Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Quality Account and Reports

2024-2025

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)

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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 2024/25.

The report also identifies and explains the Trust's quality priorities for 2025/26. The 2024/25 sections of the report refer to quality improvement activities completed during the 2024/25 financial year. These sections include the mandatory reporting requirements set out by NHS England and NHS Improvement as referenced in the following documents:

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

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

I am proud to present and share the 2024/2025 Quality Account for Sherwood Forest Hospitals NHS Foundation Trust. The information within this account describes how we have performed against our priorities, key performance metrics and statement of assurance. It demonstrates our development, achievements and our approach to improving services and care, for our patients, despite the difficult financial climate we continue to face as an NHS organisation.

It also offers a chance to assess our progress while presenting our performance and results for public review.

Attendance to our front door Urgent and Emergency Care services has again increased, reflecting the national rise in hospital demand. Inevitably, this has put significant pressure on our existing services. Despite this, we have shown our ability to respond and adapt and even in the face of this demand, we have delivered more elective procedures and operations than planned. Ensuring timely access to all treatment and planned discharges, continues to be a significant focus for us to improve services for all our patients.

None of this would be possible without the remarkable dedication, compassion, and spirit of our Sherwood colleagues. They consistently rise to the challenge, navigating increasing operational pressures, financial constraints, and an already demanding work environment that continues to grow in complexity.

Our most recent NHS National Staff Survey results continue to show strong performance nationally, with Sherwood remaining the best acute trust to work for in the East Midlands – a title we have been proud to consecutively hold, for the past 7 years. Despite such positive feedback, we know there is more we can do to make Sherwood an even greater place to work. We will continue to progress our actions to address the unacceptable violence and aggression that our colleagues all too often face. We remain committed to supporting a positive culture and working conditions. Our staff deserve to feel safe and supported in all that they do.

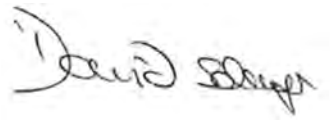
Our key focus for 2025/2026 will be to ensure that we maintain our high standards and the level of quality care that we provide, and we remain committed to improving the care that we provide for our local residents.

Central to this is our approach to quality improvement and collaborative working with our health and system partners. The inclusion of our public and safety partners in designing future healthcare, demonstrates our desire to be a true learning organisation, to strive to do better and to steadily build on our progress.

Reflecting the national requirement for the triple shift from hospital to community, analogue to digital and treatment to prevention; we look forward to our significant multimillion-pound capital commitments progressing in 2025/2026. Nottinghamshire's first Community Diagnostic Centre is under construction at Mansfield Community Hospital, due to open in spring 2026. Our commitment to digitalisation continues to develop, and our Full Business Case to introduce Sherwood's first Electronic Patient Records (EPR) system was recently approved by Trust Board. We have also commenced work on improving our diagnostic capabilities with our new MRI development underway.

Finally, we remain committed to seizing every opportunity to advance the prevention agenda, promoting lifestyle changes that make every interaction meaningful, and making every patient contact count. At the same time, we leverage the opportunities of our place-based partnership to tackle health inequalities within our communities.

I am confident that this account is an accurate and honest reflection of our performance. The balance of continuing to provide outstanding patient care while aspiring and improving within our strict financial envelope will be challenging but remains our key focus during the year ahead. I know that by supporting each other and working together, we will achieve this, demonstrating that our patients remain at the centre of everything our Team SFH colleagues do.



Dr David Selwyn
Acting Chief Executive

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

2.1 Priorities for Improvement

Sherwood Forest Hospitals NHS Foundation Trust (SFHFT) is committed to 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 2025/2026 described in 2.1.3.

The strategy sets out our approach to ensuring every patient 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, SFHFT 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, which delivers 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 through the Trust Quality Committee and onto the Board of Directors.

2.1.1 Providing high-quality, safe care.

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

- 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 ward accreditation programme
- Nursing and midwifery assurance framework and nursing metrics.
- Quality and safety reports.
- National policy.
- CQUINS (Commissioning for Quality and Innovation).
- Feedback and observations from Healthwatch through partnership working.
- Recommendations from the Coroner's office, including PFD orders (Prevention of Future Death).

In our Patient Safety and Quality Strategy (2025-2029), SFHFT will continue to build on the quality assurance and performance framework that is now well established throughout the organisation. This framework is regularly evaluated and reviewed, ensuring risks to the safety and quality of patient care are identified and managed, resulting in clinically sustainable and financially viable services.

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

2.1.2 Approach to Quality Improvement

Patient safety, clinical effectiveness and quality care remain at the very heart of our strategic vision. We pride ourselves on being an organisation committed to 'strengthening and sustaining a learning culture of 'continuous improvement', a commitment firmly embedded within our Quality Strategy (2022- 2025) and continues to be our ambition in our Patient Safety and Quality Strategy (2025-2029).

Every day, our colleagues deliver outstanding patient care, often in difficult circumstances. It is important that we continue to provide them with the best possible practice environment and support colleagues to explore, scope and adopt examples of the best clinical practice. We support colleagues to proactively collaborate across a range of different health and social care partners. Collaboration enables us to explore and implement opportunities that will promote high-quality care and improve the experience of our patients and carers through better joined up services and pathways.

We provide expert organisational support through the Trusts Improvement Faculty (IF). The IF is a centrally located, single point of contact for all colleagues and teams, seeking help and advice on any aspect of improvement, change management and transformation.

The overarching aims of the IF is to:

- improve the quality of patient care
- improve the experience of those who use our services
- improve clinical outcomes
- improve the working lives of our colleagues
- ensure the Trust makes best use of its resources.

The IF provides an evidence-based improvement offer that supports the Trust to embrace the cultural aspects of improvement, address the immediate priorities and helps plan for longer-term challenges. Since its inception, it has supported the delivery of numerous large-scale transformational programmes, including the development of additional theatre capacity at Newark Hospital and, currently ongoing, the Community Diagnostics Centre (CDC) at Mansfield Community Hospital. The IF continues to deliver a full portfolio of training, improvement and change, including the Quality, Service Improvement and Redesign (QSIR) practitioner programme.

Responding to over 150 new requests for assistance each year, it provides support to all the divisions, enabling the teams to deliver financial improvement projects.

The development and implementation of the Continuous Quality Improvement Strategy (CQIS) will support the work of the IF and, supports strategic objective 4 of the SFHFT strategy (2024-2029) 'Improving Lives' to 'Continuously Learn and Improve'.

2.1.3 Quality priorities for 2025/2026

During 2025/26, SFHFT will continue to focus on patient safety, clinical effectiveness and quality of care, the heart of the SFHFT strategic vision. We have a clear plan for consistently delivering high-quality healthcare, focusing on patient safety, clinical effectiveness, and positive patient experience. Using insight to understand the challenges ahead, by involving patients and the community around them, we will identify improvement areas, set goals, and monitor our performance against them.

Three improvement priorities for specific focus in 2025/26 are indicated 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 'Continue to understand patient safety by enhancing current systems and implementing new systems and processes to draw upon multiple sources of patient safety information'	Reviewing patient safety incidents that have been reported to identify emerging themes on safe discharge, to agree actions for improvements.	Safe discharge and re-admission metrics.
Involve 'Provide welcoming and safe care environments'	Implement the Perinatal Culture and leadership programme (PCLP).	Monitoring roll-out to appropriately identified staff groups.
Improve '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'	Further develop and roll-out the ward accreditation programme.	Ward accreditation data.

2.1.4 Review of Quality Priorities during 2024/2025

Patient Experience	Excellent Patient experience for users and the wider community. (Campaign 2, Quality Strategy 2022-2025)

Quality priority:

Increased service user / citizen engagement at key SFHFT meetings

Patient Engagement

Patient engagement is a core priority for SFHFT, ensuring the patient's voice is heard when considering improvements, shared decision-making and placing patients at the heart of everything we do.

Patients, families, carers, and the communities we serve are increasingly involved in the planning, development and delivery of our services, via various methods, detailed below. A patient's direct experience of using services at SFHFT provides a unique perspective on what is working well and where improvements can be made.

Patient Safety Partners

Patient Safety Partners (PSPs) have been actively engaged in the design of healthcare across all levels of SFHFT. Their role includes participation in safety governance committees and supporting compliance monitoring of patient safety issues. PSPs offer valuable challenge from the public patient voice perspective, informing the development and evaluation of strategies and policies, with a focus on lessons learnt during implementation.

PSPs ensure that by attending allocated committees, they prioritise the perspectives of service users, patients, carers, and families, whilst promoting diverse viewpoints.

Success Measures / Progress:

In 2024/2025, PSPs completed a specialised bespoke training package and Safety Syllabus 1 training.

The PSPs have actively participated in several key processes and committees that have included:

- Supporting the launch and opening event for the PSP role and PSIRF.
- Contributing a patient perspective on the Patient Safety Incident Response Framework (PSIRF) and Patient Safety Incident Response Plan (PSIRP) policies and plan.
- Providing patient input into the peer review processes, including a PSP participating in a peer review for Maternity services.
- Assisting with the opening event of the new Discharge Lounge.
- Held membership on the Patient Experience Committee and the Patient Safety Committee.
- Recruitment of a Governance Facilitator and a Specialist Breast Services staff member.
- Attending the CDC engagement event at Mansfield Community Hospital (MCH), offering the patient perspective on the layout and services, and engaging in discussions with the CEO and the local Mayor.
- Sharing the patient perspective on ongoing work with Pharmacy services.
- Contributing to the development of the SFHT Fundamentals of Care, collaborating with the communications team.
- Meeting with the Datix system leader to gain a deeper understanding of the process.

Patient Experience	Excellent Patient experience for users and the wider community. (Campaign 2, Quality Strategy 2022-2025)

15 Steps

The 15 Steps Challenge serves as a valuable source of qualitative data, offering insights from the perspectives of patients and relatives in various healthcare settings. It also provides an opportunity to align patient and staff experiences, fostering a positive experience for all and empowering staff to drive local service improvements.

The programme of visits continues to support the engagement and visibility of the Senior Leadership Team and Governor representation. Governors play a unique role in the 15 Steps process, capturing real-time, honest feedback from patients, families, carers and staff.

The15 Steps Challenge is used in conjunction with clinical audit to provide a comprehensive approach to evaluating the delivery of quality care.

In 2024/2025, the outcomes of these visits were positive, with numerous examples of person-centred, compassionate care, pride, positivity, and a strong demonstration of CARE values throughout SFHFT.

Patient Stories

Patient stories offer a valuable opportunity to gain insight into the care individuals receive. They are a powerful tool for continuous improvement, helping to identify areas where service quality can be enhanced and the patient and carer experience transformed.

By actively listening to, engaging and learning from the patient voice, these stories provide a richer understanding of the emotional and personal dimensions of care. Patient stories help drive improvements that foster trust, empathy, and communication that are just as valuable as the medical interventions our patients receive at SFHFT.

Patient stories are shared monthly via public board, providing members with valuable information on patient experiences and the related services. This allows us to focus on what matters most to our patients. These stories are made publicly available with honesty and transparency, irrespective of reflecting positive or negative experiences. This approach helps address areas for improvement or share positive learnings.

In 2024/2025, we engaged with numerous families, carers, and patients who had received care at SFHFT. These individuals were given the opportunity to share their voices and reflect on their experiences. Examples of stories shared include:

- A face-to-face account presented to the Public Board regarding care within Maternity services.
- A family's experience with discharge and readmission due to uncontrolled pain.
- A story about a patient with dementia and the improvements made to the service.
- A story highlighting the impact of long waiting times in Mental Health Services.

Post Board, patient stories are shared within divisions and cascaded out to staff across SFHFT to enhance learning and improve the experience and care our patients receive.

Clinical Effectiveness	Strengthen and sustain a learning culture of continuous improvement. (Campaign 3, Quality Strategy 2022-2025)

Quality priority:

Developing and embedding our approach to Patient Safety II by implementing and embedding the Patient Safety Incident Response Framework, (PSIRF).

Success Measures / Progress:

Embedded patient safety framework to match the national PSIRF. PSIRF was launched in October 2023 and is now well embedded.

The trust continues to integrate the four key aims of PSIRF with:

- compassionate engagement and involvement of those affected by patient safety incidents
- application of a range of system-based approaches to learning from patient safety incidents
- considered and proportionate responses to patient safety incidents
- provision of supportive oversight focused on strengthening response system functioning and improvement.

The introduction of a quarterly PSIRF Oversight Group in Q1 has sought assurance from the divisions that incidents that have not been reviewed at the Patient Safety Incident Review Group (PSIRG)

- Have been handled and investigated where indicated using methodologies outlined in the Trust's Patient Safety Incident Response Plan (PSIRP).
- That Duty of Candour has been undertaken in line with statutory requirements and SFHFT policy.
- All actions have been implemented that address identified contributing factors and are monitored for effectiveness.

Staff Experience	Deliver high-quality care through kindness and "joy at work" (Campaign 4, Quality Strategy 2022-2025)

Quality priority:

Reduce colleagues working experience of violence and aggressive behaviour

Success Measures / Progress:

Improved performance against the following key National Staff Survey indicators at a Trust level. We will report that staff have not experienced harassment, bullying discrimination, or abuse from:

- Patients / service users, their relatives, or members of the public.
- Other colleagues / managers

Following analysis of our National Staff Survey results, in 2023 we developed a violence and aggression (VA) improvement plan. This Improvement Plan focuses on the group's collective actions and key priorities for 2024/2025.

The plan directly linked to our Sherwood People Strategy for 2022-2025 which sets out our vision of empowering and supporting our people to be the best they can be.

The actions are set out below:

Key actions 2024/2025

NHS Sherwood Forest Hospitals NHS Foundation Trust

Priority area / Key action	Target Deadline
Build Leadership culture	
• Implement the Leadership Fundamentals training which supports leaders to create cultures built on compassion and kindness.	April 2024
• Embed CARE Values on all core training programmes.	March 2025
Promote active reporting	
• Develop a violence and aggression dashboard to be presented to the Trust People Cabinet on a bi-monthly basis.	March 2025
• Review the Datix system, exploring how the reporting process for incidents of violence and aggression can be simplified to enable improved reporting.	September 2024
Provide end to end support	
• Implement a Trauma Risk Management (TRiM) model Trust-wide.	May 2024
• Develop and distribute dedicated support material including information leaflets and support cards that can be provided to colleagues as immediate support in the event of an incident.	May 2024
Improve training resources	
• Review and implement revised restraint reduction and conflict resolution training for new and existing colleagues.	March 2025
• Work with our Medirest partners to implement restraint reduction and dementia training for new and existing colleagues employed and managed by Medirest.	October 2024
Amplify our communications	
• Design and implement a bespoke communication strategy showcasing our approach to reducing violence and aggression at the Trust.	March 2025
• Review and relaunch the Trust's Anti-Racism Improvement Plan (Strategy) for 2025-2029	March 2025
Work with local partners	
• Explore the potential for a Community Police Hub to be set up within the Trust.	November 2024
• To be an active member of the Nottingham and Nottinghamshire Violence and Reduction Partnership forum.	April 2024

- SFHFT has implemented and embedded the Leadership Fundamentals training and continue to embed the CARE values on all our core training programmes. This is further complimented by CARE values roadshows and is communicated widely throughout the divisions.
- As part of amplifying communication around this project, there is a continual focus on educating people of the importance of active reporting through Datix. Step-by-step guide and videos have been produced by the team, on how to report incidents via the Datix system.

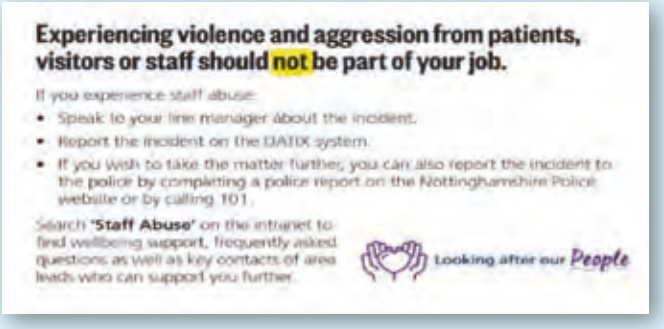
Staff Experience	Deliver high-quality care through kindness and "joy at work" (Campaign 4, Quality Strategy 2022-2025)

- Trauma Risk Management (TRiM) is a trauma-focused peer support intervention based on 'active monitoring', which involves keeping an eye on individuals who have been exposed to traumatic events. The TRiM (Trauma Risk Management) referrals process was piloted in December 2023; the Occupational Health Team are currently evaluation the impact of this. Positive feedback has been received to date.
- SFHFT website access is monitored by our communication team and a screensaver about TRiM is in regularly shared.
- The Violence and Aggression (VA) working group have commenced a service user survey to establish the effectiveness of the system and the support that subsequently follows. Recommendations will be made to support increased reporting of incidents, enabling us to have an accurate understanding of the issue and focus support in areas experiencing high levels of violence
- The VA working group have developed support leaflets, posters and information cards with QR code, providing and signposting to the support available.

The national staff survey results for 2024, highlighted that one of the most improved measures for the Trust, when compared to 2023, was 'not experienced physical violence from patients/service users, their relatives or other members of the public'. It is the first time SFHFT has seen an improvement in this category.

Our work has been recognised by NHS England and we will be presenting our and case studies at the ConfedExpo 2025 at the NHS Confederation on 11 June 2025.

Areas that remain under development include exploring the potential for a community police hub, develop a strategy for violence reduction and anti-racism and, further partnership collaboration to support all colleagues working at SFHFT. These actions have been included in the priorities for 2025/2026.



2.2.1 General Statement

During 2024/25 SFHFT provided and/or subcontracted various relevant health services.

SFHFT has reviewed all the data available to them on the quality of care in these relevant health services. The income generated in respect to Clinical Income in 2024/25 represents 84.7% of the total income generated by SFHFT.

This year, SFHFT cared for:

	2024/25	2023/24
ED Attendances KMH	131,789	124,811
Newark UCC Attendances	38,964	34,815
PC24 Attendances	29,038	29,024
Total	**199,791**	**188,650**
Births	3,466	3,494
Outpatient Attendances (all sites)	522,823	477,610
Inpatient activity	64,426	64,377
Day Case Activity	44,572	40,433

SFHFT employs 6,342 substantive people. We engage with many people through our temporary staffing, bank system which increases this number to 7,479, including 256 consultant doctors (comprising of 42 locum consultants), working in our hospital facilities, some of the best in the country.

2.2.2 Participation in Clinical Audit

Over 2024/25, the focus has been on developing and enhancing the relationship between SFHFT divisions, and strengthening the focus and visibility of patients, service outcomes, and learning. The clinical audit team has attended over 50% of the trust's specialty governance meetings to influence more locally and to share learning and good practice across SFHFT.

National Clinical Outcome Review Projects 2024/25

During 2024/25, SFHFT participated in 50 out of 54 (93%) of national clinical audits and 100% of national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that SFHFT participated in during 2024/25 are as follows:

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

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

Non-participation

***Fracture Liaison service**

SFHFT does not have a fully functioning Fracture Liaison database in place; this has been run on an ad-hoc basis and not all patients have been included so far.

A working group has been established and a business case has been submitted to formalise a substantive FLSD service and is currently under review.

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

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

Study Title	Participation	Project Status	%
Acute Limb Ischaemia	Yes	On-going	0
Emergency (non-elective) procedures in children and young people	Yes	On-going	0
Hypernatraemia	Yes	On-going	100
Hyponatraemia	Yes	On-going	100
ICU Rehabilitation	Yes	On-going	50
End of Life Care	Yes	Completed	100

Outcomes and Learning from Clinical Audits Undertaken During 2024/25

The number of clinical audits both national and local which formed part of the 2024/25 Audit Plan are as follows:

Total Number of audits in the 2024/25 plan **= 319**
Number of local / other audits **= 259**
Number of national audits, including NCEPOD **= 60**
Number of audits fully completed **= 190**

Local Audit examples

Getting It Right First Time (GIRFT)

How compliant we are to the standards of documentation for patients undergoing hip arthroplasties. This re-audit reviewed surgical documentation of hip arthroplasty's at SFHFT compared it to the Best Practice Guidelines set out by the GIRFT campaign. The GIRFT Best Practice guidelines identified key points that should be present on the operative notes of hip arthroplasties. A template was introduced to assist Orthopaedic colleagues in complying with best practice documentation. This has improved our documentation of seven points, by more than 10%, with an additional 12 points which had less than 10% increase.

To Evaluate Sedation Holds Practice within the Intensive Care Unit

The Re-audit revealed the nursing documentation has improved since the last Audit, increasing compliance to 83% from 56%, and daily sedations holds are being performed more often.

Quality Of Consent Audit - Patient Questionnaire (Medicine Division)

The findings have provided the Division with a level of assurance that patients are provided sufficient information, using language they understand, to give their informed consent to an intervention. Patients reported that they felt able to ask questions and were given sufficient time to decide to have the intervention. Information leaflets are used to reinforce the information provided verbally during the consent process.

Unilateral Tonsillectomy for Asymmetry: Histology outcome

In comparison with the previous cycle, the number of patients who have been listed for unilateral tonsillectomy for histology has dropped significantly, (a goal achieved from the previous cycle). The percentage of requested imaging increased from 40.8% to 75%. This is evidence of improved and good practice, to further investigate the patients before listing them for surgery.

Oxygen Prescription in General Surgery

Rapid improvement in results from 44% to 90%. Doctors benefitted from additional training on the prescription of oxygen. Where oxygen was prescribed, it was 100% correct, at the current saturation levels, for the correct patient.

