

Sherwood Forest Hospitals NHS Foundation Trust

Annual Report and Accounts



2023/2024

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Presented to Parliament pursuant to Schedule 7, paragraph 25(4)(a) of the National Health Service Act 2006

Contents

Performance Report.....	4
Statement from the Chair	4
Statement from the Chief Executive	6
Performance Overview.....	15
Performance Analysis	16
Accountability Report	21
Directors' Report.....	21
Quality Strategy	27
Remuneration Report.....	47
Annual Report on Remuneration (subject to audit) <i>Senior Managers' Disclosure</i>	61
Staff Report.....	68
Staff Survey	76
Modern Slavery.....	83
Valuing our Members.....	90
Valuing our Governors	91
Lead Governor annual report 2023-2024	95
Code of Governance for NHS Provider Trusts	97
Functional Standard Requirement.....	104
2023 CFFSR.....	104
Projected 2024 CFFSR	104
Compliance with the Code of Governance for NHS provider trusts	109
NHS Oversight Framework	110
Statement of the Chief Executive's responsibilities as the Accounting Officer of Sherwood Forest Hospitals NHS Foundation Trust.....	111
Annual Governance Statement	113
Annual accounts for the year ended 31 March 2024.....	138
Auditor's report.....	199
Certificate of completion of the Audit.....	204

Performance Report

Statement from the Chair

It is my pleasure to present this year's annual report at the end of what has been another hugely proud and eventful year here at Sherwood Forest Hospitals – one that has been set against an increasingly challenging national backdrop.

In the last 12 months, Sherwood has achieved a great deal, including continuing to deal with the operational challenges that we see across our NHS.

Dealing with more than 10 periods of industrial action that have been called nationally has compounded the challenges we have continued to face across our hospitals, where we continue to see rising demand in our Urgent and Emergency Care services.

Patient discharge also remains a challenge, as we continue to grapple with wider societal issues that see high numbers of patients remaining in hospital long after they have received the vital hospital care they need. Over the winter this has resulted in the Trust opening more beds than at any point in its history.

Despite those obvious challenges, there remains so much for us to be proud of here at Sherwood.

At our front door, our ambulance handover times remain among the very best in the country and in the past year alone, we have celebrated having delivered over 250,000 COVID vaccinations during the life of the vaccine programme. We have also been proud to help bring over 200 'smoke free' babies into the world.

As proud as we are of all our achievements, we recognise that our communities and patients need and deserve more. We also know that it will take a new approach to ensure that we can continue to be there for the patients and communities we serve if we are to continue to provide outstanding care for the years to come.

It is on that basis that we have built our new approach to *Improving Lives* here at Sherwood, with our new five-year strategy being launched in March that sets out how we seek to provide outstanding care over the next five years.

In that time, we want to be known as an outstanding local healthcare provider that consistently delivers quality services for our patients and improves lives. We will achieve this by delivering consistently outstanding care by compassionate people who feel enabled and supported to do their best by Sherwood Forest Hospitals.

Our new vision reflects this: **Outstanding care, compassionate people and healthier communities.**

During the life of our new five-year strategy, we will improve the lives of our patients, our people and our local population under six pillars:

- We will provide outstanding care in the best place at the right time
- We will empower and support our people to be the best they can be
- We will improve health and wellbeing within our communities
- We will continuously learn and improve

- We will make sustainable use of resources and estate
- We will work collaboratively with partners in the community

We want to look beyond the walls of a traditional local hospital by proactively seeking to contribute towards delivering healthier communities in the areas we serve of Ashfield, Mansfield, Newark and Sherwood and beyond.

We are proud of our long history of working in partnership for the benefit of our communities and our ambition during the life of this strategy is to support broader economic and social development, recognising this has a major impact on good versus poor physical and mental health.

This annual report sets out all that we are proud of over the year gone by, as well as underlining the challenges we have faced and will no doubt continue to face.

In spite of those challenges, we have so much to be proud of here at Sherwood – now and over the next five years. Making our vision of *Improving Lives* is a journey that we look forward to, working alongside our patients, local communities and partners who share this important ambition with us.



Claire Ward
Chair
Sherwood Forest Hospitals NHS Foundation Trust

Statement from the Chief Executive

As we have set out our five-year vision for Sherwood Forest Hospitals, one of the key centrepieces for setting-out our vision has been underlining the role that we know our people will play in delivering outstanding care and creating healthy communities.

In the past year alone, we have been recognised as offering a 'gold standard' service to local Armed Forces veterans, have become the first Trust in the Midlands to achieve accreditation from the international organisation for clinical research, and have continued to develop our partnerships with local organisations, including by hosting our latest *Step into the NHS* event.

We know that none of those achievements would have been possible without the incredible commitment, skill and compassion of our Trust colleagues. Without them, we know that we simply would not have been able to provide the outstanding, compassionate care and treatment that we do – 24 hours a day, 365 days a year.

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

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

Those results revealed that 74.45% of Trust staff recommended the organisation as a place to work, rating Sherwood as the third among all NHS organisations nationally as a place where staff recommend working.

The results also named Sherwood as the best nationally for morale, engagement, colleagues feeling they have the freedom to do their work, that their work being valued by the organisation, and that they have the right learning and development opportunities to help them grow.

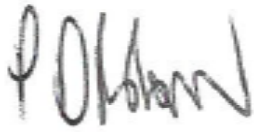
Crucially, the culture we have created is reflected in the care that we are proud to provide to the patients and communities we serve, with 77.88% of Trust staff agreeing that they would be happy with the standard of care provided at the Trust if a friend or relative needed treatment.

Despite such positive feedback, we know there is always more we can do to make Sherwood an even greater place to work – including through the action we are already taking to address the unacceptable violence and aggression that our colleagues say they face all too often.

As the financial climate continues to bite, maintaining a positive culture will be key to maintaining those high standards of care here at Sherwood.

And despite those obvious challenges, we are clear that Sherwood will continue to be an organisation that remains clinically-led but financially-sound – as demonstrated by the investments we have made to maintain high standards of patient care across our hospitals, including in delivering a new operating theatre at Newark Hospital and through our work to attract national funding to bring Nottinghamshire's first Community Diagnostic Centre to our area.

It is that balance of continuing to provide outstanding patient care and aspire and improve within a strict financial envelope that will be a key focus for us to maintain as we enter a new financial year.

A handwritten signature in black ink, appearing to read 'P Robinson', written in a cursive style.

Paul Robinson
Chief Executive Officer
Sherwood Forest Hospitals NHS Foundation Trust

Overview of Performance

This section summarises our organisation's purpose, history, objectives and key risks.

Our History and Structure

Sherwood Forest Hospitals was formed in 2001 and gained Foundation Trust status in 2007. We provide outstanding healthcare across the community to 350,000 people in Mansfield, Ashfield, Newark, and Sherwood and parts of Derbyshire and Lincolnshire. We employ more than 6,000 people in our three hospitals – King's Mill, Newark and Mansfield Community - and at Ashfield Health and Wellbeing Centre. We have well-established relationships with partners in health and social care through the Nottingham and Nottinghamshire Integrated Care System (ICS) and the Mid-Nottinghamshire Place-based Partnership.

We have five clinical divisions: Urgent and Emergency Care; Medicine; Surgery, Anaesthetics and Critical Care; Women's and Children's; and Clinical Support, Therapies and Outpatients. Each of which has a medical, nursing and managerial lead, a triumvirate, and they are supported by a corporate division.

Our Trust is managed by the Board of Directors, which is responsible for the management and performance of the organisation and for setting the future strategy. The Board ensures the quality and safety of healthcare services, education, training and research delivered by the Trust and applies the principles and standards of clinical governance set out by the Department of Health, the Care Quality Commission, and other relevant NHS bodies. It also makes sure that we exercise our functions effectively, efficiently and economically.

As a Foundation Trust we have a Council of Governors, which works with the Board of Directors and represents the interests of our members in the planning of services. The Governors play an important role in the delivery of safe, high-quality care. They are elected by our public and staff members or appointed to represent community partners, such as the local councils and commissioners.

King's Mill Hospital, where 90% of our services are based, is rated Outstanding by the Care Quality Commission and Newark Hospital and Mansfield Community Hospital are both rated Good. Our maternity services were reviewed in 2023 and achieved a good rating. All 14 our other services are rated Good for Safety with five Outstanding services.

Safe, patient centred care is delivered by well supported people and in 2023 colleagues at Sherwood rated us as being the best place to work across all acute trusts in the Midlands region in the National Staff Survey.

In March 2021 the Trust was recognised as the Acute or Specialist Trust of the Year in the prestigious Health Service Journal Awards. The HSJ awards are the most coveted accolade in UK healthcare and Trust of the Year is the most prestigious category within these awards.

In 2023 we achieved the Pathway to Excellence recognition for our commitment to outstanding care. The second hospital in the UK to achieve such status.

Our Neonatal Unit was also awarded Stage 2 Baby Friendly Initiative accreditation by the United Nations Children’s Fund (UNICEF). The accreditation recognises that neonatal colleagues at the Trust implement Baby Friendly standards to support parents (and siblings) to have close and loving relationships with their baby, promote the use of breastmilk and breastfeeding and encourage an environment where parents are involved as partners in care.

We achieved Gold Standard for Health and Safety, awarded by the Health and Safety Executive, demonstrating our commitment to safety.

We enjoy positive partnerships with public bodies including our three district councils and the County Council. This means we can actively contribute to the wider determinants of health and wellbeing through our collective work on the levelling up partnership and shared prosperity agenda. We have a strategic compact with Vision West Notts College and Nottingham Trent University which is delivering on meaningful employment opportunities for local people and in support of the local economy. We play an active role in the Nottingham and Nottinghamshire Integrated Care System (ICS).

Our purpose and activities

Over the past year the NHS has continued to face extraordinary challenges and pressures. Our colleagues consistently demonstrate remarkable commitment to keep our patients, and each other safe. We are working hard for those patients waiting for operations and treatments, while balancing the needs of those requiring emergency care, and we are doing all we can to treat people as quickly and as safely as possible according to clinical urgency.

Our focus is on managing today while planning for the future and 2023/24 was the final year of the Trust’s 2019-2024 strategy. During the year the Trust achieved the following:

<p>To provide Outstanding Care</p>	<ul style="list-style-type: none"> • The Trust developed and finalised its first Clinical Service Strategy • Day case surgery services have expanded at Newark Hospital with the opening of the new state of the art theatre • Maternity services were rated good by the CQC • Optimising Patient Journey (OPJ) improvement programme saw increases in the virtual ward activity and strong utilisation in the Medical Same Day Emergency Care (SDEC) with Surgical SDEC ready for go live in 2024/25. • Capital works at the new Community Diagnostic Centre have commenced
<p>To promote and support health & wellbeing</p>	<ul style="list-style-type: none"> • Implementation of a single maternity oversight framework • Ongoing commitment to the Provider Collaborative and Place Based Partnership • Secured permanent funding to the Phoenix Team, which works to reduce smoking at the time of delivery • Strengthened partnerships with the education sector to promote local employment opportunities and contribute to the wider determinants of health and well-being

	<ul style="list-style-type: none"> • Worked with partners external to the NHS, including councils and the voluntary sector to focus positive effort on improving the wider determinants of health.
To maximise the potential of our workforce	<ul style="list-style-type: none"> • Delivered the Year 2 "Belonging in the NHS" supporting actions of the Trust's People Strategy 2022-2025 to support and celebrate diversity in all its forms. This included strengthening the induction process, reintroducing face to face celebratory events such as long service awards and delivery against the Equality Diversity and Inclusion Improvement Plan. • Delivered the Year 2 "Growing for the Future" supporting actions of the Trust's People Strategy 2022-2025 to retain talent. This included streamlining training requirements and documentation, roll out of the strengthened leadership development offer and an increase in apprenticeships across the Trust. • Delivered the Year 2 "Looking after our people" supporting actions of the Trust's People Strategy 2022-2025 to support our people's health and wellbeing needs. This included the development of a health and wellbeing improvement plan, trauma and risk management training and increased focus and response to violence and aggression.
To continuously learn and improve	<ul style="list-style-type: none"> • Development of a business case for a Trust-wide electronic patient record • Development and implementation of patient safety incident response framework • Embedding of the Improvement Faculty in its role providing transformational and improvement support
To achieve better value	<ul style="list-style-type: none"> • Delivered Financial Improvement Programme savings of £8.25m in 2023/24. • Delivered year one of a three-year Transformation and Efficiency Programme, with an ambition to deliver efficiencies in the way we operate the hospital. • Contributed to the local economy and businesses through employment offers, procurement opportunities and through a scheme to support people become work ready.

During 2023/24 the Trust consulted with patients, our people and the community on its vision, priorities, and objectives.

2024-2029 Improving Lives – the Trust's new five-year strategy

The new strategy commences on 1 April 2024 and is summarised below.

IMPROVING LIVES

VISION:

Outstanding care, compassionate people, healthier communities.

Strategic Objectives

Provide outstanding care in the best place at the right time

Empower and support our people to be the best they can be

Improve health and wellbeing within our Communities

Continuously learn and improve

Sustainable use of resources and estate

Work collaboratively with partners in the community

Care Values

C Communicating and Working Together

A Aspiring and Improving

R Respectful, Inclusive and Caring

E Efficient and Safe

Scan the QR code for the full Trust Strategy and delivery plans.



Measures of success

- Be rated Outstanding by the CQC.
- Increase the percentage of our people who recommend Sherwood Forest Hospitals as a place to work
- Increase the percentage of people who recommend Sherwood Forest Hospitals as a place to be cared for
- Improve the number of people engaging in healthy choices and behaviours
- Be recognised locally and nationally as an organisation that is committed to partnerships

The Nottingham and Nottinghamshire Provider Collaborative at Scale

Provider collaboratives are partnerships of at least two trusts working across multiple places with a shared purpose. All statutory NHS Providers have to be involved in at least one provider collaborative. National guidance on the role and function of the Provider Collaboratives¹ set out three key aims:

- To reduce unwarranted variation and inequality in health outcomes, access to services and experience

¹ [B0754-working-together-at-scale-guidance-on-provider-collaboratives.pdf](https://www.england.nhs.uk/publications/b0754-working-together-at-scale-guidance-on-provider-collaboratives.pdf) (england.nhs.uk)

- To improve resilience by, for example, providing mutual aid
- To ensure that specialisation and consolidation occur where this will provide better outcomes and value.

Provider collaboratives are a component of Integrated Care Systems (ICSs). Effective collaboratives can help streamline the relationships between ICSs, providers and wider partners to integrate care and respond to the needs of local communities.

The Nottingham(shire) Provider Collaborative at Scale brings together the five statutory NHS providers across Nottingham and Nottinghamshire - Sherwood Forest Hospitals NHS Foundation Trust (SFH), Nottinghamshire Healthcare NHS Foundation Trust (NHT), Nottingham University Hospitals NHS Trust (NUH), Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (DBH) and East Midlands Ambulance Service NHS Trust (EMAS). The Trust contributes overarching resource across the structure providing representatives at the Chair and CEO Forum, Provider Leadership Board, Distributed Executive Group and working groups.

2023/24

The focus of the Provider Collaborative over the last year has been on the priorities in urgent and emergency care and workforce, including putting in place the necessary programme governance, leadership, and monitoring and evaluation process.

The Collaborative has established a Distributed Executive Group, comprising of executive directors from across member organisations. It has also strengthened its operating model and associated governance.

The continued development and delivery of the people and culture work programme, which consists of four sub-workstreams of talent management, portability/passporting, scaling up people services, and flexible workforce. This early work has successfully secured £250k of pump priming funding through the national Vanguard programme.

Scoping and development of the urgent and emergency care workstream was undertaken through the year and, following the identification of a more efficient vehicle for change, was paused in October. The workstream will be replaced.

Risks to delivery of objectives

Our vision, values and strategic objectives express our ambition for outstanding care provided by compassionate people leading to healthier communities. In the next five years we want to be known as an outstanding local hospital that consistently delivers quality services for our patients and improves lives. We will achieve this by delivering consistently outstanding care by compassionate people who feel enabled and supported to do their best by Sherwood Forest Hospitals. If our people recommend us as the provider of choice for their family and friends and as a place to work, we will have gone a long way to meet this ambition.

Through our risk and control framework the Board of Directors regularly scans the horizon for emergent opportunities or threats and considers the nature and timing of the response required to ensure risk is always kept under prudent control.

The most significant strategic risks facing us continue to be: (i) a significant deterioration in standards of safety and care; (ii) demand that overwhelms our capacity to deliver care effectively; (iii) critical shortage of workforce capacity and capability; and (iv) failure to achieve the Trust's financial strategy.

These risks are interrelated and incorporated into the Board Assurance Framework (BAF) and each has a lead executive director and a lead subcommittee. It is not envisaged these risks will change over the coming year. The Internal Audit Plan and Counter Fraud Plan are approved by Board members and are aligned, where appropriate, with the principal risks in the BAF.

Working in partnership through the Integrated Care System, our Provider Collaborative and Placed Based Partnerships is a fundamental mitigation to our risks. Our continued focus is on improving our internal working processes and practices to ensure patients receive high quality care in a timely manner, while also using our size, scale and reach to influence the health and wellbeing of our communities, particularly targeting those that we are not engaging with as well as we could.

Further detail about our risk management approach is included in the Annual Governance Statement, later in this report.

How we are using our FT status to develop services and improve patient care

We are dedicated to realising our vision of healthier communities and outstanding care for all. This vision statement includes our commitment and ambition to excel and continually improve the quality of our services. Our four core "CARE" values underpin this and describe the way in which we will operate:

Communicating and working together,

Aspiring and improving,

Respectful and caring,

Efficient and safe.

We develop our services and improve patient care based on evidence. We proactively seek and use feedback from patients and staff, as well as analysing data that benchmarks the performance of our services against other Trusts. It is vital that our culture engenders a desire to improve and innovate. That is why we train colleagues in our improvement methodology. This supports them to take a systematic approach to improvement, empowering colleagues to turn good ideas into sustainable reality.

Going concern

The going concern concept is further covered in IAS 1 – ‘Presentation of Financial Statements’. IAS 1 requires management to assess, as part of the account’s preparation process, the Trust’s ability to continue as a going concern. Foundation Trusts therefore need to pay particular attention to going concern issues. In the event that a Foundation Trust is dissolved by NHS England any property or liabilities of the Trust may be transferred to another Foundation Trust, an NHS Trust or the Secretary of State.

The majority of the Trust’s funding for 2023/24 came through the Nottingham & Nottinghamshire ICB (N&NICB) via an Aligned Payment Incentive (API) contract, which includes both fixed and variable elements. The API variable element means trusts are paid 100% of NHS Payment Scheme (NHSPS) unit prices for elective activity, which covers most elective ordinary and day case outpatient procedures with an NHSPS unit price, outpatient first attendances, unbundled diagnostic imaging and nuclear medicine, and chemotherapy delivery. The fixed element includes funding for all expected activity other than the variable elements. Similar contracts are in place with Derbyshire and Lincolnshire ICBs.

As part of the 2023/24 plan an efficiency target of £27.5m was built in to meet the planned break-even position. This includes centrally managed cost savings and income generation schemes, as well as a Financial Improvement Programme of £10.0m which is managed by divisions with the support of the Trust’s Improvement Faculty. The reported financial efficiency delivery for the year is £25.5m, of which £10.5m is recurrent and £15.0m non-recurrent.

As part of the 2023/24 plan an efficiency target of £27.5m was built in to meet the planned break-even position. This includes centrally managed cost savings and income generation schemes, as well as a Financial Improvement Programme of £10.0m which is managed by divisions with the support of the Trust’s Improvement Faculty. The reported financial efficiency delivery for the year is £25.5m, of which £10.5m is recurrent and £15.0m non-recurrent.

Throughout the year the trust has continued to review pay, non-pay and income in order to agree the efficiency target/plan for 2024/25. This has been set at £27.14m which represents 5.0% of turnover.

For the year ending 2023/24 the Trust is reporting a deficit of (£12.42m) which includes the impact of impairments/gains on the valuation of buildings. Removing this impairment loss/gain, which was (£0.85m), we are reporting a deficit of (£11.57m). This is adverse to our target outturn for 2023/24, agreed with NHSE in December 2023, primarily driven by the non-receipt of community diagnostic income in March of £5.5m.

Due to the in year additional deficit to the plan, revenue support of £11.0m was requested and received in 2023/24 against a planned full year outturn of nil. At the time of writing this update no request has been received from the Department of Health and Social Care (DHSC) for any return of this additional revenue PDC. In addition, due to the Private Finance Initiative (PFI) liabilities and associated repayment of borrowing, depreciation does not self-fund the Trust’s capital expenditure, therefore a Public Dividend Capital (PDC) request for £6.5m was submitted and agreed to support the capital programme.

During the year a range of additional National capital programmes were initiated by NHSE and the Trust was successful in obtaining funding for some of these programmes. This has resulted in the Trust being awarded additional PDC of £2.6m above the agreed ICB base capital funding for 2023/24. Funding was also received in respect of National capital programmes approved in 2022/23 of £13.6m.

In year the Trust restated the PFI creditor due to the implementation of IFRS16. This has resulted in a negative Statement of Financial Position (SOFP); and there is now a significant liability in respect of the PFI which will reduce over the remaining term of the contract. In year the Trust did not pay any PDC, based on 3.5% of the net average value of assets due to the impact of IFRS 16 re-measurement.

The financial framework for 2024/25 has been issued and in line with this guidance a draft financial plan, which includes capital, was submitted on the 21 March 2024 and a final plan will be submitted on 3 May 2024. The plan submitted was agreed with the ICS partners and indicates a surplus/deficit of (£14.05m) and a capital programme of (£31.84m). As detailed above the plan includes forecast efficiencies of (£38.45m)

The 2024/25 plan assumes the continuation of funding mechanisms in place throughout the 2023/24 financial year.

In applying the Trusts accounting policies management are required to make judgements, estimates and assumptions concerning the carrying amounts of assets and liabilities that are not readily apparent from other sources. Estimates and assumptions are based on historical experience and any other factors that are deemed relevant. Actual results may differ from these estimates and are continually reviewed to ensure validity remains appropriate. These revisions are recognised in the period in which they occur or the current and future periods, as appropriate.

Performance Overview

The NHS operational priorities for 2023/24 provided focus for acute Trusts to recover core services to improve patient safety, outcomes, and experience by improving ambulance response and A&E waiting times and reduce elective long waits and cancer backlogs and improve performance against the core diagnostic standard.

The national position for both Urgent and Emergency Care (UEC) and planned care (elective, cancer, and diagnostics) remained challenged in 2023/24 due to three key reasons:

1. The NHS continues to deal with significant patient backlogs that developed during the early phase of the Covid-19 pandemic.
2. Frequent instances of Industrial Action throughout 2023/24 resulted in curtailments in planned care activity across the NHS with staff working hard to maintain access to services for those patients presenting with urgent clinical needs.
3. Demand for UEC services has been high particularly over the winter period with attendance and admission surges and growth outstripping planned levels.

In 2023/24 our key initiatives included:

- Investing to increase our substantive workforce in our Emergency Department and across our bed base.
- Implementing revised operational processes e.g. streaming processes for ambulance handover supporting further improvement against the 15 minute ambulance handover target.

- Delivering insourcing, outsourcing, additional sessions, and mutual aid to support increases in planned care activity supported by the national Elective Recovery Fund (ERF) and Community Diagnostic Centre (CDC) funding.
- Opening a new theatre at Newark Hospital as part of our Targeted Investment Fund.

The challenges detailed above, which are common across the whole NHS, meant that performance against some of our key targets fell short despite our best efforts.

- Our four-hour emergency access performance deteriorated in-year, improving in March 2024 following sustained local and national focus.
- Ambulance handover remains an area of strength for SFH with performance best in the region and within the top 10 nationally.
- Our elective long waits, cancer 62-day backlog and diagnostics positions all deteriorated and then improved in-year.
- For our cancer patients we consistently delivered against the 28-day faster diagnosis standard and met our planned two-week wait 62-day backlog target that we set ourselves at the start of the year.

In common with previous years, throughout 2023/24 we prioritised treating patients in most need of clinical attention.

Performance Analysis

The Trust's vision in 2023/24 was healthier communities and outstanding care for all. To achieve this, we have a Performance Management Framework (PMF) that tracks and evaluates our progress with routine performance reporting to our Trust Board and sub-committees.

Performance Management Framework

Our Performance Management Framework (PMF) specifies the structures, systems, processes, and responsibilities required to embed a culture of performance management and accountability. Effective implementation supports the delivery of national standards and the Trust's quality, financial and operational objectives. Our performance management and oversight mechanisms support people to excel, whilst managing, understanding, and rectifying performance issues. Our performance management approach is aligned to the Single Oversight Framework, reporting in an integrated approach against quality care, timely care, best value care and people and culture with key performance indicators supporting the delivery of our annual strategic priorities.

Performance issues are escalated through service-line reporting to bi-monthly divisional performance reviews. Divisional performance reviews inform performance escalation and assurance reporting to Trust Board and sub-committees.

We review our key performance indicators and performance report on at least an annual basis to remain aligned to both external and local strategic priorities. We also consider our performance against local Trusts and nationally with benchmarking reports shared with our

clinical divisions and benchmark data sitting alongside our local data in many of our Trust Board and sub-committee reports.

Performance against key operational standards in 2023/24

In the sections below we describe a summary of operational performance for each patient care pathway.

Urgent and Emergency Care (UEC)

Demand for UEC services has been high throughout 2023/24 and particularly over the winter period with attendance and admission surges and growth outstripping planned levels. The pressure on our services from high patient demand has been sustained, much like many acute Trusts across the country. The combination of high attendance and admission demand, length of stay pressures and mismatches in admission and discharge times meant that, at times, patient demand exceeded the capacity of our hospitals. Whilst progress was made in quarters three and four to reduce the number of medically safe and long stay patients in our hospitals, the benefit did not result in reduced bed occupancy due to growth in admission demand.

Unfortunately, our four-hour emergency access performance deteriorated in-year, improving in March 2024 following sustained local and national focus. Despite the demand challenges, we continued to provide timely ambulance handover with a step change improvement in our 15-minute handover performance from November 2023 as we introduced new handover processes. We consistently benchmark as the best Trust in the region for ambulance handover and are within the top 10 nationally. We continue with a strong medical Same Day Emergency Care (SDEC) offer exceeding national targets and are excited to launch surgical and frailty SDEC in 2024/25.

We have six times daily flow meetings to provide oversight and to agree actions to mitigate potential flow issues that might delay timely patient transfer into, through and out of our hospitals. We have made developments in how we are using our information systems to gain real-time oversight of key performance indicators to support decision-making to provide the best possible care to our patients.

The Integrated Care System UEC Delivery Board, attended by leaders from across health and social care in Nottingham and Nottinghamshire, continues to oversee improvement plans for UEC. To deliver consistently better access to emergency care remains one of our top priorities for 2024/25, making sure there is sufficient system capacity to care for emergency patients alongside delivering planned care to those who have been waiting.

Planned Care

The heightened backlog of elective patients that developed over the course of the early phase of the pandemic continues to have an adverse impact on our ability to deliver against the national planned care standards.

Our elective long waits and diagnostics positions all deteriorated and then improved in-year as we faced pressure on our planned care pathways due to the frequent instances of Industrial Action. During instances of Industrial Action staff working on planned care pathways were often needed to support patients presenting and at our hospitals requiring immediate clinical attention.

The national requirement to meet zero 78-week waiters continues to be missed due to a mixture complexity or patient choice with five patients waiting greater than 78-weeks at the end of March 2024. The number of 65-week waiting patients began to reduce during quarter with further work required in 2024/25 quarters one and two to ensure no patients are waiting more than 65-weeks unless due to patient choice. We continue to work together as a system with patients being transferred between providers as part of mutual aid arrangements. We are benefiting from some mutual aid to help with our Echocardiograph position, one of our underperforming diagnostic tests, which together with insourcing plans is gradually helping us to reduce the significant backlog. Again, further focused work to support a reduction in the number of patients waiting for an Echocardiograph will continue in 2024/25.

We have successfully increased the number of outpatient appointments and daycase procedures often exceeding planned activity levels. Our overall diagnostic activity levels remain strong; albeit with further work to improve the timeliness of diagnostics to achieve pre-pandemic levels of performance against the relevant constitutional standards. The planned development of a diagnostic hub at Mansfield Community Hospital is progressing with building works taking place in 2024/25.

Access to the independent sector has supported patient care with joint working with this sector planned to continue. We made use of additional sessions together with insourcing and outsourcing options to increase capacity in areas under pressure. We do have some areas across our outpatient, diagnostic and treatment services with large backlogs that we are working hard to address. This will be a key focus of 2024/25.

We have made excellent use of Patient Initiated Follow Up (PIFU) pathways, delivering against the national ambition with more work planned to ensure that patients only return to hospital when needed.

We plan to continue to focus heavily on the recovery of our clinical services in 2024/25, which in turn will support the recovery of our underperforming planned care operational performance standards.

Cancer standards

For our cancer patients we consistently delivered against the 28-day faster diagnosis standard and met our planned two-week wait 62-day backlog target that we set ourselves at the start of the year (our local target was more ambitious than the national fair shares target). Throughout the Covid-19 pandemic we prioritised the diagnosis and treatment of patients with suspected cancers when other less urgent surgery was paused. Like other organisations we have seen growth in Cancer two-week referrals following a similar increasing trend seen over the last decade.

In October 2023 revised national cancer waiting time standards were launched with the original 10 standards reduced to three. We revised our performance reports to reflect the refreshed guidance.

We have specific tumour site challenges impacting on our 31-day and 62-day cancer performance with specific actions plans in place for skin and lower gastrointestinal.

We remain focussed on progressing actions to mitigate the risks to our cancer standards on a month-by-month basis, while addressing the underlying challenges that have been compounded by the pandemic, instances of Industrial Action and growing patient demand.

Forward look

Improving people's lives and experience of care is at the heart of what matters to us and helps to drive the change we want to see. It is widely accepted nationally that the current speed of change across health and social care, such as the spread and adoption of new ideas is too slow to meet current and upcoming challenges including higher demand for health and care.

The NHS remains in unprecedented times, balancing multiple priorities including UEC attendance and admission surges in demand, planned care waiting list challenges and ongoing pressure from Industrial Action.

Throughout 2023/24 we have innovated and developed our services and collaborated with system partners with some key initiatives listed in the earlier performance overview section. As we look forward to 2024/25, we have further exciting developments including:

- Expand our Same Day Emergency Care (SDEC) services with the launch of Surgical SDEC and Frailty SDEC.
- Open our new discharge lounge – a dedicated facility to support the timely transfer of patients ready to leave our hospital from either our Emergency Department or one of our acute wards.
- Improve our discharge processes with a new team of Discharge Coordinators supporting our ward-based teams and working with patients and their families.
- Open, refurbished procedure rooms at Newark Hospital.
- Deliver key improvement programmes for outpatients, theatres and to support optimised patient length of stay.

Emergency Planning Resilience & Response (EPRR)

The Trust has an Accountable Emergency Officer (our Chief Operating officer) with Board level responsibility for emergency preparedness.

As a category 1 responder under the Civil Contingencies Act there are a number of legal obligations:

- Plan for Emergencies
- Assess Risk
- Have Business Continuity Systems in place
- To Warn and Inform the Community
- Cooperate with Other Responders
- Share information with Other Responders

Annually the Trust is assessed against the (circa) 62 core standards for emergency preparedness and is currently rated as “Partially Compliant” with an 82% rating. The Trust, on an on-going basis, engages with its partners to assess risk and plan for system-wide incidents and emergencies, and has responded to various incidents over the past twelve months, such as flooding (from Storm Babet) and extreme operational pressures.

The EPRR structure has also been utilised to successfully manage on-going industrial action.

Reporting directly to the Accountable Emergency Officer, the Emergency Planning Officer operates within an annual workplan, which includes regular exercising and testing of plans and training of relevant response staff.

The risk of a major disruptive incident is captured as Principal Risk 7 within the Trust’s Board Assurance Framework.

Accountability Report

Directors' Report

Board of Directors

The Board of Directors is the team responsible for the management and performance of the organisation and for setting the future strategy. Our Board has overall responsibility for the preparation and submission of the Annual Report and Accounts; the Board considers the Annual Report and Accounts, taken to be fair, balanced, and understandable, and provides the information necessary for patients, regulators, and other stakeholders to assess the Trust's performance, business model, and strategy.

The primary responsibility of our Board of Directors is to promote the long-term success of the organisation by creating and delivering high quality services within the funding streams available. Our Board seeks to achieve this through setting strategy, monitoring strategic priorities, and providing oversight of implementation by the Executive Management Team. In establishing and monitoring its strategy, our Board considers, where relevant, the impact of its decisions on wider stakeholders including staff, partners, and the environment.

So far as the Directors are aware, there is no relevant audit information of which the NHS Foundation Trust's auditor is unaware, and the Directors have taken all the steps that they ought to have taken as Directors to make themselves aware of any relevant audit information and to ensure the NHS Foundation Trust's auditor is aware of that information.

The individuals who served at any time during the financial year as directors were as follows:

Name	Job Title	Commenced in post	Seconded to another role	Termination date
Claire Ward	Substantive Chair	01/10/2021		
Barbara Brady	Non -Executive Director	01/10/2018		
	Senior Independent Director	01/11/2021		
Graham Ward	Non-Executive Director	01/12/2015		
Manjeet Gill	Non-Executive Director	01/11/2018		
Steve Banks	Non-Executive Director	01/12/2021		
Dr Aly Rashid	Non-Executive Director	10/01/2022		
Dr Andy Haynes	Specialist Advisor	18/04/2021		
Andrew Rose-Britton	Non-Executive Director	01/04/2022		
Neil McDonald	Non-Executive Director	07/12/2023		
Paul Robinson	Interim CEO	01/10/2021		31/03/2022
	Substantive CEO	01/04/2022		
Dr David Selwyn	Executive Medical Director	09/12/2019		
Philip Bolton	Chief Nurse	30/05/2022		
Shirley Higginbotham	Director of Corporate Affairs	04/04/2013		31/05/2023
Rachel Eddie	Chief Operating Officer	25/07/2022		
Richard Mills	Interim Chief Finance Officer	01/10/2021		
	Chief Finance Officer	10/06/2022		
Rob Simcox	Director of People	10/06/2022		
David Ainsworth	Director of Strategy and Partnerships	01/07/2022		31/03/24
Sally Brook Shanahan	Director of Corporate Affairs	15/05/2023		
Claire Hinchley	Acting Director of Strategy and Partnerships	29/02/2024		

The balance, completeness and appropriateness of our Board membership is reviewed periodically and upon any vacancies arising among either the Executive or Non-Executive Directors. The balance of skills is appropriate to the requirements of the organisation. Board Directors are required to declare any interests that are relevant and material on appointment,

or should a conflict arise during their term. A register of Board members' interests is maintained by the Director of Corporate Affairs and is published annually as covered later in this Annual Report. Board Directors are also required to meet the Fit and Proper Persons Test, the new, strengthened framework for which came into force on 30th September 2023, and which is evidenced in their individual personal files.

The Chair, Claire Ward, is also a Non-Executive Director of Institute for Collaborative Working, a not for profit membership organisation and professional business institute working across a number of different sectors to promote collaborative working and the implementation of ISO 44001, Director of Pharmacists Defence Association Ltd, a Non-Executive Director of Groupe Eurocom Ltd., a member of the Advisory Board to Alliance Healthcare Limited and owner of Capewells Limited, a consultancy company which acts for a number of pharmacy and pharmaceutical companies and organisations and organisations and was been selected as the Labour Party candidate for the East Midlands Regional Mayor (covering Nottinghamshire and Derbyshire) on 3rd August 2023.

Attendance at Board meetings

Name	Public		Private	
	Actual	Possible	Actual	Possible
Paul Robinson	12	12	13	13
Dr David Selwyn	12	12	13	13
Shirley A Higginbotham	1	2	1	2
Sally Brook Shanahan	10	10	11	11
Richard Mills	11	12	12	13
Rob Simcox	11	12	12	13
Philip Bolton	11	12	11	13
David Ainsworth	10	11	11	12
Rachel Eddie	9	12	9	13
Claire Hinchley	1	1	1	1
Claire Ward	12	12	13	13
Graham Ward	12	12	13	13
Barbara Brady	11	12	11	13
Manjeet Gill	11	12	12	13
Steve Banks	11	12	12	13

Dr Aly Rashid	9	12	10	13
Dr Andy Haynes	9	12	10	13
Andrew Rose-Britton	11	12	12	13
Neil McDonald	3	4	3	4

Register of Interests

The Register of Interests for all members of our Board is reviewed regularly and published annually on our website <https://www.sfh-tr.nhs.uk/about-us/register-of-interests/>. The register is maintained by the Director of Corporate Affairs, who is based at Sherwood Forest Hospitals NHS Foundation Trust, Trust Headquarters, Level 1, King's Mill Hospital, Mansfield Road, Sutton-in-Ashfield, Nottinghamshire, HG17 4JL.

All members of our Board and Council of Governors must disclose details of company directorships or any other positions held, in general and more specifically with organisations who may trade with the organisation.

We maintain NHS Litigation Authority insurance, which gives appropriate cover for any legal action brought against our directors to the extent permitted by law.

Cost allocation

We have complied with the cost allocation and charging requirements as set out in HM Treasury and Office of Public Sector Information guidance.

Political donations

In accordance with historical and intended future practice, no political donations were made during the year ended 31st March 2024.

Better Payment Practice Code

Unless other terms are agreed, we are required to pay our creditors within 30 days of the receipt of goods or a valid invoice, whichever is the later. This is to ensure that we comply with the Better Payment Practice Code.

The Trust compliance fell in year against the 95% in year target. This has been reported to and is being monitored by the Audit and Assurance committee.

Our performance against this metric is shown as follows:

	2023/24		2022/23	
	Number	£000s	Number	£000s
Total non-NHS trade invoices paid in the year	74,280	315,407	72,102	279,445
Total non-NHS trade invoices paid within target	61,820	295,635	57,395	260,685
Percentage of non-NHS trade invoices paid within target	83%	93%	80%	93%
Total NHS trade invoices paid in the year	2,214	30,043	2,102	30,026
Total NHS trade invoices paid within target	1,791	28,512	1,743	28,709
Percentage of NHS trade invoices paid within target	80%	95%	83%	96%

Late Payment Interest

Legislation is in force which requires Trusts to pay interest to small companies if payment is not made within 30 days, known as the Late Payment of Commercial Debts (Interest) Act 1998. The Trust paid £2k in claims under this legislation. The total potential liability to pay interest on invoices paid after their due date during 2023/24 would be £ 25.61k. (2022/23 £15.82k). There have been minimal claims under this legislation, therefore the liability is only included within the accounts when a claim is received.

All of this relates to non-NHS invoices, and none relates to NHS healthcare contracts.

Income Disclosures

We have met the requirement under Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) that the income from the provision of goods and services for the purposes of the health service in England must be greater than its income from the provision of goods and services for any other purpose. Other income generated by us was used to support the provision of our health services.

Well-Led Framework

Grant Thornton undertook an external Well-led review of the organisation, delivering its final report to the Trust in March 2022.

The Well-Led review is an important assessment for the Trust, not only because trusts are expected to advise NHSE of any material governance concerns that have arisen from the review and the action plan in response to those concerns, but more importantly because it provides the opportunity for the Trust to fully understand the strengths and weaknesses of its current governance arrangements and implement actions at an appropriate pace.

The initial report detailing the 15 recommendations was presented to Board in April 2022 and further update reports in August 2022, February 2023, August 2023 and March 2024. At the March 2024 meeting the current status and embeddedness in relation to the recommendations was reported. A decision was taken to conclude the on-going monitoring of the actions from the 2022 Grant Thornton Report and commission a follow-up external Well-Led report in the context of the CQC's updated assessment framework.

The Care Quality Commission inspected us during 2020 and assessed our overall Trust Well-Led score as Good, and King's Mill Hospital Outstanding.

Patient Care

Our vision to support the local people to be healthier is supported by our values of:

Communicating and working together

Aspiring and improving

Respectful and caring

Efficient and safe.

We have robust systems and processes in place to enable colleagues to celebrate where we provide excellent, safe, high-quality care, but also quickly identify areas of focus for further improvement.

Patients at King's Mill Hospitals' Emergency Department have reported that they are some of the most respected patients in the region and are receiving some of the best care and treatment according to the latest independent Care Quality Commission Urgent and Emergency Care patient survey. Sherwood Forest Hospitals has scored well for the way doctors and nurses treat patients in its Emergency Department (8.5 out of 10), the care and treatment they received (8.4 out of 10), the environment and facilities (8.6 out of 10) and the respect and dignity patients receive (9.2 out of 10).

