June 2026

East and North Hertfordshire Teaching NHS Trust

Quality Account 2025-2026

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Part one

1.1 Chief Executive's Foreword

The 2025-26 Quality Account shows our performance against the commitments we have made to provide safer, more effective, and person-centred care for our patients. The data presented in this report shows how challenging our operating environment continues to be but we can be proud of the improvements we have achieved on behalf of the communities we serve.

We continued to manage high demand this year with nearly 185,000 emergency department attendances, over 52,000 inpatients, and more than 610,000 outpatient appointments. Urgent and emergency care performance improved to 74% from 70% the previous year but was below the March 2026 78% target.

Colleagues worked hard to mitigate the impacts of industrial action which inevitably affected elective care, but we largely met key targets. The number of patients waiting over 52 weeks reduced, demonstrating progress against national elective recovery priorities.

The NHS Oversight Framework, a new performance league table for NHS trusts, launched this year and we were placed in segment two throughout 2025/26. We were consistently ranked with the higher performing NHS trusts nationally.

The ENH Production System, our improvement method and management system, continues to embed into our way of life with its focus on safety culture, reducing waste, and improving the experience of both patients and staff.

Since its launch in 2024, nearly 1,700 staff have now completed ‘ENHPS for all’, the first level of training. Our next goal is to accelerate the roll-out of daily management - an integral part of ENHPS - enabling teams to identify and resolve issues earlier, continuously improving services for patients and staff.

The patient safety incident response framework (PSIRF) first adopted in 2023 is also strongly embedded and shows the incident reporting trend moving upwards. Of the more than 19,700 incidents recorded in 2025/26, 97% were low and no harm. Good care events have seen a 40% recording increase over the same period.

Call for Concern (Martha's Rule), the patient safety initiative which enables patients and carers to call for an independent clinical review has been in place for over a year across our wards, maternity, children’s services, and children’s and adults emergency departments. This year, there was a 100% response rate to the 214 calls asking for in-person clinical assessments.

While we have continued to perform above the national average across all three cancer standards there are inevitably challenges we need to meet. These include increased two-week wait referrals and capacity constraints in imaging and endoscopy. Imaging will remain a focus in 2026/27 as the service embarks on its transformation programme.

I would like to recognise the efforts of our brilliant workforce as shown in the following pages, and thank colleagues who work diligently to ensure we continue to provide high-quality compassionate care for all our communities.

Martin Armstrong
Chief Executive

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 to improve 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 the headings of Safe, Effective and Patient Experience, as outlined by Lord Darzi in his 2008 report 'High Quality Care for All'.

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

The Trust has refreshed and simplified its strategic goals for 2026/27, reducing the previous eight goals to four clear organisational priorities. Developed through a structured series of leadership 'catchball' discussions, the goals reflect learning from the past year and feedback from senior leaders requesting greater clarity and focus during a particularly challenging period for the NHS. The refined goals demonstrate an iterative process and are designed to shape leadership behaviours, culture and system design, ensuring the organisation's vision - to be trusted to consistently provide outstanding care and exemplary service - is translated into meaningful day-to-day action across services.

The Quality goal emphasises psychological safety, learning and prevention. It encourages teams to identify problems early, speak up about risks and continuously improve processes so care becomes safer, more reliable and less dependent on workarounds.

The Thriving People goal focuses on simplifying processes, reducing unnecessary bureaucracy and creating the conditions for staff to do meaningful work. It prioritises clarity, wellbeing, inclusion, development and digital support so staff have the time and capability to improve services while delivering care.

The Seamless Services goal aims to reduce fragmentation across organisational and system boundaries. It promotes stronger collaboration between teams and partners, improved information sharing and better coordination of patient pathways to reduce delays, duplication and hand-offs.

The Continuous Improvement goal strengthens the use of data, digital capability and innovation to support learning and productivity.

Progress in cascading these goals through the organisation continues to develop, with strong adoption already evident at divisional, care group and corporate department levels. The next phase of work will focus on embedding alignment at specialty, ward and departmental level so that every team can clearly connect its objectives and improvement work to the Trust's strategic priorities.

To support this, the Trust will accelerate the roll-out of daily management – an integral part of ENHPS, our improvement method and management system – strengthening visual management, local problem-solving and leadership oversight across the organisation. This will improve the line of sight between strategy and day-to-day operations, enabling teams to identify issues earlier, implement countermeasures and continuously improve services for patients and staff.

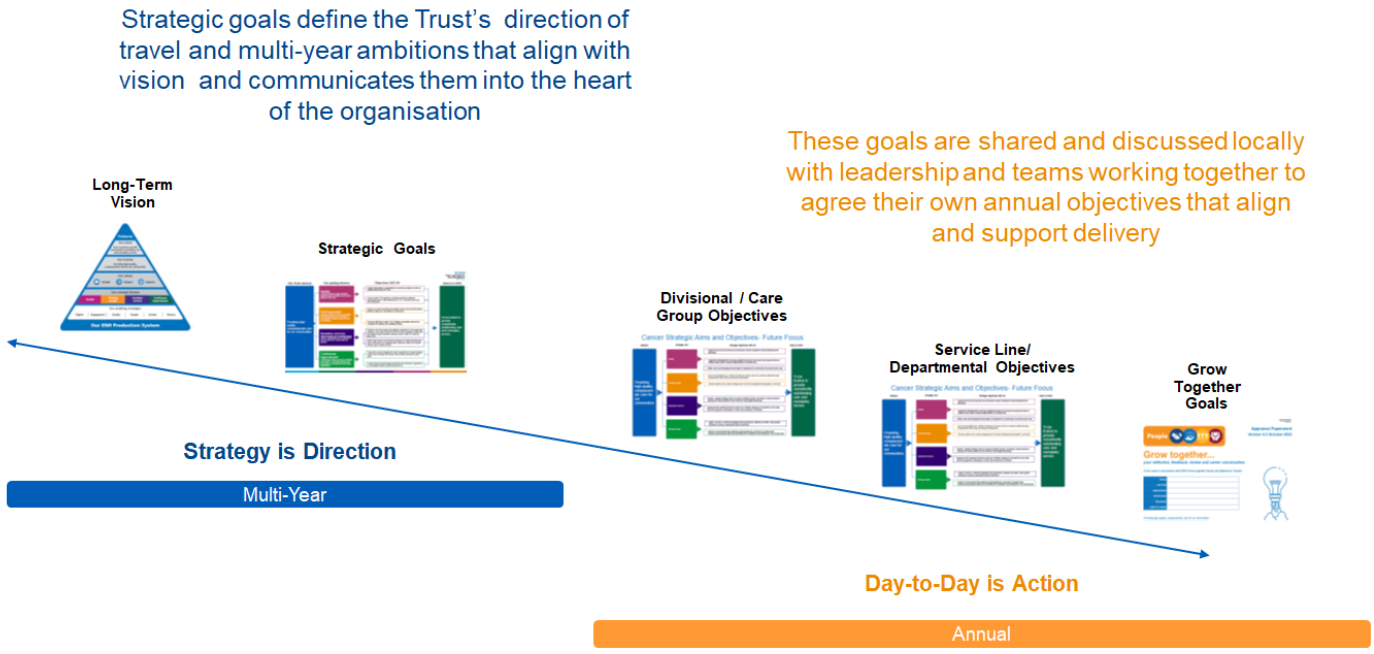


Fig 2: Strategic goal cascade from vision to individual grow together conversations

The final stage of strategic cascade follows through to our 'Grow Together' annual appraisal process where team objectives are further broken down into individual aligned objectives and personal development plans. Strategic goals set the organisation's direction and define the outcomes we must achieve for patients, staff and the communities we serve. Grow Together objectives translate these priorities into clear, individual commitments, ensuring every member of staff understands how their role contributes to delivery. By aligning personal objectives with the Trust's strategic goals, individuals can focus their efforts on the activities that matter most, while leaders can support development, accountability and learning. This alignment strengthens collective ownership of improvement, connects daily work to long-term ambition, and helps ensure that progress towards our strategic priorities is driven by the actions and growth of all our people.

ENHT organisational structure

The Trust has four clinical divisions (Women and 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.

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

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 where 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 has continued to advance improved quality oversight through the introduction of the Power Business Intelligence platform, where oversight of quality data intelligence can be triangulated with performance, workforce and finance intelligence. Further development of the quality oversight platform 'Enhance' enabling real-time, ward-to-board triangulation of incidents, risks, complaints, National Institute for Health and Care Excellence (NICE) compliance, and now safeguarding, freedom to speak up (FTSU) and learning from deaths information.

Quality Improvement (QI) capability and capacity was strengthened through the 'ENHPS for all' training delivered to a further 964 staff. A total of 1,698 staff have now completed this training. A further 'ENHPS for Leaders' was delivered to 29 staff, equating to 56 leaders in total. The patient safety incident response framework (PSIRF) has matured organisational learning with a sustained trend in incident reporting with 19,763 recorded in 2025/26, 97% of which were low and no harm. There has also been a 40% increase in good care events reported with 945 recorded in 2025/26, supporting the opportunity to apply the principles of 'safety II' methodology (which focuses on what's going right in a system).

Patient Experience: The Trust has continued to embed carer and patient involvement, overseen by the Patient and Carer Experience (PACE) Programme. Patient safety incidents have embraced strong patient and family engagement to co-design post-incident improvements to personalised care. Maternity services

received national recognition from service users for compassionate care. Specific equity actions in paediatrics, maternity and in the learning disability population have contributed to service redesign that focused on continuity and accessibility. These were supported by increased responsiveness to complaints and sustained patient engagement.

Safe:
High levels of sepsis compliance have been maintained across more than 80% of process measures, reflecting on-going clinical engagement and risk management. The organisation has been recognised for embedding a new patient safety initiative called Martha's Rule or Call for Concern where staff. or carers or relatives can call for a clinical review of a deteriorating patient. Two hundred and fourteen calls were made and all received an in-person clinical assessment. Ninety percent of calls were from patient carers or relatives across adult and paediatric services. Responding to learning from identified clinical risk has been successfully achieved through multi-disciplinary in-situ simulation, generating action-oriented and effective risk reduction.

Well-Led: Governance maturity has continued to develop and redesign the trust risk management approach. The risk register saw a further 15% reduction in open risks, supported by an improved bi-annual executive summit response to all risks scored above 15. A successful pilot of good governance self-assessment has been undertaken by the Cancer Division and will be adopted by other divisions in 2025/26. Speak Up systems saw a 5% sustained trend in concerns being raised, with 91% of staff completing Speak Up training.

2.1 1. Progress with 2025/2026 priorities

2.1.1. Quality Priorities 2025 to 2026				
Domain	**Description**	**Key focus areas**	**How we measured success**	**Achievements to date**
Safe	**# Priority 1** Strengthening fundamentals of care and governance	1.1 Incident management		
		• Daily incident huddles to support safety culture • Embedding of patient safety incident response framework (PSIRF) processes at ward and site level • Reduction in overdue incident closures	• Reduction in overdue incident closures • Staff feedback on basic care delivery • Standardise governance • Closing the loop on learning	• A 50% reduction in open incidents has been achieved within most divisional governance structures • Following a successful pilot in 2024/25 the trust has now sustained in-situ simulation programmes in response to clinical risk and incidents reported • NHS Staff Survey demonstrated that 86% of staff, who responded said they are encouraged to report incidents. This is above the staff survey national average • All care groups have embedded PSIRF oversight panels
		1.2 Compliance with core fundamental standards		
		• Sepsis • Escalation of concerns • VTE (Venous Thromboembolism)	• Sepsis recognition and time to critical management interventions • VTE risk assessment • Martha's Rule	• Sepsis intravenous antibiotics administered 92% reliably in the emergency department • Intravenous antibiotics administered 88% reliably in inpatient settings • ED sepsis six bundle in both ED and

				inpatient areas are below 90% target, due to fluid balance management starting on average at 70 minutes in ED, and delays to lactate measurement in inpatient settings, both below 60-minute target • Neutropenic antibiotic compliance within one hour sits at 95% in 2025/2026 • VTE risk assessment improved Trust-wide from 65% in 2025 to 79% in 2026 • An 'Is SAFE' in-situ simulation programme is now fully embedded within the resuscitation services work plan, supporting learning across technical and non-technical skills • 100% of 214 Martha's Rule calls received in-person clinical assessments • 90% of calls were from patient relatives/carers, 7% from staff and 3% from patients • 35% of patients had some element of clinical deterioration, with over 50% requiring some form of clinical intervention • 15 calls relating to paediatric patients

				• Component 1, patient wellness question, now rolled out across all adult inpatient wards • Component 2 and 3, published phone number is now available to staff, patients and relatives outside of usual escalation routes and fully embedded in adult and paediatric settings
		P 1.3 Infection, prevention and control		
		• Maintain weekly C. difficile multidisciplinary (MDT) reviews to sustain reductions in infection rates • Extend our Aseptic Non-Touch Technique competency training programme to all clinical areas and embed into routine practice • Continue collaborative work with specialty teams to refine post-	• C. difficile infection threshold less than or equal to 82 • Producing IPC Level 1 and Level 2 e-learning sessions completion rates (target over 90%) • MRSA bacteraemia • E. coli bloodstream infections	• Successful deployment of refreshed aseptic technique training programme, in partnership with intravenous improvement group • Successfully delivered weekly MDT C. diff prevention huddles • Improved reduction in healthcare associated C. diff cases which went from 86 in 2024/25 to 68 in 2025/26 • Infection prevention and control training level 1 achieved trust wide at 87%, aiming for 90%. • 4 MRSA bacteraemia were reported in 2025/26 (against a threshold of zero) • 51 E. coli bloodstream infections (against threshold of 46 cases)

		infection learning and strengthen PPE (Personal Protective Equipment) training for high-risk pathways		
		1.4 Safeguarding		
		• Safeguarding oversight and triangulation with other domains of quality • Increase in safeguarding referrals through enhanced awareness and training • Increased safeguarding training compliance with intercollegiate document standards • Improved outpatient attendance for patients with learning disabilities	• Improved process to apply reasonable adjustments • Recognition and referral of adult and paediatric patients at risk from neglect, abuse or harm	• During 2025/26, the Trust submitted more than 1,000 applications to a supervisory body, compared to 878 in 2024/25 • 2025/26, the Trust reported 654 safeguarding concerns on behalf of service users related to alleged abuse that took place in the community • In October 2025, the government announced its intention to commence a new consultation regarding the liberty protection safeguards (LPS) in mid-2026. • 70 of these concerns related to neglect and acts of omission with the root causes being gaps in the delivery of the fundamentals of nursing care which related to the following themes: - Hospital acquired pressure ulcers where After Action Reviews (AAR) highlighted gaps in the provision of care which contributed to the cause. - Missing documentation on discharge

				such as medical summaries, body maps, or wound management care plans which impacted on the post discharge continuity of care - Failure to discharge patients with critical medications • 75% of patient-facing Trust staff have completed training on the Mental Capacity Act in the past 3 years - 80% of registered nursing and midwifery staff have completed this training - 55% of medical staff have completed the training • During 2025/26 the Domestic and Sexual Abuse Team (DSAT) supported 623 victims of domestic abuse, 57 victims of sexual assault and 56 victims of child sexual assault or abuse. Overall, the services activity increased by 18.4% when compared to the previous year • Commissioned a targeted learning disability improvement programme in response to learning from incidents. Over 70% of actions have been completed
		1.5 Invasive Procedures		

		• Safe Invasive procedures / LocSSIP	• Compliance Percentage Tracking: Average Local Safety Standards for Invasive Procedures (LocSSIP) compliance rate of over 92% across all audited patient pathways • Quality and consistency of safety checks in (LocSSIPs)	• Most work over the past year has focused on auditing and embedding Safer Standards for Invasive Procedures across the wider organisation, extending assurance beyond main theatres and procedure areas to all settings where invasive procedures are undertaken • Published and disseminated trust NatSSIP/LocSSIP policy (National Safety Standards for Invasive Procedures/Local Safety Standards for Invasive Procedures) • Completed a thematic review of never events from the previous year, examining the application of the surgical safety checklist, site marking, swab and instrument counting, and implant checking processes • Achieved zero never events over the past year, reflecting the impact of strengthened safety practices across invasive procedures • Local compliance is monitored through real time audit dashboards ranging from 80-90% compliance • PSIRF responses that proactively seek out learning and near misses related to invasive procedures, particular focus on

				the consent process for gynaecology patients • Introduced in situ simulation in theatres to improve human factors, alongside the wider rollout of human factors training across relevant clinical teams
		1.6 Good governance compliance framework		
		• 50% staff survey response rate • Percentage of risks in approved stage review • Compliance with standardised risk scoring metrics (ISO standards) • Commissioned external validation of risk management approach	• Quality assurance framework – standardised across new operational management model • Enhanced oversight of clinical risk • Policy compliance	• Staff survey response was 41% in 2025, in comparison to national median of 47% • Cancer division successfully piloted and adopted Good Governance Institute governance self-assessment matrix • Risk management maturity has continued with a reduction in open risks from 459 in March 2025 to 390 in March 2026 • A revised trust board risk appetite that now includes Digital and Estates risks • Successful biannual risk summit where all trust risks above 15 are reviewed across senior leadership and executive teams • Newly published risk management and strategy • Improved document and policy management and oversight. Compliance improved from 80% in March 2025 to 90% in March 2026 • Internal audit review undertaken and

				risk management processes achieved reasonable assurance. • Significant development in Quality Oversight Platform to now include ward to board dashboards, FTSU data, Learning from Deaths and Mortality, Martha's Rule/Call for Concern, Safeguarding and GP liaison information.
		• FTSU	Freedom to speak up - strengthening the FTSU multidisciplinary team network	• There have been increased speaking up episodes reaching 326 in 2025/26 with sustained year-on-year growth (from 270 in 2023/24 and 311 in 2024/25) • Enhanced service capacity with speaking up support accessible 5 days a week, including weekends • Expanded FTSU Champion network to include 40 representatives across all professional streams • 2 anonymous FTSU cases were reported in 2025/26.
Priorities 2026/27	• We will deliver a structured 'Safe Fundamentals of Care' Programme, measured against core performance safety and risk indicators • Complete current learning disability improvement programme, and transition to business as usual improved processes • We will sustain and improve time to critical sepsis bundle interventions by improving timeliness of fluid balance documentation and lactate measurement from an average of 70 minutes to below 60 minutes • Enhance clinical knowledge and human factors non-technical skills through continued multidisciplinary simulation programme • Martha's Rule: scale and spread Call for Concern wellness question			

