

# MEETING OF THE BOARD OF DIRECTORS IN PUBLIC

# AGENDA

**Date:** Thursday 2<sup>nd</sup> April 2026  
**Time:** 09:00 – 13:00  
**Venue:** Boardroom, King's Mill Hospital

	Time	Item	Status	Paper
1.	09:00	<b>Welcome</b>		
2.		<b>Declarations of Interest</b> To declare any pecuniary or non-pecuniary interests not already declared on the Trust's Register of Interest :- <a href="#">Register of Interest   Sherwood Forest Hospitals</a> <i>Check – Attendees to declare any potential conflict of items listed on the agenda to the Director of Corporate Affairs on receipt of agenda, prior to the meeting.</i>	Declaration	Verbal
3.		<b>Apologies for Absence</b> Quoracy check: (s3.22.1 SOs: no business shall be transacted at a meeting of the Board unless at least 2/3rds of the whole number of Directors are present including at least one ED and one NED)	Agree	Verbal
4.	09:00	<b>Patient Story – Finding support: How the Newark SFHT Macmillan Cancer and Information and Support Centre is helping us</b> Andrea Murphy, Macmillan Cancer Information Lead, and Michelle Richardson, Macmillan Lead Cancer Nurse	Assurance	Presentation
5.	09:20	<b>Minutes of the meeting held on 5<sup>th</sup> February 2026</b> To be agreed as an accurate record	Agree	Enclosure 5
6.	09:20	<b>Action Tracker</b>	Update	Enclosure 6
7.	09:25	<b>Chair's Report</b>  • <b>Council of Governors Highlight Report</b>	Assurance Assurance	Enclosure 7 Enclosure 7.1
8.	09:30	<b>Chief Executive's Report</b>	Assurance	Enclosure 8
<b>Strategy</b>				
9.	09:40	<b>Strategic Objective 1 – Provide outstanding care in the best place at the right time</b>  • <b>Perinatal Quality and Safety</b> Report of the Director of Midwifery  • <b>Perinatal Safety Champions Update</b> Report of the Director of Midwifery  • <b>Learning from Deaths</b> Report of the Chief Medical Officer  • <b>UEC Delivery Plan for 2026</b> Report of the Chief Operating Officer  • <b>Elective Care Delivery Plan and Elective Sprint Update</b> Report of the Chief Operating Officer	Assurance Assurance Assurance Assurance Assurance	Enclosure 9.1 Enclosure 9.2 Enclosure 9.3 Enclosure 9.4 Enclosure 9.5

	Time	Item	Status	Paper
10.	10:25	<b>Strategic Objective 2 – Empower and support our people to be the best they can be</b> <ul style="list-style-type: none"> <li>• <b>Staff Survey</b> Report of the Chief People Officer</li> <li>• <b>Guardian of Safe Working</b> Report of the Chief Medical Officer / Guardian of Safe Working</li> <li>• <b>Freedom to Speak Up (FTSU)</b> Report of the FTSU Guardian (presented by the Director of Corporate Affairs)</li> </ul>	Assurance	Enclosure 10.1
			Assurance	Enclosure 10.2
			Assurance	Enclosure 10.3
11.	11:00	<b>Strategic Objective 4 – Continuously learn and improve</b> <ul style="list-style-type: none"> <li>• <b>Research Annual Report</b> Report of the Chief Nurse (presented by the Head of Research and Innovation)</li> </ul>	Assurance	Enclosure 11.1
	11:15	BREAK (10 mins)		
<b>Operational</b>				
12.	11:25	<b>Integrated Performance Report (IPR)</b> Report of the Executive Team	Consider	Enclosure 12
<b>Governance</b>				
13.	12:10	<b>Failure to Prevent Fraud Checklist</b> Report of the Chief Executive	Approve	Enclosure 13
14.	12:15	<b>Well Led Action Plan Review</b> Report of the Director of Corporate Affairs	Assurance	Enclosure 14
15.	12:20	<b>Use of Trust Seal – Annual Summary Report</b> Report of the Director of Corporate Affairs	Assurance	Enclosure 15
16.	12:20	<b>NHSE Provider Licence Self-Certification declarations</b> Report of the Director of Corporate Affairs	Approve	Enclosure 16
17.	12:25	<b>Annual Sign Off of Declarations of Interest</b> Report of the Director of Corporate Affairs	Approve	Enclosure 17
18.	12:30	<b>Assurance from Sub Committees</b> <ul style="list-style-type: none"> <li>• Finance Committee Report of the Committee Chair (last meeting)</li> <li>• Quality Committee Report of the Committee Chair (last meeting)</li> <li>• Audit and Assurance Committee Report of the Committee Chair (last meeting)</li> <li>• People Committee Report of the Committee Chair (last meeting)</li> </ul>	Assurance	Enclosure 18.1
			Assurance	Enclosure 18.2
			Assurance	Enclosure 18.3
			Assurance	Enclosure 18.4

	Time	Item	Status	Paper
19.	12:45	<b>Provider Board capability self-assessment</b> Report of the Director of Corporate Affairs	Assurance	Verbal
20.	12:50	<b>Spotlight on – Pets as Therapy</b>	Assurance	Presentation
21.	12:55	<b>Communications to wider organisation</b> (Agree Board decisions requiring communication to Trust)	Agree	Verbal
22.	13:00	<b>Any Other Business</b>		
23.		<b>Date of next meeting</b> The next scheduled meeting of the Board of Directors to be held in public will be <b>4<sup>th</sup> June 2026, Boardroom, King’s Mill Hospital</b>		
24.		<b>Chair Declares the Meeting Closed</b>		
25.		<b>Questions from members of the public present</b> (Pertaining to items specific to the agenda)		
		<b>Resolution to move to the closed session of the meeting</b> In accordance with Section 1 (2) Public Bodies (Admissions to Meetings) Act 1960, members of the Board are invited to resolve: <i>“That representatives of the press and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.”</i>		

### Board of Directors Information Library Documents

The following information items are included in the Reading Room and should have been read by Members of the meeting.

Enc 9	<b>Perinatal Safe Staffing Report</b>
Enc 9	<b>Nursing Monthly Safe Staffing</b>
Enc 9	<b>Regional Maternity Heatmap</b>
Enc 10.1	<b>Staff Survey 2025 – Slides presented to People Committee</b>
Enc 18.1	<b>Finance Committee – previous minutes</b>
Enc 18.2	<b>Quality Committee – previous minutes</b>
Enc 18.3	<b>Audit and Assurance Committee – previous minutes</b>
Enc 18.4	<b>People Committee – previous minutes</b>
Enc 18.4	<b>People Strategy Priorities 2026-2027</b>

**UN-CONFIRMED MINUTES** of the Board of Directors meeting held in Public at 09:00 on  
Thursday 5<sup>th</sup> February 2026, in the Boardroom, King's Mill Hospital

<b>Present:</b>	Graham Ward	Chair	GW
	Steve Banks	Vice Chair	SB
	Andrew Rose-Britton	Non-Executive Director	ARB
	Neil McDonald	Non-Executive Director	NM
	Lisa Maclean	Non-Executive Director	LM
	Richard Cotton	Non-Executive Director	RC
	Manjeet Gill	Non-Executive Director	MG
	Jon Melbourne	Chief Executive	JM
	Richard Mills	Chief Financial Officer	RM
	Rob Simcox	Chief People Officer	RS
	Sally Brook Shanahan	Director of Corporate Affairs	SBS
	Simon Roe	Chief Medical Officer	SR
	Phil Bolton	Chief Nurse	PB
Simon Illingworth	Chief Operating Officer	SI	
<b>In Attendance:</b>	Deborah Kearsley	Deputy Chief People Officer	DK
	Gemma Gelsthorpe	Head of People Development	GG
	Paula Shore	Director of Midwifery	PS
	Rebecca Herring	Associate Director of Nursing Workforce	RH
	Olivia Bower	Producer for MS Teams Public Broadcast	
	Caroline Kirk	Communications Specialist	
	Sue Bradshaw	Minutes	
<b>Observers:</b>	Mark Bolton	Associate Director of Operational Performance	
	Chris Wilson	Operational Performance Manager	
	Rich Brown	Head of Communications	
	Cheryl Rollinson	360 Assurance	
	Philip Marsh	Patient Safety Partner	
	1 member of the public		
<b>Apologies:</b>	Barbara Brady	Non-Executive Director	BB
	Jonathan Van Tam	Associate Non-Executive Director	JVT

Item No.	Item	Action	Date
<b>26/001</b>	<b>WELCOME</b>		
1 min	<p>The meeting being quorate, GW declared the meeting open at 09:00 and confirmed that the meeting had been convened in accordance with the Trust's Constitution and Standing Orders.</p> <p>The meeting was held in person and was streamed live. This ensured the public were able to access the meeting. The agenda and reports were available on the Trust Website and the public were able to submit questions via the live Q&amp;A function.</p>		
<b>26/002</b>	<b>DECLARATIONS OF INTEREST</b>		
1 min	There were no declarations of interest pertaining to any items on the agenda.		
<b>26/003</b>	<b>APOLOGIES FOR ABSENCE</b>		
1 min	Apologies for absence were received from Barbara Brady, Non-Executive Director and Jonathan Van Tam, Associate Non-Executive Director.		
<b>26/004</b>	<b>STAFF STORY – LEADERSHIP DEVELOPMENT OFFERS</b>		
18 mins	<p>DK and GG joined the meeting.</p> <p>DK and GG introduced the Staff Story, which highlighted the leadership development opportunities offered by the Trust.</p> <p>ARB queried how staff are selected to participate in leadership training. GG advised there are five different levels to the Leadership Framework. New leaders are automatically booked onto the Leaders' Fundamentals course, which is to be completed within the first 3 months in role. Other courses, which people can choose to attend, are the New and Aspiring Leaders Programme and Established Leaders Programme. In addition, there is the Advanced Leaders Conference, which is targeted at colleagues in Band 8a and above, and bespoke offers for medics. It was noted there is a strong uptake for most courses, but there is work to do to encourage participation from established leaders.</p> <p>NM queried if change management is included in the programmes. DK advised the Trust is constantly evaluating what is and is not relevant to include in the courses and, therefore, change and transformation is key to the leadership programmes. GG advised representatives from the Improvement Faculty present to the Established Leaders Programme</p> <p>JM queried what members of the Board of Directors can do to support the leadership training programmes. GG requested support to encourage uptake, to help normalise development as essential to role and to strengthen the coaching network approach.</p> <p>MG queried if there are opportunities for leaders to gain exposure to non-NHS organisations to stimulate creative thinking.</p>		

	<p>GG advised this is an ambition but is not yet in place. There is ongoing work with Nottingham Trent University to accredit the course, noting this may lead to discussions within the Integrated Care System (ICS) in relation to cross-organisational cohorts. However, the focus remains on consolidating internal leadership development before expanding externally.</p> <p>GW felt it would be useful for a list of available courses / programmes to be included at the end of the video.</p> <p>DK and GG left the meeting.</p>		
<b>26/005</b>	<b>MINUTES OF THE PREVIOUS MEETING</b>		
1 min	Following a review of the minutes of the Board of Directors meeting in Public held on 4 <sup>th</sup> December 2025, the Board of Directors APPROVED the minutes as a true and accurate record.		
<b>26/006</b>	<b>MATTERS ARISING/ACTION LOG</b>		
5 mins	<p>The Board of Directors AGREED that action 25/243 was complete and could be removed from the action tracker.</p> <p><i>Action 25/133</i> – SR advised he would make contact with the national Making Data Count team to establish if they are able to support a workshop session for the Board of Directors prior to scheduling a date for this to be presented.</p> <p><i>Action 25/198</i> – SR advised substantial work is under way, including the establishment of a resident doctors’ experience group aligned to the ten-point plan. Updates will be provided through the People Committee.</p> <p><i>Action 25/200.1</i> – RS advised the impact of staff reductions on quality and performance would be kept under review by the People Committee. The Board of Directors AGREED this action should transfer to the People Committee.</p> <p><i>Action 25/200.2</i> – RS advised once the embargo on the Staff Survey results is lifted, this will provide a wider lens attributed to feedback and triangulation of information. There will be a ‘Workforce Spotlight’ at each meeting of the People Committee. The Board of Directors AGREED this action should transfer to the People Committee.</p>		
<b>26/007</b>	<b>CHAIR’S REPORT</b>		
4 mins	<p>GW presented the report, which provided an update regarding some of the most noteworthy events and items over the past two months from the Chair’s perspective, highlighting governor elections, Chair recruitment, contribution of the Trust’s volunteers, charity lottery and breast cancer support group.</p> <p>The Board of Directors were ASSURED by the report.</p>		

26/008	<b>CHIEF EXECUTIVE'S REPORT</b>		
4 mins	<p>JM presented the report, which provided an update regarding some of the most noteworthy events and items over the past two months from the Chief Executive's perspective, highlighting reflections on his first 100 days at the Trust and operational pressures.</p> <p>The Board of Directors were ASSURED by the report.</p>		
26/009	<b>STRATEGIC OBJECTIVE 1 – PROVIDE OUTSTANDING CARE IN THE BEST PLACE AT THE RIGHT TIME</b>		
13 mins	<p>PS joined the meeting.</p> <p><b>Perinatal Quality and Safety</b></p> <p>PB presented the report, advising this is the new integrated perinatal quality and safety report, which triangulates maternity and neonatal information into a single Board-level view, aligned to the NHS England (NHSE) Perinatal Oversight Model. PB highlighted the perinatal quality surveillance scorecard, Statistical Process Control (SPC) charts, launch of Maternity Outcomes Signal System (MOSS) and service diverts.</p> <p>PS advised the Trust had received a MOSS alert from the national team. However, the Trust was able to provide assurance the concerns had already been identified by the organisation.</p> <p>MG sought assurance that the learning from Perinatal Mortality Review Tool (PMRT) reviews was embedded. PS advised detailed assurance was taken through the Perinatal Assurance Committee, with wider learning considered via the Trust's Learning from Deaths Group.</p> <p>MG sought clarification in relation to the paragraph in the report which references health inequalities. PS advised a new national dashboard has gone live, allowing drill-down to organisational level and showing comparative benchmarks. This highlights what is already known, for example, the Trust's area of deprivation profile and pre-term birth rates. The factors contributing to pre-term births are known, particularly related to smoking cessation. The dashboard data can be integrated into future reports to strengthen insight.</p> <p><b>Action</b></p> <ul style="list-style-type: none"> <li>• <b>Maternity and Neonatal Equalities Dashboard data to be incorporated into future Perinatal Quality and Safety reports.</b></li> </ul> <p>MG felt it would be helpful to have a deep dive at Quality Committee in relation to how safety and patient experience correlates with deprivation. PS confirmed demographic factors, such as postcode analysis, were reviewed for all moderate and above incidents and advised no particular themes had emerged. PB advised a report can be presented to Quality Committee for wider discussion and assurance.</p>	PB	02/04/26

	<p><b>Action</b></p> <ul style="list-style-type: none"> <li>• <b>Deep dive, looking at how safety and patient experience correlates with deprivation to be presented to the Quality Committee.</b></li> </ul> <p>MG felt it may be useful for the Quality Committee to look at how early-years and prevention work aligns with local authority and ICS activity. PS advised she is a member of the Best Start Partnership Board for Nottinghamshire and early-years work, including the ABC Programme, is a significant system focus.</p> <p>The Board of Directors were ASSURED by the report.</p> <p><b>Perinatal Safety Champions Update</b></p> <p>PB presented the report, highlighting staff and patient voice, change to the transitional care model and maternity triage.</p> <p>The Board of Directors were ASSURED by the report.</p>	<p>PB</p>	<p>02/04/26</p>
<p>26/010</p>	<p><b>STRATEGIC OBJECTIVE 2 – EMPOWER AND SUPPORT OUR PEOPLE TO BE THE BEST THEY CAN BE</b></p>		
<p>21 mins</p>	<p>RH joined the meeting.</p> <p><b>Nursing, Midwifery and Allied Health Professions (AHP) Staffing bi-annual report, including annual establishments review</b></p> <p>PB introduced the report and reminded members of the Board of Directors the assessment describes minimum safe establishments rather than optimum levels. Sustained compliance with safe staffing standards had enabled agile responses to activity and supported reductions in bank and agency usage, although further improvement is still required.</p> <p>RH presented the report, advising it sets out the evidence base and methodology, citing National Institute for Health and Care Excellence (NICE) endorsed approaches which are led nationally by the Shefford Group and NHSE, and confirmed that, on this basis, the Trust could declare compliance with the Developing Workforce Safeguards for the next 12 months.</p> <p>SB queried how the establishment changes would be received within the divisions, noting maternity has an increase to staffing numbers but there are efficiencies within the paediatric team. PS advised the services the Trust runs have been reviewed, particularly transitional care, including the required resources. The same approach has been taken within maternity, noting the requirements arising from Ockenden and Birthrate Plus were addressed while still seeking efficiency through redesigned roles. PB added ward teams have been involved throughout the six-month establishment process, which helps their understanding of why and how decisions are made.</p> <p>GW queried what was driving the increase in acuity, given the birth rate remains static.</p>		

PS advised seasonal variation influences peaks in demand and that the division is exploring seasonal staffing plans, including scheduling elective caesarean activity in coordination with surgical colleagues. There has been a slight growth in patients from out-of-area and the Trust is working with system partners to identify if a different approach can be taken. There is a need for the Trust to focus on internal issues and ensure everything is being done effectively. The relocation of triage has freed up capacity, but high acuity levels are the principal pressure.

PB added a high caesarean section rate contributes to longer stays and greater dependency. In addition, wider medical complexity among pregnant women is increasing. SR advised this is linked to broader determinants such as smoking and diabetes. There is a need to consider the wider health inequalities issues and what can be done to manage this.

LM queried if the Trust was working with mothers to be about the downside of having a caesarean section. PS advised nationally there are complex reasons for the growth in caesarean sections. Women do have an informed choice and have a discussion with the consultant and a professional midwifery advocate. There is currently a 50/50 split between elective and emergency caesareans. A midwife supports the elective care pathway.

JM advised there had been good discussion at the Trust Management Team (TMT) meeting in relation to the establishment figures and sought assurance the rationale, methodology and outcomes outlined in the report would be supported regionally and nationally. PB reminded members of the Board of Directors the staffing levels outlined in the report are minimum staffing levels. He advised there has been a focus, regionally and nationally, to not lose sight of the fundamental need for safe staffing across all disciplines as this reduces length of stay and safety and quality issues. The Trust has a good evidence base of a low number of harms.

GW noted establishment numbers have increased year on year, at a time when the Trust is under pressure to return to 2019/2020 staffing levels. GW queried how the Board of Directors can be assured the additional posts are required, rather than consideration being given to deliver services in a different way to manage with existing or reduced staffing levels.

PB advised the inpatient case mix is increasingly complex and patients who are admitted are those requiring higher levels of care, as more straightforward cases are managed through alternative pathways which do not require hospitalisation. A year-on-year increase is likely if the general health and wellbeing of the population is not improved, but this will take time. LM noted action to reduce the level of acuity, does not sit with the acute trust, but is 'upstream'. PB advised if ED demand and complexity can be reduced, staffing levels for ED can be reduced.

SR advised the prevention agenda takes a long period of time to have an impact on the situation within the Trust. There is a robust methodology for determining required staffing levels.

	<p>RM reminded members of the Board of Directors the report outlines the ward-based establishment, advising the whole time equivalent (WTE) figure for the whole nursing workforce was lower in December 2025 than December 2024. Although staffing had risen in earlier years, owing to COVID-related demand, this has now stabilised. The Trust has achieved real efficiencies through reduced sickness, turnover and one-to-one care requirements and planned improvements in these areas will help to offset pressure on budgets.</p> <p>MG noted safer staffing in one area could lead to perceived harm in another and queried how the Board of Directors would receive assurance of the right balance across services. PB advised the organisation had an immediate duty of care to current in-patients and staffing must reflect this reality. PB acknowledged wider prevention work and upstream demand reduction was needed over time to mitigate acuity, but this would not reduce the immediate requirement to staff safely for existing patients.</p> <p>The Board of Directors were ASSURED by the report and APPROVED the NET increase of 10.66 WTE in the establishment, at a cost of £516,144.24.</p> <p>RH and PS left the meeting.</p>		
<p>26/011</p>	<p><b>INTEGRATED PERFORMANCE REPORT (IPR)</b></p>		
<p>47 mins</p>	<p><b>QUALITY CARE</b></p> <p>PB highlighted Clostridioides difficile (C. diff), still birth rate and strong performance across many key metrics, including hospital acquired pressure ulcers, never events and patient safety incidents.</p> <p>SR highlighted the percentage of inpatient service users undergoing risk assessment for Venous Thromboembolism (VTE).</p> <p>SB noted the NHS Oversight Framework position on C. diff placed the Trust at 115 out of 134 and queried if there was scope for any different actions and if the Trust was disadvantaged in any way with estate limitations. SR advised the Trust's inpatient estate is very good. When a deep dive was conducted, a multi-factorial picture emerged. Environmental issues were identified as part of an external review and action has been taken to address these. From a prescribing perspective, high use of broad-spectrum antibiotics increases risk. There is a balance between appropriately managing sepsis and overuse of antibiotics. It was noted it is a complex picture.</p> <p>PB added system-wide work with partners is underway to share learning across pathways.</p> <p><b>PEOPLE AND CULTURE</b></p> <p>RS highlighted appraisal compliance, sickness absence, employee relations management, agency usage, job planning compliance and flu vaccination rate.</p>		

JM queried how the Board of Directors will respond to the National Staff Survey results once the embargo is lifted. RS advised it is unclear when the embargo will be lifted. However, plans are underway to describe the actions the Trust will take. A report will be presented to the Board of Directors in April 2026.

RC noted 88.3% appraisal compliance sounds positive. However, 12% of colleagues are not receiving an annual appraisal, which risks missing ambitions and developmental guidance. RS advised the intention is to prioritise meaningful appraisals, noting feedback from previous Staff Surveys in relation to tokenism which had driven the shift to quality over volume. Key appraisals are prioritised.

NM referenced the introduction of national guidelines in relation to absence management and queried if this differed significantly from existing practice. RS advised the NHS Sickness Absence Toolkit is not fundamentally different to previous guidance, but it reinforces consistency in keeping-in-touch arrangements and wellbeing conversations when individuals are away from work. The guidance also addresses appropriate use of policy and reducing variation in management discretion.

NM felt wide discretion creates inconsistency and organisational risk if parts of the Trust applied the policy differently. RS acknowledged there is a balance between empowering leaders and ensuring consistent policy application.

**TIMELY CARE**

In terms of the emergency pathway, SI highlighted the critical incident in January 2026, ED 4-hour and 12-hour waits and ambulance demand.

In terms of the cancer pathway, SI highlighted the 28-day faster diagnosis standard (FDS) and 62-day treatment performance.

In terms of elective care, SI highlighted diagnostics performance and advised the Trust had zero 65-week waits at the end of January 2026.

JM queried where support was required from partners to help ease pressure on the Trust. SI advised the Trust needed greater support with discharge processes, particularly in access to packages of care, advising delays affected both acute and community beds, with some patients waiting for access to the Trust's own community units. In terms of Urgent and Emergency Care (UEC), SI advised the Type 3 service, provided by PC24, requires improvement, but the Trust and provider are reviewing the model of care provided.

JM queried why, at a time of increased demand in ED, there is less demand on the Type 3 service. SI advised the Type 3 service at Newark Hospital had seen an 11% demand growth, but the nurse-led PC24 service at King's Mill Hospital is seeing less demand and worse performance, suggesting issues with the model rather than volume.

MG queried if deprivation patterns were contributing to ambulance demand and if any postcode analysis had been undertaken.

<p>SI advised ambulance conveyances mainly come from the local area, but there is a link to public health factors and access issues in primary and community care. The planned expansion to Majors will help. The Trust is encouraging the use of urgent-care-before-conveyance services where appropriate.</p> <p>MG queried if any analysis had been undertaken in relation to discharge delays related to social care packages versus home adaptations. SI advised 80% of patients were discharged through Pathway 0, but within that there are patients who require small-scale adaptations which can cause delays. SI acknowledged there is an under provision of care packages across Nottinghamshire. Most patients go home with a package of care and there are opportunities to look at why that is happening and what pressure this causes in the community to provide the required support. The discharge group set up with the Integrated Care Board (ICB) will help to look at issues.</p> <p>SR advised there is more work to do in terms of frailty, work with system partners and in relation to decisions around conveyance, particularly for patients in care homes.</p> <p>NM queried who determines the PC24 model of care. SI advised the model was commissioned by the ICB. Discussions between the Trust and the ICB have intensified in recent months and plans for change are being shaped jointly.</p> <p>RC felt it would be useful to reflect on lessons learned from the recent critical incident. JM acknowledged the point raised and advised a report would be prepared for the Finance Committee.</p> <p><b>Action</b></p> <ul style="list-style-type: none"> <li>• <b>Report on reflections and lessons learned from the recent critical incident to be reported to the Finance Committee.</b></li> </ul> <p><b>BEST VALUE CARE</b></p> <p>RM outlined the Trust's financial position at the end of Month 9, highlighting the deficit position, efficiency plan, cash position, progress in relation to workforce savings, non-pay efficiencies and productivity.</p> <p>MG felt successes need to be communicated to the organisation, especially to staff who might not feel the impact of improvements amidst financial constraint. JM advised the Leaders' Forum has been relaunched and the Team Brief, for all colleagues, is being relaunched as a face-to-face meeting on 6<sup>th</sup> February 2026. JM encouraged colleagues to use these channels to communicate progress on productivity, finance and transformation, etc.</p> <p>The Board of Directors CONSIDERED the report.</p>	<p>SI</p>	<p>02/04/26</p>
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26/012	<b>BOARD ASSURANCE FRAMEWORK (BAF)</b>		
4 mins	<p>JM presented the report advising all the principal risks (PR) have been discussed by the relevant sub committees. In addition, the BAF in its entirety is subject to quarterly review by the Risk Committee. The changes, and amendments which have been made, are highlighted in the report.</p> <p>It was noted five risks, namely PR1 (Significant deterioration in standards of safety and care), PR2 (Demand that overwhelms capacity), PR3 (Critical shortage of workforce capacity and capability), PR4 (Failure to achieve the Trust's financial strategy) and PR7 (Major disruptive incident) remain as significant risks. All risks, with the exception of PR5 (Inability to initiate and implement evidence-based Improvement and innovation), are above their tolerable risk ratings.</p> <p>RC advised the Finance Committee had intended to revisit PR8 (Failure to deliver sustainable reductions in the Trust's impact on climate change) following approval of the new Green Plan. However, due to the pressures of planning activity, this has not yet been possible. However, the Committee will return to this at a future meeting.</p> <p>SB reflected on the target tolerable levels shown across risks, observing that tolerances for quality and people appeared much higher than for other domains and queried if these should be reviewed. JM proposed these should be reviewed at a future Board of Directors workshop.</p> <p><b>Action</b></p> <ul style="list-style-type: none"> <li>• <b>Target and tolerable levels of risk to be reviewed at a future Board of Directors workshop.</b></li> </ul> <p>The Board of Directors REVIEWED and APPROVED the Board Assurance Framework.</p>	JM	TBC
26/013	<b>WELL LED ACTION PLAN REVIEW</b>		
5 mins	<p>SBS presented the report, highlighting the latest position against the Well Led Action Plan, reporting 9 of the 33 actions were complete and significant progress has been made in preparing the remaining updates. Once all the actions are complete, it is important to ensure the document remains live to ensure actions are embedded. Consideration will be given to commissioning a further external review in 2027/2028 to validate progress.</p> <p>GW noted the reference to Non-Executive Directors (NEDs) being provided with monthly updates on performance, advising these had not been received recently. GW requested this feedback mechanism be re-established.</p> <p><b>Action</b></p> <ul style="list-style-type: none"> <li>• <b>Monthly updates to NEDs regarding performance to be re-established.</b></li> </ul>	SI	02/04/26

	<p>JM advised there may be a need to ‘step back’ and test whether all actions remained the right ones.</p> <p>The Board of Directors were ASSURED by the report.</p>		
<b>26/014</b>	<b>ASSURANCE FROM SUB COMMITTEES</b>		
27 mins	<p><b>Finance Committee</b></p> <p>RC presented the report, highlighting Month 9 financial position, cash management, ledger implementation, financial planning, forecast outturn, strong performance of the Medicine Division, corporate expenditure and review of the Committee’s terms of reference.</p> <p>The Board of Directors were ASSURED by the report.</p> <p><b>Quality Committee</b></p> <p>LM presented the report, highlighting 12-hour waits in ED and the link of overcrowding in ED to Patient Safety Incident Investigations, reliance on 55 additional medical beds opened in response to the recent critical incident, increase in ‘no criteria to reside’ bed days, increase in the number of patients with mental health issues in ED, c. diff, review of Patient Safety across the Health and Care Landscape in England (Penny Dash Report), Safeguarding Annual Report, Nursing, Midwifery and AHP Strategy update and Patient Safety Committee highlight report.</p> <p>PB advised the Penny Dash Report would be useful as a topic for a future Board of Directors workshop.</p> <p><b>Action</b></p> <ul style="list-style-type: none"> <li>• <b>Penny Dash Report (Patient Safety across the Health and Care Landscape in England) to be a topic for a future Board of Directors workshop.</b></li> </ul> <p>SB noted the Trust opens additional beds during periods of high pressure and queried if system partners were demonstrating the same flexibility in mental health services. SR advised there are ongoing conversations and clear escalation processes in place with system partners, who support discussions regarding patients with mental health issues experiencing prolonged waits in the Emergency Department. It was noted the Board of Directors had previously discussed whether the current model was right and conversations in relation to this are continuing. SR referred to examples in other parts of the country where mental health first-aid units have been implemented and suggested this might be explored locally in discussion with partners.</p> <p>The Board of Directors were ASSURED by the report.</p>	PB	TBC

	<p><b>Audit and Assurance Committee</b></p> <p>MG presented the report, highlighting internal audit progress, counter fraud, external audit, Data Security and Protection Toolkit, ICB planning and commissioning intentions, efficiency benchmarking, learning from deaths and procurement processes.</p> <p>SB noted the reference in the report to medicine wastage within pharmacy, arguing that in-pharmacy wastage was likely to be only a small part of a far larger problem of medicines wastage on wards, etc. SB queried what action is being taken to fully understand this issue. MG advised consideration is being given to this being included in the internal audit plan for 2026/2027.</p> <p>The Board of Directors were ASSURED by the report.</p> <p><b>People Committee</b></p> <p>SB presented the report, highlighting sickness absence and Freedom to Speak Up (FTSU).</p> <p>RS advised there has been a reduction in the number of cases raised through FTSU in the last quarter, noting there has been an increase in the number of employee relation cases in the same period. RS advised work is required to understand if there is any correlation.</p> <p>The Board of Directors were ASSURED by the report.</p> <p><b>Partnerships and Communities Committee</b></p> <p>RC presented the report, highlighting progress on delivery of the Trust's Partnership Delivery Plan and the development of the Trust's Health Inequalities action plan.</p> <p>The Board of Directors were ASSURED by the report.</p> <p><b>Charitable Funds Committee</b></p> <p>ARB presented the report, highlighting review of the charity and the required capacity and resources to take it forward, recommendation to the Trustees that the charity's accounts are not consolidated into the Trust's accounts, agreement to hold a further abseil event in 2026 and a colleague's participation in the London Marathon in 2026 to raise funds for the charity.</p> <p>The Board of Directors were ASSURED by the report.</p>		
<p><b>26/015</b></p>	<p><b>NHS OVERSIGHT FRAMEWORK (NOF) SUMMARY – QUARTER 2</b></p>		
<p>3 mins</p>	<p>JM presented the report, advising the Oversight Framework report is issued quarterly. JM summarised the Trust's position for Quarter 2, with the headline assessment showing a rating of 56 of 134 acute providers, which is a deterioration from 48<sup>th</sup> in Quarter 1. The Trust remains in Segment 3, partly because of the national financial override applied to organisations in deficit.</p>		

	<p>The framework will continue to be presented to the Board of Directors on a quarterly basis, with further scrutiny by the sub-committees.</p> <p>The Board of Directors were ASSURED by the report.</p>		
<b>26/016</b>	<b>SPOTLIGHT ON – MATERNITY TRIAGE SERVICE</b>		
9 mins	A short video was played highlighting the Maternity Triage Service at the Trust.		
<b>26/017</b>	<b>COMMUNICATIONS TO WIDER ORGANISATION</b>		
1 min	<p>The Board of Directors AGREED the following items would be disseminated to the wider organisation:</p> <ul style="list-style-type: none"> <li>• Celebrate things which are going well.</li> <li>• Re-launch of Team Brief.</li> <li>• Carefully explain why investment has been made and that the organisation remains committed to supporting safe staffing on wards.</li> <li>• Staff Survey response plan.</li> </ul>		
<b>26/018</b>	<b>ANY OTHER BUSINESS</b>		
1 min	No other business was raised.		
<b>26/019</b>	<b>DATE AND TIME OF NEXT MEETING</b>		
	<p>It was CONFIRMED the next Board of Directors meeting in Public would be held on 2<sup>nd</sup> April 2026 in the Boardroom at King's Mill Hospital.</p> <p>There being no further business the Chair declared the meeting closed at 12:00.</p>		
	<p>Signed by the Chair as a true record of the meeting, subject to any amendments duly minuted.</p> <p>Graham Ward</p> <p><b>Chair</b> <span style="float: right;"><b>Date</b></span></p>		



Note: These minutes were prepared with the assistance of Copilot.

26/020	<b>QUESTIONS FROM MEMBERS OF THE PUBLIC PRESENT</b>		
1 min	<p>GW reminded people observing the meeting that the meeting is a Board of Directors meeting held in Public and is not a public meeting. Therefore, any questions must relate to the discussions which have taken place during the meeting.</p> <p>No questions were raised from members of the public.</p>		
26/021	<b>BOARD OF DIRECTOR'S RESOLUTION</b>		
1 min	<p><b>EXCLUSION OF MEMBERS OF THE PUBLIC - Resolution to move to a closed session of the meeting.</b></p> <p>In accordance with Section 1 (2) Public Bodies (Admissions to Meetings) Act 1960, members of the Board are invited to resolve:</p> <p>“That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.”</p> <p>Directors AGREED the Board of Director's Resolution.</p>		



*Note: These minutes were prepared with the assistance of Copilot.*

**PUBLIC BOARD ACTION TRACKER**

Key	
Red	Action Overdue
Amber	Update Required
Green	Action Complete
Grey	Action Not Yet Due

Item No	Date	Action	Committee	Sub Committee	Deadline	Exec Lead	Action Lead	Progress	Rag Rating
25/133	05/06/2025	Consideration of a 'making data count' approach to the IPR to be a topic for a future Board of Directors workshop	Public Board of Directors	None	TBC	S Roe	N Turner	<p><b>Update 02/10/2025</b> On list for a future Board Workshop. Date not yet allocated.</p> <p><b>Update 26/03/2026</b> National Making data count team has been disbanded. Matt Oakes, Nikki Turner and Mark Bolton have agreed to facilitate future board workshop. Nikki Turner added as action lead.</p>	Grey
25/198	02/10/2025	Trust's response to the 10-point plan to improve the working lives of resident doctors to be included in the next Guardian of Safe Working report to Board	Public Board of Directors	None	02/04/2026	S Roe		<p><b>Update 05/02/2026</b> Substantial work is under way, including the establishment of a resident doctors' experience group aligned to the ten-point plan. Updates will be provided through the People Committee.</p> <p><b>Update 26/03/2026</b> Resident doctor experience group established (chaired by James Thomas). Steve Banks nominated NED for medical workforce. Update on 10 point plan provided to People Committee March 2026.</p> <p><b>Complete</b></p>	Green
25/200.1	02/10/2025	People Committee to consider how early triggers of the impact of staff reductions on quality and performance can be identified.	Public Board of Directors	People Committee	05/02/2026	R Simcox		<p><b>Update 14/10/2025</b> To be discussed at January meeting of the People Committee.</p> <p><b>Update 30/12/2025</b> Item added to agenda for People Committee meeting on 3rd February 2026.</p> <p><b>Update 05/02/2026</b> The impact of staff reductions on quality and performance would be kept under review by the People Committee.</p> <p><b>Action to be transferred to People Committee. Complete for Board</b></p>	Green

25/200.2	02/10/2025	Consider how a report can be developed triangulating information from FTSU, exit interviews, Staff Survey, etc.	Public Board of Directors	People Committee	05/02/2026	R Simcox		<p><b>Update 14/10/2025</b> To be discussed at January meeting of the People Committee.</p> <p><b>Update 30/12/2025</b> Item added to agenda for People Committee meeting on 3rd February 2026.</p> <p><b>Update 05/02/2026</b> Once the embargo on the Staff Survey results is lifted, this will provide a wider lens attributed to feedback and triangulation of information. There will be a 'Workforce Spotlight' at each meeting of the People Committee. <b>Action to be transferred to People Committee. Complete for Board.</b></p>	Green
26/009.1	05/02/2026	Maternity and Neonatal Equalities Dashboard data to be incorporated into future Perinatal Quality and Safety reports	Public Board of Directors	None	02/04/2026 04/06/2026	P Bolton	P Shore	<p><b>Update 25/03/2026</b> Plans are in place to include the equality dashboard and should be seen in Board papers from June 2026 onwards</p>	Grey
26/009.2	05/02/2026	Deep dive, looking at how safety and patient experience correlates with deprivation to be presented to Quality Committee	Public Board of Directors	Quality Committee	02/04/2026	P Bolton	P Shore	<p><b>Update 20/03/2026</b> Item on agenda for Quality Committee meeting on 23/03/2026</p> <p><b>Update 25/03/2026</b> This paper was shared at the Quality Committee meeting on 23rd March 2026</p> <p><b>Complete</b></p>	Green
26/011	05/02/2026	Report on reflections and lessons learned from the recent critical incident to be reported to the Finance Committee	Public Board of Directors	Finance Committee	02/04/2026	S Illingworth		<p><b>Update 19/03/2026</b> Paper prepared for consideration at Finance Committee in March 2026.</p> <p><b>Complete</b></p>	Green
26/012	05/02/2026	Target and tolerable levels of risk to be reviewed at a future Board of Directors workshop	Public Board of Directors	None	01/10/2026	J Melbourne		<p><b>Update 20/02/2026</b> Added to Board workshop schedule for September 2026</p>	Grey
26/013	05/02/2026	Monthly updates to NEDs regarding performance to be re-established	Public Board of Directors	None	02/04/2026	S Illingworth		<p><b>Update 19/03/2026</b> It is proposed that we share the updated Integrated Performance Report (IPR) scorecard in the months between existing bi-monthly full IPR reports. This will provide NEDs with a monthly update of performance across all domains. The scorecard is already shared and reviewed by the Trust Management Team and can be immediately shared with NEDs. First report will be issued at the end of April 2026.</p> <p><b>Complete</b></p>	Green
26/014	05/02/2026	Penny Dash Report (Patient Safety across the Health and Care Landscape in England) to be a topic for a future Board of Directors workshop	Public Board of Directors	None	01/10/2026	P Bolton		<p><b>Update 20/02/2026</b> Added to Board workshop schedule for September 2026</p>	Grey

**Board of Directors Meeting in Public - Cover Sheet**

<b>Subject:</b>	Chair's report		<b>Date:</b>	2 <sup>nd</sup> April 2026	
<b>Prepared By:</b>	Rich Brown, Head of Communications and Graham Ward, Trust Chair				
<b>Approved By:</b>	Graham Ward, Trust Chair				
<b>Presented By:</b>	Graham Ward, Trust Chair				
<b>Purpose</b>					
An update regarding some of the most noteworthy events and items the past two months from the Chair's perspective.				<b>Approval</b>	
				<b>Assurance</b>	
				<b>Update</b>	Y
				<b>Consider</b>	
<b>Strategic Objectives</b>					
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 estates	Work collaboratively with partners in the community
Y	Y	Y	Y	Y	Y
<b>Principal Risk</b>					
<b>PR1</b>	Significant deterioration in standards of safety and care				
<b>PR2</b>	Demand that overwhelms capacity				
<b>PR3</b>	Critical shortage of workforce capacity and capability				
<b>PR4</b>	Insufficient financial resources available to support the delivery of services				
<b>PR5</b>	Inability to initiate and implement evidence-based Improvement and innovation				
<b>PR6</b>	Working more closely with local health and care partners does not fully deliver the required benefits				
<b>PR7</b>	Major disruptive incident				
<b>PR8</b>	Failure to deliver sustainable reductions in the Trust's impact on climate change				
<b>Committees/groups where this item has been presented before</b>					
None					
<b>Acronyms</b>					
CDC = Community Diagnostic Centre DL = Deputy Lieutenant ED = Emergency Department GP = General Practitioner HM = His Majesty's Courts and Tribunals Service			ICB = Integrated Care Board MDCU = Medical Day Case Unit NHS = National Health Service OBE = Officer of the Order of the British Empire PPG = Patient Participation Group		
<b>Executive Summary</b>					
An update regarding some of the most noteworthy events and items the past two months from the Chair's perspective.					

## Personal message ahead of my final Public Meeting of the Trust's Board of Directors

April's meeting will be my last Public Meeting of the Trust's Board of Directors, as I prepare to step-down as Trust Chair at the end of May 2026 at the end of my maximum term with the Trust.

It has been a real privilege to have been part of Sherwood's journey over the past 11 years – first as a Non-Executive Director from when I joined in 2015 and, later, as its Chair.

It has been the honour of my career to witness first-hand the work of Trust colleagues in providing the best possible care to the local communities we serve and I am grateful to everyone for their support and dedication throughout my time with the Trust.

## Updates from the Trust's Council of Governors

### Update on Trust Chair recruitment

Efforts have been continuing to appoint my successor to become the new Chair for the Trust, with recruitment to this role having been a governor-led process. We look forward to updating you on the outcome of that process as soon as possible.

### Welcome to our new appointed volunteer governor

We have been delighted to welcome a new appointed volunteer governor to the Trust's Council of Governors over recent months.

Julie Scarle began volunteering at King's Mill Hospital in 2022 and knows first-hand the positive contribution our volunteers make to the wellbeing and experience of our patients. She is passionate about making sure that the voices of the Trust's dedicated and caring volunteer community are heard.

Julie is registered blind and has been thrilled by the positive response she has received as a disabled volunteer from ward staff and patients at the Welcome Treatment Centre where she volunteers, and from Voluntary Services who have focused on her abilities not her sight loss to facilitate her rewarding role.



**New Trust governor, Julie Scarle**

She is mindful of the tremendous difference volunteers make across our community as she also volunteers for HM Courts and Tribunals Service, and the Patient Partnership Group (PPG) of her GP practice. Prior to taking early retirement, Julie gained valuable professional experience as a Marketing and Engagement Manager for a leading local sight loss charity and spent more than a decade working in communications at Nottingham University Hospitals NHS Trust.

We have been delighted to welcome Julie to the Trust, after she took over from our former appointed volunteer governor, Kevin Stewart, who has recently completed his maximum term as a Trust governor. We thank them both for the difference they have made as governors and Trust volunteers.

## Preparing for this year's Council of Governor elections

Preparations have been continuing to hold this year's Trust Council of Governor elections, which are due to take place before July 2026. The election will consider eight positions on the Trust's Council of Governors, as a number of serving governors reach the end of their three-year term.

The process is officially due to begin later in April and we look forward to being able to update you with more detail on that process as soon as those details are confirmed over the coming months.

## Recognising the difference made by our Trust Charity and Trust volunteers

February and March were busy months for our Trust's Community Involvement team, both in how they encouraged financial donations to be made via our Trust Charity and through the thousands of hours that continue to be committed to support the Trust by our volunteers across our hospitals.

In February and March alone, 370 Trust volunteers generously gave over 8,900 hours of their time to help make great patient care happen across the 28 services they have supported during the month.

During the past two months, we have been proud to honour a number of our volunteers with long service awards, in recognition of their commitment to Sherwood Forest Hospitals. Pictured below are Barbara, Frankie and Jackie receiving their certificates; we thank them all for their incredible commitment to making great patient care happen across our hospitals.



Other key achievements relating to our Trust Charity and Trust volunteers are detailed below:

### Second Sherwood Forest Hospitals Charity abseil announced

Following the first King's Mill Hospital abseil which took place in November last year and helped to raise over £36,000 for the Trust charity, we have been pleased to announce that we will be holding another abseil on Friday 12<sup>th</sup> June 2026. Details of how to get involved in the next abseil can be found on our Trust website.

## New ultrasound machine for Medical Day Case Unit (MDCU) at Newark Hospital

Patients attending the Medical Day Case Unit (MDCU) at Newark Hospital will benefit from a brand-new ultrasound machine to support staff in accessing difficult veins. The machine was funded by a generous donation from The Magnus Foundation, who share an annual donation with the Sherwood Forest Hospitals Charity.

This equipment will make a difference for Newark patients who require intravenous treatments such as medication and blood transfusions. Previously, patients with complex venous access needs were required to travel to King's Mill Hospital. The new ultrasound machine will ensure more patients can now receive their care closer to home.



## Swing and Sing Concert raises over £1,100 for Trust Charity

The Swing and Sing concert took place recently at Cornerstone Theatre in Sutton-in-Ashfield and it was a truly wonderful evening for the Trust.

Kevin Stewart, who until very recently was our appointed governor for volunteers, was instrumental in organising this event which has helped to raise over £1,100 for the Sherwood Forest Hospitals Charity. The funds will go toward much needed service developments across our three sites.

Thank you to Kevin for all his hard work – and also for performing on the night as part of his role in the Ravenshead Swing Band.

## Trust Charity funds purchases of new biopsy chairs

Patients attending the Urology department for a biopsy can now expect a more comfortable experience when undergoing their procedure, thanks to a generous donation to the Sherwood Forest Hospitals Charity.

The purchase of a new purpose-built, reclining, electronically-adjustable biopsy chair means that patients will benefit from increased comfort and a shorter procedure time during their appointment, where they are often required to remain in still in the same position for a long time.



The funds for the chair were made possible thanks to a portion of funding from regular fundraisers Angela McCreadie and Wendy Broughton. The pair have been fundraising for breast and urology services at the Trust since 2010 with their yearly 'Breast and Balls' event.

A huge thank you to Angela and Wendy, whose regular donations means the Sherwood Forest Hospitals Charity can continue to fund projects such as this, which are not typically funded by the NHS.

## Other notable developments

Other notable developments from our brilliant Community Involvement team and our team of volunteers during the past two months include:

- Five teams pitched passionate improvement ideas at Newark Hospital's recent *Dragons' Den* event, where funding was awarded to projects including "Tiny Tablets" activity tables for Sconce and Castle Wards, new audiology suction equipment, an Orthoptics photo screener and specialist therapy gym kit. A similar *Dragons' Den* event is now planned for Mansfield Community Hospital.
- A campaign has begun to recruit dedicated volunteers for our Emergency Department and our new Community Diagnostic Centre (CDC) at Mansfield Community Hospital to support colleagues to provide great patient care there.

We remain so grateful to everyone who has given their time, money and support in other ways to support the Trust and our hard-working colleagues over the past month.

## Other notable engagements

- I held my latest regular catch-ups with the Trust's Lead Governor, Liz Barrett OBE DL.
- I undertook '15 Steps' visits to the Stroke Unit and Maternity.
- I joined our monthly catch-up meeting with the Regional Director of NHS England (Midlands), Dale Bywater, and attended the NHSE Midlands Leadership Meeting in Leicester.
- I had my latest monthly catch-ups with Dr Kathy McLean OBE, Chair of the ICB Cluster for Derbyshire, Nottinghamshire and Lincolnshire and Jon and I met with Kathy to discuss the Trust and take her on a visit to Urgent & Emergency Care here.
- We have continued discussions on the partnering front, attending meetings with Healthwatch and having an introductory meeting with Tom Cahill, the new Chair at Nottinghamshire Healthcare NHS Foundation Trust.
- Chaired the latest Committee in Common meeting with Nottingham University Hospitals, which continues to strengthen the partnering between the two trusts.

**Council of Governor’s Chair’s Highlight Report to Board of Directors**

<b>Subject:</b>	Council of Governors Highlight Report to the Board of Directors	<b>Date:</b>	2 <sup>nd</sup> April 2026
<b>Prepared By:</b>	Sally Brook Shanahan, Director of Corporate Affairs		
<b>Approved By:</b>	Graham Ward, Chair		
<b>Presented By:</b>	Graham Ward, Chair		
<b>Purpose:</b>	To provide a formal summary of key discussions, assurance, risks, decisions and actions to the Board of Directors arising from the Council of Governors meeting held on 10 <sup>th</sup> February 2026		

Matters of Concern or Key Risks Escalated for Noting / Action	Major Actions Commissioned / Work Underway
<p><b>Concern regarding the accuracy and reliability of the Action Tracker</b>, following feedback that an action marked as completed had not been enacted as the previous commitment to engage with REACH had not progressed. This was <b>escalated for action</b>.</p> <ul style="list-style-type: none"> <li>• <b>Critical pressures in urgent and emergency care</b>, including 12-hour waits in ED linked to patient safety incidents. Although mitigations were in place, the intensity and duration of the pressure were significant and remain <b>key operational risks</b>.</li> <li>• <b>Risk of insufficient car parking capacity</b> linked to increased activity at Mansfield Community Hospital and the future CDC opening. Modelling indicates potential peak-time shortfalls requiring behavioural and travel interventions.</li> <li>• <b>Workforce pressures</b>, including sickness absence rates above national average and challenges in non-clinical workforce capacity following reductions in temporary staffing, and recruitment pressures linked to the CDC workforce plan.</li> </ul> <p>No additional immediate escalations to the Board were identified, but the themes above were highlighted for ongoing oversight.</p>	<ul style="list-style-type: none"> <li>• A review of the Action Tracker will be undertaken to ensure it accurately represents the progress made with actions.</li> <li>• Continued improvements to discharge processes and flow, including partnership work supporting medically fit for discharge patients were acknowledged.</li> <li>• Progress with the preparations for the opening of the Community Diagnostic Centre (CDC) in April 2026, including pathway design, training of practice nurses, and expansion of diagnostic services were noted.</li> <li>• Digital transformation work, including the rollout of Nervecentre in Newark UTC and confirmation of business case approval for the new Electronic Patient Record (EPR) programme were also noted.</li> <li>• Multi-year operational and financial planning underway to meet NHS England requirements up to 2028/29.in well underway</li> <li>• Recruitment processes are progressing for a new Trust Chair and for administrative support roles.</li> <li>• Deep dives have been commissioned on C. difficile and patient safety themes.</li> </ul>
Positive Assurances to Provide	Decisions Made (include BAF review outcomes)
<p>The meeting received good assurance in relation to the following areas:</p>	<ul style="list-style-type: none"> <li>• The minutes of the November 2025 meeting were approved without amendment.</li> </ul>

- highly positive patient feedback from the respiratory diagnostic services at Mansfield Community Hospital confirming improved access, reduced travel burden and high-quality patient experience.
- Despite winter pressures and a declared critical incident, quality indicators such as pressure-ulcer rates and harm measures remained stable with no deterioration in care quality.
- Significant progress against elective recovery targets, including achievement of zero 65-week waiters and a 40% reduction in 52-week waits compared with the previous year.
- Cultural insights from walkarounds and staff survey response (58%) showed clear pride in the organisation alongside commitment to improvement.
- Pharmacy workforce stability has markedly improved following targeted actions.
- Charitable fundraising continues to perform strongly with high levels of volunteer engagement and successful events.

- The Governor Remuneration & Nomination Committee recommended, and the Council of Governors approved, a two-year reappointment of Non-Executive Director Andrew Rose-Britton to 31st March 2028.
- The timetable and methodology for the Chair recruitment process were agreed, including use of stakeholder panels and the scheduling of an extraordinary Council of Governors meeting for the approval of the appointment
- Staffing establishment review recommendations for nursing and AHP staffing were endorsed via People Committee processes and noted by the Council of Governors.
- The Finance Committee and Audit & Assurance Committee reports were received and noted, including ongoing monitoring of financial deficit trajectories.
- Whilst no specific BAF ratings were amended at the meeting the discussions on flow, digital transformation and workforce will inform future BAF oversight.

#### **Comments on effectiveness of the meeting**

The meeting was quorate and well-attended, with active participation from governors and executives. Discussions were robust, with clear escalation of concerns and effective commissioning of actions with assurance provided across multiple domains. No significant issues regarding meeting effectiveness were noted.

#### **Items recommended for consideration by other Committees**

- People Committee – further analysis on the impact of reductions in temporary staffing on non-clinical functions, including letter-production and administrative capacity.
- Quality Committee – continued oversight of ED 12-hour waits, discharge delays, and the outcomes of the C. difficile deep dive.
- Finance Committee – monitoring of CDC workforce and digital programme resource implications.

#### **Progress with Actions**

Number of actions considered at the meeting - 6

Number of actions closed at the meeting – 6

Number of actions carried forward - 1

Any concerns with progress of actions – Yes. Concern was raised about the accuracy of the REACH-related action that had been recorded as completed, although it had not been progressed. A review has been commissioned.

Board of Directors Meeting in Public - Cover Sheet

<b>Subject:</b>	Chief Executive's report		<b>Date:</b>	2 <sup>nd</sup> April 2026	
<b>Prepared By:</b>	Rich Brown, Head of Communications				
<b>Approved By:</b>	Jon Melbourne, Chief Executive				
<b>Presented By:</b>	Jon Melbourne, Chief Executive				
<b>Purpose</b>					
An update regarding some of the most noteworthy events and items the past two months from the Chief Executive's perspective.				<b>Approval</b>	
				<b>Assurance</b>	
				<b>Update</b>	Y
				<b>Consider</b>	
<b>Strategic Objectives</b>					
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 estates	Work collaboratively with partners in the community
Y	Y	Y	Y	Y	Y
<b>Principal Risk</b>					
<b>PR1</b>	Significant deterioration in standards of safety and care				
<b>PR2</b>	Demand that overwhelms capacity				
<b>PR3</b>	Critical shortage of workforce capacity and capability				
<b>PR4</b>	Insufficient financial resources available to support the delivery of services				
<b>PR5</b>	Inability to initiate and implement evidence-based Improvement and innovation				
<b>PR6</b>	Working more closely with local health and care partners does not fully deliver the required benefits				
<b>PR7</b>	Major disruptive incident				
<b>PR8</b>	Failure to deliver sustainable reductions in the Trust's impact on climate change				
<b>Committees/groups where this item has been presented before</b>					
None					
<b>Acronyms</b>					
BAF = Board Assurance Framework CDC = Community Diagnostic Centre CT = Computed Tomography DM01 = Diagnostic Monitoring Standard 01 (national diagnostic waiting times standard) EPR = Electronic Patient Record			MRI = Magnetic Resonance Imaging MSK = Muscular Skeletal NOF = National Oversight Framework PR = Principal Risk RTT = Referral to Treatment UEC = Urgent and Emergency Care UTC = Urgent Treatment Centre		
<b>Executive Summary</b>					
An update regarding some of the most noteworthy events and items the past two months from the Chief Executive's perspective.					