Cycle 1: Stethoscope availability on Anaesthetic machines

The Association of Anaesthetists of Great Britain & Ireland (AAGBI) guidelines recommendation for standards of monitoring during anaesthesia and recovery 2021, states “During anaesthesia [...] a stethoscope should always be available”. Without a stethoscope immediately available on an anaesthetic machine there can be substandard patient care, monitoring, and the possibility of avoidable never events including oesophageal intubation. The audit reviewed current practice at SFHFT. It demonstrated a lack of compliance against the guidelines. Actions included the purchasing of additional stethoscopes to allocate to each anaesthetic machine to comply with the standard. This has resulted in compliance now being achieved.

Cycle 2: Management of Atrial Fibrillation

The audit evaluated current practice of management of atrial fibrillation in Same Day Emergency Care (SDEC) to identify areas of improvement. The first cycle reviewed the use of CHA2DS2-VASc, a clinical prediction scoring system for estimating the risk of stroke in people before starting anticoagulation.

After implementing the action plan of cycle 1, (included training and a checklist), there was a significant increase in the use of CHAD2DS2-VASc, rising from 32% to 88%, resulting in fewer patients receiving unnecessary anticoagulation therapy.

What we aim to achieve in 2025/26

- Continue to strengthen the link between Audit and Improvement to deliver the ‘So What’ of Clinical Audit.
- Reduce the number of ‘single cycle’ audits being undertaken and promote the importance of the audit cycle being completed to deliver improvement in outcomes.
- Ensure that we are appraising the outcomes taken from National Clinical Audit and using these to drive the local audit agenda by offering increased support to clinicians.
- Utilising other data types such as Patient Level Information and Costing System (PLICS) to demonstrate the benefits of clinical audit.
- Highlighting other areas of learning from audit such as the impact on health inequalities and sustainability to strengthen the overall ‘outcomes’ narrative.

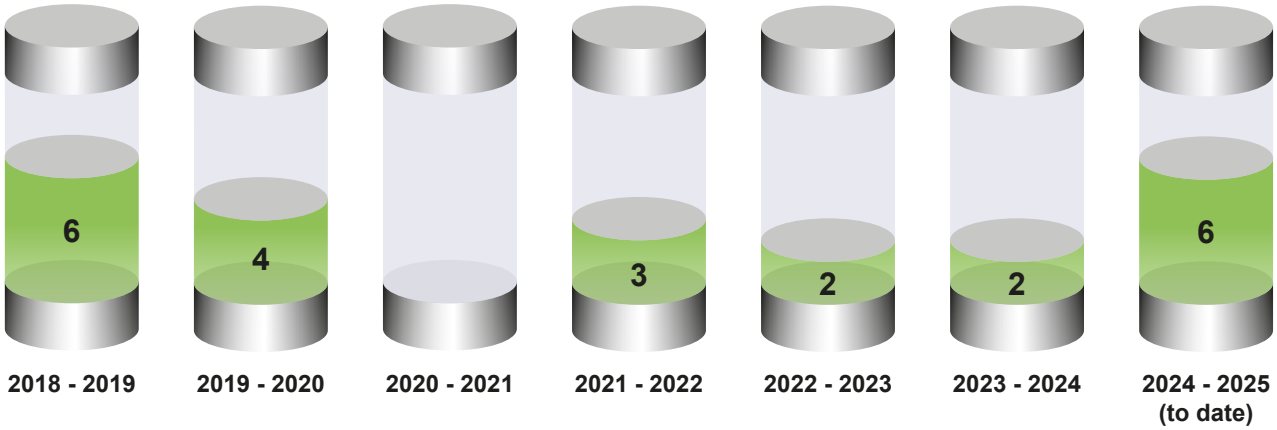
2.2.3 Participation in Clinical Research and Innovation

The number of research participants receiving relevant health services, provided or sub-contracted by SFHFT in 2024/25 was 2511. This includes research involving patient data and tissue samples in studies that have been approved by the Research Ethics Committee.

SFHFT is a research active organisation with its own dedicated Research and Innovation (R&I) department. The R&I department is responsible for developing and supporting a varied research portfolio and creating better opportunities for patients and staff to participate in research activity, whilst informing the provision of high-quality and evidence-based health care. Patient participation in research is mainly through studies adopted by the National Institute for Health Research (NIHR).

In 2024/25 the primary focus for R&I was to focus on a balanced research portfolio, with an emphasis on attracting commercial activity. Graph 1 shows an increase in commercial studies secured in 2023/24 and this is continuing to develop as we move into 2025/26.

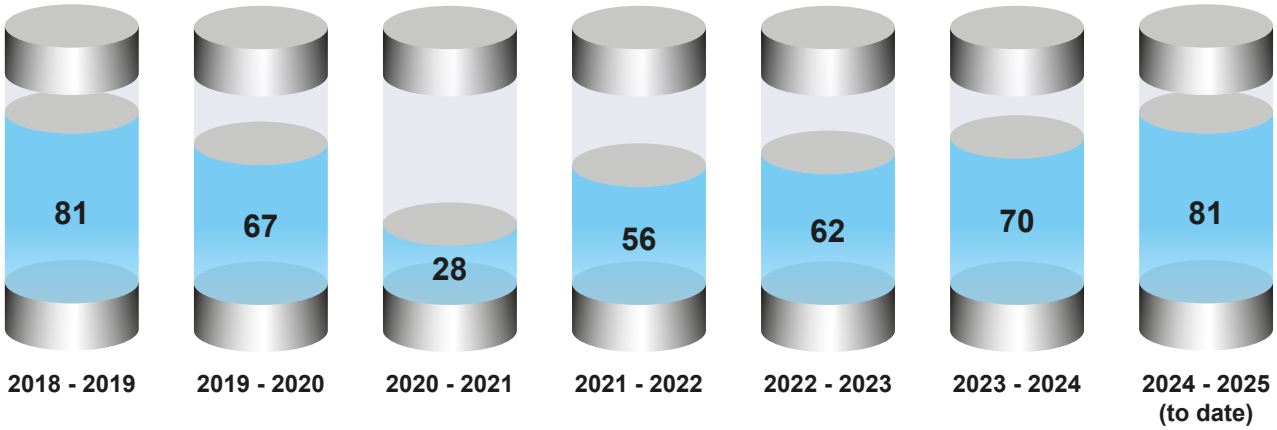
Graph1: R&I studies Commercial



In 2024/25, R&I sponsored two studies one of which was multi-site and across our partners in Primary Care settings.

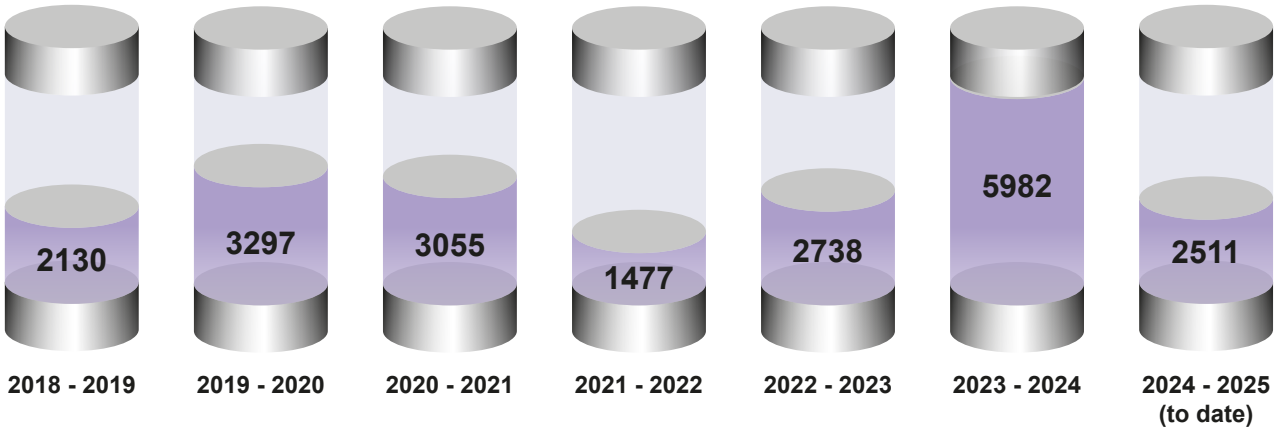
Graph 2 demonstrates an increase in our non-commercial R&I studies for 2024/2025.

Graph 2: R&I studies Non-Commercial



2024/25 has demonstrated a significant decrease in patient recruitment (Graph 3), resulting in falling short of our annual recruitment target of 4,500. Historically we open 1-2 large-scale studies per year. These large-scale studies are reflected in our previous recruitment figures. Nationally there has been a shortage of large-scale studies to apply for. All the regions were accepted for the one large-scale study available except Nottinghamshire. This in turn has considerably impacted our recruitment figures.

Graph 3: R&I Patient Recruitment



The R&I department successfully secured funding in 2022/23 to develop an infrastructure at SFHFT, to deliver high-class quality research and increase patient opportunities. Our 8-bed Clinical Research facility is currently under development and will be completed in 2025. We will increase the use of digital technologies in research and use a targeted development programme with East Midlands Clinical Research Network and commercial sponsors, to increase investment and research opportunities for our patients.

R&I's Mobile Research unit was launched in May 2025 and will be used to increase visibility and accessibility across our communities, delivering research in 'hard-to-reach' areas.

In 2024/25, for the second consecutive year, SFHFT achieved the bronze standard Work Force 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 that are being delivered. This accreditation supports SFHFT's reputationally to be more attractive to sponsors, and potentially attract further commercial research activity.

Research is a partnership between the participant and the 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 92% of respondents reported that they would agree or strongly agree their participation in research has been valued, and 83% would consider taking part in research again. One participant reported, "No pressure to take part. I feel it's important to take part in studies to help other people. I would like to take part in more studies in the future."

SFHFT has recently appointed its first Non-Executive Director, whose responsibilities include supporting delivery of our Research ambition.

What we aim to achieve in 2025/26

- Develop our Clinical Research Facility and Mobile research unit to deliver high-class quality research and provide better opportunities for patients to access and participate in research. Both units will attract commercial sponsorship into our region, in turn, affording our patients more opportunities to participate in trials for new and novel treatments and, generate an income for Mid-Nottinghamshire.
- Research activity will continue to be reviewed regularly with bi-annual reporting to the SFHFT board and the Patient Safety Committee. We also have an external reporting responsibility to the Department of Health via the Clinical Trials Platform. This is a national key performance indicator for all NHS organisations.

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. In line with this guidance and, in consultation with the Nottingham and Nottinghamshire ICB, SFHFT have not formally reported against CQUINs this year.

The 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 for 2024/2025'.*

2.2.5 Registration with the Care Quality Commission (CQC)

SFHFT has three locations registered including:

King's Mill Hospital

Newark Hospital

Mansfield Community Hospital

SFHFT currently has no restrictions on registration. The CQC has not taken any enforcement action against SFHFT during 2024/25.

SFHFT had two CQC inspections during 2024/25.

The Nuclear Medicine services were inspected to assess compliance with ionising radiation. The CQC are satisfied with the actions taken & those in progress.

The Emergency Department (Sepsis pathway) was inspected in September 2024. We continue to wait for the final report. SFHFT completed actions on the feedback that was given, at the time of the inspection.

SFHFT maintain a positive working relationship with the CQC, engaging in quarterly engagement meetings. The overall rating for SFHFT 'Good' comprises of the following ratings for each domain:

Overall trust quality rating	Good
Safe	Good
Effective	Good
Caring	Outstanding ☆
Responsive	Good
Well-led	Good
Use of resources	Requires improvement

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

SFHFT submitted records during 2024/25 to the Secondary Uses service (SUS) for inclusion in the Hospital Episode Statistics which are included in the latest published data.

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

100 % for admitted patient care.

100 % for outpatient care; and

99 % 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 % for accident and emergency care.

2.2.7. Information Governance

SFHFT's Data Security Protection Toolkit Assessment Report overall score for 2023/2024 was graded as 'standards met'. It is anticipated that the Trust will achieve the "Approaching Standards" submission for 2024/2025 by the end of June 2025. Although we have made good progress towards the 'Standards met' grading this year, we have not achieved all the standards required.

Data security aims for 2024/25

The Data Security and Protection Toolkit now encompasses the National Cyber Security Centre's, Cyber Assurance Framework. This is a rigorous test of SFHFT's security systems. SFHFT 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 (SFHFT internal auditors), who undertook a review of the standards in 2023/24 and provided an overall assessment. This review provided significant assurance which provided a high level of confidence in our data security.

Monitoring and reporting for sustained improvement

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

Serious incidents requiring investigation

In 2024 /25, SFHFT reported five data security serious incidents, which were reported on the Data Security Protection Toolkit. The incidents involved were a compromise in confidential data.

Two of those incidents were deemed not reportable and the further three no further action was required.

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

2.2.8 Clinical Coding

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 Secondary User Service (SUS) and used to support commissioning, healthcare development and improving NHS resource efficiency. Within 2024/25, the clinical coding team coded 124,991 Finished Consultant Episodes (FCE's).

Clinical Coding Aims For 2024/25

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

Performance Against Targets

SFHFT has consistently achieved 100% coding targets by the fifth working day after the month end, without exception this year and, an improvement on 23/24 where two months where over this target but still before the 1st SUS submission.

All 2024/2025 deadlines were coded by SUS first submission, improving on 2023/2024.

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

FCE Month	5th Working Day	1st SUS Submission date	Total Number of Episodes	% Coded at 1st Submission
April-24	08/05/2024	15/05/2024	11595	100%
May-24	07/06/2024	14/06/2024	11122	100%
June-24	05/07/2024	12/07/2024	11370	100%
July-24	07/08/2024	14/08/2024	11824	100%
August-24	06/09/2024	13/09/2024	10795	100%
September-24	07/10/2024	14/10/2024	11187	100%
October-24	07/11/2024	14/11/2024	12167	100%
November-24	06/12/2024	12/12/2024	10576	100%
December-24	08/01/2025	15/01/2025	11135	100%
January-25	07/02/2025	14/02/2025	12049	100%
February-25	07/03/2025	14/03/2025	10550	100%
March-25	07/04/2025	14/04/2025	10894	100%
Total			**135,264**	**100%**

Table (3) provides the volume of un-coded episodes for discharged hospital spells within each month. The total number of episodes relates to FCE's. FCE's is a subdivision of a hospital spell in which a specific consultant has responsibility for a patient's care. A hospital spell can be comprised of one or more FCE's. These figures do not represent individual patients but represents FCE numbers from admission to discharge out (Hospital Spells).

Audits

The Trust has a coding Data Quality Assurance (DQA) programme that assesses components of clinical coding prior to the final submission of activity data, to ensure coding accuracy and that the depth of coding accurately reflects the medical record. This programme identifies potential missing comorbidities for a sample of records each month and reviews them against the medical documentation. This is supplemented by targeted audits by the clinical coding auditor to improve

the quality of the coded data. Sample sizes of the DQA have varied throughout the year due to team capacity, and clinical availability through periods of industrial action and winter pressures.

Audits throughout the year highlighted opportunities for improvement which included:

- Pneumonia - Pneumonia specialist nurse highlighted potential over coding of pneumonia cases. Audit is ongoing in this area. Initial findings have helped to improve the accuracy of pneumonia identification within clinical coding and has provided feedback to the specialty about recording of pneumonia and associated comorbidities.
- Endoscopy – Coding audit was initiated because of the difficulties in coding endoscopic retrograde cholangiopancreatography's (ERCP's), due to the associated rules and regulations. Training has been conducted with the team to improve the coding standards of these procedures.
- Charlson comorbidity index audit
- Oncology coding audit
- Individual coder audits

In addition to opportunities identified above, there has been engagement relating to the learning from deaths group and the work on the effect of palliative care data on Hospital Standardised Mortality ratio (HSMR) and, Summary Hospital Level Mortality Indicators (SHMI) outcome measures. Clinical Coding have been working closely with specialties to improve the accuracy of co-morbidity recording across all audits and service improvement recommendations based on Getting It Right First Time (GIRFT) best practice. This has expanded through to the implementation of HSMR+ and the impact of frailty on the modelling of the HSMR+ algorithm.

In addition to the comorbidity audit, the clinical coding team have also started to utilise a medical history assurance tool provided by Solventum's Medicode360 encoder, which allows coders review past medical history and validate missing information with clinicians when available. The coding team also utilise Solventum's template coding function to increase the efficiency and accuracy when coding.

Data Security Protection Toolkit (DPST) - Data Quality

As part of DSPT, SFHFT has undertaken an audit of 200 FCE's (April 2024 – February 2025). Trusts must meet or exceed the required percentage across all areas to meet the attainment level for a DSPT clinical coding audit. SFHFT has previously met the standard in two selected areas and exceeds the standard in correct secondary procedures and correct secondary diagnoses.

Results for 2024/205 ongoing Clinical Coding

Table 4. below illustrates the clinical coding audit results compared to the recommended percentage of accuracy scores from the Terminology and Classifications Delivery Service, amber representing standards met and green indicating standards exceeded.

Table 4: DSPT requirements Clinical Coding audit results comparing 22/23, 23/24 and 24/25.

	Primary diagnosis correct	Secondary diagnosis correct	Primary procedure correct	Secondary procedure correct
Standard Met	>=90%	>=80%	>=90%	>=80%
Standard Exceeded	>=95%	>=90%	>=95%	>=90%
SFHFT 22/23	90%	93.4%	93.7%	89.9%
SFHFT 23/24	91%	95.6%	93.6%	96%
SFHFT 24/25	93.1%	95.0%	92.0%	92.1%

Based on the review of the DPST Recommendations, the table below (table 5) outlines the recommendations that were made and confirmation that all were actioned within the timeframe.

Table 5: DSPT audit recommendations for Clinical Coding 24/25 into 25/26.

Recommendations	Priority	Date to be completed by	Date of action complete
Coders should refresh themselves with the primary diagnosis definition.	**High**	**May 2025**	**20.05.2025**
Aim to recruit 2.0 WTE Coders	**High**	**May 2025**	**In process, awaiting approval**
Coders should refresh themselves on the four-step coding process	**High**	**May 2025**	**20.05.2025**
Aim to recruit a Trainer	**High**	**May 2025**	**Recruited**
Coders should refresh themselves on PRule 3: Axis of the classification	**High**	**May 2025**	**20.05.2025**
Coders should refresh themselves on the PCSY1: Argon plasma coagulation	**High**	**May 2025**	**20.05.2025**
Coders should refresh themselves on the PCSY6: Approach to organ and PCSY13: Insertion and removal of mesh information	**High**	**May 2025**	**20.05.2025**
Coders should refresh themselves on the PCSU1: Diagnostic imaging and procedures	**High**	**May 2025**	**20.05.2025**
Feedback to the Coding Team on the omitted Functional Endoscopic Sinus/Nasal Surgery procedures	**High**	**May 2025**	**20.05.2025**
Feedback to the Coding Team on the omitted lipoma and removal codes	**High**	**May 2025**	**20.05.2025**
Feedback to the Coding Team on all areas of coding errors	**High**	**May 2025**	**20.05.2025**

Recruitment, Training and Performance

SFHFT has made significant strides in the recruitment and development of its Clinical Coding team during the 2024/2025 period. The department successfully recruited a Deputy Manager and Clinical Coding Auditor, filling previously vacant roles.

Key achievements include:

- The Clinical Coding team is fully up to date with the mandatory training requirements set by NHS England, ensuring compliance with national standards.
- In 2024, two experienced coders achieved their national qualifications marking an improvement over the previous year. 23% of the coding team consists of trainees
- Vacancy/performance management has been supported by utilising overtime for experienced staff. This has supported audit and performance deadlines and training requirements. This proactive approach and commitment to training, has ensured the team continues to meet its responsibilities, despite the financial and staffing challenges faced this past year.

2.2.9 Data Quality Strategy

SFHFT's Data Quality Strategy aims to influence and drive improvements in outcomes for patients through effective decision making by clinical, operational, and managerial staff, 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 6 below:

Table 6: 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

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

Responsiveness

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

- Actively validate data sets to ensure decision making is based upon accurate information.
- Work with operational and clinical teams to quantify the relative risk and priorities. This results in informed choices on the necessary action and timescales for the Divisional Teams, supported by the 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.

SFHFT have developed an in-patient audit programme that allows us to continuously improve the monitoring or 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

SFHFT 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) used by SFHFT. Initial system training is delivered by Nottinghamshire Health Informatics Service (NHIS) trainers and is a prerequisite to obtaining access to the SFHFT PAS system. SFHFT DQ team & 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 will be shared with the Divisions.

Data Quality Improvement Key Performance Indicators (KPI's)

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

- Outpatient referral management
- Outpatient activity
- Inpatient activity
- Elective waiting list management
- Referral to Treatment (RTT)
- Maternity
- CareFlow PAS maintenance and generic DQ 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 DQ team, with support from the Information team & Corporate Planned Care team, have been taking the following actions to improve data quality through audit and assurance:

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

A data assurance 'kitemark' process is currently being tested, to assure the quality of our board reported indicators are being completed and once reviewed, will form part of future integrated performance reports.

SFHFT Data Quality Position 2024/2025

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

SFHFT average total DQMI score for Admitted Patient Care, Outpatients, and the Accident & Emergency Departments, is 92.1%. SFHFT submitted records during 2024/25 to the SUS for inclusion in the Hospital Episode Statistics which are included in the latest published data. The % scores are all above the National Data Item averages.

The % of records in the published data which included the patient's valid NHS number (Q3, 2024)		
Admitted Patient Care	**Outpatient Activity**	**Accident and Emergency Care**
99.9%	**100%**	**98.7%**

The % of records in the published data which included the patient's valid GP Code (Q3, 2024)		
Admitted Patient Care	**Outpatient Activity**	**Accident and Emergency Care**
100%	**100%**	**98.9%**

The % of records in the published data which included the patient's valid Ethnic Category (Q3, 2024)		
Admitted Patient Care	**Outpatient Activity**	**Accident and Emergency Care**
97.1%	**96.1%**	**95%**

2.2.10 Improving Care and Learning from Mortality Review

Performance against the Learning from Deaths Standard

In the reporting period 2024/25, 1747 of SFHFT patients have died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 407 deaths in the Q1 (first quarter)
- 416 deaths in the Q2 (second quarter)
- 451 deaths in the Q3 (third quarter)
- 473 deaths in the Q4 (fourth quarter)

The number of deaths for the previous reporting period (2023/24) was 1768.

