Public Trust Board

To be held online

09/09/2026 09:30 - 12:30

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4. Minutes of previous meeting held 8 July 2026 For approval	Trust Chair	10:05-10:10	5
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STRATEGY AND CULTURE

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For approval

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For noting

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For approval and assurance

BREAK		Trust Chair	11:10-11:20	

PERFORMANCE, ASSURANCE AND GOVERNANCE ITEMS

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For assurance

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For discussion

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For discussion

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For noting				
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For noting				
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Wednesday, 11 November 2026 - Lister Hospital				

ASSURANCE RATING GUIDE

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

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

East and North Hertfordshire Teaching NHS Trust

Minutes of the Trust Board meeting held online, on Wednesday, 8 July 2026 from 9.30am

Present:

Ms Anita Day (AAD)	Trust Chair
Mrs Karen McConnell (KMc)	Deputy Trust Chair
Dr David Buckle (DB)	Non-Executive Director
Ms Diana Skeete (DS)	Non-Executive Director
Ms Janet Scotcher (JS)	Non-Executive Director
Professor Zoe Aslanpour (ZA)	Non-Executive Director
Mr Richard Oosterom (RO)	Associate Non-Executive Director
Ms Nina Janda (NJ)	Associate Non-Executive Director
Mr Martin Amstrong (MA)	Chief Executive Officer
Ms Theresa Murphy (TM)	Chief Nurse and Deputy Chief Executive Officer
Ms Penny St Martin (PSM)	Chief People Officer
Mr Barry Jenkins (BJ)	Interim Chief Finance Officer
Dr Justin Daniels (JD)	Medical Director
Ms Claire Moore (CM)	Deputy 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

From the Trust:

Mr Stuart Dalton (SD)	Head of Corporate Governance
Mrs Debbie Okutubo (DO)	Deputy Company Secretary (Board Secretary - minutes)
Sylvia Gomes (SG)	Freedom to Speak Up Guardian

No	Item	Action
	The Chair, AAD opened the meeting in public on 8 July 2026 and welcomed Board members, staff, patients, members of the public and community representatives watching via YouTube either live or subsequently. It was confirmed that the agenda had been published on the website and seen by all Board members.	
26/071	**DECLARATIONS OF INTEREST** There were no new interests declared.	
26/072	**APOLOGIES FOR ABSENCE** The Board received apologies from Ms Lucy Davis, Chief Operating Officer, with Claire Moore attending as deputy; Ms Gillian Hooper, Non-Executive Director; and Ms Eilidh Murray, Director of Communications and Engagement.	
26/073	**MINUTES OF THE PREVIOUS MEETING** The minutes of the meeting held on 13 May 2026 were **APPROVED** as an accurate record of the meeting.	
26/074	**ACTION LOG** The Board reviewed the action log and noted progress against actions. The Head of Corporate Governance, SD Stuart that two actions remained open but were not yet due, namely the review of Terms of Reference and the UEC performance improvement timeline. Both actions were reported as on track.	

Stuart reported that two actions were recommended for closure. He reported that following the patient story presented in May, the ICB had agreed a consultant-to-consultant referral process, demonstrating the impact of feedback received through patient stories. He further reported that the Medical Director had met the patient concerned and that an update had been provided to the Quality and Safety Committee.

The Chair of QSC, DB reported that he had also met separately with the patient.

The Chief Nurse, TM advised that nursing and operational teams had arranged a further meeting with the patient during July 2026 to review concerns relating to environment, flow and operational processes.

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

26/075 STAFF STORY

The Board noted that the staff presenter, DT had initially experienced difficulties joining the meeting and the item was temporarily deferred.

Once connected, DT, a Pre-term Birth Specialist Midwife, was introduced by the Chief People Officer, PSM.

PSM reported that DT had spent approximately four years in the role and had led a significant programme of quality improvement work supporting national perinatal optimisation objectives. She highlighted DT's work in publishing educational material, presenting at regional, national and international conferences and supporting women and families affected by prematurity.

A trigger warning was given due to references to baby loss.

DT reported on the development of the trust's pre-term birth service. She outlined improvements including cervical length scanning capability, specialist education programmes, multidisciplinary study days, publication of a book on prematurity, research activity and presentation of outcomes across regional, national and international forums.

DT explained that the service delivered holistic support involving obstetric, diabetic, foetal medicine and mental health specialists where required. She emphasised continuity of care and trauma-informed support for women who had experienced previous pregnancy loss or prematurity.

DT advised that referrals to the service had increased year on year and that approximately 450 cervical length scans were undertaken annually.

DT highlighted quality improvement work including the introduction of bedside Life Start resuscitation equipment, creation of pre-term birth support boxes on the labour ward, development of dedicated web resources and establishment of a working group to review outcomes and share learning.

DT presented a patient story. She reported that J's first pregnancy involved twins, following presentations with abdominal pain and subsequent diagnosis of pre-term labour, J was transferred to a tertiary neonatal centre and delivered the twins at 24 weeks and six days' gestation. One twin sadly died approximately one week later following infection and complications of prematurity. The other survived following prolonged neonatal care.

The patient became pregnant again approximately one year later and was referred early into the specialist pre-term birth service. Through continuity of care, specialist surveillance, frequent assessment and emotional support, the patient subsequently delivered a healthy baby boy, at 38 weeks and three days by planned caesarean section.

DT reflected on the impact of previous pregnancy loss and pre-term birth on future pregnancies, highlighting anxiety, grief, mistrust and the need for sustained emotional and clinical support.

Following the presentation, a discussion ensued. TM commended DT's leadership and described her as a key figure linking maternity, obstetric and neonatal services.

The Chief Executive, MA commended the growth and impact of the service and sought DT's views regarding future sustainability. DT advised that she currently represented a significant single point of failure within the service and that additional staffing capacity and analytical support would be beneficial. She noted that national pre-term birth rates had not reduced as anticipated and that complexity within maternity services continued to increase.

MA offered support in identifying colleagues able to assist with data analysis and service evaluation.

Action: MA to facilitate analytical support for service evaluation work.

The Medical Director, JD praised both the service and DT's published work.

KMc asked what practical support the Board could provide. DT identified community engagement, education, pre-conception support and wider awareness of prematurity risks as priorities.

ZA offered support through the University of Hertfordshire, including educational, research and grant opportunities.

Action: ZA to facilitate links between DT and University of Hertfordshire colleagues.

NJ sought assurance regarding identification of women at risk during first pregnancies and the trust's work to address inequalities and potential bias. DT highlighted education, social media based communication, symptom awareness, culturally sensitive approaches and improved accessibility of information as important future developments.

The Chair thanked DT for her presentation and recognised the significant contribution being made to maternity services and patient outcomes.

The Board **NOTED** the staff story.

26/076 QUESTIONS FROM THE PUBLIC

There were no public questions.

26/077 CHAIR'S REPORT

The Chair, AAD provided an update.
The Chair formally reported the appointment of Martin Armstrong as substantive Chief Executive following a rigorous recruitment process.

The Chair also reported the appointment of Theresa Murphy as Deputy Chief Executive.

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

26/077a – SFBC Imaging equipment

The Chair sought ratification of Chair's action approving a contract for SFBC imaging equipment between formal Board meetings.

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

26/077b – Quality account

The Chair sought ratification of Chair's action approving submission of the Trust Quality Account before the statutory deadline of 30 June.

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

26/077c - Ockenden and Amos reviews

The Chair reflected on the publication of national maternity reports, including the Ockenden and Amos reviews, and acknowledged the significant concern these reports would have caused parents, families and maternity staff.

The Chair reported that NHS England had required organisations providing maternity services to undertake reviews and audits. Two reviews relating to maternity standards and joint accountability structures were required within 30 days.

RESOLVED: Responsibility for ratification of the trust's response was delegated to the Quality and Safety Committee.

Action: Complete and submit maternity review responses which were due by end of July 2026.

The Chair reassured expectant parents that concerns regarding maternal or baby wellbeing should always be raised and encouraged attendance at medical facilities where concerns existed.

The Chair read an extract from a complimentary letter received from a patient, Katie, whose fourth pregnancy-had recently been supported by the trust. Katie described outstanding maternity care, reported feeling listened to and respected and praised breastfeeding support and encouragement received from maternity staff.

The Board **DELEGATED** the **RATIFICATION** of the trust's response to the Quality and Safety Committee (QSC).

26/078 CHIEF EXECUTIVE'S REPORT

The Chief Executive, MA presented his first report as substantive Chief Executive.

MA stated that he felt privileged to have been appointed and intended to spend considerable time throughout the summer listening to patients and staff as part of shaping the next stage of the Trust's development.

He highlighted the need to improve performance in several areas and reiterated the executive team's ambition to deliver sustained improvement.

MA welcomed Theresa Murphy to the Deputy Chief Executive role and Barry Jenkins to his first Board meeting as Interim Chief Finance Officer. He confirmed that recruitment of a substantive Chief Finance Officer was underway and that an appointment decision was expected during September 2026.

He reported that the trust had achieved a National Oversight Framework segment rating of 2 for Quarter 4 of 2025/26, reflecting strong organisational performance. He noted, however, that changed national requirements would create additional challenges during 2026/27.

MA advised that the trust was reviewing learning arising from national maternity reports and that a comprehensive response would be brought to the September Board meeting.

Action: A full organisational response to be presented on the maternity review findings at the September 2026 Board meeting.

MA updated the Board regarding the Mount Vernon Cancer Centre consultation process and noted that consultation activity had concluded in June, with stakeholder feedback now being evaluated.

MA reflected on the Bedford rail incident and commended staff for supporting the wider system response.

He reported that Swift ward had reopened following completion of infrastructure works. He thanked operational and clinical teams for managing the prolonged loss of 26 inpatient beds.

MA provided an update on construction of the new Lister Hospital main entrance development and advised that completion was anticipated during September 2026. He noted that the development was commercially funded.

MA concluded by highlighting staff award nominations and upcoming Time to Shine awards.

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

The Chair formally welcomed Barry Jenkins to the board in his interim position as Chief Finance Officer.

26/079 STAFF SURVEY

The Chief People Officer, PSM presented analysis of staff survey free-text comments.

PSM explained that NHS organisations had been asked to undertake detailed review of narrative comments and identify priority themes requiring action.

PSM reported a reduction in overall survey participation compared with the previous year and stated that three principal themes had emerged:

- workforce capacity, workload and burnout;
- leadership and communication; and

- practical workplace factors such as parking, facilities and benefits.

PSM reported that comments frequently referred to pressure arising from vacancies, perceptions of a recruitment freeze, high workloads and difficulties prioritising competing demands.

PSM advised that the Trust did not operate a recruitment freeze but recognised that additional scrutiny and controls around recruitment may have created that perception.

PSM outlined actions including clearer prioritisation linked to strategic objectives, promotion of wellbeing support, review of performance management arrangements, improvement of communication channels and greater awareness of available rewards and benefits.

RO expressed concern regarding reduced response rates and questioned whether the Trust was listening effectively to staff concerns. He also sought assurance that action plans were sufficiently robust. PSM acknowledged the concern and confirmed that more detailed action plans sat behind the summary presented to the Board.

The Chair requested contextual comparative information regarding national response rates.
Action: PSM to provide benchmarking information and national comparative analysis regarding staff survey response rates.

TM highlighted the importance of strengthening speaking-up culture and ensuring staff felt safe raising concerns.

NJ highlighted burnout, appraisal quality, staff safety and consistency of leadership behaviours as key issues.

DS sought assurance that survey findings were triangulated against wider workforce indicators.

PSM confirmed that multiple indicators, including grievances, complaints, absence levels and staff concerns, were reviewed through governance processes to identify themes and areas requiring intervention.

JS referred to discussions previously held at the People and Culture Committee regarding the quality of Grow Together conversations. She stated that the focus should not solely be on the number of appraisals completed, but also on the quality and effectiveness of those conversations. JS further commented that the trust should make greater use of storytelling, as this would help staff feel listened to and strengthen the feedback loop. She suggested that the decrease in survey response rates may be linked to staff not feeling that feedback is acted upon.

The Chief Executive highlighted the wider NHS context, noting that, anecdotally, staff survey response rates had fallen significantly across the NHS and that the trust's position was consistent with national trends (but this will be confirmed once comparative data is obtained). He emphasised that the NHS Staff Survey was one of the largest annual staff surveys in the world and represented an important source of intelligence that should not be ignored. He noted that concerns regarding leadership visibility were often more reflective of staff experiences with line management than with executive or Board visibility. He also commented on staff burnout, workload pressures, prioritisation, clarity of organisational objectives and communication

challenges, recommending that the findings be incorporated into the trust's change agenda.
CM agreed with the comments regarding the importance of Grow Together conversations. She stated that the quality of conversations between staff and line managers was more important than completion rates alone. She suggested consideration be given to obtaining feedback on appraisal quality, including whether staff found the conversations valuable. CM also reflected on organisational transformation activity and stressed the importance of communicating change effectively to reduce duplication, improve understanding and support staff through periods of change.

The Chair thanked PSM for the report and noted that ongoing scrutiny would continue through the People and Culture Committee.

The Board **APPROVED** the Staff survey.

26/080 MANN REVIEW

PSM presented the report regarding the Mann review. She explained that the review had been commissioned by government to examine antisemitism and wider systemic racism within the NHS. The review had identified areas of systemic racism and challenged NHS organisations to take action. PSM advised that the trust's existing equality, diversity and inclusion (EDI) strategy had provided a foundation for work in these areas and was now being reviewed in light of the review's findings.

PSM outlined the key recommendations, including the adoption of definitions relating to antisemitism and anti-Muslim hate, and highlighted the need to create safe environments both for staff and patients. She advised that work was underway to refresh the Trust's EDI strategy and that an implementation plan would be developed setting out actions and timescales.

The Medical Director, JD welcomed the proposed commitments and requested that the Trust also consider issuing a clear organisational position regarding the wearing of political badges in the workplace. PSM confirmed that a wider range of recommendations existed within the review and that all recommendations would be considered for incorporation into Trust arrangements. She agreed to consider JD's point regarding political badges.

RO sought confirmation that the Board had formally adopted the proposed definitions and requested clarification regarding the availability of local incident data relating to the affected groups. He expressed the view that, without comprehensive triangulated data, the assurance rating should be reduced from substantial to reasonable. PSM confirmed that relevant data existed in some areas, such as grievances, but acknowledged that further triangulation and analysis were required.

DS advised that the People and Culture Committee had also discussed the need for greater analysis of the review's recommendations and their implications. She supported reducing the assurance rating to reasonable.

The Chief Executive reminded the Board that it was required formally to adopt the two definitions and noted that additional commitments would need to come back to Board in future, including requirements around anti-racism training.

The Chair summarised the discussion and noted support for reducing the assurance rating from substantial to reasonable pending further triangulated data and analysis. Members signified agreement.

The Board **AGREED** to a **REASONABLE** assurance for the Mann review.

26/081 BOARD ASSURANCE FRAMEWORK (BAF)

The Head of Corporate Governance, SD presented the first developed version of the Board Assurance Framework, noting that further refinement would occur following respective committees' feedback. He advised that the focus now needed to move towards actively reducing the identified risks.

RO highlighted a number of areas requiring further amendment, including historic closure actions, issues requiring Digital Committee review, and feedback from the Finance, Performance and Planning Committee (FPPC) that had yet to be incorporated. He questioned whether the proposed assurance level of reasonable was appropriate.

JS agreed that additional discussion and development remained necessary.

Following discussion, the Board agreed that the assurance rating should be reduced from reasonable to partial.

The Board agreed a **PARTIAL ASSURANCE** rating for the Board Assurance Framework.

26/082 LEARNING FROM DEATHS

The Medical Director, JD presented the learning from deaths report. He advised that all three mortality measures remained below expected levels. Although there had been a slight increase in the 12-month SHMI measure, this was balanced by reductions in HSMR and crude mortality. Trend data indicated overall stability.

NJ suggested the Trust should increasingly triangulate mortality data with other sources including registry data and audit information. She also stressed the importance of maintaining high-quality coding standards. JD welcomed the suggestion and advised that discussions could take place regarding further measures and data sources. He confirmed that coding quality remained strong and was regularly reviewed.

RO queried the increase in mortality alerts between quarters and sought assurance that there was no emerging cause for concern. JD reiterated that the key area requiring further investigation to ascertain whether there was an unexplained trend was the Non-Hodgkin's lymphoma cohort.

DS suggested greater dissemination of learning and trend analysis, including to patient and carer representatives and through an EDI lens. JD confirmed that mortality data was already widely shared through committees, divisional meetings and Power BI.

DB stated that QSC scrutiny of the report had been reassuring and commended the mortality review processes, whilst suggesting consideration be given to resolving recurring cardiology outliers.

The Chair thanked JD and his team and commented that it was a clear paper and requested that consideration was given as to the mechanism whereby a summary of the report could be shared with patients and carers.
The Board **AGREED** the proposed **SUBSTANTIAL** assurance rating.

26/083 FREEDOM TO SPEAK-UP ANNUAL REPORT

The Freedom to Speak Up Guardian, SG presented the annual report. She advised that the trust had experienced a fourth consecutive year of increasing Freedom to Speak Up activity. She highlighted the development of a network of 45 Freedom to Speak Up Champions. Only two anonymous cases had been received during the year, despite organisational consultation activity and change programmes.

SG recommended that the trust consider formal approaches to acknowledging harm experienced by staff, including learning, apologies and restorative actions where appropriate. She also advocated greater use of early mediation and expansion of the Trust's pool of trained mediators.

TM emphasised the importance of linking Freedom to Speak Up more strategically across organisational governance arrangements. She advised that recommendations would be progressed through relevant committees and reported back to Board. TM also highlighted the increasing workload faced by the Freedom to Speak Up Guardian and the need to consider more sustainable support arrangements. She referenced internal audit's reasonable assurance opinion.

RO noted that 70% of staff raising concerns had already spoken to their manager and questioned what action would be taken to address the underlying causes. He also highlighted the number of bullying and harassment cases resulting in staff leaving the organisation. SG responded that managers needed greater support and training to listen effectively and have meaningful conversations. She proposed inclusion of this within Grow Together discussions for managers.

PSM acknowledged that existing interventions were not yet sufficient if staff continued to escalate concerns after speaking to managers.

DS noted that an internal audit recommendation supported stronger strategic alignment and discussion of Freedom to Speak Up cases through the People and Culture Committee.

JS emphasised the importance of stronger collaboration between People Business Partners and the Freedom to Speak Up function, particularly in areas where managers were not responding appropriately to concerns.

The Chair thanked SG for her leadership and recognised the significance of the increase in concerns being raised openly rather than anonymously. The Board agreed that manager capability represented an important area for further development.

The Board **AGREED** to a **REASONABLE** assurance for the Freedom to Speak Up report.

26/084 INTEGRATED PERFORMANCE REPORT (IPR)

The Director of Estates and Facilities, KH presented the IPR. He reported stable clinical quality indicators with no evidence of deterioration in outcomes. Improvements continued in medical records performance, VTE assessment compliance, sepsis management and diagnostics. Surgical site infection investigations remained ongoing, with no direct environmental links identified to date.

Operationally, cancer performance, diagnostics and RTT performance showed improvement, though urgent and emergency care remained challenged due to capacity pressures following closure of Swift Ward. Recovery actions were underway and demonstrating early benefits.

Financially, KH advised that the trust remained in deficit and that financial recovery remained the trust's most significant organisational challenge. A fully identified £37.9 million cost improvement programme was in place, supported by strengthened governance and enhanced transformation capacity. He emphasised that there was no capacity for significant programme slippage.

In relation to workforce, retention, agency reduction, sickness absence and vacancy levels continued to show positive trends. However, appraisals and statutory and mandatory training remained below target.

The Chair summarised that there were encouraging areas of progress, but ongoing financial and operational pressures remained significant.

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

26/085 AUDIT AND RISK COMMITTEE (ARC) REPORT TO THE BOARD

The ARC Chair, KMc reported that the Trust had received an unqualified audit opinion.

She thanked finance colleagues and external auditors for their work. She advised the Board that a Section 30 recommendation would be made to the Secretary of State in relation to the trust's cumulative deficit.

KMc also highlighted the Head of Internal Audit Opinion of amber-green. External auditors had identified a significant weakness in value-for-money arrangements relating to financial sustainability and had recommended that Cost Improvement Programmes (CIPs) become a continuous rolling programme.

The Board was advised that additional recommendations related to monitoring of the front entrance project and associated accounting treatment.

The Chair thanked all individuals involved in the preparation for, and support of, the audit process this year. The Board **NOTED** the ARC report to the Board.

26/086 QUALITY AND SAFETY COMMITTEE (QSC) REPORT TO THE BOARD

The QSC Chair, DB highlighted ongoing concerns regarding orthotics and complaints about Trust activity.

A recent gynaecology review has shown that service difficulties are reflected in the patient experience. QSC examined the analysis and our action plans to deliver improvement and will review regularly.

For a long time, patient access to ADHD, AHD and some other similar services has been a problem for us in the NHS and more importantly the patient. QSC was pleased to see all the recent improvements but was less confident about the long term.

QSC had detailed discussions about the clinical consequences of our OneEPR delay and the balance of finance: quality.

PSSC (new sub-committee) has a safety remit and has particularly improved the assurance gained by detailed discussion and analysis of the Trust PSIIs and the findings discussed at private board.

DB also reported positively on stroke services, noting sustained thrombolysis rates of approximately 20%, described as internationally high performing.

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

26/087 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. RO reported that although operational improvement was evident, progress remained behind planned trajectories. Cancer standards had not been achieved in May, while financial delivery and activity performance also required acceleration. He emphasised the need to increase the pace of improvement.

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

26/088 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. JS highlighted the importance of work on business partnering and its role in supporting cultural change and transformation delivery

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

26/089 HEALTH CARE PARTNERSHIP (HCP) REPORT TO THE BOARD

The Chief Executive, MA presented to the Board. MA reported ongoing work relating to governance, alignment of transformation programmes and neighbourhood health development activity

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

26/090 DIGITAL COMMITTEE REPORT TO THE BOARD

The Digital Committee Chair, RO presented the report to the Board. RO reported concerns regarding delays in the OneEPR programme due to supplier performance. While confidence in the solution remained, concern persisted regarding implementation timescales. Mitigating actions and revised risk arrangements were in place.

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

26/091 CHARITY TRUST COMMITTEE (CTC) REPORT TO THE BOARD

NJ provided an update on the Sunshine Terrace project, fundraising activity and plans for ‘Thank You’ week. She advised that the charity would move from distributing ice creams to issuing fruit and vegetable vouchers to improve inclusivity for all staff groups.

26/092 ANNUAL CYCLE

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

East and North Hertfordshire Teaching NHS Trust

26/093 ANY OTHER BUSINESS

The Chair raised concerns regarding the ability to complete Board business within the current two- and half-hour public meeting duration.

Members discussed extending public Board meetings to three hours to allow greater time for debate, questions and appropriate breaks. Members expressed support for the proposal.

The Board **AGREED** that future public Board meetings would be extended to three hours, with a commitment to maintain discipline regarding agenda timings.

There was no other business.

26/094 DATE OF NEXT MEETING

The date of the next meeting is 9 September 2026 to be held at Hertford County Hospital.

Ms Anita Day
Trust Chair
July 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	26/060	Integrated Performance report	To present a timeline on the improvement work in the UEC.	Timeline attached.	Chief Operating Officer	September 2026 Completed
8 July 2026	26/075	Staff story	Chief Executive to facilitate analytical support for data analysis and service evaluation in linking maternity, obstetric and neonatal services.	The Chief Executive, MA has shared contact details with Associate Director of Planning & Information	Chief Executive	July 2026 Completed.
8 July 2026	26/075	Staff story	Non-Executive Director (ZA) to link DT (staff member) and University of Hertfordshire colleagues to assist with educational research and grant opportunities.		Non-Executive Director (ZA)	
8 July 2026	26/077c	Ockenden and Amos reviews	QSC to oversee and ratify the completion and submission of the maternity review		Chair, QSC – (DB)	

	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
			responses which were due by end of July 2026.			
8 July 2026	26/078	Maternity review findings (CE report)	A full organisational response to be presented on the maternity review findings at the September 2026 Board meeting	This is an agenda item	Chief Nurse	September 2026 Completed
8 July 2026	26/079	Staff survey	PSM to provide benchmarking information and national comparative analysis regarding staff survey response rates	Information attached to this action log.	Chief People Officer	September 2026 Completed

Report Coversheet

NHS
East and North Hertfordshire Teaching NHS Trust

Meeting	Trust Board		**Agenda Item**	5b	
Report title	Response to Action 26/078: Maternity Review Findings		**Meeting Date**	9 September 2026	
Author	Chief Nurse and Deputy CEO Director of Midwifery				
Responsible Director	Chief Nurse and Deputy CEO				
Purpose	**Assurance**	☐	**Approval/Decision**	☐	
	Discussion	☐	**For information only**	☒	
Proposed assurance level (*only needed for assurance papers*)	**Substantial assurance**	☐	**Reasonable assurance**	☒	
	Partial assurance	☐	**Minimal assurance**	☐	

Executive assurance rationale:

Reasonable assurance is provided that a comprehensive thematic review of perinatal mortality and MNSI-referred cases has been completed with external expert involvement. Key themes have been identified and are being incorporated into a structured improvement programme, with oversight through existing governance arrangements and a newly established Transformation Committee

Summary of key issues:

In response to concerns regarding an increased perinatal mortality rate and cases meeting referral criteria for the Maternity and Newborn Safety Investigations (MNSI) programme, a thematic review was undertaken in July 2026. The review involved six external clinical experts alongside Trust staff and examined all relevant cases between July 2025 and May 2026.

The review identified themes relating to care pathways, risk assessment, escalation, staffing and theatre capacity, communication across organisations, shared-care arrangements, and community/homebirth pathways, including risk communication, documentation, transfer arrangements and neonatal response processes. Importantly, no new themes were identified beyond those already recognised through local investigations and external MNSI reviews.

Women receiving cross-boundary/shared care represented 33% of the cases reviewed, despite accounting for approximately 22% of births within the service. In addition, 50% of reviewed cases involved women from Black, Asian, mixed Black, mixed Asian or other ethnic minority backgrounds, compared with approximately 36% of births within the Trust population. These findings reinforce existing concerns regarding cross-boundary information sharing, digital interoperability and health inequalities.

A multidisciplinary leadership team is using a thematic review tracker to prioritise and monitor improvement actions. Many findings relate to risks already captured within divisional and corporate risk registers, including cross-boundary care, and progress will be monitored through existing governance processes and the new Maternity Transformation Committee from October 2026.

The findings and resulting actions will also be cross referenced with the Trust's Maternity Improvement Programme and aligned to delivery of the Ockenden and Amos recommendations, ensuring that learning is translated into sustainable improvements in safety, quality, experience and equity of care.

Impact: *tick box if there is any significant impact (positive or negative):*													
Patient care quality	☒	**Equity for patients**	☒	**Equity for staff**	☐	**Finance/ Resourc -ing**	☐	**System/ Partners**	☒	**Legal/ Regul- atory**	☒	**Green/ Sustai- nability**	☐
The review provides additional assurance regarding maternity safety, quality governance and organisational learning. Findings and improvement actions will strengthen oversight of known risks and support continued improvement in maternity outcomes													

Trust strategic objectives: *tick which, if any, strategic objective(s) the report relates to:*							
Quality Standards	☒	**Thriving People**	☐	**Seamless services**	☒	**Continuous Improvement**	☒

Identified Risk: *Please specify any links to the BAF or Risk Register*
This review relates to existing risks on the Divisional and Corporate Risk Registers, including risks associated with cross-boundary maternity care and digital interoperability, workforce capacity and timely access to emergency intervention, and the potential impact of health inequalities on maternity outcomes.
Report previously considered at & date(s):
Women's and Children's governance processes; thematic review completed July 17 2026.

Recommendation	The Board is asked to: • Note the outcome of the thematic review and the programme of work underway to implement and monitor improvement actions arising from the findings.

To be trusted to provide consistently outstanding care and exemplary service

Survey Coordination Centre

NHS

East and North Hertfordshire Teaching NHS Trust

2025 NHS Staff Survey Benchmark Report

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Survey Coordination Centre

NHS

Introduction

Note: where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

About this Report

Survey Coordination Centre NHS

About this report

This benchmark report for East and North Hertfordshire Teaching NHS Trust contains results for the 2025 NHS Staff Survey, and historical results back to 2021 where possible. These results are presented in the context of best, average and worst results for similar organisations where appropriate. Data in this report are weighted to allow for fair comparisons between organisations.

Results for Q1, Q10a, Q26d, Q27a-c, Q28, Q29, Q30, Q31a, Q32a-b, Q33, Q34, Q35 , Q36, Q37, Q38, Q39a-b and Q40 are not weighted or benchmarked because these questions ask for demographic or factual information.

How results are reported

For the 2021 survey onwards the questions in the NHS Staff Survey are aligned to the People Promise. This sets out, in the words of NHS staff, the things that would most improve their working experience, and is made up of seven elements:

In support of this, the results of the NHS Staff Survey are measured against the seven People Promise elements and against two themes (Staff Engagement and Morale). The reporting also includes sub-scores, which feed into the People Promise elements and themes. The next slide shows how the People Promise elements, themes and sub scores are related and mapped to individual survey questions.

People Promise elements, themes and sub-scores

Survey Coordination Centre NHS

People Promise elements	Sub-scores	Questions
We are compassionate and inclusive	Compassionate culture	Q6a, Q25a, Q25b, Q25c, Q25d
	Compassionate leadership	Q9f, Q9g, Q9h, Q9i
	Diversity and equality	Q15*, Q16a, Q16b, Q21 *Due to changes in the Q15 question wording in 2025, Q15 is not included in the score calculation for this theme or sub-score.
	Inclusion	Q7h, Q7i, Q8b, Q8c
We are recognised and rewarded	No sub-score	Q4a, Q4b, Q4c, Q8d, Q9e
We each have a voice that counts	Autonomy and control	Q3a, Q3b, Q3c, Q3d, Q3e, Q3f, Q5b
	Raising concerns	Q20a, Q20b, Q25e, Q25f
We are safe and healthy	Health and safety climate	Q3g, Q3h, Q3i, Q5a, Q11a, Q13d, Q14d
	Burnout	Q12a, Q12b, Q12c, Q12d, Q12e, Q12f, Q12g
	Negative experiences	Q11b**, Q11c, Q11d, Q13a, Q13b, Q13c, Q14a, Q14b, Q14c **Due to changes in the Q11b question wording in 2025, Q11b is not included in the score calculation for this theme or sub-score.
	Other questions [Not scored]	Q17a***, Q17b***, Q22*** ***Q17a, Q17b and Q22 do not contribute to the calculation of any scores or sub-scores.
We are always learning	Development	Q24a, Q24b, Q24c, Q24d, Q24e
	Appraisals	Q23a****, Q23b, Q23c, Q23d ****Q23a is a filter question and therefore influences the sub-score without being a directly scored question.
We work flexibly	Support for work-life balance	Q6b, Q6c, Q6d
	Flexible working	Q4d
We are a team	Team working	Q7a, Q7b, Q7c, Q7d, Q7e, Q7f, Q7g, Q8a
	Line management	Q9a, Q9b, Q9c, Q9d
Themes	**Sub-scores**	**Questions**
Staff Engagement	Motivation	Q2a, Q2b, Q2c
	Involvement	Q3c, Q3d, Q3f
	Advocacy	Q25a, Q25c, Q25d
Morale	Thinking about leaving	Q26a, Q26b, Q26c
	Work pressure	Q3g, Q3h, Q3i
	Stressors	Q3a, Q3e, Q5a, Q5b, Q5c, Q7c, Q9a

Questions not linked to the People Promise elements or themes

Q1, Q10a, Q10b, Q10c, Q11e, Q16c, Q18, Q19a, Q19b, Q19c, Q19d, Q24f, Q26d, Q31b

Report structure

Survey Coordination Centre NHS

Introduction

This section provides a brief introduction to the report, including how questions map to the People Promise elements, the themes and sub-scores, as well as features of the charts used throughout.

Organisation details

This slide contains **key information** about the NHS organisations participating in this survey and details for your own organisation, such as response rate.

People Promise elements, themes and sub-scores: Overview

This section provides a high-level **overview** of the results for the seven elements of the People Promise and the two themes, followed by the results for each of the **sub-scores** that feed into these measures.

People Promise elements, themes and sub-scores: Trends

This section provides trend results for the seven elements of the People Promise and the two themes, followed by the trend results for each of the sub-scores that feed into these measures.

All the People Promise elements, themes and sub-scores are scored on a 0-10 scale, where a higher score is more positive than a lower score. For example, with the Burnout sub-score, a higher score (closer to 10) means a lower proportion of staff are experiencing burnout from their work. These scores are created by scoring questions linked to these areas of experience and grouping these results together. Your organisation results are benchmarked against the benchmarking group average, the best scoring organisation and the worst scoring organisation. These charts are reported as percentages. The meaning of the value is outlined along the y axis. The questions that feed into each sub-score are detailed on slide 5.

Note: where there are fewer than 10 responses for a question, this data is not shown to protect the confidentiality of staff and reliability of results.

People Promise elements, themes and sub-scores: Questions

This section provides trend results for **questions**. The questions are presented in sections for each of the People Promise elements and themes.
Not all questions reported within the section for a People Promise element or theme feed into the score and sub-scores for that element or theme. The first slide in the section for each People Promise element or theme lists which of the questions that are included in the section feed into the score and sub-scores, and which do not.

Questions not linked to People Promise

Results for the questions that are not related to any People Promise element or theme and do not contribute to the scores and sub-scores are included in this section.

Workforce Equality Standards

This section shows that data required for the indicators used in the **Workforce Race Equality Standard (WRES)** and the **Workforce Disability Equality Standard (WDES).**

About your respondents

This section provides details of the staff responding to the survey, including their **demographic and other classification questions**. It also includes the socio-economic background questions.

Appendices

Here you will find:

- Response rate.
- Significance testing of the People Promise element and theme results for 2024 vs 2025.
- Tips on action planning and interpreting the results.
- Information about the socio-economic background questions.
- Additional reporting outputs.

Using the report

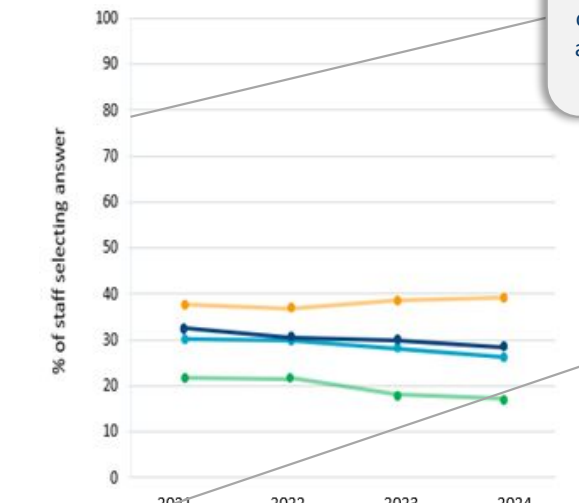
Survey Coordination Centre NHS

Note this is example data

Key features

Question number and text (or summary measure) specified at the top of each slide.

Question-level results are always reported as percentages; the **meaning of the value** is outlined along the axis. Summary measures and sub-scores are always on a 0-10pt scale where 10 is the best score attainable.

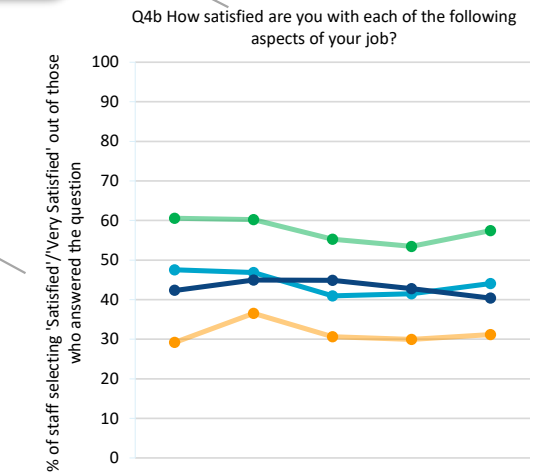


	2021	2022	2023	2024
Your org	32.6%	30.6%	30.0%	28.5%
Best result	21.8%	21.7%	18.0%	17.1%
Average result	30.2%	29.8%	28.1%	26.4%
Worst result	37.6%	36.9%	38.5%	39.2%
Responses	480	500	515	520

Colour coding highlights best / worst results, making it easy to spot questions where a lower percentage is a better or worse result.

'Best result', 'Average result', and 'Worst result' refer to the **benchmarking group's** best, average and worst **results.**

Tips on how to read, interpret and use the data are included in the Appendices



	2020	2021	2022	2023	2024
Your org	42.3%	45.0%	44.9%	42.8%	40.4%
Best result	60.6%	60.3%	55.3%	55.3%	57.4%
Average result	47.5%	46.9%	41.0%	41.5%	44.0%
Worst result	29.2%	36.5%	30.6%	29.9%	31.2%
Responses	835	1255	1491	1325	517

Number of responses for the organisation for the given question.

Note: Charts will only display data for the years where an organisation has data. For example, an organisation with three years of trend data will see charts such as q4b with data only in the 2023, 2024 and 2025 portions of the chart and table.

Survey Coordination Centre

NHS

Organisation details

Note: where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Organisation details

Survey Coordination Centre NHS

East and North Hertfordshire Teaching NHS Trust

2025 NHS Staff Survey

Organisation details

Completed questionnaires	2756
2025 response rate	41%

Survey details

Survey mode	Mixed

This organisation is benchmarked against:

Acute and Acute & Community Trusts

2025 benchmarking group details

Organisations in group: 121

Median response rate: 47%

No. of completed questionnaires: 524528

For more information on benchmarking group definitions please see the Technical Guide.

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NHS

People Promise elements, themes and sub-score results

Note: where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Survey Coordination Centre

NHS

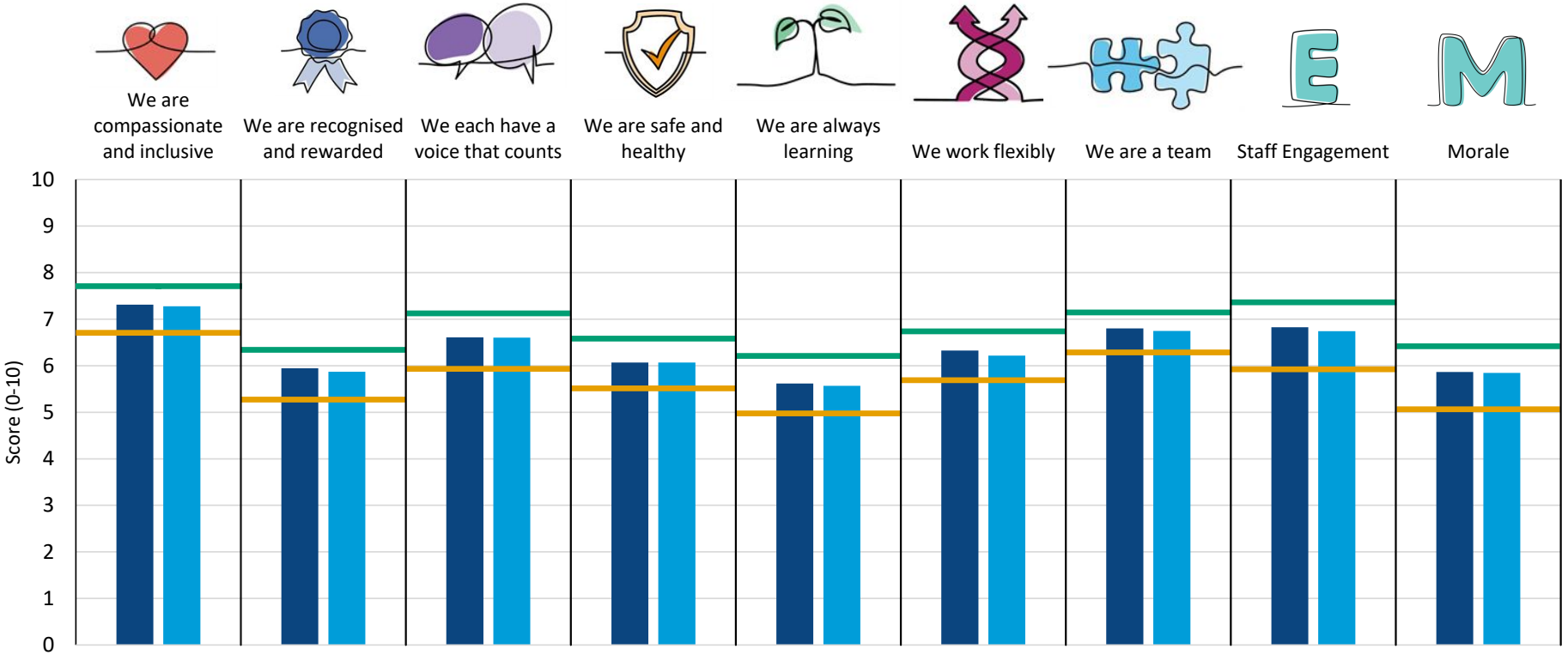
People Promise elements, themes and sub-scores: Overview

Note: where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

People Promise elements and themes: Overview

Survey Coordination Centre NHS

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.



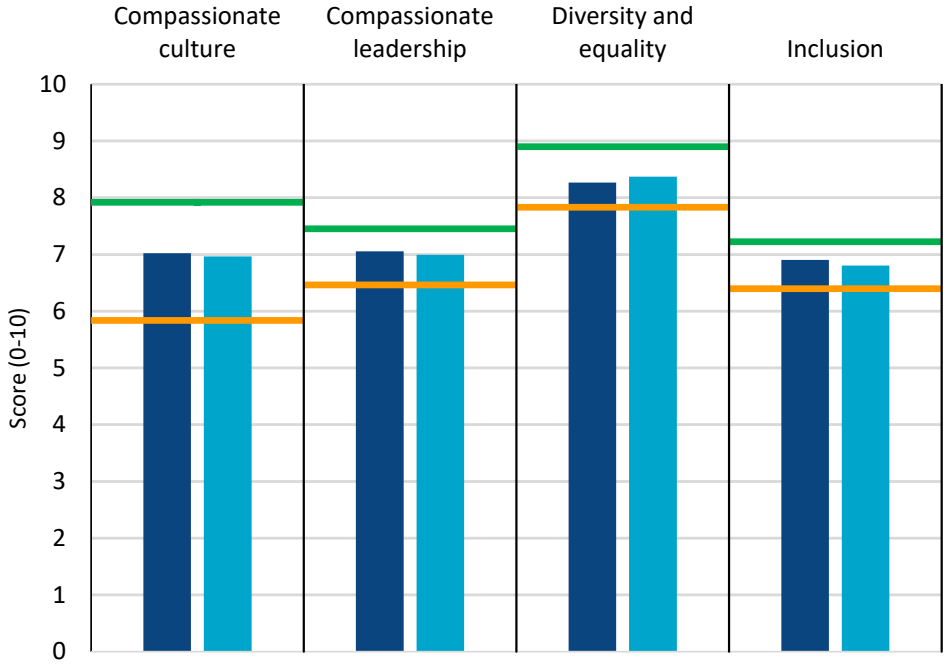
	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.31	5.94	6.61	6.07	5.62	6.33	6.80	6.83	5.86
Best result	7.71	6.34	7.12	6.58	6.21	6.74	7.14	7.36	6.42
Average result	7.28	5.87	6.60	6.07	5.57	6.22	6.75	6.74	5.84
Worst result	6.71	5.27	5.93	5.51	4.98	5.69	6.29	5.92	5.06
Responses	2743	2742	2716	2725	2631	2725	2741	2749	2749

People Promise elements, themes and sub-scores: Sub-score overview

Survey Coordination Centre NHS

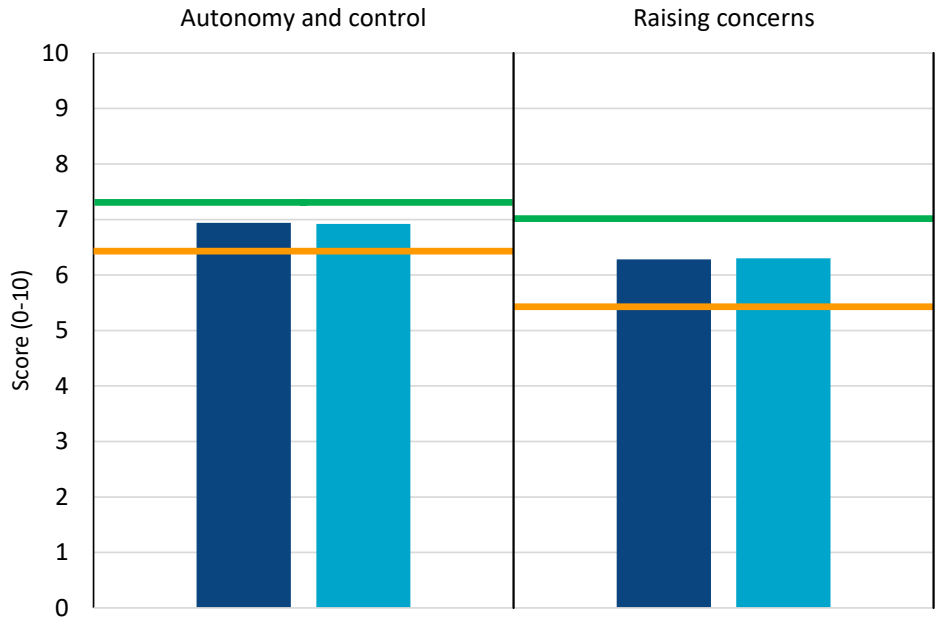
People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 1: We are compassionate and inclusive



	Compassionate culture	Compassionate leadership	Diversity and equality	Inclusion
Your org	7.02	7.05	8.27	6.90
Best result	7.92	7.45	8.90	7.22
Average result	6.97	6.99	8.37	6.80
Worst result	5.84	6.46	7.83	6.40
Responses	2736	2744	2738	2738

Promise element 3: We each have a voice that counts



	Autonomy and control	Raising concerns
Your org	6.94	6.28
Best result	7.31	7.02
Average result	6.92	6.30
Worst result	6.43	5.43
Responses	2746	2723

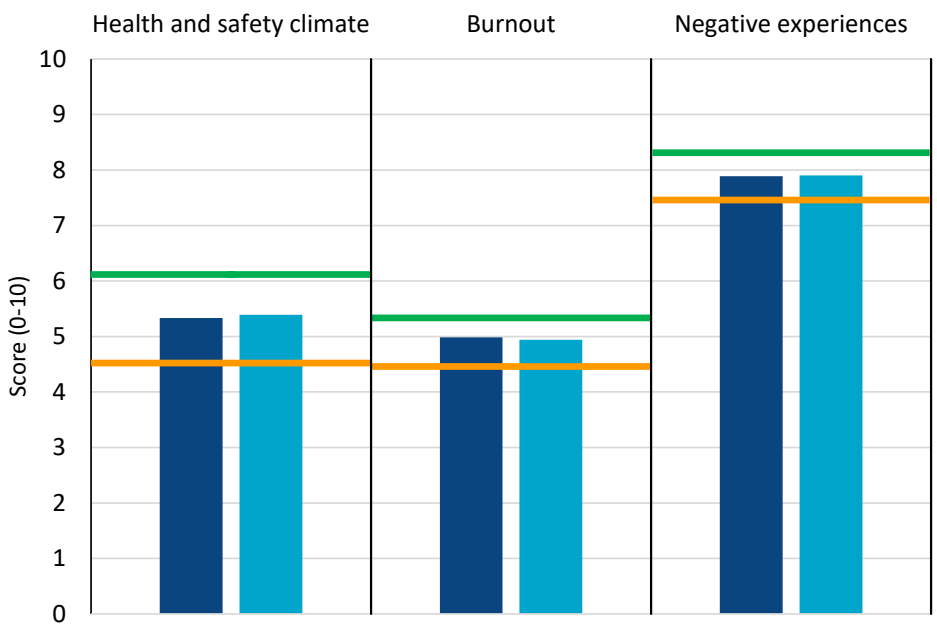
Note: People Promise element 2 'We are recognised and rewarded' does not have any sub-scores. Overall trend score data for this element is reported on slide 21.

People Promise elements, themes and sub-scores: Sub-score overview

Survey Coordination Centre NHS

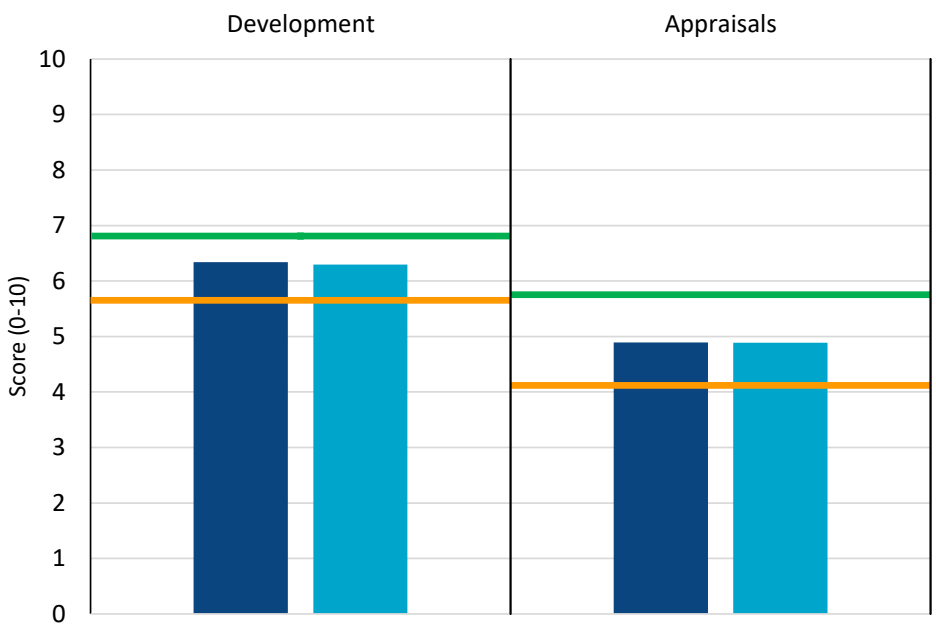
People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 4: We are safe and healthy



	Health and safety climate	Burnout	Negative experiences
Your org	5.33	4.99	7.89
Best result	6.12	5.33	8.31
Average result	5.39	4.94	7.90
Worst result	4.52	4.46	7.46
Responses	2745	2744	2740

Promise element 5: We are always learning



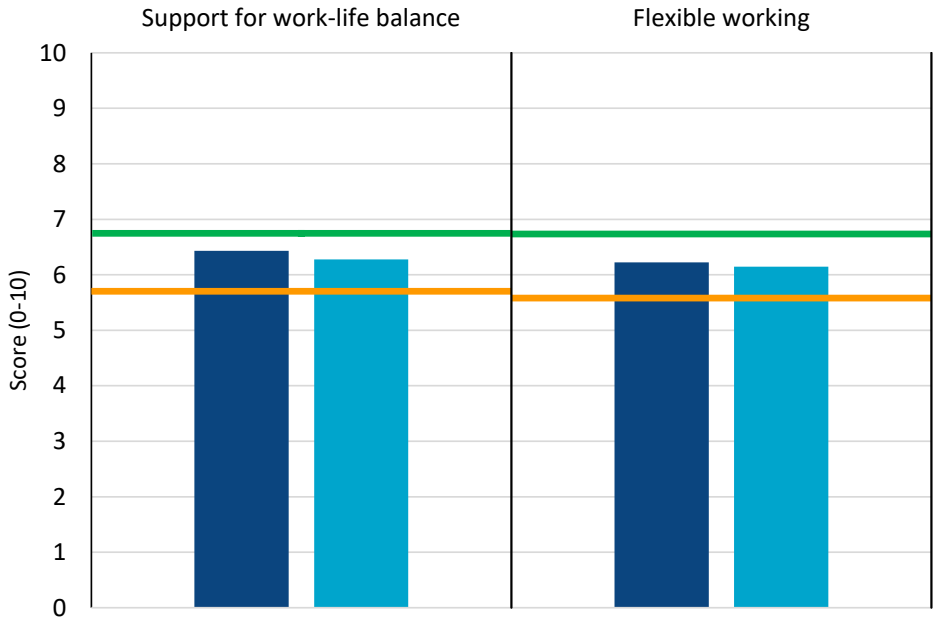
	Development	Appraisals
Your org	6.34	4.89
Best result	6.81	5.75
Average result	6.29	4.89
Worst result	5.65	4.12
Responses	2740	2637

People Promise elements, themes and sub-scores: Sub-score overview

Survey Coordination Centre NHS

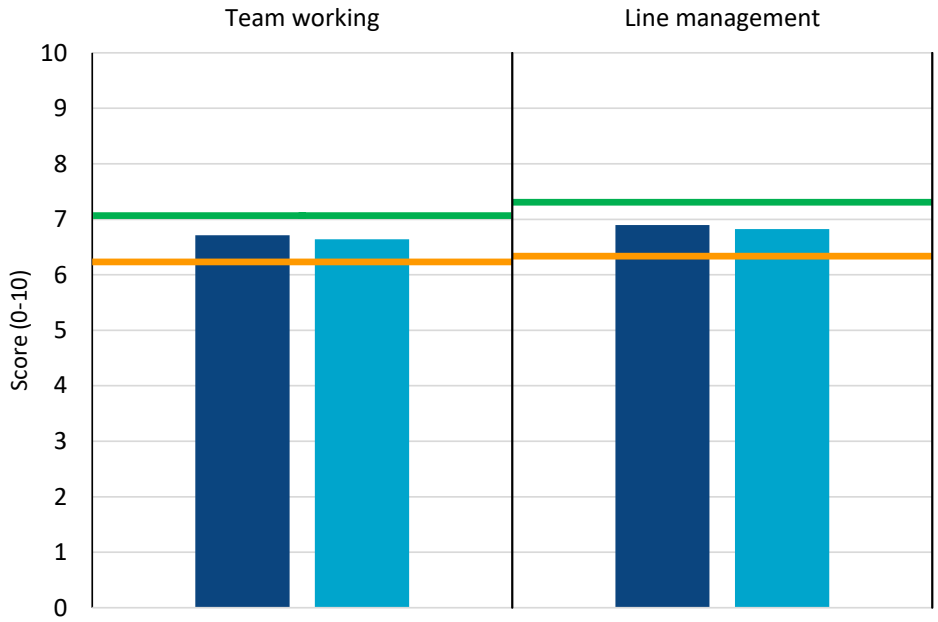
People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 6: We work flexibly



	Support for work-life balance	Flexible working
Your org	6.43	6.22
Best result	6.75	6.73
Average result	6.28	6.15
Worst result	5.70	5.58
Responses	2748	2728

Promise element 7: We are a team



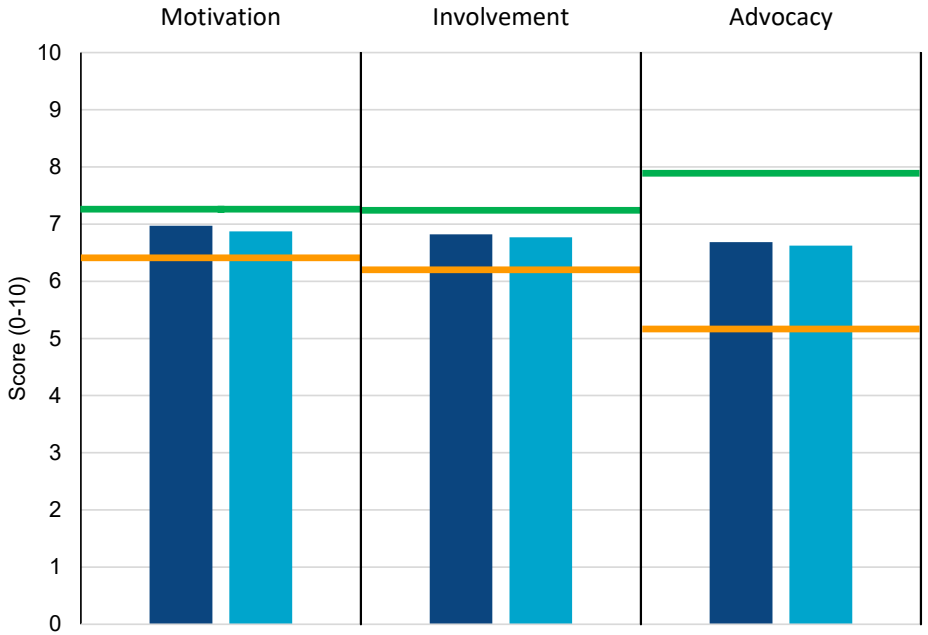
	Team working	Line management
Your org	6.71	6.90
Best result	7.07	7.31
Average result	6.64	6.82
Worst result	6.23	6.34
Responses	2742	2745

People Promise elements, themes and sub-scores: Sub-score overview

Survey Coordination Centre NHS

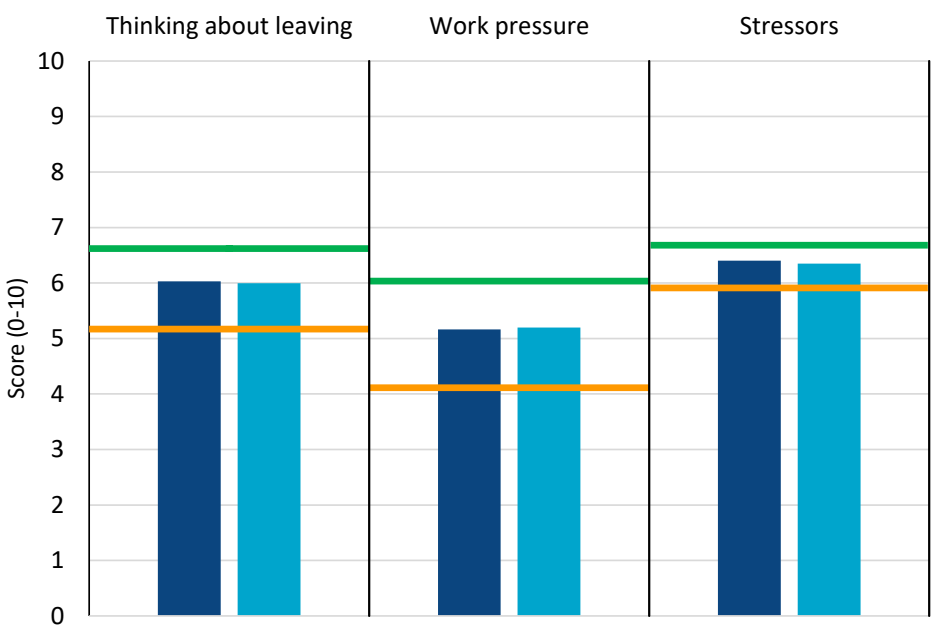
People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Theme: Staff engagement



	Motivation	Involvement	Advocacy
Your org	6.97	6.82	6.68
Best result	7.26	7.24	7.89
Average result	6.87	6.77	6.63
Worst result	6.41	6.20	5.17
Responses	2707	2746	2736

Theme: Morale



	Thinking about leaving	Work pressure	Stressors
Your org	6.03	5.16	6.40
Best result	6.62	6.03	6.68
Average result	6.00	5.20	6.35
Worst result	5.17	4.11	5.91
Responses	2744	2746	2746

Survey Coordination Centre

NHS

People Promise elements, themes and sub-scores: Trends

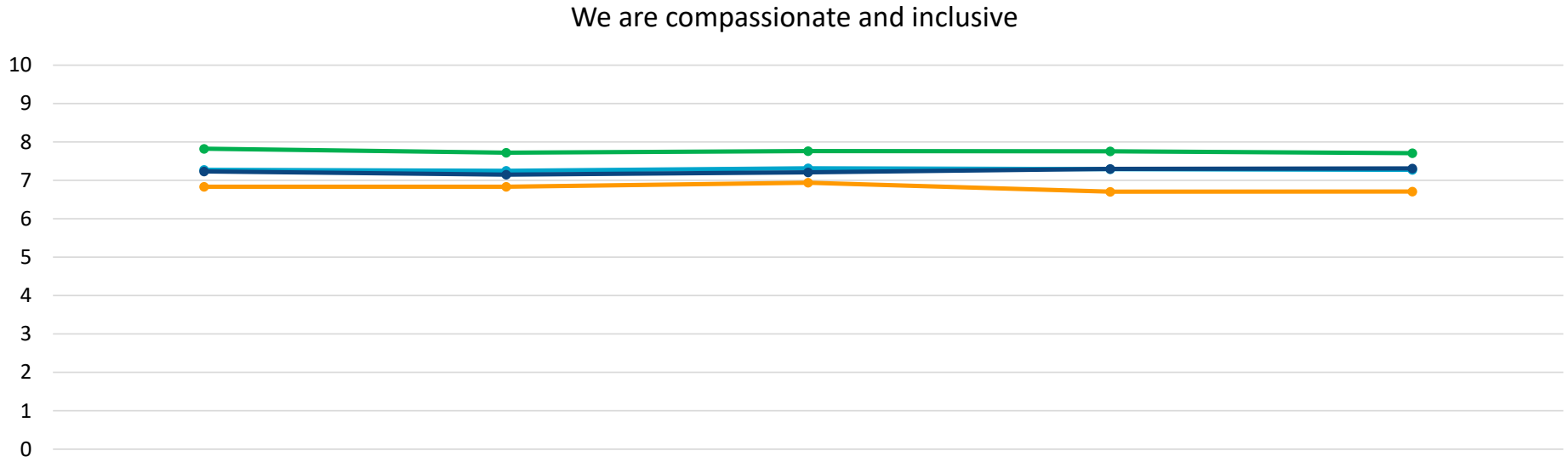
Note: where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

People Promise elements and themes: Trends

Survey Coordination Centre NHS

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 1: We are compassionate and inclusive



	2021	2022	2023	2024	2025
Your org	7.24	7.15	7.21	7.30	7.31
Best result	7.82	7.72	7.76	7.76	7.71
Average result	7.27	7.25	7.31	7.29	7.28
Worst result	6.83	6.83	6.94	6.71	6.71
Responses	2639	2951	2985	3336	2743

Note: Due to changes in the Q15 question wording in 2025, reported results for 'We are compassionate and inclusive' have been recalculated to exclude Q15 for all years. For more information, please refer to the *Technical Guide:* https://www.nhsstaffsurveys.com/survey-documents/

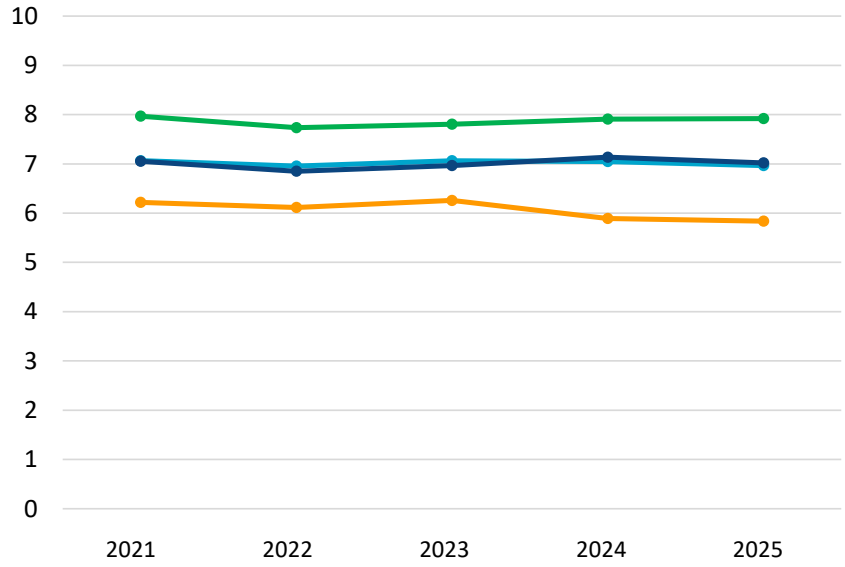
People Promise elements, themes and sub-scores: Sub-score trends

Survey Coordination Centre NHS

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

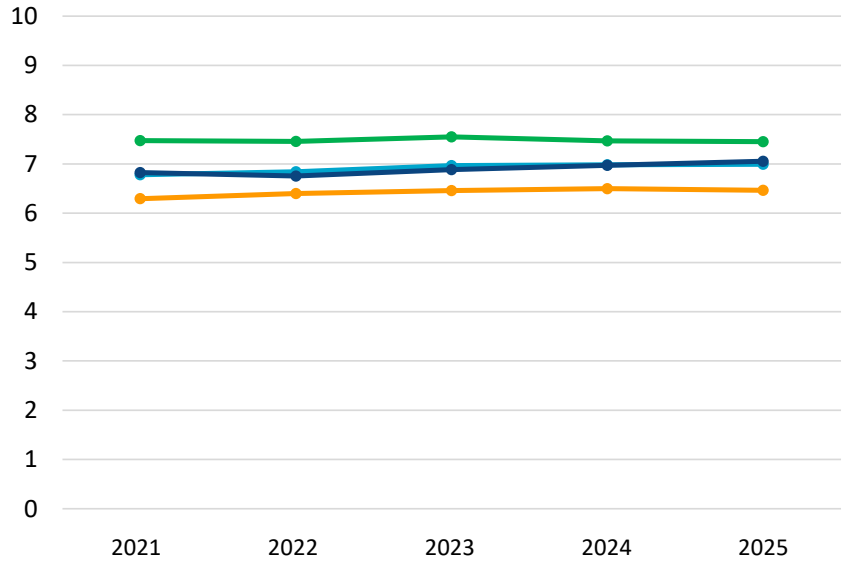
Promise element 1: We are compassionate and inclusive (1)

Compassionate culture



	2021	2022	2023	2024	2025
Your org	7.05	6.85	6.96	7.14	7.02
Best result	7.97	7.73	7.81	7.91	7.92
Average result	7.07	6.96	7.06	7.05	6.97
Worst result	6.22	6.12	6.26	5.89	5.84
Responses	2624	2940	2975	3324	2736

Compassionate leadership



	2021	2022	2023	2024	2025
Your org	6.83	6.75	6.88	6.97	7.05
Best result	7.48	7.46	7.55	7.47	7.45
Average result	6.78	6.84	6.96	6.98	6.99
Worst result	6.29	6.40	6.46	6.50	6.46
Responses	2638	2951	2984	3334	2744

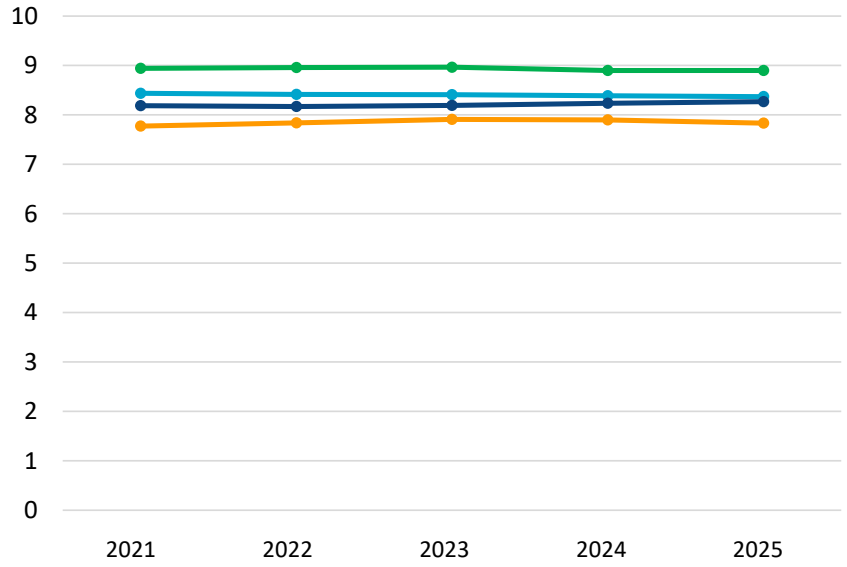
People Promise elements, themes and sub-scores: Sub-score trends

Survey Coordination Centre NHS

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

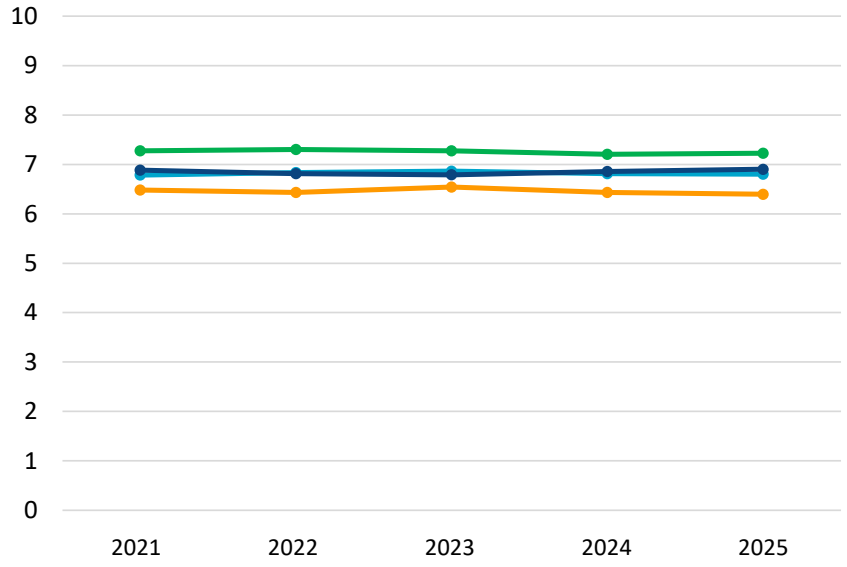
Promise element 1: We are compassionate and inclusive (2)

Diversity and equality



	2021	2022	2023	2024	2025
Your org	8.19	8.17	8.19	8.24	8.27
Best result	8.94	8.96	8.97	8.90	8.90
Average result	8.44	8.41	8.41	8.39	8.37
Worst result	7.77	7.84	7.91	7.90	7.83
Responses	2632	2948	2976	3322	2738

Inclusion



	2021	2022	2023	2024	2025
Your org	6.88	6.81	6.79	6.85	6.90
Best result	7.28	7.30	7.27	7.20	7.22
Average result	6.78	6.84	6.86	6.81	6.80
Worst result	6.48	6.43	6.54	6.43	6.40
Responses	2629	2942	2974	3319	2738

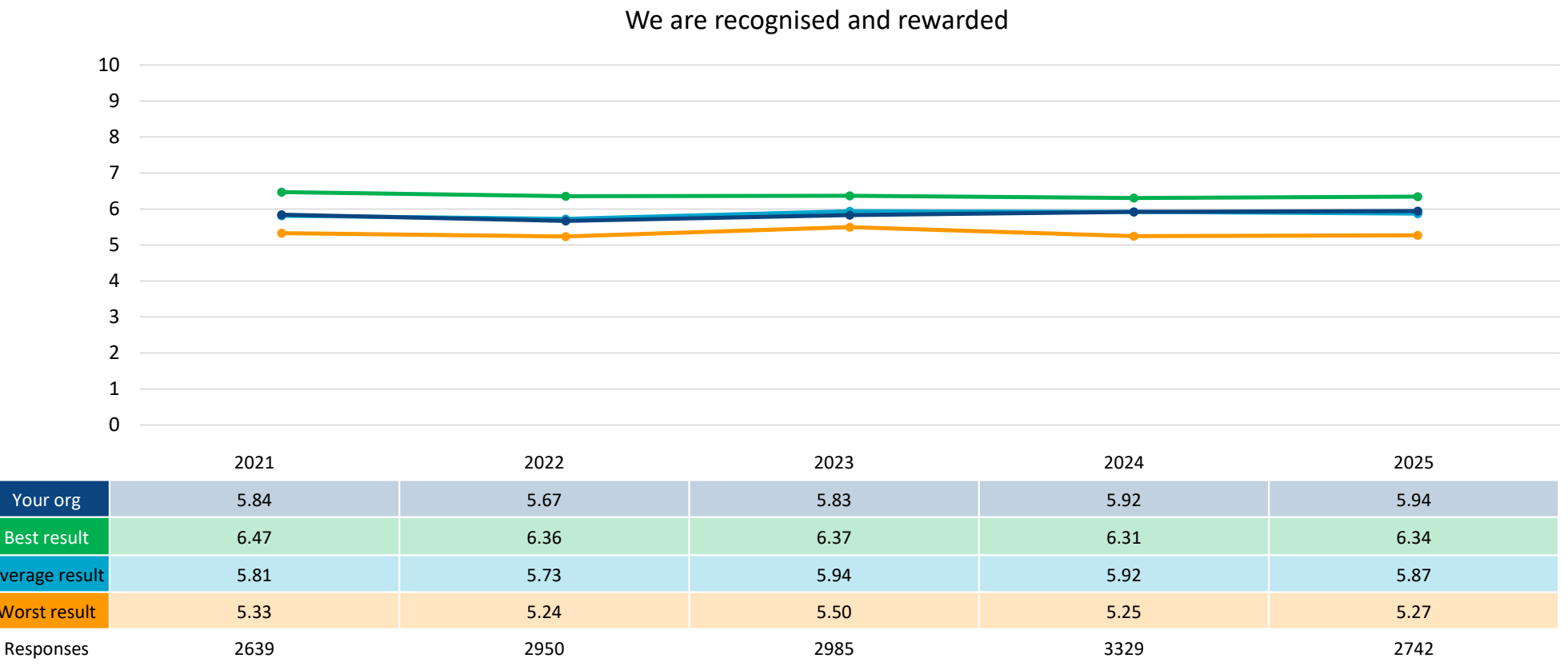
Note: Due to changes in the Q15 question wording in 2025, reported results for 'Diversity and equality' have been recalculated to exclude Q15 for all years. For more information, please refer to the *Technical Guide:* https://www.nhsstaffsurveys.com/survey-documents/

People Promise elements and themes: Trends

Survey Coordination Centre NHS

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 2: We are recognised and rewarded



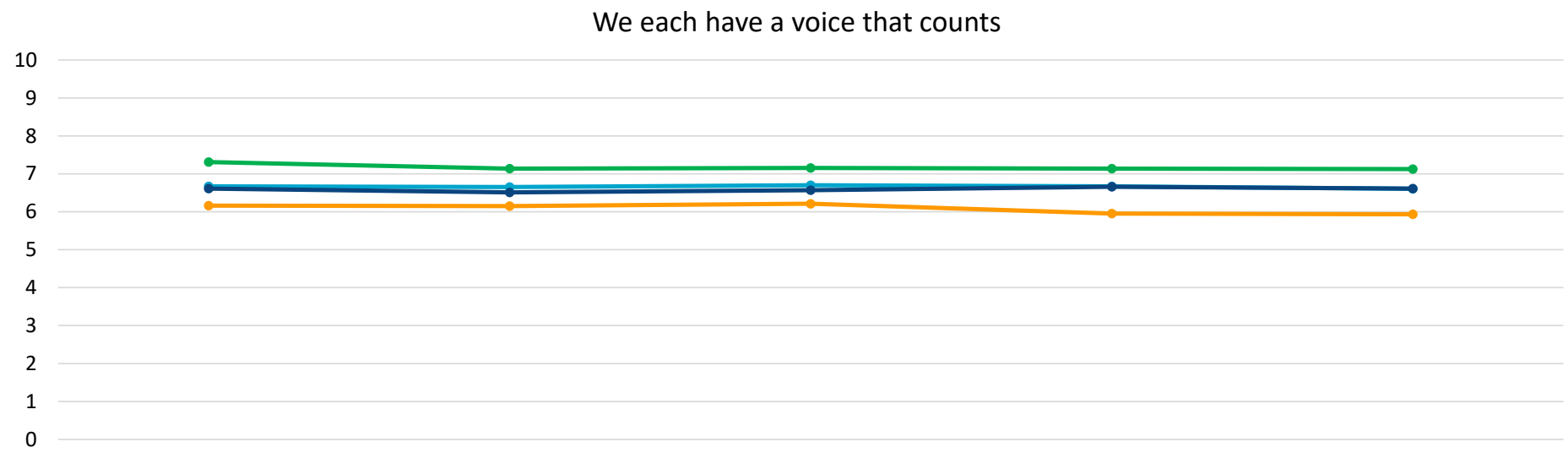
	2021	2022	2023	2024	2025
Your org	5.84	5.67	5.83	5.92	5.94
Best result	6.47	6.36	6.37	6.31	6.34
Average result	5.81	5.73	5.94	5.92	5.87
Worst result	5.33	5.24	5.50	5.25	5.27
Responses	2639	2950	2985	3329	2742

People Promise elements and themes: Trends

Survey Coordination Centre NHS

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 3: We each have a voice that counts



	2021	2022	2023	2024	2025
Your org	6.61	6.51	6.57	6.66	6.61
Best result	7.31	7.14	7.16	7.14	7.12
Average result	6.67	6.65	6.70	6.67	6.60
Worst result	6.16	6.15	6.21	5.95	5.93
Responses	2597	2923	2960	3308	2716

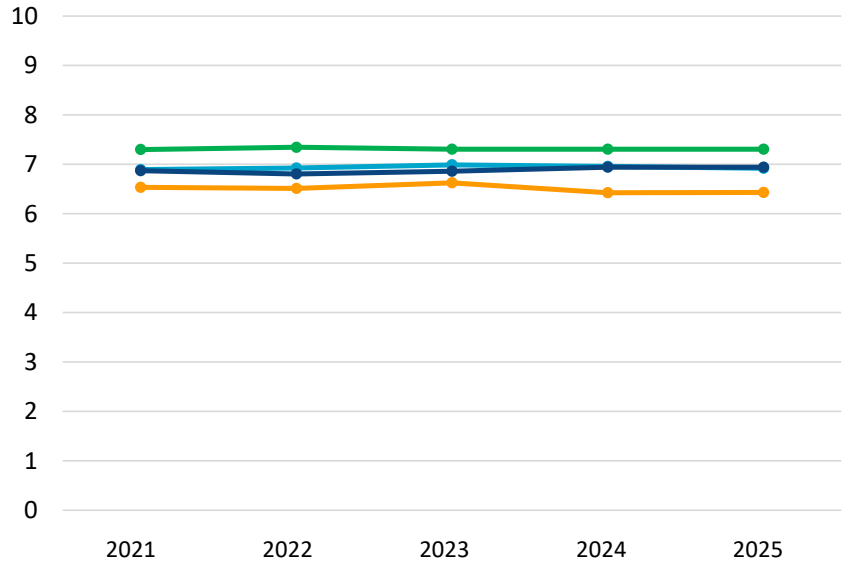
People Promise elements, themes and sub-scores: Sub-score trends

Survey Coordination Centre NHS

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

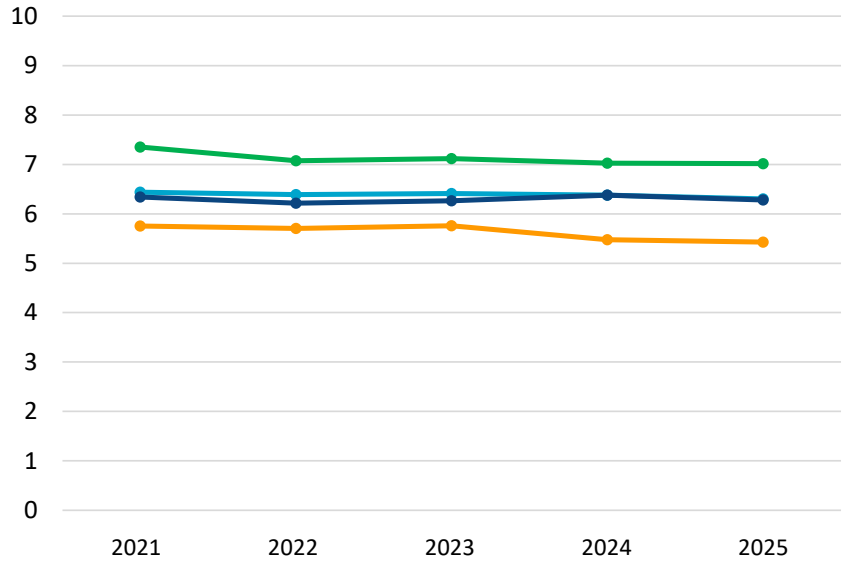
Promise element 3: We each have a voice that counts

Autonomy and control



	2021	2022	2023	2024	2025
Your org	6.87	6.80	6.86	6.94	6.94
Best result	7.30	7.35	7.31	7.31	7.31
Average result	6.89	6.93	6.99	6.96	6.92
Worst result	6.53	6.51	6.63	6.42	6.43
Responses	2640	2955	2987	3339	2746

Raising concerns



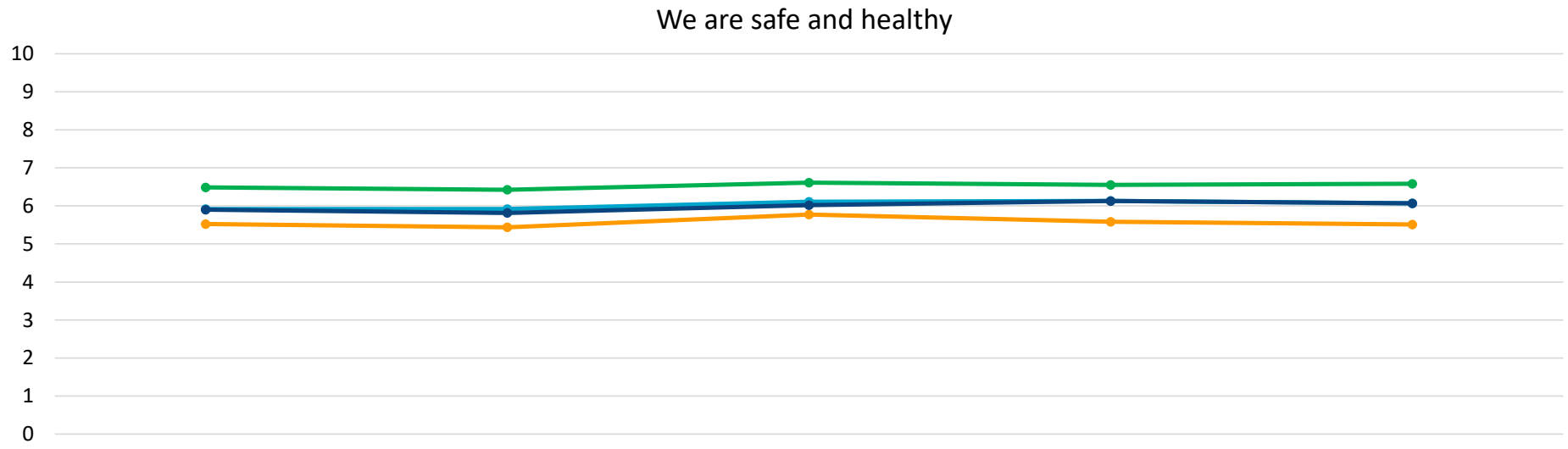
	2021	2022	2023	2024	2025
Your org	6.34	6.22	6.26	6.38	6.28
Best result	7.35	7.07	7.12	7.02	7.02
Average result	6.44	6.39	6.41	6.38	6.30
Worst result	5.75	5.70	5.76	5.48	5.43
Responses	2601	2927	2964	3311	2723

People Promise elements and themes: Trends

Survey Coordination Centre NHS

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 4: We are safe and healthy



	2021	2022	2023	2024	2025
Your org	5.90	5.81	6.02	6.13	6.07
Best result	6.48	6.42	6.61	6.55	6.58
Average result	5.92	5.92	6.11	6.13	6.07
Worst result	5.52	5.44	5.77	5.58	5.51
Responses	2614	2941	2960	3318	2725

Note: 2023 results for 'We are safe and healthy' are reported using corrected data. In addition, due to changes in the Q11b question wording in 2025, reported results for 'We are safe and healthy' have been recalculated to exclude Q11b for all years. Please see *Additional Information regarding NSS23 data collection issue* and *Technical Guide* at https://www.nhsstaffsurveys.com/survey-documents/ for more details.

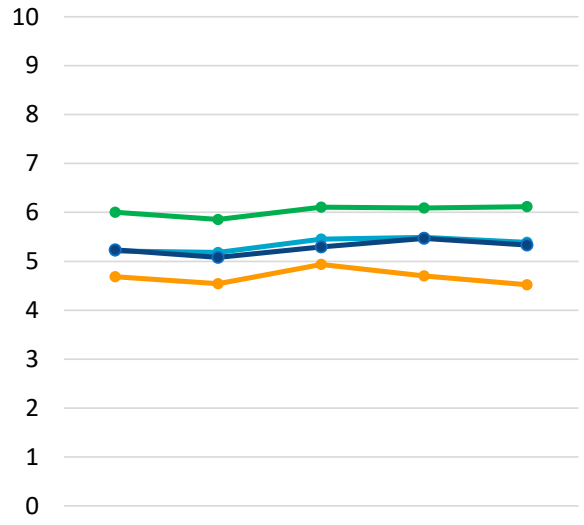
People Promise elements, themes and sub-scores: Sub-score trends

Survey Coordination Centre NHS

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

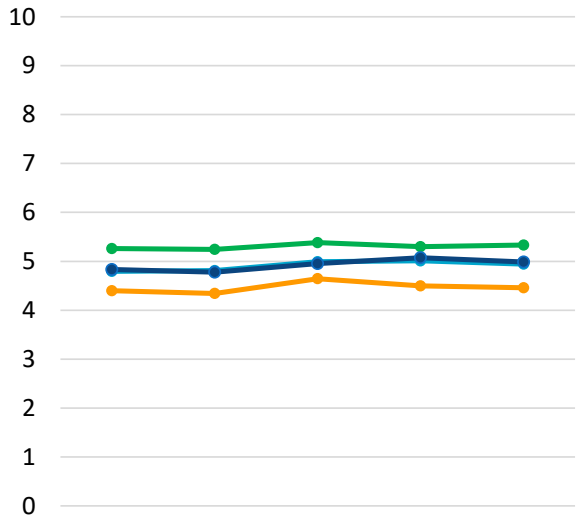
Promise element 4: We are safe and healthy

Health and safety climate



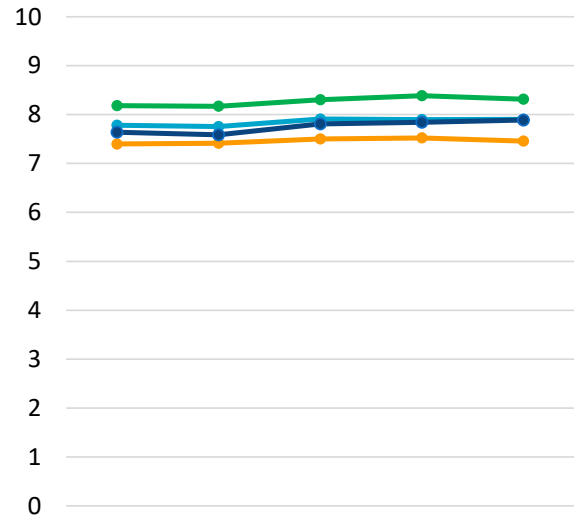
	2021	2022	2023	2024	2025
Your org	5.23	5.08	5.30	5.47	5.33
Best result	6.01	5.86	6.11	6.09	6.12
Average result	5.21	5.18	5.45	5.49	5.39
Worst result	4.68	4.54	4.94	4.70	4.52
Responses	2640	2953	2985	3338	2745

Burnout



	2021	2022	2023	2024	2025
Your org	4.83	4.78	4.96	5.07	4.99
Best result	5.26	5.24	5.38	5.30	5.33
Average result	4.79	4.81	4.99	5.01	4.94
Worst result	4.40	4.34	4.64	4.50	4.46
Responses	2631	2953	2986	3335	2744

Negative experiences



	2021	2022	2023	2024	2025
Your org	7.64	7.59	7.81	7.84	7.89
Best result	8.18	8.17	8.30	8.39	8.31
Average result	7.78	7.76	7.91	7.90	7.90
Worst result	7.40	7.41	7.50	7.52	7.46
Responses	2626	2951	2970	3329	2740

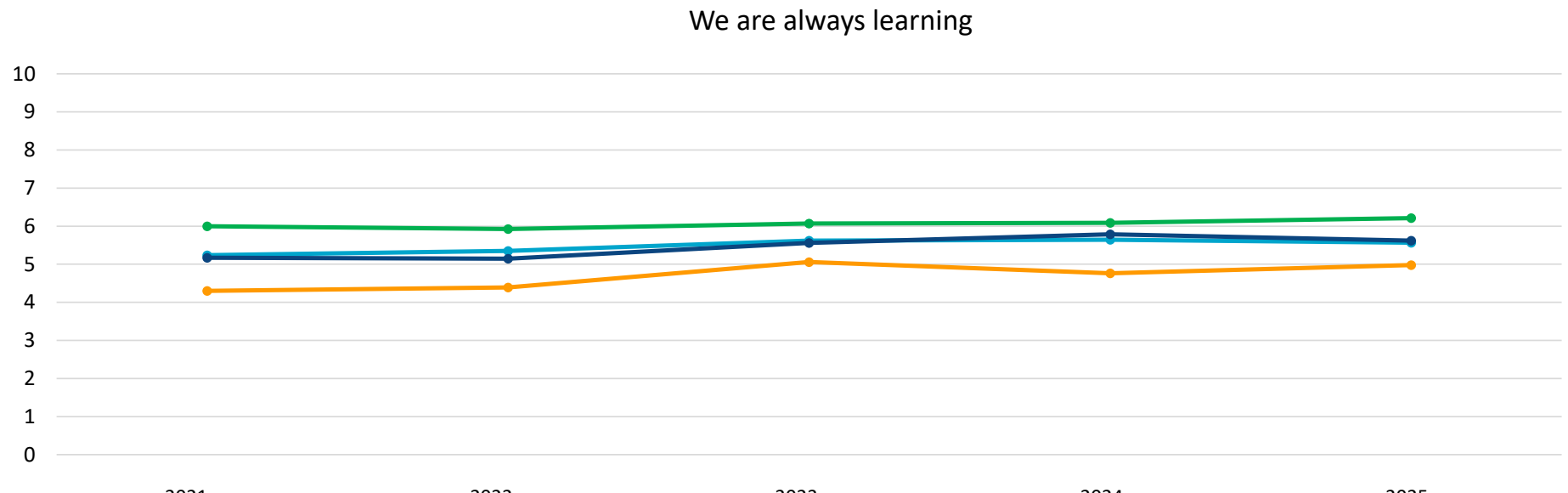
Note: 2023 results for 'Health and safety climate' and 'Negative experiences' are reported using corrected data. In addition, due to changes in the Q11b question wording in 2025, reported results for 'Negative experiences' have been recalculated to exclude Q11b for all years. Please see *Additional Information regarding NSS23 data collection issue* and *Technical Guide* at https://www.nhsstaffsurveys.com/survey-documents/ for more details.

People Promise elements and themes: Trends

Survey Coordination Centre NHS

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 5: We are always learning



	2021	2022	2023	2024	2025
Your org	5.17	5.15	5.56	5.79	5.62
Best result	6.00	5.92	6.07	6.09	6.21
Average result	5.24	5.35	5.62	5.64	5.57
Worst result	4.30	4.39	5.06	4.76	4.98
Responses	2489	2796	2858	3200	2631

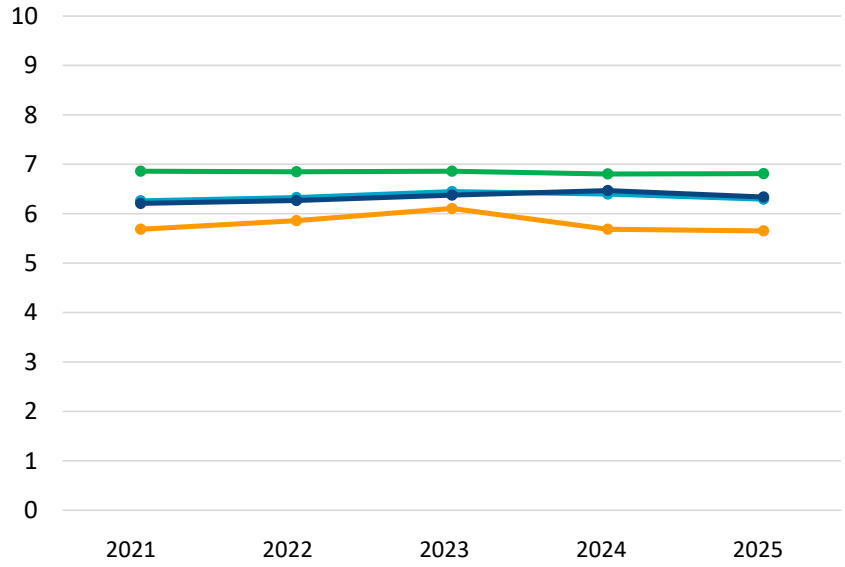
People Promise elements, themes and sub-scores: Sub-score trends

Survey Coordination Centre NHS

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

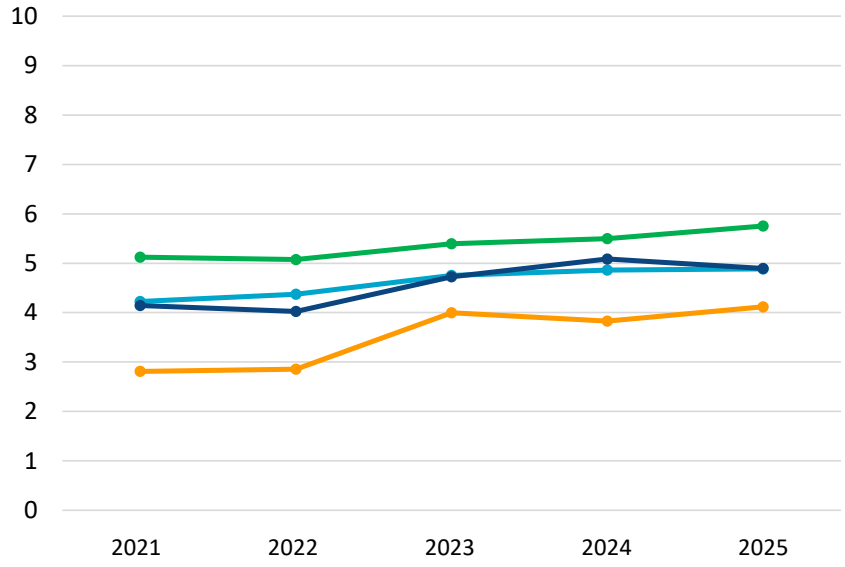
Promise element 5: We are always learning

Development



	2021	2022	2023	2024	2025
Your org	6.21	6.27	6.38	6.47	6.34
Best result	6.86	6.85	6.86	6.80	6.81
Average result	6.26	6.33	6.45	6.40	6.29
Worst result	5.68	5.86	6.11	5.69	5.65
Responses	2627	2940	2982	3330	2740

Appraisals



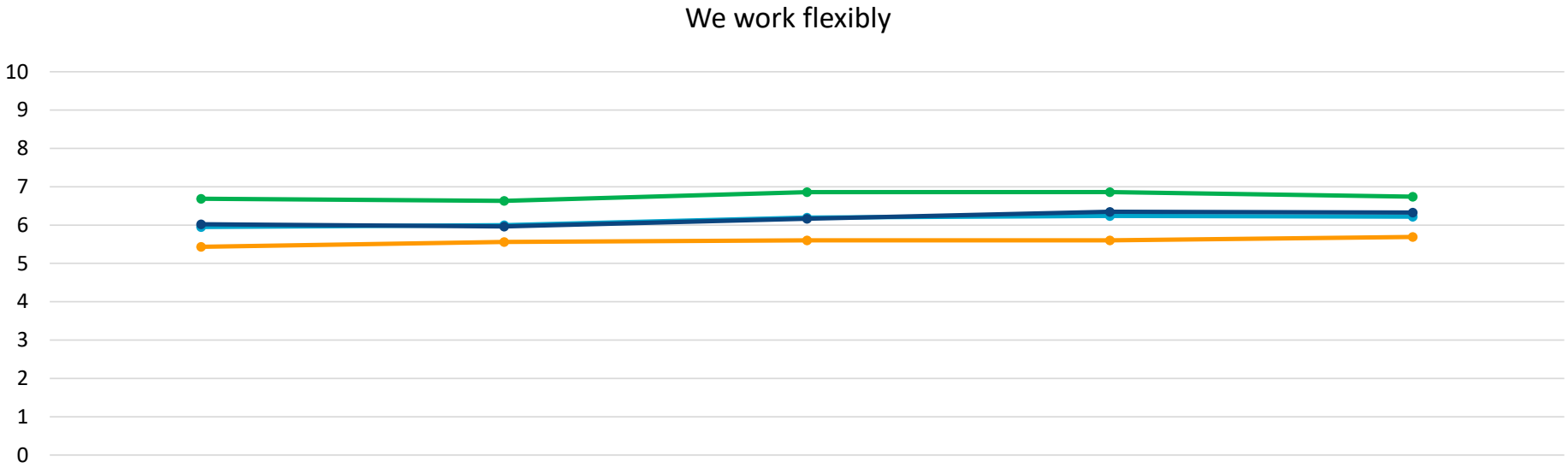
	2021	2022	2023	2024	2025
Your org	4.15	4.02	4.73	5.09	4.89
Best result	5.12	5.07	5.39	5.50	5.75
Average result	4.23	4.37	4.75	4.86	4.89
Worst result	2.81	2.86	3.99	3.83	4.12
Responses	2494	2809	2860	3207	2637

People Promise elements and themes: Trends

Survey Coordination Centre NHS

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 6: We work flexibly



	2021	2022	2023	2024	2025
Your org	6.02	5.96	6.17	6.35	6.33
Best result	6.69	6.63	6.86	6.86	6.74
Average result	5.95	6.00	6.20	6.24	6.22
Worst result	5.43	5.56	5.60	5.60	5.69
Responses	2628	2940	2964	3307	2725

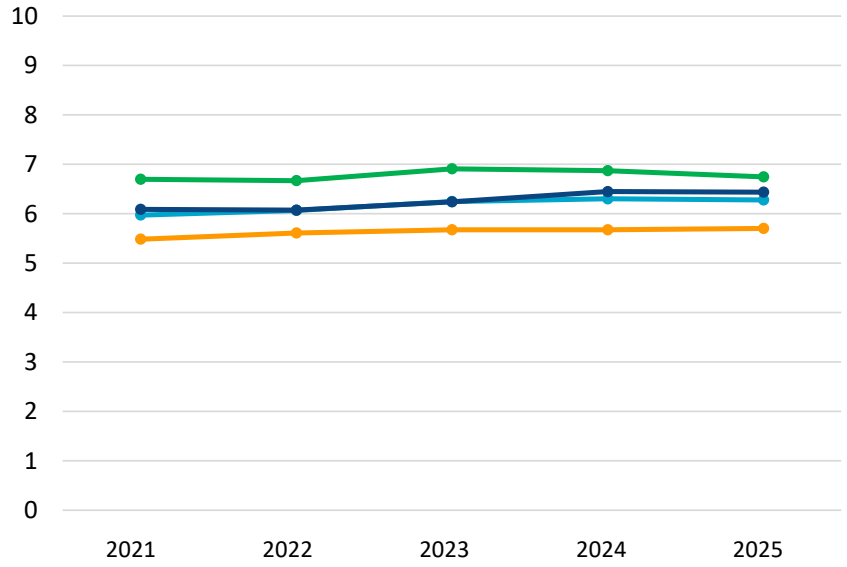
People Promise elements, themes and sub-scores: Sub-score trends

Survey Coordination Centre NHS

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

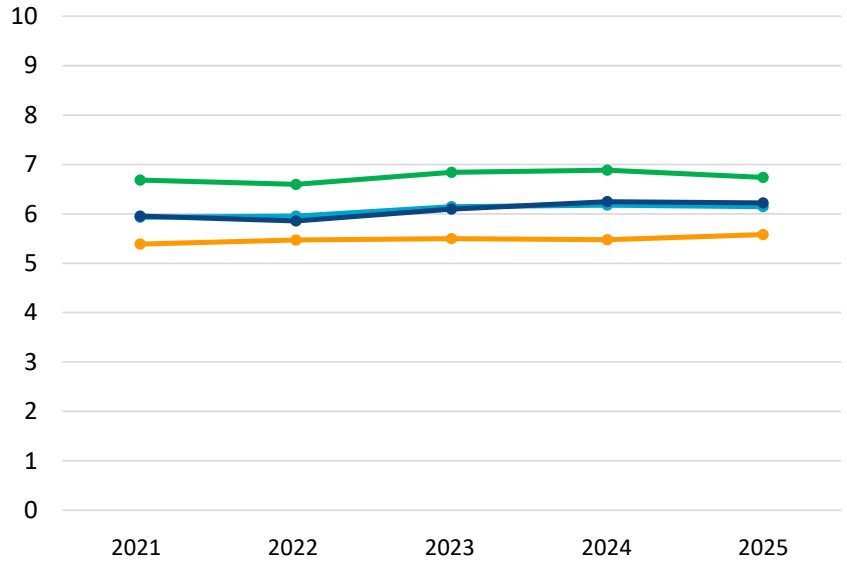
Promise element 6: We work flexibly

Support for work-life balance



	2021	2022	2023	2024	2025
Your org	6.09	6.07	6.24	6.45	6.43
Best result	6.70	6.67	6.91	6.87	6.75
Average result	5.97	6.07	6.25	6.30	6.28
Worst result	5.48	5.61	5.67	5.67	5.70
Responses	2639	2955	2984	3331	2748

Flexible working



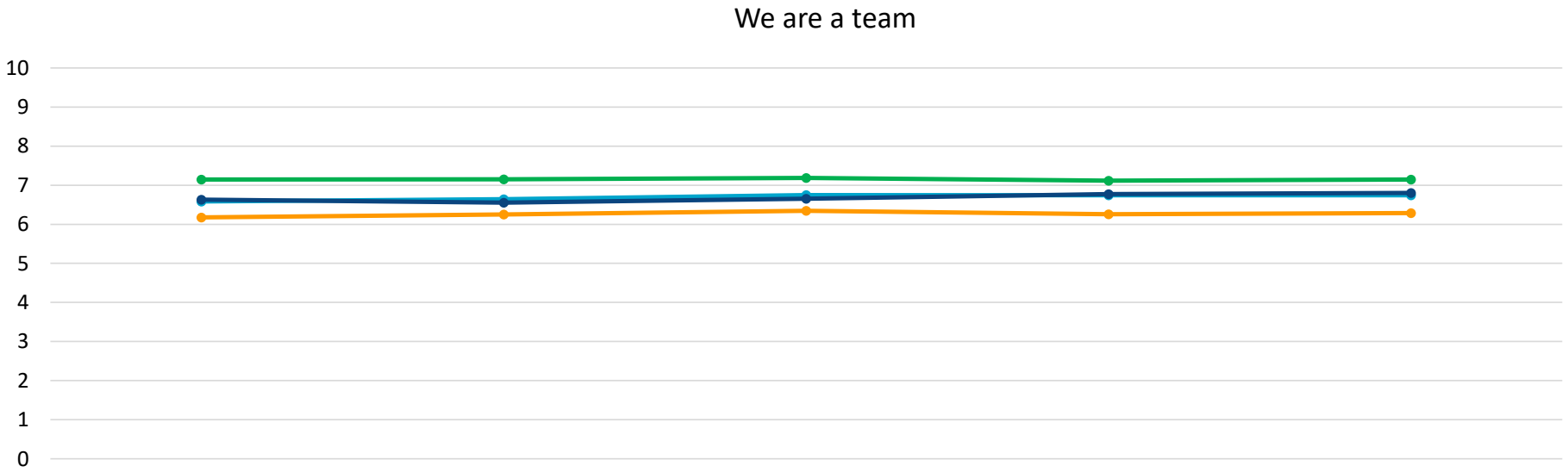
	2021	2022	2023	2024	2025
Your org	5.96	5.86	6.10	6.24	6.22
Best result	6.68	6.60	6.84	6.88	6.73
Average result	5.93	5.95	6.15	6.17	6.15
Worst result	5.39	5.47	5.50	5.48	5.58
Responses	2631	2942	2969	3315	2728

People Promise elements and themes: Trends

Survey Coordination Centre NHS

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 7: We are a team



	2021	2022	2023	2024	2025
Your org	6.63	6.55	6.65	6.77	6.80
Best result	7.15	7.15	7.19	7.12	7.14
Average result	6.58	6.64	6.75	6.75	6.75
Worst result	6.18	6.25	6.34	6.25	6.29
Responses	2634	2945	2979	3328	2741

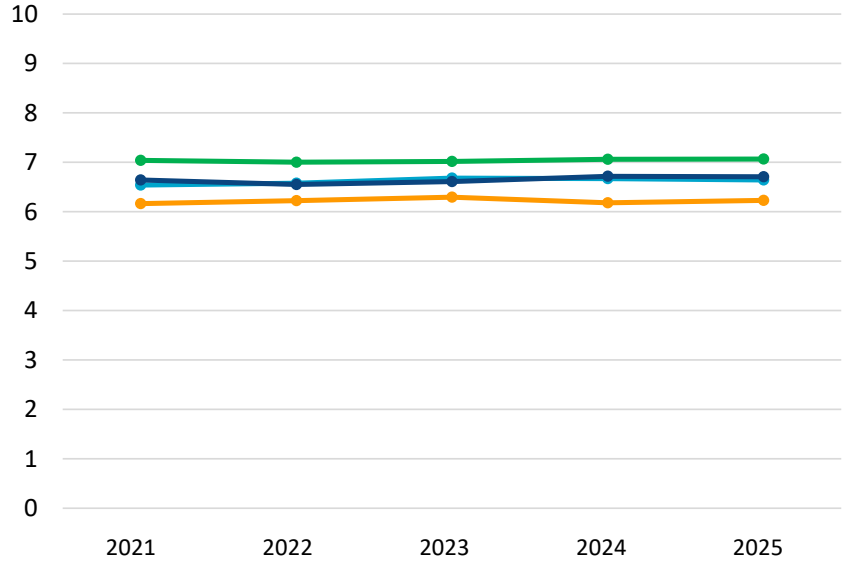
People Promise elements, themes and sub-scores: Sub-score trends

Survey Coordination Centre NHS

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

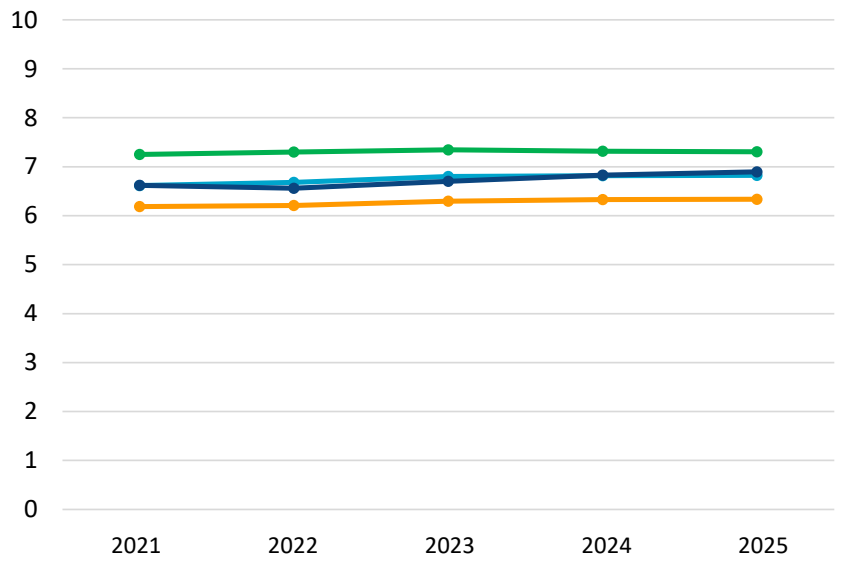
Promise element 7: We are a team

Team working



	2021	2022	2023	2024	2025
Your org	6.64	6.55	6.61	6.72	6.71
Best result	7.04	7.00	7.02	7.06	7.07
Average result	6.54	6.58	6.68	6.67	6.64
Worst result	6.16	6.22	6.29	6.18	6.23
Responses	2637	2949	2982	3335	2742

Line management



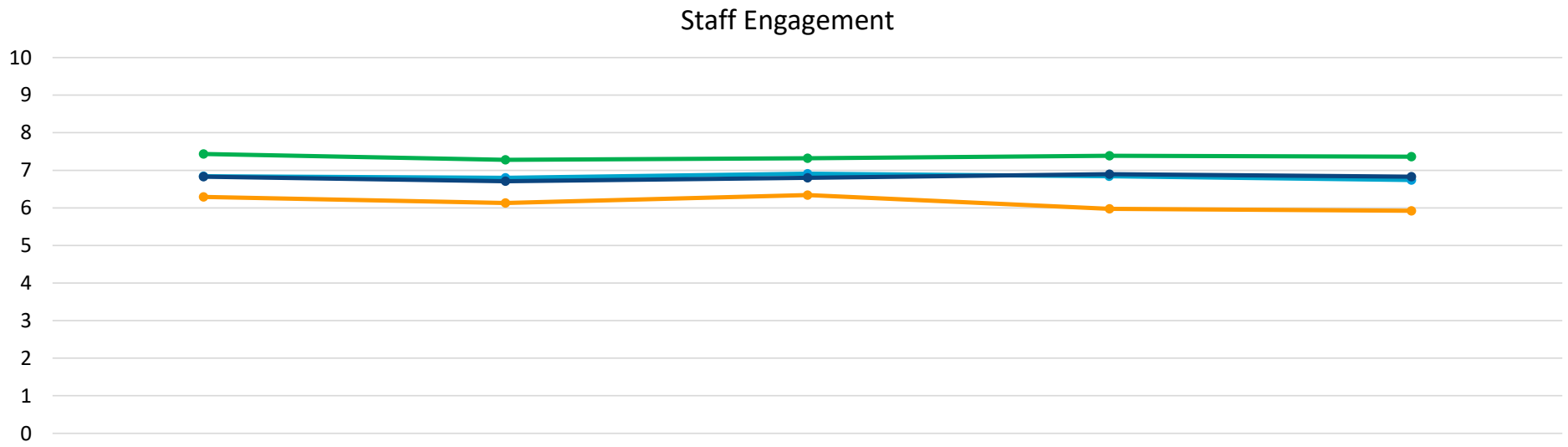
	2021	2022	2023	2024	2025
Your org	6.62	6.56	6.70	6.83	6.90
Best result	7.25	7.30	7.35	7.31	7.31
Average result	6.62	6.68	6.80	6.82	6.82
Worst result	6.19	6.21	6.30	6.33	6.34
Responses	2640	2952	2984	3333	2745

People Promise elements and themes: Trends

Survey Coordination Centre NHS

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Theme: Staff Engagement



	2021	2022	2023	2024	2025
Your org	6.83	6.71	6.80	6.90	6.83
Best result	7.43	7.28	7.32	7.39	7.36
Average result	6.84	6.80	6.91	6.84	6.74
Worst result	6.29	6.13	6.34	5.98	5.92
Responses	2640	2955	2987	3338	2749

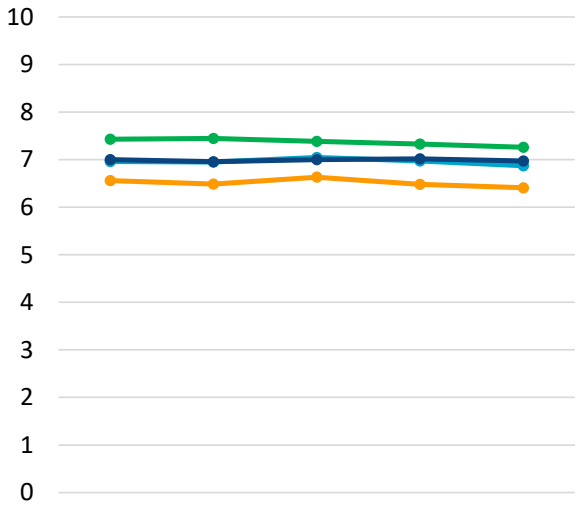
People Promise elements, themes and sub-scores: Sub-score trends

Survey Coordination Centre NHS

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

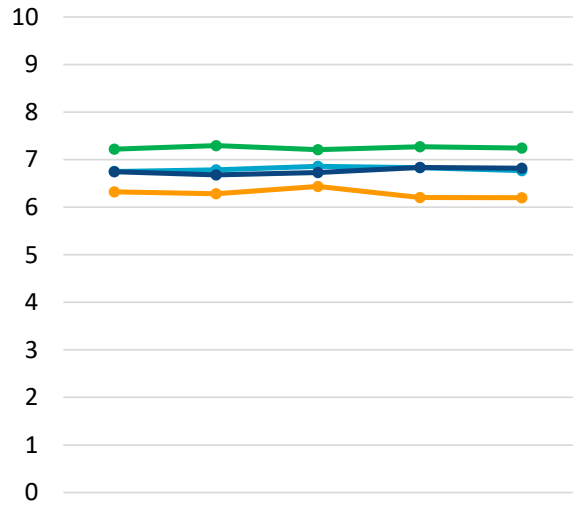
Theme: Staff Engagement

Motivation



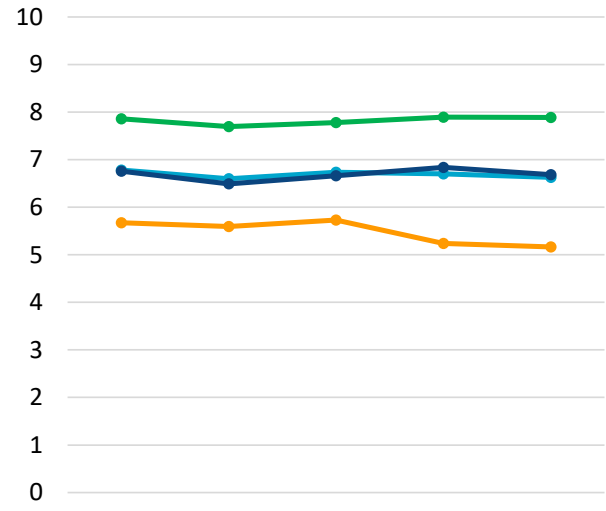
	2021	2022	2023	2024	2025
Your org	7.00	6.96	7.00	7.02	6.97
Best result	7.43	7.45	7.39	7.33	7.26
Average result	6.96	6.95	7.05	6.98	6.87
Worst result	6.56	6.48	6.63	6.48	6.41
Responses	2607	2919	2942	3297	2707

Involvement



	2021	2022	2023	2024	2025
Your org	6.75	6.68	6.73	6.84	6.82
Best result	7.22	7.30	7.21	7.27	7.24
Average result	6.75	6.78	6.86	6.83	6.77
Worst result	6.32	6.28	6.44	6.20	6.20
Responses	2639	2954	2986	3339	2746

Advocacy



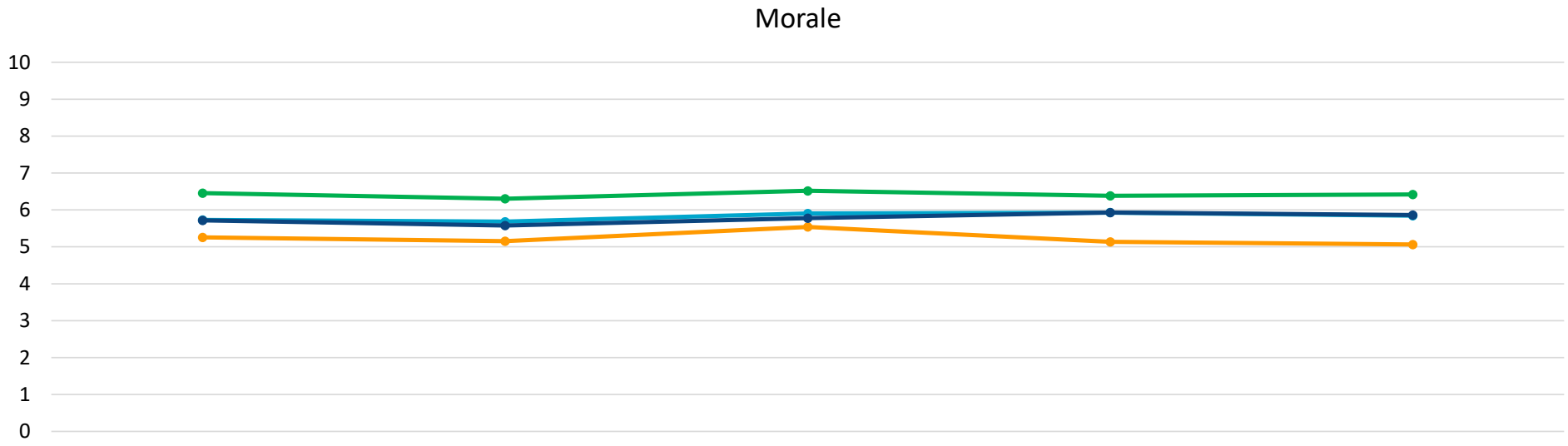
	2021	2022	2023	2024	2025
Your org	6.76	6.49	6.66	6.84	6.68
Best result	7.86	7.70	7.78	7.89	7.89
Average result	6.78	6.60	6.74	6.70	6.63
Worst result	5.67	5.60	5.73	5.24	5.17
Responses	2624	2940	2975	3323	2736

People Promise elements and themes: Trends

Survey Coordination Centre NHS

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Theme: Morale



	2021	2022	2023	2024	2025
Your org	5.72	5.58	5.78	5.93	5.86
Best result	6.45	6.30	6.52	6.38	6.42
Average result	5.73	5.68	5.90	5.93	5.84
Worst result	5.26	5.16	5.54	5.13	5.06
Responses	2641	2956	2988	3342	2749

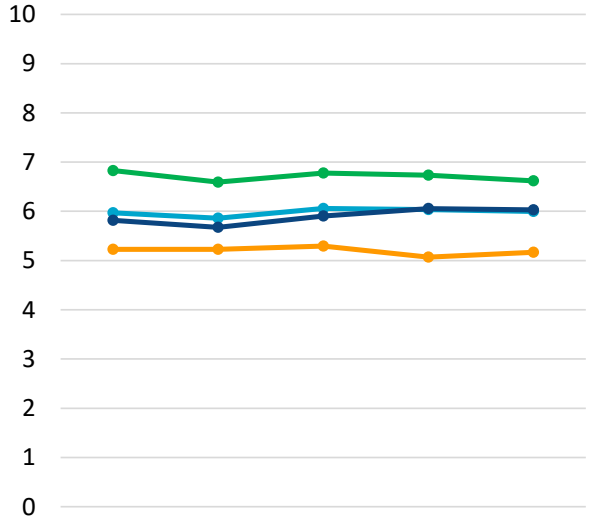
People Promise elements, themes and sub-scores: Sub-score trends

Survey Coordination Centre NHS

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

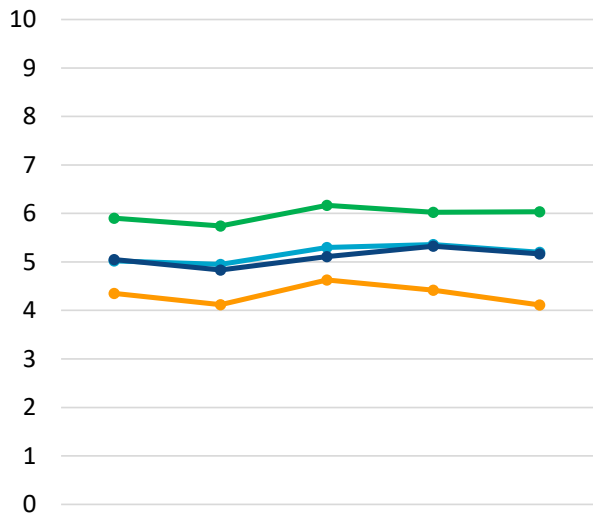
Theme: Morale

Thinking about leaving



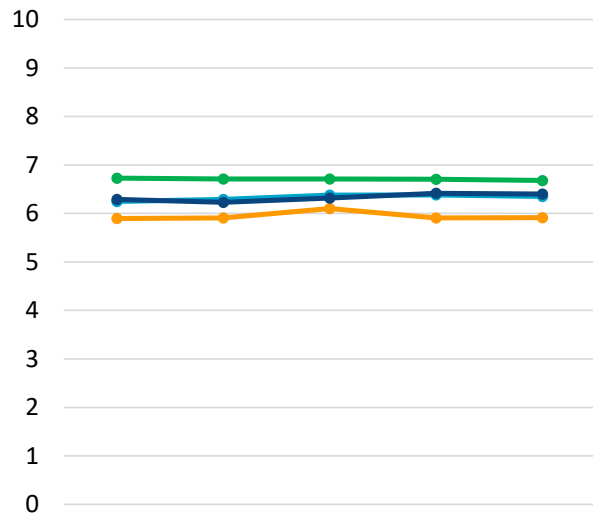
	2021	2022	2023	2024	2025
Your org	5.82	5.67	5.90	6.05	6.03
Best result	6.83	6.59	6.78	6.73	6.62
Average result	5.97	5.86	6.06	6.04	6.00
Worst result	5.23	5.23	5.29	5.07	5.17
Responses	2623	2948	2980	3325	2744

Work pressure



	2021	2022	2023	2024	2025
Your org	5.05	4.83	5.11	5.32	5.16
Best result	5.90	5.74	6.17	6.03	6.03
Average result	5.02	4.95	5.30	5.36	5.20
Worst result	4.35	4.12	4.63	4.42	4.11
Responses	2639	2949	2984	3336	2746

Stressors



	2021	2022	2023	2024	2025
Your org	6.29	6.23	6.32	6.42	6.40
Best result	6.73	6.71	6.71	6.70	6.68
Average result	6.25	6.29	6.38	6.38	6.35
Worst result	5.90	5.91	6.10	5.91	5.91
Responses	2635	2948	2985	3331	2746

Survey Coordination Centre

NHS

People Promise element – We are compassionate and inclusive

Questions included:

Compassionate culture – Q6a, Q25a, Q25b, Q25c, Q25d

Compassionate leadership – Q9f, Q9g, Q9h, Q9i

Diversity and equality – Q15, Q16a, Q16b, Q21

Inclusion – Q7h, Q7i, Q8b, Q8c

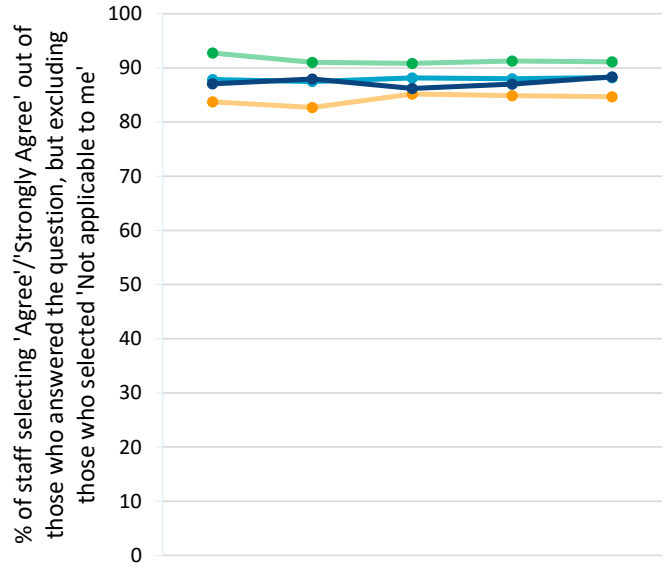
Note: where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

People Promise elements and theme results – We are compassionate and inclusive: Compassionate culture

Survey Coordination Centre

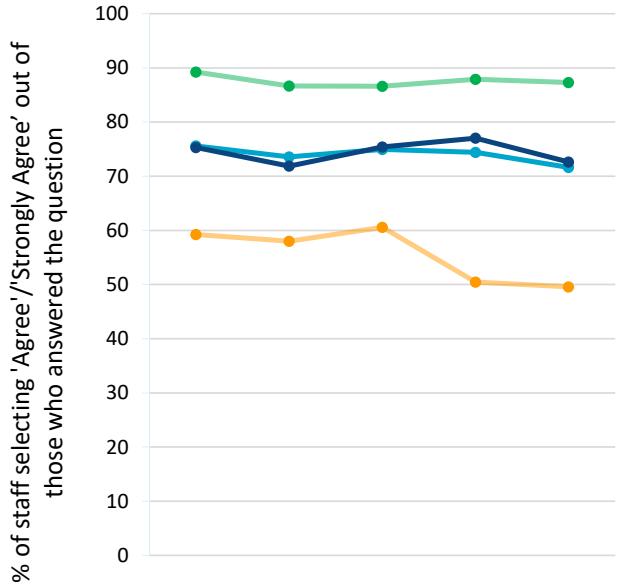
NHS

Q6a I feel that my role makes a difference to patients / service users.