# Chief Executive's update

I wrote in January that we must own our challenges and opportunities and approach them with realism, drive and ambition. I continue to see these three things across Sherwood Forest Hospitals.

As we head into spring, I firstly want to thank colleagues for their hard work over winter to keep patients safe. We recognise the challenges winter presents in the NHS and at Sherwood Forest Hospitals; thank you to all of our colleagues for their hard work during this period, and to patients for their understanding during our most pressured times.

Coming out of winter, we have begun to see performance improvements – including in reducing our longest waiters and improving our time to receive care in our Emergency Department and Urgent Treatment Centre. We want to continue to see that progress.

One of the ways in which we will do this is through the opening of Nottinghamshire's first Community Diagnostic Centre at Mansfield Community Hospital later in April 2026. I was there to open the memorial garden this week, which created a dedicated space for reflection and remembrance ahead of the building's opening to the public. The garden – which has been inspired by designs from West Notts College students – is testament to the partnership of us and our communities. I have no doubt that the CDC will be of great benefit to us and the communities we serve.

Digital change will also be a big part of our future and we were delighted to have our Electronic Patient Record (EPR) business case supported nationally a few weeks ago. Earlier in March, I had the pleasure of attending our EPR project launch event with partners, including our EPR provider Nervecentre. We will provide further updates in the coming months on our EPR programme.

Finally, we received our *NHS National Staff Survey* results this month and there is a paper on April's Board on what we heard from colleagues and our response. We want to be a great place to work and to receive care, and these two goals are aligned. There remains a great deal to be proud of in our staff survey results – and there are areas we must work together to improve. We have heard colleagues and our plans reflect this.

Culture and how we do things is so important to me and to all of our goals at Sherwood Forest. We will continue to prioritise this.

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## Operational updates

### Trust's National Oversight Framework (NOF) position updated

NHS England has updated its new National Oversight Framework (NOF), which ranks every trust in England against a number of standards – from their performance in urgent and emergency care departments to how quickly they can progress elective operations, their cancer performance, and even the experiences that patients share each year in the NHS National Staff Survey.

That framework has been published with the aim of improving information available to the public, driving-up standards and tackling variations in care across the country.

The framework places trusts into four performance segments, with the first – segment one – representing the best-performing trusts and the fourth segment showing the most challenged.

For us here at Sherwood, the league tables see us ranked 60<sup>th</sup> place in the country, placing us in the third of the four segments, recognising that any trust working in financial deficit cannot climb any higher than segment three.

## Nervecentre module rolled-out to Newark Urgent Treatment Centre

Work is continuing at pace to bring Sherwood's first Electronic Patient Record to Sherwood Forest Hospitals in 2027.

In February, we reached another major milestone of that journey, as the Nervecentre urgent and emergency care module was successfully rolled-out to our busy Newark Urgent Treatment Centre (UTC).

Nervecentre EPR will allow better access to patient information, reduction of paper and duplicate process, as well as empowering patient care. We were blown away by the enthusiasm and effort of everyone at Newark UTC and visiting clinicians, who were really proactive and supportive in getting to grips with the system.

We are grateful to all our colleagues who are working hard to make this improvement happen.

## Nottinghamshire's first Community Diagnostic Centre opening soon

In April 2026, we are proud to be opening the doors to Nottinghamshire's first Community Diagnostic Centre or 'CDC' at Mansfield Community Hospital.

The CDC is a one-stop shop for patients across Nottinghamshire to access the tests and investigations they need in a single visit, reducing the time it takes for patients to be referred to help them receive an 'all clear' or diagnosis sooner.



We look forward to sharing news of the Centre's opening when it opens later in April.

# Partnership updates

## Successful sixth 'Step into the NHS' careers showcase

Hundreds of aspiring healthcare professionals attended the sixth *Step into the NHS* careers showcase on Thursday 5<sup>th</sup> March 2026, as Sherwood Forest Hospitals, West Nottinghamshire College and Nottingham Trent University joined forces once again to highlight the wide variety of career opportunities available across the NHS.



**Trust Chief Executive Jon Melbourne with West Notts College Principal, Andrew Cropley**

The event attracted hundreds of local people, students and jobseekers to the event to learn more about clinical and non-clinical roles.

Events like *Step into the NHS* are vital in helping local people understand just how many varied and rewarding career opportunities the NHS can offer, with over 350 different career pathways available across our NHS.

It was fantastic to meet so many enthusiastic individuals exploring their next steps and to see our colleagues, students and partners coming together with such energy and passion. Supporting our future workforce is one of our biggest priorities, and events like this highlight the real impact of working in collaboration with our local education providers.

The Trust's partnership with the College was again shown in full-force the very next day, when students from Vision West Notts College visited Mansfield Community Hospital to offer free haircuts to patients, helping learners to get vital real-world experience and putting a smile on patients' faces.

## North Notts Place-based Partnerships Forum

In March, the Trust led the joint forum for the Bassetlaw and Mid Notts Place-Based Partnerships.

The forum is a quarterly event providing an opportunity for health, care, voluntary and charitable partners to come together in person to shape priorities for 2026/27.

The group provided contributions for shaping the neighbourhood target operating model focusing, which is the blueprint for how partners will work together in the future. The group considered the definition of neighbourhood and recommended priorities for the next three years. The content from the Forum is now being used to develop the model for presentation to the place-based partnerships executives.

Partners also contributed to the development of a bid for the recently announced Derbyshire, Lincolnshire and Nottinghamshire ICB Cluster Transformation Fund. The recommendations made will be woven into the bid, which is due to be submitted on 30<sup>th</sup> April 2026.

## Healthwatch stakeholder event

Representatives of the Trust attended a stakeholder event led by Healthwatch, which provided time to discuss the future of independent voice and how community voices need to be heard despite the expected upcoming legislative changes which would remove Healthwatch as an independent function.

Stakeholders in the room shared an ongoing commitment to working with community voices to ensure experiences are not just heard, but essential in the design and improvement of services across health and social care.

During the session, 21 pledges were made by NHS colleagues, councillors, VCSE partners and public contributors, which reflected a shared commitment to protecting independent community voice.

## Ashfield District Council economic growth strategy

The Trust engaged with its local partner, Ashfield District Council, in the development of the Council's economic growth strategy.

The strategy's aim is to set a clear direction for the local economy and workforce, agreeing actions that are aligned to local intent and national policy.

As a large employer committed to improving the health and wellbeing of its communities, the Trust recognises the importance of a healthy local economy.

The Trust contributed to stakeholder interviews and attended a workshop on 28 January. The workshop was attended by local businesses, public sector and voluntary organisations, evaluated the strengths, weaknesses, opportunities and threats and made recommendations as to priority actions.

## **MSK Together Partnership**

Sherwood continues to be an active partner in the MSK Together partnership, which includes health and care organisations across mid Nottinghamshire.

Sherwood has been working with Ashfield Voluntary Action, Active Notts, Ashfield District Council, Newark and Sherwood District Council, social prescribers from local primary care networks, Your CVS and Nottinghamshire Healthcare Trust to codesign a new MSK toolkit to empower partners, particularly in the voluntary sector, to support people with MSK conditions. It allows them to be confident they are offering sound advice, know how to access locally available support, and know when and how to reach into MSK services. The tool is to be launched in April.

The Trust continues to support the Department of Work and Pensions-led MSK Connect venture. A second cohort of patients with complex MSK presentations who are out of work for a long time attended a MSK Connect event. It provides the opportunity for these individuals to be linked to wider support including talking therapies, citizens advice, learning opportunities and voluntary services.

Although small numbers, the venture is having a significant impact with individuals from the first cohort seeing an improved physical health and securing employment after long periods without work. The next event will be located in Newark to ensure wider geographical impact.

## Other Trust updates

### Children and families benefit from new Paediatric Emergency Department opening hours



Children and families visiting the Emergency Department at King's Mill Hospital can now rely on a dedicated, child-friendly environment around the clock, ensuring they receive the right care in the right setting whenever they need it.

The paediatric Emergency Department now operates 24 hours a day, seven days a week, meaning children no longer need to be seen in adult areas after 2am. This ensures that every child — from newborns to teenagers — has access to a calm, age-appropriate space designed to reduce anxiety and support their wellbeing.

Families with children will still need to book in at the main Emergency Department desk. From there, they will be directed to the paediatric area.

Each year, tens of thousands of children and young people come through the doors of King's Mill Hospital's Emergency Department. The move to continuous paediatric care means families can feel confident that, no matter what time they arrive, their child will be looked after by a specialist team in an environment tailored to their needs.

The dedicated children's area offers a bright, engaging space filled with activities and distractions that help put young patients at ease. An open plan waiting area allows staff to keep a close eye on children, while newly-refurbished cubicles provide privacy and comfort during treatment. Families also benefit from dedicated breastfeeding areas and mental health rooms that offer a safe, supportive space for those who need it.

This enhanced service has also improved the experience for adult patients. With additional paediatric staff supporting the department, teams can work more efficiently, reducing waiting times and ensuring that both adults and children receive timely care.

Colleagues across the Emergency Department have welcomed the extended paediatric provision, noting smoother handovers, better continuity of care, and a more reassuring experience for families.

## Marathon runner raising money for the hospital which saved his life

A Mansfield-based runner will be running in the London Marathon this year to say thank you to King's Mill Hospital, after he received life-saving surgery there.

Nathan Sharpe, 27, wants to give back to the Trust after a harrowing journey with chronic illness led to him receiving stoma surgery.

Nathan, an employee at the Trust, was diagnosed with Ulcerative Colitis in 2020, an inflammatory bowel disease which led to multiple hospital admissions and a compromised immune system.

Medication prescribed to keep his condition under control meant that Nathan put on over four stone in weight, which deeply affected both his physical and mental health.



Four years after his surgery, Nathan has now turned his life around and through a combination of running and healthy eating has lost the weight which caused him so much unhappiness, started a running club, and become a volunteer for a men's mental health charity, Enlighten the Shadows.

Last year, Nathan took on a huge milestone by running the Nottingham Half Marathon and plans to go further this year by running the London Marathon in aid of Sherwood Forest Hospitals Charity, which supports improvements across King's Mill, Newark, and Mansfield Community hospitals.

Donations towards Nathan's marathon journey can be made by visiting his [London Marathon fundraising page on Just Giving](#).

## Trust risk ratings reviewed

The Board Assurance Framework (BAF) Principal Risk 7 – 'A major disruptive incident' – for which the Risk Committee is the lead committee, has been scrutinised by the Trust's Risk Committee.

Committee members discussed the risk scores and assurance ratings but decided that they should remain unchanged.

The full and updated Board Assurance Framework (BAF) is now due to be presented to the Trust's Board of Directors every four months, with the full BAF next due to be presented at the Public Meeting of the Trust's Board of Directors in June 2026.

**Board of Directors Meeting in Public - Cover Sheet**

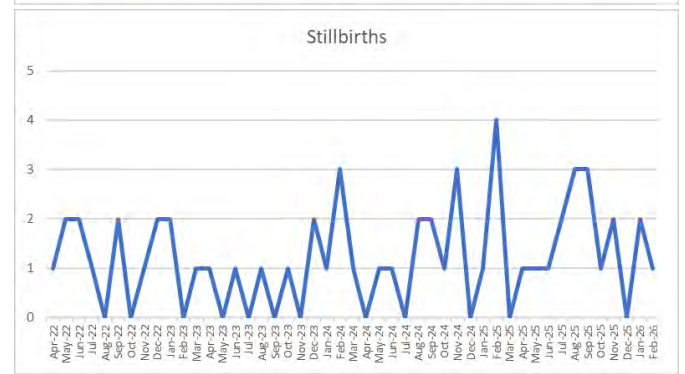
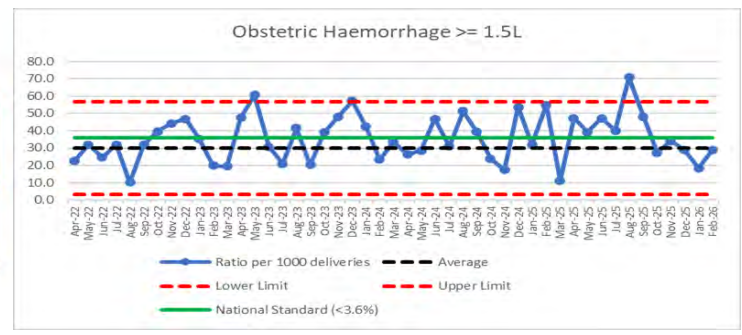
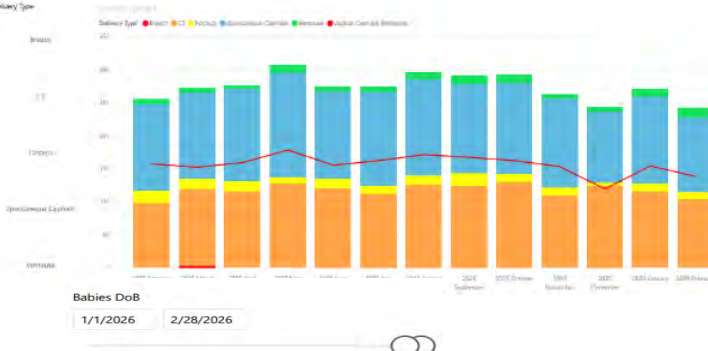
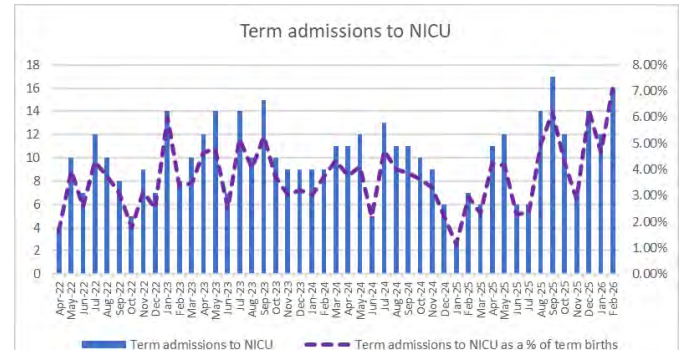
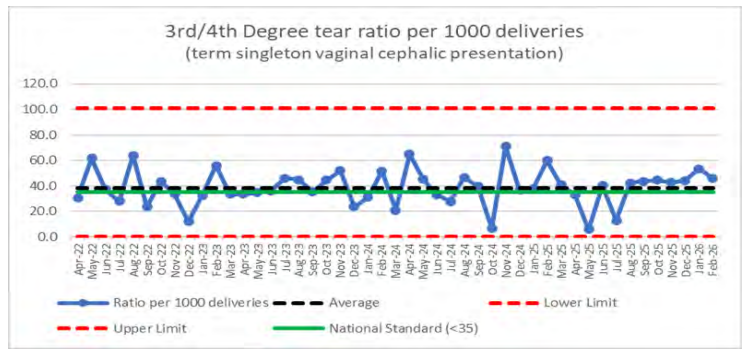
<b>Subject:</b>	Perinatal Services - Bi Monthly Assurance- Quality & Safety		<b>Date:</b>	2 April 2026	
<b>Prepared By:</b>	Sarah Ayre, Head of Midwifery, Sarah Sarjant, Lead for Quality and Safety				
<b>Approved By:</b>	Philip Bolton, Executive Chief Nurse, Neil McDonald Non-Executive Director and Paula Shore				
<b>Presented By:</b>	Sarah Sarjant, Lead for Quality and Safety				
<b>Purpose</b>					
The purpose of this paper is to provide a <b>bi monthly, integrated update</b> on maternity and neonatal (perinatal) safety and assurance activity. It brings together <b>PMRT reporting, the Legal Scorecard, and all relevant perinatal assurance information into a single, aligned reporting format</b> , in line with national and regional recommendations.			<b>Approval</b>		
			<b>Assurance</b>	<b>X</b>	
			<b>Update</b>	<b>X</b>	
			<b>Consider</b>		
<b>Strategic Objectives</b>					
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 estates	Work collaboratively with partners in the community
<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>
<b>Principal Risk</b>					
<b>PR1</b>	Significant deterioration in standards of safety and care				<b>X</b>
<b>PR2</b>	Demand that overwhelms capacity				
<b>PR3</b>	Critical shortage of workforce capacity and capability				
<b>PR4</b>	Insufficient financial resources available to support the delivery of services				
<b>PR5</b>	Inability to initiate and implement evidence-based Improvement and innovation				<b>X</b>
<b>PR6</b>	Working more closely with local health and care partners does not fully deliver the required benefits				
<b>PR7</b>	Major disruptive incident				
<b>PR8</b>	Failure to deliver sustainable reductions in the Trust's impact on climate change				
<b>Committees/groups where this item has been presented before</b>					
<ul style="list-style-type: none"> <li>• Nursing and Midwifery AHP Committee</li> <li>• Divisional Governance Meeting</li> <li>• Maternity and Gynaecology Clinical Governance</li> <li>• Service Line</li> <li>• Divisional Performance Review</li> <li>• Perinatal Forum (formally Maternity Forum)</li> <li>• Divisional People Committee</li> <li>• Senior Management Team weekly meeting</li> </ul>					
<b>Acronyms</b>					
<ul style="list-style-type: none"> <li>• Perinatal Assurance Committee (PAC)</li> <li>• Local Maternity and Neonatal System (LMNS)</li> <li>• Neonatal Intensive Care Unit (NICU)</li> <li>• Head of Midwifery (HoM)</li> <li>• Saving Babies' Lives Version Three: A care bundle for reducing perinatal mortality (SBLCBV3)</li> <li>• Transitional Care (TC)</li> </ul>					

- Maternity Outcomes Signal System (MOSS)
- Perinatal Mortality Review Tool (PMRT)
- Maternity and Neonatal Safety Improvement Programme (MNSI)
- Operational Delivery Network (ODN)
- Obstetric Anal Sphincter Injury (OASI)
- Statistical Process Control (SPC)
- Baby Born before Arrival (BBA)

### **Executive Summary**

This bi-monthly Perinatal Quality Oversight (PQOM) report provides an integrated view of maternity and neonatal safety, quality and assurance across the Trust, in line with the NHSE Perinatal Quality Oversight Model (August 2025). It brings together perinatal mortality intelligence, patient safety investigations, claims and legal insight, training assurance, national safety programme compliance and key performance metrics within a single, aligned framework. The report is designed to strengthen ward-to-board visibility, enabling early identification of emerging risks, clear triangulation of safety signals, and timely escalation where required. Overall, this report provides assurance that perinatal risks are being actively monitored, learning is systematically translated into improvement, and clear mitigation actions are in place. Areas of exception, emerging concern and required escalation are explicitly highlighted to support effective Quality Committee discussion and onward Trust Board assurance, reinforcing the Trust's commitment to safe, high-quality and equitable maternity and neonatal care.

# PERINATAL QUALITY SURVEILLANCE DATA – SPC

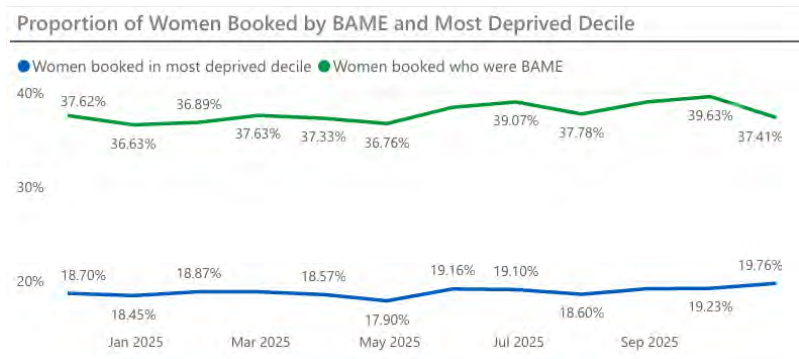


**13** Mothers' Age  $\geq 40$  Number of Deliveries

**512** Number of Deliveries

Mother's Ethnicity Sub-Group: All

Mother's Ethnicity: White, Asian, Unknown, Black, Mixed



## Report Overview

This report outlines locally and nationally agreed measures to monitor maternity and neonatal safety, as outlined in the NHSE [Perinatal Quality Oversight Model](#) (August 2025). The purpose of the report is to inform the ICB Board and Trust Board of present or emerging safety concerns or activity to ensure safety with a two-way reflection of 'ward to board' insight across the multi-disciplinary, multi-professional maternity services team.

### 1.0 SPC Data Overview

This Perinatal Quality Oversight (PQOM) report uses Statistical Process Control (SPC) to provide robust, consistent and meaningful interpretation of maternity and neonatal safety data. SPC enables the Trust to distinguish between expected variation and true change in performance, supporting early identification of emerging risk and timely, proportionate escalation.

Across all SPC measures, performance demonstrates predominantly common cause variation with no evidence of sustained deterioration or unrecognised harm. The SPC methodology provides assurance that the service remains stable while enabling early identification of emerging risks should statistically significant change occur.

#### 1.1 Delivery Numbers And Mode Of Birth

Overall birth activity remains stable month to month, with predictable seasonal variation. The proportion of women aged over 40 fluctuates but shows no sustained upward trend, remaining within expected limits and not demonstrating special cause variation. The distribution of birth modes (spontaneous vaginal, assisted vaginal and caesarean section) remains stable over time. Minor fluctuations are observed but there is no SPC evidence of a structural shift in clinical practice or outcomes.

#### 1.2 Obstetric Haemorrhage

The SPC chart shows a generally stable process with routine month-to-month fluctuation, but with several clear spikes that rise above the upper control limit. Despite these outliers, there is no sustained upward or downward movement across the timeframe, suggesting neither consistent improvement nor deterioration overall.

#### 1.3 Still Births

Monthly stillbirth numbers remain low and sporadic, with no evidence of clustering or sustained increase. SPC demonstrates random variation consistent with expected patterns for low-frequency events, providing assurance of stability.

#### 1.4 BBA and Homebirths

BBA rates remain low overall, with occasional month-to-month variation. SPC does not indicate a sustained increase, suggesting no systemic access or pathway failure, though continued surveillance is warranted.

### 1.5 Health Inequalities

The proportion of women from the most deprived decile and those identifying as BAME fluctuates across months but without sustained trend or shift. Variation reflects population flow rather than inequity signal, supporting ongoing monitoring rather than escalation.

### 1.6 3rd and 4th Degree Tear

Rates fluctuate around the centre line and remain within control limits, with no sustained upward trend or special cause signal. Performance remains broadly consistent with national expectations, providing assurance of stable perineal outcomes.

## 2.0 Perinatal Mortality Rate

### 2.1 Perinatal Mortality Summary

Cases of Stillbirths and Late fetal losses			
Ref No.	Incident Category	Outcome	Immediate actions
<b>January 2026</b>			
101936	IUFD	38+3 weeks Called triage with absent fetal movements. Unit currently on divert advised to go to Derby.  Attended Derby triage - BP 147/91 ++ protein. Absent FH on auscultation, IUFD confirmed.	Taken through rapid review with immediate actions identified and actioned. Agreed to close.
102035	IUFD	Contacted telephone triage at 35+6 weeks with absent fetal movements. Advised to attend, no fetal heart rate detected.	No immediate actions identified
<b>February 2026</b>			
102457	IUFD	29+4 weeks Call to triage – Abdo pain, actively bleeding, no movements. IUFD confirmed, EMLSCS performed for suspected DIC under general anaesthetic.	No immediate actions identified

Findings of reviews of perinatal deaths:

There were 0 intrapartum stillbirths reported during this reporting period:

For the financial year 2025-26 to February 2026 the stillbirth rate is 5.5/1000 births (running total/average) births which is above the national standard, (national standard is a stillbirth rate  $\leq 4.4/1000$  births).

Cases of Neonatal and Postnatal death			
Ref No.	Incident Category	Outcome	Immediate actions
<b>January 2026</b>			
101886	NND	Spontaneous labour onset after PPSROM for 2 days. Attended ED with vaginal pressure and abdominal pain. Transferred to SBU for labour care and confirmed to be fully dilated. Signs of life. 21/40 gestation.	No immediate actions identified.
<b>February 2026</b>			
<b>No reportable cases</b>			

## 2.2 Learning from PMRT reviews

Issue	Action	By Who	By When	
<b>2025-26 – completed actions</b>				
Q3	Learning update disseminated to ED and SBU staff regarding the CDOP and reporting process.	CDRT to provide learning on annual training regarding usual CDOP processes and correct reporting process.	CDRT Lead Midwife	January 2026 (awaiting update on completion)
	Reminder to junior Dr's during teaching regarding exploring other avenues with UTI symptoms	Teaching update	Consultant Obstetrician	January 2026 closed
	Update required regarding need for repeat bloods.	Plan to contact patient and repeat bloods as required if consents.	Consultant Obstetrician	January 2026 closed
	Incomplete plans regarding fetal monitoring	Shared learning through an after action review.	Clinical governance midwife	March 2026

	Declined GTT - No HBA1c offered	To discuss Diabetic Specialist MW to clarify if a patient is declining GTT, if any investigations should occur in place.	Clinical governance midwife	December 2025 Discussed – currently unable to offer an alternative – Gold standard is GTT – as per NICE closed
	Deranged urinalysis not actioned	Individual discussions with MW and Reg regarding management	Clinical governance midwife	December 2025 closed
	Prescribed Iron BD instead of iron infusion	Learning to staff regarding iron dosage and iron infusion	Clinical governance midwife	March 2026
Q4	No Mifepristone given to commence regime	For discussion with consultant – shared learning.	Consultant Obstetrician	March 2026
	Poor documentation around decision for birth	Individual discussions with staff	Consultant Obstetrician	March 2026
	Lack of documentation	Discussed with MW at the time of the incident – Retrospective account completed.	Clinical governance midwife	February 2026 closed

### 3.0 The Maternity and Newborn Safety Investigation Programme (MNSI) and Maternity Patient Safety Incident Investigations (PSIIs)

#### 3.1 Investigation progress update

Date	MNSI reference	MNSI - Date Reported	ENS - Reported	ENS - Date Accepted	DoC - Verbal	Draft Report Received	Final Report Received
17/01/25	MI-039331	22/01/25	ENS-002-24	17/02/25	17/01/25	23/06/25	24/06/25 Closed
08/02/25	MI-039722	11/02/25	N/A	N/A	14/02/25	Case rejected by MNSI - lack of consent	
11/04/25	MI-041409	16/04/25	N/A	N/A	23/04/25	Case rejected by MNSI - lack of consent	

01/05/25	MI-041785	02/05/25	N/A	N/A	02/05/25	16/09/25	08/10/25
22/07/25	MI-044576	23/07/25	N/A	N/A	23/07/25	26/11/25	19/12/25
13/07/25	MI-044904	01/08/25	N/A	N/A	04/08/25	Case rejected by MNSI - lack of consent	
12/08/25	MI-045323	15/08/25	N/A	N/A	15/08/25	Case rejected by MNSI - lack of consent	
30/08/25	MI-045821	01/09/25	N/A	N/A	01/09/25	12/02/2026	27/02/26
31/08/25	MI-046096	05/09/25	ENS-25-001	Not accepted	05/09/25	29/01/2026	23/02/26
30/09/25	MI-047287	02/10/25	N/A	N/A	02/10/25	19/01/2026	23/02/26
05/02/26	MI-052986	09/02/26	N/A	N/A	06/02/26		

### 3.2 Learning from MNSI reviews

Theme	Actions	Responsible role	By when
Guidance variation	Review of guidance on use of Aspirin in pregnancy	Governance team	March 2026
Communication	Ensure communication process is clear when changes to infrastructure	Senior leadership team	March 2026
Identification of a deteriorating patient	Audit to evaluate care determine issues, trends or themes in relation to the appropriate use, documentation, escalation, and response	Audit Lead Midwife	April 2026
Triage	Ensure a designated quiet space for telephone triage, protected from interruptions	Matron – Perinatal Services	March 2026
Escalation	Clarify and reinforce escalation pathways within SOPs, including consultant advice	Matron – Perinatal Services	March 2026
Latent phase of labour pathway	Review the Latent phase of Labour guidance to ensure the correct process and a holistic assessment	Consultant Midwife	April 2026
Triage	Review the Latent phase of Labour guidance to ensure there is a clearly defined pathway of care in regard to pain management in Triage	Consultant Midwife	April 2026

### 3.3 Maternity Patient Safety Incident Investigation (PSII)

Ref No.	Incident category	Summary/ Update
DW222256	HIE	Investigation underway, external input not received from GP services and EMAS to support completion therefore report completed without this element and explanation given.

### 3.4 Incident tracker for ongoing investigations

	STEIS	PSII	MNSI	Thematic review	Local response	Rapid review	AAR	SHOT	TOTAL
Maternity	8	1	7	0	2	5	3	2	28

#### MNSI

- 6 final reports received from MNSI.
- 1 ongoing MNSI investigations

#### PSII

- Service to service feedback not provided therefore report completed with this referenced. Family updated on progress of the report

#### Local response

#### SHOT report

- DW236745 - Delay in Anti D
- DW236844 - Mishandling of blood products

#### AAR

- DW218288 - commenced report and Anaesthetic review complete
- DW227875 - IUFD MNSI case rejected due to no family consent. AAR commenced in Jan 2026.
- DW235230 - Awaiting update from PSIRG
- 

To be escalated from the PAC members if further detail is needed for assurance within this meeting.

## 4.0 Coroners' report

### 4.1 Outstanding reports due

Date Listed	Summary
Nothing to report	

### 4.2 Regulation 28 report issued

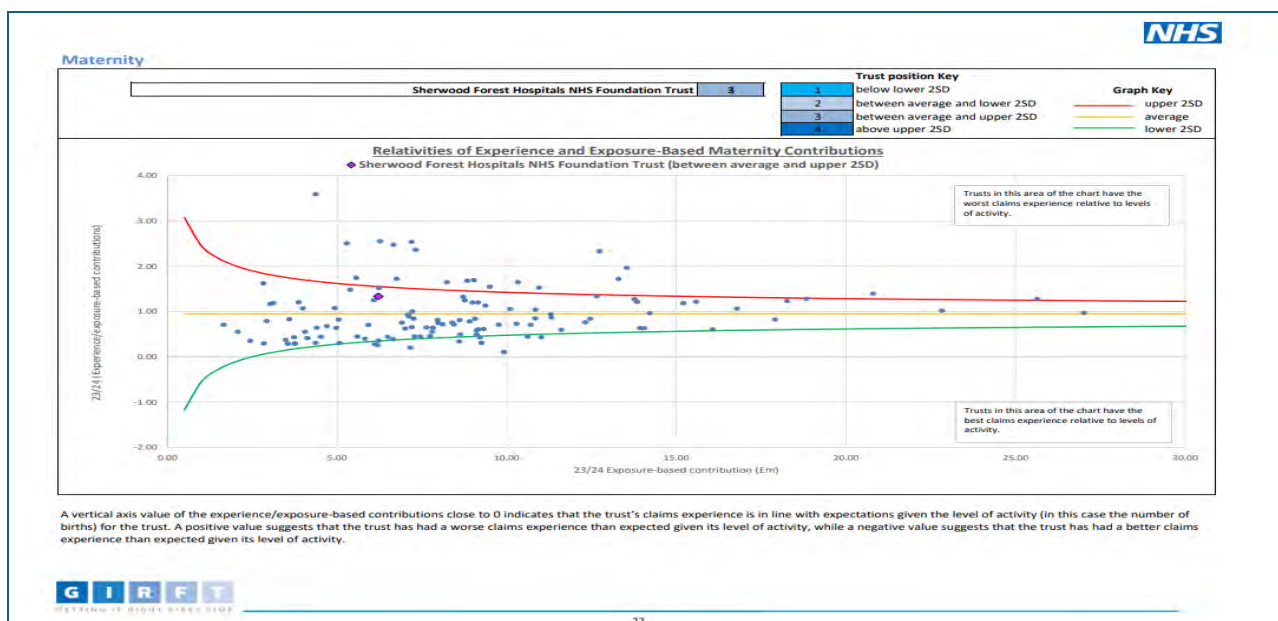
Identifier	Action required	Progress	Responsible role	By when
Nothing to report				

## 5.0 Review of NHS Resolution Scorecard

### Themes identified from Claims Scorecard (CNST claims received with an incident date between 01/04/2015 and 31/03/2025)

- Failure to monitor second stage of labour
- Failure to monitor first stage of labour
- Failure to respond to an abnormal fetal hear rate
- Failure to monitor the dose/ rate of syntocinon

Please see below the GIRFT 2025 Maternity funnel plot which compares claims experiences of Trusts within England and Wales, which is represented over 5 years. SFH is represented within the chart by the purple diamond and shows within the expected area on the funnel plot.



## 6.0 Maternity Outcomes Safety Signals System (MOSS)

The Maternity Outcomes Signal System (MOSS) was developed by NHS England in response to the East Kent [Reading the signals report](#). MOSS operates at trust site level. It is a near-real time safety signal system that supports early detection and rapid responses to potential safety issues in Intrapartum care service delivery. MOSS operates within the [perinatal quality oversight model](#) (PQOM), ensuring consistent monitoring, support, and escalation across trusts, ICBs, regions, and nationally.

MOSS presents trend data on term stillbirths and neonatal deaths in maternity units in a new way. Signals of potential safety issues are flagged in units when there has been a recent doubling in the rate of these events compared to what would normally be expected, given the total numbers of births at a given site.

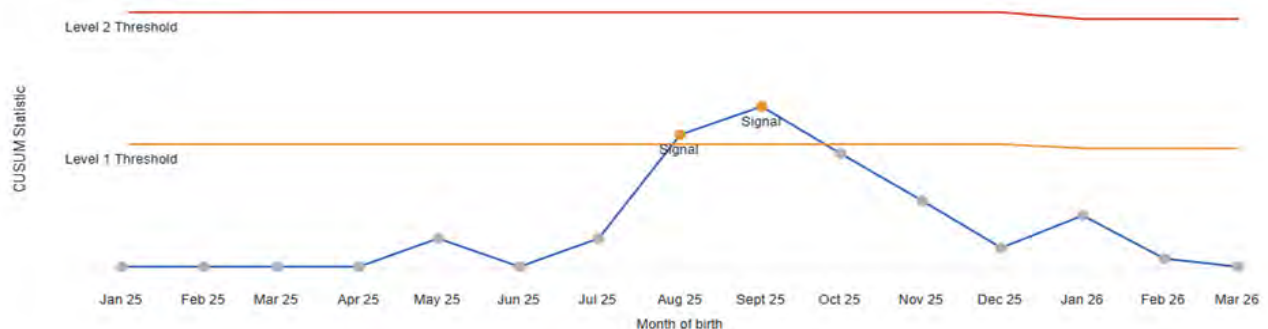
### MOSS signal received by Trust 2025/2026

Q3	No Signal received during this quarter
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#### Maternity Outcomes Signal - Cumulative sum (CUSUM) - Sherwood Forest Hospitals NHS Foundation Trust

This chart produces 'signals' of potential safety issues in maternity care arising during labour and birth using term stillbirths and term neonatal deaths up to 28 days. The maternity unit's perinatal leadership team should carry out a critical safety check when any signal arises to make sure care on the labour ward is safe. Further guidance on this is available in the MOSS Standard Operating Procedures. Chart guidance can be found using the "i" icon.

Site: King's Mill Hospital



## 7.0 Performance Metrics

### 7.1 Service Diverts

Detailed report to PAC 6 monthly: Next July 2026

**Themes from January 2026 analysis:** 9 diverts from November 2025 – February 2026, no harm identified, and all service users were written to by DHoM to apologise and follow up.

### 7.2 Term admission to NICU (Avoiding Term admission into the Neonatal unit, ATAIN)

	Jan 2026	Feb 2026	YTD total
<b>Term admission to NICU as a % of term births</b>	4.65%	7.08%	4.44%
<b>National target &lt;6%</b>			
<b>Primary reason for admission</b>	Suspected sepsis Respiratory support		
<b>Findings upon review</b>	December 2025 to February 2026, 42 term admissions with most staying over 72 hours  The annual report will include comprehensive case reviews and an assessment of the appropriateness of all admissions.		

### 7.3 Home Birth

#### Care Outside of Guidance

Between 1 January 2026 and 28 February 2026, there were 11 planned home births, with four births occurring at home.

Women who did not proceed to a home birth may have chosen to change their birth setting prior to labour, required transfer to hospital during labour, or experienced rapid labour resulting in birth prior to midwife arrival.

There were no home births planned outside Trust or national clinical guidance during this period.

*To date in March 2026, there have been three planned home births, two of which have already taken place with one remaining. No maternal or neonatal adverse outcomes have been identified.*

### 8.0 Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training

	Midwives	Obstetricians (split by consultant/ other Dr)	MSWs	Anaesthetists	Neonatal medics (split by consultant/ other Dr)	Neonatal nurses (Nrs/ ANNP)
Saving Babies Lives Care Bundle	98%	89%	98%			
Fetal monitoring and surveillance	98%	100%				
Maternity Emergencies and multi professional training	98%	100%	96%	100%		
Equality/ equity and personalised care (3-Year programme)	98%	89%	98%			
Care during labour and immediate post-natal period (3 Year programme)	98%	100%	96%	100%		
Neonatal Life Support training	93.33%				93%	90%
Mandatory & Stat training	91%	81%	95%	85%	81%	91%
Qualified in specialty						61%

## 9.0 Saving Babies' Lives V3.2

	Compliance/ progress/ action	Responsible role	Compliance required	Current compliance
<b>Element 1</b>	<b>REF 1.3</b> Smoking status at 36/40	LF	80%	67%
	<b>REF 1.6</b> Percentage of smokers who are referred into an inhouse tobacco dependence treatment service who set a quit date		40%	27.6%
<b>Element 2</b>	<b>REF 2.19</b> Percentage of pregnancies where an SGA fetus is antenatally detected	NA/SS	70%	46.5%
<b>Element 3</b>	Fully compliant	YJ	100%	100%
<b>Element 4</b>	Fully compliant	NP	100%	100%
<b>Element 5</b>	Fully compliant	BL	100%	100%
<b>Element 6</b>	Fully compliant	RW	100%	100%

Element 1 overall compliance – 80%

Element 2 overall compliance – 95%

Overall compliance across all elements – 96%

## 10.0 NHS Resolution Maternity Incentive Scheme update

Safety Action No.	Brief description	Responsible	Presented to PAC
1	PMRT	Sarah Sarjant	14.01.26
2	MSDS	Lisa Butler	21.11.25
3	Transitional Care	Rachael Giles	19.12.25
4	Clinical Workforce	Samantha Barlow	21.11.25
5	Midwifery Workforce	Lisa Butler	19.12.25
6	Saving Babies Lives	Sarah Sarjant	14.01.26

7	Listening to service users	Sarah Ayre	19.12.25
8	Training	Lisa Butler	19.12.25
9	Board Assurance	Sarah Ayre	19.12.25
10	MNSI	Sarah Sarjant	14.01.26

### 11.0 Transitional Care (MIS YR 7, SA3)

Compliant: Work continues within Transitional Care and NICU following the December 2025 merge to a perinatal service model.

### 12.0 Risk Register Highlights

**Risk 1481**- Abduction from the Maternity ward. Risk score 12. Due for review SA

**RISK 2893** - BSOTS triage system has not been fully embedded within Maternity Triage. Risk score 12. Due for review LB

**RISK 1969** - Safe & effective patient care - access to Urology services. Risk score 12. Due for review SA

New and emerging risk:

Maternity Pharmacy gap – to be completed by LB and NB

Epidural shortage risk – completed by SH and NB and to be presented at perinatal governance

**Board of Directors Meeting in Public - Cover Sheet**

<b>Subject:</b>	Bi Monthly Perinatal Safety Champions Update – January & February 2026	<b>Date:</b>	2 April 2026		
<b>Prepared By:</b>	Sarah Ayre, Head of Midwifery				
<b>Approved By:</b>	Philip Bolton, Executive Chief Nurse, Neil McDonald Non Executive Director and Paula Shore, Director of Midwifery/Divisional Director of Nursing.				
<b>Presented By:</b>	Sarah Ayre, Head of Midwifery				
<b>Purpose</b>					
The purpose of this paper is to provide clear bi-monthly assurance to the Perinatal Assurance Committee (PAC) on the safety, quality and delivery of maternity and neonatal services, in line with the Perinatal Quality Oversight Model (PQOM).				<b>Approval</b>	
				<b>Assurance</b>	<b>X</b>
				<b>Update</b>	<b>X</b>
				<b>Consider</b>	
<b>Strategic Objectives</b>					
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 estates	Work collaboratively with partners in the community
<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>
<b>Principal Risk</b>					
<b>PR1</b>	Significant deterioration in standards of safety and care				<b>X</b>
<b>PR2</b>	Demand that overwhelms capacity				
<b>PR3</b>	Critical shortage of workforce capacity and capability				
<b>PR4</b>	Insufficient financial resources available to support the delivery of services				
<b>PR5</b>	Inability to initiate and implement evidence-based Improvement and innovation				<b>X</b>
<b>PR6</b>	Working more closely with local health and care partners does not fully deliver the required benefits				
<b>PR7</b>	Major disruptive incident				
<b>PR8</b>	Failure to deliver sustainable reductions in the Trust's impact on climate change				
<b>Committees/groups where this item has been presented before</b>					
<ul style="list-style-type: none"> <li>• SLT</li> <li>• PQSG</li> </ul>					
<b>Acronyms</b>					
<ul style="list-style-type: none"> <li>• Perinatal Assurance Committee (PAC)</li> <li>• Perinatal Quality Oversight Model (PQOM)</li> <li>• Maternity Care Bundle (MCB)</li> <li>• Perinatal Quality Surveillance Group (PQSG)</li> <li>• Integrated Care Board (ICB)</li> <li>• Local Maternity and Neonatal System (LMNS)</li> <li>• Maternity and Neonatal Voices Partnership (MNVP)</li> <li>• Perinatal Services Forum (PSF)</li> <li>• Maternity Triage Centre (MTC)</li> <li>• Head of Midwifery (HoM)</li> <li>• Sherwood Forest Hospitals NHS Trust (SFH)</li> <li>• Deputy Head of Midwifery (DHoM)</li> <li>• Deputy General Manager (DGM)</li> </ul>					

- Neonatal Intensive Care Unit (NICU)
- Baby Friendly Initiative (BFI)
- Sherwood Birthing Unit (SBU)
- United Nations Children’s Fund (UNICEF)
- National Health Service (NHS)

## Executive Summary

This paper provides the Head of Midwifery (HoM) bi-monthly assurance update for January–February 2026 to the Perinatal Assurance Committee (PAC), in line with the Perinatal Quality Oversight Model (PQOM). It presents key intelligence relating to safety, quality, workforce, culture and operational performance across maternity and neonatal services.

Overall, the report demonstrates stable service delivery and continued improvement, supported by strong governance through the Perinatal Quality Surveillance Group (PQSG), Perinatal Services Forum (PSF) and PAC. Key updates include progress following the relocation of the Maternity Triage Centre (MTC), development of the Perinatal QUAD leadership model, and actions arising from the 2025 Staff Survey to strengthen staff engagement and culture across the division. The report also highlights alignment with national maternity and neonatal priorities, including preparation for the Maternity Care Bundle (MCB), learning from the National Maternity and Neonatal Investigation chaired by Baroness Valerie Amos, and Sherwood Forest Hospitals NHS Foundation Trust’s (SFH) contribution to the UNICEF Baby Friendly National Neonatal Project, where the Trust has achieved Stage 1 and Stage 2 accreditation milestones.

Overall, the intelligence presented assures that perinatal services continue to operate within a robust governance framework, with clear leadership oversight and a strong focus on safety, learning and continuous improvement to support high-quality care for women, birthing individuals, their babies and their families.

## 1.0 Three-Year Delivery Plan

The Three-Year Delivery Plan for Maternity and Neonatal Services sets out NHS England’s national framework for making care safer, more personalised and more equitable for women, babies and families over a defined three-year period. It brings together learning from national reviews, service-user feedback and workforce intelligence into a single, coherent plan with clear responsibilities for trusts, integrated care systems and national oversight.

The plan is structured around four core themes:

1. listening to and working with women and families with compassion;
2. growing, retaining and supporting the workforce;
3. developing and sustaining a culture of safety, learning and support; and
4. strengthening the standards, data and digital structures that underpin safe care.

### 1.1 Perinatal Quality Surveillance Group (PQSG) Update – January 2026

A paper was shared at the PQSG meeting held on 7 January 2026 to provide an update to the group on the Trusts delivery against Workforce Priorities within Themes 2 and 3 of the Three-Year Delivery Plan, setting out a clear, time-bound action plan in response to areas highlighted by the ICB, including staff turnover, training, supervision, workforce experience and retention. The paper offered assurance that workforce risks are understood, triangulated with intelligence from LMNS

dashboards, staff survey feedback and local governance forums, and that actions are in place to stabilise, improve and sustain workforce capacity and experience across maternity and neonatal services.

Overall, the paper provided assurance of a clear grip, improved trajectory, and robust governance through routine oversight by PQSG, with escalation to PAC as required, in line with PQOM expectations.

## 2.0 Safety Champions

Role/Name
Board Safety Champion, Executive – Phil Bolton, Chief Nurse
Board Safety Champion, Non-Executive - Neil McDonald
Perinatal Obstetric Lead - Mrs Sharon Tao, Consultant Obstetrician
Perinatal Lead - Paula Shore, Director of Midwifery/Divisional Director of Nursing
Perinatal Neonatal Lead - Alison Davies/Jess Cox, Neonatologists
Perinatal Management team - Steve Jenkins, Divisional General Manager
Maternity and Neonatal Voices Partnership (MNVP) leads - Amanda Doughty/Clare Harris

### 2.1 Safety champion feedback:

January 2026 – Maternity Triage Centre (MTC)

Feedback raised by staff	Action and progress
MTC staff reported that relocation was working well, the clinical environment and Telephone Triage were improved, but support was requested to ensure an ensuite space for isolation.	NHSE bid for capital to support ensuite works in December 2025; at the time of the MTC walkaround, there had been no update. As we write this paper, we have secured the funds, and the works should commence in Q1 2026.
Feedback raised by service users	Action and progress
Met with service users waiting in MTC – reported improved waiting area - access to toilet, water and vending machines, plus calmer waiting area that gave service users reassurance as easier access/visibility of staff.	Asked to ensure the video playback facility was fully utilised and provide updated public health information.
Additional safety champions intelligence	Action and progress
The Clinic 12 waiting area and service user experience have been reported as negatively impacted by the changes implemented to relocate MTC.	NHSE bid for capital to support ensuite works in December 2025; at the time of the MTC walkaround, there had been no update. As we write this paper, we have secured the funds, and the works should commence in Q1 2026.

Feedback raised by staff	Action and progress
<p>NICU staff shared their reflections on recent leadership changes and the appointment of a new Ward Sister Band 7. The vacant Band 7 posts for Infant Feeding and Practice Development were discussed, with positive feedback from the team regarding the Trust’s continued investment in staffing and professional development. Staff also welcomed the ongoing development of the supernumerary Band 6 in-charge role, recognising its value in strengthening clinical leadership, oversight and support for the team.</p>	<p>The NICU Matron continues to facilitate regular staff engagement sessions to gather feedback and ensure the staff’s voice is captured. In partnership with the Ward Sister (Band 7), this feedback informs a “You Said, We Did” approach, with actions and updates shared with the team through monthly feedback loops to support transparency and continuous improvement.</p>
Feedback raised by service users	Action and progress
<p>Positive feedback was received from two families during the walkaround, particularly regarding staff communication and overall experience of care within the NICU.</p>	<p>Work is underway to consider how structured feedback mechanisms for NICU families can be strengthened, particularly as the MNVP model is reconfigured, to ensure the experiences and voices of families continue to inform service improvement.</p>
Additional safety champions intelligence	Action and progress
<p>Security across the Perinatal Services footprint is an ongoing risk – currently on Risk Register under Abduction.</p>	<p>Mitigations in place as per Risk.  Baby Tagging Business Case under development – currently HoM working with the procurement team to appraise best options</p>

### 3.0 Perinatal Services Forum (PSF)

The PSF provides a regular multidisciplinary platform for staff across maternity and neonatal services to share updates, raise concerns and discuss service improvements. The forum is attended by executive and senior clinical leaders, enabling direct engagement between frontline teams and Trust leadership and supporting staff voice and transparency.

#### 3.1 PSF 8 January 2026 (Chaired by Chief Nurse)

The Chief Executive, Jon Melbourne, and Non-Executive Director, Neil McDonald, attended alongside Paula Shore, Director of Midwifery/Divisional Director of Nursing, demonstrating continued executive engagement.

Key updates included:

- Introduction of the Maternity Care Bundle, with benchmarking against the five elements underway.
- Positive feedback following the Maternity Triage relocation, which has improved patient flow and created three additional labour ward rooms.
- Elective Caesarean section capacity being expanded to five days per week from April 2026 to support rising demand.
- Development of BadgerNet dashboards, improving real-time data visibility and compliance with uterine artery Doppler scans (increased from 40% to 86%).
- Monitoring of out-of-area patient activity and review of clinic pathways.

### 3.2 PSF 12 February 2026 (Chaired by Chief Nurse)

Executive leadership were again in attendance, reinforcing visible leadership engagement.

Key discussion points included:

- Review of internal communications governance following a December bulletin referencing a sensitive case.
- Updates on maternity triage estates improvements and ongoing Phase 2 planning.
- Workforce updates including midwifery recruitment, student support and neonatal engagement initiatives.
- Progress towards BFI Gold accreditation and work addressing health inequalities in infant feeding.
- Development of midwifery-led clinic models and improvements to antenatal service flow.

Overall, the forum continues to demonstrate strong multidisciplinary engagement, open discussion and active leadership support for service improvement across perinatal services.

## 4.0 Maternity Care Bundle (MCB)

The MCB sets clear national expectations for greater standardisation of practice, stronger cross-speciality integration, enhanced monitoring of outcomes and inequalities, and more explicit Board-level assurance. Sherwood Forest Hospitals NHS Foundation Trust (SFH) is well-positioned to deliver the MCB within the national implementation timescales, supported by clear leadership ownership, established governance arrangements, and a credible phased plan to strengthen assurance further and improve outcomes over the next two years.

As of March 2026, the Trust is participating in the NHS England national webinar series covering each of the five MCB elements. Following completion of these sessions, a structured benchmarking exercise will be undertaken to assess the current position against national expectations. This will inform the development of a refined local implementation strategy and action plan.

An updated position and proposed next steps will be presented to PAC for review and assurance in July 2026. This work is being led by the Consultant Midwife, S Todd.

## **5.0 Perinatal Services QUAD Culture Project**

The Perinatal Services QUAD Culture Project marks the completion of a reconfigured perinatal leadership portfolio, established to strengthen clear, coordinated oversight of leadership across the full care pathway for women, babies, and families. The revised model brings greater alignment to accountability, acuity management, and escalation processes across maternity, neonatal services, the NICU, and Transitional Care.

### *5.1 Staff Survey 2025 Action Group*

As part of the next phase of this programme, the Perinatal QUAD has agreed that during 2026, the focus will be on supporting the Staff Survey Action Group, ensuring that the priority actions arising from the three agreed staff survey themes are embedded across the division. This will support sustained cultural improvement, strengthen staff engagement and ensure that learning from the staff survey translates into visible, practical improvements for teams across Perinatal Services.

An update on the work of this Action Group will be presented to PAC in July 2026.

## **6.0 Baroness Valerie Amos: an independent review**

The National Maternity and Neonatal Investigation, chaired by Baroness Valerie Amos, is an independent review launched in June 2025 to examine maternity and neonatal services across 12 NHS trusts in England.

The review aims to strengthen maternity safety, address racial inequalities in outcomes and investigate concerns relating to unacceptable standards of care.

The interim findings published in February 2026 highlight several areas of concern across services, including:

- Unacceptable standards of care
- Recurring safety and systemic issues
- Inequalities and racism in maternity care
- Failures to listen to women and families

The final recommendations from the review are expected in June 2026.

A comprehensive overview paper on the National Maternity and Neonatal Investigation, chaired by Baroness Valerie Amos, will be presented to PAC in March 2026 by Paula Shore, Director of Midwifery/Divisional Director of Nursing.

## **7.0 Escalation Policy – Silver On Call Support feedback**

The revised Escalation Policy and Silver On-Call support arrangements are now embedded across Perinatal Services, strengthening senior oversight and operational support during periods of pressure.

The requirement of the Silver on-call to support the divert process has improved access to timely decision-making and divisional coordination, particularly outside of normal working hours. On

several occasions, this approach has enabled the team to safely manage and resolve potential service pressures, including consideration of diverting activity out of hours, ensuring appropriate support and escalation routes are in place to maintain safe care for women and babies.

The Deputy Head of Midwifery (DHoM) and the Deputy General Manager (DGM) will continue to collate and respond to feedback from Silver on call, the Duty Nurse Management team and the SBU B7 coordinators.

## 8.0 Regional Director of Midwifery/Head of Midwifery Away Day

On 20<sup>th</sup> May 2026, we will be hosting the regional Heads of Midwifery, Directors of Midwifery and Consultant Obstetricians' Away Day.

This quarterly event will provide an important opportunity for regional colleagues to come together to share learning, discuss emerging national priorities and strengthen collaborative working across the maternity and neonatal system.

We look forward to welcoming the Regional Chief Midwifery Officer to the organisation for the day and showcasing the work taking place across our perinatal services while supporting wider regional partnership and improvement.

## 9.0 UNICEF UK Baby Friendly Initiative National Neonatal Project Final Report January 2026

The report presents the evaluation of a three-year national programme supporting neonatal units to implement the Baby Friendly neonatal standards, with a focus on improving skin-to-skin contact, breastfeeding outcomes and parent–infant bonding. Across the 18 participating units, the project demonstrated measurable improvements in practice, including increased duration of skin-to-skin contact, higher rates of babies receiving human milk, and stronger parental involvement in care, alongside significant cultural change supported by leadership commitment, staff training and improved facilities.

SFH's NICU is included as one of the participating sites within the National Neonatal Project and progressed through the Baby Friendly accreditation pathway during the programme, achieving Stage 1 and Stage 2 accreditation during the project period, reflecting continued development in embedding the neonatal standards locally. This progress reflects the dedication of our neonatal and infant feeding teams, and we must recognise and celebrate these achievements.

### The National Neonatal Project in numbers

#### By the end of the project:

- The average length of each episode of skin-to-skin increased from 43 minutes to a stable range of **73-78 minutes**
- The total minutes of skin-to-skin per baby across the audit week rose from 217 to **336 minutes**
- The percentage of babies receiving human milk in 24 hours after admission increased from **17% to 37%**
- The percentage of babies receiving human milk when they leave the unit increased from **26% to 52%**
- The percentage of mothers breastfeeding when they leave the unit increased from **19% to 44%**
- **94% of nursing staff and 90% of medical staff** had completed core training in the Baby Friendly Standards
- Three units achieved **Stage 1**, nine units reached **Stage 2**, and six units achieved **full accreditation (Stage 3)**

## **10. Summary**

Overall, the intelligence within this report demonstrates stable service delivery, strong governance oversight and continued improvement across perinatal services. Key priorities over the coming months include implementation planning for the Maternity Care Bundle, continued cultural development through the Perinatal QUAD programme, and ongoing work to strengthen escalation processes and service capacity.

PAC is asked to note the update and receive assurance that perinatal services remain focused on safety, learning and continuous improvement to support high-quality care for women, babies and families.

