Public Trust Board

At Lister hospital, Chestnut room (in the new build)

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

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Wednesday, 20 January 2027 - 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, 9 September 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 Janet Scotcher (JS)	Non-Executive Director
Professor Zoe Aslanpour (ZA)	Non-Executive Director
Mr Richard Oosterom (RO)	Associate Non-Executive Director
Ms Gillian Hooper (GH)	Non-Executive Director
Mr Martin Amstrong (MA)	Chief Executive Officer
Ms Theresa Murphy (TM)	Chief Nurse and Deputy Chief Executive Officer
Mr Barry Jenkins (BJ)	Interim Chief Finance Officer
Dr Justin Daniels (JD)	Medical Director
Ms Sarah Lucy James (SLJ)	MVHH Hospital Director
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:

Ms Eilidh Murray[EM1. (EM)	Director of Communications and Engagement
Mr Stuart Dalton (SD)	Head of Corporate Governance
Mrs Debbie Okutubo (DO)	Deputy Company Secretary (Board Secretary - minutes)
Dr Mona Modi (MM)	Head of Clinical Services for Women and Neonates (26/106)
Ms Amanda Rowley (AR)	Director of Midwifery (26/106)

Observer

Mr James Avery	Senior Consultant, Good Governance Institute (GGI)

No	Item	Action
	The Chair, AAD welcomed Board members, observers, guests and members of the public viewing via YouTube. She also welcomed a group of Graduate Management Trainees who were observing the meeting and noted that they would not be participating in proceedings. The Chair welcomed Mr James Avery from the Good Governance Institute (GGI), who was observing the meeting. She noted that Ms Sarah James was attending as deputy for the operational team.	
26/095	**DECLARATIONS OF INTEREST** There were no new interests declared.	
26/096	**APOLOGIES FOR ABSENCE** The Board received apologies from Ms Lucy Davis, Chief Operating Officer, Ms Penny St Martin, Chief People Officer, Ms Claire Moore, Deputy Chief Operating Officer, Ms Nina Janda, Associate Non-Executive Director and Ms Diana Skeete, Non-Executive Director.	

East and North Hertfordshire Teaching NHS Trust

26/097 STAFF STORY

The Board received a staff story from DS. DS reported that he had worked for the Trust since 1998 and reflected on both his clinical and leadership career and his experience of continuing to work following his diagnosis of Parkinson's disease in 2017. He explained that he had disclosed his condition early and had worked with Occupational Health, his neurologist and Trust medical leaders to implement reasonable adjustments to support him in continuing to practise safely and effectively. He outlined significant developments achieved within Women's and Children's Services during his tenure. DS stressed the positive impact of digital developments and noted that technological advances had been particularly beneficial in supporting staff with long-term health conditions.

The Chair thanked DS for his openness and noted that he was a role model for colleagues with visible and non-visible disabilities.

The Chief Executive, MA thanked DS and described him as an exemplary clinical leader who consistently demonstrated Trust values, visibility, courage and professionalism. He stated that understanding how the Trust could continue supporting staff with health conditions was extremely important.

The Chief Nurse, TM noted the profound respect held for DS across all staff groups and highlighted the impact he had made on generations of service users and families.

The Medical Director JD asked what advice DS would give to another member of staff newly diagnosed with a serious condition affecting their work. DS responded that early openness and honesty were critical. He advised staff to involve their line manager, Occupational Health and relevant clinical specialists as soon as possible, particularly where patient safety could be affected. He stated that early conversations and reasonable adjustments were essential.

RO asked whether having Parkinson's disease had influenced DS's leadership style and approach to empathy and understanding. DS responded that living with a long-term condition had increased his empathy and understanding of the adjustments others may need. He reported that his leadership style had evolved over the previous nine years and that his own experience had improved his understanding of work-life balance and the impact of health conditions on colleagues.

ZA invited DS to support education of future medical students regarding compassion, resilience and professional practice with long-term health conditions. DS accepted the invitation.

Action: ZA to arrange discussions with DS regarding participation in medical student education and teaching activities.

The Chair thanked DS on behalf of the board for his contribution and noted his reflections and observations.

The Board **NOTED** the staff story.

26/098 MINUTES OF THE PREVIOUS MEETING

The minutes of the meeting held on 8 July 2026 were **APPROVED** as an accurate record of the meeting.

26/099 ACTION LOG

The Head of Corporate Governance SD reported that most actions had been completed and gave a status update on the outstanding sections.

GH confirmed that action 26/078 the maternity thematic review follow-up had received extensive scrutiny by the PSSC which had supported reasonable assurance. She noted that additional strengthening had been requested around executive oversight.

The Chief Executive reflected on the staff survey benchmark report – 26/079. He emphasised the value of detailed survey information but proposed that future Board reporting should provide a more focused executive summary while allowing detailed scrutiny through the People and Culture Committee.

JS highlighted concerns regarding declining staff survey participation rates and requested that participation be encouraged to preserve confidence in survey findings and workforce engagement.

KMc sought clarification regarding the proposed Maternity Transformation Committee. She asked whether it was intended as an executive group rather than a Board sub-committee. TM confirmed that the committee would be an executive governance arrangement developed in response to maternity recommendations and would provide assurance regarding implementation of the maternity ten-point plan and national recommendations.

RO requested that future reports to summarise actions taken in response to staff survey findings, rather than solely presenting benchmark results.

JS advised that future People Strategy work would align staff survey findings with specific improvement programmes.

Action:

- Future staff survey findings to board to demonstrate organisational actions taken in. Full benchmark report to be taken to People & Culture Committee.
- Staff survey priorities to be incorporated into the People Strategy.

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

26/100 QUESTIONS FROM THE PUBLIC

The Board received one public question concerning the cancellation of a patient's surgery due to staffing pressures.

SD advised that the question had been received less than 48 hours before the meeting. Consequently, whilst a verbal response would be provided at the meeting, a full written response would follow once all information had been collated.

SLJ responded on behalf of the Trust. She expressed the Trust's regret for the distress and inconvenience caused to the patient and family and acknowledged that delays to critical surgery were taken very seriously by the organisation. She explained that:

- the cancellation had been caused by staff sickness
- twelve patients had been cancelled on the day concerned
- forty-nine urgent and cancer procedures had nevertheless proceeded.

The Trust had undertaken one privately funded paediatric procedure on that day because the child had been clinically assessed as requiring urgent intervention due to breathing difficulties.

In response to the question regarding cancellation prioritisation, SLJ reported that patients were reviewed through a robust clinical process involving senior doctors and nurses. She further advised that private patients were subject to the same clinical

prioritisation framework as NHS patients. She noted that the Trust aimed to protect NHS capacity whenever possible.

She confirmed that the specific patient concerned had not yet received a new date because of the complexity of the case and the requirement to secure the appropriate surgeon. However, the Trust was working urgently to resolve this and would contact the patient within 48 hours regarding a revised date.

The Chair thanked SLJ and reiterated the Trust's apology to the patient and family. She acknowledged the distress caused when surgery was cancelled and confirmed that a full written response would be issued.

Action:

- SLJ to provide a full written response to the public question once all information has been collated
- SLJ to contact patient and/or family regarding revised surgery date.

The Board **NOTED** the verbal response and the commitment to issue a formal written response.

26/101 CHAIR'S REPORT

The Chair reported on several recent developments. She highlighted the Engagement Strategy and emphasised the need for engagement activity to align increasingly with Health Care Partnership (HCP) arrangements across East and North Hertfordshire.

She reflected positively on the Trust's recent Onam celebrations and stated that the Trust's commitment to inclusivity and diversity remains as strong as ever, irrespective of events in wider society.

She also welcomed the continued growth in VIP Award nominations and recognised the important contribution of Estates and Facilities colleagues to maintaining our ability to deliver care to our patients.

The Chair advised that NHS England had requested completion of a Board Capability Self-Assessment by 2 October 2026. Following discussion, it was agreed that committee chairs would undertake scrutiny before submission and final sign-off would be delegated to the Chair and Chief Executive.

The Chair also reminded members that the AGM would take place on 14 September 2026.

The Board **APPROVED** delegation of final sign-off of the NHS England Board Capability Self-Assessment submission to the Chair and Chief Executive following scrutiny by committee chairs.

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

26/102 CHIEF EXECUTIVE'S REPORT

The Chief Executive, MA reported that despite leadership changes at government level, policy priorities remained broadly unchanged.

He highlighted significant work underway within radiology following a Radiology Risk Summit and advised that performance and delivery would continue to be closely monitored.

He congratulated Consultant Urologist, Tim Lane on his appointment as President of the Royal College of Surgeons and noted that he was the first President to be directly elected.

The Chief Executive also reported progress with the Better Places programme, explaining that staff had consistently highlighted concerns relating to estate infrastructure and working environments.

He advised that transformation programmes across theatres, outpatients, patient flow and workforce deployment continued to gain momentum and would be crucial to future performance improvement.

He further noted that planning for winter pressures remained a significant organisational focus.

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

26/103 ENGAGEMENT STRATEGY

The Director of Communication and Engagement, EM presented the refreshed Engagement Strategy, which had been developed in response to the findings of the Darzi review, publication of the NHS 10-Year Plan and evolving partnership arrangements across the local health system.

She explained that the strategy aimed to strengthen the patient voice, improve use of feedback, increase co-production, strengthen partnership engagement and ensure feedback resulted in demonstrable service improvements.

During discussion, the Chief Nurse, TM sought assurance regarding support for patients whose first language was not English. EM outlined ongoing work to improve health literacy, interpretation services and accessibility of patient information.

JS highlighted links between the strategy and organisational culture and queried future youth engagement arrangements.

RO requested clarity regarding success measures and resource implications. In response, EM explained that success measures should be developed with communities themselves and acknowledged that resource requirements would continue to be reviewed.

The Chair commented that the Engagement strategy was linked to the Patient and Carer Experience and Partnership Sub-Committee (PCEP) as it was vital that we hear from patients and carers.

The Board **APPROVED** the Engagement Strategy.

26/104 DIGITAL PROGRAMME UPDATE

The Chief Information Officer, MS provided an update on the Trust's Digital Programme. He reported that supplier, Daedalus had now committed to a late December 2026 release of the next One EPR product, with remaining functionality expected by August 2027. Although progress remained positive, he advised that implementation dates would not be confirmed until sufficient testing had demonstrated safety and usability.

Board members welcomed progress but sought assurance regarding patient support for digital outpatient pathways, organisational readiness for implementation and the criteria that would govern the go-live decision.

JS requested visibility of the critical implementation path, including organisational dependencies. MS agreed to provide a detailed timeline to the Digital Committee.

He also reported that the Trust had joined the NHS Copilot programme and received 1,000 Microsoft Copilot licences free of charge until March 2027, with an AI Governance Board being established to oversee future adoption.

Action: MS to present the detailed One EPR implementation timeline and critical path to the Digital Committee.

KMc welcomed progress and sought assurance around patient support for self-check-in kiosks and hospital wayfinding. MS confirmed staff assistance would be available but noted wider wayfinding issues remained under review.

KOH asked whether organisational readiness would become the main risk as implementation approaches. MS advised that ongoing clinical engagement and workflow reviews were supporting readiness.

GH sought assurance on implementation safety. MS confirmed that NHS clinical safety standards and Clinical Safety Officer reviews would be applied before go-live.

JS requested visibility of the programme's critical path and implementation dependencies. MS agreed to share the draft timeline with the Digital Committee.

TM welcomed progress on digital pre-operative assessment and sought assurance on wider planned care timelines. MS advised that implementation dates were still being developed but highlighted the benefits of a digital end-to-end patient record.

RO, as Chair of the Digital Committee, observed that some of the discussion would naturally continue through Digital Committee scrutiny.

Action: MS to present draft detailed One EPR implementation timeline and critical path to Digital Committee.

The Board **AGREED** to a **REASONABLE** assurance for the Digital Programme update.

26/105 WINTER PROVIDER RESILIENCE ASSURANCE TEMPLATE 2026/27

The Board received a report from the MVCC Hospital Director, SLJ who was representing the operational team regarding the Trust's Winter Provider Resilience Assurance submission. It was noted that it had already been submitted to the ICB within the required timescale.

She advised that the submission had been positively received during a recent system-wide winter planning exercise and explained that a more detailed internal winter plan would be submitted to the Board later in the year following review through Trust governance processes.

SLJ reported that significant progress had been made in preparedness planning:

- Detailed infection prevention and control arrangements were in place,
- enhanced Emergency Department screening processes had been implemented,
- frontline staff had received winter guidance, and
- 44 escalation areas had been assessed for winter use.

She advised that the staff influenza vaccination campaign would commence on 1 October 2026 with a target uptake rate of 60%. Two major system-wide exercises were also planned to test winter resilience arrangements and strengthen discharge processes with partners.

She noted that further work was required in relation to Christmas and New Year operational planning, workforce rotas, sickness contingency arrangements, bed

modelling, side-room capacity and the ongoing Urgent and Emergency Care transformation programme.

During discussion, RO welcomed the report but sought assurance regarding Christmas planning and expressed concern that future submissions should, where possible, be brought to the Board before formal submission.

KMc asked how winter planning would specifically address persistent twelve-hour waits and patient flow challenges. SLJ highlighted improvements being delivered through discharge programmes, multidisciplinary working, frailty pathways and strengthened relationships with community services.

TM advised that improvements in patient flow had already been observed during the summer period and outlined strengthened escalation and bed management arrangements.

Action: the operational team to present the detailed Internal Winter Plan to a future Board meeting following review through TMG and FPPC.

The Board **NOTED** substantial progress in winter preparedness and **APPROVED** the Winter Provider Resilience Assurance submission with a rating of **REASONABLE** assurance.

26/106 OCKENDEN AND AMOS REPORT AND 10 POINT PLAN BENCHMARKING ASSESSMENT

The Board received a report from the Chief Nurse, TM, the Director of Midwifery, AR and the Head of Clinical Services for Women and Neonates, MM regarding the Trust's response to the Ockenden and Amos Reviews and compliance with the NHS England Maternity 10-Point Plan.

TM advised that the recommendations aligned closely with work already underway across maternity services and reported a significant increase in maternity demand and patient complexity. The Board heard that more than 3,000 maternity triage calls had been received during July and that the Caesarean section rate had increased from approximately 25% to 50%, creating significant workforce and capacity implications.

AR reported that a rapid review had identified key areas including digital interoperability, workforce sustainability, leadership, culture, accountability and patient voice.

Whilst the Trust demonstrated strong compliance across many areas, gaps remained in maternity triage data collection, outcome reporting, Board oversight of triage metrics and equality analysis. Workforce pressures were identified as the most significant challenge. A workforce business case was nearing completion and would address the increasing complexity of maternity care and associated staffing requirements.

AR advised that a key requirement of the 10-point plan was enhanced accountability arrangements for maternity and neonatal services. A monthly governance group had therefore been established, with:

- The Chief Nurse, TM and the Medical Director, JD acting as executive leads. AR and MM acting as operational accountable leads.

The Board also heard that health inequalities remained a significant priority and that proposals were being developed for a vulnerable women's midwifery team. An externally supported culture improvement programme had also commenced across maternity services.

During discussion, RO sought assurance on whether triage concerns represented governance issues or patient safety risks and requested clarity regarding business

case timescales. AM acknowledged increasing staffing pressures, particularly during evening periods, and confirmed that incident reports demonstrated genuine operational risks.

GH questioned whether the proposed assurance rating was sufficiently robust given recent maternity concerns and unresolved workforce requirements.

JS requested assurance that HR colleagues were fully engaged in culture improvement work and that progress reports would be considered through the People and Culture Committee.

The Chief Executive, MA clarified that the assurance rating related specifically to the quality and completeness of the Trust's response and action plan submission, rather than providing assurance regarding overall maternity outcomes.

The Chair agreed that this distinction should be explicitly recorded within the minutes.

Actions:

- AR to submit the final NHS England assessment by 25 September 2026.
- AR to provide a progress report before December 2026.
- Culture improvement programme updates to be reported through the People and Culture Committee.
- Minutes to clearly record the basis of the assurance rating.

The Board **APPROVED** the Trust's submission and agreed a rating of **REASONABLE** Assurance, specifically in relation to the adequacy of the Trust's response and action plan.

26/107 RISK MANAGEMENT POLICY

The Chief Nurse, TM presented the revised Risk Management Policy and explained that the proposed changes represented a strengthening of the Trust's overall risk management framework rather than a routine policy refresh.

The revised arrangements provided greater clarity regarding risk ownership, escalation routes and organisational oversight.

KMc as Chair of the Audit and Risk Committee (ARC), confirmed that the policy had undergone detailed scrutiny by the committee and that amendments requested by committee members had been incorporated into the final version presented to the Board. She confirmed that the committee supported approval.

No further questions were raised.

The Board **APPROVED** the revised Risk Management Policy.

26/108 BOARD ASSURANCE FRAMEWORK

The Head of Corporate Governance, SD presented the Board Assurance Framework (BAF) update and reminded members that a number of new strategic risks had been introduced during the year. These included risks relating to estate infrastructure, patient engagement, leadership transition, One EPR and organisational transformation.

He invited members to consider whether additional measures were required within the Integrated Performance Report to support Board oversight of those risks.

KMc and JS supported continued review of BAF risks through Board committees and emphasised the importance of maintaining alignment between assurance framework risks and performance indicators. No additional metrics were proposed.

The Chair reminded members that internal audit had originally assessed the BAF as providing reasonable assurance, following previous Board discussion in July, the Board had agreed that partial assurance more accurately reflected the maturity of arrangements. Members agreed that the current rating remained appropriate.

The Board **NOTED** the update and **AGREED** to retain the existing **PARTIAL** assurance rating.

26/108 INTEGRATED PERFORMANCE REPORT (IPR)

The interim Chief Finance Officer, BJ presented the IPR and summarised performance across the People, Quality, Operations and Finance domains.

Within the People domain, vacancy levels, turnover rates and recruitment performance remained better than target. Mandatory training compliance exceeded target, while sickness absence remained slightly above the organisational target. A Return Well Taskforce had been established to support further improvement.

Within the Quality domain, incident reporting was at its highest level for two years, although approximately 97% of incidents were categorised as no harm or low harm. Themes included medical records, estates, patient flow and violence and aggression. Complaints had reduced compared with the previous month, although Trauma and Orthopaedics continued to generate the highest volume of concerns.

Within the Operations domain, urgent and emergency care performance remained below target despite some improvement in four-hour performance. Cancer performance remained strong in some areas, including a national ranking of sixth for 62-day performance during June, but concerns remained regarding growing waiting lists, referral-to-treatment performance and increasing numbers of patients waiting more than 52 weeks. Diagnostics performance continued to improve and transformation work remained underway in theatres, radiology, outpatients and urgent care.

Within the Finance domain, the Trust reported a year-to-date deficit of £2.7 million, in line with plan. Workforce expenditure and premium capacity costs remained significant pressures, while delivery of cost improvement programmes was below target.

During discussion, the Chair sought assurance regarding declining SSNAP ratings. TM and JD advised that methodological changes had contributed significantly to the reduced rating and highlighted improvements in direct access to diagnostics, thrombolysis rates and stroke care pathways.

JD reported that thrombolysis performance was currently the highest achieved by the Trust and above comparator organisations.

RO expressed concern regarding ongoing pressures across urgent care, RTT performance, cancer waiting times and finance. He acknowledged the scale of current transformation programmes but sought assurance that recovery trajectories remained realistic.

JS echoed these concerns and stressed the importance of ensuring that transformation benefits were embedded and sustained after external support arrangements ceased.

The Chair agreed and noted that similar discussions had recently taken place with the Chief Executive. She observed that the challenge of embedding sustainable improvements was recognised by both executive and non-executive members.

The Board received and noted the integrated performance report.

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

East and North Hertfordshire Teaching NHS Trust

26/109 AUDIT AND RISK COMMITTEE (ARC) REPORT TO THE BOARD

The ARC Chair, KMc advised that all key matters requiring Board attention had been highlighted within her written report.

The Board **NOTED** the Audit and Risk Committee report.

26/110 QUALITY AND SAFETY COMMITTEE (QSC) REPORT TO THE BOARD

The QSC Chair, DB observed that many of the quality and safety matters considered by the committee had already been discussed extensively elsewhere on the Board agenda.

The Board **NOTED** the Quality and Safety Committee report.

26/111 FINANCE PERFORMANCE AND PLANNING COMMITTEE (FPPC) REPORT TO THE BOARD

The FPPC Chair, RO advised that the matters he wished to highlight had already been discussed during earlier agenda items, particularly through the Integrated Performance Report discussion.

The Board **NOTED** the Finance, Performance and Planning Committee report.

26/112 HEALTH CARE PARTNERSHIP (HCP) REPORT TO THE BOARD

The Chief Executive, MA advised that there were no additional matters requiring escalation beyond those already contained within the written report.

The Board **NOTED** the HCP report.

26/113 DIGITAL COMMITTEE REPORT TO THE BOARD

The Digital Committee Chair, RO reported that no formal Digital Committee meeting had taken place during August. However, members had received an update report following the July meeting and the next committee meeting was scheduled for the following Monday.

Given the extensive earlier discussion regarding digital transformation, One EPR and AI developments, he had no additional matters to raise.

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

26/114 PEOPLE AND CULTURE COMMITTEE (PCC) REPORT TO THE BOARD

Chair of the People and Culture Committee, JS advised that there were no additional matters to highlight beyond those already discussed earlier in the meeting. She invited questions from Board members.

RO referred to previous committee discussions regarding sickness absence hotspots and targeted interventions. He asked whether progress had been made in improving visibility and understanding of hotspot areas through dashboard reporting and triangulation of information.

JS responded that some progress had been achieved, but the work remained incomplete.

She also advised that the forthcoming People Strategy would be presented to the October PCC meeting and would provide an opportunity for further detailed discussion regarding workforce health, wellbeing and culture.

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

26/115 ANNUAL CYCLE

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

26/117 ANY OTHER BUSINESS

26/117a

The Chair observed that many issues had already been thoroughly scrutinised through Board committees and noted the continued improvement in committee reporting.

26/117b

GH raised concerns regarding increasing national reports of inappropriate access to patient records and asked whether the Trust was receiving adequate assurance regarding confidentiality controls.

KMc agreed that the issue required formal scrutiny and confirmed that the matter would be considered by ARC.

TM advised that professional guidance had been reinforced with nursing staff, that a zero-tolerance approach to inappropriate access had been emphasised and that audits had been commissioned within emergency department, maternity and surgical services.

The SIRO, MS advised that all clinical systems maintained detailed audit trails that enabled inappropriate access to be identified and investigated.

JD reported that he had recently written to all medical staff following a national incident, reinforcing expectations around confidentiality and appropriate record access.

Action:

- ARC to review controls relating to patient record access.

The Board **NOTED** the discussion and **AGREED** the actions.

26/118 DATE OF NEXT MEETING

The date of the next meeting is 11 November 2026 to be held at Lister Hospital

Ms Anita Day
Trust Chair
September 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 SEPTEMBER 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
9 Sept 2026	26/097	Staff story	ZA to arrange discussions with DS regarding participation in medical student education and teaching activities.	Invite sent to DS to contribute to a session on professionalism for medical students in the new year.	Professor Zoe Aslanpour, NED	Nov 2026 Completed
9 Sept 2026	26/100	Public question	SLJ to provide a full written response to the public question once all information has been collated	Written response sent to the questioner – 28 October 2026.	MVCC Hospital Director	Sept 2026 Completed
9 Sept 2026	26/100	Public question	SLJ to contact patient and/or family regarding revised surgery date.	Update sent to the questioner 28 Oct 2026 – however a revised surgery date has not been set due to backlog.	MVCC Hospital Director	Nov 2026
9 Sept 2026	26/104	Digital Programme update	MS to present the detailed One EPR implementation timeline and critical path to the Digital	This will be an agenda item at the Digital Committee	Chief Information Officer	Sept 2026 Completed

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

Meeting Date	Minute ref	Issue	Action	Update	Responsibility	Target Date
			Committee.			
9 Sept 2026	26/105	Winter provider resilience assurance template 2026/27	The Operational team to present the detailed Internal Winter Plan to a future Board meeting following review through TMG and FPPC.	Detailed Plan went to October FPPC and was approved.	Deputy Chief Operating Officer	Dec 2026 Completed
9 Sept 2026	26/106	Ockenden and Amos report and 10-point plan benchmarking assessment	AR to provide a progress report before December 2026	Chair & CEO agreement to circulate the update to all Board members for comment followed by Chair's action.	Director of Midwifery	Dec 2026
9 Sept 2026	26/117	Access to patient records	The Audit and Risk Committee (ARC) to review controls relating to patient record access.	This will be an agenda item at the Dec ARC meeting. Was presented to the Oct ARC meeting.	Chief Information Officer	Dec 2026 Completed

East and North Hertfordshire Teaching NHS Trust

CHIEF EXECUTIVE'S REPORT
Trust Board – 11 November 2026

1. Introduction

Since my September report, the Trust has entered a more demanding phase of its improvement journey. The mid-year review with NHS England, together with the detailed work we have undertaken across our services, has reinforced the scale of the operational and financial challenge and the need to demonstrate a much stronger pace of improvement.

My first months as Chief Executive have helped clarify both the strengths of ENHT and some of the weaknesses in how we organise, manage and deliver services. We have talented and committed colleagues, but too often our systems of accountability, capacity planning, decision-making and performance management have not enabled them to achieve what patients should reasonably expect.

At the Board seminar in October I shared my reflections on these issues and the implications for our future direction. The central proposition is that immediate performance recovery and longer-term organisational renewal must proceed together. We need to deliver our existing commitments more reliably while developing the leadership, capability and strategy needed for sustainable improvement.

2. National NHS Leadership Update

On 22 September, I attended the national NHS leaders event, which brought together provider chief executives and senior national leaders, including Sir Jim Mackey and colleagues from NHS England.
The discussions reinforced the considerable pressure facing the NHS as we approach winter, alongside a clear expectation that organisations demonstrate tangible improvements in operational performance, productivity and financial delivery.

Urgent and emergency care and winter preparedness featured prominently. National leaders emphasised the importance of improving patient flow, reducing unnecessary delays and ensuring that winter plans translate into effective operational arrangements across the whole health and care system. The emphasis was on practical delivery rather than simply demonstrating that plans are in place.

Financial sustainability and productivity remain central national priorities. There was a strong emphasis on organisations making better use of existing resources, improving operational efficiency and addressing underlying cost and productivity challenges rather than relying upon short-term financial measures.

Leadership, governance and accountability were also important themes. Discussions about recent national inquiries reinforced the responsibilities of Boards and senior leaders to maintain effective oversight, listen to concerns, challenge established practice and ensure that identified weaknesses lead to meaningful action.

The event also considered the continuing evolution of national and system leadership arrangements, including the relationship between NHS England, the Department of Health and Social Care and local health systems.

For ENHT, these messages were particularly timely. They closely reflect the challenges we have identified through our own organisational assessment and were reinforced by the subsequent NHS England mid-year review.

My principal takeaway was that national expectations are increasingly focused not simply on the plans organisations produce, but on the strength of their leadership, their ability to implement decisions and the evidence of improvement that follows. That is the central challenge we are now addressing at ENHT.

3. NHS England Mid-Year Review and Performance Recovery

Our September mid-year review with NHS England was a challenging but constructive discussion. We acknowledged the deterioration in our NHS Oversight Framework position, from Segment 2 to Segment 3 at the first-quarter assessment, and the wider concerns about delivery against the 2026/27 plan. The review made clear that the region expects a step change in performance, not simply a more detailed description of the problems.

Three messages were particularly clear. First, urgent and emergency care performance needed significant and urgent improvement during October. Secondly, the Trust was expected to develop a credible recovery plan for referral-to-treatment performance, demonstrating how we would return towards the required trajectory by March. Thirdly, we must deliver the operational and financial commitments we have made, with stronger evidence of ownership, grip and execution.

The Board receives detailed performance reporting elsewhere on its agenda, so I will not repeat that information here. My focus is on the leadership response: clearer recovery plans, more frequent scrutiny, stronger divisional accountability and early intervention where delivery is slipping. The latest evidence of progress against the three mid-year review expectations will be reflected in the relevant performance and finance reports.

Our work on elective services has exposed a significant gap between timetabled theatre capacity and the core sessions actually delivered, together with historic reliance on waiting-list initiatives. Sustainable recovery requires improvements in scheduling, job planning, theatre utilisation, workforce availability and patient preparation, rather than continuing to compensate for weak core delivery through premium additional activity.

Radiology remains a major quality and operational priority. Following two risk summits involving the Planned Care Division and the radiology service, we have implemented special measures arrangements to provide more intensive leadership, oversight and assurance of the recovery programme. The programme is addressing long waits, reporting backlogs, clinical risk and reliance on premium reporting arrangements, with clearer executive and clinical oversight and a structured set of improvement workstreams. These arrangements reflect the seriousness of the concerns identified. The Radiology Department remain fully involved in our response to these challenges and are committed to the transformation steps need to support the ongoing provision of a high-quality service. Our test must be sustained improvements in access, reporting timeliness and patient safety, supported by evidence that the service is becoming more resilient and less dependent on exceptional arrangements.

4. Financial Sustainability, Transformation and Leadership

The latest financial position (Month 6) reinforces the seriousness of the challenge facing the Trust. Against our agreed breakeven plan, the forecast indicates a significant risk to delivery of our year-end commitments, driven principally by under-delivery of cost improvements, continued workforce and operational expenditure pressures, and activity levels below plan.

Addressing this position will require urgent, significant and sustained corrective action. Incremental improvements will not be sufficient. We must accelerate delivery of agreed savings, strengthen expenditure controls and make difficult decisions to secure tangible reductions in our financial run rate over the remainder of the year.

These measures include a freeze on non-clinical vacancies, significant restrictions on temporary staffing within non-clinical functions, and tighter controls over discretionary and premium expenditure. Whilst these actions will be pursued with urgency, appropriate clinical and operational fail-safe arrangements will remain in place to protect patient safety and quality, including clear escalation and exception processes where essential services or clinical standards could be compromised.

I recognise that these measures will create challenges for colleagues and services. However, they are necessary in part because we have not collectively delivered the required pace and scale of productivity improvement. We cannot continue to explain why difficult changes cannot be made without developing credible and deliverable alternatives. Where these are not forthcoming, more direct interventions become unavoidable.

This is a collective leadership responsibility, requiring every division, corporate function and budget holder to demonstrate stronger ownership, financial discipline and delivery. Alongside immediate controls, our transformation programme must accelerate sustainable improvements in productivity and efficiency, supported by clearer accountability and measurable benefits.

I am also pleased that Clare Parker has accepted the appointment as our substantive Chief Finance Officer. Her arrival will strengthen the executive team at a critical point in our financial recovery and wider organisational improvement journey.

5. Strategy and Partnership Working

The October Board seminar provided an opportunity to consider how our emerging organisational diagnosis should inform a refreshed strategy and integrated business plan. My view is that we must be more explicit about our strategic priorities, the capabilities required to deliver them and the choices we will need to make within the resources available.

The East and North Hertfordshire Health and Care Partnership is central to this. Our development discussions in early October explored how we can strengthen collective leadership around neighbourhood health, prevention, integrated pathways and care outside hospital where appropriate. This will require clearer shared priorities, practical delivery arrangements and an honest assessment of what partners can collectively achieve.

Digital transformation will be a critical enabler. The OneEPR programme, the reliability and safety of systems supporting clinical care, and the opportunities from appropriate use of digital tools and artificial intelligence must all be approached with stronger delivery discipline. Digital investment needs to improve clinical workflows, safety and productivity, rather than simply introduce new technology.

6. Our Estate and Significant Organisational Developments

The new Trust headquarters opened during October, bringing administrative colleagues together from a number of former locations into the Freeman County estate on the Lister site. This is an important step in making better use of our accommodation, reducing fragmentation and enabling closer working between corporate teams. The new retail facilities associated with the development opened on 21 October, improving the welcome and amenities available to patients, visitors and colleagues.

The Paediatrics Big Build is another important development for patients, families and staff. It provides an opportunity to improve the environment in which children receive care and colleagues work. We will continue to oversee the programme's delivery milestones, funding requirements and dependencies, and report material changes through the appropriate governance routes.

These developments sit alongside the wider need to care for and improve the estate we already have. The Better Places programme and improvements to the Lister entrance illustrate the importance of practical changes that make a visible difference to patients and staff, even while we continue to face significant longer-term infrastructure challenges.

Car parking and access to the Lister site continue to be raised consistently by colleagues, including through the Medical Advisory Committee. Our response is addressing both the availability of spaces and the ability to enter, move around and leave the site reliably at peak times. Work includes progressing additional capacity associated with St George's, reviewing how existing spaces are allocated, and engaging traffic-management specialists on options to improve circulation and exit flows around the multi-storey car park. We have also established a Car Parking Advisory Group with clinical representation. As the paediatric development progresses, particular attention is being given to appropriate replacement parking for affected colleagues. The position on the St George's arrangements, traffic-flow options and delivery timescales will be updated before publication.

7. Looking Ahead – Winter and Organisational Improvement

As we approach winter, our immediate priority is to secure more reliable urgent and emergency care, patient flow and discharge, working closely with partners across the local health and care system. Winter resilience cannot depend solely on short-term escalation arrangements; it requires strong operational performance and effective coordination throughout the pathway.

More broadly, the coming months must be about demonstrating that the changes we are making in leadership, management, decision-making and transformation are producing results. We will need to be candid about where improvement is slower than required, while recognising and supporting the many colleagues who are working hard to deliver better services.

I remain confident in the commitment and potential of ENHT. That confidence must now be matched by evidence: improved access and safety for patients, better use of our resources, more consistent leadership and a clear strategic direction for the future.

Chief Executive
East and North Hertfordshire Teaching NHS Trust
November 2026

Board

East and North Hertfordshire Teaching NHS Trust

Meeting	Public Trust Board		**Agenda Item**	9	
Report title	Capability submission to NHS England		**Meeting Date**	11 November 2026	
Author	Head of Corporate Governance				
Responsible Director	Chief Executive				
Purpose	**Assurance**	☐	**Approval/Decision**	☐	
	Discussion	☒	**For information only**	☐	
Proposed assurance level (*only needed for assurance papers*)	**Substantial assurance**	☐	**Reasonable assurance**	☐	
	Partial assurance	☐	**Minimal assurance**	☐	

Executive assurance rationale:

N/A – it is an NHSE submission rather than an assurance paper.

Summary of key issues:

This paper presents the Trust's capability self-assessment that was submitted to NHS England on 2 October in line with NHS England expectations that the submission is considered at Board.

Background

NHS England requires all NHS Trust Boards to undertake an annual self-assessment of organisational capability across six domains: Strategy and Leadership; Quality of Care; People and Culture; Access and Delivery of Services; Productivity and Improvement; and Finance.

The Provider Capability Self-Assessment was completed in accordance with NHS England guidance and draws upon a broad range of evidence including Board and committee assurance, BAF oversight, organisational performance reporting, workforce intelligence, transformation programmes, internal and external reviews and annual governance processes.

Key points

The assessment concludes that the Trust demonstrates broad organisational capability across all six domains. The submission identifies particular strengths in strategic leadership, governance, quality oversight, workforce engagement and system partnership working, and evidences progress in strengthening accountability, performance management, risk oversight, analytical capability and transformation governance.

The assessment also provides a realistic appraisal of areas where capability continues to mature. Whilst the Trust has strengthened its understanding of the factors influencing operational, productivity and financial performance, further improvement is required in relation to access standards, productivity benefits realisation, workforce utilisation and financial sustainability. The submission therefore reflects both current capability and the Board's evidence-based understanding of the key priorities and actions required to strengthen organisational effectiveness and maturity.

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 assessment is a regulatory requirement and contributes to NHS England's rating for the Trust. For the 2025 first-ever submission, NHS England rated the Trust as Green – which placed the Trust in the top 20% of Trusts nationally to obtain a Green rating.							
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 self-assessment aligns with, and reflects understanding of, the principal strategic risks contained within the BAF, particularly risks relating to quality and safety (BAF 2 health inequalities), operational performance and access standards (BAF 9), workforce sustainability and culture (BAFs 5, 6 & 7), financial sustainability (BAF 3), transformation delivery (BAF 11) and digital maturity (BAFs 8 & 10).							
Report previously considered at & date(s):							
Reviewed and approved under delegated authority by the Chair and Chief Executive, in consultation with the Chairs of the Finance, Performance and People Committee, Quality and Safety Committee, People and Culture Committee and Audit and Risk Committee, prior to submission to NHS England on 2 October 2026, in line with delegation from September's Board due to November Board being after the submission deadline. Executives, via Trust Management Group, oversaw the development of the submission in September.							
Recommendation	The Board is asked to: • Note the submission of the provider capability self-assessment to NHS England. • Note the governance arrangements through which the submission was reviewed and approved under delegated authority. • Note the key strengths and areas for further development identified within the assessment. • Endorse the continuing organisational improvement priorities identified within the submission.						

To be trusted to provide consistently outstanding care and exemplary service

EAST AND NORTH HERTFORDSHIRE TEACHING NHS TRUST

Provider capability self-assessment template 2026

Providers should use the form and the supporting annex to rate themselves across each domain and, following Chair and CEO sign-off, submit to their regional oversight lead by **5pm Friday October 2**.

I. Strategy, leadership and planning

Capability statements	Proposed domain rating
	Amber-Green
1. The trust's strategy reflects clear priorities for itself as well as shared objectives with system partners	**Context: The Board's overall assessment of organisational capability is broadly consistent with its assessment in 2025. However, the 2026 framework introduces a more graduated rating methodology (Green, Amber-Green, Amber-Red and Red) than the previous Compliant/Partially Compliant/Non-Compliant approach. The Board's view is that several domains which would previously have been assessed as broadly compliant now more appropriately align to Amber-Green, reflecting both recognised strengths and areas where organisational capability and delivery continue to mature.** The Board considers this domain to be Amber-Green. The Trust has a clear strategy to 2030 aligned to organisational, place and system priorities, supported by annual strategic objectives and strong partnership working. The Trust plays a significant leadership role within the local system, acting as Host Provider for the East and North Hertfordshire Health and Care Partnership (HCP) and leading collaborative programmes across the wider system. Since 2025, the Board has strengthened its strategic oversight and governance arrangements in response to a more challenging operational, financial and transformation environment. This has included refreshing strategic priorities, undertaking a comprehensive BAF review, strengthening transformation governance, establishing and maturing the Digital Committee, introducing Performance Senate arrangements, developing HCP governance arrangements and strengthening organisational accountability processes. The Board believes these actions demonstrate its ability to identify emerging risks and adapt arrangements in response. Through its transformation programme, the Board has gained a clearer understanding of the underlying drivers of organisational performance. This has highlighted a significant gap in some services between funded and available capacity, planned capacity and actual utilisation, alongside historical reliance on temporary staffing, waiting list initiatives, insourcing and outsourcing arrangements to sustain delivery. The Board recognises that addressing these issues requires both operational improvement and sustained cultural and behavioural change, supported by strengthened
2. **If in breach of licence:** The trust is meeting and will continue to meet any requirements placed on it by ongoing enforcement action from NHSE	
3. The board has the skills and expertise to deliver its strategy in the context of the 10-Year Health Plan.	
4. The trust is working effectively and collaboratively with its system partners and provider	

collaborative for the overall good of the system(s) and population served	accountability, leadership expectations and performance management arrangements. The Board maintains oversight of strategy, delivery and risk through regular strategy reviews, BAF workshops, horizon-scanning and committee scrutiny. During the 2026/27 BAF refresh, all but three strategic risks were new or materially revised, including specific risks relating to executive leadership transition, OneEPR delivery and transformation delivery. Governance arrangements have also been strengthened through establishment of the Digital Committee, continuation of the Patient Safety Sub-Committee and enhanced executive accountability arrangements. There is a strong and active focus on the corporate risk register. The Board has successfully managed leadership transition during 2026, including appointment of a new Chief Executive through internal succession and recruitment of a substantive Chief Finance Officer. Interim arrangements were implemented promptly where required to maintain organisational stability and continuity of leadership. The Trust strives to work effectively with partners across the system, supporting transformation through programmes focused on frailty, integrated heart failure services, primary care integration and collaborative clinical service development. Whilst system arrangements continue to evolve, the Trust has continued to convene partners, develop shared priorities and progress collaborative delivery through the HCP and wider provider collaboratives. Digital and cyber governance have also been strengthened through enhanced Board oversight, strengthened cyber assurance arrangements and active management of the delayed OneEPR programme, with risks and recovery actions subject to regular scrutiny. The Board recognises that accountability arrangements, digital benefits realisation and measurement of system impact continue to mature. Whilst significant progress has been made through the Accountability Framework, Performance Senates, strengthened transformation governance and digital oversight arrangements, these remain areas for continued development and are the principal reasons the Board has assessed this domain as Amber-Green rather than Green. **Areas for development** The Board plans to continue to embed the Accountability Framework and monthly Performance Senate arrangements, strengthen evidence of delivery accountability and transformation benefits realisation; continue delivery of the OneEPR programme and digital benefits realisation; further develop cyber assurance and Board digital capability; and strengthen measurement of system and population health impact arising from collaborative working.
5. The trust has an effective cyber security strategy and uses digital technology to support organisational improvement	

II. Quality of care

Capability statements	Proposed domain rating
	Amber-Green
6. The organisation has regard to relevant NHS England guidance (supported by Care Quality Commission information, its own information on patient safety incidents, patterns of complaints and any further metrics it chooses to adopt).	The Board considers this domain to be Amber-Green. The Trust has established quality governance arrangements that provide effective oversight of quality, safety and patient experience through triangulation of patient safety incidents, complaints, mortality reviews, patient experience, clinical audit, regulatory intelligence and external assurance activity. The Board receives comprehensive quality information through the Integrated Performance Report, Quality and Safety Committee and supporting governance structures, enabling timely escalation and management of emerging risks. Since 2025, the Trust has continued to strengthen its quality governance through further embedding of PSIRF, development of the ENHance quality oversight platform, enhanced use of real-time quality intelligence and continued development of accountability and quality oversight arrangements. The Trust actively uses learning from patient safety incidents, complaints, GIRFT reviews, peer reviews, NICE guidance and external inspections to support improvement and reduce unwarranted variation. The Board receives both quantitative and qualitative information, including patient stories, patient safety investigations, national patient surveys, complaints themes and staff feedback. Patient and carer involvement continues to strengthen through patient safety partners, Maternity Voices, dementia carers, PLACE assessments and service redesign programmes. Progress has also been made in addressing health inequalities through targeted work with vulnerable and underserved populations. The Board believes there is good evidence of organisational learning, improvement and appropriate oversight of quality risks. However, quality governance arrangements continue to evolve and opportunities remain to further embed PSIRF, strengthen triangulation of patient experience with wider quality intelligence, improve the consistency of patient experience action planning, and further develop the use of health inequalities data and service-user involvement to evidence measurable improvement. These areas are reflected within current improvement plans and are the principal reasons the Board has assessed this domain as Amber-Green rather than Green. **Areas for development**
7. The trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients	
8. Systems are in place to monitor patient experience and there are clear paths to relay safety concerns to the board	

	Continue embedding PSIRF and improvement actions; strengthen triangulation of patient experience, complaints and safety intelligence; further develop health inequalities oversight and improvement activity; continue implementation of the Quality Readiness Programme and refreshed Clinical Quality Strategy; and strengthen evidence that learning and improvement activity is resulting in sustained measurable improvements in care.

III. People and culture

Capability statements	Proposed domain rating
	Amber-Green
9. Staff feedback is used to both improve the quality of care provided by the trust and monitor and improve staff experience	The Board considers this domain Amber-Green. Staff feedback is gathered and acted upon through the NHS Staff Survey, Freedom to Speak Up, staff networks, partnership arrangements, staff forums and direct engagement with Executive Directors. Board and committee oversight of staff survey actions, EDI priorities, workforce indicators and speaking-up themes provides assurance that staff feedback is used to inform workforce, cultural and quality improvement activities across the organisation. Progress against staff survey actions, EDI priorities and workforce indicators is reviewed routinely through the People and Culture Committee and Board. The Trust has continued to strengthen its people and culture arrangements since 2025, including development of Recruitment and Selection Ambassadors, enhanced support for staff networks and implementation of NHS Staff Standards workstreams. The Trust maintained the improvements in 2025 from the 2024 NHS Staff Survey as one of the top five improved Trust results nationally, providing evidence that improvement activity is having a sustained positive impact. Progress has been supported by strengthened EDI arrangements, Recruitment and Selection Ambassadors, enhanced staff network arrangements through the United Networks approach and implementation of NHS Staff Standards workstreams. The Board maintains oversight of workforce capability through workforce planning, mandatory training compliance, talent management and leadership development reporting. Strategic workforce planning arrangements are being further strengthened to provide longer-term workforce forecasting and ensure the organisation has the skills and capability required to meet future service and neighbourhood health delivery requirements. The Trust has a well-established Freedom to Speak Up culture supported by a dedicated Guardian, Board-level reporting, NED oversight and clear escalation arrangements. Since 2025, governance has been further strengthened through introduction of a standalone whistleblowing policy, development of a single raising-concerns pathway and closer working between Freedom to Speak Up, Employee Relations and Staff Side colleagues. The Board is satisfied that staff can raise concerns and that feedback is used to drive improvement. The Board recognises opportunities to further strengthen leadership and management capability, including embedding greater accountability for delivery of transformation, productivity improvement and cultural change. Development activity is increasingly focused not only on leadership behaviours but also on equipping leaders to lead complex service redesign, workforce transformation and performance improvement.
10. Staff have the relevant skills and capacity to undertake their roles, with training and development programmes in place at all levels	
11. Staff can express concerns in an open and constructive environment	

	Areas for development Further strengthen leadership accountability and capability to lead transformation, service redesign and productivity improvement. The Board will continue to embed the NHS Staff Standards workstreams, further strengthen leadership and line management accountability and capability to lead transformation, service redesign and productivity improvement. The Trust will also embed implementation of the NHS Leadership and Management Framework, continue development of strategic workforce planning arrangements, and reduce variation in staff experience across teams. The Trust will also further strengthen psychological safety and speaking-up arrangements through implementation of the new whistleblowing policy and raising concerns pathway, while continuing to address workforce equality priorities through delivery of the refreshed EDI Strategy and implementation of associated action plans.

IV. Access and delivery of services

Capability statements	Proposed domain rating
	Amber-Red
12. Plans are in place to improve performance against the relevant access and waiting times standards 13. The trust can identify and address inequalities in access/waiting times to NHS services across its patients 14. Appropriate population health targets have been agreed with the ICB	The Board considers this domain to be Amber-Red. The Trust has a clear understanding of the factors affecting delivery of key access standards and has strengthened its ability to monitor, challenge and improve performance through enhanced use of Power BI, the new Accountability Framework, Performance Senate arrangements and dedicated transformation programmes. The Board receives regular oversight of urgent and emergency care, elective, diagnostic and community performance through established governance arrangements and has clear visibility of performance risks, recovery trajectories and mitigating actions. Performance against a number of national access standards remains below the level required, particularly within urgent and emergency care, diagnostics and elective recovery and the Trust has recently moved to National Oversight Framework (NOF) Segment 3. Key challenges remain in Referral to Treatment (RTT) performance, diagnostic waiting times, urgent and emergency care flow, and community waiting times, including community paediatric pathways. Whilst improvement plans are in place and there have been signs of progress in some areas, delivery has not yet occurred at the pace or scale required to achieve the trajectories expected. The Board is sighted on the underlying causes of underperformance, including the need to improve productivity to tackle the gap between capacity and demand, workforce pressures, infrastructure constraints, and historical reliance on temporary staffing and capacity limitations. In response, targeted transformation programmes have been established across UEC, theatres, imaging and outpatients, supported by strengthened planning, accountability and operational oversight arrangements, demand and capacity planning, accountability arrangements and enhanced performance oversight. The Board recognises that some historic approaches to achieving operational targets, including reliance on temporary staffing, waiting list initiatives and externally purchased capacity, improved short-term performance but did not sufficiently address underlying productivity and utilisation challenges. Transformation programmes are now focused on delivering more sustainable improvements in capacity utilisation and pathway performance. Since 2025, the Trust has strengthened organisational grip through its transformation programme, improved demand and capacity planning, enhanced performance management arrangements and investment in diagnostic infrastructure. Progress has also been made in recovering paediatric audiology services and working with system partners to improve community paediatric and neurodiversity pathways. The Trust

	has further enhanced its ability to identify inequalities in access and outcomes through improved analytical capability and establishment of the Health Equity Delivery Group. The Trust has also increased its focus on population health and prevention through initiatives including waiting well programmes, smoke-free pathways, Healthy Hospital work and participation in system population health management programmes. The Board is satisfied that it understands the drivers of operational performance, maintains effective oversight arrangements and has or is developing credible recovery plans in place. However, sustained improvement against a number of key access standards has not yet been achieved, and current performance remains below the level expected in several national priority areas. These factors are the principal reasons the Board has assessed this domain as Amber-Red rather than Amber-Green. **Areas for development** To continue delivery of urgent and emergency care, imaging, theatre and outpatient transformation programmes; improve performance against RTT, diagnostic, community, elective and UEC standards; reduce long waits and unwarranted variation in access; further embed health inequalities analysis within service redesign; and strengthen the consistent application of population health approaches across services to support sustained improvement in access and delivery.

V. Productivity and value for money

Capability statements	Proposed domain rating
	Amber-Green
15. Plans are in place to deliver productivity improvements as referenced in the NHS Model Health System guidance, the Insightful board and other guidance as relevant	The Board considers this domain to be Amber-Green. The Trust has a strong understanding of its productivity challenges and opportunities and, during 2025/26 and 2026/27, has significantly strengthened the governance, analytical capability and infrastructure required to improve productivity. The Board receives routine information on productivity, benchmarking, transformation delivery and efficiency performance through the Integrated Performance Report, Finance, Performance and People Committee, Transformation Programme governance and Board planning processes. Productivity is considered alongside quality, patient experience and workforce sustainability to ensure that improvements are delivered in a balanced and sustainable way. The Trust makes extensive use of external benchmarking, including NHS England productivity information, Model Hospital data, GIRFT reviews and specialty benchmarking, to identify unwarranted variation and prioritise improvement activity. The Trust's current Reference Cost Index is 0.89, whilst Model Hospital benchmarking reports a cost per weighted activity unit in the top quartile nationally and implied productivity growth in the second quartile. These insights have directly informed the Better Care, Better Value Programme and the prioritisation of major transformation programmes including workforce productivity, theatres, imaging, outpatients and UEC. The Board is satisfied that it has an increasingly robust understanding of the drivers of productivity and where the greatest opportunities for improvement exist, whilst recognising that addressing the underlying drivers of productivity will require sustained organisational and cultural change. The Board has prioritised this work and established the governance, leadership and transformation capability required to support improvement. While it is too early to demonstrate fully realised benefits, the Board believes the actions now underway provide a credible basis for improving organisational capability, productivity and performance over the medium term. Through detailed diagnostic work undertaken during 2025/26 and 2026/27, the Trust has developed a significantly better understanding of the variation between funded establishments, job-planned capacity, deployed workforce and actual productive capacity. This has identified opportunities to improve utilisation, reduce unwarranted variation and lessen reliance on temporary staffing, insourcing and outsourcing arrangements. The Board recognises that achieving these improvements requires sustained behavioural and cultural change across the organisation and that, while governance and analytical capability have materially strengthened, the full operational and financial benefits are yet to be realised.

	Since the 2025 submission, significant improvements have been made to organisational capability. These include implementation of a new Power BI reporting platform and productivity dashboards, establishment of a dedicated Transformation Programme, appointment of a Transformation Director, development of a medium-term planning framework, introduction of an enhanced Accountability Framework and Performance Senate arrangements, and engagement of external expert support to validate and accelerate productivity programmes. These developments have strengthened organisational grip, accountability and the ability to monitor delivery and benefits realisation. The Trust has established a number of major transformation programmes designed to improve utilisation of existing capacity, reduce unwarranted variation and deliver recurrent benefits. Particular focus has been given to workforce productivity, imaging, theatres, outpatients and urgent and emergency care. Emerging evidence of improvement is beginning to be seen in a number of areas, including improvements in outpatient booking performance, health records performance, strengthened workforce controls and increased operational grip across a number of pathways. Digital transformation programmes, including OneEPR, Patient Hub, imaging transformation and automation initiatives, are also expected to contribute significantly to future productivity improvement. While governance arrangements, analytical capability and improvement infrastructure have been substantially strengthened, there is not yet sufficient sustained and verified evidence that these programmes have consistently translated into measurable productivity improvement across the organisation. Improvement remains variable across services, benefits realisation arrangements continue to mature and several major programmes remain in relatively early stages of implementation. The Board is therefore satisfied that it has credible plans, good insight into productivity drivers and improving organisational grip, but recognises that delivery and demonstrable benefits remain at an insufficient level to support a Green assessment at this stage. **Areas for development** To continue embedding the Transformation Programme and Accountability Framework; strengthen benefits realisation across all major workstreams; reduce variation in improvement delivery between divisions; further increase utilisation of funded capacity; and demonstrate sustained, measurable productivity gains through workforce, digital, imaging, theatre, outpatient and urgent care transformation programmes.

VI. Financial performance and oversight

Capability statements	Proposed domain rating
	Amber-Green
16. The trust has a robust financial governance framework and appropriate contract management arrangements 17. Financial risk is managed effectively, and financial considerations (for example, efficiency programmes) do not adversely affect patient care and outcomes 18. The trust engages with its system partners on the optimal use of NHS resources and supports the overall system in delivering its planned financial outturn	The Board considers this domain to be Amber-Green. The Trust has established robust financial governance arrangements, supported by comprehensive reporting, committee oversight and clear financial accountability structures. The Board receives regular information relating to financial performance, workforce, productivity, cost improvement delivery, contracts and risk through the Finance, Performance and People Committee, Audit Committee, Board reporting and Finance Senate arrangements. Financial performance is routinely considered alongside operational delivery, workforce and quality to support informed decision-making. The Trust continues to demonstrate strong financial governance and transparency. Internal Audit provided reasonable assurance over financial controls, whilst external auditors issued an unmodified audit opinion on the financial statements. The Board has responded proactively to the identified value-for-money weakness relating to financial sustainability through enhanced workforce controls, strengthened accountability arrangements, an expanded Transformation Programme and increased focus on recurrent delivery and underlying run-rate performance. Since 2025, further improvements have been made to financial oversight through introduction of the enhanced Accountability Framework, strengthened workforce controls, greater visibility of divisional performance, improved integration of workforce and finance reporting, and increased focus on recurrent delivery, productivity and transformation. The Trust has also continued to play an active role in system financial planning, capital prioritisation and procurement governance, helping ensure organisational plans remain aligned with wider system objectives. The Board recognises that the Trust's historic financial position has been supported in part through non-recurrent measures and that a more sustainable financial position will require recurrent improvements in productivity, workforce utilisation and service delivery. Work undertaken through the Transformation Programme has improved understanding of the underlying drivers of expenditure and productivity variation and is informing a more sustainable approach to financial recovery. The Board has good visibility of the underlying drivers of financial performance and actively monitors workforce growth,

	income performance, productivity, temporary staffing expenditure and cost improvement delivery. Cost improvement governance includes formal quality impact assessment processes and established safeguards to ensure financial decisions do not adversely affect patient care, safety or workforce wellbeing. The Board continues to maintain oversight of significant contractual risks, through established governance and escalation arrangements. The Board nevertheless recognises that significant challenges remain. Delivery of recurrent improvements, workforce cost control, income recovery and financial sustainability continue to require sustained focus. Whilst governance arrangements are strong and organisational grip has improved, the Trust remains reliant on the successful delivery of transformation programmes, workforce controls and recurrent cost improvement schemes to address the underlying structural financial challenge. The Board is therefore satisfied that there is strong financial oversight and a clear understanding of the issues requiring action, but recognises that further evidence of sustained delivery is required before a Green assessment could be justified. **Areas for development** Continue strengthening workforce controls and establishment management; increase recurrent cost improvement delivery; improve income recovery and contract performance; embed transformation benefits realisation; and deliver the actions arising from the external auditor's financial sustainability findings. To continue to expand our commercial strategy to maximise alternative revenue opportunities.

Signed on behalf of the Board of Directors

Chair: _____

Signature: _____ Date: _____

Signed on behalf of the Board of Directors

Chief Executive: _____

Signature: _____ Date: _____

Annex: Using a RAG-rating approach to derive the rating – guidance for providers

The table below sets out the approach providers should take to assess themselves across the six domains. Providers should set out, in their return template, a commentary covering the rationale behind each domain's rating, the evidence referenced in their return and improvements made since the last submission in 2025.

Note that regions will take their own views of capability across the board and will not have the level of detail that providers have – while the evidence here supports the rating it should not be considered automatic or algorithmic in every instance, rather it sets a general benchmark around different levels of capability taking account of the statements.

Leadership and strategy	
Overarching expectation: the trust's board is working well as a unit to oversee the provider and has effective relationships with system partners and stakeholders. The board demonstrates the skills to oversee the delivery of safe, sustainable services, plans effectively and receives the right information to oversee performance and plan delivery as well as monitoring internal and external risk factors.	
Capability statements	**Indicative evidence**
1. The trust's strategy reflects clear priorities for itself as well as shared objectives with system partners 2. **If in breach:** The trust is meeting and will continue to meet any requirements placed on it by ongoing enforcement action from NHSE 3. The board has the skills and expertise to deliver its strategy in the context of the 10-Year Health Plan. 4. The trust is working effectively and collaboratively with its system partners and provider collaborative for	*The following are indicative aspects of each level of capability but should not be seen as exhaustive* **Green** • Strategy is coherent, measurable, aligned with provider's objectives and system priorities. • **If in breach:** all undertakings being delivered; regulatory confidence restored and trust on track to compliance • Board has requisite range of skills; development plans active; succession plans in place; no vacancies > 3 months; no interims > 6 months. • Strong collaboration with local partners; joint planning; shared outcomes delivered. • Regular board reporting on cybersecurity matters, cyber built into Board Assurance Frameworks; digital strategy embedded. **Amber-Green** • Strategy mostly aligned with the provider's objectives but lacks depth or consistent delivery.

the overall good of the system(s) and population served 5. The trust has an effective cyber security strategy and uses digital technology to support improvement	• **If in breach:** On track to compliance with credible plans; minor slippage only. • Skills mostly adequate; some gaps recognised and being addressed. • Good relationships with system partners but inconsistent joint delivery. • Cybersecurity is mostly well-managed, but some areas lack maturity or consistency. • Concerns from independent board governance reviews or CQC well-led findings in past 6 months that are in hand **Amber-Red** • Strategy unclear, outdated, or inconsistently applied. • **If in breach:** Behind trajectory on return to compliance; repeated slippage; weak assurance. • Significant capability gaps at board level; weak development; over-reliance on individuals. • CQC well-led 'requires improvement' • Patchy collaboration; strained relationships; siloed behaviour. • Outdated systems; weak cyber assurance; limited digital use. **Red** • No credible strategy; board direction fragmented. • **If in breach:** persistent non-compliance; enforcement actions escalating; board grip absent. • Board lacks a number of core skills; no development; unsafe capability. • CQC well-led 'Inadequate' • Board isolated; system relationships dysfunctional. • No credible cyber strategy; repeated material incidents.
Quality oversight	
Overarching expectation: the trust's board is set up for effective oversight of the quality of care it provides, monitoring safety, patient experience and using insights from third parties as appropriate. This is evidenced by robust information going to boards, a track record of high-quality care and an open, curious and enquiring approach on quality issues from executives and non-executives alike.	
Capability statements	**Indicative evidence**

6. The organisation has regard to relevant NHS England guidance (supported by Care Quality Commission information, its own information on patient safety incidents, patterns of complaints and any further metrics it chooses to adopt). 7. The trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients 8. Systems are in place to monitor patient experience and there are clear paths to relay safety concerns to the board	*The following are indicative aspects of each level of capability but should not be seen as exhaustive* **Green** • Guidance is used effectively to drive improvements in quality of care. • Established quality governance arrangements in place; confidence in early warning systems; systems of triangulation identify issues before they become critical • Patient experience embedded in discussions around quality; concerns reach board quickly. **Amber-Green** • Mostly compliant with guidance and it is generally used to improve care; • Some gaps in the effectiveness of quality oversight e.g. escalation approaches or learning from close calls. Triangulation is used in places. • Systems in place to monitor patient experience but aren't always used consistently to escalate. **Amber-Red** • Guidance applied inconsistently • Board tends to be reactive to quality issues and actions to address issues are not consistently effective. • Limited insight into patient experience; slow escalation; weak or non-existent triangulation. **Red** • No regard for guidance; blind spots in safety and complaints. • Quality governance failing; evidence from third parties that serious risks are unmanaged. • No reliable patient experience monitoring.
People and culture	
Overarching expectation: the board has an accurate, evidence-based view of the trust's culture and improves the organisation as a place to work. This is evidenced by: staff input being collected, valued and used in board decisions; staff being able to speak up where they have concerns; and staff have access to training and other opportunities to carry out their roles as well as possible.	
Capability statements	**Indicative evidence**

9. Staff feedback is used to both improve the quality of care provided by the trust and monitor and improve staff experience 10. Staff have the relevant skills and capacity to undertake their roles, with training and development programmes in place at all levels 11. Staff can express concerns in an open and constructive environment	*The following are indicative aspects of each level of capability but should not be seen as exhaustive* **Green:** • Evidence that staff feedback drives improvement; strong culture indicated by high scores in staff survey, and Staff Standards measures. • Workforce plans credible; training embedded across the organisation; safe staffing levels in place and reviewed regularly. • Strong speaking-up culture. **Amber-Green** • Feedback collected but not consistently acted on. • Staff skills are mostly adequate but there may be gaps/insufficient depth in key areas. • Generally open culture; some pockets of concern in specific areas of the staff survey. **Amber-Red** • Feedback intermittently collected or when reported is out of date; limited impact on care or management actions. • Persistent gaps in skill levels in key areas; weak/ineffective training; • Evidence that staff groups indicate fear of speaking up; insufficient insights at board level. • Persistently lowest quartile in NHS staff survey **Red** • Persistent lowest 10% in NHS staff survey • Staff feedback ignored; culture deteriorating. • Unsafe staffing; no development in staff. • Evidence of a toxic culture; concerns suppressed.
Access and delivery of services	
Overarching expectation: the board understands the drivers of delivery of core national access standards and uses this to optimise the trust's performance. The Board has extracted the maximum reasonable performance from the resources, workforce and authority available to it, and does all it can to mitigate the impact of external factors.	
Capability statements	**Indicative evidence**
12. Plans are in place to improve performance against the relevant	*The following are indicative aspects of each level of capability but should not be seen as exhaustive*

access and waiting times standards 13. The trust can identify and address inequalities in access/waiting times to NHS services across its patients 14. Appropriate population health targets have been agreed with the ICB	**Green** • Generally delivering on trajectory vs plans. • Clear knowledge/awareness of access and care levels across local geography and demographics in order to identify and address inequalities; can demonstrate measurable improvement. • Targets aligned with system partners; joint delivery plans in place where necessary (e.g. with provider collaborative partners). **Amber-Green** • Plans credible but inconsistent delivery. • Inequalities in access/care identified; actions underway but not yet fully addressing issues. • Targets aligned with system partners; joint delivery plans in place as necessary (e.g. provider collaborative) but not fully implemented or delivering desired outcomes. **Amber-Red** • Under-delivery or deterioration in performance but board cannot demonstrate a credible plan to address it; • Underperforming local peers with no evidence of mitigating factors • Known variation in the quality of and access to services but little or no evidence of addressing them. • Limited engagement across system partners to deliver access standards. **Red** • Behind trajectory on multiple access measures with no credible plan to address. • No insights into inequalities by demographic. • No engagement with rest of system
Productivity and value for money	
Overarching expectation: the board understands how workforce, estate, asset utilisation, activity and provision of care interact at the trust to drive productivity. This is evidenced by a track record of improvements in productivity that are delivered within the wider context of quality of care and patient experience.	
Capability statement	**Indicative evidence**

15. Plans are in place to deliver productivity improvements as referenced in the NHS Model Health System guidance, the Insightful board and other guidance as relevant	*The following are indicative aspects of each level of capability but should not be seen as exhaustive* **Green** • Board understands drivers of productivity and can use them to improve use of resources; provider in top 25% vs peers • Productivity improvements are discussed in the context of quality of care, patient experience and staff wellbeing **Amber-green** • Board has good insights and credible plans but has not fully extracted efficiencies • Performance vs peers flat/declining <12 months **Amber-red** • Board is aware of poor productivity and associated symptoms but has been unable to address them • Declining productivity vs peers >12 months **Red** • Board cannot explain the drivers behind poor productivity, quantify the upside or deliver improvement • Persistent bottom quartile in benchmarks vs peers
Financial performance and oversight	
Overarching expectation: the trust's board demonstrates a good financial understanding and literacy, leads the forecasting and risk management process and has a track record of overseeing the delivery of financial plans and efficiencies and offers strong challenge and insight. There is effective triangulation of workforce, activity and finance in both forward planning and in-year oversight.	
Capability statements	**Indicative evidence**
16. The trust has a robust financial governance framework and appropriate contract	*The following are indicative aspects of each level of capability but should not be seen as exhaustive:* **Green**

management arrangements 17. Financial risk is managed effectively, and financial considerations (for example, efficiency programmes) do not adversely affect patient care and outcomes 18. The trust engages with its system partners on the optimal use of NHS resources and supports the overall system in delivering its planned financial outturn	• Track record of delivering financial plans 'without surprises'; cost improvement programmes are generally delivered • Executives and Non-Executives understand the drivers of the trust's financial position and the board links finance discussions to quality of care, operational demand and workforce • Financial risks are reviewed regularly at board level; • Strong links between trust and system planning functions; supports system outturn. Impact of external factors outside the board's control are minimised **Amber-Green** • Occasionally off-plan, but generally returns to plan over time and by year-end • Cost improvement programs are delivered, but below forecast • Minimal reliance on one-off mitigations to hit plans **Amber-Red** • Understands headline numbers but struggles to explain or control how underlying drivers affect financial performance. • Unplanned reliance on agency/bank staff • Has recurring forecasting inaccuracies and missing planned performance – may rely on one-off mitigations to ameliorate under-performance • Shows weak linkage between workforce, activity levels, quality of care and financial performance. **Red** • Persistent plan under-delivery, with frequent unexpected in-year deterioration in performance vs plan, and little confidence in forecasts. Consistently misses savings targets. • Unplanned reliance on agency/bank staff • Board cannot clearly articulate factors behind the organisation's financial position; weak board-level financial governance, poor scrutiny of financial information and the factors behind performance • Track record of reliance on external support, regulatory intervention or year-end bailouts; little

	connection with system partners on financial planning and investment

Board

East and North Hertfordshire Teaching NHS Trust

Meeting	Public Trust Board		**Agenda Item**	10	
Report title	Clinical Quality Strategy 2026–2030 Summary and Endorsement		**Meeting Date**	11 November 2026	
Author	Director of Quality Deputy Medical Director Medical Programme Director				
Responsible Director	Chief Nurse and 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:

The strategy sets out a proposed four-year direction for manging quality with East and North Hertfordshire Teaching NHS Trust. The Board is asked to consider whether the proposed governance, measures and phased work plan provide a credible basis for implementation. Detailed milestones, accountable owners and resources remain to be agreed; and acknowledge that current governance arrangements require some further transformation to deliver against suggested objectives.