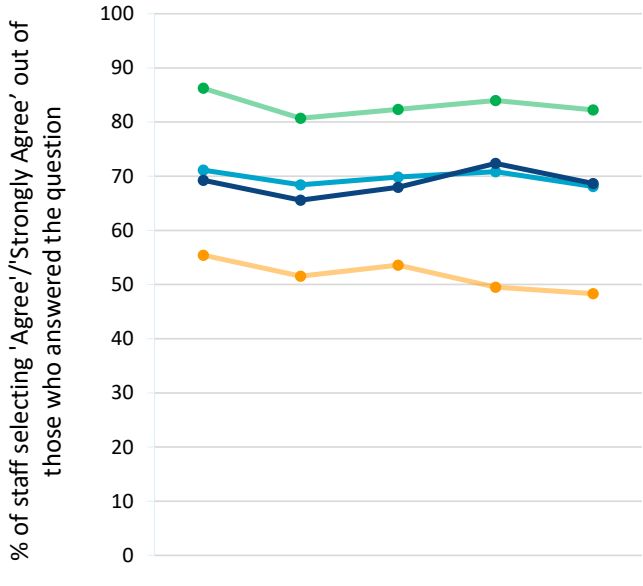
	2021	2022	2023	2024	2025
Your org	87.05%	87.97%	86.21%	87.01%	88.35%
Best result	92.75%	91.05%	90.85%	91.30%	91.11%
Average result	87.85%	87.48%	88.14%	88.02%	88.22%
Worst result	83.75%	82.70%	85.18%	84.88%	84.67%
Responses	2557	2872	2904	3238	2672

Q25a Care of patients / service users is my organisation's top priority.



	2021	2022	2023	2024	2025
Your org	75.32%	71.87%	75.42%	77.03%	72.62%
Best result	89.24%	86.64%	86.62%	87.88%	87.31%
Average result	75.58%	73.58%	74.95%	74.42%	71.63%
Worst result	59.25%	57.99%	60.58%	50.48%	49.59%
Responses	2621	2938	2972	3323	2733

Q25b My organisation acts on concerns raised by patients / service users.



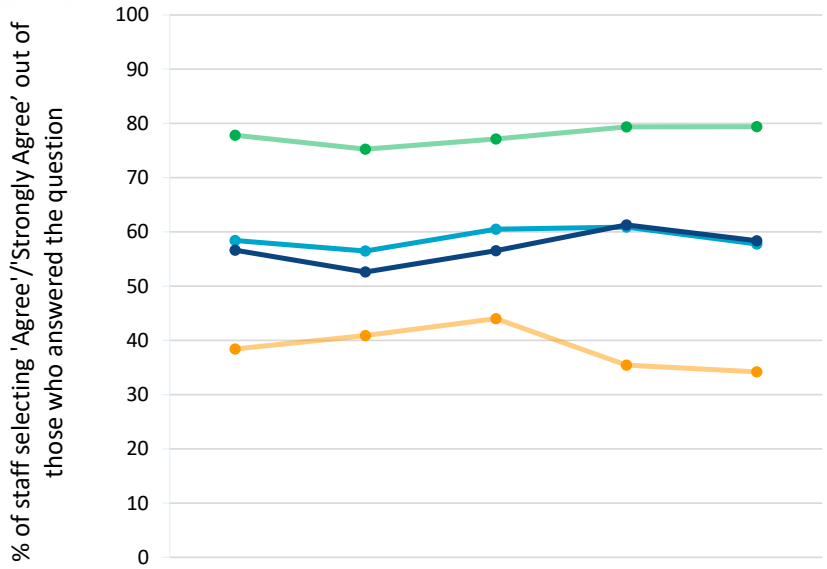
	2021	2022	2023	2024	2025
Your org	69.28%	65.58%	67.98%	72.37%	68.66%
Best result	86.24%	80.70%	82.35%	83.97%	82.23%
Average result	71.13%	68.39%	69.84%	70.86%	68.11%
Worst result	55.43%	51.54%	53.61%	49.53%	48.33%
Responses	2612	2937	2966	3312	2731

People Promise elements and theme results – We are compassionate and inclusive: Compassionate culture

Survey Coordination Centre

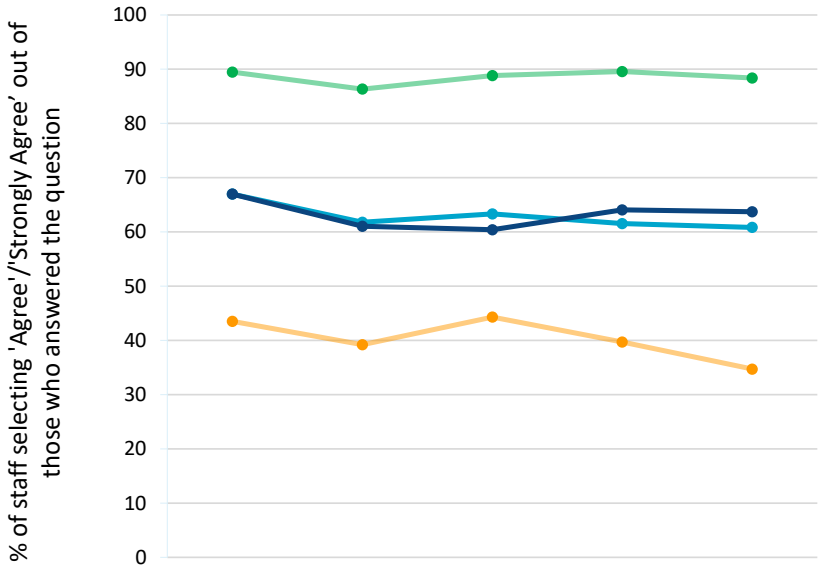
NHS

Q25c I would recommend my organisation as a place to work.



	2021	2022	2023	2024	2025
Your org	56.66%	52.61%	56.53%	61.30%	58.37%
Best result	77.86%	75.26%	77.14%	79.37%	79.40%
Average result	58.41%	56.47%	60.52%	60.89%	57.77%
Worst result	38.40%	40.90%	44.01%	35.43%	34.20%
Responses	2620	2935	2974	3321	2730

Q25d If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.



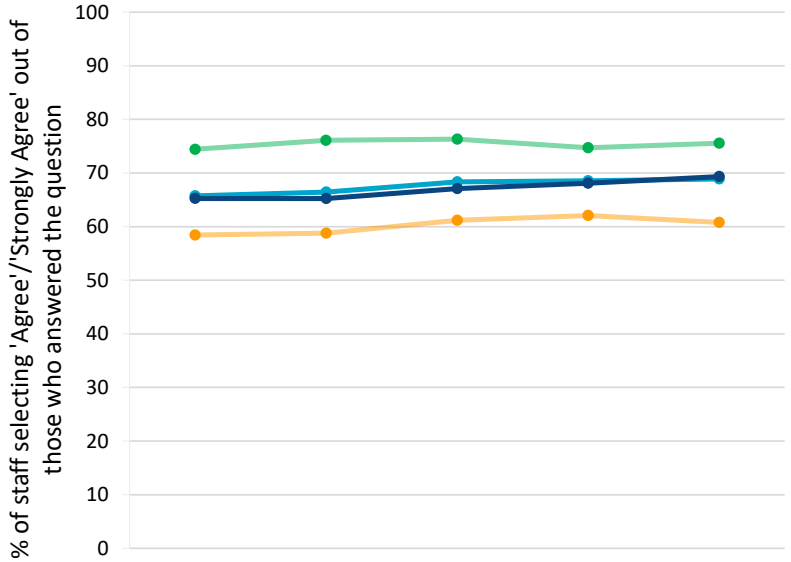
	2021	2022	2023	2024	2025
Your org	66.97%	61.04%	60.41%	64.05%	63.72%
Best result	89.49%	86.33%	88.81%	89.58%	88.41%
Average result	66.97%	61.78%	63.32%	61.55%	60.83%
Worst result	43.50%	39.20%	44.30%	39.68%	34.73%
Responses	2624	2934	2967	3318	2728

People Promise elements and theme results – We are compassionate and inclusive: Compassionate leadership

Survey Coordination Centre

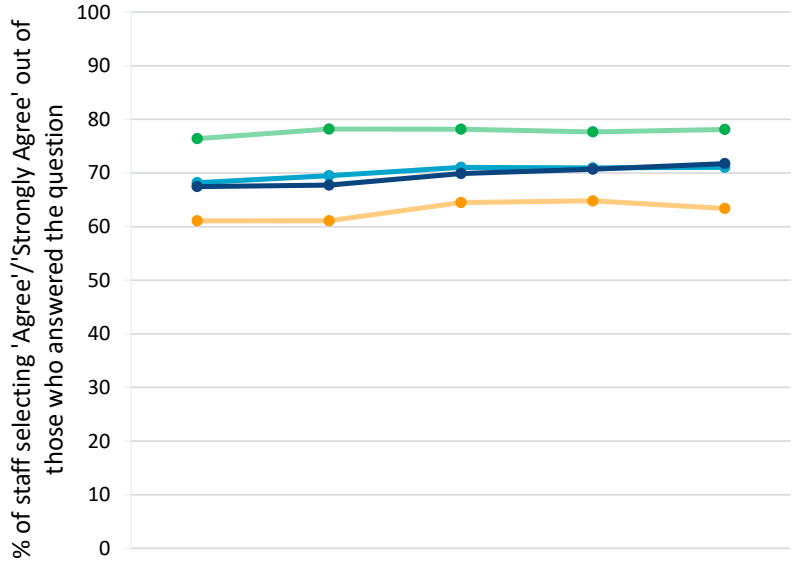
NHS

Q9f My immediate manager works together with me to come to an understanding of problems.



	2021	2022	2023	2024	2025
Your org	65.25%	65.24%	67.08%	68.09%	69.32%
Best result	74.43%	76.09%	76.31%	74.72%	75.54%
Average result	65.73%	66.46%	68.37%	68.54%	68.89%
Worst result	58.44%	58.76%	61.17%	62.06%	60.79%
Responses	2634	2949	2980	3327	2736

Q9g My immediate manager is interested in listening to me when I describe challenges I face.



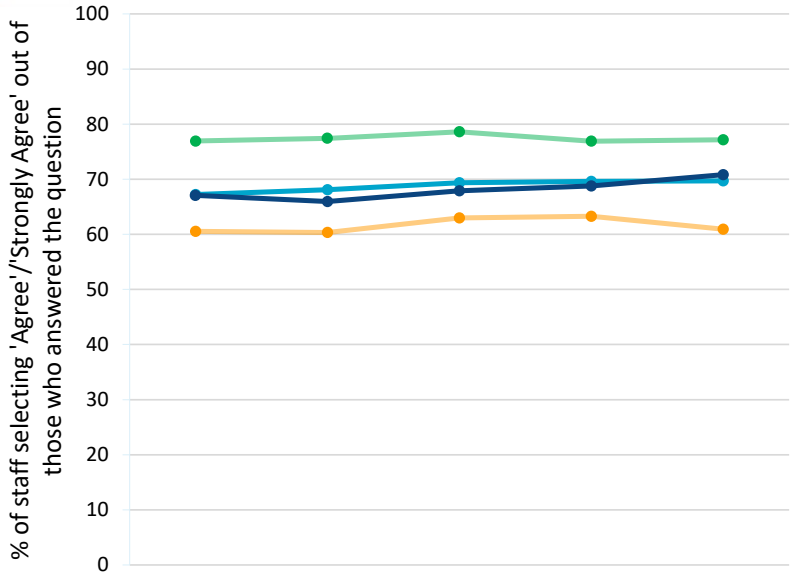
	2021	2022	2023	2024	2025
Your org	67.46%	67.75%	69.92%	70.71%	71.75%
Best result	76.40%	78.20%	78.14%	77.64%	78.12%
Average result	68.18%	69.47%	71.04%	70.96%	71.07%
Worst result	61.09%	61.09%	64.49%	64.81%	63.37%
Responses	2634	2951	2980	3327	2740

People Promise elements and theme results – We are compassionate and inclusive: Compassionate leadership

Survey Coordination Centre

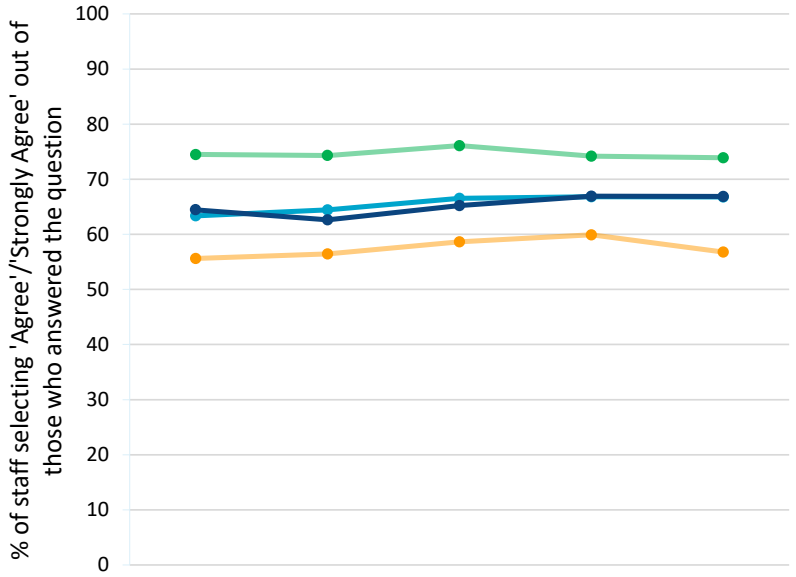
NHS

Q9h My immediate manager cares about my concerns.



	2021	2022	2023	2024	2025
Your org	67.06%	65.95%	67.91%	68.80%	70.82%
Best result	76.94%	77.42%	78.60%	76.90%	77.15%
Average result	67.22%	68.07%	69.38%	69.63%	69.71%
Worst result	60.56%	60.33%	62.96%	63.28%	60.93%
Responses	2628	2945	2975	3327	2733

Q9i My immediate manager takes effective action to help me with any problems I face.

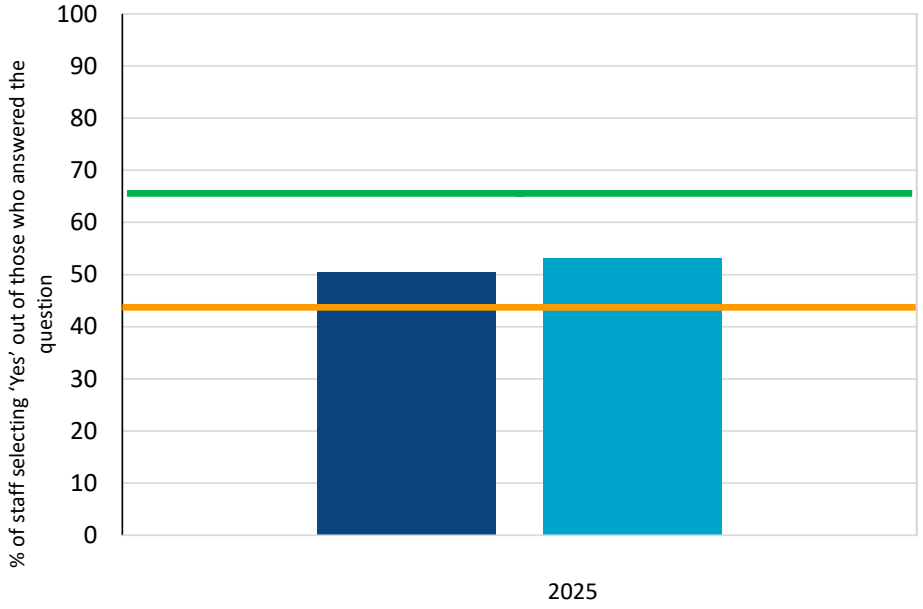


	2021	2022	2023	2024	2025
Your org	64.46%	62.63%	65.21%	66.93%	66.88%
Best result	74.50%	74.31%	76.10%	74.19%	73.90%
Average result	63.35%	64.44%	66.52%	66.82%	66.79%
Worst result	55.62%	56.43%	58.66%	59.92%	56.79%
Responses	2631	2947	2976	3322	2735

People Promise elements and theme results – We are compassionate and inclusive: Diversity and equality

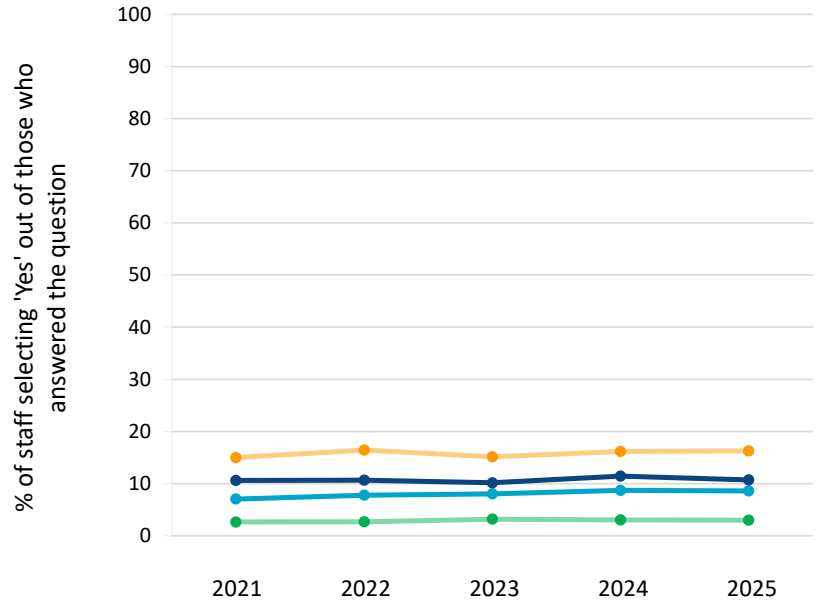
Survey Coordination Centre NHS

Q15 Does your organisation act fairly with regard to career progression/promotion, regardless of e.g. age, disability, ethnic background, gender reassignmnet, religion, sex, or sexual orientation?



	2025
Your org	50.48%
Best result	65.57%
Average result	53.05%
Worst result	43.72%
Responses	2729

Q16a In the last 12 months have you personally experienced discrimination at work from patients / service users, their relatives or other members of the public?



	2021	2022	2023	2024	2025
Your org	10.59%	10.69%	10.17%	11.45%	10.73%
Best result	2.65%	2.70%	3.17%	3.02%	2.97%
Average result	7.04%	7.76%	8.06%	8.72%	8.58%
Worst result	15.00%	16.44%	15.14%	16.17%	16.28%
Responses	2620	2939	2966	3313	2733

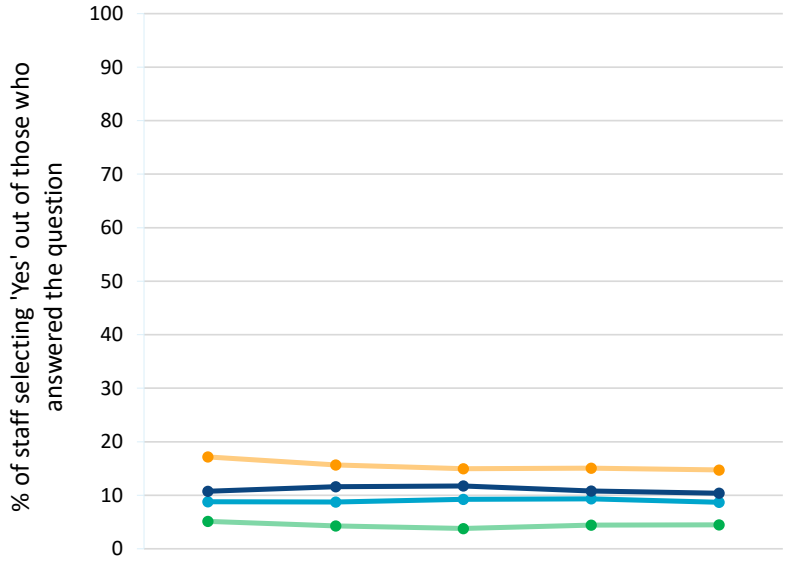
Note: Due to changes in the question wording in 2025, previous years' results for Q15 are not reported. For more information, please refer to the *Technical Guide:* https://www.nhsstaffsurveys.com/survey-documents/

People Promise elements and theme results – We are compassionate and inclusive: Diversity and equality

Survey Coordination Centre

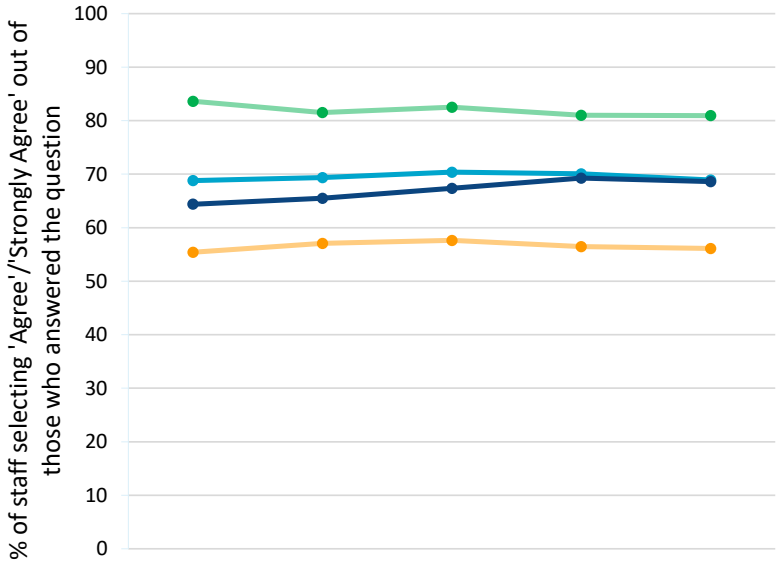
NHS

Q16b In the last 12 months have you personally experienced discrimination at work from manager / team leader or other colleagues?



	2021	2022	2023	2024	2025
Your org	10.77%	11.59%	11.73%	10.78%	10.38%
Best result	5.12%	4.25%	3.80%	4.45%	4.46%
Average result	8.81%	8.73%	9.24%	9.33%	8.69%
Worst result	17.16%	15.67%	14.95%	15.07%	14.74%
Responses	2617	2923	2948	3290	2699

Q21 I think that my organisation respects individual differences (e.g. cultures, working styles, backgrounds, ideas, etc).

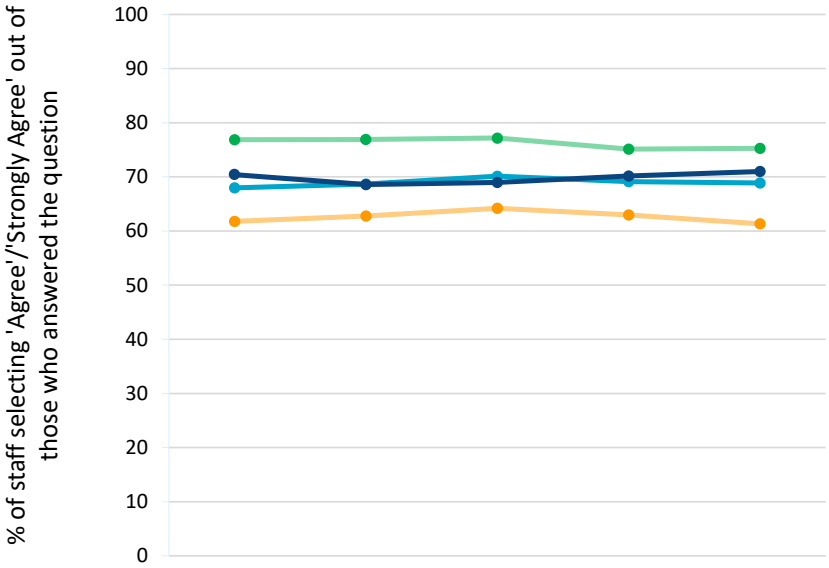


	2021	2022	2023	2024	2025
Your org	64.38%	65.52%	67.37%	69.27%	68.60%
Best result	83.63%	81.52%	82.54%	81.00%	80.94%
Average result	68.80%	69.36%	70.39%	70.09%	68.91%
Worst result	55.41%	57.05%	57.64%	56.48%	56.12%
Responses	2628	2952	2965	3322	2726

People Promise elements and theme results – We are compassionate and inclusive: Inclusion

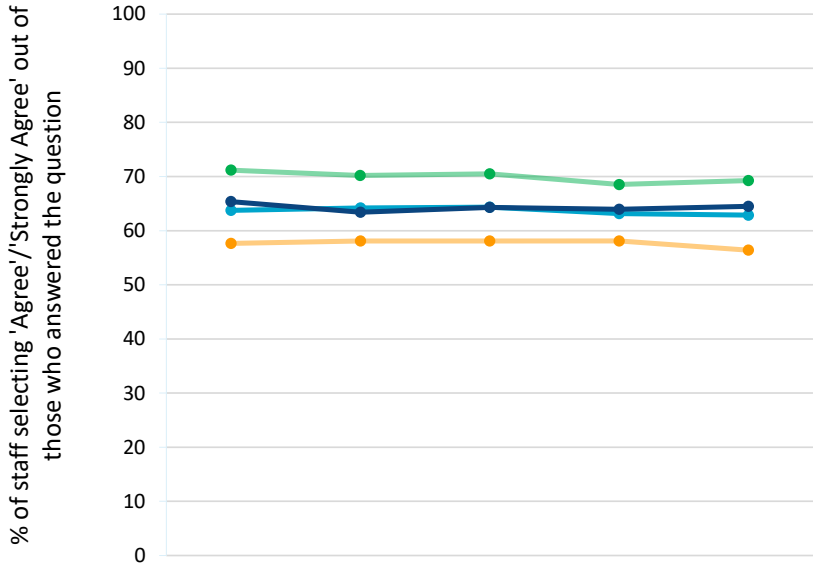
Survey Coordination Centre NHS

Q7h I feel valued by my team.



	2021	2022	2023	2024	2025
Your org	70.42%	68.59%	68.99%	70.19%	70.99%
Best result	76.87%	76.89%	77.18%	75.13%	75.29%
Average result	67.97%	68.70%	70.14%	69.10%	68.86%
Worst result	61.78%	62.75%	64.19%	62.95%	61.33%
Responses	2630	2940	2963	3312	2727

Q7i I feel a strong personal attachment to my team.

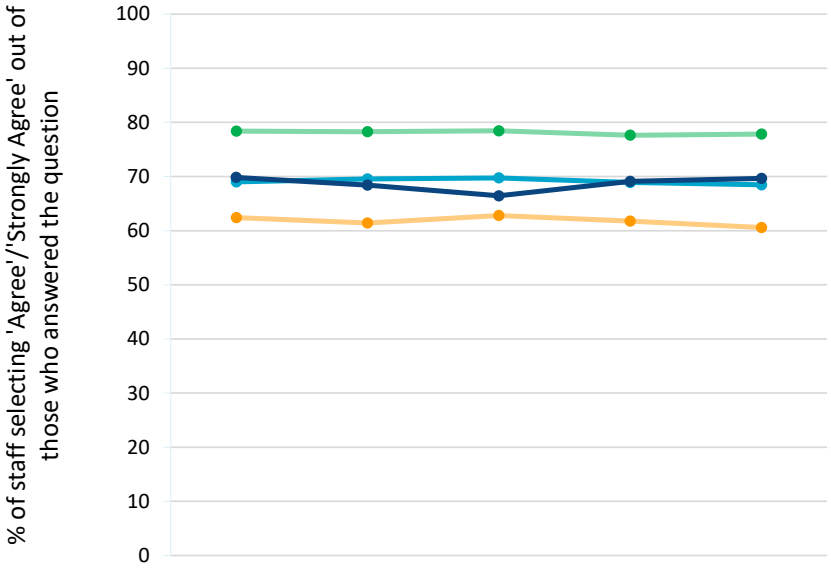


	2021	2022	2023	2024	2025
Your org	65.36%	63.41%	64.31%	63.95%	64.50%
Best result	71.18%	70.19%	70.51%	68.53%	69.25%
Average result	63.76%	64.19%	64.34%	63.17%	62.88%
Worst result	57.67%	58.08%	58.09%	58.10%	56.40%
Responses	2630	2942	2972	3316	2735

People Promise elements and theme results – We are compassionate and inclusive: Inclusion

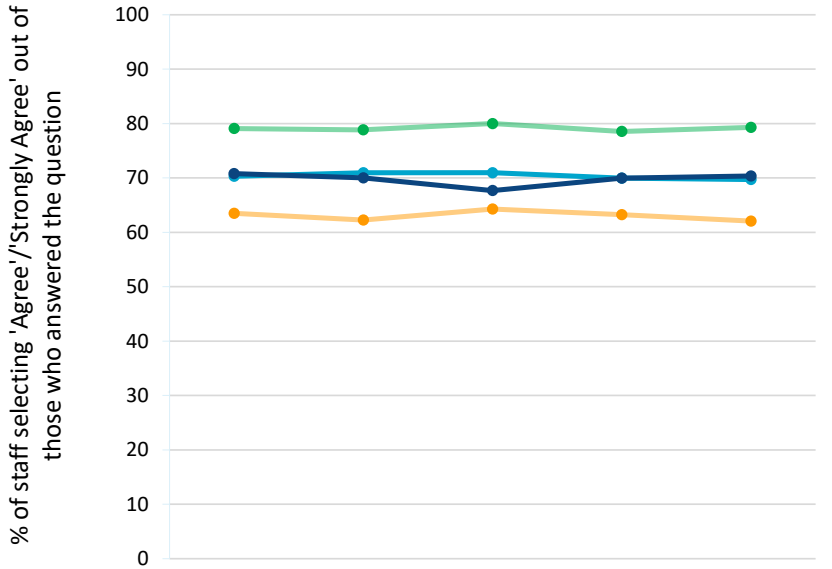
Survey Coordination Centre NHS

Q8b The people I work with are understanding and kind to one another.



	2021	2022	2023	2024	2025
Your org	69.83%	68.42%	66.45%	69.12%	69.68%
Best result	78.39%	78.27%	78.45%	77.62%	77.85%
Average result	69.03%	69.58%	69.74%	68.91%	68.48%
Worst result	62.41%	61.43%	62.79%	61.79%	60.58%
Responses	2628	2945	2977	3323	2735

Q8c The people I work with are polite and treat each other with respect.



	2021	2022	2023	2024	2025
Your org	70.79%	70.02%	67.67%	69.99%	70.36%
Best result	79.08%	78.83%	80.01%	78.54%	79.30%
Average result	70.33%	70.95%	70.97%	69.96%	69.71%
Worst result	63.50%	62.24%	64.28%	63.25%	62.07%
Responses	2628	2943	2971	3319	2736

Survey Coordination Centre

NHS

People Promise element – We are recognised and rewarded

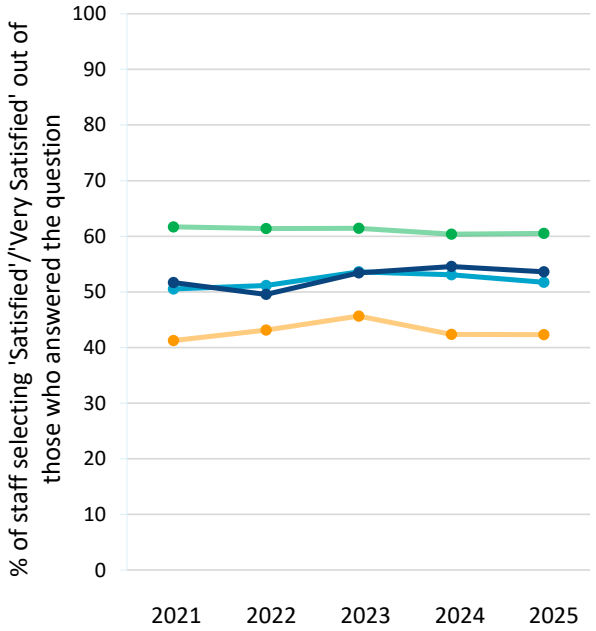
Questions included:
Q4a, Q4b, Q4c, Q8d, Q9e

Note: where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

People Promise elements and theme results – We are recognised and rewarded

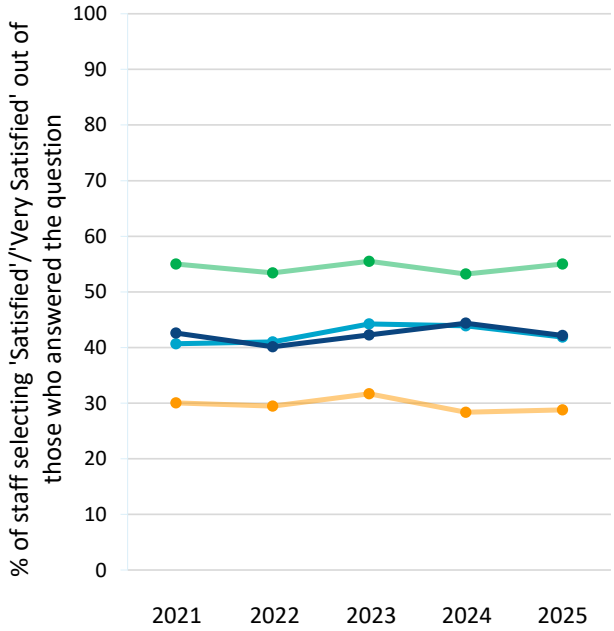
Survey Coordination Centre NHS

Q4a How satisfied are you with each of the following aspects of your job? The recognition I get for good work.



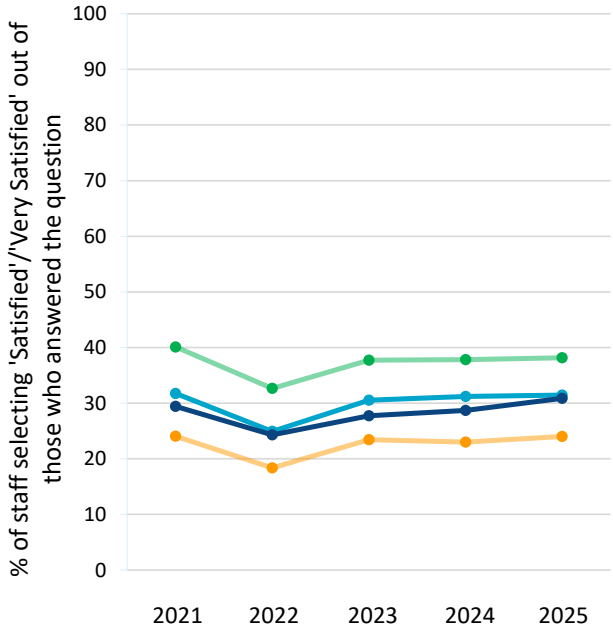
	2021	2022	2023	2024	2025
Your org	51.69%	49.54%	53.42%	54.56%	53.62%
Best result	61.69%	61.38%	61.41%	60.38%	60.51%
Average result	50.53%	51.13%	53.60%	53.06%	51.72%
Worst result	41.25%	43.14%	45.66%	42.36%	42.31%
Responses	2636	2948	2984	3329	2744

Q4b How satisfied are you with each of the following aspects of your job? The extent to which my organisation values my work.



	2021	2022	2023	2024	2025
Your org	42.59%	40.13%	42.28%	44.37%	42.14%
Best result	55.03%	53.44%	55.51%	53.21%	55.01%
Average result	40.68%	41.02%	44.24%	43.91%	41.90%
Worst result	30.03%	29.48%	31.68%	28.36%	28.77%
Responses	2635	2939	2972	3316	2732

Q4c How satisfied are you with each of the following aspects of your job? My level of pay.

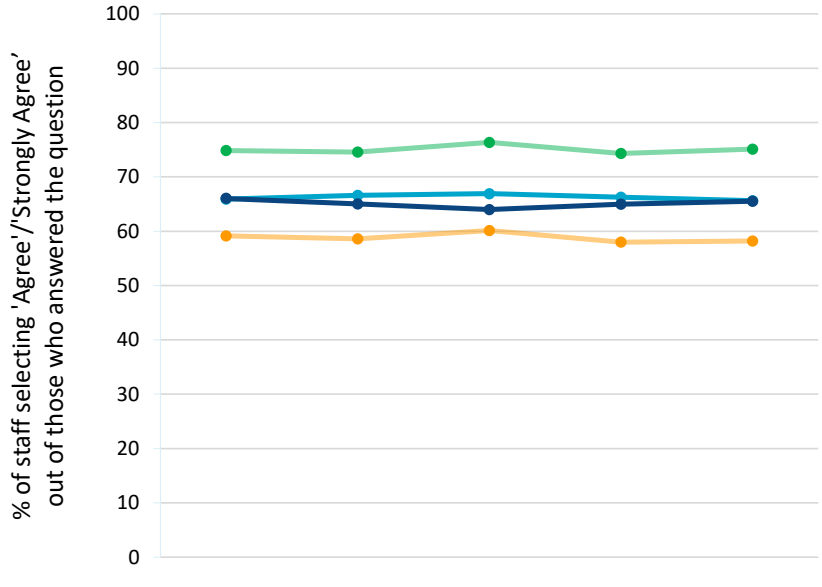


	2021	2022	2023	2024	2025
Your org	29.43%	24.29%	27.74%	28.67%	30.87%
Best result	40.11%	32.64%	37.73%	37.83%	38.14%
Average result	31.75%	24.92%	30.54%	31.19%	31.45%
Worst result	24.05%	18.36%	23.42%	22.97%	24.01%
Responses	2628	2947	2975	3325	2729

People Promise elements and theme results – We are recognised and rewarded

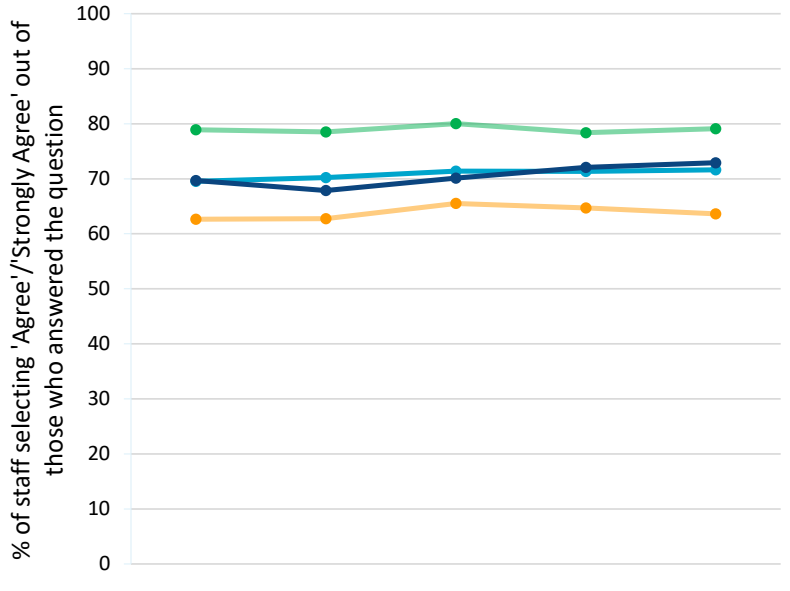
Survey Coordination Centre NHS

Q8d The people I work with show appreciation to one another.



	2021	2022	2023	2024	2025
Your org	66.01%	65.00%	63.99%	64.99%	65.51%
Best result	74.84%	74.56%	76.35%	74.30%	75.09%
Average result	65.91%	66.62%	66.92%	66.23%	65.62%
Worst result	59.15%	58.58%	60.13%	57.98%	58.20%
Responses	2627	2938	2968	3318	2732

Q9e My immediate manager values my work.



	2021	2022	2023	2024	2025
Your org	69.68%	67.87%	70.11%	72.10%	72.92%
Best result	78.90%	78.53%	80.02%	78.38%	79.12%
Average result	69.55%	70.22%	71.41%	71.32%	71.63%
Worst result	62.65%	62.75%	65.51%	64.72%	63.64%
Responses	2635	2945	2977	3331	2741

Survey Coordination Centre

NHS

People Promise element – We each have a voice that counts

Questions included:

Autonomy and control – Q3a, Q3b, Q3c, Q3d, Q3e, Q3f, Q5b

Raising concerns – Q20a, Q20b, Q25e, Q25f

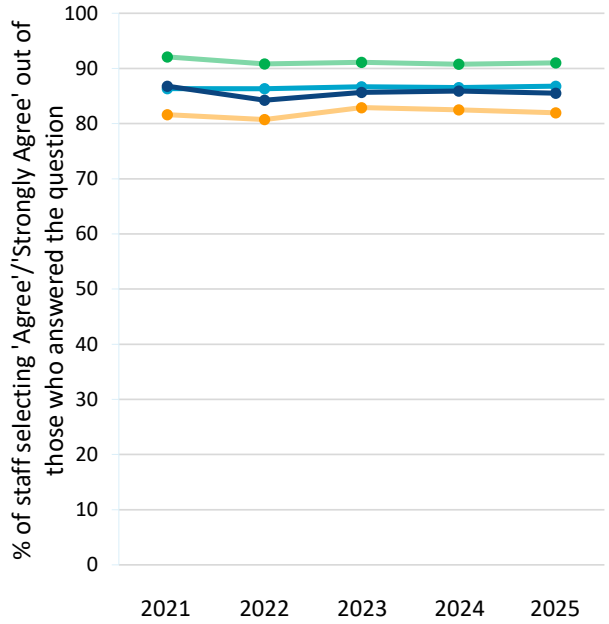
Note: where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

People Promise elements and theme results – We each have a voice that counts: Autonomy and control

Survey Coordination Centre

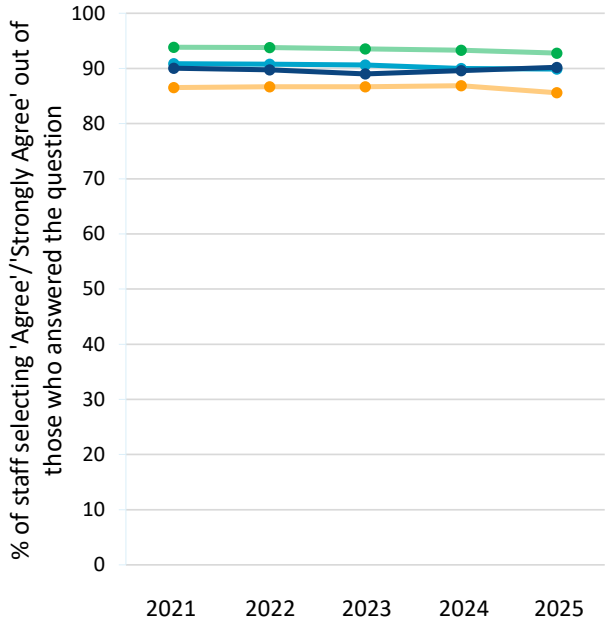
NHS

Q3a I always know what my work responsibilities are.



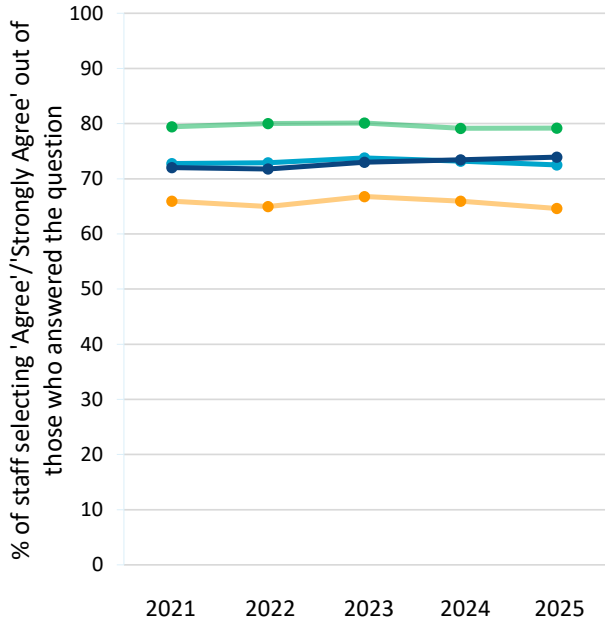
	2021	2022	2023	2024	2025
Your org	86.78%	84.24%	85.65%	85.92%	85.52%
Best result	92.09%	90.81%	91.10%	90.75%	91.00%
Average result	86.33%	86.32%	86.69%	86.53%	86.79%
Worst result	81.63%	80.73%	82.90%	82.49%	81.95%
Responses	2642	2955	2986	3337	2748

Q3b I am trusted to do my job.



	2021	2022	2023	2024	2025
Your org	90.06%	89.75%	89.00%	89.58%	90.21%
Best result	93.84%	93.80%	93.54%	93.29%	92.78%
Average result	90.85%	90.77%	90.61%	89.98%	89.88%
Worst result	86.54%	86.65%	86.66%	86.87%	85.58%
Responses	2636	2951	2981	3341	2736

Q3c There are frequent opportunities for me to show initiative in my role.

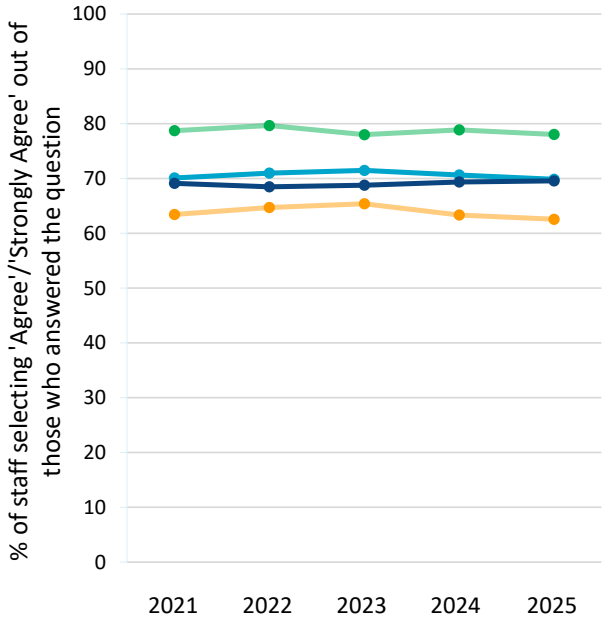


	2021	2022	2023	2024	2025
Your org	72.00%	71.76%	72.97%	73.45%	73.92%
Best result	79.41%	80.01%	80.10%	79.15%	79.17%
Average result	72.75%	72.91%	73.77%	73.20%	72.51%
Worst result	65.92%	64.98%	66.78%	65.94%	64.60%
Responses	2629	2949	2978	3334	2741

People Promise elements and theme results – We each have a voice that counts: Autonomy and control

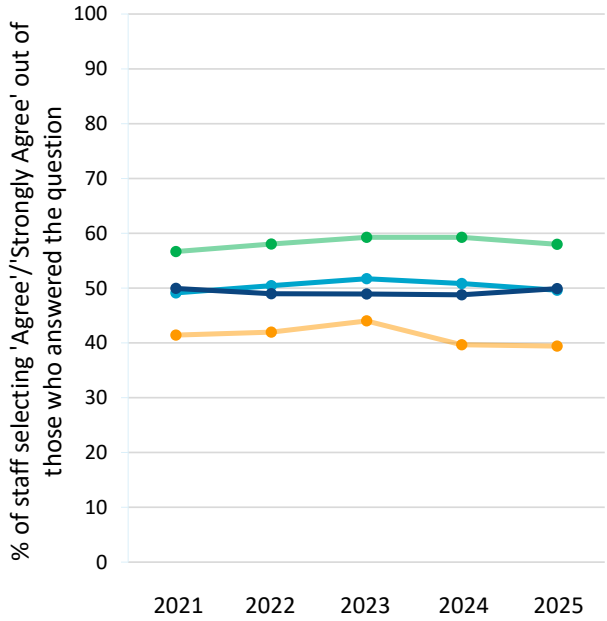
Survey Coordination Centre NHS

Q3d I am able to make suggestions to improve the work of my team / department.



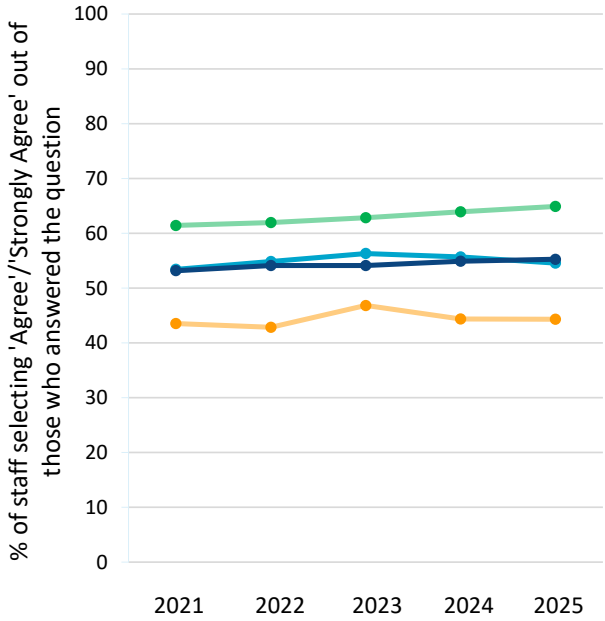
	2021	2022	2023	2024	2025
Your org	69.13%	68.48%	68.76%	69.36%	69.56%
Best result	78.70%	79.67%	78.00%	78.84%	78.03%
Average result	70.10%	70.97%	71.47%	70.61%	69.85%
Worst result	63.42%	64.70%	65.38%	63.33%	62.56%
Responses	2628	2938	2979	3331	2736

Q3e I am involved in deciding on changes introduced that affect my work area / team / department.



	2021	2022	2023	2024	2025
Your org	49.93%	48.98%	48.90%	48.77%	49.88%
Best result	56.66%	58.05%	59.27%	59.26%	58.01%
Average result	49.12%	50.45%	51.71%	50.82%	49.59%
Worst result	41.44%	41.94%	44.00%	39.68%	39.41%
Responses	2634	2943	2974	3326	2737

Q3f I am able to make improvements happen in my area of work.

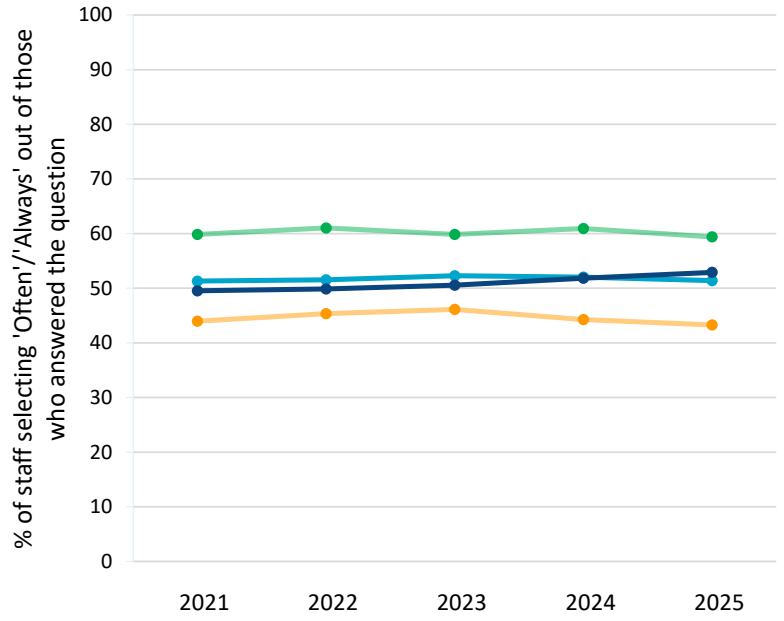


	2021	2022	2023	2024	2025
Your org	53.16%	54.09%	54.14%	54.90%	55.26%
Best result	61.43%	61.98%	62.84%	63.94%	64.90%
Average result	53.41%	54.86%	56.30%	55.71%	54.54%
Worst result	43.54%	42.85%	46.84%	44.35%	44.33%
Responses	2620	2933	2965	3322	2739

People Promise elements and theme results – We each have a voice that counts: Autonomy and control

Survey Coordination Centre NHS

Q5b I have a choice in deciding how to do my work.



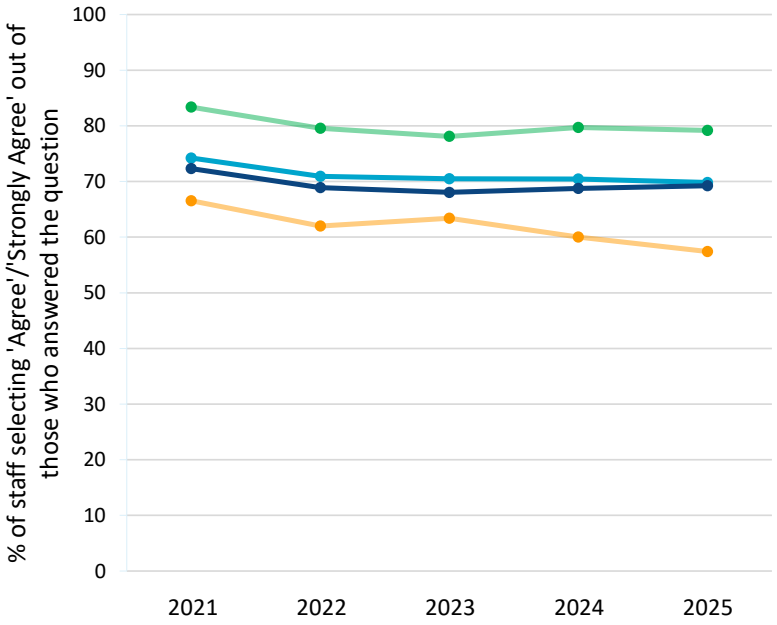
	2021	2022	2023	2024	2025
Your org	49.53%	49.85%	50.58%	51.83%	52.90%
Best result	59.84%	61.04%	59.83%	60.94%	59.39%
Average result	51.31%	51.54%	52.28%	52.02%	51.37%
Worst result	43.95%	45.34%	46.12%	44.25%	43.28%
Responses	2630	2946	2972	3320	2724

People Promise elements and theme results – We each have a voice that counts: Raising concerns

Survey Coordination Centre

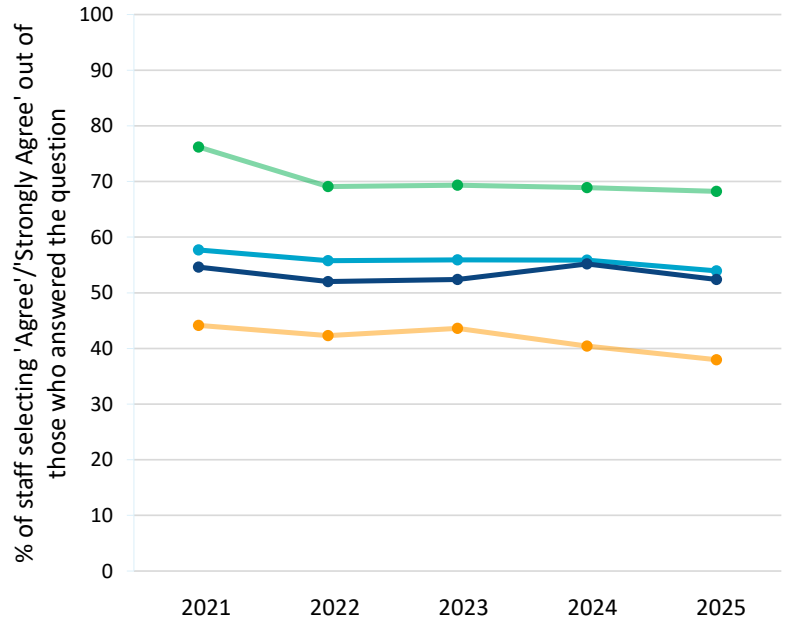
NHS

Q20a I would feel secure raising concerns about unsafe clinical practice.



	2021	2022	2023	2024	2025
Your org	72.31%	68.89%	68.05%	68.75%	69.24%
Best result	83.36%	79.55%	78.09%	79.72%	79.16%
Average result	74.22%	70.95%	70.47%	70.44%	69.82%
Worst result	66.54%	61.98%	63.38%	60.04%	57.41%
Responses	2618	2943	2975	3326	2737

Q20b I am confident that my organisation would address my concern.

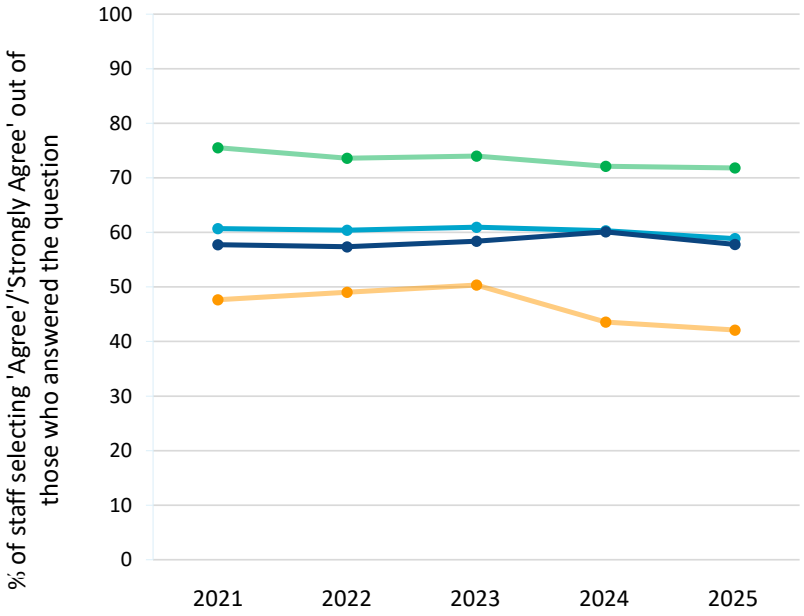


	2021	2022	2023	2024	2025
Your org	54.61%	52.02%	52.40%	55.18%	52.41%
Best result	76.20%	69.10%	69.34%	68.88%	68.23%
Average result	57.69%	55.78%	55.93%	55.88%	53.94%
Worst result	44.15%	42.28%	43.60%	40.40%	37.97%
Responses	2611	2923	2965	3309	2730

People Promise elements and theme results – We each have a voice that counts: Raising concerns

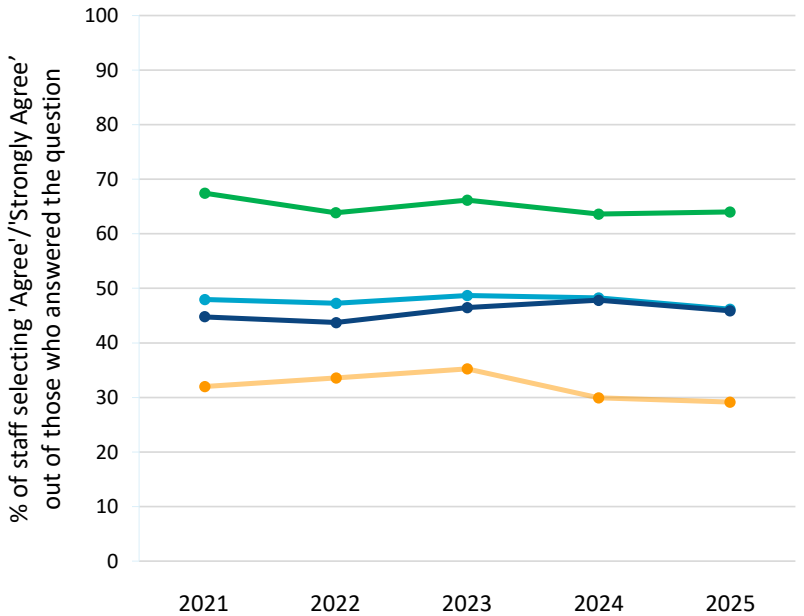
Survey Coordination Centre NHS

Q25e I feel safe to speak up about anything that concerns me in this organisation.



	2021	2022	2023	2024	2025
Your org	57.76%	57.37%	58.36%	60.09%	57.80%
Best result	75.53%	73.59%	73.99%	72.14%	71.81%
Average result	60.69%	60.38%	60.95%	60.31%	58.85%
Worst result	47.63%	49.02%	50.35%	43.57%	42.11%
Responses	2620	2934	2967	3310	2725

Q25f If I spoke up about something that concerned me I am confident my organisation would address my concern.



	2021	2022	2023	2024	2025
Your org	44.77%	43.74%	46.47%	47.83%	45.88%
Best result	67.44%	63.83%	66.16%	63.62%	63.99%
Average result	47.96%	47.24%	48.68%	48.24%	46.18%
Worst result	32.01%	33.60%	35.23%	29.95%	29.15%
Responses	2616	2928	2962	3309	2718

Survey Coordination Centre

NHS

People Promise element – We are safe and healthy

Questions included:
Health and safety climate: Q3g, Q3h, Q3i, Q5a, Q11a, Q13d, Q14d
Burnout: Q12a, Q12b, Q12c, Q12d, Q12e, Q12f, Q12g
Negative experiences: Q11b, Q11c, Q11d, Q13a, Q13b, Q13c, Q14a, Q14b, Q14c
Other questions:* Q17a, Q17b, Q22

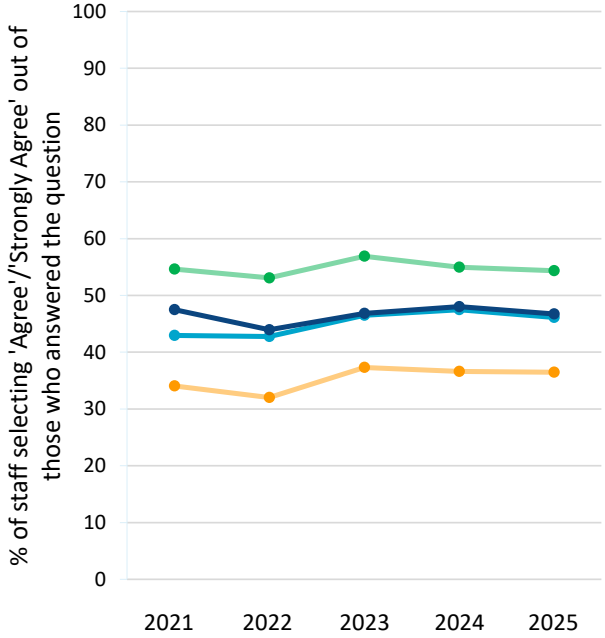
*Q17a, Q17b and Q22 do not contribute to the calculation of any scores or sub-scores.

Note: where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

People Promise elements and theme results – We are safe and healthy: Health and safety climate

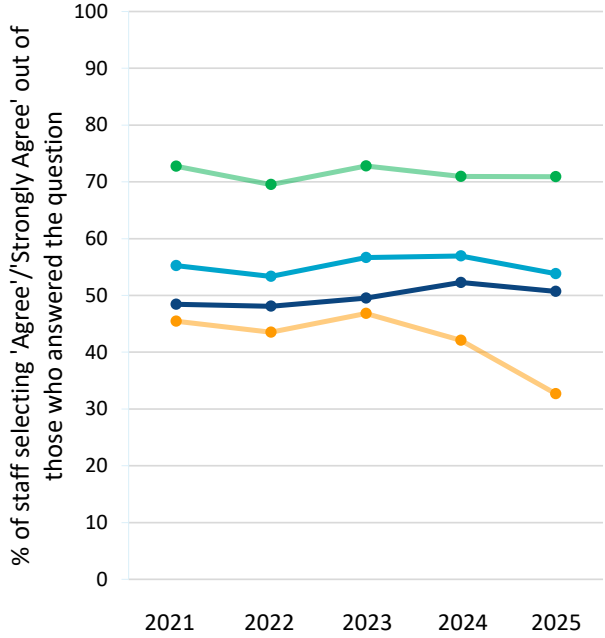
Survey Coordination Centre NHS

Q3g I am able to meet all the conflicting demands on my time at work.



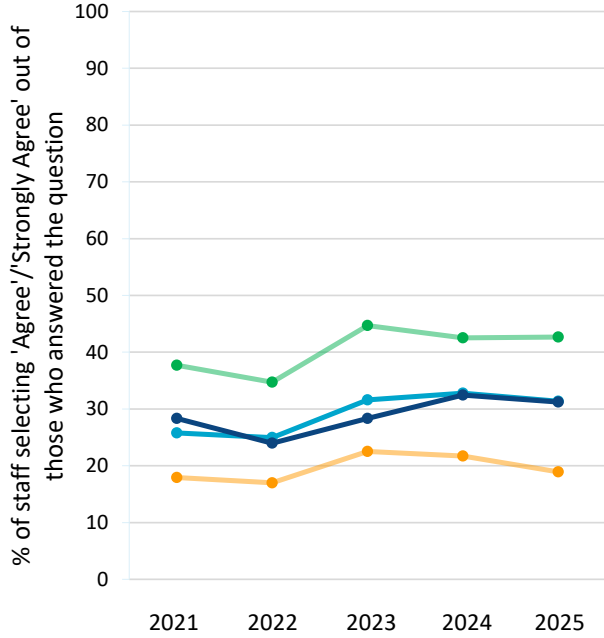
	2021	2022	2023	2024	2025
Your org	47.48%	43.95%	46.85%	48.03%	46.74%
Best result	54.61%	53.09%	56.89%	54.99%	54.34%
Average result	42.96%	42.76%	46.52%	47.47%	46.14%
Worst result	34.06%	32.02%	37.31%	36.63%	36.45%
Responses	2629	2942	2973	3321	2730

Q3h I have adequate materials, supplies and equipment to do my work.



	2021	2022	2023	2024	2025
Your org	48.45%	48.08%	49.54%	52.28%	50.71%
Best result	72.77%	69.52%	72.79%	70.96%	70.92%
Average result	55.26%	53.34%	56.68%	56.94%	53.84%
Worst result	45.45%	43.54%	46.82%	42.11%	32.70%
Responses	2628	2938	2966	3318	2723

Q3i There are enough staff at this organisation for me to do my job properly.

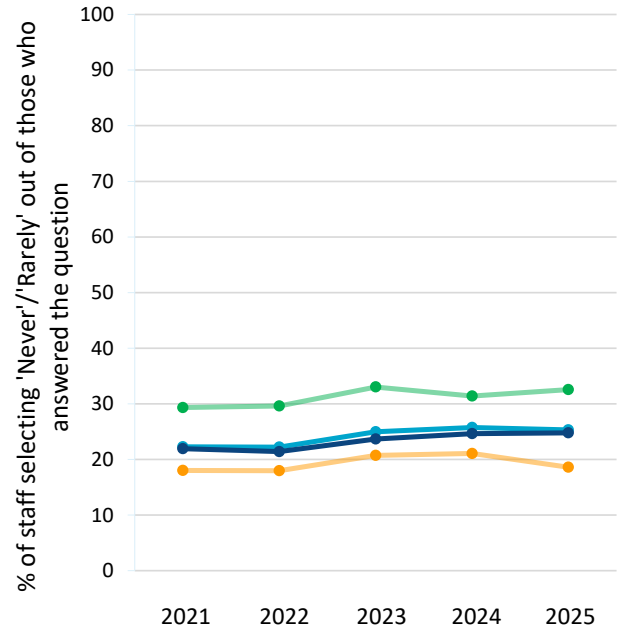


	2021	2022	2023	2024	2025
Your org	28.34%	23.97%	28.34%	32.45%	31.22%
Best result	37.72%	34.72%	44.68%	42.50%	42.65%
Average result	25.79%	24.95%	31.62%	32.78%	31.34%
Worst result	17.94%	17.00%	22.52%	21.73%	18.91%
Responses	2628	2939	2976	3327	2742

People Promise elements and theme results – We are safe and healthy: Health and safety climate

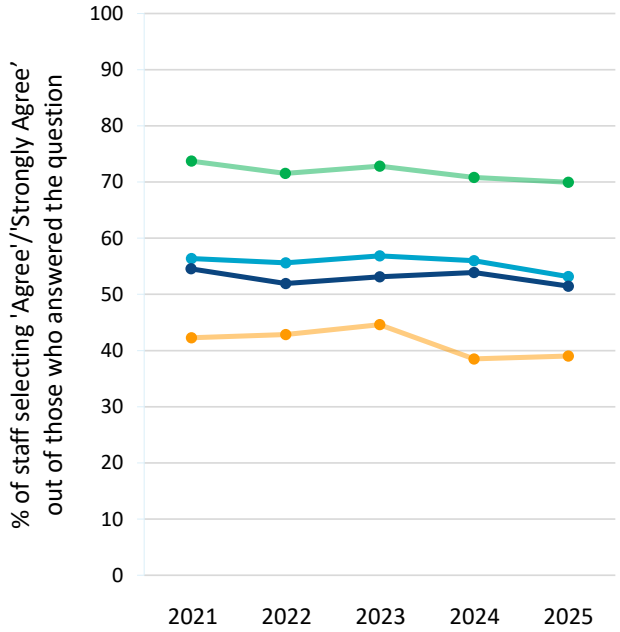
Survey Coordination Centre NHS

Q5a I have unrealistic time pressures.



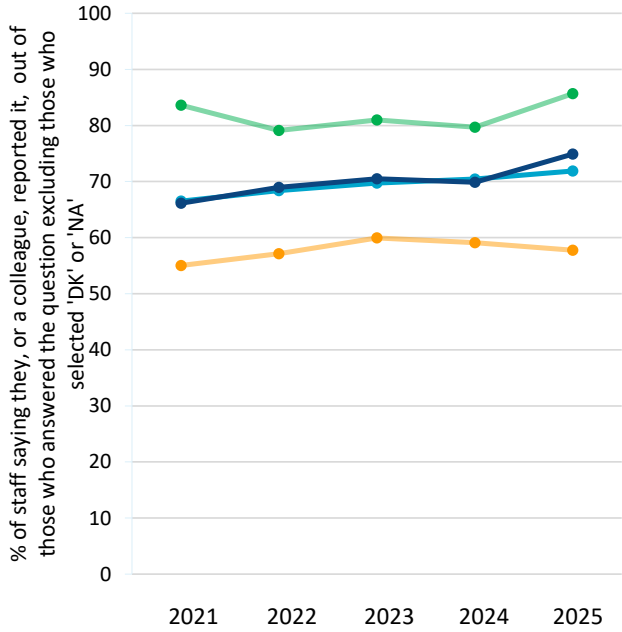
	2021	2022	2023	2024	2025
Your org	21.94%	21.41%	23.68%	24.64%	24.77%
Best result	29.33%	29.60%	33.01%	31.38%	32.55%
Average result	22.28%	22.20%	24.97%	25.73%	25.30%
Worst result	18.03%	17.97%	20.72%	21.07%	18.61%
Responses	2630	2942	2982	3325	2743

Q11a My organisation takes positive action on health and well-being.



	2021	2022	2023	2024	2025
Your org	54.54%	51.94%	53.11%	53.88%	51.48%
Best result	73.72%	71.53%	72.84%	70.83%	69.96%
Average result	56.37%	55.63%	56.85%	56.02%	53.16%
Worst result	42.30%	42.86%	44.61%	38.52%	39.02%
Responses	2611	2939	2961	3312	2713

Q13d The last time you experienced physical violence at work, did you or a colleague report it?



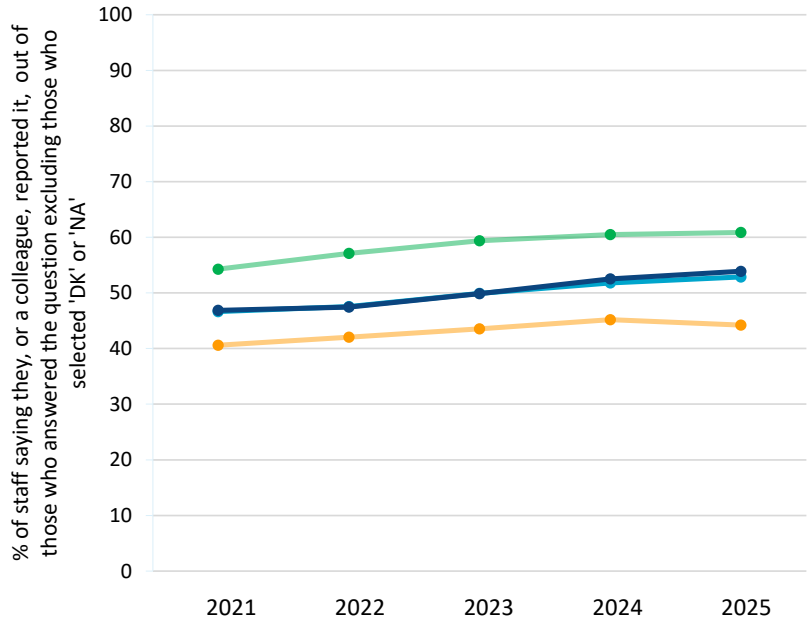
	2021	2022	2023	2024	2025
Your org	66.13%	68.97%	70.50%	69.88%	74.90%
Best result	83.62%	79.11%	80.97%	79.69%	85.67%
Average result	66.50%	68.40%	69.72%	70.46%	71.88%
Worst result	55.03%	57.15%	59.94%	59.09%	57.77%
Responses	318	383	407	408	291

Note: 2023 results for Q13d are reported using corrected data. Please see https://www.nhsstaffsurveys.com/survey-documents/ for more details.

People Promise elements and theme results – We are safe and healthy: Health and safety climate

Survey Coordination Centre NHS

Q14d The last time you experienced harassment, bullying or abuse at work, did you or a colleague report it?



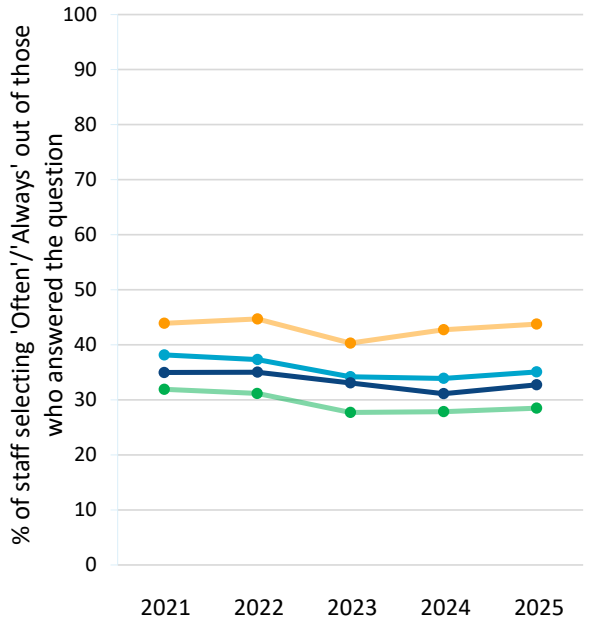
	2021	2022	2023	2024	2025
Your org	46.86%	47.45%	49.85%	52.52%	53.89%
Best result	54.28%	57.12%	59.37%	60.49%	60.86%
Average result	46.65%	47.56%	49.90%	51.81%	52.88%
Worst result	40.60%	42.04%	43.56%	45.19%	44.24%
Responses	1018	1159	1099	1204	972

Note: 2023 results for Q14d are reported using corrected data. Please see https://www.nhsstaffsurveys.com/survey-documents/ for more details.

People Promise elements and theme results – We are safe and healthy: Burnout

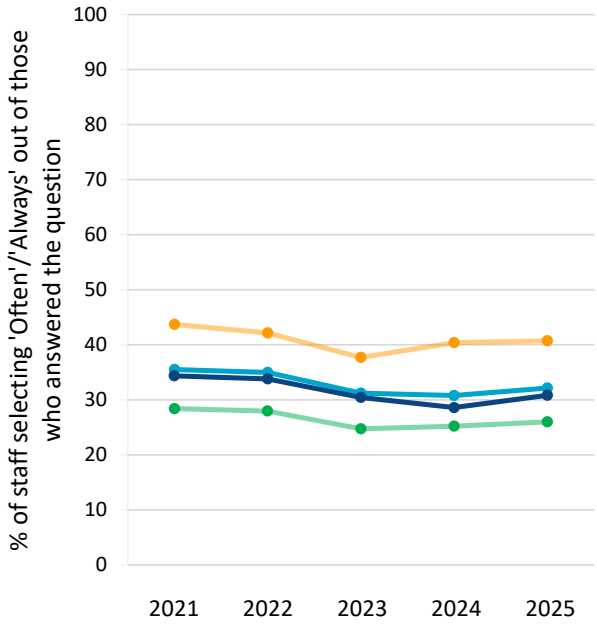
Survey Coordination Centre NHS

Q12a How often, if at all, do you find your work emotionally exhausting?



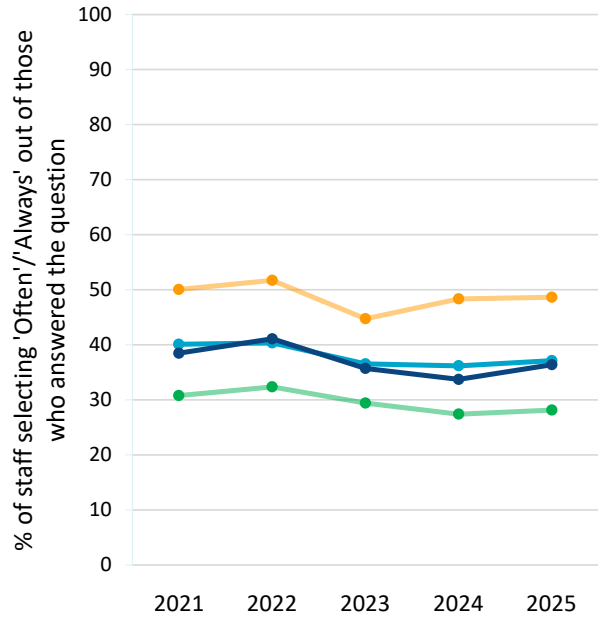
	2021	2022	2023	2024	2025
Your org	34.96%	35.02%	33.09%	31.11%	32.72%
Best result	31.92%	31.17%	27.71%	27.83%	28.48%
Average result	38.17%	37.33%	34.18%	33.89%	35.08%
Worst result	43.92%	44.70%	40.31%	42.73%	43.76%
Responses	2631	2955	2987	3337	2745

Q12b How often, if at all, do you feel burnt out because of your work?



	2021	2022	2023	2024	2025
Your org	34.36%	33.83%	30.42%	28.60%	30.81%
Best result	28.41%	27.95%	24.74%	25.23%	26.01%
Average result	35.51%	34.97%	31.21%	30.79%	32.12%
Worst result	43.71%	42.17%	37.70%	40.37%	40.74%
Responses	2628	2951	2986	3333	2743

Q12c How often, if at all, does your work frustrate you?

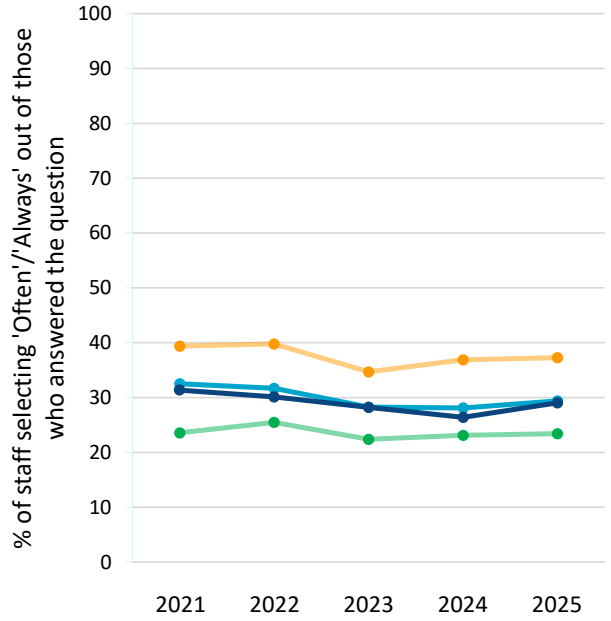


	2021	2022	2023	2024	2025
Your org	38.48%	41.09%	35.72%	33.72%	36.40%
Best result	30.78%	32.35%	29.42%	27.39%	28.16%
Average result	40.10%	40.35%	36.55%	36.17%	37.11%
Worst result	50.03%	51.71%	44.72%	48.35%	48.62%
Responses	2626	2954	2982	3326	2742

People Promise elements and theme results – We are safe and healthy: Burnout

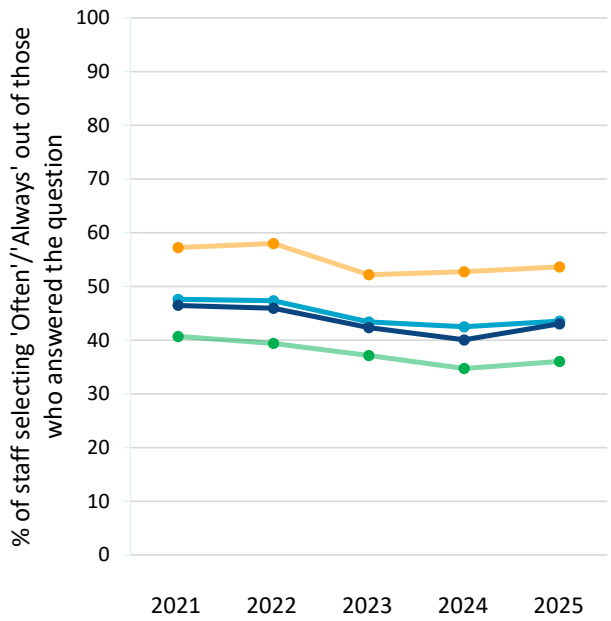
Survey Coordination Centre NHS

Q12d How often, if at all, are you exhausted at the thought of another day/shift at work?



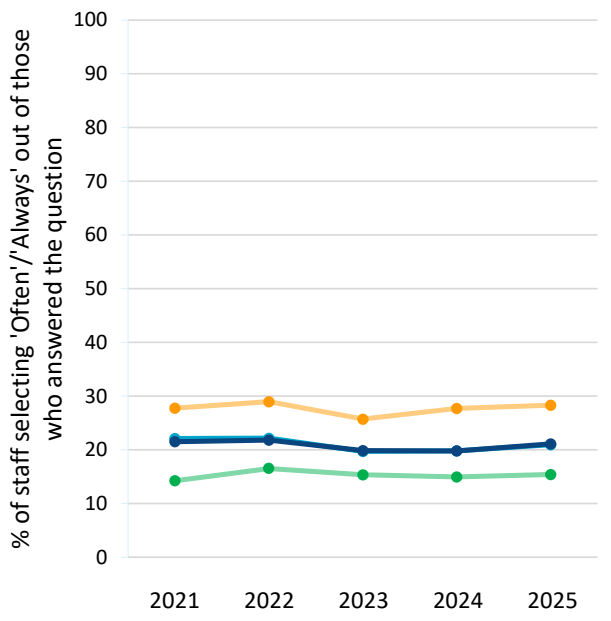
	2021	2022	2023	2024	2025
Your org	31.35%	30.14%	28.23%	26.39%	29.06%
Best result	23.58%	25.47%	22.39%	23.14%	23.42%
Average result	32.51%	31.67%	28.24%	28.10%	29.40%
Worst result	39.40%	39.79%	34.70%	36.90%	37.26%
Responses	2623	2944	2978	3326	2737

Q12e How often, if at all, do you feel worn out at the end of your working day/shift?



	2021	2022	2023	2024	2025
Your org	46.45%	45.96%	42.33%	40.06%	43.03%
Best result	40.70%	39.38%	37.14%	34.72%	36.06%
Average result	47.60%	47.34%	43.37%	42.49%	43.54%
Worst result	57.24%	58.00%	52.17%	52.73%	53.62%
Responses	2622	2940	2974	3326	2730

Q12f How often, if at all, do you feel that every working hour is tiring for you?

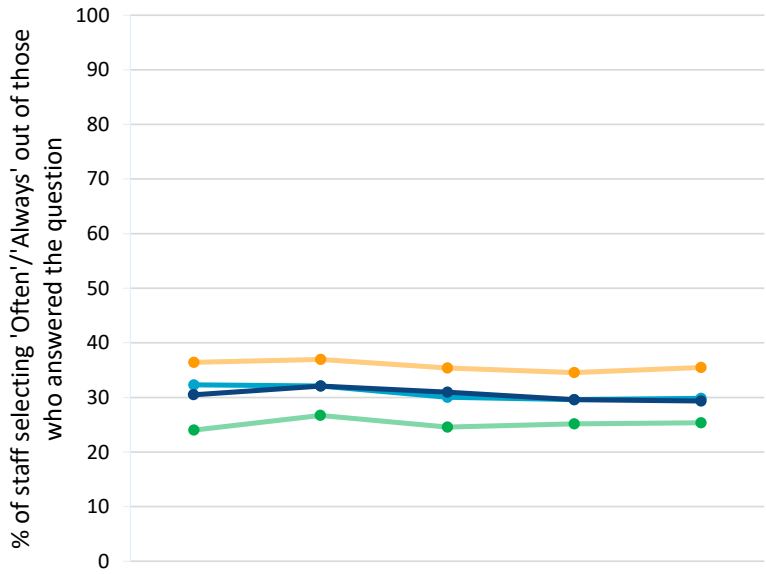


	2021	2022	2023	2024	2025
Your org	21.48%	21.80%	19.84%	19.78%	21.08%
Best result	14.23%	16.51%	15.35%	14.92%	15.41%
Average result	22.08%	22.17%	19.70%	19.78%	20.95%
Worst result	27.73%	28.96%	25.73%	27.72%	28.30%
Responses	2614	2936	2968	3325	2735

People Promise elements and theme results – We are safe and healthy: Burnout

Survey Coordination Centre NHS

Q12g How often, if at all, do you not have enough energy for family and friends during leisure time?

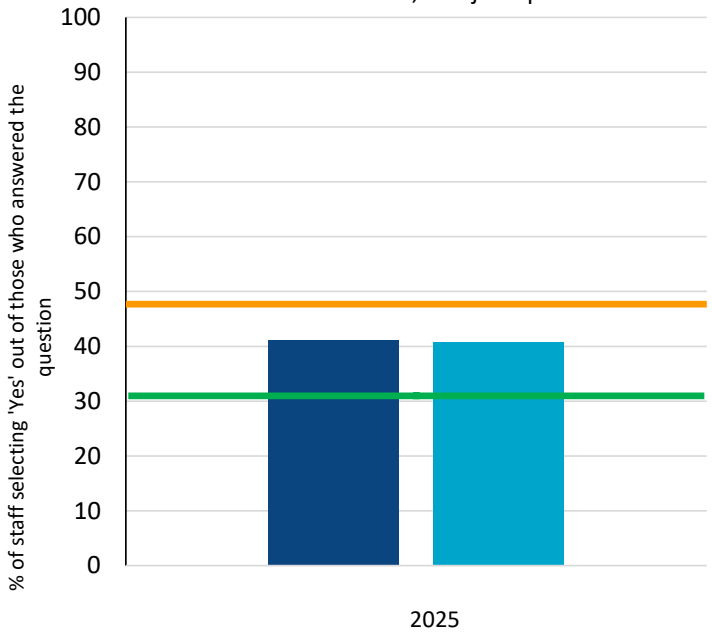


	2021	2022	2023	2024	2025
Your org	30.49%	32.08%	30.97%	29.60%	29.34%
Best result	24.01%	26.70%	24.58%	25.16%	25.35%
Average result	32.30%	32.10%	30.03%	29.60%	29.85%
Worst result	36.45%	36.95%	35.41%	34.55%	35.50%
Responses	2620	2948	2983	3327	2744

People Promise elements and theme results – We are safe and healthy: Negative experiences

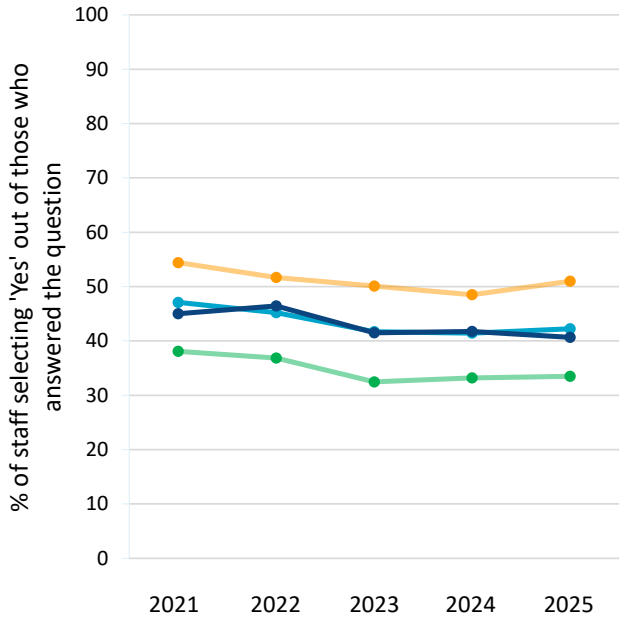
Survey Coordination Centre NHS

Q11b In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities? Examples may include back pain, neck or arm strains, and joint pain.



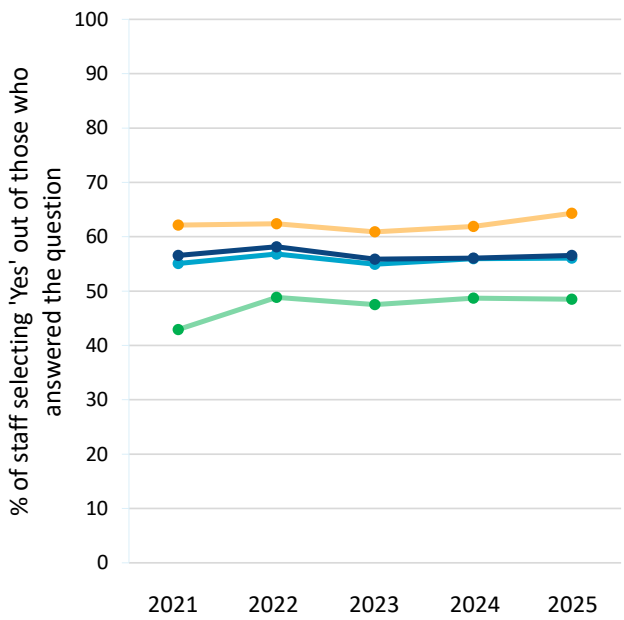
	2025
Your org	41.20%
Best result	30.97%
Average result	40.70%
Worst result	47.69%
Responses	2726

Q11c During the last 12 months have you felt unwell as a result of work related stress?



	2021	2022	2023	2024	2025
Your org	45.03%	46.45%	41.51%	41.74%	40.66%
Best result	38.09%	36.86%	32.48%	33.18%	33.51%
Average result	47.11%	45.20%	41.72%	41.44%	42.26%
Worst result	54.42%	51.68%	50.08%	48.50%	50.97%
Responses	2617	2943	2973	3316	2726

Q11d In the last three months have you ever come to work despite not feeling well enough to perform your duties?



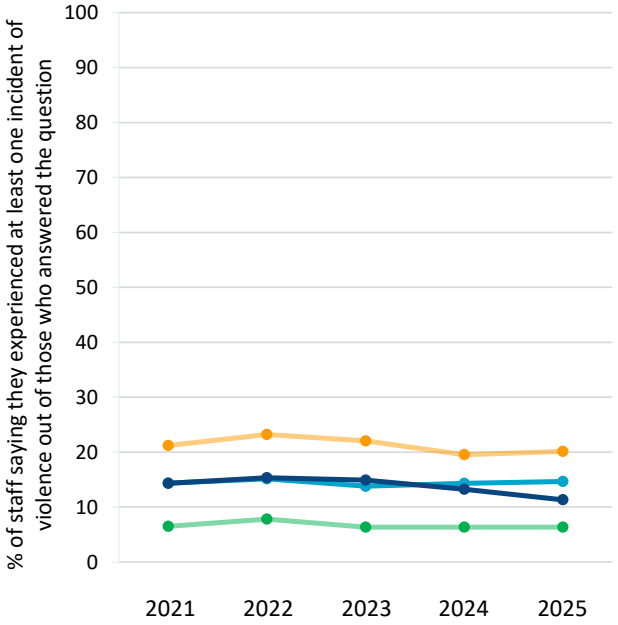
	2021	2022	2023	2024	2025
Your org	56.58%	58.16%	55.87%	56.06%	56.57%
Best result	42.92%	48.84%	47.51%	48.71%	48.53%
Average result	55.08%	56.82%	54.94%	55.96%	56.08%
Worst result	62.16%	62.39%	60.90%	61.90%	64.31%
Responses	2606	2941	2973	3328	2727

Note: Due to changes in the question wording in 2025, previous years' results for Q11b are not reported. For more information, please refer to the *Technical Guide:* https://www.nhsstaffsurveys.com/survey-documents/

People Promise elements and theme results – We are safe and healthy: Negative experiences

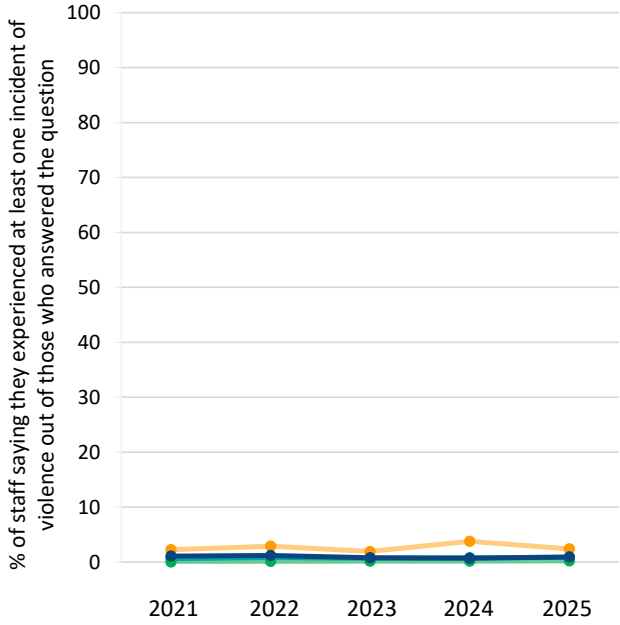
Survey Coordination Centre NHS

Q13a In the last 12 months how many times have you personally experienced physical violence at work from...? Patients / service users, their relatives or other members of the public.



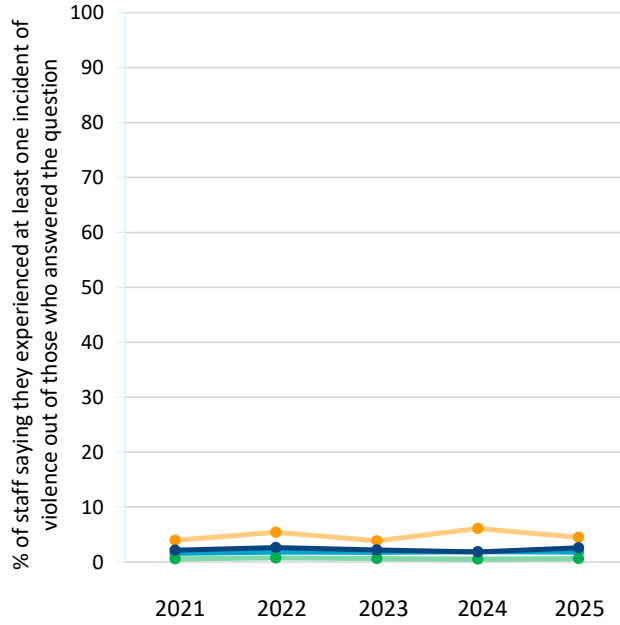
	2021	2022	2023	2024	2025
Your org	14.35%	15.35%	14.90%	13.25%	11.32%
Best result	6.50%	7.81%	6.35%	6.35%	6.35%
Average result	14.38%	15.15%	13.81%	14.31%	14.65%
Worst result	21.20%	23.21%	22.02%	19.54%	20.14%
Responses	2628	2953	2968	3321	2728

Q13b In the last 12 months how many times have you personally experienced physical violence at work from...? Managers.



	2021	2022	2023	2024	2025
Your org	1.09%	1.19%	0.80%	0.69%	0.95%
Best result	0.00%	0.11%	0.14%	0.14%	0.21%
Average result	0.63%	0.79%	0.68%	0.76%	0.76%
Worst result	2.23%	2.90%	1.93%	3.78%	2.37%
Responses	2610	2944	2962	3302	2721

Q13c In the last 12 months how many times have you personally experienced physical violence at work from...? Other colleagues.



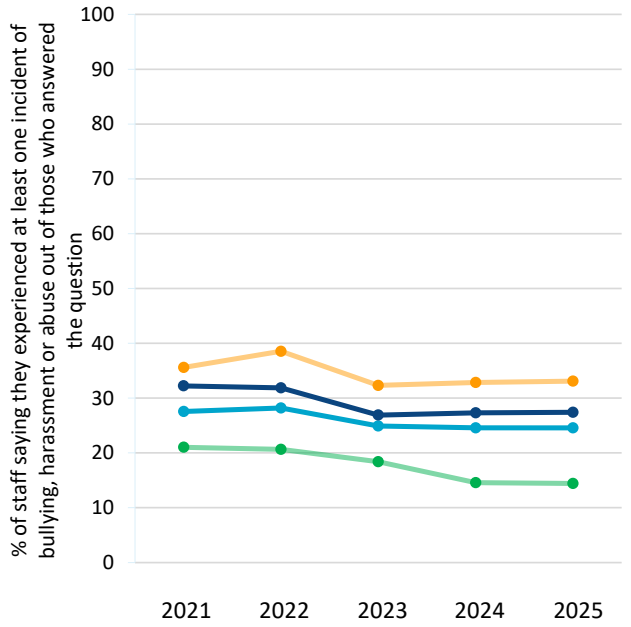
	2021	2022	2023	2024	2025
Your org	2.13%	2.64%	2.20%	1.84%	2.58%
Best result	0.56%	0.76%	0.65%	0.54%	0.63%
Average result	1.58%	1.83%	1.78%	1.88%	1.80%
Worst result	3.98%	5.44%	3.86%	6.09%	4.51%
Responses	2589	2927	2940	3277	2702

Note: 2023 results for Q13a-c are reported using corrected data. Please see https://www.nhsstaffsurveys.com/survey-documents/ for more details.

People Promise elements and theme results – We are safe and healthy: Negative experiences

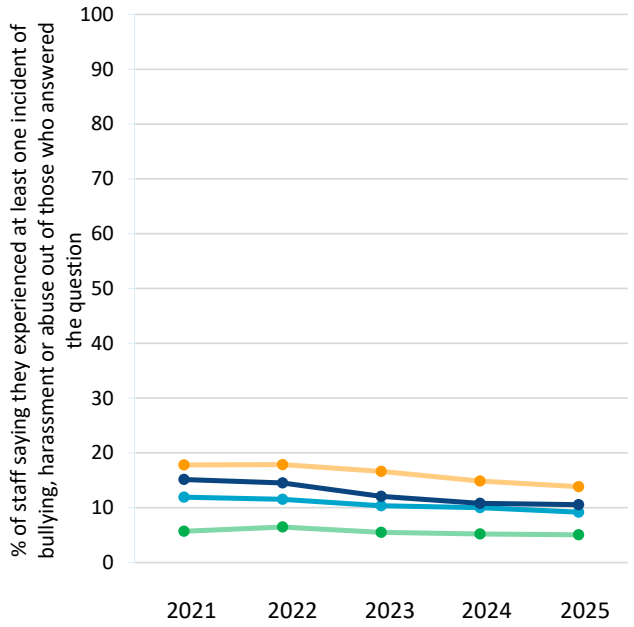
Survey Coordination Centre NHS

Q14a In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from...? Patients / service users, their relatives or other members of the public.



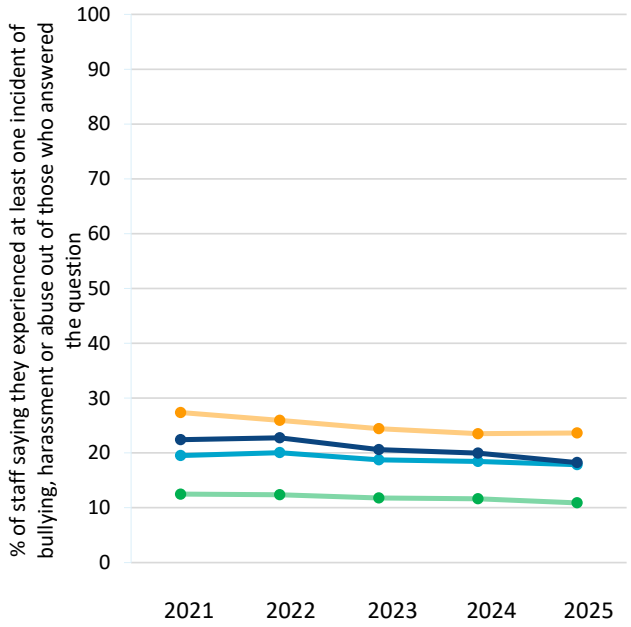
	2021	2022	2023	2024	2025
Your org	32.22%	31.87%	26.90%	27.34%	27.41%
Best result	21.03%	20.65%	18.41%	14.57%	14.44%
Average result	27.56%	28.20%	24.91%	24.59%	24.59%
Worst result	35.57%	38.56%	32.33%	32.84%	33.08%
Responses	2624	2940	2966	3320	2729

Q14b In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from...? Managers.



	2021	2022	2023	2024	2025
Your org	15.15%	14.51%	12.08%	10.81%	10.57%
Best result	5.72%	6.48%	5.50%	5.22%	5.07%
Average result	11.94%	11.52%	10.35%	10.00%	9.20%
Worst result	17.83%	17.88%	16.64%	14.86%	13.85%
Responses	2606	2915	2955	3303	2718

Q14c In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from...? Other colleagues.



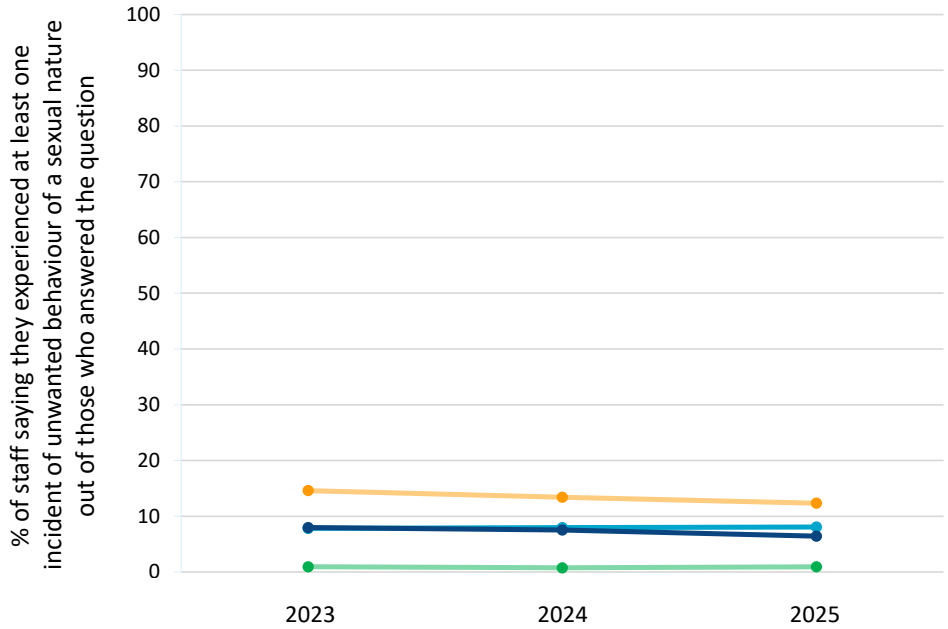
	2021	2022	2023	2024	2025
Your org	22.42%	22.76%	20.60%	19.97%	18.23%
Best result	12.50%	12.35%	11.78%	11.65%	10.89%
Average result	19.54%	20.05%	18.74%	18.47%	17.86%
Worst result	27.38%	25.97%	24.43%	23.52%	23.63%
Responses	2590	2907	2956	3310	2725

Note: 2023 results for Q14a-c are reported using corrected data. Please see https://www.nhsstaffsurveys.com/survey-documents/ for more details.