	• 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 and scale and spread Good Governance self-assessment programme • We will continue to strengthen triangulation across patient experience, complaints, and incident data, particularly in post-incident support and carer involvement via Quality Oversight Platform • Support the workforce and manage expectations when raising a concern, and/or responding to a concern through a targeted People team and FTSU Office 'Listen up' programme of work and agree protected time for Speak Up Champions to support FTSU service team			
Domain	**Description**	**Key focus areas**	**How we measured success**	**Achievements to date**
Well Led	**#Priority 2** **Learning in response to patient safety incidents**	2.1 Trust-wide PSIRF training and learning response adoption		
		• Consistent incident response tools (e.g. Swarms, AARs) • Leadership visibility on safety themes and action closures • Systematic use of governance and improvement tools to reduce risk	• Percentage of learning responses completed using PSIRF tools • Safety culture metrics • Standardised reporting across divisions • Medication safety • Improved communication and escalation for deteriorating patients • MDT simulation training	• Incident reporting has increased from 17,196 in 2024/25 to 19,763 in 2025/26 • 97% of incidents reported are low/no harm • No never events were reported in 2025/26 period • There has been a 40% increase in good care events reported (from 586 in 2024/25 to 945 in 2025/26), supporting the principles of 'safety II' methodology • Multiple role essential PSIRF training requirements have been provided for staff in oversight roles • All care group and divisions have established daily and/or weekly incident oversight panels • MDT simulation programme now

				sustainably embedded • AAR and Swarm training have been provided by external providers and are now being operationalised • The Trust has successfully partnered with the accredited Oxford University Hospital Human Factors Faculty (Oxstar) to establish the trust's Human Factors faculty, who have successfully delivered two masterclasses • Staff survey demonstrates 86% of staff feel encouraged to report errors or incidents, compared to national average of 85%. • Unconscious bias training has been commissioned in response to learning from incidents
	# Priority 3 **Embedding an inclusive and improving culture**	3.1 Continued leadership development		
		• QI projects aligned to Trust priorities • Expansion of QI capability through coaching and training	• ENHPS adoption rates • Participation in QI training • Divisional QI initiatives linked to alignment of Trust goals ward to board	• 'ENHPS for all' has reached 964 staff (13.8%), this now totals 1,698 staff (24.2%) • 'ENHPS for Leaders': 29 leaders finished the course last year; this equates to 56 leaders completed • All divisional board members have mapped service level quality priorities against strategic goals

		3.2 People strategy objectives		
		The organisation strengthened work, grow, thrive, and care pillars, which continues to effectively support strategic priorities through integrated plans aligned with NHS workforce requirements	• Equality diversity and inclusion (EDI) actions	• The ENH Academy now offers a range of training programmes covering a wide range of issues from unconscious bias to antisemitism • The 'EDI Workbook' is now the overseeing programme of work covering EDI and is aligned to the ENH EDI Strategy and the NHSE EDI Improvement Plan • EDI Steering Group now reports monthly – Divisions present their plans and actions to improve EDI in their area • Staff Networks report monthly to the EDI Steering Group and a new role 'Colleague Experience Lead' coordinates their activity • Staff Networks have continued to expand and further development has seen the introduction of a 'United Network' approach to certain organisational activities
Priorities 2026/27	• We will strengthen our PSIRF processes by improving engagement with those involved in patient safety incidents • We will improve how staff receive feedback following reporting and reviewing incidents • We will improve timeliness of learning responses to patient safety incidents • We will drive continuous improvement through learning from incidents and effective risk reduction actions • We will continue to deliver ENHPS capability to provide staff with the skills and knowledge required to drive continuous			

	improvement • A new post in the organisation 'Inclusion and Change Lead' has been recruited and will commence in the summer of 2026 • The RSA (Recruitment and Selection Ambassador) programme will launch in 2026 to improve the recruitment process – reduce bias and monitor recruitment of protected characteristic colleagues • We will increase oversight and actions with Ethnicity Pay Gap data			
Domain	**Description**	**Key focus areas**	**How we measured success**	**Achievements to date**
Effective	**#Priority 3** **Quality-driven pathways transformation**	3.1 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 and pathway efficiency (theatres, diagnostics) • Adoption of OneEPR functions • Increase in care closer to home (e.g. Systemic Anti-Cancer Therapy)	• Met all RTT (Referral to Treatment) targets, and rated 3rd best performance for cancer services nationally • Improved diagnostic waiting times • Planning and co-design of internal applications for OneEPR, recognising delays to overall programme • Successful Outpatient transformation and centralised booking • Digital outpatients Patient Engagement Portal (PEP) • 1,910 out of 2,108 clinics onboarded onto PEP • 5,712 out of 7,722 sessions onboarded (March data) • 26,070 letters read by patients via Patient Hub • 35% digital traffic through NHS app • 110,779 notifications via text message

				• 212,405 letters read by patients via Patient Hub • 39% digital traffic through NHS app in March 2026 • 1,342,449 notifications via text message Health Records • The first five sprints of seven are live with EDMS MediViewer: Sprint 1: Paediatrics, Theatres. Sprint 2: Obstetrics, Gynaecology. Sprint 3: Diabetes and Endocrine, Neurology, Care of the Elderly, Rheumatology, Ophthalmology. Sprint 4: Oral, Orthodontics, ENT. Sprint 5: Cardiology, Respiratory, Plastics and Dermatology. • 37,742 patient records scanned • 1,708,672 pages scanned Cumulative 1.9% Did Not Attend (DNA) reduction since April 2026
		3.2 End of life care: Gold Standards Framework (GSF)		
		• Speciality level MDT working to anticipate when patients entering the last 12 months	• We will complete the implementation of Phase IV wards with e-portfolios submissions and continuous training through March 2026 to	• Successful integration of 7 key GSF outcomes in clinical practice across trained wards • Successfully implemented GSF approach with Phase I applying of re-accreditation 2026 (all audits and

		of life	embed principles • We will continue systematic monitoring of Advanced Care Planning completion and preferred place of death • We will support wards with GSF Gold Standard Accreditation to maintain standards for 3-year accreditation • We will prepare wards for potential Platinum status accreditation • We will further embed GSF principles to ensure staff turnover and participation	documentation submitted to GSF) 11a and Respiratory Unit • Phase II completed and accredited (September 2024) • 5b,10b, Ashwell, Pirton. Will commence re-accreditation process September 2026 for all 4 wards • Phase III completed and accredited covering (September 2025) Barley, 9a, 9b • Phase IV completed and embedding before working to accreditation. 7a, 8a, 10a will apply for re-accreditation in 2026/7 • Phase V just commenced training AMU, 7b, ACU • Trained minimum of 2 staff per ward across 10 wards to date. 2 staff trained and then roll out of training with support from the GSF Facilitator and Palliative Care Team • Implemented systematic identification of patients in last year of life using Surprise Question approach and Key Outcome Ratio scoring • 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 • E-Portfolio submission included a 3-year action plan for each ward
		3.3 Safe and effective medication management		
		• Safe storage, management and oversight of medication regulatory standards	• Medicines optimisation and antibiotic stewardship • Implementation of Trust's medicines optimisation strategy (100%) • Improve critical medicines omission rate below or equal to 3.5% • Antimicrobial stewardship 24-72-hour review compliance above or equal to 90% • Medicines management training completion above 90%	• 100% implementation of Trust's medicines optimisation strategy, and annual report submitted and presented in January 2026 • Key achievements during 2026 have included: Improved service performance and access: Enhanced medicines reconciliation, Take Home Medications turnaround times improved and expanded weekend/bank holiday pharmacy services. Digital transformation: Strengthened digital tools (dashboards, Statistical Process Charts, Clinical Director audits) to improve efficiency and oversight. Clinical, workforce, and sustainability progress: Advanced prescribing optimisation, expanded technician/non-medical prescribing roles, and delivered greener practices • Introduced a controlled drugs assurance paper as development of the medicine's optimisation strategy oversight • Achieved critical medicines omission

				rate of 7.7%, above target of less than or equal to 3.5%. Significant work has been undertaken across the Trust into reducing the omissions and delays of critical medicines and in April 2026, we achieved a target of 3.3% • Attained 77.25% compliance with antimicrobial stewardship 24-72-hour reviews, not meeting 90% target • Achieved 74% completion rate for medicines management training (doctors, nurses, pharmacists), below the goal of above 90%
Priorities 2026/27	• Continue planning and preparation to implement One EPR • Outpatients Transformation Objectives – 26/27 • Improve non RTT waiting times • Continue to improve RTT waits and diagnostic waits • Gold standards framework plans for sustainability 2026/27: • 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 and participate in completing national GSF team assessment visits for Phase IV wards • We will focus on strengthening governance and safety through improved oversight of critical medicines and antimicrobial stewardship, alongside enhancing patient counselling to support safer, more informed care. In parallel, there will be a strong emphasis on digital and sustainability transformation, with implementation of Orbis U to improve data visibility and governance, and continued progress in greener prescribing and environmental initiatives			

Domain	Description	Key focus areas	How we measured success	Achievements to date
Patient Experience	**#Priority 4** **Person-centred and seamless pathways**	• Improved discharge coordination and continuity of care • Improving community paediatrics pathways of care • Establish effective seamless pathways in maternity • Paediatric MDT planning and personalised transitions	• Discharge planning • PALS/complaints themes on transitions • 50% reduction in transfer delays from Induction of Labour (IOL) to delivery suite (baseline measurement required) • Percentage of IOLs transferred within target timeframe (e.g. under 2 hours) • Percentage of referrals processed within agreed timeframes • Maternal satisfaction scores regarding transfer experience • Reduction in readmission through seamless step-down care	• Discharge processes have been supported through local quality improvement initiatives to develop and embed patient centred discharge passports • The proportion of emergency re-admissions within 30 days has reduced to below 5.2% in Feb 2026 from an average of 6.2% in Feb 2025 • Maternity services have successfully reduced their IOL by 50% to 8 hours 4 minutes • Response times to PALS concerns have improved from 45 days to 18 days for non-urgent queries • 710 compliments were received during 2025/26. A 26% increase from the previous year • Maternity services most improved overall women satisfaction score nationally, awarded in recognition • Paediatric services have improved the wait time in children's ED to 92% from 85% in 2024/25

	# Priority 5 **Tackling health inequalities and promoting equity**	• Targeted equity actions in maternity and paediatrics • Neonatal Intensive Care Unit (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 and triangulation of local data on underserved populations • Patient engagement feedback loops	• As part of the move to promote healthier lifestyles, the trust implemented its smoke-free sites policy from 1 April 2025 • In 2025 the outreach referral pathway was updated. It includes a guide when to transition from neonatal outreach to paediatric services • Monthly surveys are now completed by families when discharged from the outreach service. The feedback is reported in the monthly governance reports. Any concerns are escalated to neonatal matron • During 2025/26 the focus for the trust was to understand the population it serves and the health inequalities facing patients. The Health Equity Group (chaired by the executive lead for health inequalities) was formed and a health inequality self-assessment undertaken. • As well as undertaking some targeted work to address health inequalities, during 2025/26 the trust has worked with several partner organisations to address the wider determinants of health. This has included a rolling calendar of events targeting both patients and staff to raise awareness of health issues and factors influencing

				health and wellbeing. Partners include: ✓ Public Health – Hertfordshire County Council ✓ Talking Therapies (mental health provided by Hertfordshire Partnership Foundation Trust) ✓ Stevenage Healthy Hub ✓ Hertfordshire Better Health Bus ✓ Change, Grow, Live (CGL) – Drug and Alcohol Recovery Service ✓ Hertfordshire Health Walks • A working group has been running to understand barriers and processes across services, and this has now developed into a programme of work towards improved children and young people transition with chronic illness to adult pathways • A Trust Learning Disability Improvement Programme was commissioned in 2025 in response to learning from safety incidents • Working with Public Health Hertfordshire we launched HIV testing successfully in February 2026. This is providing a “safety net” for finding people living with HIV who have not been identified in other healthcare

				settings. • The trust is proud to have contributed (through its research team) to addressing health inequality through several reviews and publications. • These include: ✓ homelessness and substance use increase the risk of severe infection, prompting earlier, targeted care ✓ research into keloid scar surgery exposes unfair access affecting ethnic minority groups, supporting more equitable NHS funding decisions ✓ Tools developed to identify child exploitation help protect vulnerable children sooner ✓ Work on kidney disease emphasises fair access to mental health support for people with long-term illness ✓ Research on doctors' wellbeing and international medical graduates promotes a healthier, more inclusive workforce, ultimately improving patient care and fairness across the NHS • Martha's Rule processes include

				education contact details on purple wristbands worn by patients with learning disabilities and sticker placed in purple folder • Critical Care Outreach service is training in community settings, particularly settings housing vulnerable groups • Liaison with other community groups, raising awareness and establishing gaps, and groups who may experience health inequalities such as sickle cell patients
Priorities 2026/27	• We will deliver a structured 'Safe Fundamentals of Care' Programme, measured against core performance patient experience indicator • We will continue to improve accessibility and experience for Learning Disability patients, families and carers • We will develop improved responsiveness to patient and family concerns in real time • We will work in strong partnership with CGL and our ED team to improve outcomes for patients with alcohol dependencies • We will continue to build a programme of work across the organisation rather than pockets of good practice. This will need to be done in conjunction with the new ICB to ensure that end to end pathways are developed that tackle issues highlighted in Core20Plus5 - for both children and young people and adults • We will further develop our approach to evaluating the impact of interventions on reducing health inequalities, using disaggregated performance metrics and Board level reporting • We will widen and develop a more diverse patient safety partner cohort			

2.2 Highlighted below are our 2026/27 quality priorities which are aligned with the Trust's objective priorities. These priorities have been proposed through synthesis and consensus within corporate, clinical and operational leadership teams to achieve the ambition of providing high-quality, compassionate care for our communities.

These quality priorities and other key quality indicators will be monitored regularly with oversight at various divisional and corporate governance structures and work plans.

Quality Priorities 2026/2027			
Domain	**Quality priority**	**Key focus areas**	**How we measure success**
Safe	**#Priority 1** Strengthening fundamentals of care and governance	• Deliver structured Safe Fundamentals Breakthrough Collaborative • Improve the safe discharge of Trauma and Orthopaedic (T&O) patients by deploying patient information via video resources to promote patient self-management • Provide timely pain assessment and intervention across inpatient, outpatient and procedural settings	• Agreed safety improvement indicators against: - nursing quality fundamental indictors - regulatory fundamentals - effective risk reduction within core processes - improved staff experience • T&O attendance rates and patient feedback • Improved reliability of documented (verbal and non-verbal) pain assessment within ED and inpatient and outpatient settings.
Well Led		• Design and publish a refreshed	• Agreed Clinical Quality strategy KPIs to

	#Priority 2 Embedding a learning culture and PSIRF	Clinical Quality strategy to prioritise key clinical pathways • Improved compassionate engagement processes for people involved in incidents • Workforce culture, psychological safety and organisational learning	demonstrate improved processes and outcomes, including but not limited to: - Safe discharge processes - Admission avoidance - Professional standards across multi-speciality pathways • Improved timeliness in learning responses • Introduce qualitative data collection methods to capture experience of people involved in incidents (staff, patients and families) • Improved triangulation with clinical safety and FTSU intelligence, and support staff to have mature responses to 'listening up' within these processes
	#Priority 3 Embedding an inclusive and improving culture.	• Develop and deploy 5-year Frailty Strategy in partnership with community providers to increase focus on ageing well and community interface. • Develop Trust response to PSIRF approach across - engagement processes with vulnerable adults - timely, high quality learning response • Continue development of ENHPS capability model, including adoption	• Continuous improvement measures associated with deconditioning prevention and Multifactorial Assessment to Optimise Safe Activity (MASA), including but not limited to: - patient's environment - medical history - mobility - medication review - mobility and strength checks - environmental safety - personalised care planning • Deliver actions as needed in response to an annual patient safety training needs analysis –

		of local standard work • Champion a learning culture through clear, accessible and impactful communications	including number of people trained in Human Factors, simulations, PSIRF oversight and fundamentals, AAR, Swarm • Published Safety Attitudes Culture survey results • Staff Survey results related to learning culture • Number of people training for 'ENHPS for all' and 'ENHPS for leaders' The number of services working to a structured strategic alignment and productive board methodology • Improved feedback metrics from learning disability and profoundly deaf community service users
Effective	**#Priority 4** Quality-driven pathways transformation (incl. digital)	• Deliver agreed Digital priority objectives (including but not limited to delivery of Trust One EPR, medical records systems, maternity systems, AI maturity) • Safe and effective care through programmed delivery to reduce RTT pathways • Improve surgical and diagnostic pathways, including outpatients	Improved patient care and experience across surgical and diagnostic services • Agreed annual KPIs against service level elective GIRFT (Getting It Right First Time) priorities • Improved theatre efficiency and flow as identified in transformation priorities • Achieve high performance against 4 hour improving internal waiting times • Achieve high satisfaction scores across Extended Emergency Medicine Ambulatory Care Patients

		• Maximise theatre utilisation and start list on time. Support smooth patient flow across elective and urgent pathway • Delivery of safe and effective Extended Emergency Medicine Ambulatory Care (EEMAC) operating principles • Implementation of technology that promotes personalised radiotherapy including ETHOS adaptive radiotherapy, implementation of surface guided radiotherapy (SGRT) • Delivery of safe and effective care	Attitudes survey. • 62-day, 31-day and 28-day national targets sustained. Outpatients Transformation Objectives • Complete Outpatients Access Centre (OPAC) and front of house (FOH) transformation revisiting the principles to ensure all objectives have been achieved • To standardise and optimise booking processes across all services in OPAC and FOH teams to enable improved patient care and deliver staff productivity improvements • Deliver significant automation in our OPAC and FOH environments to improve patient experience and reduce admin costs • Deliver digital-first outpatient patient communications through PEP improving patient experience and saving money for the Trust • Deliver self-service kiosks for outpatient and diagnostics check in to free up capacity in our front of house team – improved patient experience and more effective clinic outcomes • Achieve BS10008 accreditation for our digital records service • Improve patient centred KPIs for patients presenting with primary mental health needs –

		for patients requiring mental health assessment and review within our acute hospital setting	demonstrating strong family and carer engagement • Improve reliability in partnership working with mental health services through high reliability in parallel assessments within Emergency Department.
Patient Experience	**#Priority 5** Person-centred and seamless pathways	• A more robust and proactive action orientated response for patients, families and carers who have concerns • Delver a structured GIRFT programme in our elective and non-elective care pathways by reducing waiting times and defects in care. This includes but not limited to DM01, RTT and non-RTT pathways, non-elective care by learning from incidents, complaints and optimising existing resources and improving pathways • Streamline wound care processes by standardising pathways, reducing unnecessary steps, strengthening	• Complaint responsiveness is identified within the report as an area requiring further improvement but perhaps could be more visible as a continuing quality objective • Continue to further embed escalations of patients through Martha's Rule • Reduced clinical risk RTT and non-RTT key performance indicators • Number of stratified clinical harm reviews undertaken, and outcomes • Reduced patient concerns related to wait times • Reduction in clinical risk associated with skin damage prevention and wound management • Improved skin prevention management patient outcomes through partnership working with systems partners across high-risk patient pathways • Improved national core stroke standards and rating

		professional autonomy, and empowering staff to identify and eliminate waste during wound care delivery to improve efficiency and patient outcomes • Streamline urgent care pathways by reducing waiting times including but not limited to: 4 hours to stroke ward, 4 and 12 hours in ED. We will increase redirection and stream patients to the right place earlier in their journey • Improve seven-day services and 14-hour consultant review	• Improve the 14-hour consultant review metric • Continues to strengthen collaborative stroke pathway arrangements with Bedfordshire Trust
	#Priority 6 Tackling health inequalities and promoting equity	• Safe Fundamentals of Care Breakthrough Collaborative • Improve accessibility and experience for profoundly deaf community • Reduced variation in meeting care needs of learning disability patients, families and carers • Proactive engagement with systems partners and Core20Plus5	• Agreed improvement collaborative indicators against: - Real time patient experience metrics - Patient engagement feedback loops • Improved adoption and use of translation services • Increased MDT deployment to achieve reliable application of reasonable adjustments • Improved staff engagement in proactive risk management with patients with learning disabilities and their families • Agreed KPIs against Core20Plus5 - for both children and young people and adults

		objectives • Continue to review and drive risk reduction within Maternity services	• Maternity health inequalities KPIs shall demonstrate improvement in health inequalities experienced by Black and minority women

2.3. Statements of Assurance from the Board

2.3.1. Review of services

The Trust continues to maintain an active clinical audit programme and reviews current clinical audit processes to ensure we can evidence improvements in clinical practice, patient experience and outcomes.