Summary of key issues:

- **Strategic ambition** of the paper is to move to clinical model of care that is driven by clinical outcomes through delivery of highly reliable pathways of care. Manging quality through the lens of outcomes that demonstrate safe, effective and positive experiences for patients and families.
- **Stakeholder conversations** thus far have suggested there is a reality gap between organisational responsiveness when high risk emergency scenarios present, and responsiveness through ‘business as usual’ actions show less reliability within some behaviours and processes. Hence ‘excellence as business as usual’ has been included in the ambition of this strategy.
- **Deliver measurable improvements** in outcomes and reduce avoidable risk through reliable, high-performing pathways, responsive to population needs and inequalities. The phased approach of this strategy would be to test some initial pathways (high volume high risk) in year one and design a sustainable ‘Outcomes driven pathways focused’ operational model that can be implemented as BAU.
- **Five strategic priorities suggested:**
  1. **Safe care and reliable fundamentals**: strengthen core professional care standards, recognition of deterioration, PSIRF learning, risk controls and local safety improvement plans.
  2. **Effective care and clinical outcomes**: agree specialty outcomes and baselines; use NICE, GIRFT, audit and benchmarking; reduce unwarranted variation; improve elective and non-elective pathways.
  3. **Positive patient, family and carer experience**: compassionate and coordinated care, accessible communication, reasonable adjustments, co-production and triangulation of feedback.
  4. **Highly reliable Quality Management System (QMS):** embed quality planning, control, assurance and improvement in the operational rhythm, with huddles,

escalation, dashboards and ward-to-Board triangulation that enables improved oversight of risk or limited assurance that services are safe, effective or provide a positive experience.
5. **Quality through research, digital innovation and partnerships**: translate evidence into practice, manage digital and transformation risks, and develop integrated pathways with system partners.

- **Phased delivery**
  2026/27: establish safety and specialty baselines, agree pathway priorities and KPIs, experience measures, QMS operating model and corporate service dependencies.
  2027–29: test and scale controls, redesign pathways, embed co-production and reporting, evaluate innovations against KPIs and outcome against safe, effective and patient experience and test effectiveness of governance in QMS structures.
  2029/30: demonstrate sustained risk reduction, improved outcomes and experience, QMS maturity and adoption of effective innovations.
- **Oversight and evidence of impact**
  Operational and divisional teams own delivery. The proposed Clinical Standards Board, Clinical Audit & Effectiveness Group, Patient Safety Forum and Quality and Safety Committee provide oversight and escalation, subject to agreed terms of reference. Reporting should include owners, baselines, trajectories, outcomes, patient experience, equity, risk, mitigations and decisions.

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 strategy is intended to improve safety, clinical effectiveness, equitable access and patient/carer experience. Delivery has implications for workforce capability, operational flow, productivity, resources, digital transformation, clinical partnerships and regulatory assurance.

Benefits will depend on funded and owned implementation plans and measurable impact through further transformation of existing quality governance structures.

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 is a risk that competing operational and financial pressures, workforce constraints, variable leadership capability and maturing quality management arrangements will prevent the Trust from fully implementing its Clinical Quality Strategy, resulting in continued variation in care standards, avoidable harm, inconsistent patient experience and failure to achieve sustained improvements in clinical outcomes.

The Board is asked to recognise strategic risks, support the organisational changes and resources required to mitigate them, and seek assurance through measurable improvements in safety, clinical effectiveness and patient experience.

The key consideration is whether the Trust has the capacity, capability and governance arrangements to deliver its strategic ambition while maintaining operational and financial sustainability.

Identified aligned risks to note:

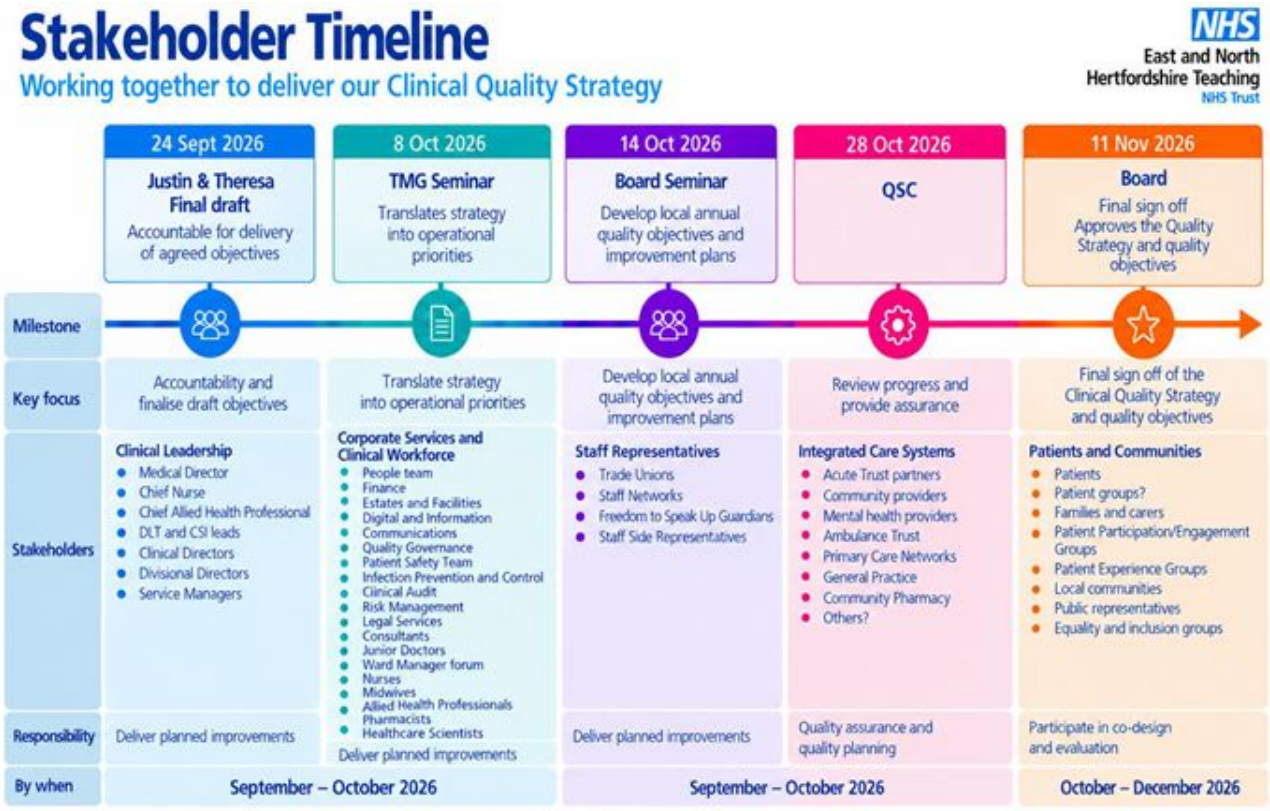
- Health inequalities (BAF 2)
- One EPR and digital clinical risk (BAF 8)
- PTL follow-up (CRR #3364)
- PSIRF engagement capacity (RR #3617)
- Patient engagement, involvement and public accountability (BAF 4)
- Leadership destabilisation and transition (BAF 6)
- Accountability, escalation, ownership & effective performance monitoring framework (BAF 7)
- Digital Transformation & AI (BAF 10)
- Duty of Candour (RR #6410)

Report previously considered at & date(s):

Trust Executive Committee 8/10/26 Board Development Forum 14/10/26 Quality and Safety Committee 29/10/26 Multiple stakeholder engagement has occurred across some, ongoing clinical, operational and governance stakeholder engagement milestones are in progress (please see below).	
Recommendation	The Trust Board is asked to **endorse** the Clinical Quality Strategy 2026–2030 and its ambition to deliver measurable delivery of reliable high quality care through a patient outcomes-driven, pathway-focused approach to deliver care. **Support** the development of a highly reliable Quality Management System, embedded within the Trust's operational rhythm and underpinned by collective leadership and shared accountability. **Agree** the principles of a consistent, outcomes-based assurance framework, enabling the Board to evaluate improvements in safety, clinical effectiveness and patient experience. **Recognise** the organisational and cultural changes required to integrate clinical quality with workforce, operational and financial priorities to achieve excellence as business as usual.

To be trusted to provide consistently outstanding care and exemplary service

Stakeholder Engagement



November
2026

East and North Hertfordshire Teaching NHS Trust

Outcomes driven • Pathway focused • Excellence as business as usual.

Clinical Quality Strategy 2026-2030



Providing high-quality, compassionate care for our community

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Introduction

Quality is experienced by patients through safe, effective and compassionate care, consistently delivered across the entire pathway. This strategy sets out how the Trust intends to make clinical quality a core organising principle of operational delivery imbedded through a programme of assurance and improvement.

The strategy is built around three outcomes: safe care, effective care and positive, compassionate experience. We will pursue them through quality planning, quality control, quality assurance and quality improvement, delivered by clinical leadership and meaningful patient involvement.

The purpose of our strategy

Our strategic aim is to deliver measurable improvements in patient outcomes and reduced avoidable risk through the safe operational delivery of high performing pathways of care.



The challenge we must address

- Increasing patient complexity, frailty and acuity.
- Workforce pressures, constrained resources and competing operational demands.
- Fragmented pathways and multiple digital systems.
- Variation in care standards, access, communication and patient experience.
- Risks arising from transformation, operational flow and changing models of care

Our Trust

The Trust aims to be trusted to deliver high-quality, compassionate care for its community. Quality is a shared responsibility across clinical services, corporate functions, system partners and every stage of the patient journey.

The East and North Herts Production System (ENHPS) provides an existing way to manage and improve services. This strategy connects its operational discipline with the four functions of a Quality Management System and an outcomes-driven, pathway-focused approach.

Our values: Include, Respect, Improve

- Include: listen to patients, carers and staff; address inequalities and make reasonable adjustments.
- Respect: deliver dignity, compassionate communication and psychologically safe learning.
- Improve: act on evidence, reduce unwarranted variation and embed sustainable change.

Our ambition

To be responsive to our community health needs, and work with partners to improve outcomes by delivering researched based innovation and improvements.



National context

The September 2026 planning material aligns the Trust's approach with NHS England's 2026 national quality strategy and the NHS 10 Year Health Plan. The themes identified include strong leadership, listening to communities, data-driven quality management, transparency, digital technology, research, and improvement-focused regulation and QMS capability.

The Trust will translate these themes into local clinical standards, safer pathways, improved outcomes and integrated care across hospital, neighbourhood, primary and community services. We will look beyond our own organisation and the healthcare sector to learn from high-performing systems and industries.

Our principles of quality

1. Outcomes driven

Judge success by clinical outcomes, avoidable harm, patient experience and equity, alongside productivity.

2. Pathway ownership

Understand quality from referral to discharge and beyond, with shared responsibility across organisational boundaries. Clear clinical model and ownership of patient centered journey.

3. Reliable fundamentals of care

Deliver evidence-based care core standards, and delver care through excellent professional standards through responsive multidisciplinary communication, escalation, huddles and visible management as part of routine practice.

4. Compassionate partnership

Listen to patients, carers and staff, and involve them in care management and improvement decisions.

5. Teamwork

Transparency and learning across disciplines imbedded in triangulation of information, sharing variation openly and respond through PSIRF-aligned learning and improvements.

6. Continuous improvement

Test, measure, adapt, embed and spread improvements through a consistent method, demonstrated by improved, safer clinical outcomes and patient experience.

Our Clinical Vision and Future Model of Care

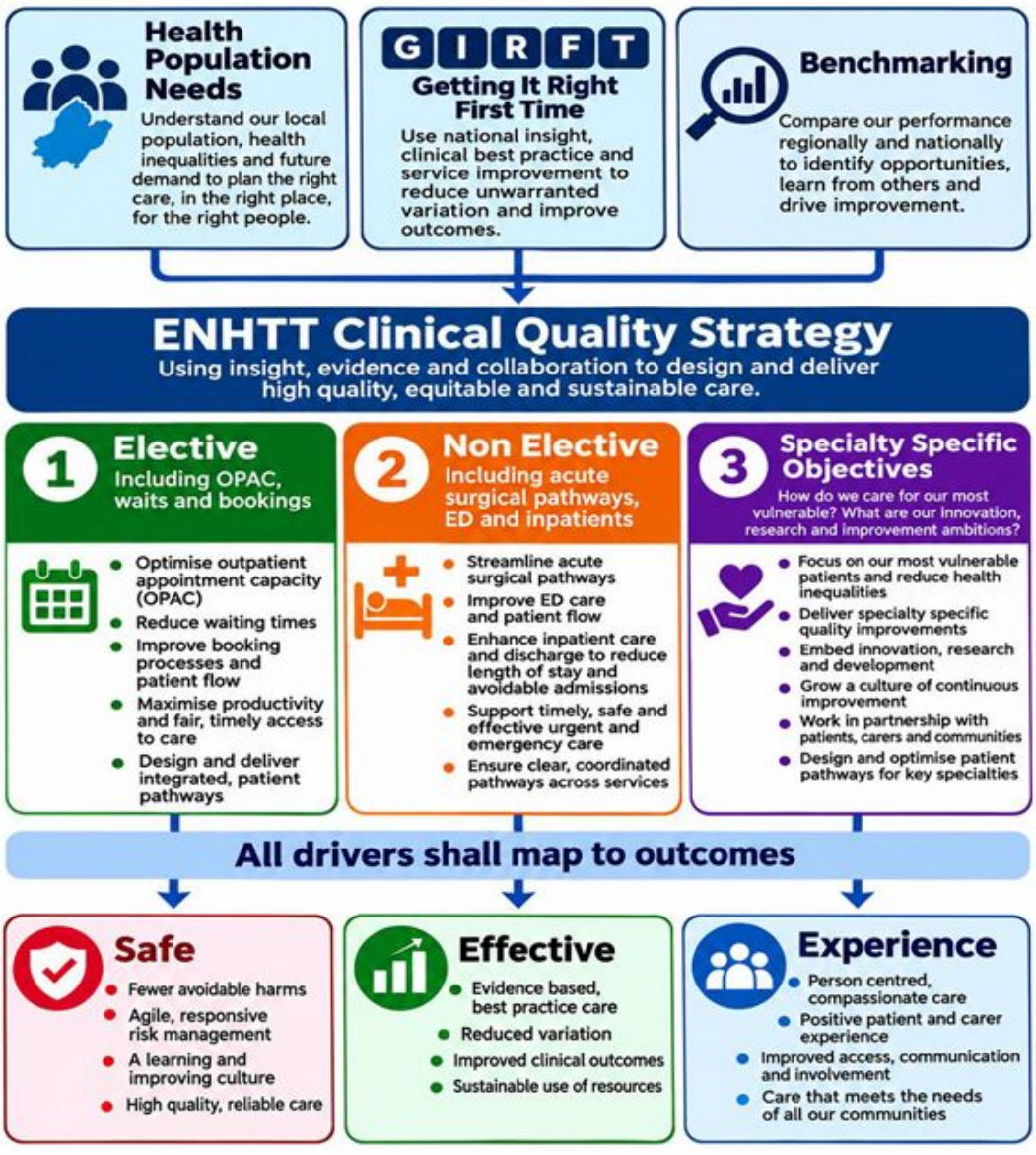
Our ambition is to **design and deliver sustainable, integrated and patient-centred clinical services** that respond to the changing health needs of our population, reduce health inequalities and improve outcomes for our communities.

Through evidence-based clinical practice, innovation and strong partnerships, we will develop future models of care that provide the **right care, in the right place, at the right**

time, ensuring services are accessible, coordinated and responsive to what matters most to patients, families and carers.

We will empower our clinical workforce to deliver **safe, effective and compassionate care**, embedding clinical excellence, continuous improvement and shared accountability across every stage of the patient journey.

Our future clinical model



Our priorities

Five connected strategic priorities translate the three quality outcomes into delivery. Each priority sets out our commitment, key actions, evidence of success and indicative benefits across the strategy period.

1. Safe care and reliable fundamentals

We will reduce avoidable harm through dependable standards of care, earlier identification of deterioration, proportionate escalation and systems-based learning.

We will

- Strengthen fundamental care standards and safety controls in every clinical area.
- Embed reliable recognition, response and escalation for deteriorating patients.
- Use PSIRF learning responses to identify contributory systems factors and inform improvement.
- Prioritise risks affecting vulnerable patients, waiting lists, medicines, transitions and discharge.
- Apply standardised safety improvement plans with named local owners and measurable outcomes.

How we will know we have improved

- Reduction in avoidable harm and priority patient safety risks.
- Improved compliance with agreed clinical safety standards.
- Evidence that learning actions and improvements have changed systems and reduced residual risk.

2026/27	2027/29	2029/30
Agree baseline, priority risks, owners and standard reporting.	Scale tested safety controls and measure risk reduction.	Demonstrate sustained improvements and spread effective practice.
• Safe delivery of professional standards across specialty referral communication channels • Deliver a targeted collaborative approach to safe nursing and midwifery care fundamental priorities: - Nutrition & Hydration	- Embedded Continuous programme improvement programme priorities across core safer, effective and experience quality domains:	• Embedded infrastructure form ward to board that drives oversight and responsive to deliver of safe and effective fundamental

- Skin care - Mobility - Continence Care - (Bowel and Bladder) - Religious cultural needs - Patient handling needs - Safe IV care - Patients able to discuss worries - Reliability of observations - Patients are involved in treatment plan - Pain management - Mouth care • Safe maternity care through improved antenatal risk management. • Imbed local standard work to manage risk through safety huddles, production board, communication and handovers.	- Person centered care - Good Governance - Nutrition and hydration - Mobility and comfort - Personal care needs - Compassionate care - IPC & Environment - Premises and equipment - Dignity and respect - Safer staffing - Complaints - Duty of candor • Delver a mature PSIRF plan that includes a robust improvement response from lessons learnt, and provide substantial assurance of risk reduction.	of care. • Embedded clinical leadership model that thrives on skills and application of excellent quality management deliverables.



2. Effective care and clinical outcomes

We will provide the right evidence-based care at the right time and improve clinical outcomes across specialties and pathways.

We will

- Set specialty-level outcomes and improvement trajectories using NICE, GIRFT, audit and benchmarking.
- Identify and reduce unwarranted variation in access, clinical standards and outcomes.
- Strengthen pathway management from elective and non-elective admission to discharge and community follow-up.
- Balance clinical quality with flow, productivity, financial stewardship and workforce capacity.
- Prioritise transformation using patient impact, care volume, population need and inequality.
- Enable and strengthen our diverse roles to deliver compassionate clinical workforce, leadership and professional practice.
- Co design clinical service configuration and portfolio to deliver pathway needs.
- Apply a consistent pathway approach for every clinical specialty

1. Where are we now?
2. Where are the gaps and variation?
3. What outcomes do we want?
4. What will we improve and by when?
5. Can we demonstrate improvement?

How we will know we have improved

- Clinical outcomes improve against agreed baselines and benchmarks.
- Better adherence to evidence-based standards and lower unwarranted variation.
- Improved timeliness, pathway completion, flow and value without compromising quality.

2026/27	2027/29	2029/30
Agree specialty outcomes and baseline variation.	Implement pathway redesign and evaluate clinical impact.	Demonstrate sustained outcomes and reduce unwarranted variation.
• Establish a robust clinical outcomes database tat include PROMS, PREMS. • Establish health population need data base to drive opportunities • Review current	• Embed reporting of clinical outcomes priority matrix • Identify and respond to health inequalities across identified pathways • Seek assurance across all service pathway reliability	• Deliver a robust workplan against agreed clinical pathway priorities • Embedded reporting mechanism for clinical outcomes and risk to pathway delivery

clinical effectiveness governance reporting structures and templates • Agree high volume /high clinical value pathways to priority Pathways • Seek to reduce unwarranted variation in quality of care out of hours care periods. • Embed and measure improvements from clinical risk learning associated with Learning disability processes, mental health pathways and fundamentals of care. • Introduce SWARM safety learning to patient safety incidents.	• Identify and respond to risk emerging against clinical outcomes • Establish annual pathway priorities for pathway improvements. • Support clinical leadership capabilities to drive quality improvements effectively.	



3. Positive patient, family and carer experience

We will deliver compassionate, dignified and coordinated care, informed by what matters to patients and their families.

We will

- Involve patients and carers in care planning, discharge and decisions affecting them.
- Embed accessible information, reasonable adjustments and responsive communication.
- Triangulate surveys, FFT, PALS, complaints, patient stories and staff feedback.
- Co-produce service and pathway improvements, aligned with the Trust engagement strategy.
- Share visible evidence of how feedback has changed care.

How we will know we have improved

- Patients report feeling heard, involved, respected, supported and informed.
- Improved patient experience indicators and evidence of feedback-led change.
- Reduced inequalities in access and experience across population groups.
- Reduced number of open complaints received

2026/27	2027/29	2029/30
Define experience measures and expectations.	Embed co-production in priority pathways and test improvements.	Demonstrate sustained patient-reported improvements and equitable experience.
• Improve the processes for patient calling appointments and booking processes for appointments • Improve communication processes for our profoundly deaf community • Apply GIRFT recommendations for NON RTT wailing list management processes • Scale Marthas rule service and imbed trust wide call for concern.	• Embed Professional Standards across specialty referrals • Clinical pathways transformation undertaken with service user influence and co-design • Proactively seek assurance form vulnerable patient groups within community. • Imbed a diverse patient safety partner network.	• Embedded, codesign improvements across identified clinical pathways. • Routine reporting and surveillance of health inequities

4. A highly reliable Quality Management System

We will establish a coherent operational rhythm in which planning, control, assurance and improvement operate together, not as disconnected programme

We will

- Integrate quality objectives into business planning, operational performance and workforce decisions.
- Establish reliable daily and weekly clinical controls, including huddles and rapid escalation.
- Introduce standard local and divisional quality reporting templates and meaningful integrated dashboards.
- Use triangulated intelligence to support challenge, action and Board assurance.
- Ensure every improvement priority has a lead, baseline, target, delivery plan and impact review.

How we will know we have improved

- Routine use of QMS methods across clinical pathways.
- More timely recognition and management of quality variation and risk.
- Consistent, comparable reports showing actions, outcomes and residual risk.

2026/27	2027/29	2028/30
Design QMS operating model and minimum reporting standards.	Embed standard controls and reporting across divisions.	Evaluate reliability, maturity and sustainability of the QMS.

Quality Management Operational function	**What teams will do**
Quality management system	Adopt AI functionality across reporting systems to triangulate quality intelligence to provide a systems view gaps and emerging risks to safe, effective and positive experience.
Quality planning	Understand need; define standards, pathway outcomes, capability and measures. Align business planning models with clinical pathways and outcomes intelligence to plan for safe, effective care that delivers compassionate care experience .
Quality control	Use standard work, fundamentals of care, visual management, tiered huddles and early escalation. Apply high level of rigor to setting and monitoring care standards through continuous quality readiness programme of work.

Quality assurance	Triangulate outcomes, audits, incidents, complaints, experience and workforce intelligence. Proactively seek, share and escalate using the agreed 4 levels assurance through agreed governance structures.
Quality improvement	Prioritise risk, test change, measure impact, sustain gains and share learning. Drive safe and effective improvements through the lens of patient, family and carer experience.

5. Quality through research, digital innovation and partnerships

We will use evidence, teaching, technology and cross-system partnerships to improve outcomes, while managing the risks associated with change.

We will

- Translate research and clinical evidence into everyday care and measurable improvement.
- Develop safe digital workflows, interoperable information and data for clinical decision-making.
- Strengthen quality planning for transformation, including prospective assessment of patient risk.
- Work with estates, neighborhood, primary and community partners to support safe, joined-up pathways.
- Build staff improvement capability and share learning through education and collaboratives.

How we will know we have improved

- Evidence-based innovations adopted with demonstrable benefits.
- Improved reliability of digital information and reduced digital-related clinical risk.
- Better continuity, access and outcomes across organisational boundaries.

2026/27	2027/29	2028/30
Identify priority innovations and system dependencies.	Test and evaluate digitally enabled and integrated pathways.	Scale safe innovations and demonstrate clinical and operational benefits.
• Adopt AI functionality within current quality management system • Stabilise and improve digital referral system ALERTIVE • Be highly responsive to Identifying and managing risk associated medical records, application of NEWS, PEWS and MEWS • Clinically lead and design One EPR content and adoption • Enable digital	• Test and imbed application within One EPR platform to safely • Imbed safe, reliable One EPR content that delivers individualised patient care needs • Imbed governance and learning across patient safety incidents learning processes, triangulating with clinical suit, staff feedback and patient feedback.	• Imbed AI across quality management processes to reduce waste and support improvement • Optimise internal and external innovations to strive for excellence, reached based evidence.

capability at the direct point of care/ bedside care to manage clinical risk. • Imbed adoption of Human factors systems thinking curriculum.	• Proactively seek neighborhood care model, and more systems wide, opportunities to improve clinical pathways.	

Governance

Clinical quality will be governed through clear operational ownership and proportionate escalation. The proposed model below must be confirmed against approved committee terms of reference.

Level	Expected responsibility	Proposed cadence
Operational teams	Own local standards, improvement plans, measures and escalation.	Ongoing / monthly
Divisional quality and safety	Review variation, progress, risks, experience and delivery barriers.	Monthly
Patient Safety Forum	Triangulate PSIRF themes and improvement; escalate systemic risk.	Bi-monthly
Clinical Standards Board	The principal operational governance forum for overseeing the reliability of clinical standards, fundamental care and clinical practice across all services.	Monthly
Clinical audit & Effectiveness Group	Provides organisational oversight and assurance that clinical care is evidence-based, meets recognised standards and delivers effective patient outcomes.	Monthly
Quality and Safety Committee / relevant sub-committees **(Patient Experience and Patient Safety)**	Challenge assurance, review outcomes and strategic risk.	Per approved terms of reference
Trust Board	Provide strategic unitary	Per approved reporting cycle

	oversight and challenge; assess whether quality is improving.

Standard reporting expectations

Reports should consistently describe the quality priority, accountable owner, baseline and trajectory, actions delivered, patient outcomes, experience and equity, emerging risk, mitigation, barriers, learning and required decisions.

What success will look like in 2030

This operational delivery of this strategy will drive to demonstrate that our patients are safer, receive more effective care and have consistently positive experience — supported by measurable, sustained improvements across our clinical pathways.

Executive assurance and reporting

- An agreed baseline and measurable outcomes across all three domains.
- Evidence of improvement against agreed trajectories and clinical standards.
- Clear accountability for delivering improvements.
- Triangulated clinical, operational and patient experience intelligence.
- Evidence that improvements are sustained and translate into better outcomes.

1. How will we know care is safer?

What we will measure	Evidence of improvement
Patient harm and avoidable mortality	Reduction in avoidable harm and mortality
Unwarranted safety variation	Reduced variation in clinical risks across pathways
Clinical safety outcomes	Improved outcomes against agreed national standards
Patient and staff involvement	Increased involvement in identifying and reducing risks
PSIRF learning and improvement	Timely learning responses, implemented actions and demonstrated risk reduction
Equity of access and outcomes	Reduced inequalities in patient safety and outcomes

2. How will we know if care is more effective?

What we will measure	Evidence of improvement
Clinical outcomes	Improvement against specialty baselines and agreed trajectories
Evidence-based care	Greater compliance with NICE, GIRFT, specialty standards and clinical audit
Unwarranted clinical variation	Reduced variation between pathways, services and patient groups
Timeliness and access	Improved access, pathway completion and timely interventions
Productivity and value	Less duplication, delay and avoidable resource use

3. How will we know our patients, family and carers have a positive experience?

What we will measure	Evidence of improvement
Heard	Patients and carers report feeling listened to and understood
Involved	People report involvement in decisions, care planning and discharge
Respected	Patients experience dignity, compassion and clear communication
Needs met	Individual needs, preferences and reasonable adjustments are addressed
Confident	Patients understand what happens next and experience coordinated care and transitions

*Evidence will be triangulated from FFT, surveys, PALS, complaints and compliments, patient stories, carer feedback and co-design activities.

Appendix 1: Work plan 2026–2030

Indicative phases: 2026/27 establishes foundations; 2027/28 embeds and scale; 2028/29 evaluate and sustain. Detailed milestones, owners and resources require agreement.

Priority	2026/27: establish	2027/29: embed and grow	2029/30 sustain
Safe care	Agree safety baselines and local improvement plans.	Test and scale reliable controls.	Demonstrate sustained risk reduction.
Effective care	Agree specialty outcomes and priority pathways.	Redesign priority pathways.	Benchmark and sustain improved outcomes.
Positive experience	Set measures and co-production expectations.	Deliver patient-led improvements.	Evaluate experience and equity.
QMS	Design operating model and reporting templates.	Embed control and assurance routines.	Assess QMS maturity and reliability.
Innovation and partnerships	Identify research, digital and partnership priorities.	Evaluate innovations and integrated pathways.	Spread evidence-based changes.

Board

East and North Hertfordshire Teaching NHS Trust

Meeting	Public Trust Board		**Agenda Item**	11	
Report title	People Strategy		**Meeting Date**	11 November 2026	
Author	Chief People Officer				
Responsible Director	Chief People Officer				
Purpose	**Assurance**	☐	**Approval/Decision**	☒	
	Discussion	☐	**For information only**	☐	
Proposed assurance level (*only needed for assurance papers*)	**Substantial assurance**	☐	**Reasonable assurance**	☐	
	Partial assurance	☐	**Minimal assurance**	☐	

Executive assurance rationale:

N/A.

Summary of key issues:

The People Strategy 2026-2029 for ENHT is clustered under four headings: care, belonging, growth and innovation, and seeks to provide clarity and assurance that the challenges and opportunities available to ENHT are supported by a credible and considered plan for our people.

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 People Strategy should make a positive impact on all of the above.

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*

Having skilled and motivated colleagues, doing the right thing with an open mind and positive mindset should deliver all of the objectives above.
BAF 5,6 and 7 refer.

Report previously considered at & date(s):

People and Culture Committee (PCC) 1 September 2026.

Recommendation	The Board is asked to sign-off the Strategy.

To be trusted to provide consistently outstanding care and exemplary service

NHS
East and North Hertfordshire Teaching
NHS Trust

People Strategy

2026 – 2029

Building a caring, inclusive and innovative workforce for the future



#ProudToBeENHT

East and North Hertfordshire Teaching NHS Trust
Draft for consultation — October 2026

1 ENHT People Strategy 2026-2029.

Contents

1. Why we need a People Strategy
2. Our challenges and opportunities
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6. Our four priorities in detail
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7. Measuring success

1. Why we need a People Strategy

An effective People Strategy creates the foundation for delivering outstanding patient care by supporting a workforce that feels valued, included and empowered.

By focusing on care, belonging, innovation and growth, the strategy promotes a compassionate culture where staff wellbeing is prioritised, diversity is celebrated, and everyone feels they belong.

It also encourages continuous learning, collaboration and innovation, enabling colleagues and services to adapt and improve in response to changing healthcare needs.

Through investing in our people and creating opportunities for development, we can build a resilient workforce that is equipped to deliver high-quality, sustainable care for the future.

IN SUMMARY

The People Strategy is the workforce transformation strategy for East and North Hertfordshire Teaching NHS Trust. It will create the culture, capability and workforce model required to deliver better patient outcomes, greater productivity and sustainable services within the financial and workforce constraints of the future.

This strategy has been developed to take account of emerging national thinking, including the NHS Staff Standards, the NHS Leadership and Management Framework, the Neighbourhood Health model, the current Equality, Diversity and Inclusion strategy and the NHS 10 Year Health Plan.

2. Our challenges and opportunities

Four themes shape the environment in which this strategy will be delivered.

Managing change at pace, and with care

We need to embrace change and innovation at a pace that meets the Trust's need for delivery and efficiency, while taking colleagues with us and demonstrating care and consideration for their welfare. There are significant opportunities to maximise digitalisation and automation, and to use innovation to drive improvement.

We will only realise that benefit, and ultimately improve patient experience, if we manage change well and take colleagues on the journey with us. Failure to do so can lead to burnout, work-related stress and change fatigue.

Building a genuinely diverse and inclusive culture

A diverse and inclusive culture is critical to ensuring that all of our colleagues — and ultimately our patients — see the Trust as a place for them.

We have 104 nationalities across the Trust. However, we do not yet see the richness of that diversity represented at all levels, and we recognise that we need to do more to identify and remove bias and barriers so that everyone can thrive: with every colleague feeling safe, supported and developed, with the tools they need, and within an environment that brings out the best in everyone.

Encouraging innovation and accountability

Removing duplication and waste activity, searching for better ways of working (including but not limited to digital solutions), and holding ourselves and others to account for doing what we say we will do all underpin the overall success of the Trust.

Through the ENH Production System, and meaningful, honest performance conversations, we will deliver value by challenging traditional thinking and demonstrating our commitment to the best service and the best patient outcomes.

Securing a sustainable workforce and operating model

We must build and retain a robust, affordable and future-proof workforce model that limits reliance on bank and agency staff, and aligns colleague deployment to when and where patients need our services most.

We must also ensure our operating model — how we are designed — delivers the services required by today's demands, while adapting to the requirements of the NHS 10 Year Health Plan and the Neighbourhood Health model.

3. What this strategy will deliver

The strategy is designed to deliver five organisational outcomes.

Outcome	What it means for the Trust
Outstanding care	A healthier, more engaged and stable workforce delivers safer, outstanding patient care and experience.
Sustainable workforce	The right skills, roles and capacity are deployed where patients need them, with reduced vacancies and temporary staffing dependency.
Higher productivity	Digitalisation, automation, skill-mix redesign and the removal of waste release capacity and improve output per WTE.
Stronger organisation	Leaders are capable, accountability is embedded, people feel they belong, and the Trust has a strong, diverse internal talent pipeline.
Financial sustainability	Reduced temporary staffing, turnover, overtime and inefficient processes generate measurable cost avoidance and productivity gains.

Measures are set out in section 7, with outputs and outcomes reported to the People and Culture Committee.

5 ENHT People Strategy 2026-2029.

4. Our People Strategy on a page



6 ENHT People Strategy 2026-2029.

5. Our vision and four priorities

> **“To be trusted to provide consistently outstanding care and exemplary service”**

We have made strong progress in developing and supporting our workforce through improved recruitment, learning, talent management and equality, diversity and inclusion initiatives.

However, challenges remain around workforce capacity, specialist staffing and future service demands, including the changes arising from the NHS 10 Year Health Plan.

Our People Strategy focuses on four priorities — Care, Belonging, Innovation and Growth — to build a resilient, inclusive and future-ready workforce that supports outstanding patient care and organisational transformation.

Care

Looking after our people, enabling them to provide outstanding care to our patients, with quality health and wellbeing support for everyone.

Belonging

Creating an inclusive culture, with a particular focus on tackling the discrimination that some staff face and addressing the increase in violence and aggression faced by our colleagues.

Innovation

Making effective use of the full range of people's skills and experience, ensuring that what we do is underpinned by digitalisation, automation and innovation.

Growth for the future

Defining the capabilities we need for the future and providing an operating model that delivers those capabilities into the Trust in the most cost-effective way.

6.1 Care

STRATEGIC OUTCOME

We will create a healthy, supported and accountable workforce where colleagues feel safe to speak up, leaders enable people to thrive, and everyone is better equipped to deliver outstanding care.

A healthy, supported and high-performing workforce where colleagues feel safe, valued and empowered to thrive, enabling them to deliver safe, compassionate and consistently outstanding care for our patients.

In short: if we look after our colleagues, they are better able to deliver great patient care.

What this will deliver

- **Wellbeing and resilience:** improved wellbeing, resilience and reduced sickness absence.
- **Leadership and management:** stronger, more confident leadership and management at every level.
- **Engagement and retention:** greater engagement and improved retention of colleagues.
- **Speaking up:** a culture where colleagues feel confident to speak up, have meaningful conversations and take accountability at the right level.

What we will do

- **Create one team.** We will create one team ENHTT, joined together under a mission to provide the highest level of care for our patients. Our staff survey has told us there is work to do in creating a health and safety climate in which colleagues can call things out when we fall below our own high standards, knowing that all feedback is given and received with positive intent and in a way that protects the individual, the Trust and ultimately our patients.
- **Strengthen the ways colleagues can raise concerns.** We will continue our Healthy Teams programme and proactively use insight from Freedom to Speak Up, Staff Side and the People Partnering team to provide a range of ways in which colleagues can raise issues that concern them and feel safe and supported in doing so.
- **Equip every leader to hold better conversations.** We will equip each leader to be confident and capable in holding wellbeing, stay and performance conversations that support, engage and retain colleagues, providing timely and honest feedback with the intention of support and improvement. This will be offered in a bite-sized way, reflecting the changing needs and preferences of learning.
- **Embed accountability at the right level.** We will create a culture of accountability at the right level, ensuring that decisions are not escalated to senior leadership unnecessarily.
- **Act on staff feedback.** We will review and act on our annual NHS Staff Survey, and pulse survey feedback by integrating it into service and local operational plans.
- **Manage change well.** We will develop and implement a Change Framework setting out how we manage change at the Trust, providing opportunities for manager skill and confidence building and ensuring that people remain at the heart of any change programme.

- **Improve access to support.** We already provide a range of ways for colleagues to access the help available. We will strengthen access to that support so colleagues can keep well and get well when they need to.
- **Extend our mental wellbeing offer.** To complement the existing offer, we have formed a collaborative partnership between five local NHS trusts and the Integrated Care Board, through the Trust's Hospitals' Charity, to provide a virtual group-based mental wellbeing programme designed to give early, accessible support to colleagues experiencing stress, anxiety, burnout or mental health challenges.

6.2 Belonging

STRATEGIC OUTCOME

We will create an inclusive and psychologically safe organisation where every colleague feels they belong, experiences fairness and respect, and has the opportunity to thrive, develop and reach their full potential.

Creating a culture of belonging is essential to ensuring that all staff feel safe, valued and able to contribute fully at work. We will continue to deliver and refine our existing Equality, Diversity and Inclusion strategy.

What this will deliver

- **Inclusion and experience:** improved NHS Staff Survey inclusion and speaking-up indicators.
- **Representation:** increased diversity across grades, particularly at Band 8 and above.
- **Progression:** improved internal promotion and succession coverage.
- **Talent:** stronger career pathways and progression for underrepresented groups.
- **Fairness and safety:** reduced discriminatory barriers and improved experience of workplace processes, including sexual safety and investigations.
- **Celebrating diversity:** support and celebration of the wealth of diversity within the Trust, particularly our internationally recruited nurses.

What we will do

- **Define what talent means here.** We will clearly define what talent means at the Trust, working to understand and remove organisational barriers while supporting individuals to thrive and become the best version of themselves.
- **Remove barriers to progression.** We will actively work to understand and remove the individual barriers that prevent underrepresented groups from growing and developing their careers, using data to identify areas of focus and insight from our Staff Network Groups to refine, test and improve our processes, removing bias and discriminatory practice.
- **Make recruitment demonstrably inclusive.** We will use triangulated data and insight to identify areas of potential discrimination in recruitment, further embedding the Recruitment and Selection Ambassador scheme to achieve greater diversity at all levels, particularly in senior management.
- **Build visible career pathways.** We will identify succession plans for key roles and career pathways for colleagues who want to grow and develop within the Trust, providing nurturing environments in which they can thrive.
- **Strengthen our Staff Network Groups.** We will review, support and continuously improve our Staff Network Groups, ensuring they evolve and provide the best supporting service, representing the diversity of our colleagues as well as unifying our colleague population.
- **Advance sexual safety.** We will develop priorities under the Sexual Safety Charter, ensuring that every colleague has a safe and supportive experience at work every day.
- **Improve workplace investigations.** We will improve workplace investigations and their impact on employee wellbeing. Recognising that some formal processes are necessary, we will strive to reduce the time they take to conclude, with all parties treated with respect and dignity. We will also continue to review the impact of people management policies to ensure they are not adversely affecting particular staff groups.

6.3 Innovation

STRATEGIC OUTCOME

We will build a digitally confident, innovative and continuously improving organisation, making better use of our people, skills and technology to simplify work, remove waste and deliver more efficient, outstanding care.

We will invest in the development of digital skills and the effective use of automation, supporting the move from analogue to digital. This includes a review of the services we continue to offer.

What this will deliver

- **Productivity:** increased activity and output per WTE, and measurable efficiency gains.
- **Digital adoption:** increased use of digital solutions, automation and emerging technologies.
- **Service redesign:** successful implementation of zero-based service design and future workforce models.
- **Learning and improvement:** stronger participation in learning, and evidence that lessons learned translate into changes in practice.
- **Process efficiency:** increased process automation and reduced duplication, waste and unnecessary administration.

What we will do

- **Pilot zero-based service design.** We will pilot a new methodology, zero-based service design, enabling a critical review of the services we currently offer and the building of a service model for the future that reflects the NHS 10 Year Health Plan and the move to a neighbourhood health model.
- **Align the workforce plan to new models of care.** Linked to zero-based service design, our workforce plan will reflect the need for 'left shift' and consideration of the right skills required to deliver the new neighbourhood model, and where services best fit.
- **Build a reputation for continuous learning.** We will develop a reputation as a Trust of continuous learning, encouraging a growth mindset, curiosity and trying new things.
- **Maximise the ENH Production System.** We will continue to use and maximise the principles of the ENH Production System/change and transformation methodology, ensuring that simplicity and the removal of waste and unhelpful processes underpin all of our services, making the job of the manager easier and more intuitive.
- **Embed lessons learned.** We will enhance our learning culture, supporting innovation and embedding lessons learned when things do not go as planned, ensuring those lessons inform changes to policy and process and that colleagues feel safe to call things out.
- **Digitise our people processes.** We will ensure our people processes are robust, compliant and timely, introducing and embedding digital solutions to enable efficiency and objectivity.
- **Normalise digital ways of working.** We will harness and normalise digital solutions to streamline, empower and speed up our ways of working, maximising the tools we already have — for example Copilot — using curiosity as a driver for improvement.

6.4 Growth

STRATEGIC OUTCOME

We will build a sustainable, future-ready workforce with the right skills, leadership and capability to meet changing patient needs, supported by an affordable and flexible operating model.

To grow for the future, we will define and deliver the workforce capabilities our Trust needs through a cost-effective, insight-led operating model. We will develop and build the right clinical skill mix, reflecting the needs of our Clinical Strategy, to meet the needs of a growing and increasingly complex population, aligning roles and rostering to patient demand in order to reduce reliance on temporary staffing and improve resilience.

What this will deliver

- **Workforce sustainability:** reduced critical vacancy rates and improved retention in priority workforce groups.
- **Leadership and talent:** increased internal promotion and succession coverage, reducing reliance on external recruitment.
- **Capability:** improved skills gap analysis, leadership development participation and digital confidence.
- **Workforce productivity:** improved activity and output per WTE through better skill mix, job planning and rostering.
- **Affordability:** reduced bank and agency dependency, overtime and workforce cost per patient.
- **Future readiness:** sustainable clinical career pathways and workforce models aligned to changing population needs and future models of care.

What we will do

- **Develop leaders at every level.** We will implement, embed and develop our leaders and managers at all levels through our management interventions and leadership development programmes, using the refreshed NHS Leadership and Management Competency Development Framework with clear milestones for progression.
- **Give timely, honest feedback.** We will provide timely and honest feedback using our Kindness and Civility Framework, ensuring that every manager and leader understands their strengths and areas for development, and is supported to become the best version of themselves.
- **Align policy to a just and learning culture.** We will ensure our employment processes and policies are continuously reviewed, improved and aligned to a just, learning and restorative culture and to the Patient Safety Incident Response Framework (PSIRF).
- **Improve job planning and rostering.** We will continue to support job planning, including different approaches to rostering and agile and flexible working, ensuring the most appropriate and affordable rosters are in place to cover core shifts according to patient demand.
- **Review clinical skill mix.** We will review, assess and make the necessary changes to the skill mix through which we provide clinical services, with patient safety and experience at the heart of any changes made.

- **Deliver the Resident Doctor 10 Point Plan.** We will continue to deliver the Resident Doctor 10 Point Plan, using the learning to improve services for all colleagues.
- **Build digital confidence.** We will support managers and colleagues to understand how to access and use the digital solutions available, building competence and confidence and recognising that colleagues may have different starting points.
- **Nurture curiosity.** We will encourage and nurture curiosity to ask whether things can be done more efficiently and effectively, learning from other trusts and other sectors and embracing continuous improvement as the norm.
- **Plan for a changing population.** We will build a plan that takes a long-term view of the requirements of our changing population and the complexity of their needs, meeting those needs with the most appropriate and affordable skill mix — which may differ from our current workforce composition — including the creation of sustainable nursing career pathways.
- **Prepare for the Future Workforce Solution.** We will undertake readiness activities in advance of the implementation of the Future Workforce Solution, providing a firm foundation on which to implement the new system and maximise its benefits.

7. Measuring success

This strategy is successful if it improves patient outcomes, increases productivity, reduces workforce risk, strengthens leadership capability and delivers financial sustainability. Outputs and outcomes will be reported to the People and Culture Committee.

7.1 Trust-focused success factors

Success factor	What it means	Indicator	Baseline
Retention of critical staff	Reduced turnover in hard-to-recruit and critical, primarily clinical, roles.	Retention rate in priority workforce groups.	7.14%
Reduction in workforce gaps	Fewer vacancies impacting service delivery.	Critical vacancy rate.	2.42%
Reduced bank dependency	A more sustainable workforce and lower costs.	Bank spend as a percentage of total pay bill.	6.85%
Better patient experience	Sufficient nursing staff providing patient care.	Inpatient survey (quarterly).	Q2 – 87.72
Culture and engagement	NHS Staff Survey results	Annual engagement score	6.83 (2025) Best 7.36 Worst 5.92 Average 6.74
Leadership and talent pipeline strength	Reduced reliance on external recruitment for senior roles.	Internal promotion and succession coverage rates.	Currently not captured
Visible diversity at senior levels	Talent initiatives, targeted recruitment campaigns and removal of organisational barriers.	Number of colleagues at Band 8 and above from underrepresented groups.	29.7% of Band 8a+ v 45.1% of total workforce
Workforce wellbeing and resilience	A healthy workforce supports sustainable service delivery.	Stress-related absence and wellbeing measures.	24.8% of all sickness absence is anxiety/stress/depression related

NB There are additional detailed metrics that sit behind both people and patient; not all have been included here.

Board

East and North Hertfordshire Teaching NHS Trust

Meeting	Public Trust Board		**Agenda Item**	12	
Report title	WRES Report 2026		**Meeting Date**	11 November 2026	
Author	Head of Colleague Development and Experience				
Responsible Director	Director of People				
Purpose	**Assurance**	☒	**Approval/Decision**	☒	
	Discussion	☐	**For information only**	☐	
Proposed assurance level (*only needed for assurance papers*)	**Substantial assurance**	☐	**Reasonable assurance**	☐	
	Partial assurance	☒	**Minimal assurance**	☐	

Executive assurance rationale:

ENHT's 2026 WRES data (April 2025 to March 2026) shows a mixed position with some work to do:

Improved: BAME workforce representation rose to 45.26% (national: 30.7%), harassment from staff fell to 25.48%, and BAME voting Board membership rose to 15.4%, though still below the national 18.2%.

Of most concern: White candidates are now 1.92 times more likely to be appointed from shortlisting, worse than the national 1.77 and worsening every year since 2020/21. BAME staff also report more discrimination (16.02%) and abuse from patients and the public (32.21%) than White staff, and lower confidence in equal career progression (49.76%).

Response: Priorities for 2026/27 are fairer recruitment, equal access to development, senior and Board diversity, and debiasing HR processes. Of 30 actions, 8 are Green, 22 Amber and none are Red, overseen by the Inclusion and EDI Steering Group.

Summary of key issues:

The Trust continues to meet its statutory requirements by providing annual data and developing actions to address the issues highlighted by the report

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**	☐

As the People Strategy emerges and with new approaches to Inclusion / EDI this is the first refreshed action plan. It will sit in the Inclusion, Change and Experience team and be aligned to other actions related to WRES, gender pay gap (GPG), Staff Survey, Mann Report and other associated expectations

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*

Failure to make progress on these areas can result in colleagues feeling demotivated, under represented and impact their motivation to provide high-quality patient care. There is also a potential negative reputational impact externally.

Report previously considered at & date(s):

At the People and Culture Committee.

Recommendation	Agree report and publish

To be trusted to provide consistently outstanding care and exemplary service

2026
WRES Report

-

East and North Hertfordshire Teaching NHS Trust

Workforce Race Equality Standard (WRES) Report 2026



1. Introduction and Scope

Since its introduction in 2015, NHS England's Workforce Race Equality Standards (WRES) programme has been providing direction and tailored support to the NHS, enabling organisations to continuously improve their performance. The WRES has required NHS trusts to annually self-assess against nine indicators of workplace experience and opportunity in relation to race, and to develop and implement robust action planning for improvement.

This report focusses on the data from ENHT and shows a comparison against the national dataset.

ENHT has committed to making anti-racism a reality[1], incorporating respect, dignity and human rights, and by ensuring equitable opportunities free from discrimination for people with protected characteristics as defined by the Equality Act 2010.

ENHT is committed to becoming a leading organisation in promoting equality, diversity, and inclusion in Hertfordshire, by creating a place where every person in our organisation is responsible for enabling an environment which is supportive, fair, and free from discrimination.

This report seeks to understand trends and patterns of inequality and outlines detailed information about our Black, Asian, and Minority Ethnic (BAME) staff, covering the period April 2025 to March 2026, and documents our progress, continuing work, and actions still to deliver equity in relation to the national NHS Workforce Race Equality Standard (WRES).

2. Context

The WRES contains nine indicators covering workforce data, national NHS Staff Survey results and Trust Board composition as follows:

1. Percentage of staff in each of the NHS pay bands 1-9, plus those on Medical & Dental and Very Senior Managers contracts (including Executive Board members) compared with the percentage of staff in the overall workforce
2. Relative likelihood of staff being appointed from shortlisting across all posts
3. Relative likelihood of staff entering the formal disciplinary process
4. Relative likelihood of staff accessing non-mandatory training and CPD
5. Percentage staff experiencing harassment, bullying or abuse from patients, relatives, or the public in the last 12 months (from NHS Annual Staff Survey)
6. Percentage staff experiencing harassment, bullying or abuse from staff in the last 12 months (from NHS Annual Staff Survey)
7. Percentage staff believing that the organisation provides equal opportunities for career progression or promotion (from NHS Annual Staff Survey)
8. Percentage staff having personally experienced discrimination at work from manager, team leader, or other colleagues in the last 12 months (from NHS Annual Staff Survey)

[1] Making anti-racism a reality, East of England Race Strategy 2021 (Appendix 1)

9. Percentage difference between the organisation's Board voting membership and its overall workforce.

All work undertaken in 2026/27 is underpinned by the current People Strategy four pillars (Work, Grow, Thrive & Care together) and by working together through and with Staff Networks.
We continue to ensure our networks flourish, and we recently launched a United Networks programme bring the networks together to jointly tackle shared challenges and increase their voice and impact.
We continue to champion the principles of intersectionality, whilst continuing delivery of the Inclusion / EDI agenda.
As opportunities arise at Board and senior level, we will increase diversity.
Our freedom to speak up guardian (FTSU) work and people policy reviews continue to support and enable staff to speak up about their experiences and to confidentially raise concerns to be addressed and resolved.

Executive Summary

Emma to add

NOTE : The action plan attached to this WRES Report will be aligned with the WDES, Mann Response, ENH EDI Strategy actions to form a cohesive and aligned plan. The work will also ne integrated into our emerging progress in responding to the NHS Staff Standards and the NHS Leadership and Management Competency Framework. In 2027 a new post will support Inclusion and Change bringing a change and transformation skill set to the work to enable our improvements to embed and be sustained.

3. Current Workforce Race Equality Standard (WRES) metrics

ENHT data from 2020/21 to 2025/26 is shown in the table below with National Data for reference.

Workforce Race Equality Standard (WRES) Indicators	East & North Herts (ENHT) WRES Data								WRES Comparison to National Data
	Staff	ENHT 2020/2021	ENHT 2021/2022	ENHT 2022/2023	ENHT 2023/2024	ENHT 2024/2025	ENHT 2025/2026	ENHT WRES Progress in comparison to last year	National WRES 2022/2023
WRES 1 – Overall workforce % by Ethnicity	White	59.60%	56.70%	55.20%	53.36%	51.75%	49.91%	Increase in Workforce Diversity	65.4%
	BAME	32.60%	34.50%	37.70%	40.84%	42.18%	45.26%		30.7%
	Unknown	7.70%	8.80%	7.10%	5.81%	6.06%	4.83%	Improvement	3.9%
WRES 2 - Relative likelihood of White staff being appointed from shortlisting compared to BAME staff		1.32	1.39	1.34	1.43	1.59	1.92	Further work to be done	1.77
WRES 3 - Relative likelihood of BAME staff entering the formal disciplinary process compared to White staff		2.25	1.41	1.47	1.96	0.91	0.93	No significant change	1.11
WRES 4 - Relative likelihood of White staff accessing non-mandatory training and CPD compared to BAME staff		1.22	1.37	0.86	0.80	0.86	0.97	Deterioration, but still below 1.00	1.02
WRES 5 - Percentage of BAME staff experiencing harassment, bullying or abuse from patients, relatives, or the public in last 12 months		BAME 30.6% White 25.9%	BAME 34.6% White 30.4%	BAME 32.2% White 32.2%	BAME 27.0% White 27.4%	BAME 31.04% White 25.77%	BAME 32.21% White 25.59%	Further work to be done	BAME 29.16% White 23.54%
WRES 6 - Percentage of BAME staff experiencing harassment, bullying or abuse from staff in last 12 months		BAME 32.7% White 25.1%	BAME 31.1% White 26.5%	BAME 30.8% White 26.5%	BAME 26.8% White 24.9%	BAME 26.23% White 22.10%	BAME 25.48% White 21.02%	Improvement	BAME 23.39% White 19.58%
WRES 7 – Percentage of BAME staff believing that Trust provides equal opportunities for career progression or promotion		BAME 69.9% White 83.8%	BAME 49.2% White 55.0%	BAME 50.2% White 54.7%	BAME 51.1% White 54.4%	BAME 50.50% White 59.02%	BAME 49.76% White 50.91%	Further work to be done	BAME 49.7% White 55.85%
WRES 8 - Percentage of BAME staff personally experienced discrimination at work from Manager/team leader/other colleagues		BAME 19.6% White 7.2%	BAME 16.8% White 7.4%	BAME 15.8% White 8.9%	BAME 16.7% White 8.1%	BAME 15.48% White 7.48%	BAME 16.02% White 6.57%	Further work to be done Improvement	BAME 13.93% White 6.51%
WRES 9 - Percentage of voting members of the Board representation by ethnicity	White	0.0%	8.3%	0.0%	9.1%	10.0%	15.4%	Improvement	18.2%

4. Progress Summary:

We have noted improvements in 3 of the 9 metrics (WRES 1, 6 and 9).

2 have deteriorated but remain favourable to BAME staff (WRES 3 and 4)

4 have deteriorated and will require further work to be done (WRES 2,5,7 and 8)

Key Improvements:

- **Workforce Diversity:** BAME representation in the ENHT workforce increased from 42.18% to 45.26%.
- **Harassment, Bullying and Abuse from Staff:** Percentages of BAME staff experiencing harassment, bullying or abuse from other members of staff has reduced from 26.23% to 25.48%.
- **Voting Board Representation:** BAME representation of Voting Trust Board members rose from 10.0% to 15.4%.
- **Data Quality:** The percentage of workforce records with 'Unknown' ethnicity has reduced from 6.06% to 4.83%

Ongoing Challenges:

- **Recruitment Disparity:** The gap in appointment likelihood between White and BME candidates continues to widen from 1.59 to 1.92.
- **Harassment, Bullying and Abuse from Patients/Relatives:** Percentages of BAME staff experiencing harassment, bullying or abuse from other members of staff has increased from 31.04% to 32.21%
- **Career Progression:** The percentage of BAME staff believing career progression in the Trust is equal deteriorated from 50.5% to 49.76%
- **Discrimination from Managers or Colleagues:** BAME staff reported an increase in discrimination from 15.48% to 16.02%.

Whilst some of the changes are small, it is worth looking back across several years' worth of data to note ongoing trends:

WRES 1 : ✓ Continued increase workforce diversity since 2020 (better than National data)
WRES 2: x Continued deterioration of likelihood of BAME staff being shortlisted (worse than National data)
WRES 3: ✓ Ongoing improvements in likelihood of BAME staff entering a disciplinary process (better than National data)
WRES 4: ✓ Ongoing improvements in likelihood of BAME staff accessing non-mandatory training (better than National data)
WRES 5: x Fluctuations in reporting of being harassed, bullied of abused by patients or relatives (worse than National data)
WRES 6: ✓ Ongoing noticeable improvements in BAME staff reporting experiencing harassment, bullying or abuse from staff (worse than National data)
WRES 7: x Significant deterioration over a period of year in relation to equal opportunities for career progression and promotion for BAME staff. (same as National data)
WRES 8: x Fluctuations in BAME staff reporting discrimination from Manager or colleagues (worse than National data)
WRES 9: ✓ Ongoing improvements in BAME representation in the Voting Board (worse than National data)

5. Our priority areas of focus 2026/27

From our 2026 WRES report the following key areas of focus were identified for the 2027 period:

1. Consistently improve our standing on the likelihood of BAME staff entering formal disciplinary processes compared to white staff
2. Improve equity and fairness in the recruitment process
3. Ensuring equity of access to development opportunities
4. Increasing diversity at senior and board level roles.
5. Interventions to debias local policy and procedures,
6. Co-create equitable, inclusive environments and recognise and appreciate differences.

The national WRES team identified three top priorities for ENHT to focus on:

High priority areas for improvement within the Trust (to a maximum of three):
Indicator 9: Board representation (overall, voting members, and executive members)
Indicator 8: discrimination from a manager/team leader or other colleagues in last 12 months against BME staff
Indicator 6: harassment, bullying or abuse from staff in last 12 months against BME staff

Possible Risks

Widening Recruitment Disparities

Risk: If White candidates continue to be more likely to be appointed than BME candidates, it may undermine trust in the fairness of recruitment processes, reduce diverse talent entering the organisation, and expose the Trust to legal risk.

Inequitable Access to Development Opportunities

Risk: The continued disparity in access to non-mandatory training and CPD may limit BME staff progression, contribute to the underrepresentation of BME staff in senior roles, and negatively impact retention and morale.

Inaccurate Workforce Data

Risk: The rise in ‘Unknown’ ethnicity declarations reduces the accuracy of ethnicity monitoring, making it harder to identify and address disparities effectively, which may lead to missed opportunities for targeted interventions.