People Promise elements and theme results – We are safe and healthy: Other questions*

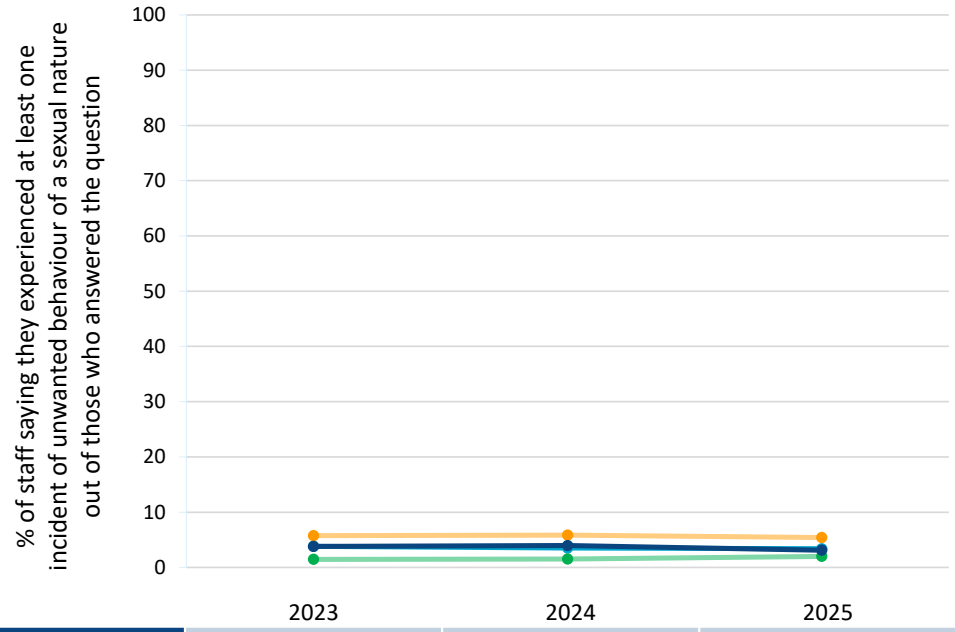
Survey Coordination Centre NHS

Q17a In the last 12 months, how many times have you been the target of unwanted behaviour of a sexual nature in the workplace? From patients / service users, their relatives or other members of the public



	2023	2024	2025
Your org	7.98%	7.55%	6.43%
Best result	0.94%	0.76%	0.92%
Average result	7.82%	7.97%	8.07%
Worst result	14.59%	13.40%	12.33%
Responses	2979	3325	2740

Q17b In the last 12 months, how many times have you been the target of unwanted behaviour of a sexual nature in the workplace? From staff / colleagues



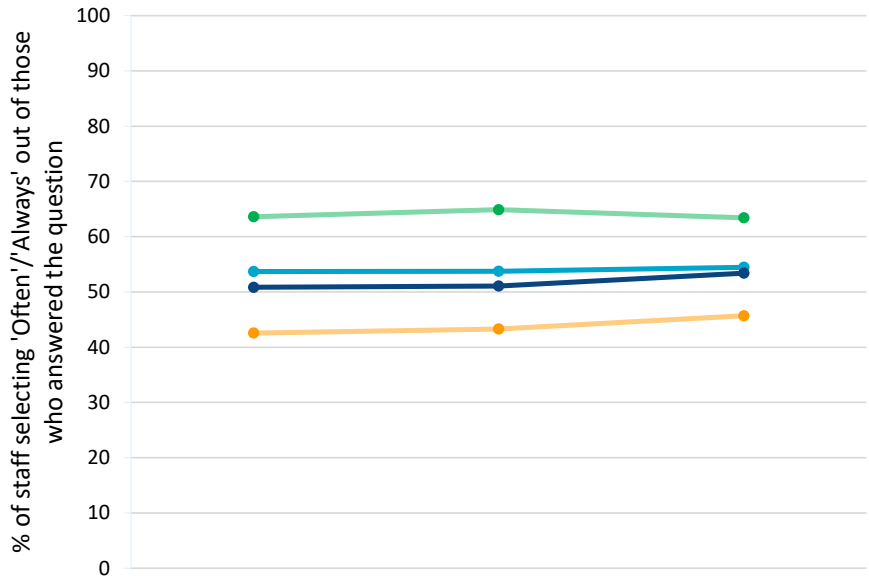
	2023	2024	2025
Your org	3.81%	3.97%	3.11%
Best result	1.45%	1.53%	1.99%
Average result	3.82%	3.53%	3.39%
Worst result	5.74%	5.85%	5.41%
Responses	2972	3314	2726

*These questions do not contribute towards any People Promise element score, theme score or sub-score

People Promise elements and theme results – We are safe and healthy: Other questions*

Survey Coordination Centre NHS

Q22 I can eat nutritious and affordable food while I am working



	2023	2024	2025
Your org	50.84%	51.05%	53.39%
Best result	63.60%	64.89%	63.41%
Average result	53.68%	53.75%	54.45%
Worst result	42.55%	43.27%	45.69%
Responses	2975	3331	2740

*These questions do not contribute towards any People Promise element score, theme score or sub-score

Survey Coordination Centre

NHS

People Promise element – We are always learning

Questions included:
Development – Q24a, Q24b, Q24c, Q24d, Q24e
Appraisals – Q23a*, Q23b, Q23c, Q23d
Other questions** - Q24f

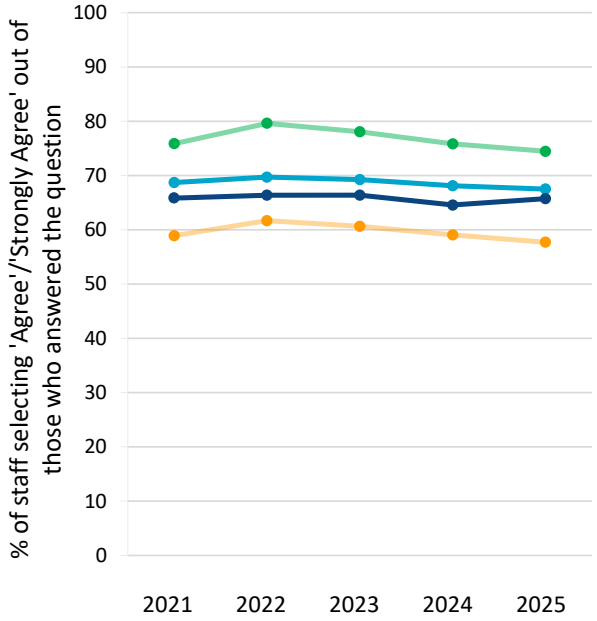
*Q23a is a filter question and therefore influences the sub-score without being a directly scored question.
**Q24f does not contribute to the calculation of any scores or sub-scores.

Note: where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

People Promise elements and theme results – We are always learning: Development

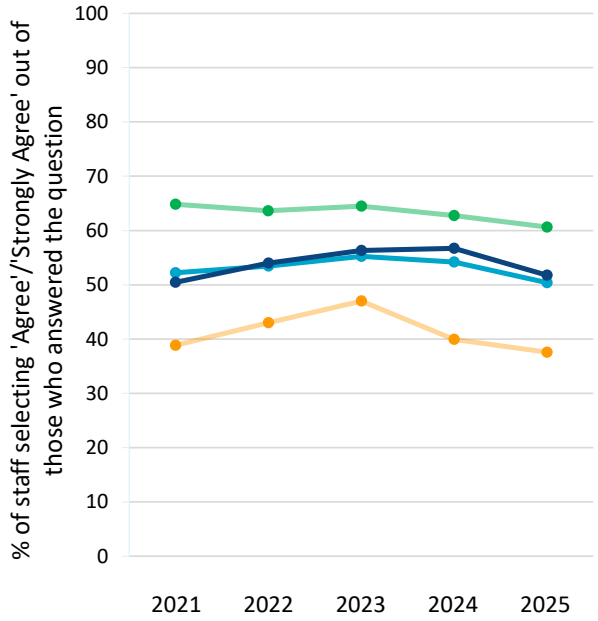
Survey Coordination Centre NHS

Q24a This organisation offers me challenging work.



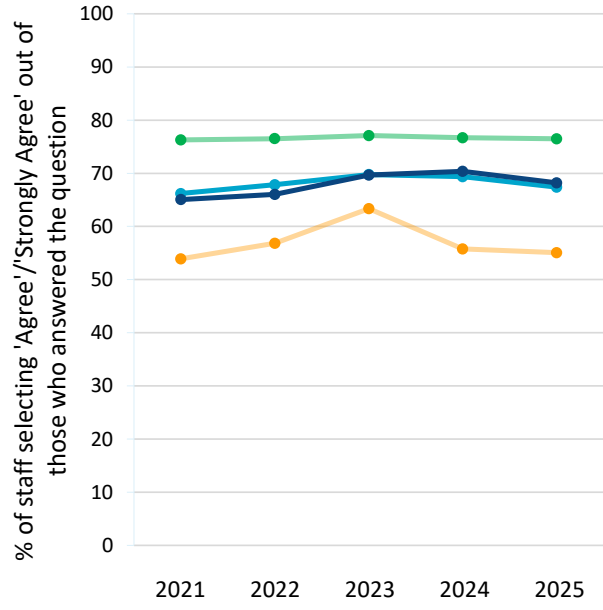
	2021	2022	2023	2024	2025
Your org	65.84%	66.36%	66.36%	64.57%	65.72%
Best result	75.85%	79.60%	78.03%	75.85%	74.46%
Average result	68.69%	69.71%	69.25%	68.11%	67.49%
Worst result	58.89%	61.69%	60.64%	59.07%	57.70%
Responses	2622	2938	2979	3325	2732

Q24b There are opportunities for me to develop my career in this organisation.



	2021	2022	2023	2024	2025
Your org	50.46%	53.99%	56.32%	56.71%	51.77%
Best result	64.83%	63.62%	64.46%	62.76%	60.64%
Average result	52.20%	53.45%	55.24%	54.21%	50.39%
Worst result	38.86%	43.01%	46.99%	39.92%	37.58%
Responses	2626	2938	2982	3328	2738

Q24c I have opportunities to improve my knowledge and skills.

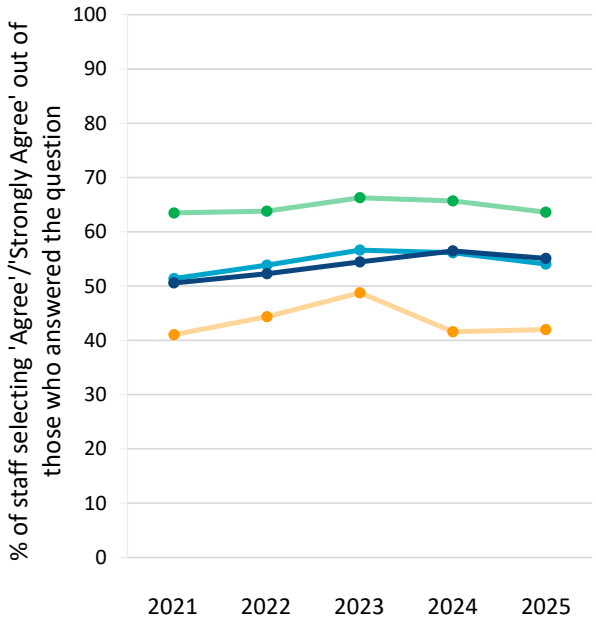


	2021	2022	2023	2024	2025
Your org	65.06%	66.05%	69.68%	70.37%	68.22%
Best result	76.28%	76.50%	77.10%	76.67%	76.47%
Average result	66.20%	67.85%	69.75%	69.36%	67.41%
Worst result	53.91%	56.82%	63.34%	55.77%	55.05%
Responses	2620	2934	2976	3324	2731

People Promise elements and theme results – We are always learning: Development

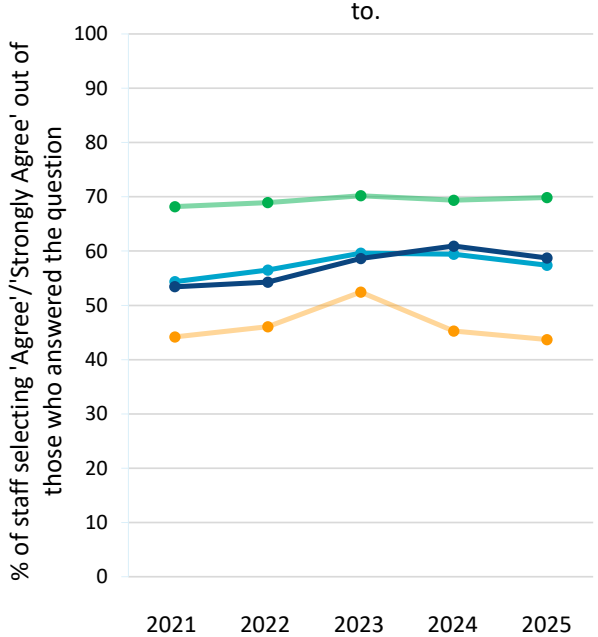
Survey Coordination Centre NHS

Q24d I feel supported to develop my potential.



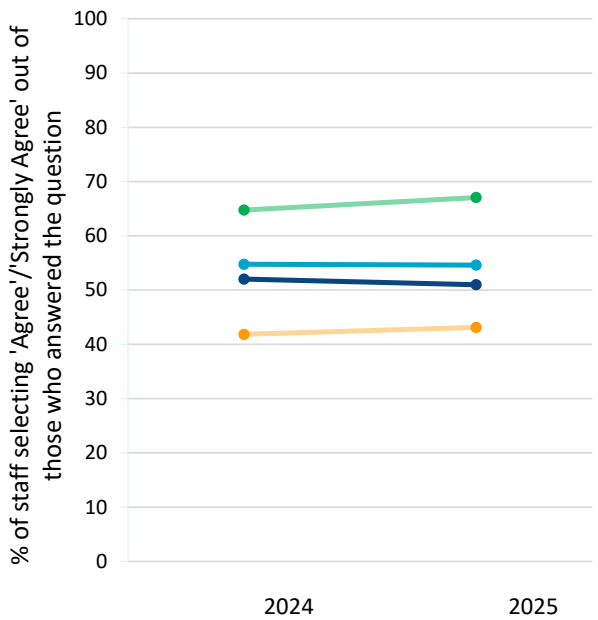
	2021	2022	2023	2024	2025
Your org	50.57%	52.30%	54.48%	56.46%	55.09%
Best result	63.48%	63.80%	66.26%	65.67%	63.62%
Average result	51.38%	53.86%	56.62%	56.16%	54.06%
Worst result	41.05%	44.35%	48.78%	41.57%	41.97%
Responses	2616	2934	2978	3317	2727

Q24e I am able to access the right learning and development opportunities when I need to.



	2021	2022	2023	2024	2025
Your org	53.41%	54.26%	58.63%	60.93%	58.75%
Best result	68.20%	68.93%	70.19%	69.39%	69.85%
Average result	54.36%	56.52%	59.61%	59.41%	57.42%
Worst result	44.17%	46.07%	52.44%	45.25%	43.71%
Responses	2618	2927	2975	3283	2718

Q24f* I am able to access clinical supervision opportunities when I need to.



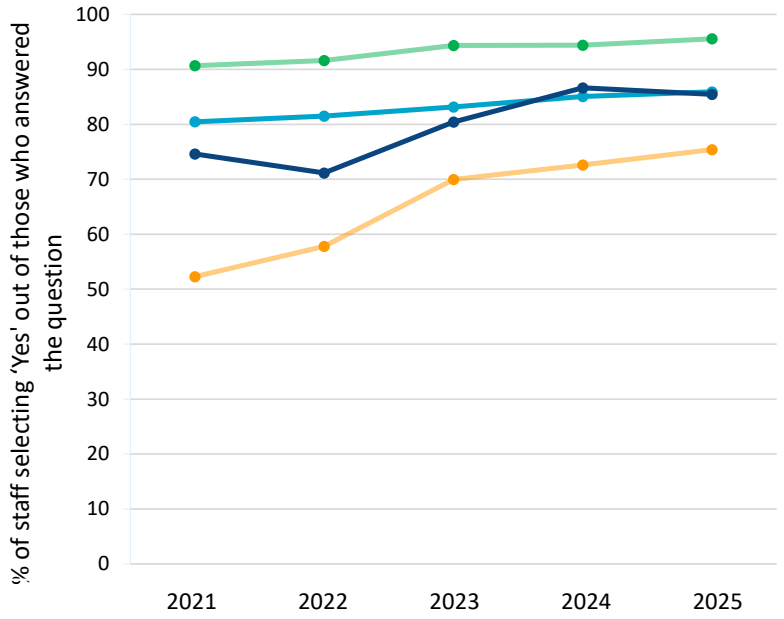
	2024	2025
Your org	52.02%	50.98%
Best result	64.74%	67.04%
Average result	54.76%	54.60%
Worst result	41.85%	43.13%
Responses	2568	2059

*Q24f was introduced in 2024 and does not currently contribute towards any People Promise element score, theme score or sub-score to protect trend data over five years.

People Promise elements and theme results – We are always learning: Appraisals

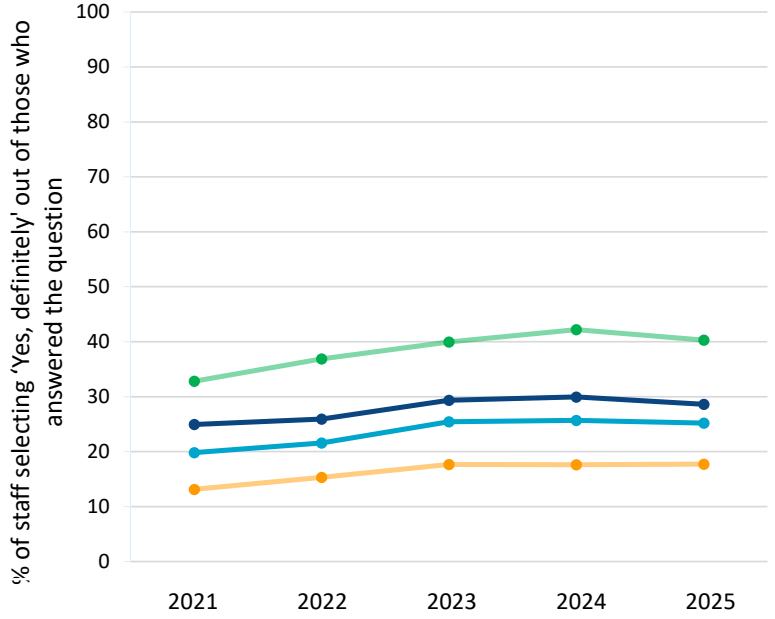
Survey Coordination Centre NHS

Q23a* In the last 12 months, have you had an appraisal, annual review, development review, or Knowledge and Skills Framework (KSF) development review?



	2021	2022	2023	2024	2025
Your org	74.62%	71.15%	80.44%	86.64%	85.46%
Best result	90.66%	91.61%	94.34%	94.40%	95.55%
Average result	80.45%	81.49%	83.18%	85.05%	85.91%
Worst result	52.28%	57.78%	69.95%	72.59%	75.40%
Responses	2617	2927	2955	3310	2729

Q23b It helped me to improve how I do my job.



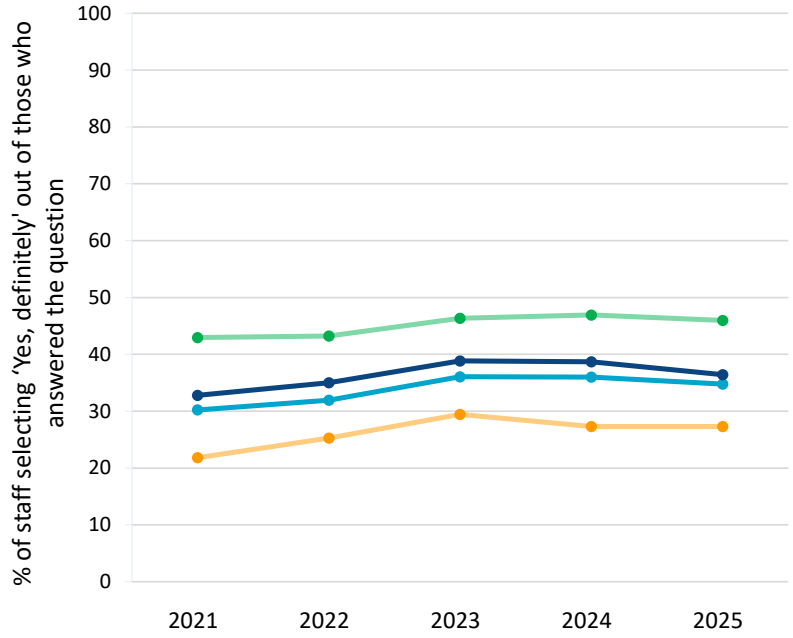
	2021	2022	2023	2024	2025
Your org	24.94%	25.95%	29.35%	29.96%	28.60%
Best result	32.81%	36.90%	39.96%	42.20%	40.32%
Average result	19.82%	21.57%	25.45%	25.69%	25.20%
Worst result	13.14%	15.33%	17.68%	17.62%	17.73%
Responses	1916	2075	2379	2867	2330

*Q23a is a filter question and therefore influences the sub-score without being a directly scored question.

People Promise elements and theme results – We are always learning: Appraisals

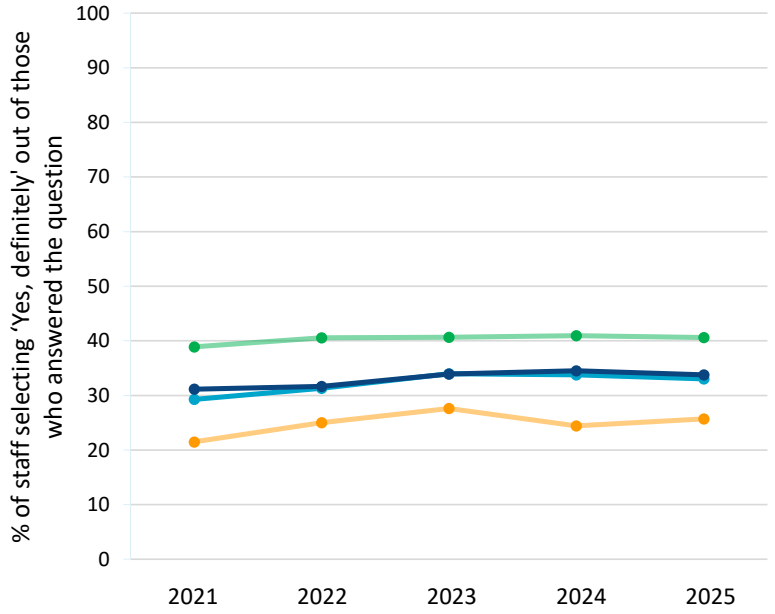
Survey Coordination Centre NHS

Q23c It helped me agree clear objectives for my work.



	2021	2022	2023	2024	2025
Your org	32.78%	35.00%	38.85%	38.69%	36.43%
Best result	42.95%	43.23%	46.32%	46.93%	45.99%
Average result	30.21%	31.94%	36.06%	36.01%	34.79%
Worst result	21.81%	25.28%	29.43%	27.29%	27.28%
Responses	1907	2074	2378	2860	2320

Q23d It left me feeling that my work is valued by my organisation.



	2021	2022	2023	2024	2025
Your org	31.14%	31.64%	33.92%	34.51%	33.76%
Best result	38.89%	40.56%	40.66%	40.93%	40.58%
Average result	29.26%	31.28%	33.97%	33.76%	33.02%
Worst result	21.49%	24.98%	27.60%	24.42%	25.69%
Responses	1912	2076	2374	2855	2320

Survey Coordination Centre

NHS

People Promise element – We work flexibly

Questions included:

Support for work-life balance – Q6b, Q6c, Q6d

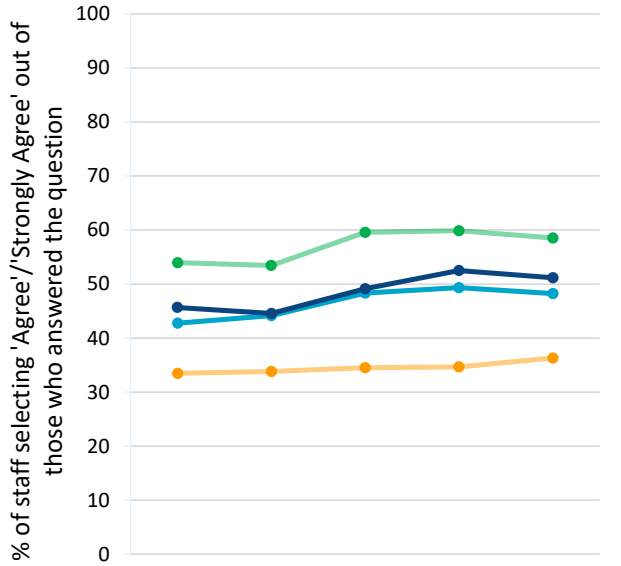
Flexible working – Q4d

Note: where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

People Promise elements and theme results – We work flexibly: Support for work-life balance

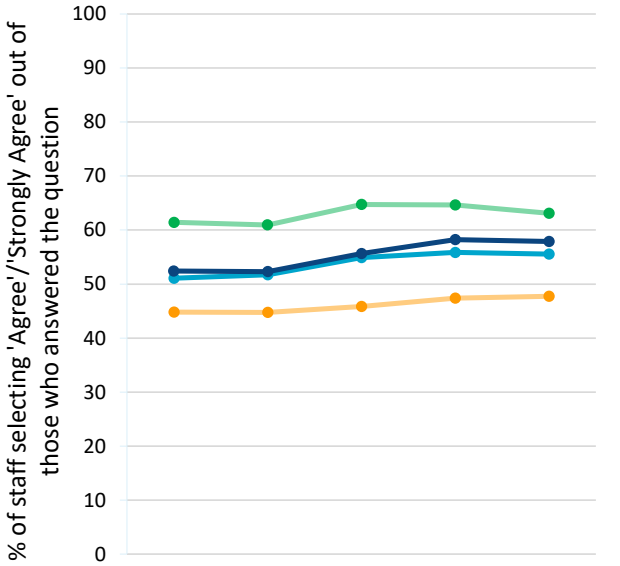
Survey Coordination Centre NHS

Q6b My organisation is committed to helping me balance my work and home life.



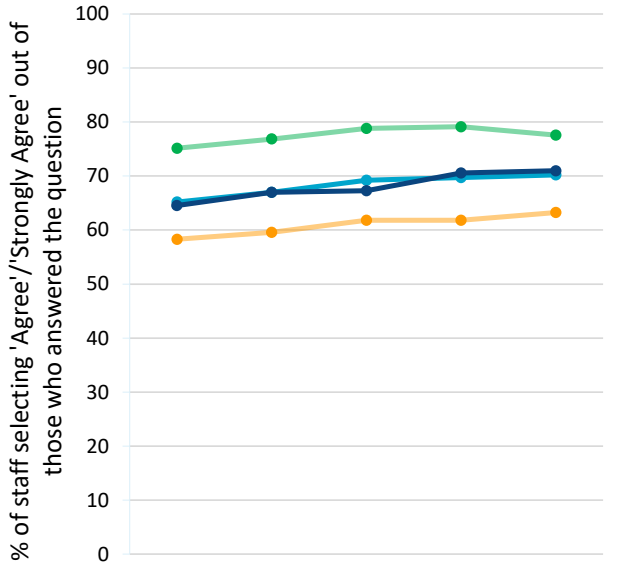
	2021	2022	2023	2024	2025
Your org	45.67%	44.56%	49.14%	52.50%	51.16%
Best result	53.96%	53.44%	59.57%	59.88%	58.52%
Average result	42.75%	44.15%	48.33%	49.34%	48.24%
Worst result	33.47%	33.80%	34.49%	34.65%	36.31%
Responses	2637	2951	2982	3326	2745

Q6c I achieve a good balance between my work life and my home life.



	2021	2022	2023	2024	2025
Your org	52.40%	52.29%	55.64%	58.22%	57.88%
Best result	61.44%	60.94%	64.73%	64.67%	63.10%
Average result	51.08%	51.70%	54.92%	55.86%	55.53%
Worst result	44.80%	44.75%	45.84%	47.38%	47.73%
Responses	2632	2950	2978	3318	2737

Q6d I can approach my immediate manager to talk openly about flexible working.

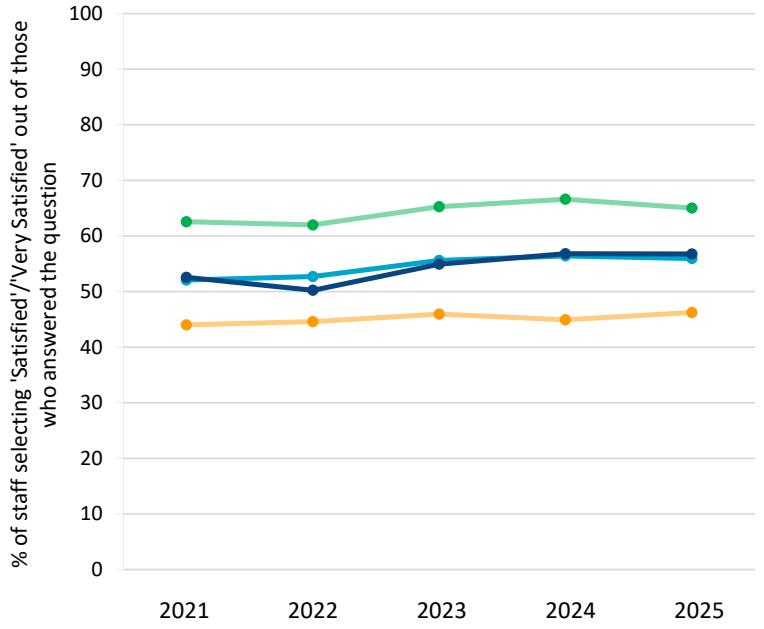


	2021	2022	2023	2024	2025
Your org	64.54%	66.98%	67.29%	70.58%	70.99%
Best result	75.15%	76.83%	78.81%	79.14%	77.58%
Average result	65.19%	66.98%	69.20%	69.72%	70.21%
Worst result	58.30%	59.56%	61.83%	61.82%	63.24%
Responses	2633	2948	2976	3329	2745

People Promise elements and theme results – We work flexibly: Flexible working

Survey Coordination Centre NHS

Q4d How satisfied are you with each of the following aspects of your job? The opportunities for flexible working patterns.



	2021	2022	2023	2024	2025
Your org	52.56%	50.23%	54.94%	56.81%	56.79%
Best result	62.56%	62.00%	65.26%	66.61%	65.03%
Average result	52.07%	52.73%	55.60%	56.41%	55.94%
Worst result	44.02%	44.60%	45.93%	44.94%	46.25%
Responses	2631	2942	2969	3315	2728

Survey Coordination Centre

NHS

People Promise element – We are a team

Questions included:

Team working – Q7a, Q7b, Q7c, Q7d, Q7e, Q7f, Q7g, Q8a

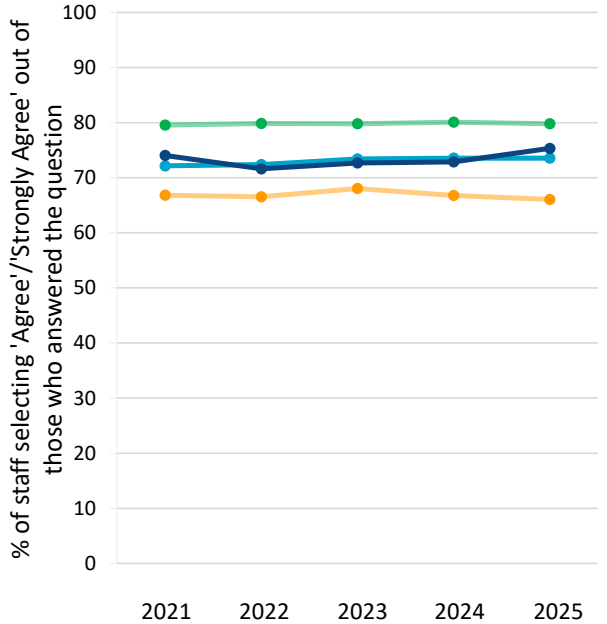
Line management – Q9a, Q9b, Q9c, Q9d

Note: where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

People Promise elements and theme results – We are a team: Team working

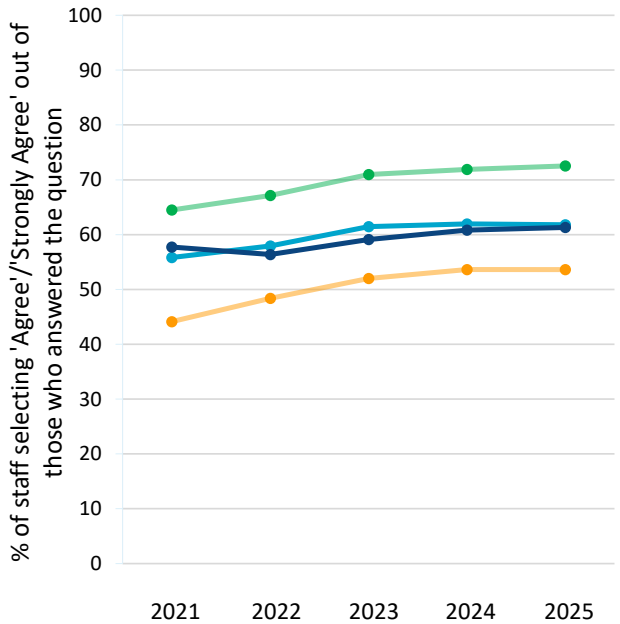
Survey Coordination Centre NHS

Q7a The team I work in has a set of shared objectives.



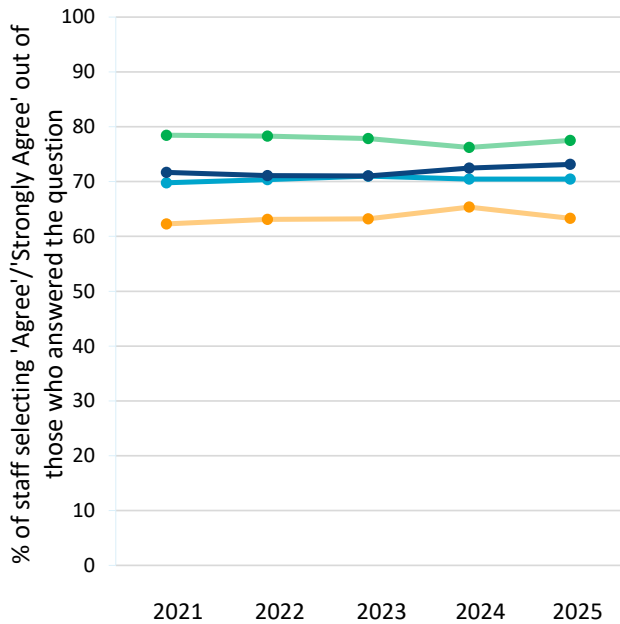
	2021	2022	2023	2024	2025
Your org	74.06%	71.62%	72.68%	72.85%	75.33%
Best result	79.56%	79.85%	79.81%	80.08%	79.77%
Average result	72.16%	72.38%	73.39%	73.54%	73.53%
Worst result	66.82%	66.53%	68.03%	66.79%	66.06%
Responses	2633	2943	2981	3334	2735

Q7b The team I work in often meets to discuss the team's effectiveness.



	2021	2022	2023	2024	2025
Your org	57.74%	56.38%	59.10%	60.80%	61.31%
Best result	64.49%	67.15%	70.95%	71.90%	72.53%
Average result	55.83%	57.91%	61.47%	61.95%	61.78%
Worst result	44.13%	48.38%	52.03%	53.63%	53.60%
Responses	2633	2944	2973	3328	2728

Q7c I receive the respect I deserve from my colleagues at work.

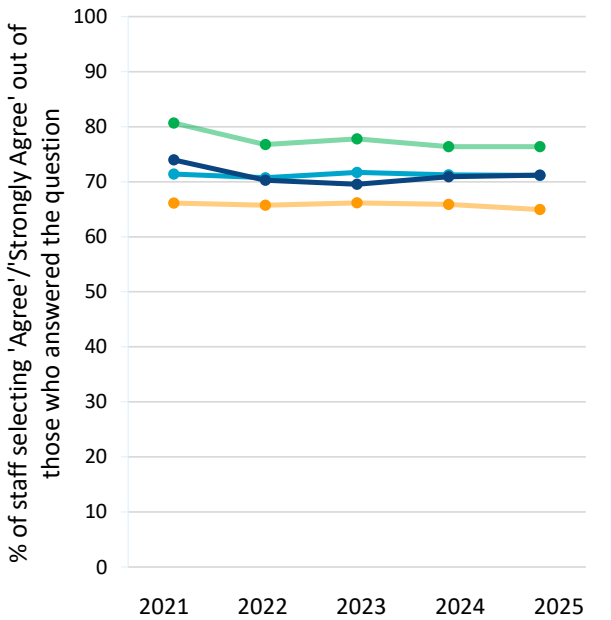


	2021	2022	2023	2024	2025
Your org	71.69%	71.10%	71.02%	72.45%	73.13%
Best result	78.46%	78.30%	77.85%	76.23%	77.49%
Average result	69.78%	70.35%	71.00%	70.47%	70.43%
Worst result	62.28%	63.13%	63.18%	65.35%	63.28%
Responses	2634	2946	2973	3330	2735

People Promise elements and theme results – We are a team: Team working

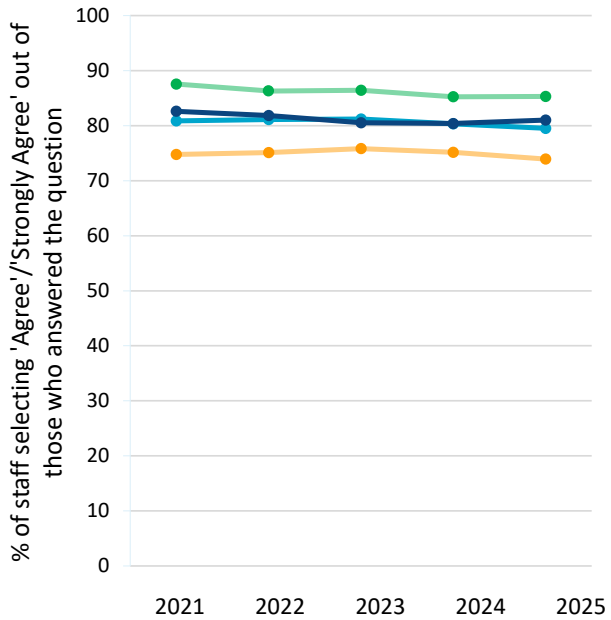
Survey Coordination Centre NHS

Q7d Team members understand each other's roles.



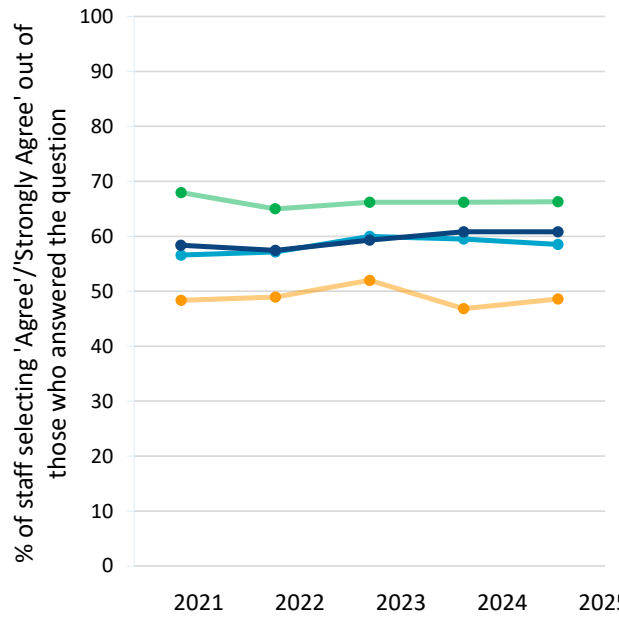
	2021	2022	2023	2024	2025
Your org	73.96%	70.29%	69.54%	70.92%	71.22%
Best result	80.67%	76.74%	77.77%	76.37%	76.38%
Average result	71.40%	70.73%	71.70%	71.27%	71.18%
Worst result	66.12%	65.71%	66.15%	65.90%	64.94%
Responses	2633	2938	2974	3328	2737

Q7e I enjoy working with the colleagues in my team.



	2021	2022	2023	2024	2025
Your org	82.60%	81.86%	80.53%	80.40%	81.01%
Best result	87.56%	86.31%	86.45%	85.24%	85.30%
Average result	80.87%	81.11%	81.20%	80.33%	79.52%
Worst result	74.78%	75.10%	75.82%	75.15%	73.93%
Responses	2632	2946	2974	3327	2737

Q7f My team has enough freedom in how to do its work.

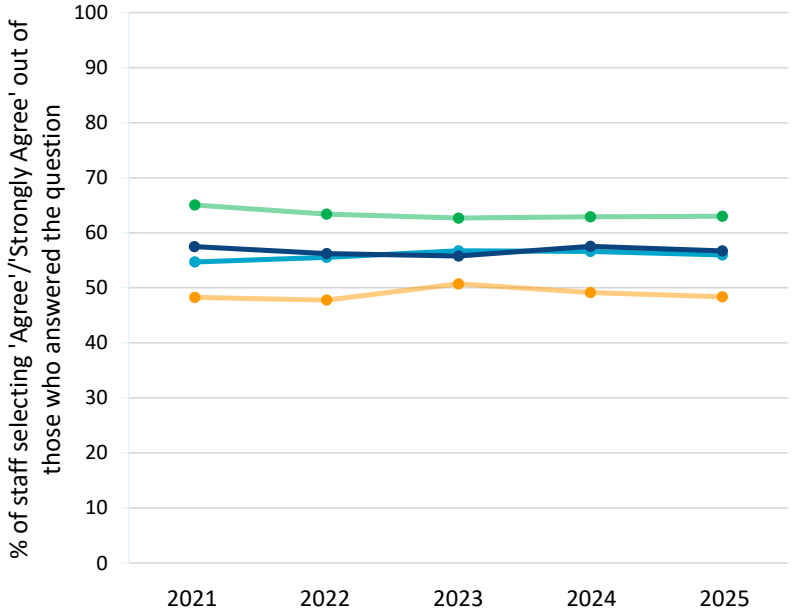


	2021	2022	2023	2024	2025
Your org	58.35%	57.43%	59.27%	60.82%	60.81%
Best result	67.96%	64.97%	66.19%	66.17%	66.26%
Average result	56.58%	57.13%	59.97%	59.48%	58.51%
Worst result	48.34%	48.92%	51.98%	46.82%	48.57%
Responses	2630	2943	2968	3318	2727

People Promise elements and theme results – We are a team: Team working

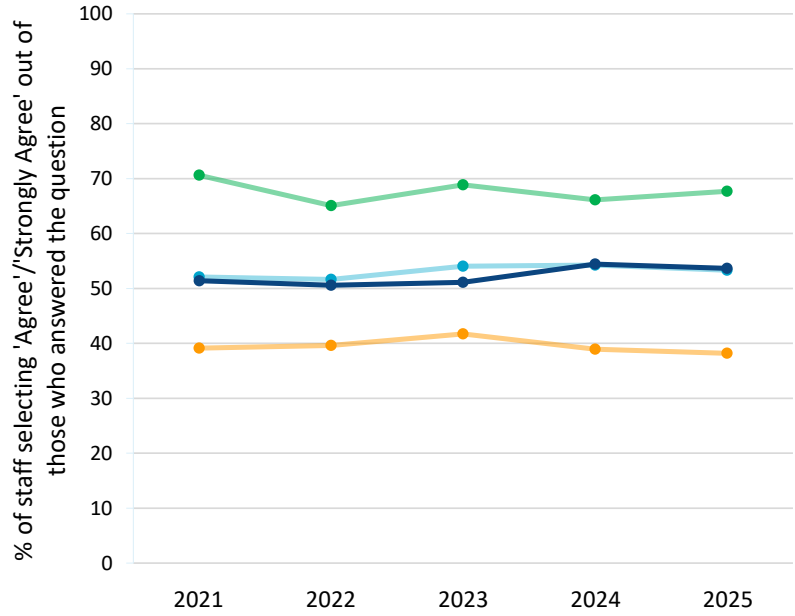
Survey Coordination Centre NHS

Q7g In my team disagreements are dealt with constructively.



	2021	2022	2023	2024	2025
Your org	57.46%	56.20%	55.78%	57.54%	56.70%
Best result	65.05%	63.39%	62.68%	62.92%	63.01%
Average result	54.69%	55.52%	56.73%	56.61%	55.99%
Worst result	48.27%	47.76%	50.72%	49.15%	48.38%
Responses	2628	2938	2971	3319	2732

Q8a Teams within this organisation work well together to achieve their objectives.

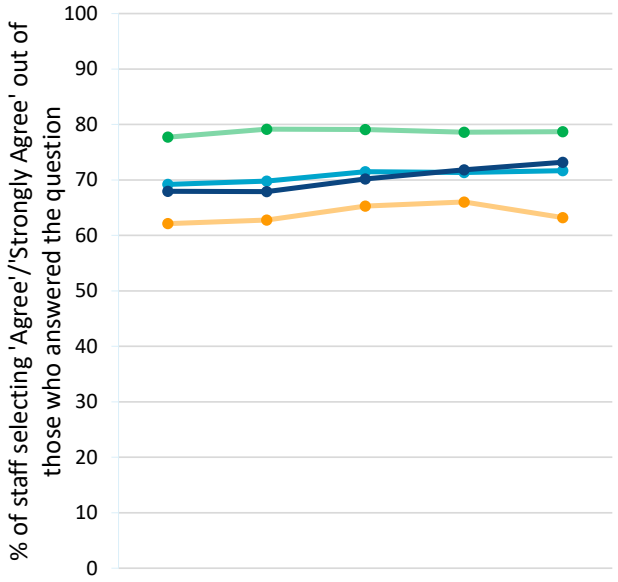


	2021	2022	2023	2024	2025
Your org	51.41%	50.58%	51.13%	54.43%	53.66%
Best result	70.61%	65.08%	68.87%	66.14%	67.71%
Average result	52.10%	51.64%	54.07%	54.26%	53.30%
Worst result	39.15%	39.64%	41.73%	38.96%	38.19%
Responses	2634	2945	2980	3323	2736

People Promise elements and theme results – We are a team: Line management

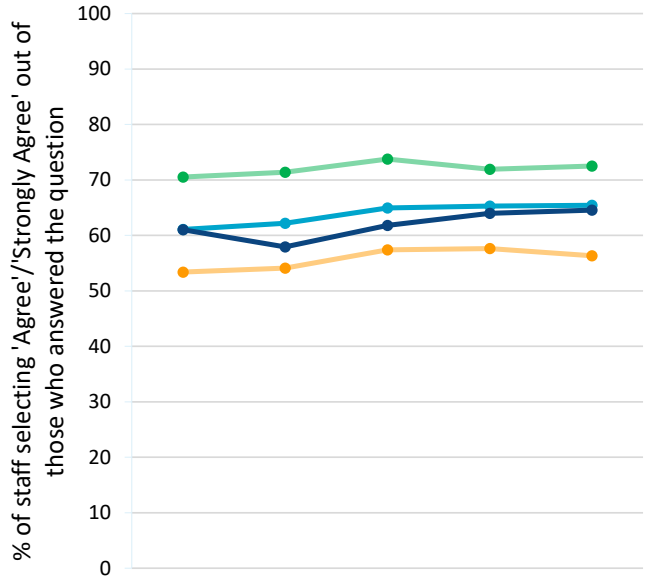
Survey Coordination Centre NHS

Q9a My immediate manager encourages me at work.



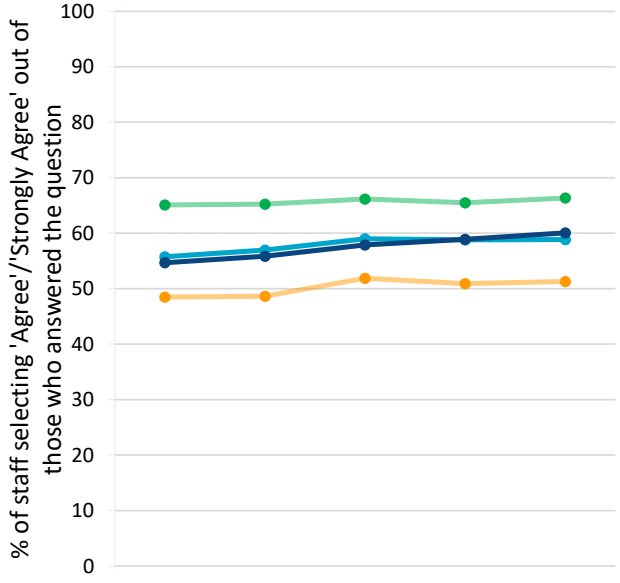
	2021	2022	2023	2024	2025
Your org	67.97%	67.90%	70.19%	71.81%	73.20%
Best result	77.71%	79.16%	79.07%	78.62%	78.70%
Average result	69.20%	69.81%	71.47%	71.36%	71.67%
Worst result	62.12%	62.77%	65.31%	66.03%	63.21%
Responses	2636	2950	2983	3332	2742

Q9b My immediate manager gives me clear feedback on my work.



	2021	2022	2023	2024	2025
Your org	61.01%	57.93%	61.82%	63.98%	64.56%
Best result	70.52%	71.41%	73.77%	71.91%	72.48%
Average result	61.07%	62.18%	64.95%	65.31%	65.43%
Worst result	53.39%	54.10%	57.39%	57.63%	56.34%
Responses	2636	2949	2979	3320	2743

Q9c My immediate manager asks for my opinion before making decisions that affect my work.

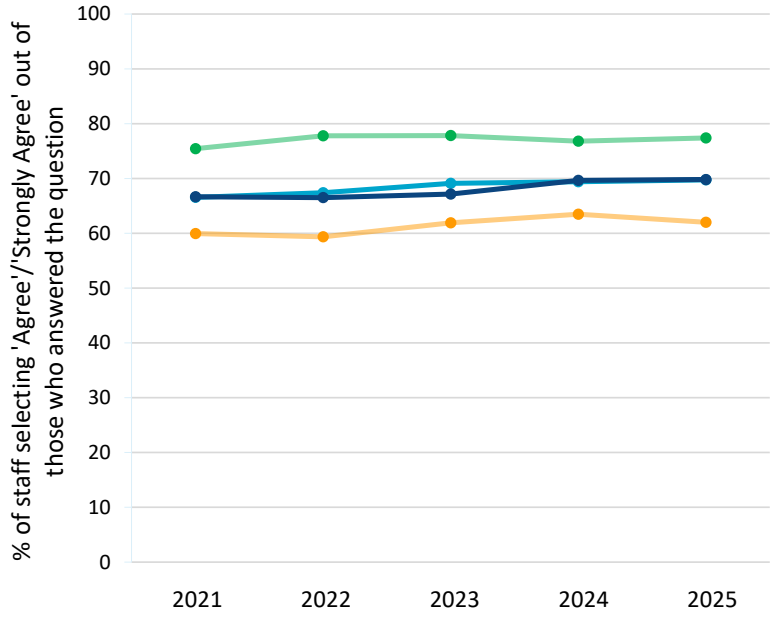


	2021	2022	2023	2024	2025
Your org	54.68%	55.83%	57.89%	58.89%	60.07%
Best result	65.10%	65.24%	66.18%	65.48%	66.34%
Average result	55.76%	56.95%	59.00%	58.82%	58.84%
Worst result	48.50%	48.63%	51.89%	50.94%	51.30%
Responses	2634	2950	2981	3329	2742

People Promise elements and theme results – We are a team: Line management

Survey Coordination Centre NHS

Q9d My immediate manager takes a positive interest in my health and well-being.



	2021	2022	2023	2024	2025
Your org	66.66%	66.50%	67.13%	69.67%	69.82%
Best result	75.43%	77.79%	77.82%	76.82%	77.40%
Average result	66.55%	67.41%	69.13%	69.39%	69.74%
Worst result	59.95%	59.35%	61.92%	63.48%	62.01%
Responses	2637	2950	2979	3330	2742

Survey Coordination Centre

NHS

Theme – Staff engagement

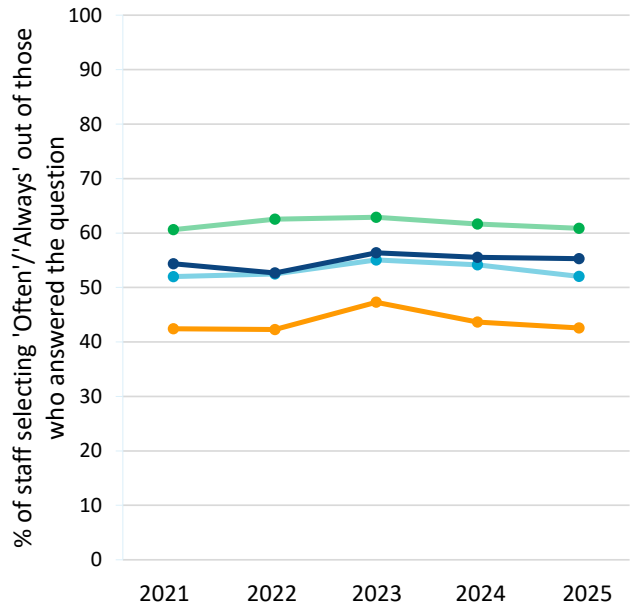
Questions included:
Motivation – Q2a, Q2b, Q2c
Involvement – Q3c, Q3d, Q3f
Advocacy – Q25a, Q25c, Q25d

Note: where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

People Promise elements and theme results – Staff engagement: Motivation

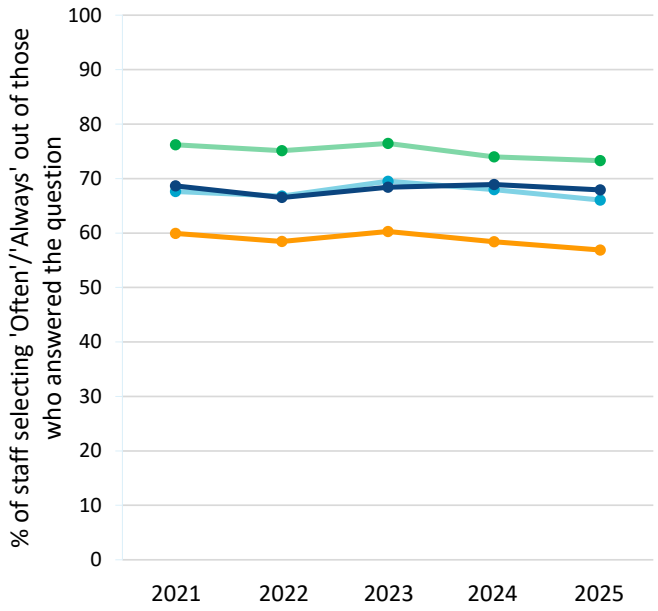
Survey Coordination Centre NHS

Q2a I look forward to going to work.



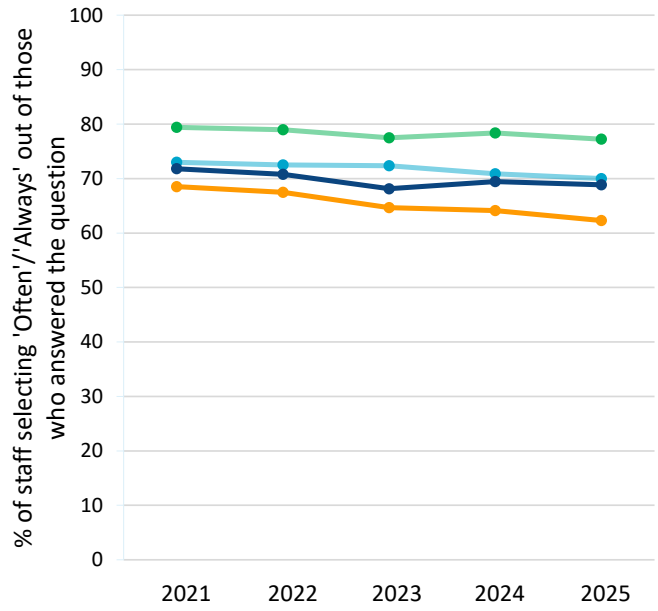
	2021	2022	2023	2024	2025
Your org	54.35%	52.66%	56.36%	55.53%	55.29%
Best result	60.62%	62.54%	62.89%	61.67%	60.88%
Average result	52.00%	52.48%	55.06%	54.17%	52.04%
Worst result	42.40%	42.29%	47.28%	43.67%	42.57%
Responses	2623	2935	2962	3321	2729

Q2b I am enthusiastic about my job.



	2021	2022	2023	2024	2025
Your org	68.64%	66.52%	68.41%	68.91%	67.89%
Best result	76.21%	75.11%	76.45%	73.98%	73.28%
Average result	67.62%	66.77%	69.51%	67.95%	66.05%
Worst result	59.95%	58.47%	60.29%	58.42%	56.88%
Responses	2608	2923	2945	3301	2713

Q2c Time passes quickly when I am working.

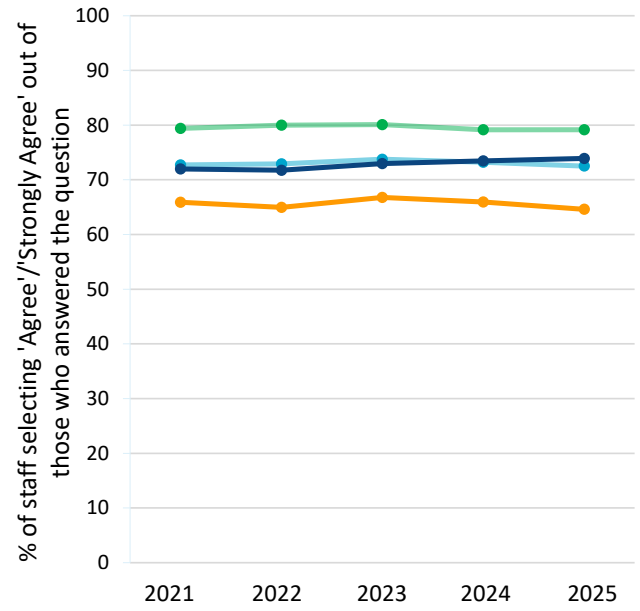


	2021	2022	2023	2024	2025
Your org	71.80%	70.77%	68.14%	69.44%	68.85%
Best result	79.40%	78.98%	77.46%	78.39%	77.22%
Average result	72.98%	72.52%	72.34%	70.90%	70.00%
Worst result	68.52%	67.46%	64.64%	64.12%	62.29%
Responses	2609	2923	2946	3291	2712

People Promise elements and theme results – Staff engagement: Involvement

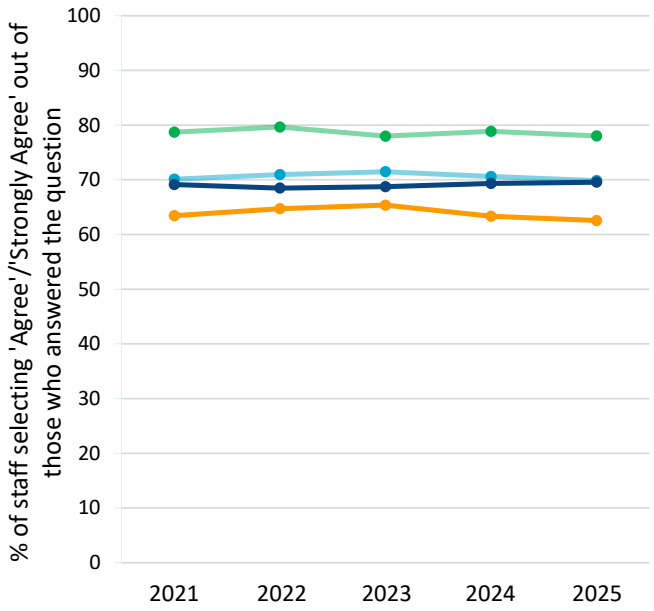
Survey Coordination Centre NHS

Q3c There are frequent opportunities for me to show initiative in my role.



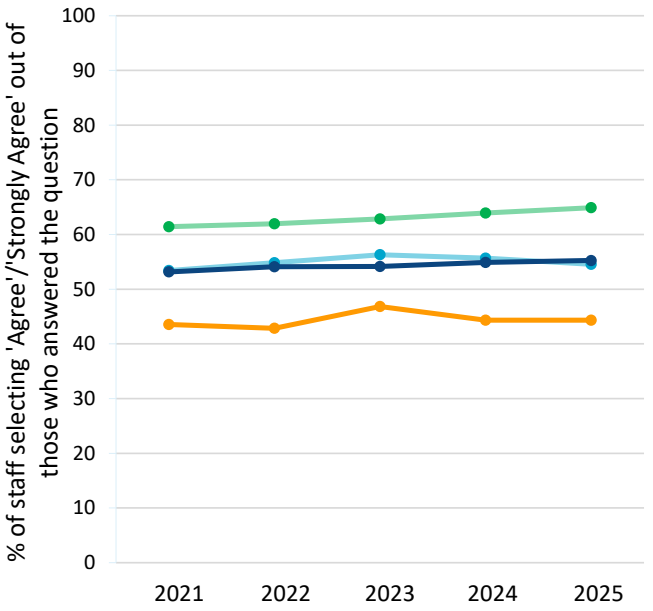
	2021	2022	2023	2024	2025
Your org	72.00%	71.76%	72.97%	73.45%	73.92%
Best result	79.41%	80.01%	80.10%	79.15%	79.17%
Average result	72.75%	72.91%	73.77%	73.20%	72.51%
Worst result	65.92%	64.98%	66.78%	65.94%	64.60%
Responses	2629	2949	2978	3334	2741

Q3d I am able to make suggestions to improve the work of my team / department.



	2021	2022	2023	2024	2025
Your org	69.13%	68.48%	68.76%	69.36%	69.56%
Best result	78.70%	79.67%	78.00%	78.84%	78.03%
Average result	70.10%	70.97%	71.47%	70.61%	69.85%
Worst result	63.42%	64.70%	65.38%	63.33%	62.56%
Responses	2628	2938	2979	3331	2736

Q3f I am able to make improvements happen in my area of work.

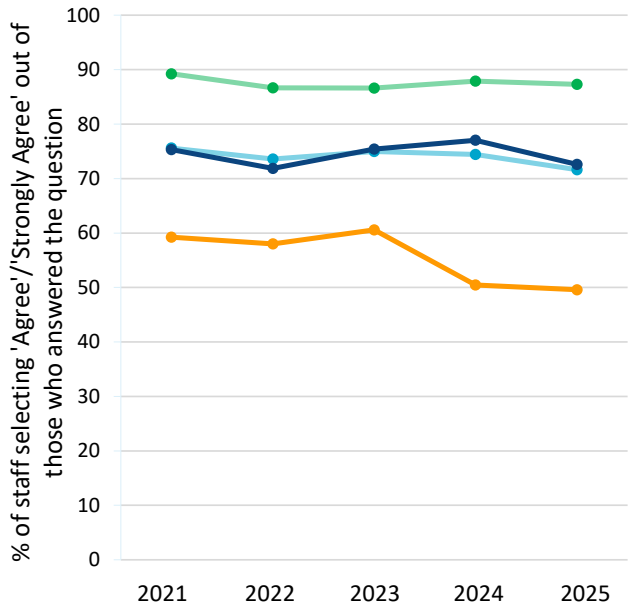


	2021	2022	2023	2024	2025
Your org	53.16%	54.09%	54.14%	54.90%	55.26%
Best result	61.43%	61.98%	62.84%	63.94%	64.90%
Average result	53.41%	54.86%	56.30%	55.71%	54.54%
Worst result	43.54%	42.85%	46.84%	44.35%	44.33%
Responses	2620	2933	2965	3322	2739

People Promise elements and theme results – Staff engagement: Advocacy

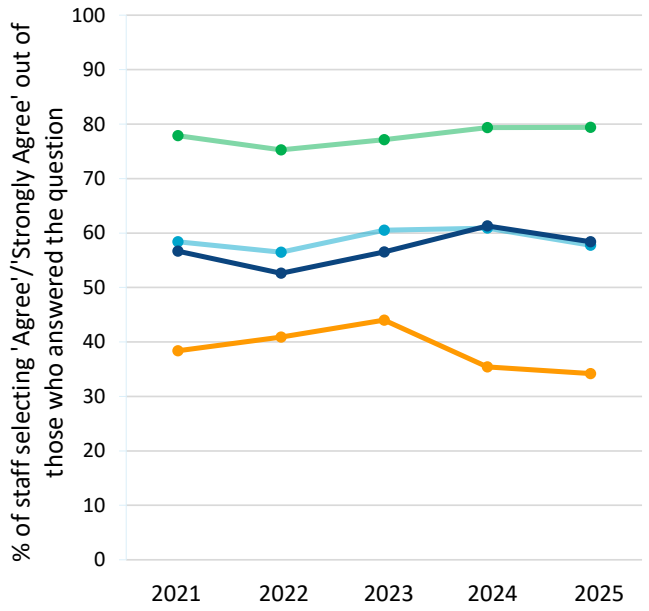
Survey Coordination Centre NHS

Q25a Care of patients / service users is my organisation's top priority.



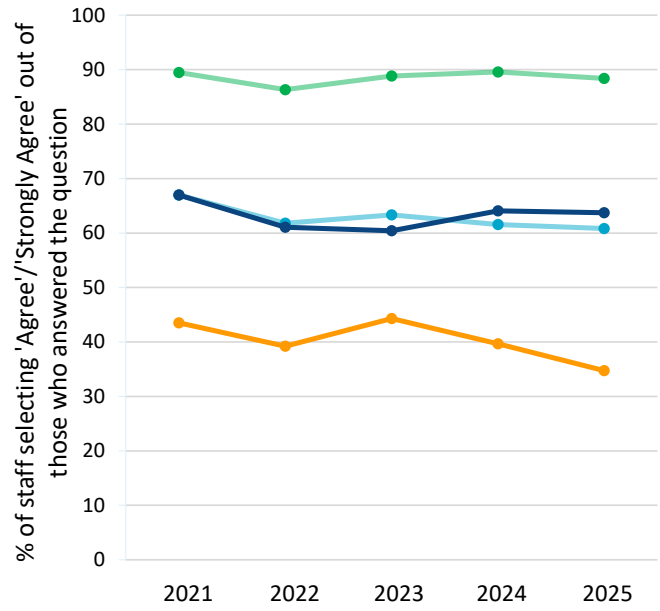
	2021	2022	2023	2024	2025
Your org	75.32%	71.87%	75.42%	77.03%	72.62%
Best result	89.24%	86.64%	86.62%	87.88%	87.31%
Average result	75.58%	73.58%	74.95%	74.42%	71.63%
Worst result	59.25%	57.99%	60.58%	50.48%	49.59%
Responses	2621	2938	2972	3323	2733

Q25c I would recommend my organisation as a place to work.



	2021	2022	2023	2024	2025
Your org	56.66%	52.61%	56.53%	61.30%	58.37%
Best result	77.86%	75.26%	77.14%	79.37%	79.40%
Average result	58.41%	56.47%	60.52%	60.89%	57.77%
Worst result	38.40%	40.90%	44.01%	35.43%	34.20%
Responses	2620	2935	2974	3321	2730

Q25d If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.



	2021	2022	2023	2024	2025
Your org	66.97%	61.04%	60.41%	64.05%	63.72%
Best result	89.49%	86.33%	88.81%	89.58%	88.41%
Average result	66.97%	61.78%	63.32%	61.55%	60.83%
Worst result	43.50%	39.20%	44.30%	39.68%	34.73%
Responses	2624	2934	2967	3318	2728

Survey Coordination Centre

NHS

Theme - Morale

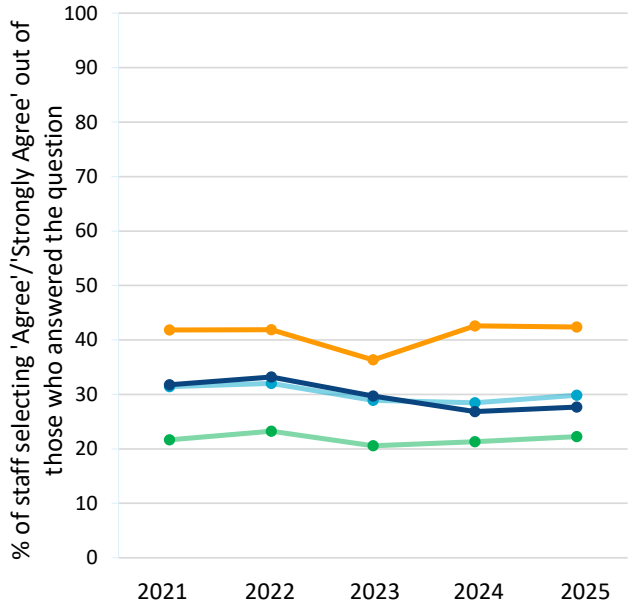
Questions included:
Thinking about leaving – Q26a, Q26b, Q26c
Work pressure – Q3g, Q3h, Q3i
Stressors – Q3a, Q3e, Q5a, Q5b, Q5c, Q7c, Q9a

Note: where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

People Promise elements and theme results – Morale: Thinking about leaving

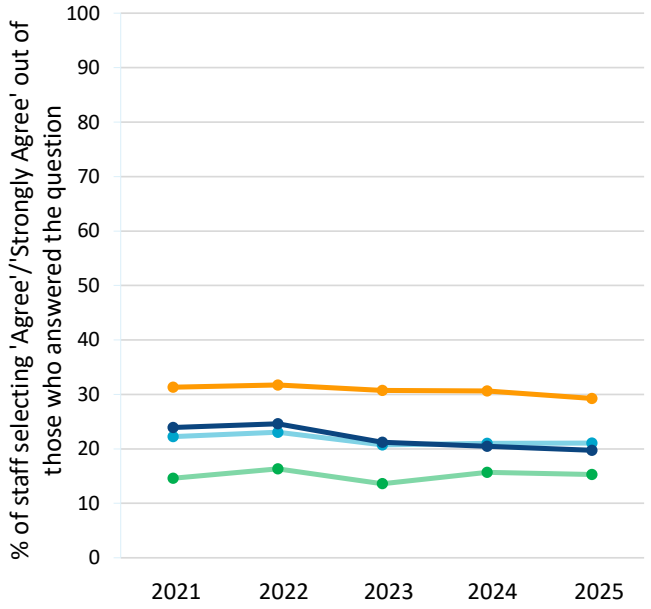
Survey Coordination Centre NHS

Q26a I often think about leaving this organisation.



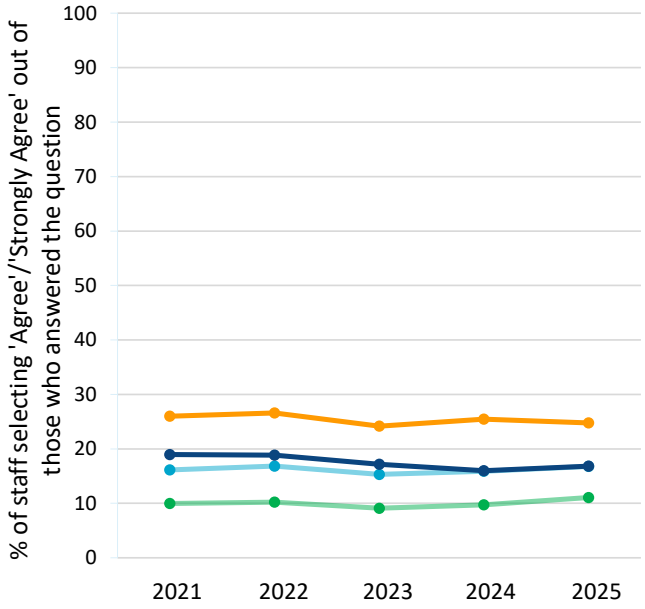
	2021	2022	2023	2024	2025
Your org	31.78%	33.19%	29.67%	26.85%	27.66%
Best result	21.67%	23.25%	20.56%	21.31%	22.27%
Average result	31.44%	32.02%	28.90%	28.46%	29.83%
Worst result	41.82%	41.89%	36.33%	42.59%	42.38%
Responses	2625	2949	2979	3325	2745

Q26b I will probably look for a job at a new organisation in the next 12 months.



	2021	2022	2023	2024	2025
Your org	23.94%	24.60%	21.24%	20.49%	19.74%
Best result	14.63%	16.33%	13.60%	15.69%	15.29%
Average result	22.24%	23.06%	20.73%	21.00%	21.07%
Worst result	31.33%	31.73%	30.75%	30.62%	29.26%
Responses	2617	2946	2976	3319	2737

Q26c As soon as I can find another job, I will leave this organisation.

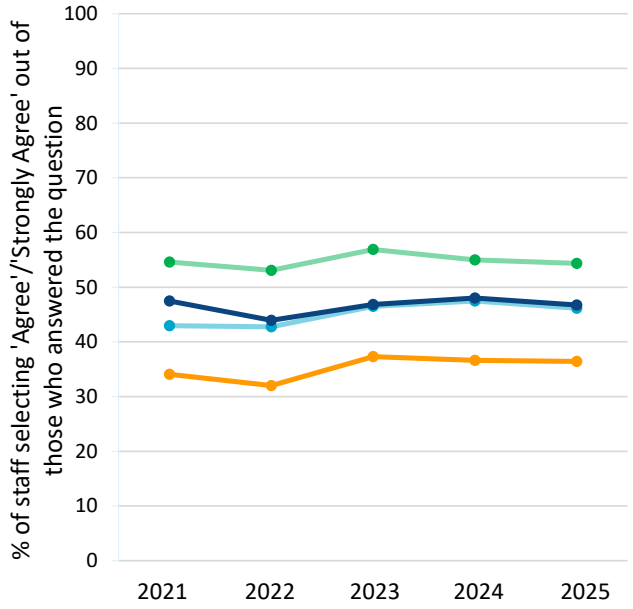


	2021	2022	2023	2024	2025
Your org	18.96%	18.86%	17.17%	15.99%	16.84%
Best result	9.95%	10.19%	9.11%	9.75%	11.07%
Average result	16.15%	16.84%	15.32%	15.87%	16.77%
Worst result	25.98%	26.59%	24.17%	25.47%	24.76%
Responses	2609	2940	2966	3310	2731

People Promise elements and theme results – Morale: Work pressure

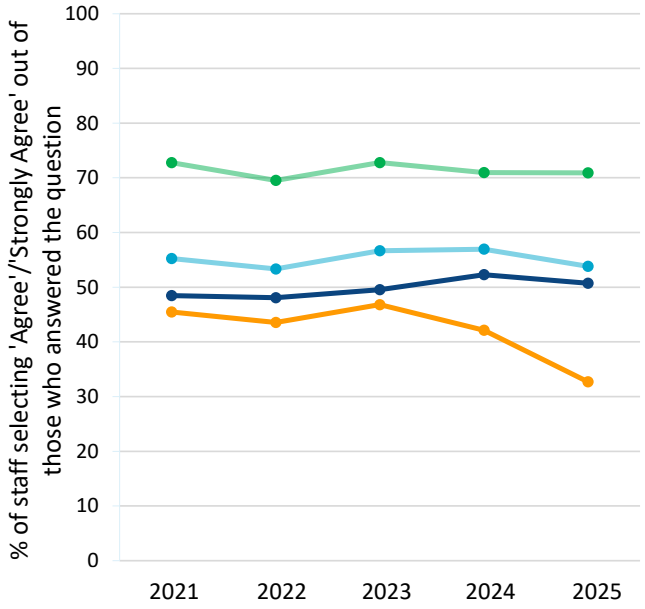
Survey Coordination Centre NHS

Q3g I am able to meet all the conflicting demands on my time at work.



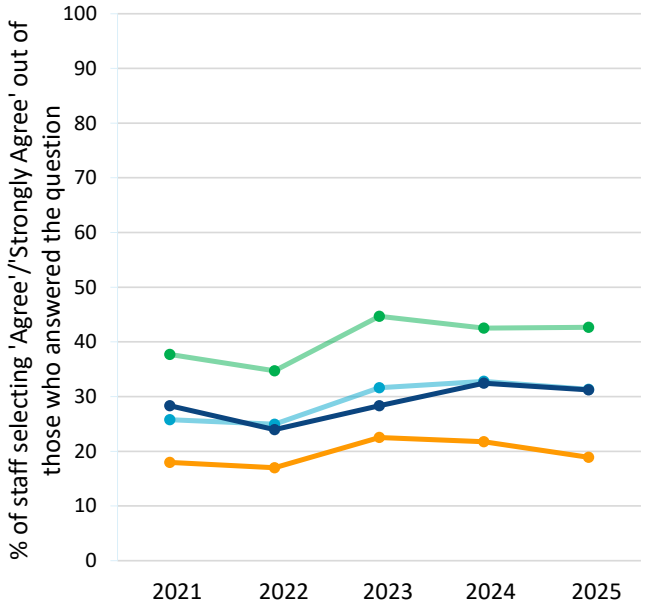
	2021	2022	2023	2024	2025
Your org	47.48%	43.95%	46.85%	48.03%	46.74%
Best result	54.61%	53.09%	56.89%	54.99%	54.34%
Average result	42.96%	42.76%	46.52%	47.47%	46.14%
Worst result	34.06%	32.02%	37.31%	36.63%	36.45%
Responses	2629	2942	2973	3321	2730

Q3h I have adequate materials, supplies and equipment to do my work.



	2021	2022	2023	2024	2025
Your org	48.45%	48.08%	49.54%	52.28%	50.71%
Best result	72.77%	69.52%	72.79%	70.96%	70.92%
Average result	55.26%	53.34%	56.68%	56.94%	53.84%
Worst result	45.45%	43.54%	46.82%	42.11%	32.70%
Responses	2628	2938	2966	3318	2723

Q3i There are enough staff at this organisation for me to do my job properly.

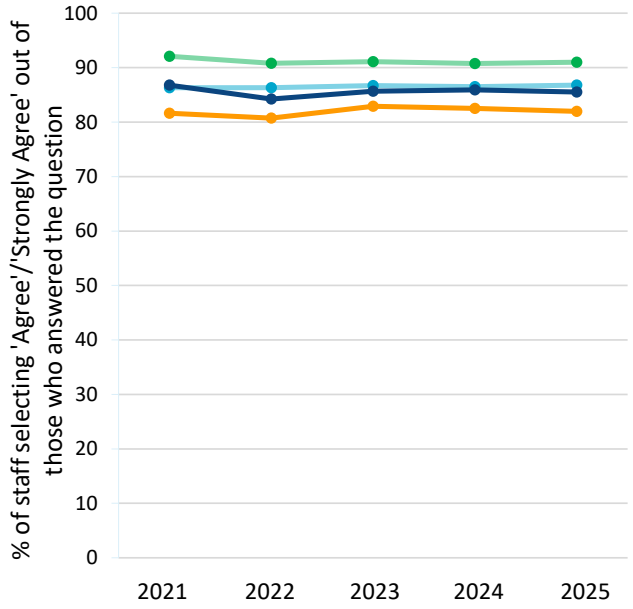


	2021	2022	2023	2024	2025
Your org	28.34%	23.97%	28.34%	32.45%	31.22%
Best result	37.72%	34.72%	44.68%	42.50%	42.65%
Average result	25.79%	24.95%	31.62%	32.78%	31.34%
Worst result	17.94%	17.00%	22.52%	21.73%	18.91%
Responses	2628	2939	2976	3327	2742

People Promise elements and theme results – Morale: Stressors

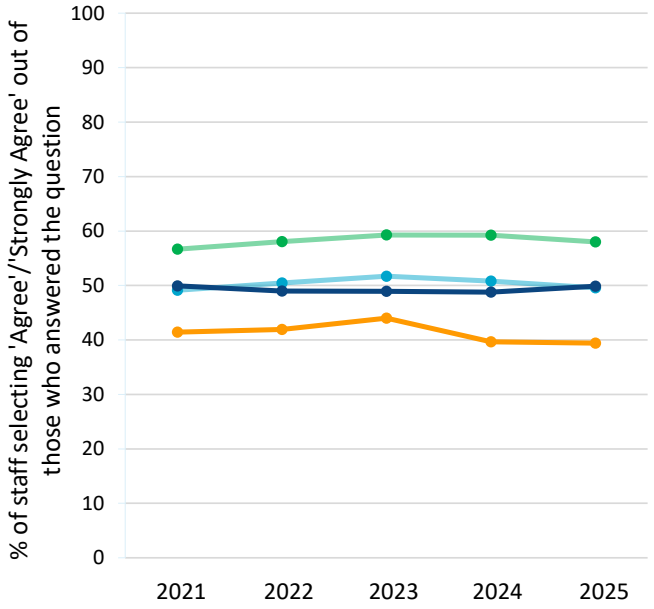
Survey Coordination Centre NHS

Q3a I always know what my work responsibilities are.



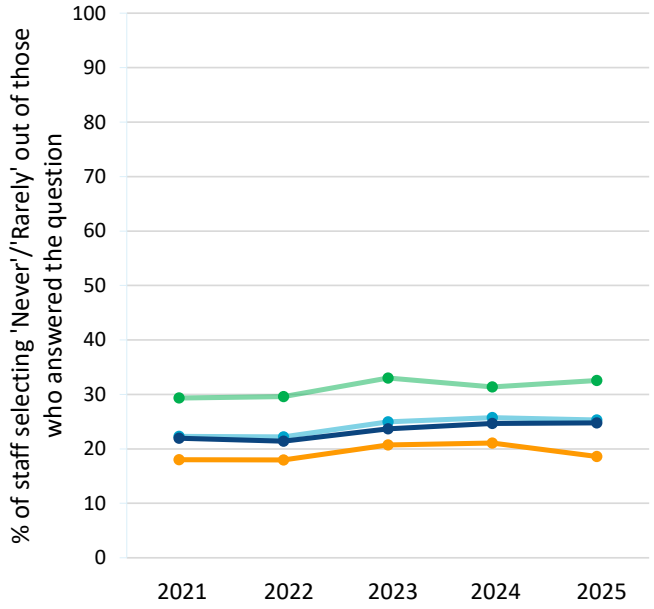
	2021	2022	2023	2024	2025
Your org	86.78%	84.24%	85.65%	85.92%	85.52%
Best result	92.09%	90.81%	91.10%	90.75%	91.00%
Average result	86.33%	86.32%	86.69%	86.53%	86.79%
Worst result	81.63%	80.73%	82.90%	82.49%	81.95%
Responses	2642	2955	2986	3337	2748

Q3e I am involved in deciding on changes introduced that affect my work area / team / department.



	2021	2022	2023	2024	2025
Your org	49.93%	48.98%	48.90%	48.77%	49.88%
Best result	56.66%	58.05%	59.27%	59.26%	58.01%
Average result	49.12%	50.45%	51.71%	50.82%	49.59%
Worst result	41.44%	41.94%	44.00%	39.68%	39.41%
Responses	2634	2943	2974	3326	2737

Q5a I have unrealistic time pressures.

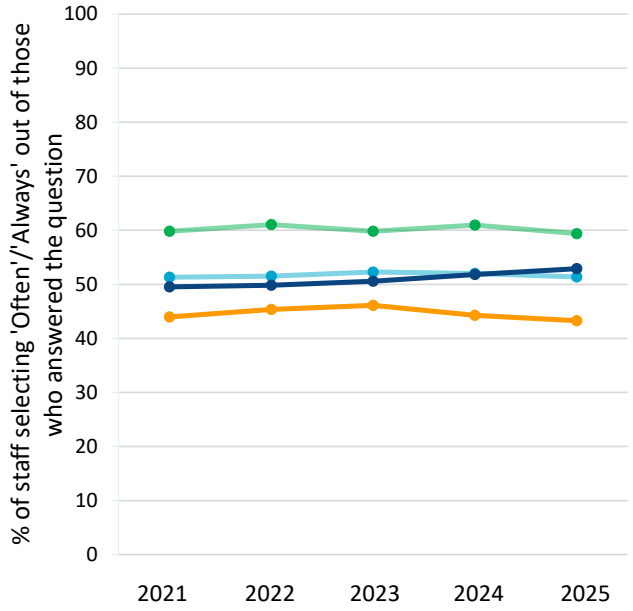


	2021	2022	2023	2024	2025
Your org	21.94%	21.41%	23.68%	24.64%	24.77%
Best result	29.33%	29.60%	33.01%	31.38%	32.55%
Average result	22.28%	22.20%	24.97%	25.73%	25.30%
Worst result	18.03%	17.97%	20.72%	21.07%	18.61%
Responses	2630	2942	2982	3325	2743

People Promise elements and theme results – Morale: Stressors

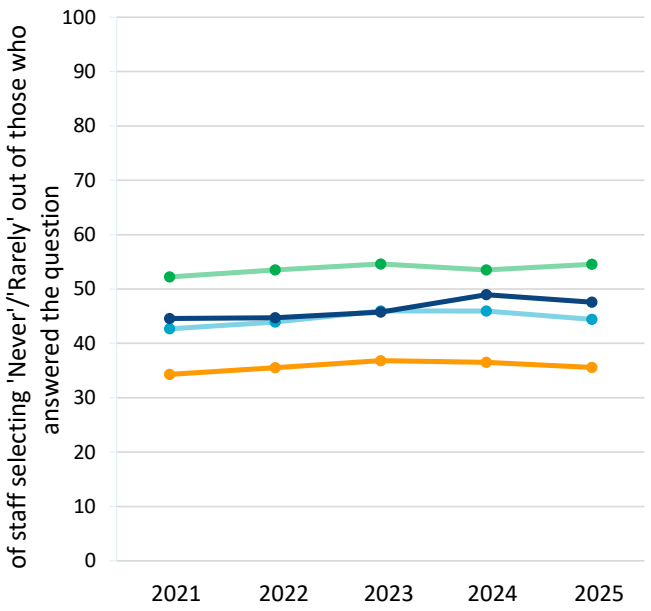
Survey Coordination Centre NHS

Q5b I have a choice in deciding how to do my work.



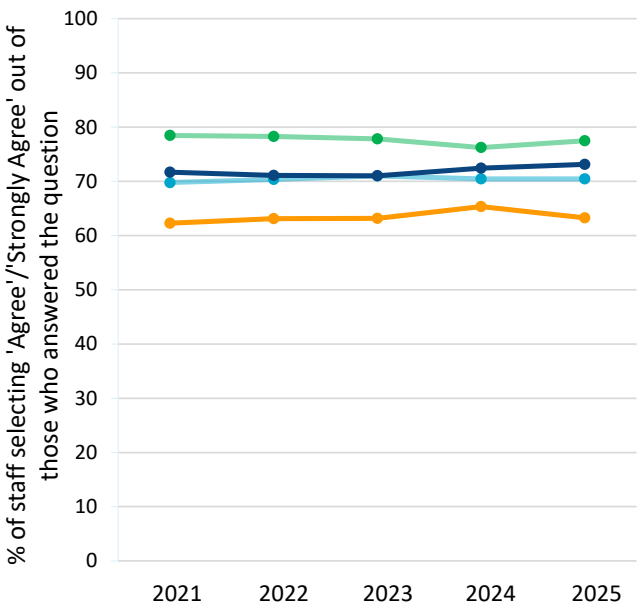
	2021	2022	2023	2024	2025
Your org	49.53%	49.85%	50.58%	51.83%	52.90%
Best result	59.84%	61.04%	59.83%	60.94%	59.39%
Average result	51.31%	51.54%	52.28%	52.02%	51.37%
Worst result	43.95%	45.34%	46.12%	44.25%	43.28%
Responses	2630	2946	2972	3320	2724

Q5c Relationships at work are strained.



	2021	2022	2023	2024	2025
Your org	44.58%	44.70%	45.75%	48.95%	47.58%
Best result	52.22%	53.50%	54.61%	53.52%	54.55%
Average result	42.67%	43.93%	45.97%	45.95%	44.43%
Worst result	34.29%	35.52%	36.82%	36.49%	35.57%
Responses	2626	2940	2972	3312	2738

Q7c I receive the respect I deserve from my colleagues at work.

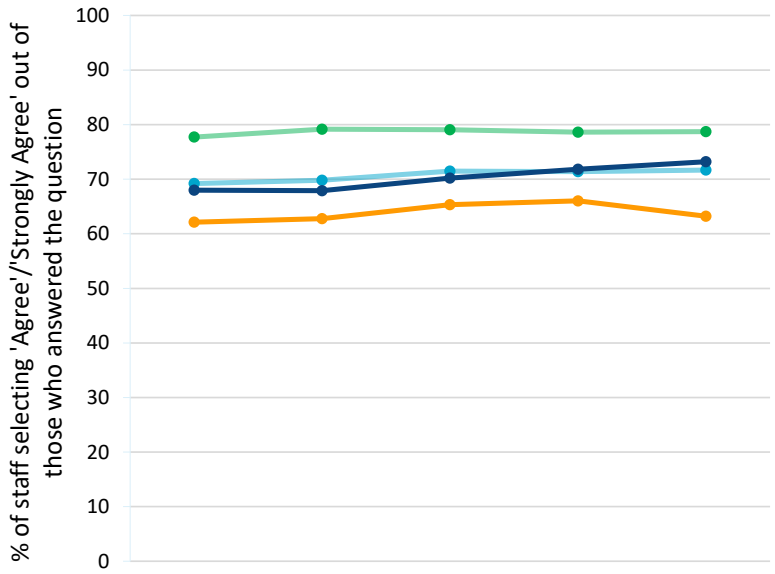


	2021	2022	2023	2024	2025
Your org	71.69%	71.10%	71.02%	72.45%	73.13%
Best result	78.46%	78.30%	77.85%	76.23%	77.49%
Average result	69.78%	70.35%	71.00%	70.47%	70.43%
Worst result	62.28%	63.13%	63.18%	65.35%	63.28%
Responses	2634	2946	2973	3330	2735

People Promise elements and theme results – Morale: Stressors

Survey Coordination Centre NHS

Q9a My immediate manager encourages me at work.



	2021	2022	2023	2024	2025
Your org	67.97%	67.90%	70.19%	71.81%	73.20%
Best result	77.71%	79.16%	79.07%	78.62%	78.70%
Average result	69.20%	69.81%	71.47%	71.36%	71.67%
Worst result	62.12%	62.77%	65.31%	66.03%	63.21%
Responses	2636	2950	2983	3332	2742

Questions not linked to People Promise elements or themes

Questions included:*

Q1, Q10a, Q10b, Q10c, Q11e, Q16c, Q18, Q19a, Q19b, Q19c, Q19d, Q31b, Q26d

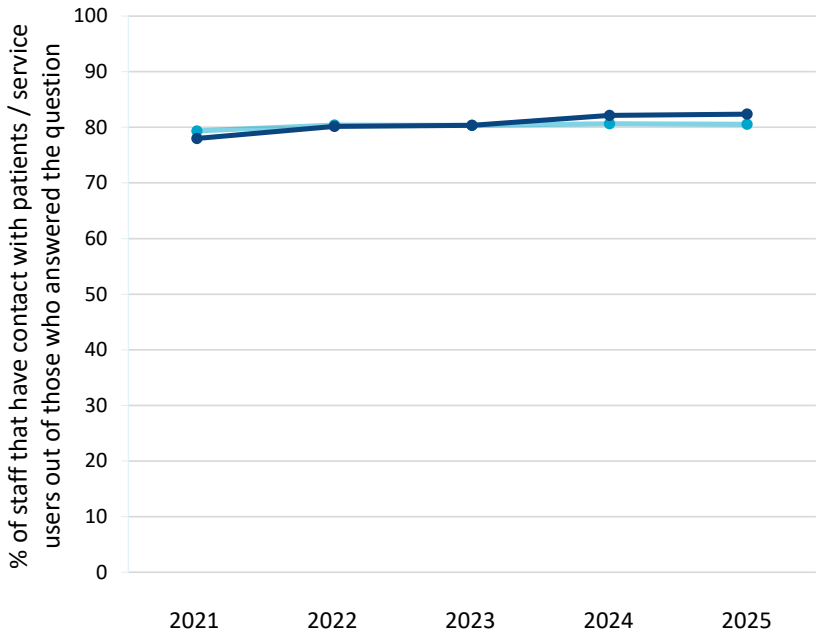
*The results for Q17a, Q17b and Q22 are reported in the section for People Promise element 4: We are safe and healthy. The results for Q24f are reported in the section for People Promise element 5: We are always learning. These questions do not contribute to any score or sub-score calculations.

Note where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

People Promise elements and theme results – Questions not linked to People Promise elements or themes

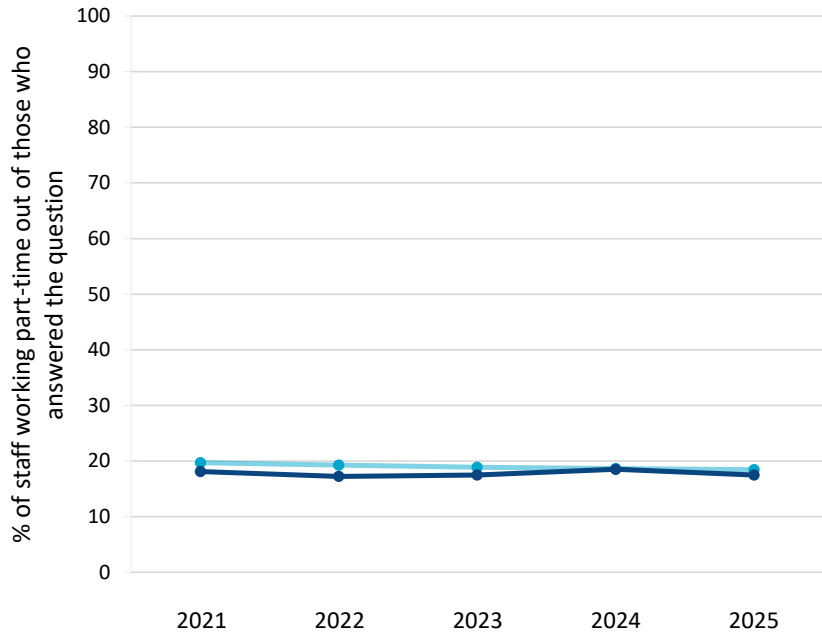
Survey Coordination Centre NHS

Q1 Do you have face-to-face, video or telephone contact with patients / service users as part of your job?



	2021	2022	2023	2024	2025
Your org	78.00%	80.18%	80.36%	82.13%	82.37%
Average	79.36%	80.42%	80.37%	80.65%	80.54%
Responses	2618	2941	2974	3324	2739

Q10a How many hours a week are you contracted to work?

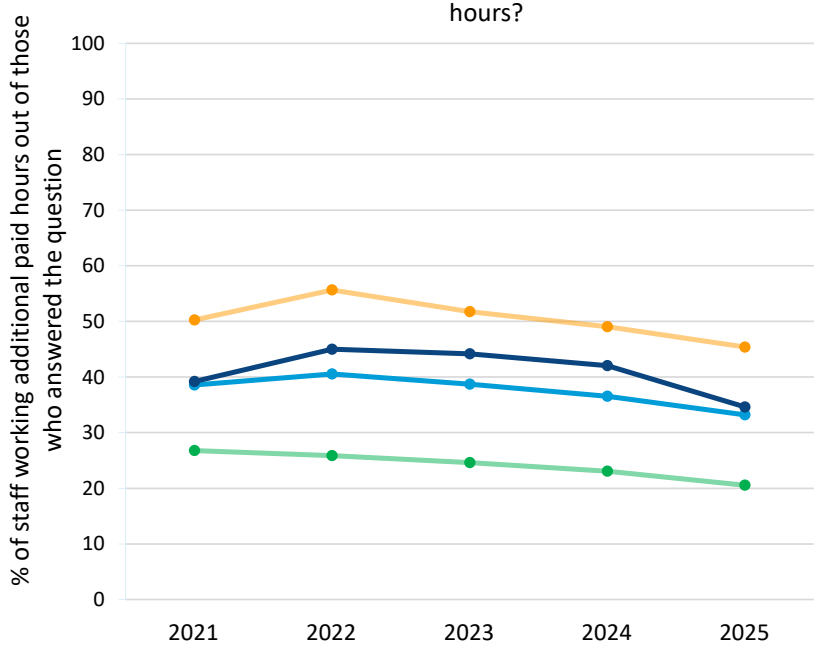


	2021	2022	2023	2024	2025
Your org	18.12%	17.22%	17.47%	18.51%	17.46%
Average	19.69%	19.24%	18.88%	18.64%	18.44%
Responses	2462	2688	2662	3014	2480

People Promise elements and theme results – Questions not linked to People Promise elements or themes

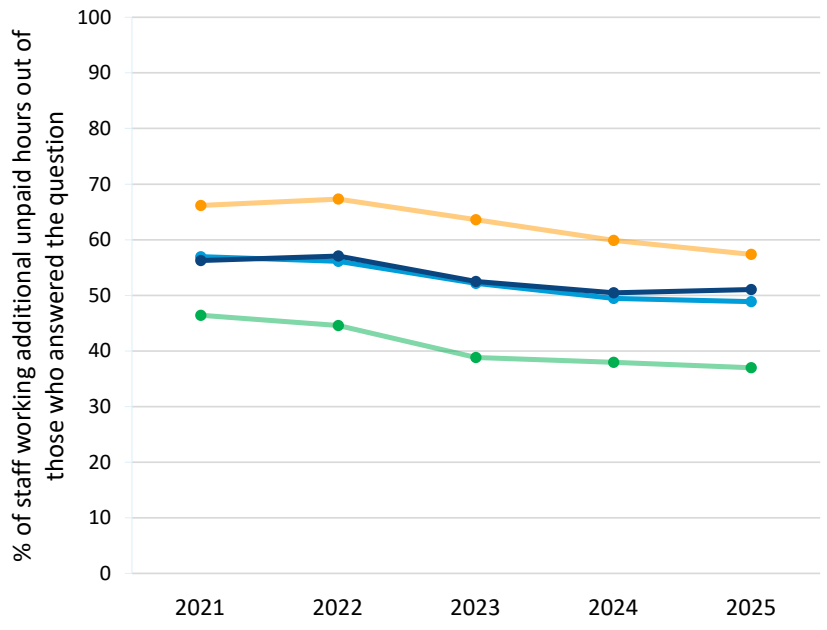
Survey Coordination Centre NHS

Q10b On average, how many additional PAID hours do you work per week for this organisation, over and above your contracted hours?



	2021	2022	2023	2024	2025
Your org	39.21%	45.01%	44.16%	42.06%	34.62%
Lowest	26.78%	25.89%	24.62%	23.04%	20.54%
Average	38.55%	40.56%	38.69%	36.54%	33.20%
Highest	50.26%	55.65%	51.73%	49.05%	45.40%
Responses	2546	2846	2877	3235	2669

Q10c On average, how many additional UNPAID hours do you work per week for this organisation, over and above your contracted hours?



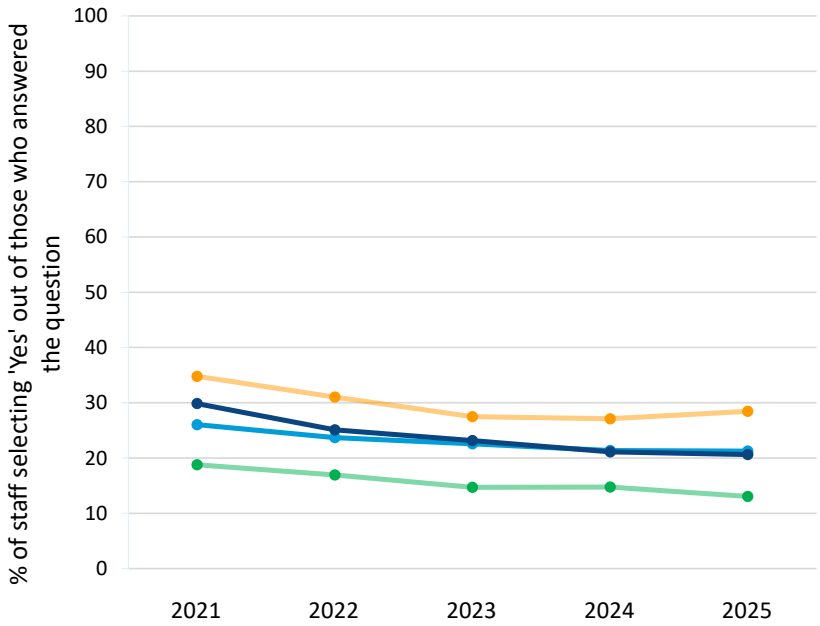
	2021	2022	2023	2024	2025
Your org	56.26%	57.06%	52.50%	50.45%	51.06%
Lowest	46.42%	44.57%	38.81%	37.94%	36.98%
Average	56.96%	56.11%	52.13%	49.47%	48.87%
Highest	66.17%	67.31%	63.58%	59.88%	57.36%
Responses	2553	2855	2867	3230	2668

People Promise elements and theme results – Questions not linked to People Promise elements or themes

Survey Coordination Centre

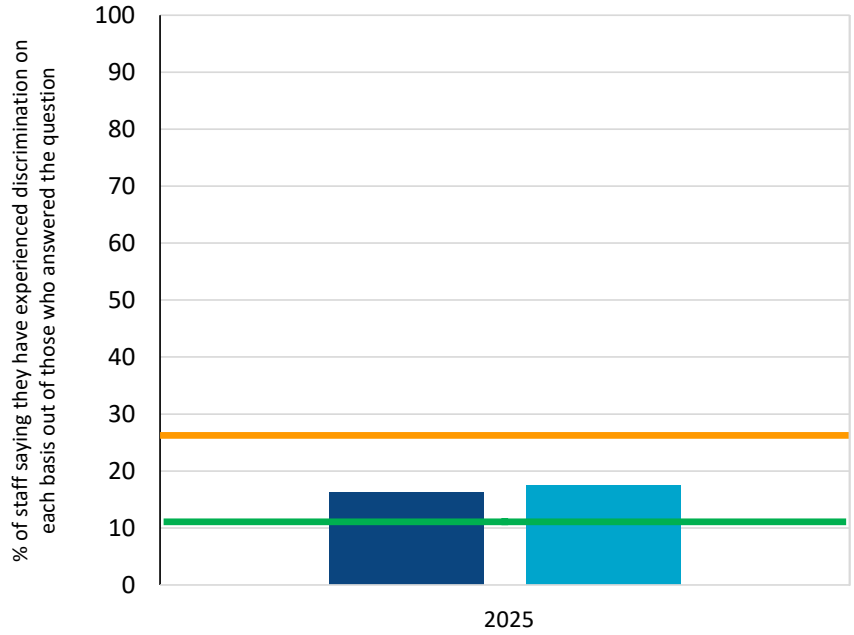
NHS

Q11e* Have you felt pressure from your manager to come to work?



	2021	2022	2023	2024	2025
Your org	29.85%	25.09%	23.18%	21.13%	20.63%
Best result	18.79%	16.95%	14.72%	14.76%	13.05%
Average result	26.04%	23.70%	22.58%	21.34%	21.25%
Worst result	34.79%	31.04%	27.49%	27.11%	28.45%
Responses	1398	1695	1649	1859	1543

Q16c.1 On what grounds have you experienced discrimination? – Age.



	2025
Your org	16.20%
Best result	11.08%
Average result	17.46%
Worst result	26.25%
Responses	475

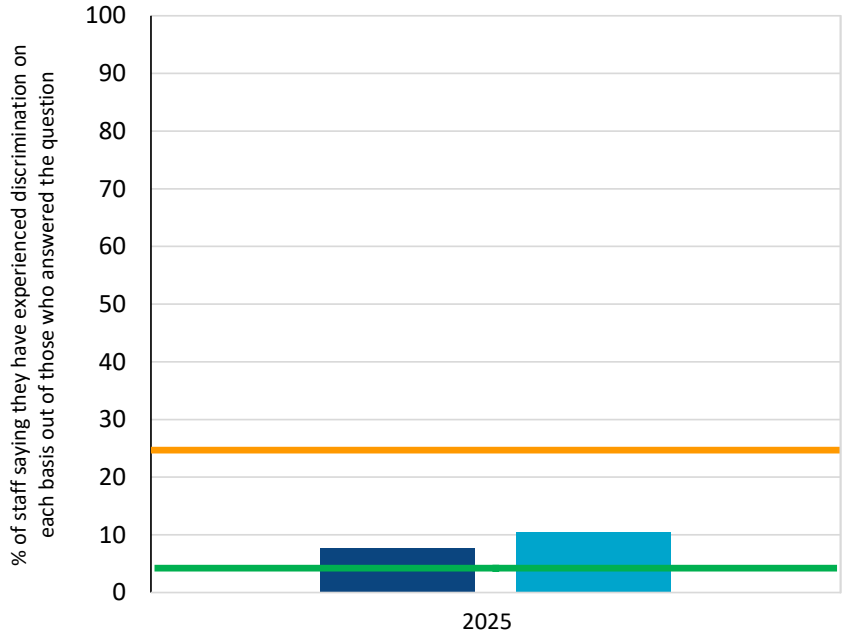
*Q11e is only answered by staff who responded 'Yes' to Q11d.

Note: Due to changes in the question options in 2025, previous years' results for Q16c are not reported. For more information, please refer to the *Technical Guide:* https://www.nhsstaffsurveys.com/survey-documents/

People Promise elements and theme results – Questions not linked to People Promise elements or themes

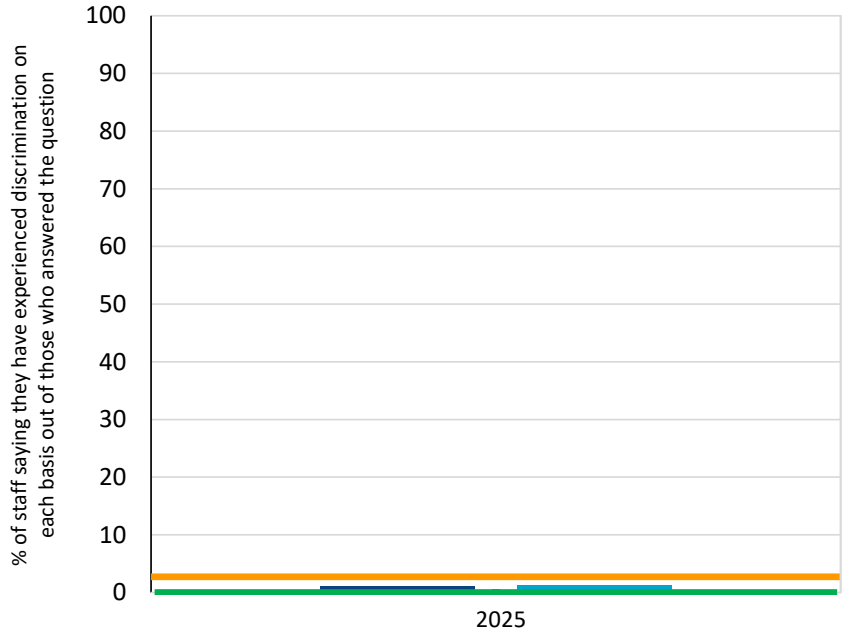
Survey Coordination Centre NHS

Q16c.2 On what grounds have you experienced discrimination? – Disability.



Your org	7.75%
Best result	4.23%
Average result	10.47%
Worst result	24.69%
Responses	475

Q16c.3 On what grounds have you experienced discrimination? – Gender reassignment.



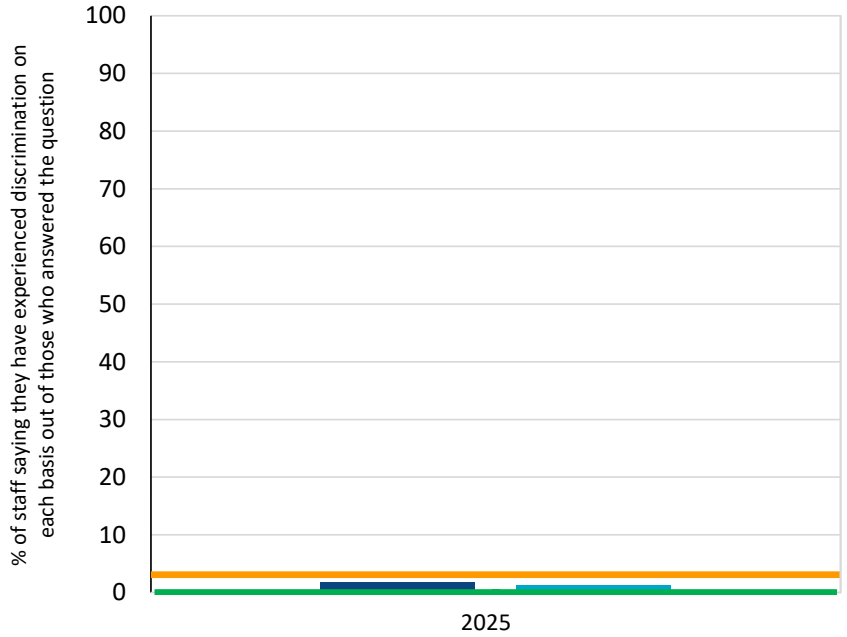
Your org	1.16%
Best result	0.00%
Average result	1.25%
Worst result	2.73%
Responses	475

Note: Due to changes in the question options in 2025, previous years' results for Q16c are not reported. For more information, please refer to the *Technical Guide:* https://www.nhsstaffsurveys.com/survey-documents/

People Promise elements and theme results – Questions not linked to People Promise elements or themes

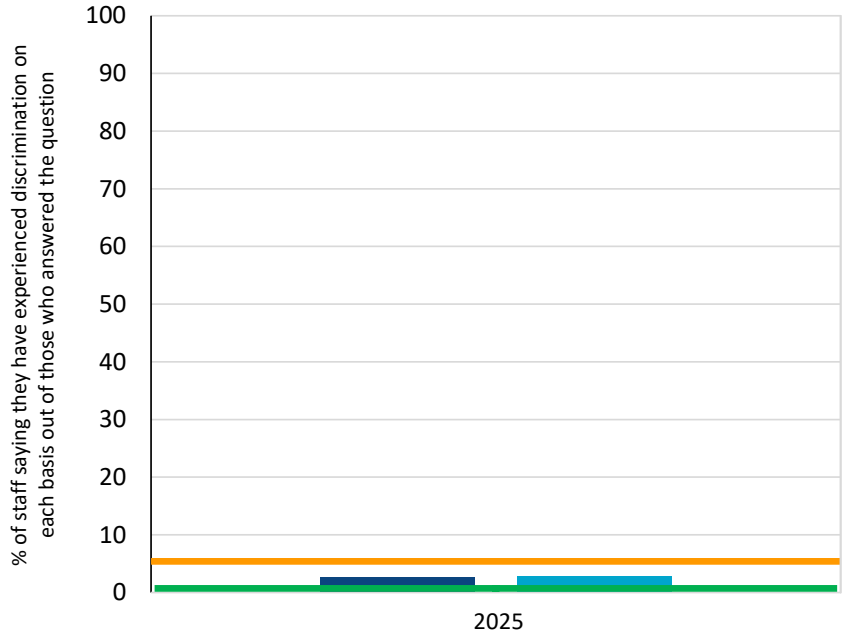
Survey Coordination Centre NHS

Q16c.4 On what grounds have you experienced discrimination? – Marriage and civil partnership.



Your org	1.91%
Best result	0.00%
Average result	1.23%
Worst result	3.09%
Responses	475

Q16c.5 On what grounds have you experienced discrimination? – Pregnancy and maternity.



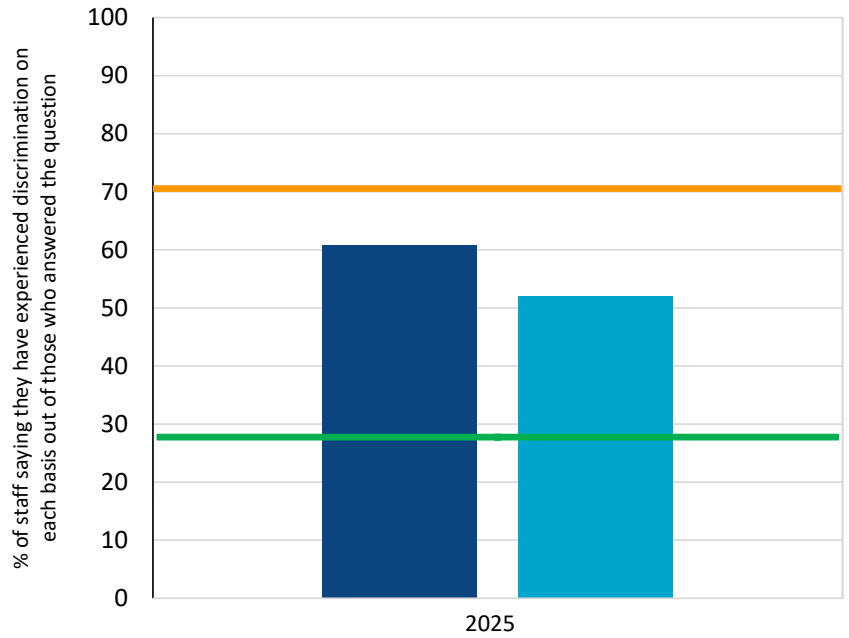
Your org	2.60%
Best result	0.72%
Average result	2.83%
Worst result	5.41%
Responses	475

Note: Due to changes in the question options in 2025, previous years' results for Q16c are not reported. For more information, please refer to the *Technical Guide:* https://www.nhsstaffsurveys.com/survey-documents/

People Promise elements and theme results – Questions not linked to People Promise elements or themes

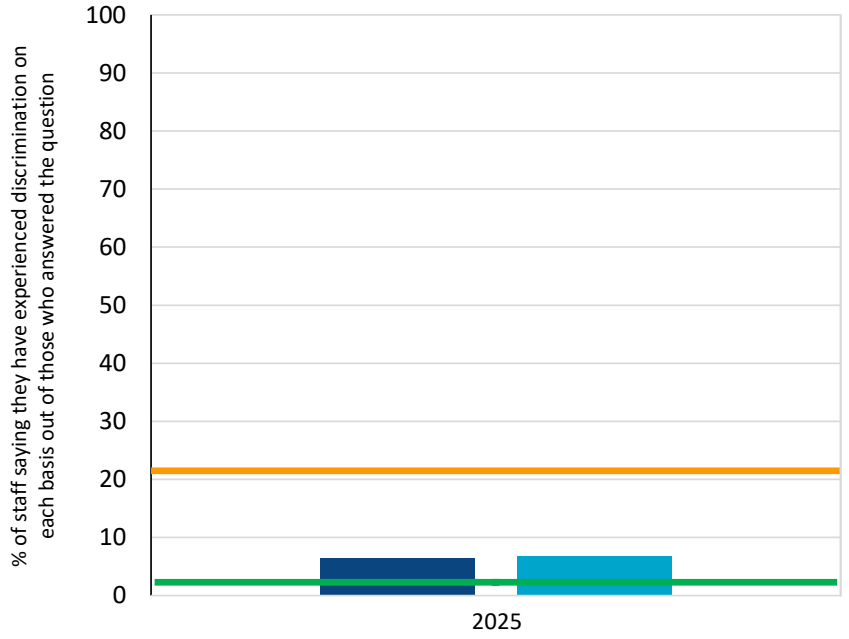
Survey Coordination Centre NHS

Q16c.6 On what grounds have you experienced discrimination? – Race.



Your org	60.76%
Best result	27.76%
Average result	52.00%
Worst result	70.56%
Responses	475

Q16c.7 On what grounds have you experienced discrimination? – Religion or belief.



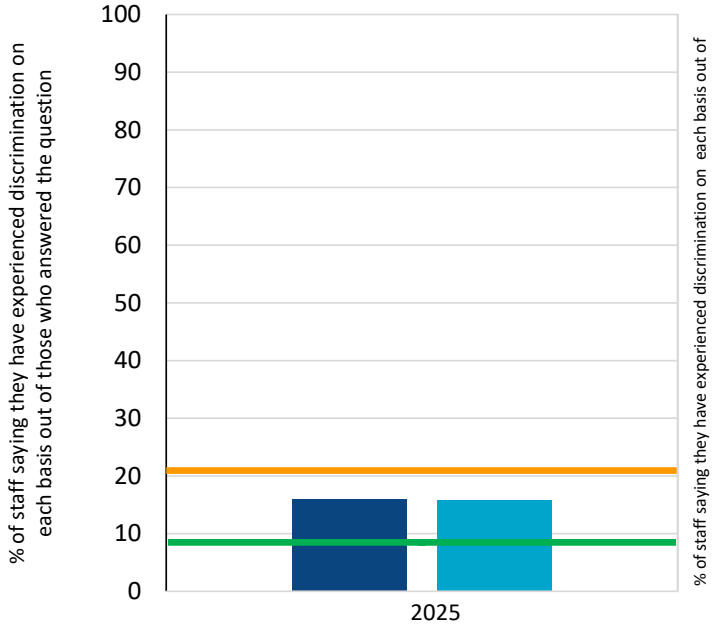
Your org	6.41%
Best result	2.29%
Average result	6.87%
Worst result	21.49%
Responses	475

Note: Due to changes in the question options in 2025, previous years' results for Q16c are not reported. For more information, please refer to the *Technical Guide:* https://www.nhsstaffsurveys.com/survey-documents/

People Promise elements and theme results – Questions not linked to People Promise elements or themes

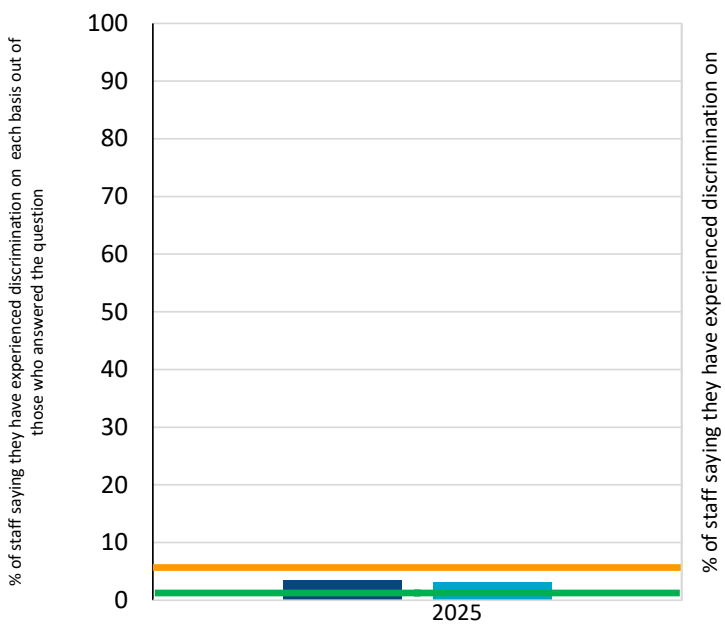
Survey Coordination Centre NHS

Q16c.8 On what grounds have you experienced discrimination? -- Sex.



