Outstanding Care,
Compassionate People,
Healthier Communities

Sherwood Forest Hospitals
NHS Foundation Trust

Quality Account and Reports

2023/24

King's Mill Hospital

Newark Hospital

Mansfield Community Hospital

Best NHS Acute Trust in the Midlands to work for as voted by our staff.
(2018, 2019, 2020, 2021, 2022 and 2023 NHS Staff Survey)

Contents

Introduction to the Quality Account 4
Part 1 Statement of the quality account from Paul Robinson, Chief Executive 5
Part 2 Priorities for Improvement and Statements of Assurance from the Board 6
2.1 Priorities for improvement 6
2.1.1 Providing high quality, safe care 6
2.1.2 Approach to quality improvement 7
2.1.3 Quality priorities 2024-2025 8
2.1.4 Review of quality priorities during 2023/24 9
2.2 Statements of Assurance from the Board 11
2.2.1 General statement 11
2.2.2 Participation in clinical audit 12
2.2.3 Participation in clinical research and innovation 22
2.2.4 Commissioning for Quality and Innovations (CQUIN) Indicators 24
2.2.5 Registration with the Care Quality Commission (CQC) 25
2.2.6 Information on Secondary Uses Service for inclusion in Hospital Episode Statistics 26
2.2.7 Information governance assessment report 26
2.2.8 Clinical coding audit 27
2.2.9 Data quality 31
2.2.10 Improving care and Learning from Mortality Review 34
2.3 Reporting against Core Indicators 35
2.3.1 Summary Hospital Level Mortality Indicator (SHMI) Banding 35
2.3.2 Patient Reported Outcome Measures (PROMs) 37
2.3.3 Percentage of patients readmitted to hospital within 28 Days 37
2.3.4 Trust responsiveness to the personal needs of patients 38
2.3.5 Staff Friends and Family responses and recommendation rates 42
2.3.6 Venous thromboembolism 46
2.3.7 Clostridium Difficile infection 46
2.3.8 Patient safety incidents 48
Part 3 Other information – Additional Quality Priorities 49
3.1 Safety – Improve the safety of our patients 49
3.2 Safety - Reduce harm from falls 51
3.3 Safety - Reduce the number of infections 55
3.4 Effectiveness – Improve the effectiveness of clinical care 61
3.5 Effectiveness – Improve our care and learning from Mortality Review 64
3.6 Effectiveness – Improve the experience of patients coming to the end of their life 65
3.7 Patient Experience – Improve the experience of care for Dementia patients and their carers 68
3.8 Patient Experience – Using feedback from patients and their carers 71
3.9 Patient Experience – Safeguarding vulnerable people 74
3.10 Mandatory Key Performance Indicators 77
Appendices
Appendix 1 Sherwood Forest NHS Foundation Trust – Committee structure – 2022/23 78
Appendix 2 Assurance over Mandated Indicators 78
Annex 1 Statements from commissioners, Health Scrutiny Committee and Healthwatch 79
Annex 2 Statement of Directors responsibilities for the Quality Report 81
Annex 3 Independent Assurance Report

Introduction to the quality account

This report is published pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006. It is designed to assure patients, the public and commissioners about the quality of care at Sherwood Forest Hospitals NHS Foundation Trust. The report provides a review of the Trust's quality improvement activities and achievements during 2023/24.

The report also identifies and explains the Trust's quality priorities for 2024/25. The 2023/24 sections of the report refer to quality improvement activities completed during the 2023/24 financial year. These sections include the mandatory reporting requirements set out by NHS England and NHS Improvement as referenced in the following documents:

- NHS Foundation Trust Annual Reporting Manual
- Detailed Requirements for Quality Reports 2022/23
- Data Dictionary

Part 1. Statement of the Quality Account: Dr David Selwyn, Acting Chief Executive

I am proud to present the Sherwood Forest Hospitals NHS Foundation Trust Quality account for the period 2023-2024. This report provides an opportunity to reflect on our progress and openly share our performance and outcomes for public scrutiny.

It describes how we have performed against our priorities, key performance metrics and statements of assurance. It also provides details on the quality priorities we will work toward in the coming year. The Quality Account has been prepared by the people closest to the services described and therefore provides confidence in the content. In addition, it has been reviewed by our Non-Executives Directors, Trust board, our Commissioners, and Local Authority.

It has been another challenging year for us at Sherwood and our colleagues and partners across Nottinghamshire, as we continue to see more patients in need of our services than ever before. Ensuring timely access to treatment continues to be a major objective for us as we continue working on reducing waiting times and strive to improve our services to ensure our patients receive the quality and timely care that they need. Our vision remains to provide healthier communities and outstanding care for all, and we know our people play a key role in delivering this. None of our achievements would be possible without the incredible commitment, skill, and compassion of our Trust colleagues.

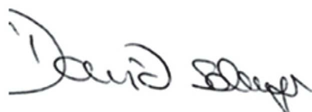
Sherwood has been on a momentous journey over recent years, emerging from 'special measures' over the past decade to now being home to the East Midlands' only NHS-run acute hospital at King's Mill that is rated as 'outstanding' for care by the Care Quality Commission (CQC).

Key to that turnaround has been creating a supportive culture that seeks to empower our people to be the best they can be – a point reflected in our 2023 NHS National Staff Survey results, announced in March 2024.

Results revealed that 74.45% of Trust staff recommended Sherwood as a place to work, rating us as the third highest amongst all NHS organisations nationally. Sherwood was also named as the best nationally for morale and engagement. Also, colleagues feeling they have the freedom to do their work, that their work is valued, and they have the right learning and development opportunities to help them grow. Crucially, the culture we have created is reflected in the care that we are proud to provide to the patients and communities we serve. 77.88% of Trust staff agree that they would be happy with the standard of care provided at the Trust if a friend or relative needed treatment.

Maintaining a positive culture will be key to sustaining high standards of care here at Sherwood. The balance of continuing to provide outstanding patient care and to aspire and improve within a strict financial climate, will be a challenge, but providing quality patient care remains a key focus for us to maintain as we enter a new financial year.

I am confident that the information in this report accurately reflects our performance and provides an honest and consistent reflection of where we have succeeded and exceed in delivery on our plans, and where we need to improve further. I hope you find this account informative and see that our patients are very much at the centre of everything our colleagues at Sherwood do.



Dr David Selwyn
Acting Chief Executive

Part 2 - Priorities for improvement and statements of assurance from the Board

2.1 Priorities for Improvement

Sherwood Forest Hospitals NHS Foundation Trust (SFHFT) is committed to providing safe, high-quality care to all patients and service users. The Trust focus is on continuous improvement and is driven by the Quality Priorities identified within the Quality Strategy 2022-2025

The Quality Strategy sets out our approach to ensuring each patient contact is safe and effective and builds on the robust foundations of quality. It outlines our objectives and the outcomes we want for our patients and, demonstrates our commitment to ensuring that high standards of quality and patient care are delivered. The campaigns and priorities are shaped by the Quality strategy and have recently been reviewed to provide the focussed priorities for 2024/2025 described in 2.1.3

The strategy is led by the Executive Medical Director, who in conjunction with the Chief Nurse, receives regular progress reports via the Patient Safety Committee. Formal reporting is through the Trust Quality Committee and the Board of Directors.

2.1.1 Providing high quality, safe care.

SFHFT uses several internal and external sources to support and drive quality improvements. The following are examples that have been used to support the delivery of the Quality Strategy 2022-2025. These include:

- Stakeholder and regulator reports, and recommendations
- Integrated Care Board (ICB), previously the Mansfield and Ashfield, and Newark and Sherwood Clinical commissioning groups feedback and observations following their quality visits.
- Commissioning for Quality and Innovation (CQUIN) priorities.
- National inpatient and outpatient surveys.
- Feedback from our Board of Directors and Council of Governors.
- Emergent themes and trends arising from complaints, serious incidents, patient safety incident investigations and inquests.
- Feedback from senior leadership assurance visits and the ward accreditation programme.
- Nursing and midwifery assurance framework and nursing metrics.
- Quality and safety reports.
- Internal peer reviews and external reviews.
- National policy.
- Feedback and observations from Healthwatch through partnership working.

SFHFT continues to build on the quality assurance and performance framework that is now well established throughout the organisation. This framework is regularly evaluated and reviewed, ensuring risks to the safety and quality of patient care are identified and managed, resulting in clinically sustainable and financially viable services.

The achievement of each quality priority is measured through a range of metrics articulated in each campaign. Progress is underpinned by the Trust assurance processes, with the formal monitoring and measurement reported through a range of committees and groups with final approval by the Board of Directors.

2.1.2 Approach to Quality Improvement

Patient safety, clinical effectiveness and quality care remain at the heart of our strategic vision. Every day, our colleagues demonstrate their commitment to providing outstanding patient-focussed care, as they strive to do their very best, in often difficult circumstances. To support our colleagues, we remain committed to 'strengthening and sustaining a learning culture of continuous improvement', a commitment that is firmly embedded within our Quality Strategy (2022-2025). This commitment aims to outline and highlight, how we will deliver patient-centred care, support our colleagues by providing the best possible practice environment and by exploring, scoping, and adopting examples of clinical best practice. We do this through collaboration with our health and social care partners across Nottinghamshire and through the work of the Improvement Faculty, (launched in May 2023). The main purpose of the Improvement Faculty is to provide a centrally located, single point of contact for all colleagues and teams seeking help and advice on any aspect of improvement, change management and transformation. The overarching aims of the Faculty are to improve the quality of patient care, improve the experience of those who use our services, improve clinical outcomes, improve the working lives of our colleagues, and help SFHFT to make best use of its resources. The Faculty provides an evidence-based improvement offer that supports SFHFT to embrace the cultural aspects of improvement, address the immediate priorities and helps plan for longer-term challenges.

Since its inception, the Faculty has supported 11 major Transformational Programmes and, continues to deliver 7 different training programmes (including contributing to the system wide Quality, Service Improvement and Redesign (QSIR) practitioner programme), supports all clinical divisions in the delivery of financial improvement and has responded to over 100 additional requests for ad-hoc support. The Faculty has brought together a multitude of partner services (for whom Improvement is a part of their role) through the establishment of a multi-professional 'Improvement Advisory Group'.

The work of the Improvement Faculty will be supported by the development and implementation of the Continuous Quality Improvement Strategy (CQIS); the purpose of which is to set out SFHFT ambition and aspirations in delivering strategic objective 4 'Continuously Learn and Improve' of the SFHFT Strategy (2024-2029) 'Improving Lives'. A strong culture of continuous improvement will enable better outcomes for our patients, our service delivery and safety, our people's experience, our finances and our population's health and wellbeing.

The CQIS is currently being launched, and through the development and delivery of an action plan, measuring impact will move away from being focused on the role of the Faculty, to the impact of the CQIS. This will include a broad range of measures, including (but not limited to):

- How effectively do we implement learning from patient safety incidents, clinical audits and other sources of clinical data and intelligence.
- How we measure against nationally set improvement maturity standards.
- The knowledge and skills of the wider organisation and whether those who have undertaken improvement training are given opportunities to undertake improvement activity.
- The views and perception of SFHFT is continuously learning and improving, which will be measured via outcomes of the national staff survey and other sources of feedback and views.

A quarterly report will be presented to the Quality committee to ensure scrutiny of the four measures are reviewed and maintain traction in delivery.

2.1.3 Quality priorities 2024/2025

During 2024/25, SFHFT will continue to focus on patient safety, clinical effectiveness and quality of care, the heart of the SFHFT strategic vision. Every day colleagues demonstrate their commitment to providing outstanding patient-focussed care, as they strive to do their very best, in often difficult circumstances. Our commitment to continuously learn and improve is firmly embedded within our Quality strategy (2022-2025), which outlines how we will achieve the aspiration to deliver safe person-centred care to our citizens and support colleagues by providing the best possible practice environment. This includes not only our Sherwood people, but everyone we collaborate with across health and social care in Nottinghamshire.

The Quality Strategy 2022-2025, incorporating the quality priorities identified, is the vehicle that will drive quality improvement across the organisation. Progress against the quality priorities is monitored and reported on at the bimonthly Quality Committee.

Three improvement priorities for specific focus in 2024/25 are indicated below; these have been included by considering local, national and international priorities.

Specific Campaign (Campaign as numbered in the Quality Strategy)	Quality Priority	Success Measure
Campaign 2 Excellent patient experience for users and the wider community	Increased service user / citizen engagement at key SFH meetings	Assurance processes / Terms of Reference / Meeting Minutes.
Campaign 3 Strengthen and sustain a learning culture of continuous improvement	Developing and embedding our approach to Patient Safety II by implementing and embedding Patient Safety Incident Response Framework, (PSIRF).	**Embedded patient safety framework to match the national patient safety incident framework.**
Campaign 4 Deliver high-quality care through kindness and 'joy at work'	Reduce colleagues working experience of violence and aggressive behaviour	Improved performance against the following key National Staff Survey indicators at a Trust level. We will report that staff have not experienced harassment, bullying discrimination, or abuse from: • Patients / service users, their relatives, or members of the public. • Other colleagues / managers

2.1.4 Review of Quality Priorities during 2023/2024

Patient Safety	**Create a positive practice environment to support the safest most effective care**

Quality priority:

Focus on Maternity Services ensuring babies have the best possible start in life.

Work with the Local Maternity and Neonatal Services (LMNS) to equitably transform our maternity services through delivering a single delivery plan in line with the recommendations from the Ockenden and Kirkup review and CQC inspection.

Plan, and where possible, deliver the recommendations of the three-year plan for maternity and neonatal services published by NHSE.

Success Measure:

- *Implementation of the single maternity oversight framework.*

  The perinatal quality surveillance model, as part of the single oversight framework, is embedded as part of the monthly reporting system within the maternity services.

- *Completion of the CQC 'must do' and 'should do' actions.*

  Following the CQC report in November 2022, both the 'must' and 'should' actions have been signed off as completed via the Trust's Quality Committee. To ensure the ongoing monitoring of these actions the Maternity and Neonatal Safety Champions review these as part of the work plan.

- *Ensure smoking at the time of delivery becomes part of our "business as usual" through planning for 2024/25.*

  Following the successful 2.5 years as a pilot site, and the establishment of the "Phoenix team", the division has now secured funding to fully establish the maternity tobacco dependency treatment service.
  The team successful to the year 23/24, has been widely acknowledge not only locally but through national recognition by NHSE as an exemplar service.

- *Optimisation and stabilisation of the preterm infant principles introduced.*

  As part of the national maternity and neonatal safety improvement programme (Mat/NeoSiP), the "home" team of Quality Improvement leads at SFHFT have supported a productive year of embedding the principles, with a particular focus on early breast milk and normothermia supporting the joint divisional work ongoing for the Baby friendly initiative accreditation.

- *Implementation of NHSE guidance on Equity and Equality.*

  Working as a key member of the equity and equality workstream within the LMNS, in 2023, SFHFT have commenced an ongoing, 2-day training around cultural safety. This training builds upon the NHSE guidance and uses local data/ information to ensure that the training is personalised to the team and birthing people our teams work with.

Patient Experience	Excellent patient experience for users and the wider community

Quality priority:

Ensure all patients nutrition and hydration needs are met. (Working on delivery in conjunction with the Nutrition & Hydration Steering Group and reporting to Clinical Outcome and Effective Care Committee)

Success Measure:

- *All patients and services users have identified level of malnutrition.*

  As part of the nursing admission documentation, there is a requirement for the nursing team to complete the MUST assessment (Malnutrition universal screening tool) within 24hrs of admission and re-asses every 7 days or, if the patient's condition changes. Currently, there is an 80% compliance of the MUST being completed within 7 days of admission and is improving monthly. This is monitored vias the Nutrition and Hydration steering group.

- *Improve pre-op nutrition screening and empower patients to optimise their nutrition status.*

  SFHFT have commenced offering Orthopaedic pre-op patients with a MUST score of 2 or above, additional supplements in advance of their surgery to improve their nutritional status. This project is under evaluation.

- *All patients' cultural aspects are catered for in the menu provision.*

  On admission as part of the nursing admission documentation there is a mandatory nutrition section that asks the patient do they require therapeutic / cultural diet? SFHFT now provide a wide range of cultural option on the new revised menu across the three sites. If there is a request that is not provided on the menu, bespoke requests are supported as able, and this is monitored via the Nutrition and Hydration steering group.

- *Mealtimes are protected and social aspects of mealtimes improved.*

  Increase knowledge & skills of staff and service users to make healthier choices for themselves and their families.

  In August 2023, SFHFT commenced a pilot of the Mealtime Volunteer programme. The mealtime volunteer role provides dedicated time supporting and assisting individuals with meal choices and mealtimes, supporting the quality measure 'to continuously improve providing the best quality, safe, nutritious food, and drinks service at SFHFT'. The role provides support with the set up and preparation of the meal service. Advocating for the patient, the mealtime volunteer assists patients' eating, encouraging, and facilitating independence, ensuring the red tray system is supported and provide an enhanced social eating experience for patients.

  A robust and structured training plan is provided by a multi -disciplinary teams, ensuring communication skills and nutritional knowledge of the volunteers is enhanced. Volunteer opportunities are currently available at lunchtimes Monday–Friday. Supporting evening meals will evolve as this service develops. Debriefs sessions are offered to all our mealtime volunteers, ensuring that they receive emotional support, aligning with SFHFT strategy and CARE values.

Clinical Effectiveness	Strengthen and sustain a learning culture of continuous improvement

Quality priority:

To embed the Improvement Faculty within the Trust, whose role will be to provide a centre of excellence for transformational and improvement support.

Success Measure:

- *Independent review of the Improvement Faculty's impact will have been completed and reported to the Finance Committee.*

  An independent review of the Faculty's impact has not been undertaken. In 2024, impact will now be measured and reported quarterly to the SFHFT Quality Committee. Having Non-Executive Director overview and scrutiny will therefore provide requisite independence. Since its inception, the faculty achievements include:
  - Supported 11 major Transformational Programmes (including 3 capital programmes).
  - Continued to deliver 7 different training programmes (including contributing to the system wide Quality, Service Improvement and Redesign (QSIR) practitioner programme).
  - Supported the clinical divisions in the delivery of financial improvement.
  - Responded to over 80 additional requests for ad-hoc support.
  - Brought together a multitude of partner services (for whom Improvement is a part of their role) through the establishment of a multi-professional 'Improvement Advisory Group'.
  - The faculty has also launched an Improvement Ambassador Award, established a series of ongoing knowledge sharing sessions and hold regular drop-in sessions at every SFHFT site; designed to celebrate success, share good practice an ensure ease of access.

2.2.1 General Statement

During 2023/24 SFHFT provided and / or subcontracted various relevant health services.

SFHFT has reviewed all the data available to them on the quality of care in these relevant health services. The income generated in respect to Clinical Income in 2023 / 24 represents 87.9% of the total income generated by SFHFT. This year, SFHFT cared for:

	2023/24	2022/23
ED Attendances KMH	124,811	116,726
Newark UCC Attendances	34,815	30,957
PC24 Attendances	29,024	31,984
Total	**188,650**	**179,667**
Births	3,494	3,492
Outpatient Attendances (all sites)	477,610	460,296
Inpatient activity	64,377	59,445
Day Case Activity	40,433	39,367

SFHFT employs **6139** substantive people. We engage with many people through our temporary staffing, bank system which increases this number to **7905,** including **235** consultant doctors (including **41** locum consultants), working in our hospital facilities, some of the best in the country.

2.2.2 Participation in Clinical Audit

Over 2023 / 24, the focus has been on developing and enhancing the relationship between the divisions at SFHFT, in addition to strengthening the focus and visibility of patients, service outcomes and learning.

National Clinical Outcome Review Projects 2023/24

During 2023/24, SFHFT participated in 53 out of 56 (95%) of national clinical audits and 100% of national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Sherwood Forest Hospitals NHS Foundation Trust participated in during 2023 / 24 are as follows:

A-Z of National Clinical Audits
BAUS Urology Audits - Nephrostomy
BAUS Urology Audits - Muscle Invasive Bladder Cancer at Transurethral REsection of Bladder Audit (MITRE)
Breast and Cosmetic Implant Registry
British Hernia Society Registry
Case Mix Programme (CMP)
Cleft Registry and Audit NEtwork (CRANE)
Elective Surgery (National PROMs Programme)
Emergency Medicine QIPs Care of Older People
Emergency Medicine QIPs Infection prevention and control
Emergency Medicine QIPs Time critical medications
Falls and Fragility Fracture Audit Programme (FFFAP) Fracturel liaison database
Falls and Fragility Fracture Audit Programme (FFFAP) National Audit of Inpatient Falls (NAIF)
Falls and Fragility Fracture Audit Programme (FFFAP) National hip fracture database
Improving Quality in Chron's and Colitis (IQICC) [the: previously named Inflammatory Bowel Disease (IBD) Audit] IBD Registry
National AKI Audit
Learning Disability and autism Programme Learning from lives and deaths – People with a learning disability and autistic people (LeDeR)
National Adult Diabetes Audit (NDA) National Core Diabetes Audit
National Adult Diabetes Audit (NDA) National Diabetes Footcare Audit (NDFA)
National Adult Diabetes Audit (NDA) National Diabetes Inpatient Safety Audit (NDISA)
National Adult Diabetes Audit (NDA) National Pregnancy in Diabetes Audit (NPID)
National Asthma and COPD Audit Programme (NACAP) Adult Asthma Secondary Care
National Asthma and COPD Audit Programme (NACAP) COPD Secondary Care

National Asthma and COPD Audit Programme (NACAP) Paediatric Asthma Secondary Care
National Audit of Cardiac Rehabilitation
National Audit of Care at the End of Life (NACEL)
National Audit of Dementia Care in general hospitals
National Cancer Audit Collaborating Centre - National Audit of Metastatic Breast Cancer
National Cancer Audit Collaborating Centre - National Audit of Primary Breast Cancer
National Cardiac Arrest Audit
National Cardiac Audit Programme (NCAP) Myocardial Ischaemia National Audit Project (MINAP)
National Cardiac Audit Programme (NCAP) National Audit of Cardiac Rhythm Management (CRM)
National Cardiac Audit Programme (NCAP) National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)
National Cardiac Audit Programme (NCAP) National Heart Failure Audit
National Child Mortality Database (NCMD) Programme
National Clinical Audit of Seizures and Epilepsies for Children and Young People (Epilepsy12)
National Comparative Audit of Blood Transfusion Audit of NICE Quality Standard QS138
National Comparative Audit of Blood Transfusion Bedside Transfusion Audit
National Early Inflammatory Arthritis Audit (NEIAA) N/A
National Emergency Laparotomy Audit (NELA)
National Gastro-Intestinal Cancer Audit Programme (GICAP) Bowel Cancer
National Gastro-Intestinal Cancer Audit Programme (GICAP) Oesophageal cancer
National Joint Registry
National Lung Cancer Audit (NLCA) Lung Cancer
National Maternity and Perinatal Audit (NMPA)
National Neonatal Audit Programme (NNAP)
National Obesity Audit (A) National Obesity Audit (A)
National Ophthalmology Database Audit (D) Age-related Macular Degeneration
National Ophthalmology Database Audit (D) Cataract Audit
National Paediatric Diabetes Audit (NPDA)
National Prostate Cancer Audit (NPCA) Prostate cancer
Perinatal Mortality Review Tool (PMRT)
Perioperative Quality Improvement Programme (PQIP) PQIP
Sentinel Stroke National Audit Programme (SSNAP) N/A

Society for Acute Medicine Benchmarking Audit (SAMBA)
The Trauma Audit & Research Network (TARN) TARN
Transurethral REsection and Single instillation intra-vesical chemotherapy Evaluation in bladder Cancer Treatment (RESECT) Improving quality in TURBT surgery.
UK Cystic Fibrosis Registry

