Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Quality Account and Reports

2025-2026

Best NHS Acute Trust in the East Midlands to work for as voted by our staff.
(2018, 2019, 2020, 2021, 2022, 2023 and 2024 NHS Staff Survey)

Contents

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 (SFHFT). The report provides a review of the Trust's quality improvement activities and achievements during 2025/2026.

The report also identifies and explains the Trust's quality priorities for 2026/2027. The 2025/2026 sections of the report refer to quality improvement activities completed during the 2025/2026 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 2022/2023
- Data Dictionary

Part 1. Statement of the Quality Account: Jon Melbourne, Chief Executive

I am pleased to present the Sherwood Forest Hospitals NHS Foundation Trust's Quality Account for 2025/2026. I am confident that the information in this account accurately reflects the services we provide to our patients and local community.

Providing safe, timely and effective care, and a great experience for our patients, is at the core of what we strive for. This report evidences our continued commitment to this. It aligns with our strategy and our vision of Outstanding Care, Compassionate People, Healthier Communities. We present our key priorities for the coming year that reflect our ambition to provide consistently high-quality care for the communities we serve. A transparent overview is provided of our performance, achievements and areas for improvement.

We are ambitious about what we can achieve together.

We recognise that our colleagues are working in challenging conditions, with rising demand for services and growing financial pressures. Despite this, we continue to see exceptional dedication and professionalism.

You will see examples of where we have delivered excellent care, and we must build upon this. We also give examples of where we must improve, learn and develop. We are proud to work for Sherwood Forest Hospitals and our communities. We will be open and honest in our pursuit to continually improve.

Patients, carers, families and communities are at the centre of all that we do, and their voices are so important to us. We will continue to listen and to take action to improve. We continue to play a key role in reducing health inequalities which we know persist in our communities and the NHS.

We recognise that there are areas that we need to improve through change, that we need to drive best practice across our services and we also want to be a great place to work. As part of our pursuit of high-quality and safe services, it is essential that we have a culture that enables this - supporting colleagues to be the best they can be, and to allow us to share best practice, and to learn lessons from mistakes to drive improvement.

Thank you to colleagues, patients, communities and partners for your support. We look forward to working with you in the years ahead to drive further improvement and to deliver care to be proud of.

Jon Melbourne
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 delivering high-quality healthcare, focused on patient safety, clinical effectiveness, and positive patient experiences.

Continuous improvement is driven by the Quality Priorities identified within the Patient Safety and Quality Strategy (2025-2029) and provides focused priorities for 2026/2027 described in 2.1.3.

The strategy sets out our approach to ensuring every patient's contact is safe and care is effective and builds on the robust foundations of quality already embedded from our Quality strategy (2022-2025).

Ensuring safety and quality of care for every patient is our top priority. We are ambitious about the quality of care we provide and want our services to provide outstanding care, delivered by compassionate people, whilst helping our community to be healthier. With this vision, the Trust is committed to fostering a culture of continuous quality improvement, having consistently delivered against the previous Quality strategy aims and goals.

Our CARE values ensure that staff and patient concerns are viewed as an early warning system, to highlight safety issues and that any concerns raised are seen as integral to continually improving the quality and safety of care, to deliver our vision.

The strategy is led by our Chief Medical Officer who, in conjunction with the Chief Nurse, receives regular progress reports via the Patient Safety Committee. Formal reporting on the Patient Safety and Quality Strategy (2025-2029), is via the Trust Quality Committee and onto the Board of Directors.

2.1.1 Providing high-quality, safe care.

The Trust uses several internal and external sources to support and drive quality improvements. The following are examples that are being used to support the delivery of our Patient Safety and Quality Strategy (2025-2029):

- Stakeholder and regulator reports, and recommendations
- Integrated Care Board (ICB), feedback and observations following their quality visits, internal peer reviews and external reviews.
- National inpatient and outpatient surveys.
- Feedback from our Board of Directors and Council of Governors.
- Emergent themes and trends arising from complaints, patient safety incident investigations and learning from deaths.
- Feedback from senior leadership assurance visits and the Exemplar Ward Accreditation (EWA) programme Nursing and midwifery assurance framework and nursing metrics.
- Quality and safety reports.
- National policy.
- Recommendations from the Coroner's office, including Prevention of Future Death (PFD) reports.

In our Patient Safety and Quality Strategy (2025-2029), we continue to build on the quality assurance and performance framework that is 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 described in each campaign. Progress is underpinned by the Trust's assurance processes, with 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 the delivery of high-quality care remain central to our strategic vision. We are committed to strengthening and sustaining a culture of continuous learning and improvement, a commitment embedded within our organisational strategy, 'Improving Lives', and reflected in all aspects of our work.

Our colleagues consistently provide exceptional care to our patients, often within complex and highly demanding environments. Sustaining this standard requires an environment that promotes innovation, encourages reflective learning and supports the adoption of evidence-informed best practice.

Central to this ambition is the Trust's Improvement Faculty (IF). The IF team provides expert organisation-wide support for improvement, change management and transformation. Acting as a single point of contact for colleagues, the team support continuous enhancement of patient safety and quality of care, improving service user experience, staff engagement and the sustainable use of Trust resources.

The IF delivers a comprehensive, evidence-based improvement offer, enabling the Trust to embed the cultural foundations necessary for sustainable change. It supports the delivery of immediate operational priorities together with longer-term strategic transformation. Since its establishment, the IF has contributed to a range of large-scale programmes, including the Emergency Care Programme and Mansfield Community Diagnostics Centre. Each year, the team responds to approximately 150 additional requests for support, including observational studies, process mapping, experience-based design and bespoke improvement guidance. The IF also promotes systematic learning from patient safety incidents, to inform future improvements and continue to provide dedicated support to the Exemplar Ward Accreditation (EWA) process.

To further enable quality and productivity improvement, the IF offers targeted expertise, practical support and accessible insights. This includes the development of the Improvement Insights Explorer Tool, an online resource available to all colleagues that brings together benchmarking and comparative data, to help identify opportunities for improvement and transformation. The tool also supports the Trust in strengthening compliance with Getting It Right First Time (GIRFT) standards.

The IF maintains a broad portfolio of training and development programmes in quality improvement and change management, including the nationally recognised Quality, Service Improvement and Redesign (QSIR) practitioner programme. This offer has recently been enhanced with the establishment of a Quality Improvement Network, providing ongoing alumni support for colleagues who have completed QSIR training. Through regular network meetings and shared learning opportunities, this will ensure that improvement capability is sustained and that expertise is shared with colleagues across the Trust.

2.1.3 Quality priorities for 2026/2027

During 2026/2027, SFHFT will continue to focus on patient safety, clinical effectiveness and quality of care, which are central to our strategic vision. We have a clear plan for consistently delivering high-quality healthcare, focusing on patient safety, clinical effectiveness, and positive patient experience. By using insight to understand the challenges ahead, and by involving patients and their communities, we will identify where improvements are needed, set clear goals, and track our progress and performance against them.

Three improvement priorities for specific focus in 2026/2027 are presented below; these have been included by considering local, national and international priorities and have been chosen from the SFHFT Patient Safety and Quality Strategy (2025-2029).

Specific Campaign	Quality Priority We will deliver by	Success Measure
Insight 'Develop robust systems for understanding patient safety'	1. Patient Safety Incident Response Framework (PSIRF) thematic review 2. Safety culture pulse check 3. CQC readiness review	PSIRF thematic review completed and actions incorporated into safety improvement plans.
Involve 'Elevating Care through Compassionate Communication'	1. Relaunch patient engagement forums	Patient engagement forums relaunched with ≥80% of planned sessions delivered. Increase attendance by 20%.
	2. Embed Coffee & Connect (C&C)	Embedded C&C in all key service areas (≥75% of services hosting monthly sessions).
	3. Early resolution training	Training completion reaches ≥90% of targeted staff groups.
	4. Increase Patient Safety Partners (PSP) / governor visibility	≥2 engagement activities per month. Increase in PSP involvement in committees or workstreams by ≥25%.
	5. Capture lived experience for Perinatal Culture and Leadership Programme) (PCLP)	Lived experience captured for 100% of PCLP priority areas.
	6. Nottingham and Nottinghamshire Integrated Care System (ICS) pathway projects	ICS pathway project contributions documented in quarterly ICS reports.
	7. Junior carer planning	Junior carer plan developed and approved with clear milestones and pilot sites identified.
Improve 'Design and support programmes that deliver effective and sustainable change'	1. Quarterly safety bulletin	Quarterly safety bulletin published on schedule with ≥75% staff readership.
	2. Swarm effectiveness review	Swarm effectiveness review demonstrates measurable impact.
	3. Care Quality Commission (CQC) trajectory	CQC trajectory milestones met, with ≥90% of actions delivered to plan.
	4. Exemplar Ward Accreditation (EWA)	EWA accreditation score demonstrates improvement.

2.1.4 Review of Quality Priorities during 2025/2026

Patient Experience	Insight - Patient Safety and Quality

Specific Campaign: Continue to understand patient safety by enhancing current systems and implementing new systems and processes to draw upon multiple sources of patient Safety Information.

We continued to strengthen our approach to patient safety by improving existing systems and introducing new processes that draw on multiple sources of safety intelligence. This included:

1. Bringing together data from incident reporting, complaints, claims, mortality reviews, audits and soft intelligence to create a more comprehensive picture of risk and harm.
2. Embedding structured review processes to ensure that emerging themes are identified early and acted upon.
3. Aligning our patient safety insights with Trust-wide improvement programmes so that learning translates into measurable change.

These developments have enabled us to move from reactive responses to a more proactive, system wide approach to safety.

Quality priority: Reviewing patient safety incidents that have been reported to identify emerging themes on safe discharge to agree actions for improvements.

We continued to review all reported patient safety incidents relating to discharge, to identify emerging themes, patterns and system risks. This work has enabled us to understand the factors contributing to unsafe or delayed discharge, including communication gaps, documentation issues and challenges in coordination with system partners.

Themes identified through incident review were escalated through the PSIRF Oversight Group and Quality Committee, ensuring senior visibility and enabling these insights to directly inform the refresh of our Patient Safety Incident Response Plan (PSIRP). This strengthened the alignment between operational learning and our strategic patient safety priorities.

Success Measure: Safe discharge and readmission metrics

Key performance indicators are being measured as part of the Nursing, Midwifery and Allied Health Professionals (NMAHP) strategy, ensuring oversight and sustained improvement. Reviewed and monitored via the NMAHP committee.

Patient Experience	Involve - Patient safety and Quality

Specific Campaign: 'Provide welcoming and safe care environments'

We have incorporated both service user and staff feedback from a range of sources to inform environmental improvements. This includes enhancements such as improved signage with the use of straightforward wording and is supported by appropriate pictures.

Quality priority: Implement the Perinatal Culture and Leadership Programme (PCLP).

The PCLP has been implemented via the quadrumvirate of senior leaders within the perinatal services. This has been implemented at multiple levels within the division and aims to create conditions for a positive culture, focusing on safety, inclusion, and continuous improvement, addressing recommendations from national perinatal reports.

Success Measure: Monitoring roll-out to appropriately identified staff groups.

The PCLP progress is monitored through the Perinatal Assurance Committee, which support celebration and escalation as required. Success measures will take time, and we anticipate seeing these through our routes of feedback from both service users and staff.

Patient Experience	Improve - Patient safety and Quality

Specific Campaign: Care is informed by consistent and up-to-date high-quality training, guidelines and evidence; designed to improve the health and well-being of our population

Quality priority: Further develop and roll-out the Exemplar Ward Accreditation (EWA) program.

- Over 2025/2026, 100% of clinical areas included in the EWA presented a quality improvement project, at their chosen panel.
- Within the reporting of the EWA data packs, there was a yearly decrease in the number of 'white' areas of data; and an increase in the 'gold' areas of data, this data driven identifier is of the quality of care patients receive in the Trust.
- The EWA data packs have an annual review to ensure they remain relevant and up to date with current clinical Key Performance Indicators (KPI's). All EWA key documents have received a review in-line with any programme changes, with Clinical Nurse Specialist knowledge and input where appropriate.
- Ongoing support for the quality improvement projects has been available to all clinical leads involved with EWA via regular check-ins from the EWA team. Specific support has also been offered by the IF and research leads.
- The research team have had representation on the EWA panels in preparation for alignment to the Self-assessment of Organisational Readiness Tool (SORT) released by NHS England.
- An EWA nurse has now been recruited to work on accreditation data packs, to ensure they are collated and disseminated in a timelier manner.
- The EWA team has maintained shared learning with other Trusts through accreditation forums and by responding to individual requests, while also gaining insights from others' processes and experiences.

Success Measure: Exemplar Ward accreditation (EWA) data

- Full review of data packs and substantive recruitment to EWA nurse role has allowed data packs to be completed regularly, enabling wards to analyse their data more frequently to reduce their 'white' areas.
- Formal 'write-ups' from the 2025 panels, have been provided by the EWA team, to the wards, divisions and the Chief Nurse office.

2.2 Statement of Assurance

2.2.1 General Statement

During 2025/2026 the Trust provided and/or subcontracted various relevant health services and 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 2025/2026 represents 91% of the total income generated by the Trust.

This year, we cared for:

	2025/26	2024/25
ED Attendances KMH	134,781	131,789
Newark UCC Attendances	42,164	38,964
PC24 Attendances	26,015	29,038
Total	**202,960**	**199,791**
Births	3,376	3,466
Outpatient Attendances (all sites)	520,212	522,823
Inpatient activity		
Elective Inpatient	5,100	
Emergency Admissions	47,908	
Maternity Admissions	12,001	
	Total 65,009	Total 64,426
Day Case Activity	43,482	44,572

SFHFT employs 6404 substantive people. We engage with many people through our temporary staffing, bank system which increases this number to 7438, with 287 consultant doctors (including 58 locum consultants) working in our hospital facilities, some of the best in the country.

2.2.2 Participation in Clinical Audit

Over 2025/2026, the focus has been on consolidating and improving working dependencies and relationships between the divisions, strengthening the visibility of patients and service outcomes and learning. A proactive approach has been taken to support colleagues undertaking clinical audits.

National Clinical Outcome Review Projects 2025/2026

We participated in 50 out of 54 (93%) national clinical audits and 100% of national confidential enquiries, which we were eligible to participate in.

The national clinical audits and national confidential enquiries that we participated in during 2025/2026 are as follows:

Table 1. National Clinical Audit participation

Workstream	Full participation
National Comparative Audit of NICE Quality Standard QS138	Yes
National Comparative Audit of Bedside Transfusion practice	Yes
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme	Yes
Core Diabetes Audit	Yes
National Diabetes Footcare Audit (NDFA)	Yes
National Diabetes Inpatient Safety Audit (NDISA)	Yes
Gestational Diabetes Audit	Yes
Transition (Adolescents and Young Adults) and Young Type 2 Audit	Yes
National Audit of Cardiac Rehabilitation	Yes
National Audit of Cardiac Rhythm Management (CRM)	Yes
Myocardial Ischaemia National Audit Project (MINAP)	Yes
National Audit of Percutaneous Coronary Intervention (NAPCI)	Yes
National Audit of Dementia (NAD)1	Yes
National Early Inflammatory Arthritis Audit (NEIAA)	Yes
COPD Secondary Care	Yes
Adult Asthma Secondary Care	Yes
Sentinel Stroke National Audit Programme (SSNAP)	Yes
Cleft Registry and Audit NEtwork (CRANE) Database	Yes
Epilepsy12: National Clinical Audit of Seizures and Epilepsies for Children and Young People	Yes
Maternal, Newborn and Infant Clinical Outcome Review Programme National Child Mortality Database (NCMD)1	Yes
National Maternity and Perinatal Audit (NMPA)	Yes
National Neonatal Audit Programme (NNAP)	Yes
National Paediatric Diabetes Audit (NPDA)1	Yes

National Perinatal Mortality Review Tool	Yes
UK Cystic Fibrosis Registry	Yes
BAUS Penile Fracture Audit	Yes
BAUS I-DUNC (Impact of Diagnostic Ureteroscopy on Radical Nephroureterectomy and Compliance with Standard of Care Practices	Yes
Environmental Lessons Learned and Applied to the bladder cancer care pathway audit (ELLA)	Yes
Breast and Cosmetic Implant Registry	Yes
British Hernia Society Registry	Yes
Case Mix Programme (CMP)	Yes
Fracture Liaison Service Database (FLS-DB)*	No
National Audit of Inpatient Falls (NAIF)	Yes
National Hip Fracture Database	Yes
National Audit of Primary Breast cancer	Yes
National Bowel Cancer Audit (NBOCA)1	Yes
National Kidney Cancer Audit (NKCA)1	Yes
National Lung Cancer Audit (NLCA)1	Yes
Lymphoma Audit (NNHLA)1	Yes
National Oesophago-Gastric Cancer Audit (NOGCA)1	Yes
National Ovarian Cancer Audit (NOCA)	Yes
National Pancreatic Cancer Audit (NPaCA)	Yes
National Prostate Cancer Audit (NPCA)1	Yes
National Emergency Laparotomy Audit (NELA) ***	No
National Joint Registry	Yes
National Major Trauma Registry	Yes
Degeneration Audit	Yes
Cataract Audit	Yes
Perioperative Quality Improvement Programme	Yes
Adolescent Mental Health **	No
Care of Older People **	No
Time Critical Medications **	No
Society for Acute Medicine Benchmarking Audit	Yes
UK Renal Registry National Acute Kidney Injury Audit	Yes

Non-participation

***Fracture Liaison service**

Our FLS does not have a fully functional Fracture Liaison service database (FLSD) in place; this has been run on an ad-hoc basis and to date does not include all patients. A business case is awaiting review to establish a substantive FLSD service.

****Emergency Medicine QIPs** - Infection prevention and control, Care of older people and Time critical medications have been challenging to report. This is due to the clinical staff in ED, responsible for undertaking the audits, having been under significant operational pressure throughout the year.

*****National Emergency Laparotomy Audit** - Due to a change in lead for the audit and operational challenges, no data has been submitted to NELA for 2025/2026. An action plan is being implemented to ensure data will be submitted for the current financial year

Table 2 - National Confidential Enquiries into Patient Outcomes and Deaths (NCEPOD):

Study Title	Participation	Study status
Stabilisation of the critically ill child	Yes	On-going
Emergency (non-elective)	Yes	On-going
Hypernatraemia	Yes	On-going
Hyponatraemia	Yes	On-going
Rib Fracture	Yes	On-going
Learning Disability	Yes	On-going
Pleural Procedures	Yes	On-going

Outcomes and Learning from Clinical Audits Undertaken During 2025/2026

The number of clinical audits both national and local which formed part of the 2025/2026 Audit Plan are as follows:

Total Number of audits in the 2025/2026 plan = 402

Number of local / other audits = 341

Number of national audits, including NCEPOD = 61

Number of audits fully completed = 199

The audit completion dates do not align with the financial year end. Many audits are started in-year, so some completion dates fall into the next financial year.

Some key learning and audit outcomes from 2025/2026 are as follows: National Audit examples

National Diabetes Footcare Audit (NDFA)

Improvement shown across all metrics. The most notable being the increase in the percentage of patients seen in clinic within 0-13 days, improved from 16% to 73%. Timely foot care is essential for diabetes patients because high blood glucose can cause nerve damage and reduced blood flow, leaving patients vulnerable to rapidly developing foot complications. The improvement in review timeliness is expected to help reduce the risk of serious complications, lower associated long term healthcare costs and improve patient outcomes.

National Emergency Laparotomy Audit.

The report published in October 2025 demonstrates we are performing well with the completion of risk assessments for our pre-operative and post-operative surgical patients. Completion rates for the proportion of patients that had a risk assessment documented were 91.7%, compared to the national average of 66.7%.

Our results also demonstrate excellent performance against the metric of the proportion of high-risk patients admitted directly to critical care postoperatively, achieving 92.7% compared to the national average of 77.6%. This strong performance highlights our commitment to patient centred care and by adhering to evidence based guidance, supports an increased chance of a positive outcome for patients.

National Respiratory Audit Programme - Adult Asthma.

The recent report published shows that the percentage of people admitted with an asthma attack, reviewed by a respiratory specialist within 24 hours of arrival, was 75%. This is significantly higher than the national average of 48%, demonstrating we are striving to ensure these patients are receiving the best care.

National Audit of Dementia.

The audit showed that 100% of carers rated the overall care provided at SFHFT as either “Excellent” or “Very Good”. Results also identified that a pain assessment was undertaken in 100% of cases for patients living with Dementia. These patients often have complex needs, so it is essential that the care given is compassionate and our commitment to this is demonstrated by these results.

National Hip Fracture Database.

The number of patients with a hip fracture receiving a perioperative medical assessment, within 72 hours as 92%. This is a 4.5% increase compared to the previous year and compares favourably to the national average of 90%. This assessment is fundamental in ensuring we balance the needs of our patients’ post-operative stay in hospital, with the risk of deconditioning. Results also concluded that patients documented as not developing a pressure ulcer, as 98% compared to a national score of 92%. Maintaining good skin health ensures a patient’s length of stay is not impacted by controllable factors, such as pressure ulcers.

Local Audit examples

Pyelonephritis Ambulatory pathway audit.

The current Pyelonephritis Same Day Emergency Care (SDEC) tool was changed to a Pyelonephritis Treatment Guideline. The audit demonstrates adoption of this guideline supported a reduction in costs of IV antibiotics and cannulas, improved patient flow and capacity in SDEC. It also resulted in patients’ multiple attendances to hospital being reduced.

Analysis of Referral Outcomes and Case Categorization Across Rheumatology Consultants.

This evaluation provided a baseline of referral patterns, caseload distribution and triage outcomes within the rheumatology service. Although no immediate changes were identified, it highlighted the natural variation across our consultants’ caseloads. The findings will support future service planning, with an annual re-evaluation planned to track trends over time.

Assessment of Utilisation of Ear, Nose and Throat (ENT) Emergency Clinic (Clinic 8, King's Mill Hospital).

A standard operating procedure has been created to identify inclusion and exclusion criteria for the ENT emergency clinic. This has streamlined the process to review which patients need to be seen in this clinic. This will improve efficiency and patient care, ensuring patients are seen in the right place at the right time.

Audit of Compliance with Guidance on Vitamin and Iron Supplementation in Infants Discharged from Transitional Care and Neonates.

The audit found that outdated guidance led to only 27% of infants being discharged with the correct supplements. After updating the guidelines and providing staff training, this improved to 100% for iron supplements and 92% for vitamins. Awareness and compliance increased significantly, and a discharge calculator is being developed to ensure current guidance is consistently used.

Use of Ultrasound in acute situations among acute medicine clinicians: A Quality Improvement Audit.

Following the Focused Acute Medicine Ultrasound (FAMUS) audit and related teaching sessions, awareness and interest in Point Of Care Ultrasound (POCUS), within acute medicine has increased. Training has strengthened clinicians' understanding of FAMUS standards and the value of ultrasound in patient assessment and decision making. Feedback from the questionnaire has directly resulted in the development of an ultrasound competency package, planned to be embedded into routine clinical practice within 2026/2027.

Are we effectively assessing and managing Pulmonary Embolism (PE) in SDEC?

A PE management flow chart has been introduced in SDEC, alongside a patient information leaflet to improve patient safety and understanding of PE. The findings and resulting actions were shared through the Acute Medicine clinical governance forum, Acute Medicine teaching sessions and via email to all acute medicine staff. Sharing the changes has led to better streaming of PE patients, improving patient flow and reducing delays in care.

Review of practice for diagnosis of Sub Arachnoid Haemorrhage (SAH) in Acute Medicine department.

There has been a significant reduction in unnecessary Lumbar Punctures (LPs), with only 2 non-positive for SAH, performed within the last 3 months. LPs are now being scheduled more appropriately, with almost no LPs done within 12 hours, indicating improved adherence to guidelines. Delays in LPs and discharges have significantly decreased, demonstrating improved workflow efficiency and decision making.

