Healthier Communities,
Outstanding Care

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

QUALITY ACCOUNTS AND REPORTS

2022/23

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. The report provides a review of the Trust's quality improvement activities and achievements during 2022/23.

The report also identifies and explains the Trust's quality priorities for 2023/24. The 2022/23 sections of the report refer to quality improvement activities completed during the 2022/23 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 ONE

Statement of the Quality Account:

Part 1: Statement of the Quality Account: Paul Robinson Chief Executive

I am proud to present our Quality Account for the period 2022/23. This Account provides an opportunity to reflect on our progress over the last year and shares our performance and outcomes for public scrutiny. It describes how we have performed against our key performance priorities, metrics, and statements of assurance. It also details our quality priorities for the coming year that include (but are not exclusive to), better maternity care, improved patient experience and embedding a culture of continuous learning and improvement. Our performance metrics evidence the continuous cultural shift which demonstrates an organisation aiming to improve and maintain outstanding patient care.

In November 2022, Sherwood Forest Hospital NHS Foundation Trust (SFHFT) was accredited as a designated 'Pathway to Excellence" organisation. SFHFT is one of only four Trusts in the UK to have achieved this accreditation, demonstrating our continued commitment to outstanding patient care. The ethos and framework for excellence continues to be embedded and integrated into the care we provide every day for our patients.

The Quality Account has been prepared by the people closest to the services provided at SFHFT, and therefore provides assurance in the content. In addition, the Quality Account has been reviewed by our Non-Executives Directors, our Commissioners, our Local Authority and shared with Healthwatch Nottinghamshire.

COVID-19 and the effects of the pandemic have once again dominated our year. During conversations I have with the staff, it is clear this has again, been a significantly challenging year with unprecedented demands on our service. During winter 2022/23 SFHFT, along with many trusts across England, experienced an increase in clinical pressures over and above that of previous years, across all our sites. Despite opening additional winter capacity, SFHFT declared Opel 4 (the highest escalation level for operational pressure), on 51 days, and internal critical incident on 14 days between 1st November 2022 and 31st January 2023 due to increased pressures.

Our teams have continued to focus on taking care of patients and their families, in often difficult circumstances. Their continued ability to deliver some truly extraordinary work and compassionate care is testament to the adaptability, resilience, and dedication of our staff.

We continue to improve and extend our well-being offer to our staff. Making life at #TeamSFH the best it can be for all our colleagues is important, because we know it creates an environment where we can support each other to provide the best care and services for all our patients.

With a response rate of 66% in the national staff survey, we are proud to have the highest engagement rate of any acute and acute community trust in the Midlands. The results, announced in March, give us rich data and a clear picture of how our colleagues are feeling about being part of #TeamSFH but also, what we need to do to make it better. There is more we can do and there are still too many colleagues who do not feel supported and experience poor behaviour during their time at work. We have redoubled efforts to listen to our staff, our patients, and our community.

While acknowledging the remarkable work of colleagues, I recognise that many patients have been waiting longer for treatment than anyone would like. I am sorry for this, and we are working as hard as we can to treat people as quickly and as safely as possible according to clinical urgency. Ensuring timely access to treatment continues to be a key objective. Over the past year we have committed significant time and resource to tackle our backlog and respond to increasing demands. Despite increased pressures, patients treated at our minor injuries' unit at Newark, PC24 and Emergency Department at Kings Mill Hospital, increased by 7.5%. Out-patient attendances (including day case) were up by 4.4%, and the number of patients requiring in-patient care in our hospitals, increased by 9%.

We have increased our work at Newark and Mansfield Hospitals to support the recovery of our out-patient activity and clinics.

I want to acknowledge how hard our staff are working to keep each other and our patients safe, to innovate and to respond to changing circumstances. Colleagues across all our services in Nottingham and Nottinghamshire, have worked ever more closely this year with our partners. As we move further towards working as a whole health and social care system in Nottinghamshire, these trusted relationships are proving critical in our ability to respond.

To the best of my knowledge, the information contained in this document accurately reflects our performance, provides a true account of the quality of the health care services we provide, and where we have succeeded and exceed in delivery on our plans. I hope you find this account informative and see that our patients are very much at the centre of everything our colleagues at Sherwood do. I would like to thank each and every member of the teams at Sherwood for their dedication and compassion during another challenging year.

Paul Robinson, *Chief Executive*
Date 8th June 2023

PART TWO

Priorities for improvement and statements of assurance from the Board

2.1 Priorities for Improvement

Sherwood Forest Hospitals NHS Foundation Trust (SFHFT) is committed to providing safe, high-quality care to all patients and service users. The Trust focus is on continuous improvement and is driven by the Quality Priorities identified within the Quality Strategy, 2018-2021, and is embedded in the renewed 2022-2025 Strategy, launched in 2022. The strategy is led by the Executive Medical Director, who, in conjunction with the Chief Nurse, receives regular progress reports via the Advancing Quality Programme. Formal reporting is through the Trust Quality Committee and the Board of Directors. The Advancing Quality Programme is monitored, updated, and amended throughout the year.

2.1.1 Providing high quality, safe care

SFHFT uses several internal and external sources to support and drive quality improvements. The following are examples that have been used to support the delivery of the Quality Strategy 2018-2021 and the development of the 2022-2025 strategy. These include:

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

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

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

During 2022, SFHFT launched its revised Quality Strategy including new Quality Priorities. This covers a three-year period 2022-2025. The campaigns and priorities will be shaped and monitored by the Advancing Quality Programme with assurance process to the Board. These have been reviewed in recent months and provide the focussed priorities described in 2.1.3

2.1.2 Approach to Quality Improvement

SFHFT aspires to continuously learn and improve to ensure that we provide outstanding care for all. We have the infrastructure in place to support this objective by developing a culture supporting continuous improvement including managing change, colleague engagement, a people-centred approach, CARE values and by establishing a psychologically safe and inclusive environment. SFHFT utilise the global 'Model

for Improvement' methodology and provide evidence-based Quality, Service Improvement and Redesign (QSIR) Fundamental and Practitioner training to all colleagues, at both Trust and at system level.

Patient safety, clinical effectiveness and quality care remain at the heart of our strategic vision. Every day, our colleagues demonstrate their commitment to providing outstanding patient-focussed care, as they strive to do their very best, in often difficult circumstances. To support our colleagues, we remain committed to continuously learning and improving. This commitment is firmly embedded within our People, Culture and Improvement Strategy, and Quality Strategy. Key aims outline and highlight how we will deliver patient-centred care, support our colleagues, by providing the best possible practice environment and by exploring, scoping, and adopting examples of clinical best practice. We will do this through collaboration with our health and social care partners across Nottinghamshire and with the launch of the Improvement Faculty at SFHFT (May 2023), a centre of excellence that will ensure everything we do is driven by a desire to improve. The faculty's role will be to align organisational expertise so that all improvement activity in our organisation is supported through training, ongoing support, and a coordinated multi-professional approach.

The work of the faculty will be grounded in evidence. This includes the continued use of the Institute of Healthcare Improvement's 'Model for Improvement', which has been widely adopted across the NHS.

As the Covid-19 recovery and restoration phase continues, we are required to consider new ways of thinking, planning and delivery, and an agile, adaptable workforce to implement them.

Despite the challenges of post Covid-19 recovery and restoration, some key achievements over 2022/23 include:

- Over 60 SFHFT colleagues undertook the QSIR Practitioner five-day course on Improvement, with system partners, and over 80 undertook the one-day QSIR Fundamental course.
- SFHFT achieved accreditation in 'Pathway to Excellence', demonstrating the best qualities of continuous improvement and the development of shared governance councils
- Senior Leaders undertook a 'QI Maturity Matrix' survey. This will be repeated in 2023/24
- A Board development session on Quality improvement (QI) was held in August 2022.
- Progress continues to be made on a system-wide approach to QI, so that there is a shared language and methodology across partner organisations

2.1.3 Quality priorities 2023/2024

During 2023/24 the Trust will continue with its aspiration to be rated as outstanding overall by the Care Quality Commission (CQC). We understand this represents an ever-increasing challenge as we learn to balance rising demand for healthcare alongside intensifying financial, quality and workforce risks.

The 2018-2021 Quality Strategy, saw the launch of a robust programme of innovative initiatives, underpinned by key priorities and measures. The 2022-2025 Quality Strategy, led by the Executive Medical Director, continues with these initiatives, and reflects the Trust's ambition for sustainable, high-value, high-quality services, delivered in partnership with other health and social care providers across the Nottinghamshire footprint within the Nottingham and Nottinghamshire Integrated Care System (ICS). As we move forward, we will witness a much closer system-wide alignment between quality, activity, and financial planning, boosting our combined efforts to deliver safe, effective, and financially sustainable services in the longer term.

The Quality Strategy provides the road map to achieve this aspiration. The quality priorities support the Trust Strategy, which has been developed in wide consultation with staff and external stakeholders. Future plans and progress against the quality priorities are the focus of agenda items at the Trust Quality Committee.

Three improvement priorities for specific focus in 2023/24 are indicated below; these have been included by considering local, national and international priorities, in addition COVID-19 and Ockenden Report. They have been agreed by the Advancing Quality Programme (AQP) oversight group and in consultation with the board of governors. They will be reported on in the relevant sections in the next Quality Account.

Specific Campaign	Quality Priority	Success Measure
Create a positive practice environment to support the safest most effective care.	Focus on Maternity Services ensuring babies have the best possible start in life. Work with the Local Maternity and Neonatal Services (LMNS) to equitably transform our maternity services through delivering a single delivery plan in line with the recommendations from the Ockenden and Kirkup review and CQC inspection. Plan and where possible, deliver the recommendations of the three- year plan for maternity and neonatal services published by NHSE.	Implementation of the single maternity oversight framework. Completion of the CQC must do and should do actions. Ensure smoking at time of delivery becomes part of our 'business as usual' through planning for 24/25. Optimisation and stabilisation of the preterm infant principles introduced. Implementation of NHSE guidance on Equity and Equality.
Excellent patient experience for users and the wider community.	Ensure all patients nutrition and hydration needs are met. (Working on delivery in conjunction with the Nutrition and hydration steering group and reporting to Clinical outcome and effective care committee).	All patients and services users have identified level of malnutrition. Improve pre-op nutrition screening and empower patients to optimise their nutrition status. All patients' cultural aspects are catered for in the menu provision. Mealtimes are protected and social aspects of mealtimes improved. Increase knowledge & skills of staff and service users to make healthier choices for themselves and their families.
Strengthen and sustain a learning culture of continuous improvement.	To embed the Improvement Faculty within the Trust whose role will be to provide a centre of excellence for transformational and improvement support.	Independent review of the Improvement Faculty's impact will have been completed and reported to the Finance Committee.

The Quality Strategy, incorporating the quality priorities identified, is the vehicle that will drive quality improvement across the organisation. Progress against the quality priorities is monitored monthly by the Executive Medical Director and Chief Nurse through the AQP Oversight Group. A report is presented quarterly to the Quality Committee, which reports to the Board of Directors.

2.1.4 Review of Quality Priorities during 2022/2023

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

Quality priority: SFHFT accredited as a designated "Pathway to Excellence" organisation.

Success Measure: Awarded Pathway to Excellence (P2E) designation by the American Nurses Credentialling Centre.

SFHFT was awarded P2E accreditation in November 2022. Over 100 pieces of evidence were submitted to demonstrate compliance against P2E accreditation requirements, in addition to the results of a survey completed by registered nurses and midwives within the Trust.

- 81% of our eligible staff completed the survey which comfortably exceeded the criteria required. 23/28 questions scored greater than or equal to 75%, favourable, (the benchmark is 50%), and all questions scored higher than or equal to 50%, favourable

SFHFT are one of only four Trusts in the UK to have achieved this accreditation.

- The P2E ethos and framework is being embedded so that an understanding of the standard's, and what they mean to care, is integrated into everyday practice. SFHFT will be required to apply for re-accreditation in 3 years' time

Progress and monitoring of the P2E framework will be via quarterly reporting to the Nursing, Midwifery and AHP Committee.

Patient Experience	Excellent patient experience for users and the wider community

Quality priority: Increased service user/ citizen engagement at key SFHFT meetings.

Success Measure: Assurance processes/ Terms of Reference / meeting minutes

Service user and patient engagement have increased in the past year.

During 2022/23 SFHFT re-commenced the Patient Led Assessment of the Care Environment, (PLACE). PLACE supports improvements by providing a clear narrative, directly from patient assessors, regarding the environment or services, and how they may be improved or enhanced. Assessments undertaken involved Patient assessors, Governors, Estates and Facilities Teams, and Patient Experience teams.

The areas visited are selected by the patient assessors, allowing them to lead the process. The assessments include the provisions of clinical care, privacy, dignity, nutrition (including a food taster session), cleanliness, general maintenance and include consideration of a dementia patients experience. Annual reports on the assessment findings are shared to drive improvement.

Through the development and sharing of patient stories, SFHFT captures information about the quality of services provided and shares learning for improvements in addition to celebrating areas of outstanding practice. Patients who choose to be identifiable in the sharing of their experience, are offered emotional and practical support in sharing their story. Patient stories provide valuable engagement with our local population, staff and stakeholders. The final video production is shared monthly at the Nursing Midwifery and AHP Committee and Trust public board meetings.

The monthly '15 Steps Challenge' also recommenced during 2022/23, enabling senior members of the team to gain an understanding of the patient's perspective to the care provided and an assessment of the experience within '15 steps' of a patient entering a clinical area. Teams undertaking these visits at SFHFT include, a member of the Senior nursing team, an Executive director, a Non-Executive Director, and a Governor. They provide an opportunity for staff and patients to discuss the provision of care with members of the senior team and allows insights into the services provided at SFHFT. A summary report is completed post visit and shared with the teams, allowing themes or trends to be identified and used as a driver for improvements in quality healthcare. '15 steps' visits are reported quarterly via the Nursing Midwifery and AHP committee, and the Council of Governors forums.

There is currently a Patient Safety Partner role out for recruitment to support the way we approach patient/citizen and service user engagement.

Clinical Effectiveness	Deliver high-quality care through kindness and 'joy at work'

Quality priority: Introduce a Trust-wide 'Cultural Humility' programme

Success Measure: Programme to be visible and rolled out to all colleagues across 2022

During 2022 we have continued to develop the Trust Cultural position and build on the work begun in 2021 led by Professor Stacey Johnson MBE. Our National Staff Survey suggests there is considerable opportunity for further work and focus.

The Chief Nurse has acted as the executive sponsor for this work. This has been refocussed following the publication from the NMC, NHS Confederation and NHS England of Nursing and midwifery anti-racism resource framework and the NMC Code

Which describes the workstreams below:

1. **Challenging Racism-Practice effectively, staff witnessing racism, staff experiencing racism (Jan-March)**
2. **Caring and Belonging-Preserve Safety, Long term psychological impact of racism (April-June)**
3. **Challenging Leadership-Promote Professionalism and trust. Ensure consistent practices, policies and procedures. Career Progression (July-**
4. **Authentic Inclusion-Prioritise People. Ethnic Minority Networks, Inclusion in Practice**

We continue to raise awareness across the organisation using new posters that signpost staff to support and provides practical guidance for Line Managers. Support offers have further developed to address some of the reported experience of our colleagues. These are further being refined against the standards published by NHSE relating to our processes relating to Bullying Harassment Violence and Aggression.

We are working to make improvements in assisting our staff to pronounce names properly by introducing phonetic spelling on name badges

The previously successful Reach Out event is to be repeated this year. This will be an opportunity to celebrate our staff from diverse backgrounds in Reach Out in September 2023 (Race, Ethnicity and Cultural Heritage).

2.2 Statements of Assurance from the Board

2.2.1 General Statement

During 2022/23 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 2022/23 represents 88% of the total income generated by SFHFT.

This year, SFHFT cared for:

	2022/23	2021/22
ED Attendances KMH	116,726	111,164
Newark UCC Attendances	30,957	25,317
PC24 Attendances	31,984	30,901
Total	**179,667**	**167,382**
Births	3,492	3,453
Outpatient Attendances (all sites)	460,296	446,554
Inpatient activity	59,445	54,179
Day Case Activity	39,367	37,896

SFHFT employ 5,735 substantive people. We engage with a large number of people through the bank system which raises this number to 8,926 including 219 consultant doctors which includes 33 locum consultants, working in hospital facilities that are some of the best in the country.

2.2.2 Participation in Clinical Audit

Over 2022/23, the focus continued to be on re-engaging colleagues with the clinical audit agenda, and to strengthen the focus and visibility of patient and service outcomes and learning. We also continue to strengthen the link between Clinical Audit and Improvement by ensuring that we utilise audit findings and encouraging the usage of Quality improvement tools and methodologies. This has been achieved through training and coaching.

National Clinical Outcome Review Projects 2022/23

During 2022/23, SFHFT participated in 54 of 55 (98%) of national clinical audits and 100% of national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Sherwood Forest Hospitals NHS Foundation Trust participated in during 2022/23 are as follows:

National programme name	Work stream / Topic name	Should we participate?	Case Ascertainment
Breast and Cosmetic Implant Registry	N/A	Yes	100%
Case Mix Programme (CMP)	N/A	Yes	100%
Elective Surgery (National PROMs Programme)	N/A	Yes	100%
Emergency Medicine QIPs	Pain in Children	Yes	100%
Emergency Medicine QIPs	Infection Prevention and Control	Yes	100%
Emergency Medicine QIPs	Mental Health self harm	Yes	100%
Epilepsy 12 – National Audit of Seizures and Epilepsies for Children and Young People	Epilepsy12 has separate workstreams/data collection for: Clinical Audit, Organisational Audit	Yes	100%
Falls and Fragility Fracture Audit Programme (FFFAP)	National Audit of Inpatient Falls	Yes	100%
Falls and Fragility Fracture Audit Programme (FFFAP)	National Hip Fracture Database	Yes	100%
Falls and Fragility Fracture Audit Programme (FFFAP)	Fracture Liaison Service Database (FLS-DB)	Yes	100%
Gastro-intestinal Cancer Audit Programme (GICAP)	National Bowel Cancer Audit	Yes	100%
Gastro-intestinal Cancer Audit Programme (GICAP)	National Oesophago-Gastric Cancer Audit (NOGCA)	Yes	100%
Inflammatory Bowel Disease Audit	N/A	Yes	100%
LeDeR – learning from lives and deaths of people with a learning disability and autistic people	N/A	Yes	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme	Maternal mortality surveillance and confidential enquiry (confidential enquiry includes morbidity data)	Yes	100%

National programme name	Work stream / Topic name	Should we participate?	Case Ascertainment
Maternal, Newborn and Infant Clinical Outcome Review Programme	Perinatal confidential enquiries	Yes	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme	Perinatal mortality surveillance	Yes	100%
Medical and Surgical Clinical Outcome Review Programme	Community acquired pneumonia	Yes	100%
Medical and Surgical Clinical Outcome Review Programme	End of Life Care	Yes	100%
National Adult Diabetes Audit (NDA)	National Diabetes Foot Care Audit	Yes	100%
National Adult Diabetes Audit (NDA)	National Diabetes Inpatient Safety Audit (NDISA) Previously NaDIA-Harms	Yes	100%
National Adult Diabetes Audit (NDA)	National Core Diabetes Audit	Yes	100%
National Adult Diabetes Audit (NDA)	National Diabetes in Pregnancy Audit	Yes	100%
National Adult Diabetes Audit (NDA)	National Diabetes Transition (linkage with NPDA)	Yes	100%
National Adult Diabetes Audit (NDA)	NDA Integrated Specialist Survey	Yes	100%
National Asthma and COPD Audit Programme (NACAP)	Adult Asthma Secondary Care	Yes	100%
National Asthma and COPD Audit Programme (NACAP)	Chronic Obstructive Pulmonary Disease Secondary Care	Yes	100%
National Asthma and COPD Audit Programme (NACAP)	Paediatric Asthma Secondary Care	Yes	100%
National Audit of Breast Cancer in Older Patients (NABCOP) *	N/A	Yes	100%
National Audit of Cardiac Rehabilitation	N/A	Yes	100%
National Audit of Dementia	Care in general hospitals	Yes	100%
National Cardiac Arrest Audit (NCAA)	N/A	Yes	100%
National Cardiac Audit Programme (NCAP)	Myocardial Ischaemia National Audit Project (MINAP)	Yes	100%
National Cardiac Audit Programme (NCAP)	National Audit of Cardiac Rhythm Management (CRM)	Yes	100%
National Cardiac Audit Programme (NCAP)	National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	Yes	100%

National programme name	Work stream / Topic name	Should we participate?	Case Ascertainment
National Cardiac Audit Programme (NCAP)	National Heart Failure Audit	Yes	100%
National Child Mortality Database (NCMD)	N/A	Yes	100%
National Emergency Laparotomy Audit (NELA)	N/A	Yes	100%
National Joint Registry	N/A	Yes	100%
National Lung Cancer Audit	N/A	Yes	100%
National Maternity and Perinatal Audit (NMPA)	N/A	Yes	100%
National Ophthalmology Database Audit (NOD)	Adult Cataract Surgery Audit	Yes	100%
National Paediatric Diabetes Audit	N/A	Yes	100%
National Perinatal Mortality Review Tool	N/A	Yes	100%
National Prostate Cancer Audit (NPCA)	N/A	Yes	100%
National Vascular Registry	N/A	Yes	100%
Perioperative Quality Improvement Programme (PQIP)	N/A	Yes	100%
Renal Audits	National Acute Kidney Injury Audit	Yes	100%
Renal Audits	UK Renal Registry Chronic Kidney Disease Audit	Yes	100%
Sentinel Stroke National Audit Programme (SSNAP)	N/A	Yes	100%
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	N/A	Yes	100%
Society for Acute Medicine Benchmarking Audit (SAMBA)	N/A	Yes	100%
Trauma Audit & Research Network (TARN)	N/A	Yes	100%
UK Cystic Fibrosis Registry	N/A	Yes	100%
UK Parkinson's Audit	N/A	Yes	100%

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

Study Title	Participation	Project Status	%
Community Acquired Pneumonia Organisational Questionnaire	Yes	Submitted	100%
Epilepsy Study Organisational Questionnaire	Yes	Submitted	100%
Testicular torsion study: Organisational questionnaire	Yes	In progress	100%
Transition from child to adult health services: Organisational Questionnaire	Yes	Submitted	100%
Crohn's Disease: Organisational Questionnaire	Yes	In progress	100%

Non-Participation/Exceptions

The National Audit of Breast Cancer in Older Patients

Outcomes and Learning from Clinical Audits Undertaken During 2022/23

The number of clinical audits both national and local which formed part of the 2022/23 Audit Plan are as follows:

Total Number of audits in the 2022/23 plan: = 363

Number of local/other audits: = 293

Number of national audits, including NCEPOD: 60

Number of audits fully completed: = 135

Some of the key learning from 2022/23 is as follows:

British Thoracic Society National Smoking Cessation Audit. The result of the audit demonstrates SFHFT have achieved a rate of 92.0% of patient notes documenting their smoking status in comparison to a national rate of 78.6%. In addition, 55.0% of current smokers being offered nicotine products to help them abstain, compared to a rate of 32.4% nationally. These results suggest that the Trust is performing better than the national average at giving patients very brief advice (VBA) and starting pharmacological treatment to help them quit smoking.