National programme name	Work stream / Topic name	Case Ascertainment
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme	N/A	100%
Learning Disability and autism Programme	Learning from lives and deaths – People with a learning disability and autistic people (LeDeR)	100%
National Comparative Audit of Blood Transfusion	Audit of NICE Quality Standard QS138	100%
National Comparative Audit of Blood Transfusion	Bedside Transfusion Audit	100%
National Obesity Audit (NOA)	National Obesity Audit (NOA)	100%
Improving Quality in Chron's and Colitis (IQICC) [Note: previously named Inflammatory Bowel Disease (IBD) Audit]	IBD Registry	100%
National Adult Diabetes Audit (NDA)	National Core Diabetes Audit	100%
National Adult Diabetes Audit (NDA)	National Diabetes Footcare Audit (NDFA)	100%
National Adult Diabetes Audit (NDA)	National Diabetes Inpatient Safety Audit (NDISA)	100%
National Adult Diabetes Audit (NDA)	National Pregnancy in Diabetes Audit (NPID)	100%
National Asthma and COPD Audit Programme (NACAP)	Adult Asthma Secondary Care	100%
National Asthma and COPD Audit Programme (NACAP)	COPD Secondary Care	100%
National Asthma and COPD Audit Programme (NACAP)	Paediatric Asthma Secondary Care	100%
National Audit of Cardiac Rehabilitation	N/A	100%
National Audit of Care at the End of Life (NACEL)	N/A	100%
National Audit of Dementia	Care in general hospitals	100%
National Cardiac Arrest Audit	N/A	100%
National Cardiac Audit Programme (NCAP)	Myocardial Ischaemia National Audit Project (MINAP)	100%
National Cardiac Audit Programme (NCAP)	National Audit of Cardiac Rhythm Management (CRM)	100%

National Cardiac Audit Programme (NCAP)	National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	100%
National Cardiac Audit Programme (NCAP)	National Heart Failure Audit	100%
National Early Inflammatory Arthritis Audit (NEIAA)	N/A	100%
Sentinel Stroke National Audit Programme (SSNAP)	N/A	100%
BAUS Urology Audits	Muscle Invasive Bladder Cancer at Transurethral REsection of Bladder Audit (MITRE)	100%
Breast and Cosmetic Implant Registry	No	100%
Case Mix Programme (CMP)	No	100%
Cleft Registry and Audit NEtwork (CRANE)	No	100%
Elective Surgery (National PROMs Programme)	No	100%
Falls and Fragility Fracture Audit Programme (FFFAP)	*Fracture liaison database	*0%
Falls and Fragility Fracture Audit Programme (FFFAP)	National Audit of Inpatient Falls (NAIF)	100%
Falls and Fragility Fracture Audit Programme (FFFAP)	National hip fracture database	100%
National Cancer Audit Collaborating Centre	National Audit of Metastatic Breast Cancer	100%
National Cancer Audit Collaborating Centre	National Audit of Primary Breast Cancer	100%
National Emergency Laparotomy Audit (NELA)	No	100%
National Gastro-Intestinal Cancer Audit Programme (GICAP)	Bowel Cancer	100%
National Gastro-Intestinal Cancer Audit Programme (GICAP)	Oesophogeal cancer	100%
National Lung Cancer Audit (NLCA)	Lung Cancer	100%
National Prostate Cancer Audit (NPCA)	Prostate cancer	100%
Perioperative Quality Improvement Programme (PQIP)	PQIP	100%
The Trauma Audit & Research Network (TARN)	TARN	100%
BAUS Urology Audits	Nephrostomy	100%

BAUS Urology Audits	Transurethral REsection and Single instillation intra-vesical chemotherapy Evaluation in bladder Cancer Treatment (RESECT) Improving quality in TURBT surgery.	100%
National Ophthalmology Database Audit (NOD)	Cataract Audit	100%
National Ophthalmology Database Audit (NOD)	Age-related Macular Degeneration	100%
National Joint Registry	National Joint Registry	100%
Emergency Medicine QIPs	Infection prevention and control*	0%
Emergency Medicine QIPs	Time critical medications**	0%
Society for Acute Medicine Benchmarking Audit (SAMBA)	No	100%
Kidney Audits	Yes	100%
National Child Mortality Database (NCMD) Programme	No	100%
National Clinical Audit of Seizures and Epilepsies for Children and Young People (Epilepsy12)	No	100%
National Maternity and Perinatal Audit (NMPA)	No	100%
National Neonatal Audit Programme (NNAP)	No	100%
National Paediatric Diabetes Audit (NPDA)	No	100%
Perinatal Mortality Review Tool (PMRT)	No	100%
UK Cystic Fibrosis Registry	No	100%

*Fracture Liaison database (FSLD)

SFHT has had a fully functioning Fracture Liaison database in place; this has been run on an ad hoc basis and not all patients (e.g., referrals from primary care) have been captured. Steps are now being undertaken to put in place that include a business case has been updated and is awaiting review and, a working group to establish requirements.

**Emergency Medicine QIPs - Infection prevention and control and Time critical medications have been challenging to report on due to operational pressures.

National Confidential Enquiries into Patient Outcomes and Deaths (NCEPOD):

Study Title	Participation	Project Status	%
Epilepsy Study Organisational Questionnaire	Yes	Submitted	100
Testicular torsion study: Organisational questionnaire	Yes	In progress	71
End of Life Care	Yes	Submitted	100
Endometriosis	Yes	In progress	83

Outcomes and Learning from Clinical Audits Undertaken During 2023/24

The number of clinical audits both national and local which formed part of the 2023/24 Audit Plan are as follows:

Total Number of audits in the 2023/24 plan **= 331**
Number of local / other audits **= 268**
Number of national audits, including NCEPOD **= 61**
Number of audits fully completed **= 103**

Some of the key learning from 2023/24 is as follows:

National Emergency Laparotomy Audit (NELA)

The Eighth Patient Report of the NELA has shown improvements in patient care. Patients who have a risk factor documented pre-operatively has increased from 92.3% in Year 7 to 96.2% in year 8 and compares favourably against the national average of 86.8%. There has also been an increase in the number of patients arriving in theatre within the standardise time appropriate to their case. This has improved from 67.2% in Year 7 to 81.2 for year 8 and is 10% above the national average.

National Neonatal audit Programme (NNAP)

Babies born at less than 32 weeks gestation should have a first temperature on admission which was both between 36.5°C to 37.5°C and measured within an hour of birth. The recent published report shows that the proportion of babies receiving this screening has risen from 46.7% to 80% which is higher than the national average and shows a significant improvement against this measure of care.

National Audit of Dementia

This is the fifth round of the national audit. At SFHFT, patients with suspected or diagnosed dementia, had a delirium screening performed 95% of the time compared to a national rate of 87%. In addition, pain assessment and a pain reassessment were performed at SFHFT 100% of the time compared to a national rate of 92%. SFHFT greatly exceeds the national median admissions of dementia patients in the period, as well as having a higher-than-average percentage of patients admitted to SFHFT with dementia.

Local Audits. The reports and outcomes of 103 local clinical audits were reviewed in 2023/24 at the Improvement and Clinical Audit Group, in addition to the Advancing Quality Programme (AQP) meetings.

SFHFT results demonstrate that most of our patients are defined as being from deprived areas. (Index of Multiple Deprivation, 2019). All recommendations and resulting examples of completed local audits are below (Table 1):

Table 1

Speciality	Audit code	Title	Post Project Impact / Actions
Emergency Care	Emergency Care/CA/2023-24/01	Appropriateness of the radiological investigation for adult patients presented to Emergency department (ED) following an ankle injury.	This audit was conducted to evaluate SFHFTs adherence to NICE guidelines in managing adult patients with ankle injuries and has yielded promising results. The utilization of the 'Ottawa Ankle Rule' as a clinical decision support mechanism, has demonstrated its effectiveness in our ED, showcasing a good level of compliance. By adhering to the Ottawa Ankle Rule, SFHFT has succeeded in substantially reducing unnecessary X-ray examinations, thereby reducing radiation exposure for patients and associated costs. This not only contributes to more efficient resource utilisation but also aligns with our commitment to providing safe and patient-centred care. The audit results highlight our dedication to evidence-based practice and quality improvement initiatives within SFHFT. It is imperative that we maintain this high level of compliance with best practice in diagnosing and managing ankle injuries. Therefore, we recommend periodic monitoring to sustain this audit. Doing so will ensure that our patients continue to receive the highest standard of care, demonstrating accuracy and efficiency, in line with the latest medical guidelines and protocols.
Critical Care (Intensive Critical Care Unit, ICCU).	Critical Care/ SE/2022-23/02	Nervecentre in ICCU- How well do we update?	This audit highlighted the status of ICCU electronic handover updates. Drawing attention to the need to set out an expectation on how and when the electronic handover should be completed and facilitate timely updates. As a result of this audit, we have developed a Nervecentre Standard Operating Procedure, available on the intranet, that allow clinicians to understand what is on electronic handover updates. Depending upon the results of a re-audit, we will consider the development of a Nervecentre e-learning package for clinical staff to complete as part of the SFHFT induction process.

Speciality	Audit code	Title	Post Project Impact / Actions
Acute Paediatrics	Acute Paeds/ SE/2021-22/03	Outcome following sleep studies in children with SDB (Sleep disorder breathing). (Retrospective)	We conclude that our use of MCSS (Multi-channel sleep study) in children with SDB, is associated with reduced rates of surgery and low rates of treatment failure. We estimate that with changes to our patient pathways, it is likely that the service costs will be comparable to those of standard care. A proposed change to patient pathways to allow children to have a sleep study prior to their initial appointment with Otolaryngologists, would result in the service being cost neutral compared with the standard UK model of care. The resulting report has been submitted to Sleep Medicine X for national publication.
Geriatrics	Geriatrics/ CA/2023-24/02	Audit of inpatient referrals to the Movement Disorders Team	The Nervecentre team will add a flag to the system, ensuring Parkinson patients are referred to the specialist PD (Parkinson's Disease) and Dementia team during their admission. This will facilitate the team to review every inpatient with PD, whilst also being able to review their medications to ensure they are getting them in a timely manner. Trust-wide communication will be distributed, and all acute admissions areas will also be visited. This flag will enable SFHT to meet the recommendations by Parkinson's UK. A virtual ward round of all PD inpatients will take place weekly, to ensure those who aren't referred via the 'ICE' system for advice are also remotely reviewed.
Trauma and Orthopaedics	T&O/CA/2023-24/04	Re-audit of the adequacy of utilisation of the American Spinal Injury Association (ASIA) chart when assessing spinal pathology prior to specialist referral	The 2nd cycle of the audit showed there was a significant increase in the use of the ASIA chart. It improved from 33% compliance in the previous cycle to 75% in this cycle. This has been achieved by adding the ASIA chart to the trauma clerking booklet to ensure junior doctors' compliance completing the chart. Patients referred with suspected spinal pathology required a full neurological assessment. The ASIA chart is a globally accepted tool for documenting clinical findings in this cohort of patients. This improvement will positively impact on patient outcomes.

Speciality	Audit code	Title	Post Project Impact / Actions
Trauma and Orthopaedics	T&O/CA/2023-24/14	Re-audit: Assessing the quality of surgical discharge summary in Trauma and Orthopaedics	The audit has demonstrated an Improvement in documentation in all sections of the discharge summary compared to the previous cycle carried out. More than 70% of the discharge summary audited included the following • patient's presenting complaint • primary diagnosis • investigations done • which procedure has been done • follow-up plan • the length of their VTE prophylaxis • any planned further • investigations • weight bearing status • osteoporosis plan documented. This will result in a more accurate picture of a patients' care following their discharge by the surgical team.
Ophthalmol-ogy	Ophth/SE/2023-24/04	Service Evaluation of New Orthoptic Secondary Screening Pathway	Action resulting from this audit is a change in the ophthalmology outpatient pathway. Benefits include an improved patient experience by reducing the need to instil eye drops, leading to a reduction in the number of outpatient appointments required. There are also capacity benefits in optometry clinics allowing better use of resources for urgent appointments and improved capacity for more comprehensive children services clinics. As a result of the pathway changes, the backlog for the optometry clinics is currently at 0 weeks. The new pathway also allows greater autonomy for the Orthoptists supporting staff experience and retention.
Other	Other/SE/2022-23/03	Theatre transfer documentation	Documentation compliance was higher than expected but issues remain that will impact on flow and efficiency. Evidence of incorrect consent forms should be a high priority as should documenting skin issues (59% compliance) and PUPP charts (78% compliance) correctly. 50% of questions reached a KPI of 95%. 3 questions reached a KPI of 100% compliance. All remaining shortfalls present a patient safety issue. Surgical matrons requested to share with Sister/Charge Nurses.

Speciality	Audit code	Title	Post Project Impact / Actions
Trauma and Orthopaedics	T&O/CA/2022-23/06	VTE compliance on discharge following lower limb surgery	There was an improvement in compliance of VTE prescribing on discharge. There was an overall increase in compliance of 68% (32% pre-intervention, 100% post-intervention). A 62% increase in use of the correct drugs (38% pre-intervention, 100% post-intervention). An increase of 32% in correct duration of VTE prescribed (68% pre-intervention, 100% post-intervention).
Therapy Services	Therapy/ QI/2021-22/03	A service evaluation of pre-operative education for patients who are undergoing elective hip and knee replacement surgery at Newark Hospital.	The service evaluation has given a clearer picture in understanding of the importance the pre-operative (pre-op) education component of hip and knee surgery and, the value patients gain from it. The evaluation measured the impact of changes implemented, and, the effectiveness of the session to holistically support patients in preparing for surgery. This will be repeated in six months then implemented across Orthopaedic teams at both Newark and King's Mill Hospital sites to ensure data shared results in the most effective and synchronised methods of service delivery. This will ensure we gain accurate information to justify the introduction of effective changes to our service.

Review of 2023/24:

Strengthen both the assurance and visibility of clinical audit within the organisation via the Improvement in Clinical Audit Group and by learning from and sharing activities on key Trust-wide themes. This has commenced via the 'Antimicrobial Stewardship QI group' which has brought together different teams, previously working in silos, into one cohesive project team.

To further connect audit to the continuous improvement and learning cycle; this will focus on process outcomes by being more directly involved as a team at Divisional Governance level, to influence more locally and to pull forward learning and good practice across the organisation.

The team has attended over 50% of the trust's specialty governance meetings.

To further align Clinical Audit and Improvement with key organisational strategies; The vision for continuous improvement at SFHFT is driven by the People, Culture, and Improvement Strategy, and through its 'Improvement Foundations', it is also a key enabler to achieving both clinical effectiveness and efficiency, and outcomes defined within the Quality Strategy. In May 2023 Audit, alongside the Improvement team and Transformation teams was a founder member of the SFHFT Improvement Faculty.

There is still further work to do, and the focus is detailed in the plan below.

Looking forward to 2024/25 we aim to:

- Continue to strengthen the link between Audit and Improvement to deliver the 'so what' element of clinical audit.
- Reduce the number of 'single cycle' audits being undertaken and promote the importance of the audit cycle being completed to deliver improvement in outcomes.
- Ensure that we are appraising the outcomes taken from National Clinical Audit and using these to drive the local audit agenda.
- Assess the value of Trust wide audits being undertaken to ensure the program is delivering against priorities.

2.2.3 Participation in Clinical Research and innovation

The number of patients receiving relevant health services, provided or sub-contracted by SFHFT in 2023/24, participating in research, approved by the Research Ethics Committee was 5138. This includes research involving patient data and tissue samples.

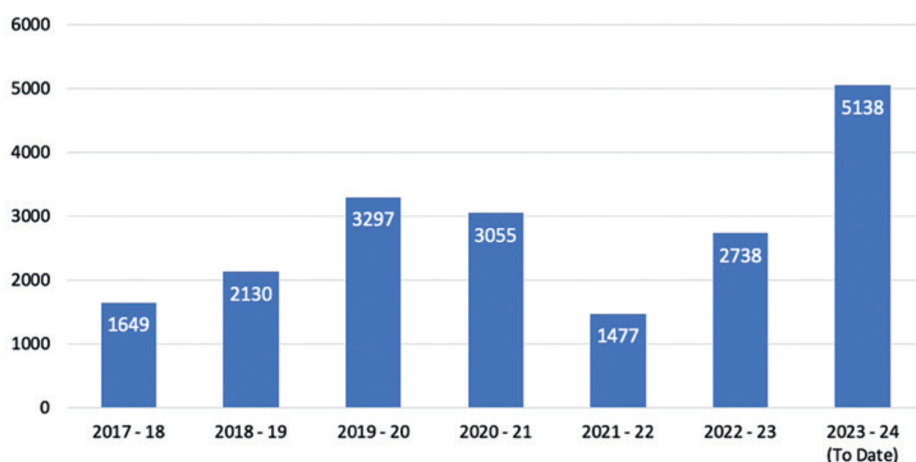
SFHFT is actively involved in clinical research and has a dedicated Research and Innovation department (R&I). The R&I department is responsible for developing and supporting a varied research portfolio and creating better opportunities for patients and staff to participate in research activity, whilst informing the provision of high quality and evidence-based health care. Patient participation in research is mainly through studies adopted by the National Institute for Health Research (NIHR). SFHFT is involved in a small number of non-adopted studies which are typically undertaken for educational purposes.

In 2022/23 the primary focus for Research and Innovation was to focus on recovering the pre Covid-19 research portfolio, where we opened 28 new studies, recruited 55 studies across 14 specialties with a total of 2818 participants.

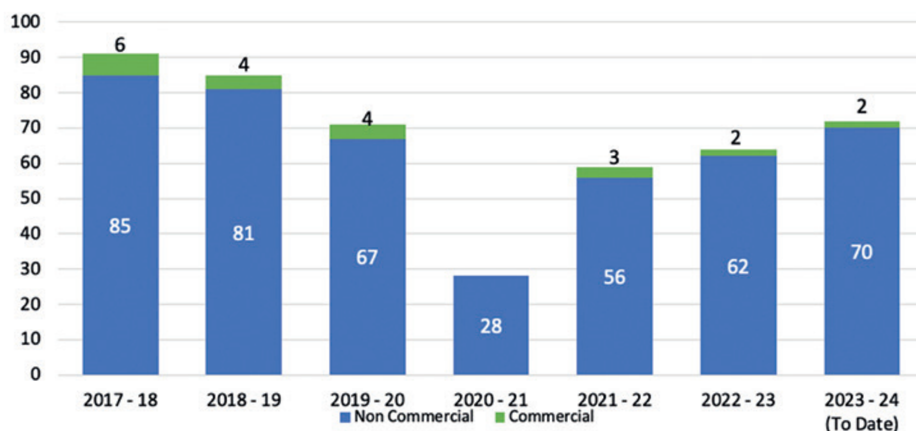
2023/24 has demonstrated a dramatic increase in patient recruitment and extending our portfolio, exceeding our stretched target of 3,500 recruits and 72 studies open. To date we have 2,320 more recruits compared to 2022/23 and the highest number of recruits to date for SFHFT. (Graphs 1 & 2).

These figures are in line with our strategic direction that are set out in our 2022-27 'Research is for Everyone strategy.'

Graph 1: R&I Recruitment participants



Graph 2: R&I studies



In 2022/23, SFHFT secured investment to transform existing space into a Clinical Research Facility. In 2024/25, we will open this facility and offer more patients trials of new drugs, devices, and diagnostics. We will also increase the use of digital technologies in research and use a targeted development programme with East Midlands Clinical Research Network and commercial sponsors to increase investment and research opportunities for our patients.

In 2023/24, SFHFT achieved the bronze standard Work Force Accreditation awarded by the IAOCR (International Accrediting Organisation for Clinical Research). We are the only trust in the East Midlands to have this award. The independent assessment provides a benchmark of the highest standards for those working within the organisation to pride themselves on, as well as for potential sponsors who want formal evidence of the workforce standards that are being delivered. This accreditation will support the trust reputationally to be more attractive to sponsors to open SFHFT up to further commercial research activity.

In the past 18 months, SFHFT have developed and launched our joint research programme with Nottingham Trent University, 'Research Communities of Practice', to support and equip our workforce with the skills they need to pursue research careers, develop projects, implement research findings, and create a unique selling point for SFHFT as an employer. We will continue this collaboration in 24/25 and work towards making SFHFT a regional centre for Nursing, Midwifery and Allied Health Professionals research.

Research is a partnership between participant and researcher. Every year, as part of the NIHR participant experience survey, we ask people who have volunteered for health research at SFHFT to tell us about their experience so we can make improvements. Our survey found that of those respondents, 94% report they would agree or strongly agree their participation in research has been valued, and 88% would consider taking part in research again. One participant reported, "I have always been treated courteously and with respect whilst completing trials. This puts me at ease and makes me think that my time is being well spent". With another stating, "The fact that research is going on and that results will help people in the future lessen their health issues. I was happy to be of help."

In 2024/25, the R & I focus will be to continue to grow a balanced research portfolio with an emphasis on attracting commercial activity to support our developing infrastructure. The research activity will continue to be reviewed regularly with bi-annual reporting to the SFHFT board and the Patient Safety Committee (PSC). We also have an external reporting responsibility to the Department of Health via the Clinical Trials Platform. This is a national key performance indicator for NHS organisations.

2.2.4 Commissioning for Quality and Innovations (CQUIN) Indicators

The Commissioning for Quality and Innovation Scheme (CQUIN) is offered by NHS commissioners to providers of healthcare services commissioned under an NHS contract, to reward excellence by linking a proportion of the provider's income to the achievement of local and national improvement goals.

A proportion of SFHFT income in 2023/24 was conditional upon achieving quality improvement and innovation goals agreed between SFHFT and any person or body they entered a contract agreement or arrangement with for the provision of relevant health services, through the CQUIN payment framework.

During 2023/24 the Trust engaged in all the following eligible national CQUINS

- CQUIN 1 – Flu vaccinations for frontline workers
- CQUIN 3 – Prompt switching of intravenous to oral antibiotic
- CQUIN 4 – Compliance with timed diagnostic pathways for cancer services
- CQUIN 6 – Timely communication of changes to medicines to community pharmacists via the Discharge Medicine Service
- CQUIN 7 – Recording of and response to NEWS2 score for unplanned critical care admissions.

The following section provides an overview of the 2023/2024 CQUIN year-end position.

A – Achieved
PA – Partially Achieved
NA – Not achieved

Name	Description	Results Submitted Q4	RAG rating
CQUIN 1 – Flu vaccinations for frontline healthcare workers	Achieving 80% uptake of flu vaccinations by frontline staff with patient contact.	**58.9%**	**PA**
CQUIN 3 – Prompt switching of intravenous to oral antibiotic	Achieving 40% (or fewer) patients still receiving IV antibiotics past the point at which they meet switching criteria.	**2%**	**A**
CQUIN 4 – Compliance with timed diagnostic pathways for cancer services	Achieving 55% of referrals for suspected prostate, colorectal, lung, oesophago-gastric, head and neck and gynaecological cancer meeting timed pathway milestones as set out in the rapid cancer diagnostic and assessment pathways	**39.2%**	**PA**
CQUIN 6 – Timely communication of changes to medicines to community pharmacists via the Discharge Medicine Service	Achieving 1.5% of acute Trust inpatients having changes to medicines communicated with the patient's chosen community pharmacy within 48 hours following discharge, in line with NICE guideline 5, via secure electronic message.	**0.74%**	**PA**
CQUIN 7 – Recording of and response to NEWS2 score for unplanned critical care admissions.	Achieving 30% of unplanned CCU admissions from non-critical care wards having a timely response to deterioration, with the NEWS2 score, escalation and response time recorded in clinical notes.	**42%**	**A**

2.2.5 Registration with the Care Quality Commission (CQC)

SFHFT has three locations registered including:

King's Mill Hospital

Newark Hospital

Mansfield Community Hospital

SFHFT currently has no restrictions on registration. The CQC has not taken any enforcement action against SFHFT during 2023/24.

SFHFT has not participated in any special reviews or investigations by the CQC during the reporting period.

SFHFT have maintained a positive working relationship with the CQC, engaging in regular meetings with the SFHFT CQC relationship owner. The overall rating for SFHFT 'Outstanding' comprises of the following ratings for each domain:

Safe	Good
Effective	Good
Caring	Outstanding
Responsive	Good
Well-led	Good
Use of resources	Requires improvement
Combined Rating	Good

2.2.6 Information on Secondary Uses Service for inclusion in Hospital Episode Statistics

SFHFT submitted records during 2023/24 to the Secondary Uses service (SUS) for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data which included the patient's valid NHS number was:

100 % for admitted patient care.

100 % for outpatient care; and

99.0 % for accident and emergency care.

The percentage of records in the published data which included the patient's valid General Medical Practice Code was:

100 % for admitted patient care.

100 % for outpatient care; and

99.0 % for accident and emergency care.