Venous Thromboembolism (VTE) risk assessment and prophylaxis within 24 hours for medical in-patients (Re-audit).

The second VTE audit shows clear improvement across all measures, demonstrating that the changes introduced were effective. Ongoing education, use of improved electronic systems, and regular audits will be key to maintaining patient safety and meeting NICE standards.

Improving communication of bone health assessments on discharge summaries.

An initial audit found poor recording of bone health in discharge letters (7%). Introducing a dedicated bone health proforma increased this to 43% by prompting clinicians to include key information. Better documentation improves handover to GPs, supports safe follow-up care, and may help reduce future fragility fractures and NHS costs.

Improving Completion of Lying and Standing Blood Pressure (LSBP) in Patients over 65 years old, on Ward 42.

The audit results showed a 51% increase in patients receiving an LSBP within 72 hours, highlighting the effectiveness of visual, ward-based prompts in improving timeliness. In addition, a 40% increase in assessments completed in line with Royal College of Physicians guidance demonstrates the benefit of combining multidisciplinary teaching with bedside prompts. LSBP measurements were performed more appropriately, increasing the likelihood of accurate diagnosis of orthostatic hypotension (a rise in blood pressure when someone stands up). Embedding these interventions into routine clinical practice has streamlined LSBP assessment, improved identification of falls risk, and enhanced overall patient care and outcomes.

Review of 2025/2026:

Delivery and compliance

1. High completion rates for national audits, with the majority submitted on time.
2. Improved local audit delivery, with fewer overdue projects and stronger forward planning.
3. Improved NICE compliance in key high-risk pathways, including sepsis, stroke, and antimicrobial stewardship.

Quality improvement impact

1. More audits produced clear, measurable action plans, with better follow-up through divisional governance.
2. Audit activity supported tangible improvements, including faster antibiotics in sepsis, improved VTE documentation, and more consistent perioperative care.
3. Increased use of quality improvement methods supported more sustainable change.
4. Stronger Clinical engagement across specialties, with wider multidisciplinary involvement and improved ownership of outcomes.

Governance and assurance

1. Improved escalation of audit findings to Divisional and Trust committees, strengthening risk visibility and assurance.
2. Better alignment of the audit programme with CQC domains, patient safety themes, and Trust strategic risks.
3. Clearer, more accessible reporting through improved dashboards.

Key Risks and Gaps

1. Action plan sustainability: Action plans have improved, but completion is inconsistent and long-term monitoring is not always in place.
2. Digital limitations: Continued reliance on manual data collection limits efficiency and data quality, with a lack of digital audit tools restricting real time reporting and standardisation.
3. Programme prioritisation: The audit programme remains broad, with variable impact, highlighting the need to streamline activity and focus on high risk, high-value areas.

Priorities for 2026/2027:

1. Strengthen quality of patient care by using clinical audit to ensure practice aligns with national standards, NICE guidance, and local policy, addressing unwarranted variation that affects safety and outcomes.
2. Drive meaningful quality improvement by translating audit findings into clear, actionable plans and embedding continuous improvement approaches rather than one off audit cycles.
3. Enhance clinical engagement by increasing involvement of clinicians, Nurses, AHPs, and operational teams in audit design, delivery, action planning, and promoting audit as a supportive improvement tool.
4. Improve data quality and insight by using audit results to provide clear, accessible information that informs governance and strategic decisions.
5. Strengthen assurance and accountability by providing robust evidence of compliance to the Trust Board, Quality Committee, and regulators, aligning audit activity with organisational risks, CQC domains, specialty priorities, and patient safety priorities.
6. Build organisational capability by offering training, coaching, and resources to develop a confident workforce able to lead and sustain audit-driven improvement

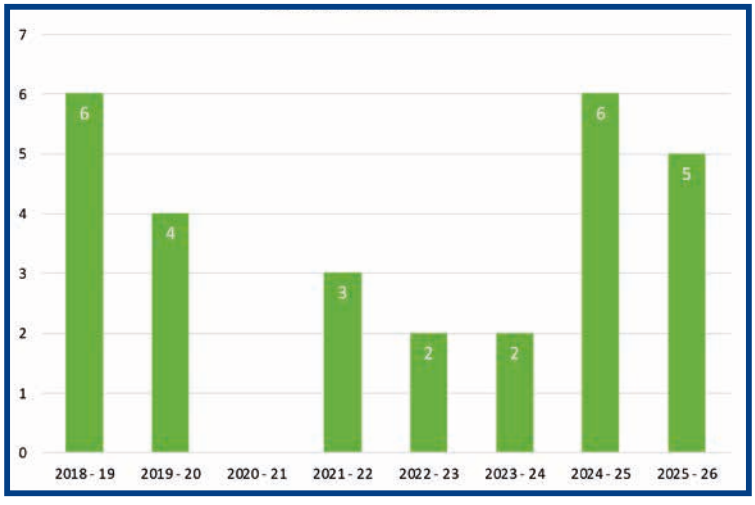
2.2.3 Participation in Clinical Research and innovation

The number of research participants receiving relevant health services, provided or sub-contracted by the Trust in 2025/2026 was 1647. This includes research involving patient data and tissue samples in studies that have been approved by the Research Ethics Committee.

We are a research-active organisation with a dedicated Research and Innovation (R&I) Department. The department leads the development and support of a diverse research portfolio and work to increase opportunities for patients and staff to engage in research activity. This helps to inform the delivery of high-quality, evidence-based healthcare. Patient participation in research is primarily facilitated through studies adopted by the National Institute for Health Research (NIHR).

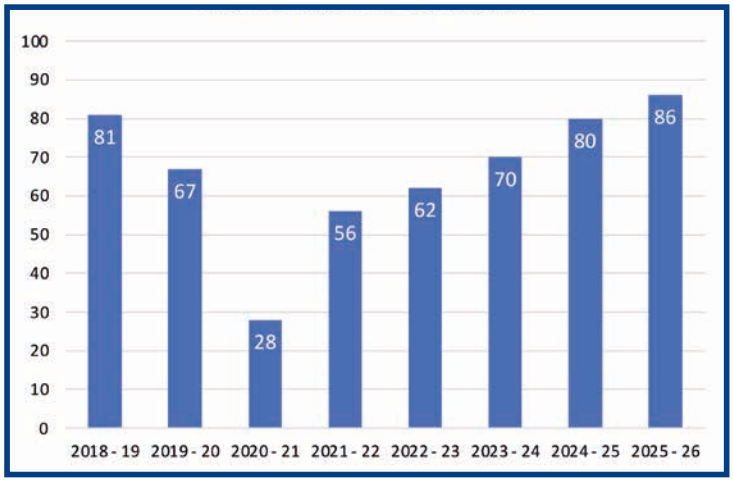
In 2025/2026, the R&I team prioritised the development of a balanced and sustainable research portfolio, with a clear emphasis on increasing commercial research activity. This strategic direction continues into 2026/2027, underpinned by the opening of the new Clinical Research Facility, which significantly enhances the organisation's commercial appeal and capacity to deliver high-quality studies. Graph 1 reflects the commercial study activity from 2018 to present day.

Graph 1: R&I Commercial Studies



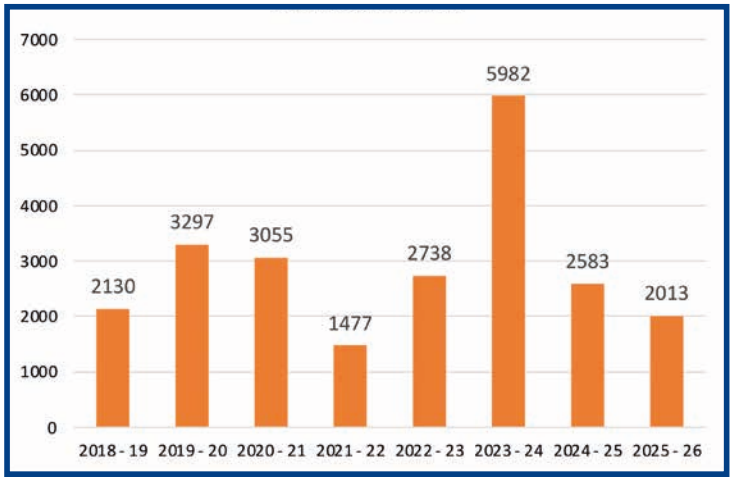
Graph 2 demonstrates an increase in our non-commercial R&I studies for 2025/2026.

Graph 2: R&I Non-Commercial Studies



During 2025/2026, a significant reduction in patient recruitment was observed (Graph 3), resulting in the Trust not meeting its annual recruitment target of 3,500 participants. Historically, overall recruitment performance has been strongly influenced by the opening of one to two large-scale studies each year, which have contributed substantially to previous recruitment figures. There has been a national shortage of large-scale studies available for application, limiting opportunities across all regions.

Graph 3: R&I Patient Recruitment



In January 2026, we opened our new 8-bedded Clinical Research Unit to patients. This is operating successfully and supports the development of a high-quality research infrastructure at SFHFT, allowing increasing opportunities for patient participation. There are further plans to attract more commercial studies as the year progresses.

We will continue to expand the use of digital technologies in research and, through a targeted development programme with the East Midlands Clinical Research Network and commercial sponsors, we aim to increase investment and broaden research opportunities for our patients.

R&I's Mobile Research Unit (MRU), launched in March 2025, is now visible and accessible across our communities, delivering research in traditionally 'hard-to-reach' areas. Funding has been secured for a permanent MRU, enabling the continued development of community-based research and supporting alignment with the NHS 10-Year Plan to shift care from hospital to community settings.

In 2025/2026, for the third consecutive year, we achieved the bronze standard Workforce Accreditation awarded by the IAOCR (International Accrediting Organisation for Clinical Research). We remain the only trust in the East Midlands to have achieved this. The independent assessment provides a benchmark of the highest standards for those working within SFHFT to be proud of. It also provides potential sponsors with formal evidence of the workforce standards being delivered. This accreditation enhances our reputation and makes it more attractive to sponsors, potentially attracting more commercial research activity.

Research is a partnership between participant and researcher. Every year, as part of the NIHR participant experience survey, we ask participants involved in research at SFHFT to tell us about their experience. This allows us to make any improvements and highlight our strengths as a service.

Our survey demonstrated that 94% of respondents reported they would agree or strongly agree that their participation in research has been valued, and 83% would consider taking part in research again.

One participant reported, "I feel I am contributing to getting better treatment and understanding for asthma. The nurses who performed the tests and questions went above and beyond. Making it a wonderful experience."

Priorities for 2026/2027:

1. Further develop our clinical research facility and mobile research unit to deliver high-quality research and provide improved opportunities for patients to access and participate in research. Both units will attract commercial sponsorship to the region, increasing patient access to trials of new and novel treatments while generating income for mid-Nottinghamshire.
2. Extend our research academy to include academic research.
3. Research activity will be reviewed on an ongoing basis, with bi-annual reporting to the Trusts Board and the Patient Safety Committee. This is in addition to external reporting to the Department of Health via the clinical trials platform, a national key performance indicator for all NHS organisations.
4. Continue to develop key partnerships across the region, including delivering a devolved model of research delivery with GP Practices as part of the Mid Nottinghamshire Research Partnership and identifying research priorities to collaborate on projects and workforce development with Nottingham Trent University.

2.2.4 Commissioning for Quality and Innovations (CQUIN) Indicators

In March 2024, NHSE published guidance that the mandatory CQUIN scheme for 2024/2025, was paused. The Mandatory CQUIN scheme remains paused for 2025/2026.

The Nottingham and Nottinghamshire ICB confirmed that whilst the principles of the quality schedule activity and reporting outcomes, via system routes, still applies, no CQUIN plans were formalised locally. In line with this guidance, SFHFT have not formally reported against CQUINs for 2025/2026.

2.2.5 Registration with the Care Quality Commission (CQC)

The Trust has three locations registered including:

King's Mill Hospital (KMH)

Newark Hospital (NH)

Mansfield Community Hospital (MCH)

There are currently no restrictions on our registration. The CQC undertook no enforcement action against the Trust in 2025/2026.

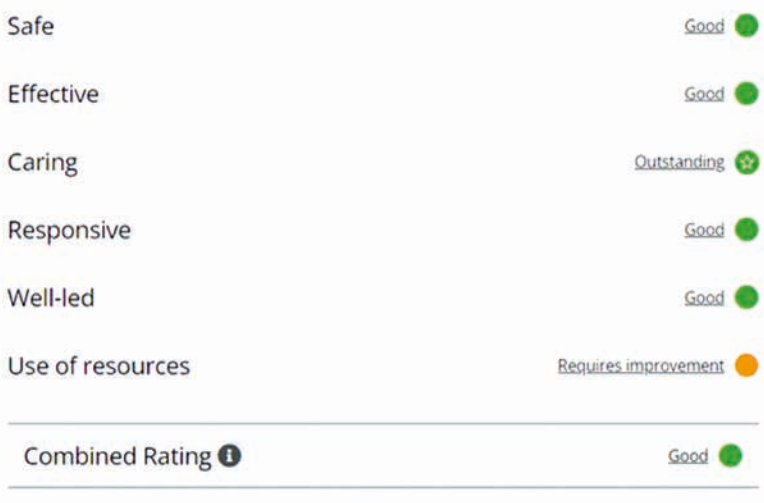
SFHFT had two CQC inspections during 2025/2026.

NH has maintained its overall 'Good' rating in the latest Care Quality Commission report, with inspectors upgrading end of life care from 'Requires improvement' to 'Good' and awarding a rare 'Outstanding' rating for Caring. The inspection, carried out in November 2025, published in April 2026, highlighted that staff worked collaboratively and placed patients and families "at the center of everything they did" when planning and delivering care. Inspectors found that patients and their loved ones felt exceptionally well supported and treated with dignity and respect.

Several internal peer reviews took place during 2025 and will continue into 2026.

Our statements of purpose were updated in January 2026 to reflect changes in the Executive team and the opening of a new Clinical Diagnostic Facility (CDC) at MCH in April 2026.

We maintain a positive working relationship with CQC, with quarterly engagement meetings. Our overall rating is 'Good' and comprises of the following ratings for each domain:



The Care Quality Commission (CQC) undertook a two-day onsite inspection at King's Mill Hospital in March 2026, as part of its national winter pressures programme. A team of eight inspectors reviewed the Emergency Department (including paediatrics), medicine wards, and medicines management, alongside formal assessments of both Medical Care Services and Urgent and Emergency Services. Inspectors reported that staff across all areas were welcoming, open and constructive in their engagement, and that effective multidisciplinary working and clear communication was evident during handovers and board rounds.

The Trust awaits the publication of the final inspection report.

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

We submitted records during 2025/2026 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:

- 99.9% for admitted patient care.
- 100% for outpatient care; and
- 99.6% 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
- 99.9% for accident and emergency care.

2.2.7. Information Governance

Our Data Security Protection Toolkit Assessment Report overall score for 2024/2025 was graded as 'Standards Met'. It is anticipated that the Trust will achieve the "Standards Met" submission for

2025/2026 by the end of June 2026. Good progress has already been made towards the 'Standards Met' grading this year.

Data security aims for 2025/2026:

The Data Security and Protection Toolkit now encompass the National Cyber Security Centre's, Cyber Assurance Framework. This is a rigorous test of our security systems. We will continue to be working towards achieving the framework to provide assurance that data is protected at the highest level.

How was this achieved?

The Data Security Team was audited by 360 Assurance (our internal auditors), who undertook a review of the standards in 2024/2025 and provided an overall assessment. This review provided a rating on our self-assessment, resulting in a Low level of deviation between the independent assessment and self-assessment. The confidence level in the veracity of the Toolkit self-assessment is therefore High.

Monitoring and reporting for sustained improvement

All actions taken from internal audits are monitored by the Data Protection & Cyber Security Committee and the Audit and Assurance Committee.

Serious incidents requiring investigation

In 2025/26, we reported zero data security serious incidents reported on the Data Security Protection Toolkit.

2.2.8 Clinical Coding

We were not subject to the Audit commission's Payment by Results Clinical Coding audit during 2025/2026.

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.

In 2025/2026, the clinical coding team coded 135,095 Finished Consultant Episodes (FCE's), this was an increase of 10,077 from 2024/2025, an 8% activity increase.

Clinical coding plans for 2025/2026:

- Targets: Achieve 100% coding 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

All 2025/2026 deadlines were coded by SUS first submission, remaining the same as on 2024/2025. However, 5th working day target performance has declined in 2025/2026, due to financial pressures and removal of overtime capacity. Coding remains 100% complete by 1st SUS submission.

Table 3: Secondary Users Service (SUS) Submission Data Report

FCE Month	5th Working Day	1st SUS Submission date	Total Number of Episodes	Working Day Deadline	% Coded at 1st SUS Submission
April 2025	08/05/2025	15/05/2025	11,233	5th	100%
May 2025	06/06/2025	13/06/2025	10,833	5th	100%
June 2025	07/07/2025	14/07/2025	10,871	5th	100%
July 2025	07/08/2025	14/08/2025	12,277	5th	100%
August 2025	05/09/2025	12/09/2025	10,682	6th	100%
September 2025	07/10/2025	14/10/2025	11,399	6th	100%
October 2025	07/11/2025	14/11/2025	11,173	7th	100%
November 2025	05/12/2025	12/12/2025	11,008	7th	100%
December 2025	08/01/2026	15/01/2026	11,578	8th	100%
January 2026	06/02/2026	13/02/2026	11,282	7th	100%
February 2026	06/03/2026	13/03/2026	10,899	7th	100%
March 2026	09/04/2026	16/04/2026	11,860	8th	100%
Total			**135,095**		**100%**

Table 3 shows the number of un-coded episodes for discharged hospital spells within each month. The total number of episodes relates to Finished Consultant Episode (FCE). 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).

The number of FCE's coded is demonstrating a year-on-year growth of around 4.5% across all Day Case/Elective and Non-Elective workstreams (Table 4).This consistent 4.5% growth in FCEs positively supports our performance against targets by increasing activity capture and throughput, while careful monitoring and resource planning ensures we maintain coding accuracy and data quality, despite the higher volumes, as evidenced year on year in this report.

Table 4 Secondary Users Service (SUS) Submission Data Report- Workstreams

Year	Day case	Elective	Non-elective	Total Activity	Growth vs previous year	Year-on-year increase
2022/2023	39,373	3,785	43,665	86,823	-	
2023/2024	40,433	4,211	51,723	96,367	+9,544	+11%
2024/2025	44,572	4,951	52,783	102,306	+5,939	+6.2%
2025/2026	**44,010**	**5,123**	**53,080**	**102,213**	**-93**	**-0.09%**

Audits

We have a coding Data Quality Assurance (DQA) programme that reviews elements of clinical coding before the final submission of activity data. This ensures coding accuracy and that the depth of coding fully reflects the medical record. Each month, the programme identifies potential missing comorbidities from a sample of records and reviews these against the clinical documentation. This is supported by targeted audits carried out by the clinical coding auditor to further improve the quality of coded data. DQA sample sizes variations throughout the year are due to team capacity, periods of industrial action, and winter pressures affecting clinical availability.

Audits conducted during the year identified several opportunities for improvement, including:

- Comorbidity Validation
- Medical History Assurance
- Charlson / Elixhauser comorbidity index audit
- Individual coder audits
- Speciality Audits (Gynaecology/Surgical/Medical/T&O)
- Data Security Protection Toolkit Audit
- Learning From Deaths Group – Outlier Audits (Superficial Contusions/Anaemia & Deficiencies)
- Rules Audits
- Code / Scenario Specific Audits (Pacemaker Insertion Audit/Transnasal Endoscopies)
- Clinical Audit Support (Breast)

In addition to the opportunities identified through audit findings, there has been continued engagement with the Learning from Deaths Group and work to address data outliers identified with the Trust's former data supplier, Telstra.

The Clinical Coding team has worked closely with clinical specialties to improve the accuracy of comorbidity recording across all audits, alongside service improvement recommendations aligned with Get It Right First Time (GIRFT) best practice. This work has expanded to include a continued increase in comorbidity validation, the introduction of specialty-based audits and support for clinically led audits.

The clinical coding team have continued to utilise a medical history assurance tool provided by Solventum's Medicode360 encoder, which allows coders to look at past medical history and validate missing information with clinicians when available. The coding team also utilise Solventum's template coding function to increase efficiency and accuracy when coding.

Data Security Protection Toolkit (DPST) - Data Quality

As part of DSPT, we undertook an audit of 200 FCE's (April 2025 – February 2026). Trusts must meet or exceed the required percentage across all areas to meet the attainment level for a DSPT clinical coding audit. We have previously met the standard in two selected areas and exceeded the standard in correct secondary procedures and correct secondary diagnoses.

Results for 2025/2026

Table 5 illustrates the clinical coding audit results compared to the recommended percentage of accuracy scores from the Terminology and Classifications Delivery Service.

Green = standards met

Blue = standards exceeded.

Table 5: DSPT requirements Clinical Coding audit results.

SFHFT	Primary diagnosis correct	Secondary diagnosis correct	Primary procedure correct	Secondary procedure correct
Standard Met	>=90%	>=80%	>=90%	>=80%
Standard Exceeded	>=95%	>=90%	>=95%	>=90%
2022/2023	90%	93.4%	93.7%	89.9%
2023/2024	91%	95.6%	93.6%	96%
2024/2025	93.1%	95.0%	92.0%	92.1%
2025/2026	**91%**	**91.8%**	**93.7%**	**89.6%**

Based on the review of the DPST, table 6, outlines the recommendations that were made and confirmation that all were actioned within the timeframe.

Table 6: DSPT audit recommendations for Clinical Coding 2025/2026 into 2026/2027.

Recommendations	Responsibility	Priority	Date to be completed
Individual Coder Obstetrics re-audit	Clinical Coding Deputy Manager & Auditor	High	**May 2026**
Individual Coder Full Audit with Feedback & Learning Support	Clinical Coding Deputy Manager & Auditor	High	**March 2026**
Coders should refresh themselves on the four-step coding process	Clinical Coding Deputy Manager & Auditor	High	**May 2026**
Coders should refresh themselves on DCS.XIX.7: Postprocedural complications of medical and surgical	Clinical Coding Deputy Manager & Auditor	High	**May 2026**
Coders should refresh themselves on DChS.XVIII.1 Signs, symptoms and abnormal laboratory findings	Clinical Coding Deputy Manager & Auditor	High	**May 2026**
Coders should refresh themselves on DCS.I.4: Bacterial, viral and other infectious agents (B95-B98)	Clinical Coding Deputy Manager & Auditor	High	**May 2026**
Coders should refresh themselves on DGCS.9: Acute on chronic conditions	Clinical Coding Deputy Manager & Auditor	High	**May 2026**
Coders should refresh themselves PGCS3: Incomplete, unfinished, abandoned and failed procedures	Clinical Coding Deputy Manager & Auditor	High	**May 2026**
Coders should refresh themselves on the documentation that should be consistently reviewed	Clinical Coding Deputy Manager & Auditor	High	**May 2026**
Feedback to the Coding Team on the omitted Diagnoses on Endoscopies, Hysteroscopies and Cystoscopies	Clinical Coding Deputy Manager & Auditor	High	**May 2026**
Feedback to the Coding Team on all areas of coding errors	Clinical Coding Deputy Manager & Auditor	High	**May 2026**

Recruitment, Training and Performance

We have made significant progress in the recruitment and development of our Clinical Coding team during 2025/2026. Successful recruitment included a Clinical Coding Trainer and two Trainee Clinical Coders, filling previously vacant roles.

Despite constraints, the team has maintained a high level of performance and efficiency. Key achievements include:

- The Clinical Coding team is fully compliant with the mandatory training requirements set by NHS England national standards. The department is structured with three levels of clinical coders, supported by a management team and coding assistants.
- In 2025, two experienced coders achieved their national qualification, marking continuous improvement.
- Trainees now make up 33% of the team. The use of overtime by experienced staff has helped manage vacancies and performance pressures, supporting audits, performance targets, and training. This proactive approach has enabled the team to meet its responsibilities despite financial and staffing challenges.