**Board of Directors Meeting in Public - Cover Sheet**

<b>Subject:</b>	Learning from Deaths (LfD)	<b>Date:</b>	02/04/2026		
<b>Prepared By:</b>	Dr Nigel Marshall (Chair- Learning from Deaths Group)				
<b>Approved By:</b>	Dr Simon Roe (Chief Medical Officer)				
<b>Presented By:</b>	Dr Simon Roe				
<b>Purpose</b>					
To provide an update summary of mortality intelligence reviewed by the Learning from Deaths group and advise of ongoing work to respond to findings and improve organisational and wider learning.		<b>Approval</b>			
		<b>Assurance</b>	<b>X</b>		
		<b>Update</b>	<b>X</b>		
		<b>Consider</b>			
<b>Strategic Objectives</b>					
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 estates	Work collaboratively with partners in the community
<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>		<b>X</b>
<b>Principal Risk</b>					
<b>PR1</b>	Significant deterioration in standards of safety and care				<b>X</b>
<b>PR2</b>	Demand that overwhelms capacity				
<b>PR3</b>	Critical shortage of workforce capacity and capability				
<b>PR4</b>	Insufficient financial resources available to support the delivery of services				
<b>PR5</b>	Inability to initiate and implement evidence-based Improvement and innovation				
<b>PR6</b>	Working more closely with local health and care partners does not fully deliver the required benefits				<b>X</b>
<b>PR7</b>	Major disruptive incident				
<b>PR8</b>	Failure to deliver sustainable reductions in the Trust's impact on climate change				
<b>Committees/groups where this item has been presented before</b>					
Learning from Death Highlight Report is presented at Patient Safety Committee (PSC) quarterly					
<b>Acronyms</b>					
<ul style="list-style-type: none"> <li>• <b>SFH(T)</b> - Sherwood Forest Hospitals (Trust)</li> <li>• <b>SHMI</b> - Summary Hospital-Level Mortality Indicator</li> <li>• <b>HSMR</b> - Hospital Standardised Mortality Ratio</li> <li>• <b>HSMR+</b> - Hospital Standardised Mortality Ratio "Plus" (Telstra metric)</li> <li>• <b>HED</b> – Healthcare Evaluation Data</li> <li>• <b>VLAD</b>- Variable Life Adjusted Display (charts)</li> <li>• <b>CUSUM</b> - Cumulative Sum</li> <li>• <b>SJR</b>- Structured Judgement Review</li> <li>• <b>LfD</b> – Learning from Deaths (Committee)</li> <li>• <b>SPC</b>- Specialist Palliative Care</li> <li>• <b>EOL</b>- End of Life</li> <li>• <b>ReSPECT</b> - Recommended Summary Plan for Emergency Care and Treatment</li> <li>• <b>PSIRF</b>- Patient Safety Incident Response Framework</li> <li>• <b>ICB/S</b>- Integrated Care Board / System</li> <li>• <b>LMC</b>- Local Medical Council</li> <li>• <b>LD / LeDeR</b> Learning Disabilities / Learning Disabilities Mortality Review</li> <li>• <b>ICB / ICS</b>- Integrated Care Board / System</li> </ul>					

## Executive Summary

### Summary:

This report provides an overview of mortality intelligence reviewed by the Learning from Deaths Group for Q3 and Q4 of 2025-26. It seeks assurance on current performance (and process) alongside outlining future intentions and priorities for the group and wider trust.

### Key Metrics: (Values as of 19.03.2026)

- **SHMI** (Summary Hospital-Level Mortality Indicator) NHS Digital: **1.0423 ("as expected")**
  - SHMI is the key mortality metric referenced in the "NHS performance framework".
  - Previous report (Q1-Q2) = 1.0686
  - The SHMI has continued to be in band 2 ("as expected") over the reporting period.
- **HSMR** (Hospital Standardised Mortality Ratio) HED: **97.1** (excl. SPC adjustment); Jan-Dec25
  - Trust formal tracking of HSMR (and HSMR+) stopped, as of Oct 25, due to the Telstra (Dr Foster) contract ceasing and SHMI being recognised as the key mortality metric.

HED (Healthcare Evaluation Data) modules have been updated with data for Month 9 (December 2025)- there is a lag due to the necessity of data checks and validation.

The report highlights key areas of work, including:

- Mortality intelligence and focused divisional / speciality mortality reporting
- Themes of focus and learning- accuracy of coding and documentation, importance of effective communication and emphasis on End of Life (and ReSPECT).
- Updates to Mortality benchmarking provider and In-House functionality.

### Clinical Reviews and Learning:

- Outlier summary-
  - Identified areas: intestinal infection and pneumonia- for further review / monitoring
- Structured Judgement Reviews (SJRs)- acute hospital deaths:
  - Q3- 26 raised (459 total deaths) = 5.7%
  - Q4 (to 21.3.26) – 28 raised (404 total deaths) = 6.9%
  - SJR requests for 2025/26 (to date) represent approximately 7% of total deaths.
- Use of Datix-IQ platform and further development of Power BI dashboard.
- LeDeR Reviews: 3 received; LD nurse continues to support system-wide learning
- Coronial Cases (Q3):
  - 9 inquests heard and concluded with improvements / learning
  - 2 Regulation 28 (Prevent Future Deaths) reports received
- Governance and Assurance:
  - 360 Assurance Independent Review highlighted areas for improvement and greater assurance- actions identified include revision of Mortality Management (Learning from Deaths) Policy alongside clarification of governance process regarding SJRs and wider Learning from Deaths.

### The Board is asked to note:

- The continued focus on clinical engagement with emphasis on clear documentation and effective communication between patients, families and clinical teams.
- HED (new mortality benchmarking provider) implemented December 25, aligning best value to Trust with potential improvements to ICB partnership working.
- Ongoing focus on divisional or speciality ownership of data and governance, with attention to the value of clinically led learning and actions.
- Reporting of "key themes" by speciality areas with further embedding of "BIG5" summary communication to support sharing across Trust and wider forums.

## Mortality Surveillance

### SHMI- Crude and adjusted mortality rates

Latest SHMI reporting values are for the period Nov 2024 – Oct 2025 (March 2026 reporting)  
Source- NHS Digital and HED (Healthcare Evaluation Data)



- The Trust currently reports being “as- (or within-) expected” values for SHMI
- SHMI value has seen a general downward trend over recent months, with a minimal upturn in the last reporting month.

The contract with Telstra (Dr Foster), and therefore formal HSMR(+) reporting, finished in September 2025, after a 12-month extension. This additional period was, in part, intended to help the Trust understand and experience the impact of the modelling changes and revised mortality index, Hospital Standardised Mortality Ratio “Plus” (HSMR+), introduced by Telstra. HSMR+ was understood, and reported, to be more robust and based on improved metrics and standards; removal of Palliative Care adjustment from the model was one of their key changes.

Further analysis showed correlation when comparing against the trend for the Summary Hospital-level Mortality Indicator (SHMI), which had also seen a more consistent reporting of “as expected for the Trust.” In addition, the SHMI had been acknowledged as the key performance indicator within the NHS England Oversight Framework.

At the point of moving, HSMR+ reporting had demonstrated SFHT to be “as expected” compared to previously being an outlier for historical HSMR reporting. To note, the last formal Telstra report highlighted no new triggers when triangulating across the different reporting metrics (HSMR+, CUSUM and SHMI) and no fresh concerns or significant highlights to bring to the Trust’s attention.

The Trusts relatively stable mortality position, as shown by both SHMI and HSMR+, alongside the decision to focus on SHMI as the key mortality metric, provided an ideal opportunity to explore improvements in data provision, align with NUH to help support improved data and mortality intelligence, and led to the decision to change mortality benchmarking provider.

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

December 2025 saw the implementation of Healthcare Evaluation Data (HED), developed by University Hospitals Birmingham NHS Foundation Trust, as the mortality benchmarking tool and platform at SFHFT. This was after a period of discussion at system and local level and the thought that alternative provision could not only support provision of the necessary functionality but enhance the potential for improving data analysis, alignment and collaborative working with our neighbouring trust and colleagues, alongside greater engagement of clinical teams. The Trust is currently undertaking more detailed understanding of functionality, metric analysis, and

wider roll-out / training with divisions, teams, and individuals, including those who hold positions within mortality oversight and Learning from Deaths.

HSMR+ is no longer formally monitored by SFHT, but the HED platform reports a version of HSMR (without adjustment for Palliative Care), helping with assurance in previous values, monitoring, and potential triangulation.

Although it is recognised there are different models available with which mortality data can be analysed and reported, there has been a great deal of work within the Trust to identify what information is required and how local information and analytics can work with other sources to support greater understanding and assurance of reporting.

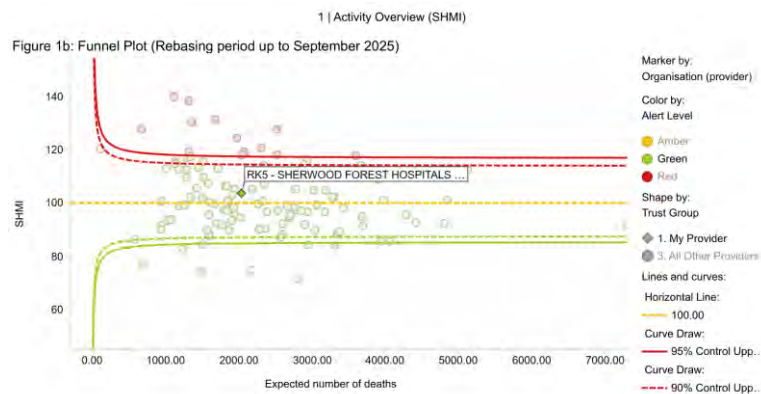
Common to all data sources is a reliance on accurate and relevant data being provided; factors which play into this include clear documentation, capture of co-morbidities, correct and consistent alignment to coding, and timely and accurate diagnosis. These work towards reflecting complexity of the patient and support a more assured picture of activity being undertaken.

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

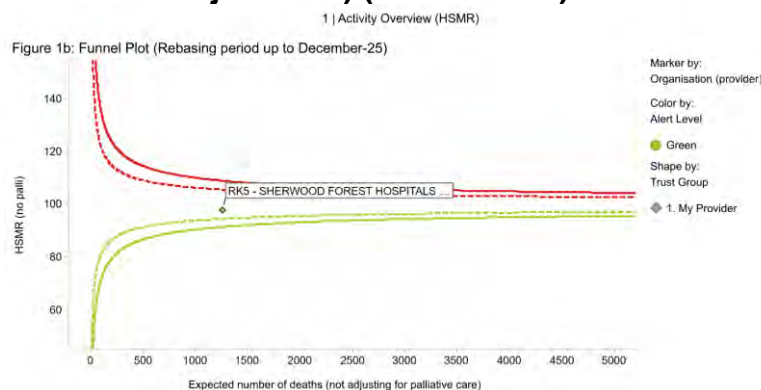
### Peer comparison (Last 12 months)

Peer analysis continues to see SFHT within the middle of the funnel-plot distribution for both SHMI and reported values for HSMR (excl. Palliative Care adjustment) provided by HED.

### SHMI (HED Extract)



### HSMR (without Palliative Care adjustment) (HED Extract)



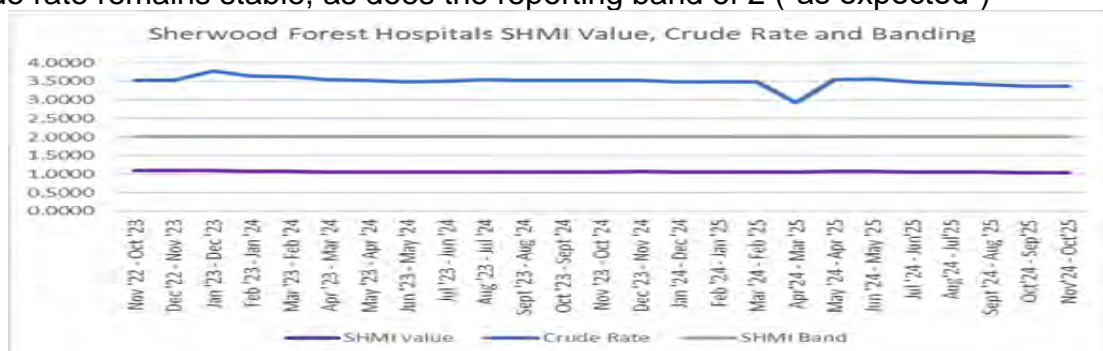
## SHMI Value

SHMI continues to report “as expected” with an overall reduced value over the past 5 months.



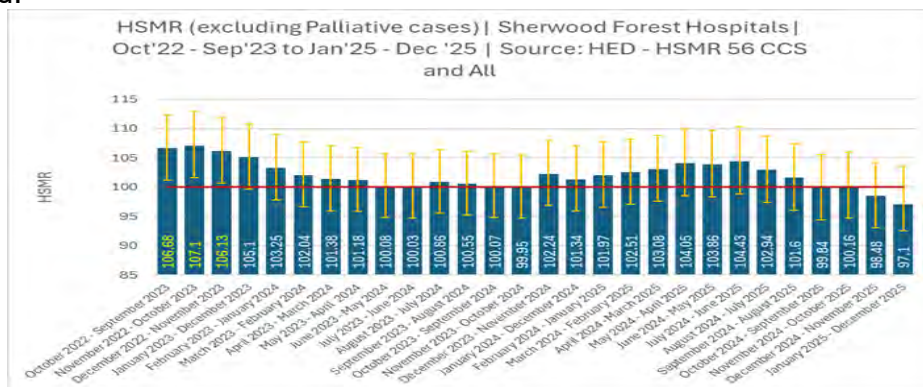
## SHMI Crude Rate

The crude rate remains stable, as does the reporting band of 2 (“as expected”)



## HSMR Trends (HED Data):

Background HSMR monitoring (without Palliative Care adjustment) shows a continued “as expected” trend.



## Outlier Areas:

To support data analysis and triangulation, VLAD (Variable Life-Adjusted Display) charts support monitoring of SHMI for specific clinical diagnoses. Alongside this, CUSUM alerts, derived from cumulative sum statistical process control charts, plot patients’ actual outcomes against their expected outcomes sequentially over time with a breach triggering an alert.

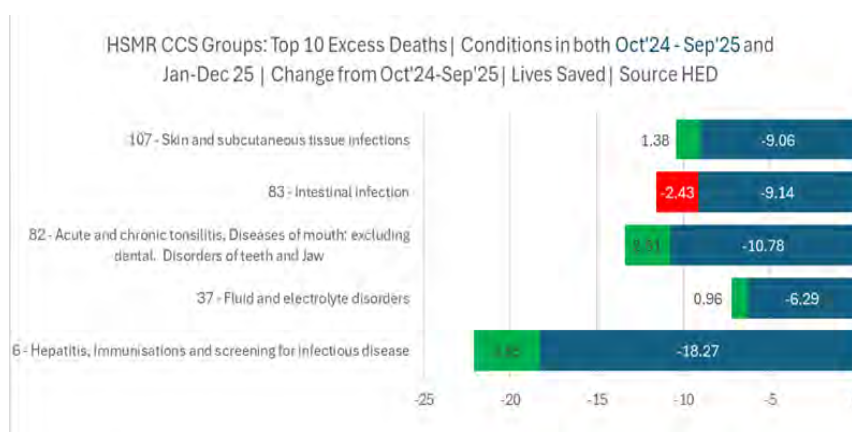
The insights team are currently in the process of understanding the wider functionality of HED and how, alongside in-house data, it can provide a more assured picture of mortality and identify opportunities for learning in a more-pro-active manner.

Although headline metrics are stable and report “as expected”, preliminary scoping has been undertaken, using both VLAD and CUSUM methodology, to highlight deteriorating changes and consider overlap of top 10 diagnosis areas. Initial overlap for top 10 “excess deaths” (HED SHMI VLAD) and variance between observed / expected (HSMR CUSUM) include:

- Intestinal Infection
- Gastro-intestinal haemorrhage
- Fluid and Electrolytes

Further evaluation and monitoring are to be undertaken as to trends and triggers. It is also noted that challenges with data occur due to differences in reporting periods and comparator assumptions as to where deaths may be likely to occur (SHMI also considers deaths occurring within 30 days of discharge from acute setting).

When focusing on VLAD top 10 excess deaths, 5 conditions were identified to trigger in both Dec 24–Nov 25 and Oct 24–Sept 25 periods; however, all but one (Intestinal infection) showed improvement. This diagnosis also showed on top 10 CUSUM variance of observed v expected. As a result, this area has been highlighted for further evaluation, including review of coding.



#### • Intestinal Infection:

- Previously highlighted HSMR alert Mar 2025
- Last CUSUM patient level trigger- Sept 25
- No further reported CUSUM alerts in this diagnosis group over the last 3 months
- Previous clinical review highlighted alternative diagnoses, potentially non-infective, but presenting as non-specific abdominal symptoms.
- This has been raised within Learning from Deaths for re-review, including coding.

In addition, Pneumonia has been highlighted as one of the diagnosis areas with high volume trigger in VLAD but not through CUSUM; this area has also been highlighted for further review and monitoring.

#### Clinical Coding:

Latest reports from the coding team highlighted the finished outlier review for “anaemia and deficiency”. All planned audits from Telstra reporting had been completed with no new or outstanding queries.

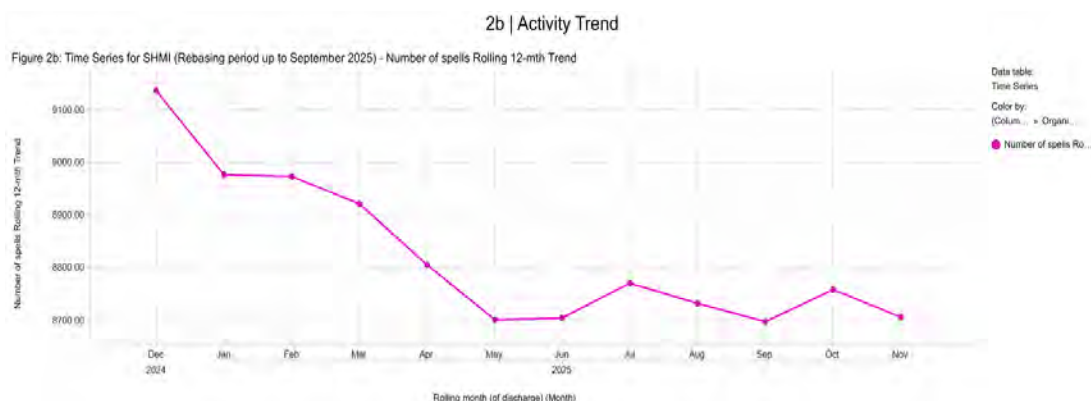
More recent focus has been on review of specific coding irregularities, including R69.x (Unknown and unspecified causes of morbidity) in primary diagnosis positions- initial investigations confirms zero inpatient admissions but the need to ensure accounting for how the data is recorded and captured to ensure clarity and understanding; further work is planned.

In recent years, emphasis has been placed on the significance of precise and timely documentation, highlighting its impact on coding.

The Trust had previously felt “Depth of coding”, including accurate capture of diagnoses and co-morbidities, to be a key factor in explaining the gap between observed and expected rates. In

addition, an improving (reducing) picture for symptoms and signs coding is thought to correlate with enhanced diagnosis capture and supports data quality. Further work includes linking with a peer trust, recognised as benchmarking well in this area, to help identify areas of improvement.

## Percentage of Spells in Symptom and Signs Chapter (Rolling Trend)- HED extract



Ongoing reminders and educational opportunities are regularly incorporated into different forums and clinical team discussions, as well as formal meetings, to ensure coding remains a priority. This emphasis helps maintain the quality of data upon which our understanding depends.

To further support understanding, enhance effectiveness, and help improve quality of clinical coding practice, departmental data is being collated from East Midlands Acute Providers (EMAP) for benchmarking purposes.

Moving forwards, the coding team are keen to assist the wider Learning from Deaths agenda through specific outlier reviews, procedure coding and continuing their work with speciality areas on co-morbidity coding improvements.

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

### End of Life Care (EoL):

Due to the nature of strict criteria and previous inclusion within metrics, the Trust has historically been reported an outlier in terms of "Specialist Palliative Care" coding. The new HED platform allows for continued monitoring and is part of the wider plan for ensuring understanding, capture and sharing of important information.

The last quarterly report (verbal) highlighted:

- Concerns / complaints with 2 specific references to communication around dying and transfers from Kings Mill Hospital.
- Compliment for Ward 23 - good End of Life Care
- Continued roll-out of the Amber Care Bundle; improvements to staff training and non-medical prescribing to support enhanced working with clinical teams and patient care.
- Post 48-hour audit, continued efforts to enhance pathways for patients admitted to the ED whose preferred place of death is at home or in a care home.
- Developments to the End-of-Life Care Hub to support effective utilisation of resource, assist families and carers, and help with potential admission avoidance.

A CQC visit was noted to have taken place in Q3 for which the formal report is awaited.

**NACEL (National Audit of Care at End of Life):**

In Dec 2025, an audit summary discussion took place to review outcomes from the 2024 NACEL report. This allowed for benchmarking, sharing of understanding and highlighting future improvements and aspirations. Specific feedback and discussion centred around the good work being undertaken and importance of being able to demonstrate a consistent approach to working, alongside the vital aspect of continuity of care, especially regarding sharing information and effective communication. Involving families and patients in discussion was raised as an area of focus and importance, especially Advanced Care Planning and the ReSPECT process. This audit and multi-disciplinary discussion have provided the EoL service (and Trust) with a foundation to move forwards and set goals to maintain and achieve high levels of quality and care for our patients.

**ReSPECT:**

Improvements and developments are ongoing, including a focus on timely and effective identification of patients who are deteriorating or approaching end of life, meaningful and clear advanced care planning (for which documentation, such as ReSPECT, plays a key part), and more effective ways of ensuring patient's wishes are considered. Recent approaches have included "sticker notification" for Specialist Palliative Care involvement / awareness. In addition, the ReSPECT group are working with the Trust and wider system to support mobilisation of an electronic version of the ReSPECT form, thereby enhancing communication and effective capture of information relating to patient care and their wishes / plans. Funding for a digital ReSPECT solution to be delivered via the Notts Shared Care Record has been agreed and this will be managed via the ICB EOL board. ReSPECT and EoL awareness and education are delivered through various formats, including Grand Rounds, alongside offers of targeted training for areas or specialties.

**Learning Disabilities (LD)- Feedback from LeDeR Reviews:**

The January report to Learning from Deaths referred to Q3 (Oct – Dec) 2025.

Within Q3 there were 4 deaths reported to LeDeR of patients with a learning disability in the Trust, with no cases where death was felt to be avoidable. LeDeR redacted reviews, relating to patients who have died whilst at Sherwood Forest Hospitals, are shared with the Trust and can support thematic learning across the organisation; of three returned case reviews, two had no further comment or identified learning for the Trust and one related to a patient who died at NUH after transfer for further investigation, highlighting the importance of discussion and clinical decision making to assess appropriate transfer approaches.

Clinical teams have been encouraged to have greater awareness and utilise the resource of the LD team, with a recognition of the importance of documenting interactions. This has been highlighted in the BIG 5 communication to divisions and for sharing amongst speciality areas.

The LD Nurse is involved with the LeDeR working group and ICB LeDeR reviewers, being able to support with information and opportunities to review the paper records, as required.

**Divisional Reporting:**

Divisions and Specialty leads report into Learning from Deaths on a quarterly basis; this approach includes a reporting template, in addition to any verbal update, whereby further discussion and actions can be evaluated.

Examples of highlights and themes:

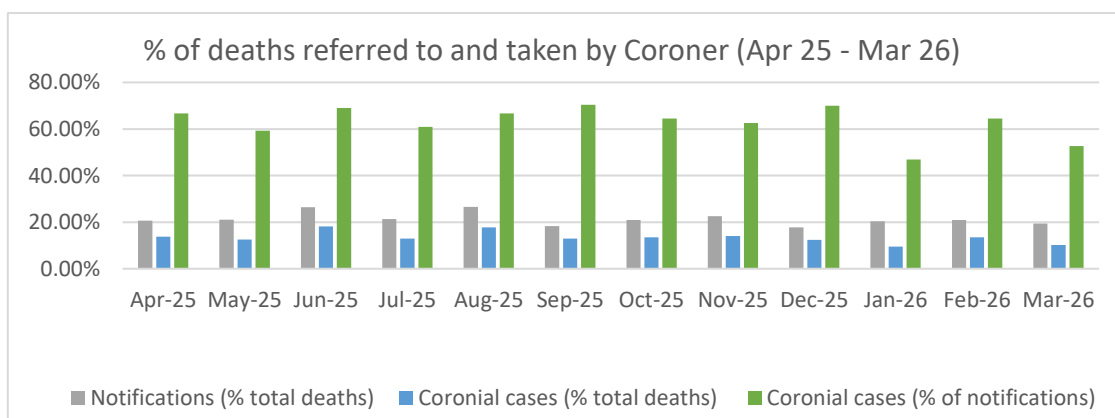
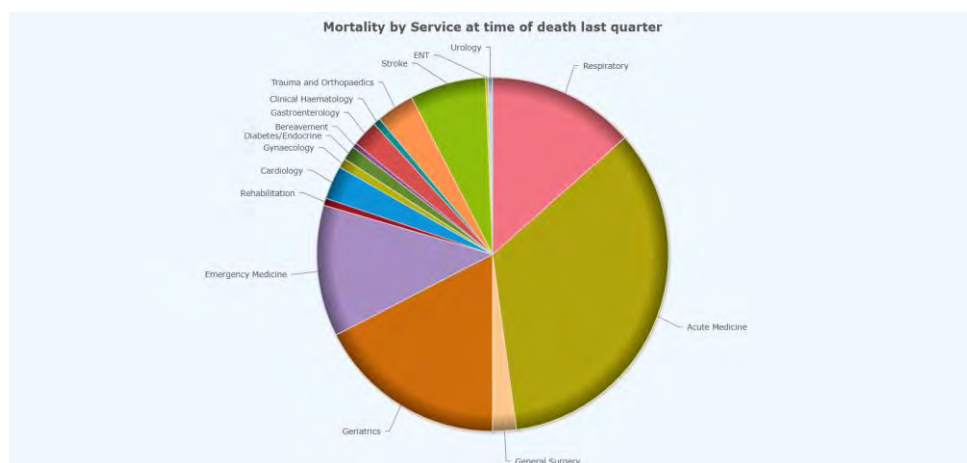
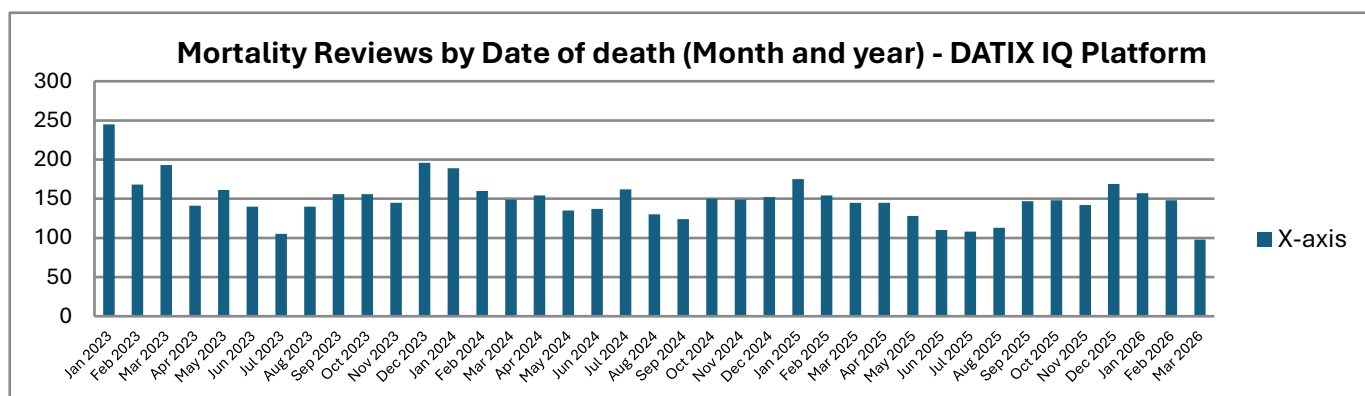
- Previous concerns / themes- VTE (assessment) performance. Overcrowding and flow (ED to wards) impact remain on agenda, within wider reporting and as part of discussion.
- Continued - communication, documentation (ceilings of care), timely specialist input.

- Early identification of End-of-Life care and use of specialist Palliative Care resource
- Specific case- long QT syndrome- planned ECG training and sharing amongst divisions.
- Child Death Review: theme- collisions on motorbikes, e-bikes or cars; parental smoking.
- Alignment of paediatrics with CDOP; identified need for Bereavement Nurse
- Women and Children Division- Progress with surgical pathway between SFH and NUH
- Surgery- Daily STOP moment implemented across Trauma MDT- capacity and demand
- Critical Care- ReSPECT, staff Simulation (Sim) Training in place for major haemorrhage.
- Medical Examiner- urology cases raised with surgical division; report / feedback awaited

## Review of deaths and SJRs

Legislative changes to the process of Death Certification and role of the Medical Examiner have been in place since September 2024, with the Medical Examiner Service providing independent and proportionate scrutiny of all cases.

## Data from the Medical Examiner Service and LfD Dashboards (Datix IQ):



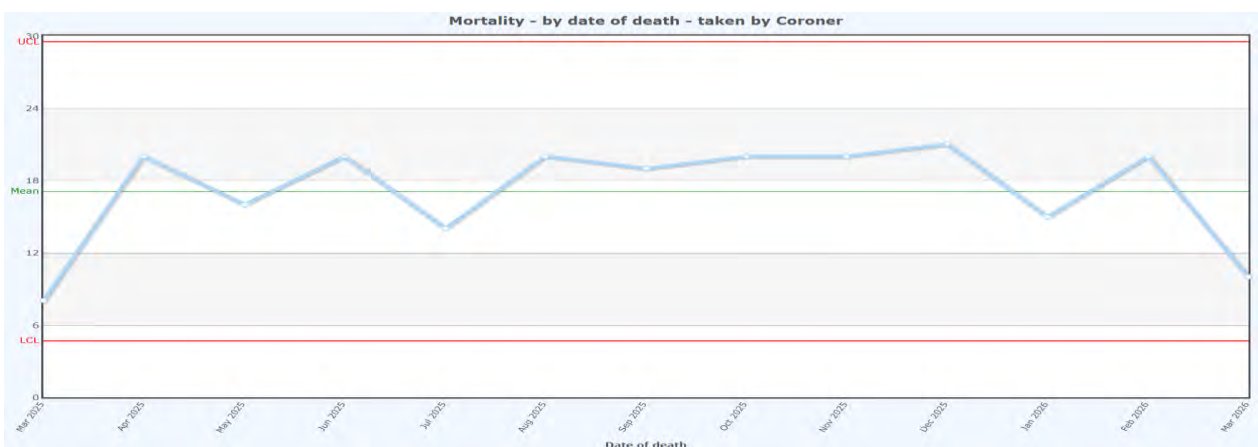
Reporting from the Medical Examiner and Bereavement services are acknowledged to be slightly different to that from DATIX IQ because of potential variance in data entries (including timings, recording at death or scrutiny) and aspects of data cleansing.

**Medical Examiner / Bereavement Centre Q3 reporting summary:**

- 998 deaths processed
- Acute-
  - 452 adult deaths- 361 MCCD issued, 91 referred to coroner (54 taken over)
  - 1 child death – case taken for postmortem
- Community-
  - 545 adult deaths- 402 MCCD issued, 143 referred to the coroner (116 taken over)
- Acute cases have seen 28 SJRs raised for the Q3 period, including 7 mandatory Learning Disability / Mental Health related cases.
- Interaction with families was just under 99% across both acute and community settings; the 11 cases where no interaction was undertaken reported no Next of Kin (NoK)
- There was 1 urgent release case, reported to be managed appropriately with no delays.
- Reported average days from death to registration are 5 days (acute) and 9 days (community).

Work continues to ensure a high-quality service is maintained, with a focus on minimal delay to processing, effective discussion with the clinical team (as part of the scrutiny process), clear process for coronial referral and / or raising concerns and interaction with the family / NOK. Matters needing detailed review and reports, including FROE (Factual Recollection of Events) documentation, and feeding into patient safety investigations is a part of the continual improvement and governance assurance process.

**Mortality- Coroner Notifications and Taken by Coroner:**



## **Structured Judgement Reviews:**

The SFHFT DATIX IQ mortality review tool provides data on internal trust related deaths and has been operational since October 2024. Mortality reviews are managed by this platform which has the capacity to capture Structured Judgement Reviews (SJRs), avoidability assessments and other learning outcomes. Prior to access, users are required to undergo training in both use of the DATIX-IQ platform and SJR methodology.

The Trust continues to approach case-note review methodology in the form of Structured Judgement Reviews (SJRs) to support its approach for further investigation and learning.

Mortality leads are responsible for their specialty / divisional SJR submissions; it is felt this process supports the drive for clinical and divisional ownership, helps meet improved standards for quality assurance and provides consistency in the Trust approach to mortality reviews and wider learning. Mortality and Clinical Leads are encouraged to ensure timely SJR completion and sign off to ensure the system is as up to date as possible. Information from this is used to support Specialty and Divisional teams with their governance processes, assurance measures, and overall learning.

The latest Structured Judgment Review update (March 2026) highlighted the ongoing development of the Power BI dashboard, which includes SJR data, and can be “tailored to Divisional and Speciality views for most measures.”

Work is ongoing to support individual speciality requirements, with a focus on speciality and divisional accountability, process and governance. Dashboard functionality includes reviews open for over 45 days alongside tracking of progress against staged review completion.

SJR “overall phases of care” are a part of reporting with the predominant rating currently reported being that of “good”. Where poor care is identified, the escalation process includes review through Divisional Governance meetings and Patient Safety Incident Review Group (PSIRG). This supports identification of cases requiring a Patient Safety Incident Investigation (PSII) under the Patient Safety Incident Response Framework (PSIRF) where it is believed a problem in care has more than likely contributed to a death.

### **SJR quarterly reporting to LfD – DATIX IQ outputs (as of 03/03/2026):**

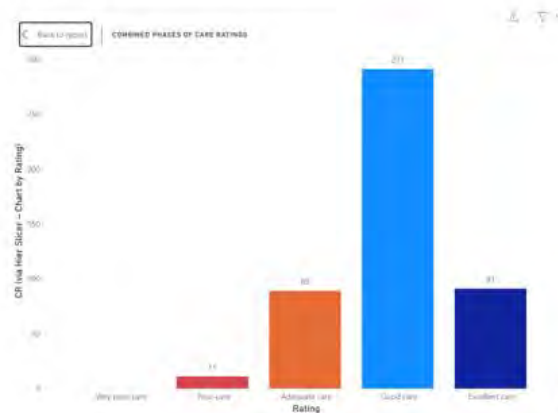
- 158 SJRs have been requested on the new system, with monthly requests not showing any clear special cause variation.
- 94% SJRs had been raised by / via the Medical Examiner Service, with approximately a quarter of these being LeDeR cases
- Increase noted in proportion of SJRs waiting to be both done and completed (closed).
  - The report highlighted recently approved job descriptions for Divisional and Speciality-level Mortality and Governance Leads which should allow clarity and sufficient job-planned time to undertake governance activities.
- Summary template report highlighted good engagement with training but improvements still to be made around:
  - Effective SJR completion and reducing residual “blank fields” (an identified action for the SJR lead alongside the Medical Examiner Office and Bereavement service)
  - Further clarity around how SJRs fit in with other processes after death; this is hoped will resolve with revision of the Mortality Management (Learning from Deaths) policy.

Work continues between the Clinical Director for Patient Safety, Divisional Governance Leads and GSU to support consistent approach to oversight, sign off and other governance processes.

## Outputs from DATIX-IQ- SJR Report (March 2026)

### Outcome

#### Trust Level Phases of care ratings



#### Individual phases of care breakdown



### DATIX-IQ reporting (Acute Deaths)- Q1-4 (2025-26):

2025 / 26	Q1	Q2	Q3	Q4 (to 21.3.26)	TOTAL
<b>Mortality by Date</b>	383	368	459	404	1614
<b>Coroner Notified</b>	86	80	93	82	341
<b>Taken by Coroner</b>	54	53	61	45	213
<b>ME Requested SJR</b>	46	18	26	28	118
<b>SJR Quarter (%)</b>	12.0	4.9	5.7	6.9	<b>7.3</b>

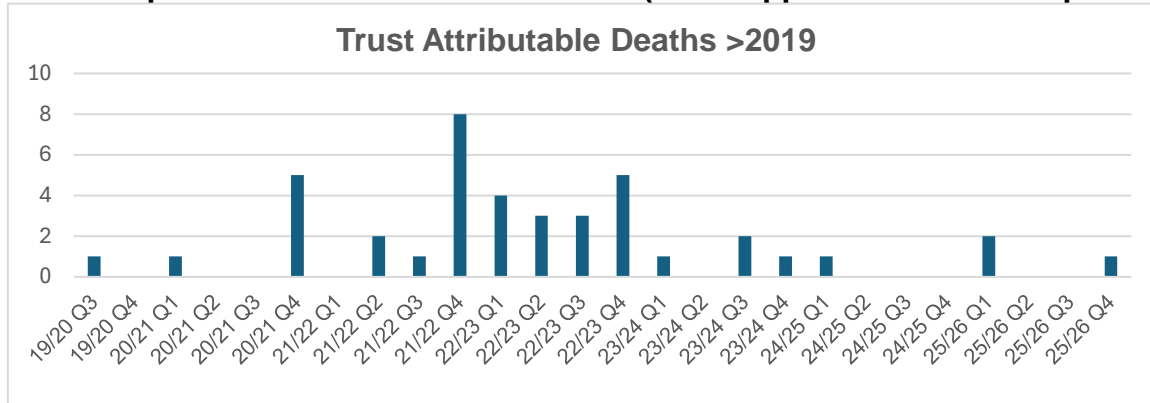
Previous issues in Q2, relating to TGRs (Trust Governance Review) data, are now understood to be resolved; SJRs are requested and captured through DATIX-IQ. Requests include statutory cases (e.g. LeDeR (Learning from Lives and Deaths – People with a Learning Disability and Autistic People) and patients detained under the Mental Health Act) alongside cases where concerns or issues have been raised during patient management, family contact and as part of the ME scrutiny process.

For SFHT, SJR requests for the 2025/26 period requests represent approximately 7% of total deaths. The National Medical Examiner Report 2024 (published Sept 2025) indicated Medical Examiners in England referred around 7 to 8% of deaths in acute trusts for case record review or equivalent, and 5 to 6% of all deaths for some form of clinical governance review.

## Feedback and Serious Incident Investigations from Coroner:

There is a requirement to report to board an estimate of deaths where a problem in care has been felt to contribute to a death. STEIS and PSII are felt to provide insight into these cases, with these being regularly taken for coronial investigation. Investigations and inquests can take months to conclude and report; however, learning will be reported as becomes available. Numbers over the past 5 years appear reasonably small. It is understood 3 cases for 25/26, identified as pertaining to potential “catastrophic harm”, have been escalated through the coronial process.

## Deaths where a problem in care has contributed (Trust-apportioned catastrophic harm):



## SFHT Legal Service Inquest Report:

Q3 (2025/26) report to Learning from Deaths highlighted the following:

- Between Q1 and Q3 2025-26, SFHFT Legal Services reported 93 newly open coronial matters. This contrasts to 130 for the full 2024/25 reporting period.

Quarter 3 reporting:

- 11 inquests and 12 investigations have opened in relation to new coronial matters.
- 20 investigations have closed without inquest
- 9 inquests have been heard and concluded with outcomes including accident / misadventure, industrial disease, narrative conclusion and natural causes.
- 2 Regulation 28 notifications received; the previous notification was over a year ago.
  - Notable conclusions included a paediatric case and improvements in both learning and process for diagnosing long QT syndrome (heart condition abnormality on ECG). A further case, involving a jury inquest for a patient detained under the Mental Health Act, highlighted the need to address issues around communication between acute and mental health trusts. Action plans support the assurance process and include work on pathway improvement, targeted teaching and sharing of specific learning
- A further case with identified learning but no regulation 28 was highlighted, relating to delay in diagnosis of urological cancer.

Requests for information by the coroner or other cases of legal enquiry have highlighted the challenges in ensuring accurate recall and account of incidents. As part of its drive for improvement, the Trust has implemented, and encourages use of, a Factual Recollection of Events (FROE) template to help provide a clear factual description of involvement in an event at the time it occurred. The Governance Support Unit (GSU) plays a key role in supporting the team individual(s) to undertake this task.

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

## **Learning from Deaths (LfD) Meetings at SFHT:**

These occur monthly and continue to have trust-wide multi-disciplinary engagement. The forum supports discussion and review of themes arising from clinical reporting, data and other trust (or specific) identified areas of concern or importance.

Divisional and speciality reports are received and presented as a rolling agenda item; active discussion and review of mortality trends are supported through involvement of the Insights and Clinical Coding teams, alongside engagement from our Medical Examiner and Bereavement Services. The Improvement and Information Analyst Teams have been integral to providing assurance of underlying data alongside helping guide how the Trust uses data to improve wider learning and improvement

The last year has seen a purposeful shift to encourage thematic learning and placed a greater emphasis (and accountability) on clinically led oversight of good care and performance in relation to mortality and learning. Divisional reporting continues to report recurring themes related to communication, ceilings of care, early recognition of EOL and specialist palliative provision; these remain a focus for the Trust.

Moving forwards, there is a desire to embrace the functionality of HED and, alongside developments related to the Power BI dashboard, encourage pro-active clinical ownership of data at all levels (both divisional and speciality). Opportunities for specific training on data, coding and tools such as HED are in the plans for the coming year.

Initiatives to aid consistency in reporting and enable sharing of key information have become more embedded over the past 6 months. The standardised reporting template (to highlight themes and learning actions) is used by most speciality / divisional areas as part of their regular reporting. In addition, the BIG 5 communication to triumvirates (and divisional Heads of Service) is felt to be a simple, but effective means by which to share a summary of some of the key themes for review and learning.


Besides the bi-annual Learning from Deaths summary report to the Board of Directors, Patient Safety Committee (PSC) receives a Learning from Deaths quarterly highlight report, accompanied by a summary dashboard of some key high-level metrics and performance data; this committee escalates and feeds into the Quality Committee.

## **Wider learning, accountability and collaboration:**

System wide understanding is supported through the regional / ICB Learning from Deaths forum; this is still in the early stages but is an ideal platform to improve sharing of information, monitoring understanding themes on a larger scale. Consistent reporting templates and reporting should help with accountability but more effective sharing of information.

The Mid-Notts "Interface Workstream", which includes Primary and Secondary Care, alongside involvement from Local Medical Council (LMC) and ICB colleagues continues to be a useful group by which challenges at the interface or recurring themes can be raised and fed into working groups (or specific pieces of work) allowing a system-wide approach to considerations around effective patient care. This is particularly pertinent with areas such as End of Life.

## Standardised Divisional Reporting Template:

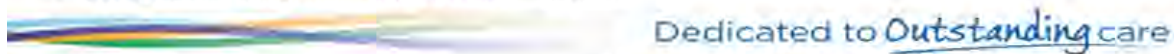
Learning from Deaths – Divisional Summary Report (2025/26)			Sherwood Forest Hospitals  NHS Foundation Trust	
REPORTING PERIOD		Standard Quarterly LfD Report		
DIVISION		Targeted Review (Diagnosis Group)		
DIVISION LEAD		Other		
SUMMARY OVERVIEW				
Total Deaths in period		Number of cases with potential sub-optimal care		
SJR's Undertaken		Please confirm ALL /any cases with highlighted issues or themes felt contributory to (or to have had any impact on) death have been escalated / managed appropriately		
Coroner referrals				
KEY THEMES AND LEARNING (Summarise recurring / pertinent themes e.g. communication, documentation, pathways.....)				
1:				
2:				
3:				
AREAS / EXAMPLES OF GOOD CARE:		AREAS OF SUB-OPTIMAL CARE / EXAMPLES FOR IMPROVEMENT:		
1:		1:		
2:		2:		
ACTIONS IDENTIFIED:		RESPONSIBILITY	DUE DATE	PROGRESS
1.				
2.				
3.				
IMPACT OF LEARNING (Measurable outcomes / changes)		FEEDBACK (How has learning been shared?)		
1:		1:		
2:		2:		
OTHER INFORMATION (for reporting / sharing):				

## The BIG 5 (Example- Q3 2025/26):

### Learning from Deaths – “The BIG 5” Learning Themes for Q3 2025



- **1 Mortality Metrics:**
  - SHMI (Summary Hospital-Level Mortality Indicator) remains “as expected”.
  - HED (Healthcare Evaluation Data) is the Trust's new benchmarking tool and is now “live”; Divisions / Specialities are encouraged to familiarise and use the tool; “super-users” are available to help teams and individuals understand their mortality data and areas of focus.
- **2 Documentation and effective communication** remain priority areas:
  - The value of communication between teams, prompt referrals and timely patient reviews / face-to-face advice.
  - End-of-Life (EoL) Care highlighted as an area of focus with a reminder for timely identification, pro-active implementation and completing documentation. Recent EoL audit included emphasis for advanced care planning and ReSPECT. *For training opportunities (please contact the EoL Care Team).*
- **3 Governance and SJRs-**
  - Ensure familiarity and adherence with Governance processes (including Divisional / Speciality)
  - Importance of reporting, escalation and learning outcomes.
  - Complete requests for SJRs in a timely manner (using DATIX IQ). SJR is a recognised case-note review methodology.
    - o *For training opportunities, please contact Patient Safety Specialist and SJR Lead.*
- **4 Example key themes:**
  - Communication and documentation of ceilings of care reported to be good in a number of reviews
  - Importance and value of early speciality involvement and MDT care
  - Request and report (document) Learning Disability Nurse input, where required
  - VTE risk assessment and completion (reminders for effective review, prescription and Nerve Centre use)
  - Sepsis- screening and bundle adherence
- **5 Case Highlight:**
  - ECG Interpretation- “Long QT”- identification and further training identified



## Assurance- Learning from Deaths and SJR methodology:

In mid-2025, an Independent review of Learning from Deaths was commissioned (360 Assurance); the audit summary “opinion” highlighted areas for improvement and further assurance regarding reporting alignment with workplans, updates to the Mortality Management Policy, and greater clarity of the SJR process. Actions have been identified, including a revision of the Mortality Management Policy and the Terms of Reference, with these having an agreed timeframe for completion and being managed through Audit and Assurance committee.

## **Reflections on Q3&4 2025/26**

### **Original Plans:**

- Embed new benchmarking approach (including established contract with provider and enhanced use of internal support).
- Standardisation- use of Divisional Reporting Templates to:
  - Aid consistency and provide a framework for use in reviews of mortality.
  - Identified themes and improve learning and feedback.
- Sharing of Information and Learning:
  - Use of “BIG5” as a source for direct communication of learning themes
  - Make the most of opportunities (e.g. Grand Round) and encourage wider involvement / engagement from specialities and other areas.

### **Summary of Key Themes:**

- End of Life Care and the ReSPECT process appear to be recurring priority areas, specifically advanced care planning, timely identification of the deteriorating patient and effective escalation. It is hoped the development of an electronic ReSPECT form will help with collaborative working and more seamless care across organisations and securing funding for this at a system level is a significant step forward.
- Effective communication and timely and accurate documentation remain key parts for supporting and maintaining high-quality care and effective patient management.
- Understanding the principles of clinical coding and how good documentation can help provide a clear and more reflective account of activity.

### **Benchmarking / Mortality Intelligence:**

- SHMI is the measure identified in the Performance Framework and has become the established mortality metric for benchmarking at the Trust.
- December 2025 saw the launch of Healthcare Evaluation Data (HED) platform at SFHFT. Although early days, it is hoped this will support a more comprehensive approach to benchmarking, greater engagement of clinical teams, and alignment with neighbouring colleagues, where system-wide discussion can potentially take on greater meaning.
- The Trust Power BI dashboard continues in its development, the intention being to provide a meaningful data resource at both Trust and speciality level. The focus over the coming year will be to engage with speciality and divisional mortality leads to take greater ownership of their data and provide a pro-active approach to review and shared learning.

### **Plans for 2026/7**

- Revision of the Mortality Management Policy (Learning from Deaths) to address issues highlighted from the 360 Assurance review and create a more robust and assured approach to mortality oversight.
- Monitor and improve reporting within the DATIX-IQ Platform, including completion of SJRs and outcomes for learning.
- Support Trust roll-out and establishment of the HED benchmarking tool, encourage Power BI dashboard use and greater “ownership of data” by Divisions / speciality teams, with a more pro-active and improved approach to mortality review, learning and sharing.

**Board of Directors Meeting in Public - Cover Sheet**

<b>Subject:</b>	Urgent and Emergency Care (UEC) Improvement Plan for 2026/27		<b>Date:</b>	2 April 2026	
<b>Prepared By:</b>	Simon Illingworth, Chief Operating Officer				
<b>Approved By:</b>	Simon Illingworth, Chief Operating Officer				
<b>Presented By:</b>	Simon Illingworth, Chief Operating Officer				
<b>Purpose</b>					
To provide Trust Board with assurance that plans are in place to make improvements on our UEC pathway in 2026/27.				<b>Approval</b>	
				<b>Assurance</b>	✓
				<b>Update</b>	
				<b>Consider</b>	
<b>Strategic Objectives</b>					
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 estates	Work collaboratively with partners in the community
✓					
<b>Principal Risk</b>					
<b>PR1</b>	Significant deterioration in standards of safety and care				✓
<b>PR2</b>	Demand that overwhelms capacity				✓
<b>PR3</b>	Critical shortage of workforce capacity and capability				
<b>PR4</b>	Insufficient financial resources available to support the delivery of services				
<b>PR5</b>	Inability to initiate and implement evidence-based Improvement and innovation				
<b>PR6</b>	Working more closely with local health and care partners does not fully deliver the required benefits				
<b>PR7</b>	Major disruptive incident				
<b>PR8</b>	Failure to deliver sustainable reductions in the Trust's impact on climate change				
<b>Committees/groups where this item has been presented before</b>					
Trust Recovery Group Emergency Care Steering Group (ECSG) Trust Management Team					
<b>Acronyms</b>					
CDU: Clinical Decisions Unit CFS: Clinical Frailty Score DQ: Data Quality EAU: Emergency Assessment Unit ED: Emergency Department EDD: Estimated Date of Discharge (PDMS: Predicted Date of Medically Safe is the term used at SFH) FIT: Frailty In reach Team GIRFT: Getting It Right First Time ICB: Integrated Care Board LOS: Length of Stay MFFD: Medically Fit For Discharge MH: Mental Health NCTR: No Criteria To Reside NUH: Nottingham University Hospitals NHS Trust SDEC: Same Day Emergency Care					

## Executive Summary

The attached paper and appendices provide a summary of our strategic UEC improvement plan for 2026/27.

Key messages are:

- Focuses on long-term, sustainable changes to UEC at Sherwood Forest Hospitals, moving beyond short-term recovery actions ending in March 2026.
- Three core improvement pillars (flow in, through, and out of hospital) that provide a whole-system approach addressing how patients enter the hospital, move through it, and are supported to leave safely and efficiently.
- Enhancing flow in through stronger front-door model including: expanding and improving SDEC pathways; implementing a robust frailty model; increasing use of Criteria to Admit and Clinical Frailty Score; and improving type three performance to increase diversion and reduce ED pressure.
- Improving flow through with better hospital processes and specialty input including: strengthening inter-professional standards; ensuring timely specialty in-reach; optimising use of Nervecentre for safer bed allocation; streamlining ED-to-ward moves; and delivering the Trusted Assessor approach for faster complex discharge decisions.
- Strengthening Flow Out to accelerate and standardise discharge including: increasing early-morning discharges via a “Ten Before Ten” model; improving board rounds and data quality; enhancing preparation in the 48 hours before discharge; and expanding effective use of community hospitals and step-up/step-down pathways.
- Embedding GIRFT recommendations throughout the improvement plan to ensure alignment with external best practice (especially around frailty, SDEC, operational standards, discharge processes and workforce models).
- Clear governance through the Emergency Care Steering Group (ECSG) which will have oversight across all workstreams, with structured reporting to Trust Management Team, Finance and Performance Committee, and Trust Board to maintain progress and accountability.

This paper does not include the detailed action plan which is managed via Emergency Care Steering Group but summarises those actions which are included within the plan. This summary plan will be shared with staff across the Hospital via the Senior Leaders Forum.

The plan will deliver the performance trajectories and targets set out in appendix B

Trust Board are requested to review, comment and take assurance from the UEC Improvement Plan for 2026/27.

## URGENT AND EMERGENCY CARE (UEC)

### IMPROVEMENT PLAN

2026/27

#### 1. Introduction

This paper sets out of the key areas of work which will be progressed during 2026/27 to improve and sustain UEC performance at Sherwood Forest Hospitals NHS Foundation Trust. This paper supports the previous update to Board which set out the shorter term / immediate improvement areas currently managed via the Trust Recovery Group, which will cease at the end of March 2026.

The actions described in this paper are more strategic than those managed via the Trust Recovery Group and will aim to build capacity and capability to sustain improved performance over time. They also deliver the recommendations set out in the January 2026 UEC GIRFT report.

#### 2. Background and context

The actions set out in the paper and in Appendix A aim to deliver the recommendations set out in the GIRFT UEC Report as well as more strategic schemes to improve UEC, how we manage hospital flow management and configure the wards and how we work with system partners to reduce demand and stream patients. The paper set out actions based around the following themes:

- Flow in (to the hospital)
- Flow through (the hospital)
- Flow out (of the hospital)

**Flow in** will focus on work which manages patients at the front door such as how patients arrive at our UEC service, streaming practices once they have arrived, and how we utilise our physical space and capacity to see and treat patients in the right place in the timeliest way.

**Flow through** will focus efforts on actions within the hospital such as how teams work together (inter professional standards), the use of Nervecentre and data quality to improve flow decisions, improving board rounds and discharge decisions, processes to improve the time taken to move patients from ED to wards and the implementation of Trusted Assessor model for speedier complex discharge.

**Flow out** will consider schemes to improve discharge from the hospital including establishing clear performance standards around discharge, agreeing good practice initiatives with system partners, how we utilise the resources of our community hospitals more effectively and how we can continue to derive benefits from the discharge lounge.

#### 3. Governance for improvement

Management of the various improvement schemes set out in this paper and Appendix A will be overseen via the Emergency Care Steering Group (ECSG) and onwards into Trust Management Team (TMT). This actions and action plan supporting this will draw together actions that will be managed in a variety of workstreams; all overseen through the ECSG.

There will also be updates at Trust Committee meetings such as Finance (and Performance) Committee and via Trust Board at intervals. This paper is supported by a detailed action plan to oversee the key workstreams and manage delivery during 2026/27.