2.2.7 Information Governance

SFHFT's Data Security Protection Toolkit Assessment Report overall score for 2022/2023 was graded as 'standards met'. It is anticipated that the Trust will again achieve a "standards met" submission for 2023/2024 by the end of June 2024.

Data security aims for 2023/24

The Data Security and Protection Toolkit encompasses Cyber Essentials PLUS certification which is a rigorous test of SFHFT's security systems. SFHFT will continue to be working towards achieving the certification to provide assurance that data is protected at the highest level.

How was this achieved?

The Data Security Team will be audited by 360 Assurance (SFHFT internal auditors), who undertook a review of the standards in 2022/23 and provided an overall assessment. This review provided moderate assurance which provided a medium level of confidence in our data security. We hope to achieve the same assurance or improve for the 2023/24 submission.

Monitoring and reporting for sustained improvement

All actions taken from internal audits are monitored by the Information Governance Committee and the Audit and Assurance Committee.

Serious incidents requiring investigation

In 2023/24, SFHFT reported three data security serious incidents, which were reported on the Data Security Protection Toolkit. The incidents involved were a compromise in confidential data.

To date, the SFHFT has received no regulatory action because of the incident reported. Lessons have been learned and recommendations implemented to mitigate further reoccurrence.

2.2.8 Clinical Coding audit

SFHFT was not subject to the Payment by Results Clinical Coding audit during 2023/24 by the Audit Commission.

SFHFT has a dedicated team of qualified and trainee clinical coders that are responsible for coding all inpatient activity for the trust, which is subsequently submitted to SUS and used to support commissioning, healthcare development and improving NHS resource efficiency. Within 2023/24, the clinical coding team coded 124,991 finished Consultant episodes (FCE's).

Clinical coding aims for 2023/24

- Deadline and targets: Achieve 100% coding target by the fifth working day after the month end.
- Audits: Improve coding accuracy by conducting monthly audits of coded data before the final submission.
- Data Security Protection Toolkit (DSPT) standards met compliance.
- Recruitment and Training: Recruit and develop trainee clinical coders.

Performance against targets

SFHFT has consistently achieved 100% coding targets by the fifth working day after the month end, except for December 2023 and March 2024 which was completed on the 6th working day.

All 2023/2024 deadlines were coded by SUS first submission date as achieved in 2022/23.

Table 2 Secondary Users Service (SUS) Submission Data Report

FCE Month	5th Working Day	1st SUS Submission date	Total Number of Episodes	% Coded at 1st Submission
April-23	09/05/2023	15/05/2023	9170	100%
May-23	07/06/2023	14/06/2023	10231	100%
June-23	07/07/2023	13/07/2023	10227	100%
July-23	07/08/2023	11/08/2023	10018	100%
August-23	07/09/2023	13/09/2023	10038	100%
September-23	06/10/2023	12/10/2023	10271	100%
October-23	07/11/2023	13/11/2023	10590	100%
November-23	07/12/2023	13/12/2023	11134	100%
December-23	08/01/2024	12/01/2024	10047	100%
January-24	07/02/2024	14/02/2024	10674	100%
February-24	07/03/2024	13/03/2024	10895	100%
March-24	08/04/24	12/04/2024	11400	100%
Total			**124,991**	**100%**

The table above (table 2), provides the volume of un-coded episodes for discharged hospital spells within each month. The total number of episodes relates to FCE's. FCE's is a subdivision of a hospital spell in which a specific consultant has responsibility for a patient's care. A hospital spell can be comprised of one or more FCE's. These figures do not represent individual patients but represents FCE numbers from admission to discharge out (Hospital Spells).

Audits

The Trust has a coding Data Quality Assurance (DQA) programme that assesses components of clinical coding, prior to the final submission of activity data to ensure coding accuracy, and that the depth of coding accurately reflects the medical record. This programme identifies potential missing comorbidities for a sample of records each month and reviews them against the medical documentation. This is supplemented by targeted audits by the clinical coding auditor to improve the quality of the coded data. Sample sizes of the DQA have varied throughout the year due to team capacity, and clinical availability through periods of industrial action and winter pressures.

Audits throughout the year highlighted opportunities for improvement which included:

- Pneumonia – Pneumonia specialist nurse highlighted potential over coding of pneumonia cases. Audit is ongoing in this area, however initial findings have helped to improve the accuracy of pneumonia identification within clinical coding, as well as providing feedback to the specialty about recording of pneumonia and associated comorbidities.
- Pressure Ulcer – work started with tissue viability nurses to allow accurate reporting of pressure ulcers. A local policy has been created to help with the accurate translation of terminology.

- Endoscopy – Coding audit was initiated due to the difficulties in coding endoscopic retrograde cholangiopancreatography's (ERCP's) due to the associated rules and regulations. Training has been conducted with the team to improve the coding standards of these procedures.

In addition to opportunities identified through the findings of audits, there has been engagement relating to the learning from deaths group and the work on the effect of palliative care data on HSMR and Summary Hospital Level Mortality Indicators (SHMI) outcome measures. Clinical Coding have been working closely with specialties to improve the accuracy of co-morbidity recording across all audits, and service improvements recommendations based on Get It Right First Time (GIRFT) best practice.

In addition to the comorbidity audit, the clinical coding team have also started to utilise a medical history assurance tool provided by 3M's Medicode encoder, which allows coders to look at past medical history and validate missing information with clinicians when available.

Data Security Protection Toolkit (DPST) - Data quality:

As part of DSPT, SFHFT has undertaken an audit of 200 FCE's (June 2023 – September 2023). Trusts must meet or exceed the required percentage across all four areas to meet the attainment level for a DSPT clinical coding audit. SFHFT has met the standard in two selected areas and exceeds the standard in correct secondary procedures and correct secondary diagnoses.

Table 3. below illustrates the clinical coding audit results compared to the recommended percentage of accuracy scores from the Terminology and Classifications Delivery Service, amber representing standards met and green indicating standards exceeded.

Table 3 DSPT requirements Clinical Coding audit results 22/23 compared to 23/24

	Primary diagnosis correct	Secondary diagnosis correct	Primary procedure correct	Secondary procedure correct
Standard Met	>=90%	>=80%	>=90%	>=80%
Standard Exceeded	>=95%	>=90%	>=95%	>=90%
SFH 22/23	90%	93.4%	93.7%	89.9%
SFH 23/24	91%	95.6%	93.6%	96%

Based on the review of the DPST Recommendations, the table below (table 4) outlines the recommendations that were made and confirmation that all were actioned within the timeframe, with one planned for completion in April 2024.

Table 4 Data Security and Protection Toolkit Recommendation Action Plan

Recommendations	Priority	Date to be completed by	Date of action complete
Feedback on all the areas of error found during the audit to the coding team	**High**	**Dec 2023**	**Dec 2023**
Coders need to refresh themselves with primary diagnosis definition, to ensure accurate assignment of primary diagnosis	**High**	**Dec 2023**	**Dec 2023**
Four step coding process should always be followed to ensure that conditions are recorded to the furthest level of specificity required for accurate coding.	**High**	**Dec 2023**	**Dec 2023**
Coders need to refresh the ICD-10 General coding standard. DGCS .3: Co-morbidities & Appendix 1 in the national clinical coding standards ICD 10.	**High**	**Dec 2023**	**Dec 2023**
Clinical documentation for the hospital provider spell must be read in its entirety to capture all the relevant diagnoses, comorbidities & procedures.	**High**	**Dec 2023**	**Dec 2023**
Coders to refresh the coding standards on sepsis and sequencing of the infectious agent for postoperative wound infection.	**High**	**Dec 2023**	**Dec 2023**
A targeted audit on episodes coded from electronic systems and proformas to access the level of the comorbidity information provided vs medical records and work with the specialty clinical leads to improve the capture of comorbidity information	**Medium**	**April 2024**	**April 2024**

Recruitment and training:

SFHFT has successfully recruited three trainee clinical coders to replace staff resignations. All coders are up to date with the mandatory training requirement set by NHS England. SFHFT has three levels of clinical coder within the current structure supported by a management team and coding assistants.

Of the three separate coder level positions in the team, trainees make up 35% off all coders within the department currently. This has been progressed over the course of the year with one experienced coder passing their national qualification in 2023/2024, along with two trainee coders progressing to experienced clinical coder status. Two more trainees are currently being evaluated.

Clinical Coding have carried a vacancy at Band 6 for all the 2023/2024 period. This has been utilised in supplementing the training needs of the department by providing overtime to all experienced staff. This has allowed continual deadlines to be met and audit capabilities to be performed.

2.2.9 Data Quality Strategy

SFHFT's Data Quality Strategy aims to influence and drive improvements in outcomes for patients through effective decision making by clinical, operational, and managerial staff by ensuring timely availability of accurate and high-quality information.

Shared decision making is part of the NHS Long Term Plan's commitment to make personalised care 'business as usual' across the health and care system. Personalised care requires a whole-system approach, integrating all services around the patient. It recognises a positive shift to empowering patients and care professionals to make informed decisions, based on robust and trusted information. Information collected and used to enable this process must therefore support the patient care pathway.

Data Quality (DQ) is everyone's responsibility. All members of SFHFT are responsible for the data that they record, manual or electronic. The Audit Commission identifies 6 dimensions to data quality, which when addressed, will support the achievement of high-quality data. These dimensions are shown in table 5 below:

Table 5 Audit Commission – 6 Dimensions to data quality

Timeliness	Data captured quickly after the event, and made available for use as quickly as possible
Completeness	The extent to which data is complete (e.g. how many missing records are there)
Validity	Data is recorded and used in accordance with any rules / definitions (allowing for comparison)
Relevance	Data should be relevant for the purpose for which it is being used
Reliability	Data should be based on stable and consistent collection processes (danger that improvements in performance reflect changes in collection, rather than practice)
Accuracy	How 'correct' is the data

At SFHFT, we maintain three key behaviours in our approach to providing data quality: Responsiveness, proactivity, and continuous improvement. SFHFT undertake the following actions to improve data quality:

Responsiveness

Validation: in response to known areas of data quality concerns (as identified through reporting or operational processes) we:

- Actively validate data sets to ensure decision making is based upon accurate information.
- Work with operational and clinical teams to quantify the relative risk and priorities. This results in informed choices on the necessary action and timescales for the Divisional Teams, supported by the data quality (DQ) team and Corporate Planned Care Team to remedy any identified issues.

Addressing errors where data errors are identified, in addition to informing operational and clinical teams, and, to enable the patient impact to be understood and addressed, we:

- Identify the root cause.
- Correct the information, as necessary.
- Ensure feedback is provided to the originator of the root cause and that an action plan is implemented.
- Obtain assurance that the appropriate actions have been taken by the Divisions to reduce or prevent repetition of the issue and that all associated actions have been closed.

Proactivity

Reporting: SFHFT continue to develop and use Key Performance Indicators (KPIs) to:

- Monitor levels of DQ.

Continuous improvement

- Identify improvements or deterioration in DQ.
- Identify areas for validation, corrections, training, process improvements or ad-hoc audits.

Auditing: SFHFT will develop and implement an audit programme to:

- Systematically check for DQ issues across the Trust, through sampling of records and providing appropriate feedback
- Allow for ad-hoc audits in response to suspected data quality weaknesses.

Data Quality training

SFHFT continue to review all system based and operational DQ training materials, including standard operating procedures, to ensure that they are fit for purpose in terms of data collection, recording, analysis, and reporting adherence to data dictionary standard requirements.

CareFlow is the Patient Administration System (PAS) used by SFHFT. Initial system training is delivered by Nottinghamshire Health Informatics Service (NHIS) trainers and is a prerequisite to obtaining access to the SFHFT PAS system. SFHFT DQ & the Corporate Planned Care trainers continue to deliver a comprehensive training plan for both DQ and Elective care. Annual compliance of training undertaken, will be monitored, and followed up with the Divisions.

Data Quality improvement Key Performance Indicators (KPI's)

SFHFT has a fully developed data quality analytical dashboard to support the improvements of data collection in the following areas:

- Outpatient referral management
- Outpatient activity
- Inpatient activity
- Elective waiting list management
- Referral to Treatment (RTT)
- Maternity
- CareFlow PAS maintenance and generic DQ

This enables the teams to proactively identify areas of potential DQ improvement or issues that need to be actioned and addressed.

Data quality internal audit programme

The DQ team, with support from the Information Team & Corporate Planned Care Team, have been taking the following actions to improve data quality through audit and assurance:

- Continuing to keep SFHFT informed of emerging data quality issues through our regular communication channels.
- Maintaining the process of continuous evaluation of documentation designed to support system users to maintain data quality standards e.g., Standard Operating Procedures and user guidelines.
- Amending documentation and delivering appropriate user awareness sessions in response to system upgrades and configuration changes taking place to support local and national requirements.

A new Data Quality Kite mark system to support the Board / Executive teams' assessment of performance of the KPI's is being scoped in preparation for 25/26.

SFHFT data quality position 2023/2024

The Data Quality Maturity Index (DQMI) is a quarterly publication intended to highlight the importance of data quality in the NHS. It provides data submitters with timely and transparent information about their data quality.

SFHFT average total DQMI score for Admitted Patient Care, Outpatients, and the Accident & Emergency Departments, has improved from 90.4% to 93.4% from the previous year.

SFHFT submitted records during 2023/24 to the SUS for inclusion in the Hospital Episode Statistics which are included in the latest published data. The % scores are all above the National Data Item averages.

The percentage of records in the published data which included the patient's valid NHS number (as at Q2 2023)		
Admitted Patient Care	**Outpatient Activity**	**Accident and Emergency Care**
100%	**100%**	**98%**

The percentage of records in the published data which included the patient's valid GP Code (As at Q2 2023)		
Admitted Patient Care	**Outpatient Activity**	**Accident and Emergency Care**
100%	**100%**	**98.7%**

The percentage of records in the published data which included the patient's valid Ethnic Category (as at Q2 2023)		
Admitted Patient Care	**Outpatient Activity**	**Accident and Emergency Care**
97%	**97%**	**95%**

SFHFT will be taking the following actions to improve data quality:

- Examine individual data items within the DQMI to identify areas that require improvement.
- Develop interactive DQ exceptions reports to identify where data feeding the DQMI is 'missing' or 'incorrect.'
- Integrate spot checks with divisional services to support validation against policy.
- Publication of a revised data quality strategy and plan
- An Internal audit programme will be in place and provide regular information to the Board relating to data quality, findings, and improvement plan.
- Aim to increase total average DQMI score to > 94%

2.2.10 Improving Care and Learning from Mortality Review Performance against the Learning from Deaths Standard

During the reporting period 2023/24, 1768 of SFHFT patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 418 deaths in the Q1 (first quarter)
- 381 deaths in the Q2 (second quarter)
- 481 deaths in the Q3 (third quarter)
- 488 deaths in the Q4 (fourth quarter)

The number of deaths for the previous reporting period (2022/23) was 2005.

All deaths were subject to proportionate independent scrutiny by the Medical Examiners Service and discussion with the attending clinical team. All these reviews were conducted within 5 days of death except in 3 cases where bank holidays were involved.

Following scrutiny of hospital deaths further investigation, using the Royal College of Physicians' Structured Judgement Review (SJR) Methodology, was requested in 111 cases. This is approximately 7%, an improvement on the last reporting period (4.5%).

The number of deaths in each quarter for which a SJR has been raised is:

- 40 in Q1
- 29 in Q2
- 30 in Q3
- 20 in Q4

Clinical engagement in the SJR process has been good with both a reduction in the backlog of reviews and good qualitative feedback, despite the challenges of clinical workload and industrial action. We hope this will be further facilitated by proposed migration of the full mortality review process onto the Datix system, of which, the Medical examiner and Bereavement Centre components have been completed within the last year.

Following review, overall care was found to be generally good. The small number of cases where poor care is identified by SJR are escalated through formal governance processes. These cases are then review for further investigation under the Serious Incident Framework and more recently the Patient Safety Incident Response Framework (PSIRF) which went live on October 2023. SFHFT is currently working hard on the transition between these two frameworks. These cases are also typically subjected to coronial processes.

These further investigations have highlighted difficulties associated with use of early warning scores identified in a paediatric case.

Following a recent adult inquest, the Trust received a Regulation 28 (Prevention of Future Deaths) order. Some of this was directed at our arrangements for managing Necrotising Fasciitis, a rare and difficult-to-diagnose condition. The case also highlighted weaknesses in our more generic processes, particularly in transferring patients between our Newark and King's Mill sites. The Trust was already making good progress towards implementing actions at the time of the inquest. The new approaches to incident response, available under PSIRF, were felt by the clinical teams to have facilitated better action.

2.3 Reporting against Core indicators

2.3.1 Summary Hospital Level Mortality Indicator (SHMI) banding

The SHMI is the ratio between the actual number of patients who die following hospitalisation at SFHFT and the number that would be expected to die, on the basis of average England figures, given the characteristics and acuity of the patients treated at SFHFT. It includes deaths which occur in hospital and, deaths which occur outside of hospital within 30 days (inclusive), of discharge from SFHFT. SHMI gives an indication for each non-specialist acute NHS trust in England whether the observed number of deaths within 30 days of discharge from hospital was 'higher than expected' (SHMI banding=1), 'as expected' (SHMI banding=2) or 'lower than expected' (SHMI banding=3) when compared to the national baseline.

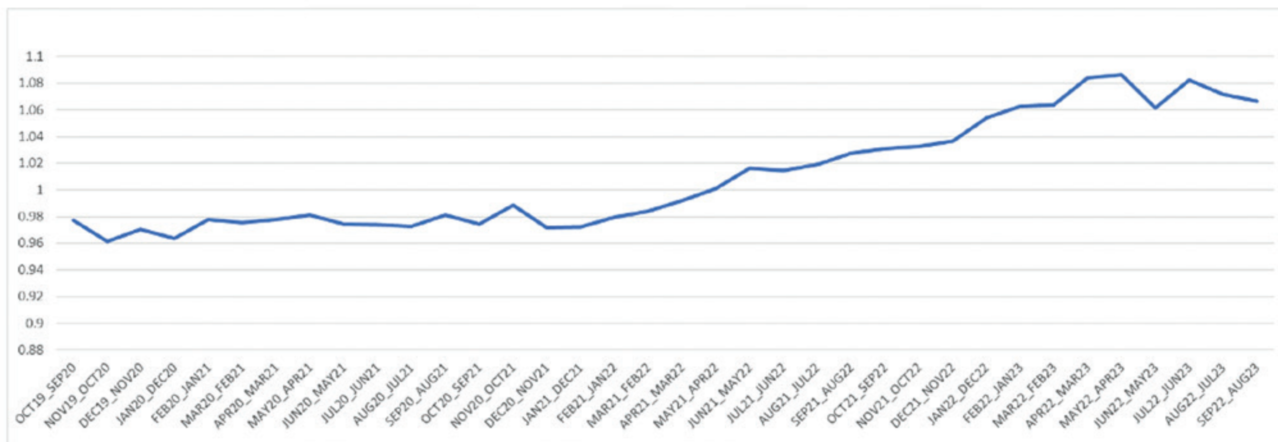
The most recent data (published Jan 2024) is in the table below (Table 6). This data runs 4-5 months in arrears due to handling processes.

Table 6 SHMI value and banding

Reporting period	Published	SHMI value	Banding
October 2021 - September 2022	February 2023	1.0309	2
November 2021 - October 2022	March 2023	1.0327	2
December 2021- November 2022	April 2023	1.0364	2
January 2022 - December 2022	May 2023	1.054	2
February 2022 - January 2023	June 2023	1.0625	2
March 2022 - February 2023	July 2023	1.064	2
April 2022 - March 2023	August 2023	1.0842	2
May 2022 - April 2023	September 2023	1.0864	2
June 2022 - May 2023	October 2023	1.0614	2
July 2022 - June 2023	November 2023	1.0824	2
August 2022 - July 2023	December 20233	1.0719	2
September 2022 - August 2023	January 2023	1.0664	2

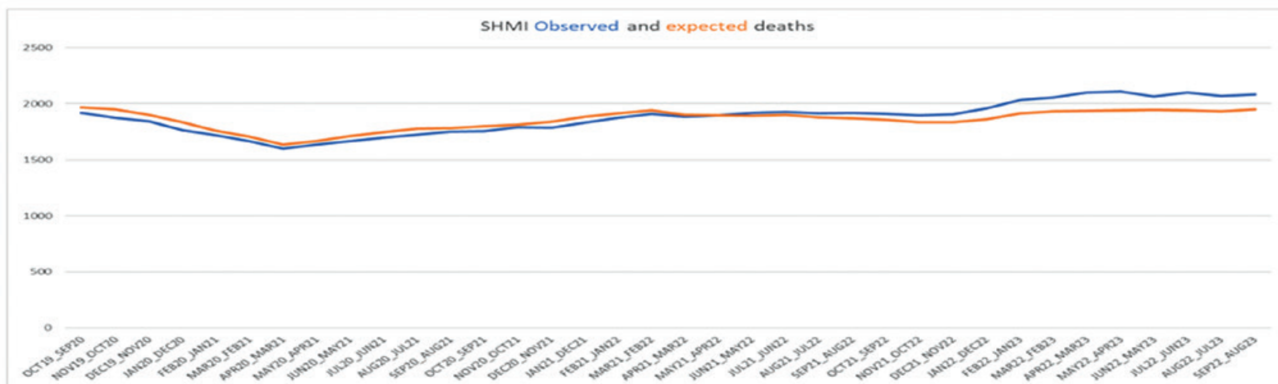
SFHFT remain "as expected" according to this metric. The upward drift in the context of the last 3 year observed in the last report, continued in the first part of this year's reporting period. This has started to be reversed in graph 3 below.

Graph 3: 3-year SHMI Trend



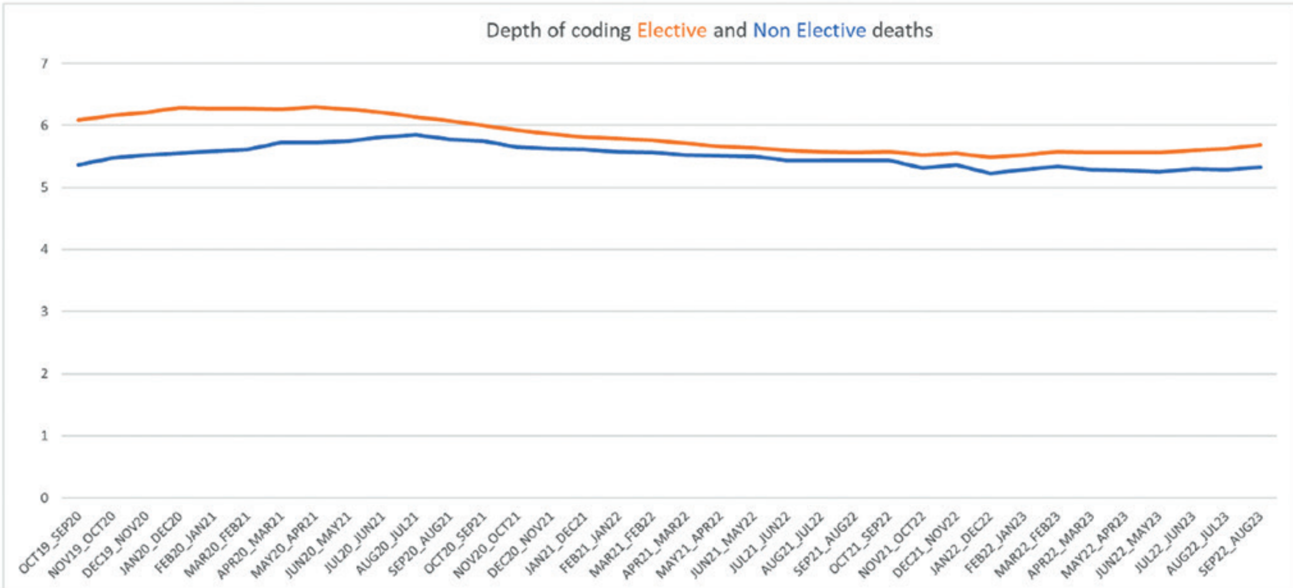
When we examine the observed and expected deaths over this period (Graph 4) the point where these lines cross represent the time where our SHMI became greater than 1.

Graph 4: SHMI observed and expected deaths.