Quality Strategy

The Quality Strategy sets out our approach to ensuring each patient contact is safe and effective and builds on the robust foundations of quality. The strategy outlines our objectives and the outcomes we want for our patients and demonstrates our commitment to ensuring that high standards of quality and patient care are delivered.

We are proud of in our achievements during the last 12 months. We have continued to make, and sustain, improvements in quality and safety whilst facing significant operational pressures.

Campaign One: Create a positive practice environment to support the delivery of safest and most the effective care:

How have we performed:

- Gained accreditation and awarded the Pathway to Excellence designation by the American Nurses Credentialling Centre (ANCC)
- Our Pathology, Pharmacy and Decontamination departments have maintained their accreditation for a further year.
- We have developed an e learning package for new starters and since April 2023 have had 0 lapses in care from falls with harm.
- EPMA is now live across the Trust in Medicine, Surgery and UEC division.
- Campaign Two: Excellent patient experience for users and the wider community

How have we performed:

- Recent recruitment of four Patient Safety Partners, who supported the launch of PSIRF, this role out will continue to be embedded and will develop moving forwards with consideration to audits, recruitment and feedback campaigns.
- We continue to produce monthly patient stories, allowing shared learning, improvement, and positive working.
- We are very proud of our Patients are encouraged to provide feedback during the 15 Steps Challenge, seeing discussions taking place with executive team members, senior leaders, Non-Executive Directors, and Trust Governors.

Campaign Three:

Strengthen and sustain a learning culture of continuous improvement.

How have we performed:

- The Patient Safety went live on 2 October 2023 following approval of the Patient Safety Incident Response Plan and policy and is now embedded across the Trust.
- An oversight group was formed to provide assurance to the Quality Committee and Board.
- People strategy was launched in June 2023

Campaign Four:

Deliver high quality care through kindness and supporting each other.

How have we performed:

- The Trust Reward and Recognition Strategy was refreshed in 2023.
- Enhanced visibility of Trust recognition awards with the return to face-to-face annual Excellence awards
- Further promotion of recognition opportunities (Daisy and Tulip)
- Focus on reduction of violence and aggression: strategic group formed with Executive and Safeguarding representation.
- TRiM Pilot is underway and progress will be evaluated on completion.
- Staff survey published in October 2023 showed a 62% response rate, 3rd best for recommending Sherwood as a place of work and best in the Midlands for recommending the Trust for care.

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

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

The work of the Improvement Faculty will be supported by the development and implementation of a Continuous Quality Improvement Strategy (CQIS); the purpose of which is to set out the Trusts ambition and aspirations in terms of delivering strategic objective 4 of the Trusts Strategy 2024-29 'Improving Lives'. Strategic objective 4 is to 'Continuously Learn and Improve'. A strong culture of continuous improvement will enable better outcomes for our patients, our service delivery and safety, our people's experience, our finances and our population's health and wellbeing.

The CQIS will be launched in late spring 2024, and through the development and delivery of an associated action plan, the emphasis in terms of measuring impact will move away from being focused on the role of the Faculty, and instead focus on the impact of the CQIS. This will include a broad range of measures, including (but not limited to):

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

Enhanced Quality Governance

The Trust's quality governance and leadership structure ensure that the quality and safety of care is routinely monitored across all services. The Board is committed to quality governance and ensures that the combination of structures and processes at Board level and below supports quality performance throughout the Trust. The effectiveness of the Trust's governance arrangements is regularly assessed through internal and external audit. The Trust has well developed, robust structures and reporting mechanisms to ensure that quality goals are identified, monitored and, where performance is sub-standard action is taken to rectify the situation. The Patient Safety Committee provide oversight for quality governance arrangements within the Trust. The reporting structure from 'ward to board' provides the required assurances that our patients receive the high quality, safe care they deserve.

The Patient Safety Committee (PSC) are overseen by the Executive Team, and meet monthly, providing a reporting and assurance role to the Trust Board's Quality Committee. Performance information related to quality and patient safety metrics are reviewed and cross referenced with other intelligence available to the governance team prior to inclusion in Trust performance and quality reporting, the metrics are regularly reviewed. The PSC work plan is aligned to that of the Quality Committee. Sub-groups provide assurance in relation to compliance with CQC essential standards and NICE guidance, risks to clinical quality are proactively identified, prioritised, and managed. Effective learning is embedded from serious incidents and Duty of Candour, inquests and claims, complaints, and patient feedback.

The Trust has not had any onsite inspection from the CQC during 2023/24. The recently relaunched quarterly engagement meetings maintain an excellent relationship with the CQC who are invited to the Patient Safety Incident Review panels, Patient Safety committee and the Patient Safety incident response Oversight Group. We encouraged them and our Integrated Care Board colleagues to visit wards and departments on a regular basis.

Involvement of Governors

Our Council of Governors have continued to play an important role in the delivery of safe, high-quality care, working in partnership with the Board of Directors, giving them support and advice to help shape the Trust's plans and ensure high quality services are delivered. During 2023/24 members of the Governing Body have taken an active role in our formal and informal visits to wards and departments, and have provided an invaluable, impartial, and observational perspective on how we conduct business. They continue to support our Quality Committee acting as representatives of patients, the public and staff and providing a direct link between the Trust and the communities they represent.

Patient Care: Improvements in patient/carer information

The patient information service continues to provide specific and tailored information, education, and support. Information is evidence-based, clinically accurate, up-to-date, and written in a way to enable patients and their families/carers to better understand their care and treatment.

Leaflets are stored in an easily accessible patient information library on the Trust's website. Accessibility tools and information on interpreting and translation are available.

The patient information leaflet section on our intranet site helps colleagues in their production of patient information leaflets for their respective specialties/services. As well as a policy and instructions on how to create a new/reviewed leaflet, accessible information, and health literacy (including a literacy checker) pages are available to further educate colleagues.

To tackle health inequalities, mainly poor health, and digital literacy among the local population, we signed the Patient Information Forum (PIF) Health and Digital Literacy Commitment Charter in 2020. Aspiring to become health and digital literacy friendly, accredited training sessions were put in place for Trust staff to learn how to implement techniques to enhance approaches and practice that effectively support people with low levels of health and digital literacy.

To further improve effective patient communication, a series of QR code posters have been introduced across the Trust linking to relevant Trust-approved patient information leaflets. The aim is to get the information patients need directly on to their digital devices where they can access it more easily. These posters will not completely replace direct website downloads or paper copies of leaflets (due to poor digital literacy), they will enhance the service, while also supporting the Trust's Green Plan commitments by reducing use of paper.

Following a comprehensive accessibility of the Trust's public-facing website, further work has been planned for 2024/25 to make it even easier for patients to access this vital information online.

Complaint Handling

SFH 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.

SFH 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.

During 2023/24 to date we have received 290 complaints, a 19% increase compared to 2022/23, this is a further increase of 26 % from the previous year. Of these, 37% were completed within 25 working days or locally agreed timescales with the complainant demonstrating a 30% increase from the previous year. Whilst performance against the time frames standard was noted to be reduced, all complainants were kept updated on the progress of their complaint and an apology was provided to all complainants.

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
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The top five themes for complaints 2022/23 are highlighted below.

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

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

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

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

In 2023/24, the PHSO initiated 7 additional new complaints reviews, had 4 cases currently under ongoing investigation, and had concluded 3 investigations. The Patient Experience Team pre-empt that correspondence from the PHSO will continue to increase in during 2024/25 and that new contacts made will include requests for further Local Resolution, written responses of meetings that have taken place and financial remedy for those partially or fully upheld.

Sherwood Forest Hospitals NHS Foundation Trust intends to take actions to improve these percentages, sharing data with all divisions, enabling learning in all areas, triangulating with other data collection sources for patient feedback.

Action plans will be developed, around learning and improvements from the complaints received, and the data will be collated and analysed for any themes and trends that could be occurring, allowing improvements to the services that SFH is providing to patients.

Stakeholder relations

We continue to deliver on our role within the health and care system in order we make a valuable contribution to improving the lives of our citizens.

The Trust published its first Partnerships Strategy in February 2024, setting out its ambitions as a partnership organisation, the priorities for the next five years and how it will improve lives through intentional partnerships. The Trust also developed its first Clinical Services Strategy (CSS) which was finalised in April 2024. It commits to work with partners to prevent the onset and development of disease; to develop our role in population health management and contribute to increasing healthy life expectancy; and for patients' and carers' experiences of health and social care to be seamless regardless of the provider organisation.

Our partnerships are focused on delivering those strategic aims and through collaboration we will be able to improve patient care and the health of everyone we serve. Our strategic partnerships are summarised below.

We have a leading role in the Nottingham and Nottinghamshire Integrated Care System (ICS), which brings together local NHS services, councils and the voluntary sector with the ambition for people living in Nottingham and Nottinghamshire to live longer, happier, healthier and more independent lives. The strategic priorities are focusing on prevention of ill-health, for there to be equity in everything and integration by default. In 2023/24, the Trust contributed to the ICS's Joint Forward Plan, which sets out how partner organisations will deliver the strategy.

All statutory NHS providers are required to be involved in at least one provider collaborative, which is a partnership bringing together NHS trusts to work together at scale to benefit their populations. The Trust is a partner in two.

One is a county-wide partnership, the Nottingham(shire) Provider Collaborative at Scale (NNPC). During 2023/24 the partnership has focused on scoping opportunities for identifying

and developing efficiency opportunities through joint working focused on people and corporate services.

The Trust is also a partner in the East Midlands Acute Provider (EMAP) Network, which is a partnership of acute trusts across the East Midlands primarily focused on specialist areas identified as challenged.

The Trust is also a committed partner in the Mid Nottinghamshire Place-based Partnership (PBP), which covers Ashfield, Mansfield, Newark and Sherwood and comprises of local statutory and voluntary, community and social enterprise organisations. It is a collaboration of six primary care networks, community and voluntary services, district councils, NHS trusts, other healthcare providers and public health.

In 2023/24 the PBP established its vision to “*work together to create happier, healthier communities and reduce the gap in healthy life expectancy across Mansfield, Ashfield, Newark and Sherwood*”. Its priorities are to:

- designing and implementing integrated services and
- undertaking population health management work to reduce health inequalities and increase preventative care

We are committed to improving patient experience through responding to stakeholder feedback. Through 2023, as part of the development of a new five-year strategy, the Trust engaged with patients and carers, local citizens, foundation trust members and volunteers. We also held workshops and listening events with our people. This ensured that our new strategy was developed with the voices of all our stakeholders to come through into our future priorities.

Consultation with local groups and organisations

Engagement with local groups and organisations has continued over the past year, with much of this engagement centred around the hundreds of conversations that have helped to shape our new five-year Trust Strategy.

Through those conversations, our communities have stressed the need for:

1. Shorter waiting times
2. Better communication
3. Joined-up care; and
4. Personalised care

Maintaining that engagement has been more important than ever over recent years following the pandemic and, over the past year, the Trust has invested in its partnerships work to better engage with local organisations who share our commitment to deliver ‘healthier communities’ together.

Through the #TeamSFH website, social media accounts and close working with local digital, print, and broadcast media, we have continued to keep patients and the wider public informed about what is happening at our hospital sites and supporting everyone to keep safe. This has been broadened to include our Trust’s social media, which continues to reach tens of thousands of local people each week. We have continued to use these same channels to

celebrate our successes and to share important information about service developments at all our sites.

We have also strengthened our links with Primary Care with regular attendance in each other's key meetings opening channels between GPs and the Trust and we are now part of the Integrated Care Board.

The Mid-Nottinghamshire Place Based Partnership continues to meet in public monthly. Bringing together key partners including the voluntary sector and local authorities. In ways that add value to the communities we serve.

A key part of how we engage with our local communities over the coming year will involve a refreshed approach to how we engage with our Trust's public of over 13,000 public members. This work will continue with our elected Council of Governors under the leadership of our new Lead Governor.

We continued our focus on engaging and recruiting more young members to the membership, establishing links with our local further education colleges, and developing a communications and engagement strategy.

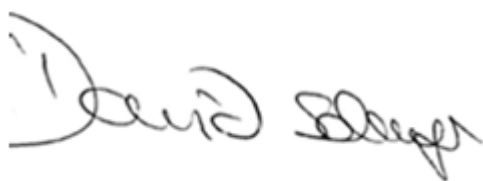
Our Patient Experience Team is often the first point of call for patients with both negative and positive experiences of our services, and they work closely with our divisions to ensure we respond appropriately to individuals. The service has a clear governance process for reporting themes or concerns for oversight and action via our Patient Safety Committee. We respond to comments made via Care Opinion, and regularly share both positive and negative comments on social media, encouraging patients to share their feedback to help us improve.

We continue to meet with our MPs, local politicians and other partners and stakeholders, including district council leaders and Healthwatch representatives.

We are the largest employer in our area by a significant margin and we know that by engaging effectively with our staff (evidenced by staff engagement which remains the best in the country in the *NHS National Staff Survey*) we are, by extension, also communicating effectively with our service users and community.

We communicate and engage with #TeamSFH colleagues using a range of channels, including staff briefings across all sites, blogs, a weekly e-newsletter, WhatsApp and a closed Facebook group with more than 3,200 members. Specific networks for ethnic minority disabled and LGBTQ+ colleagues has also all been strengthened.

We've developed a strategic compact with Vision West Notts College and started delivering on our year 1 priorities. This has been inclusive of Nottingham Trent University.



David Selwyn
Acting Chief Executive Officer

25th June 2024

Statement of Health Inequalities 2023-24

Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society. In accordance with NHS England's statement on information on health inequalities, we report here the Sherwood Forest Hospitals NHS Trust (SFH) position in the domains relevant to our trust:

- Elective recovery
- Urgent and emergency care
- Smoking cessation
- Oral health

Deprivation and ethnicity are two key drivers of inequality and often affect a person's ability to access healthcare, their outcomes when receiving a diagnosis or treatment for a condition and their experiences of settings when receiving care. Evidence shows these elements are more likely to be negative when compared to people accessing care living in the least deprived areas. There are also other population groups who may have additional complexities which increase their risk of health inequalities, such as learning disabilities or those with severe and multiple disadvantage.

Population profile

SFH serves a population of 350,000 across Ashfield, Mansfield, Newark and Sherwood (Mid Nottinghamshire) and beyond.

Deprivation

Mid Nottinghamshire is more deprived overall than the England average, with 28% of the population living in the most deprived areas of England (defined as in the most deprived 20%, source: eHS Profile Tool, N&N ICB SAIU). The area has a higher proportion of older people, with 20.1% of the Mid Nottinghamshire population aged 65 years and over against an England average of 18.6%.

More people in Mid Nottinghamshire report a long-term illness or disability and poor health. The period of life people have before illness or disability, also known as healthy life expectancy, is lower overall in Mid Nottinghamshire than other areas of the county. Healthy life expectancy in Mid Nottinghamshire spans 58 to 66 years compared to the best in the County (Rushcliffe) where healthy life expectancy is 70.

There are also disparities between men and women when looking at years spent in good health. Although women may live longer, they are living in poorer health for longer and at a younger age than men.

The prevalence of major illness such as diabetes, respiratory illness, heart failure, dementia, asthma and stroke and use of tobacco and alcohol is higher in Mid Nottinghamshire than the England average, but it is not equally distributed across all areas. Poor healthy life expectancy not only decreases quality of life but also has wider reaching economic consequences for the local system. If people become ill at a younger age it can increase the risk of economic inactivity, creating losses for the local economy in addition to increased costs incurred by the NHS.

Ethnicity

The Mid Nottinghamshire population is less diverse than England. 88.2% of the population is white compared to 74.4% nationally and 6% is black and minority ethnic, of which the largest group is Asian / Asian British (2% of the population). In addition, 3.1% have chosen not to state their ethnicity and 2.7% have not had their ethnicity recorded.

Elective care

Elective care covers a broad range of non-urgent services often delivered in a hospital setting including, diagnostic tests and scans, outpatient care, surgery and cancer treatment. The COVID-19 pandemic has had a significant impact on the delivery of elective care, meaning that many patients are now waiting longer for treatment than they were before the pandemic began. Elective restoration is one of the five strategic NHS Health Inequality Priorities.

The impact of waiting longer for treatment on individuals, their families and carers is wide ranging. It may result in existing conditions worsening, more complicated surgeries, an increased use of medication, reduced independence, and overall outcomes may be worse, including a reduced quality of life.

In this section the indicator used is elective activity for the previous year compared with pre-pandemic levels for patients under 18 years old and adults (patients aged 18 years and over) split by ethnicity and deprivation.

Elective Admissions

Overall, elective admissions have increased from 43,082 in 2019/20 to 44,634 in 2023/24 (both day case and inpatient), an increase of 3.6%. Data quality on missing postcodes and ethnicity has remained comparable.

The largest proportion of elective admissions are in the most deprived quintiles for both adults and those under 18 years (current and pre-pandemic). However, there is a distinct difference in the findings over time between adults and under 18's.

The picture for adults has remained comparable between 2019/20 and 2023/24. Quintiles 1, 2 & 3 show a very similar position with around 23% of activity in each of these quintiles (Figure 1). Around 10,000 elective admissions occurred in both years in the most deprived quintile (Figure 2).

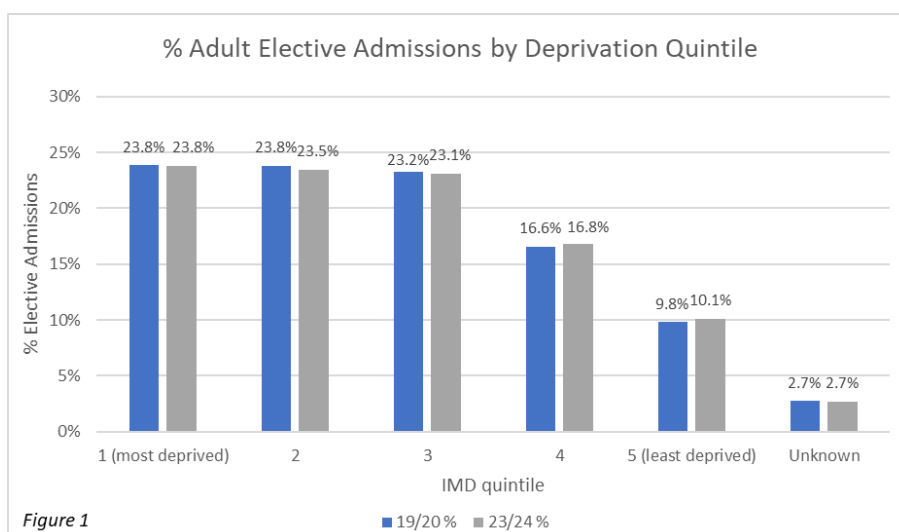
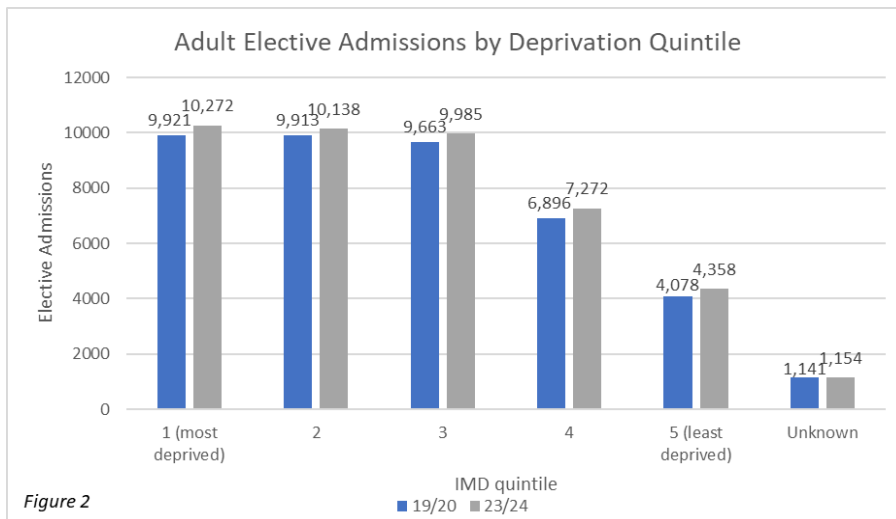
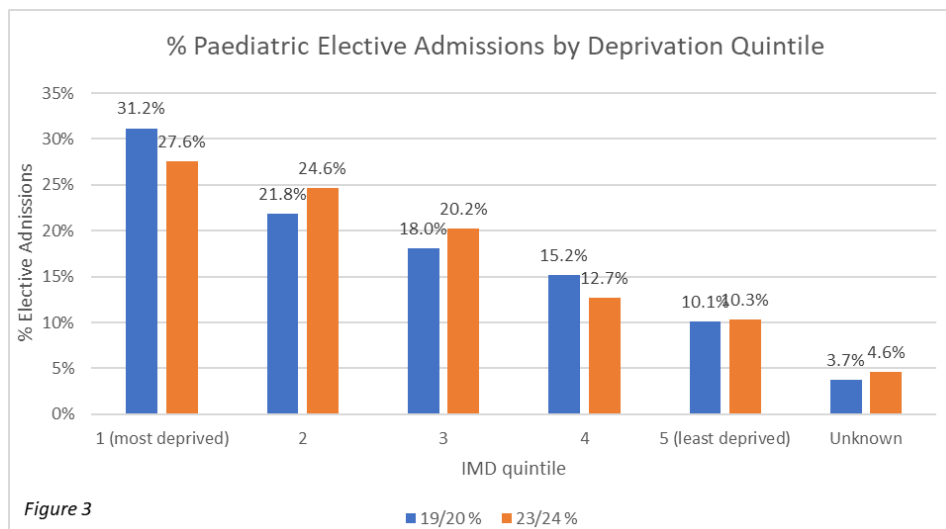
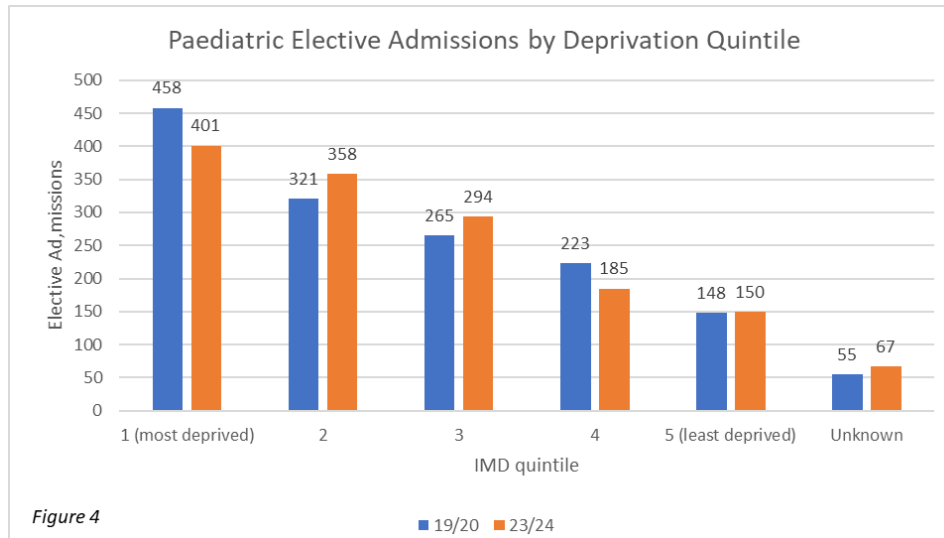


Figure 1



For under 18's there has been a significant reduction in the number of elective admissions in the most deprived quintile. 2019/20 saw 31.2% of under 18 elective admissions in quintile 1 this compares to 27.6% in 23/24 (3.6% reduction – figure 3). In terms of actual admission numbers this is a reduction of 57 admissions from the most deprived quintile (figure 4) however it remains the highest volume quintile. Quintiles 2 and 3 has seen the largest increase in elective admissions (proportionately and volume).





Elective admissions by ethnicity shows that SFH treats a predominantly white population. There have been very minimal changes in the ethnicity of adult elective admissions from pre-covid levels. Under 18's elective admissions are more diverse compared to the over 18's. They have also seen a change since pre-pandemic levels, elective admissions from a white background have decreased from 89.8% in 19/20 to 88.4% in 23/24 (1.4%) (Table 1).

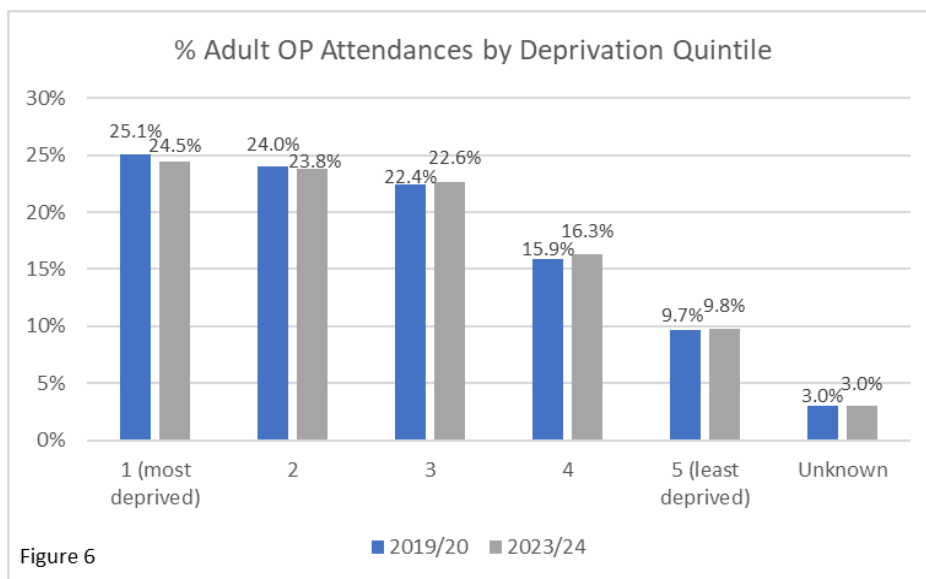
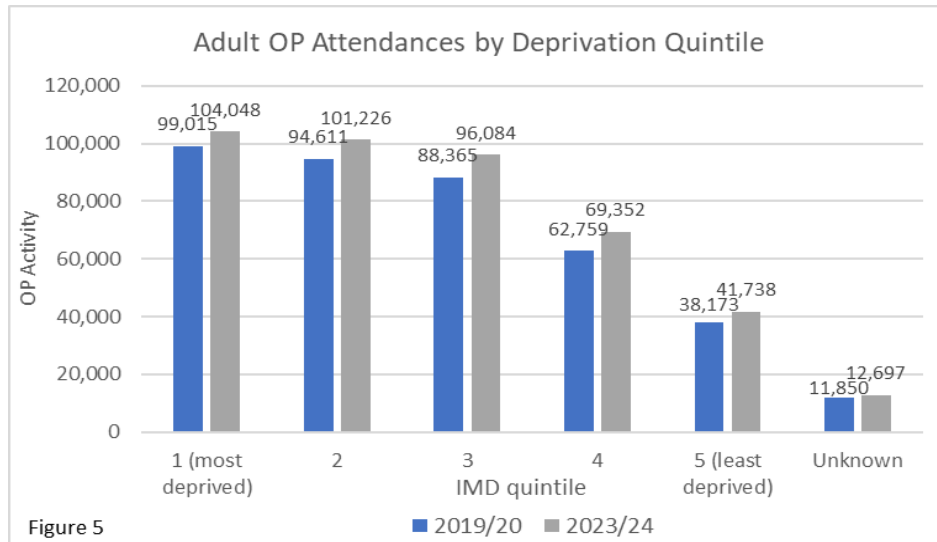
Ethnicity	Adults				CYP			
	19/20 (volume)	19/20 (%)	23/24 (volume)	23/24 (%)	19/20 (volume)	19/20 (%)	23/24 (volume)	23/24 (%)
Asian	47	0.1%	73	0.2%	8	0.5%	4	0.3%
Black, Black Caribbean or African	145	0.3%	170	0.4%	15	1.0%	32	2.2%
Mixed or Multiple ethnic groups	99	0.2%	167	0.4%	25	1.7%	42	2.9%
Other ethnic groups	280	0.7%	480	1.1%	32	2.2%	27	1.9%
Unknown	2,060	5.0%	1,889	4.4%	70	4.8%	64	4.4%
White	38,981	93.7%	40,400	93.6%	1,320	89.8%	1,286	88.4%
Grand Total	41,612	100.0 %	43,179	100.0 %	1,470	100.0 %	1,455	100.0 %

Outpatients

Overall, outpatient attendances have increased from 445,280 in 2019/20 to 477,665 in 2023/24, an increase of 7%. Data quality on missing postcodes has deteriorated marginally since 19/20 however ethnicity data quality has improved with the number of unknown ethnicities reducing by 1,500 despite rising activity levels.

Adult outpatient attendances have risen in every quintile compared to pre-pandemic levels. The highest activity levels continue to be witnessed in the most deprived quintiles, however

the largest increase in activity volume was witnessed in quintile 3 (7,719 additional attendance in 2023/24 compared to 2019/20) (Figure 5). Despite volume in the most deprived quintile rising since pre-pandemic it has reduced by 0.6% in terms of proportion of activity seen (largest % decrease of all quintiles) (Figure 6). Quintile 4 saw the largest proportional increase in activity. 2019/20 quintile 4 saw 15.9% of the activity, this has risen to 16.3% in 2023/24.



For under 18's, we continue to see the highest activity levels in quintile 1. There have been increases and decreases in activity volume compared to pre-pandemic levels. The largest increase in outpatient activity was witnessed in quintile 1 and 3 (increase of 632 (1), 820 (3) - figure 7). There was a reduction in activity in quintile 4 (-177). In terms of the proportion of activity, quintiles 3 and 5 saw their proportion of activity increase in 23/24 compared to 19/20, whilst quintiles 1,2 and 4 saw their activity proportion decrease compared to 19/20 (figure 8).

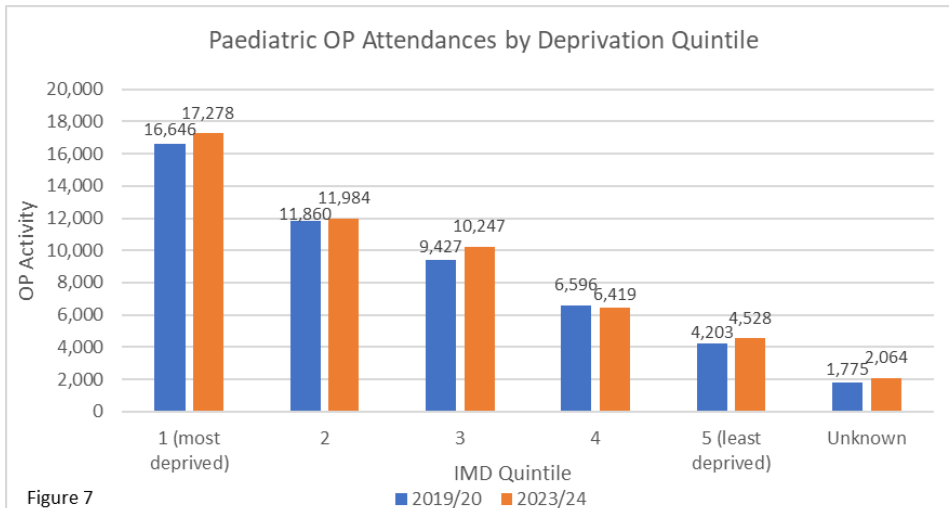


Figure 7

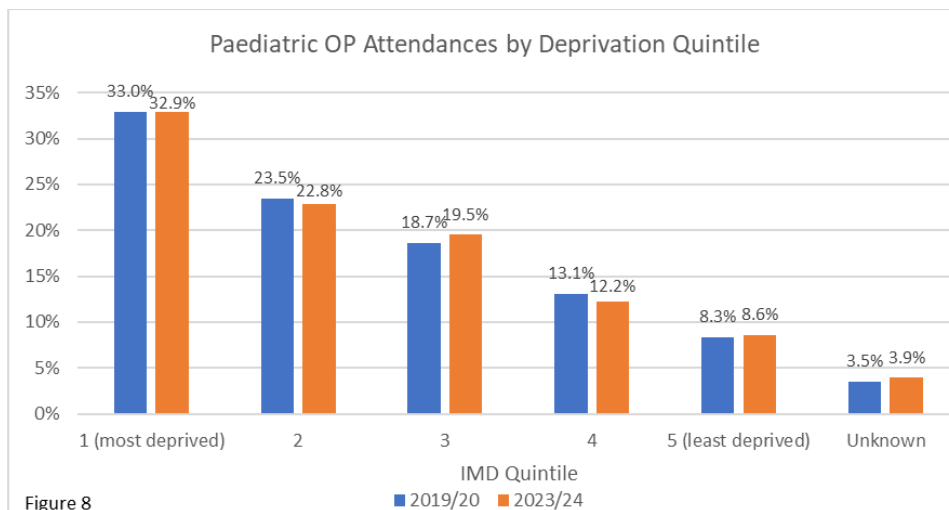


Figure 8

Outpatient attendance by ethnicity shows that SFH treats a largely white population (Table 2).

For adults, there has been a reduction in the number of patients without an ethnicity recorded compared to pre-pandemic data. There has been an increase in volume in all ethnic groups because of increasing activity. The proportion of activity from minority ethnic groups has seen a percentage increase in activity compared to pre-pandemic. Under 18's outpatient attendances are more diverse compared to the adults. Compared to pre-pandemic levels, outpatient attendances from a white background have decreased from 91.6% in 2019/20 to 89.8% in 2023/24 (1.8%) and all minority ethnic groups have witnessed a percentage increase in 2023/24 activities.

Ethnicity	Adult				CYP			
	19/20 (volume)	19/20 (%)	23/24 (volume)	23/24 (%)	19/20 (volume)	19/20 (%)	23/24 (volume)	23/24 (%)
Asian	622	0.2%	1,057	0.2%	139	0.3%	255	0.5%
Black, Black Caribbean or African	1,497	0.4%	2,798	0.7%	232	0.5%	574	1.1%

Mixed or Multiple ethnic groups	1,409	0.4%	2,192	0.5%	898	1.8%	1,223	2.3%
Other ethnic groups	3,732	0.9%	5,179	1.2%	712	1.4%	1,122	2.1%
Unknown	17,213	4.4%	15,832	3.7%	2,265	4.5%	2,191	4.2%
White	370,300	93.8%	398,087	93.6%	46,261	91.6%	47,155	89.8%
Grand Total	394,773	100%	425,145	100%	50,507	100%	52,520	100%

SFH action to respond to health inequalities in elective care.

Actions are ongoing to reduce waiting lists and the number of long waiters. SFH has recently opened a state-of-the-art theatre suite at Newark Hospital, which has the dual benefit of increasing elective activity and freeing up capacity at Kings Mill Hospital.

The Epilepsy Service is aligning its work to the Core20plus5² landscape. The service regularly submits data and participates with the Epilepsy12 national audit. This increasingly highlights variation relating to ethnicity, deprivation, and the co-morbidities of learning disability and autism. This is providing the groundwork for the service to continue reshaping how care is equitably achieved in the future.

SFH is also focused on improving pre-treatment optimisation to help increase access to care whilst improving experiences and outcomes for patients, by including a focus on disparities and health inequalities. In order to help improve patient outcomes on the elective care pathway, a risk stratification process has been outlined, increasing support and intervention for those with more complex needs.

Alongside the pre-treatment optimisation work, SFH has worked with primary care to enable data sharing between the systems, to identify patients who are current smokers. The intention is to use this data to invite patients to intervention services to reduce smoking rates which will, in turn, improve a person's preparedness for surgery.

Both schemes aim to help reduce the risk of procedure cancellation and delays, reducing waiting times overall and improving patient experience and outcomes.

Fixed term funding has been utilised at SFH for a project using a digital pre-op assessment, which includes a patient facing digital questionnaire to support early screening and triage. Although virtual appointments have helped to increase access to healthcare for some, care must be taken for those at risk of digital exclusion which is one of the five NHS five strategic health inequality priorities. Risk factors for digital exclusion include age, ethnicity and deprivation.

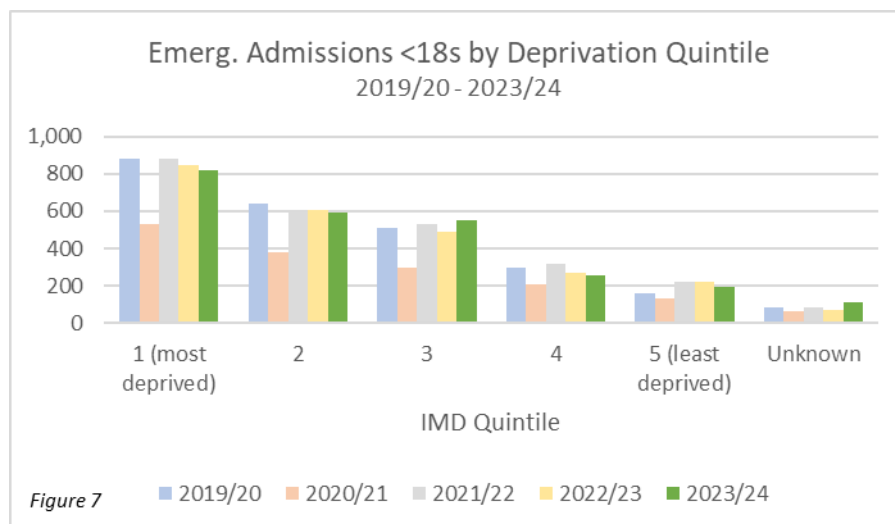
SFH is also embedding personalised care approaches such as shared decision making within elective care pathways to further improve patient experience during treatment.

² Core20Plus5 is national NHS England approach to support the reduction of health inequalities

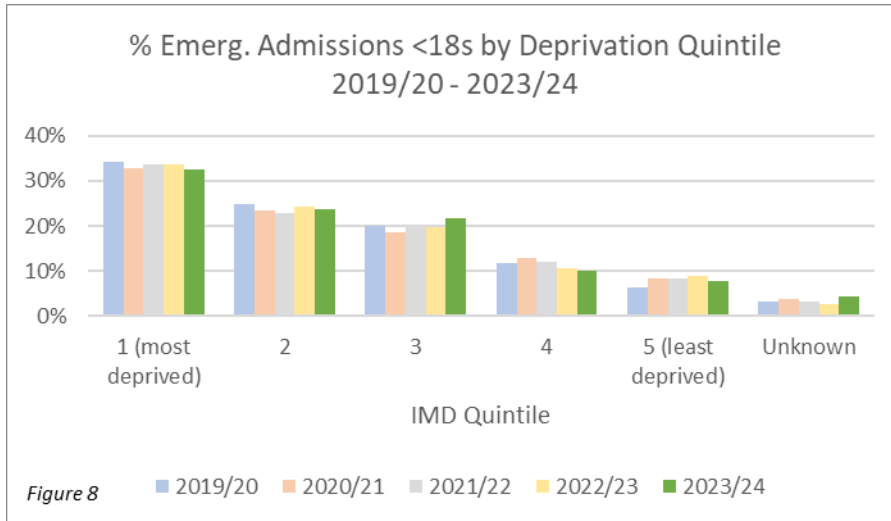
Urgent and emergency care

Urgent and emergency care services provide a critical role in healthcare, often treating people with serious or life-threatening injuries or illnesses who cannot be treated in primary care or in the community. National data shows that people living in the most deprived areas are 1.7 times more likely to attend an emergency department than those in the least deprived areas³. This statement will focus on emergency admissions for under 18's (by ethnicity and deprivation).