#### 4. Key workstreams – Flow In

**Improving our SDEC pathways** as set out in the GIRFT UEC visit will be a key action over the next 12 months. Creating the correct frailty model as recommended by GIRFT will be an important development. Frailty SDEC should be based on a model which promotes discharge, via a medically led / FIT team supported care model. The outcome of this should be a reduction in admission and LOS and an ability to pull patients from ED each morning supporting flow. Expanding the use of Criteria to Admit across more specialties and assessment areas is also key to success for teams at the front door and in our assessment area, with adoption of the Clinical Frailty Score (CFS) being a key component.

**Improvement in type three** performance is a significant priority area. ICB colleagues have established a scoping meeting with key members of the UEC operational team at SFH to consider ways to improve matters. The current model: a nurse led service commissioned only to deliver around 78% in terms of 4-hour emergency access performance is not sustainable. There are numerous change options available, but the key deliverable is for a service which achieves 99% in a sustainable way. On current numbers of patients this would provide an additional 3 or 4 % to overall UEC performance but of course with the right model there is scope to divert more patients through a type three service. Longer-term, a discussion around KMH UTC model is required.

**Working with system partners** to deliver more benefit from call before convey and better use of the UCCH (and other deflection strategies such as the Silver Phone in ED) to divert patients to alternative receiving areas is required and this will be fed into the regional UEC Board. Developing and leading on discussions around improving the frailty model outside of the hospital will also be a key action during the year. Opportunities exist to deepen the use of Clinical Frailty Score (CFS) in ED and in community settings such as Care Homes, who we can work with much more closely. There is also requirements to improve our understanding of frailty in younger adults (under 65 years).

#### 5. Key workstreams – Flow Through

**Inter professional standard** and how the specialties work with acute medicine is a key enabler for long term UEC improvement. The recent UEC GIRFT visit identified that current adherence to Internal Professional Standards was weak, with specialty in reach into EAU and SSW in particular needing improvement. Progress needs to be made to ensure that as soon as patients are referred to a specialty from Acute Medicine and accepted by the specialty, the care for that patient moves to the specialty, irrespective of where the patient is care for.

**Discharge Improvement Group** has been set up to include members from SFH, the ICB and NUH and adult social care to look at how complex discharge can be improved. One of the key deliverables in this group is the creation of the Trusted Assessor model. This will enable SFH complex discharge staff to assess and determine intermediate care needs for patients who they have seen and personally assessed. This will reduce the administrative burden of the Transfer of Care Hub, reduce paperwork and speed up discharge decisions. Common and agree performance standards and a full review of discharge practices is also required. The outcome for this workstream will be reduce bed days lost to NCTR and increase complex discharges to a less variable level.

**Right sizing the wards** and ensuring that flow through the hospital is optimised will be important part of developing sustainable flow model. A review of EAU, SSW and how patients move from ED through to these wards and to their specialty base ward will be undertaken. The adoption of Virtual Wards has been slow but significant opportunities exist to expand this and learn from other organisations. We will also need to review and consider longer terms options for the location of our SDEC service. While SDEC is working well after it was combined with Medical Day Care, work is required on how we best co-locate these services closer to the front door (ED)

## 6. Key Workstream – Flow Out

**Improving early morning discharge** is a significant component of improved flow. While the Board Round work has increased the average number of discharges per day from our medical wards by around 9, the Trust continues to struggle with early morning flow. Creating a *Ten Before Ten* approach to use of the Lounge is recommended by the UEC GIRFT report. In addition to early morning discharge, opportunities exist through improved DQ on the wards and better forward planning of discharge decisions to start preparing patients for discharge in the 48 hours prior. Expected Date of Discharge (EDD) and our work towards effective board rounds support this aim.

**Further work is needed around the Board Rounds**, specifically ensuring that they help to create a single version of the truth in relation to patient level data quality around discharge, to help manage flow through the hospital. The Trust remains committed to using Nervecentre to manage patients into the right bed at the right time. To achieve this, we must improve the quality of the information.

**Community** Sherwood Forest Hospitals is fortunate to have access to its own community care facilities – with Newark and Mansfield a key enabler of improved flow. We currently have two wards dedicated to caring for patients discharged on P2 pathway at Mansfield and 12 beds for the same at Newark. Opportunities exist to provide step up care, preventing admissions. In addition, working with the ICB to ensure we manage these wards appropriately, against the right level of resource and the right type of pathways will be an important part of improving discharge. In addition to our own community sites, there is more work to be done on support patients with Mental Health back into the community and reducing length of stay in ED.










## 7. Conclusion

There remain significant areas of improvement required to improve UEC performance ahead of next winter - some of which will require fundamental changes to how services operate and how clinical care is delivered. It may also mean a reallocation of money towards different outcomes. Some will require system partners to change how they operate as we start to commissioning for improvement. Many of these conversations are already underway and there is good early engagement.

The summary improvement plan (Appendix A) sets out these areas of work against the three themes of Flow In, Flow Through and Flow Out and describe the key plans the operational teams must deliver over the next 12 months to achieve the performance ambitions we have committed to in our operational plan (detailed in Appendix B).

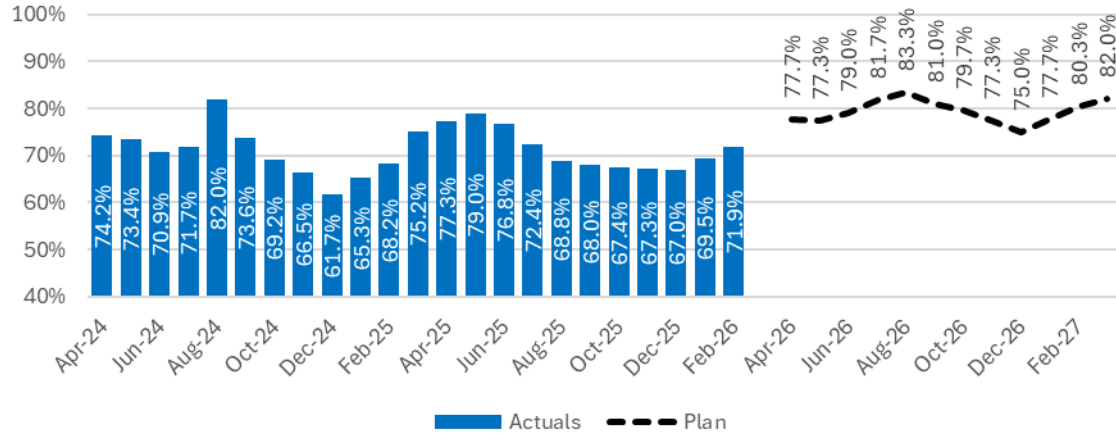
All of this work is supported by a detailed Action Plan which, while not included with this paper, is comprehensive and supported by the Trusts Improvement Team and which is managed via Emergency Care Steering Group, reporting via TMT.

# Appendix A: UEC Improvement Plan 2026/27

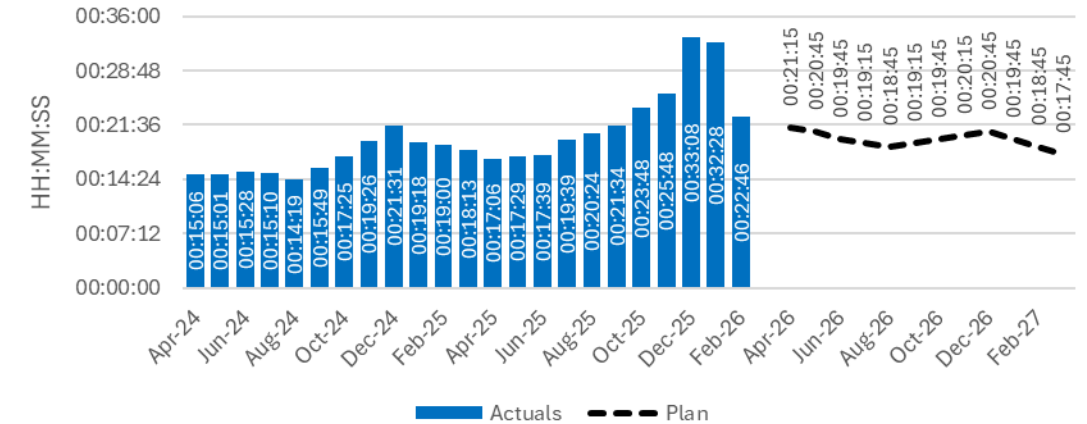
Flow in	Flow through	Flow out
<b>Processes &amp; Productivity</b>		
 <ul style="list-style-type: none"> <li>Develop and improve Criteria to Admit processes</li> <li>Review Type 3 service delivery model</li> <li>Improve specialty in reach into ED/EAU</li> </ul>	 <ul style="list-style-type: none"> <li>Improve management of long waiting patients from ED to wards</li> <li>Internal Professional Standards</li> <li>Recruit to medical roles</li> </ul>	 <ul style="list-style-type: none"> <li>Use of Discharge Lounge – including 10 before 10</li> <li>Imbed Board Rounds early identification (48hrs)</li> <li>Strategies to reduce LOS in key medical specialties</li> </ul>
<b>Capacity</b>		
 <ul style="list-style-type: none"> <li>ED Build</li> <li>Create a Frailty SDEC with FIT team support / embed CFS in ED</li> <li>Comprehensive Surgical SDEC pathways</li> </ul>	 <ul style="list-style-type: none"> <li>Right size wards</li> <li>Expand Virtual Wards</li> <li>CDU / EMACC model</li> <li>Tackle specialty LOS on EAU/SSW</li> </ul>	 <ul style="list-style-type: none"> <li>Review processes and pathways for our community wards – best use of resource</li> <li>Improve the use of EDD metrics</li> </ul>
<b>Partnerships (SFH and ICB)</b>		
 <ul style="list-style-type: none"> <li>Lead discussions around Frailty offer across Mid Notts</li> <li>Increase the use of call before convey / Care Homes</li> <li>Frequent Attenders workstream</li> </ul>	 <ul style="list-style-type: none"> <li>Trusted Assessor model in place to support complex discharge</li> <li>Improve processes in the Transfer of Care Hub to reduce time from MFFD to discharge</li> </ul>	 <ul style="list-style-type: none"> <li>Revise discharge performance metrics for Notts</li> <li>Improve MH pathway</li> <li>Reduce number of bed days lost to NCTR</li> </ul>

# Appendix B: UEC Improvement Trajectories 2026/27

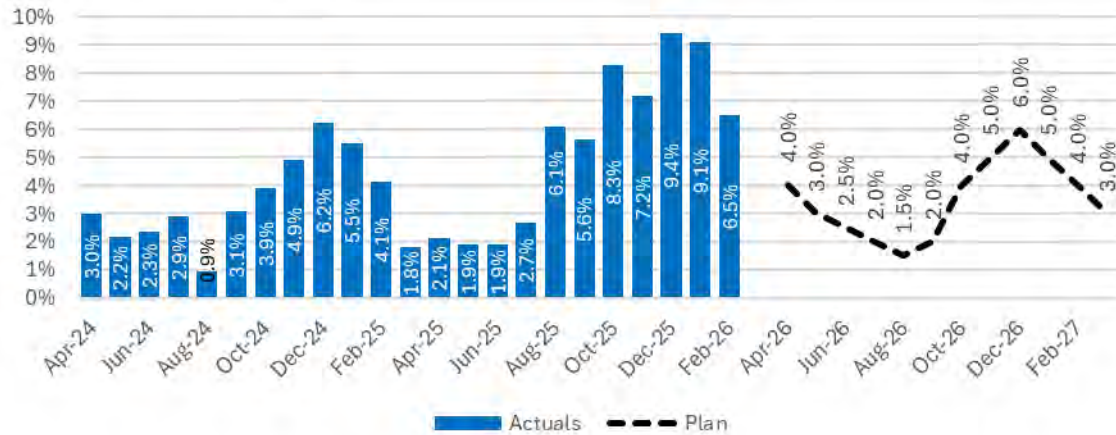
A&E 4-Hour Performance



Average Ambulance Turnaround Times



A&E 12-Hour Performance



Metric	Mar-27	Mar-28	Mar-29
4-hour	82%	84%	86%
12-hour	3%	2.5%	2%
Average Ambulance Turnaround Time	17 min	15 min	15 min

**Trust Board - Cover Sheet**

<b>Subject:</b>	Planned Care Improvement Plan 2627	<b>Date:</b>	2 <sup>nd</sup> April 2026		
<b>Prepared By:</b>	Charlotte Ainger – Associate Director of Operations for Planned Care				
<b>Approved By:</b>	Simon Illingworth – Chief Operating Officer				
<b>Presented By:</b>	Simon Illingworth – Chief Operating Officer				
<b>Purpose</b>					
Provide update for Trust Board on the Planned Care Improvement Plan for 2026/27				<b>Approval</b>	
				<b>Assurance</b>	
				<b>Update</b>	<b>X</b>
				<b>Consider</b>	
<b>Strategic Objectives</b>					
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 estates	Work collaboratively with partners in the community
			<b>X</b>		
Indicate which strategic objective(s) the report support					
<b>Identify which Principal Risk this report relates to:</b>					
<b>PR1</b>	Significant deterioration in standards of safety and care				
<b>PR2</b>	Demand that overwhelms capacity				<b>X</b>
<b>PR3</b>	Critical shortage of workforce capacity and capability				
<b>PR4</b>	Insufficient financial resources available to support the delivery of services				
<b>PR5</b>	Inability to initiate and implement evidence-based Improvement and innovation				
<b>PR6</b>	Working more closely with local health and care partners does not fully deliver the required benefits				
<b>PR7</b>	Major disruptive incident				
<b>PR8</b>	Failure to deliver sustainable reductions in the Trust's impact on climate change				
<b>Committees/groups where this item has been presented before</b>					
Planned Care Steering Group Trust Management Team Meeting					
<b>Acronyms</b>					
<b>AI</b> – Artificial Intelligence <b>CDC</b> – Community Diagnostic Centre <b>DM01</b> – Diagnostic Modality 01 (core diagnostic activity category) <b>EPR</b> – Electronic Patient Record <b>FDP</b> – Federated Data Platform <b>GIRFT</b> – Getting It Right First Time <b>HVLC</b> – High Volume Low Complexity <b>OPFA</b> – Outpatient First Appointment <b>OPPROC</b> – Outpatient Appointment with Procedure <b>RTT</b> – Referral to Treatment					
<b>Executive Summary</b>					
This paper and attached PowerPoint sets out the Planned Care Improvement Plan for 2026/27 for Sherwood Forest Hospitals NHS Foundation Trust, describing the strategic actions required to improve and sustain performance across elective care, diagnostics and cancer pathways. The plan builds on recent operational recovery and shifts focus towards medium- to longer-term productivity, capacity and pathway redesign, aligned to national priorities including GIRFT Further					

Faster, RTT standards, cancer performance expectations and system-wide productivity requirements.

The Trust enters 2026/27 from a strengthened position following participation in the NHSE Q4 elective sprint, which focused on outpatient first appointments and procedures. This has delivered improvements in RTT performance and waiting list size, supported by specialty-led productivity schemes, with further improvement forecast based on sustained activity levels.

The Plan adopts a whole-pathway approach to planned care, addressing access, diagnostics, outpatient and surgical pathways, and reducing delays, cancellations and unwarranted variation. Delivery is structured by Elective Care, Diagnostics and Cancer, underpinned by four cross-cutting improvement themes: Productivity and Capacity; Partnerships and Equity; Prevention and Early Diagnosis; and Digital.

Key priorities include

- Elective priorities include improving outpatient and theatre productivity, strengthening pre-operative processes, progressing Newark Hospital as a High Volume Low Complexity elective hub, expanding partnership working to support demand management and pathway efficiency.
- Diagnostic improvement will focus on stewardship, improved reporting turnaround times and the opening of the Community Diagnostic Centre to improve access and reduce inequalities.
- Cancer priorities include strengthened demand and capacity modelling, improved pathway sequencing, expanded early diagnosis and increased use of digital tools such as Cancer 360.

Delivery will be overseen via a detailed action plan which will be managed through the Planned Care Steering Group, with escalation via the Trust Management Team and reporting to Trust Committees and the Trust Board.

Overall, the Plan sets out a coherent programme to improve productivity, reduce waiting times, enhance equity and deliver a more resilient, patient-centred planned care service during 2026/2, which meet the requirements of the medium term performance plan and trajectories

# Planned Care Improvement Plan

**2026/27**

## **Introduction**

This paper sets out the key areas of work to be progressed during 2026/27 to improve and sustain Planned Care (Elective) performance at Sherwood Forest Hospitals NHS Foundation Trust.

The plan builds on recent operational recovery actions and shifts focus towards medium- to longer-term capacity, productivity and pathway redesign, supporting delivery of national elective recovery priorities including GIRFT Further Faster, Referral to Treatment (RTT) standards, cancer performance and productivity expectations.

The actions described are designed to improve patient experience and ensure that elective pathways are delivered in a safe, timely and equitable manner.

## **Elective Sprint**

To get the Trust to the strongest starting position for 2026/27, SFH has been actively engaged in the NHSE Q4 elective sprint aimed at enhancing RTT performance. This initiative was focused on Outpatient First Appointment (OPFA) and Outpatient Appointments with Procedure (OPPROC) with income attached to that activity.

Specialty leads designed sprint bids at pace, with some areas able to operationalise their schemes quicker than others.

Overall key headlines from the elective sprint are

- A significant improvement in performance. As of February 2026, RTT performance reached 60.9%, representing the highest level achieved since September 2025.
- The total waiting list stood at 34,355, marking its lowest point since December 2024.
- Made a positive contribution to Trust overheads of approximately £440,000

Based on current activity levels throughout March, the Trust is forecasting a further improvement against our RTT performance levels, a reduction in total waiting list size and an income benefit based on the overall success of the operationalised schemes.

## **Context and Strategic Framework**

The improvement actions for 2026/27 follow the Operational Improvement Plan, taking a comprehensive approach to elective care, from access and diagnostics to outpatient, surgical pathways, and reducing delays, cancellations, and waste.

The plan aligns with national and system priorities including:

- GIRFT recommendations (Further Faster)
- National Elective Recovery and Productivity expectations
- System-wide working across acute, community and primary care

Delivery is structured by area of care:

- Elective Care (Surgery and Outpatients)
- Diagnostics
- Cancer

And by cross-cutting improvement themes:

- Productivity and Capacity
- Partnerships and Equity
- Prevention and Early Diagnosis
- Digital

### **Elective Care (Surgery and Outpatients)**

The strategy for improving elective care focuses on increasing productivity and capacity by minimising variation in outpatient pathways, optimising theatre utilisation, and reducing cancellations through improved scheduling and pre-operative processes. Newark hospital is currently subject to a High Volume Low Complexity (HVLC) elective hub accreditation process. This will strengthen the sites position as a high turnover, cost-effective cold site to ensure the Trust maintains its elective programme throughout the year.

Partnerships will remain central to supporting elective delivery, through targeted insourcing and outsourcing as well as stronger collaboration with primary care and patient groups to improve referral processes and outpatient pathways. Efforts in prevention and early diagnosis will emphasize the use of Advice and Guidance to prevent unnecessary appointments and make follow-up visits more efficient, thereby reducing low-value activities.

Digital transformation includes the rollout of Ambient AI to improve clinical communications with patients and more efficient administration processes, as well as an

expanded use of FDP (Federated Data Platform) for scheduling and outcome tracking, and wider use of digital tools such as text reminders, patient portals and the NHS App to improve communication and reduce non-attendance and cancellations.

## **Diagnostics**

Diagnostic improvement will focus on diagnostic stewardship to ensure tests are clinically appropriate and support timely decision-making. Actions to improve reporting turnaround times in radiology and histopathology will support both elective and cancer pathways.

The transition from mobile diagnostic units to permanent facilities will be enabled through the opening of the Community Diagnostic Centre, alongside recovery planning to address capacity pressures in non-DM01 diagnostics. The Community Diagnostic Centre will also improve access and reduce health inequalities, supported by system collaboration to provide direct access to diagnostics and targeted use of capacity to address unwarranted variation.

Early diagnosis activity will prioritise expansion of direct access testing to remove unnecessary outpatient steps through one stop pathways and review processes for managing incidental findings to prevent avoidable pathway inflation. Digital developments include increased use of digital pathology to enhance cross organisational decision making for complex reporting requirements, improved tracking and reporting of diagnostic activity, and stronger integration of diagnostic systems within FDP to enhance oversight of diagnostic pathways.

## **Cancer**

Building on a successful 12 months of improvement in Cancer pathways and performance, For 2026/27 improvement initiatives will prioritise productivity and capacity through comprehensive demand and capacity reviews across outpatient, diagnostic, and treatment stages. This is complemented by enhanced job planning and robust capacity modelling to ensure adequate provision of elective and cancer services. Strengthening pathway management and sequencing is intended to protect planned care capacity.

Collaborative efforts with tertiary centres aim to streamline care pathways and minimise delays. The utilisation of health inequality indicators and engagement with community services supports equitable access and facilitates appropriate transitions of care from acute settings. Prevention and early diagnosis strategies encompass the full rollout of the Faster Diagnosis Standard across all tumour sites, expansion of community-based clinics, integration of Cancer 360 for improved pathway oversight, and increased early diagnostic opportunities to reduce escalation and breaches.

Digital advancements will leverage AI-enabled tools such as Cancer 360 to enhance pathway management and data quality, improve transparency via existing EPR and cancer information systems, and strengthen digital enablement to support performance monitoring and operational decision-making.

### **Governance and Delivery**

Delivery of the Planned Care Improvement Plan will be overseen through the existing Planned Care Steering Group, with escalation through the Trust Management Team and formal reporting to relevant Trust Committees and the Trust Board. A detailed action plan will support delivery throughout 2026/27, with clear ownership, milestones and performance measures aligned to RTT, diagnostics, cancer, outpatient and theatre productivity, and patient experience outcomes.

### **Conclusion**

Sustained improvement in planned care performance will require continued transformation of elective pathways, disciplined capacity management and strong system collaboration. This plan sets out the key strategic actions required during 2026/27 to improve productivity, reduce waiting times, enhance equity and deliver a more resilient and patient-centred elective service.

The summary improvement plan (Appendix A) sets out these areas of work against the three areas Elective, Cancer and Diagnostics and describe the key plans the operational teams must deliver over the next 12 months to achieve the performance ambitions we have committed to in our operational plan (detailed in Appendix B).

# SFH Improvement Plans 2026/27

This document provides a summary of our operational improvement plans for 2026/27 to provide patients with safe, timely and accessible care.

**March 2026**



# Planned Care (Electives) Improvement Plan 2026/27

## Productivity and Capacity



- Implement Outpatient Transformation work via GIRFT Further Faster
- Continue to improve Theatre Productivity via Improvement Group
- Newark Accreditation as an Elective Hub
- Invest in technology where possible to improve efficiency and reduce waiting times
- Reduce cancellations of all types through improvements to booking / scheduling and pre-op

## Partnerships and Equity (Acute to Community)



- Increase benefits of A&G between Primary and Secondary care
- Continue to provide mutual aid across the acute providers in Nottinghamshire via the Elective Hub.
- Work with GPs and primary on improvements in outpatient pathways
- Implement insourcing and outsourcing where gaps to plan emerge

## Prevention and Early Diagnosis (Treatment to Prevention)



- Review of A&G usage and performance to streamline patient pathways
- Improve waits for first appointment to shorten patient pathways, improve RRT performance and reduce the total PTL size
- Use of Health inequalities index to inform operational decisions

## Digital (Analogue to Digital)



- Implementation of FDP for RTT pathway management and use of AI for validation (ClearPTL)
- Implementation of Ambient AI for clinical correspondence
- Review and enhance use of text reminders service / patient portal capacity
- Realise benefits from deployment of EPR modules

# Diagnostics Improvement Plan 2026/27

Objective: Safe, timely and accessible care for patients

## Productivity and Capacity



- Increase efficiency in diagnostic capacity through diagnostic stewardship programme
- Improve turnaround times of reporting (Radiology and Histo) to support Cancer and RTT pathways
- Transition from mobile units to substantive capacity following the opening of the CDC and MRI build at KMH
- Understand capacity required for non-DM01 tests and work on recovery

## Partnerships and Equity (Acute to Community)



- Opening of the Community Diagnostic Centre in 26/27 which will help reduce inequalities related to access to healthcare

## Prevention and Early Diagnosis (Treatment to Prevention)



- Access to timely diagnostic tests and reporting turnaround time
- Direct access where possible to be available

## Digital (Analogue to Digital)



- Expansion of digital pathology to improve from 80.73% to 98%

# Cancer Improvement Plan 2026/27

Objective: Safe, timely and accessible care for patients

## Productivity and Capacity



- Further develop and increase alignment with best practice timed pathways
- Continue to work towards implementation of robotic surgery in 27/28
- Action the improvements that come from demand and capacity reviews, informing job planning
- Continue with advance planning of capacity during peak holiday periods

## Partnerships and Equity (Acute to Community)



- Lung Cancer Screening programme to be continued and expanded to Newark
- Continue to develop the use of the flag for additional needs and healthcare inequalities
- Ensure appropriate access to both surgical and oncological capacity for SFH patients
- Work closely with tertiary centre to improve pathways And reduce delays
- Engage with patient groups to design services which reduce delays

## Prevention and Early Diagnosis (Treatment to Prevention)



- Review of processes for upgrading incidental findings for Cancer at a diagnostic test
- Radiology and histopathology improvements to be made (digital solutions) to support tumour sites to meet FDS
- Develop a community-based breast pain pathway and review the processes regarding post menopausal bleed pathways.

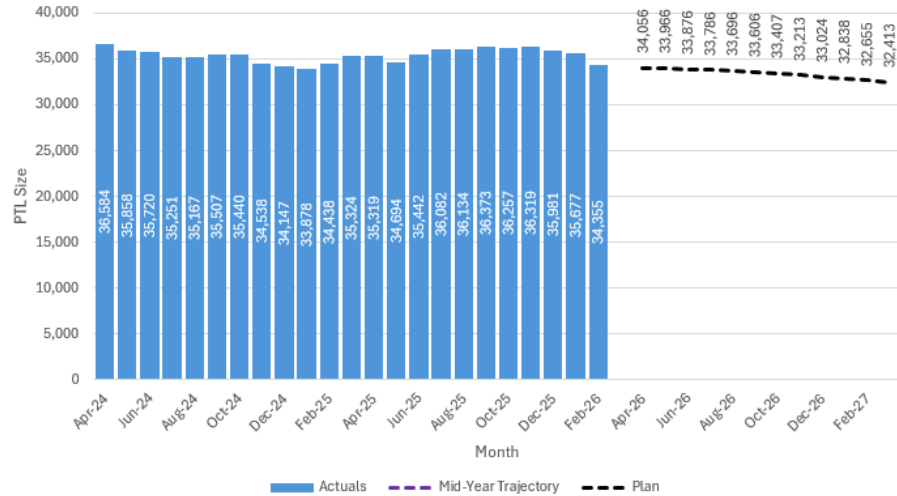
## Digital (Analogue to Digital)



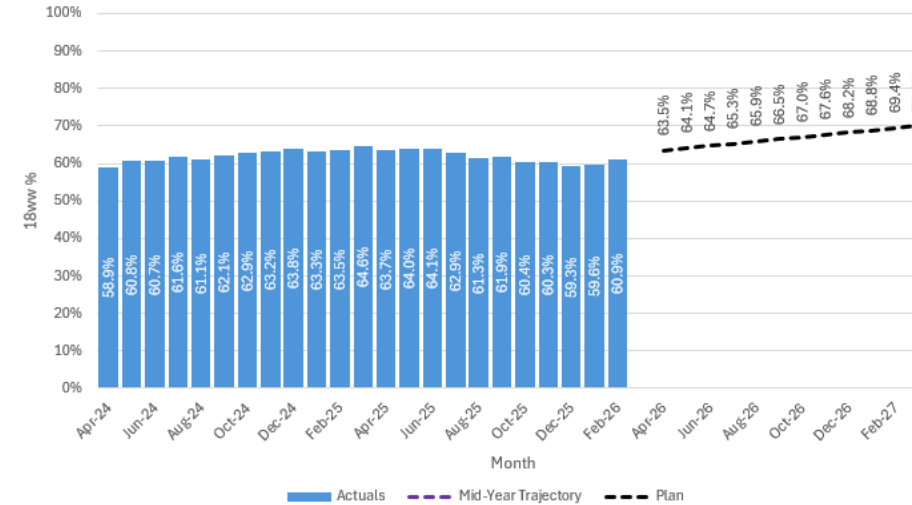
- Embed Cancer 360 into operational teams to improve pathway oversight
- Implementation of Ambient AI for clinical correspondence
- Review and enhance use of text reminders service / patient portal capacity
- Derive benefits from NHS App eg patient input into personalised care plans and receiving treatment summaries.

# Planned Care Improvement Trajectories 2026/27

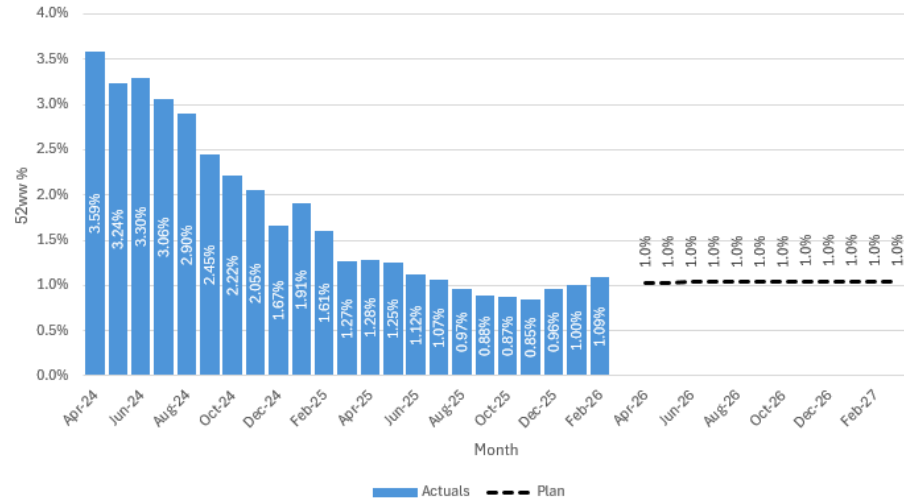
Elective Total Incomplete PTL



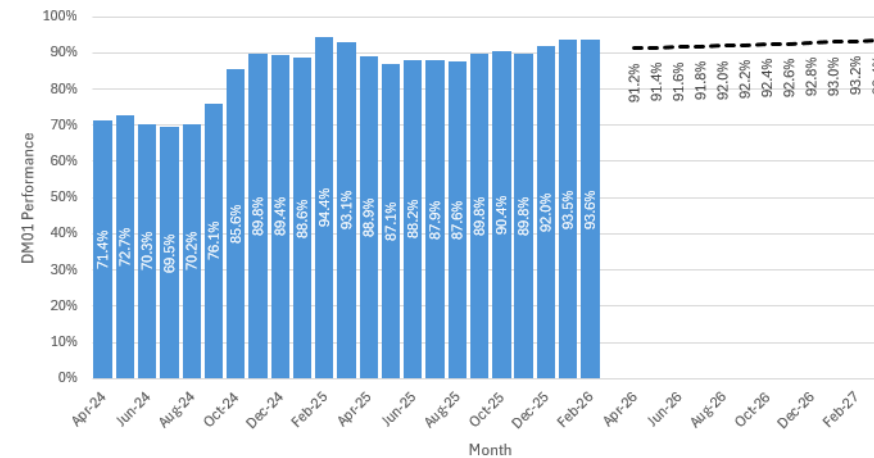
18-Week Wait RTT Performance



52-Week Wait % of Total Incomplete PTL



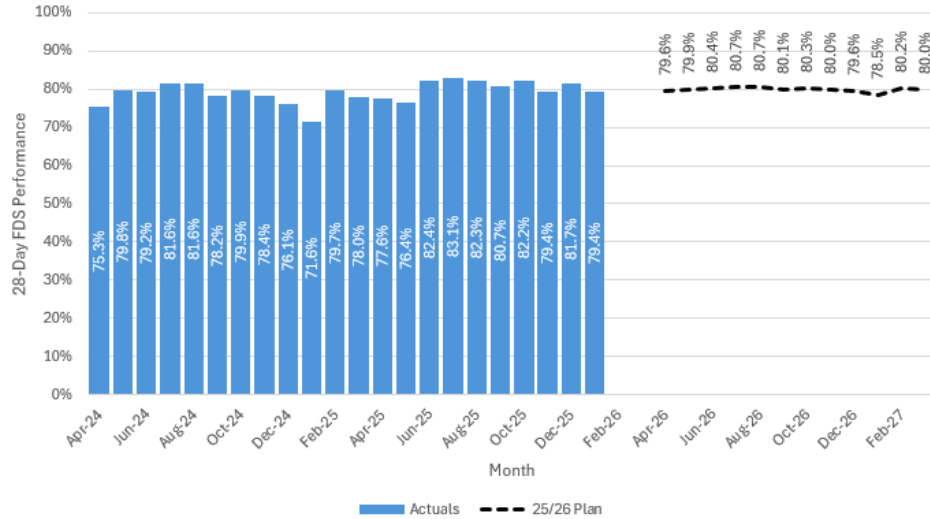
DM01 Performance - All Modalities



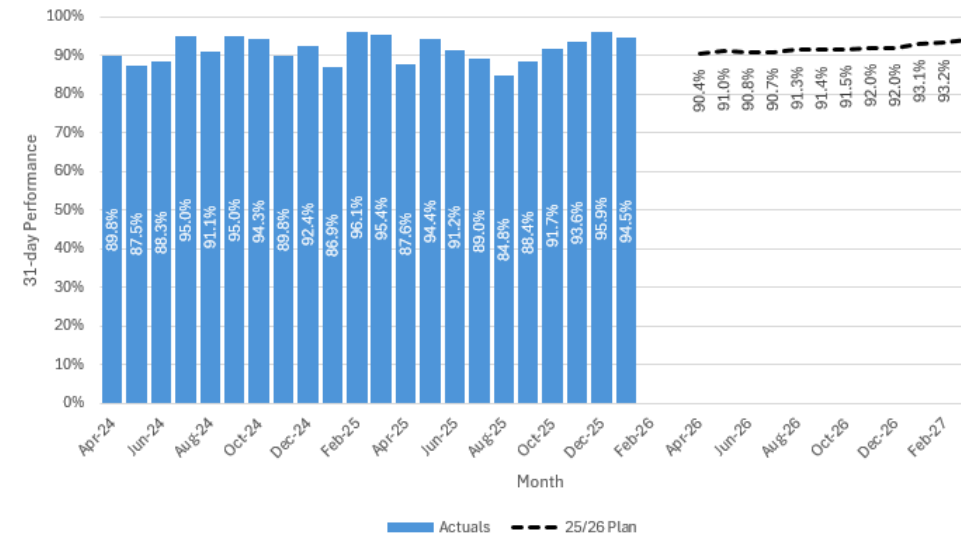
# Planned Care Improvement Trajectories 2026/27



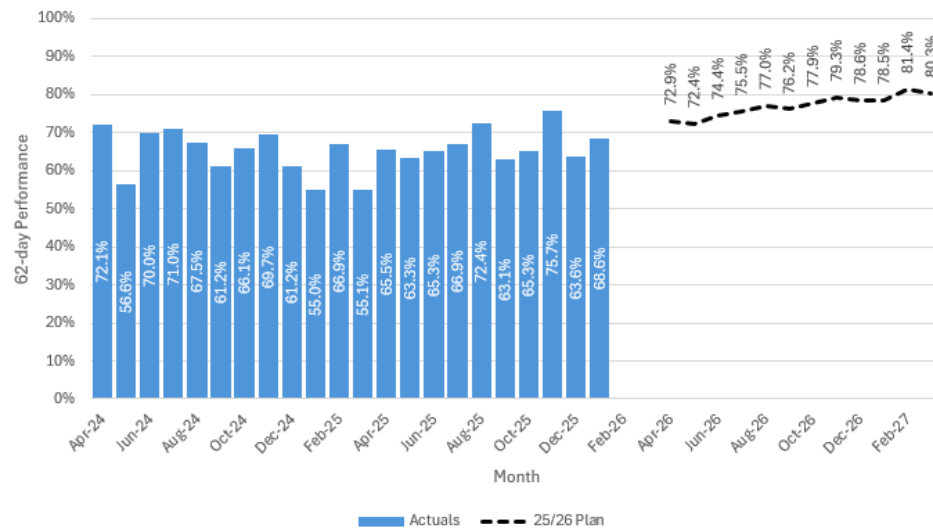
Cancer 28-day Faster Diagnosis Standard



Cancer 31-day Performance



Cancer 62-day Performance



Measure	Year 1	Year 2	Year 3
Total PTL Size	32413	30954	30541
18-week RTT	70%	77%	92%
52-week wait % of total PTL (number)	1% (339)	1% (324)	1% (320)
DM01	93.4%	96.2%	99%
28-day Faster Diagnostic Standard	80%	80%	80%
31-day	94%	96%	96%
62-day	80%	83%	85%

**Board of Directors Meeting in Public - Cover Sheet**

<b>Subject:</b>	National Staff Survey Results 2025	<b>Date:</b>	2 <sup>nd</sup> April 2026		
<b>Prepared By:</b>	Jacqueline Read, Associate Director of People (Operations)				
<b>Approved By:</b>	Rob Simcox, Chief People Officer				
<b>Presented By:</b>	Rob Simcox, Chief People Officer				
<b>Purpose</b>					
To provide Trust Board with an overview of the 2025 National Staff Survey results, including themes from the result and next steps under the Trusts "Together we Will" commitments		<b>Approval</b>			
		<b>Assurance</b>	X		
		<b>Update</b>	X		
		<b>Consider</b>			
<b>Strategic Objectives</b>					
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 estates	Work collaboratively with partners in the community
X	X	X	X		
<b>Principal Risk</b>					
<b>PR1</b>	Significant deterioration in standards of safety and care			X	
<b>PR2</b>	Demand that overwhelms capacity				
<b>PR3</b>	Critical shortage of workforce capacity and capability			X	
<b>PR4</b>	Insufficient financial resources available to support the delivery of services				
<b>PR5</b>	Inability to initiate and implement evidence-based Improvement and innovation			X	
<b>PR6</b>	Working more closely with local health and care partners does not fully deliver the required benefits				
<b>PR7</b>	Major disruptive incident				
<b>PR8</b>	Failure to deliver sustainable reductions in the Trust's impact on climate change				
<b>Committees/groups where this item has been presented before</b>					
Trust Management Team March 2026 Team Brief March 2026 Leaderships Forum March 2026 People Committee March 2026					
<b>Acronyms</b>					
<ul style="list-style-type: none"> <li>NSS – National Staff Survey</li> </ul>					
<b>Executive Summary</b>					
<b>Background</b>					
<p>The NHS National Staff Survey is one of the largest workforce surveys in the world and is carried out every year to improve staff experiences across the NHS. The survey is aligned to the NHS People Promise.</p> <p>The survey offers a snapshot in time of how people experience their working lives, gathered at the same time each year.</p>					

The survey not only captures a national picture but local detail, enabling a range of organisations to understand what it is like for staff across different parts of the NHS and for those organisations to work to make improvements.

## National Context

On 12 March 2026, NHS England (NHSE) published the annual NHS Staff Survey results.

The survey ran from across autumn 2025 and gathered responses from 766,285 staff (2 per cent down from 2024). This is equivalent to fewer than half of all NHS staff (49 per cent). Results cover staff from 238 NHS organisations, including all 206 trusts.

The results showed a decline with results the lowest they have been since the survey began in the following areas

- Workload, Burnout and Pressure
- Staff Engagement and Morale
- Staff report experiencing discrimination from patients or the public
- Harassment, bullying and abuse
- Workload, Burnout and Pressure
- Staff Engagement and Morale
- Staff report experiencing discrimination from patients or the public
- Career Development
- Freedom to Speak up
- Friends and Family needed treatment

## Sherwood Forest Hospitals

3615 colleagues took the time to respond to the survey. 2025 saw the second-highest number of colleagues completing the staff survey from the past 5 year

Trust results indicated a drop across all seven People Promise elements, as well as in Staff Engagement and Morale, compared to 2024. Despite declines relative to other Acute and Community Trusts, we continue to benchmark at or above average, with the Compassionate & Inclusive element remaining above average.

The Trust performs above or around the benchmark average in:

- Compassionate leadership and team working
- Feeling role makes a difference to patients
- Equal opportunities
- Staff engagement for those without long-term conditions
- Appraisal completion rates

## How we compare locally

1. We are **top** in the East Midlands for recommending Sherwood as a place to receive care to friends and family
2. **Third** in the East Midlands for saying patients are our top priority
3. **Third** in the East Midlands for recommending Sherwood as a place to work

Overall, we continue to perform well.

## “Together We Will”

The Trust is dedicated to supporting its NSS outcomes through four key areas, each overseen by an Executive leader.

Outstanding Care, Compassionate People, Healthier Communities

# Together, we will

### Value

We will value and recognise all colleagues  
Lead executives: Sally Brook Shanahan and Simon Illingworth

### Include

We will be inclusive and work together to reduce daily pressures  
Lead executives: Simon Roe

### Support

We will support your wellbeing, tackle burnout and continue to address your experience of violence and aggression  
Lead executives: Rob Simcox and Phil Bolton

### Improve

We will improve the experience at work through digital and estate developments, and we will equip you to do your jobs  
Lead executives: Rich Mills

This is underpinned by Divisional and Corporate leadership team commitments

Outstanding Care, Compassionate People, Healthier Communities

**NHS**  
Sherwood Forest Hospitals  
NHS Foundation Trust

## NATIONAL STAFF SURVEY 2025

### Together We Will:

- Improve Morale
- Strengthen team support and development
- Enhanced Communication

**CSTO**  
Lindsay Chapman  
Divisional Director of Nursing

## Commitment Updates and Next Steps

Regular communication and updates will be managed through Trust-wide governance forums, including the People Committee, to provide broader Trust oversight of actions and plans.

A 12<sup>th</sup> month rolling programme of engagement will take place throughout the Trust with regular updated communications on actions being taken under each of the Trust and Divisional Commitments. This will be undertaken through various Trust wide communications.

We will ensure we celebrate and communicate our actions, celebrations and achievements through our own Trust events under “Together We Will” and “Your Voice Counts”.

### **Conclusion**

The Public board are asked to take note of the Trusts Staff Survey results, the commitments under the brand “Together We Will” and support regular and on-going updates going through the Trusts People Committee and wider Trust communication channels..

# Sherwood Forest Hospitals 2025 National Staff Survey results

2nd April 2026



# What our survey results tell us

- 3615 colleagues took the time to respond to the survey.
- Nationally NHS Staff survey results are at the lowest they have ever been
- National Staff results for 2025 at Sherwood Forest Hospitals results reflect challenges experienced at SFH
- Trust results have indicated a drop but we continue to benchmark at or above national average

# What our survey results tell us

- Working patterns: more staff reported working no additional paid hours compared to last year
- Resources: fewer staff feel they have adequate supplies, materials, and equipment to do their work
- Wellbeing:
  - more staff find their work frustrating.
  - fewer staff feel able to meet conflicting work demands
  - more staff often or always feel exhausted by their work
  - more staff are experiencing burnout

Outstanding Care,  
Compassionate People,  
Healthier Communities



Sherwood Forest Hospitals  
NHS Foundation Trust

There remains  
so much to be  
proud of





# Sherwood remains a place where you are proud to work

- We remain above the national average for recommending the Trust as a place to work
- We're third in the East Midlands for this measure
- 59.3% compared to national average of 57.8%

# We have improved appraisals to ensure you are receiving the development you need and deserve

- More of you are reporting having had an appraisal over the past year (90.1%)
- Our appraisals are better than the national average in making you feel valued by the organisation



# Overall, you're happy with the standard of care we provide

- 67% of you would be happy with the standard of care the organisation would provide if it were your friend or relative that needed treatment






# Your wellbeing remains a priority

- 71.5% of you said that your immediate manager takes a positive approach to your health and wellbeing
- This is better than the national average



# How we compare locally

-  We are top in the East Midlands for recommending Sherwood as a place to receive care to friends and family
-  Third in the East Midlands for saying patients are our top priority
-  Third in the East Midlands for recommending Sherwood as a place to work

Outstanding Care,  
Compassionate People,  
Healthier Communities

# Together, we will

How we will respond to feedback

We will focus on four key areas as a Trust underpinned by  
Divisional and Corporate commitments

# Together, we will

## Value

We will value and recognise all colleagues

Lead executives: Sally Brook Shanahan and Simon Illingworth

## Include

We will be inclusive and work together to reduce daily pressures

Lead executives: Simon Roe

## Support

We will support your wellbeing, tackle burnout and continue to address your experience of violence and aggression

Lead executives: Rob Simcox and Phil Bolton

## Improve

We will improve the experience at work through digital and estate developments, and we will equip you to do your jobs

Lead executives: Rich Mills

Outstanding Care,  
Compassionate People,  
Healthier Communities



Urgent and  
Emergency Care  
Richard Kemp  
Divisional Director  
of Nursing

**NHS**  
Sherwood Forest Hospitals  
NHS Foundation Trust

### NATIONAL STAFF SURVEY 2025

*Together*

#### We Will:

- Create a visible and reliable listening system
- Reduce daily frustration
- Help staff feel valued

Outstanding Care,  
Compassionate People,  
Healthier Communities



CSTO  
Lindsay Chapman  
Divisional  
Director of  
Nursing

**NHS**  
Sherwood Forest Hospitals  
NHS Foundation Trust

### NATIONAL STAFF SURVEY 2025

*Together*

#### We Will:

- Improve Morale
- Strengthen team support and development
- Enhanced Communication

Outstanding Care,  
Compassionate People,  
Healthier Communities



Women and  
Children's  
Sinni Vindia  
Divisional  
Clinical Director

**NHS**  
Sherwood Forest Hospitals  
NHS Foundation Trust

### NATIONAL STAFF SURVEY 2025

*Together*

#### We Will:

- Support staff development, address work pressures
- Improve safety climate, prevent burnout
- Share achievements, act on feedback

Outstanding Care,  
Compassionate People,  
Healthier Communities



Surgery,  
Anaesthetics  
and Critical  
Care  
Matthew  
Warrlow  
Divisional  
General Manager

**NHS**  
Sherwood Forest Hospitals  
NHS Foundation Trust

### NATIONAL STAFF SURVEY 2025

*Together*

#### We Will:

- Support the health and well-being of staff and ensure everyone feels valued
- Ensure fair career progression
- Ensure everyone has the right resources and staffing levels in place

Outstanding Care,  
Compassionate People,  
Healthier Communities



Corporate areas  
Debbie Kearsley,  
Deputy Chief  
People Officer

**NHS**  
Sherwood Forest Hospitals  
NHS Foundation Trust

### NATIONAL STAFF SURVEY 2025

*Together*

#### We Will:

- Reduce Workload Pressure and Prevent Burnout
- Strengthen Psychological Safety, Speaking Up and Learning Culture
- Improve Development, Appraisals and Career Progression

Outstanding Care,  
Compassionate People,  
Healthier Communities



Medicine  
Deanne Carr  
Divisional  
Director of  
Nursing

**NHS**  
Sherwood Forest Hospitals  
NHS Foundation Trust

### NATIONAL STAFF SURVEY 2025

*Together*

#### We Will:

- Strengthen listening, engagement and involvement
- Improve communication
- Focused speciality action and local ownership

Outstanding Care,  
Compassionate People,  
Healthier Communities

**NHS**

Sherwood Forest Hospitals  
NHS Foundation Trust

# Thank you for listening



**Guardian of Safe Working Report – Public Board**

<b>Subject:</b>	Guardian of Safe Working Report	<b>Date:</b>	24/3/2026		
<b>Prepared By:</b>	Rebecca Freeman – Head of Medical Workforce Jayne Cresswell – Medical Workforce Specialist				
<b>Approved By:</b>	Dr Simon Roe – Chief Medical Officer				
<b>Presented By:</b>	Dr Simon Roe – Chief Medical Officer				
<b>Purpose</b>					
The paper provides the Board with an update on the exception reports received from Resident Doctors between 1 <sup>st</sup> November 2025 and 31 <sup>st</sup> January 2026		<b>Approval</b>			
		<b>Assurance</b>	<b>X</b>		
		<b>Update</b>	<b>X</b>		
		<b>Consider</b>			
<b>Strategic Objectives</b>					
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 estates	Work collaboratively with partners in the community
<b>X</b>	<b>X</b>		<b>X</b>		
<b>Principal Risk</b>					
<b>PR1</b>	Significant deterioration in standards of safety and care			<b>X</b>	
<b>PR2</b>	Demand that overwhelms capacity			<b>X</b>	
<b>PR3</b>	Critical shortage of workforce capacity and capability			<b>X</b>	
<b>PR4</b>	Failure to achieve the Trust's financial strategy				
<b>PR5</b>	Inability to initiate and implement evidence-based Improvement and innovation				
<b>PR6</b>	Working more closely with local health and care partners does not fully deliver the required benefits				
<b>PR7</b>	Major disruptive incident				
<b>PR8</b>	Failure to deliver sustainable reductions in the Trust's impact on climate change				
<b>Committees/groups where this item has been presented before</b>					
This report has been presented to the Joint Local Negotiating Committee and People Committee (March 2026)					
<b>Acronyms</b>					
ED – Emergency Department CT – Core Trainee ST – Specialty Trainee TCS – Terms and Conditions of Service NHSE – National Health Service – England LTFT – Less than Full Time PA – Programmed Activity WTE – Whole Time Equivalent TOIL – Time off in Lieu FY1 – Foundation Year 1 Doctor					

## **Executive Summary**

The Board is asked to note the following, alongside the actions planned for the next quarter (Appendix 1).

- 83 exception reports have been received in this quarter.
- The highest number of exception reports are from F1 doctors, 25 (30%) of all reports.
- 28 (34%) of exception reports are from resident doctors working in General Internal Medicine/Diabetes & Endocrinology. On reviewing these exception reports, in most instances the doctors have stayed later than the finishing time for their shift and have raised concerns about support.
- The number of exception reports being received from St3+ doctors is still quite low but is improving.
- The changes to the Exception Reporting Process were implemented on 4<sup>th</sup> February 2026.

## **Recommendations**

- Board is asked to note the report which was discussed in detail at the March People Committee.
- Moving forward it is recommended that the report continues to be produced on a quarterly basis, presented alternately to People Committee and Board. The reports that are presented to People Committee will be provided in the board reading room.

## Guardian of Safe Working Report covering the period from 1<sup>st</sup> November 2025 until 31<sup>st</sup> January 2026.

### Introduction

This report provides an update on exception reporting data, from 1<sup>st</sup> November 2025 to 31<sup>st</sup> January 2026. It outlines the exception reports that have been received during the last three months, the actions and developments that have taken place during this time and work that is ongoing to provide assurance that there is safe working as per TCS of the 2016 junior doctors' contract.

As can be seen from the data below, 266 (250.7 wte) resident doctors have been allocated to the Trust by NHSE. The Trust has an establishment of 293 resident doctor posts, so for this rotation, there are 35 vacant resident doctor posts. This is due to NHSE not being able to fill these posts for a variety of reasons, including doctors being on maternity leave, unanticipated lack of training progress (not passing their exams), doctors leaving the training programme early, or there not being enough trainees following a particular training pathway to fill the posts across the country. The Trust is not always informed of the reasons for the vacant posts and as can be seen from previous reports, these vacancy numbers fluctuate for each rotation. It is generally the first rotation of the year where there are the least number of vacancies and the last rotation from April where there are the highest number of vacancies. The number of vacancies for this rotation is particularly high and they have increased from the previous report by 8 which is surprising given the difficulties being experienced by doctors nationally in obtaining training places. Further information is included in the vacancies section of the report.

### High level data as of 31<sup>st</sup> January 2026

Established resident doctor posts:	293		
Established trust grade doctor posts:	110		
	<b>Posts</b>	<b>Heads</b>	<b>WTE</b>
Number of resident doctors in post:	258	266	250.7
Number of vacant resident doctor posts:	35	-	42.3
Number of unfilled resident doctor posts filled by a trust grade doctor:	14	-	13.8
Number of trust grade doctors in post:	98	98	97.4
Number of vacant trust grade doctor posts:	12	-	12.6

### High level data from previous quarter (as of 31<sup>st</sup> October 2025)

Established resident doctor posts:	293		
Established trust grade doctor posts:	109		
	<b>Posts</b>	<b>Heads</b>	<b>WTE</b>
Number of resident doctors in post:	266	278	262.7
Number of vacant resident doctor posts:	27	-	30.3
Number of unfilled resident doctor posts filled by a trust grade doctor:	9	-	8.8
Number of trust grade doctors in post:	93	93	92.4
Number of vacant trust grade doctor posts:	16	-	16.6

Amount of time available in the job plan for the guardian:	1 PA
Administrative support provided to the guardian:	0.1 WTE
Amount of job planned time for Educational Supervisors:	0.25 PA per trainee

## Establishment Changes

Since the previous report there have been some changes to the Trust Grade Resident Doctor establishment as per the table below.

Grade	Specialty	WTE	Reason
Clinical Fellow	Integrated Sexual Health Services	+ 1	Conversion of a vacant Consultant post
International Training Fellow	Microbiology	+ 1	Post funded by Sri Lankan government
Senior Clinical Fellow	General Surgery	+ 1	Conversion of a vacant Specialty Doctor post
Clinical Fellow	Respiratory Medicine	- 2	Posts removed to bring establishment back in line with 7 per ward
		+ 1	

## Exception reports from 1<sup>st</sup> November 2025

The data from 1<sup>st</sup> November 2025 to 31<sup>st</sup> January 2026 shows there have been 83 exception reports in total.

Of the 83 exception reports from the resident doctors, 4 were categorised as an immediate safety concern.

By month there were 26 exception reports in November 2025, 24 in December 2025 and 33 in January 2026.

Of the 83 exception reports 78 were due to working additional hours, 3 were educational and 3 were relating to service support.

All 83 exception reports from this period have been closed.

For the exception reports where there has been an initial meeting with the supervisor the median time to the first meeting is 11 days. The time to the first meeting has increased since the previous report.