Our interpretation for this reduction in our expected rate was a decline in the depth of coding which can be seen in Graph 5. The depth of coding refers to the mean number of secondary diagnosis codes, per finished provider spell, within an elective / non-elective admission. One interpretation of this would be that our population has become less unwell with less complex needs, however, this would not be consistent with the observations and experience of our clinical colleagues, and the demand on our services. It is far more likely that we are not capturing the information completely. We have continued a coordinated approach of education and communication around the importance of documentation and a redesign of documentation involving frontline users during the reporting period. The graph shows that this decline has begun to reverse for elective cases and plateaued for non-elective cases. This could be because of our intensive educational activities. The updated version of the admission paperwork for the Emergency Department, which should drive better documentation behaviours, is in the early stages of implementation. We expect to see further improvements in the non-elective cases, resulting in further reductions of our SHMI.

Graph 5: Depth of coding (mean number of additional codes) for Elective and Non-Elective deaths



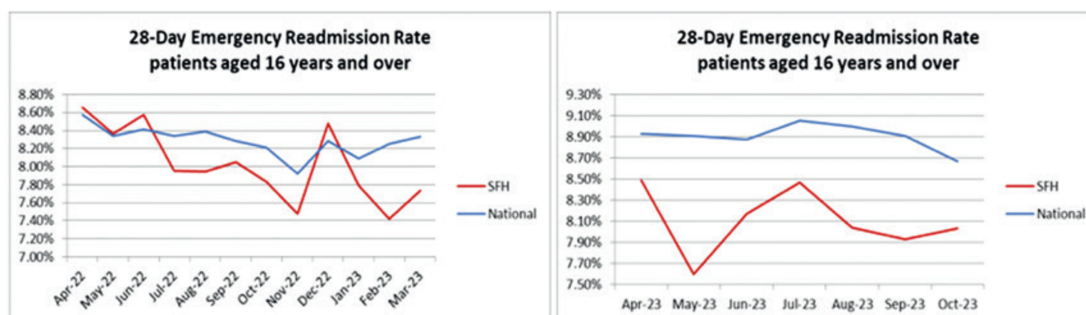
2.3.2 Patient Reported Outcome Measures (PROMS)

The publication date for PROMs has been altered. As a result, there has been a reduced number of submissions to PROMs. Because of the current insufficient data, SFHFT have not been able to do the score comparison tool to produce meaningful data. Final data will be available in July 2024 and will be added retrospectively to this account.

2.3.3 Percentage of patients readmitted to hospital within 28 days.

- The readmission rate for 0-15 years old has deteriorated overall from financial year (FY) 22/23 (9.68%) to H1 (first 6 months of a financial year), FY23/24 (11.11%).
- The 16 years + readmission rate has however, remained relatively consistent overall, from 8.01% (FY22/23) to 8.10% (H1 FY23/24).
- The 0-15 years cohort compares favourably to the national performance during FY22/23, then deteriorates somewhat during FY23/24. The 16+ years cohort continues to improve during this period against the national performance. See graph 6 below.

Data Source: Dr Foster Graph 6



SFHFT will take the following action to improve the quality of its services, as measured by these percentages by safe, timely discharge planning, which ensures patients are discharged to the appropriate place of residence. SFHFT continue to build effective relationships with community and external partners to ensure patients are supported safely through their discharge.

The 28-day readmission rate for patients across the Trust continues to be monitored monthly through the executive-led divisional performance meetings.

2.3.4 Trust Responsiveness to the Personal Needs of Patients

SFHFT is committed to resolving any concerns at the earliest opportunity and this is often achieved through the patient, relative or carer discussing their concerns directly with the team. The Patient Experience Team (PET) is available to provide confidential advice and support to any patient, relative or carer who may not feel comfortable raising their concern with the department or service directly, or, where they have done so but their concern remains unresolved. The PET aims to resolve any concerns that are raised with them quickly and informally.

SFHFT operates a centralised complaints service. It ensures that a patient-centred approach is taken to the management of complaints. All complaints received are thoroughly investigated and responded to within a timely manner, within an agreed timescale ranging from 25 to 60 working days dependent on complexity. It was recognised that the blanket 25-day timescale for completion for all complaint responses, regardless of complexity, is no longer achievable with the current resource available. This means that complainants will be advised of a more realistic expected response date and therefore reducing the frustration often felt by complainants when responses are overdue.

Learning and improvements that result from individual concerns or complaints are analysed to identify any themes and the intelligence generated is shared across the organisation to drive the necessary improvements.

In 2023/24 we received 313 complaints, a 29% increase compared to 2022/23, this is a further increase of 26% from the previous year. Of the 391 complaints closed throughout 2023/24, 30% were completed within 25 working days or locally agreed timescales with the complainant demonstrating a 23% increase from the previous year.

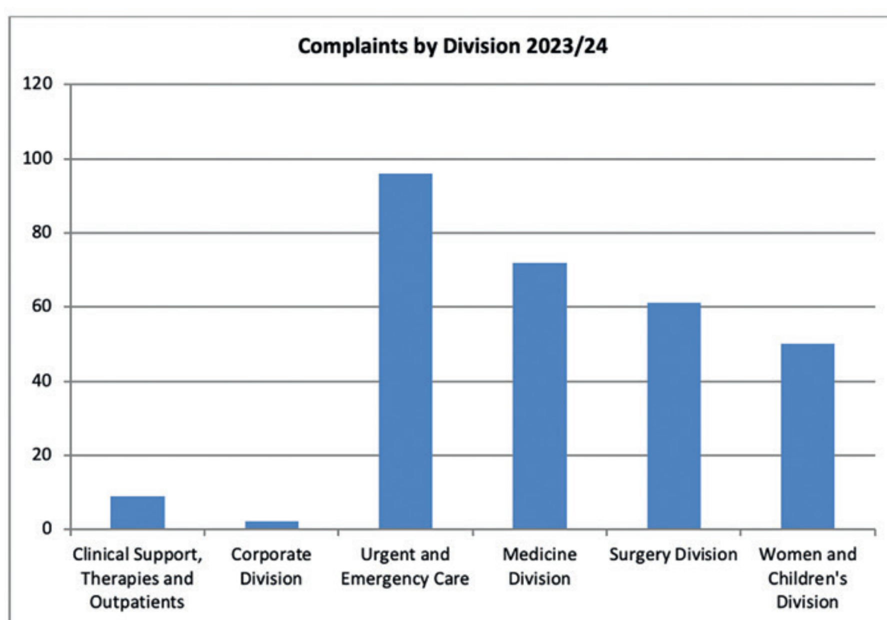
Whilst performance against the time frames standard was noted to be reduced, all complainants were kept updated on the progress of their complaint and a personal apology was provided to all complainants. The Complaints team has been through a challenging time recently due to decreased staffing levels due to long term sickness. This has impacted on the ability to achieve the current complaint response timeframes set by SFHFT.

The table below (table 7), shows the revised complaint timescales according to the severity of the concerns raised.

Table 7 Complaint timescales according to the severity of the concerns raised:

Category & PET Timescale	Criteria – Severity of concerns raised /cross division concerns	Division Timescale
Complex / Multiple Divisions and Specialties / legal involvement. **60 working Days**	Complaint involves numerous issues across multiple Specialties / Divisions / Organisations or is significantly complex involving multiple issues / treatment pathways. May be legal involvement and or incident / safeguarding involvement	**30 working days**
Complicated / Cross two Divisions / more than one specialty in Divisions **40 working Days**	More than one Division and multiple specialties involved. Multiple clinicians required to provide responses.	**20 working days**
Moderately complex / More than one specialty involvement **30 working Days**	The issues raised relate to more than one specialty however minimal concerns / generally straight forward	**15 working days**
Standard – Only a few concerns relating to one division / specialty **25 working Days**	The complaint involves issues contained within one specialty / Division and is considered straight forward with minimal concerns	**10 working days**

Graph 7: Complaints by Division



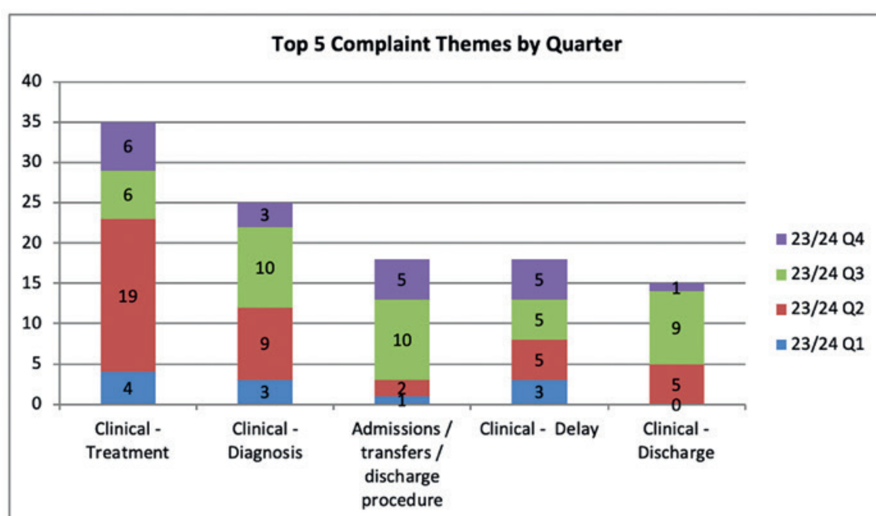
An overall increase of complaints relating to discharge was noted in 2023/24.

Table 8 Top five themes for complaints 2023/24

	Clinical Support, Therapies and Outpatients	Urgent and Emergency Care	Medicine Division	Surgery Division	Women & Children's Division	Total
Clinical - Treatment	2	17	9	7	10	**45**
Clinical - Diagnosis	2	9	3	6	6	**26**
Admissions / transfers / discharge procedure	0	8	6	6	3	**23**
Clinical - Delay	0	5	8	7	1	**21**
Clinical - discharge	0	6	6	3	1	**16**
Total	**4**	**45**	**32**	**29**	**21**	**131**

Clinical treatment and clinical diagnosis continue to be the most frequently reported subjects of dissatisfaction, along with issues relating to the admissions, transfers and discharge procedures. Complaints regarding clinical delays and discharge have replaced the previous top five themes relating to communication of the nursing / midwifery team and nursing care and treatment during this reporting period, (table 8). These complaints have been triangulated, to ensure safeguarding, any patient safety issues and concerns are escalated and managed via the appropriate routes, and, to further analyse themes and trends for escalation to the relevant divisions.

Graph 8: Top 5 Themes – Complaints received Quarterly by Division



Of the complaints responded to within 2023/24, 70% were upheld or partially upheld, showing a decrease of 2% from the previous year. This has provided an opportunity for learning and service improvements.

A total of 33 complaints were re-opened in 2023/24 because the complainant had raised additional concerns to the original complaint. This demonstrates a decrease of 12% of re-opened complaints from 2022/23. All requests are formally responded to, reiterating the options relating to the next steps, which include Public Health Service Ombudsman (PHSO), independent advocate and access to medical records procedure.

In 2023/24, the PHSO initiated 7 additional new complaints reviews, had 4 cases currently under ongoing investigation, and had concluded 3 investigations.

The Patient Experience Team pre-empt that correspondence from the PHSO will continue to increase in during 2024/25 and the new contacts made will include requests for further Local Resolution, transcriptions of meetings that have taken place and financial remedy for those partially or fully upheld.

Table 9 Cases closed by the PHSO during 2023/24

ID	Division/ Specialty	Subject	PHSO Open Date	PHSO Outcome	Date PHSO Closed	Learning from PHSO
	Medicine	Communication	16/02/22	No further investigation	02/05/23	No further learning identified
43779	Medicine / Urgent & Emergency care	Care & Treatment	27/02/23	No further investigation	21/08/23	No further learning identified
30455	Medicine	Care & Treatment	14/10/22	Partially upheld	23/01/24	Failings during the palliative stages of patient's life and missed opportunities to provide information to the family in anticipation of the patient passing. £500 compensation awarded.

2.3.5 Staff Friends and Family responses and recommendation rates

National NHS Staff Survey – 2023

The ongoing impact of continued NHS pressures and the after-effects of the Covid-19 pandemic on our people, remained evident throughout 2023/24. An important vehicle for listening to the voices of our staff is through the annual National Staff Survey (NSS).

The NSS 2023 closed at the end of November, with 3568 colleagues taking the opportunity to share their voice, which was a 62% response rate from across SFH (compared to 61% last year). To note; this is the highest number of colleagues completing the survey over the last five years (65% was the highest percentage in 2021, but we now have more staff hence this year's lower percentage despite more colleagues replying).

The national average response rate for Acute Trusts who ran their survey with Picker was 45.8%, down from 46% the previous year. Our response rate is ~16% higher than national average.

This survey is complemented by quarterly pulse surveys, and with engagement from the trust on the commitments made by SFHFT following the NSS, completes a year-round engagement and consultation period with staff.

Each year the aim is to raise staff participation to identify key areas that need improvement that will benefit the Trust as a whole.

A total of 100 questions were asked in the 2023 survey. 80 questions had improved responses from NSS 2022, with 94 questions scoring above the Picker average. However, 17 questions had responses which have deteriorated from 2022, only 6 questions had responses lower than the Picker average.

Within the 2023/2024 NHS Staff Survey the questions align to the seven elements of the NHS 'People Promise' including two additional themes of engagement and morale. All indicators are based on a score out of 10 for specific questions with the indicator score being the average of those.

Each year, SFHFT priorities are reviewed and refreshed in line with the results from the survey, along with feedback from quarterly pulse surveys, Freedom to Speak Up Guardians, People information and divisional feedback.

Evidence from these indicate that SFHFT overall continues to have a high quality, positive culture, and where there are challenges, teams and individuals are supported to resolve these.

Engagement with colleagues continues to be a priority, within the People Directorate, working closely with the Communications team to maximise internal communication channels and provide opportunities for 2-way communication wherever possible.

The 2023 National Staff Survey results placed SFHFT as 1st in the midlands and 1st nationally, for staff engagement and morale across 122 Acute and Acute Community Trusts.

2023/24 and 2022/23

Scores for each indicator together with that of the survey benchmarking group (122 Acute and Acute community trusts) are presented below:

Indicators ('People Promise' elements and themes)	2023/24		2022/23	
	SFHFT Score	Benchmarking Group Score	SFHFT Score	Benchmarking Group Score
People Promise				
We are compassionate and inclusive	**7.6**	7.2	**7.6**	7.2
We are recognised and rewarded	**6.3**	5.9	**6.1**	5.7
We each have a voice that counts	**7.1**	6.7	**7.1**	6.6
We are safe and healthy	**6.4**	6.0	**6.2**	5.9
We are always learning	**6.1**	5.6	**5.9**	5.4
We work flexibly	**6.7**	6.2	**6.5**	6.0
We are a team	**7.1**	6.7	**7.0**	6.6
Staff Engagement	**7.3**	6.9	**7.2**	6.8
Morale	**6.5**	5.9	**6.3**	5.7

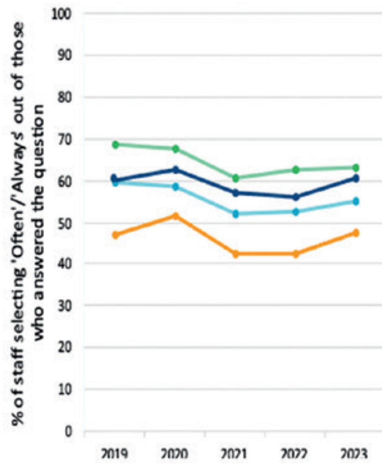
For 2023/24 our benchmarking position regionally and nationally is as follows:

Theme	National Position (/122 Acute / Acute Community Trusts)	Regional Position (/21)
We are compassionate and inclusive	**5th**	2nd
We are recognised and rewarded	**6th**	2nd
We each have a voice that counts	**2nd**	1st
We are safe and healthy	**Awaiting data from the national team**	
We are always learning	**2nd**	1st
We work flexibly	**3rd**	2nd
We are a team	**5th**	2nd
Staff Engagement	**1st**	1st
Morale	**1st**	1st

People Promise elements and theme results – Staff engagement: Motivation

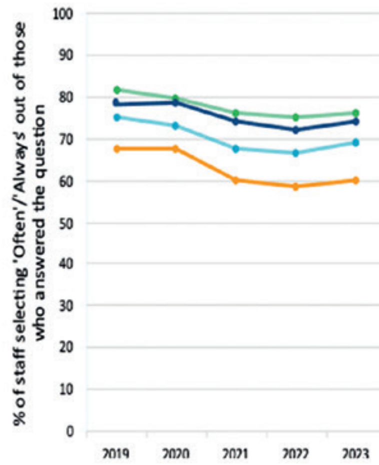
Survey Coordination Centre NHS

Q2a I look forward to going to work.



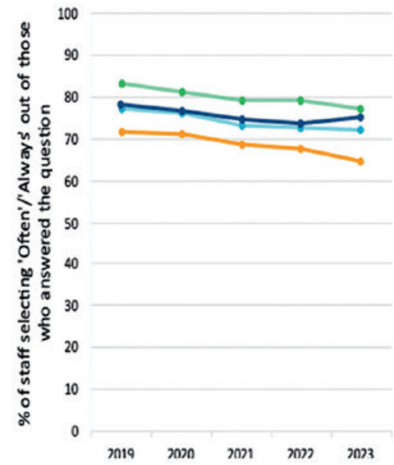
	2019	2020	2021	2022	2023
Your org	60.29%	62.63%	57.22%	55.84%	60.64%
Best result	68.55%	67.55%	60.68%	62.60%	62.92%
Average result	59.47%	58.55%	52.01%	52.49%	55.00%
Worst result	47.07%	51.81%	42.48%	42.39%	47.34%
Responses	3143	3036	3363	3365	3532

Q2b I am enthusiastic about my job.



	2019	2020	2021	2022	2023
Your org	78.32%	78.51%	73.98%	71.95%	74.23%
Best result	81.75%	79.97%	76.25%	75.09%	76.43%
Average result	75.37%	73.16%	67.57%	66.74%	69.39%
Worst result	67.68%	67.81%	59.95%	58.50%	60.20%
Responses	3131	3016	3346	3353	3509

Q2c Time passes quickly when I am working.

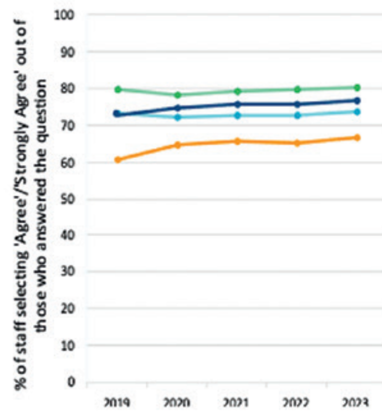


	2019	2020	2021	2022	2023
Your org	78.05%	76.58%	74.90%	73.45%	75.20%
Best result	83.13%	81.17%	79.41%	79.01%	77.42%
Average result	77.41%	76.10%	73.00%	72.50%	72.33%
Worst result	71.54%	71.21%	68.52%	67.44%	64.58%
Responses	3124	3021	3347	3355	3504

People Promise elements and theme results – Staff engagement: Involvement

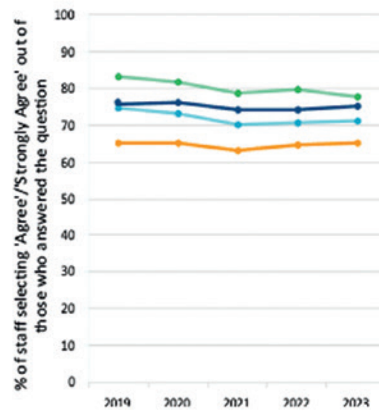
Survey Coordination Centre NHS

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



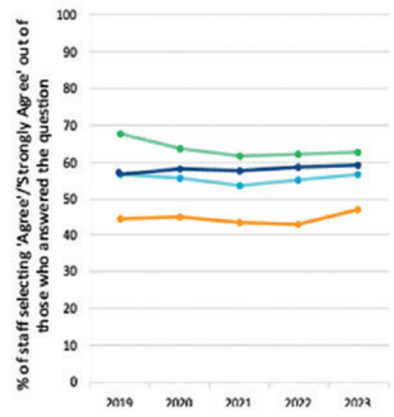
	2019	2020	2021	2022	2023
Your org	72.70%	74.81%	75.54%	75.91%	76.66%
Best result	79.93%	78.22%	79.35%	79.92%	80.07%
Average result	73.35%	72.23%	72.68%	72.83%	73.66%
Worst result	60.61%	64.80%	65.90%	64.90%	66.74%
Responses	3144	3024	3367	3380	3548

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



	2019	2020	2021	2022	2023
Your org	75.83%	76.02%	74.04%	74.25%	75.33%
Best result	83.24%	81.60%	78.73%	79.63%	77.96%
Average result	74.65%	73.16%	70.05%	70.92%	71.43%
Worst result	65.38%	65.04%	63.37%	64.73%	65.35%
Responses	3147	3027	3365	3376	3552

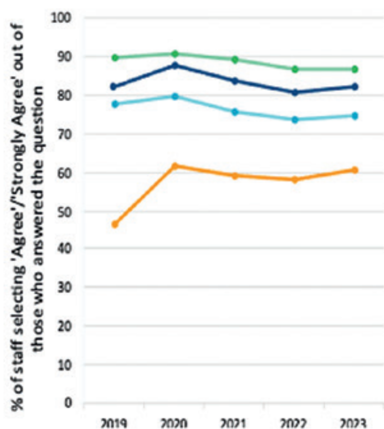
Q3f I am able to make improvements happen in my area of work.



	2019	2020	2021	2022	2023
Your org	56.68%	58.13%	57.62%	58.41%	59.21%
Best result	67.76%	63.68%	61.57%	61.93%	62.79%
Average result	56.56%	55.62%	53.39%	54.84%	56.35%
Worst result	44.73%	45.18%	43.63%	42.93%	46.89%
Responses	3139	3016	3360	3372	3541

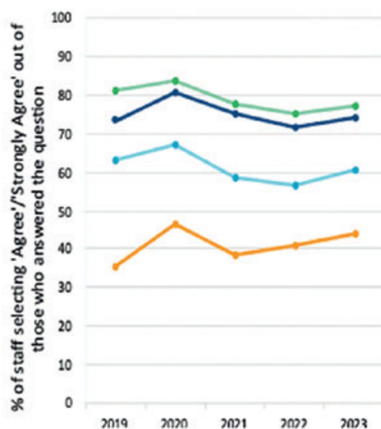
People Promise elements and theme results – Staff engagement: Advocacy (Survey Coordination Centre NHS)

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



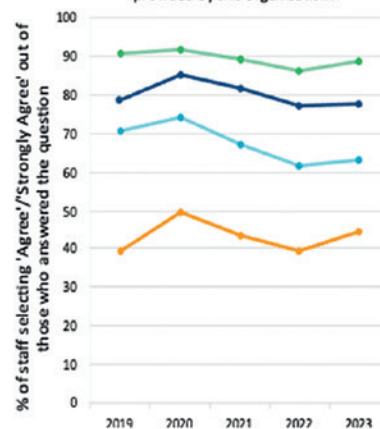
	2019	2020	2021	2022	2023
Your org	82.03%	87.80%	83.87%	80.61%	82.02%
Best result	90.05%	90.77%	89.25%	86.61%	86.57%
Average result	77.64%	79.53%	75.57%	73.56%	74.83%
Worst result	46.76%	61.70%	59.27%	58.09%	60.55%
Responses	3102	2994	3312	3355	3542

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



	2019	2020	2021	2022	2023
Your org	73.44%	80.53%	74.98%	71.58%	74.45%
Best result	81.18%	83.99%	77.82%	75.24%	77.09%
Average result	62.94%	67.00%	58.40%	56.48%	60.52%
Worst result	35.64%	46.44%	38.47%	41.03%	44.05%
Responses	3084	2990	3310	3356	3542

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



	2019	2020	2021	2022	2023
Your org	78.71%	85.32%	81.73%	77.33%	77.88%
Best result	90.62%	91.76%	89.51%	86.38%	88.82%
Average result	70.57%	74.32%	66.99%	61.82%	63.32%
Worst result	39.54%	49.58%	43.54%	39.27%	44.31%
Responses	3102	2993	3318	3356	3544

Whilst it is important to note that scores across some of these questions declined in 2022, this was a national theme. Sherwood Forest has improved in 2023 across all areas and continues to perform favourably.