2.3.2. Participation in clinical audits

During 2025-26 East and North Hertfordshire NHS Teaching Trust (ENHT) was eligible to participate in 76 prioritised National Clinical Audit and Patient Outcomes Programmes (NCAPOP) and other national quality improvement programmes. During this period the Trust participated in 62 (82%) NCAPOP and other prioritised national quality improvement programmes/projects relevant to the Trust's services (Tables 1, 2 and 3).

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

Table 1 NCAPOP and other prioritised national quality improvement programmes the trust was eligible to participate in during 2025-26

Audit programme and workstream	Workstream	Participated ?	Cases submitted
BAUS Data and Audit Programme	British audit of the investigatiOn and referral of Women with rEcurrent uRinary Tract infectioN using recent Guidance (BOOMERANG)	Y	13
	Evaluating the Management Pathway for Suspected Testicular Cancer Referrals (EMPAST)	N	
Breast and Cosmetic Implant Registry (BCIR)		Y	
British Spine Registry		Y	60 (100%)
Case Mix Programme (CMP)		Y	1060 (100%)
Emergency Medicine QIPs	Adolescent Mental Health (AMH) Y1	Y	In progress
	Adolescent Mental Health (AMH) Y2	Y	In progress
	Care of Older People (COP) Y3	Y	In progress
	Care of Older People (COP) Y4	Y	In progress
	Mental Health Self Harm (MH) Y3	Y	Unable to obtain
	Time Critical Medications (TCM) Y2	Y	In progress
	Time Critical Medications (TCM) Y3	Y	In progress
	Time Critical Medications (TCM) Y4	Y	In progress
National clinical audit of seizures and epilepsies for children and young people (Epilepsy12)		Y	33 (100%)
Falls and Fragility Fractures Audit Programme (FFFAP)	National Audit of Inpatient Falls (NAIF)	Y	10 (100%)
	National Hip Fracture Database (NHFD)	Y	500 (100%)
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE)	Perinatal Mortality Surveillance	Y	100%
	National surveillance of maternal deaths	Y	100%
National Adult Diabetes	National Diabetes Core Audit.	N	

Audit programme and workstream	Workstream	Participated ?	Cases submitted
Audit (NDA)	National Diabetes Footcare Audit (NDFA)	N	
	National Diabetes Inpatient Safety Audit (NDISA)	N	
	National Pregnancy in Diabetes Audit (NPID)	Y	100%
	Transition (Adolescents and Young Adults) and Young Type 2 Audit	N	
	Gestational Diabetes Audit	Y	100%
National Audit of Cardiac Rehabilitation		N	
National Audit of Care at the End of Life (NACEL)		Y	80 (100%)
National Audit of Dementia (NAD)		Y	
National Cancer Audit Collaborating Centre (NATCAN)	National Kidney Cancer Audit (NKCA)	Y	100%
	National Prostate Cancer Audit (NPCA)	Y	100%
	National Audit of Metastatic Breast Cancer (NAoMe)	Y	100%
	National Audit of Primary Breast Cancer (NAoPri)	Y	100%
	National Oesophago-Gastric Cancer Audit (NOGCA)	Y	100%
	National Pancreatic Cancer Audit (NPaCA)	Y	100%
	National Bowel Cancer Audit (NBOCA)	Y	100%
	National Lung Cancer Audit (NLCA)	Y	100%
	National Ovarian Cancer Audit (NOCA)	Y	27 (100%)
	National Non-Hodgkin Lymphoma Audit (NNHLA)	Y	107
National Cardiac Arrest Audit (NCAA)		Y	95 (100%)
National cardiac audit programme (NCAP)	National Heart Failure Audit (NHFA)	N	
	National Audit of Cardiac Rhythm Management (NACRM)	N	
	Myocardial Ischaemia National Audit Project (MINAP)	N	
	National Audit of Percutaneous Coronary Interventions (NAPCI)	Y	c. 95%
National Comparative Audit of Blood Transfusion	Audit of NICE Quality standard QS138	Y	48 (100%)
	2025 Major Haemorrhage Audit	Y	10 (100%)
National Early Inflammatory Arthritis (NEIAA)		Y	149 (100%)
National Emergency Laparotomy Audit (NELA)	Laparotomy	Y	108 (77%)
	No Laparotomy	Y	7
National Joint Registry (NJR)		Y	1030 (100%)
National Major Trauma Registry		Y	
National Maternity and Perinatal Audit (NMPA)		Y	100%
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)		Y	522 (100%)
National Ophthalmology Database (NOD)	Age-related Macular Degeneration Audit	N	
	Cataract Audit	N	
National Paediatric Diabetes Audit (NPDA)		Y	337 (100%)
Perinatal Mortality Review Tool (PMRT)		Y	15 (100%)
National Respiratory Audit Programme (NRAP)	COPD Secondary Care	Y	
	Adult asthma in secondary care	Y	
	Children and young people asthma in secondary care	N	
National Vascular Registry (NVR)		Y	Carotid - 57 (100%) Aneurysm - 64 (100%) Amputations - 67 (100% angioplasties - 38 bypasses - 40 (100%)
Perioperative Quality Improvement Programme (PQIP)		Y	240 (79%)

Audit programme and workstream	Workstream	Participated ?	Cases submitted
Sentinel Stroke National Audit Programme (SSNAP)		Y	955 (c. 90%+)
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme		Y	23 (100%)
UK Interstitial Lung Disease (ILD) Registry		N	
UK Parkinson's Audit		Y	75 (375%)
UK Renal Registry	Chronic Kidney Disease (CKD) Audit	N	
	National Acute Kidney Injury (AKI) Audit	Y	

Table 2 NCAPOP confidential enquiries the trust participated in during 2025-26

Confidential enquiry	Work stream	Participated?	Cases submitted	Organisational questionnaires assigned and completed
Child Health Clinical Outcome Review Programme (NCEPOD)	Stabilisation of the critically ill child	Y	3/4 (75%)	1/1
	Emergency (non-elective) procedures in surgery in children and young people	Y	12/12 (100%)	1/1 (100%)
Medical and Surgical Clinical Outcome Review Programme (NCEPOD)	Pleural procedures	Y	21/21 (100%)	2/2 (100%)
	Managing acute illness in people with a learning disability	Y	4/4 (100%)	1/1 (100%)
	Rib fractures	Y	In progress at time of reporting	In progress at time of reporting
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE)	Confidential enquiries into maternal deaths	Y	1 (100%)	n/a
	Perinatal Mortality and Morbidity Confidential Enquiries	Y	100% Pre-labour IUDs = 11 Intrapartum IUDs = 0 Early Neonatal deaths = 6	n/a
	Confidential enquiries into maternal morbidity	Y	100%	n/a
Learning from lives and deaths – People with a learning disability and autistic people (LeDeR)		Y	10 (100%)	n/a
National Child Mortality Database (NCMD)		Y	100%	n/a

Table 3 Twenty-four NCAPOP projects the Trust was not eligible to participate in during 2025-26

NCAPOP or other quality improvement programme and workstreams
Cleft registry and audit network (CRANE)
Falls and Fragility Fractures Audit Programme (FFFAP) -Fracture Liaison Service Database (FLS-DB)
Mental Health Clinical Outcome Review Programme
National Adult Diabetes Audit (NDA) - Diabetes Prevention Programme (DPP) Audit
National Audit of Cardiovascular Disease Prevention in Primary Care (CVDPrevent)
National Audit of Eating Disorders (NAED)
National Bariatric Surgery Registry (NBSR)
National cardiac audit programme (NCAP) - National Adult Cardiac Surgery Audit (NACSA)

NCAPOP or other quality improvement programme and workstreams
National cardiac audit programme (NCAP) - National Congenital Heart Disease Audit (NCHDA)
National cardiac audit programme (NCAP) - UK Transcatheter Aortic Valve Implantation (TAVI) Registry
National cardiac audit programme (NCAP) - Left Atrial Appendage Occlusion (LAAO) Registry
National cardiac audit programme (NCAP) - Patent Foramen Ovale Closure (PFOC) Registry
National cardiac audit programme (NCAP) -Transcatheter Mitral and Tricuspid Valve (TMTV) Registry
National Clinical Audit of Psychosis (NCAP)
National Obesity Audit (NOA)
National Pulmonary Hypertension Audit
National Respiratory Audit Programme (NRAP) -Pulmonary Rehabilitation
Out of Hospital Cardiac Arrest Outcomes (OHCAO)
Paediatric Intensive Care Audit Network (PICANet)
Prescribing Observatory for Mental Health (POMH) - Improving the quality of valproate prescribing in adult mental health services
Prescribing Observatory for Mental Health (POMH) - Use of clozapine
Prescribing Observatory for Mental Health (POMH) - Use of medicines with anticholinergic (antimuscarinic) properties in older people's mental health services
UK Cystic Fibrosis Registry - Cystic Fibrosis - Adults
UK Cystic Fibrosis Registry - Cystic Fibrosis - Children

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

Twenty four national clinical audit and patient outcomes programme (NCAPOP) publications were reviewed during 2025-26 (Table 4). The Trust intends to use the intelligence derived from participation in NCAPOPs to improve the quality and effectiveness of clinical care and ensure it is based upon nationally agreed standards of good practice and evidence-based care.

Table 4 A summary of 8 out of 24 NCAPOP reports reviewed during 2025-26

NCAPOP	Key successes, lessons learned and actions
Medical and Surgical Clinical Outcome Review Programme (NCEPOD) INSIDE HEALTHCARE: A review of healthcare provided to people who died from a 'natural' or other 'non-natural' cause of death while detained in prison or were transferred to an acute NHS hospital or hospice, while detained	Multiple Trust services report fully conforming, to the 1 recommendation relevant to
Child Health Clinical Outcome Review Programme (NCEPOD) Twist and Shout: A review of the pathway and quality of care provided to children and young people aged 2-24 years who presented to hospital with testicular torsion	The Women's and Children's Divisional Board reported the service fully conforms to the report's relevant national recommendations
National Maternity and Perinatal Audit (NMPA) NMPA Induction of Labour Snapshot Audit-Based on births in NHS maternity services in England, Scotland and Wales during 2023	The Women's and Children's Divisional Board reviewed the report and reported the national recommendations to not be relevant to the Trust
National Audit of Dementia Care in General Hospitals 2023-2024: Round 6 Audit Report (published December 2024)	The Trust continues to meet 2 of the report's relevant national recommendations.

NCAPOP	Key successes, lessons learned and actions
Perinatal Mortality Review Tool (PMRT) Learning from Standardised Reviews When Babies Die National Perinatal Mortality Review Tool Sixth Annual Report	The Women's and Children's Divisional Board reported they fully conform to all the report's relevant national recommendations
Perinatal Mortality Review Tool (PMRT) National Perinatal Mortality Review Tool- Learning from Standardised Reviews When Babies Die Seventh Annual Report 2025	Key successes: A Patient Safety Midwife has been appointed to oversee PMRT. A bereavement Midwife has been appointed. Robust external attendance for bereavement midwives and neonates. Key lessons learned: Senior Midwifery Leadership team and external Obstetric attendance. Obstetric Lead cover during annual leave. Recommendations from PMRT not developed into SMART actions and monitored robustly with strategic oversight. Key actions: Immediate improvement of Midwifery SLT attendance. Escalation to ICB for external Obstetric attendance. Lead Midwife for Quality & Assurance to commence in post Nov 2025 - for QI on action development and strategic oversight of triangulated themes with key divisional stakeholder involvement.
National Joint Registry National Joint Registry 22nd Annual Report 2025	Key successes: Trust in line with national comparator for hip and knees 90-day mortality, 5 year revision and 10 year revision. Trust also in line with the national comparator for likability of patient records that include a valid NHS number compared to the number of procedures on the registry Key action: To strengthen and standardise the process for obtaining NJR consent prior to surgery
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE) - State of the Nation Report 2021 Stillbirths and neonatal deaths in twin pregnancies	The Women's and Children's Divisional Board reported they fully conform to all the report's relevant national recommendations, except for recommendation 2.2

Local clinical audits

East and North Hertfordshire Teaching NHS Trust continues to improve the quality of healthcare by implementing actions arising from local clinical audit projects. During 2025-26, 200 local clinical audit projects were completed, a summary of projects completed by specialty/service are summarised in table 5

Table 5 A selection of projects completed during 2025-26 by specialty/service

	Audit	Key successes	Key actions/areas for improvement	Lessons learned
Acute Medicine	Audit of Microbiology discussion documentation Aim: evaluate the quality of Microbiology clinician documented discussions to referring clinicians on a standardised proforma Partial conformance to the evaluated standards	80% of Microbiology discussions included relevant information on past investigations such as culture results, and that doctors were diligent in including information on how those cultures had informed antimicrobial choice	• 30% of documented discussion included past antibiotic regimens • 26% of discussions included drug dosages There were 7 cases where relevant antimicrobial allergies that had influenced regimen choice were not documented	Many documented discussions lacking in vital information as per Trust and NICE guidelines, Teaching clinicians how to use a standardised proforma resulted in an improvement of the quality of documented discussions
Anaesthetics	Availability of emergency	Most locations did	No availability of	Initial stock cost

	Audit	Key successes	Key actions/areas for improvement	Lessons learned
	drugs for anaesthesia Aim to evaluate the availability of emergency medication in areas where procedures requiring anaesthesia or sedation are performed by Anaesthetists. Partial conformance to the evaluated standards	have availability of emergency medications	Dantrolene for ED/nearby locations including radiology. Starter pack has now been introduced into ED in liaison with Pharmacy team	implications associated with the use of rarely used emergency drugs is to be mitigated by the creation of a starter pack with instructions on how to access the rest of the stock
Breast surgery	Reaudit of the comparison of SAVISCOUT vs RFID localisation for non-palpable breast cancer Aim: evaluate the positive surgical margins for both localisation techniques and the re-excision rates in terms of technical success, specimen weight, retrieval rates and scheduling flexibility by breast radiology department Full conformance to the evaluated standards	The positive margin rate for breast cancer excision is lower than recommended average national rate		
Mount Vernon Cancer Centre	MVCC Radiotherapy IR(ME)R audit programme- EP J - Clinical evaluation of Radiation doses in Radiotherapy - Pre-treatment Aim: evaluate compliance with the Procedures laid down in EP J - Clinical evaluation of Radiation doses in Radiotherapy Full compliance to the evaluated standards	Aspects of protocol which directly affect patient health and wellbeing were well adhered to overall. This was consistent for patients at different treatment sites		
Cardiology	Reporting turnaround time (RTAT) for cardiac CT at Lister Hospital Aim: to evaluate whether cardiac CT reports are completed and made available within 12 working days for the clinician, in a non acute unit patients are referred for assessing stable chest pain. Partial conformance to the evaluated standards	Most Radiology scan reports had a turnaround time of 24h	Improve capacity and vetting processes	The on-time availability of final reported scan reports is critical to the management of patients
Child health acute	Audit of paediatric egg allergy The aim of this audit is to analyse the Lister Hospital Paediatric Allergy teams' current management of patients with egg allergy and compare it with the national	Local management of paediatric egg allergy aligns with BSACI/NICE standards, with all patients receiving appropriate follow-up, AAI prescriptions, and assessment for	This audit identified that up to 27% of children in the audited population, who had a mild egg allergy could have been safely managed in primary care thus streamlining referrals and reserving	We will share our new guideline (when written) with our local paediatric dietetic colleagues and with primary care colleagues

	Audit	Key successes	Key actions/areas for improvement	Lessons learned
	standard BSACI 2021 Guideline for the Management of Egg Allergy. Full conformance to the evaluated standards	asthma and peanut allergy	secondary care for complex cases	
Child health neonates	Audit to evaluate the blood culture contamination rate in a UK level 2 NICU from January 2023 to December 2024 Aim: to evaluate whether the blood culture contamination rate in all neonates screened for sepsis in a UK level 2 NICU (Lister Hospital) from January 2023 to December 2024 is in line with the national acceptable comparator rates Partial conformance to the standards evaluated	The overall contamination rate Over the 2-year period was 2% below the national comparator benchmark rate of 3%.	There were some months where the Contamination rate was well above the benchmark (up to 9%). Additionally, although the yearly contamination rates were below the acceptable benchmark of 3%, the yearly contamination rate doubled from 2023 to 2024, suggesting a need for interventions to avoid a further rise	The main learning point was the need for Intervention to reduce the rise in the neonatal blood culture contamination rates. Learning points were shared with other teams in the RHD, including the paediatric team who were doing a similar project on blood culture contamination
Diabetes and Endocrinology	Optimising SGLT2 inhibitors prescriptions were indicated in patients admitted with T2DM having CKD,HF or both Aim: to evaluate prescription practices in T2DM with CK, HF in accordance with national guidance Partial conformance to the standards evaluated	SGLT2 was prescribed for heart failure, CKD and high CV risk patients	To improve the prescribing of SGLT2 for patients with Diabetes and with CKD, heart failure etc.	
Elderly Care	Audit of clinical frailty score and Gold Standards Framework documentation with secondary analysis of associated clinical factors Aim: to evaluate documentation of CFS and GSF in patients admitted to the Elderly Care ward in accordance with national guidance Partial conformance to the standards evaluated		Not appropriately documenting GSF during admission or on discharge. Not documenting clinical frailty score on admission to hospital or ward	Routinely document CFS as of 2 weeks prior to admission as a routine part of clerking. Documentation of GFS routinely during MDT, to encourage documentation of this on DS
Emergency Medicine	Reaudit of the optimisation of basic radiation protection knowledge amongst Emergency Department Nursing staff Aim: Re-audit the basic radiation protection knowledge amongst Emergency Department nursing staff to enhance patient education, reduce anxiety, and ensure safe	• 80% of nurses found the recent teaching session either effective or very effective • 80% of participants found the radiation protection materials to be accessible • 75% of nurses expressed a strong likelihood of using the intranet course	20% of nurses still faced challenges with the accessibility of radiation protection materials, indicating that while progress has been made, further improvements in the visibility and placement of resources are necessary • 25% of nurses	The use of a QR code-enabled poster demonstrated innovative communication methods can significantly enhance resource accessibility. This approach could be adopted by other teams to improve staff engagement

	Audit	Key successes	Key actions/areas for improvement	Lessons learned
	practice during radiological procedures. Partial conformance to the standards evaluated	• 75% of participants showed interest in participating in future exercises and questionnaires	expressed hesitation in using the intranet course, suggesting that additional strategies are required to increase engagement, possibly through further promotion or simplifying access • Despite improvements, there is still a need for more interactive content and practical examples in future training sessions, as highlighted by the 35% of nurses who requested these elements for better learning	with important educational materials • The high interest in more interactive and practical training methods, such as workshops and case studies, suggests that hands-on learning could be more widely implemented by other specialties to improve knowledge retention and application. • The positive reception to feedback mechanisms (with 50% rating it as very useful) highlights the importance of incorporating continuous feedback in training and educational initiatives other departments
ENT and Audiology	Daily Ward Round Documentation Audit Aim: to evaluate the quality and completeness of daily ward round documentation against GMC Good Medical Practice standards. Partial conformance to the standards evaluated	Timely documentation for examination findings and management plans	Completeness and accuracy of documentation - including discussions with patients and relatives	The need to document more precisely
Trust and Nursing Practice	Audit of link nurse pressure ulcer risk assessment Aim: Evaluate conformance of patient pressure ulcer care according to NICE QS89 and CG179 Partial conformance to the standards evaluated	Peer teaching found to be useful in improving practice and standards of care	For the ward to reach 100% conformance in risk assessment, practice must change. Staff need to know to conduct the risk assessment when a patient is new to their department or transferred to them. The digital system does not flag this prompt/option, once the initial risk assessment is done. Hence, staff knowledge and practice are vital	Importance of peer teaching and shared purpose for change in practice
Gastroenterology	Clinical Documentation of Large Volume Paracentesis Procedures in Patients with Liver Cirrhosis Aim: to evaluate the quality of clinical documentation of large volume paracentesis procedural notes against the BSG safety toolkit form for		Intervention is key to improve our clinical documentation to protect healthcare workers and patients	Compliance to the BSG safety toolkit at Lister Hospital has certainly improved, but there is still room for further improvement