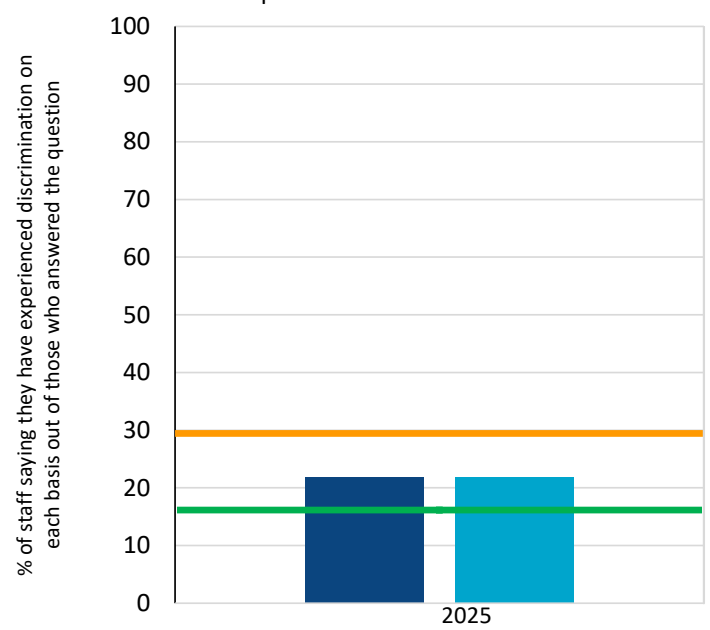
Your org	15.88%
Best result	8.47%
Average result	15.75%
Worst result	20.93%
Responses	475

Q16c.9 On what grounds have you experienced discrimination? -- Sexual orientation.



Your org	3.51%
Best result	1.25%
Average result	3.12%
Worst result	5.67%
Responses	475

Q16c.10 On what grounds have you experienced discrimination? -- Other.



Your org	21.77%
Best result	16.16%
Average result	21.87%
Worst result	29.43%
Responses	475

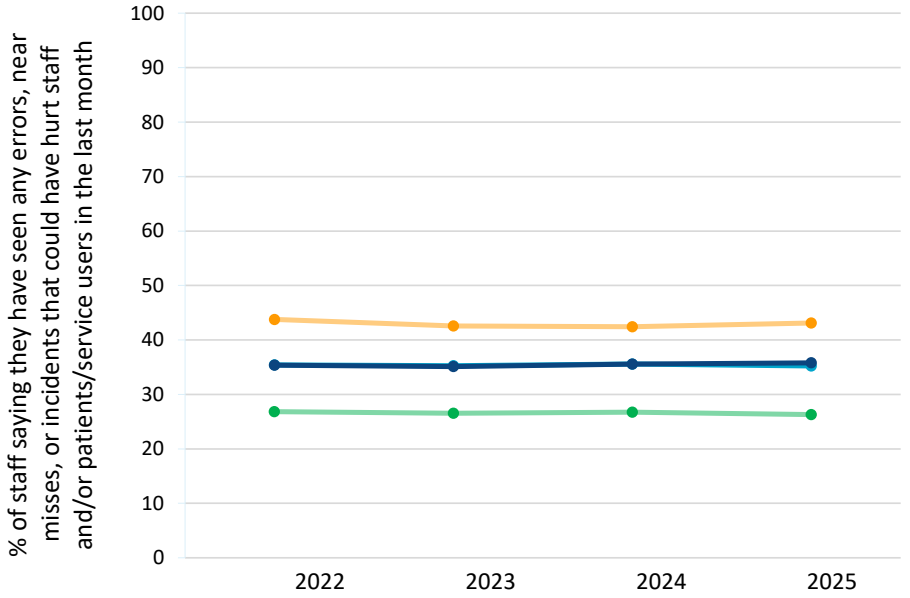
Note: Due to changes in the question options in 2025, previous years' results for Q16c are not reported. For more information, please refer to the *Technical Guide:* https://www.nhsstaffsurveys.com/survey-documents/

People Promise elements and theme results – Questions not linked to People Promise elements or themes

Survey Coordination Centre

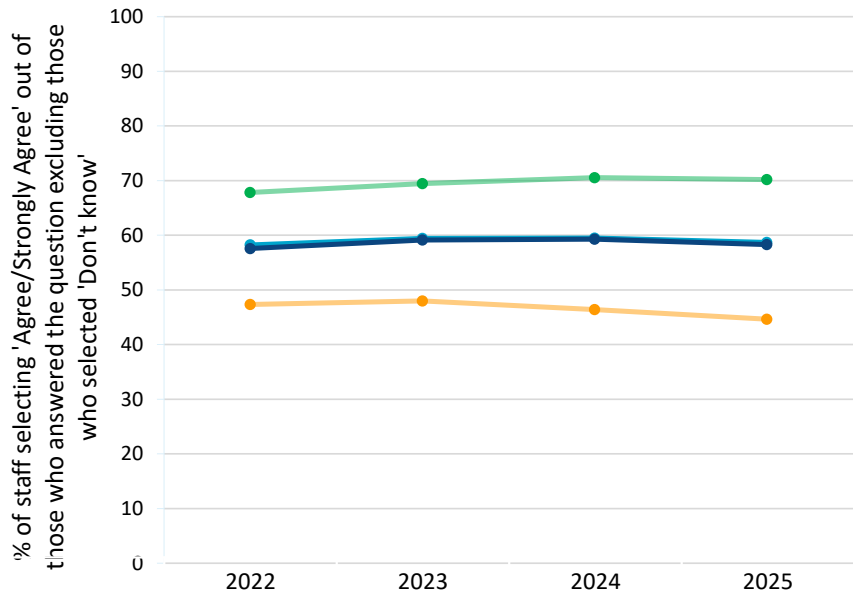
NHS

Q18 In the last month have you seen any errors, near misses, or incidents that could have hurt staff and/or patients/service users?



	2022	2023	2024	2025
Your org	35.36%	35.11%	35.59%	35.79%
Best result	26.83%	26.55%	26.76%	26.30%
Average result	35.40%	35.27%	35.58%	35.22%
Worst result	43.77%	42.55%	42.43%	43.10%
Responses	2940	2899	3254	2683

Q19a My organisation treats staff who are involved in an error, near miss or incident fairly.

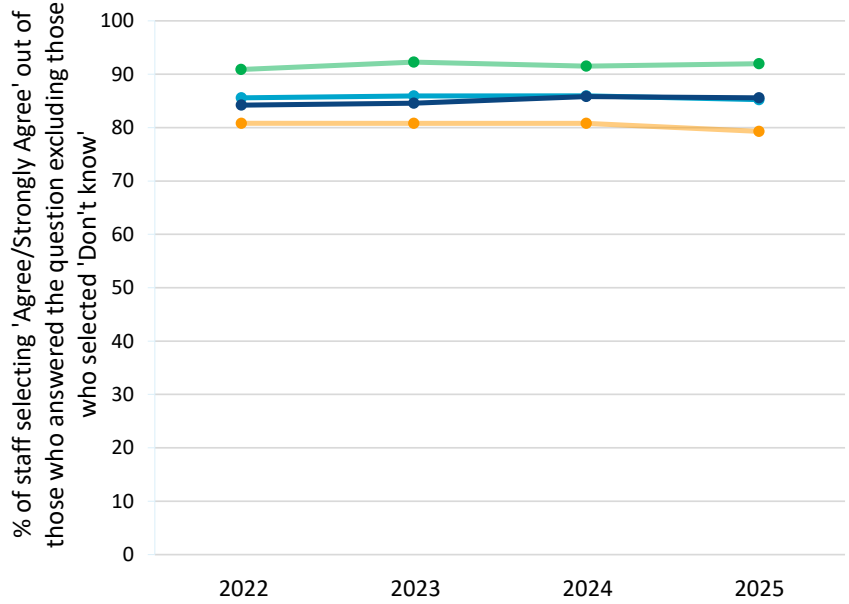


	2022	2023	2024	2025
Your org	57.58%	59.15%	59.29%	58.31%
Best result	67.83%	69.44%	70.55%	70.22%
Average result	58.23%	59.41%	59.50%	58.69%
Worst result	47.33%	47.99%	46.42%	44.65%
Responses	2239	2229	2501	2092

People Promise elements and theme results – Questions not linked to People Promise elements or themes

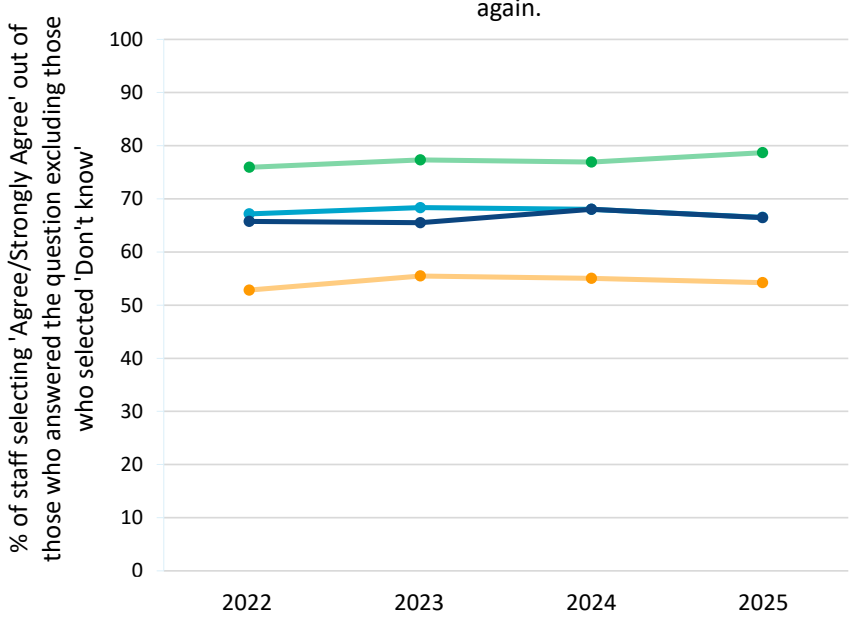
Survey Coordination Centre NHS

Q19b My organisation encourages us to report errors, near misses or incidents.



	2022	2023	2024	2025
Your org	84.21%	84.59%	85.81%	85.59%
Best result	90.89%	92.27%	91.54%	91.95%
Average result	85.58%	85.93%	85.95%	85.24%
Worst result	80.81%	80.78%	80.79%	79.29%
Responses	2780	2816	3146	2595

Q19c When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again.



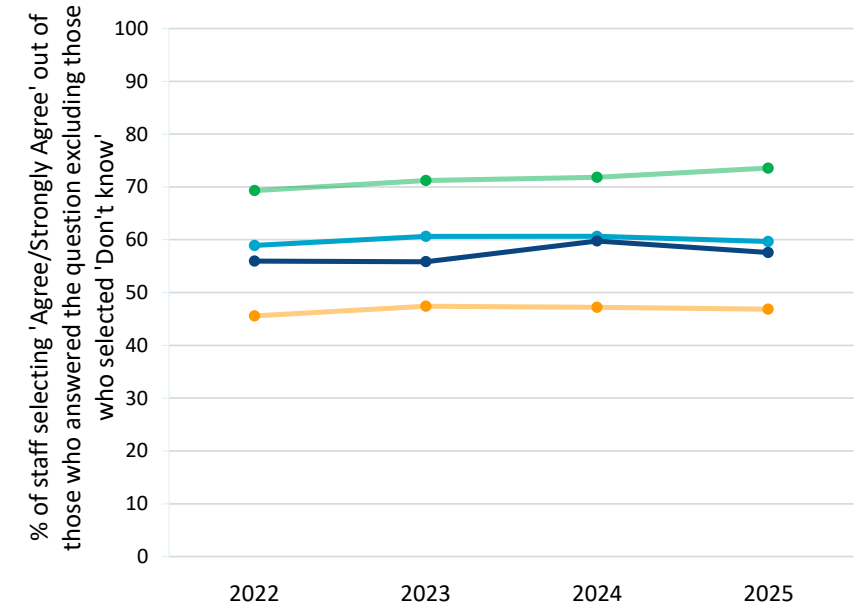
	2022	2023	2024	2025
Your org	65.77%	65.51%	68.03%	66.44%
Best result	75.93%	77.33%	76.90%	78.69%
Average result	67.15%	68.35%	68.04%	66.50%
Worst result	52.84%	55.47%	55.03%	54.21%
Responses	2554	2570	2879	2386

People Promise elements and theme results – Questions not linked to People Promise elements or themes

Survey Coordination Centre

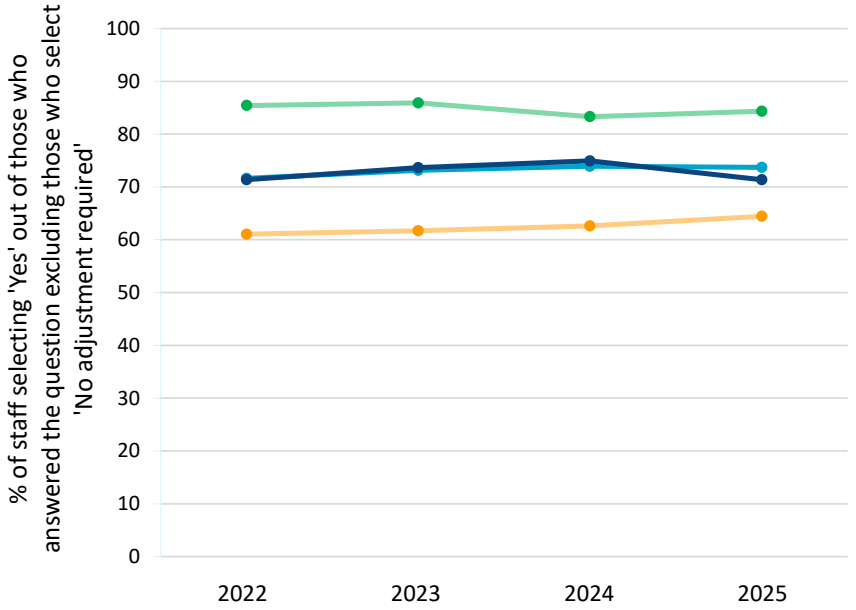
NHS

Q19d We are given feedback about changes made in response to reported errors, near misses and incidents.



	2022	2023	2024	2025
Your org	55.95%	55.83%	59.76%	57.56%
Best result	69.30%	71.19%	71.81%	73.58%
Average result	58.93%	60.62%	60.66%	59.69%
Worst result	45.58%	47.41%	47.19%	46.87%
Responses	2574	2613	2938	2398

Q31b Has your employer made reasonable adjustment(s) to enable you to carry out your work?



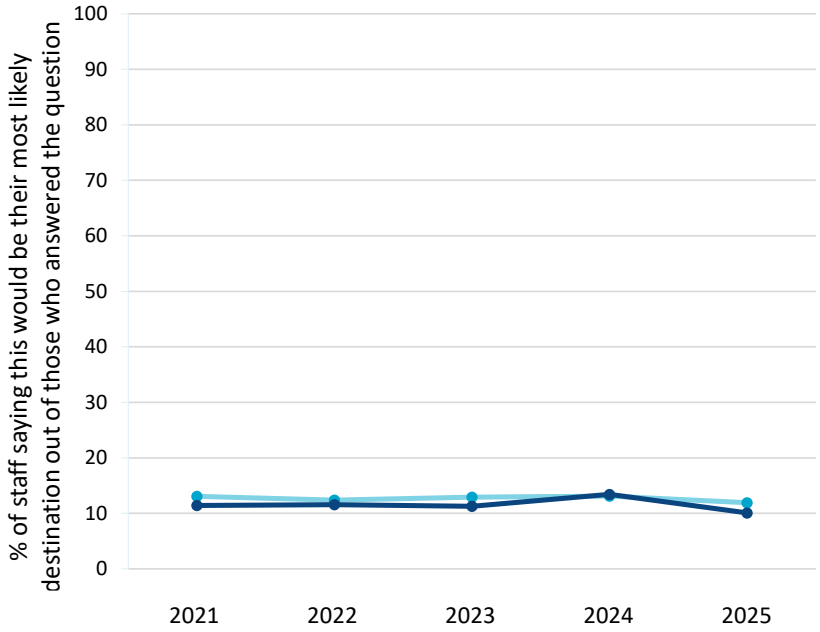
	2022	2023	2024	2025
Your org	71.38%	73.67%	74.94%	71.39%
Best result	85.42%	85.92%	83.30%	84.36%
Average result	71.63%	73.15%	73.92%	73.70%
Worst result	61.05%	61.73%	62.61%	64.44%
Responses	361	373	436	370

People Promise elements and theme results – Questions not linked to People Promise elements or themes

Survey Coordination Centre

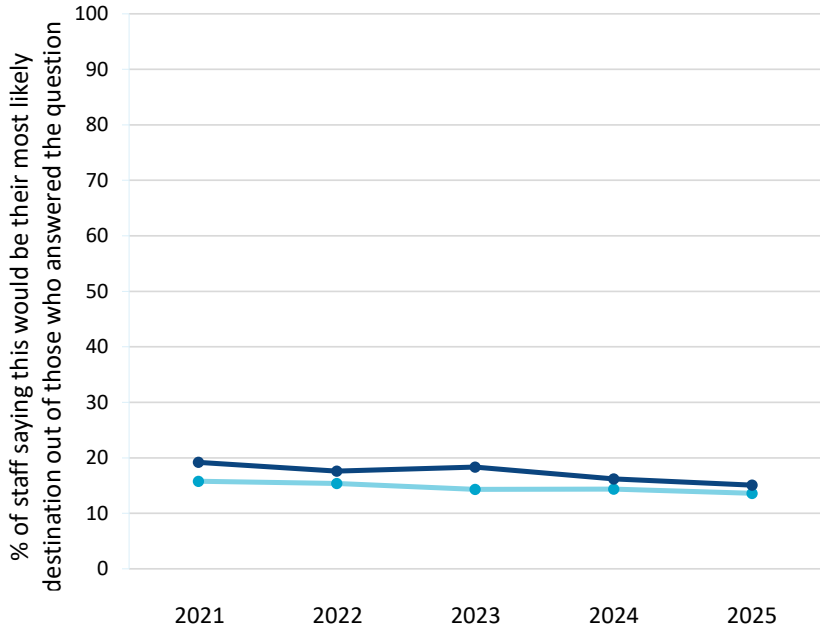
NHS

Q26d.1 If you are considering leaving your current job, what would be your most likely destination? - I would want to move to another job within this organisation.



	2021	2022	2023	2024	2025
Your org	11.43%	11.57%	11.28%	13.42%	10.08%
Average	13.04%	12.40%	12.94%	13.10%	11.91%
Responses	2335	2687	2731	3085	2500

Q26d.2 If you are considering leaving your current job, what would be your most likely destination? - I would want to move to another job in a different NHS Trust/organisation.

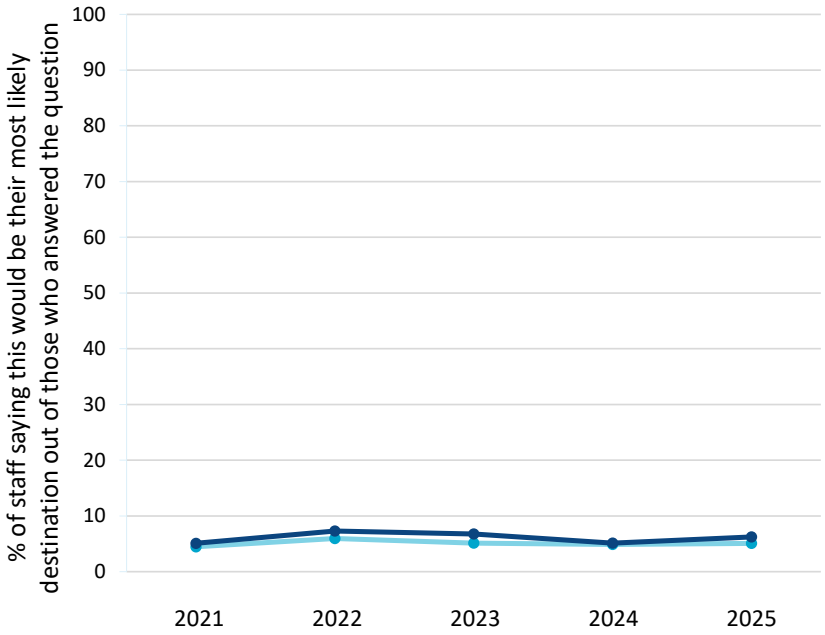


	2021	2022	2023	2024	2025
Your org	19.19%	17.60%	18.34%	16.21%	15.08%
Average	15.78%	15.37%	14.32%	14.36%	13.61%
Responses	2335	2687	2731	3085	2500

People Promise elements and theme results – Questions not linked to People Promise elements or themes

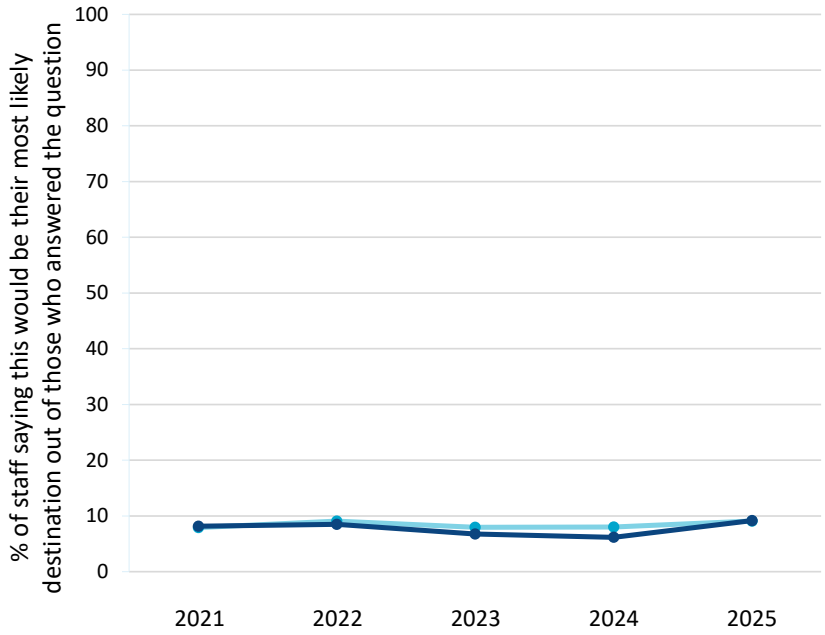
Survey Coordination Centre NHS

Q26d.3 If you are considering leaving your current job, what would be your most likely destination? - I would want to move to a job in healthcare, but outside the NHS.



	2021	2022	2023	2024	2025
Your org	5.10%	7.29%	6.74%	5.12%	6.24%
Average	4.47%	5.95%	5.12%	4.90%	5.07%
Responses	2335	2687	2731	3085	2500

Q26d.4 If you are considering leaving your current job, what would be your most likely destination? - I would want to move to a job outside healthcare.

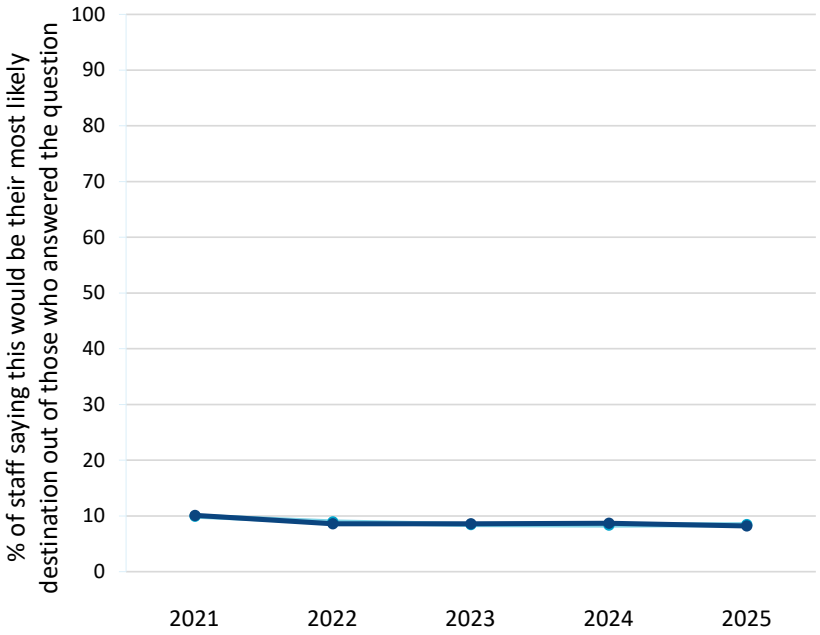


	2021	2022	2023	2024	2025
Your org	8.18%	8.49%	6.74%	6.16%	9.16%
Average	7.91%	9.06%	7.96%	8.00%	9.09%
Responses	2335	2687	2731	3085	2500

People Promise elements and theme results – Questions not linked to People Promise elements or themes

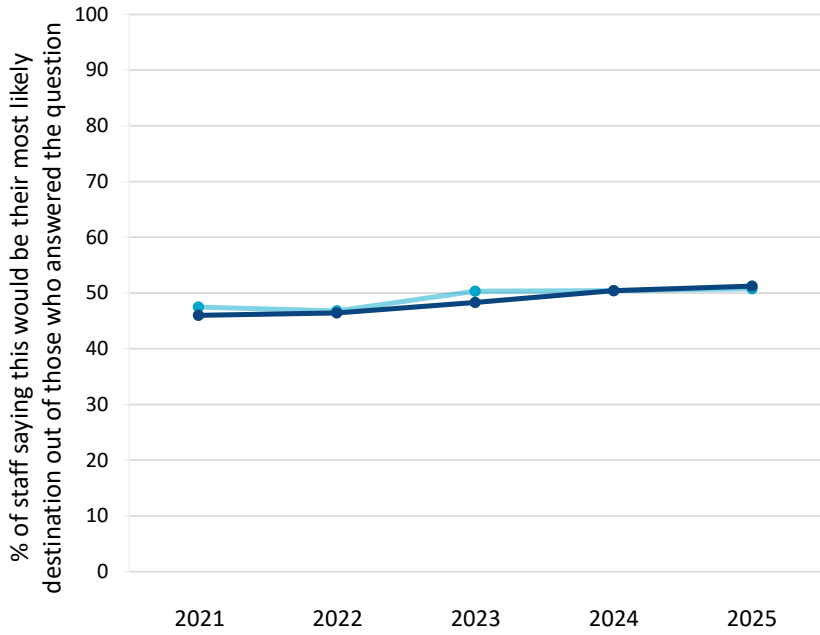
Survey Coordination Centre NHS

Q26d.5 If you are considering leaving your current job, what would be your most likely destination? - I would retire or take a career break.



	2021	2022	2023	2024	2025
Your org	10.11%	8.60%	8.60%	8.69%	8.20%
Average	9.95%	8.94%	8.46%	8.35%	8.42%
Responses	2335	2687	2731	3085	2500

Q26d.9 If you are considering leaving your current job, what would be your most likely destination? - I am not considering leaving my current job.



	2021	2022	2023	2024	2025
Your org	46.00%	46.45%	48.30%	50.41%	51.24%
Average	47.46%	46.79%	50.34%	50.41%	50.77%
Responses	2335	2687	2731	3085	2500

Survey Coordination Centre

NHS

Workforce Equality Standards

Note where there are fewer than 10 responses for a question, results are suppressed to protect staff confidentiality and reliability of data.

Workforce Equality Standards

Survey Coordination Centre NHS

Workforce Race Equality Standards (WRES)

This section contains data for the organisation required for the NHS Staff Survey indicators used in the Workforce Race Equality Standard (WRES). It includes the 2021-2025 organisation and benchmarking group median results for q13a, q13b&c combined, and q16b split by ethnicity (by white staff / staff from all other ethnic groups combined). Organisation and benchmarking group median results for q15 are included for 2025 only*.

Workforce Disability Equality Standards (WDES)

This section contains data for the organisation required for the NHS Staff Survey metrics used in the Workforce Disability Equality Standard (WDES). It includes the 2021-2025 organisation and benchmarking group median results for q4b, q11e, and q14a-d split by staff with a long lasting health condition or illness compared to staff without a long lasting health condition or illness. Organisation and benchmarking group median results for q15 split by staff with a long lasting health condition or illness compared to staff without a long lasting health condition or illness are shown for 2025 only*. It also shows results for q31b (for staff with a long lasting health condition or illness only), and the staff engagement score for staff with a long lasting health condition or illness, compared to staff without a long lasting health condition or illness and the overall engagement score for the organisation.

In 2022, the text for q31b was updated and the word ‘adequate’ was changed to ‘reasonable’.

The WDES breakdowns are based on the responses to q31a Do you have any physical or mental health conditions or illnesses lasting or expected to last for 12 months or more?

*Due to changes in the question wording in 2025, previous years’ results for WRES indicator 7 and WDES metric 5 (Q15) are not reported. For more information, please refer to the *Technical Guide:* https://www.nhsstaffsurveys.com/survey-documents/

Workforce Equality Standards

Survey Coordination Centre NHS

This section contains data required for the staff survey indicators used in the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES). Data presented in this section are unweighted.

Workforce Race Equality Standards (WRES)

Indicator	Qu No	Workforce Race Equality Standard
		For each of the following indicators, compare the outcomes of the responses for white staff and staff from all other ethnic groups combined
5	Q14a	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
6	Q14b & Q14c	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months
7	Q15	Percentage believing that their organisation provides equal opportunities for career progression or promotion (2025 only)
8	Q16b	In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues

Workforce Disability Equality Standards (WDES)

Metric	Qu No	Workforce Disability Equality Standard
		For each of the following metrics, compare the responses for staff with a LTC* or illness vs staff without a LTC or illness
4a	Q14a	Percentage of staff experiencing harassment, bullying or abuse from patients/service users, their relatives or other members of the public
4b	Q14b	Percentage of staff experiencing harassment, bullying or abuse from managers
4c	Q14c	Percentage of staff experiencing harassment, bullying or abuse from other colleagues
4d	Q14d	Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it
5	Q15	Percentage believing that their organisation provides equal opportunities for career progression or promotion (2025 only)
6	Q11e	Percentage of staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties
7	Q4b	Percentage staff saying that they are satisfied with the extent to which their organisation values their work
8	Q31b	Percentage of staff with a long lasting health condition or illness saying their employer has made reasonable adjustment(s) to enable them to carry out their work
9a	theme_engagement	The staff engagement score for staff with LTC or illness vs staff without a LTC or illness

*Staff with a long term condition

Survey Coordination Centre

NHS

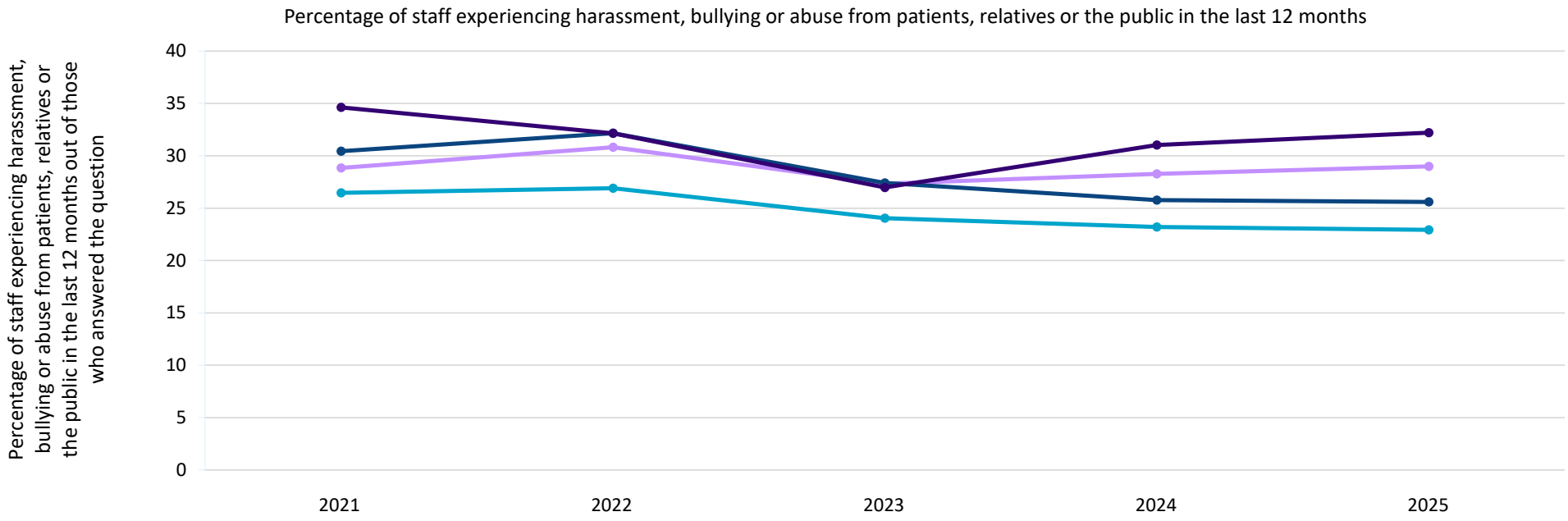
Workforce Race Equality Standards (WRES)

Vertical scales on the following charts vary from slide to slide and this effects how results are displayed. This allows incremental changes and small differences between results for subgroups to be more easily interpreted.
Data shown in the WRES charts are unweighted.
Averages are calculated as the median for the benchmark group.

Note: where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Workforce Race Equality Standard (WRES)

Survey Coordination Centre NHS



	2021	2022	2023	2024	2025
White staff: Your org	30.45%	32.16%	27.41%	25.77%	25.59%
All other ethnic groups*: Your org	34.62%	32.15%	26.98%	31.04%	32.21%
White staff: Average	26.47%	26.91%	24.05%	23.21%	22.93%
All other ethnic groups*: Average	28.84%	30.82%	27.34%	28.27%	28.98%
White staff: Responses	1721	1875	1813	1944	1641
All other ethnic groups*: Responses	852	1017	1112	1321	1043

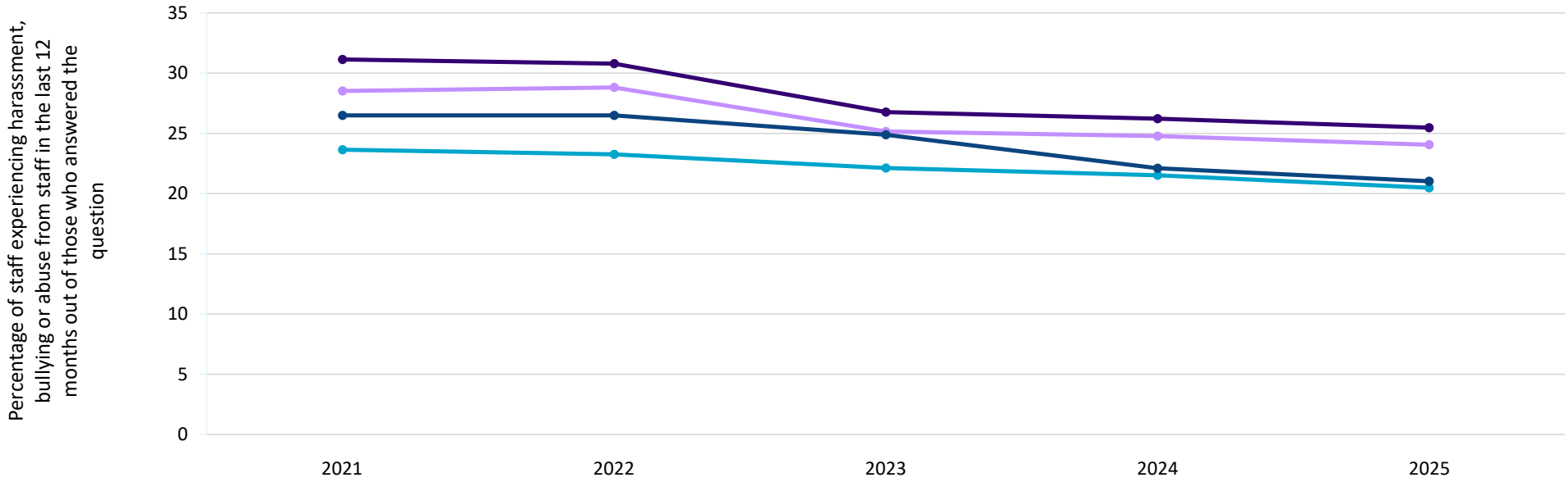
*Staff from all other ethnic groups combined

Note: 2023 results for WRES indicator 5 (Q14a) are reported using corrected data. Please see https://www.nhsstaffsurveys.com/survey-documents/ for more details.

Workforce Race Equality Standard (WRES)

Survey Coordination Centre NHS

Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months



	2021	2022	2023	2024	2025
White staff: Your org	26.50%	26.49%	24.89%	22.10%	21.02%
All other ethnic groups*: Your org	31.14%	30.80%	26.76%	26.23%	25.48%
White staff: Average	23.65%	23.25%	22.12%	21.53%	20.48%
All other ethnic groups*: Average	28.53%	28.81%	25.16%	24.78%	24.06%
White staff: Responses	1721	1876	1820	1950	1641
All other ethnic groups*: Responses	851	1013	1106	1323	1044

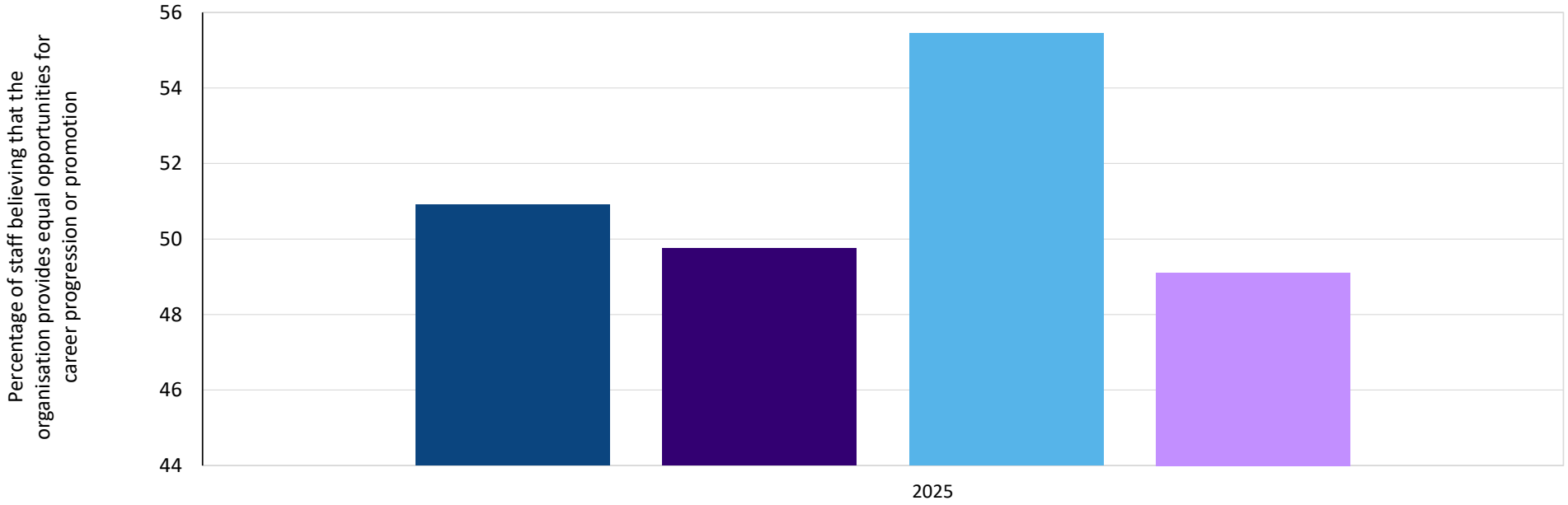
*Staff from all other ethnic groups combined

Note: 2023 results for WRES indicator 6 (Q14b & Q14c) are reported using corrected data. Please see https://www.nhsstaffsurveys.com/survey-documents/ for more details.

Workforce Race Equality Standard (WRES)

Survey Coordination Centre NHS

Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion.



White staff: Your org	50.91%
All other ethnic groups*: Your org	49.76%
White staff: Average	55.46%
All other ethnic groups*: Average	49.11%
White staff: Responses	1640
All other ethnic groups*: Responses	1041

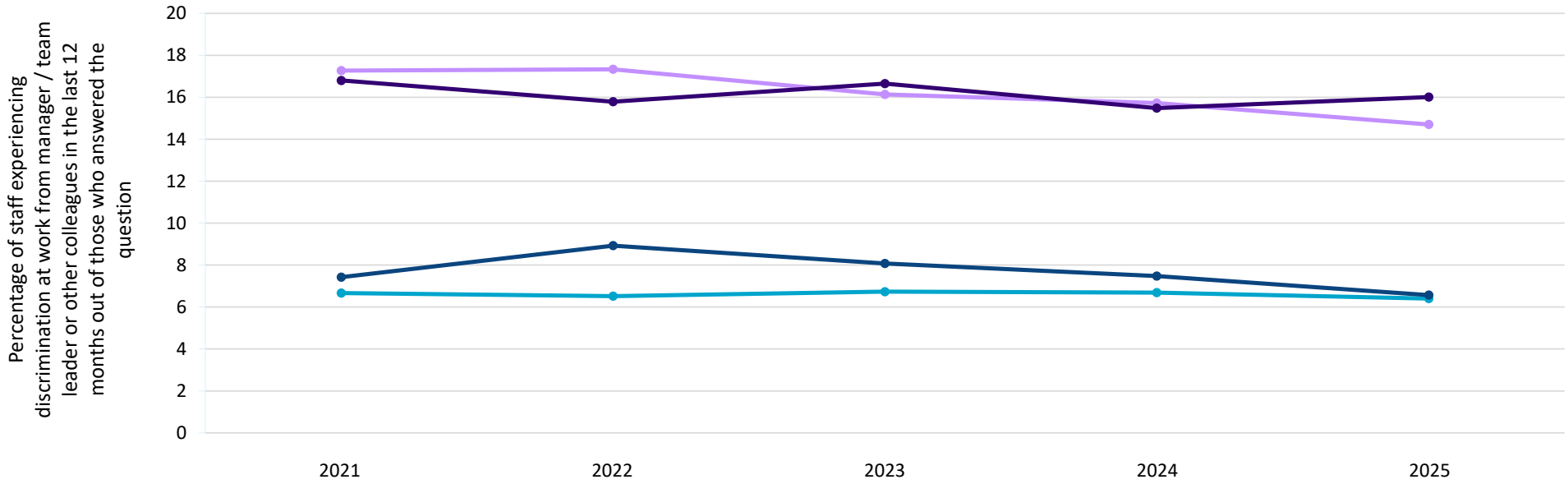
*Staff from all other ethnic groups combined.

Note: Due to changes in the question wording in 2025, previous years' results for WRES indicator 7 (Q15) are not reported. For more information, please refer to the *Technical Guide:* https://www.nhsstaffsurveys.com/survey-documents/

Workforce Race Equality Standard (WRES)

Survey Coordination Centre NHS

Percentage of staff experiencing discrimination at work from manager / team leader or other colleagues in the last 12 months.



	2021	2022	2023	2024	2025
White staff: Your org	7.43%	8.93%	8.08%	7.48%	6.57%
All other ethnic groups*: Your org	16.80%	15.79%	16.65%	15.48%	16.02%
White staff: Average	6.67%	6.52%	6.73%	6.69%	6.40%
All other ethnic groups*: Average	17.28%	17.33%	16.14%	15.72%	14.70%
White staff: Responses	1723	1871	1808	1926	1629
All other ethnic groups*: Responses	845	1007	1099	1311	1024

*Staff from all other ethnic groups combined

Survey Coordination Centre

NHS

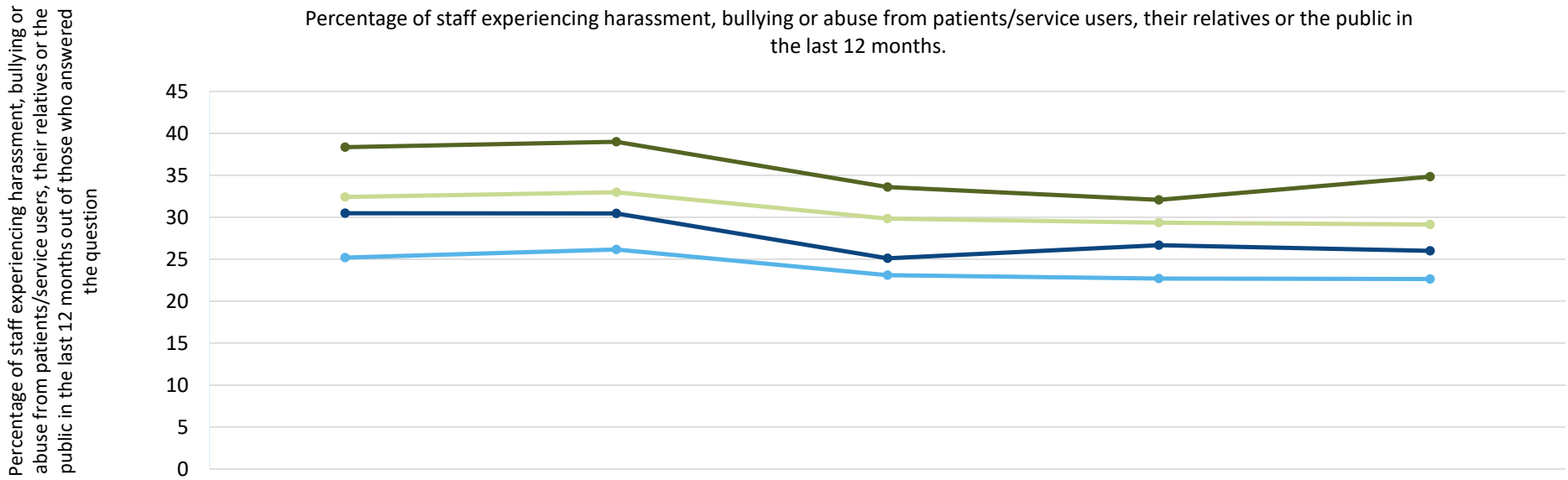
Workforce Disability Equality Standards (WDES)

Vertical scales on the following charts vary from slide to slide and this effects how results are displayed. This allows incremental changes and small differences between results for subgroups to be more easily interpreted.
Data shown in the WDES charts are unweighted.

Note: where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Workforce Disability Equality Standards

Survey Coordination Centre NHS

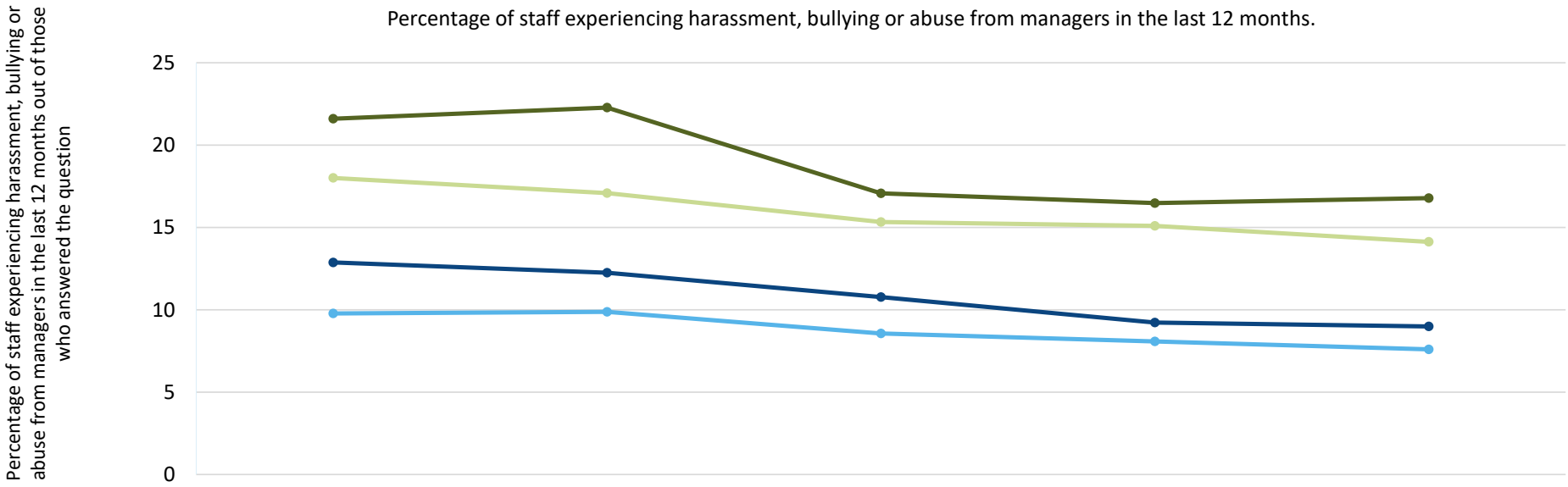


	2021	2022	2023	2024	2025
Staff with a LTC or illness: Your org	38.36%	39.00%	33.61%	32.08%	34.85%
Staff without a LTC or illness: Your org	30.48%	30.45%	25.11%	26.67%	26.00%
Staff with a LTC or illness: Average	32.43%	32.98%	29.83%	29.37%	29.14%
Staff without a LTC or illness: Average	25.19%	26.16%	23.11%	22.71%	22.64%
Staff with a LTC or illness: Responses	537	618	610	717	594
Staff without a LTC or illness: Responses	2044	2299	2282	2531	2065

Note: 2023 results for WDES metric 4a (Q14a) are reported using corrected data. Please see https://www.nhsstaffsurveys.com/survey-documents/ for more details.

Workforce Disability Equality Standards

Survey Coordination Centre NHS

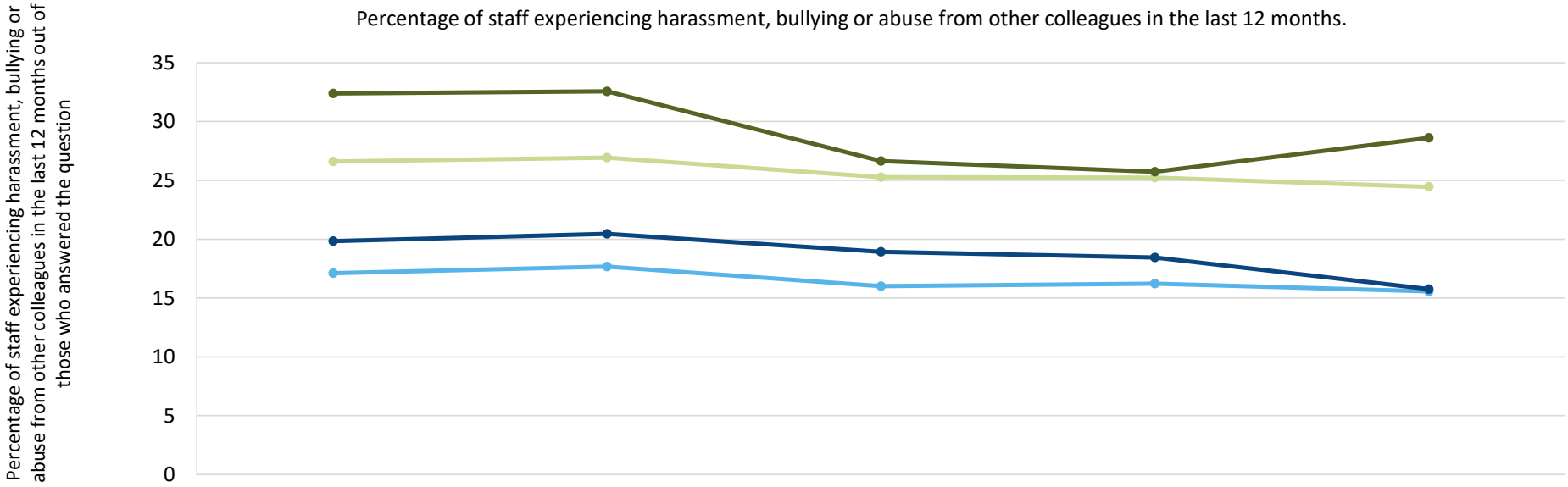


	2021	2022	2023	2024	2025
Staff with a LTC or illness: Your org	21.60%	22.28%	17.08%	16.48%	16.78%
Staff without a LTC or illness: Your org	12.88%	12.25%	10.78%	9.22%	8.99%
Staff with a LTC or illness: Average	18.00%	17.09%	15.33%	15.10%	14.12%
Staff without a LTC or illness: Average	9.77%	9.88%	8.56%	8.08%	7.60%
Staff with a LTC or illness: Responses	537	615	609	716	590
Staff without a LTC or illness: Responses	2027	2277	2273	2516	2058

Note: 2023 results for WDES metric 4b (Q14b) are reported using corrected data. Please see https://www.nhsstaffsurveys.com/survey-documents/ for more details.

Workforce Disability Equality Standards

Survey Coordination Centre NHS

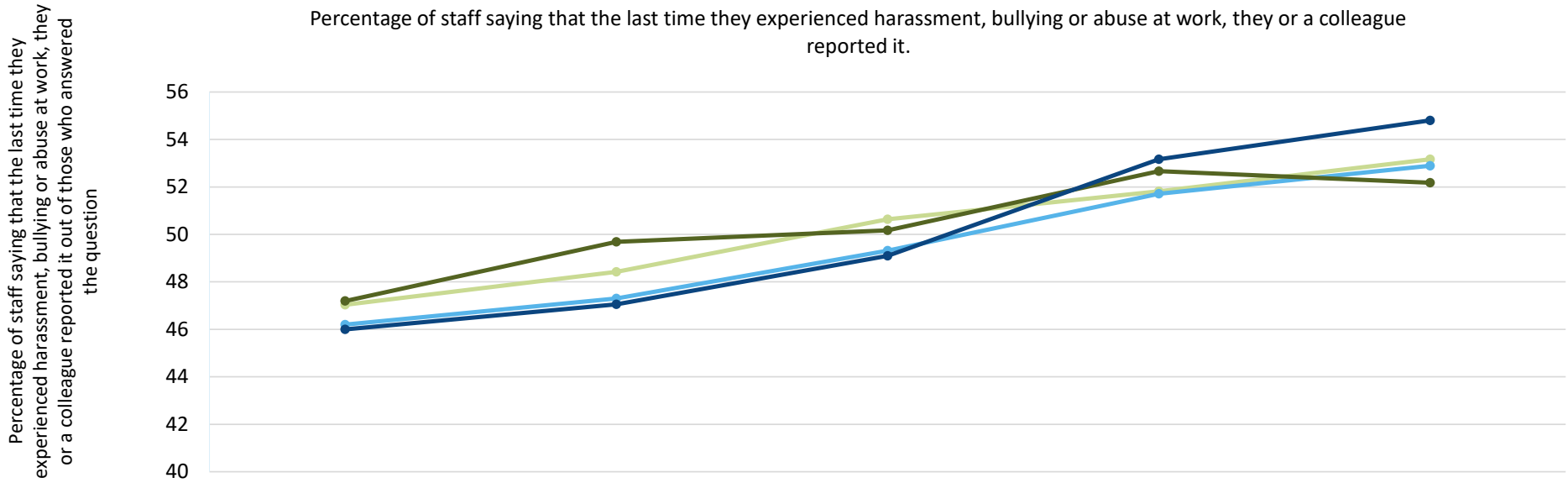


	2021	2022	2023	2024	2025
Staff with a LTC or illness: Your org	32.39%	32.57%	26.64%	25.73%	28.62%
Staff without a LTC or illness: Your org	19.83%	20.46%	18.94%	18.45%	15.76%
Staff with a LTC or illness: Average	26.60%	26.93%	25.26%	25.24%	24.45%
Staff without a LTC or illness: Average	17.11%	17.67%	16.01%	16.22%	15.57%
Staff with a LTC or illness: Responses	531	611	608	719	594
Staff without a LTC or illness: Responses	2017	2273	2276	2521	2062

Note: 2023 results for WDES metric 4c (Q14c) are reported using corrected data. Please see https://www.nhsstaffsurveys.com/survey-documents/ for more details.

Workforce Disability Equality Standards

Survey Coordination Centre NHS



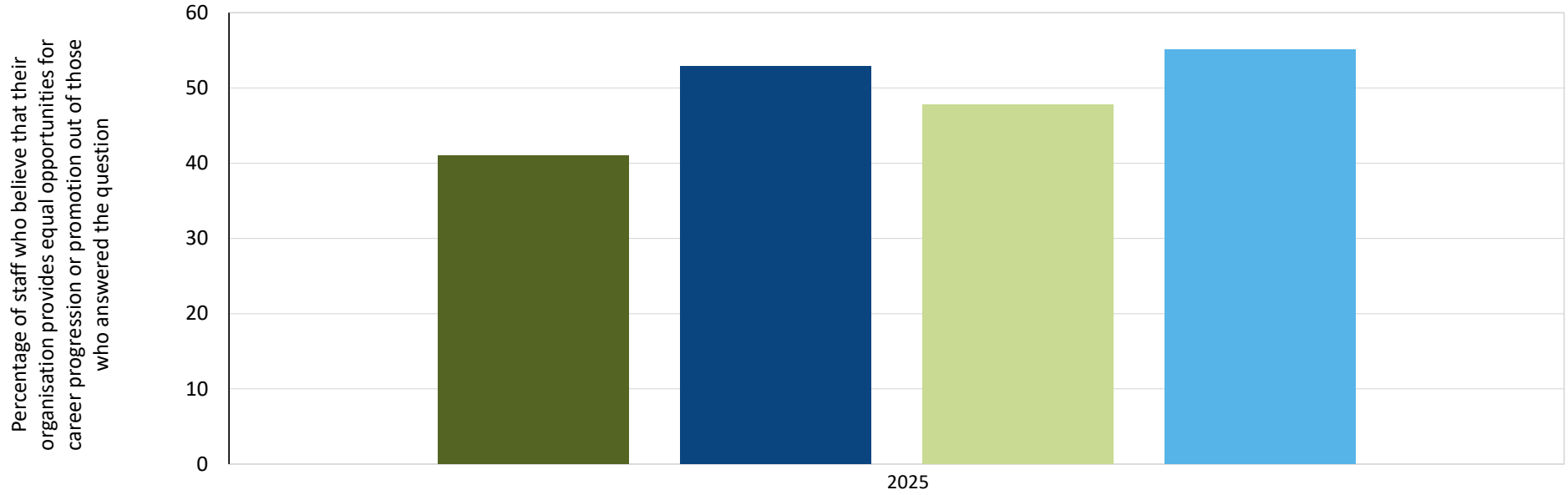
	2021	2022	2023	2024	2025
Staff with a LTC or illness: Your org	47.19%	49.69%	50.17%	52.66%	52.17%
Staff without a LTC or illness: Your org	46.00%	47.05%	49.09%	53.16%	54.80%
Staff with a LTC or illness: Average	47.03%	48.43%	50.64%	51.82%	53.16%
Staff without a LTC or illness: Average	46.20%	47.30%	49.31%	51.71%	52.89%
Staff with a LTC or illness: Responses	267	318	297	319	276
Staff without a LTC or illness: Responses	737	831	772	854	666

Note: 2023 results for WDES metric 4d (Q14d) are reported using corrected data. Please see https://www.nhsstaffsurveys.com/survey-documents/ for more details.

Workforce Disability Equality Standards

Survey Coordination Centre NHS

Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion.

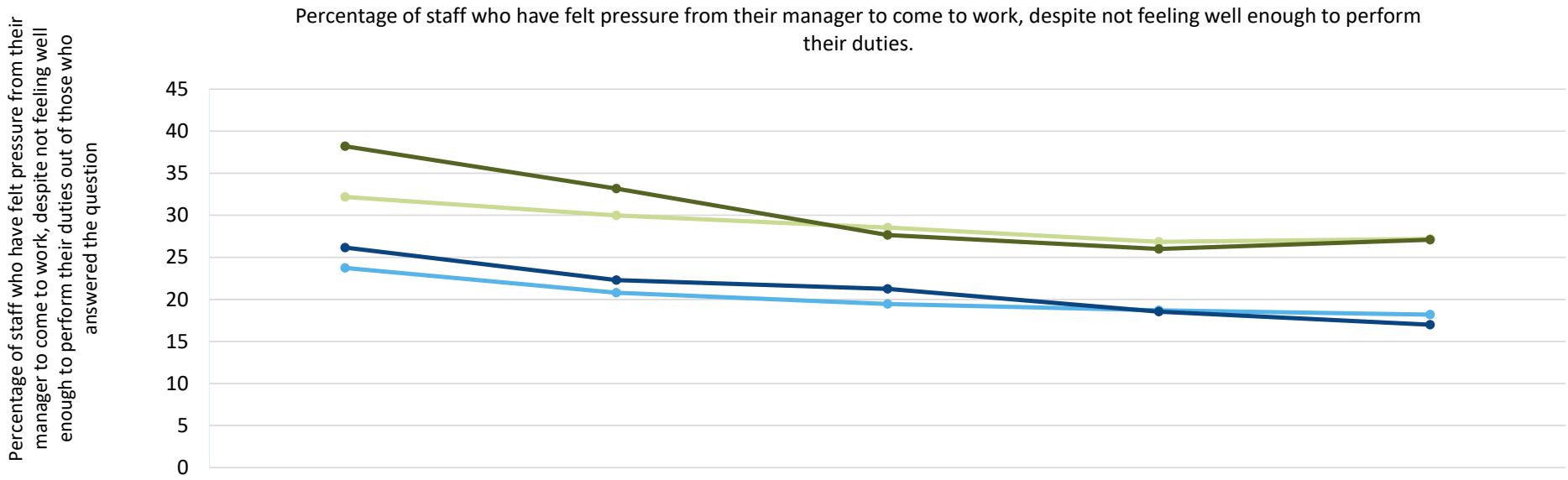


Staff with a LTC or illness: Your org	40.98%
Staff without a LTC or illness: Your org	52.88%
Staff with a LTC or illness: Average	47.79%
Staff without a LTC or illness: Average	55.09%
Staff with a LTC or illness: Responses	593
Staff without a LTC or illness: Responses	2065

Note: Due to changes in the question wording in 2025, previous years' results for WDES metric 5 (Q15) are not reported. For more information, please refer to the *Technical Guide:* https://www.nhsstaffsurveys.com/survey-documents/

Workforce Disability Equality Standards

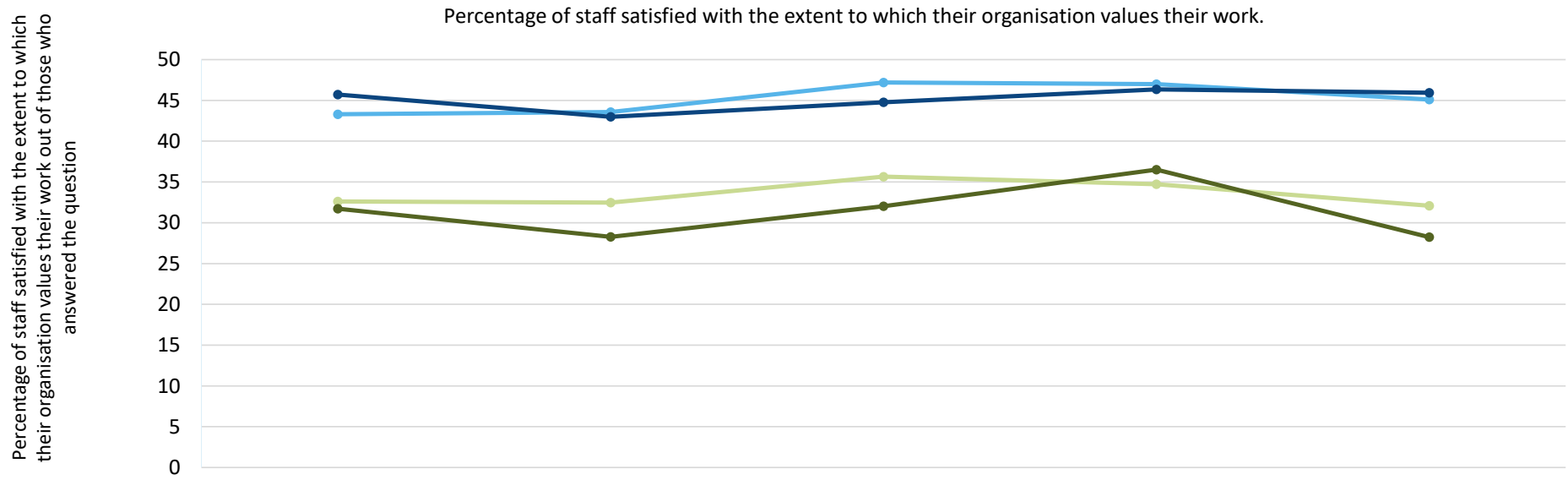
Survey Coordination Centre NHS



	2021	2022	2023	2024	2025
Staff with a LTC or illness: Your org	38.21%	33.18%	27.65%	26.00%	27.10%
Staff without a LTC or illness: Your org	26.16%	22.29%	21.24%	18.56%	16.99%
Staff with a LTC or illness: Average	32.18%	29.97%	28.55%	26.85%	27.19%
Staff without a LTC or illness: Average	23.74%	20.80%	19.46%	18.71%	18.19%
Staff with a LTC or illness: Responses	369	440	434	527	428
Staff without a LTC or illness: Responses	1009	1238	1177	1288	1083

Workforce Disability Equality Standards

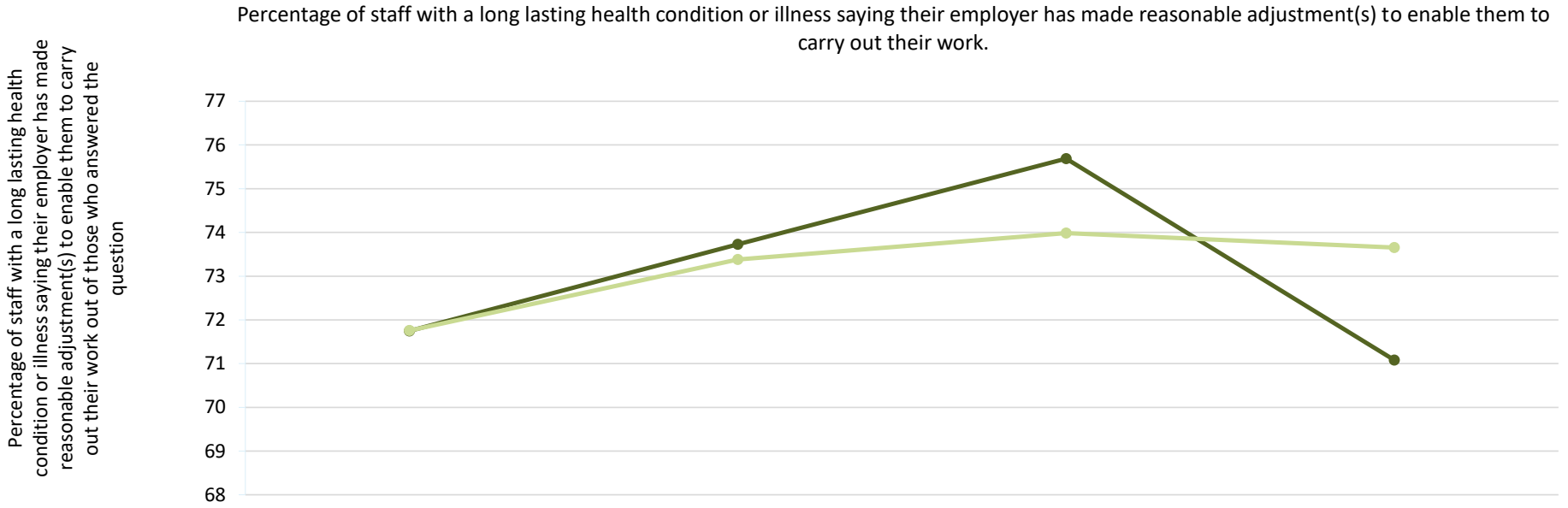
Survey Coordination Centre NHS



	2021	2022	2023	2024	2025
Staff with a LTC or illness: Your org	31.73%	28.27%	32.03%	36.51%	28.24%
Staff without a LTC or illness: Your org	45.71%	42.99%	44.76%	46.35%	45.94%
Staff with a LTC or illness: Average	32.62%	32.46%	35.66%	34.73%	32.09%
Staff without a LTC or illness: Average	43.30%	43.56%	47.19%	46.98%	45.10%
Staff with a LTC or illness: Responses	539	619	615	723	595
Staff without a LTC or illness: Responses	2050	2296	2281	2520	2068

Workforce Disability Equality Standards

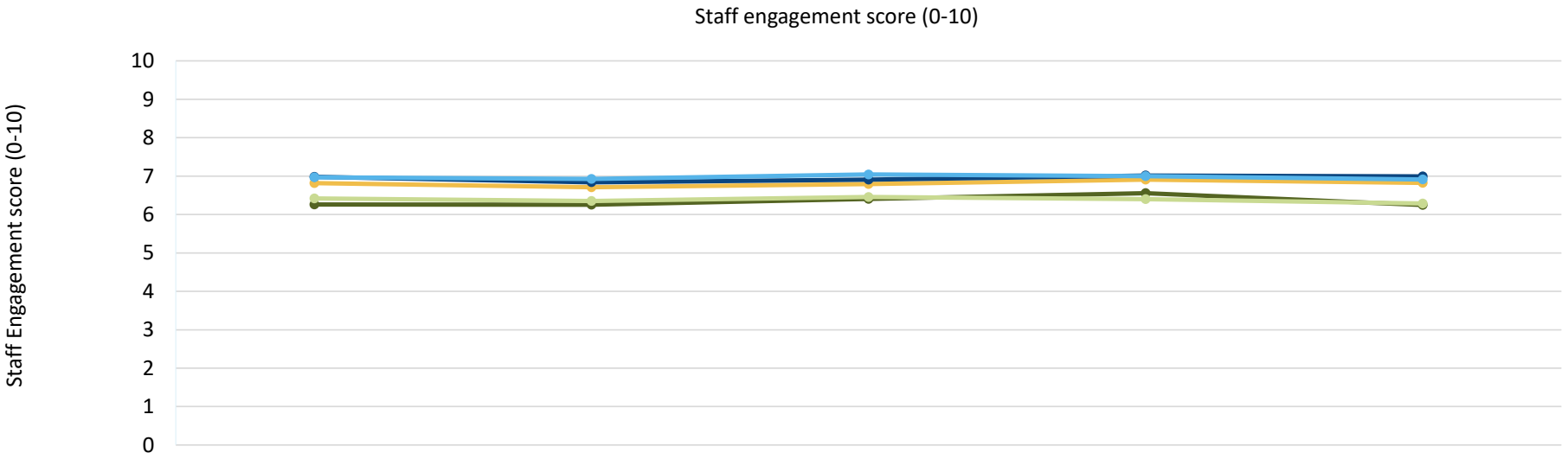
Survey Coordination Centre NHS



	2022	2023	2024	2025
Staff with a LTC or illness: Your org	71.75%	73.73%	75.69%	71.08%
Staff with a LTC or illness: Average	71.76%	73.38%	73.98%	73.65%
Staff with a LTC or illness: Responses	361	373	436	370

Workforce Disability Equality Standards

Survey Coordination Centre NHS



	2021	2022	2023	2024	2025
Organisation average	6.82	6.71	6.80	6.91	6.82
Staff with a LTC or illness: Your org	6.26	6.25	6.40	6.56	6.25
Staff without a LTC or illness: Your org	6.98	6.84	6.91	7.01	6.99
Staff with a LTC or illness: Average	6.42	6.35	6.46	6.40	6.29
Staff without a LTC or illness: Average	6.97	6.92	7.04	7.00	6.91
Staff with a LTC or illness: Responses	539	620	616	726	599
Staff without a LTC or illness: Responses	2055	2312	2295	2538	2079

Note: Data shown in this chart are unweighted therefore will not match weighted staff engagement scores in other outputs.

Survey Coordination Centre

NHS

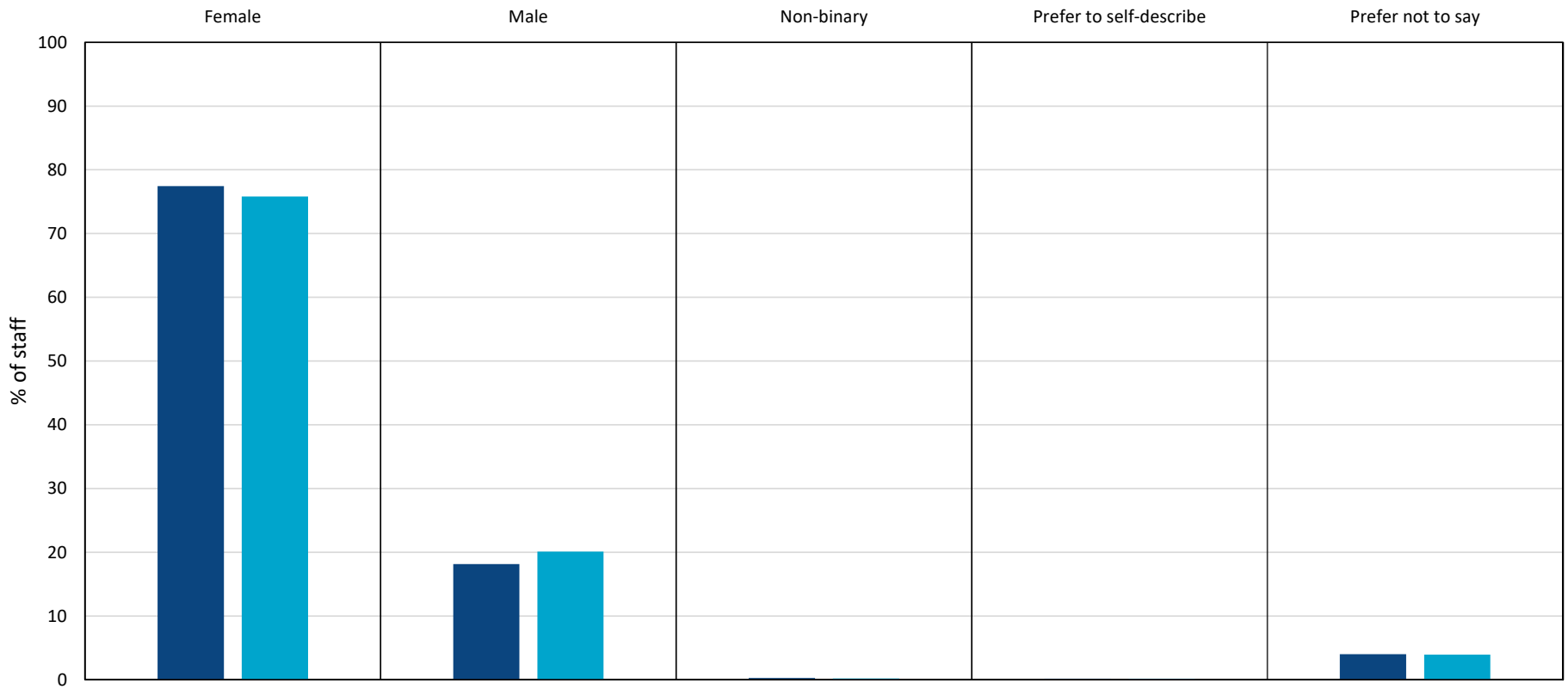
About your respondents

This section shows demographic and other background information for 2025.

Note: where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Background details - Which of the following best describes you?

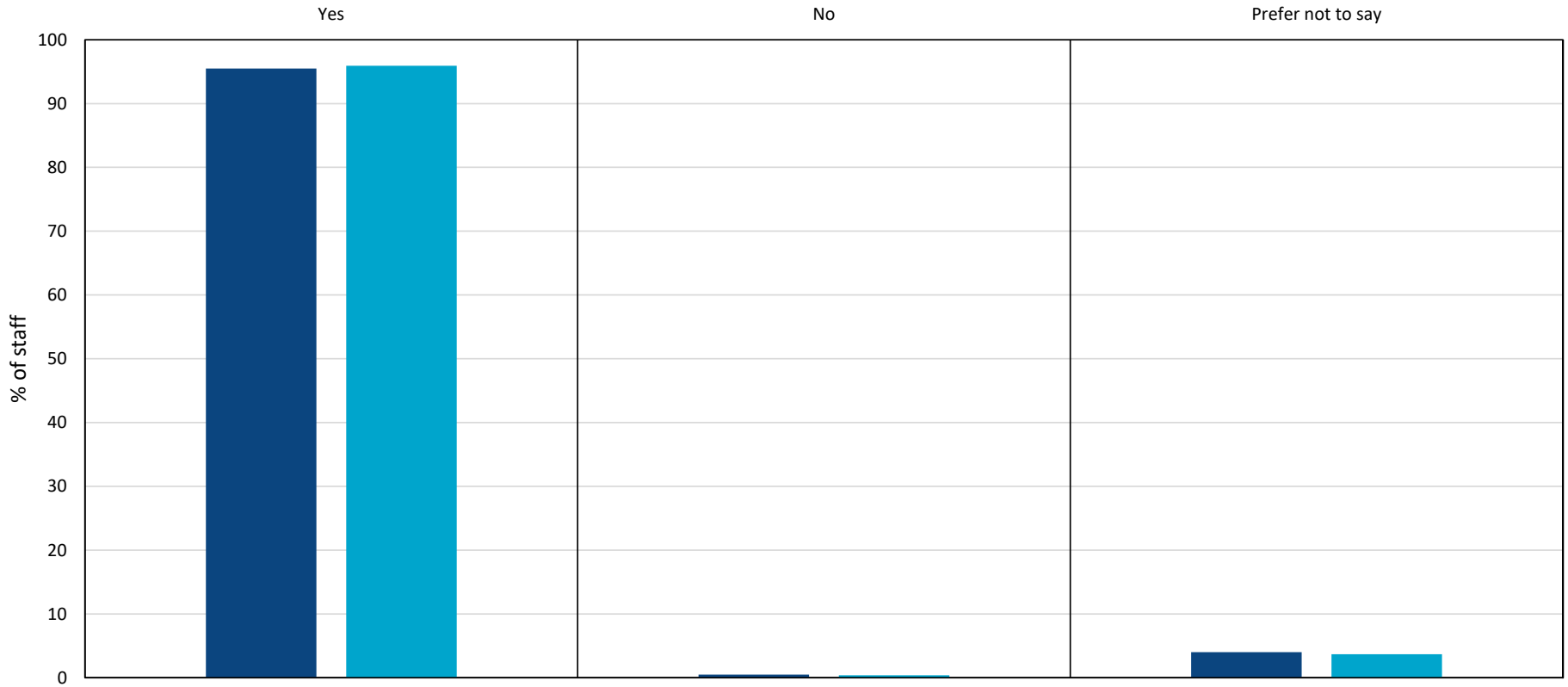
Survey Coordination Centre NHS



	Female	Male	Non-binary	Prefer to self-describe	Prefer not to say
Your org	77.46%	18.14%	0.26%	0.15%	4.00%
Average	75.82%	20.10%	0.19%	0.12%	3.92%
Responses	2724	2724	2724	2724	2724

Background details - Is your gender identity the same as the sex you were registered at birth?

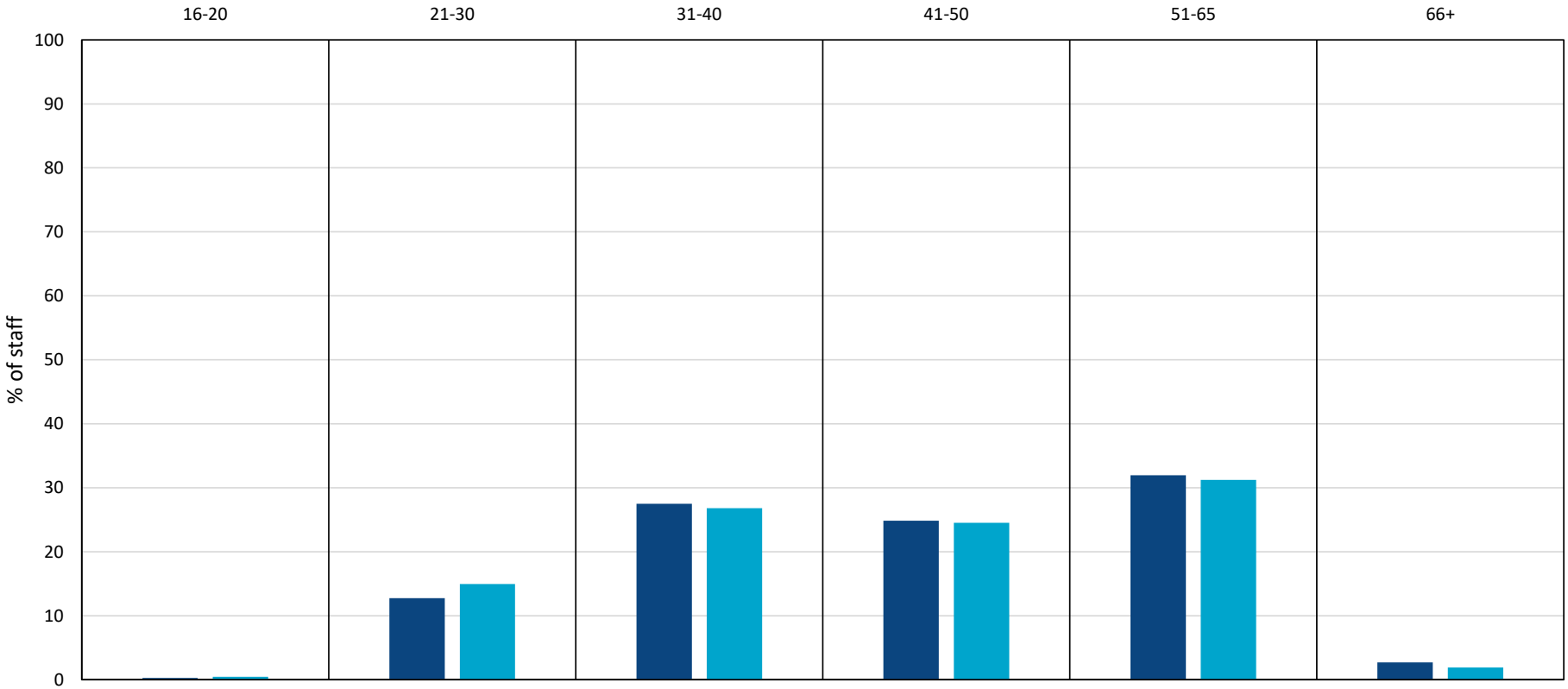
Survey Coordination Centre



	Yes	No	Prefer not to say
Your org	95.50%	0.50%	4.01%
Average	95.94%	0.37%	3.67%
Responses	2620	2620	2620

Background details - Age

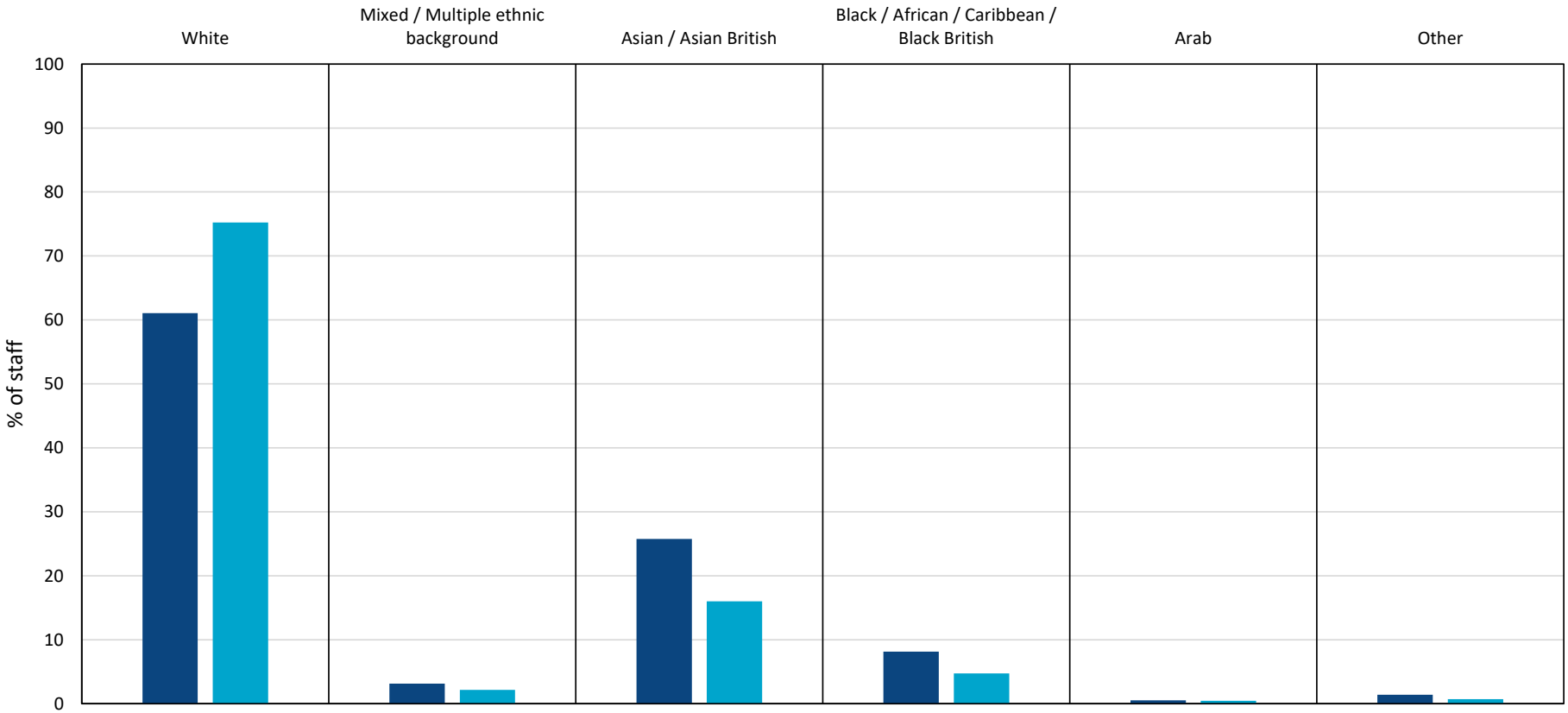
Survey Coordination Centre NHS



	16-20	21-30	31-40	41-50	51-65	66+
Your org	0.26%	12.73%	27.51%	24.86%	31.96%	2.68%
Average	0.44%	14.95%	26.81%	24.51%	31.23%	1.89%
Responses	2719	2719	2719	2719	2719	2719

Background details - Ethnic group

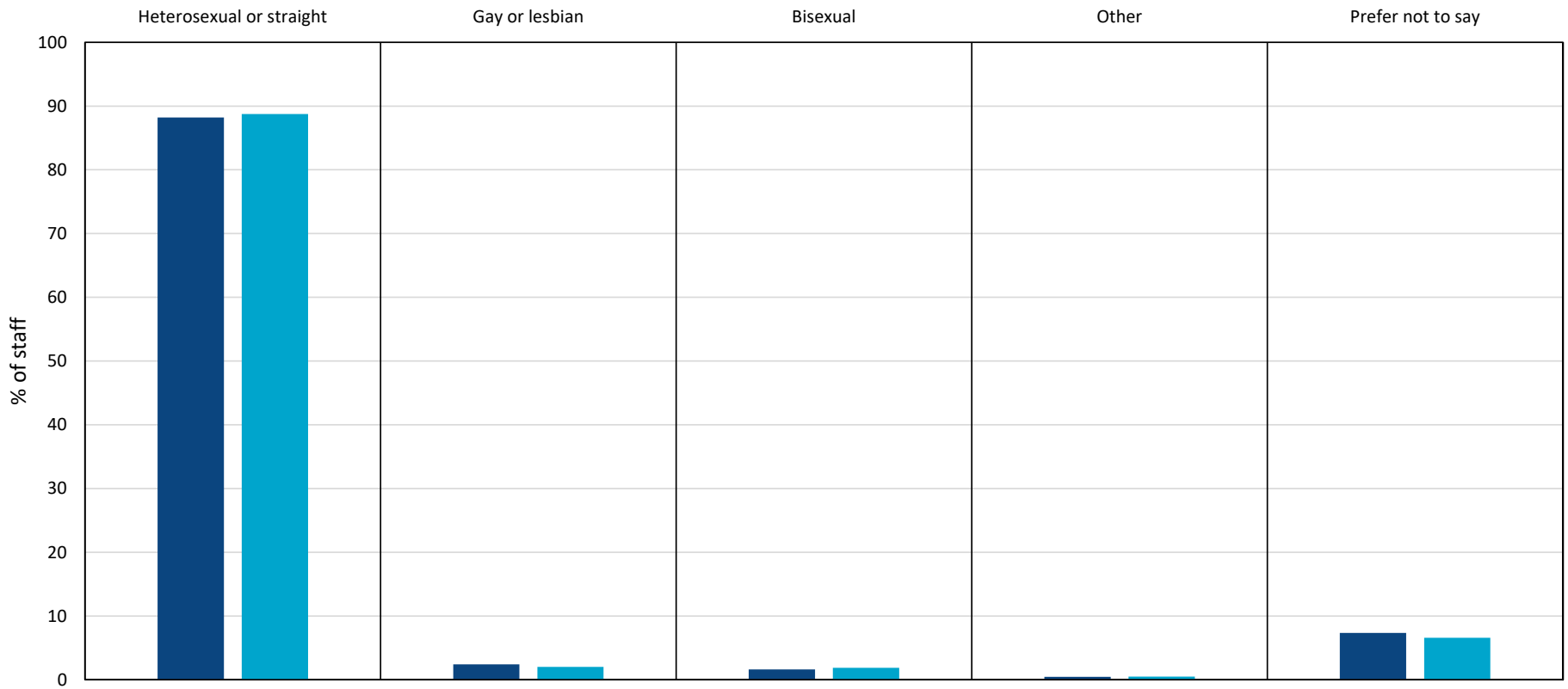
Survey Coordination Centre NHS



	White	Mixed / Multiple ethnic background	Asian / Asian British	Black / African / Caribbean / Black British	Arab	Other
Your org	61.06%	3.14%	25.75%	8.13%	0.52%	1.40%
Average	75.23%	2.15%	16.00%	4.74%	0.47%	0.69%
Responses	2707	2707	2707	2707	2707	2707

Background details - Sexual orientation

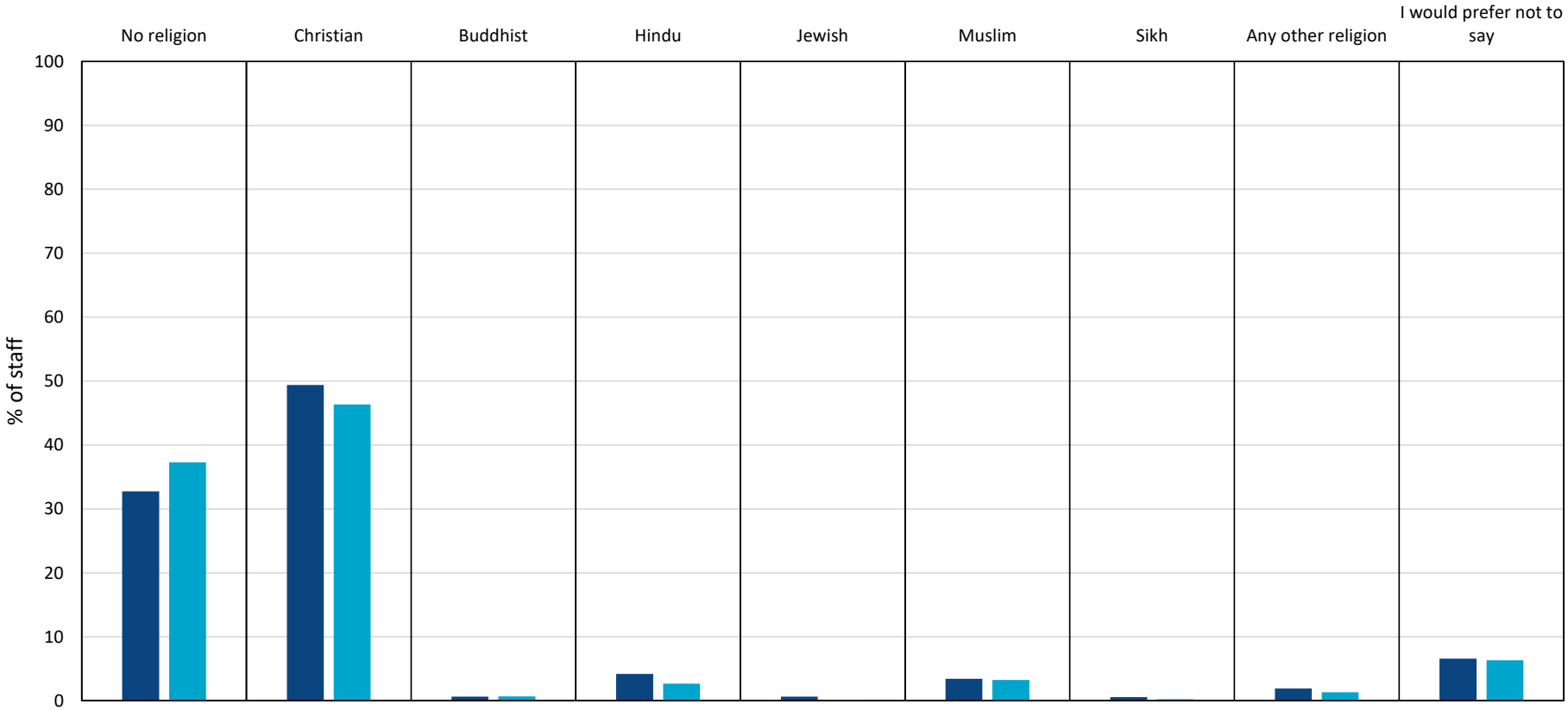
Survey Coordination Centre NHS



	Heterosexual or straight	Gay or lesbian	Bisexual	Other	Prefer not to say
Your org	88.19%	2.41%	1.61%	0.44%	7.35%
Average	88.76%	2.01%	1.86%	0.49%	6.59%
Responses	2735	2735	2735	2735	2735

Background details - Religion or belief

Survey Coordination Centre NHS

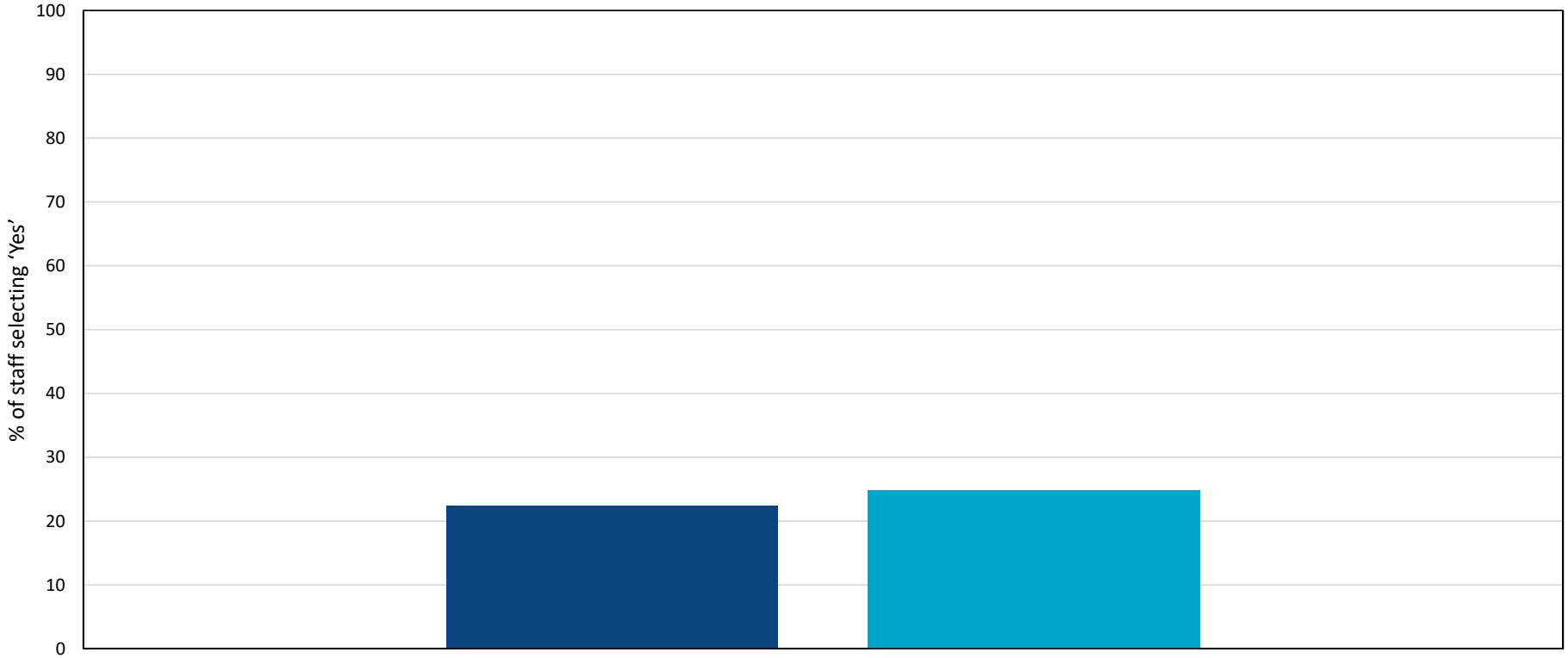


	No religion	Christian	Buddhist	Hindu	Jewish	Muslim	Sikh	Any other religion	I would prefer not to say
Your org	32.75%	49.39%	0.62%	4.18%	0.62%	3.41%	0.55%	1.91%	6.56%
Average	37.27%	46.34%	0.69%	2.66%	0.14%	3.25%	0.25%	1.32%	6.32%
Responses	2727	2727	2727	2727	2727	2727	2727	2727	2727

Background details - Long lasting health condition or illness

Survey Coordination Centre NHS

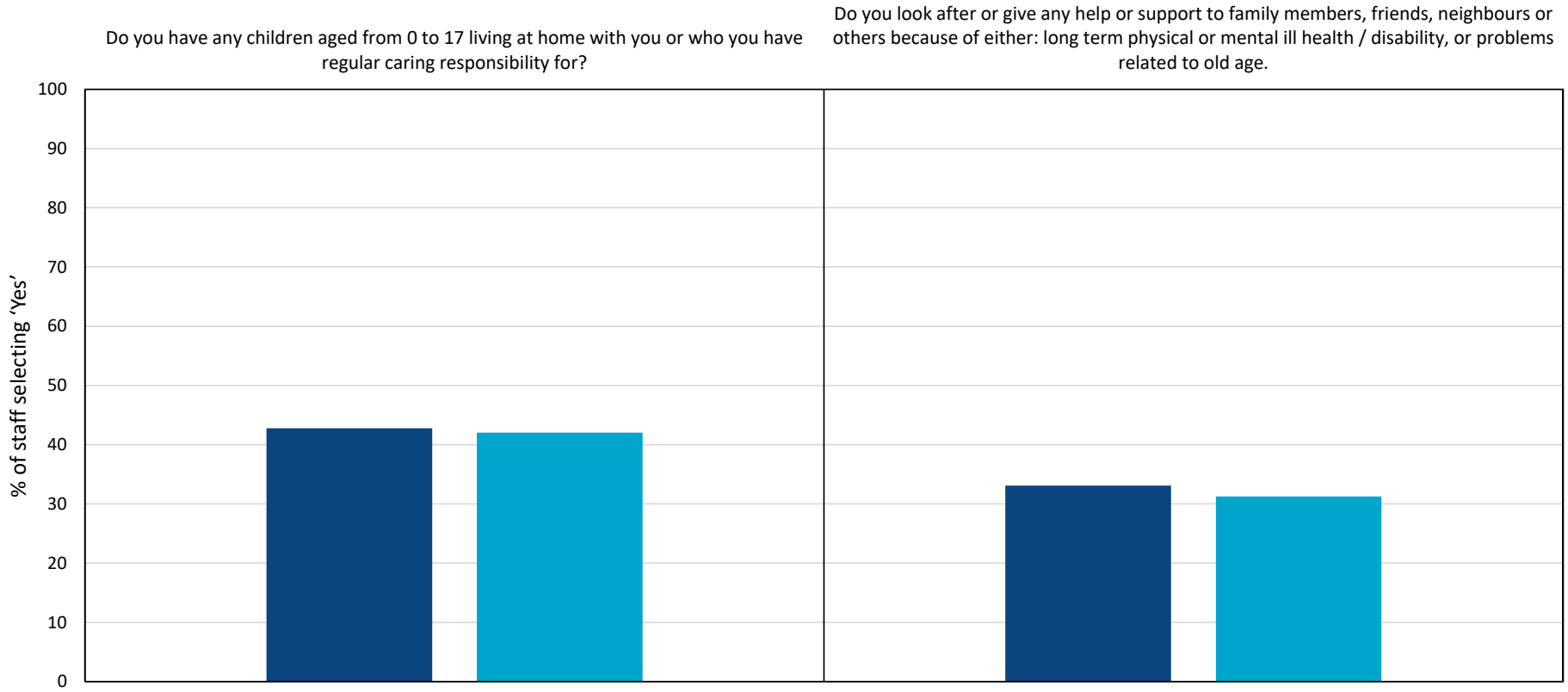
Do you have any physical or mental health conditions or illnesses lasting or expected to last for 12 months or more?



Your org	22.33%
Average	24.90%
Responses	2682

Background details - Parental / caring responsibilities

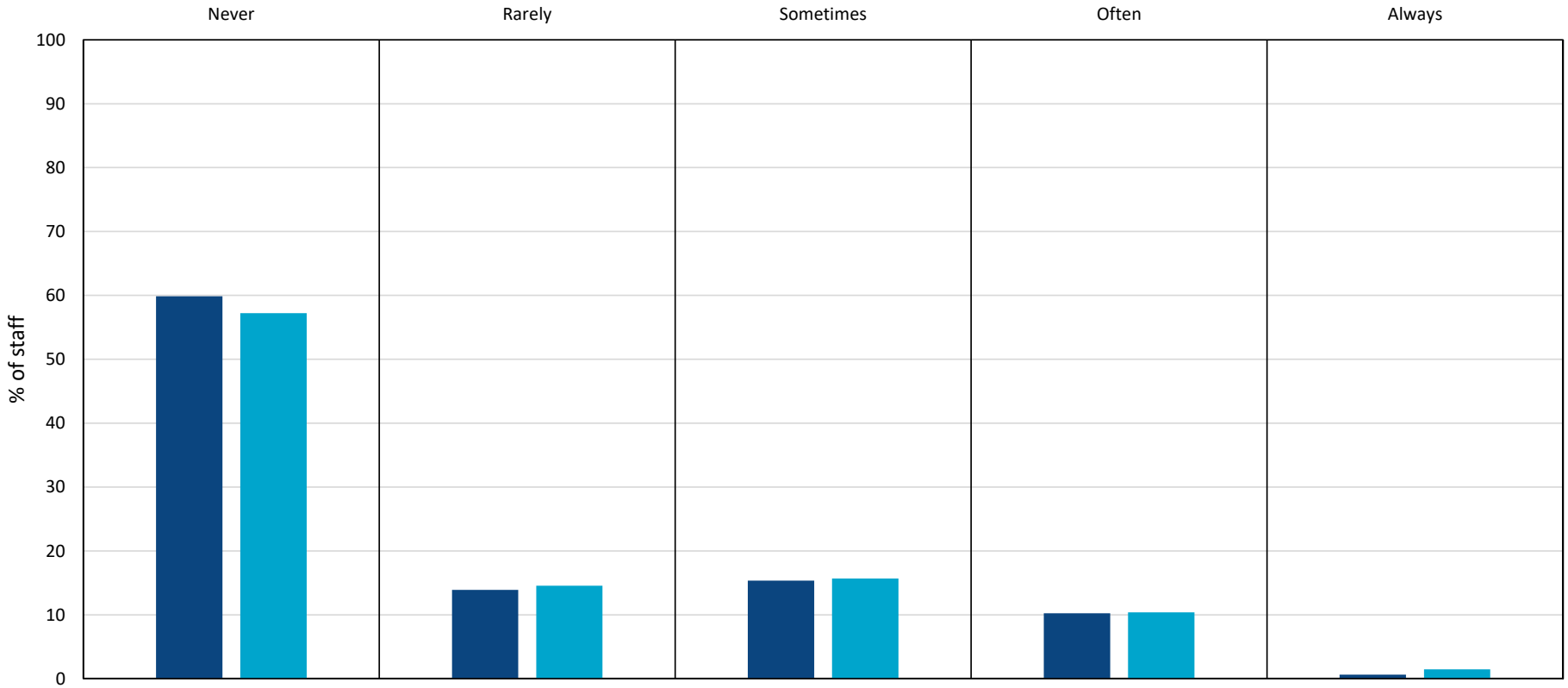
Survey Coordination Centre NHS



Your org	42.77%	33.10%
Average	42.03%	31.25%
Responses	2719	2725

Background details - How often do you work at/from home?

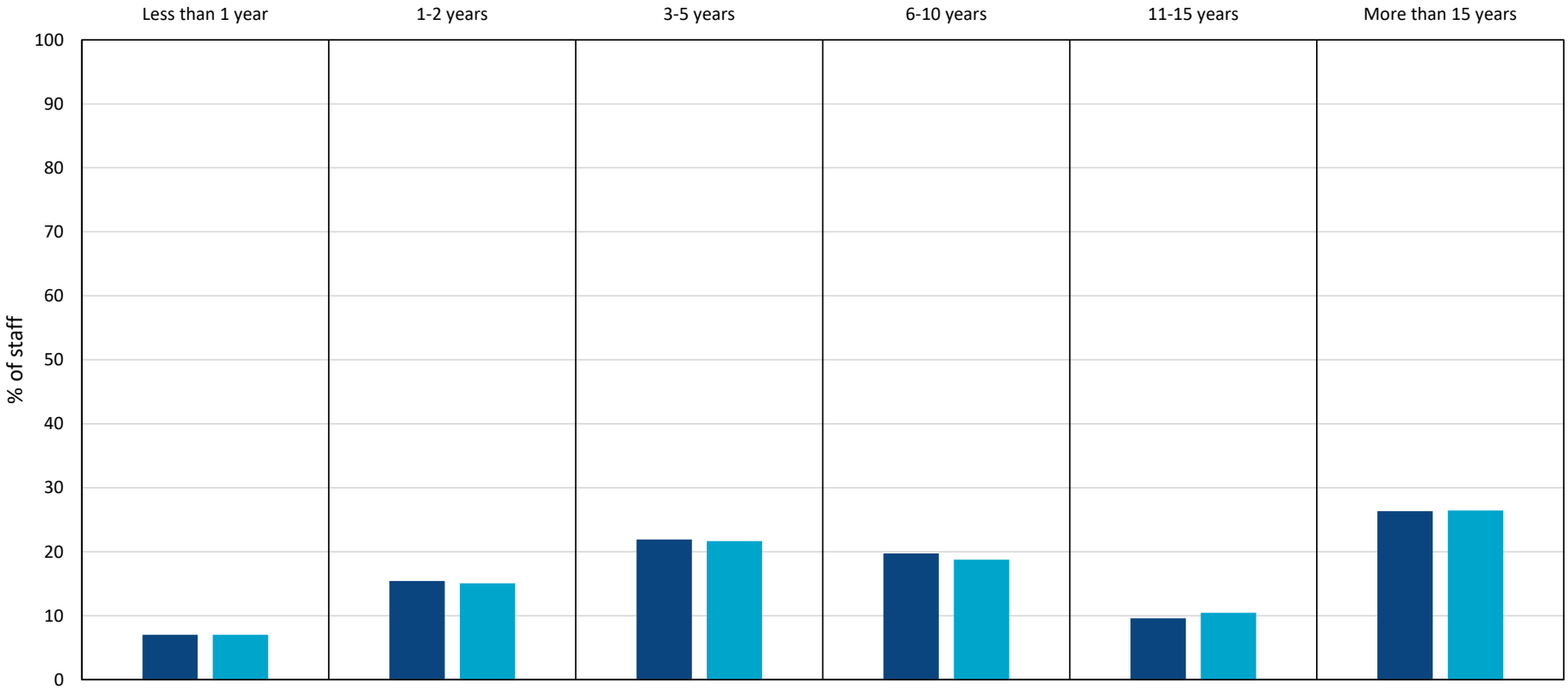
Survey Coordination Centre NHS



	Never	Rarely	Sometimes	Often	Always
Your org	59.87%	13.91%	15.34%	10.25%	0.63%
Average	57.23%	14.54%	15.67%	10.40%	1.48%
Responses	2711	2711	2711	2711	2711

Background details - Length of service

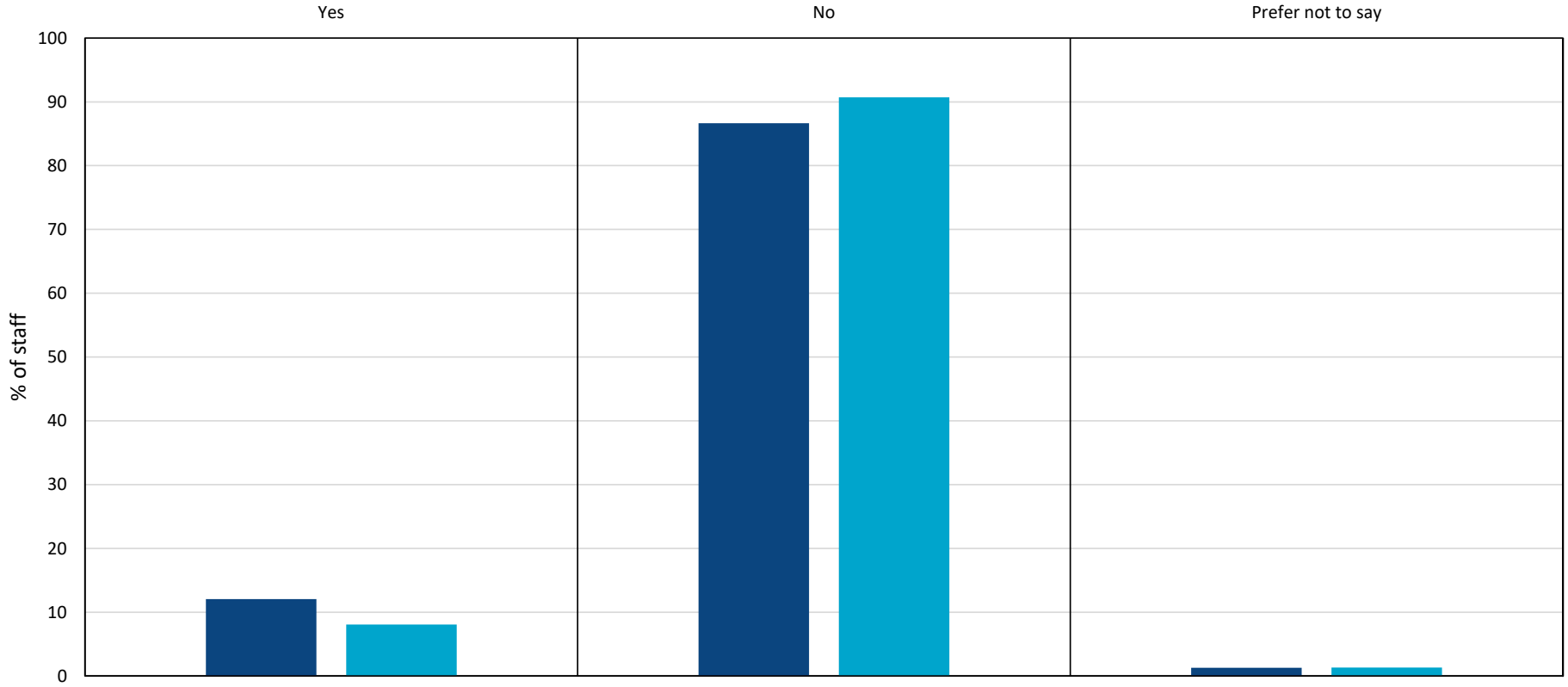
Survey Coordination Centre NHS



	Less than 1 year	1-2 years	3-5 years	6-10 years	11-15 years	More than 15 years
Your org	7.00%	15.43%	21.92%	19.73%	9.59%	26.33%
Average	7.03%	15.07%	21.68%	18.76%	10.47%	26.44%
Responses	2742	2742	2742	2742	2742	2742

Background details - When you joined this organisation, were you recruited from outside of the UK?