For the sixth year running, SFHFT scored the highest score as the most recommended Acute Trust to work for in the Midlands and was the overall the second best Acute or Acute/Community Trust in England.

Actions

Whilst there have been some positive improvements in our NSS result scores in 2023, there are some areas that do require continued focus into 2024 including:

- Improving experience and reporting of Physical violence including Sexual Safety
- Physical and emotional wellbeing of our people (burnout/exhaustion/motivation)
- Improve experiences for colleagues living with disabilities, colleagues from ethnic minorities and those from our LGBTQ+ communities.
- Continued improvement in reporting and addressing of unsafe clinical practice, including feedback and fairness in relation to clinical incidents.
- Leadership – wellbeing support from managers and colleagues, manager valuing and recognising colleague work, colleague involvement in management decision making.

SFHFT intends to take the actions to continue to improve these percentages, and the quality of its services through key focus areas.

We also recognise a need to ensure we engage with colleagues more meaningfully, through 1-2-1 interactions with our teams, ensuring that everyone's voice is heard, including those who chose not to take part in the survey. SFHFT want to ensure that for the NSS in 2024, we improve our response rates by reaching those whose voices we haven't yet heard.

2.3.6 Venous Thromboembolism (VTE)

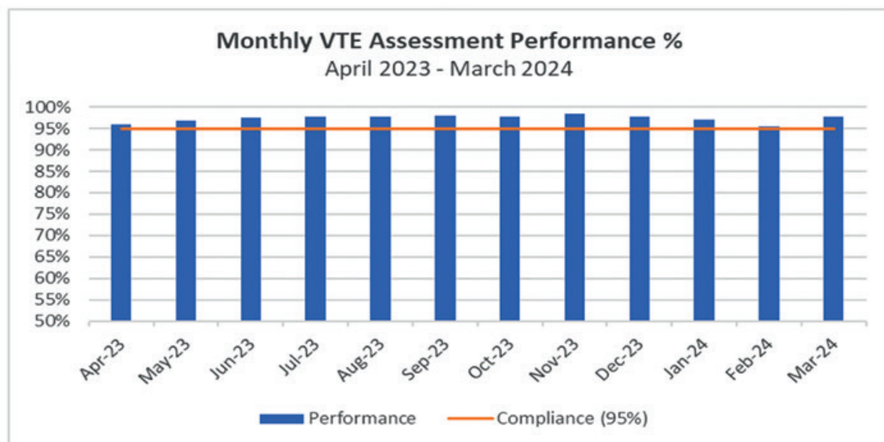
A Venous Thromboembolism (VTE) is a blood clot (thrombus) that forms within a vein that can cause occlusion within the lung (pulmonary embolism) or in the deep leg veins (deep vein thrombus). The House of Commons Health Committee reported in 2005 that an estimated 25,000 people in the UK die from preventable, hospital acquired VTE every year. This includes patients admitted to hospital for medical and surgical care. VTE is a significant cause of death in hospital patients, and treatment of non-fatal symptomatic VTE and related long-term morbidities associated with VTE, are associated with considerable costs to the patient and health service.

The Trust considers that this data is as described for the following reasons:

- All young people aged 16 or over and adult patients should have a VTE risk assessment on admission to hospital using a nationally recognised risk assessment tool.
- SFHFT aims to achieve 95% or above compliance with this standard.
- Any patient over the age of 16 being admitted to SFHFT, automatically triggers the system that the patient needs to have a VTE assessment completed within 14 hours.

Graph 9 demonstrates SFHFT performance against the level of compliance required.

Graph 9: Monthly VTE Assessment Performance



2.3.7 Clostridium Difficile infections

Clostridioides Difficile infection (CDiff) is acknowledged as an issue that impacts upon the whole health economy. There continues to be a partnership approach to this across the Integrated Care Board (ICB). The trajectory for 2023/24 had been set at 57 Trust associated cases. CDiff cases have continued to rise regionally and nationally over the past year and there are now regional task and finish groups have been implemented to help drive improvement.

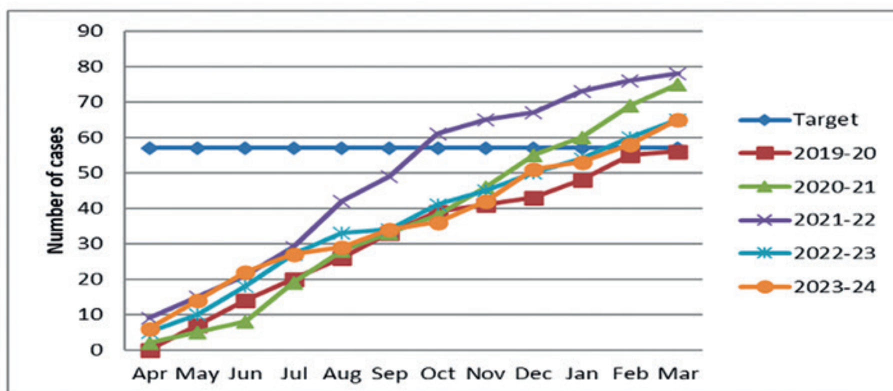
SFHFT aims for 2023/24 are outlined below:

- To re-establish and maintain the Trusts deep clean programme.
- To conduct root cause analysis on each case to identify common themes across the organisation and within the whole healthcare economy.
- To share relevant learning between divisions at SFHFT and with the local infection prevention teams.
- To ensure that the SFHFT attributable cases in the reporting period remain below 93.

How was this achieved?

In 2023/24 the numbers of cases identified as Trust associated is 65 (Graph 10).

Graph 10: SFHFT cumulative total of Trust associated CDiff cases.



A root cause analysis of all cases was performed to establish any common themes and to help identify if cases were avoidable or unavoidable. There have been no links established to identify any cross transmission or outbreaks following any of our cases. To ensure this, we have sent CDiff samples to the CDiff reference laboratory to look for the Ribotype of the cases to establish links. Lapses of care were monitored for all cases and these included delays in obtaining samples, delays in isolation and a small number of antibiotic prescribing issues.

SFHFT continue to take action to reduce the number of CDiff cases and improve the quality of its services by focusing further on CDiff management and implementing the interventions outlined below:

- Deep cleaning programme recommenced and maintained.
- Maintaining bed decontamination process and increased this to include trolleys from ED.
- Full thematic review of all Trust associated cases.

Cleanliness

The standard of cleaning is fundamental in reducing the risks of transferring CDiff. The IPCT continue to work with Medirest, Skanska, SFHFT colleagues and commercial companies to improve the consistency of the cleaning processes throughout the organisation, ensuring all staff are aware of their responsibilities. We have maintained red cleans with hydrogen peroxide vapour for all rooms after a patient has recovered / been discharged with CDiff.

Monitoring and reporting

All cases of CDiff infections within SFHFT are reported to United Kingdom Health Security Agency (UKHSA). These have been reported within both internal governance structures and externally.

The trajectory for 2024/25 has not yet been set. Monitoring will continue through the Infection Prevention and Control Committee.

2.3.8 Patient Safety Incidents

SFHFT is committed to reporting and investigating adverse events and near misses, recognising this provides the Trust with opportunities to learn, improve the quality of services and reduce the risk of those types of events happening again. The process for the management of reported incidents is described within the Trust's Incident Reporting Policy and Procedures and within the Patient Safety Incident Response Plan.

SFHFT implemented the Patient Safety Incident Response Framework (PSIRF) on 2 October 2023 ensuring that we continue to learn and improve following a patient safety incident, and work better with patients and families when things go wrong.

Shifting culture towards the importance of systems, tools, understanding everyday work and making recommendations that make sense in this context, will deliver impact for patients.

An appointed Family Liaison Officer (FLO) has been in post since May 2023 to support SFHFT with maintaining contact and building relationships with patients, and their relatives following an incident. Following the implementation of the PSIRF model, SFHFT offer families the opportunity to meet to discuss any questions or concerns they have and that they are provided with an opportunity to review the draft investigation report, for factual accuracy, prior to final approval. As PSIRF continues to be embedded within the Trust, it is anticipated that the role of the FLO will evolve and develop to meet the needs of the service and the families involved.

During 2023 the Trust engaged in a significant implementation phase in preparation for the launch of Learn From Patient Safety Events (LFPSE) on 2 April 2024.

Level of patient safety reporting

From the 1 April 2023 to 1 October 2023 (launch of PSIRF), SFHFT declared a total of 18 Serious Incidents in accordance with NHS England's Serious Incident Framework (May 2015).

From the launch of PSIRF on 2 October 2023 to 31 March 2024 SFHFT declared 9 Patient Safety Incident Investigations (PSIIs). This included 1 Never Event.

All Serious Incidents and PSII's are investigated, and action plans developed to mitigate the risk of recurrence. Identified and dissemination of the learning arising from incidents, detailing immediate actions taken, are provided to the Patient Safety Committee and Quality Committee. All Maternity serious incidents and PSII's are routinely shared with SFHFT Board.

Part 3 Other Information - additional quality priorities

3.1 Safety – Improving the safety of our patients.

Aims for 2023/24

- To optimise colleague psychological safety by developing a standardised platform and approach for any colleague to access psychological support following human-facing incidents at work.
- Implement the Patient Safety Implementation Framework (PSIRF), including patient safety syllabus education and the recruitment and training of Patient Safety Partners.
- To ensure that service users are actively engaged within all key safety meetings at SFHFT.

Performance against this Target

- In December 2023, a six-month pilot of the TRiM (Trauma Risk Management) model was launched. TRiM provides a structured approach to identifying and support staff involved in a traumatic event and, provides space for staff to understand what to expect emotionally, sign posting to our existing suite of wellbeing offers and, to identify colleagues requiring further support. Colleagues from across the Trust have undertaken TRiM training and the pilot has included TRiM in the Emergency Department (ED) and Maternity. A thorough evaluation is to be undertaken to identify the benefit of TRiM to the psychological wellbeing of colleagues involved in traumatic events.
- PSIRF went live in October 2023. Preparation included formal Incident Investigation training for 18 investigators and oversight training for Board for members and senior leaders within the organisation. The Patient Safety Incident Response Plan (PSIRP) was ratified prior to "go live" and socialised within the Trust, ICB and partner organisations. The PSIRP describes our priorities for incident response allocation:

	Incident Type	Description	Number of responses (PSII)
1	Treatment & Care to include concerns over appointments, admission, transfer & discharge	Delays to follow-up and to include incidents regarding issues with movement of patients / flow / capacity	2
2	Medication	Relating to wrong dose, omitted / delayed / wrong / duplicate medication	2
3	Delays in care	Delays to treat the deteriorating patient	2
4	Communication	Consent / DoLS / MCA	2
5	Health Records, Consent & Confidentiality	Incidents relating to health records and consent issues	2
6	Obstetrics / Maternity	Postpartum Haemorrhage in excess of 1.5L requiring return to theatre or activation of major haemorrhage protocol	2

- The PSIRF Oversight Group was commissioned by the Quality Committee to provide assurance that an effective patient safety incident response system has been undertaken that integrates four key aims of PSIRF. The groups principal duties are to provide oversight and seek assurance from the divisions that incidents which have not been reviewed at Trust level have been:
  - o Handled and investigated where indicated using methodologies outlined in the Trust's Patient Safety Incident Response Plan.
  - o Duty of Candour has been undertaken in line with statutory requirements and Trust policy.
  - o Actions have been put in place which address identified contributing factors and are monitored for effectiveness.
- SFHFT have launched the Patient Safety Partner role (PSP). Four PSP's have been recruited with additional recruitment planned in 2024. PSPs participated in the launch of PSIRF and are members of the PSIRF Oversight Group. They have contributed a patient's perspective in relation to the policy. In February 2024, they provided support and feedback during the Community Diagnostics Centre (CDC) engagement event at Mansfield Community Hospital.
- SFHFT have upgraded the current digital platform (Datix Web) to accommodate the implementation of LFPSE (Learning from Patient Safety Events), the new platform replacing National Reporting and Learning System (NRLS) and STEIS (Strategic Executive Information System). Whilst this has been challenging, SFHFT are implementing 'go live' in April 2024. Datix Web forms have been updated to include the necessary capture fields to allow monitoring and reporting and a program of communications is currently underway.

Aims for 2024/25 include:

- Embed PSIRF within the organisation and continue to roll out the Level 1 Patient safety Syllabus to all staff.
- Continue to develop the PSP role, including them in areas of interest, recruitment events and data collection / analysis.
- Recruit further PSP's, introducing them to key safety/governance committees and involving them in areas of interest to them.
- Transition all patient safety event reporting from NRLS and STEIS to the new LFPSE platform including, Patient Safety Incidents, STEIS reportable PSI, Good Care Events and explore reporting Outcome and Risk events guided by NHSE.

3.2 Safety – Reduce Harm from Falls

It is recognised that falls have a significant impact on patients, with the causes of a fall being multifactorial. The more risks factors a person has, the greater their risk of falling. Examples of risk factors include delirium, cognitive impairment, dementia, postural instability, muscle weakness, deconditioning, peripheral neuropathy, poor vision, poor mobility and/or balance problems, arthritis, and vitamin D deficiency.

SFHFT is committed to reducing harm from falls, identified as a quality priority in the SFHFT Quality Strategy 2022-2025.

Aims for 2023/24

- Continue to promote and embed a culture of activity and mobility of our inpatients, reducing deconditioning.
- Scope how we capture harms from immobility and make it our ambition that no patient is harmed secondary to immobility.
- Further develop and celebrate the work of our adult critical care team, especially with respect to early mobilisation pathways.
- Reduce falls in our emergency and short stay areas, introduction of 'THINK YELLOW'.
- Maintain investment in additional falls prevention practitioner post to support across our site, wards, and departments.
- Strengthen leadership through dedicated matron support.
- Relaunch and rename SFHFT's falls and mobility steering group, to Physical Activity and Falls Committee (PAFC) with multidisciplinary attendance and an updated terms of reference for 2023/2024.
- Continue to take a lead role in developing further the falls and physical activity COP across Nottingham and Nottinghamshire.

Performance against this Target

- As part of recognising deconditioning of patients within SFHFT, the Falls and mobility Team (FMT have been raising awareness and identifying where deconditioning has had an impact on our patients. This is strengthened via our governance process and streamlining the Datix reporting tool by introducing a category for 'deconditioning of patients' contributing to incidents. The Falls Prevention Practitioners have developed a leaflet accessible for staff, patients, and carers to raise awareness of deconditioning and the impact this has on the patient.
- Evidence continues to evolve demonstrating, that early mobilisation on critical care is safe, feasible, cost-effective and improves patient outcomes. At SFHFT we have been liaising with other trusts to learn different ways of working, resulting in the production of an evidence-based guideline, with safety criteria, on early mobilisation of with the critically ill patients. New equipment has been purchased and a significant amount of education to the wider team of the benefits of early mobilisation of these patients. Data is currently being collected for evaluation as part of a quality improvement project.

- The purpose of the THINK YELLOW project was to reduce falls for patients that meet a high falls risk criteria in the Emergency Department (ED), by 50%. The project was introduced in 2024 to the ED team as a 3-month pilot, acquiring funding from charitable funds. Due to operational pressures, the evaluation for this project has not yet concluded.

Criteria for the "Think Yellow" project.

Project Scope (IN) 2 or more of the following criteria (Full Think Yellow package; blanket, socks, yellow plaque, and wristband)	**Project Scope (OUT)** If only 1 of the above criteria met, yellow wristband to be applied and yellow plaque used
• Patients presenting with a fall. • Patients with cognitive impairment such as: dementia, delirium, acute behavioural changes, reduced Glasgow coma score. • Patients with restricted mobility. • Likely to attempt to mobilise on their own when unsafe to do so due to e.g., agitation, acute confusion etc. • Alcohol and drug misuse resulting in challenging behaviour. • Clinical Frailty Score of 6 or more.	• If none of the criteria met, no immediate actions required. Monitor for changes and re-assess should the condition / circumstances change.

The ED project team were supported by the FMT with training and the analysis of the falls data prior to the start of the quality improvement project. The ED project team altered their documentation and included stickers to indicate the patient's inclusion in the audit.

A retrospective audit was completed by the ED project team to monitor the efficacy of the project and feedback was gained via a survey. The feedback included staff, patients, and relatives / carers point of view.

Staff Feedback

> ***Good idea that makes you extra careful regarding the patient's movement***

> ***I saw a patient with a THINK YELLOW pack and knew immediately that I needed to offer assistance***

Patient and Relative Feedback

> *Yellow pack is a great idea as my mobility has declined and I don't like to ask for help, so the pack is a great icebreaker for me*

> *I feel safe with a yellow blanket and I feel reassured staff will know I'm at risk*

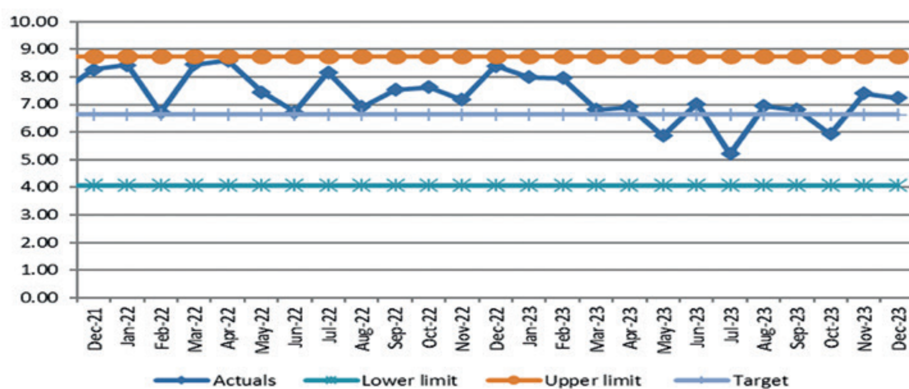
> *Will increase safety and reduce risk as patient has dementia*

SFHFT successfully appointed an additional Falls Prevention Practitioner (currently a fixed term post). An increase in staffing within the FMT has supported our ambitious target for falls to be below 6.63 per 1000 Occupied Bed Days (OBDs), in line with the Royal College of Physicians (RCP) guidance.

SFHFT current performance for 2023/24 indicates falls / per 1,000 OBDs exceeds the published ambition, however, shows an improving trajectory against the 2022/2023 data.

Graph 11 demonstrates the percentage of all inpatient falls at SFHFT calculated by 1,000 Occupied Bed Days (OBDs).

Graph 11: Percentage of all inpatient falls at SFHFT calculated by 1,000 Occupied Bed Days (OBDs).



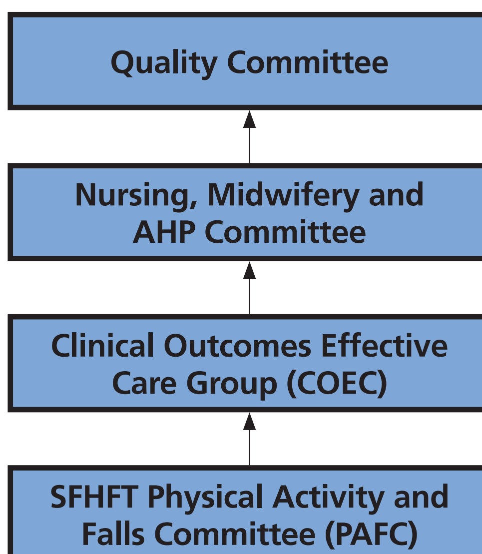
- In 2023, a Matron was appointed to provide leadership to the FMT.
- SFHFT has continued to take a lead role in the falls and physical activity community of practice (COP) across the Nottingham and Nottinghamshire ICS (NICS). This virtual network includes acute, community and the care sector with a shared ambition and vision to promote and prioritise movement. This COP has continued to influence a culture where 'movement really matters' and is fundamental in prioritising the aim that our people, patients, and residents in all our settings, are stronger, healthier, and at less at risk of falls. SFHFT have hosted three webinars focusing on making movement a priority in our hospitals, care homes and communities. The webinars have been well attended by a diverse audience from across the NICS.

How was this achieved?

The FMT are dedicated to continuously improve the service provided to our patients at SFHFT. The team meet regularly to discuss and update work plans and the reintroduction of Physical Activity Falls Committee (PAFC) has supported a multidisciplinary approach to the risk of falls within the organisation.

Monitoring and Reporting for Sustained Improvement

A report from PAFC is presented at the Clinical Outcomes Effective Care Group (COEC) quarterly. The Falls Prevention Practitioners present monthly at COEC to ensure any items of concern or relevance are discussed and escalated upwards to the Nursing, Midwifery and AHP committee and Patient Safety Committee.



Aims for 2024/25

- FMT will work with the Digital team to transform the falls risk assessment by adding a visual acuity assessment to Nervecentre. A visual acuity assessment is a new tool from the RCP, enabling ward staff to quickly assess a patient's eyesight to help prevent them falling or tripping while in hospital.
- Maintain and continually promote SFHFT's PAFC ensuring a multidisciplinary attendance.
- Continue to take a lead role in the physical activity and falls community of practice across NICS including 'making movement a priority' webinars.
- Embed After Action Reviews and hot debriefs in relation to falls at SFHFT in line with the Patient Safety Incident Response Framework (PSIRF).
- Revision of training provision.
- Promotion of preconditioning/ reconditioning and prevention of deconditioning as a priority a cross, ensuring no patient comes to harm at SFHFT as a result of hospital acquired functional decline.
- FMT will support ED with evaluation and an extended rollout of the THINK YELLOW project, then to be cascaded throughout the organisation.
- Datix to be streamlined to incorporate deconditioning as a harm.

3.3 Safety - To reduce the number of infections.

Aims for 2023/24

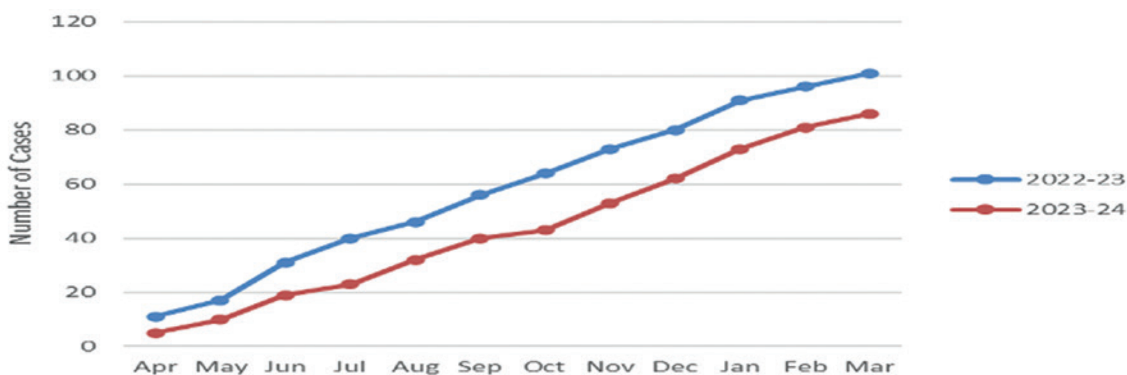
- To reduce the number of SFHFT acquired EColi blood stream infections.
- To meet our trajectories for MRSA and Pseudomonas.