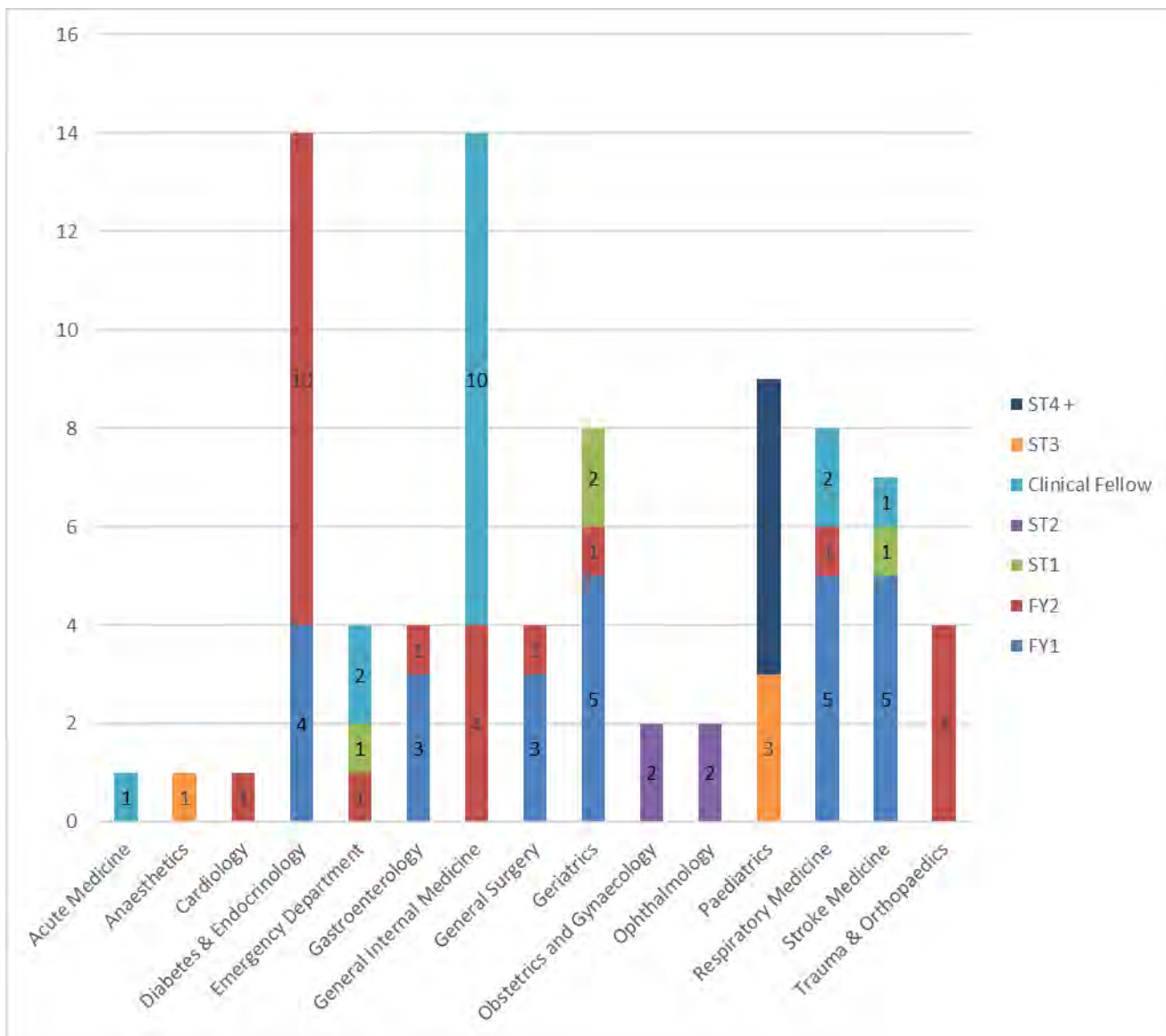
Recommendations are that the initial meeting with the supervisor should be within 7 days of the exception report. In total 55 (66%) of all exception reports either had an initial meeting beyond 7 days or have not had an initial meeting, which is higher than the 56% reported in the previous quarter.

Reminders are sent automatically to the Educational Supervisors listed by the resident doctor to respond to the exception report. These reminders are sent regularly until the reports are responded to. For the straightforward exception reports, the Medical Workforce Team will respond, however, in some instances further information is needed from the Educational Supervisor to complete the response. Where a doctor is on nights, or the Educational Supervisor is on leave or absent for other reasons, it can be difficult to ensure that the initial meeting takes place within 7 days.

Where an outcome has been suggested there are 26 (31%) with time off in lieu (TOIL) totalling 23 hours and 55 minutes, 49 (59%) with additional payment totalling 48 hours and 38 minutes at normal hourly rate and 10 hours and 26 minutes at premium rate and 8 (10%) with no further action.

The Allocate software used to raise exception reports and document the outcome does not have the facility to be able to link to the Health Roster system to confirm TOIL has been taken or additional payment received, therefore this is actioned manually by the Medical Workforce Team, a report is completed for the rota coordinators and the Payroll Team to ensure that time off in lieu is added to the doctor's record or any payment is made. This is completed monthly in line with payroll cut off

periods. With the exception reporting system changing, it is likely this will be addressed in due course.

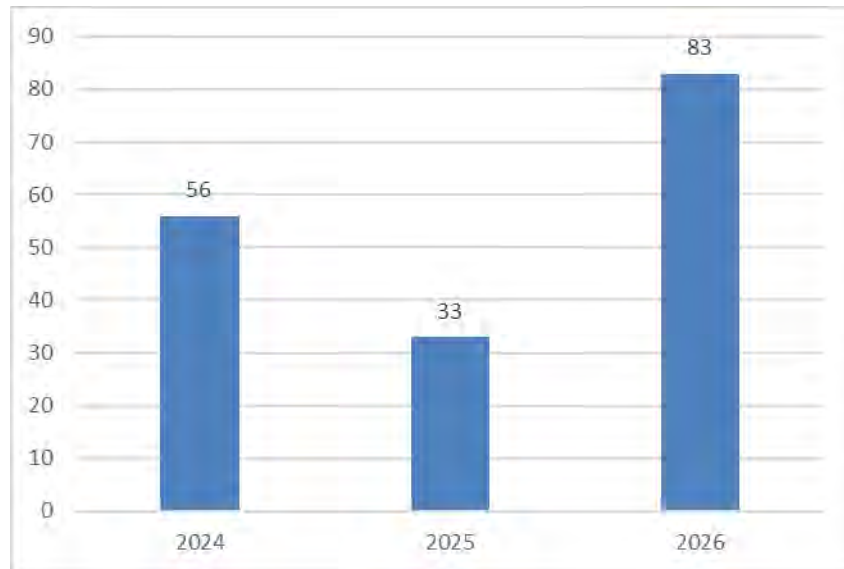


**Figure 1. Exception reports submitted by Specialty and Grade.**

Figure 1 shows that many of the exception reports received during this period - 28 (34%) in total - are from resident doctors working in General Internal Medicine/Diabetes & Endocrinology.

On reviewing these exception reports, in most instances the doctors have stayed later than the finishing time for their shift and have raised concerns about support. A separate rota was fully implemented in December which has provided more support for these specialties.

In total 25 (30%) of the exception reports are from the Foundation Year 1 doctors, 24 (29%) from the Foundation Year 2 doctors, 24 (29%) from the ST1/2 doctors (including Clinical Fellows) and 10 (12%) from ST3+ doctors (including Senior Clinical Fellows).



**Figure 2. Comparison of number of exception reports for the same quarter between 2023, 2024 and 2025.**

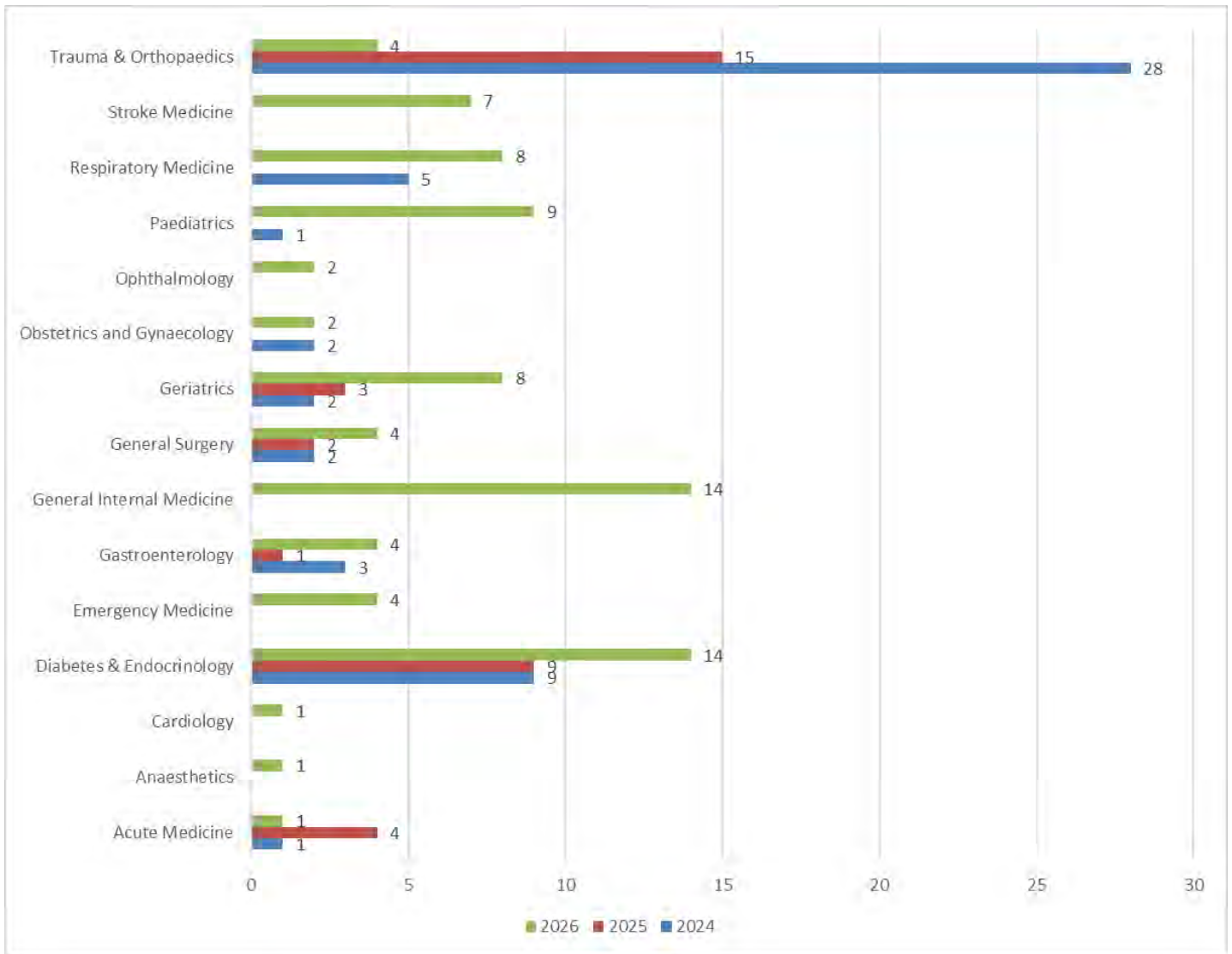
Figure 2 shows that for this period this year there have been more exception reports in total than in the previous two years.

Date	Grade and Specialty of Doctor	Details of Immediate Safety Concern reported by the Trainee	Action Taken	Status of the Concern
13/11/2025	F1 in Respiratory Medicine	Had to undertake care of 11 patients and come up with a management plan to be actioned for all - none of whom I had met before on an unfamiliar and understaffed ward (25 patients between two resident doctors). Could not read the writing in records for number of patients and not enough other regular W43 doctors around to ask. Was also being argued with by gastro to consent a patient for a gastroscopy - never consented for one before and had never met the patient.	Situation was reviewed by the Head of Service. It was not appropriate for the doctor to consent the patient for a gastroscopy.	The concern has been closed
06/01/2026	Clinical Fellow in Stroke Medicine	This is a recurrent issue, only 2 juniors in the ward with 3 extra patients as overboard, TTO delays and other management plan delays which delaying discharges in return. feeling burnout and overwhelmed over the last week and this week because of this recurrent issue of staffing.	There have been discussions with the Medical Division regarding the numbers and skill mix of doctors on wards particularly during periods of high demand where wards are having additional patients.	The concern has been closed

			A review of the rotas is being undertaken in preparation for August 2026.	
12/01/2026	Clinical Fellow in Respiratory Medicine	3 overboard patients, resulting in 27 patients on the ward in total split between 2 resident doctors	<p>There have been discussions with the Medical Division regarding the numbers and skill mix of doctors on wards particularly during periods of high demand where wards are having additional patients.</p> <p>A review of the rotas is being undertaken in preparation for August 2026.</p>	The concern has been closed
14/01/2026	F2 in Trauma & Orthopaedics	<p>I just wanted to provide some feedback regarding the T&amp;O night on-call shift that I recently completed from 20:00 14/01/26-08:00 15/01/26.</p> <p>I began the shift with a very busy workload on the T&amp;O ward. Early in the night, I was required to closely monitor a T&amp;O inpatient who was awaiting a CTPA and to remain with the patient in the CT department until the scan was completed. I also had a number of unstable patients on the T&amp;O ward handed over from the twilight team, which required ongoing review and management.</p> <p>At approximately 10:15 pm, I was asked to attend the ED office by HOOH, where I was informed that I would be required to assist with medical patients on the wards, with jobs being allocated via Nervecentre. These patients were unfamiliar to me, and I had not received any prior handover regarding their clinical backgrounds.</p>	<p>This exception report was discussed with the Head of Service and the circumstances were also discussed with the Hospital out of Hours Team. As can be seen from the narrative, the hospital was in a critical incident at this point.</p>	The concern has been closed

		<p>During this time, I was also continuing to support my fellow T&amp;O on-call colleague with ED referrals, in addition to managing constant ward jobs across multiple wards and hospital levels. These included reviewing unwell patients, chasing investigations, prescribing, and making clinical decisions, alongside my own T&amp;O on-call responsibilities.</p> <p>While I did my best to help wherever possible, I found it very challenging and felt that it was unsafe to be making overnight clinical decisions for medical patients unfamiliar to me, particularly without adequate handover. The shift felt overwhelming and physically exhausting due to the volume and complexity of tasks, and I am concerned about the potential impact on patient safety.</p> <p>I fully appreciate the current pressures on the hospital and am aware of the recent critical incident. However, I would kindly suggest that arranging dedicated medical cover for medical patients overnight would be much safer and more appropriate, rather than reallocating an FY2 covering T&amp;O, who already has significant ward and on-call commitments.</p>		
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**Table 1. Immediate Safety Concern Concerns Raised.**



**Figure 3. Comparison of number of exception reports submitted by Specialty for the same quarter between 2024, 2025 and 2026.**

Figure 3 shows that for this period this year there have been more exception reports from the doctors across some specialties than in previous years, specifically in the Medical Division. The number of reports received from Trauma & Orthopaedics has continued to decrease for the same period each year.

### Work Schedule Reviews

There have been no work schedule reviews during this period.

### Fines

There have been no fines.

### Vacancies

The Trust currently has 266 resident doctors allocated by NHSE. As mentioned in the introduction, there are 35 vacancies where the Trust has not been allocated resident doctors by NHSE the reasons for these posts not being filled were also mentioned in the introduction, 14 of the vacancies are currently filled by trust-grade doctors.

The remaining gaps will be filled by doctors on the bank where needed to support the rotas, which represents a cost pressure to the Trust.

There are considerable fluctuations in the fill rate between each changeover throughout the year and therefore it is difficult to predict likely vacancies, this has become especially difficult to predict due to several doctors requesting less than full-time posts throughout the year.

## Qualitative information

Table 3 below indicates the number and percentage of exception reports that were not responded to within the required time frame of 7 days over the last year. This number remains high and is an ongoing theme, however, the Guardian of Safe Working regularly reminds Educational Supervisors of their responsibility to respond to exception reports within the required timescale of 7 days. As can be seen from the data below, although this improved in the second reporting quarter of the year, it has been high in the last two quarters of the year.

Date of the Guardian Report	Number and Percentage of reports <u>not</u> responded to within 7 days
November 2025 – January 2026	66% of all reports received. 55 reports
August 2025 – October 2025	56% of all reports received. 66 reports
May 2025 – July 2025	57% of all reports received. 30 reports
February 2025 – April 2025	64% of all reports received. 23 reports

**Table 3 Exception reports not responded to within 7 days.**

### Resident Doctor Forums

The second meeting of the Resident Doctor Board took place on 6<sup>th</sup> January 2026. This was well attended by both the Associate College Tutors and the Trust Executive and Chaired by the Chief Registrar. At the meeting, concerns were also raised about the rota in Medicine, in particular the IMT rota. Discussions were held regarding weekend frequency and the 8am start times.

The booking of annual leave was also raised as an issue in Medicine and it was agreed to hold a separate meeting with the Associate College Tutors in Medicine to discuss the concerns raised.

The meeting took place on 14<sup>th</sup> January where several issues were discussed and plans to address these issues were agreed. As mentioned earlier there are also plans to review the rotas in Medicine for the changeover in August and the ACT's will be involved in those discussions.

### National Review of the Exception Reporting Process

The revised Exception Reporting process commenced on 4<sup>th</sup> February 2026.

The key changes to the exception reporting process have been highlighted below.

### Access to Exception Report

Doctors are required to have access to the allocate system to be able to exception report within 7 days of commencing in post. Where access has not been given and it is raised as a concern, if not rectified within 7 days, a fine will be applied by the guardian. At Sherwood Forest, the Medical Workforce Team aim to ensure that all doctors have access to the allocate system on commencement in post. The Medical Workforce Team ensured that doctors completed a test exception as part of the induction to confirm they have access to the system.

All doctors in post have been given access to the revised software system by Allocate. A cross-checking process took place yesterday afternoon by the Guardian of Safe Working confirming all doctors commencing in post yesterday had access to the system.

### Processing of Exception Reports

The new reforms have moved the responsibility for verifying and processing exception reports from the Educational Supervisor to the Medical Workforce Team where additional hours have been worked up to 2 hours in any instance. Doctors are required to submit an exception report within 28 days, and the Medical Workforce Team are required to verify and action the exception report within 10 days (7 days from 5<sup>th</sup> August 2026). The doctor will also state whether they want TOIL or pay for the exception report submitted.

### Educational Exception Reports

All educational exception reports will go to the Director of Medical Education for approval. They can take action to replace or reinstate any missed educational opportunities.

### Time off in Lieu/Payment for Exception Reports

Doctors will be able to choose either time off in lieu or payment following the verification of an exception report and where time off in lieu is chosen, this must be arranged within one day of the award where it is mandatory and 10 days (7 days from 5<sup>th</sup> August 2026) of the award if it has been requested.

### Penalties and Distribution of Fines

To protect doctors, exception report data must be treated as confidential and cannot be accessed, shared or requested to be shared beyond specific pathways included in the framework, proven violations will be subject to an information breach penalty. Penalties of £500 per doctor per instance for proven information breaches will be levied.

In addition, where access to exception reporting has been raised and is not rectified within 7 days, a fine of £500 will be levied per doctor per week.

## **Conclusion**

The People Committee is asked to note the following and the actions planned for the next quarter detailed in Appendix 1.

- 83 exception reports have been received in this quarter.
- The highest number of exception reports are from F1 doctors, 25 (30%) of all reports.
- 28 (34%) of exception reports are from resident doctors working in General Internal Medicine/Diabetes & Endocrinology. On reviewing these exception reports, in most instances the doctors have stayed later than the finishing time for their shift and have raised concerns about support.
- The number of exception reports being received from St3+ doctors is still quite low but is improving.
- The changes to the Exception Reporting Process were implemented on 4<sup>th</sup> February 2026.

## Appendix 1

### Issues/Actions arising from the Guardian of Safe Working Report to be taken forward.

Action/Issue	Action Taken (to be taken)	Date of completion/Deadline
National Review of the Exception Reporting Process	<p>Ensure the changes to the process are implemented and communicated to stakeholders prior to the implementation date.</p> <p>All involved are becoming familiar with the new reforms process. Ongoing support is being provided.</p>	<p>Implementation complete.</p> <p>Ongoing to ensure all stakeholders are familiar with the revised reforms.</p>
Actions from the meeting held on 14 <sup>th</sup> January 2026 to be taken forward	Actions are being taken forward and further work taking place to review the rota in Medicine for the August Changeover will be undertaken.	30 <sup>th</sup> April 2026

**Board of Directors Meeting in Public**

<b>Subject:</b>	Freedom to Speak Up / Raising Concerns		<b>Date:</b>	April 2 <sup>nd</sup> 2026	
<b>Prepared By:</b>	Kerry Bosworth, FTSU Guardian				
<b>Approved By:</b>	Sally Brook Shanahan – Director of Corporate Affairs				
<b>Presented By:</b>	Sally Brook Shanahan – Director of Corporate Affairs				
<b>Purpose</b>					
This report provides an overview of speaking up cases for Q3 and Q4 2025/26 YTD, covering the period since the FTSU report was last presented to the SFH Board in October 2025. Included within the paper are FTSU activity updates, the NSS results for raising concerns questions and an update on the wider FTSU agenda, locally and nationally.				<b>Approval</b>	
				<b>Assurance</b>	X
				<b>Update</b>	X
				<b>Consider</b>	
<b>Strategic Objectives</b>					
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 estates	Work collaboratively with partners in the community
X	X		X		
<b>Identify which Principal Risk this report relates to:</b>					
<b>PR1</b>	Significant deterioration in standards of safety and care				X
<b>PR2</b>	Demand that overwhelms capacity				
<b>PR3</b>	Critical shortage of workforce capacity and capability				
<b>PR4</b>	Insufficient financial resources available to support the delivery of services				
<b>PR5</b>	Inability to initiate and implement evidence-based improvement and innovation				
<b>PR6</b>	Working more closely with local health and care partners does not fully deliver the required benefits				
<b>PR7</b>	Major disruptive incident				
<b>PR8</b>	Failure to deliver sustainable reductions in the Trust's impact on climate change				
<b>Committees/groups where this item has been presented before</b>					
<b>Acronyms</b>					
FTSU – Freedom to Speak Up			VSM – Very Senior Manager		
FTSUG - Freedom to Speak Up Guardian			LTS – Long Term Sickness		
EM – Ethnic Minority			TMT – Trust Management Team		
WRES – Workforce Race Equality Standard			JSPF – Joint Staff Partnership Forum		
AFC – Agenda For Change			OH - Occupational Health		
NSS – National Staff Survey			OD – Organisational Development		
EDI – Equality, Diversity & Inclusion			MAST- Mandatory & Statutory Training		
NHSE – NHS England			NGO – National Guardians Office		
NSS – National Staff Survey			2026GMC – General Medical Council		
<b>Executive Summary</b>					
In Q3 and Q4, 2025/2026 YTD, 53 concerns were raised with the FTSUG. The following report provides an overview of speaking up cases for that period. Included within the report are FTSU activity updates, the NSS results for raising concerns questions and the wider FTSU agenda, locally and nationally.					

## Freedom To Speak Up Report

### Overview

During Q3 there were 30 concerns raised and in Q4 to date, 23 concerns have been raised with the FTSU Guardian: a total of **53** concerns to date in that period.

Of the 53 concerns, 3 are now in a formal ER process, having not found resolution informally. 19 concerns have used informal escalation processes, with 10 of these cases remaining open. Due to the remaining 31 cases being raised confidentially, this means further escalation was not possible meaning only their themes can be shared.

### FTSU Concerns Statistics

Quarterly Comparison of all FTSU Concerns			% change
Quarter	24/25 Concerns	25/26 Concerns	↓
Q1	42	41	-2%
Q2	47	36	-23%
Q3	75	30	-60%
Q4	42	to date 23	

Overall, the number of concerns reported in 25/26 to date is **lower in every quarter** compared to 2024/25.

*The average quarterly submission number of concerns in the Acute & Acute Community NHS Trust category is 45.9. (NGO Survey of Speaking Up Data to FTSUG 24/25 published Aug 2025)*

### Status of concerns raised

Following on from the Q2 shift from concern raisers raising concerns openly, to wanting to raise them confidentially; there was a resulting swing in Q3 to confidential reporting. This means that the concern raiser is known only to the FTSUG, limiting options for resolution and escalation or in many cases preventing the concern being progressed. However, in Q4, there is now a modest shift to more concerns being raised openly.

Quarter	Openly Raised	Confidential	Anonymous	Total
Q1	33	7	1	41
Q2	18	17	1	36
Q3	9	21	0	30
Q4 to date	14	9	0	23

All divisions continue to show workers engaging with FTSU and experiencing similar barriers in taking concerns forward. With recent publication and triangulation with the NSS results of “We Each Have A Voice That Counts” and noting the decline in confidence in raising concerns openly, a question for consideration is whether the Trust should implement an anonymous reporting function, to allow staff voice to be heard without perceived barriers. This has been previously considered in the past but decided against due to a perception at the time that it was incompatible with an open culture.

### People Profile of Concern Raisers

**Workforce Groups** – engagement in Q3 /Q4 is welcomed from Additional Professional, Scientific and Technical workforce as well as consistent engagement from medical workforce. This represents awareness of the FTSU option to these workforces, where historically they have not been represented or were underrepresented.

Gender breakdown of concern raisers in this period – female 79% and male 21%. The majority of concerns are raised from white British females. Of the concerns raised in Q3/ Q4, 32% were from an ethnic minority background. The SFH Ethnic Minority (AFC and VSM) workforce demographic is 19% (WRES data 2025), demonstrating that these workers engage with and raise concerns through FTSU. FTSU has representation in the Ethnic Minority Staff Network and we have Champions who are from an ethnic minority background, who focus their support to these workers. The FTSUG meets monthly with the Lead for EDI, to triangulate and collaborate on engagement with ethnic minority colleagues. Despite the decrease in number of concerns raised, those raised by ethnic minority colleagues has increased.

Workers with disabilities are represented with 18% of concerns in this period involving a worker with a disability, and with the disability forming the concern, in relation to experience of SFH processes, policies and leadership style. Out of the concerns in the Worker Safety & Wellbeing Category, 10 related to a disability, of which five were signposted to FTSU after visiting OH.

### **Overview Q& Q4 FTSU Concerns – 53 concerns**

<b>Reporting Category</b>	<b>Description - NGO Categorisation</b>	<b>Number of Concerns</b>	<b>% of Total</b>
Staff Group	Registered Nurses and Midwives	18	34%
	Administrative and Clerical	10	19%
	Medical and Dental	9	17%
	Additional Professional, Scientific and Technical	6	11%
	Allied Health Professionals	6	11%
	Additional Clinical Services	3	6%
	Estates and Ancillary	1	2%
Case Themes	Patient Safety and/or Quality	13	25% ↑
	Worker Safety or Wellbeing	25	47%
	Bullying and/or Harassment	5	9%
	Other Inappropriate Attitudes or Behaviours	9	17%
	Detriment - as a result of speaking up	1	2%

During Q3/Q4 there is an increase in concerns relating to Patient Safety & Quality, from previous quarters. The Worker Safety or Wellbeing category remains the most prevalent theme of concerns raised.

### **FTSUG Observations from FTSU Conversations raised confidentially with a barrier to allowing onward escalation -**

- **Fear of detriment** – career limiting, “next to go”, fragile teams
- **Low confidence in leadership**
- **Futility** – unable to resolve, well known concerns not actioned/no feedback
- **Perception that speaking up is a low priority for line managers** in the current financial and operational climate. Speaking up is not perceived to be a leadership priority mindful of current operational pressures - e.g. leadership workload - too busy, no curiosity, no face-to-face meetings. If they believe concerns involve a financial cost, due to current climate believe it is futile to ask.
- **Leadership engagement** – operational pressures are detrimental to leaders being able to provide the engagement needed in hearing and following up concerns.

## **Overview of the 25 Worker Safety & Wellbeing concerns in Q3 and Q4 25/26**

**People Processes** – 8 cases were in active people processes.

*Sickness & Absence , Informal Capability and Flexible Working Processes concerns* – work related stress, on LTS due to behaviours in team. Poor induction processes, feeling ostracised and not part of team. Conduct and communication in Stage 2 meetings – stressful processes made worse. Informal Capability – conflicting information, unjust approach, line management support poor. Attitudes to reduction in hours, bias and favouritism – not equal across team.

### **Poor Response to Raising Concerns**

*Impact of poor behaviours from team members* – raised to line managers, listened to, but no follow up or improvement, no feedback, no check in.

*Impact of poor behaviour from line managers* – feeling treated differently to others, micromanaged, work criticised more than other colleagues. Has raised before but feels detriment for raising.

*Communication routes* - workers closest to patient care report poor or non-existent communication. Unable to raise concerns therefore, feeling unvalued and unimportant. Unable to contribute ideas for improvement yet hold the greatest detail of how things are. Simple asks never get progressed.

*Leadership visibility and capacity* – unable to raise concerns as managers too busy, not seen and no local opportunity to raise. Feeling that operational pressures reduce ability of leaders to create time and space for speaking up.

### **Burnout in role**

Overwhelmed in role / capacity issues, raised with line managers – no responsive action. Admin workers working in role beyond scope – e.g. supporting clinicians and patients clinically. Communication from managers all via messaging apps - anxiety provoking and can feel punitive and can feel punitive with the amount of messaging being overwhelming. If opt out, then feels not included and miss important information. No regular face-to-face contact with leadership.

### **Physical Safety to staff**

Equipment to improve staff and patient experience broken, not replaced in a timely way or at all. Capacity issues, poor environment – the effect is less ability to deal with violent and aggressive behaviour, unsupervised 1-1s. Inability to support staff after violence and aggression episodes as acuity too high.

The impacts of all the above concerns in the Worker Safety & Wellbeing category reflect culture, which underpins patient safety and has direct consequences on recruitment and retention, financial costs to service lines, reputation, and the capacity of Occupational Health. It increases demand for the wellbeing services, who the FTSUG used to regularly triangulate information with and refer colleagues. With the withdrawal of the clinical psychology service and the Lead for Wellbeing role, this impacts the support that staff can access on site and options for concern raisers' welfare. The FTSUG has recognised that it is common for concern raisers to be on sick leave, recently returned from sickness absence or be on the threshold of taking sickness absence. Five concern raisers were signposted to FTSU after visiting OH, highlighting that the root of workers ill health was directly related to work and leadership style.

## **Patient Safety & Quality Concerns**

There is an increase in Q3 & 4 of concerns in this category.

Examples are :-

- Poor performance management of individuals – safety risks in process due to no action on poor performance
- Impacts on service relocation on outpatients from other specialties
- Safeguarding concerns – sexual safety concern
- Change in practice – impact on team relationships and practice
- Quality / value concerns on third party providers / contracts
- Patient pathway for a surgical speciality - poor quality
- Workload in urgent care – beyond safe care capacity, acute medicine areas struggling – processes deteriorate
- Safe storage of patient medication

## **Detriment Concern**

In Q3 there was 1 case of detriment reported from raising concerns previously about a leader. The concern raiser reported they felt that verbal interactions and the way they were treated in the team declined after this concern was raised. Concern raiser felt they couldn't escalate this through the detriment process for fear of repercussions, therefore FTSUG unable to progress.

## **Inappropriate Attitudes & Behaviour Concerns**

- Incivility
- “Gaslighting” behaviours
- Racism – racial slurs between colleagues – said in jest / banter, not challenged
- Unresolved conflict in medical divisional leadership
- Lack of compassion in processes
- Lack of professionalism – hierarchy prevents speaking up

## **Bullying & Harassment**

- Leadership not addressing concerns about behaviour – protracted exposure to poor behaviour
- Poor handling of speaking up relating to behaviour – minimised impact
- Line manager style
- Fact finds not comprehensive and poor communication, with poor support after raising
- Line managers feeling bullied by workers

Common themes that cross all Divisions can be seen from the data

1. Handling of concerns in initial stages and lack of resolution and ownership to commit to bringing to resolution
2. Lack of experience and skill in handling concerns
3. Leadership style and behaviour impacting negatively
4. Lack of support, care and “person-centred approach” in dealing with situations or people processes
5. Timely response to concerns is an issue – citing leadership visibility and capacity.

Feedback from concern raisers remains positive despite many concerns personally unresolved due to confidential status of many of the concerns.

### Feedback received –

- Gratitude for the time and space to listen and for the signposting information provided by the FTSUG
- Feeling better for speaking to someone, especially related to where health and wellbeing is impacted
- If FTSU had not supported the concerns, then staff would still feel unable to return to work from sickness absence
- Accessed wellbeing personal support after speaking with FTSU
- Able to remain at work whilst concerns progressed due to support given
- Felt understood processes and policies available to them better now
- Now able to access training needed to perform in role
- Support now in place for a phased return and supportive package led by a senior manager
- Improvements in team cohesion – understanding each other better accepting cultural differences , now feeling less ostracised and happy to stay.
- Was able to access coaching and personal development, to build resilience skill set.

### NSS Results for Raising Concerns / We Each Have a Voice That Counts

Nationally the sub-score for “ We Each Have A Voice That Counts” in 2025/26 has fallen to 6.59, from 6.69 in 2024/25.

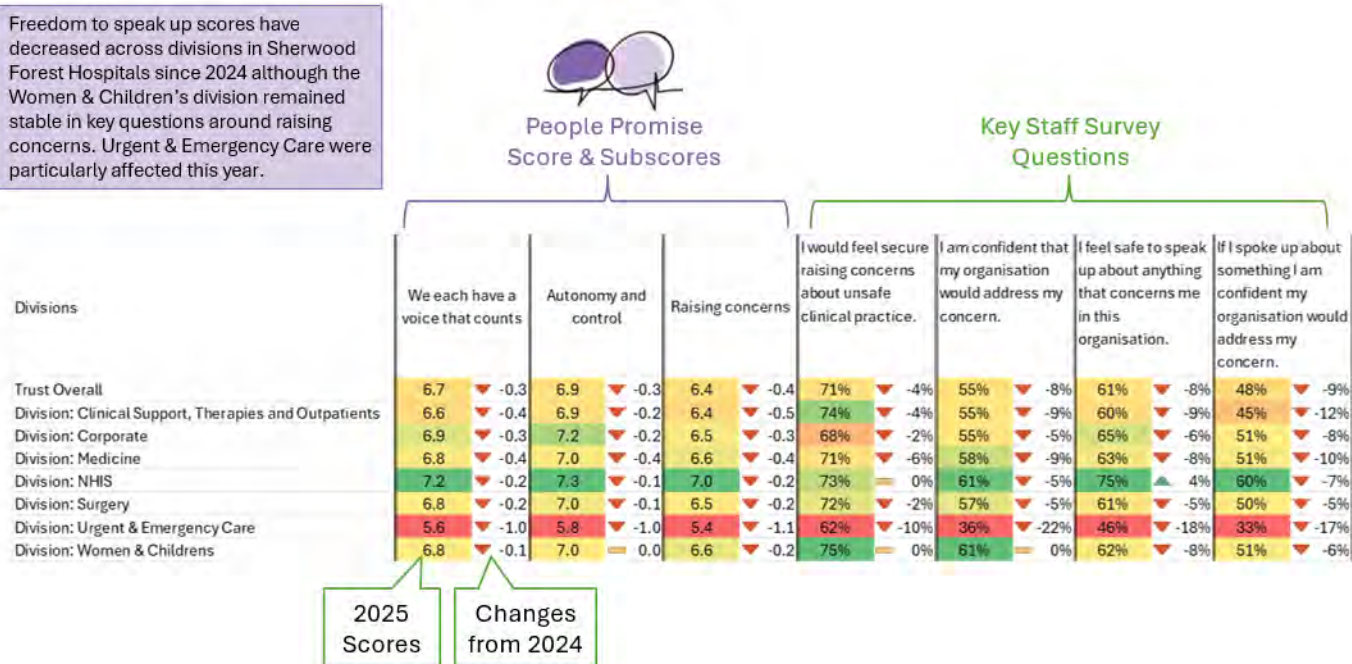
At SFH the sub score for this category has declined by 0.3 to 6.7 but remains above the national average in this domain.

The national survey found six in ten staff felt safe to speak up about anything that concerns them, while just under one in two (47.6%) believe their organisation would act if they did so.

This is reflected locally at SFH with a decline in the confidence between raising concerns and believing the trust will follow up and act on concerns.

NHS Staff Survey 2025 - Freedom to Speak Up: SFH & Divisions

Freedom to speak up scores have decreased across divisions in Sherwood Forest Hospitals since 2024 although the Women & Children’s division remained stable in key questions around raising concerns. Urgent & Emergency Care were particularly affected this year.



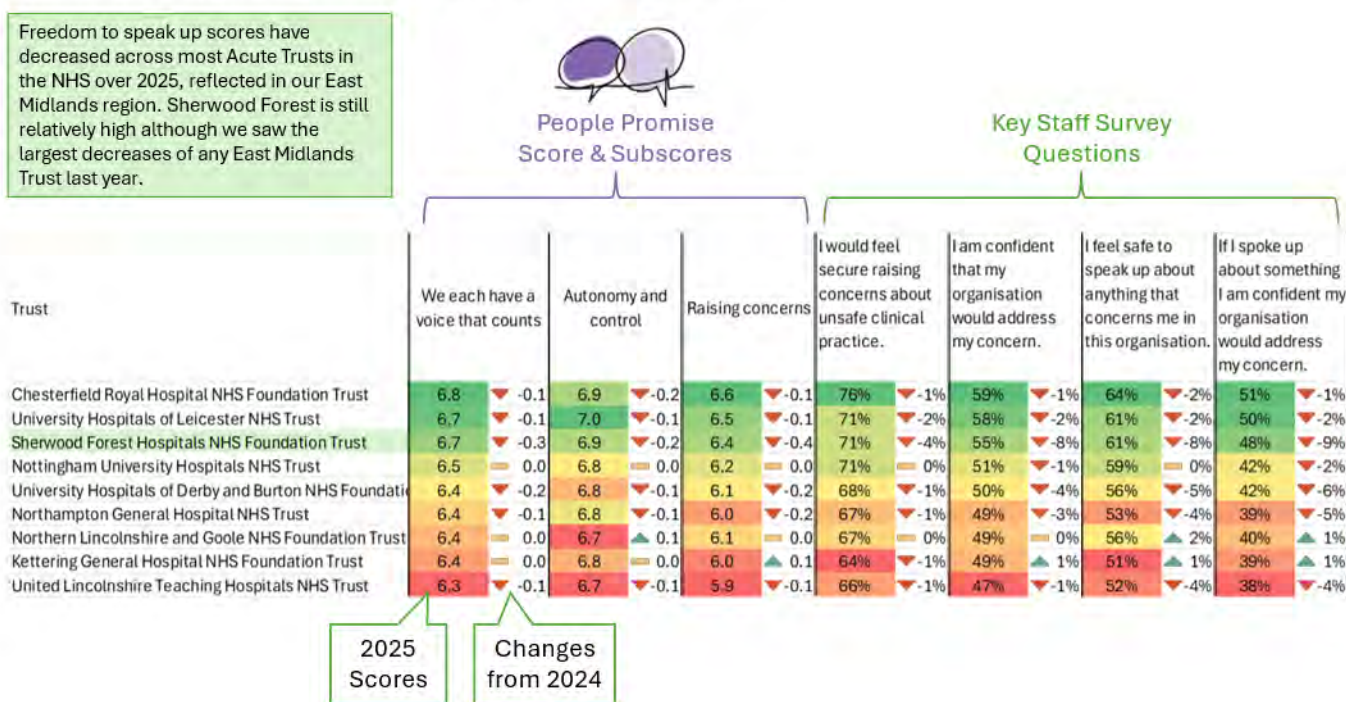
Safety concerns - There is a decline in the confidence in raising concerns about unsafe practice and confidence in following up of those concerns as a Trust overall. Addressing safety concerns confidence is now at 55% overall. The national average for an Acute / Acute & Community Trust is 54.07%.

Feeling safe to speak up about anything and the follow up of addressing concerns scores, has significantly decreased, with only 48% of the trust workforce confident concerns would be addressed. In comparison, the national average is 46.1 % so SFH is now more aligned to the national position whereas in the past, it has been well above the national average scores.

This triangulates with the FTSU specific data held by the FTSUG, potentially explaining the barriers existing preventing concerns being taken forward and a lack of confidence, locally, that resolutions will be found.

Of all the East Midlands Trusts, SFH was third in the region in this domain, despite still being relatively high in scoring, SFH saw the largest decrease in psychological safety across the region.

NHS Staff Survey 2025 - Freedom to Speak Up: East Midlands Trusts



This trend highlights the importance of reinforcing messaging and commitment to actions needed to restore and promote a speak up culture at SFH, with commitment to create space to listen and assure staff that follow up will happen.

An assurance of a commitment to seek a resolution and to feedback, has been highlighted as the key in encouraging staff to go forward to raise openly. Currently this is not how the majority of FTSU concern raisers feel and is also reflected in the above NSS results for speaking up culture.

### Learning, triangulation and developments from FTSU concerns

Patient safety and quality concerns are all referred to senior nursing or have executive oversight. Action plans have been put in place for these types of concerns.

Concerns raised about a surgical pathway, now have oversight from the CMO and therefore benefit from senior input into resolution. A Safeguarding concern relating to sexual safety, is now being followed up by the Safeguarding team and a historical check is in progress. A Tannoy has

been purchased by the Hospitals' Charity for ED reception, to support quality in the patient booking in process and to improve staff experience and safety.

Triangulation of themes and areas of concern are shared regularly with the OD Team, EDI Team and OH, via 1-1s or monthly intelligence sharing catch ups. This is to support a joined-up approach to concerns and support colleagues who may not want to take formal steps with concerns but to ensure support and guidance is available.

Since this report last came to Board the FTSUG has established regular touch points with each Division. This is vital to build feedback loops from concerns and due to the swing in confidential cases, allows the FTSUG to feed in themes, where direct escalations are not possible. Diarised are 8-12 weekly touch points with Medicine, U&EC, Surgery, W&C. Arrangements for CSTO remain to be finalised.

Following on from the FTSUG session with the East Midlands GMC Advisor, on "Challenging Conversations", in March 2026, the FTSUG co-hosted a session on "Raising Concerns", to over 30 current F1 doctors, with the GMC Advisor. This is to continue visibility of FTSU in our medical cohorts and demonstrate collaboration with external stakeholders.

FTSU Champion numbers declined in early 2025, so active recruitment began in Autumn 2025, leading to 5 newly trained Champions now in situ. New Champions for Medicine, ED and Maternity are all now active. The total for the Champion team is now 25.

Despite operational pressures in the Winter period, executive meetings have continued with the FTSUG, demonstrating commitment to the speak up culture agenda.

The FTSUG role is focussed on reactive and proactive activity. The visibility of the FTSUG is maintained through the Champion network and the involvement in proactive trust wide activity such as, leadership development programmes – clinical and non-clinical, presence at all Trust inductions, preceptorship programmes and student inductions. This is alongside bespoke listening events, engagement events and regular divisional and corporate meetings. The FTSUG is also directly involved in improvement projects – currently the Violence & Aggression Reduction Group and added recently to the Workforce & Professional Leadership Standards Working Group for Surgery, following the Value Circle Report recommendations. FTSUG is actively supporting actions from this report in the domain of Psychological Safety and hosting safe space sessions as well as supporting leadership with feedback from cases and lessons learnt.

## **FTSU Process & Timescale Guidance**

This was introduced as a recommendation from the Grant Thornton LLP developmental Well Led Review 2025. The new FTSU Process & Timescale Guidance was shared with divisions prior to its approval by TMT and launched in September 2025. The guidance has now been in use for 6 months and the FTSUG has reviewed its efficacy and received feedback from the TMT regarding its use. The FTSUG has now incorporated the feedback with the guidance now separated into 2 documents – one for staff and one for managers. The guidance documents are now being progressed through the JSPF pathway for approval.

A case study on the positive use of the new guidance by Maternity was presented to the People Committee in January 2026.

## Leadership training in handling concerns

In response to another recommendation from the Grant Thornton LLP developmental Well Led Review 2025, leadership training in handling and responding concerns is now required by all leaders at SFH.

In the context of the Trust's current financial position, existing resources have been utilised to meet these training needs. The 3 linked modules titled: Speak-up, Listen-up and Follow-up are now the required training to be completed. This training is recommended nationally as well. An agreed action plan, supported by the People Development Team, with oversight from the Director of Corporate Nursing is now in action phase, to communicate the need for completion of this training to all leaders at SFH and monitor compliance.

As of the end February 2026, the following training had been undertaken:

	Speak Up:	Listen Up:	Follow Up
Dec-25	149	25	16
Jan-26	175	124	73
Feb-26	204	147	86

The Director of Corporate Nursing will provide updates to the Local MAST and Training Oversight Group from February 2026, with progress reported to the People Cabinet quarterly and escalated in turn to the People Committee.

## National Updates

### FTSU National Governance

The closure of the NGO is being jointly managed by the CQC, NHSE and Department for Health & Social Care. The Dash Review recommends that the NGO's responsibilities are absorbed by providers, with staff voice functions aligned within NHSE. Oversight of implementation across commissioners and providers sits with CQC as the independent regulator. The Department for Health & Social Care, NHSE, the NGO and CQC are working together to implement these recommendations, with further updates to follow.

### Engagement and next steps

NHSE has led engagement on behalf of the Closure Board with NGO staff, FTSU guardians, NHS leaders and stakeholders to inform the future of the Freedom to Speak Up functions. Feedback will shape proposals on which activities will stop, start or continue, and which will transfer to employers. To enable this engagement and support guardians through transition, the NGO closure date has been extended to 30 June 2026.

NHSE and the NGO have confirmed that the FTSUG role will remain mandated in the NHS Contract for 2026/2027, despite the NGO function being dissolved and governance being taken into the Department for Health & Social Care.

### Recommendations from this report

The Board is asked to:

- receive the report and note the most recent speaking up data
- note the learning, triangulation and on-going developments arising from FTSU concerns.

- take assurance from the continued development of the FTSU operational process including the Process & Timescale Guidance review and the development of the regular divisional engagement with the FTSUG.
- note the significance of the latest NSS data for SFH and the triangulation of this with the latest FTSU data and the limitations this brings to resolution, with futility and fear being the reported barriers in the current climate.

**Board of Directors Meeting in Public - Cover Sheet**

<b>Subject:</b>	Research and Innovation Annual Performance and Progress Report. 2025/26		<b>Date:</b>	2 <sup>nd</sup> April 2026		
<b>Prepared By:</b>	Terri-Ann Sewell, Research Operations Manager					
<b>Approved By:</b>	Jonathan Vanm Tam Non-executive director					
<b>Presented By:</b>	Alison Steel, Head of Research and Innovation					
<b>Purpose</b>						
To provide 2025/26 annual performance and progress, and a strategy update.			<b>Approval</b>			
			<b>Assurance</b>			
			<b>Update</b>	<b>X</b>		
			<b>Consider</b>			
<b>Strategic Objectives</b>						
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 well-being within our communities	Continuously learn and improve	Sustainable use of resources and estates	Work collaboratively with partners in the community	
		<b>X</b>	<b>X</b>		<b>X</b>	
<b>Principal Risk</b>						
<b>PR1</b>	Significant deterioration in standards of safety and care					
<b>PR2</b>	Demand that overwhelms capacity					
<b>PR3</b>	Critical shortage of workforce capacity and capability					
<b>PR4</b>	Insufficient financial resources available to support the delivery of services					
<b>PR5</b>	Inability to initiate and implement evidence-based Improvement and innovation					<b>X</b>
<b>PR6</b>	Working more closely with local health and care partners does not fully deliver the required benefits					
<b>PR7</b>	Major disruptive incident					
<b>PR8</b>	Failure to deliver sustainable reductions in the Trust's impact on climate change					
<b>Committees/groups where this item has been presented before</b>						
None to date						
<b>Acronyms</b>						
EMRRDN – East Midlands Regional Research Delivery Network						
R&I – Research and Innovation						
DHSC – Department of Health and Social Care						
RCF – Research Capability Funding						
NMAHP's – Nursing, Midwifery and Allied Health Professionals						
CRF – Clinical Research Facility						
MRU – Mobile Research Unit						
CRN- Clinical Research Network						
NIHR – National Institute for Health Research						
GCP – Good Clinical Practice						
NTU – Nottingham Trent University						
IAOCR – International Accrediting Organisation for Clinical Research						
GSCA – Global Standard Clinical Trial Accreditation						

## **Executive Summary**

### Performance -

- Recruitment into research studies at the end of Q4 2026 – 1,916. Lowest recruitment since 21-22
- Recruitment into commercial studies – 05 participants compared to 23 in 24/25. However, a number of studies have closed, and we have 2 commercial studies in the pipeline.
- Studies open or in follow-up 90 in 18 specialities
- 33 new studies have been opened in 25/26
- Study set up times commercial 24 days and non-commercial 19 days.

### Finance

- R&I Budget - **£920,788.00** allocated by EMRRDN, excl additional £105,000 won through successful bids.
- Income at end of Q4- **£26,961.01**
- DHSC RCF - £35,000 to maintain research capacity and capability

### Patient Experience

- 189 PRES surveys completed in 2025/26
- 95% of participants felt research staff valued their participation in studies, and additional comments in the report.

### Research Impact

- NMAPS -Visual map showing activity and outputs to support research engagement, led by Dr Kerry Evans and R&I
- Mobile Research unit- increasing community engagement and recruitment in hard-to-reach communities.
- Clinical Research facility- building complete, successful Launch October 2025 and 1<sup>st</sup> patient booked in January 2026.
- Poster workshops and research drop-in sessions success 2025
- How research links in with the NHS 10-year plan 3 shifts- number of studies in each section displayed in the report.

# Research & Innovation

## 2025-2026 Annual Performance and Strategy Update

**We are pleased to present the 2025/26 annual performance and strategy update for Research and Innovation**

The Research and Innovation team is responsible for developing and supporting a varied research portfolio and ensuring better opportunities for patients and staff to participate in research activity, whilst informing the provision of high-quality, evidence-based health care.

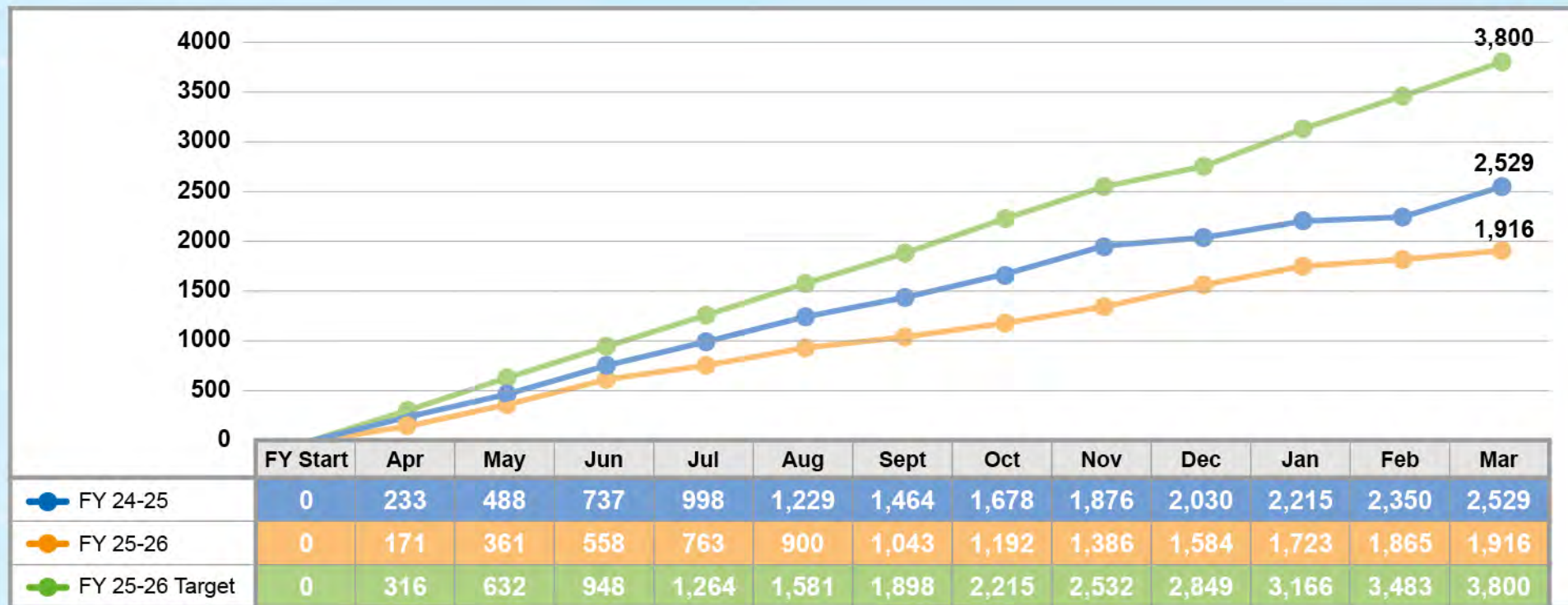
In 2026/27, the focus is on growing a balanced research portfolio, increasing commercial research activity, and maintaining regular oversight through bi-annual Board reporting and monthly updates to Divisions and investigators.

The R&I strategy 2022-2027, 'Research is for Everyone', sets out a clear vision to embed research into everyday practice, realising the research potential in all areas of our hospitals for the benefit of patients, staff, and our community. This includes 4 key pillars: Place, Progress, People, and Partnership. This report provides an update on recruitment activity and outlines progress against the key strategic objectives for year 4.