Proactive management of vacancies, alongside continued investment in staff training and development, has supported the team to continue meeting its data protection responsibilities. Challenges associated with the reduction and removal of overtime, supporting new trainees and maternity leave have contributed to fluctuations in performance and audit progress.

Monitoring and Measurement of Progress in 2026/2027

Progress against Clinical Coding priorities for 2026/2027 will be monitored through a performance framework aligned with Trust governance. Timeliness will be reviewed monthly against the working day target via the Data Assurance Group (DAG), with escalation where variance persists. Accuracy and tracking of improvement will be measured through monthly DQA activity, targeted specialty audits, and annual DSPT audits. Workforce development, including trainee progression and vacancy impact, will be reviewed quarterly. Key findings, risks, and improvement actions will be reported through DAG.

Priorities for 2026/2027:

Deadline and targets: Return to 100% coding target by the fifth working day after the month end.

- Audits: Improve audit capacity and thereby coding accuracy by conducting wider data quality assurance audits.
- Data Security Protection Toolkit (DSPT): standards met compliance. Recruitment / training: Maintain trainee progression to alleviate demand and capacity issues over the next year.

2.2.9 Data Quality Strategy

Our Data Quality Strategy aims to influence and drive improvements in outcomes for patients through effective decision making by clinical, operational, and managerial staff, 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 7 below:

Table 7: Audit Commission - 6 Dimensions to data quality

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

We maintain three key behaviours in our approach to providing data quality: Responsiveness, proactivity, and continuous improvement. We 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 DQ team and Corporate Planned Care Team to remedy any identified issues.

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.

We have developed an in-patient audit programme that allows us to continuously improve monitoring of records and ad hoc audits 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

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

CareFlow is the Patient Administration System (PAS) we use. Initial system training is delivered by Nottinghamshire Health Informatics Service (NHIS) trainers and is a prerequisite to obtain access to our PAS. Our Electronic Patient Record (EPR) Applications & Data Assurance team, and the Corporate Planned Care trainer continue to deliver a comprehensive training plan for both DQ and Elective care. Annual compliance of training undertaken is being monitored and will be shared with the Divisions. Completion of DQ e-learning has increased in the past 2 years to 62%.

Data Quality Improvement Key Performance Indicators (KPI's)

We have a fully developed data quality analytical dashboard to support the improvements in 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 enabling the team to proactively identify areas of potential DQ improvement or issues that need to be actioned and addressed.

Data Quality Internal Audit Programme

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

- Continuing to keep the Trust 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 data assurance 'kitemark' process is currently being tested, to ensure the quality of our board reported indicators are being completed and once reviewed, they will form part of future integrated performance reports.

Data Quality Position 2025/2026

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.

Our overall average total DQMI score for Admitted Patient Care is 96.6% Outpatients is 96.1%, and the Accident & Emergency Departments is 79.19%.

We submitted records during 2025/2026 to 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.

Indicator	Admitted Patient Care	Outpatient Activity	Accident & Emergency Care
The % of records in the published data which included the patient's valid NHS number	99.9%	100%	**99.9%**
The % of records in the published data which included the patient's valid GP Code	100%	100%	**99.9%**
The % of records in the published data which included the patient's valid Ethnic Category	98.5%	98.1%	**95%**

2.2.10 Improving Care and Learning from Mortality Review

Performance against the Learning from Deaths Standard

Our DATIX-IQ Dashboard provides data on internal trust-related deaths.

During the reporting period 2025/2026, 1662 of our patients died at the Trust. Below is a quarterly breakdown of this total number for that reporting year:

- 383 deaths in Q1 (first quarter)
- 368 deaths in Q2 (second quarter)
- 459 deaths in Q3 (third quarter)
- 452 deaths in Q4 (fourth quarter)

The number of deaths for the previous reporting year (2024/2025) was 1767 (Datix-IQ).

Legislative changes to the process of Death Certification and role of the Medical Examiner (ME) have been in place since September 2024.

The Medical Examiner Service provides independent and balanced scrutiny of all cases. The process involves discussion with the clinical teams, consideration of any concerns raised, and communication with bereaved individuals regarding the proposed cause of death, including any questions or issues they may have. The ME has responsibility for ensuring an agreed cause of death is accurately reflected on the Medical Certificate of Cause of Death (MCCD), addressing any concerns and facilitating escalation or referral to the coroner, when appropriate.

We apply case-note review methodology, in the form of Structured Judgement Reviews (SJRs), as an approach to further investigation and learning. In 2025/2026, SJRs were requested in 124 cases, representing approximately 7% of total deaths. This figure is consistent with the previous year (2024/2025). SJR requests include statutory cases e.g. LeDeR (Learning from Lives and Deaths – People with a Learning Disability and Autistic People Review) and patients detained under the Mental Health Act, alongside cases where concerns or issues have been raised during patient management, family contact and as part of the ME scrutiny process.

The number of deaths for each quarter of this reporting period, where an SJR has been raised is:

- 46 in Q1
- 18 in Q2
- 27 in Q3
- 33 in Q4

The Datix IQ mortality review tool has been in use since October 2024. Mortality reviews are managed via this platform which can capture ME Processes, SJRs, avoidability assessments and other learning outcomes. Prior to access, users must undergo training in both use of the DATIX-IQ platform and SJR methodology.

Mortality leads are responsible for their specialty/divisional SJR submissions. This supports the drive for clinical and divisional ownership and helps us meet improved standards for quality assurance and providing consistency in our approach to mortality reviews and wider learning. The Business Insights Team (as part of the IF) have been instrumental in the development of a Power BI dashboard to support oversight and analysis of SJRs.

The dashboard includes SJRs “overall phases of care” with the predominant rating currently reported as “good”. Where poor care is identified, the escalation process includes a review via Divisional Governance meetings and Patient Safety Incident Review Group (PSIRG). This supports identification of cases that require us to undertake a Patient Safety Incident Investigation (PSII) under the Patient Safety Incident Response Framework (PSIRF) where we believe that issues in the care provided, have probably contributed to a person’s death.

Mortality and Clinical Leads are encouraged to complete and sign off, timely SJR submission, to ensure the system remains up to date. Information from this is used to support Specialty and Divisional teams with their governance processes, assurance measures and overall learning.

Moving forward, the focus is to encourage thematic reviews and use specific examples, and include them in Divisional Mortality meetings, for wider learning. A common theme from divisional reporting has been a need to ensure effective communication and documentation between clinical teams but also with patients or family members. A particular emphasis has been acknowledged around End of Life (EoL) and maintaining highest standards of care throughout this time.

Legal Service Reporting:

Between Quarter 1 (Q1) and Quarter 3 (Q3) 2025/2026, our Legal Services reported 93 newly open coronial matters. 130 have been provisionally disclosed for the full reporting year 2025/2026, the same number as for the previous full year (2024/2025). During 2025/2026, the Trust received two Prevention of Future Deaths Reports.

The reports highlight specific concerns and formally request appropriate action. These include a paediatric case and the need to improve both learning and processes for diagnosing long QT Syndrome (heart condition abnormality on ECG).

A further case, involving a jury inquest for a patient detained under the Mental Health Act, highlights the need to improve communication between acute and Mental Health Trusts. Action plans support the assurance process and include work to improve pathways, provide targeted teaching and share key learning.

Requests for information by the coroner or other cases of legal enquiry have highlighted the challenges in ensuring accurate recall and account of incidents. As part of its drive for improvement, the Trust has implemented a Factual Recollection of Events (FROE) template to help record a clear factual description of involvement, that staff can use at the time that an event occurs.

Engagement with the bereaved, facilitated by the Bereavement Centre Team, ME Service, and Patient Experience Team, combined with enhanced governance and assurance processes, help ensure essential information is readily available to support inquests and subsequent inquiries.

2.3 Reporting against Core indicators

2.3.1 Summary Hospital Level Mortality Indicator (SHMI) banding

The SHMI reports on mortality at Trust level across the NHS in England, using a standard and transparent methodology. It is the ratio between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die based on average England figures, given the characteristics of our patients treated at SFHFT.

It includes any deaths which occur in hospital and deaths which occur outside of hospital within 30 days of discharge from the Trust.

SHMI reports on mortality data for each non-specialist acute NHS trust in England, indicating whether the actual (observed) number of deaths was:

- ‘higher than expected’ (SHMI banding = 1),
- ‘as expected’ (SHMI banding = 2) or
- ‘lower than expected’ (SHMI banding = 3) versus the national baseline.

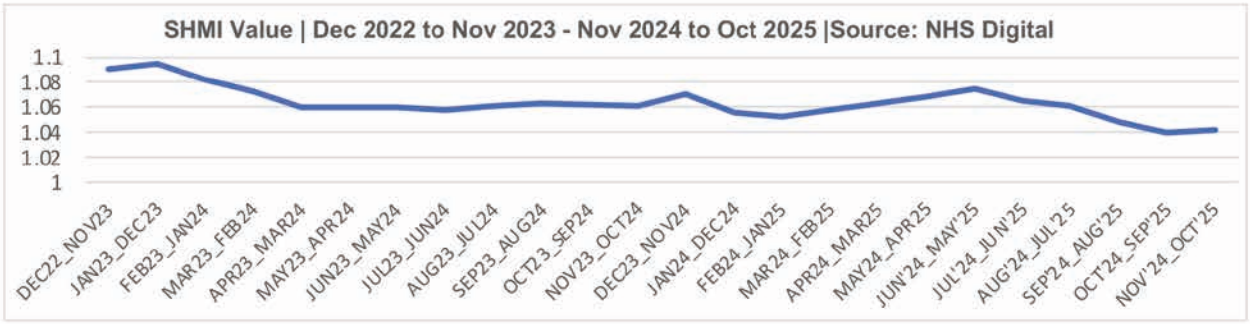
Our most recent SHMI data, published in February 2026, is presented below in Table 8. The reporting period is delayed by several months, because of the required processes involved in the data submission and validation.

Table 8: SHMI value and banding

Reporting period	Published	SHMI value	Banding
December 2023- November 2024	April 2025	1.0703	2
January 2024 - December 2024	May 2025	1.0559	2
February 2024 - January 2025	June 2025	1.0529	2
March 2024 - February 2025	July 2025	1.0576	2
April 2024 - March 2025	August 2025	1.0630	2
May 2024 - April 2025	September 2025	1.0686	2
June 2024 - May 2025	October 2025	1.0750	2
July 2024 - June 2025	November 2025	1.0655	2
August 2024 - July 2025	December 2025	1.0608	2
September 2024 - August 2025	January 2026	1.0482	2
October 2024 - September 2025	February 2026	1.0401	2
November 2024 – October 2025	March 2026	1.0423	2

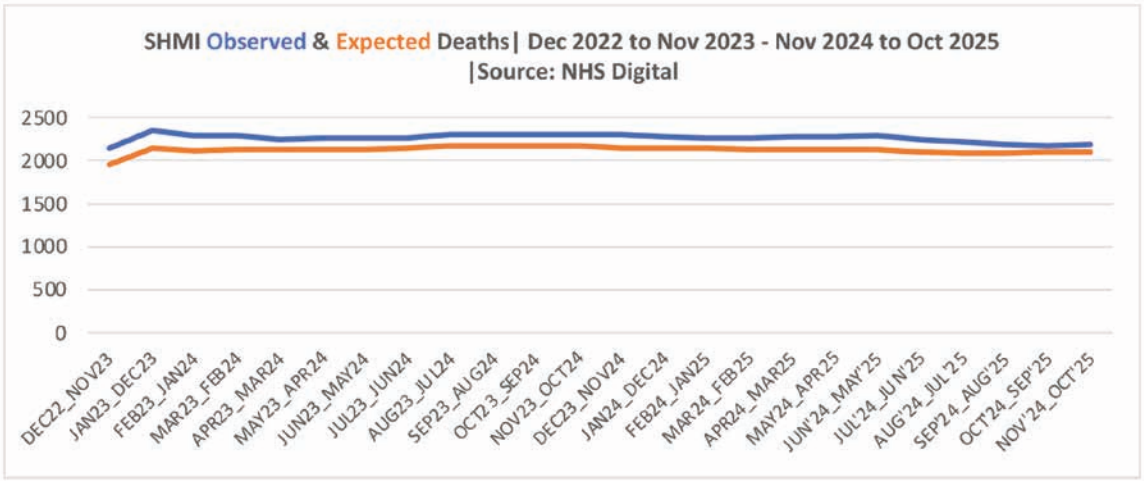
The Trust remains “as expected” in band 2.

Graph 4: 2-year SHMI Trend



The difference between the number of observed and expected deaths should not be used as a definitive indicator of avoidable deaths for the trust; neither is it considered to be a direct measure of quality of care. See Graph 5.

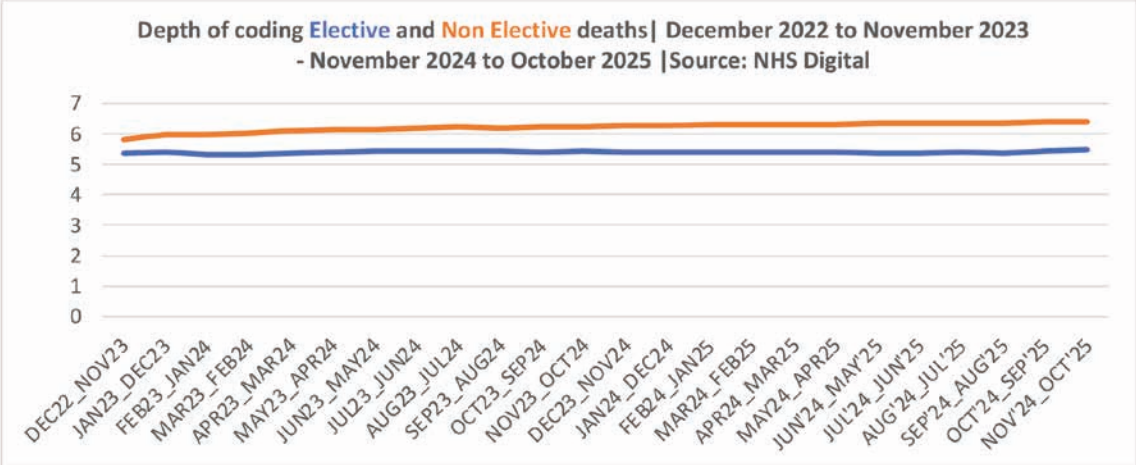
Graph 5: SHMI observed and expected deaths



NHS Digital defines 'Depth of coding' as "the number of secondary diagnosis codes for each record in the data. A higher mean depth of coding may indicate a higher proportion of patients with multiple conditions and/or comorbidities but may also be due to differences in coding practices between Trusts.

We believed "Depth of coding", including accurate capture of diagnoses and co-morbidities, to be a key factor in explaining the gap between observed and expected rates. Over the past 36 months, specific focus has been on accurate documentation and how this impacts coding; particular emphasis has been on ensuring clear and timely recording of diagnoses, as opposed to symptoms and signs, where we continue to see an overall improved picture. The coding team have been integral to this work, supporting education, communication of standards and helping with a wider understanding of where gaps, or opportunities for improvement exist. See Graph 6.

Graph 6: Depth of coding (mean number of additional codes) for Elective and Non-Elective deaths



SHMI is the key mortality metric referenced in the NHS Oversight Framework and has become the primary indicator for the Trust.

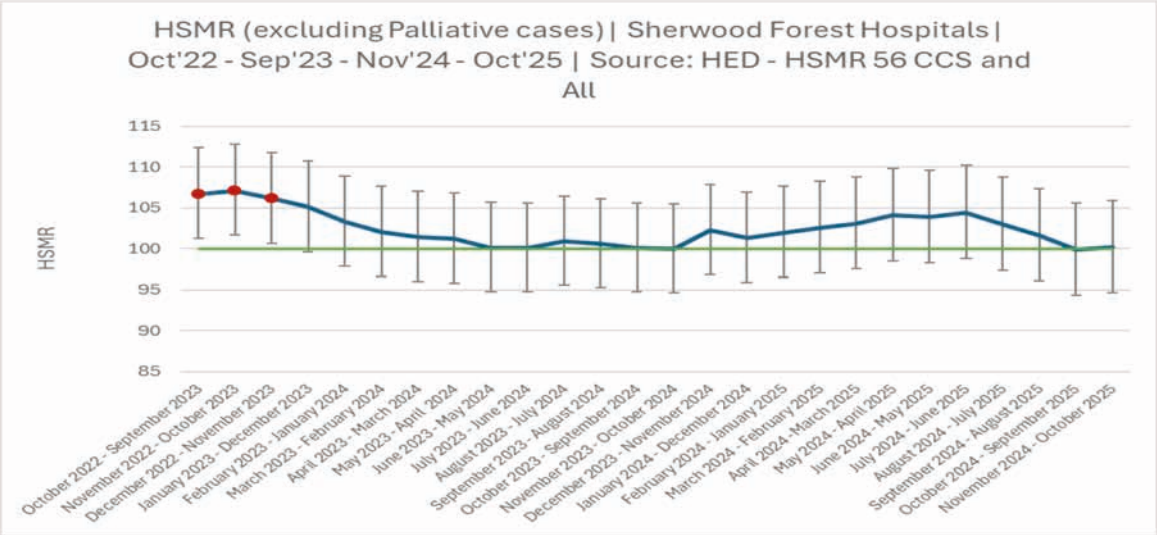
In November 2024, Telstra revised its reporting methodology from Hospital Standardised Mortality Ratio (HSMR) to HSMR+ (plus). Amongst other parameters and metrics, this included changes with specialist palliative care coding for which the Trust had consistently been an outlier. Since this revision, we have observed a markedly reduced value for HSMR+, versus HSMR, with consistently reporting "within expected" and in a stable position when compared to peers and National benchmarking.

The longer-term strategy is for a more pro-active and clinically driven approach to mortality oversight and learning. By taking greater ownership of their data, teams and individuals can spot early signals or trends to help identify areas for further review and analysis.

Our relatively stable mortality position, as shown by both SHMI and HSMR+, alongside the decision to focus on SHMI as the key mortality metric, provided an ideal opportunity to explore improvements in data provision and consider a potential change in mortality benchmarking provider.

Formal HSMR+ tracking stopped as of September 2025 with the primary focus being that of SHMI. See Graph 7.

Graph 7: HSMR overview (Sept 2023 - October 2025)



In December 2025, we launched the Healthcare Evaluation Data (HED) platform. It is anticipated this will support a more comprehensive approach to benchmarking, greater engagement of clinical teams, and improved co-ordination with neighbouring Trusts.

2.3.2 Patient Reported Outcome Measures (PROMS

PROMs measures health gain in patients undergoing hip and knee replacement surgery in England, based on responses to questionnaires before and after surgery. This provides an indication of the outcomes or quality of care delivered to NHS patients and has been collected by all providers of NHS-funded care since April 2009.

The EQ-5D health questionnaire has two parts. The EQ-5D self-classifier asks patients to describe their health in terms of the level of problem (no problems, some problems or extreme problems) giving a health profile.

The EQ-VAS is a visual analogue scale between 0 (worst imaginable health) and 100 (best imaginable health) on which patients provide a global assessment of their health.

EQ VAS - the higher score indicates better health and a higher perceived quality of life. EQ-5D – a score of 1 indicates ‘full health’.

The Oxford scores assess both pain and function most relevant to the diseased joint. All scores are validated for the use in judging improvement in patient satisfaction

SFHFT performance in relation to national data is based on 3-6% response rate of the 1000 joint replacements carried out at SFHFT each year. This is deemed sufficient for analysis and assessment of outlier status.

Table 9 below, demonstrates how SFHFT compares with the national average for measuring generic health status (EQ VAS and EQ-5D) and the Oxford Hip and Knee scores (2024/2025).

Procedure	EQ VAS (SFHFT)	EQ VAS (England)	EQ-5D (SFHFT)	EQ-5D (England)	Oxford Score (SFHFT)	Oxford Score (England)
THR (Hip)	14.4	14.5	0.4	0.4	23.6	22.4
TKR (Knee)	9.3	8.8	0.36	0.3	16.6	23.4

THR (Total Hip Replacement), TKR (Total Knee Replacement

Summary:

1. SFHFT is not outlier.
2. For both Hip and Knee surgery SFHFT are within normal parameters of National scores
3. Knee replacement data is comparable to the national average based on 12% responses. (variations within statistical limits)

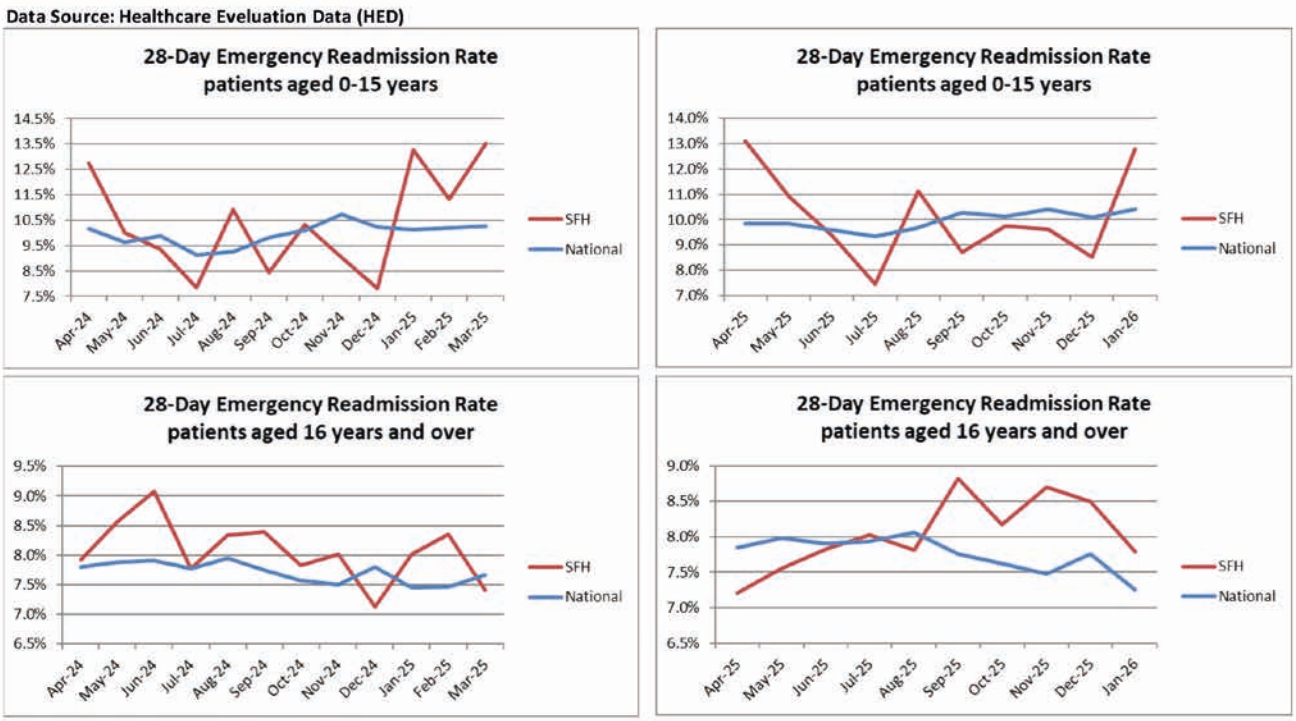
SFHFT has begun a research programme to optimise patients in relation to physiotherapy and general health. The primary goal of this is to ensure that they are fit for surgery and support a quicker recovery post-surgery.

2.3.3 Percentage of patients readmitted to hospital within 28 days

Data is now being sourced from the benchmarking tool 'HED'. The collection methods and metric definition are different to data published by Telstra (Dr Foster), so historic figures, although similar, may not be directly comparable.