WRES action plan — aligned with the Inclusion and EDI Action Plan and governed by the Inclusion and EDI Steering Group

Objective	Action	Metric	Update (Autumn 2026)	RAG Rating
Training on inclusion and related topics, including cognitive and unconscious bias.	In summer 2026, a single training portfolio brought together programmes from ENH Academy, NHSE and 'Skills Booster'. Topics include: Equality Legislation Bias Awareness Problematic Behaviour Bullying and Harassment Promoting Respect and Inclusion Allyship Conflict Resolution Diversity and Inclusion Diversity Awareness Inclusion Essentials Intersectionality Over 50 programmes and connections support knowledge and understanding. **Lead : Colleague Development Lead**	A development dashboard will track programme uptake from autumn 2026. Promotion during onboarding Update Grow Together Review (GTR) training to show how these programmes can support the inclusion objective, which will be mandatory for all colleagues from 2027. WRES 8 – Percentage of BAME staff who personally experienced discrimination at work from a manager, team leader or other colleagues, measured through the Staff Survey. WRES 4 - Relative likelihood of White staff accessing non-mandatory training and CPD compared to BAME staff	The development and inclusion leads will survey colleagues across the organisation. GTR training and policy are being revised, with completion due in January 2027. The Trust has joined NHS Elect, increasing the range of development support available to colleagues and managers.	Green
Restorative Just Culture and Mediation will form part of the response to incidents of racism, alongside greater use of mediation, facilitated conversations and informal resolution. Increase awareness of the harm that investigations and disciplinary processes can cause those involved.	Colleagues from ER and the Medical Director's Office (MDO) attended training in 2025. People Team members began mediator training in 2026. Mediation is now an available option for responding to incidents and complaints. **Lead : ER Lead (partnering)**	WRES 5 and 6 – Percentage of BAME staff who experienced harassment, bullying or abuse in the last 12 months from patients, relatives or the public (WRES 5), or from staff (WRES 6). WRES 8 – Percentage of BAME staff who personally experienced discrimination at work from a manager, team leader or other colleagues. WRES 3 - Relative likelihood of BAME staff entering the	Training of mediators is set to increase. The Restorative and Just Culture initiative is currently paused.	Amber

		formal disciplinary process compared to White staff Increase in the number of trained mediators.		
Recruitment and Selection Ambassador (RSA) Programme Eliminate bias and discrimination in recruitment.	The RSA Programme provides real-time oversight of selection processes. Panels will be observed and assessed to promote consistent and equitable treatment of candidates. **Lead: Resourcing and Talent Lead**	Increase the proportion of candidates with protected characteristics who are successful during recruitment. WRES 2 - Relative likelihood of White staff being appointed from shortlisting compared to BAME staff WRES 7 – Percentage of BAME staff who believe the Trust provides equal opportunities for career progression or promotion. WRES 1 – Percentage of the overall workforce by ethnicity.	Launch in January 2027	Green
Career progression for colleagues from diverse backgrounds Improve progression and representation across all Agenda for Change pay bands.	Develop and share “Share Your Story” case studies featuring colleagues from diverse backgrounds across grades and professions. **Lead: Colleague Experience Specialist & REACH Network** A resourced and supported talent management approach began in 2026. The team will ensure equity in its approach and recommendations. **Lead : Resourcing & Talent Lead**	Progress will be monitored through Staff Survey data and the Inclusion/EDI Dashboard. WRES 7 – Percentage of BAME staff who believe the Trust provides equal opportunities for career progression or promotion.	Colleague-experience stories are published throughout the year in Trust News and on the intranet, including features on specific conditions. In 2026, the People Team plans to launch a newsletter featuring colleagues’ experiences and highlighting opportunities within the Trust. An Inclusion/EDI Dashboard was created in 2026 to inform the Inclusion/EDI Steering Group. Organisational and local actions are reviewed against Staff Survey findings and other available data.	Amber

Appreciation and recognition Ensure colleagues from diverse backgrounds feel recognised, valued and appreciated for their contributions.	**Benefits promotion** Deliver a Trust-wide campaign explaining the practical benefits of NHS employment, including discounts, pensions, and terms and conditions. **Targeted benefits focus** Use the autumn 2026 colleague-experience dashboard, Staff Survey evidence and colleague accounts to promote support for diverse colleagues, including reasonable adjustments and flexible working. **Lead: Colleague Experience Specialist**	Satisfaction and engagement across diverse groups, measured through the Staff Survey and reflected in the Colleague Experience dashboard.	The benefits campaign is scheduled to begin in autumn 2026. Targeted activity will be informed by the 2026 Staff Survey and related datasets and surveys.	Amber
Reasonable adjustments Increase the proportion of colleagues from diverse backgrounds who report having the adjustments they need to do their work. **Aim: create the conditions for diverse colleagues to succeed at ENH.**	**Quality Line Management Programme (QLM)** The 2026 NHS Staff Standards identify line management as a priority. The QLM programme will define management expectations and support effective workplace practice. **Lead: Colleague Development Lead** The other initiatives described are joint work by the Health at Work Team and People Partnering Team.	WRES 7 – Percentage of BAME staff who believe the Trust provides equal opportunities for career progression or promotion.	QLM is scheduled to launch in late 2026 and is intended to strengthen line management throughout recruitment, onboarding and development. The Trust has joined NHS Elect, increasing the range of development support available to colleagues and managers. The Trust has introduced Shine Bright, an online mental wellbeing programme that supports NHS colleagues to care for their wellbeing. We plan to develop guidance and a reasonable adjustments (RA) passport by the end of 2026, initially as a pilot for disabled colleagues, with scope to expand. Return Well is a six-month project that began in June 2026. People partners, occupational health and wellbeing colleagues, and managers work together to prevent and reduce sickness absence, including targeted	Amber

			guidance for managers on reasonable adjustments.	
Dignity at work Improve colleagues' experience by preventing and responding effectively to bullying, harassment and abuse in the workplace.	From autumn 2026, the colleague-experience dashboard will consolidate data on the experiences of groups across the Trust. Evidence will include formal case data, Staff Survey findings and reports from the Freedom to Speak Up service. Resulting actions will be included in the Inclusion Action Plan and overseen by the Inclusion Steering Group. **Lead: Colleague Experience Specialist**	WRES 8 – Percentage of BAME staff who personally experienced discrimination at work from a manager, team leader or other colleagues. ER will monitor disputes involving the Dignity and Respect at Work (DRAW) Policy and report them through the Inclusion Dashboard.	The relaunched Inclusion Steering Group will refresh the colleague-experience dashboard and resulting Inclusion Action Plan in autumn 2026. The new Violence and Aggression Steering Committee includes network representatives and perspectives reflecting overlapping experiences and identities.	Amber
RISE Proactively offer feedback to candidates who are not selected at interview, supporting their development and future applications.	Offer candidates who are not selected clear, constructive feedback and, where appropriate, a development plan to support future applications. **Lead: Resourcing and Talent Lead**	Monitor participation in the RISE process and the outcomes of candidates who make a subsequent application. WRES 7 – Percentage of BAME staff who believe the Trust provides equal opportunities for career progression or promotion.	Launched in autumn 2026.	Green
Equality Impact Assessment (EQIA) Strengthen the use of EQIA in policy and change, and explore its application in other areas, including education.	The EQIA process was reviewed in summer 2026. The revised approach and training programme are scheduled for autumn 2026. **Lead: People Partners and Inclusion and Change Lead**	Ongoing audit of EQIA processes, feedback from training, and evidence of improved organisational awareness.	The revised process is scheduled to launch in autumn 2026. It will strengthen the use of EQIA in organisational change and policy review, while considering how the principles can be applied more widely. Examples include education and initiatives responding to the NHS Staff Standards.	Green
Staff Networks Support colleagues through active communities built on shared experiences and challenges.	The Trust's networks support colleagues across many protected characteristics and other groups. Each network has a Board member working with them as a sponsor.	Co-chairs' actions recorded in network meeting minutes. Progress against the action log. Annual report	Refreshed terms and conditions for chairs Active campaign to secure protected time for co-chairs	Green

	Lead: People Partners and Inclusion and Change Lead			
United Networks GEMBA Bring staff networks together to strengthen awareness, understanding, support and capacity.	The Trust's staff networks raise awareness and address network-specific concerns. United Networks supports joint action through collaborative events. GEMBA uses the Trust's improvement methodology to review work and colleague experience where services are delivered. United Networks GEMBA brings networks together to review practice and lived experience. **Lead: Colleague Experience Specialist and network members**	Record and escalate identified issues, with clear feedback to the relevant local areas.	Launched in summer 2026.	Amber
REACH Race Equity and Cultural Heritage Formerly the BAME Network.	REACH (Race Equity and Cultural Heritage) is the Trust's staff network. It represents colleagues, identifies barriers, raises awareness and informs change. The network provides peer support, guidance and practical input to strengthen inclusion across the Trust. **Lead: REACH Co Chair and Colleague Experience Specialist**	Network reports and monthly and annual Colleague Experience reports.	Ongoing. The network will share insights into issues affecting its members and the wider workforce, and encourage every division to support inclusion for all colleagues. A programme of topics is planned for the year, with meetings held every two months.	Green
Trust Values More than 500 colleagues helped establish the Trust's values in 2024: INCLUDE, RESPECT and IMPROVE.	These values define expected and unacceptable behaviours. Teams can translate them into locally agreed Team Charters, supported by accountability training and annual review as recommended best practice. **Lead : Resourcing and Talent Lead and Colleague Development Manager**	Recruitment is being strengthened through values-based approaches and questions on values and inclusion. The RSA programme will monitor this practice. The GTR quality audit will explore how line managers and colleagues discuss behaviours aligned with Trust values.	The RSA programme launches in January 2027. GTR Policy and practice revised in Autumn 2026	Amber
Values Charters	Support each team to agree a values charter.	Over 100 teams have completed charters.	Best practice was piloted in summer 2026	Amber

Ensure each team has an agreed values charter.	The charter or pledge sets agreed team standards and expectations aligned with the organisation's values. The charter supports constructive feedback and improvement by providing a shared standard for everyday team behaviours. **Lead : Head of People Partnering**	Anecdotal evidence suggests an impact; a formal review and impact assessment are planned for 2027.	All team members come together to agree behaviours in line with organisational values The whole team signs this pledge The team learns how to give constructive feedback and hold one another accountable respectfully. The charter should be reviewed annually	
Mann Report In June 2026 the Mann Report was published. The report set out recommendations and actions. ENH is already implementing some recommendations; others are planned.	The Trust's Inclusion and EDI approach will be refreshed in 2027 through a new strategy aligned with the seven principles of the NHS Race and Health Observatory. In response to the Mann Report, the Trust has completed an escalation flowchart, adopted the relevant definitions and aligned its work with the NHS Race and Health Observatory's seven anti-racism principles for NHS staff. **Lead : Inclusion and Change Lead**	Immediately after publication, three recommendations were presented to PCC for adoption by the Board and organisation. Embed the NHS Race and Health Observatory's seven anti-racism principles Adopt the International Holocaust Remembrance Alliance (IHRA) working definition of antisemitism Adopt the Government's non-statutory definition of anti-Muslim hostility Other actions will follow over time	Antisemitism and Anti Racism – approach and Training - Access to this national training to help address Antisemitism and Racism following communication from the DoHSC is expected in 2026	Amber
FTSU (Freedom to Speak Up) Create a safe, open environment where colleagues can raise concerns about patient	The FTSU Guardian contributes to key organisational activity, including PCC, while maintaining their role and independence. This brings a Freedom to Speak Up perspective to actions and decisions.	Annual report issued in summer 2026.		Green

safety, bullying or working conditions without fear of disadvantage.	A network of FTSU Champions has been established. **Lead : FTSU Guardian**			
Inclusion Objectives Extend the inclusion objectives originally set out in the EDS report across ENH.	Ensure every Board member, including non-executive directors, has a published, specific, measurable, achievable, relevant and time-bound (SMART) objective to tackle racism. This objective was voluntary but recommended for all colleagues in 2026 and will become mandatory in 2027. **Lead : Colleague Development Lead**	Board GTR Colleagues GTR Dashboard	The GTR Policy is being revised in autumn 2026 to reflect these changes.	Amber
Health Inequalities Reduce health inequalities for colleagues.	Occupational Health and wellbeing programmes consider unequal experiences of ill health, stress, burnout, bullying and harassment. Weekly wellbeing updates, targeted support groups, the ENH ABLE Network and Grow Together Review conversations help colleagues access support and improve their wellbeing and experience at work. **Lead : Head of Health at Work**	Health at Work is represented on the inclusion groups and reports annually under EDS Domain 2.	The Health at Work Team has completed the EDS Domain 2 report for January 2027.	Amber
Values-based recruitment Reflect the Trust values of INCLUDE, RESPECT and IMPROVE in recruitment. Inclusion and EDI questions help assess candidates' understanding of inclusive practice and personal responsibility.	Combine the following approaches to improve recruitment: Values-based recruitment Recruitment and Selection Ambassador Scheme Inclusion questions at interview An inclusive approach to talent Lead : Recruitment Lead and Resourcing and Talent Lead	WRES 2 - Relative likelihood of White staff being appointed from shortlisting compared to BAME staff WRES 7 – Percentage of BAME staff who believe the Trust provides equal opportunities for career progression or promotion. WRES 1 – Percentage of the overall workforce by ethnicity.	The programmes will be agreed by the end of 2026 and launched in January 2027.	Amber

Update grievance, disciplinary and investigative processes. Ensure these processes respond sensitively to experiences of racism and discrimination and are applied fairly and without bias.	The NHS Staff Standards' 'Tackling Racism' domain supports this work, which will become a dedicated workstream and agenda item for the Inclusion / EDI Steering Group. **Lead : Head of People Partnering**	Reviewed policies Feedback on how policies are applied Improved EQIA process	The People Team was restructured in summer 2026, bringing investigations and employee relations within the People Partnership function. The team will review relevant policies and investigation processes to strengthen consistency and reduce bias.	Amber
Escalation Flowchart Help colleagues raise and escalate concerns about poor experiences at work.	In response to the Mann Report, the Trust has completed an escalation flowchart. **Lead : Colleague Experience Specialist**	Communicated through policy, the intranet and onboarding.	Launched in October 2026.	Green
Flexible Working Review all job adverts to ensure flexible working information is clear and aligned with the new 2026 employment rights. Inclusive Recruitment Strategy	All Trust job adverts, including external, internal and secondment opportunities, will offer flexible working options. New employment rights relating to flexible working in 2026. **Lead : Head of People Partnering**	Number of flexible working requests Number of requests not granted Requests by protected characteristic		Amber
Trust Welcome **Induction** **Onboarding** Welcome new colleagues with clear expectations and the support they need to succeed at ENH.	Resourcing and Colleague Development will work with recruitment to support colleagues joining the organisation. This approach has two purposes: (1) Explain the organisation's principles and expectations for behaviour and inclusion. (2) Support management practices that help new starters feel heard and supported, with the adjustments they need to succeed in their roles. Onboarding goes beyond induction: it begins at application and continues as Resourcing and Colleague Development hand over to local management.	Each onboarding session is evaluated.	Following the launch of the NHS Staff Standards, an additional onboarding event has been introduced for new colleagues with line management responsibilities.	Amber

	Lead : Colleague Development Manager and Resourcing and Talent Lead			
Staff Survey The Staff Survey provides data on colleagues' experiences, including discrimination, bullying and development.	Survey response rates have varied. Renewed efforts aim to increase participation, and the survey became fully digital in 2026. When results are published, the Trust agrees organisational actions. Local teams are also expected to develop actions that reflect their circumstances. **Lead : Colleague Experience Specialist**	Survey Data Local relevance Action plans Local teams present inclusion issues to the Inclusion / EDI Steering Group each month.	Data collection for the 2026 Staff Survey is underway.	Amber
Kindness **Civility** **Microaggressions** **Psychological Safety** An active, organisation-wide initiative.	Build psychological safety through open discussion of team challenges. The MDO People Partnering team delivers kindness and civility training, including psychological safety and microaggressions. **Lead : Head of Partnering and MDO Team**	Update of training Evaluation and participant feedback	Plans are underway to refresh the organisational video commissioned in 2024.	Amber
Inclusion EDI Strategy Based on the NHS EDI Improvement Plan and its six High Impact Actions.	The ENH EDI Strategy was approved in 2024, with a review due in 2026. Following an interim review, a two-year extension is proposed to embed the plan developed by the Inclusion / EDI Steering Group for that two-year period. This would also allow new inclusion resources to contribute following the People Team restructure. **Lead : Inclusion and Change Lead**	The Inclusion / EDI Steering Group monitors strategy actions and has developed a dashboard to show their impact.	The strategy review will consider: Mann Report Recommendations NHS Staff Standards The expected NHS refresh in 2027	Amber
ENH Management Competencies A modular programme to support ENH managers.	Module 5 focuses on inclusion and bias for line managers. ENH subject matter experts provide content and support.	Review programme uptake by pay band and other characteristics.	The programme will be reviewed in autumn 2026, mapping its modules against the new NHS Leadership framework and code of conduct.	Amber

	Lead : Colleague Development Manager.	Evaluate the module's impact.		
EDS Equality Delivery System	The Trust submits an annual update on the previous year, its current position and planned actions. The three domains are: D1 Health Inequalities D2 Health & Wellbeing D3 Leadership **Lead : Inclusion and Change Lead**	Each submission reports on the impact of the previous year's actions.	The team has begun collecting data for the 2027 report, due for publication in February 2027.	Amber
Inclusion / EDI Steering Group Oversee inclusion actions and report progress to PCC.	The group meets monthly. Each month, a local service reports on inclusion progress, including its Staff Survey action plan. The group reviews the Inclusion Dashboard. Staff networks provide monthly updates. **Lead : Head of Colleague Development and Experience**	The Steering Group reviews its action plan.	The following steps will begin in early 2027, when a new Inclusion and Change Lead joins the team. Actions from the Mann Report, Staff Survey, WRES, WDES, GPG, NHS Staff Standards and Inclusion Steering Group will be reviewed and brought together in one Inclusion Action programme. Related dashboards will be combined and tested during this period. A comprehensive work programme will be in place by April 2027, covering a full cycle of actions and initiatives through March 2028.	Amber
NHS Staff Standards and NHS Leadership and Management Competency Framework Both launched in summer 2026.	Both initiatives support the Trust's inclusion ambitions. Both will be incorporated into the Colleague Development and Experience work programme. **Lead : Colleague Development Lead**	Action plans and dashboards are under development. Reporting on the NHS Staff Standards uses Staff Survey data.Leadership self-assessment generates monthly completion data.	The six NHS Staff Standards are being mapped against current Trust actions using the NHS toolkit. Plans for QLM, continuous GTR and other initiatives are under development.	Amber

Board

East and North Hertfordshire Teaching NHS Trust

Meeting	Public Trust Board		**Agenda Item**	11.1	
Report title	WDES Report 2026		**Meeting Date**	11 November 2026	
Author	Chief People Officer				
Responsible Director	Chief People Officer				
Purpose	**Assurance**	☐	**Approval/Decision**	☐	
	Discussion	☒	**For information only**	☐	
Proposed assurance level (*only needed for assurance papers*)	**Substantial assurance**	☐	**Reasonable assurance**	☐	
	Partial assurance	☐	**Minimal assurance**	☐	

Executive assurance rationale:

The Trust recognises that overall performance requires continued improvement despite progress in some areas. The relaunch of the ENH ABLE Network refreshed network leadership and stronger EDI governance are intended to drive improvement, although the nature of the stronger governance is still a live discussion. The main positive improvements include Disabled staff representation improving in 5 of the 7 workforce categories, suggesting increased confidence in declaring disabilities. There are also improvements in recruitment outcomes, with Metric 2 reducing from 1.26 to 1.12, indicating less disparity between disabled and non-disabled applicants being appointed from shortlist.

Areas of concern and continued focus include representation which has deteriorated in Band 8c+ and Very Senior Manager posts, as well as non-consultant career grade medical staff.

For the first time, disabled staff were more likely than non-disabled staff to enter a formal capability process (Metric 3). The report notes that small numbers may distort results. Seven staff-survey related measures declined compared with the previous year and were below national averages.

The overall summary is that whilst green shoots are appearing there is much work to be done for overall improvement.

Summary of key issues:

The Trust continues to meet its statutory requirements by providing annual data and developing actions to address the issues highlighted by the report

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**	☐		

Failure to have an inclusive and fair experience for colleagues, can not only impact on how they feel, but also have an impact on the care they feel motivated to provide our patients.

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 5

Report previously considered at & date(s):	
N/A	
Recommendation	To note the report

To be trusted to provide consistently outstanding care and exemplary service

July 2026

WDES Report

NHS
East and North Hertfordshire Teaching NHS Trust

Workforce Disability Equality Standard (WDES) Report 2026



1. Introduction

In 2019 NHS England, with its partners, prioritised its commitment to tackling discrimination and the Workforce Disability Equality Standard (WDES) came into force. It contains 10 metrics to compare the experiences of Disabled and non-Disabled staff, which is then used to implement action plans. The Trust is required to submit the data set using the national format. In 2023/24 the Trust launched its EDI Strategy which was aligned to the NHS EDI Improvement Plan and the 6 high impact areas identified. An Inclusion / EDI Steering Group was established to oversee an organisational action plan and focus on areas of the organisation. The steering group reports int the People and Culture Committee. Actions underway are highlighted towards the end of this report.

2. Executive Summary

The Trust recognises that overall performance requires continued improvement despite progress in some areas.
The relaunch of the ENH ABLE Network refreshed network leadership and stronger EDI governance are intended to drive improvement.

Main Positives
Disabled staff representation has improved in 5 of the 7 workforce categories, suggesting increased confidence in declaring disabilities.
Recruitment outcomes improved, with Metric 2 reducing from 1.26 to 1.12, indicating less disparity between disabled and non-disabled applicants being appointed from shortlist.

Significant improvements in disability declaration rates were seen across:

- Bands 2-4
- Bands 5-7
- Bands 8a-8b
- Consultants
- Trainee grade doctors

Areas of Concern
Representation deteriorated in:

- Band 8c+ and Very Senior Manager posts.
- Non-consultant career grade medical staff.

For the first time, disabled staff were more likely than non-disabled staff to enter a formal capability process (Metric 3).
The report notes that small numbers may distort results.
Seven staff-survey related measures declined compared with the previous year and were below national averages.

Staff Experience Findings
Disabled staff (staff with long-term conditions) reported:

- Higher levels of bullying, harassment and abuse from patients, managers and colleagues than non-disabled staff.
- Less confidence that the Trust provides equal career progression opportunities (41.0% vs 52.9%).
- Greater pressure from managers to attend work when unwell (27.1% vs 17.0%).
- Lower satisfaction that their work is valued (28.2% vs 45.9%).
- Lower staff engagement scores (6.25 vs 6.99).
- Lower levels of reasonable adjustments being implemented compared with the previous year (71.1% vs 75.7% previously).

Board Representation

- Disability declaration among voting board members fell from 27% to 23%.
- Executive board declaration remained at 11%.

Overall board disability representation remains above the national average but deteriorated from the previous year.

The report presents a mixed picture. Representation and recruitment outcomes have improved, but disabled colleagues continue to report poorer workplace experiences than non-disabled colleagues across most staff-survey measures. The Trust acknowledges the gaps and has put in place a comprehensive improvement plan through the Inclusion and EDI Steering Group

3. WDES Metrics and context

The 10 metrics of the WDES are set out here for clarity and context of the report:

1. % of Disabled staff in the Workforce
2. Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts.
3. Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process on the grounds of performance
4. Relates to Q14a-d in the NHS Staff Survey) Questions are related to staff with Long Term Conditions (LTC): Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse
5. (Relates to Q15 in the NHS Staff Survey) Questions are related to staff with Long Term Conditions (LTC): Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.
6. (Relates to Q11e in the NHS Staff Survey) Questions are related to staff with Long Term Conditions (LTC): Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.
7. (Relates to Q4b in the NHS Staff Survey): Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.
8. (Relates to Q30b in the NHS Staff Survey); Questions are related to staff with Long Term Conditions (LTC): Percentage of Disabled staff saying that their employer has made reasonable adjustment(s) to enable them to carry out their work.
9. (Relates to the staff engagement theme of the NHS Staff Survey, made up from Q2a, Q2b, Q2c, Q3c, Q3d, Q3f, Q23a, Q23c and Q23d in the NHS Staff Survey); Questions are related to staff with Long Term Conditions (LTC), the staff engagement score for Disabled staff, compared to non-disabled staff.
10. The percentage of the board's membership who have declared a disability

4. WDES Metrics and performance

Our performance overall in our WDES metrics requires continued improvement and focus. In 2025 we refreshed our Staff Network chairs and executive sponsors. The launch of the ENH ABLE Network has resulted in renewed activity to improve the experience at ENH. An update on the activities across the inclusion portfolio will be presented to People and Culture Committee and Trust Board at the end of 2026.

The WDES metrics data below shows our performance since 2022/2023. Over the last 2 years a focus has been in place, encouraging staff to update their personal equality data. Representation has improved in 5 of the 7 categories this is likely linked to improved declarations as staff are feeling more secure in declaring a disability in the workplace. We recognise there is more work to do overall around inclusivity in our workforce.

Workforce Disability Equality Standard (WDES) Indicators	East & North Herts (ENHT) WDES Data						
		ENHT 2022/23	ENHT 2023/24	ENHT 2024/25	ENHT 2025/26	WDES Progress 25/26 v 24/25	National WDES 2025/26
Metric 1 – % of Disabled staff in the Workforce	**Cluster 1: AfC Bands 1 - 4**	Non-Clinical = 4.0% Clinical = 3.0%	Non-Clinical = 4.8% Clinical = 3.2%	Non-Clinical = 5.5% Clinical = 3.7%	Non-Clinical = 6.9% Clinical = 6.5%	Improvement	6.7%
	Cluster 2: AfC Bands 5 - 7	Non-Clinical = 4.1% Clinical = 2.0%	Non-Clinical = 4.9% Clinical = 2.8%	Non-Clinical = 4.9% Clinical = 3.2%	Non-Clinical = 7.2% Clinical = 4.6%	Improvement	
	Cluster 3: AfC Bands 8a and 8b	Non-Clinical = 2.2% Clinical = 1.0%	Non-Clinical = 3.0% Clinical = 1.9%	Non-Clinical = 5.7% Clinical = 1.8%	Non-Clinical = 10.9% Clinical = 1.9%	Improvement	
	Cluster 4: AfC Bands 8c, 8d, 9 and VSM	Non-Clinical = 0% Clinical = 0%	Non-Clinical = 1.4% Clinical = 3.0%	Non-Clinical = 7.4% Clinical = 3.2%	Non-Clinical = 2.7% Clinical = 2.6%	Deterioration	
	Cluster 5: Medical and Dental staff, consultants	Non-Clinical = n/a Clinical = 0.0%	Non-Clinical = n/a Clinical = 0.25%	Non-Clinical = n/a Clinical = 0.9%	Non-Clinical = n/a Clinical = 2.1%	Improvement	
	Cluster 6: Medical and Dental staff, non-consultant career grades	Non-Clinical = n/a Clinical = 0.48%	Non-Clinical = n/a Clinical = 1.52%	Non-Clinical = n/a Clinical = 3.5%	Non-Clinical = n/a Clinical = 3.1%	Deterioration	
	Cluster 7: Medical and Dental staff, trainee grades	Non-Clinical = n/a Clinical = 1.46%	Non-Clinical = n/a Clinical = 0.75%	Non-Clinical = n/a Clinical = 1.4%	Non-Clinical = n/a Clinical = 6.3%	Improvement	
Metric 2 - Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts.		1.6	1.23	1.26	1.12	Improvement	0.95
Metric 3 - Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process on the grounds of performance		0	0	0	2.55	Deterioration	n/a

The overall make-up of the workforce is outlined in Metric 1 above – this shows a continuing improving picture disabled staff representation in the workforce. Two areas show deterioration, Band 8c+ and Non-Consultant Career Grade medics.

Metric 2 demonstrates an improvement in the likelihood of disabled staff compared to non-disabled staff being appointed from shortlisting; a result of 1.00 indicates there is no bias/difference between appointment of disabled versus non-disabled staff.

For the first time, the Trust has data showing more disabled staff enter into formal capability performance processes than non-disabled staff (metric 3). However it is worth noting the numbers of staff in formal capability processes is small, therefore this can cause skewed results. The national WDES report for 2025 offers no data at a national level stating “This data is not published at Trust level due to volitivity and small numbers”.

The tables below shows the national data taken form the 2025 staff survey benchmark average. Compared to the 2024 results, all metrics have shown a deterioration, with 7 scores being lower than the national average too.

	East & North Herts (ENHT) WDES Data						
Workforce Disability Equality Standard (WDES) Indicators		**ENHT**	**ENHT**	**ENHT**	**ENHT**	**WDES Progress 25/26 v 24/25**	**National WDES 2025/26**
		2022/23	**2023/24**	**2024/25**	**2025/26**		
Metric 4 (Relates to Q14a-d in the NHS Staff Survey) Questions are related to staff with Long Term Conditions (LTC) Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from:	Patients/Service users, their relatives or other members of the public	With LTC = 38.4% Without LTC = 30.5%	With LTC = 39% Without LTC = 30.4%	With LTC = 33.61% Without LTC = 25.11%	With LTC = 34.9% Without LTC = 26.0%	Deterioration	With = 29.7% Without = 23.4%
	Managers	With LTC = 21.6% Without LTC = 12.9%	With LTC = 22.3% Without LTC = 12.3%	With LTC = 16.48% Without LTC = 9.22%	With LTC = 16.8% Without LTC = 8.99%	Deterioration	With = 13.6% Without = 7.4%
	Other colleagues	With LTC = 32.4% Without LTC = 19.8%	With LTC = 32.6% Without LTC = 20.5%	With LTC = 25.73% Without LTC = 18.45%	With LTC = 28.6% Without LTC = 15.8%	Deterioration	With = 22.9% Without = 14.8%
	Percentage of Disabled staff saying they or a colleague reported the harassment/bullying or abuse.	With LTC = 47.2% Without LTC = 46.0%	With LTC = 49.7% Without LTC = 47.1%	With LTC = 52.66% Without LTC = 53.16%	With LTC = 52.2% Without LTC = 54.8%	Deterioration	With = 54.9% Without = 54.9%
Metric 5 (Relates to Q15 in the NHS Staff Survey) Questions are related to staff with Long Term Conditions (LTC) Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.		With LTC = 42.1% Without LTC = 55.6%	With LTC = 46.7% Without LTC = 54.3%	With LTC = 46.9% Without LTC = 54.6%	With LTC = 40.98% Without LTC = 52.9%	Deterioration	With = 48.6% Without = 55.7%

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	East & North Herts (ENHT) WDES Data						
Workforce Disability Equality Standard (WDES) Indicators		**ENHT**	**ENHT**	**ENHT**	**ENHT**	**WDES Progress 25/26 v 24/25**	**National WDES 2025/26**
		2022/23	**2023/24**	**2024/25**	**2025/26**		
Metric 6 (Relates to Q11e in the NHS Staff Survey) Questions are related to staff with Long Term Conditions (LTC) Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.		With LTC = 38.2% Without LTC = 26.2%	With LTC = 33.2% Without LTC = 22.3%	With LTC = 26.0% Without LTC = 18.6%	With LTC = 27.1% Without LTC = 16.99%	**Deterioration**	With = 25.6% Without = 17.5%
Metric 7 (Relates to Q4b in the NHS Staff Survey) Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.		With LTC = 31.7% Without LTC = 45.7%	With LTC = 28.3% Without LTC = 43.0%	With LTC = 36.5% Without LTC = 46.4%	With LTC = 28.2% Without LTC = 45.9%	**Deterioration**	With = 34.4% Without = 46.1%
Metric 8 (Relates to Q30b in the NHS Staff Survey) Questions are related to staff with Long Term Conditions (LTC) Percentage of Disabled staff saying that their employer has made reasonable adjustment(s) to enable them to carry out their work.		71.75	73.7%	75.7%	71.1%	**Deterioration**	74.9%

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	East & North Herts (ENHT) WDES Data						
Workforce Disability Equality Standard (WDES) Indicators		**ENHT**	**ENHT**	**ENHT**	**ENHT**	**WDES Progress 25/26 v 24/25**	**National WDES 2025/26**
		2022/23	**2023/24**	**2024/25**	**2025/26**		
Metric 9a (Relates to the staff engagement theme of the NHS Staff Survey, made up from Q2a, Q2b, Q2c, Q3c, Q3d, Q3f, Q23a, Q23c and Q23d in the NHS Staff Survey) Questions are related to staff with Long Term Conditions (LTC) The staff engagement score for Disabled staff, compared to non-disabled staff.		With LTC = 6.25 Without LTC = 6.84	With LTC = 6.40 Without LTC = 6.91	With LTC = 6.56 Without LTC =7.01	With LTC = 6.25 Without LTC = 6.99	Deterioration	With = 6.31 Without = 6.91
Metric 10 - The percentage of the board's membership who have declared a disability	**Voting Membership of the Board**	0%	0%	27%	23%	Deterioration	5.6%
	Non-Voting Membership of the Board	0%	0%	0%	0%		6.1%
	Executive Membership of the Board	0%	0%	11%	11%		5.4%
	Non-Exec Membership of the Board	0%	0%	29%	22%		6.0%

WDES action plan — aligned with the Inclusion and EDI Action Plan and governed by the Inclusion and EDI Steering Group

Objective	Action	Metric	Update (Summer 2026)	RAG Rating
Career progression for colleagues with disabilities Improve disabled colleagues' progression and representation across all Agenda for Change pay bands.	Develop and widely share "Share Your Story" case studies featuring disabled colleagues from a range of grades and professions. **Lead: Colleague Experience Specialist and ENH ABLE Network**	WDES 1: representation of disabled colleagues across pay bands, medical and dental subgroups, and very senior management, compared with the overall workforce. Feedback on the relevance and usefulness of shared stories, and the number of colleagues seeking career-progression support. WDES 5: disabled and non-disabled colleagues' views on equal opportunities for career progression or promotion. Progress will be monitored through Staff Survey data and the Inclusion/EDI Dashboard.	Colleague-experience stories are published throughout the year in Trust News and on the intranet, including features on specific conditions. In 2026, the People Team plans to launch a newsletter featuring colleagues' experiences and highlighting opportunities within the Trust. An Inclusion/EDI Dashboard was created in 2026 to inform the Inclusion/EDI Steering Group. Organisational and local actions are reviewed against Staff Survey findings and other available data.	Amber
Reasonable adjustments Achieve a year-on-year increase in the proportion of disabled colleagues who say that adequate adjustments have been made to enable them to carry out their work.	**Quality Line Management Programme (QLM)** The 2026 NHS Staff Standards identify line management as a priority. The QLM programme will define management expectations and	WDES 3: relative likelihood of disabled colleagues entering the formal capability process compared with non-disabled colleagues. WDES 6: disabled and non-disabled colleagues who report feeling pressure from their manager to work when they	QLM is scheduled to launch in late 2026 and is intended to strengthen line management throughout recruitment, onboarding and development. The Trust has joined NHS Elect, increasing the range of development support	Amber

	support effective workplace practice. **Lead: Colleague Development Lead** Other initiatives detailed are collaborations between the Health at Work Team and People Partnering Team	were not well enough to perform their duties. WDES 8: disabled colleagues who report that adequate workplace adjustments have been made. WDES 9: engagement scores for disabled colleagues, compared with non-disabled colleagues and the organisation overall.	available to colleagues and managers. The trust has introduced the shine bright initiative which provides an online mental wellness programme that gives NHS colleagues the power to take control of their wellbeing. The offer is 3 live sessions over three weeks: The first is 1.5 hours and the next two are 2 hours each (5,5 hours in total) . Between sessions you'll have some short, optional exercises and for two months afterwards you'll get gentle prompts to help your new habits stick. Staff Network ENH Able are running a project to bring in reasonable adjustments passport this has been drafted, case studies of colleagues that have had reasonable adjustments is planned for disability history month and linked project looking at pathways and cost of equipment is underway. We plan to develop guidance and a RA	

			‘passport’ before the end of the year. The Return Well project began in June 2026, this is a 6-month project where people partners, occupational health and wellbeing and managers work collaboratively to prevent and reduce sickness absence. The work of the return well project includes targeted support and guidance for managers on implementing reasonable adjustments.	
Appreciation and recognition Ensure that disabled colleagues feel recognised, valued and appreciated for their contribution.	**Benefits promotion** Deliver a Trust-wide campaign explaining the practical benefits of NHS employment, including discounts, pensions, and terms and conditions. **Targeted benefits focus** Use the autumn 2026 colleague-experience dashboard, Staff Survey evidence and colleague accounts to promote support for disabled colleagues, including reasonable adjustments and flexible working.	WDES 7: disabled and non-disabled colleagues who are satisfied with the extent to which the organisation values their work.	The benefits campaign is scheduled to begin in autumn 2026. Targeted activity will be informed by the 2026 Staff Survey and related datasets and surveys.	Amber

	Lead: Colleague Experience Specialist and ENH ABLE			
Dignity at work Improve colleagues' experience by preventing and responding effectively to bullying, harassment and abuse in the workplace.	From autumn 2026, the colleague-experience dashboard will consolidate data on the experiences of groups across the Trust. Evidence will include formal case data, Staff Survey findings and reports from the Freedom to Speak Up service. Resulting actions will be included in the Inclusion Action Plan and overseen by the Inclusion Steering Group. **Lead: Colleague Experience Specialist**	WDES 4a: disabled and non-disabled colleagues reporting harassment, bullying or abuse. WDES 4b: disabled and non-disabled colleagues who say that the most recent incident of harassment, bullying or abuse was reported by them or a colleague.	The colleague-experience dashboard and resulting Inclusion Action Plan are due to be refreshed through the relaunched Inclusion Steering Group in autumn 2026 The new Violence and Aggression Steering committee has network representation and intersectional voices.	Amber
Recruitment and Selection Ambassador (RSA) Programme	The RSA Programme provides real-time oversight of selection processes. Panels will be observed and assessed to promote consistent and equitable treatment of candidates. **Lead: Resourcing and Talent Lead**	Increase the proportion of candidates with protected characteristics who are successful during recruitment. Monitored through WDES 1, 2, 5 and 10.	Launched in January 2027	Amber
RISE	Provide unsuccessful candidates with clear, constructive feedback and, where appropriate, a development plan for future applications.	Monitor participation in the RISE process and the outcomes of candidates who make a subsequent application.	Launched in autumn 2026.	Amber

	Lead: Resourcing and Talent Lead			
Equality Impact Assessment (EQIA)	The EQIA process was reviewed in summer 2026. The revised approach and training programme are scheduled for autumn 2026. **Lead: People Partners and Inclusion and Change Lead**	Ongoing audit of EQIA processes, feedback from training, and evidence of improved organisational awareness.	The revised process is scheduled to launch in autumn 2026. It will strengthen the use of EQIA in organisational change and policy review, while considering how the principles can be applied more widely.	Amber
United Networks GEMBA	The Trust's staff networks raise awareness and address network-specific concerns. United Networks supports joint action through collaborative events. GEMBA applies the Trust's improvement methodology to work and colleague experience at the point of delivery. United Networks GEMBA enables networks to assess practice and lived experience jointly. **Lead: Colleague Experience Specialist and network members**	Record and escalate identified issues, with clear feedback to the relevant local areas.	Launched in summer 2026.	Amber
ENH ABLE	ENH ABLE is the Trust's staff network for disabled colleagues. Formerly the Disabled Members Network, it represents colleagues,	Network reports and monthly and annual Colleague Experience reports.	Ongoing. The network will share knowledge about physical and mental health and hidden disabilities with the wider Trust workforce,	Amber

	identifies barriers, raises awareness and informs change. The network provides peer support, guidance and practical input to strengthen inclusion across the Trust. **Lead: ENH ABLE and Colleague Experience Specialist**		and encourage every division to support disabled colleagues. A programme of topics is planned for the year, with meetings held every two months.	
ENH ABLE: coaching for neurodivergent colleagues	In autumn 2026, ENH ABLE began assessing the feasibility of a coaching faculty for neurodivergent colleagues. **Lead: ENH ABLE and Colleague Experience Specialist**	Creation of a coaching faculty; patterns of access and participation; and impact surveys.	A feasibility assessment and recommended next steps will be reported in autumn 2026.	Amber
Equitable representation in the capability process Work towards proportionate representation of disabled and non-disabled colleagues entering the formal capability process.	Undertake a detailed review of the data to identify themes that may contribute to poorer experiences or outcomes for disabled colleagues and use the findings to inform appropriate action. **Lead: People Partners**	WDES 3.	In 2026, employee relations moved to People Partners as part of the People Team restructure. This should improve analysis by linking case data with organisational knowledge; its impact will be monitored.	Amber

Summary

In 2026, the Trust reset its approach to inclusion and colleague experience. Leadership changes, inconsistent strategic focus and an overly broad portfolio had affected delivery. The team is now defining clearer priorities aligned with the Trust's Inclusion Strategy and the NHS EDI Improvement Plan, providing a stronger basis for meeting national standards.

The Trust acknowledges inconsistent progress and instances where colleague experience fell below the expected standard. These outcomes reflect wider system challenges, not a lack of colleague commitment. Governance is being strengthened. Although further improvement is required, available data shows progress in several areas.

The Trust will act on the findings, deliver the actions above and report openly on progress, challenges and further improvement.

Board

East and North Hertfordshire Teaching NHS Trust

Meeting	Public Trust Board		**Agenda Item**	13	
Report title	Thirlwall Inquiry: Trust Response and Board Assurance		**Meeting Date**	11 November 2026	
Author	Director of Midwifery Neonatal Matron Clinical Director for Neonatal services				
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:

The Trust has reviewed the Thirlwall Inquiry recommendations and NHS England immediate actions, and an assurance rating of substantial is proposed. Robust arrangements are in place to support neonatal safety, safeguarding, governance and organisational learning. A small number of actions remain in progress to meet future national requirements, with appropriate plans and oversight in place.

Summary of key issues:

Following publication of the Thirlwall Inquiry Report, NHS England requested all Trust Boards to review the findings in public, consider whether similar events could occur within their organisations and seek assurance that appropriate safeguards are in place.

The Trust has undertaken a detailed assessment against the Inquiry recommendations and NHS England immediate actions. This paper summarises the findings of that review and outlines the actions being taken to strengthen neonatal safety, safeguarding, organisational learning and speaking-up arrangements.

The report provides assurance regarding existing controls whilst identifying a small number of actions requiring continued oversight through established governance arrangements.

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

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

This report relates directly to the quality and safety of care provided to babies and children and supports implementation of national patient safety recommendations. The review has implications for staff culture, safeguarding responsibilities and speaking-up arrangements.

Delivery of some recommendations may require future investment in infrastructure and security systems. The recommendations support compliance with national regulatory expectations and require partnership working with safe guarding agencies, Child Death Review partners and regional neonatal networks.

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 review identified the following areas requiring ongoing monitoring: • Delivery of future insulin storage and medicine security requirements. • Implementation of any further national guidance arising from the Thirlwall Inquiry. • Sustaining a culture that supports professional challenge, psychological safety and speaking up. • Continued oversight of mortality review processes and emerging patient safety trends.	
Report previously considered at & date(s):	
N.A	
Recommendation	The Trust Board is asked to: 1. Note the findings of the Thirlwall Inquiry and the associated NHS England immediate actions. 2. Receive assurance that the Trust has undertaken a comprehensive review of neonatal safety, safeguarding, governance and cultural arrangements. 3. Receive assurance that actions arising from the review are being progressed through established governance arrangements. 4. Support ongoing oversight of delivery through the Quality and Safety Committee, with escalation of any significant risks to Trust Board as required.

To be trusted to provide consistently outstanding care and exemplary service

Board

East and North Hertfordshire Teaching NHS Trust

Meeting	Public Trust Board		**Agenda Item**	13a	
Report title	Thirlwall Inquiry: Trust Response and Board Assurance		**Meeting Date**	11 November 2026	
Author	Director of Midwifery Neonatal Matron Clinical Director for Neonatal services				
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:

Substantial assurance can be provided that neonatal services have completed a comprehensive review of the Thirlwall recommendations and are largely compliant with national expectations. The ODN benchmarking exercise is expected to validate the findings of the Trust's self-assessment.

Summary of key issues:

Purpose

Following publication of the Thirlwall Inquiry Report, NHS England requested that all NHS Trusts review the findings and recommendations at a public Board meeting and consider whether similar circumstances could occur within their own organisations. Boards were asked to satisfy themselves that appropriate arrangements are in place to safeguard babies and children, support staff to raise concerns, and respond effectively to patient safety risks.
The purpose of this report is to provide assurance to the Trust Board regarding the Trust's response to the Thirlwall Inquiry recommendations and NHS England's immediate actions and seeks Board oversight of the ongoing implementation programme.

Executive Summary

The Thirlwall Inquiry identified significant failures in patient safety, safeguarding, organisational culture, leadership, and escalation processes within neonatal services at the Countess of Chester Hospital. Many of the recommendations have relevance across the NHS and extend beyond neonatal services alone.
In response, the Trust has undertaken a comprehensive review against:

- The recommendations arising from the Thirlwall Inquiry.
- NHS England's immediate actions for providers.
- The self-assessment tool shared with Trusts by the Regional Neonatal Operational Delivery network (ODN) issued following publication of the Inquiry report.

The review demonstrates that many of the required controls and processes are already established within the Trust. Areas of strength include:

- Robust divisional and Trust governance and patient safety structures.
- Established mortality review and Medical Examiner processes.
- Strong safeguarding arrangements.
- Freedom to Speak Up processes and mechanisms for raising concerns.
- Established bereavement support services.
- Incident reporting and learning processes operating within the Patient Safety Incident Response Framework (PSIRF).

- Active engagement with regional neonatal ODN governance arrangements.

While the Trust can demonstrate compliance with the majority of the recommendations a small number requiring further work or are dependent upon future national implementation timescales or investment, particularly in relation to enhanced insulin security arrangements and medicine storage access controls.

Overall, substantial assurance can be provided that systems, processes and governance arrangements are in place to support the safety of babies and children receiving care within the Trust. Actions identified through the review are being progressed through established governance arrangements.

Board Responsibilities and Assurance
NHS England has highlighted that the findings of the Inquiry are relevant to all NHS organisations. Trust Boards are expected to:

- Consider the findings of the Inquiry in a Public Board meeting.
- Assess whether similar circumstances could occur within their own organisation.
- Ensure effective governance and oversight of neonatal and paediatric services.
- Promote a culture in which staff feel empowered to raise concerns and challenge poor practice.
- Ensure safeguarding arrangements are robust and appropriately prioritised.
- Seek assurance regarding mortality review processes, learning from patient safety events and implementation of national recommendations.
- Review compliance with the immediate actions issued following publication of the Inquiry.

The Trust's review has considered each of these expectations and assessed existing controls against the recommendations.

Trust Response
1. Patient Safety and Governance
The Trust has established systems for identifying, investigating and learning from patient safety incidents. Neonatal incidents are reviewed through divisional and Trust governance processes, with escalation through the Quality and Safety Committee and Board assurance framework where appropriate.
Neonatal mortality reviews are undertaken through established multidisciplinary review processes. Learning is disseminated through governance forums and incorporated into quality improvement activity.
The Trust has implemented PSIRF arrangements which support a systems-based approach to identifying contributory factors and organisational learning.

2. Mortality Review and Learning
The Inquiry highlighted the importance of robust mortality review processes and effective identification of concerning patterns or trends.
The Trust has established processes for review of neonatal deaths, including oversight through Child Death Review mechanisms, mortality review structures and Medical Examiner scrutiny. There are defined escalation routes where emerging themes or concerns are identified.
Board level oversight of mortality and patient safety indicators is provided through routine quality reporting and committee structures.

3. Safeguarding
The Inquiry reinforced the need for strong safeguarding arrangements and professional curiosity where concerns arise regarding patient safety.
The Trust has established safeguarding governance arrangements supported by specialist safeguarding leadership, mandatory training programmes and clear escalation pathways.
Existing policies support staff in escalating concerns and seeking safeguarding advice when concerns regarding babies, children or vulnerable people are identified.
Further work is being undertaken to ensure training, guidance and escalation processes continue to reflect the learning arising from the Inquiry.

4. Speaking Up, Culture and Staff Wellbeing
A key theme of the Inquiry was organisational culture and the extent to which staff concerns were heard, acted upon and appropriately escalated.
The Trust continues to strengthen a culture of openness, transparency and psychological safety. Staff have access to multiple routes for raising concerns, including line management structures, executive leadership teams, Freedom to Speak Up Guardians, safeguarding teams and incident reporting systems.
The Trust is committed to creating an environment where concerns can be raised without fear of detriment and where professional challenge is welcomed as an essential component of safe patient care.
As part of wider maternity and neonatal improvement work, external support has been commissioned to strengthen team culture and behaviours within clinical services where indicated.

5. Insulin Security and Medicines Management
The Inquiry recommendations included specific requirements relating to insulin storage and access controls within neonatal services.

The Trust has secure medicines management processes in place, including restricted access arrangements, pharmacy oversight and routine audit. Work is underway to implement the additional requirements outlined within national guidance, including CCTV monitoring and progression towards auditable access controls in line with national expectations. Future implementation of biometric access systems will require capital investment and forms part of a longer-term programme of compliance.

The Thirlwall recommendations also highlight the risks associated with paper-based prescribing and documentation processes. While current controls provide assurance regarding the safe prescribing, administration and monitoring of medicines, paper-based records carry an inherent risk of delays in information availability, legibility issues and reduced ability to undertake real-time oversight and audit. In line with national requirements, the Trust is progressing plans to implement electronic prescribing and medicines administration (ePMA) within neonatal services by January 2028. This will further strengthen medication safety, improve traceability and support enhanced governance and surveillance of medicines use.

6. Sudden Unexpected Death in Infancy and Childhood (SUDIC)
The Trust has reviewed local processes relating to SUDIC requirements and Child Death Review procedures.
Guidance has been shared with relevant clinical teams to reinforce the requirement for SUDIC processes to be considered where applicable, including neonatal settings. Work continues alongside regional partners to ensure local arrangements remain fully aligned with evolving national guidance and best practice.

7. Bereavement Care
The Trust has established bereavement support services for families experiencing neonatal loss and participates in relevant national programmes, including implementation of the National Bereavement Care Pathway.
Families are provided with access to specialist bereavement support and clear pathways for ongoing care following the death of a baby.

Key Risks
The review identified a number of areas requiring ongoing monitoring:

Risk	Mitigation
Delivery of future insulin security requirements and biometric access controls	Included within Trust action plan with executive oversight and capital planning
Emerging national guidance regarding CCTV and cot-side monitoring	Monitoring through neonatal governance and regional networks

Ongoing compliance with new recommendations arising from national reviews	Routine review through governance structures and Quality & Safety Committee
Sustaining a culture that encourages escalation and speaking up	Continued investment in leadership development, Freedom to Speak Up and workforce wellbeing initiatives

At present no significant concerns have been identified that would suggest an inability to identify, escalate or respond to patient safety concerns within neonatal services.

Staff Wellbeing and Culture
The review has highlighted the importance of maintaining a positive, open and supportive culture within neonatal services. The recommendations arising from the Thirlwall Inquiry reinforce the need for staff to feel confident in raising concerns, challenging practice and escalating issues through established governance, safeguarding and Freedom to Speak Up processes.

Neonatal services continue to support this through visible leadership, regular leadership rounds, active engagement with the People Team, and promotion of Freedom to Speak Up processes. These arrangements help ensure staff have access to support, feel psychologically safe to raise concerns and can contribute to continuous learning and improvement.

Conclusion
The Trust has undertaken a comprehensive review of the Thirlwall Inquiry recommendations and associated NHS England immediate actions.
The review demonstrates that robust arrangements are in place across governance, safeguarding, mortality review, patient safety, medicines management, bereavement care and staff escalation of concerns. The Board can be assured that the Trust has considered whether similar circumstances could occur within its own services and has assessed the effectiveness of the controls currently in place.
Whilst a small number of actions remain in progress and some future requirements are dependent upon national implementation timelines, no significant gaps have been identified that would compromise the Trust's ability to provide safe care for babies and children.
Ongoing actions will continue to be monitored through established governance arrangements and reported through the Quality and Safety Committee.

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: Strengthens assurance regarding neonatal safety, governance, safeguarding and mortality review arrangements.
Legal / Regulatory: Demonstrates the Trust's response to NHS England requirements arising from the Thirlwall Inquiry.
Continuous Improvement: Identifies opportunities to further strengthen SUDIC processes and informs ongoing quality improvement through ODN benchmarking.
Finance / Resourcing: Costs may include infrastructure, equipment, secure data storage, maintenance, governance and workforce requirements.
System / Partners: Supports collaborative working with the Neonatal ODN and regional partners to validate compliance with national expectations.

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*

- Ongoing compliance with emerging national requirements arising from the Thirlwall Inquiry.

• Lack of national guidance and agreed standards relating to cot-side CCTV/camera monitoring, including information governance, consent, data storage and operational oversight. • Potential future financial and infrastructure requirements associated with implementation of cot-side camera recommendations. • Current SUDIC processes require refinement to explicitly address babies who die prior to discharge following birth and ensure clarity of responsibilities and pathways.	
Report previously considered at & date(s):	
N.A	
Recommendation	The Trust Board is asked to: 1. Note the findings of the Thirlwall Inquiry and the associated NHS England immediate actions. 2. Receive assurance that the Trust has undertaken a comprehensive review of neonatal safety, safeguarding, governance and cultural arrangements. 3. Receive assurance that actions arising from the review are being progressed through established governance arrangements. 4. Support ongoing oversight of delivery through the Quality and Safety Committee, with escalation of any significant risks to Trust Board as required.

To be trusted to provide consistently outstanding care and exemplary service

Board

East and North Hertfordshire Teaching NHS Trust

Meeting	Public Trust Board			**Agenda Item**	14
Report title	Summary Learning from Deaths			**Meeting Date**	11 November 2026
Author	Mortality Improvement Lead				
Responsible Director	Medical Director				
Purpose	**Assurance**	☒		**Approval/Decision**	☐
	Discussion	☐		**For information only**	☐
Proposed assurance level (*only needed for assurance papers*)	**Substantial assurance**	☒		**Reasonable assurance**	☐
	Partial assurance	☐		**Minimal assurance**	☐

Executive assurance rationale:

East and North Hertfordshire Teaching NHS trust seeks to learn from every death that occurs.

This paper provides assurance to the Board that:

- Our rates of death remain lower than would be expected
- That we learn from scenarios when care does not meet the standard that we and our patients and carers set
- That we interrogate data to ensure we understand its meaning
- That we innovate to reduce mortality.

Summary of key issues:

Mortality improvement work is a continual on-going process within the Trust. This quarterly report outlines key results of this work, including the regular monitoring of mortality rates, together with outputs from our 2026-27 Q1 learning from deaths work. It also incorporates information and data mandated under the National Learning from Deaths Programme.

The report is being provided to the Mortality Surveillance Group for discussion and approval, prior to submission to the Quality and Safety Committee. The following are proposed as the key highlights, current topics and activity of particular relevance for providing assurance to the Executive regarding this workstream.

Points of note this quarter include:

- Mortality rates remain stable and well positioned against national and Model Hospital Peer, with HSMR in the first quintile and SHMI in the 'as expected' band 2.
- One 3SD HSMR alert. Three 4SD SHMI alerts.
- Our neonatal service had indicated that extended perinatal mortality for 2025 may be above the national average when reported by MBRRACE in 2027. An

in-depth review, including external peer review, has been undertaken to ensure robust learning and governance. Outcomes were shared with the Mortality Surveillance Group. No major issues or themes were identified.

- Following initial consideration of how health inequality/deprivation data can be used in our learning from deaths work, investigation continues as to additional metrics that might support our understanding.
- Following Aqua's decision to decommission their online SJRPlus review tool at the end of March 2026, development of a mortality module on ENHance is now complete. The SJR hub went live on 9 June 2026.
- Learning from SJRs continues to be promoted by asking all clinical governance leads to ensure they are discussed at specialty Mortality and Morbidity meetings.
- To date no Q1 deaths receiving an SJR has been judged by the reviewer to have been more likely than not due to a problem in healthcare.
- To date no Q1 deaths receiving an SJR have been assessed as evidencing poor care or very poor care thereby requiring escalation as a patient safety incident.
- Cardiology basket: collaborative work between Coding and Cardiology remains ongoing, with one element of the cardiology basket currently alerting (acute myocardial infarction).

  The Cardiology service has raised a concern regarding current delays to TAVI CT caused by capacity issues in radiology. The issue was highlighted by a recent patient safety incident, and focussed work is in progress to improve the situation.

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

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

Ongoing focus on the areas detailed in this report are vital for the following reasons:

Equality:

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

Patients' benefit/detriment:

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

Legal/Regulatory:

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

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

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

Identified Risk: *Please specify any links to the BAF or Risk Register*	
Please refer to page 5 of the report.	
Report previously considered at & date(s):	
Mortality Surveillance Group: 9 September 2026: Full report presented. Quality and Safety Committee: 30 September 2026: Full report presented.	
Recommendation	The Board is invited to note the contents of this report.

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1. Executive Summary

1.1 Summary

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

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

1.2 Impact

1.2.1 Strategic ambitions

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

1.2.2 Compliance with Learning from Deaths NQB Guidance

The national Learning from Deaths guidance states that trusts must collect and publish certain key data and information regarding deaths in their care via a quarterly public board paper. This paper provides this information for Q1 2026-27. An in-depth Learning from Deaths Report covering the same period was provided to both the Quality & Safety Committee, and Mortality Surveillance Group in June 2026.

1.2.3 Potential impact in all five CQC domains

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

Figure 1: Learning from deaths and CQC



1.3 Risks

The following represent areas identified where there is currently an element of concern. Two of these (ref 3491 and 3807) constitutes a formal risk on the Trust's risk register.

Table 1: Current risks

Risks	Red/amber rating
Extended neonatal mortality Our neonatal service gave an early indication that extended perinatal mortality for 2025 may be above the national average when reported by MBRRACE in 2027. An in-depth review, including external peer review has been undertaken to ensure robust learning and governance. While no major concerns or themes were identified, this will be badged as a risk pending the 2027 MBRRACE report.	
Delays to delivery of patient records to support SJRs The SJR review backlog is being significantly impacted by ongoing delays in the provision of patient records. While clinical care must remain the priority, continued issues will reduce our ability to provide timely learning and assurance, as reviews involving areas such as ED and ITU require access to paper records. A request has been made to the owner of the corporate risk relating to this issue to update the risk description to include the negative impact on the Trust's mortality review process and associated reduction in learning and governance.	Risk 3807
Cardiology: recurrent SHMI alerts to various elements of the cardiology basket of diagnosis groups Following recurrent mortality alerts across the cardiology diagnosis basket, and a report by the Cardiology Clinical Director, a joint initiative between Cardiology and Coding was implemented and remains ongoing. The latest update was at September Mortality Surveillance when it was agreed the collaborative work should continue with a further update in 12 months' time. One element of the cardiology basket of diagnosis groups is currently alerting: acute myocardial infarction, which will be reviewed as part of the ongoing collaborative work.	
Cardiology: Delays to TAVI CT scans The service has raised a concern regarding current delays to TAVI CT caused by capacity issues in radiology. The issue was highlighted by a recent patient safety incident and focussed work is in progress to improve the situation. Current risk score: 16.	Risk 3491
Ovarian Cancer SACT 30 Day Mortality: External review findings Following identification as a 30-day mortality outlier in the 2017-20 national SACT audit, an external review found gaps in integrated care at MVCC. A formal SI report has been completed, with a small number of outstanding actions expected to be completed by early 2027.	

	Low risk		Medium risk		High risk

2. Context

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

2.1 Headline mortality metrics

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

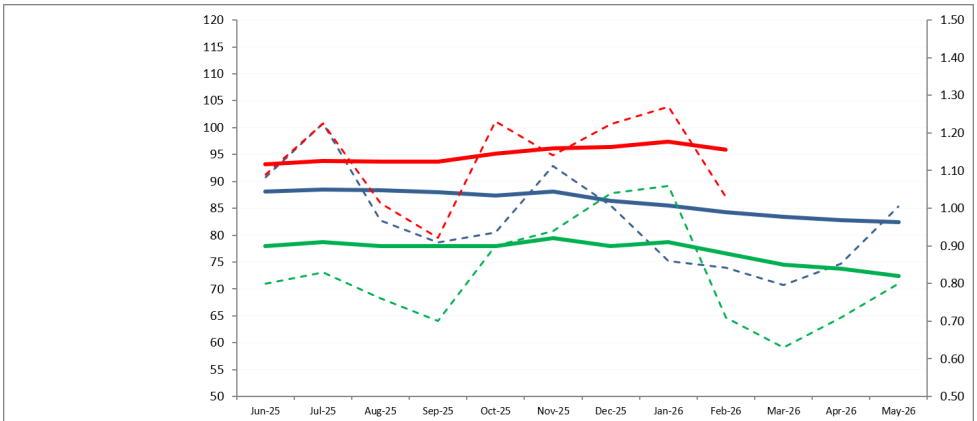
Table 2: Key mortality metrics

Metric	Headline detail
Crude mortality	Crude mortality is 0.83% for the 12-month period to May 2026 compared to 0.89% for the latest 3 years.
HSMR (data period Jun25 – May26)	HSMR for the 12-month period is **82.44, *'First quartile'*.**
SHMI (data period Mar25 – Feb26)	SHMI for the 12-month period is **95.91, 'as expected' band 2.**
HSMR – Peer comparison	ENHT ranked 2nd (of 11) within the Model Hospital list* of peers.

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

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

Figure 2: Trust key mortality metrics: Latest position



	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
HSMR - Monthly	90.7	100.8	82.7	78.7	80.5	92.9	85.4	75.2	73.9	70.7	74.7	85.3
HSMR - Rolling Month	88.1	88.5	88.3	88.0	87.3	88.1	86.4	85.5	84.3	83.4	82.8	82.4
SHMI - Monthly	91.3	100.8	85.9	79.6	101.2	94.9	100.6	103.9	87.0			
SHMI - Rolling Month	93.2	93.7	93.7	93.7	95.1	96.2	96.3	97.4	95.9			
Mortality Rate - Monthly	0.80	0.83	0.76	0.70	0.90	0.94	1.04	1.06	0.71	0.63	0.71	0.80
Mortality Rate - Rolling Month	0.90	0.91	0.90	0.90	0.90	0.92	0.90	0.91	0.88	0.85	0.84	0.82

Rolling 12-month SHMI reported by CHKS stands at **95.91** to Feb 2026.This represents a slight decrease from the last reported **96.2** for the12 months to Nov 2025. It marks the end of an upward trend that began in January 2025.

2.2 Mortality alerts

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

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

Table 3: HSMR CUSUM alert outliers: Rolling 12 months to May 2026

	Relative Risk	Observed Deaths	Expected Deaths	"Excess" Deaths	Included Spells
199 - Chronic ulcer of skin	288.00	15	5	10	77

2.2.3 SHMI CUSUM alerts
CHKS also reported four SHMI CUSUM red alerts constituting a rolling 12-month 3 standard deviation outlier for the latest period to February 2026.

Table 4: SHMI CUSUM alert outliers: Rolling 12 months to February 2026

	SHMI	Observed Deaths	Expected Deaths	"Excess" Deaths	Included Spells
57 - 100: Acute myocardial infarction	153.80	59	38	21	611
100 - 156, 158: Nephritis; nephrosis; renal sclerosis, Chronic renal failure	301.36	20	7	13	364
142 - 38: Non-Hodgkin's lymphoma	199.44	21	11	11	55
114 - 54, 202, 203, 208, 209, 210, 212: Rheumatoid arthritis related diseases, acquired deformities, bone disease	321.10	6	2	4	885

A coding review is in progress regarding chronic ulcer of skin, rheumatoid arthritis is to be discussed at September Mortality Surveillance. The nephritis group, non-Hodgkin's lymphoma and acute myocardial infarction are being monitored as part of ongoing coding/clinician initiatives.

When the full Learning from Deaths report was discussed at Quality & Safety Committee in September, a request was made for some additional assurance to be provided in the current summary report to Board regarding the SHMI myocardial infarction outlier alert.

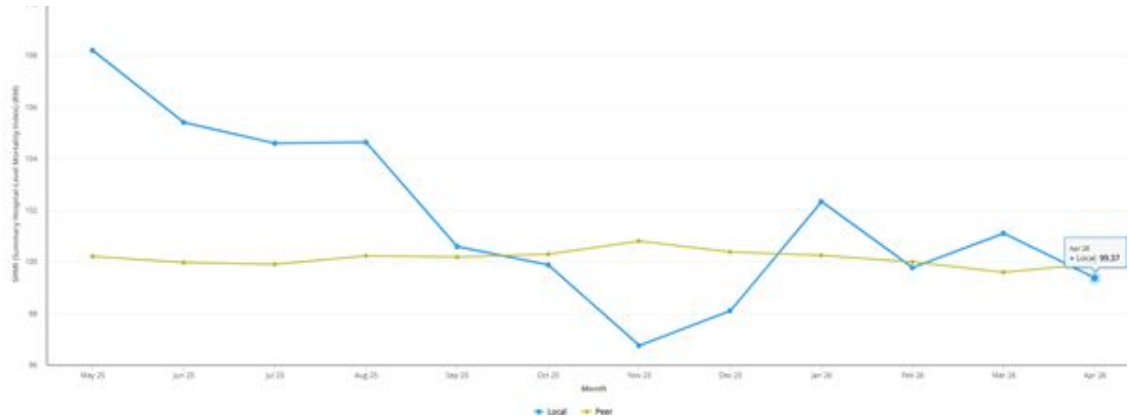
The Medical Director had indicated that while at a granular level, elements of the basket might alert, when viewed overall, the picture did not give rise to concern.

'Baskets' of diagnosis groups such as those which sit within cardiology, can be complex. Deciding which element of the 'basket' a particular case should be coded to is not always straightforward. Even with constant monitoring, inconsistencies arise, especially as patients whose deaths are coded as cardiology, are not always under the care of the cardiology service. For this reason, there is particular value in considering the basket as a whole when trying to gain assurance.

It is also important to understand that diagnosis group mortality alerts are not an indicator of poor quality but are a valuable tool for highlighting areas of potential concern.

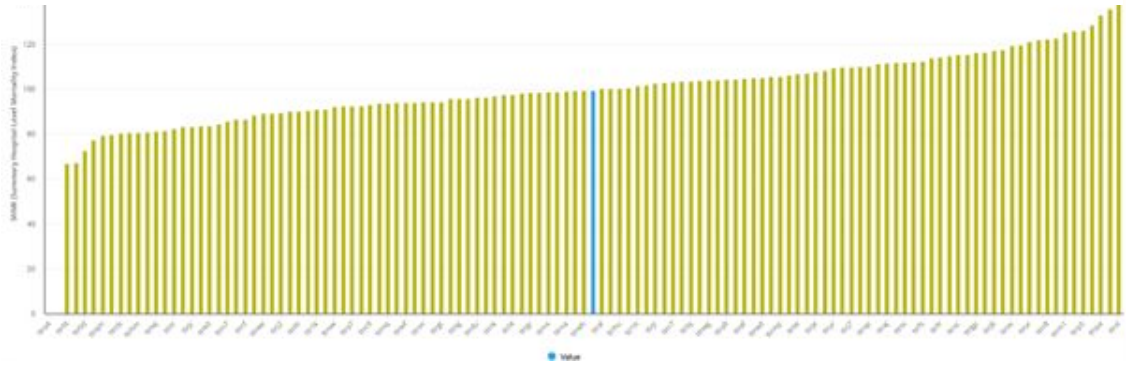
When the different elements of the SHMI cardiology diagnosis basket are viewed together, figure 3 below shows the rolling 12-month trend over the last year. This indicates an improving trend.

Figure 3: SHMI Cardiology basket of diagnosis groups R12M SHMI: May 2025 to April 2026



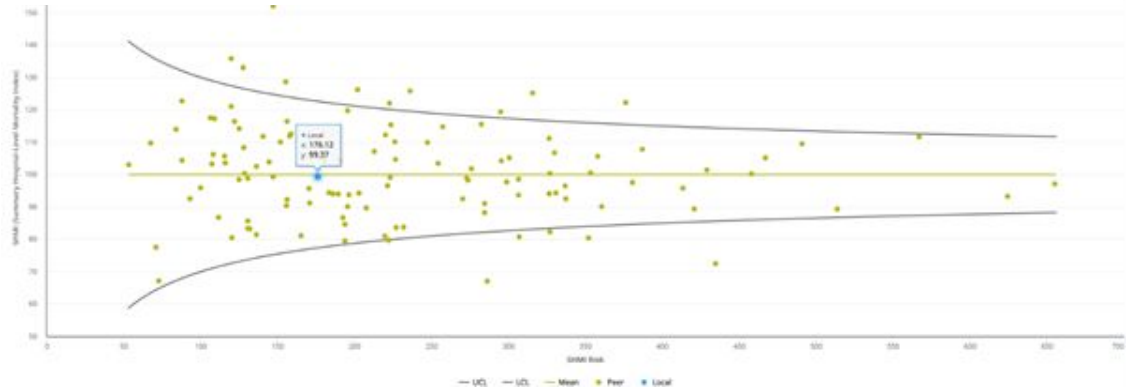
CHKS data also reveals that when the cardiology basket is viewed as a whole, we are positioned in the mid-range of trusts nationally, as shown in the below peer distribution chart:

Figure 4: Cardiology basket SHMI: May 2025 to April 2026: Peer distribution



Additionally, the below funnel diagram shows us positioned on the midline of the range of expected deaths, well within control limits.

Figure 5: SHMI Cardiology basket of diagnosis groups: Position within expected deaths range:



While the above data provides a degree of assurance, the real assurance comes from detailed clinical and coding reviews.

Due to the complexity of the cardiology basket and the recurrent/intermittent alerts regarding elements of it, collaborative work remains ongoing between the service and Coding. To date this work has not identified any significant clinical concerns. It continues to work to understand the alerts as they arise and provides an annual update to the Mortality Surveillance Group. The next report is scheduled for November.

It is a combination of the mortality data above, coupled with the findings from our ongoing clinical/coding collaborative which provide assurance regarding mortality within our cardiology service.

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

2.3 Health inequalities and deprivation

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

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

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

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

We are now routinely monitoring this indicator. To date this has shown that our Trust has a significantly higher percentage of activity relating to those in quintile 5 (least deprived) and significantly less activity relating to those in quintile 1 (most deprived) than the national average and that this is mirrored by the percentage of deaths in those quintiles.

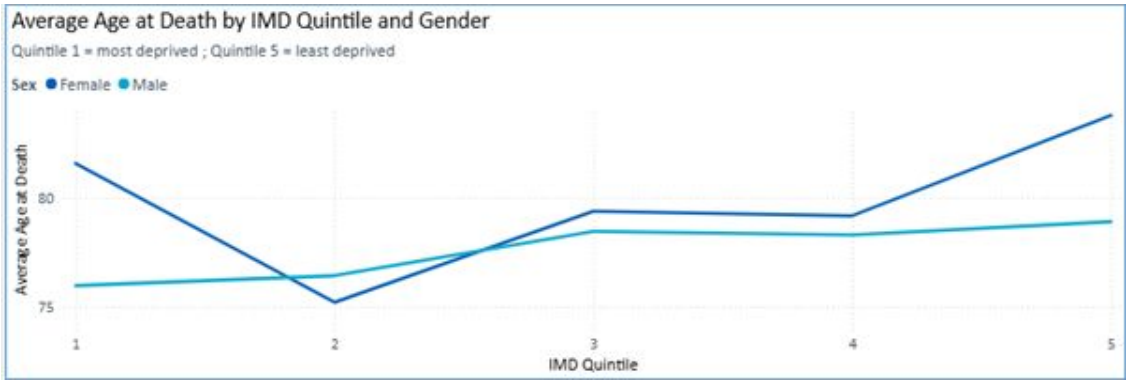
We have worked with our business intelligence colleagues to improve the accessibility of this deprivation information. The mortality space within Power BI now details deprivation quintile for each in-patient death. This detail is used to identify deaths of patients from lower quintiles so these can be selected for structured judgement review, thereby enabling us to identify any specific learning or themes that may help us to address potential health inequalities for this small, but vulnerable cohort of patients in our geographical area.

While we have recognised above that in comparison to the national picture, we have relatively low levels of deprivation in our geographical area, we still feel it important to glean whatever information we can.

Since looking at the comparison of the number of deaths in each socioeconomic quintile with the population proportion in that quintile had not provided much information about health service performance based on socioeconomic status, we have started to investigate other measures that may be more informative.

As a starting point we have added a metric to our Power BI mortality space that shows average age at death by deprivation quintile and gender.

Figure 6: Average age at death (in-patient) by IMD quintile and gender Jun-25 to May-26



With the exception of women in quintile 1, the overall profile is what we would have expected to see. We will consider what further review or investigation may be of benefit.

SJR outputs vs deprivation quintile data
When we initially decided to conduct SJRs of deaths in areas of the lowest deprivation, we were unsure whether we should only look at the first quintile or extend our review to cover quintile 2. The above chart suggests that our decision to include quintile 2 is justified. The initial exercise which was undertaken to review SJR outcomes by the patients' deprivation quintile, with a focus on those in the bottom two quintiles, will be repeated for 2025-26 deaths.

2.4 Key Learning from Deaths Data

2.4.1 Mandated mortality information

The Learning from Deaths framework states that trusts must collect and publish certain key data and information regarding deaths in their care via a quarterly public board paper. This mandated information is provided below for Q1 2026-27.