National Hip Fracture Database. The results of the report demonstrated that 94.6% of patients seen at King's Mill Hospital received a crude perioperative medical assessment within 72 hours which is above the national aggregate of 89%. The results also showed that the risk-adjusted 30-day mortality rate was also above the national average.

National Emergency Laparotomy Audit. The most recent report regarding Emergency Laparotomies carried out at the SFHFT shows that the crude proportion of cases with pre-operative documentation of risk of death is 92.3% which is higher than the national average and standard of 85%. The results also show that the risk adjusted 30-day mortality was found to be 2% compared to 6.7% in the previous round of the audit. SFHFT are performing better than the national average of 8.7%.

National Neonatal Audit Programme. Our results show that for people who deliver babies below 30 weeks gestation, and therefore should be given Magnesium Sulphate in the 24 hours prior to delivery, our performance has increased from 58.8% in 2018 to 67.7%. We have also demonstrated an improvement in the incidence of babies of very low birthweight or <32 weeks gestation who receive appropriate screening for retinopathy of prematurity, rising from 93.9% in 2018 to 100% in the November 2022 report. This is also higher than the national average against this standard of 95.1%

National Maternity and Perinatal Audit. Ethnic and Socio-economic Inequalities in NHS Maternity and Perinatal Care for Women and their Babies 2021/22. The results of the audit demonstrate differences in outcomes of maternity and perinatal care among people and their babies, when comparing those living in the most deprived households versus the least deprived households and those from ethnic minority groups versus white ethnic groups. This mirrors actions are already being reviewed and implemented by the SFHFT and include several actions already implemented to address health inequalities.

National Joint Registry. The results from the registry show that our risk adjusted 5-year revision ratios (for hips excluding tumours and fractured neck of femur), has fallen from 0.67% in 2018 to 0.5% in 2022. This pattern of improvement continues as this figure was previously 1.1% prior to 2018. This performance has been performance labelled as 'better than expected' compared to other Trusts performing the same procedures. The is also the case for the risk adjusted 5-year revision ratios (for knees excluding tumours) which has seen a fall from 1.2% in 2018 to 0.73 in 2022.

Local Audits. The reports and outcomes of 116 local clinical audits were reviewed quarterly in 2022/23 at the Improvement and Clinical Audit Group, in addition to AQP meetings.

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

Speciality	Audit code	Title	Post Project Impact/Actions
Maternity	Mat/ CA/2022-23/08	[Planned re-audit: 01/10/2022] Meconium Management Audit	The results of the re-audit have improved since the original audit: **Question 1:** 13/23 cases the Neonatal team were contacted prior to the birth but were not present at the birth. However, they were present within minutes of the birth to review the baby. Hence why the Neonatal team did not need to be contacted after the baby was born. This has highlighted the need for an additional question in the audit if the audit was to be completed again. **Question 2:** 10/23 cases a Neonatologist was not contacted prior to the birth, however, there were x7 cases where contacting a Neonatologist could not be facilitated due to the clinical circumstances (BBA x2, meconium only present during birth x2, rapid birth x3). **Question 3:** 7/23 cases a Neonatologist was present at the birth. **Question 4:** x5 cases a Neonatologist was contacted after the birth, x5 cases a Neonatologist was not contacted after the birth - unknown why- documentation does read that the baby was born in good condition and a clear management plan documented. x13 cases the question did not apply- the neonatal team did not need to be contacted after the birth as the Neonatologists were present within minutes of the birth to review the baby.
Surgery	T&O/SE/2022-23/20	Assessing the quality of surgical discharge summary in Trauma and Orthopedics	Junior doctors are constantly reminded to ensure discharge summaries are safe. The strength of these interventions will be tested by carrying out a re-audit to see if the quality of the information being recorded in the discharge summaries has improved.
Surgery	Ophth/ CA/2022-23/03	Audit of second HESP vouchers issued	The HESP second voucher issue guidelines have been updated. The patient information leaflet 'Why does my child need glasses' has been updated to include a section on 2nd vouchers so that parents/carer's are aware that a 2nd voucher may not be issued. Staff involved in issuing HESP vouchers have been reminded of the guidelines and the correct way to record in case notes. In particular, waiting until a child has been seen with glasses before issuing second set. The benefit to this is to ensure an equitable system for patients with a potential cost saving to the orthoptic budget for HESP vouchers.

Speciality	Audit code	Title	Post Project Impact/Actions
Surgery	GS/CA/2022-23/05	Oxygen Prescription in General Surgery	The first cycle of the audit has raised awareness of our compliance to oxygen prescription and the need to improve. The presentation at the clinical governance meeting also gave the opportunity to remind doctors about the need to prescribe oxygen whilst clerking patients in, in addition to patients under their care on the ward.
Clinical Support, Therapies and Outpatients	Rad/CA/2022-23/04	Re-audit: Rate of IV Contrast Extravasation in Radiology	This is a re-audit for the previous audit completed 16/11/2021.There is a considerable improvement in documentation as per the previous audit recommendations. The lead radiographers have agreed and assured, upon implementing the EEEE code in addition to liaising with radiographers in mobile CT, to ensure prompt documentation of contrast extravasation cases.
Surgery	Breast Surgery/ CA/2022-23/02	Re-audit: An Audit on margin re-excision and surgical site infection following partial Breast reconstruction with chest wall perforator flap	Very good volume replacement technique. Shorter learning curve than LD flap implant reconstruction One stage surgery Covid-19 pandemic did not affect partial breast reconstruction when implant base reconstruction were stopped Recommendations: As the margin re-excision rate was 26% in this small subgroup, a further audit regarding margins with all wide local excision patient and larger data is recommended to capture the overall margin involvement rate. A further re-audit with larger data of chest wall perforator flap in 12-18 months' time to check SSI and Margin re-excision rate remain within the national standards.
Surgery	T&O/ CA/2022-23/01	Re-audit: Standardising Venous Thromboembolism (VTE) Prophylaxis Regime for Neck of Femur Fracture.	This audit has successfully standardised VTE prophylaxis practice within our department, despite this issue being a widely contested topic for many years previously. Our quick-guide document was created with pharmacy input, making this a successful collaboration between both departments. Feedback from junior doctors has been very positive as most found this document to be easily accessible, concise, and clear. "Routine extended thromboprophylaxis choices at Sherwood Forest Hospital Foundation Trust" has been displayed around: Ward 11, Ward 12, Ward 43, DCU, Clinics, Junior doctors' office, WhatsApp group. The results showed 87.9% were discharged on enoxaparin, which is significant improvement from 1.5% previously. Results also showed there was no incidence of DVT/PE or clinically significant bleed.

Speciality	Audit code	Title	Post Project Impact/Actions
Women's and Children	Mat/ CA/2022-23/04	Re-audit: May 2022 Foetal Monitoring Audit	This re-audit has shown 8 out of 9 criteria were marked as 'Achieved'. Excellent results that demonstrate effective review, documentation, and escalation.
Surgery	ENT/SE/2022-23/01	Unilateral tonsillectomy for asymmetry: Histology outcome	As a result of this audit, imaging of patients is to be requested more frequently, with the intention to perform a re-audit at the end of 2023.

Review of 2022/23

Clinical Audit now reports directly into the AQP oversight group, which has strengthened both visibility and assurance by having bi-monthly agenda time to share outputs from the Improvement and Clinical Audit Group (ICAG). It also plays a central underpinning role in the newly launched Quality Strategy.

The governance of the audit cycle has been hampered over 2022/23 by capacity issues within the Clinical Audit team; there have been two vacancies held over 6 months which has left the team with one third of its capacity. This has impacted on the ability to curate our Clinical Audit platform and prompt colleagues to complete or to close audits, hence the current low completion rate.

This is also relevant to the capacity of the team to pull out insights from clinical audits undertaken over this period, but outputs have still been shared widely at ICAG meetings and during the annual Clinical Audit Awareness Week, which showcases examples of positive impacts on patient health outcomes and provides an opportunity for colleagues to share their stories. From January 2023, the team is now at full complement again.

Looking forward to 2023/24 we aim to:

Strengthen both the assurance and visibility of clinical audit within the organisation via the ICAG and AQP inclusion and by learning from and sharing activities on key Trust-wide themes.

The Clinical Audit team is at full capacity and will focus specifically on:

- Curating the Clinical Audit platform to ensure that audits are progressed against the timescales reported
- Stratifying actions in terms of efficacy, and closing the improvement loop with clinical colleagues
- Supporting the Antimicrobial Stewardship Trust wide audit
- In collaboration with the digital team, scope whether data can be collated automatically, to reduce the burden on colleagues.

The ambition and opportunities presented by the Improvement Faculty will amalgamate improvement, safety, governance, clinical audit, and transformation, and will provide further opportunities for aligned working towards better outcomes and learning.

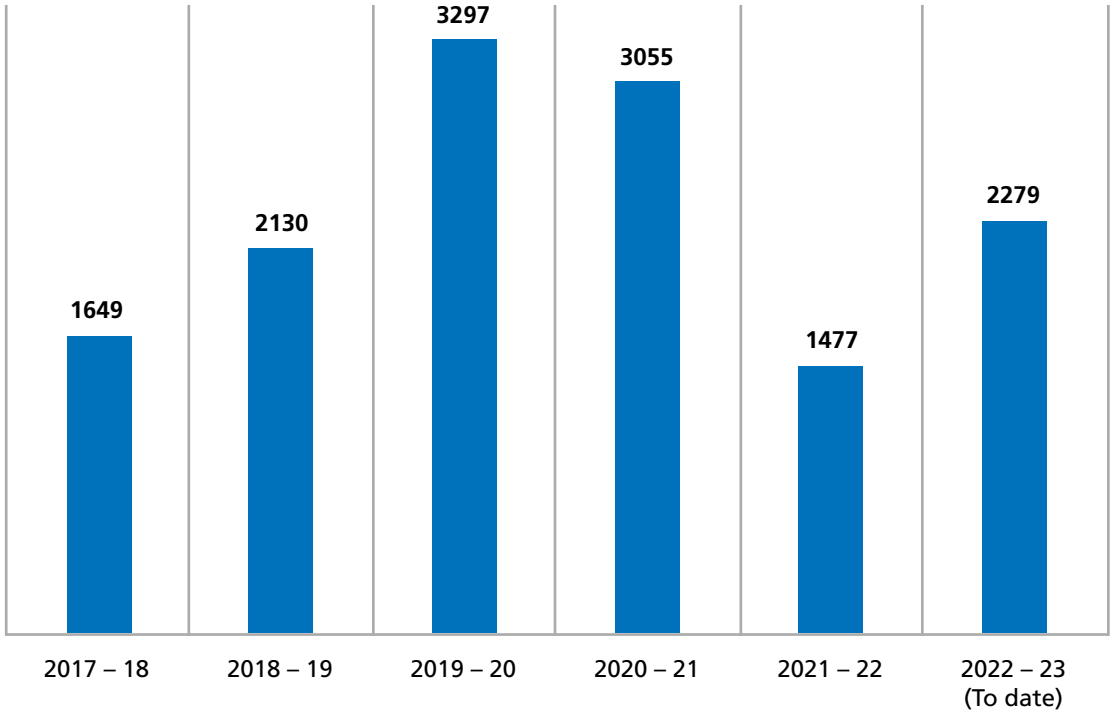
2.2.3 Participation in Clinical Research and innovation

The number of patients receiving relevant health services, provided or sub-contracted by SFHFT in 2022/23, participating in research approved by the Research Ethics Committee was 2818. This includes research involving patient data and tissue samples.

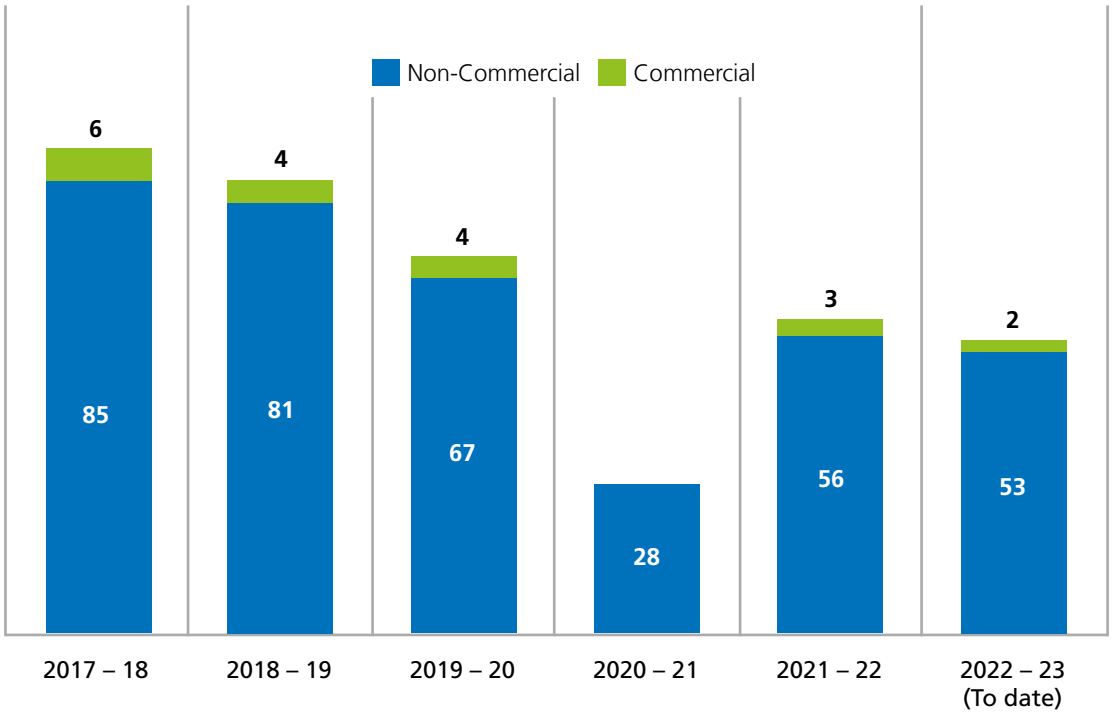
SFHFT is actively involved in clinical research and has a dedicated Research and Innovation department (R&I). The R&I department is responsible for developing and supporting a varied research portfolio and creating better opportunities for patients and staff to participate in research activity, whilst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

Historically, research activity has shown a year-on-year increase in recruited participants. However, due to the global Covid-19 pandemic, in 2021/22, SFHFT research activity focused on Urgent Public Health (UPH) studies, resulting in increased numbers of participants recruited into a smaller number of studies. In 2022/23 the primary focus has been on recovering the pre Covid-19 research portfolio. SFHFT has opened 28 new studies, recruited 55 studies across 14 specialties in the year and has recruited a total of 2818 participants into trials, exceeding the annual target of 2,200, (Graph 1).

Graph 1



Graph 2



The focus for R&I in 2023/24 is to continue growing a balanced research portfolio, including attracting increased activity from commercial sponsors, (Graph 2). The research activity will be reviewed regularly with bi-annual reporting to the Trust board and monthly reporting to divisional teams and research investigators. SFHFT also has an external reporting responsibility to the Department of Health via the Clinical Trials Platform. This is a national key performance indicator for NHS organisations.

The new R&I strategy 2022-2027, 'Research is for Everyone' sets out a clear vision to incorporate research into our daily business, realising the potential in all areas of our hospitals for the benefit of patients, staff, and our community. This includes 4 key pillars:

- Place – Investing in our research infrastructure by creating a new clinical research facility.
- Progress – Transforming our approach to managing research at SFHFT to ensure the best use of resources and to maximise research opportunities
- People – By delivering world-class research we will make it easier for people to get involved at any level
- Partnership – Ensure partnership and integrated working, key to research growth, sustainability and innovate

In 2022/23, we secured investment to transform existing space at SFHFT into a Clinical Research Facility. In 2023/24, we will open this facility and offer more patients trials of new drugs, devices, and diagnostics alongside hosting the Nottinghamshire Mobile Research Unit. We will also increase the use of digital technologies in research and use a targeted development programme with East Midlands Clinical Research Network and commercial sponsors to increase investment and research opportunities for our patients.

In the last year, we have developed and launched our joint research programme with Nottingham Trent University, "Research Communities of Practice", to support and equip our workforce with the skills they need to pursue research careers, develop projects, implement research findings, and create a unique selling point for SFHFT as an employer. We will continue this collaboration in 23/24 and work towards making SFHFT a regional centre for Nursing, Midwifery and Allied Health Professionals research.

In 2022/23, R&I also commenced collaborative working with Primary Care to support the development, operation and delivery of clinical research and training across Mansfield and Ashfield. In the last 12 months, research activity in GP Practices in Sutton in Ashfield has doubled, offering over 1000 patients the opportunity to take part in research. R&I is also working closely with research partners across the Nottingham and Nottinghamshire ICS to ensure research opportunities and engagement are offered system wide.

Research is a partnership between participant and researcher. Every year, as part of the National Institute of Health Research (NIHR) participant experience survey, we ask people who have volunteered for health research at SFHFT to tell us about their experience so we can make improvements. Our survey found that of those respondents, 96% report 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, "the nurses were kind and considerate", with another stating, "it feels good to know I am helping in research".

2.2.4 Commissioning for Quality and Innovations (CQUIN) Indicators

The Commissioning for Quality and Innovation Scheme (CQUIN) is offered by NHS commissioners to providers of healthcare services commissioned under an NHS contract. It rewards quality improvement and innovation by linking a proportion of the provider's income to the achievement of local and national improvement goals. A proportion of SFHFT's income in 2022/23 would normally be conditional upon achieving quality improvement and innovation goals agreed between SFHFT and any person or body they entered a contract, agreement, or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

SFHFT have faced significant challenges in restoring clinical activity in 2022/23 and without the ring fencing of financial support being offered to support CQUIN delivery, have not managed to achieve full compliance with delivery of the CQUINs programmes.

Four CQUINs have been delivered but have not met the national targets set by the CQUIN national team in June 2022. This has also been the experience in other acute providers mandated to deliver national CQUINs during 2022/23.

The CQUINs that were delivered and reported included:

- CCG1: Staff flu vaccinations
- CCG2: Appropriate antibiotic prescribing for UTI in adults aged 16+
- CCG3: Recording of NEWS2 score, escalation time and response time for unplanned critical care admissions
- CCG4: Compliance with timed diagnostic pathways for cancer services

CQUINs not delivered or reported included:

- CCG5: Treatment of community acquired pneumonia in line with BTS care bundle was not
- CCG9: Cirrhosis and fibrosis tests for alcohol dependent patients

The restoration of activity, significant changes in the executive and operational teams, and the unprecedented pressure on our clinical teams has meant the prioritisation patient care from our clinicians. Despite this, the four CQUINs that have been delivered, have demonstrated some improvement over the year.

A review of the challenges and barriers experienced in 2022/23 has been undertaken and a robust action plan to support CQUINs has been agreed with executive leads and divisional teams to support the successful delivery of the 2023/24 schemes.

2.2.5 Registration with the Care Quality Commission (CQC)

The Care Quality Commission (CQC) is the independent regulator for health and social care in England. It ensures that services, such as hospitals, care homes, dentists and GP surgeries provide people with high quality safe, effective, responsive, and caring, treatment and support. The CQC monitors and inspects these services and then publishes their findings and ratings to help people make choices about their care.

SFHFT is required to register with the CQC, and its current registration status is fully registered without conditions or any restrictions in place.

SFHFT has four locations registered including:

King's Mill Hospital

Newark Hospital

Mansfield Community Hospital

Victoria Health Centre

Ashfield Health Village and Hayden Road were registered during 2022/23 but are now closed

During 2022/23, SFHFT has continued its support for multiple Covid-19 vaccination centres included within its registration.

The CQC inspected maternity services at King's Mill Hospital as part of their national maternity inspection programme. The inspection involved an onsite visit on 22 November 2022 followed by interviews and high-level feedback on 23 and 24 November 2022.

This short notice, focused inspection of the maternity service, reviewed the safe and well led key questions:

Is the service Well led? The rating of well led stayed the same as 'good'.

Is the service safe? The rating of safe reduced to 'requires improvement'.

As a result of the inspection, the CQC have not change the rating of King's Mill Hospital. The rating of Outstanding remains.

Areas for improvement were identified and two actions that SFHFT 'MUST' take to comply with its legal obligations were highlighted

- SFHFT 'MUST' ensure staff complete mandatory, safeguarding and maternity specific training in line with the Trust's own target.
- SFHFT 'MUST' ensure they implement a robust system in maternity triage to include escalation process, monitoring and documentation.

In addition, three actions that SFHFT 'SHOULD' take were noted, and an action plan has been submitted:

Action taken and already completed relate to a full review of the compliance position for the Obstetric team, Midwives, Nurses and Maternity support workers. Resharing of the mandatory training workbook and guiding information, and the provision of additional courses to meet demand has resulted in all non-compliant staff now booked to attend training. SFHFT has achieved compliance with the maternity specific training.

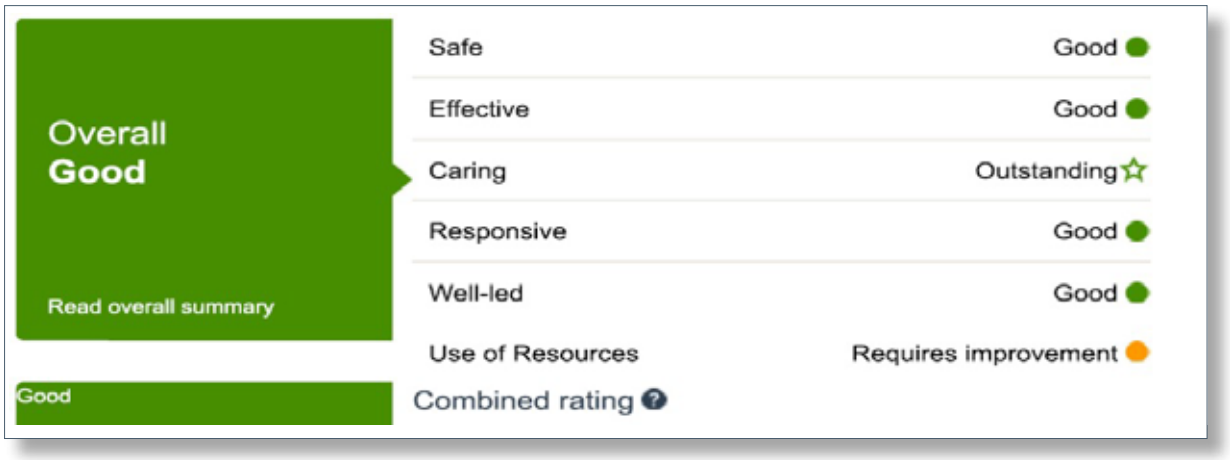
The Birmingham Symptom-specific Obstetric Triage System (BSOTS) go live date is April 2023. All standard operating policies, guidelines & polices related to BSOTS have completed the governance processes. Training and resource needs have been identified, met and additional recruitment is underway

In February 2023, SFHFT participated in and contributed to an Ofsted and CQC area Special Educational Needs (SEND) inspection that reviewed the support provided to children and young people with SEND or disabilities. The visit was not an inspection of SFHFT provision, but information gathered supported the inspectors inform their evaluation of the local area partnership.