All deaths were subject to proportionate independent scrutiny by the Medical Examiners (ME) Service and discussion with the attending clinical team.

Following scrutiny of hospital deaths, further investigation using the Royal College of Physicians' Structured Judgement Review (SJR) Methodology was requested in 105 cases. This is approximately 7%, consistent with the last reporting period.

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

- 32 in Q1
- 32 in Q2
- 30 in Q3
- 32 in Q4

The Datix QI system went live in October 2024, and new requests for SJR are administered entirely within this system. User access is only granted following training in both system use and SJR methodology. Final approval of submitted SJRs is allocated to mortality leads which we anticipate will provide an increase in quality assurance over the previous arrangements. Although qualitative feedback from independent reviewers, LeDeR (Learning Disabilities Mortality Review) and ME (Medical Examiner) has generally been good, an audit of completed SJRs is planned to investigate the impact of the new platform.

When sufficient reviews have been completed on the new system, standard dashboards that will feed into Specialty and Divisional Governance processes will be created.

Following the review, overall care was found to be generally good. The small number of cases where poor care is identified by SJRs are escalated through formal governance processes. These cases are then reviewed for further investigation under the Serious Incident Framework and, more recently, the Patient Safety Incident Response Framework (PSIRF). These cases are also typically subjected to coronial processes.

The Trust received two Prevention of Future Deaths Reports in the reporting period 2024-5, addressing our arrangements for paediatric care in the emergency department and our recognition and response to antepartum haemorrhage. Detailed action plans have been submitted in response to these cases. The Coroner also observed some difficulties in establishing exact details in certain cases. Whilst this is likely to be a result of a shift in emphasis in the investigative approach to thematic from individual cases under PSIRF, SFHFT acknowledges this and has modified processes to include early capture of Factual Recall of Events (FROE) from those involved.

In other deaths resulting in inquests, our improved engagement with the bereaved and extensive involvement of frontline staff, including detailed process mapping, both enabled by PSIRF, have contributed to more favourable inquest outcomes, with learning to support future improvements.

2.3 Reporting against Core indicators

2.3.1 Summary Hospital Level Mortality Indicator (SHMI) banding

The SHMI is the ratio between the actual number of patients who die following hospitalisation at SFHFT and the number that would be expected to die, based on average England figures, given the characteristics and acuity of the patients treated at SFHFT. It includes deaths which occur in hospital and deaths which occur outside of hospital within 30 days (inclusive) of discharge from SFHFT. SHMI indicates each non-specialist acute NHS trust in England whether the observed number of deaths within 30 days of discharge from hospital was ‘higher than expected’ (SHMI banding=1),

‘as expected’ (SHMI banding=2) or

‘lower than expected’ (SHMI banding=3) when compared to the national baseline.

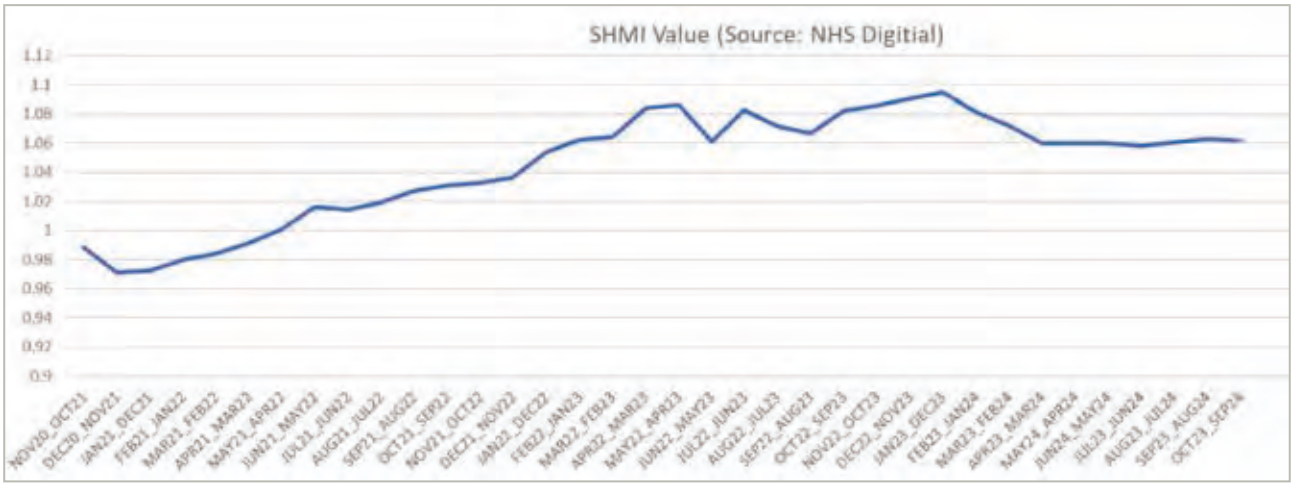
The most recent data (published Jan 2025) is in the table below (Table 7). This data runs 4-5 months in arrears due to handling processes.

Table 7: SHMI value and banding

Reporting period	Published	SHMI value	Banding
November 2022 - October 2023	March 2024	1.0856	2
December 2022- November 2023	April 2024	1.0904	2
January 2023 - December 2023	May 2024	1.0949	2
February 2023 - January 2024	June 2024	1.0816	2
March 2023 - February 2024	July 2024	1.0724	2
April 2023 - March 2024	August 2024	1.0596	2
May 2023 - April 2024	September 2024	1.0601	2
June 2023 - May 2024	October 2024	1.0596	2
July 2023 - June 2024	November 2024	1.0579	2
August 2023 - July 2024	December 2024	1.0605	2
September 2023 - August 2024	January 2025	1.063	2
October 2023 - September 2024	February 2025	1.0615	2

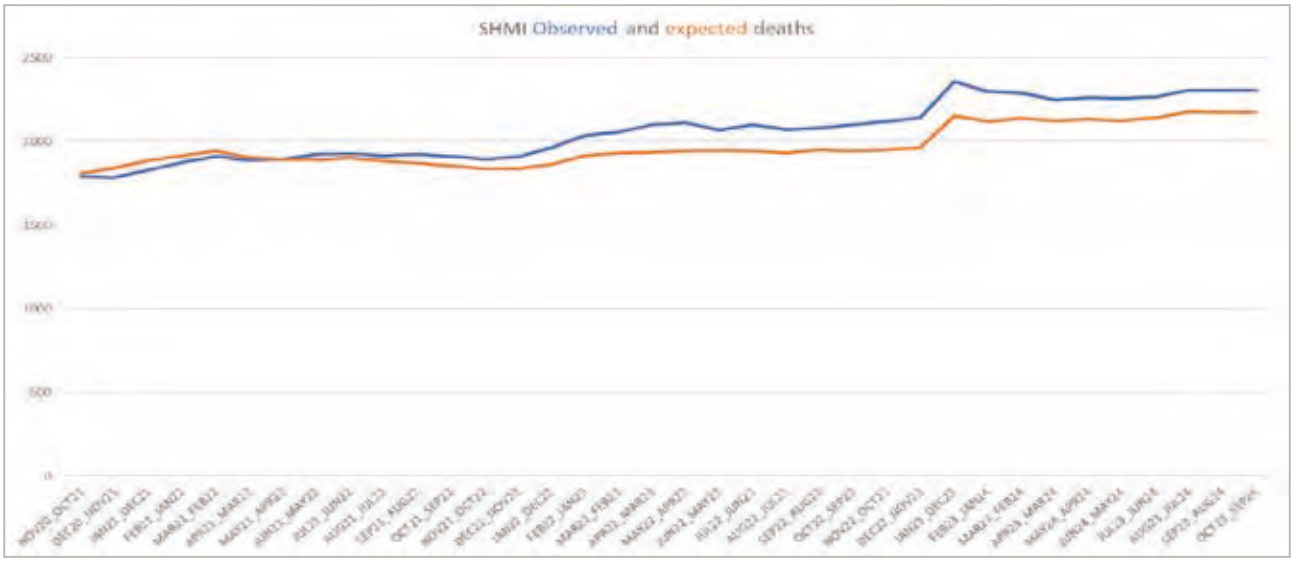
SFHFT remain “as expected” according to this metric. Within this band we have seen a small improvement in the SHMI over the last 12 months below as shown in the graph below

Graph 4: 3-year SHMI Trend



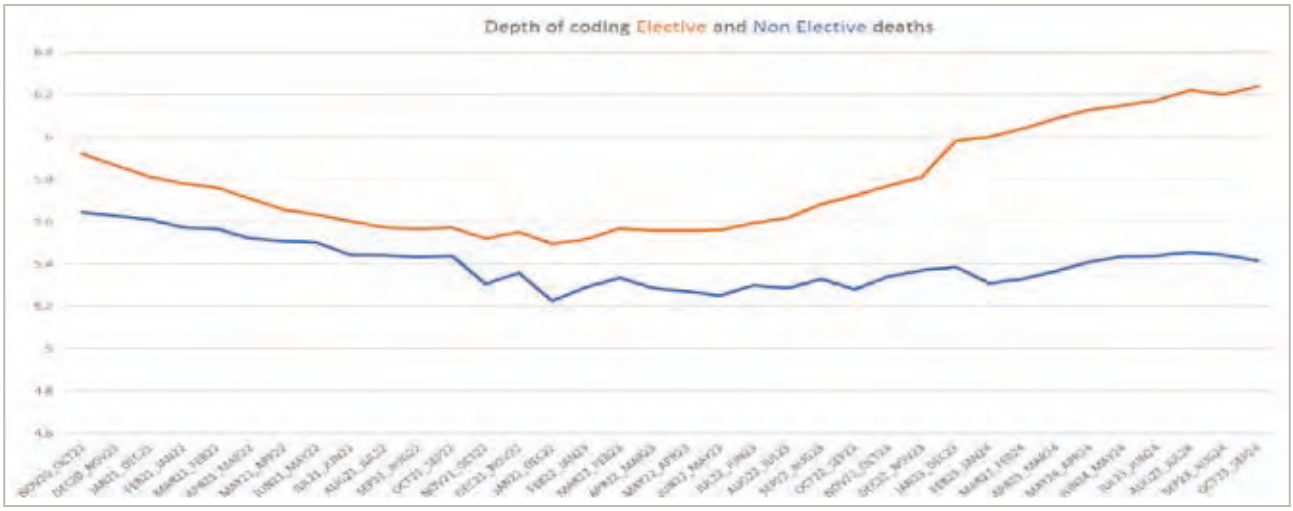
When we examine the observed and expected deaths over this period (Graph 5) the point where these lines cross represent the time where our SHMI became greater than 1.

Graph 5: SHMI observed and expected deaths



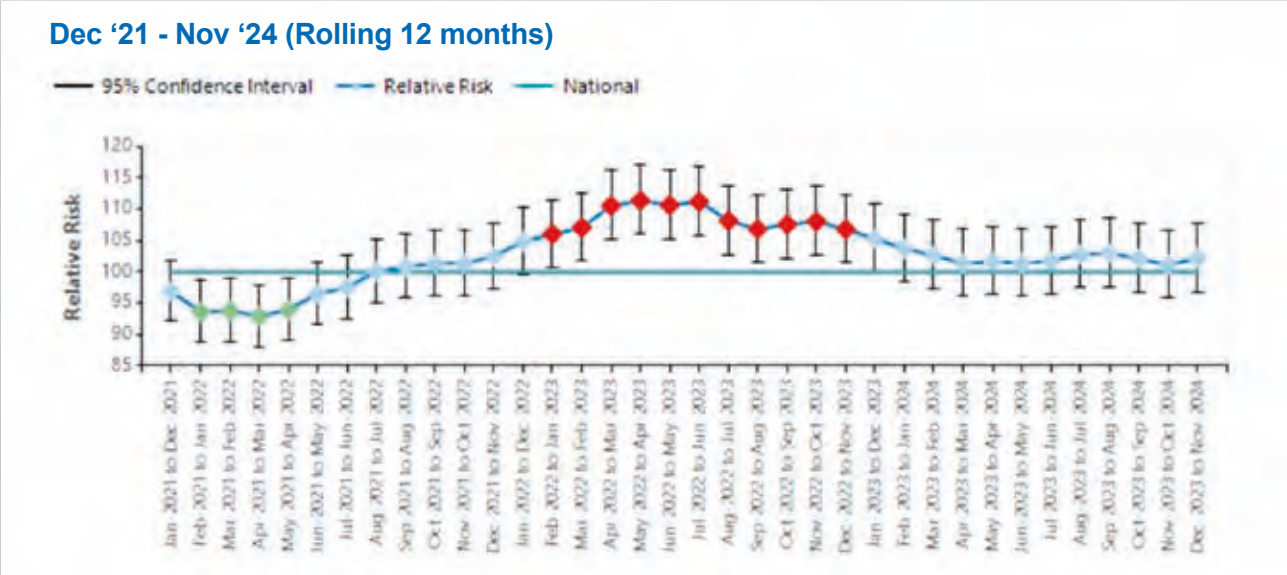
Our interpretation for this gap between our expected and observed rates was a decline in the depth of coding which can be seen in Graph 6. The depth of coding refers to the mean number of secondary diagnosis codes, per finished provider spell, within an elective/non-elective admission. One interpretation of this would be that our population has become less unwell with less complex needs, however, this would not be consistent with the observations and experience of our clinical colleagues, and the demand on our services. It is far more likely that we are not capturing the information completely. Our coordinated approach of education and communication around the importance of documentation and a redesign of documentation involving frontline users during the last several years appears to be working. Over this reporting period there has been significant improvement for elective cases and more modest improvement for non-elective cases despite unprecedented pressures on Urgent and Emergency Care.

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



The methodology of calculation of our other hospital level mortality metric HSMR, has been updated. This revision has resulted in an overall retrospective downshift in our HSMR over the last 3 years and ongoing improvements during the reporting period. Prior to this revision, SFHFT were not reflected well in our presentation of palliative care management. With the implementation of the revisions, the calculation aligns us align towards the national average and SFHFT are now graded as “as expected” for both SHMI and HSMR.

Graph 7: HSMR+/Mortality (in hospital) 3-year trend using updated algorithm.



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 problems (‘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

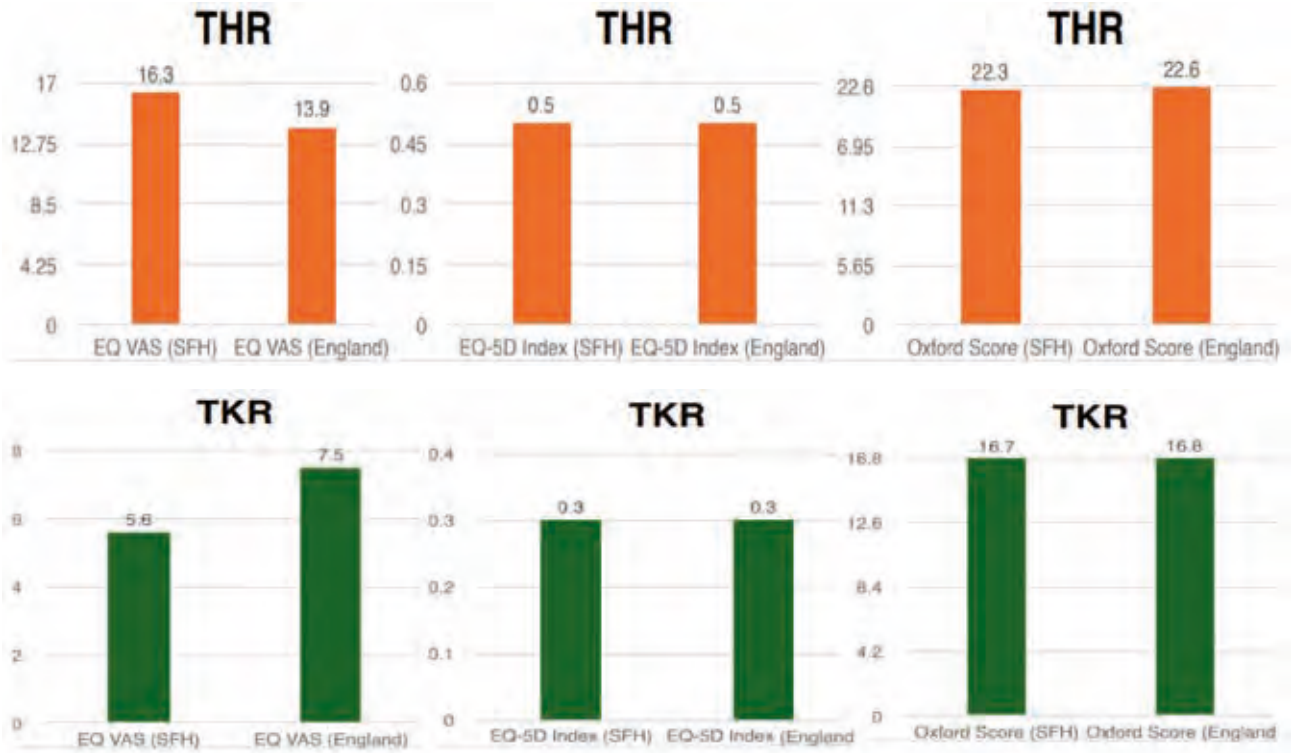
SFHFT performance in relation to national data is based on 3-6% response rate of the 1000 joint replacements carried out at SFHFT each year. This is deemed sufficient for analysis and assessment of outlier status.

Table 8 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 (2023/2024).

Table 8: EQ VAS compared to the Oxford Scores

Procedure	EQ VAS (SFH)	EQ VAS (England)	EQ-5D (SFH)	EQ-5D (England)	Oxford Score (SFH)	Oxford Score (England)
THR (Hip)	16.3	13.9	0.5	0.5	22.3	22.6
TKR (Knee)	5.6	7.5	0.3	0.3	16.7	16.8

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



Summary:

1) SFHFT is not outlier.

2) Hip replacement data is slightly better than the national average based on 6% responses

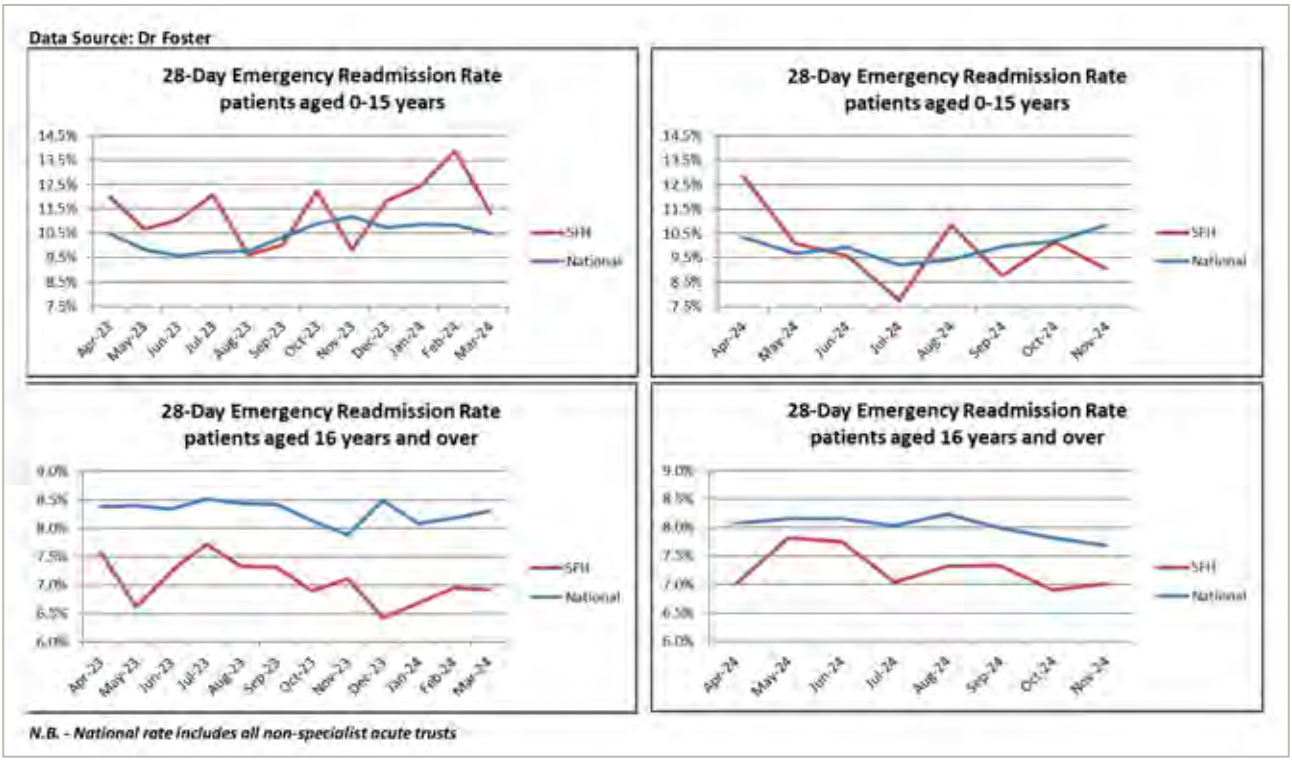
3) Knee replacement data is comparable to the national average based on 12% responses. (variations within statistical limits)

SFHFT pre-operative assessment department has developed strategies to ensure patients are optimised and in the best health prior to surgery. In collaboration with our partners, we have implemented initiatives to improve patients' general health prior to undergoing surgery that include support for smoking cessation, weight-loss referrals and gym memberships.