Performance against this target

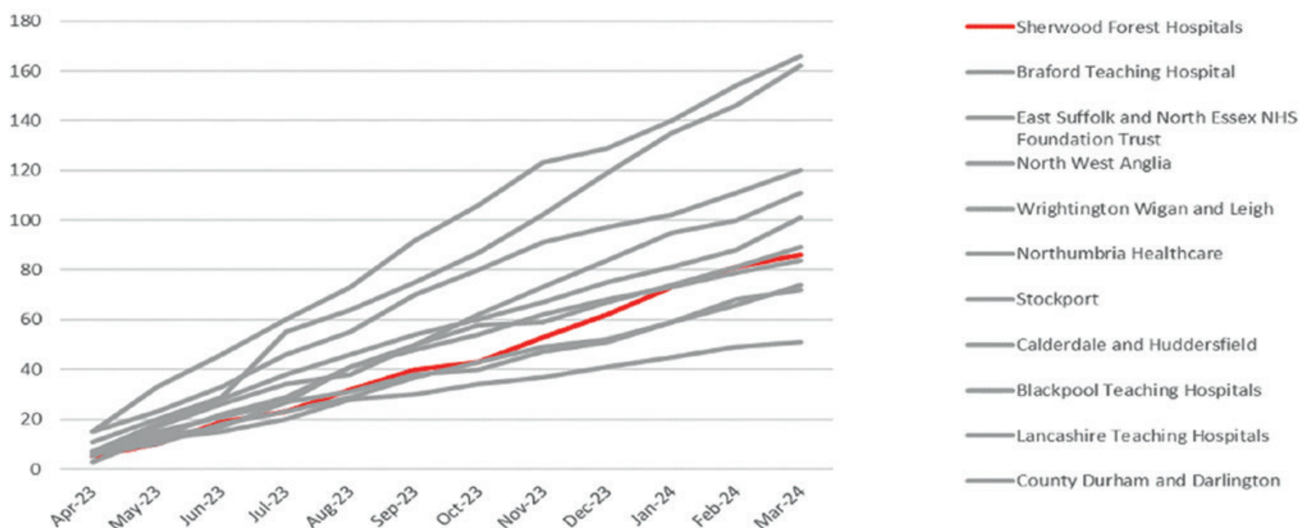
Below is a summary of the performance against the aims outlined above:

- Nationally there is a focus on the reduction of gram-negative blood stream infections (GNBSI). However there has been an increase nationally over the last year. The main causative organism is EColi. There was a national trajectory set for each organisation and the SFHFT target for 2023/24 was 86. SFHFT achieved this target by ending the year on 86. During 2023/24 there has been a decrease in the number of SFHFT associated cases compared with 2022/23, (Graph 12). Comparing our performance against that of our peer Trusts (Graph 13), shows that SFHFT sit in the top half of the group. Although this decrease in EColi bacteria has not replicated in the number of Catheter-Associated Urinary Tract Blood Steam Infections (CAUTI) we have seen as this has increased this year (Graph 15).

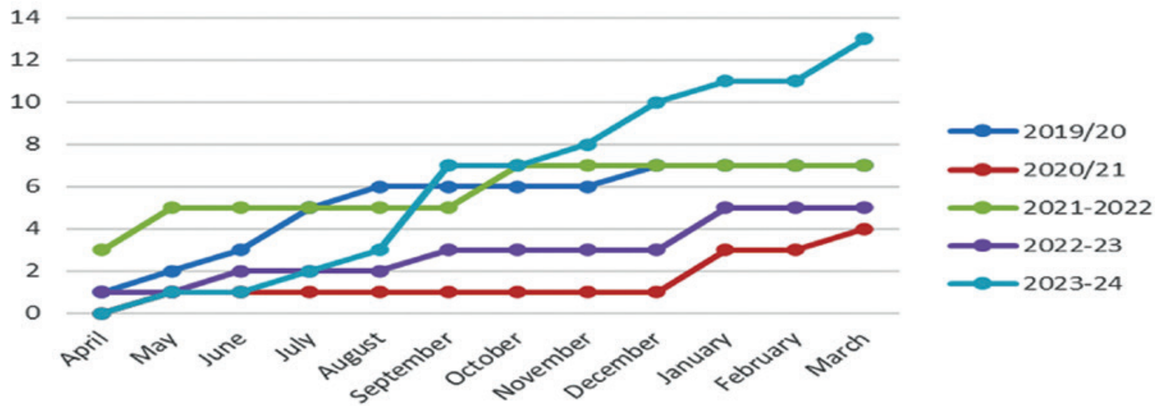
Graph 12: SFHFT cumulative total of hospital onset EColi cases



Graph 13: Cumulative total of hospital onset EColi cases against Peer Trusts

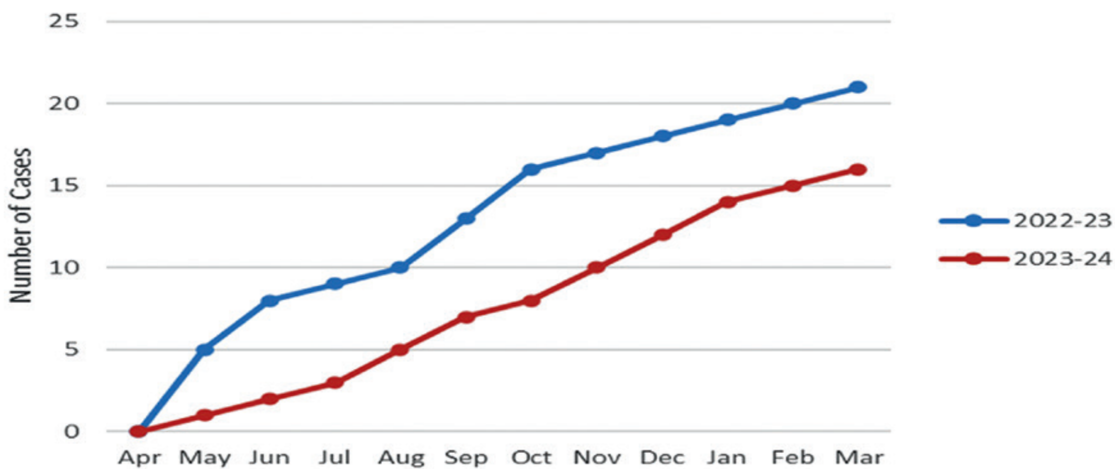


Graph 14: SFHFT cumulative total of hospital onset Catheter Associated Urinary Tract Infection BSI

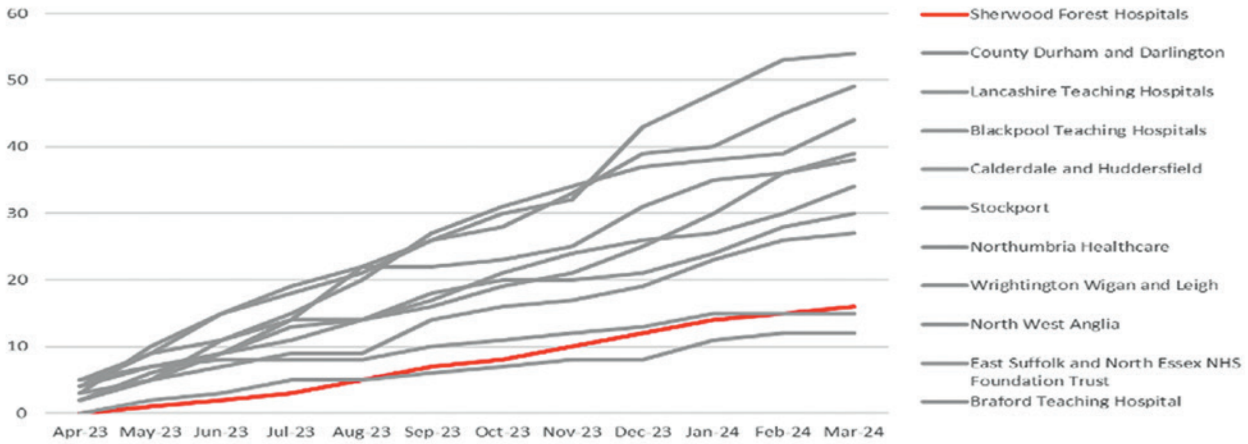


- The second gram negative trajectory is for all Klebsiella species blood stream infections and the SFHFT trajectory was 22. SFHFT achieved a total of 16 for the year, below target (Graph 15). Graph 16 shows our performance benchmarked against our peer Trusts and shows we are one of the best performing Trust.

Graph 15: SFHFT cumulative total of hospital onset Klebsiella cases

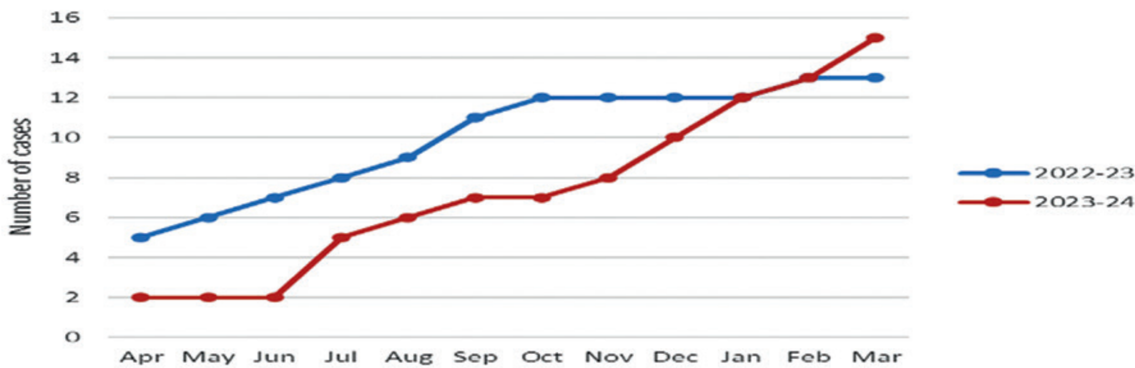


Graph 16: Cumulative total of hospital onset Klebsiella cases against Peer Trusts

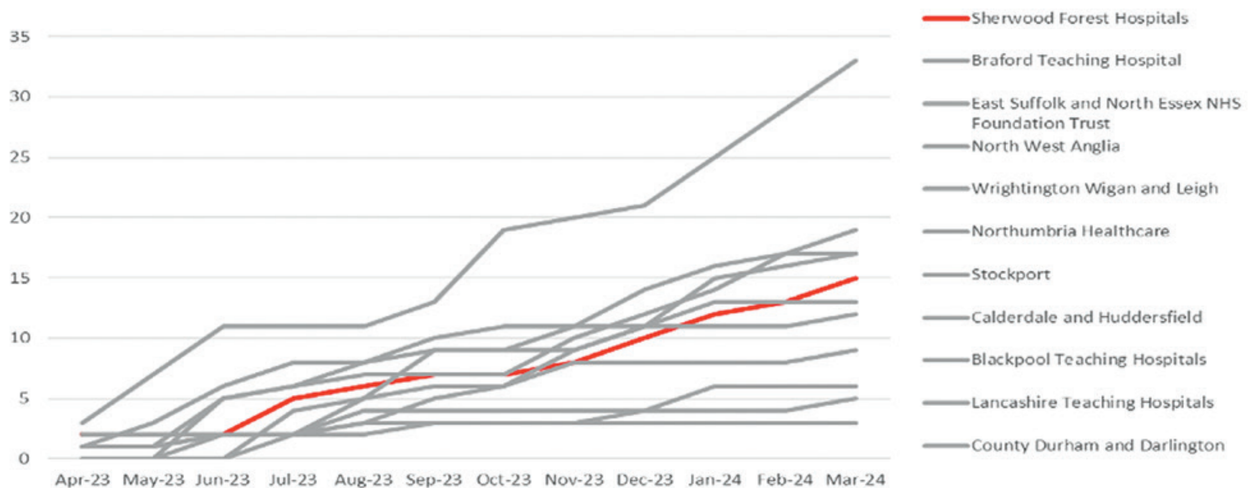


- The third gram negative trajectory is for all Pseudomonas aeruginosa blood stream infections and SFHFT Trust trajectory was 10. SFHFT breached this target with a total of 15 for the year, (Graph 17). Comparing our performance against that of our peer Trusts (Graph 18) shows that we are sitting in the top half of the group.

Graph 17: SFHFT cumulative total of hospital onset Pseudomonas Aeruginosa cases

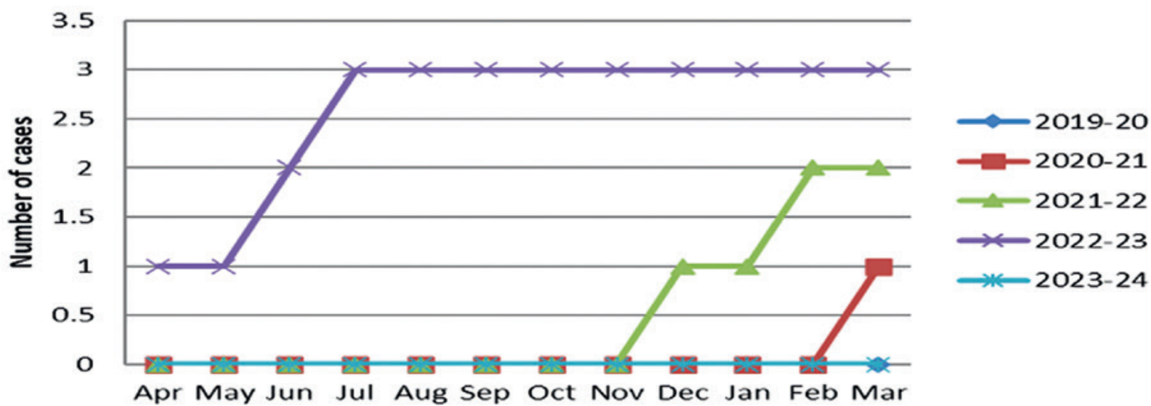


Graph 18: Cumulative total of hospital onset Pseudomonas Aeruginosa cases against Peer Trusts

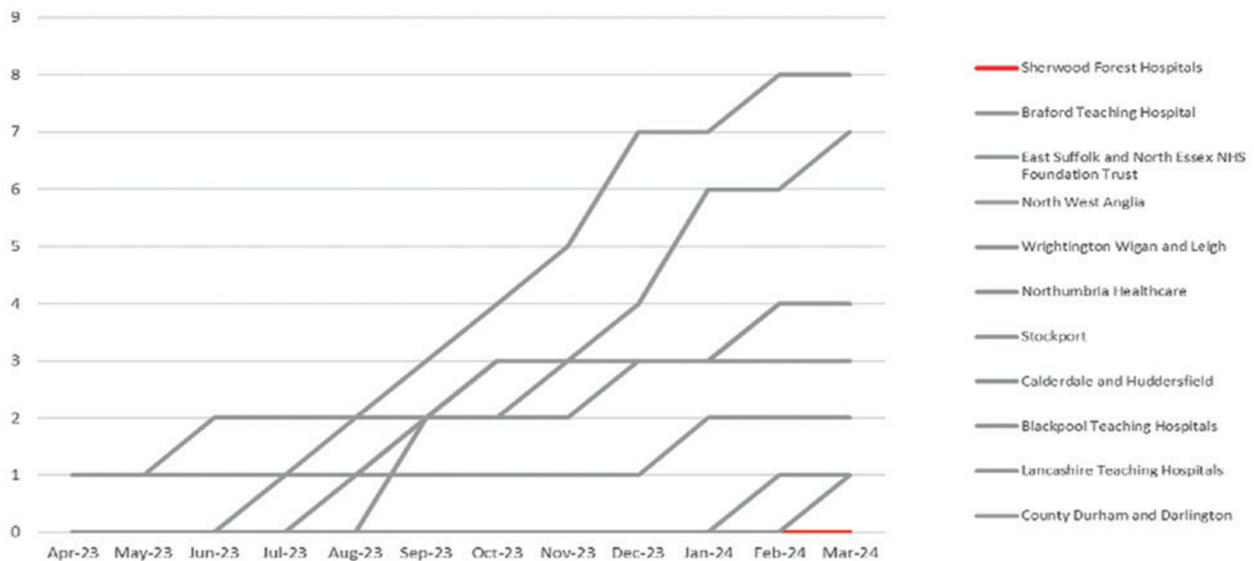


- As with all other NHS acute organisations, SFHFT target for MRSA blood stream infections was zero. SFHFT achieved this target with a total of 0 for the year, (Graph 19). SFHFT is one of 5 of our peer Trust who have achieved the target of 0 (Graph 20).
- We continue to monitor and report our MSSA blood stream infection cases nationally. There currently remains no trajectory set for this, SFHFT have identified 29 Trust associated cases in 2023/24, which is an improved picture on 2022/23 (Graph 21). Graph 22 shows our performance benchmarked against our peer Trusts and shows we are one of the best performing Trust.

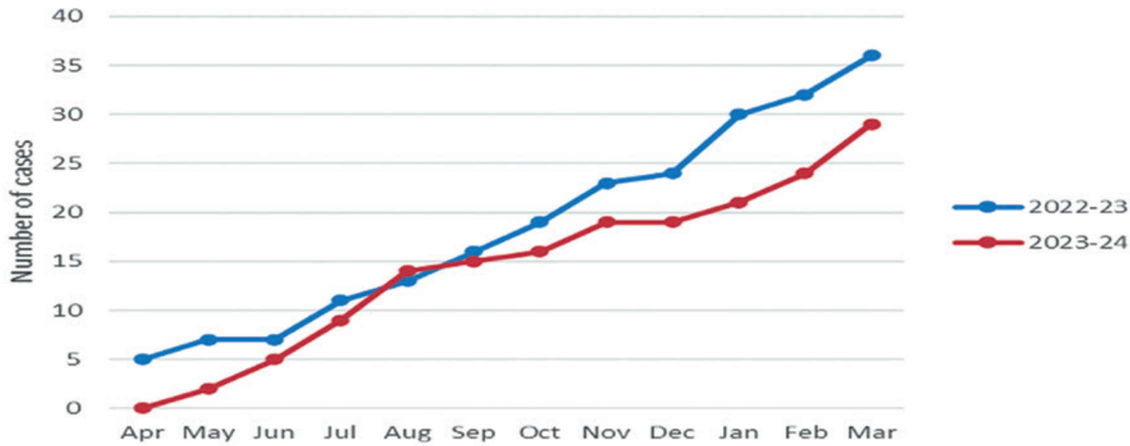
Graph 19: SFHFT cumulative total of hospital onset MRSA cases



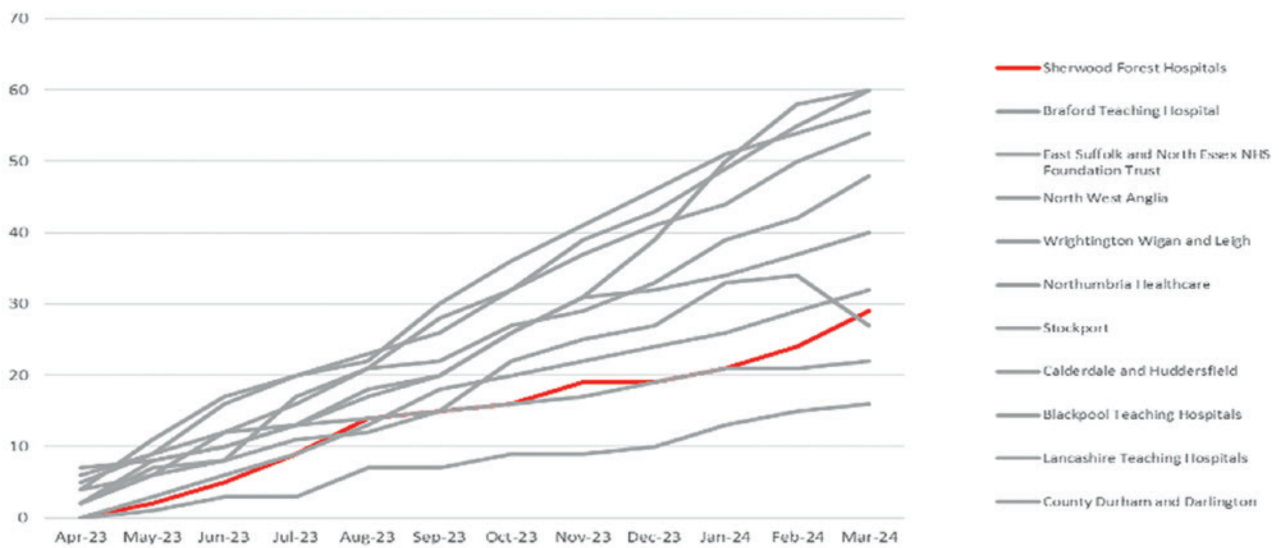
Graph 20: Cumulative total of hospital onset MRSA cases against Peer Trusts



Graph 21: Cumulative total of hospital onset Klebsiella cases against Peer Trusts



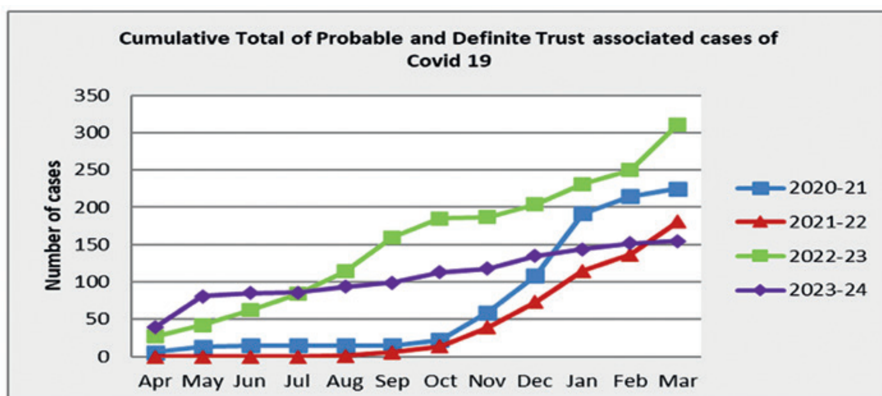
Graph 22: SFHFT cumulative total of hospital onset Pseudomonas Aeruginosa cases



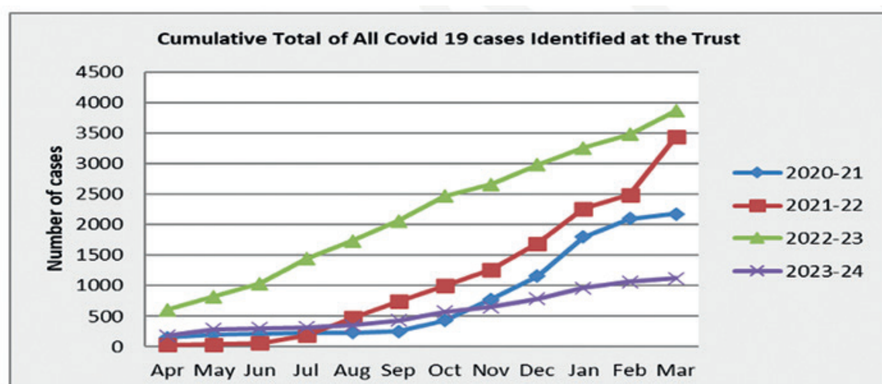
Covid-19

SFHFT have continued to comply with national guidance and made changes as required and been monitoring cases closely. During 2023/24, we identified the lowest number of Covid-19 cases, compared to the previous year, and in line with that, a lower number of probable and definite hospital associated cases as shown in Graphs 23 and 24.

Graph 23: SFHFT cumulative total of Trust apportioned Covid-19 cases



Graph 24: SFHFT cumulative total of all Covid-19 cases



Actions in place to reduce the number of hospital associated infection:

- A Root cause analysis has been completed for most cases.
- Re-introduction of the deep clean programme.
- Monthly campaigns and newsletters have been developed.
- Thematic reviews being undertaken of all above infections.
- Attendance at regular meetings with NHSE and UKHSA to monitor outbreak progress.

Monitoring and reporting for sustained improvement

- All elements identified above are monitored and reported externally by UKHSA and NHS England.
- Internal processes are also in place to monitor these infections and that is through our Infection Prevention and Control Committee and challenged via the SFHFT governance processes.

What do we aim to achieve in 2024/25?

- To continue to reduce the number of SFHFT acquired EColi blood stream infections.
- To implement new project workstreams related to urinary catheters.
- To implement new project work related to taking of blood cultures.
- To meet trajectories set for Pseudomonas.

3.4 Effectiveness – Improving the Effectiveness of Discharge Planning

Aims for 2023/24

- Full system access to Nervecentre for all partners
- To reduce the number of separate IT platforms used such as Orion and SystmOne with the ambition of one IT platform. This will give a real time account of the patients journey throughout SFHFT.
- To ensure or aim of a 95% daily discharge rate from the trust of patients that become safe for transfer.
- To reinvigorate the daily hub call, focussing away from discussing the same patients and refocusing on new patients and complex patients.
- For the Frailty intervention team (FIT) to focus on admission avoidance. To ensure that the frailty score (Rockwood clinical frailty scale) is completed on Nervecentre and identify that a raised score would indicate the need for further assessment.
- To progress from admission avoidance to hospital at home and virtual wards.

