June 2025

East and North Hertfordshire Teaching NHS Trust

Quality Account 2024-2025

Contents

Part one

1.1 Chief Executive's Foreword

It has been a challenging 12 months, both for our Trust, and in the wider NHS and health landscape. However, the following quality accounts show that there is much to be proud of.

Earlier this year, our application to be recognised as a teaching trust was approved by the Department for Health and Social Care. This change reflects the immense hard work that happens day in and day out, to ensure all our students and trainees receive high quality education.

After the launch and implementation of the ENH production system, our patient-centred partnership with Virginia Mason Institute, I am pleased to report that 731 staff (0ver 10% of our workforce) have completed the introduction course. This is already having an instrumental impact on patient care and will be an important step in quality improvement both now and in future years.

After successfully transitioning the patient safety incident response framework (PSIRF) back in 2023, a programme that was co-designed with patients and carers, we have seen a 20% increase in incident reporting. This increase indicates a much-improved safety and learning culture. We know that any safety incident is one too many, however the standardisation, oversight and governance have seen a vast improvement and increase in good care reporting, as well as a reduction in the number of overall risks.

Patient care and accountability is the main aim across the trust. A key focus area has been adult and paediatric deteriorating patients, and we are proud to have embedded Marthas Rule (MR) and Call4Concern more widely into our everyday practice.

100% of MR calls were actioned with an in-person clinical assessment and we were ranked third in the region for the volume of MR activation calls. This is all down to effective communications and emphasises the uptake of the escalation process.

As always, as vital and rewarding as these successes are, there are still areas where we need to improve.

Patient waiting times remain an area of focus. As does the need to develop targeted services to better understand and meet the needs of those with learning disabilities.

As a trust, we are dedicated to working on these improvements and I'd like to take this opportunity to thank all those who have worked hard to ensure we continue to provide high-quality compassionate care for our communities.

Performance overview

1.2 Accountability for quality: how we hold ourselves accountable

The Quality Account is a mandatory document required under the Health Act 2009 and subsequent regulations (Health and Social Care Act 2012, and the National Health Service (Quality Accounts) Regulations 2010) which serves as a key accountability mechanism. The Quality Account is therefore a key mechanism that provides demonstrable evidence of measures undertaken in improving the quality of the Trust's services.

As part of the development of the Quality Account all NHS Trusts are required to identify measurable priorities mapped against Darzi headings of Safe, Effective and Patient Experience.

This document serves multiple functions:

- Demonstrates quality improvements and achievements
- Identifies areas requiring further development
- Maps priorities against the Safe, Effective and Patient Experience framework
- Promotes quality improvement across the NHS
- Enhances public accountability
- Facilitates stakeholder engagement and feedback

The Trust's overall vision is to be trusted to provide consistently outstanding care and exemplary service. We will deliver our vision by focusing on our strategic themes - quality, thriving people, seamless services, and continuous improvement which will in turn support operational performance.

1.2.1. Our Strategic Goals

In 2024/25, our strategic goal was to deliver safer, more efficient, and compassionate care by embedding continuous improvement across all levels of the organisation. This included a commitment to zero harm, empowering staff through leadership and improvement capability, working in partnership to enhance services, and making best use of our resources.

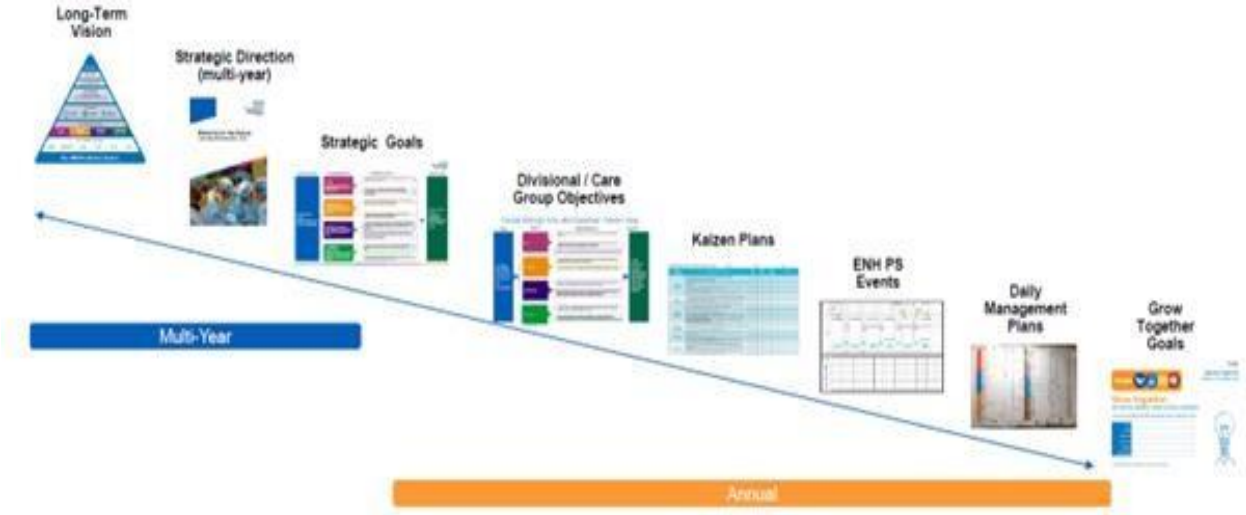


Fig:1: Strategic goal cascade from vision to individual grow together conversations

We are achieving this through a range of initiatives—from large-scale cross-functional transformation programmes to small, team-led daily improvements. Key activities in the last year have included rapid process improvement workshops, a new senior leadership development programme, the formation of an Acute Provider Collaborative to improve care and efficiency across partner trusts, and wide-scale staff training in waste reduction and lean methodologies.

For 2025/26, as a Trust, we have agreed moving away from narrow, targeted annual objectives to broader, multi-year strategic goals designed to drive meaningful, long-term transformation. This shift enables teams to better align their work and resources with the Trust's overarching priorities.

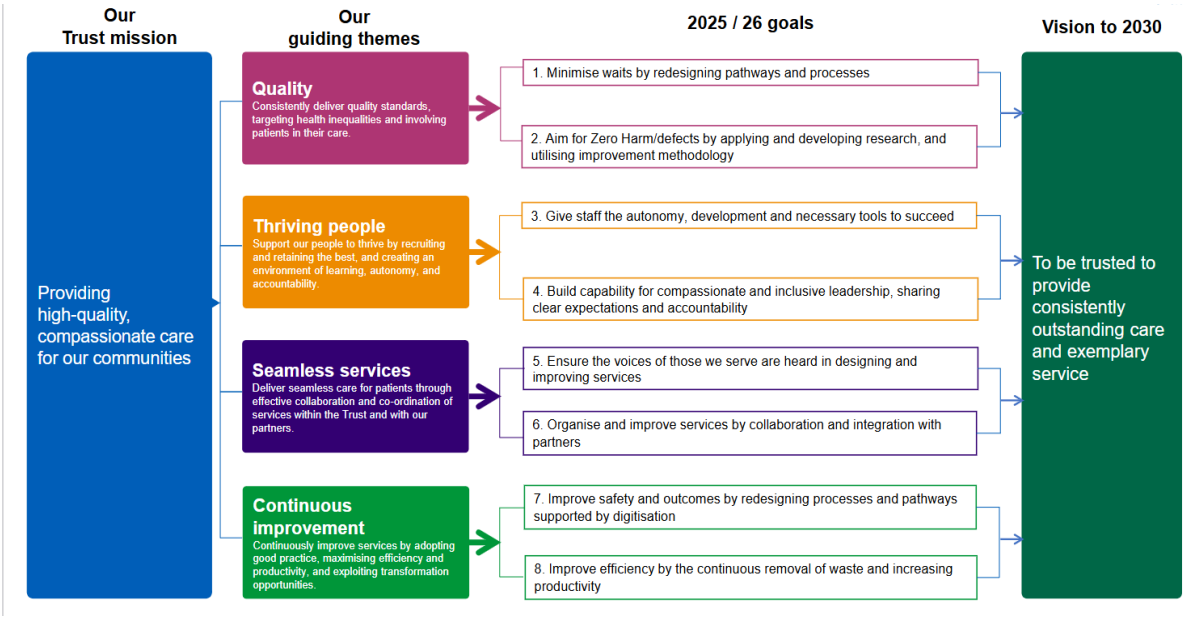


Fig 2: East and North Hertfordshire 2025/26 strategic goals

Our strategic goals for 2025/26 will focus on transforming care quality through innovation, particularly via the rollout of a new unified Electronic Patient Record (OneEPR). This digital transformation will streamline outpatient services, improve access and choice for patients through a dedicated portal, and introduce artificial intelligence to optimise scheduling and reduce waiting times.

We are also strengthening our commitment to inclusive leadership and workforce wellbeing through the delivery of a new EDI strategy and the ongoing expansion of our Healthy Teams framework and staff networks.

To ensure services are shaped by the people who use them, we are enhancing patient and community engagement, working with local partners to integrate insights into planning and embedding co-production into all improvement activities.

Through these strategic goals, we aim to deliver high-quality, efficient, equitable care by empowering our teams, improving patient experience, and embracing digital innovation.

1.2.2. ENHT Organisational Structure

The Trust operates with four clinical divisions (Women & Children, Planned Care, Unplanned Care, and Cancer Services), each led by a triumvirate structure of divisional medical director, nursing/quality director, and operations director.

This structure extends to the specialty level. Supporting corporate teams cover finance, digital, medical practice, education, estates, transformation, and workforce development.

The organisation is strengthened by its established people strategy (2020) built on work, grow, thrive, and care pillars, which continues to effectively support strategic priorities through integrated plans aligned with NHS workforce requirements.

1.2.3. Clinical and Quality Strategy

Our Quality Strategy has continued to support the continuous improvement journey toward an ‘East and North Herts Trust' quality management system. The successful procurement of a single Improvement Partner will enable a systems approach to manging quality. These will continue to build on the current quality objectives (see below).

Understand where variation exists and use data to proactively drive improvement by reducing the ‘unwarranted variation and strengthening ward to board oversight of quality fundamentals of care

 **To foster a culture** where staff can generate ideas, lead improvement efforts, feel valued and confident to influence the care they deliver. Driving continuous improvements through Patient Safety Symposiums and learning through multidisciplinary simulation.

 **To enable our people** with skills and knowledge that strengthens their craftsmanship and expertise to execute their work well by delivering a ENHT Accredited Human Factors curriculum and leadership development programme.

 **To prioritise and understand what matters to staff, patients and carers** who experience our organisation. Improving responsiveness to staff patient and family experience through SWARM processes and real time feedback.

1.2.4. Quality Governance

The Chief Nurse and Medical Director serve as Trust Executives for Quality. The Board delegates quality oversight to the Quality and Safety Committee (QSC) and Trust Audit and Risk Committee.

The Trust operates a comprehensive "ward to board" quality governance framework featuring regular self-assessments and division-led evidence stacks providing annual CQC well-led domain assurance.

Key Components:

- Quality Governance Standards Framework programme
- Patient Safety Incident Response Framework (PSIRF) with defined roles and clinical risk identification
- Culture of openness and organisational learning via QSC
- CQC standards compliance monitoring with performance review meetings
- Annual Report quality priority determination

The Trust recognises that robust systems cannot capture all issues in complex healthcare environments and continues working to triangulate data, minimise unexpected issues, and address governance non-compliance.

Part two: Priorities for improvement and statements of assurance from the board

2. Progress with 2024/2025 priorities

As a Trust, we set out clear priorities for improvement last year that reflected both our local challenges and national ambitions for safer, more effective, and person-centred care. Presented below is a summary of how we have performed against those commitments highlighting areas we have made meaningful progress – from embedding a culture of learning and improvement to strengthening safety systems, enhancing patient experience, and leading with greater accountability. These outcomes are the result of collective effort across our teams, and they provide a strong foundation for the year ahead.

Effective: The Trust advanced digital capability and quality oversight through the implementation of the 'Enhance' platform, enabling real-time, ward-to-board triangulation of incidents, risks, complaints, NICE compliance, and quality indicators.
Quality Improvement (QI) capacity was strengthened through ENHPS training, with 731 staff trained and 42 leaders completing the intensive leadership programme, establishing a strong base for quality improvement. The PSIRF framework was embedded, enabling thematic reviews and capturing 582 episodes of good care. These efforts represent progress toward a sustainable, data-driven improvement culture.

Patient Experience: The Trust was named the most improved Trust in the 2023 CQC governance maternity survey, performing significantly better in 15 areas. The Patient and Carer Experience (PACE) Programme, co-designed post-incident support, and discharge planning improvements helped embed personalised care. Specific equity actions in paediatrics and maternity contributed to service redesign that focused on continuity and accessibility. These were supported by increased responsiveness to complaints and sustained patient engagement.

Safe: The Trust published and implemented its Patient Safety Incident Response Plan and Policy, meeting national safety standards and embedding the Learning from Patient Safety Events (LFPSE) system. A 20% increase in incident reporting and improved thematic reviews reflect an enhanced safety culture.
Medicines optimisation and infection control saw improvements, including a reduction in C. difficile infections to 86 cases (6.5% improvement), near-target performance on antimicrobial stewardship reviews, and high IPC training compliance.
Safeguarding referrals rose due to improved staff awareness and training. In addition, Martha's Rule was implemented Trust-wide, providing a clear escalation route for patients, families, and staff to raise concerns about deterioration. Collaboration with regional and national partners supported shared learning, with early impacts including ITU interventions and improved responsiveness to concerns. Work continues to address equity of access and embed patient wellness checks into routine observations through the EPR.
Sepsis pathway compliance continues to be an improvement priority although there is sustained increase in compliance year on year.

Well-Led: Governance maturity was reinforced by a comprehensive good governance review, redesign of the risk management approach, and implementation of a new strategy. The risk register saw a 14% reduction in open risks, supported by improved triangulation of feedback, incidents, and board-level risk escalation. Staff engagement and psychological safety improved, with national recognition as the 4th most improved Trust in the 2024 staff survey. Speak Up systems saw a 15% year-on-year rise in concerns raised, with 87% of staff completing Speak Up training.

2.1.1. Quality Priorities 2024 to 2025				
Domain	**Description**	**Key Focus Areas**	**How we Measured Success**	**Achievements to Date**
Effective	**Priority 1: Build quality improvement (QI) capability and capacity** Good governance • Excellent responsiveness to incidents • Learning from incidents Reason: Adoption of quality improvement to become an integral part of everything we do requires an infrastructure that supports all staff.	Digital transformation	**Staff Training Engagement**: ENHPS training program launched, with 731 staff (10.3% of workforce) completing the introduction course and 42 senior leaders participating in the intensive leadership program, demonstrating strong initial adoption that establishes the foundation for our quality management transformation.	• Successfully embedded East and North Hertfordshire Production System (ENHPS) in partnership with Virginia Mason Institute with a fully staffed office complement. • Implemented methodologies for both daily quality management & continuous improvement using kaizen principles.
		Ward to board assurance of Patient Safety Incident Response Framework (PSIRF) safety standards	• Increased Incident reporting rates with substantial year-on-year improvement. • Increased number of good care reporting across the Trust. • Thematic reviews to identify cross-cutting learning opportunities across specialties	• Successfully transitioned to the Patient Safety Incident Response Framework (PSIRF) in November 2023, with Board-approved Policy and Plan • Achieved 20% increase in incident reporting (16,502 in 2024/25 vs 13,767 in 2023/24), demonstrating enhanced safety learning culture. • Implemented Learning from Patient Safety Events system, capturing 582 "good care" events in 2024/25 • Commissioned 17 Patient Safety Incident Investigations, supporting thorough safety reviews and systemic learning

Plans for 2025/26- EFFECTIVE:

- Embed PSIRF through agile development of our incident reporting system to support real-time ward-to-board oversight, internal monitoring, and national reporting.
- Expand thematic reviews and standardised learning, applying a systems approach to cross-cutting safety risks and supporting directorates with targeted improvement pathways.
- Grow leadership capability in quality improvement, increasing participation in the ENHPS for Leaders programme from 60 to 90 and embedding QI methods across divisions.
- Deliver our digital transformation roadmap, completing the OneEPR rollout, implementing AI-supported waiting list optimisation, and launching patient portal access as part of outpatient redesign.
- Advance our equity and inclusion goals, ensuring the EDI strategy is embedded through the Trust's EDI Steering Group and integrated into all improvement workstreams.

Progress against these priorities will be tracked through the Trust's Quality & Safety Committee, Risk and Audit Committee, and Divisional boards

** Pathways to Excellence: Following a strategic review, the Trust is refreshing the framework in which this strategy will be integrated going forward. A data-driven Pathways to Excellence Framework—now a 2025/26 strategic priority—will be co-design to deliver an aggregated recognition table to ensure sustainable improvement in quality standards. **

2.1.2. Adult and paediatric deteriorating patients (including sepsis)

<table>
<tr><th>Domain</th><th>Description</th><th>Key Focus Areas</th><th>How we Measured Success</th><th>Achievements to Date</th></tr>
<tr><td rowspan="2">Safe</td><td rowspan="2">Valuing the basics: Keeping our patients safe</td><td>Adult and paediatric deteriorating patients (including sepsis)</td><td>Achieve >95% in sepsis pathway compliance
Achieve 50% compliance with reliability of all observations
Improve physiological observation assessment competencies for nursing staff.</td><td>Sustained increase in sepsis compliance performance year on year.
<table>
<tr><td></td><td></td><td></td></tr>
<tr><td>Antibiotics in Emergency Department (ED) within an hour</td><td>83%</td><td>89%</td></tr>
<tr><td>Antibiotics on the ward within an hour</td><td>64%</td><td>82%</td></tr>
<tr><td>Neutropenic sepsis antibiotic within an hour</td><td>67%</td><td>88%</td></tr>
<tr><td>ED Sepsis six bundle</td><td>60%</td><td>74%</td></tr>
<tr><td>Inpatient (IP) Sepsis six bundle</td><td>37%</td><td>56%</td></tr>
</table></td></tr>
<tr><td>Documentation – adopt new documentation standard to include SBARD Tool (Situation, Background, Assessment, Recommendation, and Decision)</td><td>Improved communication and escalation for deteriorating patients
Simulations training</td><td>SBARD week held to promote use of the communication tool.</td></tr>
</table>

		National pilot for Martha's rule and imbed call for concern	• Full implementation of components 2 and 3 (escalation routes for staff, patients, and families) across all inpatient wards, maternity, paediatrics, and ED • Pilot of component 1 (patient wellness question) in one ward area, with ongoing collaboration on data collection • Volume of Activation Calls • Clinical Outcomes & Interventions arising from the use of Martha's rule • Equity & Inclusion Insight using demographic data • Process improvements	• 100% of Martha's Rule calls received in-person clinical assessments, resulting in 25% ITU reviews, 48% of patients remaining under CCOT review for over 48 hours, and one patient (100% of applicable cases) directly transferred to ITU as a result of a family-initiated escalation. • Full rollout of MR escalation routes (components 2 & 3) across all key clinical areas. • Ranked third in the region for the volume of Martha's Rule activation calls, indicating effective uptake of the escalation process. • Active participation in regional and national learning collaboratives. • Progress towards integrating MR into digital systems (OneEPR), Enhance for data triangulation with incidents and complaints. • Identified areas for improving equity of access to MR, guiding future improvement work.

Plans for sustainability 2025/26:

Sepsis:

- Sustain and Improve current improved sepsis bundle compliance and target further incremental improvements.
- Improve fluid balance documentation compliance by +10% from current baseline by Q4.
- Enhance clinical knowledge and practice through continued multi-disciplinary sepsis education.

SBARD Tool:

- We will continue to deliver targeted training on communication and escalation protocols to ensure effective embedding into practice.