2.3.3 Percentage of patients readmitted to hospital within 28 days

- The readmission rate for 0-15 years old has improved overall from FY23/24 (11.46%) to the year to November FY24/25 (9.86%).
- The 16 years + readmission rate has however, remained relatively consistent overall, from 7.06% (FY23/24) to 7.27% (year to November FY24/25).
- The 0-15 years cohort compares unfavourably to the national performance during FY23/24 but has been improving during FY24/25. The 16+ years cohort continues to perform better than the national performance during this period. See Graph 8 below.

Graph 8: Data Source: Dr Foster/Telstra Health UK



SFHFT will take the following action to improve the quality of its services, as measured by these percentages by safe, timely discharge planning, which ensures patients are discharged to the appropriate place of residence. SFHFT continue to build effective relationships with community and external partners to ensure patients are supported safely through their discharge. The 28-day readmission rate for patients across the Trust continues to be monitored monthly through the executive-led divisional performance meetings.

2.3.4 Trust Responsiveness to the Personal Needs of Patients

SFHFT is dedicated to addressing any concerns promptly, often through direct discussions between the patient, relative, and/or carer and the relevant team. For those who may feel uncomfortable bringing up their 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.

SFHFT currently operates a centralised complaints service, which is currently under review. A pilot has commenced to facilitates complaints to be managed directly by the relevant divisions. The PET is collaborating with the divisions, tailoring support provided during implementation. Clinical Support, Therapies and Outpatients (CSTO), and Women's and Children's (W&C) divisions are trialling the entire process for new complaints related to their areas, while Urgent Emergency Care (UEC), Surgery, and Medicine divisions are currently assisting with drafting responses to both new and existing complaints within their departments. It is acknowledged that the rollout of the new complaints process may temporarily affect the Trust's overall response times to complaints.

This approach ensures that complaints are handled with a patient-centred focus. All complaints are thoroughly investigated and addressed within a timely manner, with response times varying between 25 and 60 working days depending on complexity of the issue.

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

During 2024/25, we received 270 new complaints, a 15% decrease compared to 2023/24.

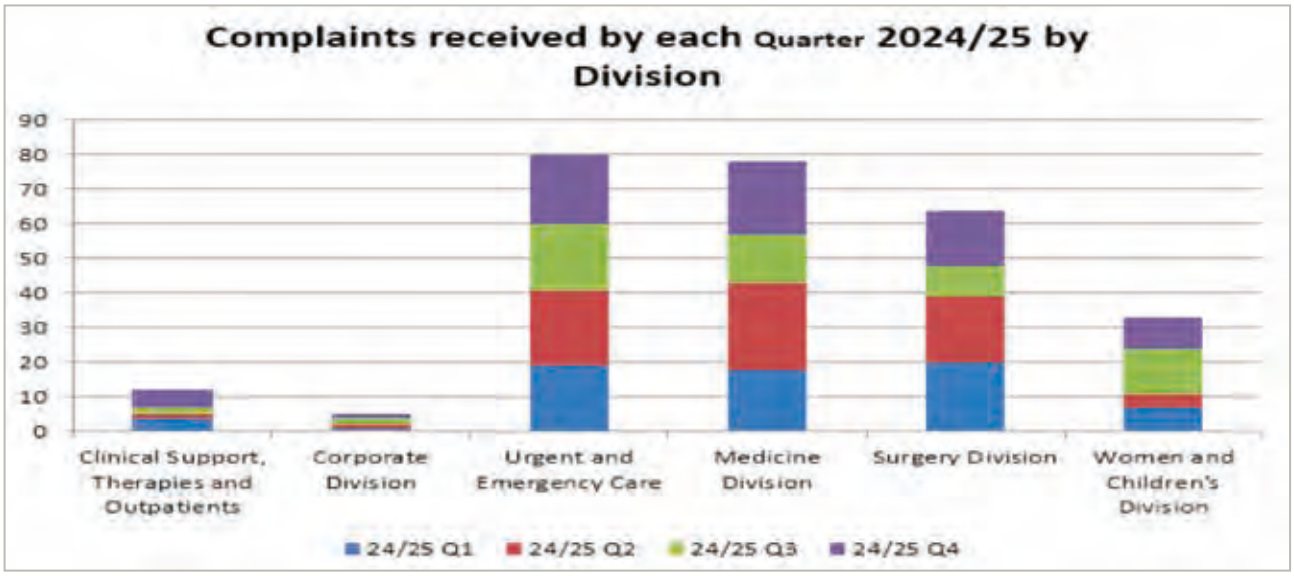
A breakdown of the complaints received during each quarter is demonstrated below (Table 9):

Table 9: Number of complaints received

	2023/24	2024/25	% difference
Quarter 1	70	69	1% decrease
Quarter 2	94	73	22% decrease
Quarter 3	81	57	30% decrease
Quarter 4	65	71	9% increase
Total	**310**	**270**	**15% decrease**

The graph below (Graph 9) shows a breakdown of the number of complaints received by each quarter by division.

Graph 9: Complaints by Division



During 2024/2025 291 complaints were closed. 37% were completed within the timeframe agreed with the complainant, which is unchanged from the previous year.

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. The PET continues to circulate a weekly complaints tracker to divisions, ensuring ongoing local monitoring.

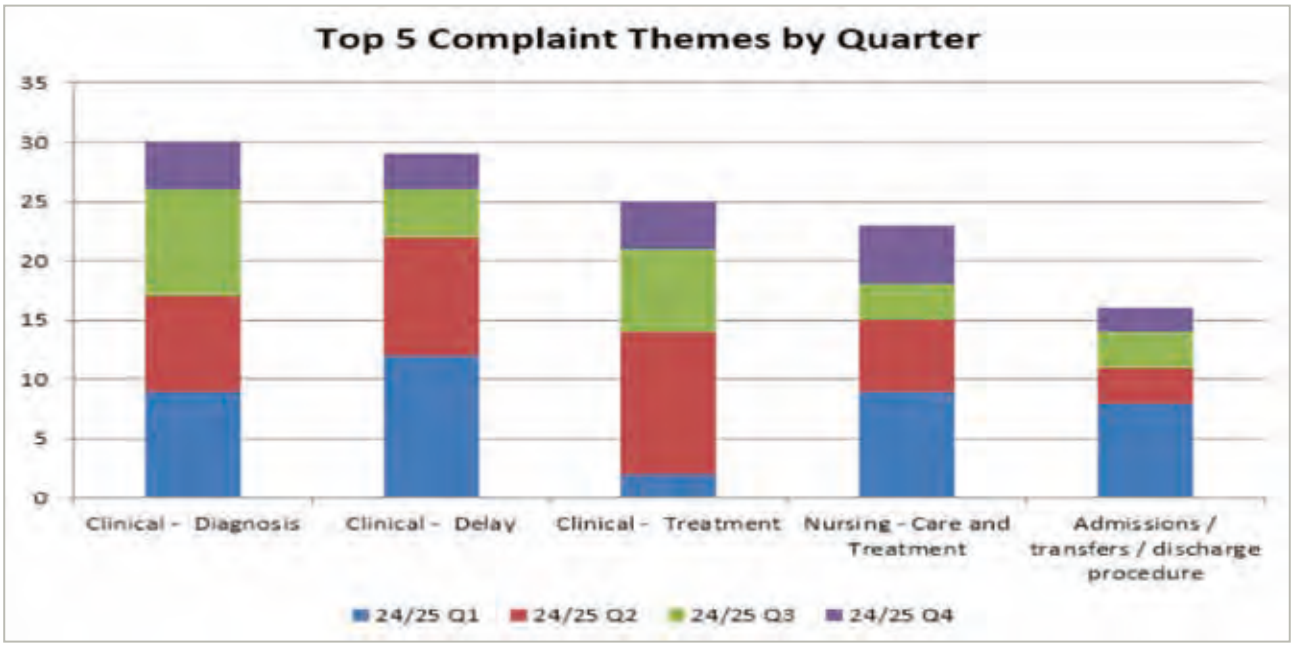
The table below (table 10), shows the top five themes for the complaints closed throughout 2024/25.

Table 10: Top five themes for complaints 2024/25

	Clinical Support, Therapies and Outpatients	Corporate Division	Urgent and Emergency Care	Medicine Division	Surgery Division	Women and Children's Division	Total
Clinical - Delay	1	0	3	4	10	5	23
Clinical - Diagnosis	1	0	8	5	3	1	18
Clinical - Treatment	0	0	8	4	4	2	18
Admissions / transfers / discharge procedure	1	2	3	4	2	0	12
Nursing - Care and Treatment	0	0	2	5	4	0	11
Total	3	2	24	22	23	8	82

Clinical treatment and diagnosis remain the most reported sources of dissatisfaction, alongside concerns related to admissions, transfers, and discharge procedures. These complaints have been carefully analysed to ensure that any safeguarding or patient safety issues are promptly escalated and addressed through the appropriate channels. Additionally, this analysis helps identify recurring themes and trends, which are then shared with divisions for further action.

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



Of the complaints responded to within 2024/25, 44% were upheld or partially upheld, showing a decrease of 26% from the previous year. This has provided an opportunity for learning and service improvements.

Between 1st April and 31st December 2024, a total of 18 complaints were re-opened because the complainant had raised additional concerns to the original complaint. It was agreed with the divisional teams that a further response could be offered. This demonstrates a decrease of 45% of total re-opened complaints from 2023/24. 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.

From 1st April 2024 to 31st December 2024, the PHSO initiated 6 additional new complaint reviews and closed 2 without further investigation. Five cases are currently under ongoing investigation, and SFHFT awaits confirmation of the scope for 3 cases. 4 investigations have been concluded so far for 2024/2025.

Table 11: Cases closed by the PHSO during 2024/25

Division/ Specialty	Subject	Date PHSO Open	PHSO Outcome	Date PHSO Closed	Learning from PHSO
UEC	Clinical Diagnosis Clinical Delay	25/07/22	Upheld and financial redress	18/04/24	An adequate examination of the eye was not undertaken in the ED resulting in the loss of an opportunity for a better outcome.
Surgery / CSTO	Patient Property	22/01/24	Upheld and financial redress	24/06/24	Failings in handling of patient property.
UEC	Care & Treatment Communication - Nurse/Midwife	29/07/24	Financial redress	20/09/24	No further lapses identified and PHSO acknowledged apologies already provided to patient. PHSO requested SFHFT provide financial redress.
UEC	N/A	20/08/24	Not upheld	27/09/24	Reviewed by PHSO – closed with no further action
Medicine	N/A	12/12/23	Not upheld	15/10/24	Reviewed by PHSO – closed with no further action

2.3.5 Staff Friends and Family responses and recommendation rates

National NHS Staff Survey – 2024

The ongoing impact of NHS pressures and the after-effects of the COVID-19 pandemic on our people remained evident throughout 2024/25. An important vehicle for listening to the voices of our staff is the annual National Staff Survey (NSS).

The NSS 2024 closed at the end of November, with 3856 colleagues taking the opportunity to share their voices. There was a 63% response rate from across SFHFT (compared to 62% last year). This is the highest number of colleagues completing the survey over the last five years.

The national average response rate for Acute Trusts, which ran its survey with Picker, was 48.1%, up from 45.8% the previous year. Our response rate is ~15% higher than the national average.

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

The aim is to raise staff participation each year to identify key areas for improvement that will benefit SFHFT.

A total of 101 questions were asked in the 2024 survey. 7 questions had improved responses from NSS 2023, with 92 questions scoring above the Picker average. However, 85 questions had responses which have deteriorated from 2023, 9 questions had responses lower than the Picker average.

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

Each year, SFHFT priorities are reviewed and refreshed based on the survey results, along with feedback from quarterly pulse surveys, Freedom to Speak Up Guardians, People directorate team and divisional feedback.

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

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

The 2024 National Staff Survey results placed SFHFT as Best Acute Trust in the East Midlands for the 7th year running, with 70.6% of colleagues recommending SFHFT as a place to work. It was also placed as the Best Acute Trust in the East Midlands for receiving care, with 73.1% of colleagues recommending that a friend or relative needing treatment would be happy with the standard of care provided by the organisation.

Table 12 demonstrates a 2024/25 and 2023/24 comparison. Scores for each indicator, together with those of the survey benchmarking group (122 Acute and Acute community trusts), are presented below:

Table 12: Indicator comparison 2023/24 and 2024/2025

Indicators ('People Promise' elements and themes)	2024/25		2023/24	
	SFHFT Score	Benchmarking Group Score	SFHFT Score	Benchmarking Group Score
People Promise				
We are compassionate and inclusive	**7.5**	7.2	**7.6**	7.2
We are recognised and rewarded	**6.2**	5.9	**6.3**	5.9
We each have a voice that counts	**7.0**	6.7	**7.1**	6.7
We are safe and healthy	**6.3**	6.1	**6.4**	6.0
We are always learning	**6.0**	5.6	**6.1**	5.6
We work flexibly	**6.5**	6.2	**6.7**	6.2
We are a team	**7.0**	6.7	**7.1**	6.7
Staff Engagement	**7.1**	6.8	**7.3**	6.9
Morale	**6.3**	5.9	**6.5**	5.9

Table 13: Demonstrates 2024/25 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	9th	2nd	1st
We are recognised and rewarded	17th	3rd	1st
We each have a voice that counts	9th	2nd	1st
We are safe and healthy	11th	3rd	2nd
We are always learning	6th	2nd	1st
We work flexibly	21st	6th	3rd
We are a team	9th	2nd	1st
Staff Engagement	12th	2nd	1st
Morale	13th	2nd	1st

Whilst it is important to note that scores across questions declined in 2024, SFHFT is still a high-performing Trust. This is in line with national staff survey scores, which have nationally seen either no improvement or a decline in results.

We are incredibly proud that, for the seventh year running, SFHFT scored the highest as the most recommended Acute Trust to work for in the East Midlands and as the most recommended Acute Trust for receiving care in the East Midlands.

Actions

Whilst there have been some positive improvements in our NSS result scores in 2024, there are some areas that do require continued focus into 2025, including:

- Reporting and addressing of unsafe clinical practice, including feedback.
- CARE values
- Reward and Recognition
- Basics to enable a role to be undertaken (equipment, space etc.)

SFHFT intends to take action to continue improving these percentages and the quality of its services through key focus areas. We also recognise a need to ensure we engage with colleagues more meaningfully through 1-2-1 interactions with our teams, ensuring that everyone's voice is heard, including those who chose not to take part in the survey. SFHFT wants to ensure that for the NSS 2025, we improve our response rates by reaching those whose voices we haven't yet heard.

2.3.6 Venous Thromboembolism (VTE)

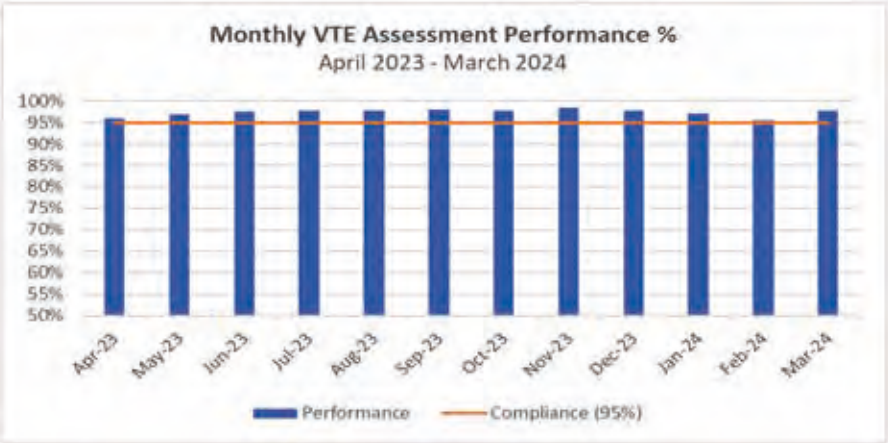
A Venous Thromboembolism (VTE) is a blood clot (thrombus) that forms within a vein that can cause occlusion within the lung (pulmonary embolism) or in the deep leg veins (deep vein thrombus). The House of Commons Health Committee reported in 2005 that an estimated 25,000 people in the UK die from preventable,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

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

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

The graph below (Graph 11) demonstrates the performance against the level of compliance required.

Graph 11: Monthly VTE Assessment Performance



2.3.7 Clostridium Difficile infections

Clostridioides Difficile infection (CDiff) is acknowledged as an issue that impacts upon the whole health economy. During December 2024 the UKHSA released a briefing note alerting Trusts to an increase in Clostridioides difficile in England. The Trust continues to have a partnership approach to this across the Integrated Care Board (ICB). The trajectory for 2024/25 had been set at 65 Trust associated cases and the Trust have breached this target with 75 cases to date.

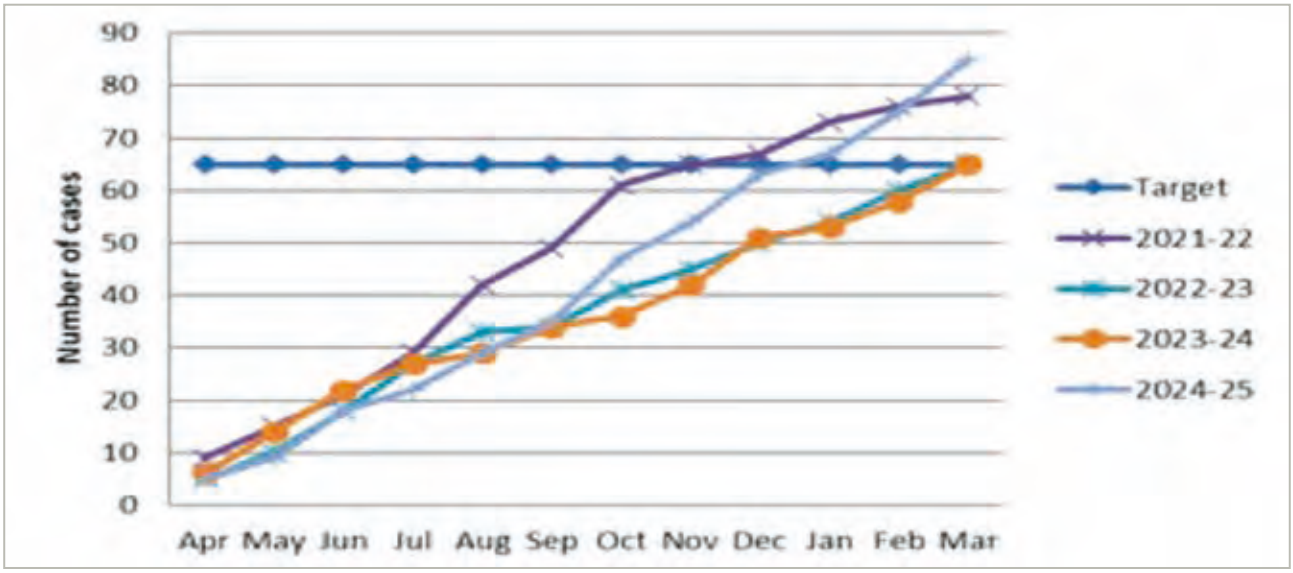
SFHFT aims for 2024/25 are outlined below:

- To conduct root cause analysis on each case to identify common themes across the organisation and within the whole healthcare economy.
- To share relevant learning between divisions at SFHFT and with the local infection prevention teams.
- To ensure that the SFHFT attributable cases in the reporting period remain below 65.

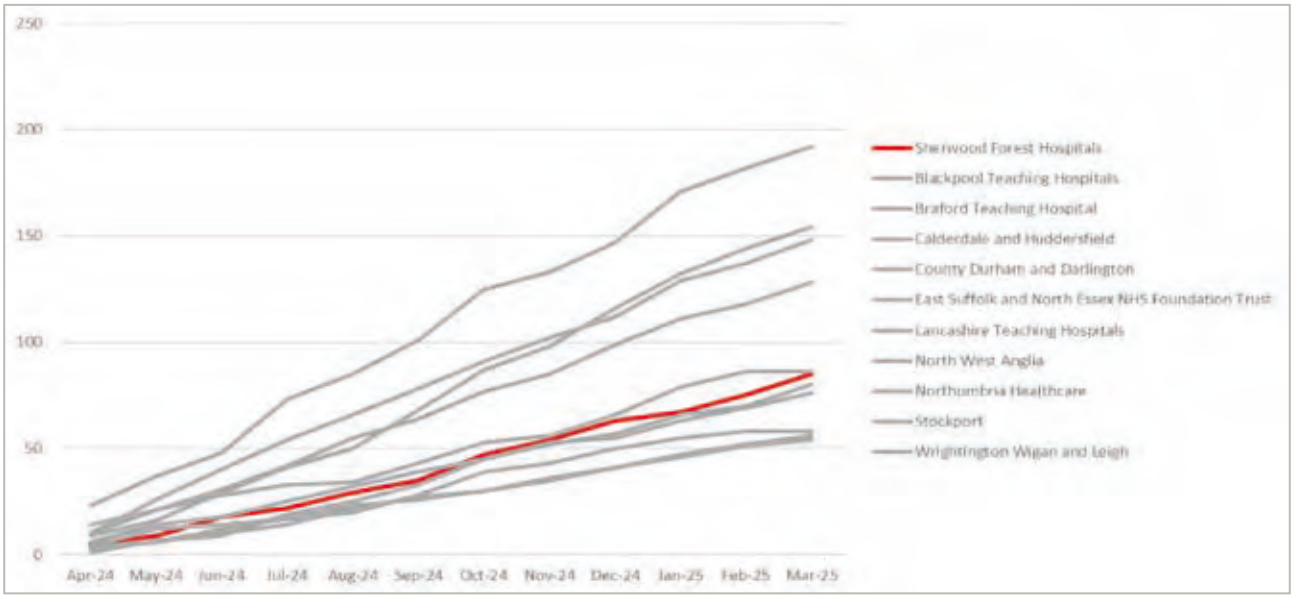
How was this achieved?