- The readmission rate for 0-15 years old has deteriorated slightly in April 2025-year to January 2026, to 10.13% compared to the same period last year (9.97%).
- The 16 years + readmission rate is relatively stable during the same period (8.04% 2025/2026 compared with 8.11% 2024/2025), with the most recent reporting months showing a reduction, in line with the national trend.
- The 0-15 years cohort compares unfavorably to the national performance during the previous year (2024/2025) by 0.4% but has been improving during 2025/2026. The 16+ years cohort has performed worse than the national rate since 2024/2025, particularly during the winter period of 2025/2026.

Graph 8: Data Source: Healthcare Evaluation Data (HED)



N.B. - National rate includes all non-specialist acute trusts

We continue to build effective relationships with community and external partners to ensure patients are supported through safe and timely 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

The Trust is dedicated to addressing any concerns promptly, often through direct discussions between a patient, relative, and/or carer and the relevant team. For those who feel uncomfortable bringing up concerns directly with the department or service, or if their concerns remain unresolved after doing so, the Patient Experience Team (PET) is available to offer confidential advice and support. The PET strives to resolve any raised concerns in a timely and informal manner.

We currently operate a centralised complaints service, to ensure a patient-focused approach in managing complaints. Each complaint is thoroughly investigated, with responses provided within a timescale of 25 to 60 working days, depending on complexity.

Divisions continue to receive ongoing support throughout a newly implemented complaints process, which encompasses leadership of complaints from divisions and is supported by the PET, whilst

remaining tailored to meet the specific needs of each area. Oversight of complaint responses completed by divisions is maintained by the Director of Nursing, Quality and Governance, ensuring quality assurance, with additional assistance provided to divisional teams as required.

Multi-divisional responses continue to be coordinated centrally. Next steps include the divisions taking the lead on these complaints.

Learning and improvements arising from individual complaints are carefully analysed to identify recurring themes. This information is shared across the organisation to drive necessary improvements.

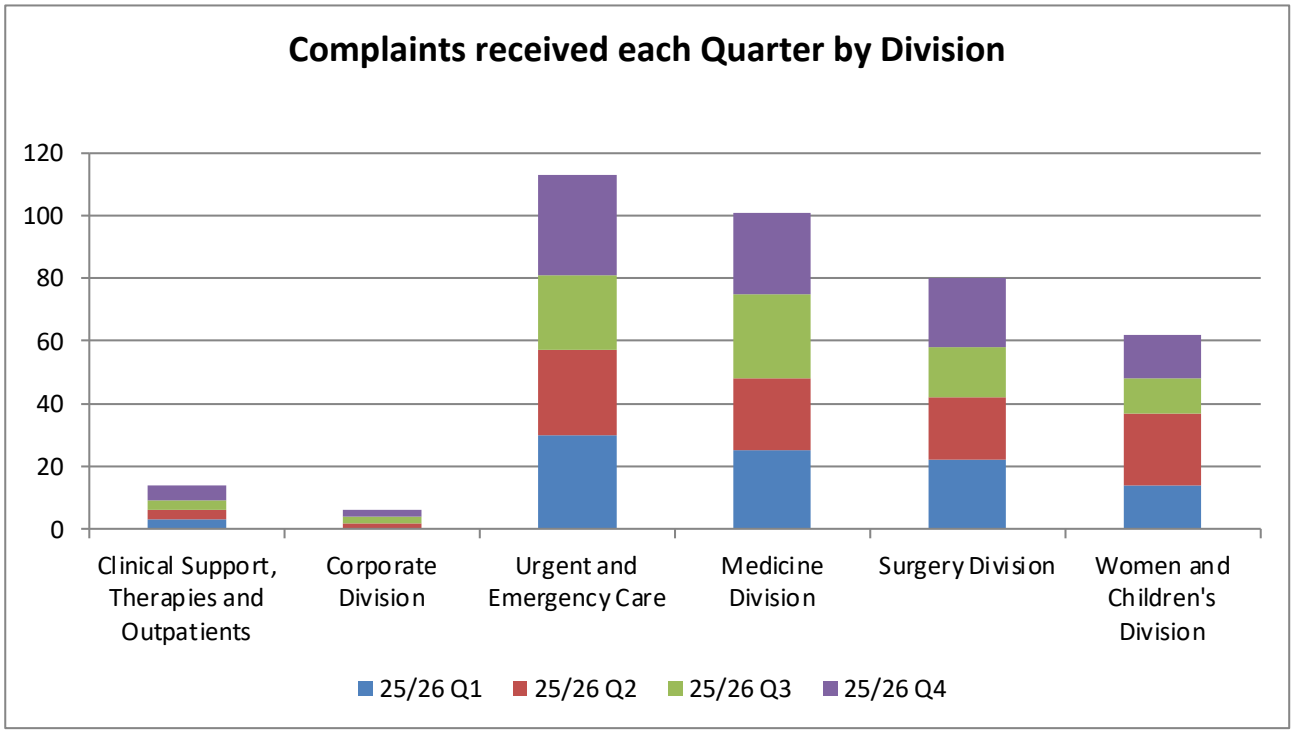
During 2025/2026, we received 376 new complaints, a 39% increase compared to 2024/2025. A breakdown of the complaints received during each quarter is shown below Table 10.

Table 10: Number of complaints received

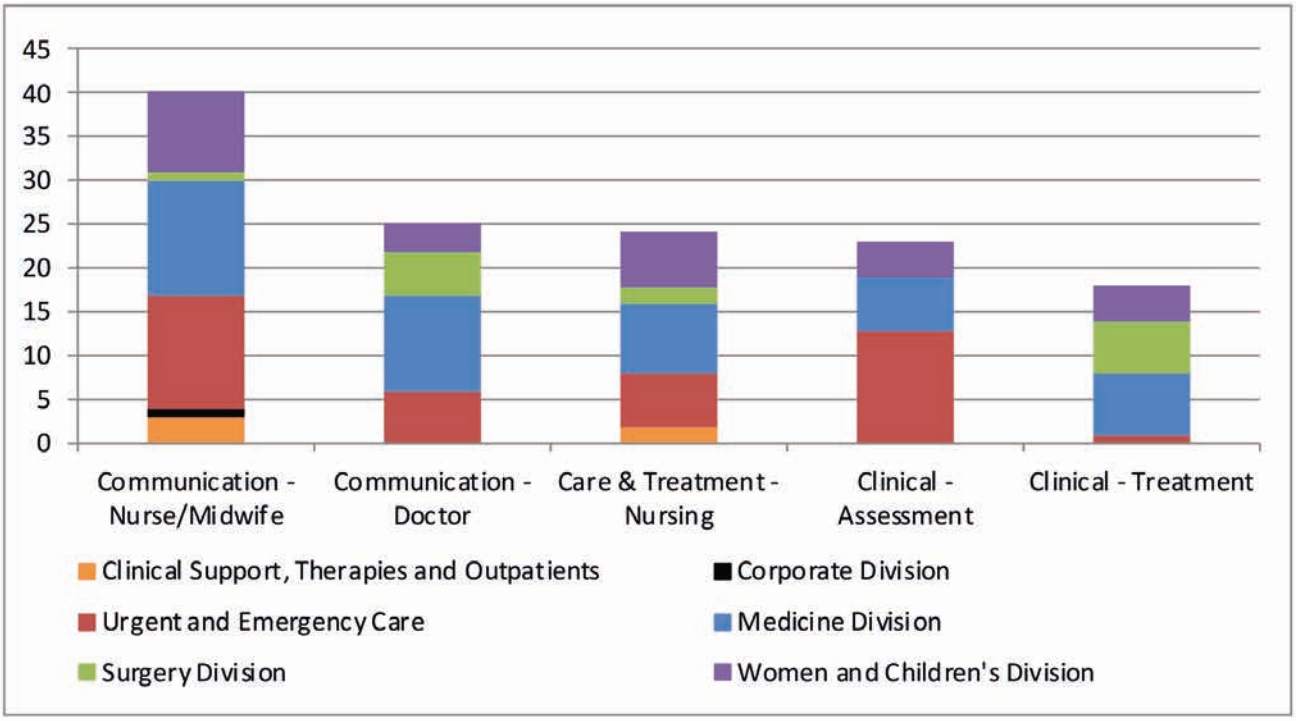
	2024/2025	2025/2026	% difference
Quarter 1	69	94	36% increase
Quarter 2	73	99	36% increase
Quarter 3	57	82	44% increase
Quarter 4	71	101	42% increase
Total	**270**	**376**	**39% increase**

The graphs 9 and 10 below show a breakdown of the number of complaints and themes received, each quarter by division.

Graph 9: Complaints by Division



Graph 10: Top 5 Themes - Complaints received Quarterly by Division



In 2025/2026, 331 complaints were closed. 44% were completed within the timeframe agreed with the complainant. All complainants were kept informed of the progress of their complaint, and a personal apology was offered to each. During this period, the backlog of complaints has been significantly reduced.

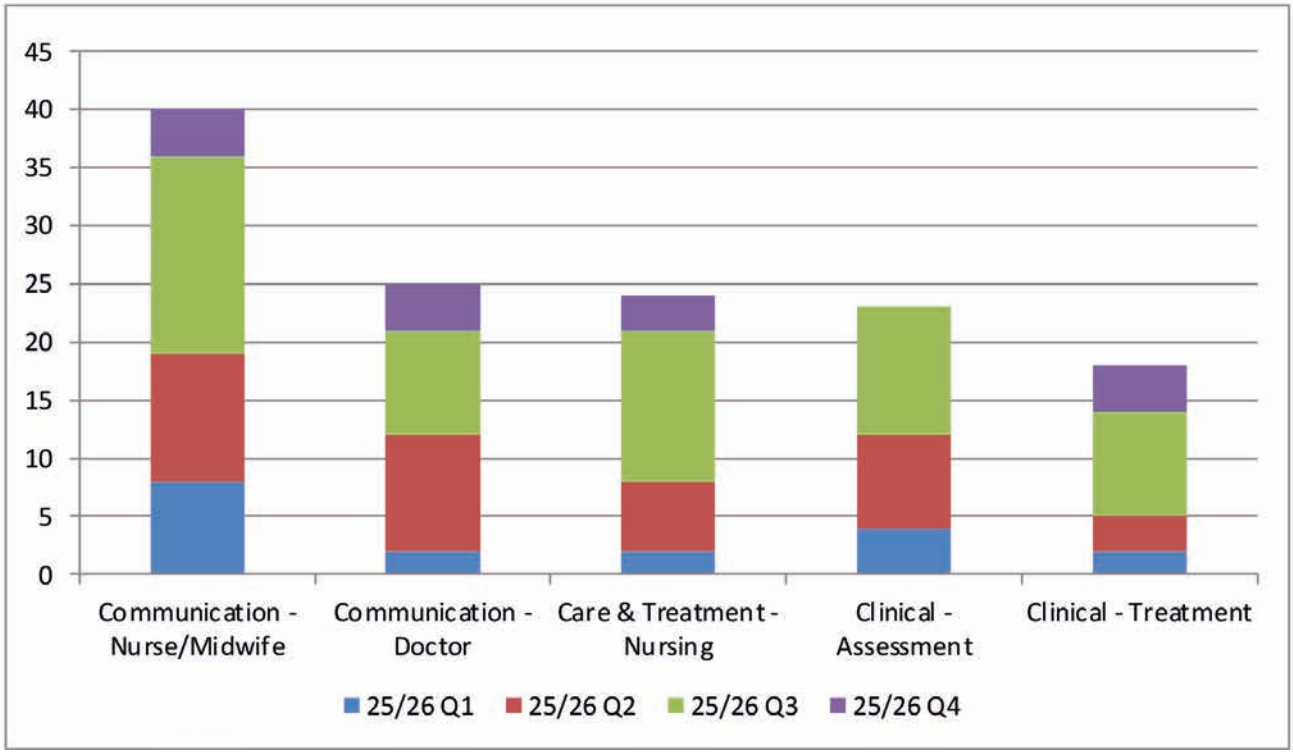
Complaints are reviewed during monthly divisional governance meetings and at a dedicated Patient Experience Committee. To ensure local monitoring and ownership, the PET continues to circulate a weekly complaints Datix tracker, ensuring divisions are provided with all relevant information for individual cases.

Table 11 and graph 11 below show the top five themes for the complaints closed throughout 2025/2026.

Table 11: Top five themes for complaints received 2025/2026

	Clinical Support, Therapies and Outpatients	Corporate Division	Urgent and Emergency Care	Medicine Division	Surgery Division	Women and Children's Division	Total
Communication - Nurse/Midwife	3	1	13	13	1	9	**40**
Communication - Doctor	0	0	6	11	5	3	**25**
Care & Treatment - Nursing	2	0	6	8	2	6	**24**
Clinical - Assessment	0	0	13	6	0	4	**23**
Clinical - Treatment	0	0	1	7	6	4	**18**
Total	**5**	**1**	**39**	**45**	**14**	**26**	**130**

Graph 11: Top 5 complaint themes closed 2025/2026



Communication is the most frequently reported source of dissatisfaction, alongside concerns relating to the care and treatment provided by the nursing team and the clinical assessment and treatment provided.

All complaints are carefully analysed to ensure that any safeguarding or patient safety issues are promptly escalated and addressed. The analysis identifies any recurring themes and trends, which are then shared with divisions for further action.

Of the 331 complaints responded to in 2025/2026, 66% were upheld or partially upheld, a similar result to the previous year. This has provided an opportunity for learning and service improvements.

A total of 22 complaints were re-opened because the complainant had raised additional concerns to the original complaint, and it was agreed with the divisional teams that a further response could be offered. This reflects a 16% increase in the number of re-opened complaints, compared with

cases re-opened in 2024/2025. 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.

The PHSO initiated 6 new complaint reviews in 2025/2026. 4 were closed without further investigation. 1 case is currently undergoing investigation, and we await confirmation of the scope for 2 of these cases.

A total of 11 investigations were closed by the PHSO between April 2025 and March 2026. Of these, 7 did not require any further investigation.

Table 12 provides an overview of the 4 investigations completed by the PHSO across the specialties of Medicine, Urgent & Emergency Care (UEC), and Surgery.

Table 12: Cases closed by the PHSO during 2025/2026

Division / Speciality	Subject	Date PHSO Open	Date PHSO Closed	PHSO outcome	Learning from PHSO
Medicine / UEC/ Surgery	Care and Treatment	09/06/2022	10/04/2025	Partially Upheld	Poor record keeping of food and fluid intake, Inaccurate completion MUST assessments, delayed referrals, lack of patient engagement regarding food intake in addition to poor communication and consideration for the patient's learning disability. Divisional work streams around nutrition were also highlighted as necessary improvements.
Medicine	Care and Treatment	23/11/2023	31/08/2025	Partially Upheld	Poor communication between the nursing team and the patient's family. Failure to progress the complaint in a timely manner and update family.
UEC / Medicine	Care and Treatment	02/09/2024	23/10/2025	Partially Upheld and Financial Remedy	Failure to provide adequate pain relief, and manage pain symptoms, during end-of-life care. PHSO requested, SFHFT provide financial redress
UEC	Care and Treatment	16/08/2024	25/11/2025	Partially Upheld	Delays in assessments, pain relief, and antibiotic treatment, resulting in inadequate management of patient symptoms.

2.3.5 Staff Friends and Family responses and recommendation rates

National NHS Staff Survey – 2025

The ongoing impact of NHS pressures and the after-effects of the COVID-19 pandemic on our people continue to impact in 2025/2026. An important vehicle for listening to the voices of our staff is the annual National Staff Survey (NSS).

The NSS 2025 closed at the end of November, with 3615 colleagues taking the opportunity to share their voices. There was a 58% response rate across the Trust (compared to 63% last year).

This was the second highest number of colleagues completing the survey in the last five years. The national average response rate for Acute Trusts was 47%, down from 48% the previous year. Our response rate is 11% higher than the national average.

This survey is supported by quarterly pulse surveys and ongoing engagement within the Trust about the commitments made by the Trust following the NSS. Together, these provide a full year-round process for staff engagement and consultation. The aim is to increase staff participation each year so we can identify the key areas for improvement.

A total of 99 questions were included in the 2025 survey. Of these, 1 question showed significant improvement, 57 showed significant decline, and 41 showed no significant change.

When compared with the Acute and Acute & Community sectors (where 71 of 122 organisations are contracted to IQVIA), we scored significantly better than the sector average on 21 questions, significantly worse on 23 questions, and showed no significant difference on 67 questions.

The 2025 NHS Staff Survey questions are aligned to the seven elements of the NHS People Promise, along with two additional themes: engagement and morale. All indicators are based on scores out of 10 for specific questions, and each indicator score represents the average of those question scores.

Each year, our priorities are reviewed and refreshed based on survey results, quarterly pulse survey feedback, Freedom to Speak Up Guardians, the People Directorate Team, divisional feedback and the National Education and Training Survey (NETS).

Evidence from feedback indicates that we continue to have a high-quality, positive culture overall. Where there are challenges, teams and individuals are supported to resolve them.

Engagement with colleagues remains a priority for the People Directorate, working with the Communications team to make full use of internal channels, supporting communication, and deliver a rolling 12 month engagement and communication programme.

The 2025 NSS results showed that SFHFT remains a place where colleagues are proud to work (59%), which remained above the national average, and were happy with the standard of care provided (67%), which also remained above the national average.

Table 13 and 14 demonstrate the comparison between 2024/2025 and 2025/2026. Scores for each indicator, together with those of the survey benchmarking group (122 Acute and Acute community trusts), are presented below:

Table 13: Indicator comparison 2024/25 and 2025/2026

Indicators ('People Promise' elements and themes)	2025/26		2024/25	
	SFHFT Score	Benchmarking Group Score	SFHFT Score	Benchmarking Group Score
People Promise				
We are compassionate and inclusive	7.4	7.3	7.5	7.2
We are recognised and rewarded	5.9	5.9	6.2	5.9
We each have a voice that counts	6.7	6.6	7.0	6.7
We are safe and healthy	6.0	6.1	6.3	6.1
We are always learning	5.7	5.6	6.0	5.6
We work flexibly	6.2	6.2	6.5	6.2
We are a team	6.8	6.8	7.0	6.7
Staff Engagement	6.7	6.7	7.1	6.8
Morale	5.9	5.8	6.3	5.9

Table 14: Demonstrates 2025/26 our benchmarking position regionally and nationally

Theme	National Position Acute /Acute Community Trusts (/122)	Regional Position (/21)	East Midlands (/9)
We are compassionate and inclusive	37th	5th	2nd
We are recognised and rewarded	63rd	6th	3rd
We each have a voice that counts	49th	7th	3rd
We are safe and healthy	65th	8th	4th
We are always learning	43rd	6th	3rd
We work flexibly	75th	13th	6th
We are a team	39th	5th	3rd
Staff Engagement	66th	8th	3rd
Morale	53rd	7th	3rd

Although scores have declined across many questions in 2025, we continue to perform well compared with other Acute and Acute Community Trusts. This reflects the national trend, where staff survey results have generally shown no improvement or further decline. The NSS highlights a workforce under increasing pressure, increasing operational strain, with signs of declining wellbeing and morale and a rise in negative behaviours from patients and the public. Overall, this presents a picture of a system struggling to sustain a positive and supportive working environment.

Actions

Whilst there have been some positive improvements in some of our NSS result scores in 2025, there are areas that require continued focus into 2026. We are taking action to improve colleagues' work experience through key Trust and Divisional commitments below. We also recognise the need for more meaningful engagement, including regular one-to-one conversations, so every colleague feels heard - including those who chose not to take part in the survey. Our aim for NSS 2026 is to increase response rates by reaching colleagues whose voices we have not yet heard.

These are underpinned by commitments from within our clinical and Corporate Divisions.

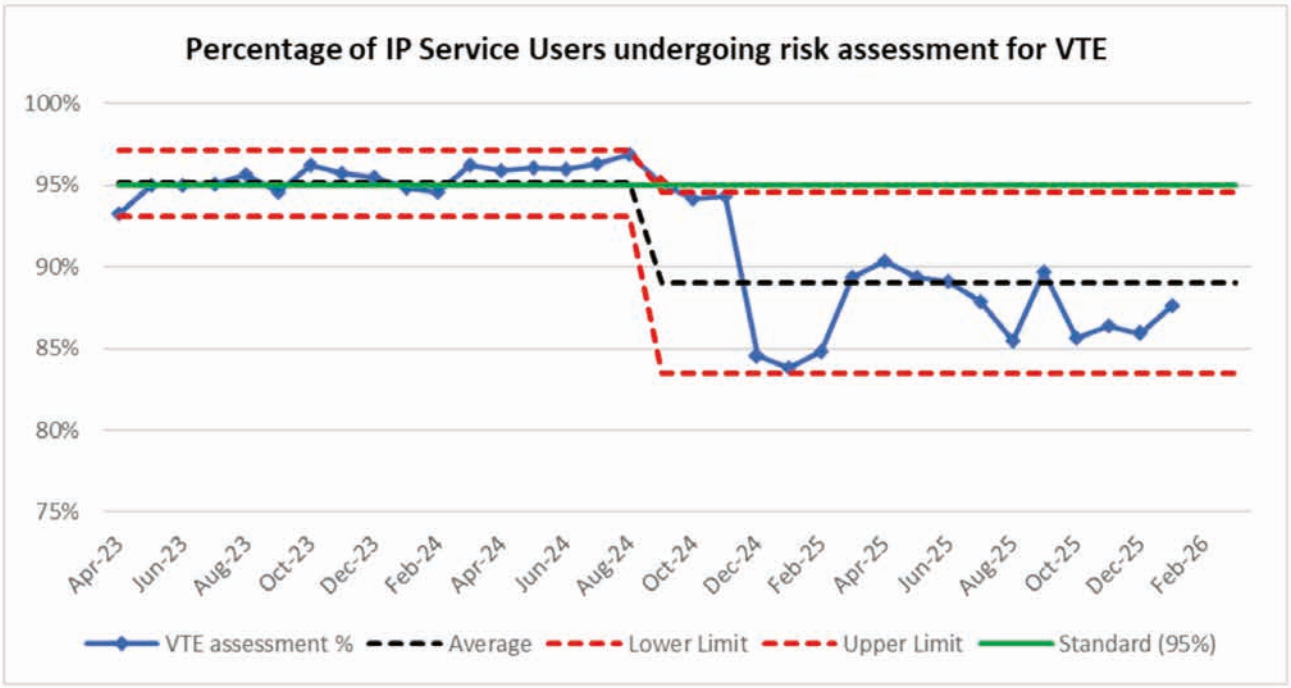
2.3.6 Venous Thromboembolism (VTE)

A VTE is a blood clot that forms within a vein that can cause occlusion within the lung or in the deep leg veins. 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.

- 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.

The graph 12 below demonstrates the performance against the level of compliance required

Graph 12: Monthly VTE Assessment Performance



VTE assessment performance declined at the point when Electronic Prescribing and Medicines Administration (EPMA) was introduced within the Emergency department. Subsequent diagnostic work has indicated that the reduction in compliance is likely attributable to a system design issue.

VTE assessment remains a key indicator within the Trusts' Integrated Performance Report. Supporting the prioritisation of digital transformation actions identified by the VTE improvement group, has been approved by the Patient Safety Committee.

2.3.7 Clostridium Difficile infections

CDiff is acknowledged as an issue that impacts upon the whole health economy. During 2025 there has been a continued increase in Clostridioides in England. The Trust has maintained its partnership approach to this across the Integrated Care Board (ICB). The trajectory for 2025/2026 was set at 65 Trust associated cases. Unfortunately, the Trust reported 82 cases.