In March 2023, the Sherwood Community Unit was assessed using the Direct Monitoring Approach (DMA) that the CQC have recently adopted. The CQC subsequently reported back that no further regulatory activity was required

SFHFT have maintained a positive working relationship with the CQC, engaging in regular meetings with the SFHFT CQC relationship owner.

The overall rating for SFHFT 'GOOD' comprises of the following ratings for each domain:



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

SFHFT submitted records during 2022/23 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

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

99.8 %for admitted patient care

99.9 %for outpatient care; and

98.2 %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

98.6 % for accident and emergency care.

2.2.7 Information Governance

SFHFT's Data Security Protection Toolkit Assessment Report overall score for 2022/23 graded the Trust as approaching standards. The Data Security and Protection Toolkit for 2022/23 included 109 items: out of 110 mandatory evidence items that meet the standards required.

Data security aims for 2022/23

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

How was this achieved?

The Data Security Team were audited by 360 Assurance (SFHFT internal auditors), who undertook a review of the standards. The overall assessment provided the Trust with substantial assurance which provides 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 2022/23, the SFHFT reported one data security serious incident, reported on the Data Security Protection Toolkit. The incident involved data integrity being compromised.

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 audit

SFHFT was not subject to the Payment by Results (PbR) Clinical Coding audit during 2022/23 normally undertaken by the Audit Commission.

SFHFT has a dedicated team of qualified and trainee clinical coders that are responsible for coding approximately 110,812 (report generated on 17/03/23) inpatient episodes for 2022/23. Coded activity data is submitted to Secondary User Services (SUS) which is used to support commissioning, healthcare development and improving NHS resource efficiency.

Clinical coding aims for 2022/23

- 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.
- Recruitment and Training: Recruit and train trainee clinical coders
- Clinical engagement : Improve clinical engagement and raise coding awareness among the junior doctors.

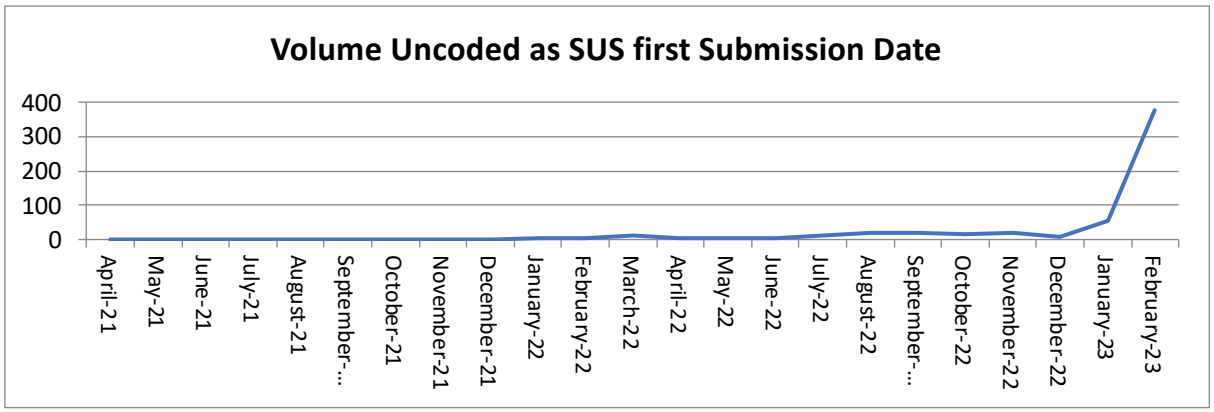
Performance against this target

The Trust has consistently achieved over 99.9% coding targets by the fifth working day after the month end.

FCE Month	1st SUS Submission date	Total Number of Episodes	Volume Uncoded as SUS first Submission Date Actual & Trajectory	Actual Uncoded %	% Total Uncoded Trajectory	% Coded at 1st Submission
Jan-22	19/05/22	9964	3	0.03%	2.0%	100.0%
Feb-22	19/05/22	9365	5	0.05%	2.0%	99.9%
Mar-22	17/06/22	10398	11	0.11%	2.0%	99.9%
Apr-22	15/07/22	9691	6	0.06%	2.0%	99.9%
May-22	15/08/22	10105	3	0.03%	2.0%	100.0%
Jun-22	15/09/22	9717	4	0.04%	2.0%	100.0%
Jul-22	18/10/22	10073	11	0.11%	2.0%	99.9%
Aug-22	11/11/22	9791	20	0.20%	2.0%	99.8%
Sep-22	15/12/22	10006	21	0.21%	2.0%	99.8%
Oct-22	18/01/23	10339	18	0.17%	2.0%	99.8%
Nov-22	16/02/23	10700	21	0.20%	2.0%	99.8%
Dec-22	16/03/23	10000	10	0.10%	2.0%	99.9%
Jan-23	16/03/23	10273	53	0.52%	2.0%	99.5%
Feb-23	16/03/23	9533	378	3.97%	2.0%	96.0%
Total		**229723**	**570**		**0.2%**	**99.8%**

The table above (Table 1) provides an indication of the volume of un-coded episodes for discharged hospital spells within each month. The first submission date and percentage of un-coded (Graph 3 on next page), will aid users on what period to select for mortality reports to ensure a more robust picture. All discharges are coded for the post PbR reconciliation deadlines and a refreshed SUS submission sent.

Graph 3



Audits

SFHFT has a coding quality assurance programme that automatically assesses clinical coding prior to monthly submission of activity data. This is supplemented by targeted audits by the Clinical Coding Auditor to improve the quality of the coded data.

SFHFT has been able to carry out several missing comorbidity audits with a limited sized due to a high level of trainee coders versus experienced coders. A small number of individual clinical coder's audits were completed in addition to a Trauma and Orthopaedic deceased review and a review on a newly introduced procedure, Endoscopic Ultrasound (EUS).

Table 2

By Area	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Clinical Coding Audit	£35,162	£32,533	£21,081	£0	£0	£0	£0	£0	£0	£0	£0	£0	£88,776
Clinician Audit	£12,691	£0	£0	£6,937	£0	£36,010	£24,781	£11,938	£26,030	£20,520	£0	£0	£138,908
Rules Audit	(£161)	£2,077	(£4,525)	£2,730	£1,672	£7,622	£22,535	£6,782	£17,318	£7,954	£0	£0	£64,002
EUS Check	£0	£755	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£755
Total	**£47,692**	**£35,365**	**£16,556**	**£9,667**	**£43,632**	**£43,632**	**£47,316**	**£18,720**	**£43,348**	**£28,473**	**£0**	**£0**	**£292,441**

Data security standard One – Data quality:

As part of Data Security and Protection Toolkit, SFHFT has undertaken an audit of 200 completed consultant episodes (September 2022-December 2022) to assess the accuracy of clinical coding. SFHFT's coding accuracy met the required standard across all four areas.

The table 3 below illustrates the clinical coding audit results compared to the recommended percentage of accuracy scores from the Terminology and Classifications Delivery Service.

Table 3	Primary diagnosis correct	Secondary diagnosis correct	Primary procedure correct	Secondary procedure correct
Standard Met	>=95%	>=90%	>=95%	>=90%
Standard Exceeded	>=90%	>=80%	>=90%	>=80%
SFH Trust	90%	93.4%	93.7%	89.9%

Recruitment and training

SFHFT has successfully recruited six trainee clinical coders to replace the six experienced coders who resigned due to higher pay band and opportunities for remote working within the Nottingham and Nottinghamshire ICS. All coders are up to date with the mandatory training requirement set by NHS Digital.

2.2.9 Data Quality Strategy for 2022/23

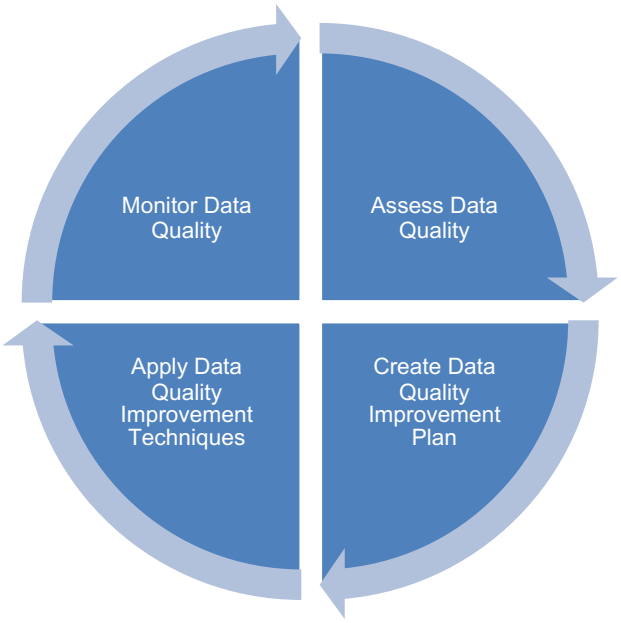
SFHFT's Data Quality Strategy aims to influence and drive improvements in outcomes for patients through effective decision making by clinical, operational, and managerial staff by ensuring timely availability of accurate and high-quality information.

Shared decision making is part of the NHS Long Term Plan's commitment to make personalised care 'business as usual' across the health and care system. Personalised care requires a whole-system approach, integrating all services around the patient and 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.

To ensure good quality data underpins the assessment of quality performance, SFHFT adhere to the six dimensions of data quality, each of which is fundamental in providing fit for purpose information and include: accuracy, validity, reliability, timeliness, relevance, and completeness.

Through the Data quality strategy, SFHFT promote a sense of accountability and commitment to the on-going improvement of the quality of the data amongst all staff handling and using data, for which they are responsible. This strategy supports a culture of 'getting it right first time' (GIRFT) regardless of job role, whether this be clinical, technical, or administrative. This will in turn releases staff time from correcting data and ensuring that patients outcomes are based on accurate information.

Our approach to improvement relies on a continual process as described in the diagram below:



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 will:

- 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 will result in informed choices on the necessary action and timescales for the Divisional Teams, supported by the data quality (DQ) team to remedy any identified issues.

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

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

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

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

Continuous improvement

Training: SFHFT develop and deliver consistent DQ training programmes for all members of staff in line with the Elective Care Training Strategy. In addition, we will provide targeted training in response to themes or repeated errors, as identified through audit, reporting or operational issues

Process improvements: Where necessary, will systematically change operational processes to maximise data quality. Any such process changes are:

- Clinically and operationally owned, designed, and supported
- Underpinned by procedural documents
- Not be to the detriment of patient care
- Reviewed in line with the action plan

Data Quality training

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

CareFlow is the Patient Administration System (PAS) used by SFHFT. Initial system training is delivered by Nottinghamshire Health Informatics Service (NHIS) trainers and is a prerequisite to obtaining access to SFHFT PAS system. SFHFT DQ trainers continue to deliver a comprehensive training plan for both DQ and Elective care.

Data Quality improvement Key Performance Indicators (KPI's)

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

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

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

Data quality internal audit programme

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

- Implement a Data Quality Assurance Indicator into the Trust Board reporting mechanisms e.g., the Single Oversight Framework process.
- 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.
- Amending documentation and delivering appropriate user awareness sessions in response to system upgrades taking place

SFHFT data quality position March 2023

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.

The Trusts' average total DQMI score has improved from 89.2% to 90.4% (as of Q3 22/23)

The percentage of records in the published data which included the patient's valid NHS number (as at Q3 2022)		
Admitted Patient Care	**Outpatient Activity**	**Accident and Emergency Care**
99.8%	**99.9%**	**98.3%**

The percentage of records in the published data which included the patient's valid GP Code (as at Q3 2022)		
Admitted Patient Care	**Outpatient Activity**	**Accident and Emergency Care**
100%	**100%**	**98.7%**

SFHFT submitted records during 2022/23 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

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

- Examine individual data items within the DQMI to identify areas that require improvement
- Develop interactive DQ exceptions reports to identify where data feeding the DQMI is 'missing' or 'incorrect'
- Aim to increase total average DQMI score to > 91%

2.2.10 Improving Care and Learning from Mortality Review

During 2022/23, 2,005 of Sherwood Forest Hospitals NHS Foundation Trust patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 443 deaths in the Q1 (first quarter)
- 440 deaths in the Q2 (second quarter)
- 551 deaths in the Q3 (third quarter)
- 571 deaths in the Q4 (fourth quarter)

By 6/4/2023, 1077 of deaths (54%) had been entered into the Trust's Mortality Review Tool (MRT) against a target of 80%. However, in 2022/23, 100% of deaths were independently scrutinised by the Medical Examiner Service.

Following scrutiny further investigation, using the Royal College of Physicians' Structured Judgement Review (SJR) Methodology was requested in 152 cases

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

- 23 in Q1
- 37 in Q2
- 18 in Q3
- 13 in Q4

Following review, overall care was found to be generally good. No death was deemed to be avoidable although free text entries did reveal a range of understanding of the concept of avoidability. Further training on completion of SJRs is planned.

Specific learning around management of falls (e.g., the importance of lying and standing Blood Pressure) was noted and communicated formally via specialty teaching, Medical grand round teaching and less formally, via staff messaging "Serious issues" WhatsApp groups.

The Medical Examiners (ME) raised concerns about cardiology cases who had been managed for Acute Ischaemic Heart problems. There was a total of five cases where concerns were raised regarding management of acute ischaemia, with three cases focussing on the Trent Cardiac pathway. Specifically, concerns centred around delays in transfers of patients' care and, following this review, this has led to important learning for our clinical teams and SFHFT as an organisation.

The ME's have seen a positive increase in clinical participation from the cardiology teams. This is evident by shared decision making, reflected in the medical files of cases scrutinised by the ME Service. There is more adherence of the DAPT (Dual Antiplatelet Therapy) protocol being used by various clinical teams in cases of acute ischaemia of the heart. This is in line with the Trust Pathways prescribed by the Trust. The pathway for referring cases to the Trent Cardiac unit in Nottingham has also been updated.

The importance of multidisciplinary 'best interest' meetings, involving relatives was highlighted. When reviewed, there were examples where care could have been better, particularly where last-days-of life care could have been expedited, but there were also examples of good recognition of dying patients with significant family involvement.

The importance of making decisions regarding escalation and ReSPECT forms (Recommended Summary Plan for Emergency Care), has been communicated and discussed via multidisciplinary team handover forums, and relayed to the admissions and ward teams.

Similar themes around capacity and decision-making were identified in feedback from external Learning from Death (LeDeR) reviews. The Chair of LFD and Learning Disability Specialist Nurse met with the Regional LeDeR team which is undergoing some significant organisational changes. SFHFT will work closely together to support them through this change.

Use of the MRT is poor and subject to significant delays. The ME scrutiny occurs almost invariably within 5 days of death and considers feedback from the bereaved. As a result, SFHFT provides a more reliable and superior qualitative source of mortality intelligence. Many of the other elements of mortality monitoring are now captured by a new Bereavement Centre database. Consequently, we believe the MRT is largely obsolete and are actively working on an alternative process which avoids duplication and can be completed in a timelier way.

2.3 Reporting against Core indicators

2.3.1 Summary Hospital Level Mortality Indicator (SHMI) banding

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

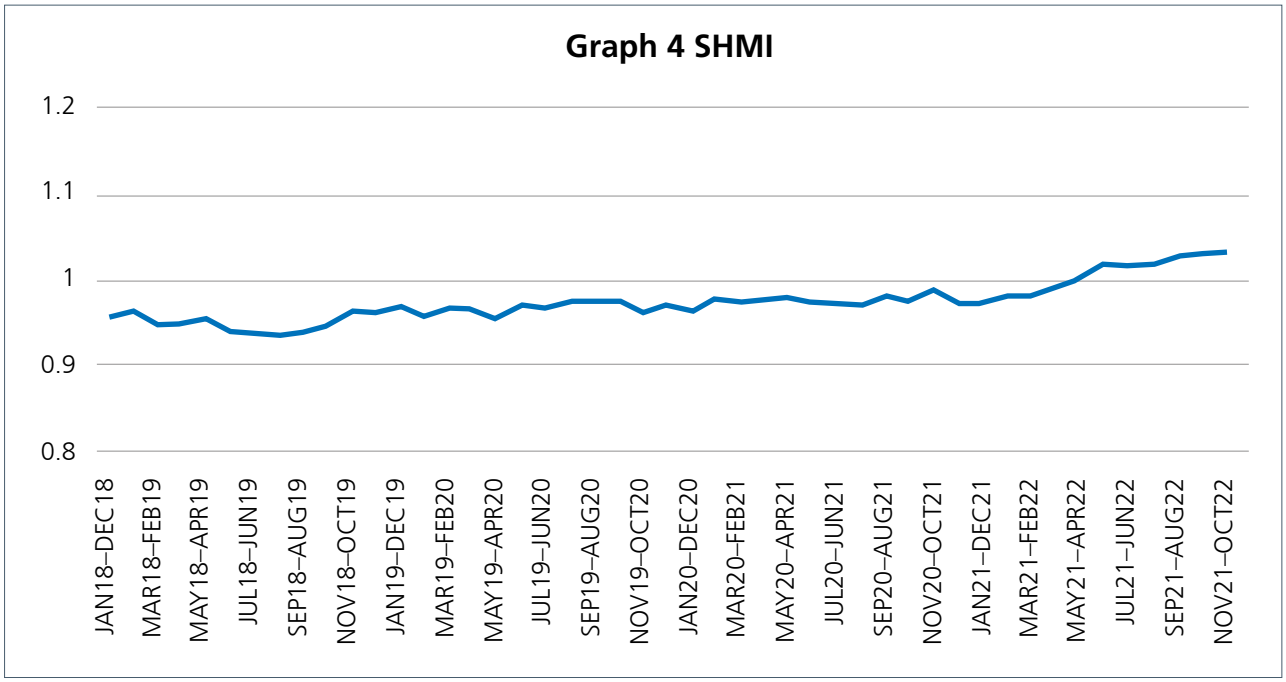
The last year's most up to date data (published March 2023) is in the table below (Table 4). This data runs 4-5 months in arrears due to handling processes.

Table 4

Reporting period	SHMI value	Banding
JAN21 – DEC21	0.9723	2
FEB21 – JAN22	0.9796	2
MAR21 – FEB22	0.9839	2
APR21 – MAR22	0.9917	2
MAY21 – APR22	1.0007	2
JUN21 – MAY22	1.0164	2
JUL21 – JUN22	1.0144	2
AUG21 – JUL22	1.0191	2
SEP21 – AUG22	1.0273	2
OCT21 – SEP22	1.0309	2
NOV21 – OCT22	1.0327	2

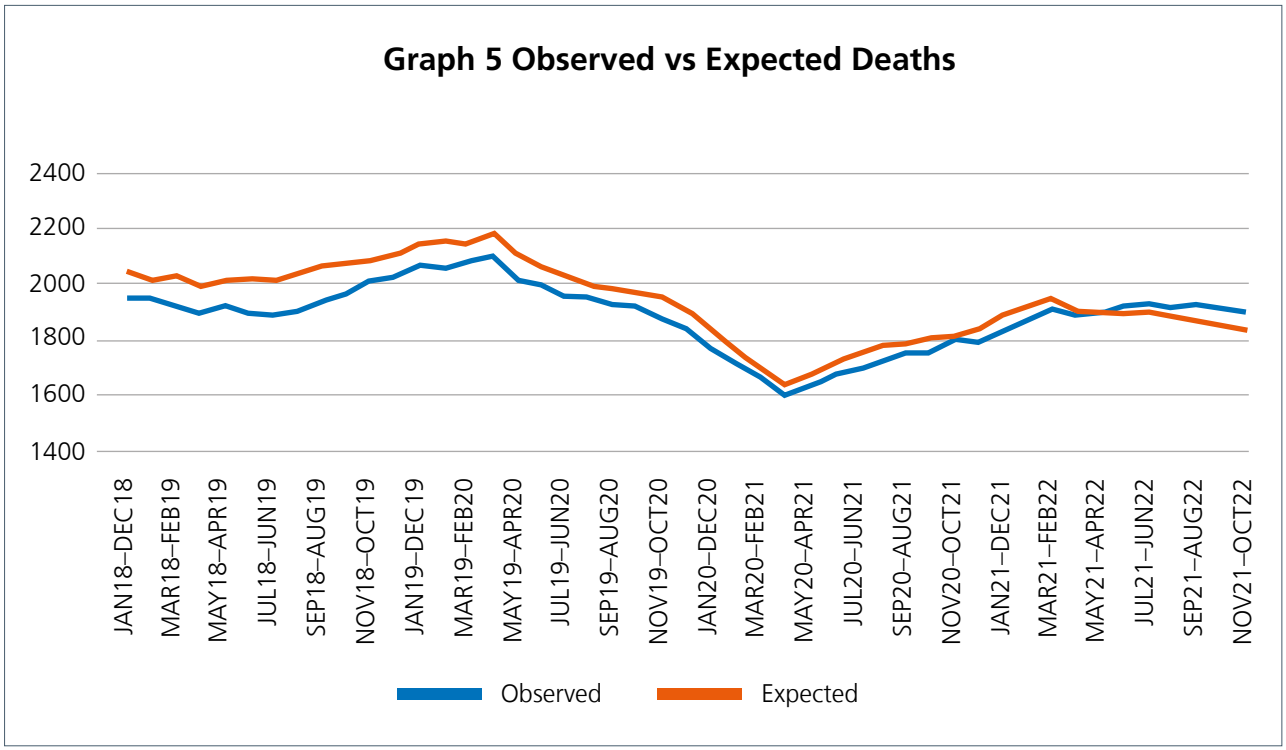
SFHFT remain "as expected" according to this metric. We are aware that within this banding there appears to be a slight upward drift in the context of the last 3 years (Graph 4).