In 2024/25 the number of cases identified as Trust associated is 85 (Graph 12). 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 13).

Graph 12: SFHFT cumulative total of Trust associated CDiff cases



Graph 13: Cumulative total of hospital associated CDiff cases against national Peer Trusts



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

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

- Deep cleaning programme recommenced and maintained.
- Maintaining bed decontamination process
- Full thematic review of all Trust associated cases.
- Review of antimicrobial stewardship

Cleanliness

SFHFT have implemented new national cleaning standards, and these are 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, SFHFT colleagues and commercial companies to improve the consistency of the cleaning processes, ensuring all staff at SFHFT 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 maintained an 'in-situ' deep clean, with the Decant Team carrying out deep cleans on wards with patients still in the area.

Monitoring and reporting

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

The trajectory for 2025/26 has not yet been set, however we are expecting it to be similar to this year. Monitoring will continue through the Infection Prevention and Control Committee and escalated to Patient Safety Committee.

What we aim to achieve in 2025/26

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

2.3.8 Patient Safety Incidents

SFHFT is committed to reporting and investigating adverse events and near misses, recognising this provides the Trust with opportunities to learn, improve the quality of services and reduce the risk of these type 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 SFHFT with maintaining contact and building relationships with patients and their relatives following an incident. The FLO received over 100 contacts during the period 2024/2025 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:

- 13 Patient Safety Incident Investigations (PSIIs)
- 15 After Action Reviews
- 1 MNSI (Maternity Newborn Safety Investigation)
- 1 thematic review
- 103 local responses including x1 Never Event.

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

All Patient safety incident investigations (PSII) are investigated, 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 SFHFT Board.

Part 3 Other Information - Additional priorities

3.1 Safety – Improving the safety of our patients.

Aims for 2024/25 include:

- Embed PSIRF within the organisation and continue to roll out the Level 1 Patient Safety Syllabus to all staff.
- Continue to develop the 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.
- Transition all patient safety event reporting from NRLS (National Reporting and learning System) and STEIS to the new LFPSE (learning from Patient Safety Events) platform including, Patient Safety Incidents, STEIS (Strategic Executive Information System) reportable PSI, Good Care Events and explore reporting Outcome and Risk events guided by NHSE.

How did we do? (Performance against these Targets)

PSIRF went live in October 2023 and is well embedded within the organisation. The PSIRP was refreshed in April 2024. During 2024/25 there has been a focus on ensuring all staff undertake the Level 1 Patient Safety Syllabus training.

In 2023 we recruited 4 PSPs to support all elements of governance, monitoring and improvement related to patient safety. We held our first quarterly meeting for PSPs in late 2024 and reflected on the work undertaken which includes:

- o Completion of safety syllabus training
- o Attending Engagement/opening events
- o Gaining an understanding around Datix reporting system
- o Interviews for key Governance staff members
- o Giving patient perspective opinions on documents
- o Joining of the Patent Experience Committee
- o Attendance at the Patient Safety Committee,
- o Completing a production around fundamentals with our clinical illustration team

Plans are in place to recruit further PSPs and collaboration has commenced with the Communications Team. PSPs will be joining 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.

In April 2024, we transitioned to the new national way of reporting incidents called Learn from Patient Safety Events (LFPSE). Following upgrades to our incident reporting system and a communication and engagement programme to help support our staff with the planned changes the transition went well.

What we aim to achieve in 2025/2026

- 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.

3.2 Safety – Reduce Harm from Falls

Falls significantly affect patients and their causes are multifactorial. The greater the number of risk factors a person has, the higher their risk of falling. Examples of risk factors include delirium, cognitive impairment, dementia, postural instability, muscle weakness, deconditioning, peripheral neuropathy, poor vision, mobility, balance problems, arthritis, and vitamin D deficiency. SFHFT is dedicated to minimising fall-related harm, which is a quality priority in the SFHFT Quality Strategy 2022-2025.

Aims for 2023/24

- Falls Prevention Practitioners (FPPs) will work with the Digital team to transform the falls risk assessment by adding a visual acuity assessment to Nervecentre. The visual acuity assessment is a new tool from the Royal College of Physicians, enabling ward staff to quickly assess a patient's eyesight to help prevent them falling or tripping while in hospital.
- Maintain and continually promote SFHFT's Physical Activity and Falls Committee (PAFC) ensuring a multidisciplinary attendance
- Continue to take a lead role in the PAFC community of practice across Nottingham and Nottinghamshire Integrated Care System (NNICS) including 'making movement a priority' webinars
- Embed After Action Reviews and hot debriefs in relation to falls at SFHFT in line with the Patient Safety Incident Response Framework (PSIRF)
- Revision of training provision
- Promotion of preconditioning/ reconditioning and prevention of deconditioning as a priority, ensuring no patient comes to harm at SFHFT because of hospital acquired functional decline
- FPPs will support ED with evaluation and an extended rollout of the THINK YELLOW (falls prevention project), then to be cascaded throughout the organisation

How did we do? (Performance against this target)

- The FPPs have developed the visual acuity checks for patients over 65 years old. This is currently being tested by the team and Orthoptists to ensure the efficacy of the checklist.
- The Falls team now directly report into the Clinical Outcomes and Effective Care Committee (COEC), enabling update on any escalations, major work commissioned and positives assurances.
- The Community of Practice (COP) has been actively promoted across the SFHFT, fostering a culture of continuous learning and improvement and supporting practical applications of best practice. Training has delivered a wide range of topics and has been enriched by the inclusion of guest speakers from diverse professional backgrounds. Their contributions have provided valuable insights and practical knowledge, enhancing the overall learning experience for the attendees.
- The FPPs have commenced benchmarking against other organisations to learn how after-action reviews are conducted.
- The training provision by the falls team continues to be delivered on request to the wards, and face-to-face training is delivered for preceptees.
- Strategies are ongoing to promote preconditioning, reconditioning, and prevent deconditioning among patients at risk of falls at SFHFT, that include education and goal setting, and early mobilisation.
- The THINK Yellow falls project has been partially evaluated by the Emergency Department Team with the support from the FPPs. The extended rollout is yet to be agreed and cascaded through SFHFT.

How was this achieved?

The FPPs constantly strive to improve standards of care for patients at risk of falls and respond to the needs of the service. Every fall reported at SFHFT is reviewed by the FPPs, and the team complete a comprehensive falls review for any incident of moderate harm or above. In addition, the FPPs aim to visit any patient who has a repeat fall within the same month. Liaising with the multi-disciplinary team and ward/departmental colleagues, the FPPs provide expert advice, guidance, support, and improvement suggestions to mitigate falls risks and effectively explore falls incidents.

Monitoring and Reporting for Sustained Improvement

The FPPs attend and report monthly at COEC to ensure any items of concern or relevance are discussed and escalated to the Nursing, Midwifery and AHP committee and Patient Safety Committee.

What we aim to achieve in 2025/26

- 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 audit, for example bed rail audits, National Audit Inpatient Falls (NAIF)

3.3. Safety - To reduce the number of infections

Aims for 2024/25

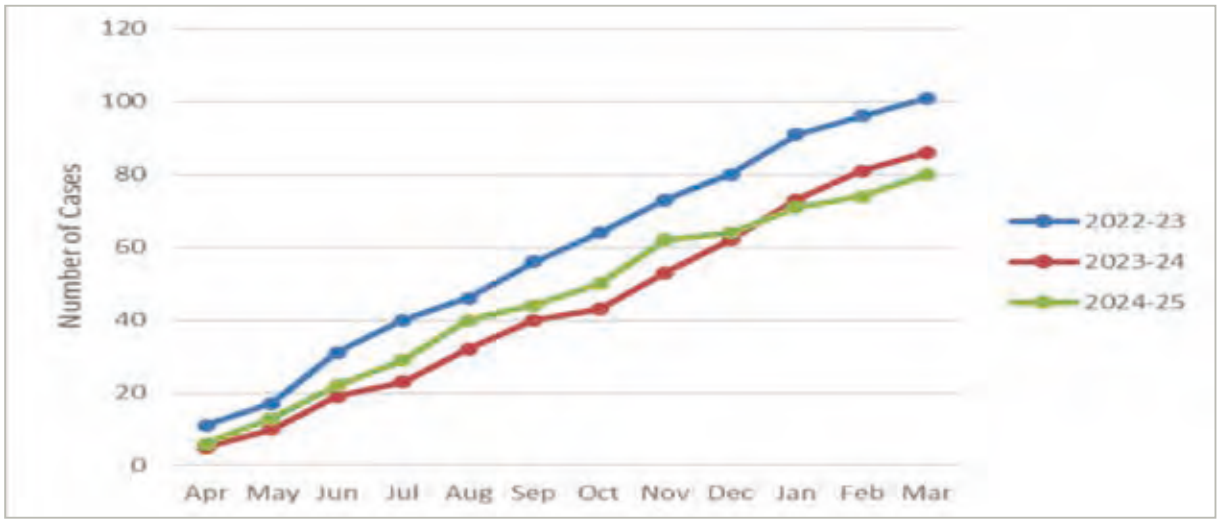
- To continue to reduce the number of SFHFT acquired EColi blood stream infections.
- To implement new project workstreams related to urinary catheters.
- To implement new project work related to taking of blood cultures.
- To meet trajectories set for Pseudomonas.

How did we do? (Performance against this target)

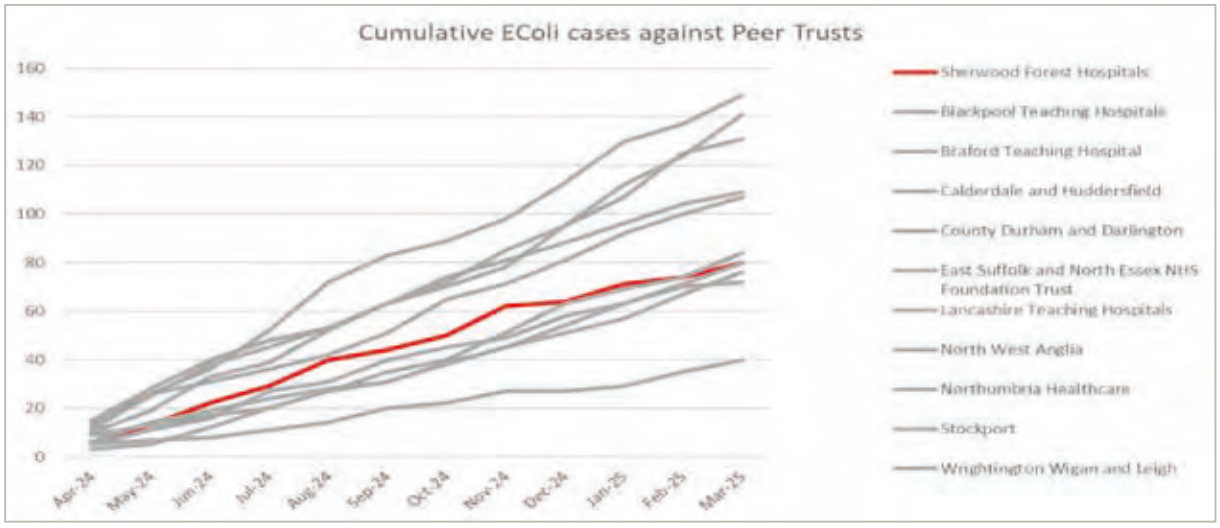
There has been an increase nationally over the last year. The main causative organism is EColi. There was a national trajectory set for each organisation and for SFHFT, the target for 2024/25 was 83.

SFHFT have achieved this target ending the year with 80 cases. During 2024/25 there has been a similar number of SFHFT associated cases compared with 2023/24, (Graph 14). Comparing our performance against that of our national peer Trusts (Graph 15), shows that SFHFT sit in the middle of the group. Although the EColi bacteraemia position has not replicated in the number of Catheter-Associated Urinary Tract Blood Steam Infections (CAUTI) we have seen as this has increased this year (Graph 16).

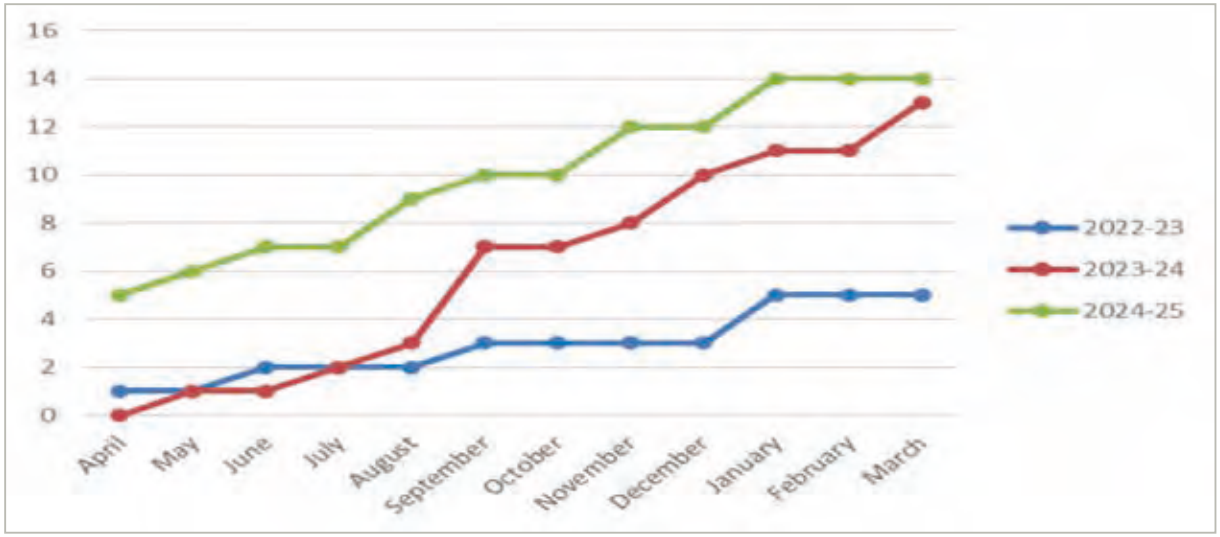
Graph 14: SFHFT cumulative total of hospital onset EColi cases



Graph 15: Cumulative total of hospital onset EColi cases against national Peer Trusts

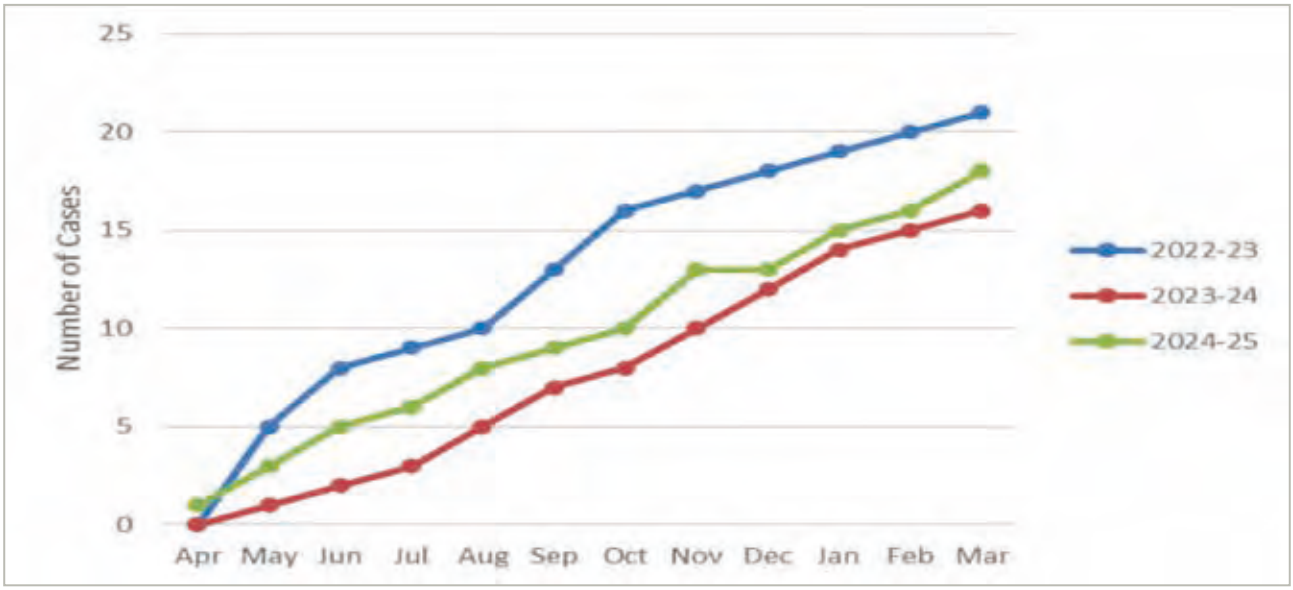


Graph 16: SFHFT cumulative total of hospital associated Catheter Associated Urinary Tract Infection BSI

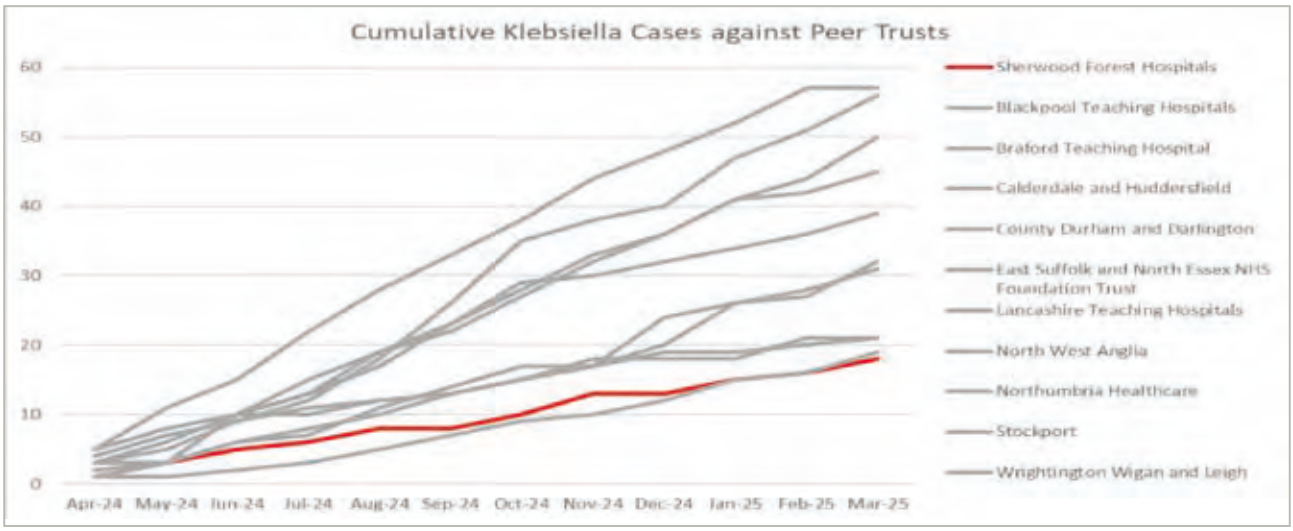


The second gram negative trajectory is for all Klebsiella species blood stream infections and the SFHFT trajectory was 16. SFHFT have not achieved this target with a total of 18 for the year, below target (Graph 17). Graph 18 shows our performance benchmarked against our peer Trusts and shows we are one of the best performing Trust.