Table 5: Q1 2026-27: Learning from deaths data

	Apr	May	Jun
Total in-hospital deaths (ED & inpatient)	86	99	117
SJRs completed on in-month deaths (at 30.06.2026)	12	6	5
Patient safety incident escalation from SJR (by month of death) (at 30.06.2026)	1	0	0
SJR outcome: Deaths more likely than not due to problem in care (≥50%) (at 31.03.26)	0	0	0
Learning disability deaths	0	1	0
Mental illness deaths	6	1	0
Stillbirths	0	1	0
Child deaths (including neonates/CED) *	1**	0	1***
Maternity deaths	0	0	0
PSIIs reported regarding deceased patient	2	3	2
PSIIs approved regarding deceased patient****	0	2	0
Complaints received in month regarding deceased patient	4	1	1
Requests received in month for a Report to the Coroner	16	9	11
Inquests attended	8	2	3
Regulation 28 (Prevention of Future Deaths)	0	0	0

Notes:

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

** Child death in CAU in April was a palliative care case of a 3-year-old boy diagnosed with a high-risk neuroblastoma in November 2023.

*** This pre-term neonatal death in June was also a palliative care case. Although the pregnancy had passed the point for gestational viability, the baby had a non-viable prognosis due to antenatal diagnosis of lethal skeletal dysplasia (thanatotropic dysplasia). Born with signs of life and died 2 hours later with parents and family in CLU without NICU admission.

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

2.4.2 Learning from deaths dashboard

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

3.0 Scrutiny to SJR

3.1 Medical Examiner Scrutiny

Table 6: Medical Examiner scrutiny data: Q4 2025-26

Scrutiny detail	Jan	Feb	Mar	Q4 Total
Total in-hospital deaths (excluding MVCC)*	88	101	118	307
ENHT deaths scrutinised by ME	88	101	118	307
MCCDs not completed within 3 calendar days of death	17	11	12	40
ME referrals to Coroner	17	20	21	58
Deaths where significant concern re quality of care raised by bereaved families/carers	0	0	1	1
Patient safety incidents notified by ME office as a result of scrutiny	1	6	6	13
ME referrals for SJR	16	11	12	3
Community deaths reviewed	232	215	204	652
Deaths referred by the Coroner to ME office to review	30	32	24	86
Total deaths reviewed				1045

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

3.2 Structured Judgement Reviews

3.2.1 SJR and deaths YTD headline data

Table 7: Headline 2026-27 Q1 SJR and deaths data

Data count	Apr	May	Jun	Year Total
Total in-patient deaths	83	94	105	282
Total ED deaths	3	5	12	20
SJRs completed on in-month deaths (at 30.06.2026)	12	6	5	23

The above table shows that by 30th June 2026, 8% of 2026-27 hospital deaths have received a formal structured judgement review. This is currently below our internal target of 25%. This is due to the fact that there was a hiatus in the conduct of reviews following the decommissioning of the Aqua SJR tool at the end of March and go-live of our newly developed hub on ENHance at the beginning of June. Our aim will still be to achieve our 25% target by the end of the financial year.

Unfortunately, at the moment our SJR reviewer team's ability to catch up on the backlog of deaths for review is being seriously jeopardised by the current Trust-wide

issue with delivery of patient records by the Medical Records department. We are aware that this has been raised as a risk on the corporate risk register.

While we understand that while challenges persist, priority must be given to those needing notes for patient facing clinic appointments and surgical operations, if this issue is not addressed it will have a negative impact on the quantity and quality of learning and assurance we are able to provide in the current financial year. While reviewers are able to glean much of the information they need from electronic notes, the review of critically important areas such as ED and ITU still require the paper notes.

3.2.2 Learning beyond SJR
3.2.2.1 SJR patient safety incident escalations

Table 8: Year to end of Q1 Patient Safety Incidents reported following SJR

Escalations for deaths in month (at 30.06.2026)	Apr	May	Jun	Total
Patient Safety Incident Escalations from SJRs	1	0	0	1

For deaths in the current year which have been subject to an SJR, 1 case have been escalated as a patient safety incident.

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

In Q1, one case matching these criteria were concluded and discussed at Mortality Surveillance.

Table 9: Q1 2026-27: Concluded Escalated Cases Summary

SJR/ SI/PSII	Death Preventability (Final MSG decision)	Incident category	Learning themes
PSII	Strong evidence of preventability	Management of Patient with an LD	Multiple opportunities for improvement were identified: • Assessment, investigation or diagnosis • Nutrition • Treatment/Management Plan • Clinical Monitoring/Observations/Planning • Communication with patient, relatives and carers

			• Fundamentals of Care • Recognition of a deteriorating patient.

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

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

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

4.0 Improvement activity

Table 10: Focus Areas for Improvement

Diagnosis group	Summary update
Ovarian Cancer	In the 2017-20 national Systemic Anti-Cancer Therapy (SACT) audit, the Trust was identified as an outlier for 30 Day Mortality. The subsequently commissioned external peer review identified a lack of integrated care at MVCC. Following completion of the review of patient care, a formal SI report was completed. A small number of associated actions remain outstanding. This risk will be maintained until these are confirmed as complete. Revised anticipated completion Spring 2027.
Cardiology diagnoses	Following recurrent mortality alerts across the cardiology diagnosis basket, and a report by the Cardiology Clinical Director, a joint initiative between Cardiology and Coding was implemented and remains ongoing. The latest update was at September Mortality Surveillance when it was agreed the collaborative work should continue with a further update in 12 months' time.
Sepsis	While HSMR performance relative to national peer remains extremely well placed, achievement of sepsis targets remains variable. The sepsis team continues to develop multiple initiatives aimed at improving compliance.
Stroke	SSNAP recently published the mortality report covering the year 2024-25. While SSNAP risk adjusted mortality had increased from the 2023-24 year (105) (standing at 111 for the year Apr24-Mar25), performance was well within the confidence interval, with the Trust not being categorised as

	an outlier. The Trust had maintained the D rating with improvements in two domains and a drop in only one. Our overall score (rounded up) improved from 44-50. There is a multidisciplinary team which continues to work on all aspects of performance which is reflected in the service's overall action plan and is discussed at their regular performance meetings.
Emergency Laparotomy	In the 2019 National Laparotomy Audit Report, the Trust's risk adjusted mortality for emergency laparotomy stood at 13%, with the Trust ranked in the bottom 20% of reporting Trusts nationally. Since this time the NELA service has worked tirelessly to improve performance. In collaboration with Coding/Business Intelligence the service is working to create a script to identify all NELA cases aimed at significantly increasing case ascertainment. In the meantime, manually checking theatre activity has resulted in a significant improvement to case ascertainment (currently close to 100%). Once the script is functioning, work is proposed to enable more real time access to data. There has been significant improvement to the service by virtue of 80% of NELA patients now being seen by a consultant geriatrician. Strategic focus is maintained via a regular NELA meetings. The current focus is on time from front door to theatre, including ED assessment and CT scan. Establishing a dedicated radiology request on ICE for NELA CT remains a challenge.

5.0 Preventable deaths

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

The table below provides year to end of Q1 deaths/SJR/Preventability data (detailing SJRs conducted up to 30 June 2026). The outcome of investigations and actions relating to deaths judged more than 50:50 preventable are discussed by the Mortality Surveillance Group.

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

Table 11: SJR preventable deaths data for 2026-27 year

Data count (at 30.06.2026)	**A**pr	May	**J**un	**Total**
Hospital deaths (ED & inpatient)	86	99	117	302
SJRs completed on in-month deaths	12	6	5	23
% of deaths subject to SJR to date	14%	6%	4%	8%
Deaths judged more likely than not to be due to a problem in healthcare	0	0	0	0
% SJRs assessed ≥50:50 preventable	0%	0%	0%	0%

6.0 Options/recommendations

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

Appendix 1: Learning from Deaths Dashboard

East and North Hertfordshire Trust: Learning from Deaths Dashboard - June 2026-27

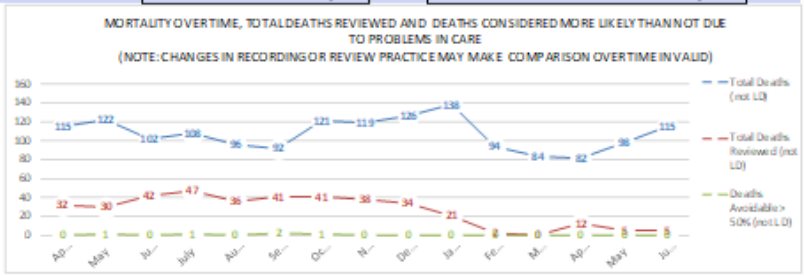
Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

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

Total Number of Deaths, Deaths Reviewed and Deaths Deemed more likely than not due to problems in care (does not include patients with identified learning disabilities)

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered more likely than not due to problems in care PRISM Score<=3 or equivalent measure	
This Month	Last Month	This Month	Last Month	This Month	Last Month
115	98	5	5	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
295	316	22	23	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
295	1317	22	364	0	5

Time Series: Start date 2025-26 Q1 End date 2026-27 Q1



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

Score 1 Definitely preventable			Score 2 Strong evidence of preventability			Score 3 Probably preventable (more than 50:50)			Score 4 Probably preventable but not very likely			Score 5 Slight evidence of preventability			Score 6 Definitely not preventable		
This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	5	100.0%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	1	4.5%	This Quarter (QTD	21	95.5%
This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	1	4.5%	This Year (YTD)	21	95.5%

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

Total Number of Deaths, Deaths Reviewed and Deaths Deemed more likely than not due to problems in care for patients with identified learning disabilities

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered more likely than not due to problems in care	
This Month	Last Month	This Month	Last Month	This Month	Last Month
0	1	0	1	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
1	3	1	2	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
1	9	1	8	0	0

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



Board

East and North Hertfordshire Teaching NHS Trust

Meeting	Public Trust Board			**Agenda Item**	15
Report title	Fuller Report update			**Meeting Date**	11 November 2026
Author	Head of Operations - Diagnostics				
Responsible Director	Chief Nurse				
Purpose	**Assurance**	☒		**Approval/Decision**	☐
	Discussion	☐		**For information only**	☐
Proposed assurance level	**Substantial assurance**	☐		**Reasonable assurance**	☒
	Partial assurance	☐		**Minimal assurance**	☐

Assurance rationale:

The Board is asked to take reasonable assurance from this review of the actions completed from the Fuller Review. This is monitored through the division and reported into Trust Management Group (TMG) and at Quality and Safety Committee (QSC). One action remained as outstanding from the Fuller Part 2 review, which relates to 24hr CCTV and sitting with the Estates & Facilities Department.

Summary of key issues:

- All actions completed in place and audited regularly
- Mortuary also had a HTA unannounced inspection in early 2026 – all actions complete from this inspection and good outcome reported.

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

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

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

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

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

One action remains outstanding relating to 24 hr CCTV and sitting with estates and facilities department

Report previously considered at & date(s):

Report presented to TMG 10 September 2026 and QSC 28 October 2026.

Recommendation	The Board is asked to take Reasonable Assurance from this paper, and to support progression towards full assurance.

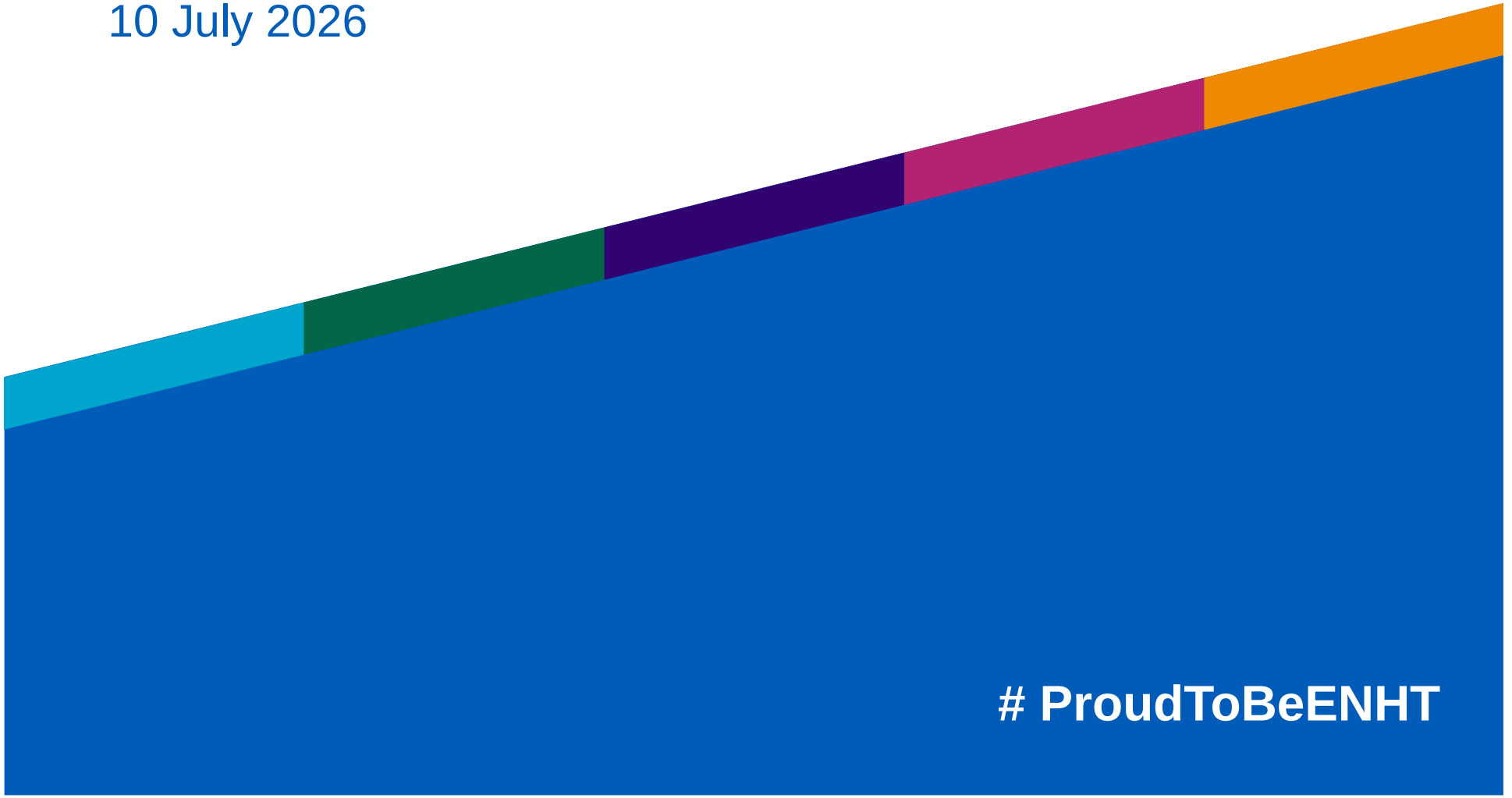
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NHSE Fuller Independent Inquiry Compliance Update and HTA Unannounced Visit Action Plan

East and North Hertfordshire Teaching NHS Trust

HTA Designated Individual

10 July 2026



Annex 3 – Board Assurance Statement for NHS Provider Trusts.

East and North Hertfordshire Teaching NHS Trust

Assurance Statement	Confirmed (yes/no)	Additional comments or qualifications (optional)
The roles and responsibilities between the relevant teams responsible for mortuary care, including estates, safeguarding, pathology, bereavement, mortuary and corporate services, are clear, understood and are tested on a regular basis.	Yes	Roles and responsibilities are clear (HTA Designated Individual and Persons Designated, mortuary manager works with other stakeholders in ensuring that the security and dignity of the deceased are protected
The Board has undertaken a review of progress against the 21 recommendations immediately relevant to the NHS as made by the Fuller Inquiry. Where the Trust is not fully meeting a specific recommendation, a time-limited action plan is in place to close any gaps.	Yes	Review of the 21 recommendation of the Fuller Phase report completed: • 20 recommendations compliant • 1 recommendation partially compliant that relates to recommendation 1 which also a non-compliant for the PAM. The trust currently do not have a centralised 24/7 monitoring of CCTV cameras
In line with updates to the NHS Safeguarding Accountability and Assurance Framework, executive leadership has been reviewed with clear oversight of arrangements for the safeguarding of people after they die.	Yes	In line with updates to the NHS Safeguarding Accountability and Assurance Framework, executive leadership arrangements have been reviewed to ensure clear accountability and oversight for the safeguarding of people after death.

East and North Hertfordshire Teaching NHS Trust

Assurance Statement	Confirmed (yes/no	Additional comments or qualifications (optional)
The Board can assure itself the organisation has a plan in place to ensure the effective oversight of matters relating to mortuaries, related storage areas (or wider facilities) where the deceased are cared for, including the correct information and governance arrangements. If it cannot, it has identified the actions necessary to address this and a plan is in place to implement them as a matter of urgency.	Yes	The Chief Nurse has overall responsibility in assuring the board that the mortuary management is delivered that protects the security and dignity of the deceases through various cadence of oversight.
For all issues related to estates, there is an agreed timeline in place to undertake a self-assessment against the latest version of the NHS Premises Assurance Model and submit data within the current window (closing 8 September 2026), ensuring that your plan includes PAM sign-off from your Board prior to submission.	Yes	SH22.2 and SH22.3 that relates to centralised 24/7 monitoring of CCTV cameras - we do not have timeline for implementation However, as part of the implementation of Martin's Law, we need to be compliant with the centralised monitoring of CCTV cameras by Aril 2027

Board

East and North Hertfordshire Teaching NHS Trust

Meeting	Public Trust Board		**Agenda Item**	16	
Report title	Safeguarding Annual Report		**Meeting Date**	11 November 2026	
Author	Lead Nurse for Adult Safeguarding Head of Children's & Maternity Safeguarding				
Responsible Director	Chief Nurse				
Purpose	**Assurance**	☒	**Approval/Decision**	☐	
	Discussion	☐	**For information only**	☐	
Proposed assurance level (*only needed for assurance papers)*	**Substantial assurance**	☒	**Reasonable assurance**	☐	
	Partial assurance	☐	**Minimal assurance**	☐	

Executive assurance rationale:

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

Summary of key issues:

The Safeguarding Annual Report 2025/2026 outlines the work undertaken by the Trust during the past year. Safeguarding is the term used for protecting children and adults from abuse or neglect.

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

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

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

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

Key highlights of 2025/2026 include:

- Launch of new trust wide Safeguarding Digital Hub – ENHance
- Business Case Planning – uplift to clinical nurse specialist hours approved supporting service growth and development
- Key involvement in multi-agency practice audits and locally led audit schedule
- Enhanced and strengthened integration between Perinatal Mental Health (PNMH) and Maternity Safeguarding services through creation of risk assessment tool

- Introduction of Vulnerable Women's Study Day – Integrating all aspects of supporting vulnerable women and unborn baby (UBB) into midwifery care and practice
- A HSCP Peer review Section 11 multiagency assessment result of good/areas of outstanding
- The Safeguarding Team has led on and coordinated several improvement initiatives to strengthen processes and procedures across the Trust, supporting staff to deliver safe, effective, and person-centred care to individuals with a learning disability including appointing the Trusts 1st Learning disability lead consultant.
- Retained a domestic abuse and sexual assault practitioner post the disbandment of the Trusts DSAT team.

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

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

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

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

Report previously considered at & date(s):

Quality and Safety Committee 30 September 2026.

Recommendation	The Board is asked to NOTE the report.

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Introduction

Welcome to the combined East and North Hertfordshire Teaching NHS Trust (ENHT) safeguarding annual report 2025-2026. ENHT continues to be committed to safeguarding all patients, their families and our staff, and safeguarding is a fundamental component of our Trust values. Safeguarding is everyone's responsibility, and we all have a duty to protect our patients from abuse and harm.

This report reflects the arrangements to safeguard and promote the welfare of children, young people, and adults at risk within ENHT. In doing so, the Trust discharges part of its responsibility for Board-level assurance, scrutiny and challenge of safeguarding practice within the Trust, as outlined in the statutory requirements of section 11 of the Children's Act (2004), Working Together to Safeguard Children (2026), the Mental Capacity Act (2015) and the Care Act (2014).

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

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

Safeguarding governance and oversight

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

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

The Learning Disability Working Group continued to meet as a sub-group of the Safeguarding Committee throughout 2025/26, providing oversight of safeguarding matters relating to individuals with learning disabilities and supporting the Trust's commitment to reducing health inequalities and improving patient experience through the provision of reasonable adjustments. During the 3rd and 4th quarters of 2025/26, the group transitioned from bi-monthly to monthly meetings, operating as a focused Learning Disability Improvement Forum. This enhanced governance arrangement was established to oversee and expedite delivery of the service improvement recommendations arising from the Patient Safety Incident Investigation ER (PSII) and Hertfordshire Safeguarding Adults Board (HSAB) Safeguarding Adults Review for ER.

Safeguarding team leadership Structure and Statutory Roles

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

The safeguarding leadership structure includes:

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

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

Demand and Capacity

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

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

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

Performance Monitoring

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

Embedding Safeguarding across the Trust

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

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

Trust safeguarding policies and procedures

Trust Safeguarding policies and procedures are reviewed and updated regularly to reflect changes in practice, learning from case reviews, and national guidance and recommendations. The Safeguarding Team currently has responsibility for overseeing 13 policies and 10 standard operating procedures across the organisation. Any revisions to existing policies, as well as the development of new policies, continue to be subject to approval through the Trust's Safeguarding Committee.

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

- Paediatric Was Not Brought in Policy (WNBI)
- SUDIC Child Death Policy
- Child Protection Medical Standard Operating Procedure
- Trust-wide policy for the Mental Capacity Act 2005
- The care of adult patients with learning disabilities
- Trust-wide Policy for safeguarding adults at risk of abuse and neglect, including radicalisation LeDeR programme notification, in the event of the death of inpatients who have learning disabilities or autism

In addition, the Safeguarding Team is routinely involved in the development, review, and updating of policies and procedures for the Hertfordshire Safeguarding Adults Board and the Hertfordshire Children's Safeguarding Partnership, working collaboratively with our partner agencies.

Assurance Visits

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

A Section 11 audit was carried out alongside the HSCP in March 2026 to ensure compliance with our responsibilities under the Children's Act (2004) and the Care Act. The audit and peer review found good assurance with areas of outstanding across all aspects of Safeguarding practice at East and North Hertfordshire Teaching NHS Trust. An action plan is currently in place and being worked through in view of the key recommendations and findings.

The most recent Adult Safeguarding, Multiagency service Review was undertaken in March 2024. The Safeguarding Team are currently awaiting confirmation from the Integrated Care Board (ICB) and the Hertfordshire Safeguarding Adults Board regarding the assurance and self-assessment arrangements for the next review cycle in 2026.

In the interim, the team continues to maintain oversight of safeguarding assurance through established governance processes, including regular reporting to the Safeguarding Committee, monitoring compliance with statutory safeguarding responsibilities, and progressing service improvement initiatives. This approach ensures that the Trust remains well positioned to demonstrate ongoing compliance with safeguarding standards and readiness for future Multiagency Service Review assurance requirements.

Data Reporting

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

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

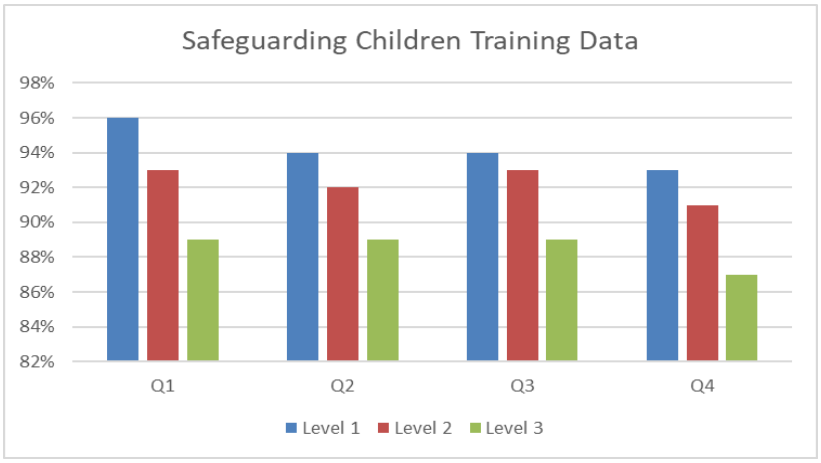
We are now able to collect and collate data which identifies the number of children affected by domestic abuse, through referrals to children's social care and cases heard at Multi Agency Risk Assessment Conference (MARAC). During the reporting period, the Maternity Safeguarding team attended 32 MARACs,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

Knife crime data is shared for all child and adult attendances to the organisation with the county safety unit.

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

Children and Maternity Safeguarding

Safeguarding Children Training Compliance 2025 – 2026



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

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

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

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

Launch of new Trust Wide Digital Safeguarding Hub – ENHANCE



The Safeguarding HUB on the Trusts ENHance software was launched in November 2025 and represents a significant advancement in the digitalisation of safeguarding processes across the Trust. The Hub has strengthened the management of safeguarding activity by providing a centralised platform through which staff can submit safeguarding referrals and information-sharing communications directly to the Safeguarding Team for triage, review, and action.

The introduction of the Safeguarding Hub has streamlined referral pathways and improved the timeliness, consistency, and quality of safeguarding processes. It has enhanced the Trust's ability to share information effectively, communicate safeguarding concerns and outcomes, and provide a

clear audit trail of decision-making and actions taken. This enables patient-facing teams to access timely safeguarding advice and supports accurate documentation within the Trust's electronic patient record systems.

Additional benefits include improved oversight of safeguarding activity, enhanced record-keeping, and greater visibility of safeguarding interventions across the organisation. The Hub facilitates more effective multidisciplinary working by enabling the timely exchange of information between clinical teams and safeguarding professionals, ensuring safeguarding concerns are managed in a coordinated, transparent, and accountable manner.

The implementation of the Safeguarding Hub has also significantly reduced the administrative burden associated with the day-to-day management of safeguarding services.

Local partnership working

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

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

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

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

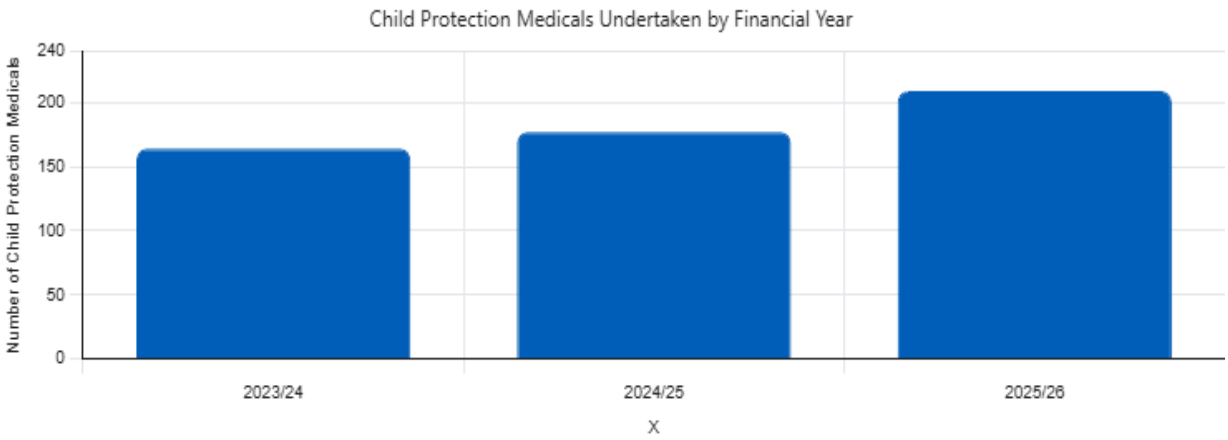
The Trust safeguarding team have also been involved in the following areas of partnership work:

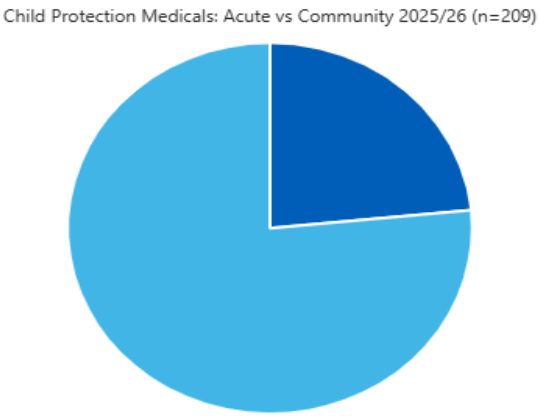
- Task and Finish Group – LADO
- HSCP – Whole Family Working Group
- Multi-Agency Audit – Bruising
- Multi-Agency Audit – Domestic Abuse
- Multi-Agency Audit – Child Sexual Abuse
- Multi-Agency working groups to incorporate learning from SAR's and DHR's throughout the local health and social care economies.

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

Safeguarding Activity

Child Protection Medicals 2025/2026





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

Children who attend the acute hospital with concerns relating to injuries or significant neglect will also be offered a child protection medical for a detailed and holistic assessment of any injuries of concern. This service is covered by the Acute Paediatric Team and Safeguarding Nurse Specialists are involved in oversight and coordinating professionals to support safe discharge arrangements.

The chart above details an increase from 164 Child Protection Medicals Conducted in 2023/2024 to 209 in 2025/2026. This upward trend may reflect improved awareness and recognition of safeguarding concerns, enhanced referral pathways, or increased reporting of suspected abuse and neglect. The data highlights the continued demand for the Trust's Community Child Protection Medical Service, which provides a holistic and multidisciplinary approach to safeguarding children,

ensuring that both medical and emotional needs are thoroughly assessed. The second chart reflects a significantly higher amount of Child Protection medicals remain via the community route, which supports avoiding prolonged hospital admissions and distress for children and their families. A total of 160 Child Protection medicals took place via the Community Route and 49 where children were found to have injuries of concern during their attendance to unscheduled care settings.

Referrals to Social Care



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

The chart illustrates the number of social care referrals made between 2019–2020 and 2024–2025, categorised by Maternity, Children, and total referrals. Across the reporting period, there has been a sustained upward trajectory in overall referrals, indicating a continued and growing focus on safeguarding within the organisation. Maternity referrals have shown a gradual but consistent increase, particularly evident from 2021–2022 onwards. This suggests heightened professional awareness and proactive identification of safeguarding concerns relating to unborn and new-born babies. During this year, the team have had heightened focus on improving recognition and response to safeguarding concerns for unborn babies (UBB), with the introduction of the Maternity Rag Rating Tool, to support safeguarding risk assessments at the point of booking. This innovation and practice development, alongside an increase in training activity and strengthening of policies, has supported this increase and drive for safeguarding vulnerable women and UBBs.

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

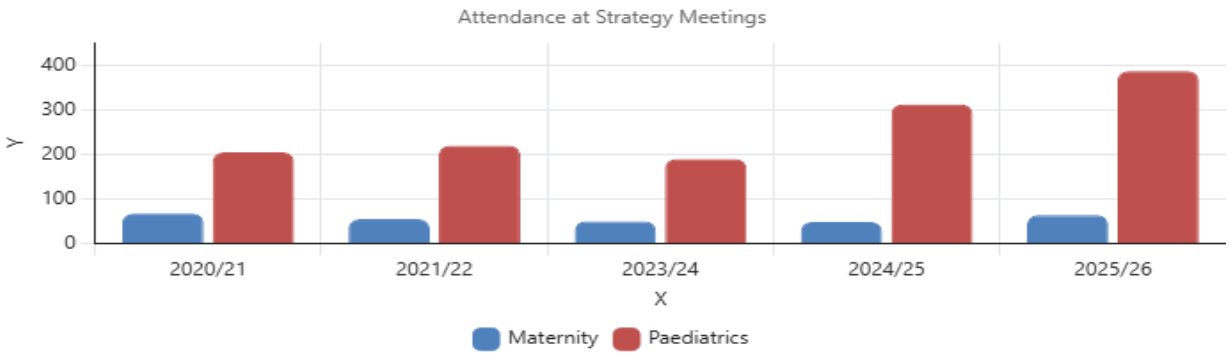
The most frequently recorded concerns relate to children's mental health and parental or family mental health, which together account for a significant proportion of referrals, which is in keeping with our previous year data. This reflects the continuing impact of mental health challenges on children and families and social complexity for CYP and their families.

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

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

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

Strategy Discussions



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

At ENHT, we have been committed to working with our partner agencies to improve our attendance and participation at strategy meetings. There has been a clear year-on-year increase in the amount of strategy meetings which are attended by both the safeguarding team and paediatric team, enabling the development of effective rapid action plans with an effective health focus. In 2025/2026, the safeguarding team attended a total of 451 strategy meetings which is in keeping with the increased referral and recognition across the partnership for children requiring child protection medical assessments for concerns of physical abuse and neglect. A reflection on complexity of safeguarding children concerns for children attending the acute trust, also accounts for a significant number of these meetings.

Maternity Risk Assessment

Between 1 April 2025 and 31 March 2026, a total of 4,332 births were recorded, compared to 4,329 births in 2024/2025.

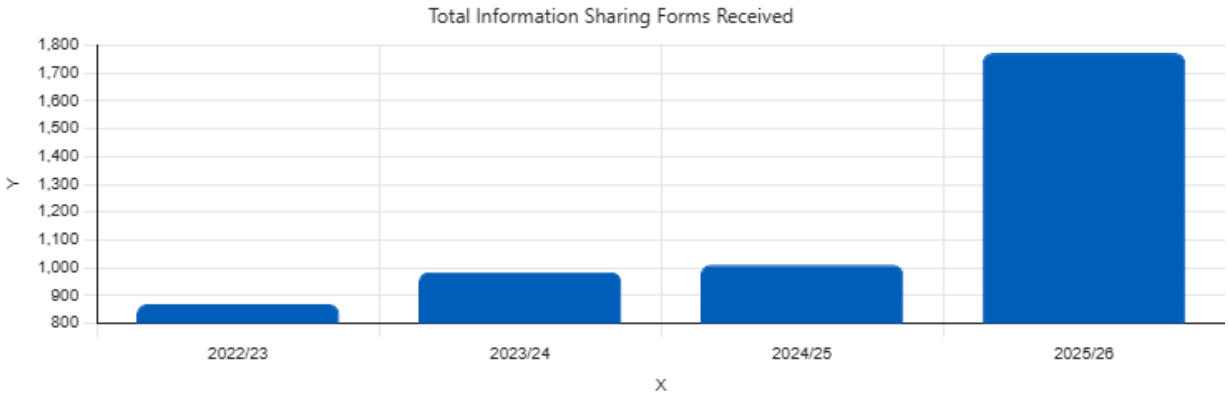
Risk assessment continues to be undertaken through the review of Information Sharing Forms (ISFs) completed by midwives and other professionals. These forms are triaged by the Maternity Safeguarding Team using community safeguarding records and shared care systems to ensure comprehensive assessment.

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

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

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

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



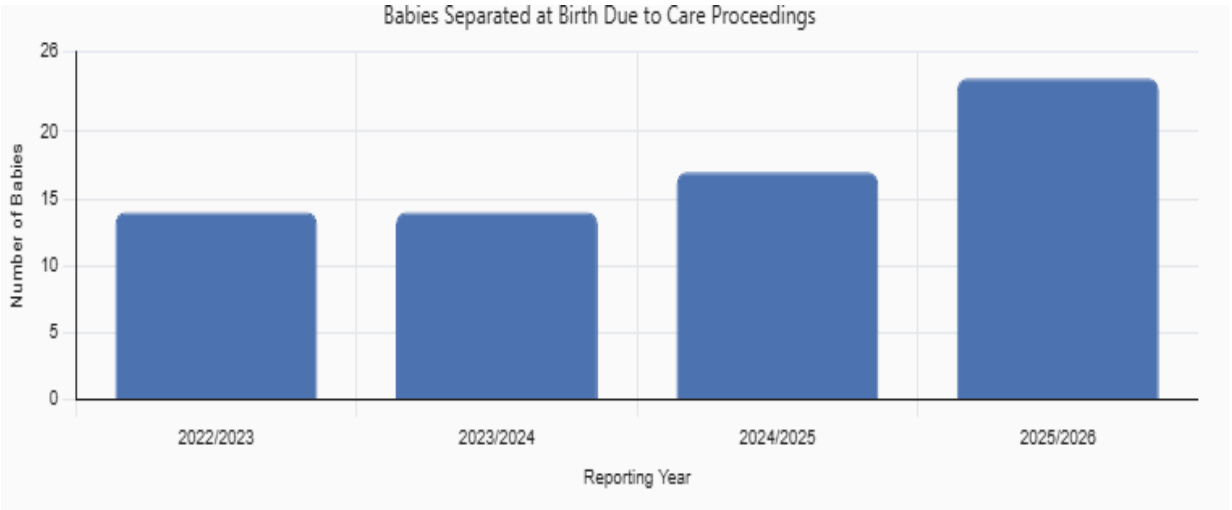
The following chart illustrates the number of Information Sharing Forms (ISFs) received during the reporting period; we have seen a significant increase in the amount of information sharing forms received. This rise is reflective of the positive impact of enhanced maternity safeguarding training, policy development, and a stronger organisational focus on early identification and response to vulnerability and safeguarding concerns – alongside the digital and pathway improvements made this year.

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

Maternity Cases Involving Initiation of Care Proceedings

In previous reporting periods, there were 14/17 cases in which care proceedings were initiated at birth, resulting in the separation of babies from their mothers. During the 2025–2026 reporting year, this number increased to 24 cases, representing a 41% compared with the previous year. This rise will need to be monitored, and some thematic analysis required to further understand this if the rise is sustained, or further increases.

Debriefs and safeguarding supervision is now routinely embedded for all staff involved in parent child removal, offering a psychological space for reflection and support.

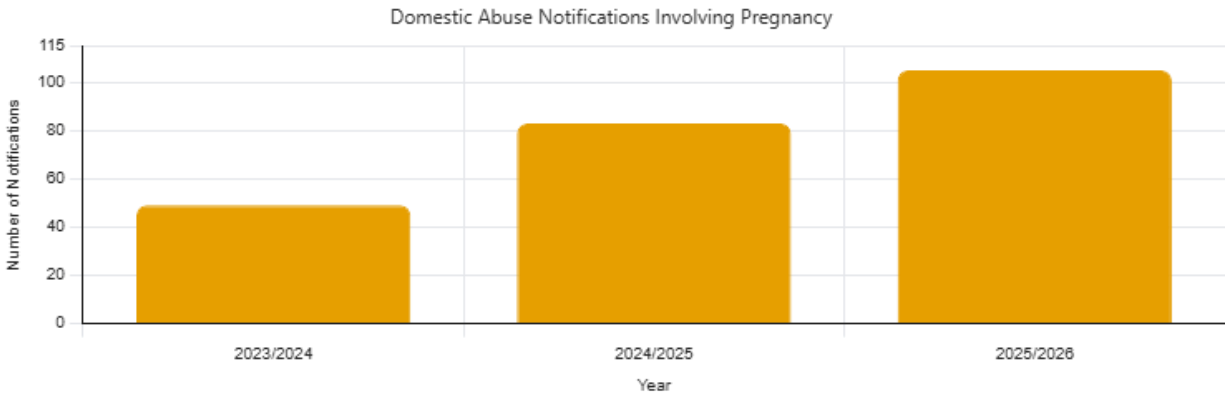


Domestic Abuse Notifications

Throughout this reporting period processes for Domestic Abuse (DA) notifications involving pregnancy have been improved through strengthened working relationships and enhanced

information sharing with the Police. As a result, all DA notifications involving pregnancy are now received, where previously notifications were limited to women over 28 weeks' gestation.

There has been a notable year on year increase in receipt and information sharing surrounding Domestic Abuse notifications involving pregnancy. All domestic abuse notifications are informed to the safeguarding team and shared with the community midwife supporting the individual – Domestic Abuse Services and further risk assessments are completed to support safety for both the survivor and unborn baby.



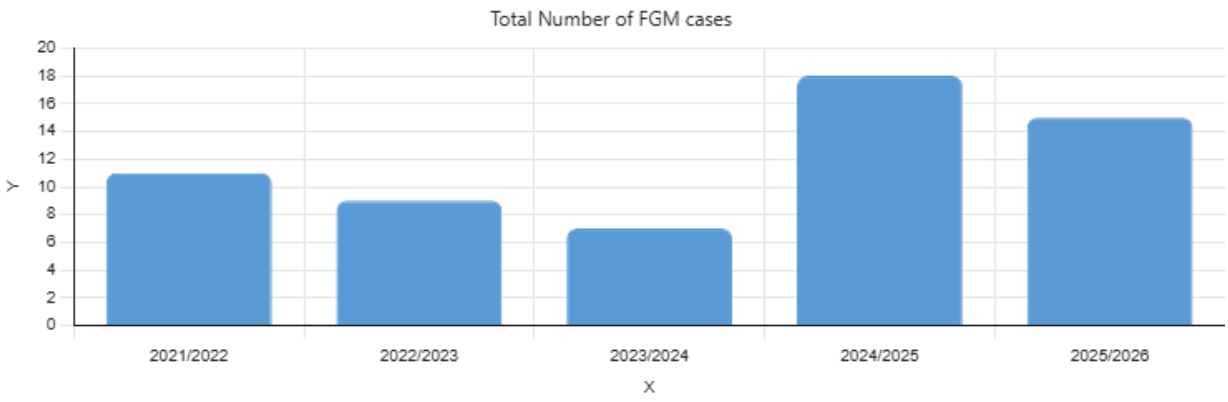
Female Genital Mutilation (FGM)

The number of women booked for maternity care within ENHTT who have undergone Female Genital Mutilation (FGM) remains low. However, from 2023/2024, we have seen a consistent upward recognition and support for women who have undergone FGM.

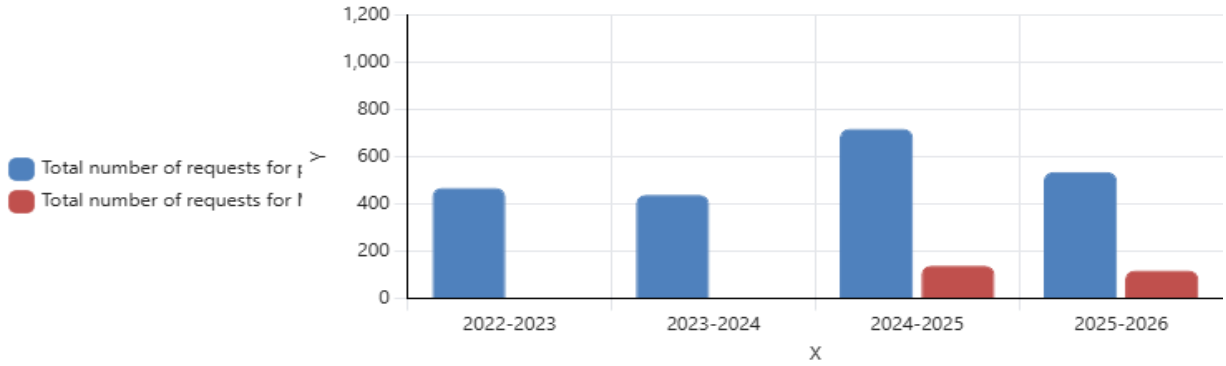
The chart below illustrates the number of women identified with FGM at booking over the past three reporting years. In all cases, a comprehensive risk assessment is undertaken, and referrals are made to Children's Social Care in line with the Hertfordshire Safeguarding Children Partnership policy. Additionally,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

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

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



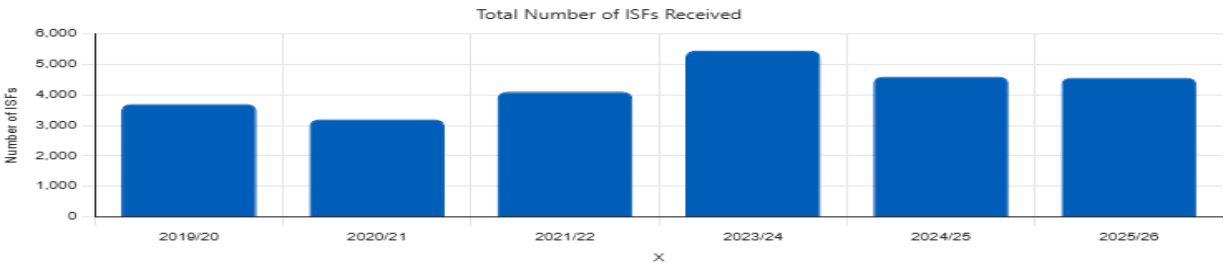
Requests for Information – S17 and 47 requests



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

In previous years, it was identified that all S17/47 and MASH requests were directly being requested to ENHTT safeguarding team, in instances where children were not known, and no information was held by ENHTT about the child or family. There has been effective partnership working over the last 2 years looking at streamlining requests for information for children who are known to our service, therefore supporting an appropriate and proportionate information sharing process which is tailored to the child and their family. Notably an increase from 2023-2024, which also reflects and aligns with the increase in Safeguarding activity seen across the Trust – this increase has also been maintained into 2025/2026.

Paediatric Liaison



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

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

To further strengthen this process the enhance safeguarding hub has now been a full digital solution to our paediatric liaison service, increasing accessibility for staff, timely information sharing practices and clear records of risk assessments and decisions made.

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

There has been a year-on-year increase in recognition and information sharing from the Trust to partner agencies. Frontline staff are more frequently identifying children and young people who require further support or follow-up from community health services such as Health Visiting and School Nursing. The safety netting process, screening all discharge summaries for children and

young people under 18, remains a crucial part of the service. It ensures that all attendances meeting information sharing criteria are reviewed by the Paediatric Liaison Team.

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

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

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

Looked-After Children (LAC) Health Assessments ENHT 2025-2026

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

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

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

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

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

Child Death

ENHT have a child death lead who is a Consultant Paediatrician who has responsibility and oversight for the involvement of ENHT in all child deaths.
In addition, the paediatric liaison/safeguarding children's team, along with the divisional quality manager, also supports and continues to be the link between professionals for CDOP, Hertfordshire Community NHS Trust (HCT) and ENHT. The link professionals represent the Trust at rapid response meetings quarterly and share agency summary reports.

All child deaths continue to be reported on the Trust risk management and incident reporting system ENHance and are reviewed at divisional incident review meetings which take place weekly in Paediatrics. This incorporates the PSIRF which supports the decision-making process if further

investigation is required. In all cases a Rapid Incident Review/Child Death Review is completed and taken to panel for further decision making on any further investigation required.

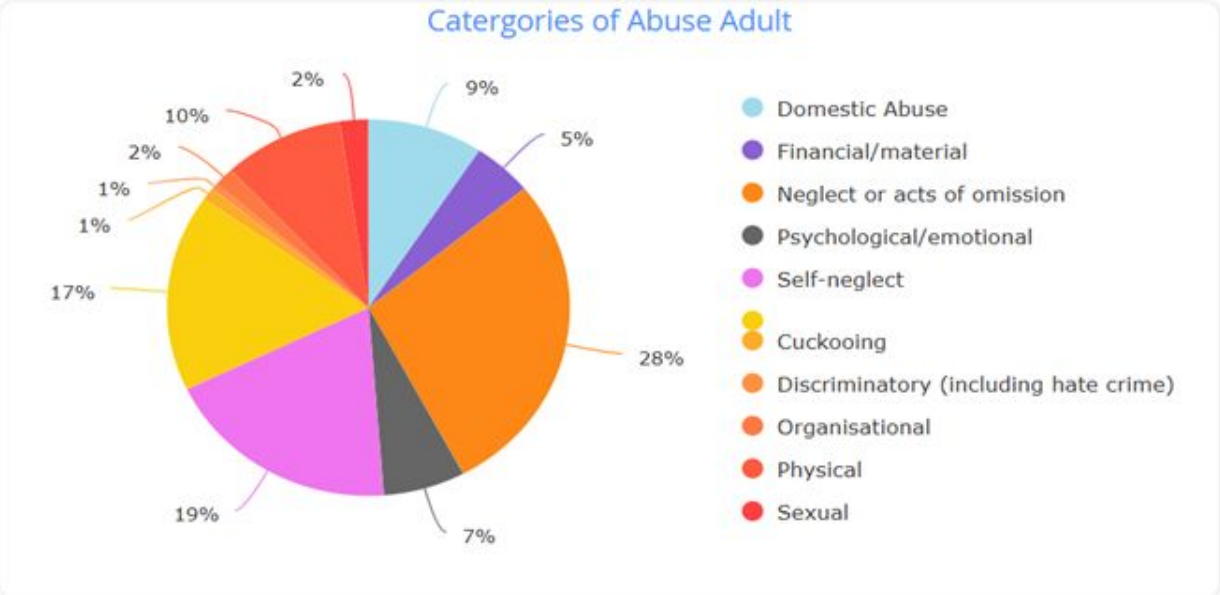
ENHT continue to be an active member of the rapid Response to Child Death steering group and have trust wide paediatric mortality review meetings, which examine the dissemination of learning and good practice across the division and Trust.

Safeguarding Adults

Activity

During 2025/26, the Trust's Adult Safeguarding Team received a total of 658 safeguarding concerns relating to vulnerable adults. This represents a marginal increase of 1.5% compared to the previous year. These concerns were raised by Trust staff on behalf of service users and related to suspected or actual incidents of abuse occurring within the community.

The chart below, taken from the Safeguarding Hub on ENHance, illustrates the distribution of adult safeguarding concerns reported during 2025/26. The most frequently reported categories of abuse were self-neglect, complex domestic abuse cases, neglect and acts of omission all of which required management by the safeguarding team locally or escalation to S42 enquiry for multiagency management support. These concerns also involved vulnerable adults receiving care from external providers, as well as individuals experiencing neglect, abuse, or exploitation within their own homes, the case mix activity was consistent with previous reporting periods.



During 2025/26, a total of 62 Section 42 (S42) safeguarding concerns were escalated to the Trust by the Local Authority in relation to concerns about care delivered by Trust services. Of these concerns, 38 (61%) were raised during the first half of the financial year.

40% of safeguarding concerns raised against the Trust related to the development of hospital-acquired pressure ulcers during an episode of care. The Tissue Viability Team, in collaboration with the relevant ward teams and Practice Standards Matrons, reviewed each incident. These cases were also scrutinised through divisional governance processes to identify contributory factors and lessons learned. The reviews informed the development of action plans aimed at reducing recurrence and strengthening preventative care planning for future patients.

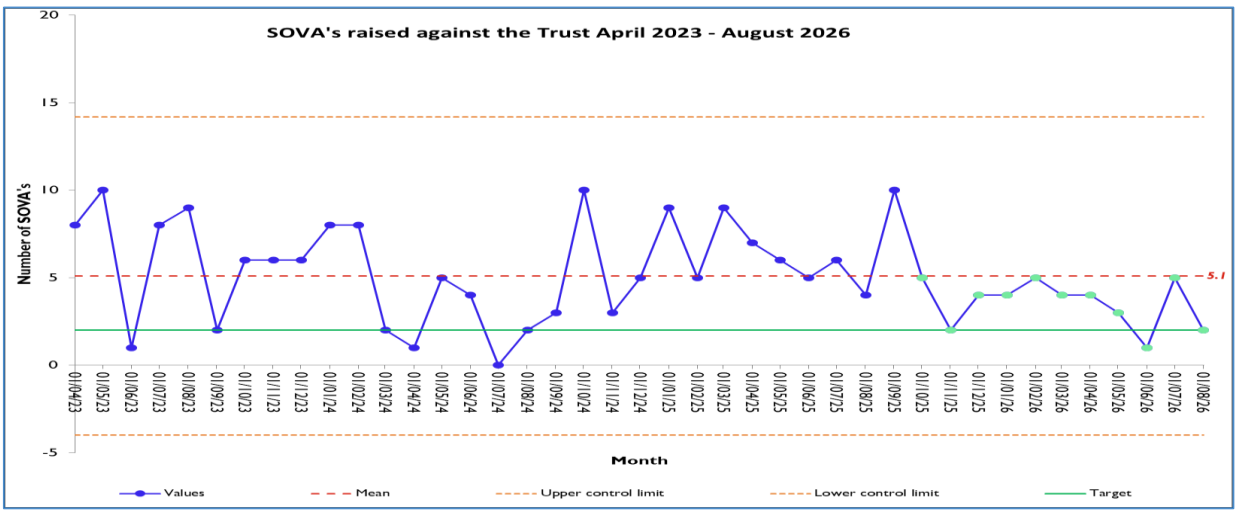
21% of concerns related to omissions within the discharge process, predominantly involving patients being discharged without an adequate supply of essential medication and/or a completed discharge summary. Such omissions have the potential to adversely affect continuity of care, delay ongoing treatment, and compromise patient safety. These incidents were reported to members of the Trust's Discharge Steering Group to ensure that learning is incorporated into future discharge policies,

procedures, and staff training programmes, produced by the group with the aim of reducing the prevalence of discharge-related omissions.

Five concerns raised during the year related to allegations of physical or sexual abuse alleged to have been perpetrated by Trust employees. Four of these incidents were referred to the police for investigation. The non-police reported incident related to a patient living with dementia and, following discussion with the patient's family, the concern was not referred to the police due to the family's concerns that a criminal investigation could cause further distress and trauma to the individual. The family were advised that they have the option to report the matter to the police at a future date should they wish to do so. On this occasion, no member of staff matching the description of the alleged perpetrator could be identified as having worked in the clinical area. None of the four incidents referred to the police resulted in formal police action being taken during 2025/26.

The Trust's established approach is to routinely refer allegations of physical or sexual abuse allegedly perpetrated by Trust staff to the police, as allegations of this kind meet the threshold for criminal investigation and cannot be fully addressed through safeguarding enquiries alone. Where a potential perpetrator is identified, appropriate risk management measures are implemented, including the removal of the individual from patient-facing duties, where necessary, pending the outcome of police and safeguarding investigations.

The SPC chart below demonstrates a sustained downward trend during the second half of the year, highlighting a significant reduction in the number of S42 safeguarding concerns raised against the Trust. This reduction suggests that the quality improvement and governance measures implemented across the organisation are having a positive impact on the safety and quality of care provided to patients.



Domestic and Sexual Abuse

During 2025/26, the Trusts Domestic and Sexual Abuse Team (DSAT) supported 753 individuals affected by domestic abuse and sexual violence. Approximately 4-5% of the team's caseload comprised of Trust employees who were victims of domestic abuse and sought specialist support.

The service was delivered by three full-time specialist practitioners employed on rolling temporary contracts. Working closely with the Trust's Safeguarding Team, they provided expert support, advocacy, and safeguarding interventions for individuals affected by domestic abuse and sexual violence. The service was funded through a grant provided by the Police and Crime Commissioner's (PCC) Office. However, in March 2026, this funding arrangement ceased following a strategic decision by the PCC to redirect financial resources towards a county-wide service aimed at reducing violence against women and girls across Hertfordshire.

Throughout the year, DSAT provided personalised, trauma-informed, and victim-centred support to individuals experiencing domestic abuse or sexual violence. The team offered impartial advice and guidance to adults aged 18 years and over, while also providing access to specialist expertise for children and young people (CYP) under the age of 18. Support was tailored to the needs of each

individual, ensuring that victims were fully informed of the options available following disclosure of abuse. This included advice regarding reporting incidents to the police, accessing Sexual Assault Referral Centre (SARC) services, and signposting to a range of specialist support organisations.

DSAT worked collaboratively with a wide range of multidisciplinary partners to assess and manage risk, ensuring that the safeguarding, health, and wellbeing needs of individuals were appropriately addressed. The team's contribution to the wider safeguarding agenda strengthened the Trust's ability to identify, support, and protect vulnerable people within the community it serves.

Following the withdrawal of external funding, the DSAT service was disbanded. However, the Trust's Safeguarding Team retained one experienced DSAT practitioner to ensure that victims of abuse, including Trust staff, continue to have timely access to specialist advice, support, and safeguarding interventions.

Refuge's MIMRAM service has been commissioned as the new provider of domestic abuse services across Hertfordshire, and the Trust's Safeguarding Team is able to make referrals directly to this service. At the time of writing, the Trust has not yet received formal confirmation of the service level agreement with MIMRAM. However, it is understood that a practitioner employed by the service, will working under a Trust honorary contract and will be based on the Lister site for up to 30 hours per week to provide specialist support and facilitate partnership working.

Prevent – referrals to Channel Panel

No referrals were submitted by the Trust to channel panel. All Trust staff are required to complete the home office WRAP prevent level 3 training. Currently, 94% of Trust staff have completed Level 3 training.

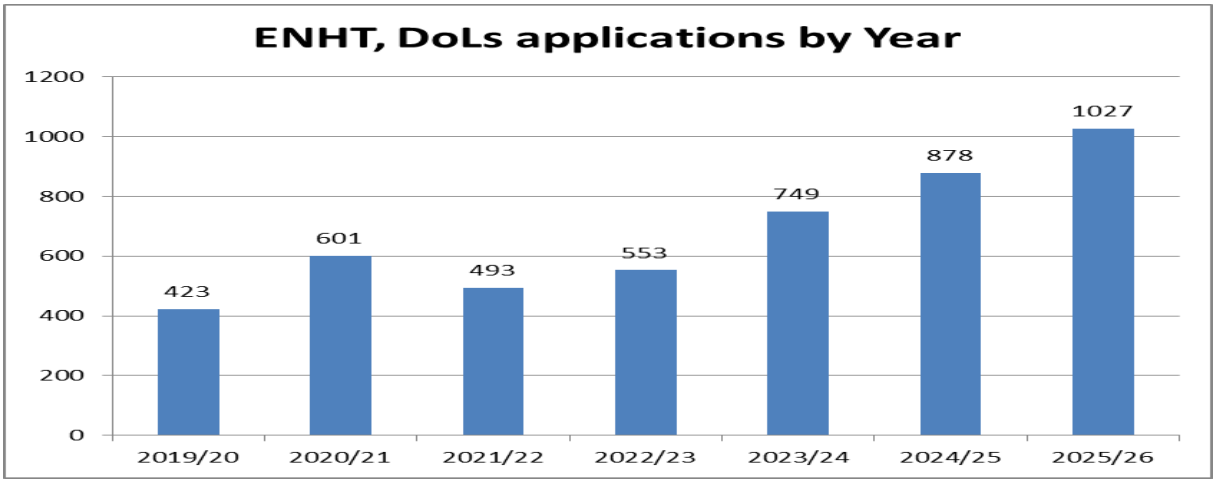
Deprivation of Liberty Safeguards (DoLS)

Deprivation of Liberty Safeguards (DoLS) provide a legal framework to protect individuals aged 18 years and over who lack the mental capacity to consent to arrangements for their care or treatment in a hospital or care home setting. The safeguards apply where a person is deprived of their liberty, within the meaning of Article 5 of the European Convention on Human Rights, and where such restrictions are necessary and proportionate to prevent harm and are in the person's best interests.

Over the past seven years, the Trust has experienced a significant increase in the number of DoLS applications. Prior to submission to the relevant supervisory body, all applications are reviewed by the Adult Safeguarding Team to ensure that the legal requirements of the Mental Capacity Act 2005 and DoLS framework have been appropriately considered and applied.

The increase in applications is considered to reflect improved recognition and understanding of deprivation of liberty among clinical staff, supported by targeted training, ongoing advice, and enhanced oversight provided by the Safeguarding Team. This has strengthened compliance with legislative requirements and increased assurance that patients who may be subject to restrictive care arrangements are afforded the appropriate legal protections.

The graph below illustrates the number of DoLS applications submitted by the Trust during the past seven years, demonstrating the sustained growth in activity over this period.



In June 2026, the Supreme Court overturned the long-standing *Cheshire West* "acid test" used to determine whether an individual is deprived of their liberty for the purposes of the Deprivation of Liberty Safeguards (DoLS). The Court concluded that the *Cheshire West* ruling had been applied in an overly rigid manner and had, in some cases, led to a misinterpretation of the legal framework. A new multifactorial test has now been introduced, requiring a broader assessment of an individual's circumstances when determining whether a deprivation of liberty exists.

This change will be incorporated into a revised Trust DoLs policy and guidance. It is anticipated that the revised legal test will result in a reduction in the number of inpatients within secondary care settings meeting the threshold for DoLS. Consequently, a decrease in DoLS activity is expected to be reflected in Trust data during 2026/27.

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

The Trust is a member of the Hertfordshire Safeguarding Adults Board (HSAB) Safeguarding Adults Review (SAR) Subgroup and regularly contributes to SAR processes. Learning identified through reviews is incorporated into staff training programmes and informs the ongoing review and development of relevant Trust policies and procedures.

Key themes emerging from SARs undertaken during 2025/26 included self-neglect within the community and consideration of whether opportunities to engage individuals had been missed across health and social care services. Hoarding behaviours were also identified as a contributory factor in cases involving domestic fires. The offence of cuckooing, whereby vulnerable individuals are exploited and their homes used for criminal activity, was highlighted as an emerging safeguarding concern. In addition, domestic abuse and elder abuse featured prominently within a number of the reviews.

These themes reinforce the importance of early identification of risk, professional curiosity, effective multi-agency working, and proactive engagement with individuals who may be difficult to reach or reluctant to accept support. The Trust will continue to embed learning from SARs to strengthen safeguarding practice and improve outcomes for adults at risk.

In the period of 2025/26, the Trust presented two formal referrals to a safeguarding board for a request regarding the SAR review process ultimately for both referrals HSAB decided not to progress these to formal commissioned review.

The Trust participated in a number of Domestic Homicide Reviews (DHRs) during 2025/26. Learning and actions identified through these reviews have been incorporated into relevant Trust safeguarding policies and procedures and have informed the development of educational content delivered to staff.

The Safeguarding Team, including our teams Domestic Abuse and Sexual Assault Specialist Practitioner, has utilised findings from DHRs to enhance training programmes, raising awareness of risk factors, opportunities for early intervention, and the importance of effective multi-agency working.

This approach supports the Trust's commitment to embedding learning from reviews into practice and strengthening the identification and management of domestic abuse and related safeguarding concerns.

Adult Safeguarding Training

To protect children, young people, adults from harm, all healthcare staff must be competent in recognising safeguarding concerns across the lifespan and responding appropriately within the scope of their role. Safeguarding training is a fundamental component of the Trust's statutory responsibility to safeguard and promote the welfare of vulnerable individuals.

All Trust safeguarding training programmes are aligned to the recommendations set out within the intercollegiate documents Adult Safeguarding: Roles and Competencies for Health Care Staff (2024) and Safeguarding children and young people & children and young people in care: Competencies for health care staff (2025). The Trust's safeguarding learning and development strategy, including its training needs analysis, is designed to ensure compliance with these national competency frameworks.

Safeguarding training packages are subject to regular review to ensure content remains current and reflects emerging safeguarding themes, legislative changes, lessons learned from reviews, and best practice guidance. Training is delivered predominantly through eLearning modules, supported by additional classroom-based training for staff requiring Level 3 safeguarding competencies in both adult and children's safeguarding.

The Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training was previously delivered alongside Adult Safeguarding Level 2 training. Following the introduction of the Trust's eLearning programme, MCA/DoLS training is now completed as a standalone module available through the Staff Academy. To further enhance knowledge and application in practice, staff are also offered opportunities to attend supplementary face-to-face training sessions delivered by the Adult Safeguarding Team.

This blended approach to safeguarding education supports the development and maintenance of staff competence, ensuring that safeguarding concerns are identified promptly and managed effectively in accordance with statutory requirements and best practice standards.

A WRAP prevent level 3 module for health care developed by the home office was also uploaded to ESR for all staff to complete. Currently 94% of Trust staff have completed this eLearning module in the past 3 years.

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

Module	Trust Compliance % (Current position on Power BI)	Target
Adult safeguarding L1 (All Trust staff)	**93%**	90%
Adult safeguarding L2 (safeguarding training strategy for staff inclusion criteria)	**92%**	90%
WRAP prevent L3 (All Trust staff) (NHS digital target for Trusts 85%)	**94%**	85%
Adult safeguarding L3	TBC (Added to corporate risk register ID 6893)	90%
MCA/DoLS (Patient facing health care professionals)	**83%**	90%
Oliver McGowan Tier 1 e-Learning	**91%**	85%
Oliver McGowan Tier 1	**67%**	85%

(interactive)		
Oliver McGowan Tier 2*	**65%**	90%

Training compliance is monitored by the divisions through Power BI and reported bi-monthly to the Safeguarding Committee, together with actions being taken to address areas of non-compliance.

Medical and dental staff continue to demonstrate the lowest levels of training compliance across the Trust. This issue has been escalated to the Trust Medical Director, and a range of actions are currently being developed to improve compliance within these staff groups. The impact of this can be seen in the Trust's overall training compliance rates for this staff group, which currently stand at 79% for statutory training and 67% for mandatory training. Improving compliance amongst medical and dental staff is therefore a key priority in increasing overall Trust training attainment.

Our staff are also routinely encouraged to attend external safeguarding training events provided by the Hertfordshire Safeguarding Children Partnership and the Hertfordshire Safeguarding Adults Board to enhance their knowledge and support ongoing professional development.

To support compliance with Adult Safeguarding Level 3 training requirements, the Safeguarding Team has developed a Safeguarding Training Passport. This initiative enables staff to demonstrate compliance with the Level 3 standards outlined within the intercollegiate guidance. Approximately 3,500 members of staff are required to evidence the completion of four hours of safeguarding training and four hours of safeguarding-related practice over a three-year period.

Given the significant number of staff required to evidence compliance, alongside the limited resources available within the Safeguarding Team, it is not feasible for the team to manually review and validate every individual passport. Consequently, a digital solution has been proposed to the Trust Academy and Education Teams that would enable line managers to review and validate safeguarding passports electronically as part of the annual appraisal process for staff within their clinical areas.

The proposed system would operate in a similar manner to professional revalidation platforms, allowing for electronic validation, monitoring, and reporting of compliance. This would provide oversight of Trust-wide compliance rates and support more effective governance and assurance processes. Delays in implementing the system remain outside the control of the Safeguarding Team. The associated risk has been escalated through the Trust Safeguarding Committee and the STAT/MAN Steering Group and has been included on the Trust Corporate Risk Register, with responsibility for management assigned to the People Team.

The Oliver McGowan Mandatory Training on Learning Disability and Autism was launched within the Trust in April 2024. Tier 1 training is primarily delivered through e-learning, supplemented by an interactive component known as Tier 1 part 2. To date, 67% of the identified target staff group have completed all components of the Tier 1 training requirements.

Tier 2 training consists of a seven-hour face-to-face programme delivered by a provider commissioned through the Integrated Care Board (ICB). The programme is delivered at both the Mount Vernon and Lister Hospital sites. Participant numbers are intentionally restricted to support the wellbeing and psychological safety of people with a learning disability and autistic people who are directly involved in the delivery of the training. Whilst these capacity limitations affect the volume of staff who can attend each session, demand remains high and courses continue to be well attended. Based on current uptake and planned delivery schedules, the Trust is on course to achieve 80% compliance with Tier 2 training during Quarter 4 of 2026/27.