# Performance

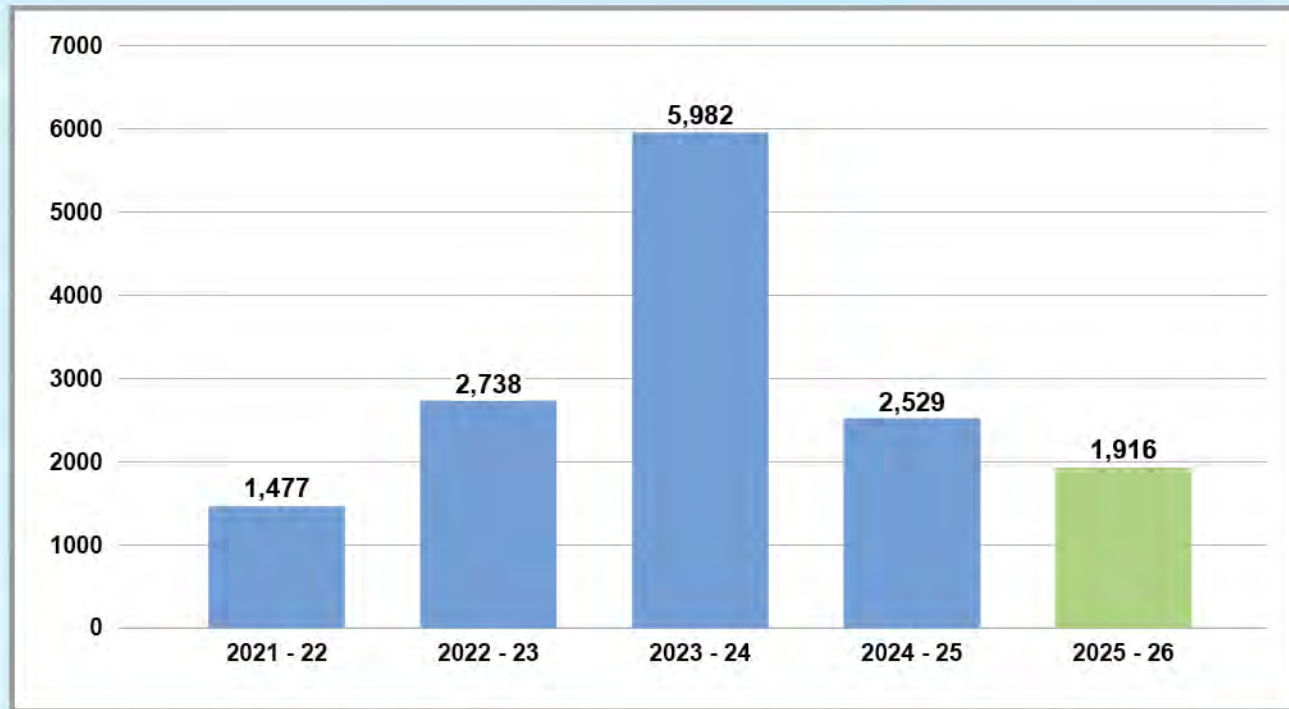
## FY 2025 - 2026 Cumulative Monthly Recruitment



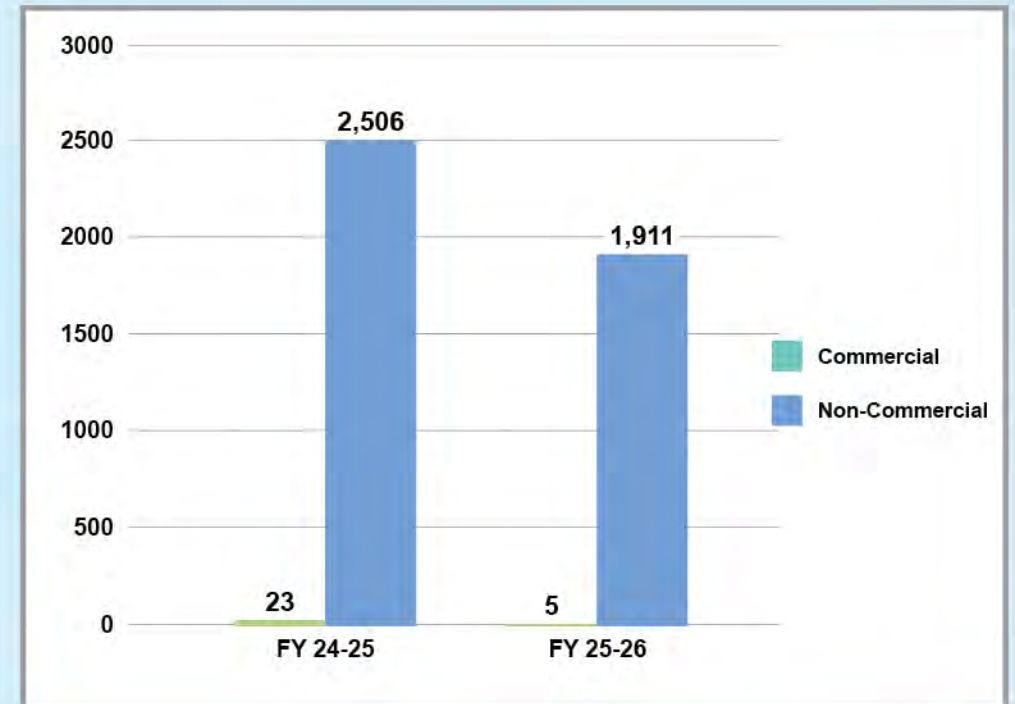
(Data cut: 16/03/2026)

# Recruitment

### Annual recruitment over five years



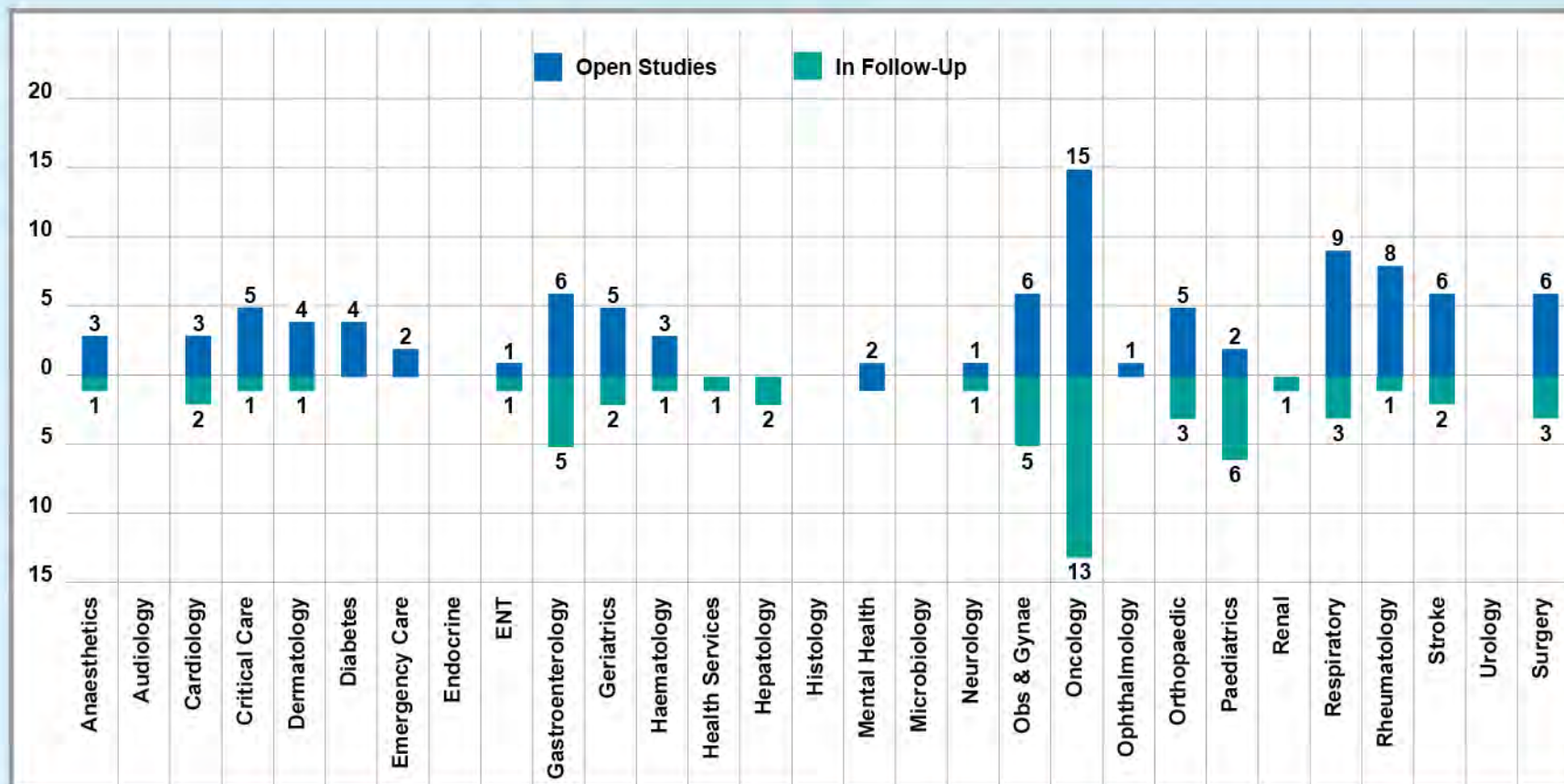
### Recruitment 24-25 & 25-26 at Q4



(Data cut: 16/03/2026)

# Performance

Total studies open & in, follow-up 2024 – 2025 Q1 - NEW

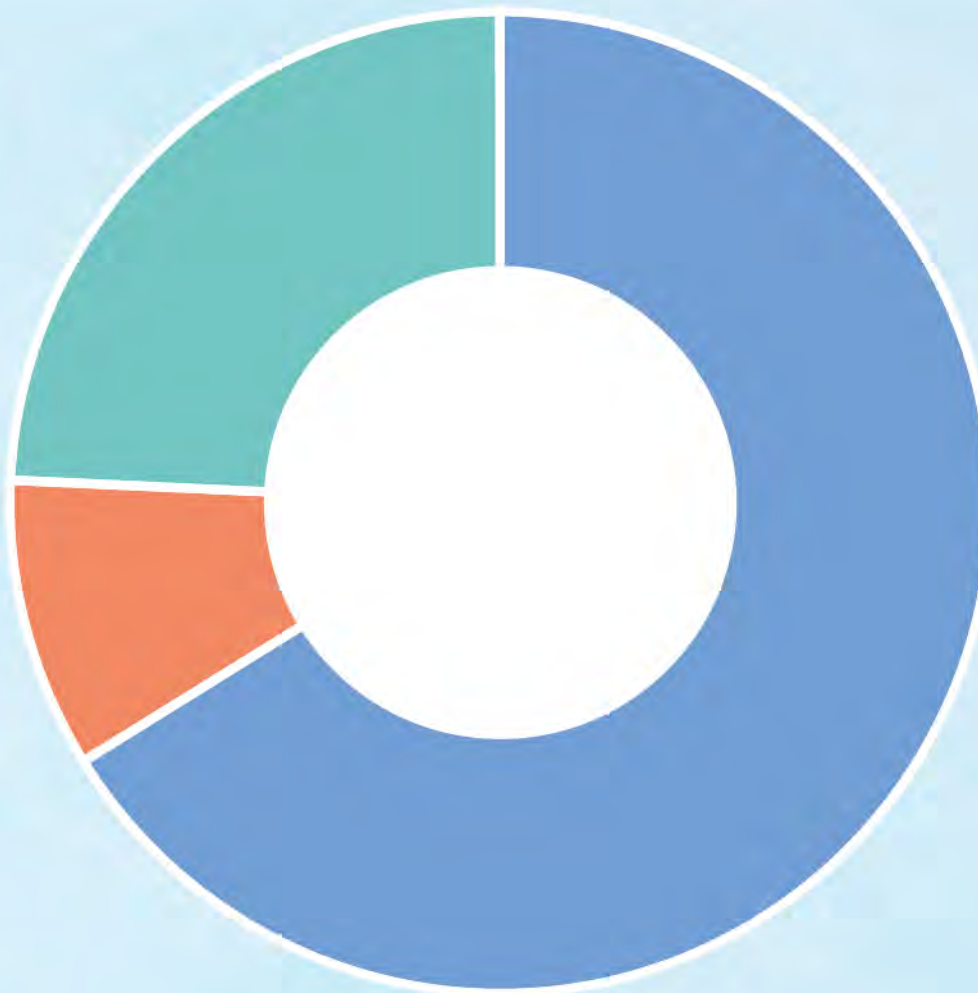


	Open Studies	In Follow-up
Anaesthetics	2	1
Audiology	0	0
Cardiology	3	2
Critical Care	5	1
Dermatology	4	1
Diabetes	2	1
Emergency Care	4	0
Endocrine	0	0
ENT	1	1
Gastroenterology	6	5
Geriatrics	5	2
Haematology	3	1
Health Services	0	1
Hepatology	0	2
Histology	0	0
Mental Health	2	0
Microbiology	0	0
Neurology	1	1
Obs & Gynae	6	5
Oncology	15	13
Ophthalmology	1	0
Orthopaedic	5	3
Paediatrics	2	7
Renal	0	1
Respiratory	9	3
Rheumatology	8	1
Stroke	6	2
Urology	0	0
Surgery	6	3

# Portfolio Management

New Studies  
Opened 2025 –  
2026: **33**

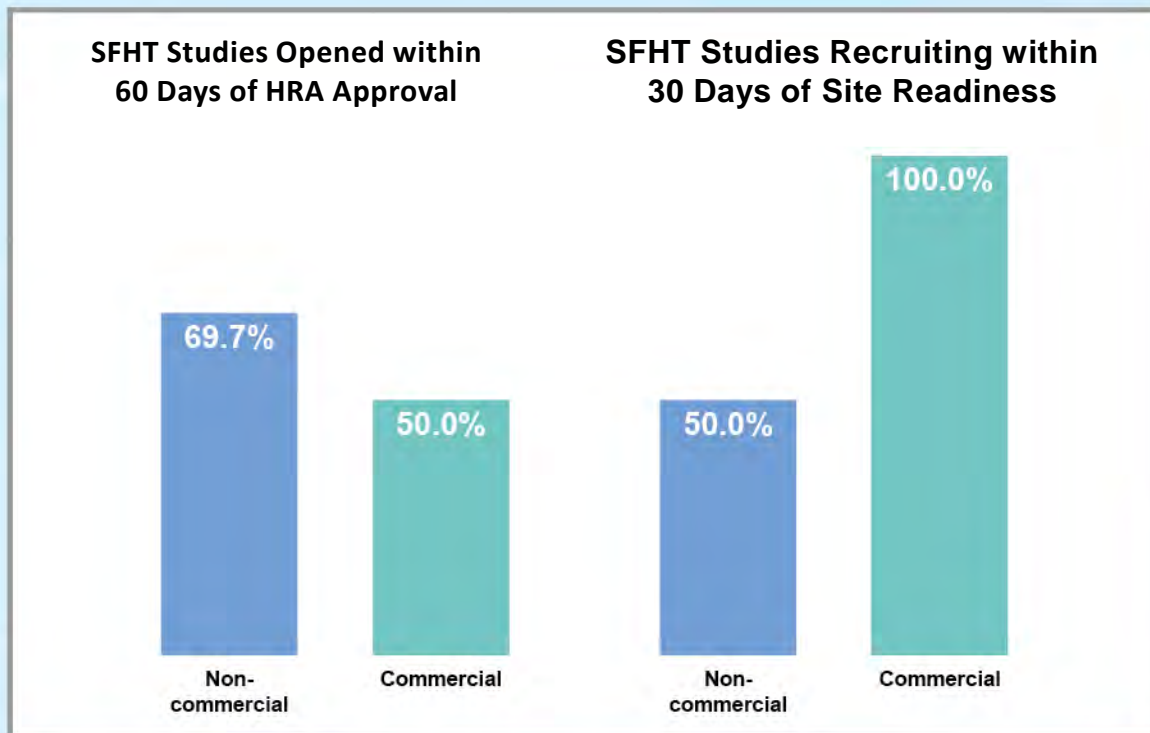
Studies Closed  
FY 2025 - 2026:  
**13**



Studies Actively  
Recruiting  
FY 2025-2026: **90**

# 150 Day Metrics

## SFHT Average Set Up Timings



# Finance

**2026/27**

**RRDN  
East Midlands  
Income**

Budget **£920,787.00**

**2025/26**

**Q4  
Commercial Income**

**£26,961.01**

For re-investment into future  
research capability  
and capacity  
across SFH

**Department of  
Health Funding**

**£35,000**

To maintain research  
capability and capacity

# Patient Research Experience

**95%**

Felt research staff have valued my taking part in this research study

The team were very polite and carefully explained everything about the research.

I personally feel research is really important in improving service and learning from issues to better practices.

Kind researcher, no pressure, felt like I was adding value.

Everyone involved very friendly and supportive.

The staff were brilliant, couldn't wish for better. I would highly recommend, I felt like one of the team. I came away totally uplifted, thank you all

FY 2025/2026  
Responses: 189

# NHS 10 Year Plan Three Shifts

SFHT Studies Working Towards Three Shifts



Sickness to Prevention	56
Hospital to Community	26
Analogue to Digital	4

(Datacut: 16/03/2026)

# Research Academy 2026 RE-LAUNCH

**Research Academy Training Programme** – Currently hosting two nurses, both submitted for extremely funded research training awards. Offering a further 4 places in 2026-2027

- One dedicated day per week embedded in the R&I team
- Practical exposure to real-world research delivery
- Support to develop and refine own research ideas
- Access to Academy workshops and development sessions

## Research Academy Associate COP (launch June 2026)

Bringing together staff who have / are completing research training.

- Network and collaborate across disciplines
- Share expertise and learning
- Develop research skills and partnerships
- Embed evaluation and innovation into clinical practice

**Coming soon: Research Academy Champions Forum**



## Join the Sherwood Forest Hospitals Research Academy! For Nurses, Midwives & Allied Health Professionals

At Sherwood Forest Hospitals, research is at the heart of exceptional patient care. It drives new treatments, better diagnostics, and smarter prevention – transforming health outcomes and quality of life for the people we serve. We know that research-active hospitals have better patient outcomes, happier patients, and more fulfilled staff – and now you can be part of that.

We are offering Nurses, Midwives and Allied Health Professionals the opportunity to join our Research & Innovation (R&I) Department for one day a week over 10 months as part of our exciting Research Academy.

### Why join the Research Academy?

This is your chance to:

- **Step into the world of research** explore a variety of research careers and activities.
- **Shape patient care** help embed research into everyday clinical practice.
- **Get hands-on experience** work on trials across multiple specialties.
- **Learn from the best** receive mentorship from experienced Research Nurses and AHPs.
- **Boost your skills** access accredited training in the conduct and management of research.
- **Pursue your own ideas** if you're keen to lead your own research, our Clinical Academic Lead will guide you through opportunities for funded research training.

Our work spans a diverse portfolio – from pharmaceutical and medical device trials to health services research, observational studies, and academic collaborations. We cover specialties including Respiratory, Oncology, Critical Care, Reproductive Health, Gastroenterology, Stroke, Paediatrics, Dermatology, Rheumatology, Trauma & Orthopaedics... and more.

### Choose your pathway:

1. **Exploring Research** Perfect for beginners curious about research and ready to take their first steps.
2. **Advancing Research** For those with some research training or experience who want to deepen their skills.
3. **Research Networks** Stay connected, share knowledge, and build collaborations for future research.

### How to apply

Send an expression of interest (max 1000 words) supported by your manager to [kerry.evans30@nhs.net](mailto:kerry.evans30@nhs.net) Tell us:

- Why you want to join the Research Academy.
- What skills and experience you'll bring.
- How the Academy will support your career and benefit your clinical area.
- Which pathway you'd like to take.

**Applications for Exploring and Advancing Research pathways close on 27 February 2026.** Applications to join the Research Academy Network Pathway are always open. We will hold quarterly meetings with research teams and academy members.

# NMAHP Research Awards 2025/2026



**Supporting NMAHPS through workshops, mentorship and tailored support....**

- **3 nurses and 1 midwife awarded the new NIHR HCP Internship award**  
Funded time to embed research in practice and develop evidence-based care
- **2 nurses on the NIHR INSIGHT award** (funded MA research) (+2 in 2024/2025)  
Exploring ED nursing skills and care for stroke patients > trajectory to PhD
- CA NMAHP lead awarded the **NIHR Senior Research Leader Award** –  
funded time for 3 years to embed research active cultures and build capacity and capability

**Esteem indicators for SFH NMAHP Research**

- RRDN speciality lead for Reproductive Health and Childbirth
- CNO Research Transformational Leaders Network (Case study included SFH Academy)
- Council of Deans CARIN network

# Pump Priming

Launched in Dec 2024 – awarded two projects

- Nurse-led regional study to explore the use of a monitoring 'app' to improve management of chronic wounds – in the final stages of completion
- Paediatric collaborative bid to develop PTT to diagnose sleep apnoea in children – completed and submitted for NIHR next stage funding in Feb 2026

2026 Competition now open with a collaborative panel from SFH / UoN / NTU

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Healthier Communities

RESEARCH IS TOMORROW'S  
HEALTHY

Sherwood Forest Hospitals  
NHS Foundation Trust

## RESEARCH PUMP PRIMING COMPETITION

Funding available for SFH staff to  
develop research ideas

Research and Innovation welcome applications from all SFH registered  
medical, nursing, midwifery, allied healthcare professionals.  
We would especially welcome applicants working collaboratively across professions/specialties.

Application  
deadline  
16 March  
2026

**Your chance to apply  
for research funding**

Pump priming provides small awards to enable clinicians to develop research applications for larger scale external funding in the future - this may include, for example, obtaining pilot data, completing systematic reviews or small-scale preliminary studies.

To apply please use link below or scan QR code and click on 'Pump Priming Application Form 2026.  
For further information contact **alison.steel1@nhs.net**  
or **kerry.evans30@nhs.net**  
<https://sfhnet.nnotts.nhs.uk/admin/webpages/default.aspx?RecID=6544>

Supporting research at SFH and all the people making research  
come to life for our patients and communities

# Research workshops and drop-ins.....

## Poster workshop

Preparing for  
Celebrating Excellence  
conferences or display...



Come along to the library learning room for a step by step guide to creating posters from templates



13th & 21st  
12-1



1st & 16th  
1-2

Please email [kerry.evans30@nhs.net](mailto:kerry.evans30@nhs.net) to book

## Research drop-in



Opportunity for all healthcare professionals to discuss research and innovation ideas  
Join an informal discussion with Professor Sir Jonathan Van-Tam and the Research and Improvement teams

- Where to start with your research idea
- How, what and where to publish
- Is it research / improvement / evaluation?
- Internships and fellowships
- .... anything research related

If you want to discuss specific ideas - book a 30 minute timeslot and send a brief overview of your ideas to: [kerry.evans30@nhs.net](mailto:kerry.evans30@nhs.net)

To come along and listen to the research conversations and learn about ways SFH can support research - drop-in anytime between 11-2

November  
28

11 - 2 in the library learning room

	Progress	Place	People	Partnerships
Objectives	<p>1.1 Collaboration with EMCRN &amp; commercial sponsors to increase commercial research opportunities</p> <p>1.2 Streamline the set-up process for faster delivery</p> <p>1.3 Engage with ICS-wide research partners to develop a Nottingham-wide commercial study set-up network.</p>	<p>2.1 Open a new Clinical Research Facility at Kings Mill Hospital in for early phase clinical trials of new drugs, devices, and diagnostics</p> <p>2.3 Secure SFH mobile research unit to deliver research across primary care settings and undertake "Research Ready" engagement with our communities</p>	<p>3.1 Further develop the role of the Research Academy and research opportunities for SFH staff</p> <p>3.2 Investment into our management workforce to ensure a sustainable future for research and future developments</p> <p>3.3 Research to be a fundamental element of NED role</p>	<p>4.1 Increase our academic and industry partnerships to maximise mutual benefits from collaboration</p> <p>4.2 Collaboration with Chesterfield Royal NHS Trust in securing and utilising the mobile research unit</p> <p>4.3 Pursuing NTU collaboration as part of EMERGE bid</p>
Risks	<p>1.1 Reduction in access to novel interventions and medicines. Loss of income, reputation, and future growth as a research system partner</p> <p>1.2 Loss of repeat business, reduction in portfolio size. Failure to meet CRN targets</p> <p>1.3 Inability to consistently attract industry to the EM region</p>	<p>2.1 Significant impact on achieving objectives 1.1 and 4.1. Negative impact recruitment and retention and ability to fulfil our partnership with NUH for NIHR CRF bid 2026</p> <p>2.3 As 2.2, but also lack of response to the changing research landscape and popularity for de-centralised trials will have a negative impact on commercial activity</p>	<p>3.1 Unable to offer the development and training opportunities to SFH staff reduce research engagement. Negative impact on staff satisfaction</p> <p>3.2 Inadequate career pathways for research staff, impact on recruitment and retention. Loss of expertise to develop R&amp;I at SFH</p> <p>3.3 Missed opportunity to engage in high level leadership and promotion of SFH's growing positive research culture</p>	<p>4.1 Fail to secure and sustain business from industry and showcase SFH research capabilities, linked to 1.1. Reduced access to research expertise and training for our staff. Inability to be an equitable research partner across the system</p> <p>4.2 As 2.2 and 2.3</p> <p>4.3 Missed opportunity to co-create in the Med Tech space</p>
Progress	<p>IAOCR Bronze level accreditation achieved-year 3 Bronze level achieved for 25/26. GCSA due to launch in May2026.</p> <p>MRU is successfully recruiting patients into research studies in hard-to-reach areas. Increased engagement with partners and community settings.</p>	<p>CRF is officially open, and patients are routinely being seen in the space. Commercial sponsor interest has increased since the opening of the CRF. Successful bid with RRDN to fund a clinical fellow a day a week to increase research capacity and delivery and enhance opportunities to conduct an increased number of commercial studies to give our patients a wider opportunity to be a part of clinical research studies.</p> <p>MRU is successfully recruiting patients into research studies in hard-to-reach areas. Increased engagement with partners and community settings.</p>	<p>3.1 Kerry Evans is leading the academy process- Clinical and academic posts now available. Research Champions liked in with ward accreditation.</p> <p>3.2 Band 5 Study set up manager appointed to assist the Band 4 and to streamline study set up times and increase portfolio.</p> <p>NED commenced in October 2024.</p> <p>F2 foundation doctor to work in the CRF- post currently being created.</p>	<p>Access to select platforms to showcase our capabilities</p> <p>Membership of the Global Advisory Board for GSCA IAOCR</p> <p>Joint Primary care commercial link nurse developing new relationships and interest from commercial sponsors .</p> <p>Collaborations started with Health Innovation East Midlands.</p>

**Board of Directors Meeting in Public - Cover Sheet**

<b>Subject:</b>	Integrated Performance Report – To February 2026	<b>Date:</b>	2 <sup>nd</sup> April 2026		
<b>Prepared By:</b>	Domain leads and Mark Bolton, Associate Director of Operational Performance				
<b>Approved By:</b>	Domains approved by lead Executive				
<b>Presented By:</b>	Domains to be presented by lead Executive				
<b>Purpose</b>					
To provide assurance to Trust Board regarding the performance of the Trust as measured in the Integrated Performance Report (IPR).				<b>Approval</b>	
				<b>Assurance</b>	✓
				<b>Update</b>	
				<b>Consider</b>	
<b>Strategic Objectives</b>					
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 estates	Work collaboratively with partners in the community
✓	✓	✓	✓	✓	
<b>Principal Risk</b>					
<b>PR1</b>	Significant deterioration in standards of safety and care				✓
<b>PR2</b>	Demand that overwhelms capacity				✓
<b>PR3</b>	Critical shortage of workforce capacity and capability				✓
<b>PR4</b>	Insufficient financial resources available to support the delivery of services				✓
<b>PR5</b>	Inability to initiate and implement evidence-based Improvement and innovation				
<b>PR6</b>	Working more closely with local health and care partners does not fully deliver the required benefits				
<b>PR7</b>	Major disruptive incident				
<b>PR8</b>	Failure to deliver sustainable reductions in the Trust's impact on climate change				
<b>Committees/groups where this item has been presented before</b>					
Domain reports have been considered by the appropriate Trust Board sub-committee. The full report was approved by Trust Management Team on 25 March 2026.					
<b>Acronyms</b>					
All acronyms are defined within the paper.					
<b>Executive Summary</b>					
The Integrated Performance Report (IPR) provides the Board with assurance regarding the performance of the Trust in respect of the indicators allocated under the following domains: Quality of Care, People and Culture, Timely Care and Best Value Care. Key activity metrics are provided as context to support all domains.					
This report covers performance to Feb-26. Performance indicators are marked as 'met' or 'not met' using a green tick and red cross respectively where a standard or plan value exists.					
The integrated scorecard is included at the start of the report and in appendix A. Appendix A also includes graphs for each indicator that identify trends over a two-year period and the plan or standard for the rest of 2025/26.					

Appendix B contains benchmarking data for the People and Culture and Timely Care domains to show our performance relative to other Trusts in England.

The integrated scorecard includes an assessment against STAR data quality assurance. Further details explaining the make up of the data assurance assessment are included within Appendix C. The area of weakness in our indicator data quality assurance relate to the 'A' item which is 'audit and accuracy'. The low assurance rating for many of the indicators relate to a lack of regular internal or external audit processes. This is being reviewed by our Analytical and Intelligence team to agree an audit process.

During Jan-26 and Feb-26 (latest reporting period), the sustained operational pressures, particularly across Urgent and Emergency Care (UEC), have persisted. As we enter Mar-26 there are early signs that some of the intense winter pressures are beginning to ease.

- **Quality of Care** saw three off-track metrics in Jan-26 and Feb-26, including elevated clostridioides difficile infections in both months, Venous Thromboembolism (VTE) risk assessment compliance challenges in both months and an elevated still birth rate in Jan-26. Positive outcomes included zero MRSA bacteraemia and zero never events.
- Seven of 14 **People and Culture** metrics were on track in the latest period including our time to hire, turnover, mandatory and statutory training, bank usage and agency off framework and over-price cap. Challenging performance areas in this domain include vacancy rate, appraisals, sickness absence, employee relations management and agency usage.
- Within the **Timely Care** domain, in Feb-26 we saw some of the challenges within our Urgent and Emergency Care (UEC) pathway over winter begin to ease. This is reflected in several of our reported UEC performance metrics delivering an improved position; however, remained worse than plan. Planned care performance remains challenged against the Referral to Treatment (RTT) 18-week performance standard, although performance is now improving because of the Elective Sprint. Positive areas include consistently strong performance against the patient initiated follow up and cancer 28-day faster diagnostic standards.
- Financially, from a **Best Value Care** perspective, the Trust has reported a £28.5m year-to-date deficit, driven by cost improvement programme underperformance, removal of deficit support funding, Mutually Agreed Resignation Scheme payments, income planning issues and critical incident and winter costs. Our year-end forecast is a £34m deficit excluding deficit support funding (a £24.2m variance to plan).

There were three reported metrics triggering special cause variation in Jan-26 or Feb-26. All three metrics triggered because of performance challenges/deteriorations:

- The number of compliments received in month fell below the lower control limit in Nov-25 and has remained in special cause variation since.
- Mandatory and Statutory training fell below the lower control limit in Feb-25; however, performance remains favourable to the standard of 90%.
- 18-week RTT performance was below the lower control limit in Nov-25, Dec-25 and Jan-26. In Feb-26 performance improved to return to within the control limits.

The main report includes domain summaries that provide the opportunity to celebrate successes and identify areas of challenge. The indicators in focus pages provide an overview against each underperforming indicator together with details of the root causes and actions to improve performance.

Trust Board is asked to comment on the report, celebrate successes, and be assured that actions are in place to improve performance in challenged areas.

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Sherwood Forest Hospitals  
NHS Foundation Trust

# Sherwood Forest Hospitals

## Integrated Performance Report

Reporting Period: To February 2026



# Integrated Scorecard

The Integrated Scorecard together with graphs for all indicators is included in appendix A.

Performance is assessed as met/did not meet the standard set for the financial year. Where the metric is being assessed against plan; details of the plan for the forthcoming year are included in the graphs in the appendix.

The graphs present monthly data typically from Apr-22. Where appropriate, the graphs are Statistical Process Control (SPC) charts.

Metrics with a tick in the NOF column relate to the NHS Oversight Framework.

Guidance on STAR data quality assurance can be found in appendix C.

Category	At a Glance	NOF	Indicator	2024/25	2025/26	2024/25	2025/26	2024/25	2025/26	2024/25	2025/26	S	T	A	R			
				Standard	Standard	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26					Final	YTD	
Quality of Care	Safe	✓	Rate of inpatients to suffer a new hip fracture	n/a	No Standard	1.8	2.4	2.6	2.5	2.3	1.8	2.2	2.2					
			Never events	0	0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	
			MRSA reported in month	0	0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	
			Cdifficile (hospital-acquired) reported in month	≤13 qtr	0	✗ 7	✗ 9	✓ 4	✗ 8	✗ 5	✗ 6	✗ 6	✗ 6	✗ 1	✗ 2	✗ 1	✗ 2	
			Number of gram-negative bloodstream infections reported in month	n/a	8	✓ 5	✓ 3	✓ 3	✓ 2	✓ 7	✓ 6	✓ 6	✓ 6	50	✓ 48	50	✓ 48	
	Caring	✓	HAPU (cat 2) per 1000 occupied bed days with a lapse in care	No Standard	No Standard	0.1	0.2	0.1	0.2	0.2	0.2	0.1	0.1	0.1	0.1	0.1	0.1	
			HAPU (cat 3/4) and ungradable pressure ulcers with lapse in care	0	0	✓ 0	✗ 1	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✗ 6	✗ 2	✗ 6	✗ 2	
			Patient Safety Incident Investigations (PSII) and Duty of Candour	No Standard	No Standard	10	9	5	4	7	7	7	7	17	83	17	83	
			Percentage of inpatient Service Users undergoing risk assessment for VTE	≥95%	≥95%	✗89.7%	✗85.6%	✗86.4%	✗85.9%	✗87.7%	✗89.7%	✗89.7%	✗89.7%	✗87.9%	✗87.9%	✗87.9%	✗87.9%	
			Complaints per 1000 occupied bed days	≤1.9	≤1.9	✓ 1.3	✓ 1.4	✓ 1.0	✓ 1.3	✓ 1.3	-	-	-	✓ 0.9	-	✓ 0.9	-	-
Effective	✓	Compliments received in month	No Standard	No Standard	137	98	64	38	65	104	-	1831	-	1831	-	-		
		SHMI	As Expected	As Expected	✓ 107	✓ 106	✓ 106	✓ 105	✓ 104	✓ 104	✓ 104	✓ 104	✓ 107	✓ 104	✓ 107	✓ 104		
		Still birth rate	≤4.4	≤4.4	✗ 10.2	✓ 3.4	✗ 7.6	✓ 0.0	✗ 7.2	✓ 4.1	✓ 4.1	✓ 4.3	✗ 5.5	✓ 4.3	✗ 5.5			
People and Culture	Belonging in the NHS	✓	Early neonatal deaths per 1000 live births	≤1	≤1	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.3	✓ 0.0	✓ 0.3	✓ 0.0			
			Engagement score	≥6.8	≥6.9	✗ 6.8	-	-	-	-	-	-	✓ 7.1	-	✓ 7.1	-	-	
			Vacancy rate	≤8.5%	≤8.5%	✓ 8.0%	✓ 7.9%	✓ 7.8%	✓ 8.2%	✗ 8.6%	✗ 9.1%	✓ 8.0%	✗ 8.7%	✓ 8.0%	✗ 8.7%	✓ 8.0%	✗ 8.7%	
	Growing the Future	✓	Time to hire	n/a	≤53.1 days	✓ 25.0	✓ 36.0	✓ 21.0	✓ 19.0	✓ 32.0	✓ 22.0	✓ 22.0	✓ 25.9	✓ 25.9	✓ 25.9	✓ 25.9		
			Turnover in month	≤0.9%	≤0.9%	✓ 0.8%	✗ 1.0%	✓ 0.6%	✓ 0.6%	✓ 0.5%	✓ 0.4%	✓ 0.7%	✓ 0.6%	✓ 0.7%	✓ 0.6%	✓ 0.7%	✓ 0.6%	
			Appraisals	≥90%	≥90%	✗88.2%	✗87.5%	✗87.4%	✗87.5%	✗86.7%	✗87.6%	✗89.0%	✗88.1%	✗89.0%	✗88.1%	✗89.0%	✗88.1%	
	Looking after our People	✓	Mandatory & statutory training	≥90%	≥90%	✓92.9%	✓93.3%	✓93.6%	✓93.6%	✓92.8%	✓92.4%	✓92.4%	✓91.5%	✓93.0%	✓91.5%	✓93.0%		
			Medical job plan compliance	n/a	≥95%	✗94.0%	✓95.9%	✓96.6%	✓97.8%	✓97.8%	✓98.5%	✓98.5%	✓98.5%	✓86.6%	✓98.5%	✓86.6%		
			Sickness absence	≤4.2%	≤4.2%	✗4.8%	✗5.7%	✗5.6%	✗5.9%	✗5.6%	✗5.5%	✗5.0%	✗5.2%	✗5.0%	✗5.2%	✗5.0%	✗5.2%	
			Flu vaccinations uptake (front line staff)	≥75%	≥75%	-	✗35.8%	✗50.7%	✗54.3%	✗54.7%	✗54.5%	✗58.0%	✗54.7%	✗58.0%	✗54.7%	✗58.0%	✗54.7%	
New Ways of Working	✓	Employee relations management	<17	<21	✓ 20	✗ 21	✓ 20	✗ 26	✗ 24	✗ 23	✗ 21	✓ 21	✓ 21	✓ 21	✓ 21			
		Bank usage	≤8.8%	≤7.8%	✓ 5.2%	✓ 4.8%	✓ 6.8%	✓ 7.5%	✓ 7.3%	✓ 6.4%	✗ 8.9%	✓ 6.5%	✗ 8.9%	✓ 6.5%	✓ 6.4%	✓ 6.5%		
		Agency usage	<3.2%	<1.9%	✗ 2.3%	✗ 2.6%	✗ 2.0%	✗ 2.0%	✓ 1.9%	✗ 2.4%	✗ 4.0%	✗ 2.5%	✗ 4.0%	✗ 2.5%	✗ 4.0%	✗ 2.5%		
Timely Care	Urgent Care	✓	Agency (off framework)	0.0%	0.0%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✓ 0.01%	✓ 0.0%	✓ 0.01%	✓ 0.0%			
			Agency (over price cap)	≤40.0%	≤40.0%	✗40.9%	✓33.4%	✓33.6%	✓39.5%	✓38.9%	✓37.9%	✗52.9%	✓37.7%	✗52.9%	✓37.7%			
			Ambulance turnaround times <30 mins	≥95%	≥95%	✗82.3%	✗76.2%	✗72.8%	✗62.2%	✗64.4%	✗77.8%	✗91.4%	✗79.6%	✗91.4%	✗79.6%			
			Ambulance turnaround times >60 mins	0.0%	0.0%	✗2.5%	✗3.7%	✗6.0%	✗13.4%	✗11.8%	✗3.0%	✗0.7%	✗4.2%	✗0.7%	✗4.2%			
			ED 4-hour performance	≥76%	≥Plan	✗68.0%	✗67.4%	✗67.3%	✗67.0%	✗69.5%	✗71.9%	✗71.0%	✗71.4%	✗71.0%	✗71.4%			
	Electives	✓	ED 12-hour length of stay performance	≤2%	≤2024/25	✗5.6%	✗8.2%	✗7.2%	✗9.2%	✗9.3%	✗6.5%	✗3.4%	✗5.5%	✗3.4%	✗5.5%			
			Mental health patients spending over 12 hours in A&E	n/a	No Standard	23	27	17	9	17	24	23	221	23	221			
			Adult G&A bed occupancy	≥92%	≥92%	✗96.3%	✗97.4%	✗96.1%	✗95.9%	✗97.1%	✗96.9%	✗94.5%	✗96.1%	✗94.5%	✗96.1%			
			Average number of days between planned and actual discharge date	n/a	≤Plan	✓ 3.5	✓ 3.4	✗ 4.0	✗ 4.0	✓ 3.4	✓ 3.1	✓ 3.5	✓ 3.5	✓ 3.5	✓ 3.5			
			Inpatients medically safe for transfer for greater than 24 hours	≤40	≤40	✗ 82	✗ 72	✗ 84	✗ 89	✗ 85	✗ 67	✗ 64	✗ 74	✗ 64	✗ 74			
Diagnostics	✓	Added to Patient Initiated Follow Up (PIFU) pathway	≥5%	≥5%	✓ 10.7%	✓ 10.7%	✓ 10.8%	✓ 10.7%	✓ 10.3%	✓ 11.0%	✓ 6.0%	✓ 10.4%	✓ 6.0%	✓ 10.4%				
		Percentage of incomplete Referral to Treatment (RTT) pathways completed in less than 18 weeks	n/a	≥Plan	✗61.9%	✗60.4%	✗60.3%	✗59.3%	✗59.6%	✗60.9%	-	✗61.7%	-	✗61.7%				
		Percentage of RTT waits over 52 weeks for incomplete pathways	n/a	≤Plan	✓ 0.9%	✓ 0.9%	✓ 0.8%	✓ 1.0%	✓ 1.0%	✗ 1.1%	✓ 1.0%	✓ 1.0%	✓ 1.0%	✓ 1.0%				
		Diagnostic DM01 performance under 6-weeks	≥Plan	≥Plan	✗89.8%	✗90.4%	✗89.8%	✗92.0%	✗93.5%	✗93.6%	✓ 93.1%	✓ 93.5%	✓ 93.1%	✓ 93.5%				
		Cancer 28-day faster diagnosis standard	≥75%	≥Plan	✓80.7%	✓82.2%	✓79.4%	✓81.7%	✓79.4%	-	✓78.3%	✓80.6%	✓78.3%	✓80.6%				
Best Value Care	Financial Performance	✓	Cancer 31-day treatment performance	≥Plan	≥Plan	✗88.4%	✗91.7%	✗93.6%	✗95.9%	✗94.5%	-	✓91.9%	✓91.0%	✓91.9%	✓91.0%			
			Cancer 62-day treatment performance	≥Plan	≥Plan	✓63.1%	✓65.3%	✓75.7%	✗63.6%	✗68.6%	-	✗64.4%	✓66.7%	✗64.4%	✓66.7%			
			Financial surplus / deficit	n/a	≥£0.00m	✗£1.62	✗£2.37	✗£2.63	✗£2.65	✗£14.04	✗£3.55	-	✓£0.01	✓£28.52	-	✓£28.52		
			Variance YTD to financial plan	≥£0.00m	≥£0.00m	✗£2.08	✗£2.95	✗£2.46	✗£2.34	✗£13.54	✗£4.00	✓£0.01	✓£28.35	✓£0.01	✓£28.35			
			Financial efficiency variance YTD to plan	≥£0.00m	≥£0.00m	✗£2.81	✗£1.83	✗£0.93	✗£0.55	✗£1.25	✗£0.44	✓£0.08	✓£11.95	✓£0.08	✓£11.95			
Activity (for context)	Urgent Care	✓	Risk adjusted efficiency forecast to plan (%)	n/a	100%	✓74.0%	✗81.0%	✗82.0%	✗80.0%	✗78.0%	✗80.0%	✓0.0%	✓0.0%	✓0.0%				
			Reported agency expenditure	No Standard	No Standard	£0.69	£0.77	£0.58	£0.60	£0.58	£0.72	£13.70	£8.13	£13.70	£8.13			
			Reported bank expenditure	No Standard	No Standard	£1.57	£1.43	£2.02	£2.27	£2.20	£1.91	£30.55	£21.09	£30.55	£21.09			
			Rate of Productivity	3.1%	2.0%	✓ 5.5%	-	-	-	-	-	-	-	-	-	-		
			BPPC - Number of bills paid within target	n/a	≥95%	✗87.5%	✗83.9%	✗50.4%	✗21.3%	✗13.8%	✗10.7%	-	✗49.6%	-	✗49.6%			
Electives	✓	BPPC - Value of bills paid within target	n/a	≥95%	✗91.6%	✗90.6%	✗84.3%	✗81.3%	✗67.7%	✗60.6%	✓77.7%	✓77.7%	✓77.7%					
		Operating expenditure days	n/a	≥5	✓ 6	✓ 5	✗ 4	✗ 3	✗ 1	✓ 12	✓ 9	✓ 9	✓ 9					
		Capital expenditure against plan	≤£33.61m	≤£0.00m	✗£0.85	✗£1.36	✗£4.29	✗£4.24	✓£0.63	✗£3.05	✓£33.58	✓£16.34	✓£33.58	✓£16.34				
		A&E attendances (inc. PC24)			550	561	563	537	542	550	547	555	547	555				
		Non-elective admissions			148	151	142	143	148	160	145	145	145	145				
Diagnostics	Electives	✓	Average daily elective referrals			354	354	328	320	329	358	341	325	341	325			
			Outpatients - first appointment			364	334	318	291	335	348	347	325	347	325			
			Outpatients - follow up			891	854	812	774	837	834	852	833	852	833			
			Outpatients - procedures			283	280	269	260	273	300	265	271	265	271			
			Day case			121	125	121	115	121	125	122	120	122	120			
Diagnostics	Electives	✓	Elective inpatient			13	16	16	12	13	15	14	14	14	14			
			Diagnostics			478	488	481	459	469	488	479	476	479	476			

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# Quality of Care



# Domain Summary: Quality of Care

## Overview

Lead: Executive Chief Nurse and Chief Medical Officer

During Jan-26 and Feb-26, the Trust continued to face challenges across the Urgent and Emergency Care (UEC) pathway. We maintained patient services and safety during days of record-high emergency attendances that created operational pressure and strained our ability to deliver timely, safe care. Persistent delays for admission beds and overcrowding in the Emergency Department (ED) affected patients, carers and staff. Despite these challenges, our teams performed exceptionally, enabling us to continue providing safe, high-quality care.

Within the Quality of Care domain, there were three off-track metrics during Jan-26 and Feb-26:

- **Clostridioides difficile (C. diff):** During Jan-26 and Feb-26 we reported 11 hospital-onset, hospital acquired (HOHA) and four community-onset, hospital acquired (COHA) infections. This is above our target. We have continued to observe an increase in our rates compared to the same period last year. Benchmarking against our peers shows we are not an outlier and sit in the middle of the group. However, our numbers are higher than the Trust has seen in the past and our rates per beds has increased. We continue working closely with the Antimicrobial Pharmacist and Consultant Microbiologists relating to the Antimicrobial Resistance action plan. We have a Trust-wide Infection Prevention and Control (IPC) action plan to support the reduction in infection rates; this is on track for completion.
- **Percentage of inpatient service users undergoing risk assessment for Venous Thromboembolism (VTE):** Year-to-date compliance with inpatient VTE risk assessment is 87.9%. Diagnostic work has confirmed VTE non-compliance as a system design issue arising from the Electronic Prescribing and Medicines Administration (EPMA) rollout within our Emergency Department (ED), and that the required solutions depend on the digital team's capacity to configure and test system changes. Despite agreement for this work to progress across over the winter period, the digital workstreams have yet to commence due to ongoing resource constraints.
- **Still birth rate:** During Jan-26 and Feb-26, we have reported three cases of antenatal stillbirth. Each case received an individual review and was reported through the Perinatal Mortality Review Tool (PMRT) and Maternity and Newborn Safety Investigations (MNSI) process, where they will receive a further review. All cases were reported within the Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE) recommended timescales.

Five Patient Safety Incident Investigations (PSIIs) were commissioned during Jan-26 and Feb-26 by the Patient Safety Incident Response Group (PSIRG) following in-depth discussion during which the Integrated Care Board (ICB) were present. Summary Hospital-level Mortality Indicator (SHMI) remains as expected.

The following slides provide further detail on performance against key Quality of Care domain metrics and the actions we are taking to resolve areas of underperformance.

# Scorecard: Quality of Care

## Quality of Care

Green tick = target met/exceeded; Red cross = target not met

At a Glance	Indicator	2024/25 Standard	2025/26 Standard	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	2024/25 Final	2025/26 YTD	STAR Data Quality Assurance			
												S	T	A	R
Safe	Rate of inpatients to suffer a new hip fracture	n/a	No Standard	1.8	2.4	2.6	2.5	2.3	1.8		2.2	●	●	●	●
	Never events	0	0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✗ 2	✗ 1	●	●	●	●
	MRSA reported in month	0	0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✗ 1	✗ 2	●	●	●	●
	Cdifficile (hospital-acquired) reported in month	≤13 qtr	4	✗ 7	✗ 9	✓ 4	✗ 8	✗ 5	✗ 6	✗ 55	✗ 70	●	●	●	●
	Number of gram-negative bloodstream infections reported in month	n/a	8	✓ 5	✓ 3	✓ 3	✓ 2	✓ 7	✓ 6	50	✓ 48	●	●	●	●
	HAPU (cat 2) per 1000 occupied bed days with a lapse in care	No Standard	No Standard	0.1	0.2	0.1	0.2	0.2	0.1	0.1	0.1	●	●	●	●
	HAPU (cat 3/4) and ungradable pressure ulcers with lapse in care	0	0	✓ 0	✗ 1	✓ 0	✓ 0	✓ 0	✓ 0	✗ 6	✗ 2	●	●	●	●
	Patient Safety Incident Investigations (PSII) and Duty of Candour	No Standard	No Standard	10	9	5	4	7	7	17	83	●	●	●	●
Percentage of inpatient Service Users undergoing risk assessment for VTE	≥95%	≥95%	✗ 89.7%	✗ 85.6%	✗ 86.4%	✗ 85.9%	✗ 87.7%	✗ 89.7%		✗ 87.9%	●	●	●	●	
Caring	Complaints per 1000 occupied bed days	≤1.9	≤1.9	✓ 1.3	✓ 1.4	✓ 1.0	✓ 1.3	✓ 1.3	-	✓ 0.9	✓ 1.3	●	●	●	●
	Compliments received in month	No Standard	No Standard	137	98	64	38	65	-	1831	1079	●	●	●	●
Effective	SHMI	As Expected	As Expected	✓ 107	✓ 106	✓ 106	✓ 105	✓ 104	✓ 104	✓ 107	✓ 104	●	●	●	●
	Still birth rate	≤4.4	≤4.4	✗ 10.2	✓ 3.4	✗ 7.6	✓ 0.0	✗ 7.2	✓ 4.1	✓ 4.3	✗ 5.5	●	●	●	●
	Early neonatal deaths per 1000 live births	≤1	≤1	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.3	✓ 0.0	●	●	●	●

# Indicator in Focus: Infection Prevention and Control

## Performance observations

### Cdifficile (C. diff)

Our target for C. diff this year for hospital and community onset is 65 and we have currently had 90 cases up to the end of Feb-26. There has been a national increase in cases and when reviewing our numbers against peer Trusts and we sit in the middle of the group with four other organisations also breaching their target. During Jan-26 and Feb-26, we have had 11 HOHA and four COHA infections. We have continued to observe an increase in our rates compared to the same period last year.

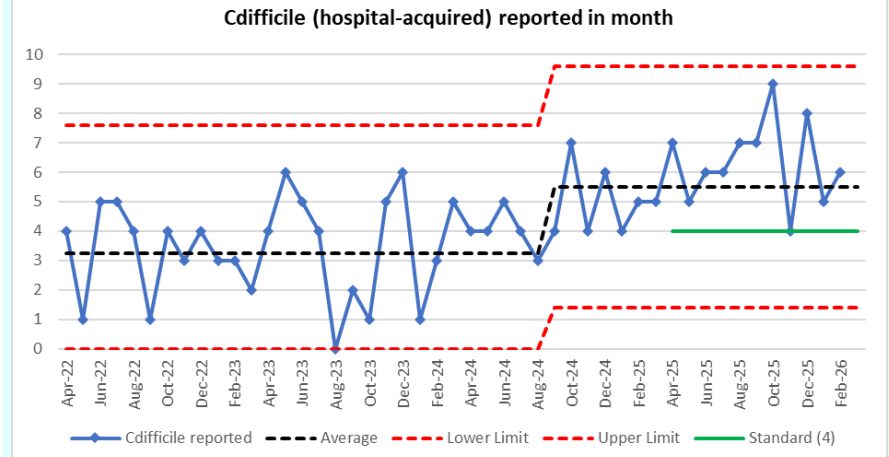
### MRSA

We have had zero HOHA MRSA cases in Jan-26 and Feb-26. When considering benchmarking against our peer organisations, there has been an increase in cases both regionally and nationally and all our peer organisations have breached their trajectories.

### Gram-negative bacteraemia

We have breached our Pseudomonas and Klebsiella trajectory, we are not an outlier when benchmarking against our peer organisations. We are currently in a good position for Ecoli (currently 10 cases lower than the same period last year) and when benchmarking against our peers, we remain one of two Trusts with the lowest numbers.

## Data



## Root causes

## Actions and timescale

## Impact

Increase in our rates of C. diff

Initial deep dive completed and identified other areas to review such as diagnostics; this is now underway.

To identify any areas of improvement to support a reduction in patients acquiring C. diff.

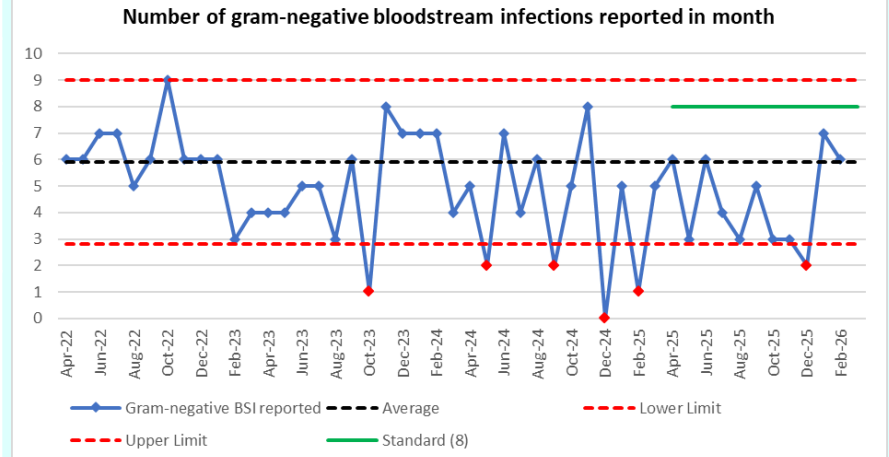
Increase in all infection rates

Delivery of IPC action plan continues.

To improve patient environment and reduce cross infection.

IPC annual plan under development for 2026/27.

To improve patient environment and reduce cross infection.



# Indicator in Focus: Percentage of inpatient Service Users undergoing risk assessment for VTE

## Performance observations

Year-to-date compliance with inpatient VTE risk assessment is 87.9%.

Diagnostic work has confirmed VTE non-compliance is a system design issue arising from the EPMA rollout within ED, and that the required solutions depend on digital team capacity to configure and test system changes. Despite agreement for this work to progress across the winter period, the digital workstreams have yet to commence due to ongoing resource constraints.

In Mar-26 the Patient Safety Committee (PSC) was asked to support prioritisation of this patient safety critical work within digital transformation plans, with proposed timescales including configuration of the Nervecentre (NC) test environment for VTE assessment testing by mid-Mar-26; completion of resident doctor testing by the end of Mar-26; and completion of the Quality Impact Assessment (QIA) through the UEC Clinical Oversight and Design Authority (CODA) meeting by the end of Apr-26.

## Actions

Analysis in Jan-26 identified specific system changes potentially required:

- Configure NC to make VTE assessment compulsory in ED with override function
- Modify NC to direct from completed assessment to prescription page
- Integrate VTE status into board round view for visibility
- Engage supplier for decision-triggered or time-triggered prompts

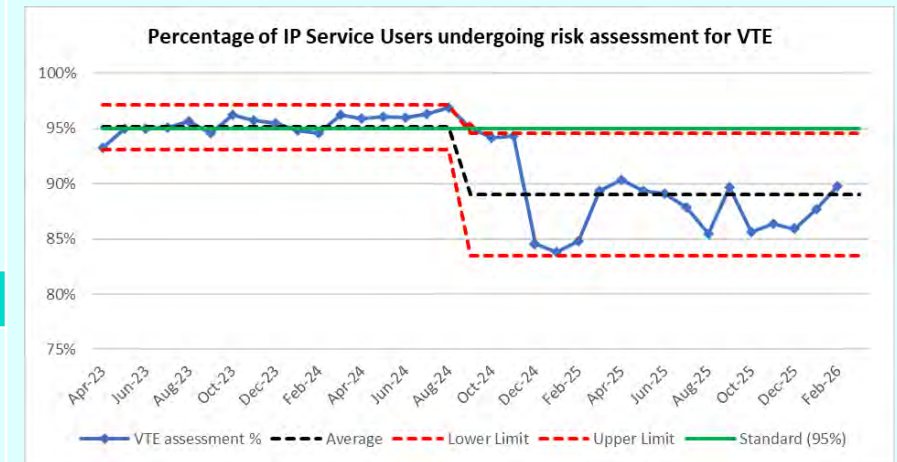
Progress: VTE assessment dashboards are displayed on screens in clinical areas. Hospital Out of Hours (HOOH) team are engaged and the new 'in reach' model is hoped to increase compliance. Digital asks not commenced.

In Feb-26 the VTE improvement group agreed specific next steps:

- Coordinate with digital team to implement mandated VTE assessment in NC test system with changed 'drop down' menus instead of free text.
- Involve resident doctors from Emergency Assessment Unit (EAU) and ED in testing
- Conduct time and motion study to assess workflow impact
- Develop Quality Impact Assessment (QIA) risk score for ED workflow impact

Progress: Not commenced. In Mar-26, the PSC was asked to support prioritisation of this work within digital transformation plans.