Graph 17: SFHFT cumulative total of hospital onset Klebsiella cases

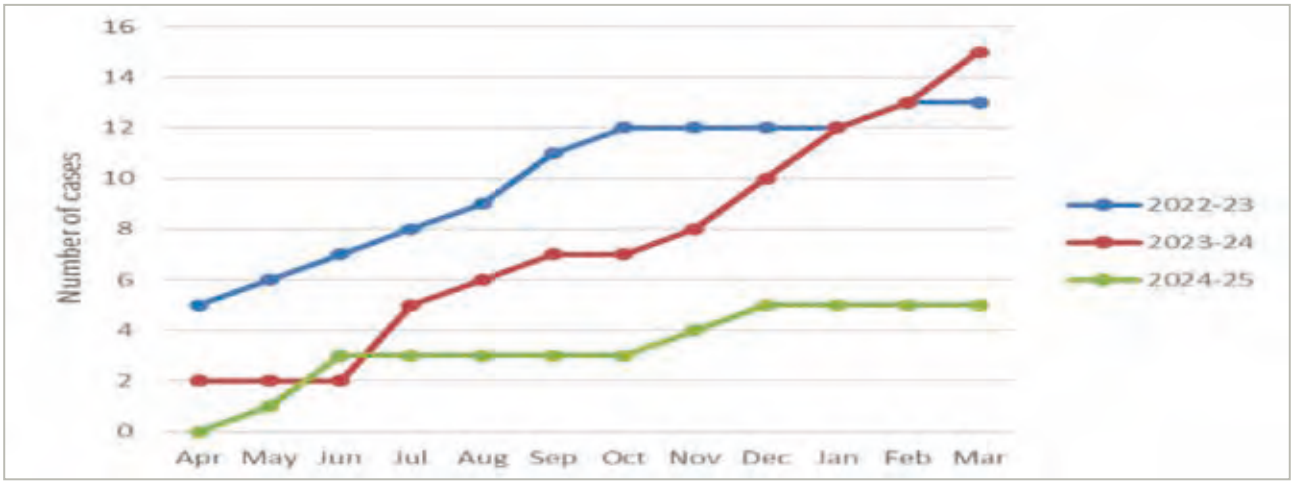


Graph 18: Cumulative total of hospital onset Klebsiella cases against national Peer Trusts

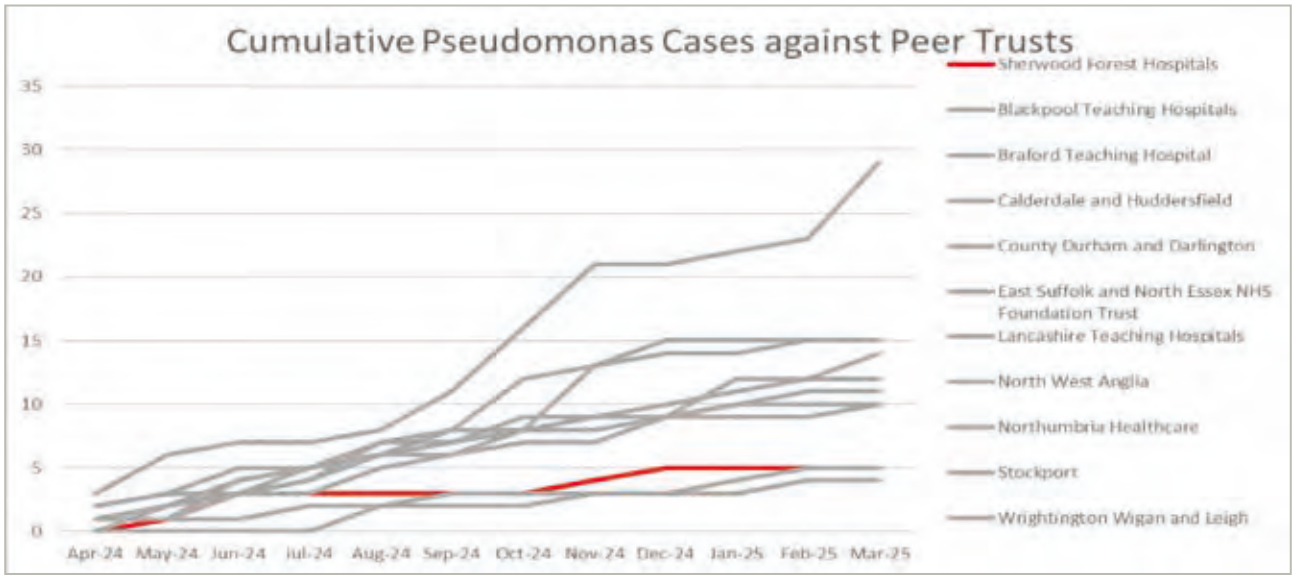


The third gram negative trajectory is for all Pseudomonas aeruginosa blood stream infections and SFHFT Trust trajectory was 14. SFHFT have achieved this target with a total of 5 cases for the year, (Graph 19). Comparing our performance against that of our national peer Trusts (Graph 20) shows that we have one of the lowest number of cases of the group.

Graph 19: SFHFT cumulative total of hospital onset Pseudomonas Aeruginosa cases

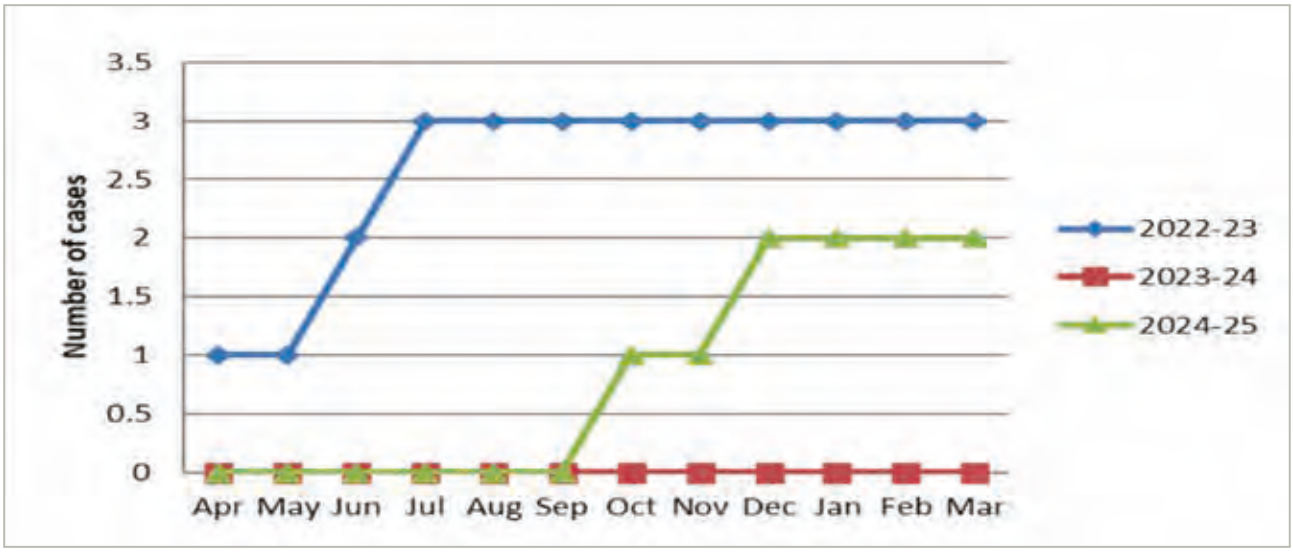


Graph 20: Cumulative total of hospital onset Pseudomonas Aeruginosa cases against national Peer Trusts



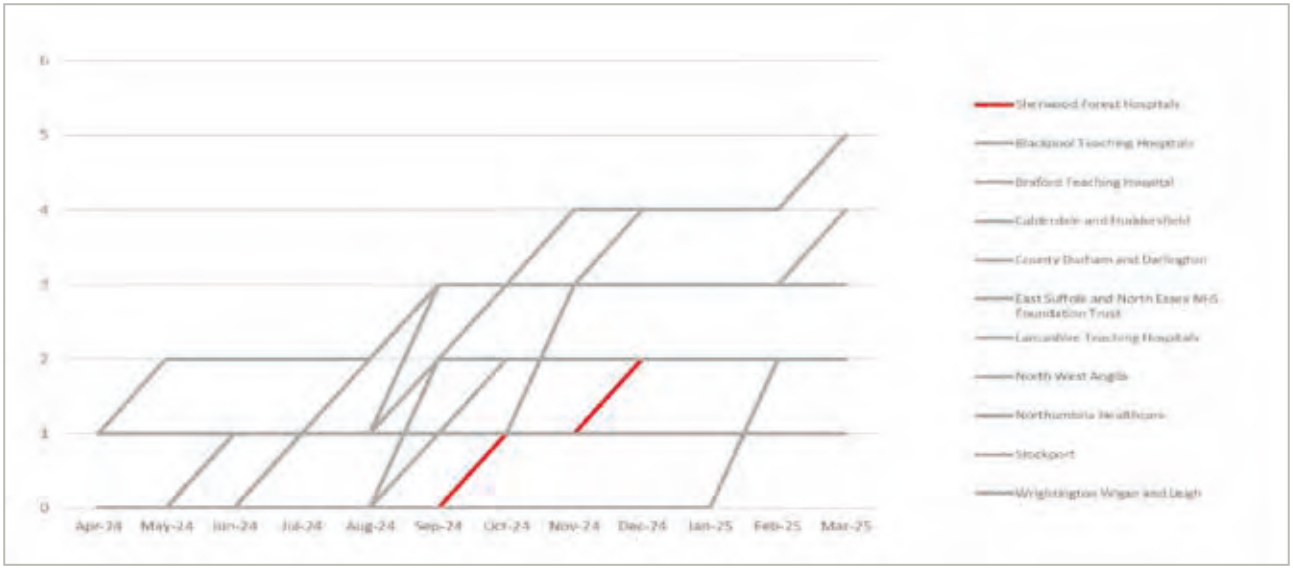
As with all other NHS acute organisations, SFHFT target for MRSA blood stream infections was zero. SFHFT has not achieved this target with a total of 2 for the year, (Graph 21).

Graph 21: SFHFT cumulative total of hospital onset MRSA cases



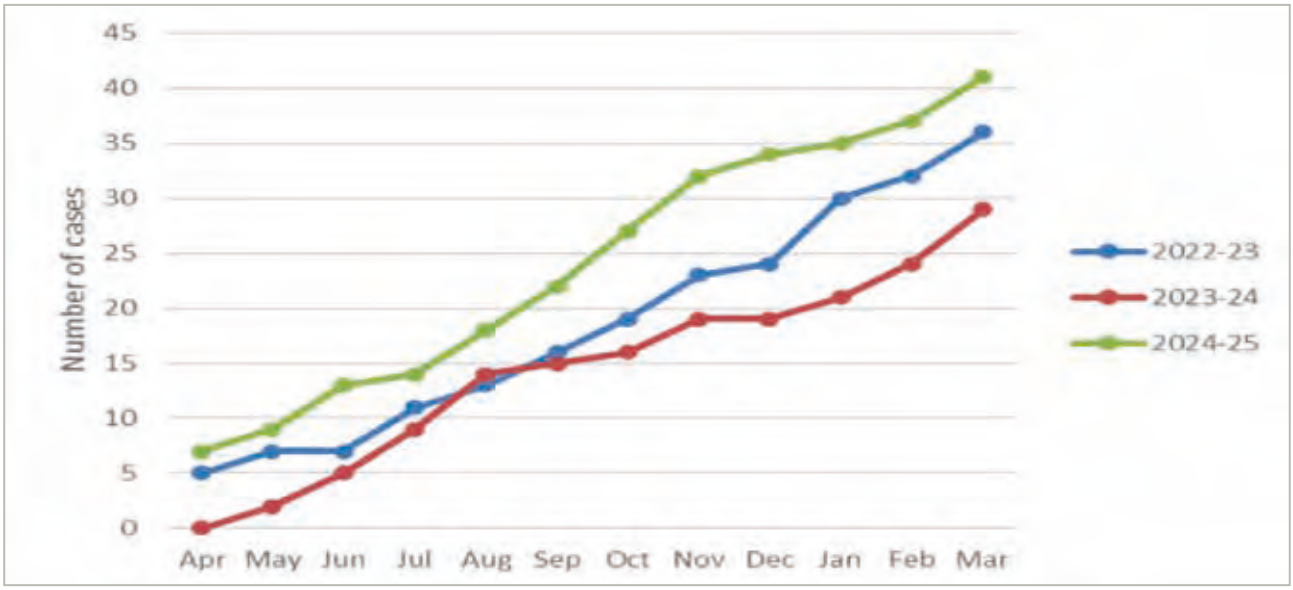
SFHFT is one of 11 of our national peer Trust who have not achieved the target of 0 (Graph 22).

Graph 22: Cumulative total of hospital onset MRSA cases against national Peer Trusts

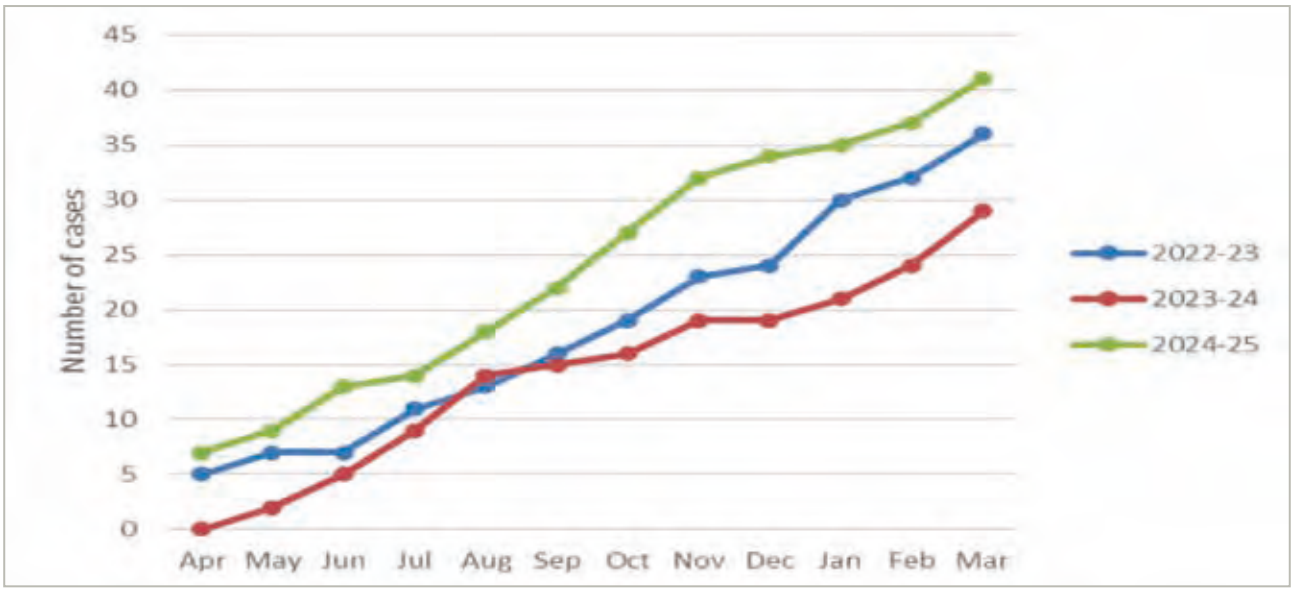


We continue to monitor and report our MSSA blood stream infection cases nationally. There currently remains no trajectory set for this. SFHFT have identified 41 Trust associated cases in 2024/25, an increase compared with the picture on 2023/24 (Graph 23). Graph 24 shows our performance benchmarked against our national peer Trusts and shows we are in the middle of the group.

Graph 23: SFHFT Cumulative total of hospital onset MSSA cases



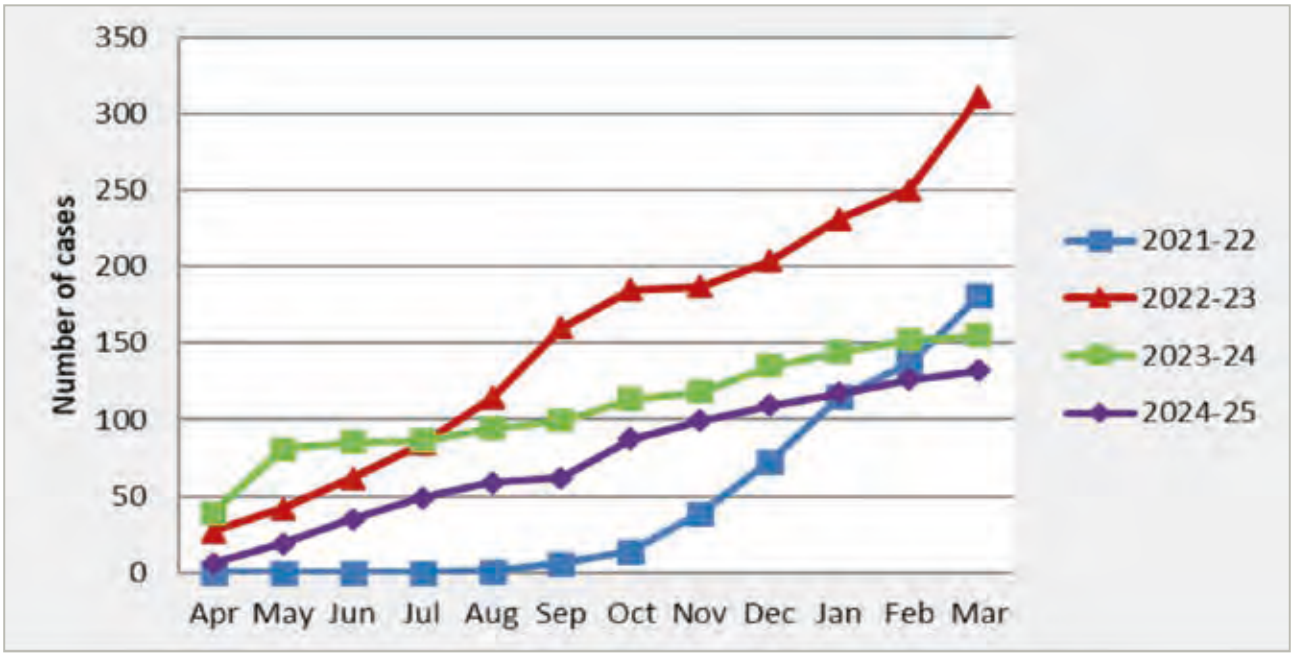
Graph 24: Cumulative total of hospital onset MSSA cases against national Peer Trusts



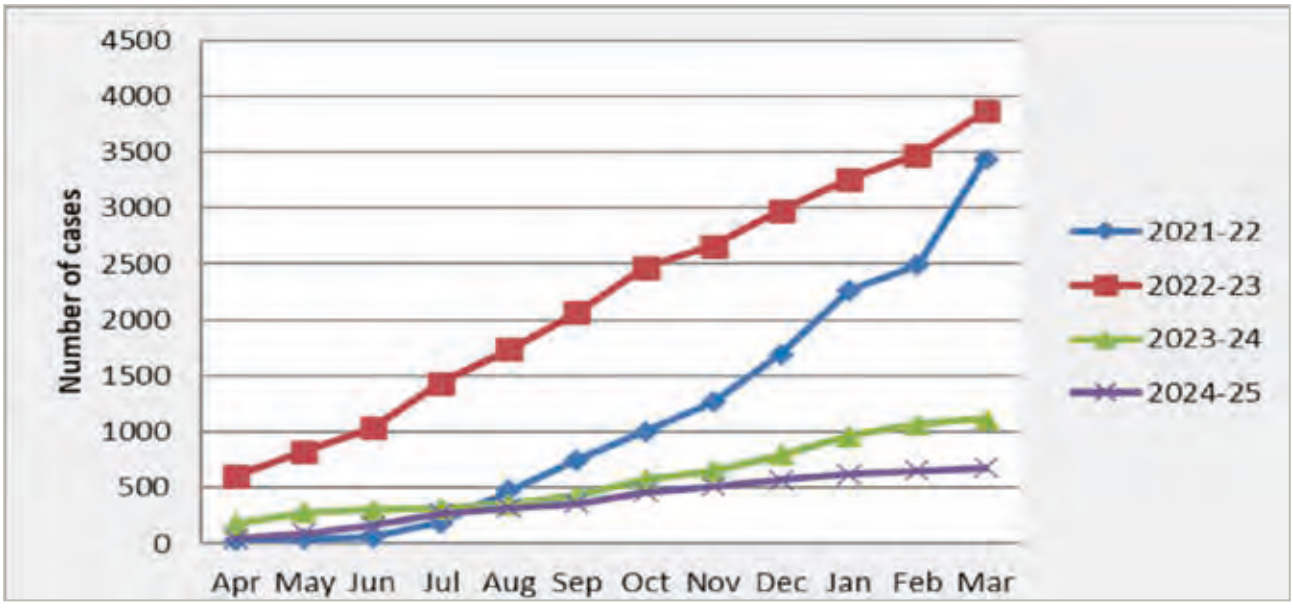
COVID-19

SFHFT have continued to comply with national guidance and during peak respiratory virus season, we amended our guidance and have gone above the national requirement. During 2024/25, we have continued to identify 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 25 and 26.

Graph 25: SFHFT cumulative total of Trust apportioned Covid-19 cases



Graph 26: SFHFT cumulative total of all Covid-19 cases



Actions in place to reduce the number of hospital associated infection (HAI's):

- A rapid review is completed for all hospital associated cases named above.
- Quarterly thematic reviews being undertaken of all above infections.
- Deep dive into MSSA cases by FY1
- Blood culture project to ensure correct procedures and blood levels are used.
- Project reviewing the previous antibiotics of each CDiff case commenced
- Project to review current MRSA treatment and our clearance rates commenced
- Project to reduce the duration of a urinary catheter commenced
- Attendance at regular meetings with NHSE and UKHSA to monitor outbreak progress.
- Reviewing complex infections with the Community IPC team to look at all aspects of care delivered

Monitoring and reporting for sustained improvement

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

What we aim to achieve in 2025/2026

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

3.4 Effectiveness - Improving the Effectiveness of Discharge Planning

Aims for 2024/25

- Percentage of discharge to assess (D2A) sent to the hub prior to medically safe date, 24 hours = 50%, 48 hours 40%.
- Average days from medically safe for transfer (MSFT) to hub pathway decided, pathway 1, target = 2 days.
- Average days from medically safe for transfer (MSFT) to hub pathway decided, pathway 2, target = 1.5 days.
- Average days from medically safe for transfer (MSFT) to hub pathway decided, pathway 3, target = 5 days.
- Reduction in the volume of the number of D2As returned to the hub due to lack of information, target = 5%
- Reduction in delayed and abandoned discharges per week, target = 5.8 days.
- Reduction in length of stay of patients in P2, target = 18 days.

How did we do? (Performance against this Target)

	Target	Actual achieved
Percentage of discharge to assess (D2A) sent to the hub prior to medically safe date	24 hours = 50% 48 hours = 40%	60% 31%
Average days from MSFT to Transfer of care hub (TOCH) pathway decided,	Pathway 1 (P1) target = 2 days	Nottinghamshire Healthcare = 1.1 days Notts local authority = 2.1 days
Average days from MSFT to TOCH pathway decided	Pathway 2 (P2) target = 1.5 days	0.6 days
Average days from MSFT to TOCH pathway decided	Pathway 3 (P3) target = 5 days	5 days
Reduction in the volume of the number of D2As returned to the TOCH due to lack of information	Target = 5%	3%
Reduction in delayed and abandoned discharges per week	Target 5.8 days	17 days
Reduction in length of stay (LOS) of patients in P2	Target 18 days	19 days

How was this achieved?