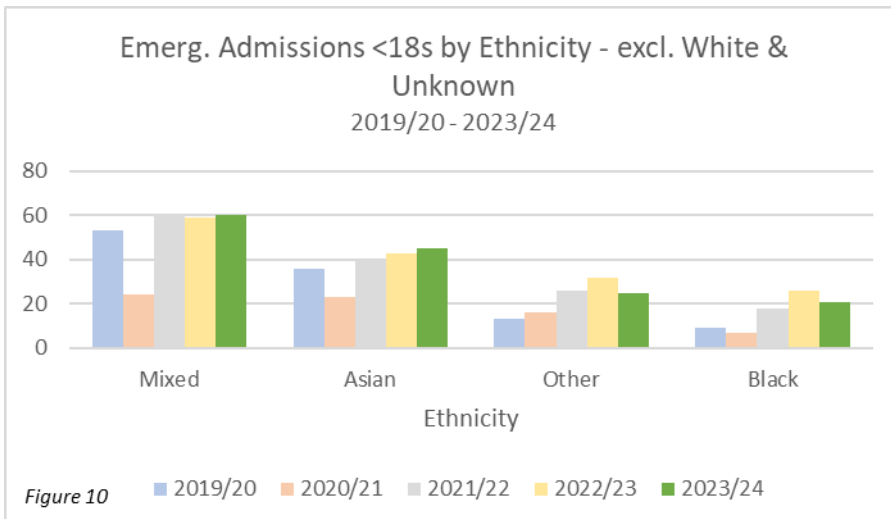
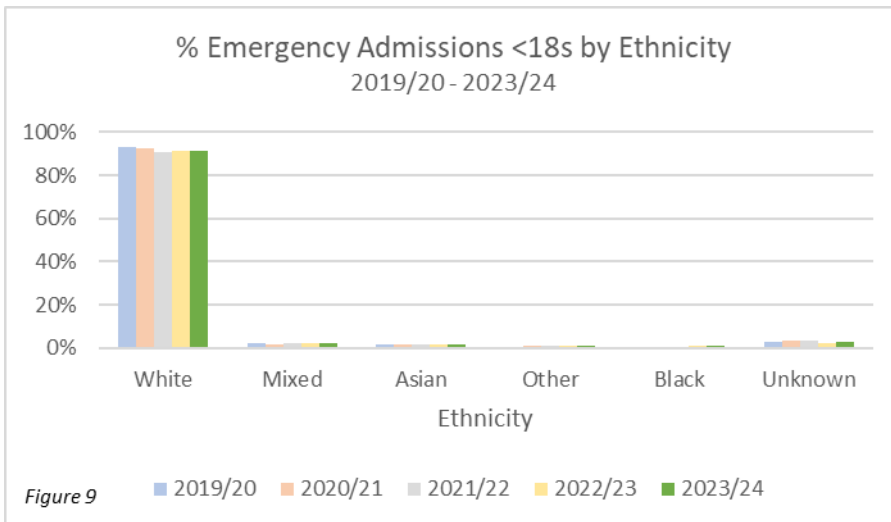
During the last financial year, 2023/24 there were a total of 2,522 emergency admissions for under 18's. Deprivation data were available for 2,414 (95.7%) and ethnicity data were available for 2,455 (97.3%). Emergency admissions for children and young people living in the most deprived quintile was over four times higher than those in the least deprived (Figure 7). There is also a clear trend across the deprivation quintiles over the last five financial years, showing the higher the deprivation, the higher the proportion of emergency admissions for under 18's. There has been a general uptick in the proportion of the middle deprivation quintile since 2019/20, compared with a slight reduction in the quintile 4 (Figure 8).

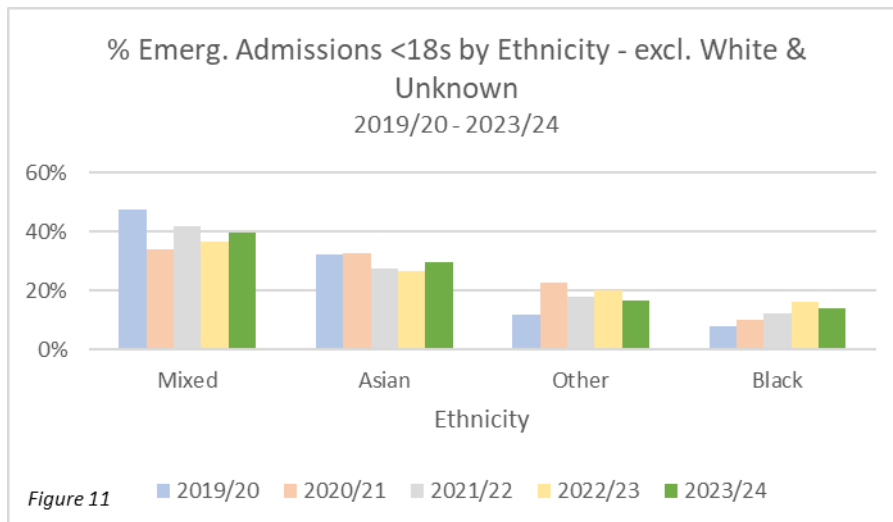


³ Inequalities in Accident and Emergency department attendance, England: March 2021 to March 2022 [Inequalities in Accident and Emergency department attendance, England - Office for National Statistics \(ons.gov.uk\)](https://www.ons.gov.uk/peoplepopulationandcommunity/healthandcare/articles/inequalities-in-accident-and-emergency-department-attendance-england-march-2021-to-march-2022)



Emergency admissions in the white population account for over 90% of activity and this is consistent year-on-year (Figure 9). Excluding the white population, the mixed and Asian groups comprise nearly 70% of the ethnic minority groups (105 as of 2023/34) (Figures 10 and 11). The size order of the ethnic minority groups has remained consistent over the past five financial years.





Actions in Mid Notts to respond to health inequalities in urgent and emergency care

Elective and emergency care admission rates can highlight inequalities prevalent throughout the healthcare system in relation to access and outcomes. The data above indicates that people from more deprived populations are more likely to use emergency care routes and are less likely to be admitted for elective care which may highlight issues in access to preventative care.

SFH's Drug and Alcohol Liaison Team (DALT) work to improve the health and wellbeing of patients identified as having substance misuse issues. The team are employed by Change Grow Live, a social care and health charity commissioned by Notts County Council. Working together with SFH, they support the health and wellbeing of individuals across the hospital and community.

The work of DALT includes ensuring a safe patient journey, specialist assessment and tailored advice, health education and promotion, motivational work to reduce harm and promote healthier behaviours, signposting, and referral on for continued support. They offer education to hospital staff and community clinicians to support them and share best practice.

Together with Gastroenterology services, they offer fibro scan diagnostics (a type of ultrasound to measure inflammation and scarring of the liver). This contributes to the identification and support of some of the most complex cases and high intensity users of the hospital and other services. It also helps to reduce the wider social and economic harms associated with drug and alcohol use.

Evidence shows the work of teams like DALT can reduce overnight stays in hospitals and re-admissions by 3%, and emergency department attendances related to alcohol by 43%. This reduces the pressure on urgent care services and frees up beds and time for others to receive care.

Smoking cessation

SFH has a tobacco dependency service operating across all inpatient settings, which includes behavioural advice and provision of smoking cessation aids, including nicotine replacement therapy (NRT) and e-cigarettes for use post-discharge only. It refers into the Public Health commissioned smoking cessation services provided by A Better Life.

The Trust also provides a maternity smoking cessation service, the Phoenix Team. Smoking is the single most important modifiable risk factor in pregnancy. It recognises that specific intervention beyond changes to universal care is needed to reduce the health inequality between the most and least deprived groups. The Phoenix Team provides behavioural and pharmacological support to families to give up smoking during pregnancy and encourages smokefree births. Pregnant smokers who set a quit date can receive financial incentives following carbon monoxide verified periods of abstinence with the aim of rewarding a smoke-free pregnancy.

Oral health

Tooth decay is the most common oral disease affecting children and young people in England, yet it is largely preventable. Almost 9 out of 10 hospital tooth extractions among children aged 0 to 5 years are due to preventable tooth decay and tooth extraction is still the most common hospital procedure in 6 to 10 year olds, according to data up to 2019⁴. Data also shows that children in the most deprived populations have more than twice the level of tooth decay than those in the least deprived areas.

Actions in Mid Nottinghamshire to respond to health inequalities relating to oral health.

Water fluoridation, a scientifically proven method of adding small amounts of fluoride to drinking water, is a key player in the fight against tooth decay. Already, 30% of Nottinghamshire residents, around 247,000 people have access to fluoridated water, however the vast majority of the ICS do not, creating an inequality. Therefore, Nottinghamshire County Council is exploring extending these benefits to other areas of the County with campaigns ongoing. If actioned, this could generate a 35% reduction in decayed, missing and filled teeth in five-year-old children, a 56% decrease in hospital admissions for tooth extractions in children from the most deprived areas, and a return of £12.71 after five years and £21.98 after ten years for every £1 invested in fluoridation.

In 2023, Nottingham City Council and Nottinghamshire County Council secured £100,000 of ring-fenced funding from NHS England to buy and distribute toothbrushing packs to foodbanks and other organisations in the community, who provide support for vulnerable people and families who may be most at risk of experiencing poor oral health. The packs are being distributed to help enable people who are currently unable to purchase these supplies, to brush their teeth by the recommended two times a day.

⁴ Child oral health: applying All Our Health 2022 [Child oral health: applying All Our Health - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/publications/child-oral-health-applying-all-our-health-2022)

Remuneration Report

Scope of the report

The Remuneration Report summarises our remuneration policy and, particularly, its application in connection with the executive directors. The report also describes how the Trust applies the principles of good corporate governance in relation to directors' remuneration as defined in the NHS FT Code of Governance, in sections 420 to 422 of the Companies Act 2006 and the Directors' Remuneration Report Regulation 11 and Parts 3 and 5 of Schedule 8 of the Large and Medium sized Companies and Groups (Accounts and Reports) Regulations 2008 (SI 2008/410) ('the Regulations') as interpreted for the context of NHS Foundation Trusts, Parts 2 and 4 of Schedule 8 of the Regulations and elements of the Foundation Trust Code of Governance.

Annual Statement on Remuneration from the Chair of the Remuneration Committee

The Remuneration Committee met twice during the year and key decisions made included: executive team remuneration, approval of a pension restructuring payment, approval of the salary increase for VSM staff and the consideration of executive directors' appraisals.

Senior managers' remuneration policy

We must attract, develop, and retain executive directors and senior managers of a high calibre to ensure the organisation is well led and able to deliver its strategy and vision.

Executive directors and senior managers receive an annual appraisal, in accordance with our performance management framework. This ensures the performance of the executive directors and senior managers is based on the delivery of objectives as defined within the annual plan.

There are, however, no contractual provisions for performance-related pay for executive directors and senior managers and, as such, no performance related payments were made relating to 2023/24.

Our approach to remuneration is modelled on guidance in The NHS Foundation Trust: Code of Governance and the Pay Framework for Very Senior Managers in the NHS (Department of Health and Social Care).

The key principles of the approach are that pay and reward are firstly assessed relative to the financial performance of the Trust as a whole, and secondly in line with available benchmarks, including NHS Providers, the NHSE published pay ranges and the wider pay policies of the NHS.

Executive appointments to the Board of Directors continue under permanent contracts

Governance for the approval of remuneration packages, in line with the policy, is in place through the Remuneration Committee, which considers pay on an individual basis attributed to scope and remit of role. Through the Remuneration Committee, the Board assures itself

that salaries are commensurate with other organisations of similar size and complexity. It also considers the nature of the patient, quality, and safety challenges to provide assurance that any given salary reflects the degree of responsibility and accountability.

Senior manager remuneration

Set out below are the components of the senior managers' remuneration package. All substantive senior managers receive basic pay and business expenses. They also receive the employer's contribution to the NHS pension scheme where they are eligible to join it.

Relocation expenses are paid in accordance with the Trust's general relocation policy, where an appointee is required to maintain two properties or move their primary residence to take up their position.

	Basic pay	Pension	Business expenses	Relocation Expenses	Clinical Excellence Awards	Personal Responsibility Payments
	All senior managers receive a basic pay element to their remuneration, which is pro-rata for part time staff	The Trust pays employer contributions for all senior managers who are enrolled in the NHS pension scheme. This is a % of pay set by NHS Pensions Authority	Reimbursement of business mileage and subsistence expenses incurred on official duties in line with Agenda for Change: National NHS terms	Up to £5,000 is available to newly appointed senior managers in accordance with the terms of the Trust's general relocation scheme	Payment is only applicable to the Medical Director and is in accordance with the local and national scheme	The Trust pays remuneration to senior managers who have additional system / duties above the expressed duties in the contract of employment. The Chief Executive and Medical Director receive a responsibility allowance associated with additional duties which are undertaken.
How the component supports short-term and long-term objectives of the Trust	Set at point of recruitment, reviewed using pay benchmarking and other relevant information.	Ensure the recruitment / retention of directors of sufficient calibre to deliver the Trust's objectives	Ensure the recruitment / retention of directors of sufficient calibre to deliver the Trust's objectives	Ensure the recruitment / retention of directors of sufficient calibre to deliver the Trust's objectives	Ensure the recruitment / retention of directors of sufficient calibre to deliver the Trust's objectives	Ensure the recruitment / retention of directors of sufficient calibre to deliver the Trust's objectives

	Basic pay	Pension	Business expenses	Relocation Expenses	Clinical Excellence Awards	Personal Responsibility Payments
	Recruiting high-calibre senior managers is crucial to the delivery of the Trust's objectives. Benchmarking takes into consideration other similar large-sized acute district general hospitals to ensure salary levels are competitive, but also represent value for money					
How the component operates	Standard monthly pay	Contributions paid by both employee and employer, except for any employee who has opted out of the scheme	Reimbursed as incurred, paid via monthly payroll	Reimbursed as incurred on appointment	Determined by local and national policy	Determined by guidance for approval of senior pay

	Basic pay	Pension	Business expenses	Relocation Expenses	Clinical Excellence Awards	Personal Responsibility Payments
Maximum payment	Basic pay	Contributions are made in accordance with the NHS Pension Scheme	Expenses incurred on official duties reimbursed	£5,000	Determined by local and national policy	£17,500
Framework used to assess performance	Trust appraisal system	N/A	N/A	N/A	N/A	N/A
Performance measures	Individual objectives agreed as part of appraisal process	N/A	N/A	N/A	N/A	N/A
Performance Period	Annual Appraisal	N/A	N/A	N/A	N/A	N/A
Amount paid for minimum level of performance and any further levels of performance	No performance-related payment arrangements	N/A	N/A	N/A	N/A	N/A
Explanation of whether there are any provisions for recovery of sums paid to	Any sums paid in error may be recovered in accordance with Trust Policy.	N/A	N/A	N/A	N/A	N/A

	Basic pay	Pension	Business expenses	Relocation Expenses	Clinical Excellence Awards	Personal Responsibility Payments
directors, or provisions for withholding payments	A performance-related clawback of up to 10% arrangement is in place					

The senior manager remuneration policy does not provide for automatic annual inflation-related increases. Any such increase needs to be expressly approved by the Remuneration Committee.

The Trust does not have any executive directors or senior managers who are members of a different pension scheme who receive an employer contribution from the Trust as part of their remuneration.

From 1st April 2023, the Committee approved: to align the Executive Directors salary to the medium quartile of the large acute hospital senior manager pay benchmark. The alignment resulted in five Executive Directors receiving a pay increase.

In 2023/2024 the Trust has not appointed any new Executive Directors.

In accordance with the NHS England (NHSE) letter to Chief People Officers of Trusts and NHS Foundation Trusts dated 19 October 2023, the Senior Salaries Review Body (SSRB) made recommendations regarding the 2023/2024 pay award for Very Senior Managers (VSMs), which were accepted in full by the government. The SSRB recommended an across the board increase of 5% for all VSMs to be applied and back dated to 1 April 2023 and a further 0.5% of the VSM pay bill in each employing organisation is used as a pot to address any specific pay anomalies. The Remuneration Committee accepted and have implemented the principles of the letter from NHSE with Executive Directors on VSM contracts receiving a 5% pay increase (on basic pay) from 1 April 2023. The additional 0.5% increase was not implemented as this was not applicable to any of the Executive Directors on VSM contracts. Any salary which exceeded or further exceeded the £150,000 threshold did not require His Majesty Treasury (HMT) approval providing the 5% was not exceeded.

During the year Non-Pensionable Personal Responsibility payments have been paid to directors where they have taken on additional responsibilities over and above their substantive role.

Senior managers paid more than £150,000 per annum

Where a senior manager is paid more than £150,000 per annum, the Remuneration Committee has taken robust steps to provide assurance that this remuneration is reasonable. This is done by applying the principles of good corporate governance as described in the NHS FT Code of Governance, in Sections 420 to 422 of the Companies Act 2006 and the Directors' Remuneration Report Regulation 11 and Parts 3 and 5 of Schedule 8 of the Large and Medium sized Companies and Groups (Accounts and Reports) Regulations 2008 (SI 2008/410) (the Regulations) as interpreted for the context of NHS Foundation Trusts, Parts 2 and 4 of Schedule 8 of the Regulations. In addition, benchmark information is used, particularly that appertaining to the NHS, such as remuneration surveys conducted and supplied by NHS providers and NHSEI's published pay ranges.

The Remuneration Committee also seeks approval from His Majesty's Treasury (HMT), NHSE, the Department of Health and Social Care and the Minister of State for Health for salaries that exceed £150,000 per annum, as required by NHS England's guidelines on pay for very senior managers in NHS Trusts and Foundation Trusts.

Since June 2015, any salary approved in excess of £150,000 is subject to a 10% earn-back in the event of under-performance of the post-holder.

Non-Executive Directors' remuneration

Fee	Car allowance	Pension	Business expenses	Relocation Expenses
All Non-Executive Directors received a fee	Not applicable	Not applicable	Refund of business mileage and subsistence expenses incurred on official duties in line with Agenda for Change: National NHS terms	Not applicable

The remuneration for Non-Executive Directors has been determined by the Council of Governors and is set at a level to recognise the significant responsibilities of non-executive directors in NHS Foundation Trusts, and to attract individuals with the necessary experience and ability to make an important contribution to the Trust's affairs.

Non-Executive Directors each have terms of no more than three years and can serve two concurrent terms (no more than six years), dependent on formal assessment and confirmation of satisfactory on-going performance. Non-executive directors can apply for a third term if the Council of Governors agrees.

Their remuneration framework, as agreed previously by the Council of Governors, is consistent with best practice and external benchmarking, and remuneration during 2023/24 has been consistent with that framework. Benchmarking is provided via the NHS provider annual remuneration survey. There were no cost-of-living increases applied for non-executive directors during 2023/24.

None of the Non-Executive Directors are employees of the Trust; they receive no benefits or entitlements other than fees and expenses incurred while on Trust business and are not entitled to any termination payments. The Council of Governors determines the terms and conditions of the Non-Executive Directors.

The Trust does not make any contribution to the pension arrangements of Non-Executive Directors. Fees reflect individual responsibilities, including chairing the committees of the Board, with all Non-Executive Directors otherwise subject to the same terms and conditions.

The balance of the Board complies with the Code of Governance, which requires that at least half the Board of Directors, excluding the Chair, should comprise Non-Executive Directors determined by the Board to be independent, and our constitution, which states the number of executive Directors is less than the number of Non-Executive Directors. There are six Non-Executive Directors, excluding the Chair, and five voting Executive Directors including the Chief Executive.

Termination payments for senior managers and policy on payment for loss of office

Termination payments for senior managers are contained in the contract of employment regarding notice periods. Notice periods set out under senior managers' substantive employment contracts are in line with statutory requirements. Interim contractors and fixed-term senior managers have a notice period of one month.

Entitlements to severance payments are in line with those of other employees within the Trust, namely those provisions contained in section 16 of Agenda for Change: National NHS terms. This is based on length of continuous and reckonable NHS service and basic pay. The basic pay element had a salary cap of £80,000 during 2023/2024.

Statement of consideration of employment conditions elsewhere in the Foundation Trust

We do not consult with employees when setting our senior manager remuneration policy. The pay and conditions of other Trust employees, however, were considered. All other national NHS terms are mirrored for Trust senior managers, including annual leave and sick pay.

In accordance with the policy on diversity and inclusion the remuneration committee ensures that in terms of the constitution of the board and with regards to pay and remuneration decisions are made in accordance with the principles of this policy. This links to the Trust's strategy in terms of recruiting and retaining the right people.

Annual Report on Remuneration (not subject to audit)

Senior manager remuneration

Name	Title	Start Date	Expiry	Notice Period
Paul Robinson	Chief Executive	01/04/2022		6 months
Rachel Eddie	Chief Operating Officer	25/07/2022		6 months
Shirley A Higginbotham	Director of Corporate Affairs	04/04/2013	31/05/2023	6 months
Robert Simcox	Director of People	10/06/2022		6 months
Philip Bolton	Chief Nurse	30/05/2022		6 months
Dr David Selwyn	Medical Director	09/12/2019		6 months
Richard Mills	Chief Finance Officer	10/06/2022		6 months
David Ainsworth	Director of Strategy and Partnerships	01/07/2022	31/03/2023	6 months

Non-Executive Directors' remuneration

Service Contracts

Senior managers' service contracts do not contain any obligation on the Trust.

Name	Title	Start Date	Expiry	Notice Period
Claire Ward	Non-Executive Director (Chair)	01/10/2021	30/09/2024	1 month
Graham Ward	Non-Executive Director	01/12/2015	29/11/2024	1 month
Barbara Brady	Non-Executive Director	01/10/2018	30/09/2024	1 month
Manjeet Gill	Non-Executive Director	01/11/2018	31/10/2024	1 month
Steven Banks	Non-Executive Director	01/12/2021	30/11/2024	1 month
Dr Aly Rashid	Non-Executive Director	10/01/2022	09/01/2025	1 month
Andrew Rose Britton	Non-Executive Director	01/04/2022	28/03/2025	1 month
Dr Andrew Haynes	Specialist Non-Executive Advisor to the Board	19/04/2021	18/04/2025	1 month

Major decisions on senior managers' remuneration

Executive Directors pay is approved by the Remuneration Committee. Pay and reward are assessed relative to the financial performance of the Trust as a whole, and in line with available benchmarks, including NHS Providers, the NHSE published pay ranges and the wider pay policies of the NHS.

Substantial changes to senior managers' remuneration during the year and the context for these changes in remuneration were made because of aligning Executive Director pay to a large acute hospital pay benchmarking for VSM pay as a result of the Trust annual turnover increasing to being in accordance with the definition of a large acute hospital. Additional and extended duties outside of the organisation and relevant benchmarking data was considered when making any additional or personal responsibility payments.

Payments for loss of office

No payments for loss of office were made during 2023/24.

Payments to past senior managers

No payments to past senior managers were made during 2023/24, or to any individual who was not a senior manager during the financial year but has previously been a senior manager at any time.

Remuneration and Nominations Committees

We have two remuneration and nominations committees: one which serves as a committee of the Board and is responsible for recruiting and appointing the Chief Executive and executive directors; and the other which serves as a committee of the Council of Governors and is responsible for recruiting and appointing the Chair and Non-Executive Directors and approving the appointment of the Chief Executive.

Our Board appoints the Remuneration and Nominations Committee, its membership comprises only Non-Executive Directors. The committee meets to determine, on behalf of the Board, the remuneration strategy for the organisation, including the framework of executive and senior manager remuneration.

The following Non-Executive Directors have served on the committee, which has met twice during the year:

Name	Meetings attended out of possible total
Graham Ward (Chair of Committee)	2/2
Barbara Brady	1/2
Manjeet Gill	2/2
Dr Aly Rashid	1/2

The committee also invited the assistance of our Chief Executive (Paul Robinson) and the Director of Corporate Affairs (Shirley Higginbotham at the May 2023 meeting and her successor, Sally Brook Shanahan thereafter). None of these individuals, nor any other executive or senior manager, participated in any decision relating to their own remuneration.

Our Council of Governors appoints the Remuneration and Nominations Committee, its membership comprises of the Chair and public, staff and appointed governors. The Committee meets to determine, on behalf of the Council of Governors, the remuneration for the Chair and Non-Executive Directors, the composition of the Board regarding skills and experience, and to agree the recruitment process for the Chair and Non-Executive Directors.

During the year, the following served on the Committee, which met three times:

Name	Meetings attended out of possible total
Claire Ward (Chair)	2/3
Sue Holmes (Lead Governor)	3/3
Ian Holden (Public Governor)	3/3
Liz Barratt (Public Governor)	2/3
John Wood (Public Governor)	0/3
Nikki Slack (Appointed Governor)	1/3
Justin Wyatt (Staff Governor)	3/3

The Committee also invited the assistance of the Director of Corporate Affairs (Shirley Higginbotham at the meeting in April 2023 and Sally Brook Shanahan at the following

meetings in October and November 2023) and our Senior Independent Director (Barbara Brady) who chaired the meeting at which the Chair's appraisal was considered. Neither they, nor any other executive or senior manager, participated in any decision relating to their own remuneration.

The Committee successfully recommended the following to the Council of Governors for approval:

- Chair's Appraisal Outcome and Objectives
- Revised Code of Governance
- The Job Description and Person Specification for the new Non-Executive Director role and the proposed level of remuneration (noted as being aligned to NHSE rates)
- The appointment of a new Non-Executive Director, and
- The re-appointment of a Non-Executive Director who had reached the end of his tenure.

Disclosures required by Health and Social Care Act

Governor and Director Expenses

During the year the total number of Directors who served on our Board was 18 and the number of Governors serving on our Council of Governors totalled 28 during the year. We reimbursed expenses incurred in respect of Trust business as follows:

Directors		Total paid 2023/2024 £'00	Total paid 2022/2023 £'00
Claire Ward	Chair	13.40	24.53
Neal Gossage	Non-Executive Director	N/A	0
Graham Ward	Non-Executive Director	0	0
Barbara Brady	Non-Executive Director	0	0
Manjeet Gill	Non-Executive Director	0	0
Steve Banks	Non-Executive Director	0	0
Dr Aly Rashid	Non-Executive Director	7.27	5.12
Andrew Rose-Britton	Non-Executive Director	0	4.30
Neil McDonald	Non-Executive Director	0	N/A
Dr Andrew Haynes	Specialist Adviser to the Board	0	0
David Selwyn	Chief Executive Officer	5.75	5.90
Julie Hogg	Chief Nurse	N/A	2.99
Clare Teeney	Director of People	N/A	0
Emma Challans	Director of Culture and Service Improvement	N/A	33.60
Simon Barton	Chief Operating Officer	N/A	0
Dr David Selwyn	Medical Director	4.36	0.65
Shirley Higginbotham	Director of Corporate Affairs	0	0
Richard Mills	Chief Finance Officer	0	0
Rob Simcox	Director of People	2.00	0
Philip Bolton	Chief Nurse	0	0

Directors		Total paid 2023/2024 £'00	Total paid 2022/2023 £'00
Rachel Eddie	Chief Operating Officer	0.85	0.66
David Ainsworth	Director of Strategy & Partnerships	0	0
Sally Brook Shanahan	Director of Corporate Affairs	0.99	N/A
	TOTAL	34.62	77.74

Governors	Constituency	Area	Total 2023/24 £'00	Total 2022/23 £'00
Angie Jackson	Appointed Governor	Mansfield District Council	No claim	N/A
Ann Mackie	Public Governor	Newark and Sherwood	No claim	No claim
Craig Whitby	Appointed Governor	Mansfield District Council	No claim	No claim
David Ainsworth	Appointed Governor	Local Commissioning Group	No claim	No claim
David Walters	Appointed Governor	Ashfield District Council	No claim	No claim
Dean Wilson	Public Governor	Rest of East Midlands	No claim	N/A
Gerald Smith	Public Governor	Rest of East Midlands	N/A	No claim
Ian Holden	Public Governor	Newark and Sherwood	No claim	No claim
Jacqueline Lee	Staff Governor	Staff	N/A	No claim
Jane Stubbings	Public Governor	Rest of East Midlands	£2.34	£0.92
Jayne Revill	Staff Governor	Staff	N/A	No claim
John Doddy	Appointed Governor	Nottinghamshire County Council	No claim	No claim
John Dove	Public Governor	Rest of East Midlands	£0.07	N/A
John Wood	Public Governor	Rest of East Midlands	No claim	No claim
Justin Wyatt	Staff Governor	Staff	No claim	No claim
Karen Nadin	Public Governor	Newark and Sherwood	£0.79	N/A
Kevin Stewart	Public Governor	Rest of East Midlands	N/A	No claim
Kevin Stewart	Appointed Governor	Sherwood Forest Hospitals Volunteers	No claim	No claim
Lawrence Abrams	Public Governor	Rest of East Midlands	N/A	No claim
Linda Dales	Appointed Governor	Newark and Sherwood District Council	No claim	No claim

Governors	Constituency	Area	Total 2023/24 £'00	Total 2022/23 £'00
Liz Barrett	Public Governor	Rest of East Midlands	No claim	No claim
Martin Stott	Public Governor	Newark and Sherwood	N/A	No claim
Maxine Huskinson	Public Governor	Rest of East Midlands	No claim	No claim
Michael Longdon	Public Governor	Rest of East Midlands	No claim	No claim
Nadia Whitworth	Appointed Governor	Sherwood Forest Hospitals Volunteers	N/A	No claim
Neal Cooper	Public Governor	Rest of East Midlands	No claim	No claim
Nikki Slack	Appointed Governor	West Notts College	No claim	No claim
Pam Kirby	Public Governor	Rest of East Midlands	No claim	N/A
Peter Gregory	Public Governor	Newark and Sherwood	£1.20	N/A
Philip Marsh	Public Governor	Rest of East Midlands	N/A	No claim
Richard Boot	Staff Governor	Staff	N/A	No claim
Roz Norman	Staff Governor	Staff	N/A	No claim
Ruth Scott	Public Governor	Rest of East Midlands	No claim	No claim
Samantha Musson	Staff Governor	Staff	No claim	N/A
Shane O'Neill	Public Governor	Newark and Sherwood	No claim	N/A
Steven Hunkin	Public Governor	Rest of East Midlands	No claim	N/A
Susan Holmes	Public Governor	Rest of East Midlands	No claim	£0.85
Tracy Burton	Public Governor	Rest of East Midlands	No claim	N/A
Vikram Desai	Staff Governor	Staff	No claim	No claim
TOTAL			4.40	1.77

Annual Report on Remuneration (subject to audit) Senior Managers' Disclosure

Remuneration report – salaries and allowances (subject to audit)

2023/24								2022/23					
Name	Title	Salary (Bands of £5,000) £'000	Expense payments (taxable) total to nearest £100 £	Performance pay and bonuses (Bands of £5,000) £'000	Long term performance pay and bonuses (Bands of £5,000) £'000	All pension- related benefit (Bands of £2,500) £'000	TOTAL (Bands of £5,000) £'000	Salary (Bands of £5,000) £'000	Expense payments (taxable) total to nearest £100 £	Performance pay and bonuses (Bands of £5,000) £'000	Long term performance pay and bonuses (Bands of £5,000) £'000	All pension- related benefit (Bands of £2,500) £'000	TOTAL (Bands of £5,000) £'000
Executive Directors													
Mr P Robinson (1)	Chief Executive	205-210	5,300	0	0	-	210-215	185-190	600	0	0	-	185-190
Mr P Bolton (2)	Chief Nurse	150-155	-	0	0	-	150-155	110-115	-	0	0	-	110-115
Ms R Eddie (3)	Chief Operating Officer	140-145	-	0	0	-	140-145	90-95	100	0	0	-	90-95
Dr D Selwyn (4)	Medical Director and Deputy Chief Executive	205-210	-	0	0	-	205-210	180-185	100	0	0	-	180-185
Ms S Higginbotham (5)	Director of Corporate Affairs	15-20	-	0	0	-	15-20	105-110	-	0	0	-	120-125
Mr R Simcox (6)	Director of People (HR)	130-135	-	0	0	50.0-52.5	185-190	115-120	-	0	0	45-47.5	160-165
Mr D Ainsworth (7)	Director of Strategy and Partnerships	125-130	-	0	0	2.5-5.0	130-135	85-90	-	0	0	52.5-55	140-145
Mr R Mills (8)	Chief Financial Officer	145-150	1,100	0	0	155.0-157.5	300-305	135-140	-	0	0	60-62.5	195-200
Mrs S Brook Shanahan (9)	Director of Corporate Affairs	75-80	100	0	0	15.0-17.5	95-100	-	-	0	0	-	-
Ms C Hinchley (10)	Interim Director of Strategy and Partnerships	5-10	100	0	0	0-2.5	10-15	-	-	0	0	-	-
Ms J Hogg (11)	Chief Nurse	-	-	0	0	-	-	15-20	300	0	0	-	15-20
Mr S Barton (12)	Chief Operating Officer	-	-	0	0	-	-	30-35	-	0	0	22.5-25	50-55
Ms M McManus (13)	Acting Chief Operating Officer	-	-	0	0	-	-	10-15	-	0	0	75-77.5	85-90
Mr R Binks (14)	Acting Chief Nurse	-	-	0	0	-	-	5-10	-	0	0	-	5-10
Ms C Teeney (15)	Director of People (HR) Non Voting	-	-	0	0	-	-	0-5	-	0	0	-	0-5
Ms E Challans (16)	Director of Culture and Improvement Non Voting	-	-	0	0	-	-	115-120	3,400	0	0	-	120-125
Mr M Duffied (17)	Head of Communications Non Voting	-	-	0	0	-	-	20-25	-	0	0	2.5-5	25-30
Non Executive Directors													
Ms C Ward (18)	Chairman	50-55	1,300	-	-	-	50-55	50-55	2,500	-	-	-	50-55
Ms B Brady (19)	Non-Executive Director	10-15	-	-	-	-	10-15	15-20	-	-	-	-	15-20
Ms M Gill (20)	Non-Executive Director	10-15	-	-	-	-	10-15	10-15	-	-	-	-	10-15
Mr G Ward (21)	Non-Executive Director	10-15	-	-	-	-	10-15	15-20	-	-	-	-	15-20
Dr A Rashid (22)	Non-Executive Director	10-15	700	-	-	-	10-15	10-15	500	-	-	-	10-15
Mr S Banks (23)	Non-Executive Director	10-15	-	-	-	-	10-15	10-15	-	-	-	-	10-15
Mr A Rose-Britton (24)	Non-Executive Director	10-15	-	-	-	-	10-15	10-15	400	-	-	-	10-15
Mr N McDonald (25)	Non-Executive Director	0-5	-	-	-	-	0-5	-	-	-	-	-	-
Mr N Gossage (26)	Non-Executive Director	-	-	-	-	-	-	0-5	-	-	-	-	0-5
Dr A Haynes (27)	Dr A Haynes (Specialist Advisor to the Board)	10-15	-	-	-	-	10-15	10-15	-	-	-	-	10-15

Notes (2023/24)

1 - Mr P Robinson CEO from 4th October 2021. Chose not to be covered by the pension arrangements during the reporting year.

2 - Mr P Bolton Appointed Chief Nurse 30th May 2022. Chose not to be covered by the pension arrangements during the reporting year.

4 - Dr D Selwyn Appointed Medical Director 9th December 2019. 2 programme activities per week for the Royal College of Anaesthetists. Appointed Deputy CEO from May 2022. Chose not to be covered by the pension arrangements during the reporting year.

5 - Ms S Higginbotham (Director of Corporate Affairs) left 31st May 2023.

7 - Mr D Ainsworth (Director of Strategy and Partnerships) left 31st March 2024.

9 - Mrs S Brook Shanahan (Director of Corporate Affairs) commenced 15th May 2023.

10 - Ms C Hinchley (Acting Director of Strategy and Partnerships) commenced in post 29th February 2024.

All increases in directors salary are monitored and approved by the Trusts remuneration committee.

Notes (2022/23)

1 - Mr P Robinson CEO from 4th October 2021. Chose not to be covered by the pension arrangements during the reporting year.

2 - Mr P Bolton Appointed Chief Nurse 30th May 2022. Chose not to be covered by the pension arrangements during the reporting year.

3 - Ms R Eddie Appointed Chief Operating Officer from 25th July 2022.

4 - Dr D Selwyn Appointed Medical Director 9th December 2019. 2 programme activities per week for the Royal College of Anaesthetists. Appointed Deputy CEO from May 2022. Chose not to be covered by the pension arrangements during the reporting year.

5 - Ms S Higginbotham (Director of Corporate Affairs / Company Secretary dual role with Nottinghamshire Healthcare NHS Foundation Trust from 1st Oct 2020 to 31 May 2022. Total salary across both organisations £106,700.

6 - Mr R Simcox Appointed Director of People July 2022, (Acting) from 10th June 2022.

7 - Mr D Ainsworth Appointed Director of Strategy and Partnerships 25th July 2022.

8 - Mr R Mills Appointed CFO July 2022 (Acting) CFO from 4th October 2021

11 - Ms J Hogg (Chief Nurse) Resigned from post 8th May 2022. Chose not to be covered by the pension arrangements during the reporting year, (Incl Arrears in Lieu of notice).

12 - Mr S Barton - Resigned from post 12th June 2022 (Incl Arrears in Lieu of notice).

13 - Ms M McManus (Acting) Chief Operating Officer from 13th June to 24th July 2022.

14 - Mr R Binks (Acting) Chief Nurse from 9th May 2022 to 29th May 2022.

15 - Ms C Teeney Resigned from post June 2022 dual role with Nottinghamshire Healthcare NHS foundation Trust. Total salary across both organisations £26,500.

16 - Ms E Challans Resigned from post November 2022. Chose not to be covered by the pension arrangements during the reporting year.

15 - Mr M Duffield Resigned from post 30th June 2022.

18 - Ms C Ward, Chair for Sherwood Forest Hospitals NHS Foundation Trust from 17th April 2021.

22 - Dr A Rashid, Non-Executive Director from 10th October 2021.

23 - Mr S Banks, Non-Executive Director from 1st December 2021.

24 - Mr A Rose-Britton, appointed Non-Executive Director February 2022.

26 - Mr N Gossage, Resigned as Non-Executive Director 30th April 2022.

27 - Dr A Haynes Specialist Advisor to the Board from 19th April 2021. Chose not to be covered by the pension arrangements during the reporting year.

Expenses relate to travel/subsistence claims which may be taxable dependent on value/type.

Pensions-related benefit is disclosed for each senior manager based on their time in post as Director.

As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV reflects the increase in CETV effectively funded by the employer. This calculation does not take account of any increase due to inflation or contributions paid by the employee.

On 1 April 2015, the government made changes to public service pension schemes which treated members differently based on their age. The public service pensions remedy puts this right and removes the age discrimination for the remedy period, between 1 April 2015 and 31 March 2022. Part 1 of the remedy closed the 1995/2008 Scheme on 31 March 2022, with active members becoming members of the 2015 Scheme on 1 April 2022. For Part 2 of the remedy, eligible members had their membership during the remedy period in the 2015 Scheme moved back into the 1995/2008 Scheme on 1 October 2023. This is called 'rollback'. Where a member is affected by rollback, the benefits in respect of their rolled back pensionable service during the remedy period are valued as being in the 1995/2008 Scheme.

The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights.

This value derived does not represent an amount that will be received by the individual. It is a calculation that is intended to provide an estimation of the benefit being a member of the pension scheme could provide.

The pension benefit table provides further information on the pension benefits accruing to the individual.

Fair Pay Multiple

NHS foundation trusts are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid director in the Foundation Trust in the financial year

2023-24 was £205,000 - £210,000 (2022-23 was £210,000 - £215,000. This is a change in salary between years of 3.53%. (2022-23 2.4%). Excluding 6 agency and bank staff who worked on the 31 March 2024, where their salary has been extrapolated to full year equivalent costs, no employees (2022-23, 0) received remuneration more than the highest-paid director.

For all employees of the trust as whole the remuneration ranged from £10,324 to £207,496 (2022-23, £9,405 to £212,320). This excludes the agency and bank salaries more than the highest paid director, which have been extrapolated to yearly cost. The percentage change in average employee remuneration (based on total for all employees on an annualised basis divided by full time equivalent number of employees) between years is 0.06% (2022-23 15.96%).

Total remuneration includes salary, non-consolidated performance related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

The median remuneration is based on annualised, full-time equivalent remuneration of all employees as at the reporting date. This has been calculated excluding any enhancements or overtime payments.

Staff benefits in kind are not included as the information is not available until July.

There were no agency Board members as of 31 March 2024.

The remuneration of the employee at the 25th percentile, median and 75th percentile is set out below. The pay ratio shows the relationship between the total pay and benefits of the highest paid director (excluding pension benefits) and each point in the remuneration range for the organisation's workforce.

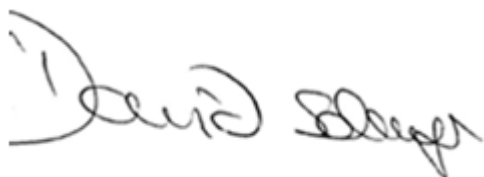
2023/24	25 th Percentile £	Median £	75 th Percentile £	2022/23	25 th Percentile £	Median £	75 th Percentile £
Salary Component of Pay	22,816	30,639	43,742	Salary Component of Pay	23,415	30,621	42,750
Total benefits excluding pension benefits	22,816	30,639	43,741	Total benefits excluding pension benefits	23,415	30,621	42,750
Pay and Benefits: Pay ratio for highest pay director	9.1	6.8	4.7	Pay and Benefits: Pay ratio for highest pay director	9.08	6.94	4.97

Related party transactions

No related party transactions have been identified from a review of the register of interests.