## Data



# Indicator in Focus: Still Birth Rate

## Overview and national position

During Jan-26 and Feb-26, we reported three cases of antenatal stillbirth. Each case received an individual review and were reported through the Perinatal Mortality Review Tool (PMRT) and Maternity and Newborn Safety Investigations (MNSI) process, where they will receive a further review.

All cases were reported within the Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE) recommended timescales.

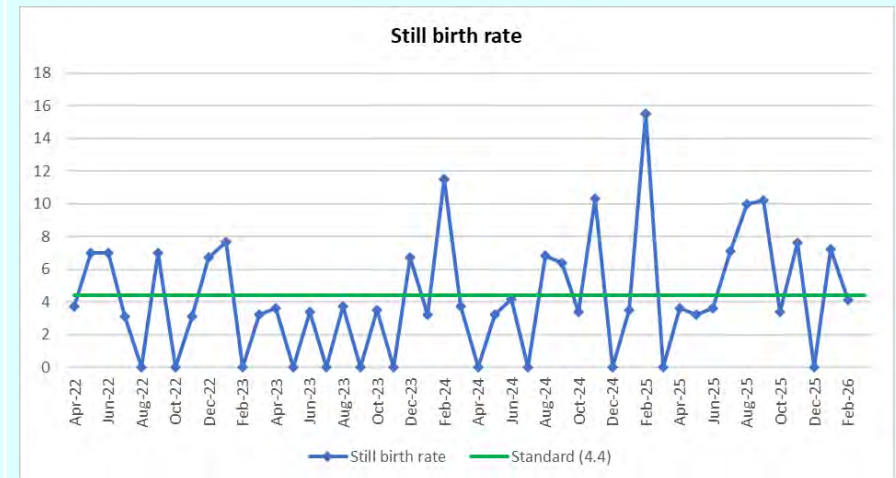
### Jan-26

- Called triage during a closure with altered fetal movements at 38 weeks gestation; antenatal stillbirth confirmed by transferred unit. Ongoing care and bereavement support provided at SFH.
- Attended triage at 36 weeks gestation with altered fetal movements; no fetal heart rate detected and antenatal still birth confirmed on scan.

### Feb-26

- Contacted triage at 29 weeks with abdominal pain, bleeding and altered fetal movements. Advised to attend via 999 ambulance, active antepartum haemorrhage on arrival; antenatal still birth confirmed upon arrival. Transferred to theatre for an emergency section.

## Data



# Indicator in Focus: Patient Safety Incident Investigations (PSII)



## Overview and national position

In line with SFH’s Patient Safety Incident Response Plan, five PSII’s were commissioned during Jan-26 and Feb-26 by the Patient Safety Incident Response Group (PSIRG) following in-depth discussion during which the Integrated Care Board (ICB) were present.

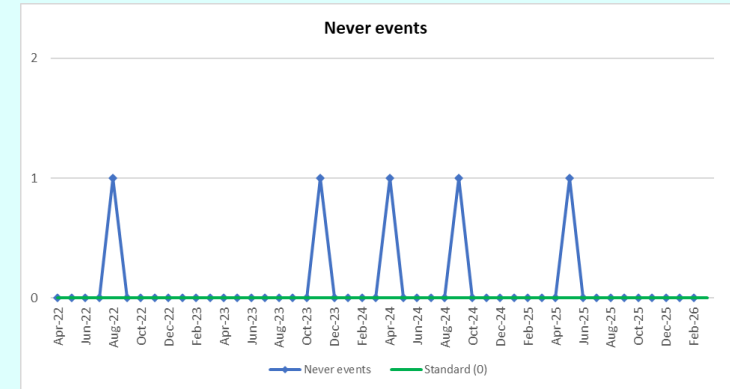
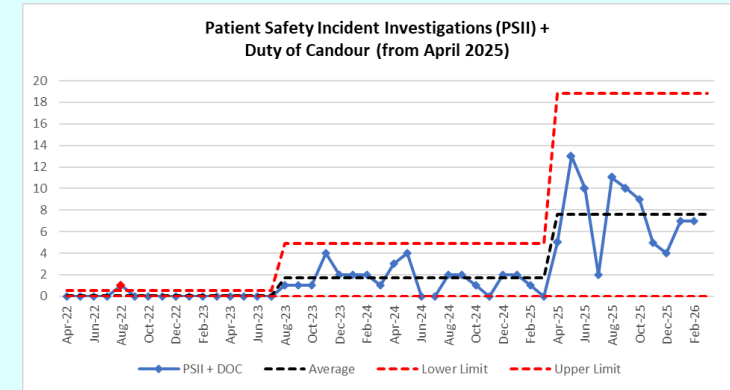
PSII with potential coronial interest	MSNI investigation	Never Events
5	None commissioned	None reported in Jan-26 and Feb-26

During Jan-26, there was an addendum to an MNSI investigation report signed off. It was confirmed that all recommendations from the MNSI review had been addressed, including reviewing and updating guidance, making clinical tools more accessible, and providing additional training for obstetrics and neonatal staff.

During Feb-26, one PSII was signed off in relation to delay in care within the Emergency Department for a patient who had presented with an Abdominal Aortic Aneurysm (AAA). Key actions agreed included:

- Review the use of Nervecentre in ED at SFH and confirm if past medical history can be pre-populated using previous attendance codes.
- Review process for requesting bloods and venous blood gas tests (VBGs) within STREAM and ED to promote consistency, which has an auditable trail within patients’ documentation.

## Data



Summary of incident	Actions and timescale	Impact
Postpartum subarachnoid haemorrhage (SAH) - Delays in care.	After action review undertaken by the division which identified delays in care. Immediate actions taken and PSII commissioned.	PSII ongoing
Cardiac arrest whilst under Section 3.	Joint PSII with Nottinghamshire Healthcare (NHC) and The Priory commissioned. Two meetings held with NHC already. FROES obtained; draft questions to ask staff produced. Patient safety partner invited to be part of investigation team. Postmortem outcome confirmed 1a) epileptic seizure.	PSII ongoing
Cardiac arrest in ED majors department. Patient was a medical bed waiter.	Awaiting confirmation of PSII investigators. Patient notes requested.	PSII ongoing
Delays in care and acute hypoglycaemic (hypoxic) brain injury.	Investigators confirmed and first PSII planning meeting arranged for 30/03/26. Notes and FROES requested. Learning disability nurse specialist part of investigation team.	PSII ongoing
Patient choked (RIP) following incorrect diet.	Awaiting confirmation of PSII clinical lead investigator. Background work commenced by supporting investigators. FROES and notes requested.	PSII ongoing

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# People and Culture



# Scorecard: People and Culture

Green tick = Best performing 40%  
Amber dash = Middle performing 20%  
Red cross = Worst performing 40%

## People and Culture

Green tick = target met/exceeded; Red cross = target not met

At a Glance	Indicator	2024/25 Standard	2025/26 Standard	Green tick = target met/exceeded; Red cross = target not met						2024/25 Final	2025/26 YTD	Latest Benchmark Position (Dec 25)	STAR Data Quality Assurance			
				Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26				S	T	A	R
Belonging in the NHS	Engagement score	≥6.8	≥6.9	✗ 6.8						✓ 7.1	-	66 / 121	●	●	●	●
Growing the Future	Vacancy rate	≤8.5%	≤8.5%	✓ 8.0%	✓ 7.9%	✓ 7.8%	✓ 8.2%	✗ 8.6%	✗ 9.1%	✓ 8.0%	✗ 8.7%		●	●	●	●
	Time to hire	n/a	≤53.1 days	✓ 25.0	✓ 36.0	✓ 21.0	✓ 19.0	✓ 32.0	✓ 22.0		✓ 25.9		●	●	●	●
	Turnover in month	≤0.9%	≤0.9%	✓ 0.8%	✗ 1.0%	✓ 0.6%	✓ 0.6%	✓ 0.5%	✓ 0.4%	✓ 0.7%	✓ 0.6%	✗ 108 / 118	●	●	●	●
	Appraisals	≥90%	≥90%	✗ 88.2%	✗ 87.5%	✗ 87.4%	✗ 87.5%	✗ 86.7%	✗ 87.6%	✗ 89.0%	✗ 88.1%		●	●	●	●
	Mandatory & statutory training	≥90%	≥90%	✓ 92.9%	✓ 93.3%	✓ 93.6%	✓ 93.6%	✓ 92.8%	✓ 92.4%	✓ 91.5%	✓ 93.0%		●	●	●	●
	Medical job plan compliance	n/a	≥95%	✗ 94.0%	✓ 95.9%	✓ 96.6%	✓ 97.8%	✓ 97.8%	✓ 98.5%		✗ 86.6%		●	●	●	●
Looking after our People	Sickness absence	≤4.2%	≤4.2%	✗ 4.8%	✗ 5.7%	✗ 5.6%	✗ 5.9%	✗ 5.6%	✗ 5.5%	✗ 5.0%	✗ 5.2%	67 / 118	●	●	●	●
	Flu vaccinations uptake (front line staff)	≥75%	≥53.1%	-	✗ 35.8%	✗ 50.7%	✗ 54.3%	✗ 54.7%	✗ 56.9%	✗ 58.0%	✗ 54.7%		●	●	●	●
	Employee relations management	<17	<21	✓ 20	✓ 21	✓ 20	✗ 26	✗ 24	✗ 23	✗ 21	✗ 21		●	●	●	●
New Ways of Working	Bank usage	≤8.5%	≤7.8%	✓ 5.2%	✓ 4.8%	✓ 6.8%	✓ 7.5%	✓ 7.3%	✓ 6.4%	✗ 8.9%	✓ 6.5%	115 / 195	●	●	●	●
	Agency usage	<3.2%	<1.9%	✗ 2.3%	✗ 2.6%	✗ 2.0%	✗ 2.0%	✗ 1.9%	✗ 2.4%	✗ 4.0%	✗ 2.5%	✗ 150 / 187	●	●	●	●
	Agency (off framework)	0%	0%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✗ 0.01%	✓ 0.0%		●	●	●	●
	Agency (over price cap)	≤40.0%	≤40.0%	✗ 40.9%	✓ 33.4%	✓ 33.6%	✓ 39.5%	✓ 38.9%	✓ 37.9%	✗ 52.9%	✓ 37.7%		●	●	●	●

# Domain Summary: People and Culture

## Overview

**Lead: Chief People Officer**

In Feb-26, six of fourteen People and Culture indicators were meeting or exceeding standards year-to-date (YTD), reflecting our commitment to our People. Key areas of compliance include Mandatory and Statutory Training (MaST) compliance, which has consistently surpassed targets throughout 2025/26. Recruitment timelines, bank usage, and off-framework agency levels remain compliant. Since the last report we have incorporated stronger benchmarking comparators, indicating how the Trust is performing against areas where national benchmarking data is available.

Vacancy rate remains above the 8.5% standard, driven by the planned impact of the internal Mutually Agreed Redundancy Scheme (MARS) programme, strengthened vacancy control processes, and the Trust's intention to reduce overall staffing levels. Turnover is reported at 0.6% and sits lower than the Trust standard (0.9%). Against the national benchmarking position, turnover shows that the Trust is ranked within decile 10, fluctuating through 2025/26 and directly influenced by our MARS programme.

Appraisal compliance remains below the 90% Trust target, with performance plateauing at 88.1% YTD and moving within normal statistical variation. This position reflects ongoing operational pressures, including patient demand, annual leave and staff absence, which have impacted the ability of teams to release time for appraisals. Actions are underway to strengthen compliance, including a plan to promote the value of appraisals, the consideration of an 'appraisal season' whereby appraisals are undertaken within a timeframe, and enhanced reporting to managers. A paper for the People Cabinet has been developed to agree mechanisms to support improvement. Divisionally, we also understand areas of lower compliance across Medicine, Surgery and Women and Children's divisions.

Sickness absence remains above the 4.2% standard, with a YTD position of 5.2%, though levels have begun to improve since Dec-25 as both short- and long-term sickness fall. Stress and anxiety continue to be the most prominent causes of absence, reflecting the operational pressures experienced across the Trust. Actions underway include strengthening sickness management through a refreshed 'Managing Attendance at Work' policy, incorporating absence management into leadership fundamentals training, and targeted preventative programmes focusing on musculoskeletal (MSK) and stress-related absence hotspots. It is envisaged that, between stronger management of absence and preventative strategies, the Trust will see lower and sustainable absence levels. Our flu vaccinations position is above our standard for 2025/26 (53.1%). Additionally, the Trust position is ranked within the top five across provider Trusts across the Midlands, which is a strong position.

Employee relations activity remains elevated with 23 active cases in Feb-26, driven by increased operational pressures and a stronger application of Trust policies. The caseload includes disciplinaries, grievances, dignity at work concerns and several complex safeguarding matters. Actions are focused on strengthening early informal resolution, enhancing manager confidence through revised processes and training, and ensuring appropriate support for all colleagues involved, alongside continued promotion of Active Bystander principles to improve workplace behaviours.

Bank usage is reported at a position under standard (6.4% in Feb-26) and is showing a decreasing trend after winter pressures. Benchmarking ranks the Trust within decile six in Dec-25. The YTD agency usage position is reported at 2.5%, sitting above our standard (1.9%), with the monthly position reported at 2.4% in Feb-26. The position shows an increase to the previous month (1.9%). The position has increased due to the elective sprint and hospital capacity. However, this is an expected short-term position driven by national elective targets that will reduce at the end of Mar-26. Against the NHS England agency reduction expectation, the Trust has reduced agency expenditure by 37.1% and there has been zero use of 'off framework' agency and over price cap agency is below standard.

The following pages provide more detailed performance information, relating to six areas of exception across the People and Culture domain. These were discussed in depth with supporting deeper analysis at the Trust People Committee in Mar-26, where we also presented the national benchmarking analysis.

# Indicator in Focus: Vacancy Rate

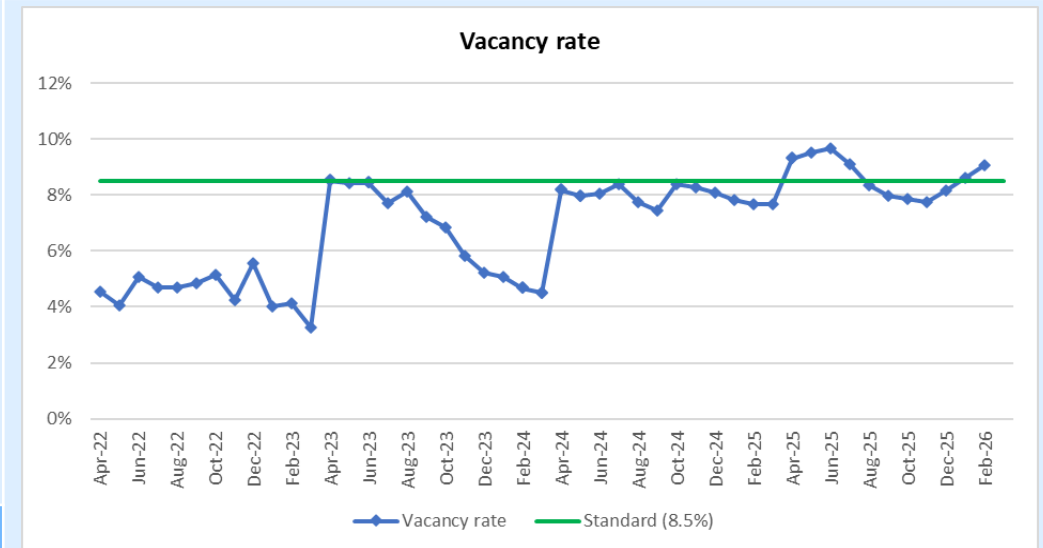
## Observations

The position for Feb-26 and the quarter to date sits above the standard. This is an expected position due the impact of our internal MARS programme, a strengthened vacancy control process and ambition to see a reduced staffing position.

The current year to date vacancy rate is reported at 8.7%, which is a position that sits above the standard (8.5%). There is a correlating impact on turnover which has a year-to-date position of 0.6%, which sits below our standard. However, national benchmarks indicate we sit within decile 10 for turnover (further details on the next slide). It is noted that the Dec-25 national range is between 0.47 to 1.34%.

We have noted that there are increases to the vacancy levels across Administration and Clerical staff that directly relate to the MARS programme. These will be disestablished as part of the budget setting establishment review process.

## Local Data (to Feb-26)



Root Causes	Actions and Timescale	Impact
Leavers aligned to the internal MARS programme.	We are expecting MARS leavers until the end of the financial year due to notice periods and have phased these leavers against the Trust efficiency programme.	Although we are seeing elevated vacancy rate, this is aligned to the Whole Time Equivalent (WTE) reduction noted across the Trust between Jan-26 and Feb-26.
Strengthened Vacancy Control Panel (VCP) processes.	Aligned to financial control, we monitor vacancies via our VCP. We have re-assigned role categories where all roles are scrutinised prior to advertisement.	

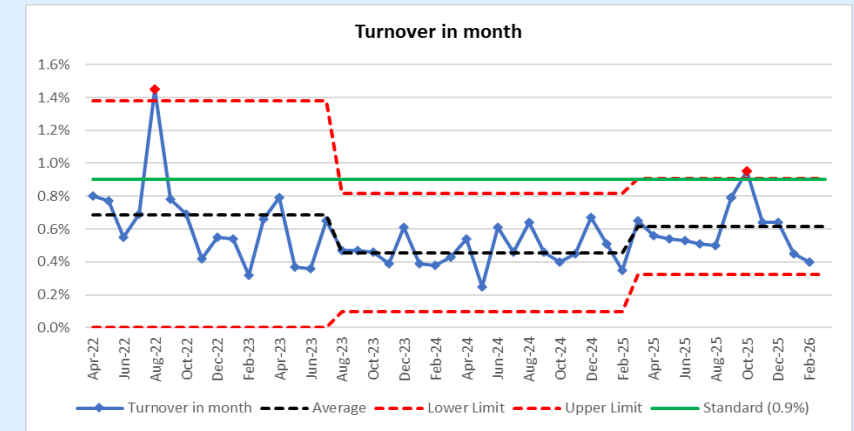
# Indicator in Focus: Turnover

## Observations

The position for Feb-26 and the quarter to date sits below the standard and shows a reducing trend from the Oct-25 high. The year-to-date position is 0.6%, which sits below our standard. National benchmarking indicates that for Dec-25 we sit within decile 10.

During the last quarter, there has been an increase in turnover impacted by normal leavers and our internal MARS programme.

## Local Data (to Feb-26)



## Root Causes

Leavers aligned to the internal MARS programme.

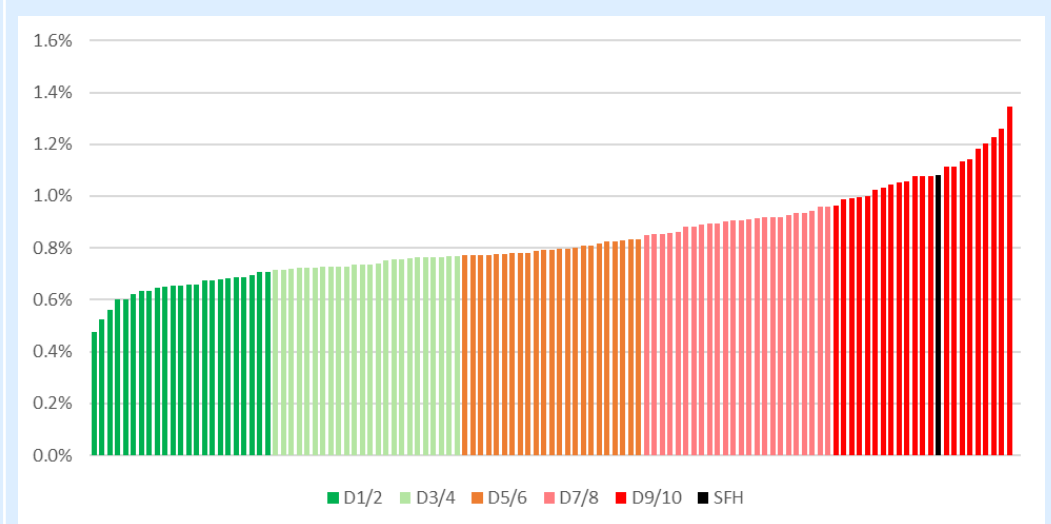
## Actions and Timescale

We are expecting MARS leavers until the end of the financial year. This is due to notice periods and have phased these leavers against the Trust efficiency programme.

## Impact

Although we are seeing elevated turnover levels, this is aligned to the programmes of transformation noted across the Trust.

## Benchmark Position (Dec-25)



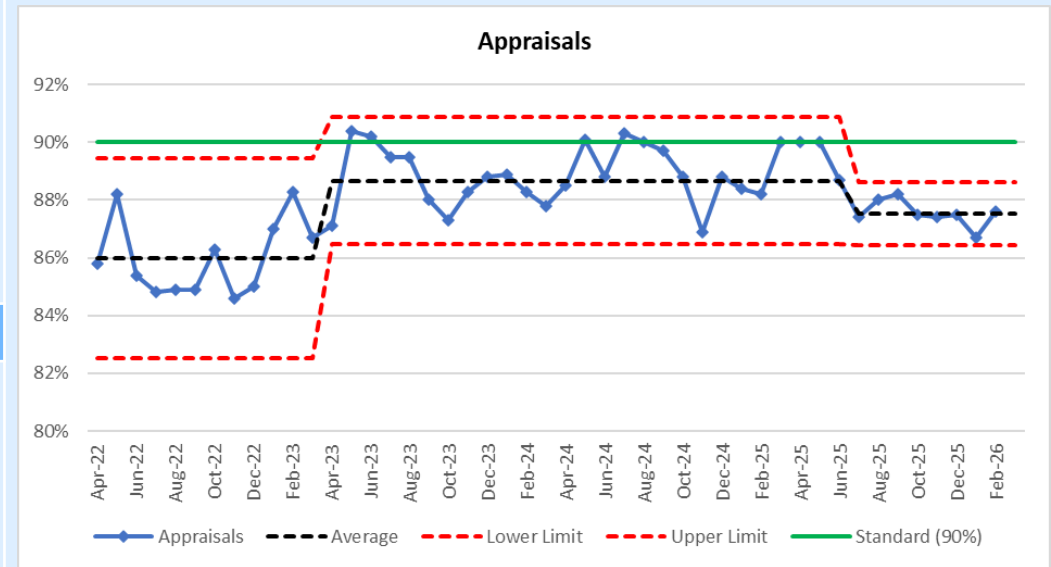
# Indicator in Focus: Appraisals

## Observations

Our appraisal level sits below the Trust target (90%). Performance has plateaued during 2025/26 quarters three and four and has remained at a level that is lower than the standard.

The year-to-date position is at 88.1%. There has been a control limit change since our last report with the average and upper control limit reducing following a period of lower performance since Jun-25. Although the position is below standard, this is a strong level compared to the wider Integrated Care Board (ICB) performance (83.2% in Jan-26).

## Local Data (to Feb-26)



## Root Causes

Patient demand and hospital acuity has impacted on compliance.

Annual leave and absence levels.

## Actions and Timescale

To support with meeting compliance level, additional actions are being developed. These actions, which are aligned to the staff survey, include:

- Communication around promoting the importance and benefits of appraisals
- Consideration of an 'appraisal season'
- For a short period, we are enhancing reporting to managers to support achievement of the standard
- Proposing showing a monthly and rolling average appraisal position.

A paper is being developed for People Cabinet to agree the mechanisms.

## Impact

Appraisal compliance levels to gradually increase, with an ambition to see levels of 90% and above.

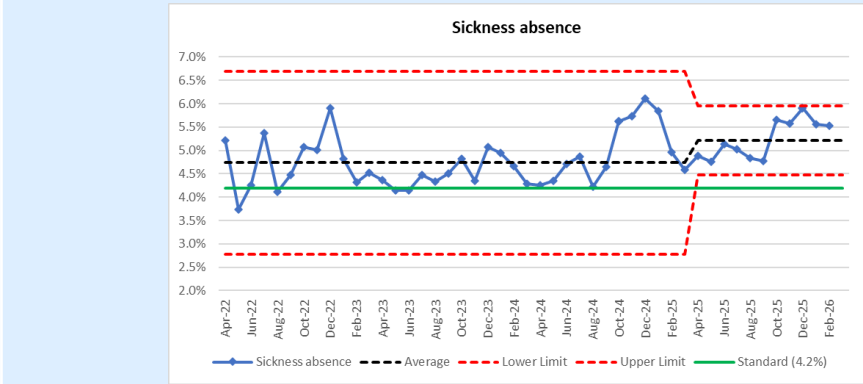
# Indicator in Focus: Sickness Absence



## Observations Local Data (to Feb-26)

The year-to-date sickness position is reported at 5.2%, sitting above our standard (4.2%). Feb-26 sits above the mean and below the upper statistical process control limit (5.5%), improving marginally from Jan-26 (5.6%). There has been a slight decrease in short term sickness and decreases to long term sickness. Most absence reasons relate to stress and anxiety.

The Nov-25 benchmarking shows the Trust ranking within decile six and our overall position rank as 67 out of 118. Across the Integrated Care System (ICS), the total provider sickness for Jan-26 is 6.3%.



## Root Causes Benchmark Position (Nov-25)

Our sickness level is reflective of the acuity of the hospital, including being on a high level of escalation (OPEL 4) and at times implementing our Full Capacity Protocol (FCP).

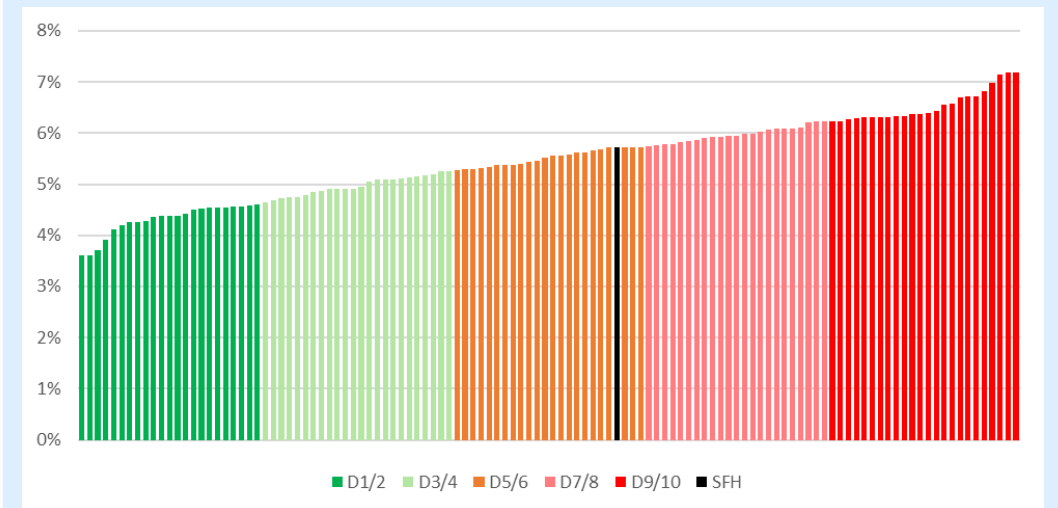
We are focusing on the management of sickness absences and re-enforcing the basics to managers. In Mar-26 we will be reviewing the Sickness Absence Policy, renaming this to 'Managing Attendance at Work'. We will re-define the discretion element and set managers expectations. We will bring absence management into the leadership fundamentals training and focus on absence prevention in-line with the NHS sickness absence toolkit.

Reduce levels of sickness.

We actively manage sickness cases through a person-centred approach and are aware of outside influences that are contributing to an elevated sickness level.

Higher levels are attributed to higher physical and emotional demands on frontline staff, greater exposure to infectious diseases and increased stress and burnout, especially in emergency and inpatient services.

As well as the management of absences, we are looking at root causes. Primarily across our healthcare assistant workforce, we are seeing absence hotspots and have identified service line and ward areas. Aligned to these areas, we are validating our assumptions and plan to bring in preventative programmes to support a sustained reduction to absence. This is focused across MSK and stress and anxiety reasons.



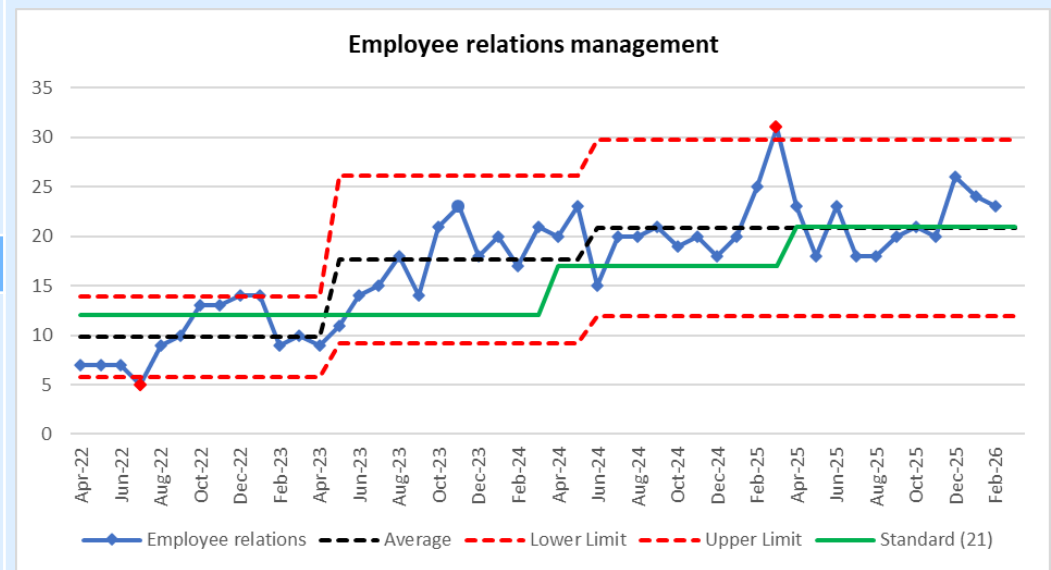
# Indicator in Focus: Employee Relations Management

## Observations

During 2025/26, the employee relations level has fluctuated between 18 and 26 cases, with an average of 21 cases and Feb-26 position of 23 cases. The employee relations position sits above the standard; however, this increase is influenced due to the stronger application of policies resulting in increased disciplinarys.

SFH is not an outlier in relation to employee relations casework, with other organisations reporting an ongoing increase in employee relations case management.

## Local Data (to Feb-26)



## Root Causes

The increase in cases is driven by hospital pressures and the stronger application of policies. Some cases are due to strained relationships at work, that are driving poor employee behaviour.

Disciplinary investigations, dignity at work and grievances cases are the key employee relations reason within the quarter.

## Actions and timescale

We are managing in line with the Trust policy and are ensuring concerns are dealt with informally within the first instance. We have had several complex cases recently whereby this has not been possible. We are seeing a rise in grievances and dignity at work relating to behaviours either colleague-to-colleague and/or manager behaviours in relation to decision or actions taken towards the employee. There are also several safeguarding cases that we are finalising.

Continued actions are being put in place to ensure support is put in place for all colleagues involved in employee relations matters and we continue to promote Active Bystander training and encourage staff to speak up. To support managers in dealing with more cases informally, we are developing a revised process and training so that managers feel more enabled and are confident in dealing with staff concerns informally.

## Impact

Reduced and sustained levels of employee relation cases.

# Indicator in Focus: Agency Usage

## Observations

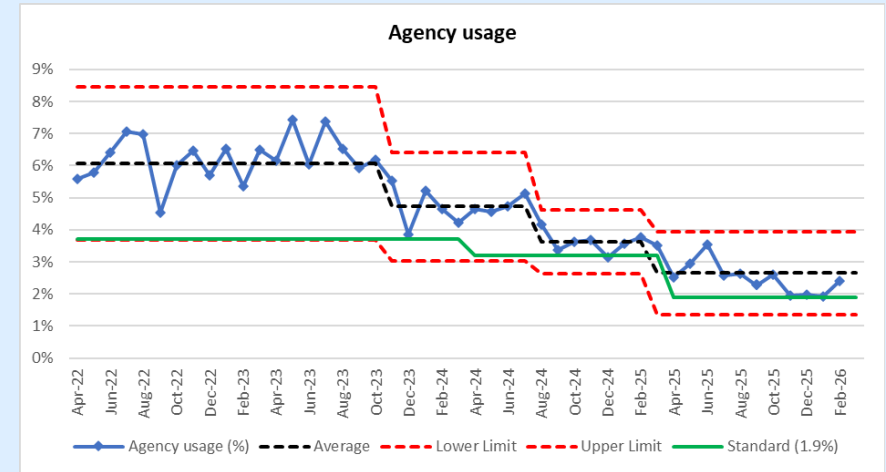
The year-to-date agency position is reported at 2.5% and Feb-26 at 2.4%, sitting above our standard (1.9%). This is a deterioration from Jan-26, where we achieved the standard.

Against the NHS England agency reduction expectation, the Trust has reduced agency expenditure by 37.1% from Nov-24 (target 40%) and has been achieving this over the past four months.

There has been zero use of 'off framework' agency and over-price cap agency is performing well against the standard.

The benchmarked position shows the Trust within decile 9. It is noted that this is Dec-25 position, when the Trust agency usage level was at 2% and was adversely impacted by winter pressures and sustained OPEL pressures.

## Local Data (to Feb-26)



## Root Causes

Our biggest risk is medical and dental staff over the NHS England price cap; these are also impacted by some of our fragile services where there are national specialty shortages.

The Feb-26 position has deteriorated due to the elective sprint and hospital capacity; this is an expected short-term position driven by national elective targets that will reduce at the end of Mar-26.

## Actions and Timescale

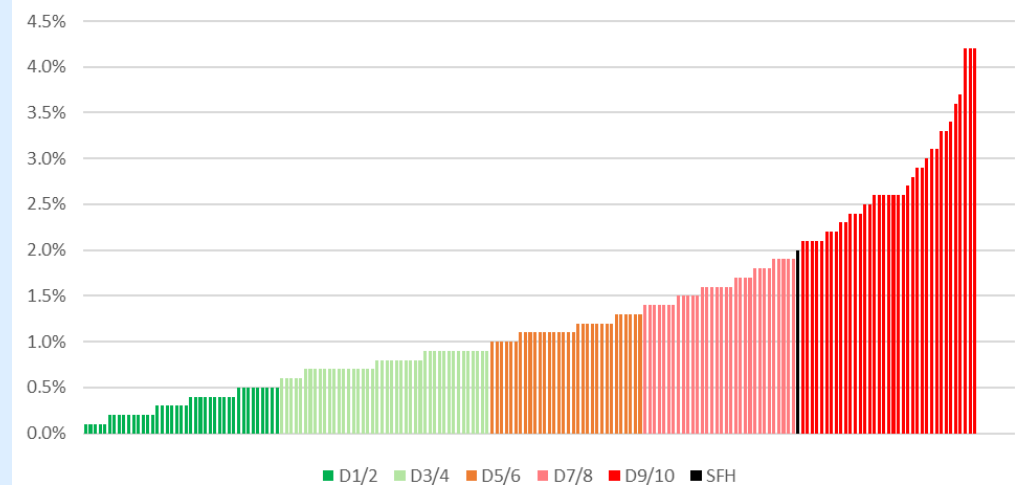
Throughout 2025/26, the Trust has been focusing on medical staff who are on-framework, but over the NHS England price-cap, and have been developing plans to exit these agency workers and replace them with substantive roles.

To achieve the elective sprint the Trust are using temporary staffing to support the required increased performance targets. This usage will be temporary until Mar-26.

## Impact

Target to reduce the agency level to 1.5%.

## Benchmark Position (Dec-25)



Outstanding Care,  
Compassionate People,  
Healthier Communities



Sherwood Forest Hospitals  
NHS Foundation Trust



# Timely Care

# Domain Summary: Timely Care

## Overview

Lead: Chief Operating Officer

In Feb-26 we saw some of the challenges within our Urgent and Emergency Care (UEC) pathway over winter begin to ease. This is reflected in several of our reported UEC performance metrics delivering an improved position; including ambulance turnaround times, 4-hour and 12-hour emergency access performance and discharge delays for medically safe for transfer patients (known as patients with no criteria to reside in hospital). These improvements were driven by better flow through and out of our hospitals resulting in patients spending less time in our Emergency Department waiting for admission.

Accident and Emergency (A&E) 4-hour performance exceeded 70% in Feb-26 for the first time since Jul-25, continuing the improving trend we saw in Jan-26. Ambulance turnaround times also improved in Feb-26; this supports our ambulance crews to respond to our local population in a timely manner. Our overall 4-hour emergency access performance was 3.5% better than Feb-25, with this improvement being driven by our King's Mill Hospital type one service. The UEC performance improvement is against a backdrop in Feb-26 of a 6% (average of 21 patients per day) growth in attendance demand to our King's Mill type one service (compared to Feb-25). Since Sep-25, the Nottingham Emergency Medical Services (NEMS) primary care 24 service has seen less patients than in the same periods in the last three years; in Feb-26 the reduction was 19.5% (average of 15 patients per day less) compared with Feb-25. Our Newark type three service continues to see high attendance demand with Feb-26 levels like the same period in 2025. Non-elective admissions in Feb-26 were very high; however, an ease in discharge delays meant that bed occupancy reduced marginally from Jan-26 and hospital flow improved. In Feb-26, the number of inpatients medically safe for transfer for greater than 24 hours reduced to the lowest levels seen since Jun-25.

In terms of planned care, our 52-week wait backlog deteriorated to 1.1% of the total Patient Tracking List (PTL) in Feb-26; above the 1% operational planning guidance target to be achieved by the end of 2025/26. This is due to a combination of a small increase in the number of long wait patients (numerator) and a reduction in the overall waiting list (PTL) size (denominator). Our PTL size decreased in Feb-26 to the lowest level for over one year. 18-week Referral to Treatment (RTT) performance has improved in Feb-26 to 60.9% with further improvements expected in Mar-26 due to the Elective Sprint. We continue to benchmark well nationally against our RTT long wait metric, and we continue with strong performance providing patient initiated follow up delivering performance consistently better than the standard and amongst the best in the country.

Our diagnostic DM01 performance continues to improve following a dip in the summer of 2025, closing at 93.6% in Feb-26. The improvements in recent months is reflected in our benchmarking position which is consistently above the national average.

Our cancer performance for the 28-day faster diagnosis standard remains favourable to plan. Cancer 31-day and 62-day treatment standards have been moving within standard variation (since mid-2024 for the 31-day standard) and both closed just below plan in Jan-26 (the latest reporting period). The 31-day position has improved from a low in Aug-25. 62-day performance remains variable within statistical control limits with our focus on sustainably reducing the backlog of patients waiting over 62-day for treatment. Recovery plans are in place across several tumour sites with further details included in this report.

The following pages provide further detail on performance against key Timely Care domain metrics and the actions we are taking to resolve areas of underperformance.

# Scorecard: Timely Care

Green tick = Best performing 40%  
Amber dash = Middle performing 20%  
Red cross = Worst performing 40%

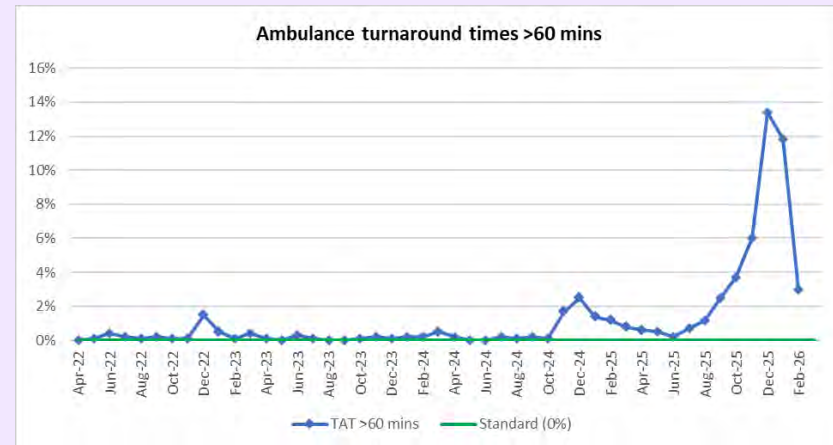
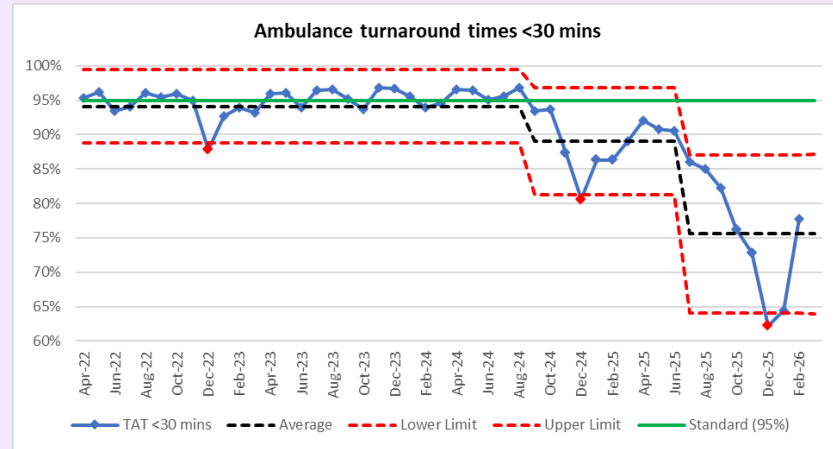
## Timely Care

Green tick = target met/exceeded; Red cross = target not met

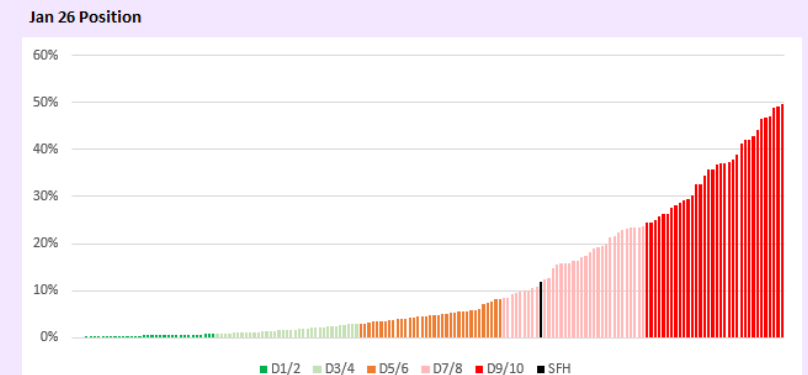
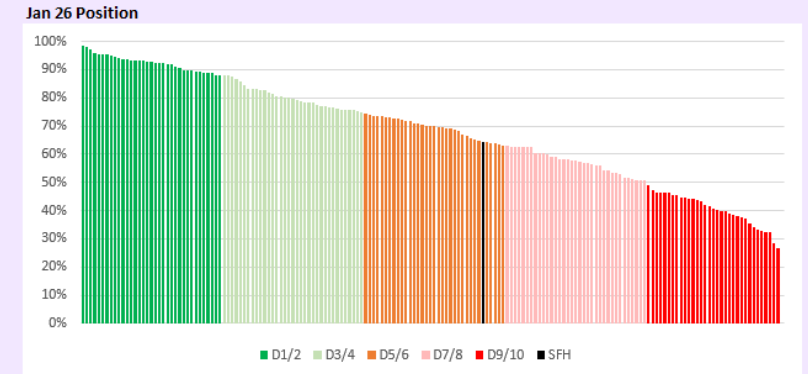
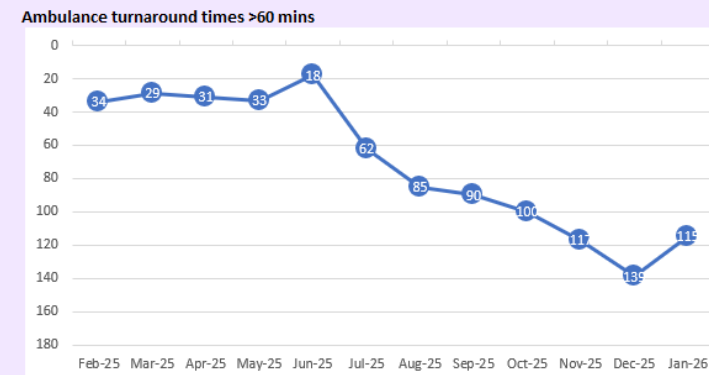
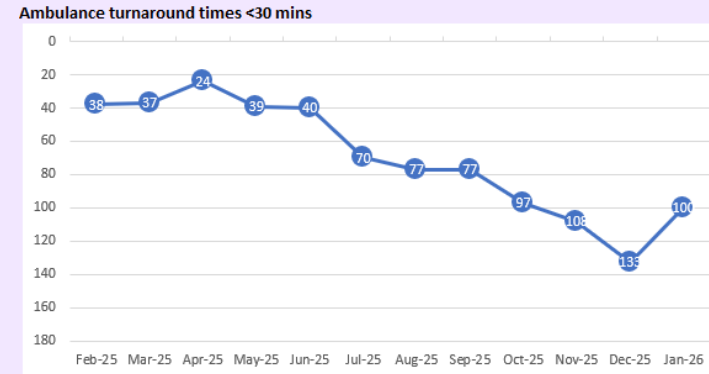
At a Glance	Indicator	2024/25 Standard	2025/26 Standard	2024/25						2024/25 Final	2025/26 YTD	Latest Benchmark Position (Jan 26)	STAR Data Quality Assurance			
				Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26				S	T	A	R
Urgent Care	Ambulance turnaround times <30 mins	≥95%	≥95%	✗ 82.3%	✗ 76.2%	✗ 72.8%	✗ 62.2%	✗ 64.4%	✗ 77.8%	✗ 91.4%	✗ 79.6%	100 / 176	●	●	●	●
	Ambulance turnaround times >60 mins	0.0%	0.0%	✗ 2.5%	✗ 3.7%	✗ 6.0%	✗ 13.4%	✗ 11.8%	✗ 3.0%	✗ 0.7%	✗ 4.2%	115 / 176	●	●	●	●
	ED 4-hour performance	≥76%	≥Plan	✗ 68.0%	✗ 67.4%	✗ 67.3%	✗ 67.0%	✗ 69.5%	✗ 71.9%	✗ 71.0%	✗ 71.4%	77 / 141	●	●	●	●
	ED 12-hour length of stay performance	≤2%	≤2024/25	✗ 5.6%	✗ 8.2%	✗ 7.2%	✗ 9.2%	✗ 9.3%	✗ 6.5%	✗ 3.4%	✗ 5.5%	68 / 177	●	●	●	●
	Mental health patients spending over 12 hours in A&E	n/a	No Standard	23	27	17	9	17	24	23	221		●	●	●	●
	Adult G&A bed occupancy	≤92%	≤92%	✗ 96.3%	✗ 97.4%	✗ 96.1%	✗ 95.9%	✗ 97.1%	✗ 96.9%	✗ 94.5%	✗ 96.1%	125 / 179	●	●	●	●
	Average number of days between planned and actual discharge date	n/a	≤Plan	✓ 3.5	✓ 3.4	✗ 4.0	✗ 4.0	✓ 3.4	✓ 3.1	3.1	✓ 3.5		●	●	●	●
Inpatients medically safe for transfer for greater than 24 hours	≤40	≤40	✗ 82	✗ 72	✗ 84	✗ 89	✗ 85	✗ 67	✗ 64	✗ 74		●	●	●	●	
Electives	Added to Patient Initiated Follow Up (PIFU) pathway	≥5%	≥5%	✓ 10.7%	✓ 10.7%	✓ 10.8%	✓ 10.7%	✓ 10.3%	✓ 11.0%	✓ 6.0%	✓ 10.4%	6 / 134	●	●	●	●
	Percentage of incomplete Referral to Treatment (RTT) pathways completed in less than 18 weeks	n/a	≥Plan	✗ 61.9%	✗ 60.4%	✗ 60.3%	✗ 59.3%	✗ 59.6%	✗ 60.9%	64.6%	✗ 61.7%	96 / 149	●	●	●	●
	Percentage of RTT waits over 52 weeks for incomplete pathways	n/a	≤Plan	✓ 0.9%	✓ 0.9%	✓ 0.8%	✓ 1.0%	✓ 1.0%	✗ 1.1%	1.3%	✓ 1.0%	50 / 149	●	●	●	●
Diagnostics	Diagnostic DM01 performance under 6-weeks	≥Plan	≥Plan	✗ 89.8%	✗ 90.4%	✗ 89.8%	✗ 92.0%	✗ 93.5%	✗ 93.6%	✓ 93.1%	✗ 93.5%	23 / 133	●	●	●	●
Cancer	Cancer 28-day faster diagnosis standard	≥75%	≥Plan	✓ 80.7%	✓ 82.2%	✓ 79.4%	✓ 81.7%	✓ 79.4%	-	✓ 78.3%	✓ 80.6%	35 / 133	●	●	●	●
	Cancer 31-day treatment performance	≥Plan	≥96%	✗ 88.4%	✗ 91.7%	✗ 93.6%	✗ 95.9%	✗ 94.5%	-	✓ 91.9%	✗ 91.0%	63 / 134	●	●	●	●
	Cancer 62-day treatment performance	≥Plan	≥Plan	✓ 63.1%	✓ 65.3%	✓ 75.7%	✗ 63.6%	✗ 68.6%	-	✗ 64.4%	✗ 66.7%	74 / 135	●	●	●	●

# Indicators in Focus: Urgent Care – A&E (1/4)

## Local data (to Feb-26)

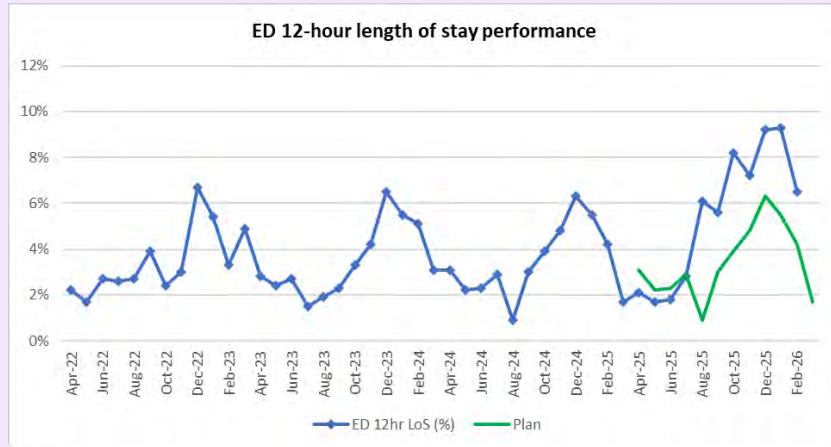
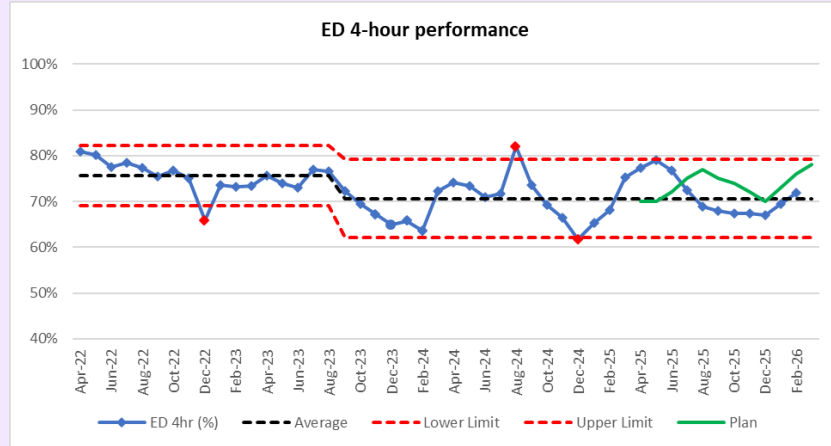


## Benchmark position (to Jan-26)

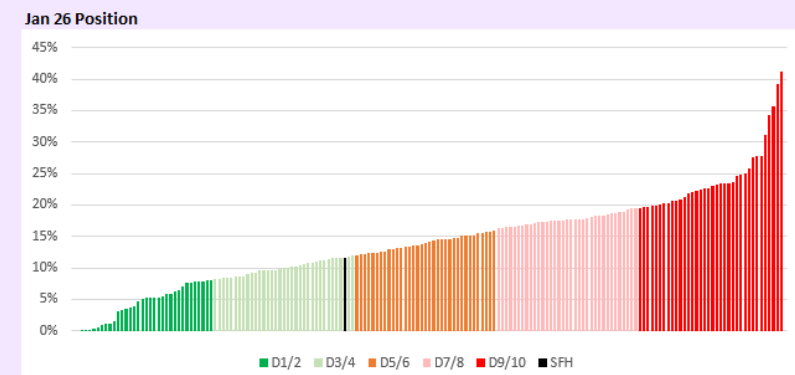
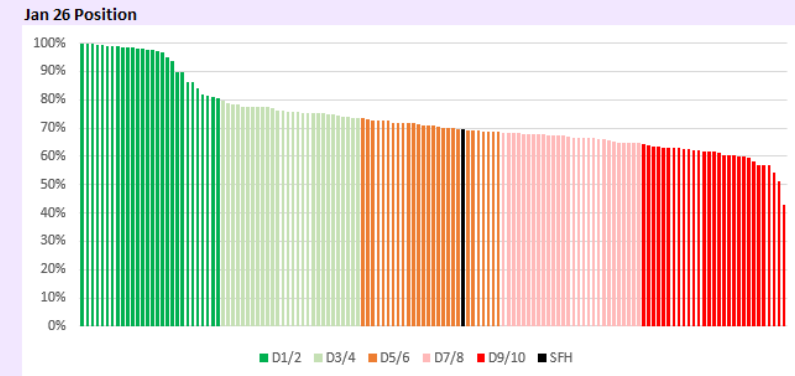
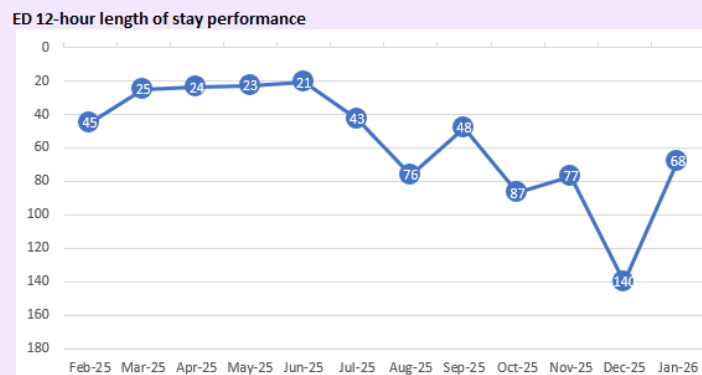
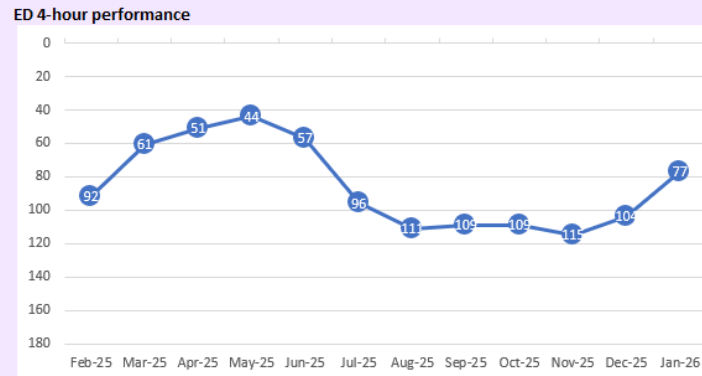


# Indicators in Focus: Urgent Care – A&E (2/4)

## Local data (to Feb-26)



## Benchmark position (to Jan-26)



# Indicators in Focus: Urgent Care – A&E (3/4)

## Performance observations

In Feb-26 we saw some of the challenges within our Urgent and Emergency Care (UEC) pathway over winter begin to ease. This is reflected in several of our reported UEC performance metrics delivering an improved position; including ambulance turnaround times, 4-hour and 12-hour emergency access performance. These improvements were driven by better flow through and out of our hospitals resulting in patients spending less time in our Emergency Department waiting for admission.