Martha's Rule: Call for Concern:

- Strengthen acute patient care capacity by supporting enhanced care beds, implementing a Hospital at Night model, merging Sepsis and CCOT teams into an Acute Response Team, and expanding paediatric response capabilities.

2.1.3. Medicines management and antibiotic stewardship

Domain	Description	Key Focus Areas	How we Measured Success	Achievements to Date
Safe	**Priority 2: Keeping our Patients Safe.** Valuing the basics: Keeping our patient's safe Reason: Part of our quality goals within the Trust's quality strategy- valuing the basics and keeping our patients safe (2019-2024)	Medicines management and antibiotic stewardship	• Implementation of Trust's medicines optimisation strategy (100%) • Improve critical medicines omission rate ≤3.5% • Antimicrobial stewardship 24-72-hour review compliance ≥90% • Medicines management training completion >90% • Maintain pathway compliance rates >90% across all departments • Increase audit sample sizes by 300% during focused review periods	• 100% implementation of Trust's medicines optimisation strategy, including development of Power BI KPI dashboard and ePMA benefits realisation. • Achieved critical medicines omission rate of 3.9%, slightly above target of ≤3.5% due to staffing challenges and winter pressures • Attained 84.8% compliance with antimicrobial stewardship 24-72-hour reviews, approaching but not meeting 90% target. • Implemented weekend reviews of high-risk antibiotics, significantly reducing incidents related to monitoring of complex antimicrobials • Achieved 74% completion rate for medicines management training (doctors, nurses, pharmacists), below >90% goal • Successfully implemented anticholinergic burden identification system supporting ICB de-prescribing initiative • Developed manual prioritisation system for ward-based pharmacy teams and built additional Lorenzo ePMA order sets

Plans for sustainability 2025/26:

- We will continue to focus on implementing the integrated Orbis U system, enhancing electronic prescribing capabilities, improving training compliance to 90%, strengthening antimicrobial stewardship, optimising discharge procedures, and standardising cross-departmental audit methodologies to address identified performance gaps while maintaining our achievements in medicines optimisation and pathway safety.

2.1.4. Infection prevention control (IPC) – C.Diff improvement programme

Domain	Description	Key Focus Areas	How we Measured Success	Achievements to Date
Safe	**Priority 2: Keeping our Patients Safe.** Valuing the basics: Keeping our patients' safe	Infection prevention control (IPC) – C.Diff improvement programme	• C. difficile infection threshold ≤92 cases for 2024/25. • MRSA bacteraemia threshold of 0 cases • Carbapenems Producing Organisms threshold of 0 cases • E. coli blood stream infections threshold ≤55 cases. • Pseudomonas aeruginosa BSI threshold ≤12 cases • IPC Level 1 and Level 2 e-learning sessions completion rates (target >90%)	• Successfully implemented peripheral intravenous cannulation competency program. • Reduced C. difficile infections to 86 cases (6.5% reduction from 2023/24) against threshold of 92. • Established weekly C. difficile MDT meetings led by Medical Director or Chief Nurse • 99% of hospital onset C. diff cases reviewed (deemed clinically unavoidable) • Achieved 98% completion of IPC training (up from 93% last year) • Improved antimicrobial stewardship with enhanced 24-72 hour review processes. • Reduced E. coli BSI by 9% compared to previous year (52 cases vs. threshold of 55). • Limited MRSA bacteraemia to 2 cases for 2024/25

Plans for sustainability 2025/26:

- Maintain weekly C. difficile MDT reviews to sustain reductions in infection rates.
- Extend our Aseptic Non-Touch Technique competency training program to all clinical areas and embed into routine practice.
- Continue collaborative work with specialty teams to refine post-infection learning and strengthen PPE training for high-risk pathways

2.1.5. Safeguarding oversight

Domain	Description	Key Focus Areas	How we Measured Success	Achievements to Date
Safe	**Priority 2: Keeping our Patients Safe.** Valuing the basics: Keeping our patients' safe	Safeguarding oversight and triangulation with other domains of quality	• Increase in safeguarding referrals through enhanced awareness & training • Increased safeguarding training compliance with intercollegiate document standards • Improved outpatient attendance for patients with learning disabilities	• Achieved historic high levels of safeguarding referrals for both adults and children likely due to enhanced awareness/identification by staff teams. • Maintained Trust Domestic and Sexual Abuse Team (DSAT) supporting almost 600 victims. As a result of our work, the Police and Crime Commissioner's office has extended the DSAT service grant through to the end of the 2025/26 financial year due to its demonstrated success. • Completed 815 Deprivation of Liberty Safeguards applications (8.1% increase from previous year) • Increased attendance rates for patients with learning disabilities through 'was not brought initiative' • Ensured all safeguarding policies are in date and ratified

Plans for sustainability 2025/26:

- We will continue and expand the DSAT service under extended funding through 2025/26.
- Enhance training on safeguarding recognition and escalation for all staff.
- Develop targeted services to better meet the needs of individuals with learning disabilities and autism
- Strengthen our collaborative work with external safeguarding MDT

2.1.6. Invasive procedures LocSSIP Compliance

Domain	Description	Key Focus Areas	How we Measured Success	Achievements to Date
Safe	**Priority 2: Keeping our Patients Safe.** Valuing the basics: Keeping our patients' safe	Invasive procedures LocSSIP compliance across non theatre specialties	• Compliance Percentage Tracking: Average compliance rate of > 92% across all audited patient pathways. • Quality and consistency of safety checks in Local Safety Standards for Invasive Procedures (LocSSIPs) • >95% department participation rate in pathway safety monitoring • >90% adherence to standardised documentation across all clinical areas.	• Achieved sustained compliance rates of >90% across patient pathway audits for 95% of measured time periods. • Expanded monitoring coverage by 300% in specialised departments (Ophthalmology, Radiology) compared to baseline with focused quality improvement initiatives. • Improved data collection with 400% larger sample sizes (from ~35 to ~140) during focused audit periods. • Demonstrated 100% implementation of standardised audit methodology across all six clinical areas which reflects a consistent audit approach shown across all departments. • Maintained >95% compliance in documentation standards during peak activity periods.

Plans for sustainability 2025/26:

- We will conduct a comprehensive review of all sites delivering invasive procedures.
- We will conduct focused audits to assess both the quality of LocSSIPs and the consistency of their application in practice
- Establish a cross-departmental learning framework to share best practices and address variation

2.1.7. End of life care – Gold Standards Framework (GSF)

Domain	Description	Key Focus Areas	How we Measured Success	Achievements to Date
Safe	**Priority 2: Keeping our Patients Safe** Valuing the basics: Keeping our patients safe	End of life care – Gold Standards Framework (GSF)	• Completion of GSF implementation phases and accreditation • Staff confidence questionnaires pre and post training • After Death Analysis Audit Tool to track preferred place of death achievement • Assessment of Advanced Care Planning documentation completion rates • Number of staff and wards trained in GSF principles	• Successful integration of 7 key GSF outcomes in clinical practice across trained wards • Successfully implemented a phased GSF approach with Phase I completed and accredited (September 2023) • Phase II completed and accredited (September 2024) covering 4 wards (5b, 10b, Ashwell & Pirton) • Phase III implementation completed covering 4 wards (Barley, CCU, 9a, 9b), currently awaiting accreditation • Trained minimum of 2 staff per ward across 10 wards to date (Phase I-III) • Implemented systematic identification of patients in last year of life using Surprise Question approach • Established Advanced Care Planning conversations as standard practice • Improved documentation of patient preferences including preferred place of death • Enhanced staff confidence in end-of-life care delivery through structured training

Plans for sustainability 2025/26:

- We will complete the implementation of Phase IV (commenced April 2025) covering 4 additional wards (10a, 8a, 6b, 7a) with e-portfolios submissions & continuous training through March 2026 to embed principles
- We will continue systematic monitoring of Advanced Care Planning completion and preferred place of death achievement
- We will support wards with GSF Gold Standard Accreditation to maintain standards for 3-year accreditation period
- We will prepare phase I wards for potential Platinum status accreditation
- We will further embed GSF principles to ensure sustainability despite staff turnover & participate in completing national GSF team assessment visits for Phase IV wards.

2.1.8. Medical devices – improved EBME service and equipment library.

Domain	Description	Key Focus Areas	How we Measured Success	Achievements to Date
Safe	Valuing the basics: Keeping our patients safe	Medical devices – improved EBME service and equipment library	• Improved inventory oversight (through systematic tracking of medical devices, enabling real-time visibility of usage, maintenance needs, and availability. • Maintenance logs compliance monitored via logged service records, ensuring timely and documented completion of device servicing. • Digital enhanced safety assurance by tracking completion rates of compliance checks and certification renewals, supporting regulatory readiness. • Incident reduction and learning by using ENHance to analyse year-on-year trends and drive safety improvements. • User-informed improvement through regular collection & review of feedback to guide device-related enhancements and training.	• Achieved 93% service compliance and 90% repair compliance for hospital equipment in FY 2024–25, with strategies in place to further improve scheduling and tracking • 15.24% of medical devices (2,515 of 16,492), RFID-tagged and audited with full completion targeted by year-end. Tracking scanners are being integrated into the IT network to enhance visibility and control. • Risk-Based Preventive Planned Maintenance (PPM) schedule implemented prioritising high-risk equipment to improve safety and efficiency • Efficient Equipment Use: The Equipment Library loaned 2,367 devices Trust-wide, ensuring timely access to vital equipment and minimising care disruption. • Proactive Capital Planning: Developed a 5-year capital replacement plan to forecast needs and reduce financial risk by systematically replacing aging or obsolete devices. • Digital Integration: Supported EPR implementation by ensuring equipment compatibility, enabling seamless data flow and improved patient care.

Plans for sustainability 2025/26:

- Continued EPR integration support to future-proof device connectivity and enhance digital transformation efforts across the Trust.
- Full RFID rollout by year-end to improve long-term asset tracking and operational efficiency.

2.1.9. Patient & Carer Experience (PACE) Programme

Domain	Description	Key Focus Areas	How we Measured Success	Achievements to Date
Patient Experience	**Priority 3:** **Patient & Carer Experience (PACE) Programme** **Reason: Further improvements required to embed and sustain progress made.**	Excellent engagement and co-design following patient safety incidents	We acknowledge that while significant progress has been made in developing our PSIRF engagement processes, we have not achieved our ambition to fully demonstrate measurable impact from these initiatives over the past 12 months. Our analysis reveals that although we have successfully established co-design processes with families and staff for Patient Safety Incident Investigations, implemented focus groups with appropriate support mechanisms, and facilitated Board-level story sharing, we require enhanced data collection to evidence the effectiveness of these approaches. We have identified gaps in quantitative metrics, engagement satisfaction measures, and outcome tracking that would typically demonstrate comprehensive stakeholder involvement and improvement impact.	
		Responsiveness to complaints- driving improvements across key themes: We acknowledge limited progress against our complaint responsiveness targets over the past 12 months. However, this period has provided valuable insights into implementation challenges, enabling us to identify specific opportunities for improvement. Our analysis confirms that while our complaint resolution framework is robust, consistent execution across all organisational levels requires strengthening. We have identified key areas where enhanced coordination and adherence to established timelines between clinical areas, divisional teams, and central complaints functions will significantly improve our responsiveness.		

Priorities for 2025/26:

Engagement and Co- design following patient safety incidents

- Establish comprehensive measurement frameworks for PSIRF engagement by March 2026, including real-time feedback systems, satisfaction metrics from involved parties, and demonstrable evidence of improvements implemented through co-design processes

Complaints Responsiveness

- Strengthen Divisional Accountability and Escalation (Achieve 85% of complaints resolved within agreed timescales by March 2026 through enhanced divisional accountability and improved first-time response quality)
- Enhance Response Quality and Coordination: (Achieve 90% first-time comprehensive complaint responses by March 2026 through strengthened divisional-central team coordination and improved communication pathways).

2.1.10. Good governance compliance framework

Domain	Description	Key Focus Areas	How we Measured Success	Achievements to Date
Well Led	**Priority 4:** Good governance compliance framework Reason: Part of our quality goals within the Trust's quality strategy- valuing the basics and keeping our patients safe (2019-2024)	Staff survey • Staff engagement & morale • People Promise implementation • Equality, Diversity and Inclusion (EDI)	• >50% staff survey response rate • Improved National Staff Survey scores across People Promise elements • National ranking for improvement in survey results	• Nationally recognised as 4th most improved Trust • Detailed scores for all seven People Promise elements • Overall Staff Engagement score improved from 6.80 to 6.89 • Morale score improved from 5.78 to 5.93 • 50.4% staff survey completion rate
		Embedding Risk Management Strategy	• Review number of open risks • Percentage of risks in approved stage review • Compliance with standardised 5x4 risk scoring metrics (ISO standards) • Commissioned external validation of risk management approach	• Demonstrated risk reduction by 14% from 532 in April 2024 to 459 in March 2025, demonstrating more sustainable approach. • Improved risk triangulation with incidents and patient feedback • Established clear risk escalation pathway from divisional level to Risk Management Group for high-rated risks

Plans for sustainability 2025/26:

Staff survey

- We will give continued focus on 'Voice that counts' theme with additional focus on developing Reward and Recognition initiatives
- We will reduce discrimination through EDI strategy and training and share narratives from FTSU Champions.

Risk Management

- We will develop formal e-learning digital risk management training programme
- We will expand the risk register functionality in our electronic system- Enhance
- We will continue to iteratively improve cross cutting narrative between Corporate Risk management priorities and Board Assurance Framework
- We will continue to embed & further develop cross-referencing between risks, incidents & patient feedback on our digital platform

2.1.11. Quality Assurance framework and Freedom to Speak Up

Domain	Description	Key Focus Areas	How we Measured Success	Achievements to Date
Well Led	**Priority 4:** Good governance compliance framework	Quality assurance framework – standardised across new operational management model	Since the launch of our Quality Strategy in 2019, & Quality Governance Standard Framework in 2023/244 we have made significant strides in embedding a whole-system approach to quality—framing our work across planning, assurance, and improvement. Success has been measured through • enhanced oversight of clinical risk, • increased reliability of care processes, • strengthened patient and carer engagement, and • improved staff capability in delivering safe, effective services.	• Delivered on Patient Safety Incident Response Framework (PSIRF), co-designed with patients and carers, enabling a more compassionate, learning-oriented response to harm. • Established a comprehensive Quality Governance Standards Oversight Framework with clear lines of accountability at both divisional and system levels • Scaling of in-situ simulation training to support early recognition and management of deteriorating patients and sepsis. • Implementation of the Gold Standards Framework to enhance quality and consistency of end-of-life care • Development and roll-out of 'ENHance', a trust-wide digital platform that improves data access, quality oversight, and real-time decision-making
		Freedom to speak up- strengthening the FTSU MDT network	• Increased number of staff speaking up to raise concerns • Percentage of staff completing Speak Up training • Percentage of managers completing Listen Up training • Number and distribution of Speak Up Champions across staff groups • Staff survey responses regarding confidence in the speak up process • Reduction in anonymous concerns/whistleblowing	• Increased speaking up episodes to 311 in 2024/25- sustained year-on-year growth (from 190 in 2022/23 and 270 in 2023/24) • Enhanced service capacity with speaking up support accessible 5 days per week, including weekends • Achieved 87% completion rate for Speak Up training and 83% for managers' Listen Up training • Expanded FTSU Champion network to 40 representatives across all professional streams • Eliminated anonymous FTSU cases completely (0 in 2024/25)

Plans for sustainability 2025/26:

Quality assurance framework

- We will continue to ensure alignment with Trust strategic objectives and the Integrated Care System's transformation programmes.
- We will continue to embed Valuing the Basics and Good Governance principles as foundational to how care is delivered and monitored.
- We will continue to develop a learning health system, supported by digital innovation, patient safety partners, and a culture of continuous improvement
- We will continue to strengthen triangulation across patient experience, complaints, and incident data, particularly in post-incident support and carer involvement

Freedom to speak up

- We will continue to expand healthy teams action plan to promote psychological safety, with emphasis on compassionate accountability
- We will continue our collaborative work between FTSU Guardian, OD team and Governance to embed learning from Speak Up themes
- We will ensure protected time for Speak Up Champions to carry out their work
- We will ensure FTSU accessibility across all staff groups, with proportional representation from diverse ethnic backgrounds
- We will ensure Speak Up training completion for remaining 13% of staff and Listen Up training for remaining 17% of managers
- We will develop coaching for managers to enhance their ability to respond effectively to staff concerns.
- We will implement formal service level agreement between FTSU function and People Team with agreed timeframes for responses and actions
- We will integrate FTSU reports into Audit and Risk Committee and Quality and Safety Committee discussion

2.1.12. People strategy – Equality diversity and inclusion (EDI) actions

Domain	Description	Key Focus Areas	How we Measured Success	Achievements to Date
Well Led	Good governance compliance framework	Clinical leadership programmes- nursing excellence faculty	Increase in education and development places	• 118 students across all programmes on site (excluding 100 UCL & 200 Cambridge medical students- yr 4-6) • 99 staff enrolled on the preceptorship programme • Preceptorship team shortlisted for Nursing Times Workforce Award • Staff satisfaction with flexible working improved from 6.17(2023) to 6.35 (2024), exceeding acute sector average of 6.24
		People strategy – Equality diversity and inclusion (EDI) actions		• Recruitment training on unconscious bias developed in 2024; to become mandatory in 2025/26 • EDI action plan workbook implemented • EDI Steering Group established to lead Trust-wide Inclusion work • Staff Network membership expanded with successful events including EID, Windrush Day & Pride participation

Plans for sustainability 2025/26:

- We will continue to address race discrimination and harassment
- Support staff disclosure of experiences with programmes in place to reduce harm from public and staff related incidents

2.2 Highlighted below are our 2025/26 priorities which are aligned with the Trust's objective priorities. These priorities were developed following appropriate consultation with relevant parties and presented to Trust Leaders

Quality Priorities 2025 to 2026			
Domain	**Quality Priority**	**Key Focus Areas**	**How We Measure Success**
Safe	**#Priority 1** Strengthening Fundamentals of Care & Governance (**All Divisions)**	• Daily incident huddles to support safety culture • Embedding of PSIRF processes at ward and site level • Governance standardisation • Closing the loop on learning from harm Safe staffing, core standards (NEWS2, escalation)	• Reduction in overdue incident closures • Compliance with core standards (NEWS2, Obs, escalation) • Staff feedback on basic care delivery
Well Led	**#Priority 2** Embedding a Learning Culture and PSIRF **(Planned, Unplanned & Cancer Services) (Trust-wide Governance)**	• Trust-wide PSIRF training and learning response adoption • Consistent incident response tools (e.g., Swarms, AARs) • Leadership visibility on safety themes and closures • Systematic use of governance tools and the Good Governance Matrix	• % learning responses completed using PSIRF tools • Audit compliance with learning closure loops • Safety culture metrics (staff survey, FTSU themes) • Standardised reporting across divisions
	#Priority 3 Embedding Leadership for Quality Improvement **(Trust-wide leadership and divisional QI leads)**	• Continued leadership development and ENHPS implementation • Divisional QI projects aligned to Trust priorities • Inclusive and resilient clinical engagement • Expansion of QI capability through coaching and training	• ENHPS adoption rates • Participation in QI training • Divisional QI initiatives linked to Trust goals • Clinical engagement metrics"

Domain	Quality Priority	Key Focus Areas	How We Measure Success
Effective	**#Priority 4** Quality-Driven Pathways Transformation (incl. Digital) **(Planned Care, Digital, Estates, Cancer)**	• Elective and emergency pathway redesign (same-day surgery, emergency theatre access) • Use of digital tools (OneEPR, remote MDTs) • Outpatient transformation and centralised booking • Estates improvements to streamline care delivery	• Improved waiting times & pathway efficiency (theatres, diagnostics) • Adoption of OneEPR functions • Increase in care closer to home (e.g. SACT)
Patient Experience	**#Priority 5** Person-Centred and Seamless Pathways **All divisions (esp. Women & Children's, Unplanned Care, Cancer)**	• Improved discharge coordination and continuity of care • Improving community paediatrics pathways of care • Establish effective seamless pathways in maternity - reducing delays in transfer of IOL's to delivery suite by 50% • MDT planning and personalised transitions • Reduction in readmission through seamless step-down care	• Discharge planning compliance • PALS/complaints themes on transitions • 50% reduction in transfer delays from IOL to delivery suite (baseline measurement required) • Percentage of IOLs transferred within target timeframe (e.g., <2 hours) • Percentage of referrals processed within agreed timeframes (baseline vs. target) • Pathway completion rates (children completing full care pathway) • Maternal satisfaction scores regarding transfer experience
	#Priority 6 Tackling Health Inequalities and Promoting Equity **(Women & Children's, Cancer, Trust-wide Strategy)**	• Targeted equity actions in maternity and paediatrics • NICU outreach and community transition models • Expanding access to cancer treatment closer to home • Use of local population data to prioritise access improvement'	• Reduction in access gaps (e.g. Paediatrics, NICU outreach • Development & triangulation of Local data on underserved populations • Patient engagement feedback loops

These quality priorities and other key quality indicators will be monitored regularly with oversight at various quality and patient safety forums. A quarterly report on progress against these priorities will be produced for the Trust Management Group and the Quality and Safety Committee.