Compliance statement

In compliance with the UK Directors Remuneration Report Regulations 2002, the auditable part of the remuneration report comprises executive Director's remuneration and Non-Executive Director's fees.



David Selwyn
Acting Chief Executive Officer

25th June 2024

Staff Report

The largest group employed by us is nursing, midwifery, and health visiting staff, followed by administration and estates staff, then healthcare assistants and other support staff, and medical and dental staff. The smallest group is those employed as healthcare science staff.

Our average workforce numbers from 1 April 2023 to 31 March 2024 are:

Average number of persons employed (Whole Time Equivalent) Subject to Audit

		2023/24		2022/23
	Total	Permanent	Other	Total
Medical and dental	856	754	102	728
Ambulance	2	2	0	2
Administration and estates	1,311	1,266	45	1,235
Healthcare assistants and other support staff	1,337	1,115	222	1,047
Nursing, midwifery and health visiting staff	1,687	1,479	208	1,557
Nursing, midwifery and health visiting learners	19	19	0	21
Scientific, therapeutic and technical staff	440	412	28	402
Healthcare science staff	157	155	2	154
Other	40	40	0	38
Total average numbers	5,849	5,242	607	5,184
Of which:				
Number of employees (WTE) engaged on capital projects	2	2		2

While only 2 full time members of staff were employed to permanently manage capital, other staff costs have been incurred and capitalised relating to specific 2023/24 capital projects.

The permanent WTEs numbers disclosed are based on the average number of monthly employees. This is different to the methodology set out in the FT ARM which is calculated based on weekly numbers.

Breakdown of staff (actual headcount at 31 March 2024)

	Male	Female	Total
Director	11	4	15
Other Senior Manager	97	207	304
Employee	1098	4771	5869
Grand Total	1309	4879	6188

Staff Costs - Subject to audit

	Total	Permanent	Other	Total
	31-Mar-24	31-Mar-24	31-Mar-23	31-Mar-23
	2023/24	2023/24	2022/23	2022/23
Salaries and wages	244,165	244,165	0	235,677
Social security costs	28,105	28,105	0	25,474
Apprenticeship levy	1,240	1,240	0	1,197
Pension cost - employer contributions to NHS pension scheme	27,186	27,186	0	25,092
Pension cost - employer contributions paid by NHSE on provider's behalf (6.3%)	11,857	11,857	0	10,959
Pension cost - other*	131	131	0	174
Other post employment benefits	0	0	0	0
Other employment benefits	0	0	0	0
Termination benefits	0	0	0	0
Temporary staff - external bank	0	0	0	0
Temporary staff - agency/contract staff	16,580		16,580	18,148
TOTAL GROSS STAFF COSTS	329,264	312,684	16,580	316,721
Recoveries from DHSC Group bodies in respect of staff cost netted off expenditure	0	0	0	0
Recoveries from other bodies in respect of staff cost netted off expenditure	0	0	0	0
TOTAL STAFF COSTS	329,264	312,684	16,580	316,721
Included within:				
Costs capitalised as part of assets	409	409	0	469

Sickness absence

Information regarding our sickness absence data is published by NHS Digital at: <https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates>

The sickness absence data for the Trust is outlined below. Please note the figures given are in calendar years (January 2023 to December 2023).

	Figures converted by DH to Best Estimates of Required Data Items			Statistics Published by NHS Digital from ESR Data Warehouse	
	Average FTE for 2023	Adjusted FTE days lost to Cabinet Office definitions	Average Sick Days per FTE	FTE-Days Available	FTE-Days Lost to Sickness Absence
Sherwood Forest Hospitals NHS Foundation Trust	5,168	54,838	10.6	1,886,219	88,959

Health and Safety at Work 2023/2024

The Trust recognises the importance of ensuring the health, safety and well-being of all Trust employees as enshrined within the NHS Constitution. The Trust strives to provide all colleagues with a healthy and safe working environment.

The Trust's Health and Safety team works collaboratively with a wide range of different organisations, line managers, specialist teams and individuals to secure the health and safety of staff, patients, visitors, and contractors. This is in keeping with the ethos of the Health and Safety at Work Act 1974. The act recognises that everybody has a part in ensuring all who come in to contact with the work activities of the Trust are kept safe.

The Trust encourages divisional management teams and staff side representatives to work in partnership to ensure that all parties are engaged in health and safety management across the organisation.

The Trust's Health and Safety Committee acts as the main mechanism for consultation on work related health and safety matters. This forum meets every two months and reports to the Risk Committee which is chaired by the Chief Executive. The Health and Safety Committee also works closely with the People Wellbeing and Belonging Sub-Cabinet, the Estates Governance Group and the Infection Prevention and Control Committee to ensure that the full range health and safety related risks are properly identified, and suitable and sufficient controls are put in place.

The Trust uses a range of both reactive and proactive measures to monitor health and safety performance. One measure adopted is the rate of non-fatal injuries occurring that require reporting to the Health and Safety Executive under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013.

In 2023/24 The Trust reported 11 staff injuries (12 in the previous year) and 1 patient injury under the reporting requirements of RIDDOR. Staff headcount for the Trust as of 31/03/2024 was 6,139 people (5,810 in the previous year) excluding bank and agency staff. We have successfully reduced the number of RIDDOR reportable injuries which is a success given the increase in staff headcount year on year.

The Trust's rate of RIDDOR reportable non-fatal injuries per 100,000 employees was 179 against a reported latest national average rate of 259 non-fatal injuries per 100,000 employees (for the human health activities sector). This is an improvement compared to last year's result of 206 non-fatal injuries per 100,000 employees against a national average of 307. The Trust continues to reduce serious injuries steadily year on year since 2017/18.

In line with both local and national health and safety priorities the work plan for the coming year will focus on reducing workplace ill-health, improving staff wellbeing, with a focus on the prevention of work-related musculoskeletal disorders plus violence and aggression. The aim of the function is to contribute to excellent patient care by make our people feel safe in both their working lives and their working environment.

Staff policies and actions applied during the financial year

We follow a clear governance structure for the approval and ratification of policies and procedures for matters relating to current and prospective staff members. Each policy document has a complete Equality Impact Assessment covering all relevant equality strands. This ensures that we can mitigate any possible areas of direct or indirect discrimination as part of the approval and ratification process.

The associated people related policies capture aspects from the commencement of employment, identifying relevant statutory and mandatory training, and ensuring development to support career progression. Our policies also establish minimum expectations in relation to conduct, behaviour and performance, as well as supportive approaches to allow staff members to raise matters of concern in a safe and protected way.

We continue to operate fair recruitment practices to ensure equal access to employment opportunities for all.

We have been awarded 'Disability Confident Employer' status until March 2026 which supports the Trust to make the most of the talents disabled people can bring to the workplace.

This is used on our recruitment material (advertisements and offer letters) to show we encourage applications from applicants with disabilities. As an employer this status means we are committed to the following:

- Interviewing all applicants with a disability who meet the essential criteria for a job vacancy. Special adjustments to support attendance at interviews are made for candidates wherever possible as indicated by the candidate.
- Supporting and empowering staff on an annual basis to declare any disabilities via wellbeing conversations to support development and use abilities at work.
- Making every effort when employees become disabled to make sure they stay in employment.
- Taking action to ensure that all employees develop the appropriate level of disability awareness.
- Reviewing these commitments every year and assessing what has been achieved, planning ways to improve on them and letting employees and Jobcentre Plus know about progress and future plans.

We continue to expand our policies and procedures supporting colleagues' wellbeing throughout their employment, embedding the wellbeing agenda throughout the Trust with focus on supporting employees with the opportunities to talk about their mental health, financial wellbeing and overall wellbeing.

Information to be published under Regulation 8 revised Trade Union (Facility Time Publication Requirements) Regulations 2017

Table 1: Relevant union officials

What was the total number of your employees who were relevant union officials during the relevant period?

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
34	24.98

Table 2: Percentage of time spent on facility time

How many of your employees who were relevant union officials employed during the relevant period spent a) 0%, b) 1%-50%, c) 51%-99% or d) 100% of their working hours on facility time?

Percentage of time	Number of employees
0%	20
1-50%	10
51%-99%	0
100%	4

Table 3: Percentage of pay bill spent on facility time

Provide the figures requested in the first column of the table below to determine the percentage of your total pay bill spent on paying employees who were relevant union officials for facility time during the relevant period.

First Column	Figures
Provide the total cost of facility time	106,033.89
Provide the total pay bill	328,967,926.13
Provide the percentage of the total pay bill spent on facility time, calculated as: $(\text{total cost of facility time} \div \text{total pay bill}) \times 100$	0.03%

Table 4: Paid trade union activities

As a percentage of total paid facility time hours, how many hours were spent by employees who were relevant union officials during the relevant period on paid trade union activities?

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: $(\text{total hours spent on paid trade union activities by relevant union officials during the relevant period} \div \text{total paid facility time hours}) \times 100$	77.9%
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Expenditure on consultancy

Consultants have been used where specific expertise is required which is not available in-house or where the capacity to complete a time limited exercise does not exist. No consultancy has been used for Executive level appointments. We spent £0.23m on consultancy during the year, (2022/23 £0.082m).

Off-payroll engagements

The following tables disclose the number of staff with a significant influence over the management of the organisation where payment has been made directly to these staff or their companies, rather than via the Trust payroll.

Table 1: For all off-payroll engagements as of 31 March 2024, for more than £245 per day and that last for longer than six months	
Number of existing engagements as of 31 March 2024	0
Of which...	
No. that have existed for less than one year at time of reporting	0
No. that have existed for between one and two years at time of reporting.	0
No. that have existed for between two and three years at time of reporting.	0
No. that have existed for between three and four years at time of reporting.	0
No. that have existed for four or more years at time of reporting.	0

Table 2: For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2023 and 31 March 2024, for more than £245 per day and that last for longer than six months

Number of new engagements, or those that reached six months in duration, between 1 April 2023 and 31 March 2024	0
Of which:	
Number assessed as within the scope of IR35	0
Number assessed as not within the scope of IR35	0
Number engaged directly (via PSC contracted to trust) and are on the trust's payroll	0
Number of engagements reassessed for consistency/assurance purposes during the year	0
Number of engagements that saw a change to IR35 status following the consistency review	0

Table 3: For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2023 and 31 March 2024

Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	0
Number of individuals that have been deemed 'board members and/or senior officials with significant financial responsibility' during the financial year. This figure must include both off-payroll and on-payroll engagements.	0

Process for off-payroll arrangements

The Trust's Temporary Worker Engagement Policy has a section covering the Engagement of Self-Employed Contractors wherein it is stated that Self Employed Contractors must never be engaged to cover business as usual operational resourcing requirements, staff vacancies and/or rota gaps. The engagement of Self-Employed Contractors would only ever be considered for specific project work and then only when an output-based and/or staged payment mechanism is possible.

Any manager considering the engagement of a Self-Employed Contractor is required to first seek the approval of the Trust's External Engagement Group. If the engagement is deemed appropriate and is approved by the External Engagement Group, then the requesting manager must refer to the Trust's Procurement Department for the specialist procurement and contracting advice and support that will be required to enable the engagement.

Exit packages (subject to audit)

	2023/24			2022/23		
	Number of Compulsory Redundancies	Number of Other Departures agreed	Total Number of exit Packages by Cost Band	Number of Compulsory Redundancies	Number of Other Departures agreed	Total Number of exit Packages by Cost Band
<£10,000	0	3	3	0	1	1
£10,001 - £25,0000	0	2	2	0	1	1
£25,001 - £50,000	0	1	1	0	3	3
£50,001 - £100,000	0	0	0	0	0	0
£100,001 - £150,000	0	0	0	0	0	0
£150,001 - £200,000	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0
Total number of packages by type	0	6	6	0	5	5
Total resource used	0	81	81	0	118	118

	2023/24		2022/23	
	Agreements Number	Total Value of Agreements £000	Agreements Number	Total Value of Agreements £000
Voluntary redundancies including early retirement	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	0	0	0	0
Early retirement in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	5	66	5	118
Exit payments following Employment Tribunals or court orders	1	16	0	0
Non contractual payments requiring HMT approval	0	0	0	0
Total	6	82	5	118
Of which:				
non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months of their annual salary	1	16	1	14

Staff Survey

National Staff Survey

Staff Experience and Engagement

The ongoing impact of the Covid-19 pandemic on our people remained evident throughout 2023/24. At the beginning of 2022 the People Directorate and the Culture and Improvement Directorate therefore developed a joint 3-year People, Culture, and Improvement Strategy, in response to the continued challenges our People face working in Sherwood Forest Hospitals and the wider NHS. The teams in both directorates have been committed to working collaboratively to support colleagues across SFH and the wider health and care system. A key enabler to this strategy has been the strong foundation of staff engagement at the organisation, and the document encompasses priority areas driven by what our colleagues have told us matters most to them. In June 2023 the People, Culture and Improvement Strategy was streamlined into the People Strategy 2022-2025 to align with the current Executive Leadership portfolios and Year 2 priorities.

An important vehicle for hearing the voices of our staff is the annual National Staff Survey. Each year the Trust culture improvement priorities are reviewed and refreshed in line with the results from this, along with feedback from the quarterly pulse surveys, Freedom to Speak Up Guardian, HR workforce information and Divisional feedback. Evidence from these indicates that Sherwood 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 Trust priority, with the People Directorate working closely with the Trust Communications team to maximise internal communication channels and provide opportunities for 2-way communication wherever possible. The 2023 National Staff Survey results placed Sherwood Forest as 1st in the Midlands (and 1st nationally) for Staff Engagement anywhere in the country.

NHS Staff Survey

The NHS staff survey is conducted annually. From 2022/23 the survey questions align to the seven elements of the NHS 'People Promise' and retains the two previous themes of engagement and morale. All indicators are based on a score out of 10 for specific questions with the indicator score being the average of those.

The response rate to the 2022/23 survey among trust staff was 62% (2021/22: 61%) against a national average of 45%. This was the 8th highest response rate in the country for our comparator group.

2023/24 and 2022/23

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

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

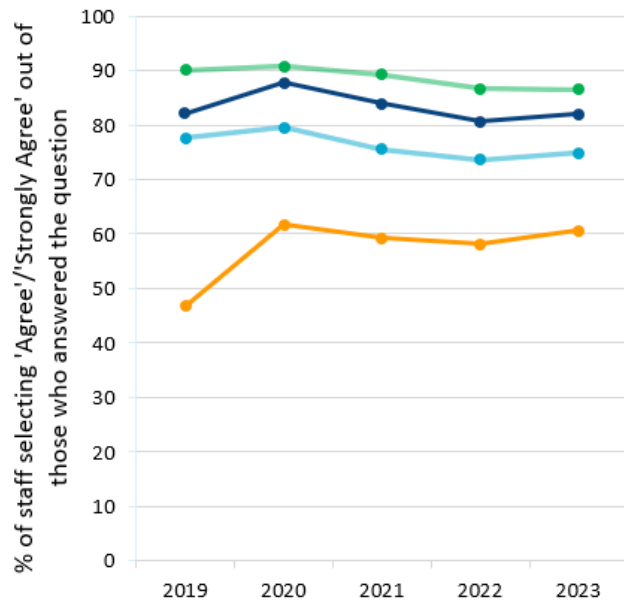
Theme	National Position (/124 Acute/Acute Community Trusts)	Regional Position (/21)
We are compassionate and inclusive	5th	2 nd
We are recognised and rewarded	6th	2 nd
We each have a voice that counts	2nd	1 st
We are safe and healthy	TBC*	TBC*
We are always learning	2nd	1 st
We work flexibly	3rd	2 nd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

*These figures are not currently available due to a national issue with the data

Sherwood Forest Hospitals is above the national average for our comparator peer group in all nine themes and the highest achieving Trust nationally for Staff Engagement and Morale.

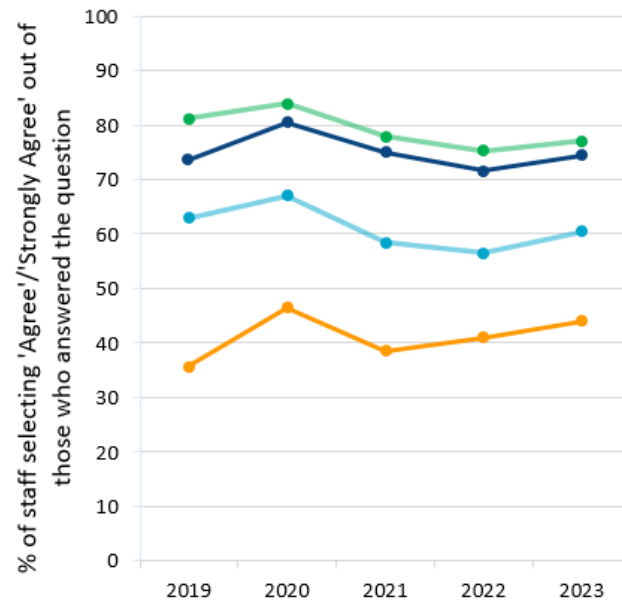
The graphs below summarise the Trust 2023 National Staff Survey results for three key questions:

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



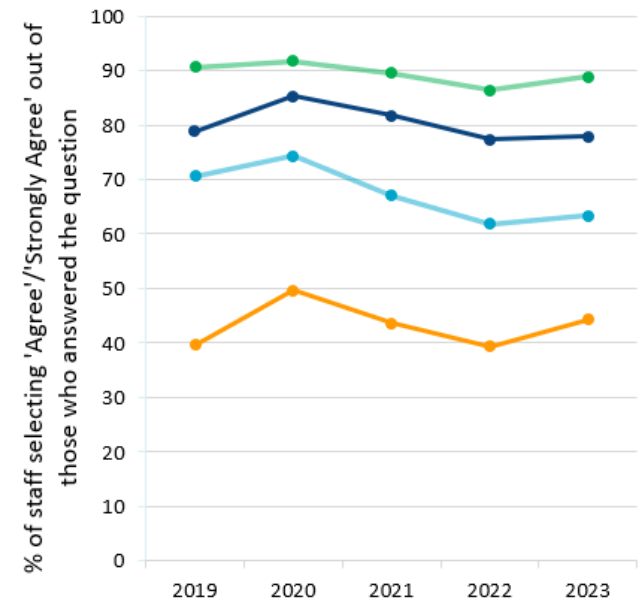
	2019	2020	2021	2022	2023
Your org	82.03%	87.80%	83.87%	80.61%	82.02%
Best result	90.05%	90.77%	89.25%	86.61%	86.57%
Average result	77.64%	79.53%	75.57%	73.56%	74.83%
Worst result	46.76%	61.70%	59.27%	58.09%	60.55%
Responses	3102	2994	3312	3355	3542

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



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

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



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

Whilst we had a dip in 2022, SFH has made great progress this year with the sixth year running the Trust scored the highest score as the most recommended Acute Trust to work for in the Midlands and was the overall the second best Acute or Acute/Community Trust in England, which is a fantastic achievement.

2023/24 and 2022/23

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

	2023/24		2022/23	
	Trust	Benchmarking Group	Trust	Benchmarking Group
We are compassionate and inclusive				
Compassionate Culture	7.64	7.06	7.53	6.95
Compassionate Leadership	7.32	6.96	7.29	6.84
Diversity and Equality	8.48	8.12	8.49	8.11
Inclusion	7.08	6.86	7.05	6.83
We have a voice that counts				
Autonomy and Control	7.26	6.99	7.19	6.93
Raising Concern	6.94	6.41	6.94	6.39
We are safe and healthy				
Health and Safety Climate	6.08	5.45	5.80	5.19
Burnout	5.23	5.00	4.98	4.82
Negative Experience	7.87	7.75	7.80	7.68
We are always learning				
Development	6.83	6.44	6.80	6.32
Appraisals	5.29	4.74	4.96	4.37
We Work Flexibly				
Support for work-life balance	6.75	6.25	6.52	6.08
Flexible Working	6.53	6.15	6.43	5.96
We are a team				
Team Working	6.96	6.68	6.88	6.58
Line Management	7.15	6.80	7.12	6.68
Staff Engagement				
Motivation	7.28	7.04	7.16	6.95
Involvement	7.18	6.86	7.09	6.79
Advocacy	7.50	6.74	7.39	6.60
Morale				
Thinking about leaving	6.74	6.06	6.51	5.86
Work Pressure	6.17	5.13	5.75	4.96
Stressors	6.65	6.38	6.55	6.29

Future Priorities and Targets:

Our priority areas for 2024 will be:

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

We also recognise a need to focus on true engagement and communication to all colleagues in relation to the results, our priorities and more focused examples showcasing how we have improved throughout the year. This will be our commitment in 2024.

We also recognise a need to ensure we engage with colleagues more meaningfully through 121 interactions with our teams ensuring that everyone's voice is heard, including those who chose not to take part in the survey. We want to ensure that for the National Staff Survey in 2024 we improve our response rates by reaching those whose voices we haven't heard.

Actions and Monitoring

The results have been communicated to colleagues in a number of ways including electronic and face-to-face briefings. Some of the positive results also feature in our recruitment campaigns.

The reports are analysed including a review of the anonymous comments that were captured in the free text as these provide further important context. Analysis is also undertaken by staff group, division, department, and site. Our People Cabinet will consider the themes and comments in detail and maintain oversight of Trust cultural improvements, with regular updates to the Trust People Committee.

Divisions and Department leads are sent a copy of the Trust report, their divisional results and the free text anonymous comments. They then actively explore the themes further with their teams and develop improvement initiatives pertinent to their division to address areas of concern. This also applies to corporate areas. We will undertake engagement sessions with divisional triumvirate leadership teams for them to present their reflections on their findings and to identify what support they need to improve the culture within their divisions.

The results are triangulated with other data sources such as the quarterly pulse surveys, workforce Key Performance Indicators (KPIs) and Speaking Up concerns. This enables more targeted actions and interventions to be identified and supported by People Directorate teams. In 2021/22 we designed an in-house survey explorer tool hosted on the intranet to allow any leader or individual in the organisation to review their own area's results which has again been updated with 2023/24 results.

The diversity and inclusivity results will be scrutinised by our staff networks and appropriate actions incorporated into their work programmes. The performance of the programme is

reported through to the People Committee. Such performance and activity is also reviewed in light of key priorities associated with the Trust's requirements under the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) for example.

Equality Reporting

During the last year, the Trust has been working to deliver on the Sherwood EDI Improvement Plan following the publishing of the NHS EDI Improvement Plan in June 2023. The three-year plan sets out targeted actions to address the prejudice and discrimination – direct and indirect – that exists through behaviour, policies, practices and cultures against certain groups and individuals across the NHS workforce.

The Improvement plan will support our continued efforts to ensure that Sherwood is an inclusive place to work. Highlights from Year one include;

- All Executive Directors have an EDI related objective within their appraisal
- Introduction of agile working in addition to flexible working to support colleagues to work in different ways. The inclusion of agile working in our benefits guide for job seekers enhances our ability to attract candidates to Sherwood
- Ethnicity Pay Gap data has shown pay is favourable for BAME colleagues

One of the highlights of 23/24 has been the appointment of Amelia Tsolakis as People EDI Support Officer. Amelia joined the team at the end of November 2023 and has already made significant contributions to the EDI work programme.

Other highlights for our work during 2023/24 include;

- One of our colleague's shared their lived experience of hearing loss in a video we shared during Deaf Awareness Week (May '23) and another colleague shared their story of overcoming difficulties during Covid as a deaf person training to be a nurse during Disability History Month (Dec '23)
- We maintained our Carer Friendly Employer Accreditation from Nottinghamshire Carers and our nationally recognised Disability Confident Accreditation
- Reviewed our Allyship training content and re-commenced delivery of sessions in February '24
- Our usual PRIDE celebrations took place during July 2023 and this year, for the first time, Sherwood had a stand at Nottingham City PRIDE where we were able to showcase the Trust as a safe place to receive care and to work to thousands of citizens who visited the city for the event
 - In July 2023, we also launched our new Transgender and Non-Binary Policy and Guidance for colleagues and provided lunch and learn session throughout the month to improve colleagues understanding and awareness
- We have supported Divisions to embed EDI within their workforces through bespoke EDI training sessions delivered to Urgent and Emergency Care and Clinical Support, Therapies and Outpatients colleagues
- Successfully delivered our second annual REACH OUT! day where we celebrate Race, Ethnicity and Cultural Heritage at Sherwood. The day was a great success and included inspiring staff stories, entertainment and we were honoured to welcome Prof. Laura Serrant OBE as our guest speaker who delighted the audience with her very honest and inspirational story of her journey in Nursing

- Launched the NHS Health Passport during Disability History Month in December 2023 to support those with disabilities and/or long-term health conditions to have conversations with their manager about support that will help them at work
- Renewed our flag wall art at Kings Mill and flag banners at Newark and Mansfield to celebrate the race diversity within our teams; the number of flags has increased from 92 in 2023 to 102 in 2024
- We have developed an EDI Calendar showcasing the EDI awareness raising events during the year; we have also included the dates from our faith calendar
- Reviewed and improved the content of our EDI pages on the Intranet including updated Staff Network pages
- Very successful Women's Day celebration with over 30 colleagues joining a virtual coffee break which included a presentation on the importance of women's inclusion and Rachel Eddie shared her journey to Executive Leadership in the NHS which was well received by those in attendance
- Delivered a very well attended Neurodiversity lunch and learn session during Neurodiversity week
- Developed and delivered EDI training on the new Leadership Fundamentals training session
- Reviewed and updated our Reasonable Adjustments Guidance

Mandatory Reporting

The Trust has met its obligations to report on Gender Pay Gap, the Workforce Race Equality Standard and the Workforce Disability Equality Standard and the results of these are published on our website. The results are examined and appropriate action plans to address any disparity are put in place.

Gender Pay Gap

Sherwood Forest Hospitals has complied with the expectations associated with the gender pay regulations. Our report for 2023/24 can be viewed at the following link: [Sherwood Forest Hospitals \(sfh-tr.nhs.uk\)](https://www.sfh-tr.nhs.uk)

WRES and WDES

Our reports for 2022/23 can be accessed via our website [Sherwood Forest Hospitals \(sfh-tr.nhs.uk\)](https://www.sfh-tr.nhs.uk)

We also meet our obligation to report our compliance with the Public Sector Equality Duty through our annual EDI Activity Report which is published in June each year and our latest report can be accessed via our website [Sherwood Forest Hospitals \(sfh-tr.nhs.uk\)](https://www.sfh-tr.nhs.uk).

Staff Networks:

In June 2023, Staff Network Chairs featured in a Board Story highlighting the importance of our networks here at Sherwood and some of our achievements; our Chairs were grateful to be able to showcase what they do behind the scenes to support inclusion here at Sherwood. Staff Network Chairs were also invited by our Chief Executive to represent Sherwood Forest Hospitals at a special service at Westminster Abbey to celebrate the 75th Birthday of the NHS.

We have continued to promote staff networks throughout the Trust and encourage colleagues to be actively involved with the activities of the networks. Like previous years, engagement has been difficult for colleagues due to continued and unprecedented pressure on our services.

Despite difficulties, staff network members have contributed to key awareness raising activities and have supported with the review of the Reasonable Adjustment's Guidance and the Transgender and Non-Binary Policy and Guidance.

Modern Slavery

This section outlines the Trust's responsibilities and responses to section 54 of the Modern Slavery Act 2015, it sets out the steps that the Trust has taken, and is continuing to take, to ensure that modern slavery and/or human trafficking is not taking place within our business or supply chain.

Modern slavery encompasses slavery, servitude, human trafficking and forced labour. At SFHFT we recognise the significant role the NHS has to play in both combatting it and supporting victims of modern slavery and human trafficking and we fully support the governments objectives to eradicate this type of abuse. We are strongly committed to acting ethically and with integrity and transparency in all business dealings, ensuring effective systems and controls are in place to safeguard against any form of modern slavery.

We publish assurance on our Trust website that we do not support commissioning of any services linked to Modern Slavery and engage with any reviews locally and nationally where our patients may have been subject to modern slavery.

All members of staff have a personal responsibility for the successful prevention of modern slavery and human trafficking, with the Procurement Department taking a lead responsibility for compliance in the supply chain.

During 2023/24 procurement and the Trust safeguarding team have continued to work in collaboration to actively ensure all staff within the procurement team are aware of the risk of modern slavery and the responses required where this is suspected.

Policies on Slavery and Human Trafficking

We are aware of our responsibilities towards patients, carers, employees, and the local community and expect all suppliers to adhere to the same ethical principles. Our supply chain includes procurement of agency staff, medical services, medical and other consumables, facilities maintenance, utilities, and waste management. We are committed to ensuring that there is no modern slavery or human trafficking in our supply chains or in any part of our business. Our internal policies replicate our commitment to acting ethically and with integrity in all our business relationships.

Currently all awarded suppliers sign up to our terms and conditions of contract which provide provision to ensure each supplier's commitment to anti-slavery and human trafficking in their supply chain; and that they conduct their business in a manner that is consistent with Trust policies.

We operate several internal policies to ensure that we are conducting business in an ethical and transparent way. These include the following:

Recruitment Policy: We operate a robust recruitment policy and under due diligence to identify and mitigate the risks of modern slavery and human trafficking in our own business and our supply chain we:

- Complete pre-employment checks on staff we employ, confirming their identities and right to work in the United Kingdom.
- Ensure agencies are on NHS England's nationally approved frameworks and are audited to provide assurance that pre-employment clearance has been obtained for agency staff to safeguarding against human trafficking or individuals being forced to work against their will.
- Follow NHS Agenda for Change Terms and Conditions to ensure that staff receive fair pay rates and contractual terms.
- Consult with Trade Unions on any proposed changes to employment terms and conditions.

Equal Opportunities: We have a range of controls to protect staff from poor treatment and/or exploitation, which complies with legal and regulatory frameworks. These include terms and conditions of employment, mandatory Equality, Diversity and Inclusion training for all staff and access to further training and development.

Safeguarding Policies inc. Managing Allegations Policy: We adhere to the principles inherent in our Think Family Safeguarding Adult and Safeguarding Children policies. These are compliant with Nottinghamshire multiagency safeguarding arrangements and provide clear guidance to support our staff if they are raising safeguarding concerns about how colleagues or people receiving our services are being treated, or about practices within our business or supply chain.

Speaking Up Policy: We operate a Speaking Up Policy to support all employees to be able know that they can raise concerns about how colleagues or people receiving our services are being treated, or about practices within our business or supply chain, without fear of reprisal.

Employment policies (including Policy and Procedure for Disclosure and Barring Service (DBS) Checks, Employment Records and Information Policy and Procedures, Professional Registration Policy, Induction Policy). These policies explain our vetting and barring procedures, including conducting eligibility to work in the UK checks for all employees to safeguarding against human trafficking, or individuals being forced to work against their will. The Trust adheres to the National NHS employment Checks/Standards including guidance for Health Staff on identifying and supporting victims of modern slavery and guidance on the duty to notify the Home Office of potential victims of modern slavery.

Working with Suppliers

Sherwood Forest Hospitals will work to identify and mitigate risk and put in place contractual terms allowing the Trust to gain assurance that slavery and human trafficking have no place in our business. We will work with suppliers to ensure that they treat their obligations towards modern slavery with the same importance that we do.

Suppliers are vetted through a robust Selection Questionnaire process before being appointed to any framework agreement.

All contracts are awarded under the NHS Terms and Conditions which contain clauses giving Sherwood Forest Hospitals the right to terminate a contract for failure to comply with labour laws.

When procuring goods and services, we additionally apply NHS Terms and Conditions (for non-clinical procurement) and the NHS Standard Contract (for clinical procurement). Both require suppliers to comply with relevant legislation.

The staff of Sherwood Forest Hospitals must contact and work with the Procurement department when looking to work with new suppliers so appropriate checks can be undertaken.

Where it is verified that a subcontractor has breached child labour laws or human trafficking, then this subcontractor will be excluded in accordance with Regulation 57 of the Public Contracts Regulation 2015. The Trust will require that the main contractor substitute a new subcontractor.

The Procurement team upholds the Chartered Institute of Procurement and Supply (CIPS) Code of Professional Conduct.

Training

Advice and training about modern slavery and human trafficking is available to staff through our mandatory safeguarding adults and children training programs, safeguarding policies and procedures, and the Trust safeguarding team. It is also discussed at our mandatory safeguarding induction day for staff starting employment with Sherwood Forest Hospitals.

We are continuously looking at ways to increase awareness across the organisation, and to ensure a high level of understanding of the risks involved with modern slavery and human trafficking in our supply chains and in our business.

Our Performance Indicators

- We will know the effectiveness of the steps we are taking to ensure that modern slavery and/or human trafficking is not taking place within our business or supply chain if:
- No reports are received from our staff, the public, or law enforcement agencies to indicate that modern slavery practices are operational within our organisation.
- We monitor referrals to Social Care and will actively refer any cases we identify through the delivery of our services that may indicate any of our service users have been victim to modern day slavery, whilst in the community.

We report quarterly and annually via our safeguarding reporting mechanisms data relating to any safeguarding issues, along with trends and themes.

Sustainability

In line with national NHS guidelines, for 2023/24 the Trust are for the first-time reporting following the 'task force on climate-related financial disclosures' (TCFD) requirements. As the NHS is taking a phased approach to TCFD during this inaugural year the Trust has fully complied with the NHS phase 1 reporting requirements.

In future Annual Reports the Trust will aim to comply with phase 2 & 3 requirements, HM Treasury guidance for which is still in draft format at the moment.

Trust Board oversight of climate-related issues.

The Board is provided with oversight of climate related issues via the Board Assurance Framework (BAF) in which Principal Risk 8 (PR8) is recorded as Failure to deliver sustainable reductions in the Trust's impact on climate change. The Finance Committee is the Lead Committee in relation to the management of Principal Risk 8 and is reported to the Board of Directors following its review at each Finance Committee meeting via the Committee's quadrant report.

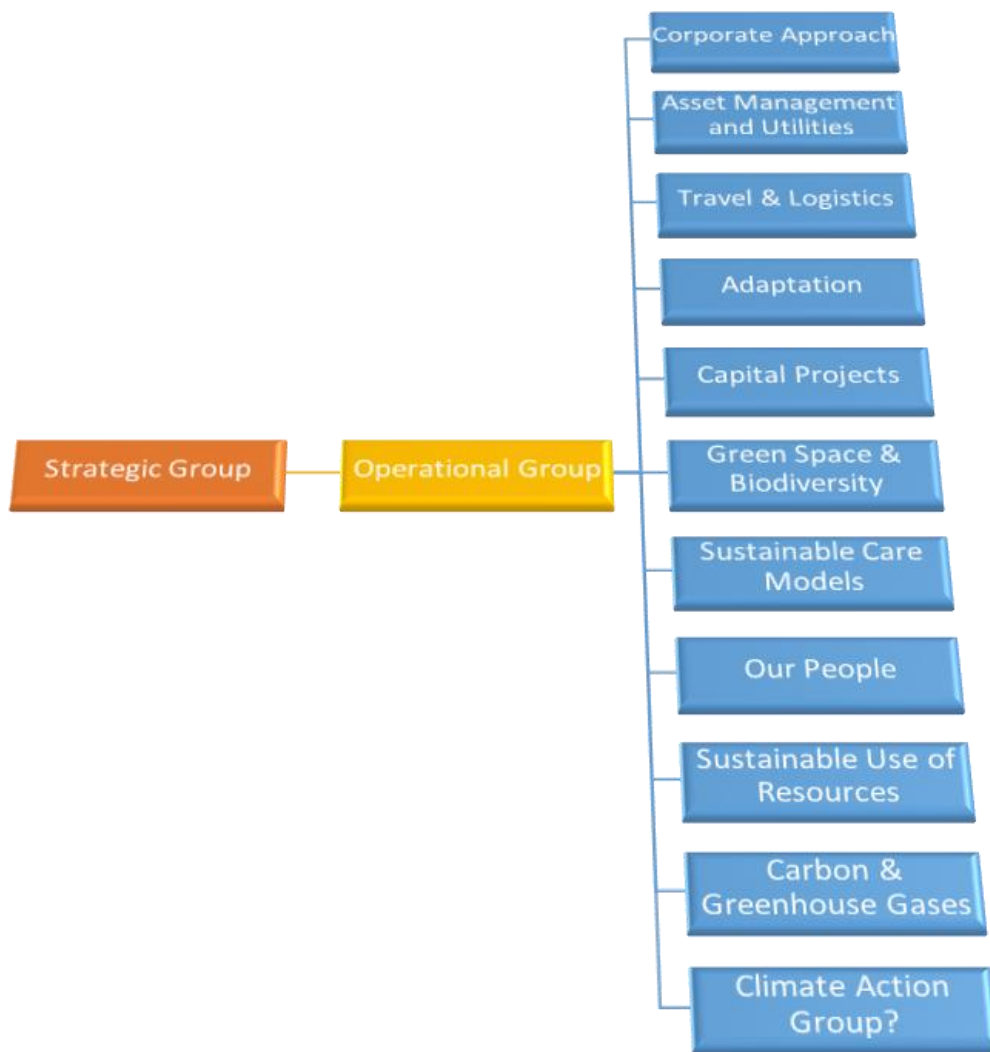
PR8 is reviewed at the Sustainability Development Operational Group (SDOG) chaired by the Associate Director of Estates & Facilities, with oversight from the Sustainability Development Strategic Group (SDSG) chaired by the Chief Financial Officer.

The Board of Directors approved the Green Plan in 2021 and this document now guides the strategic direction of the Trust to align to its commitments to the Green agenda in accordance with NHS and national climate commitments. The Green Plan influences policy direction at the Strategic Planning Oversight Group (SPOG) and is overseen by the Finance Committee. The Trust is an active member of the ICS Green Group, a collaboration of ICS providers in Nottinghamshire to influence the green agenda for the benefit of patients, staff and visitors across the population.

The Board monitors and oversees progress against goals and targets for addressing climate related issues via the SDSG report which informs the BAF PR8.

The Trust utilises a sustainability reporting structure to ensure that key areas of focus are considered on a regular basis. It has a basis of 11 chapter groups comprising of a variety of roles from within the Trust. These report in to the Sustainable Development Operational Group, which reports into the Sustainable Development Steering Group that provides assurance to the Finance Committee and the Board.

In addition to the reporting structure, the Trust employs a Sustainability Service Lead and Associate Medical Director (Clinical Lead for Climate Action) and Clinical Sustainability Fellows all of which have a focus on increasing sustainability within the Trust and working collaboratively with colleagues from across the Trust within the Climate Action Team.



The Trust has historically reported on historic carbon emissions back to 2014, however in looking to increase the data captured within its Carbon Footprint to include Nitrous Oxide, Entonox and Volatile Anaesthetic Gases, it will be reporting back to 2019 in line with NHSE requirements.

The Carbon emissions data will be reported using the internationally recognised convention of Scope 1, Scope 2 and Scope 3 emissions.

The Trust has nominated its Climate Action Clinical Lead (Associate Medical Director) to represent the Trust as Net Zero Lead.

In 2021 the Trust published its Green Plan, and report on progress as part of the Trust's Annual Report.

With regards to air pollution, in 2023 the Trust installed two bus stops near to the main entrance at Kings Mill Hospital to reduce the number of vehicles on site by making travel by public transport more appealing and convenient for all. It also has plans in place to install an additional 24 EV chargers to encourage staff to switch to cleaner vehicles where commuting by car is necessary.

Due to the Hospital operating a PFI contract the Trust does not own many vehicles but is looking to select cleaner alternatives when the lease on the current vehicles expires. Its PFI partners operate a number of electric vehicles which have charging facilities available for on-site use.

In summer 2023 (before publication of the Net Zero Travel and Transport Strategy) the Trust considered if it should restrict the vehicles offered via its salary sacrifice scheme to zero emission vehicles only. However, data analysis showed those on the lowest salary band were leasing lower cost petrol or diesel vehicles and it was not considered right to further increase vehicle costs for staff during the cost of living crisis.

To promote sustainable travel throughout the Trust is working alongside Travel Choice to offer free cycle training, advice on active travel routes to our sites and free Dr Bike maintenance events for staff, patients and visitors. Early in 2024 the Trust completed a staff travel survey and is using the results to make improvements to its active travel offer whenever possible. As a result of completing the travel surveys the Trust has been able to apply for a grant improve the cycle facilities at both Kings Mill and Newark hospital sites.

Working in collaboration with the NHS Forest the Trust has secured 150 wellbeing and wild food trees to plant around its Kings Mill Hospital site that will aid wellbeing for all on site as they grow and help reduce air pollution and increase biodiversity within the site.