Performance against this Target

- Nervecentre is now accessed by all system partners via the transfer of Care Hub. The hub includes partners from Nottinghamshire Healthcare, Adult Social Care and several other care providers, including Age UK. Joint triage of patients within 48hrs of MSFT (Medically safe for transfer) date is completed as a group and therefore each patient record updated contemporaneously with all partners in the room.
- Different system partners still use their own IT systems and will continue to do so however the development of the Transfer of Care Hub has meant that this issue is considerably minimised.
- We continue to work on the number of medically safe patients within the trust, however, we are seeing improvements in discharge numbers each day.
- The hub call is no longer in existence and the Transfer of Care Hub has twice daily triage 6 days a week (excluding Sundays) This triage focuses on those referred to IDAT since the previous triage and a focus on those still awaiting a Package of Care (POC)
- Frailty recording is still completed on paper (CGA form) however is currently being transitioned on to Nervecentre and will merge with the Discharge to Assess paperwork when complete.
- Admission avoidance is still a focus however virtual wards now pull directly from acute wards and many patients are triaged within the hub and a decision made that their ongoing therapy care can be managed at home thus shortening their LOS.

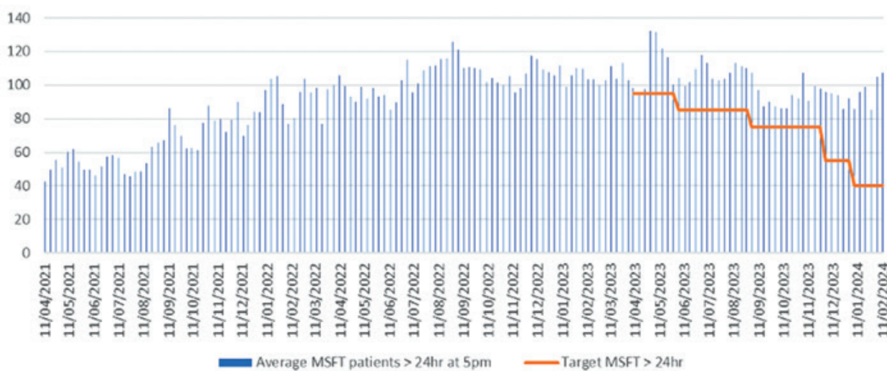
How was this achieved?

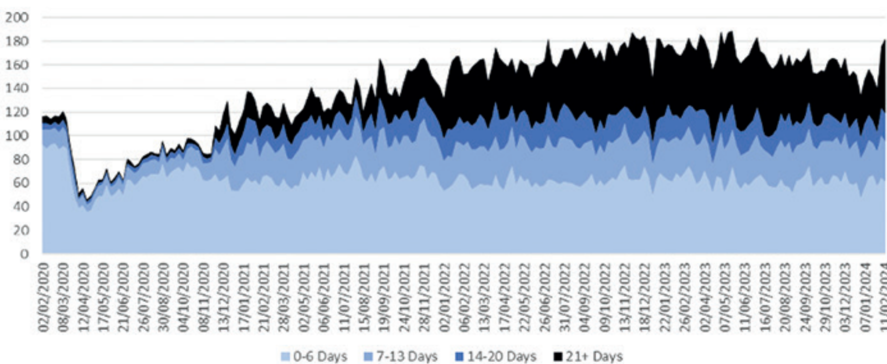
- Creation of the Transfer of Care Hub. Funding from the Integrated Care Board along with system partner collaboration has led to a well-functioning, multi-agency hub where we are able to swiftly triage, make decisions and allocate packages of care, community beds and residential placements either contemporaneously or shortly after decisions are made. Care bridging services also within the hub help to ensure that delays are minimised.
- Appointment of a Transfer of Care hub manager to coordinate triage and ensure decision making is objective and consistent.
- A focussed programme of work with the digital team to standardise paperwork and move paper forms to e-forms.
- Development of virtual wards, tracked via the Emergency Care Steering Group.
- A programme of focused work with the SFHFT digital team to identify weaknesses within current Nervecentre flows and develop improved and clearer pathways.

Monitoring and Reporting for Sustained Improvement

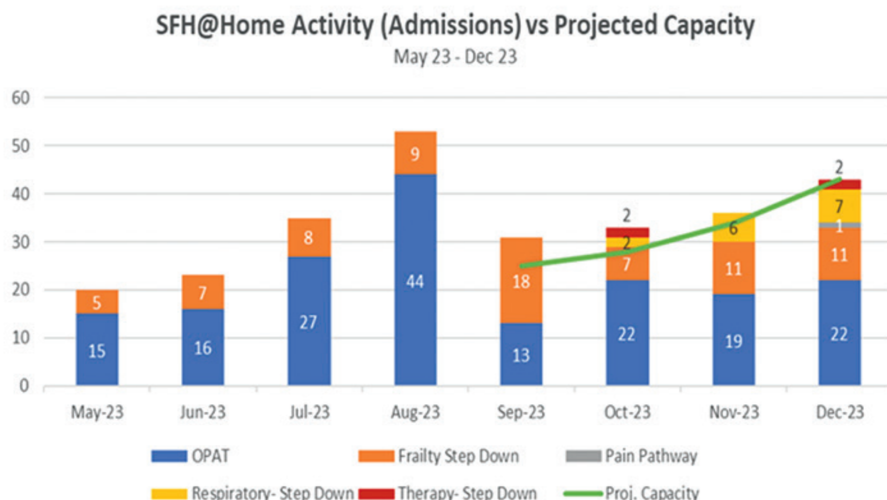
All metrics described above are tracked through the Emergency Care steering board. A sample of current metrics can be seen below.

LOS and MSFT





Virtual Ward activity and Impact



SFH@ Home Bed Days Saved

	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Total
OPAT	369	295	501	487	219	399	345	449	3064
Frailty Step Down	20	62	65	87	110	116	90	94	644
Pain Pathway								3	3
Respiratory Step Down							64	73	137
Therapy Step Down						5	0	8	13

Aims for 2024/25

1. Nervecentre – further development providing improved dashboards specifically 3 new ones for
   - Discharge teams.
   - Operational managers.
   - Delays in process which will negatively impact upon discharge.
2. Improved identification of patients requiring supported discharge earlier on in their patient journey leading to reduction in barriers to discharge and subsequently leading to shorter lengths of stay.
3. Further development of Virtual wards enabling more people to receive treatment at home rather than as an inpatient.
4. Reduction in MSFT by 5%.
5. Improved Board rounds focussing on Predicted Date Medically Safe (PDMS) dates and discharge plans.
6. Reduction in No. of 'abandoned discharges' because of transport and TTO issues.

3.5 Effectiveness – Improve the care and learning from Mortality Review

Aims for 2023/24

The focus for 2023/24 was the further development of mortality intelligence at service and divisional levels. The support from Dr Foster (Telstra) was to be reconfigured to work more closely with individual clinical teams, supporting them to understand where the mortality data fits into the care they deliver.

Performance against this Target

The Learning from Deaths Group continues to meet monthly to discuss and triangulate the external view of the Trust's mortality position and an increasing range of internal quantitative and qualitative measures.

A Learning from Deaths Report is prepared and presented to the Patient Safety Committee and then quarterly escalated to the Quality Committee. This is accompanied by a dashboard summarising high-level mortality metrics, performance and output from internal mortality management and learning processes. An additional bi-annual summary is provided directly to the board of Directors.

SFHFT are phasing out use of the Trust's own Mortality Review Tool (MRT) as the initial review process and will no longer report on its use. The MRT was developed to facilitate National Guidance on Learning from Deaths which pre-dated the introduction of the Medical Examiners (ME) Service. In 2023/24,100% of adult hospital deaths at SFHFT were independently scrutinised by the ME Service with engagement from the clinical teams in each case. Justification for this change was that the first stage of the MRT duplicated much of this work, and, after an interval of weeks, and in some cases many months, did not demonstrate added value.

The Royal College of Physician's Structured Judgment Review (SJR) methodology remains the preferred approach for capturing a more in-depth mortality review, (if indicated by these initial processes). Specialty and divisional arrangements for conducting reviews have slight variations dependent on differences in organisational structure. Paediatric deaths are also subject to external Child Death Review Processes.

SJR's were requested in 111 cases. This is 7% which is an improvement on 2022/2023 (4.5%). The new Datix IQ digital platform has been successfully implemented in the ME Office and Bereavement Centre as part of our development of the Mortality Review process and, we are able to monitor these SJRs in real time.

How was this achieved?

Progress on implementation of the remaining elements of the Mortality Review Process have been delayed by the functionality of the Datix Platform. Additional factors that impacted this include12 months of Doctors' industrial action, the roll out of the scrutiny of community deaths by the ME office, and prioritisation of deployment of other functions of the Datix platform, specifically the mandated requirement of implementing the Learning from Patient Safety Events interface. A change in the line management to include the datix team within the Governance support unit has been enacted and aims to enable progress. The mortality module is the next project planned. Despite these challenges, there has been an increase in clinical engagement and the appointment of several new Divisional mortality leads. To support this further we have renegotiated the provision of mortality data, data analytics and support from Telstra (Dr Foster) our external provider, to make this more accessible to divisions, specialties, Non-executive Directors and Governors.

Monitoring and Reporting for Sustained Improvement

We will continue to monitor the metrics described above through the Datix Platform analysing variations using statistical process control charts.

Following the next stages of implementation of the mortality review tool on Datix we will be able to monitor the progress and outputs of the SJRs digitally.

Additionally, we now have insight into the number of cases referred to and taken for further action by our local Coroners. This should enable quicker progress in identifying trends or individual cases of concern. We have utilised this to investigate a peak of referrals and provide assurance.

Aims for 2024/25

- Complete migration of the mortality review process onto Datix.
- Undertake a re-tendering process for mortality data and analytics provision to ensure that our evolving needs continue to by met and we are getting the best value for our patients.
- Review SFHFT being actively involved in arrangements for sharing learning across the Integrated Care System and Region particularly in the light of the implementation of Medical Examiner Scrutiny for community deaths.

3.6 Effectiveness – To improve the experience of patients who are coming to the end of their life.

Improving Palliative and End of Life Care (EoLC) remains a priority within SFHFT. We are committed to delivering outstanding, accessible, and equitable EoLC through the support and training of staff, in delivering honest and open communication, supporting patients' preferences and experiences, all underpinned by the best available evidence. SFHFT works in partnership with the ICB and the Mid-Nottinghamshire End of Life Care Together Alliance. The priorities and delivery of EoLC within SFHFT focus upon the 6 key Ambitions, outlined in the National Strategy (Ambitions for Palliative and End of Life Care: A National Framework for Action 2021 – 2026) and the Nottinghamshire EoLC Strategy, 2021. The 6 Ambitions are:

01 **Each person is seen as an individual**
I, and the people important to me, have opportunities to have honest, informed and timely conversations and to know that I might die soon. I am asked what matters most to me. Those who care for me know that and work with me to do what's possible.

02 **Each person gets fair access to care**
I live in a society where I get good end of life care regardless of who I am, where I live or the circumstances of my life.

03 **Maximising comfort and wellbeing**
My care is regularly reviewed and every effort is made for me to have the support, care and treatment that might be needed to help me to be as comfortable and as free from distress as possible.

04 **Care is coordinated**
I get the right help at the right time from the right people. I have a team around me who know my needs and my plans and work together to help me achieve them. I can always reach someone who will listen and respond at any time of the day or night.

05 **All staff are prepared to care**
Wherever I am, health and care staff bring empathy, skills and expertise and give me competent, confident and compassionate care.

06 **Each community is prepared to help**
I live in a community where everybody recognises that we all have a role to play in supporting each other in times of crisis and loss. People are ready, willing and confident to have conversations about living and dying well and to support each other in emotional and practical ways.

The General Palliative and End of Life Care Committee (GPEoLCC) is a multi-professional forum, which aims to lead and advise SFHFT in the provision of outstanding end of life and palliative care. It provides assurance that effective communication, co-ordination, and consistent practices are being maintained in relation to EoLC across the Trust. Meeting quarterly, it provides a forum for strategic and operational planning to drive forward effective EoLC service delivery within SFHFT.

Aims for 2023/24

- Substantive recruitment to EoLC Lead Nurse and EoLC Medical Lead roles
- AMBER Care Bundle Project – Enhancing Recognition of Dying
- Further enhancement of EoLC Champion role
- Introduction of Comfort Observations
- Introduction and monitoring of the EoLC Bereavement Survey
- Review of EoLC questions within Ward Metrics, with a proposal for the EoLC Team to undertake the auditing of these going forward.

Performance against this target and how was this achieved.

- Substantive recruitment to the EoLC Lead Nurse and EoLC Medical Lead positions.
- Following staff education, the EoLC Team has initiated safe testing of the Amber Care Bundle with 1 x Ward initially. Feedback and outcomes will be reviewed following completion then any adjustments made in advance of further roll out in the year ahead.
- Following review of the EoLC Champions network, a programme of quarterly Study Days was developed, Two have been delivered in Q4. This has included accredited SAGE & THYME® Foundation Level Communication training for Champions, enabling them to provide person-centred support. The study days were well attended and evaluated positively. Further Study Days are planned for 2024/25. An EoLC Champions e-learning package is near completion.
- The Comfort Observations module is an electronic assessment method that can be used to ensure staff are able to monitor a patient's comfort and symptoms in the final days of life, by promoting prompt review and timely intervention. Work is ongoing to add a Comfort Observations module into Nervecentre.
- The Trust Bereavement Survey was reviewed and updated to create a combined EoLC and Bereavement Survey and re-launched in June 2023.
- Results are shared GP&EoLCC. It was noted that Survey responses were less than anticipated; a review of the Survey distribution was performed, and processes amended accordingly. As a participant of the National Audit of Care at the End of Life (NACEL), SFHFT is considering how the Trust survey aligns to the National Survey. Discussions are planned on how to take forward the SFHFT Survey results in conjunction with NACEL Survey in 2025.
- The EoLC Team Clinical Nurse Specialists (CNSs) have routinely completed the Ward Metrics Audits for patients in the Last Days of Life. Audit results are provided monthly to the Nursing, Midwifery and Allied Health Professionals Committee to provide assurance of EoLC at SFHFT.

Monitoring and Reporting for Sustained Improvement

- Dedicated EoLC beds continue to be utilised within the Short Stay Unit (SSU).
- SFHFT continued to participate in the NACEL Audit. NACEL is a voluntary national comparative audit of the quality and outcomes of care experienced by the dying person and those important to them, during the last admission leading to death in acute hospitals, community hospitals and mental health inpatient providers in England and Wales. The NACEL Audit was paused in 2023 to allow for redesign of the Audit format. SFHFT contributed to the audit providing feedback on the proposed changes.

Table 10

NACEL Round 4 Summary Scores – 2022/23		
Audit Theme	**National Summary Score**	**SFH Summary Score**
Communication with the dying person	8.0	**8.4**
Communication with families and others	7.1	**7.6**
Involvement in decision making	9.2	**9.7**
Individualised plan of care	7.6	**8.8**
Needs of families and others	5.5	**6.6**
Families' and others' experience of care	6.3	**6.4**
Workforce/Specialist Palliative Care	8.1	**10**
Staff confidence	7.5	**7.9**
Staff support	7.1	**7.6**
Care and culture	7.6	**8.1**

The NACEL Audit re-commenced on 1st January 2024 and will be undertaken on a quarterly basis. Results of the audit are yet to be received and are expected bi-annually.

The EoLC Team continues to provide a wide range of education and training. The EoLC Team Clinical nurse specialists continue to provide bespoke EoLC education in a range of forums including visits to wards and clinics, drop in session and respond to bespoke requests.

- 11 additional EoLC Butterfly Volunteers were trained and continue to enhance the experience of patients identified in the last days of life. Feedback from patients, families/those important to them and staff has been overwhelmingly positive.
- In collaboration with the Community Involvement Hub, 3 x EoLC Comfort and Memory Making Trolleys have been developed and implemented across the Trust that include a variety of a variety of resources for patients and their relatives/those important to them, to utilise during the patient's last days of life and after their death.
- John Eastwood Hospice have extended their Bereavement Support Group scheme to relatives those important to patients, who die whilst in SFHFT. SFHFT continue to host Nottinghamshire Hospice Bereavement Counselling drop-in sessions at Mansfield Community Hospital site.

Aims for 2024/25

- Finalisation of the Specialist Palliative care in-reach provision to SFHFT service specification (provided by Nottinghamshire Healthcare NHS Trust).
- Expand rollout of the AMBER Care Bundle project Trust-wide (enhancing recognition of uncertain outcomes).
- Continue to deliver EoLC champion study days.
- Introduction of comfort observations on Nervecentre.
- Participation in the quarterly NACEL Audit, including the NACEL Bereavement Survey
- Complete review of the EoLC education plan.
- Create an EoLC team activity dashboard,
- Review and further develop the EoLC teamwork plan.

3.7 Patient Experience – Improve the experience of care for dementia patients and their carers.

SFHFT is committed to improving the service provided for people living with dementia, their families, and carers. The aim is the provision of an excellent service, facilitating the development of dementia care through a collaborative approach, ensuring a consistent and outstanding service throughout all areas of SFHFT. SFHFT are responsible for ensuring patients living with dementia receive the best standard of care that is equitable, accessible, and community-focused throughout the whole trajectory of the condition, from diagnosis to end-of-life.

SFHFT will continue to work towards maximising the potential of our workforce by continuously learning and adopting evidence-based practice, utilising information, and advancements in digital technology, and continue to be innovative and forward-thinking to the benefit patients and the local community.

Aims for 2023/24

- Shared governance will continue to be progressed and evolve.
- SFHFT have appointed one Admiral nurse and are in the process of appointing a second.
- The focus on identifying individuals with a confirmed diagnosis on digital systems will continue. A review of the necessary resources to achieve this will be required.
- As the Integrated Care Partnership's shared aim is to continue with the process off ensuring that all partner organisations provide Tier 1 dementia training for all employees. This will become an element of the pre-induction workbook for new staff joining the organisation. Addition negotiations are underway to facilitate a workforce agreement for ancillary staff to include the Skanska and Medirest teams.
- Delirium continues to have a significant impact on our patients, with dementia being a predisposing factor associated with this. 2023/24 will see the introduction of online delirium training for Medical, Nursing, Healthcare assistants and Allied Health Professionals. It will continue to be reported monthly and will be aligned with the awaited publication of the national dementia audit results.
- Continued collaboration and delivery of dementia, falls, and manual handling champion days.
- The Dementia Team will continue to support and promote the carers passport, working in collaboration with the patient experience Matron. A patient with dementia story, is scheduled to be presented at Trust board.

- The dementia specialist nurse will continue to have a presence on the carer's forum allowing staff to be able to seek help and advice regarding their own relatives.
- The dementia agenda and action plan will continue to be monitored and reviewed monthly and adjusted if the need arises.
- SFHFT are currently awaiting the results of the National Audit of Dementia, following its completion. The report is due for publication in August 2024 and the findings will generate an action plan should any shortfalls in dementia care be identified.

Performance against this Target.

- The Dementia shared governance council has gained further members from a diverse range of staff groups, all with individual experiences and insights to contribute. There remain staff groups and areas of SFHFT not represented recruitment of additional members to the council continues. Ideas have been developed, and work is progressing on further ideas of how to enhance the quality of patient stay.
- The decision was made to just recruit one Admiral Nurse and to collaborate with the existing dementia specialist nurse and support worker. The newly appointed Admiral Nurse commenced work at the organisation in January 2024, in which their service will be reviewed and evaluated throughout the year to monitor its value to dementia care within the organisation.
- The process of adding patients' dementia diagnosis to our electronic systems remains challenging. Liaising with community partners, work is underway to utilise the 'Patient Knows Best' platform to ensure that all patient information, particularly dementia diagnosis, are consolidated within one system.
- Training continues to be a priority at SFHFT. 2023-24 saw significant changes to the orientation and induction programme, resulting in Tier 1 Dementia Training becoming an optional workbook to all new starters. The aim is to ensure that all hospital staff, including our ancillary colleagues, receive a minimum level of Tier 1 Dementia training as standard. Compliance has declined this year and has been reported as part of the National Audit of Dementia figures. Plans to improve this have already commenced.
- Changes made to dementia training hindered the planned progress of training related to delirium. Proposals are to integrate delirium and dementia training as a mandatory requirement.
- As a result of poor uptake for the falls, dementia, and manual handling training days were cancelled. It has since been established that the requirements and needs differ and it has been agreed that manual handling will runs separately to falls and dementia in the future. Dates are planned for 2025 and uptake has already increased.
- The patient story was well received by both the Trust Executive Board and the Council of Governor's Committee. The Carer's Passport highlighted in the story, continues to be monitored and promoted by the team and remains an integral part of our workload commitments. The 5th Round results for the National Audit of Dementia arrived after we had completed the data collection for the 6th round. A key area that required improvement was carer feedback. In response, we have liaised closely with the Patient Experience Team and formulated a dementia specific friends and family questionnaire. This will be in the form of a QR code and support will be offered by the team to aid completion of the questionnaire.
- The dementia plan has been reviewed monthly and continually evolves, responding to the demands of the service and support development.

How was this achieved?

The Dementia Team constantly strives to improve standards of care and plans are regularly updated and adapted to respond to the needs of the service. A work plan is reviewed and updated by the Dementia Matron and team. Monthly reporting is presented at COEC, demonstrating developments, and identifying any areas of concern. This forum allows the discussion and collaboration of the wider MDT and has supported progress so far.

Monitoring and Reporting for Sustained Improvement

The Matron works closely with all team members and has established regular meetings to monitor progress and provide support and guidance.

SFHFT continues to report on the compliance achieved regarding dementia screening via the Patient Safety Committee. When reporting against the national target was mandatory, SFHFT achieved 90%. This has decreased to 85% but has been agreed as an acceptable level, however, this is under constant monitoring and review to ensure this does not drop further.

Dementia and Delirium continue be an essential element of the COEC. A report is produced and discussed during the monthly meeting and escalations are taken to the Nursing, Midwifery and AHP committee and Quality committee as appropriate.

The Dementia Team's Shared Governance Council continues to develop, with increasing numbers of attendees joining the forum. Progress identified is recognised and support given to identify further opportunities or issues to escalate.

Aims for 2024/25

- Admiral Nurse to launch the referral service by 8th April 2024. A standard operating policy for referral is being developed with the support from Dementia UK.
- The Dementia Team will collaborate and identify workstreams for all its members, producing a document that clarifies and identifies areas of responsibility.
- Emphasis on the collaboration with key stakeholders, including EoLC and FMT specialist teams, to further enhance the quality of dementia care and training within SFHFT, including champion days and awareness days/weeks.
- A revision of the training provision, ensuring Tier 1 Dementia Training is a mandatory requirement and will include all hospitals staff, including our ancillary colleagues.
- Embed a culture of dementia visibility in line with the 'Well Pathway for Dementia', ensuring all wards and departments are aware of the support offered by the team to patients, families, and staff.
- The Admiral Nurse will focus on the Carer's Passport campaign, with the aid of the dementia support worker, to provide information to all appropriate unpaid carers, aiming to enhance the quality of the patient stay, individualised care planning and support a reduction in the length of in-patient stay.
- Delirium training packages will be developed with an emphasis on recognising and treating delirium.
- The dementia team with continue to develop the shared governance council, supporting staff to deliver outstanding dementia care at SFHFT.

- The Dementia Strategy 2024-2027 will be developed to define the culture and future of dementia care within SFHFT. This strategy will set out a positive, shared vision for dementia, aligning to key objectives of the National Dementia Strategy and the Prime Ministers Challenge on Dementia (2020), recognising the vision to transform dementia services.
- Collaboration with an external company to develop an enhanced dementia training package for staff directly involved with dementia patients. This will be the legacy of a donation gratefully received of a financial gift by a dementia patients' family and will complement the plans to develop a Tier 2 training package, available initially for all dementia champions.

3.8 Patient Experience – Using Feedback from patients and their carers. Friends and Family Test (FFT) themes and trends

The Friends and family test (FFT) is an important feedback tool that supports the fundamental principle that, people using NHS services should have the opportunity to provide feedback on their experience.

Every patient receiving treatment within SFHFT can provide feedback about the quality of care they have received. This enables the views of patients and their families to be heard, helping us to continuously improve our services and share evidence of good practice. Most patients rate their experience highly at SFHFT. However, we also want to know where we have not met expectations so that we can make improvements. FFT feedback is one of our best tools for understanding where we are doing well or where we could do better.