Graph 4



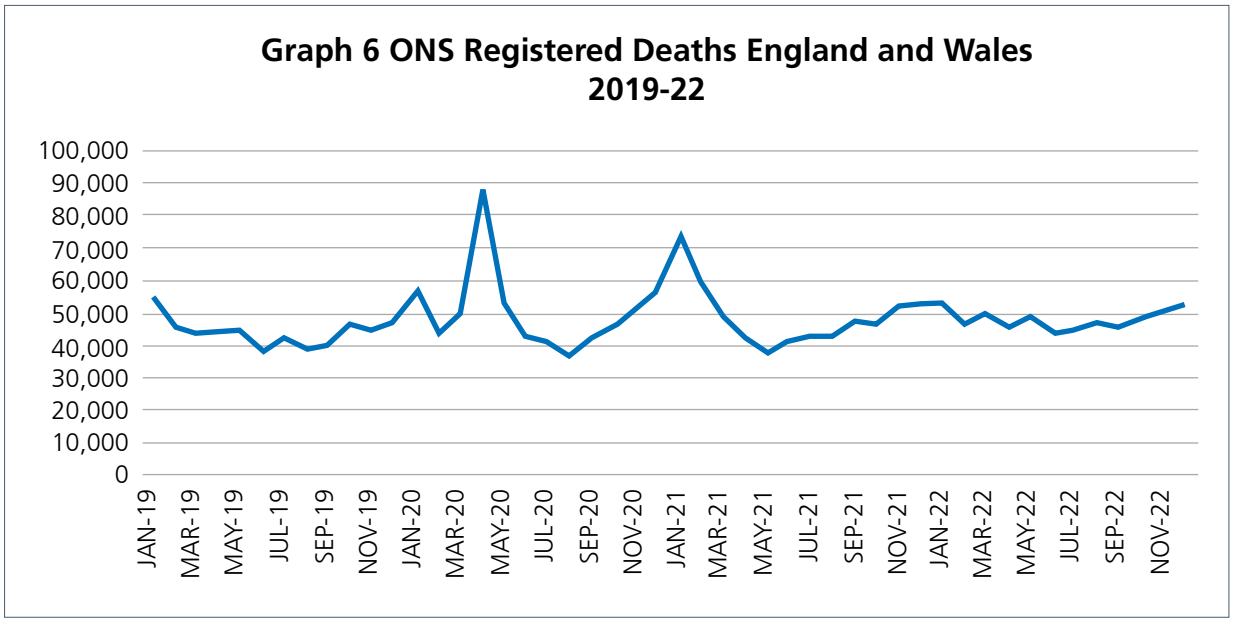
When we examine the observed and expected deaths over this period (Graph 5) we see that despite fluctuations, observed deaths are around pre-pandemic levels. Expected deaths are lower and appear to be on a downward trajectory. The point where they cross represents the time where our SHMI became greater than 1.

Graph 5



This fall in expected mortality is not consistent with our clinical experience of an ageing, multi-morbid population or the National picture which shows relatively stable mortality either side of the pandemic waves. (Graph 6)

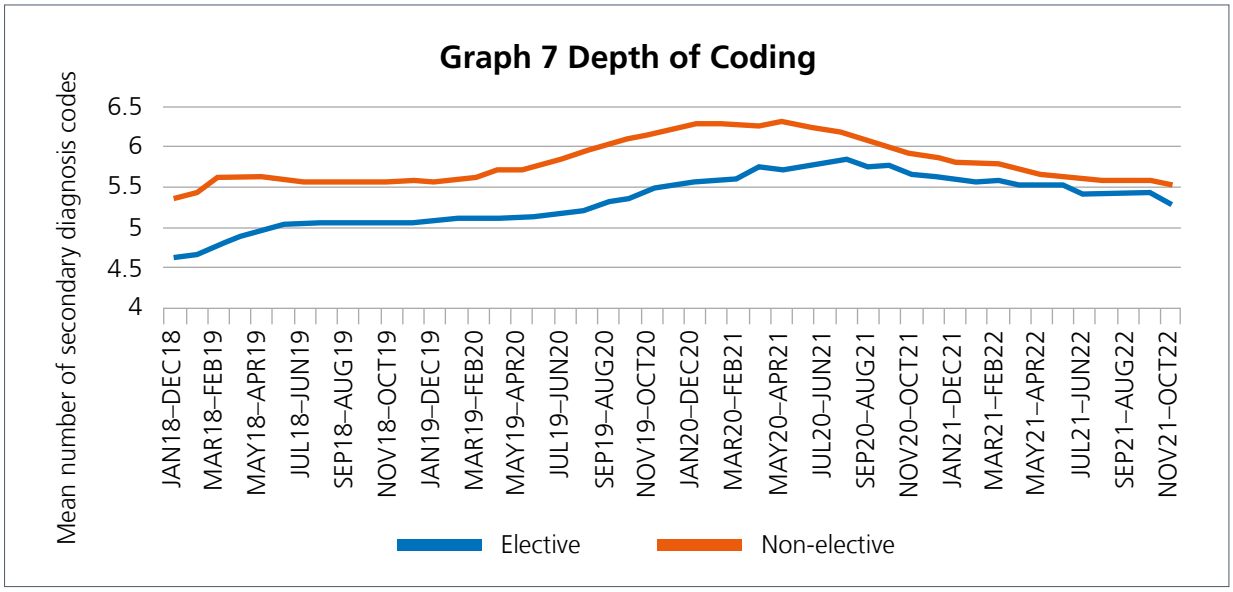
Graph 6



Source of data Deaths registered monthly in England and Wales – Office for National Statistics (ons.gov.uk).

A potential explanation for this is the clear decline in the depth of coding which can be seen in Graph 7. Which shows the mean number of secondary diagnosis codes per finished provider spell with an elective/ non-elective admission. This is consistent with concerns we have around clinical documentation which are also suggested by other mortality metrics.

Graph 7



Activity within the coding department has been externally validated and we are confident that we are capturing what is written in the notes, within the coding rules. A clinically led working group, headed by the Deputy Medical Director, is reviewing our documentation and processes to see if there is scope for improvement which could reverse this upward trend in the SHMI.

2.3.2 Patient Reported Outcome Measures (PROMS)

PROMs (data made available by NHS Digital), measures health gain in patients undergoing hip and knee replacement surgery in England, based on responses to questionnaires pre and post-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 PROMs data is usually published annually, and this quality report should be reporting on the period April 2021 to March 2022. However, at present this information is unavailable and the following statement is listed on the NHS Digital PROMs webpage:

"In 2021 significant changes were made to the processing of Hospital Episode Statistics (HES) data and its associated data fields which are used to link the PROMs-HES data. Redevelopment of an updated linkage process between these data are still outstanding with no definitive date for completion at this present time. This has unfortunately resulted in a pause in the current publication reporting series for PROMs at this time.

We endeavour to update this linage process and resume publication of this series as soon as we are able but unfortunately are unable to provide a timeframe for this. We will provide further updates as soon as this is known".

Summary of Improved health gains as reported in the 2021/2022 Quality account: April 2020 – March 2021

SFHFT benchmark incredibly well against the national average and have improved over the last few years. Last year we exceeded the national average across all three measures including: Improved health gain, Oxford Hip score and Oxford knee score.

Whilst there is currently no updated data for April 2022 to March 2023, we have continued to undertake strategies to ensure that our patients are optimised and in their best health prior to surgery. There are programmes in place to improve our patient's general health prior to undergoing surgery, through smoking cessation and gym memberships. In addition, we have re-introduced the hip and knee school post Covid-19, which had previously been very successful at educating and optimising patients ready for surgery.

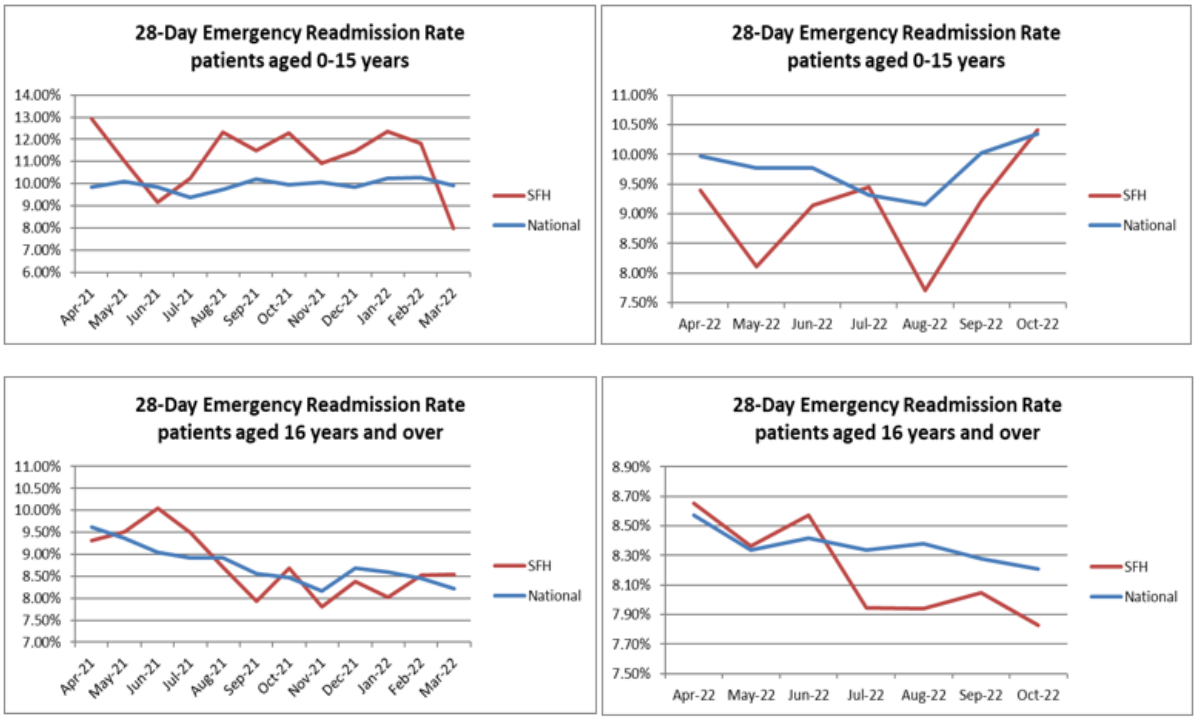
We implemented elective joint replacements at Newark hospital in line with the Getting It Right First Time (GIRFT) review outcomes. This site has a significantly lower risk of operations being cancelled and is focussed purely on elective surgery. Patient's experience improved outcomes, fewer infections and have shorter lengths of stay with targeted physio and OT support. There are plans in place to extend the number of hip and knee replacements undertaken at Newark across 2023 with the addition of a new theatre. This will enable the transfer of more elective orthopaedic work across to the Newark site. In addition, the Surgical Division will be implementing a ward reconfiguration on the Kings Mill campus which will result in a dedicated ring fenced 10 to 12 bedded ward, specifically for elective orthopaedics. This again will protect this activity and support the delivery of better patient outcomes.

We anticipate that once results are published, we should have at least maintained the previous excellent results demonstrated during 2021/2022 and expect to see further improvements through 2023 onwards.

2.3.3 Percentage of patients readmitted to hospital within 28 days

- The readmission rate for 0-15 years old has improved overall from financial year (FY) 21/22 (11.13%) to H1 (first 6 months of a FY) FY22/23 (9.07%).
- The 16 years + readmission rate has also continued to improve, from 8.74% (FY21/22) to 8.19% (H1 FY22/23).
- Both readmission cohorts compare favourably to the national performance during this period, with the 0-15 years cohort being on a par with the national trend as at Oct 22.

Data Source: Dr Foster Graph 8



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

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

2.3.4 Trust Responsiveness to the personal needs of patients

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

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

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

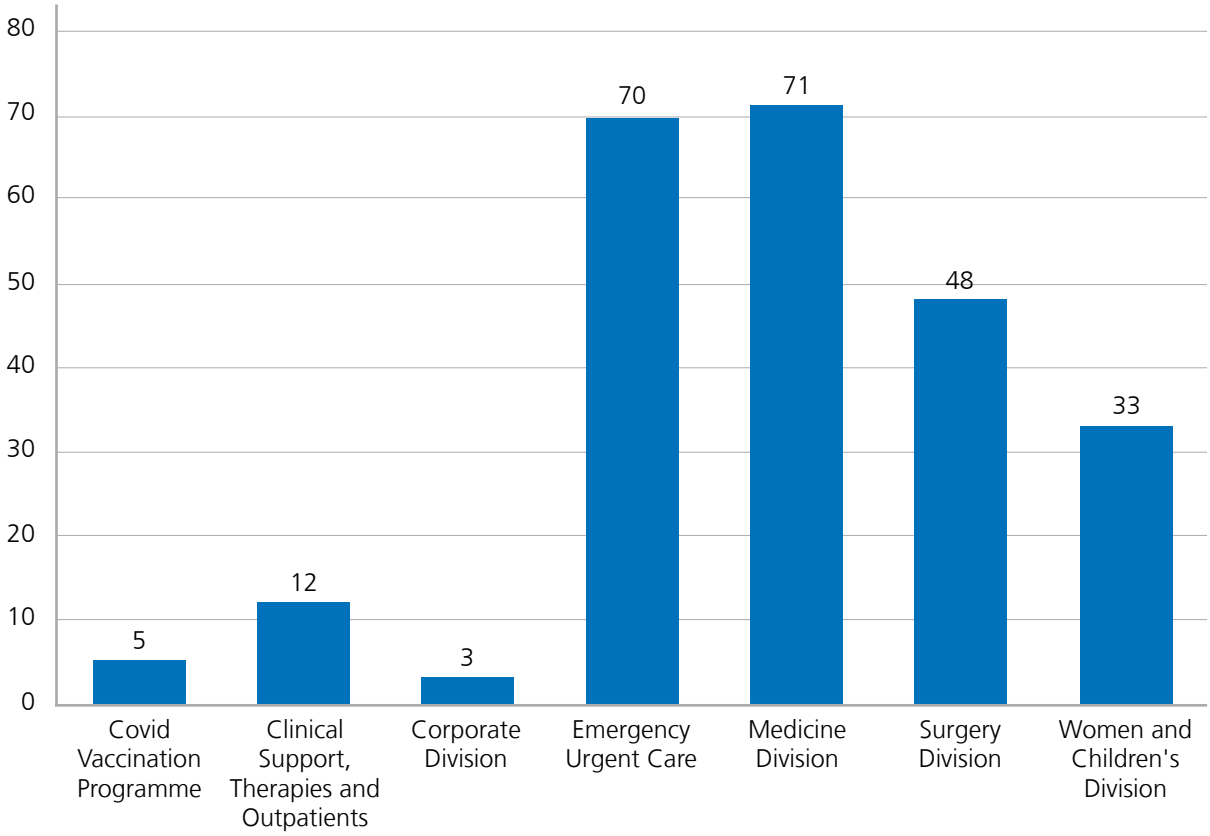
To date in 2022/23 we have received 242 complaints, demonstrating a 26% increase compared to 2021/22. Of these, 7% were completed within 25 working days or locally agreed timescales with the complainant. Whilst performance against the time frames standard was reduced, all complainants were kept updated on the progress of their complaint and a personal written apology was provided to all complainants. The Complaints team have been through a challenging time recently due to decreased staffing levels. This is making it increasingly difficult to meet the current complaint response timeframes set by SFHFT, however recruitment processes commenced in January 2023 so this is expected to improve.

The table below (table 5) shows the revised complaint timescales according to the severity of the concerns raised.

Table 5: Complaint timescales according to the severity of the concerns raised:

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

Graph 9 Complaints by Division



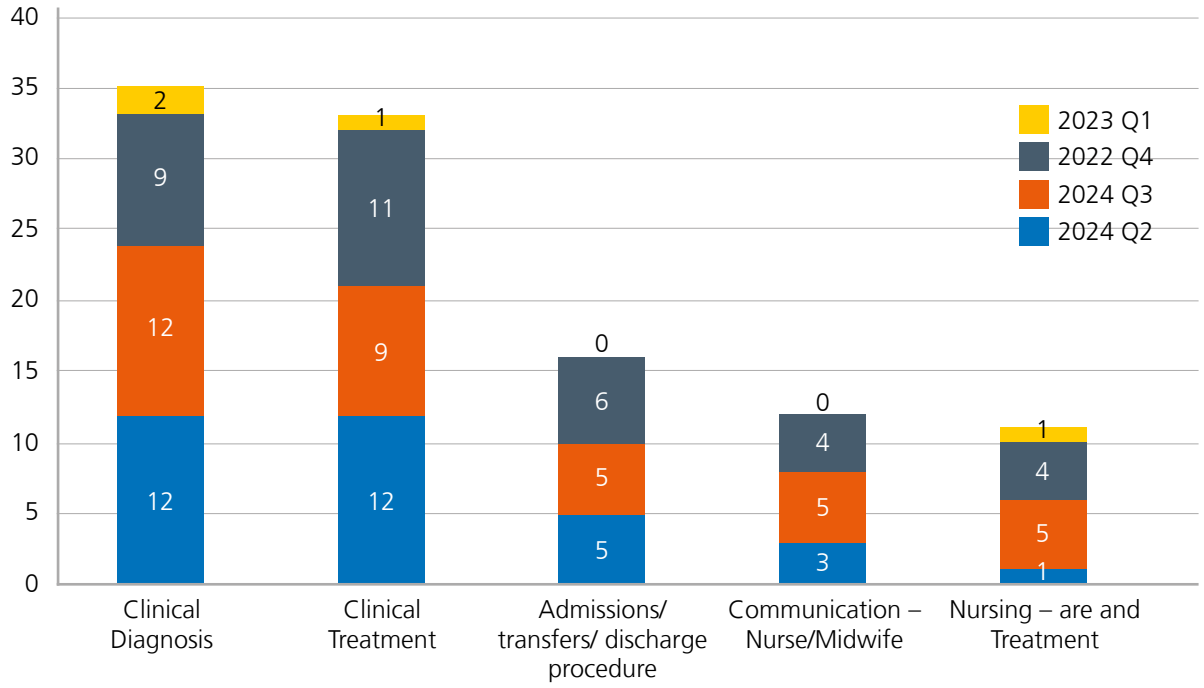
An increase of complaints relating to discharge was noted in 2022/23.

Table 6. Top five themes for complaints 2022/23

	Clinical Support, Therapies and Outpatients	Emergency Urgent Care	Medicine Division	Surgery Division	Women and Children's Division	**Total**
Clinical – Diagnosis	3	13	9	6	4	35
Clinical – Treatment	1	15	5	8	4	33
Admissions/ transfers/ discharge procedures	0	4	10	0	2	16
Communication – Nurse/Midwife	0	2	5	3	2	12
Nursing – Care and Treatment	0	2	7	1	1	11

Clinical treatment and clinical diagnosis continue to be the most frequently reported subjects of dissatisfaction. Complaints regarding attitude of doctors has been replaced in the top five themes by complaints regarding nursing care and treatment during this reporting period. (Table 6). These complaints have been triangulated, to ensure safeguarding and patient safety issues and concerns are escalated and managed via the appropriate routes, and to further analyse for themes and trends for escalation to the relevant divisions.

Graph 10 Top 5 Themes – Complaints received Quarterly by Division



Of the complaints responded to within 2022/23, 72% were upheld or partially upheld, showing an increase of 19% with previous year. This has provided an opportunity for learning and service improvements.

A total of 37 complaints were re-opened in 2022/23 because the complainant had raised additional concerns to the original complaint. This demonstrates a decrease of 82% of re-opened complaints from 2021/22. All requests are formally responded to, reiterating the options relating to the next steps, which include Public Health Service Ombudsman (PHSO), independent advocate and access to medical records procedure.

In 2022/23, the PHSO initiated 6 additional new complaints, had 5 cases currently under ongoing investigation, and had concluded 7 complaints.

The Patient Experience Team pre-empt that correspondence from the PHSO will continue to increase in during 2023/24. This is due to the backlog because of suspending investigations in 2020/21 because of the Covid-19 pandemic.

Table 7 Cases closed by the PHSO during 2022/23

ID	Division/ Specialty	Subject	PHSO Open Date	PHSO Outcome	Date PHSO Closed	Learning from PHSO
28699	Medicine	Communication	31/3/19		25/05/22	The complaints process provided flexibility in this case.
36759	Urgent & Emergency Care / Surgery	Care & treatment	28/10/20		28/5/22	Improve communication in relation to delays and investigations
27871	Urgent & Emergency Care / Medicine	Care & treatment	30/3/20		31/5/22	Ensure patients are referred for appropriate investigations/ receive medications and assessments in a timely manner. Reflect and learn from patient feedback.
43071	Urgent & Emergency Care/ Surgery	Clinical/ Discharge	19/7/22	No investigation	7/10/22	N/A
43059	Surgery	Communication (written)/ Clinical/ Diagnosis/ Waiting time	01/7/22	No investigation	24/10/22	N/A
15412	Surgery	Clinical Diagnosis	09/10/18	Partially Upheld	11/11/22	To review guidelines relating to biopsies being completed. To improve communication for patients with terminal cancer, particularly relating to financial support. Payment of £800
41031	Urgent & Emergency Care	Care & treatment	09/3/22	Upheld	16/12/22	To ensure patients are referred for appropriate investigations at the time of presentation, to avoid delays in diagnosis. Payment of £1,185

2.3.5 Staff Friends and family responses and recommendations rates

National NHS Staff Survey – 2022

Staff Experience and Engagement

The ongoing impact of the Covid-19 pandemic on our people remained evident throughout 2022/23. An important vehicle for hearing the voices of our staff is the annual National Staff Survey. Each year, SFHFT culture improvement priorities are reviewed and refreshed in line with the results from the survey, along with feedback from the quarterly pulse surveys, Freedom to Speak Up Guardians, HR workforce information and divisional feedback. Evidence from these indicate that SFHFT overall continues to have a high quality, positive culture, and where there are challenges, teams and individuals are supported to resolve these.

Engagement with colleagues continues to be a priority, with the People Directorate working closely with the Communications team to maximise internal communication channels and provide opportunities for 2-way communication wherever possible. The 2022 National Staff Survey results placed SFHFT as 1st in the Midlands (and 6th nationally) for Staff Engagement across 124 Acute and Acute Community Trusts.

NHS Staff Survey

The NHS staff survey is conducted annually.

From 2021/22, the survey questions moved to align to the seven elements of the NHS 'People Promise' and retained the two previous themes of engagement and morale. These replaced the ten indicator themes used in previous years. All indicators are based on a score out of 10 for specific questions with the indicator score being the average of those.

The response rate to the 2022/2023 survey among Trust staff was 61% (2020/21: 66%), against a national average of 44%. This was the 3rd highest response rate in the country.