2.3. Statements of Assurance from the Board

2.3.1. Review of services

The Trust continues to provide a range of acute and specialised services in 2024/25, including directly provided and sub-contracted services across four care divisions. The Trust has reviewed the data across all the relevant health services and operated in accordance with the NHS Operating Framework. For further details please refer to the Trust Annual Report.

2.3.2. Participation in clinical audits

East and North Hertfordshire NHS Trust (ENHT) continues to maintain a robust clinical audit programme, with ongoing reviews to ensure improvements in clinical practice, patient experience, and outcomes can be evidenced. In 2024/2025, the Trust was eligible to participate in 74 National Clinical Audit and Patient Outcomes Programmes (NCAPOP) and other national quality improvement initiatives, and actively engaged in 69 (93%) of those aligned with its services, following NHS England's guidance on prioritisation.

The Trust was ineligible for 26 national audits, primarily where specific services were not provided. This included several audits in Oral and Maxillofacial Surgery (oncology, trauma, reconstruction, and orthognathic surgery), cardiology and cardiovascular procedures (e.g., cardiac surgery, congenital heart disease, TAVI, LAAO, PFO closure), respiratory services (Pulmonary Rehabilitation, Pulmonary Hypertension), diabetes and obesity (National Obesity Audit, Diabetes Prevention Programme), and specialist surgery areas such as bariatric surgery and cleft services.
In mental health, the Trust did not participate in Prescribing Observatory for Mental Health (POMH) audits covering rapid tranquillisation, melatonin, and opioids, and was also ineligible for the National Clinical Audit of Psychosis and the Mental Health Clinical Outcome Review Programme. Participation was similarly not applicable to a range of paediatric and emergency audits, such as the Paediatric Intensive Care Audit Network and the Out-of-Hospital Cardiac Arrest Outcomes audit.

2.3.3. National Clinical Audit & Patient Outcomes Programme (NCAPOP) & NHS England prioritised national quality improvement programmes participation

The Trust's participation in NCAPOP and other prioritised national quality improvement programmes with completed data collection in 2024–2025 is summarised below, showing the number of cases submitted as a percentage of eligible cases.

Audit programme	Workstream	Participated?	Cases submitted	Case ascertainment
National Adult Diabetes Audit (NDA)	National gestational diabetes mellitus audit	Y	Data not available at time of reporting	
Medical and Surgical Clinical Outcome Review Programme (NCEPOD)	Acute limb ischaemia	Y	7/7 clinical questionnaires & 1 organisational questionnaire	100%
Child Health Clinical Outcome Review Programme (NCEPOD)	Emergency paediatric surgery	Y	14/14 clinical questionnaires & 1 organisational questionnaire	100%
Medical and Surgical Clinical Outcome Review Programme (NCEPOD)	Rehabilitation following critical illness	Y	6/6 clinical questionnaires & 1 organisational questionnaire	100%
Medical and Surgical Clinical Outcome Review Programme (NCEPOD)	Blood sodium	Y	7/7 clinical questionnaires & 1 organisational questionnaire	100%
Child Health Clinical Outcome Review Programme (NCEPOD)	Juvenile idiopathic arthritis	Y	4/5 clinical questionnaires & 1 organisational questionnaire	80%
UK Renal Registry	Chronic Kidney Disease Audit	Y	Data not available at time of reporting	100%
UK Renal Registry	National Acute Kidney Injury Audit	Y	336	100%
Society for Acute Medicine's Benchmarking Audit (SAMBA)		Y	112	95.70%
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme		Y	19	100%
National Comparative Audit of Blood Transfusion	Audit of NICE Quality standard QS138	Y	49	100%
National Comparative Audit of Blood Transfusion	Reaudit of Bedside Transfusion Practice	Y	14	140%
Sentinel Stroke National Audit Programme (SSNAP)		Y	883	>90%
Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS):	Non-melanoma skin cancers	N		

Audit programme	Workstream	Participated?	Cases submitted	Case ascertainment
Perioperative Quality Improvement Programme (PQIP)		Y	169	Data not available at the time of reporting
National Vascular Registry (NVR)		Y	AAA repair 18 cases, carotid procedure 23 cases, lower limb bypass 23 cases, lower limb angioplasty 21 cases & lower limb amputation 18 cases	Data not available at the time of reporting
National Respiratory Audit Programme (NRAP)	Chronic Obstructive Pulmonary Disease (COPD) Secondary Care	Y	329	Data not available at the time of reporting
National Respiratory Audit Programme (NRAP)	Adult Asthma Secondary Care	Y	134	Data not available at the time of reporting
National Cancer Audit Collaborating Centre (NATCAN)	National Lung Cancer Audit (NLCA)	Y	211	100%
National Respiratory Audit Programme (NRAP)	Children & young people asthma in secondary care	Y	Data not available at time of reporting	
National Paediatric Diabetes Audit (NPDA)	Care and outcomes	Y	Data not available at time of reporting	
National Child Mortality Database (NCMD)	National Child Mortality Programme	Y	Data not available at time of reporting	
National clinical audit of seizures and epilepsies for children and young people (Epilepsy12)		Y	Data not available at time of reporting	
Perinatal Mortality Review Tool (PMRT)		Y	Data not available at time of reporting	
National Maternity and Perinatal Audit (NMPA)		Y	Data not available at time of reporting	
National Ophthalmology Database (NOD)	Age-related Macular Degeneration Audit	N		
National Ophthalmology Database (NOD)	Cataract Audit	N		
National Adult Diabetes Audit (NDA)	National Diabetes Core Audit	Y	Data not available at time of reporting	

Audit programme	Workstream	Participated?	Cases submitted	Case ascertainment
National Adult Diabetes Audit (NDA)	National Diabetes Footcare Audit (NDFA)	Y	230	100%
National Adult Diabetes Audit (NDA)	National Diabetes Inpatient Safety Audit (NDISA)	Y	Data not available at time of reporting	
National Adult Diabetes Audit (NDA)	National Pregnancy in Diabetes Audit (NPID)	Y	68	100%
National Adult Diabetes Audit (NDA)	Transition (Adolescents and Young Adults) and Young Type 2 Audit	Y	Data not available at time of reporting	
BAUS Data & Audit Programme	BAUS Penile Fracture Audit	Y	1	100%
BAUS Data & Audit Programme	BAUS I-DUNC (Impact of Diagnostic Ureteroscopy on Radical Nephroureterectomy and Compliance with Standard of Care Practices)	Y	Data not available at time of reporting	
BAUS Data & Audit Programme	Environmental Lessons Learned and Applied to the bladder cancer care pathway audit (ELLA)	Y	Data not available at time of reporting	
National Cancer Audit Collaborating Centre (NATCAN)	National Kidney Cancer Audit (NKCA)	Y	Data not available at time of reporting	
National Cancer Audit Collaborating Centre (NATCAN)	National Prostate Cancer Audit (NPCA)	Y	Data not available at time of reporting	
National Cancer Audit Collaborating Centre (NATCAN)	National Ovarian Cancer Audit (NOCA)	Y	Data not available at time of reporting	
National Major Trauma Registry		Y	Data not available at time of reporting	
Royal College of Emergency Medicine (RCEM)- Emergency Medicine QIPs	Adolescent Mental Health	Y	Data not available at time of reporting	

Audit programme	Workstream	Participated?	Cases submitted	Case ascertainment
Royal College of Emergency Medicine (RCEM)- Emergency Medicine QIPs	Time Critical Medications	Y	Data not available at time of reporting	
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)		Y	Data not available at time of reporting	
Royal College of Emergency Medicine (RCEM)- Emergency Medicine QIPs	Care of Older People	Y	Data not available at time of reporting	
Royal College of Emergency Medicine (RCEM)- Emergency Medicine QIPs	Mental Health: self-harm	Y	Data not available at time of reporting	
National cardiac audit programme (NCAP)	National Heart Failure Audit (NHFA)	Y	Data not available at time of reporting	
National cardiac audit programme (NCAP)	Cardiac Rhythm Management (CRM)	Y	Data not available at time of reporting	
National cardiac audit programme (NCAP)	Myocardial Ischaemia National Audit Project (MINAP)	Y	Data not available at time of reporting	
National Audit of Cardiac Rehabilitation		Y	2019	Data not available at the time of reporting
Intensive Care National Audit & Research Centre (ICNARC)	National Cardiac Arrest Audit (NCAA)	y	107	100%
Intensive Care National Audit & Research Centre (ICNARC)	Case Mix Programme (CMP)	Y	491	100%
National Cancer Audit Collaborating Centre (NATCAN)	National Audit of Metastatic Breast Cancer (NAoMe	Y	Data not available at time of reporting	
National Cancer Audit Collaborating Centre (NATCAN)	National Audit of Primary Breast Cancer (NAoPri)	Y	Data not available at time of reporting	
National Joint Registry (NJR)		Y	1050	98.50%
Falls & Fragility Fractures Audit Programme (FFFAP)	National hip fracture database (NHFD)	Y	420	99.10%
National Early Inflammatory Arthritis (NEIAA)		Y	138	100%
National Cancer Audit Collaborating Centre (NATCAN)	National Bowel Cancer Audit (NBOCA)	Y	Data not available at time of reporting	
British Hernia Society Registry		N		

Audit programme	Workstream	Participated?	Cases submitted	Case ascertainment
National Cancer Audit Collaborating Centre (NATCAN)	National oesophago-gastric cancer (NOGCA)	Y	Data not available at time of reporting	
National Cancer Audit Collaborating Centre (NATCAN)	National Pancreatic Cancer Audit (NPaCA)	Y	Data not available at time of reporting	
National Cancer Audit Collaborating Centre (NATCAN)	National Non-Hodgkin Lymphoma Audit (NNHLA)	Y	43	100%
National Audit of Dementia (NAD)		Y	Data not available at time of reporting	
Breast and Cosmetic Implant Registry (BCIR)		Y	25	
Learning disability and autism programme - Learning from lives and deaths – People with a learning disability and autistic people (LeDeR)		Y	11	100%
Falls & Fragility Fractures Audit Programme (FFFAP)	National Audit of Inpatient Falls (NAIF)	Y	6	100%
National Audit of Care at the End of Life (NACEL)		Y	80	100%
National Emergency Laparotomy Audit (NELA)		Y	69	45%
National Emergency Laparotomy Audit (NELA)	No Laparotomy	Y	5	
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE)	Confidential enquiries into maternal deaths	Y	Data not available at time of reporting	
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE)	Perinatal Mortality Surveillance	Y	Data not available at time of reporting	
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE)	Perinatal Mortality and Morbidity Confidential Enquiries	Y	Data not available at time of reporting	
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE)	National surveillance of maternal deaths	Y	Data not available at time of reporting	
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE)	Confidential enquiries into maternal morbidity	Y	Data not available at time of reporting	

2.3.4. Reviewed National Clinical Audit and Patient Outcomes Programme (NCAPOP) reports

In 2024/2025, East and North Hertfordshire NHS Trust reviewed 15 National Clinical Audit and Patient Outcomes Programme (NCAPOP) reports, alongside a broader set of national audits across emergency care, critical care, stroke, maternity, and end-of-life services. The Trust achieved high compliance with national recommendations in most areas, demonstrating strong performance in most areas and a clear commitment to learning and continuous improvement**.** The Trust used insights gained to strengthen clinical quality, drive local service improvement, and ensure alignment with evidence-based practice.

Full compliance was achieved in audits covering oesophago-gastric cancer, lower limb amputation, neonatal care, infection control (2022–23), endometriosis, and cognitive assessments in older adults. These reflect strong multidisciplinary collaboration and quality oversight, with successes including faster cancer diagnosis times, robust COVID-19 symptom screening, and accurate pain and cognitive assessments in emergency care.
Where partial compliance was identified—such as in transitional care, end-of-life planning, sepsis management, stroke care, and perinatal mortality reviews—the Trust implemented targeted actions. These included introducing e-prescribing systems for timely antibiotic administration, enhancing stroke triage through AI and imaging protocols, developing personalised care plans, and strengthening perinatal governance through dedicated clinical leads and real-time action tracking.

Lessons learned across the audit reviews emphasised the need for improved isolation room capacity, earlier end-of-life conversations, and integrated mental health triage in EDs.
The Trust responded by enhancing pain assessment in fracture care, introducing shared access to mental health assessments, reviewing policies around mental health legislation, promoting shared clinical access to assessments, and embedding multidisciplinary planning. Delays in critical care discharges, identified through ICNARC, are being addressed through longer-term discharge planning solutions and real time monitoring.
These audit-driven improvements have positively influenced service design, operational performance, and patient safety, supporting the Trust's ongoing commitment to evidence-based, person-centred care.

Nos	Audit Title	Compliance	Key Action/Learning	Status
1	NATCAN Oesophago-Gastric Cancer	100%	Improved clinician attendance and diagnosis coding	Completed
2	NCEPOD Lower Limb Amputation	100%	All recommendations met	Completed
3	NNAP Neonatal Intensive and Special Care	100%	All recommendations met	Completed
4	RCEM Cognitive Impairment in Older People	100%	All recommendations met	Completed
5	RCEM Infection Prevention (2022/23)	100%	Excellent COVID symptom screening	Completed
6	NCEPOD Endometriosis	100%	All recommendations met	Completed

Table 2: Summary of reviewed National Clinical Audit and Patient Outcomes Programme (NCAPOP) reports

2.3.5. Local clinical audits

Nos	Audit Title	Compliance	Key Action/Learning	Status
7	NCEPOD Cancer in Children, Teens and Young Adults	85%	Introduce e-prescribing and staff retraining for timely antibiotics in sepsis	In Progress
8	NCEPOD End of Life Care	83%	Implement GSF training and normalise palliative discussions	In Progress
9	RCEM Mental Health (Self-Harm)	83%	Develop triage process and mental health policy	In Progress
10	NCEPOD Transitional Care	75%	Ensure consistent use of personalised care plans	In Progress
11	NCEPOD Cancer in Children, Teens and Young Adults	75%	Improve isolation room availability	In Progress
12	Perinatal Mortality Review Tool	75%	Appointed leads, central action log, improved MDT oversight	In Progress
13	RCEM Fractured Neck of Femur	50%	Improve pain scoring and documentation	In Progress
14	SSNAP Stroke Care	50%	AI decision support, improve access to stroke unit and rehab	In Progress
15	ICNARC Critical Care (CMP)	Not rated	Address discharge delays; improve planning	In Progress

In 2024/25, East and North Hertfordshire NHS Trust carried out 110 local clinical audits across a wide range of specialties, reflecting a strong organisational commitment to quality improvement and evidence-based care. The audits covered clinical, diagnostic, and support services, with a focus on high-impact areas such as Obstetrics, Trauma and Orthopaedics, Cancer Services, Pharmacy, Emergency Medicine, and ENT & Audiology. Key themes included safe prescribing, guideline compliance, documentation standards, patient safety in complex clinical scenarios, and the effectiveness of multidisciplinary care pathways.

Many of these audits aligned with national priorities, including the Maternity Incentive Scheme, GIRFT, and the Ockenden recommendations. Outcomes from the audits supported targeted improvements such as enhanced obstetric documentation, safer antibiotic practices, and better adherence to imaging protocols.