The Trust has identified that Bee Orchids are growing within the grass at Kings Mill hospital, so the specific area has been protected from mowing. In addition, a no-mow campaign has been implemented across the majority of grassy areas on site during the summer months where it is planned to sow native wildflower seeds to improve biodiversity.

In order to phase out fossil fuel use at the Trust an application has been made via the Public Sector Decarbonisation Scheme to reduce the Greenhouse Gas emissions associated with our Central Sterile Services Department (CSSD) operations. The application was unsuccessful due to the initial Trust capital outlay requirements.

The Trust is proud to be Desflurane free and has taken positive steps to reduce the appeal of using Desflurane internally via sharing knowledge and best practice with colleagues, plus reducing the accessibility of this potent Greenhouse Gas anaesthetic which had a significant effect on use.

As part of its efforts to reduce emissions, the NHS targeted a reduction in Desflurane use from 20% in 2020/2021 to 10% in 2021/2022 across all its providers.

The SFH anaesthetic team has exceeded the NHS targets to use below 2% in 2020/2021, below 1% in 2021/22 and to 0% in 2022/2023. Through changes to current practice, the Trust has successfully removed Desflurane from its hospitals.

The Trust has considered the use of Nitrous Oxide manifolds within its hospitals. During 2022/23 approximately 93% of its piped Nitrous Oxide was lost. A proposal was put together to support capping off the manifold and switching to using cylinders of Nitrous Oxide at the point of use, but the necessary equipment changes required could not be funded. Recently the Trust has learnt from another Trust about a different, more cost-effective approach that has meant plans are underway to investigate the feasibility of removing the Nitrous Oxide manifolds via this alternative solution.

When procuring goods, services and/or works, the Trust complies with the requirements set out in the NHS Net Zero Supplier Roadmap.

During the year the Trust submitted an internal application for funds to support a solar PV installation – but unfortunately there was no capital available to support.

Understanding the requirements of NHS England for Trusts to have a Heat Decarbonisation Plan in place by the end of 2023/24, the Trust applied for internal funds to support the preparation of this document – however no funding was available to support. The Trust has since learnt that the upcoming Low Carbon Skills Fund 5 will provide grants to support the provision of Heat Decarbonisation Plans and so an application is being submitting.

The Trust is looking into alternative strategies to realise its sustainability goals as self-funding is challenging in the current financial climate. By working with other organisations the Trust can decarbonise and improve its greener transport offers without the capital outlay usually associated with these schemes.

The Trust will continue to monitor the availability of grants such as the Low Carbon Skills Fund (LCSF) and Public Sector Decarbonisation Scheme (PSDS) as and when they are released by the government. The Trust actively applies for all suitable grant schemes although there is no guarantee that the funding can be secured as demand is high.

The Trust's main risk assessment relating to climate change is the Board Assurance Framework (PR8). As the workstreams mature, specific areas including adaption planning will be subject to further risk assessment as the plans progress.

Valuing our Members

Membership information as at May 2024

Public breakdown by constituency

Newark & Sherwood	3,145
Rest of East Midlands	10,133

Public membership breakdown

	Number of members	Membership profile	Population profile
Age (years)			
0-16	0	0.00%	19.59%
17-21	76	0.56%	6.04%
22-29	250	1.86%	9.90%
30-39	853	6.33%	12.50%
40-49	852	6.33%	11.81%
50-59	1,795	13.33%	13.91%
60-74	3,794	28.17%	16.69%
75+	4,824	35.82%	9.56%
Not stated	1,025	7.61%	N/A
Ethnicity			
White	11,949	88.72%	82.05%
Mixed	37	0.27%	1.75%
Asian	90	0.66%	5.94%
Black	38	0.28%	1.64%
Other	8	0.06%	0.52%

Not stated	1,347	10.00%	8.09%
Gender			
Male	4,747	35.24%	49.51%
Female	8,524	63.29%	50.49%
Transgender	1	0.01%	0.00%
Not stated	197	1.46%	0.00%

Membership activity, events, and communication

As with the previous years, the Governors' Membership and Engagement Committee has continued to focus on how best to engage with members. We have continued to issue a monthly e-newsletter, Trust Matters to maintain communication with our members.

Annual General Meeting / Annual Members' Meeting

The AGM was held at the Kings Mill Hospital site on 26th September 2023.

The Trust will continue to work closely with its members to help it to be truly accountable for the quality of the services it provide to the local communities.

Members can contact their governors either through the Trust website or by contacting the Director of Corporate Affairs, Sherwood Forest Hospitals NHS Foundation Trust, Trust Headquarters, Level 1, King's Mill Hospital, Mansfield Road, Sutton in Ashfield, Nottinghamshire, NG17 4JL or by emailing sfh-tr.governors@nhs.net.

Valuing our Governors

As an NHS Foundation Trust, we are accountable to the Council of Governors, which represents the views of members. The two key statutory duties of the Council of Governors are:

- To hold the non-executive directors individually and collectively to account for the performance of the Board of Directors.
- To represent the interests of our members and of the public.

In addition, the Council of Governors, among other matters, is responsible for making decisions regarding the appointment or removal of the Chair, the Non-Executive Directors, and the Trust's External Auditors.

Our Constitution makes clear the process to appoint or remove the Chair and the other Non-Executive Directors, including the Governors' role in deciding the remuneration and allowances and other terms and conditions of office of the Non-Executive Directors.

The Council met several times during the year (see table). The meetings were well attended, with debate across several areas of interest.

One of the key roles of the Governors is engagement with their constituencies to gain feedback and report to the Council and subsequently the Board of Directors. Governors achieve this by holding regular 'Meet Your Governor' events across all three hospital sites and in the community. At these events new members are recruited and patients, visitors and staff can discuss their views of the services provided. These events have been well supported by governors throughout the year.

The Governors continue to observe Board Committees to fulfil their statutory duty of holding the Non-Executive Directors to account. This enables the governors to gain assurance regarding how the Non-Executive Directors hold the executive to account and how strategic objectives are progressed and implemented. The observers then report their observations from the meetings back to the quarterly Council of Governors meetings.

Governor elections were held with the results announced in July 2023 to fill the five vacancies in the Rest of the East Midlands public constituency that covers Mansfield, Ashfield and the rest of the East Midlands, the three further vacancies in the Trust's public constituency for Newark and Sherwood, and one staff governor.

External development is offered to and undertaken by governors through an expressions of interest process where the Governors who attend share their learning with other Governors. In addition, regular internal development is undertaken through quarterly workshops, the topics of which are suggested and agreed by the Governors.

Attendance at Council of Governor meetings

There have been four full general Council of Governors meetings during the year. The following table details the Governors, the constituency they represent, their attendance and the date elected/appointed.

Attendance at Full COG (scheduled meetings)

NAME	AREA COVERED	CONSTITUENCY	FULL COG MEETING DATES				TERMS OF OFFICE	DATE ELECTED	TERM ENDS
			09/05/2023	31/07/2023	14/11/2023	13/02/2024			
Angie Jackson	Mansfield District Council	Appointed		P	P	P	4	23/05/23	31/05/27
Ann Mackie	Newark & Sherwood	Public	A				3	01/05/22	30/04/25
Craig Whitby	Mansfield District Council	Appointed	X				4	21/05/19	31/05/23
David Walters	Ashfield District Council	Appointed	A	A	A	A	1	23/04/20	31/05/24
Dean Wilson	Rest of East Midlands	Public		A	A	P	3	06/07/23	31/10/26
Ian Holden	Newark & Sherwood	Public	P	P	P	P	3	01/05/22	30/04/25
Jane Stubbings	Rest of East Midlands	Public	P	P	P	P	3	01/05/22	30/04/25
John Doddy	Nottinghamshire County Council	Appointed	P	P	X	X	4	14/07/21	31/05/25
John Dove	Rest of East Midlands	Public		P	A	P	3	07/07/23	06/07/26
John Wood	Rest of East Midlands	Public	P	A	P	A	3	01/05/22	30/04/25
Justin Wyatt	Staff	Staff	X	P	P	X	3	01/05/22	30/04/25
Karen Nadin	Newark & Sherwood	Public		P			3	07/07/23	06/07/26
Kevin Stewart	Volunteers	Appointed	P	P	A	P	3	28/02/23	28/02/26
Linda Dales	Newark & Sherwood District Council	Appointed	A	P	P	A	1	15/07/21	31/05/24
Liz Barrett	Rest of East Midlands	Public	P	P	P	P	3	01/05/22	30/04/25
Michael Longdon	Rest of East Midlands	Public	X				3	01/05/22	30/04/25
Neal Cooper	Rest of East Midlands	Public	P	P	P	X	3	13/05/22	30/04/25
Nikki Slack	Vision West Notts	Appointed	A	P	A	A	N/A	17/07/19	N/A
Pam Kirby	Rest of East Midlands	Public		P	P	P	3	07/07/23	06/07/26
Peter Gregory	Newark & Sherwood	Public		P	A	A	3	07/07/23	06/07/26
Ruth Scott	Rest of East Midlands	Public	X	P	A	X	3	01/05/22	30/04/25

Sam Musson	Staff	Staff		P	P	P	3	07/07/23	06/07/26
Shane O'Neill	Newark & Sherwood	Public		P	P	P	3	07/07/23	06/07/26
Steven Hunkin	Rest of East Midlands	Public		P	X	X	3	07/07/23	06/07/26
Sue Holmes	Rest of East Midlands	Public	P	P			3	01/11/20	31/10/23
Tracy Burton	Rest of East Midlands	Public		P	P	A	3	07/07/23	06/07/26
Vikram Desai	Staff	Staff	A	X	A	P	3	01/05/22	30/04/25

P = Present
A = Apologies
X = Absent

Non-Executive Director Attendance at Council of Governors

NAME	FULL COG MEETING DATES			
	09/05/2023	31/07/2023	14/11/2023	13/02/2024
Claire Ward	P	P	P	P
Graham Ward	P	P	P	P
Barbara Brady	P	P	P	P
Manjeet Gill	P	P	A	P
Steve Banks	P	A	P	A
Dr Aly Rashid	P	P	P	P
Andrew Rose-Britton	P	P	A	P
Neil McDonald				P

P = Present
A = Apologies
X = Absent

Lead Governor annual report 2023-2024

It has been a busy year for Sherwood Forest Hospital Governors and a year of change. We have said 'thank you and goodbye' (in a Governor stance) to Sue Holmes who was our fabulous Lead Governor. Sue worked tirelessly to support SFHFT over a nine-year period as a governor (and part of this time as Lead Governor) and her legacy and impact is evident for all to see. Sue was passionate about the community and about hearing their voices as to what was working well within SFHFT and what we could do better. Sue trailblazed getting SFHFT governors out and about into the community at events. These included Ashfield Day and visiting Food Banks which all had a positive impact upon recruiting new SFHFT members and hearing hospital experiences which were formally fed back to the SFHFT team. Along with Sue leaving the team of Governors we have also said 'thank you and goodbye' to five governors for different reasons, from their term of office naturally expiring to personal circumstances leading to them needing to resign. Each and every Governor has contributed to the SFHFT shared mission, and we are very grateful for this.

This year we have also been blessed to welcome ten new governors. We conducted the governor recruitment process slightly different this year to ensure that all who applied had a secure understanding as to the SFHFT 'ask' of them as governors before they joined. This transparency is critical in enabling a good 'match' both ways from the start. We have been truly blessed with the quality of the new governors who are now part of our governing body. Their skill sets, knowledge, care and commitment combined with existing well experienced governors is having a really positive impact upon the volunteer work that the SFHFT governing body do. On the 1st November 2023 I also become Lead Governor.

As a team of governors, we have continued to routinely engage in the fabulous '15 Steps' initiative which enables us to work alongside the executive team to 'temperature check' different wards and areas within SFHFT. This process also enables us to learn more about the Trust and to spend time with patients and staff. It allows us first hand to 'sense check' information presented in meetings by the SFHFT team and to be able to relay positives and areas for improvement back to the SFHFT team.

Governors also actively participate in 'Meet your governor' on a monthly basis. This has helped us to meet patients, the community and staff and to feedback issues, concerns and praise. We do however feel that we can improve this even further during 2024/25 by ensuring that it is more focused. This will form a topic during our governor conference on the 16th April 2024 with the new process then being trialled shortly afterwards.

As an active Governing body, we also engage in Governwell courses along with attending different SFHFT meetings as observers. This approach facilitates even greater transparency over critical areas such as finance, quality etc. We also actively engaged in the SFHFT 5-year strategy.

In my role as Lead Governor, I am really keen to ensure that as governors we can raise questions / concerns at any point to gain further clarity on matters. To this end, questions on mortality after the mortality presentation were raised by governors. To further discussion, debate and transparency a whole agenda item meeting on mortality was conducted. Governors, Exec Team members, NEDs and a consultant all attended. The meeting was rich in data and content and really did foster a positive culture of questions, answers, probing, explanation, modelling etc.

I have continued to work with the Lead Governors from Notts Healthcare and Doncaster and Bassetlaw Foundation Trust after Sue Holmes departure on different shared issues / topics linked to the ICB and governance. We have had several meetings with Healthwatch who are working with us to develop governance memorandum of understanding linked to the ICB.

Our aforementioned Governor conference is to be held on the 16th April 2024. I have tried hard to listen to all what governors have been sharing and work with the Director of Corporate Affairs to ensure that governance remains as strong as possible and continues to improve in terms of its reach, focus and impact. The conference will provide a reflection point for us as a governing body team and a reframe in terms of focuses moving forward.

A handwritten signature in black ink, appearing to read 'Liz Barrett OBE'. The signature is stylized, with the letters 'L', 'B', and 'O' being prominent and connected by a horizontal line.

Liz Barrett OBE

Lead Governor

Code of Governance for NHS Provider Trusts

Sherwood Forest Hospitals NHS Foundation Trust has applied the principles of the Code of Governance for NHS provider trusts on a comply or explain basis. The Code of Governance for NHS provider trusts replaced the NHS Foundation Trust Code of Governance on 1st April 2023.

Part of Schedule A	Code section	Summary of requirement	Reference Page numbers
Disclose	A.2.1	The board of directors should assess the basis on which the trust ensures its effectiveness, efficiency and economy, as well as the quality of its healthcare delivery over the long term, and contribution to the objectives of the ICP and ICB, and place-based partnerships. The board of directors should ensure the trust actively addresses opportunities to work with other providers to tackle shared challenges through entering into partnership arrangements such as provider collaboratives. The trust should describe in its annual report how opportunities and risks to future sustainability have been considered and addressed, and how its governance is contributing to the delivery of its strategy.	11, 37 & 117
Disclose	A.2.3	The board of directors should assess and monitor culture. Where it is not satisfied that policy, practices or behaviour throughout the business are aligned with the trust's vision, values and strategy, it should seek assurance that management has taken corrective action. The annual report should explain the board's activities and any action taken, and the trust's approach to investing in, rewarding and promoting the wellbeing of its workforce.	8, 14, 15, 18, 29, 30, 75, 77, 79, 103, 123 & 135
Disclose	A.2.8	The board of directors should describe in the annual report how the interests of stakeholders, including system and place-based partners, have been considered in their discussions and decision-making, and set out the key partnerships for collaboration with other providers into which the trust has entered. The board of directors should keep engagement mechanisms under review so that they remain effective. The board should set out how the organisation's governance processes oversee its collaboration with other organisations and any associated risk management arrangements.	8, 11, 13, 15, 35, 36, 103 & 115
Disclose	A.2.6	The board of directors should identify in the annual report each non-executive director it considers to be independent. Circumstances which are likely to impair, or could appear to impair, a non-executive director's independence	24, 25, 55, 58, 101 & 103

		<p>include, but are not limited to, whether a director:</p> <ul style="list-style-type: none"> • has been an employee of the trust within the last two years • has, or has had within the last two years, a material business relationship with the trust either directly or as a partner, shareholder, director or senior employee of a body that has such a relationship with the trust • has received or receives remuneration from the trust apart from a director's fee, participates in the trust's performance-related pay scheme or is a member of the trust's pension scheme • has close family ties with any of the trust's advisers, directors or senior employees • holds cross-directorships or has significant links with other directors through involvement with other companies or bodies • has served on the trust board for more than six years from the date of their first appointment • is an appointed representative of the trust's university medical or dental school. <p>Where any of these or other relevant circumstances apply, and the board of directors nonetheless considers that the non-executive director is independent, it needs to be clearly explained why.</p>	
Disclose	B.2.13	The annual report should give the number of times the board and its committees met, and individual director attendance.	25, 26 & 103
Disclose	B.2.17	For foundation trusts, this schedule should include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by the board, the council of governors, board committees and the types of decisions which are delegated to the executive management of the board of directors.	10, 26, 32, 58, 89, 90, 101 & 108
Disclose	C.2.5	If an external consultancy is engaged, it should be identified in the annual report alongside a statement about any other connection it has with the trust or individual directors.	72

Disclose	C.2.8	The annual report should describe the process followed by the council of governors to appoint the chair and non-executive directors. The main role and responsibilities of the nominations committee should be set out in publicly available written terms of reference.	58, 89 & 107
Disclose	C.4.2	The board of directors should include in the annual report a description of each director's skills, expertise and experience.	24, 25, 58, 100 & 101
Disclose	C.4.7	All trusts are strongly encouraged to carry out externally facilitated developmental reviews of their leadership and governance using the Well-led framework every three to five years, according to their circumstances. The external reviewer should be identified in the annual report and a statement made about any connection it has with the trust or individual directors.	100
Disclose	C.4.13	The annual report should describe the work of the nominations committee(s), including: <ul style="list-style-type: none"> • the process used in relation to appointments, its approach to succession planning and how both support the development of a diverse pipeline • how the board has been evaluated, the nature and extent of an external evaluator's contact with the board of directors and individual directors, the outcomes and actions taken, and how these have or will influence board composition • the policy on diversity and inclusion including in relation to disability, its objectives and linkage to trust vision, how it has been implemented and progress on achieving the objectives • the ethnic diversity of the board and senior managers, with reference to indicator nine of the NHS Workforce Race Equality Standard and how far the board reflects the ethnic diversity of the trust's workforce and communities served • the gender balance of senior management and their direct reports. 	39, 56, 58,79, 81 & 107
Disclose	C.5.15	Foundation trust governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.	10 & 32

Disclose	D.2.4	<p>The annual report should include:</p> <ul style="list-style-type: none"> • the significant issues relating to the financial statements that the audit committee considered, and how these issues were addressed • an explanation of how the audit committee (and/or auditor panel for an NHS trust) has assessed the independence and effectiveness of the external audit process and its approach to the appointment or reappointment of the external auditor; length of tenure of the current audit firm, when a tender was last conducted and advance notice of any retendering plans • where there is no internal audit function, an explanation for the absence, how internal assurance is achieved and how this affects the external audit • an explanation of how auditor independence and objectivity are safeguarded if the external auditor provides non-audit services. 	104 – 106, 110 & 127
Disclose	D.2.6	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's performance, business model and strategy.	23
Disclose	D.2.7	The board of directors should carry out a robust assessment of the trust's emerging and principal risks. The relevant reporting manuals will prescribe associated disclosure requirements for the annual report.	15, 69, 103, 105 & 114
Disclose	D.2.8	The board of directors should monitor the trust's risk management and internal control systems and, at least annually, review their effectiveness and report on that review in the annual report. The monitoring and review should cover all material controls, including financial, operational and compliance controls. The board should report on internal control through the annual governance statement in the annual report.	104, 112, 113 & 117
Disclose	D.2.9	In the annual accounts, the board of directors should state whether it considered it appropriate to adopt the going concern basis of accounting when preparing them and identify any material uncertainties regarding going concern. Trusts should refer to the DHSC group accounting manual and NHS foundation trust annual reporting manual which explain that this assessment should be based on whether a trust anticipates it will continue to provide its services	16 & 129

		in the public sector. As a result, material uncertainties over going concern are expected to be rare.	
Disclose	E.2.3	Where a trust releases an executive director, eg to serve as a non-executive director elsewhere, the remuneration disclosures in the annual report should include a statement as to whether or not the director will retain such earnings.	Not applicable in the reporting year
Disclose	Appendix B, para 2.3 (not in Schedule A)	The annual report should identify the members of the council of governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor.	60, 61 & 91
Disclose	Appendix B, para 2.14 (not in Schedule A)	The board of directors should ensure that the NHS foundation trust provides effective mechanisms for communication between governors and members from its constituencies. Contact procedures for members who wish to communicate with governors and/or directors should be clear and made available to members on the NHS foundation trust's website and in the annual report.	10, 32, 37 & 89
Disclose	Appendix B, para 2.15 (not in Schedule A)	The board of directors should state in the annual report the steps it has taken to ensure that the members of the board, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS foundation trust, eg through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations.	91, 92 & 101
Disclose	Additional requirement of FT ARM resulting from legislation	If, during the financial year, the Governors have exercised their power* under paragraph 10C** of schedule 7 of the NHS Act 2006, then information on this must be included in the annual report. This is required by paragraph 26(2)(aa) of schedule 7 to the NHS Act 2006, as amended by section 151 (8) of the Health and Social Care Act 2012. * Power to require one or more of the directors to attend a governors' meeting for the purpose of obtaining information about the foundation trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the foundation trust's or directors' performance).	Not applicable in the reporting year

		** As inserted by section 151 (6) of the Health and Social Care Act 2012)	
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Our Board of Directors is focused on achieving long-term success for the organisation and our vision of becoming an outstanding organisation, through the application of sound business strategies and the maintenance of high standards in corporate governance and corporate responsibility. The Trust commissioned an independent Well-Led review that reported in April 2022 with 15 recommendations made. The progress against the recommendations and embeddedness of the actions taken has been reported to the Board most recently in March 2024, at which meeting it was agreed to commission a follow up report in the context of the CQC’s updated assessment framework.

The following statements explain our governance policies and practices and provide insight into how the Board and management run the Trust for the benefit of patients, carers, the community, and our membership.

Our Board of Directors bring a range of experience and expertise to its stewardship of the organisation and continues to demonstrate the vision, oversight and encouragement required to enable our organisation to thrive and improve on a continuous basis. During the past year we welcomed new members to the Board, each bringing excellent skills and expertise to the organisation and providing crucial stable leadership.

At the end of the reporting year the Board comprised eight Non-Executive Directors including the Chair (holding majority voting rights), six Executive Directors (voting), including the Chief Executive, two corporate Directors (non-voting) and one specialist advisor (non-voting).

The Chair is responsible for the effective working of the Board, for the balance of its membership subject to Board and Governor approval, and for making certain all Directors play their full part in setting and delivering our strategic direction and ensuring effective and efficient performance. The Chair conducts annual appraisals of the Non-Executive Directors as well as the Chief Executive.

The Chief Executive is responsible for all aspects of the management of the organisation. This includes developing appropriate business strategies agreed by the Board, ensuring related objectives and policies are adopted throughout, the effective setting of budgets, and monitoring performance. The Chief Executive is also responsible for conducting the annual appraisals of the executive and corporate Directors of the Board.

The Chair, with the support of the Director of Corporate Affairs ensures the Directors and Governors receive accurate, timely and clear information. Directors are encouraged to update their skills, knowledge, and familiarity with the organisation’s business through their induction, on-going participation at Board and committee meetings, attendance and participation at development events and through meetings with Governors.

There is an understanding that any Non-Executive Director, wishing to do so in the furtherance of their duties, may take independent professional advice through the Director of Corporate Affairs at the organisation's expense.

Our Non-Executive Directors offer a wide range of skills and experience and bring an independent perspective on issues of strategy, performance, and risk through their contribution at Board and committee meetings. The Board considers that, throughout the year, each Non-Executive Director has been independent in character and judgement and met the independence criteria set out within the Code of Governance for NHS Provider Trusts. Non-Executive Directors have ensured they have sufficient time to carry out their duties. During the year, time has been spent with Governors to help understand external views of the organisation and our strategies, and all Non-Executive Directors and the Chief Executive attend the Council of Governors meetings.

Several key decisions and matters are reserved for the Board's approval and are not delegated to management. Our Board delegates certain responsibilities to its committees, to assist it in carrying out its function of ensuring independent oversight. The Board of Directors has a formal schedule of matters reserved for its decisions and has in-date and relevant terms of reference for all Board committees. Monthly updates on our performance are discussed at the Board of Directors meetings. The Board delegates the management of overall performance to the Chief Executive who leads the setting of clear priorities so that the organisation is managed efficiently to the highest quality standards and in keeping with our values.

The Board committees report annually on their effectiveness and review their Terms of References and work plans to ensure alignment with the organisation's priorities and the Board work schedule.

Our engagement policy outlines the mechanisms by which the Council of Governors and Board of Directors communicate with each other to support engagement, ensure compliance with the regulatory framework, and specifically provide for any circumstances where the Council of Governors may raise concerns about the performance of the Board of Directors, compliance with the Trust's Provider Licence, or other matters related to the overall wellbeing of the organisation.



























Counter fraud

Our Board of Directors attaches significant importance to the issue of fraud and corruption. Reported concerns have been investigated by the local counter fraud specialists in liaison with NHS Counter Fraud Authority (NHSCFA). All investigations are reported to the Audit and Assurance Committee.

Functional Standard Summary:

The Trust is required to self-assess against the 13 requirements of the Counter Fraud Functional Standard (CFFS) annually by completing and submitting the Trust's Counter Fraud Functional Standard Return (CFFSR). The assessment for 2024 is expected to be a 'Green' rating in all 13 requirements.

The table below shows how the Trust scored itself for each component as part of the 2023 CFFSR, and the projection for the 2024 CFFSR.

Functional Standard Requirement	2023 CFFSR	Projected 2024 CFFSR
Component 1A: Accountable individual		
Component 1B: Accountable individual		
Component 2: Counter fraud, bribery and corruption strategy		
Component 3: Fraud, bribery and corruption risk assessment		
Component 4: Policy and response plan		
Component 5: Annual action plan		
Component 6: Outcome-based metrics		
Component 7: Reporting routes for staff, contractors and public		
Component 8: Report identified loss		
Component 9: Access to trained investigators		
Component 10: Undertake detection activity		
Component 11: Access to and completion of training		
Component 12: Policies and registers for gifts and hospitality and COI		

The Trust has a nominated Counter Fraud Specialist (CFS) in place. The CFS is responsible for carrying out a range of activities in compliance with the above standards that are overseen by the Chief Finance Officer and the Audit and Assurance Committee.

Colleagues have access to counter fraud awareness training which forms part of employee induction training, and several bulletins were issued during the year to highlight how colleagues should raise concerns and suspicions. The CFS has also developed a range of role specific training sides which are available to all staff.

We continue to work to maintain an anti-fraud culture and we have in place a range of policies and procedures to minimise risk in this area. This includes the Counter Fraud Bribery and Corruption Policy, which is designed to make all staff aware of their responsibilities, should they suspect offences being committed.

NHS Resolution

Our CNST premium reduced marginally £0.15m in 2023/24 (£15.32m to £15.21m).

Committees of the Board

All committees of the Board are chaired by a Non-Executive Director. In 2023/24 these committees included:

- The Audit and Assurance Committee, the principal purpose of which is to enhance confidence in the integrity of the Trust's processes and procedures relating to internal control and corporate reporting.
- The Quality Committee, which enables the Board to obtain assurance regarding standards of care and to ensure that adequate and appropriate clinical governance structures, processes and controls are in place.
- The Finance Committee, which oversees the development and implementation of our strategic financial plan and the management of the principal risks to achieving that plan.
- The People Committee's principal purpose is to provide scrutiny and assurance of the development, delivery and impact of the Trust's workforce strategy and plan, together with providing assurance concerning organisational development activity undertaken to promote and embed an effective organisational culture.
- The Remuneration and Nomination Committee ensures the remuneration packages are sufficient to attract, retain and motivate Executives and senior officers (Directors) of the highest quality.
- The Partnerships and Communities Committee, a new committee, which reports on System wide activities in order to give assurance to the Board that the Trust is fulfilling its role as an anchor organisation and to assess the priorities and benefits from strategic partnerships.

Audit and Assurance Committee

1. The Audit and Assurance Committee was chaired by Non-Executive Director Graham Ward, who is a fellow of the Chartered Institute of Management Accountants and has extensive financial expertise until the July 2023 meeting, around which time all Committee Chairs changed. From September 2023 Manjeet Gill succeeded Graham Ward as Committee Chair. Manjeet brings wide experience from both the NHS and other sectors, especially in relation to wider system working. Graham remains as Vice Chair and fulfils the requirement in the Committee's terms of reference that one or other of the Chair and Vice Chair should have recent relevant financial experience. The terms of Reference also make it clear that the membership exclusively comprises Non-Executive Directors, with executives and others considered being 'in attendance'. Attendance of Non-Executive members at meetings is detailed below:

Graham Ward	7/7
Barbara Brady	2/3
Steve Banks	7/7
Manjeet Gill	3/4

In assessing the quality of our control environment, the Committee received reports during the year from the external auditors, KPMG, and the internal auditors, 360 Assurance, on the work they had undertaken in reviewing and auditing the control environment.

The Committee works with the Local Counter Fraud Service and Trust colleagues to actively promote, raise awareness, and encourage people to raise concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters. The Local Counter Fraud Service has a standing invitation to all meetings, with relevant policies readily available on our intranet. The Audit and Assurance Committee routinely receives financial information, including cash and liquidity and the going concern status of the organisation, as well as operational information.

Principal review areas

The five key duties of the Committee as set out in the terms of reference.

1. Governance and internal control

The Committee has reviewed relevant disclosure statements, in particular the Annual Governance Statement (AGS) together with the Head of Internal Audit Opinion, External Audit opinions (Financial and Quality Accounts) and other appropriate independent assurances and consider that the AGS is consistent with the Committee's view on the Trust's system of internal control.

The Committee has received update reports on Information Governance including that the Data Security Protection Toolkit compliance was Met. The internal auditors provided their overall assessment on compliance with the toolkit as Moderate, with seven out of the 10 NDG Standards rated as substantial and the remaining three as Moderate.

2. Internal audit

Through the year the Committee has worked effectively with internal audit to strengthen the Trust's internal control processes. The Committee has also in year:

- Reviewed and approved the internal audit operational plan and more detailed programme of work initially and then on an on-going basis, while ensuring the provision of the internal audit service continued to be sufficient in supporting the Committee to fulfil its role
- Considered the major findings of internal audit and are assured that the Head of Internal Audit Opinion and AGS reflect any significant internal control issues.
- Invited the lead director of the one internal audit reports issued with Limited Assurance to attend Committee meetings, present the report, and provide assurance actions will be implemented within agreed timescales.
- Worked with colleagues internally and externally to maintain and improve performance regarding the provision of evidence and the achievement of internal audit actions.
- Held regular review of outstanding audit actions and are assured a robust progress monitoring process is in place.

3. Counter Fraud Service

The Committee received regular progress reports on activity conducted as part of the agreed Counter Fraud Work Plan, including:

- Annual Report
- Updates on investigations
- Conflicts of Interest Policy and Declarations of Interest Register review
- Risk assessment in line with Counter Fraud Functional Standards

4. External audit

The Committee reviewed and agreed the external audit's annual plan, noting that the Trust's significant risks are: Fraud risk – expenditure recognition, Management override of controls, Valuation of Land & Buildings, and PFI Transition to IFRS 16.

The Committee reviews and comments on reports prepared by external audit and welcomes their advice on areas of specific expertise.

5. Management

The Committee has continually challenged the assurance process when appropriate and has requested and received assurance reports from Trust management and various other sources both internally and externally throughout the year. This process included calling managers to account when considered necessary to obtain relevant assurance.

Standards of business conduct

The Board of Directors recognises the importance of adopting the organisation's Standards of Business Conduct. These standards provide information, education, and resources to help colleagues make well-informed business decisions and to act on them with integrity.

Internal audit (360 Assurance)

The Audit Plan for 2023/24 was developed in line with the mandatory requirements of the Public Sector Internal Audit Standards. 360 Assurance, an external service, has worked with us to ensure the plan was aligned to the risk environment. In accordance with the internal audit work plan, full scope audits of the adequacy and effectiveness of the control framework in place are either complete or under way. All audits with Limited Assurance are reported directly to the Audit and Assurance Committee and the lead director is asked to present the findings and confirm agreement of the actions and timescales. Audits with Significant Assurance are reported directly to the most appropriate Board committee; however, our Audit and Assurance Committee receives a report stating which reports have been reported to other committees. Outstanding recommendations from internal audit are reported to our Audit and Assurance Committee. This ensures all recommendations are sustainably implemented within the organisation. Where owners of recommendations have not completed the actions by the implementation date they are invited to Audit and Assurance Committee to report on progress.

External Audit Service

We incurred £175k net of VAT in audit service fees in relation to the statutory audit of the accounts for the 12-month period to 31 March 2024 (£125k net of VAT for the period to 31 March 2023). Non-audit services amounted to £Nil net of VAT (£Nil net of VAT for the period to 31 March 2023) in respect of the Quality Report.

KMPG has not provided any non-audit services to the Trust during the year, and this is the first year of their re-appointment.

Remuneration and Nomination Committee

As of 31 March 2023, and on-going, membership of the Remuneration and Nomination Committee comprises Graham Ward as Chair, Barbara Brady (a member throughout the reporting year and Vice Chair from September 2023), Manjeet Gill and Aly Rashid, all Non-Executive Directors. The attendance of Non-Executive Directors is detailed within the Remuneration Report.

The primary role of the Committee is to recommend to the Board the remuneration strategy and framework, giving due regard to the financial health of the organisation and to ensure the executives are fairly rewarded for their individual contributions to the organisation's overall performance. The Remuneration Report is set out in its own section of this report.

Remuneration and Nomination Committee of the Council of Governors

The Council of Governors' Remuneration and Nominations Committee comprises Claire Ward as Chair and representatives from the public, staff, and appointed Governor classes. The role of this Committee is to ensure appropriate procedures are in place for the nomination, selection, training, and evaluation of Non-Executive Directors and for succession plans. The Committee is also responsible for setting the remuneration of Non-Executive Directors, including the Chair. It considers Board structure, size, and composition, thereby keeping under review the balance of membership and the required blend of skills, knowledge, and experience of the Board.

Compliance with the Code of Governance for NHS provider trusts

The purpose of the Code of Governance (that replaced the former NHS foundation trust code of governance on 1st April 2023) is to set out a common overarching framework for the corporate governance of trusts, reflecting developments in UK corporate governance and the development of integrated care systems. Trusts must comply with each of the provisions of the Code or, where appropriate, explain in each case why the trust has departed from the code.

The Board of Directors is committed to high standards of corporate governance. Throughout the year ending 31 March 2024, the Board considers that it was compliant with the Code of Governance for NHS Provider Trusts with some exceptions.

In common with the health service and public sector, we are operating in a fast-changing and demanding external environment. We recognise the need to deliver significant increases in efficiency whilst maintaining high quality care at a time when budgets are tight, and demand is high. We will continue to build on the improvements made to date in responding to these challenges, working through our exceptional and dedicated members of #TeamSFH.

The roles and responsibilities of the Council of Governors are described in our Constitution, together with details of how any disagreements between the Board and Council of Governors would be resolved. The types of decisions taken by the Council of Governors and the Board, including those delegated to committees, are described in the approved Terms of Reference.

We have a detailed scheme of delegation which is regularly reviewed. This sets out, explicitly, those decisions reserved to the Board, those which may be determined by standing committees and those which are delegated to managers.

The Chair, the Chairs of all Board Committees and the Chief Executive are invited to attend all public meetings of the Council of Governors; other Executive Directors are invited to attend as appropriate to specific agenda items. Internal assurance visits (15 steps) for all Governors and Non-Executive Directors resumed during the year. These visits to clinical and non-clinical areas provide triangulation of assurance for the participants.

In an NHS Foundation Trust, the authority for appointing and dismissing the Chair rests with the Council of Governors. The appraisal of the Chair is therefore carried out for and on behalf of our Council of Governors by the senior independent director, supported by the lead Governor. Together they review the Chair's performance against agreed objectives and discuss any development needs before reporting the outcome of the appraisal to the Nomination and Remuneration Committee of the Council of Governors. This Committee in turn reports to the Council of Governors.

The directors of the Board are appraised by the Chief Executive who, in turn, is appraised by the Chair. The Council of Governors does not routinely consult external professional advisers to market test the remuneration levels of the Chair and other Non-Executive Directors. The recommendations made to the Council of Governors are based on independent advice and benchmarking as issued from time to time by NHS Providers.

NHS Oversight Framework

NHS England's NHS Oversight Framework provides the framework for overseeing systems including providers and identifying potential support needs. NHS organisations are allocated to one of four 'segments'.

A segmentation decision indicates the scale and general nature of support needs, from no specific support needs (segment 1) to a requirement for mandated intensive support (segment 4.) A segment does not determine specific support requirements. By default, all NHS organisations are allocated to segment 2 unless the criteria for moving into another segment are met. These criteria have two components:

- A) Objective and measurable eligibility criteria based on performance against the six oversight themes using the relevant oversight metrics (the themes are: quality of care, access and outcomes; people; preventing ill-health and reducing inequalities; leadership and capability; finance and use of resources; local strategic priorities)
- B) Additional considerations focused on the assessment of system leadership and behaviours, and improvement capability and capacity

An NHS foundation trust will be in segment 3 or 4 only where it has been found to be in breach or suspected breach of its licence conditions.

Segmentation

The latest information published on the NHS England's website (15th May 2024) places Sherwood Forest Hospitals Foundation Trust in segmentation 2, and as at 4th March 2024 the Nottinghamshire Integrated Care System in segmentation 3.

The segmentation information is the Trust's position as of May 2024. Current segmentation information for NHS trusts and foundation trust is published on the NHS England website: <https://www.england.nhs.uk/publication/nhs-system-oversight-framework-segmentation/>.

Foundation Trust License

There are no additional conditions on our Foundation Trust Licence.

Statement of the Chief Executive's responsibilities as the Accounting Officer of Sherwood Forest Hospitals NHS Foundation Trust

The NHS Act 2006 states that the Chief Executive is the accounting officer of the NHS Foundation Trust. The relevant responsibilities of the Accounting Officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS England.

NHS England has given Accounts Directions which require Sherwood Forest Hospitals NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Sherwood Forest Hospitals Foundation Trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

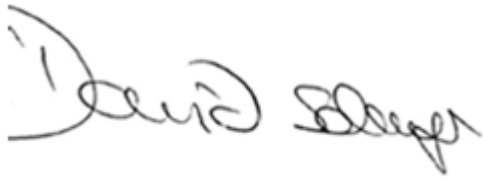
In preparing the accounts and overseeing the use of public funds the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care Group Accounting Manual and in particular to:

- Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- Make judgements and estimates on a reasonable basis
- State whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health and Social Care Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements
- Ensure that the use of public funds complies with the relevant legislation, delegated authorities, and guidance
- Confirm that the annual report and accounts, taken as a whole, is fair, balanced, and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy and
- Prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

As far as I am aware, there is no relevant audit information of which the foundation trust's auditors are unaware and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the NHS Foundation Trust Accounting Officer Memorandum.

A handwritten signature in black ink, appearing to read "David Selwyn". The signature is written in a cursive style with a large initial 'D'.

David Selwyn
Acting Chief Executive Officer

25th June 2024

Annual Governance Statement

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Foundation Trust's policies, aims and objectives, while safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an on-going process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Sherwood Forest Hospitals NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively, and economically. The system of internal control has been in place in Sherwood Forest Hospitals NHS Foundation Trust for the year ended 31 March 2024 and up to the date of approval of the annual report and accounts.

Regulation

The Care Quality Commission (CQC) undertook a full announced inspection of our Core Services during February 2020 including a well-led review and use of resources assessment; the final report was received in May 2020. We improved our overall rating of Good and King's Mill Hospital improved its rating to Outstanding.

	Safe	Effective	Caring	Responsive	Well Led	Overall
King's Mill Hospital	Good	Good	Outstanding	Good	Outstanding	Outstanding
Newark	Good	Good	Good	Good	Good	Good
MCH	Good	Good	Outstanding	Good	Good	Good
Overall	Good	Good	Outstanding	Good	Good	Good

An extract from the Final CQC report states:

Our rating of the trust stayed the same. We rated it as good because: We rated safe, effective, responsive, and well-led as good and caring as outstanding for core services, the trusts well led was rated as good. We rated eight of the trust services as good and one, which was end of life care at Newark hospital as requires improvement overall. We rated well led for the trust as good overall.

The Trust remains fully compliant with the registration requirements of the Care Quality Commission.

The Trust has regular engagement meetings, involving the Medical Director and Chief Nurse with the Trust CQC Relationship Manager and the regional CQC Inspection Manager. The meetings are held every six to eight weeks and include a discussion on a wide range of issues ranging from examples of good practice in addition to areas of concern.

