight, noting that previously available high-level financial reporting previously completed by the ICB is no longer in place due to system changes. Alongside this, there are ongoing issues with data visibility, access to dashboards, and availability of integrated reporting tools. This creates a risk that decision-making is being undertaken without sufficient financial and performance intelligence. 				
Assurances provided to the Board:				
<ul style="list-style-type: none"> Ongoing Governance Refresh to Strengthen Clarity and Alignment: Assurance was provided that the HCP governance refresh is actively progressing, with a clearer structure being developed around three core delivery groups. Further refinement is planned to ensure alignment with system priorities, improve reporting lines, and better organise interdependent workstreams. There is also a commitment to define clearer six-month deliverables to strengthen focus and accountability. Alignment of Transformation Programmes to System Priorities: The Board was assured that transformation activity is increasingly being aligned to Integrated Care Board (ICB) disease priorities. Active programmes in cardiovascular, respiratory, and children's services are continuing with strong engagement, supported by pathway redesign and targeted interventions to improve capacity and patient outcomes. An exercise is underway to match transformation programmes to available project resources. Progress in Neighbourhood Health Development: Significant assurance was provided regarding progress in the Neighbourhood Health Development Programme. Work is ongoing to establish a consistent, system-wide model, including mapping multidisciplinary team arrangements, embedding risk stratification tools, strengthening proactive care, and integrating social prescribing and voluntary sector support into neighbourhood delivery. Strengthening Patient and Community Engagement: The Board was assured that work is underway to strengthen patient voice within the partnership. This includes exploring the establishment of a patient panel, aligning with existing engagement structures, and working with patient forums and community groups to ensure meaningful co-production in service design. 				

<ul style="list-style-type: none"> Strong Engagement from the VCFSE Sector: Feedback from the VCFSE Alliance Conference provided assurance of strong engagement and alignment between the voluntary sector and system priorities. The sector is actively contributing to prevention, population health management, and demand reduction, and is being recognised as a strategic partner in delivery. 	
Advise (Matters the Board should be aware of not covered above e.g. on-going monitoring, new developments etc):	
<ul style="list-style-type: none"> Ongoing Strengthening of VCFSE Integration: The VCFSE Alliance continues to develop its role within the system, including plans to establish thematic groups and strengthen links with system partners. The Board should note that further work is planned to embed VCFSE involvement more fully into service design, referral pathways, and decision-making processes. Neighbourhood Model Still in Design Phase: The design of neighbourhood footprints and the development of a consistent delivery model remain in progress. While a hybrid footprint model is emerging as a preferred option, final decisions have not yet been confirmed and further work is needed to define implementation details and ensure system-wide consistency. 	
Decisions made by the committee or major actions commissioned and work under way:	
<ul style="list-style-type: none"> Action to Update Declarations of Interest Process: The Board agreed that the Declarations of Interest process requires updating and commissioned reissue of revised forms, alongside follow-up to ensure completion by members and alignment with current system structures. Direction to Strengthen Outcomes and Impact Reporting: The Board set a clear expectation that future reporting should move beyond activity updates and demonstrate measurable impact through defined outcomes, metrics, and timelines. This establishes a shift towards greater accountability and performance monitoring. 	
Any actions recommended to improve effectiveness of the meeting:	
<p>Action on Improving Financial Reporting and Data Visibility: The meeting highlighted limitations in financial reporting and data visibility. To improve effectiveness, it was recommended that regular, standardised financial and performance reports are reinstated, supported by clear dashboards and accessible system-wide data. This will enable more informed discussion and reduce time spent addressing gaps in information during meetings.</p> <p>Improve Risk Reporting Clarity and Usability: The risk log was noted as complex and unclear. It was recommended that risk reporting be simplified, with clearly defined risks, transparent scoring methodology, and concise mitigation actions, enabling the Board to focus on key strategic risks rather than interpreting the framework.</p>	
Recommendation	The Board is asked to NOTE the report from the Committee.