We use FFT feedback in conjunction with compliments, concerns, complaints, and the National Survey Programme, to understand what matters most to our patients and family members. There are several ways our patients can provide FFT feedback:

- Online questionnaire via the SFH website
- Text message
- QR Code
- Paper survey

Aims during 2023/24:

- Increase engagement with patient families and carer's, to continue FFT and support divisional teams to deliver FFT locally, resulting in increased recommendation rates.
- Introduce feedback events and be visible in in-patient areas to support the improvement of quantitative and qualitative data collection.
- Develop a plan to expand the QR access and implement across the Trust to support and improve the recommendation rates.
- Complete a package of e-learning for staff to access in relation to the system provider for FFT, ensuring divisions use this to its full potential aiding improvements across the Trust.

Performance against target.

- We have increased engagement with patient families and carer's, to continue supporting FFT and the divisional teams to deliver FFT locally, resulting in further increased recommendation rates.
- We introduced our first face to face feedback event, at the CDC launch event, collating live feedback from patients using the new services.

- One of our newly recruited Patient Safety Partners, (PSP) also supported the CDC launch. The PSP provided observations on the service, environment and what is feels like to be a patient, reporting back to the service lead, mayor, and the Trusts Chief Executive.
- Our Patient Experience Involvement and Engagement Officer, continues to be visible in in-patient areas to support the improvement of quantitative and qualitative data collection and help to drive forward key involvement and engagements.
- We have recruited four PSP's, who have all been involved in the launch of PSIRF, are involved data collection, attending key safety meetings and who are looking at other areas of interest.
- We have delivered a significant amount of training to staff across the Trust to enable them to access up to date feedback around the FFT service and to enable the teams to make local improvements.
- We continue to receive support from the volunteer services with both the collection and inputting of our FFT results, allowing continued engagement with patients, families, and carers.
- QR codes are continuing to be reviewed for use in all areas for FFT and is being utilised for other satisfaction surveys.

Results demonstrate a fluctuation in response rates, (table 11) and our newly recruited Patient Experience Engagement and Involvement officer, has worked closely with divisions to develop and support action plans to increase response rates and to provide an increase in qualitative data to help shape future services.

Table 11: FFT data April 2023 – January 2024

	Recommendation Rate %									
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
Inpatients	93.13%	92.83%	94.10%	94.31%	94.82%	95.50%	94.49%	90.45%	93.24%	92.89%
Emergency/Urgent care	90.09%	86.82%	84.48%	86.99%	91.30%	85.59%	87.56%	83.94%	83.07%	82.85%
Outpatients	94.68%	94.83%	94.46%	95.84%	94.68%	94.22%	93.91%	94.91%	94.72%	94.94%
Maternity	97%	97%	91.20%	88%	85.50%	75%	82%	93%	79%	83.75%

The FFT feedback is triangulated with the 15 Steps Challenge, compliments, concerns, complaints and shared with all divisions for learning and reflection, sharing of both positive practices, and to focus on areas of improvement.

The following responses are examples of FFT feedback during 2023/24:

> *Everything was quick, saw three people and everything so efficient.*

> *All staff friendly and helpful.*

> *It was professional and on time.*

> *Excellent service.*

> *Everyone courteous, punctual, attentive, and very thorough explanations and relevant leaflets provided.*

Aims for 2024/25

- Working alongside our Involvement and Engagement Officer, PSP's and volunteers to increase engagement with families and communities.
- Look at developing further face to face engagement sessions with patients' families and the local communities, aligned with improvements and the FFT programme.
- Develop new training packages to incorporate the FFT relevance and importance, allowing shared learning not only for improvements but the positive elements also.
- Engage with the communication teams to share FFT findings through digital media outlets in a Trust wide and public approach.

3.9 Patient Experience – Safeguarding vulnerable people.

Throughout 2023/2024 the adult and children safeguarding teams continued to align and coordinate activity across the team using the Think Family approach to safeguarding, whilst also taking into consideration the local and national safeguarding agenda. The team work closely with the wider external and internal multi-agency partners and includes a hospital independent domestic abuse advisor, enabling us to provide direct support to survivors of domestic abuse at the point of disclosure.

Our priority is to understand any safeguarding risk factors for patients and their families and refer them to the appropriate agencies for ongoing support and intervention. We continue to advocate for those patients throughout their stay at SFHFT, often coordinating and liaising with family members and other professionals to ensure the best outcomes are achieved.

The SFHFT Safeguarding Committee continues to monitor and provide assurance to the board via the Patient Safety and Quality Committees regarding the safeguarding teams ongoing activity around their individual work streams, in line with the Trusts statutory obligations as defined in the Children Act 1989/2004 and The Care Act 2014. The Head of Safeguarding represents SFHFT at both the Nottinghamshire Safeguarding Adult Board (NSAB) and Nottinghamshire Safeguarding Children's Partnership (NSCP) and is also a member of the e ICS Safeguarding and Public Protection Assurance Group.

Aims for 2023/24

The aim for 2023/24 was to ensure safeguarding remained a priority within our care and service delivery, maintaining system safety processes. We built on established work and strengthened our approach by aligning with the SFHFT strategic objectives below:

To provide outstanding care.

- Review the 'Think Family' audit plan for 2023/24, to focus on benchmarking safeguarding standards set out in the Markers of Good Practice and Partner Assurance Tool (PAT) and be responsive to the priorities as set out by the NSAB and NSCP.
- Review and update safeguarding team workplans to ensure they reflect NSAB / NSCP priorities.
- Review and update safeguarding strategies and key performance indicators.
- Continue to monitor safeguarding training compliance.
- Work to further develop the Mental Capacity Act workstream and DoLS database.
- To embed delivery of the Mental Health Strategic Plan
- Review of restrictive practice service and development of robust service delivery plan.

To Promote and support health and wellbeing.

- To agree the strategic priorities around the Domestic Violence workstream
- To enhance the personalisation of care to patients with a Learning Disability

To continually learn and improve to achieve better value.

- Continue to embed organisational learning through mandatory training, serious incidents, and adult / child reviews.

Performance against this Target

Safeguarding has remained a key focus of SFHFT throughout 2023/24. We have continued to work with external partners through representation at safeguarding board and partnership events and participation in local and national safeguarding reviews with learning being embedded into mandatory training.

Assurance processes have been reviewed with clear key performance indicators, audit and work plans established aligning to the local board and partnership priorities. Safeguarding training continues to be delivered through the trust mandatory training programme which has seen compliance increase across all levels of training. Compliance is monitored through divisional governance and Safeguarding Committee.

SFHFT has a newly formed Mental Capacity Act (MCA) Steering group whose focus is on improving the trust legislative compliance surrounding MCA and Deprivation of Liberty Safeguarding (DoLS).

During 2023/24 the SFHFT restrictive practice team was added to the safeguarding team portfolio. The restrictive practice service was reviewed and redesigned into a wider focusing violence reduction team, incorporating restraint reduction, security management and violence reduction. The wider safeguarding team also consists of a Mental Health Specialist Nurse and Learning Disability Team, both of which have been focusing their work on benchmarking and improving service delivery.

How was this achieved?

- Review of current assurance processes ensuring these align with local and national safeguarding standards and that these are reflected in workplans.
- Development of a safeguarding dashboard with clear key performance indicators
- Training reviewed, and compliance monitored and reported through divisional governance meetings and safeguarding committee.
- MCA steering group established chaired by the Named Doctor for safeguarding adults.
- Service review focusing on restrictive practice.
- Safeguarding representation at all divisional governance groups to ensure safeguarding remains a key focus for services.
- Safeguarding named nurses have continued input to external local, regional, and national forums to ensure that current themes/trends, best practice and learning is shared.

Monitoring and Reporting for Sustained Improvement

- The safeguarding team will continue to provide quarterly reports with key information to provide assurance that SFHFT are meeting its statutory responsibilities.
- Input into divisional governance meetings will continue.
- Workplans will be regularly reviewed and performance against these reported through safeguarding governance processes.

Aims for 2024/25

- Whilst we have seen safeguarding training compliance increase over the last year during 2024/25 there will be a focus on reviewing safeguarding training, its effectiveness and impact. Ensuring it continues to meet the necessary standards but that what is learnt is being translated into practice.
- Implementation of the new trust audit programme.
- Continued focus on MCA legislative compliance.

- Further service reviews to be undertaken around Learning Disabilities and Mental Health.
- Development of service delivery plans and KPIs for the newly formed Violence Reduction Service, aligning to national standards.

National Learning Disability Improvements Standards

SFHFT has a specialist Learning Disability team, this is a small team with a Specialist Lead Nurse and a Complex Care Nurse whose role is to provide support in relation to adults with Learning Disabilities. The Team sits within the wider safeguarding and vulnerability team and is strategically led by the Head of Safeguarding.

Each year SFHFT submits a response to NHSi in relation to the National Learning Disability (LD) improvement standards. In 2023 in addition to providing quantitative data we were able to report that: -

- SFHFT demonstrates they have made reasonable adjustments to care pathways to ensure people with learning disabilities, autism, or both, can access highly personalised care and achieve equality of outcomes.
- We have processes to investigate the death of a person with learning disabilities, autism, or both, while using our services, and to learn lessons from the findings of these investigations.
- We demonstrate that we vigilantly monitor any restrictions or deprivations of liberty associated with the delivery of care and treatment to people with learning disabilities, autism, or both.
- SFHFT can demonstrate they empower people with learning disabilities, autism or both, and their families and carers to exercise their rights.
- Staff are being trained and then routinely updated in how to deliver care to people with learning disabilities, autism, or both, who use our services, in a way that takes account of their rights, unique needs and health vulnerabilities; adjustments to how services are delivered are tailored to each person's individual needs.
- We ensure staff have the specialist knowledge and skills to meet the unique needs of people with learning disabilities, autism, or both, who access and use our services, as well as those who support them.
- SFHFT have accredited trainers able to provide training to staff in restraint techniques in line with the 'restraint reduction network' training standards.
- SFHFT are represented on the local Learning Disability Mortality Review Programme (LeDeR) steering group.
- The LD team review the plans for DNACPR for adult inpatients with an LD where appropriate and discuss with clinicians where documentation is not complete or if there are concerns regarding the decision-making process.
- SFHFT has a board level lead (Chief Nurse), responsible for monitoring and assuring the quality of service being provided to children, young people and adults with a learning disability and/or autistic people.
- SFHFT uses Learning disability care plans for all patients admitted to the organisation with a diagnosed learning disability.
- The LD Team has a flagging system in place to ensure all patients identified as having a learning disability, are flagged on all hospital systems which ensures all staff are aware someone has a diagnosed LD but also so that they LD team are notified when a patient with a flag is admitted.

Priorities in 2024-25:

- Undertake a full-service review and look at how we extend the current LD service in order that the service it offers to adults with a learning disability, can be replicated to offer an equitable service to adults who are autistic.
- The first wave of the Oliver McGowan Mandatory Training (OMMT) in Learning Disabilities & Autism will be implemented.
- The SFHFT Learning Disability strategy will be review and updated.
- Further develop the patient flagging system
- Develop a trust action plan for Learning Disabilities including actions identified following previous rounds of benchmarking against the Improvement Standards.

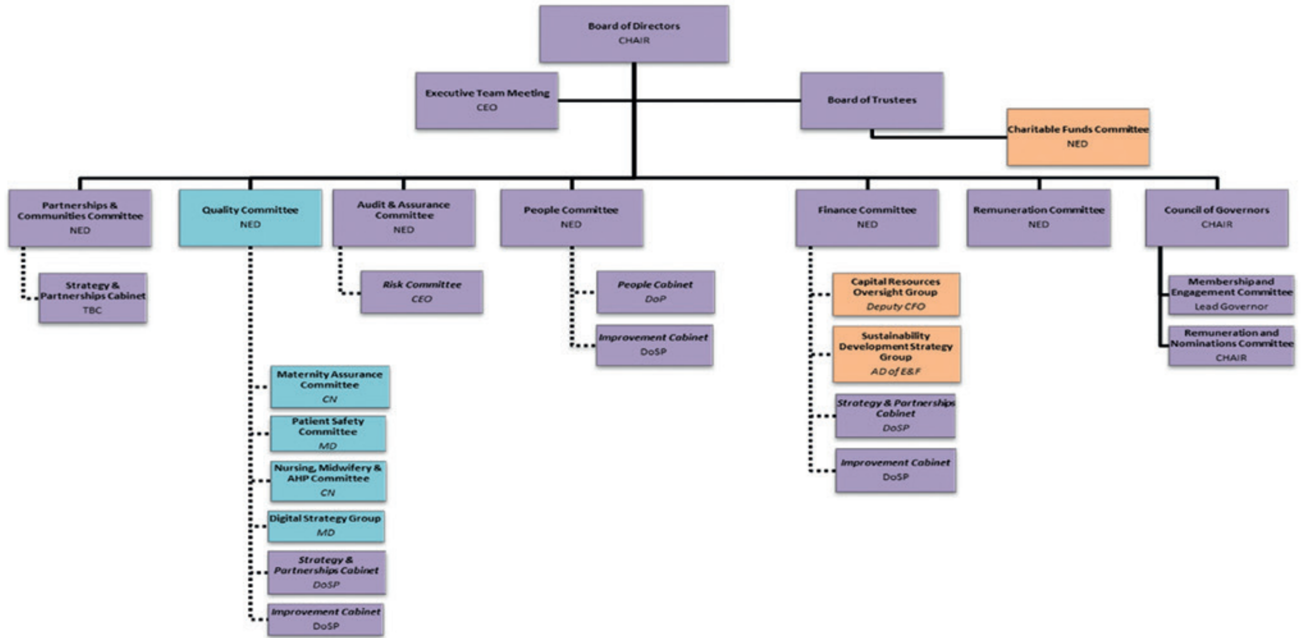
3.10 Mandatory Key Performance indicators

Indicators identified within the Single Oversight Framework for November 2022	Target	Performance	Performance
		Yr2022/23 Apr '22-Mar '23	Yr2023/2024 Apr '23-Mar '24
*Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – Patients on an incomplete pathway	92%	69.2%	61.14%
*A&E: maximum waiting time of four hours for arrival to admission / transfer / discharge	>95%	75.6%	70.92%
Cancer 2 week wait: all cancers	93%	84.1%	93.4%
Cancer 2 week wait: breast symptomatic	93%	94.3%	93.6%
Cancer 31 day wait: from diagnosis to first treatment	96%	88.2%	81.4%
Cancer 31 day wait: for subsequent treatment – surgery	94%	88.2%	89.1%
Cancer 31 day wait: for subsequent treatment – drugs	98%	92.4%	97.1%
Cancer 62 day wait: urgent GP referral to treatment for suspected cancer	85%	63.6%	65.1%
Cancer 62 day wait: for first treatment – NHS cancer screening service referral	90%	83.7%	52.9%
Maximum 6-Week wait for diagnostic procedures	99%	69.4%	70.46%
Clostridium difficile variance from plan	57	39	37
VTE Risk assessment (2022/2023 not comparable due to different data source, definition, and methodology)	95%	97.7%	94.6%
**Summary Hospital-level Mortality Indicator (SHMI)	100	102.73 (Sep'21-Aug'22)	109.04 (Dec 22-Nov 23)

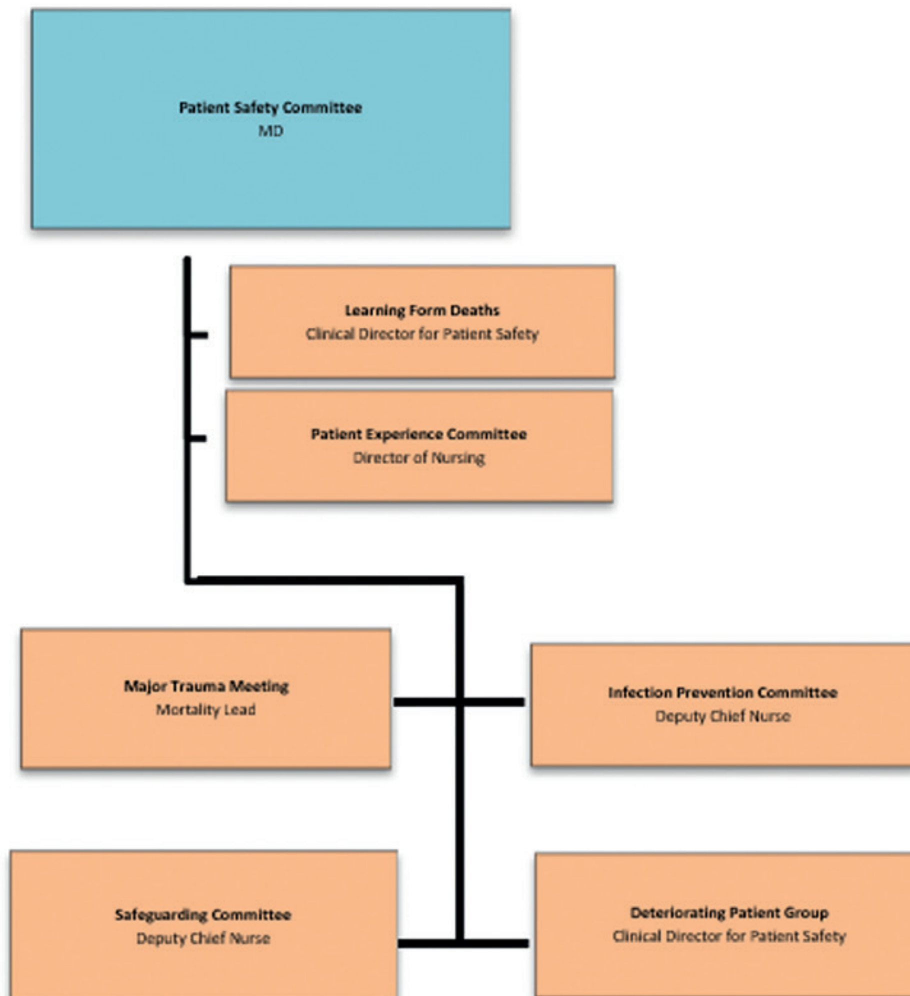
** The Summary Hospital-level Mortality Indicator (SHMI) is a rolling reporting period. The figures reported represent most current data available:

98.09 September-20 – August-21
102.73 September-21 – August-22

Appendix 1 Sherwood Forest NHS Foundation Trust Committee structure – 2023/2024



Appendix 2 Sherwood Forest NHS Foundation Trust Quality & Safety structure – 2023/2024



Sherwood Forest Hospitals (SFHFT) Quality Account 2023-24 NNICB Corroborative Statement

Introduction

1.1 In July 2022 the Integrated Care Board was established in line with the Health and Social Care Act. As such, Nottingham & Nottinghamshire ICB (NNICB) has a statutory duty to secure continuous improvement in the quality of services; and in the outcomes for people using those services. The first year of the NNICB has coincided with an exceptionally demanding system landscape with ongoing recovery from the Covid pandemic and additional challenges of clinical demand and industrial action which continued through 2023.

1.2 NNICB has continued to work with Sherwood Forest Hospitals Foundation Trust in pursuit of the monitoring and continuous improvement of services during 2023/24, in accordance with the statutory functions of the ICB described above.

1.3 The intention for 2023/24 was for NNICB and the Trust to continue fostering and developing collaborative and systems-based working, and this statement provides a reflection of progress.

Quality Visits

2.1 There have been multiple visits, meetings, and touchpoints with SFHFT during 23/24. SFHFT has continued to develop services across the system including the ongoing development of the Mansfield Community Diagnostics Centre (CDC).

2.2 Frequent peer review visits have been undertaken to facilitate insight and a supportive approach. Services have been responsive to local need, focusing on reducing waiting times and widening access. This has been supported by the ongoing work in developing the patient safety strategy framework of insight, involvement, and improvement.

2.3 A transparent and open approach to visits and collaborative working has been seen. NNICB involvement activities have shown the pride that staff have in their services and the care they provide. This is reflected in the National Staff Survey results.

3. Working as system partners

3.1 There has been engagement in system groups including shared learning during the development phase of the Patient Safety Incident Response Framework (PSIRF) with other providers. The Trust has membership to several shared system groups including the Partner Quality Assurance & Improvement Group (PQAIG); and the over-arching System Quality Group. SFHFT are also key contributors to the Local Maternal and Neonatal System Workstreams and committed to continuous improvement in this space.

3.2 Tackling inequality and supporting recovery plans across the system is clearly a key driver to the development of services. Multiple research and audits activities have clearly demonstrated the focus on continued improvements across the system. This involves the ongoing work with the CDC and development of increased theatre space at Newark Hospital. Close links and involvement of patient groups and communities in the development of services has supported this.

3.3 SFHFT have engaged with and supported the development of the local quality schedules and the provision to support improved system insight and information sharing to support focused improvement activity.

4. Looking forward to 24/25

4.1 SFHFT have moved at pace with their adoption of the Patient Safety Incident Response Framework. This work has been strengthened through ensuring the adoption of a just culture for patients and staff. Oversight governance continues to develop thematic areas for focused improvement activity.

4.2 Collaboration with system partners in the development of multiple improvement plans remain a key focus for SFHFT. Priorities have been developed to consider and respond to population need across the continuum of patient needs.

4.3 Consistent development of the digital infrastructure aims to support and improve the insight and efficiencies of patient pathways. This is underpinned by a clear drive within education and staff involvement and development opportunities.

[1] https://www.legislation.gov.uk/ukpga/2022/31/part/1/crossheading/integrated-care-boards-functions/enacted

[2] https://www.england.nhs.uk/patient-safety/incident-response-framework/

Statement from the Health Scrutiny Committee on Sherwood Forest Hospitals NHS Foundation Trust Quality Account

The Health Scrutiny Committee for Nottinghamshire welcomes this Quality Account and the opportunity to comment on it.

The committee fully supports Sherwood Forest Hospitals NHS Foundation Trust's commitment to provide patient safety, clinical effectiveness and quality care. We fully support the work of the Improvement Faculty which we hope will make improvements to both the long term and short term priorities and challenges. We hope the Continuous Quality Improvement Strategy (CQIS) which is currently being launched also helps strengthen the continuous improvement and outcomes for the population.

The committee fully support the three improvement priorities to demonstrate the commitment to outstanding patient focussed care. We understand the focus on maternity services, ensuring babies have the best possible start in life through making sure the actions from the CQC report are actioned. The meal time volunteer programme pilot and the volunteering opportunities will help ensure patients nutrition needs are met. The Improvement ambassador award will also help to inspire further improvements.

The committee note that SFHFT participated in 95% of national clinical audits and 100% of national confidential enquiries which it was eligible to participate in.

The committee note the continued joint research project with Trent University 'Research Communities of Practice' and supports the work towards SFHFT being a regional centre for Nursing, Midwifery and Allied Health Professionals research.

The committee note there has been no CQC enforcement actions and so the overall rating remains as 'outstanding'. The committee also note the results of the National Staff Survey which placed SFHFT 1st in the Midlands and Nationally for staff engagement and morale.

The committee look forward to engaging more with SFHFT and will continue to scrutinise, as we always have done and look forward to them returning to the committee.

Cllr Roger Jackson, Chairman of Nottinghamshire Health Scrutiny committee

Cllr Bethan Eddy, Vice Chair of Nottinghamshire Health Scrutiny committee

Statement from Healthwatch

The Quality Account has been offered to Healthwatch for comment in line with requirements of NHSE. Due to the additional roles and capacity requirements of Healthwatch within the new Integrated Care System, the Healthwatch team have declined to provide a statement for the SFHFT Quality accounts this year.

Annex 2 - Statement of Directors responsibilities for the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

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

- The content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2022/23 and supporting guidance.
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
  1. Board minutes and papers for the period April 2023 to March 2024
  2. Papers relating to quality reported to board over the period April 2023 to March 2024
  3. Feedback from commissioners dated 19 June 2024
  4. Feedback from local Healthwatch organisation dated – not submitted, see annex 1
  5. Feedback from Overview and Scrutiny Committee 12 June 2024
  6. The Trust's complaints report published under regulation 18 of the Local Authority Social and Complaints Regulations 2009,
  7. The 2023 survey was published in March 2024
  8. The 2023 national staff survey dated 30 March 2024
  9. The Head of Internal Audit's annual opinion of the trust's control environment dated XXXX
  10. CQC Inspection report dated 14 May 2020
- The Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered.
- The performance information reported in the Quality report is reliable and accurate.
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, 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 Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review.
- The Quality report has been prepared in accordance with NHS Improvement's annual reporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the board

30/06/2024 .... Graham Ward, Acting Chair