To demonstrate on-going compliance the Trust undergoes inspections by the Care Quality Commission of all core service areas across the Trust providing further opportunity to ensure the Trust continues to meet the requirements of its registration.

Capacity to handle risk & prepare for emergencies

Our Board of Directors provides leadership on the overall governance agenda. On the Board's behalf our Risk Committee has maintained and kept under review a policy for the management of risk. Our Board of Directors is supported by a range of Committees that scrutinise and review assurances on internal control; such Committees include the Resilience Assurance Committee (which is Chaired by the Trust's Accountable Emergency Officer), Audit & Assurance Committee, Finance Committee, Quality Committee, People Committee and Partnerships & Communities Committee. Our Risk Committee is an executive committee focussing on all high or significant risk exposures and oversees risk treatment to ensure: (a) the correct strategy is adopted for managing risk; (b) controls are present and effective; and (c) action plans are robust for those risks that remain intolerant. Our Risk Committee is chaired by our Chief Executive (CEO) and comprises the Executive Team and selected members of the Senior Leadership Team. Senior managers and specialist advisers routinely attend each meeting. We have kept under review and updated risk management policies during the year. The output of the Risk Committee's work is reported to our Board and the CEO also ensures the Risk Committee works closely with front line divisional teams and all Committees of the Board to anticipate, triangulate and prioritise risk, working collectively to continuously balance and enhance risk treatment.

Our Resilience Assurance Committee oversees the resilience against disruptive incidents and ensures there are plans in place to deal with emergencies. Its work is regularly reviewed by the Risk Committee.

The Trust also prepares an annual submission relating to its level of compliance with the sixty plus NHSE Core Standards for Emergency Preparedness. Its current rating is "Partial" compliance of 83% against the standards.

Training is provided to relevant colleagues on risk assessment, incident reporting and incident investigation. In addition, the Board has set out the minimum requirements for employee training required to control key risks as part of the requirements for essential training.

Incidents, complaints, claims, patient feedback and audit findings are routinely analysed to identify risks and single points of failure and learn from them. Lessons for learning are disseminated to colleagues using a variety of methods including customised briefings, bulletins, and personal feedback where necessary.

All significant risk exposures are reported to the Board of Directors and at each Risk Committee meeting. All new significant risks are subject to validation by the Risk Committee and are escalated to the Executive Team. The residual risk score determines the escalation of risk, and this is clearly established and embedded.

The Board of Directors regularly scans the horizon for emergent opportunities or threats and considers the nature and timing of the response required to ensure risk is always kept under prudent control.

The risk and control framework

The risk management process is set out in six key steps as follows:

1. Determine priorities

The Board of Directors determines corporate objectives annually and these establish the priorities for Executive Directors and clinical services.

2. Risk Identification

Risk is identified in many ways. We identify risk proactively by assessing corporate objectives, work-related activities, analysing adverse event trends and outcomes, and anticipating external possibilities or scenarios that may require mitigation.

3. Risk Assessment

Risk assessment involves the analysis of individual risks, including any plausible risk aggregation (the combined effect of different risks) where relevant. The assessment evaluates the severity and likelihood of each risk and determines the priority based on the overall level of risk exposure.

4. Risk Response (Risk Treatment)

For each risk, controls are established, documented, and understood. Controls are implemented to *avoid risk*; *seek risk* (take opportunity); *modify risk*; *transfer risk* or *accept risk*. Gaps in control are subject to action plans which are implemented to reduce residual risk. The Board of Directors has considered its appetite for taking risk and expressed its appetite in the form of target risk ratings in the Board Assurance Framework.

5. Risk Reporting

Significant risks are reported at formal meetings of the Board of Directors and Risk Committee. In addition, in the event of a significant risk arising, arrangements are in place to escalate a risk to the Executive Team. The level at which risk must be escalated is clearly set out in the Risk Management and Assurance Policy. The Audit and Assurance Committee and Board of Directors lead the acquisition and review of assurances, in line with the Board Assurance Framework, to keep risk under prudent control. The Board of Directors has in place an up-to-date and continually reviewed Board Assurance Framework.

6. Risk Review

Those responsible for managing risk regularly review the output from local, community and national risk registers to ensure they remain valid, reflect changes and support decision-making. In addition, risk profiles for all Divisions remain subject to detailed scrutiny as part of a rolling programme by the Risk Committee. The purpose of the rolling programme of review is to track how the risk profile is changing over time; evaluate the progress of actions to treat risk; ensure controls are aligned to the risk; ensure risk is managed in accordance with the Board's appetite; check resources are reprioritised where necessary; and ensure risk is escalated appropriately.

Incident reporting and investigation is recognised as a vital component of risk and safety management and is critical to the success of a learning organisation. An electronic incident reporting system is operational throughout the organisation and is accessible to all colleagues. Incident reporting is promoted through induction and routine mandatory training programmes, regular communications, patient safety walk rounds or other visits and inspections that take place. In addition, arrangements are in place to raise any concerns at work confidentially and anonymously if necessary.

The most significant strategic risks facing the Trust are: (i) Significant deterioration in standards of safety and care (ii) Demand that overwhelms capacity to deliver care effectively (iii) A critical shortage of workforce capacity and capability; (iv) Failure to achieve the Trust's financial strategy. These risks are inter-related and incorporated into the Board Assurance Framework (BAF). Should one or more of these risks materialise, or any other risk captured in the BAF, it may trigger a compound effect upon the safety/quality of care and/or financial sustainability. Our Board of Directors has focused throughout the year on delivering sustainable improvements in the quality and safety of clinical services, and strengthening our ability to meet demand, supported by refreshed recruitment and retention strategies and prudent financial management.

Standards of safety and care are perpetual risks, as are financial sustainability, working closely with local health and care partners and the potential for major disruptive incidents. Capacity and demand for care, and workforce capacity are expected to remain for the foreseeable future, and strategic partnerships will further develop over the coming months and years.

A breakdown of the risks addressed in the BAF, and how those risks are being mitigated, is captured in table 1 below.

Table 1: Clinical, Operational and Financial Sustainability Risks

Potential Risk	How the risk might arise	How the risk is being mitigated	How are the outcomes assessed
Significant deterioration in standards of safety and care.	This may arise if safety-critical controls are not complied with, there are shortfalls in staffing to meet patient need,	Maintaining a strong emphasis and focus on safety, clinical outcomes and patient experience as part of the Trust's governance and performance management framework; striving for	Progress and outcomes are monitored through the Quality Committee, supported by the Patient Safety Committee and other sub-groups. This includes safety and quality indicators, incident

	demand exceeds capacity for a prolonged period, or there is a loss of organisational focus on safety and quality in the governance of Sherwood Forest Hospitals.	excellence and challenging unsatisfactory performance regarding organisational control; delivering training, complying with safety-critical organisation policies and procedures, and learning from adverse events are ways we are currently mitigating this risk.	investigations and key performance indicators.
Demand that overwhelms capacity.	This risk may arise if growth in demand for care exceeds planning assumptions and capacity in secondary care; primary care is unable to provide the service required or there is a significant failure of a neighbouring acute provider. The risk may also arise if there are unexpected surges in demand, such as those created by pandemic disease.	Managing patient flow, developing and maintaining effective working relationships with primary and social care teams, working collaboratively across the wider health system to reduce avoidable admissions to hospital are some of the risk treatment strategies that will feature in how we mitigate this risk going forward.	Progress and outcomes are monitored through the Quality Committee, supported by the Patient Safety Committee. This includes safety and quality indicators, incident investigations and key performance indicators.
A critical shortage of workforce capacity and capability.	Due to the number of clinical staff eligible for retirement, the availability of newly qualified practitioners, and increasing competition for the clinical workforce, we anticipate the staffing challenges continue to be significant.	The People Strategy is specifically designed to help mitigate this risk. By focussing on attracting and retaining high calibre practitioners, building and sustaining high-performing teams, by engaging and developing clinical teams, and adapting to meet the needs of a changing workforce, we aim to make Sherwood Forest Hospitals the employer of choice.	Progress and outcomes are monitored through the People Committee, supported by the People Cabinet. This includes vacancy levels, training and development progress.
Failure to achieve the Trust's financial strategy.	The delivery of high-quality care helps to mitigate financial risk by reducing avoidable expenditure, minimising harmful care that extends length of stay or requires additional treatment. This risk	Local and system-wide Financial Plans are specifically designed to address the financial challenge and deliver financial outturn in accordance with agreed control totals, gradually progressing towards break-even (no surplus or deficit at the year-end). To safeguard	Frequent assessment of performance and forecast trajectories is monitored through the Finance Committee.

	may arise if the trust is not able to secure sufficient funds to meet planned expenditure, maintain or replace vital assets, and/or is not able to reduce expenditure in line with system-wide control totals.	quality, proposals to reduce expenditure are subject to Quality Impact Assessment – overseen by the Medical Director and Chief Nurse.	
Inability to initiate and implement evidence-based improvement and innovation.	This risk may arise if there is a lack of support, capability and agility to optimise strategic and operational opportunities to improve patient care.	Maintaining a strong emphasis and focus on safety, clinical outcomes and patient experience as part of the Trust's improvement agenda; striving for excellence and challenging unsatisfactory performance regarding organisational development; delivering training, complying with safety-critical organisation policies and procedures, and learning from adverse events are ways we are currently mitigating this risk.	In addition to the Trust's Improvement Strategy, frequent correspondence and discussions with our partners and commissioners to ensure focus is maintained on quality and systems improvement, whilst maintaining compliance with regulatory requirements.
Working more closely with local health and care partners does not fully deliver the required benefits.	This risk, which is currently being mitigated, may arise where strategic partners are unable to balance competing demands and/or work collaboratively across the whole health and social care system.	Active participation and engagement with all ICS stakeholders to ensure effective planning, implementation and governance at a system level. We continue to play a leading role in the Integrated Care System.	Frequent review of progress through ICS and Place Based Partnership engagement to monitor the effectiveness of system planning and project implementation.
A major disruptive incident.	This risk, which is currently being mitigated, may arise where there is an expected or unexpected event which could lead to rapid operational instability and put safety and quality at risk. Such events include fire, cyber security and prolonged loss of utility (water, gas, electricity supplies).	This risk is mitigated through planned preventative maintenance, proactive inspection, regular testing of business continuity arrangements and horizon scanning.	This is monitored through the Risk Committee, supported by various sub-groups. Includes reporting of emerging risks and events to ensure effective management and mitigation.

Failure to deliver sustainable reductions in the Trust's impact on climate change.	This risk may arise if the Trust's vision to further embed sustainability, through actions outlined in our Green Plan, are not achieved.	This risk is mitigated through management of the action plan, engagement and awareness campaigns (internal/external stakeholders) and Environmental Sustainability Impact Assessments built into project implementation processes.	This is monitored through the Risk Committee, supported by various sub-groups. It includes reporting of progress and emerging risks to ensure effective management.
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It is not envisaged these risks will change over the coming year. The Internal Audit Plan and Counter Fraud Plan are approved by Board members and are aligned, where appropriate, with the principal risks in the BAF. The Audit and Assurance Committee uses the reports of management and internal audit to provide assurance to the Board as to the effectiveness of the BAF as a component of the internal control framework.

Clinical Audit 2023/24

At the beginning of the 2023/2024 financial year we set out the following priorities:

- Strengthen both the assurance and visibility of clinical audit within the organisation via the Improvement in Clinical Audit Group, Advancing Quality Programme and by learning from, and sharing activities on key Trust-wide themes.
- To further connect audit to the continuous improvement and learning cycle. This will focus on process outcomes by aligning clinical audit at a Divisional Governance level. This will help to pull forward learning and good practice across the organisation. The team has attended over 50% of the trust's specialty governance meetings.
- To further align Clinical Audit and Improvement with key organisational strategies. The vision for Continuous Improvement at SFH is driven by the Quality Strategy, which is a key enabler to achieving both clinical effectiveness and efficiency. In May 2023 the Trust created an Improvement Faculty. Clinical Audit is a key component of the Improvement Faculty which has allowed Audit to become a key tool to identify areas that need improvement support, helping to drive forward the continuous improvement of care at Sherwood.

There is still work to do in relation to the above areas and the focus around these is detailed in the plan for the forthcoming financial year.

National clinical audits 2023/24

During 2023/24, Sherwood Forest Hospitals NHS Foundation Trust participated in 56 national clinical audits and 4 National Confidential Enquiries into Patient Outcomes and Death (NCEPOD).

Total Number of audits in the 2023/24 plan = 331

Number of local / other audits = 268

Number of national audits, including NCEPOD = 60

Number of audits fully completed = 103

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

National Emergency Laparotomy Audit (NELA)

The Eighth Patient Report of the National Emergency Laparotomy Audit has shown a number of improvements in patient care. Patients who have a risk factor documented preoperatively has increased from 92.3% in Year 7 to 96.2% in year 8 and compares favourably against the national average of 86.8%. There has also been an increase in the number of patients arriving in theatre in a time appropriate to the urgency of their case. This has risen from 67.2% in Year 7 to 81.2 for year 8 and is 10% higher than the national average.

National Neonatal audit Programme (NNAP)

The recent published report shows that the proportion of babies born at less than 32 weeks gestation who had a first temperature on admission which was both between 36.5°C to 37.5°C and measured within an hour of birth has risen from 46.7% to 80%. This is also higher than the national average.

National Audit of Dementia

This is the fifth round of the national audit, which has changed its perspective from the previous round in 2019 to look at data prospectively to give more timely information for NHS bodies. In terms of National compared to local audit results, patients with suspected or diagnosed dementia had a delirium screening performed 87% of the time nationally, compared to a local rate of 95%, as well as both a pain assessment and a pain reassessment being performed 92% nationally, with a rate of 100% locally. In terms of national dementia admissions, the Trust greatly exceeds the national median admissions of patients in the period, as well as having a greater than average percentage of patients admitted to the hospital with dementia.

Looking forward to 2024/25 we aim to:

- Continue to strengthen the link between Audit and Improvement to deliver the 'So What' of Clinical Audit.
- Reduce the number of 'single cycle' audits being undertaken and promote the importance of the audit cycle being completed in order to deliver improvement in outcomes.
- Ensure that we are appraising the outcomes taken from National Clinical Audit and using these to drive the local audit agenda.

Assess the value of Trust wide audits being undertaken in order to ensure the program is delivering against priorities and delivering.

Workforce and supporting strategies

Our People Strategy for 2022-2025 and supporting Strategic People Plan 2022-2027 are linked to the national NHS People Plan and associated People Promise. Both the People Strategy and Strategic People Plan were introduced in Spring/Summer 2022 and are

underpinned by an annual implementation plan, with progress regularly reported to our Board and associated Committees. A key part of the implementation plan has been to respond to the challenges faced during the global pandemic of Covid-19 and the recovery of our workforce to 'business as usual' over the course of financial years' 2022/2023 and 2023/2024.

Despite the unprecedented challenges and significantly increased demand for our services over the last few years, we are proud to say that 74% of our colleagues voted Sherwood as a great place to work (according to our 2023 Staff Survey, ranking 1st in Midlands and 2nd in the country, which is an increase of 1 place since 2022)

We will continue to use this message as a positive recruitment tactic to support workforce growth and our People Strategy ambitions of 'Growing for the future' and 'New ways of working and delivering care'.

Our Strategic People Plan is supported by HR and Finance teams to ensure workforce capacity is both affordable and sufficient to deliver on projected activity levels, in the short, medium and longer term. This bottom-up approach to ensuring we have safe and adequate staffing levels is supported by our executive-led People Cabinet.

Regular, staffing establishment reviews are also carried out and we have invested in E-Rostering, E-Job Planning and Clinical Activity Manager system. These all help better align our staffing to our activity and acuity levels. In 2023/2024 there has been a high level of focus to reduce agency usage and support staffing and financial efficiencies as a Trust.

We have shifted focus from recovery and restoration following the Covid-19 pandemic – our People Strategy and Strategic People Plans were updated in 2023/2024 with a focus on growth, development and improvement.

Our People Strategy 2022-2025 vision statement is now aligned to Strategic Objective 2 (SO2) of the new Trust Strategy 2024-2029: Improving Lives which was launched in March 2024.

Vision of the People Strategy: Empower and support our people to be the best they can be

We have continued to embed and deliver actions against our People Strategy delivery pillars which deliberately anchor back to the NHS People Plan.

People Strategy – Our delivery pillars:

1. Looking after our people
2. Belonging in the NHS
3. Growing for the future
4. New ways of working and delivering care

Strategic People Plan:

1. Growth and supply
2. Career Development
3. Workforce efficiency
4. Health and wellbeing

Positive stories and key achievements which have been shared and identified via People Committee throughout 2023/2024 include:

- Sherwood being voted 'Best Trust in the Midlands' for the 6th year running according to National Staff Survey 2023 results.
- NHS Employers case study showcasing results from the work completed under our Wellbeing portfolio and Rest, Rehydrate and Refuel agenda at Sherwood: [Link to Case Study](#)
- Won ROSPA Gold Award in recognition of our Health & Safety service.
- 5 entries submitted for HSJ National and HPMA Excellence Awards, recognising programmes of work including Just Culture, Financial Wellbeing and People Transformation (Newark TIF & Mansfield CDC)
- Significant assurance provided via the 360 Assurance report on Wellbeing.
- A successful and well attended Menopause Conference on World Menopause Day 2023.
- Continued to promote Just Culture learnings within the Trust, including Council of Governors in November 2023.
- Wellbeing fundamentals audit completed in 90% of areas. Free tea & coffee provision secured up to and including Quarter 4 of 2023.
- Development of Wellbeing Improvement Plan aligned to NHS England Wellbeing Framework.
- Long service awards reintroduced in Summer 2023 following pause during COVID-19 pandemic.
- Launched new Appraisal and 121 paperwork in September 2023 for all Managers and employees on Agenda for Change contracts, giving less paperwork to complete and an easy-to-use template.
- Continued to embed Step into the NHS careers fairs throughout 2023/2024 to support organisational recruitment needs.
- Supported the launch of Newark TIF (Targeted Investment Funding) and Mansfield CDC (Community Diagnostics Centre) site development projects.
- Continued to lead in key system meetings, representing Sherwood in groups such as the ICS People Collaborative and the ICS Organisational Development and Improvement Community of Practice.

Assurance of legal obligations:

Assurance is provided regarding the Trust's Equality, Diversity and Inclusion (EDI) agenda at People Committee, ensuring legislation is complied with.

The Trust ensures staff entitled to membership of NHS Pension Scheme are offered the scheme and measures are in place to ensure Scheme regulations are complied with regarding relevant deductions and contributions. The Trust also ensures that in accordance with Scheme rules records are accurately kept and updated in accordance with Regulation timescales.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are

complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

NHS England's Workforce Safeguards (2018) were adopted in 21/22 and continue to be reported to the People Committee. These standards ensure our staffing governance processes are informed, safe and sustainable, these includes:

- Embedding the National Quality Board standards
- Ensuring safe staffing processes include evidence-based tools, professional judgement and outcomes
- Receiving assurance from the Chief Nurse and the Medical Director that they are satisfied with the outcome of any assessment that staffing is safe, effective and sustainable

Principal Risk 3: Workforce capacity and capability

The People Committee monitors the Board Assurance Framework (BAF) workforce risks at a strategic level. Principal risk 3: Workforce capacity and capability is presented as part of the BAF to People Committee. The strategic threats posed by this risk are;

- Inability to attract and retain staff
- A significant loss of workforce productivity arising from short-term reduction in staff availability or a reduction in effort above and beyond contractual requirements

Key risks concerning workforce capacity and capability were regularly reviewed by the People Committee during 2023/2024. They will continue to be reported in 2024/2025 as part of the Board Assurance Framework.

Over the last 12 months the action plans delivered as part of our People Strategy have supported mitigation of these risks, for example; enhancing our Step into the NHS careers fairs, continued focus on reward and recognition, wellbeing support and staff networks. We are excited that the Trust has recently become a People Promises Exemplar organisation, sponsored by NHS England. This funding will allow us to support developments to improve staff experience and retention at Sherwood over the next 12 months.

Beneath our strategic risks are operational risks specific to the running of services within the People Directorate. All operational risks are logged on DATIX with appropriate action plans and any risks mitigation plans in place. At the time of this report, 20 operational risks are logged on the DATX Risk Register for the People Directorate.

A robust governance process was put into place in Summer 2023 whereby the Deputy Director of People and the Business Support Officer meet with senior People service leads on a bi-monthly basis to keep track of operational risks and progress mitigation plans.

Any operational risks scored as 'high risk' will be identified on the annual People Department Risk Report that will be presented at Risk Committee.

People priorities 2024/2025

We will continue to ensure our People Strategy and Strategic People Plan are effective, updated annually and signed off by the Board of Directors. The below priorities are highlighted within our People Strategy.

Looking after our people

Governance is provided on these actions through the Trust's People Wellbeing and Belonging Sub-Cabinet.

Our vision - What does this mean in practice?

- Our people are healthy and psychologically safe, allowing them to deliver safe, high-quality care.

Our priorities - How will we deliver this?

- We will follow a person-centred approach, supporting our people based on their individual needs. We acknowledge there is an overlap professionally and personally and will support our people to take appropriate time to rest, rehydrate and refuel. We will provide the practical and emotional support our people need to do their jobs.

Belonging in the NHS

Governance is provided on these actions through the Trust's People Wellbeing and Belonging Sub-Cabinet.

Our vision - What does this mean in practice?

- We have an embedded culture of kindness, civility and respect at SFH, where our CARE values are disseminated. Our people feel a sense of belonging and have a voice through Freedom to Speak Up, Staff Networks, National Staff Survey plus Quarterly Pulse Surveys.

Our priorities - How will we deliver this?

- We will create an inclusive culture and take action to reduce our people's experience of violence, bullying and discrimination. We will recognise and reward our people through key celebration events.

Growing for the future

Governance is provided on these actions through the Trust's People Resourcing and Development Sub-Cabinet.

Our vision - What does this mean in practice?

- We are the employer of choice in the local area, with recruitment, development and promotion practices that are inclusive, fair and equitable. We attract and retain talent.

Our priorities - How will we deliver this?

- We will support the Trusts' workforce needs by continuing to recruit locally and through targeted international recruitment plans. We will develop our workforce by expanding our Step into the NHS programme and investing in our people. We

will utilise internal and external education opportunities to develop our people including growth of apprenticeships, aligned to the NHS Long Term Workforce Plan.

New ways of working and delivering care

Governance is provided on these actions through the Trust's People Transformation sub-cabinet.

Our vision - What does this mean in practice?

- We are leaders in transformation, innovation and partnership working within the Sherwood and the Nottinghamshire system.

Our priorities - How will we deliver this?

- We will empower our people to work flexibly and in different ways, working more digitally and efficiently. We will design multi-professional teams based on recruitment needs highlighted in Trust-wide strategic workforce plans. We will actively seek ways to reduce agency usage to demonstrate productive services.

As 2024/2025 is the 3rd and final year of our current People Strategy we are keen to start developing our priorities for our next People Strategy. To ensure our priorities are meaningful we will engage with colleagues around the organisation to get their feedback throughout development. We will align the end date of our next People Strategy to the same end date of the new Trust Strategy, therefore our new People Strategy will be a 4-year strategy covering financial years' 2025-2029. Engagement will commence in July 2024 to understand. Engagement is due to commence in July 2024 and our People Strategy for 2025-2029 will launch in April 2025.

Compliance with NHS Foundation Trust Condition 4 (Foundation Trust governance)

The annual self-certification provides assurance that NHS providers are compliant with the conditions of their NHS provider licence. Compliance with the licence is routinely monitored through the Oversight Framework, on an annual basis. The licence requires providers to self-certify they have:

- a) Complied with governance arrangement (condition FT4)

Our self-certification was approved by the Board in May 2023. The self-certification process requires a response to the following five questions:

1. The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.
2. The Board has regard to such guidance on good corporate governance as may be issued by NHS England from time to time .
3. The Board is satisfied that the Licensee has established and implements:
 - (a) Effective board and committee structures

- (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees
- (c) Clear reporting lines and accountabilities throughout its organisation.

4. The Board is satisfied that the Licensee has established and effectively implements systems and/or processes:

- a. To ensure compliance with the Licensee's duty to operate efficiently, economically, and effectively
- b. For timely and effective scrutiny and oversight by the Board of the Licensee's operations
- c. To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board, and statutory regulators of health care professions
- d. For effective financial decision-making, management, and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern)
- e. To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making
- f. To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence
- g. To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery
- h. To ensure compliance with all applicable legal requirements

5. The Board is satisfied that there are systems and /or processes referred to in paragraph 4 (above) that should include but not be restricted to systems and processes to ensure:

- a. That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided
- b. That the Board's planning and decision-making processes take timely and appropriate account of quality-of-care considerations
- c. The collection of accurate, comprehensive, timely and up to date information on quality of care
- d. That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care
- e. That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders
- f. That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.

6. The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.

The Board considered the risks to each element of the self-certification and confirmed evidence of compliance with condition 4; the key elements are noted below.

Our governance committee structure has provided our Board of Directors with assurance during the year regarding quality, including compliance with the CQC standards and finance, particularly regarding specific issues raised by NHSE.

During the year, our Board has received assurance regarding the performance through the Single Oversight Framework Integrated Performance Report and supporting exception reports for indicators rated as red on the performance dashboard, bringing together performance metrics and information relating to workforce, quality priorities, staffing and finance.

Reports to Board from the Board committees provide further assurance to the Board on the effectiveness of risk management and internal control, including the reporting of incidents through either Quality Committee for clinical incidents and Audit and Assurance Committee for Information Governance incidents. Reports from internal and external audit are reported to Board through the committee structure with any escalations being highlighted in the committee chair's report to Board.

During 2023/2024 SFHFT was registered to provide healthcare on the following hospital sites – King's Mill Hospital, Newark Hospital, Mansfield Community Hospital, Sherwood Community Unit and Ashfield Health Village.

The Chief Executive, Medical Director, Chief Nurse, and the Director of Nursing Quality & Governance facilitate a regular engagement meeting every six weeks with our CQC Relationship Manager and the Lead Inspector. This meeting provides an opportunity for us to demonstrate on-going improvements in care but also an opportunity for CQC colleagues to gain assurance that timely and appropriate actions are in place to address issues raised through incident reporting, complaints, and patient experience feedback. Since July 2017 CQC colleagues have visited a specialty area during the engagement meeting to enable them to meet SFH colleagues and further understand about the care we provide to our patients. These visits have been received very positively by both parties and have provided additional assurance that we understand where we provide excellent care and where there is further work to do.

We are fully compliant with the registration requirements of the Care Quality Commission.

We have published on our website an up-to-date register of interests, including gifts and hospitality, for decision-making colleagues (band 7 and above) within the past 12 months, as required by the Managing Conflicts of Interest in the NHS guidance.

As an employer with employees entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

The foundation trust has undertaken risk assessments and has plans in place which take account of the Delivering a Net Zero Health Service report under the Greener NHS programme. We ensure our obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Review of economy, efficiency, and effectiveness of the use of resources

Our Board of Directors performs an integral role in maintaining the system of internal control, supported by the Board Committees and internal and external audit.

The internal audit plan is agreed by the Audit and Assurance Committee and is focused on key risk areas, identified through our Board Assurance Framework and via escalation processes from other board committees. Follow up audits are also included in the plan to ensure that actions are implemented, and improvements sustained.

The Board receives regular updates and assurance on the economic, efficient and effective use of resources, including:

Finance Committee - the Finance Committee receives detailed financial operating and outturn information, including historical and forecast pay and non-pay spending analysis, monitoring of the underlying financial position and assurance about financial control. A regular update on the financial position of the ICS is presented to the Finance Committee. The Finance Committee is supported by two key financial groups:

- Finance Resource Oversight Group meets monthly with a quarterly deep dive into each of the three key areas of Finance; Financial Services (Financial Risk, Cash, Capital, Accounts Receivable, Accounts Payable, Payroll and Charity), Financial Management (Divisional Financial Performance and Trust wide forecast outturn reporting) and Financial Business Intelligence (Costing, Income & Contracts, Systems and Financial Strategy).
- Capital Resources Oversight Group meets monthly to provide governance to the delivery of the Trusts capital programme; capital leads present on the progress against achieving the objectives of the annual capital plan and prioritisation of capital resources are agreed.

Risk Committee - this Committee receives assurance regarding the risks on the Board Assurance Framework, with divisional risks reviewed on a cyclical basis. The risks reviewed include those relating to workforce recruitment and retention, organisational sustainability and financial performance.

Trust Board - the Board receives assurance from its committees mentioned above. The main element of performance reporting is the Single Oversight Framework (SOF) which provides the Trust Board with key operational performance indicators on a monthly basis. For each of these indicator's standards and thresholds are agreed up front to help drive when indicators are flagged for specific follow up. The SOF highlights performance in different domains in line with the Trust's strategy and draws out key areas for improvement within each domain.

Improvement Cabinet - the Cabinet leads on the delivery of longer-term strategic change on behalf of the Trust Board with a nominated executive lead supporting the programme leads.

The cabinet meets monthly to review progress to deliver transformational change that will improve services for the local population and deliver financial efficiencies.

People and Inclusion Cabinet - the People and Inclusion Cabinet provides scrutiny and assurance of the development, delivery and impact of the Trust's People and Inclusion strategy and plan. This includes the review of associated BAF risks, to provide assurance that those risks are being effectively mitigated or managed in a controlled way, and to provide assurance that suitable structures, systems and processes are in place and functioning to support colleagues to deliver high-quality patient care.

PFI contract management is overseen by a contract management team, who ensure the outputs in the PFI specifications are met. Due to the contribution of the scheme to the wider underlying deficit the Trust has engaged with PFI specialists to review the nature of the contract. A monthly report is taken to Trust Board to update on PFI-related issues.

Throughout the financial year 2023/24, income and expenditure has been received on an actuals basis and changes to run rate are reviewed and explained as part of the monthly reporting process.

We have ended the year with a deficit of £13.97m after adjusting for asset impairments and other non-control total items. This value is aligned with the forecast outturn agreed between the Nottinghamshire ICS and NHSE for the financial year 2023/24. Details relating to this position are included elsewhere in this report. Although the financial outturn is consistent with the agreed position, we remain in a financially challenged position with a significant underlying deficit.

During 2023/24 the Trust has accessed additional interim revenue support of £11.00m and capital of £22.68m which was agreed with NHSE and drawn down in the form of Public Dividend Capital. Our forecast cash position remains challenged due to timing of cash receipts and the significant efficiency programme built in to the 2024/25 plan, which is weighted for cash delivery saving in q3 and q4. As a consequence, the Trust is forecasting the need for revenue support in 2024/25. The cash forecast is monitored and reported to the Finance Committee and Board.

The Trust continues to work on its planned reduction in agency expenditure but incurred costs of £16.58m in 2023/24 against a plan of £13.01m. There is a target reduction for 2024/25 with a planned spend of £13.72m. The Trust has also relied upon the use of bank employees which has in part mitigated the need and cost of agency expenditure, however, remains committed to reductions in all variable pay including bank workers in line with NHSE targets.

The Trusts overall Efficiency Plan consists of four primary parts:

- The Financial Improvement Programme (FIP) is led by the Divisional Triumvirates supported by the Improvement Faculty. For 2023/24 we achieved £22.45m FIP against a plan of £25.85m.
- Vacancy Control Process is executive led controls for approval of recruitment to posts within the Trust plus non-recurrent underspends on pay. For 2023/24 this delivered £10.66m against a plan of £9m.

- Elective Recovery Fund (ERF) aims to reduce backlogs for elective care whilst attracting financial incentive which exceeds the cost of delivery. For 2023/24 this contributed a stretch achievement above base activity plan of £2.5m benefit (Income less cost to deliver).
- Other Income stretch targets aim to look to seek additional funding opportunities which have supported £1.54m against a plan of £1.6m in 2023/24.

The Trust uses benchmarking information from the Model Hospital and other sources including the Trusts Patient Level Information and Costing System (PLICS) to help to identify efficiency opportunities. Overall, the Trust achieved £37.1m efficiencies in 2023/24 and is in the process of development of the efficiency plan for 2024/25 which amounts to a total of £38.5m across all 4 efficiency areas.

The Nottinghamshire ICS has strengthened governance arrangements over the past year, which has supported closer system working and encouraged a greater level of transparency and consistency between organisations. The ICS Transformation Cabinet and ICS Finance Committee facilitate the sustainable recovery and transformation of services.

The underlying deficit indicate that there is uncertainty which may cast doubt about the Trust's ability to continue as a Going Concern, however, the assurance provided by the immediate continuing provision of healthcare services and improved access to funding through changes in the NHS financing regime significantly mitigates this and under the existing guidance as issued by the Financial Reporting Council, Practice Note 10, the accounts have been prepared on a going concern basis.

The Board of Directors has taken steps to ensure that this remains the case for the next 12 months.

A detailed going concern paper was reviewed and approved by the Audit and Assurance Committee in support of this assessment and is subject to an external audit review as part of the annual accounts process.

Information Governance

Information Governance (IG) is the responsibility of both the Director of Corporate Affairs, who is also our Senior Information Risk Owner (SIRO) and the Medical Director who is our Caldicott Guardian. The SIRO is supported by a network of information asset owners, who ensure the integrity of, and monitor access to, the systems for which they are responsible. The Director of Corporate Affairs as SIRO and the Caldicott Guardian share the chair of the IG Committee. A working group also operates as part of the IG governance structure. The reporting and management of risks relating to data and security are safeguarded by ensuring all our employees are reminded of their data security responsibilities through education, at induction and through mandatory training requirements. More than 4,000 colleagues received mandatory IG training in 2023/24, and regular reminders are shared via internal communications. Near misses and lessons learned are used to inform the training programme, ensuring the programme remains dynamic and reflects current and meaningful issues to facilitate greater employee engagement and ownership of IG processes.

Work continues to raise the profile of IG using a variety of mediums to ensure incidents and lessons learned are brought to the attention of all employees.

Reports are shared at appropriate divisional and corporate meetings and colleagues are notified about updates to policies and guidelines via the Trust Bulletin as soon as they are published on the intranet.

Risk Management and Assurance

As part of ensuring continued compliance with the IG agenda, we review the Terms of Reference for the IG Committee on an annual basis. The group has a strategic focus to ensure effective policies, processes and management arrangements are in place covering all aspects of information governance, including:

- Information security
- Data quality
- Digital continuity
- Records management
- Information disclosure
- Information sharing
- Legal and regulatory compliance.

This strategically focused group meets on a bi-monthly basis and is supported by the IG Working Group, which reviews Data Impact Assessments, as part of the wider stakeholder engagement. This is to assess the level of risk and consider both the likelihood and the severity of any impact on individuals' rights and freedoms. The group also reviews national guidance to inform both strategy and policy development together with implementation plans and processes.

The IG Committee monitors the completion of the Data Security and Protection Toolkit (DSPT) submission, data flow mapping, and information asset registers. We submitted a DSPT as standards met.

The SIRO and Caldicott Guardian received formal training on their statutory responsibilities during 2023/24 to refresh skills and awareness of legislative changes.

Data Flow Mapping

Data from and to SFH is mapped and reviewed on an annual basis. The data flow mapping template has been updated in line with GDPR legal basis Article 6 and Article 9, which now includes categories of data subject / personal data, categories of recipients, information transferred overseas, whether data is retained or disposed of in line with policies, if not why, and whether there is a data sharing agreement in place.

The SIRO is responsible for the development and implementation of the organisation's Information Risk agenda. During 2023/24 we have undertaken an annual review of information flow mapping to ensure we are assured information flows into and out of the organisation are identified, risk assessed and addressed. This is then expanded to ensure we have assurance all information is stored securely and appropriately and any partners in

delivery of either shared care or information storage achieve the same high levels of information governance assurance.

Serious Incidents Requiring Investigation (SIRI)

As part of the Annual Governance Statement, we are required to report on any Serious Incidents (SIRIs) or Cyber Incidents which are notified on the DSPT reported through to either the Information Commissioners Office (ICO) or NHS Digital.

There have been three incidents reported to the ICO. We have had no further action from the regulators after investigation. Incidents varied from data not being stored correctly to inappropriate sharing of information.

Information Sharing

The IG department is actively involved in developing meaningful partnership working with neighbouring healthcare providers. The intention being to ensure the sharing of patient data is protected in line with national guidance in a seamless, robust, and effective way across partner organisations.

Freedom of Information (FOI)

During 2023/24 the Trust processed a total of 863 FOI requests. This function is managed by the Information Governance Team and the activity is demonstrated in the table below.

Total	Breached timeframe of 20 days	Escalated to ICO
863	446	1

The breaches in the 20-working day statutory response timeframe are due to complex requests that require input from multiple teams. The high volume of FOIs consistently being received within the department along with the Impact of operational pressures and industrial action has also affected compliance rates; several of the FOIs are assigned to departments who are inundated with work within these areas, such as the finance team and information services.

Of the requests, 743 are completed, six are on hold waiting further information, fifteen closed due to clarification not received from the requester and 99 are still in progress. Of the requests completed 417 have been completed within 20 days which show a compliance rate of 48% (417/863).

Subject Access Requests (SARs)

The Trust has received 3725 requests for access to patient records. Cases are processed in line with national guidance which is exemplary given some of these cases represent hundreds of pages of information and require methodical attention to detail to ensure information is released appropriately.

There have been no complaints to the Information Commissioner. Any requests for review of content of records by patients have been handled locally and achieved satisfactory resolutions for patients.

The Trust has also received 41 requests for access to staff employment records.

The table below shows the requests processed by the Access to Health Record Team in 2023/24:

April 2023 to March 2024		Completed within 21 days	Completed 21-30 days	Completed more than 30 days
Patient records	3684	3188	493	3
Staff employment records	41	25	4	12

Horizon Scanning

It is impossible to eliminate human error in relation to data security, however a greater focus will be placed on understanding and improving working practices for those who come into contact with data.

Phishing emails are still prevalent in the working environment; and these are becoming more sophisticated attacks. The Trust will use the learning as part of its on-going awareness programme for staff.

Data Protection legislation is currently under review, and we will see a greater focus on ethics and human rights as individuals feel more confident in withdrawing consent for their data to be processed.

Data Quality and Governance

SOP – Quality Assurance and sign off process

In accordance with the NHS Standard Contract, the Trust is required to participate in a range of national audits and clinical outcome reviews. In addition, the Trust is required to make routine information submissions to NHS Digital, NHSE, Unify and the Integrated Care Board. These submissions are quality assured and signed off before submission for the following reasons:

- **Quality assurance of data pre-submission** – to ensure the data has integrity and can be used in confidence to inform decision making and service development.
- **Sign off data pre-submission** – to ensure that data are a true and accurate reflection of the Trust's position.

A comprehensive list of routine external submissions, together with the relevant operational and Executive Director leads is maintained. Quality assurance of National Audits is provided by clinical lead and head of service before signing off by the Clinical Chair and Executive Medical Director. Information requirements for example elective waiting time data is quality assured pre submission by the Divisional General Manager before signing off by the relevant Executive Director.

The relevant Executive Director may delegate responsibility for frequent, routine submissions, such as the daily situation report, but the Executive Director will remain the accountable officer for the submission.

The Trust assures the quality and accuracy of its Audit and Information requirements (for example elective waiting time data), and mitigates risks to the quality and accuracy of this data through the quality assurance and sign off procedure above and the work of the Data Quality Team which covers the following areas:

- **Validation** – in response to known areas of data quality concern (as identified through reporting or operational processes), we will:
 - Actively validate data sets to ensure decision making is based on accurate information.
 - Ensure operational/clinical teams are informed to enable necessary action to be taken in cases where patient care is affected.
- **Addressing errors** – where data errors are identified, in addition to informing operational/clinical teams 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 (for example user, system provider, etc.)
 - Ensure action is taken to reduce or prevent repetition of the issue.
- **Reporting** – use of key performance indicators (KPIs) to:
 - Monitor levels of data quality
 - Identify improvements or deterioration in data quality.
 - Identify areas for validation, corrections, training, process improvements or ad hoc audits.
- **Auditing** – delivery of an audit programme to:
 - Systematically check for data quality issues across the Trust, through sampling of records and providing appropriate feedback
 - Allow for ad hoc audits in response to suspected Data Quality weaknesses.
- **Training** – delivery of Data Quality training for relevant members of staff. In addition, we provide targeted training in response to themes or repeated errors, as identified through:
 - Audit
 - Reporting
 - Operational issues
- **Process improvements** – where necessary, we 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 once implemented.