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Board committee report

Meeting	Public Trust Board	Agenda Item	20
Report title	Digital Committee Report to the Board for 11 May 2026	Meeting Date	11 May 2026
Chair	Richard Oosterom, Committee Chair		
Author	Governance Business Administrator		
Quorate	Yes	<input checked="" type="checkbox"/>	No <input type="checkbox"/>
Alert (Matters of concern or key risks to escalate to the Board):			
<p>OneEPR Programme Delivery and Assurance: The Committee expressed significant concern regarding the continued delays to delivery of the OneEPR Programme and the impact these delays are having on organisational confidence in the programme's ability to deliver against previously agreed timescales. Members noted the pattern of revised implementation dates and the continued absence of sufficiently mature and reliable delivery plans across all programme milestones. At the time of the meeting, approximately 45% of supplier delivery dates remained unconfirmed, limiting the Trust's ability to undertake effective operational planning and manage key programme dependencies.</p> <p>The Committee acknowledged the considerable work being undertaken by the executive team to strengthen programme governance, intensify oversight of supplier performance and implement mitigations to address emerging clinical and operational risks. However, members concluded that further improvements in delivery certainty, contractual accountability and programme assurance remain essential.</p> <p>The Committee remains concerned that the current level of delivery certainty is not yet commensurate with a programme of this strategic importance. Whilst recognising that the assessment of alternative options has concluded that continuation of the current programme remains the least-risk and most deliverable route to achieving a strategic Electronic Patient Record, the Committee expects sustained focus on strengthening governance, supplier performance management, contractual accountability and clinical risk mitigation. Enhanced Committee oversight will continue until there is demonstrable evidence of stable, reliable and deliverable programme milestones.</p>			
Assurances provided to the Board:			
<ul style="list-style-type: none"> • Clear Prioritisation of Minimum Viable Product (MVP): The Committee was assured that the programme has been refocused on delivery of the Minimum Viable Product (MVP) as the immediate priority, with all activity aligned to maximise early safety and operational benefits. MVP is expected to deliver safer, more integrated systems, particularly within unplanned care, and both supplier and internal resources have been redirected to support its delivery. • Strengthened Programme Oversight and Challenge: The Committee received assurance that programme governance has been strengthened, with robust oversight and active challenge of supplier performance, delivery timelines and quality of outputs. Delivered functionality continues to be subject to rigorous testing and is rejected where not fit for purpose, while a more iterative development and assurance approach has been adopted to improve quality and reliability. 			

- **Targeted Mitigation of Identified Clinical Risks:** Assurance was provided that patient safety risks continue to be actively identified, assessed and managed. Priority areas, including endoscopy, pre-operative assessment and paediatric diabetes, are subject to targeted mitigation, with costed interventions and practical solutions progressing independently of the overall EPR delivery timetable.
- **Continuation of Digital Transformation Through Alternative Initiatives:** The Committee noted that wider digital transformation continues despite delays to OneEPR. A range of complementary initiatives, including ambient voice technology, AI-supported webchat, self-check-in kiosks, digital PIFU and automation projects, remain funded and are progressing to deliver incremental improvements in patient care, staff experience and operational efficiency.

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

- **Ongoing Assessment of Wider Organisational Impact:** The Committee noted that further work is underway to understand the wider organisational implications of the OneEPR delays, including the impact on other digital programmes and transformation initiatives. This work is also considering how the extended implementation period can be used productively to maximise improvements to existing systems and continue delivering benefits whilst the EPR programme progresses.
- **Increased Executive and Senior Clinical Engagement:** The Committee welcomed the sustained involvement of executive, clinical and operational leaders in programme oversight, risk management and decision-making. This enhanced level of engagement reflects the strategic importance and complexity of the programme and provides assurance that key decisions are receiving appropriate senior leadership attention.

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

- **Requirement for Firm Delivery Timelines from EPR supplier:** The Committee required the supplier to provide clearly defined and reliable delivery milestones across the MVP, Core EPR and Full EPR phases to improve planning certainty and strengthen accountability.
- **Legal Review of Contractual Position and Options:** A formal legal review was commissioned to clarify the Trust's contractual rights, obligations and available options, including potential enforcement mechanisms, ensuring the organisation is fully informed in managing supplier performance and programme risk.
- **Trust-wide Communication on Programme Status:** The Committee commissioned timely communication across the organisation to provide clarity regarding programme status, delivery risks, patient safety implications and mitigation actions.
- **Progression of Contingency Planning:** The Committee requested continued development of contingency planning, together with consideration of defined decision points should programme delivery fail to improve, ensuring the Trust remains appropriately prepared whilst recognising that continuation of the current programme remains the most viable strategic option.
- **Enhanced Focus on Contract Management and Financial Oversight:** The Committee agreed to maintain strengthened oversight of supplier performance, contractual management and financial exposure arising from programme delays, whilst ensuring that patient safety remains the overriding priority.