	Audit	Key successes	Key actions/areas for improvement	Lessons learned
	large volume paracentesis. Partial conformance to the standards evaluated			
General Surgery	Reaudit of intravenous fluid therapy in acute pancreatitis patients Aim: to evaluate the intravenous fluid management in acute pancreatitis patients in accordance with NICE guidance Partial conformance to the standards evaluated	Patient IV fluid resuscitation adequacy improved to 75% from 45% between the first to second clinical audit cycles	25% of patients were not appropriately resuscitated	
Gynaecology	Audit of menopause patient care in accordance with NICE NG23 and QS143 Full conformance to the evaluated standards reported	Despite not having a dedicated menopause service we fully conform to 4/5 of NICE menopause quality standards	The service could be improved by ensuring individuals registered female at birth and over 45 years presenting with menopausal symptoms are diagnosed with peri menopause or menopause based on their symptoms alone, without confirmatory laboratory tests	
Oral and maxillofacial surgery	Improving Outcomes for Head and Neck Cancer Patients: Evaluating the Pre-Radiotherapy/Chemotherapy Dental Assessment Pathway Aim: to evaluate the dental assessment pathway for pre-radiotherapy/chemotherapy (RTCT) patients and identify any shortcomings that may hinder providing effective patient-centred management. Partial conformance to the standards evaluated reported	82% of patients received a dental assessment and treatment (extractions) within 2 weeks of the ENT MDT referral. The 14% who were not treated in this timeframe were due to failure to attend appointments because of illness, liaising with GDP about tx planning, or the patient died from their disease All patients had 10 days or more between extractions and commencing radiotherapy treatment in line with RCS guidelines	In response to 10% of patients receiving oral health education and 3% of H+N proformas having the RT dose, regime, grays, site fields completed Improvements implemented include 1) Updates to the H+N proforma to the patient GDP details, as well as size and size of dose exposure intra orally aid tx plan 2) Changes to the referral enabling Oncologists to make direct referrals to relieve pressure on the ENT department. 3) All proformas are now stored safely on a shared drive to facilitate future auditing Created an oral health toolkit leaflet to support head and neck cancer patients	

	Audit	Key successes	Key actions/areas for improvement	Lessons learned
Oncology and Clinical Haematology	Review of neoadjuvant immunotherapy in triple negative early stage breast cancer, their response and challenges related to its toxicities Full conformance to the evaluated standards reported	The service fully conforms to the relevant protocol		
Palliative Care	ReSPECT Audit Evaluation – May 2025 Partial conformance to the standards evaluated		Actions are being undertaken to address the following areas: 1) Timeliness: A notable concern was the delay in completing ReSPECT forms, with a significant percentage being filled out late in the admission process (most after day 8). This could impact the effectiveness of advance care planning 2) Documentation Gaps: A substantial number of forms lacked important details, particularly regarding patients' values and fears, legal proxies, and clinical recommendations 3) Many forms did not include essential information about emergency contacts, however this information could be found in other sections of the medical / nursing records. Significant forms were left blank regarding patients' capacity assessments Need for Review and Training: The audit	The audit emphasises the importance of reviewing practices around the completion and usage of ReSPECT forms to enhance patient safety and care quality. Overall, while the forms were mostly completed, significant gaps were noted in documenting patient values, involvement, and emergency contacts, which are crucial for ensuring patient-centred care. A limitation of this audit should have defined the healthcare professional completing this form, by profession (Doctor or Nurse) and grade

	Audit	Key successes	Key actions/areas for improvement	Lessons learned
			indicates a need for increased awareness and training for staff involved in completing and reviewing ReSPECT forms to ensure that all relevant sections are addressed thoroughly and in a timely manner	
Pathology	Evaluation of PAX2, PTEN and Beta Catenin in EIN (Endometrial intraepithelial neoplasia/atypical hyperplasia) Aim: to evaluate immunohistochemistry used to confirm a diagnosis of EIN/atypical hyperplasia of endometrium compared to national published data Partial conformance to the standards evaluated	We have begun using the immunomarkers PAX8, PTEN and betacatenin in cases of endometrial hyperplasia which are difficult to interpret, assisting the diagnosis of difficult cases	We started applying all these immunomarkers on the cases of the endometrial hyperplasia which we were not doing earlier. This has really helped in making diagnosis in difficult cases	The diagnosis and differentiation between endometrial hyperplasia with and without atypia is a challenging area and is prone to interoperator diagnosis discrepancy. The appropriate use of these immunomarkers supports the discrimination between these 2 entities
Plastics and Reconstructive Surgery	Audit and reaudit of lacerations with extensor tendon involvement Aim: to evaluate the treatment and management of lacerations with extensor tendon involvement according to BSSH guidelines Partial conformance to the standards evaluated reported	Patients were promptly scheduled for surgery, with a median time to theatre of 2 days. Registrars primarily perform these procedures providing robust training opportunities Only one case of rupture and one case of tenolysis were identified during the review period and were discussed and reflected upon during the clinical governance rolling half day meetings	Actions to be impemented include 1) patients being scheduled for hand therapy directly after surgery within 3-5 days **2)** Hand therapy service standardising their documentation on functional outcomes	
Radiology	Fibroadenomas in young women - can we safely avoid sampling? Aim: to evaluate the patients presenting with solid lump, number of biopsies done, imaging appearance and histology result Partial conformance to the standards evaluated	Biopsies were consistently performed for women aged 25 and above		The audit shows the unit can raise a higher cut off age to 30 as suggested by the guidelines

	Audit	Key successes	Key actions/areas for improvement	Lessons learned
Respiratory	Improving the timeliness and quality of inpatient discharge summaries to support safe continuity of care in Primary Care Aim: to evaluate the timeliness of discharge summaries according to the local and national standard of within 24h of discharge Full conformance to the standard(s) reported	Education and awareness among resident doctors regarding importance of completing inpatient discharge summaries within 24 hours for continuity of care in the community post discharge	Change in clinical practice on daily ward rounds, to include 24-hour target in daily board rounds post morning rounds, safe discharge communication	
Stroke Medicine	Audit of discharge advice and follow-up care for patients with intracerebral haemorrhage Aim: To evaluate practice against NICE guideline recommendations for the post-discharge management of patients with intracerebral haemorrhage (ICH), specifically assessing whether appropriate discharge advice was provided, follow-up MRI imaging was arranged or completed, and outpatient clinic follow-up was conducted. Partial conformance to the standards evaluated reported	Areas highlighted • safety netting • OP investigations Patients having follow up clinics	Areas for improvement include: • Providing blood pressure control advice • Providing lifestyle advice • Documenting clear cause of ICH on discharge letters • Sleep hygiene advice especially for those CAA Documenting discharge advice for patients in the 'information given to patient' section of the discharge summary	.
Trauma and Orthopaedics	Length of Stay Post Elective Orthopaedic Surgery Aim: to evaluate hip and knee replacement surgery patient treatment and factors influencing length of stay, according to guidance Partial conformance to the standards evaluated reported	6% of patients were discharged on day 0-1 of elective surgery	Almost a quarter of patients required a length of stay of 3 days or more. This was attributed to factors such as need for therapy, leaky wounds, medical complications, comorbidities and constipation To share the following recommendation with the Anaesthetics team - identification of medical co-morbidities pre-operatively may allow for advanced planning and may reduce the risk of medical complications	.
Urology	Audit of VTE Prophylaxis in Elective Urology Patients at Lister Hospital Aim: to evaluate VTE	NICE and EAU standards were met in full for the day case patients evaluated as part of this clinical audit	Actions to be taken to address the following findings: 56% of non-robotic inpatient cases audited did not have a	There were mixed rates of conformance to the NICE and EAU guidelines, and this was often related to specific procedures.

	Audit	Key successes	Key actions/areas for improvement	Lessons learned
	prophylaxis practice amongst elective urology patients in accordance to EAU and NICE guidance Partial conformance to the standards evaluated reported	100% of all elective robotic cases had a VTE documented plan in their operation notes 0/123 patients had a subsequent hospital acquired thrombosis (HAT)	VTE plan documented in their operation notes 30% of inpatients had no mechanical VTE prophylaxis prescribed	Post MDT discussion this was accepted as being standard departmental practice and dependent on a Consultant's post-op VTE plan General themes identified that were applicable to all surgical specialties include: ensuring VTE risk assessments are done on time; VTE plans are documented in operation notes; ensuring mechanical and chemical prophylaxis is prescribed in line with the local and national guidelines 7/123 patients had post-operative bleeding complications however they were not suspected to be related to their VTE prophylaxis
Vascular	Re-audit of inpatient VTE assessment and prophylaxis in vascular and colorectal surgery patients Aim: to evaluate VTE assessment, treatment and management in surgical inpatients in accordance with NICE guidance Partial conformance to the standards evaluated reported	Statistically significant improvement cycle 2 for VTE assessment completion is less than or equal to14h in the vascular department (p = 0.03) and in colorectal (though this did not reach significance, p = 0.07). The proportion of patients who had VTE prophylaxis prescribed within 14 hours was above 95% for both groups. VTE reassessment showed improvement for vascular surgical patients after intervention though this was not statistically significant (p = 0.1952)	Although statistically significant improvement was seen for VTE assessment completion, the rate of assessment completion within 14h did not reach 100% for either group. Though above 95% of patients in both groups received VTE prophylaxis under or equal to <=14h of admission, this could be improved further. Furthermore, the proportion of patients demonstrating evidence of reassessment remained low for both groups (11.32% in vascular; 3.03% in colorectal)	Key barriers to completion of VTE assessments on time included: emergency patients being admitted out of hours and outlier patients in different wards. New strategies for improvement were proposed to address some of these barriers e.g. on call team encouraged to complete assessments for patients admitted after hours to facilitate future improvement of these measures, a checklist for essential 'on admission' tasks to be circulated to resident doctors including completion of VTE assessment forms and prescription of VTE prophylaxis

Participation in research

Feedback from people who volunteered to take part in research at our Trust:

‘The team are very approachable and friendly, appointments run on time and it is easy to access’.

'Our research team have been totally comforting, professional and supportive.
They have made us feel important and valued.'

Thank you: Patients are central to our research efforts. We begin by thanking everyone who participated in or supported research at the Trust. Without research, and research participants, we cannot develop new treatments or improve healthcare practices.

We invite you to look at our Trust Research webpage for more details and if you would like more information about what we do or how you can be more involved, contact us via researchanddevelopment.enh-tr@nhs.net

The number of patients receiving relevant health services, provided or sub-contracted by the Trust in 2025/26 that were recruited during that period to participate in research approved by a research ethics committee was 4,062 from 103 projects covering 15 different clinical specialties.

In 2025, the Trust had 321 research publications authored by Trust staff, including 34 jointly published with the University of Hertfordshire. The publications encompass a diverse array of research fields and are disseminated in several high-impact journals. You can find more details on the research papers via the trust's website.

The Trust is proud to be part of the National Institute for Health and care Research which exists to enable and deliver world-leading health and social care research that improves people's health and wellbeing and promotes economic growth.

Benefits of research: Being research-active has two main benefits. Firstly, patients who participate in research receive direct benefits from new treatments. Secondly, all patients whether they participate in research or not, benefit indirectly from the Trust being research-active, leading to better overall care and outcomes. Research evidence supports this: Research active hospitals have lower mortality rates and patients’ perception, and experience of care is higher in research active organisations. Staff have increased job satisfaction and NHS employers can improve recruitment and retention when staff are enabled to be involved in research.

Patient and public involvement in research: From our ongoing research participant survey in 2025/6, we received 39 responses. Responses to three questions (as percentage saying strongly agree or agree) are given below for the last three years.

Questions	2025/6
• My taking part in the research has been valued	82%
• I have always been treated with courtesy and respect	92%
• I would consider taking part in research again	82%

Research participants also provided responses to the following questions.

What was positive? A total of 32 responses were received, and this can be summarised as follows. Most participants felt respected, comfortable, and well supported by professional, caring staff who communicated clearly throughout their involvement. Many valued the opportunity to contribute to research and hoped their experiences would help improve future treatments and health outcomes. Several participants appreciated consistent updates, good monitoring, and straightforward, well explained processes. A few noted areas for improvement, such as lack of feedback or earlier communication issues at certain hospitals. Overall, participants reported positive interactions, feeling valued, and recognising the importance and usefulness of the studies they took part in.

What could be improved? A total of 29 responses were received, and this can be summarised as follows. Patients generally reported positive experiences, with many stating they had no complaints and felt their treatment had been successful. Several people expressed a desire for more regular feedback, especially regarding MRI scans, blood tests, and overall study results. A few participants wanted clearer comparisons of their results with others in the research. Some noted practical issues outside the study team's control, such as hospital parking or initial discharge decisions. Overall, most participants were satisfied, highlighting good staff interactions and minimal suggestions for improvement.

The Trust's Patient and Public Involvement in Research Panel meets on a regular basis to help us better understand how we can design our local research to meet the needs of our patients.

As a Trust we also place information on our website to support public and patient engagement events, to signpost how people can find out how research affects patient care and to provide examples of how research can enhance patient outcome and experience. In addition, we signpost people to the #BePartofResearch website – this is a free service which makes it easy to find and take part in vital health and care research across the UK.

Strategic approach: At the start of 2024/5, we published our four-year research strategy, developed in conjunction with patients, the public, and our wider healthcare partners. Our goal is to be recognised and valued as an organisation where people can take part in and benefit from research. The research strategy supports the organisation's mission to provide consistently outstanding care and exemplary service.

We set six objectives for the four-year research strategy:

1. Align research with local needs by listening to and acting on the voice of our people.
2. Make research inclusive for all people and put in place actions to make research more accessible.
3. Foster local and national collaborations to increase research opportunities for local participation.
4. Include the opportunity for people to take part in research as an essential design consideration for all our services.
5. Ensure all colleagues recognise research as an essential and rewarding part of effective patient care.
6. Implement national approaches to make best use of data, digital systems, and AI to support research in a way that is trusted.

In the second year of the new strategy, we continued to build on our current research strengths, developing plans to address known areas for improvement, implementing government initiatives, and developing a plan for financial growth to expand our research offerings to patients.

We have continued to provide leadership and support across our local system, the East of England, and nationally. Examples include leading the East and North Hertfordshire Health Care Partnership Research and Innovation Group, seconding research staff to the Hertfordshire and West Essex Integrated Care system and working with the National Institute for Health and care Research East of England Regional Research Delivery Network.

Future: Our focus in 2026/7 is to deliver the third year of our research strategy. We plan to make progress against each of our objectives and success indicators; ensuring research is aligned with local needs, is inclusive, and supported by partnerships, data, and digital tools. This is supported by additional funding to increase our research capacity and offer research access at the evening and the weekends.

2.3.4. Care Quality Commission

The Trust is required to register with the Care Quality Commission (CQC). Its current registration status is 'requires improvement'. The CQC did not take enforcement action against the Trust during 2025/26.

	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

Following the Trust's CQC hospital inspection in 2023, no further formal inspections by the CQC have occurred in 2025/26.

Following successful application and embedding of improvement actions in maternity services, NHSE formally removed the required intensive improvement programme support in 2025.

Other quality regulatory visits have included:

- May 2025 - Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) to Radiology
- June 2025 - NHS England QI Team visit to Respiratory
- June 2025 - Human Tissue Authority inspection to Mortuary
- August 2025 - Food and Drug Administration inspection of Mount Vernon Cancer Centre
- November 2025 - Medicines and Healthcare Products Regulatory Agency (Quality Control Laboratory GMP (Good Manufacturing Practice) inspection) to Lister Pharmacy
- November 2025 - re-audit evidence review

During 2025/26, the Trust has continued to review the quality governance framework. Measuring and monitoring actions to embed cultural change in good governance standards including new reporting frameworks to support operational management structures. This is measured by an internal and external workplan of mock inspections and quality assurance reviews, and also by the well-led governance of quality governance mock inspections.

2.3.5. Reporting to Secondary Uses Service (SUS)

During 2025/26 (M01-11), 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: 99.8%)
- 99.6% for A&E care (national average: 98.5%)

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

- 99.0% for admitted patient care (national average: 99.8%)
- 99.9% for outpatient care (national average: 99.6%)
- 100.0% for A&E care (national average: 99.0%)

2.3.6. Update on data quality

The Data Quality team is responsible for ensuring the accuracy, completeness, and timeliness of data captured within the Trust's Patient Administration System (Lorenzo). This includes patient information, activity recording, and performance management data.

During 2025/26, the team maintained a strong focus on improving the quality of performance data across the trust. High quality data underpins all operational and strategic functions, enabling reliable reporting and informed decision-making to support the communities we serve. The team plays a critical role in ensuring that data is accurate, valid, and recorded promptly. This supports effective performance monitoring, regulatory compliance and service improvement initiatives across the organisation.

Priorities for 2026/27

To further enhance data quality across the Trust, the team will focus on the following key actions:

- Implementing the recently ratified Trust's Data Quality Strategy and Data Quality Policy
- Increasing awareness of data quality issues by highlighting areas requiring improvement through the:
    - monthly Data Quality Assurance Group
    - Data Alignment Group
    - bi-weekly Operational Group meetings
- Reviewing and refining the Data Quality dashboard
- Supporting the implementation of the Trust's new Electronic Patient Record (EPR) system

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

All health and care organisations are required to implement the 10 National Data Guardian (NDG) standards for data security and protection. These standards are designed to safeguard sensitive information and ensure the resilience of critical services and IT infrastructure against increasing cyber security threats.

The Data Security and Protection Toolkit (DSPT) is the national online self-assessment tool used by NHS organisations to measure compliance against the NDG standards and demonstrate that confidential information is protected from unauthorised access, loss, damage, and destruction.

The Trust continues to strengthen its approach to information governance and cyber security in response to the evolving threat landscape across the health and care sector, including cyber-attacks, ransomware incidents, data breaches, and accidental data loss.

The Trust achieved a 'Standards Met' outcome in its DSPT 2024/2025 submission.

During 2024/25, the DSPT framework was aligned to the National Cyber Security Centre's Cyber Assessment Framework (CAF), significantly increasing the level of assurance and evidential requirements across 232 audit controls. The Trust has continued to develop its cyber maturity through improvements in governance, risk management, technical controls, staff awareness training, and incident response arrangements.

The Trust incurred 23 data breaches during 2025/2026 of which 2 were reportable to the Information Commissioners Office.