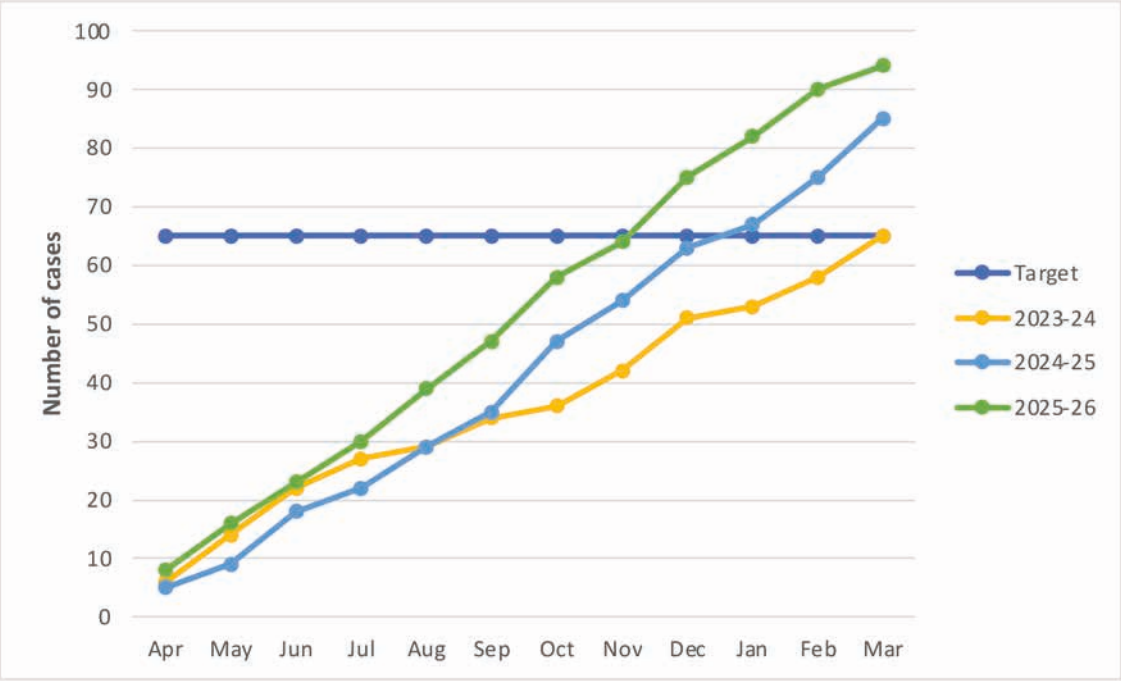
Aims for 2025/2026:

- To maintain the Deep Clean programme
- To work closer with our antimicrobial pharmacists looking at antimicrobial stewardship and deep diving into the antibiotic history of our 85 cases identified.
- Continue to carry out infection control reviews on all Trust associated cases and refer for PSII if required.

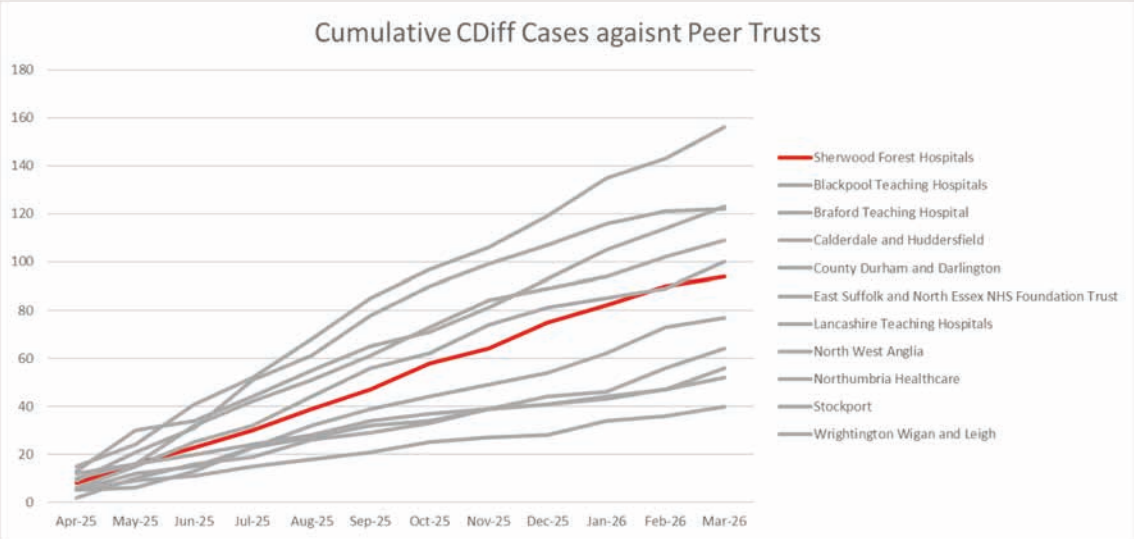
How was this achieved?

In 2025/2026 the number of cases identified as Trust associated is 92 (Graph 13). When benchmarking our position against our national peer Trust we sit in the middle of the group with the number of cases we have identified. (Graph 14)

Graph 13: SFHFT cumulative total of Trust associated CDiff cases



Graph 14: Cumulative total of hospital associated CDiff cases against national Peer Trusts



An infection control review of all cases was performed to establish any common themes and to identify if cases were avoidable or unavoidable. There have been 3 outbreaks with links established identifying cross transmission. To validate this link, we sent CDiff samples to the CDiff reference laboratory to look for the Ribotype of the cases. Lapses of care were monitored for all cases and included missed opportunities with cleaning, delays in obtaining samples, delays in isolation and a small number of inappropriate antibiotic prescribing.

We continue to take action to reduce the number of CDiff cases and invited NHS England to conduct a review. Following this review there were areas for improvement identified and action plan developed. There was also a 'deep dive' into all the CDiff cases to look at the number and type of antibiotics used and the indication for those antibiotics. Next steps of this review are to:

- Review the number of doses of antibiotics given
- Review the diagnostic testing undertaken to confirm the indication of the antibiotics.

Cleanliness

We have continued to implement the national cleaning standards and have now moved to a cleaning pathway system to support the increased cleaning of high touch surfaces and sanitary wear. This is monitored through joint audits and reported to the Infection Prevention and Control Committee.

Correct cleaning is fundamental in reducing the risks of transferring CDiff. The Infection Prevention and Control team (IPCT) continue to work with Medirest, Skanska, Trust colleagues and commercial companies to improve the consistency of the cleaning processes, 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.

The Trust have carried out deep cleans, with the Decant Team on the wards when CDiff outbreaks occur, periods of increased incidences or patients are still in the area.

Monitoring and reporting

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

The trajectory for 2026/2027 has not yet been set, however we are expecting it to be similar this year. Monitoring will continue through the Infection Prevention and Control Committee and escalated to Patient Safety Committee.

Priorities for 2026/2027:

- To maintain and expand the Deep Clean programme
- To work closely as a team on the call to action for antimicrobial resistance, with our 3 priorities including changes to our CDiff diagnostic testing adding in a further line of testing to confirm positive results and the IV to oral switch
- Continue the next steps of the deep dive into cases.

2.3.8 Patient Safety Indicators or incidents?

We are 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 these 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 (PSIRP).

This is now well embedded, and we continue to learn and improve following a patient safety incident, working alongside patients and families when things go wrong. We continue to develop the use of the SEIPS (Systems Engineering Initiatives for Patient Safety) framework to help understand the outcomes within complex systems.

The Family Liaison Officer (FLO) continues to support the Trust by maintaining contact and building relationships with patients and their relatives following an incident. The FLO received over 100 contacts during 2025/2026 and gave support in the form of regular telephone updates, meetings, and the opportunity to meet to discuss any questions or concerns. The role of the FLO continues to evolve with plans to develop further reports and audits to ensure accountability and assurance for the work carried out by the Divisions and Governance Support Team.

Level of patient safety reporting

During the year we have applied a range of system-based approaches by commissioning:

- 12 Patient Safety Incident Investigations (PSIIs)
- 14 After Action Reviews
- 7 MNSI (Maternity Newborn Safety Investigation)
- 1 thematic review
- 1321 local responses

We have continually reviewed the number of learning responses commissioned, and the timeframes for completion.

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

Part 3 Other Information - Additional priorities

3.1 Safety – Improving the safety of our patients.

What we planned to achieve in 2025/2026

- Continue to develop the Patient Safety Partner (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.

How did we do?

Quarterly meetings for PSPs continue and the PSP's have joined a systems-based approach in 2025, via a system level network meeting. Work reflected includes:

1. Attending Engagement/opening events
2. Interviews for key Governance staff members
3. Giving patient perspective opinions on documents
4. Attendance at the Patent Experience Committee
5. Attendance at the Patient Safety Committee,
6. Shared learning from all providers across the ICB

PSPs have now joined the weekly Executive led Patient Safety Incident Review Group (PSIRG) meetings, and will gain an understanding around incidents, Patient Safety Incident Investigations (PSII), the processes involved, training, after action reviews, and will be able to provide the patient perspective. Their invite extends to the PSIRG oversight group, where focused actions and learning are shared from incidents.

We have re-launched an internal reporting method, Greatix', which captures evidence of good care.

In 2024, SFHFT transitioned to a new national way of reporting incidents, Learning from Patient Safety Events (LFPSE). The implementation requirements of 'Good Care' and 'Risk' events for LFPSE have yet to be fully defined by NHSE. We will continue to align and monitor this into 2026/2027 and follow NHSE guidance as it is published.

Priorities for 2026/2027:

- 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.
- Review how we can report Good Care Events on datix and LFPSE and explore reporting Outcome and Risk events in line with NHSE guidance.
- The implementation requirements of 'Good Care' and 'Risk' events for LFPSE will be monitored into 20206/2027 and follow guidance from NHSE once received.
- Continue to focus on shared learning and improvements.

3.2 Safety – Reduce Harm from Falls

Falls have a major impact on patients, and the reasons behind them are often complex. Common risk factors include delirium, cognitive impairment, dementia, postural instability, muscle weakness, deconditioning, peripheral neuropathy, poor vision, mobility or balance difficulties, arthritis, and vitamin D deficiency. As the number of risk factors increases, so does an individual's likelihood of falling. We are committed to reducing harm caused by falls.

What we planned to achieve in 2025/2026:

- Roll out visual acuity checks across all three hospital sites and educate staff on how to perform the check.
- Connected Care volunteers to promote activities for our patients, to reduce deconditioning.
- Embed after action reviews.
- Staff training and education to be revised, including planning the champions days for falls as a stand-alone session.
- Continue to participate in local and national audits, for example bed rail audits, National Audit Inpatient Falls (NAIF)

How did we do?

- Visual acuity checks assessments are available and completed on the digital system Nervecentre by the Falls Prevention Practitioner's (FPP's) during repeat falls visits. The Trust wide rollout has been delayed due to capacity challenges, but the team remains committed to full implementation during 2026/2027.
- Two Connected Care Volunteers are now promoting activity on Woodland Ward. Recruitment delays have slowed further expansion at present; however, efforts continue to increase volunteer numbers during 2026/2027.
- The new After-Action Review template is in its final stages of approval. This combines the current falls template with the rapid review template, reducing duplication and improving consistency and compliance.
- Training continues to be delivered on request, including face-to-face sessions for preceptees. Supportive visits are now provided to areas experiencing an increase in falls, focusing on identifying themes, sharing learning, and developing mitigating actions. Development of a stand-alone session for falls champions has been delayed due to capacity within the team; however, the team remains committed to achieving this aim throughout 2026/2027.
- The FPPs continue to actively participate in local and national audits.

How was this achieved?

- Collaboration between FPP's and the Digital Team has enabled the development and introduction of digital visual acuity checks for patients aged 65+.
- The team continue to support all volunteers within the organisation and educate around falls.
- The falls team continue to have oversight of all falls reported at SFHFT and complete a comprehensive falls review for any incident resulting in moderate harm and above. In addition, the team aim to visit any patient who experiences a repeat fall within the same month.
- Supportive meetings have been initiated for teams experiencing clusters or peaks in falls, working alongside MDT colleagues to analyse incidents, identify themes and provide targeted improvement recommendations.
- When completing reviews, the falls team have incorporated audits within the review.

Ongoing monitoring and reporting :

The Falls team attend and report monthly at Clinical Outcomes Effective Care (COEC) to ensure that any items of concern or relevance are discussed and, where appropriate, escalated to the Nursing, Midwifery and Allied Health Professional Committee and the Patient Safety Committee.

Priorities for 2026/2027:

- Secure Executive approval for the Trust wide rollout of the digital visual acuity checks, supported by a communication and engagement plan. Share the tool at regional forums.
- Increase the number of Connected Care volunteer numbers to strengthen prevention of deconditioning.
- Fully embed the 'After Action Reviews' for moderate harm or above, fall related incidents across the Trust, using a collaborative approach between the FPPs and the ward/departmental leader to deliver a single comprehensive review.
- Update and enhance training provision, including additional support for incident handlers and development of a stand-alone Falls Champion training day.
- Support the Emergency Department with the evaluation and broader rollout of the THINK YELLOW falls prevention project, with plans for Trust wide implementation.
- Continue participation in key local and national audits, including bed rails and National Audit for In-patient Falls (NAIF).
- Support ongoing work to prevent deconditioning across inpatient pathways.

3.3. Safety - To reduce the number of infections

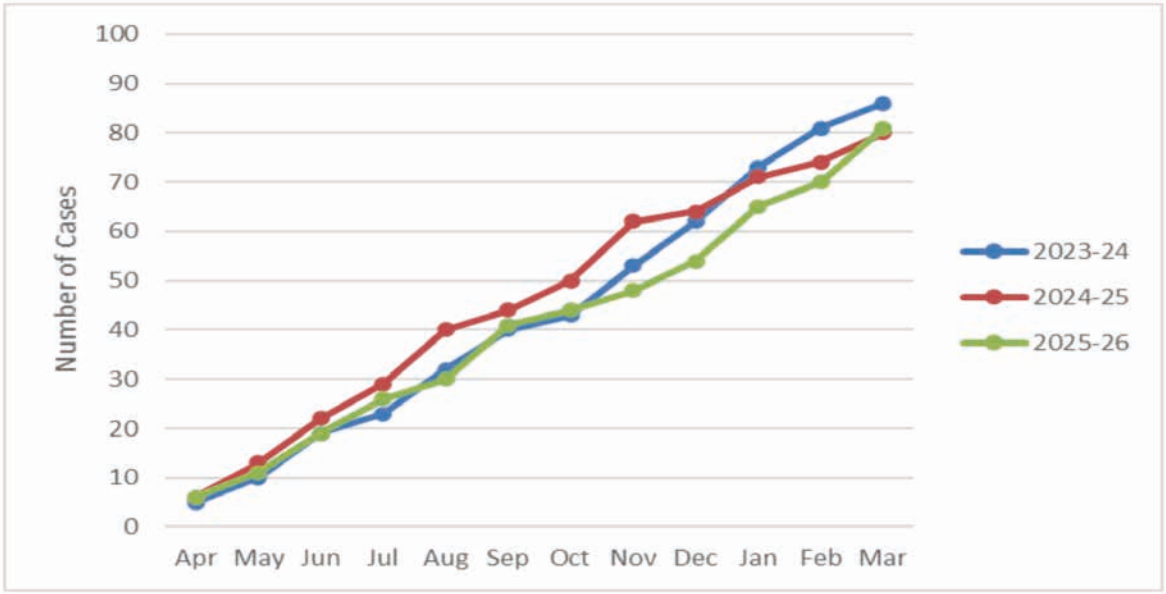
What we planned to achieve in 2025/2026:

- To continue to reduce the number of Trust acquired Gram Negative blood stream infections.
- To support the reduction of Trust associated MRSA cases
- To review new alternatives to indwelling urinary catheter use.
- To implement targeted training programmes on Wards and Departments.

How did we do?

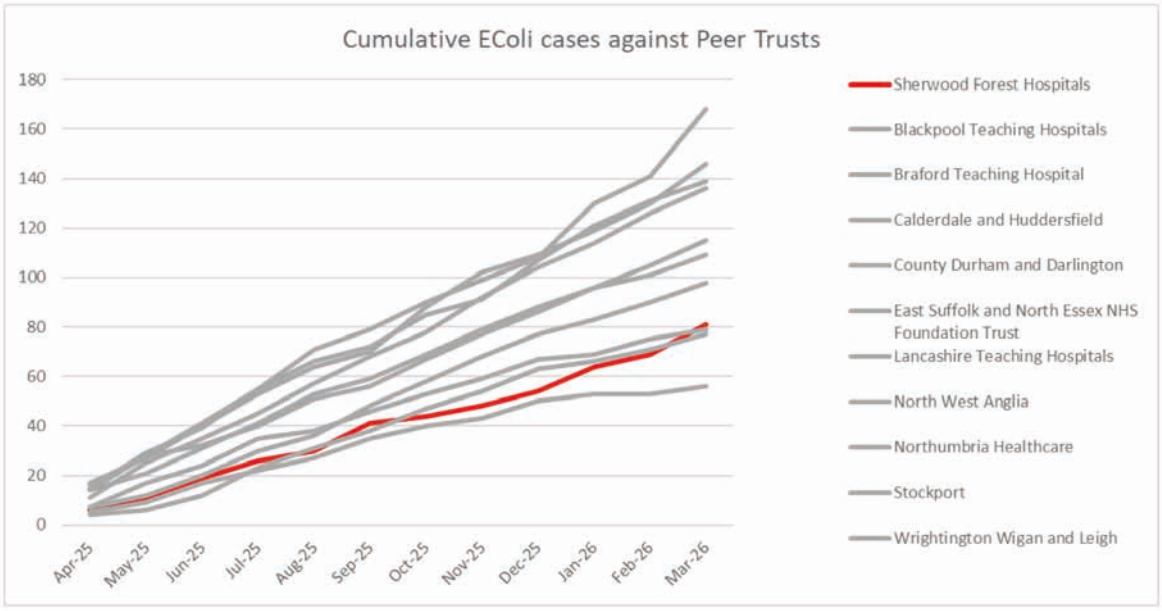
The main causative organism is EColi. There was a national trajectory set for each organisation and the SFHFT target for 2025/2026 was 80 or less. SFHFT have exceeded this ending the year with 81 cases. During 2025/2026 there has been a slightly higher number of SFHFT associated cases compared with 2024/2025, (Graph 15).

Graph 15: Cumulative total of hospital onset EColi cases



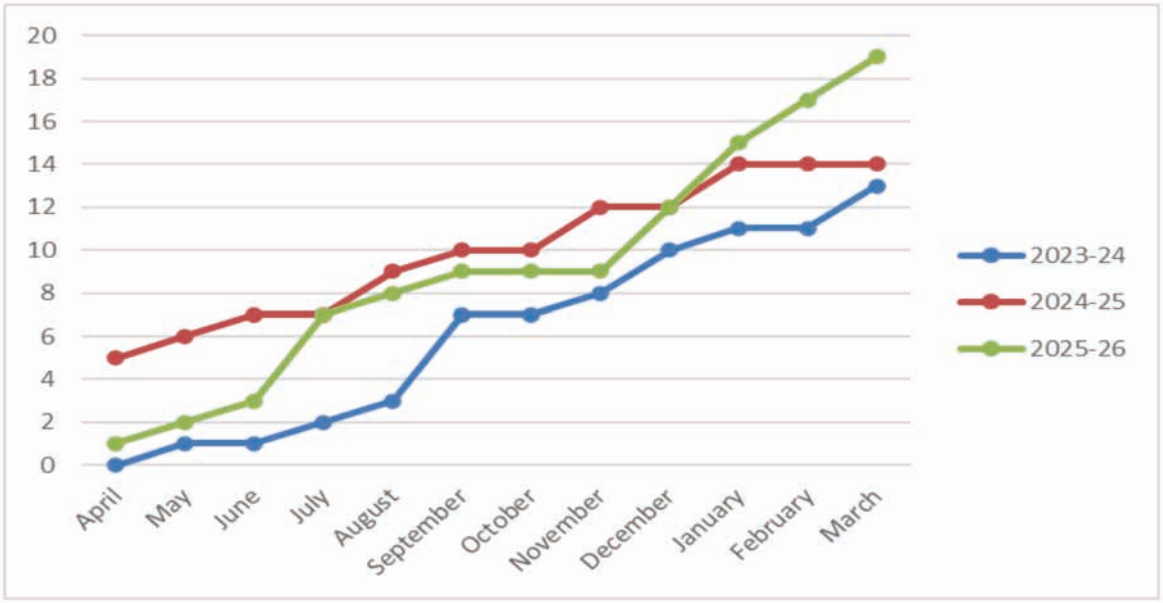
Comparing our performance against that of our national peer Trusts (Graph 16), shows that the Trust is 4th in the group.

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



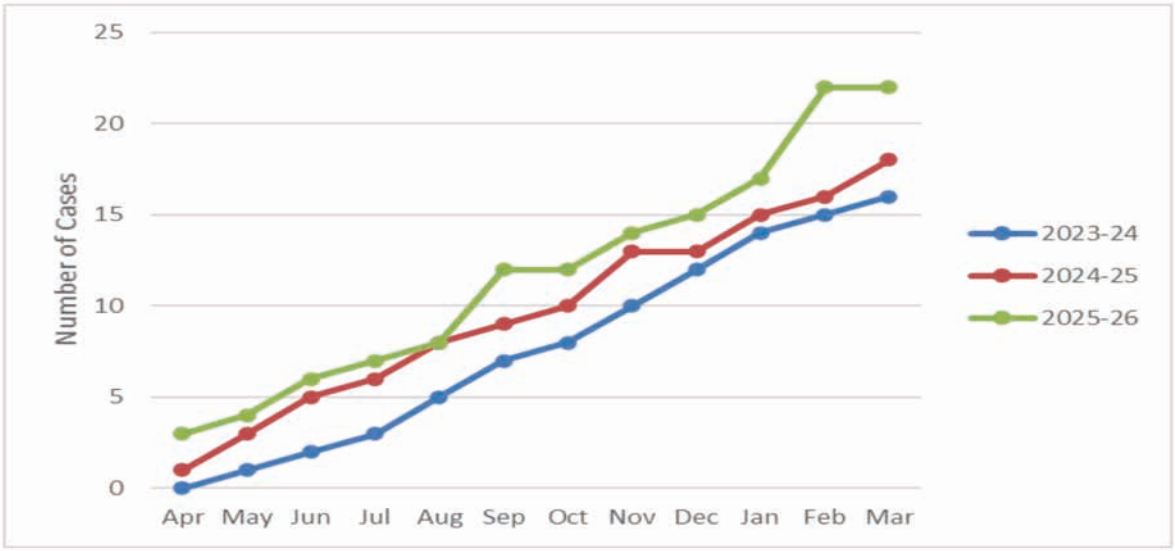
Although the position for EColi bacteraemia has not been mirrored in the number of Catheter-Associated Urinary Tract Bloodstream Infections (CAUTI) shown in Graph 17, there has been an increase of nearly 25% this year

Graph 17: Cumulative total of hospital associated CAUTI



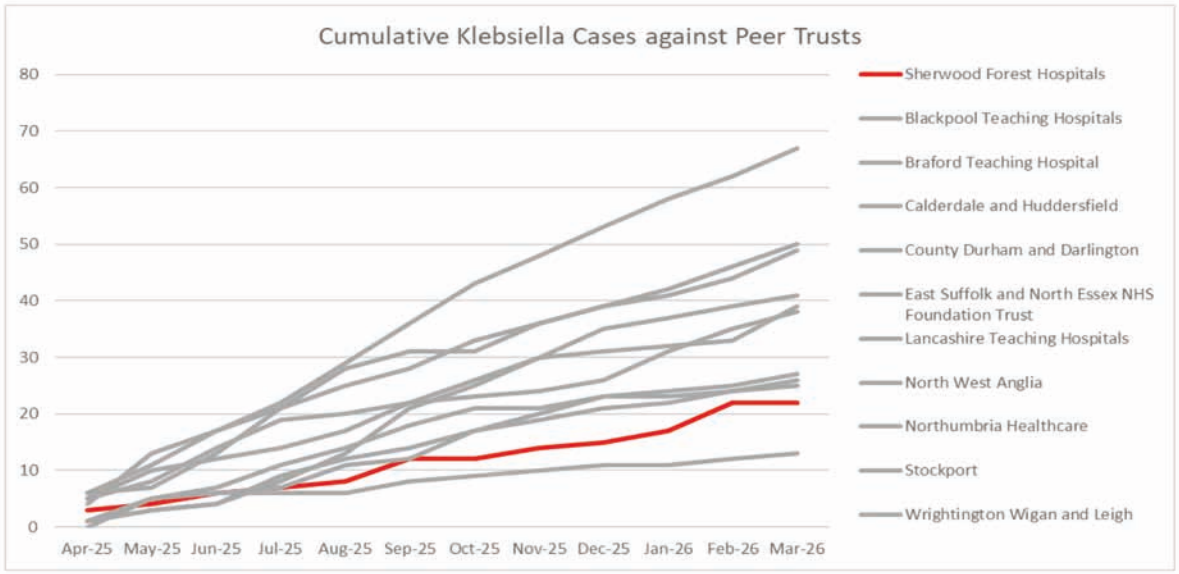
The second gram negative trajectory is for all Klebsiella species blood stream infections and our trajectory was 15. We have not achieved this target with a total of 22 for the year, (Graph 18).