Safeguarding Audits and Quality Assurance Activity

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

Children's Safeguarding

HSCP Multi-Agency Audit: Bruising in Children Over 6 Months

Methodology: Multi-agency case file audit

Key Findings: Practice was largely compliant with policy requirements. Several cases managed by ENHTT demonstrated examples of good and outstanding safeguarding practice.

Implementation: Learning completed and embedded

HSCP Child Sexual Abuse Audit

Methodology: Case file audit.

Key Findings: No significant learning identified for ENHTT

Implementation: Completed

Burns Audit

Methodology: Audit of clinical assessment for children presenting with burn injuries

Key Findings: Identified the importance of robust clinical assessment and safeguarding consideration of potential non-accidental injury. Training and education programmes supported improvements.

Implementation: Action plan completed

Children's Social Care Multi-Agency Referral Audit

Methodology: Review of referrals to Children's Social Care and multi-agency outcomes.

Key Findings: Need identified for practitioner training to improve referral quality. Challenges with referral portal functionality and referral rejections were escalated via the ICB, resulting in system mitigations.

Implementation: Learning implemented across the Trust.

Child Protection Medical Audit

Methodology: Case file audit

Key Findings: Improvement across key performance indicators. Enhanced documentation standards, including recording of chaperone name and role.

Implementation: Learning implemented

Voice of the Child Audit

Methodology: Review of documentation of children's views within transition and healthcare planning.

Key Findings: Identified learning regarding Gillick competence and improved capture of children's voices in care planning.

Implementation: Action plan in place

Care Proceedings Maternity Audit

Methodology: Audit of timeliness of Children's Social Care referrals for women subject to care proceedings.

Key Findings: Referrals were submitted within required timescales. Learning highlighted prolonged post-delivery admissions while awaiting court decisions.

Implementation: Shared across Hertfordshire Safeguarding Children Partnership (HSCP) and wider system partners to support multi-agency learning.

Adult Safeguarding

Annual Mental Capacity Act (MCA) Audit

Methodology: Multi-case file audit undertaken by the Adult Safeguarding Team

Key Findings:

- Good overall quality of MCA assessments and Best Interest decisions.
- Some assessments did not clearly define the specific decision being assessed.
- In a small number of cases, documentation lacked sufficient clarity regarding the decision-specific nature of capacity assessments.

Actions:

- Re-audit planned using a larger sample.
- MCA assessment and Best Interest documentation revised and incorporated into Trust policy.
- Continued face-to-face MCA training programmes.
- Revised MCA e-learning package to be launched following Supreme Court ruling and DoLS changes.
- Trust MCA policy under review.

Implementation: In progress

National Learning Disability Standards Benchmarking Audit

Methodology: Gap analysis against NHS England Learning Disability Standards, staff survey, and review of patient experience for people with learning disabilities.

Key Findings:

- Year 8 report presented to Learning Disability Working Group and Safeguarding Committee.
- Implementation of the *Ask, Listen, Do* framework remains a priority.
- Progress delayed pending funding for Easy Read resources and photo-symbol software.
- Business case approved for a substantive Band 7 Learning Disability Nurse, although recruitment remains pending due to recurrent funding arrangements.

Implementation:

- Final implementation of *Ask, Listen, Do* scheduled during 2026/27
- Funding secured for accessible communication resources
- Recruitment to Band 7 Learning Disability Nurse post pending

National LeDeR Comparative Audit

Methodology: Comparison of Learning Disability mortality reviews against a sample of 100 patients without a learning disability.

Key Findings:

- Mean age of death for people with a learning disability was above the national average but below the Trust average
- For the second consecutive year, care for patients with learning disabilities were more likely to be rated adequate than that of the wider patient population
- Learning informed the review of the Trust's *Caring for Adults with a Learning Disability or Autism Policy*

Implementation:

- Revised policy strengthens expectations around reasonable adjustments
- Future Learning Disability Nurse will support mortality reviews and LeDeR activity

'Was Not Brought' Audit

Methodology: Monthly review of missed outpatient appointments involving people with learning disabilities.

Key Findings:

- Supports identification of attendance barriers and inequalities
- Provides opportunities for rescheduling and follow-up
- Monitors impact of digital service developments on attendance rates

Implementation: Ongoing monthly review programme.

Maternity Safeguarding

Domestic Abuse Audit

Methodology: Bi-annual maternity safeguarding audit

Key Findings:

- Recommendations included auditing cross-border cases
- Need identified for enhanced domestic abuse training
- Trust-wide communication issued alongside Domestic Abuse Policy

Implementation: Actions underway with consideration given to increasing audit frequency to quarterly reviews.

Female Genital Mutilation (FGM) Audit

Methodology: Annual review of all FGM cases booked during the reporting period.

Key Findings:

- Reviewed current pathways and service effectiveness
- Identified need to embed FGM screening questions within the maternity digital system
- Improved staff awareness of referral and safeguarding processes

Implementation: Communications issued across maternity services and pathway improvements underway.

Overall Audit Assurance

Audit activity throughout the reporting period demonstrates generally good safeguarding practice across children's, adult, learning disability and maternity services. Key themes included improving documentation quality, strengthening referral processes, embedding the voice of service users, enhancing reasonable adjustments for people with learning disabilities, and ensuring robust safeguarding responses within maternity services. Where learning was identified, action plans have been implemented or are actively progressing through established governance arrangements.

Supervision and peer Review

Supervision – Children's safeguarding

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



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

For 2025/2026, Safeguarding supervision compliance remained below the Trust target of 90% throughout 2025/2026, although performance remained relatively stable across the year. Compliance was 84% in Quarter 1, increased marginally to 85% in Quarter 2, and reached a peak of 87% in Quarter 3 before declining back to 84% in Quarter 4. While the service did not achieve the 90% compliance target in any quarter, performance remained within a narrow range, demonstrating consistent engagement with safeguarding supervision processes. The safeguarding team prioritised areas of supervision to ED, paediatrics and community services. In addition, the team have provided weekly supervision time for ED nursing staff, monthly supervision to medical staff working in the ED, alongside the usual safeguarding supervision offer to paediatrics and the Trust as a whole. There has a specific focus on creating improved service lead awareness of supervision dates, staff access to safeguarding supervision sessions and follow up of non compliant staff. There continues to be a qreuriement for electronic recording and capture of staff attendance at safeguarding supervision, improving.

Supervision – Maternity Safeguarding

The safeguarding team have continued to offer safeguarding sessions for all identified staff, plus extra sessions for ward based staff and leaders. A plan is in place to not only increase the number of midwives who access safeguaring supervision but the way we showcase the value. The agreed action is to hold weekly safeguarding supervision which community midwives will be rostered to attend. This has been agreed by both the maternity safeguarding team and the community team leaders. This will put a safety net in planning in advance and a commitment to engagement. All specialist midwives will be offered safeguarding supervision to not only support them in experiencial learning but to offer guidance to the team when requiring advice and support . All leadership teams will have the opportunity to engage with an aim to support the smooth running of active cases that require acute and pre planning of cases.

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

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

Supervision – Adult Safeguarding

The Trust's Adult Safeguarding Team provides education and training to staff on national and local safeguarding processes, while raising awareness of the signs, indicators, and causes of abuse and neglect. The team also routinely provides advice, support, and case-specific supervision to frontline staff who are actively managing safeguarding concerns and undertaking safeguarding referrals.

In addition to direct case supervision provided by Adult Safeguarding Practitioners, the Trust's safeguarding supervision pathway enables line managers to provide safeguarding supervision and reflective discussion for staff where specialist case supervision is not required. This approach supports staff in developing their safeguarding knowledge, confidence, and decision-making skills, while promoting good safeguarding practice across clinical services.

The supervision process also provides an opportunity for staff to evidence continuing professional development and demonstrate compliance with Adult Safeguarding Level 3 requirements. The Trust's Safeguarding Supervision Standard Operating Procedure (SOP) is available to staff via the Trust intranet and outlines the roles, responsibilities, and processes for accessing and delivering safeguarding supervision.

Peer Review

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

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

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

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

Learning disabilities

The Acute Health Liaison Learning Disability Nurses (HLT are employed by Hertfordshire Health and Community Services continue to play a vital role in supporting patients with learning disabilities and their carers to access and navigate hospital services. Working collaboratively with Trust staff, they facilitate the implementation of reasonable adjustments to ensure patients receive equitable, person-centred care. This includes providing advice on appropriate adjustments, supporting the use of effective communication methods, assisting with the coordination of discharge planning and care packages, and contributing to end-of-life care planning where required. The Learning Disability Liaison Team works closely with the Trust's Learning Disability Lead Consultant, who was appointed during 2025/26, to strengthen clinical leadership and support the continued development of services for people with learning disabilities.

The Trust has a Learning Disability (LD) alert function embedded within its electronic patient record systems, accessible through both NerveCentre and Lorenzo. As of January 2026, almost 4,000 individuals across all age groups had been identified within the electronic patient record as having a learning disability alert, the majority of whom are residents of Hertfordshire.

The NerveCentre alert system continues to generate a daily report identifying patients with a learning disability who are admitted to hospital. This report is distributed to the Learning Disability Nurses and Matrons to ensure timely awareness and oversight of these patients. In addition, all inpatients identified as having a learning disability are discussed at the daily Site Safety Huddle at Lister Hospital. This process provides an opportunity to review any issues or concerns highlighted by the Learning Disability Health Liaison Team and supports the timely escalation and resolution of barriers to care, ensuring that appropriate reasonable adjustments and support arrangements are in place throughout the patient's hospital stay. This multidisciplinary approach supports the delivery of personalised care and helps to improve the experiences and outcomes of patients with learning disabilities accessing acute hospital services.

The most impactful Key Learning Disability and Autism Improvements undertake during 2025/26:

Several significant improvements have been implemented during the reporting period to enhance the quality, safety, and accessibility of care provided to people with a learning disability and autistic people the key actions are listed below.

- **Enhanced Pain Assessment**

The Bolton Pain Assessment Tool was introduced for use with adults with a learning disability, alongside the implementation of the FLACC (Face, Legs, Activity, Cry, Consolability) Pain Assessment Tool for children with a learning disability or autism. These tools support staff in recognising and assessing pain in patients who may have communication difficulties, promoting more timely assessment and management.

- **Introduction of a Virtual Learning Disability Ward**

A virtual Learning Disability ward was created on the NerveCentre main dashboard to facilitate the identification and location of patients with a learning disability across the Trust. This development enables improved oversight, monitoring, and coordination of care by clinical teams and specialist practitioners.

- **Enhanced Clinical Surveillance**

All patients with a learning disability admitted to the Trust are now reviewed by the Critical Care Outreach Team (CCOT), either in person or remotely, regardless of whether they meet physiological escalation criteria through National Early Warning Score (NEWS) monitoring. This proactive approach aims to identify early deterioration and ensure timely intervention and reasonable adjustments to care are made where required.

- **Development of Policies and Procedures**

The Trust's Care of Adults with a Learning Disability Policy was reviewed and updated during the year. In addition, a new Standard Operating Procedure (SOP) for the Care of Children with a Learning Disability was developed and launched, representing the first dedicated procedural guidance of its kind within the Trust. The development of both documents was informed by learning from incidents, LeDeR reviews, and best practice guidance.

- **Introduction of Learning Disability and Autism Wristbands**

All patients with a learning disability or autism admitted to hospital now receive a purple wristband. The wristband includes key contact information for Learning Disability Services and the Trust's Call4Concern service, supporting patients, families, and carers to access assistance and escalate concerns where necessary.

- **Strengthening Organisational Learning Through Lived Experience**

The parents and carers involved in a Patient Safety Incident Investigation (PSII) and Early Response (ER) process were invited to present at a Trust Patient and Carer Experience (PACE) Forum. They shared their experience of care delivered without appropriate reasonable adjustments being in place for a person with a learning disability. This powerful account highlighted the impact that the absence of reasonable adjustments can have on patient outcomes and reinforced the importance of personalised, equitable care, several members of the Trust board were present.

- **Implementation of a Reasonable Adjustments Flag**

A Reasonable Adjustments Flag was introduced within the Trust's electronic patient record system. While compliance with the minimum national standard has been achieved, further development and system enhancement are planned during 2026/27 to improve the identification, recording, and communication of reasonable adjustments across care settings.

These developments demonstrate the Trust's continued commitment to improving the experience, safety, and outcomes of people with learning disabilities and autistic people through service development, organisational learning, and the embedding of reasonable adjustments across clinical practice.

Key LD service need for 2026/27

The Trust has historically invested in a range of specialist adult nursing roles to support the delivery of high-quality care across a variety of clinical specialties. However, this approach has not been replicated for patients with a learning disability or autism, despite this population representing some of the most vulnerable individuals accessing Trust services. This disparity may reflect an inequality in the allocation of resources to support the needs of people with a learning disability and autistic people.

The appointment of a substantive Learning Disability Lead Nurse is essential to provide strategic leadership and drive the Trust's agenda for improving services for people with a learning disability and autism. The post would provide dedicated oversight of the implementation of national Learning Disability benchmarking standards, support achievement of the Learning Disability Improvement Standards for NHS Trusts and ensure that actions arising from Learning from Lives and Deaths (LeDeR) reviews are progressed in a timely, coordinated, and sustainable manner.

The Trust benefits from support provided by the Learning Disability Health Liaison Team (HLT), these practitioners are commissioned externally and employed by Hertfordshire County council. Their role is primarily advisory and focused on supporting individual patients through a limited commissioning framework. The service is not resourced or commissioned to lead Trust-wide strategy, quality improvement programmes, compliance assurance initiatives, policy development, workforce development, or the local implementation of national standards relating to learning disability and autism care.

The future commissioning arrangements for the Health Liaison Team remain uncertain because of ongoing changes to Integrated Care Board and local authority reconfiguration. As a result, there can be no assurance that the current model of support will continue in its present form beyond 2027. Further, changes to the national LeDeR programme are expected to place greater responsibility on provider organisations to undertake reviews, identify learning, implement improvements, and provide assurance regarding the delivery of actions before submission to regional review panels.

Recognising these challenges, neighbouring organisations have strengthened their internal learning disability service arrangements. West Hertfordshire Teaching Hospitals NHS Trust, which has access to the same commissioned Health Liaison Team model, appointed a substantive Learning Disability Lead Nurse in 2024. The role provides strategic leadership, drives service improvement initiatives, and supports staff to deliver high-quality care that meets the needs of people with a learning disability and autistic people. This decision acknowledged the limitations of relying solely on externally commissioned liaison services to achieve organisational objectives and national standards.

Given the increasing national focus on reducing health inequalities, improving outcomes for people with a learning disability and autism, and strengthening organisational accountability through programmes such as LeDeR, it is important that recurrent funding is identified to enable the appointment of a substantive Learning Disability Lead Nurse in the Trust. Without dedicated leadership, there is a risk that progress against national standards, benchmarking requirements, and service improvement objectives will be delayed and that opportunities to improve patient experience, safety, and outcomes will not be fully realised.

Priorities for 2026/2027

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

Training and Supervision:

- Review all Safeguarding Training in line with the new intercollegiate document (2025) Safeguarding children and young people in care: Competencies for health care staff.
- Achieve and maintain safeguarding supervision and all levels of Safeguarding training compliance at 90%
- Create tailored, introductory bitesize learning packages to enhance staff understanding and confidence
- Continue to strengthen the Safeguarding Champions initiative to strengthen local leadership, promote best practice, and enhance safeguarding awareness and accountability across all teams – including the role of transition within these key roles
- Continued provision of Face to Face or MS teams hoisted MCA/DoLS training for staff
- Strengthen and develop culturally informed safeguarding practice – integrating learning specifically looking at intersection of safeguarding and antiracism practice.
- Continue to strengthen organisation wide knowledge of managing allegations against children and vulnerable adults.

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

- Amplify patient voice, working towards co-production of service improvement & development.
- Strengthen how the child's voice is captured, recorded, and used in assessments and care planning.
- Ensure consistent, meaningful integration of the child's voice/awareness of right to be free from harm/abuse into all safeguarding and clinical processes.

Continue to build Digital Transformation for Safeguarding

- For the safeguarding team to work closely with the ORBIS implementation team to ensure software at launch is fit for safeguarding purposes.
- Ensure the integration of the child protection information service (CPIS - 2) to our scheduled care settings.
- Continue to strengthen safeguarding alerts Trust Wide
- Continue to ensure all Community Staff have access to system one – Community EPR to support safeguarding assessments.
- Build a digital solution to recording staff supervision compliance on the academy – support manager oversight

Wider Priorities – Safeguarding

- Review and audit trust wide responses to children who are not brought to their appointments – embedding learning Trust Wide
- Recruit and employ a new Named Dr for Looked after Children to support oversight of the quality and timeliness of IHA report & champion the needs of children looked after and care leavers
- Recruit and Adult Learning disabilities lead nurse.

Board

East and North Hertfordshire Teaching NHS Trust

Meeting	Public Trust Board		**Agenda Item**	17	
Report title	Board Assurance Framework (BAF) – Strategic Risks		**Meeting Date**	11 November 2026	
Author	Head of Corporate Governance				
Responsible Director	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 2026 Board feedback driven by Board wanting to see progress against these newly identified key risks. Whilst the below update shows significant mitigation actions being completed for a number of BAF risks further progress and risk score reductions are needed to justify moving to a reasonable assurance recommendation.

Summary of key issues:

Key matters to highlight

All BAF risks have been reviewed by their lead committee since September's Board. There are no proposed risk score reductions.

Board spotlight on two BAF risks

Spotlighted Risk 9 *(Demand, capacity and flow)* - COO

- Two actions have been completed 1) IPR updated to include 26/27 RTT targets 2) Estates work to theatres and Swift ward.
- All actions are within date for their March 2027 deadlines – however, the strong caution is there are 56 actions to complete by March 2027, so it was flagged at FPPC that by the next FPPC BAF update a significant number of these actions need to start being completed to stay on track.

Spotlighted Risk 10 *(Digital Transformation & AI)* – CIO

- October's Digital Committee supported the current risk ratings but concluded further development of the BAF narrative, particularly around cyber security, resilience and future controls would be helpful. This will be progressed by the CIO as the executive lead, supported by the Head of Corporate Governance.
- Reviewed by the CIO, as executive lead, and there are no changes, following significant updates provided in the update on this risk to July's Digital Committee and September Board.
- None of the actions are overdue. Equally, a number of actions are marked as ongoing which has been highlighted to Digital Committee to consider if there are any ongoing actions where a completion date is appropriate or helpful to add.

Latest on the other BAF risks:

Risk 1 (Estates infrastructure to meet growing demand):

- Has seen good progress with two gaps proposed to close with all identified actions completed: 1) Dependency on Transformational Capital that is not yet secured 2) Lack of S106 and CIL monies in prior years.

Risk 2 (Health inequalities) – Chief Medical Officer

- Two gaps have been added in light of the NHSE capability self-assessment with July QSC reducing the assurance rating from 4 to 3: 1) The Board tracks unwarranted variations in access to and delivery of services across the trust's patients/population for those with protected characteristics and patterns of actual and expected access from the trust's communities (see below IPR suggestions) 2) The Trust has mechanisms in place to address newly emerging unwarranted variation in access to and delivery of services that are not in the annual plan.

Risk 3: (System and internal financial constraints) - CFO

- Positively, six new controls have been added.
- Some dates have passed and revised target dates added e.g. Productivity dashboard in development was Q4 2025 and is now November 26. Original target dates have been kept for transparency.

Risk 4 (Patient engagement, involvement & public accountability) – Director of Comms

- Excellent progress 1) the new Engagement Strategy was approved at September 26 Board. 2) The new Patient and Carer Engagement Partnership sub-committee ToRs were approved by October's QSC and the inaugural meeting is being arranged.

Risk 5 (Employee relations) - CPO

- Significant action completed: Refreshed People Strategy on agenda for November Board. However, both "Staff survey comments plan" actions are overdue.

Risk 6 (Leadership destabilisation and transition) – Chief Executive

- A significant overhaul has been made to this risk (see BAF documents), including a revised risk description which PCC supported.
- Strong appointments progress: the new permanent CFO, Clare Parker, starts 29 November and two new NEDs have started (Dr Elliot Goodman and Adesola Obunge).

Risk 7 (Accountability, escalation, ownership & effective performance monitoring framework) – CPO

- New Target Culture Model introduced for discussion at PCC in September.

Risk 8 *(OneEPR) – Mark Stanton*

- Re gap: "Supplier delivery commitments and product roadmap dependencies remain unresolved" with a due date of September 26 for actions, the update is: Delivery date for product Phase 1 now committed by Dedalus as 21/12/26.

Risk 11: *"Failure to deliver transformation and achieve financial sustainability"* Kevin O'Hart

- Board Seminar on 14 October agreed a sustainable Transformation and Improvement model.
- Positively, six actions have been completed since June's FPPC.

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):	
9 September Board. QSC 30 September. Digital Committee 9 October. PCC 23 October. FPPC 26 October.	
Recommendation	The Board is asked to: • review the BAF and highlight any key feedback; • 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

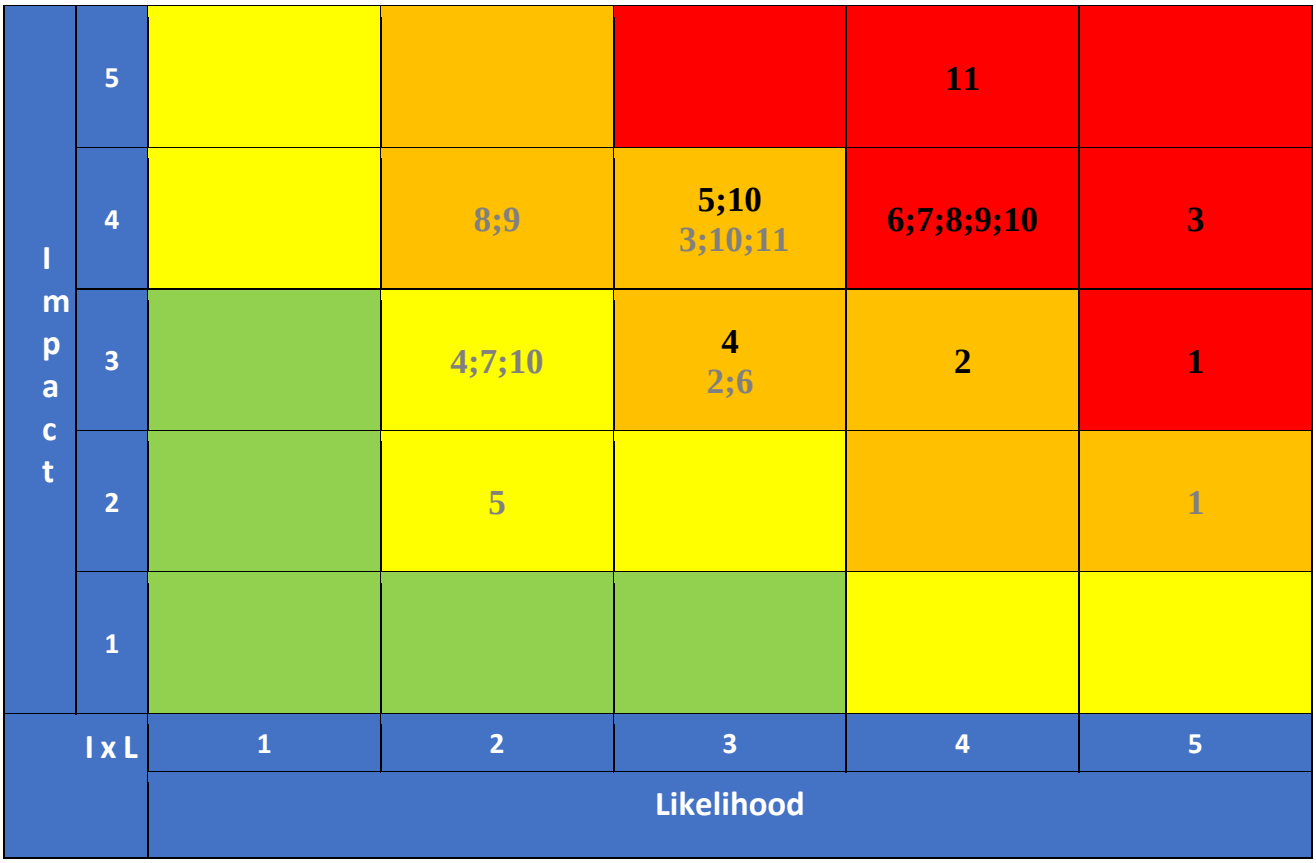
BOARD ASSURANCE FRAMEWORK REPORT

Section 1 - Summary

Risk no	Strategic Risk	Lead(s) for this risk	Assurance committee	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 Comms & Engagement	Quality & Safety	9	⟷
Support our people to thrive by recruiting and retaining the best, and creating an environment of learning, autonomy, and accountability					
5.	**Employee relations**	Chief People Officer	People & Culture	12	⟷
6.	**Leadership destabilisation and transition**	Chief People Officer	People & Culture	16	⟷
7.	**Accountability, escalation, ownership**	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					✓	
Digital					✓	
Estates				✓		

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.

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	Rumours Potential for public concern	Local media coverage Short term reduction in public concern	Local media coverage Long term reduction in public confidence	National Media coverage < than 3 days	National media coverage > 3 days.

Publicity/ Reputation		Elements of public expectation not being met		Service well below reasonable public expectation	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 CPS. Local Press interest	Multiple Staff members committing fraud offences / conspiracy Loss >£10,000. Consideration given for case to be submitted to CPS. Local/ National Press interest. Potential Staff disquiet	Multiple Staff members committing Fraud offences / conspiracy loss >£10,000. Consideration given for case to be submitted to CPS. Local/ National Press interest. Potential Service Disruption both staff and Financial. National Press Interest.	Bribery / Corruption offences, Multiple Staff / Senior staff Fraud. Loss >£10,000. Consideration given for case 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

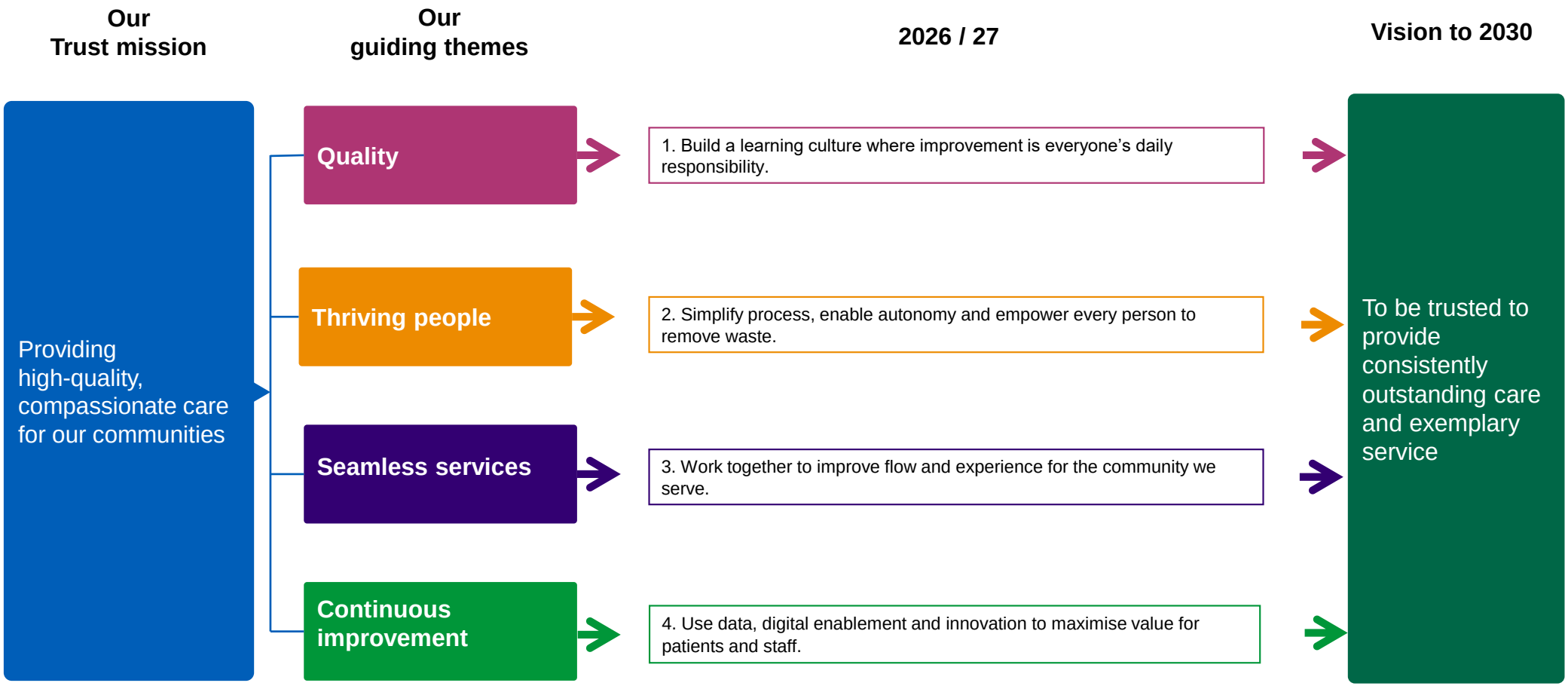
The 'frequency-based' score is usually easiest to identify and should be used whenever possible.

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**

Risk Assess	Grading
15 – 25	**Extreme**
8 – 12	**High**
4 – 6	**Medium**
1 – 3	**Low**

Trust Strategic Goals

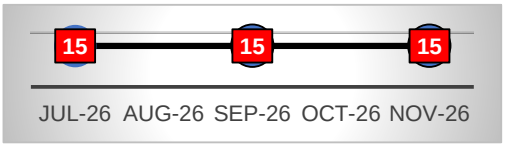


Assurance Rating	ACTIONS	OUTCOMES
Level 7	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systematic causes/reasons for performance variation.	Evidence of delivery of the majority or all of the agreed actions, with clear evidence of the achievement of desired outcomes over a defined period of time i.e. 3 months.
Level 6	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systematic causes/reasons for performance variation.	Evidence of delivery of the majority or all of the agreed actions, with clear evidence of the achievement of desired outcomes.
Level 5	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systematic causes/reasons for performance variation.	Evidence of delivery of the majority or all of the agreed actions, with little or no evidence of the achievement of desired outcomes.
Level 4	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systematic causes/reasons for performance variation.	Evidence of several agreed actions being delivered, with little or no evidence of the achievement of desired outcomes.
Level 3	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systematic causes/reasons for performance variation.	Some measurable impact evident from actions initially taken AND an emerging clarity of outcomes sought to determine sustainability with agreed measures to evidence improvements.
Level 2	Comprehensive actions identified and agreed upon to address specific performance concerns.	Some measurable impact evident from actions initially taken.
Level 1	Initial actions agreed upon, these focused upon directly addressing specific performance concerns.	Outcomes sought being defined. No improvements yet evident.
Level 0	Emerging action not yet agreed with all relevant parties.	No improvements evident.

Strategic Priority: **Consistently deliver quality standards, targeting health inequalities and involving patients in their care**		**Risk score 15**
Strategic Risk No.1: **Estates infrastructure to meet growing demand**		
If the Trust's estates and physical infrastructure is not capable of meeting changing patient and staff demand, due to legacy infrastructure and investment constraints	***Then*** the Trust will be unable to deliver safe, effective and timely services at the scale and quality required, and will have limited flexibility to redesign services, increase productivity or respond to system pressures and provide a satisfactory staff environment (including parking and accommodation)	***Resulting in*** 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
Inherent	5	5	25	4
Current	3	5	15	
Target	2	5	10	

Risk Trend



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

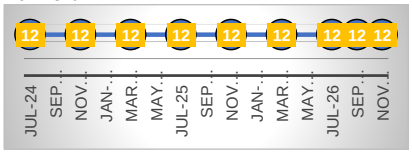
Gaps in Controls and Assurances	Actions and mitigations to address gaps	Lead	Target date
Alignment of Capital Investment Priorities with Operational & Strategic Need	• Strengthen triangulation between the estates strategy, the Integrated Business Plan and long-term capital requirements. [21 Sept 26: Update CIG meets weekly]	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 – complete & to close. • Work with NHSE transformation leads to ensure ENHT's priorities are reflected in system submissions (including RtCS-linked allocations and diagnostics programs) - complete. • Develop local contingency plans in the event that system capital does not materialise – complete - CIG reports into TMG & FPPC.	CFO	To close~~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 [Update 21 Sept 26 – complete]. • All derogation from new/refurbished compliant estate to have CEO formal sign off [Update 21 Sept 26: nearly there – anticipated by Q4]. • Suitable and sufficient register of derogation to be held by the capital projects team [Update 21 Sept 26: nearly there – anticipated by Q4]. • Create a capital and minor works policy with standardization equipment document and derogation form template [Update 21 Sept 26: nearly there – anticipated by Q4].~~.~~	Dir of Estates	[Original: Q1 26/27] Revised to Q4 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~~Complete

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
3079	Risk to the safety of children, young people, staff and visitors and risk to the reputation of East and North Herts NHS Trust due to the significant and visible disrepair of the building Fabric and unmet electrical needs and mechanical requirements relating to Bluebell Ward, Bramble Day Services and Children's Outpatient services including the Hub.	20
3441	HTM 05 Fire - If known fire safety deficiencies in the external facade and window assemblies of the main ward block are not addressed, then the Trust remains exposed to significant fire risk, resulting in potential large scale patient harm, fatalities, and regulatory non-compliance.	16

Strategic Priority: **Consistently deliver quality standards, targeting health inequalities and involving patients in their care**			**Risk score 12**
Strategic Risk No.2: **Health inequalities**			
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	3	
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~~ HIV testing commenced March 26, now working on hepatitis B and C testing	6
Health equity group projects ~~(homelessness; Inability to work due to health delays; Childhood; Smoking; Blood born viruses)~~ focused on core20+5 projects for adults and children	Reports to health equity group (1) 6 monthly written report to QSC (2)	3

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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
• 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
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
The Board tracks unwarranted variations in access to and delivery of services across the trust's patients/population for those with protected characteristics and patterns of actual and expected access from the trust's communities	• TBC – added in light of the NHSE capability self-assessment	MD	
The Trust has mechanisms in place to address newly emerging unwarranted variation in access to and delivery of services that are not in the annual plan	• TBC – added in light of the NHSE capability self-assessment	MD	

Current Performance – Highlights from the Integrated Performance Report:
• ED 4 hour standard, 12 hour performance • 28 day faster diagnosis standards • DMO1 – audiology • 65 week waits for community Paediatrics Update 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

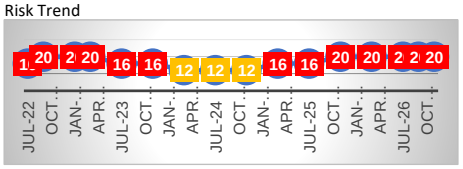
Associated Risks on the Corporate Risk Register		
Risk no.	Description	Current score

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	16
3114	Risk to new mothers and babies due to cross-border care	16
3550	Sight loss risk for paediatric patients within the ophthalmology service due to long waits for follow up 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~~Transformation Board (2)	4
	26/27 Financial plan submitted to & approved by NHSE (3)	4
Operational Systems and Resources		
Planning approach	Reported to TMG and FPPC as appropriate (2)	4
Financial Reporting & BI Systems	Monthly financial reporting to NHSE & ~~HWE System (1~~ICB (3)	6
Detailed monthly CIP performance reporting	Reports to FPPC and ~~FRG~~Transformation Board and national reporting (2)	4
~~Monthly ERF & Productivity Report~~SLR Reporting to FPPC	~~Internal performance monitoring and Model Hospital / GIRFT / Use of Resources benchmarking (2)~~Monthly reporting to FPPC (2)	~~3~~
Activity Reporting included within the finance report	Monthly reporting through TMG FPPC and used to inform accountability at the Performance Senate (1, 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~~Quarterly review of position with EOE regional team and mid year review of overall performance position of the Trust	Regional confirm and challenge of Trust ~~and system financial deliver~~position (3)	3
Resource Control Panel (Vacancy Review Panel ~~&~~) Discretionary Review Panel (Non-Pay controls)	~~Daily /~~Twice 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~~Performance Senate (1)	3
FPPC, ~~FRG~~Transformation Board & TMG Reporting	Monthly meetings Exec/ NED chaired – agreed agenda (2)	4
~~Divisional Finance Boards meetings~~Performance Senate Monthly reviewing KLOE across all performance areas – People, Quality, Activity, Finance	Monthly meetings Exec chaired – finance delivery review (2)	4
Monthly Investment Group	Monthly meeting DDOF chaired – capital plan review (2)	4
Monthly ~~Delivery~~Transformation Board	Monthly meeting CEO chaired – CIP delivery reviewed (2)	~~5~~4
Weekly D&C ~~/ ERF delivery~~ meetings	Weekly session – Info led / divisional attendance – review of ~~ERF~~activity and income 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 Establishment Oversight Group medical staffing group	Monthly workforce groups (exec chaired) to review temporary staffing deployment across key workforce groups (2)	2
Weekly medical temporary staffing panel	Weekly exec chaired by the MD (1)	2
Weekly nursing temporary staffing panel	Weekly chaired by the AND (1)	2
Revamped safer staffing for nursing	Weekly chaired by AND with finance input to aid scrutiny (1)	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
26/27 Forecast developed in September	FPPC, TMG and Transformation Board monthly (1)	3

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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~~X2 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~~In Place
Structural under-delivery of CIP reflecting historic incremental schemes insufficient to close the underlying deficit	~~Delivery~~Transformation Board to oversee CIP delivery. Embed Accountability Framework, implementation of the agreed Transformation Programme	Execs / TD	~~Q4 &~~In place 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.~~Productivity dashboard in development - TMG and FPPC monthly reporting	DDoF/ADoP~~DDOF / PMO~~	Original Q3 25/ Revised November 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~~
Simplifying and Refreshing Service level AI driven opportunity packs	Rolling programme of updates to Divisional Board Reporting	DDOF	Q3 26/27
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.~~Monthly Finance Meetings to be reinstated with division	DDOF(FM)	Ongoing
Lack of Long-Term Workforce Affordability Plan Insufficient Integration of Finance, Workforce, Activity, Digital and Capital Plans	Develop multi-year workforce affordability plan aligned to CIP, productivity and digital/capital transformation. Sept 26 Update: The different approach being taken this year to business planning allows Finance and HR to take a longer term look at the Trust operating model i.e. what services do we continue to require, and what we don't. This will enable a long term workforce plan that is anchored into providing only those services that are commissioned or deliberate choices. This will follow the business planning timeline.	CPO/CFO	Original Q4 25/26 Revised Q4 26/27
~~Insufficient Integration of Finance, Workforce, Activity, Digital and Capital Plans~~ [Proposed to combine with above gap]	~~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~~Monthly performance senates followed by TMG ~~Performance to progress consequences~~performance • Clear accountability from CEO to divisions	• ~~CFO~~CEO	• ~~May 25~~ • ~~31 June 26~~Ongoing

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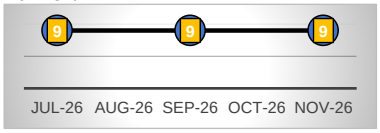
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Current Performance – Highlights from the Integrated Performance Report:
Finance • £2.7m year-to-date deficit against a £2.7m deficit plan. • The Trust has managed to remain on plan despite slippage in CIP schemes. This has been offset by pay underspends, lower WLI payments due to reduced activity and the early release of provisions. • Nursing and medical workforce cost pressures and divisional overspends persist. Despite strengthened controls, worked WTE has not reduced during the year. • Elective performance and productivity gaps are masked by block contract arrangements. • The 2026/27 position requires continued focus on transformation programme savings, stronger financial controls and improvements in productivity.

Associated Risks on the Board Risk Register		
Risk no.	Description	Current score
3664	If the Trust fails to deliver its agreed financial plan and Cost Improvement Programme (CIP), then it may not achieve its required financial targets, resulting in increased external scrutiny and oversight, reputational damage, and potential loss of future financial independence.	16
1834	Renal service demand versus operational capacity	20
3137	Gastro outpatient capacity	20
~~1079~~	~~Epilepsy staffing~~	~~8~~
3421	Staffing levels in critical care	20

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	Risk Trend
Inherent	4	4	16	4	
Current	3	3	9		
Target	3	2	6		

Risk Lead	Director of Communications and Engagement	Assurance committee	Quality & Safety Committee

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~~updated strategy approved by Sept 26 Board)	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	Minutes and reports to Trust groups (1)	3

• Equality / seldom-heard group engagement mechanisms		
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 Update 21 Sept 26: Initial conversation with ICB communications lead – booked in for a follow up.)	Director of Comms	September 2026
~~Engagement strategy to be renewed by 2027~~	• ~~Refresh and renew engagement strategy~~ (Update 21 Sept 26: Refreshed Engagement Strategy approved by Board in Sept 2026	~~Director of Comms~~	~~April 2027~~ COMPLETE – to close
Limited engagement team capacity	• Review capacity required in communications and engagement team to deliver activity (Update 21 Sept 26: Review underway of structure of communications team-)	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

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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~~ • Second workshop to be arranged with a broader group although a helpful discussion with FTSU and PCC NEDs to agree a way forward • Regular meetings now set up with People Team and FTSU for closer management of the issues	• Director of People	• ~~July 2026~~Complete **TBC** • **Already in progress**
• Signed off refreshed People Strategy	• Finalise slides and agree with Chair PCC • Agenda item at PCC	• CPO	• ~~June 2026~~ • ~~July 26~~November Board
• 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	• Original date: July 2026 Update: Has been in progress since June 2026 and will continue to include Deloitte handover

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Inconsistent management capability in handling ER issues	• Gap analysis as part of ER strategy	• CPO	• Dec 26 Update: Improvement plan underway in classifying and dealing with cases.
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

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~~ consolidate recent NED and Executive ~~leaving and NEDs retirement transition effectively including maintaining~~changes and strengthen leadership ~~stability~~capability, cohesion ~~and clarity of authority~~, accountability and clinical partnerships	***Then*** there is a risk of ~~wider leadership turnover,~~ fragmented decision-making, inconsistent operational control, weakened clinical-management relationships ~~within the leadership team~~ and reduced ~~strategic focus~~confidence in leadership	***Resulting in*** slower improvement in ~~derailing delivery of our strategy~~quality, access, productivity and ~~impaired decision-making~~financial sustainability, and loss of staff and stakeholder 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 appointed~~Chief Executive appointed; initial transition arrangements operating and leadership priorities being established	~~Report~~CEO report to Board (2); October Board seminar scheduled (2)	7
NED succession ~~and~~/ recruitment ~~plan (interviews scheduled for Sept 26~~ for two ~~replacement NEDs)~~replacements: confirm outcome of September selection process and induction arrangements	~~With Board Chair – no separate assurance~~ Chair update to Board (2~~)~~); completion and induction assurance pending	4
~~Identified~~Permanent CFO appointment confirmed, commencing 29 November 2026; interim ~~leadership~~cover and handover arrangements. ~~Formal process in place for CFO appointment in Sept 26~~Deputy Chief Operating Officers appointment confirmed in October 2026, strengthening operational leadership.	~~Report~~CEO update to Board (2~~)~~); transition / handover to be verified	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~~, with proposed refreshed decision-making and communication arrangements to clarify authority ~~during transition)~~and delivery	Annual Board review (2~~)~~); TMG framework proposed 1 October (1); effectiveness to be tested	6

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~~Committee structure stability with~~ Named Board and committee Chairs / deputies ~~& contingency plans for turnover~~ and planned cover through NED changes	~~With Board Chair – no separate assurance~~Chair oversight; confirm committee coverage and succession arrangements	N/A
Leadership Cohesion & Culture		
Board ~~Seminar: Regular~~/ Executive~~/NED~~ development ~~sessions~~and strategy seminars, including October leadership reflections	Board ~~Seminar~~seminar plan (2~~)~~); effectiveness follow-up planned	4
~~Structured~~ Executive ~~Team~~team cohesion, leadership development and ~~support to maintain~~ alignment ~~& team cohesion (external)~~around clear responsibilities and delivery expectations	~~With CEO – no separate assurance~~CEO-led oversight (1); formal evaluation / independent assurance not yet in place. 2X Weekly Executive Director meetings in place	N/A
Leadership capability and accountability: develop consistent "know, run, improve" expectations, practical assessment, support and intervention	ASSURANCE GAP: use Senates / TMG to test capability, decision-making and service outcomes; formal assessment to be established	0
Stakeholder & System Relationship Management		
~~New~~ CEO ~~integrated into~~engagement with NHS England, system ~~meetings~~partners, regulators and ~~regulatory infrastructure partner Trusts & Healthwatch~~HCP to maintain confidence and shared priorities	CEO report to Board (2); HCP report to Board (2)	4
Workforce Confidence & Engagement		
Regular CEO / Executive communications ~~(~~, staff forums and Meet Martin~~)~~ sessions	~~Feedback from regulators & partners;~~Partner feedback (3~~)~~ ~~Pulse surveys~~); pulse checks (1~~)~~ ~~Staff~~); staff survey (3~~)~~); Leadership Forum (1)	6
Clinical leadership partnership: direct consultant engagement, MAC/LNC dialogue and planned Chief Executive Consultant Forum (October 2026)	CEO response to MAC (1); Board update (2); evidence of shared decisions and improved delivery to be developed	N/A
~~Visibility of leadership (~~Executive and senior management visibility through service visits, walkarounds~~,~~ and briefings~~)~~	~~Gap in assurance~~ASSURANCE GAP: consistent record of feedback and action to be introduced	0
~~Monitoring (~~Workforce sentiment, staff survey, ~~Pulse~~pulse checks~~;~~ FTSU themes~~)~~ and timely response to material concerns	Reports to ~~PCC~~People & Culture Committee (2)	4
Performance & Strategic Delivery Controls		
Board IPR~~;~~, priority transformation ~~programme~~/ recovery work and ~~strategic priorities~~Senate review of executive and divisional delivery ~~tracking~~	Reports to Board (2~~)~~ ~~Reports to)~~; Senate~~/~~ / TMG (2~~)~~); sustained benefits to be demonstrated	4
Board Effectiveness & Capability		
Board and Committee effectiveness reviews	Board Seminar annually and Annual Report (2)	6
~~Induction~~Structured induction and development for ~~new~~incoming NEDs	ASSURANCE GAP~~– Introduce an~~; assess induction effectiveness ~~survey for new NEDs~~following appointment	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~~Incomplete transition ~~plan~~and succession assurance	• ~~Board Seminar re medical leadership relations~~ Complete CFO induction and handover for 29 November start; confirm Deputy COO remit and decision rights, NED recruitment outcomes and Board committee cover.	• CEO / Chair	• ~~Oct~~Nov~~r~~ 26
~~Limited~~ Board / Executive ~~Cohesion Assurance & risks of fragmented behaviours~~cohesion and effectiveness	• ~~A structured assessment of team dynamics & alignment post-transition~~ • ~~Conduct Board/executive team development session~~ • ~~360 for Board members~~Use October Board seminar to agree leadership priorities; undertake a follow-up review of team alignment, behaviours and effectiveness, including 360 feedback if agreed.	• Chair & CEO	• Mar 27
~~Stakeholder Confidence Not Actively Managed / tracked~~Operational leadership capability not consistently evidenced	• ~~Stakeholder confidence report to private Execs meeting~~ Define the "know, run, improve" leadership standard; test service grip and delivery through Senates; provide targeted support and appropriate intervention.	• ~~Dir of Comms~~CEO / COO / CPO	• Dec 26
~~Agreed long-term CEO objectives~~Clinical leadership partnership requires embedding	• ~~New CEO objectives set for the year ahead~~ • Launch CEO Consultant Forum in October; build on MAC/LNC dialogue and one-to-ones to enable earlier clinical input, shared decisions and measurable service change.	• ~~Chair~~CEO / CMO	• ~~Sept~~Dec 26
~~Lack of verification of efficacy of new NED induction~~Workforce / stakeholder confidence needs triangulation	• ~~Introduce an induction effectiveness survey for new NEDs~~Bring together pulse / staff survey, FTSU, consultant and partner feedback; report themes, fair assessment of concerns and actions through PCC and Board.	• CPO / Comms~~Head of Corp Gov~~	• Dec 26~~July 27~~
~~External perspective on NED interview panel~~NED induction effectiveness remains untested	• ~~Determine if an external perspective would help~~Confirm induction arrangements for incoming NEDs and collect structured effectiveness feedback after appointment.	• Head of Corp Gov~~CPO~~	• July 27~~Sept 26~~
~~Well-led developmental review (3)~~Decisions and communications not reliably translated into action	• ~~Progress an updated review given new leadership and changed circumstances~~Subject to TMG agreement, test clear decision rights, an owned decision log and leader-led communication; review implementation and outcomes after four weeks.	• CEO / TMG~~Head of Corp Gov~~	• ~~Initiating Nov~~Dec 26
~~Assurance re positive leadership rounds/visibility~~Independent Well-led perspective required	• ~~Kim to produce a report to TMG~~Scope and initiate updated developmental review reflecting leadership transition, organisational capability and emerging operating-model challenges.	• Head of Corp Gov~~CEO~~	• ~~Dec~~Start Nov 26
~~Board Seminar effectiveness~~ Leadership visibility / seminar benefits need verification	• ~~Extend Board effectiveness to Board Seminar~~Report walkaround feedback and follow-through to TMG; evaluate whether Board seminars and leadership communication lead to meaningful change.	• ~~Head of~~CEO / Corp Gov	• Dec 26 / Apr 27

Current Performance – Highlights from the Integrated Performance Report:
• Leadership continuity: Chief Executive established in post; permanent CFO appointment confirmed for 29 November; Deputy COO appointment confirmed in October. NED recruitment / induction outcome to be verified. • September Mid-Year Review: variation in leadership capability, accountability and clinical-management relationships

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remains material alongside access, productivity and finance challenges. Q1 NHS Oversight Framework classification moved from Segment 2 to Segment 3.

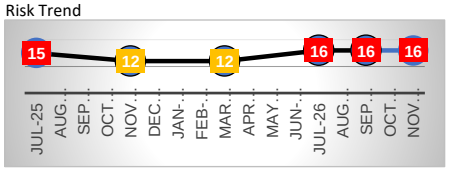
- Mitigation underway: strengthened operational leadership, CEO consultant engagement and October forum plans, focused recovery and a proposed decision-making framework. Board assurance must now test changed delivery and workforce confidence, not solely activity or appointments.

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
Strategic Risk No.7: **Accountability consequences & ownership**			**16**
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 • This is a regular item at the Performance Senates and has seen an improvement which takes us (marginally) above target at 90.8%	• 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 – in progress and will align to the new Leadership and Management Development Framework/NHS Staff Standards. 1st draft shared with PCC September 2026	• 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 • See above -	• CPO	• Oct 2026
ASSURANCE GAPS			
Independent assessment and assurance of leadership accountability	• Well-led developmental review	Head of Corporate	• Dec 2027

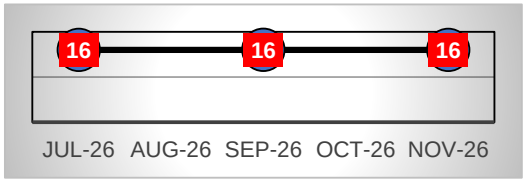
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culture		Governance	

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 postion	• MS	• Controls in place
• Current System become unsupportable	• Contractual arrangements in place with Nerve entre until July 2028	• MS	• COMPLETE

• Clinical risks requiring mitigation through EPR are ongoing	• 22 risks that's 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 26 • Projects are now in delivery, full project plans due at October Digital committee
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 Delivery date for product Phase 1 ~~)~~now committed by Dedalus as 21/12/26

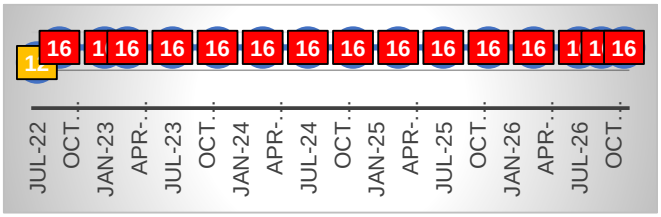
Current Performance – Highlights from the Integrated Performance Report:
• Programme status remains RED. • ~~Outstanding delivery commitments for Full EPR, MVP and Core requirements.~~ • Multiple workstreams remain RED including Integration, User Experience, CPOE, Pathways, ED/IP, Outpatients and Comms. • 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)	4

	• Accountability Framework (2)	
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 includes adoption of a 6-4-2 model • 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	• 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)	• Paul Thorp DOD Unplanned Care • Junaid Qazi, Divisional Medical Director UPC • Justin Daniels,	• March 2027

estate, leading to regular but unplanned IP bed closures to resolve urgent estates issues	• Refreshed implementation of Principles of Safe & Effective Emergency Care • Working with system partners on winter planning • 7-day band 7 nursing in place in paediatric ED • Corridor Care Elimination Plan • Pilot of Acute Medics in Urgent Care Coordination Hub (June 2026) • EEMAC implementation • Use of patient stories • Regular liaison between ENHT and HPFT wrt shared pathways • Estates work to SSU, Renal, Swift	• Medical Director • Theresa 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 Apr 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 • Winter planning group	• 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, imaging reporting • 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) • Imaging reporting delays	• Changeology support for Imaging Transformation Programme • Risk summit x 2 completed, interim governance arrangements to be implemented to support and oversee improvement progamme across Imaging service • 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 • Scanner replacement progamme in place for 2	• Claire Moore, Deputy COO • Ben Gainsford~~Kate Fruin~~, ~~Acting~~ DOD Planned Care • Praveen Jeevartnam, Interim Imaging Director • Mark	• March 2027

	x MRI / 2 x CT scanners by Match 27~~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	Stanton, diagnostic transformation SRO	
• Theatre utilisation below 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	• Recruitment plans ongoing including review of over recruitment strategy~~.~~ • Insourcing model being implemented for a short period of time to mitigate vacancy and sickness nursing gaps • 'Drumbeat' huddles to manage activity • Theatre Transformation Programme 2026/7 including review of theatre timetable • POA Kaizen workstream • POA Digital programme • ~~Estates work to Theatres, Swift~~	• Ben Gainsford~~Kate Fruin~~ DOD • Lucy Davies COO - theatre tranformation SRO	• March 2027

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

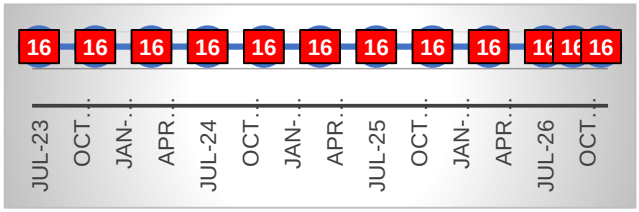
Associated Risks on the Board Risk Register		
Risk no.	Description	Current score
3634	Ex ward referrals not being booked into clinic	20
3470	The risks associated with flow in ED related to congestion	16
3255	ICU discharge guidelines compliance	15
1722	OOH radiology provision	16
3723	Orthotics demand	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
0013	Delay in patient treatment due to specialist trained theatre staff	15
3491	Long waiting times for CT TAVI scans	16
3833	Lack of acute therapy weekend & bank holiday cover	15

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

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

Risk Trend



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
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

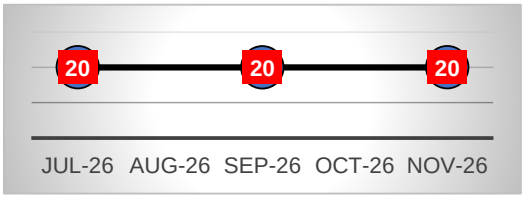
Current Performance – Highlights from the Integrated Performance Report:
• Current AI programmes including Ambient voice technology (AVT) scoped as a pilot • OP AI within the plan such as digital PIFU

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
Inherent	5	5	25	3
Current	**5**	**4**	**20**	
Target	4	3	12	

Risk Trend



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 Complete~~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	Complete~~Sept 2026~~ Mar 2027 Ongoing ~~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	Complete~~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 Ongoing~~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	Complete~~Jun 2026~~ Ongoing~~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	Complete~~Apr 2026~~ Complete~~June 2026~~ Ongoing~~Apr 2026~~ ~~J~~Ongoing~~un 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:
• KPO resource redirected into transformation priorities and Brilliant Basics, a new programme to scale-up deployment of daily management underway with VMI support. • New performance framework meeting structure, Day of the Senates, established including the formalised introduction of the escalation and consequence framework confirmed in writing by CEO to divisional leadership teams. • A range of supportive interventions introduced across priority areas involving theatres, imaging and UEC to enable delivery of transformation priorities. • NHSE Leadership and Management Competency Framework launched, including a self-assessment process to inform the Grow Together Review process. • NHSE capability self-assessment including Domain 5 productivity completed in preparation for Board review and sign-off prior to external submission. • Planning framework including a GGI review regarding a well-led review approved at TMG in August. • Pilot for a new approach to transformation involving zero-based design with the pain services specialty has now commenced. • New Target Culture Model introduced for discussion at P&CC in August , including a high-level overview of the new emerging People Strategy.

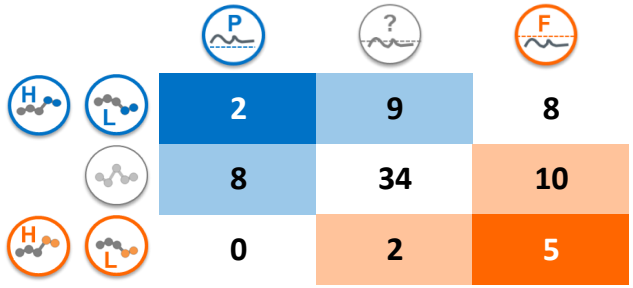
Associated Risks on the Board Risk Register		
Risk no.	Description	Current score

NHS
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Integrated Performance Report

Month 06 | 2026-27





Data correct as at 23/10/2026

Performance Highlights

NHS East and North Hertfordshire Teaching NHS Trust

Quality

- Increase in good care events, particularly in paediatrics and in oncology at Mount Vernon.
- For the second month running 100% of inpatients diagnosed with sepsis received antibiotics within an hour.
- VTE assessment rates, hospital acquired pressure ulcers and falls rates are stable but work needs to take place to see what would drive further improvement.
- Stroke rates have dropped leading to improved flow within the pathway. Thrombolysis and thrombectomy rates remain above previous proportions.
- Mortality metrics are stable.

Operations

- **Cancer Waits:** 62-day performance improved from 74.9% to 79.5% in August. FDS deteriorated from 73.4% to 65.5% attributed to Radiology reporting and skin backlog
- **Diagnostics:** Monthly improvement in DM01 performance in line with trajectory.
- **RTT (excl. Community):** The Trust delivered 64.2% in performance and 0.3% behind revised trajectory. Efficiency and productivity remain the key focus of transformation, alongside strengthened financial controls.
- **Community waits:** Proof of Concept completed for Herts integrated CYP Neurodiversity pathway, organisations now working together on next steps to operationalise new ways of working.
- **UEC:** Both Adult and Paeds performance remain below trajectory, improvement trajectory in place with additional operational resilience measure implemented throughout October.

Finance

- £2.0m YTD deficit against a £2.0m 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.
- Elective performance and productivity gaps are masked by block and productivity needs to increase to improve the underlying run rate.
- Financial recovery mitigation workstreams have now been agreed which should improve the underlying run rate in the second half of the year.

People

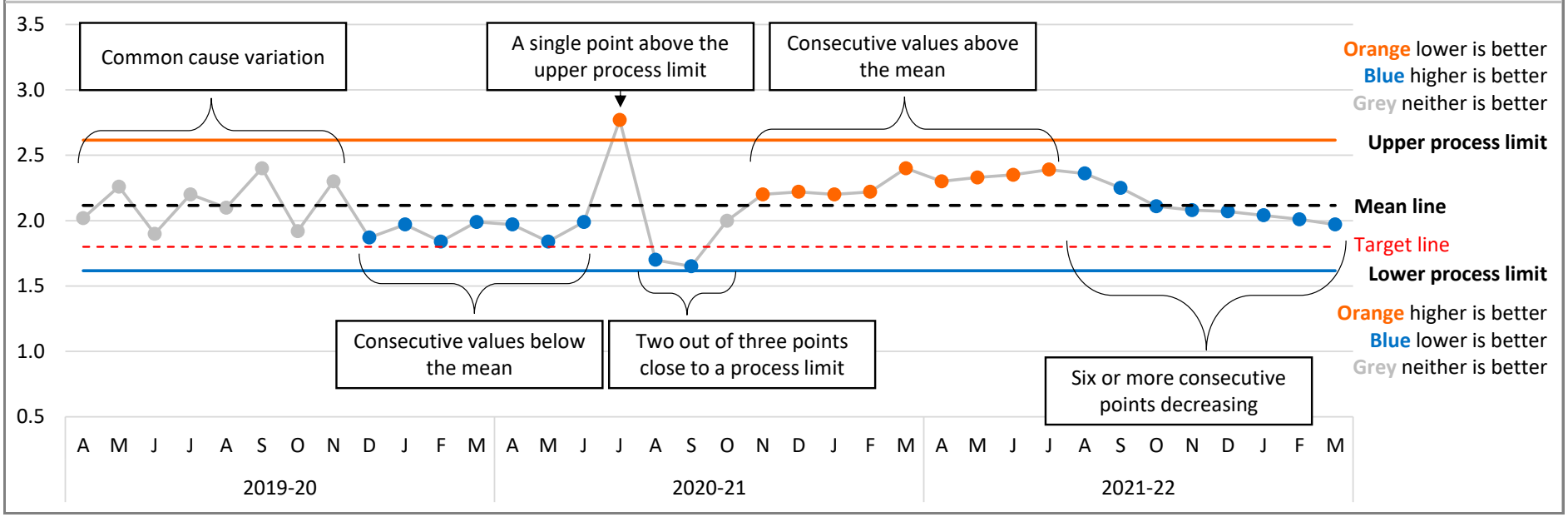
- Staff turnover rate at 7.1% - the lowest figure since October 2025.
- Stat/Mand compliance has fallen below target at 88.8%
- Agency spend is low at 0.7% and vacancies low at 2.3%
- Bank spend as a proportion of WTE has reduced to 6.1% - lowest on record.
- GROW together compliance has increased by 8% demonstrating positive progress in appraisal and development activity.
- Worsening sickness rate position (5.5%) despite the Return Well programme - stress & mental health conditions continue to be a leading cause of sickness absence with 119 OH assessment referrals in M6.
- Noted improvement on average length of suspension to 30 days.
- Policy compliance remains at 93% with outstanding policies prioritised.