	Project title & reference
Obstetrics	Venous thromboembolism in adults / reducing risk in hospital QS201: Antenatal and postnatal VTE management (24/25_Trust_Obstetrics_47)
OMFS	Tongue tie audit - An audit of the management of tongue-ties referred to the oral surgery outpatient setting. (23/24_ENT_2)
Executive SMT	Reaudit of Seven Day Hospital Services Self-Assessment Survey [Standards 2 (time to consultant review), 5 (diagnostics), 6 (interventions or key services) & 8 (ongoing review)] (24/25_Trust_ExecSMT_04)
Pharmacy	Reaudit of safe and secure storage of medicines (24-25_Pharmacy_02)
Dermatology	Re-audit of British Association of Dermatologists guidelines for biologic therapy for psoriasis 2020: a rapid update (24/25_Trust_Dermatology_04)
Diabetes and Endocrinology	Performance of Touch the Toes Test in renal wards for Diabetic Patients (24-25_Trust_Diabetes_05)
Trauma and Orthopaedics	Whether GIRFT National Suspected Cauda Equina Syndrome Pathway is followed by the referring clinicians while referring suspected acute cauda equina patients, taking into consideration the criterion of chronicity of symptoms (24-25_Trust_T&O_11)
Obstetrics	Reaudit of vaginal birth after caesarean section (23/24_Trust_Obstetrics_18)
Trauma and Orthopaedics	Use of Intraoperative Tourniquets Based on BOAST Guidelines (24/25_Trust_T&O_08)
General Surgery	Reaudit of the use of Gastrographic for management of ASBO (Re-audit of 18247) (23/24_Trust_GeneralSurgery_03)
Obstetrics	Risk assessment in labour (24-25_Trust_Obstetrics_62)
ENT & Audiology	RF ablation of thyroid nodules in accordance with NICE IPG562 (23/24_Trust_ENT_01)
ENT & Audiology	Referral pathway to audiology (24/25_ENT/Audiology_05)
ENT & Audiology	Rate of Post-thyroidectomy Infection, Hypocalcaemia, and Nerve Palsy (24/25_ENT/Audiology_04)
Emergency Medicine	QIP: Are chest radiographs conducted in accordance with British Thoracic Society recommendations for adults diagnosed with community acquired pneumonia (24/25_Trust_Emergency Med_02)
Obstetrics	Pulse Oximetry screening in Newborns (23/24_Trust_Obstetrics_19)
Obstetrics	Post-partum bladder care audit (inpatient & community (24/25_Trust_Obstetrics_05)
General Surgery	Post-operative hospital stays after appendectomy - why is it longer at Lister hospital (24/25_Trust_General Surgery_01)
Gastroenterology	Post Colonoscopy colorectal cancer (15540)
Obstetrics	Placenta praevia & accreta (24/25_Trust_Obstetrics_64)
Obstetrics	Perinatal mental health audit 2023 (24/25_Trust_Obstetrics_07)
Pharmacy	Outpatients prescribing of sodium valproate in under 55 years (men and women) according to the new NPSA alert released on 28th November 2023 (24-25_Pharmacy_06)

Acute Medicine	Outpatient pulmonary emboli management (24/25_Trust_Acute Medicine_03)
Gynaecology	Reaudit of the outpatient management of hyperemesis gravidarum (re-audit of 15575) (24/25_Trust_Gynaecology_01)
Trauma and Orthopaedics	Outcomes, Satisfaction & Reflection of Junior Doctor / Resident Doctor Rotation Induction (24-25_Trust_T&O_12)
Obstetrics	Operative Vaginal Delivery (unsuccessful instrumental births) (24/25_Trust_Obstetrics_46)
Pharmacy	Reaudit of omitted and delayed doses of critical medicine (24-25_Pharmacy_01)
ENT & Audiology	NHS national newborn hearing screening programme (24/25_ENT/Audiology_02)
Cancer Centre	MVCC Radiotherapy IR(ME)R audit programme: EP E - Assessment of patient dose and administered activity (24/25_Trust_MVCC_03)
Cancer Centre	MVCC Radiotherapy IR(ME)R audit programme: EP B.2 Practitioner audit (24/25_Trust_MVCC_04)
Cancer Centre	MVCC Radiotherapy IR(ME)R audit programme: EP B.3 Referral form audit (24/25_Trust_MVCC_05)
Cancer Centre	MVCC Radiotherapy IR(ME)R audit programme: EP.1 & EP1.3Consent, Communication of risk & benefit of radiation exposure & Enquiries of individuals to establish pregnancy and breastfeeding status: Pre-treatment (24/25_Trust_MVCC_06)
Cancer Centre	MVCC Radiotherapy IR(ME)R audit programme: EP.1 & EP1.3Consent, Communication of risk & benefit of radiation exposure & Enquiries of individuals to establish pregnancy and breastfeeding status: Treatment (24/25_Trust_MVCC_07)
Cancer Centre	MVCC Radiotherapy IR(ME)R audit programme: EP A Patient Identification Compliance Audit - treatment (24/25_Trust_MVCC_08)
Cancer Centre	MVCC Radiotherapy IR(ME)R audit programme: EP A Patient Identification Compliance Audit: Pre-treatment (24/25_Trust_MVCC_09)
Cancer Centre	MVCC Radiotherapy IR(ME)R audit programme: EP J - Clinical evaluation of radiation doses in Radiotherapy (24/25_Trust_MVCC_10)
Cancer Centre	MVCC Radiotherapy IR(ME)R audit programme: EP H – Written Information for Sealed Sources (24/25_Trust_MVCC_11)
Cancer Centre	MVCC Radiotherapy IR(ME)R audit programme: Non-medical exposures audit (24/25_Trust_MVCC_12)
Cancer Centre	MVCC Radiotherapy IR(ME)R audit programme: EP N IR(ME)R Procedure Comforters and Carers (24/25_Trust_MVCC_27)
Cancer Centre	MVCC Radiotherapy IR(ME)R audit programme: reaudit of EP K reduction of probability and magnitude of radiation incident (24/25_Trust_MVCC_15)
Radiology	MRI Foot and ankle: key clinical questions, leveraging iRefer (24/25_Trust_Radiology_03)
Plastic and Reconstructive Surgery	Metalwork MDT Review of Target Rate of Cases Discussed (24-25_Trust_Plastics_08)
Obstetrics	MEOWS / escalation audit - focus recovery care (24/25_Trust_Obstetrics_19)
Obstetrics	Maternity Incentive Scheme & Ockenden: Consultant attendance (at high risk/emergency cases) - Theme 3rd/4th degree tears (24/25_Trust_Obstetrics_11)

Obstetrics	Maternity Incentive Scheme & Ockenden: Reduced fetal movements in triage / Raising awareness of reduced fetal movements (MIS Element 3) (24/25_Trust_Obstetrics_12)
Obstetrics	Maternity documentation audit (2023-2024 attendances) (24/25_Trust_Obstetrics_04)
Obstetrics	Maternity Baby Friendly Standards Audit (24-25_Trust_Obstetrics_59)
Trauma and Orthopaedics	Management of children with acute musculoskeletal infection based on BOAST guidelines (24/25_Trust_T&O_06)
Safeguarding	Reaudit of Liberty Protection, Deprivation of Liberty (DOLs) & Mental Capacity Act (MCA) Audit (18499)
Pharmacy	Laxative prescribing on intensive care unit (24-25_Trust_Pharmacy_07)
Safeguarding	Reaudit of Laming (Child protection medical audit) (17922)
Radiology	Intravascular lithotripsy (IVL) for the treatment of calcified lesions in peripheral vascular disease Interventional Procedure (18310)
Stroke Medicine	Intracranial haemorrhage (ICH) (24_25_Trust_Stroke-03)
Obstetrics	HIV in Pregnancy: A 5-year review of the care of women at East and North Hertfordshire NHS Trust (24/25_Trust_Obstetrics_06)
Radiology	GP CXR pathway for suspected lung cancer (18734)
Executive SMT	GIRFT: Head trauma CT (24/25_Trust_ExecSMT_02)
Trauma and Orthopaedics	Follow up of lumbar discectomy patients in Lister Hospital (24-25_Trust_T&O_15)
OMFS	Follow Up Appointments in in Oral Surgery East and North Herts, How Long Is the Wait? (24/25_Trust_OMFS_02)
Plastic and Reconstructive Surgery	Reaudit of excision rates of BCC and SCC (23/24_Trust_Plastics_04)
Obstetrics	Evolution of IOL at ENHT (24/25_Trust_Obstetrics_03)
Gastroenterology	Endoscopic Ultrasound: Post-Clinical Effectiveness Committee approval (24/25_Trust_Gastroenterology_03)
Gastroenterology	Endoscopic Ultrasound: CEC conditional approval (23/24_Trust_Gastro_01)
Gastroenterology	Endoscopic full thickness resection (FTRD) using an over the scope clip (OTSC) in accordance with IPG580 (23/24_Trust_Gastro_02)
Trauma and Orthopaedics	Early Management of Paediatric Forearm Fractures Based on BOAST Guidelines (24/25_Trust_T&O_07)
Obstetrics	Duty of candour (24/25_Trust_Obstetrics_65)
Obstetrics	Diagnosis and management of early miscarriage (24/25_Trust_Obstetrics_01)
General Surgery	Delay in laparoscopic cholecystectomy in patients presenting with pancreatitis (24/25_Trust_General Surgery_02)
Obstetrics	Consultant presence at MOH (24-25_Trust_Obstetrics_61)

Emergency Medicine	Compliance with National Guidelines (RCR, BAUS) for Acute Renal Colic: Focus on CT-KUB Protocols and Analysis of Patient Wait Times (24/25_Trust_Emergency Med_03)
Gynaecology	Reaudit of complex endometriosis surgery audit - Domain 2 Enhancing the Quality of Life of people with long term conditions (24-25_Trust_Gynaecology_15)
Plastic and Reconstructive Surgery	Audit of complete excision rates of BCC and SCC (24/25_Trust_Plastics_02)
Gynaecology	Colposcopy: Patient Experience (24/25_Trust_Gynaecology_05)
Gastroenterology	Colorectal endoscopic submucosal dissection (ESD) in accordance with IPG335 (23/24_Trust_Gastro_03)
Cardiology	Clinical audit of the effectiveness of maximum fixed versus low escalating energy selection for direct current cardioversion of atrial fibrillation patients (23/24_Trust_Cardiology_02)
Dermatology	Clinical Audit against British Association of Dermatologists guidelines for biologic therapy for psoriasis 2020: a rapid update (24/25_Trust_Dermatology_01)
Dermatology	Clinical Audit against British Association of Dermatologists and British Photo dermatology Group guidelines for narrowband ultraviolet B phototherapy 2022 (24/25_Trust_Dermatology_03)
Stroke Medicine	Clerking of Patients Pre-Alerted as a Stroke at Lister Hospital (24_25_Trust_Stroke-02)
CH community	Children taking melatonin on East & North Hertfordshire community paediatricians' caseload; a prospective audit of numbers and associated workload (18292)
CH community	Reaudit of child protection medical audit 2022/2023. Safeguarding: Child Protection Audit of Standard Operating Procedures and review of 2019 Action Plan (24/25_Trust_CH Comm_01)
Pathology	Cervical biopsy and LLETZ Audit 2024 to look if all the core parameters for reporting are being followed (24-25_Trust_Pathology_01)
Obstetrics	Care in labour: 1st and 2nd stage labour observations and care (24-25_Trust_Obstetrics_61)
Diabetes and Endocrinology	Canagliflozin (10298)
Obstetrics	Caesarean birth NICE NG192 / QS 32 VBAC / Maternal request (24/25_Trust_Obstetrics_13)
Plastic and Reconstructive Surgery	Breast implant Audit (23/24_Trust_Plastics_01)
Obstetrics	Battle of the wrist bands: An Audit to assess wrist band use in Obstetric care (handwritten versus printed) (24-25_Trust _Obstetrics_63)
Trauma and Orthopaedics	Audit of post-operative inpatient care for orthopaedic patients undergoing joint replacement surgery of the lower limb. (23/24_Trust_T&O_3)
Ophthalmology	Audit of large macular holes. (23/24_Trust_Ophthalmology _1)
Critical Care	Audit of DNA CPR orders in General Intensive Care Unit (Lister Hospital) (17742)
ENT & Audiology	Audit of dictated letters from Lister ENT department (23/24_ENT_1)

Trauma and Orthopaedics	Audit of adherence to trust protocol for calibrated pelvic radiographs for elective total hip replacements at Lister Hospital (24/25_Trust_T&O_02)
Obstetrics	Reaudit of assessment of foetal growth GROW (24-25_Trust_Obstetrics_60)
ENT & Audiology	Antibiotics Guidance for Acute ENT Infections (24-25_ENT-Audiology_09)
Anaesthetics	Antibiotic prophylaxis in theatre (23-24_Anaesthetics_05)
Plastic and Reconstructive Surgery	Annual re-audit of SCC and BCC excision rates in the Plastic Surgery Department (24-25_Trust_Plastics_06)
Plastic and Reconstructive Surgery	Annual re-audit of outcomes of all free tissue flaps carried out by the plastic surgery department (24-25_Trust_Plastics_05)
Pharmacy	An Audit to Show Dexmedetomidine Prescribing Practice Compared Against our Critical Care Local Guideline (24-25_Trust_Pharmacy_08)
Child Health Acute	An Audit Report on Paediatric Registrar Review Clinic Referral and Outcome in a Secondary Care Hospital-Documentation Audit (24-25_Trust_CH Acute_02)
Oncology and Clinical Haematology	An audit of the management of Older Patients with early-stage lung cancer Radical radiotherapy for lung cancer in Older Patients (NICE Lung cancer: diagnosis and management, NG122 March 2024) (24-25_Trust_OCH_03)
Gynaecology	Abortion care QS199 including legal requirements (24/25_Trust_Gynaecology_10)
General Surgery	A&E referrals to General Surgery: Safe and Effective Emergency Care (24/25_Trust_General Surgery_03)
Child Health Neonates	A review of outcomes for babies placed on kaiser sepsis observations November 2023- March 2024 (23/24_CH Neonates_02)
Trauma and Orthopaedics	BPT guidelines Fragility hip and femur fracture (24-25_Trust_T&O_16)
Trauma and Orthopaedics	BOAST - Mobilisation and weightbearing after orthopaedic surgery– hip and lower limb (24-25_Trust_T&O_17)
Cancer Centre	PT4 – CT Simulation Breast July 2024 (24/25_Trust_MVCC_17)
Cancer Centre	PT 14- Head & Neck July 2024 (24/25_Trust_MVCC_18)
Emergency Medicine	Re-audit on the documentation of the neurovascular assessment in traumatic shoulder dislocation. (24-25_Trust_Emergency Med_05)
Stroke Medicine	Reaudit of the impact of MRI Scans on Stroke and Patient Flow (24-24_Trust_Stroke_05)
Cancer Centre	Real-world single centre experience of neoadjuvant nivolumab plus chemotherapy in respectable non-small cell lung cancer (24/25_Trust_MVCC_24)
Cancer Centre	Audit measuring quality of on call referrals in MVCC against the SBAR tool standard (24/25_Trust_MVCC_25)
Ophthalmology	Audit of surgical treatment of vitreomacular traction also known as VMT (24_25_Trust_Opthalmology-03)

2.3.6. Participation in Research

East and North Hertfordshire NHS Trust continues to place patients at the heart of its research efforts, with 3,151 patients recruited across 69 ethically approved research projects in 2023/24, spanning 15 clinical specialties. The Trust's top five recruiting studies ranged from cancer screening (BEST4, 2,071 participants) and dialysis care (RESOLVE) to perioperative outcomes, quality of life in cancer, and biomarker research for eosinophilic oesophagitis. These achievements were made possible by innovations such as mobile screening units and strong patient engagement.

The Trust's four-year research strategy aims to be recognised as an organisation where patients can meaningfully engage in and benefit from research. Objectives include aligning research with local needs, improving accessibility and inclusion, embedding research in service design, and leveraging data and digital tools responsibly. To better understand and improve the research experience, the Trust gathered feedback through a structured survey. The results are summarised in the table below.

Questions	2024/5 responses (total number = 132)
1. The information that I received prepared me for my experience on the study	92.1% Agree or Strongly Agree
2. I feel I have been kept updated about the research	72.0% Agree or Strongly Agree
3. I know how I will receive the results of the research	70.5% Yes or Yes to some extent
4. I know how to contact the research team if I have any questions or concerns	86.4% Yes or Yes to some extent
5. The researchers have valued my taking part in the research	87.1% Yes or Yes to some extent
6. Research staff have always treated me with courtesy and respect	94.7% Yes or Yes to some extent
7. I would consider taking part in research again	83.3% Yes or Yes to some extent

In 2024, Trust staff contributed 348 research publications, 35 of which were in collaboration with the University of Hertfordshire, showcasing a broad range of research in high-impact journals. Patient and public feedback remains central, with 132 survey responses in 2024/25 highlighting strong satisfaction with care, communication, and overall experience.

The monthly Patient and Public Involvement in Research Panel supports the design of locally relevant, patient-centred studies. Projects under review include digital therapies for tinnitus, AI in menopause care, outcome measures in end-of-life care, and inclusive communication tools in critical care for people with intellectual disabilities. This commitment to collaborative, inclusive research ensures that ENHT remains a forward-thinking organisation contributing to national and international health improvement.

2.3.7. Update on Commissioning for Quality and Innovation (CQUIN)

For 2024/25, the nationally mandated CQUIN scheme was paused, so there are no adjustments to reflect achievement of CQUIN metrics, although fixed payments should include the 1.25% funding previously identified for CQUIN.

2.3.8. Care Quality Commission

The Trust is required to register with the Care Quality Commission (CQC). It's current registration status is 'requires improvement'. The CQC did not take enforcement action against the Trust during 2024/25.

Following the 2023 CQC inspection, East and North Hertfordshire NHS Trust successfully submitted its action plan addressing all 'must' and 'should' requirements, with supporting evidence for 'should' actions submitted on 30 August 2024.

	Safe	Effective	Caring	Responsive	Well-led	Overall
Lister Hospital	Requires Improvement ↑ Nov 2023	Requires Improvement ↓ Nov 2023	Good →← Nov 2023	Requires Improvement →← Nov 2023	Requires Improvement →← Nov 2023	Requires Improvement →← Nov 2023
Mount Vernon Cancer Centre	Requires improvement Dec 2019	Good Dec 2019	Good Dec 2019	Requires improvement Dec 2019	Requires improvement Dec 2019	Requires improvement Dec 2019
Queen Elizabeth II Hospital	Requires improvement Dec 2019	Good Dec 2019	Good Dec 2019	Requires improvement Dec 2019	Requires improvement Dec 2019	Requires improvement Dec 2019
Hertford County Hospital	Good Apr 2016	Not rated	Good Apr 2016	Good Apr 2016	Good Apr 2016	Good Apr 2016
Overall trust	Requires Improvement →← Nov 2023	Good →← Nov 2023	Good →← Nov 2023	Requires Improvement →← Nov 2023	Requires Improvement →← Nov 2023	Requires Improvement →← Nov 2023

The Maternity service at the Trust participated in the National Maternity improvement programme in inspection in 2023, following assessment from the national programme they successfully stepped down from this improvement program in 2024/25.

In the same year, the Trust participated in several regulatory reviews, including a Joint Targeted Area Inspection (JTAI) on safeguarding children, and additional quality assessments from the Environment Agency (waste management), NHS England (cervical screening), JAG (endoscopy services), and the ICB (SEND services).

Throughout the year, the Trust continued to strengthen its quality governance framework, embedding a culture of continuous improvement through revised reporting structures that support operational delivery. This work has been underpinned by a structured programme of internal and external mock inspections, quality assurance reviews, and well-led governance assessments. Additionally, the Trust expanded its Urgent Treatment services at the Lister site to further enhance patient access.

2.3.9. Reporting to Secondary Uses Service (SUS)

The Secondary Uses Service is designed to provide anonymous patient-based data for purposes other than direct clinical care such as healthcare planning, commissioning, public health, clinical audit and governance, benchmarking, performance improvement, medical research and national policy development.

During 2024/25, the Trust submitted data to the Secondary Uses Service for inclusion in Hospital Episode Statistics, all of which were included in the latest published dataset.

The percentage of records containing a valid NHS number was:

- 99.9% for admitted patient care (national average: 99.7%)
- 99.9% for outpatient care (national average: 99.7%)
- 99.5% for A&E care (national average: 98.2%)

The percentage of records with a valid General Medical Practice code was:

- 99.1% for admitted patient care (national average: 99.4%)
- 99.9% for outpatient care (national average: 99.4%)
- 100.0% for A&E care (national average: 99.2%)

2.3.10. Update on data quality

In 2024/25, the Data Quality Team focused on improving the quality of data captured in the Trust's patient administration system, Lorenzo, particularly around patient information, activity recording, and performance management. Accurate, valid, and timely data remains critical to the integrity of Trust reporting and supports decision-making across all areas of the organisation, ensuring services meet the needs of the local population.

For 2025/26, the team will review the Trust's Data Quality Strategy and Policy and continue to raise awareness of data quality issues through the monthly Data Quality Assurance Group and Data Alignment

Group. Key actions also include reviewing the data quality KPI dashboard to align with Trust objectives, developing a new Directory of Services covering all Trust sites, and supporting the implementation of the new Electronic Patient Record (EPR).

2.3.11. Update on Information Governance Toolkit (IGT)/ Data security

All health and care organisations are expected to implement the 10 National Data Guardian (NDG) standards for data security. These standards are designed to protect sensitive data, and to also protect critical services which may be affected by a disruption to critical IT systems (such as in the event of a cyber-attack).
The Data Security and Protection Toolkit (DSPT) is an online self-assessment tool that enables the Trust to measure their compliance against the NDG standards and demonstrate and that sensitive information is protected from unauthorised access, loss, damage and destruction.

The Trust remains vigilant in addressing rising data security threats affecting the health and care sector, including cyber-attacks, data breaches, and accidental losses.
In 2023/24, a dedicated Cyber and Information Governance function was established within the Chief Information Officer's directorate. This contributed to the Trust achieving "Standards Met" in its annual Data Security and Protection Toolkit (DSPT) submission for the first time since 2020/21.
In September 2024, the DSPT was aligned with the National Cyber Security Centre's Cyber Assessment Framework, significantly raising the level of assurance required. The Trust is preparing its 2024/25 submission against 232 new audit controls, aiming for a rating of "Partially Achieved." Between July 2024 and year-end, 39 incidents were reported via DSPT, with 5 meeting the threshold for reporting to the Information Commissioner's Office. The inclusion of personal data breaches logged in Enhance demonstrates strengthened awareness and compliance across the organisation.