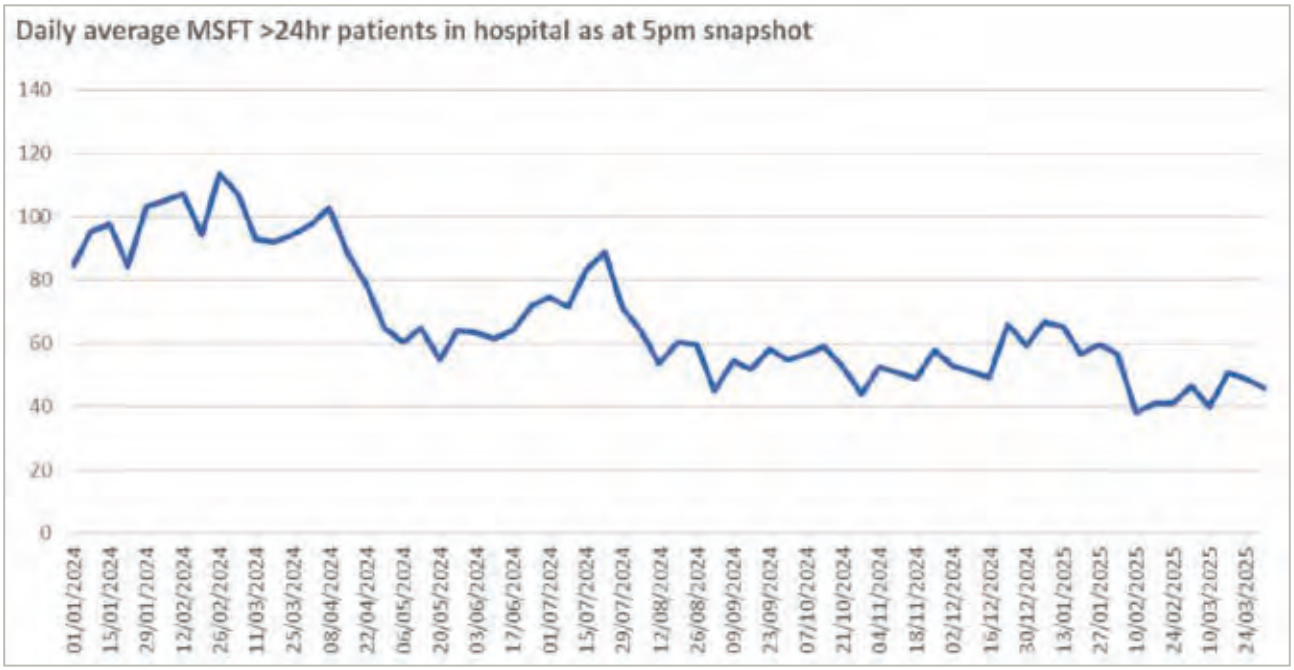
- Additional funding from the ICB to fund 4.0 WTE (Whole time equivalent) discharge coordinators and 1.0 WTE band 6 for the Integrated Discharge Advisory Team (IDAT) team. This increased visibility on the wards and in the hub to push 'home first' principles and encourage supported discharges to be referred earlier to IDAT. Band 6 discharge nurse embedded within TOCH to support safe decision making with system partners.
- Weekly LOS meetings with both the acute wards and peripheral wards to push discharge for medically safe patients and forward plan for pending complex discharges.
- Twice weekly P2 meetings with system partners to facilitate timely supported discharges.
- Recruitment of a P3 navigator to source P3 nursing placements. P3 navigators also support adult social care in sourcing long-term care placements to reduce delays once funding agreed.
- Proactive action taken for patients with 'No Criteria To Reside' (NCTR) by issuing NCTR letter, created in conjunction with trust legal team with executive approval.
- IDAT working closely with street health nurses including a weekly meeting to push discharges for those patients deemed medically safe.
- Increased joint working with system partners to unblock barriers to discharge.
- A programme of focused work with the SFHFT digital team to identify weaknesses within current Nervecentre flows and develop improved and clearer pathways.
- Focused workshop on LOS in P2 beds with a multi-disciplinary focus.
- IDAT managers frequent shadowing of board rounds to push home first and encourage referrals of patients requiring support on discharge to IDAT 72-48 hours pre-medically safe.
- Daily review of medically safe patients with escalation of actions for all divisions.
- Supplying the discharge coordinators with a daily list of all the patients on their ward who should be medically safe in the next 48 hours to commence the D2A as early as possible.

Monitoring and Reporting for Sustained Improvement

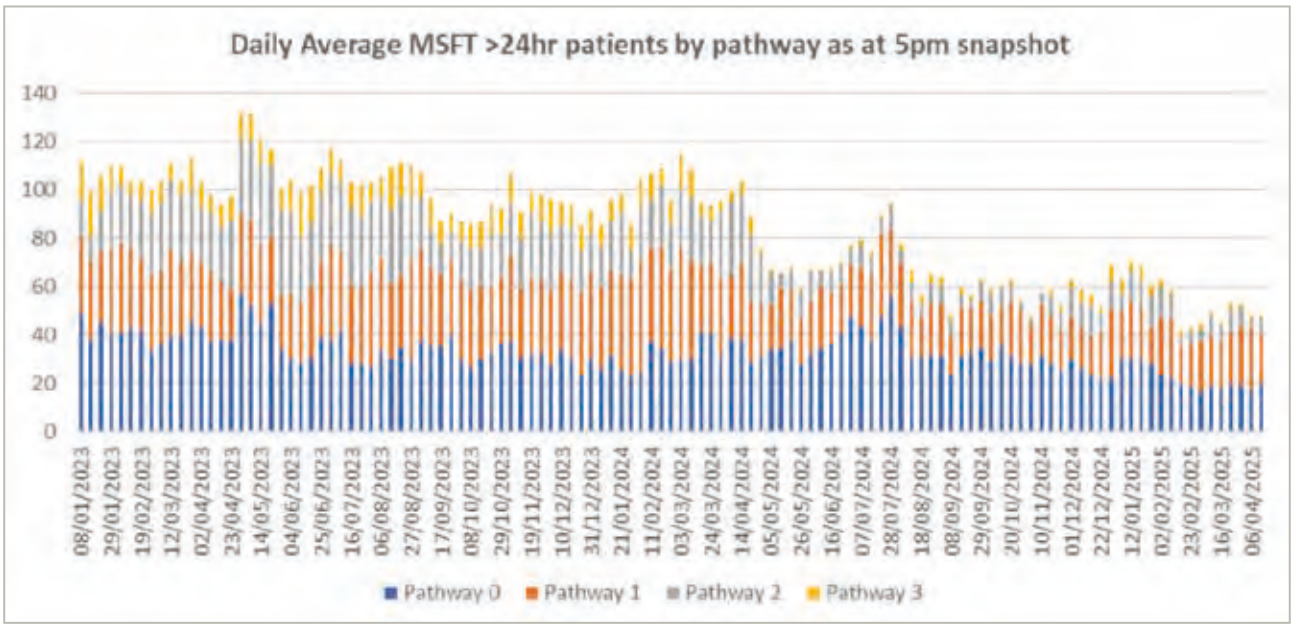
All metrics described above are tracked through the Emergency Care steering board. A sample of current metrics can be seen below.

Benchmark against national standards, national average LOS for patients in acute hospital is 4.3 days, SFHFT (inc. P2 patients is 3.9 days), excluding P2 patients average is 3.6 days.

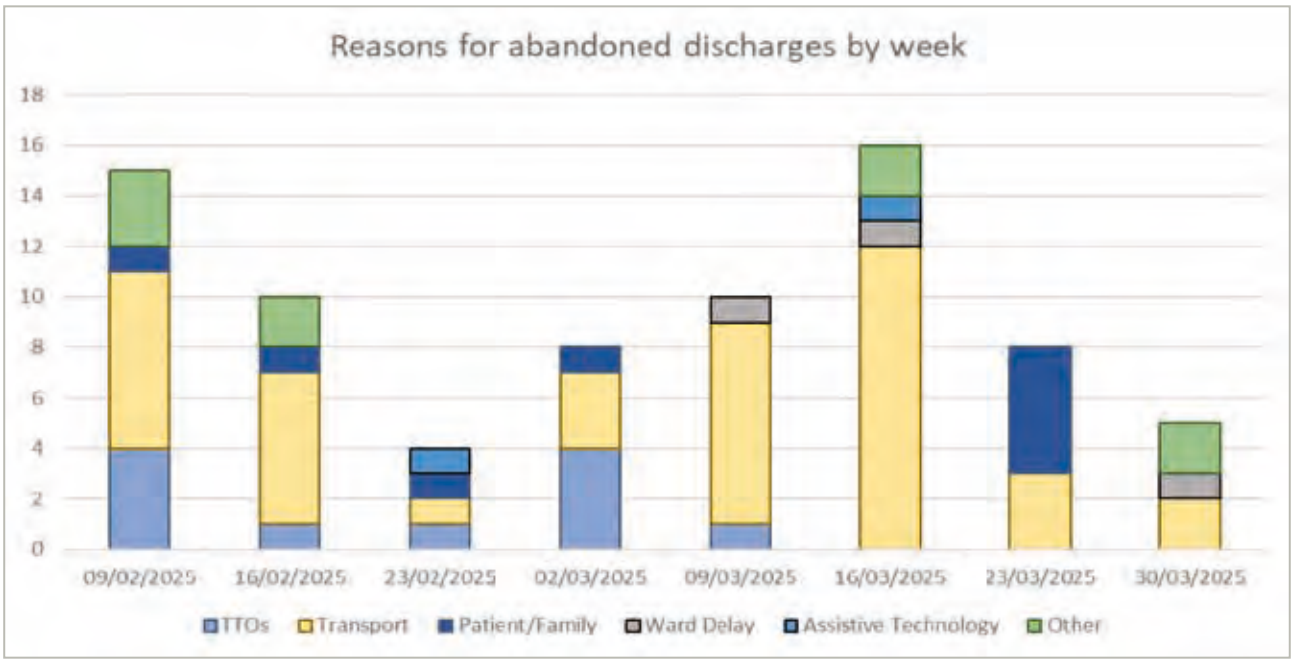
Graph 27: Length of stay and Medically Safe for Transfer



Graph 28: Daily average Medically Safe For Transfer >24hrs



Graph 29: Example of reasons for abandon discharge



What we aim to achieve in 2025/26

1. Aim to bring average LOS below 3.5 days.
2. Improved identification of patients requiring supported discharge earlier on in their patient journey leading to reduction in barriers to discharge and subsequently leading to shorter LOS.
3. Aim for a further 15-minute reduction of the average discharge time to 14:45pm.
4. Improve the process for 'fast track' patients by improving efficiency of the discharge process to nursing homes/community, aim for discharge within 72 hours from when discharge pathway is decided.
5. Improved Board rounds focusing on Predicted Date Discharge (PDD) dates and discharge plans.
6. Reduction in the number of 'abandoned discharges' for all reasons.

3.5 Effectiveness - Improve the care and learning from Mortality reviews

Aims for 2024/25

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

How did we do? (Performance against this Target)

The Datix IQ mortality platform went live in October 2024 for all new review requests.
Clinical colleagues continue to reduce the backlog on the Datix Web platform, and we are in the process of removing links to the standalone Trust Mortality Review tool (to prevent confusion and archiving historical data). All new users of the Datix IQ system are being provided with training and Mortality Review methodology before access to the system is approved. Lack of training was one of the criticisms of the previous arrangements. Qualitative and quantitative analytical functions are being developed and reports will become available to feed into other Trust governance processes as reviews are completed.

Mortality review using Datix IQ is currently dedicated to hospital inpatient deaths due to its ability to interface with Trust systems.

SFHFT's contract with Dr Foster/Telstra has been extended for a further year. A significant factor contributing to this decision was the external independent review and significant redesign of the company's mortality model. The new model that has been implemented nationally, which now demonstrates SFHFT to be "as expected" for its Hospital Standardised Mortality Ratio+ (HSMR+) metric, where it was previously a high outlier. This is consistent with the Summary Hospital Mortality Index (SHMI), which has consistently been "as expected." SFHFT are keen to explore what additional insights this model will provide into our Trust-level data submissions but will consider our longer-term strategy when Nottingham University Hospitals' contract with their current provider is due for renewal in 2025-6. There may be advantages for procurement where a joint tender process may be considered.

Analytic capability has been developed using data from our local data warehouse via a Power BI dashboard. This allows drill down to patient level (not available in either HSMR or SHMI) and is not subject to several months' lag. Our local data linking to published SHMI data shows less than 0.1% unmatched, which gives us significant assurance. This facility has been shared with mortality leads with the intention that clinical signals can be investigated in the data, rather than investigation being data-led.

We await news regarding NICS-level arrangements for Learning from Deaths, which have been complicated by changes at NHSE level. We are keen to contribute our considerable local expertise to any future plans.

How was this achieved?

The development and launch of the of the Mortality Review Platform has involved significant clinical user engagement and testing supported by the Governance Support Unit, Datix and Bereavement teams.

SFHFT have developed an effective working relationship with our current Dr Foster/Telstra consultant and have been reassured by the company's willingness to listen and act on our concerns around their previous model. We were pleased to have been included in the consultation with their independent expert. We are keen to ensure that this provision is retained either externally or internally following the tender process.

Development of the Mortality Power BI dashboard was made possible with support from the Trust Analytics Team and the Benchmarking Team from the Sherwood Improvement Faculty.

Monitoring and Reporting for Sustained Improvement

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

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

What we aim to achieve in 2025/26

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

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

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

The 6 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 SFHFT in the provision of outstanding end of life and palliative care. It provides assurance that effective communication, co-ordination, and consistent practices are being maintained in relation to EoLC across the Trust and drives the strategic and operational planning for effective EoLC service delivery at SFHFT.

Aims for 2024/25

- Finalisation of the Specialist Palliative care in-reach provision to SFHFT service specification, provided by Nottinghamshire Healthcare NHS Trust (NHCT)
- Expand the rollout of the AMBER Care Bundle project Trust-wide (enhancing recognition of uncertain outcomes)

- Continue to deliver EoLC Champion Study Days.
- Introduction of Monitoring Adult Care and Comfort Observations (MACC OBS) on Nerve Centre
- Continued participation in the quarterly National Audit of Care at the End of Life (NACEL) Audit, including the NACEL Bereavement Survey
- Complete the review of the EoLC education plan
- Create an EoLC team activity dashboard
- Review and further develop the EoLC team, work plan

How did we do? (Performance against this target)

- Specialist Palliative Care in-reach (SPC) continues to be provided by NHCT. The EoLC Team continues to work closely with the SPC Team. The SPC service specification has been agreed and signed by SFHFT. Final sign-off of the specification is awaited by NHCT.
- The AMBER Care Bundle has been rolled out by the EoLC Team across Ward 36/Short Stay Unit (SSU) and the Emergency Assessment Unit (EAU). An electronic version of the AMBER Care Bundle has been developed and launched on Nerve Centre. Training on the electronic version is being provided by the EoLC Team to Doctors to complete.
- 3 EoLC Champions study days were delivered during 2024/25. Topics to develop the knowledge and skills of staff who support patients in their last days of life, and their families/those important to them. The study days were well attended and evaluated positively. The EoLC Champions e-learning package is now available for colleagues to access.
- The Last days of life Observations MACC OBS (comfort observations) module is an electronic assessment used to ensure staff can monitor a patient's comfort and symptoms in the final days of life, by promoting prompt review and timely intervention. The module design has been built by the Nerve Centre Team (supported by the SFHFT Digital Team) and was launched May 2025.
- During 2024, 129 invitations were forwarded to invite families/those important to the patient to complete the NACEL Quality Survey. (NACEL is a voluntary national comparative audit of the quality and outcomes of care experienced by the dying person and those important to them, during the last admission leading to death in acute hospitals). 16 surveys were returned, and feedback was overall positive for SFHFT. Processes to distribute the survey have been modified to increase participation.
- The Training and Education provided across SFHFT by the EoLC Team is under review 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). A gap analysis and action plan will be formulated on completion.,
- A final version of the EoLC Team activity dashboard has been agreed and implemented in 2025.
- The EoLC team, work plan has been developed and used to help track progress and performance. It is constantly under review and refined as required.

Monitoring and Reporting for Sustained Improvement

- In 2024, a new EoLC education and training offer commenced including Fundamentals training, ReSPECT training for Specialist Nurses, SAGE & THYME® Foundation level communication sessions and, Recognition of Dying (for Nursing and Medical colleagues).
- The EoLC Team continue to support students to spend time observing the EoLC Clinical Nurse Specialist roles, and placements are being developed to include Paramedic Students
- Eight dedicated beds continue to be utilised within Ward 36/SSU for EoLC.
- SFHFT continued to participate in the NACEL audit throughout 2024/25. SFHFT completed all elements of the audit during 2024. The outcomes and feedback were overall, very positive for the Trust. Key recommendations from the findings have been considered and formulate part of the work plan for 2025/26. Progress updates will be presented to the GP & EoLCC meetings.
- The EoLC team, engaged in conversations with colleagues and the public during Dying Matters Awareness Week (May 2024) and Grief Awareness Week (December 2024). The aim was to raise awareness about dying, death and grief and bereavement support locally and nationally.
- The EoLC Butterfly Volunteers continue to enhance the experience of patients identified as being in the last days of life and requiring support, by providing companionship to patients. A further 8 volunteers were trained in 2024/25.

What we aim to achieve in 2025/26

- Finalisation of the Specialist Palliative Care in-reach provision to SFHFT service specification (provided by Nottinghamshire Healthcare NHS Trust)
- Further expand rollout of the AMBER Care Bundle project Trust-wide Continue to deliver EoLC Champion Study Days
- Continued participation in the quarterly NACEL Audit, including the NACEL Bereavement Survey
- Complete review and mapping of the EoLC education plan and review and finalise the EoLC Team work 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 of grief and bereavement support resources
- End of Life Care Comfort Rooms
- Create an End of Life Care Quality Improvement Network.

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

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

Aims for 2024/25

- Admiral Nurse to launch the referral service by April 2024. A standard operating policy for referral is being developed with the support from Dementia UK.
- The Dementia Team (DT) will collaborate and identify workstreams for all its members, producing a document that clarifies and identifies areas of responsibility.
- Emphasis on the collaboration with key stakeholders to further enhance the quality of dementia care and training within SFHFT, including champion days and awareness days/weeks.
- A revision of the training provision, ensuring Tier 1 Dementia Training is a mandatory requirement and will include all hospitals staff, including our ancillary colleagues.
- Embed a culture of dementia visibility in line with the 'Well Pathway for Dementia,' ensuring all wards and departments are aware of the support offered by the team to patients, families, and staff.
- The Admiral Nurse will focus on the Carer's Passport campaign, with the aid of the dementia support worker, to provide information to all appropriate unpaid carers, aiming to enhance the quality of the patient stay, individualised care planning and support a reduction in the length of in-patient stay.
- Delirium training packages will be developed with an emphasis on recognising and treating delirium.
- The DT will continue to develop the shared governance council, supporting staff to deliver outstanding dementia care at SFHFT.
- The Dementia Strategy 2024-2027 will be developed to define the culture and future of dementia care within SFHFT. This strategy will set out a positive, shared vision for dementia, aligning to key objectives of the National Dementia Strategy and the Prime Ministers Challenge on Dementia (2020), recognising the vision to transform dementia services.
- Collaboration with an external company to develop an enhanced dementia training package for staff directly involved with dementia patients, available initially for Dementia Champions.

How did we do? (Performance against this Target)

- The Admiral Nursing service commenced in April 2024 and has received excellent feedback. Assurance of the service is provided through a quarterly report completed by Dementia UK.

  Links developed with other specialist teams throughout, have led to a significant increase in referrals. Collaborative working has provided additional support to patients, carers and staff and the team continues to cultivate alliances with both internal and external groups.
- SFHFT employed staff now receive access to the NHS England eLearning package 'Understanding Dementia', achieving compliance against Tier 1 training objective. All clinical staff also receive a face-to-face session as part of their Trust induction programme.
- The DT have successfully completed a full campaign programme trust wide, to further promote the service. A culture of visibility has been embedded and increased referrals to the team reflects this.
- The Admiral Nurse, in collaboration with the Patient Experience Team, has promoted the Carer Passport campaign. Survey posters have been developed and capture live feedback via a QR code, to identify any gaps within the service.
- A delirium training package is currently under development.

- The DT have collaborated with the Digital Team, Liaison Psychiatry Team, and Lead Geriatrician to develop an updated Dementia Screening tool via Nervecentre, to support in the identification of delirious patients. The delirium training is currently under development.
- The DT continue to support colleagues' ideas and initiatives through the Dementia Shared Governance Council. Ideas have been developed, and work is currently underway to further enhance the patient experience.
- The Dementia Strategy 2025-2028 has been developed and will be launched in May 2025. This has been developed to define the culture and future of dementia care within SFHFT, demonstrating a positive, shared vision for dementia.
- The Dementia Champions training session received excellent feedback. More sessions are planned in 2025.

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, demonstrating developments, and identifying any areas of concern. These forums allow the discussion and collaboration of the wider MDT and has supported progress so far.

Monitoring and Reporting for Sustained Improvement

Dementia continues to be an essential element of COEC and Patient Experience Committee meetings. Reports are produced and discussed, and escalations are taken 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.

What we aim to achieve in 2025/26

- The Dementia Team (DT) 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 DT will collaborate with all key stakeholders to ensure that SFHFT 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 DT will facilitate and increased awareness and education by:
  - o 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.
  - o Provide monthly Dementia Drop-in sessions to provide support to staff, patients and families,
  - o Educate and support staff and families to complete the 'This is me' documentation to increase its use throughout SFHT.
  - o Support the development of 'Connected Care Volunteers'
  - o Offer student nurse placements to undertake a supported intern position with the DT.
  - o Continued attendance at the Violence and Aggression Working Group and, MCA/DoLs working group to raise clinical awareness and provide expertise.