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Integrated Performance Report

NHS East and North Hertfordshire Teaching NHS Trust

How to interpret a Statistical Process Control (SPC) Chart



Variation

H L	Special cause variation of **concerning** nature due to **H**igher or **L**ower values
H L	Special cause variation of **improving** nature due to **H**igher or **L**ower values
	Common cause variation No significant change

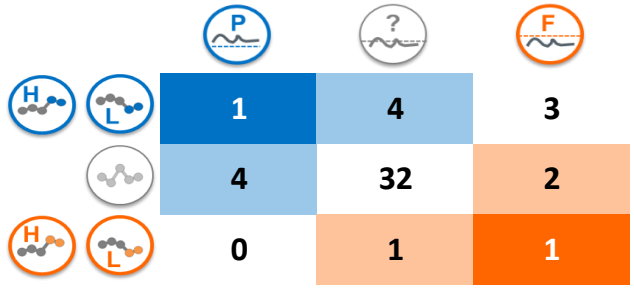
Assurance

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

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Quality

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Quality

Summary

NHS East and North Hertfordshire Teaching NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Patient Safety Incidents	Total incidents reported in-month	Sep-26	n/a	1,565			Common cause variation No target
Infection Prevention and Control	Hospital-acquired MRSA Number of incidences in-month	Sep-26	0	0	L	?	8 points below the mean Metric will inconsistently pass and fail the target
	Hospital-acquired c.difficile Number of incidences in-month	Sep-26	0	7		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired MSSA Number of incidences in-month	Sep-26	0	4		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired e.coli Number of incidences in-month	Sep-26	0	7		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired klebsiella Number of incidences in-month	Sep-26	0	2		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired pseudomonas aeruginosa Number of incidences in-month	Sep-26	0	1		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired CPOs Number of incidences in-month	Sep-26	0	3		?	Common cause variation Metric will inconsistently pass and fail the target
	Hand hygiene audit score	Sep-26	80%	92.0%		P	Common cause variation Metric will consistently pass the target
Safer Staffing	Overall fill rate	Sep-26	n/a	81.4%			Common cause variation No target
	Staff shortage incidents	Sep-26	n/a	48			Common cause variation No target

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Quality

Summary

NHS East and North Hertfordshire Teaching NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Cardiac Arrests	Number of cardiac arrest calls per 1,000 admissions	Sep-26	n/a	0.70			Common cause variation No target
	Number of deteriorting patient calls per 1,000 admissions	Sep-26	n/a	0.81			Common cause variation No target
Sepsis Screening and Management	Inpatients receiving IVABs within 1-hour of red flag	Sep-26	95%	100.0%		?	Common cause variation Metric will inconsistently pass and fail the target
	Inpatients Sepsis Six bundle compliance	Sep-26	95%	57.1%		F	Common cause variation Metric will consistently fail the target
	ED attendances receiving IVABs within 1-hour of red flag	Sep-26	95%	89.1%		?	Common cause variation Metric will inconsistently pass and fail the target
	ED attendance Sepsis Six bundle compliance	Sep-26	95%	73.4%		F	Common cause variation Metric will consistently fail the target
VTE Risk Assessment	VTE risk assessment stage 1 completed	Sep-26	85%	78.0%	H	F	16 points above the mean Metric will consistently fail the target
HATs	Number of HAT RCAs in progress	Sep-26	n/a	172			Common cause variation No target
	Number of HAT RCAs completed	Sep-26	n/a	1			Common cause variation No target
	HATs confirmed potentially preventable	Sep-26	n/a	0			Common cause variation No target
PU	Pressure ulcers All category ≥2	Sep-26	0	10		?	Common cause variation Metric will inconsistently pass and fail the target

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Quality

Summary

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	Sep-26	n/a	4.1			Common cause variation No target
	Proportion of patient falls resulting in serious harm	Sep-26	n/a	0.0%			Common cause variation No target
	Proportion of patient falls resulting in Moderate harm	Sep-26	n/a	4.8%			Common cause variation No target
Friends and Family Test	Inpatients positive feedback	Sep-26	95%	95.9%			Common cause variation Metric will inconsistently pass and fail the target
	A&E positive feedback	Sep-26	90%	93.7%			Common cause variation Metric will inconsistently pass and fail the target
	Maternity Antenatal positive feedback	Sep-26	93%	95.0%			Common cause variation Metric will inconsistently pass and fail the target
	Maternity Birth positive feedback	Sep-26	93%	100.0%			Common cause variation Metric will inconsistently pass and fail the target
	Maternity Postnatal positive feedback	Sep-26	93%	97.3%			Common cause variation Metric will inconsistently pass and fail the target
Friends and Family Test	Maternity Community positive feedback	Sep-26	93%	100.0%			Common cause variation Metric will inconsistently pass and fail the target
	Outpatients FFT positive feedback	Sep-26	95.0%	95.9%			Common cause variation Metric will inconsistently pass and fail the target
PALS	Number of PALS referrals received in-month	Sep-26	n/a	474		-	Common cause variation No target

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Quality

Summary

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Complaints	Number of written complaints received in-month	Sep-26	n/a	157	H	-	8 points above the mean No target
	Number of complaints closed in-month	Sep-26	n/a	120		-	Common cause variation No target
	Proportion of complaints acknowledged within 3 working days	Sep-26	75%	58.9%	L	?	1 point below the lower process limit Metric will inconsistently pass and fail the target
	Proportion of complaints responded to within agreed timeframe	Sep-26	80%	33.3%	L	F	14 points below the mean Metric will consistently fail the target
Maternity Safety Metrics	Caesarean section rate Total rate from Robson Groups 1, 2 and 5 combined	Jul-24	60 - 70%	70.4%		?	Common cause variation Metric will inconsistently pass and fail the target
	Massive obstetric haemorrhage >1500ml vaginal	Sep-26	3.3%	4.3%		?	Common cause variation Metric will inconsistenly pass and fail the target
	3rd and 4th degree tear vaginal	Sep-26	2.5%	3.7%		?	Common cause variation Metric will inconsistenly pass and fail the target
	Massive obstetric haemorrhage >1500ml LSCS	Sep-26	4.5%	4.8%		?	Common cause variation Metric will inconsistenly pass and fail the target
	3rd and 4th degree tear instrumental	Sep-26	6.3%	11.1%		?	Common cause variation Metric will inconsistently pass and fail the target
	Term admissions to NICU	Sep-26	6.0%	4.3%	L	?	8 points below the mean Metric will inconsistently pass and fail the target
	ITU admissions	Sep-26	0.7	0		?	Common cause variation Metric will inconsistently pass and fail the target

Month 06 | 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	Sep-26	12.5%	1.9%		P	Common cause variation Metric will consistenly pass the target
	Smoking at time of delivery	Sep-26	2.3%	1.4%		?	Common cause variation Metric will inconsistently pass and fail the target
	Bookings completed by 9+6 weeks gestation	Sep-26	50.5%	78.1%		P	Common cause variation Metric will consistenly pass the target
	Breast feeding initiated	Sep-26	72.7%	76.8%		?	Common cause variation Metric will inconsistently pass and fail the target
	Number of MNSI PSII	Sep-26	0.5	1		?	Common cause variation Metric will inconsistently pass and fail the target
Mortality	Crude mortality per 1,000 admissions In-month	Sep-26	12.8	7.8	L	?	8 points below the mean Metric will inconsistently pass and fail the target
	Crude mortality per 1,000 admissions Rolling 12-months	Sep-26	12.8	8.3			Rolling 12-months - unsuitable for SPC
	HSMR In-month	Jul-26	100	83.7		?	Common cause variation Metric will inconsistently pass and fail the target
	HSMR Rolling 12-months	Jul-26	100	81.7			Rolling 12-months - unsuitable for SPC
	SHMI In-month	Apr-26	100	79.7		?	Common cause variation Metric will inconsistently pass and fail the target
	SHMI Rolling 12-months	Apr-26	100	93.8			Rolling 12-months - unsuitable for SPC

Month 06 | 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	Jul-26	n/a	691	L		9 points below the mean No target
	Rate of emergency re-admissions within 30 days of discharge	Jul-26	9.0%	5.6%	L	P	11 points below the mean Metric will consistently pass the target
Length of Stay	Average elective length of stay	Sep-26	2.8	2.0		P	Common cause variation Metric will consistently pass the target
	Average non-elective length of stay	Sep-26	4.6	5.0		?	Common cause variation Metric will inconsistently pass and fail the target
Palliative Care	Proportion of patients with whom their preferred place of death was discussed	Sep-26	n/a	88.6%			Common cause variation No target
	Individualised care pathways	Sep-26	n/a	23	L		8 points below the mean No target
Stroke Services	Trust SSNAP grade	Q2 2026-27	A	D			
	4-hours direct to Stroke unit from ED	Sep-26	63%	61.2%	H	F	1 point above the upper process limit Metric will consistently fail the target
	4-hours direct to Stroke unit from ED with Exclusions (removed Interhospital transfers and inpatient Strokes)	Sep-26	63%	60.4%	H	F	1 point above the upper process limit Metric will consistently fail the target
	Number of confirmed Strokes in-month on SSNAP	Sep-26	n/a	55			Common cause variation No target
	If applicable at least 90% of patients' stay is spent on a stroke unit	Sep-26	80%	92.3%		?	Common cause variation Metric will inconsistently pass and fail the target
	Urgent brain imaging within 20 minutes of hospital arrival for suspected acute stroke	Sep-26	40%	41.8%		?	Common cause variation Metric will inconsistently pass and fail the target
	Urgent brain imaging within 60 minutes of hospital arrival for suspected acute stroke	Sep-26	50%	74.5%		?	Common cause variation Metric will inconsistently pass and fail the target

Month 06 | 2026-27

Quality

Summary

East and North Hertfordshire Teaching NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
	% of all stroke patients who receive thrombolysis	Sep-26	11%	16.4%			Common cause variation Metric will inconsistently pass and fail the target
	Discharged with ESD	Sep-26	50%	82.9%			1 point above the upper process limit Metric will inconsistently pass and fail the target

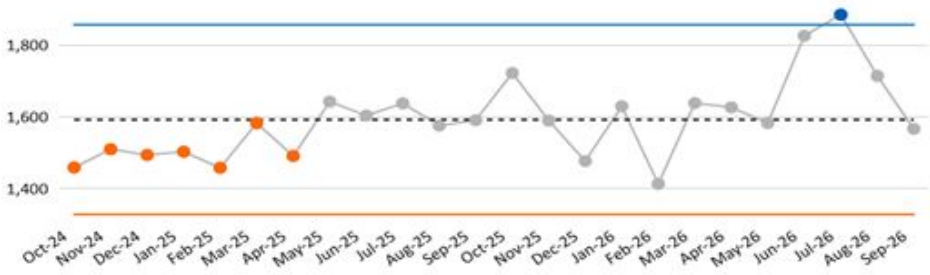
Month 06 | 2026-27

Quality

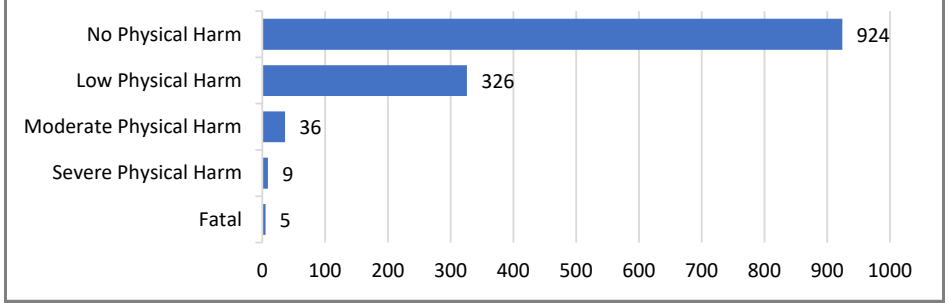
Patient Safety Incidents

NHS East and North Hertfordshire Teaching NHS Trust

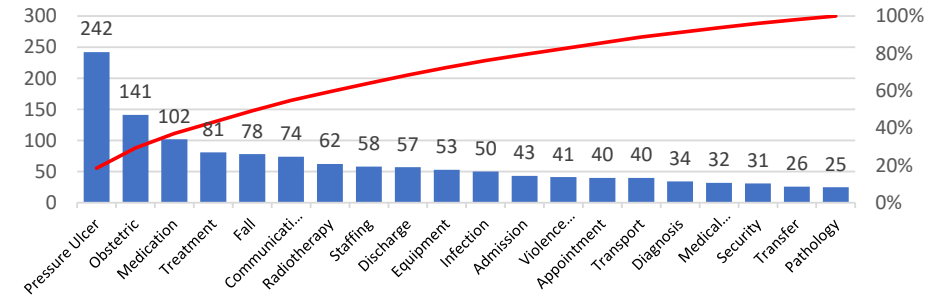
Total incidents reported



Number of patient safety incidents by level of harm - Sep-26



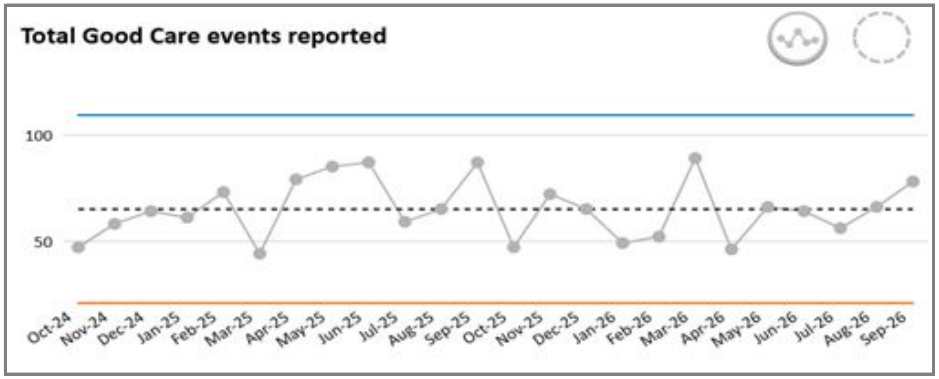
Incidents Themes - Sep-26



Key Issues and Executive Response

- 96% of patient safety incidents reported resulted in no harm / low harm.
- Obstetrics & Emergency Medicine continue as highest reporting areas
- Positive reduction in incidents relating to communication & discharge
- Notable improvement in timely incident management seen with the Acute Medicine specialty.
- Third risk summit into ongoing clinical impact of medical records systems challenges (08/10/26)
- Ongoing risk management response to multiple diagnostic incidents in radiology
- Fatal harm incidents ongoing review through PMRT, and unexpected deaths incident review pilot.
- 1 new PSii commissioned; failure to rescue (cross-divisional incident with Gastro and General Surgery). Early learning regarding handover processes, medical staffing and communication.
- Ongoing focus and locally lead improvement work to support timely closure of open incidents
- Increase in 'good care' events reported; particularly in Paediatrics and Mount Vernon with 'effective clinical management' and 'teamwork' remaining the most frequent themes.

Total Good Care events reported

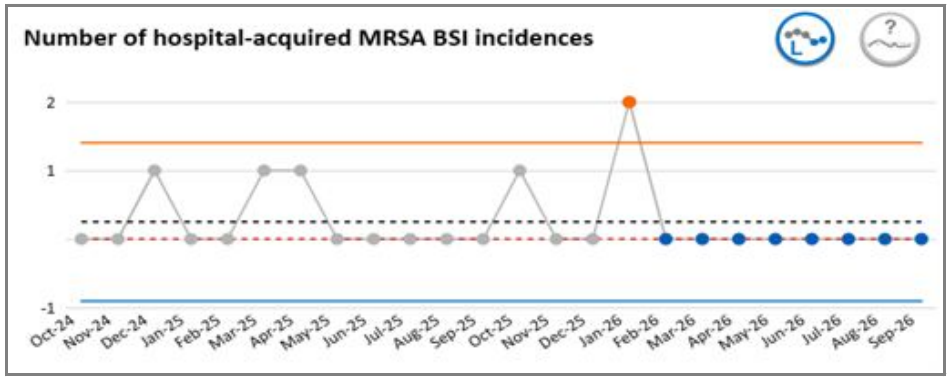


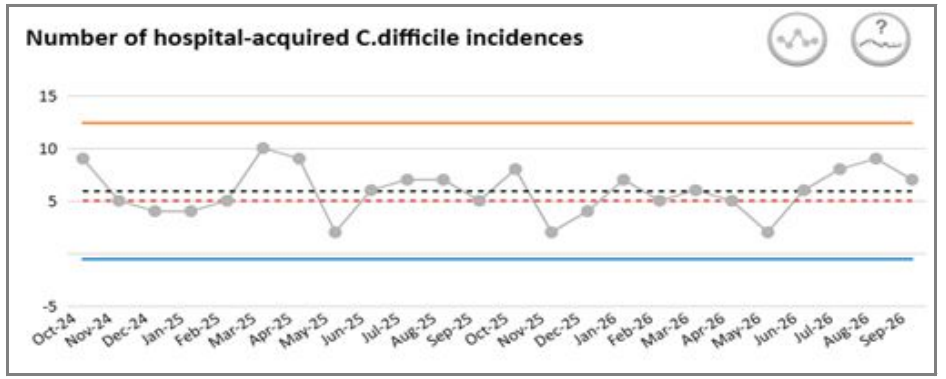
Month 06 | 2026-27

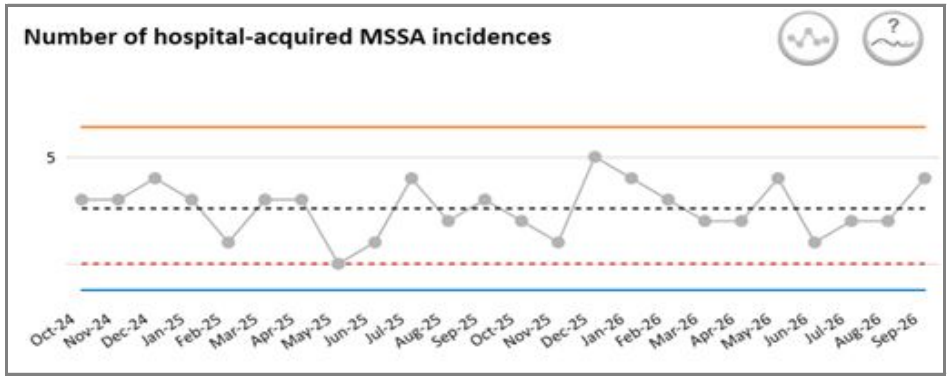
Quality

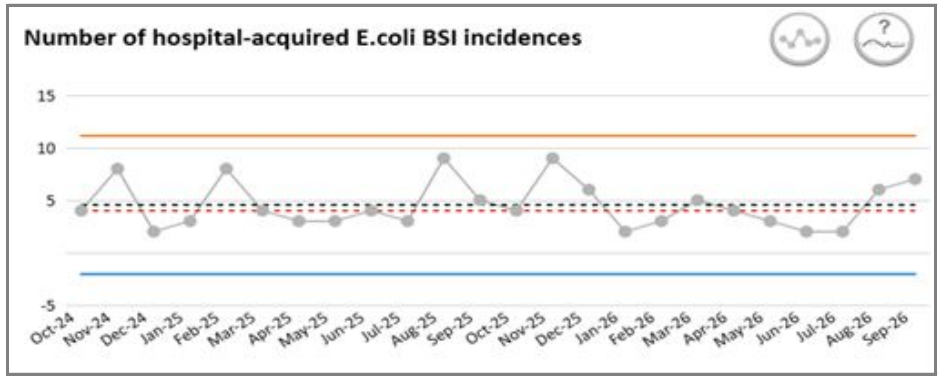
Infection Prevention and Control

East and North Hertfordshire Teaching NHS Trust









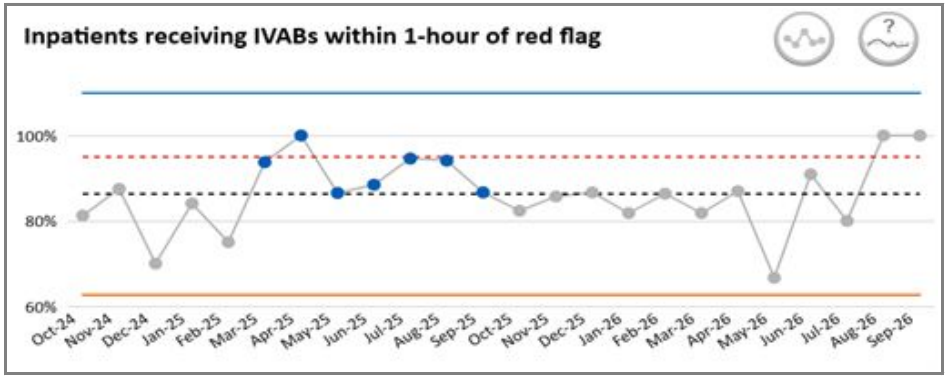
- MRSA BSI - there were zero MRSA Bloodstream Infections (BSI) reported during Sep-26. Year to date (YTD), there are zero cases.
- MSSA BSI - a total of four MSSA BSI were reported in Sep-26. YTD total is 15, which is three cases below the total for the same period last year. The common theme is identified as skin/wound, demonstrating local colonisation.
- *C. difficile (C diff.)* infection (CDI) - seven hospital-associated CDI cases were reported in Sep-26. YTD total is 37 against an annual threshold of 61. This is slightly above the 36 cases reported at the same point year. The reduced threshold for 2026/27 provides less tolerance for variation in monthly case numbers, increasing the importance of sustained focus on prevention activities. Multi-disciplinary team (MDT) review has been scheduled, pending clinician availability. Initial IPC review showed that samples were sent appropriately and patients were isolated promptly. Ongoing engagement with the clinical team especially with regards to antimicrobial stewardship is in place.
- *E.coli BS*I - seven cases were reported in Sep-26. YTD, 24 cases have been recorded, which is three cases fewer for the same period last year. Five out of seven common source is upper urinary tract, previous colonisation in the urine.

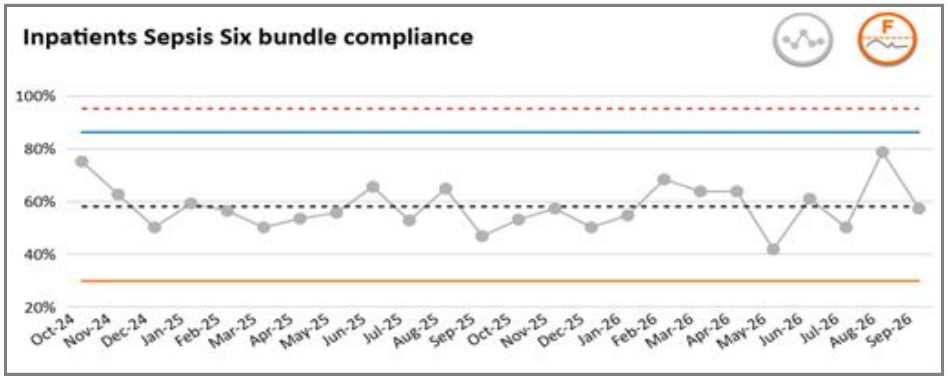
Month 06 | 2026-27

Quality

Sepsis Screening and Management | Inpatients

East and North Hertfordshire Teaching NHS Trust





Themes

Sepsis IP	2025-26						2026-27					
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Oxygen	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Blood cultures	73%	81%	92%	57%	91%	73%	74%	89%	81%	89%	85%	79%
IV antibiotics	87%	82%	86%	86%	82%	82%	88%	67%	91%	80%	100%	100%
IV fluids	100%	82%	92%	100%	88%	82%	83%	86%	87%	83%	100%	100%
Lactate	50%	81%	64%	71%	82%	64%	87%	64%	70%	56%	79%	64%
Urine measure	80%	82%	93%	75%	73%	73%	83%	83%	83%	80%	100%	71%
Sepsis Six bundle	53%	57%	50%	55%	68%	64%	64%	42%	61%	50%	79%	57%

Key Issues and Executive Response

Themes

- 8/14 patients received the sepsis six within an hour in inpatients - 4/6 patients who failed compliance deteriorated out of hours.
- IV antibiotic compliance sits at 100%.
- IV fluid sits at 100% for the month of September
- Lactate measurement remains a challenge amongst inpatients with 9/14 and 64%.
- Urine output measurement continues to fluctuate sitting at 71% in September.
- Blood culture compliance sits at 79% with 11/14 patients having them in a timely manner.

Response

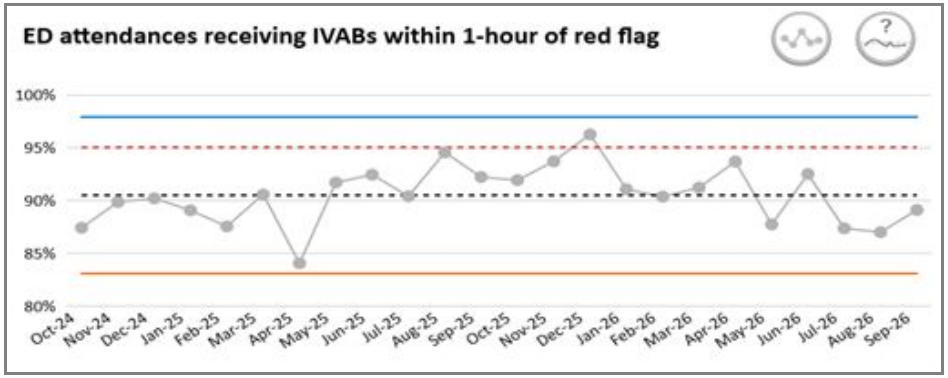
- The team are utilising formal and bedside education, alongside working with practice educators to push for sustainability in compliance.
- The team are trying to intercept unwell septic patients and assist in the delivery of the sepsis six in a timely manner.
- The team delivered a Sepsis/AKI study day with a focus on applying knowledge into practice at the end of September.
- World Sepsis Day created an opportunity for the team to further spread awareness and knowledge across the hospital with a stall and trolley dashes to the wards.
- Weekly AMU team time teaching is ongoing to reach many acute care staff.
- Teaching was delivered to the new intake of FY1's with a focus on recurring themes within sepsis management, key focuses for timely sepsis management and how the team can support them in practice.

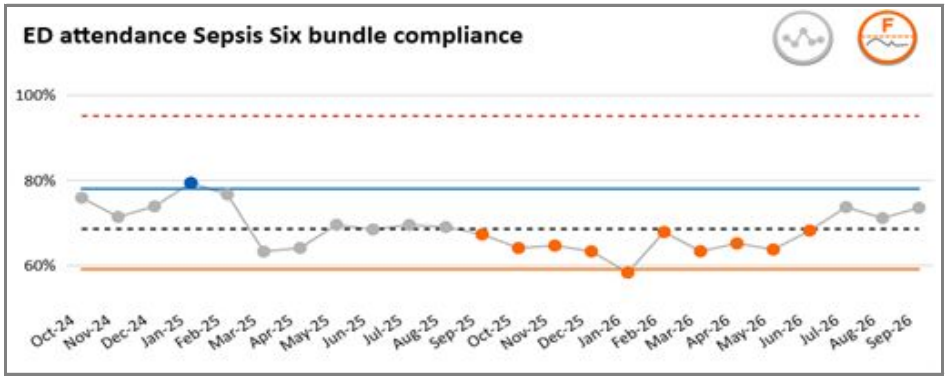
Month 06 | 2026-27

Quality

Sepsis Screening and Management | Emergency Department

East and North Hertfordshire Teaching NHS Trust





Themes

Sepsis ED	2025-26						2026-27					
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Oxygen	100%	100%	100%	100%	100%	100%	98%	100%	100%	100%	100%	100%
Blood cultures	92%	97%	94%	95%	96%	96%	95%	97%	96%	99%	94%	100%
IV antibiotics	92%	92%	94%	96%	91%	91%	94%	88%	92%	87%	87%	89%
IV fluids	93%	94%	98%	100%	97%	90%	98%	88%	95%	95%	92%	94%
Lactate	100%	99%	97%	100%	99%	100%	98%	97%	100%	99%	97%	100%
Urine measure	70%	68%	66%	67%	62%	68%	75%	73%	73%	76%	78%	77%
Sepsis Six bundle	64%	65%	63%	58%	68%	63%	65%	64%	68%	74%	71%	73%

Key Issues and Executive Response

Themes

- 47/64 (73%) patients audited across September demonstrated sepsis compliance, having all six elements completed within an hour.
- Urine output sits at 77% with 49/64 patients having fluid balance completed within the hour reflecting consistency which needs to be built on. Of the 15 patients who has fluid balance outside the hour, only 8 had no fluid balance at all with 7 having delayed fluid balance.
- Lactate measurement and blood culture compliance sits at 100% in September.
- IV antibiotic compliance sits at 89% with 57/64 patients receiving antibiotics within 1 hour. The lengthiest delay sat at 1hr47mins.
- IV fluid compliance sits at 94% with 50/53.

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 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.
- The team are arranging future simulation days for staff allowing them to apply theory into practice in a controlled environment.

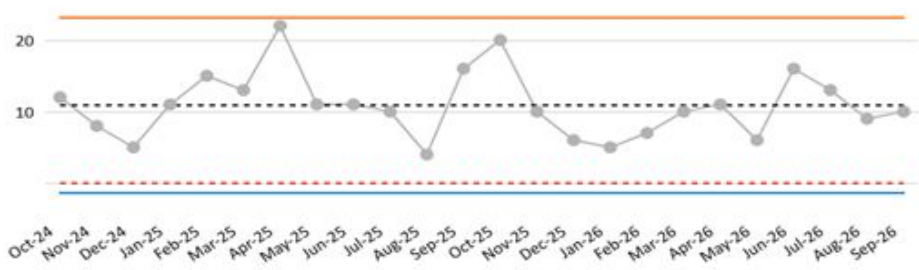
Month 06 | 2026-27

Quality

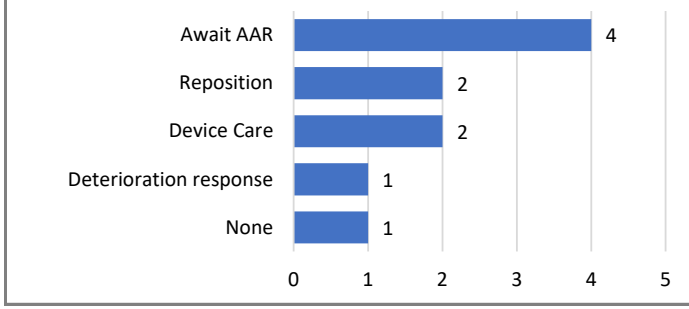
Pressure Ulcers | VTE

NHS East and North Hertfordshire Teaching NHS Trust

Number of hospital-acquired pressure ulcers



Themes - Sep-26



617

days since last category 4

as at 21/10/2026

VTE risk assessment stage 1 completed



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. Work with digital team has begun to build Purpose-T into Nerve Centre
- Community acquired PUs (CA PU) unvalidated data =**139**: PU1=30 / PU2 =109. Validated by TVN CAPU = **27**: PU2 =2 / PU3=17 / PU4 =3 / SDTI 5. Total reported incidents of CA PU = **166**

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.
- 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.
- National updates regarding the Maternity Care Bundle have implications for additional risk assessments in Obstetric patients, with changes to current ante-natal and post natal risk assessment.

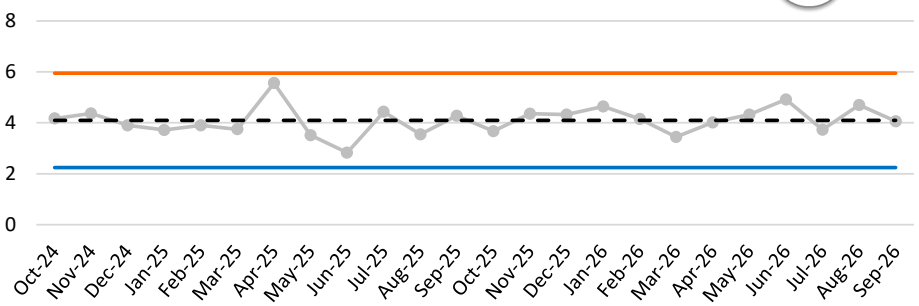
Month 06 | 2026-27

Quality

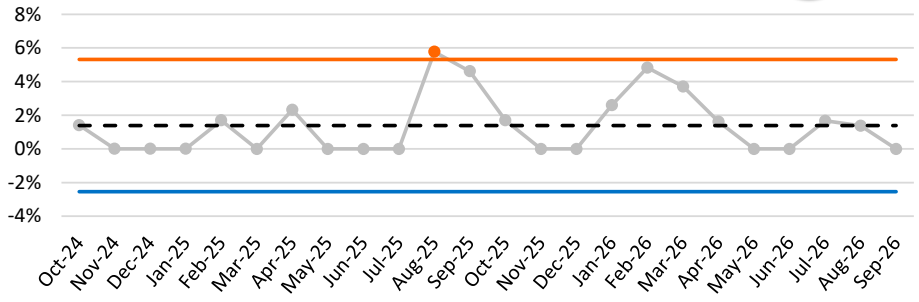
Patient Falls

East and North Hertfordshire Teaching NHS Trust

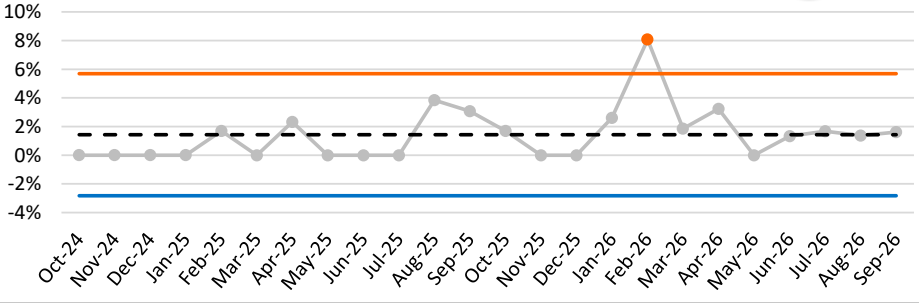
Rate of patient falls per 1,000 overnight stays



Proportion of patient falls resulting in Severe physical harm



Proportion of patient falls resulting in Moderate physical harm



Key Issues and Executive Response

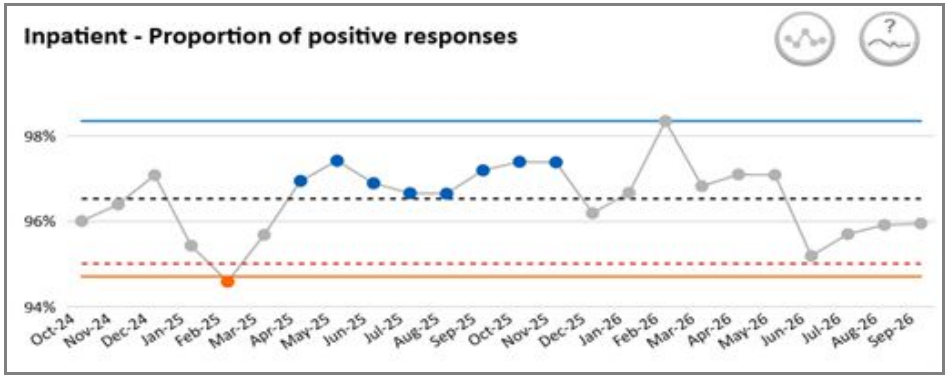
- Inpatient falls data continues to show common cause variation, with an average of 4 per month per 1000 bed days.
- Inpatient fall incidences is lower compared to previous month.
- One fall resulting in moderate harm was recorded during September. The incident involved an unwitnessed fall, which resulted in the patient sustaining a minimally displaced nasal bone fracture. Prior to the incident, safety measures, including non-slip socks, bed rails and access to the call bell, were offered to the patient but declined. The patient was assessed as having full mental capacity prior to the incident. All relevant falls documentation was updated at the time of the incident.
- A falls Quality Improvement (QI) project has been initiated in the Emergency Department (ED) to improve compliance with falls risk assessments. The project is led by ED doctors, with support from ED leaders and the Falls Lead, to promote adherence to falls assessment procedures and enhance patient safety.
- The ED Falls Risk Assessment compliance dashboard is now live on Power BI. This will enable the department to monitor compliance in real time, identify areas for improvement, and implement targeted actions to further enhance compliance with falls risk assessment requirements and improve patient safety.

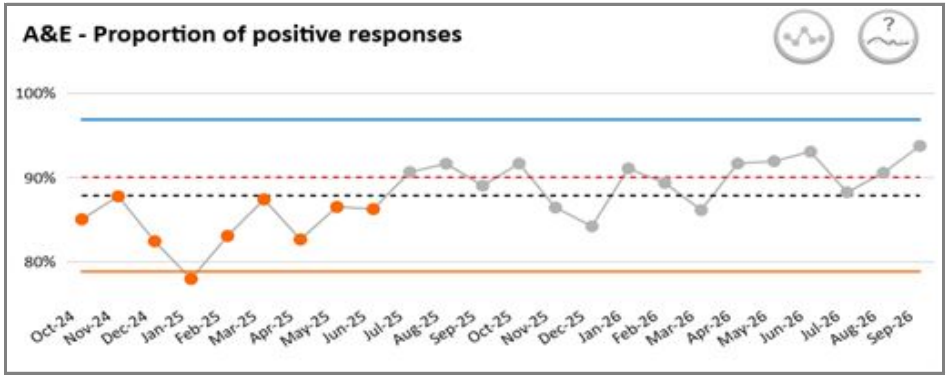
Month 06 | 2026-27

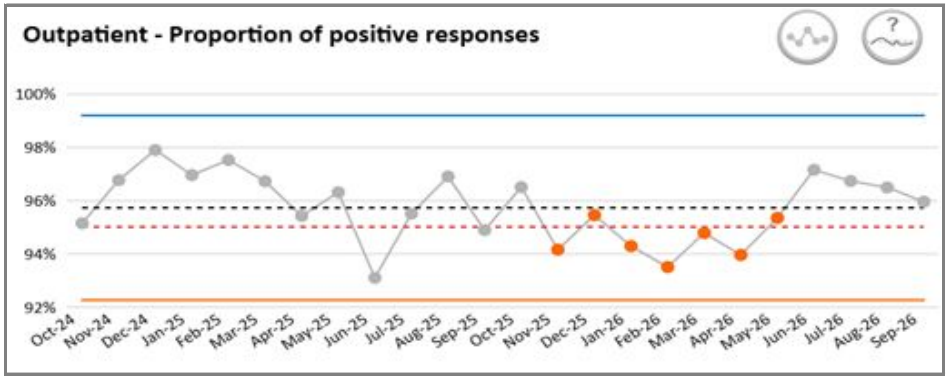
Quality

Friends and Family Test

NHS East and North Hertfordshire Teaching NHS Trust







Key Issues and Executive Response

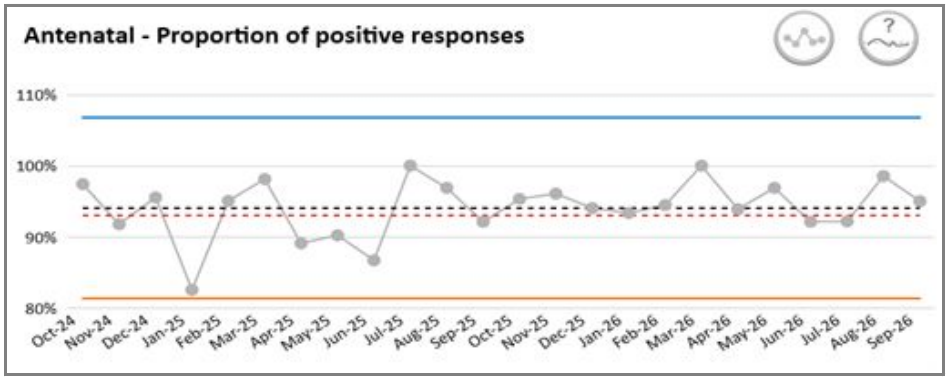
- The response rate for the Inpatient/Day Case surveys increased to 17.07% in September after dropping for the previous 2 months (15.66% Aug). The proportion of positive responses stayed the same whilst the poor/very poor score improved to 0.60% (1.32% Aug).
- For the combined ED-UCC departments, both scores improved in September with 93.71 % good/very good (90.51% Aug) and 3.50% poor/very poor (7.30% Aug). The number of responses to the survey continue to be extremely low for the number of patients discharged despite the provision of FFT QR code posters and paper surveys available for patients to use - 143 surveys completed in September and 137 in August.
- The proportion of positive responses for Outpatients decreased again for the third month with % good/very good at 95.94% (96.48% Aug) and % poor/very poor slightly worse at 1.35% (1.11% Aug). In September there were 813 responses, the lowest recorded since August 2025, compared to a high of 1079 responses in August.
- The Antenatal element of maternity had 140 responses to the survey in September an increase from 68 received in August. However, the proportion of positive responses decreased to 95% good/very good (98.53% Aug) and the poor/very poor score increased to 1.43% (0.00% Aug).
- In comparison, the birth element % good/very good increased to 100% (91.67%) and % poor/very poor deceased to zero (8.33% Aug). However, with only 11 responses out of the 350 women eligible to respond, a reflection of the standard of service provided by the service user is limited.
- The overall Trust score for September was 95.84% good/very good (96.06% Aug) and 1.18% poor/very poor (1.53% Aug).
- Divisions report back on actions regarding FFT response rates and results as part of PACE monthly updates.

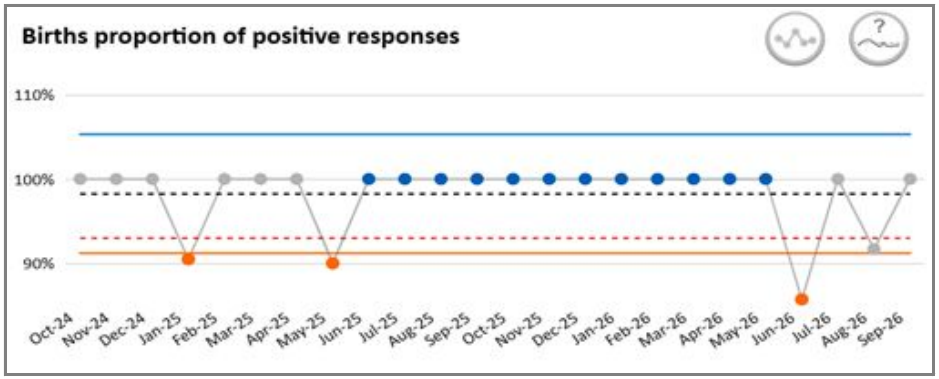
Month 06 | 2026-27

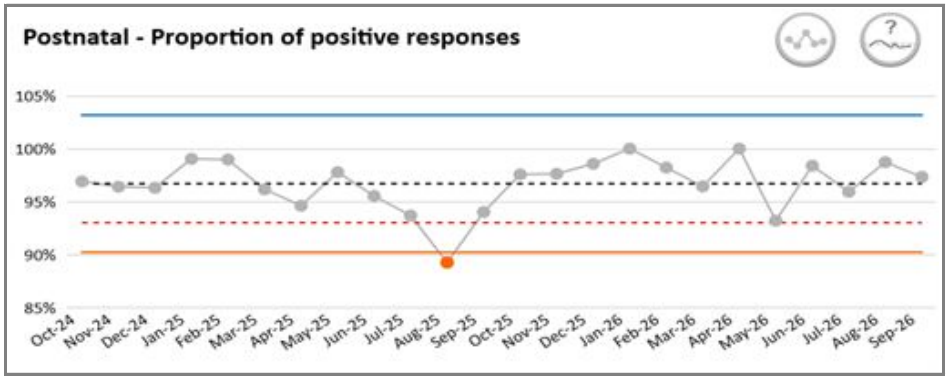
Quality

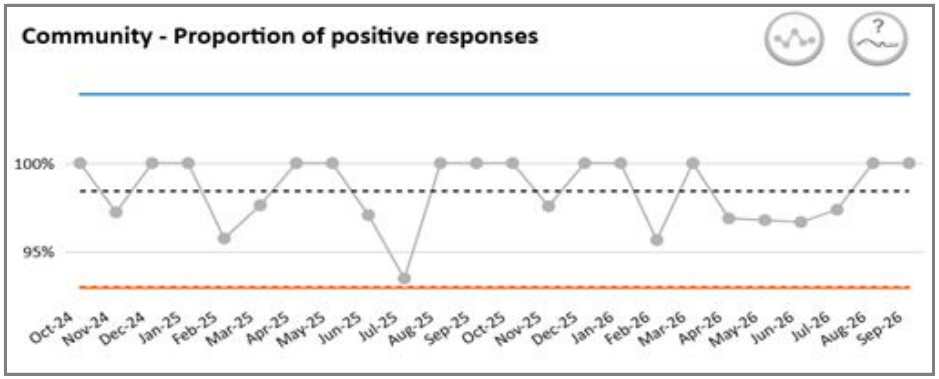
Friends and Family Test

East and North Hertfordshire Teaching NHS Trust









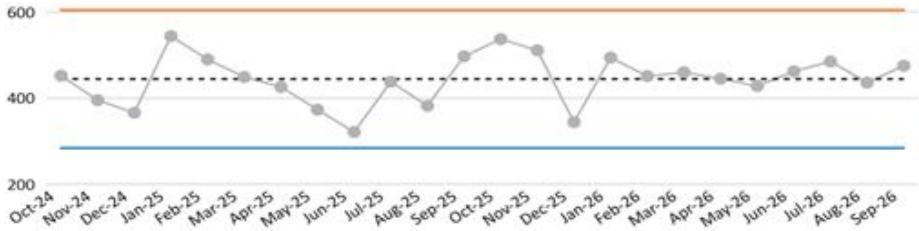
Month 06 | 2026-27

Quality

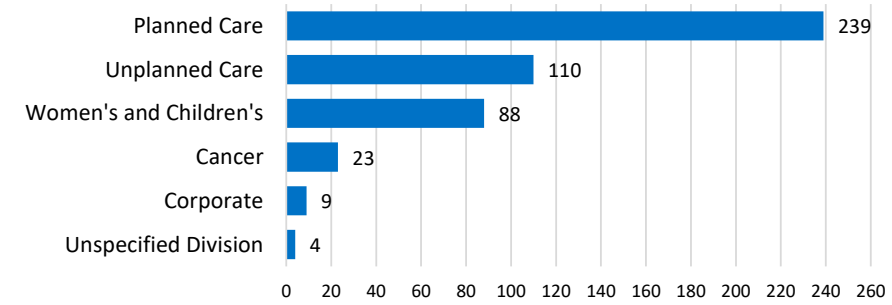
Patient Advice and Liaison Service

East and North Hertfordshire Teaching NHS Trust

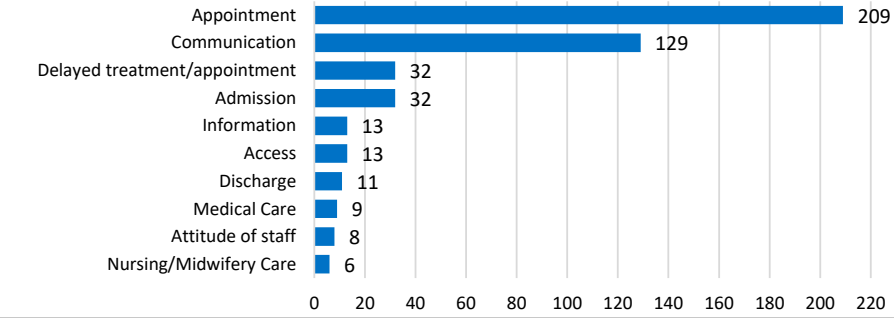
Number of PALS referrals



PALs by Division - Sep-26



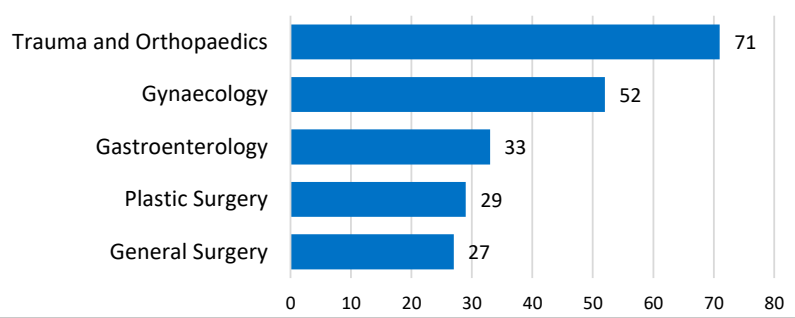
PALs Top 10 subjects - Sep-26



Key Issues and Executive Response

- A total of 472 PALS concerns were raised in September 2026, compared to 434 in August 2026.
- Performance against the 7-day review target for non-urgent PALS concerns was maintained due to the new online form process reducing email traffic and administration time.
- The main themes raised continue to be appointment delays, delays in follow-up appointments, waiting times, and difficulties contacting services directly.
- Trauma and Orthopaedics (T&O) received the highest number of enquiries, closely followed by Gynaecology.
- Gastroenterology remains in the top 3 services to receive the highest amount of enquiries, these are round appointments and communication.
- Access to appointment lines within Gynaecology and T&O remains a significant concern. It is estimated that addressing these issues could reduce PALS contacts by approximately 100 cases per month.
- Timeframes for surgeries and appointments still remain a concern due to patients not being updated and managing expectations.

PALs Top 5 specialties - Sep-26

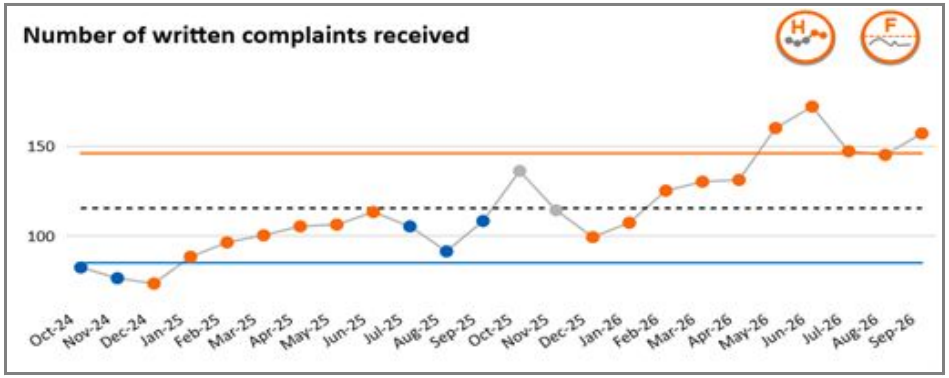


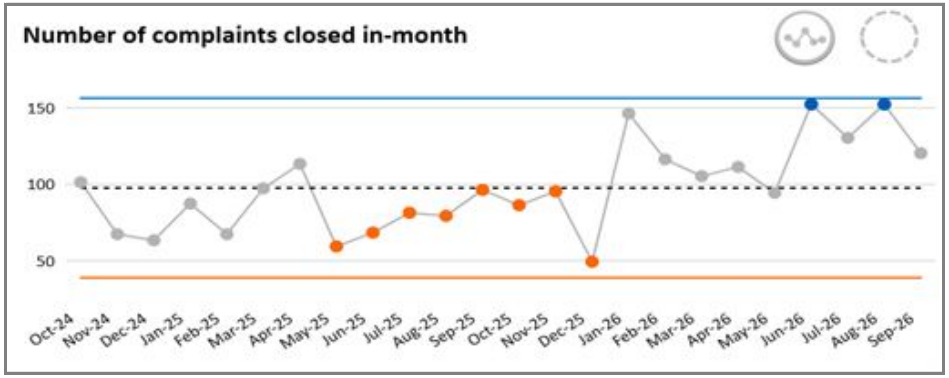
Month 06 | 2026-27

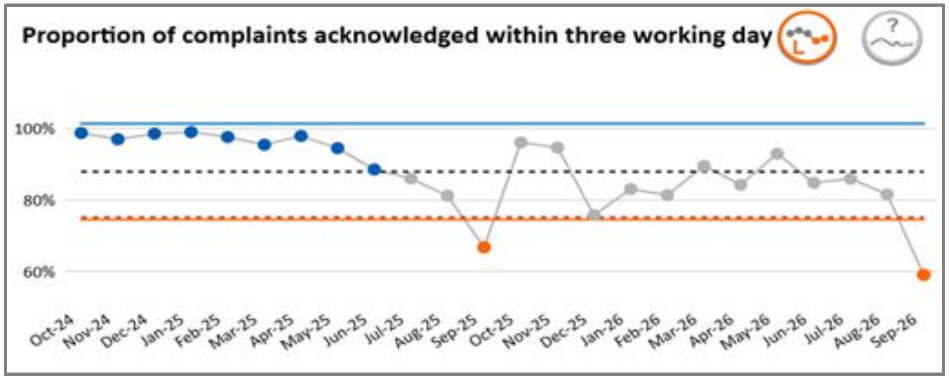
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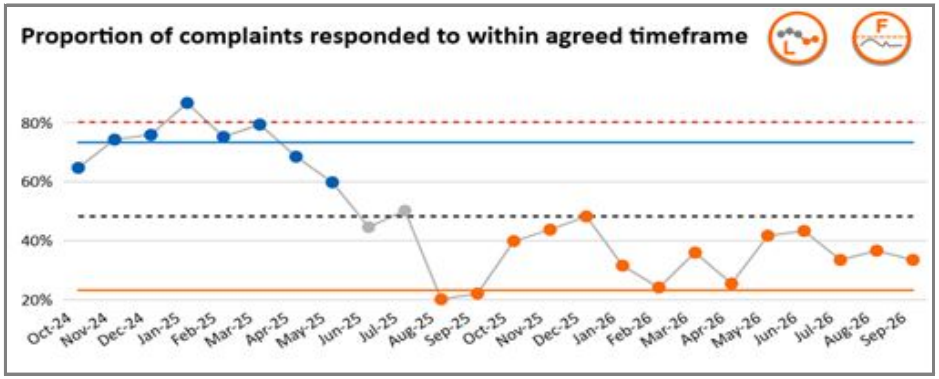
Complaints

NHS East and North Hertfordshire Teaching NHS Trust









Key Issues and Executive Response

- The Trust has seen an increase in the number of complaints received in September - 159 formal complaints (140 received in August 2026). This represents a significant increase compared to September 2025, when 108 complaints were received.
- Planned Care continues to receive the highest number of complaints.
- The Gynaecology Service (15), Trauma and Orthopaedic (14) and the Emergency Department (14) were the top three services receiving complaints in September 2026: top themes raised - Medical Care, Delayed treatment/appointments and appointments to include poor communication.
- The number of open complaints increased to 448 by the end of September 2026, with 111 complaints closed during the month. The percentage of complaints acknowledged within three working days decreased significantly, due to long term sickness absence, bereavement and annual leave within the team. This has a significant impact on an already very small complaints team.
- Performance against the target for closing complaints within the agreed timeframe remained relatively the same during September as a result of additional support from a staff member currently redeployed to focus on complaint drafting.

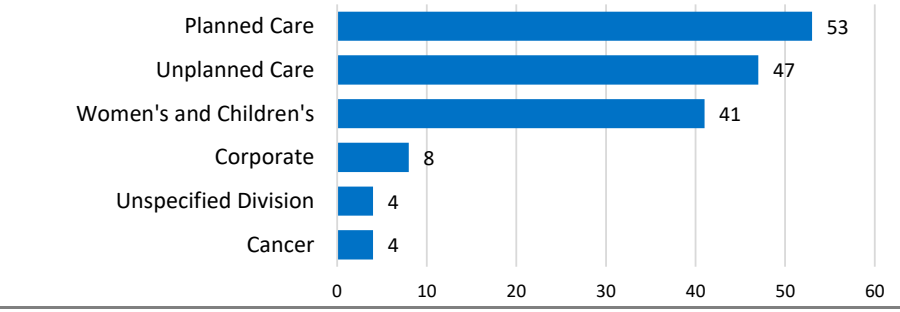
Month 06 | 2026-27

Quality

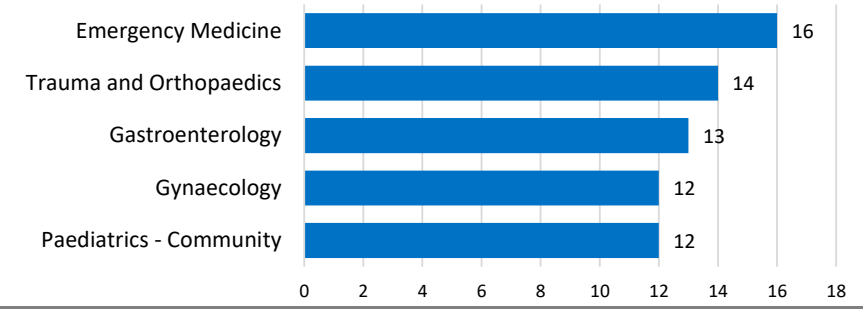
Complaints Themes

NHS East and North Hertfordshire Teaching NHS Trust

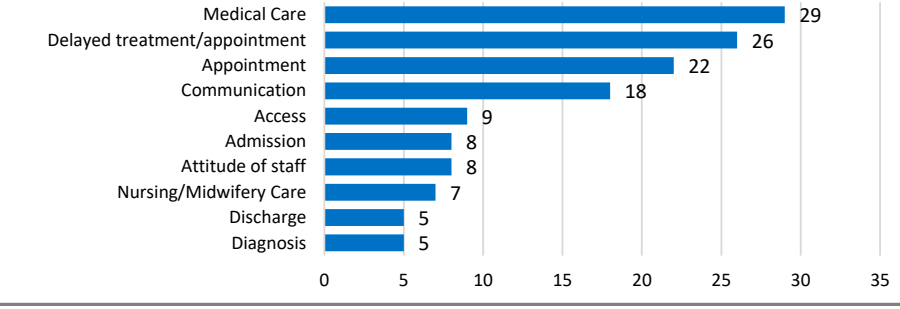
Complaints by Division - Sep-26



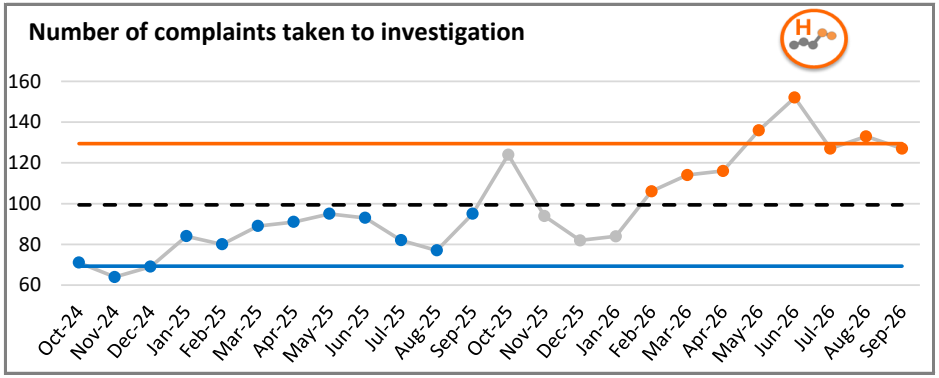
Complaints top 5 specialties - Sep-26



Complaints Top 10 subjects - Sep-26



Number of complaints taken to investigation



Month 06 | 2026-27

Operations

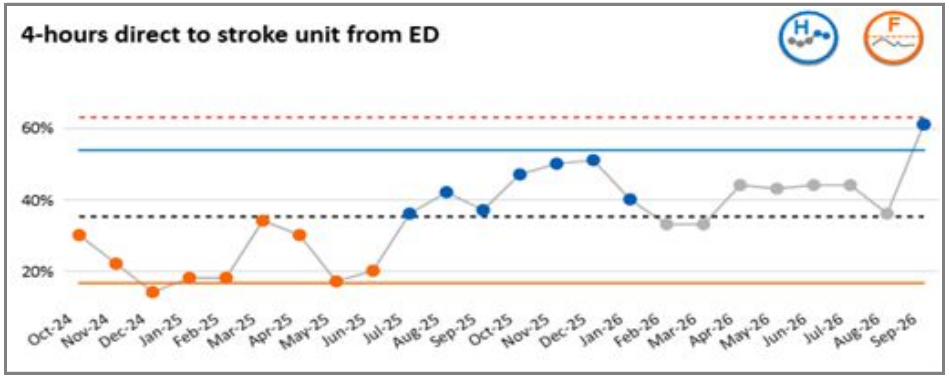
Stroke Services

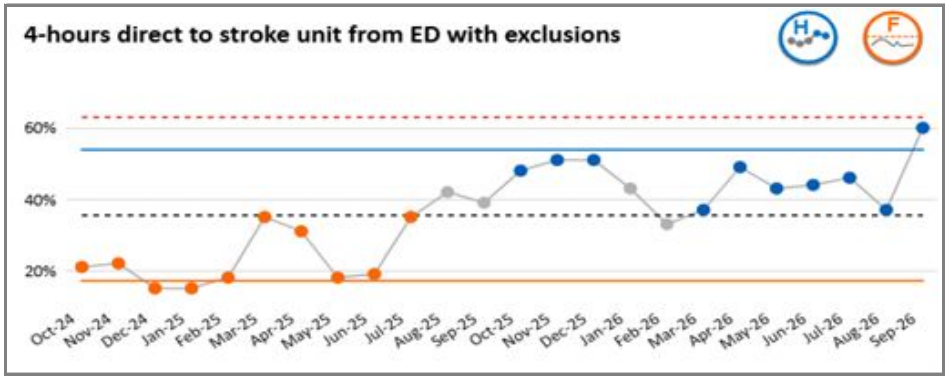
East and North Hertfordshire Teaching NHS Trust

Trust SSNAP grade	Q2 2026-27	D

Breach reasons: Sep-26

In-hours	18	Out-of-hours	19
Challenging Diagnosis/Complex Patient pathway/Clinical Need	2	Bed Capacity	1
		Inpatient Stroke	0
		COVID POC	0
Late Referral	7	Other	0
Share Care Transfers	6	No breaches	22
Pathway (ED Delays)	5		





Key Issues and Executive Response

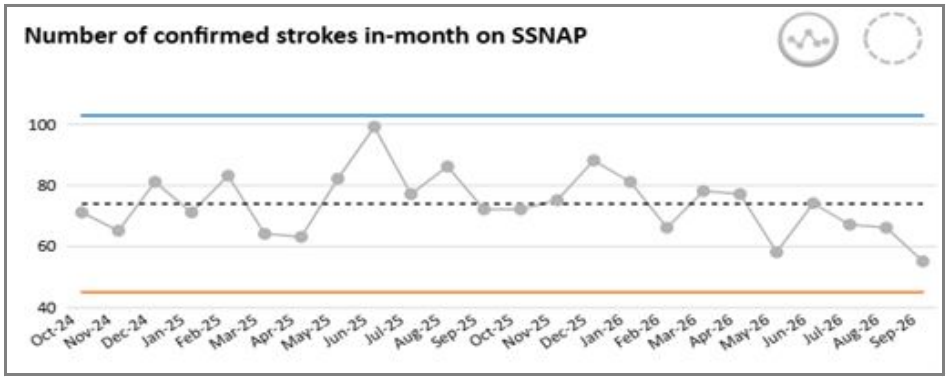
- **SSNAP:** Q1 2026 sustained performance of D rating. Audit compliance drop due to reduction in admin submitting SSNAP data.
- **Thrombolysis/Thrombectomy:** Door to needle time worsened to 01.03 mins from 44mins. Sustained performance of 16.4% of patients receiving thrombolysis against bespoke 14% target. CTP 24/7 is live. Thrombectomy improved to 7.3% against 10% target
- **4 hr performance 61.2%** has improved markedly to 61.2% (63% for all SU admissions), driven by the introduction of a Stroke-radiology led outpatient MRI pathway which has increased available capacity. The largest contributor to improved performance has been the current case mix, with average of 50%+ of admissions subsequently confirmed as non-stroke. These patients typically have simpler pathways and can often be discharged following MRI, creating substantial flow benefits. This has resulted in fewer discharges overall. Given that the reduction in confirmed stroke presentations may be seasonal, there is a significant risk that current performance levels will not be sustained through winter unless further diagnostic capacity improvements, particularly MRI access, are delivered. Lastly, the use of the HASU/ASU for medical outliers will have an impact on sustained flow. Most breaches due to OOH & late referrals.
- **Length of stay:** decreased due to fewer stroke presentations. MRI delays, ESD solution & Bedford repat out processes required to support flow.
- **CT within 20 minutes:** improvement to 41.8% (national target of 40%). Supported by Stroke Video Triage implementation in sept.
- **TIA performance:** 24hr standard at 1.8 days. Not NICE compliant due to lack of MRI provision which increases TIA admissions to SU.
- **Stroke MDT:** Continued staffing constraints across nursing. Lack of therapy rehab space. Therapy/nursing staffing non-compliant. MDT Development event in September to improve efficiency of MDT working and team coordination led by SM and therapy.