2.3.12. Update on clinical coding

Data Security Standard 1, Personal and Confidential Data: The Trust conducts annual data quality audits to verify coded clinical data accuracy against patient records. Clinical coding validation is regularly performed for both admitted patient spells and outpatient attendances, with Admitted Patient Care (APC) audit results shown below:

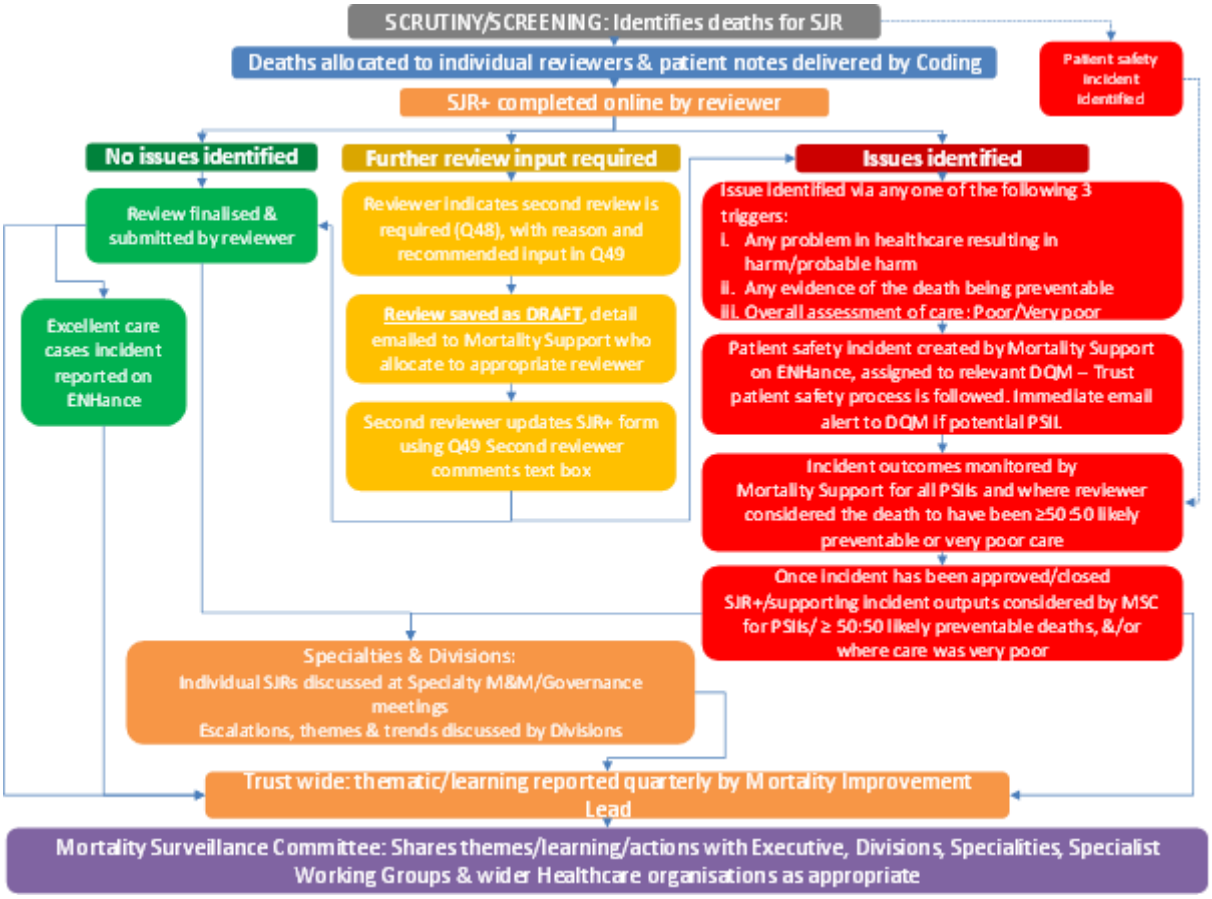
The Trust provides annual clinical coding training for all staff, with mandatory 3-yearly refresher courses completed by all. Two additional team members recently achieved the National Clinical Coding Qualification (NCCQ), with 4 more having sat the March 2025 exam, bringing our total Accredited Clinical Coders (ACC) to 11 staff members.

	2024/25	Previous year (2023/24)	Standards Exceeded
Primary diagnosis	95.5%	97.5%	>=95%
Secondary diagnosis	98.0%	97.0%	>=90%
Primary procedure	96.1%	97.1%	>=95%
Secondary procedure	98.0%	98.5%	>=90%

2.3.13. Update on learning from deaths

In 2024/25, East and North Hertfordshire NHS Trust continued to embed a strong learning from deaths process as part of its wider commitment to reducing avoidable mortality. The Trust uses the Structured Judgement Review Plus (SJRPlus) model, aligned with the *Better Tomorrow* framework (supported by Aqua and NHS England's *Making Data Count* approach).

Mortality governance is supported by clinical reviews, divisional governance, and thematic learning shared through mortality and morbidity meetings, safety forums, and working groups. While overall mortality rates remain within expected levels, the Trust recognises that mortality statistics alone do not reflect the quality of care and continues to focus on case-level learning and system improvement.



During the year, 1,395 deaths were recorded, of which 283 underwent case record review and 6 were investigated under the new Patient Safety Incident Response Framework (PSIRF). No cases were judged to be more likely than not due to problems in care, although 10 cases remain under active review (4 with preliminary findings suggesting preventability and 6 under PSII). Additionally, 74 retrospective reviews were completed from the prior year, with no preventable deaths identified.

Key themes identified from structured judgment reviews include delays in senior medical review, discharge planning, medication issues, and inconsistencies in end-of-life documentation (ReSPECT/TEP forms). Communication breakdowns during ward transfers, imaging delays, and inconsistent palliative care planning were also noted. These findings continue to inform targeted quality improvement efforts across the organisation.

The content and format of the learning from deaths information below has been provided in accordance with the statutory instrument 2017 No 744 'The National Health Service (Quality Accounts) (Amendment) Regulations 2017.

Statutory Ref	Prescribed information/indicator	2024/25 Summary	Additional Comments
27.1	Total deaths in 2024/25	1.395 deaths recorded. Q1: 315 Q2: 307 Q3:392 Q4:381	Deaths include those who died in ED and inpatient wards.
27.2	Case record reviews/investigations	283 reviews and 6 investigations Q1: 34 Q2:90 Q3:106 Q4: 59	In 0 cases a death was subjected to both a case record review and an investigation. Since adoption of the Patient Safety Incident Response Framework (PSIRF), investigation has been interpreted as referring to PSIIs
27.3	Deaths Judged more likely than not due to care problems	0% to date; 10 cases under active review	10 cases remain under review and may be reclassified in next year's report following further investigation under the Trust's SJRPlus and PSIRF processes.
27.4	Learning from reviews judged preventable	Pending	Investigations in progress
27.5	Actions taken as a result	Awaiting finalisation.	Investigations in progress
27.6	Impact of actions	Impact assessment pending implementation of actions	
27.7	Late reviews from 2023/24	72 case reviews 2 investigations	Relate to inpatient deaths which took place before the start of the reporting period.
27.8	Preventable deaths in late Reviews	0 deaths judged preventable	Estimated using the mortality review process methods detailed above in 27.3
27.9	Revised preventable deaths total for 2023/24	3 deaths (0.22%)	Represents revised total figures incorporating the sum of 27.3 from last year's report and 27.8 above.

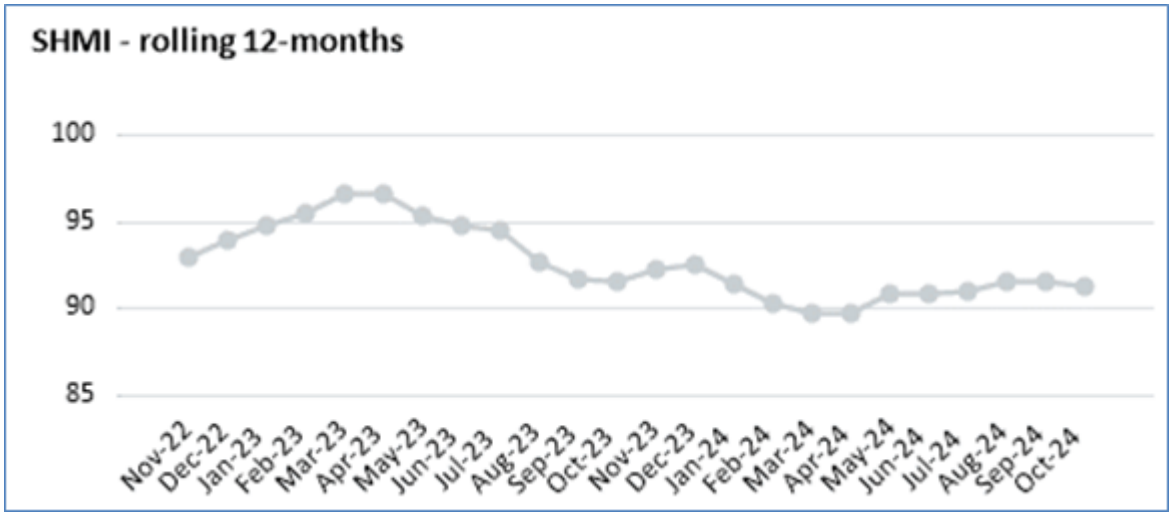
2.4. Performance against national core indicators

In this section the outcomes of a set of mandatory indicators are shown. This benchmarked data, provided in the tables, is the latest published on the NHS Digital website and is not necessarily the most recent data available. More up to date information, where available, is given.
For each indicator the Trust's performance is reported together with the national average and the performance of the best and worst performing trusts, where applicable.

2.4.1. Mortality

Performance against national core indicators

The Summary Hospital-level Mortality Indicator (SHMI) is expressed as a ratio of observed to expected deaths so that a number smaller than '1' represents a 'better than expected' outcome. The Trust's SHMI for the 12 months to November 2024 is 0.9015, positioned within the 'as expected' Band 2 category. SHMI is generally available five months in arrears.
The Trust's latest Summary Hospital-Level Mortality Indicator (SHMI) for the period December 2023 to November 2024 was 0.9015, within the 'as expected' range (Band 2), and ranked 19th out of 119 acute non-specialist trusts nationally.

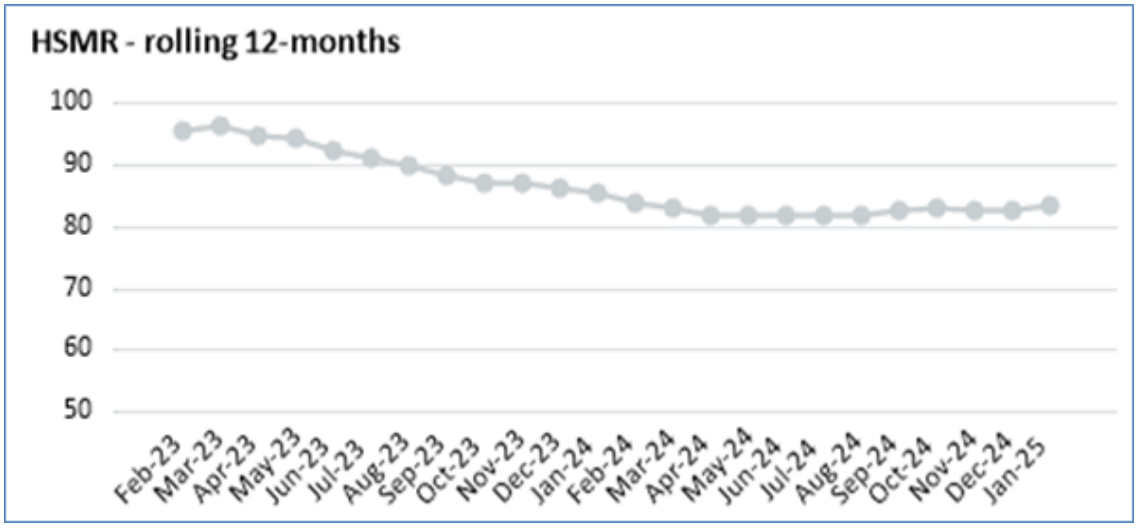


Rolling 12-month SHMI: November 2022 to October 2024

In the chart above, SHMI values are scaled by 100 for direct comparison with HSMR, where a value of 100 indicates observed deaths equal expected deaths.
SHMI values for each trust are published along with bandings indicating whether a trust's SHMI is '1 - higher than expected', '2 - as expected' or '3 - lower than expected'.

Indicator	Measure	Trust result	Time period	Trust previous result	Best performing trust	Worst performing trust	National average
SHMI	Value	0.9015	Dec-23 to Nov-24	0.9194*	0.7016	1.2849	1.0
	Banding	2		2	3	1	-
% deaths with palliative care coding	Percentage	41.0		44.0*	66.0	17.0	44.0

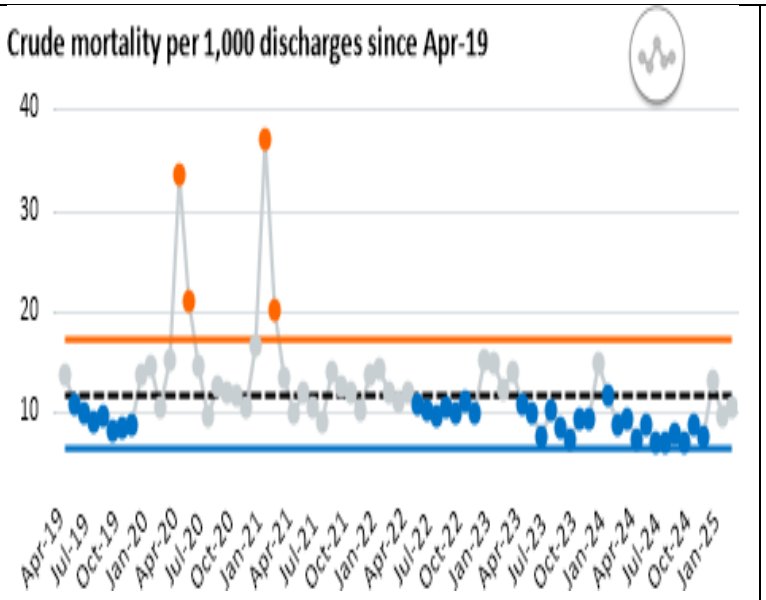
The Hospital Standardised Mortality Ratio (HSMR) for the year to January 2025 was 83.5, compared to a national average of 89.3. These results reflect sustained performance improvement supported by accurate clinical coding, timely reviews, and multidisciplinary learning processes.

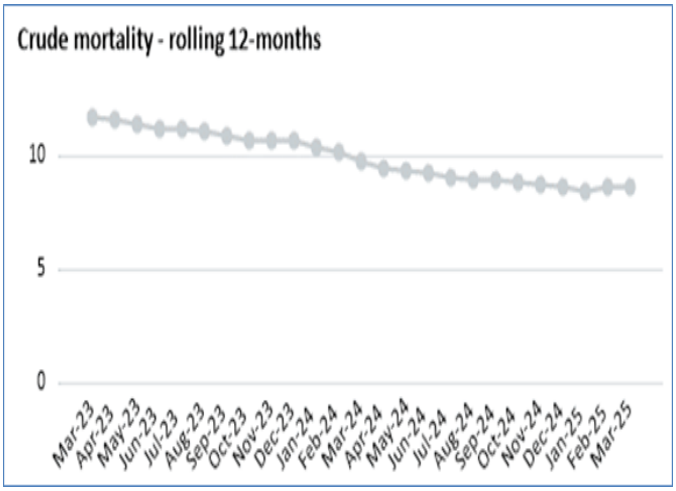


The Trust considers that this data is as described, as it is based on data submitted by the Trust to a national data collection and reviewed as part of the routine performance monitoring. The Trust has processes in place and takes on-going action to improve these scores, and consequently the quality of its services, including presenting and tracking monthly data to identify and investigate changes. The mortality data is also captured by diagnosis so any deviation can be investigated at a case-by-case level.

Crude mortality

Crude mortality also remained below national average for most of the year, with monthly monitoring and case-level diagnosis tracking used to identify variations and support responsive clinical governance. The Trust continues to use this data to refine local care delivery and prioritise safe, high-quality care for all patients**.**





2.4.2. Patient Reported Outcome Measures PROMs (EQ-5D Index Score)

PROMs use a standardised tool as a measure of health outcomes. It is applicable to a wide range of health conditions and treatments and provides a simple descriptive profile and a single index value for health status; the health gain index is primarily designed for self-completion by respondents and is ideally suited for use in postal surveys, in clinics and face-to-face interviews.
The Trust did not collect any data related to PROMs.

2.4.3. 30 Day/ Emergency readmissions

Readmissions data is only available until Jan 2024 and hence the data below is comparison of data from Apr - Jan period.

30 Day Readmissions	Apr 22 - Jan 23			Apr 23 - Jan 24			Apr 24 - Jan 25		
	0-15	16 & over	Total	0-15	16 and over	Total	0-15	16 and over	Total
Discharge	10533	86496	97029	8544	95657	104201	10369	111585	121954
30day readmissions	1317	4856	6173	894	5621	6515	1127	6824	7951
30day readmission rate 5	12.50%	5.61%	6.36%	10.46%	5.88%	6.25%	10.8%	6.12%	6.52%

*Data up to January 2025

We consider the above data as described because it is extracted directly from CHKS, which is an established and recognised source of data nationally.

2.4.4. The Friends and Family Test (responsiveness to patient needs)

The Friends and Family Test (FFT) is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. This kind of feedback is vital in transforming NHS services and supporting patient choice.
Throughout 2024/25, we have maintained high performance in FFT scores across most areas. Positive feedback has remained consistent in our inpatient, outpatient, and maternity services. Areas for improvement have been identified through theme analysis from previous surveys, with targeted initiatives implemented in response. FFT data is submitted directly by patients and extracted from the NHS England national dataset.

The Trust considers that this data is as described for the following reason: the data has been extracted directly from the NHS England, which is an established and recognised source of data nationally.

Service Area	2022/23	2023/24	2024/25
Inpatient	96.3%	96.45%	96.34%
Outpatient	96.09%	96.34%	96.40%
Maternity	96.25%	98.17%	97.28%
Emergency Department	88.10%	92.61%	83.87%

*data as at March 2024. At the time of writing no figures have been released by NHS England.

As of March 2024, FFT response rates for A&E and inpatient services were 0.48% and 18.19% respectively. NHS England data for 2024/25 has not yet been released at the time of reporting.

2.4.5. Venous Thromboembolism (VTE)

VTE, which includes deep vein thrombosis and pulmonary embolism, remains a key patient safety focus. Since the launch of the Trust's Venous Thromboembolism (VTE) quality improvement programme in July 2021, significant progress has been made in prevention, governance, and clinical engagement.

Since October 2024, the Trust has adopted the NHS England standard requiring VTE risk assessments, prescribing, and prophylaxis to be completed within 14 hours of admission. This led to an initial compliance drop to 51%, now improving steadily to 63% by March 2025, with Low Molecular Weight Heparin (LMWH) prescribing maintained above 88%.