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

The Friends and Family Test (FFT) is 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 SFHFT 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 at SFHFT, 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

Aims during 2024/25:

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

How did we do? (Performance against target)

- We have 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.
- Our PSPs are presented FFT findings via the Patient Experience Committee, facilitating discussions on the results and potential improvements that could be made.
- The PEIE officer collaborates with all divisions and has been supporting improvements in the collection of both quantitative and qualitative data, while driving key involvement and engagement initiatives.
- Extensive training has been delivered to staff across the Trust, enabling them to access live feedback from the FFT service, empowering teams to make local improvements. Evidence of local improvements based on FFT responses is regularly shared by leaders with the PEIE Officer.
- We continue to 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 used, seeing this increase across multiple areas of the Trust.

- The PEIE officer works closely with both clinical and non-clinical staff to create tailored surveys for their specific areas and provides training to help them access feedback. This enables teams to monitor and enhance the services provided to patients.
- The findings of FFT have been aligned with the National Inpatient Survey results and provide a triangulated approach to improvements.

The findings from the FFT, along with any resulting improvements, are discussed and shared at the Patient experience committee, ensuring clear focus and meaningful discussions are generated on the results.

Results

The results show a variation in response rates (see table 14), and our PEIE officer 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 14: FFT data April 2024 – January 2025

	Recommendation Rate %									
	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-24
Inpatients	92%	95%	93%	92%	93%	91%	93%	93%	92%	91%
Emergency / Urgent Care	88%	86%	85%	90%	90%	85%	82%	81%	83%	83%
Outpatients	95%	95%	95%	96%	95%	94%	94%	95%	96%	96%
Maternity	89%	70%	83%	84%	91%	78%	90%	87%	70%	100%

The FFT feedback is integrated with the 15 Steps Challenge, 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 2024/25:

- “Staff are polite.”
- “Excellent waiting times.”
- “Prompt service.”
- “Good communication on this occasion.”

What we aim to achieve in 2025/26

- Continue collaborating with our 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 an enhanced patient experience.

3.9 Patient Experience - Safeguarding vulnerable people

Throughout 2024 and 2025, our adult and children safeguarding teams have consistently aligned and coordinated activities, employing the 'Think Family' approach to safeguarding. This approach integrates local and national safeguarding priorities. Our team collaborates effectively with a range of external and internal multi-agency partners, including a hospital independent domestic abuse advisor, which enables us to provide immediate support to survivors of domestic abuse at the time of disclosure.

Our primary objective is to identify safeguarding risk factors affecting patients and their families and to facilitate referrals to the appropriate agencies for ongoing support and intervention. We remain committed to advocating for our patients throughout their stay at SFHFT, often working closely with family members and other professionals to ensure optimal outcomes are achieved.

The SFHFT Safeguarding Committee continues to monitor our safeguarding activities and provide assurance to the SFHFT Board via the Patient Safety and Quality Committees. This encompasses our ongoing work streams in alignment with the Trust's statutory obligations as outlined in the Children Act 1989/2004 and The Care Act 2014. The Head of Safeguarding represents SFHFT at the Nottinghamshire Safeguarding Adult Board (NSAB) and the Nottinghamshire Safeguarding Children's Partnership (NSCP) and is also a member of the NICS Safeguarding and Public Protection Assurance Group.

Aims for 2024/25

SFHFT ensures safeguarding is a crucial aspect of our care and service delivery. We are committed to ensuring that the necessary safety processes are firmly in place.

- Whilst we have seen safeguarding training compliance increase over the last year during 2024/25 we aimed to focus on reviewing safeguarding training, its effectiveness and impact. Ensuring it continued to meet the necessary standards but that what is learnt is being translated into practice.
- Implementation of the new trust audit programme.
- Continued focus on MCA legislative compliance.
- Further service reviews to be undertaken around Learning Disabilities and Mental Health.
- Development of service delivery plans and KPIs for the newly formed Violence Reduction Service, aligning with national standards.

How did we do? (Performance against this target)

Throughout 2024/25, SFHFT placed a strong emphasis on safeguarding. Our collaboration with external partners has persisted, reflected in our active participation in safeguarding board meetings and various partnership events. Furthermore, we have engaged in local and national safeguarding reviews, ensuring that the insights gained are integrated into our mandatory training practices.

The SFHFT mandatory training program has successfully maintained its focus on safeguarding training, resulting in enhanced compliance at all training levels. This compliance is overseen through Divisional governance forums and the Safeguarding Committee. The safeguarding team has also undertaken audit work around the training's effectiveness. This work has identified key areas for improvement, which will inform our ongoing work into 2025/26.

The safeguarding adults and children audit programmes have been reviewed and implemented. Audits findings are shared with divisions with local action plans being developed and monitored through divisional and safeguarding governance processes.

Our focus on the Mental Capacity Act (MCA) and Deprivation of Liberty (DoLS) has remained a priority throughout 2024/25. The MCA Steering Group, led by the Named Doctor for Safeguarding Adults, includes strong representation from all divisions and has formulated a comprehensive trust-wide development plan regarding MCA/DoLS. Additionally, we have engaged in a PSII and a 360-assurance audit, both of which produced comparable findings, with the 360-audit offering only limited assurance. These findings have been integrated into our wider development strategy. Although we have completed some of the initiatives, we acknowledge that there is more to do, and this is just the beginning of our journey with MCA/DoLS. It will continue to be a focus in 2025/26.

Service reviews related to Learning Disabilities, Mental Health, and Violence Reduction, including restrictive practices, are currently in progress. In 2025/26, our goal is to develop key performance indicators along with updated audit and assurance processes.

Monitoring and Reporting for Sustained Improvement

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

What we aim to achieve in 2025/26

- Continued focus on training, monitoring compliance whilst monitoring the effectiveness and impact of training provided.
- Continued focus on MCA legislative compliance.
- Undertake process mapping across the safeguarding and vulnerabilities team alongside the ongoing service review work.
- Review of safeguarding children and adult supervision across the organisation.
- Explore the role of Champions across safeguarding and vulnerabilities.
- Review the process around how we share learning and track action plans relating to safeguarding across all divisions within the organisation.

National Learning Disability Improvement Standards

SFHFT has a specialist Learning Disability (LD) team. This is a small team with a Specialist Lead Nurse and a Complex Care Nurse whose role is to provide support to adults with Learning Disabilities. The LD team is integrated within the wider safeguarding and vulnerability team and is strategically led by the Head of Safeguarding.

Each year SFHFT submits a response to NHSi in relation to the National Learning Disability (LD) improvement standards. Our 2024 response to NHSi has been submitted.

We can report that:

- SFHFT has made reasonable adjustments to care pathways to ensure people with learning disabilities, autism, or both, can access highly personalised care and achieve equality of outcomes.
- We have processes to investigate the death of a person with learning disabilities, autism, or both, while using our services, to learn lessons from the findings of these investigations.
- We vigilantly monitor any restrictions or deprivations of liberty associated with the delivery of care and treatment to people with learning disabilities, autism, or both.

- We empower people with learning disabilities, autism or both, and their families and carers, to exercise their rights.
- Staff are being trained and then routinely updated in how to deliver care to people with learning disabilities, autism, or both, who use our services, in a way that takes account of their rights, unique needs and health vulnerabilities; adjustments to how services are delivered are tailored to each person's individual needs.
- Will ensure staff have the specialist knowledge and skills to meet the unique needs of people with learning disabilities, autism, or both, who access and use our services, as well as those who support them.
- SFHFT have accredited trainers providing training to staff in restraint techniques in line with the 'restraint reduction network' training standards.
- SFHFT are represented on the local Learning Disability Mortality Review Programme (LeDeR) steering group.
- The LD team review the plans for DNACPR (Do Not Attempt Cardiac Pulmonary Resuscitation) for adult inpatients with an LD where appropriate and, discuss with clinicians where documentation is not complete or if there are concerns regarding the decision-making process.
- SFHFT has a board level lead (Chief Nurse), responsible for monitoring and assuring the quality of service being provided to children, young people and adults with a learning disability, autism, or both.
- SFHFT uses LD care plans for all patients admitted to the organisation with a diagnosed learning disability.
- The LD Team has a flagging system in place to ensure all patients identified as having a learning disability, are flagged on all hospital electronic systems, which ensures all staff are aware someone has a diagnosed LD but also, highlights to the LD team when a patient with a flag is admitted.

Aims for 2024-25:

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

How did we do? (Performance against target)

A service review has commenced, and an action plan has been established that aligns with the National Improvement Standards.

The Trust has commenced the implementation of the OMMT by incorporating it into the mandatory training program for 2024/25, with compliance currently at 85%. The rollout of Tier 1 and Tier 2 has been challenging due to limited training resources available via the ICB, coupled with the SFHFT's capacity constraints in releasing staff during an exceptionally busy period for the acute trust. The second phase of the implementation plan, involving scheduling the relevant staff for Tier 1, commences in April 2025, followed by the rollout of Tier 2.

Discussions with external providers regarding the flagging systems for patients with learning disabilities

are ongoing, and we continue to collaborate with community teams on this matter.

What we aim to achieve in 2025/26

- Continue with service review work with a key focus on how we can extend the current service to support patient 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.

3.10 Mandatory Key Performance indicators

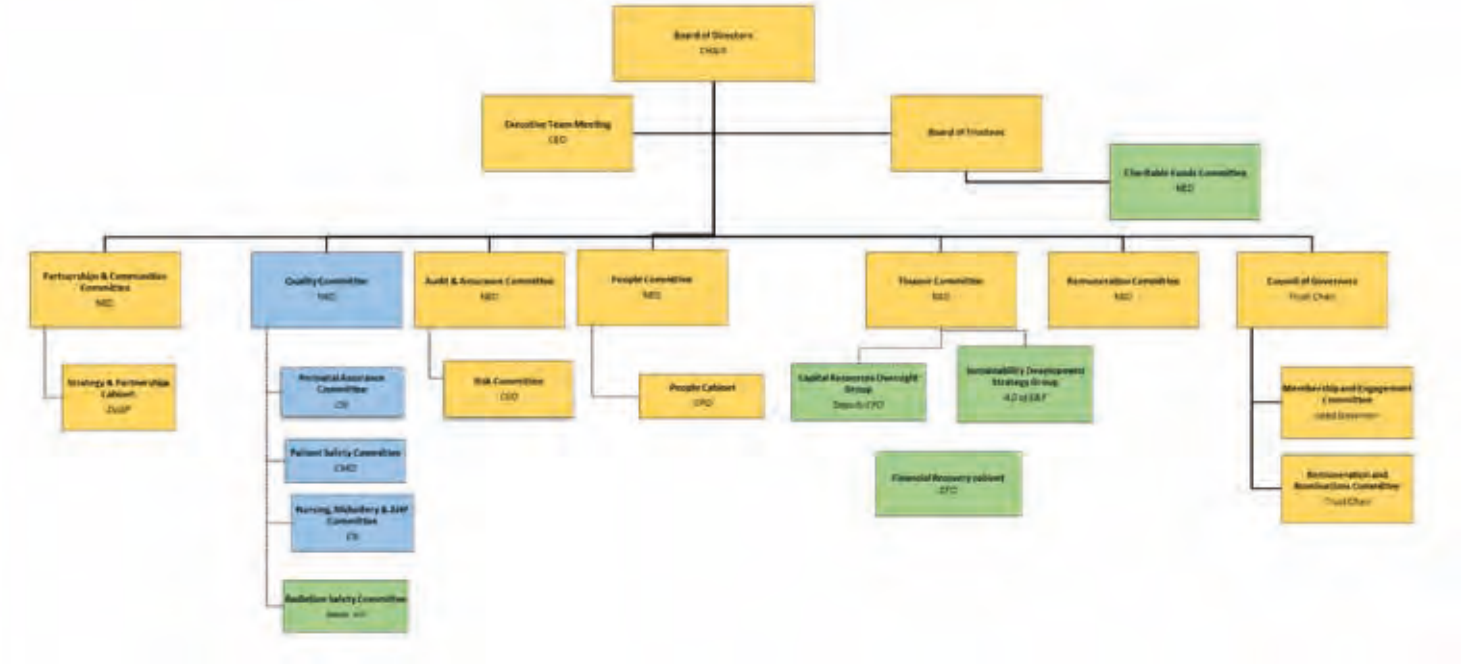
Indicators identified within the Integrated Performance Report	Target	Performance	Performance
		Yr 2023/24 Apr '23 - Mar '24	Yr 2024/2025 Apr '24 - Mar '25
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – Patients on an incomplete pathway	92%	61.14%	64.60%
A&E: maximum waiting time of four hours for arrival to admission / transfer / discharge	>95%	70.92%	70.97%
*Cancer Faster Diagnosis Standard	75%		78.32%
*Cancer 31 day treatment standard	96%		91.88%
*Cancer 62 day treatment standard	85%		64.24%
Maximum 6-Week wait for diagnostic procedures	99%	70.46%	93.07%
Clostridium difficile variance from plan	65	37	85
VTE Risk assessment	95%	97.7%	96.1%
**Summary Hospital-level Mortality Indicator (SHMI)	100%	109.04 (Dec 22-Nov 23)	106.74 (Dec 23-Nov 24)

*The Cancer metrics have been simplified in line with national standards. All individual 31 day, 62 day and FDS metrics have been merged to provide one overall percentage score

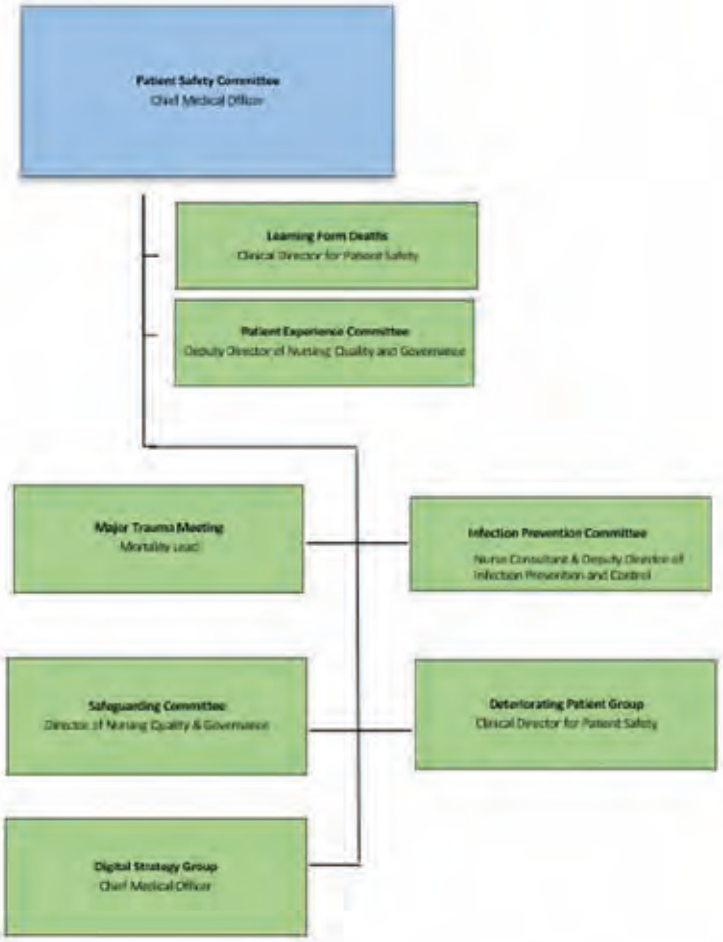
** The Summary Hospital-level Mortality Indicator (SHMI) is a rolling reporting period. The figures reported represent most current data available:

102.73 September-21 – August-22
109.04 December 22 – November 23
106.4 December 23 – November 24

Appendix 1 Sherwood Forest NHS Foundation Trust Committee structure – 2024/2025



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



Sherwood Forest Hospitals Foundation Trust – ICB Corroborative Statement 2024/25

Introduction

1. Nottingham and Nottinghamshire Integrated Care Board (NNICB) have continued to work with Sherwood Forest Hospitals NHS Foundation Trust (SFHFT) in pursuit of the monitoring and continuous improvement of services during 2024/25, in accordance with the statutory functions of the ICB[1].
2. The intention for 2024/25 was for Nottingham and Nottinghamshire ICB and SFHFT to continue fostering and developing collaborative and systems-based working, and this statement provides a reflection of progress.
3. The SFHFT Quality Account for 2024/25 illustrates the scope of work undertaken in the last year and an organisation that continues to develop.
4. Key achievements with the account include:
   a) The development of additional theatre capacity at Newark Hospital and the Community Diagnostics Centre based at Mansfield Community Hospital.
   b) Sustained and improved results though audit and staff surveys are positive with resultant clear aspirations for the future financial year where required.
   c) An improved position in reducing staff experience of violence and aggression at work through implementation of the violence and aggression improvement plan.
   d) Established oversight governance processes in line with the Patient Safety Incident Response Framework (PSIRF)[2] to develop thematic areas for focused improvement activity. Proportionate and sustainable improvement plans when incidents or concerns are found are evident. Review processes have resulted in actions that span pathways to align with continuous improvement approaches.

Oversight Arrangements

5. The Trust was last inspected and received an overall CQC rating in 2020 of Good. In 2024/25, the Nuclear Medicine services were inspected to assess compliance with ionising radiation. The CQC were satisfied with actions taken and those in progress.
6. The Emergency Department was inspected, considering the sepsis pathway, in September 2024. Actions derived from feedback provided at the time of inspection were completed and final report is yet to be published.
7. SFHFT are in segment 2 of the NHS Oversight Framework (NOF). The Trust continues to receive ongoing engagement and support of improvement activities reflective of routine oversight through the support of the NNICB Quality Team.

Quality Visits

8. There have been several quality visits across sites during 2024/25 with a continued focus on patient experience, staff experience and ongoing improvement work.
9. NNICB have continued to support the Trust with peer reviews and 15 steps challenges during 2024/25 allowing collaborative working with appropriate challenge welcomed.
10. Visits have been welcomed, reflecting an open and transparent approach alongside a strong commitment to providing high quality care. Staff have been seen to demonstrate pride in the services and care they provide.

Working as System Partners

11. SFHFT continues to engage in several system groups including the Partner Quality Assurance and Improvement Group (PQAIG) and the over-arching System Quality Group (SQG). The Trust also continues to contribute to the Local Maternity and Neonatal System groups and our quality improvement workstreams.
12. The Trust continues to welcome NNICB attendance at key meetings to support insight and improvement activity.
13. Patient Safety Partners have been actively involved in several key processes and committees with the opportunity to contribute their perspective in the development of services. The use of patient stories and increasing patient safety partner involvement supports a system approach for shared learning.

Forward View 2025/26

14. Plans for a continued focus on patient safety, clinical effectiveness and quality of care is evident in SFHFT's quality account. The Trust is dedicated to amplifying the patient voice by further developing and recruiting additional patient safety partners.
15. Further development of the "so what" aspects from audits to support continuous improvement.
16. Further expansion and roll out of ward accreditation is planned, leading to improvements in the services and care delivered to patients.
17. NNICB looks forward to continued collaboration with SFHFT and partners to drive improvement both within the organisation and across the wider system.

[1] **Health and Care Act 2022**

[2] **NHS England » Patient Safety Incident Response Framework**

Statement from the Health Scrutiny Committee

Nottinghamshire County Council's Health Scrutiny Committee appreciates the opportunity to comment on the Quality Account 2024/25 and welcomes the improvements described in the draft.

It is noted that the Trust has been the highest recommended Acute Trust for two years running and is the most recommended Acute Trust for receiving care in the East Midlands.

We welcome the Trust's emphasis on enhanced safety and learning through a positive culture around reporting. It is good to see a reduction in the number of complaints received this year, with fewer complaints upheld. It is also noted that improvements to end-of-life care have been effective.

The readmission rates for the 16+ age range showed no improvement over the course of the year. We would like to learn more around how the Trust is focussing on this area, and we are keen to learn what steps the Trust is taking to bring readmission rates in the 0-15 age range more consistently in line with the national average.

The draft reflects positive results regarding discharge data. However, transport has often been the reason when a discharge has been abandoned. As part of health scrutiny discussions this year, we will seek further information around what is being done within the Trust and across the system to reduce the impact of transport on discharges.

We are also interested to learn more around how the Trust is delivering on improvements in care for patients with Learning Disabilities. Completing staff training, establishing working proficiency in essential sign language, and collaborating with community groups will be important in this process.

The Trust's commitment to continuous improvement is welcome. Health Scrutiny Committee will continue to support the Trust in its improvement efforts through public scrutiny in the coming year.

We note our sincere thanks to the clinicians, nurses, and operational staff for their dedication in caring for our residents.

Councillor Mike Robertson, Chair of Health Scrutiny Committee

Councillor Simon Wright, Vice-Chair of Health Scrutiny Committee

Statement from Healthwatch

The SFHFT 2024-2025 Quality Account has been shared with Healthwatch in line with the requirements of NHSE.

Once the Healthwatch statement has been received, it will be added here, and the updated version of the Quality Account will be published.

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 Account, Directors are required to take steps to satisfy themselves that:

- The content of the Quality Account meets the requirements set out in the NHS foundation trust annual reporting manual 2022/23 and supporting guidance.
- The content of the Quality Account is not inconsistent with internal and external sources of information including:
    1. Board minutes and papers for the period April 2024 to March 2025
    2. Papers relating to quality reported to board over the period April 2024 to March 2025
    3. Feedback from commissioners dated 19 June 2025
    4. Feedback from local Healthwatch organisation (Not submitted, see annex 1)
    5. Feedback from Health Scrutiny Committee dated 30 June 2025
    6. The Trust's complaints report published under regulation 18 of the Local Authority Social and Complaints Regulations 2009,
    7. The 2024 national staff survey dated 13 March 2025
    8. The Head of Internal Audit's annual opinion of the trust's control environment dated xxx
    9. CQC Inspection report dated 14 May 2020
- The Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered.
- The performance information reported in the Quality report is reliable and accurate.
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice.
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review.
- The Quality report has been prepared in accordance with NHS Improvement's annual reporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the board

30/06/2025  Chair