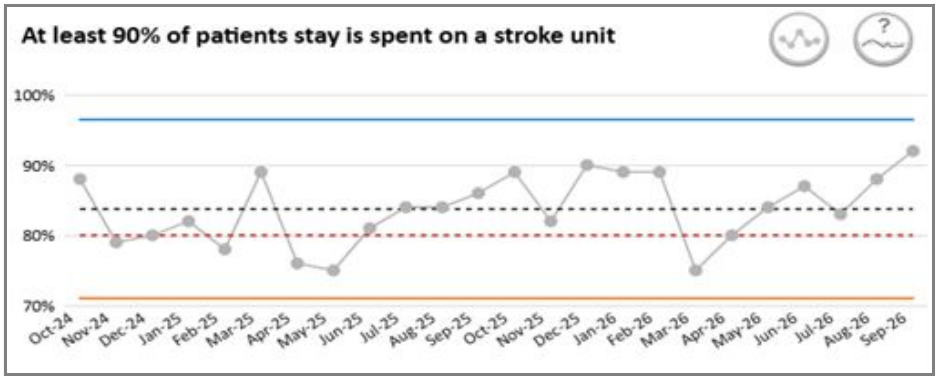
Month 06 | 2026-27

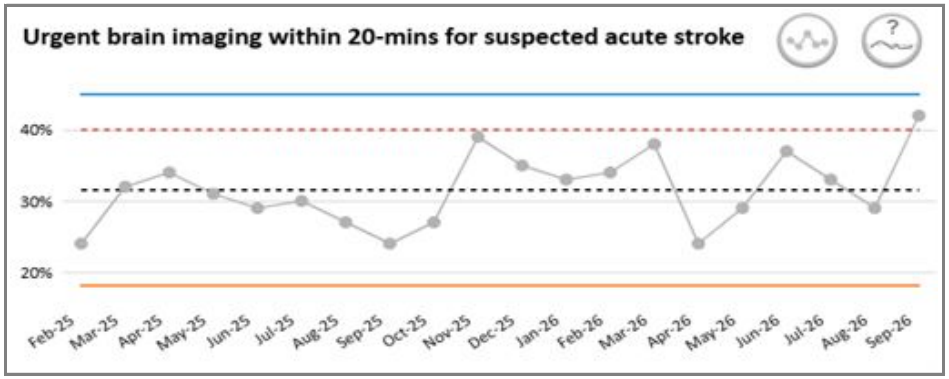
Operations

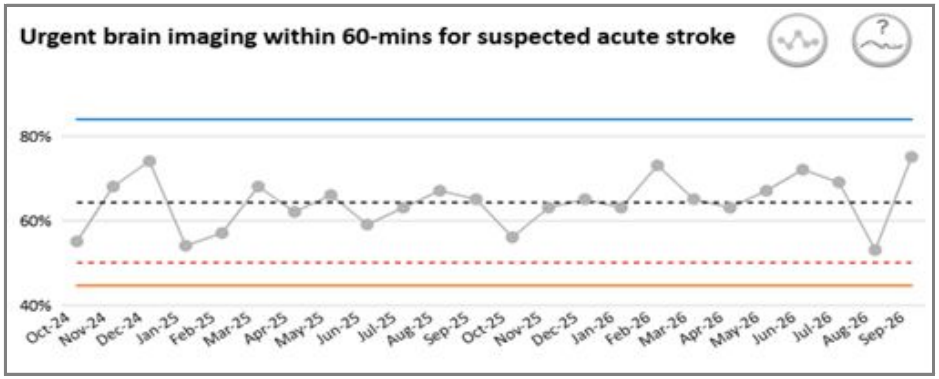
Stroke Services

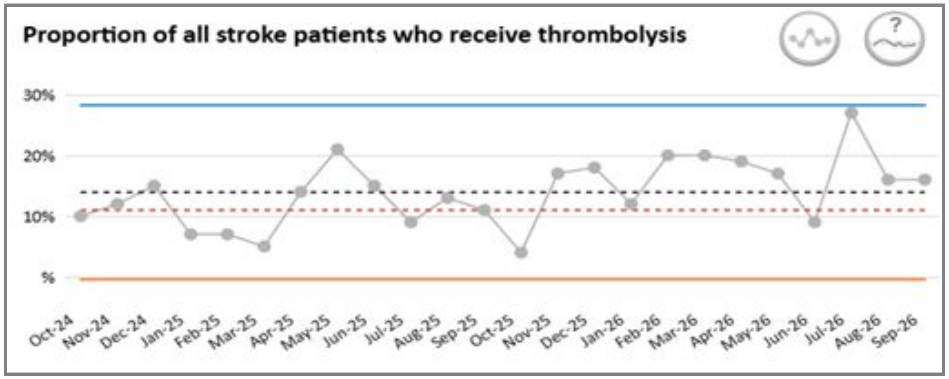
NHS East and North Hertfordshire Teaching NHS Trust

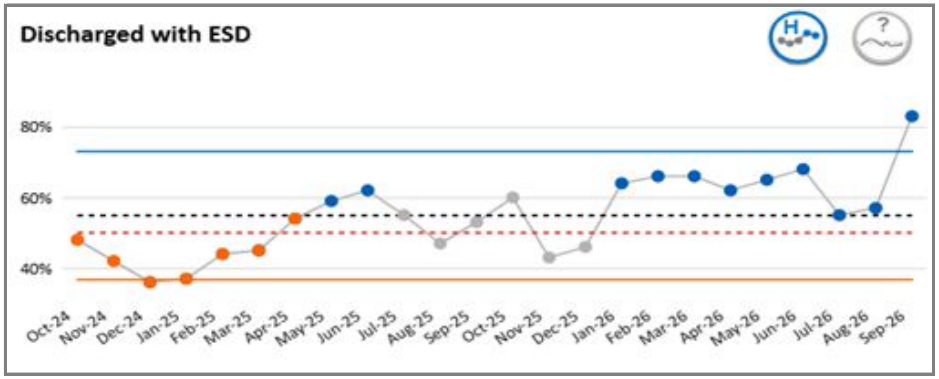










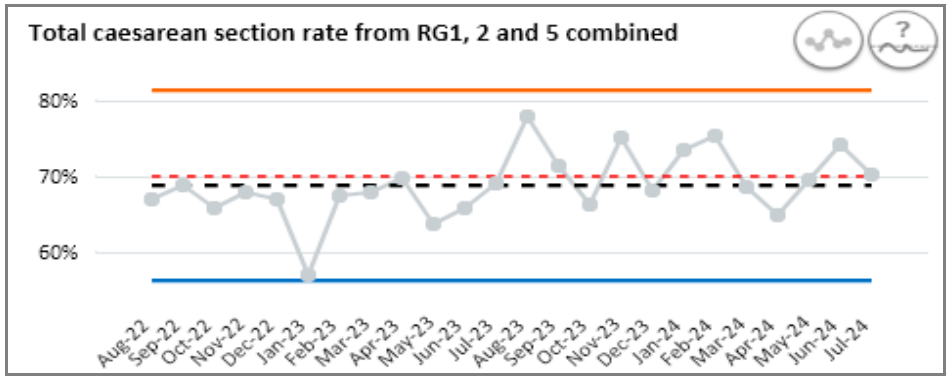


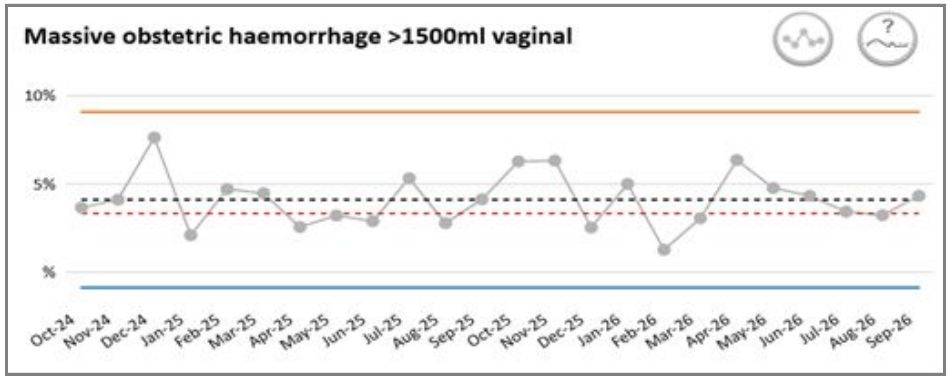
Month 06 | 2026-27

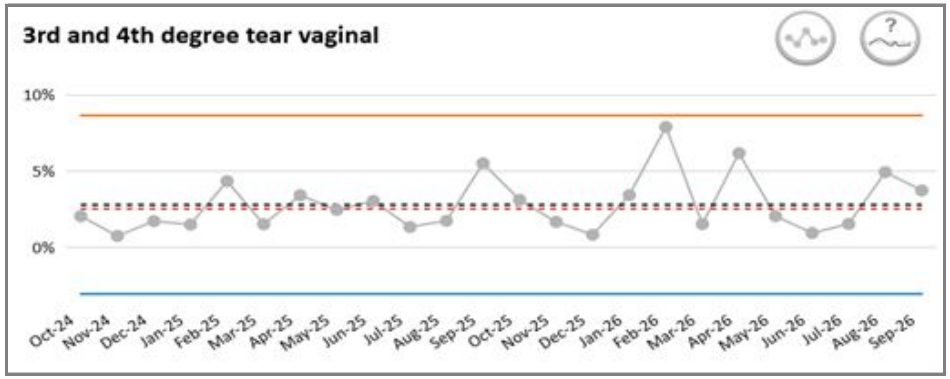
Quality

Maternity | Safety Metrics

East and North Hertfordshire Teaching NHS Trust







Key issues and executive response

- One case referred to the MNSI and qualifying as PSII in September 2026 (Intrapartum IUD @ 37+6/40, attended Triage in labour, no FH).
- Two cases of moderate harm (1% of all incidents) including one MOH of 2.4L after IOL and significant delays to theatre for LSCS due to high acuity, and one postnatal readmission and return to theatre for appendectomy and hernia repair (CT showed appendix caught in hernia of rectus sheath at LSCS). No cases of severe harm, one fatality (Intrapartum IUD). All cases following PSIRF review process via DIRM.
- 16 cases of MOH>1500ml overall, eight cases (4.30%) at vaginal births and eight cases (4.80%) at LSCS, an increase on previous months for both modes of birth. NHSE Maternal Care Bundle improvement plan ongoing including guideline update, fibrinogen POC testing in theatres, buttock drapes and scales in room for timely, accurate measurement, MOH champions in all departments and anaesthetic representation at monthly thematic reviews for learning.
- Five cases (11.10%) of 3rd/4th degree perineal trauma out of 45 instrumental deliveries and five cases (3.70%) out of 135 vaginal births in September 2026. Continued thematic review reported monthly to Divisional RMG. Themes at instrumental birth addressed at junior doctors induction where compliance with OASI training has previously been poor. Trial of single-use, sharp episiotomy scissors planned.
- One case of intrauterine death >22/40 gestation. One case of neonatal death >20/40 gestation. No cases of maternal death.
- Sustainable improvement evidenced by eight months ATAIN rate below target (<6%). No avoidable admissions September 2026.
- Total LSCS= 177 (47.97%), Total Cat 1-3 (Emergency) = 88 (23.85%), Total Cat 4 (Elective) = 89 (24.12%) reflective of increasing national rate and impacting flow and delays (Kaizen event scheduled October 2026). Emergency rate may be reported higher than actual as elective cases moved to cat 3 lists due to capacity. Robson Group Criteria RC1 = 16.70%, RC2 = 46.67%, RC5 = 81.10%.

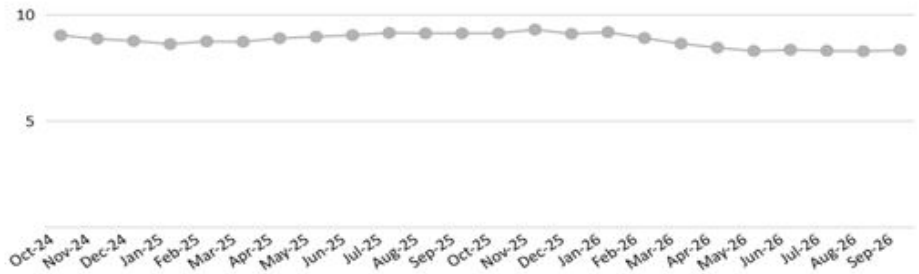
Month 06 | 2026-27

Quality

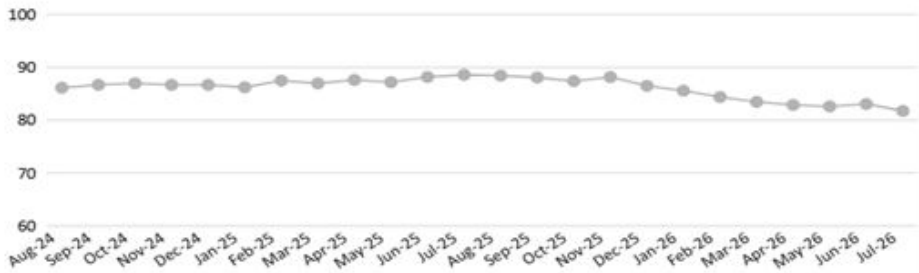
Mortality

East and North Hertfordshire Teaching NHS Trust

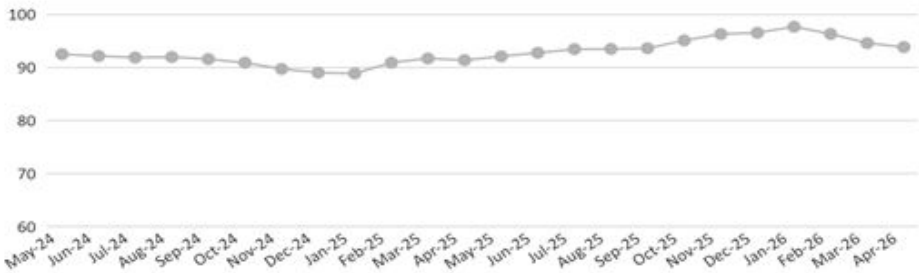
Crude mortality - rolling 12-months



HSMR - rolling 12-months



SHMI - rolling 12-months



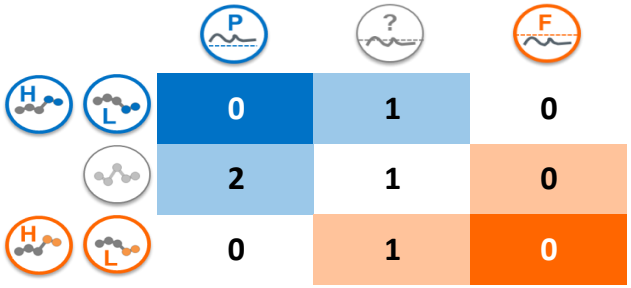
Key Issues and Executive Response

- Crude mortality is the factor which usually has the most significant impact on HSMR. The exception was during the COVID pandemic, when the usual correlation was weakened by the partial exclusion of COVID-19 patients from the HSMR metric. This partial exclusion continues for the CHKS HSMR metric that the Trust uses.
- The general improvements in mortality (excluding the COVID-19 period) seen over recent years have resulted from corporate level initiatives such as the learning from deaths process and focussed clinical improvement work. Of particular importance has been the continued drive to maintain a high standard of clinical coding.
- There was a significant downward trend in rolling 12-month HSMR from March 2023 to April 2024, when the metric plateaued, with a slight upward trend. Since November 2025 there has been a steady downward trend.
- The latest rolling 12-month HSMR to Jul-26, reported by CHKS, stands at 81.7. 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 have since been fluctuations, with further smaller spikes in Nov-25 (92.9) and Jun-26 (95.3). The latest figure for July 2026 stands at 83.7.
- Latest NHSD published rolling 12-month SHMI available to May-26 2026, stands at 91.94, a decrease from the previous month's 93.77. This positions us within the 'as expected' band 2.
- Although there has been a gradual negative shift in our position nationally, the most recent 3 months saw improvements from 45/118 to 33/118 to 26/118 vs other acute trusts.
- The latest figures provided by CHKS for April are 79.7 in-month and 93.8 for rolling 12-month.

East and North Hertfordshire Teaching NHS Trust

Operations

Month 06 | 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	Sep-26	95%	72.4%		F	Common cause variation Metric will consistently fail the target
	Patients waiting more than 12 hours from arrival to admission, transfer or discharge	Sep-26	5%	9.9%	L	F	7 points below the mean Metric will consistently fail the target
	Percentage of ambulance handovers within 15-minutes	Sep-26	65%	24.2%	H	F	7 points above the mean Metric will consistently fail the target
	Time to initial assessment - percentage within 15-minutes	Sep-26	80%	46.1%		F	Common cause variation Metric will consistently fail the target
	Average (mean) time in department - non-admitted patients	Sep-26	240	191		P	Common cause variation Metric will consistently pass the target
	Average (mean) time in department - admitted patients	Sep-26	tbc	488	L		7 points below the mean No Target
	Median ambulance handover time	Sep-26	15	21	L	F	7 points below the mean Metric will consistently fail the target
RTT & Diagnostics	Patients on incomplete pathways waiting no more than 18 weeks from referral	Sep-26	92%	64.2%	H	F	12 points above the mean Metric will consistently fail the target
	Patients waiting more than six weeks for diagnostics	Sep-26	0%	45.2%	L	F	8 points below the mean Metric will consistently fail the target

Month 06 | 2026-27

Urgent and Emergency Care

Summary

NHS East and North Hertfordshire Teaching NHS Trust

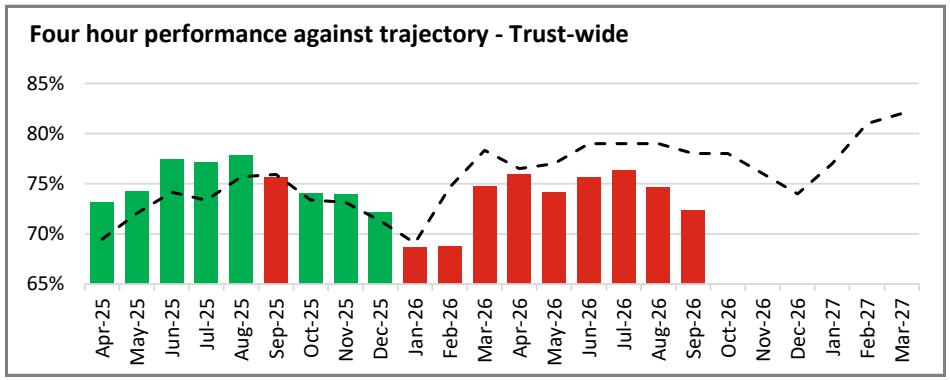
Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Cancer Waiting Times	62-day referral to treatment standard	Aug-26	85%	79.5%		P	Common cause variation Metric will consistently pass the target
	31-day decision to treat to treatment standard	Aug-26	96%	96.5%		?	Common cause variation Metric will inconsistently pass and fail the target
	28-day Faster Diagnosis standard	Aug-26	80%	65.6%	L	?	1 point below the lower process limit Metric will inconsistently pass and fail the target
	Proportion of cancer PTL waiting more than 62 days	Sep-26	7%	37.8%	H	F	4 points above the upper process limit Metric will consistently fail the target

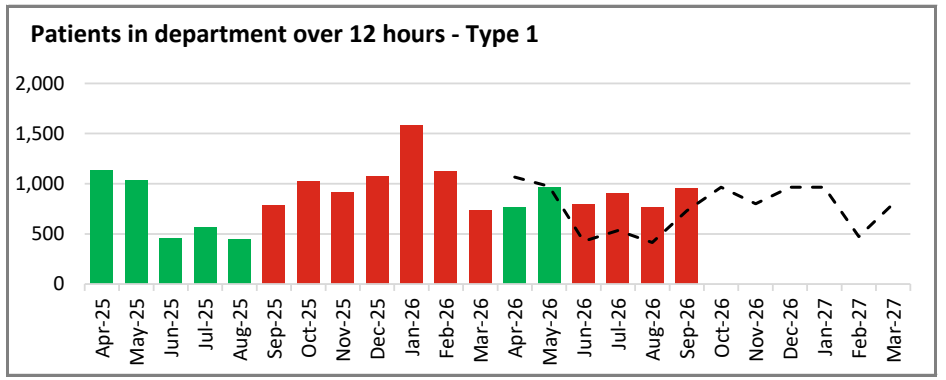
Month 06 | 2026-27

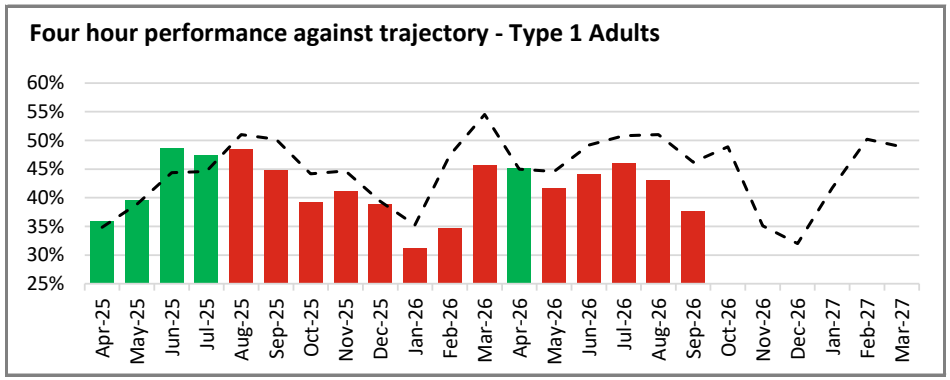
Urgent Emergency Care

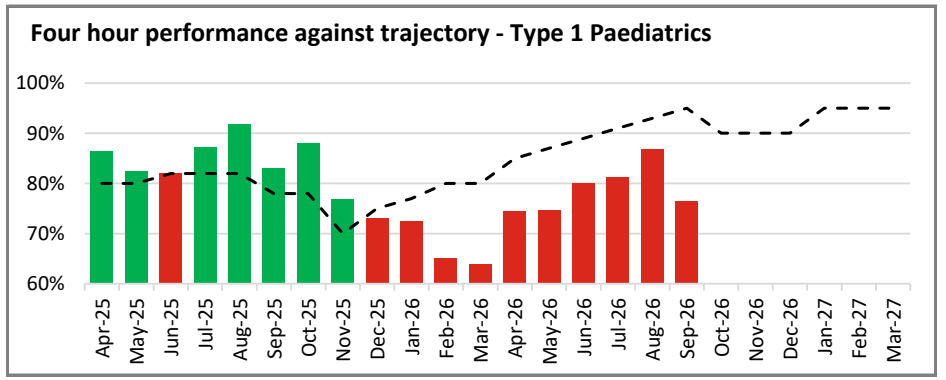
Trajectory Monitoring 2026-27

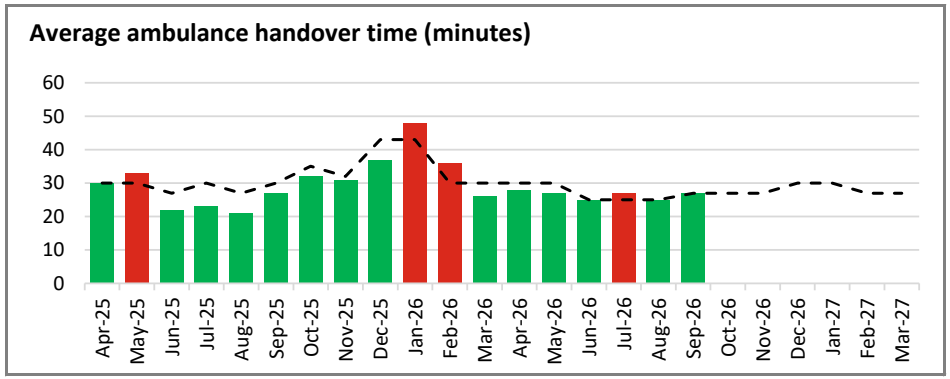
NHS East and North Hertfordshire Teaching NHS Trust









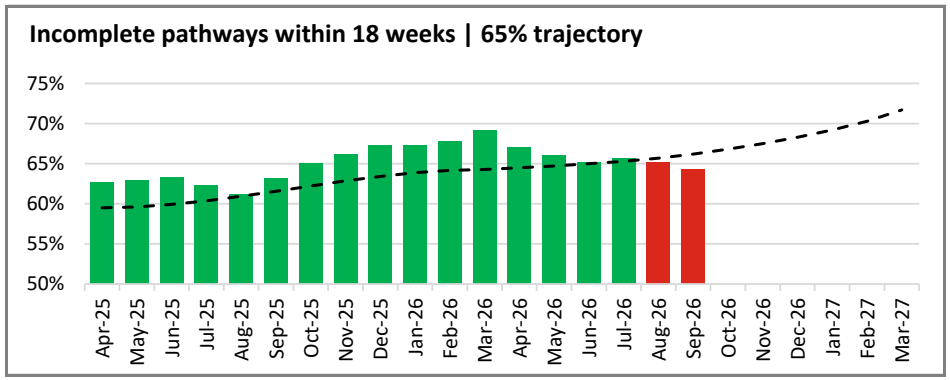


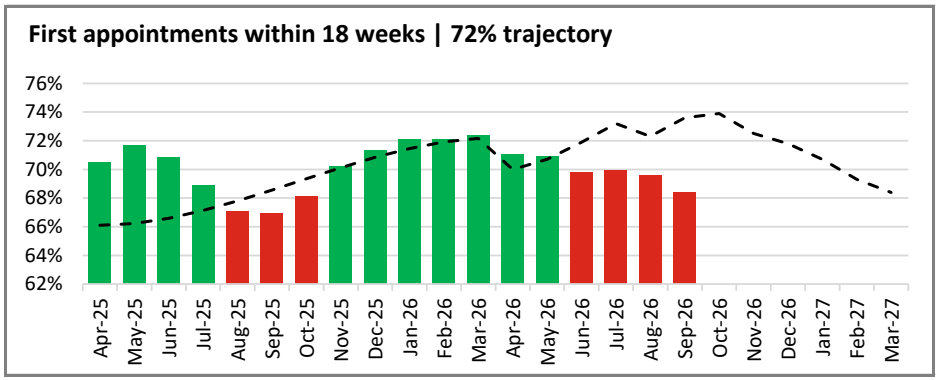
Month 06 | 2026-27

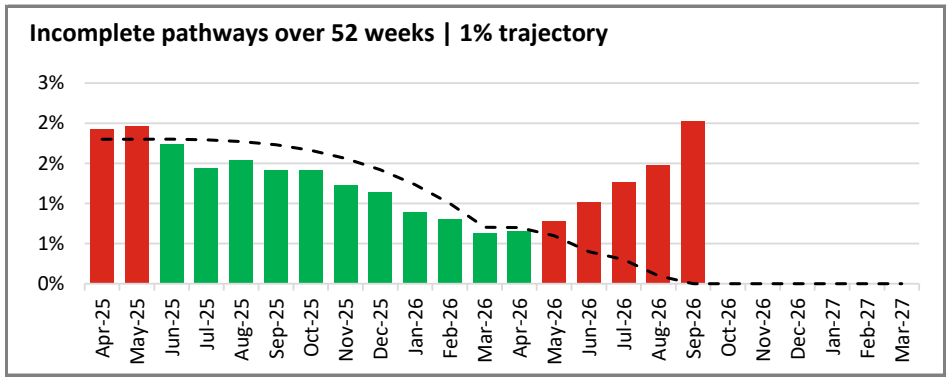
Cancer Waiting Times | RTT 18 weeks

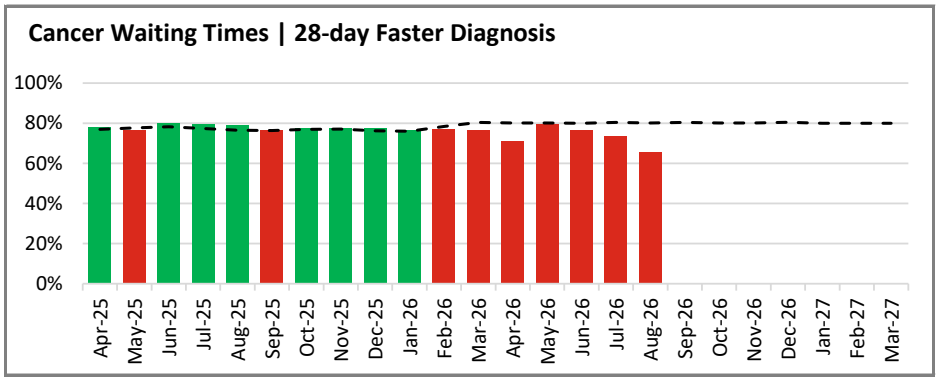
Trajectory Monitoring 2026-27

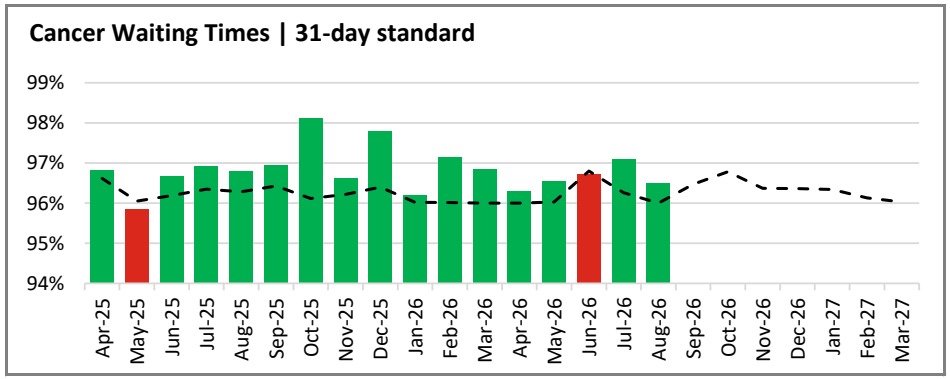
NHS East and North Hertfordshire Teaching NHS Trust

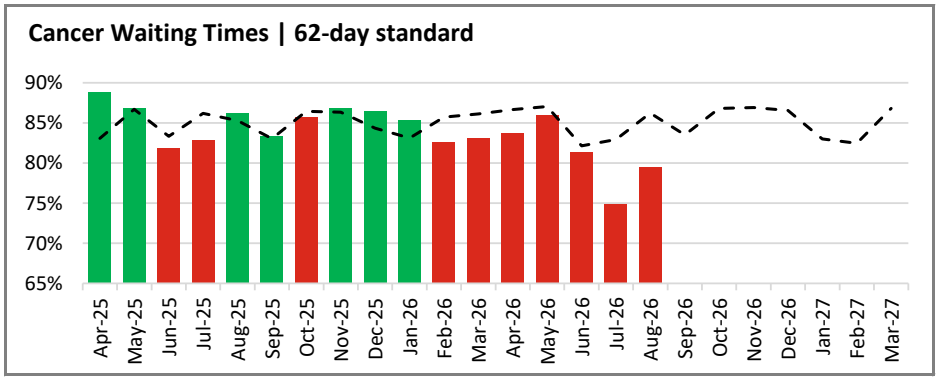










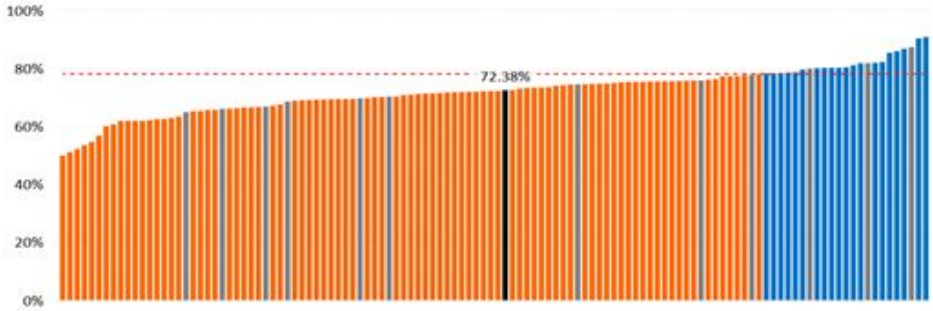


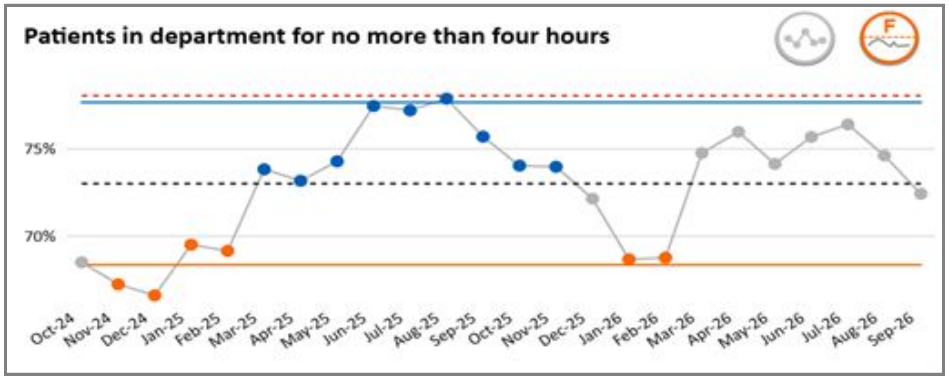
Month 06 | 2026-27

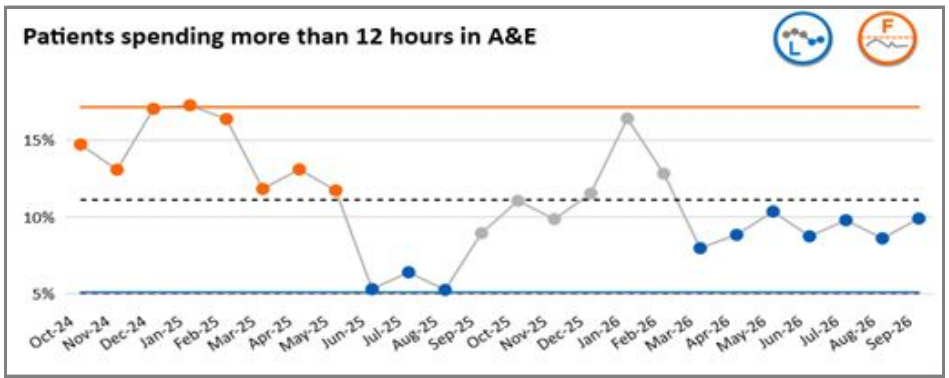
Operations

Urgent and Emergency Care New Standards

NHS
East and North Hertfordshire Teaching
NHS Trust

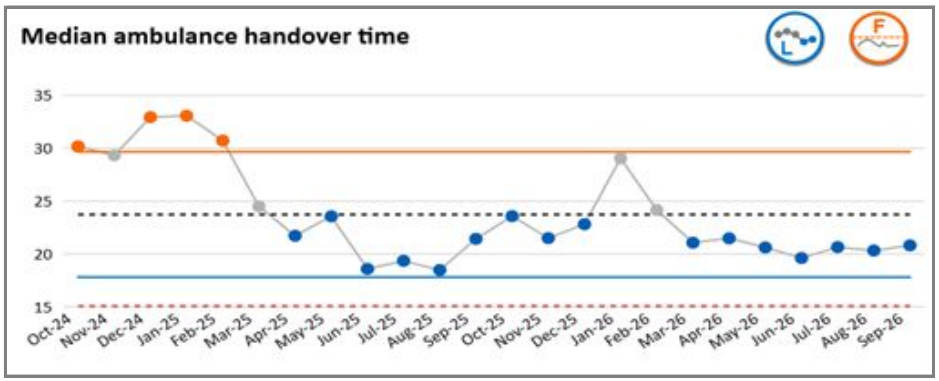






Key Issues and Executive Response

- September 2026 4-hour performance achieved 72.4% against a planned trajectory of 78%. Demand remained high, with an increase in Adult Type 1 attendances and a significant increase in attendance seen across Adults, paediatrics and the Urgent treatment centres. Performance was further challenged by a rise in high-acuity presentations, resulting in delays across the urgent and emergency care pathway impacting staffing and extended.
- Adult Type 1 performance was 37.6%.
- Patients in department over 12hrs performance 951 against 732 trajectory.
- Average ambulance handover meet trajectory of 27 mins despite a significant increase in ambulance attendances throughout September.
- Continued focus on UEC transformation programmes, including optimisation of front door triage processes to achieve the 15-minute KPI, reduce time to clinician assessment, and strengthen role clarity and accountability across UEC pathways. This supports the delivery of the right care, in the right place, first time.

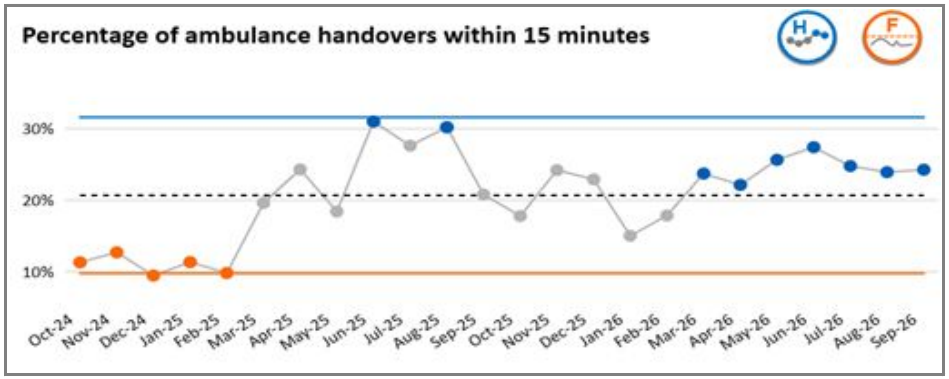


Month 06 | 2026-27

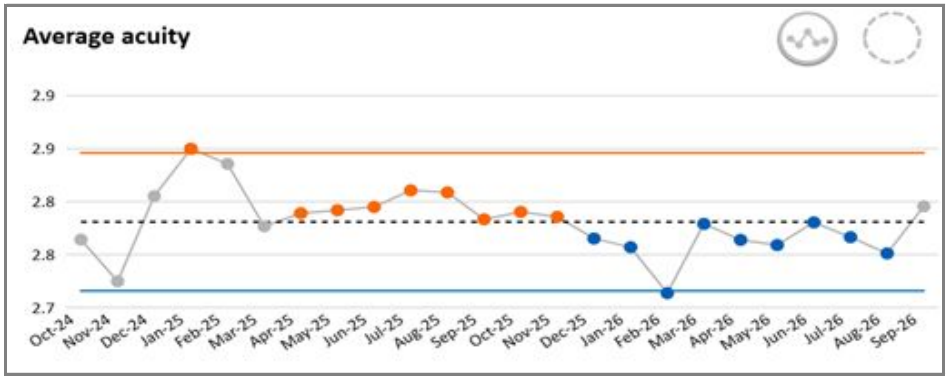
Operations

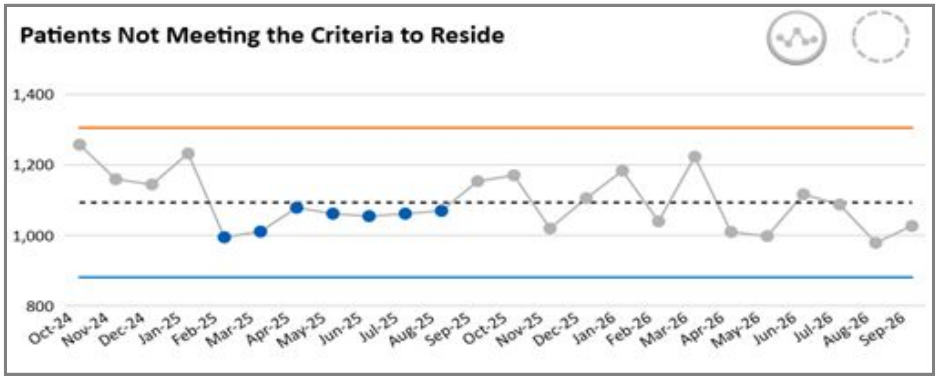
Urgent and Emergency Care | Supporting Metrics

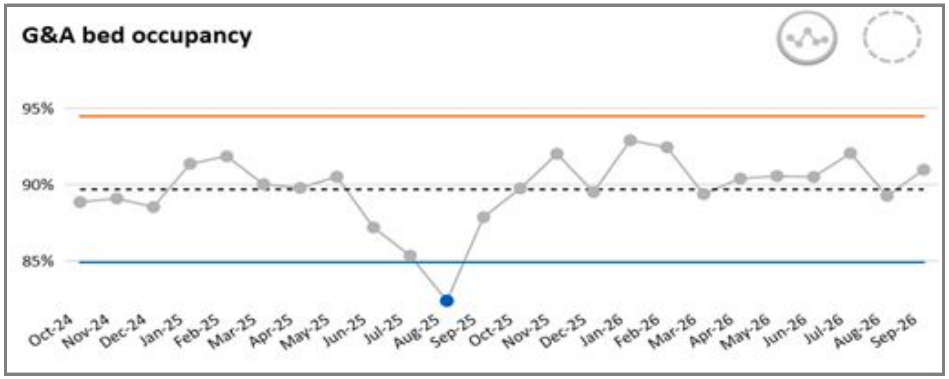
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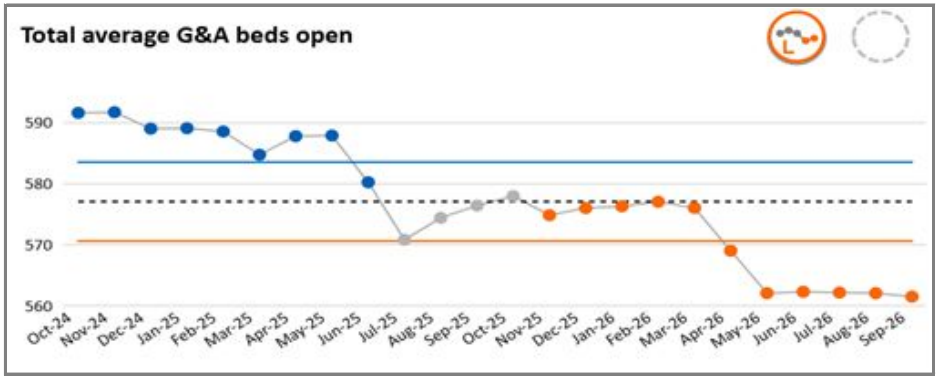










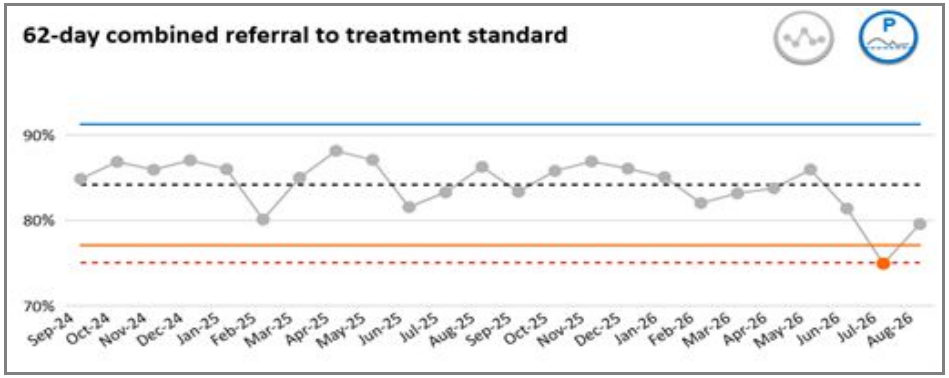


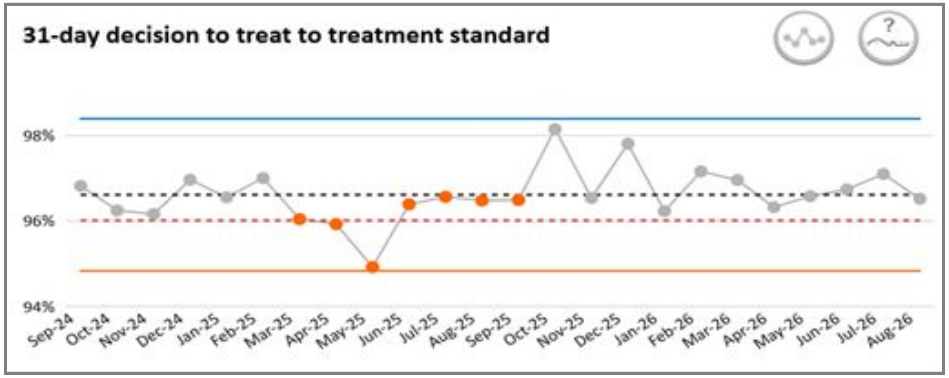
Month 06 | 2026-27

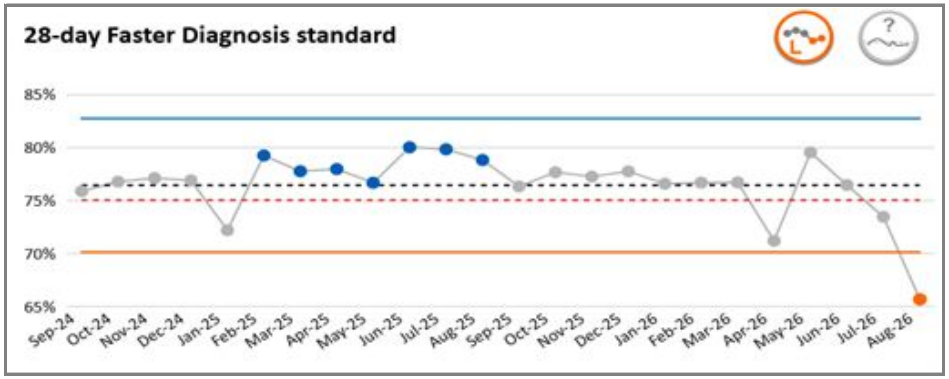
Operations

Cancer Waiting Times | Supporting Metrics

NHS East and North Hertfordshire Teaching NHS Trust







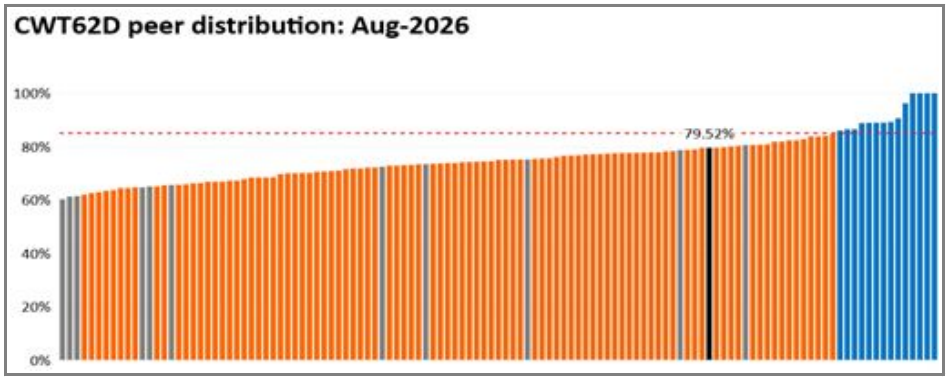
Key Issues and Executive Response

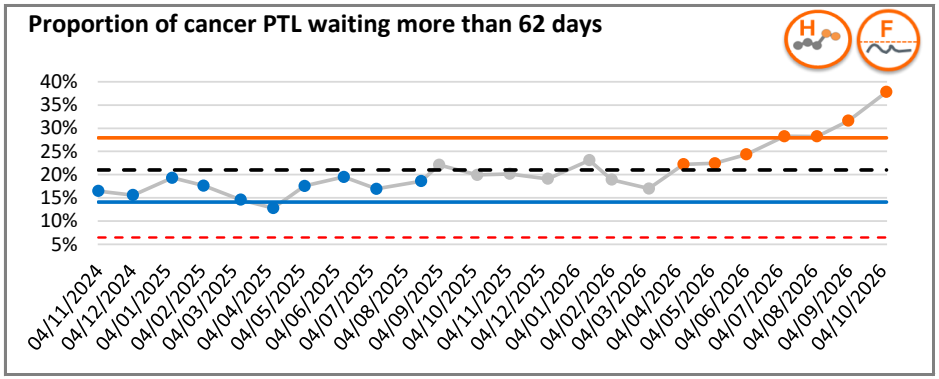
- We achieved 1 of the 3 national standards in August '26 with compliance in the 31 day combined standard. The 62-day referral-to-treatment standard (85%) was not met in August with performance improving from 74.90 -79.50%. The 28 day FDS standard has deteriorated from 73.40% - 65.60%. This is attributable to delays in radiology reporting, Oral surgery capacity, Skin OPA capacity and inpatient hysteroscopy capacity.
- To improve the 28 day FDS performance we are working closely with radiology and operational teams to reduce acquisition and reporting delays across MRI, CT colon capacity, colonoscopy capacity, Oral Surgery and Skin outpatient capacity. The benefits of the new upper GI 2ww triage rota has not yet taken effect.
- Two pathways are the main contributors to non-compliance against the 62-day cancer performance standard: Lower GI due to CT colon and colonoscopy capacity which requires business case approval; Urology due to MRI capacity and reporting delays, partially mitigated by using One Stop Health Care, and MRI VAN at Lister and RALP theatre capacity which requires operationalisation of Saturday lists to meet core demand.
- An enhanced escalation process has been put in place to ensure prioritised reporting of cancer patients. Haematology delays due to outpatient capacity mitigated with additional lists whilst we appoint to the sixth consultant post. Gynae delays are driven by inpatient hysteroscopy capacity, mitigating by converting routine slots.
- The 62-day performance in August ranked 23rd nationally out of 119 NHS providers. This exceeded both regional by 14% and national by 9%, and we are still amongst the top-performing hospital in the East of England region but Watford have now taken the lead.

Month 06 | 2026-27

Operations

Cancer Waiting Times | Supporting Metrics





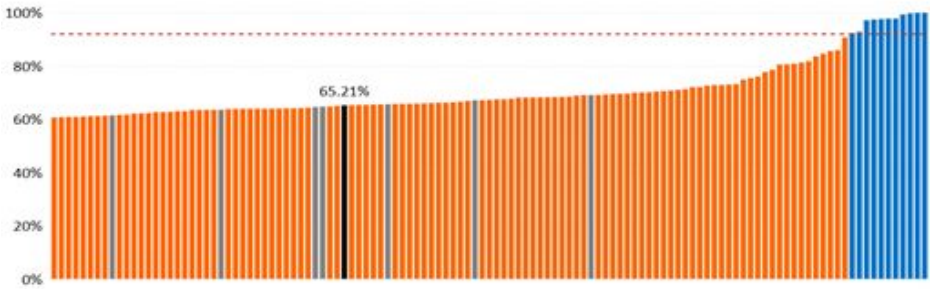
Month 06 | 2026-27

Operations

RTT 18 Weeks

NHS East and North Hertfordshire Teaching NHS Trust

RTT peer distribution: Aug-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, albeit at approx. 90 referrals per month higher than core capacity, so the waiting list continues to increase, with high numbers over 104ww.
- Proof of Concept pilot commenced on 09/06/26 was completed early September - one single system pathway with partners at HCT and HPFT. This is now being reviewed and discussed in the CYP neurodiversity group. Workshops with ENHTT, HCT and HPFT took place on 15th October following the proof of concept to move forward with planning of single pathway.
- System workstreams continue with oversight via 3 COOs ENHT, HPFT, HCT
- Single point of referral for neurodiversity hosted at HCT is live, improving completeness of information ahead of triage, alongside improved signposting whilst waiting.
- **78 Weeks -** There were 4,067 patients waiting over 78 weeks at the end of September, an increase compared to 3,936 the previous month.
- **65 Weeks -** There were 4,537 Community Paediatric patients waiting over 65 weeks, an increase from 4,110 at the end of August.

Key Issues and Executive Response

Excluding community paediatrics

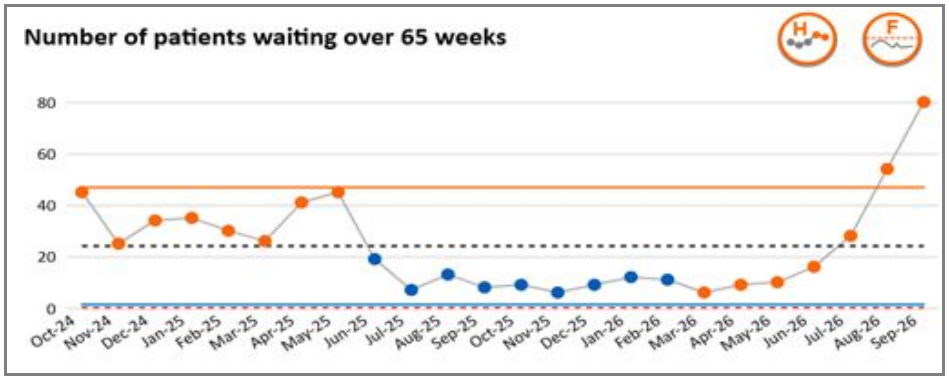
- **18 Week Performance** - At the end of September, 64.2% of patients were waiting under 18 weeks, a deterioration from 65.21% in August. Performance has now fallen below the plan of 64.5%.
- **52w proportion of PTL** - At the end of August, 1,191 (1.95%) patients were waiting above 52 weeks. This is a deterioration from 853 in the previous month. Increases have been seen in most services, but particularly Trauma and Orthopaedics, Gynaecology, Gastroenterology, Oral Surgery, Plastic Surgery, ENT and Urology, where urgent/trauma and cancer demand coupled with reduced 'ad hoc' activity and increased cancellations has reduced flexible capacity to treat the longest waiting patients.
- The Patient Treatment List (PTL) has increased by 1,128 patients to 58,764 and is ahead of the amended trajectory of 59,363.
- **65 Weeks** - At end of September, 80 patients were waiting over 65 weeks: 59 in Trauma & Orthopaedics, 13 in Oral Surgery, 5 in Orthodontics, 2 in Plastic Surgery and 1 in Ophthalmology.
- Key programmes of transformation work in place in outpatients and theatres to maximise efficiency and productivity opportunities. Services are exploring reconfiguring theatre timetables in September particularly for T&O.
- RTT and 52 week meetings are in place with service managers to monitor and track patients through these pathways, including a weekly escalation meeting with divisional leaders.
- During October, all outpatient appointments booked for November were reviewed to release additional capacity for first appointments, supporting the NHS England Focus on First programme.

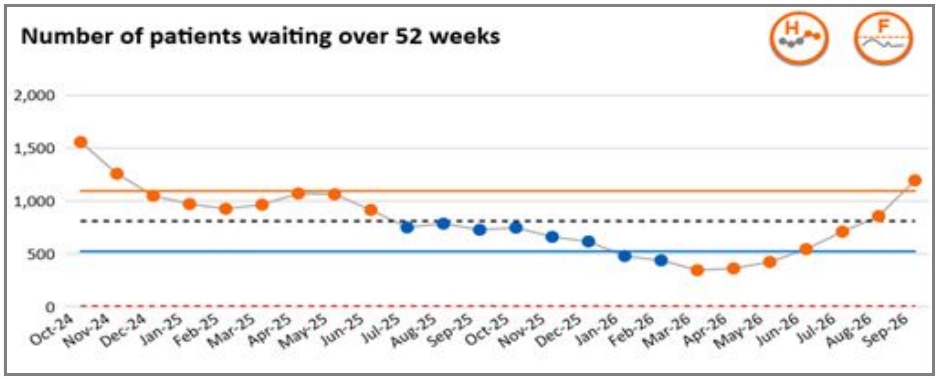
Month 06 | 2026-27

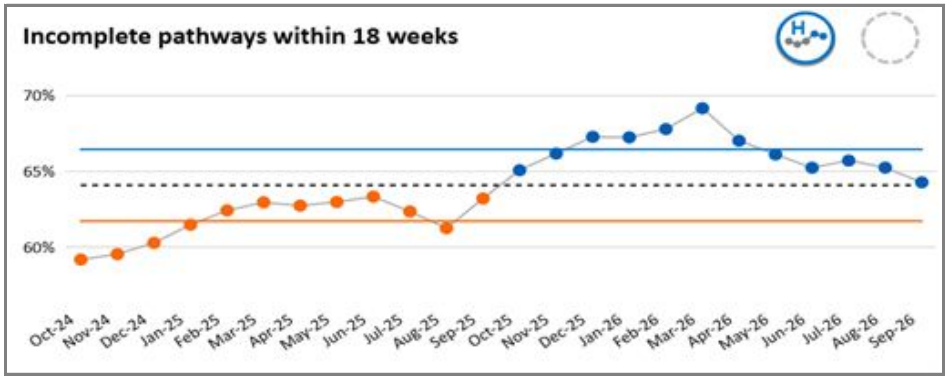
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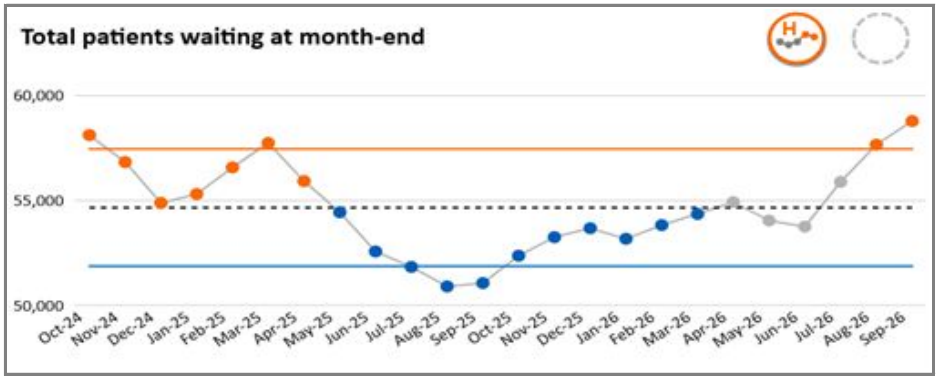
RTT 18 Weeks - excl. Community Paediatrics

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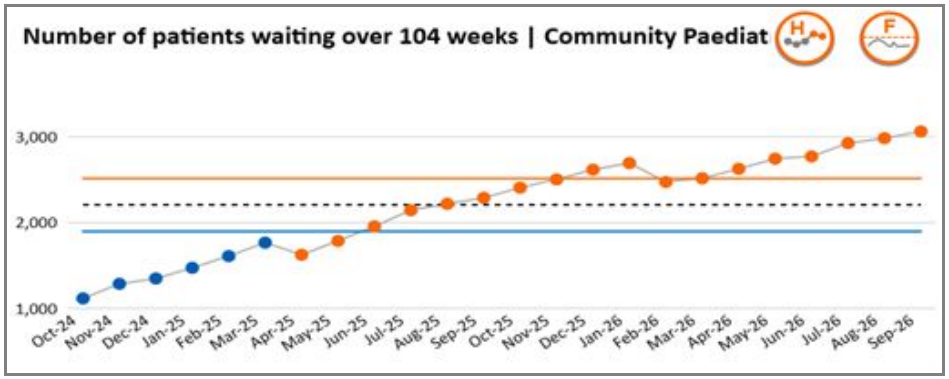


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Operations

RTT 18 Weeks - Community Paediatrics ONLY

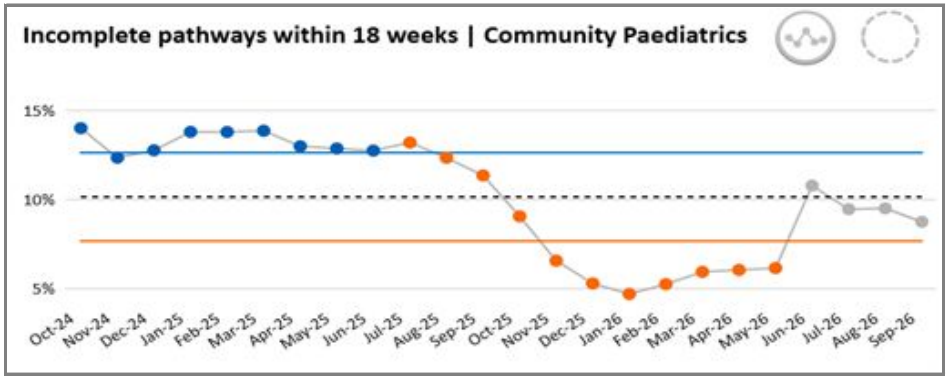
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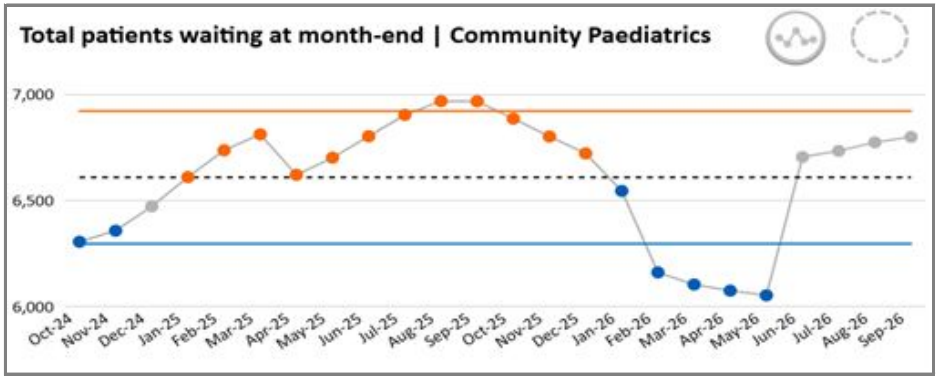










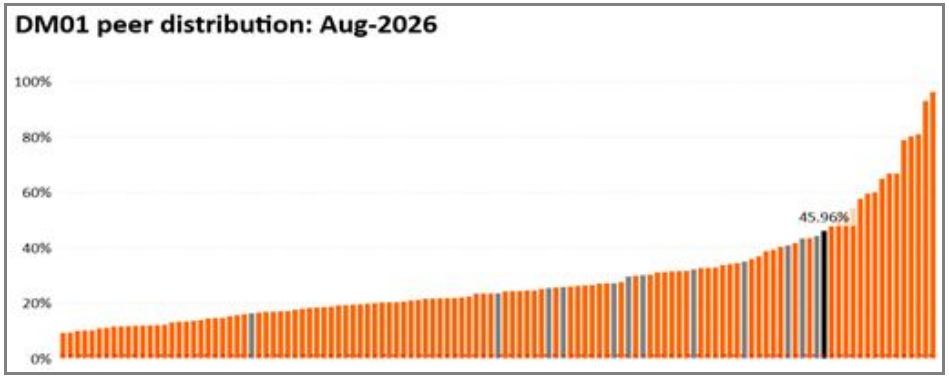


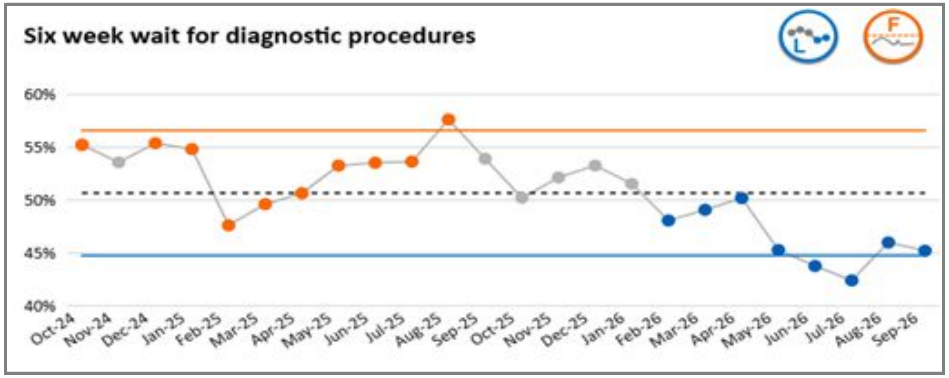
Month 06 | 2026-27

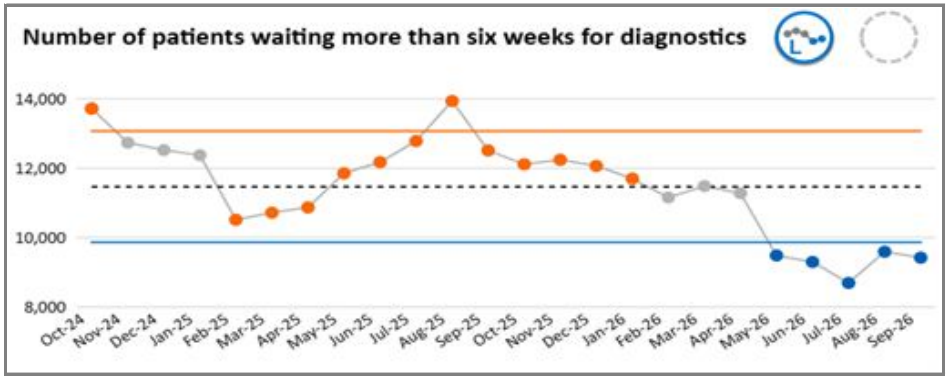
Operations

Diagnostics Waiting Times

NHS East and North Hertfordshire Teaching NHS Trust







Key Issues and Executive Response

- In September, DM01 performance (% waiting over 6 weeks for diagnostics) slightly improved from 45.95% to 45.17%.
- Without Audiology, there are 5,304 patients waiting >6 weeks; with 629 patients waiting >13 weeks, most waiting for US.
- Weekly escalation meetings are in place with services who are not compliant which follow the same rigour as RTT meetings.

Challenges / Actions

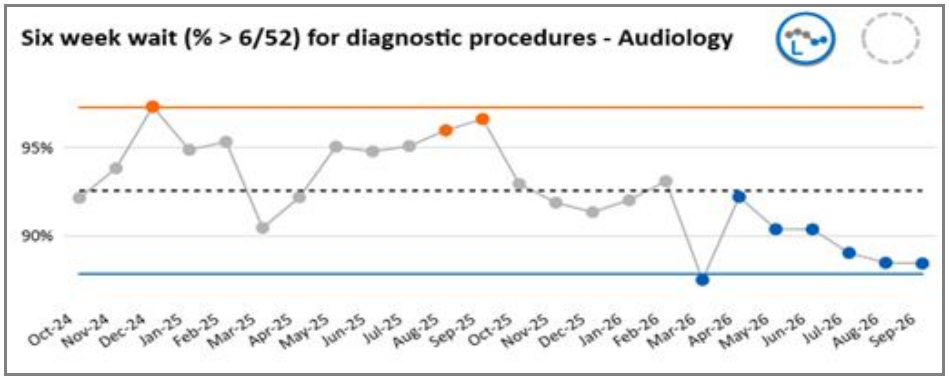
- **Non-Obstetric ultrasound** Current performance has deteriorated from 40.78% to 44.96%, with breaches 4,241; mean wait increased to 5.26 weeks. This has been impacted by staffing gaps (20% vacancy, 4.00 sonographers wte out to ad) and sonographers training; Extension of insourcing agreed until end of November. Consultation for standardised shifts to deliver 6-day working completed and in implementation phase.
- **MRI** Outsourcing of MRI activity to One Stop Health Care continues until end of Nov; 65 scans per week. The MRI van has been signed for 4 lists(16-20 per list) per week until Nov. Current performance improved to 15.32%, 301 patients over 6 weeks; mean wait 2.88 weeks. Replacement MRI scanners have now been ordered.
- **Audiology** continues to improve in line with the planned trajectory at 88.4%. Adult audiology currently 87.06% (from 3,103 to 2,732 breaches) with mean wait of 38.98 weeks. Paeds currently 91.28% (from 1,507 to 1,371 breaches) with mean wait of 37.98 weeks.
- **Endoscopy** A substantive capacity gap exists in endoscopy to enable sustained delivery of DM01 to the value of 300 slots of meeting demand monthly. A business case has been written for consideration. Historically this shortfall was covered by non core sessions.