2022/23 and 2021/22

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

Indicators ('People Promise' elements and themes)	2022/23		2021/22	
	SFHFT Score	Benchmarking Group Score	SFHFT Score	Benchmarking Group Score
People Promise				
We are compassionate and inclusive	7.6	7.2	7.6	7.2
We are recognised and rewarded	6.1	5.7	6.2	5.8
We each have a voice that counts	7.1	6.6	7.1	6.7
We are safe and healthy	6.2	5.9	6.2	5.9
We are always learning	5.9	5.4	5.8	5.2
We work flexibly	6.5	6.0	6.5	5.9
We are a team	7.0	6.6	7.0	6.6
Staff Engagement	7.2	6.8	7.3	6.8
Morale	6.3	5.7	6.4	5.7

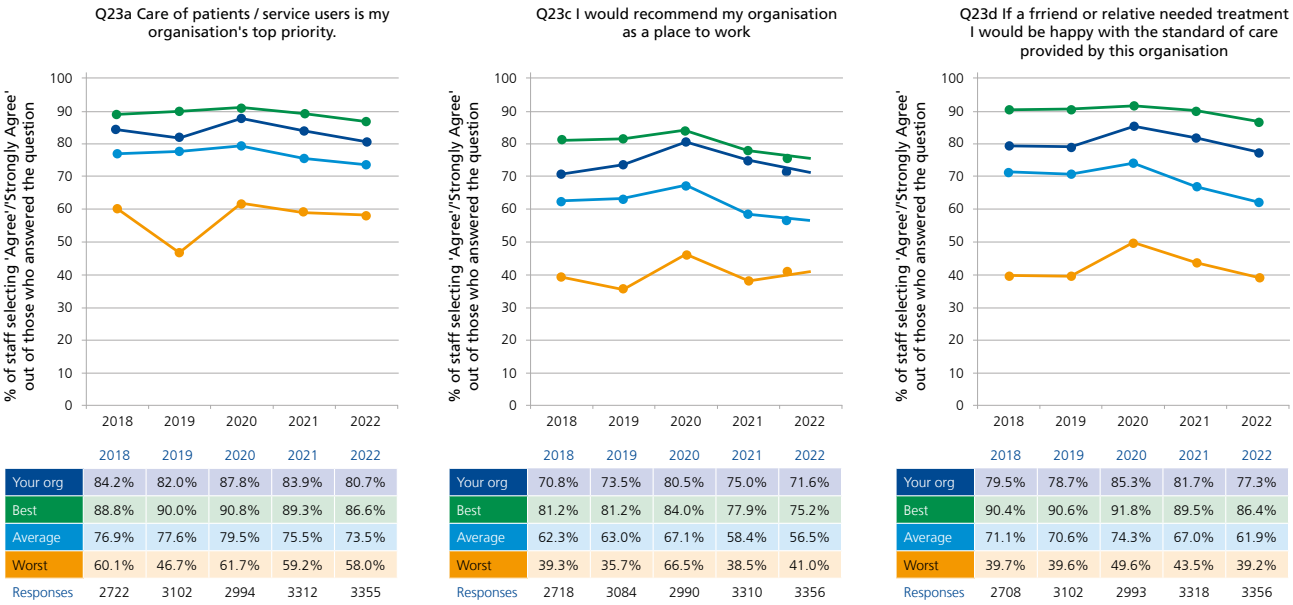
For 2022/23 our benchmarking position regionally and nationally is as follows:

Theme	National Position (/124 Acute/ Acute Community Trusts)	Regional Position (/21)
We are compassionate and inclusive	5th	2nd
We are recognised and rewarded	6th	2nd
We each have a voice that counts	3rd	1st
We are safe and healthy	6th	1st
We are always learning	3rd	2nd
We work flexibly	5th	2nd
We are a team	4th	2nd
Staff Engagement	6th	1st
Morale	2nd	1st

SFHFT is above the national average for our comparator peer group in all nine themes and is within 0.2 points of the highest achieving organisation in eight out of these nine themes.

The graph below (graph 11) summarises the SFHFT 2022 National Staff Survey results for three key questions:

Graph 11



	2018	2019	2020	2021	2022
Your org	84.2%	82.0%	87.8%	83.9%	80.7%
Best	88.8%	90.0%	90.8%	89.3%	86.6%
Average	76.9%	77.6%	79.5%	75.5%	73.5%
Worst	60.1%	46.7%	61.7%	59.2%	58.0%
Responses	2722	3102	2994	3312	3355

	2018	2019	2020	2021	2022
Your org	70.8%	73.5%	80.5%	75.0%	71.6%
Best	81.2%	81.2%	84.0%	77.9%	75.2%
Average	62.3%	63.0%	67.1%	58.4%	56.5%
Worst	39.3%	35.7%	66.5%	38.5%	41.0%
Responses	2718	3084	2990	3310	3356

	2018	2019	2020	2021	2022
Your org	79.5%	78.7%	85.3%	81.7%	77.3%
Best	90.4%	90.6%	91.8%	89.5%	86.4%
Average	71.1%	70.6%	74.3%	67.0%	61.9%
Worst	39.7%	39.6%	49.6%	43.5%	39.2%
Responses	2708	3102	2993	3318	3356

Whilst it is important to note that scores across these questions declined again in 2022/23, this was a national theme. From a benchmarking perspective, SFHFT still performs very favourably. For the fifth year running, SFHFT scored the highest score as the most recommended Acute Trust to work for in the Midlands and was the overall the third best Acute or Acute/Community Trust in England for which we are very proud.

SFHFT intend to take the following actions in 2023/24 to improve these results and in doing so, improve the quality of the services we provide by:

Continuing our actions for improvement under our 3 commitment themes.

- Valuing You
- Caring about You
- Developing You

Priority Area	Executive Lead	Timescales
Overarching		
To engage with the Divisions on a regular basis using a culture heatmap approach to celebrate successes and focus collaborative support to areas in need	Director of People/ Chief Operating Officer	Ongoing
Valuing You		
Focussed programme of work to attract and retain people to work at Sherwood – 'Step into the NHS'	Director of People	Ongoing
Roll out workforce strategy to maximise recruitment and retention opportunities	Director of People	Ongoing
Continue to provide a people focussed employee support service embedding the Just and Restorative Culture principles to reduce absence from work	Director of People	Ongoing
Refresh reward and recognition offer to ensure staff feel valued and recognised paying particular attention to long service and retirement acknowledgement	Director of People	Launch offer Q1 2023
Update Trust engagement calendar and ensure clarity over events occurring each month sponsored by relevant Executive Directors as required	Director of People/ Director of Strategy and Partnerships	Update and review monthly
Caring about You		
Violence and Aggression Task and Finish Group re-launched, and areas of focus reframed in-light of most recent NSS results with primary aim to reduce experience of Violence and Aggression from Patients, Carers and the Public	Chief Nurse/ Director of People	From Q1 2023
Continue to roll out breakaway and clinical holding skills training courses to better protect staff	Director of People	Ongoing
Introduce TRIM programme to support debrief after traumatic incidents	Director of People	Q2 2023
Continue to review wellbeing offer to ensure it is agile in its approach to what matters most to people	Director of People	Ongoing
Civility, Respect and Kindness working group has merged with Just and Restorative Culture group to continue, and reframe areas of focus in light of most recent results	Director of People	Ongoing
Develop specific offer to fragile teams identified in culture heat map exercises with support from OD, Wellbeing, People Partner Team and others	Director of People	Q2 2023
Continue to engage with EDI Staff Networks to feedback Staff Survey Results and co-create actions for improvement to tackle issues of poor EDI experience	Director of People	Ongoing
Further embed Trust anti-racism strategy and continue targeted zero tolerance campaigns to expand to an 'anti-hate' strategy	Chief Executive/ Director of People	Ongoing
Developing You		
Support career development and talent recognition across all services and SFH workforce, including review of appraisal process and documentation	Director of People	Q2 2023
Improve sense of belonging across the administration professional group through the admin transformation programme	Director of People/ Chief Operating Office	Ongoing
Introduction of Leadership Development Strategy	Director of People	Q2 2023

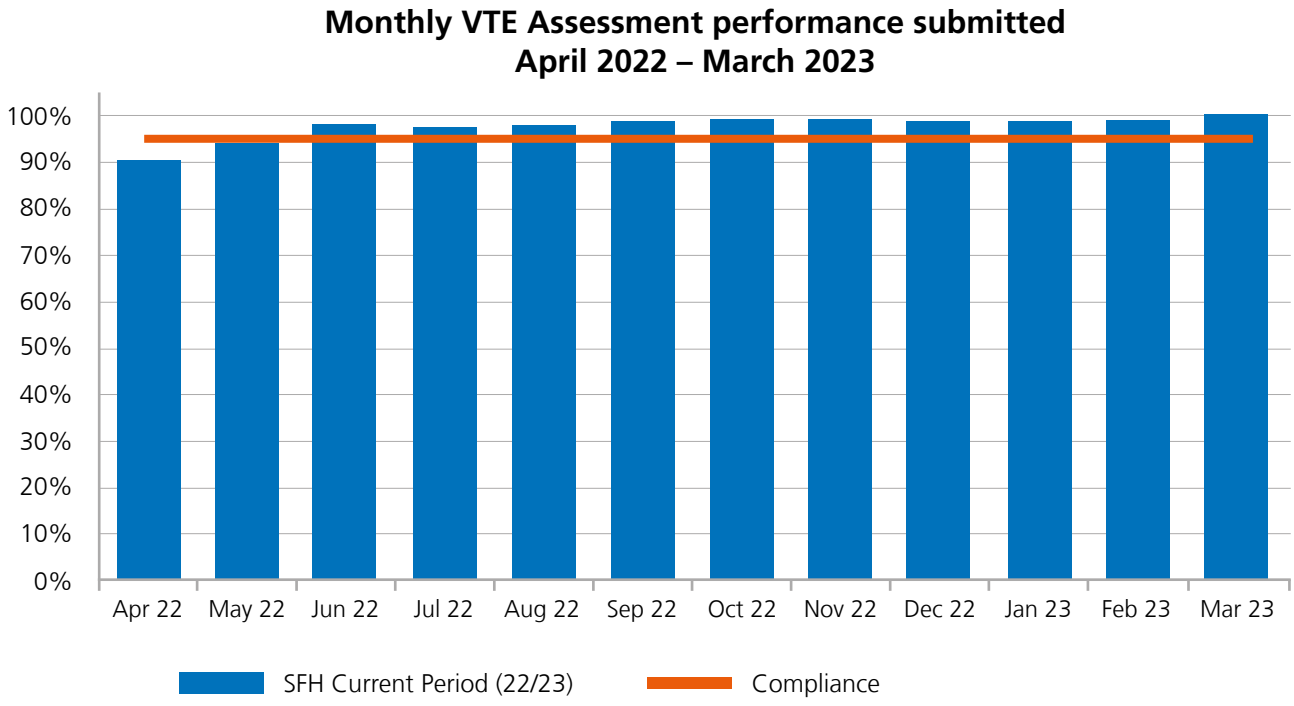
2.3.6 Venous Thromboembolism (VTE)

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. At SFHFT, collection of data is a manual process requiring time on the wards, gathering the risk assessments for analysis. Due to the infection control constraints during Covid-19, normal practice had to be suspended at the beginning of 2022/23 period and different ways of data collection identified and tested. The resultant dip is seen in the usual compliance rates.
- The roll out of an electronic, mandatory VTE screening tool on the Nerve Centre system has been implemented in addition to the roll out of Electronic Prescribing and Medicines Administration (EPMA). 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. To validate the data, manual collecting is continuing alongside the electronic version, consisting of checking patient notes for completed VTE risk assessments.
- Additional actions are in place and consist of reviewing patients who have a potential or confirmed VTE to identify if there were any missed risk assessments.
- SFHFT can report there has been no hospital acquired deep vein thrombosis incident identified yet during this period. There are 42 investigations still ongoing pertaining to this period.
- National performance figures are no longer collected.

Graph 12



2.3.7 Clostridium Difficile Infections

Clostridioides Difficile infection (CDiff) is acknowledged as an issue that impacts upon the whole health economy. There continues to be a partnership approach to this across the Health Economy. The definition of an SFHFT acquired case changed in 2019/20 and SFHFT is now responsible for any case identified more than 2 days after admission and, any case where the patient has been an inpatient at SFHFT within the preceding four weeks, known as Community Onset Hospital Associated (COHA). The trajectory for 2023 has been set at 93. CDiff cases have been raising regionally and nationally over the past year and there are now regional task and finish groups have been implemented to help drive improvement.

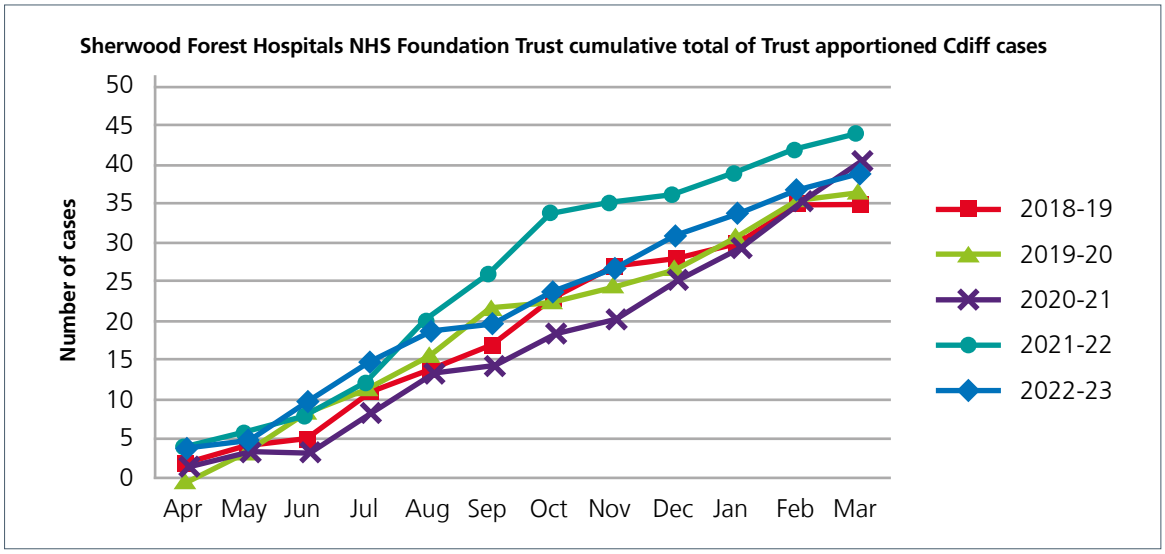
SFHFT aims for 2022/23 are outlined below:

- 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 93.

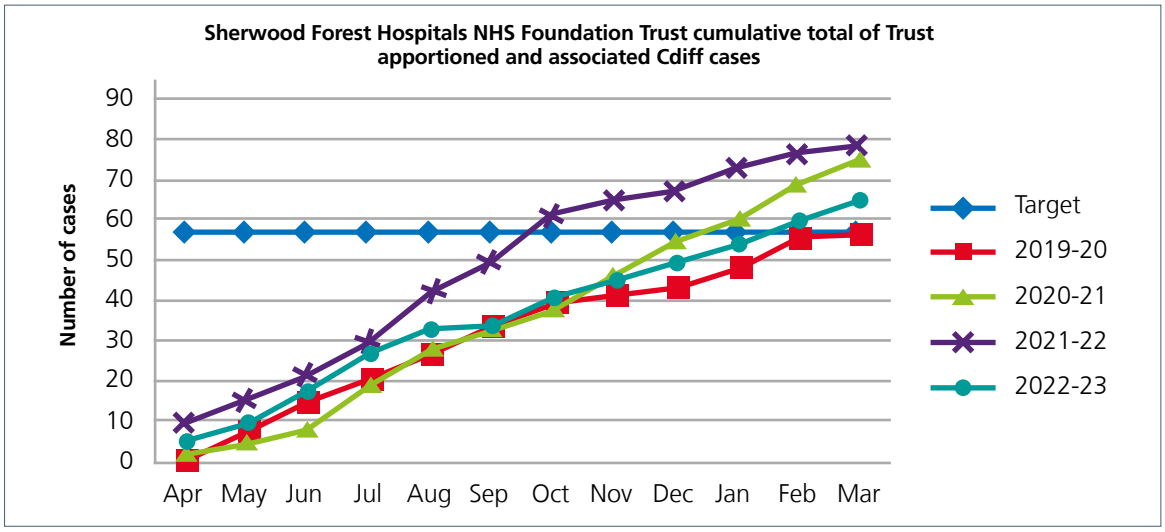
How was this achieved?

In 2022/23 the numbers of cases identified as post two days of admission were 39, (excludes COHA's). (Graph 13). The total number of cases identified including the COHAs is 65, this is a significant reduction on the 78 cases identified in 2021/22. (Graph 14).

Graph 13



Graph 14



A root cause analysis of all cases was performed to establish any common themes and to help identify if cases were avoidable or unavoidable. There have been no links established to identify any cross transmission or outbreaks. 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.

Patient management is a core element of improving patient outcomes following a diagnosis of CDiff infection and reducing the risk of onward transmission. It is closely monitored by the Infection Prevention & Control Team (IPCT).

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:

- Development of a CDiff e-learning course
- Learning boards have been developed to share learning across the organization
- Re-introduction of the deep clean program, without the ward move.
- Development of CDiff awareness month.
- Continuation and expansion of the bed decontamination services

Cleanliness

The standard of cleaning is fundamental in reducing the risks of transferring CDiff. The IPCT continue to work with Medirest, Skanska, SFHFT colleagues and commercial companies to improve the consistency of the cleaning processes throughout the organisation, ensuring all staff are aware of their responsibilities. SFHFT have now implemented the new National Standards of Cleanliness.

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. Themes have been identified and work undertaken to review and manage those actions both in the immediate and for future planning.

The trajectory for 2023/24 has not yet been set. Monitoring will continue through the Infection Prevention and Control Committee.

2.3.8 Patient safety Incidents

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

Any incidents that affect patients are graded according to the Data Quality Standards (2009), published by the National Reporting and Learning System (NRLS) and, along with all other types of adverse incidents, are reported and investigated using the Trust's Datix Risk Management System.

All patient safety incidents recorded by SFHFT are reported to the NRLS on a regular basis. The NRLS publishes an annual report which provides information on the quantity and types of reported incidents, comparing SFHFT with other non-specialist acute trusts.

During this reporting period the design and frequency of NRLS reports has changed from bi-annual to annual in preparation for the launch of Learning from Patient Safety Events (LFPSE). When launched this will replace NRLS. There is no longer any analysis to indicate how well a Trust is reporting. The data is delayed and the most up to date data is detailed below.

Table 8 demonstrates the comparative level of patient safety incident reporting within SFHFT compared with other non-specialist acute providers.

Table 8

	Sherwood Forest Hospital Foundation Trust			All non-specialist acute providers
Period	**Number of incidents uploaded to NRLS from SFHFT**	**Number of incidents reported by NRLS**	**Rate per 1,000 bed days, reported by NRLS**	**Median average rate per 1,000 bed days**
1st April 2019 – 30th Sept 2019	4,190	4,083	40.82	Report indicates 'No evidence for potential under reporting'
1st Oct 2019 – 31th March 2020	4,457	4,388	44.58	Report indicates 'No evidence for potential under reporting'
1st April 2020 – 31st March 2021	8,040	7,387	47.2	Data extracted from NRLS organisational data workbook
1st April 2022 – 31st March 2023	10618	9540 (excludes March as this month is not yet published)	39.21 (based on number of incidents reported)	

Level of patient safety reporting

From the 1 April 2022 to 31 March 2023, SFHFT declared a total of 36 Serious Incidents in accordance with NHS England's Serious Incident Framework (May 2015). Of the 36 Serious Incidents, 1 was deemed to be a Never Event.

All Serious Incidents are investigated, and action plans developed to mitigate the risk of recurrence. Identifying and disseminating the learning arising from incidents in order to improve patient safety remains a key priority. Monthly incidents reports, detailing immediate actions taken, are provided to the Patient Safety Committee, Quality Committee, and all maternity serious incidents (SIRIs) requiring review are routinely shared with Trust Board.

Duty of Candour

SFHFT continues to be open and honest with patients, their relatives and carers following serious concerns or incidents related to care and treatment provided.

To enhance this process, SFHFT has invested in the role of a Family Liaison Officer who will assist in further developing and improving the process in relation to the information and updates provided to the patient, their relatives and carers following an incident.

PART THREE

Other Information – additional quality priorities

3.1 Safety – Improving the safety of our patients

Aims for 2022/23

- To re-commission a Trust-wide Safety Attitudes Questionnaire and build on the baseline established by PASCAL
- To optimise colleague psychological safety by developing a standardised platform and approach for any colleague to access psychological support following human-facing incidents at work
- Continue preparations for Patient Safety Implementation Framework (PSIRF) implementation, including patient safety syllabus education and Human factors training. Strong links between Governance and Service Improvement are essential to this work.
- To ensure that service users are actively engaged within all key safety meetings at SFHFT

Performance against this Target

- The contract with PASCAL having ended, SFHFT has moved to the SCORE safety culture survey provided by www.safeandreliablecare.com

Schwartz rounds continue under the portfolio of the people and wellbeing lead. Following work undertaken by a Chief Nurse Clinical Fellow, funding for training of Trauma Risk Management (TRiM) practitioners has been approved to support staff involved in safety incidents

- Good progress continues towards the implementation of PSIRF by the September 2023 deadline. Formal incident investigation and oversight training has been commissioned from an approved NHSE provider (MedLed - with whom we have successfully worked previously) and is scheduled to be delivered in June and July 2023. Following review of a wide range of safety intelligence, our Patient Safety Incident Response Plan (PSIRP) will be presented for approval to the SFHFT and Integrated Care Boards in May 2023. The PSIRP will describe our priorities for incident response allocation of our governance resources according to those priorities, together with a description of the Patient Safety Incident Investigations (PSIIs) and alternative response models which are available within PSIRF. PSIRF investigations are focussed exclusively on learning and the PSIRP describes how the PSIIs will fit in with other required responses for patients (Coronial, complaints, claims etc) and Staff (debriefing, psychological support as outlined above)
- The Sherwood Improvement Faulty opened on 4th May 2023, combining the complementary skill sets and work of the Project management, Transformation, and Improvement Teams. Governance and Safety colleagues have been involved in the formation of this initiative, as designing and delivering achievable action plans, will be a key part in responding to the findings of PSIIs and other leaning from safety incidents. Previously this has been challenging to evidence.
- Job descriptions for Patient Safety Partners (PSPs) have been finalised and response has been positive. Interviews are planned for May 2023.