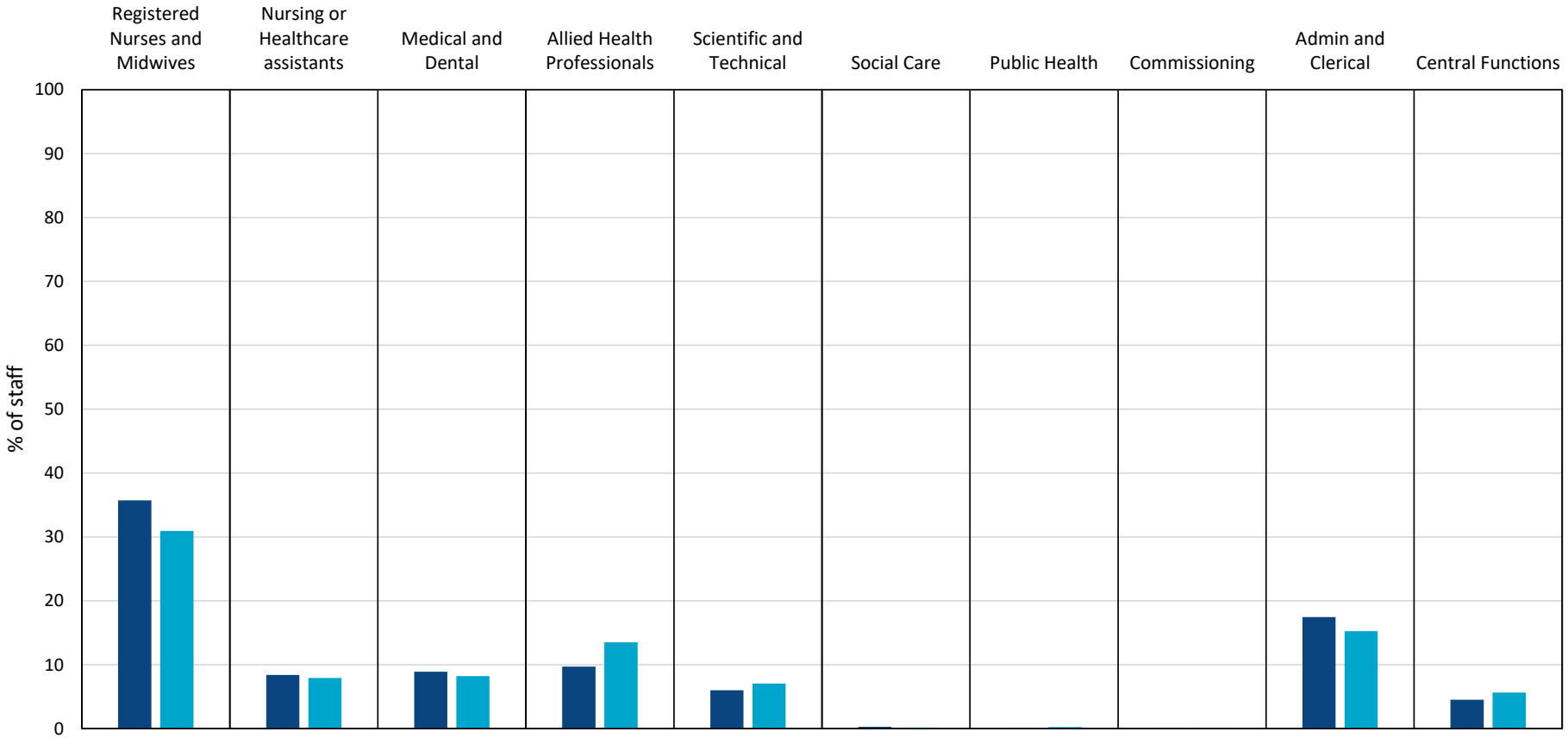
Survey Coordination Centre NHS



	Yes	No	Prefer not to say
Your org	12.07%	86.65%	1.28%
Average	8.07%	90.72%	1.31%
Responses	2726	2726	2726

Background details - Occupational group

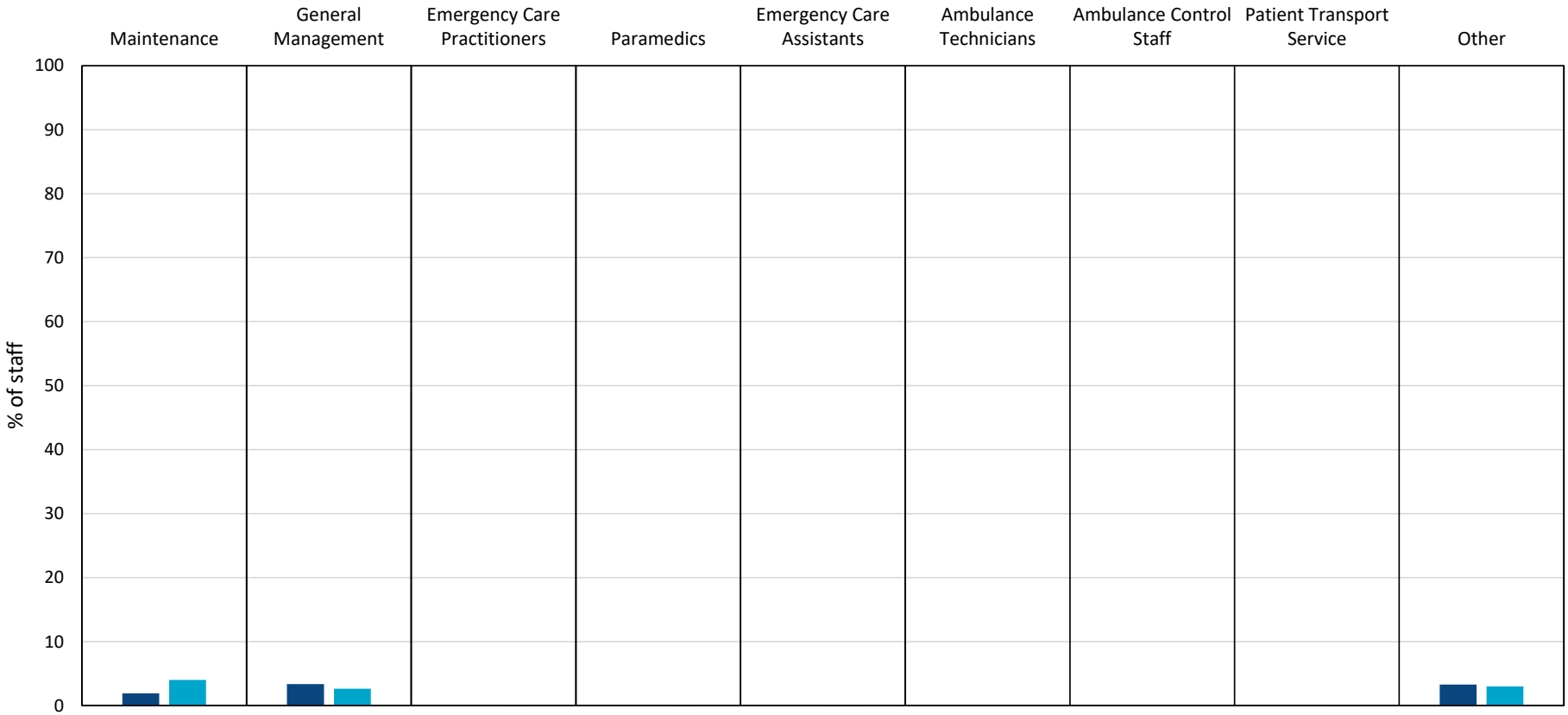
Survey Coordination Centre NHS



	Registered Nurses and Midwives	Nursing or Healthcare assistants	Medical and Dental	Allied Health Professionals	Scientific and Technical	Social Care	Public Health	Commissioning	Admin and Clerical	Central Functions
Your org	35.74%	8.40%	8.92%	9.69%	5.99%	0.26%	0.11%	0.11%	17.46%	4.51%
Average	30.95%	7.91%	8.21%	13.49%	7.06%	0.18%	0.25%	0.08%	15.26%	5.63%
Responses	2703	2703	2703	2703	2703	2703	2703	2703	2703	2703

Background details - Occupational group

Survey Coordination Centre NHS



	Maintenance	General Management	Emergency Care Practitioners	Paramedics	Emergency Care Assistants	Ambulance Technicians	Ambulance Control Staff	Patient Transport Service	Other
Your org	1.92%	3.37%	0.07%	0.04%	0.07%	0.00%	0.00%	0.04%	3.29%
Average	3.99%	2.62%	0.01%	0.02%	0.04%	0.00%	0.00%	0.01%	2.99%
Responses	2703	2703	2703	2703	2703	2703	2703	2703	2703

Survey Coordination Centre

NHS

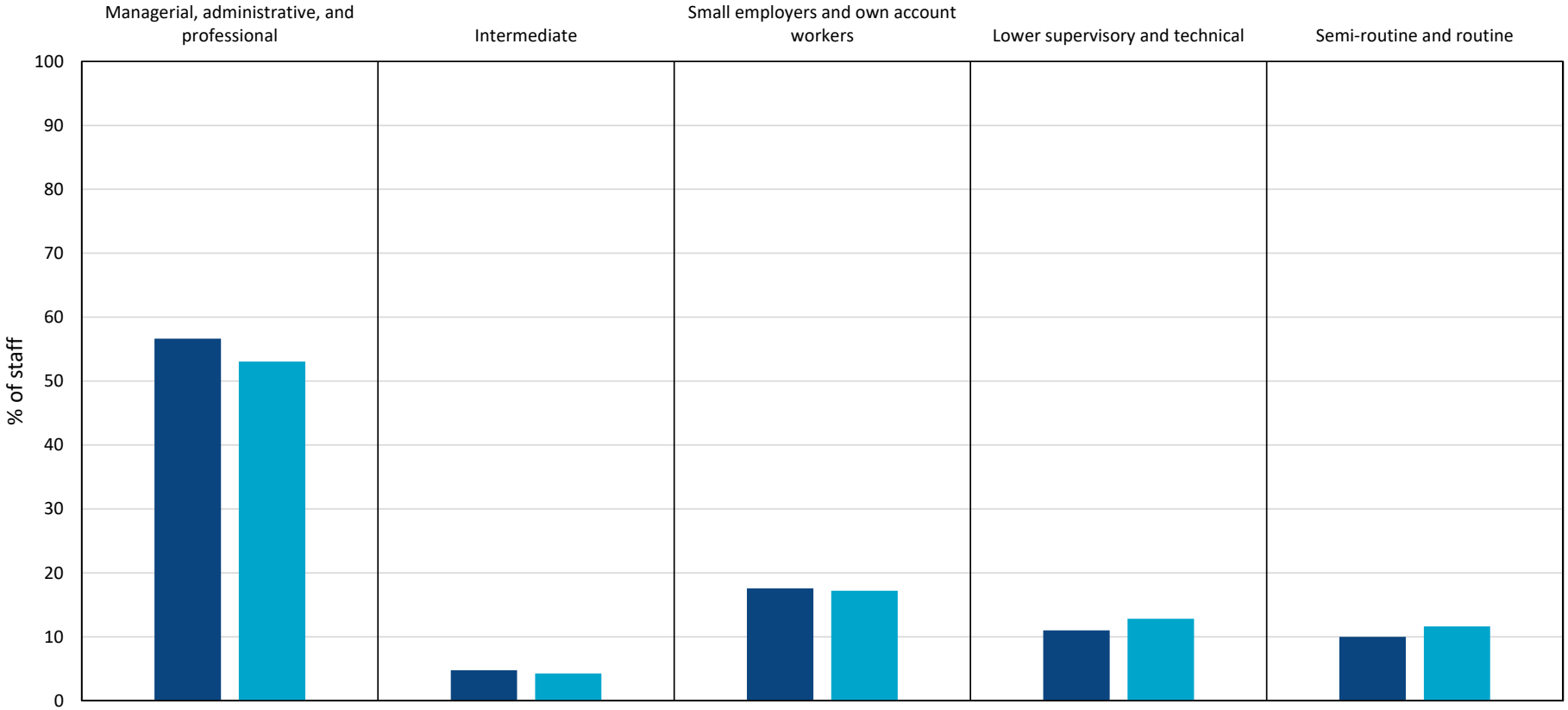
Socio-economic Background

This section shows information about the socio-economic background of staff and People Promise scores by socio-economic background. These questions are only included in the online questionnaire and were not answered by those responding to the paper questionnaire.

Note: where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Socio-economic background: Five classes

Survey Coordination Centre NHS

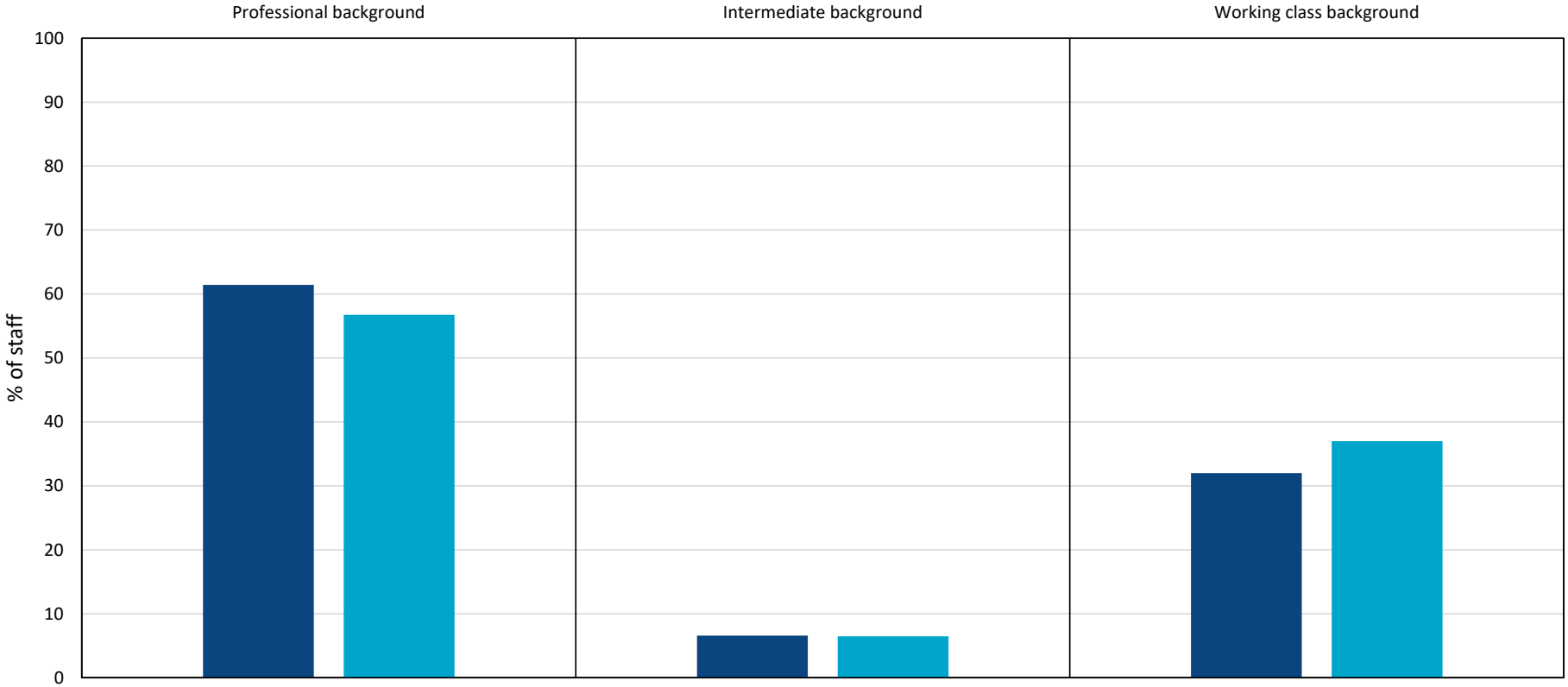


	Managerial, administrative, and professional	Intermediate	Small employers and own account workers	Lower supervisory and technical	Semi-routine and routine
Your org	56.64%	4.77%	17.58%	11.02%	10.00%
Average	53.05%	4.27%	17.19%	12.81%	11.63%
Responses	1280	1280	1280	1280	1280

Please note – These questions are online only.
There was a higher than typical level of non-response to the socio-economic background questions, which resulted in 48.02% of respondents not receiving a Five class score at the national level. For more information about socio-economic background, please see appendix D.

Socio-economic background: Three classes

Survey Coordination Centre NHS



	Professional background	Intermediate background	Working class background
Your org	61.42%	6.57%	32.00%
Average	56.73%	6.48%	36.98%
Responses	1856	1856	1856

Please note – These questions are online only.
There was a higher than typical level of non-response to the socio-economic background questions, which resulted in 28.32% of respondents not receiving a Three class score at the national level. For more information about socio-economic background, please see appendix D.

Socio-economic background: People Promise elements and themes

Survey Coordination Centre NHS

People Promise elements and themes in your organisation by socio-economic background (Five class)	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff engagement	Morale
1 Managerial, administrative and professional	7.30	5.93	6.62	5.98	5.53	6.31	6.76	6.86	5.79
2 Intermediate	7.49	6.43	6.74	6.38	5.74	7.09	7.24	6.96	6.11
3 Small employers and own account workers	7.42	6.09	6.67	5.98	5.51	6.51	6.92	6.82	5.90
4 Lower supervisory and technical	7.41	6.05	6.60	5.79	5.59	6.27	7.06	6.81	5.84
5 Semi-routine and routine	7.37	6.03	6.58	6.06	5.56	6.21	6.81	6.76	5.82

People Promise elements and themes in your organisation by socio-economic background (Three class)	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff engagement	Morale
1 Professional	7.33	5.94	6.63	6.04	5.55	6.35	6.78	6.85	5.84
2 Intermediate	7.43	6.26	6.81	6.10	5.77	6.68	7.08	6.99	5.91
3 Working class	7.37	6.02	6.60	6.01	5.62	6.36	6.89	6.81	5.88

Please note – These questions are online only.
There was a higher than typical level of non-response to the socio-economic background questions. For more information about interpreting socio-economic background data, please see appendix D.

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Appendices

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Appendix A: Response rate

Appendix A: Response rate

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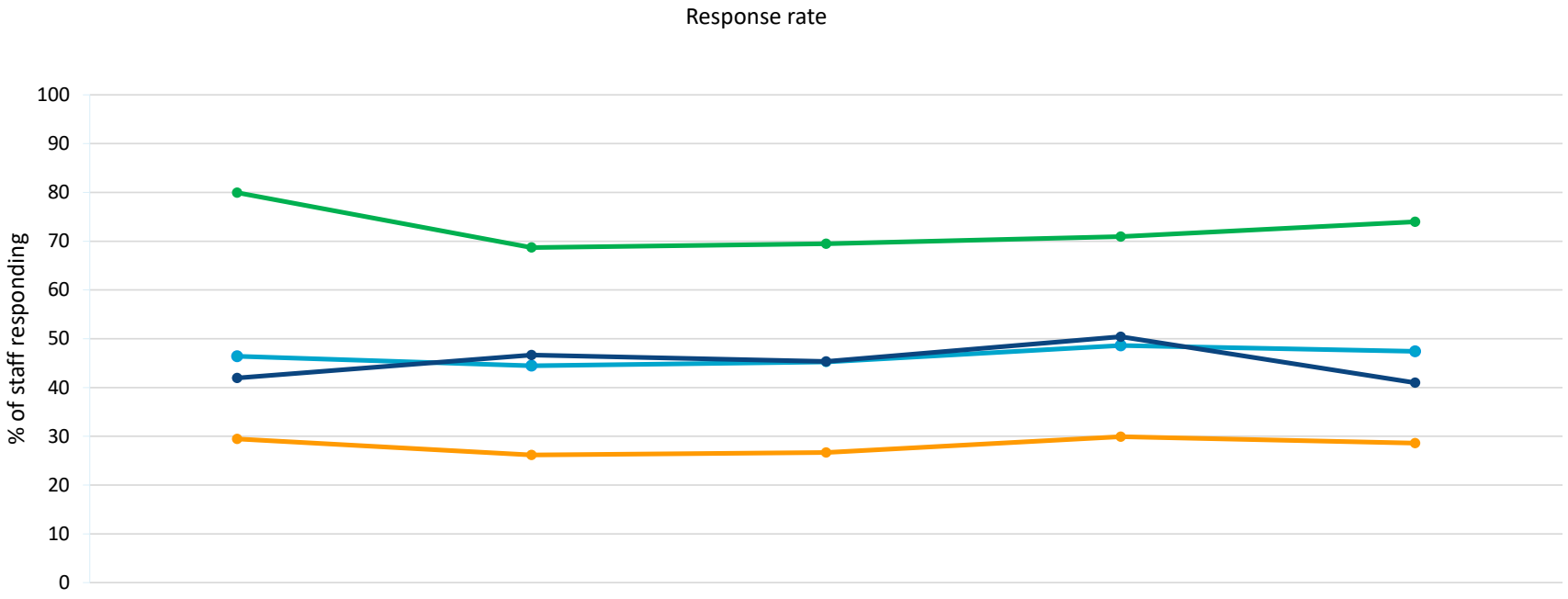

	2021	2022	2023	2024	2025
Your org	41.95%	46.65%	45.32%	50.41%	40.97%
Highest	79.95%	68.69%	69.45%	70.92%	73.97%
Average	46.38%	44.46%	45.23%	48.61%	47.42%
Lowest	29.47%	26.17%	26.65%	29.91%	28.60%
Responses	2647	2963	2994	3347	2756

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Appendix B: Significance testing 2024 vs 2025

Appendix B: Significance testing – 2024 vs 2025

Survey Coordination Centre NHS

Statistical significance helps quantify whether a result is likely due to chance or to some factor of interest. The table below presents the results of significance testing conducted on the theme scores calculated in both 2024 and 2025*. For more details, please see the Technical Guide.

People Promise elements	2024 score	2024 respondents	2025 score	2025 respondents	Statistically significant change?
We are compassionate and inclusive	7.30	3336	7.31	2743	Not significant
We are recognised and rewarded	5.92	3329	5.94	2742	Not significant
We each have a voice that counts	6.66	3308	6.61	2716	Not significant
We are safe and healthy	6.13	3318	6.07	2725	Not significant
We are always learning	5.79	3200	5.62	2631	Significantly lower
We work flexibly	6.35	3307	6.33	2725	Not significant
We are a team	6.77	3328	6.80	2741	Not significant
Themes					
Staff Engagement	6.90	3338	6.83	2749	Not significant
Morale	5.93	3342	5.86	2749	Not significant

* Statistical significance is tested using a two-tailed t-test with a 95% level of confidence.

Survey Coordination Centre

NHS

Appendix C: Tips on using your benchmark report

Appendix C: Data in the benchmark reports

Survey Coordination Centre NHS

The following pages include tips on how to read, interpret and use the data in this report. The **suggestions are aimed at users who would like some guidance on how to understand the data** in this report. These suggestions are by no means the only way to analyse or use the data but have been included to aid users.

Key points to note

The seven People Promise elements, the two themes and the sub-scores that feed into them cover key areas of staff experience and present results in these areas in a clear and consistent way. The People Promise elements, themes and sub-scores are scored on a 0-10 scale, where a higher result is more positive than a lower result. These results are created by scoring questions linked to these areas of experience and grouping these results together. Details of how the results are calculated can be found in the Technical Guide available on the Staff Survey website.

A key feature of the reports is that they **provide organisations with up to five years of trend data**. Trend data provides a much more reliable indication of whether the most recent results represent a change from the norm for an organisation than comparing the most recent results only to those from the previous year. Taking a longer-term view will help organisations to identify trends over several years that may have been missed when comparisons are drawn solely between the current and previous year.

People Promise elements, themes and sub-scores are benchmarked so that organisations can make comparisons to their peers on specific areas of staff experience. Question results provide organisations with more granular data that will help them to identify particular areas of concern. The trend data are benchmarked so that organisations can identify how results on each question have changed for themselves and their peers over time by looking at a single chart.

Appendix C: 1. Reviewing People Promise and theme results

Survey Coordination Centre NHS

When analysing People Promise element and theme results, it is easiest to start with the **overview** page to quickly identify areas of interest which can then be compared to the best, average, and worst result in the benchmarking group.

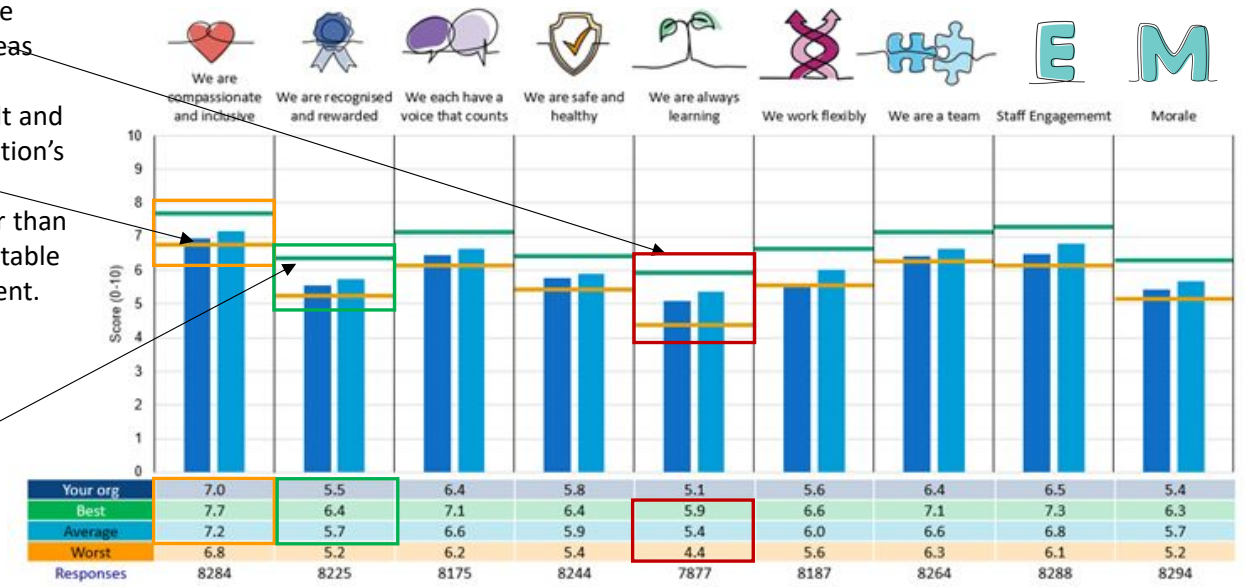
It is important to **consider each result within the range of its benchmarking group 'Best result' and 'Worst result'**, rather than comparing People Promise element and theme results to one another. Comparing organisation results to the benchmarking group average is another point of reference.

Areas to improve

- By checking where, the 'Your org' column/value is lower than the benchmarking group 'Average result' you can quickly identify areas for improvement.
- It is worth looking at the difference between the 'Your org' result and the benchmarking group 'Worst result'. The closer your organisation's result is to the worst result, the more concerning the result.
- Results where your organisation's result is only marginally better than the 'Average result', but still lags behind the 'Best result' by a notable margin, could also be considered as areas for further improvement.

Positive outcomes

- Similarly, using the overview page it is easy to identify People Promise elements and themes which show a positive outcome for your organisation, where 'Your org' results are distinctly higher than the benchmarking group 'Average result'.
- Positive stories to report could be ones where your organisation approaches or matches the benchmarking group's 'Best result'.



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.0	5.5	6.4	5.8	5.1	5.6	6.4	6.5	5.4
Best	7.7	6.4	7.1	6.4	5.9	6.6	7.1	7.3	6.3
Average	7.2	5.7	6.6	5.9	5.4	6.0	6.6	6.8	5.7
Worst	6.8	5.2	6.2	5.4	4.4	5.6	6.3	6.1	5.2
Responses	8284	8225	8175	8244	7877	8187	8264	8288	8294

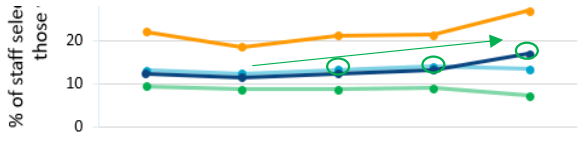
Only one example is highlighted for each point

Appendix C: 2. Reviewing results in more detail

Survey Coordination Centre NHS

Review trend data

Trend data can be used to identify measures which have been consistently improving for your organisation (i.e. showing an upward trend) over the past years and ones which have been declining over time. These charts can **help establish if there is genuine change in the results** (if the results are consistently improving or declining over time), or whether a change between years is just a minor **year-on-year** fluctuation.



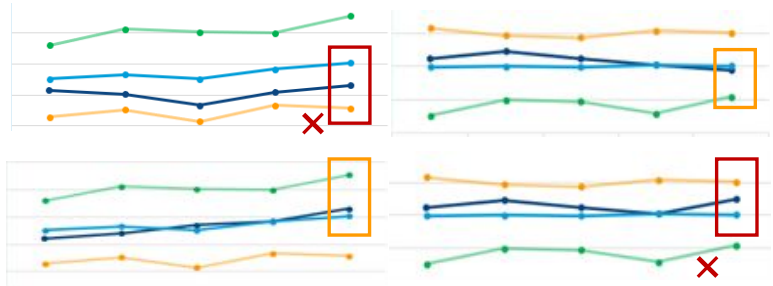
	2020	2021	2022	2023	2024
Your org	12.4%	11.5%	12.5%	13.4%	17.0%
Best result	9.5%	8.7%	8.7%	9.1%	7.3%
Average result	13.2%	12.5%	13.4%	14.1%	13.5%
Worst result	22.2%	18.6%	21.3%	21.4%	27.0%
Responses	1200	1115	1200	1200	595

Benchmarked trend data also allows you to review local changes and benchmark comparisons at the same time, allowing for various types of questions to be considered: e.g. how have the results for my organisation changed over time? Is my organisation improving faster than our peers?

Review the sub-scores and questions feeding into the People Promise elements and themes

In order to understand exactly which factors are driving your organisation's People Promise element and theme results, you should review the sub-scores and questions feeding into these results. The **sub-score results** and the '**Question results**' section contain the sub-scores and questions contributing to each People Promise element and theme, grouped together. By comparing 'Your org' results to the benchmarking group 'Average', 'Best' and 'Worst' results for each question, the **questions which are driving your organisation's People Promise element and theme results can be identified**.

For areas of experience where results need improvement, action plans can be formulated to **focus on the questions where the organisation's results fall between the benchmarking group average and worst results.** Remember to keep an eye out for questions where a lower percentage is a better outcome – such as questions on violence or harassment, bullying and abuse.



✕ = Negative driver, org result falls between average and worst benchmarking group result for question

Appendix C: 3. Reviewing question results

Survey Coordination Centre NHS

This benchmark report displays results for all questions in the questionnaire, including benchmarked trend data wherever available. While this a key feature of the report, at first glance the amount of information contained on more than 140 pages might appear daunting. The below suggestions aim to provide some guidance on how to get started with navigating through this set of data.

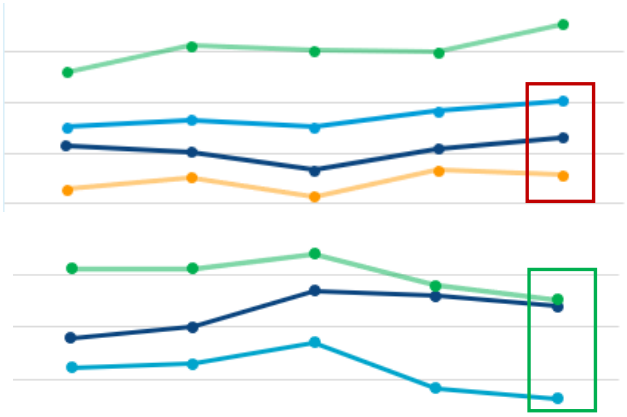
Identifying questions of interest

- **Pre-defined questions of interest – key questions for your organisation**

Most organisations will have questions which have traditionally been a focus for them - questions which have been targeted with internal policies or programmes, or whose results are of heightened importance due to organisation values or because they are considered a proxy for key issues. Outcomes for these questions can be assessed on the backdrop of benchmark and historical trend data.

- **Identifying questions of interest based on the results in this report**

The methods recommended to review your People Promise and theme results can also be applied to pick out question level results of interest. However, **unlike People Promise elements, themes and sub-scores where a higher result always indicates a better result, it is important to keep an eye out for questions where a lower percentage relates to a better outcome** (see details on the 'Using the report' page in the 'Introduction' section).



- **To identify areas of concern:** look for questions where the organisation value falls between the benchmarking group average and the worst result, particularly questions where your organisation result is very close to the worst result. Review changes in the trend data to establish if there has been a decline or stagnation in results across multiple years but consider the context of how the organisation has performed in comparison to its benchmarking group over this period. A positive trend for a question that is still below the average result can be seen as good progress to build on further in the future.

- **When looking for positive outcomes:** search for results where your organisation is closest to the benchmarking group best result (but remember to consider results for previous years), or ones where there is a clear trend of continued improvement over multiple years.

Survey Coordination Centre

NHS

Appendix D: Socio-economic background

Note: where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Appendix D: Socio-economic background

Survey Coordination Centre NHS

Starting in 2025, the online NHS Staff Survey includes questions on staff members' socio-economic background. The questionnaire included questions (Q33-37) from the Socio-economic background harmonised standard from the Government Statistical Service (GSS) Harmonisation Team.

What is socio-economic background?

The Socio-economic background harmonised standard uses the Social Mobility Commission's definition of socio-economic background, which is:

> "[…] the particular set of social and economic circumstances that an individual has come from. It permits objective discussion of the influence of these circumstances on individuals' educational and career trajectories; and it can be objectively measured by capturing information on parental occupation and level of education."

Measuring socio-economic background

The NHS Staff Survey used the self-coded question set designed to place respondents into five classes, the Five Class System of National Statistics Socio-economic Classification (NS-SEC). During quality assurance processes, analysts at the Survey Coordination Centre (SCC) identified a high rate of non-response or non-substantive responses, resulting in 48.02% of respondents from across the country not being allocated a score with the Five Class System. This includes 4.85% that said their parents/guardians were not employed. Using an alternative Three Class System (that is derived only using *Q37 - When you were aged about 14, what was the occupation of the main or highest income earner?*) reduced the proportion without a score to 28.32%.

SCC also found the rate of responses not resulting in a score varied between demographic groups. This occurs with both the Five and Three Class Systems, though to lesser extent for the Three Class System. Groups less likely to produce a score include:

- People from **Mixed / multiple**, **Asian / Asian British**, **Black / African / Caribbean / Black British**, **Arab** or **Other** ethnic backgrounds (as compared to people from **White** backgrounds)
- **Younger people (**particularly those aged 16-30)
- People **recruited from abroad**

National results are shown in more detail on the following page.

Appendix D: Socio-economic background

Survey Coordination Centre NHS

Comparison of Three and Five Class approaches

The following tables show the proportion of respondents that are excluded from scoring using the Five and Three Class Systems using national data.

	Total
Five Class (No Score)	48.02%
Three Class (No Score)	28.32%

Ethnic background / group	White	Mixed / multiple ethnic background	Asian / Asian British	Black / African / Caribbean / Black British	Arab	Other
Five Class (No Score)	43.10%	52.19%	61.15%	57.92%	52.65%	63.00%
Three Class (No Score)	22.27%	33.96%	44.78%	39.38%	31.19%	48.15%

Age	16-20	21-30	31-40	41-50	51-65	66+
Five Class (No Score)	59.53%	50.72%	49.32%	46.39%	45.51%	49.12%
Three Class (No Score)	36.00%	29.37%	29.11%	27.12%	26.44%	29.81%

Recruited from aboard	Yes	No
Five Class (No Score)	59.67%	46.42%
Three Class (No Score)	42.17%	26.36%

Survey Coordination Centre

NHS

Appendix E: Additional reporting outputs

Note: where there are fewer than 10 responses for a question this data is not shown in the chart to protect the confidentiality of staff and reliability of results.

Appendix E: Additional reporting outputs

Survey Coordination Centre NHS

Below are links to other key reporting outputs that complement this report. A full list and more detailed explanation of the reporting outputs is included in the Technical Guide.

Supporting documents

Guide to Understanding and Using Results: Provides a brief overview of the NHS Staff Survey data and details on what is contained in each of the reporting outputs.

Technical Guide: Contains technical details about the NHS Staff Survey data, including data cleaning, weighting, benchmarking, People Promise, historical comparability of organisations and questions in the survey.

Other reporting outputs

Online Dashboards: Interactive dashboards containing results for all trusts nationally, each participating organisation (local), and for each region and ICS. Results are shown with trend data for up to five years where possible and show the full breakdown of response options for each question.

Breakdown reports: Reports containing People Promise and theme results split by breakdown (locality) for East and North Hertfordshire Teaching NHS Trust.

National Briefing Document: Report containing the national results for the People Promise elements, themes and sub-scores. Results are shown with trend data for up to five years where possible.

Detailed spreadsheets Contain detailed weighted results for all participating organisations, all trusts nationally, and for each region and ICS.

Board

NHS
East and North Hertfordshire Teaching
NHS Trust

CHIEF EXECUTIVE'S REPORT

Trust Board – 9 September 2026

1. Introduction

Since my last report to the Board, I have continued to spend considerable time meeting colleagues across the trust, visiting services and speaking with clinical and operational teams.

My early impressions remain positive. There is considerable expertise, commitment and ambition within the trust and a strong desire amongst colleagues to improve services for patients.

The past two months have also reinforced some of the areas where we need to improve. These include greater consistency of leadership and management, clearer accountability, better use of our existing clinical capacity and a stronger ability to translate decisions into delivery at pace.

My first months as chief executive have necessarily involved listening and understanding. That will continue, but we are increasingly moving into a phase where the emphasis must be on action and measurable improvement.

2. National NHS developments

The most significant change in the national context since the Board last met has been the appointment in July of Yvette Cooper MP as Secretary of State for Health and Social Care.

While it remains relatively early in her tenure, the messages from Government and NHS England continue to suggest considerable continuity in the overall direction of travel for the NHS. The emphasis remains firmly upon improving access and outcomes for patients while restoring financial sustainability and significantly improving productivity.

Sir Jim Mackey, Chief Executive of NHS England, has continued to emphasise the need to move beyond short-term recovery and address some of the more fundamental ways in which care is organised. This includes transforming traditional outpatient models, reducing avoidable hospital admissions and bed days through stronger neighbourhood services, improving urgent-care pathways and making much greater use of technology to improve productivity and access.

There is also an increasingly clear expectation that financial sustainability and quality improvement should be mutually reinforcing rather than competing objectives. The new Quality Strategy for NHS-funded care in England, published in July, reinforces this approach, placing greater emphasis upon consistent quality management, reducing unwarranted variation, transparency, effective leadership and the systematic use of improvement methods.

For the trust, the overall national message is therefore one of continuity but also increasing expectation. The direction is well established: better access and outcomes for patients, greater productivity and value from the resources available to us, more care delivered outside traditional hospital settings where appropriate, greater use of digital technology and stronger leadership and accountability for delivery.

These priorities are closely aligned with the improvement agenda we are already pursuing within the trust. Our challenge is increasingly less about understanding the national direction and more about ensuring that we have the leadership, capability and organisational discipline to translate it into meaningful and sustained improvement for our patients.

3. Quality, safety and diagnostics

The Board receives detailed information on operational and clinical performance elsewhere on today's agenda and I will therefore not duplicate that reporting here. I do, however, want to continue to highlight diagnostic services, and radiology in particular, as an area requiring significant organisational focus.

Waiting and reporting performance has been unacceptable for too long and has attracted concern from both NHS England and the Care Quality Commission. A substantial improvement programme is now under way, supported by additional transformation capacity and increasing clinical and managerial engagement.

Our objective must be to establish a sustainable diagnostic service which provides timely access and reporting for patients while reducing the trust's exceptional reliance upon outsourced and premium-cost arrangements.

The Board will also consider maternity and neonatal services and the implications of recent national reviews in greater detail elsewhere on today's agenda. The wider message for the trust is clear: we need continually to learn not only from our own experience but from national investigations and emerging evidence across the NHS.

4. Our people, leadership and management

Two significant national developments over the summer have reinforced the importance of leadership, management and staff experience.

The new NHS Staff Standards establish minimum expectations around line management, health and wellbeing, tackling racism, flexible working, violence prevention and sexual safety.

Alongside these, the new NHS Leadership and Management Framework seeks to establish greater consistency in the behaviours, standards and competencies expected of NHS leaders and managers. I welcome both developments.

Much of an individual's experience of working within the NHS is determined by the quality of their immediate leadership and management. Good management creates clarity, supports people, addresses poor behaviour and performance when necessary and creates an environment in which staff can do their best work.

Neither framework represents wholly new work for the trust. We will use them to bring together and strengthen the leadership, management, culture and staff-experience work already under way across the Trust.

This also connects with the extensive engagement I have undertaken with our consultant body during my first months as chief executive. Those discussions have reinforced both the commitment of our medical workforce and the importance of developing stronger clinical leadership and a closer partnership between clinicians, operational managers and executive leaders.

5. Tim Lane - President, Royal College of Surgeons of England

I am delighted to recognise the appointment of Mr Tim Lane, Consultant Urological Surgeon at East and North Hertfordshire Teaching NHS Trust, as president of the Royal College of Surgeons of England. Tim's appointment is particularly significant as he is the first president in the College's history to be directly elected by its members and fellows. Having been part of our trust since 2007, Tim has built an exceptional career combining clinical excellence with innovation, research, education and training. His election is an outstanding personal achievement and a source of enormous pride for the trust, demonstrating the national and international impact our clinicians can have while continuing to serve our local communities.

6. Our estate, summer resilience and Better Places programme

This summer has again demonstrated the challenges increasingly warm weather can create for patients and staff.

I want to thank colleagues across the trust who have worked extremely hard during periods of high temperature to keep patients, visitors and staff as safe and comfortable as possible.

That resilience should be recognised, but it cannot be our long-term answer. Increasingly frequent periods of extreme heat mean we need to give greater attention to summer resilience, alongside our established planning for winter. This includes understanding vulnerabilities within our estate and considering ventilation, cooling and wider climate resilience within future capital and business-continuity planning.

We have also launched Better Places, a trust-wide programme through which £1 million of our capital programme has been allocated to practical improvements across our sites.

During my visits around the organisation, colleagues have repeatedly highlighted everyday estate problems which can appear small individually but collectively have a significant impact upon safety, dignity, morale and the experience of patients and staff.

Better Places is intended to enable us to respond more quickly to those concerns and demonstrates an important principle: if something matters to colleagues who work in our buildings every day, it should matter to the organisation.

Alongside this work, October will see the opening of the new main entrance at the Lister. The development will provide a much-improved welcome for patients and visitors, new retail facilities and modern flexible workspace for staff. It will also allow us to reduce our reliance upon leased accommodation, generating savings of approximately £350,000 each year.

Together, these developments demonstrate that while we must continue to make the case for significant national investment in our estate, we must also take better care of the buildings we have and be creative in how we invest for the future.

7. Digital resilience and protecting patient information

NHS England has recently reinforced the importance of treating cyber security as a clinical and operational risk, rather than simply an IT issue.

The trust will continue to review its resilience against strengthened national requirements, including our preventative controls, business-continuity arrangements and ability to recover critical clinical services following a significant digital incident.

NHS England has also written to organisations following incidents nationally in which staff accessed patient records without a legitimate clinical or professional reason. The expectation is straightforward: access to patient information must only take place where there is a legitimate reason connected with an individual’s role.

We will reinforce this message with colleagues and continue to strengthen our arrangements for preventing, monitoring and investigating inappropriate access. Patients entrust the NHS with highly sensitive information. Protecting that information is fundamental to maintaining their confidence in us.

8. Transformation Programme – Better Care, Better Value

The trust’s transformation programme, Better Care, Better Value, continues to progress, with the full 2026/27 CIP requirement now identified. To date 81.5% of the target has been validated, with the remaining progressing through the validation process.

Delivery is increasingly focused on securing recurrent benefits through the trust's priority transformation programmes covering theatres, outpatients, diagnostics, medical and , nursing workforce and urgent and emergency care and flow.

Programme governance and delivery arrangements are established, with work progressing across productivity, workforce controls, establishment reviews, temporary staffing, patient flow and operational efficiency. This governance has seen the transformation programme deliver ahead of plan both in-month (M4) and year to date. The robust delivery cadence is essential as the trust strives to make large-scale changes and financial savings in tandem and hence the governance of the programme is of paramount importance.

Quality impact assessment remains embedded within the programme with moderate and high-risk schemes subject to enhanced oversight and regular review through established governance arrangements.

The immediate priority is to maintain delivery momentum, complete full validation, address areas currently behind plan and continue to strengthen recurrent delivery to support achievement of the full-year target.

9. Looking ahead – winter and organisational improvement

Planning for winter 2026/27 is already well advanced. National expectations place increasing emphasis upon the contribution of the whole health and care system, including primary care, community response, virtual wards, discharge and social care.

This is welcome. Winter resilience cannot simply be an acute hospital capacity exercise.

The trust is therefore working with partners to ensure that learning from last winter translates into practical improvements for the coming months. Ultimately, the best preparation for winter remains strong operational performance, effective patient flow and good partnership working throughout the year.

More broadly, the autumn will be an important period for the trust. We have significant operational and financial challenges to address, but also an opportunity to strengthen the organisation for the longer term.

Sustainable improvement will require better leadership and management, clearer accountability, more effective use of our clinical capacity, stronger partnership with our clinicians and greater discipline about the priorities upon which we focus.

I remain optimistic about our ability to make that progress.

That optimism does not come from underestimating the challenges. It comes from what I continue to see across the trust: considerable clinical expertise, colleagues who care deeply about the services they provide and a genuine appetite for the organisation to improve.

Our responsibility now is to translate that commitment into sustained improvement for our patients and staff.

Martin Armstrong
Chief Executive
East and North Hertfordshire Teaching NHS Trust
September 2026

Board

East and North Hertfordshire Teaching NHS Trust

Meeting	Public Trust Board		**Agenda Item**	9	
Report title	Patient and Public Engagement Strategy		**Meeting Date**	9 September 2026	
Author	Director of Communications and Engagement				
Responsible Director	Director of Communications and Engagement				
Purpose	**Assurance**	☐	**Approval/Decision**	☒	
	Discussion	☐	**For information only**	☐	
Proposed assurance level (*only needed for assurance papers*)	**Substantial assurance**	☐	**Reasonable assurance**	☐	
	Partial assurance	☐	**Minimal assurance**	☐	

Executive assurance rationale:

N/A

Summary of key issues:

The trust public and Patient Engagement Strategy provides a high level road map for our engagement activities up to 2030.

There is a legal requirement to engage and consult with our public in service changes. And beyond this, engaging effectively with our communities ensures that they have a voice in how we deliver and improve our services.

The strategy details how the trust will:

1. Strengthen patient and community voice in our trust
2. Build an inclusive and representative approach
3. Listen, learn and act
4. Increase co-production
5. Improve partner and community engagement

It's recognised that many networks already exist to reach our communities, and we will work with NHS and local authority partners to join up our contact with communities, and also to share intelligence.

A proposed timeline is included in the strategy, and is of course dependent on resource to deliver this work.

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

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

This strategy should increase equity for patients – particularly through seeking out and listening to those who may seldom have a voice in shaping services.

System partners will work together to join up engagement activity, and also to share insight.

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

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

Identified Risk: *Please specify any links to the BAF or Risk Register*	
The Board Assurance Framework identifies patient and public engagement as an area requiring focus.	
Report previously considered at & date(s):	
This is a refreshed and updated strategy – the previous iteration was considered and approved in July 2024 at Trust Board.	
Recommendation	The Board is asked to APPROVE the strategy.

To be trusted to provide consistently outstanding care and exemplary service

August 2026

East and North Hertfordshire Teaching NHS Trust

Public and Patient Engagement Strategy 2026 – 2030

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Introduction

One of the findings of Lord Darzi's 2024 review into the NHS states that "the patient voice is not loud enough" in pursuing high-quality care and better patient experience.

We know the people who use our services are experts in their own experiences. Patients, carers, families and local communities hold invaluable insight that helps us improve care, design services and ensure we are delivering what matters most.

We also know that we need to do better at listening to that insight and amplifying the patient voice – involving, engaging, consulting and co-creating with our communities on service improvements and changes.

Through this strategy we aim to make the voice of our patients, carers, families and communities stronger, and we will listen and where possible act on what you tell us. We will also be honest about where we may not be able to take action.

Our legal duty to engage:

We also have a duty to involve patients, as laid out in the National Health Services Act 2006 (as amended by the Health and Care Act 2022).

A requirement to involve the public is also a service condition in the NHS Standard Contract for Providers:

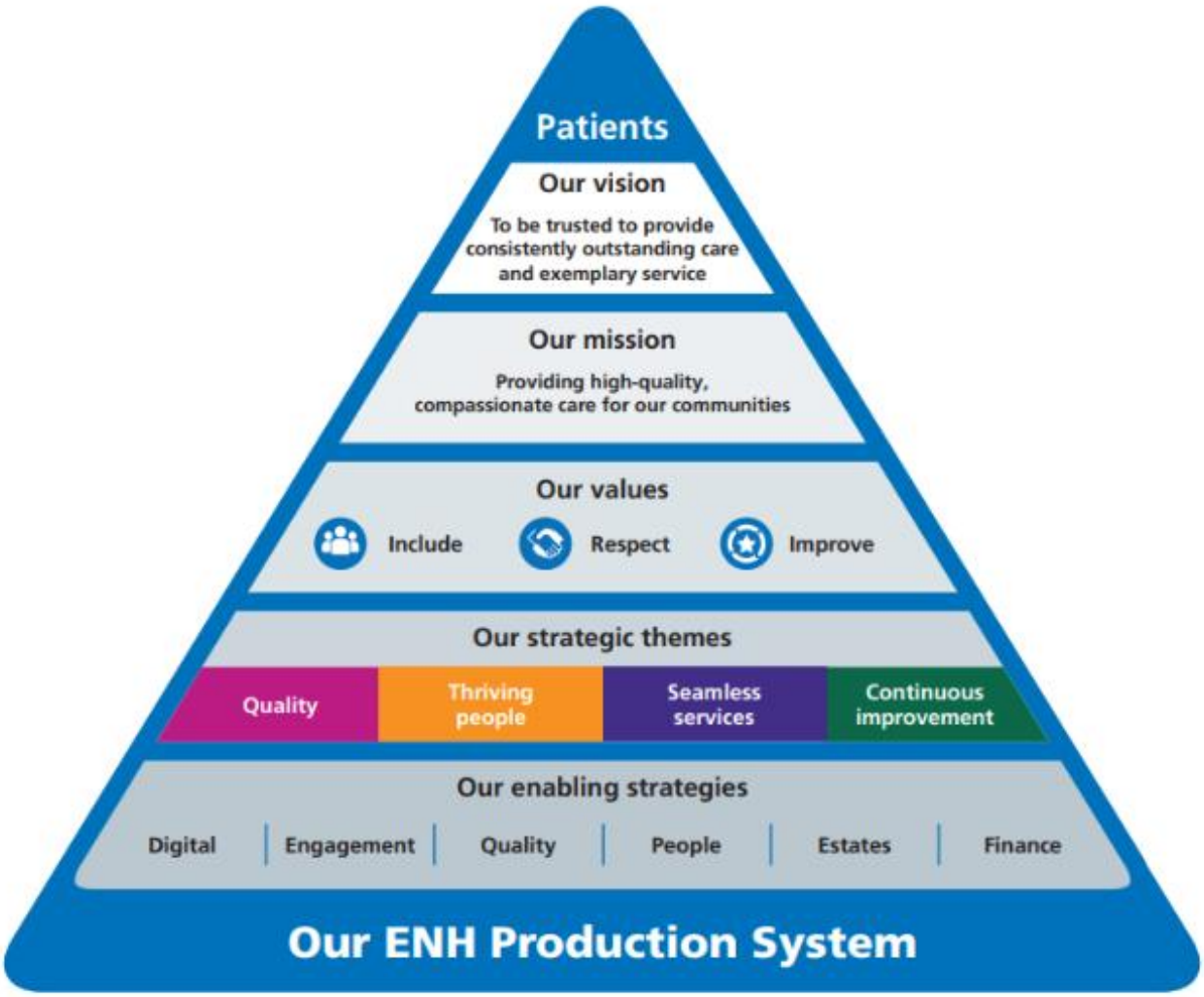
- The trust must comply with the Accessible Information Standard
- The trust must actively engage, liaise and communicate with service users (and, where appropriate, their carers and legal guardians), staff, GPs and the public in an open, clear and accessible manner, seeking feedback whenever practicable …the provider must have regard to health literacy in order to support people to make informed decisions.
- The trust must involve service users (and, where required by law or otherwise appropriate, their carers and legal guardians), staff, service users' GPs and the public when considering and implementing developments to and redesign of services.

Indeed, there are situations where the trust is legally obliged to formally consult our patients and publics – rather than simply engage with them. This strategy does not cover formal consultation, and teams who are considering changes to how a service is delivered or accessed should immediately contact:

- The trust's communications and engagement team
- The trust's contracting team

This strategy sets out how we will work in partnership with patients, carers, communities, voluntary organisations, Healthwatch, local authorities and wider stakeholders between 2026 and 2029. It builds on our previous Public and Patient Engagement Strategy and aligns closely with our forthcoming Patient and Carer Experience Strategy, placing the patient voice at the heart of decision making, quality improvement and service development.

Our trust – a summary



Engagement with our patients, public and stakeholders is essential at all points throughout the work of our trust.

Our vision **to be trusted to provide consistently outstanding care and exemplary service** can be broken down into three elements, each with patients at the centre:

Trusted: That the manner and outcomes of our services means our communities trust us with their care.

Consistent: No matter where, when or how people access our services, their experience should be of consistently outstanding care.

Exemplary service: Ensuring that our patients and communities receive a high standard of service in addition to their clinical care – from the first contact to the last.

Our work is underpinned by the East and North Herts Production System (ENHPS) – how we run our services, and improve our services. A core part of the ENHPS is involving patients in improvement – and truly understanding how it feels to be cared for by the trust.

Our values: Include, Respect, Improve

Our values drive how we behave – towards each other, with patients, carers and families, and with our partners.

In all our engagement work we will seek to:

- **Include** as many voices as possible, and create opportunities for people to get involved in ways that best support them.
- **Respect** the viewpoints of those who engage with us, and our patients families and carers. We will be clear about what is possible to change, and what is not, so that people's time is respected.
- **Improve** how we work with our communities, and use their voices to improve our services.

National context

The NHS 10 Year Health Plan places communities at the heart of designing and delivering health services, recognising that better outcomes are achieved when people are actively involved in decisions about their care and the services they use.

The three key ambitions of the plan are to:

1. Hospital to Community
2. Analogue to Digital
3. Sickness to Prevention

Meaningful community engagement is therefore essential, ensuring that patients, carers, residents and community groups have a genuine voice in setting priorities, influencing service development and helping the NHS to create more accessible, responsive and equitable care.

Our principles of engagement

The trust will align with the principles of engagement as set out by NHS England in its statutory guidance, and with our local system partners:

1. We will be open and transparent. We will make our decision-making public, through livestreaming our Board meetings and annual general meeting, and we will be open where things need to improve.
2. We will listen and act. We will ask for feedback, respond to what we hear, and demonstrate how involvement has influenced decisions and improvements.
3. We will improve equality and inclusion. We will proactively engage with people and communities whose voices are often underrepresented and work to address health inequalities in accessing care, and in patient experience.
4. We will provide clear, accessible information. We will make information available in a range of formats and ensure it is written in plain English, helping people to understand health information and terminology.
5. We will work in partnership. We will work with our NHS and public sector partners, and voluntary, community, faith and social enterprise groups, representative groups, and charities. We will seek to use existing networks where possible to reduce the burden on groups. We will work as a network to create more opportunities for care to be given closer to home.
6. We will ensure patients, carers and communities can influence trust decision-making. We will focus on the impact of engagement and how it shapes our work, rather than simply measuring participation numbers.

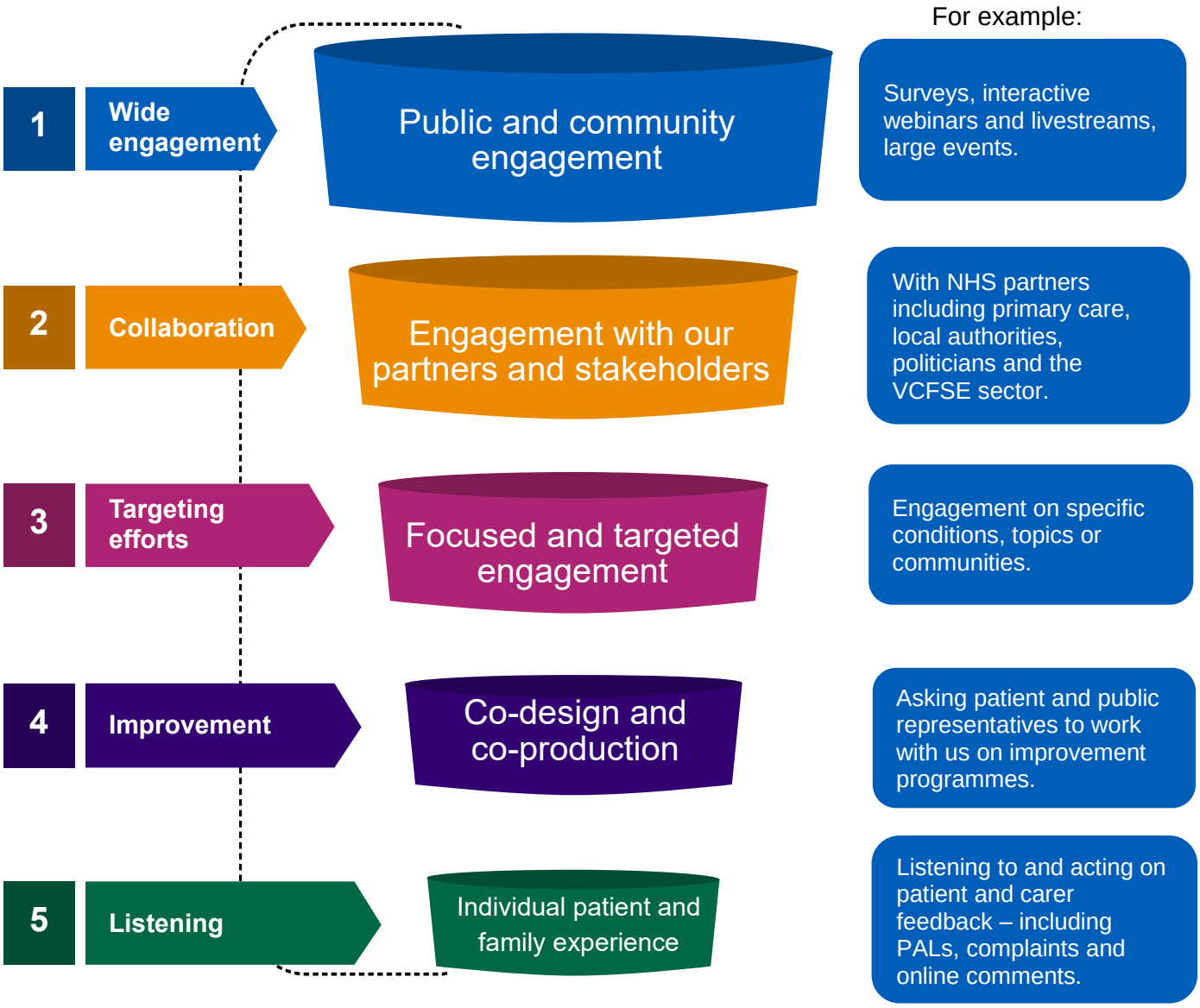
Co-producing priorities

This strategy focuses on how the trust will strengthen patient, public and community engagement.

It does not set out the specific topics we will engage on. This is intentional. Engagement priorities will be shaped through feedback from our patients, communities and stakeholders, alongside the forthcoming East and North Herts (ENH) Patient and Public Panel, national priorities, and data highlighting areas of health inequality.

However, as mentioned above, the three areas in the NHS 10 Year Plan will form much of the basis of our engagement work.

How we will engage



The image above shows our framework for engagement – from public and community engagement, through to more focused engagement, to the individual patient and family experience.

How we will improve our engagement over the next few years:

1. Strengthen patient and community voice in our trust

We will create accessible and meaningful opportunities for involvement across the trust.

We will:

1. Continue to develop our membership – with multiple levels of involvement, and clear service areas to get involved in.
2. Develop the ENH Patient and Public Panel as a place wide forum, linking primary, secondary, community and council services.
3. Increase staff awareness of the value and methods of engagement
4. Support routes for patient feedback and involvement in services – establishing a menu of involvement for patients and carers to get involved as experts by experience
5. Increase patient representation in trust projects, appropriate committees, and governance structures.
6. Support patient participation in service redesign and improvement.
7. Create opportunities for young people to engage in providing feedback and improving services
8. Ensure flexible hybrid opportunities are available to engage.

How we will know if we have improved in this area:

- A clearer offer for members and improved database for finding the right people to involve
- The ENH Patient and Public Panel will be set up and running, with a clear work plan
- Increased diversity of participants involved in projects and services – with greater influence
- Positive patient feedback on involvement experience and influence
- Patient representation at committees and in services and work programmes

When will patients see benefits:

2026/27	2027/28	2028/29	2029/30
• review membership arrangements • establish ENH Patient and Public Panel • create menu of involvement for staff and communicate • identify representation opportunities • develop youth engagement proposals	• relaunch membership • launch ENH Panel work programme • Share good practice examples internally • implement youth involvement options • build case studies	• expand participation across committees and programmes • review and evaluate involvement arrangements	• review effectiveness of the ENH Panel • refresh membership and involvement pathways • agree future priorities

2. Build an inclusive and representative approach

We want people to find it easy to get involved in sharing views about our services, and to get involved in improving them. We also want to make sure that our engagement activities support improving health equity, and also the accessibility of our services.

We will:

1. Report regularly to the ENH Patient and Public Panel, and also the trust board, on engagement activity, including demographic data and highlighting impact
2. Focus outreach on underserved communities and groups experiencing health inequalities – particularly those with intersectionality.
3. Strengthen relationships with voluntary, community, faith, and social enterprise groups
4. Improve accessibility of our information – continuing our patient information refresh – and ensuring our engagement methods are accessible to as many as possible.
5. Develop and grow the trust Readers Panel to support more accessible information.
6. Develop targeted engagement plans for specific communities when needed.

How we will know if we have improved in this area:

- Increased participation from under-represented groups
- Participants feedback on accessibility of information and engagement opportunities.
- Increased membership of Readers Panel with more diversity.

When will patients see benefits:

2026/27	2027/28	2028/29	2029/30
• establish demographic reporting • map underserved communities • strengthen VCFSE links • continue patient information refresh • develop Readers Panel • establish equity priorities for engagement	• deliver targeted outreach • establish website improvement group	• develop targeted plans where participation remains low • use engagement data to support health inequalities work	• evaluate progress on representation, inclusion and accessibility • identify future priorities

3. Listening, learning and acting

We will bring together insight from all sources to better understand patient and community experience.

We will:

1. Triangulate feedback from patient experience feedback (for example Friends and Family Tests, complaints, PALS) with surveys, patient stories, social media and engagement activities.
2. Use digital tools and AI-enabled analysis where appropriate to identify themes and trends.
3. Use the patient voice to share the impact of improvements.
4. Share feedback and actions openly with patients, staff and stakeholders.
5. Ensure all services demonstrate how they have responded to feedback.
6. Publish regular "You Said, We Did" updates – with a dedicated section on our website and in member updates.

How we will know if we have improved in this area:

- Increased evidence of service changes resulting from feedback.
- Improved patient experience indicators.
- Increased staff awareness of patient feedback themes.

When will patients see benefits:

2026/27	2027/28	2028/29	2029/30
• map feedback sources • develop insight framework • design You Said, We Did approach • establish reporting arrangements • introduce AI analysis	• launch regular You Said, We Did reporting • support services to demonstrate actions • increase digital reporting	• further develop AI-enabled thematic analysis where appropriate • improve sharing of patient stories and improvements	• publish four-year impact report • demonstrate how feedback influenced decisions and improvements

4. Increase co-production

We will embed co-production as a standard approach to improvement.

We will:

1. Ensure patients, carers and communities are involved from the earliest stages of service change.
2. Develop a trust service change checklist which outlines the need to engage and potentially consult.
3. Create a framework supporting co-design and co-production activities, with a clear compact for people getting involved in our projects.
4. Develop a menu of involvement opportunities for quality improvement projects and service redesign.
5. Ensure all major transformation programmes include lived experience input.
6. Support our teams to work more effectively with patient partners.
7. Share examples of successful co-produced improvements across the trust.

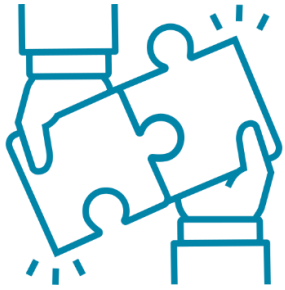
How we will know if we have improved in this area:

- Number of co-produced projects.
- Patient partner participation in improvement work.
- Evidence of service changes influenced by lived experience.

When will patients see benefits:

2026/27	2027/28	2028/29	2029/30
• input into and share Service Change Checklist • create co-production framework • finalise and share menu of involvement in QI	• introduce patient partners into QI projects • create recruitment standard work	• ensure major transformation programmes include lived experience input • share co-production examples	• evaluate adoption of co-production • identify future priorities

5. Improve partner and community engagement



We will strengthen our relationships with organisations and communities across Hertfordshire.

We will:

1. Work ever more closely with the partner organisations in the East and North Herts Health and Care Partnership on local joined up approaches.
2. Build relationships with schools, youth organisations and community groups – using existing networks if appropriate.
3. Continue to develop AGM activity, public events and webinars.
4. Maintain strong stakeholder relationships with local authorities, MPs and wider partners.

How we will know if we have improved in this area:

- Increased joint engagement initiatives.
- Positive stakeholder feedback.
- Greater reach into local communities.

When will patients see benefits:

2026/27	2027/28	2028/29	2029/30
• strengthen relationships with Healthwatch, community organisations and HCP partners • review stakeholder arrangements • build framework for MP engagement • strengthen local authority links	• explore join engagement initiatives • work with local authorities to share messaging via community networks • expand AGM as engagement opportunity	• embed engagement activity with new local authorities • evaluate activity	• review partnership arrangements • co-produce priorities for next strategy

Governance

The strategy will be overseen through:

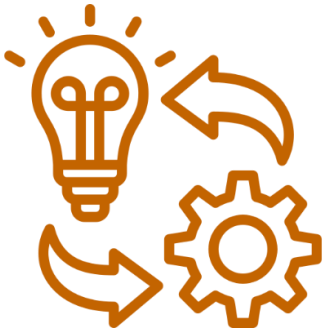
- Patient Experience Sub-Committee
- Quality and Safety Committee
- Trust Board

The ENH Patient and Public Panel will provide direct input into governance arrangements and strategic discussions, ensuring the patient voice remains central to decision making.

A formal reporting pathway through the Patient Experience Sub-Committee will connect up:

- ENH Patient and Public Panel
- Community groups
- Healthwatch
- PALS and Complaints
- Patient surveys
- Divisional forums

What success will look like in 2030



- Patients and carers will be recognised as equal partners in improvement.
- The ENH Patient and Public Panel will be a respected and influential voice within health care partnership and trust governance.
- Diverse communities will feel heard and represented.
- Co-production will be embedded across major programmes and service redesign.
- Feedback from patients and carers will routinely drive improvements.
- Patients and the public report having meaningful engagement in the three priorities of the 10 Year Plan.
- The trust will be able to demonstrate measurable improvements in both patient experience and involvement.

Appendix 1: Work plan 2026 - 2030

This draft work plan will be shaped by emerging priorities and public shaping. Pace of progress will be influenced by resourcing – and may be expedited should future resource become available.

Priority	2026/27 Establish Foundations	2027/28 Embed Engagement	2028/29 Scale and Strengthen	2029/30 Evaluate and Sustain
1. Strengthen patient and community voice	• review membership arrangements • establish ENH Patient and Public Panel • create menu of involvement for staff and communicate • identify representation opportunities • develop youth engagement proposals	• relaunch membership • launch ENH Panel work programme • share good practice examples internally • Implement youth involvement options • build case studies	• expand participation across committees and programmes • review and evaluate involvement arrangements	• review effectiveness of the ENH Panel • refresh membership and involvement pathways • agree future priorities
2. Build an inclusive and representative approach	• establish demographic reporting • map underserved communities • strengthen VCFSE links • continue patient information refresh • develop Readers Panel • establish equity priorities for engagement	• deliver targeted outreach • establish website improvement group	• develop targeted plans where participation remains low • use engagement data to support health inequalities work	• evaluate progress on representation, inclusion and accessibility • identify future priorities
3. Listening, learning and acting	• map feedback sources • develop insight framework • design You Said, We Did approach • establish reporting arrangements • introduce AI analysis	• launch regular You Said, We Did reporting • support services to demonstrate actions • increase digital reporting	• further develop AI-enabled thematic analysis where appropriate • improve sharing of patient stories and improvements	• publish four-year impact report • demonstrate how feedback influenced decisions and improvements

4. Increase co-production	• input into and share Service Change Checklist • create co-production framework • finalise and share menu of involvement in QI	• introduce patient partners into QI projects • create recruitment standard work	• ensure major transformation programmes include lived experience input • share co-production examples	• evaluate adoption of co-production • identify future priorities
5. Improve partner and community engagement	• strengthen relationships with Healthwatch, community organisations and HCP partners • review stakeholder arrangements • build framework for MP engagement • strengthen local authority links	• explore join engagement initiatives • work with local authorities to share messaging via community networks • expand AGM as engagement opportunity	• embed engagement activity with new local authorities • evaluate activity	• review partnership arrangements • co-produce priorities for next strategy

Board

East and North Hertfordshire Teaching NHS Trust

Meeting	Trust Public Board		**Agenda Item**	10	
Report title	Digital Programme Update		**Meeting Date**	9 September 2026	
Author	Chief Information Officer				
Responsible Director	Chief Information Officer				
Purpose	**Assurance**	☐	**Approval/Decision**	☐	
	Discussion	☐	**For information only**	☒	
Proposed assurance level (*only needed for assurance papers*)	**Substantial assurance**	☐	**Reasonable assurance**	☐	
	Partial assurance	☐	**Minimal assurance**	☐	

Executive assurance rationale:

Not applicable – this report is presented for information.

Summary of key issues:

The Trust's digital programme continues to support key clinical and operational priorities. Progress is being made across outpatient transformation, clinical risk reduction and innovation.

OneEPR remains rated Red because of delays in software delivery from the supplier. The supplier has now committed to making the required core software available in January 2027, supporting a go-live within the 2027/28 financial year. End-to-end assurance will remain essential to confirm that complete clinical pathways operate safely and reliably.

MediViewer remains stable, with approximately 92% of outpatient records available within the required timeframe. Work continues to address delays affecting the remaining records which primarily are associated with legacy process.

Targeted solutions for diabetes, pre-operative assessment and gastroenterology are being progressed to reduce immediate clinical and operational risks while the full OneEPR capability is developed. These projects require clear ownership, confirmed funding, appropriate safety assurance and defined transition plans.

Innovation, including the responsible use of AI, is focused on practical opportunities to release clinical time, improve patient access and reduce administrative workload. Wider adoption will depend on clear evidence of safety, benefit, value and staff and patient uptake.

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

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

Positive impact is expected through safer clinical workflows, improved patient access and capacity, reduced administrative burden, stronger system integration and measurable financial and operational benefits.

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

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

Identified Risk: *Please specify any links to the BAF or Risk Register*	
Strategic Risk 07 – OneEPR; associated clinical continuity, supplier dependency, integration, infrastructure and organisational-readiness risks.	
Report previously considered at & date(s):	
Recommendation	The Board is asked to **NOTE** the Digital Programme update, the current delivery position and the assurance implications set out in the accompanying presentation.

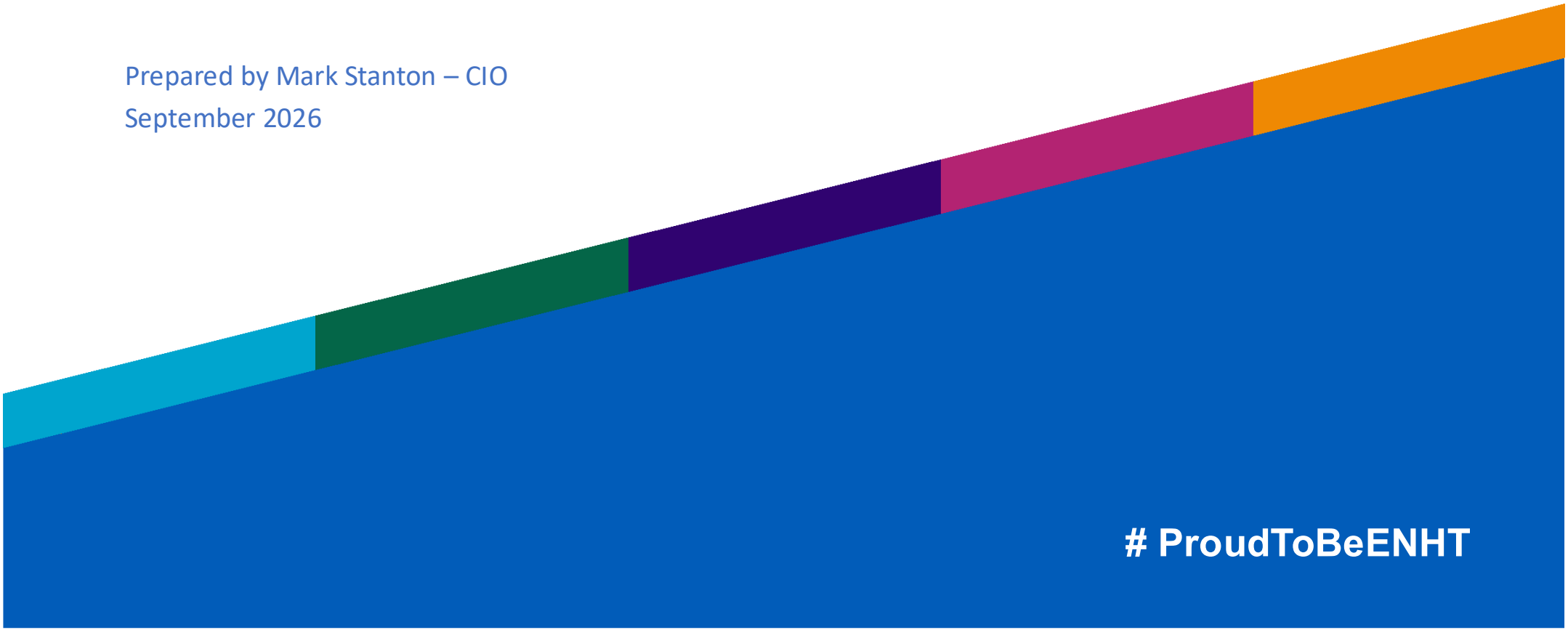
To be trusted to provide consistently outstanding care and exemplary service

Digital Programme Update

East and North Hertfordshire Teaching NHS Trust

Prepared by Mark Stanton – CIO

September 2026



NHS
East and North Hertfordshire Teaching NHS Trust

Digital Programme Update

Trust Board Update | September 2026

Digital delivery now extends across the enterprise EPR, outpatient transformation, clinical risk mitigation, innovation, pathology and specialist clinical systems.

OneEPR Integrated clinical platform	**Outpatients** Pathway redesign & digital access	**Clinical Mitigations** Risk reduction during transition
Innovation Capacity, access & productivity using AI	**Pathology** Systems, integration & service transition	

ONEEPR PROGRAMME

OneEPR is creating an integrated clinical platform but delivery confidence depends on proving the solution end to end

The programme reaches across clinical workflows, medicines, diagnostics, devices, operational information and patient access.

Delivery Footprint

- Urgent and emergency care, electronic prescribing, order communications and results, and outpatients.
- Planned care, theatres, anaesthetics and intensive care.
- Clinical workflow configuration, pathway design and validation with frontline teams.
- Integration with diagnostics, patient administration, monitoring equipment and end-user devices.
- Data migration, reporting, clinical safety and organisational readiness.

Progress Achieved

- 2,300 drug lines configured and progressing through clinical validation.
- Clinical assessments and forms completed or approved; integration and outpatient scenario testing under way.
- Technical work progressing across infrastructure, devices, monitoring, identity and performance.
- ENH and Dedalus leadership have established stronger joint ownership and escalation
- Integration into Ward clinical equipment (Spot Monitors)

Shift in Delivery Approach

The programme is moving from testing individual components to demonstrating complete clinical pathways. End-to-end walkthroughs and integrated testing will show how the overall solution operates across teams, systems and care settings.

Key Delivery Milestones

January 2027

Core OneEPR software delivered to support a 2027 go-live

August 2027

Planned-care functionality software delivered

⚠ ⚑ **Board Implication:** The programme remains **Red** not because of insufficient activity, but because the integrated solution, supplier dependencies and delivery baseline are not yet fully assured. Board confidence should be linked to evidence that complete clinical pathways work safely, reliably and at the required scale.

OUTPATIENT TRANSFORMATION

Digital enablement spans the full pathway and is central to converting operational redesign into measurable capacity

The Digital programme has been split with Operational efficiency (1&2) moving to the Transformation programme led by Deloitte and Item 3 remaining as an aligned Digital delivery. The CIO remains SRO for all streams

1 (TBC)

Manage Demand More Effectively

- Improved referral and triage processes; waiting-list validation and improved demand visibility.
- Better information to direct patients to the most appropriate service.

2 (TBC)

Increase Productivity

- Standardised clinic templates aligned with demand and capacity; improved booking and scheduling using the 6-4-2 approach.
- Better use of clinic rooms and available appointment slots.
- Automation of selected booking and administrative processes.
- Redesigned follow-up pathways and risk-stratified discharge.

3 (Q4 26/26)

Improve Patient Access/Digital Frontdoor

- Patient Hub, digital appointment information and digital self-check-in.
- Digital AI patient-initiated follow-up and remote/virtual pathways where clinically appropriate.
- Automated responses to routine outpatient enquiries.
- Enhance on current level of NHS App integration

Health Records

Full deployment of MediViewer across outpatient services. The platform is stable and operating to specification, enabling digital access to outpatient records. Approximately 92% of records are available within the required timeframe. Improvement work is addressing the remaining delays arising from warehouse efficiency, local processes and legacy-record issues.

⚑ **Board Implication:** Digital and operational change must be managed as **one transformation**. Success should be demonstrated through reduced waiting times, improved clinic utilisation, fewer avoidable follow-ups, lower administrative workload and better patient experience — not simply delivery of technology.

CLINICAL RISK MITIGATION

Targeted digital interventions are protecting clinical services while the complete OneEPR capability is developed

The Trust is not waiting for the strategic EPR where delays create immediate clinical or operational exposure.

Adult and Paediatric Diabetes

Dedicated product lead assigned; due diligence and current-state assessment under way with clinical stakeholders; preferred replacement solution identified; delivery plan in development for 2026.

Pre-operative Assessment

Product leadership and clinical engagement in place; preferred solution and procurement route identified; programme will support assessment, preparation and information flow ahead of surgery; detailed implementation plan being prepared for 2026.

Gastroenterology

Configurable Lorenzo-based order and results solution proposed; faster route to clinical functionality; delivery could be completed within **six weeks** of stakeholder approval.

Common Assurance Controls Across All Interventions

Ownership

Named clinical and operational ownership

Safety

Clinical-safety assessment and hazard management

Integration

Integration with existing and future systems; end-to-end pathway testing

Transition

Defined implementation and transition arrangements

Benefits

Measurement of clinical, operational and financial benefits

⚠ ⚑ **Board Implication:** These interventions should be viewed as **clinical continuity and risk-reduction measures**, not tactical IT projects. Each requires an accountable owner, agreed implementation date, safety case, funding position and a clear exit or integration strategy once OneEPR capability becomes available.

INNOVATION PORTFOLIO

The innovation portfolio is targeting clinical capacity and patient access, with scale dependent on measurable evidence

NHS East and North Hertfordshire Teaching NHS Trust

Technology is being applied to defined service problems rather than pursued as a series of disconnected pilots.

Release Clinical Time

- Ambient voice technology to support clinical documentation and reduce avoidable administrative effort.
- Pre-operative assessment and ENT identified as initial pilot areas; interface with clinical-document repository designed.
- **First pilot targeted: October 2026.**

Improve Patient Access

- Patient portals, digital self-check-in and digital patient-initiated follow-up.
- Digital Waiting Well tools to support patients before treatment.

Automate Routine Work

- AI-enabled responses to routine outpatient enquiries; automation of selected booking and scheduling activities.
- Full copilot AI licenses now live within the ENH N365 tenant. **Pilot starts September 2026**
- Robotic process automation for repetitive administrative processes; better use of data to support patient flow and operational decision-making.

Scale-Up Test — Five Criteria for Wider Deployment

Clinical Safety

Does the technology operate safely within the clinical workflow?

Adoption

Do patients and staff use it consistently?

Capacity

Does it release measurable clinical or administrative time?

Experience

Does it improve patient and staff experience?

Value

Is there a sustainable financial and operational case for wider deployment?

⚑ **Board Implication:** The Trust should maintain a **controlled route from pilot to adoption**. Innovation should scale only where it produces evidenced improvements in safety, capacity, access, experience or cost — and where ownership moves into normal operational delivery.

PATHOLOGY PROGRAMME

Pathology demonstrates the breadth of Digital delivery beyond OneEPR, combining systems, integration, infrastructure and service transition

The programme is a multi-year clinical transformation involving HSL, Digital, clinical services, estates and operational teams.

Clinical Systems

- New laboratory information-management systems for blood sciences, microbiology and blood transfusion.
- Helix and supporting digital capabilities for cellular pathology; BloodTrack to strengthen management and traceability of blood products.
- Integration of analysers, imaging, reporting, dictation and specialist laboratory equipment.
- Continued access to legacy pathology information during and after transition.

Enterprise Integration

- Connection with OneEPR and the existing order communications and results environment.
- Integration with patient administration systems; connectivity with primary-care and community ordering and reporting.
- End-to-end testing across clinical, laboratory and technical pathways.

Digital Foundations

- Networks, workstations, printers, scanners and sample-tracking technology.
- Data extraction, migration, validation and reconciliation; identity, access and cyber-security controls.
- Business intelligence, service reporting and turnaround-time information; service-desk readiness, training, information governance and operational support.

⚠ ⚑ **Board Implication:** The critical challenge is **orchestration rather than any single system**. Safe transition depends on aligning laboratory works, equipment, applications, interfaces, data, testing, training and operational readiness to the same clinical milestones.

BOARD SUMMARY

Digital delivery is now embedded across the Trust's principal transformation priorities

NHS East and North Hertfordshire Teaching NHS Trust

OneEPR

Establishes the strategic clinical platform across all care settings and workflows.

Outpatient Digital Services

Convert pathway redesign into measurable capacity and improved patient access.

Clinical Mitigations

Protect services and reduce clinical risk during the strategic transition.

Innovation

Targets clinical time, patient experience and productivity through evidenced pilots.

Pathology & Specialist Systems

Extend the transformation across diagnostics and supporting infrastructure.

Board assurance should therefore consider Digital as an **integrated enterprise delivery portfolio** with common dependencies across clinical leadership, workforce capacity, supplier performance, data, infrastructure and benefits realisation.

Clinical Leadership

Named ownership and clinical engagement across every workstream

Workforce Capacity

Sustained organisational readiness and change management

Supplier Performance

Joint accountability with Dedalus, HSL and Deloitte

Data & Infrastructure

Foundations enabling safe migration and integration

Benefits Realisation

Measurable outcomes linked to each programme strand

Board

NHS
East and North Hertfordshire Teaching
NHS Trust

Meeting	Public Trust Board		**Agenda Item**	11	
Report title	Winter Provider Resilience Assurance Template 26/27		**Meeting Date**	9 September 2026	
Author	Deputy Chief Operating Officer and Hospital Director				
Responsible Director	Chief Operating Officer				
Purpose	**Assurance**	☐	**Approval/Decision**	☒	
	Discussion	☐	**For information only**	☐	
Proposed assurance level (*only needed for assurance papers*)	**Substantial assurance**	☐	**Reasonable assurance**	☒	
	Partial assurance	☐	**Minimal assurance**	☐	

Executive assurance rationale:

The winter provider resilience Assurance template has been completed for submission to the ICB by 31 August 2026. Board is asked to approve this submission.

Summary of key issues:

ENHT Winter Plan is in development with divisional and corporate leads taking into consideration national guidance and organisation experience and learning, this plan is supported by the Trust's established full capacity protocol and infection prevention and control policies.

The Trust will continue to work with CE system colleagues to proactively respond to winter pressures.

The winter plan will be approved by Trust Management Group and FPPC prior to being presented to Trust Board.

The Board is asked to note that the Trust will be running two multi-agency discharge events (MADE) in September and December to support with flow over the winter period, these will have executive sponsorship across key areas.

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

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

The delivery of key operational and quality performance standards is an important element of the Trust's statutory obligations, the winter plan will support delivery of these during periods of high acuity and demand.

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

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

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

There are no new risks which been added to the risk register	
Report previously considered at & date(s):	
N/A	
Recommendation	The Board is asked to approve the ICB submission and note the development of the full winter plan.

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Organisation:	East and North Hertfordshire NHS Trust
Completed by:	Redacted mails: Head of Site operations
Date:	27.08.2027

	Questions	Details	Evidence
1	What governance structures are in place to oversee winter planning and operational delivery?	The Trust's winter planning and operational delivery are monitored through the organisation's established performance assurance forums, including the Trust Management Group, Divisional Performance Senates, the Finance and Performance Committee, and the Quality and Safety Committee. These groups provide oversight of operational performance, delivery against key targets, and associated improvement programmes. The Specialist Advisory Group (SAG) is established and provides expert oversight of winter-related infection prevention and control risks, outbreak preparedness, surveillance activities, and organisational resilience. Day-to-day operational delivery is supported through a programme of daily operational meetings, the frequency and seniority of which are determined by the Trust's and UEC Operational Escalation (OpEL) status. These forums focus on patient flow across the hospital, length of stay, safer staffing, and the timely implementation of escalation actions where required. Urgent and Emergency Care (UEC) Board, chaired by the Chief Nurse as Senior Responsible Officer (SRO), is in place to oversee delivery of a comprehensive improvement programme aimed at enhancing urgent and emergency care performance and patient flow. Executive leadership is provided by the Chief Operating Officer, Chief Nurse, Medical Director, and Divisional Triumvirates, ensuring a coordinated, organisation-wide response to winter pressures and supporting the safe and effective delivery of services throughout the winter period	Daily operational and escalation meeting records. Specialist Advisory Group (SAG) minutes and action logs. Trust Management Group (TMG) minutes. Senate meeting minutes and assurance reports. Trust Quality and Safety Committee reports and action logs. UEC Board papers *Winter Planning Programme Board minutes.* *Patient Flow Steering Group and discharge governance reports.* *Winter risk register and assurance framework.*
2	Are IPC plans (PPE, Fit testing, IPC control measures) fit for purpose?	Yes. The Trust's Infection Prevention and Control (IPC) arrangements are fit for purpose and supported by robust governance structures, established policies, and operational procedures designed to mitigate healthcare-associated infections and manage seasonal infectious disease risks. The Infection Prevention and Control Policy provides the overarching framework for the prevention, surveillance, and management of healthcare-associated infections, including winter-related respiratory viruses and other communicable diseases. Personal Protective Equipment (PPE) provision is managed through the Trust's Logistics and Divisional teams, with regular monitoring of stock levels, usage trends, and supply chain resilience to ensure adequate availability during periods of increased demand. Respiratory Protective Equipment (RPE) fit testing is coordinated by the Corporate People Team in partnership with the Infection Prevention and Control Team and a network of trained divisional fit testers. This approach ensures compliance with national requirements and supports workforce readiness throughout the winter period. The Trust maintains a dedicated IPC Winter Booklet, which provides comprehensive guidance on the management of respiratory viruses, patient placement, isolation requirements, cohorting arrangements, PPE usage, outbreak management, and escalation processes. The booklet is reviewed and updated regularly to reflect national guidance and emerging risks. Compliance with IPC standards is monitored through a programme of IPC audits, divisional governance meetings, and oversight by the Infection Prevention and Control Committee. Learning from incidents, outbreaks, and audit findings is used to drive continuous improvement and strengthen organisational resilience. The Specialist Advisory Group (SAG) provides additional oversight of winter-related infection prevention and control risks, ensuring that surveillance data, outbreak preparedness, and response arrangements remain effective and responsive to changing system pressures.	Infection Prevention and Control Policy. IPC Winter Booklet. PPE stock assurance reports. Fit testing compliance reports. IPC Committee minutes and reports. IPC audit programme results and compliance dashboards. Outbreak surveillance and seasonal respiratory virus reports.
3	Is there sound IPC governance for management of infectious diseases?	Yes. The Trust has robust IPC governance arrangements for the prevention, monitoring, escalation and management of infectious diseases. Governance is supported by the Infection Prevention and Control Policy, local outbreak management procedures, national UKHSA guidance and established incident management processes. The Infection Prevention and Control Team provides specialist leadership and oversight of healthcare-associated infections, seasonal respiratory infections and emerging infectious disease threats. Where increased incidence or outbreaks occur, multidisciplinary Incident Management Teams (IMTs) are convened to undertake risk assessment, coordinate control measures, monitor transmission risks and oversee recovery actions.This includes clear cohorting protocols, use of redi rooms, PPE compliance etc	Infection Prevention and Control Policy. Outbreak Prevention and Management Procedures. Incident Management Team (IMT) records and action logs. IPC Committee minutes and annual reports. Trust Management Group (TMG) reports. Senate assurance reports. Trust Quality and Safety Committee reports. Hospital Discharge and Transfer Planning Policy (CSEC 023). Inpatient Board and Ward Rounds SOP (CP295). Hospital at Home SOP (CP312).
4	What operational plans are there to reduce avoidable bed occupancy & improve patient flow?	The Trust operates a structured patient flow model through daily multidisciplinary board rounds and ward rounds, utilisation of the SAFER Patient Flow Bundle, Expected Date of Discharge (EDD) within 14 hours of admission, Criteria to Reside (C2R) reviews, discharge pathway allocation, Hospital at Home (Virtual Ward), Transfer of Care Hub processes and seven-day discharge planning. Patients suitable for early supported discharge are actively identified through board rounds and referred to Hospital at Home where clinically appropriate. UEC transformation programme in place with workstream focussed on alternative pathways, triage and streaming to appropriate areas	Inpatient Board & Ward Rounds SOP CP295 Hospital at Home SOP CP312 EDD and C2R reporting Board Round records Hospital at Home referrals UEC Board
5	Have bed escalation capacity arrangements have been agreed and tested?	Yes. The Trust has a Full Capacity Escalation Policy with defined escalation levels, surge capacity arrangements, operational command structures and executive oversight. Escalation arrangements are regularly enacted and tested through periods of operational pressure.	Full Capacity Policy CP302; Operational escalation logs; OPEL meeting records; Site Team reports.
6	Is there a pre-winter review of bed demand and capacity planned?	Yes. Bed demand, occupancy trends, elective activity, discharge performance and escalation requirements are reviewed through winter planning governance and operational planning processes to inform winter capacity requirements.	Winter Planning Programme; Demand and Capacity Modelling; Operational Planning Group minutes.
7	Are the model discharge pathway requirements being met?	Yes. The Trust operates a Home First / Discharge to Assess approach. Daily board rounds require review of EDD, C2R status, Clinical Criteria for Discharge and discharge pathway allocation. Discharge home remains the default pathway, with consideration of Discharge Home to Assess and Hospital at Home to avoid unnecessary prolonged admission.	Hospital Discharge & Transfer Planning Policy CSEC023; Inpatient Board & Ward Rounds SOP CP295; Hospital at Home SOP CP312.
8	Is there executive oversight of required and actual daily discharges, patients with no criteria to reside by pathway, discharge performance and long discharge delays?	Yes. Daily operational management processes monitor discharge trajectories, EDD performance, C2R compliance, patients with discharge delays and medically optimised patients. Escalation and performance oversight are provided through divisional and executive operational meetings.	Daily SITREP reports; Nervecentre dashboards; Operational Flow meetings; Patient Flow governance reports.
9	Are there clear measures to eliminate corridor care?	Yes. Measures focus on improving patient flow and reducing unnecessary occupancy through daily board rounds, EDD management, Criteria to Reside reviews, Hospital at Home pathways, discharge lounges, escalation capacity management and proactive discharge planning. Risks relating to flow and overcrowding are escalated through the Full Capacity framework.UEC Board in place supporting transofrmation work. All agreed escalation spaces have been clinically risk assessed for safety of use.	Full Capacity Policy CP302; Inpatient Board & Ward Rounds SOP CP295; Hospital at Home SOP CP312.
10	Is there evidence of discharge planning undertaken jointly with social care and local authority partners?	Yes. Complex discharge planning is coordinated through the Transfer of Care Hub and multidisciplinary discharge planning processes involving local authority, community and social care partners.	Transfer of Care Hub records; MDT documentation; Social care assessments; Discharge meeting records.
11	Are there effective system discharge coordination arrangements, clear processes to identify, escalate and resolve discharge delays?	Yes. Daily board rounds and MDT reviews identify barriers to discharge at the earliest opportunity. Specific discharge delay reasons are recorded, escalated and monitored. The Hospital at Home pathway provides an additional system-wide mechanism to facilitate early supported discharge and reduce avoidable delays.	Inpatient Board & Ward Rounds SOP CP295; Hospital at Home SOP CP312; Discharge escalation process documentation.
12	Is there evidence that providers have baselined current discharge arrangements against the model discharge pathway, identified gaps, and agreed improvement actions across acute, community and social care partners.	Yes. Trust discharge improvement programmes, pathway audits, Hospital at Home development work and system-wide discharge workstreams support continuous review of compliance with the model discharge pathway and identification of improvement opportunities.	Discharge Improvement Group reports; Pathway audits; Hospital at Home implementation plans; System action plans.
13	Have pre-Christmas and holiday-period occupancy reduction plans have been agreed and are they likely to be implemented.	Partial - draft plans in place which will be refined in Q3 following output of transformation programme in theatres and UEC The Trust maintains seven-day board rounds and discharge processes, including weekends and bank holidays. Consultant-led Friday reviews include weekend discharge planning to maximise discharge opportunities over holiday periods and reduce bed occupancy.	Inpatient Board & Ward Rounds SOP CP295; Christmas operational plans; Discharge trajectory reports
14	Have bed escalation capacity arrangements have been agreed and tested across system partners.	Yes. Escalation processes are coordinated with ICB, ambulance, community and local authority partners through system operational pressure arrangements and winter planning governance.	System Control Centre records; ICB escalation framework; Winter planning meeting minutes.
15	Are there plans are in place to support staff welfare through periods of high demand?	Yes. Staff wellbeing arrangements include Occupational Health support, psychological wellbeing services, wellbeing hubs, flexible deployment, leadership visibility and workforce escalation processes during periods of sustained operational pressure.	People Directorate wellbeing programme; Occupational Health service information; Winter staff welfare plans.
16	Mental Health Trusts: are the specific actions for Mental Health Trusts in place within the winter plan?	Not applicable. ENHT is an Acute Trust.	N/A
17	Mental Health Trusts: are the specific actions for Mental Health Trusts in place within the winter plan?	Not applicable. ENHT is an Acute Trust.	N/A

Organisation:	
Completed by:	
Date:	

	Questions	Details	Evidence
1	What governance structures are in place to oversee winter planning and operational delivery?		
2	Are IPC plans (PPE, Fit testing, IPC control measures) fit for purpose?		
3	Is there sound IPC governance for management of infectious diseases?		
4	What operational plans are there to reduce avoidable bed occupancy & improve patient flow?		
5	Is there a pre-winter review of bed demand and capacity planned?		
6	Are the model discharge pathway requirements being met?		
7	Is there executive oversight of required and actual daily discharges, patients with no criteria to reside by pathway, discharge performance and long discharge delays?		
8	Is senior clinical decision-making accessible through a single point of access at least 12 hours a day, 7 days a week?		
9	Is there evidence of discharge planning undertaken jointly with social care and local authority partners?		
10	Are there effective system discharge coordination arrangements, clear processes to identify, escalate and resolve discharge delays?		
11	Is there evidence that providers have baselined current discharge arrangements against the model discharge pathway, identified gaps, and agreed improvement actions across acute, community and social care partners.		
12	Have pre-Christmas and holiday-period occupancy reduction plans have been agreed and are they likely to be implemented.		
13	Have bed escalation capacity arrangements have been agreed and tested across system partners.		
14	Are there plans are in place to support staff welfare through periods of high demand?		
15	Is the provider participating in the Central East Winter Simulation Exercise?		

Board

East and North Hertfordshire Teaching NHS Trust

Meeting	Public Trust Board		**Agenda Item**	12	
Report title	Ockenden and Amos Reports Summary and 10-point plan Benchmarking Assessment.		**Meeting Date**	9 September 2026	
Author	Director of Midwifery and Lead Divisional Director Clinical Service Lead				
Responsible Director	Chief Nurse and Deputy CEO Medical Director				
Purpose	**Assurance**	☐	**Approval/Decision**	☐	
	Discussion	☒	**For information only**	☐	
Proposed assurance level (*only needed for assurance papers*)	**Substantial assurance**	☐	**Reasonable assurance**	☒	
	Partial assurance	☐	**Minimal assurance**	☐	

Executive assurance rationale:

Reasonable assurance is proposed following completion of the Trust's baseline assessment against the NHS England Maternity and Neonatal 10 Point Plan. The assessment demonstrates strong compliance across the majority of requirements, with improvement actions underway in relation to maternity triage, workforce sustainability, health inequalities, patient experience and future demand and capacity planning.

Summary of key issues:

Summary of Key Issues

The Trust has completed its baseline assessment against the NHS England Maternity and Neonatal 10 Point Plan **(Appendix 2)** and the NHS England Maternity Triage Benchmarking Assessment.

The assessment provides overall reasonable assurance, with the majority of requirements assessed as compliant or substantially in place. Completion of the maternity triage benchmarking assessment has provided additional assurance regarding the safety and effectiveness of local maternity triage services and informed a targeted improvement programme.

Key improvement priorities relate to:

- Maternity triage workforce capacity, medical review timeliness and performance reporting.
- Health inequalities reporting and the use of demographic data to inform service improvement.
- Patient experience reporting, feedback analysis and strengthening visibility of learning and improvement actions.
- Workforce sustainability and actions arising from the Birthrate Plus review.
- Digital reporting functionality, interoperability and future demand and capacity planning.

No immediate patient safety concerns have been identified. Improvement actions have been incorporated into the maternity improvement programme and will be monitored through established governance arrangements, including the Maternity Executive Oversight Group, Quality & Safety Committee and Trust Board. A further progress update will be provided in December 2026 as part of the NHS England assurance process.

A comprehensive self-assessment and benchmarking has also been undertaken against the

National Triage Specification Audit tool to establish a baseline position **(Appendix 4**) and supporting evidence has been collated to substantiate the Trust's self-assessment against each element of the NHS England 10-point plan assurance framework assessment.

Collated evidence and the full triage benchmarking assessment are available to Board members on request.

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

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

- **Patient Care Quality:** Supports improvements in maternity and neonatal safety, quality, experience and personalised care.
- **Equity for Patients:** Focus on reducing inequalities and improving outcomes and experiences for all women and families.
- **Equity for Staff:** Supports workforce wellbeing, psychological safety and sustainable staffing.
- **Finance/Resourcing:** Resource implications relating to workforce, capacity planning, training and delivery of national requirements.
- **System/Partners:** Requires collaboration with the ICB, MNVP, NHS England and wider system partners.
- **Legal/Regulatory:** Supports compliance with the NHS England 10 Point Plan, Martha's Rule, Fuller Review recommendations and post-death care assurance requirements.
- **Green/Sustainability:** Supports long-term sustainability through workforce, capacity and infrastructure planning in response to increasing maternity complexity and demand and delivery of national requirements.

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

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

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

Current divisional risks as outlined within the main report relate to:

- Digital
- Workforce
- Capacity
- IOL delays
- Bereavement
- Diabetes
- Escalation

Report previously considered at & date(s):

N/A

Recommendation	**The Trust Board is asked to:** • Receive assurance regarding the Trust's baseline assessment against the NHS England Maternity and Neonatal 10 Point Plan. • Approve the baseline assessment and supporting benchmarking submissions to NHS England. • Note the findings of the NHS England Maternity Triage Benchmarking Assessment and the associated improvement priorities. • Note the key areas requiring ongoing Executive and Board oversight, particularly workforce sustainability, maternity triage, health inequalities, patient experience and future demand and capacity planning. • Note that supporting evidence has been collated against each element of the benchmarking tool and is available for review on request. • Receive a further progress update in December 2026.

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Board

East and North Hertfordshire Teaching NHS Trust

Meeting	Public Trust Board		**Agenda Item**	12.1	
Report title	Ockenden and Amos Reports Summary and 10-point plan Benchmarking Assessment.		**Meeting Date**	9 September 2026	
Author	Director of Midwifery and Lead Divisional Director Clinical Service Lead				
Responsible Director	Chief Nurse and Deputy CEO Medical Director				
Purpose [See note 7]	**Assurance**	☐	**Approval/Decision**	☐	
	Discussion	☒	**For information only**	☐	
Proposed assurance level (*only needed for assurance papers)*	**Substantial assurance**	☐	**Reasonable assurance**	☒	
	Partial assurance	☐	**Minimal assurance**	☐	

Executive assurance rationale:

Reasonable assurance is proposed following completion of the Trust's baseline assessment against the NHS England Maternity and Neonatal 10 Point Plan. Whilst many requirements are already in place, further work is required in relation to maternity triage, workforce sustainability, health inequalities and future capacity planning, with improvement actions underway and subject to ongoing Board oversight.

Summary of key issues:

Purpose of the Report:
The purpose of this report is to provide Board assurance regarding the Trust's response to the Amos and Ockenden reports and the NHS England Maternity and Neonatal 10 Point Plan, including the emerging baseline assessment and identified priorities for improvement.

Executive Summary:
The Amos and Ockenden reviews have led to a nationally mandated assurance process through the NHS England Maternity and Neonatal 10 Point Plan. NHS England requires all Trust Boards to complete a baseline assessment by 25 September 2026 and provide a progress update by 31 December 2026 (**Appendix 1**).

The Trust has completed its baseline assessment using the national assurance framework (**Appendix 2**), providing overall reasonable assurance that appropriate governance, safety and improvement arrangements are in place. The assessment demonstrates a positive position overall, with the majority of requirements assessed as compliant and many areas of established good practice. Key strengths include governance and leadership arrangements, implementation of Martha's Rule, maternity safety processes, post-death care assurance, and significant progress in maternity triage through implementation of the Birmingham Symptom-Specific Obstetric Triage System (BSOTS).

A number of improvement opportunities have been identified, principally relating to maternity triage, workforce sustainability, health inequalities, listening to women and families, and future demand and capacity planning. The national maternity triage benchmarking assessment (**Appendix 3**) confirmed opportunities to strengthen workforce capacity, patient experience intelligence, equity reporting, digital functionality and maternity triage performance measurement. Whilst much of the required information is captured through existing systems, routine analysis, triangulation and reporting are not yet consistently embedded across a number of these areas. These priorities have been incorporated into the maternity

improvement programme and will be monitored through existing governance arrangements.

Key messages from Ockenden and Amos Reports:

Whilst Ockenden and Amos approach maternity improvement from different perspectives, there is strong consistency in their findings. Collectively, the reports signal a shift from identifying problems and producing recommendations towards demonstrating measurable implementation, improvement, and accountability. An infographic has been produced to summarise key messages and priorities and to support information cascade to staff across the service **(Appendix 4)**.

Baseline Assessment Against the NHS England 10 Point Plan

Detailed assessment against the NHS England Maternity and Neonatal 10 Point Plan confirms overall reasonable assurance, with most requirements assessed as compliant or substantially in place. Improvement opportunities relate principally to maternity triage, workforce sustainability, health inequalities, patient experience, and future demand and capacity planning.

The assessment has been informed by a comprehensive review of governance reports, audits, workforce data, policies, committee papers and assurance documentation, together with completion of the NHS England Maternity Triage Benchmarking Tool. Evidence has been collated and cross-referenced against the national assurance framework to support self-assessment ratings and identify priority areas for improvement. Supporting evidence and documentation are available to Committee and Board members on request.

Overall, the Trust assesses itself as providing reasonable assurance against the NHS England Maternity and Neonatal 10 Point Plan, with no immediate patient safety concerns identified and improvement plans in place for all areas of partial compliance.

Table 1. ENHTT 10 Point Plan Baseline Assurance Summary

Theme	Baseline Position	Board Assurance
Martha's Rule	Compliant	Green
Listening to Women & Families	Partially compliant	Amber
Executive Accountability	Compliant	Green
Health Inequalities	Partially compliant	Amber
24/7 Safe Staffing & Responsiveness	Partially compliant	Amber
Homebirth Review	Compliant	Green
Incidents, Complaints & Duty of Candour	Compliant	Green
Maternity Triage	Partially compliant	Amber
Post Death Care	Compliant	Green

National Maternity Triage Benchmarking Assessment

The Trust has completed the NHS England Maternity Triage Benchmarking Tool (released 12 August 2026), which confirms a generally positive level of compliance with the National Maternity Triage Specification. The assessment identified opportunities to strengthen workforce capacity, medical review timeliness, patient experience intelligence, equity reporting and maternity triage performance measurement. Whilst no immediate patient safety concerns were identified, these priorities have been incorporated into the maternity improvement programme and will be subject to ongoing Executive and Board oversight.

Key Trust priorities:

The Trust's baseline assessment demonstrates a number of areas of strong compliance and established good practice. The following priorities reflect those areas where further assurance, development or strategic investment is required to respond to the recommendations arising from the Amos and Ockenden reviews and support delivery of the

NHS England Maternity and Neonatal 10 Point Plan

1. **Martha's Rule**

The Trust has assessed itself as compliant against the baseline Martha's Rule requirement and has implemented Martha's Rule within maternity services. Established escalation processes are in place to support women, families and staff to raise concerns regarding deterioration, and the Trust continues to work with the national Martha's Rule programme to support ongoing implementation and standardisation. Current activity is focused on embedding the approach within routine practice, increasing awareness and ensuring equitable access for all women and families.

2. **Listening to Women and Families**

Although multiple sources of patient feedback are routinely collected, including complaints, incidents, Friends and Family Test data and Maternity and Neonatal Voices Partnership (MNVP) intelligence, further work is required to ensure these sources are consistently triangulated and presented in a way that demonstrates learning, improvement actions and their impact. Strengthening the visibility of women's voices within performance and quality reporting remains a key priority.

3. **Shared Accountability and Governance Arrangements**

In line with the NHS England 10 Point Plan, the Trust has reviewed its maternity governance arrangements and strengthened shared executive accountability for maternity and neonatal services. Joint oversight is provided by the Chief Nurse and Medical Director, working closely with the Director of Midwifery and Head of Clinical Service for Women's Services. To support this approach, a dedicated Maternity Executive Oversight group has been established to provide focused review of maternity safety, quality, workforce, performance and improvement activity. These arrangements provide clear accountability, coordinated leadership and robust assurance in support of the NHS England 10 Point Plan.

4. **Health Inequalities and Equity**

The Trust has established mechanisms to monitor inequalities in maternity outcomes and is actively participating in national and regional equity programmes. A local maternity health inequalities dashboard has been developed to align ethnicity data with local outcomes, and work is underway to introduce risk stratification using booking information, protected characteristics and social complexity factors to support personalised care and identify women who may benefit from enhanced support. Whilst progress is being made, there remains an opportunity to strengthen Board oversight of variation in outcomes and experience by ethnicity, deprivation and other protected characteristics, and to demonstrate the impact of actions taken to reduce inequalities and improve outcomes for women and families.

5. **Workforce Sustainability and Service Capacity**

The baseline assessment confirms compliance with a number of workforce-related standards; however, workforce sustainability remains a key strategic priority. A recent Birthrate Plus® review identified increasing acuity and complexity within the maternity population and confirmed a shortfall within the current midwifery establishment, for which a business case is being developed. The national maternity triage assessment also identified medical review timeliness, registrar availability within triage, and workforce capacity at weekends as key areas requiring further development. Collectively, these findings highlight the need to review both midwifery and obstetric workforce capacity to ensure staffing models remain aligned with increasing demand, clinical complexity and national standards. Ongoing Executive and Board oversight will be required to support delivery of the workforce expansion programme and ensure sufficient capacity across the maternity pathway.

6. **Demand, Capacity and Future Service Planning**

Maternity activity continues to become increasingly complex, with rising intervention rates placing additional pressure on existing service capacity. Caesarean section rates now regularly exceed 50% of births, whilst over 30% of women undergo induction of labour. These changes have significant implications for theatre utilisation, recovery capacity, inpatient flow and workforce requirements. Current infrastructure and capacity arrangements were not

designed for this level of activity and complexity, and there is a need to review future service requirements to ensure a sustainable maternity that remains responsive to demand. Demand and capacity planning, including assessment of theatre, recovery, triage and day assessment capacity, will therefore form a key component of the service's longer-term improvement and workforce strategy.

7. Maternity Triage and Clinical Oversight

The Trust has completed the NHS England Maternity Triage Benchmarking Tool as required by the Maternity and Neonatal 10 Point Plan. The assessment confirmed a generally positive level of compliance with the National Maternity Triage Specification and has informed a targeted maternity triage improvement programme. Key strengths include implementation of the Birmingham Symptom-Specific Obstetric Triage System (BSOTS), dedicated maternity triage facilities, robust governance arrangements, digital documentation through K2, and established processes for assessment, escalation and clinical oversight.

The assessment identified a number of areas for further development, principally workforce sustainability, medical review timeliness, delivery of a dedicated 24/7 telephone triage model, equity and health inequalities reporting, patient experience intelligence, and maternity triage-specific performance measurement. Whilst much of the required information is captured through existing systems, routine analysis, triangulation and reporting of maternity triage data are not yet consistently embedded.

Key improvement priorities include progression of the Birthrate Plus workforce business case, review of obstetric workforce capacity, development of a maternity triage performance dashboard, strengthening patient experience and equity reporting, improved monitoring of medical review times, and enhancement of digital reporting functionality within the electronic patient record.

No immediate patient safety concerns were identified during the assessment. Improvement actions have been incorporated into the maternity improvement programme and will be monitored through existing governance arrangements, including oversight through a newly established Maternity Executive Oversight Group and Quality & Safety Committee. A progress update will be reported to Trust Board in December 2026 as part of the NHS England Maternity and Neonatal 10 Point Plan assurance process.

8. Digital Enablement and Information Sharing

Consistent with the findings of the Amos Review, digital maturity and interoperability remain areas requiring continued development. Whilst maternity services benefit from an electronic patient record and BSOTS-compliant triage documentation within K2, the maternity triage benchmarking assessment identified opportunities to strengthen reporting functionality, performance monitoring and data analytics. Current limitations in information sharing across maternity, neonatal and cross-organisational pathways may impact seamless care and safety surveillance. Further work is required to maximise existing digital capability and support longer-term interoperability across care settings. Delivery of these improvements will require alignment with wider Trust and system digital transformation programmes.

9. Post-Death Care and Fuller Review Assurance

The Trust submitted the required NHS England Board Assurance Statement by 31 July 2026, signed by the Trust Chair and Chief Executive, confirming compliance with national requirements. One remaining recommendation relates to the installation of 24/7 CCTV monitoring within the mortuary, which remains on track for completion by March 2027.

Conclusion:

The Trust's baseline assessment provides reasonable assurance against the NHS England Maternity and Neonatal 10 Point Plan. The assessment demonstrates strong governance, safety and improvement arrangements, with many requirements already embedded within existing practice. Completion of the NHS England Maternity Triage Benchmarking Tool has provided additional assurance regarding the safety and effectiveness of local maternity triage services, whilst identifying a number of opportunities to strengthen workforce sustainability,

equity reporting, patient experience intelligence, digital functionality and performance measurement.

No immediate patient safety concerns were identified, and improvement actions have been incorporated into the maternity improvement programme. Progress will be monitored through established governance arrangements, including the Maternity Executive Oversight Group and Quality & Safety Committee, and reported through the NHS England assurance process.

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

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

- **Patient Care Quality:** Supports improvements in maternity and neonatal safety, quality, experience and personalised care.
- **Equity for Patients:** Focus on reducing inequalities and improving outcomes and experiences for all women and families.
- **Equity for Staff:** Supports workforce wellbeing, psychological safety and sustainable staffing.
- **Finance/Resourcing:** Resource implications relating to workforce, capacity planning, training and delivery of national requirements.
- **System/Partners:** Requires collaboration with system partners.
- **Legal/Regulatory:** Supports compliance with the NHS England 10 Point Plan, Martha's Rule, Fuller Review recommendations and post-death care assurance requirements.
- **Green/Sustainability:** Supports long-term sustainability through workforce, capacity and infrastructure planning in response to increasing maternity complexity and demand. delivery of national requirements.

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

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

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

Digital

#3334 (12) Large Scale transformational change associated with digital implementation and ongoing functionality concerns causing impact on patient safety and data collection for national submission.

#3114 (16) Risk to the safety of mothers and babies due to risks associated with cross-border working due to digital immaturity and lack of digital interoperability between Trusts.

Workforce

#3134 (6) The Trust does not currently support the BMA and RCOG recommended compensatory rest. There is a risk to patient safety where consultants and senior Speciality and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day.

#3658 (12) Risk of delays in treatment and care because of redeployment of midwives to cover staffing gaps within obstetric theatres scrub nurse and recovery nurse roles.

#3574 (12) Lack of sufficient maternity ward clerks.

#3407 (9) Community midwifery staffing shortages, high caseloads, and limited appointment times.

#0070 (12) The current headroom within the midwifery establishment is insufficient to mitigate the full impact of high maternity leave and sickness absence. This is compromising staff and service user safety and experience due to impact on fill rate of clinical rosters.

Capacity

#3789 (16) Insufficient DAU Capacity for third trimester scanning and monitoring leading to delays and increased clinical risk.

IOL delays

#3235 (12) Lack of a robust IOL pathway / process which may lead to delays and an increased risk to women and their babies

Bereavement

#3537 (6) Risk to wellbeing and safety of mothers and babies as a result of having insufficient capacity within the Bereavement Service.

Diabetes **#3797 (9)** There is a risk of compromised maternal and neonatal outcomes due to insufficient midwifery resource within the diabetes team, which could result in increased morbidity, and failure to deliver safe, effective care. **Escalation** **#1138 (6)** There is a risk of delay or failing to recognise the deteriorating woman due to the inability to capture MEWS scores on Nervecentre. **#3790 (12)** Absence of maternity-specific digital VTE risk assessment and/or misalignment with Trust and national guidance, leading to incorrect management of VTE risk.	
Report previously considered at & date(s):	
N/A	
Recommendation	**The Trust Board is asked to:** • Receive assurance regarding the Trust's baseline assessment against the NHS England Maternity and Neonatal 10 Point Plan. • Approve the baseline assessment and supporting benchmarking submissions to NHS England. • Note the findings of the NHS England Maternity Triage Benchmarking Assessment and the associated improvement priorities • Note the key areas requiring ongoing Executive and Board oversight, particularly workforce sustainability, maternity triage, health inequalities, patient experience and future demand and capacity planning. • Note that supporting evidence has been collated against each element of the benchmarking tool and is available for review on request. • Receive a further progress update in December 2026.

To be trusted to provide consistently outstanding care and exemplary service

Classification: Official

NHS England

To: NHS trust:
- chief executives
- chairs
- chief nursing officers
- medical directors
- chief operating officer
- communications directors

cc. Integrated care bard (ICB):
- chief executives
- chief nursing officers
- medical directors

NHS England:
- regional directors
- regional chairs
- regional chief nurses
- regional chief midwives
- regional medical directors
- regional obstetricians

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

12 August 2026

Dear colleagues,

Maternity and Neonatal 10 Point Plan assurance process

Following the publication of Baroness Amos' independent investigation into maternity and neonatal services in England and Donna Ockenden's independent review of maternity services at the Nottingham University Hospitals NHS Trust, our chief executive, chief nursing officer, and medical director leadership community came together to discuss a 10 Point Plan of urgent actions for maternity and neonatal services.

We are now writing to outline the assurance process and the expectations for trusts.

While trusts will want to reflect on the findings of both reports, the immediate priority is delivery of the 10 Point Plan. This sets out the most urgent actions arising from the reports and should be the focus of local leadership, improvement activity and board oversight while the Maternity and Neonatal Taskforce develops a comprehensive national action plan by the end of the year.