For 2025/26, the Trust remains focused on embedding the CAF requirements and further enhancing organisational resilience against cyber threats. Work continues to strengthen compliance across all DSPT domains, with particular emphasis on third-party assurance, vulnerability management, business continuity, and cyber incident preparedness. The Trust is committed to achieving and sustaining compliance with

national data security standards while ensuring the confidentiality, integrity, and availability of patient and corporate information.

2.3.8. 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:

	2025/26	Previous Year (2024/25)	Standards Exceeded
Primary diagnosis	97.10%	95.50%	>=95%
Secondary diagnosis	96.00%	98.00%	>=90%
Primary procedure	98.00%	96.10%	>=95%
Secondary procedure	97.00%	98.00%	>=90%

>= (greater than or equal to)

2.3.9. Update on learning from deaths

Reducing mortality is one of the Trust's key objectives and processes have been established to undertake mortality reviews, monitor mortality rates, and maximise learning from our learning from deaths work.

The Trust is committed to seeking ways to continuously strengthen our governance and quality improvement initiatives to support the learning from deaths framework.

While our mortality rates have remained well placed versus national peers, it is increasingly recognised that while monitoring these rates has a role to play in mortality governance, there is limited correlation between them, and the quality of care provided by organisations.

To learn from deaths and improve the quality of the care we provide, we recognise that it is vital that we have a robust process for reviewing the care received by our patients at the end of their life. In recent years we reviewed our processes and introduced several reforms which we believe have built on the solid mortality review processes already embedded at the Trust, enabling us to further improve our learning framework and subsequently the quality of the care we provide.

Central to this work was the adoption in 2022 of the Structured Judgement Review Plus (SJRPlus) format for review which was developed by the 'Better Tomorrow' team and based heavily on the original Royal College of Physicians' SJR model. Work is underway to incorporate our mortality review process into the Trust's Ideagen ENHance platform. This will improve accessibility to data and enable better triangulation with other Trust processes for the purposes of both learning and governance.

Currently learning from our mortality review process, whether specific cases or themes, is shared across the Trust with clinical staff via clinical governance and quality forums such as mortality and morbidity meetings, specialty Quality, Improvement, Safety and Strategy (QISS) sessions and divisional quality and safety meetings. It may also be shared with relevant working groups such as those focussing on deteriorating patient and end of life care. Where appropriate, thematic review outcomes are also shared in the wider healthcare community, including with the ICB and community trust. We continue to seek ways to build on our existing processes to make our learning even more accessible to the staff who can make a difference.

Some of the key themes identified during our learning from deaths work are detailed below.

Theme	What worked well	Learning / improvement opportunity
Recognition of deterioration	Timely identification of dying phase; appropriate DNACPR/TEP/ICP use (Do Not Attempt Cardiopulmonary Resuscitation/Treatment Escalation Plan/Integrated Care Pathway)	Escalation planning should happen earlier, before crisis points
Multidisciplinary working	Good collaboration across medical, surgical, CCOT, ICU, SALT and palliative teams (Critical Care Outreach Team, Intensive Care Unit, Speech and Language Therapy)	Earlier MDT discussions in prolonged or complex admissions may improve coordination
Clinical management	Care largely aligned with guidelines and specialty advice	Delays to key treatments (e.g. antibiotics, surgery, anticoagulation) need system-level focus
Communication with patients/families	Compassionate, honest discussions commonly highlighted as good practice	Communication not always timely or consistently documented
Emergency Department processes	Appropriate triage and escalation in many cases	Recurrent delays in ED review, investigations and transfer to wards
Documentation	Clear and comprehensive notes supported decision-making in well-managed cases	Gaps in documentation, especially around deterioration and death, reduced clarity
Nutrition and swallowing	Correct procedures generally followed	Delays to feeding/SALT input led to patient and family distress
Monitoring and reassessment	Appropriate escalation when deterioration recognised	Inconsistent monitoring and delayed response to early warning signs in some cases
Organisational factors	Staff acted appropriately within constraints	Flow, staffing and access to imaging/specialist input remain key risks

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

	Prescribed information	2025-26
27.1	The number of its patients who have died during the reporting period, including a quarterly breakdown of the annual figure.	During 2025-26, 1331 Trust patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period: 343 in the first quarter 297 in the second quarter 369 in the third quarter 322 in the fourth quarter These deaths include those who died in ED and inpatient deaths.

27.2	The number of deaths included in item 27.1 which the provider has subjected to a case record review or an investigation to determine what problems (if any) there were in the care provided to the patient, including a quarterly breakdown of the annual figure.	By 31 March 2026, 369 case record reviews and 2 investigations have been carried out in relation to 1331 of the deaths included in item 27.1. In 0 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was: 104 SJR+1 PSII in the first quarter 124 SJR+0 PSII in the second quarter 116 SJR+1 PSII in the third quarter 25 SJR+0 PSII in the fourth quarter Note: since adoption of the Patient Safety Incident Response Framework (PSIRF), investigation has been interpreted as referring to PSIIs (Patient Safety Incident Investigation)
27.3	An estimate of the number of deaths during the reporting period included in item 27.2 for which a case record review or investigation has been carried out which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient (including a quarterly breakdown), with an explanation of the methods used to assess this.	0 representing 0% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of: 0 representing 0% for the first quarter 0 representing 0% for the second quarter 0 representing 0% for the third quarter 0 representing 0% for the fourth quarter These numbers have been estimated using the Trust's Mortality Review process, the outcomes from PSIIs and final discussion of cases by the Mortality Surveillance Committee. At this point in time there are 2 SJRs with a preliminary finding of greater than 50:50 preventability undergoing patient safety review. There are a further 2 PSIIs in progress where the preventability of death has not yet been agreed. On conclusion some or all of these may be deemed more likely than not due to a problem in healthcare which will be indicated in next year's report. Of note there were a further 2 cases where the reviewer judged the death to be more likely than not due to a problem in healthcare, where the concern related to care in the community prior to admission. As these did not reflect problems in the care we provided, they have not been included in our figures. However, one case was shared with our ICB and the other with our local community trust for further review/action. Since 1 July 2022 the Trust has used the SJR*Plus* review format. Based heavily on the original Royal College of Physician's SJR model, this was developed by the 'Better Tomorrow' initiative, which was initially hosted on the Future NHS platform and has since transferred to Aqua (Advancing Quality Alliance). Included in the review, is an assessment by the reviewer of the preventability of death. It must be remembered that the question of the preventability of a death is the subjective assessment of an individual reviewer based on a SJR desktop review. While not definitive, the assessment by them that the death was more likely than not due to a problem in healthcare (more than 50:50% preventable) triggers a patient safety incident, enabling further in-depth investigation of the case in line with current patient safety processes.

27.4	A summary of what the provider has learnt from case record reviews and investigations conducted in relation to the deaths identified in item 27.3.	As indicated in 27.3, while there are cases where patient safety investigations are ongoing, conclusions have not yet been reached regarding whether the death was considered to be due to a problem in healthcare. For this reason, it is not yet possible to detail the learning.
27.5	A description of the actions which the provider has taken in the reporting period, and proposes to take following the reporting period, in consequence of what the provider has learnt during the reporting period (see item 27.4).	As indicated in 27.4 rigorous patient safety investigations are still in progress meaning that action plans have yet to be finalised/implemented.
27.6	An assessment of the impact of the actions described in item 27.5 which were taken by the provider during the reporting period.	It will only be possible to assess the impact once actions have been agreed and implemented.
27.7	The number of case record reviews or investigations finished in the reporting period which related to deaths during the previous reporting period but were not included in item 27.2 in the relevant document for that previous reporting period.	52 case record reviews and 3 PSII investigations completed after 1 April 2025 which related to inpatient deaths which took place before the start of the reporting period.
27.8	An estimate of the number of deaths included in item 27.7 which the provider judges because of the review or investigation were more likely than not to have been due to problems in the care provided to the patient, with an explanation of the methods used to assess this.	0 *[of the 52 case record reviews and 3 PSII investigations reported in 27.7 above]* representing 0.22% of the patient deaths before the reporting period *[ie 2024-25]* are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the mortality review process methods detailed above in 27.3.
27.9	A revised estimate of the number of deaths during the previous reporting period stated in item 27.3 of the relevant document for that previous reporting period, taking account of the deaths referred to in item 27.8.	3 representing 0.22% of the patient deaths during 2024-25 are judged to be more likely than not to have been due to problems in the care provided to the patient *[this represents a revised total figure 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 December 2025 is 0.9500, positioned within the ‘as expected’ Band 2 category. SHMI is generally available six months in arrears.

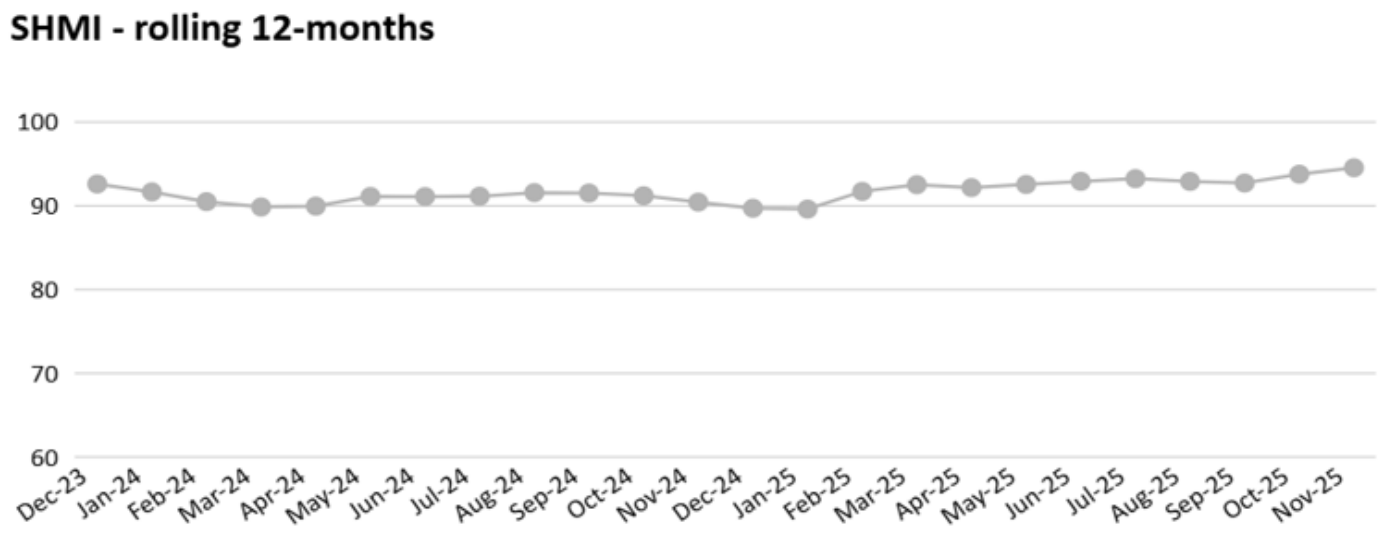
Following significant improvements in SHMI, there has now been a sustained period of stability with a recent gradual upward trend. Our position relative to our national peers currently stands at 40/118 out of all acute non-specialist trusts.

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	0.9500	Jan-25 to Dec-25	0.9015*	0.7118	1.3308	1.0
	Banding	2		2	3	1	-
Percentage of deaths with palliative care coding	Percentage	47.0		41.0	69.0	17.0	44.0

*Time period: November 2023- October 2024

Rolling 12-month SHMI: Dec 2023 to November 2025



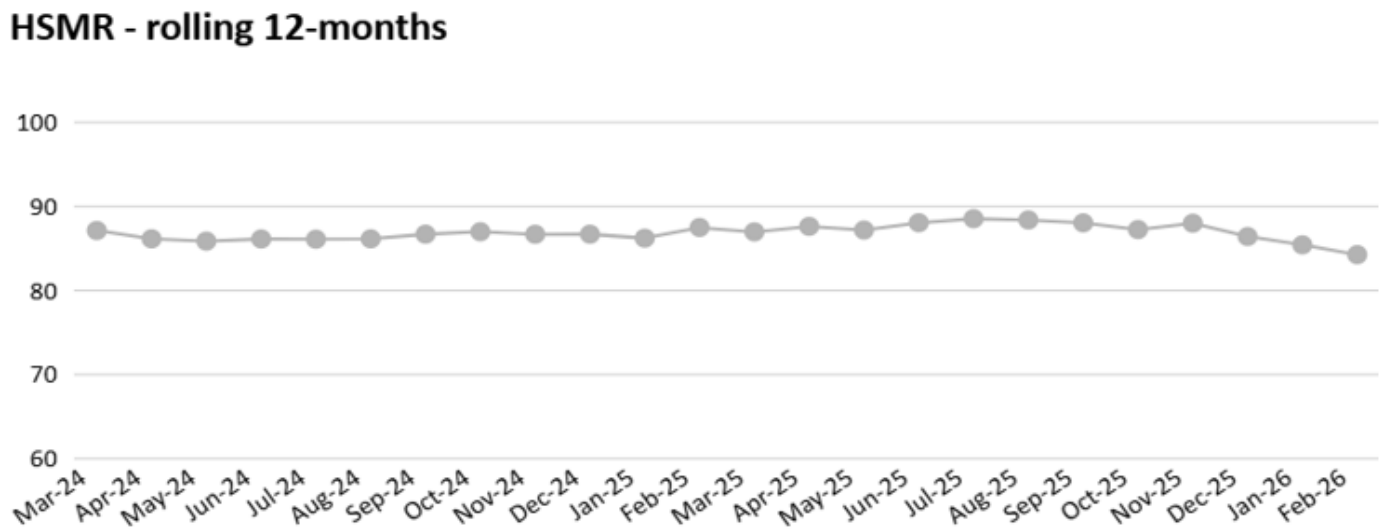
Note: In the chart above, the observed to expected deaths have been multiplied by 100 (comparable to HSMR (Hospital Standardised Mortality Ratio) methodology) so that ‘100’ is comparable to the ‘1’ as described above, where the number of observed deaths exactly matches the number of expected deaths.

A different measure of mortality is the Hospital Standardised Mortality Ratio (HSMR) which measures the actual number of patients who die in hospital against the number that would be expected to die given certain characteristics, for example, demographics, for a basket of 56 diagnosis groups, which account for approximately 80% of all deaths.

In this metric the observed to expected deaths ratio is multiplied by 100 so that when observed deaths match expected deaths the rate stands at 100 (blue line in the graph below).Generally, this means that a figure below 100 indicates a ‘lower than expected’ number of deaths. However, unlike SHMI, our informatics provider CHKS, do not rebase the HSMR metric monthly. They currently rebase every one to

two years. This should be borne in mind when assessing performance. Our performance is currently within the mid-range of acute trusts. HSMR is generally available 3 months in arrears and the latest HSMR for the rolling 12 months to Feb 2026 is 84.2, this positions us in the first quartile of trusts nationally.

Rolling 12-month HSMR: March 2024 to Feb 2026



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

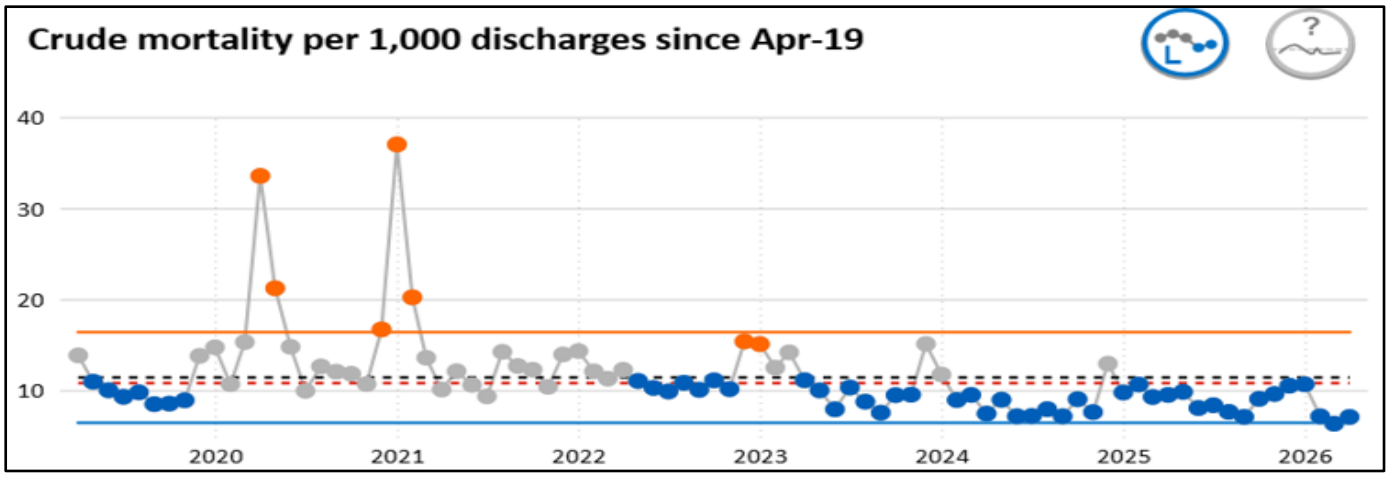
Crude mortality is based upon the number of patients who die in the Trust whilst an inpatient. It is measured per 1,000 admissions.

This measure is available the day after the month end and is the factor with the most significant impact on HSMR.

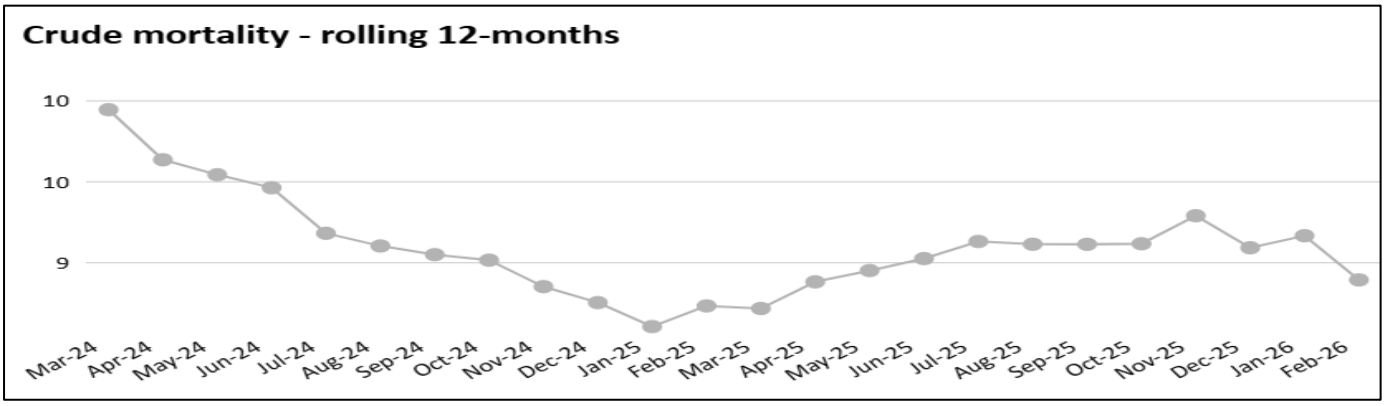
The general improvements in mortality over recent years have resulted from corporate level initiatives such as the learning from deaths process, focussed clinical improvement work, together with a continued drive to improve the quality of our coding.

While the COVID-19 pandemic saw peaks in April 2020 and January 2021, most of the intervening and subsequent periods have seen us positioned below, or in line with, the national average, with rolling 12-month crude mortality consistently tracking below national.