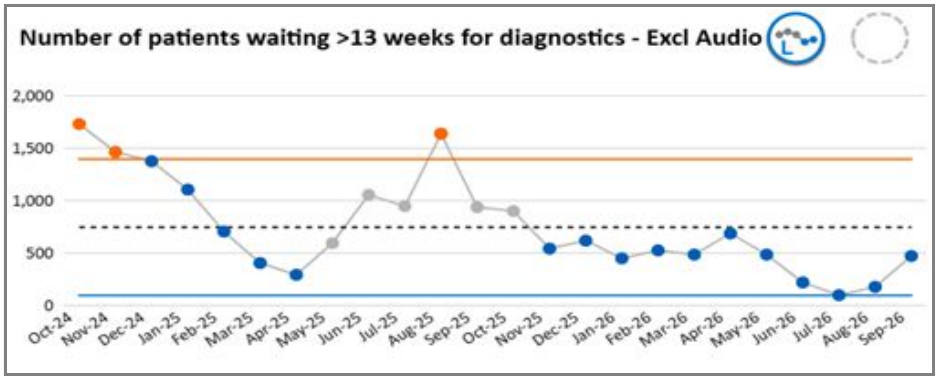
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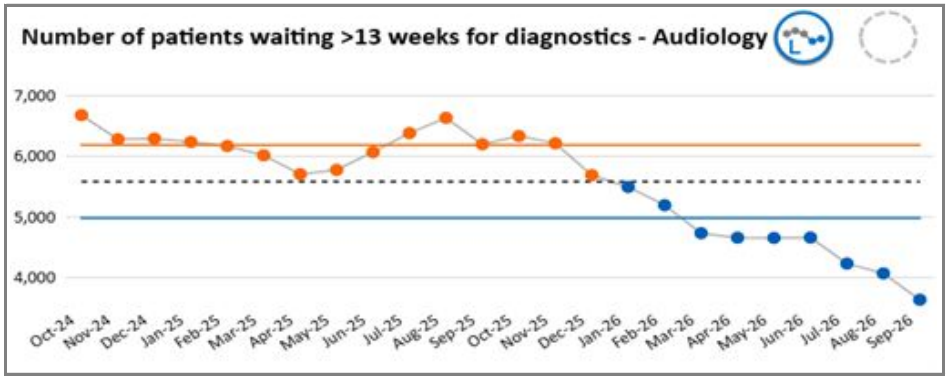
Operations

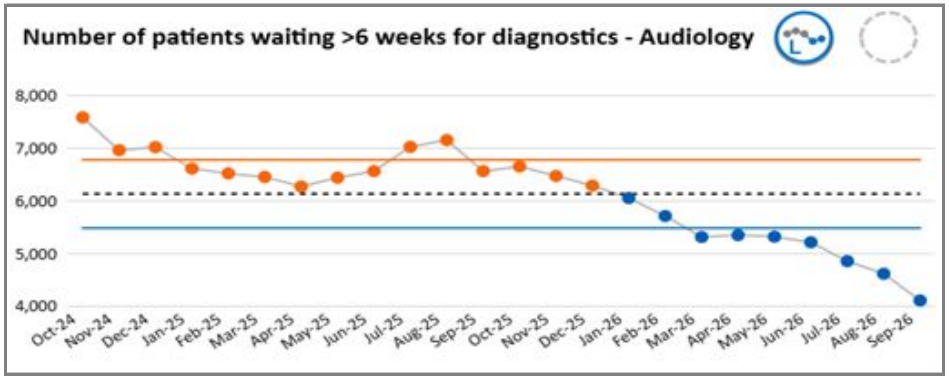
Diagnostics Waiting Times - Audiology

NHS East and North Hertfordshire Teaching NHS Trust







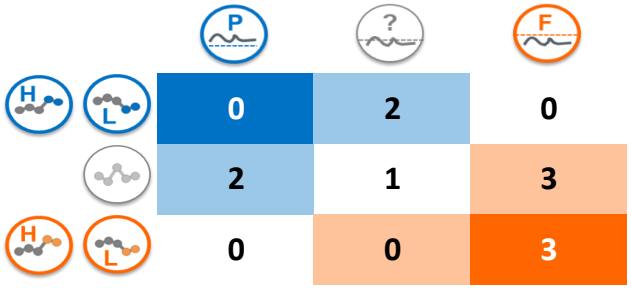


Month 06 | 2026-27

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NHS Trust

Finance

Month 06 | 2026-27



Finance

Summary

NHS East and North Hertfordshire Teaching NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Summary Financial Position	Surplus / deficit	Sep-26	0.8	0.82		?	Common cause variation Metric will inconsistently pass and fail the target
	CIPS achieved	Sep-26	2.7	1.9			Common cause variation No target
	Cash balance	Sep-26	36.2	37.4		F	Common cause variation Metric will consistently fail the target
Key Financial Drivers	Income earned	Sep-26	62.1	62.8		P	Common cause variation Metric will consistently pass the target
	Pay costs	Sep-26	37.0	38.0	H	F	8 points above the mean Metric will consistently fail the target
	Non-pay costs (including financing)	Sep-26	24.3	24.0		F	Common cause variation Metric will consistently fail the target

Month 06 | 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	Sep-26	36.1	35.5			8 points above the mean Metric consistently fail the target
	Average monthly substantive pay costs (000s)	Sep-26	5.8	5.8			11 points above the mean Metric will consistently fail the target
	Agency costs	Sep-26	0.0	0.2			12 points below the mean No target
	Unit cost of agency staff	Sep-26	11.3	10.1			Common cause variation No target
	Bank costs	Sep-26	0.8	2.2			1 point below the lower process limit Metric will inconsistently pass and fail the target
	Overtime and WLI costs	Sep-26	0.3	0.1			3 points below the lower process limit Metric will inconsistently pass and fail the target
Other Financial Metrics	Private patients income earned	Sep-26	0.6	0.6			Common cause variation Metric will consistently pass the target
	Drugs and consumable spend	Sep-26	4.7	4.6			Common cause variation Metric will consistently fail the target

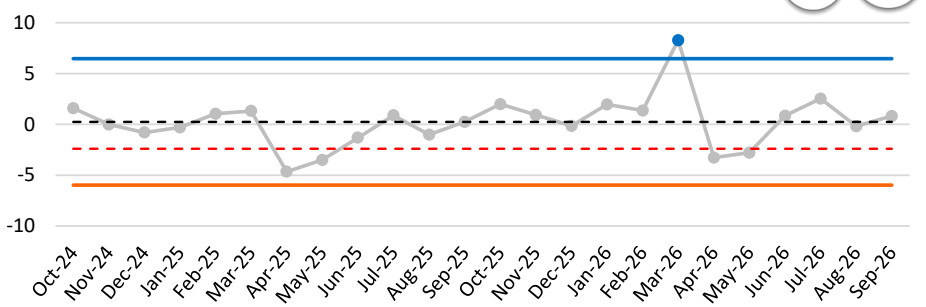
Month 06 | 2026-27

Finance

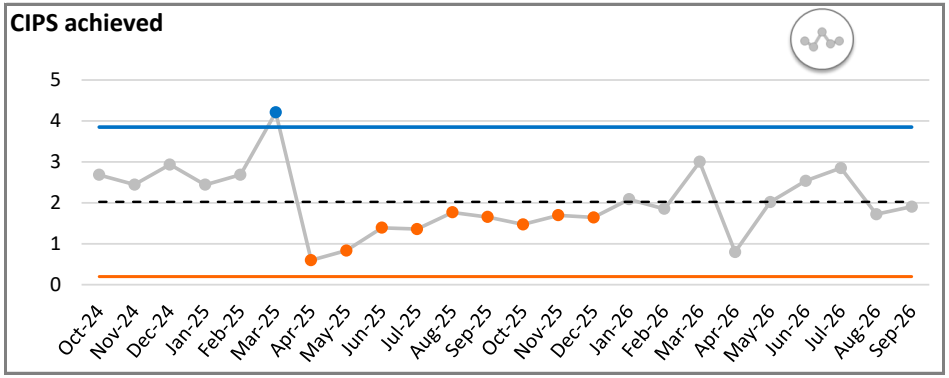
Summary Financial Position

NHS East and North Hertfordshire Teaching NHS Trust

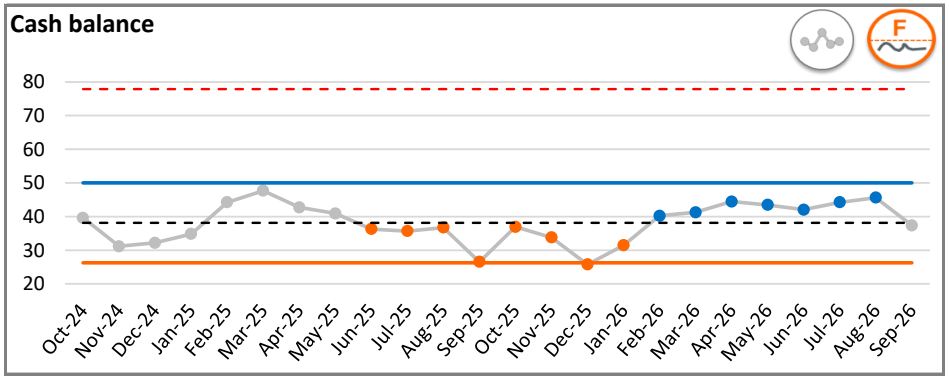
Surplus / deficit



CIPS achieved



Cash balance



Key Issues and Executive Response

Executive Overview

- The Trust reported a £2.0m YTD deficit at Month 6 YTD against a plan of £2.0m. The in month position was £0.8m surplus which was break-even to plan.
- In month there was a £0.8m adverse variance against the internal CIP plan (£1.1m YTD) due to slippage in transformation schemes. This was mitigated by the identification of non recurrent additional technical benefits, which is not sustainable.
- 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 (£5.2m).
- The above pressures have been partially mitigated by £1.3m favourable variances on consumables and prosthesis and £1.2m WLI payments due to low elective activity, as well as early release of reserves/provisions.
- Elective performance remains materially challenged with September performance significantly below plan. 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

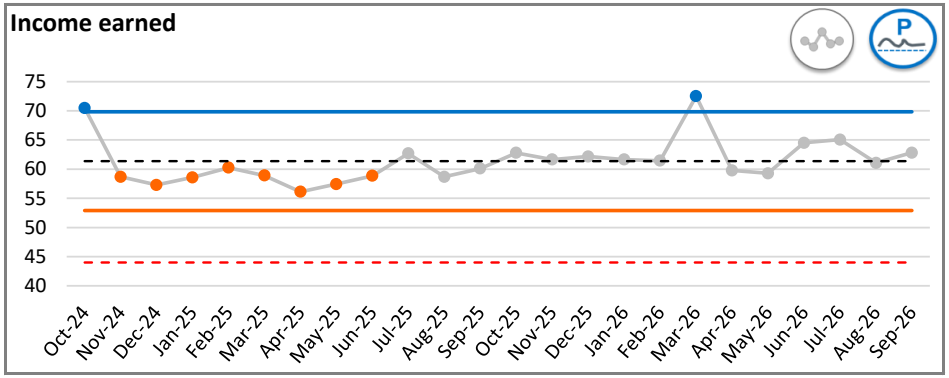
- Significant reduction in run rate and step up in recurrent CIP and transformation CIP delivery is required for latter months of the year.
- Strengthening financial controls for both workforce and temporary staffing.

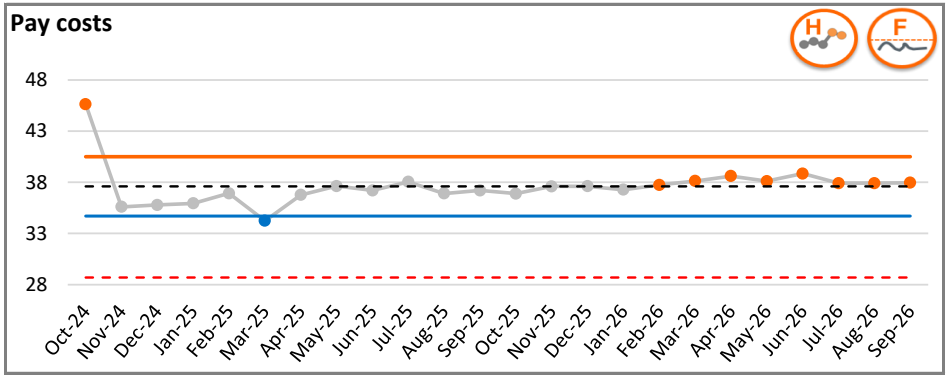
Month 06 | 2026-27

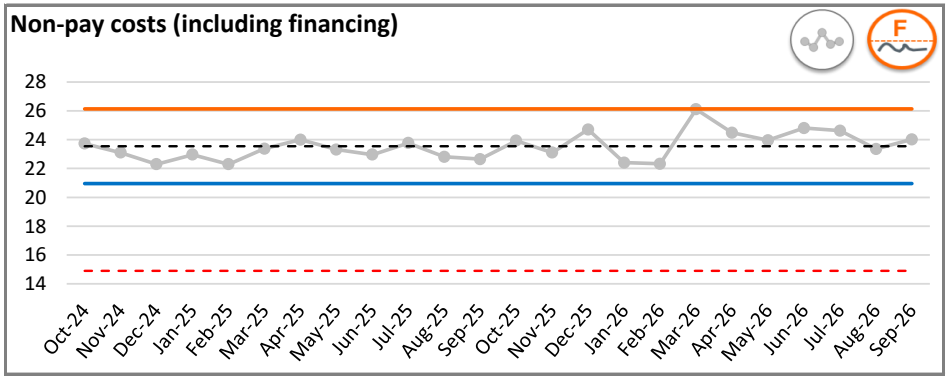
Finance

Key Financial Drivers

East and North Hertfordshire Teaching NHS Trust







Income Performance

- Month 6 income performance continues to be significantly behind plan in a number of service lines and shows no sign of recovery. This is in part due to a reduction in number of waiting list sessions undertaken, without a stepped increase in productivity of core capacity.

Pay Position

- Pay expenditure remains above plan due to:
- Nursing premium pay,
- Medical staffing pressures,
- Sickness absence,
- Temporary staffing usage.

Worked WTE has decreased in month, particularly for admin and nursing staff.

Productivity & Operational Delivery

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

2026/27 Focus Areas

- Divisions to identify and deliver recovery actions plans to ensure that the Trust is able to achieve its statutory break-even duty.
- Deliver recurrent CIP schemes.
- Reduce premium pay expenditure.
- Improve theatre productivity.
- Strengthen divisional accountability & tighten non-pay control.

Key Message

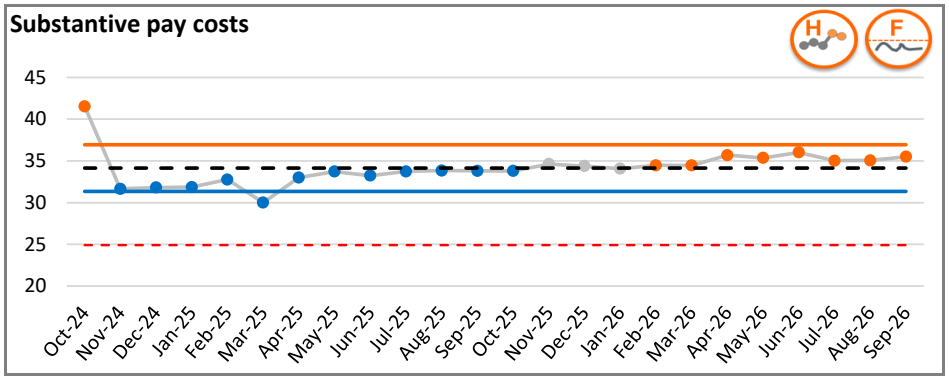
- Sustained operational improvement and recurrent productivity delivery will be required to achieve financial recovery during 2026/27 as the current run rate is not sustainable.

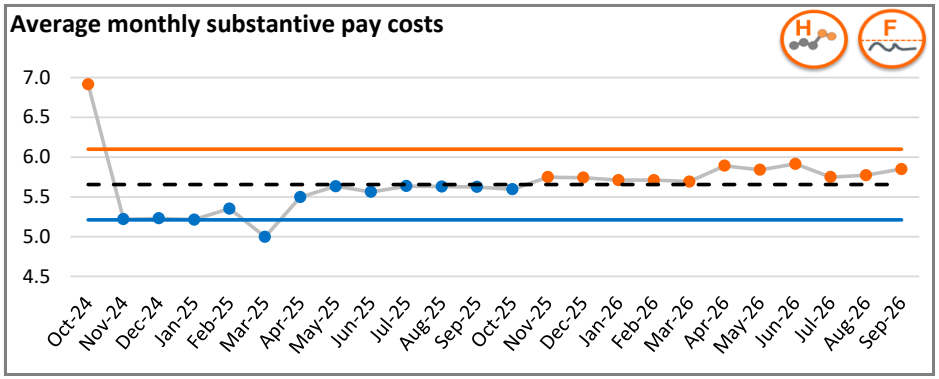
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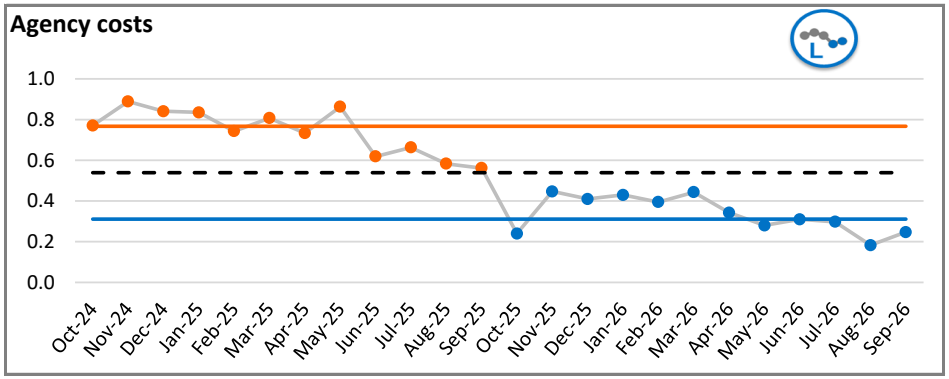
Finance

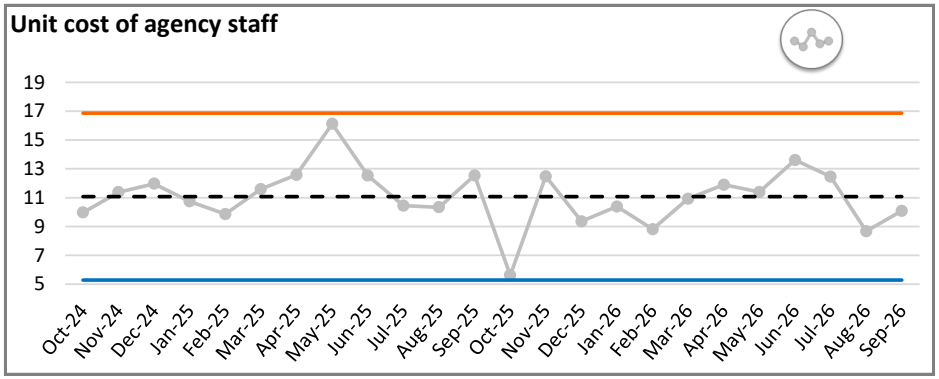
Other Financial Indicators

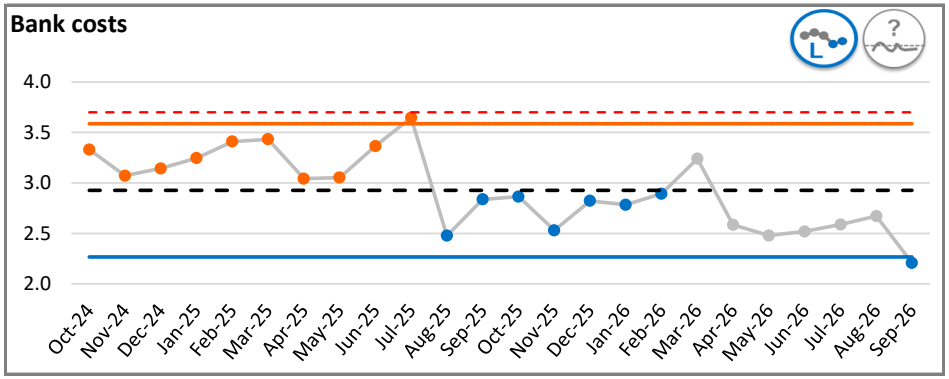
NHS East and North Hertfordshire Teaching NHS Trust

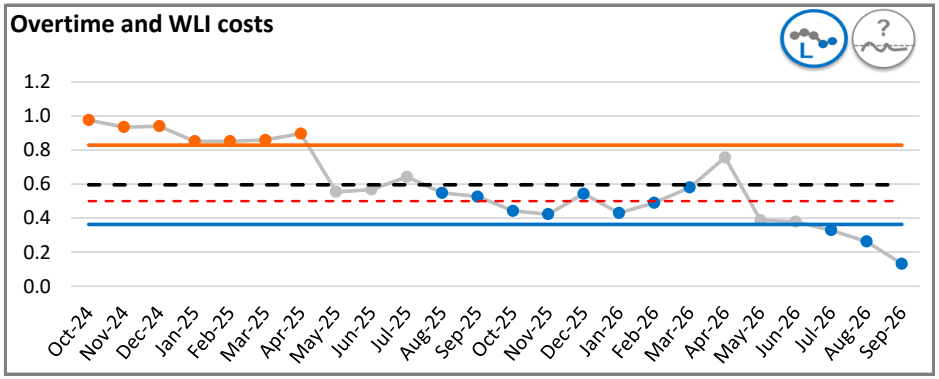










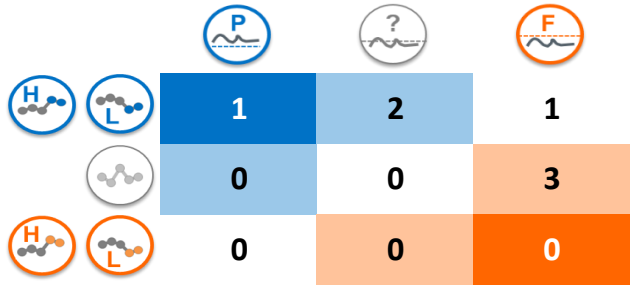


Month 06 | 2026-27

NHS
East and North Hertfordshire Teaching
NHS Trust

People

Month 06 | 2026-27



People

Summary

NHS East and North Hertfordshire Teaching NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Work	Vacancy rate	Sep-26	8%	2.3%	L	?	6 points below the lower process limit Metric will inconsistently pass and fail the target
	Bank spend as a proportion of WTE	Sep-26	5%	6.0%	L	F	1 point below the lower process limit Metric will consistently fail the target
	Agency spend as a proportion of WTE	Sep-26	3%	0.6%	L	?	13 points below the mean Metric will inconsistently pass and fail the target
Grow	Statutory and mandatory training compliance rate	Sep-26	90%	88.8%		F	Common cause variation Metric will consistently fail the target
	Appraisal rate	Sep-26	90%	82.5%		F	Common cause variation Metric will consistently fail the target
Thrive	Turnover rate	Sep-26	10.5%	6.9%	L	P	1 point below the lower process limit Metric will consistently pass the target
Care	Sickness rate	Sep-26	4.0%	5.5%		F	Common cause variation Metric will consistently fail the target

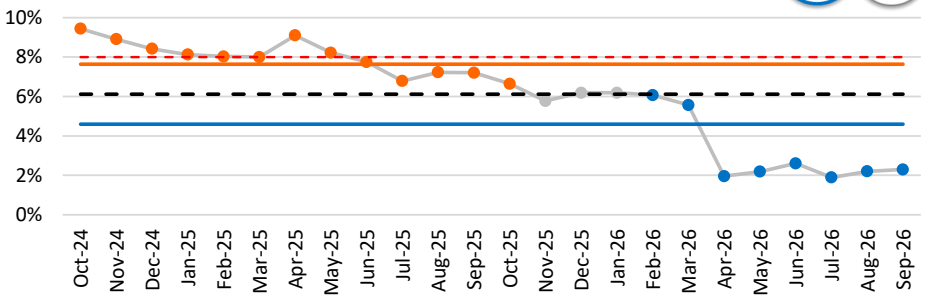
Month 06 | 2026-27

People

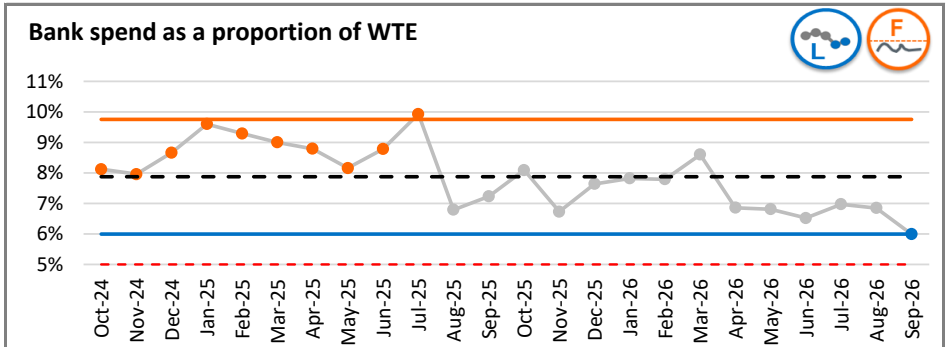
Work Together

East and North Hertfordshire Teaching NHS Trust

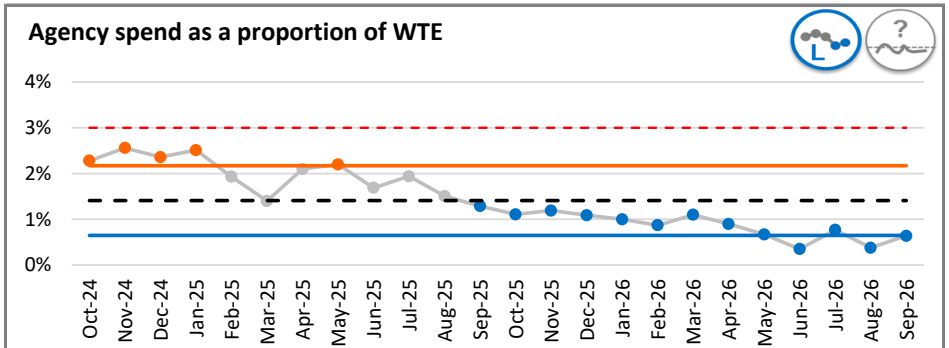
Vacancy rate



Bank spend as a proportion of WTE



Agency spend as a proportion of WTE



Key Issues and Executive Response

- **Workforce** – Recruitment performance remained under pressure during September, although improvements within General Resourcing demonstrate early benefits from strengthened leadership capacity and proactive candidate management. Focus remains on recovering overall recruitment timelines.
- **Recruitment Performance** – Average time to hire increased from 13 to 14 weeks across all staff groups, although General Resourcing improved significantly from 16 to 13 weeks. Continued focus on recruitment delays and pre-employment checks aims to restore overall performance.
- **Candidate Experience** – Candidate satisfaction improved from 4.71 to 4.80 reflecting sustained positive engagement despite recruitment pressures. Proactive communication and candidate support remain a priority.
- **Recruitment Activity** – CSW recruitment processes are being streamlined through combined assessment, interview and ID checks to accelerate appointments. The Newly Qualified Nurse campaign has concluded successfully, with starters expected from late October.
- **Inclusive Recruitment** – Work continues to improve equality of recruitment outcomes through targeted inclusive recruitment initiatives, with local recruitment activity supporting broader candidate reach and access to employment opportunities.
- **Temporary Staffing Performance** – Bank fill rates reduced to 82.4%, driven by nursing sickness pressures and Theatre vacancies. Enhanced bank rates have been agreed for Theatres to improve fill rates and maintain service delivery while vacancies remain high.
- **Bank Utilisation** – Bank fill performance deteriorated during September, reflecting increased staffing pressures across nursing and Theatres. Focus remains on improving shift coverage and addressing recruitment gaps whilst maintaining appropriate workforce controls.

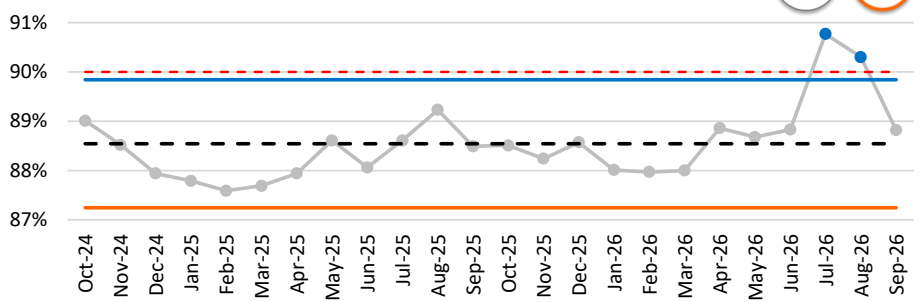
Month 06 | 2026-27

People

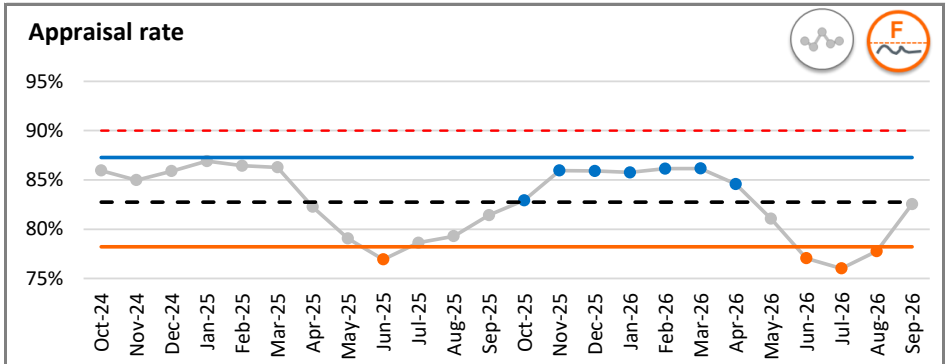
Grow Together

NHS East and North Hertfordshire Teaching NHS Trust

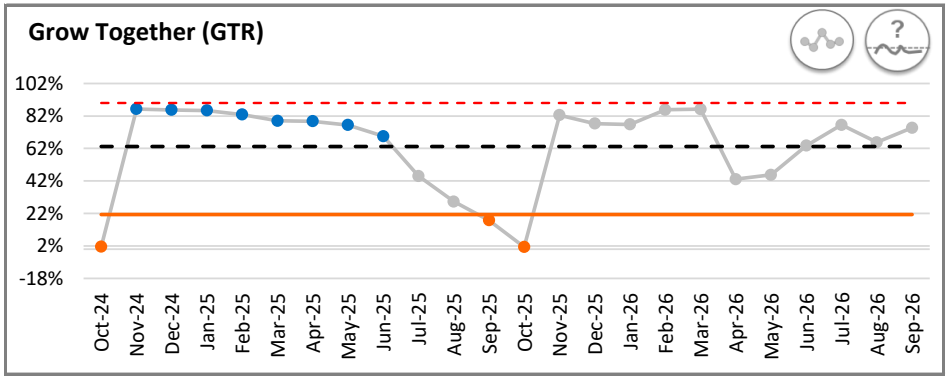
Statutory and mandatory training compliance rate



Appraisal rate



Grow Together (GTR)



Key Issues and Executive Response

- **GTR compliance** for September sits at 74.7% and is climbing again after the annual dip to 60.8% seen in August. GTR improvement plans are underway with new policy expected, continuous process in place and improved training and line management expectations. These will be linked to QLM (Quality Line Management) which is part of our Trust response to the NHS Staff Standards.
- Annualised **appraisal rate** is now at 82.9% (another increase)
- **StatMand** - After previous high figures of 90.8% and 90.3% the fall has now dropped below 90% target at 88.8%. Improvements plans continue and new graphics representations indicate clearly the areas that need focussed attention from local management. The QLM and in particular the launch of DEVELOPMENT GATEWAY are part of the planned actions to improve. The link to 100% compliance to several development opportunities for colleagues has kept the topic active in exchanges across the Trust.

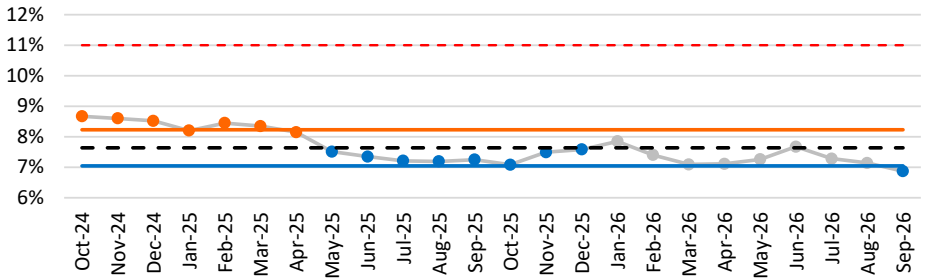
Month 06 | 2026-27

People

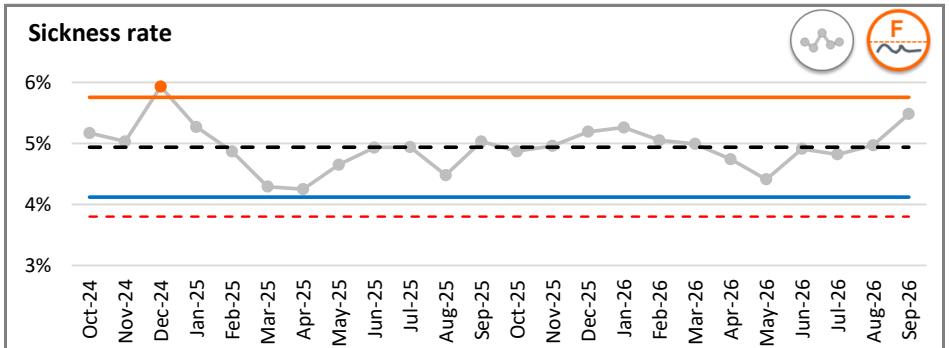
Thrive Together | Care Together

East and North Hertfordshire Teaching NHS Trust

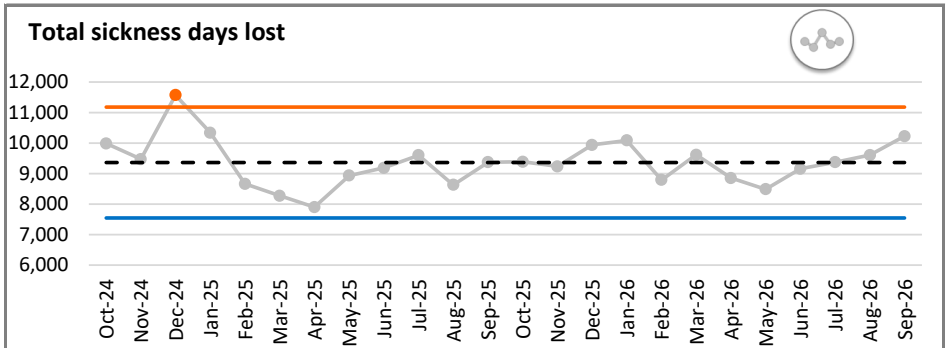
Turnover rate



Sickness rate



Total sickness days lost



Key Issues and Executive Response

Thrive Together

- suspensions - improved average due to conclusion at hearing which resulted in dismissal, other case being heard next month.
- disciplinary - improved due to the conclusion of long standing cases, however is likely to increase over the coming months due to complex external cases being reported and opened.
- Staff concerns - remain over KPI due to leave period.
- 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 compliance remains at 93% this month. Outstanding policies being prioritised.

Care Together

- 119 managers have referred a colleague for an occupational health assessment in September, advice has been offered on fitness for work, and adjustments to protect wellbeing and reduce sickness absence. During occupational health appointments colleagues have been encouraged to utilise support services, referrals have been made for talking therapies and fast track physiotherapy.
- Proactive approaches to reduce sickness absence and protect wellbeing in September included webinars on sleeping better and building resilience, free exercise classes and Shine Bright virtual support groups.
- The collaborative 'Return Well Programme' continues, with bi monthly meetings to review sickness hotspots, LTS, High BScore cases, working with relevant managers/leads; objective to reduce sickness absence to ≤4% by end Q4. Focused working groups on effective return-to-work, wellbeing interventions, improved manager confidence/effectiveness in attendance management. Monthly progress report to Senate. Focus next month on improved guidance on restrictions on practice/medical sickness management.

Month 06 | 2026-27

Board committee report

NHS East and North Hertfordshire Teaching NHS Trust

Meeting	Public Trust Board			**Agenda Item**	18
Report title	Audit and Risk Committee report to the Board			**Meeting Date**	11 November 2026
Chair	Karen McConnell, Chair of Audit and Risk Committee				
Author	Deputy Trust Secretary				
Quorate	**Yes**	☒	**No**		☐

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

- The Committee expressed concern regarding the absence of established governance arrangements for Artificial Intelligence (AI) and highlighted the potential risks of staff adopting AI tools without appropriate controls, policies, or oversight arrangements being in place.
- Concerns remain regarding cyber security and compliance with the Data Security and Protection Toolkit (DSPT). Whilst progress has been made, the Trust remains at "Approaching Standards" and requires delivery of a comprehensive improvement programme by May 2027.
- The Committee received assurance that ventilation and fire compliance processes are in place; however, concerns remain regarding the condition, resilience and maintenance backlog of critical estate infrastructure, including theatre ventilation systems and fire compartmentation. Steps taken to include appropriate mitigation in the capital program were noted.
- Financial sustainability continues to represent a significant Board-level risk and has been identified by External Audit as a key value-for-money focus area, particularly in relation to unidentified savings schemes.
- The Committee received a Patient Experience/Learning from Complaints Internal Audit report that resulted in a Partial Assurance opinion. Key weaknesses identified related to the design of the control framework including strategy and policy documentation and non-compliance with agreed actions and deadlines. Progress on the implementation of recommendations will be monitored.

Assurances provided to the Board:

- External Audit reported positive progress in audit delivery, improved timeliness and increasing resilience of the Trust's year-end financial reporting process.
- The Committee received assurance that delivery of the Internal Audit Plan remains on track, with most fieldwork expected to be completed before Christmas and an early indication of the Head of Internal Audit Opinion anticipated in February 2027.
- The Committee received assurance that progress continues to be made in reducing overdue internal audit recommendations, with 24 recommendations closed since the previous meeting.
- Progress against External Audit recommendations was noted, including improvements in financial controls and work to address historical Trust wide pharmacy accrual reconciliation issues.

- The Committee noted significant reductions in both the volume and value of Single Tender Waivers compared with previous reporting periods although further work was requested on reducing retrospective approvals.
- The Committee noted that pharmacy losses had reduced compared with the previous year and continued to represent only a small proportion of overall drug expenditure. Steps taken to reduce losses (£144.7k in 2025/26) through recycling drugs at ward level were commended.
- Improvements were noted within Sterile Services, including progress towards ISO accreditation and the closure of all fire-related internal audit actions.

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

- The Anti-Fraud and Bribery Policy was reviewed but not approved pending further amendments relating to governance arrangements, reporting routes, alignment with the Whistleblowing Policy and equality considerations. Approval will be sought via Chair's Action following revision.
- Freedom of Information performance has improved by 5% despite a 17% increase in request volumes, although performance remains below target. Further work is planned to address recurring themes and proactive publication opportunities.
- The Committee discussed medical records access controls and highlighted the importance of strengthening role-based access arrangements and oversight.
- Work is underway to strengthen the alignment between the Corporate Risk Register and strategic organisational objectives, with additional focus on thematic risk analysis and assurance processes.
- Workforce challenges remain a recurring theme across several risk areas, including specialist engineering, scientific and technical staffing, as well as operational risks affecting clinical services.

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

- The Committee discussed and approved the External Auditors (BDO)_Audit Plan for the year ending 31 March 2027
- The Committee approved the Conflicts of Interest Policy which had been amended to reflect legislative requirements arising from the Economic Crime and Corporate Transparency Act. The approval was given subject to agreed changes.
- AI Governance will become a standing Audit and Risk Committee agenda item until satisfactory governance arrangements are established.
- A detailed DSPT implementation plan has been commissioned and will be presented through Trust management and Board governance structures.
- An AI Governance Framework Policy will be developed and presented through appropriate governance routes for approval.
- Further assurance reports have been requested regarding policy compliance, overdue policies, corporate risk presentation, IT controls, stock management, pharmacy accrual reconciliation and Front Entrance project governance arrangements.
- The Committee commissioned further work to review and strengthen declaration of interest compliance through line management routes.
- An invitation will be extended to the Chair of the Risk Management Group to provide direct assurance regarding risk management arrangements and thematic risks.

Charitable Funds • The Committee discussed and approved the Audit Plan for the Charitable Funds for the year ending 31 March 2026. • Positive progress was reported in relation to the Charity Audit, with no significant concerns identified and audit fieldwork substantially complete.	
Any actions recommended to improve effectiveness of the meeting:	
• The Committee supported the development of thematic internal audit reporting to improve identification of recurring control weaknesses and root causes across the organisation. • Further work will be undertaken to improve the presentation of the Corporate Risk Register, including thematic grouping of risks and clearer differentiation between risks requiring intervention and those being effectively managed. • Future committee scheduling will be re-aligned with changing external reporting deadlines and audit timetables to support effective governance and timely decision-making.	
Recommendation	The Board is asked to **NOTE** the matters of assurance provided by the Audit and Risk Committee

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Board committee report

NHS East and North Hertfordshire Teaching NHS Trust

Meeting	Public Trust Board			**Agenda Item**	20
Report title	Quality and Safety Committee report to Board QSC on September 30 and October 28 PSSC on 15October			**Meeting Date**	11 November 2026
Chair	Dr. David Buckle – Non-Executive Director - East and North Herts NHS Trust				
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):

Orthotics Service Patient Safety Risk and Assurance Concern: The Committee wishes to draw the Board's attention to the ongoing concerns regarding the Orthotics Service. Following review of the Orthotics Harm Review report, members concluded that the evidence presented did not provide sufficient assurance that the risks to patients had been adequately mitigated and therefore downgraded the assurance rating to Minimal Assurance. Particular concern was expressed regarding delays in clinical triage, the potential impact on patient outcomes, especially for children requiring timely intervention, and the lack of resolution of contractual matters outside the Trust's direct control. The Committee considered the matter to represent a significant patient safety risk requiring continued Board oversight and wider system engagement with the Integrated Care Board.

Patient Safety Sub-Committee (PSSC):

- **Patient Safety Oversight and Clinical Risk Management:** The Sub-Committee identified a number of patient safety risks requiring continued Board oversight. Particular concern was expressed regarding the volume of incidents remaining open for more than 100 days, which limited the Committee's ability to take full assurance regarding incident management. Members also noted ongoing risks associated with non-RTT waiting lists, where uncertainty regarding timescales for resolution continued to present a potential risk of patient harm from delayed patient pathways. In addition, the Sub-Committee highlighted the need for greater assurance regarding the management and oversight of digital clinical risks, particularly in relation to access to patient records at the point of care and the effectiveness of governance arrangements for monitoring these risks.

Assurances provided to the Board:

Quality and Safety Committee (QSC):

- **Cancer Services Performance and Quality:** The Committee received assurance that cancer performance remained strong, with sustained achievement against key standards, continued improvements in diagnostic pathways, and positive performance across a number of tumour sites.
- **Maternity Safety and Quality Improvement:** The Committee received assurance that maternity services continued to demonstrate improvement across key safety and quality indicators, supported by national review findings, ongoing workforce initiatives and strengthened governance arrangements.
- **Maternity Incentive Scheme year 8 compliance report**
  Three papers were received and examined by QSC which detailed our good progress against the scheme's requirements. All three papers were viewed as providing substantial assurance.
  Good progress was also seen against the Thirlwall recommendations. We are largely compliant and clear plans are in place so QSC gave a substantial assurance

rating.

- **Learning Disability Improvement Plan:** The Committee received assurance that progress against the Learning Disability Improvement Plan was being maintained, with a range of actions completed to enhance patient experience, reasonable adjustments, staff awareness and oversight arrangements.
- **Safeguarding Service Performance:** The Committee was assured that safeguarding arrangements remained effective, with statutory responsibilities being met, strong partnership working in place and ongoing oversight of emerging safeguarding themes and risks.
- **Patient Safety Incident Response Framework (PSIRF) Implementation:** The Committee received assurance that implementation of PSIRF continued to mature, with oversight processes embedded, learning from investigations being identified and mechanisms in place to strengthen organisational learning and quality improvement.In October QSC received and reviewed the PSIRF plan.
- **The human tissue annual report was discussed**
- **QSC had health inequalities update report**
- **The six-monthly Nursing establishment review provided reasonable assurance. The quality detail and thoroughness of the report was noted and should provide the Board with assurance that nurse staffing is taken very seriously. The measurement of CHPD by the NHSI model health system is just one marker, but our score of 7.9 was noted and discussed in detail as the trust is significantly below average when compared with our peer group.**
- **The chair of the clinical ethics committee attended and provided an informative paper.**
- **The estates quarterly report was seen as partial assurance as there continue to be significant quality and safety concerns around the condition of the critical infrastructure.**

Patient Safety Sub-Committee (PSSC):

- **Patient Safety Investigation Oversight and Organisational Learning:** The Sub-Committee received assurance regarding oversight of ongoing Patient Safety Incident Investigations (PSIIs) and Maternity and Neonatal Safety Investigations (MNSIs), together with the actions being taken to strengthen organisational learning. Members noted continued development of learning mechanisms, including patient safety symposiums, human factors training and the planned implementation of the iPHASES framework.
- **Patient Safety Forum Governance Arrangements:** The Sub-Committee received assurance regarding the effectiveness of the Patient Safety Forum's oversight of incidents, learning responses, Duty of Candour compliance, audit programmes and patient safety improvement activity. Improved Duty of Candour compliance was noted, and the report was assessed as providing Partial Assurance.
- **Safeguarding Governance and Organisational Action:** The Sub-Committee received assurance that safeguarding arrangements remain effective, supported by fully staffed safeguarding teams and ongoing work to strengthen safeguarding policies, governance processes and organisational learning, including actions arising from the Lucy Letby Inquiry.

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

Quality and Safety Committee (QSC):

- **Medical Records Risk Improvement Programme:** The Committee received an update on actions arising from the Third Medical Records Risk Summit, including work to improve record availability, strengthen tracking processes and support digitisation initiatives. Progress will continue to be monitored through regular reporting.
- **Corporate Risk Register Developments:** The Committee noted the addition of a new corporate risk relating to acute therapy capacity and the escalation of the mesh backlog risk to corporate oversight. These risks will continue to be monitored through established governance arrangements.
- **National Maternity Review Requirements:** The Committee noted the findings of the independent national maternity review and the emerging requirement for Trusts to

develop funded implementation plans. The potential financial and operational implications will continue to be assessed.

- **Specialist Haematology Workforce Sustainability:** The Committee noted ongoing challenges relating to specialist haematology workforce capacity and succession planning, particularly within red cell services, against a backdrop of wider national workforce shortages.

Patient Safety Sub-Committee (PSSC):

- **Non-RTT Waiting List Position:** The Sub-Committee reviewed the position in relation to non-RTT waiting lists and noted the ongoing work to reduce backlog pressures and mitigate the risks associated with delays in patient pathways.
- **Digital Clinical Risk Governance:** The Sub-Committee discussed digital clinical risk management and highlighted the importance of continued oversight of risks relating to patient record availability, accessibility and the effectiveness of digital governance arrangements. These issues have now been raised with the Digital Committee Chair to help ensure scrutiny and oversight .
- **Long-Open Incident Monitoring:** The Sub-Committee noted the continued monitoring of incidents remaining open beyond 100 days and the work underway to improve timeliness of investigation closure and implementation of learning.
- **Lucy Letby Inquiry Response:** The oversight.ee noted the Trust's ongoing consideration of findings and emerging recommendations arising from the Lucy Letby Inquiry, with actions being incorporated into existing governance and oversight arrangements.

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

Quality and Safety Committee (QSC):

- **Quality Strategy Development:** The September Committee agreed that key questions and themes identified through Committee discussions should be explicitly reflected within the developing Quality Strategy which was featured at the October meeting.
- **Learning from Maternity and Neonatal Safety Investigations:** The Committee agreed that themes relating to staff wellbeing, burnout, violence and aggression, and workplace civility should be escalated to the People and Culture Committee for further consideration.
- **Enhancing Quality Reporting:** The Committee agreed that future reports should consistently include the outcomes of divisional and governance reviews to provide greater transparency regarding scrutiny, challenge and organisational learning.

Patient Safety Sub-Committee (PSSC):

- **Review of Long-Open Patient Safety Incidents:** The Sub-Committee requested further assurance regarding incidents remaining open for more than 100 days and commissioned continued oversight to ensure timely investigation completion, action implementation and case closure.

Any actions recommended to improve effectiveness of the meeting:

Quality and Safety Committee (QSC):

- Paper Length and Report Focus: The Committee emphasised the need for reports to be concise and appropriately focused, noting that excessively lengthy papers can detract from clear identification of key issues, risks and assurances. Authors were encouraged to ensure reports are proportionate, focused on matters requiring Committee attention and supported by clear summaries to aid effective scrutiny and discussion.

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**	21
Report title	Finance, Performance and Planning Committee	**Meeting Date**	11 November 2026
Chair	Richard Oosterom – Associate Non-Executive Director		
Author	Committee Secretary		
Quorate	**Yes** ☒	**No** ☐	

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

- Financial position: The Trust is broadly on its YTD deficit plan (£2.8m), but this relies on central contract adjustments and reserves. The Forecast ranges from £5m surplus to an £11.4m deficit, with a most likely outcome of about £7.6m deficit. Break-even is still achievable but depends on savings, productivity and tighter controls.
- Savings and transformation: Recurrent savings are under-delivering and about £7m of identified savings is unverified. The challenge is now executive accountability and pace. Transformation is rated Partial assurance, and reasonable assurance was judged not appropriate.
- Financial control: Stronger control is needed especially on recruitment and temporary staffing, This will have significant workforce impact and needs clear communication and Board Support.
- Operational performance: Cancer, diagnostics and UEC remain concerning. Recovery work is underway but not yet showing consistent results. UEC wait-to-be-seen is a particular concern, with no cohesive recovery plan yet. Minimal assurance was debated, but partial assurance as kept given the actions underway.
- Theatre Productivity: About 14% of capacity is being lost to staffing constraints and day-of-surgery cancellations. Sustainable cross-cover, job planning and workforce arrangements are needed to deliver a fully resources 50-week timetable by 1 April 2027.

Assurances provided to the Board:

- A more transparent forecast with best, likely and worst-case scenarios.
- A clearer recovery approach for Planned care/theatres: interim insourcing, recruitment, consultant cross cover, job planning and trajectory to the 50-week timetable.
- Targeted sickness absence interventions have worked in some areas, though there is no Trust-wide trajectory yet.
- Recovery trajectories are being developed for cancer and key specialties, and stronger imaging leadership should help diagnostics.
- Daily operational resilience meetings have started in UEC.
- Good direction and quality of work on the 2027/28 annual plan, including more flexible capacity models and better integrated planning.

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

- The Trust is moving to a more intensive turnaround approach, with Deloitte support refocused on UEC grip and control on workforce and recruitment. External support must build sustainable internal capability, with a clear exit model.
- The 2026/27 exit position will shape the 2027/28 planning challenge, and national planning guidance had not yet been issued.
- Medical job planning is critical to the 2027/28 operating model. A plan and timeline are needed before 1 April 2027.

- Private Patient income is about £6.9m, with potential growth to £12-£17M.The Committee supported further development, subject to profitability analysis and assessment of the impact on NHS capacity, workforce and services.
- The overarching theme was the need to move from planning to pace, execution and demonstrable outcomes. The next meeting will test whether actions have led to measurable improvement.
- The Committee should agree how it gets assurance that available capacity (theatres, paid workforce) is being well used.

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

- Executive team: Define and implement stronger financial controls, including recruitment and temporary staffing, and show their impact in later reports.
- Planned care: Produce a theatre recovery plana and trajectory to the 50-week timetable by 1 April 2027, with clearer theatre and workforce utilisation reporting.
- Performance: Cancer and other recovery trajectories to return with milestones. PTL validation and speciality engagement to be reviewed.
- UEC: Continue daily resilience oversight and develop the outstanding wait-to-be-seen recovery approach.
- Transformation: Clarify Deloitte's remaining role, sustainability after they leave, and the key decisions needed to delivery benefits.
- 2027/28 planning: Include scenario modelling for different year-end positions and transformation outcomes.
- Job Planning: Divisions and Executive Team to set a timeline ahead of April 2027.
- Private Patients: Develop the proposal with profitability analysis, standardised tariffs and package pricing, competitor analysis and assessment of unintended consequences, through the business case process.
- Next meeting: Assess the impact of agreed actions and decide whether further escalation to the Board is needed.

Any actions recommended to improve effectiveness of the meeting:

- Papers should distinguish activity from measurable outcomes, so assurance ratings rest on evidence of delivery.
- Reports should include clearer trajectories, milestones and success measures across finance, transformation, theatres, cancer and UEC.

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**	21b
Report title	Finance, Planning and Performance Committee Report – Oct			**Meeting Date**	11 November 2026
Chair	Richard Oosterom – Associate Non-Executive Director				
Author	Committee Secretary				
Quorate	**Yes**	☒	**No**		☐

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

- Financial, RTT and UEC performance remain principal concerns.
- Whilst month 6 financials were on plan (supported by reserve releases), the year-end position remains dependant on delivery of financial controls, CIP improvement and transformation savings.
- RTT, cancer and UEC performance have deteriorated significantly, with the Trust moving into Tier 2 oversight arrangements for RTT and Cancer.
- Concerns remain around the gap between transformation activity and realised benefits, with delivery remaining behind trajectory.
- Winter delivery risks remain, particularly where financial recovery actions interact with operational capacity and patient flow.

Assurances provided to the Board:

- The Committee received assurance that financial risks are being well understood, transparently reported and subject to active management through strengthened financial recovery arrangements.
- Comprehensive package of recovery actions had been developed to improve the Trust's forecast position, including workforce controls, expenditure controls and strengthened monitoring arrangements.
- Robust governance arrangements remain in place for the Capital programme, with active prioritisation for resources and oversight of key risks.
- Performance recovery plans are in place across RTT, Cancer and Diagnostics and UEC and ED and oversight arrangements continue to strengthen.
- Significant work had been undertaken in preparation for Winter, including escalation planning, patient flow initiatives, discharge improvements and vaccination programmes.
- The Trust's transformation programme was supported by stronger governance, accountability and monitoring arrangements. Whilst some schemes are beginning to demonstrate benefit it was noted that delivery remains behind trajectory.
- Committee assured that the revised Performance and Consequences Framework was strengthening organisational accountability and oversight of divisional performance, with a clearer focus on addressing underperformance and supporting recovery.
- The Committee received assurance that the proposed approach for utilising surplus Apprenticeship Levy funding represents a well-governed opportunity to maximise workforce development benefits across the wider system whilst supporting local employment and skills development.

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

- The Committee challenged management to place greater emphasis on delivery trajectories, pace of recovery and measurable outcomes rather than narrative explanations of underperformance.

• Particular focus was placed on capacity utilisation, PTL management and operational productivity as key indicators of future success. • Members welcomed the increased level of executive challenge and focus on organisational accountability.
Decisions made by the committee or major actions commissioned and work under way:
• Agreed enhanced monitoring of financial recovery actions and associated savings delivery. • Requested improved reporting of recovery trajectories and confidence levels against performance and financial plans. • Supported the transfer of unused Apprenticeship Levy funding to maximise workforce development opportunities across the system. • Requested further updates on medical job planning, RTT recovery requirements and PTL governance arrangements.
Any actions recommended to improve effectiveness of the meeting:
• Future reports should focus on outcomes, delivery milestones and trajectory achievement. • Continued strengthening of Board Assurance Framework metrics, particularly within Estates and Facilities assurance. • Greater use of leading indicators to support earlier identification of emerging risks

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**	22
Report title	People and Culture Committee Report to Board – Oct 2026			**Meeting Date**	11 November 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):

- WRES and WDES performance remains below the level expected in several areas, with further improvement activity required. Key areas requiring further assurance included reasonable adjustments, disability inclusion, workforce representation, career progression and strengthening accountability arrangements.
- The Committee highlighted the ongoing challenge of violence, aggression and discrimination experienced by staff and requested further assurance regarding preventative actions, support mechanisms and outcome measures.
- Culture and leadership continue to represent areas of partial assurance within the BAF, with ongoing work required to strengthen leadership capability, accountability, employee relations and organisational culture.

Assurances provided to the Board:

- The Committee received assurance regarding progress against the Resident Doctor 10-Point Plan, including actions associated with staff wellbeing and annual leave policy implementation.
- The Committee supported the development of a Culture Diagnostic Toolkit, providing assurance that a structured approach is being developed to assess and improve organisational culture using qualitative evidence.
- The Committee reviewed and supported the Trust's draft People Strategy, subject to amendments, and was assured that key priorities including workforce sustainability, leadership development, equality, diversity and inclusion, and workforce planning are being addressed.
- The Committee received an update on implementation of the Leadership and Management Framework it was agreed that future reports should demonstrate how leadership development activities contribute to wider cultural and strategic objectives.
- The Committee received assurance regarding Responsible Officer and medical revalidation arrangements, confirming appropriate governance processes are in place to support professional standards and compliance.
- The Committee reviewed BAF risks within its remit and endorsed the proposed assurance position.

Advise (Matters the Board should be aware of not covered above e.g. on-going monitoring, new developments etc):
• Development of a Culture Toolkit will continue, with a phased implementation approach, pilot activity and the creation of a Board-Level cultural temperature check. • Future monitoring will focus on workplace violence and aggression, leadership development outcomes, customer service standards within the People Directorate, and progress against WRES and WDES improvement plans. • The Committee requested ongoing reporting to demonstrate how leadership and people initiatives translate into measurable improvements in staff experience and organisational culture.
Decisions made by the committee or major actions commissioned and work under way:
• Supported further development and phased implementation of the Culture Diagnostic Toolkit. • Supported progression of the People Strategy to Board, subject to amendments discussed during the meeting. • Commissioned a future report on workplace violence and aggression, including preventative actions, support mechanisms and outcome measures. • Requested additional detail regarding WRES and WDES improvement plans, performance targets and accountability arrangements. • Requested continuing assurance through routine People Dashboard reporting as a key mechanism supporting oversight of workforce and culture risks.
Any actions recommended to improve effectiveness of the meeting:
• Continue development of Board-level indicators and dashboard measures to strengthen oversight of organisational culture and workforce outcomes. • Ensure future reports provide clearer outcome measures, baseline data and evidence of impact to support effective Committee scrutiny. • Strengthen triangulation of workforce intelligence through integration of staff survey results FTSU information, patient feedback and workforce metrics.

Recommendation	The Board is asked to **NOTE** the report from the People and Culture Committee.

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Board committee report

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East and North Hertfordshire Teaching NHS Trust

Meeting	Public Trust Board			**Agenda Item**	23
Report title	Digital Committee report to the Board			**Meeting Date**	11 November 2026
Chair	Richard Oosterom – Associate Non-executive Director				
Author	Business Manager to Chair and CEO				
Quorate	**Yes**	☒	**No**		☐

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

OneEPR — partial assurance.
The Committee remained unable to confirm readiness to proceed. Revised implementation dates were indicative and insufficiently assured for wider mobilisation. Dedalus reiterated confidence in December delivery, but further evidence was required on functionality, quality and progress against intermediate milestones.

Medicines reconciliation.
Pharmacy identified changes required to make the functionality clinically workable. Dedalus indicated that most might not be available until July/August 2027. A clinical impact assessment was planned to determine whether safe workarounds were available, alongside clarification of the supplier's delivery commitment.

Clinical pathway testing.
Several pathway walkthroughs remained outstanding or unconfirmed. The Committee requested urgent scheduling and completion, including EPMA, CPOE, theatres and anaesthetics.

Gastroenterology.
Paper-based orders and results management continued to present a clinical risk, including previous patient harm associated with lost paperwork. An immediate electronic mitigation was being progressed.

Assurances provided to the Board:

The Committee reaffirmed that OneEPR would go live only when all pathways had been tested, reviewed for clinical safety and accepted.

Clinical and nursing engagement remained positive. E-Take had received positive clinician feedback and was progressing towards final sign-off.

Dedalus agreed to provide detailed development milestones, share testing findings and investigate delays in pathway walkthroughs. The Trust would retain responsibility for deciding whether releases containing known issues should enter its test environment.

Paediatric diabetes and pre-operative assessment interim systems had reached procurement, with delivery being pursued within the calendar year.

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

Ambient voice technology.
An ENT and pre-operative assessment pilot was planned for early October. Integration work was progressing to ensure content entered the correct patient record. Success criteria would return to the Committee, with wider implementation subject to a successful pilot and procurement.

Microsoft Copilot.
The Trust accepted 1,000 fully integrated licences offered by NHS England until 31 March 2027 to evaluate benefits. Continued use would cost £80,000 annually per 1,000 users from April 2027. Initial rollout remained limited while information governance concerns, particularly confidential SharePoint access, were addressed.

Pathology.
Digital support continued for HSL outsourcing, with the Medical Director identified as Senior Responsible Owner. Infrastructure and integration work was required. Continued use and funding of ICE for GP pathology and radiology ordering after migration remained unresolved.

Outpatient transformation.
Patient portal engagement was reported in the high 70% range. A Waiting Well business case would be developed. A combined room-booking and self-check-in solution was progressing, with implementation required within the financial year. Operational flow, support arrangements and workforce implications remained under consideration.

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

- Retained **partial assurance** for OneEPR.
- Requested detailed supplier milestones, evidence of development progress and greater visibility of testing findings.
- Requested clarification of medicines reconciliation delivery and assessment of safe workarounds.
- Requested urgent completion of outstanding clinical pathway walkthroughs.
- Supported Lorenzo electronic requesting as the proportionate immediate gastroenterology mitigation, rather than an ICE upgrade costing approximately £150,000 and taking around six months.
- Supported establishing a broader clinical advisory group for digital matters.
- Requested ambient voice pilot success criteria for review.

Any actions recommended to improve effectiveness of the meeting:

No specific changes to meeting arrangements were recorded. More granular supplier reporting and more frequent testing updates were requested to strengthen scrutiny and assurance.

Recommendation	The Board is asked to note: • The Committee's **partial assurance** on OneEPR and the unresolved delivery, functionality and clinical readiness risks. • The further evidence and clinical assurance required before readiness to proceed can be confirmed. • Progress with interim clinical risk mitigations and wider digital programmes, including their information governance, funding and operational dependencies.

Board committee report

East and North Hertfordshire Teaching NHS Trust

Meeting	Public Trust Board	**Agenda Item**	23b
Report title	Digital Committee Report to the Board - 9 October	**Meeting Date**	11 November 2026
Chair	Richard Oosterom, Committee Chair		
Author	Governance Business Administrator		
Quorate	**Yes** ☒	**No** ☐	

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

- **OneEPR Programme Delivery Risk and Supplier Performance Concerns (Dedalus):** The Digital Committee remains concerned about delays in delivery of the OneEPR Programme by Dedalus, particularly the delayed SU2 release, and the potential impact on programme milestones, readiness activities, pathway development, and overall implementation timelines. Whilst Dedalus provided revised delivery commitments, including deployment of SU2 to the Trust environment and assurances that planned December functionality remains on track, the Committee concluded that assurance can only be achieved through demonstrable delivery against these commitments.

  As a result, both the OneEPR Programme Update and Dedalus Update were assessed as providing **Minimal Assurance**. The Committee recommends continued close monitoring of Dedalus performance, programme risks, and delivery milestones.

Assurances provided to the Board:

- **Supplier Remediation and Revised Delivery Plan:** Dedalus confirmed that issues identified during supplier testing had been addressed and that a revised SU2 release was expected on 15 October 2026, with deployment to the Trust environment anticipated on 19 October 2026, subject to successful testing.
- **Active Management of Strategic Digital Risks:** The Committee reviewed the Board Assurance Framework risks relating to the OneEPR Programme and wider Digital Transformation Programme. Risks continue to be actively monitored, with further work planned to strengthen controls relating to cyber security, digital resilience and emerging technologies.
- **Ongoing Committee Scrutiny:** The Committee agreed continued monitoring of Dedalus delivery against agreed milestones and commitments, recognising that future assurance will be dependent on successful delivery of the commitments made.

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

- **Continued Monitoring of Dedalus Delivery Commitments:** The Committee will continue to closely monitor delivery against the commitments provided by Dedalus, particularly the deployment of the SU2 release and delivery of functionality required for the planned December implementation.
- **Development of Digital Transformation and Innovation Governance:** The Committee received updates on work to strengthen governance arrangements supporting digital transformation, innovation, emerging technologies, and artificial intelligence, with further development to continue through the Digital Transformation Programme.
- **Digital Programme Delivery:** The Committee noted progress on the Trust's wider digital programme, including developments relating to room booking systems, digital dictation (PIFY), diabetes systems, endoscopy digitisation and cyber security initiatives. This work contributes to the mitigation of risks on the corporate risk register relating to delays in the

delivery of OneEPR and will continue to be monitored through routine reporting to the Committee. • **Digital Risk Assurance:** The Committee requested further consideration of opportunities to strengthen the articulation of controls and assurances within digital risk reporting to ensure continued visibility and oversight of strategic digital risks.
Decisions made by the committee or major actions commissioned and work under way:
• **Minimal Assurance Rating Maintained:** The Committee concluded that both the OneEPR Programme Update and Dedalus Update should receive a **Minimal Assurance** rating, reflecting ongoing concerns regarding supplier delivery and programme risk. • **Further Development of the Board Assurance Framework:** The Committee supported the proposed amendments to the Digital Board Assurance Framework and commissioned further refinement of risk descriptions, controls and sources of assurance to improve clarity and oversight.
Any actions recommended to improve effectiveness of the meeting:
N/A

Recommendation	• The Committee recommends working collaboratively with other UK ORBIS customers and NHS England to ensure Dedalus understands the urgency of delivering a UK ORBIS product. • 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	Trust Public Board		**Agenda Item**	24
Report title	Charity Trustee Committee Report to Board - September 2026		**Meeting Date**	11 November 2026
Chair	Nina Janda, Committee Chair and Associate Non-Executive Director			
Author	Committee Secretary			
Quorate	**Yes**	☒	**No**	☐

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

• Sunshine Terrace: regulatory approval has been received with conditions. The Committee requested patient and workforce impact assessments, confirmation of practical patient accessibility and safety requirements, and an early lessons-learned exercise to inform the Paediatric Big Build.

• Fundraising for the 'Big Build' is going well, to support the next stage the team is pulling together more information to promote the project

• Investment oversight: while current Rathbones performance was considered acceptable, the Committee identified a need for additional support and Charity Director is looking for an independent advisor independent to support future scrutiny.

Assurances provided to the Board:

• Charity finances remain healthy. Income is ahead of budget

• A £100,000 legacy was received in August, taking legacy income ahead of budget.

• Month 4 charity performance was reported at £82,000 above plan, with continued strong engagement across fundraising activity.

• Rathbones reported Q2 2026 investment performance of 8.9%, ahead of the ARC Charity Steady Growth comparator of 8.1% and the reported inflation-related target of 2.6%.

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

Any actions recommended to improve effectiveness of the meeting:

• Ensure lead presenters or nominated deputies are confirmed in advance for substantive agenda items, particularly major projects and funding requests, so that the Committee can obtain the assurance required within the scheduled meeting.

• For future investment reviews, agree the Committee's key questions in advance and request a more focused, charity-specific presentation from Rathbones.

Recommendation	The Board is asked to **NOTE** 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	Oct 2026	Nov 2026	Dec 2026	Jan 2027 In person	Feb 2027	Mar 2027 Online	Apr 2027	May 2027 In person	Jun 2027	July 2027 Online	Aug 2027	Sept 2027 in person
Chief Executive's Report		X		X		X		X				X
Integrated Performance Report		X		X		X		X				X
Board Assurance Framework		X		X		X						X
Corporate Risk Register (Part 2)		X				X						
Patient/Staff Story (Part 1 where possible)		X		P		S		P		S		P
Employee relations (Part 2)		X		X		X		X				X
Audit Committee Report		X		X		X		X				X
Charity Trustee Committee Report		X		X		X		X				X
Finance, Performance and Planning Committee Report		X		X		X		X				X
Quality and Safety Committee Report		X		X		X		X				X
People Committee		X		X		X		X				X
Digital Committee		X		X		X		X				X
Digital Committee ToR				X								
Planning guidance				X								
Winter Planning (annual)												X

East and North Hertfordshire Teaching NHS Trust

Board Annual Cycle 2026-27

Items	Oct 2026	Nov 2026	Dec 2026	Jan 2027 In person	Feb 2027	Mar 2027 Online	Apr 2027	May 2027 In person	Jun 2027	July 2027 Online	Aug 2027	Sept 2027 in person
Digital update								X				X
Trust Strategy refresh and annual objectives						X						
Antimicrobial resistance						X						
Strategy delivery report				X								
Strategic transformation & digital update				X						X		
Integrated Business Plan						X						
Annual budget/financial plan						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										X
Estates and Facilities Strategy				X								
People Strategy		X										
Green Strategy				X								
Quality& Clinical Strategy		X										
Equality, Diversity and Inclusion Strategy						X						

East and North Hertfordshire Teaching NHS Trust

Board Annual Cycle 2026-27

Items	Oct 2026	Nov 2026	Dec 2026	Jan 2027 In person	Feb 2027	Mar 2027 Online	Apr 2027	May 2027 In person	Jun 2027	July 2027 Online	Aug 2027	Sept 2027 in person
Digital Strategy								X				
Engagement Strategy												X
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						X						
FPPC TOR and Annual Report												
Quality and Safety Committee												
Complaints, PALS and Patient Experience Annual Report				X								
Safeguarding and L.D. Annual Report (Adult and Children)		X										
Learning from Deaths		X		X				X				
Nursing Establishment Review				X								
PSIRF (MM lead)				X								

East and North Hertfordshire Teaching NHS Trust

Board Annual Cycle 2026-27

Items	Oct 2026	Nov 2026	Dec 2026	Jan 2027 In person	Feb 2027	Mar 2027 Online	Apr 2027	May 2027 In person	Jun 2027	July 2027 Online	Aug 2027	Sept 2027 in person
Quality account (delegate sign off to QSC at their June meeting)								X				
Fuller enquiry response		X										
QSC TOR and Annual Review (if required)				X								
Patient Safety and Incident Report (Part 2)		X										
People and Culture Committee												
Staff Survey Results								X				
Workforce Plan						X						
Gender Pay Gap Report								X				
Freedom to Speak Up Annual Report						X						
Other												
Trust Values refresh						X						
Healthwatch Hertfordshire annual report/presentation on key findings and recommendations												X
ENHPS update				X								
ENH Pharma (Part 2) shareholder report to Board				X								