Freedom to Speak Up

During the year 23/24, 151 cases were raised to the FTSU Guardian compared with 153 cases raised the previous year, demonstrating consistent engagement with the FTSUG.

Supporting the FTSUG, and creating visibility across SFH, there are now 29 trained FTSU Champions.

Top themes raised were:

1. Worker safety and wellbeing - which includes the emotional impact of people related processes, mental health impacts of working in pressurised teams and impact on emotional wellbeing from behaviours outside the SFH Care Values
2. Leadership styles and behaviours – this includes failure to respond to concerns or manage teams effectively.
3. Inappropriate attitudes and behaviour including bullying – poor leadership styles and behaviour, engrained poor behaviour in teams.

Organisational learning from the themes is fed through the People Committee and its subgroups, regular and direct communication with the Executive Team and the FTSU Guardian involvement in Training & Development Programmes.

Feedback is requested from all those who raise concerns. Feedback received on the process is positive and colleagues say they value the service.

Results from the 2023 National Staff Survey, show SFH is above the national average in domains related to confidence in speaking up and the organisation responding to the concerns.

Quality

A review of our performance from 1 April 2023 to 31 March 2024 indicates there are appropriate controls in place. These controls include:

- Corporate level leadership for the quality account is assigned to the Chief Nurse
- Quality governance, quality and performance reports are included in our performance management framework
- Internal audits of some of our indicators have tested how the indicators included in the Quality Report are derived, from source to reporting, including validation checks
- Key individuals involved in producing the report are recruited on the basis that they have the appropriate skills and knowledge to deliver their responsibilities

We have engaged with a wide range of stakeholders in our activity to improve the quality of care provided. The same assurance processes are used for other aspects of performance.

Ockenden Report

On 30 March 2023 NHS England published a three-year delivery plan for maternity and neonatal services. Following several national plans and reports, including the reports by Donna Ockenden and Dr Bill Kirkup, the plan brings together the key objectives that services are asked to deliver against over the next three years.

This new delivery plan in consultation with service users, healthcare staff, trust leaders and other stakeholders, as well as with the Independent Working Group on maternity chaired by the Royal College of Midwives and the Royal College of Obstetricians and Gynaecologists (RCOG). This consultation has supported NHS England to triage and review the actions remaining from the Ockenden and Kirkup reports as well as existing NHS England plans for maternity.

The report sets out the 12 priority actions for trusts and systems for the next three years, across four themes:

- Listening to women and families with compassion
- Supporting the workforce
- Developing and sustaining a culture of safety
- Meeting and improving standards and structures.

Acknowledging that organisations are already, due to the previous immediate and essential actions from the Ockenden report delivering priority actions within the plan, NHS England have supported systems to develop systems plan. Now into year one of the plan the local priority focus as a system are:

1.Embedding the voice of women, birthing people and families – and ensuring key learning from service users is the main driver in transforming our maternity and neonatal services. This includes but is not limited to development of the Maternity Voices Partnership (MVP) and Nausea and Vomiting in Pregnancy (NVP)

2. Equity as the lens through which we view all areas of the Local Maternity and Neonatal System (LMNS)– ensuring equity across our services and local population, with a focus on experience as well as outcomes, looking at localized data for Nottingham and Nottinghamshire.

As a Trust, we are proud of what we have achieved and how we are performing but we are never complacent. We have worked hard to ensure our maternity and neonatal services deliver good and safe care and are looking at the whole report. This is reflected in the feedback we receive from families and our safe outcomes as a service. We recently received the results of a CQC Maternity Survey carried out among women that gave birth at Sherwood Forest and continued to score very well, particularly in areas such as staff treating new mums with respect and dignity during the birth, being supportive and speaking to them in a way that they understand, as well as involving them in decision making.

The board of directors alongside the externally supported Maternity Assurance Committee will have full oversight of the Three-year Plan progress.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework.

I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their management letter and reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit and Assurance Committee, and the other Board

Committees and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The process for maintaining and reviewing the effectiveness of the system of internal control is monitored by the Board and its committees. The chairs of these committees play a key role in assuring me of the performance, quality and financial position of the organisation, which in turn supports the management of risks across the organisation.

The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through an annual programme of internal audit work. The Head of Internal Audit has provided me with an opinion for 2023/24 below:

I am providing an opinion of **significant assurance** that there is a generally sound framework of governance, risk management and control designed to meet the organisation’s objectives, and controls are generally being applied consistently.

Strategic risk management and Board Assurance Framework – I am providing an opinion of significant assurance. There has been regular reporting and updates across the year.

Internal Audit Plan outturn – I am providing an opinion of significant assurance. Some changes were made to the Internal Audit Plan in year reducing the extent of planned assurances. Of the eight core reviews reported in year, one provided limited assurance, one provided moderate assurance (NHS England opinion) and six provided significant assurance.

Implementation of Internal Audit actions – I am providing an opinion of significant assurance. The Audit and Assurance Committee has maintained good oversight of the implementation of internal audit actions, alerting the Board to the Trust’s performance throughout the year. The Trust has also continued to enhance the internal processes for monitoring the implementation of actions. The first follow up rate has shown steady improvement over the last two years.

There have been 11 internal audit assignments completed during the year, including one advisory report on Governance Arrangements for MSK Services – Final Report 22/23 SFHT13. These comprise 8 significant assurance reports (22/23SFH10 Data Quality Framework Final report, 22/23SFH11 Recruitment engagement of agency staff - Final report, 22/23SFHFT08 Key Financial Systems - Pay Expenditure - Final Report, 22/23SFH15 Review of Cancer waiting times Final report, 23/24SFH Policy Management Framework Final report, 23/24 SFH04 Staff Wellbeing Final Report, 23/24SFH06 Accounts Payable and Treasury and Cash Management Final Report and 23/24SFH07 Financial Ledger and Reporting, one moderate assurance report (23/24 DSPT Final Report) and one limited assurance report (2223/SFH/Governance of Statutory Regulatory Committees). None contained any high-risk actions.

In relation to the Limited Assurance opinion report issued in 2023/24, progress in implementing the agreed actions is as follows:

2023/24 Internal Audit Report	Opinion	High Risk Actions	Medium Risk Actions	Low Risk Actions	Current Progress
Governance of Statutory and Regulatory Committees	Limited	0	4	2	4 medium risk and 2 low risk actions implemented.

The internal audit report providing Limited Assurance has been presented to the Audit and Assurance Committee by the executive lead. Implementation of actions identified in the report are monitored through the Quality committee.

All internal audit reports providing Significant Assurance are presented to the most appropriate committee, where the implementation of actions is also monitored.

Any actions which become overdue are reported back to the Audit and Assurance Committee and the action owners are invited to attend to discuss progress.

The Audit and Assurance Committee has maintained good oversight of the position and challenges throughout the year and we have enhanced our internal processes for monitoring of the implementation of actions to ensure managers are supported in achieving the deadlines agreed in the individual internal audit reports.

Managers and Executive Directors provide me with assurance through regular Board and management reports, all which evidence areas of effective internal control and risk management. The Audit and Assurance Committee and the Risk Committee ensure effective operation of risk management and focus on the establishment and maintenance of controls designed to give assurance that assets are safeguarded, waste and inefficiency are avoided, reliable information is produced and value for money is sought continuously.

My review for 2023/24 is also informed by:

- Regular executive reporting to Board and escalation processes through the Board Committees
- Assessment of financial reports submitted to NHS England
- NHS Oversight Framework segmentation for providers – the segmentation score for the Trust is 2.
- NHS Oversight Framework segmentation for ICSs – the segmentation score for the Nottinghamshire ICS changed from 2 to 3 during the year due to the system financial position. The segmentation score indicates the scale and general nature of NHSE support needed by the system. A score of 3 means bespoke, mandated support being provided.

2023 National Staff Survey

- The Trust's results show improvement for all elements. For two elements, staff engagement and morale, the Trust's scores were the best for all trusts and for seven out of nine elements they were above average.
- Patient surveys
- Clinical Audits

Conclusion

There are no significant control issues

I am satisfied the organisation has a sound system of internal control supported by a robust governance structure.

A handwritten signature in black ink, appearing to read 'David Selwyn', written in a cursive style.

David Selwyn
Acting Chief Executive Officer

25th June 2024

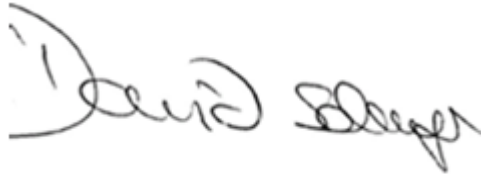
Sherwood Forest Hospitals NHS Foundation Trust

Annual accounts for the year ended 31 March 2024

Foreword to the accounts

Sherwood Forest Hospitals NHS Foundation Trust

These accounts, for the year ended 31 March 2024, have been prepared by Sherwood Forest Hospitals NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.



Signed

Name David Selwyn
Job title Acting Chief Executive Officer
Date 25th June 2024

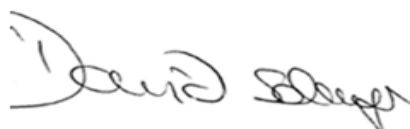
Statement of Comprehensive Income

		2023/24	2022/23
	Note	£000	£000
Operating income from patient care activities	3	453,180	438,752
Other operating income	4	62,562	61,132
Operating expenses	7.1, 9	(510,050)	(485,814)
Operating surplus/(deficit) from continuing operations		5,692	14,070
Finance income	11	1,294	565
Finance expenses	12.1	(63,198)	(16,692)
PDC dividends payable		-	(2,009)
Net finance costs		(61,904)	(18,136)
Other gains / (losses)	13	(71)	26
Share of profit / (losses) of associates / joint arrangements	20	-	-
Gains / (losses) arising from transfers by absorption	33	-	-
Corporation tax expense		-	-
Surplus / (deficit) for the year from continuing operations		(56,283)	(4,040)
Surplus / (deficit) on discontinued operations and the gain / (loss) on disposal of discontinued operations	15.1	-	-
Surplus / (deficit) for the year		(56,283)	(4,040)
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	8	(1,213)	(245)
Revaluations	17	-	-
Other recognised gains and losses		-	2
Total comprehensive income / (expense) for the period		(57,496)	(4,283)
Adjusted financial performance (control total basis):			
Surplus / (deficit) for the period		(56,283)	(4,040)
Remove net impairments not scoring to the Departmental expenditure limit		855	(136)
Remove (gains) / losses on transfers by absorption		-	-
Remove I&E impact of capital grants and donations		163	284
Prior period adjustments		-	-
Remove non-cash element of on-SoFP pension costs		-	-
Remove impact of IFRS 16 on IFRIC 12 schemes		41,297	
Remove net impact of inventories received from DHSC group bodies for COVID response		-	-
Remove loss recognised on peppercorn lease disposals		-	-
Remove loss recognised on return of donated COVID assets to DHSC		-	-
Adjusted financial performance surplus / (deficit)		(13,968)	(3,892)

Statement of Financial Position

		31 March 2024	31 March 2023
	Note	£000	£000
Non-current assets			
Intangible assets	14	3,185	4,775
Property, plant and equipment	15.1	335,698	320,712
Right of use assets	18.1	4,812	4,003
Investment property	19	-	-
Investments in associates and joint ventures	20.1	-	-
Other investments / financial assets	21	-	-
Receivables	20.1	1,451	1,261
Other assets	22.1	-	-
Total non-current assets		345,145	330,751
Current assets			
Inventories	19	6,161	5,685
Receivables	20.1	31,010	27,504
Other investments / financial assets	21	-	-
Other assets	22.1	-	-
Non-current assets for sale and assets in disposal groups	23	-	-
Cash and cash equivalents	21.1	4,736	23,541
Total current assets		41,907	56,730
Current liabilities			
Trade and other payables	22.1	(52,383)	(63,349)
Borrowings	24.1	(19,069)	(10,651)
Other financial liabilities	25.1	-	-
Provisions	25.1	(238)	(187)
Other liabilities	23	(1,193)	(1,727)
Liabilities in disposal groups	23.2	-	-
Total current liabilities		(72,883)	(75,914)
Total assets less current liabilities		314,169	311,567
Non-current liabilities			
Trade and other payables	22	-	-
Borrowings	24	(404,343)	(213,149)
Other financial liabilities	25	-	-
Provisions	25	(757)	(877)
Other liabilities	23	-	-
Total non-current liabilities		(405,100)	(214,026)
Total assets employed		(90,931)	97,541
Financed by			
Public dividend capital		496,313	462,632
Revaluation reserve		14,548	16,022
Financial assets reserve		-	-
Other reserves		-	-
Merger reserve		-	-
Income and expenditure reserve		(601,792)	(381,113)
Total taxpayers' equity		(90,931)	97,541

The notes on pages 146 to 198 form part of these accounts.



Name David Selwyn
Position Acting Chief Executive Officer
Date 25th June 2024

Statement of Changes in Equity for the year ended 31 March 2024

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2023 - brought forward	462,632	16,022	(381,113)	97,541
Application of IFRS 16 measurement principles to PFI liability on 1 April 2023	-	-	(164,657)	(164,657)
Surplus/(deficit) for the year	-	-	(56,283)	(56,283)
Other transfers between reserves	-	(21)	21	-
Impairments	-	(1,213)	-	(1,213)
Revaluations	-	-	-	-
Public dividend capital received	33,681	-	-	33,681
Other reserve movements	-	(240)	240	-
Taxpayers' and others' equity at 31 March 2024	496,313	14,548	(601,792)	(90,931)

Statement of Changes in Equity for the year ended 31 March 2023

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2022 - brought forward	415,445	16,511	(377,319)	54,637
Prior period adjustment	-	-	-	-
Taxpayers' and others' equity at 1 April 2022 - restated	415,445	16,511	(377,319)	54,637
Implementation of IFRS 16 on 1 April 2022	-	-	-	-
Surplus/(deficit) for the year	-	-	(4,040)	(4,040)
Other transfers between reserves	-	(20)	20	-
Impairments	-	(245)	-	(245)
Revaluations	-	-	-	-
Other recognised gains and losses	-	-	2	2
Remeasurements of the defined net benefit pension scheme liability/asset	-	-	-	-
Public dividend capital received	47,187	-	-	47,187
Other reserve movements	-	(224)	224	-
Taxpayers' and others' equity at 31 March 2023	462,632	16,022	(381,113)	97,541

Information on reserves

Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Financial assets reserve

This reserve comprises changes in the fair value of financial assets measured at fair value through other comprehensive income. When these instruments are derecognised, cumulative gains or losses previously recognised as other comprehensive income or expenditure are recycled to income or expenditure, unless the assets are equity instruments measured at fair value through other comprehensive income as a result of irrevocable election at recognition.

Merger reserve

This legacy reserve reflects balances formed on previous mergers of NHS bodies.

Income and expenditure reserve

The balance of this reserve is the accumulated surpluses and deficits of the trust.

Statement of Cash Flows

	Note	2023/24 £000	2022/23 £000
Cash flows from operating activities			
Operating surplus / (deficit)		5,692	14,070
Non-cash income and expense:			
Depreciation and amortisation	7.1	15,722	15,817
Net impairments	8	855	(136)
Income recognised in respect of capital donations	4	(92)	(56)
Amortisation of PFI deferred credit		-	-
Non-cash movements in on-SoFP pension liability		-	-
(Increase) / decrease in receivables and other assets		(3,719)	(13,490)
(Increase) / decrease in inventories		(476)	(720)
Increase / (decrease) in payables and other liabilities		(9,753)	3,783
Increase / (decrease) in provisions		(69)	241
Other movements in operating cash flows		1	1
Net cash flows from / (used in) operating activities		8,161	19,510
Cash flows from investing activities			
Interest received		1,314	435
Purchase and sale of financial assets / investments		-	-
Purchase of intangible assets		(176)	(1,303)
Sales of intangible assets		-	-
Purchase of PPE and investment property		(31,411)	(19,235)
Sales of PPE and investment property		40	94
Net cash flows from / (used in) investing activities		(30,233)	(20,009)
Cash flows from financing activities			
Public dividend capital received		33,681	47,187
Capital element of finance lease rental payments		(903)	(994)
Capital element of PFI, LIFT and other service concession payments		(19,049)	(10,150)
Other interest		(2)	-
Interest paid on finance lease liabilities		(141)	(50)
Interest paid on PFI, LIFT and other service concession obligations		(9,906)	(16,641)
PDC dividend (paid) / refunded		(413)	(1,636)
Net cash flows from / (used in) financing activities		3,267	17,716
Increase / (decrease) in cash and cash equivalents		(18,805)	17,217
Cash and cash equivalents at 1 April - brought forward		23,541	6,324
Prior period adjustments		-	-
Cash and cash equivalents at 1 April - restated		23,541	6,324
Cash and cash equivalents transferred under absorption accounting	33	-	-
Unrealised gains / (losses) on foreign exchange		-	-
Cash and cash equivalents at 31 March	21.1	4,736	23,541

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

NHS England has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2023/24 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts

Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.2 Going concern

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case. The Trust has a negative statement of financial position however, this is not a concern as the organisation is a government body.

Note 1.3 Interests in other entities

The Trust is the Corporate Trustee of Sherwood Forest Hospitals General Charitable Fund. The Charity is not consolidated as the balances are not deemed material, however, the revenue and capital grants are reflected in the accounts. Non consolidated balances as at 31 March 2023 were £1.55m. This decision is ratified by the Board on an annual basis.

Note 1.4 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Standard credit terms apply to invoiced revenue with all NHS debt due for payment within 14 days and all non NHS receivables due within 30 days of the invoice date. Invoices are not raised where revenue is recognised on performance of a contractual obligation until this has been met.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. Funding envelopes are set at an Integrated Care System (ICS) level. The majority of the Trust's NHS income is earned from NHS commissioners under the NHS Payment Scheme (NHSPS) which replaced the National Tariff Payment System on 1 April 2023. The NHSPS sets out rules to establish the amount payable to trusts for NHS-funded secondary healthcare.

Aligned payment and incentive contracts form the main payment mechanism under the NHSPS. In 2023/24 API contracts contain both a fixed and variable element. Under the variable element, providers earn income for elective activity (both ordinary and day case), out-patient procedures, out-patient first attendances, diagnostic imaging and nuclear medicine, and chemotherapy delivery activity. The precise definition of these activities is given in the NHSPS. Income is earned at NHSPS prices based on actual activity. The fixed element includes income for all other services covered by the NHSPS assuming an agreed level of activity with 'fixed' in this context meaning not varying based on units of activity. Elements within this are accounted for as variable consideration under IFRS 15 as explained below.

In 2022/23 fixed payments were set at a level assuming the achievement of elective activity targets within aligned payment and incentive contracts. These payments are accompanied by a variable-element to adjust income for actual activity delivered on elective services and advice and guidance services. Where actual elective activity delivered differed from the agreed level set in the fixed payments, the variable element either increased or reduced the income earned by the Trust at a rate of 75% of the tariff price.

The Trust also receives income from commissioners under Commissioning for Quality Innovation (CQUIN) and Best Practice Tariff (BPT) schemes. Delivery under these schemes is part of how care is provided to patients. As such CQUIN and BPT payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the overall contract with the commissioner and accounted for as variable consideration under IFRS 15. Payment for CQUIN and BPT on non-elective services is included in the fixed element of API contracts with adjustments for actual achievement being made at the end of the year. BPT earned on elective activity is included in the variable element of API contracts and paid in line with actual activity performed.

Elective recovery funding provides additional funding to integrated care boards to fund the commissioning of elective services within their systems. In 2023/24, trusts do not directly earn elective recovery funding, instead earning income for actual activity performed under API contract arrangements as explained above. The level of activity delivered by the trust contributes to system performance and therefore the availability of funding to the trust's commissioners. In 2022/23 elective recovery funding for providers was separately identified within the aligned payment and incentive contracts.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when performance obligations are satisfied. In practical terms this means that treatment has been given, it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Note 1.5 Other forms of income

Grants and donations

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grants is used to fund capital expenditure, it is credited to the Statement of Comprehensive Income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship service income

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Other income

Income from various sources including items such as pharmacy sales and on site creche services.

Note 1.6 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

Note 1.7 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.8 Discontinued operations

Discontinued operations occur where activities either cease without transfer to another entity, or transfer to an entity outside of the boundary of Whole of Government Accounts, such as private or voluntary sectors. Such activities are accounted for in accordance with IFRS 5. Activities that are transferred to other bodies within the boundary of Whole of Government Accounts are 'machinery of government changes' and treated as continuing operations.

Note 1.9 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential be provided to, the trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably
- the item has cost of at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives. The Trust following advice from the District Valuer does not separately recognise any components within the PFI property as it is the responsibility of the PFI provider to maintain all assets at condition B until the date of transfer to the Trust in 2043.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (ie operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the location requirements of the services being provided.

Valuation guidance issued by the Royal Institute of Chartered Surveyors states that valuations are performed net of VAT where the VAT is recoverable by the entity. This basis has been applied to the trust's Private Finance Initiative (PFI) scheme where the construction is completed by a special purpose vehicle and the costs have recoverable VAT for the trust.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'held for sale' cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenditure.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

De-recognition

Assets intended for disposal are reclassified as 'held for sale' once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

This includes assets donated to the trust by the Department of Health and Social Care or NHS England as part of the response to the coronavirus pandemic. As defined in the GAM, the trust applies the principle of donated asset accounting to assets that the trust controls and is obtaining economic benefits from at the year end.

Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) transactions

PFI and LIFT transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's *FReM*, are accounted for as 'on-Statement of Financial Position' by the trust. Annual contract payments to the operator (the unitary charge) are apportioned between the repayment of the liability including the finance cost, the charges for services and lifecycle replacement of components of the asset.

Initial recognition

In accordance with HM Treasury's *FReM*, the underlying assets are recognised as property, plant and equipment, together with an equivalent liability. Initial measurement of the asset and liability are in accordance with the initial measurement principles of IFRS 16 (see leases accounting policy).

Subsequent measurement

Assets are subsequently accounted for as property, plant and equipment and/or intangible assets as appropriate.

The liability is subsequently reduced by the portion of the unitary charge allocated as payment for the asset and increased by the annual finance cost. The finance cost is calculated by applying the implicit interest rate to the opening liability and is charged to finance costs in the Statement of Comprehensive Income. The element of the unitary charge allocated as payment for the asset is split between payment of the finance cost and repayment of the net liability.

Where there are changes in future payments for the asset resulting from indexation of the unitary charge, the Trust remeasures the PFI liability by determining the revised payments for the remainder of the contract once the change in cash flows takes effect. The remeasurement adjustment is charged to finance costs in the Statement of Comprehensive Income.

The service charge is recognised in operating expenses in the Statement of Comprehensive Income.

Lifecycle replacement costs are reviewed and charged to revenue or capital when they meet the capital definition and are then accounted for as part of the annual valuation assessment." In 2023/24 all lifecycle replacement costs were capitalised in line with the PFI model.

Initial application of IFRS 16 liability measurement principles to PFI and LIFT liabilities

IFRS 16 liability measurement principles have been applied to PFI, LIFT and other service concession arrangement liabilities in these financial statements from 1 April 2023. The change in measurement basis has been applied using a modified retrospective approach with the cumulative impact of remeasuring the liability on 1 April 2023 recognised in the income and expenditure reserve.

Comparatives for PFI, LIFT and other service concession arrangement liabilities have not been restated on an IFRS 16 basis, as required by the DHSC Group Accounting Manual. Under IAS 17 measurement principles which applied in 2022/23 and earlier, movements in the liability were limited to repayments of the liability and the annual finance cost arising from application of the implicit interest rate. The cumulative impact of indexation on payments for the asset was charged to finance costs as contingent rent as incurred.

Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	1	57
Dwellings	1	57
Plant & machinery	5	15
Information technology	5	8
Furniture & fittings	5	10

Note 1.10 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised. Expenditure on development is capitalised where it meets the requirements set out in IAS 38.

Software

Software, which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Intangible assets held for sale are measured at the lower of their carrying amount or fair value less costs to sell.

Amortisation

Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

Useful lives of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Software licences	5	10

Note 1.11 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method.

The Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department.

Note 1.12 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.13 Financial assets and financial liabilities

Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets or financial liabilities in respect of assets acquired or disposed of through leasing arrangements are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets are classified as subsequently measured at amortised cost, fair value through income and expenditure.

Financial liabilities classified as subsequently measured at amortised cost fair value through income and expenditure.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Derecognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Note 1.14 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

The Trust as a lessee Recognition and initial measurement

At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments includes fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 3.51% applied to new leases commencing in 2023 and 4.72% to new leases commencing in 2024.

The Trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight-line basis over the lease term or other systematic basis. Irrecoverable VAT on lease payments is expensed as it falls due.

Subsequent measurement

As required by a HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

The Trust as a lessor

The Trust assesses each of its leases and classifies them as either a finance lease or an operating lease. Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Where the Trust is an intermediate lessor, classification of the sublease is determined with reference to the right of use asset arising from the headlease.

Finance leases

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Operating leases

Income from operating leases is recognised on a straight-line basis or another systematic basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Initial application of IFRS 16 in 2022/23

IFRS 16 Leases as adapted and interpreted for the public sector by HM Treasury was applied to these financial statements with an initial application date of 1 April 2022. IFRS 16 replaced *IAS 17 Leases*, *IFRIC 4 Determining whether an arrangement contains a lease* and other interpretations.

The standard was applied using a modified retrospective approach with the cumulative impact recognised in the income and expenditure reserve on 1 April 2022. Upon initial application, the provisions of IFRS 16 were only applied to existing contracts where they were previously deemed to be a lease or contain a lease under IAS 17 and IFRIC 4.

Where existing contracts were previously assessed not to be or contain a lease, these assessments were not revisited.

The Trust as lessee

For continuing leases previously classified as operating leases, a lease liability was established on 1 April 2022 equal to the present value of future lease payments discounted at the Trust's incremental borrowing rate of 0.95%. A right of use asset was created equal to the lease liability and adjusted for prepaid and accrued lease payments and deferred lease incentives recognised in the Statement of Financial Position immediately prior to initial application. Hindsight was used in determining the lease term where lease arrangements contained options for extension or earlier termination.

No adjustments were made on initial application respect of leases with a remaining term of 12 months or less from 1 April 2022 or for leases where the underlying assets had a value below £5,000. No adjustments were made in respect of leases previously classified as finance leases.

The Trust as lessor

Leases of owned assets where the Trust was lessor were unaffected by initial application of IFRS 16. For existing arrangements where the Trust was an intermediate lessor, classification of all continuing sublease arrangements was been reassessed with reference to the right of use asset.

Note 1.15 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective from 31 March 2024:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	4.26%	3.27%
Medium-term	After 5 years up to 10 years	4.03%	3.20%
Long-term	After 10 years up to 40 years	4.72%	3.51%
Very long-term	Exceeding 40 years	4.40%	3.00%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective from 31 March 2024:

	Inflation rate	Prior year rate
Year 1	3.60%	7.40%
Year 2	1.80%	0.60%
Into perpetuity	2.00%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's post-employment benefits discount rate of 2.45% in real terms (prior year: 1.70%).

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at Note 25.2 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

The trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.16 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in Note 26 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in Note 26, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.17 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined by the Department of Health and Social Care.

This policy is available at <https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts>.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.18 Value added tax

Most of the activities of the trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.19 Climate change levy

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

Note 1.20 Foreign exchange

The functional and presentational currency of the trust is sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

- monetary items are translated at the spot exchange rate on 31 March
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

Note 1.21 Third party assets

Assets belonging to third parties in which the Trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's *FReM*.

Note 1.22 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.23 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

Note 1.25 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2023/24.

Note 1.26 Standards, amendments and interpretations in issue but not yet effective or adopted

Other standards, amendments and interpretations

Financial year for which the change first applies	Standard
Not EU-endorsed.* Applies to first time adopters of IFRS after 1 January 2016. Therefore not applicable to DHSC group bodies.	IFRS 14 Regulatory Deferral Accounts
Application required for accounting periods beginning on or after 1 January 2021. Standard is not yet adopted by the FReM which is expected to be from April 2025	IFRS 17 Insurance Contracts

Note 1.27 Critical judgements in applying accounting policies

In applying the Trust's accounting policies management are required to make judgements, estimates and assumptions concerning the carrying amounts of assets and liabilities that are not readily apparent from other sources. Estimates and assumptions are based on historical experience and any other factors that are deemed relevant. Actual results may differ from these estimates and are continually reviewed to ensure validity remains appropriate. These revisions are recognised in the period in which they occur or the current and future periods, as appropriate. In relation to buildings a 2% change in value would equate to £4.9m.

Assumptions have been made regarding the treatment of Lifecycle costs which have all been capitalised in year, £2.09m based on the PFI model.

External Valuation where reliance has been placed on the valuation report as at 31 March 2023, as this represents the best available evidence of current value. Further details are included in note 1.9, and note 17.

Note 2 Operating Segments

No segmental analysis is shown as Sherwood Forest Hospitals NHS Foundation Trust acts solely in the UK and operates as a segment providing healthcare. The "Chief Operating Decision Maker" is deemed to be the Trust Board.

The Board currently receives only high level financial information and does not therefore review information or allocate resources in any way that could be perceived to represent operating segments.

The Trust is split into 5 clinical divisions, Urgent and Emergency Care, Medicine, Surgery, Women's and Children's and Clinical Support Therapies & Outpatients. In addition there is a 'upporting corporate function. all of these divisions are engaged directly in the provision of healthcare and hence are reported as one segment."

A detailed analysis of all income is disclosed in note 3 to these accounts.

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4

Note 3.1 Income from patient care activities (by nature)	2023/24	2022/23
	£000	£000
Acute services		
Income from commissioners under API contracts - variable element*	91,817	
Income from commissioners under API contracts - fixed element*	314,167	374,317
High cost drugs income from commissioners	16,875	14,636
Other NHS clinical income	-	-
Community services		
Income from commissioners under API contracts*	14,376	13,971
Income from other sources (e.g. local authorities)	3,070	2,931
All services		
Private patient income	23	115
Elective recovery fund	-	11,452
National pay award central funding***	183	9,563
Additional pension contribution central funding**	11,857	10,959
Other clinical income	812	808
Total income from activities	453,180	438,752

*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2023/25 NHS Payment Scheme documentation.

<https://www.england.nhs.uk/pay-syst/nhs-payment-scheme/>

**The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. Since 2019/20, NHS providers have continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

*** Additional funding was made available by NHS England in 2023/24 and 2022/23 for implementing the backdated element of pay awards where government offers were made at the end of the financial year. 2023/24: In March 2024, the government announced a revised pay offer for consultants, reforming consultant pay scales with an effective date of 1 March 2024. Trade Unions representing consultant doctors accepted the offer in April 2024. 2022/23: In March 2023, the government made a pay offer for staff on agenda for change terms and conditions which was later confirmed in May 2023. The additional pay for 2022/23 was based on individuals in employment at 31 March 2023.

Note 3.2 Income from patient care activities (by source)

	2023/24	2022/23
Income from patient care activities received from:	£000	£000
NHS England	27,947	37,795
Clinical commissioning groups		97,197
Integrated care boards	421,188	299,376
Department of Health and Social Care	-	-
Other NHS providers	13	421
NHS other	-	-
Local authorities	3,070	2,931

Non-NHS: private patients	23	115
Non-NHS: overseas patients (chargeable to patient)	127	109
Injury cost recovery scheme	812	808
Non NHS: other	-	-
Total income from activities	<u>453,180</u>	<u>438,752</u>
Of which:		
Related to continuing operations	453,180	438,752
Related to discontinued operations	-	-

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	2023/24	2022/23
	£000	£000
Income recognised this year	127	109
Cash payments received in-year	15	10
Amounts added to provision for impairment of receivables	-	-
Amounts written off in-year	34	15

Note 4 Other operating income

	2023/24			2022/23		
	Contract	Non-		Contract	Non-	
	income	contract	Total	income	contract	Total
	£000	£000	£000	£000	£000	£000
Research and development	865	-	865	776	-	776
Education and training	14,820	971	15,791	12,952	720	13,672
Non-patient care services to other bodies	36,740		36,740	36,354		36,354
Reimbursement and top up funding				4,633		4,633
Income in respect of employee benefits accounted on a gross basis	217		217	219		219
Receipt of capital grants and donations and peppercorn leases		92	92		56	56
Charitable and other contributions to expenditure		374	374		1,220	1,220
Revenue from operating leases		725	725		731	731
Amortisation of PFI deferred income / credits		-	-		-	-
Other income	7,755	3	7,758	3,470	1	3,471
Total other operating income	60,397	2,165	62,562	58,404	2,728	61,132
Of which:						
Related to continuing operations			62,562			61,132
Related to discontinued operations			-			-

Note 5.1 Additional information on contract revenue (IFRS 15) recognised in the period

	2023/24	2022/23
	£000	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	-	-

Note 5.2 Income from activities arising from commissioner requested services

The trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2023/24	2022/23
	£000	£000
Income from services designated as commissioner requested services	452,218	437,720
Income from services not designated as commissioner requested services	962	1,032
Total	<u>453,180</u>	<u>438,752</u>

Note 5.3 Profits and losses on disposal of property, plant and equipment

No land and buildings assets used in the provision of commissioner requested services have been disposed of during the year.

Note 6 Operating leases - Sherwood Forest Hospitals NHS Foundation Trust as lessor

This note discloses income generated in operating lease agreements where Sherwood Forest Hospitals NHS Foundation Trust is the lessor.

Note 6.1 Operating lease income

	2023/24	2022/23
	£000	£000
Lease receipts recognised as income in year:		
Minimum lease receipts	725	731
Variable lease receipts / contingent rents	-	-
Total in-year operating lease income	<u>725</u>	<u>731</u>

Note 6.2 Future lease receipts

	31 March	31 March
	2024	2023
	£000	£000
Future minimum lease receipts due in:		
- not later than one year	767	544
- later than one year and not later than two years	590	472
- later than two years and not later than three years	570	472
- later than three years and not later than four years	465	472
- later than four years and not later than five years	456	472
- later than five years	456	-
Total	<u>3,304</u>	<u>2,432</u>

Note 7.1 Operating expenses

	2023/24	2022/23
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	1,931	1,949
Purchase of healthcare from non-NHS and non-DHSC bodies	3,982	5,412
Purchase of social care	-	-
Staff and executive directors costs	328,809	316,140
Remuneration of non-executive directors	158	174
Supplies and services - clinical (excluding drugs costs)	38,581	35,718
Supplies and services - general	3,789	4,379
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	30,388	28,048
Inventories written down	-	-
Consultancy costs	231	82
Establishment	3,940	4,228
Premises	24,356	23,215
Transport (including patient travel)	894	732
Depreciation on property, plant and equipment	13,956	13,777
Amortisation on intangible assets	1,766	2,040
Net impairments	855	(136)
Movement in credit loss allowance: contract receivables / contract assets	221	409
Movement in credit loss allowance: all other receivables and investments	-	-
Increase/(decrease) in other provisions	70	-
Change in provisions discount rate(s)	(8)	(5)
Fees payable to the external auditor		
audit services- statutory audit	170	125
other auditor remuneration (external auditor only)	-	-
Internal audit costs	147	113
Clinical negligence	15,964	14,648
Legal fees	232	138
Insurance	-	-
Research and development	-	-
Education and training	2,258	2,286
Expenditure on short term leases	1,633	-
Expenditure on low value leases	-	-
Variable lease payments not included in the liability	-	-
Early retirements	30	38
Redundancy	17	74
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	27,660	24,959
Charges to operating expenditure for off-SoFP PFI / LIFT schemes	92	132
Car parking & security	-	-
Hospitality	494	282
Losses, ex gratia & special payments	124	-
Grossing up consortium arrangements	-	-
Other services, eg external payroll	-	-
Other	7,310	6,857
Total	<u>510,050</u>	<u>485,814</u>

Of which:

Related to continuing operations	510,050	485,814
Related to discontinued operations	-	-

Note 7.2 Other auditor remuneration

	2023/24 £000	2022/23 £000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the trust	-	-
2. Audit-related assurance services	-	-
Total	<u>-</u>	<u>-</u>

Note 7.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £1 million (2022/23: £1 million).

Note 8 Impairment of assets

	2023/24 £000	2022/23 £000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	855	(136)
Other	-	-
Total net impairments charged to operating surplus / deficit	<u>855</u>	<u>(136)</u>
Impairments charged to the revaluation reserve	<u>1,213</u>	<u>245</u>
Total net impairments	<u>2,068</u>	<u>109</u>

Material impairments / (reversals) charged to the SOCI resulting from changes in market price

The District Valuer has undertaken a walk round review of the Trust estate as at 31 March 2024. This takes account of numerous factors contributing to an overall assessment of each building asset on a modern equivalent basis: these include functional and external obsolescence, investment into the property since the previous valuation and any changes of use.

Note 9 Employee benefits

	2023/24	2022/23
	Total	Total
	£000	£000
Salaries and wages	244,166	235,677
Social security costs	28,105	25,474
Apprenticeship levy	1,240	1,197
Employer's contributions to NHS pensions	39,043	36,051
Pension cost - other	131	174
Other post employment benefits	-	-
Other employment benefits	-	-
Termination benefits	-	-
Temporary staff (including agency)	16,580	18,148
Total gross staff costs	<u>329,265</u>	<u>316,721</u>
Recoveries in respect of seconded staff	-	-
Total staff costs	<u>329,265</u>	<u>316,721</u>
Of which		
Costs capitalised as part of assets	409	469

Note 9.1 Retirements due to ill-health

During 2023/24 there were 6 early retirements from the trust agreed on the grounds of ill-health (4 in the year ended 31 March 2023). The estimated additional pension liabilities of these ill-health retirements is £654k (£249k in 2022/23).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

Note 10 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”. An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2024, is based on valuation data as at 31 March 2023, updated to 31 March 2024 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from April 2024. The Department of Health and Social Care has recently laid Scheme Regulations confirming the employer contribution rate will increase to 23.7% from 1 April 2024 (previously 20.6%).

National Employment Savings Trust (NEST)

The National Employment Savings Trust (NEST) Corporation is the Trustee of the NEST occupational pension scheme. The scheme, which is run on a not-for-profit basis, ensures that all employers have access to suitable, low-charge pension provision. The Trust is required to comply with workplace pension legislation and to auto enrol employees into a pension scheme. Where employees are ineligible to join the NHS Pension Scheme the Trust enrolls the employee into NEST. NEST is a defined contribution scheme.

As at 31 March 2024 there were 7,866 members of the NHS Pension Scheme, 685 are enrolled within NEST and 4,562 are not currently contributing through a workplace pension scheme.

Note 11 Finance income

Finance income represents interest received on assets and investments in the period.

	2023/24	2022/23
	£000	£000
Interest on bank accounts	1,294	565
Total finance income	<u>1,294</u>	<u>565</u>

Note 12.1 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money or asset financing.

	2023/24	2022/23
	£000	£000
Interest expense:		
Interest on lease obligations	141	50
Interest on late payment of commercial debt	2	-
Finance costs on PFI, LIFT and other service concession arrangements:		
Main finance costs	9,906	5,261
Contingent finance costs*	-	11,381
Remeasurement of the liability resulting from change in index or rate*	53,149	
Total interest expense	<u>63,198</u>	<u>16,692</u>
Unwinding of discount on provisions	-	-
Other finance costs	-	-
Total finance costs	<u>63,198</u>	<u>16,692</u>

* From 1 April 2023, IFRS 16 liability measurement principles are applied to PFI, LIFT and other service concession liabilities. Increases to imputed lease payments arising from inflationary uplifts are now included in the liability, and contingent rent no longer arises. More information is provided in Note 29.