Crude Mortality per 1000 discharges since April 2019



Rolling 12-month Crude Mortality March 2024 to February 2026



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.
Below figures are for 2024-25, which is the latest publication, from April 2026.

Category	Measure	Trust	England	Outlier Status
Hip Replacement Primary	EQ VAS	13.12	14.54	Not an outlier
Hip Replacement Primary	ED-5D Index	0.47	0.45	Not an outlier
Hip Replacement Primary	Oxford Hip Score	22.95	22.40	Not an outlier
Hip Replacement Revision	EQ VAS	-	9.88	Insufficient records
Hip Replacement Revision	ED-5D Index	-	0.35	Insufficient records
Hip Replacement Revision	Oxford Hip Score	-	15.51	Insufficient records
Total Hip Replacement	EQ VAS	12.11	14.55	Not an outlier
Total Hip Replacement	ED-5D Index	0.45	0.44	Not an outlier
Total Hip Replacement	Oxford Hip Score	21.63	22.01	Not an outlier
Knee Replacement Primary	EQ VAS	11.45	8.61	Not an outlier
Knee Replacement Primary	ED-5D Index	0.31	0.32	Not an outlier
Knee Replacement Primary	Oxford Knee Score	17.36	16.68	Not an outlier
Knee Replacement Revision	EQ VAS	-	4.12	Insufficient records
Knee Replacement Revision	ED-5D Index	-	0.33	Insufficient records
Knee Replacement Revision	Oxford Knee Score	-	14.80	Insufficient records
Total Knee Replacement	EQ VAS	10.56	8.83	Not an outlier

Total Knee Replacement	ED-5D Index	0.31	0.32	Not an outlier
Total Knee Replacement	Oxford Knee Score	17.18	16.42	Not an outlier

*Please note the groin hernia and varicose veins data collections ceased in 2017.

2.4.3. 30 Day/Emergency readmissions

The readmissions data below is comparison of data from Apr-Jan period *.

30 day re-admissions	Feb-23 - Jan-24			Feb-24 - Jan-25			Feb-25 - Jan-26		
	0-15	16 and over	Total	0-15	16 and over	Total	0-15	16 and over	Total
Discharges	9,963	112,759	122,722	12,242	132,167	144,409	11,972	129,654	141,626
Number of 30-day re-admissions	1,024	6,601	7,625	1,333	8,121	9,454	1,357	6,925	8,282
30-day re-admission rate	10.3%	5.9%	6.2%	10.9%	6.1%	6.5%	11.3%	5.3%	5.8%

*Data up to January 2026

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 national dataset, which is an established and recognised source of data nationally.

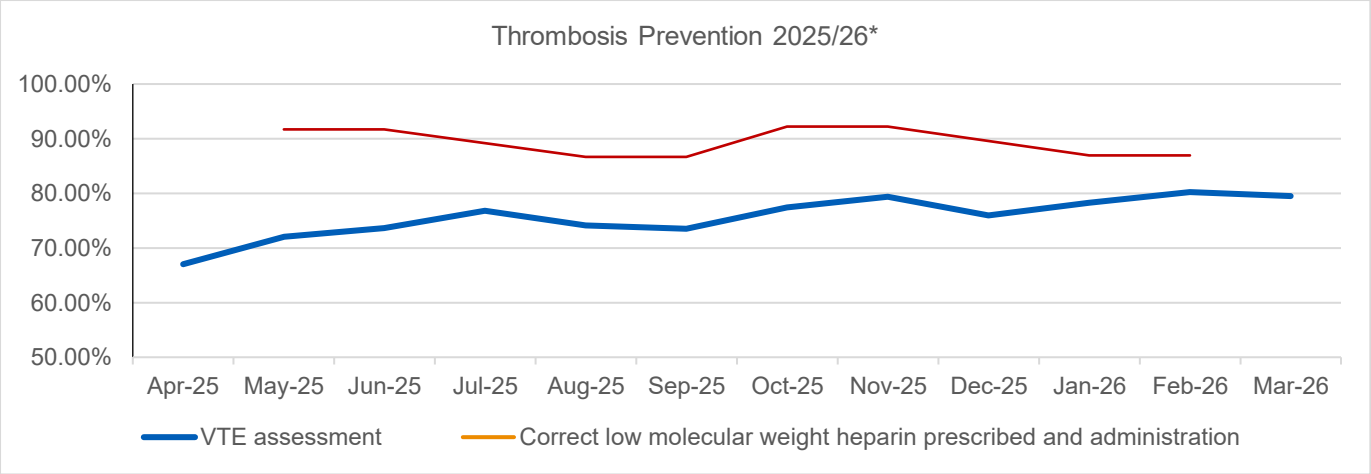
Service Area	2023/24	2024/25	2025/26
Inpatient	96.45%	96.34%	97.05%
Outpatient	96.34%	96.40%	94.99%
Maternity	98.17%	97.28%	99.07%
Emergency Department	92.61%	83.87%	88.15%

*As of March 2026

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 80% by March 2026, with Low Molecular Weight Heparin (LMWH) prescribing maintained at 80%.



*Audit data of clinical areas compliance with VTE prevention 2025/26.

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.

2.4.6. Clostridioides Difficile (C.diff)

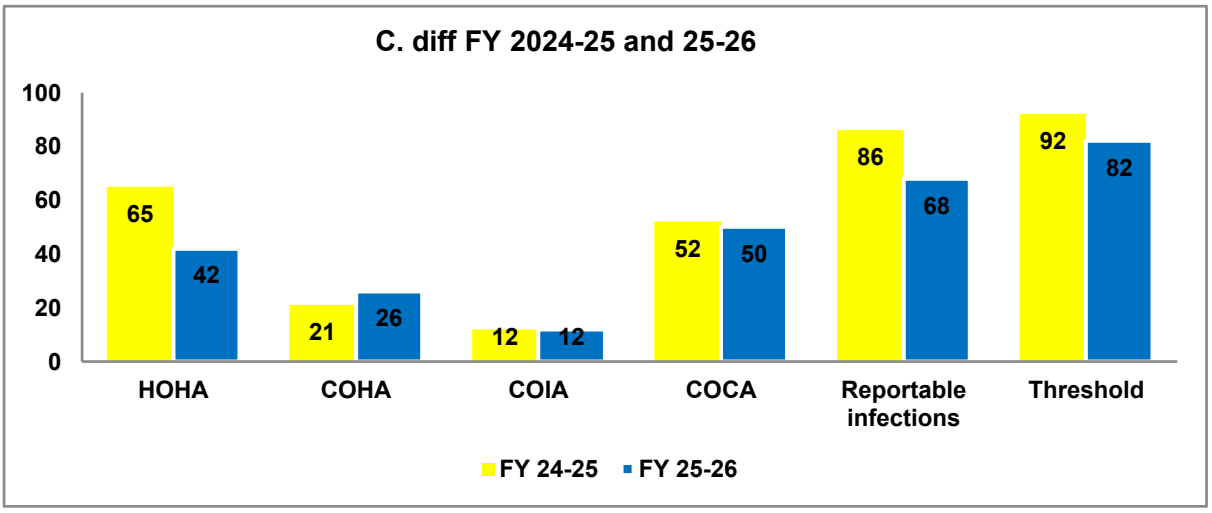
During 2025–26, the Trust demonstrated sustained improvement in the prevention and control of healthcare associated Clostridioides difficile (C. diff) infection, with the total number of acquisitions below the nationally agreed threshold, showing a year on year reduction.

IPC Table 1

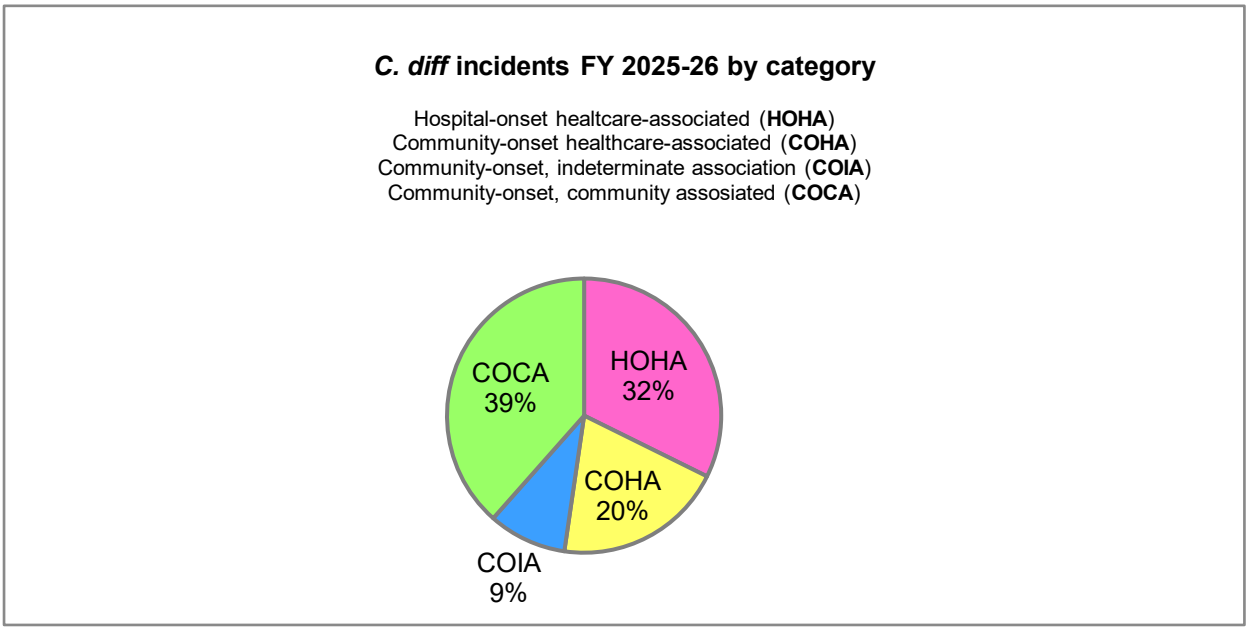
Prior healthcare exposure group	Definition
Hospital-onset healthcare-associated (HOHA)	Specimen date is ≥3 days after the current admission date* (where day of admission is day 1)
Community-onset healthcare-associated (COHA)	Is not categorised HOHA and the patient was most recently discharged from the same reporting trust in the 28 days prior to the specimen date (where day 1 is the specimen date)
Community-onset, indeterminate association (COIA)	Is not categorised HOHA and the patient was most recently discharged from the same reporting trust between 29 and 84 days prior to the specimen date (where day 1 is the specimen date)
Community-onset, community associated (COCA)	Is not categorised HOHA and the patient has not been discharged from the same reporting organisation in the 84 days prior to the specimen date (where day 1 is the specimen date)

*Admission date refers to the date of admission to the reporting acute Trust, or where the patient was admitted via A&E (of the same reporting Trust), the decision to admit date
**As a result of this definition change, case classifications will change from community-onset to hospital-onset

IPC Figure 1



IPC Figure 2



Of the 130 cases of C. diff infection identified at the trust, 50 (39%) were identified as community-onset community acquired (COCA) infections, 12 (9%) were identified as community-onset indeterminate acquired (COIA) infections, 26 (20%) were identified as community-onset healthcare acquired (COHA) infections, and 42 (32%) were identified as hospital onset healthcare acquired (HOHA) infections. Both COHA and HOHA infections are attributable to the trust and reportable to NHS England. Community onset community associated cases remained higher than HOHA cases at 39%, indicating that a greater proportion of C. diff infections are occurring in the community. Indeterminate cases remained stable at 9%. See IPC figure 1 and 2.

A total of 68 healthcare associated C. diff cases were recorded and reported compared to 86 cases in the same period during 2024–25. The total number is below the trust threshold of 82, as apportioned by NHS England for this financial year (FY) 2025-26. This demonstrates robust infection prevention and control (IPC) systems and processes, reflecting a growing trust IPC culture. A multidisciplinary collaborative approach has been greatly beneficial in supporting effective action plans (such as the Unplanned Care

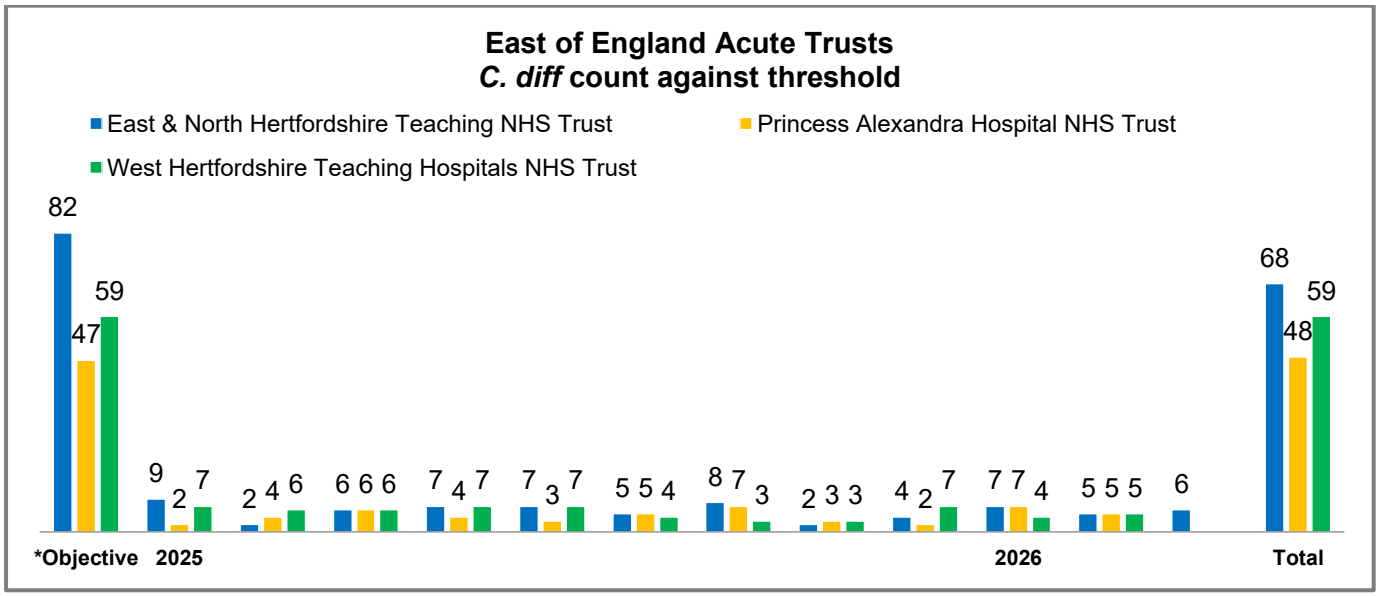
Division's C. diff action plan); considered antimicrobial stewardship (with microbiology consultant and antimicrobial pharmacy leadership); and robust governance structures, that have supported practice improvements.

A marked reduction in hospital onset healthcare associated (HOHA) cases was achieved, falling from 65 cases (FY 2024-25) to 42 cases (FY 2025-26). This represents a 35% decrease in this category alone, reflecting strengthened inpatient prevention measures, including early identification, prompt isolation and treatment, enhanced environmental cleaning, and effective antimicrobial stewardship. The weekly C. diff MDT has played a pivotal role in, not only in identifying avoidable and unavoidable infections, but supported open discussion leading to improvements in practice and patient safety outcomes.

No outbreaks were identified demonstrating strong IPC practice standards on inpatient wards. All cases were managed through established IPC escalation, review, and governance processes. This places the trust in a good position, with continued internal, local, and system wide collaboration, to positively impact the safety of our patient population.

Integrated Care System Performance

IPC Figure 3



Based on the above data

- East and North Hertfordshire Teaching NHS Trust reported 68 cases against a ceiling of 82 for FY 2025-26
- Princess Alexandra Hospital NHS Trust **recorded** 48 cases against a ceiling of 47 (Apr 2025 to Feb 2026 data)
- West Hertfordshire Teaching Hospitals NHS Trust **recorded** 59 cases against a ceiling of 59 (Apr 2025 to Feb 2026 data)

Overall performance in 2025–26 provides strong assurance of effective prevention and control of healthcare associated C diff risk, with notable reductions in hospital onset cases and delivery within threshold. Continued focus on healthcare associated and community interface cases will support further improvement in 2026–27.

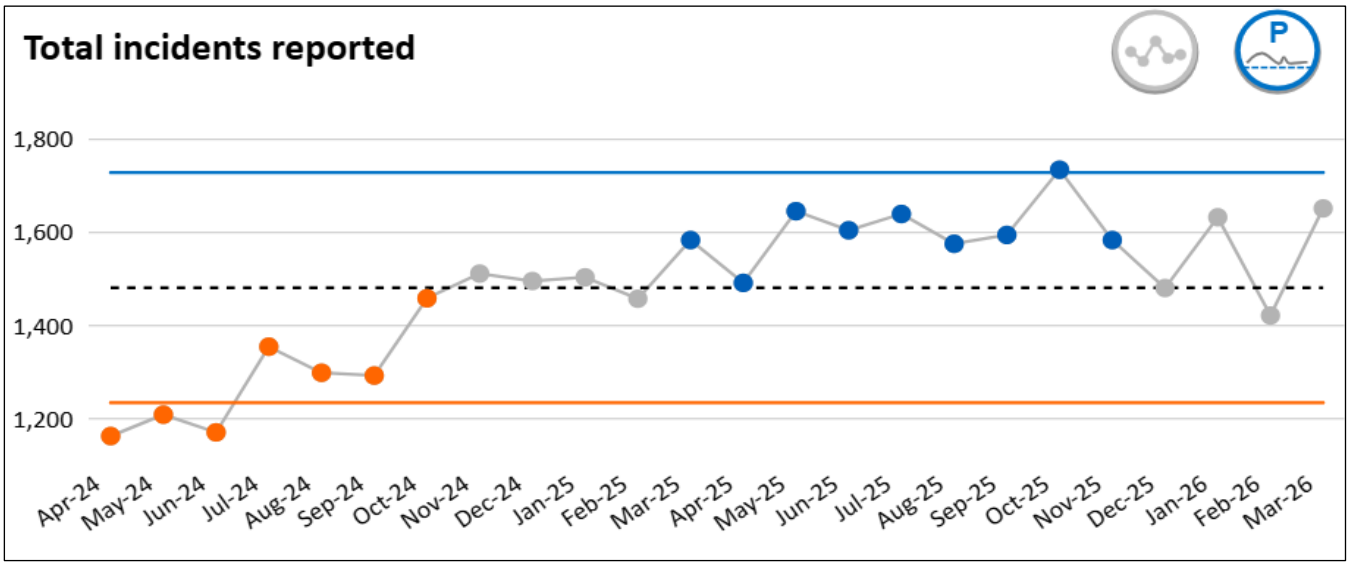
2.4.7. Patient safety incidents

In 2025/26, the Trust progressed through its third year operating under the Patient Safety Incident Response Framework (PSIRF). This national framework guides organisations to focus on learning and improvement following patient safety incidents. It has meant a cultural shift away from bureaucratic investigations mandated by harm level and instead advocates for proportionate, systems-based responses that compassionately involve those affected. The PSIRF embeds learning responses within a wider system of improvement.

The Trust has had a PSIRF policy and PSIRF plan in place since we adopted the PSIRF in November 2023. During 2025/26, the plan was reviewed and updated following review of relevant safety data including incidents, clinical claims, complaints and risks with key stakeholders. This enabled us to revise and refocus our safety priorities for the year to reflect the learning from previous years and to reflect the current safety profile at the Trust. Through the PSIRF we have developed a governance process to ensure local service oversight of incident data on a daily and weekly basis. This further supports the key principles of early intervention, engagement, support and learning.