Aims for 2023/24 include:

- Meet the PSIRF implementation deadline
- Appoint and incorporate PSPs into key safety/ governance committees
- NRLS and STEIS reporting systems will be discontinued. The replacement Learning from Patient Safety Events (LFPSE) platform is proving challenging to NHSE and digital provider (Datix etc) we will continue to work with these stakeholders to migrate to this.

3.2 Safety – Reducing harm from falls

Aims for 2022/23

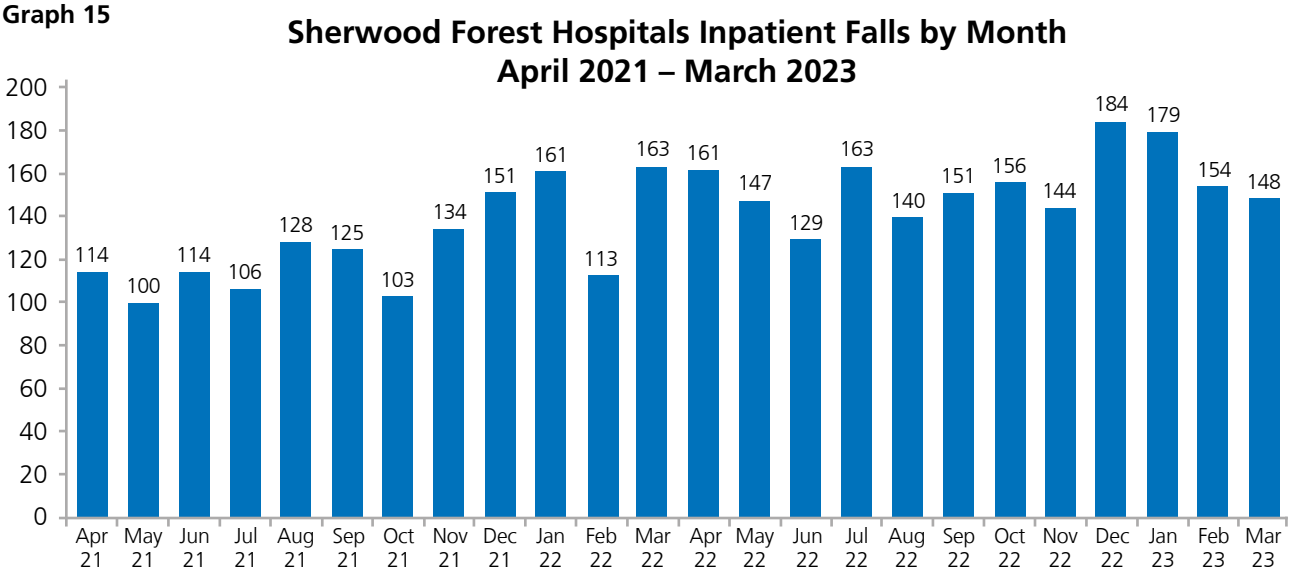
- Month on month review, report and share giving assurance to SFHFT and the wider health community that reducing inpatient falls is of high priority in line with the Royal College of Physicians (RCP) ambition of 6.63 per 1,000 bed days
- A multidisciplinary approach that mitigates risk of falls and harm from falls.
- Reduce deconditioning through promoting a hospital that encourages safe and early mobility at every opportunity as a priority
- Working together with our community partners, we will further develop opportunities and pathways that will encourage our patients and population to be active, strong and maintain independence.

Performance against this Target

Reducing harm from falls is identified as a quality priority in line with the Quality Strategy (2022-2025). Our ambition, as a Trust, is to be below the RCP ambition for falls of 6.63 per 1,000 Occupied Bed Days (OBDs).

Graph 15 demonstrates the percentage of falls calculated by 1,000 Occupied Bed Days (OBDs) as per the National Audit of Inpatient Falls (2015) criteria. Currently, SFHFT performance at year end for , 2022/23 indicates falls / per 1,000 OBDs exceeds this target.

Graph 15



How was this achieved

Falls mitigation and improvement is guided by recommendations contained in the SFHFT Multi-Disciplinary Falls Prevention and Post Fall Strategy, supported by the Falls and Mobility Group Meetings. The strategy outlines best practice approaches for mitigating falls in the hospital, including implementing standard falls prevention strategies and identifying falls risks. The National Audit for inpatient Falls have provided assurance that we are compliant with all national recommendations, including falls mitigation and post fall actions/support.

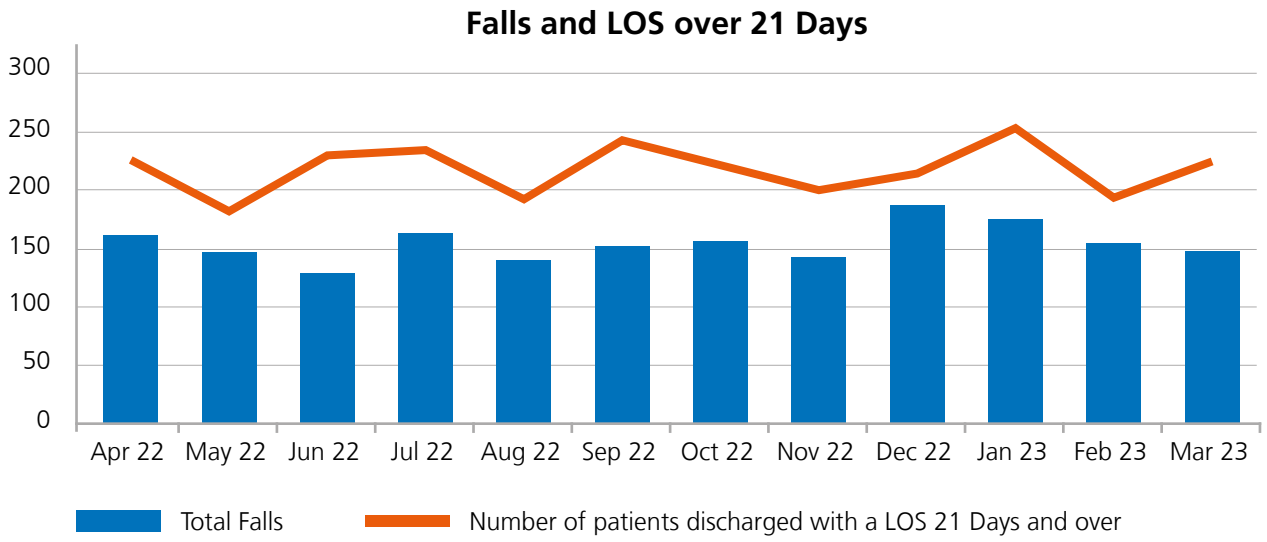
Whilst the risk of falls in our hospitals can never be removed fully removed, actions can support reducing the risks. Staff at SFHFT are committed to do all they can to mitigate against falls and encourage early and safe mobility.

Staff are reporting incidences via Datix, with quality and accuracy, which allows for shared learning and further mitigation. In year changes have been made to the Datix platform to further improve and enhance the reporting of and investigating falls.

Patients are encouraged to maintain and gain independence utilising mobility and functional activities, to improve strength, balance, engagement and resulting in a reduced incidence of falls.

In 2022/23, there has been an increase in complexity of acute admissions. People are being admitted who are already deconditioned, as a result of reduced activity levels and social isolation, in the aftermath of the Covid-19 pandemic. Alongside significant challenges faced within the whole health and social care system, to navigate an effective discharge once medically optimized, these people have had to remain in acute hospital care for protracted periods of time. There is a correlation between our incidences of falls and length of stay data, and we have reviewed the evidence to affirm that as length of stay increases so does the incidence of falls.

Graph 16



Whilst we have not seen the desired reduction in falls, we have seen significant improvements in mobility of patients and confidence in our functional assessments to promote early mobility. We have developed a community of practice (COP) internally with colleagues, to connect our resources, to include falls, moving and handling, enhanced patient observations, delirium and dementia care and have further developed our champions role.

Our COP for falls and physical activity across Nottingham and Nottinghamshire has continued to evolve over the year, collaborating with partners, enhancing networks and resources to encourage people to remain active and live well. The COP vision is to realise the impact of meaningful conversations and create actions supporting re-conditioning and falls prevention in every aspect of the patient pathway. Linking the connections between health, leisure, and sport, the COP aim to promote the benefits of strength, balance and activity across the whole lifetime, resulting in our local population living stronger, happier, healthier lives.

Within SFHFT, we continue to promote and monitor mobility to reduce deconditioning, improve functional outcomes and falls mitigation via:

- Education, promotion and visual information for staff, patients and carers' to address the importance of regular mobility.
- Embedded movement and mobility care plans for all inpatient areas and Improved partnership working and reporting of incidences with all Health Professionals within SFHFT.

Continue to reduce falls with harm

We are committed to continuing to reduce all falls, whilst continuing our commitment to encourage our patients to mobilise and be as active as their capability allows.

"If we risk nothing our patients risk losing everything"
"mobility saves lives"

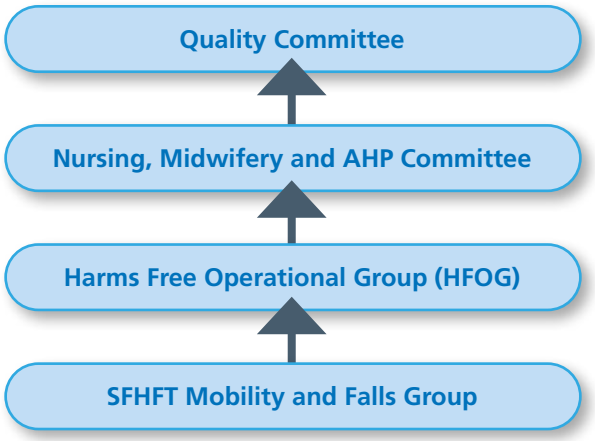
We saw a high incidence of falls with severe harm in December 2022, 5 were reported and verified. Our low harm and moderate harm falls remaining consistent with little variation, and our catastrophic harm falls remaining at 0. During this period, SFHFT was under unprecedented clinical pressures and went into protracted period of critical incident, over 3 episodes that was declared by the organisation and the wider health community system.

Table 9

In-patient Falls by severity of harm						
	Grade 1 – No harm falls	Grade 2 – Low harm falls	Grade 3 – Moderate harm falls	Grade 4 – Severe harm falls	Grade 5 – Catastrophic harm falls	Total
Apr-21	88	26	0	0	0	114
May-21	70	30	0	0	0	100
June-21	81	32	0	1	0	114
Jul-21	88	16	0	2	0	106
Aug-21	95	32	0	1	0	128
Sep-21	105	18	0	2	0	125
Oct-21	89	14	0	0	0	103
Nov-21	112	20	0	2	0	134
Dec-21	128	23	0	0	0	151
Jan-22	132	25	2	2	0	161
Feb-22	91	22	0	0	0	113
Mar-22	131	31	0	1	0	163
Apr-22	130	28	1	2	0	161
May-22	121	23	1	2	0	147
Jun-22	108	19	0	2	0	129
Jul-22	136	27	0	0	0	163
Aug-22	119	19	1	1	0	140
Sep-22	127	23	0	1	0	151
Oct-22	139	16	0	1	0	156
Nov-22	122	21	0	1	0	144
Dec-22	154	25	0	5	0	184
Jan-23	152	26	0	1	0	179
Feb-23	137	16	0	1	0	154
Mar-23	110	37	0	1	0	148

Monitoring and Reporting for Sustained Improvement

In 2022/2023, falls and mobility performance was reported through the SFHFT mobility and falls group.



Monthly data and performance is distributed to matrons and ward leaders and objectively monitored via monthly ward assurance meetings. The ward and department audit results are shared and communicated to the full team. Progress is continually reviewed, and robust systems are in place to celebrate good practice and challenge and educated on poor practice.

In our multidisciplinary commitment to reducing falls, mobility and falls data is a standing agenda item (safer mobility and falls) and is shared at the monthly at the Therapy speciality governance forum.

Aims for 2023/24

- Continue to promote and embed a culture of activity and mobility of our inpatients, reducing deconditioning.
- Scope how we capture harms from immobility and make it our ambition that no patient is harmed secondary to immobility.
- Further develop and celebrate the work of our adult critical care team, especially with respect to early mobilisation pathways.
- Reduce falls in our emergency and short stay areas, introduction of THINK YELLOW

- Maintain investment in additional falls prevention practitioner post to support across our site, wards and departments.
- Strengthen leadership through dedicated matron support.
- Relaunch and rename SFHFT's falls and mobility steering group, to Physical Activity and Falls Committee (PAFC) with multidisciplinary attendance and a updated terms of reference for 2023/2024
- Continue to take a lead role in developing further the falls and physical activity COP across Nottingham and Nottinghamshire.

3.3 Safety – To reduce the number of infections

Aims for 2022/23

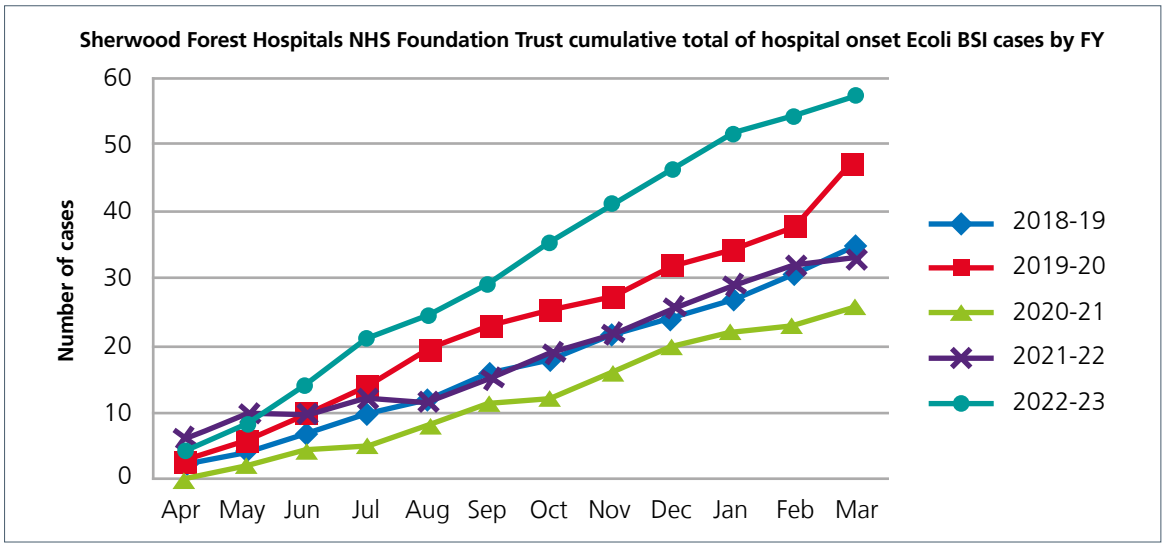
- To improve practice standards in use of invasive devices including urinary catheters and cannula
- To achieve the new Clostridium Difficile (CDiff) Infection target
- To reduce the number of all hospital associated infection cases

Performance against this target

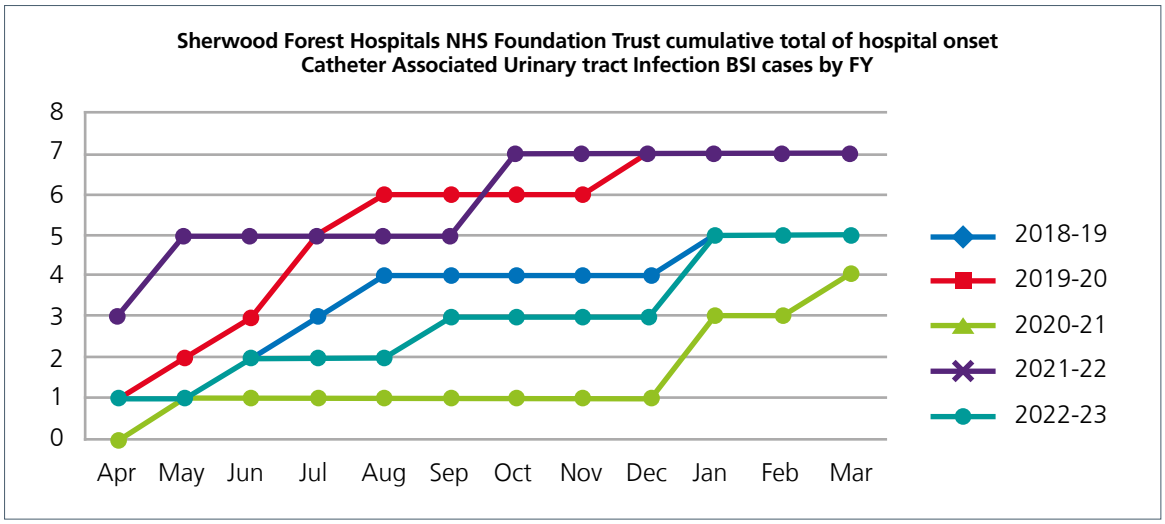
Below is a summary of the performance against the aims outlined above:

- Nationally there is a focus on the reduction of gram-negative blood stream infections (GNBSI) with an ambition to reduce these by 50% across our ICS system by 2024. The main causative organism is E.Coli. There was a national trajectory set for each organisation and the SFHFT target for 2022/23 was 95. This trajectory included all Trust associated cases including Community Onset Hospital Associated (COHA), not only hospital acquired. SFHFT breached this target by 2 cases ending the year on 97. During 2022/23 there has been an increase in the number of SFHFT acquired cases compared with 2021/22, (Graph 17) This increase in EColi bacteremia has not impacted the number of Catheter-Associated Urinary Tract Blood Steam Infections (CAUTI) we have seen as this has decreased this year (Graph 18).
- The second gram negative trajectory is for all Klebsiella species blood stream infections and the SFHFT trajectory was 23. We achieved a total of 21 for the year, below target. 12 COHA's and 9 Trust acquired cases. (Graph 19)
- The third gram negative trajectory is for all Pseudomonas aeruginosa blood stream infections and SFHFT Trust trajectory was 10. SFHFT breached this target with a total of 13 for the year, 9 COHA's and 4 Trust acquired cases. (Graph 20). A deep dive was carried out to review each of these cases, but no themes or connections were identified. As with all other NHS acute organisations, SFHFT target for MRSA blood stream infections was zero. SFHFT breached this target with a total of 3 for the year, with the last one being in July 2022 (Graph 21). Each case was investigated and all 3 were identified as having had previous histories of MRSA and were related to devices and wounds.
- We also monitor and report our MSSA blood stream infection cases nationally, although we do not have a trajectory set for this, SFHFT have identified 20 Trust acquired cases in 2022/23, this remains static with 2021/22 data (Graph 22).