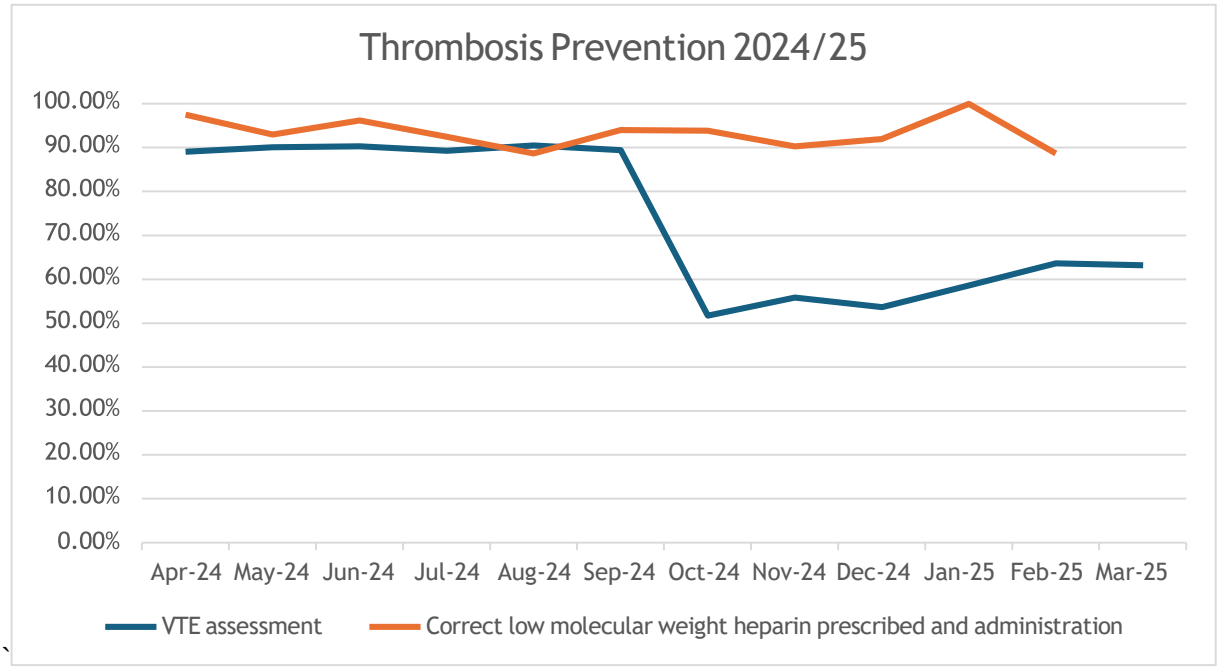


Figure 1: Audit data of clinical area's compliance with VTE prevention 2023/2024.

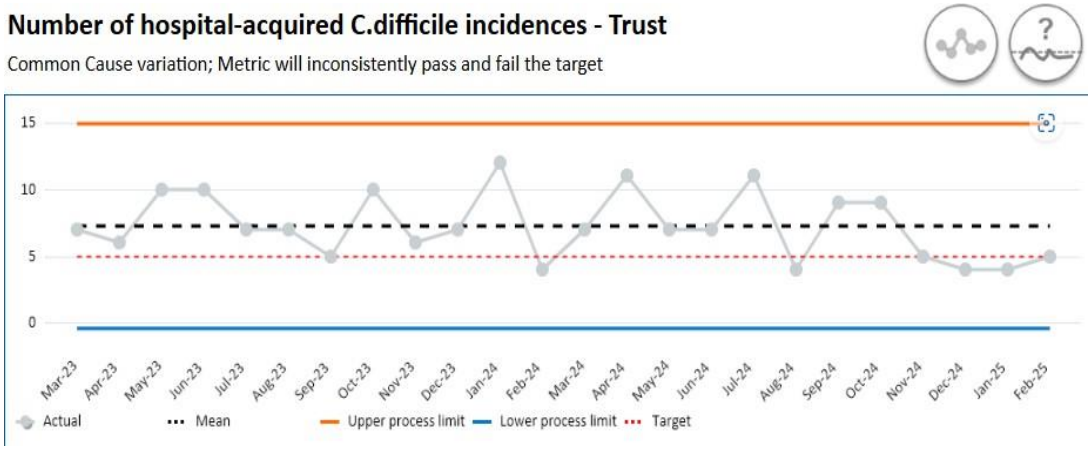
The Trust continues to investigate all potential Hospital Acquired Thrombosis (HAT) cases, with 8 preventable HATs identified in 2024/25—one declared a Patient Safety Incident Investigation (PSII) and reviewed under PSIRF.

The Trust has strengthened its VTE/HAT governance, introduced real-time digital dashboards, and embedded training and VTE standards into ward accreditation. Learning is shared through the Thrombosis Action Group, and patient information has been enhanced via digital discharge updates.

Priorities for 2025/26 include expanding the VTE improvement work to Emergency and Planned Admission pathways, redesigning the Thrombosis Action Group, and appointing a pharmacist to lead ongoing improvement initiatives. National benchmarking resumed in April 2024, with the first submission scheduled for July.

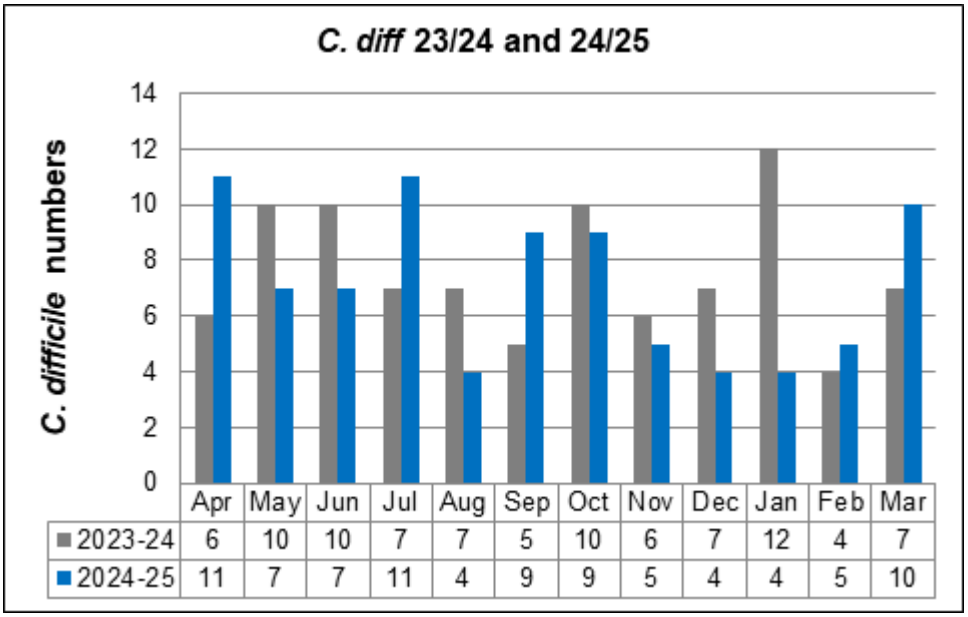
2.4.6. Clostridioides Difficile (CD)

In 2024/25, the Trust reported 86 cases of C. difficile, a 6.5% reduction compared to the previous year and within the threshold of 92. A multidisciplinary action plan and weekly C. diff review meetings supported this improvement, with 99% of cases found to be clinically unavoidable. Antimicrobial stewardship also improved significantly, particularly in timely review and appropriate use of antibiotics.



The Trust recorded two MRSA bloodstream infections, matching the 2023/24 total. Both cases were investigated through post-infection reviews, with learning actions implemented. E. coli bloodstream infections reduced by 9%, with most other gram-negative infection rates remaining within or just above thresholds. The

IPC team continued internal PIRs for all healthcare-associated infections and collaborated with specialist teams to strengthen ANTT and PIVC competencies.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2023-24	6	10	10	7	7	5	10	6	7	12	4	7
2024-25	11	7	7	11	4	9	9	5	4	4	5	10

IPC training compliance increased from 93% to 98% across Level 1 and 2, reflecting sustained investment in workforce education. Key IPC highlights included the launch of the Trust-wide Winter Ready Campaign, an improved Power BI IPC dashboard, and enhanced training in high consequence infectious disease (HCID) pathways and aseptic technique. The Trust also maintained an active IPC engagement programme, with over 500 staff involved across audits, themed days, and targeted campaigns.

2.4.7. Patient safety incidents

In 2024/25, the Trust fully embedded the Patient Safety Incident Response Framework (PSIRF), marking a cultural shift from classifying incidents by harm level to proportionate, systems-based responses. The Trust's revised PSIRF policy and response plan, shaped by our inaugural year of implementation, was approved by the Patient Safety Forum and is being presented to Trust Board in July 2025.

Learning responses targeted key areas such as escalation of deteriorating patients, drug administration errors, discharge safety, and waiting list risks. The Learning from Patient Safety Events (LFPSE) system supported both incident and good care reporting, reinforcing a culture of transparency and continuous learning.

Incident reporting rose significantly, with 17,195 incidents reported in 2024/25, a 25% increase from 13,767 the year before and reflecting staff engagement in safety and transparency.

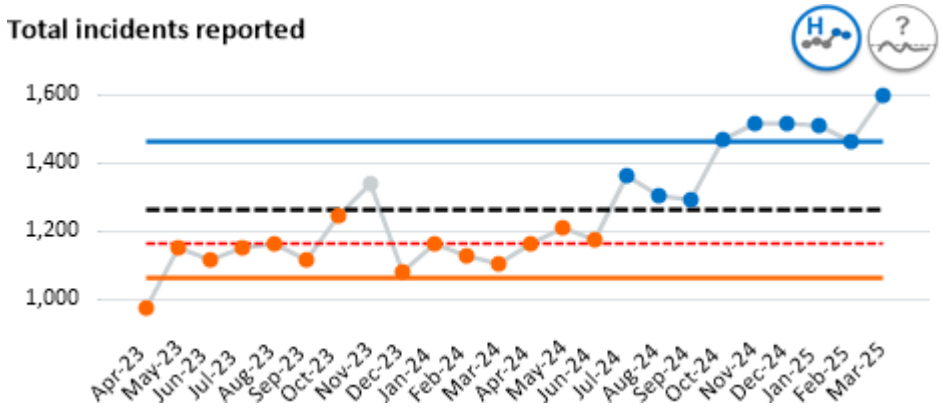
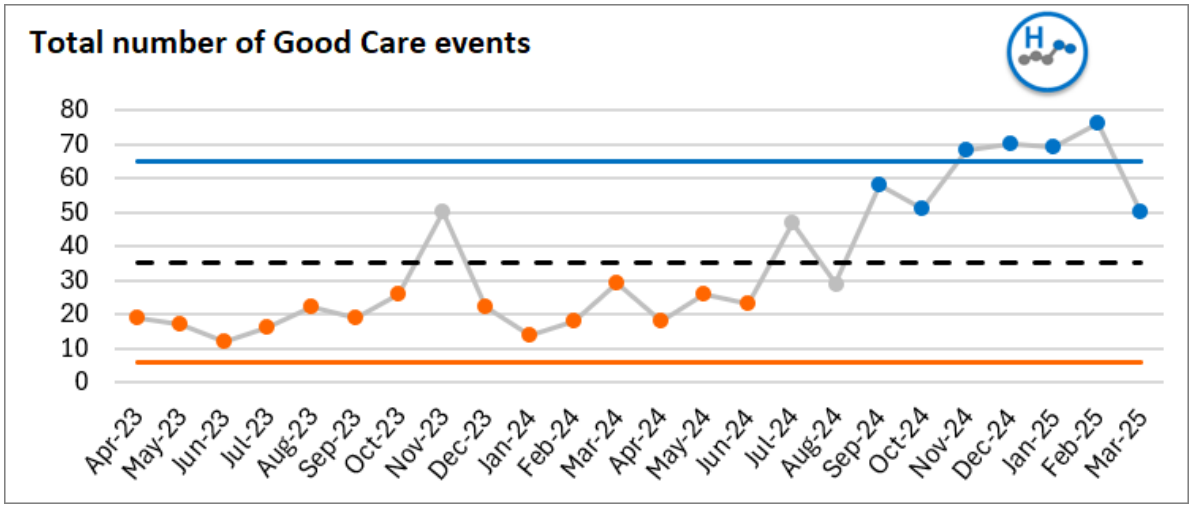


Figure 1: Total incidents reported – showing increased reporting year-on-year

Of these, 97% caused no or minimal harm, with 83% relating to patients and 11% to staff. The Trust continues to promote the reporting of good care events, with nearly 2,000 cases recognised, although this remains an area for further cultural embedding.



Top themes for patient safety included pressure ulcers, medication errors, obstetrics, and treatment concerns. For staff-related reported incidents, top themes included violence and aggression, staffing, security, and communication.

Patient Safety Incident Investigations (PSII) and Serious Incidents (SI)

Under PSIRF, 12 Patient Safety Incident Investigations (PSIIs) were undertaken, including events involving Never Events, safeguarding concerns, potentially avoidable deaths, and clinical errors. All investigations were initiated in response to incidents that met local or national PSII criteria, and each followed systems-based methodologies to understand root causes and prevent recurrence.

Themes included surgical safety (e.g., wrong site procedures, retained items), anticoagulation management, anaphylaxis, safeguarding, emergency care, and mental health-related incidents. Two investigations were externally led by the Maternity and Newborn Safety Investigations (MNSI) programme.

All cases were reviewed by the Patient Safety Event Response Panel, and learning disseminated through divisional governance structures, clinical education sessions, and thematic safety campaigns. Actions have included updates to invasive procedure documentation, strengthened clinical sign-off protocols, and improved oversight through the Trust's Invasive Procedure Oversight Group.

A legacy Serious Incident investigation continued throughout 2024/25 relating to the Trust's Paediatric Audiology Services, following a 2023 national peer review of the Neonatal Hearing Screening Programme. The review raised concerns regarding data quality, risk identification, and follow-up pathways, prompting the Trust to pause elements of the service due to potential patient harm. An improvement committee chaired by the Chief Nurse was established, supported by Integrated Care Board (ICB) partners and subject matter experts from Guy's and St Thomas' NHS Foundation Trust. The Trust also invited UKAS to undertake an external audit, which identified multiple safety concerns. While mutual aid pathways were implemented, access remained limited due to national capacity constraints.

The Trust's improvement plan focuses on six key domains: quality and safety, environment and equipment, digital systems, operational flow, workforce, and communication, with oversight by the Quality and Safety Committee. The full investigation report is scheduled for completion and sign-off in May 2025.

Never Events

The Trust reported five Never Events across different specialities, including wrong site surgery (2 cases), a retained surgical swab, incorrect prosthesis, and a misplaced nasogastric tube. A thematic review of the surgical events highlighted key contributory factors, including variation in safety check processes, time pressures, inconsistent whiteboard use and labelling, and inexperienced or unfamiliar theatre teams.

In response, the Trust has updated safety documentation, enhanced staff training, and introduced 7-day pre-operative list sign-off to reduce errors linked to pooled theatre lists. An Invasive Procedure Oversight Group has been established to lead on standardisation and cross-speciality learning, supported by the development of a central LocSSIP library on ENHance.

2.5. Other Quality Information

Operational performance appraisal summary- Emergency Department (ED) performance

The Trust managed high demand with 184,926 ED attendances, 52,012 inpatients, and 610,180 outpatient appointments. Industrial action impacted elective care, but key targets such as eliminating 104-week waits (except community paediatrics) and improving 78-week wait compliance were largely met. Trauma and orthopaedics remain an outlier, with improvement plans in place.

The Trust's focus throughout 2024/25 has been on improving urgent and elective care performance, reducing waiting times, sustaining strong cancer outcomes, delivering financial stability, and addressing diagnostic and stroke service improvements to enhance patient care and system resilience.

- The Trust prioritised improving emergency care and reducing ED waiting times, making significant capacity investments to support patient flow and ambulance handovers. Parallel efforts expanded elective capacity, resulting in higher levels of day-case, inpatient, and outpatient activity compared to the previous year, with further improvements planned for 2025/26.
- Diagnostic turnaround times remain a challenge, though capacity and demand modelling indicate DM01 compliance (except MRI) by March 2025. Community Diagnostic Centres (CDC) largely met targets, except cardiology due to GP uptake and workforce issues. Stroke care performance improved, with the Trust now rated 'B' and aiming for an 'A' rating through continued focused efforts.
- Cancer care remained a strong focus, with the Trust sustaining 75% compliance against the faster diagnosis standard. Collaborative efforts continue to address 62-day wait breaches, and the Trust's early adopter role in pathway analyser work has been nationally recognised.
- Incremental progress was made towards the four-hour ED target, achieving 73.18% (a 10% improvement year-on-year) despite increased demand. Ambulance handover times saw notable improvements through SDEC expansion, UTC development, and strengthened system collaboration, reaching 66.1% compliance for handovers within 30 minutes.

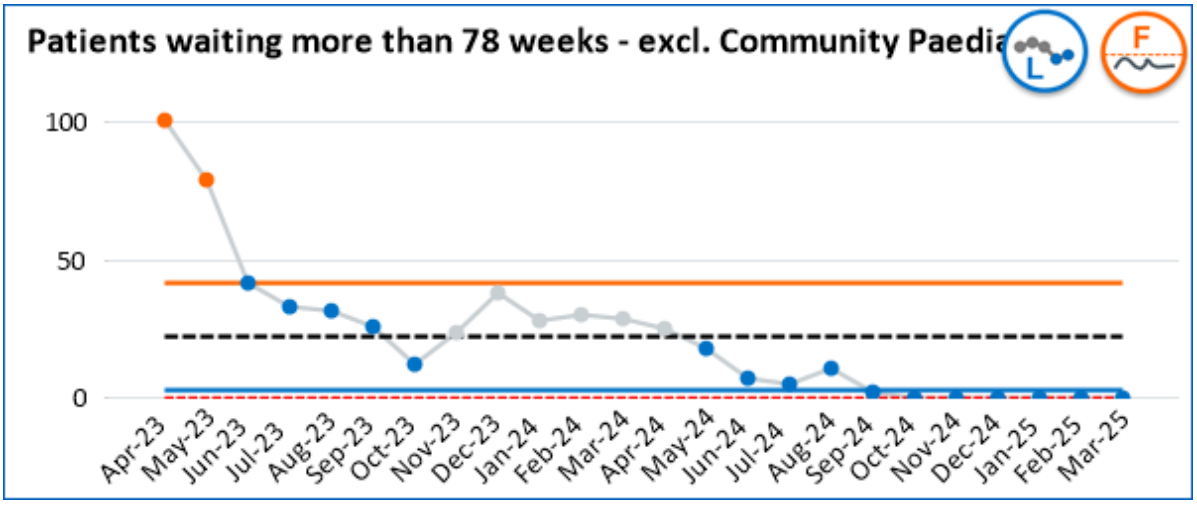
2.5.1. Performance Analysis: In-depth performance review

Operational Performance

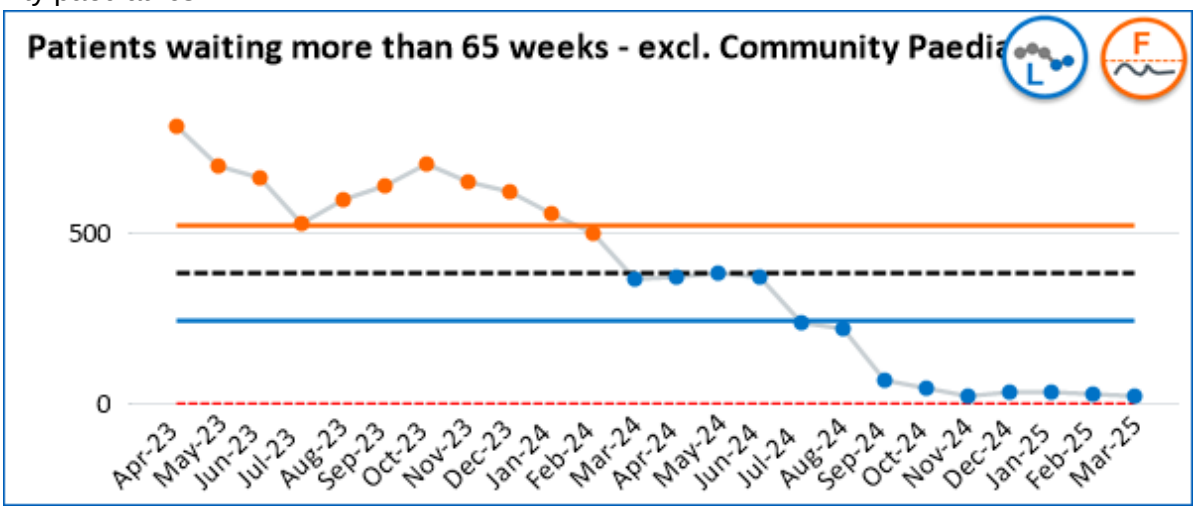
A summary of performance against the key metrics is provided below:

Referral To Treatment (RTT)

In line with national efforts to eliminate waits over 65 weeks and progress toward the 18-week referral-to-treatment target, the Trust has made significant improvements in waiting times during 2024/25. This has been achieved through targeted recruitment, increased clinical sessions, improved validation, and outpatient and theatre transformation. The Trust also participated in the national GIRFT programme to support shared learning and faster delivery of care.