At the Trust our incident reporting system is aligned to the national Learning from Patient Safety Events (LFPSE) system. This supports both incident and good care reporting and allows the data to be reviewed externally by relevant bodies, including NHS England contributing to national patient safety initiatives. This further supports our culture of transparency and continuous learning.

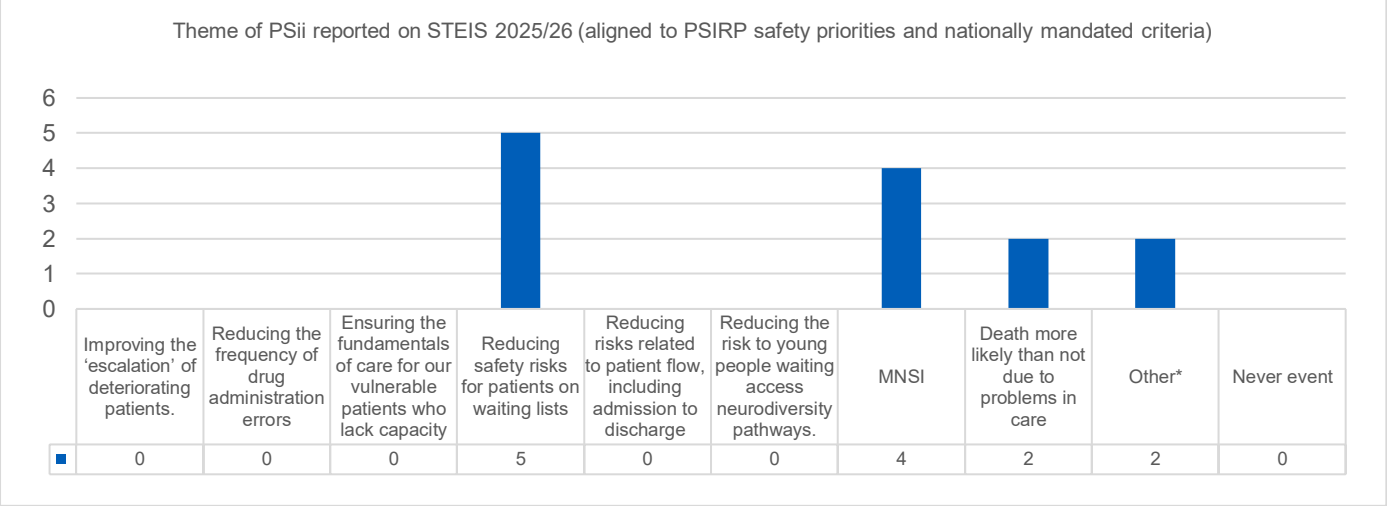
Incident reporting rose significantly, with 19,763 incidents reported in 2025/26 compared to 17,196 incidents reported in 2024/25 (and 13,767 reported in 2023/24). Of the incidents reported in 2025/26, 98% of them caused no or low physical harm. This reflects the positive safety reporting culture that has developed at the Trust.



Through the LFPSE system the Trust also reports ‘good care’ events allowing us to celebrate and learn from when things have gone well. In 2025/26, 945 good care events were reported. This is a 61% increase from 586 being reported in 2024/25. Although there has been an increase, it remains an area we continue to promote and review as a safety metric.

Patient Safety Incident Investigations (PSII)

Under PSIRF, 13 Patient Safety Incident Investigations (PSIIs) were commissioned on the national reporting system (STEIS). All investigations were initiated in response to incidents that met local or national PSII criteria, and each followed systems-based methodologies to understand the contributory factors and develop safety actions to prevent recurrence. The graph below demonstrates the themes of the PSIIs aligned to the Trust's Patient Safety Incident Response Plan safety priorities and the nationally mandated criteria.



* The 2 cases in the category of 'other' shown above – relate to a) delayed diagnosis and treatment and b) gaps in fundamental standards of care.

The incidents involving patients on waiting lists ("reducing safety risks for patients on waiting list") were reviewed together in one thematic review. This covered multiple specialties and services; Gastroenterology, Hepatology, Cardiology and Ophthalmology (medical retina pathway). The thematic review highlighted key contributory factors including reduced oversight and visibility of follow-up / non-RTT activity, absence of clear escalation mechanisms for un-booked referrals or when patients breeched their clinical due date, insufficient clinic space, long-term capacity challenges (locally and nationally). The MNSI investigations are based on national criteria of incidents and externally led by the Maternity and Newborn Safety Investigations (MNSI) programme. Three of the cases involved incidents where babies were born unexpectedly unwell and required transfer out to a tertiary centre for cooling. Learning included communication tools, delays and documentation.

All cases were reviewed by the Patient Safety Event Response Panel and Quality and Safety Committee. The learning is disseminated through divisional governance structures, clinical education sessions, and thematic safety campaigns.

Never Events

The Trust did not report any Never Events during 2025/26. Following Never Event patient safety incident investigations undertaken last year, the Invasive Procedure Oversight Group is now embedded and enables a forum for oversight and cross-speciality learning relating to Local Safety Standards and Invasive Procedures (LocSSIPS).

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 was ranked in segment two in the NHS Oversight Framework (the new performance league table for NHS trusts) throughout 2025/26. The league table is separated into four segments, with segment one

being the highest-rated and segment four being the worst-rated. Segment two places the Trust consistently in the higher performing NHS trusts nationally.

2.5.1. Performance Analysis: In-depth performance review

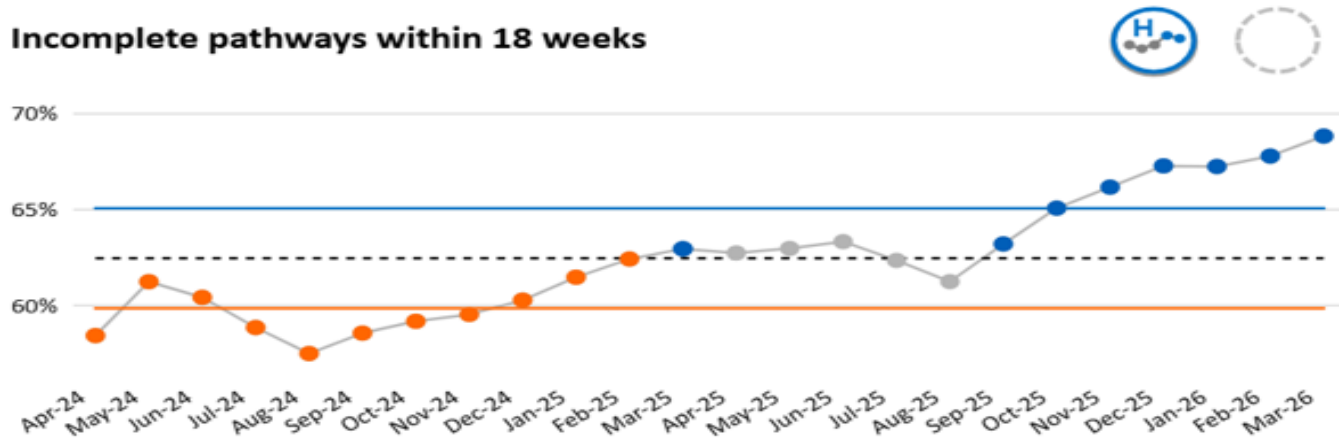
Operational performance

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

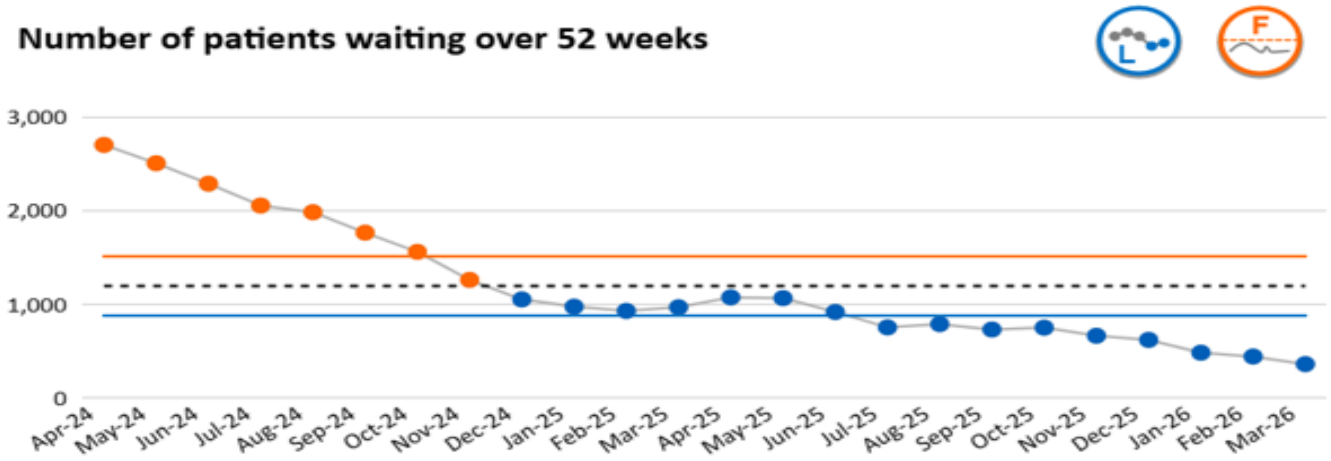
- Cancer standards: The Trust met the national 62-day cancer standard (85%) across the year and continued to perform above the national average across all three cancer standards
- Elective care (Referral to Treatment - RTT): RTT 18-week performance has improved and exceeded recovery expectations. The number of patients waiting over 52 weeks reduced, demonstrating progress against national elective recovery priorities
- Urgent and Emergency Care: Performance improved to 74% from 70% the previous year but was below the March 2026 78% target
- Diagnostics: The number and percentage of patients waiting over six weeks reduced in the second half of the year, representing improvement
- Community Paediatric waiting times remained high, driven by a mixture of capacity and demand pressures within neurodiversity pathways

Referral to Treatment (RTT)

The Trust has improved access for patients on elective pathways with achievement of the referral to treatment (RTT) targets, for percentage waiting within 18 weeks and reduction in percentage waiting over 52 weeks in 2025/26. RTT target for 2025/26 was set at 64.2% (excluding community paediatrics) which represented a 5% improvement on 24/25. The Trust delivered 69.1% of patients waiting within 18 weeks, exceeding the target by 4.9%.



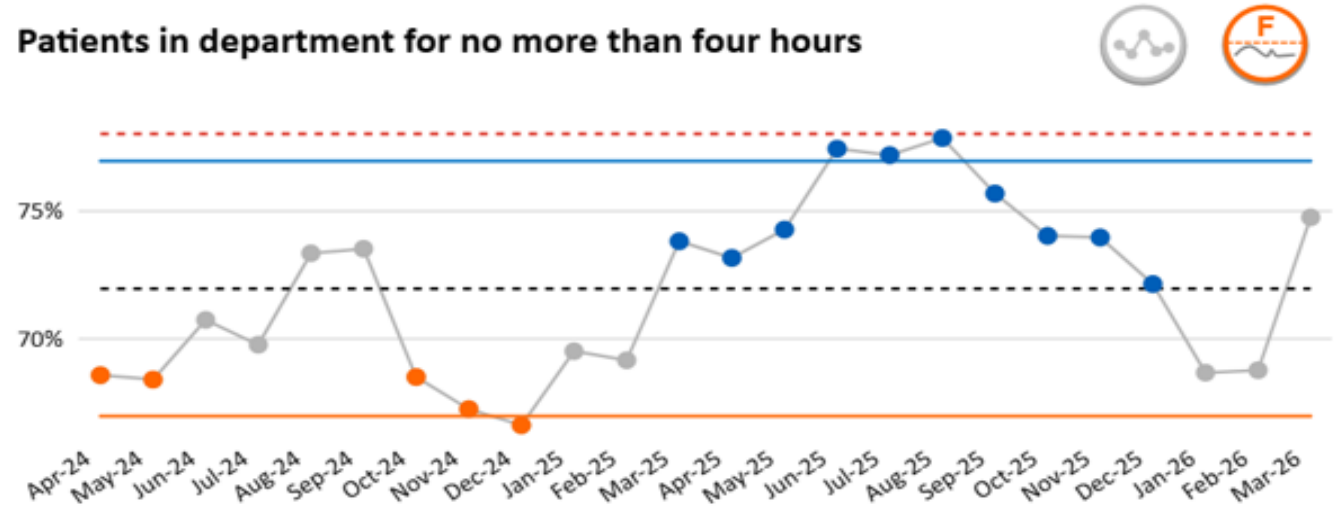
The target for the percentage of patients waiting over 52 weeks (excluding community paediatrics) by the end of 2025/26 was 0.7% or less; the Trust exceeded this target by 0.1% with a delivery of 0.6%.



Community paediatric services remain a focus for the Trust with internal pathway improvements starting to deliver additional capacity and positive impact on access times. Work is accelerating with healthcare partners in Hertfordshire to further improve neurodiversity waits for our children and young people through standardising pathways and moving to more multidisciplinary models of care.

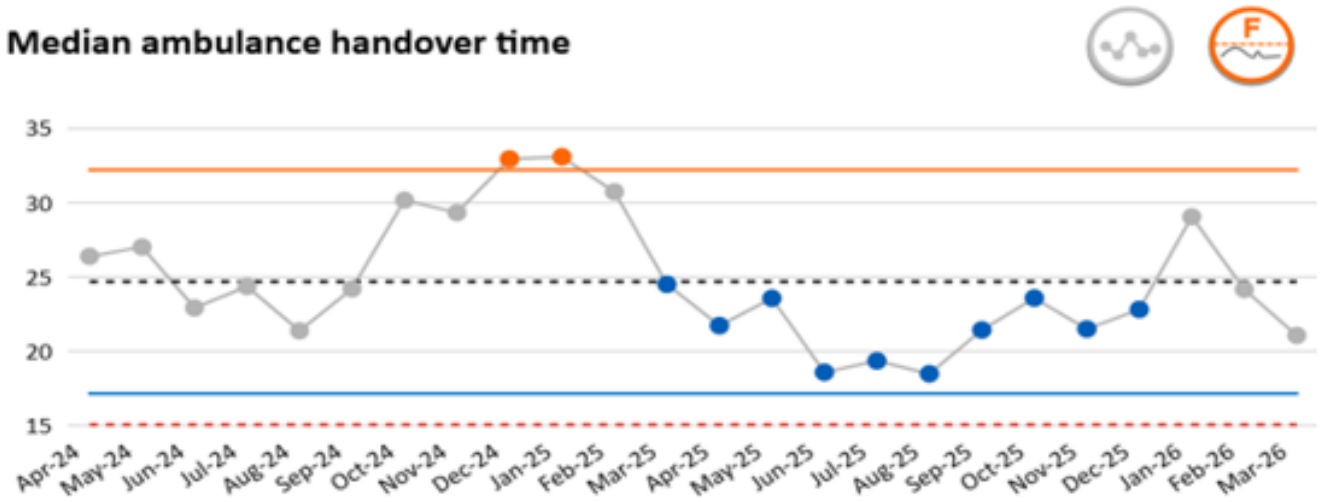
Urgent Care pathways

In 2025/26, the Trust continued to work towards the national four-hour emergency care standard, Waits in Urgent and Emergency Care (UEC) have improved year-on-year, with 74% of patients seen within four hours in 2025/6, up from 70% in 24/25. To drive further improvement, the Trust has a major improvement programme underway for UEC pathways for adults and children. This includes improving streaming and triage, increasing Same Day Emergency Care capacity and enabling extended emergency medicine ambulatory care.



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, continued to work hard to significantly reduce handover time for those patients brought to the department by ambulance. The Trust has reduced the median handover time from 27.3 minutes in 2024/25 to 22 minutes in 2025/26.

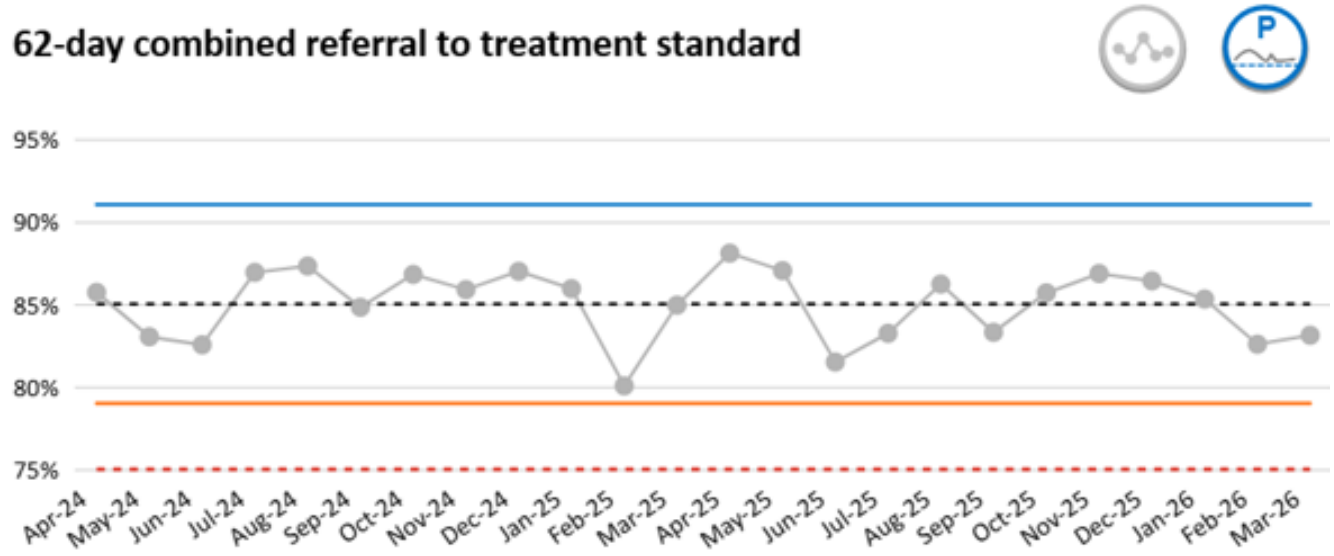


Cancer performance

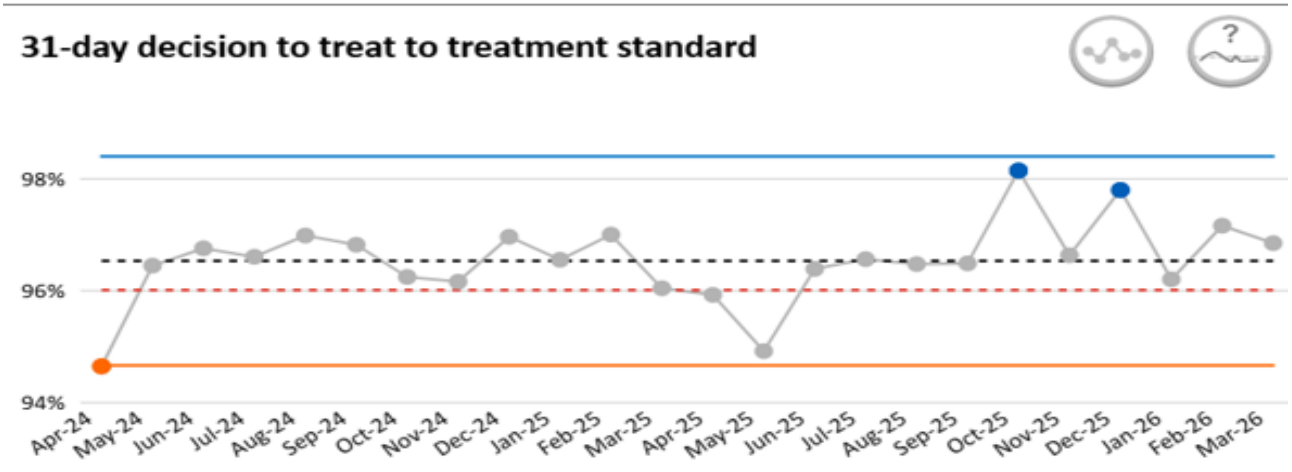
During 2025/26, the Trust reported on the three national cancer standards: the 28-day Faster Diagnosis, the 31-day Treatment, and the 62-day General standards.