Graph 18: Cumulative total of hospital onset Klebsiella cases



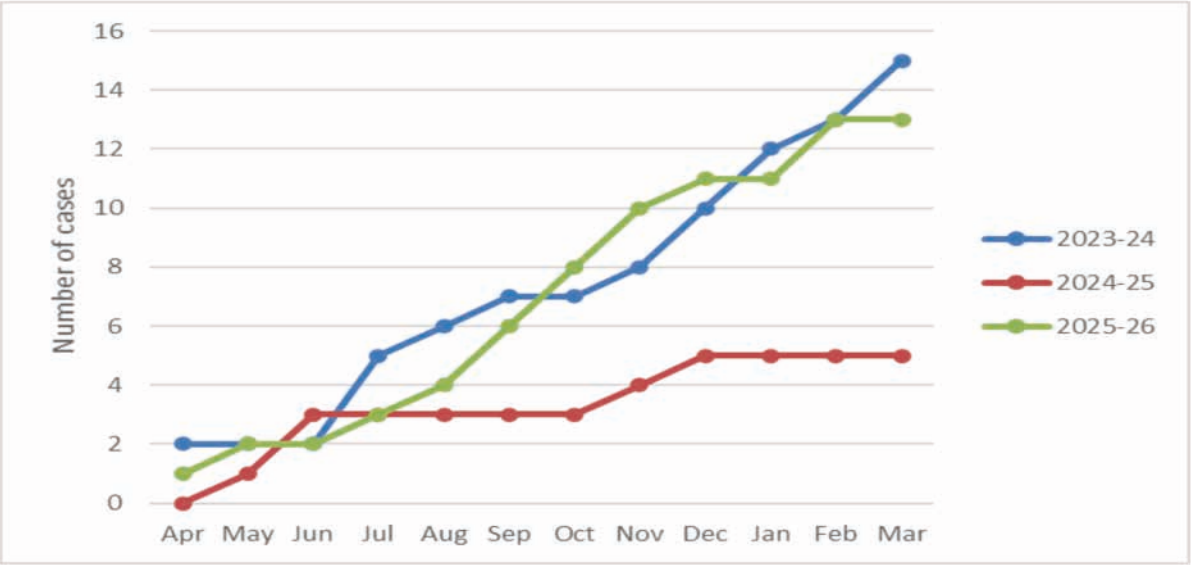
Graph 19 shows our performance benchmarked against our peer Trusts and shows we are one of the best performing Trust.

Graph 19: Cumulative total of hospital onset Klebsiella cases against national Peer Trusts

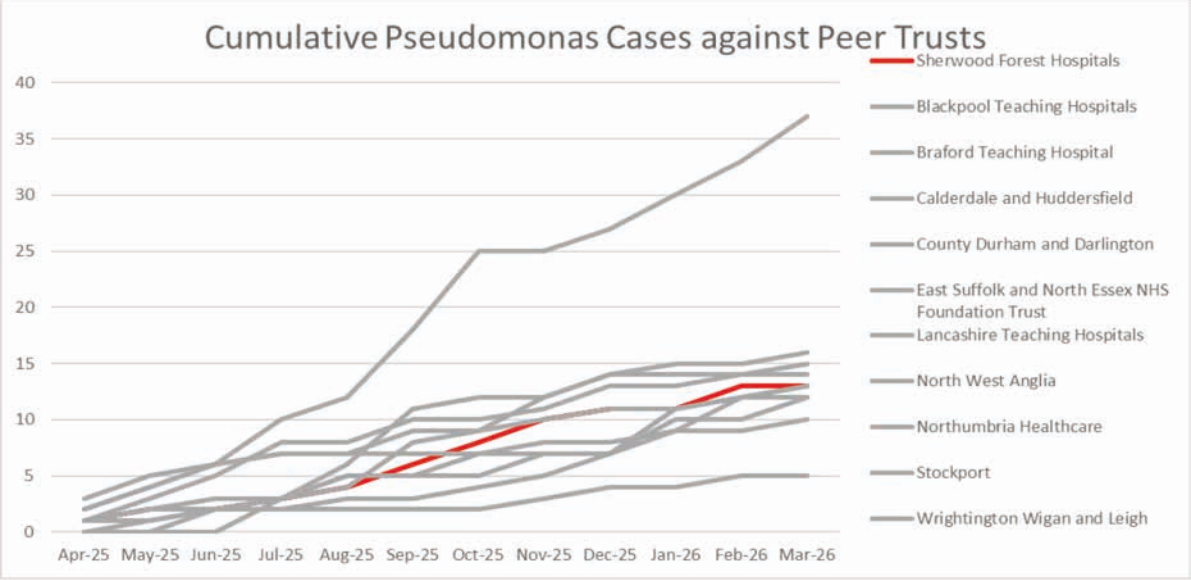


The third gram negative trajectory is for all Pseudomonas Aeruginosa blood stream infections, and our trajectory, was 9. We have not achieved this target with a total of 13 cases for the year, (Graph 20). Comparing our performance against that of our national peer Trusts, Graph 21 shows that we sit in the middle of the group.

Graph 20: Cumulative total of hospital onset Pseudomonas Aeruginosa cases

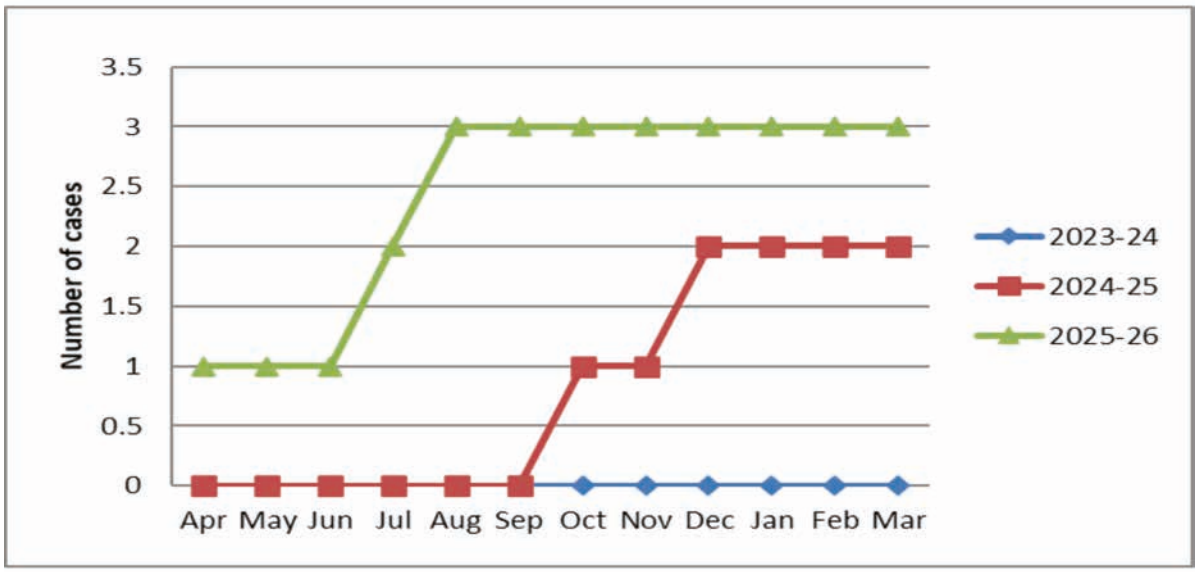


Graph 21: Cumulative total of hospital onset Pseudomonas Aeruginosa cases against national Peer Trusts



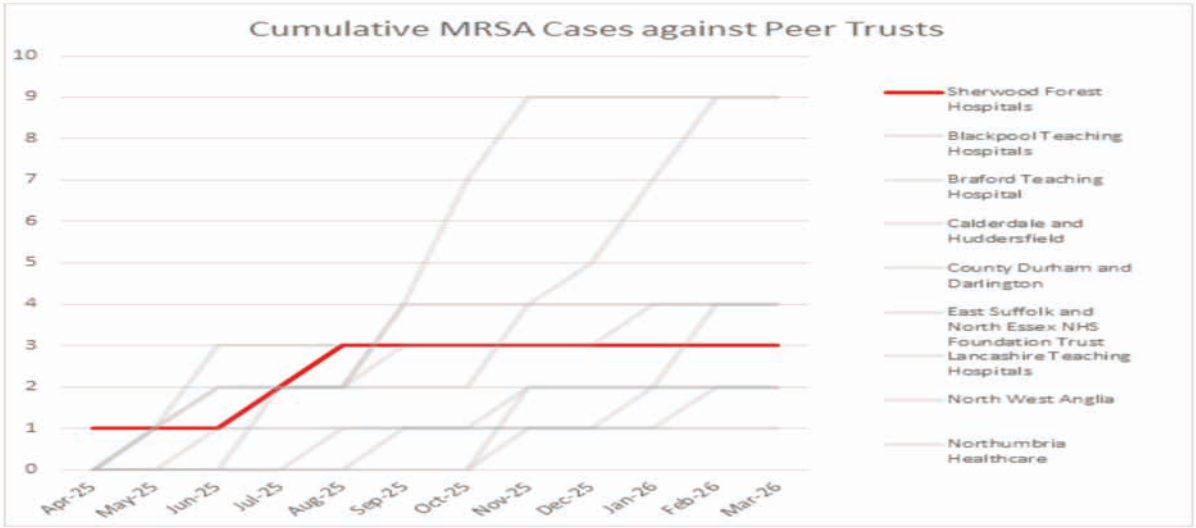
As with all other NHS acute organisations, our target for MRSA blood stream infections was zero. We have not achieved this target with a total of 3 for the year (Graph 22).

Graph 22: Cumulative total of hospital onset MRSA cases



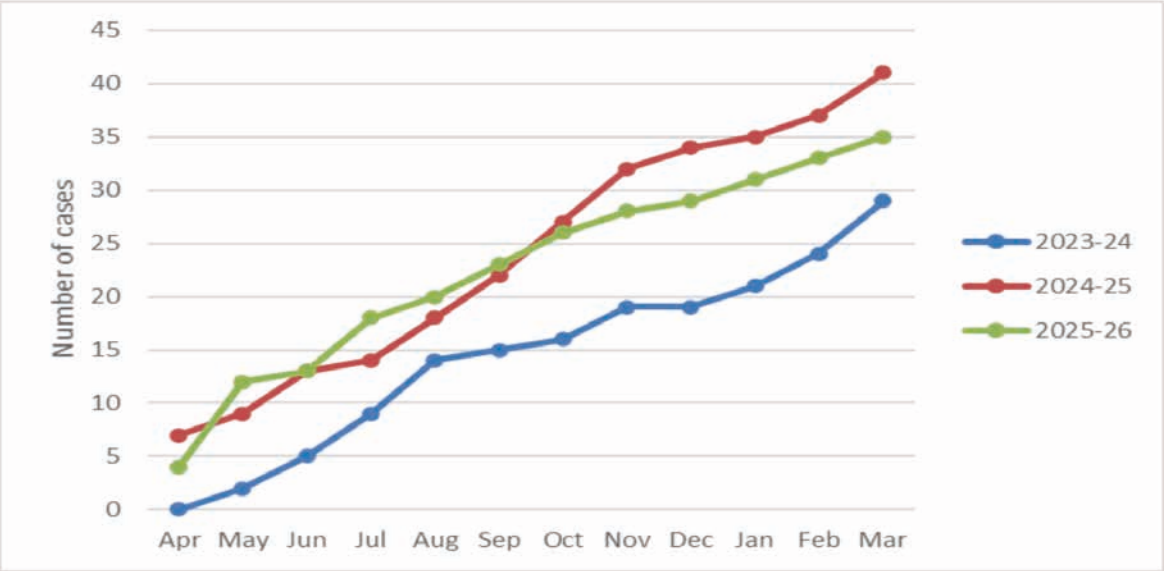
SFHFT is one of 11 of our national peer Trust who have not achieved the target of 0 (Graph 23).

Graph 23: Cumulative total of hospital onset MRSA cases against national Peer Trusts

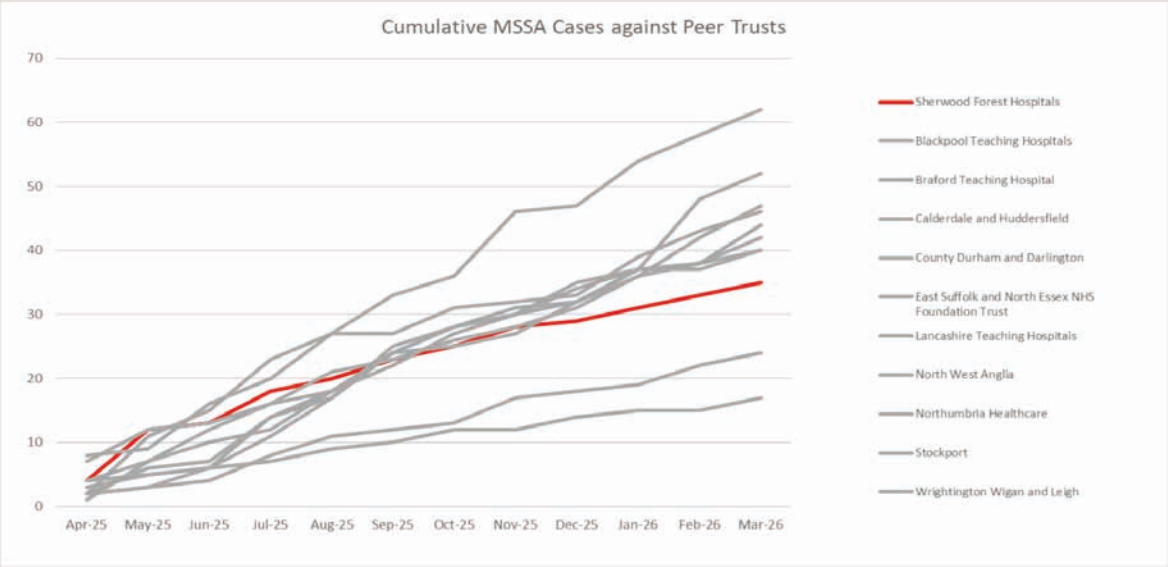


We continue to monitor and report our MSSA blood stream infection cases nationally. There currently remains no trajectory set for this. We have identified 35 Trust-associated cases in 2025/2026, which is a decrease of 6 cases compared with 2024/2025 (Graph 24).

Graph 24: Cumulative total of hospital onset MSSA cases



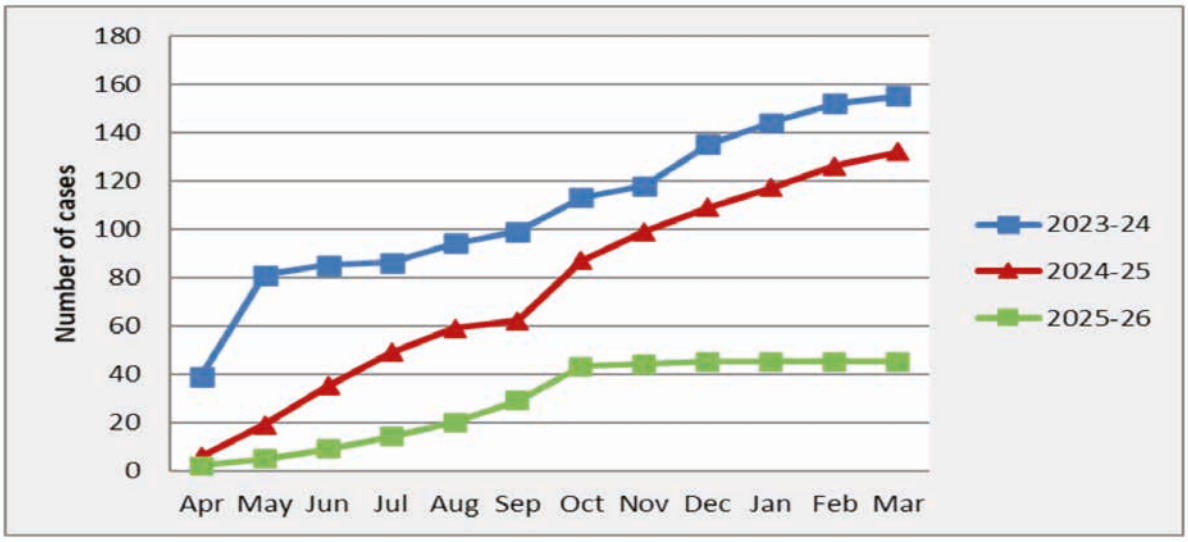
Graph 25: Cumulative total of hospital onset MSSA cases against national Peer Trusts



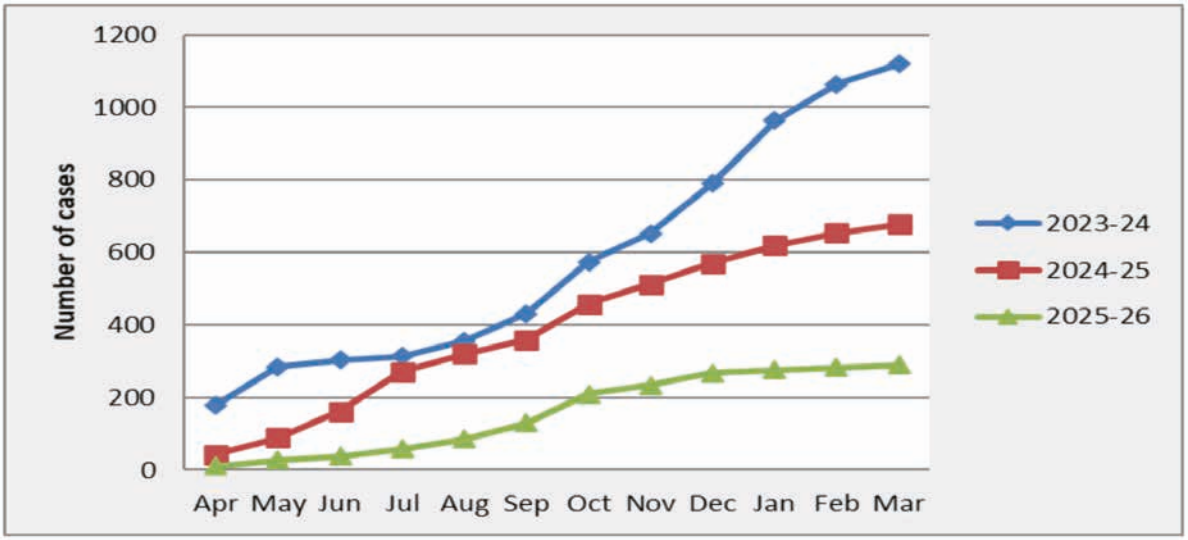
COVID-19

We have continued to comply with national guidance and during peak respiratory virus season, we have amended our guidance and gone above the national requirement. During 2025/2026, we have identified lower numbers of Covid-19 cases, compared to previous years, and in line with that, a lower number of probable and definite hospital associated cases as shown in Graphs 26 and 27.

Graph 26: Cumulative total of Trust apportioned Covid-19 cases



Graph 27: Cumulative total of all Covid-19 cases



Actions in place to reduce the number of Hospital Associated Infection (HAI's):

1. An infection control review is completed for all hospital associated cases named above.
2. Quarterly thematic reviews are being undertaken of all above infections.
3. Blood culture project has commenced to ensure correct procedures and blood levels are used.
4. Project to review current MRSA treatment and our clearance rates commenced
5. Attendance at regular meetings with NHSE and UKHSA to monitor outbreak progress.
6. Reviewing complex infections with the Community IPC team to look at all aspects of care delivered
7. Full action plan in place following an NHSE review requested by the Trust following increases in infection rates.

Ongoing monitoring and reporting:

- 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, Patient Safety Committee and challenged via our governance processes.

Priorities for 2026/2027:

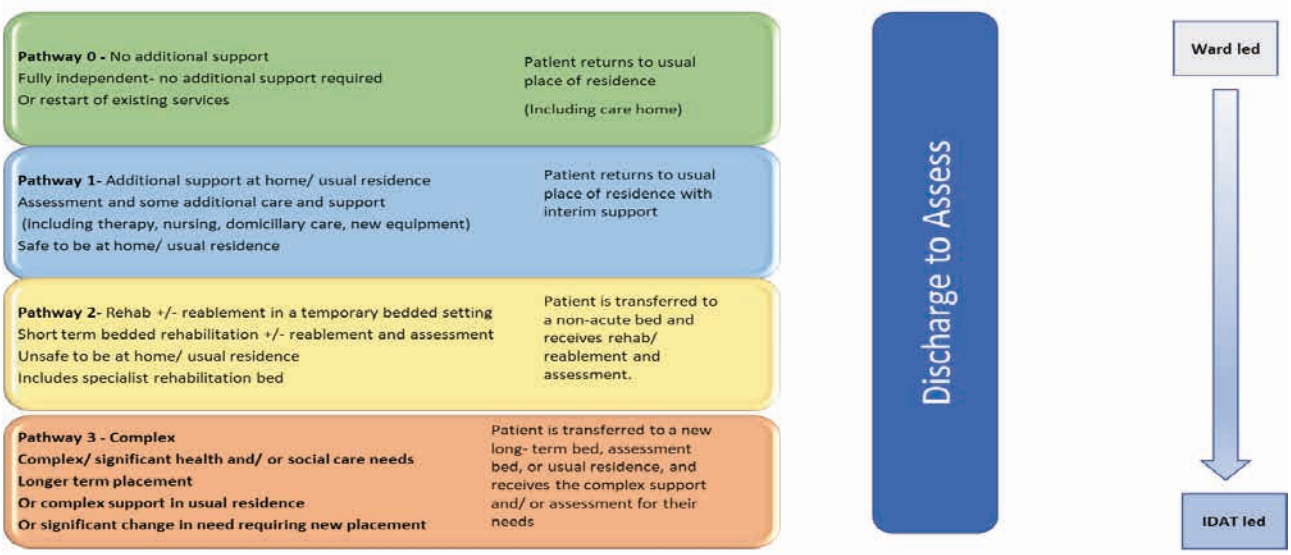
- To continue to reduce the number of Trust acquired Gram Negative blood stream infections.
- To implement the recommendations from NHSE following their thematic review of all MRSA blood stream infections in the region.
- To conduct a PSII for all MRS bacteraemia
- To participate in the NHSE task and finish groups for the reduction of CAUTI and UTI.