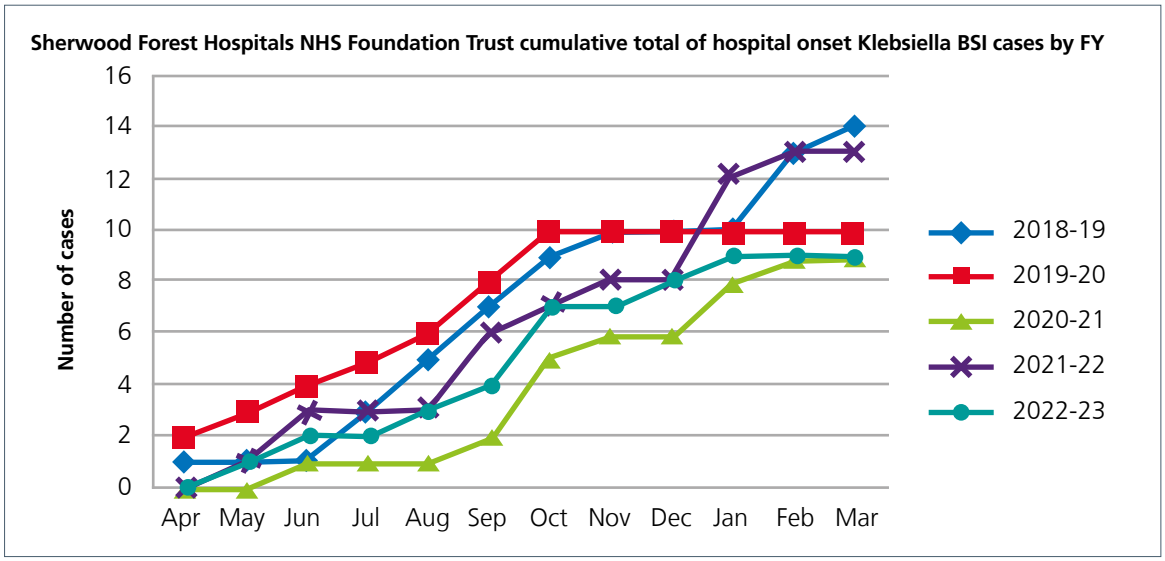
Graph 17



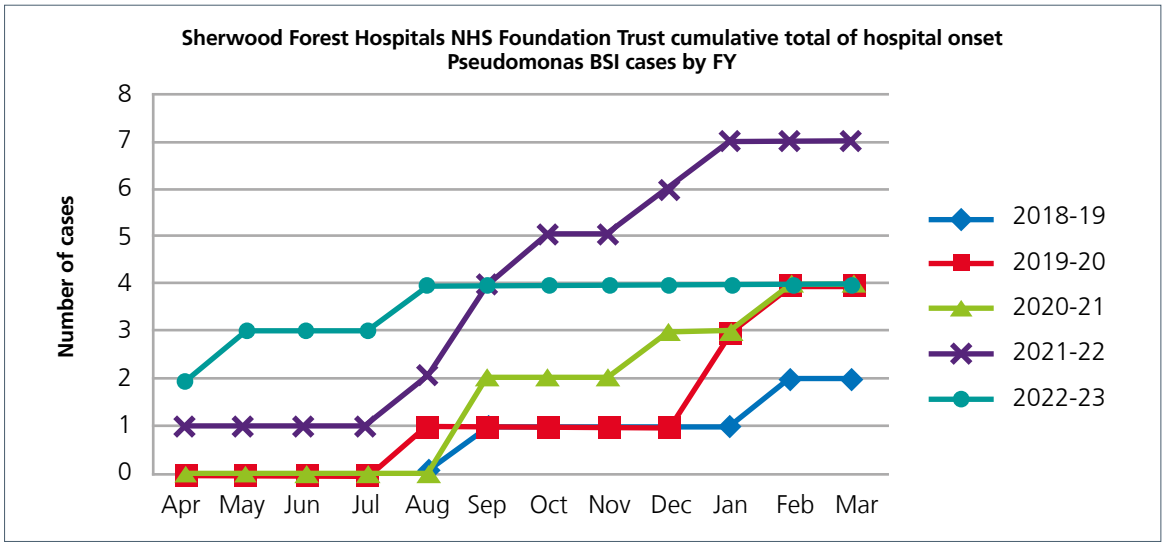
Graph 18



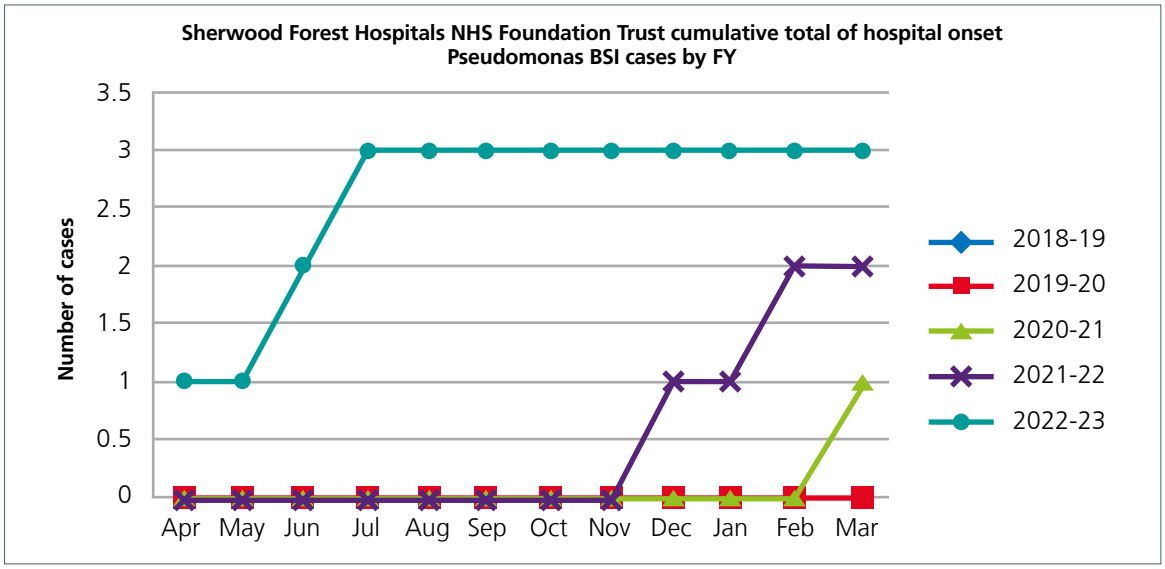
Graph 19



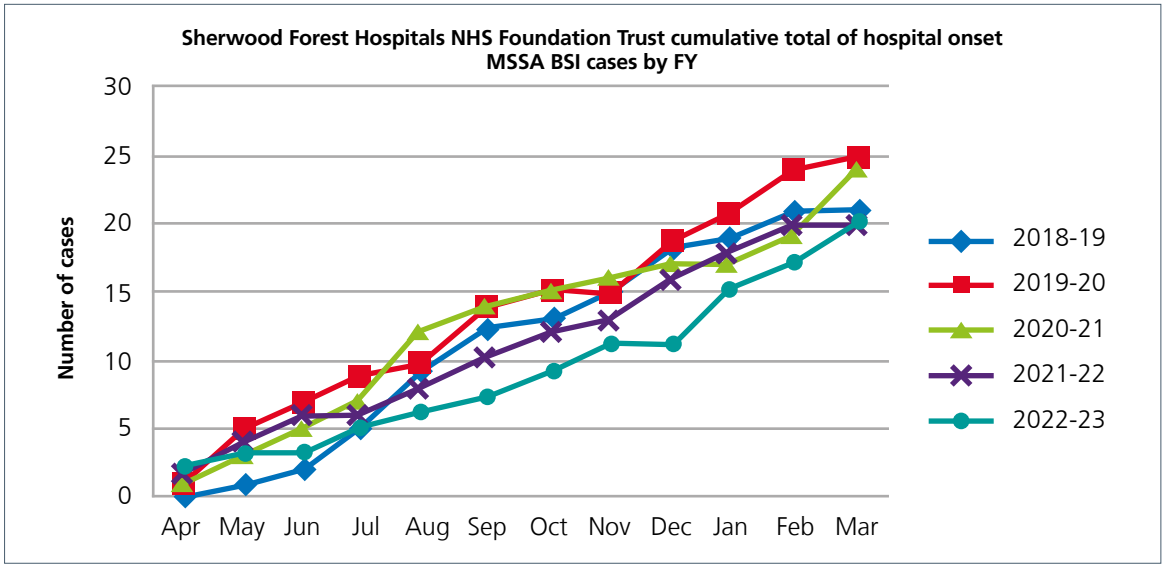
Graph 20



Graph 21



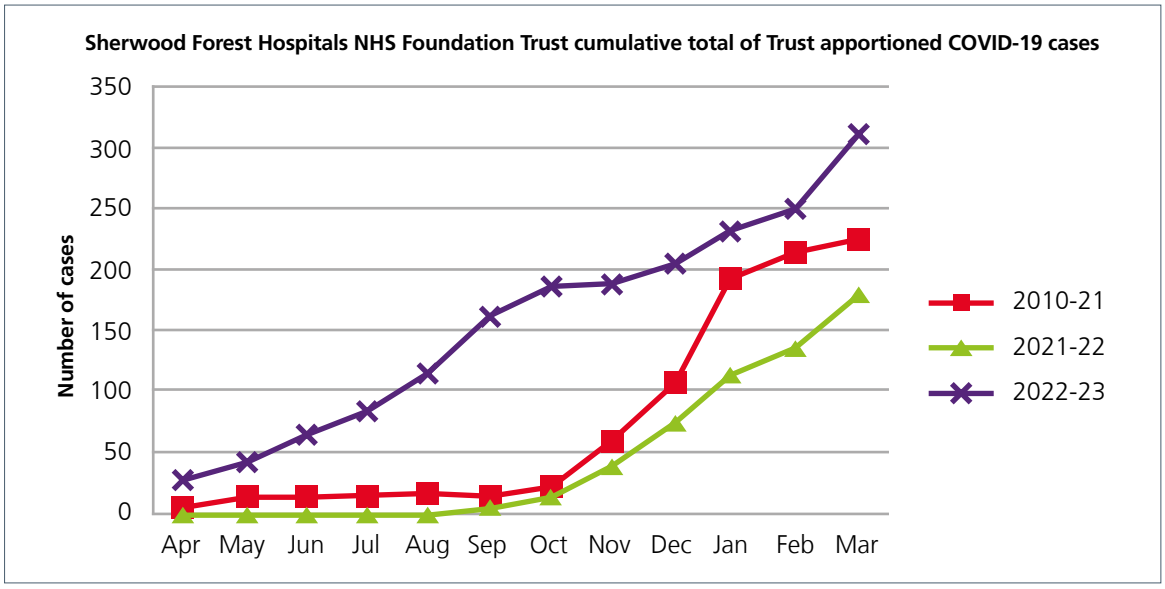
Graph 22



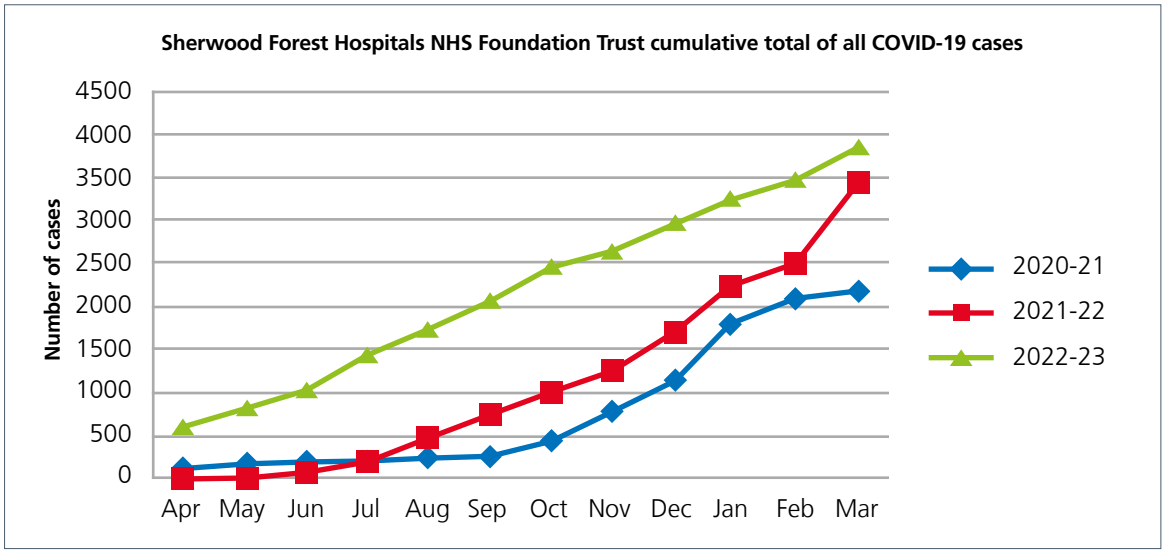
Covid-19

During the Covid-19 pandemic there have been many changes in national guidance both in hospitals and in the community. SFHFT have complied with national guidance and made changes as required and been monitoring cases closely. During 2022/23, we identified the highest number of Covid-19 cases, compared to the previous 2 years, and in line with that, the highest number of probable and definite hospital associated cases as shown in Graphs 22 and 23.

Graph 22



Graph 23



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

- A Root cause analysis has been completed for most cases
- Changes to IPC training to include more face-to-face training sessions has been implemented
- Monthly campaigns and newsletters have been developed
- Attendance at regular meetings with NHSE/I and UKHSA to monitor outbreak progress
- Regular monitoring of screening compliance

Monitoring and reporting for sustained improvement

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

Information on infection rates is available publicly via UKHSA via the link https://fingertips.phe.org.uk This website provides data against which SFHFT can evaluate performance against the national dataset.

What do we aim to achieve in 2023/24?

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

3.4 Effectiveness – Improving the effectiveness of Discharge planning

Aims for 2022/23

- Nervecentre is a software application linking aspects of healthcare across SFHFT including observations, escalations and key discharge information. For the next stage of its development, it is intended to allow full access to the community partners. This will allow them to review and input onto Nervecentre which will provide real time updates for the wards.
- Implementation of a true Discharge to Assess (D2A) pathway where patients can be discharged within 4-24 hours of them being Medically safe for discharge (MSFT).
- To provide an integrated workforce, providing both acute and community services, (a wraparound service).
- To support clinical divisions with the introduction of criteria-led discharge and fully embedded in 2022.

Performance against this Target

- Nervecentre - Through the development a read only access, has been achieved for Social care services and Nottinghamshire Healthcare Trust. Full access has not been completed at this time.
- D2A has not been achieved in its entirety due to lack of domiciliary care in the community. Covid-19 has been a contributing factor to this.
- A workforce change has now been completed and we are working towards a fully integrated discharge model
- The Criteria-Led Discharge policy has been reviewed and updated

How was this achieved

- Though collaborative partnership working with Social care services and Nottinghamshire Healthcare Trust.
- A comprehensive dashboard was developed which allowed the referrals to come directly through to the Integrated Discharge Assessment Team (IDAT) from all areas.
- Nervecentre has allowed a full audit trail of referrals and metrics regarding all pathways and Length of stay (LOS).

Aims for 2022/23

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

3.5 Effectiveness – Improve the care and learning from Mortality Review

SFHFT recognises that learning from the care given to patients in their final days of life, enables identification of excellent care delivery, in addition, identifies opportunities for learning and improvement and will improve the standard of care for all patients.

The National Guidance on Learning from Deaths (LFD) is now well embedded across SFHFT. SFHFT has a mortality review process, supported by the Trust Learning from Deaths Group (LFD).

The Royal College of Physician's Structured Judgment Review (SJR) methodology remains the preferred vehicle for conducting a more in-depth mortality review, if indicated by the initial Mortality Review Tool. The purpose of the SJR is to identify possible lapses in care and offer opportunities for learning and improvement. Any review that has necessitated a further avoidability assessment is presented to LFD group for independent scrutiny and discussion.

Aims for 2022/23

The Trust planned to focus on mortality within specific services and continue to develop the SJR methodology. After work in 2022/23 to improve the methodology and increase engagement within the Trust, it is the aim of the LFD group to continue to develop the processes to complete more robust SJR's, resulting in more widespread learning resulting in, improved patient care. This will be strengthened in 2023 with the introduction of the new Mortality Tool Module from Datix IQ.

Performance against the Learning from Deaths Standard

A 'Learning from Deaths Report' is presented to the Board of Directors quarterly with an annual report summarising both compliance against the standard of reviewing >90% of all deaths and the subsequent learning themes identified.

How was this achieved?

The standard for completing a review within six weeks of a death remains a significant challenge for some specialties, particularly those where high numbers of deaths occur. The significant operational pressures experienced this past year, have also put additional pressure on maintaining this standard. This has been identified by SFHFT as an area for improvement. The 2022/23 reporting period did see a small improvement but due to clinical pressures, this was lower than expected. In 2023/24 the expectation is that we will achieve a significant improvement and resolutions of the challenges faced in some specialties.

Monitoring and reporting for sustained improvement

The LFD group has continued to work closely with each division to support the overall mortality review process. SFHFT received regular intelligence from 'Dr Foster' – who provide the external view of the Trust mortality position.

The LFD group has met monthly where performance against the specific mortality indicators are monitored for achievement and sustainability; however the key focus of the group is on the learning and improvement opportunities identified through the review process.

Aims for 2023/24

The focus for 2023/24 will be on the further development of the mortality agenda at service level. The support from 'Dr Foster' will be reconfigured to work more closely with individual clinical teams, supporting them to understand where the mortality agenda fits into the care they deliver.

Since 1 April 2022, it is now statutory for the medical examiner (ME) service to review community deaths alongside Trust deaths. This had been delayed from 1st April 2021. The ME service is developing plans to meet this requirement with the aim of liaising with the key community stakeholders, working towards achieving compliance by the end of the 2023/24 reporting period.

3.6 Effectiveness – Improve the experience of patients who are coming to the end of their life

Improving Palliative and End of Life Care (EoLC) remains a priority within SFHFT and for our local communities. SFHFT is committed to delivering outstanding EoLC through the support and training of staff, and in delivering honest and open communication, supporting patients' preferences and experiences. The Trust works in partnership with the ICS and the Mid-Nottinghamshire PLACE Based Partnership - End of Life Care Together. The priorities and delivery of EoLC within SFHFT focus around 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.

Aims for 2022/23

During 2022/23, key areas of focus planned were:

- Sustaining the EoLC Team resource through the business case process.
- Develop Business Case for dedicated EoLC Beds to support choice and enhance patient experience.
- Developing an EoLC Work Plan around the national and local ICS Strategy.
- Enhance measures to capture patients and their relatives' experience.
- Development of the EoLC Champions Network.
- Participate in the next cycle of National Audit for Care at End of Life (NACEL). The Trust fully participated in Round 3 and 4 of the NACEL Audit.
- Further work is required in relation to supporting staff in recognising dying. Recognition and support of people in the last year of life to optimise care and support across the system
- Wider aspects of Advance Care Planning improvements and at an earlier stage
- Anticipatory medicines – to coach staff to explain the use and side effects e.g., sedation.

Performance against target

- A business case presented to the Trust was approved to support substantive funding for the EoLC Nursing Team. This has enabled a specialist team to continue to drive delivery of outstanding EoLC across the Trust, through direct support to patients and their families and via the training, development and support of staff. In addition to the addition of substantive nursing staff, we have gained an additional 1 x PA of medical support within the Team during this period.
- A business case has not been required for dedicated beds. No additional beds were opened and utilised for EoLC in early 2022 within the Short Stay Unit (SSU). Since opening, progress has been made in that these are now dedicated ring-fenced beds for patients in their last days of life. Navigation of patients to the beds continues to improve.
- A robust Work Plan has been developed throughout the last year based on the 6 Ambitions in the National Strategy, and actions identified from Audits and practice. The 6 Ambitions are:

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

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

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

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

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

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

- The team had envisaged that a patients and relatives experience leaflet would be developed to support Advance Care Planning discussions. This work is now progressing within the wider ICS, therefore a specific information leaflet for SFHFT has not been produced. The Trust Bereavement Survey has been reviewed and updated to create a combined EoLC and Bereavement Survey; this will be launched in April 2023.
- The EoLC team facilitated the EoLC Champions Network within the Trust and during 2022/23 the Champions Network meetings were reconvened. The purpose of the Champions Network is to build capacity within our workforce to deliver outstanding EoLC through sharing learning, support and education.
- Overall, the Audit results were positive.

The SFHFT Round 3 NACEL Audit Results

The National Team has advised that Round 4 (2022/23) will be the final year of the Audit in its current format. 2023 will be a scoping year, the next Audit will open in 2024 and in the interim the EoLC Team will focus on the actions from previous Audits.

- EoLC Education and Training
  The EoLC Team continue to provide a wide range of education and training. The team deliver ad hoc/in situ training in clinical areas continually during visits to wards and departments as part of the role.

Table 10 (table below) shows the number of staff who have completed EoLC training courses during 2021/22:

Course Title	Staff Group	Number	Comments
Mandatory EOLC Booklet	Registered Nurses (RNs), Health Care Support Workers (HCSWs) and Allied Health Professionals (AHPs)	3,323	The Trust target for completion of mandatory training is 93%. The compliance for each quarter is: Q1: 88% (1, 228) Q2: 82% (761) Q3: 85% (702) Q4: 89% (632) Despite the limitations of attending training due to the Covid-19 pandemic overall compliance is 86%
Induction	RNs and HCSWs	495	This includes the regular induction programme, and additional sessions to support the recruitment of HCSWs due to the Covid-19 Pandemic (between April and June 2021)
T34 Syringe Pump Training	RNs	20	Face to face training in ward areas
EoLC e-learning package	RNs, HCSWs and AHPs	35	This training session was created by the EoLC Team Clinical Nurse Specialists in the Winter of 2020/21 and reviewed / updated during 2021/22.
Preceptorship Training	Newly qualified RNs	108	Symptom control and an introduction to T34 Syringe Pumps
Student Insight Visits	Students on placements within the Trust (mainly Nursing students)	6	Opportunity for Students to shadow the EoLC Team
EoLC Overview Presented to West Nottinghamshire College Students	West Nottinghamshire College Students	9	1 session was provided for students in November 2021 (a further session was planned but unfortunately cancelled)
Volunteer Training	Potential Trust Butterfly volunteers	23	4 sessions: July 2021=12 Sept 2021=4 Dec 2021=2 Nov 2022 = 5

Progress has also been made to improve patient experience as follows:

EoLC Butterfly Volunteers Scheme initiative was first introduced as a pilot in 2021.

EoLC Butterfly Volunteers enhance the experience of patients identified as being in the last days of life, by having volunteers provide company to patients, read to them, or participate in conversations with patients as appropriate. This may give loved ones a break or support patients who have no visitors. Butterfly Volunteers also work as part of the ward team and help to undertake non-clinical activities in relation to end of life care, such as re-stocking end of life care related resources for the ward.

Throughout 2022, a further 5 Volunteers were trained. Feedback from patients and significant others and staff has been extremely positive

Taste for Pleasure Initiative was launched in 2022

Around 80% of people who are dying experience swallowing difficulties in the last days of life. An alternative to nil by mouth for such patients is Taste for Pleasure, which improves both patient experience and enables loved ones to be involved in care.

'Taste for Pleasure' means that when receiving end of life mouth care (cleaning and hydrating the mouth), hospital staff can use the patient's favourite flavours to provide moisture. These flavours can be anything from blackcurrant squash, tea, all the way up to whisky!

The EoLC and Speech and Language Therapy teams have developed a Standard Operating Procedure, and patient and relative information. The initiative aims to educated and change the culture of nil by mouth and roll out Taste for Pleasure across the Trust.

By introducing 'Taste for Pleasure' to a patient's routine, as well as aiding their hospital care, facilitates conversations about a patient's life, what their favourite food and drink is, and can remind them and their loved ones of joyful past experiences.

Aims for 2023/24

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

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

SFHFT is committed to improving the service we provide when caring for people living with dementia, their family, and carers. The aim is to provide an excellent service, facilitating the development of dementia care through a collaborative approach to provide an outstanding service. It is our responsibility to provide people living with dementia the very best standard of care that is equitable, accessible, and community-focused from diagnosis to the end of life.

The Trust continues to work towards maximising the potential of our workforce, by continuously learning, adopting evidence-based practice, utilising information, and advancements in digital technology, being innovative and improving for the benefit of the local community.

Aims for 2022/23

- Recruit and commence the development of dementia focused shared governance council that is diverse and inclusive of Trust staff.
- Dementia boxes are to be developed for each of the wards and departments to increase the quality interactions with patients, especially those requiring enhanced patient observations
- The Dementia Nurse Specialist will promote new options available for support, including referrals to the Alzheimer's society for patients, carers, family and friends, and health and social care employees. This will be supported by two newly appointed Admiral nurses.
- A continued focus on our registered nurses' ability to complete the dementia assessment, the aim of achieving the national target of 90%, through a collaborative approach between nurses and doctors
- The focus on identifying individuals with a confirmed diagnosis of dementia on digital systems. A review of the necessary resources to achieve this will be required
- The Integrated Care Partnerships shared aim is to continue ensuring that all partner organisations provide Tier 1 dementia training for all employees. SFHFT has achieved this as part of their induction programme, the groups of staff that currently do not receive any training are the Skanska and Medirest teams.
- The introduction of online delirium training for medical, nursing and healthcare assistants. Following an in depth focus on the potential causes of hospital acquired delirium
- Dementia, falls and manual handling champion days will be coordinated and presented quarterly
- The Dementia Team will continue to support and promote the carers passport, including adding the information to the internet pages on dementia and as part of the information sharing with the individuals supporting the new Dementia Pathway

Performance against this Target

- Shared Governance councils have been implemented and remain a high priority to cascade further. Unprecedented clinical demands have resulted in poor attendance so a review with the matron, specialities, and the leadership council, has been undertaken and alternative options are being explored
- SFHFT are in the process of taking delivery of activity 'cupboards' (to replace activity boxes). Local businesses and the SFHFT charity have kindly supported the content of these units for distribution to ward areas.
- The Dementia pathway has been implemented and has seen significant numbers of referrals to the Alzheimer's connected care service. This is a pilot project that is currently funded for two years. Service user feedback is overwhelmingly positive to date. The Admiral Nurse for Ashfield is now in post, and collaborative work has commenced. Key partnership working has allowed an improved understanding of the patient and their carers needs, resulting in improved communication and enabling seamless care for patients known to the Admiral Nurse.
- Work is ongoing to support compliance of completion if the dementia screening tool on Nervecentre. Compliance remains between 80-90%. Further work is required to understand the data.
- During a 4-week period, we identified potentially 240 patients who were admitted to the organisation for more than 24hrs with either a confirmed or suspected dementia diagnosis. We proceeded to identify using Systmone and Rio that of the 240 patients 172 had a recorded dementia diagnosis, over half of these were unknown to us prior to the study.
- 2022/23 has seen some significant changes to the process of orientation and induction of staff that are recruited to the Trust, resulting in a higher number of staff who have completed dementia training.
- While the focus on delirium has significantly increased during 2022/23, it has not yet translated into an improved position. The training that was planned has not been fully implemented.
- The lead dementia, falls and manual handling practitioners, have collaborated to deliver training and support to the champions for each of the disciplines. Feedback provided through evaluation of the sessions has evidenced that all attending both enjoyed the style and approach to champion training.
- 2022/23 has seen a large uptake in the use of the carers' passport within wards and departments. Initial analysis is positive.