Note 12.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2023/24	2022/23
	£000	£000
Total liability accruing in year under this legislation as a result of late payments	-	-
Amounts included within interest payable arising from claims made under this legislation	2	-
Compensation paid to cover debt recovery costs under this legislation	-	-

Note 13 Other gains / (losses)

	2023/24	2022/23
	£000	£000
Gains on disposal of assets	40	94
Losses on disposal of assets	(111)	(68)
Total gains / (losses) on disposal of assets	<u>(71)</u>	<u>26</u>
Gains / (losses) on foreign exchange	-	-
Fair value gains / (losses) on investment properties	-	-
Fair value gains / (losses) on financial assets / investments	-	-
Fair value gains / (losses) on financial liabilities	-	-

Recycling gains / (losses) on disposal of financial assets mandated as fair value through OCI	-	-
Gains/(losses) on remeasurement of finance lease receivables (lessor)	-	-
Gains/(losses) on termination of finance leases (lessor)	-	-
Other gains / (losses)	-	-
Total other gains / (losses)	(71)	26

Note 14.1 Intangible assets - 2023/24	2023/24	2022/23
	Software licences	Software licences
	£000	£000
Valuation / gross cost at 1 April 2023 - brought forward	11,497	10,232
Transfers by absorption	-	-
Additions	176	1,303
Disposals / derecognition	-	(38)
Valuation / gross cost at 31 March 2024	11,673	11,497
		-
Amortisation at 1 April 2023 - brought forward	6,722	4,720
Transfers by absorption	-	-
Provided during the year	1,766	2,040
Disposals / derecognition	-	(38)
Amortisation at 31 March 2024	8,488	6,722
		-
Net book value at 31 March 2024	3,185	
Net book value at 1 April 2023	4,775	4,775

Note 15.1 Property, plant and equipment - 2023/24

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2023 - brought forward	17,793	244,326	2,767	8,343	56,764	-	34,548	602	365,143
Additions	-	8,460	208	12,668	4,609	-	4,215	12	30,172
Impairments	(2,318)	(14,463)	-	-	-	-	-	-	(16,781)
Reversals of impairments	-	14,713	-	-	-	-	-	-	14,713
Revaluations	-	(6,194)	-	-	-	-	-	-	(6,194)
Reclassifications	-	5,442	-	(5,442)	-	-	-	-	-
Disposals / derecognition	-	-	-	-	(1,050)	-	-	-	(1,050)
Valuation/gross cost at 31 March 2024	15,475	252,284	2,975	15,569	60,323	-	38,763	614	386,002
Accumulated depreciation at 1 April 2023 - brought forward	-	-	-	-	26,794	-	17,116	521	44,431
Provided during the year	-	6,194	-	-	2,894	-	3,895	24	13,007
Revaluations	-	(6,194)	-	-	-	-	-	-	(6,194)
Disposals / derecognition	-	-	-	-	(939)	-	-	-	(939)
Accumulated depreciation at 31 March 2024	-	-	-	-	28,749	-	21,011	545	50,305

Net book value at 31 March 2024	15,475	252,284	2,975	15,569	31,574	-	17,752	69	335,698
Net book value at 1 April 2023	17,793	244,326	2,767	8,343	29,970	-	17,432	81	320,712

Note 15.2 Property, plant and equipment - 2022/23

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation / gross cost at 1 April 2022 - as previously stated	18,656	242,210	2,567	701	48,018	-	26,019	612	338,783
Prior period adjustments	-	-	-	-	-	-	-	-	-
Valuation / gross cost at 1 April 2022 - restated	18,656	242,210	2,567	701	48,018	-	26,019	612	338,783
Additions	-	7,433	200	7,642	10,590	-	8,529	-	34,394
Impairments	(863)	(6,615)	-	-	-	-	-	-	(7,478)
Reversals of impairments	-	7,369	-	-	-	-	-	-	7,369
Reclassifications	-	(6,071)	-	-	10	-	-	(10)	(6,071)
Disposals / derecognition	-	-	-	-	(1,854)	-	-	-	(1,854)
Valuation/gross cost at 31 March 2023	17,793	244,326	2,767	8,343	56,764	-	34,548	602	365,143
Accumulated depreciation at 1 April 2022 - as previously stated	-	-	-	-	24,684	-	14,359	482	39,525
Prior period adjustments	-	-	-	-	-	-	-	-	-
Accumulated depreciation at 1 April 2022 - restated	-	-	-	-	24,684	-	14,359	482	39,525
IFRS 16 implementation - reclassification of existing finance leased assets to right of use assets	-	-	-	-	-	-	-	-	-

Provided during the year	-	6,071	-	-	3,896	-	2,757	39	12,763
Reclassifications	-	(6,071)	-	-	-	-	-	-	(6,071)
Disposals / derecognition	-	-	-	-	(1,786)	-	-	-	(1,786)
Accumulated depreciation at 31 March 2023	-	-	-	-	26,794	-	17,116	521	44,431
Net book value at 31 March 2023	17,793	244,326	2,767	8,343	29,970	-	17,432	81	320,712
Net book value at 1 April 2022	18,656	242,210	2,567	701	23,334	-	11,660	130	299,258

Note 15.3 Property, plant and equipment financing - 31 March 2024

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Owned - purchased	15,475	14,057	1	15,569	30,527	-	17,751	58	93,438
On-SoFP PFI contracts and other service concession arrangements	-	237,167	-	-	-	-	-	-	237,167
Off-SoFP PFI residual interests	-	-	2,974	-	-	-	-	-	2,974
Owned - donated/granted	-	1,060	-	-	1,047	-	1	11	2,119
Total net book value at 31 March 2024	15,475	252,284	2,975	15,569	31,574	-	17,752	69	335,698

**Note 15.4 Property, plant and equipment financing -
31 March 2023**

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Owned - purchased	17,793	11,396	-	8,343	28,771	-	17,430	80	83,813
On-SoFP PFI contracts and other service concession arrangements	-	231,838	-	-	-	-	-	-	231,838
Off-SoFP PFI residual interests	-	-	2,767	-	-	-	-	-	2,767
Owned - donated/granted	-	1,092	-	-	1,199	-	2	1	2,294
Total net book value at 31 March 2023	17,793	244,326	2,767	8,343	29,970	-	17,432	81	320,712

**Note 15.5 Property plant and equipment assets subject to an operating lease (Trust as a
lessor) - 31 March 2023**

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Subject to an operating lease	-	3,724	-	-	-	-	-	-	3,724
Not subject to an operating lease	17,793	240,602	2,767	8,343	29,970	-	17,432	81	316,988
Total net book value at 31 March 2023	17,793	244,326	2,767	8,343	29,970	-	17,432	81	320,712

Note 16 Donations of property, plant and equipment

The Trust received donations during the year of £281k. (2022/23 £227k). No restrictions were placed on these donations of which £92k funded the purchase of tangible capital assets.

Note 17 Revaluations of property, plant and equipment

An independent walk round revaluation was undertaken of the Trust's buildings by the District Valuer with an effective date of 31st March 2024. The review was performed by Rob Mapletoft, (MRICS), RICS registered valuer.

Assets in existing use:

For specialised properties (i.e. those for which no active market exists), depreciated replacement cost has been used and is considered to be a satisfactory approximation of current value in existing use.

Within this methodology, consistent with previous years, a Modern Equivalent Asset (MEA) approach was undertaken referenced to National Indices acceptable to the RICS. Consideration was given to improvements carried out during the year and where appropriate asset lives were adjusted accordingly based on the remaining useful life advised by the District Valuer. This had minimal effect on remaining lives. Modern Equivalent Asset (MEA) concept is applied: the "replacement cost" being based on the cost of a modern replacement asset that has the same productive capacity as the property being valued.

The Trust has no assets identified as no longer in operational use and therefore 'surplus' or any assets held for sale. The carrying value of land building and dwellings valued on an open market valuation basis at 31 March 2024 is detailed in note 15.1.

The useful economic asset lives for intangibles and plant and equipment are initially assessed when an asset is first recognised. Periodically the Trust does review these lives to identify and adjust for any assets impaired or where the useful economic life requires adjustment. This exercise was undertaken in 2019/20 for I.T assets.

The asset lives for individual buildings and dwellings are in accordance with the latest valuation report prepared by the external valuer.

The valuer has utilised assumptions with the valuation report to determine the conclusion, but responsibility over challenging the assumptions used is management's responsibility. The following assumptions have been utilised in the report:

1. Index – This is used as part of desktop review which is undertaken annually between full valuations. Utilising BCIS indexation figures to consider for inflation in building trade i.e., additional inflation cost for building a new build This is a consistent method used and is industry standard in line with RIC's and accounting standards. Therefore, we have no issue in the index used in the valuation. There are no alternatives to compare with, therefore current indexation method the most appropriate.
2. Building Cost Information Service (BCIS) Rates – the valuation reflects construction cost increases this year in view of evidence coming through from industry data produced by the RICS Building Cost Information Service (BCIS).
3. Depreciation - Essentially the valuation has resulted in depreciation being one year less than last year, which is line with expectations. Continue to apply design and remaining lives elements of each building where they are present. No change has occurred from previous year's calculations, therefore, applies a consistent approach and we would not expect a change in depreciation methodology as there has been neither change in guidance from RICS nor any change in accounting standards to facilitate any change in depreciation calculation. The depreciation has not adjusted the residual values.

4. Land - It is difficult to prove the price for commercial land, as it is commercially sensitive and not advertised publicly to be able to test exactly what land is going for currently. Therefore, it is reasonable to use the information the valuer provides, particularly as they are involved in selling and valuing of commercial land so understand the market.

Based on the valuation report if there was a 5% positive or negative movement in the valuation of buildings this would have resulted in a movement of £12.74m in the value of assets. This movement would have been reflected in either the revaluation reserve or income and expenditure as a revaluation adjustment as appropriate, however, It would have had no impact of the depreciation charge in year or the underlying reported position.

Note 18 Leases - Sherwood Forest Hospitals NHS Foundation Trust as a lessee

This note details information about leases for which the Trust is a lessee.

The Trust has entered into a number of leases as per IFRS16. These relate solely to equipment and buildings. The only material lease relates to wards at Mansfield Community Hospital.

Note 18.1 Right of use assets - 2023/24

	Property (land and buildings) £000	Plant & machinery £000	Total £000	Of which: leased from DHSC group bodies £000
Valuation / gross cost at 1 April 2023 - brought forward	4,440	577	5,017	-
Transfers by absorption	-	-	-	-
Additions	1,370	114	1,484	-
Remeasurements of the lease liability	274	-	274	-
Movements in provisions for restoration / removal costs	-	-	-	-
Valuation/gross cost at 31 March 2024	6,169	606	6,775	-
Accumulated depreciation at 1 April 2023 - brought forward	720	294	1,014	-
Transfers by absorption	-	-	-	-
Provided during the year	748	201	949	-
Accumulated depreciation at 31 March 2024	1,468	495	1,963	-
Net book value at 31 March 2024	4,701	111	4,812	-
Net book value at 1 April 2023	3,720	283	4,003	-
Net book value of right of use assets leased from other NHS providers				-
Net book value of right of use assets leased from other DHSC group bodies				-

Note 18.2 Right of use assets - 2022/23

	Property (land and buildings) £000	Plant & machinery £000	Total £000	Of which: leased from DHSC group bodies £000
Valuation / gross cost at 1 April 2022 - brought forward	-	-	-	-
IFRS 16 implementation - adjustments for existing operating leases / subleases	4,440	563	5,003	-
Transfers by absorption	-	-	-	-
Additions	-	14	14	-
Valuation/gross cost at 31 March 2023	4,440	577	5,017	-
Accumulated depreciation at 1 April 2022 - brought forward	-	-	-	-
Transfers by absorption	-	-	-	-
Provided during the year	720	294	1,014	-
Accumulated depreciation at 31 March 2023	720	294	1,014	-
Net book value at 31 March 2023	3,720	283	4,003	-
Net book value at 1 April 2022	-	-	-	-
Net book value of right of use assets leased from other NHS providers				-
Net book value of right of use assets leased from other DHSC group bodies				-

Note 18.3 Revaluations of right of use assets

No external valuations have been made in year relating to building or PPE.

Note 18.4 Reconciliation of the carrying value of lease liabilities

Lease liabilities are included within borrowings in the statement of financial position. A breakdown of borrowings is disclosed in note 24.1.

	2023/24 £000	2022/23 £000
Carrying value at 31 March	4,023	-
Prior period adjustments		-
Carrying value at 31 March - restated	4,023	-
IFRS 16 implementation - adjustments for existing operating leases		5,003
Transfers by absorption	-	-
Lease additions	1,484	14
Lease liability remeasurements	274	-
Interest charge arising in year	141	50
Early terminations	-	-
Lease payments (cash outflows)	(1,044)	(1,044)
Other changes	-	-
Carrying value at 31 March	4,878	4,023

Lease payments for short term leases, leases of low value underlying assets and variable lease payments not dependent on an index or rate are recognised in operating expenditure. These payments are disclosed in Note 7.1. Cash outflows in respect of leases recognised on-SoFP are disclosed in the reconciliation above.

Note 18.5 Maturity analysis of future lease payments

	Total 31 March 2024 £000	Of which leased from DHSC group bodies: 31 March 2024 £000	Total 31 March 2023 £000	Of which leased from DHSC group bodies: 31 March 2023 £000
Undiscounted future lease payments payable in:				
- not later than one year;	1,158	-	1,043	-
- later than one year and not later than five years;	4,581	274	3,386	-
- later than five years.	-	-	-	-
Total gross future lease payments	5,739	274	4,429	-
Finance charges allocated to future periods	(861)	-	(406)	-
Net lease liabilities at 31 March 2024	4,878	274	4,023	-
Of which:				
Leased from other NHS providers		-		-
Leased from other DHSC group bodies		274		-

Note 19 Inventories

	31	31
	March	March
	2024	2023
	£000	£000
Drugs	2,407	2,065
Work In progress	-	-
Consumables	3,549	3,426
Energy	205	194
Other	-	-
Total inventories	<u>6,161</u>	<u>5,685</u>
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £32,544k (2022/23: £30,595k). Write-down of inventories recognised as expenses for the year were £0k (2022/23: £0k).

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2023/24 the Trust received £132k of items purchased by DHSC (2022/23: £993k).

These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in the expenses disclosed above.

The deemed cost of these inventories was charged directly to expenditure on receipt with the corresponding benefit recognised in income.

Note 20.1 Receivables

	31 March 2024 £000	31 March 2023 £000
Current		
Contract receivables	26,409	22,924
Allowance for impaired contract receivables / assets	(418)	(527)
Allowance for other impaired receivables	-	-
Prepayments (non-PFI)	2,491	2,677
PFI prepayments - capital contributions	-	-
PFI lifecycle prepayments	-	-
Interest receivable	123	143
VAT receivable	2,372	2,263
Corporation and other taxes receivable	-	-
Other receivables	33	24
Total current receivables	<u>31,010</u>	<u>27,504</u>
Non-current		
Contract receivables	2,647	2,011
Contract assets	-	-
Capital receivables	-	-
Allowance for impaired contract receivables / assets	(1,740)	(1,410)
Allowance for other impaired receivables	-	-
PFI prepayments - capital contributions	-	-
PFI lifecycle prepayments	39	42
Interest receivable	-	-
Other receivables	505	618
Total non-current receivables	<u>1,451</u>	<u>1,261</u>
Of which receivable from NHS and DHSC group bodies:		
Current	21,010	18,261
Non-current	505	618

Note 20.2 Allowances for credit losses

	2023/24	2022/23
	Contract receivables and contract assets	Contract receivables and contract assets
	£000	£000
Allowances as at 1 April - brought forward	1,937	1,565
Prior period adjustments	-	-
Allowances as at 1 April - restated	1,937	1,565
Transfers by absorption	-	-
New allowances arising	221	454
Changes in existing allowances	-	-
Reversals of allowances	-	(45)
Utilisation of allowances (write offs)	-	(37)
Changes arising following modification of contractual cash flows	-	-
Foreign exchange and other changes	-	-
Allowances as at 31 Mar 2024	2,158	1,937

Note 20.3 Exposure to credit risk

The majority of carrying debt relates to NHS organisations, therefore no significant credit risk is assumed in non impaired receivables.

Note 21.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2023/24	2022/23
	£000	£000
At 1 April	23,541	6,324
Prior period adjustments	-	-
At 1 April (restated)	23,541	6,324
Transfers by absorption	-	-
Net change in year	(18,805)	17,217
At 31 March	4,736	23,541
Broken down into:		
Cash at commercial banks and in hand	6	6
Cash with the Government Banking Service	4,730	23,535
Total cash and cash equivalents as in SoFP	4,736	23,541
Bank overdrafts (GBS and commercial banks)	-	-
Drawdown in committed facility	-	-
Total cash and cash equivalents as in SoCF	4,736	23,541

Note 21.2 Third party assets held by the trust

Sherwood Forest Hospitals NHS Foundation Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties and in which the trust has no beneficial interest. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31	31
	March	March
	2024	2023
	£000	£000
Bank balances	-	-
Monies on deposit	3	5
Total third party assets	3	5

Note 22.1 Trade and other payables

	31 March 2024 £000	31 March 2023 £000
Current		
Trade payables	5,253	5,853
Capital payables	17,657	18,991
Accruals	14,016	13,509
Receipts in advance and payments on account	-	168
PFI lifecycle replacement received in advance	-	-
Social security costs	3,459	3,177
VAT payables	-	-
Other taxes payable	3,790	3,161
PDC dividend payable	-	413
Pension contributions payable	3,894	3,454
Other payables	4,314	14,623
Total current trade and other payables	<u>52,383</u>	<u>63,349</u>
Non-current		
Other payables	-	-
Total non-current trade and other payables	<u>-</u>	<u>-</u>
Of which payables from NHS and DHSC group bodies:		
Current	1,955	1,673
Non-current	-	-

Note 22.2 Early retirements in NHS payables above

The payables note above does not include any liabilities in relation to early retirements.

Note 23 Other liabilities

	31 March 2024 £000	31 March 2023 £000
Current		
Deferred income: contract liabilities	1,193	1,727
Total other current liabilities	<u><u>1,193</u></u>	<u><u>1,727</u></u>
Non-current		
Deferred income: contract liabilities	-	-
Total other non-current liabilities	<u><u>-</u></u>	<u><u>-</u></u>

Note 24.1 Borrowings

	31 March 2024 £000	31 March 2023 £000
Current		
Lease liabilities	1,158	1,043
Obligations under PFI, LIFT or other service concession contracts	17,911	9,608
Total current borrowings	<u><u>19,069</u></u>	<u><u>10,651</u></u>
Non-current		
Lease liabilities	3,720	2,980
Obligations under PFI, LIFT or other service concession contracts	400,623	210,169
Total non-current borrowings	<u><u>404,343</u></u>	<u><u>213,149</u></u>

Note 24.2 Reconciliation of liabilities arising from financing activities

	Lease Liabilities £000	PFI and LIFT schemes £000	Total £000
Carrying value at 1 April 2023	4,023	219,777	223,800
Cash movements:			
Financing cash flows - payments and receipts of principal	(903)	(19,049)	(19,952)
Financing cash flows - payments of interest	(141)	(9,906)	(10,047)
Non-cash movements:			
Application of IFRS 16 measurement principles to PFI liability on 1 April 2023		164,657	164,657
Transfers by absorption	-	-	-
Additions	1,484	-	1,484
Lease liability remeasurements	274	-	274
Remeasurement of PFI / other service concession liability resulting from change in index or rate	-	53,149	53,149
Application of effective interest rate	141	9,906	10,047
Carrying value at 31 March 2024	4,878	418,534	423,412

	Lease Liabilities £000	PFI and LIFT schemes £000	Total £000
Carrying value at 1 April 2022	-	229,927	229,927
Prior period adjustment	-	-	-
Carrying value at 1 April 2022 - restated	-	229,927	229,927
Cash movements:			
Financing cash flows - payments and receipts of principal	(994)	(10,150)	(11,144)
Financing cash flows - payments of interest	(50)	(5,261)	(5,311)
Non-cash movements:			
Impact of implementing IFRS 16 on 1 April 2022	5,003		5,003
Transfers by absorption	-	-	-
Additions	14	-	14
Lease liability remeasurements	-	-	-
Application of effective interest rate	50	5,261	5,311
Carrying value at 31 March 2023	4,023	219,777	223,800

Note 25.1 Provisions for liabilities and charges analysis

	Pensions: early departure costs £000	Pensions: injury benefits £000	Legal claims £000	Equal Pay (including Agenda for Change) £000	Other £000	Total £000
At 1 April 2023	250	59	113	-	642	1,064
Transfers by absorption	-	-	-	-	-	-
Change in the discount rate	(6)	(2)	-	-	(81)	(89)
Arising during the year	51	8	108	-	-	167
Utilised during the year	(48)	(6)	(55)	-	(4)	(113)
Reclassified to liabilities held in disposal groups	-	-	-	-	-	-
Reversed unused	-	-	(15)	-	(19)	(34)
Unwinding of discount	-	-	-	-	-	-
At 31 March 2024	247	59	151	-	538	995
Expected timing of cash flows:						
- not later than one year;	48	6	151	-	33	238
- later than one year and not later than five years;	192	24	-	-	42	258
- later than five years.	7	29	-	-	463	499
Total	247	59	151	-	538	995

Pensions relate to liabilities for employees who retired pre 1994 for whom the Trust retains responsibility for the payments being made. Other relates to pension tax liability where there is an offsetting accounts receivable balance held with the DoHSC.

Note 25.2 Clinical negligence liabilities

At 31 March 2024, £146,941k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Sherwood Forest Hospitals NHS Foundation Trust (31 March 2023: £164,728k).

Note 26 Contingent assets and liabilities

	31 March 2024 £000	31 March 2023 £000
Value of contingent liabilities		
Other	(107)	(242)
Gross value of contingent liabilities	<u>(107)</u>	<u>(242)</u>
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	<u>(107)</u>	<u>(242)</u>
Net value of contingent assets	-	-

Note 27 Contractual capital commitments

	31 March 2024 £000	31 March 2023 £000
Property, plant and equipment	11,283	14,044
Intangible assets	-	1
Total	<u>11,283</u>	<u>14,045</u>

Note 28 Other financial commitments

The trust is committed to making payments under non-cancellable contracts (which are not leases, PFI contracts or other service concession arrangement), analysed by the period during which the payment is made:

	31 March 2024 £000	31 March 2023 £000
not later than 1 year	-	-
after 1 year and not later than 5 years	-	-
paid thereafter	-	-
Total	<u>-</u>	<u>-</u>

Note 28 On-SoFP PFI, LIFT or other service concession arrangements

The Trust is currently committed to two on-statement of financial position PFI schemes as the transaction meets the IFRIC 12 definition of a service concession, as interpreted in the Government Accounting Manual. The Trust is required to account for the PFI scheme 'on-statement of financial position' and therefore the Trust treats the assets as if it were assets of the Trust.

The Trust has entered into private finance initiative contracts with:

a) Central Nottinghamshire Hospitals plc to construct and refurbish the Trust's buildings on the King's Mill and Newark hospital sites and then to operate them (estates, facilities management and life cycle replacement) for the Trust for the period to 2043. The contract requires that throughout the contract they are maintained to category B building standards. This PFI is known as the Modernisation of Acute Services (MAS). The MAS PFI scheme was completed and all assets were brought into use by 31 March 2012, with an estimated capital value of £366.5m.

b) Leicester Housing Association (LHA)*, to construct a day nursery and out of hours facility, on the King's Mill hospital site. All assets were brought into use by 2002, with a capital value of £1.3m. Throughout the term of the agreement there is a requirement to keep the premises clean, tidy and in good order and to keep in good and substantial repair and condition in accordance with the Operating Agreement.

In respect of both PFI schemes the Trust has the rights to use the specified assets for the length of the Project Agreements. At the end of the Project Agreements the assets of both schemes will transfer to the Trust's ownership for no additional consideration.

The annual charge relating to the MAS scheme is subject to an annual inflation uplift based on RPI. The LHA schemes are a fixed charge over the life of the contract. All liquidity and associated market and financing risks for both schemes rests with Central Nottinghamshire plc and Leicester Housing Association respectively.

* Leicester Housing Association is now known as Paragon Asra Housing (PA Housing).

Note 28.1 On-SoFP PFI, LIFT or other service concession arrangement obligations

The following obligations in respect of the PFI, LIFT or other service concession arrangements are recognised in the statement of financial position:

	31 March 2024 £000	31 March 2023 £000
Gross PFI, LIFT or other service concession liabilities	518,430	276,122
Of which liabilities are due		
- not later than one year;	27,362	14,634
- later than one year and not later than five years;	109,183	55,993
- later than five years.	381,885	205,495
Finance charges allocated to future periods	(99,896)	(56,345)
Net PFI, LIFT or other service concession arrangement obligation	418,534	219,777
- not later than one year;	17,911	9,608
- later than one year and not later than five years;	75,567	38,037
- later than five years.	325,056	172,132

Note 28.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

Total future commitments under these on-SoFP schemes are as follows:

	31 March 2024 £000	31 March 2023 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	1,202,080	1,124,518
Of which payments are due:		
- not later than one year;	63,304	46,039
- later than one year and not later than five years;	253,126	195,485
- later than five years.	885,650	882,994

Note 28.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the unitary payments made to the service concession operator:

	2023/24 £000	2022/23 £000
Unitary payment payable to service concession operator	60,528	53,793
Consisting of:		
- Interest charge	9,906	5,261
- Repayment of balance sheet obligation	19,048	10,150
- Service element and other charges to operating expenditure	27,659	24,911
- Capital lifecycle maintenance	3,915	2,090
- Contingent rent	-	11,381
Other amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment	1	48
Total amount paid to service concession operator	60,529	53,841

Note 29 Impact of change in accounting policy for on-SoFP PFI, LIFT and other service concession liabilities

IFRS 16 liability measurement principles have been applied to PFI, LIFT and other service concession arrangement liabilities from 1 April 2023. When payments for the asset are uplifted for inflation, the imputed lease liability recognised on the SoFP is remeasured to reflect the increase in future payments. Such increases were previously recognised as contingent rent as incurred.

The change in measurement basis has been applied retrospectively without restatement of comparatives and with the cumulative impact on 1 April 2023 recognised in the income and expenditure reserve. The incremental impact of applying the new accounting policy on (a) the allocation of the unitary charge in 2023/24 and (b) the primary statements in 2023/24 is set out in the disclosures below.

Note 29.1 Impact of change in accounting policy on the allocation of unitary payment

	IFRS 16 basis (new basis) 2023/24 £000	IAS 17 basis (old basis) 2023/24 £000	Impact of change 2023/24 £000
Unitary payment payable to service concession operator	60,528	60,528	-
Consisting of:			
- Interest charge	9,906	5,023	4,883
- Repayment of balance sheet obligation	19,048	9,615	9,433
- Service element	27,659	27,659	-
- Lifecycle maintenance	3,915	3,915	-
- Contingent rent	-	14,316	(14,316)
- Addition to lifecycle prepayment	-	-	-

Above tables includes the main PFI and Little Millers, Byron House which are accounted for as on balance sheet.

Note 29.2 Impact of change in accounting policy on primary statements

Impact of change in PFI accounting policy on 31 March 2024 Statement of Financial Position:

Increase in PFI / LIFT and other service concession liabilities	£000
Decrease in PDC dividend payable / increase in PDC dividend receivable	(208,373)
Increase in cash and cash equivalents (impact of PDC dividend only)	-
	<u>2,419</u>
Impact on net assets as at 31 March 2024	(205,954)

Impact of change in PFI accounting policy on 2023/24 Statement of Comprehensive Income:

PFI liability remeasurement charged to finance costs	£000
Increase in interest arising on PFI liability	(53,149)
	(4,883)

Reduction in contingent rent	14,316
Reduction in PDC dividend charge	2,419
Net impact on surplus / (deficit)	<u>(41,297)</u>

Impact of change in PFI accounting policy on 2023/24 Statement of Changes in Equity:

	£000
Adjustment to reserves for the cumulative retrospective impact on 1 April 2023	(164,657)
Net impact on 2023/24 surplus / deficit	<u>(41,297)</u>
Impact on equity as at 31 March 2024	<u>(205,954)</u>

Impact of change in PFI accounting policy on 2023/24 Statement of Cash Flows:

	£000
Increase in cash outflows for capital element of PFI / LIFT	(9,433)
Decrease in cash outflows for financing element of PFI / LIFT	9,433
Decrease in cash outflows for PDC dividend	<u>2,419</u>
Net impact on cash flows from financing activities	<u>2,419</u>

Note 29.3 Off-SoFP PFI, LIFT and other service concession arrangements

Sherwood Forest Hospitals NHS Foundation Trust incurred the following charges in respect of off-Statement of Financial Position PFI and LIFT arrangements:

	31 March 2024 £000	31 March 2023 £000
Charge in respect of the off SoFP PFI, LIFT or other service concession arrangement for the period	92	132
Commitments in respect of off-SoFP PFI, LIFT or other service concession arrangements:		
- not later than one year;	420	400
- later than one year and not later than five years;	1,822	1,735
- later than five years.	<u>3,678</u>	<u>3,991</u>
Total	<u>5,920</u>	<u>6,126</u>

Note 30 Financial instruments

A financial instrument is a contract that gives rise to a financial asset in one entity and a financial liability or equity instrument in another entity. The nature of the Trust's activities means that exposure to risk, although not eliminated, is substantially reduced.

Note 30.1 Financial risk management

Because of the continuing service provider relationship that the Trust has with Integrated Care Boards (ICB's) and the way those ICB's are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the Board of Directors. Trust treasury activity is subject to review by the Finance Committee.

Note 30.2 Currency Risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and Sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Note 30.3 Market (Interest Rate) Risk

All of the Trust financial assets and all of its financial liabilities carry nil or fixed rates of interest. The Trust is not therefore, exposed to significant interest rate risk.

Note 30.4 Liquidity Risk

The Trust's net operating costs are incurred under annual service agreements with Integrated Care Boards (ICB's) and NHS England, which are financed from resources voted annually by Parliament. The Trust ensures that it has sufficient cash to meet all its commitments when they fall due. This is regulated by the Trust's compliance with the 'Use of Resources Risk Rating' system created by NHSI, the Independent Regulator.

The Board continues to monitor its monthly and future cash position and has governance arrangements in place to manage cash requirements throughout the year. The Trust is not, therefore, exposed to significant liquidity risks.

Note 30.5 Fair Values

All of the financial assets and all of the financial liabilities of the Trust are measured at fair value on recognition and subsequently amortised cost.

The fair values recognised in these accounts do not differ materially from the carrying amounts.

Note 30.6 Credit Risk

The majority of the Trust's income comes from contracts with other public sector bodies, resulting in low exposure to credit risk. The Trust mitigates its exposure to credit risk relating to receivables from customers through regular review of debtor balances and by calculating an expected allowance for credit losses at the end of the year. Changes have been made to funding flows at least for the period April to July 2020 as part of the COVID 19 response.

These changes are not seen as an increase to credit risk as the operational expenditure and related financing is provided by the DHSC.

Note 30.7 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2024	Held at amortised cost £000	Held at fair value through I&E £000	Held at fair value through OCI £000	Total book value £000
Trade and other receivables excluding non financial assets	27,559	-	-	27,559
Other investments / financial assets	-	-	-	-
Cash and cash equivalents	4,736	-	-	4,736
Total at 31 March 2024	32,295	-	-	32,295

Carrying values of financial assets as at 31 March 2023	Held at amortised cost £000	Held at fair value through I&E £000	Held at fair value through OCI £000	Total book value £000
Trade and other receivables excluding non financial assets	23,783	-	-	23,783
Other investments / financial assets	-	-	-	-
Cash and cash equivalents	23,541	-	-	23,541
Total at 31 March 2023	47,324	-	-	47,324

Note 30.8 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2024	Held at amortised cost £000	Held at fair value through I&E £000	Total book value £000
Loans from the Department of Health and Social Care	-	-	-
Obligations under leases	4,878	-	4,878
Obligations under PFI, LIFT and other service concession contracts	418,534	-	418,534
Other borrowings	-	-	-
Trade and other payables excluding non financial liabilities	43,026	-	43,026
Other financial liabilities	-	-	-
Provisions under contract	995	-	995
Total at 31 March 2024	467,433	-	467,433

Carrying values of financial liabilities as at 31 March 2023	Held at amortised cost	Held at fair value	Total book value
---------------------------------------------------------------------	-------------------------------	---------------------------	-------------------------

		through I&E	
	£000	£000	£000
Loans from the Department of Health and Social Care	-	-	-
Obligations under leases	4,023	-	4,023
Obligations under PFI, LIFT and other service concession contracts	219,777	-	219,777
Other borrowings	-	-	-
Trade and other payables excluding non financial liabilities	56,430	-	56,430
Other financial liabilities	-	-	-
Provisions under contract	1,064	-	1,064
Total at 31 March 2023	281,294	-	281,294

Note 30.9 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	31 March 2024 £000	31 March 2023 £000
In one year or less	71,784	72,294
In more than one year but not more than five years	114,022	59,628
In more than five years	382,384	206,123
Total	568,190	338,045

Note 31 Losses and special payments

	2023/24		2022/23	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Cash losses	2	8	30	25
Fruitless payments and constructive losses	-	-	-	-
Bad debts and claims abandoned	75	35	85	19
Stores losses and damage to property	1	1	3	2
Total losses	78	44	118	46
Special payments				
Compensation under court order or legally binding arbitration award	-	-	-	-
Extra-contractual payments	-	-	-	-
Ex-gratia payments	24	76	40	124
Special severance payments	1	16	1	14
Extra-statutory and extra-regulatory payments	-	-	-	-
Total special payments	25	92	41	138
Total losses and special payments	103	136	159	184
Compensation payments received				

Note 32 Related parties

The Trust undertakes a large number of related party transactions with other Government bodies. Related parties include but are not limited to

Department of Health and Social Care ministers
The Department of Health and Social Care
Board members of the Trust
Nottingham University Hospitals NHS Trust
University Hospitals of Leicester NHS Trust
Chesterfield Royal Hospital NHS Foundation Trust
Nottinghamshire Healthcare NHS Foundation Trust
Northampton General Hospital NHS Trust
University Hospitals of Derby and Burton NHS Foundation Trust
Leeds Teaching Hospitals NHS Foundation Trust
NHS Lincolnshire ICB
NHS Derby and Derbyshire ICB
NHS Nottingham and Nottinghamshire ICB
NHS England
Health Education England
NHS Resolution
NHS Property Services
NHS Providers
Department of Health and Social Care
HM Revenue & Customs
NHS Pension Scheme
NHS Blood and Transplant
Criminal Injuries Compensation Authority
Nottinghamshire County Council
NHS charitable funds (where not consolidated)

The Trust as Corporate Trustee also has a relationship with Sherwood Forest Hospitals General Charitable Fund. Charitable Income of £281k (2022/23 £227k) has been recognised in these accounts all of which relates to Sherwood Forest Hospitals General Charitable Fund. In addition a recharge of £53k (2022/23 £53k) has been made to Sherwood Forest Hospitals General Charitable Fund in relation to management / staff costs.

The accounts are not consolidated on the basis of materiality as approved by the Trustees subject to annual review and approval.

The Trust made no payments to related parties for whom the Chair, Non Executive or Executive Directors are named Directors.

Note 33 Prior period adjustments

No prior period adjustments have been recognised in this accounting period.

Note 34 Events after the reporting date

There are non events after the reporting date that impact on these financial statements and disclosures.

**INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF
SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST**

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of Sherwood Forest Hospitals NHS Foundation Trust ("the Trust") for the year ended 31 March 2024 which comprise the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2024 and of the Trust's income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by NHS England with the consent of the Secretary of State in February 2024 as being relevant to NHS Foundation Trusts and included in the Department of Health and Social Care Group Accounting Manual 2023/24; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006 (as amended).

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the Trust in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Going concern

The Accounting Officer has prepared the financial statements on the going concern basis as they have not been informed by the relevant national body of the intention to either cease the Trust's services or dissolve the Trust without the transfer of its services to another public sector entity. They have also concluded that there are no material uncertainties that could have cast significant doubt over their ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

In our evaluation of the Accounting Officer's conclusions, we considered the inherent risks associated with the continuity of services provided by the Trust over the going concern period.

Our conclusions based on this work:

- we consider that the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate; and
- we have not identified and concur with the Accounting Officer's assessment that there is not a material uncertainty related to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a going concern for the going concern period.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the above conclusions are not a guarantee that the Trust will continue in operation.

Fraud and breaches of laws and regulations – ability to detect

Identifying and responding to risks of material misstatement due to fraud

To identify risks of material misstatement due to fraud ("fraud risks") we assessed events or conditions that could indicate an incentive or pressure to commit fraud or provide an opportunity to commit fraud. Our risk assessment procedures included:

- Enquiring of management, the Audit and Assurance Committee and internal audit and inspection of policy documentation as to the Trust's high-level policies and procedures to prevent and detect fraud, including the internal audit function, and the Trust's channel for "whistleblowing", as well as whether they have knowledge of any actual, suspected or alleged fraud.
- Assessing the incentives for management to manipulate reported financial performance because of the need to achieve financial performance targets delegated to the Trust by NHS England
- Reading Board and Audit and Assurance Committee minutes.
- Using analytical procedures to identify any unusual or unexpected relationships.
- Reading the Trust's accounting policies.

We communicated identified fraud risks throughout the audit team and remained alert to any indications of fraud throughout the audit.

As required by auditing standards, we performed procedures to address the risk of management override of controls in particular the risk that Trust management may be in a position to make inappropriate accounting entries. On this audit we did not identify a fraud risk related to revenue recognition because of the non-complex recognition due to the nature of the revenue, which limits the opportunities to fraudulently misstate revenue.

In line with the guidance set out in Practice Note 10 Audit of Financial Statements of Public Sector Bodies in the United Kingdom we also recognised a fraud risk related to non-pay expenditure recognition, particularly in relation to year-end accruals.

We performed procedures including:

- Identifying journal entries to test based on risk criteria and comparing the identified entries to supporting documentation. These included unusual cash combinations, unusual year end postings to reduce accruals, and material post close journals.
- Assessing whether the judgements made in making accounting estimates are indicative of a potential bias.
- Inspecting cash payments and purchase invoices in the period prior to and following 31 March 2024 to verify expenditure had been recognised in the correct accounting period.

Identifying and responding to risks of material misstatement related to non-compliance with laws and regulations

We identified areas of laws and regulations that could reasonably be expected to have a material effect on the financial statements from our general sector experience and through discussion with the Accounting Officer (as required by auditing standards) and discussed with the Accounting Officer the policies and procedures regarding compliance with laws and regulations.

We communicated identified laws and regulations throughout our team and remained alert to any indications of non-compliance throughout the audit.

The potential effect of these laws and regulations on the financial statements varies considerably.

The Trust is subject to laws and regulations that directly affect the financial statements, including the financial reporting aspects of NHS legislation. We assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items.

Whilst the Trust is subject to many other laws and regulations, we did not identify any others where the consequences of non-compliance alone could have a material effect on amounts or disclosures in the financial statements.

Context of the ability of the audit to detect fraud or breaches of law or regulation

Owing to the inherent limitations of an audit, there is an unavoidable risk that we may not have detected some material misstatements in the financial statements, even though we have properly planned and performed our audit in accordance with auditing standards. For example, the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely the inherently limited procedures required by auditing standards would identify it.

In addition, as with any audit, there remained a higher risk of non-detection of fraud, as these may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal controls. Our audit procedures are designed to detect material misstatement. We are not responsible for preventing non-compliance or fraud and cannot be expected to detect non-compliance with all laws and regulations.

Other information in the Annual Report

The Accounting Officer is responsible for the other information, which comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work:

- we have not identified material misstatements in the other information; and
- in our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Annual Governance Statement

We are required by the Code of Audit Practice published by the National Audit Office in April 2020 on behalf of the Comptroller and Auditor General (the "Code of Audit Practice") to report to you if the Annual Governance Statement has not been prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2023/24. We have nothing to report in this respect.

Remuneration and Staff Reports

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared in all material respects, in accordance with the NHS Foundation Trust Annual Reporting Manual 2023/24.

Accounting Officer's responsibilities

As explained more fully in the statement set out on page 26, the Accounting Officer is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for: such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to either cease the services provided by the Trust or dissolve the Trust without the transfer of their services to another public sector entity.

Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are

considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities.

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

Report on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report if we identify any significant weaknesses in the arrangements that have been made by the Trust to secure economy, efficiency and effectiveness in its use of resources.

We have nothing to report in this respect.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

As explained more fully in the statement set out on page 102, the Accounting Officer is responsible for ensuring that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Under Section 62(1) and paragraph 1(d) of Schedule 10 of the National Health Service Act 2006 we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have planned our work and undertaken our review in accordance with the Code of Audit Practice and related statutory guidance having regard to whether the Trust had proper arrangements in place to ensure financial sustainability, proper governance and to use information about costs and performance to improve the way it manages and delivers its services. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice to report to you if any reports to the Regulator have been made under paragraph 6 of Schedule 10 of the National Health Service Act 2006. We have nothing to report in this respect.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To

the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust, as a body, for our audit work, for this report, or for the opinions we have formed.

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of Sherwood Forest Hospitals NHS Foundation Trust for the year ended 31 March 2024 in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice.

A handwritten signature in black ink, appearing to be 'Richard Walton', is written over a faint, light-colored rectangular stamp or watermark.

Richard Walton

for and on behalf of KPMG LLP

Chartered Accountants

Nottingham

26 June 2024