3.4 Effectiveness - Improving the Effectiveness of Discharge Planning

What we planned to achieve for 2025/2026:

- Percentage of discharge to assess (D2A) sent to the Transfer of care hub (TOCH) discharge hub prior to medically safe for transfer (MSFT), 24 hours = plan 66%.
- Percentage of D2A forms sent to the TOCH on or post MSFT plan 15%.
- Average days from TOCH accepted to discharge pathway 1 (P1) Notts plan 3 days, Notts LA plan 3 days, Derbyshire plan 3 days.
- Average days from MSFT to TOCH pathway decided, pathway 3 (P3), target= 5.5 days.
- Reduction in the volume of the number of D2A returned to the TOCH due to lack of information, target = 5.5%.
- Reduction in avoidable abandoned discharges per week, see details / graphs below.
- Aim for 100 supported discharges per week.
- Work with system partners to improve P1 capacity to facilitate timely discharges.

Definition of discharge pathways and terminology



Loss of beds days refers to the fact the hospital 'cannot free up beds when patients are medically fit', so bed capacity is effectively 'lost'.

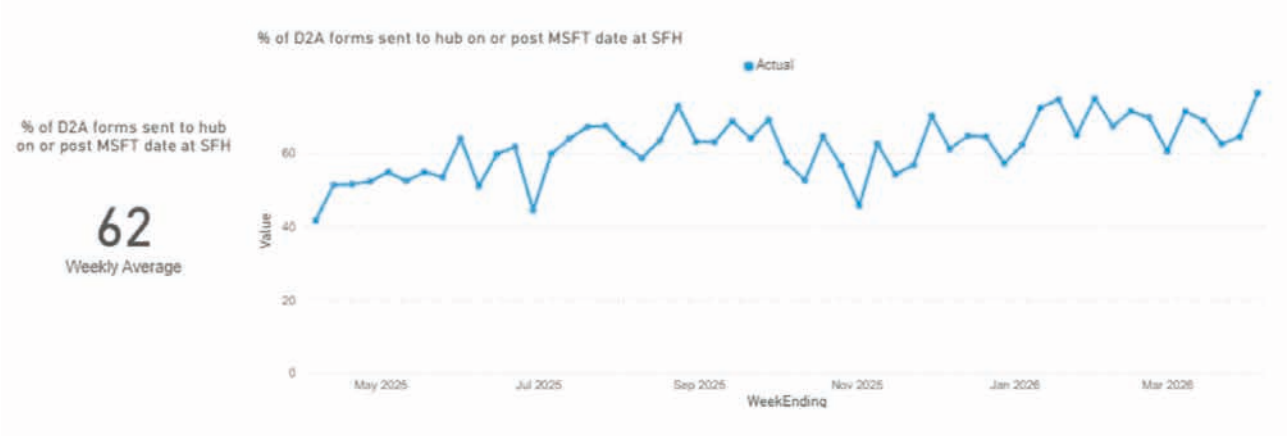
Medially Safe To Discharge (MSTD) and Medically Safe To Transfer (MSTT) are interchangeable phrases used by system partners but refer to the same status of a patient on the 'discharge pathway'.

How did we do?

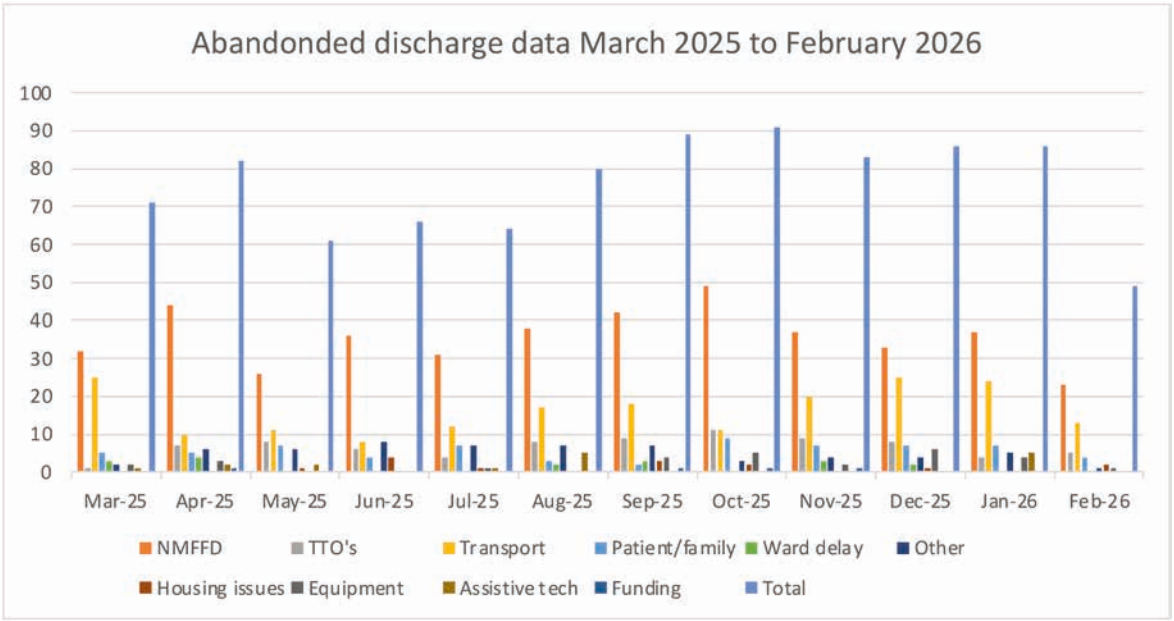
	Target	Actual achieved
Percentage of D2A sent to TOCH prior to MFFT, 24 hours...	24 hours = 50%	Average 38% Deterioration since 24/25.
Percentage of D2A forms sent to the TOCH on or post MSFT.	15%.	Average 62% improvement since August 2025 (graph 28)
Average days from TOCH accepted to discharge pathway.	P 1 target = 3 days	Nottinghamshire Healthcare = 4.8 days Notts local authority = 3.3 days Derbyshire = 4.8 days. Deterioration since 24/25.
	P 2 target = 1.5 days	Average 2-4 days.
	P3 target = 5.5 days	Average 4 days Improvement since 24/25.
Reduction in the volume of the number of D2A returned to TOCH due to lack of information	Target = 5.5%	Average 28% returned. Deterioration since 24/25.
Reduction in avoidable abandoned discharges per week	12%	8% average. See graph 29 below for more detail. Improvement since 2025.
Reduction in length of stay (LOS) of patients in P2	28 days	19.1 days Improvement since 2025. Rest of the NNICS partners is 24 days.

	Target	Actual achieved
Supported discharges per week	100 per week (average)	74 per week (average)
Work with system partners to improve P1 capacity to facilitate timely discharges.	Over the past year, there has been a significant increase in patients waiting for community care packages. This has impacted on timely discharge and contributed to a loss of inpatient bed days.	

Graph 28: % of discharge to assess (D2A forms) sent to the hub on or post MSFT



Graph 29: Abandoned discharges



How was this achieved?

- The past year has been challenging due to reduced staffing levels. This has been driven by higher sickness rates within the Integrated Discharge Team (IDAT) and delays linked to new recruitment processes. As a result, there has been reduced presence of IDAT at board rounds and less proactive working by discharge coordinators. This led to fewer timely D2A transfers and a loss of bed days.
- Two experienced IDAT administrators left through a mutually agreed redundancy scheme. One post was replaced with a Band 2 administrator. Planned automatic D2A information sharing, with Adult Social Care (ASC), intended to remove the need for manual transcription, is not yet operational.
- The weekly length of stay meeting is in place with both acute and peripheral wards to support the timely discharge of medically fit patients and enabling early planning for complex discharges.
- Twice-weekly P2 meetings and escalation meetings are held with system partners to facilitate timely and supported P2 discharges.
- IDAT managers work closely with Street Health nurses, including a weekly meeting, to proactively manage patients prior to them becoming medically fit and to support earlier discharge planning.
- Joint working with system partners has been strengthened to help identify and remove barriers to discharge.
- Medically fit patients are reviewed daily, with actions are escalated across all divisions as required.

Ongoing monitoring and reporting:

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

Benchmark against national standards: The national average LOS for patients in acute providers is 4.3 days. Our LOS has improved from last year and is **3.5 days, including P2 beds.**

Priorities for 2026/2027:

1. Interoperability function with ASC to reduce transcribing burden on IDAT admin staff.
2. Aim to bring average LOS below 3.5 days.
3. Reduction in the number of ‘abandoned discharges’ for all reasons.
4. Work with the ICB to improve/support P1 provision.
5. Recruitment into vacant IDAT posts.
6. Actively fill vacant Ashmere beds with P1 waiters to maintain flow.
7. Reduction in the number of D2A returned from the hub requesting additional information.

3.5 Effectiveness - Improve the care and learning from Mortality reviews

What we planned to achieve in 2025/2026:

- Establish analysis and reporting from the Datix IQ Platform
- Agree longer-term Trust-level mortality metric and benchmarking provision, possibly as a joint or ICS-level tender process.
- Continue to encourage and facilitate clinically led learning and mortality review.

How did we do?

Since October 2024, all new requests for review of in-patient deaths have been managed via the DATIX-IQ platform.

The Learning from Deaths (LfDs) Group receive community death numbers as a headline figure; however, these deaths are not currently recorded within Datix IQ for subsequent review purposes.

Over 2025/2026, clinical colleagues focused on completing reviews still pending on the previous Datix-Web platform. In response to feedback and to enhance both engagement and quality, regular training is provided on the Datix IQ platform and on mortality review methodology. Completion of this training is required before users are granted access.

Efforts are ongoing to improve analytics and provide teams with relevant and informative data. There is a continued emphasis on improving Divisional and Trust-wide reporting, strengthening governance, and creating a foundation for meaningful learning.

The benchmarking tool contract between SFHFT and Telstra (Dr Foster) ended in September 2025, following a 12-month extension. This additional year was intended to give the Trust time to understand and assess the impact of the modelling changes introduced by the company, including the revised mortality index, Hospital Standardised Mortality Ratio “Plus” (HSMR+).

HSMR+ was reported to be a more robust measure, based on updated metrics and standards. One of the key changes was the removal of specialist palliative care coding from the model.

The new HSMR+ model, implemented nationally, shows the Trust to be “as expected” compared to being an “outlier” for historical HSMR reporting.

Further analysis showed correlation with the SHMI, which had also been reporting results within the “as expected” range. SHMI is recognised as the key mortality performance indicator in the NHS England Oversight Framework.

Our relatively stable mortality position, as shown by both SHMI and HSMR+, together with the decision to focus on SHMI as the key mortality metric, provided an ideal opportunity to explore improvements

in data provision, data and mortality intelligence and align with our neighbouring Trust (Nottingham University Hospitals NHS Trust, (NUHT), led to the decision to change the mortality benchmarking provider. After further discussion with NUH and system partners, the new solution needed to provide the right functionality, support collaborative working, and fit within the agreed budget.

Although contracting and procurement were delayed in Q3, the Healthcare Evaluation Data (HED) system (developed by University Hospitals Birmingham NHS Foundation Trust) was successfully implemented in mid-December 2025.

Work is underway to gain a fuller understanding of the system’s capabilities, carrying out detailed metric analysis, and delivering wider roll out and training. This includes supporting divisions, teams, and individuals involved in mortality oversight and LfDs.

During the interim period (September – December 2025), SHMI reporting via the national database (NHS Digital) and information provision through the Trust Insights team were used.

HSMR+ is no longer formally monitored by the Trust, but the HED platform reports a version of HSMR (without adjustment for Palliative Care), helping with assurance in previous values, monitoring, and triangulation of data. The Trust has previously reported that its local data aligns closely with published SHMI data, with fewer than 0.1% of cases unmatched. This provides a high level of confidence in the integrity of our data.

The focus of work has been on developing their internal Power BI mortality dashboard, bringing together our data in one easy-to-access place, capable of being delivered at speciality level, and including information on patient quality and safety metrics. This has the potential advantage of presenting more up-to-date data, trends and supporting mortality oversight and learning to be clinically led, pro-active and having a more thematic approach.

Mortality leads use the Power BI dashboard to support clinically led, bottom-up ownership of the data. Individuals and teams can use this data to review trends, inform clinical discussions, and constructively challenge findings to build a shared, consistent understanding of the evidence and narrative.

NNICS level LfDs meetings have been in place since May 2025. Using a forward planner of key topics, these meetings focus on local experience, data correlation, system wide reporting, and opportunities for wider learning. The quarterly meetings include representatives from organisations across the system.

We are an active and engaged member, offering support and leadership to promote shared learning, while recognising the geographical and demographic differences that exist across the ICS.

How was this achieved?

Use of the DATIX IQ platform has improved, with mortality leads and clinical teams engaging with it more effectively. There is a clear commitment to increasing ownership of the process, including

completing SJRs and other mortality review processes. This work continues to be supported by key teams such as Governance and the Medical Examiner Service.

Although we have now moved to a new mortality benchmarking tool provider, the previous partnership and experience have helped shape our understanding of the functional requirements needed in a system. The Improvement and Information analyst teams have been integral in providing assurance for future requirements and capability.

Development of the Mortality Power BI dashboard required investment of time and support from the IF. This work continues as the opportunities and requests to extract and analyse meaningful data increase.

Ongoing monitoring and reporting:

Our LfDs Group meets monthly to review mortality data, compare external metrics with internal analytics, and receive regular speciality or divisional reports on mortality trends and lessons learned.

A recent focus has been on divisional/speciality ownership, supported by a concise summary reporting template for presenting baseline data, identifying key themes and learning. In addition, the “Big 5’ mortality categories, containing key themes, help support communication to divisions and speciality areas across the Trust.

In mid-2025, an external audit summary “Opinion” of LfDs highlighted areas for improvement and further assurance regarding reporting alignment with workplans, updates to the Mortality Management Policy, and greater clarity of the SJR process. Actions were identified, with agreed timeframes for completion, and are reported via the Audit and Assurance committee.

Patient Safety Committee receives a LfDs quarterly highlight report, accompanied by a summary dashboard of key high-level metrics and performance data; this committee escalates and reports into Quality Committee. An additional bi-annual LfDs summary is provided directly to the Board of Directors.

Priorities for 2026/2027:

- Monitor and improve reporting within the DATIX-IQ Platform, including completion of SJRs and outcomes for learning.
- Support the full roll-out and establishment of HED (new benchmarking tool) across the Trust.
- Encourage use and "ownership of data" by Divisions / speciality team use to improve learning, sharing, and overall mortality review approach.

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 high priority for us. We are committed to delivering outstanding EoLC, which is individualised, accessible, coordinated and underpinned by the best available evidence. We work in partnership with the ICB and the Mid-Nottinghamshire End of Life Care Together Alliance. The priorities and delivery of EoLC within the Trust 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 Key Ambitions outlined are:

- Each person is seen as an individual
- Each person gets fair access to care
- Maximising Comfort and well-being
- Care is coordinated
- All staff are prepared to care
- Each community is prepared to help

The General Palliative and End of Life Care Committee (GP&EoLCC) is a multi-professional forum which leads and advises the Trustin the provision of outstanding end of life palliative care. It provides assurance that effective communication, co-ordination, and consistent practices are being maintained in relation to EoLC across the Trust and drives the strategic and operational planning for effective EoLC service delivery at the Trust.

What we planned to achieve in 2025/2026:

- Finalisation of the Specialist Palliative Care in-reach provision (provided by Nottinghamshire Healthcare NHS Trust (NHFT))
- Further expand rollout of the AMBER Care Bundle project Trust-wide
- Continued participation in the quarterly NACEL Audit, including the NACEL Bereavement Survey
- Complete review and mapping of the EoLC education plan
- Implement an EoLC Team activity dashboard
- Further implementation of the EoLC enhanced rooms
- Establishment of the Department of End of Life, Spiritual and support services
- Participation in Dying Matters Awareness Week and Grief Awareness Week (2025)
- Development of an internet page including grief and bereavement support resources
- Create an EoLC Quality Improvement Network.

How did we do?

- Specialist Palliative Care (SPC) in-reach continues to be provided by NHFT. The EoLC Team continues to work closely with the SPC Team. The SPC In-reach Service Specification final sign-off was completed March 2025.
- The AMBER Care Bundle has been rolled out by the EoLC Team across Ward 36/Short Stay Unit (SSU), the Emergency Assessment Unit (EAU), Ward 52/Woodland Ward, Ward 51, Ward 41, Ward 53/54, Ward 22 and Ward 44. Rollout is continuing a phased (ward by ward) basis across the Trust. The electronic version of the AMBER Care Bundle is now 'live' and being utilised on Nervecentre. Training on the electronic version continues to be provided by the EoLC Team.
- We continued to participate in the NACEL audit throughout 2025 and have completed all elements. Overall, the feedback was positive.
- The EoLC training and education programme, delivered by the team, has been reviewed, to ensure the training delivered is compliant against the core standards noted in the Health Education England, Skills for Health and Skills for Care - Core Skills Education and Training Framework for End of Life Care (2017). An 'End of Life Care Education Delivery Plan, 2025' has also been developed. Associated training packages and materials are also being reviewed and updated. The EoLC Team will continue to progress this during 2026
- An activity dashboard remains under development and will be implemented during 2026
- A total of 15 EoLC enhanced side rooms were established and refurbished to enhance the experience of patients receiving EoLC at the Trust, and those important to them, during 2025.
- The Department of End of Life, Spiritual and Support Services has been established and includes End of life and, Mortuary Team, Bereavement Centre, Medical Examiner and Spiritual and Pastoral team.

  The EoLC Lead Nurse's duties extended to become the new Matron for the Department of End of Life, Spiritual and Support Services. The establishment of the new department seeks to enhance EoLC care by promoting a collaborative approach between the specialist teams caring for patients and those important to them during the final phase of life and after death.
- The EoLC team participated in both Dying Matters Awareness Week 2025 and Grief Awareness Week 2025.
- An EoLC internet page, including bereavement resources, is in development and will be launched in 2026
- Initial discussions between the IF team and EoLC team have commenced to consider implementing an End-of-Life Care Quality Improvement Network. This remains an ambition and will be progressed in 2026.

Ongoing monitoring and reporting:

- Three End of Life Care (EoLC) Champions study days were delivered, covering a wide range of topics to develop staff knowledge and skills. The sessions were well attended and positively evaluated. An EoLC Champions e learning package is available, and a quarterly Champions Times newsletter continues to share key developments and planned EoLC activity across the Trust.
- The Last Days of Life Comfort Observations module, an electronic assessment to support monitoring comfort and symptoms in the final days of life, was developed by the EoLC and Nervecentre teams (with Digital Team support) and launched on 28 May 2025.

- An audit of adult deaths within 48 hours of ED admission (Jan–Mar 2025) was completed in August 2025. Key findings and recommendations have been shared across the Trust and are now being cascaded across the Mid Nottinghamshire system to influence wider EoLC provision.
- EoLC education and training continued in 2025, including ReSPECT, SAGE & THYME® communication skills, syringe driver training, RN preceptorship input, and Recognition of Dying training for nursing and medical staff.
- The EoLC team supported students across multiple professions (Nurses, Paramedics, Specialist community Practioners) through observational placements. We have begun T-Level student training with West Nottinghamshire College, and delivered Recognition of Dying teaching to 4th year medical students to John Eastwood Hospice palliative rotation.
- Eight dedicated EoLC beds continue to be used on Ward 36/SSU.
- EoLC Butterfly Volunteers continue to provide companionship and support to patients in the last days of life.
- The EoLC Team were finalists in the Palliative and End of Life Care Awards 2025 and SFHFT Excellence Awards (Most Improved Team) and received the SFHFT Improvement Ambassador Award for contribution to improvement through a range of projects

Priorities for 2026/2027:

- Expand rollout of the AMBER Care Bundle project Trust-wide
- Continue to deliver EoLC Champion Study Days
- Continued monitoring of the Last Days of Life Observations module on Nerve Centre
- Participation in the 2026 quarterly NACEL Audit, including the NACEL Bereavement Survey
- Complete review and mapping of the EoLC training resources
- Implement an EoLC Team activity dashboard
- Participation in Dying Matters Awareness Week and Grief Awareness Week (2026)
- Complete the review and re-launch of the public-facing end of life care internet page
- Create and launch EoLC, essential to role eLearning for Doctors, Nurses, Therapists and Healthcare Support Workers.

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

The Trust is committed to delivering high quality dementia care for people living with dementia, their families, and carers. Through a collaborative approach, the Trust aims to provide outstanding, consistent, accessible, and person centred care across all services, from diagnosis through to end of life. We will continue to strengthen our workforce by learning from evidence based practice, using digital innovation, and working in forward thinking ways, to improve outcomes for patients and the local community.

What we planned to achieve for 2025/2026:

- The Dementia Team will work alongside the Memory Assessment Service (MAS), Liaison Psychiatry and Lead Geriatrician to provide the optional direct referral to MAS from the inpatient setting.
- The Dementia Team will collaborate with all key stakeholders to ensure that the Trust is conducive in becoming a ‘dementia-friendly’ environment in alignment with the King’s Fund criteria.

- The Admiral Nurse and dementia support worker will continue to support the promotion of the Carer Passport, and support colleagues in the Dementia Shared Governance Council ensuring that the latest ideas and innovations are shared with key stakeholders.
- The Dementia Team will facilitate and increased awareness and education by:
  1. Developing a Tier 2 training package for staff in regular direct contact with patients with dementia and support Dementia Champions by facilitating bespoke training sessions.
  2. Provide monthly Dementia Drop-in sessions to provide support to staff, patients and families,
  3. Educate and support staff and families to complete 'This is me' documentation and to increase its use throughout SFHT.
  4. Support the development of 'Connected Care Volunteers'
  5. Offer student nurse placements to undertake a supported intern position with the Dementia Team.
  6. Continued attendance at the Violence and Aggression Working Group and, MCA/DoLs working group to raise clinical awareness and provide expertise.

How did we do?

- Working jointly with MAS, Liaison Psychiatry and the Lead Geriatrician, a robust pathway for referring inpatients with suspected dementia directly to the Memory Assessment Service has been developed. This has made the referral process more efficient, reduced waiting times for diagnosis and eased pressures on GP practices. The pathway remains under evaluation, with data being collected to understand its long term impact. Regular meetings between the Dementia Team and Liaison Psychiatry are now embedded, helping improve the consistency and quality of support offered to both patients and staff.
- The Dementia Team has worked in collaboration with multiple clinical teams, to ensure environments align with King's Fund dementia friendly principles. Through PLACE (Patient Led Assessments of the Care Environment) and King's Fund audits, key areas for improvement - such as orientation and signage - were identified and addressed. This has included installing dementia-friendly clocks across wards and clinics and improving signage within the King's Treatment Centre. The team has also supported the new Clinical Diagnostic Centre, to ensure it meets dementia friendly standards in both design and layout.
- The Admiral Nurse has led on the renewal of the Carer Passport, creating an updated passport card, guidance and information, which has been shared with all clinical staff. Carer feedback continues to be gathered through QR code surveys, and themes, compliments and concerns are routinely presented to the Patient Experience Committee.
- Due to staffing changes within the Dementia Team, the Dementia Shared Governance Council was temporarily paused. This will now be reinstated and led by the Admiral Nurse. Staff will again be invited to participate as key stakeholders, sharing ideas and innovations to improve the experience of people living with dementia throughout their inpatient and outpatient journeys.

Awareness, education and support delivered by the Dementia Team

The Dementia Team has strengthened dementia and delirium awareness through a range of initiatives, including:

1. Annual Dementia Champions update delivered with internal and external facilitators, with positive feedback.
2. Dementia and delirium sessions provided as part of clinical staff induction.
3. Targeted teaching sessions for medical colleagues to support wider clinical understanding.
    - Dementia drop-in sessions expanded across all three hospital sites, with positive feedback from patients, carers, and staff.
    - "This Is Me" document embedded within Nervecentre, enabling staff to record key personal information directly in the patient profile. Ongoing education continues, with future audits planned.
    - Connected Care Volunteer role expanded, with two volunteers now supporting Woodland Ward. Recruitment delays have occurred due to process changes, but further growth remains a priority for 2026/2027.
    - Support provided to the Trust's first Project SEARCH intern to complete a clinical placement within the Trust.
    - Active involvement in the Violence Reduction and Sexual Safety Working Group, offering specialist clinical advice.
    - Ongoing participation in the MCA/DoLS Working Group, supporting the transition from DoLS to Liberty Protection Safeguards (LPS) and considering the implications for SFHFT.