Publication reference: PRN02631

The assurance process is intended to support and evidence progress, not create additional reporting burdens. Expectations for provider boards, chief executives and regional teams are set out and accountability for delivery is embedded within existing governance arrangements wherever possible.

For example, the template has been designed to align with Maternity Incentive Scheme (MIS) Year 8 requirements, enabling trusts to draw on existing assurance activity for this, as well as evidence from board papers and minutes.

Trusts are asked to submit the standardised national template to their NHS England region at two points:

- **Baseline assessment:** 25 September 2026
- **Progress update:** 31 December 2026

Both submissions must be approved by the trust board. Boards should provide visible ownership and scrutiny of delivery, ensuring actions are progressing at pace, risks are managed appropriately and any significant concerns are escalated through ICB and regional routes.

Regional teams will review returns, provide constructive challenge where needed, identify where additional support is required, and escalate significant concerns nationally to enable timely action.

Alongside this, ‘Amos into action’ will launch an NHS-wide opportunity for an open conversation for all our maternity and neonatal staff to help shape real and sustainable change in services. Further details will follow shortly about how staff can get involved and how the outputs will help support culture change and improvement work in your trust. This builds on feedback from more than 9,000 staff members who contributed their views to the Amos investigation.

As Sir Jim set out in his letter, this is a moment that requires collective leadership across the NHS. We must act with urgency to address the failings and harm experienced by women, babies and families.

We have listened carefully to what you told us you need to deliver the Maternity and Neonatal 10 Point Plan successfully. You asked for practical tools and best practice templates, opportunities to learn from peers and exemplar services, and clearer guidance. In response, we are providing practical support including webinars, standardised audit tools and templates, and opportunities for peer learning. We are also today sharing a maternity

triage benchmarking tool to support implementation of the national maternity triage specification. You can find the full detail in the Appendix.

We remain committed to working alongside trusts and systems to improve outcomes for women, babies and families.

As part of our wider work, we are keen to highlight and share how and where progress and improvement is taking place – and the positive impact for women and families and our staff. We would welcome working with you and your communications teams to showcase this work.

Thank you for your continued leadership and commitment to improving maternity and neonatal care. As ever, if you need any further support, please do not hesitate to reach out to us or colleagues in the regional team.

Yours sincerely,

Duncan Burton
Chief Nursing Officer for England

Professor Frankie Swords
National Medical Director

Appendix: Maternity and Neonatal 10 Point Plan – support available

The assurance return is designed to help trusts articulate how they are providing the oversight and support NHS maternity and neonatal services need, rather than establishing a standalone process. Where evidence is already available, for example through board papers, committee reports, dashboards or evidence collected to inform Maternity Incentive Scheme returns, trusts should reference that evidence rather than producing new material. If not already doing so, trusts may wish to use the Model Board Report to support their reporting process.

Support will be available to help trusts and systems implement the 10 Point Plan and complete the assurance process consistently. An outline of the available and upcoming support is provided in the table below. For any queries relating to the reporting template, please contact england.maternitytransformation@nhs.net.

Action	National Support Available
Martha's Rule	Trusts should follow the implementation and reporting processes outlined by the Martha's Rule national team in NHS England. A webinar is scheduled for **Wednesday 12 August, 15:00–16:30hrs** to provide information on implementation support and reporting requirements. Trusts will be expected to work closely with national and regional colleagues triangulating data to minimise reporting burden and duplication. The session will provide key information to support local implementation, including: • an overview of the three components of Martha's Rule • the national implementation approach • learning and insights from sites already implementing Martha's Rule in maternity and neonatal settings • the implementation support, resources and tools available to local teams.

	The webinar is an opportunity for colleagues to understand what implementation involves, hear from early implementer sites, and begin their local Martha's Rule implementation journey with the support of the national programme team. The session will be recorded and uploaded to Futures for those who cannot join live. If you haven't already received an invite and would like to attend, please email england.psimprovement@nhs.net
Maternity and Neonatal 10 Point Plan supporting webinar series	The national team will host a series of webinars for clinical directors, chief nursing officers, directors/heads of midwifery, obstetric Leads, neonatal Leads, quality Leads and other senior maternity leaders in **August.** The webinars are designed to support trusts in delivering the actions in the plan, with a particular focus on: 1. Listen to women and their families using real-time and transparently reported outcomes and experience, **Monday 17 August 2026, 11:30 – 12:00** 2. Clinical audit, **Wednesday 19 August 206, 15:30 – 16:00** 3. Ensuring 24/7 safety and responsiveness of services, **Wednesday 19 August 2026, 11:30 – 12:00** 4. Responding to patient safety incidents, complaints and concerns within maternity and neonatal services with openness, humanity and candour, **Thursday 20 August 2026, 12:00 – 12:30** Further information will be shared soon.
Amos into Action staff listening exercise	This action is being nationally led and no return is required within the template. 'Amos into action' is an NHS-wide open conversation for all our staff to help shape real and sustainable change in services. Trusts are encouraged to engage in these NHS wide conversations and support staff to do the same. Trusts should consider how local learning will be governed and action any recommendations that

	follow. We will be in touch shortly with details on how staff can get involved and how the outputs will help support culture change and improvement work in your trust.
Safe and effective maternity triage	The triage benchmarking tool has been shared by NHS England to support implementation of the maternity triage specification. Trusts should use the triage benchmarking tool to assess their current position, identify gaps and develop an action plan to deliver against the national triage specification. The tool will be shared alongside the letter and reporting template and should be used to complete the board-level triage audit. The expectation is that the audit will be completed by the September submission, with board oversight of triage quality and performance and plans to implement improvements in line with national triage guidance within 12 months.
Post death care	Trusts should confirm completion of the board assurance statement by 31 July 2026. Evidence should demonstrate continued board assurance and oversight of matters relating to mortuaries, as outlined by existing actions and recommendations. Communications and templates shared for completion can be found here: NHS England » Nottingham maternity review findings on post-death care and key actions required following the Fuller Inquiry

Submission A: Baseline Assessment (Starting Position Against the 10-Point Plan)

This template should be completed once and submitted on the Friday 25th September 2026. It is intended to provide a baseline assessment of delivery against the 10-point plan actions and is separate to the tab 2. Progress Report submission.

Columns K & L should be used by regional teams only to provide independent assessment against Trust Board assurance.

The RAG rating should describe delivery risk and confidence: red where there is no credible route to compliance or an immediate safety risk; amber where a plan is in place but gaps or risks remain; and green where evidence confirms the requirement is met or on track. A completed review alone should not result in a green rating if significant residual risk remains.

Baseline compliance definitions
The baseline compliance / compliance ratings should be used to provide a consistent assessment of the current level of compliance against each requirement. Ratings should be based on available evidence, professional judgement and the extent to which the requirement has been fully implemented, embedded and sustained.

Not applicable: The requirement does not apply to the service, pathway, function or organisation being assessed. For example, trusts may not yet be eligible for onboarding onto the PEADP programme at the time of submission, therefore 'Not applicable' would be apply.
Non-compliant: There is no, or very limited, evidence that the requirement has been met.
Partially compliant: There is evidence that some elements of the requirement have been met, but implementation is incomplete, inconsistent or not yet fully embedded.
Compliant: There is sufficient evidence that the requirement has been fully met and is being implemented consistently

To be completed once, at the start of the reporting cycle, to establish the trust's baseline position for each action before tracking ongoing progress.

Report signed off by Trust Board (named Exec): Martin Amstrong CEO

Trust Board sign off date: 09/09/2026

Trust Board Assurance Template

No.	Deliverable / Scoping Prompt	Baseline Compliance Rating	Baseline Evidence Reference *Please input reference number as listed in 3. Evidence Log tab*	Gaps in Assurance *Please provide detail of any gaps in assurance*	Improvement Actions (Including Temporary Mitigations)	Comments
1. Listening to women and families by rolling out Martha's Rule						
1.1	Has the trust commenced rollout of Martha's Rule across maternity and neonatal services?	Compliant	**EV-01 Poster - Trust wide and maternity specific** **EV-02 Wellness Questions Posters (Pregnancy and Postnatal)**	Trust Standard Operating Procedure in Development. MEWS not yet live on nervecentre (Trust EPR) but work close to completion.	A maternity and neonatal specific Patient Wellness Questionnaire is in the process of being developed with input from key stakeholders, including the Maternity and Neonatal Voices Partnership (MNVP), and incorporates consideration of neurodiversity and protected characteristics. Work has also been undertaken to improve the consistency of physiological observations (MEWS outside of maternity) and escalation processes for obstetric patients attending areas outside Women's and Children's Services. Local improvement work specific to neonatal unit has commenced which will follow the East of England guidance.	The Trust has commenced and implemented Martha's Rule within maternity services, acting as a pilot site. The Trust Martha's Rule Lead has worked with the Matron for Inpatient Services and Lead Midwife for Training, Education and Development to standardise the maternity approach and strengthen existing arrangements. This has included review of escalation pathways, development of a maternity-specific escalation flowchart, identification of escalation responders (including CCOT), and adaptation of the Trust's Call for Concern materials for maternity services. Arrangements are in place to ensure concerns raised through Martha's Rule are appropriately triaged and escalated, providing assurance that the principles of Martha's Rule are embedded within maternity services and continue to be strengthened through ongoing quality improvement. MEWS now live on nervecentre (Trust EPR)
2. Listen to women and their families using real-time and transparently reported outcomes and experience, and clinical audit that are acted upon at board level.						
2.1	Has the trust established a monthly cycle of collecting and analysing the latest available maternity and neonatal clinical audit and patient outcome & experience data representative of the local population, including but not limited to, FFT, CQC survey findings when available, local intelligence from MNVPs and targeted outreach?	Compliant	**EV-03 PACE Report** **EV-04 QSC Perinatal Assurance Report** **EV-05 Perinatal Quality Assurance report coversheet**	None		The Trust has robust arrangements in place to review and monitor patient experience feedback. A monthly Patient and Carer Experience report is submitted to the Trusts (PACE) committee incorporating Friends and Family Test (FFT) feedback, compliments, PALS concerns, complaints themes and patient stories. Key themes, emerging issues and areas of good practice are reviewed through divisional governance processes, with patient experience metrics, including complaints, FFT data and CQC survey actions, also reported through the Trust Integrated Performance Report and reviewed by the Trust Board on a monthly basis for assurance and oversight
2.2	Does the trust board receive and publish a regular summary report that brings these sources of intelligence together, and can it demonstrate the decisions, actions or escalation resulting from its scrutiny, including how progress and impact are tracked?	Compliant	**EV-06 Claims, Incidents and Complaints Q3 and Q4 25/26 Triangulation Report**	None		The Trust triangulates patient experience data to identify themes, learning and opportunities for improvement. A quarterly complaints, incidents and claims triangulation report is presented to the Divisional Board and Quality, Safety and Compliance (QSC) Committee (meeting MIS reporting requirements). Learning from complaints, FFT feedback, PALS concerns and patient experience reports informs quality improvement activity, service redesign and action planning. Recent examples include work to improve communication, access to care, induction of labour pathways, discharge processes and gynaecology care pathways, with progress monitored through established governance arrangements.
2.3	Does the report identify variation in outcomes and experience by ethnicity and deprivation, including any important gaps or limitations in the available data, and can the board demonstrate how the trust is responding to the variation identified?	Partially compliant	**EV-07 Health Inequalities Dashboard_Aug 2026** **EV-08 Health Inequalities Project Presentation (incl. Aug 2026 Update)**		The Trust is continuing to develop its health inequalities dashboard and reporting processes to ensure routine reporting of variation by ethnicity and deprivation, including data limitations, and to provide assurance on actions taken in response to identified variation.	The Trust has developed a maternity health inequalities dashboard which aligns ethnicity data with local maternity outcomes and has been used to support clinical governance reviews, including OASI audits. This has enabled the service to begin identifying variation in outcomes and experience for different population groups and provides a foundation for future health inequalities reporting
3. Dual board-level accountability between medical directors and chief nursing officers for maternity and neonatal care						
3.1	Has the trust board established clear joint accountability for maternity and neonatal services with Medical Directors and Chief Nurses holding a shared responsibility?	Compliant	**EV-09 QSC Terms of Reference**	None		Joint oversight of maternity and neonatal governance is provided by the Chief Nurse and Medical Director, working with the Director of Midwifery and Head of Clinical Service for Women's Services. A dedicated monthly maternity executive oversight forum has been established to provide focused review of maternity safety, quality, workforce, performance and improvement activity. CMO as well as CNO are identified as Board level safety champions, both contributing to safety champion walkarounds.
3.2	Do Directors of Midwifery and Clinical Directors leading maternity and neonatal services attend boards and take part in discussions when maternity and neonatal matters are on the agenda?	Partially compliant	**EV-10 Trust Board minutes** **EV-11 Quality and safety Committee Minutes June 2026**	Head of Clinical Service / Divisional Medical Director do not routinely attend Trust Board		Director of Midwifery and Head of Clinical Service for Women's services attend QSC. DoM is a core member of QSC (subcommittee of Trust Board). The DoM attends Trust Board by Invitation.
5. Addressing inequalities in maternity and neonatal outcomes						
5.1	Has the trust board ensured that provision is in place to allow staff to be released for the Perinatal Equity and Anti-Discrimination Programme with full participation across multidisciplinary teams?	Compliant	**EV-12 Email Confirmation of organisational attendance**	None	An internal focused programme of cultural improvement work is commencing in September 2026 supported by external expertise. A proposed response framework has been developed which focuses on four interconnected areas: •Patient safety, escalation and governance •Organisational culture and psychological safety •Race, inclusion and belonging	East of England due to commence the programme in January 2027. Webinar attended by Medical Director and Director of Ops. Initial Trust level meeting scheduled for September 28th. Staff identified for attendance / participation and plans in place to ensure staff are released to attend with backfill to maintain service safety,
5.2	Can the trust board demonstrate that the trust is regularly reviewing and acting on trends identified by their inequalities data dashboards every 6 months?	Partially compliant	**See EV-07 and 08**	No formalised six-monthly Board review of a health inequalities dashboard with documented actions and outcome monitoring. Current dashboard is primarily retrospective and focused on ethnicity data, rather than a comprehensive health inequalities dashboard Further development required to address data quality, completeness and digital infrastructure to support robust reporting and risk stratification.	Whilst health inequalities are regularly discussed through governance processes, a formalised six-monthly Board review of dashboard trends and associated action plans is not yet fully established.	The Trust has an established Health Inequalities Group, chaired by the Medical Director, with health inequalities regularly reviewed through Quality and safety Committee and reported to the Trust Board. A maternity health inequalities dashboard has been developed and is being used to review ethnicity-related outcomes and support clinical governance activities. Further work is underway to enhance the dashboard and develop risk stratification tools to better identify and support women at increased risk of health inequalities.

5.3	Has the trust board approved a plan to implement the Maternal Care Bundle by March 2027?	Partially compliant	**EV-13 NHS Futures Maternal Care Bundle (MCB) Benchmarking Tool**	The Trust has completed the national Maternal Care Bundle benchmarking tool; however, a formally approved implementation plan is not yet in place. Board assurance has not yet been received regarding delivery trajectories, risks and mitigations required to achieve implementation by March 2027.	An implementation plan is being developed following completion of the benchmarking assessment. A report is scheduled for Quality and Safety Committee (QSC) on 27 September 2026 to provide assurance on implementation plans, risks, challenges and governance oversight. Progress will continue to be monitored through governance processes to support delivery of the Maternal Care Bundle by March 2027.	The Trust has completed the Maternal Care Bundle benchmarking assessment and is developing an implementation plan for delivery by March 2027. Key areas requiring further work include the Venous Thromboembolism (VTE) first point of contact pathway, joint epilepsy clinic capacity and funding, and implementation of a digital solution for the Edinburgh Postnatal Depression Scale (EPDS). Within the Acute and Pre-Hospital Care element, further work is required to implement an electronic Maternity Early Warning Score (MEWS) solution, which is currently reliant on paper-based documentation, and to develop and implement community-based skills and drills training. An updated Perinatal Mental Health Guideline is awaiting ratification, and the acute and pre-hospital care elements remain under multidisciplinary review. Progress, risks and implementation plans will be presented to the Quality and Safety Committee in September 2026 to support governance oversight and delivery.
6. Ensuring 24/7 safety and responsiveness of services						
6.1	Is the trust complying with the RCOG "Roles and Responsibilities of the Consultant providing acute care" standard? In line with MIS Year 8, is there a minimum ≥80% consultant presence in defined acute care situations?	Compliant	**EV-14 Consultant Attendance monthly exception report**	None		The Trust is compliant with the RCOG Roles and Responsibilities of the Consultant Providing Acute Care standard. Monthly audits undertaken by the Labour Ward Lead demonstrate 100% consultant presence in defined acute care situations, exceeding the MIS Year 8 requirement of ≥80%. Compliance is routinely monitored through established governance processes to ensure this high level of performance is maintained and any emerging issues are identified and addressed promptly.
6.2	Is the trust ensuring locum certification and maintaining a local (trust-specific), continuously updated database of all short-term locums (≤2 weeks) working on tier 2/3 obstetric rotas? *(In line with MIS Year 8)*	Compliant	**EV-15 RCOG Audit - Evidence for Maternity Incentive scheme yr 8**	None		The Trust has robust processes in place to ensure appropriate certification of all short-term locums (≤2 weeks) working on tier 2/3 obstetric rotas. A trust-specific database is maintained and updated by the Temporary Staffing Team, providing oversight of locum activity and compliance requirements. Quarterly audit activity is undertaken to provide assurance that records remain accurate and complete, demonstrating continued compliance with MIS Year 8 standards.
6.3	Does the trust have a clear plan for a fully funded neonatal nursing and medical establishment that aligns with the relevant BAPM standards for their unit designation and the neonatal nursing workforce calculator output (2020)? *(In line with MIS Year 8)*	Compliant	**EV-16 Neonatal nursing workforce plan**	None		Neonatal nursing workforce demonstrates that the funded nursing establishment broadly supports current activity; however against BAPM and the Neonatal Nursing Workforce Calculator identifies gaps in staffing resilience, (QIS) capacity, advanced practice provision and AHP support. Current QIS compliance is 74%, exceeding the minimum 70% benchmark, but retirement risk, vacancies and sickness absence continue to create pressure on maintaining compliance and safe staffing levels. Following substantive recruitment of the 7th neonatal consultant the Trust is fully complaint with BAPM medical workforce standards.
6.4	Does the trust have a fully funded midwifery establishment that aligns with a Birthrate Plus (BR+) review completed within the last three years as a minimum baseline, with further adjustments based on the professional judgement of the Director and Head of Midwifery? *(In line with MIS Year 8)*	Partially compliant	**EV-17 Bi-annual Workforce report Q1 2025/26** **EV-18 QSC Coversheet - Perinatal Assurance Report Sept 2026**	Birthrate Plus review identifies a workforce gap	A business case is currently being developed to address the identified workforce gap and align the funded establishment with Birthrate Plus recommendations.	The Trust has completed a recent Birthrate Plus® review and while previously complaint with BR plus establishment recommended staffing now reports an overall workforce shortfall of approximately 20 - 25 WTE midwives against the Birthrate Plus recommended establishment. Maternity workforce metrics are reported monthly on the maternity dashboard and through the required six-monthly integrated workforce report. Professional judgement has been applied to workforce planning, including additional funding for maternity leave backfill, review of workforce resilience, and adjustments to staffing models in response to increasing acuity and complexity within the maternity population.
6.5	Do the trust's obstetric services have a duty anaesthetist available 24/7 in line with ACSA standards 1.7.2.1 and a trained anaesthetic assistant available 24/7 in line with ACSA standards 1.3.1.2? *(In line with MIS Year 8)*	Compliant	**EV-32 Consultant Anaesthetic Rota Jan to May 2026**	None		The Trust was fully compliant with MIS Year 7 requirements and continues to provide 24/7 access to a duty anaesthetist and trained anaesthetic assistant in line with ACSA standards. Compliance is monitored through governance reporting arrangements established under MIS Year 8. The Trust remains on track to maintain full compliance through ongoing workforce oversight and review of maternity, obstetric and anaesthetic staffing capacity.
6.6	Does the trust board oversee workforce acuity, service pressures and escalation activity across maternity and neonatal services, ensuring they can a) respond to periods of increased demand, reduced workforce availability or changing clinical risk; b) address local gaps and c) eliminate siloed working, so that services can consistently and safely respond to the needs of women, babies and families?	Compliant	**EV-19 RQOG Dashboard** **EV 04 Perinatal Quality Assurance Report**	None		Quality and Safety committee receives monthly assurance on workforce acuity, service pressures and escalation through the integrated workforce report, monthly maternity dashboard, risk register and governance processes. Workforce risks, staffing gaps, sickness absence, service pressures and escalation activity are routinely monitored, with the Birthrate Plus® acuity tool, red flag monitoring and workforce metrics used to support operational and strategic decision-making. Cross-divisional working supports the management of workforce pressures and service resilience across maternity and neonatal services.
6.7	Has the trust board undertaken a review of internal resource deployment, including consideration of a) whether roles not directly supporting frontline delivery can be redirected to strengthen service provision; b) where specialist posts exist (including in bereavement care and infant feeding), what education and training is required to ensure other staff have the knowledge and skills to ensure that care is not compromised when the specialist midwives are not immediately available; c) the impact of redeployment across the service.	Partially compliant	**EV-17 Bi-annual Workforce Report**	Workforce planning through the Birthrate Plus business case - Gap in specialist Midwives noted as part of establishment review No documented Board-level review of internal resource deployment across maternity services. Further evaluation required on the impact of redeployment on specialist services and frontline care.	Continued evaluation of the impact of specialist staff redeployment on service delivery.	The Trust reviews workforce deployment through its integrated workforce and governance processes. Specialist midwives support the clinical rota through regular shifts and redeployment in response to acuity and escalation requirements. A dedicated Robin Team provides 24/7 bereavement care through clinical midwives with additional bereavement training, improving service resilience. The Trust also has a robust training needs analysis (TNA) programme to strengthen wider workforce skills in specialist areas including diabetes, preterm birth and autism, helping ensure safe care when specialist midwives are not immediately available
7. Trust review of homebirth services						
7.1	Has the trust board received, scrutinised and actioned an urgent review of homebirth services in line with the letter of the Chief Midwifery Officer and the regional chief midwife of 26 November 2025?	Compliant	**EV-20 Homebirth Assurance Report** **EV-21 Homebirth Assurance Report coversheet**	Full assurance is dependent on the successful delivery of the identified workstreams and continued national alignment on homebirth guidance.	A Homebirth and Out-of-Guidance Task & Finish Group has been established (March 2026) to oversee delivery of improvement actions arising from the Coroner's report.	A report was presented to Trust Board by the Chief Nurse and the Director of Midwifery on 11/03/26 to provide assurance to the Trust Board and the Chief Midwife for England that robust governance, clinical pathways, and oversight arrangements are in place to support the safe provision of homebirth and birth outside of clinical guidance, in response to the Coroner's Prevention of Future Deaths (PFD) report (November 2025). The Trust has responded appropriately to the Coroner's Prevention of Future Deaths notice within the specified time frame. Governance arrangements are in place, there are robust risk assessment and informed choice processes, and no systemic safety concerns have been identified.
7.2	Where significant risks and mitigations have been identified, has an action plan with agreed timescales to mitigate and remove the risks been agreed and shared with the Regional NHSE team?	Not applicable		N/A		
8. Responding to incidents, complaints and concerns with humanity and candour						
8.1	Does the trust have the Patient Safety Incident Response Framework (PSIRF) embedded within Maternity and Neonatal Services through clearly defined governance processes? Is the learning, any actions and outcomes regularly reviewed, shared with women and families, and routinely monitored at trust board through board safety reporting?	Compliant	**EV-22 Trust PSIRF Policy** **EV-23 Trust PSIRF Plan** **EV-24 RMG Report** **EV-25 QSF Terms of Reference**	None	The Thematic Review Tracker is continuously under development to refine priorities for actions and improvement based on trends and associated risks. A divisional Transformation Committee is scheduled to launch in October 2026 to maintain oversight of quality improvement work and ensure progress on actions and evidence of sustainability of improvements.	The Trust has embedded the NHS England Patient Safety Incident Response Framework (PSIRF) through its approved PSIRF Policy and Plan. Maternity and Neonatal Services operate a mature patient safety governance framework, with incidents reviewed through daily safety huddles, multidisciplinary incident review meetings and Trust-wide patient safety oversight processes. Learning, actions and outcomes are triangulated with audit, mortality reviews, complaints, claims and national investigations to inform improvement priorities. Oversight is maintained through established governance structures, including the Patient Safety Sub-Committee, Quality and Safety Committee and Trust Board, with learning regularly shared with staff, women and families.
8.2	Does the trust review complaints and concerns thematically, with learning actions and improvement plans monitored for impact? Are the themes and learning actions routinely reported to the trust board?	Compliant	**EV-06 Claims, Incidents and Complaints Q3 and Q4 25/26 Triangulation Report**	None	A health inequalities dashboard has been developed allowing retrospective review of inequity based on outcomes. Work is underway in partnership with Community teams, Safeguarding and Hertfordshire County Council (HCC) to develop a weighted 'vulnerability scoring system' that will allow proactive risk assessment at booking and personalised care planning to avoid inequity (due Jan 2027).	Complaints, incidents, claims, mortality reviews and national investigation findings are reviewed thematically to identify learning and improvement opportunities. Actions are monitored through divisional governance processes and triangulated through regular quality and safety reporting. A bi-annual Claims, Incidents and Complaints (CIC) triangulation report is presented to Divisional Board and Quality and Safety Committee, while key themes, trends and risks are reported through established governance routes, including Trust Board reporting, providing assurance that learning is translated into service improvement.
8.3	Does the Trust have embedded processes for open learning and compassionate debriefing, with staff supported to engage effectively with women and families, use feedback to inform practice, provide each family with a key contact, and ensure early duty of candour by a senior manager?	Compliant	**EV-26 PSERP Oversight Reports** **EV-27 Patient Safety Forum Report**	None	A Governance newsletter is in development which will capture all safety intelligence and ensure dissemination to the MDT on a monthly newsletter. The patient safety team are exploring possibilities of a 'patient safety channel' to communicate learning via video shorts.	The Trust has embedded a culture of open learning, compassionate engagement and compliance with Duty of Candour. Women and families are actively supported to contribute to investigations and reviews through dedicated patient engagement and women's experience roles, with senior clinical and governance leaders offering debriefs where appropriate. Duty of Candour processes are embedded and monitored, with families receiving timely communication regarding reviews and findings. Staff are supported through trauma-informed approaches, including TRIM training, staff debriefs and After Action Reviews, ensuring learning is shared and used to improve care and experience for women, babies and families.
9. Deliver safe and effective triage in maternity services						

9.1	Has the trust board completed and reported to NHSE regions an audit, including dedicated staffing and clinical capacity with a focus on ensuring that maternity triage services are consistently safe, responsive and appropriately resourced?	Partially compliant	**EV-28 EoE regional Triage Scoping Tool**	Missed-call performance and telephone triage capacity signify resource gaps	Obstetric staffing business case is in draft and due to go to Finance and performance committee for review in September.	The Trust has completed a maternity triage scoping and gap analysis against the East of England Regional Maternity and Neonatal triage tool recommendations, identifying strengths and areas for improvement. Established BSOTS processes, dedicated triage facilities, staff training and senior escalation arrangements provide assurance that core triage processes are in place. However, further audit work is required to fully assess demand, capacity and staffing requirements, particularly out of hours and at weekends, to support the development of an obstetric staffing business case. Findings have been escalated through governance processes, with reporting to QSC and regional workstreams underway. We currently do not sufficiently audit the Dr review times in accordance with BSOTS.
9.2	Does the board have clear oversight of triage quality and performance, supported by regular data on waiting times, assessment and review times, redeployment, delays and outcomes with a focus on inequalities?	Non-compliant	**EV-28 EoE regional Triage Scoping Tool**	Monitoring of waiting times, Dr review times, delays and outcomes as per BSOTS recommendations. This requires strengthened data quality and monitoring to achieve We do not currently have an established tool for monitoring inequalities, ethnicity or deprivation-related outcomes within triage. Currently trust Board have oversight of a limited data set.	Some elements of triage performance are monitored, including BSOTS Midwifery assessment compliance, as reported on to Regional Quality Oversight Group, and telephone audit data.	Whilst some elements of triage performance are monitored, including Midwifery BSOTS assessment compliance and telephone audit data, the Trust does not yet have a comprehensive triage performance dashboard providing routine Board-level oversight. Monitoring of waiting times, review times, delays, outcomes and inequalities is not yet consistently reported.
9.3	Is the trust on track to implement improvements in line with national triage guidance to ensure women have consistent access to high-quality, responsive triage across the NHS within 12 months?	Partially compliant	**EV-28 EoE regional Triage Scoping Tool**	Expansion of telephone triage provision and reduction in missed-call rates. Business case in development to strengthen staffing resilience during peak periods and weekends.	Actions are underway to address staffing capacity, telephone responsiveness, performance reporting and service user feedback towards greater compliance with the requirements within the national tool.	Improvements over the last 3 years include implementation of the BSOTS model, dedicated triage facilities, competency-based training with a dedicated telephone triage eLearning training package, locally developed and nationally adopted. Introduction of a twilight resident Dr role and escalation of triage risks through Trust governance processes. Actions are underway to address staffing capacity, telephone responsiveness, inequalities monitoring, performance reporting and service user feedback, providing assurance that the Trust is progressing towards full compliance
10. Post death care						
10.1	Has the trust board completed an assurance statement and submitted it by 31 July 2026?	Compliant	**EV- 29 ENHTT Fuller Response Letter**			The Trust Board completed and submitted the NHS England Annex 3 Board Assurance Statement on 29 July 2026, ahead of the national deadline. The submission confirmed review of the Fuller Inquiry recommendations and identified one outstanding area relating to centralised 24-hour CCTV monitoring, for which a time-bound action plan is in place with implementation planned before April 2027.The submission confirmed review of the Fuller Inquiry recommendations and identified one outstanding area relating to centralised 24-hour CCTV monitoring, for which a time-bound action plan is in place with implementation planned before April 2027.
10.2	Has the board assured itself that it is continuing regular oversight and implementations of national actions and recommendations around matters relating to mortuaries including review of incident records over the past 10 years?	Compliant	**EV-30 QSC July 2026 Fuller Inquiry Annex 3 compliance report** **EV-31 Nov 2025 Mortuary Performance meeting presentation**	A comprehensive review demonstrated compliance with 20 of 21 recommendations, with the only outstanding action relating to centralised CCTV monitoring	CCTV on track to be installed by March 2027	The Trust Board has received assurance through Divisional Board and the Trust Quality and Safety Committee regarding compliance with the Fuller Inquiry recommendations and ongoing mortuary oversight arrangements. A comprehensive review demonstrated compliance with 20 of 21 recommendations, with the only outstanding action relating to centralised CCTV monitoring. Governance arrangements, led by the Chief Nurse and HTA Designated Individual, provide ongoing oversight of compliance, quality and risk. Additional assurance was provided through the 2025/26 HTA inspection, with all actions completed and embedded into practice

Appendix 3. Maternity Triage Specification Benchmarking Audit Tool – ENHTT Baseline Assessment September 2026

Appendix 3. Maternity Triage Specification Benchmarking Audit Tool – ENHTT Baseline Assessment September 2026

Maternity Triage Specification Benchmarking Audit Tool Dashboard

Click below to link through to each principle		Fully in place	Partially in place	Not in place	Not relevant	Data not complete	Estimated cost to progress compliance of specification standard
Principle 1: Access and integration	Clear, local 24/7 pathways so women know where to go and are supported between services.	45%	55%	0%	0%	0%	£0.00
Principle 2: Recognition as urgent care	Maternity triage is the safety-critical emergency front door for urgent and unscheduled care and must be recognised and treated as such.	60%	40%	0%	0%	0%	£0.00
Principle 3: Assessment and care of women	Every woman receives timely assessment, prioritisation and a clear plan of care.	60%	20%	0%	20%	0%	£0.00
Principle 4: Clear information for women	Information and messaging must be clear, welcoming and unambiguous: contact triage if you are worried.	100%	0%	0%	0%	0%	£0.00
Principle 5: Telephone maternity triage	A dedicated 24/7 maternity helpline must be answered promptly and not diverted to labour ward.	88%	13%	0%	0%	0%	£0.00
Principle 6: Service user voice and experience	Women's feedback must shape service design, improvement and experience.	40%	40%	0%	20%	0%	£0.00
Principle 7: Facilities and estates	Triage needs safe, visible, fit-for-purpose space designed for urgent care.	100%	0%	0%	0%	0%	£0.00
Principle 8: Staffing	Staffing must support timely assessment and prompt midwifery and medical review when escalation is needed.	50%	33%	8%	8%	0%	£0.00
Principle 9: Equity and equality	Services must use data and targeted action to identify and reduce inequalities.	60%	40%	0%	0%	0%	£0.00
Principle 10: Data and measurement	Data must drive oversight, learning from incidents and continuous improvement.	57%	43%	0%	0%	0%	£0.00

Ockenden / Amos – Initial Trust response and Priorities

Amanda Rowley

16/07/26

East and North Hertfordshire Teaching NHS Trust

ProudToBeENHT

NHS
East and North Hertfordshire Teaching
NHS Trust

STAFF WELLBEING AND SUPPORT

Commitment to Staff Support

The Trust is committed to supporting staff through open listening, engagement sessions, and safe spaces for reflection.

Access to Wellbeing Resources

Staff will have access to pastoral support, and reflective practice for complex or traumatic cases.

Compassionate Leadership

Compassionate leadership and open communication are central to maintaining morale and trust during challenging times.

Board

East and North Hertfordshire Teaching NHS Trust

Meeting	Public Trust Board			**Agenda Item**	14
Report title	Risk Management Policy			**Meeting Date**	9 September 2026
Author	Compliance and Risk Lead Director of Quality Associate Director of Quality Governance				
Responsible Director	Chief Nurse and Medical Director				
Purpose [See note 7]	**Assurance**	☐		**Approval/Decision**	☒
	Discussion	☐		**For information only**	☐
Proposed assurance level (*only needed for assurance papers)*	**Substantial assurance**	☐		**Reasonable assurance**	☐
	Partial assurance	☐		**Minimal assurance**	☐

Executive assurance rationale:

N/A

Summary of key issues:

The revised Risk Management Policy provides a strengthened Trust-wide framework for the identification, assessment, escalation and management of risk. The policy aligns with NHS England guidance, CQC Well-Led standards, ISO 31000 and the Trust's governance framework. Key changes include establishment of the Risk Management Group (RMG) as the sole gatekeeper for entry to and exit from the Corporate Risk Register, clearer escalation and de-escalation criteria, enhanced risk appetite statements, strengthened accountability arrangements, and improved alignment between divisional risk management, the Corporate Risk Register and the Board Assurance Framework. The policy has been reviewed and endorsed by the Risk Management Group and Trust Management Group.

- Full review and update of the Trust Risk Management Policy (Version 12).
- Consolidates and strengthens the Trust's approach to risk identification, assessment, monitoring, escalation and assurance.
- Establishes the Risk Management Group as the sole gatekeeper for Corporate Risk Register inclusion and removal.
- Clarifies governance arrangements, executive accountability and divisional responsibilities.
- Updates the Trust's Risk Appetite Statement and aligns risk management processes with strategic objectives and Board Assurance Framework requirements.
- Supports a consistent ward-to-board approach to risk management and strengthens assurance arrangements for the Board and its committees.

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

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

These are supported by the policy's Trust-wide application, regulatory compliance requirements, ICS partnership arrangements and governance responsibilities.

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

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

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

BAF 7-Accountability, escalation, ownership & effective performance monitoring framework	
Report previously considered at & date(s):	
Considered at TMG on 11 June 2026 RMG June 2026. ARC 21 July 2026- minor amendments made to content, new appendix added related to QIA guidance.	
Recommendation	The Board is asked to **APPROVE** this policy.

To be trusted to provide consistently outstanding care and exemplary service

Doc ID: 148

East and North Hertfordshire Teaching NHS Trust

Risk Management

About this document						
Version	12		Review Date			30/09/2029
Document Type *highlight selection	Guideline	Policy	Procedure	Protocol	SOP	Other *please specify
Usage & Applicability			Trust wide for all staff			
Overarching Policy (for non-policies only)			*N/A*			
Division	Corporate Services		Speciality* (Unit if required)			Nursing & Quality -Quality & Safety
Document Author	Margaret Okojie, Associate Director for Quality Governance Sonia Marshall, Compliance and Risk Lead					

Version Control

Version	Date	Summary of changes
1	August 2007	Registration no Ex001 New policy following recommendation from NHS Litigation Authority
2	August 2009	Refresh – no significant changes
3	June 2012	Refresh – to update committees, monitoring arrangements
4	June 2015	Scheduled review. Registration no changed to CP 208
5	June 2016	Revised to strengthen arrangement for controls & oversight inc checklist to ensure actions & controls mitigate the risks
6	March 2018	Comprehensive revision to align with Risk Management Strategy
7	June 2018	Updated to align nomenclature with Datix, Risk Management Strategy & Board Assurance Framework
7.1	August 2018	Correction of table on page 7
8	March 2019	Escalation process added page 5 and 8, risk appetite referenced page 5, roles updated to reflect new risk function and alerts management changes and all Internal Audit recommendations (20.12.2018).
9	March 2020	Through the March 2020 Audit Committee risk report, the Committee was asked to approve proposed Datix changes in principle (for confirmation by the Audit Committee meeting in June 2020) and the unchanged Risk Management Strategy and Procedure.
10	May 2021	Updated to reflect current processes - Removed the information regarding the executive committee, updated the risk scoring matrix and update the section on 15 and above risks on the corporate risk register once gone through divisional test and challenge.
11	November 2023	Other Trust documents have been merged as listed below: o Risk management strategy o Risk management procedure o Risk appetite policy
12	September 2026	Establishes Risk Management Group as sole gatekeeper for CRR. References to issues log removed.

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Scope and Purpose

This policy sets out the Trust's overarching framework, mandate, and commitment for the effective identification, assessment, management, and escalation of risk. it provides a consistent and proportionate approach to risk management that supports patient safety, regulatory and statutory compliance, and delivery of the Trust's strategic objectives.

The policy applies to all Trust staff, contractors, and honorary appointees across clinical, operational, research, and corporate services, and to all divisions including Planned Care, Unplanned Care, Women & Children, Cancer Services, and Corporate Services. It also encompasses relevant system-level and place-based partnership risks within the Integrated Care System (ICS) where these directly affect the Trust or require shared management.

As an acute teaching hospital, the Trust recognises the complexity of delivering high-quality care across specialist and general services, alongside research, education, and collaborative system working. This policy therefore focuses on organisational risk management arrangements and includes the management of clinical, operational, financial, regulatory, strategic, and reputational risks.

The policy provides a single, Trust-wide risk management framework aligned with CQC Well-led standards, NHS England guidance, ISO 31000, and the East and North Hertfordshire Production System (ENHPS).

It supports transparent ward-to-board escalation, effective oversight, and regulatory assurance, and clearly differentiates between the Corporate Risk Register (aligned to the Board Assurance Framework), and Divisional Risk Registers. Strategic risks are articulated through the Board Assurance Framework, ensuring alignment between objectives, risks, controls, assurance and gaps.

Definitions

Acronym	Definition
QIA	Quality Impact Assessment.
ARC	Audit and Risk Committee
BAF	Board assurance framework
CIP	Cost Improvement Programme
CRR	Corporate risk register
CQC	Care Quality Commission
EIA	Equality Impact Assessments
ENHance	Trust quality management system, which contains a risk module for electronic management of risk
ENHT	East and North Hertfordshire Teaching NHS Trust
FTSU	Freedom to Speak Up
ICS	Integrated Care Systems
NHSE	NHS England
HSE	Health and Safety Executive
PLACE	Place-based partnerships exist to make more effective use of the combined resources available within a local area.
PSIRF	Patient Safety Incident Response Framework
RMG	Risk Management Group
TMG	Trust Management Group

Roles & Responsibilities accountable to this document

Trust Board - Holds ultimate accountability for risk management, approves the Strategy and Policy, defines risk appetite and tolerance, and assures itself through its committees.

Audit & Risk Committee (ARC) - Provides independent assurance of the adequacy of the Trust's risk management systems, escalation processes, and the Corporate Risk Register.

Quality & Safety Committee (QSC) - Focuses on all domains of clinical quality, health and safety and patient safety. The QSC shall in its capacity identify clinical and patient safety risks that are deemed to have a significant impact should it materialise and escalate it for inclusion to the corporate risk register.

Trust Management Group (TMG-Executive Team) - Owns the operational delivery of the risk framework, ensures divisional and corporate compliance, and endorses risks for escalation.

Risk Management Group (RMG) - The Risk Management Group (RMG) is responsible for;

- Acting as the gatekeeper for risks entering and exiting the Corporate Risk Register (CRR), ensuring they are material, evidence-based, and aligned with Trust priorities.
- Reviewing, challenging, and approving risks proposed for escalation from Divisional or Corporate Risk Registers, confirming that each meets the agreed CRR inclusion criteria and is supported by robust evidence.
- Receiving and scrutinising risk reports from all divisions, seeking assurance on the validity and management of risks.
- Monitoring Trust-wide compliance with the Risk Management Framework and associated KPIs.
- Providing assurance on the effectiveness of risk management to the Audit & Risk Committee and the Board.
- Operating in full accordance with its Terms of Reference.

Executive Sponsors - The Executive Sponsor will usually be the Executive responsible for the area of risk and leading risk score.

Chief Executive Officer - as Accountable Officer has overall responsibility for risk management and for ensuring the Trust has a Risk Management Strategy and infrastructure in place to provide a comprehensive system of internal control and systemic and consistent management of risk. The Chief Executive will delegate specific roles and responsibilities as required, to ensure risk management is coordinated and implemented equitably to meet the Trust's objectives.

Chief Nurse/Deputy Chief Executive - As executive lead for patient safety and quality, the Chief Nurse holds delegated board responsibility for clinical risks and governance.
They shall ensure clinical risk management is integrated with financial and organisational processes, providing assurance to the Board through the BAF and CRR.
The Chief Nurse shall seek assurance from internal and external reviews on the effectiveness of clinical governance and patient safety systems.

Director of Finance - The Director of Finance holds delegated board responsibility for financial constraints, estates, and financial risks. They shall ensure financial planning and risk management are integrated with clinical and organisational risk processes, assuring the Board through the BAF and CRR. They shall seek the Internal Auditor's opinion on the effectiveness of internal and financial controls.

Medical Director - As executive lead for quality and effectiveness, the Medical Director holds delegated board responsibility for strategic and clinical risks relating to quality of care.

They shall ensure clinical governance and effectiveness are integrated with organisational and financial risk processes, providing assurance to the Board through the BAF and CRR.
They shall seek assurance from internal and external reviews on the effectiveness of medical governance and quality systems.

Chief Operating Officer - Responsible for the operational delivery of the Trust's services, and as such holds the executive level ownership for risks relating to the delivery of operational services.

Director of Quality - As lead for quality governance, the Director of Quality holds operational responsibility for risk management and assurance processes, including line management of the corporate quality, compliance, and risk team. They lead the development, review, and renewal of the Trust Quality Strategy and ensure the risk register accurately reflects the organisational risk profile, informing the Board and driving improvements in practice and care. The Director of Quality also holds delegated responsibility for patient safety within risk management processes.

Associate Director of Quality Governance - Responsible for leading the Trust's risk management function and ensuring robust strategic risk management systems are developed and embedded. The role shall lead on Trust-wide risk management training, ensuring role-specific provision is in place, and oversees the monitoring of risks and safety requirements from external agencies.

Director of Estates and Facilities - Responsible for the management of risks within their areas of operational responsibility. They are responsible for ensuring that risks are appropriately escalated according to the Trust Risk Management policy through to Executive and Trust Board where appropriate. They are responsible for ensuring that there are nominated individuals in their teams with explicit risk management responsibilities.

Head of Corporate Governance - The Head of Corporate Governance is the Trust's lead for corporate governance and Secretary to the Board. The role supports the Board of Directors in fulfilling its governance responsibilities and holds primary responsibility for developing, maintaining, and coordinating the Board Assurance Framework (BAF). They shall ensure the BAF provides clear alignment between strategic objectives, risks, and assurance, and that it is used effectively by the Board in its decision-making and oversight.

Compliance and Risk Lead - Will provide operational support for Trust-wide compliance monitoring, maintain the Corporate Risk Register, and produce compliance assurance reports. This role supports divisional teams through training delivery, guidance on risk registers, and facilitation of the Trust's Risk Management Strategy and Policy implementation.

Risk and Action Leads/Owners - Every risk recorded on the Trust's risk management system must have an identified Risk Lead and associated actions with action owners. They are responsible for:

- Ensuring the risk is actively managed, monitored, and controlled
- Confirming controls and further actions are in place and updated
- Escalating risks scoring 15 and above in line with the Trust escalation process
- Implementing assigned mitigating actions
- Updating on ENHance progress with assigned risk and actions

Risk Leads must ensure that each risk held on ENHance is fully complete, that scores are in line with our score definition and the risk is well-evidenced.
They will ensure relevant actions are in place to actively reduce the risk; unless it is deemed tolerable.
They must review risks as per this Framework and ensure that progress notes contain a relevant audit trail

All Managers and Staff - All managers and staff share responsibility for managing risks within their service areas and must ensure they complete appropriate risk management training commensurate with their role.
All staff are accountable for the quality and safety of the services they deliver. They must:

- Participate in risk assessment processes as required
- Comply with national, professional, and Trust policies, procedures, and safe systems of work relevant to their role
- Report quality and safety issues through the Trust's reporting systems to enable timely action.

Vision and objectives

At East and North Hertfordshire Teaching NHS Trust (ENHT), risk is defined as the combination of the likelihood of an event occurring and the potential impact of its consequences. This means that, risks can represent both:

- Threats: to patient safety, quality of care, regulatory compliance, finances, reputation, or delivery of our strategic objectives.
- Opportunities: to improve outcomes, strengthen systems, innovate, and achieve excellence.

Our Risk Management Framework provides a structured and consistent approach to identifying, assessing, reporting, and managing risks, so that the Trust can maximise opportunities while effectively mitigating threats to patients, staff, and services.

Our vision is to embed risk management into everyday practice, supporting safe care and strong performance through clear accountability from ward to Board creating a "no surprises" culture where risks are identified early and managed consistently. We achieve this through clear accountability from ward to Board to protect patients, deliver strategic objectives, and maintain public confidence.

Our integrated Risk Management Strategy ensures risks to all stakeholders including patients and staff are systematically identified, evaluated, and controlled to an acceptable level. This approach is aligned to the Trust's governance framework, supported by the Board Assurance Framework (BAF) for strategic risks and a dedicated electronic risk register (ENHance) for operational risks. It is guided by our values (Include, Respect, Improve) and our strategic themes.
Effective risk management helps us:

- Improve quality: Ensure clinical and non-clinical risks are reduced to support the delivery of high-quality, safe services.
- Support thriving people: Provide a safe environment that supports and protects our staff.
- Enable seamless service: Minimise disruption to care delivery for patients by managing operational risks effectively.
- Drive continuous improvement: Maximise opportunities and learn from both successes and failures to continuously improve our services.

The Trust acknowledges that some residual risk is unavoidable and is committed to managing this responsibly. Accountability for effective risk management is embedded across the entire organisation.

Capital Investment and Risk

As a healthcare organisation, risks associated with estates, infrastructure, and capital equipment are recorded and managed within the Trust's risk management system where failure, obsolescence, or delay could compromise safety, compliance, or service continuity. However, the

Corporate Risk Register is not used to escalate or inflate risk scores to justify or secure capital funding.

Capital-related risks provide transparency to inform prioritisation within the approved Capital Programme and enable evidence-based discussion at the Finance, Performance and Planning Committee.

Escalation is driven by the level of threat to patient safety, service delivery, or statutory compliance and not by the financial value of potential investment.

Psychological Safety, PSIRF, and Speaking Up

The Trust recognises that effective risk management depends on an open and psychologically safe culture where staff feel empowered to raise concerns without fear of blame. Under the Patient Safety Incident Response Framework (PSIRF) and the Freedom to Speak Up (FTSU) principles, all staff are encouraged to identify, report, and discuss risks, near misses, and safety concerns as opportunities for learning and improvement.

The Trust values psychological safety as an essential element of its risk culture: people must feel able to challenge decisions, disclose errors, and highlight system vulnerabilities. The FTSU Guardian and Whistleblowing Policy provide formal mechanisms to escalate concerns, while the risk management framework ensures these concerns are assessed, recorded, and addressed proportionately within the Trust's governance system. This integrated approach links PSIRF, FTSU, and the Corporate Risk Register, reinforcing a "no-surprises" learning culture. (These policies have been included in the associated documents section with Associated ID and can be accessed via ENHance).

Risk Framework

A structured approach to the management of risk must be taken regardless of whether it is clinical or non-clinical in nature. Risks are identified, assessed and controlled and, where appropriate, escalated or de-escalated through the governance mechanisms of the Trust. The Trust adopts a Three Lines of Defence model, under which risks are owned and managed at operational level (first line), overseen and challenged through corporate governance and risk functions (second line), and independently assured through internal audit and external bodies (third line), providing the Board with confidence in the effectiveness of risk management and internal control

Sources of risk:

- Risks for inclusion on the risk register may be identified from a number of sources including horizon-scanning, business planning, operational service delivery, audits, incidents/near-misses, inspections, health and safety risk assessments, complaints and enforcement action.

Figure 1: Ward to board risk discussion forums

This inclusive approach ensures that the organisation systematically assesses potential risks and maximises opportunities in line with its objectives. Our risk process is visualised below:

Figure 2: Risk Management process

Risk Management Process

East and North Hertfordshire NHS Teaching Trust's risk management process systematically applies policies, procedures and practices to communicate, assess, treat, monitor, review, record and report risk.

The Trust follows ISO31000 principles, integrating risk management into its structure, operations and decision-making at all levels (strategic, divisional, care group, specialty, and projects). The process is iterative, accounting for human behaviour, human factors and culture. https://pecb.com/en/whitepaper/iso-31000-risk-management-principles-and-guidelines

The Trust has a single Risk Register which operates at Unit, Specialty (department), Divisional and Trust level (Corporate risk register). Its purpose is to evaluate the level of existing internal control in place and to help prioritise actions, funding or resources and inform decisions. It is a live document which must be regularly reviewed and updated.

ENHance has a 'open and awaiting approval' area where risks can be drafted before being agreed and placed as a live risk on one of the three levels of our Risk Register. ENHance contains a step-by-step guide on how to add a risk.

Risks must not remain at 'new status' for more than 1 month (30 days) and must be progressed to a live register or closed if no longer relevant.

Each division shall hold an aggregated risk register populated by risks identified at speciality and care group. This register must be reviewed on a monthly basis by the Division's Divisional Board.

Once a risk has been agreed by the specialty / department / relevant group and placed on the specialty risk register, it must be escalated for discussion at divisional forums.

Risks may:

- affect multiple departments causing an accumulative effect
- give rise to a moderate breach of legislation
- may result in a more serious safety incident
- has the possibility of a moderate financial penalty or loss
- poses a moderate threat to operational stability
- has implications for Fraud, Corruption or Bribery
- where current resources fall below the safe operational threshold
- may affect the achievement of organisational objectives if not reduced

Divisional Boards remain accountable for managing and monitoring their own ≥15 risks. Strengthened governance at divisional level ensures only robust, well-described risks are proposed for escalation.

If a risk exceeds the divisional risk register criteria it must still be placed on the divisional risk register (if approved) but must be escalated to the next Risk Management Group (RMG) meeting for approval onto the Trust corporate risk register.

Raising New Risks: Any staff member can identify and raise a risk to their line managers. Divisional senior managers review all new risks to determine if they constitute a risk (requiring mitigation) or an issue (manageable within business as usual), and verify that the risk title, description, scoring and mitigations are accurate and appropriate.

Risk Identification

Risks are identified proactively and reactively through multiple sources including:

- Performance indicators and audits
- Incidents, complaints, claims and serious incidents
- Clinical and workplace risk assessments
- Internal/external reviews, inspections and accreditation
- National guidance, legislation and safety alerts
- Equipment issues and system failures
- Staff/patient surveys and Raising Concerns Policy
- Committee meetings and change control processes
- Capital projects and service developments

Please see Appendix 1 for a generic risk assessment to assist in identifying risks before addition to risk registers.

Risk versus Issue:
A *risk* describes the potential for a future event to occur.
An *issue* describes an event that has already occurred and requires operational management.
Where likelihood becomes ‘almost certain’, risks should be reviewed and re-framed to be future focused.

Each risk must be clearly defined using simple, unambiguous language and the 'If/Then/Resulting in' concept.
Example:

If the necessary digital transformation improvements are not prioritised, funded or delivered	***Then*** the Trust will lack the digital means to deliver its plans including using obsolete legacy systems that are unsupportable	***Resulting in*** 1) not delivering transformation plans that are crucial to improving efficacy and productivity 2) not achieving the nationally mandated minimum digital foundations and 3) a failure to optimize patient experience and quality of care

Risk Analysis and Evaluation: Risk analysis develops understanding of causes, consequences and likelihood to determine appropriate management. Analysis should be objective using independent evidence and quantitative data where available. Where uncertainty exists, assessors should take a precautionary approach.

Consequence is scored using the Table of Consequences (highest domain applies). Likelihood is scored using the Table of Likelihood with existing controls
Risk score = Consequence × Likelihood (See Appendix 2 and 3).

Risk Profile and Scoring

The Risk Score Matrix (Appendix 3) determines overall risk score and grade/rating, which guides risk appetite, treatment urgency, ownership, reporting and oversight as defined in the Risk Treatment Table.

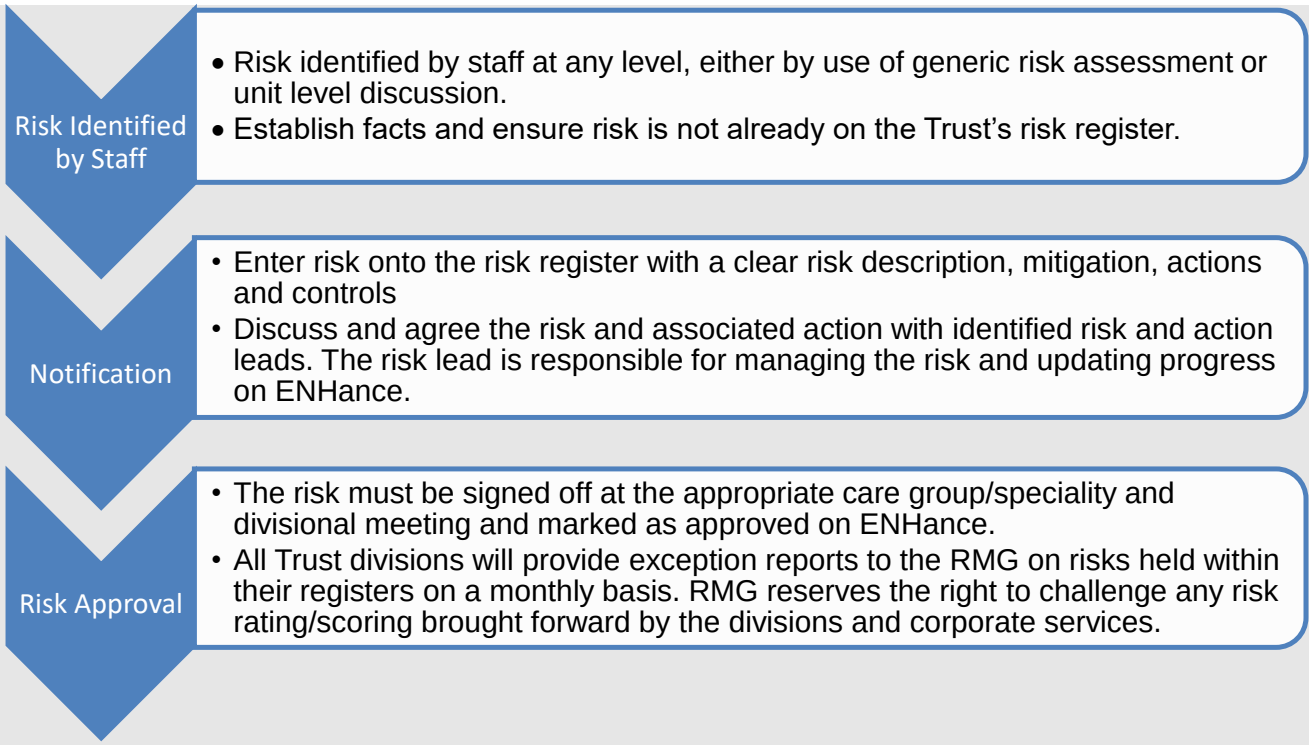
The Trust uses three risk scores:

- Initial Risk Score: Score when first identified if no actions were taken; remains unchanged as a benchmark
- Current Risk Score: Current score with applied controls; should reduce toward target as actions are implemented

- Target Risk Score: Expected score after full implementation of mitigations to reach tolerable level

A trend line is present on ENHance to reflect previous current scores recorded and demonstrate changes in score across the life of the risk.

Risk Grade/Scoring: For grading risks, the scores obtained from the risk matrix are assigned grades as per the Grade descriptor. Risk grading makes evaluation of the risk easier with reference to the Trust wide risk profile; providing a systemic framework by which to identify the level at which risks will be managed, prioritising remedial action and availability of resources to address risks.



Risk Management and Monitoring

All risks must have clear descriptions of risk title, description, controls/mitigations, monitoring and actions.

A control is any measure that is in place which reduces either or both the likelihood of the risk materialising or its effect/ consequence. Examples of controls include:

- Resources including structured training, review processes and procedures such as supervision or quality assurance checks which can dramatically reduce the likelihood of a risk occurring.
- Processes including press/ communications management and contingency planning are effective at minimising the effects of most adverse events.
- Prevention Controls prevent a hazard or problem from occurring; (for example IT logical controls, policies and procedures).
- Detection Controls provide an early warning of control failure; (for example audit, inspection, monitoring, incident reporting, smoke detectors, complaints).
- Corrective Controls remedy problems discovered through detection controls.
- Contingency Controls provide effective reaction in response to a significant control failure or overwhelming event and are designed to mitigate harm and improve resilience and service restoration.

- Directive Controls designed to ensure a particular outcome is achieved. These are based on giving directions to people or a third party, including instructions provided to staff.

An effective control should always reduce the effects or likelihood of a risk occurring, and therefore the current score be documented as lower than the initial score. If this is not the case, then the control is ineffective and needs to be reconsidered.

Control owners shall consider the effectiveness of each control by obtaining assurance that the control is both in place and operating effectively.

These assurances may be obtained from a variety of internal and external sources, such as management reports, direct review, performance data, internal and external audit and other external sources.

These assurances may indicate the control is working effectively, or identify the control is ineffective and needs to be redesigned or reinforced. Assurances can therefore be either:

- Positive Assurance: Demonstrates the control is working effectively. For example, a reduction in related incidents.
- Negative Assurance: Demonstrates the control is not working effectively. For example, an increase in related incidents.

All risks must have documents actions which will detail steps to be taken to close or tolerate the risk. These must clearly define what action is to be taken, by whom, and by what date.

The following minimum periods for review have been set for all risks and are aligned to the risk score.

Score	Level	Review Period
Tolerated	Tolerated	Six monthly (Bi-annual) Review
(1 - 3)	Very low	Six monthly (Bi-annual) Review
(4 - 6)	Low	Three Monthly (Quarterly) Review
(8 - 12)	Moderate	Two Monthly Review
(15 - 25)	High	Monthly

Event-Triggered Reviews: In addition to scheduled reviews, risks must be reviewed immediately when:

- Significant changes occur to the internal or external context affecting the risk
- New information emerges that impacts the risk assessment
- Controls fail or prove ineffective
- An incident occurs related to the risk
- Legislation, regulation, or national guidance changes
- Stakeholder concerns are raised
- Risk owners are responsible for initiating event-triggered reviews and updating risk assessments accordingly.

All risks must be reviewed and documented on the electronic risk management system in line with these timeframes; however more frequent review may be undertaken as necessary/required.
Risks must be escalated when

- The current risk score increases by 4 points or more from the previous assessment
- A risk moves from one risk level to another (e.g., Moderate to High)
- The consequence score reaches 5 (catastrophic/major), regardless of likelihood
- Mitigating actions are significantly delayed or cannot be implemented
- Resource constraints prevent adequate risk management

- The risk exceeds the Trust's risk appetite or tolerance threshold
- Escalation must occur within 5 working days to the appropriate governance group and, where applicable, to the RMG/Trust Management Group/ Board.

Risks with a consequence score of 5 (catastrophic/major) i.e. High Impact low probability risks, regardless of overall risk score, require

- Monthly monitoring at Divisional Level
- Bi-annual in-depth review at Divisional level with associated reports provided to the RMG
- Immediate escalation to Board if likelihood increases
- Annual Board assurance on control effectiveness

The board and its identified sub-committees shall maintain oversight of extreme risks (scores 15-25) through:

- Reports/ escalations from the Risk Management Group (RMG)
- Inclusion on the Board Assurance Framework
- Monthly reporting via the Integrated Governance Report
- Direct accountability assigned to an Executive Director as the executive lead
- Six monthly bi-annual executive led review of all risks scoring 15 and above

Risks leads and owners shall consider the following when undertaking risk reviews

Consideration	Description / Question	Impact / Outcome
Risk Description	Is the risk still the same or has it changed?	Risk updated to reflect the new nature of the risk or a new risk raised
Realisation of the risk	Has the risk occurred? To what extent?	Consider any new risks because of the risk occurring
Incidents, Complaints or Claims	Have there been related incidents, complaints or claims? or has the number of incidents, complaints or claims increased/ decreased?	May change the likelihood Score or Consequence
Control Effectiveness	Are the controls put in place effective in reducing the risk?	Change of consequence or likelihood score
Completed Actions & Effectiveness	Have mitigating actions been completed? If so, how effective are they in reducing the risk?	Change to consequence or likelihood score
Consequence Score	Has the likelihood or consequence changed?	Change to consequence or likelihood score
Target Score	Is the target score still achievable or has it been reached?	Change to target score or closure of risk.

Managing Risk: The Trust may opt for 4 ways of managing risk, Treat, Transfer, Tolerate or Terminate.

Treating a risk involves taking action to modify risk severity and effect. This is the most common approach to risk treatment. It is important to ensure that actions are proportionate to the risk identified

Transferring or sharing a risk is where exposure is transferred to a third party, such as an insurance company or by sub-contracting. In practice, it is very unlikely an organisation can fully

transfer a risk and for that reason the term ‘risk sharing’ is often used. Other examples of risk transfer include joint ventures, outsourcing and risk financing.

Risk Tolerance: Risks that have been identified, assessed and evaluated and do not require any further mitigating actions. The risks we are prepared to accept to achieve our strategic and operational goals. The risk may be accepted with no prospect of immediate action. For example, if the risk is low or if taking action is disproportionately costly.

Risk will normally be tolerated if the risk’s perceived severity is less than the risk appetite. Tolerating a risk does not result in any reduction in severity as the risk is being tolerated at its current level.

The toleration of high-severity risk makes an organisation especially vulnerable. Where a risk must be tolerated, a robust monitoring system must be in place to measure outcomes and agreed parameters (the target risk level).

Where monitoring indicates that the risk is increasing and/ or has changed considerably, a new risk may be opened on the risk register with a plan to introduce further controls to reduce the risk to the tolerated level.

The level at which a toleration decision is approved is proportionate to the risk's consequence rating and CRR status: risks scoring below 15 may be tolerated at divisional director level with documentation on ENHance; risks scoring 15 or above (CRR-level) require RMG recommendation and Audit & Risk Committee ratification on a quarterly basis.

No CRR-level risk may be recorded as tolerated without documented Board-level visibility.

Risk owners should ensure that all relevant information is captured on ENHance including the date the risk forum agreed the risk closure. All closed risks will remain on the Trust Risk Register for audit purposes.

Any risks closed with a tolerated residual risk, should have the effects of the controls monitored through the relevant governance forum in the Trust. The forum monitoring the controls and the parameters for re-opening the risk must be noted in the progress notes on ENHance when closing the risk, for audit purposes.

To terminate a risk is the termination of the activity associated with the risk.

Termination is usually undertaken reluctantly and because the residual severity of the risk is simply too high after consideration of all other possible cost-effective responses (from transfer or treat).

There are circumstances where an organisation cannot terminate even its highest severity risks, especially in the public services (where there can be a statutory obligation to deliver certain services) or where the loss of reputation would be deemed a greater risk. In these situations, the only option left is to tolerate the residual risk that remains, even though it exceeds risk appetite.

Closing Risks/ Risk Closure: When a risk has been terminated, or mitigated to the agreed tolerated level, the risk register entry may be closed subject to the agreement of the risk sponsor and risk manager, with the endorsement of the chair of the relevant risk forum.

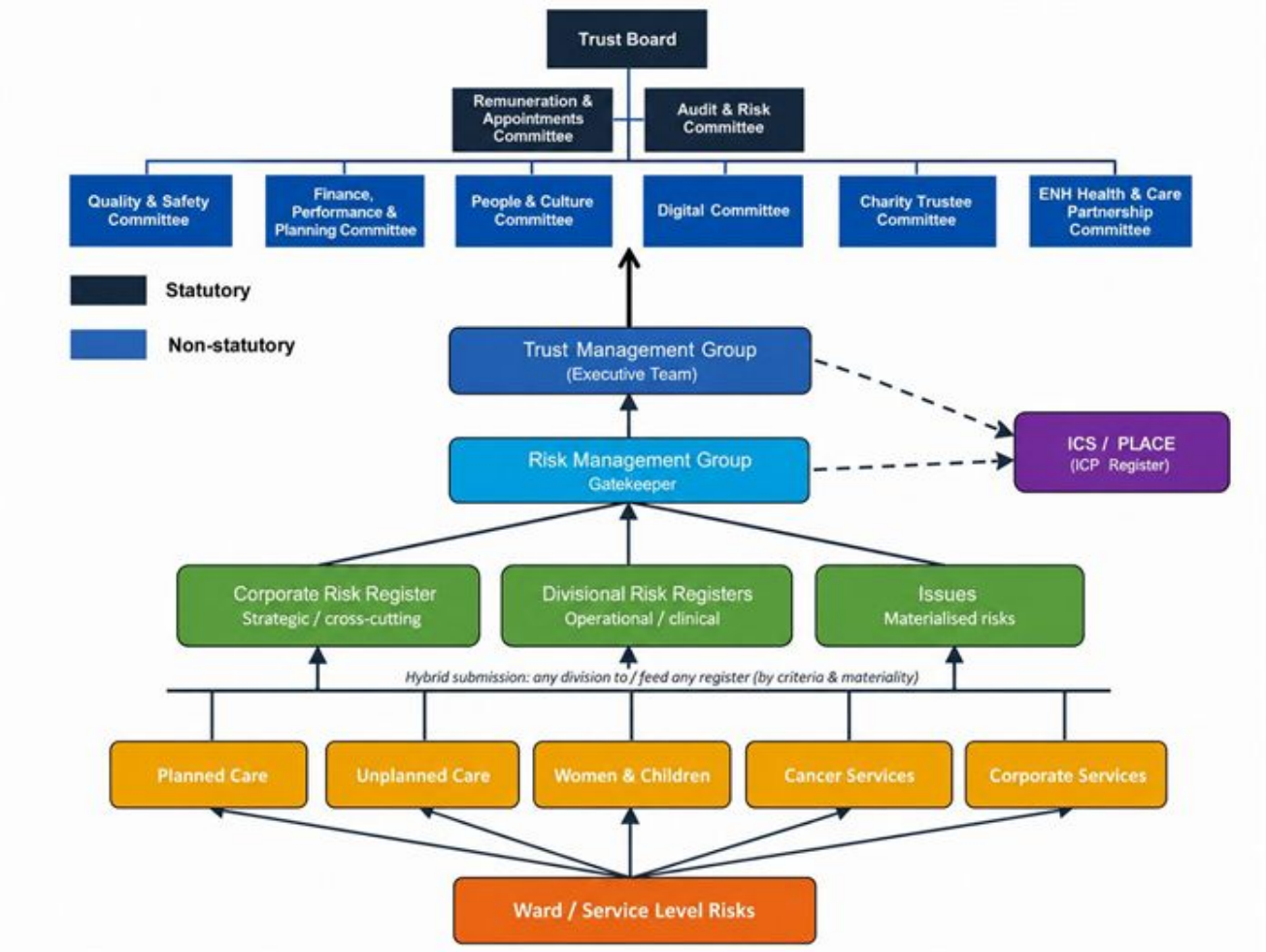
Risk Management Governance Structure

Risk management governance is based on risks that are recognised, acted upon, reported, and the assurance that the risk management framework is effective and working.

ENHT governance structure for risk is overseen by the Board of Directors, which sets strategy and risk appetite, supported by the Board Assurance Framework (BAF) for strategic risks.

This framework is cascaded through multiple committees, including the Audit and Risk, Quality and Safety, and Finance and Performance Committees, as well as divisional teams and service leads. Operational risks requiring executive oversight are recorded on the Corporate Risk Register (CRR).

Trust committees shall provide the Board of Directors with assurance by receiving regular reports on the achievement of objectives, delivery, weaknesses, and all significant risks. They review material changes and milestone progress to effectively manage corporate risks. These are identified and aligned with the Trust's accountability framework.



Risk Appetite Statement

ENHT adopts a differentiated approach to risk appetite. We have minimal tolerance for preventable harm, unlawful non-compliance and safety critical estates risks.

We are open to seek in domains essential to sustainability (workforce, digital, transformation and strategic delivery), taking intentional, transparent and controlled risk where benefits to patients, staff and long-term resilience are clear.

Our risk appetite is dynamic, reviewed every three years (or sooner if the external environment materially changes), and is applied consistently through business cases, the CRR/BAF and committee oversight (See appendix 4).

The Trust board has agreed the following domains and our position in terms of what we will allow

Quality (Open-3):
ENHT has an open appetite to take managed quality improvement and transformation risk where this demonstrably improves patient outcomes, reduces unwarranted variation and supports PLACE-based system working.
The Trust has very low tolerance for preventable harm, unsafe care or failure to meet fundamental standards. Deliberate quality risk may only be taken where robust controls, clinical leadership, defined outcome measures and Board visibility are in place, with clear escalation triggers where safety thresholds approach tolerance limits.
We actively support research and innovation in pursuit of quality improvement.

Regulatory (Open-3):
ENHT has an open appetite for regulatory and statutory compliance risk in circumstances where interpretation, innovation or system leadership require confident and constructive engagement with regulators.
The Trust has minimal tolerance for unlawful or unsafe non-compliance. Any compliance gap must be transparent, formally owned and supported by a time-bound recovery plan with clear Board visibility.
The Trust operates a “no surprises” approach, maintaining proactive engagement and strong oversight, while retaining the ability to challenge proportionately where this is in the best interests of patients and system partners.

Financial (Seek-4):
ENHT has an open-to-seek appetite for financial risk where investment demonstrably protects patient safety, enables transformation and strengthens long-term sustainability.
This appetite is exercised intentionally through strategic investment and transformation programmes, not through unmanaged cost growth or control failure. Financial risk-taking must be supported by defined benefits realisation, clear ownership, milestones and appropriate stop-loss mechanisms.
The Trust has very low tolerance for recurrent cost growth without identified recurrent funding, unfunded service expansion, or risk-taking that worsens the underlying run-rate deficit.
Financial risks rated high or extreme remain within low tolerance and must be transparently managed through the Board Assurance Framework and formal governance processes.
This appetite will be reviewed periodically in light of external financial conditions and delivery confidence

Workforce (Seek-4):
ENHT has a risk-seeking appetite for workforce redesign, new roles and culture change, accepting controlled short-term disruption to strengthen capability, retention and psychological safety. This appetite is exercised within defined tolerances for wellbeing, safe staffing, vacancy and turnover

levels, and is supported by clear learning and assurance mechanisms to ensure risks are identified early, reviewed and escalated where thresholds are approached or breached.

Reputation (Seek-4):
ENHT has a risk seeking appetite to act transparently and take difficult decisions in the public interest, accepting scrutiny where decisions improve safety, quality and sustainability.
The Trust has low tolerance for reputational risk arising from lack of candour, delayed escalation or unsafe practice

Digital (Seek-4):
ENHT has a risk-seeking appetite for digital transformation, recognising that managed implementation risk and short-term disruption may be necessary to achieve safer, more reliable and efficient care, and to support workforce sustainability.
This appetite is exercised within clear guardrails. The Trust has very low tolerance for unmanaged cyber security risk, data protection breaches or clinical digital safety risk. These risks must be clearly defined, owned and subject to robust controls and escalation in line with the Trust's risk management framework.

Estates & Infrastructure (Open-3):
ENHT has an open appetite to take managed estates and infrastructure risk to enable strategic delivery, service continuity and transformation where robust controls and mitigations are in place.
The Trust has very low tolerance for safety-critical estates risks, including fire safety, structural integrity or critical plant failure. Estates risks must be transparently prioritised and time-bound through a Board-visible programme.

Trust Management Capability

At ENHT, management capability in risk management refers to the Trust's collective ability to consistently identify, assess, manage, and assure risks from ward to Board. This includes the knowledge, skills, behaviours, and systems required to apply the Risk Management Framework effectively, ensuring risks are clearly described, appropriately scored, and supported by robust controls, actions, and evidence.

Management capability is enabled through structured training, use of the ENHance system, and clear governance processes, ensuring that risk information is translated into informed decision-making, effective mitigation, and reliable assurance to the Board.

Management capability is a shared organisational responsibility and is fundamental to delivering a mature risk culture aligned with CQC Well-Led standards and the Trust's "no surprises" approach.

Leaders at all levels are expected to promote psychological safety, enable constructive challenge, and ensure risks are managed at the appropriate level rather than escalated unnecessarily.

The effectiveness of this capability is demonstrated through consistent risk calibration, quality of divisional risk management, and the ability of the Risk Management Group to provide robust challenge and assurance, ensuring that the Trust maintains a clear, accurate, and actionable risk profile.

Quality Impact Assessment (QIA) and Risk Management

Processes involving transformation, Cost Improvement Programme (CIP) and any other change management process that demonstrates inherent or emerging risk, whether intended or unintended should complete a QIA. QIAs should be completed as per associated change

management process/policy and are to be understood and accountable to the identified risk owners. Relevant QIAs should be documented within the ENHance system, attached in the documents section (See Appendix 5).

Corporate Risk Register

All risks scoring 15 or above will be considered for escalation and consideration for inclusion onto the corporate risk register. All divisions must undertake rigorous review of any identified CRR risks and follow divisional protocols for its sign off, rejection or inclusions in its risk registers.

The CRR shall contain only those risks scored 15 and above that meet ENHT defined criteria, requiring Board-level oversight and Executive coordination, and have been agreed via RMG.

Clear risk ownership and oversight shall be established at both divisional and Executive levels.

Escalation decisions shall be based on objective criteria and documented evidence.

The process ensures that the CRR remains focused on genuinely strategic risks that require Executive leadership and Board visibility, while maintaining appropriate divisional accountability for operational risk management.

Before escalation may be considered, the current risk score should be ≥15 on the Trust's 5×5 risk matrix. To support entry to the CRR a risk should demonstrate genuine strategic character linked to the following strategic criteria:

- Materiality: The risk has significant cross-divisional impact, affects multiple care pathways, requires coordination at PLACE/Integrated Care System (ICS) level, or necessitates Executive-level coordination beyond the authority of a single Division.
- Statutory/Regulatory Compliance: There is a clear breach or high likelihood of breach of statutory duty, regulatory requirement, or NHS Provider Licence condition, with probable enforcement action by CQC, NHS England, or other regulator.
- Reputational Impact: There is high likelihood of serious reputational damage at regional or national level, including sustained national media coverage, parliamentary scrutiny, or significant public/commissioner concern.
- Financial Impact: The risk presents potential financial loss exceeding £5 million, material financial penalty, Cost Improvement Plan (CIP) failure with Trust-wide financial consequences, or threat to the Trust's going concern status.
- Operational Instability: The risk creates daily service instability preventing safe care delivery, presents imminent Major Incident risk, constitutes critical infrastructure failure affecting multiple services, or represents an intolerable resource gap below safe threshold.
- Ethical/Fraud/Integrity: There are credible concerns of fraud, bribery, corruption, or whistleblowing allegations with serious systemic implications requiring Board awareness and action.
- Board Assurance Framework (BAF) Link: The risk directly undermines a Trust Strategic Objective, significantly impacts BAF risk scoring or controls, or creates a gap in assurance that cannot be addressed at divisional level.
- Quality Impact Assessment (QIA) Trigger: The risk has been identified through a QIA for a CIP, service change, or operational modification, with unacceptable safety or quality impacts that require Board-level decision-making to proceed.

Corporate Risk Register Escalation Process

When a risk on the Divisional Risk Register scores ≥15 and has been divisionally approved the department/divisional representative should include this risk within the escalation section of their RMG papers. Presenters must be prepared to share and discuss:

- Current, inherent, and target risk scores
- Existing controls and identified gaps
- Assurance sources (1st, 2nd, and 3rd line)
- Evidence that the risk cannot be effectively managed at divisional level
- Completed QIA (where applicable)
- Incident or complaint trend analysis
- External correspondence from regulators or commissioners
- Business case or resource request
- Previous Board or Committee papers related to the risk
- Identified actions and requirements for executive sponsorship

The Divisional Board shall: Review the Escalation Case and assess whether the risk genuinely meets the strategic criteria and whether escalation is appropriate. Challenge and validate and apply critical scrutiny to:

- Accuracy of risk scoring
- Validity of strategic criteria assessment
- Completeness of controls and mitigations attempted at divisional level
- Clarity of rationale for why the risk cannot be managed divisionally

If satisfied that escalation is warranted, the Divisional Board shall:

- Formally endorse the escalation
- Document a clear rationale explaining why the risk requires CRR inclusion
- Identify an appropriate Executive Sponsor from the Executive Team
- Ensure the Executive Sponsor is briefed on the risk and accepts ownership
- All documentation must be captured on the Trust’s risk management system- ENHance.

If the Divisional Board determines that escalation is not warranted, the risk shall be returned to the Risk Owner/Care Group with documented feedback and remain on the Divisional Risk Register with enhanced monitoring.

Risk Management Group (RMG) Strategic Review: The RMG acts as the Trust's gatekeeper for CRR inclusion. The RMG shall validate scoring accuracy and review the risk score to ensure it is:

- Calculated correctly using the Trust's 5×5 risk matrix. Identified risks must meet the minimum escalation threshold before submission to RMG: Risk score ≥15.
- Based on accurate assessment of consequence and likelihood
- Reflective of current controls (not artificially inflated) and that there is a clear action plan with accountable owners and timescales.
- Consistent with similar identified risks across the Trust

Assess Strategic Character: Apply a strategic lens to determine whether the risk genuinely requires Board-level oversight by considering:
Strategic Significance: Does this risk affect Trust-wide objectives or remain primarily divisional?

- Board Value-Add: What will Board involvement achieve that divisional management cannot?
- Resource Authority: Does mitigation require resources or decisions beyond divisional authority?
- BAF Alignment: Is this genuinely a BAF-level strategic risk or a serious operational risk better managed divisionally?
- Cross-Boundary Coordination: Does effective management require coordination across divisions or with external organisations?

Challenge the Narrative: Ensure that:

- The risk description clearly articulates cause, event, and consequence

- The strategic criteria assessment is substantiated by evidence
- The escalation rationale is compelling and specific

The RMG shall make one of the following recommendations:

- Approve for CRR Inclusion: The risk meets all criteria and requires Board oversight.
- Return to Division with Enhanced Monitoring: The risk is well-articulated but can be effectively managed at divisional level with enhanced divisional oversight and quarterly exception reporting via summary dashboard with a lower score.
- Request Further Information: The escalation case requires additional evidence, clarification, or refinement before a decision can be made.
- Challenge Scoring: The risk score appears inflated or inconsistent; recommend rescoring workshop with the Division before re-submission.

Risks approved by the RMG shall be:

- Added to the CRR: The risk is formally identified as being added to the CRR within ENHance, and the date of agreement recorded.
- Report to Board: The risk is included in the next CRR report to the Board, with executive summary, controls, gaps, and action plan.
- Assigned to Executive Sponsor: The Executive Sponsor assumes formal accountability for oversight, reporting, and commissioning of Trust-wide mitigations.
- Subject to Regular Review: CRR risks shall be reviewed monthly by the RMG and reported to the Board quarterly (or more frequently for risks scoring ≥20 or as required by the board), with bi-annual review of all risks scoring 15 and above.

Risk De-escalation Process

De-escalation decisions shall be made by the RMG and shall be documented in ENHance

A risk may be de-escalated from the Corporate Risk Register (CRR) and accepted as a tolerated risk where there is clear evidence that all reasonably practicable controls and mitigations have been implemented and embedded, and the residual risk is understood, stable, and demonstrably within the Trust's agreed risk appetite.

This decision must be supported by explicit executive ownership, with a documented rationale outlining why further risk reduction is not feasible or proportionate, and confirmed through formal review via the Trust's governance structures.

Acceptance of a tolerated risk does not imply that the risk has been eliminated; rather, it reflects a conscious and informed decision to manage the residual risk at an appropriate level, with ongoing monitoring through divisional governance processes and clear triggers for re-escalation should the risk profile change.

Risks shall be de-escalated from the CRR and returned to Divisional Risk Registers when:

- Risk Score Reduction: The risk scores <15, AND the RMG is satisfied that the reduction can be sustained and is evidenced.
- Risk Closed: The risk has been successfully mitigated to target score or is no longer relevant.
- Transferred: The risk has been transferred to another organisation (e.g., ICS, Commissioner) with formal acceptance of accountability.

Risk escalation identified from Board Sub-committees

Risks may be identified and escalated directly to the Risk Management Group (RMG) by the Chairs of Trust Board sub-committees that provide oversight of risk and governance, including but not limited to:

- Quality & Safety Committee
- Audit & Risk Committee
- Finance & Performance Committee
- Other Board-level committees as appropriate

And in the following instances:

- Where a Board sub-committee identifies a risk of strategic significance that may warrant Corporate Risk Register inclusion, the Chair of that committee shall recommend the risk for RMG consideration. This recommendation may be communicated verbally or in writing to the Chair of the Risk Management Group.
- Where a Board sub-committee identifies a risk of strategic significance that may warrant Corporate Risk Register inclusion, the Chair of that committee shall recommend the risk for RMG consideration. This recommendation may be communicated verbally or in writing to the Chair of the Risk Management Group.
- The recommendation shall be captured within the minutes and action log of the sub-committee meeting.
- The Trust's risk office shall be informed of the recommendation and support appropriate capture and dissemination to the relevant division (if not already aware) for assessment and presentation at the RMG.

Escalation Criteria and Gatekeeping:

- Board sub-committee identification of a risk does not bypass the established escalation criteria or RMG gatekeeping function.
- This pathway recognises the strategic significance identified by executive-level oversight, but risks must still meet the threshold for CRR inclusion consideration as described in section 9.2 of this policy.
- Risks recommended by Board sub-committees that do not meet both threshold requirements shall be subject to the same review and decision-making process as risks escalated through standard pathways, including potential recommendations for enhanced divisional monitoring or further information gathering.
- Risks identified through Board sub-committee escalation shall be owned and presented to the RMG by the Division or Corporate Service within which the risk has been identified or has primary impact.

Training and Implementation

The Trust shall provide risk training through:

- Online videos via ENH Academy for all identified staff (certificates provided)
- Ad hoc face-to-face training on request
- ENHance system navigation support on request
- System training manuals within the ENHance electronic risk system

References & Associated Documents

- 025 - Standing orders, reservation and delegation of powers and standing financial instructions Policy
- 030 - Information Security Records Management Policy
- 046 - Health and Safety Management Policy
- 063 - Management of complaints and concerns Policy

- 123 - Patient Safety Incident Response Framework (PSIRF) Policy
- 135 - Infection Prevention & Control Trust Management Policy
- 136 – Digital Clinical Safety Policy
- 139 - Managing Safety Alerts and Other External Queries (Central Alerts System and Other Alerts)
- 163 - Emergency Preparedness, Resilience and Response (EPRR) Policy Statement
- 1896 -Cost Improvement Programme
- Accountability Framework
- ENHance Risk User Guide

Quality Indicators

Key Performance Indicators (KPIs) and metrics that measure adherence to policies and external regulations. Activity to monitor the use of this document is listed below

Policy Area/Objective	Monitoring Activity/Control	Key Performance Indictors (KPIs)	Frequency	Lead
Risk Management Process	Monitoring themes and trends of total numbers of open risk in the Trust and by division	Total numbers of open risks to be between 350 and 400	Monthly as part of Risk Management Report presented at RMG, TMG and QSC	Compliance and Risk Lead
Risk profile and scoring	Monitoring of numbers of high scoring risks.	100% of all approved risks scoring 15 or above to be represented on the CRR or under active review for discussion at RMG	Numbers of high scoring risks to be reported monthly at RMG. Comparison of numbers of high scoring risks to those represented on the CRR to be reported quarterly to ARC	Compliance and Risk Lead
	Monitoring and review of risks with a catastrophic score of 5 in consequence	All risks with a catastrophic score of 5 in consequence to be reviewed at RMG	Numbers to be reported monthly to RMG	
	Monitoring and review of risks identified as aged (open for more than 4 years)	There will be no risks open for more than 4 years without documented revision	Numbers of aged risks to be reported monthly to RMG	
Risk management and monitoring	Monitoring of risks becoming overdue for review	95% of all open risks should be within set review dates	Numbers to be reported monthly to RMG	Compliance and Risk Lead

Policy Area/Objective	Monitoring Activity/Control	Key Performance Indictors (KPIs)	Frequency	Lead
	Monitoring of risks in the 'open and awaiting approval' category Review of actions and controls documented on ENHance. Review of effectiveness of actions and controls including length of time actions are open, and compliance to expected closure dates	0% of risks will be open and awaiting approval for longer than one calendar month 95% of risks will have documented actions on ENHance 100% of risks will demonstrate reduction in scoring from initial to current unless there are documented control failures. 90% of risk actions will be closed within set timeframes	Numbers to be reported monthly to RMG Numbers to be reported monthly to RMG Numbers to be reported monthly to RMG and discussed by exception Quarterly report to ARC	
Capital investment and Risk	Consideration of numbers of risks with identified costs and type of cost identified	100% of risks with costs identified to have selected type of cost and numerative amount entered	To be reported to RMG monthly	Compliance and Risk Lead
Corporate Risk Register	Review of themes and trends, compliance to actions, length of time open, including changes in score on the CRR	100% of risks on the CRR will have defined controls and actions 100% of risks on the CRR will identify risk appetite categories and links to BAF Risks will not remain on the CRR without reduction in score for more than 6 months	To be reported to ARC quarterly	Compliance and Risk Lead / Director of Quality

Policy Area/Objective	Monitoring Activity/Control	Key Performance Indictors (KPIs)	Frequency	Lead
Risk Appetite Statement	The Trust will regularly review its risk appetite and consider changes to national and local practice and guidance	Risk Appetite to be agreed and documented in Trust Board minutes	Annually	Trust Board
Training and Implementation	Risk effectiveness survey to be completed including effectiveness of the RMG Review of numbers of staff trained in risk	90% of respondents to provide positive responses to effectiveness survey 100% of Trust induction sessions to include risk Numbers of staff trained as part of Management Competency Development Programme Number of ad hoc risk training sessions completed Number of staff completing online training	Annually	Chair of RMG Compliance and Risk Lead / Head of Legal Services, Safety and Learning Compliance and Risk Lead

Impact and Accessibility

The Trust supports the practice of evidencing due regard to equality considerations. This means those involved have ensured the document and the function, outlined therein, applies to all, regardless of protected characteristic - age, sex, disability, gender-re-assignment, race, religion/belief, sexual orientation, marriage/civil partnership and pregnancy and maternity.

Positively supporting individuals with a learning disability or Autism: All Trust policies and Standard Operating Procedures (SOPs) should include service arrangements relating to the provision of reasonable adjustments to support the care or management of service users who have an LD or Autism. These should be highlighted below, or where specific practices are used, included in the document content.

Protected characteristics impacted by this documented	Impact Type (Positive, Negative, or No Impact)	Reasoning & Mitigations
Age, sex, disability, Learning Disability, gender-re-assignment, race, religion/belief, sexual orientation, marriage/civil partnership and pregnancy and maternity	No Impact	This policy applies universally to all staff regardless of age. Training provision is available in accessible formats to support all age groups. Policy applies equally to all genders. No differential impact identified. Policy applies to all staff. Reasonable adjustments to training delivery are available per Trust Disability Policy. Virtual attendance options are provided. Staff with caring responsibilities: Flexible scheduling and virtual attendance available

Dissemination and Access

This document is considered valid when viewed via ENHance or the staff intranet for East & North Hertfordshire NHS Trust. If this document is printed (in hard copy), or saved at another location, users of this document must ensure they are using the same version that is available on these platforms.

Appendices

Appendix 1: Generic Risk Assessment

Subject of risk assessment:
Date of Assessment:
Assessment completed by:

What are the risks? (to patients, staff, visitors or assets)	What is being done already to control these risks?	What action (if any) needs to be taken to improve control of these risks?	Who is responsible for taking action?	How much of a priority is the action? (Urgent / Essential / Recommended / Suggested)	Action completed date (dd/mm/yy)

Appendix 2: Risk Grading Matrix

Consequence Score:

Choose the relevant domain(s) from the left-hand column e.g. "B Injury".
Then work across the row to identify the most appropriate consequence score e.g. "3 - moderate injury requiring professional intervention".
The consequence scores should be based on the reasonable worst-case scenario.

DOMAINS	1	2	3	4	5
A Objectives/ Projects	Insignificant cost increase Schedule slippage	< 5% over budget Schedule slippage	5-10% over budget Schedule slippage	Non-compliance with national target or key objectives not met 10-25% over project budget	> 25% over budget Schedule slippage. Key objectives not met
B Injury	Minimal injury requiring no/minimal intervention/ treatment No time off work	Minor injury/illness requiring minor intervention Time off work < 7 days Increase in LOS by 1-3 days	Moderate injury requiring professional intervention Requiring 4-14 days off work RIDDOR/ Agency Reportable An event which effects small numbers (3-5)	Major injury leading to long term incapacity/disability Requiring > 14 days off work Mismanagement of patient care with long term effects An event which effects moderate numbers (18-50)	Death Multiple permanent or irreversible health effects An event which effects large numbers (50+).
C Quality/ Complaints/ Audit	Peripheral element of treatment or service suboptimal Locally resolved complaint	Overall treatment or service suboptimal Formal complaint Single failure to meet internal standards Minor implications for patient safety if left unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Low performance rating Critical report	Totally unacceptable level or quality of service Gross failing of patient safety if findings not acted upon Gross failure to meet national standards
D Service/ Business Interruption/ Environment	Loss of service/ interruption 1 to 8 hours Loss of premises 1 to 8 hours No or minimal effect on environment	Loss of service/ interruption 8 hours to 1 day Loss of premises 8 hours to 1 day Minor effect on environment	Loss of service/ interruption 1 day to 1 week Loss of premises1 day to 1 week Moderate effect on environment	Temporary loss of service/ interruption >1 week Loss of premises >1 week Major effect on environment	Permanent loss of service or facility Requires suspension of service/ activity for an unspecified period Catastrophic effect environment
E Human Resources/ Organisational Development/ Staffing/ Competence	Short term low staffing level temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality (>1 day)	Late delivery of key objective/service due to lack of staff. Poor attendance at mandatory training. Unsafe staffing level > 1 day	Uncertain delivery of key objective/service due to lack of staff. Loss of key staff. No staff attending mandatory training	Non-delivery of key objective / service due to lack of staff. Loss of several key staff. No staff attending mandatory training on an ongoing basis
F Finance (whole Trust budget)	Small loss of whole Tru4st budget < £50,000	Loss more than 0.25% of whole Trust budget £50K - < £250K	Loss more than 0.5% of whole Trust budget £250K - < £1M	Loss more than 1.0% of whole Trust budget £1M - <£5M	Loss of > 2% of whole Trust budget > £5M
G Claim	Risk of claim remote	Claim < £100,000	Claim between £100K - £1M	Claim between £1M-£5M	Claim > £5M
H Inspection/ Audit	No or minimal effect or breech of guidance/ statutory duty	Breech of statutory duty Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement Action. Low performance rating/critical report. Multiple breeches in statutory duty Improvement Notice	Multiple breeches Prosecution Zero performance rating Severely critical report
I Adverse Publicity/ Reputation	Rumours Potential for public concern	Local media coverage Short term reduction in public concern Elements of public expectation not being met	Local media coverage Long term reduction in public confidence	National Media coverage < than 3 days Service well below reasonable public expectation	National media coverage > 3 days. MP Concern (Questions in House) Total loss of public confidence
J Fraud / Bribery	Single fraud offence. Low level loss <£2,000. Possible internal HR action taken. Limited adverse publicity	Multiple fraud offences. Fraud loss between £2,000 and £10,000. Consideration given for case to be submitted to	Multiple Staff members committing fraud offences / conspiracy Loss >£10,000. Consideration given for case to be submitted	Multiple Staff members committing Fraud offences / conspiracy loss >£10,000. Consideration given for case to be	Bribery / Corruption offences, Multiple Staff / Senior staff Fraud. Loss >£10,000. Consideration given for case

		CPS. Local Press interest	to CPS. Local/ National Press interest. Potential Staff disquiet	submitted to CPS. Local/ National Press interest. Potential Service Disruption both staff and Financial. National Press Interest.	to be submitted to CPS. Local/ National Press interest resulting in adverse publicity for the Trust. Possible criminal action against Board members. Potential Fines >10M
K Data Breach	Minimal effect on the organisation. Less than 5 individuals affects or risk to individual assessed as low.	Potential impact on individuals. E.g. Unencrypted records of up to 20 people. Damage to organisation reputation, possible local media. Likely ICO reporting required.	Serious breach of data protection or confidentiality and/or up to 100 individuals effected by loss of data or unavailability of data. Reportable to the ICO.	Serious breach of data protection or confidentiality with particular sensitivity e.g. sexual health or HIV details with high impact on individual(s). Or up to 1000 people affected. Potential for ICO enforcement and legal claims.	Serious breach of data protection or confidentiality with potential for ID theft, or severe unavailability of data impacting provision of healthcare for 50+ people. Potential for ICO enforcement and legal claims.

Likelihood Score

The likelihood score refers to the likelihood of the identified consequences happening, not of the core risk event
The 'frequency-based' score is usually easiest to identify and should be used whenever possible.

It is important to note that risks with a likelihood of 5 (categorised as almost certain) should be considered as a short term measure since the risk has almost materialised and should be reframed or translated into an issue for management.

	1	2	3	4	5
Descriptor	Rare	Unlikely	**Possible**	**Likely**	**Almost Certain**
LIKELIHOOD - Broad descriptors	Harm at the level indicated will probably never happen/never recur	Do not expect harm at the level indicated to happen/recur but it is possible it may do so	Harm at the level indicated might happen or recur occasionally	Harm at the level indicated will probably happen/ recur	Harm at the level indicated will undoubtedly happen/recur, possibly frequently
FREQUENCY - Time Related	Not expected to occur for years	Expected to occur at least annually	**Expected to occur monthly**	**Expected to occur at least weekly**	**Expected to occur at least daily**

Document accessed from the good governance Institute. www.good-governance.org.uk/wp-content/uploads/2017/04/Risk-Appetite-for-NHS-Organisations.pdf

Appendix 3: Risk Score Matrix used at ENHT

	Consequence				
Likelihood	1. None/Insignificant	2. Minor (Green)	3. Moderate (Yellow)	4. Major (Orange)	5. Death/Catastrophic (Red)
5. Certain - Expected to occur at least **daily**					
4. Likely - Expected to occur at least **weekly**					
3. Possible - Expected to occur at least **monthly**					
2. Unlikely - Expected to occur at least **quarterly**					
1. Rare - Expected to occur at least **annually**					

Likelihood Scores – time framed description of frequency

Likelihood score	1	2	3	4	5
Descriptor	Rare	Unlikely	Possible	Likely	Certain
Frequency	Expected to occur at least annually	Expected to occur at least quarterly	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily

Key Principles

- Always score risks with current controls in place (not worst-case scenario)
- Use the highest consequence domain to determine consequence score
- Consider proximity (how soon could this happen?) and velocity (how fast would impact occur?)
- Initial Risk Score: Remains unchanged as benchmark
- Current Risk Score: Updates as controls improve
- Target Risk Score: Acceptable level after full mitigation

How to Use This Matrix

- Determine Consequence: Using the Trust's Table of Consequences, identify the highest consequence level (1-5) across all domains (clinical, financial, reputational, etc.)
- Determine Likelihood: Based on existing controls, assess how often the risk event is expected to occur (1-5)
- Calculate Risk Score: Multiply Consequence × Likelihood to get the risk score
- Apply Risk Grade: Use the score to determine the risk level and required

Example Risk Scoring

Risk: "If the CT scanner fails and there is no backup, then emergency patients cannot receive timely scans, leading to diagnostic delays and potential patient harm"

Consequence: 4 (Major - potential for serious patient harm)
Likelihood: 3 (Possible - equipment failures occur at least monthly without maintenance)
Current Risk Score: 4 × 3 = 12 (Moderate/Yellow)
Target Risk Score: 4 × 2 = 8 (Moderate/Yellow)

With enhanced maintenance contract:
Likelihood reduces: 2 (Unlikely - quarterly

Appendix 4: Risk Appetite Matrix

Risk Appetite for NHS Organisations
A matrix to support better risk sensitivity in decision taking

Developed in partnership with the board of Southwark Pathfinder CCG and Southwark BSU – January 2012

Good Governance Institute

Risk levels ▶ / Key elements ▼	0 **Avoid** Avoidance of risk and uncertainty is a Key Organisational objective	1 **Minimal** (ALARP) (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
Financial/VFM	Avoidance of financial loss is a key objective. We are only willing to accept the low cost option as VfM is the primary concern.	Only prepared to accept the possibility of very limited financial loss if essential. VfM is the primary concern.	Prepared to accept possibility of some limited financial loss. VfM still the primary concern but willing to consider other benefits or constraints. Resources generally restricted to existing commitments.	Prepared to invest for return and minimise the possibility of financial loss by managing the risks to a tolerable level. Value and benefits considered (not just cheapest price). Resources allocated in order to capitalise on opportunities.	Investing for the best possible return and accept the possibility of financial loss (with controls may in place). Resources allocated without firm guarantee of return – 'investment capital' type approach.	Consistently focussed on the best possible return for stakeholders. Resources allocated in 'social capital' with confidence that process is a return in itself.
Compliance/ regulatory	Play safe, avoid anything which could be challenged, even unsuccessfully.	Want to be very sure we would win any challenge. Similar situations elsewhere have not breached compliances.	Limited tolerance for sticking our neck out. Want to be reasonably sure we would win any challenge.	Challenge would be problematic but we are likely to win it and the gain will outweigh the adverse consequences.	Chances of losing any challenge are real and consequences would be significant. A win would be a great coup.	Consistently pushing back on regulatory burden. Front foot approach informs better regulation.
Innovation/ Quality/Outcomes	Defensive approach to objectives – aim to maintain or protect, rather than to create or innovate. Priority for tight management controls and oversight with limited devolved decision taking authority. General avoidance of systems/ technology developments.	Innovations always avoided unless essential or commonplace elsewhere. Decision making authority held by senior management. Only essential systems / technology developments to protect current operations.	Tendency to stick to the status quo, innovations in practice avoided unless really necessary. Decision making authority generally held by senior management. Systems / technology developments limited to improvements to protection of current operations.	Innovation supported, with demonstration of commensurate improvements in management control. Systems / technology developments used routinely to enable operational delivery Responsibility for non-critical decisions may be devolved.	Innovation pursued – desire to 'break the mould' and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of devolved authority – management by trust rather than tight control.	Innovation the priority – consistently 'breaking the mould' and challenging current working practices. Investment in new technologies as catalyst for operational delivery. Devolved authority – management by trust rather than tight control is standard practice.
Reputation	No tolerance for any decisions that could lead to scrutiny of, or indeed attention to, the organisation. External interest in the organisation viewed with concern.	Tolerance for risk taking limited to those events where there is no chance of any significant repercussion for the organisation. Senior management distance themselves from chance of exposure to attention.	Tolerance for risk taking limited to those events where there is little chance of any significant repercussion for the organisation should there be a failure. Mitigations in place for any undue interest.	Appetite to take decisions with potential to expose the organisation to additional scrutiny/interest. Prospective management of organisation's reputation.	Willingness to take decisions that are likely to bring scrutiny of the organisation but where potential benefits outweigh the risks. New ideas seen as potentially enhancing reputation of organisation.	Track record and investment in communications has built confidence by public, press and politicians that organisation will take the difficult decisions for the right reasons with benefits outweighing the risks.
APPETITE	**NONE**	**LOW**	**MODERATE**	**HIGH**	**SIGNIFICANT**	

Appendix 5: Quality Impact Assessment (QIA) Governance Framework

Purpose
Quality Impact Assessments (QIAs) are a fundamental component of the Trust's governance arrangements and ensure that all transformation, service improvement and Cost Improvement Programme (CIP) schemes are assessed for their potential impact on quality before implementation. A QIA is not a one-off approval exercise. It is a live document that should evolve alongside the development and delivery of each scheme.

The purpose of the QIA process is to:

- Protect patient safety and quality of care.
- Support safe delivery of financial and operational improvement.
- Identify and mitigate potential risks at the earliest opportunity.
- Provide assurance to clinical leaders, Executive Directors and Trust Committees.
- Ensure quality considerations are embedded within decision-making.

Governance Principles
Every QIA should demonstrate the following principles.

1. Clinical Ownership: Each scheme must have identified clinical ownership appropriate to the nature of the proposal. This includes engagement with relevant:

- Medical Leads
- Nursing Leads
- Allied Health Professionals where appropriate
- Operational Leads
- Subject Matter Experts
- Clinical ownership should be evident throughout scheme development rather than sought solely at the point of approval.

2. Early Assessment: QIAs should begin during scheme design rather than immediately before implementation. Early assessment enables:

- redesign of proposals where quality concerns are identified;
- development of appropriate mitigations;
- informed decision-making;
- sufficient time for stakeholder engagement.

3. Evidence-Based Assessment: Assessments should be supported by objective evidence wherever possible. Examples include:

- incident trends;
- complaints and compliments;
- clinical audit findings;
- national guidance;
- benchmarking;
- workforce information;
- activity and performance data;
- Equality Impact Assessments;
- patient feedback;
- external reviews.
- Professional judgement should be documented where evidence is limited.

4. Proportionate Assessment: The depth of assessment should reflect the scale and complexity of the proposal. Low-risk operational improvements may require a concise assessment.

Major service redesigns should demonstrate:

- wider stakeholder engagement;
- detailed evidence;
- comprehensive mitigation plans;
- implementation monitoring arrangements.

5. Multidisciplinary Review: QIAs should be developed collaboratively rather than by a single individual. Appropriate contributors may include:

- clinical teams;
- nursing teams;
- operational managers;
- finance;
- workforce;
- quality improvement specialists;
- patient safety teams;
- infection prevention;
- digital teams where applicable.

6. Risk-Based Decision Making: The purpose of the QIA is to inform decision-making - not to prevent change. Where risks are identified they should be:

- clearly described;
- appropriately scored;
- mitigated wherever possible;
- documented risk score review process – high score >8 are reviewed and agreed by Medical Director and Chief Nurse
- All moderate and high risks are reviewed monthly and reported to QSC via compliance and risk reporting processes.

Schemes with residual risks should only proceed where decision-makers are satisfied that risks are understood and managed.

7. Dynamic Review: QIAs should remain live throughout implementation. Assessments should be reviewed:

- when the scope changes;
- following significant incidents;
- if implementation is delayed;
- where benefits differ from those expected;
- at agreed programme review points.

8. Transparency: The rationale for all assessments should be clearly documented. This includes:

- evidence considered;
- assumptions made;
- mitigation actions;
- residual risks;
- approval history.

The QIA should provide an audit trail that enables reviewers to understand how conclusions were reached.

Roles and Responsibilities

Role	Responsibility
Scheme Lead	Completes and maintains the QIA.
Clinical Lead	Provides clinical assurance and supports impact assessment.
Nursing Lead	Reviews nursing and patient safety implications.
Finance Lead	Ensures alignment between the business case and QIA.
Transformation Team	Quality assurance of QIA completion, governance and reporting.
CIP Panel	Reviews QIA quality, challenges assessments where required and agrees escalation.
Executive Sponsors	Ensure quality risks have been appropriately considered before implementation.
Quality & Safety Committee	Receives escalated schemes with significant residual quality risks.

Governance Expectations

Every QIA submitted for approval should demonstrate:

- Appropriate clinical engagement.
- Evidence-based assessment.
- Clear description of impacts.
- Appropriate mitigations.
- Named owners for all actions.
- Defined monitoring arrangements via Transformation Programme workstreams, via RMG to QSC risk reporting processes.
- Executive sign-off where risk score >8 have been identified

Escalation

Schemes should be escalated where:

- residual quality risk exceeds agreed thresholds;
- significant patient safety concerns remain;
- clinical consensus cannot be reached;
- implementation changes materially alter the original assessment;
- new risks emerge during delivery.

Escalation should follow the Trust Risk Management Framework and include referral to Divisional and Corporate Risk Registers where appropriate.

Monitoring Following Approval

Quality impacts should continue to be monitored after implementation using agreed KPIs. Monitoring should normally include:

- Risk score trends
- patient safety indicators;
- clinical outcome measures;
- patient experience metrics;
- workforce indicators;
- operational performance;
- financial benefits;
- unintended consequences.

The frequency of monitoring should reflect the level of risk associated with the scheme.

Key Principle
No transformation or CIP scheme should be approved solely on the basis of financial benefit. Successful schemes demonstrate that quality has been fully considered, risks are understood, appropriate mitigations are in place and ongoing monitoring arrangements provide assurance that patient care remains safe, effective and sustainable.

Document Governance

Document stakeholders involved in the creation/update and review of this document

Document Stakeholder	Date Agreed	Contribution Type	Signature (People Team only)
Margaret-Mary Devaney, Director of Quality	01/05/2026	Content contribution and approval	*N/A*
Douglas Salvesen, Consultant Obstetrician and Gynaecologist, Divisional Medical Director Women's & Children's Services	04/05/2026	Document approval	*N/A*
Kimberley Walker, Business Manager to the Chief Executive & Trust Chair & Gareth Jenkins, Transformation Director	17/08/2026	Content contribution and approval	*N/A*

Document Endorsement Record	
Meeting/Group/Committee Name	Date of meeting/approval
Risk Management Group	02/06/2026
Trust Management Group	11/06/2026
Audit and Risk Committee	21/07/2026

Admin use only	
Date of Endorsement at PCG* *(Policies only)*	DD/MM/YYYY
Governance checks completed	*Policy Officer*
Date Uploaded to ENHance and Trust intranet	DD/MM/YYYY
Legacy ID	

Board

East and North Hertfordshire Teaching NHS Trust

Meeting	Public Trust Board		**Agenda Item**	14	
Report title	Board Assurance Framework (BAF) – Strategic Risks		**Meeting Date**	9 September 2026	
Author	Stuart Dalton, Head of Corporate Governance				
Responsible Director	Martin Armstrong, Chief Executive				
Purpose	**Assurance**	☒	**Approval/Decision**	☐	
	Discussion	☐	**For information only**	☐	
Proposed assurance level (*only needed for assurance papers*)	**Substantial assurance**	☐	**Reasonable assurance**	☐	
	Partial assurance	☒	**Minimal assurance**	☐	

Executive assurance rationale:

The BAF and risk management process received a reasonable assurance rating from internal audit for 2023-24 and 2024-25, and 2025-26. However, a partial rating recommendation reflects July Board feedback.

Summary of key issues:

Key matters to highlight

- All BAF risks have been reviewed by their lead committee since being agreed at May's meeting. With no committees in August, the next review for BAF risks at committee level will be after Board in September or October bar People and Culture Committee which met on 1 September.
- The only BAF not fully drafted in time for last Board, **Risk 6 (Leadership destabilisation and transition)**, has now been fully developed and considered by its oversight committee. Four new gaps with proposed actions have been identified 1) CEO objectives (now agreed); 2) Well-led developmental review (which is starting in September); 3) Assurance re positive leadership rounds/visibility (report to TMG to address) 4) Board Seminar effectiveness assessment (separate survey questions for Board Seminar to be added as part of the Board effectiveness survey).
- **Risk 2 (Health inequalities)**: 22 July 26 QSC agreed for gap 'Dedicated resource for health inequalities' to be removed as a tolerated gap recognising budgetary constraints mean dedicated resource is not possible. However, it also agreed to improve assurance by introducing 6-monthly written updates to QSC going forward instead of verbal updates on health inequalities. This is in the context health inequalities was a recognised development area in the Board's capability self-assessment 2025 submission to NHSE. The Audiology service is now fully reopened.
- **Risk 4 (Patient engagement, involvement and public accountability)**: The updated Engagement Strategy is due to come to Board and the new Patient and Carer Experience and Partnership Sub-Committee is due to launch in the autumn.
- There are no proposed risk score changes.
- The two highest risk scores are 20 for **Risk 3 (Financial constraints)** and **Risk 11 (Failure to deliver transformation and achieve financial sustainability)**.

Board spotlight on two BAF risks

Spotlighted BAF Risk 6 ***(Accountability, escalation, ownership & effective performance monitoring framework) – CEO, Martin Armstrong***

- In addition to the new accountability framework, monthly all-day Performance Senates have been established to bring enhanced focus and ownership.

Spotlighted BAF Risk 7 *(OneEPR) – CIO, Mark Stanton*

- This risk being on the BAF reflects the Board's recognition of the risk posed by the delay and issues with the OneEPR.
- September's Digital Committee was cancelled meaning the BAF will go to October's committee. Therefore, a verbal update will be provided.

IPR

Given the Board has chosen to significantly reframe the BAF risks, the Board is asked to highlight if any changes to the IPR are important to help track these key strategic risks.

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

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

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

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

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

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

Linked corporate risks are set out at the bottom of individual BAFs.

Report previously considered at & date(s):

8 July Board. PCC 1 September. The other lead committees will review the BAF in September and October.

Recommendation	The Board is asked to: • review the BAF and highlight any key feedback; • highlight if the new BAF risks warrant any changes to what is reported in the IPR; and • agree the assurance rating, with partial recommended.