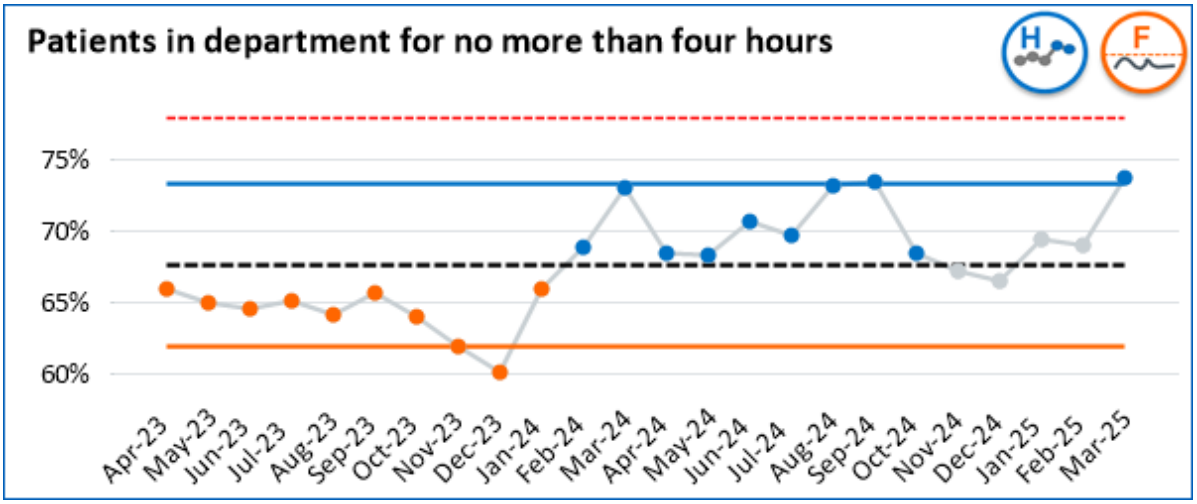


At year-end, only 26 patients (0.05% of the waiting list, excluding Community Paediatrics) were waiting over 65 weeks, with most services achieving the 52-week target. Exceptions included Trauma & Orthopaedics, Pain Management, Oral Surgery, and Urology. Proactive patient engagement efforts included over 114,000 text messages sent to validate patient willingness to wait, with 6.89% requesting removal from the list. The Trust continues to expand the use of Patient Initiated Follow-Up (PIFU) to improve flexibility and access for appropriate patients and is working with system partners to address longstanding capacity challenges in community paediatrics.

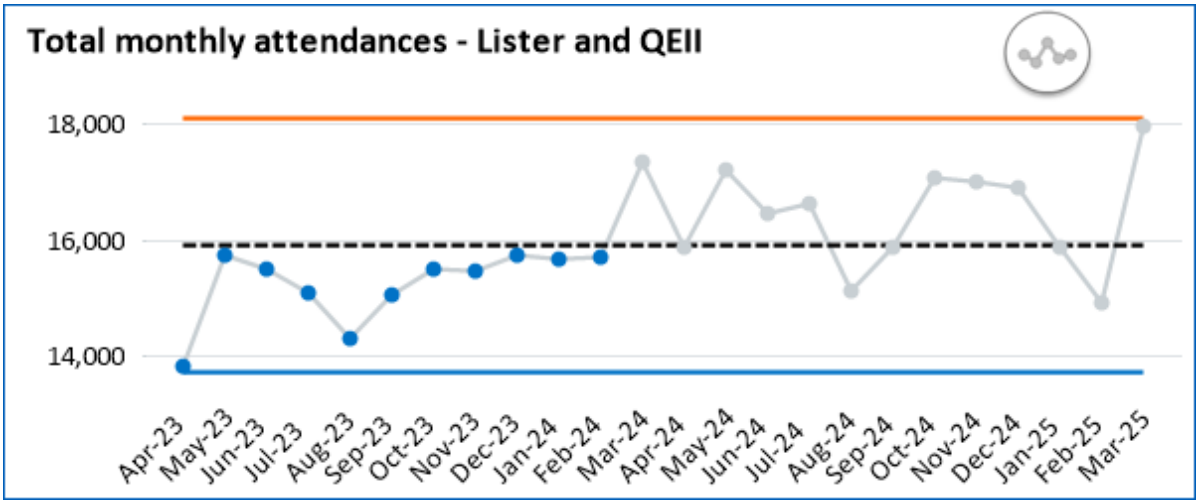


Urgent Care Pathways

In 2024/25, the Trust continued to work towards the national four-hour emergency care standard, which requires that 78% of patients attending ED or UTCs are admitted, transferred, or discharged within four hours. While performance in Urgent Treatment Centres and Children's ED remained consistently strong, improving outcomes for adults attending the main Emergency Department has remained a key focus.

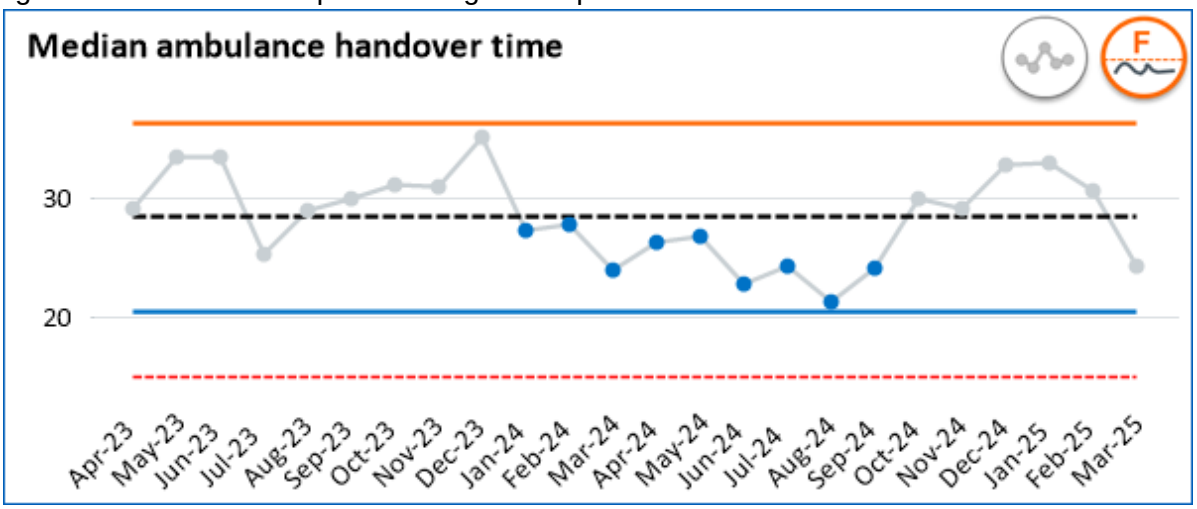


To address this, the Trust progressed a system-wide emergency care transformation programme aimed at reducing unnecessary ED attendances, improving flow, and enhancing patient experience. Key developments included the formal re-establishment of the Surgical Assessment Unit (SAU) and launch of the Surgical Same Day Emergency Care (SSDEC) service, both of which assess over 30 patients daily and now accept direct GP referrals. The Acute Medical Services (AMS) team will reset its service model from April 2025 to improve flow from ED and reduce inpatient admissions. Additionally, the Same Day Emergency Care (SDEC) service extended opening hours to 10pm to increase streaming capacity, and Children's ED improvements—such as an additional triage room and redesigned rosters—contributed to a measurable improvement in performance. By March 2025, Trust-wide four-hour performance had improved to 74%.



Ambulance handover

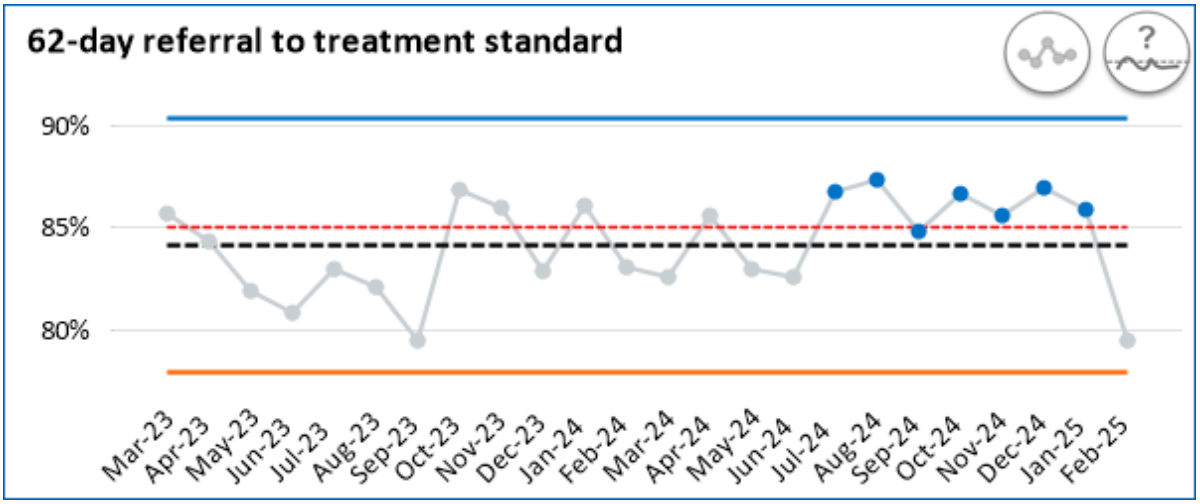
The Trust with East of England Ambulance Service Trust (EEAST) and other partners including Hertfordshire Community Trust, primary care, and other acute providers, worked hard to significantly reduce handover time for those patients brought to the department by ambulance. The target is 65% handover within 15 minutes. During the first nine months of the year, our ambulance handover times consistently remained under 30 minutes. However, as winter approached, we experienced an increase in patient acuity, leading to longer handover times. Despite these challenges, we are now observing a positive trend, with handover times beginning to decrease as we implement targeted improvements.



Cancer performance

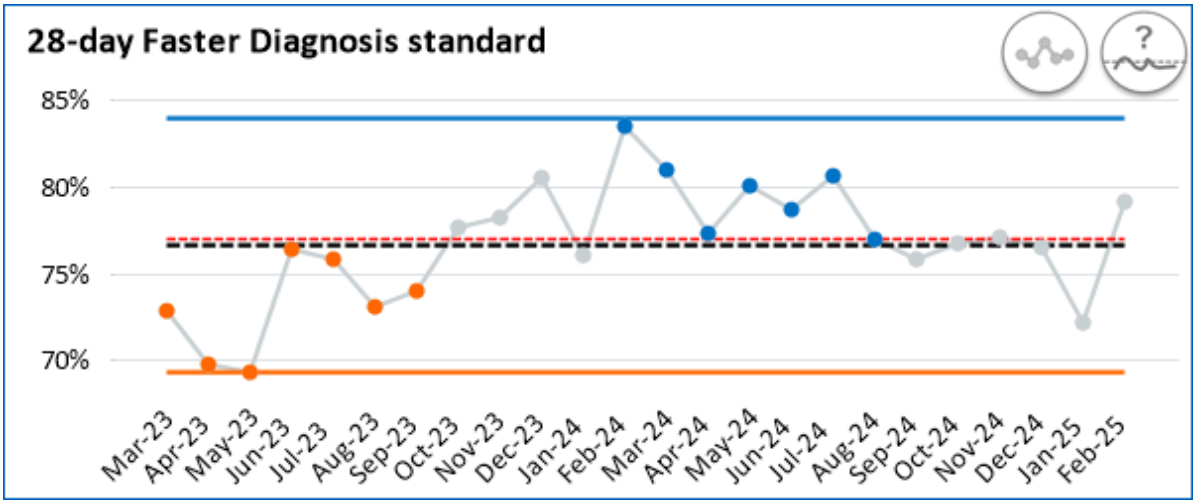
During 2024/25, the Trust reported on the three national cancer standards: the 28-day Faster Diagnosis, the 31-day Treatment, and the 62-day General standards.

The 62-day standard, while not consistently sustained, remained one of the strongest regionally and among the top ten performing trusts nationally. Challenges included increased two-week wait referrals, capacity constraints in imaging and endoscopy, and complex diagnostic pathways. Remedial actions are in place for 2025/26.



The 31-day treatment standard was maintained throughout the year, with one temporary dip due to radiotherapy capacity issues. These have been resolved through new linac machines and full staffing.

The 28-day Faster Diagnosis standard was consistently met, with performance reset to an 80% target by March 2026. The Trust's early adoption of the NHS England cancer pathway analyser tool has supported improvements and been nationally recognised.



Diagnostics: Standard: less than 1% of patients should wait 6 weeks or more for a diagnostic test
In diagnostics, while the Trust did not fully meet the national target of <1% of patients waiting over 6 weeks for a test, there has been a 43% reduction in >6-week waits and a 64% reduction in >13-week waits since April 2024. These improvements were driven by targeted capacity planning and productivity initiatives, despite increased demand from urgent and cancer referrals.

Stroke performance

The Trust maintained a B rating overall in the Sentinel Stroke National Audit Programme (SSNAP) since July 2023, with further ratings expected in mid-2025 following national methodology changes introduced in October 2024. Notably, confirmed stroke cases have exceeded the SSNAP monthly baseline of 63, with 91 confirmed cases reported in February 2025.

Significant progress was achieved across several domains. The Hyperacute Stroke Unit (HASU) was awarded an A rating, driven by improvements in rapid CT scanning under the new 'Straight to CT' pathway. The service also met its Trust-specific thrombolysis target of 14%, supported by a collaborative NHS England improvement programme. Future gains are expected from the introduction of CT Perfusion (CTP) in April 2025 and the full rollout of Stroke Video Triage, which has already shown benefit in speeding up pre-alert response.

Therapy services improved MDT input in 2024, though upcoming SSNAP changes will raise therapy frequency targets to three hours daily, likely impacting scores in the short term. Plans to mitigate this include establishing a new therapy gym and growing the speech and language therapy workforce through a development pipeline.

Challenges remain in timely admitting patients to the Stroke Unit within four hours and safeguarding dedicated stroke beds during periods of peak demand. The team aims to address these through pathway redesign, enhanced collaboration with other departments, and expanded out-of-hours and weekend medical cover.

The Trust continues to hold an A rating for case ascertainment, reflecting the consistent performance of the Stroke Data Team.

Seven Day Service

The national Seven Day Hospital Services (7DS) Programme is a quality improvement initiative providing acute provider organisations with a framework to work to reduce variation in outcomes for patients admitted to hospitals in an emergency and at the weekend across NHS trusts in England. There are four priority standards:

Standard 1: all emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant within 14 hours of admission. An audit undertaken in 2023 identified that approximately 66% of patients were reviewed within 14 hours of admission by a consultant.
The table below details the schedule for on-site consultant cover for our acute specialities: -

Specialty	7-day Consultant on-site rota cover
Acute Medicine/General Internal Medicine	0800-2100
Anaesthetics	0800-1800
Critical Care	0800-1800
Emergency Department	0800-2200
General Surgery	0800-1800
Obstetrics	24-hour consultant cover on site: 08:30 to 17:00 Monday to Sunday
Paediatrics	0830-2100
Respiratory	0830-1730
Trauma and Orthopaedics	0800-1800

Standard 5: inpatients must have scheduled 7-day access to diagnostic services.
The table below details our compliance with standard 5 regarding access to these emergency diagnostic tests

Emergency diagnostic test	Available at weekends
USS	Yes
CT	Yes
MRI	Yes
Endoscopy	Yes
Echocardiography	Yes
Microbiology	Yes

Standard 6: inpatients must have timely 24-hour access to key consultant -directed interventions.
The table below shows compliance regarding access to emergency consultant-led interventions:

Emergency Intervention	Available on site at weekends	Available via network at weekends	Not available
Intensive Care	Yes		
Interventional radiology			Yes
Interventional endoscopy	Yes		

Emergency Intervention	Available on site at weekends	Available via network at weekends	Not available
Surgery	Yes		
Renal Replacement Therapy (RRT)*	Yes		
Radiotherapy		Yes	
Stroke Thrombolysis		Yes	
Stroke thrombectomy		Yes	
PCU for MI	Yes		
**Cardiac pacing			Yes**

**RRT is available 7 days a week 24 hours a day. This is for haemodialysis and is carried out by nursing staff with medical oversight in an emergency where access needs to be established, and the patient reviewed prior to commencing RRT.*
***Cardiac pacing is not available on site at weekends on site. It is provided by the network if required.*

Standard 8: patients with high dependency needs should be seen by a consultant twice daily; then daily once a clear plan of care is in place. An audit during 2023 identified that approximately 60% of a sample of patients were reviewed within 14 hours of admission.

Rota Gaps

As part of the annual review, all departments are required to assess resident doctor rotas to ensure they meet both service needs and the educational and contractual requirements for doctors in training. This process addresses rota gaps arising from staffing changes, with prompt recruitment efforts and a focus on improving role attractiveness and induction processes to expedite full rota participation.

In 2024/25, the Trust's new shared leadership structure across care groups further supported improved rota gap coverage and workforce resilience.

Staff/ National staff survey

For 2025/26, we will focus primarily on themes around the following and continue work in other areas:

- 'Voice that counts'
- Reward and Recognition

Our overall scores shown below indicate improvements in all categories:

People Promise elements	2023 score	2024 score	Statistically significant change?
We are compassionate and inclusive	7.13	7.22	Significantly Improved
We are recognised and rewarded	5.83	5.91	Not significant
We each have a voice that counts	6.56	6.65	Significantly Improved
We are safe and healthy	5.99	6.09	Significantly Improved
We are always learning	5.55	5.78	Significantly Improved
We work flexibly	6.17	6.34	Significantly Improved
We are a team	6.65	6.76	Significantly Improved
Themes			
Staff Engagement	6.80	6.89	Significantly Improved
Morale	5.78	5.93	Significantly Improved

The Trust 2024 staff survey results resulted in 50.4% of staff completing the survey and the returns showed as statistically valid. ENHT is nationally recognised as the 4th most improved trust in its survey results.
In 2025/26, the Trust will continue its focus under the theme **"A Voice That Counts,"** with particular emphasis on strengthening how staff concerns about unsafe clinical practice are captured, shared, and acted upon through the Freedom to Speak Up Champions. This work aims to ensure that raising concerns leads to tangible improvements in patient care.