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 committee report

Meeting	Charity Trustee Committee		Agenda Item	21
Report title	Charity Trustee Committee June Report to Board		Meeting Date	8 July 2026
Chair	Nina Janda – Non-Executive Director			
Author	Committee Secretary			
Quorate	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>
Alert (Matters of concern or key risks to escalate to the Board):				
<ul style="list-style-type: none"> • Delivery risk associated with the Sunshine Terrace project, specifically uncertainty around Building Safety Regulator (BSR) approval timelines, which may impact project start dates. An update was scheduled for the 8 June and has been missed. CPO is tracking the progress of the project and keeping the CTC Chair updated. • Track slightly behind benchmark, due to the market's volatility. 				
Assurances provided to the Board:				
<ul style="list-style-type: none"> • Strong financial performance with a year-end surplus of approximately £400k against a planned deficit and no material concerns regarding cashflow, fund balances or overall financial health. • Income performance continues above plan with expenditure controlled in line with expectations. • Charity operations demonstrate continued growth, strong fundraising performance, an increasing maturity of the charity function and increased connection across the local community and trust. 				
Advise (Matters the Board should be aware of not covered above e.g. on-going monitoring, new developments etc):				
<ul style="list-style-type: none"> • Significant progress in the Children's Big Build programme, with fundraising campaigns targeting £2 million fundraising this year. • Establishment of a Philanthropy Board to enhance engagement with high-net-worth donors and to accelerate fundraising efforts. Computer generated imagery (CGI) marketing is being produced to support the Board's fundraising. • Continued emphasis on delivering enhancements "above and beyond" NHS provision, focusing on patient experience and staff wellbeing. 				
Decisions made by the committee or major actions commissioned and work under way:				
<ul style="list-style-type: none"> • Amended proposal for "Thank You Week" - a more inclusive and health-aligned initiative (fruit and vegetable vouchers). <p>Agreed actions to:</p>				

<ul style="list-style-type: none"> • Monitor Sunshine Terrace progress closely with more frequent updates. • Support fundraising through trustee networks. • Develop visual materials for the Children’s Big Build campaign. • Review investment strategy and assess optimal use of funds 	
<p>Any actions recommended to improve effectiveness of the meeting:</p> <ul style="list-style-type: none"> • Introduction of more frequent updates outside of the formal committee cycle for major capital projects (e.g. Sunshine Terrace) to enable proactive oversight. • Continued focus on strategic-level discussion, particularly around long-term investment planning and major fundraising programmes. 	
Recommendation	The Board is asked to DISCUSS the report from the Committee.

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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	Mar 2026	April 2026	May 2026	June 2026	July 2026	Aug 2026	Sept 2026	Oct 2026	Nov 2026	Dec 2026	Jan 2027	Feb 2027	Mar 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				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		

Board Annual Cycle 2026-27

Items	Mar 2026	April 2026	May 2026	June 2026	July 2026	Aug 2026	Sept 2026	Oct 2026	Nov 2026	Dec 2026	Jan 2027	Feb 2027	Mar 2027
Strategic reports													
Planning guidance											X		
Winter Planning (annual)							X						
Digital update			X										
Trust Strategy refresh and annual objectives	X												X
Antimicrobial resistance	X												X
Strategy delivery report					X						X		
Strategic transformation & digital update			X						X				
Integrated Business Plan									X				
Annual budget/financial plan													
System Working & Provider Collaboration (ICS and HCP) Updates	X		X		X		X		X		X		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												X
NHS England capability self-assessment					X								
Enabling Strategies													
Estates and Facilities Strategy									X		X		

Board Annual Cycle 2026-27

Items	Mar 2026	April 2026	May 2026	June 2026	July 2026	Aug 2026	Sept 2026	Oct 2026	Nov 2026	Dec 2026	Jan 2027	Feb 2027	Mar 2027
People Strategy			X								X		
Green Strategy									X				
Quality& Clinical Strategy									X				
Equality, Diversity and Inclusion Strategy	X												X
Digital Strategy			X										
Engagement Strategy							X						
Other Items													
<i>Audit Committee</i>													
Review of Trust Standing Orders and Standing Financial Instructions (if required)			X										
<i>Charity Trustee Committee</i>													
Charity Annual Accounts and Report									X				
Charity Trust TOR and Annual Committee Review											X		
<i>Finance, Performance and Planning Committee</i>													
FPPC TOR and Annual Report											X		
<i>Quality and Safety Committee</i>													
Maternity Incentive Scheme for sign-off													
Complaints, PALS and Patient Experience Annual Report									X				

Board Annual Cycle 2026-27

Items	Mar 2026	April 2026	May 2026	June 2026	July 2026	Aug 2026	Sept 2026	Oct 2026	Nov 2026	Dec 2026	Jan 2027	Feb 2027	Mar 2027
Safeguarding and L.D. Annual Report (Adult and Children)									X				
Staff Survey Results			X										
Learning from Deaths			X		X				X		X		
Nursing Establishment Review									X				
Patient Safety and Incident Report (Part 2)			X						X				
Teaching Status Report													
QSC TOR and Annual Review (if required)									X				
Quality account (delegate sign off to QSC at their June meeting)			X										
<i>People Committee & Culture</i>													
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						

Board Annual Cycle 2026-27

Items	Mar 2026	April 2026	May 2026	June 2026	July 2026	Aug 2026	Sept 2026	Oct 2026	Nov 2026	Dec 2026	Jan 2027	Feb 2027	Mar 2027
Shareholder / Formal Contracts													
ENH Pharma (Part 2) shareholder report to Board					X								