To be trusted to provide consistently outstanding care and exemplary service

NHS
East and North Hertfordshire Teaching NHS Trust

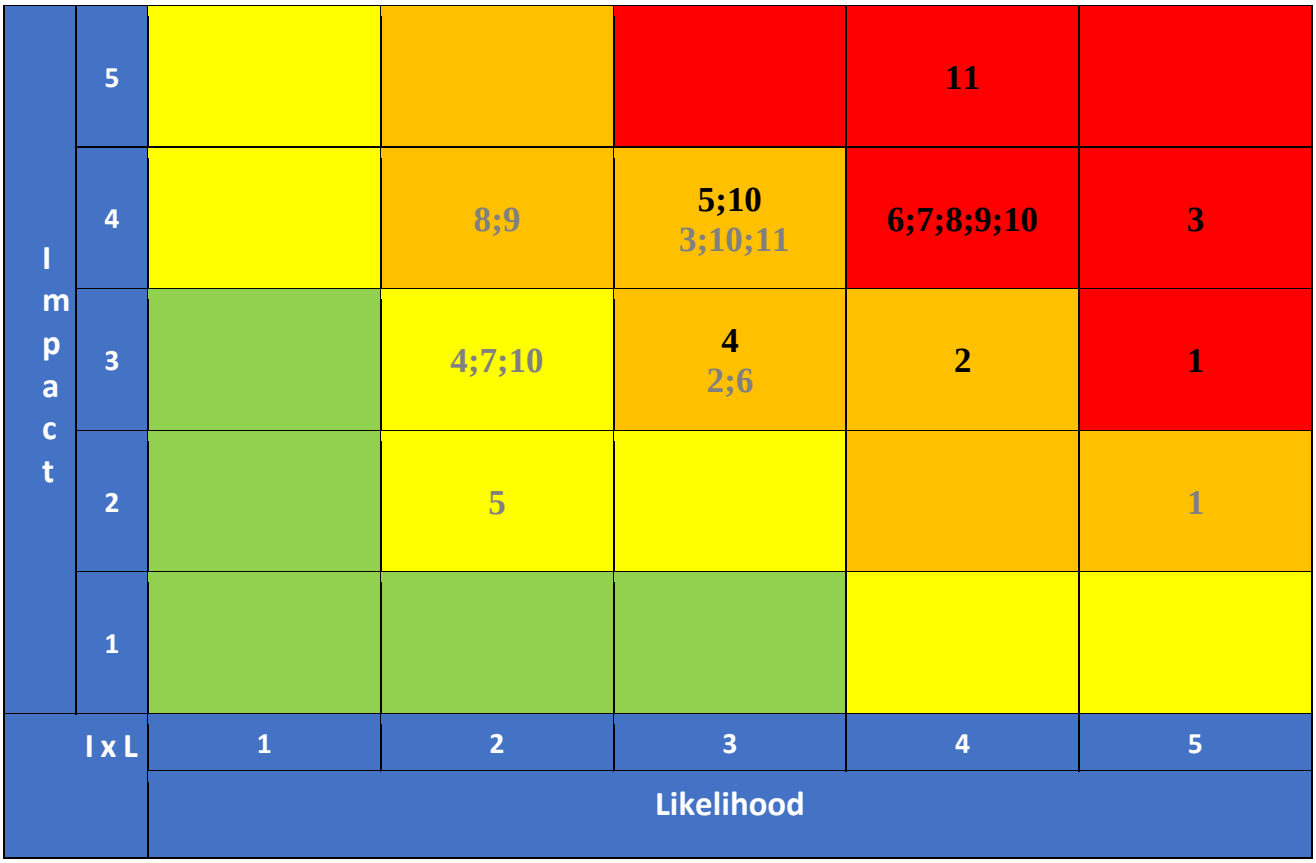
BOARD ASSURANCE FRAMEWORK REPORT

Section 1 - Summary

Risk no	Strategic Risk	Lead(s) for this risk	Assurance committee(s)	Current score	Trajectory
Consistently deliver quality standards, targeting health inequalities and involving patients in their care					
1.	**Estates infrastructure to meet growing demand**	Director of Estates & Facilities	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.	**Patient engagement, involvement and public accountability**	Director of Communications and 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.	**Employee relations**	Chief People Officer	People & Culture	12	⟷
6.	**Leadership destabilisation and transition**	Chief People Officer	People & Culture	16	⟷
7.	**Accountability, escalation, ownership & effective performance monitoring framework**	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.	**OneEPR**	Chief Information Officer	Digital Committee	16	⟷
9.	**Demand, capacity and flow**	Chief Operating Officer	Finance, Performance & Planning	16	⟷
Continuously improve services by adopting good practice, maximising efficiency and productivity, and exploiting transformation opportunities					
10.	**Digital Transformation & AI**	Chief Information Officer	Digital Committee	16	⟷
11.	**Failure to deliver transformation and achieve financial sustainability**	Chief Kaizen Officer	Finance, Performance & Planning	20	⟷

Section 2 Strategic Risk Heat Map

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



Section 3 Risk Appetite

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

Section 4 Risk Scoring Guide

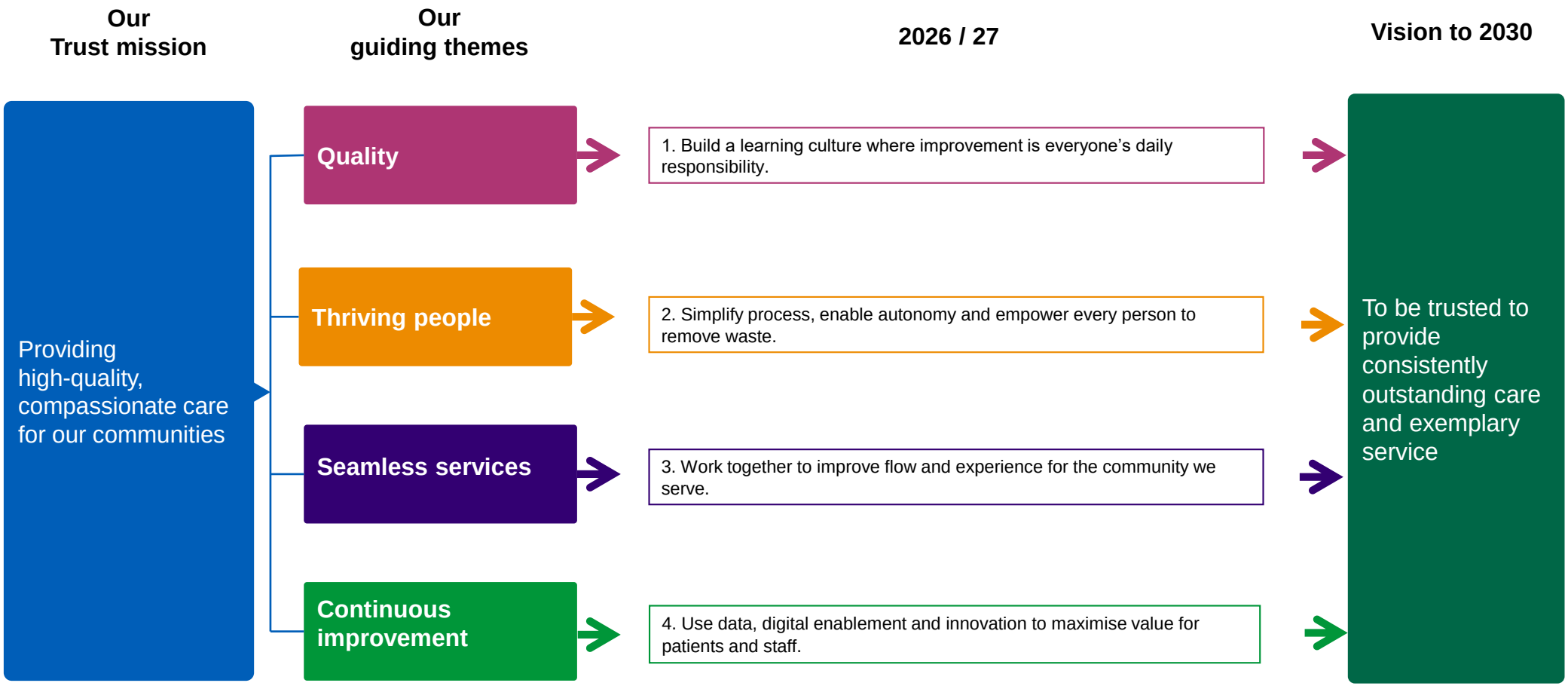
Risks included in the Risk Assurance Framework (RAF) are assessed as extremely high, high, medium and low based on an Impact/Consequence X Likelihood matrix. Impact/Consequence – The descriptors below are used to score the impact or the consequence of the risk occurring. If the risk covers more than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

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

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

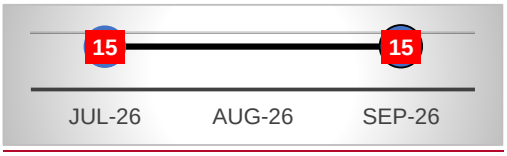
Risk Assessment	Grading
15 – 25	**Extreme**
8 – 12	**High**
4 – 6	**Medium**
1 – 3	**Low**

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 ie 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*** 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)

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

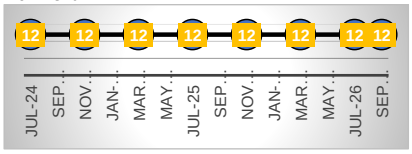
Gaps in Controls and Assurances	Actions and mitigations to address gaps	Lead	Target date
Alignment of Capital Investment Priorities with Strategic Need	• Strengthen triangulation between the estates strategy, the Integrated Business Plan and long-term capital requirements.	CFO	Dec 26 [Original: Dec 25]
Capital Envelope Insufficient to Reduce Backlog Risk	• Escalation through ICS capital framework • Escalation through NHSE funding groups	CFO	Ongoing – March annually
Long-Term Capital & Estate Planning Infrastructure Not Fully Embedded	• Present capital lifecycle modelling and 10-year infrastructure scenarios to FPPC.	CFO	Q4 26/27
Dependency on Transformational Capital That Is Not Yet Secured	• 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	• 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	• 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	• Develop multi-year backlog trajectory model	Dir of Estates	Q4 26/27
Long-Term Planning Not Embedded	• Integrated model: estates + digital + finance • Annual "State of the Estate" Board session	Dir of Estates	Q4 26/27
Development areas (Backlog, Fire, Regulatory)	• 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	• 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	• 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 public confidence in East and North Hertfordshire Teaching 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**			
If we do not address health inequalities in line with mandated NHS expectations and ICB priorities including neighbourhood models	***Then*** avoidable variation in access, experience and outcomes will widen, particularly for our most deprived communities	***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.	

	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

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)	1
System Plans		
ICS EDI Policy and Strategy 23-27	No current report on delivery of the Trust's elements	1
Trust Plans		
EDI strategy – which includes health inequalities	Report to People Committee and Board (2)	3
Appointment of deputy MD with responsibility for health inequalities (Started 1.11.24)		2
Changes to waiting lists for patients with learning disability	Report to QSC on LD annually (2) 23.1.26 Needs further work as not fully enacted	1
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	5
DH mandate to do opt out testing for blood borne viruses in ED	Process being worked through	6
Health equity group projects (homelessness; Inability to work due to health delays; Childhood; Smoking; Blood born viruses)	Reports to health equity group (1) 6 monthly written report to QSC (2)	3

Health inequalities workplan Based on core20+5 Health equity group has identified 2 adult and 2 paediatric priorities for work over the course of the year	Health equities group progress report (1) Assurance report to QSC (2)	3

Gaps in Controls and Assurances	Actions and mitigations to address gaps	Lead	Target date
• Large PTLs with associated risk post-pandemic	• Increasing service awareness	COO	Individual national targets
• ~~Paediatric audiology~~	• ~~Weekly meetings with ICB and region whilst the service restarts [21 Jan 25 update: parts of the service have re-opened], waiting list has dropped by 2,000 (August 25) but still needs further infrastructure change~~	~~DON~~	AUDIOLOGY SERVICE RE-OPENED – Gap closed
• Community paediatric long waits for assessment	• Ongoing ICB working group, national and regional focus on improvement – 23.1.26 – EoE national focus to narrow the wait gap – clear mandate to do this locally • 1.6.26 – 9 box model agreed with partners and being piloted with first cohort. Small decreases in waiting list seen.	COO	See Corporate Risk Register
• Childrens wellbeing bill • Tobacco and vape bill • Mental health bill	• Implement actions once legislation enacted	MD	TBC once enacted
• ~~Dedicated resource for health inequalities~~ *22 July 26 QSC agreed for this gap to be removed as a tolerated gap recognising budgetary constraints mean dedicated resource is not possible*	• ~~TBC~~	~~MD~~	
Transition from paediatric to adult care	• Good work in individual disease groups eg sickle cell disease and diabetes, and complexity - work to do in epilepsy and a number of other disease areas • 1.6.26 – hospital wide transition group now set up with nursing and medical leads	MD	31 Dec 2026

Current Performance – Highlights from the Integrated Performance Report:

- ED 4-hour standard, 12-hour performance
- 28-day faster diagnosis standards
- DMO1 – audiology
- 65-week waits for community paediatrics

Update 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

Associated Risks on the Corporate Risk Register

Risk no.	Description	Current score

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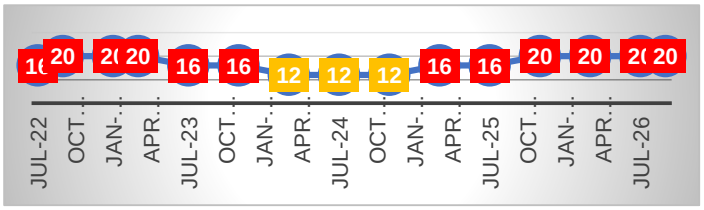
~~3027~~	~~Risk of Regulatory non-compliance within Audiology Service~~	~~16~~
3079	Disrepair of the Building Fabric and unmet electrical needs and mechanical requirements relating to Bluebell Ward & Bramble Day Services.	20
3420	Risk of increased waiting times for initial and subsequent appointments within Community Paediatrics	~~20~~16
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
3827	Learning disability and autism nurse gap	15

Strategic Priority: **Consistently deliver quality standards, targeting health inequalities and involving patients in their care**		**Risk score 20**
Strategic Risk No.3: System and internal **financial constraints**		
If far-reaching financial savings are required (either due to system financial instability or internal pressures), and we do not deliver greater efficiencies	***Then*** we will need to make difficult decisions that could have a negative impact on quality and delivery of our strategy	***Resulting in*** poorer patient outcomes, longer waiting times; reduced staff morale, reputational damage and not delivering all of our strategy.

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

Risk Trend



Risk Lead	Chief Financial Officer	Assurance committee	FPPC

Controls	Assurances against stated controls, with assurance level *1st line (front line); 2nd (corporate); 3rd (independent)*	Assurance score
Strategies and Plans		
Approved 26/27 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 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
Interim Transformation Director and team in place	Transformation Board monthly (1)	3

Gaps in Controls and Assurances	Actions and mitigations to address gaps	Lead	Target date
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	• Paper to Board 13 May 26 • Senates followed by TMG Performance to progress consequences	• CFO	• May 25 • 31 June 26

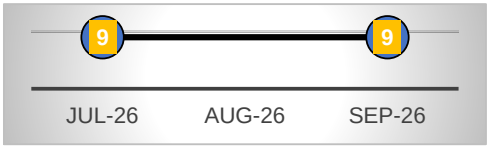
Current Performance – Highlights from the Integrated Performance Report:

Associated Risks on the Board Risk Register		
Risk no.	Description	Current score
1834	Renal service demand versus operational capacity	20
3137	Gastro outpatient capacity	20
1079	Epilepsy staffing	8

Strategic Priority: **Consistently deliver quality standards, targeting health inequalities and involving patients in their care**			**Risk score** 9
Strategic Risk No.4: **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
Inherent	4	4	16	4
Current	3	3	9	
Target	3	2	6	

Risk Trend



Risk Lead	Director of Communications and Engagement	Assurance committee	Quality & Safety Committee

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: • 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	Silktide 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	• Create and report to new PACE on engagement sentiment framework.	Director of Comms	March 2027
Seldom-Heard Groups Underrepresented	• 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"	• 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

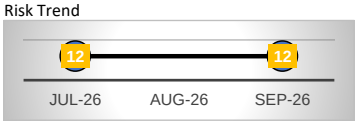
Clarifying ICS engagement priorities	• Work with ICS engagement lead to understand approach	Director of Comms	September 2026
Engagement strategy to be renewed by 2027	• Refresh and renew engagement strategy	Director of Comms	April 2027
Limited engagement team capacity	• Review capacity required in communications and engagement team to deliver activity	Director of Comms	December 2026
Systematic inclusion of patient voice in: Business cases; Service change proposals & Transformation programmes	• 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	• 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.	• Work with Healthwatch and ICB to facilitate an external review	Director of Comms	November 2026
Inclusion of engagement in decision-making coversheets & business cases	• 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	• 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	• 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	• Monthly report to new PACE	Director of Comms	December 2026

Targeted engagement strategies for seldom-heard groups	• 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

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

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
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
People Dashboard	Figures incorporated into the IPR which are taken to PCC and Trust Board (2)	6

Gaps in Controls and Assurances	Actions and mitigations to address gaps	Lead	Target date
• Development of an ER plan	• Workshop with Trust Staff Side, FTSU and ER consultant to agree roles and responsibilities including ways of working	• Director of People	• July 2026
• Signed off refreshed People Strategy	• Finalise slides and agree with Chair PCC • Agenda item at PCC	• CPO	• June 2026 • July 26
• Staff survey comments plan	• Agreement with PCC • Agreement at Trust Board	• Head of Colleague Development and Experience • CPO	• June 2026 9 September 2026
• Medical workforce transformation delivery plan	• Agree the medical workforce plan and delivery model	• CPO & Transformation Director	• July 2026
Inconsistent management capability in handling ER issues	• Gap analysis as part of ER strategy	• CPO	• Dec 26
No real-time workforce intelligence dashboard at team level	• 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)	• CFO	• Dec 26
Transformation engagement and communication plan	• Development of a transformation communications and engagement plan (in delivery) including 'scripts' for managers to use with colleagues to ensure consistent messaging	• Dir of Comms	• TBC

	• Increased senior leadership PLR/ engagement activity resulting from issues raised and/or areas of high change e.g. Theatres.	All Execs	In progress

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

Risk Lead	Chief Executive	Assurance committee	People & Culture Committee

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~~ appointed	Report to Board (2)	7
NED succession and recruitment plan (interviews scheduled for Sept 26 for two replacement NEDs)	With Board Chair – no separate assurance Chair update to Board (2)	4
Identified interim leadership arrangements Formal process in place for CFO appointment in Sept 26	Report to Board (2)	4
Executive and senior leadership succession pipeline / plan	RemCo report annually (2)	6
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)	6
Committee structure stability with Named Chairs / deputies & contingency plans for turnover	With Board Chair – no separate assurance	N/A
Leadership Cohesion & Culture		
Board Seminar: Regular Executive/NED development sessions	Board Seminar plan (2)	4
Structured Executive Team development and support to maintain alignment & team cohesion (external)	With CEO – no separate assurance	N/A
Stakeholder & System Relationship Management		
New CEO integrated into system meetings and regulatory infrastructure ~~Clear transition comms plan - Engagement & clear messaging with ICS, NHSE, CQC,~~	CEO report to Board HCP report to Board	4

partner Trusts & Healthwatch		
Workforce Confidence & Engagement		
Regular CEO / Executive communications (Meet Martin)	Feedback from regulators & partners (3) Pulse surveys (1) Staff survey (3) Leadership Forum (1)	6
Visibility of leadership (walkarounds, briefings)	Gap in assurance	0
Monitoring (staff survey, Pulse checks; FTSU themes)	Reports to PCC (2)	4
Performance & Strategic Delivery Controls		
IPR; transformation programme and strategic priorities delivery tracking	Reports to Board (2) Reports to Senate/TMG (2)	4
Board Effectiveness & Capability		
Board and Committee effectiveness reviews	Board Seminar annually and Annual Report (2)	6
Induction and development for new NEDs	ASSURANCE GAP – Introduce an induction effectiveness survey for new NEDs	1
Skills gap analysis	Provided to Chair to help inform focus of NED recruitment (1)	6
Appraisals linked to Leadership competency framework	*NHSE submission annually (3)*	*6*
Board Values and behaviour charter	*Aligned to CEO objectives (1)* *Positive leadership rounds (1)*	*4*

Gaps in Controls and Assurances	Actions and mitigations to address gaps	Lead	Target date
Lack of documented CEO/NED transition plan Lack of documented development plan for newly appointed CEO and DCEO	• Board Seminar re medical leadership relations ~~Produce and approve transition plans~~ • Structured analysis and supporting plan to address the gaps	• CEO • CPO	• Oct 26 • Oct 26
Lack of robust succession planning with 2 experienced Committee Chairs leaving Lack of retained critical skill within the NED population e.g. finance.	• Develop a risk mitigation plan and delivery plan to ensure that the subsequent recruitment and induction mitigate this. • Recruitment plan and attraction campaign to specifically include Finance experience	• Head of Governance • Head of Governance	• TBC
Limited Board / Executive Cohesion Assurance ~~&~~ risks of fragmented behaviours	• A structured assessment of team dynamics & alignment post-transition~~?~~ • Conduct Board/executive team development session • 360 for Board members~~?~~	• Chair & CEO	• Mar 27
Stakeholder Confidence Not Actively Managed / tracked	• Stakeholder confidence report to private Execs meeting ~~comms and engagement plan for transition?~~	• Dir of Comms	• Dec 26
~~Absence of agreed transition risk metrics & insufficient real-time intelligence for early warning/action~~Agreed long-term CEO objectives	• New CEO objectives set for the year ahead • ~~Agree transition KPIs/real-time workforce sentiment monitoring such e.g. Leadership turnover rate; Time to fill roles; Board attendance / stability; Stakeholder sentiment~~	• Chair	• Sept 26

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Lack of verification of efficacy of new NED induction	• Introduce an induction effectiveness survey for new NEDs	• Head of Corp Gov	• July 27
External perspective on NED interview panel	• Determine if an external perspective would help	• CPO	• Sept 26
Well-led developmental review (3)	• Progress an updated review given new leadership and changed circumstances	• Head of Corp Gov	• Initiating Nov 26
Assurance re positive leadership rounds/visibility	• Kim to produce a report to TMG	• CEO	• Dec 26
Board Seminar effectiveness	• Extend Board effectiveness to Board Seminar	• Head of Corp Gov	• Apr 27

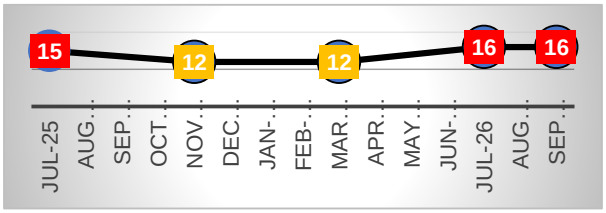
Current Performance – Highlights from the Integrated Performance Report:
•

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 consequences & ownership**		
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
Inherent	5	5	25	3
Current	**4**	**4**	**16**	
Target	3	2	6	

Risk Trend



Risk Lead	Chief People Officer	Assurance committee	People & Culture Committee

Controls	Assurances against stated controls, with assurance level *1st line (front line); 2nd (corporate); 3rd (independent)*	Assurance score
Strategies and Plans		
Accountability Framework	Accountability framework progress report to FPPC (2)	6
Policies	Scheduled reports to PCC (2) (since introduced in July 25)	7
People Dashboard	Dashboard Report to PCC with trend data, hotspots (2)	4
Q&S framework	Quality & Safety Committee (2)	4
People Strategy	People Committee reports (2) Annual report to Board (2)	6
ENHT Production System	Reported annually to board (2)	6
EDI Strategy	People Committee reports (2) Annual report to Board (2) EDI Steering Group (1)	6
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

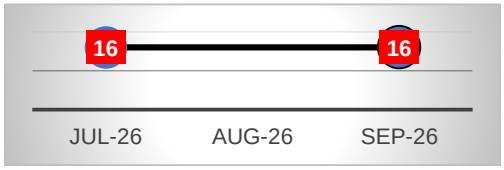
Management Structures		
Divisional operating model – structure and responsibilities	Reviewed as part of Trust Management Group (1)	4
Divisional boards	Divisional Performance Reviews (1)	6
Grow together reviews and talent forums	Reported annually to PCC (2)	6
Improvement Partner		
Principles and values 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
• Organisation goals affectively cascaded to all divisions and teams	• Focus on driving up Grow Together Review compliance rates • Assessment of dissemination and understanding of goals as part of Positive Leadership Rounds • Reviewed in day of the senates	• Exec and Divisional Directors • TP	• Mar27
• Transformation delivery plan	• In development following discovery phase by Deloitte	• CEO	• July 2026
• People Dashboard remedial action plan	• Develop proposal for dealing with non compliance of statman training	• Director of People	• Sept 2026
Accountability framework embedded into: - Objectives and appraisal system - Job descriptions and Scheme of Delegation - Leadership behaviours framework linked to consequences in GROWS	• Commission internal audit of accountability framework in 2027-28. • Amend GROW process to include leadership behaviours linked to consequences	• CFO/CPO • CPO	• Dec 2027 • Mar 2027
Performance management framework with consequences (moving from activity to tracking impact): - Defined escalation routes - Consistent application across divisions and Corporate Directorates	• Introduce monthly accountability reporting dashboard	• CFO	• Dec 2026
Statutory & mandatory training & appraisal enforcement mechanism	• Agree Trust position on non-compliance – paper to agree position at People Senate	• CPO	• Oct 2026
ASSURANCE GAPS			
Independent assessment and assurance of leadership accountability culture	• Well-led developmental review	Head of Corporate Governance	• Dec 2027

Current Performance – Highlights from the Integrated Performance Report:

Associated Risks on the Corporate Risk Register		
Risk no.	Description	Current score
3823	ED Policy & principles of referral	15
0905	Discharge letter delay	15
0973	Asthma clinical specialist nurse gap	15

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: **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	Trend
Inherent	4	4	16	4	
Current	**4**	**4**	**16**		
Target	4	2	8		

Risk Lead	Chief Information Officer	Assurance committee	Digital Committee

Controls	Assurances against stated controls, with assurance level *1st line (front line); 2nd (corporate); 3rd (independent)*	Assurance score
Strategies and Plans		
Board approved OneEPR Business case (2/24)	• 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.	• 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
• Variation in business-as-usual systems and processes	• Adoption of lean thinking in pathway redesign model as part of the ENH production system for later phases of the project	• Mark Stanton	Optimisation phase (2028)

• Improvement training compliance is variable across staff groups and levels of seniority	• Develop a robust training program to include classroom and f2f and communicate requirements with notice via the programme board. Senior stakeholder to share responsibility • Date realigned with plan • Outline Plan approved by Steering group • Compliance to be monitored and reported to divisional leads	• MS	December 26
• Digital Solutions and Delivery team has been historically funded through Capital using contract resource, but new Capitalisation rules mean a move towards revenue, this could significantly reduce the size of the team for Road map deliveries	• Move towards a substantive team to reduce spend • Seek NHS E revenue funding streams • This is now funded through an agreed Benefits case through Trust Revenue • Trust financial position could impact Digital Resources which is being closely monitored	• MS	• Ongoing
• If change is not managed effectively	• Strengthen executive sponsorship and leadership visibility through the Digital Committee to reinforce accountability for change outcomes, prioritisation, and resourcing. • Ensure early and sustained clinical and operational engagement in system design, pathway redesign, and implementation, with protected time for staff participation. • Embed change impact assessments into programme governance to identify readiness gaps, capacity constraints, and risks to adoption at divisional and service levels.	• TGT	• ongoing
• Engagement in the design and adoption of digital systems	• Review of mechanisms to ensure stakeholders have adequate time to engage in design and transformation. • Executive Programme Board to provide oversight and leadership regarding alignment resourcing and decisions	• MS	• Ongoing
• OneEPR does not progress (e.g. running out of funding/supplier issues/not delivering agreed specification etc)	• Maintain robust programme governance through the Executive Programme Board and Digital Committee, with clear escalation routes for delivery, financial, and supplier risks. • Secure and regularly review programme funding and affordability, including contingency planning within Trust revenue and alignment to agreed benefits realisation. • Implement active supplier management, including contractual performance monitoring, milestone assurance, and formal issue escalation to address delivery delays or specification risk. • Full legal review of contract position	• MS	• Controls in place
• Current System becomes unsupportable	• Contractual arrangements in place with Nervecentre until July 2028	• MS	• COMPLETE

• Clinical risks requiring mitigation through EPR are ongoing	• 22 risks that require a new EPR • Full mitigation of all controls with 3 risks (Gastro ORM, Diabetes, Post-operative assessment identified as needing a standalone system. Approval to proceed agreed.	• MS	• October 2026
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

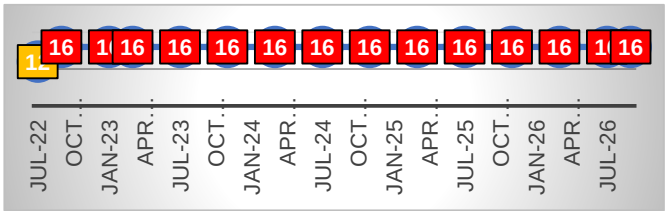
Current Performance – Highlights from the Integrated Performance Report:
• Programme status remains RED. • Outstanding delivery commitments for Full EPR, MVP and Core requirements. • Multiple workstreams remain RED including Integration, User Experience, CPOE, Pathways, ED/IP, Outpatients and Comms. • 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: **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: **Demand, capacity and flow**			
If we do not achieve further improvements to clinical pathways, matching capacity to demand, and flow within the Trust and wider system, including left shift	***Then*** 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	***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*	

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

Risk Trend



Risk Lead	Chief Operating Officer	Assurance committee	FPPC (sent to QSC too)

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 • 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	• 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 • 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	• 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) • 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	• 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 • 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	• Board IPR (2) • 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)	4
Theatre & Productivity Management Controls • Utilisation and cancellation thresholds • Weekly review with divisional escalation • Theatre Transformation Programme	• Board IPR (2) • Power BI info suite (1) • Performance Senate; monthly review including gap analysis, recovery trajectories and improvement plans 1)	4
Diagnostic Capacity & Demand Controls • Modality-level demand/capacity tracking • Weekly PTL reviews for diagnostics • Diagnostic Transformation Programme	• Board IPR (2) • Power BI info suite (1) • Performance Senate; monthly review including gap analysis, recovery trajectories and improvement plans 1)	4
System Flow & Ambulance Interface Controls • Handover escalation protocols • Call-before-convey compliance oversight	• 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
• Need for a consistent weekly PTL validation process across specialties • Inconsistent application of prioritisation criteria • Limited visibility of demand vs capacity mismatch by specialty	• 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	• Laura Moore, Associate Director of Planning and Information • Claire Moore, Deputy COO • Mark Stanton, CCIO • Lucy Davies, COO	• March 2027
• 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 inpatient bed closures to resolve urgent	• 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	• Paul Thorp DOD Unplanned Care • Junaid Qazi, Divisional Medical Director UPC • Justin Daniels, Medical Director • Theresa	• March 2027

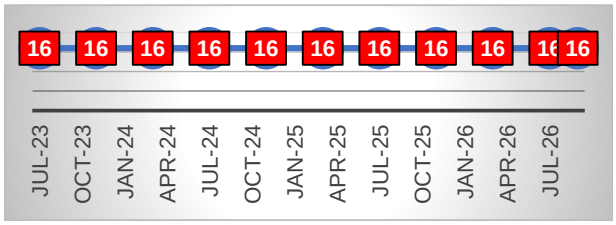
estates issues	planning • 7-day band 7 nursing in place in paediatric ED • Corridor Care Elimination Plan • Pilot of Acute Medics in Urgent Care Coordination Hub (June 2026) • EEMAC implementation • Use of patient stories • Regular liaison between ENHT and HPFT with regard to shared pathways • Estates work to SSU, Renal, Swift	Murphy, Chief Nurse (SRO for 26/7 UEC transformation) • Lucy Davies, COO • Claire Moore, Deputy COO	
Ambulance Handover • Limited control over conveyance decision-making • Inconsistent use of call-before-convey protocols	• 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 • *Handover @ 45* • Lister ED new Ambulance handover process May 2025 • National UEC capital allocation for extended Ambulance Handover Bay, work completed April 2026 • Pilot of Acute Medics in Urgent Care Coordination Hub (June 2026)	• Lucy Davies, COO • EEAST • Central East SCC	• March 2027
Inpatient Flow • 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	• 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	• Redeemed Mzila, Head of Site • Junaid Qazi • Moreblessing Zvorwadza, Divisional Nursing Director • Heidi Hall, Head of Service HCC	• March 2027
Diagnostic wait times – MRI and U/S, Audiology • 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)	• 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	• Claire Moore, Deputy COO • Kate Fruin, Acting DOD Planned Care • Mark Stanton, diagnostic transformation SRO	• March 2027
• Theatre utilisation below	• Recruitment plans ongoing.	• Kate Fruin	• March 2027

benchmark • 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	• 'Drumbeat' huddles to manage activity • Theatre Transformation Programme 2026/7 including review of theatre timetable • POA Kaizen workstream • Estates work to Theatres, Swift	DOD • Lucy Davies COO - theatre tranformatio n SRO	

Current Performance – Highlights from the Integrated Performance Report:
• % of 62-day PTL over 62 days • 28-day faster diagnosis • Cancer 31 day waits • RTT performance • 65 and % 52 weeks RTT • 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
3679	Non-RTT wait times and capacity	20
0263	Paediatric radiologist capacity	15
3358	Children ED doctor capacity	16
3641	CYP bookings and cancellations	16
3789	DAU capacity	16

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 optimise patient experience and quality of care

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

Risk Lead	Chief Information Officer	Assurance committee	Digital Committee

Controls	Assurances against stated controls, with assurance level *1st line (front line); 2nd (corporate); 3rd (independent)*	Assurance score
Strategies and Plans		
Board approved OneEPR Business case (2/24)	• 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.	• Programme update monthly report to Digital Committee (2) • Report to Clinical Safety Committee (1)	5
Cyber Security & Resilience	• 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).	4
AI Governance and Assurance	• 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).	4
Data Quality & Interoperability	• Controls: Data quality programme, master data governance, interoperability standards. Assurances: Data quality dashboards (1), integration reporting (1), benchmarking/audit (3).	4

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

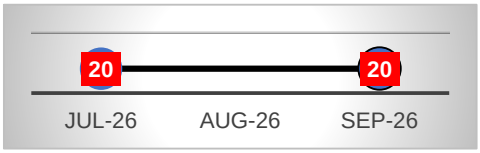
Gaps in Controls and Assurances	Actions and mitigations to address gaps	Lead	Target date
•	• Spare line?		•
Variation in business-as-usual systems and processes	• Adoption of lean thinking in pathway redesign model as part of the ENH production system for later phases of the project	MS	• ongoing
Improvement training compliance is variable across staff groups and levels of seniority	• Develop a robust training program to include classroom and f2f and communicate requirements with notice via the programme board. Senior stakeholder to share responsibility • Date realigned with plan • Outline Plan approved by Steering group • Compliance to be monitored and reported to divisional leads	MS	December 26 •
Digital Solutions and Delivery team has been historically funded through Capital using contract resource, but new Capitalisation rules mean a move towards revenue, this could significantly reduce the size of the team for Road map deliveries	• Move towards a substantive team to reduce spend • Seek NHS E revenue funding streams • This is now funded through an agreed Benefits case through Trust Revenue • Trust financial position could impact Digital Resources which is being closely monitored	MS	• Ongoing
If change is not managed effectively	• Strengthen executive sponsorship and leadership visibility through the Digital Committee to reinforce accountability for change outcomes, prioritisation, and resourcing. • Ensure early and sustained clinical and operational engagement in system design, pathway redesign, and implementation, with protected time for staff participation. • Embed change impact assessments into programme governance to identify readiness gaps, capacity constraints, and risks to adoption at divisional and service levels.	TMG	• ongoing
Engagement in the design and adoption of digital systems	• Review of mechanisms to ensure stakeholders have adequate time to engage in design and transformation. • Executive Programme Board to provide oversight and leadership regarding alignment resourcing and decisions • Board education in AI	MS	• Ongoing
Appropriate skills within the Digital team to deliver Digital solutions specifically AI	• Identify appropriate training • Consideration of AI skillsets within all recruitment	MS	• Ongoing
AI governance, ethics and regulatory compliance	• Implement Trust-wide AI policy, AI review panel, AI inventory and DPIA/clinical safety assessments before deployment	MS	• June 2027
Cyber resilience and legacy technology risk	• Develop legacy system retirement roadmap, resilience testing and annual recovery exercises	MS	• March 2027

Data quality and benefits realisation	Define benefits framework with KPI ownership, baselines and quarterly benefits tracking	MS	December 2026

Current Performance – Highlights from the Integrated Performance Report:
• 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	16
3399	Risk of inaccurate allergy documentation	16
0942	Endoscopy paper processing timescales	15
3773	Replacing CIPTS	16

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

Controls	Assurances against stated controls, with assurance level *1st line (front line); 2nd (corporate); 3rd (independent)*	Assurance score
Strategies and Plans		
Trust strategy, vision and 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
• Variable ENHPS adoption and daily management maturity limits organisational discipline and delivery pace.	• 2026/ 27 ENHPS work plan approved via TGT. • Mandate minimum daily management standards monitored and escalated through TGT. • Divisional and corporate targets and trajectories.	• CKO • CKO • CKO	Mar 2027 Sept 2026 Mar 2027
• Inconsistent accountability and escalation arrangements restrict timely intervention and reduce delivery assurance.	• 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.	• Interim CEO • CPO • Interim TD	Sept 2026 Mar 2027 Sept 2026
• Inconsistent strategic cascade weakens alignment between organisational priorities and operational delivery.	• 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	• CKO • CKO • Execs	Jul 2027 Mar 2027 Nov 2026
• Current leadership capacity and capability limit the pace, scale and effectiveness of transformation delivery.	• Mandated standards for ENHPS for Leaders Programme. • Leadership and Management Competency Development framework. • Targeted executive-led intervention support for high-risk transformation priorities.	• CKO • CPO • Execs	Sept 2026 Mar 2027 Sept 2026
• Immature benefits realisation arrangements limit evidence of transformation impact and value.	• Introduce a mandated benefits realisation framework for all transformation programmes.	• CKO	Dec 2027
• Current business partnering and governance arrangements lack sufficient proactive challenge, intervention and delivery support.	• Redesign business partnering model.	• CPO/ Interim CEO	Dec 2027
• Multiple internal/external partners create complexity, reducing clarity of ownership and accountability.	• Implement a single integrated transformation governance structure and operating model. • Establish robust consultancy oversight and contract management process.	• Interim CEO • Interim TD	Jun 2026 May 2026
• Inconsistent cultural and leadership behaviors limit psychological safety, transparency, escalation and organisational learning.	• Freedom to speak up framework. • Whistle-blowing policy. • Positive leadership rounds. • Accountability and escalation framework	• CPO • CPO • CKO • Interim CEO	Apr 2026 June 2026 Apr 2026 Jun 2026
• Insufficient integration of workforce and financial planning and clinical redesign.	• Introduce new integrated workforce , financial and clinical redesign planning as a mandatory component of annual planning processes.	• CPO/ Interim CEO	Mar 2027
Gaps in Assurance	**Actions and mitigations to address gaps**	**Lead**	**Target date**
• Independent assessment and assurance of leadership accountability culture.	• Well-led developmental review. • ENHPS Health Check processes	• Head of Corporate Governance • CKO	Dec 2027

• Strong data availability and benchmarking is not consistently translated into action.	• Introduce specialty-level productivity review and action process.	• Head of PMO	Oct 2026

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. • Brillant basics launched during early quarter one with 2-day-per-week SME on-site support provided though 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
3028	Cancer acute/comorbidities services not on same site	16

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NHS Trust

Integrated Performance Report

Month 04 | 2026-27

	P	?	F
H / L	1	3	5
	11	40	11
H / L	0	0	6

Data correct as at 20/08/2026

Performance Highlights

NHS East and North Hertfordshire Teaching NHS Trust

Quality

- Most metrics are stable across month 4.
- Positives - continued high thrombolysis rate in stroke, slight fall in complaints, rise in incident reporting with the vast majority low or no harm.
- Stable but needs further improvement - VTE assessment, sepsis 6 bundle.
- Needs improvement - Impact of UEC delays on clinic outcomes, diagnostic delays.

Operations

- **Cancer Waits:** 62-day performance ranked 6/119 nationally in June. Faster Diagnosis Standard fell short of the target 76.43%, focussed transformation work regarding reporting turnaround times.
- **Diagnostics:** Monthly improvement in DM01 performance continues with improvements across all modalities in July. Transformation programme focussed on both acquisition and reporting.
- **RTT (excl. Community):** 0.5% improvement in performance and remains above trajectory. Efficiency and productivity remain the key focus of transformation, alongside strengthened financial controls.
- **Community waits:** Proof of Concept continues for Herts integrated CYP Neurodiversity pathway, due to complete early September.
- **UEC:** Both Adult and Paeds performance remain below trajectory, impacted by Swift ward closure, higher attendances. UEC transformation continues to focus on pathway improvements and ED wait to be seen.

Finance

- £2.7m YTD deficit against a £2.7m deficit plan
- The Trust has managed to plan despite slippage in CIP schemes which have been offset by underspends on pay and WLI payments due to low activity, as well as the early release of provisions.
- Nursing and Medical workforce cost pressures and divisional overspends persist. Despite strengthened controls, the worked WTE has not reduced in year.
- Elective performance and productivity gaps masked by block.
- 2026/27 position needs to continue to focus on transformation programme savings, strengthening financial controls and improvements in productivity.

People

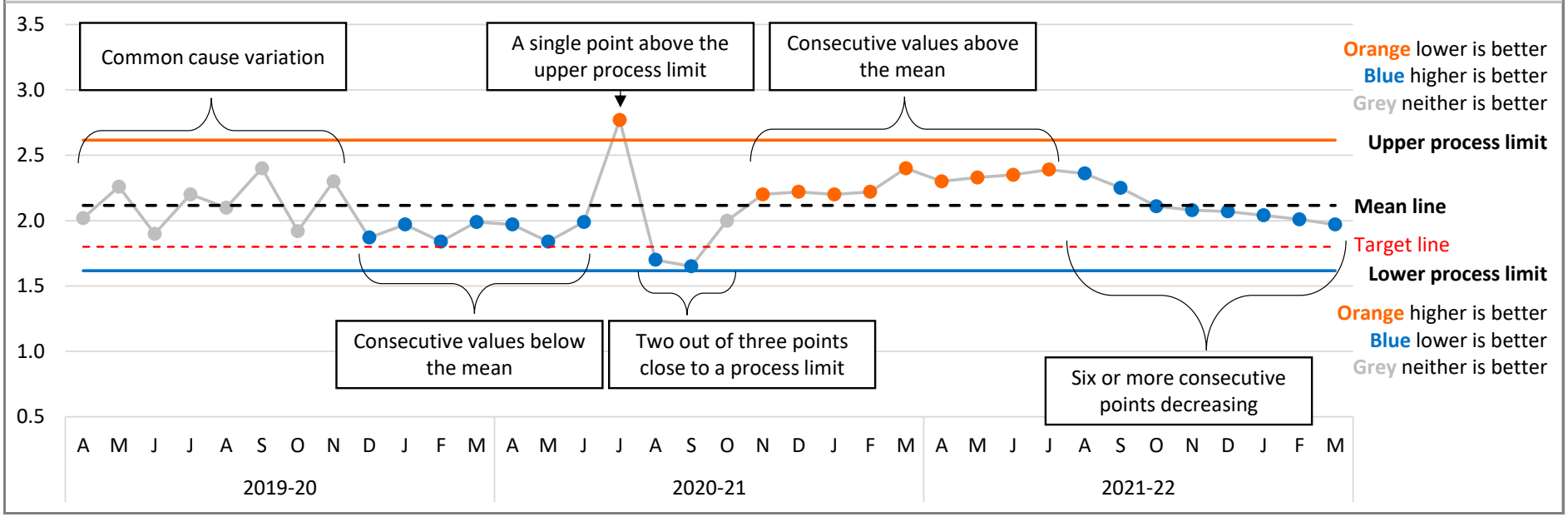
- Staff turnover rate at 7.3% and remains below target.
- Stat/Mand compliance is now above target at 90.8%
- Agency spend is low at 0.8% and vacancies low at 1.9%
- GROW together compliance has increased by 10%
- Stat Mand and Grow Together have both been the focus of compliance processes as well as transformation plans linked to ne NHS Staff Standards.
- Sickness target monitoring improving position vs previous month.
- Stress & mental health conditions continue to be a leading cause of sickness absence.

Month 04 | 2026-27

Integrated Performance Report

NHS East and North Hertfordshire Teaching NHS Trust

How to interpret a Statistical Process Control (SPC) Chart



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

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

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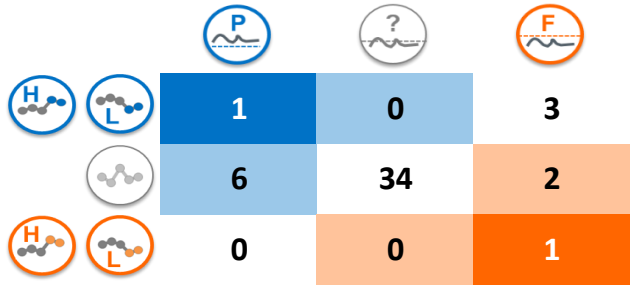
Quality

Month 04 | 2026-27



Quality

Summary

NHS East and North Hertfordshire Teaching NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Patient Safety Incidents	Total incidents reported in-month	Jul-26	n/a	1,894	H		2 points above the upper process limit No target
Infection Prevention and Control	Hospital-acquired MRSA Number of incidences in-month	Jul-26	0	0		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired c.difficile Number of incidences in-month	Jul-26	0	8		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired MSSA Number of incidences in-month	Jul-26	0	2		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired e.coli Number of incidences in-month	Jul-26	0	2		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired klebsiella Number of incidences in-month	Jul-26	0	1		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired pseudomonas aeruginosa Number of incidences in-month	Jul-26	0	1		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired CPOs Number of incidences in-month	Jul-26	0	4		?	Common cause variation Metric will inconsistently pass and fail the target
	Hand hygiene audit score	Jul-26	80%	92.2%		P	Common cause variation Metric will consistently pass the target
Safer Staffing	Overall fill rate	Jul-26	n/a	85.7%	H		7 points above the mean No target
	Staff shortage incidents	Jul-26	n/a	78			Common cause variation No target

Month 04 | 2026-27

Quality

Summary

NHS East and North Hertfordshire Teaching NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Cardiac Arrests	Number of cardiac arrest calls per 1,000 admissions	Jul-26	n/a	0.56			Common cause variation No target
	Number of deteriorting patient calls per 1,000 admissions	Jul-26	n/a	0.45			Common cause variation No target
Sepsis Screening and Management	Inpatients receiving IVABs within 1-hour of red flag	Jul-26	95%	80.0%		?	Common cause variation Metric will inconsistently pass and fail the target
	Inpatients Sepsis Six bundle compliance	Jul-26	95%	50.0%		F	Common cause variation Metric will consistently fail the target
	ED attendances receiving IVABs within 1-hour of red flag	Jul-26	95%	87.3%		?	Common cause variation Metric will inconsistently pass and fail the target
	ED attendance Sepsis Six bundle compliance	Jul-26	95%	73.6%		F	Common cause variation Metric will consistently fail the target
VTE Risk Assessment	VTE risk assessment stage 1 completed	Jul-26	85%	78.0%	H	F	14 points above the mean Metric will consistently fail the target
HATs	Number of HAT RCAs in progress	Jul-26	n/a	150			Common cause variation No target
	Number of HAT RCAs completed	Jul-26	n/a	0			Common cause variation No target
	HATs confirmed potentially preventable	Jul-26	n/a	0			Common cause variation No target
PU	Pressure ulcers All category ≥2	Jul-26	0	14		?	Common cause variation Metric will inconsistently pass and fail the target

Month 04 | 2026-27

Quality

Summary

NHS East and North Hertfordshire Teaching NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Patient Falls	Rate of patient falls per 1,000 overnight stays	Jul-26	n/a	3.7			Common cause variation No target
	Proportion of patient falls resulting in serious harm	Jul-26	n/a	0.0%			Common cause variation No target
	Proportion of patient falls resulting in Moderate harm	Jul-26	n/a	5.0%			Common cause variation No target
Friends and Family Test	Inpatients positive feedback	Jul-26	95%	95.7%		?	Common cause variation Metric will inconsistently pass and fail the target
	A&E positive feedback	Jul-26	90%	88.2%		?	Common cause variation Metric will inconsistently pass and fail the target
	Maternity Antenatal positive feedback	Jul-26	93%	92.2%		?	Common cause variation Metric will inconsistently pass and fail the target
	Maternity Birth positive feedback	Jul-26	93%	100.0%		P	Common cause variation Metric will consistently pass the target
	Maternity Postnatal positive feedback	Jul-26	93%	95.9%		?	Common cause variation Metric will inconsistently pass and fail the target
Friends and Family Test	Maternity Community positive feedback	Jul-26	93%	97.4%		?	Common cause variation Metric will inconsistently pass and fail the target
	Outpatients FFT positive feedback	Jul-26	95.0%	96.7%		?	Common cause variation Metric will inconsistently pass and fail the target
PALS	Number of PALS referrals received in-month	Jul-26	n/a	486		-	Common cause variation No target

Month 04 | 2026-27

Quality

Summary

NHS East and North Hertfordshire Teaching NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Complaints	Number of written complaints received in-month	Jul-26	n/a	140		-	Common cause variation No target
	Number of complaints closed in-month	Jul-26	n/a	128		-	7 points above the mean No target
	Proportion of complaints acknowledged within 3 working days	Jul-26	75%	87.9%		P	Common cause variation Metric will consistently pass the target
	Proportion of complaints responded to within agreed timeframe	Jul-26	80%	31.5%	L	F	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	60 - 70%	70.4%		?	Common cause variation Metric will inconsistenly pass and fail the target
	Massive obstetric haemorrhage >1500ml vaginal	Jul-26	3.3%	3.4%		?	Common cause variation Metric will inconsistenly pass and fail the target
	3rd and 4th degree tear vaginal	Jul-26	2.5%	1.5%		?	Common cause variation Metric will inconsistenly pass and fail the target
	Massive obstetric haemorrhage >1500ml LSCS	Jul-26	4.5%	2.8%		?	Common cause variation Metric will inconsistenly pass and fail the target
	3rd and 4th degree tear instrumental	Jul-26	6.3%	10.0%		?	Common cause variation Metric will inconsistenly pass and fail the target
	Term admissions to NICU	Jul-26	6.0%	5.3%		?	Common cause variation Metric will inconsistenly pass and fail the target
	ITU admissions	Jul-26	0.7	0		?	Common cause variation Metric will inconsistenly pass and fail the target

Month 04 | 2026-27

Quality

Summary

NHS East and North Hertfordshire Teaching NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Maternity Other Metrics	Smoking at time of booking	Jul-26	12.5%	2.8%			Common cause variation Metric will consistenly pass the target
	Smoking at time of delivery	Jul-26	2.3%	2.0%			Common cause variation Metric will inconsistently pass and fail the target
	Bookings completed by 9+6 weeks gestation	Jul-26	50.5%	77.3%			Common cause variation Metric will consistenly pass the target
	Breast feeding initiated	Jul-26	72.7%	76.1%			Common cause variation Metric will inconsistently pass and fail the target
	Number of MNSI PSII	Jul-26	0.5	0			Common cause variation Metric will inconsistently pass and fail the target
Mortality	Crude mortality per 1,000 admissions In-month	Jul-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	Jul-26	12.8	8.3			Rolling 12-months - unsuitable for SPC
	HSMR In-month	May-26	100	85.3			Common cause variation Metric will inconsistently pass and fail the target
	HSMR Rolling 12-months	May-26	100	82.4			Rolling 12-months - unsuitable for SPC
	SHMI In-month	Mar-26	100	83.0			Common cause variation Metric will inconsistently pass and fail the target
	SHMI Rolling 12-months	Mar-26	100	94.5			Rolling 12-months - unsuitable for SPC

Month 04 | 2026-27

Quality

Summary

NHS East and North Hertfordshire Teaching NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Re-admissions	Number of emergency re-admissions within 30 days of discharge	May-26	n/a	645	L		7 points below the mean No target
	Rate of emergency re-admissions within 30 days of discharge	May-26	9.0%	5.5%	L	P	9 points below the mean Metric will consistently pass the target
Length of Stay	Average elective length of stay	Jul-26	2.8	2.3		P	Common cause variation Metric will consistently pass the target
	Average non-elective length of stay	Jul-26	4.6	5.1		?	Common cause variation Metric will inconsistently pass and fail the target
Palliative Care	Proportion of patients with whom their preferred place of death was discussed	Jul-26	n/a	85.5%			Common cause variation No target
	Individualised care pathways	Jul-26	n/a	29			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%	H	F	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%	H	F	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 04 | 2026-27

Quality

Summary

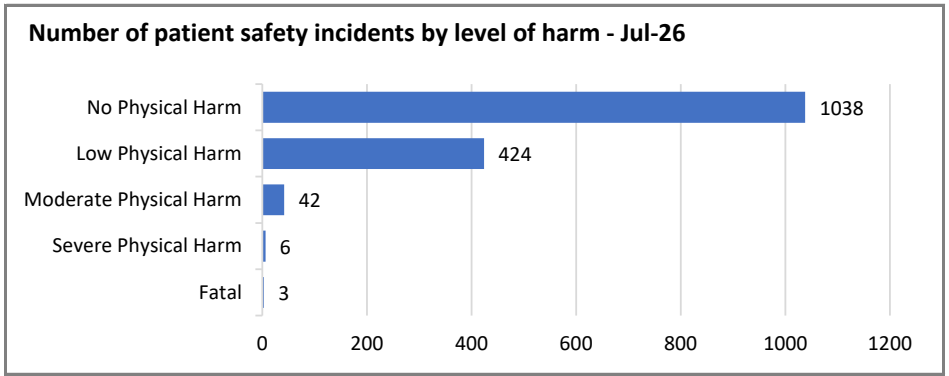
Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
	% of all stroke patients who receive thrombolysis	Apr-26	11%	20.0%			Common cause variation Metric will inconsistently pass and fail the target
	Discharged with ESD	Apr-26	50%	66.0%			Common cause variation Metric will inconsistently pass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

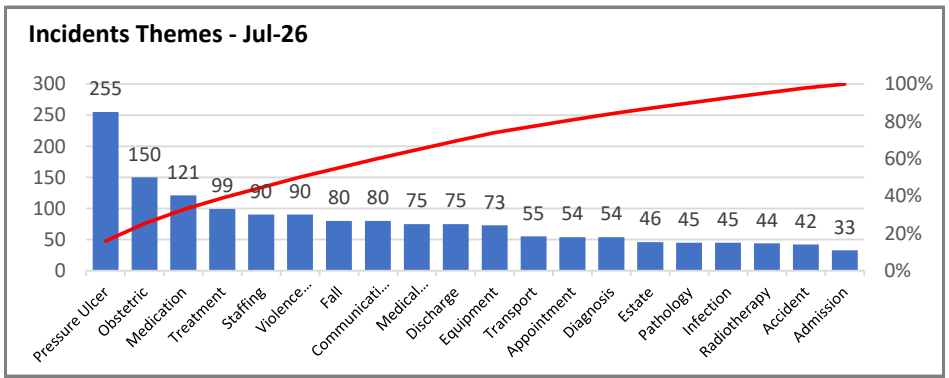
Month 04 | 2026-27

Quality

Patient Safety Incidents

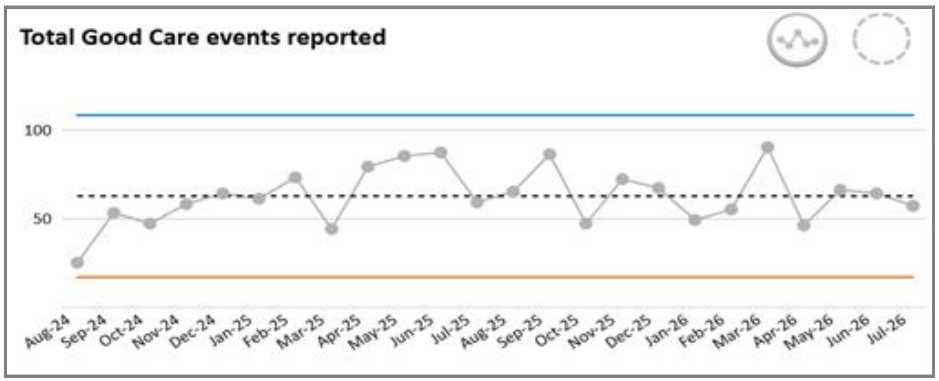
East and North Hertfordshire Teaching NHS Trust





Key Issues and Executive Response

- Noted highest data point for incident reporting over last 24 months
- 97% of patient safety incidents reported resulted in no harm / low harm.
- Obstetrics & Emergency Medicine continue as highest reporting specialty
- Neonatal equipment related incidents noted, including monitor alarms and ET availability. Immediate action taken locally to standardise equipment and review stock management processes
- Continued high reporting of incidents regarding medical records (77)
- Increase in incidents within Renal Services, largely relating to transport issues. Estates-related incidents had also increased due to water pressure concerns affecting clinical areas.
- Patient flow and bed capacity pressures continue to influence incident reporting across Planned Care services, particularly in relation to delayed discharges from critical care and the impact on wider patient flow.
- 53% increase in violence and aggression incidents. 55% of the incidents happened in 3 areas; ED, ward 8A and ward 10B
- 2 x neonatal death - 1 at 22+2 and 1 at 23+5. Both being reviewed through PMRT with ongoing engagement and support to family.
- 1 new PSii commissioned; Never Event following retained swab after Gynaecology surgery. Ongoing engagement with patient and staff, observational work in theatres has commenced.

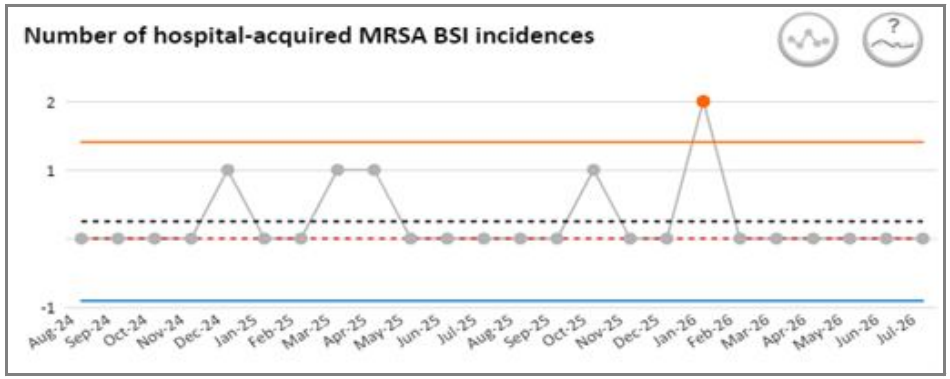


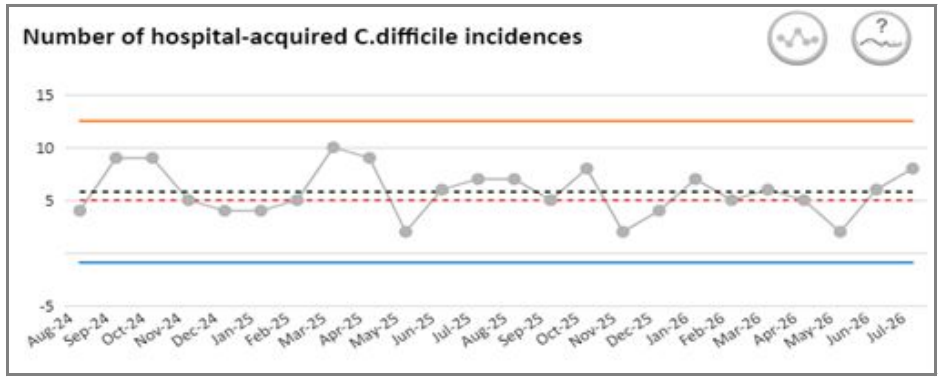
Month 04 | 2026-27

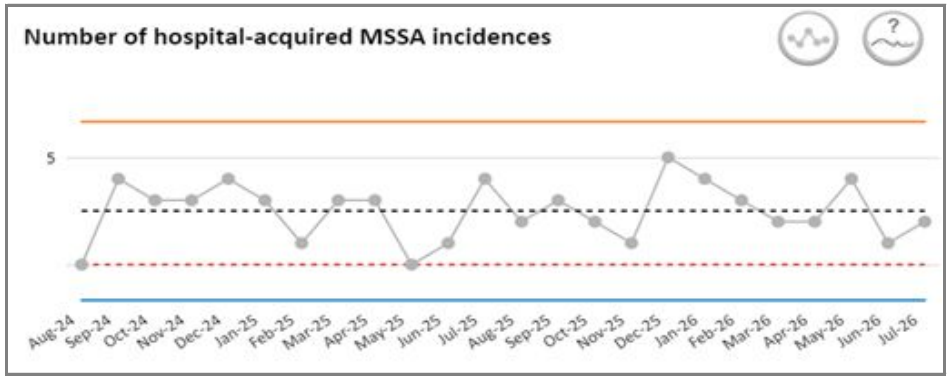
Quality

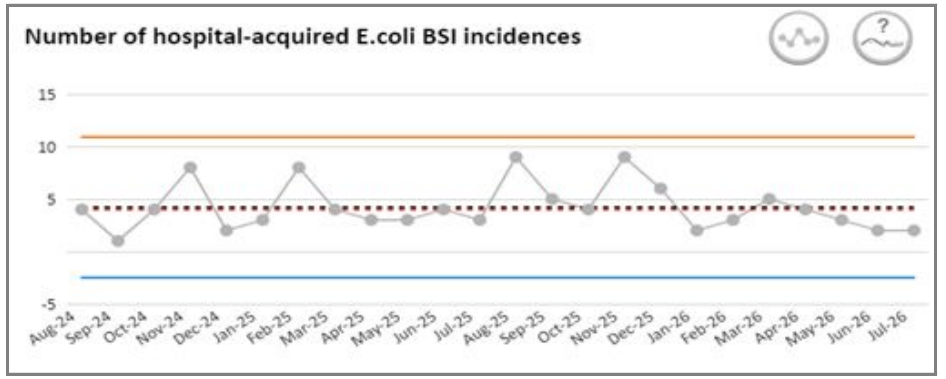
Infection Prevention and Control

East and North Hertfordshire Teaching NHS Trust









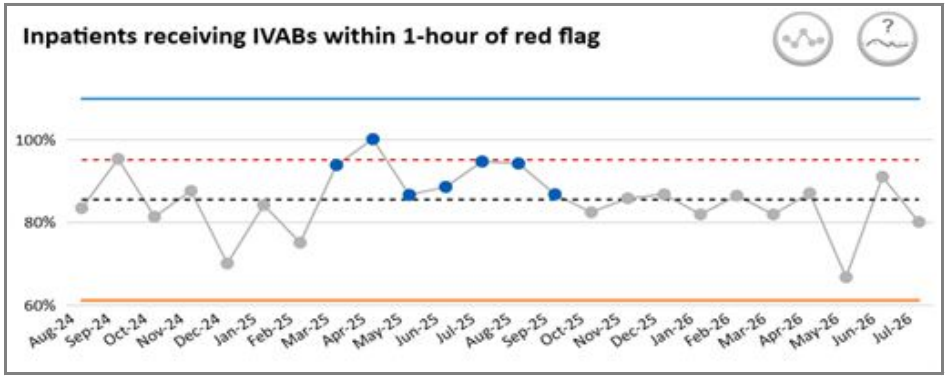
- MRSA BSI - there were zero MRSA Bloodstream Infections (BSI) reported during Jul-26. Year to date (YTD), there are zero cases at this stage.
- MSSA BSI - a total of two MSSA BSI were identified in Jul-26. YTD total is nine, which is one case above the total for the same period last year.
- *C. difficile (C diff.)* infection (CDI) - following improved performance in 2025/26, NHS England reduced the Trust's annual CDI threshold from 82 to 61 cases for 2026/27. Eight hospital-associated CDI cases were reported in Jul-26, predominantly in patients with significant pre-existing risk factors and clinically justified antimicrobial exposure. Antimicrobial stewardship remains a key priority. The MDT deemed five cases unavoidable. Improvement actions focus on stool chart documentation, timely isolation, environmental cleaning, and IPC surveillance. YTD, 21 cases have been reported compared with 24 in the same period last year.
- *E.coli BS*I - two cases were reported in Jul-26. YTD, 11 cases have been recorded, which is two cases fewer for the same period last year.

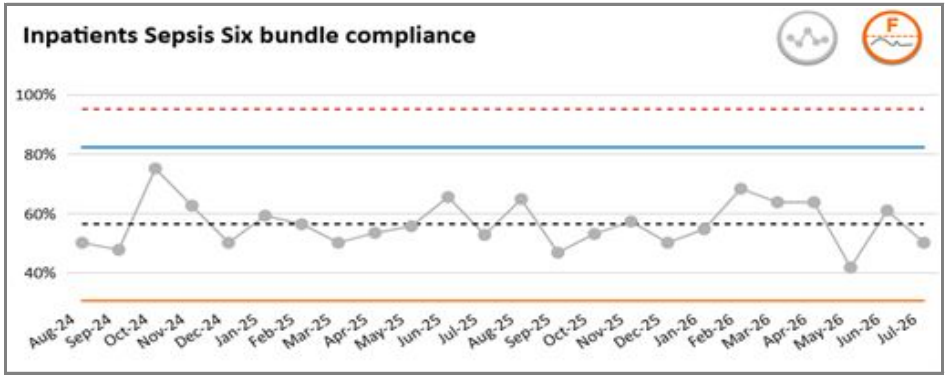
Month 04 | 2026-27

Quality

Sepsis Screening and Management | Inpatients

East and North Hertfordshire Teaching NHS Trust





Themes

Sepsis IP	2025-26									2026-27		
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Oxygen	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Blood cultures	86%	94%	94%	73%	81%	92%	57%	91%	73%	74%	89%	81%
IV antibiotics	87%	94%	94%	87%	82%	86%	86%	82%	82%	88%	67%	91%
IV fluids	89%	93%	92%	100%	82%	92%	100%	88%	82%	83%	86%	87%
Lactate	73%	71%	76%	50%	81%	64%	71%	82%	64%	87%	64%	70%
Urine measure	93%	68%	88%	80%	82%	93%	75%	73%	73%	83%	83%	83%
Sepsis Six bundle	53%	65%	47%	53%	57%	50%	55%	68%	64%	64%	42%	61%

Key Issues and Executive Response

Themes

- 5/10 patients received the sepsis six within an hour in inpatients - where Sepsis six did not happen, 3 out of 5 patients deteriorated out of hours.
- IV antibiotic compliance sits at 80% (8/10).
- IV fluid sits at 83% with 5/6 patients having an appropriate fluid bolus within an hour.
- Lactate measurement remains a challenge with 5/9 and 56%. 8/10 patients had a fluid balance completed within an hour in July.
- Blood culture compliance sits at 89% with 8/9 patients having them in a timely manner.
- Due to a reduced service in the team, only 10 inpatients were audited in July reflecting the variable compliance percentages when compared to June.

Response

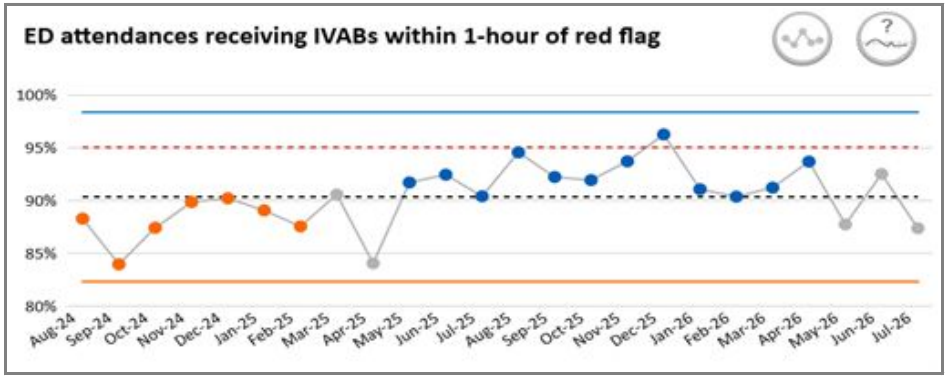
- The team are utilising formal and bedside education, alongside working with practice educators to push for sustainability in compliance.
- The team are trying to intercept unwell septic patients and assist in the delivery of the sepsis six in a timely manner.
- The team have organised sepsis simulation sessions as well as Sepsis study days in August and September.
- Fluid balance continues to be addressed through the use of teaching and posters.
- We undertook a junior doctors simulation session in July focusing on sepsis management and overcoming some of the challenges to completing timely sepsis management.
- Teaching is being planned for the new intake of junior doctors.

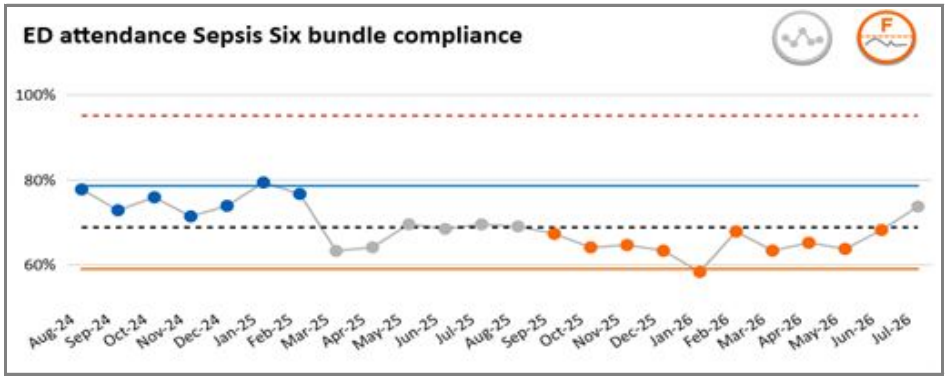
Month 04 | 2026-27

Quality

Sepsis Screening and Management | Emergency Department

East and North Hertfordshire Teaching NHS Trust





Themes

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

Key Issues and Executive Response

Themes

- 53/72 ED patient audits demonstrated sepsis compliance, with 74% having all six elements completed within an hour in July.
- Urine output sits at 76% with 53/70 patients having fluid balance completed within the hour, showing small steps in the right direction. Of the 17 patients who had fluid balance outside the hour, only 6 had no fluid balance at all with 11 having delayed fluid balance, therefore we are seeing an increase in the amount of fluid balance charts being stated.
- Lactate and blood cultures both sit at 99% in July.
- IV antibiotic compliance sits at 87% with 62/71 patients receiving antibiotics within 1 hour and an average time of 52 minutes for antibiotic administration.
- IV fluid compliance remained consistent at 95% again in July.

Response

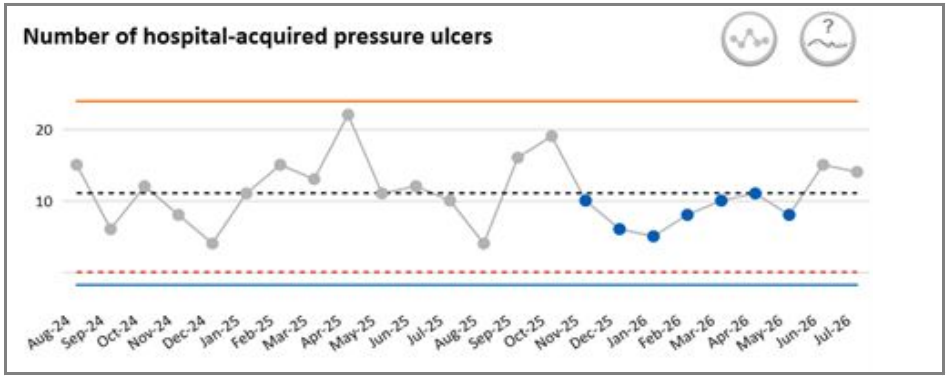
- The Sepsis Team continue to attend patients in ED assessing and going through the Sepsis Screening Tool in real time. Whilst in the department the team utilises this as an education opportunity and works with the team to improve sepsis management.
- The team have just completed a 14 week team-time programme giving weekly sepsis teaching to the ED team.
- The team remains available on Alertive for referrals, queries and support for staff in ED.
- The sepsis team are working closely with the senior team in ED to provide support and a focus on the continued improvement of supporting accurate fluid balance and this is being discussed daily during huddles.

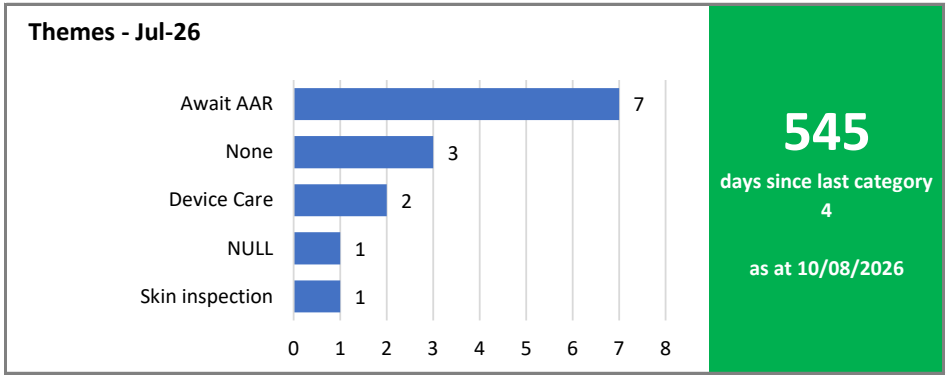
Month 04 | 2026-27

Quality

Pressure Ulcers | VTE

NHS East and North Hertfordshire Teaching NHS Trust

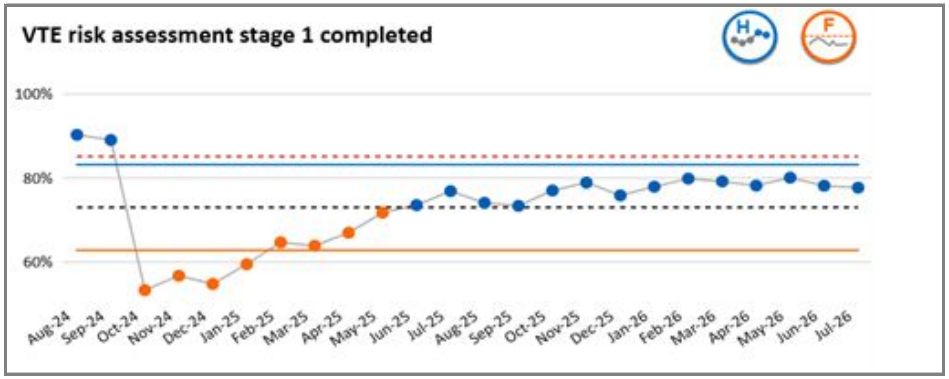




545

days since last category 4

as as at 10/08/2026



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 expert input
- 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
- Plan to adopt PURPOSE-T PU prevention risk assessment tool is in progress. This has been put on the risk register due to delays in ONE ePR roll out
- Community acquired PUs (CA PU) unvalidated data = 87: PU1=28 / PU2 =59. Validated by TVN CAPU = 39: PU2 =3 / PU3=27 / PU4 =3/ MM (D) =1 / SDTI =5. Total reported incidents of CA PU = 126

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.
- A current priority is to ensure day-case patients are VTE risk assessed.
- Nerve Centre has been updated to allow for day-case VTE risk assessment.
- BI team continue to work on a solution to ensure day-case VTE risk assessments reflect in Power BI.
- A method for a cohort approach to VTE risk assessment is in development.

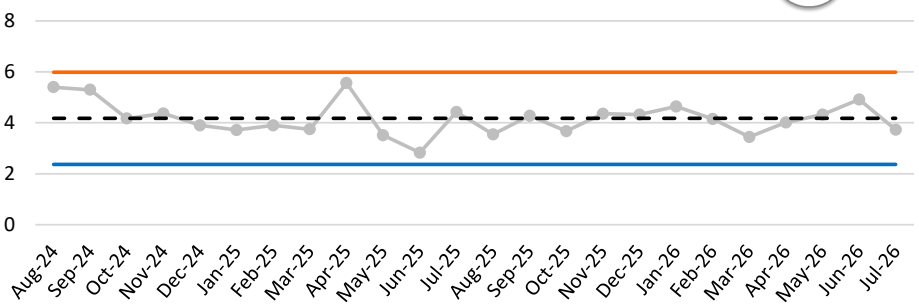
Month 04 | 2026-27

Quality

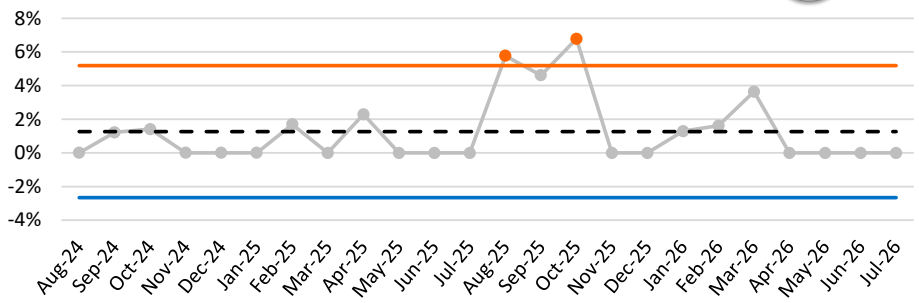
Patient Falls

East and North Hertfordshire Teaching NHS Trust

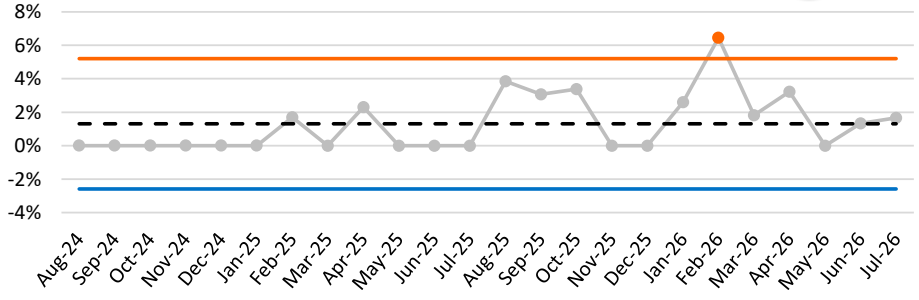
Rate of patient falls per 1,000 overnight stays



Proportion of patient falls resulting in Severe physical harm



Proportion of patient falls resulting in Moderate physical harm



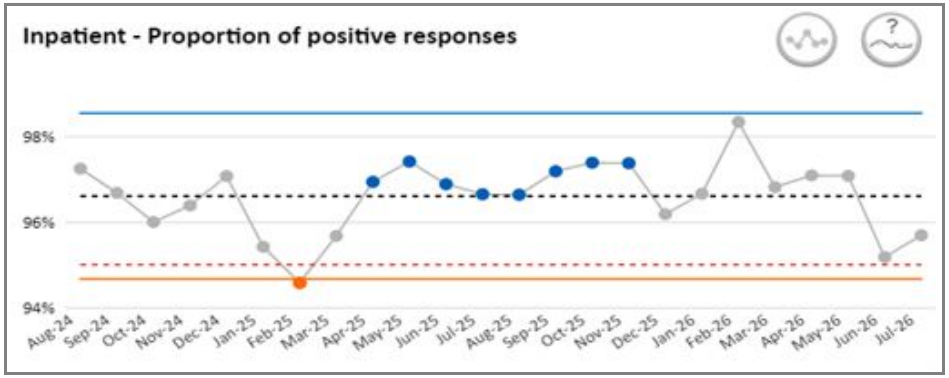
Key Issues and Executive Response

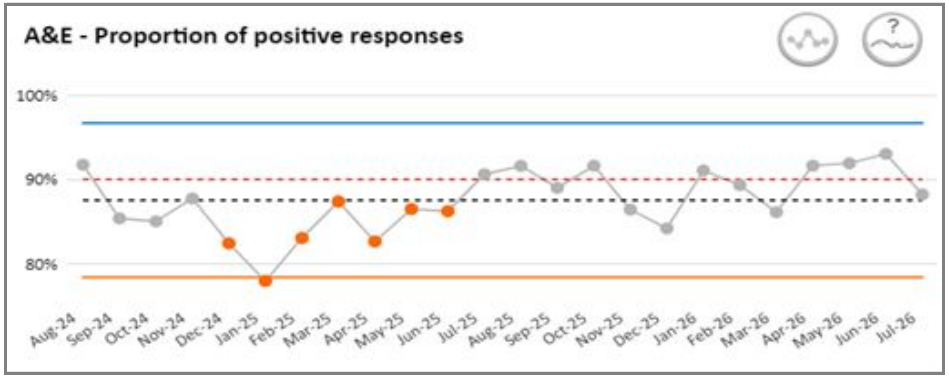
- Inpatient falls data continues to show common cause variation, with an average of 4 per month per 1000 bed days.
- Falls incidences for the month of July is lower compared to the previous month.
- One fall resulting in moderate harm was recorded during the month of July. The patient lost her balance and fell to the floor during personal care, sustaining a head injury as a result of the fall. The patient was subsequently diagnosed with an acute subdural haematoma. The incident is being managed locally. The patient had capacity at the time of the incident. All required post-fall actions have been completed.
- Falls Training – Getting the Basics Right and Falls Champion Training will resume in September following the summer holidays.

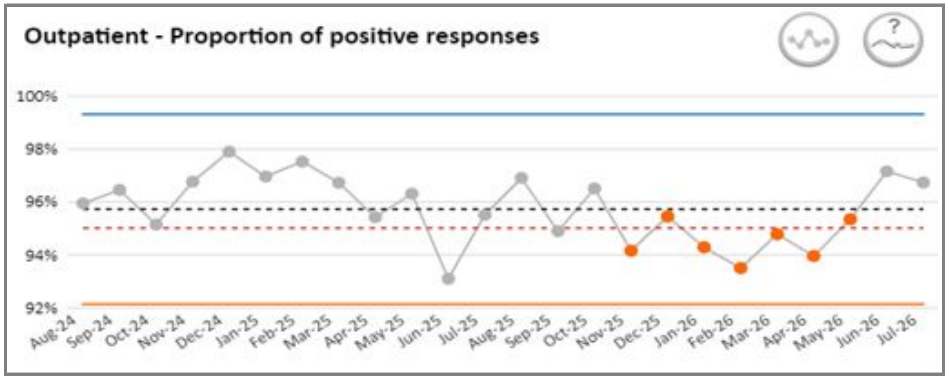
Month 04 | 2026-27

Quality

Friends and Family Test







Key Issues and Executive Response

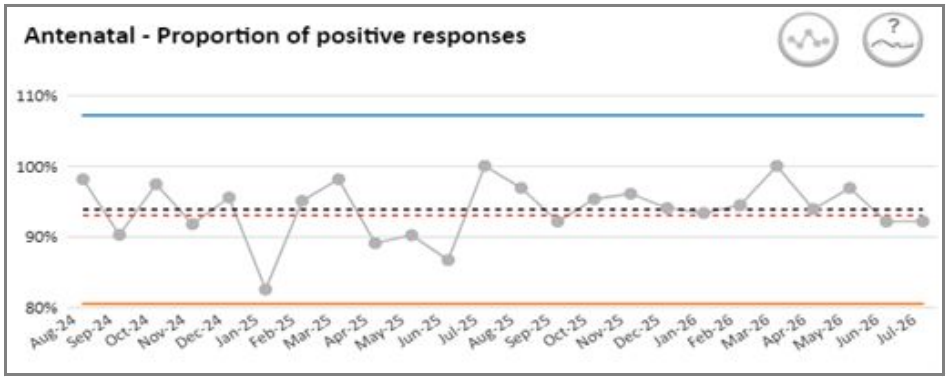
- Although the number of discharges (patients eligible to respond) increased this month, the response rate to the Inpatient/Day Case surveys dropped to 18.65% (20.99% June). However, the proportion of positive responses increased just slightly to 95.69% (95.18%June) but the last two months' results still remain as the lowest for the last 12 months.
- The total number of responses to the ED/UCC surveys decreased from last month with the response rate reducing to 0.56% (0.81% June). The score for % good/very good also decreased to 88.20% (93.01% June) with the score for poor/very poor increasing for a second month in a row to 9.32% (6.11% June). The main theme in comments giving the poor rating concern communication, being listened to by doctors and being given information in a timely manner.
- Outpatients had a general decrease in the total number of responses to the surveys this month with the proportion of positive responses also slightly lower at 96.72% (97.23% June) and the % poor/very poor remaining about the same at 1.38% (1.33%June). The best improvement this month was the combined satellite dialysis units with an increase in responses and the % good/very good at 99.07% (96.43% June) and % poor/very poor at 0.00% (1.19% June).
- The antenatal element of maternity have remained steady with the proportion of positive responses this month, but there was a reduction in the % poor/very poor score to 1.96% (7.89% June).
- Whilst the birth element shows a recovery to 100% in the proportion of positive responses this month (85.71 % June) there were only a total of 10 responses received (7 in May) out of the 381 eligible to respond. The % poor/very poor is zero this month compared 14.29% in June. The service have been made aware of the continued decline and have been asked to provide what action they will be taking.

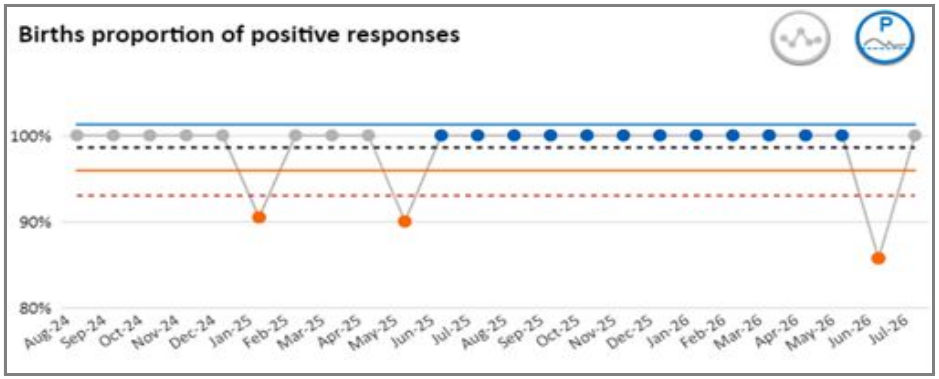
Month 04 | 2026-27

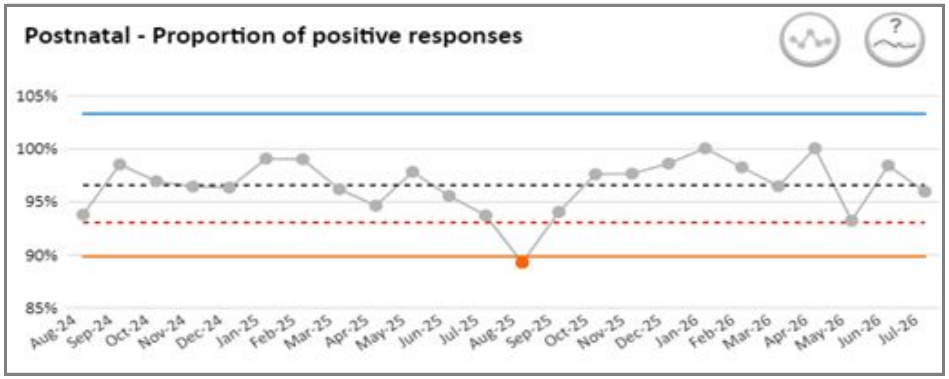
Quality

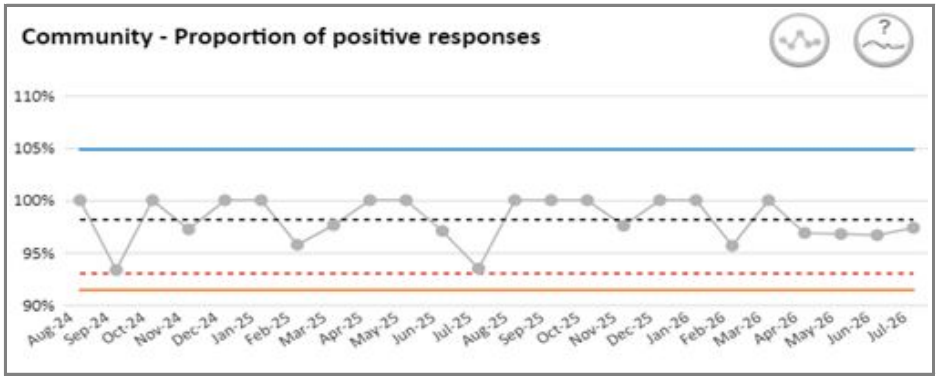
Friends and Family Test

East and North Hertfordshire Teaching NHS Trust









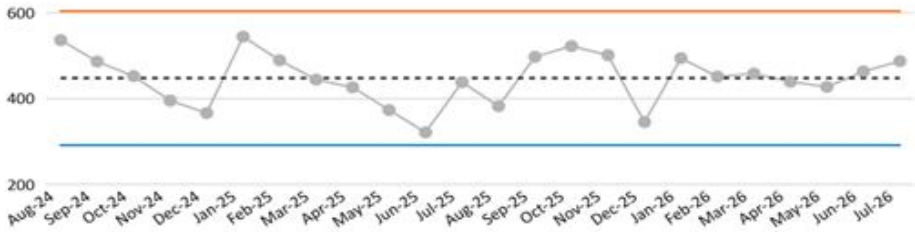
Month 04 | 2026-27

Quality

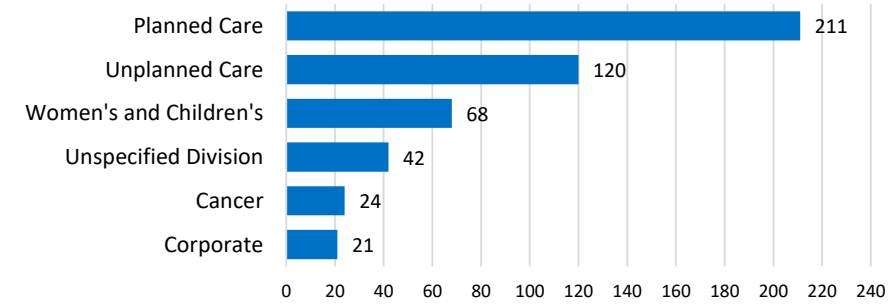
Patient Advice and Liaison Service

East and North Hertfordshire Teaching NHS Trust

Number of PALS referrals



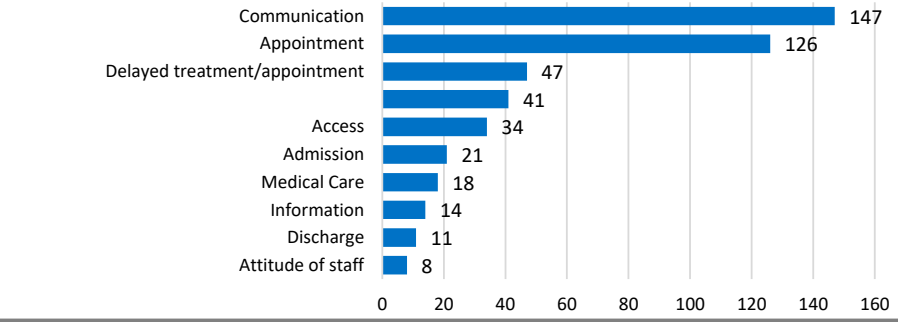
PALs by Division - Jul-26



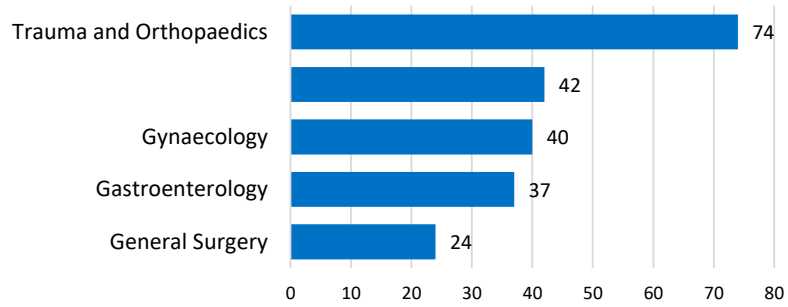
Key Issues and Executive Response

- 485 concerns were raised in July, slight increase on the 460 cases raised in June 2026.
- PALS review of cases now sits at 7 days for non urgent concerns.
- 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.
- T&O received the highest number of concerns in July, with a rise from 56 concerns in June to 81 in July. These are in relation to appointments, waiting times and cancellations. T&O continue to action the below, but concerns are not decreasing. Further action needed by the Trust.
    - Monitoring waiting times weekly and review delays at RTT meeting.
    - Prioritising patients using agreed clinical criteria.
    - Identifying common causes of delays and develop improvement actions at RTT meeting and/or performance reviews.

PALs Top 10 subjects - Jul-26



PALs Top 5 specialties - Jul-26

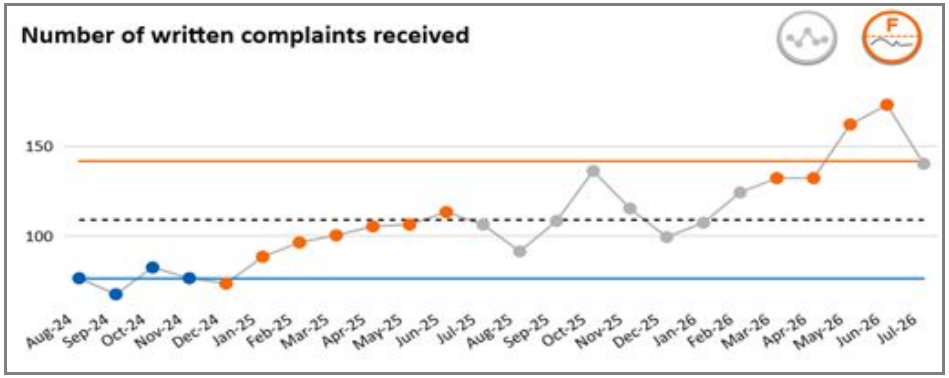


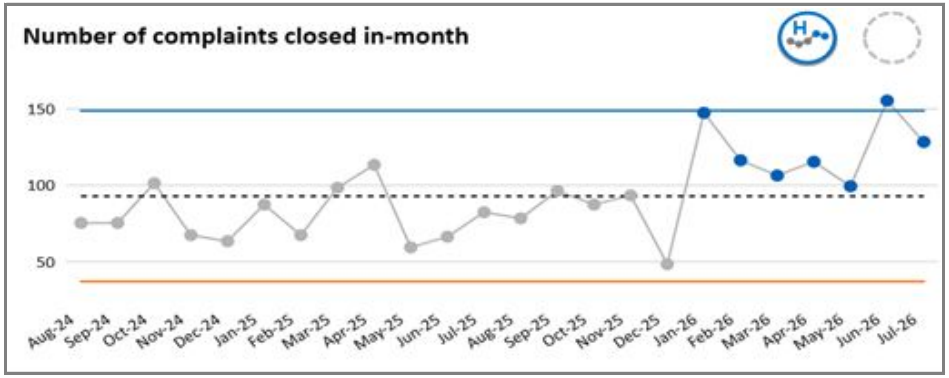
Month 04 | 2026-27

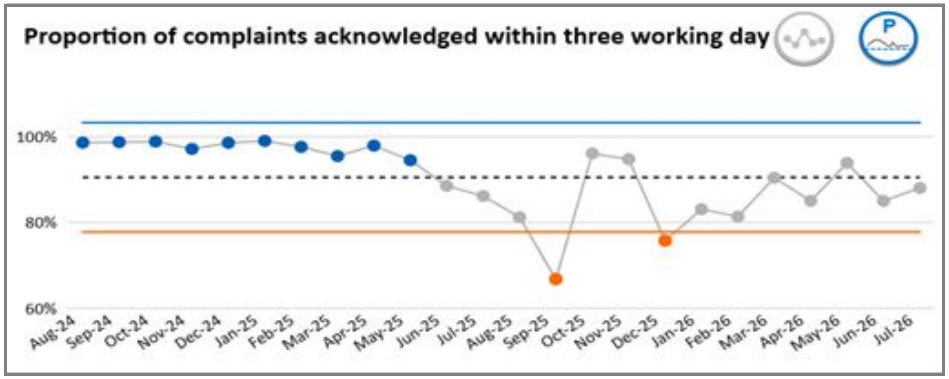
Quality

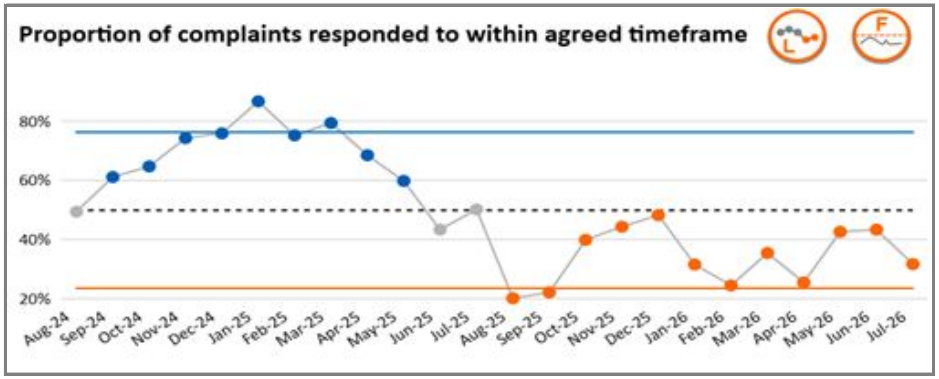
Complaints

NHS East and North Hertfordshire Teaching NHS Trust









Key Issues and Executive Response

- The Trust has seen a slight decrease in the number of complaints being raised. The Trust received 141 formal complaints in July 2026 compared to 166 formal complaints being received in June with 86 of these currently under investigation.
- Planned care continue to receive the highest number of complaints with Trauma and Orthopaedics service receiving the highest number of formal complaints. The service is calling many of the patients who are raising complaints about surgery delays for early resolution.
- The top three themes raised in July 2026 relate to medical care, delayed treatment and appointments.
- The number of open complaints has reduced to 395 the end of June 2026 with 128 complaints closed in the month of July 2026.
- In the month of July 2026 37.5% of complaints were responded to within the agreed timeframe due to annual leave, sickness and over 400 complaints open Trust wide for the team to manage.
- Currently working with NHSP to obtain bank staff to solely draft complaints within the team and chase divisional input. This will be a fixed term contract of 3 months.

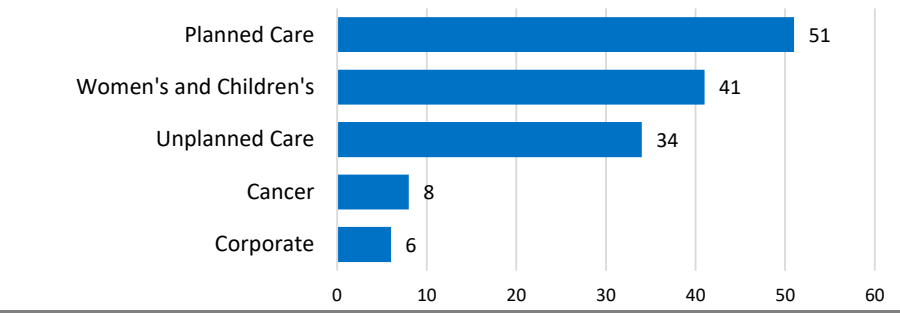
Month 04 | 2026-27

Quality

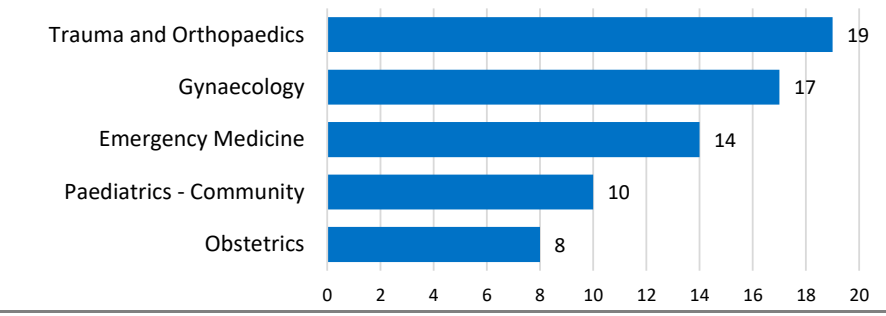
Complaints Themes

NHS East and North Hertfordshire Teaching NHS Trust

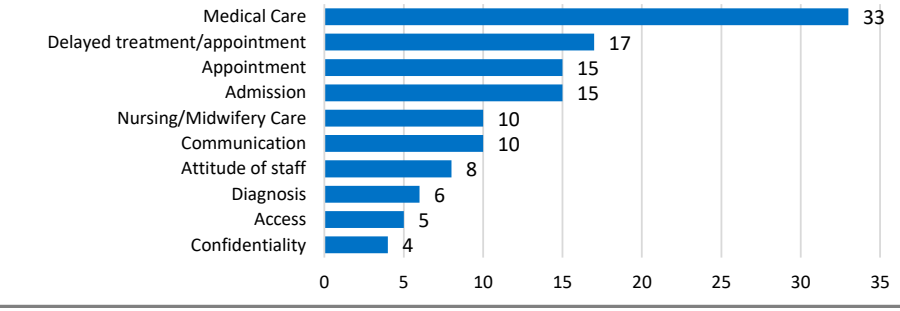
Complaints by Division - Jul-26



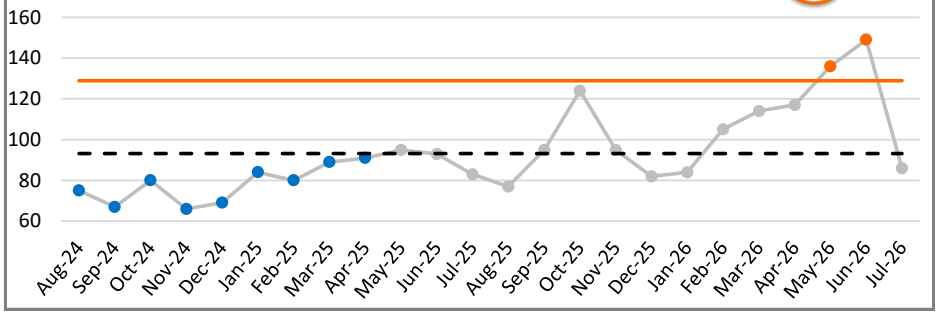
Complaints top 5 specialties - Jul-26



Complaints Top 10 subjects - Jul-26



Number of complaints taken to investigation

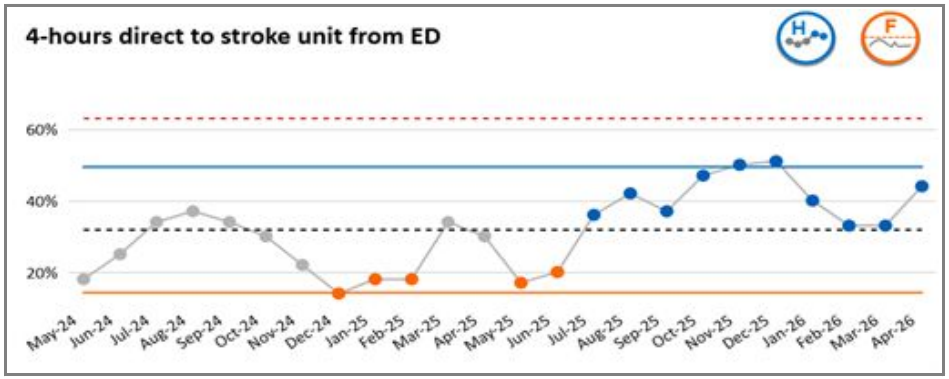


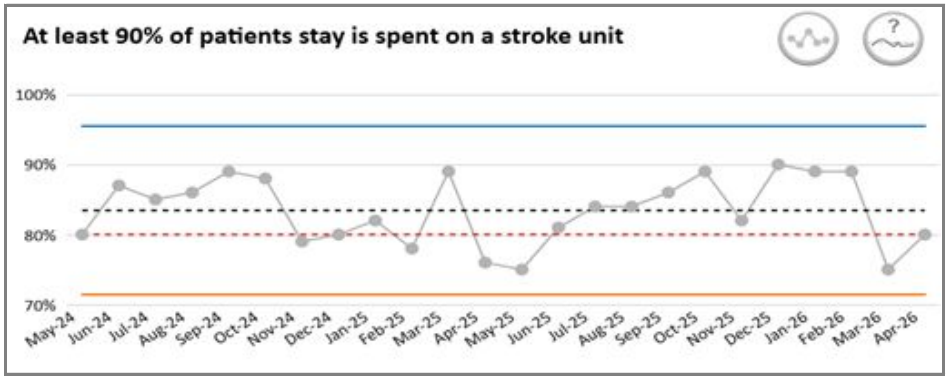
Month 04 | 2026-27

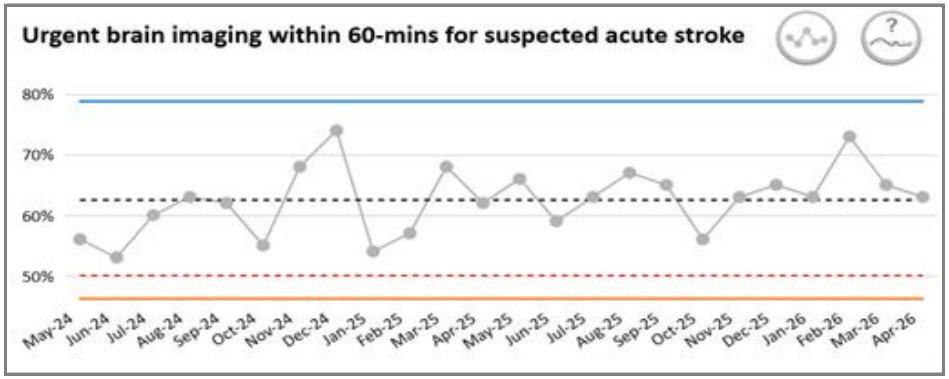
Operations

Stroke Services

East and North Hertfordshire Teaching NHS Trust

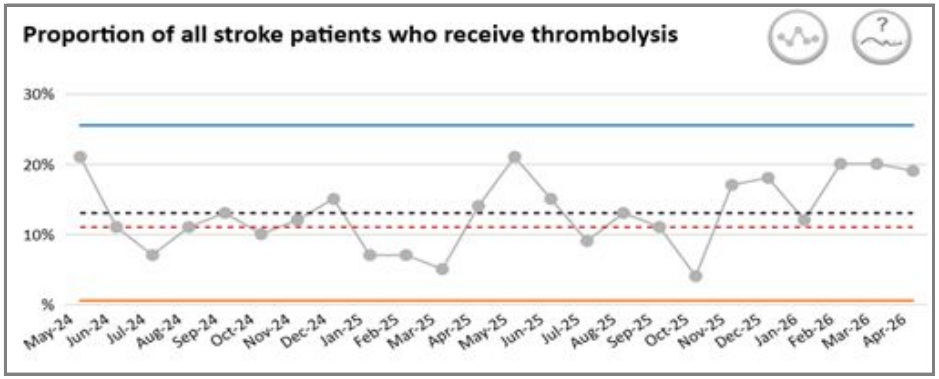






Key Issues and Executive Response

- **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 & repat 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.

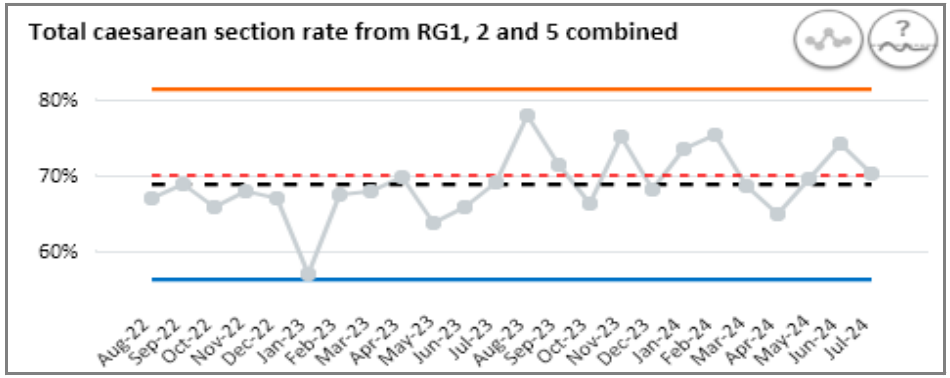


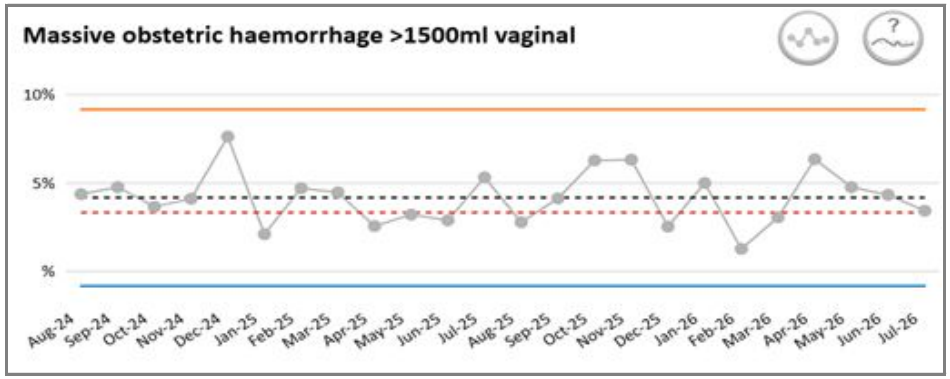
Month 04 | 2026-27

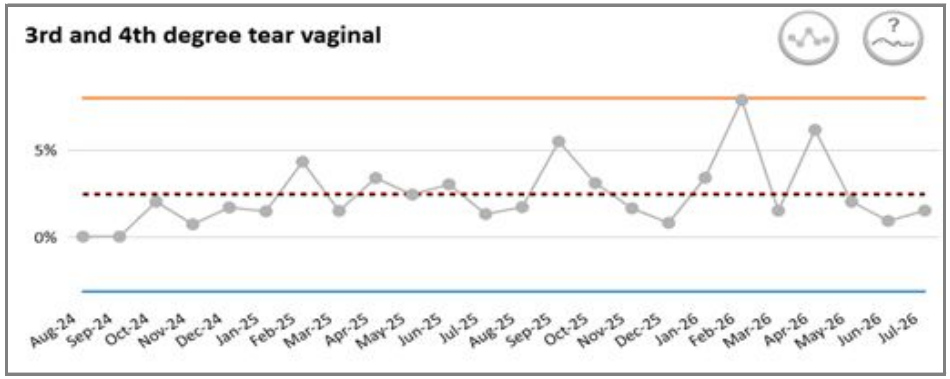
Quality

Maternity | Safety Metrics

East and North Hertfordshire Teaching NHS Trust







Key issues and executive response

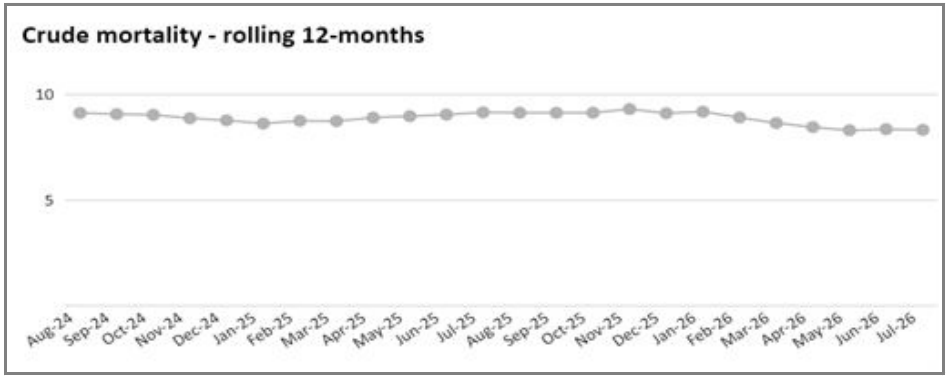
- No cases referred to the MNSI or qualifying as PSII in July 2026.
- Five cases of moderate harm (2% of all incidents) one for bilateral PE (woman on antenatal enoxaparin), one for impacted fetal head at EL LSCS and transfer to tertiary unit for cooling (MNSI criteria not met), one for missed referral to pre-term clinic and transfer to tertiary unit at 25/40 following premature rupture of membranes, one ITU admission following EM LSCS at 36/40 for cardiac anomaly and one for incorrect stock of ETT impacting neonatal resuscitation.
- There were 11 cases of MOH>1500ml overall, six cases (3.40%) at vaginal births, five cases (2.80%) at LSCS. Thematic review work ongoing and targeted improvement plan in line with maternal care bundle, element 5, underway.
- There were four cases (10.0%) of 3rd/4th degree perineal trauma out of 40 instrumental deliveries and two cases (1.50%) out of 133 spontaneous vaginal births in July 2026. This is an increase on previous months and improvement work, including OASI training, is ongoing to effect sustainable change. Continued thematic review and audit reported monthly to Divisional RMG. Themes around instrumental birth to be addressed.
- No cases of intrauterine deaths and three neonatal deaths, one at 20+2/40, one at 22+2/40 and one at 23+5 (transfer of care). All were precipitate on admission so unable to transfer out. Excellent wrap-around bereavement care. No cases of maternal death.
- ATAIN rate consistently below national target of <6% for six months.
- Total LSCS= 206 (52.15%), Total Cat 1-3 (Emergency) = 114 (28.86%), Total Cat 4 (Elective) = 92 (23.29%) reflective of increasing national rate and impacting flow and delays (thematic review work underway). Emergency rate may be reported higher than actual as elective cases moved to cat 3 lists due to capacity. Robson Group Criteria RC1 = 12.20%, RC2 = 69.72%, RC5 = 94.90%.

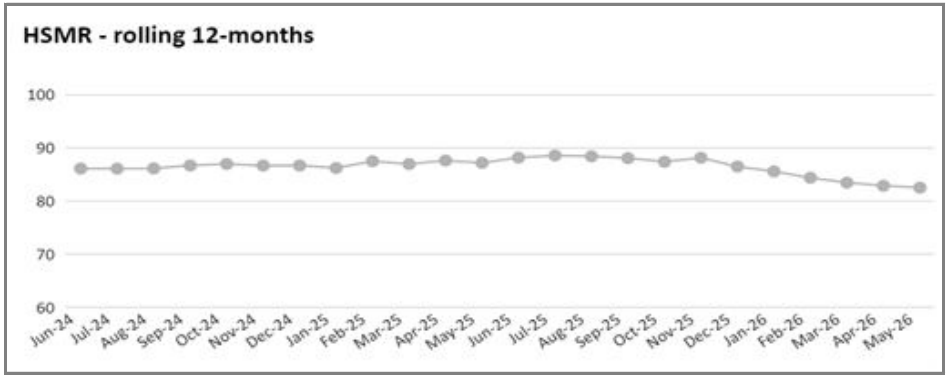
Month 04 | 2026-27

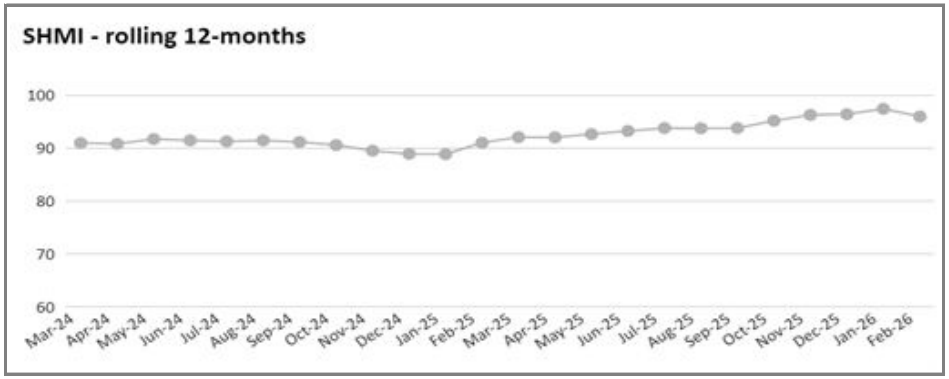
Quality

Mortality

East and North Hertfordshire Teaching NHS Trust







Key Issues and Executive Response

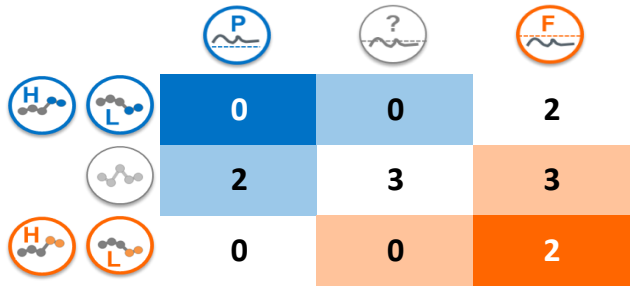
- Crude mortality is the factor which usually has the most significant impact on HSMR. The exception was during the COVID pandemic, when the usual correlation was weakened by the partial exclusion of COVID-19 patients from the HSMR metric. This partial exclusion continues for the CHKS HSMR metric that the Trust uses.
- The general improvements in mortality (excluding the COVID-19 period) seen over recent years have resulted from corporate level initiatives such as the learning from deaths process and focussed clinical improvement work. Of particular importance has been the continued drive to maintain a high standard of clinical coding.
- 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 May-26, reported by CHKS, stands at 82.4. This positions us in the first quartile of trusts nationally.
- Since the Jul-25 spike in in-month HSMR of 100.8, levels reduced. There was a further small spike in Nov-25 (92.9). There have since been reductions, with the latest in-month figure for March standing at 85.3.
- Latest NHSD published rolling 12-month SHMI available to Mar-26 2026, stands at 94.55, a decrease from the previous month's 95.91. This positions us within the 'as expected' band 2.
- Although there has been a gradual negative shift in our position nationally, the most recent month saw an improvement from 45/118 to 36/118 vs other acute trusts.
- The latest figures provided by CHKS for February are 87.0 in-month and 95.9 for rolling 12-month.