The Trust will also build on its commitment to reducing discrimination from patients, service users, and between staff by advancing actions from the Equality, Diversity and Inclusion (EDI) strategy. This will be supported by the newly established EDI Steering Group, which will enhance organisational learning and assurance.
Ongoing efforts will include training in recognising bias, holding courageous conversations, and continuing programmes such as de-escalation and breakaway training to support an inclusive, respectful, and safe workplace.

Patient Experience

Complaints and Compliments

In 2024/25, the Trust received 904 formal complaints, an 18% increase from 763 in the previous year. Complaint's themes most commonly related to communication and medical care.
The Trust recorded 5,864 PALS enquiries, a 26% rise from 2023/24, with 53% resolved within five days. Encouragingly, 68% of formal complaints were responded to within an agreed timeframe, an improvement on 48% the previous year, though below the Trust's 80% target. A total of 503 compliments were received and shared with staff, divisional leads, and the Chief Executive, up from 295 the year prior.

Indicator	22/23	23/24	24/25
Number of formal complaints	746	763	904
Number of PALS concerns	3496	4657	5864
Number of PALS concerns closed within 5 days/ % performance	1951 55%	2508 54%	3116 53%
Complaints – response within agreed timeframe	50%	48%	68%

*The Trust KPI is 80% of formal complaints to be responded to within an agreed timeframe

Our Trust recognises that complaint responsiveness improvements have not met expectations over the past 12 months, requiring sustained focus to embed progress made. The PACE Programme targets enhanced service responsiveness, volunteer engagement, and carer support accessibility.
We delivered over 12,000 volunteer hours across 4,000+ shifts while recruiting 23 Carer Volunteers into key support roles. Trust-wide initiatives included carer concessions, information packs, dementia grab packs, and personalized care posters to better meet patient and carer needs.
To strengthen resolution and responsiveness, new divisional dashboards using RAG ratings have been introduced to track complaint stages. The Trust will launch targeted complaints and PALS eLearning for Band 5 staff and above, and continues to promote early, face-to-face resolution with families. A business case has been submitted to enhance PALS staffing capacity to meet growing demand.

Parliamentary and Health Service Ombudsman complaints

In the reporting year, fifteen re-opened complaints were assessed by the Parliamentary and Health Service Ombudsman (PHSO). Five complaints were closed with no further investigation, three were partially upheld with learning for the Trust and seven remain under investigation.

Freedom to Speak Up / Raise Concerns:

In 2024/25, 311 staff raised concerns through the Freedom to Speak Up (FTSU) service, continuing a year-on-year increase (190 in 2022/23 and 270 in 2023/24). This sustained rise reflects a growing culture of openness and psychological safety. In response to rising demand, the FTSU service expanded its availability to five days per week, including weekends. The service continues to support improvements in patient safety, staff experience, and organisational learning. Key achievements include 87% completion of Speak Up training and 83% completion of Listen Up training among managers.

Staff Group	Numbers
Additional Professional Scientific & Technical	2
Additional Clinical Services	5
Administrative & Clerical	10
Allied Health Professionals	4
Medical & Dental	6
Nursing & Midwifery Registered	13
Total	**40**

The Speak Up Champion network grew to 40 trained champions representing all staff groups and grades. Concerns raised spanned worker wellbeing (47%), inappropriate behaviours (35%), patient safety (12%), and bullying and harassment (6%). Notably, no anonymous FTSU cases were recorded, and there was a marked reduction in anonymous CQC whistleblowing concerns. The Trust also reported a 3% increase in staff survey responses indicating confidence that concerns would be addressed.

Who is Speaking Up: In the year 2024/25, all staff groups across all sites accessed Speaking Up Service. The table below provides further details:

Staff Group	Number of Concerns Raised	Percentage
Additional Professional Scientific & Technical	16	5%
Additional Clinical Services	29	9.5%
Administrative & Clerical	52	17%
Allied Health Professionals	34	11%
Estates & Ancillary	7	2.3%
Healthcare Scientists	15	5%
Medical & Dental	62	20%
Nursing & Midwifery Registered	89	29%
Students	6	1.9%
Unknown (anonymous)	0	0
Other	1	0.3%
Total	311	100%

The predominant themes raised through the FTSU service in 2024/25 were worker safety and wellbeing (47%), inappropriate behaviours and incivility (35%), and patient safety concerns (12%), with a smaller proportion relating to bullying and harassment (6%).

Key issues included workplace stress linked to office moves, breakdowns in staff-manager relationships, failure to follow key HR processes, perceived discrimination, and concerns over staffing levels, skill mix, and clinical standards. These themes continue to highlight the importance of strong people management, inclusive communication, and psychologically safe team cultures as enablers of both staff wellbeing and patient safety

Part 3: Other information

Annex 1: Statements from commissioners, local Healthwatch organisations and overview and scrutiny committees

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Integrated Care Board (HWE ICB) response to the Quality Account of East and North Hertfordshire Teaching NHS Trust for 2024/2025.

NHS Hertfordshire and West Essex Integrated Care Board (HWE ICB) welcomes the opportunity to provide this statement on the East and North Hertfordshire Teaching NHS Trust (ENHTT) Quality Account for 2024/25. The ICB would like to thank ENHTT for preparing this Quality Account, developing future quality priorities, and acknowledging the importance of quality at a time when they continue to deliver services during ongoing challenging periods. We recognise the dedication, commitment and resilience of staff, and we would like to thank them for this.

HWE ICB is responsible for the commissioning of health services from ENHTT. During the year the ICB has been working closely with ENHTT in gaining assurance on the quality of care provided to ensure it is safe, effective, and delivers a positive patient experience. In line with the NHS (Quality Accounts) Regulations 2011 and the Amended Regulations 2017, the information contained within the Quality Account has been reviewed and checked against data sources, where this is available, and confirm this to be accurate and fairly interpreted to the best of our knowledge.

During 2024/25 the Nursing and Quality Team have worked closely with the Trust, meeting routinely to review a range of areas related to both quality and safety, for example regarding paediatric audiology services. We expect this joint work to continue in 2025/26 to deliver the transformation required.

The ICB has also worked in partnership with the Trust to undertake Partnership Quality Visits using an improvement approach to support driving improvements in patient safety and experience.

The Trust's Care Quality Commission (CQC) rating has remained as 'Requires Improvement'. The Trust continue to focus on their CQC Improvement Plan and progress is regularly reported to the ICB as well as the Trust Board and CQC. The ICB notes that in 2024/25 the Trust's Maternity service successfully stepped down from the National Maternity Safety Support Programme.

During 2024/25 ENHTT achieved a range of results in areas regarding quality, patient safety and patient experience, and the ICB is pleased to see the progress so far in relation to Quality Improvements in these areas. This is particularly pertinent in relation to the recognition of deteriorating patients, the ongoing work of the Patient and Carers Experience programme, and the successful launch of the East and North Hertfordshire Production System leadership training programme.

The ICB notes the sepsis pathway compliance continues to be part of the Trust's sustainability plans for 2025/26. We will continue to seek assurance that this, alongside venous thromboembolism risk assessments, continues to move in the required direction and that related performance is sustained.

The Summary Hospital-level Mortality Indicator data reported throughout the year is positioned in the 'as expected' range. It is encouraging to see the work undertaken to reduce mortality and ensure learning and robust processes are in place.

In relation to Infection Prevention Control (IPC), the Trust reported two MRSA bacteraemia cases for 2024/25 with post infection reviews held to ensure actions from the learning were carried out and sustained. Cases of Clostridium difficile have reduced by 6.5% compared to the previous year and cases have undergone a review, to support learning and improvement, and the aligned work undertaken by the IPC team in providing education, training and support is also noted. The ICB will continue to have oversight and seek assurance regarding Clostridium difficile cases for 2025/26.

During 2024/25 the Trust reported 5 Never Events; an increase from the two reported the previous year. The ICB notes the Trust's ongoing actions and identified learning related to these incidents to prevent similar incidents in future, as well as engagement with the wider system work to encourage learning from Never Events is identified and shared. The ICB will continue to monitor this closely and offer support to ensure learning is appropriately embedded.

The timeliness of complaint responses has seen an increase in performance during 2024/25 and the Trust recognises the sustained focus required to meet the complaint responsiveness target. The ICB acknowledges the ongoing work related to strengthening complaints resolution and responsiveness and looks forward to seeing continued improvements in this area and in ensuring that patients and families receive prompt responses to concerns raised.

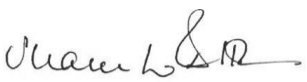
During 2024/25, the Trust reported on three national cancer standards. For the 28-day faster diagnosis standard, the Trust has consistently met the target threshold throughout the year and the Trust's early adoption of the NHS England cancer pathway analyser tool has supported improvements and has been nationally recognised. For the 31- day treatment standard the Trust has also met the target throughout the year with the exception of one month. For the 62-day treatment standard, while not consistently sustained, the Trust's performance against this standard has remained one of the strongest regionally and among the top ten performing trusts nationally. The ICB is pleased to see that improvements continue to be made and would encourage the Trust to sustain a strong commitment and focus in this area.

In 2024/25, the Trust continued to work towards the national four-hour emergency care standard, achieving 73.18% which is a 10% improvement year-on-year. The Trust have progressed a system-wide emergency care transformation programme aimed at reducing unnecessary Emergency Department attendances, improving flow, and enhancing patient experience. Key developments included the formal re-establishment of the Surgical Assessment Unit, the launch of the Surgical Same Day Emergency Care service and the Adult Urgent Treatment Centre. In 2025/26 the ICB would like to see the Trust focusing on its work with partners to improve the experiences for patients who access urgent and emergency care services.

The 2024 annual National staff survey results for the Trust showed improvements in all categories and the Trust was recognised as the 4th most improved Trust nationally. The ICB recognises the ongoing work and commitment within the Trust in progressing the identified themes of the staff survey.

The ICB acknowledges ENHTT for their dedication in implementing the Patient Safety Incident Response Framework (PSIRF), strengthening how the NHS learns from patient safety incidents to enhance care and outcomes. We will continue our joint working with ENHTT and system partners as part of continued progression with PSIRF and the National Patient Safety Strategy and recognise that evidencing key principles such as compassionate engagement, proportionality, and system-wide approaches will be vital to ensure its ongoing success.

Looking forward to 2025/26, the ICB supports ENHTT quality priorities, and we look forward to a continued collaborative working relationship, including through building on existing successes and collectively taking forward needed improvements to deliver high-quality services for this year and thereafter.



Sharn Elton
Place Director,
East and North Hertfordshire Hertfordshire and West Essex ICB

Healthwatch Hertfordshire's response to the East and North Hertfordshire Hospital NHS Trust (ENHT) Quality Account 2024/2025

Healthwatch Hertfordshire is pleased to provide a response to ENHT's Quality Account 2024/25.
ENHT demonstrates a learning culture with a good level of openness in the Quality Account and has been open to Healthwatch Hertfordshire being a critical friend, with opportunities for us to be involved in their public Trust Board meetings. Over the past year, conversations about the best ways to communicate and engage with patients in their community have been rightly high on their agendas, and we continue to be a supporting partner in making sure patient voices are part of their decision making.

Collaborative work with system partners is evident. For example, the work with the East of England Ambulance Service NHS Trust (EEAST) and other partners including Hertfordshire Community NHS Trust, primary care, and other acute providers to improve ambulance handover times to under 30 minutes and seeing a positive trend (although understandably winter pressures created a blip in performance). The Acute Provider Collaboration also enables better working across partner trusts.

We are pleased to see that advance care planning is continuing to be a focus. We are doing a piece of work on advance care planning together with resources on ageing well and working closely with charities which support people. We would be interested in collaborating on this work or would be happy to share with ENHT once completed (at the end of 2025).

We welcome the explicit focus on tackling health inequalities (Priority 6) around paediatrics and maternity. We know from our Making Local Healthcare Equal: Healthcare Concerns in Black and Asian Communities | Healthwatch Hertfordshire that Black and Asian people experience significantly poorer health outcomes than their White counterparts. As reducing health inequalities is a key area our own work, we would welcome collaboration with the Trust.

We commend the work on Priority 3 'Patient and Carer Experience Programme', and the Trust's acknowledgement that there is still more to do. We look forward to seeing how this programme develops in the coming year particularly around complaints responsiveness.

Children's community waits are a significant area of concern in Hertfordshire, and we particularly note the ongoing work on the Trust's Paediatric Audiology Services and commend the system collaborative work and mutual aid and support from other organisations to improve the situation for families and children. We hope to start seeing improvements in the coming year.

We congratulate the Trust on being named the most improved Trust in the 2023 CQC governance maternity survey, showing how the Trust is building up the quality of their services especially since the National Maternity Improvement programme inspection in 2023, although we note that the highest number of Speak Up incidents being reported from staff are still in Nursing and Midwifery so a continued focus on this is important.

We welcome the rollout of a new unified Electronic Patient Record (OneEPR) and the ambition to streamline outpatients and improve patient access and choice. However, our recent work looking at online GP services highlighted that many people were concerned about the accessibility of online services and the impact digitalisation may have on those who struggle to use technology. We hope that ENHT's enhanced patient, community engagement and embedded coproduction processes will be fully utilised in understanding what patients need to engage effectively with the system. We would be happy to share our expertise on coproduction and engagement with the Trust.

To reduce the risk of patients deteriorating, we particularly note the work to implement Martha's Rule (a patient safety initiative for families and staff to call for an independent review if they are concerned about a patient's deterioration). At the Trust this is known as Call for Concern, and we know that the Trust is doing a

lot of work around this to ensure families are listened to by analysing how it is working in order to raise awareness and improve communications to engage wider areas of the community.

We congratulate the Trust on their work on safeguarding and the plans for sustainability in 2025/26 and in particular to better meet the needs of individuals with learning disabilities and autism.

We welcome the continued focus on staff engagement and morale and the 'A Voice That Counts' work, focussing on how staff concerns about unsafe clinical practice are captured, shared, and acted upon through the Freedom to Speak Up Champions. The Trust is rightly proud that it is nationally recognised as the 4th most improved trust in its survey results. We also note the focus on reducing discrimination via the Equality Diversity and Inclusion strategy and Steering Group. Our research on the experience of International Recruits in the NHS highlights the support that staff need in their roles. Retaining and supporting staff to provide high quality care is crucial to ensuring patient safety and experience.

We look forward to continuing to work closely with the Trust to help enhance opportunities for patient voices to be heard and services to be improved, including supporting the quality priorities outlined in this Quality Account.

Neil Tester, Chair Healthwatch Hertfordshire
June 2025

Statement from Social Care Health and Housing Overview and Scrutiny Committee.

Central Bedfordshire Council's Social Care Health and Housing Overview and Scrutiny Committee holds decision-makers to account for improving outcomes and services for the residents of Central Bedfordshire. As a critical friend to the Trust, we are pleased to have an opportunity to provide feedback on the Trust's Quality Account for East and North Hertfordshire NHS Trust.

We would like to start by acknowledging the many highlights and achievements delivered by the Trust during the last year.

We make specific reference to:

- being named the most improved Trust in the 2023 CQC governance maternity survey having performed significantly better in 15 areas.
- The focus on improving patient safety and the resulting 20% increase in incident reporting and improved thematic reviews which we hope reflects improved awareness of the importance of patient safety within the Trust.
- We also welcome the improvement in staff survey results, and the Trust's standing as the fourth most improved Trust nationally.

We welcome the inclusion of the quality priority 5 focused on Person-Centred and Seamless Pathways and hope that this work helps to ensure that care is accessible, timely, and of high quality and focuses on engaging and empowering people to take an active role in their health. In addition, that quality priority 6 Tackling Health Inequalities and Promoting Equity seeks to address the disparities in health outcomes and access to care that exist among different population groups.

We also welcome the focus in the coming year on the rollout of a new unified Electronic Patient Record and hope that this will offer patients a more joined-up and efficient service from the Trust and allow for more efficient working between teams and departments as well as improved patient communication.

We highlight the following areas of concern and areas for improvement.

- That the Trust's current registration status with the CQC is 'requires improvement.' We would welcome more detail in the report on the actions the Trust is undertaking in order to address the areas of concern identified in the most recent CQC inspection.
- The Trust's performance in meeting the national four-hour emergency care standard remains below the target, with a current performance of 74% although we recognise the focus on delivering improvement against this target over the past year including the extension of the Same Day Emergency Care service hours.
- The continued challenge of reducing ambulance handover times and the need for further progress on this, an area which has been of particular interest to the Committee over the past year.
- The Trust has not fully met the national target of less than 1% of patients waiting over six weeks for a diagnostic test.
- The Trust's responsiveness to formal complaints has improved but still falls short of the 80% target, with 68% of complaints responded to within the agreed timeframe.

We would like further information in the future illustrating the ways in which patients and the public were involved with the production of the Quality Account. We would also like to see an Executive Summary included in the report with summaries of key achievements and key areas of concern. We also believe that important information, such as the Trust's CQC rating, and learning from deaths workstream would benefit from being more prominent in the document with a clearer summary of action going forward.

In conclusion we welcome the opportunity to consider and comment on the report and we look forward to working constructively with the Trust to support the scrutiny process and our residents.

Cllr Emma Holland-Lindsay,
Chair, Central Bedfordshire, Social Care Health and Housing Overview and Scrutiny Committee.

Statement of adjustment following receipt of written statements required by section 5(1) (d) of the National Health Service (Quality Account) Regulations 2010

There are no major adjustments to be made following the receipt of written statements.

Annex 2: Statement of Directors' Responsibilities

Statement of directors' responsibilities in respect of the Quality Account

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended by the National Health Service (Quality Accounts) Amendment Regulations 2011, 2012, 2017 and 2020).

In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

- the Quality Accounts presents a balanced picture of the trust's performance over the period covered.
- the performance information reported in the Quality Account is reliable and accurate.
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice.
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health guidance.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.

By order of the Board

28 June 2025 Date Anita Day, Chair

28 June 2025 Date Adam Sewell-Jones, Chief Executive

Glossary

Acronym	Meaning
AAR's	After Action Review
AMS	Antimicrobial Stewardship
B. I	Business Intelligence
C-DIFF	Clostridium difficile
CCU	Critical Care Unit
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
DSAT	Domestic and Sexual Abuse Team
DSPT	Data Security and Protection Toolkit
Enhance	Trust's Risk and Incident Management System
ENHT	East and North Hertfordshire NHS Trust
ENHPS	East and North Herts Production System
ED	Emergency Department
ePMA	Electronic Prescribing Medicines Management
EPR	Electronic Patient Records
EOLC	End of Life Care
FFT	Friends and Family Test
GDPR	General data protection regulation
GSF	Gold Standards Framework (for End of Lice Care)
H@H	Hospital at Home
HAT	Hospital acquired thrombosis
HSMR	Hospital Standardised Mortality Ratio
ICB	Integrated Care Board
IPC	Infection Prevention and Control
KPI	Key Performance Indicator
LocSIPPs	Local Safety Standards for Invasive Procedures
MRSA	Methicillin-Resistant Staphylococcus Aureus
NHS	National Health Service
NIHR	National Institute for Health Research
PALS	Patient Advice and Liaison Service
PHSO	Parliamentary and Health Service Ombudsman
PROM	Patient Reported Outcome Measures
PSIRF	Patient Safety Incident Response Framework
QI/P	Quality Improvement/Project
RCA	Root Cause Analysis
PIFU	Patient initiated follow up
RTT	Referred to Treatment
SDEC	Same day Emergency Care
SHMI	Summary Hospital Level Mortality Indicator
SJR	Structured Judgement Review
SJRPlus	Structured Judgement Review Plus
SUS	Secondary Uses service
QI	Quality Improvement
VTE	Venous thromboembolism

East and North Hertfordshire Teaching NHS Trust

Our vision is: To be trusted to provide consistently outstanding care and exemplary service.