The Trust has continued to deliver strong Cancer performance in 2025/6. Work continues to improve access to diagnostic imaging, in particular MRI, to support improved rates of diagnosis within 28 days. The Trust ranks well nationally on all three cancer standards.

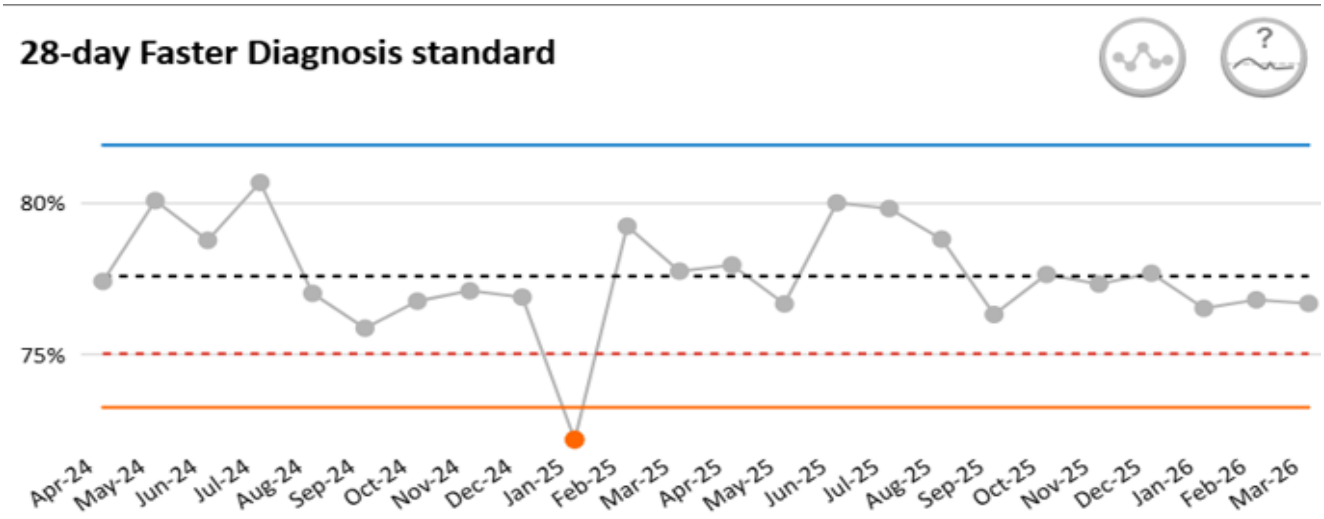
The 62-day standard, while not consistently sustained, (delivered the 85% target in 7 out of 12 months) remained strong nationally, ranking 14th out of 119 Trusts in March 2026. Challenges included increased two-week wait referrals and capacity constraints in imaging and endoscopy. Imaging will remain a focus in 2026/27 as the service embarks on their transformation programme.



The 31-day treatment standard was maintained throughout the year, with one temporary dip due to radiotherapy capacity issues due to linac machine annual servicing.

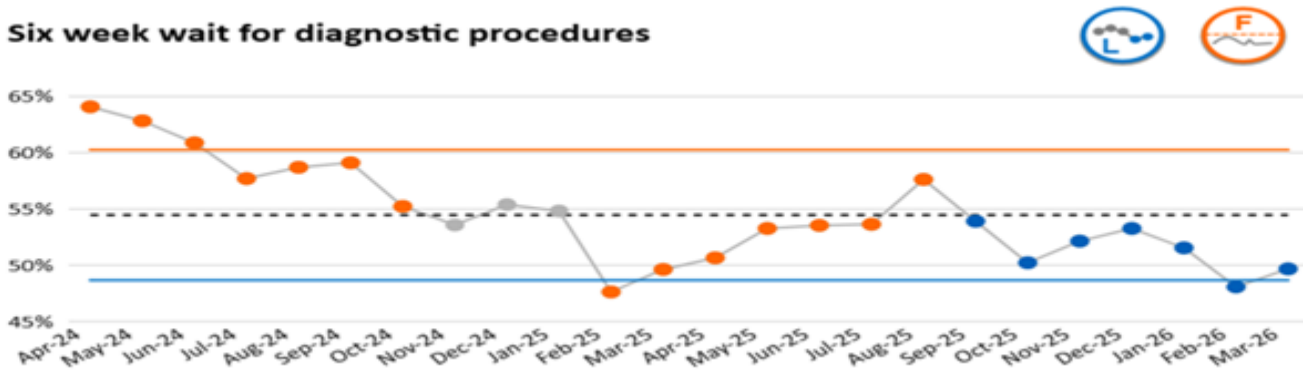


The 28-day Faster Diagnosis (75%) standard was consistently met throughout the year. The standard for 2026/27 has increased to 80% and the transformation programme for imaging will support the Trust to deliver this target.



*Diagnostics: Standard: less than 1% of patients should wait 6 weeks or more for a diagnostic test

In diagnostics, while the Trust did not meet the national target of less than1% of patients waiting over 6 weeks for a test, the performance has improved from 2024/25. Significant capital investment and transformation work has taken place within the Audiology service during 2025/26, which will see the Trust improve access to these diagnostic services in 2026/27. Imaging will be a focus for 2026/27, with the implementation of their transformation programme and a large-scale capital investment plan to replace and update some of the diagnostic equipment.



Stroke performance

In October 2024, the Sentinel Stroke National Audit Programme (SSNAP) domains were substantially revised to align with the latest NICE and national guidance. As a result, the service rating moved from B to E. This change did not reflect deterioration in the quality of care provided, but rather the introduction of more patient-centred performance metrics, particularly within the therapy domains. In 2025/26, the service demonstrated improvements across almost all domains, resulting in an improved SSNAP rating of D. In addition, confirmed stroke activity has consistently exceeded the SSNAP monthly baseline of 63 cases, with an average of 80–90 confirmed stroke cases reported each month throughout 2026.

Significant progress has been achieved across all domains. The Hyper-Acute Stroke Unit (HASU) achieved a C rating under the new national metrics with performance against the 20-minute CT scan target improved from 28% to 37%, against a national target of 40%. The Trust has also successfully implemented CT Perfusion during working hours, with plans to expand to a 24/7 service from June 2026.

The Specialist Stroke Pathway domain has seen significant improvements, particularly in the proportion of patients admitted to the stroke unit within four hours. Performance has improved from 17% to 52%. This is 1% against a regionally agreed target of 60%, with forecast data indicating further improvement beyond this target. This has moved us from an E to a D for the first time in four years.

Improvements have also been demonstrated in reperfusion therapy, with the service exceeding its Trust-specific SSNAP target of 14% by achieving 16.7%. There have also been improvements in the proportion of patients referred for thrombectomy, with additional work underway to reduce transfer times to the nearest Mechanical Thrombectomy Centre (MTC). The service is also in the final stages of implementing Pre-Hospital Video Triage.

Therapy assessments completed within 24 hours have improved alongside performance against the four-hour admission standard. Additional progress has been made within Speech and Language Therapy through targeted process improvements. However, the introduction of new national three-hour therapy targets has created performance challenges across the sector and impacted overall ratings.

Seven Day Service

The national Seven Day Hospital Services (7DS) Programme is a quality improvement initiative providing acute provider organisations with a framework for reducing variation in outcomes for patients admitted to hospitals in an emergency and at the weekend across NHS trusts in England. There is a working group overseeing the necessary work to meet these standards, chaired by the deputy medical director. 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 2025 identified that 60.71% of the sample 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:

	0830 to 1700 Monday to Sunday
Paediatrics	0830-2100
Respiratory	0830-1730
Trauma and Orthopaedics	0800-1800
Renal	0800-1830

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**	

* The Trust is currently working to deliver 6 days interventional radiology to start during 2026.Currently, IR at weekends is arranged by liaison with other provider organisations, there is not a formal network
**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 always available on site at weekends. 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 2025 identified that approximately 96.3% of 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. We are currently working to address the challenges of the vacancy factor related to increasing numbers of less than full time doctors in post.

NHS Staff Survey

Our overall scores shown below indicate improvements in all categories:

People Promise elements	2024 score	2025 score	Statistically significant change?
We are compassionate and inclusive	7.30	7.31	Not Significant
We are recognised and rewarded	5.92	5.94	Not Significant
We each have a voice that counts	6.66	6.61	Not Significant
We are safe and healthy	6.13	6.07	Not Significant
We are always learning	5.79	5.62	Significantly lower
We work flexibly	6.35	6.33	Not Significant
We are a team	6.77	6.80	Not Significant
Themes			
Staff Engagement	6.90	6.83	Not Significant
Morale	5.93	5.86	Not Significant

The Trust 2025 staff survey was completed by 41% of staff and the returns showed as statistically valid. We achieved above the national average for 'We are compassionate and inclusive'; 'We are recognised and rewarded'; 'We work flexibly'; 'We are a team' and 'Staff Engagement'.

In 2026/27, the Trust will continue its focus under the theme 'A Voice That Counts', with particular emphasis on strengthening the capacity of 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.

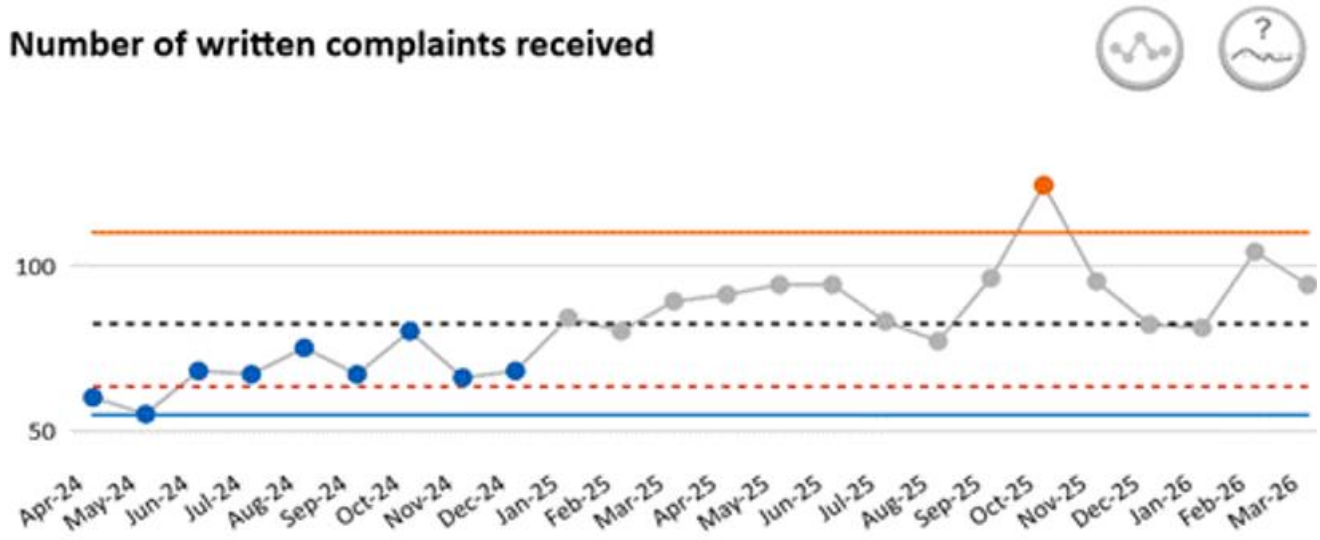
Patient Experience
Complaints and Compliments

All complaints data is sourced from the Trust's internal quality management system ENHance. The Complaints and PALS Department (Patient Advice and Liaison Service) records and responds to complaints, concerns, comments and compliments received from all areas of the Trust, which are triaged to identify the most appropriate method of handling.

It is the Trust's ambition for complainants to have their concerns resolved as swiftly as possible, by offering a formal or informal method of resolution. The Trust captures and monitors any concerns raised by our patients and their families to introduce high impact actions and improvements across the organisation.

In 2025/26 1,115 formal complaints were received. This is a 23% increase in complaints from the 904 received the previous reporting year of 2024/25.

There was also a significant increase in the number of PALS enquiries received. There was a 26% rise leading to a total of 5778. This is a rise of over 1000 enquiries from 4657 received the previous year 2023/24.



Patient Advice and Liaison Service (PALS)

Indicator	**23/24**	**24/25**	**25/26**
Number of formal complaints	763	904	1,115
Number of PALS concerns	4657	5864	5486
Complaints – response within agreed timeframe	48%	68%	46%

Key themes from our Patient Advisory Liaison Service (PALS) are related to delays in appointments, poor communication and delayed/poor care/treatment.

Plans for 2025/26:

- New PALS online form to be launched which will replace the email system into the service
- Bi-weekly carers online training – available to all staff
- New formal complaints processes to be launched Trust wide
- Continue to promote face to face meetings with families for early resolution before escalation to a formalised written response.

Compliments

710 compliments were received during 2025/26, a 26% increase on the preceding year.

Parliamentary and Health Service Ombudsman complaints
In the reporting year 2025/2026, eight complaints were assessed by the Parliamentary and Health Service Ombudsman (PHSO). Three complaints were closed with no further investigation, four remain under investigation. One was partially upheld with learning for the Trust.

Freedom to Speak Up / Raise Concerns

The Freedom to Speak Up (FTSU) service includes 1.0 WTE Freedom to Speak up Guardian and a network of 43 diverse Speak Up Champions representing all staff groups. The executive lead for FTSU is Theresa Murphy, Chief Nurse.

There were 326 Speaking Up episodes in 2025/26. This report demonstrates sustained year on year increase in Speaking up episodes. The Trust compliance with Speaking Up training has successfully been maintained at 91%, and improved from 87% last year.

Speaking Up episodes

Financial Year	2021/22	2022/23	2023/24	2024/25	2025/26
Number of Speaking Up episodes	90	190	270	311	326

The FTSU service has been available 5 days a week including weekends since April 2022. The enhanced FTSU service and active network of Speak Up Champions has addressed barriers to Speaking Up and improved staff confidence in Speaking Up.

In 2025/26 there were two anonymous Speak Up episodes. This needs to be considered in the context of a challenging year for all colleagues due to consultations and the increased fear of job losses.

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

Who is Speaking Up by staff group, April 2025 to March 2026

Colleagues across all staff groups accessed the FTSU Speak Up service

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

Future next steps for improvement include:

1. Embed opportunities to promote psychological safety within teams
2. Increase the number of trained mediators within our Trust
3. Continuous support for all managers to listen and respond to staff when voicing concerns
4. Embed processes to enable Speaking Up learning and improvements to be shared as business as usual
5. Embed ‘civility saves lives’ interventions
6. Support the workforce to manage expectations when raising a concern, and/or responding to a concern
7. Agree protected time for Speak Up Champions to support FTSU service

Part 3: Other information

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

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

The committee notes the contents and will use them to inform future scrutiny work. We would like to recommend that the Trust continue to engage proactively with the Committee and ensure that scrutiny findings inform service improvement.

The Committee is grateful for the Trust's engagement in its work over the last 12 months and looks forward to continued engagement with NHS partners to ensure that improvements in quality are realised for all residents.

Next year we would appreciate having more time to be able to read the report. This would improve your service to your stakeholders.

Your sincerely

Cllr Rachel Carter
Chair Health Scrutiny Committee

NHS Central East Integrated Care Board response to the Quality Account of East and North Hertfordshire Teaching NHS Trust for 2025/2026

The ICB considers that this Quality Account provides a clear, comprehensive and balanced overview of the quality of services delivered by the Trust. It reflects a strong commitment to continuous improvement, supported by robust governance, effective use of data, and active participation in clinical audit, research and innovation.

The ICB recognises the significant progress made against the Trust's quality priorities during 2025/26. We particularly welcome the continued embedding of the Patient Safety Incident Response Framework (PSIRF), implementation of Martha's Rule, strengthening of patient and family involvement in quality improvement activities, and the Trust's ongoing commitment to fostering a culture of learning and continuous improvement. The Trust has also continued to invest in quality improvement capability, human factors training and multidisciplinary simulation to support safer care and improved patient outcomes.

The ICB particularly welcomes the significant investment and transformation work undertaken within Audiology services during 2025/26, which is expected to improve diagnostic access and reduce waiting times for patients during 2026/27.

We also recognise the Trust's openness in identifying and responding to risks associated with follow-up waiting lists, including learning identified through thematic reviews of the ophthalmology medical retina pathway and other specialist services. The willingness to undertake detailed reviews, identify system weaknesses and implement improvements demonstrates a strong commitment to patient safety and organisational learning.

The Trust has continued to deliver improvements against a backdrop of sustained operational pressures, including challenges associated with urgent and emergency care demand, patient flow, diagnostic waiting times and elective recovery.

The proposed quality priorities for 2026/27 are well aligned with both Place and system priorities. The focus on:

- Strengthening the fundamentals of safe, effective and compassionate care
- Embedding a culture of learning, quality improvement and patient safety
- Reducing health inequalities and improving patient experience

represents a balanced and appropriate approach to improving safety, outcomes and experience.

The ICB also acknowledges the Trust's commitment to learning and continuous improvement, including:

The continued development of PSIRF, investment in staff education and quality improvement capability, implementation of digital solutions to support quality oversight, and the active involvement of patients, carers and families in service improvement and organisational learning.

As the Trust moves forward, the ICB encourages continued focus on:

- Sustaining improvements in urgent and emergency care performance, patient flow and timely discharge
- Reducing diagnostic and elective waiting times, including ensuring equitable access to services across all patient groups

- Focused delivery and implementation of digital solutions including OneEPR and embedded data quality enhancement
- Supporting workforce wellbeing, retention and leadership development whilst continuing to strengthen a culture of safety and learning

Central East ICB wishes to acknowledge and commend the staff at East and North Hertfordshire Teaching NHS Trust who continue their ongoing commitment to support the NHS and deliver high quality, safe and effective care to populations served in our system. We also commend the commitment to improvement and innovation. We look forward to continuing to work in partnership with the Trust over the forthcoming year and hope that the Trust finds these comments helpful.

Rowan Procter
Deputy Director Quality Assurance
NHS Central East Integrated Care Board

Healthwatch Hertfordshire's response to the East and North Hertfordshire Teaching Hospital NHS Trust Quality Account 2025/2026

Thank you for sharing your Quality Account with us. Healthwatch Hertfordshire values its positive relationship with the East and North Hertfordshire Teaching NHS Trust and looks forward to continuing to work together to ensure patient voices help shape improvements, including those reflected in the Trust's quality priorities for the coming year.

Neil Tester, Chair Healthwatch Hertfordshire
June 2026

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

Anita Day
Chair
28 June 2026

Martin Armstrong
Chief Executive
28 June 2026

Glossary

Acronym	Meaning
AAR	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 Teaching 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 Life 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.