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. Monthly reporting is presented at Clinical Outcomes and Effective Care Meeting (COEC) and, quarterly at the Patient Experience Committee (PEC), demonstrating developments, and identifying any areas of concern. These forums allow the discussion and collaboration of the wider MDT and have supported progress so far.

Ongoing monitoring and reporting:

Dementia continues to be an essential element of COEC and PEC meetings. Reports are produced and discussed, and escalation structures exist via Patient Safety Committee to Board level.

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.

Priorities for 2026/2027:

- Work is in progress to expand the Dementia Specialist Team with an additional Admiral Nurse (Transition of Care), supported by Dementia UK. This role will support complex discharge and transition pathways, reduce hospital admissions and length of stay, and provide continuity of care within both the acute and community settings.
- After a 2-year gap pause from the collection of the National Audit of Dementia data, the Dementia Team have committed to two shorter elements of the audit, to provide an annual census and service-user feedback, in preparation for the full audit being re-instated in 2027.

- A particular focus will be placed on ReSPECT and enhancing the quality of this for people living with dementia. The Dementia Team will be trained and competent in the completion of ReSPECT forms and discussions to enhance individualised care and treatment, in line with the Dementia Well 'Dying Well' Pathway.
- Strengthen assurance processes by creating a consistent, transparent, and standardised system for collecting, analysing, and presenting data on referrals, activity, and outcomes. This will involve implementing uniform data capture methods to support the production of an annual service report. The improved data intelligence will help demonstrate impact, highlight trends, and drive service improvements. Ultimately, the aim is to provide the Board with clear evidence-based insights into the team's performance and its contribution to delivering high quality dementia care across the Trust

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

The FFT is a vital feedback tool that upholds the core principle that individuals using NHS services should have the opportunity to share their experiences. Every patient receiving care at the Trust can provide feedback on the quality of their treatment, ensuring that the voices of patients and their families are heard. This helps us continuously improve our services and highlight examples of good practice.

While most patients rate their experience highly, we also value feedback on areas where we may not have met expectations, allowing us the opportunity to make necessary improvements. FFT feedback is one of our most valuable resources for understanding both our strengths and areas for development.

We utilise FFT feedback with compliments, concerns, complaints, and insights from the National Survey Programme, to better understand what matters most to our patients and their families. Our patients provide FFT feedback via:

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

What we planned to achieve for 2025/2026:

- Continue collaborating with our Patient Experience Involvement and Engagement (PEIE) Officer, PSPs, patients, families, communities, staff.
- Commence face-to-face feedback sessions.
- The launch of an online feedback forum, "Experience Matters - Coffee and Connect," will facilitate discussions with patients, families, carers, and communities, while triangulating findings with the FFT.
- Continue collaborating with divisions to plan and implement improvements based on FFT findings, resulting in enhanced patient experience.

How did we do?

- Implementation of a monthly engagement forum, Experience matters - coffee and connect with members of the public, attended by PPSP's and staff members. The forum aim is to share hot topics, to co-produce and engage with the community to improve the services we provide at SFHFT.

- Flash reports are now shared at the quarterly Patient Experience Committee (attended by PSP's), highlighting improvements made with FFT, National Patient Survey, complaints, concerns and compliments.
- PSP's attend the Patient Safety Incident Response Framework (PSIRG) meeting held twice weekly, the PSIRG Oversight Group and the Patient Safety Committee.
- PSPs are also involved in the system wide PSP network.
- Patient Stories are created through collaboration with patients and carers to share their experiences and facilitate Trust-wide learning.
- Work alongside Trust Volunteers, who provide valuable support in collecting and inputting FFT results, ensuring ongoing engagement with patients, families, and carers
- QR codes for FFT and other bespoke satisfaction surveys are available in all areas and are being actively utilised, seeing this increase in use across multiple areas of the Trust.
- Strengthened engagement with patients, families, and carers to further support FFT and assist divisional teams in delivering FFT locally, resulting in a continued increase in recommendation rates.
- The PET have worked closely with clinical and non-clinical staff, to create tailored surveys for their specific areas and provide training to help them access feedback. This enables teams to monitor and enhance the services provided to patients.
- The findings of FFT have been triangulated with the National Inpatient Survey results to provide an informed approach to improvements.

The findings from the FFT, along with any resulting improvements, are shared at the Patient Experience Committee, ensuring clear focused discussions and actions are generated.

Results

The results show a variation in response rates (see table 15), and our PET continues to collaborate closely with divisions to develop and support action plans, aimed at boosting response rates and enhancing the collection of qualitative data to inform the development of future services.

Table 15: FFT data April 2025 – March 2026

	Recommendation Rate %											
	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Inpatients	94%	95%	94%	94%	94%	95%	94%	94%	93%	91%	93%	94%
Emergency Urgent Care	88%	89%	86%	83%	83%	80%	80%	80%	84%	81%	77%	78%
Outpatients	96%	95%	95%	95%	95%	95%	94%	95%	96%	94%	95%	95%
Maternity	84%	90%	80%	85%	83%	79%	85%	58%	83%	89%	73%	78%

The FFT feedback is integrated with compliments, concerns, and complaints and is shared with all divisions for learning and reflection. This process highlights positive practice and areas that need improvement.

The following are examples of FFT feedback received during 2025/2026:

- "The whole team were fantastic, very knowledgeable and supportive, nothing was too much trouble."
- "The staff I encountered were approachable, knowledgeable, and professional."
- "I am so grateful for the compassionate team that took care of me."
- "Really good communication and service."

Priorities for 2026/2027:

- New system implementation due to current FFT provider leaving the market.
- Continued growth of engagement via Coffee and Connect including work around the 10 Year Plan, co-production and a focus on improvements and engagement
- Continue collaboration with divisions to plan and implement improvements based on FFT findings, patient feedback resulting in an enhanced patient experience.

3.9 Patient Experience - Safeguarding vulnerable people

Throughout 2025/2026, our adult and children's safeguarding teams continued to work closely together, using a shared Think Family approach. This integrated model ensures our safeguarding practice remains aligned with local and national priorities and supports a consistent, whole family approach across all areas of care.

Our wider vulnerability services-including Learning Disability (LD), Mental Health, Mental Capacity and Security and Violence Reduction, continue to play a key role in strengthening our overall approach. By working closely with safeguarding colleagues, these teams help deliver a cohesive, person centred response that recognises the complex and interconnected needs of the people we support.

We maintain strong partnerships with a wide range of internal and external multi agency professionals. This includes our commissioned, hospital based Independent Domestic Violence Advisor (IDVA), whose presence enables us to offer immediate, trauma informed support to survivors of domestic abuse at the point of disclosure. These partnerships are essential in ensuring timely and well-coordinated interventions for those at risk.

Our core aim is to identify safeguarding and vulnerability risks affecting patients and their families, and to make prompt referrals to the most appropriate agencies for continued support. We remain committed to advocating for our patients throughout their stay with us and work closely with families and partner organisations to help secure the best possible outcomes.

Governance and oversight remain strong. Our Safeguarding Committee continues to monitor safeguarding and vulnerability activity, providing assurance to our Board through the Patient Safety and Quality Committees. This includes oversight of statutory responsibilities under the Children Act 1989/2004 and the Care Act 2014. The Head of Safeguarding represents the Trust at both

the Nottinghamshire Safeguarding Adult Board and the Nottinghamshire Safeguarding Children's Partnership, ensuring that we remain fully engaged in system wide safeguarding priorities and developments.

What we planned to achieve in 2025/2026:

The Trust places safeguarding and vulnerabilities at the heart of our care and service delivery. We remain committed to maintaining robust safety processes that protect and promote the wellbeing of everyone we support.

1. Continued focus on training, monitoring compliance whilst monitoring the effectiveness and impact of training provided.
2. Continued focus on MCA legislative compliance.
3. Undertake process mapping across the safeguarding and vulnerabilities team alongside the ongoing service review work.
4. Review of safeguarding children and adult supervision across the organisation.

5. Explore the role of Champions across safeguarding and vulnerabilities.
6. Review the process around how we share learning and track action plans relating to safeguarding across all divisions within the organisation.

How did we do?

Strong progress has been made in strengthening safeguarding and vulnerability practice across the Trust. Safeguarding training compliance has remained consistently high, supported by a focus on high quality training delivery, close monitoring of uptake, and regular evaluation of impact. This has helped ensure that staff feel confident and capable of recognising and responding to safeguarding concerns.

Through the MCA Working Group and the Trust wide development plan, we have maintained a clear organisational focus on Mental Capacity Act (MCA) compliance. Work continues to ensure the

principles of the act are embedded in everyday clinical practice and aligned with statutory expectations.

The Safeguarding and Vulnerabilities Team has continued detailed process mapping to support the wider service review. This has helped to streamline pathways, clarify roles and responsibilities, and improve the overall experience for patients.

We have completed a full review of safeguarding supervision arrangements for both adults and children, ensuring all our staff have access to high quality, reflective supervision that supports safe and effective practice. We also reviewed the Safeguarding Champions model to understand its impact and to identify further opportunities to strengthen local ownership of safeguarding within clinical areas.

Mechanisms for sharing learning and tracking safeguarding related action plans across all divisions have also been strengthened. This has improved visibility, accountability, and the timely implementation of learning from incidents, reviews, and external reports.

These developments demonstrate our ongoing commitment to delivering safe, effective, and person centred safeguarding and vulnerability practice, that meet statutory duties and the needs of our local population.

Priorities for 2026/2027:

1. Maintain a strong focus on safeguarding training, ensuring ongoing delivery, close monitoring of compliance, and regular evaluation on the effectiveness and impact of all training provided.
2. Sustain compliance with the Mental Capacity Act and associated legislation through continued oversight, guidance, and targeted support for clinical teams.
3. We will continue progressing the implementation of Learning Disability and Autism Training, aligned to the Oliver McGowan Mandatory Training (OMMT) Code of Practice, ensuring staff are equipped with the knowledge and skills required to meet national standards.
4. Establish a robust assurance framework for our vulnerability services, ensuring alignment with national requirements and strengthening oversight across Learning Disability, Mental Health, and Security and Violence Reduction.
5. Advance our work on violence reduction, including the development and delivery of training programmes, completion of environmental risk assessments, strengthening of policies and pathways, and exploration of the wider use of body worn cameras to support staff and patient safety.

National Learning Disability Improvement Standards

The Trust has a specialist Learning Disability (LD) team comprising a Specialist Lead Nurse and a Complex Care Nurse, providing dedicated support to adults with a LD. The team is fully integrated within the wider Safeguarding and Vulnerabilities service and is strategically led by the Head of Safeguarding.

Each year, we submit our response to NHSE in relation to the National Learning Disability Improvement Standards. Our 2025 submission has been completed, and we are able to report the following:

1. Reasonable adjustments have been embedded across care pathways to ensure people with LD's, autism, or both can access personalised care and achieve equitable outcomes.
2. Robust processes are in place to investigate the deaths of people with LD, autism, or both, while using our services, ensuring that learning is identified and acted upon.
3. Monitoring of restrictions and deprivations of liberty remains vigilant, ensuring that any restrictions associated with care and treatment are lawful, proportionate, and regularly reviewed.
4. Empowerment of patients, families, and carers continues to be a core focus, supporting individuals to understand and exercise their rights.
5. Progress continues in the implementation of Learning Disability and Autism (LDA) training in line with the OMMT Code of Practice. In the interim, staff are receiving LD and Autism training through the SFHFT mandatory training programme via the OMMT e-learning module
6. Specialist knowledge and skills continue to be strengthened across the workforce to ensure high-quality, person-centred care.
7. SFHFT is represented at the local LeDeR steering group.
8. DNACPR (Do Not Attempt Cardiopulmonary Resuscitation) plans for adult inpatients with a LD, are reviewed by the LD team. Any concerns are escalated to clinicians where documentation or decision making requires clarification.
9. Board level leadership is provided by the Chief Nurse, who is responsible for oversight and assurance of services for people with LD and autism.
10. LD care plans are used for all inpatients with a diagnosed LD.
11. A flagging system is in place across all electronic systems to ensure patients with a LD are clearly identified, enabling staff awareness and timely

What we planned to achieve in 2025/2026:

- Continue a service review with a key focus on how we can extend the current service to support patients with an autism diagnosis.
- Continue to roll out the OMMT.
- Review the process of how we share learning from LeDeR and embed this into practice.

How did we do?

Work has begun to improve support for autistic patients and their families, starting with pathway mapping, identifying gaps in current provision, exploring how we develop a more responsive and inclusive offer and, working with community partners on future improvements. Although capacity pressures and wider system demands have slowed progress at times, the review has provided a clearer understanding of what is needed to support autistic patients more effectively.

The rollout of the OMMT has faced several internal and external challenges. Internally, operational pressures and conflicting priorities have required careful planning of implementation activity. Externally, changes in national guidance and system expectations have required us to adapt our approach to remain aligned with current standards. Despite these challenges, progress continues, and staff have received Learning Disability and Autism training as part of their mandatory requirements through the OMMT e-learning package.

A review of how LeDeR learning is shared across the Trust has resulted in clearer processes for disseminating findings and monitoring related actions. Engagement with the local LeDeR steering group remains strong. Work continues to ensure that learning is consistently embedded into practice by improving feedback loops, increasing visibility of actions, and ensuring that learning informs both service development and individual patient care.

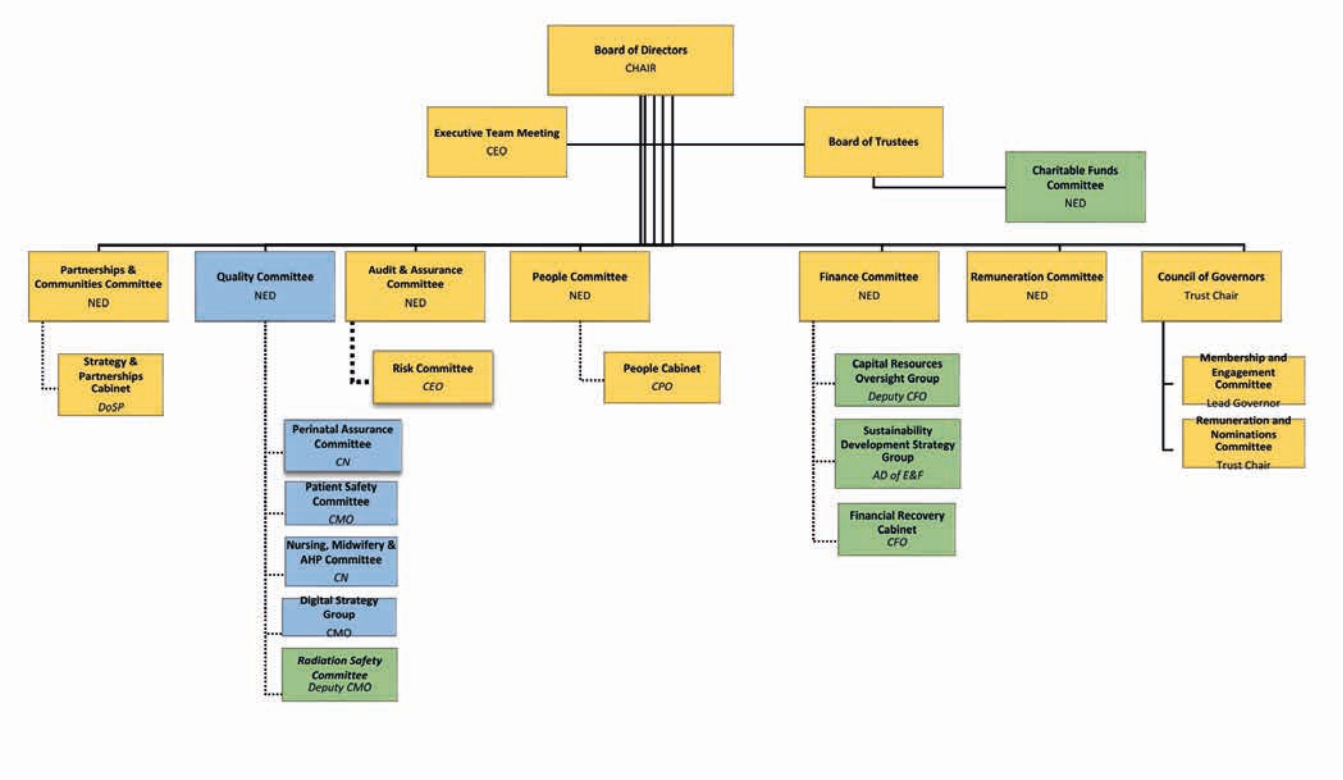
Priorities for 2026/2027:

- Continue to advance the implementation of Learning Disability and Autism (LDA) training, ensuring staff are equipped with the knowledge and skills required to meet national expectations.
- Develop and embed a robust assurance framework for Learning Disability services, providing clear oversight and alignment with national standards.
- Work collaboratively with system partners to support the implementation of the national Reasonable Adjustment Flag, ensuring consistent identification and support for people with additional need local health and care system.

3.10 Mandatory Key Performance indicators

Indicators identified within the Integrated Performance Report	Target	Performance	Performance
		2024/2025	2025/2026
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – Patients on an incomplete pathway	92%	64.60%	63.63%
A&E: maximum waiting time of four hours for arrival to admission / transfer / discharge	>95%	70.97%	72.0%
Cancer Faster Diagnosis Standard	75%	78.32%	81.3%
Cancer 31 day treatment standard	96%	91.88%	91.9%
Cancer 62 day treatment standard	85%	64.24%	66.9%
Maximum 6- Week wait for diagnostic procedures	99%	93.07%	87.45%
Clostridium difficile variance from plan	48	85	72
VTE Risk assessment	95%	96.1%	88.1%
Summary Hospital-level Mortality Indicator (SHMI)	100	105.59 (Jan 24-Dec 254)	104.40 (Jan 24-Dec 25)

Appendix 1 Sherwood Forest NHS Foundation Trust Committee structure – 2025/2026



Appendix 2 Sherwood Forest NHS Foundation Trust Quality & Safety structure – 2024/2025

Annex 1 - Statement from Nottingham and Nottinghamshire Integrated Care Board

Sherwood Forest Hospitals NHS Foundation Trust Quality Account ICB Corroborative statement 2025/26

Introduction

1. Nottingham and Nottinghamshire Integrated Care Board (NNICB) has continued to work with Sherwood Forest Hospitals NHS Foundation Trust in pursuit of the monitoring of continuous improvement of services during 2025-26, in accordance with the statutory functions of the ICB[1].
2. The intention for 2025-26 was for NNICB and Sherwood Forest Hospitals NHS Foundation Trust to continue fostering and developing collaborative and systems based working, and this statement provides a reflection of that progress.
3. The Sherwood Forest Hospitals NHS Foundation Trust Quality Account for 2025-26 illustrates the scope of work undertaken in the last year and where the organisation continues to develop.

Key highlights included within the account are:

a) Expansion of the role of the improvement faculty to embed a continuous improvement culture, providing organisational wide support for change, transformation and quality improvement.

b) Strengthened governance and learning systems with improved integration between incident learning, quality priorities and strategic planning.

c) High participation in national clinical audits demonstrates strong engagement with national benchmarking and improvement frameworks.

d) Strengthened patient and public involvement with an increased focus on patient engagement forums and lived experience, including work such as the perinatal culture and leadership programme.

e) Advancing ward level quality through Exemplar Ward Accreditation with demonstrated improvement in quality metrics and strengthened data driven improvement at ward level.

f) SFHFT has strengthened its research capability through participation in national programmes, integration of research into clinical improvement and expansion of infrastructure including a mobile research unit and new dedicated research bed capacity.

[1] Health and Care Act 2022

Oversight Arrangements

4. The CQC inspected the Urgent and Emergency Care pathway in addition to medical wards and medicines management as part of the national winter pressures programme in March 2026. Actions derived from feedback provided at the time of inspection are in progress with the final report yet to be published.
5. SFHFT are in segment 3 of the NHS Oversight Framework (NOF). The Trust continues to receive ongoing engagement and support of improvement activities through the support of the NNICB Quality Team.
6. Newark Hospital was last inspected in November 2025 with a focus on end-of-life services and maintained an overall Care Quality Commission (CQC) rating of Good. The end-of-life services rating was upgraded from Requires Improvement to Good with Caring rated as Outstanding. CQC were satisfied with actions taken following the inspection and those in progress.

Quality Visits

7. During 2025-26, several quality visits were undertaken across sites with a continued focus on patient experience, staff experience and quality improvement.
8. NNICB has continued to support the Trust through peer reviews and 15 Steps challenges during 2025-26, enabling collaborative working with constructive challenge welcomed.
9. These visits have been positively received and demonstrate the Trust's open and transparent approach alongside its ongoing commitment to delivering high quality care.

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8. NNICB has continued to support the Trust through peer reviews and 15 Steps challenges during 2025-26, enabling collaborative working with constructive challenge welcomed.
9. These visits have been positively received and demonstrate the Trust's open and transparent approach alongside its ongoing commitment to delivering high quality care.

Working as System Partners

10. SFHFT continues to play an active role in a range of system groups, contributing to ICS pathway development and supporting delivery through established ICS governance arrangements. The Trust also remains engaged in Local Maternity and Neonatal System (LMNS) groups and wider quality improvement workstreams.
11. The Trust continues to welcome NNICB attendance at key meetings, supporting shared insight, constructive challenge and ongoing improvement activity.
12. Engagement with Patient Safety Partners has continued to strengthen enabling active involvement in key processes and committees and ensuring that patient perspectives inform service development. The use of patient stories alongside increasing Patient Safety Partner involvement further supports a system wide approach to shared learning.

Forward View 2026/2027

13. Continued alignment with SFHFT's Patient Safety and Quality Strategy (2025–2029) is evident throughout the Trust's Quality Account with a clear focus on patient safety, clinical effectiveness and patient experience, alongside an emphasis on data driven improvement, population health and reducing inequalities.
14. Stronger system wide intelligence and assurance capability to allow robust systems to understand patient safety with learning embedding into improvement plans.
15. Strengthening co-production and ICS collaboration with expanded and embedded patient engagement forums, patient safety partnership involvement and ICS pathway projects.
16. Further development of delivering sustainable, system wide change through improvement programmes to deliver consistent quality improvement across pathways and services including effectiveness of incident reviews, CQC improvement trajectory and continued roll out of the Exemplar Ward Accreditation.

Conclusion

17. NNICB considers that Sherwood Forest Hospitals NHS Foundation Trust's Quality Account for 2025-26 provides a fair, balanced and transparent reflection of quality performance, improvement activity and remaining challenges.
18. NNICB commends SFHFT's continued openness, engagement with partners and commitment to improvement and will look forward to continued collaboration with the Trust and partners to drive improvement both within the organisation and across the wider system.

Statement from the Health Scrutiny Committee

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 2022/2023 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 2025 to March 2026
  2. Papers relating to quality reported to board over the period April 2025 to March 2026
  3. Feedback from commissioners dated June 2026
  4. Feedback from local Healthwatch organisation dated – not applicable
  5. Feedback from Overview and Scrutiny Committee June 2026
  6. The Trust's complaints report published under regulation 18 of the Local Authority Social and Complaints Regulations 2009,
  7. The 2025 survey was published in March 2026
  8. The 2025 national staff survey dated November 2025
  9. The Head of Internal Audit's annual opinion of the Trust's control environment dated n/a
  10. CQC Inspection report dated April 2026
- 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

30/06/2026 ..... Chair