How was this achieved

The dementia work plan continues to evolve and be refreshed. It is reviewed monthly by the dementia team and matron and is scored using a RAG rating to monitor progress. An action tracker is reviewed and updated monthly, and adjusted processes are implemented where required, enabling progress to be made.

Many of the restrictions placed on us due to the pandemic in previous years have been changed, but with Covid-19 still present there are some aspects of restrictions remain. Unfortunately, the one aspect that has significant impact on the needs of dementia patients is the continued use of masks by staff and this hinders non-verbal and verbal interactions.

Collaborative multi-disciplinary teamwork has facilitated much of the progress demonstrated.

Monitoring and Reporting for Sustained Improvement

The Dementia matron responsible for the workstream, works closely with all team members and has outlined requirements, established meetings to monitor progress, and gives support and guidance to teams. Training within SFHFT is reported and monitored via a training enabling data and evaluation collation. The evaluations have enabled changes to be made to the content and style of the presentation, the continued desire to improve remains an integral element of all training provided.

SFHFT continue to report on the compliance achieved regarding dementia screening and this is reported via the Patient Safety Committee. A review of the national target required, originally 90% when figures were published for the national database, has provided a slightly reduced accepted target of 85%. An action plan is in development.

Delirium continues be an essential element of the Harms free operational group (HFOG). From April 2023, this will be known as the Clinical Outcomes and Effective Care Committee, (COECC). A report is produced and discussed during the monthly meeting. Escalations from this meeting taken for further review to the Nursing, Midwifery and AHP committee by the Deputy to the Chief Nurse/Director of AHPs.

The dementia team have been developing a shared governance council. The lead for this council will report to the Trust shared governance leadership council, chaired by the Chief Nurse. Any progress identified is recognised, the leader is also given the opportunity to identify any elements that require additional support which includes advice, guidance, funding options and executive backing.

Aims for 2023/24

- Shared governance will continue to be progressed and evolve
- SFHFT have appointed one Admiral nurse and are in the process of appointing a second. A clear demonstration of the dedication and desire to continue the journey to outstanding dementia care, building upon services provided by local Healthcare partners
- The focus on identifying individuals with a confirmed diagnosis on digital systems will continue. A review of the necessary resources to achieve this will be required
- As the Integrated Care Partnership's shared aim is to continue with the process off ensuring that all partner organisations provide Tier 1 dementia training for all employees. SFHFT leaders have agreed that this will become an element of the pre-induction workbook for new staff joining the organisation. Additionally, negotiations are underway to facilitate a workforce agreement for ancillary staff to include the Skanska and Medirest teams
- Delirium continues to have a significant impact on our patients, with dementia being a predisposing factor associated with this. 2023/24 will see the introduction of online delirium training for Medical, Nursing, Healthcare assistants and Allied Health Professionals. It will continue to be reported monthly and will be aligned with the awaited publication of the national dementia audit results.
- Collaboration and delivery of dementia, falls, and manual handling champion days will continue.
- The Dementia Team will continue to support and promote the carers passport, working in collaboration with the patient experience Matron. A patient with dementia story, is scheduled to be presented at Trust board. The dementia specialist nurse will continue to have a presence on the carer's forum allowing staff to be able to seek help and advice regarding their own relatives.
- Following the completion of the National Audit for dementia, SFHFT awaits the Audit results. The report is due for publication in August 2023 and the findings will generate an action plan if any shortfalls in dementia care for patients are identified.
- The dementia agenda and action plan will continue to be monitored and reviewed monthly and adjusted if the need arises.

3.8 Patient Experience – Using Feedback from patients and their carers

Friends and Family Test (FFT) themes and trends

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

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

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

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

Aims for 2022/23

- Relaunch of FFT in 2022 to raise awareness and engagement, resulting in an improvement of quantitative and qualitative data
- Reintroduction of volunteers supporting FFT completion in ward and outpatient areas, post COVID-19 restrictions being lifted
- Development of engagement plan to continue to refresh FFT and support divisional teams to deliver FFT locally resulting in increased recommendation rates.

Performance against target

- Re-Introduction of QR codes in Maternity and the ED to support increased accessibility to provide feedback real-time.
- Expansion of SMS messaging in all areas throughout SFHFT, including adult inpatient areas, which has resulted in increase in response rates.
- Training sessions provided on the new system, to ensure all areas have access to their FFT data.
- Training delivered to support accessing FFT data from the dashboard to empower leaders to review and action FTT feedback.
- Introduction of FFT feedback mechanisms to Children and Young People.
- Re-introduction of volunteers supporting FFT completion in wards and departments.

SFHFT have continued to collect FFT feedback during the pandemic, complying with IPC guidance, by increasing services using the SMS text messaging service due to the increase in virtual clinics.

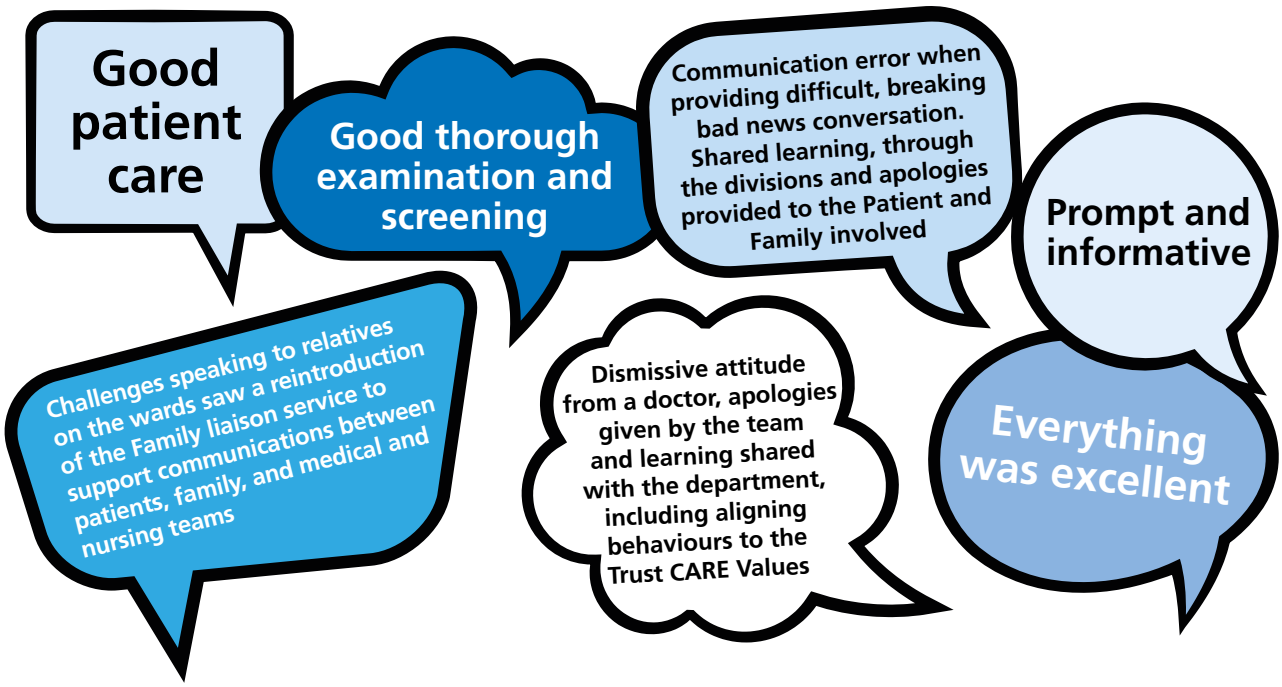
Results have shown a fluctuation in response rates during 2022/23 (table 11)and the Patient Experience Team, led by the matron for Patient Experience, have worked closely with divisions to develop and support action plans to increase response rates and to provide an increase in qualitative data to help shape future services.

Table 11 – FFT data April 2022 – Feb 2023

	Recommendation Rate %										
	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sept 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23
Inpatients	94.7%	94.7%	95.9%	96.8%	94.9%	94.1%	95.3%	94.6%	94.1%	94.0%	94.8%
Emergency / Urgent Care	91.1%	89.5%	89.7%	90.1%	88.8%	86.5%	87.4%	88.3%	84%	93%	88.3%
Outpatients	91.42 %	93.02 %	92.59 %	94.35 %	93.15 %	93.86 %	94.83 %	94.03 %	94.34 %	94.12 %	93.25 %
Maternity	100%	100%	92.9%	76.1%	88.5%	84.5%	87.7%	87.9%	87.0%	90.9%	85.4%

The FFT feedback is triangulated with compliments, concerns and complaints and shared with all divisions for learning and reflection, sharing of positive practice, and to focus on areas of improvement.

The following responses are examples of FFT feedback during 2022/23:



Aims for 2023/24

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

3.9 Patient Experience – Safeguarding vulnerable people

SFHFT safeguarding team works alongside the local Safeguarding Children Partnerships and Safeguarding Adult Boards throughout all the statutory processes. These processes enable the team to identify and share learning from national and regional cases across the communities served by the Trust, and work together to develop policies, training and protocols that will support the SFHFT provide an effective safeguarding service.

Aims for 2022/23

During Covid-19, the combined impact of increased stressors on caregivers, increased vulnerability as a result of social isolation, and 'hidden harms' such as domestic and online abuse, disproportionately exacerbated the risk of abuse and neglect for both adults and children. Nationally and locally safeguarding continues to see an impact since the easing of restrictions. Not only has there been an increase in incidents there also appears to be an increase in the complexity of these cases.

During 2022/23 the key aims of SFHFT have continued to be:

- Ensure safeguarding remains a top priority within our care and service delivery, working to ensure systemic safety nets are in place and recovery plans are implemented.
- Review the role of the Hospital Independent Domestic Violence Advocate (IDVA) service, impact and outcome measures.
- Continued focus on our commitments to support the health and well-being of our workforce, particularly in relation to domestic abuse and mental health.
- Undertake further work to embed the principles of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Alongside developing and implement the organisational legislative responsibilities to Liberty Protection Safeguards (LPS).

Performance against this Target

Safeguarding has remained a key focus of the Trust throughout 2022/23 with the safeguarding service remaining a top priority. Recovery plans have been implemented and are working effectively.

The Hospital IDVA role review has taken place with evidence of positive impact for both our patients and workforce.

SFHFT has continued to work with external partners through representation at safeguarding board and partnership events and participation in local and national safeguarding reviews with learning being embedded into mandatory training.

Staff have received ongoing support with domestic abuse issues and mental health through the hospital Independent Domestic Violence Advocate (IDVA) and Mental Health Specialist Nurse.

Work has been undertaken to further embed MCA training along with ongoing representation at LPS working groups and development of action plans to support delivery.

How was this achieved

- Attendances to the Emergency Department have been monitored to ensure direct support can be provided to patients presenting with complex safeguarding, including potential domestic abuse.
- Named Nurse representation at all divisional governance groups to ensure safeguarding remains a key focus for services.
- A safeguarding training recovery plan was developed and implemented with good effect. Training compliance has been monitored and reported through divisional governance meetings.
- Hospital IDVA role reviewed via an internal service review process with data evidencing positive impact and outcomes for our patients and workforce experiencing domestic abuse in their own relationships.
- The Hospital IDVA and Named Nurses continue to provide support to managers and HR advisors in relation to staff cases where domestic abuse and mental health are a feature.
- Mental Capacity Act (MCA) audits have continued, and action plans developed.
- Working group develop meetings undertaken with the Named Doctor for Safeguarding Adults to support medical team engagement.
- SFHFT have been represented at external LPS working groups and analysis is under way.
- Safeguarding named nurses have continued input to external local, regional and national forums to ensure that current trends, best practice and pressures are shared

Monitoring and Reporting for Sustained Improvement

- The safeguarding team will continue to provide quarterly reports with key information to provide assurance that SFHFT are meeting its statutory responsibilities.
- Input into divisional governance meetings will continue

- Workplans are under review to ensure these reflect the needs of the service
- An updated audit programme will be identified for key issues relating to the safeguarding and vulnerabilities agenda

Aims for 2023/24

The long-lasting safeguarding impact of the Covid-19 pandemic is still evident today. As anticipated, with lock down, restrictions coming to an end, along with continued impact upon people's mental health, poverty due to loss of employment and the rise in the cost of living, concerns with hidden abuse are coming to the forefront.

The Hospital IDVA role will continue into 2023/24 as domestic abuse continues to be a high priority for the organisation.

SFHFT recognises safeguarding remains a priority within our care and service delivery. We will work to maintain that system safety processes are in place. We will build on established work and strengthen our approach to 2022/23 by aligning with the Trust strategic objectives below:

To provide outstanding care

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

To Promote and support health and wellbeing

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

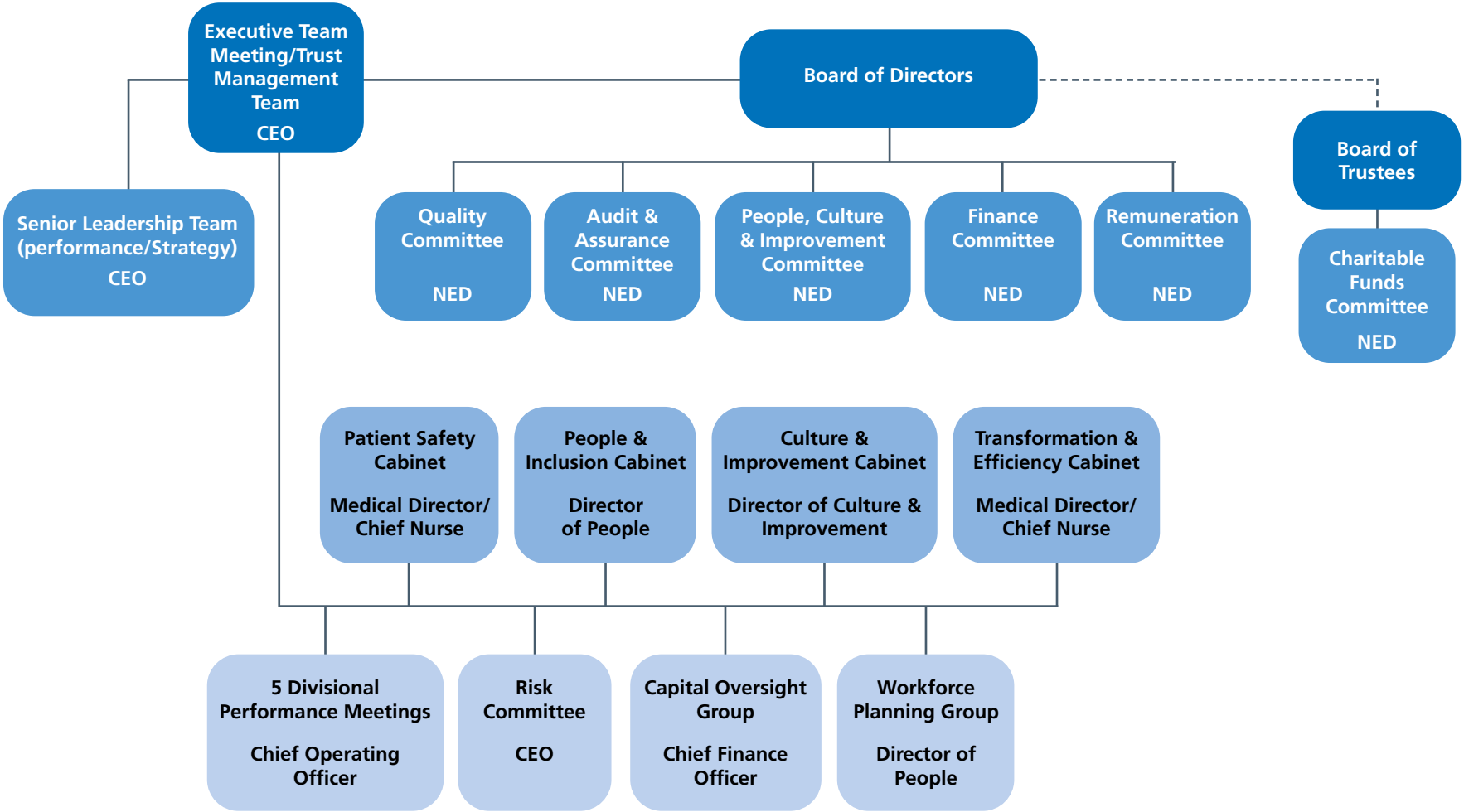
To continually learn and improve to achieve better value.

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

3.10 Mandatory Key Performance indicators

Indicators identified within the Single Oversight Framework for November 2022	Target	Performance	Performance
		Yr 2021/22 April 21 – March 22	Yr 2022/23 April 22 – March 23
*Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – Patients on an incomplete pathway	92%	70.3%	69.2%
*A&E: maximum waiting time of four hours for arrival to admission / transfer / discharge	>95%	85.7%	75.6%
Cancer 2 week wait: all cancers	93%	90.4%	84.1%
Cancer 2 week wait: breast symptomatic	93%	93.2%	94.3%
Cancer 31 day wait: from diagnosis to first treatment	96%	91.7%	88.2%
Cancer 31 day wait: for subsequent treatment – surgery	94%	85.5%	88.2%
Cancer 31 day wait: for subsequent treatment – drugs	98%	91.8%	92.4%
Cancer 62 day wait: urgent GP referral to treatment for suspected cancer	85%	65.1%	63.6%
Cancer 62 day wait: for first treatment – NHS cancer screening service referral	90%	75.7%	83.7%
Maximum 6 – Week wait for diagnostic procedures	99%	75.8%	69.4%
Clostridium difficile variance from plan	57	44	39
VTE Risk assessment	95%	93.2%	97.7%
**Summary Hospital-level Mortality Indicator (SHMI)	100	98.09 (Sep'20-Aug'21)	102.73 (Sep'21-Aug'22)
** The Summary Hospital-level Mortality Indicator (SHMI) is a rolling reporting period. The figures reported represent most current data available: 98.09 September-20 – August-21 102.73 September-21 – August-22			

Sherwood Forest NHS Foundation Trust Committee Structure – May 2023



Statement from Nottingham and Nottinghamshire Integrated Care Board

1. Introduction

1.1 In July 2022 the Integrated Care Board was established in line with the Health and Social Care Act.[7] As such, Nottingham & Nottinghamshire ICB (NNICB) has a statutory duty to secure continuous improvement in the quality of services; and in the outcomes for people using those services. The first year of the NNICB has coincided with an exceptionally demanding system landscape with ongoing recovery from the Covid pandemic and additional challenges of clinical demand and industrial action during Winter 22/23.

1.2 NNICB has continued to work with Sherwood Forest Hospitals NHS Foundation Trust in pursuit of the monitoring and continuous improvement of services during 2022/23, in accordance with the statutory functions of the ICB described above.

1.3 The intention for 2022/23 was for NNICB and the Trust to continue fostering and developing collaborative and systems-based working, and this statement provides a reflection of progress.

2. Quality Visits

2.1 Two quality visits were made during 22/23, the first in April to the maternity services at SFH; and the second in July to Newark Hospital.

2.2 The maternity visit was led by ICB colleagues in partnership with the Local Maternity and Neonatal System (LMNS). The key lines of enquiry were aligned to the national recommendations for standards and improvements, and views of women, families and staff were sought during the visit.

2.3 The visit to Newark Hospital in July was an informal insight visit which allowed new members of the ICB quality assurance team to meet SFH colleagues, view a variety of services, and develop understanding of planned developments.

2.4 Both visits were positive with warm recommendations from service users and a transparent approach from staff who demonstrated pride in their service.

3. Working as system partners

3.1 SFH continues to demonstrate focus and intention on their role as partners in the wider system. The Trust has active membership of the system Patient Safety Network; the Partner Quality Assurance & Improvement Group (PQAIG); the newly established Quality Improvement Design Collaborative Hub; and the over-arching System Quality Group.

3.2 At a Trust level, NNICB colleagues are routinely welcomed into key quality meetings including the Patient Safety Committee; the Maternity Assurance Committee; and Quality Committee as examples. Partnership working continues to be fostered in this environment with input invited and valued from all attendees.

4. Looking forward to 23/24

4.1 The Trust are developing their approach to the implementation of the Patient Safety Incident Response Framework[8] which will positively impact the adoption of a just culture for patients and staff and enable resources to be focused on learning from incidents and quality improvement.

4.2 Maternity services are developing in accordance with national requirements and in response to CQC recommendations.

4.3 The Trust continue to collaborate with system partners in development of the local Quality Schedule and adoption of nationally recommended quality improvement schemes[9].

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

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

[9] https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-23-24/

Statement from the Health Scrutiny Committee

Statement from Healthwatch in response to 2022-31 Quality Accounts

The Quality Account has been shared with Healthwatch in line with requirements of NHE. On this occasion and due to the additional roles and requirements of Healthwatch in the new Integrated Care System, the Healthwatch team have chosen not to provide a statement for the SFHFT Quality accounts this year.

ANNEX TWO

Statement of Directors responsibilities for the Quality Report

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

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

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

- The content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2022/23 and supporting guidance
- The content of the Quality Report is not inconsistent with internal and external sources of information including:

1. Board minutes and papers for the period April 2022 to March 2023
2. Papers relating to quality reported to board over the period April 2022 to March 2023
3. Feedback from commissioners dated 04/05/2023
4. Feedback from local Healthwatch organisation dated 04/05/2023
5. Feedback from Overview and Scrutiny Committee not received on date of submission
6. The Trust's complaints report published under regulation 18 of the Local Authority Social and Complaints Regulations 2009,
7. The 2022 survey was published in March 2023
8. The 2022 national staff survey dated March 2023
9. The Head of Internal Audit's annual opinion of the trust's control environment dated 18 May 2023
10. CQC Inspection report dated 14 May 2020

- The Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
- The performance information reported in the Quality report is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
- The Quality report has been prepared in accordance with NHS Improvement's annual reporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the board

Claire White, *Chair, SFHFT*
12/06/2023