Month 04 | 2026-27

NHS
East and North Hertfordshire Teaching
NHS Trust

Operations

Month 04 | 2026-27



Urgent and Emergency Care

Summary

NHS East and North Hertfordshire Teaching NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Emergency Department	Patients waiting no more than four hours from arrival to admission, transfer or discharge	Jul-26	95%	76.4%		F	Common cause variation Metric will consistently fail the target
	Patients waiting more than 12 hours from arrival to admission, transfer or discharge	Jul-26	5%	9.8%		?	Common cause variation Metric will inconsistently pass and fail the target
	Percentage of ambulance handovers within 15-minutes	Jul-26	65%	24.7%		F	Common cause variation Metric will consistently fail the target
	Time to initial assessment - percentage within 15-minutes	Jul-26	80%	51.1%	L	F	9 points below the mean Metric will consistently fail the target
	Average (mean) time in department - non-admitted patients	Jul-26	240	173		P	Common cause variation Metric will consistently pass the target
	Average (mean) time in department - admitted patients	Jul-26	tbc	510			Common cause variation No Target
	Median ambulance handover time	Jul-26	15	21		F	Common cause variation Metric will consistently fail the target
RTT & Diagnostics	Patients on incomplete pathways waiting no more than 18 weeks from referral	Jul-26	92%	66.4%	H	F	10 points above the mean Metric will consistently fail the target
	Patients waiting more than six weeks for diagnostics	Jul-26	0%	42.4%	L	F	3 points below the lower process limit Metric will consistently fail the target

Month 04 | 2026-27

Urgent and Emergency Care

Summary

NHS East and North Hertfordshire Teaching NHS Trust

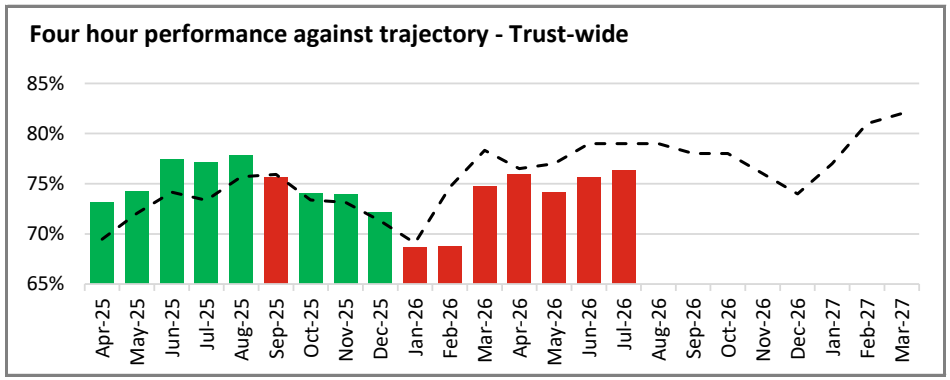
Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Cancer Waiting Times	62-day referral to treatment standard	Jun-26	85%	81.3%			Common cause variation Metric will consistently pass the target
	31-day decision to treat to treatment standard	Jun-26	96%	96.7%			Common cause variation Metric will inconsistently pass and fail the target
	28-day Faster Diagnosis standard	Jun-26	80%	76.4%			Common cause variation Metric will inconsistently pass and fail the target
	Proportion of cancer PTL waiting more than 62 days	Jul-26	7%	28.2%			2 points above the upper process limit Metric will consistently fail the target

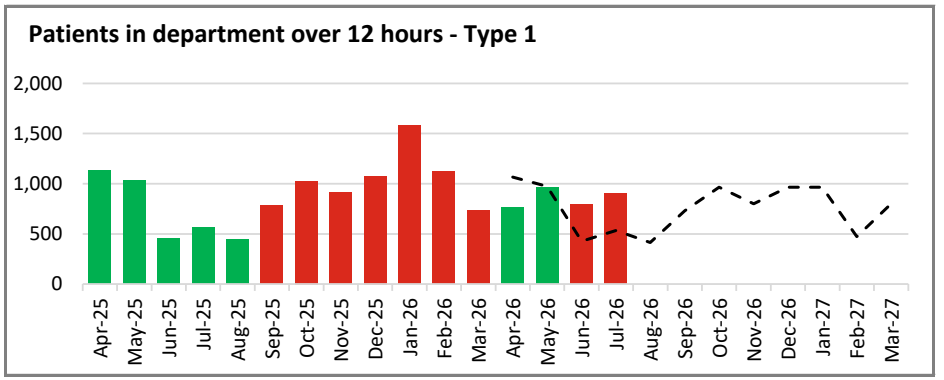
Month 04 | 2026-27

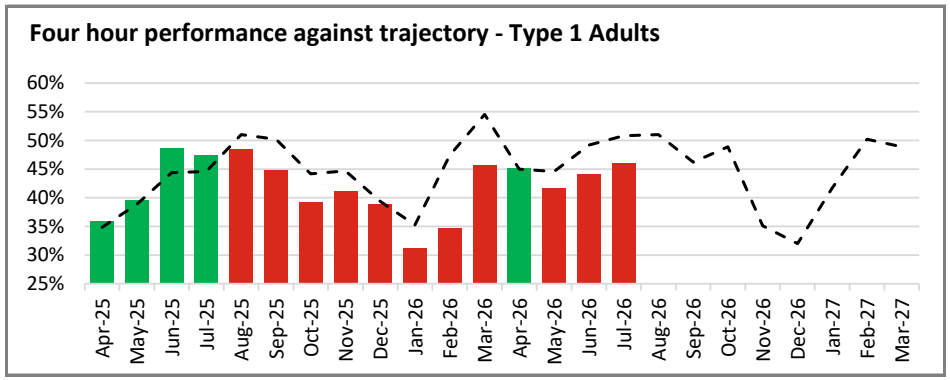
Urgent Emergency Care

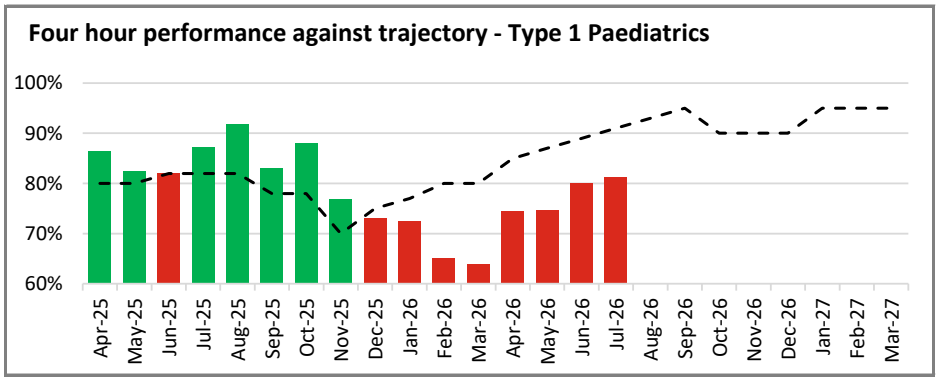
Trajectory Monitoring 2026-27

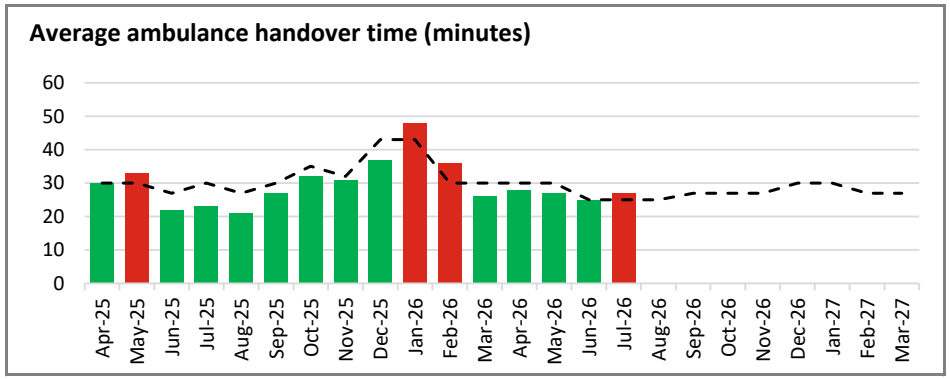
NHS East and North Hertfordshire Teaching NHS Trust









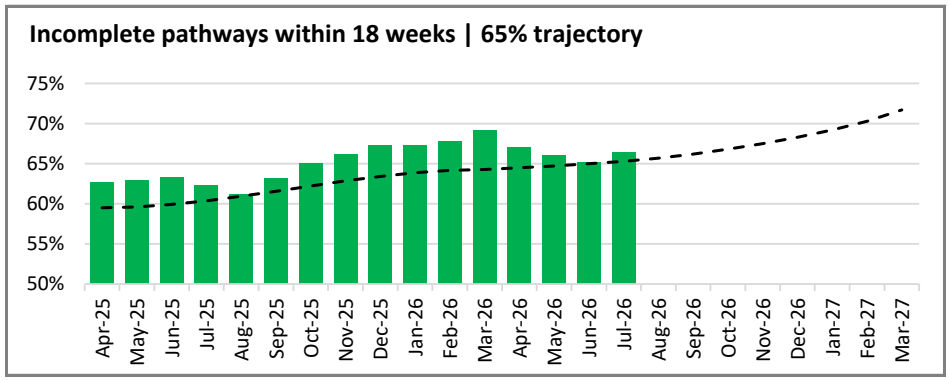


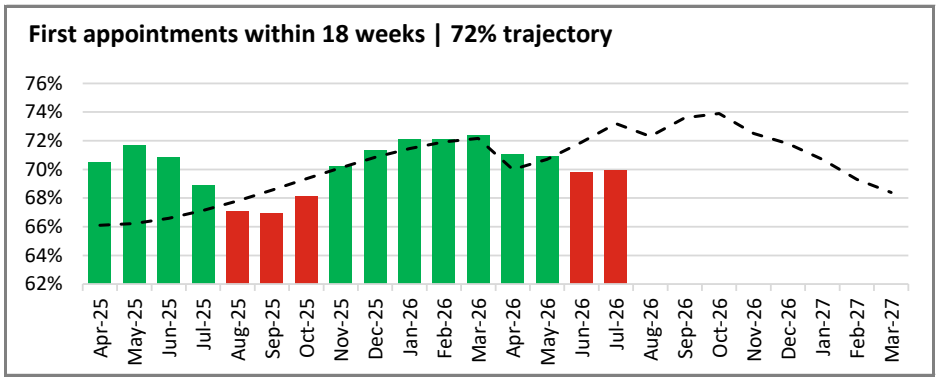
Month 04 | 2026-27

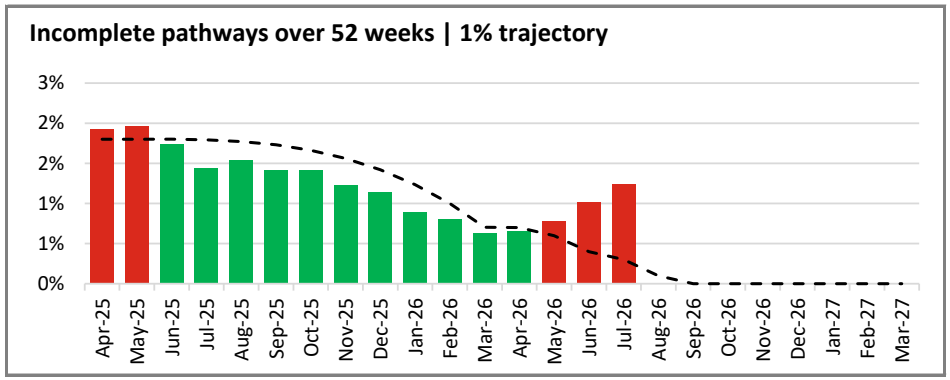
Cancer Waiting Times | RTT 18 weeks

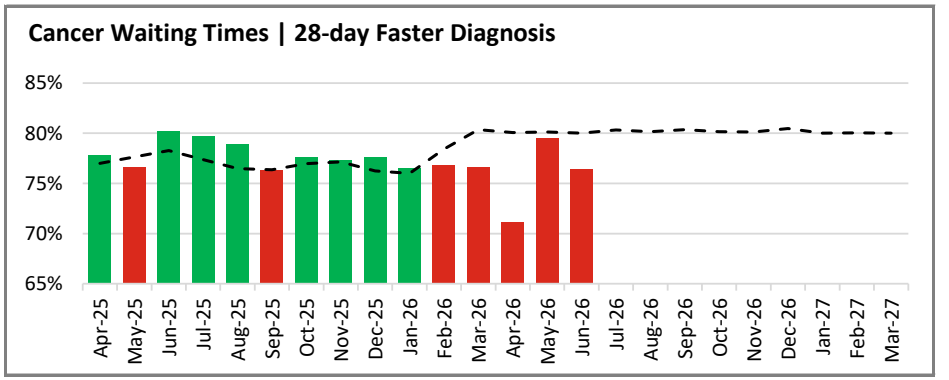
Trajectory Monitoring 2026-27

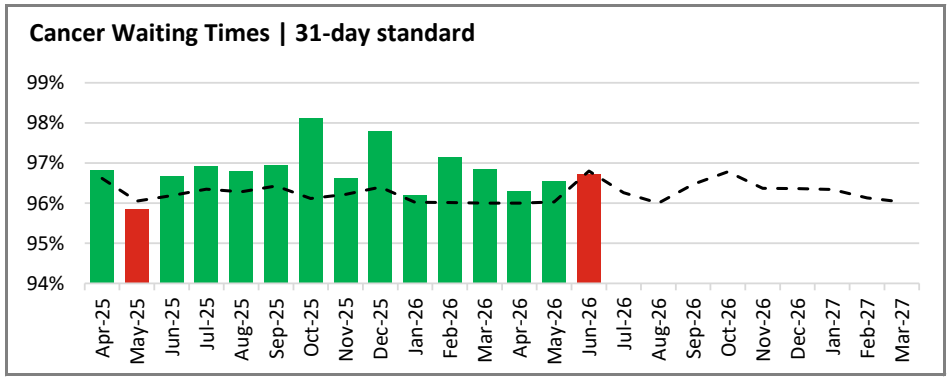
NHS East and North Hertfordshire Teaching NHS Trust

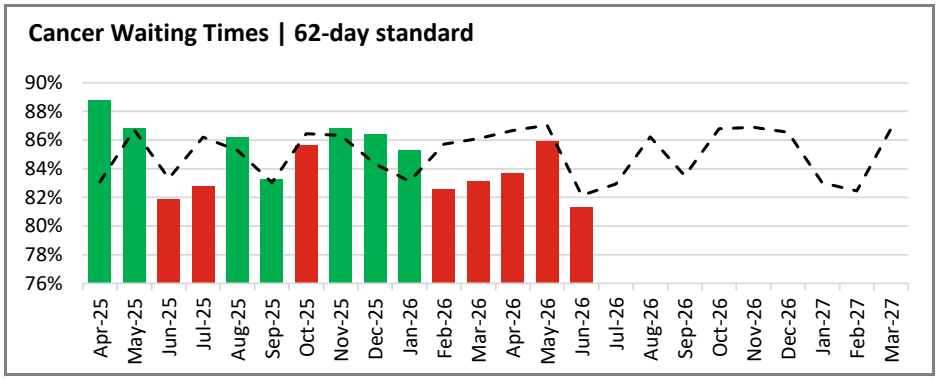










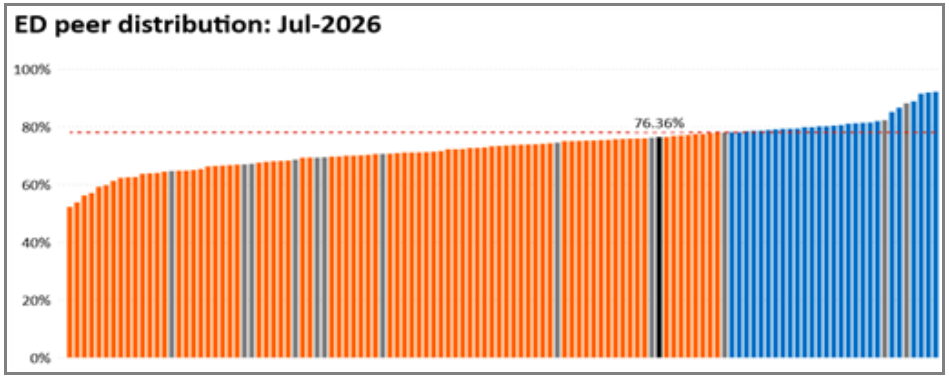


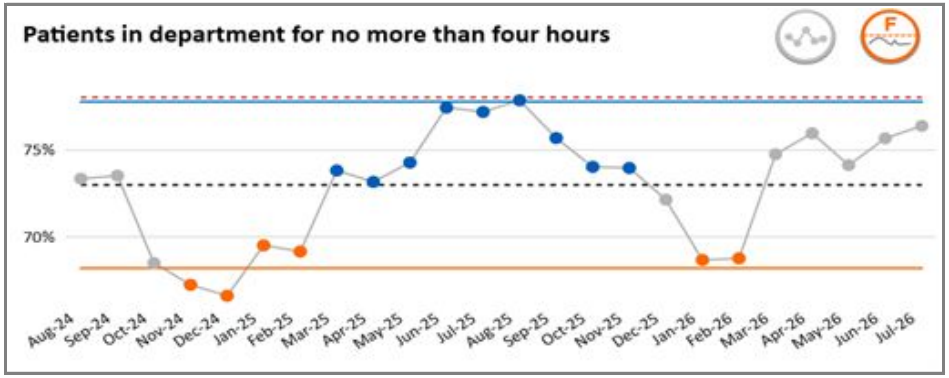
Month 04 | 2026-27

Operations

Urgent and Emergency Care New Standards

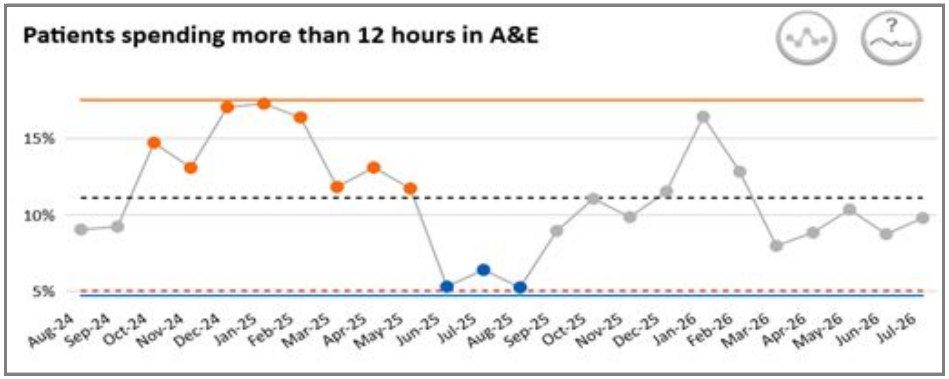
NHS
East and North Hertfordshire Teaching
NHS Trust

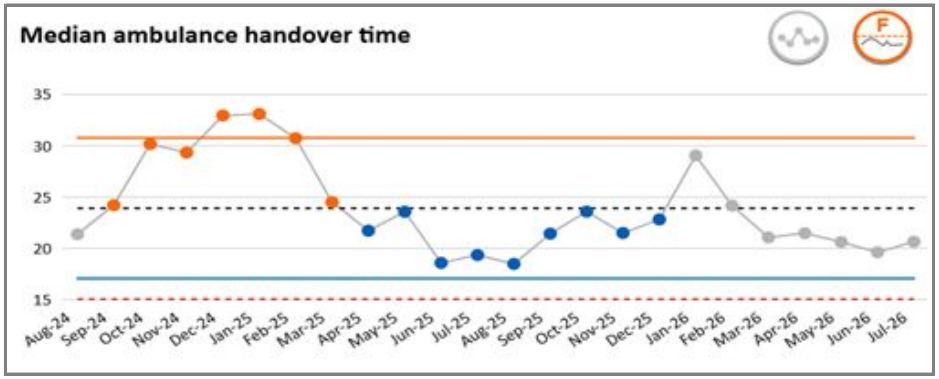




Key Issues and Executive Response

- In July 2026, 4-hour performance achieved 76.4% against a planned trajectory of 80%. July saw a rise in patients over 12 hours in ED, 905 patients against trajectory of 533. July also saw a significant rise in GA bed occupancy from previous month. Despite the restricted flow within ED and continued growth in Adult Type 1 and Paediatric attendances , performance has continued to improve month-on-month.
- Adult Type 1 performance was 46.1%, an improvement of 2% from previous month and month on month improvements. Non admitted performance was 54.4% a 3.6% improvement from previous month. Admitted pathway performance 21% a 2.2% decline reflected within increase of 12 hours LOS within ED and GA bed occupancy.
- Average ambulance handover time was 27 mins for July 2026, a 2 min decline in performance from previous month impacted by restricted flow within ED.
- Focus on front door triage processes to meet 15 minute kpi, improvement of Doctors waits to be seen implementing Trustwide triggers to respond to demand. SDEC focus on increasing activity and review of pathways. UTC finalising model and workforce to implement pathway for Paeds minor illness mirroring QE2 delivery of service.



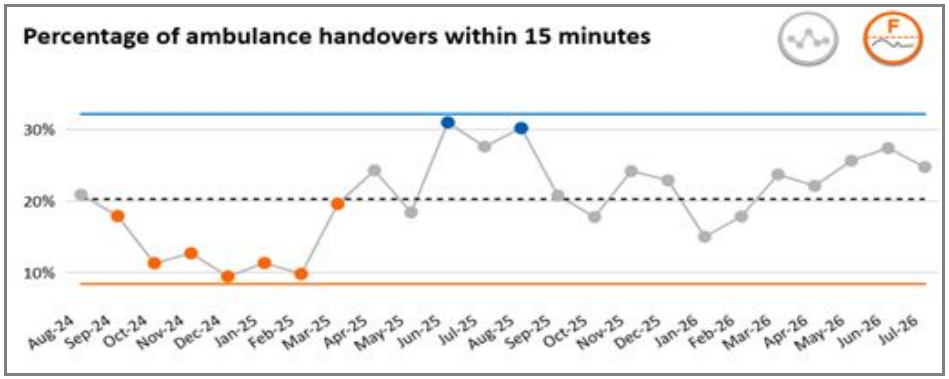


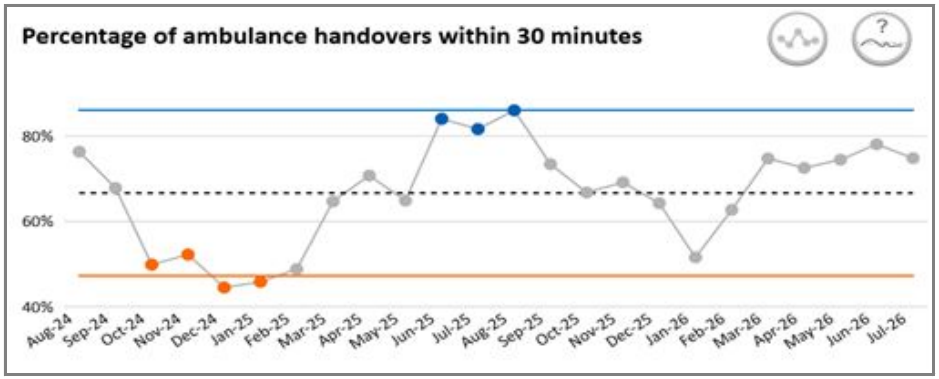
Month 04 | 2026-27

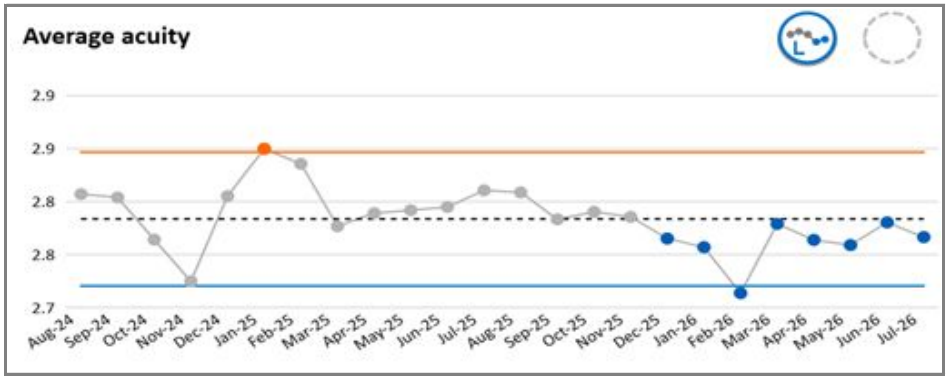
Operations

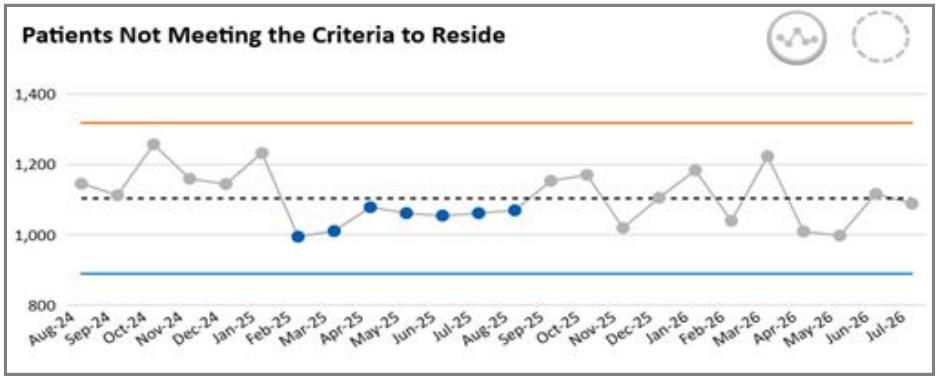
Urgent and Emergency Care | Supporting Metrics

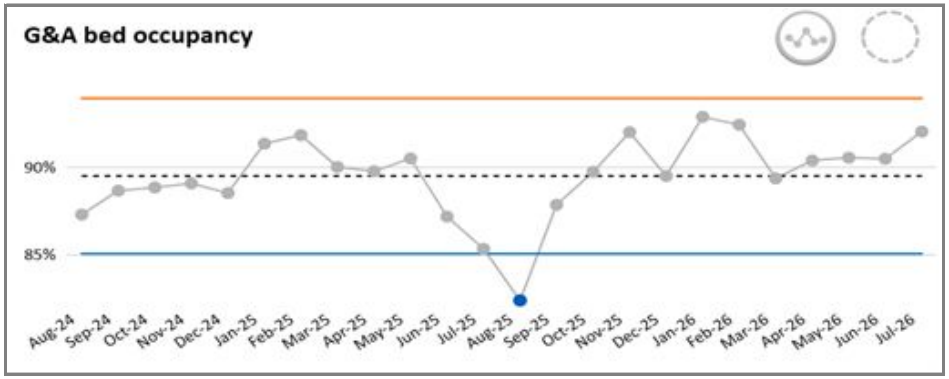
NHS
East and North Hertfordshire Teaching
NHS Trust

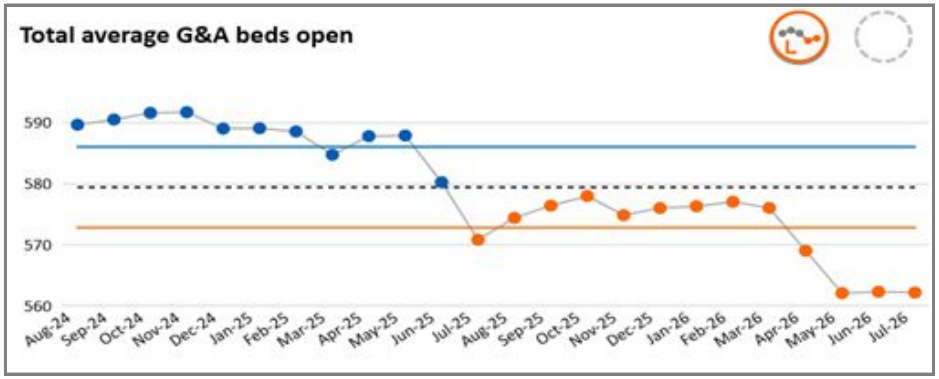










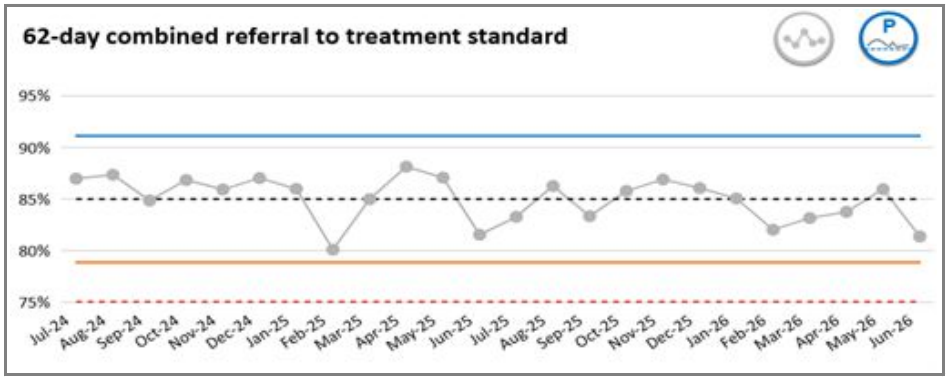


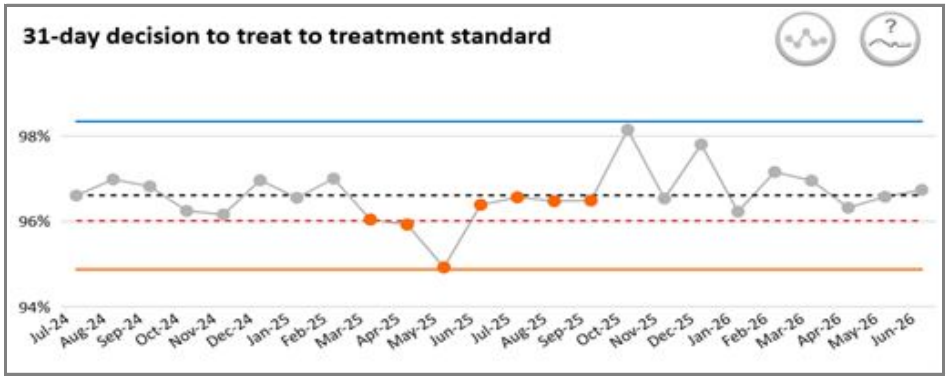
Month 04 | 2026-27

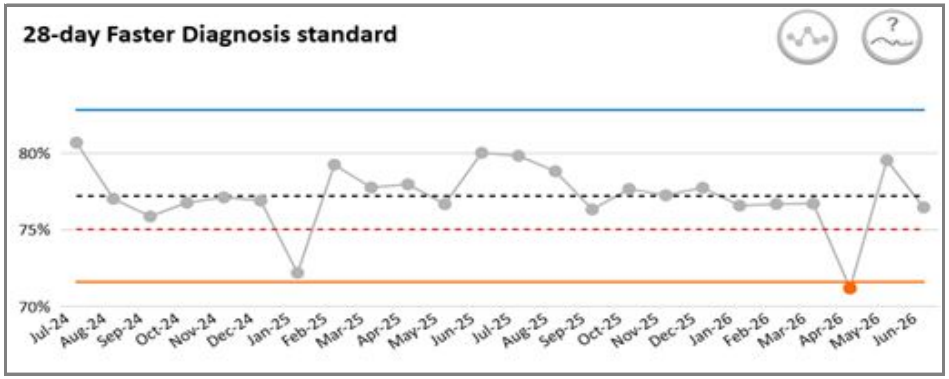
Operations

Cancer Waiting Times | Supporting Metrics

NHS East and North Hertfordshire Teaching NHS Trust







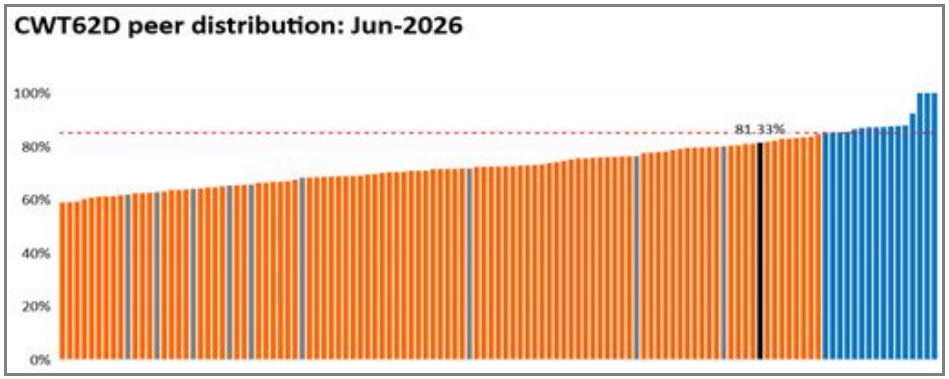
Key Issues and Executive Response

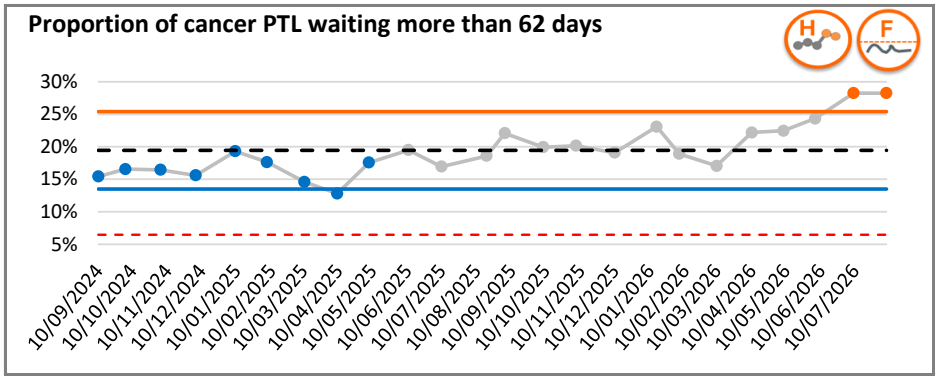
- We achieved 1 of the 3 national standards in June '26 with compliance in the 31 day combined standard. The 28 day Faster Diagnosis standard (FDS) target has increased from 75% to 80% from April 26. FDS in June is 76.4%.
- We are working closely with radiology and operational teams to reduce reporting delays across MRI and CT colon. Oral Surgery and Gynaecology outpatient capacity remain a challenge with insourcing being explored. Turn around times for triaging of referrals for Upper GI will improve following implementation of a new triage rota from 6th July 26.
- The 62-day referral-to-treatment standard (85%) was not met in June, with performance at 81.3% which is still above national performance. This is attributable to delays in the diagnostic pathway as above and insufficient RALP capacity.
- Four pathways mainly remain non compliance: Lower GI due to CT colon and colonoscopy capacity, partially mitigated with additional lists; Urology due to MRI capacity and reporting delays partially mitigated by using One Stop Health Care, and MRI VAN at Lister. In addition TP biopsy and flexi capacity is causing delays in the Urology pathway. An enhanced radiology escalation process has been put in place to ensure prioritised reporting of cancer patients. Gynae delays are driven by slow referral triage, OPA capacity and inpatient hysteroscopy capacity, mitigated by converting routine slots for 2WW patients and additional lists.

Month 04 | 2026-27

Operations

Cancer Waiting Times | Supporting Metrics





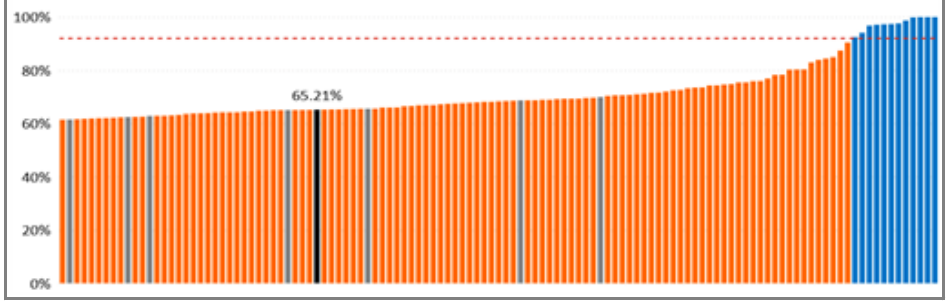
Month 04 | 2026-27

Operations

RTT 18 Weeks

NHS East and North Hertfordshire Teaching NHS Trust

RTT peer distribution: Jun-2026



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. October 2025 single point of access commenced and has started to reduce total waiting list size; however service has a high number over 104ww.
- Proof of Concept pilot commenced on 09/06/26 and is on plan to finish at the end of August/early September - one single system pathway with partners at HCT and HPFT.
- 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 continues and working well, improving completeness of information ahead of triage, alongside improved signposting whilst waiting.
- **78 Weeks -** There were 3,867 patients waiting over 78 weeks at the end of June, an increase compared to 3,799 the previous month.
- **65 Weeks -** There were 4,347 Community Paediatric patients waiting over 65 weeks, an increase from 4,279 at the end of June.

Key Issues and Executive Response

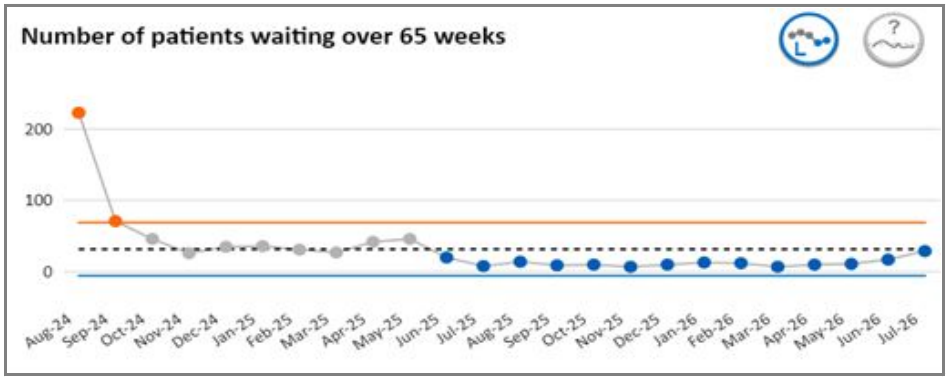
Excluding community paediatrics

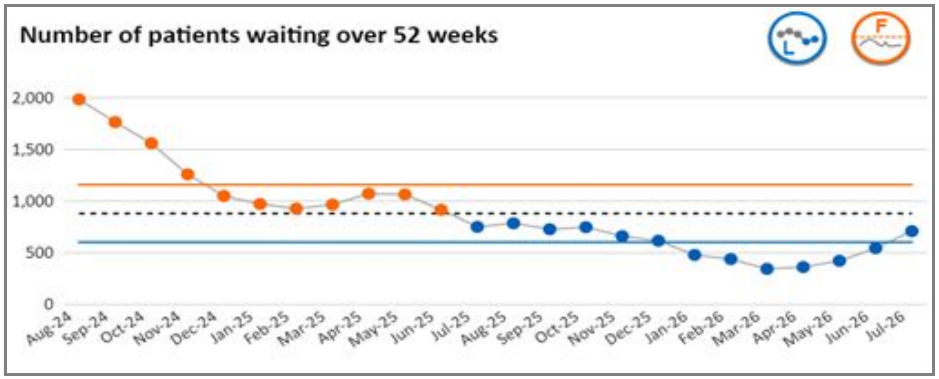
- **18 Week Performance -** At the end of July, 65.7% of patients were waiting under 18 weeks, an improvement from 65.2% in June. Performance remains above plan.
- **52w proportion of PTL -** At the end of July, 705 (1.262%) patients were waiting above 52 weeks. This is a deterioration from 504 in the previous month. The impact was particularly significant for Trauma & Orthopaedics, where the loss of protected beds and theatre time in May to June has created a backlog of complex long waiting patients. Increases have been seen in most services, but particularly Trauma and Orthopaedics, Dermatology, Urology and ENT, where urgent/trauma and cancer demand coupled with reduced 'ad hoc' activity has reduced flexible capacity to treat the longest waiting patients
- The Patient Treatment List (PTL) has increased by 2,131 patients to 54,861 and remains behind trajectory.
- **65 Weeks -** At end of July, 28 patients were waiting over 65 weeks: 23 in Trauma & Orthopaedics, 2 in Oral Surgery, 1 in Orthodontics, 1 in Ophthalmology and 1 in Urology.
- Key programmes of transformation work in place in outpatients and theatres to improve efficiency and productivity opportunities and reduce reliance on activity delivered through temporary workforce solutions. Services are planning to reconfigure the theatre timetable in September particularly for T&O and are working other NHS providers to secure appropriate mutual aid.
- RTT and 52-week meetings are in place with service managers to monitor and track patient through these pathways, including a weekly escalation meeting with divisional leaders.

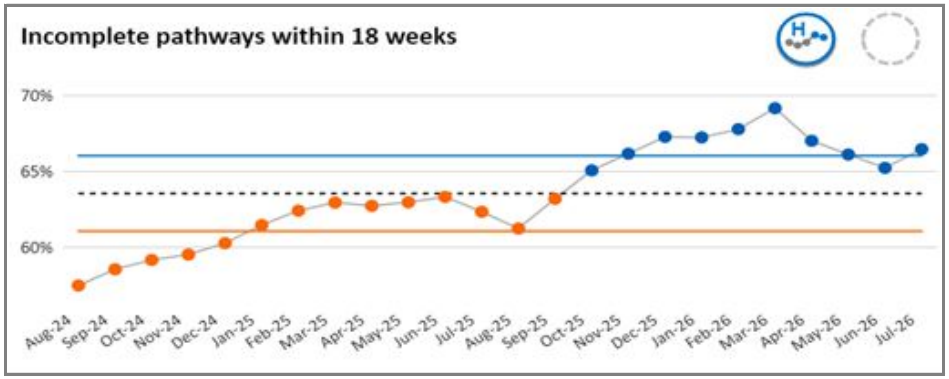
Operations

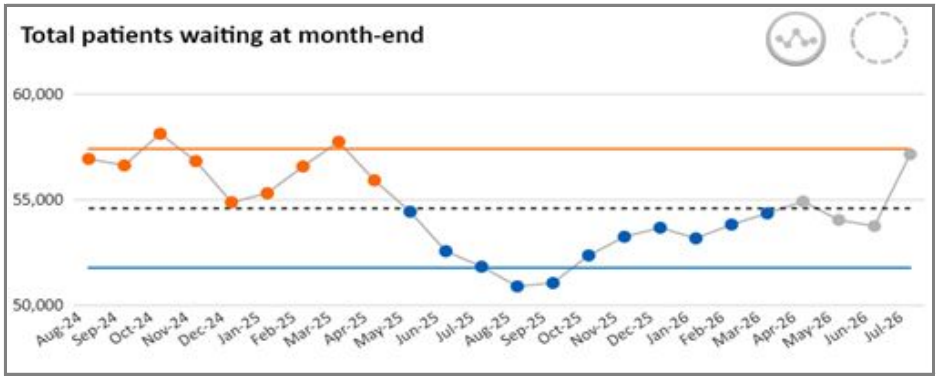
RTT 18 Weeks - excl. Community Paediatrics

NHS East and North Hertfordshire Teaching NHS Trust









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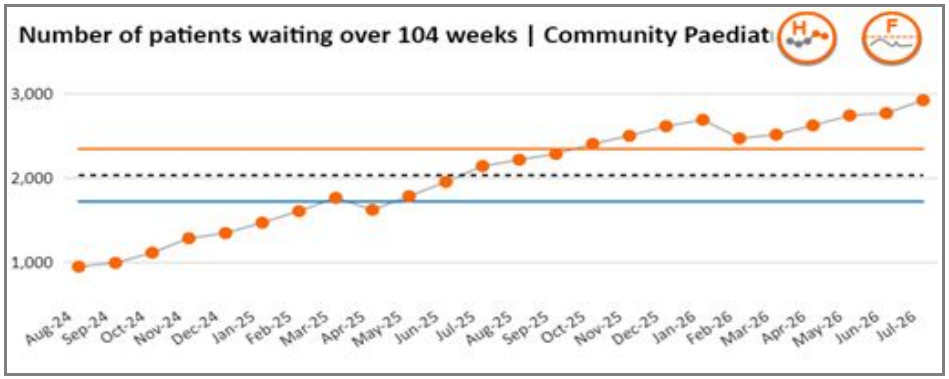
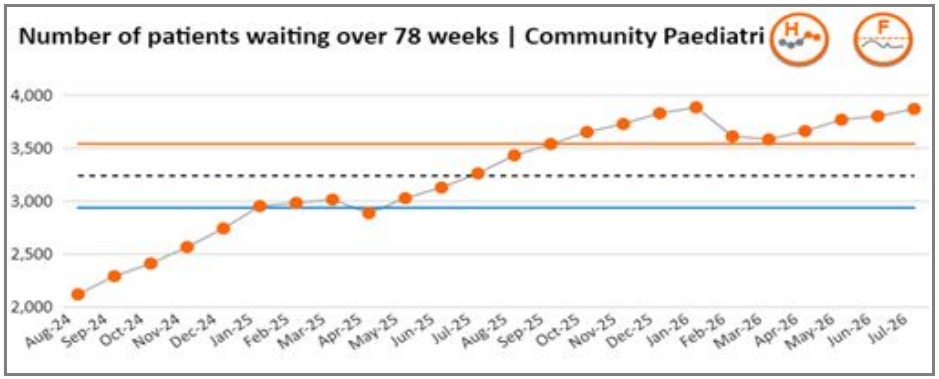
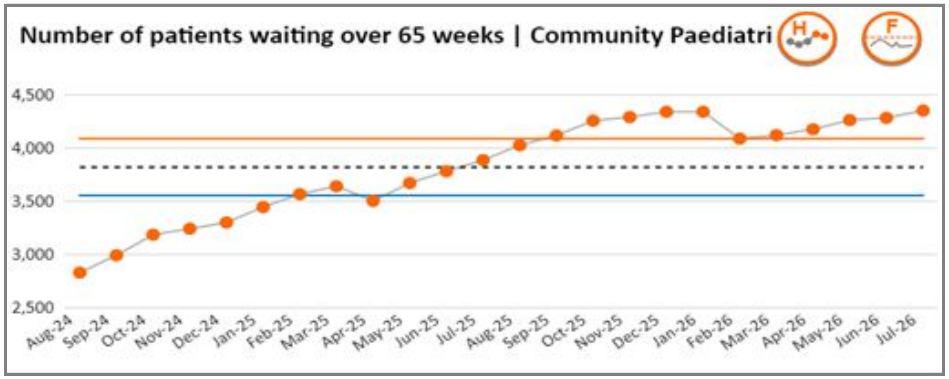
Operations

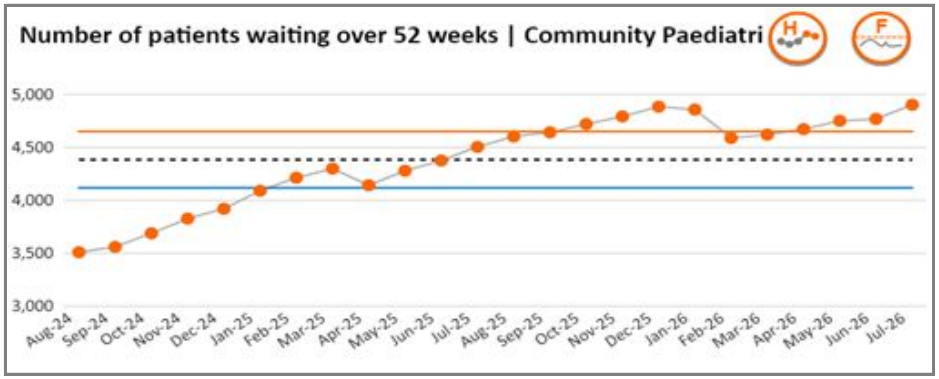
RTT 18 Weeks - Community Paediatrics ONLY

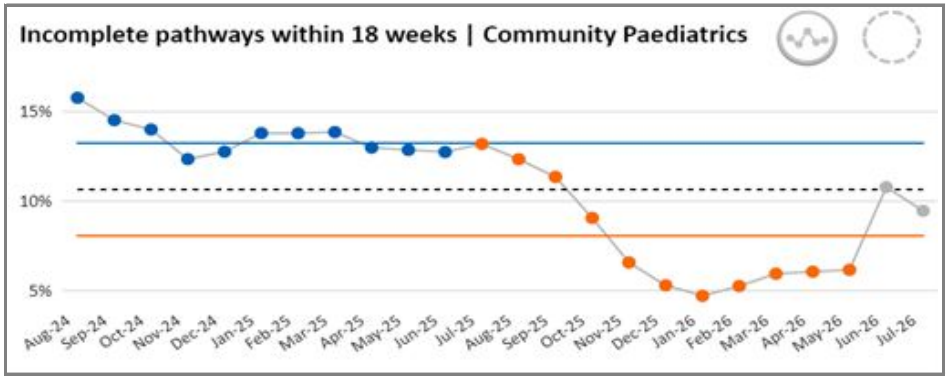
NHS
East and North Hertfordshire Teaching NHS Trust

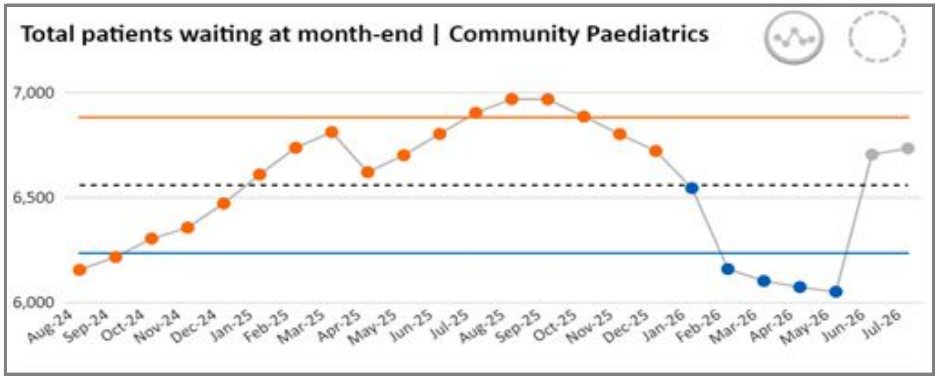












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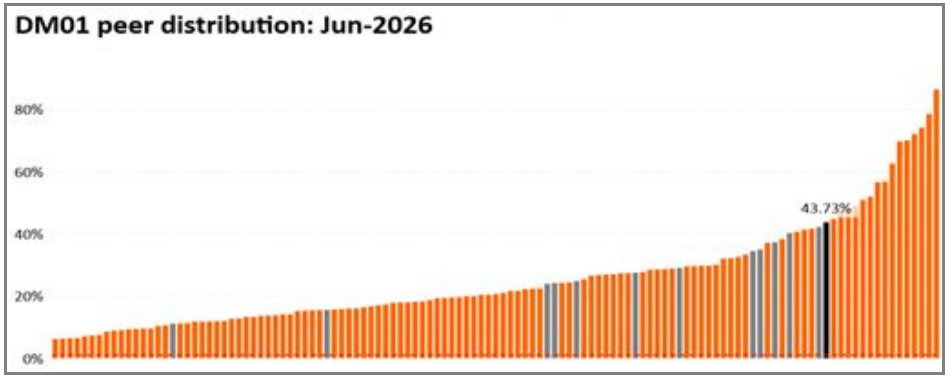
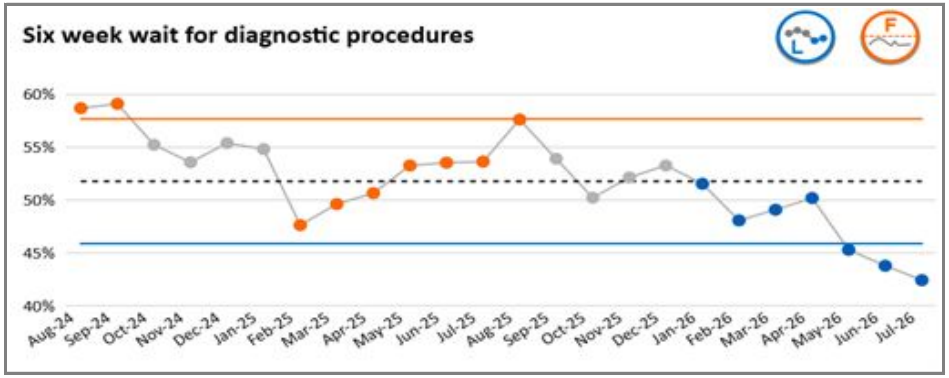
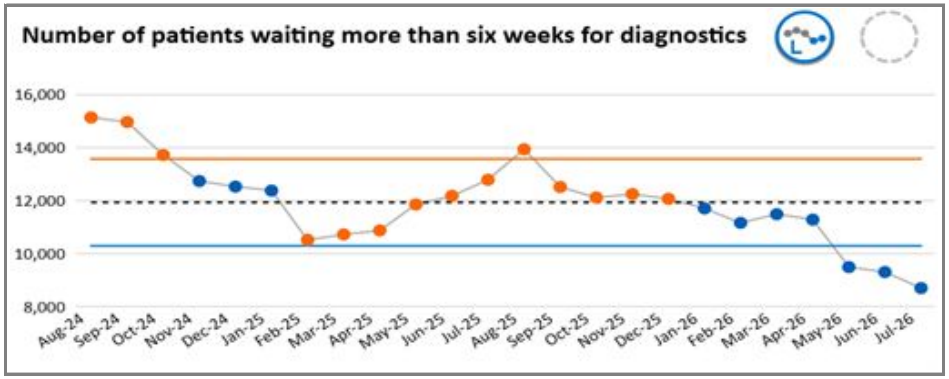
Operations

Diagnostics Waiting Times

NHS East and North Hertfordshire Teaching NHS Trust







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 July, DM01 performance (% waiting over 6 weeks for diagnostics) improved from 43.73% to 42.37%.
- Excluding Audiology position has improved from 26,36% to 25,47%, there are 3,829 patients waiting >6 weeks; with 145 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 September. Launch of consultation for standardised shifts to deliver 6-day; 9-hour service started 27/4. Current performance has reduced to 32.33%, with breaches remaining to 2,531; mean wait improved to 3.87 weeks in June.
- 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 started in August, 1 B6 out to ad., Performance improved from 35.26% to 29.33%, with 736 patients over 6 weeks; mean wait 3.93 weeks. Replace two MRI scanners in 26/27.
- Capital works for paeds **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 89.22% (3,395 breaches) with mean wait of 42.93 weeks. Paeds currently 88.55% (1,454 breaches) with mean wait of 35.23 weeks.

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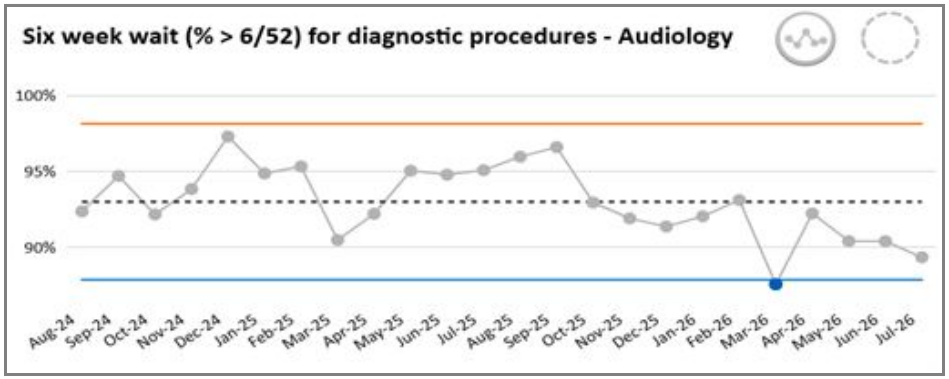
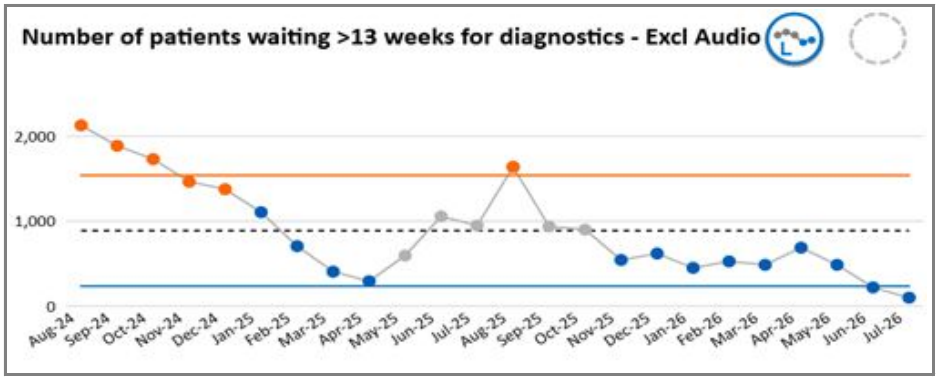
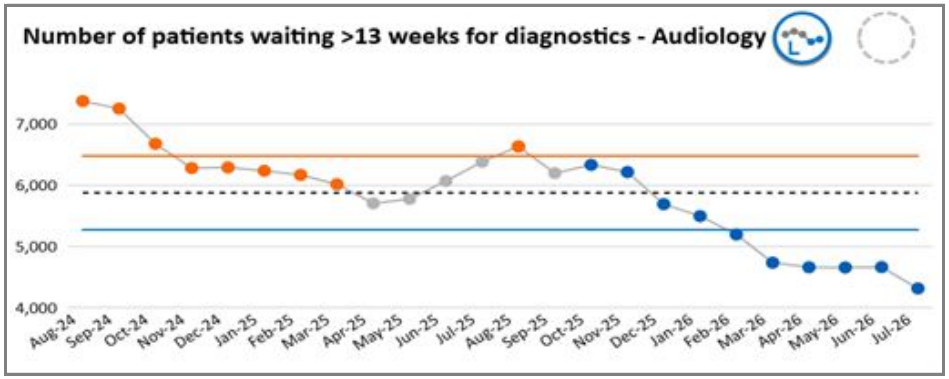
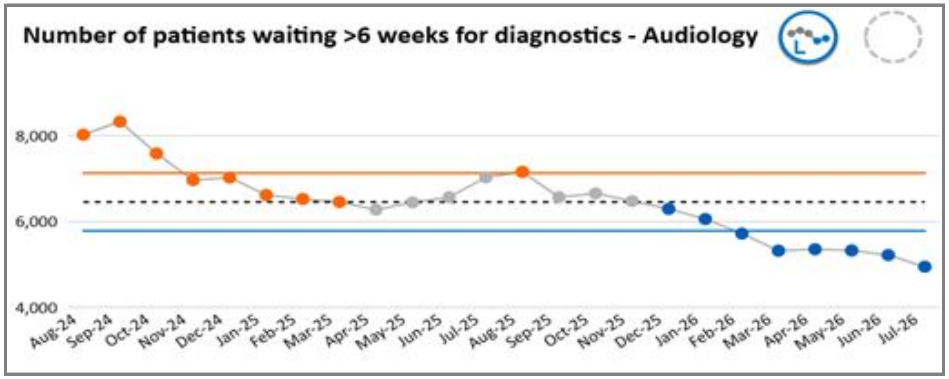
Operations

Diagnostics Waiting Times - Audiology









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NHS Trust

Finance

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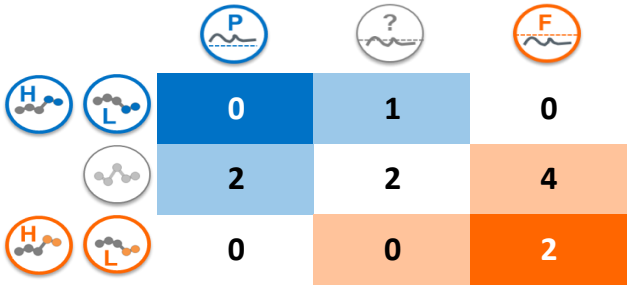


Finance

Summary

East and North Hertfordshire Teaching NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Summary Financial Position	Surplus / deficit	Jul-26	2.5	2.55			Common cause variation Metric will inconsistently pass and fail the target
	CIPS achieved	Jul-26	2.7	2.8			Common cause variation No target
	Cash balance	Jul-26	36.2	44.2			Common cause variation Metric will consistently fail the target
Key Financial Drivers	Income earned	Jul-26	63.6	65.1			Common cause variation Metric will consistently pass the target
	Pay costs	Jul-26	39.5	37.9			Common cause variation Metric will consistently fail the target
	Non-pay costs (including financing)	Jul-26	21.7	24.6			Common cause variation Metric will consistently fail the target

Month 02 | 2026-27

Finance

Summary

NHS East and North Hertfordshire Teaching NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Key Payroll Metrics	Substantive pay costs	Jul-26	38.5	35.0	H	F	13 points above the mean Metric consistently fail the target
	Average monthly substantive pay costs (000s)	Jul-26	5.8	5.7	H	F	13 points above the mean Metric will consistently fail the target
	Agency costs	Jul-26	0.1	0.3	L		12 points below the mean No target
	Unit cost of agency staff	Jul-26	11.3	12.5			Common cause variation No target
	Bank costs	Jul-26	0.8	2.6		?	Common cause variation Metric will inconsistently pass and fail the target
	Overtime and WLI costs	Jul-26	0.5	0.3	L	?	3 points below the lower process limit Metric will inconsistently pass and fail the target
Other Financial Metrics	Private patients income earned	Jul-26	0.6	0.7		P	Common cause variation Metric will consistently pass the target
	Drugs and consumable spend	Jul-26	4.8	5.0		F	Common cause variation Metric will consistently fail the target

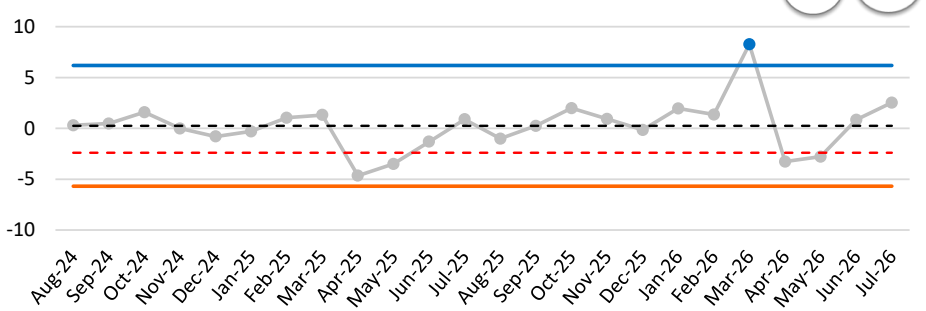
Month 02 | 2026-27

Finance

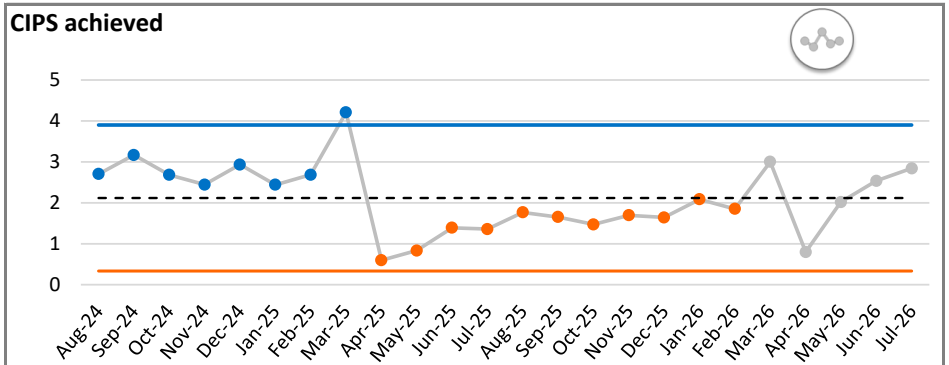
Summary Financial Position

NHS East and North Hertfordshire Teaching NHS Trust

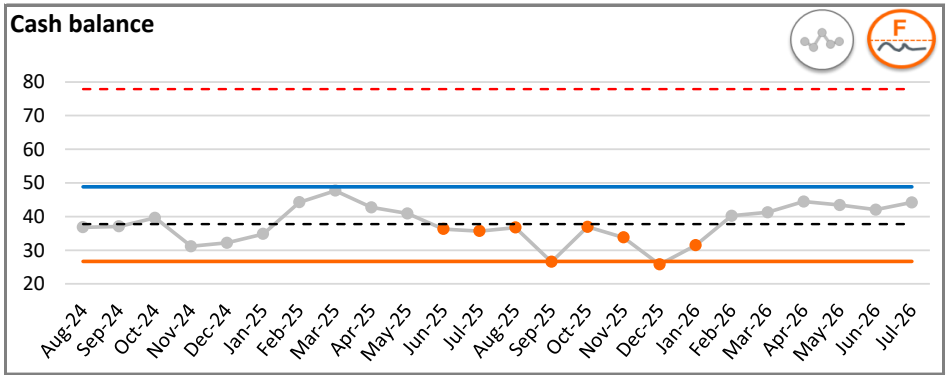
Surplus / deficit



CIPS achieved



Cash balance



Key Issues and Executive Response

Executive Overview

- The Trust reported a £2.7m YTD deficit at Month 4 YTD against a plan of £2.7m. The £2.5m surplus in month position was break-even to plan.
- The reported position assumes that the £0.5m of costs incurred for industrial action will be offset by funding. However, this has not yet been confirmed and so is a risk to the reported position.
- The primary drivers of the YTD position are sustained workforce pressures within nursing and premium capacity solutions within radiology and an adverse variance against the external CIP plan phasing (£1.7m).
- The above pressures have been partially mitigated by £0.9m favourable variances on consumables and prosthesis and £0.7m WLI payments due to low elective activity, as well as early release of reserves/provisions.
- Elective performance remains materially challenged and activity is below agreed levels. This is mainly mitigated by the block contract agreed with Central East ICB.
- Significant Divisional overspends persist particularly within the Planned Care and Unplanned Care Divisions, driven by unidentified savings, low activity and workforce pressures.

Executive Response

- Significant reduction in run and rate and step up in recurrent CI/transformation CIP delivery is required for latter months of the year.
- Driving productivity performance within theatres, outpatients and bed utilisation.
- Undertaking detailed year end forecasting exercise, which includes the underlying position into 2027/28.

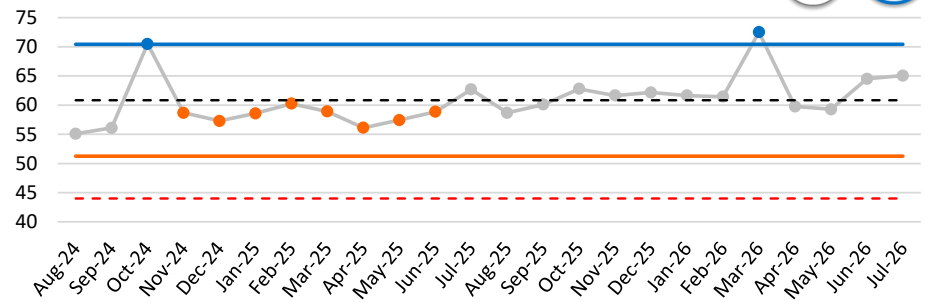
Month 02 | 2026-27

Finance

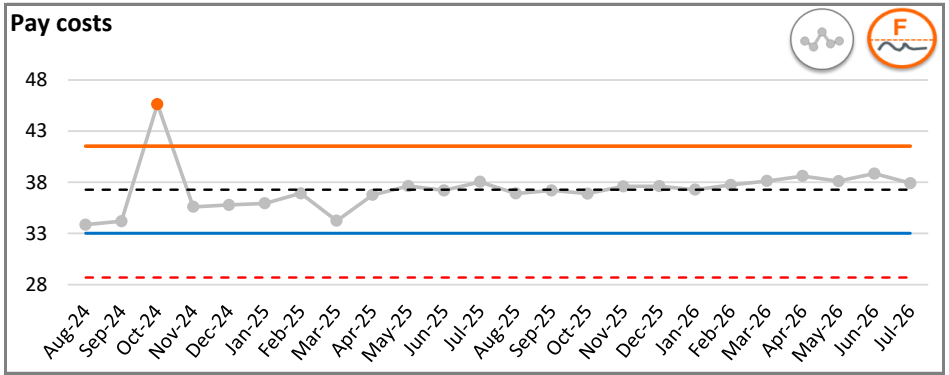
Key Financial Drivers

NHS East and North Hertfordshire Teaching NHS Trust

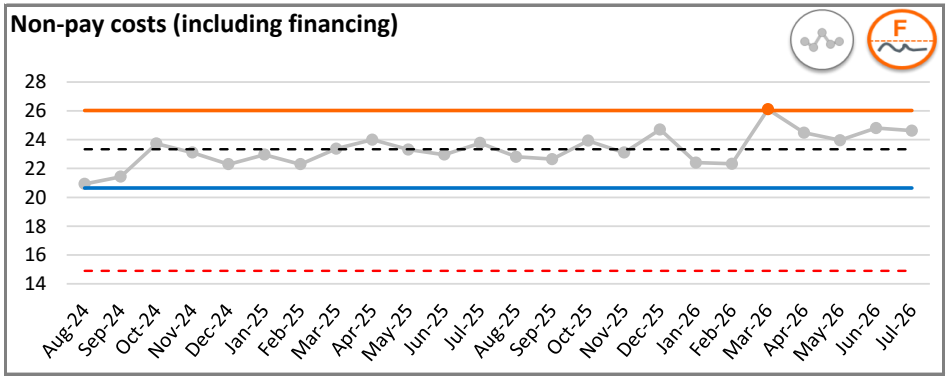
Income earned



Pay costs



Non-pay costs (including financing)



Income Performance

- Month 4 income performance continues to be significantly behind plan in a number of service lines. Activity and RTT recovery workshops have been held with key specialities to agree recovery plans to improve elective activity delivery.

Pay Position

- Pay expenditure remains above plan due to:
- nursing premium pay,
- medical staffing pressures,
- sickness absence,
- temporary staffing usage.

Despite enhanced pay controls, the worked WTE has increased since April 2026.

Non-Pay Position

- Underspent in month 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 schemes
- Reduce premium pay expenditure
- Improve theatre productivity
- Strengthen divisional accountability & tighten non-pay control

Key Message

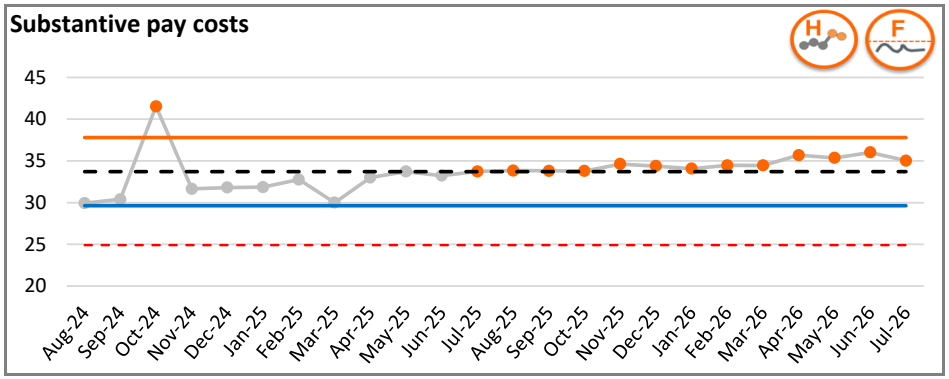
- Sustained operational improvement and recurrent productivity delivery will be required to achieve financial recovery during 2026/27.

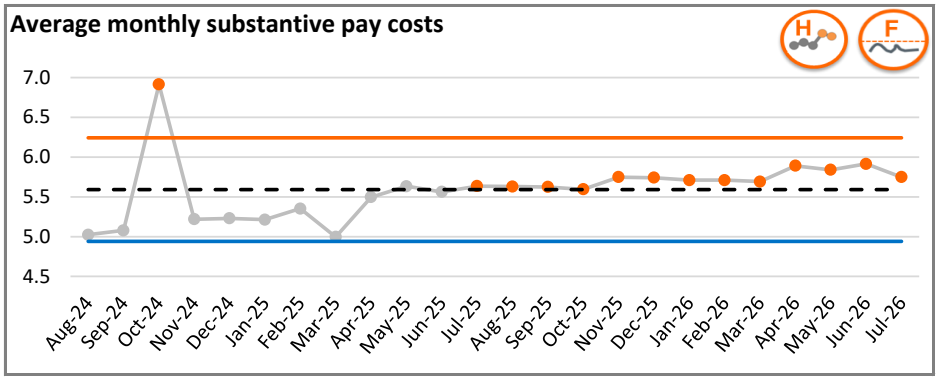
Month 02 | 2026-27

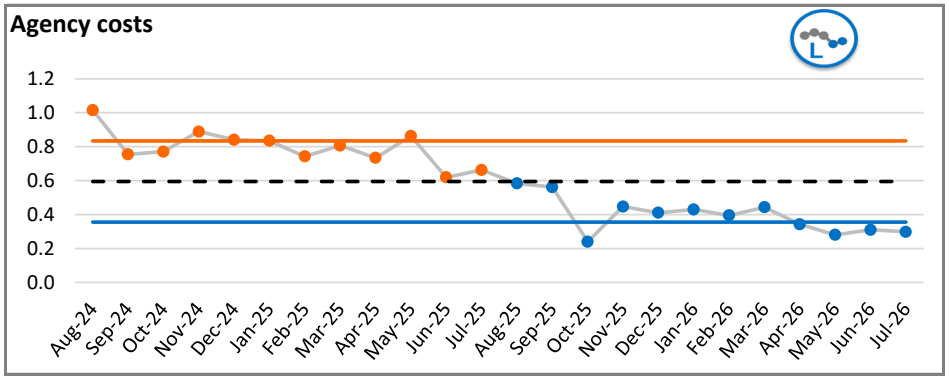
Finance

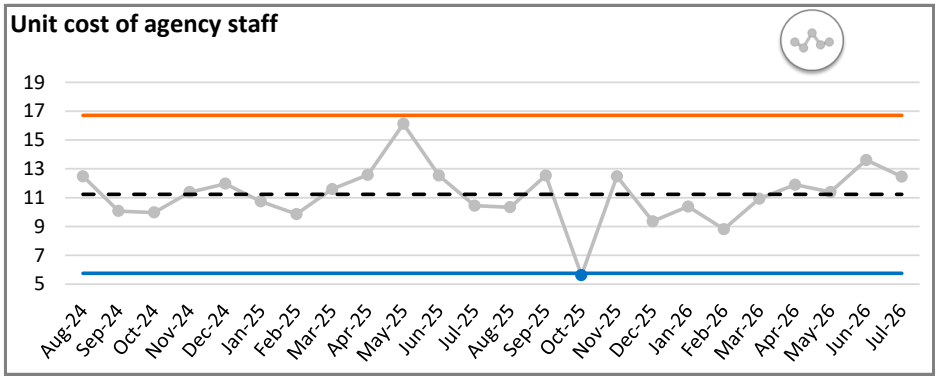
Other Financial Indicators

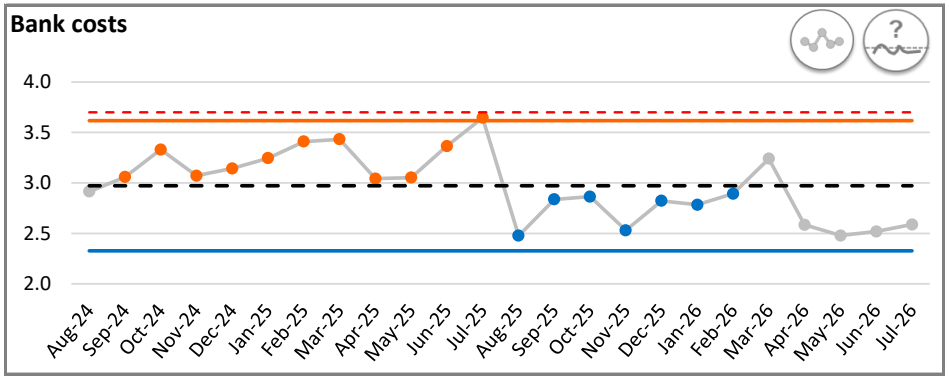
East and North Hertfordshire Teaching NHS Trust

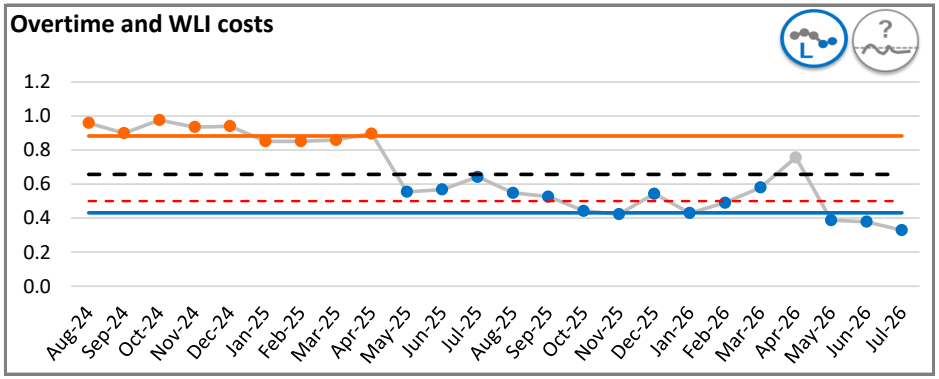












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People

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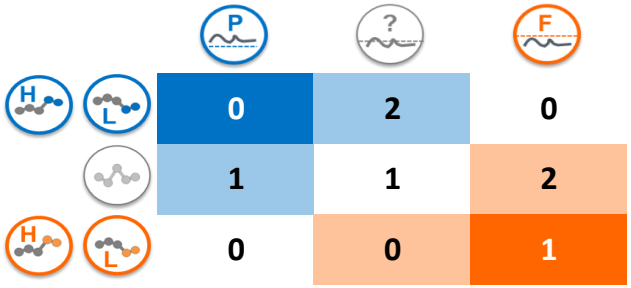

People

Summary

NHS East and North Hertfordshire Teaching NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Work	Vacancy rate	Jul-26	8%	1.9%			4 points below the lower process limit Metric will inconsistently pass and fail the target
	Bank spend as a proportion of WTE	Jul-26	5%	7.0%			Common cause variation Metric will consistently fail the target
	Agency spend as a proportion of WTE	Jul-26	3%	0.8%			3 points below the lower process limit Metric will inconsistently pass and fail the target
Grow	Statutory and mandatory training compliance rate	Jul-26	90%	90.8%			1 point above the upper process limit Metric will inconsistently pass and fail the target
	Appraisal rate	Jul-26	90%	76.0%			2 points below the lower process limit Metric will consistently fail the target
Thrive	Turnover rate	Jul-26	10.5%	7.3%			Common cause variation Metric will consistently pass the target
Care	Sickness rate	Jul-26	4.0%	4.8%			Common cause variation Metric will consistently fail the target

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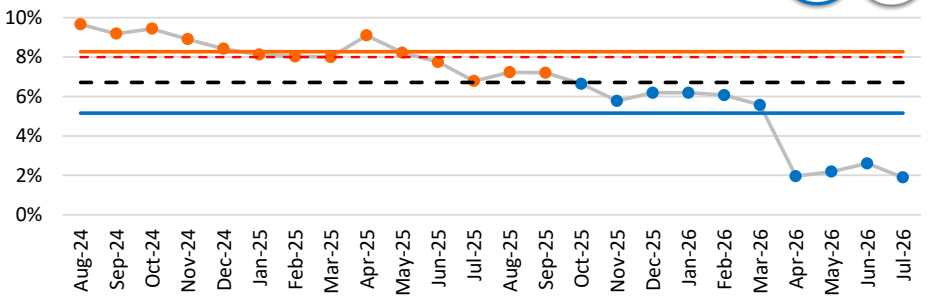
People

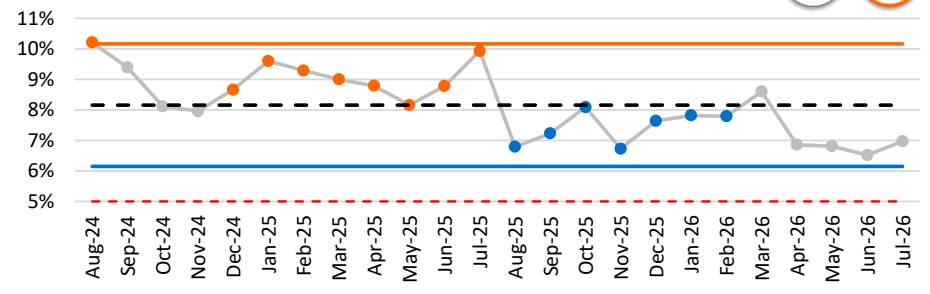
Work Together

NHS East and North Hertfordshire Teaching NHS Trust

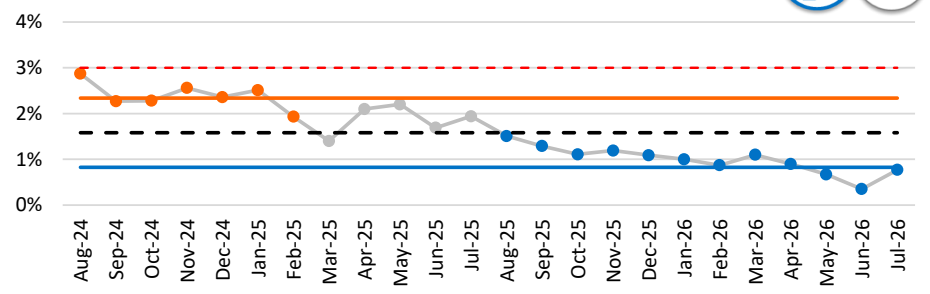
Vacancy rate



Bank spend as a proportion of WTE



Agency spend as a proportion of WTE



Key Issues and Executive Response

- **Workforce** – Recruitment activity remained strong, supported by improved recruitment timelines and active candidate management.
- **Recruitment Performance** – Average time to hire reduced significantly from 13 weeks to 11 weeks, at it's lowest since December 2024, supported by proactive candidate management.
- **Candidate Experience** – Candidate satisfaction increased from 4.17 to 4.80 out of 5, with feedback highlighting clear communication and a smooth recruitment process.
- **Recruitment Activity** – Newly qualified recruitment progressed strongly, including successful registered nursing (RN) and midwifery campaigns and the development of managed talent pools, providing a pipeline of appointable candidates.
- **Inclusive Recruitment** – Work continues to improve equality of recruitment outcomes through targeted inclusive recruitment.
- **Temporary Staffing Performance** – Overall temporary staffing expenditure remains below the Trust's target. Agency price cap breaches at lowest ever recorded. Bank utilisation remains above target, overall performance reflects continued progress in reducing reliance on temporary staffing.
- **Bank Utilisation** – Bank workforce utilisation remained favourable against plan, driven by continued reductions in bank usage across RN and clinical support staff. Focus remains on areas of higher utilisation, particularly Medical & Dental and Admin/Estates & Facilities.
- **Agency Reduction** – Agency utilisation remained significantly below plan, with RN, Midwifery & Health Visiting usage sustained at just 0.24 FTE, demonstrating that reductions are being maintained.
- **Workforce Controls** – The Nursing Workforce Dashboard launched in July, providing greater assurance that staffing is planned and deployed within agreed parameters. Learning will now be used to strengthen controls across other staff groups, alongside development of the DCC tracker and regional benchmarking of best practice.

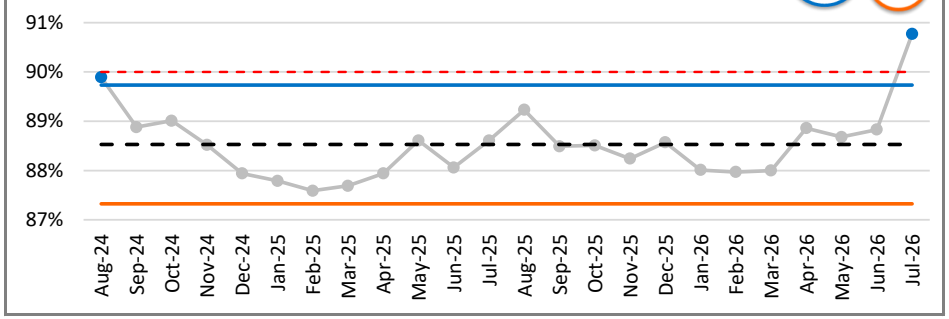
Month 04 | 2026-27

People

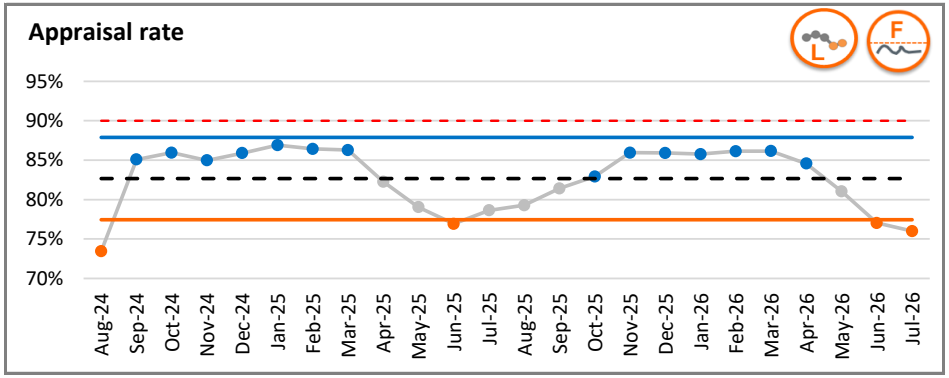
Grow Together

NHS East and North Hertfordshire Teaching NHS Trust

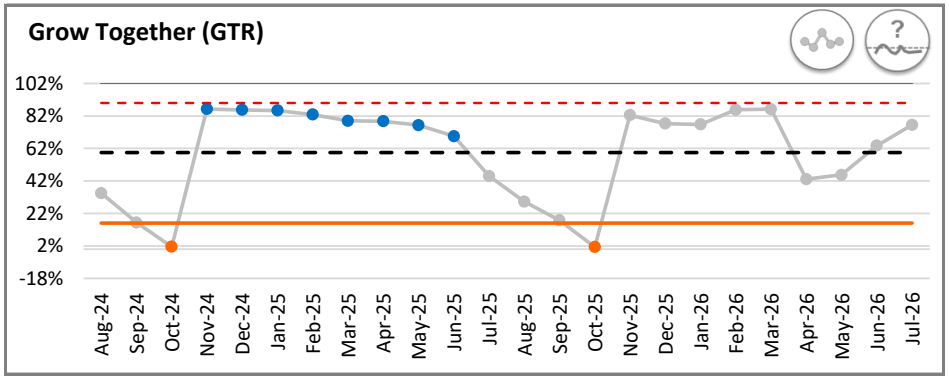
Statutory and mandatory training compliance rate



Appraisal rate



Grow Together (GTR)



Key Issues and Executive Response

- **GTR compliance** for July has moved up 10% to 73%. Previous trends have shown that August compliance dips due to summer holiday and the inclusion of all bands in the compliance calculation. GTR improvement plans are linked to stat/mand actions. GTR review underway to review the cycle and expectations in line with ENHPS and NHS Staff Standards.
- Annualised **appraisal rate** is now at 81% (2% increase form June -78%).
- **StatMand** - Compliance has improved for the month and is now above 90% at 90.8%. Improvements plans continue and new graphics representations indicate clearly the areas that need focussed attention from local management. The link to 100% compliance to several development opportunities for colleagues has kept the topic active in exchanges across the Trust. Surgery remains one of the areas requiring increased attention. The importance of stat/mand training will be part of the NHS Staff Standards work on 'line management' as regular 1:1 conversations are encouraged with compliance a recurring part of that check in process.
- Updates and assurance around training was provided at during June's Stat/Mand Steering Group, with reminders given to attendees that while organisationally we are aiming for above 90% there remains a need for full individual compliance for colleagues to access development.

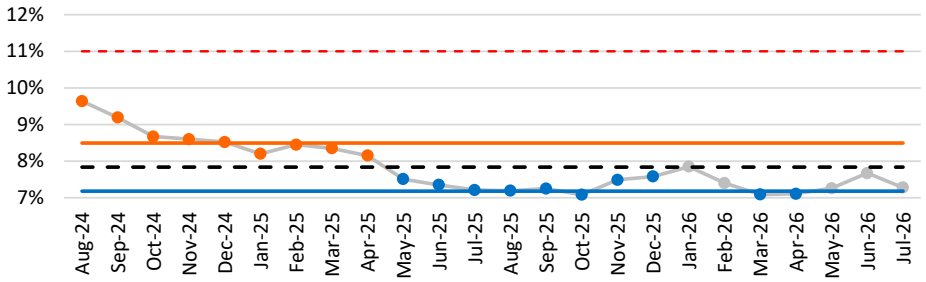
Month 04 | 2026-27

People

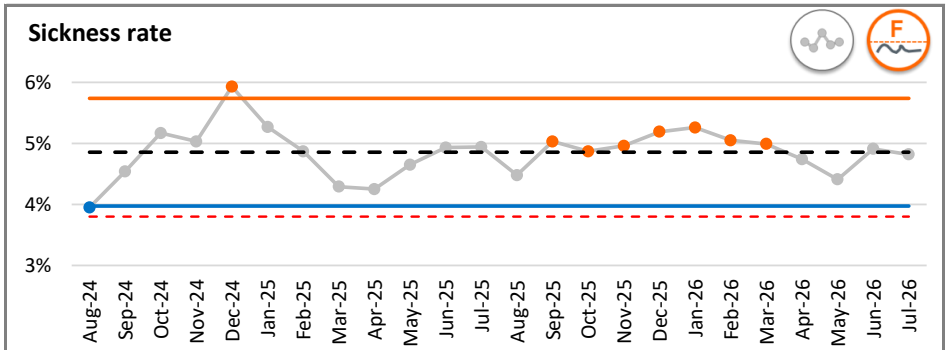
Thrive Together | Care Together

NHS East and North Hertfordshire Teaching NHS Trust

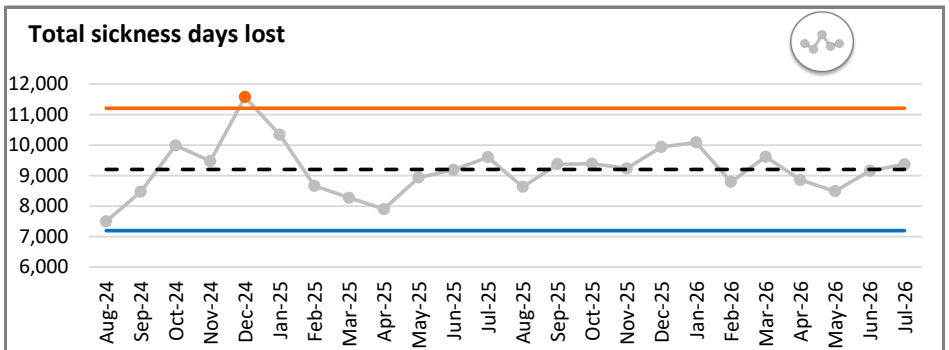
Turnover rate



Sickness rate



Total sickness days lost



Key Issues and Executive Response

Thrive Together

- There are currently two suspensions in month, with investigations taking considerable amount of time due to complexity and number of witnesses being seen.
- Average duration for disciplinary and staff concerns have minimal change however, sourcing IOs and hearing chairs is becoming problematic causing further delays.
- ER investigating officer, hearing and appeal chair training will be rolled out in Autumn 2026 for 8a and above with the expectation that they will undertake the roles on a rolling basis.
- 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

- The 'Return Well Taskforce' has been established, its objective is to work collaboratively to reduce sickness absence to ≤4% by quarter four through a Trust-wide programme focused on return-to-work excellence, targeted wellbeing interventions, and improved manager confidence and effectiveness in attendance management. The Return Well programme progress is shared monthly at the People Senate, this month will include feedback from the first monthly Bradford Score Top 100 Summit reviews and a focus on LTS cases/management. Interventions and best practice, such as case conferences, NHSE sickness toolkit are included in the scope of work.
- Proactive approaches to enhance wellbeing and reduce sickness absence in month 4 include onsite support from the Samaritans, healthy living skills boosters, free and impartial financial support from Money Helper and promotion of musculoskeletal health support such as free exercise programmes and fast track physiotherapy.

Month 04 | 2026-27

Board committee report

-

NHS
East and North Hertfordshire Teaching
NHS Trust

Meeting	Public Trust Board			**Agenda Item**	16
Report title	Audit and Risk Committee (ARC) report to the Board			**Meeting Date**	9 September 2026
Chair	Karen McConnell, ARC Chair				
Author	Deputy Trust Secretary				
Quorate	**Yes**	☒	**No**		☐

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

- The trust's Data Security and Protection Toolkit (DPST) submission was completed by 30 June 2026 and has been rated as “Standards not met”. Officers are working with the NHS England (NHSE) to agree an action plan for improvement. Once this plan is agreed, the DSPT status is anticipated to be upgraded to “Approaching Standards”. NHSE will monitor progress against this action plan to ensure all agreed improvements are achieved by 31 May 2027. The action plan will be shared with the Audit Committee.
- The Committee discussed concerns related to Information Governance including in relation to FOI performance. These have been escalated to Trust Management Group (TMG) and an update is expected at the next Audit and Risk Committee.

Assurances provided to the Board:

- Internal Audit provided reasonable assurance opinions for Change Management and Divisional Governance as part of the 25/26 Audit Plan.
- Partial Assurance was provided by Internal Audit in relation to Emergency Planning, Preparedness and Resilience. An action plan has been agreed and is being actively monitored through the EPRR Committee and TMG. Oversight will remain with QSC with any overdue actions or issues of concern being escalated to ARC.
- The Internal Audit plan for 26/27 is on track with the recent Freedom to Speak Up Audit receiving a reasonable assurance opinion.
- Risk Management - continued improvement in the maturity, consistency and governance of risk management across the trust was discussed. The following points were noted:
    - Active oversight by Risk Management Group (RMG) including actions arising from the recent risk summit was welcomed
    - Cancer Services, Women and Children's Services and Planned Care had demonstrated improvement.
    - Unplanned Care remained an area requiring focused support
    - further work was required to improve action quality and timeliness.
    - The quality and maturity of the Corporate Risk Register has improved significantly over the last six months.
- The trust has met the requirements of the Government Functional Standard GovSO13 Counter Fraud for 25/26. Work is planned in 2026/27 to enable the Trust to meet the requirements of the Economic Crime and Corporate Transparency Act 2023 particularly in relation to the failure to prevent fraud offence.

- The KPMG/ENH Pharma action plan has strengthened governance and reduced off-contract pricing costs substantially. Action is being taken to ensure similar issues are not impacting the Trust.

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

- Recurring Internal Audit themes continue to relate to record keeping, data quality and compliance.
- Counter fraud benchmarking identified higher levels of recruitment fraud and private work referrals compared with peer organisations.
- The Quality Governance Self-Assessment pilot in Cancer Services has demonstrated positive benefits and is being considered for wider rollout.

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

- Commissioned further work on identification and testing of mission-critical systems, suppliers and contingency arrangements.
- Requested escalation of Information Governance and FOI risks through the Trust Management Group (TMG), with this committee retaining oversight.
- Requested further analysis of recruitment fraud and private work referral trends.
- Supported continued testing and refinement of the Quality Governance Self-Assessment framework.
- Endorsed and recommended to the board the revised Risk Management Policy, subject to the amendments suggested by the Committee.
- QSC to review areas of concern identified within the clinical audit annual report and provide assurance to ARC at the October meeting

Any actions recommended to improve effectiveness of the meeting:

- Review 2027 meeting dates, timing, purpose and paper volume to ensure sufficient capacity for assurance reporting.
- Continue a flexible approach to meeting frequency, including the use of virtual meetings where appropriate and for additional/ short notice meetings.

Recommendation	The Board is asked to discuss the report.

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Board committee report

NHS
East and North Hertfordshire Teaching NHS Trust

Meeting	Public Trust Board			**Agenda Item**	17
Report title	Quality and Safety Committee report to Board			**Meeting Date**	9 September 2026
Chair	Dr David Buckle – Non-Executive Director				
Author	Corporate Governance Officer/ David Buckle, Chair, QSC				
Quorate	**Yes**	☒	**No**		☐

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

Quality and Safety Committee (QSC):

- **Demand, Capacity and Flow Pressures:** The Committee noted continued pressure across urgent and emergency care pathways, with prolonged waiting times and delays to admission remaining a significant contributor to patient experience concerns and operational risk. Whilst mitigation and oversight arrangements remain in place, the Committee considers this an area requiring ongoing Board attention.
- **Patient Access and Communication:** Persistent challenges relating to outpatient communication, telephone responsiveness and patient access to services continue to generate complaints and dissatisfaction. An executive-led review has been commissioned to identify improvement opportunities and strengthen patient experience.
- **Estate Infrastructure and Capacity Constraints:** Multiple reports highlighted the growing impact of estate limitations on patient experience, accessibility, service capacity and quality outcomes. The Committee noted that infrastructure pressures are emerging as a recurring strategic theme and warrant continued oversight through the Board Assurance Framework.
- **Renal Service Capacity:** Increasing demand for dialysis services is placing sustained pressure on existing capacity. The Committee was assured that mitigating actions are in place and welcomed planned investment in home dialysis provision, whilst recognising the need for longer-term strategic solutions.

Patient Safety Sub-Committee (PSSC):

- **Patient Safety and Governance Assurance:** The Committee noted that patient safety governance arrangements continue to develop, with partial assurance received regarding aspects of incident oversight, safety governance and divisional assurance reporting. Actions are underway to strengthen performance metrics, evidence of impact and assurance reporting to support improved oversight of quality and patient safety risks.

Assurances provided to the Board:

Quality and Safety Committee (QSC):

- **Maternity Services:** The Committee received Substantial Assurance regarding maternity and perinatal services. The Committee noted a stable safety position, positive improvement in key clinical outcomes, robust governance arrangements and proactive work to respond to the recommendations arising from the Ockenden and Amos reviews.
- **Quality and Patient Safety Governance/Organisational Learning:** The Committee was assured that governance arrangements continue to mature, with stronger triangulation of patient safety, complaints and claims data providing greater insight into emerging themes and supporting a more proactive approach to risk management, learning and quality

improvement across the Trust.

- **Risk Management and Regulatory Preparedness:** The Committee received assurance that work is progressing to strengthen the Trust's assurance framework, improve visibility of risk and align evidence against regulatory requirements. Preparations for future regulatory inspection activity continue to develop positively.
- **Patient Experience and Engagement:** The Committee was encouraged by the increasing use of patient feedback, survey findings and patient experience intelligence to inform service improvement, with further work underway to strengthen patient engagement arrangements.
- **Divisional Governance Improvement:** The Committee recognised the continuing development of governance processes within Unplanned Care, including stronger triangulation of incidents, complaints, risks and patient feedback, providing greater confidence in divisional oversight arrangements.

Patient Safety Sub-Committee (PSSC):

- **Patient Safety Governance:** Through assurance received from the Patient Safety Sub-Committee, the Committee noted continued progress in patient safety learning and incident management arrangements. Reasonable assurance was received regarding the thematic review of MNSIs and oversight of longstanding open incidents, demonstrating a systematic approach to learning, monitoring and continuous improvement.

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

Quality and Safety Committee (QSC):

- **Health Inequalities Programme**: Ongoing work continues to identify and address variation in access, experience and outcomes, with current priorities including cancer pathways and outcomes for children and young people with diabetes. A more detailed progress update will be brought through future governance arrangements.
- **Quality Reporting and Assurance Frameworks**: Further development of the Integrated Performance Report and Integrated Compliance Report is underway to strengthen the quality of assurance available to Committees and the Board and to improve visibility of safety culture, compliance and performance indicators.

Patient Safety Sub-Committee (PSSC):

- **Patient Safety Strategy and Organisational Learning:** The Committee noted that learning arising from recent Patient Safety Incident Investigations (PSIIs) and Maternity and Neonatal Safety Investigations (MNSIs) is being incorporated into the development of the Trust's refreshed Safety Strategy and wider Quality Strategy, helping to ensure that recurring themes inform organisational improvement priorities.
- **Safety Culture and Governance Maturity:** The Committee discussed themes emerging from patient safety oversight and recognised continued progress in governance and learning systems. Areas identified for ongoing development included organisational responsiveness to identified risks, reducing variation in safety maturity across services, evidencing the impact of learning, and strengthening psychological safety and staff engagement.
- **Safeguarding:** The Committee noted significant progress in addressing previously outstanding safeguarding issues, providing increased confidence in oversight and risk management arrangements

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

Quality and Safety Committee (QSC):

- **Patient Experience and Multidisciplinary Care**: The Committee commissioned further work on strengthening multidisciplinary ward rounds and patient involvement in care planning, with a progress update requested for a future meeting.
- **Estates Improvement and Patient Environment**: The Committee requested a consolidated review of outstanding estates issues and improvement actions arising from PLACE findings, to support continued oversight of environmental improvements and patient experience
- **Board Assurance Framework Enhancement**: The Committee supported revisions to

Board Assurance Framework oversight, including greater visibility of Estates, Demand and Capacity, and Digital Transformation risks due to their wider impact on quality and patient safety.

- **Health Inequalities**: A more detailed update was requested to demonstrate progress against the Trust's health inequalities priorities and support ongoing assurance.

Patient Safety Sub-Committee (PSSC):

- **Organisational Learning and Benchmarking:** The Committee endorsed continued collaboration and benchmarking with West Hertfordshire Teaching Hospitals NHS Trust to support shared learning and the further development of divisional governance and assurance reporting.
- **Maternity Risk Oversight:** Further assurance was requested regarding the management and escalation of identified maternity risks and the organisational response to operational pressures impacting maternity services.

Any actions recommended to improve effectiveness of the meeting:

Quality and Safety Committee (QSC):

- **Agenda Planning and Prioritisation:** The Committee agreed to review the balance and sequencing of future agendas, particularly where multiple substantial reports are scheduled, to ensure sufficient time is available for detailed discussion of priority assurance matters.

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

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Board committee report

NHS East and North Hertfordshire Teaching NHS Trust

Meeting	Public Trust Board	**Agenda Item**	18
Report title	Finance, Planning and Performance Committee Board report July 2026	**Meeting Date**	9 September 2026
Chair	Richard Oosterom – Non-Executive Director		
Author	Committee Secretary		
Quorate	**Yes** ☒	**No** ☐	

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

- Diagnostic performance remains a significant concern, particularly within Radiology reporting, where productivity remains substantially below expected levels, contributing to increasing reporting backlogs and associated patient safety, cancer pathway, RTT and regulatory risks. NHS England and Care Quality Commission (CQC) scrutiny continues.
- RTT recovery performance has deteriorated for a fourth consecutive month, with particular risks within Trauma & Orthopaedics and Dermatology.
- Although the trust remains on plan financially at Quarter 1, delivery of the annual financial plan requires a significant improvement during Quarter 2 and remains dependent upon successful implementation of the transformation programme and delivery of workforce affordability measures
- The Committee noted continued risks relating to workforce growth, agency expenditure, bank spend, outsourcing costs and the organisation's ability to reduce overall workforce numbers in line with affordability requirements.
- The Committee expressed concern that £8.6m of the transformation programme remains unvalidated and requested greater clarity regarding programme risks and assurance arrangements

Assurances provided to the Board:

- The Trust delivered its Month 3 transformation target, with approximately £2.2m of savings delivered broadly in line with plan.
- Quarter 1 financial performance remains on plan with a reported deficit of £5.2m
- Cancer services continue to demonstrate strong financial and operational performance, including achievement of two of the three national cancer standards and maintaining the strongest 62-day cancer performance in the region.

- Improvement activity continues across urgent care, diagnostics and outpatient transformation programmes, with recovery actions and escalation processes in place to mitigate risk.
- Work has commenced on the 2027/28 planning cycle significantly earlier than previous years, with a stronger focus on integration between workforce, activity, capacity and financial planning.

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

- Deloitte's outpatient review identified approximately £1.5m of recurrent opportunity through improved utilisation of existing outpatient capacity, greater use of PIFU, clinic standardisation and optimisation of booking processes
- A Diagnostic Risk Summit is planned for August to establish a shared case for change and support recovery planning.
- External expert support has been commissioned to assist with Radiology performance improvement and challenge existing practice.
- The Committee supported development of a rolling multi-year planning approach to strengthen organisational sustainability and improve financial forecasting

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

- Requested strengthened transformation reporting, including a clearer distinction between identified and validated schemes and greater visibility of programme risks
- Commissioned further work to strengthen alignment between transformation benefits and divisional financial reporting.
- Supported implementation of the diagnostics recovery programme, including external challenge and development of a formal recovery trajectory.
- Requested trajectories for increased PIFU utilisation and action to reduce the volume of appointments managed outside central booking arrangements.
- Endorsed enhanced workforce affordability controls and early development of the 2027/28 planning framework.
- Requested future planning updates including workforce, productivity, capacity and demand assumptions.
-

Any actions recommended to improve effectiveness of the meeting:

- Continue development of assurance reporting to ensure clearer articulation of risks, mitigations, programme validation status and delivery trajectories
- Ensure future deep dives maintain focus on implementation and measurable outcomes rather than problem diagnosis alone.
- Further strengthen integration between operational, workforce, performance and financial discussions to support holistic decision-making.

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

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Board committee report

East and North Hertfordshire Teaching NHS Trust

Meeting	Public Trust Board			**Agenda Item**	19
Report title	ENH Health Care Partnership Committee report to Board			**Meeting Date**	9 September 2026
Chair	Chief Executive				
Author	Corporate Governance Officer				
Quorate	**Yes**	☒	**No**		☐

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

- **Neighbourhood Model Development** Work continues to develop a hybrid neighbourhood model across the Partnership. While there is broad support for the proposed direction of travel, further clarification is required regarding responsibilities, governance arrangements and alignment with wider system developments before final recommendations are brought forward.

Assurances provided to the Board:

- **Transformation Programme Alignment and Governance:** The Board was assured that the HCP Transformation Programme has been streamlined and aligned to HCP priorities, system objectives and national policy, supported by revised governance and delivery structures.

- **Strengthened Programme Oversight:** Assurance was provided that future transformation reporting will include clearer identification of programme risks, issues, milestones and timelines, strengthening Board oversight and accountability for delivery.

- **Women's Health Transformation Programme:** The Board was assured that the development of future women's health services is being informed by national guidance, service-user feedback, partnership working and evidence-based improvement methodologies.

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

- **Patient Engagement Programme:** A partnership-wide Patient Engagement Plan is being developed to strengthen public involvement and improve coordination of engagement activity across organisations. Progress updates will be reported through future Board meetings.

- **Winter Preparedness:** Initial discussions have commenced regarding winter planning arrangements, with further consideration through partner governance structures and potential partnership workshops to support system preparedness

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

- **Technology-Enabled Proactive Care Programme:** The Board agreed that further clinical, financial and operational development work should be undertaken on the Doccla proactive care proposal before any decision on implementation is considered. A further update has been commissioned for a future meeting.

Any actions recommended to improve effectiveness of the meeting:

- **Enhanced Risk and Performance Reporting**: Future reports should include clearer articulation of programme risks, escalating issues, milestones, timelines and measurable outcomes to enable more effective Board scrutiny and decision-making

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

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Board committee report

East and North Hertfordshire Teaching NHS Trust

Meeting	Public Trust Board	**Agenda Item**	20
Report title	Digital Committee Report to the Board – 13/07/2026	**Meeting Date**	9 September 2026
Chair	Richard Oosterom, Committee Chair		
Author	Business Manager to the Chief Executive and Trust Chair		
Quorate	**Yes** ☒	**No** ☐	

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

The Committee reviewed the revised OneEPR Programme delivery plan and received direct assurance from Dedalus regarding the revised implementation timetable. Whilst progress has been made, members concluded that sufficient assurance has not yet been obtained to support an increase in the overall assurance rating.

The principal risk remains delivery of the revised programme milestones, particularly achievement of the planned December 2026 software delivery and the subsequent implementation activities, including testing, pathway validation, training and deployment. The Committee also recognised the risks associated with phased implementation and the temporary operation of multiple clinical systems.

The Committee agreed that the overall assurance rating should remain **Partial Assurance** pending further evidence that delivery milestones are being achieved.

Assurances provided to the Board:

The Committee received assurance that:

- Dedalus has now provided delivery dates for all remaining MVP, Core EPR and Full EPR requirements.
- Formal contractual change control is being implemented to strengthen supplier accountability and link delivery milestones to contractual remedies.
- Governance arrangements between the Trust and Dedalus have significantly strengthened, including enhanced executive oversight and weekly assurance meetings.
- A formal assurance checkpoint is expected during late August/early September to provide an early indication of confidence in achieving the December delivery milestone.
- Outpatient Transformation continues to make good progress, with improvements in Contact Centre performance, outpatient slot utilisation, Patient Hub implementation and Digital Records. Several elements of the programme are transitioning into business-as-usual.
- The Committee reviewed the Digital Board Assurance Framework risks and agreed that current controls remain appropriate, whilst noting the Board's **revised assurance rating of Partial Assurance.**

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

The Committee recognised that whilst software delivery remains critical, successful implementation will depend equally upon operational readiness, including comprehensive testing, pathway validation, user training and deployment planning.

Members also discussed the future role of the Digital Committee and agreed that, where programmes have successfully transitioned into operational delivery, ongoing performance monitoring should transfer to the appropriate operational governance committees, allowing the Digital Committee to maintain strategic oversight of transformation, digital delivery and benefits realisation.

The Committee also agreed that Artificial Intelligence (AI) should form part of its future strategic work programme in recognition of the growing opportunities and governance requirements associated with AI adoption.

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

The Committee:

- Agreed to continue planning on the basis of a phased OneEPR implementation, subject to further assurance from Dedalus.
- Agreed that the overall assurance rating should remain Partial Assurance.
- Endorsed continuing with Dedalus as the preferred supplier, supported by strengthened contractual controls and enhanced supplier accountability.
- Commissioned further assurance discussions with Dedalus regarding phased delivery and milestone confidence.
- Requested further reporting on follow-up Patient Tracking Lists and clinical prioritisation.
- Agreed that Health Records operational performance should transition to routine oversight through the appropriate Board Committee.
- Approved the Digital Committee Annual Work Programme for 2026/27.

Any actions recommended to improve effectiveness of the meeting:

Recommendation	The Board is asked to: • Note the matters discussed by the Digital Committee. • Note that the Committee has maintained an overall Partial Assurance rating for the OneEPR Programme pending further supplier assurance and evidence of delivery against the revised milestones. • Note the strengthened governance and contractual arrangements with Dedalus and the Committee's continued oversight of delivery through enhanced assurance arrangements.

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Board committee report

NHS East and North Hertfordshire Teaching NHS Trust

Meeting	People and Culture Committee	**Agenda Item**	21
Report title	People and Culture Board report September	**Meeting Date**	9 September 2026
Chair	Janet Scotcher – Non executive director		
Author	Committee Secretary		
Quorate	**Yes** ☒	**No** ☐	

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

- Leadership transition risk arising from the appointment of the new Chief Executive and Deputy Chief Executive, together with forthcoming NED and Committee Chair changes. Additional focus required on succession planning, handover arrangements and executive support.
- Workforce and cultural risks associated with ongoing organisational transformation and service redesign.
- Continued workforce hotspots relating to sickness absence, appraisal compliance, turnover and recruitment delays in specific divisions.
- Need for further evolution of workforce intelligence, triangulation of data and deeper analysis of trends to support decision making.

Assurances provided to the Board:

- Committee supported the emerging People Strategy structured around:
  - Care
  - Belonging
  - Growth
  - Innovation.

  This will then form the foundation for a strategic workforce plan, subject to board approval of the strategy in October.
- NHS Staff Standards framework baseline process begun with identified leads.
- People operating model review nearing completion with consultation concluded and appointments progressing. Implementation will include evolution of the business partnering model which will come back to the committee for scrutiny.

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

- A Culture Framework has been developed as a diagnostic tool to support culture improvement and organisational development. This will be coming to the board for review/discussion.
- Committee requested further development of workforce dashboard reporting including:
  - Trend analysis.
  - Narrative commentary.
  - Hotspot identification.
  - Deep-dive reviews.
- Significant focus will continue on strengthening management capability, accountability and leadership behaviours. The culture model will be mapped to the various national standards and targets to ensure that it allows us to track delivery.
- It is proposed that this should simplify the messaging to staff so that we have a clearer understanding of our target culture.

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

- Agreed support for the draft People Strategy subject to further refinement and return to Committee.
- Agreed development of:
  - Organisation-wide culture gap analysis.
  - Culture diagnostic toolkit.
  - Ongoing culture monitoring arrangements.
- Requested all ongoing actions be converted into specific actions with clear owners and deadlines.
- Requested further dashboard development to include:
  - Narrative reporting.
  - Trend information.
  - Targeted recovery plans.
  - Triangulated workforce intelligence.
- Requested additional work on payroll assurance and resident doctor risk mitigation.

BAF Updates / Changes Discussed

- Agreement that leadership transition controls and assurances should be strengthened within the BAF to reflect:
  - CEO transition.
  - Deputy CEO appointment.
  - Committee Chair succession arrangements.
- Workforce transformation risks to include stronger evidence of:
  - Staff engagement activity.
  - Communication plans.

- Monitoring arrangements.
- Mitigation of unintended consequences.

- Workforce metrics, hotspots and deep-dive reviews should provide clearer assurance against workforce and culture-related BAF risks.
- Existing leadership destabilisation risk to be updated to reflect the current transition phase and associated succession arrangements.

Any actions recommended to improve effectiveness of the meeting:

- Record clear decisions and actions against each agenda item.
- Ensure all actions have owners and target dates.
- Remove any generic “ongoing” actions and replace with measurable deliverables.
- Further streamline dashboard reporting with executive summary and exception-based reporting.

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

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East and North Hertfordshire Teaching NHS Trust

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	July 2026	Aug 2026	Sept 2026	Oct 2026	Nov 2026	Dec 2026	Jan 2027	Feb 2027	Mar 2027	Apr 2027	May 2027
Standing Items											
Chief Executive's Report	X		X		X		X		X		X
Integrated Performance Report	X		X		X		X		X		X
Board Assurance Framework	X		X		X		X		X		
Corporate Risk Register (Part 2)	X				X				X		
Patient/Staff Story (Part 1 where possible)	X		X		X		X		X		X
Employee relations (Part 2)	X		X		X		X		X		X
Board Committee Summary Reports											
Audit Committee Report	X		X		X		X		X		X
Charity Trustee Committee Report	X		X		X		X		X		X
Finance, Performance and Planning Committee Report	X		X		X		X		X		X
Quality and Safety Committee Report	X		X		X		X		X		X
People Committee	X		X		X		X		X		X
Digital Committee	X		X		X		X		X		X
Digital Committee ToR							X				

East and North Hertfordshire Teaching NHS Trust

Board Annual Cycle 2026-27

Items	July 2026	Aug 2026	Sept 2026	Oct 2026	Nov 2026	Dec 2026	Jan 2027	Feb 2027	Mar 2027	Apr 2027	May 2027
Strategic reports											
Planning guidance							X				
Winter Planning (annual)			x								
Digital update			x								x
Trust Strategy refresh and annual objectives									X		
Antimicrobial resistance									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		
Mount Vernon Cancer Centre Transfer Update (Part 2)	X		X		X		X		X		x
Estates and Green Plan											
Workforce Race Equality Standard					X						
Workforce Disability Equality Standard					X						
Whistle blowing									X		
NHS England capability self-assessment	X										
Enabling Strategies											
Estates and Facilities Strategy					X		X				

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Board Annual Cycle 2026-27

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People Strategy							X				x
Green Strategy					X						
Quality& Clinical Strategy					X						
Equality, Diversity and Inclusion Strategy									X		
Digital Strategy											x
Engagement Strategy			X								
Other Items *Audit Committee*											
Review of Trust Standing Orders and Standing Financial Instructions (if required)											x
Charity Trustee Committee											
Charity Annual Accounts and Report					X						
Charity Trust TOR and Annual Committee Review							X				
Finance, Performance and Planning Committee											
FPPC TOR and Annual Report							X				
Quality and Safety Committee											
Maternity Incentive Scheme for sign-off											
Complaints, PALS and Patient Experience Annual Report					X						

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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
Fuller enquiry response					X						
People Committee & Culture											
Workforce Plan											
Trust Values refresh											x
Freedom to Speak Up Annual Report	X										
Equality and Diversity Annual Report and WRES					X						
Gender Pay Gap Report											x
Healthwatch Hertfordshire annual report/presentation on key findings and recommendations					X						

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ENHPS update							X				
Shareholder / Formal Contracts											
ENH Pharma (Part 2) shareholder report to Board	X										