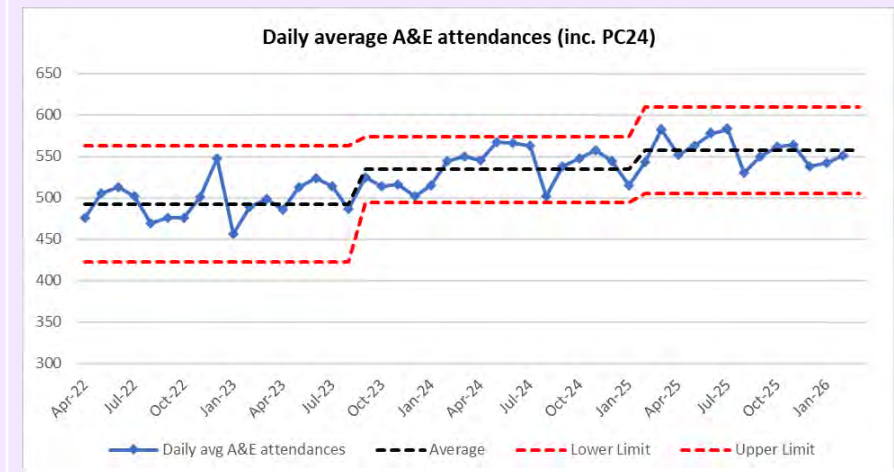
As detailed on slide one of four within this section of the report, ambulance 30-minute handover performance recovered to 77.8% in Feb-26, our strongest position since Sep-25. Our improvement is beginning to be reflected in our benchmarking position, which we expect to improve further when Feb-26 benchmarking data is available. Ambulance 60-minute handover performance also recovered, with 3% of arrivals being handed over in more than one-hour in Feb-26; again, our strongest position since Sep-25. Our average ambulance turnaround time in Feb-26 was just under 23 minutes which is our best monthly position since Sep-25. Comparing Jan/Feb-26 with the same period in 2025, we have seen a 7% growth in ambulance conveyance demand (just over 7 more conveyances per day on average).

As detailed in slide two of four within this section of the report, Accident and Emergency (A&E) 4-hour performance exceeded 70% in Feb-26 for the first time since Jul-25 (delivering 71.9%) continuing the improving trend we saw in Jan-26. Our overall 4-hour emergency access performance was 3.7% better than Feb-25 with this improvement being driven by our King's Mill Hospital type one service. A&E 12-hour performance improved in Feb-26 to 6.5%; this is our strongest performance since Sep-25.

The UEC performance improvement is against a backdrop in Feb-26 of a 6% (average of 21 patients per day) growth in attendance demand to our King's Mill type one service (compared to Feb-25). Since Sep-25, the Nottingham Emergency Medical Services (NEMS) primary care 24 service has seen less patients than in the same periods in the last three years; in Feb-26 the reduction was 19.5% (average of 15 patients per day less) compared with Feb-25. Our Newark type three service continues to see high attendance demand with Feb-26 levels like the same period in 2025.

Hospital flow challenges are still causing some outflow issues in our A&E department; however, we are seeing an improving picture. We have improvement initiatives in place across our UEC pathways with headline actions described in the subsequent pages.

## Additional data (to Feb-26)

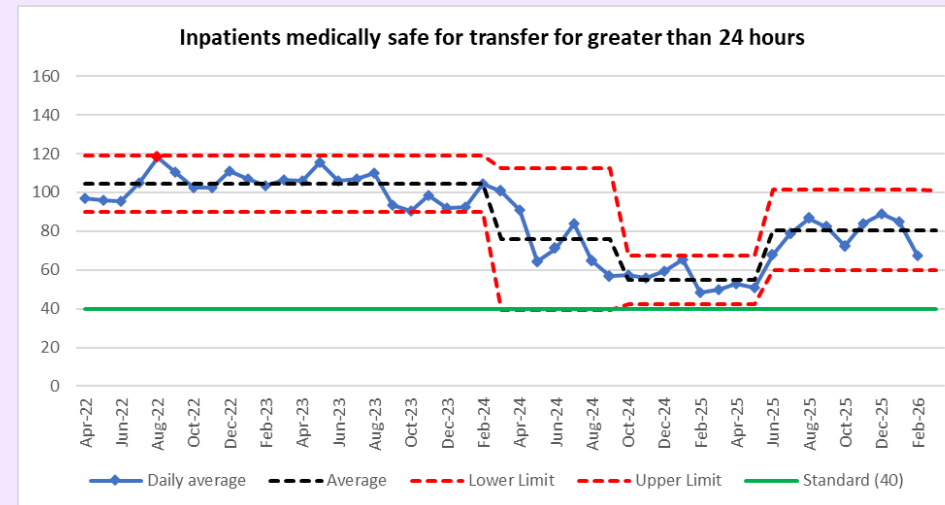
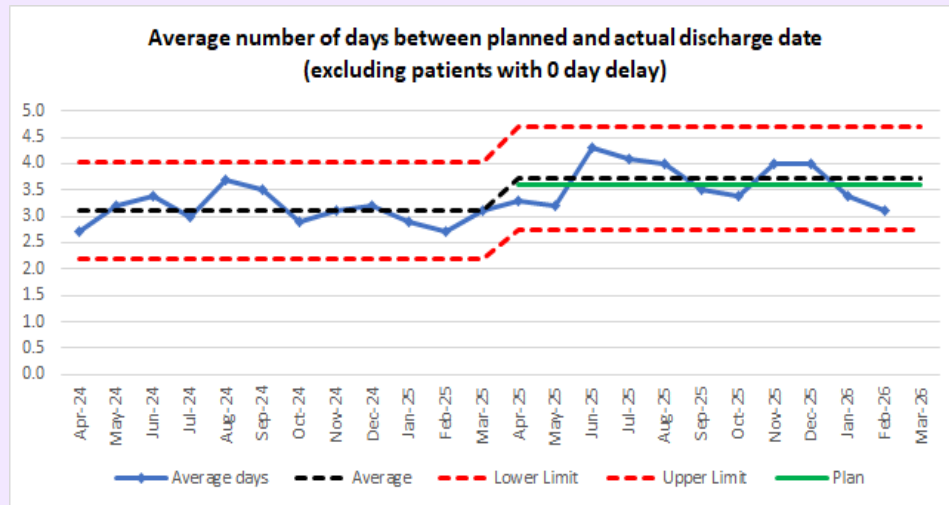
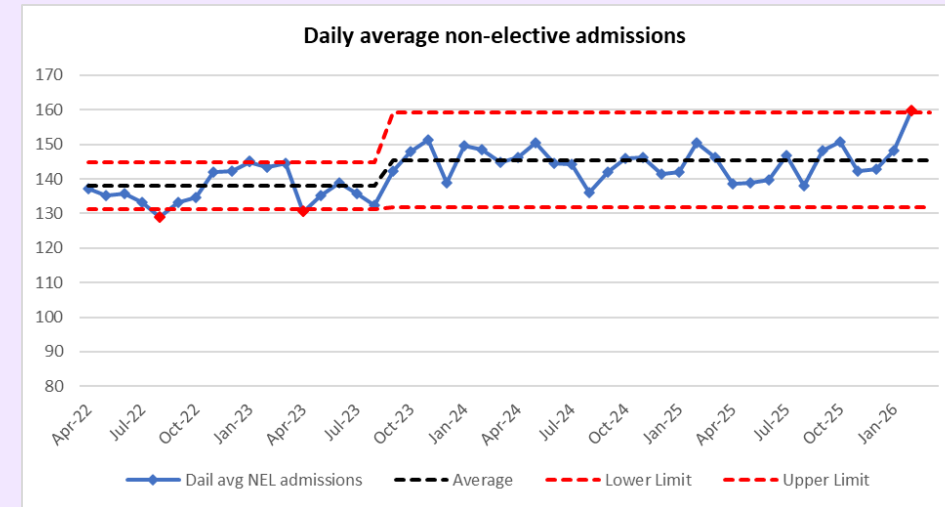
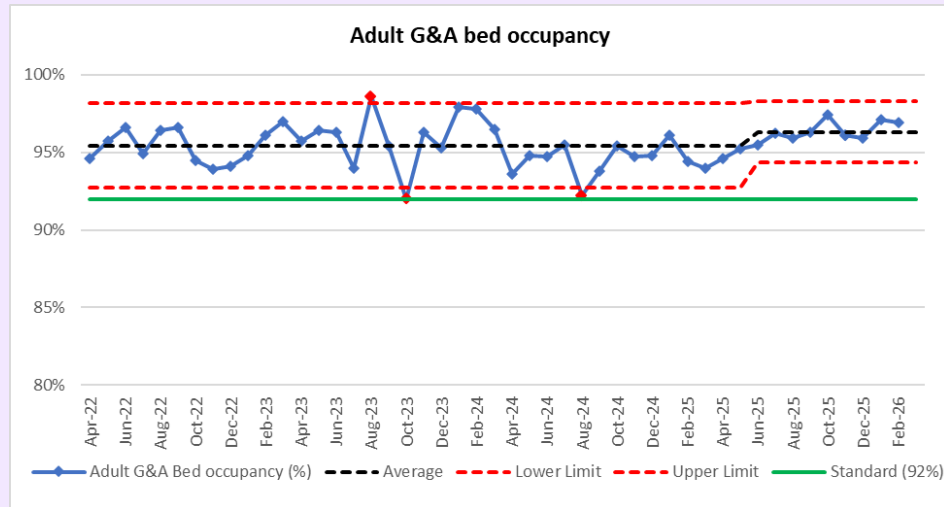


# Indicators in Focus: Urgent Care – A&E (4/4)

Root causes	Actions and timescale	Impact
<p>High Accident and Emergency (A&amp;E) attendance demand, patient acuity and ambulance conveyance levels.</p>	<ul style="list-style-type: none"> <li>Admission and attendance avoidance with system partners include:                             <ul style="list-style-type: none"> <li>Regular engagement with East Midlands Ambulance Service (EMAS) to discuss out of area conveyances.</li> <li>Focus on frailty attendances: Call before you convey; use of urgent care community response teams.</li> <li>Development of alternatives to ED workstream in line with the Emergency Care Improvement Plan.</li> <li>Redirection of patients to Urgent Treatment Centres.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Reduction in out of area conveyances.</li> <li>Reduction in category 3 ambulance conveyances.</li> <li>Reduction in over 65-year-olds where length of stay is one day plus.</li> </ul>
	<ul style="list-style-type: none"> <li>Development of an expanded Emergency Department (ED) ambulatory unit. Expansion of our Clinical Decisions Unit (CDU) commenced 25-Feb.</li> </ul>	<ul style="list-style-type: none"> <li>Increase the number of patients cared for in ambulatory pathways and via alternatives to ED.</li> </ul>
	<ul style="list-style-type: none"> <li>Clinically agree and implement ambulatory pathways to reduce ED waiting across Cellulitis, DVT, Heart Failure, Anaemia and Gastroenterology in line with our Emergency Care Improvement Plan.</li> </ul>	
	<ul style="list-style-type: none"> <li>Delivered Navigator role to aid timely triage and streaming.</li> </ul>	
<p>Insufficient staffing to manage A&amp;E demand.</p>	<ul style="list-style-type: none"> <li>Liaise with colleagues at NEMS and local commissioners to support appropriate patients to be seen and treated within four-hours in the type three primary care (PC24) service at King’s Mill Hospital (KMH).</li> </ul>	<ul style="list-style-type: none"> <li>Reduce the number of type three breaches of the four-hour performance standard within the NEMS PC24 service.</li> </ul>
	<ul style="list-style-type: none"> <li>Additional clinical shifts added to our minors department throughout 2025/26 quarter four to improve and protect minor and paediatric staffing and support timely patient care in these patient streams.</li> </ul>	<ul style="list-style-type: none"> <li>Reduce the number of non-admitted breaches of the four-hour performance standard.</li> </ul>
	<ul style="list-style-type: none"> <li>Maintain medical staffing levels at Newark Urgent Treatment Centre (UTC) to support timely patient care and strong type three performance.</li> </ul>	<ul style="list-style-type: none"> <li>Consistently deliver type three performance greater than 95% with the aim to increase to 98%.</li> </ul>
	<ul style="list-style-type: none"> <li>Recruit five new ED Consultants following review of all vacancies with a move to Consultant on site cover until 2am and improve senior presence during evenings and weekends through rota redesign by end of May-26 (following a delay in start dates for two Consultants).</li> </ul>	<ul style="list-style-type: none"> <li>Decrease in mean time in department for non-admitted patients to &lt;180 minutes.</li> </ul>
	<ul style="list-style-type: none"> <li>Implement two-hourly huddles and clear escalation triggers in ED to support stronger co-ordination.</li> </ul>	
	<ul style="list-style-type: none"> <li>Implement ED Nervecentre to improve visibility of tasks and escalations to progress patients care journey. Nervecentre deployed in Newark UTC in Feb-26. Deployment date for KMH ED is being agreed with NHS England.</li> </ul>	
<ul style="list-style-type: none"> <li>Dedicated minor injuries stream implemented to see and treat with dedicated area within minors.</li> </ul>		
<p>A&amp;E overcrowding driven by bed capacity pressures and mismatches in admission and discharge demand.</p>	<ul style="list-style-type: none"> <li>Additional bed spaces created across our medical base wards over winter by installing additional curtain rails. These spaces are used during periods of local escalation to allow our wards to accommodate more patients earlier in the day to help improve hospital flow.</li> </ul>	<ul style="list-style-type: none"> <li>Reduce ED overcrowding and reduce 12-hour length of stay to less than 2%.</li> </ul>
	<ul style="list-style-type: none"> <li>Patient flow actions detailed on the following slides.</li> </ul>	

# Indicators in Focus: Urgent Care – Hospital Flow (1/2)

Data (to Feb-26)



# Indicators in Focus: Urgent Care – Hospital Flow (2/2)

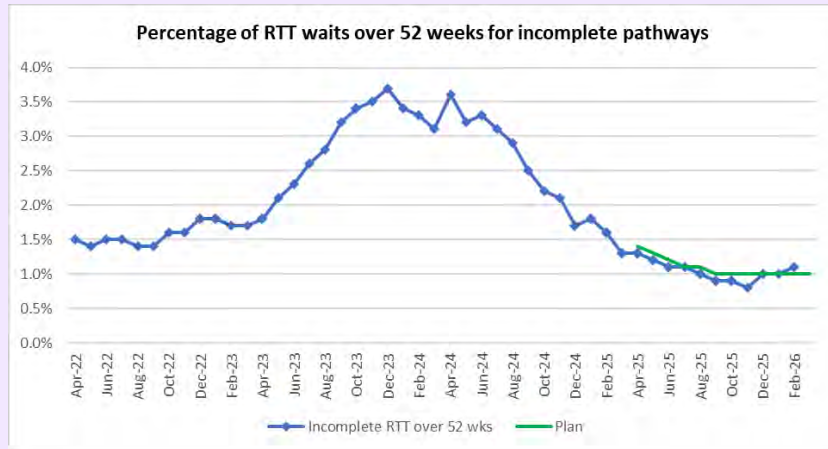
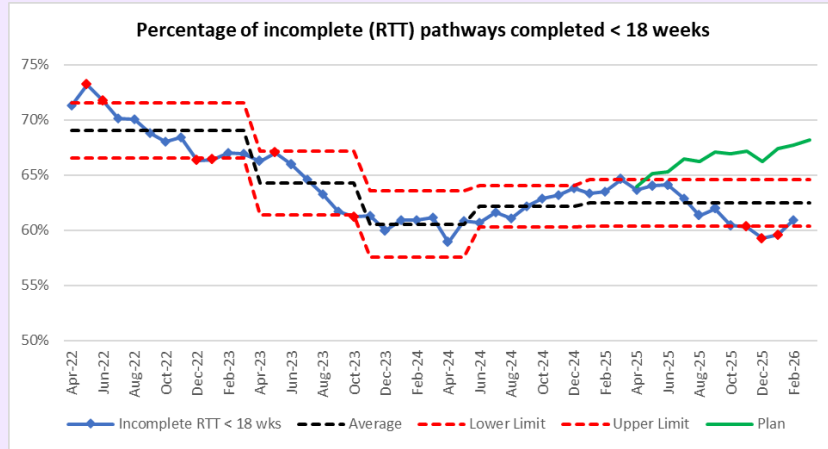
## Performance observations

- General and Acute (G&A) bed occupancy remains high, which has resulted in an increase in the lower statistical process control limit and average.
- The daily average number of non-elective admissions triggered as special cause variation in Feb-26 due to levels being just above the upper control limit.
- In Feb-26, the number of inpatients medically safe for transfer for greater than 24 hours reduced to the lowest levels seen since Jun-25.

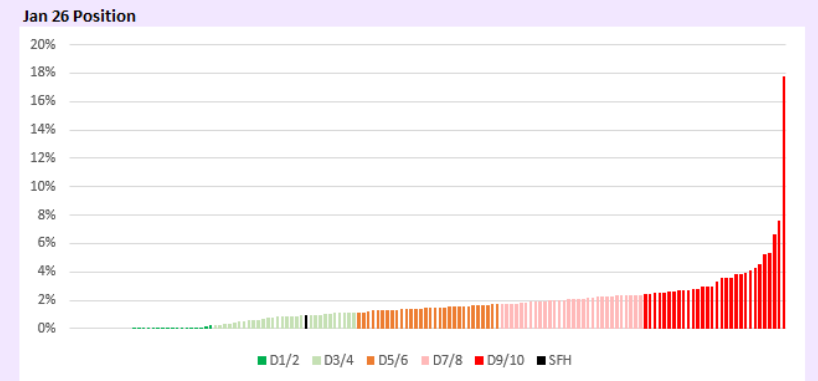
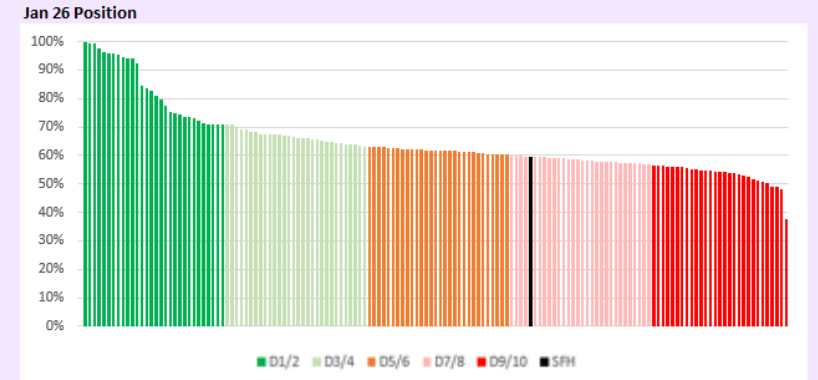
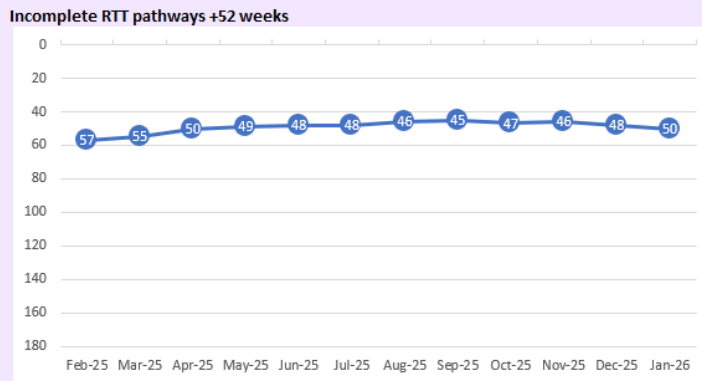
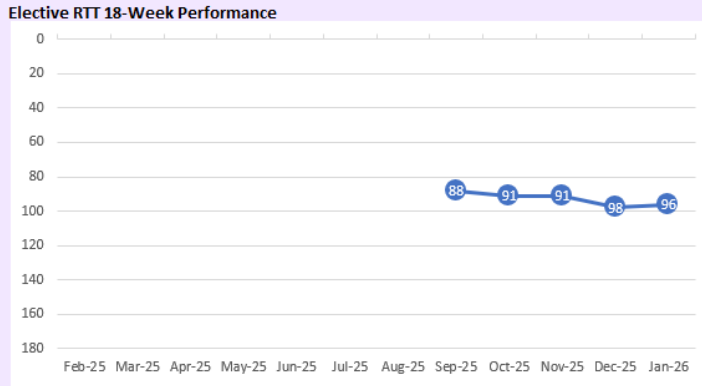
Root causes	Actions and timescale	Impact
Delays to pre-medically safe processes on inpatient wards (flow through our hospitals).	• The 'Getting the Basics Right' programme championed by the Chief Operating Officer and Chief Medical Officer. Focus on effective board rounds and ward processes to reduce delays and improve patient length of stay.	• Reduced delays and improved patient length of stay across all discharge pathways.
	• Daily ward-level discharge targets in place since Nov-25 and used daily in Capacity and Flow meetings.	
	• Increased focus on the importance of keeping our clinical systems up to date with items including the predicted date of becoming medically safe, medically safe status and home today status.	
Delays to post-medically safe discharge processes (flow out of our hospitals).	• The discharge team undertake a daily review of all patients medically safe for greater than 24 hours to identify actions to support timely discharge. Actions are on a live patient tracking list with updates and resolutions monitored throughout the day. Shared medically safe list embedded across all Divisions, enabling timely updates of actions to assist patient discharge.	• Improve length of stay (LOS) for complex discharges across our hospitals. • Eliminate barriers to discharge and further reduction in the number of abandoned discharges.
	• Maximising use of the discharge lounge for patients being discharged and transferred between sites.	• High utilisation of the discharge lounge.
	• Patient Transport Services (PTS) continue to be a challenge to timely discharge. EMED Group and Ambicorp conveyances continue to be under local and system-wide review.	• Identify opportunity for operational and financial efficiency. • Eliminate barriers to discharge.
Insufficient community capacity to meet supported discharge demand.	• Working with health and care partners (predominantly Adult Social Care) to resolve issues with a lack of Packages of Care (POCs) and delays in allocation of social workers to complex cases.	• Reduce the number of medically safe patients in our hospitals.
	• Working with Derbyshire social care to address delays in placing pathway two patients.	

# Indicators in Focus: Referral To Treatment (1/2)

## Local data (to Feb-26)



## Benchmark position (to Jan-26)



# Indicators in Focus: Referral To Treatment (2/2)

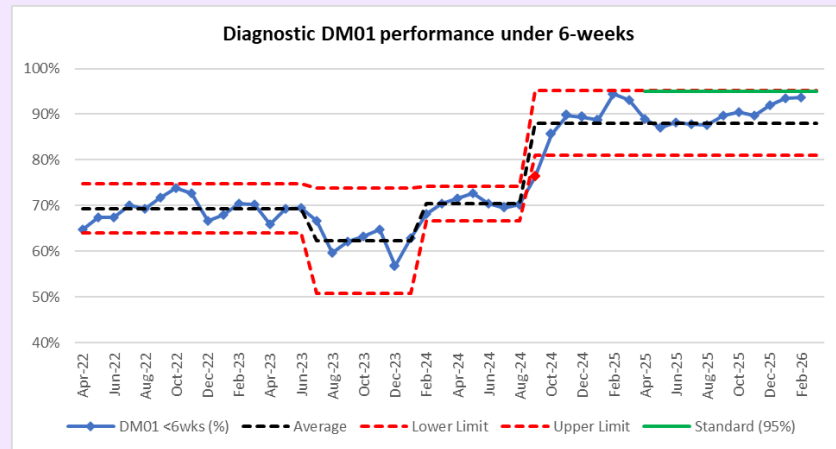
## Performance observations

- Referral to Treatment (RTT) 18-week performance at SFH has improved to return within statistical process control limits in Feb-26. Performance in Feb-26 was 6.8% below our operational plan, which was set to deliver a 5% improvement on our Nov-24 position (as mandated in the national planning guidance). Latest national benchmarking data places us in the seventh decile. We expect to see further improvement in this metric in Mar-26 as we deliver the Elective Sprint.
- 52-week wait pathways was at 1.1% of the total Patient Tracking List (PTL) in Feb-26; above the 1% operational planning guidance target to be achieved by the end of 2025/26. This deterioration is due to a combination of a small increase in the number of long wait patients and a reduction in the overall waiting list (PTL) size. Our PTL size decreased in Feb-26 to the lowest level for over one year. Our 52-week wait benchmark position remains strong and in the fourth decile nationally.
- We continue to provide support to Nottingham University Hospitals through treatment of Urology long waits; which increases risk to our PTL and long wait backlog size.

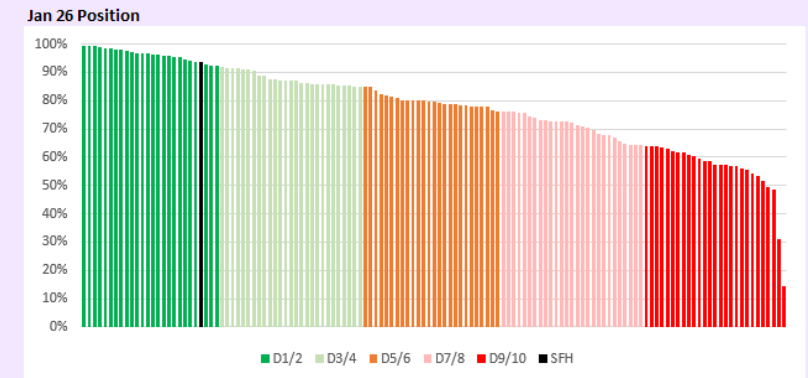
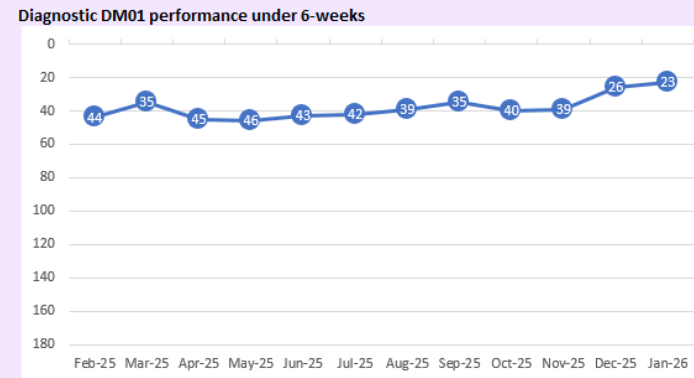
Root causes	Actions and timescale	Impact
Insufficient anaesthetic capacity (deficit of seven consultant vacancies) increasing the risk of list cancellation due to insufficient staffing cover.	<ul style="list-style-type: none"> <li>• Strategy for anaesthetic staffing levels and recruitment plan in place including:                             <ul style="list-style-type: none"> <li>_ Interviews scheduled for two whole time equivalent Consultant vacancies with one shortlisted candidate interview scheduled in Mar-26.</li> <li>_ Interim escalated rates remaining in place for Consultants.</li> <li>_ Recruitment to Resident Doctor posts underway, due to complete by Aug-26.</li> <li>_ Continue insourcing for priority areas until sustainable internal solutions are in place during 2026/27.</li> <li>_ Building relationships with University Hospitals of North Midlands to enhance specialist registration opportunities for neuro and cardiothoracic surgery training from Aug-26.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Enable reduction in theatre list cancellations due to anaesthetic availability, reducing risk to RTT long wait cancellations.</li> <li>• Sufficient and sustainable workforce.</li> </ul>
Insufficient baseline capacity to reduce first appointment backlogs.	<ul style="list-style-type: none"> <li>• Use of Audiology capacity to triage patients waiting for ENT new appointments.</li> <li>• Gynaecology clinic template restructure to increase new capacity.</li> </ul>	<ul style="list-style-type: none"> <li>• Improve Trust performance against first appointment trajectory.</li> <li>• Impact the Trust long wait position.</li> <li>• Reduce the number of patients waiting &gt;18 weeks for their first appointment.</li> </ul>
	<ul style="list-style-type: none"> <li>• 2025/26 quarter four Elective Sprint activity to increase new capacity is underway.</li> </ul>	
PTL data quality and ability to sustain a 'clean' PTL and management of all failsafe reports due to insufficient validation resource.	<ul style="list-style-type: none"> <li>• Robotic Process Automation (RPA) pilot and Federated Data Platform (FDP) to support validation and developments to manage patient pathways to be fully operational by end quarter one 2026/27.</li> </ul>	<ul style="list-style-type: none"> <li>• PTL will be 'clean' and represent only those patients genuinely waiting treatment.</li> <li>• Enable more timely management of patient pathways and oversight of actions.</li> </ul>
	<ul style="list-style-type: none"> <li>• Source Clear PTL model to review the total PTL for any quick validation opportunities for up to 1,000 patients is underway.</li> </ul>	

# Indicators in Focus: Diagnostics (1/2)

## Local data (to Feb-26)



## Benchmark position (to Jan-26)



## Performance observations

- Our diagnostic DM01 performance continues to improve following a dip in the spring 2025, closing at 93.6% in Feb-26. The improvements in recent months is reflected in our benchmarking position which is consistently above the national average.
- The 2024/25 improvement and subsequent deterioration in Apr-25 from Feb/Mar-25 highs was driven by Echocardiography following the introduction and then the release of insourcing capacity. Echocardiography is the main driver of overall Trust DM01 performance. Trends in this service generally result in a similar overall position trend; this includes the improved performance since Sep-25, which was driven by Echocardiography.
- Sleep studies was the second most challenged modality with performance trending in recent months between 65 and 70%. This position has also improved following extra testing capacity being in place.

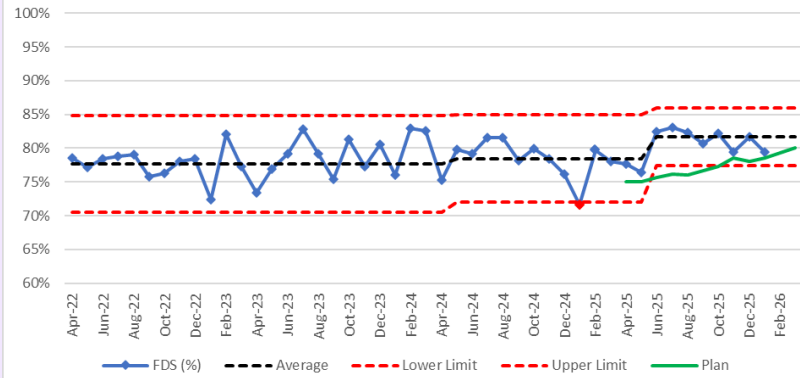
# Indicators in Focus: Diagnostics (2/2)

Root causes	Actions and timescale	Impact
Insufficient Echocardiography baseline capacity to reduce the number of patients waiting and reduced Administration and Clerical (A&C) capacity to manage bookings.	<ul style="list-style-type: none"> <li>• Insourcing remains in place to support delivery of planned activity levels.</li> <li>• Increasing specialist capacity.</li> </ul>	<ul style="list-style-type: none"> <li>• DM01 performance in this modality increased to &gt;80% in Dec-25 for the first time since Mar-25 and is sustained into Feb-26.</li> <li>• Reduction in patients waiting over 13-weeks.</li> </ul>
	<ul style="list-style-type: none"> <li>• Move to Health Roster for rota planning to ensure rotas are available to schedule patients a minimum of six weeks in advance is underway to be complete for quarter one 2026/27.</li> <li>• Improved booking process to enable timely patient choice.</li> </ul>	<ul style="list-style-type: none"> <li>• Advanced booking of appointments to enable greater patient choice, improved scheduling and better utilisation of capacity.</li> </ul>
Insufficient baseline capacity to reduce backlogs in Sleep (backlog caused by an increase in out of area referrals throughout 2024 which has now stabilised in 2025).	<ul style="list-style-type: none"> <li>• Additional backflash devices and storage lockers procured from end Nov-25. Scoping the potential to expedite Community Diagnostic Centre (CDC) is underway.</li> </ul>	<ul style="list-style-type: none"> <li>• DM01 performance in this modality increased to &gt;80% in Jan-26 for the first time since Mar-25.</li> <li>• Reduction in the volume of patients waiting over 6 weeks to its lowest number since Apr-25.</li> <li>• Eradication of 13-weeks achieved.</li> <li>• Additional 16 sleep studies per week.</li> </ul>
	<ul style="list-style-type: none"> <li>• Successful recruitment to technician and physiologist capacity to increase sleep studies following a successful bid to purchase an additional 11 devices.</li> </ul>	
Insufficient CT Cardiac capacity due to equipment failure and CT Colon capacity demand.	<ul style="list-style-type: none"> <li>• Outsourcing scans in quarter four to support delivery of planned activity levels.</li> </ul>	<ul style="list-style-type: none"> <li>• DM01 performance in this modality increased to &gt;90% in Jan-26.</li> <li>• Reduction in patients waiting over 13 weeks.</li> </ul>

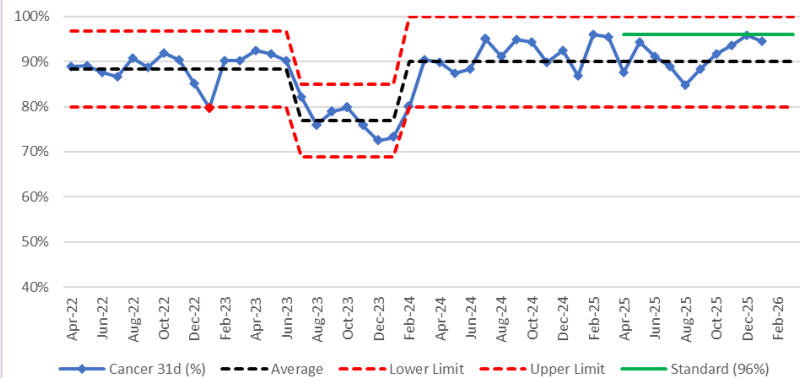
# Indicators in Focus: Cancer (1/3)

## Local data (to Jan-26)

Cancer 28-day faster diagnosis standard

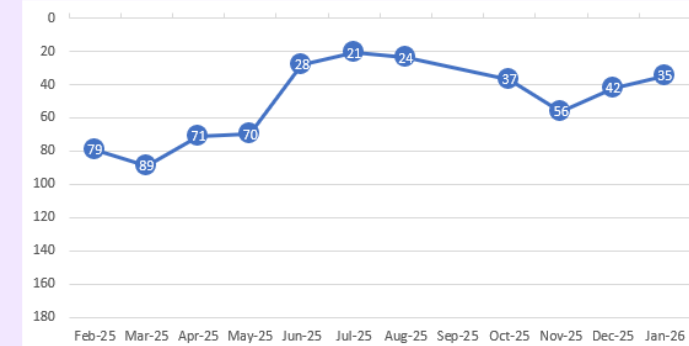


Cancer 31-day treatment performance

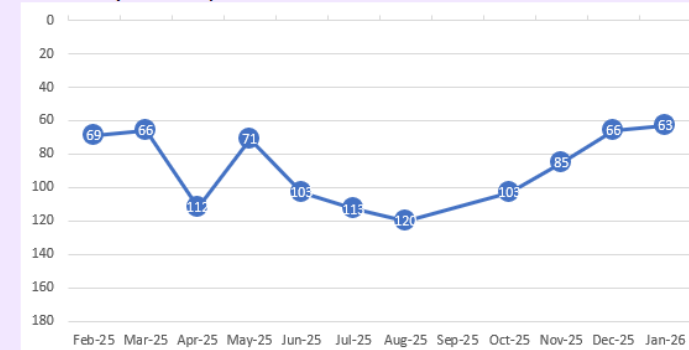


## Benchmark position (to Jan-26)

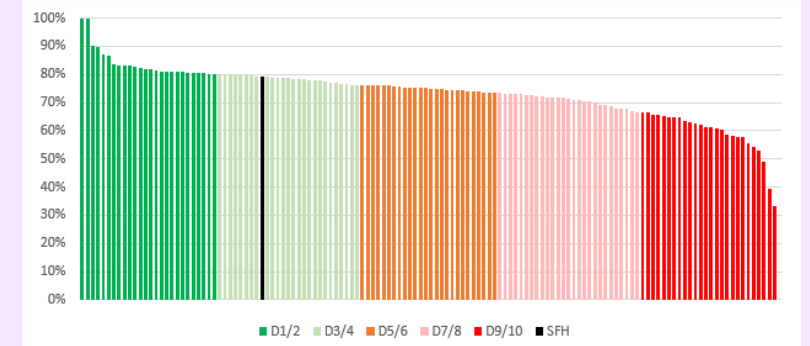
Cancer 28-day faster diagnosis standard



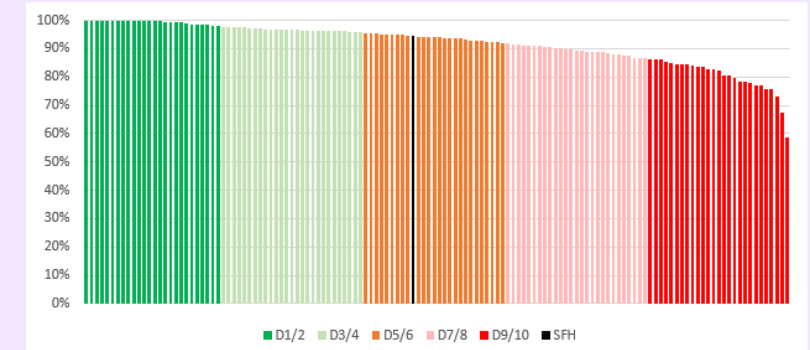
Cancer 31-day treatment performance



Jan 26 Position

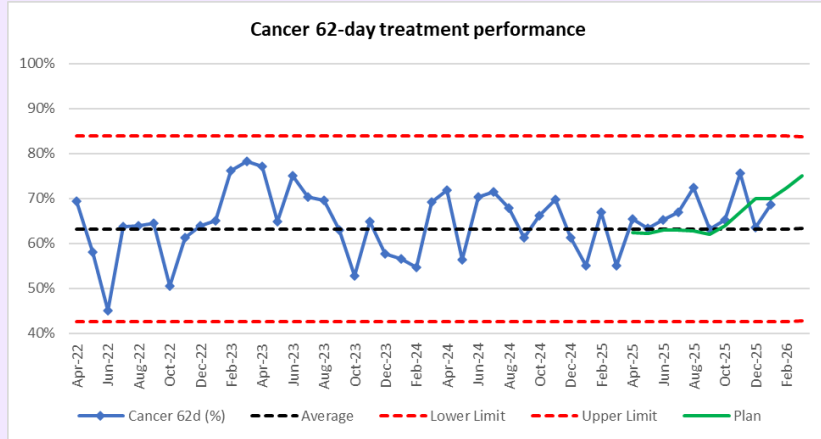


Jan 26 Position

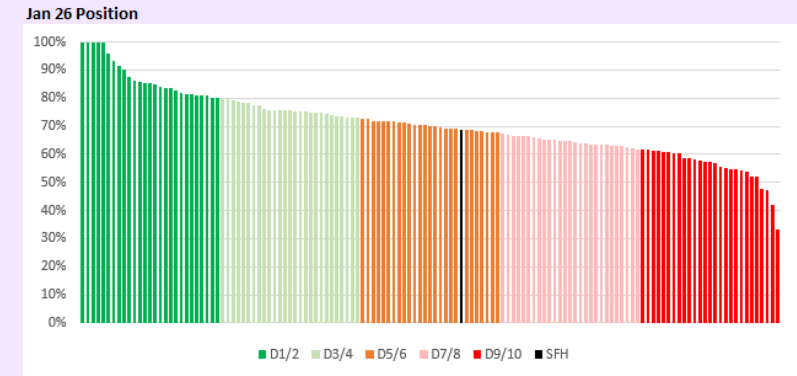
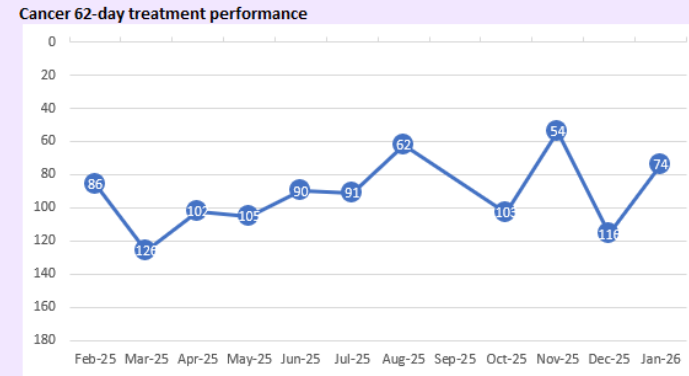


# Indicators in Focus: Cancer (2/3)

## Local data (to Jan-26)



## Benchmark position (to Jan-26)



## Performance observations

- Cancer 28-day Faster Diagnosis Standard (FDS) is moving within statistical process control limits and is better than our operational plan, which requires performance of 80% by the end of 2025/26 as part of the national ambition. In the latest reporting period, there has been a control limit change due to our sustained improvement. Our benchmark position remains in the top quartile nationally.
- Cancer 31-day treatment performance (first treatment) has been moving within standard variation since mid-2024, closing in Jan-26 at 94.5%. This is below the 96% national standard, which is our operational plan. Our benchmarking position is mid-pack nationally.
- Cancer 62-day treatment performance was 68.6% in Jan-26 fall below plan for the second time this year. The operational plan requires improvement to 75% by the end of 2025/26 as part of the national ambition. Our Jan-26 performance resulted in us being mid-pack nationally from a benchmarking perspective.

# Indicators in Focus: Cancer (3/3)

Root causes	Actions and timescale	Impact
Insufficient capacity to meet Radiology reporting turnaround targets and specialist capacity.	<ul style="list-style-type: none"> <li>Recruitment to four Whole Time Equivalent (WTE) Consultant Radiologists to commence for 2026/27 Community Diagnostic Centre (CDC) deployment.</li> <li>East Midlands Cancer Alliance (EMCA) funding additional sessions and increased outsourcing for reporting.</li> </ul>	<ul style="list-style-type: none"> <li>Improve Radiology reporting turnaround.</li> </ul>
	<ul style="list-style-type: none"> <li>Review of Head and Neck ultrasound referrals and demand to understand capacity issues. Pathway improvement are being taken through clinical governance for approval and trial in 2026/27 quarter one.</li> <li>Three Head and Neck Radiologists are now in post and delivering ultrasound-guided biopsies.</li> </ul>	<ul style="list-style-type: none"> <li>Reduce backlog.</li> </ul>
	<ul style="list-style-type: none"> <li>Appointment of substantive Radiologist commenced Feb-26, trained in Lung Biopsies. New consultant induction and processes underway prior to Lung Biopsy go live in 2026/27 quarter two.</li> </ul>	<ul style="list-style-type: none"> <li>Reduce backlog and improve 62-day performance.</li> </ul>
Increase in Urology demand and complex patients requiring multiple investigations.	<ul style="list-style-type: none"> <li>Introduction of clinical capacity at the local PTL and an additional 'hot' clinical PTL throughout the week to increase timely decision-making.</li> </ul>	<ul style="list-style-type: none"> <li>Improvement in cancer waiting times standards. 62-day performance achieved &gt;70% in Jan-26.</li> </ul>
Insufficient Histopathology workforce to meet demand creating pathway delays across multiple tumour sites.	<ul style="list-style-type: none"> <li>Ongoing pay per point scheme to support additional cancer reporting.</li> <li>Recruitment to additional Consultant and Medical Laboratory Assistant vacancies for 2026/27 CDC deployment.</li> </ul>	<ul style="list-style-type: none"> <li>Improved histopathology turnaround and increased compliance with the 10-day standard.</li> <li>Turnaround increased to a high of 80% in Feb-26 from a low 48% in May-25.</li> </ul>
	<ul style="list-style-type: none"> <li>EMCA funding to implement seven-day working across Histopathology commenced in 2025/26 quarter three and due to complete by Mar-26.</li> </ul>	
	<ul style="list-style-type: none"> <li>Review of processes for second opinion histopathology is underway, working with Nottingham University Hospitals NHS Trust.</li> <li>Audit underway to review processes in Breast to increase efficiency.</li> </ul>	
	<ul style="list-style-type: none"> <li>Following successful approval of constitutional standards bid, an order has been placed for three digital scanners. Procurement timeframe to be confirmed. EMCA project initiation document submitted for dedicated fixed-term capacity to oversee implementation and go live.</li> </ul>	
Insufficient capacity to meet demand in Lower Gastrointestinal (LGI) and patient compliance issues.	<ul style="list-style-type: none"> <li>Implementation of revised faecal immunochemical test (FIT) criteria went live in Oct-25 to align with the Nottinghamshire system agreed referral pathway. Monitoring of impact is ongoing; however, referrals appear to have reduced.</li> </ul>	<ul style="list-style-type: none"> <li>Sustained reduced in 62-day backlog achieved for 5 consecutive months.</li> <li>First seen within 7-days sustained &gt;50%.</li> </ul>
Insufficient UGI test capacity to enable timely diagnosis decision making.	<ul style="list-style-type: none"> <li>Dedicated pre-operative assessment capacity for General Anaesthetic (GS) Endoscopy pathways identified to commence from Apr-26. Additional bi-weekly GA list to commence from Apr-25.</li> <li>Increased Endoscopy capacity for 2026/27 CDC deployment.</li> <li>Trial of one stop CT and clinic outpatient attendance to commence following CDC go live.</li> </ul>	<ul style="list-style-type: none"> <li>Improved Faster Diagnosis Standard.</li> <li>Reduced Backlog.</li> <li>Improved 62-day performance.</li> </ul>

Outstanding Care,  
Compassionate People,  
Healthier Communities



Sherwood Forest Hospitals  
NHS Foundation Trust

# Best Value Care



# Domain Summary: Best Value Care

## Overview

Lead: Chief Financial Officer

The financial plan for 2025/26 is break-even. The Trust has reported an in-month deficit position of £3.55m in Feb-26; this was £4m behind the £0.45m surplus plan with the inclusion of the impact of International Financial Reporting Standard 16 (IFRS16) on the Private Financial Initiative (PFI). The year-to-date (YTD) deficit is £28.52m, £28.35m behind plan. The reasons for the year-to-date position being behind plan are: three periods of resident doctor industrial action during Jul-25, Nov-25 and Dec-25 totalling £1.35m, £11.95m adverse Cost Improvement Programme (CIP) performance, £4.10m removal of deficit support funding, £1.09m Mutually Agreed Resignation Scheme (MARS) payments, route to balance income reduction £4.10m and some other issues including planned income assumptions being unachieved, and critical incident and winter costs. Some of this was offset by funding received in respect to PFI income and industrial action funding.

We are forecasting a deficit position of £34m excluding all Deficit Support Funding (DSF), against a planned deficit of £9.80m excluding all DSF; a £24.20m adverse variance to plan. This change to a revised forecast position was notified to NHS England on 9 February 2026.

The annual Financial Improvement Programme (FIP) target is £45.83m in 2025/26. Feb-26 saw a YTD delivery of £29.66m against a YTD plan of £41.62m.

The 2025/26 Capital Expenditure Plan (CEP) has been prepared and submitted as part of the overall financial plan with a current in-year plan of £42.39m. Expenditure for Feb-26 totalled £3.05m, which was £0.48m below plan. YTD expenditure totals £16.33m, which was £16.59m below plan, with the variance relating to the quarterly phasing of the Electronic Patient Record (EPR) system and constitutional standards expenditure.

Closing cash on 28 February 2026 was £15.55m, an increase of £16.84m in-month and a reduction of £7.98m YTD. The large opening cash balance was due to the receipt of capital funding in 2024/25 quarter four of £24.49m, additional ICB funding received in Mar-25 and working capital support of £8.31m received in Mar-25. The significant increase in-month was due to the receipt of Public Dividend Capital (PDC). This balance will unwind through 2026/27 quarter one and there remains an underlying pressure on available revenue cash resource due to the requirement to deliver significant efficiency savings, which will be managed by extending payment terms to suppliers if required. The forecast for Mar-26 onwards assumes delivery of efficiency savings.

The Trusts agency expenditure in Feb-26 was £0.72m and YTD £8.13m, which is 40% lower than the 2024/25 YTD expenditure due to the increased grip and control in place through the Workforce Transformation Group and on medical agency. The 2024/25 run rate was £1.14m with £1.05 in the second half of the year and £1.03m in quarter four. Total agency expenditure as a proportion of our total pay spend is 3% YTD compared to an average of 4% in 2024/25. The largest proportion of our agency spend is on medical pay.

The Trust's bank expenditure in Feb-26 was £1.91m and YTD is £21.09m, which is 26% lower than the 2024/25 YTD expenditure. This figure is inclusive of the target reduction set in the Trust plan of 15%, therefore, we are significantly exceeding performance.

The following pages contain more detailed performance information across the Best Value Care domain.

# Scorecard: Best Value Care

## Best Value Care

Green tick = target met/exceeded; Red cross = target not met

At a Glance	Indicator	2024/25 Standard	2025/26 Standard	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	2024/25 Final	2025/26 YTD	STAR Data Quality Assurance			
												S	T	A	R
Financial Performance	Financial surplus / deficit	n/a	≥£0.00m	✗-£1.62	✗-£2.37	✗-£2.63	✗-£2.65	✗-£14.04	✗-£3.55		✗-£28.52	●	●	●	●
	Variance YTD to financial plan	≥£0.00m	≥£0.00m	✗-£2.08	✗-£2.95	✗-£2.46	✗-£2.34	✗-£13.54	✗-£4.00	✓£0.01	✗-£28.35	●	●	●	●
Efficiency	Financial efficiency variance YTD to plan	≥£0.00m	≥£0.00m	✗-£2.81	✗-£1.83	✗-£0.93	✗-£0.55	✗-£1.25	✗-£0.44	✓£0.08	✗-£11.95	●	●	●	●
	Risk adjusted efficiency forecast to plan (%)	n/a	100%	✗74.0%	✗81.0%	✗82.0%	✗80.0%	✗78.0%	✗80.0%		✗0.0%	●	●	●	●
Variable Pay	Reported agency expenditure	No Standard	No Standard	£0.69	£0.77	£0.58	£0.60	£0.58	£0.72	£13.70	£8.13	●	●	●	●
	Reported bank expenditure	No Standard	No Standard	£1.57	£1.43	£2.02	£2.27	£2.20	£1.91	£30.55	£21.09	●	●	●	●
Rate of Productivity	Implied productivity growth (YTD compared to last year)	3.1%	2%	✓5.5%	-	-	-	-	-		-	●	●	●	●
Cash & Liquidity	BPPC - Number of bills paid within target	n/a	≥95%	✗87.5%	✗83.9%	✗50.4%	✗21.3%	✗13.8%	✗10.7%		✗49.6%	●	●	●	●
	BPPC - Value of bills paid within target	n/a	≥95%	✗91.6%	✗90.6%	✗84.3%	✗81.3%	✗67.7%	✗60.6%		✗77.7%	●	●	●	●
	Operating expenditure days	n/a	≥5	✓6	✓5	✗4	✗3	✗1	✓12		✓9	●	●	●	●
Capital	Capital expenditure against plan	≤£33.61m	≤£0.00m	✗£0.85	✗£1.36	✗£4.29	✗£4.24	✓-£0.63	✗£3.05	✓£33.58	✗£16.34	●	●	●	●

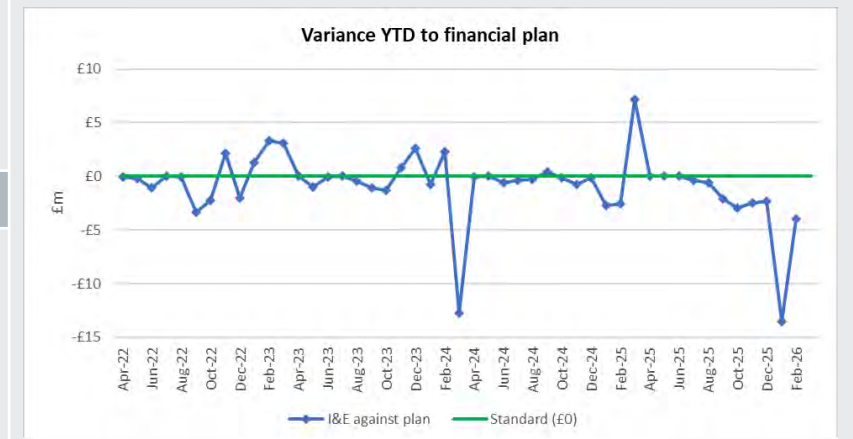
# Indicator in Focus: Financial Performance

## Performance observations

- The standard is the Trust financial plan, which is a break-even position for 2025/26. This is aligned to the Trust’s share of the 2025/26 Revenue Plan Limit set for the Nottingham and Nottinghamshire ICB by NHS England.
- The Trust has a YTD £28.52m deficit, which is £28.35m behind the planned deficit of £0.17m for the YTD position by Feb-26.
- Forecast deficit of £34m excluding all Deficit Support Funding (DSF), against a planned deficit of £9.80m excluding all DSF; a £24.2m adverse variance to plan. This change to a revised forecast position was notified to NHS England on 9 February 2026.

Root Causes	Actions and timescale/areas of risk	Impact
Urgent and Emergency Care demand pressures.	<ul style="list-style-type: none"> <li>• If emergency care pathway growth is higher than planned levels, then it will cause pressure on our income and expenditure position.</li> </ul>	Deliver annual plan.
Non-delivery of the FIP.	<ul style="list-style-type: none"> <li>• After Feb-26, the Trust is £11.95m behind the plan. In the revised forecast deficit position, we have a forecast of £36.55m delivery of FIP which is £9.28m behind plan. Divisional and corporate areas are continuously working towards this target and identifying opportunities for 2026/27.</li> </ul>	
Variable activity plan.	<ul style="list-style-type: none"> <li>• We need to ensure as a Trust that we maintain the variable elements of our activity to ensure we maintain the level of income associated with this.</li> </ul>	
Industrial action.	<ul style="list-style-type: none"> <li>• We have received funding to support industrial action for periods incurred to date in 2025/26.</li> </ul>	
Payback of 2024/25 financial support within the Nottinghamshire system.	<ul style="list-style-type: none"> <li>• Trust plan did not assume any payback of the financial support that delivered the 2024/25 financial position.</li> <li>• The payback value from SFH has been agreed at £4.1m and is built into the revised outturn position.</li> </ul>	

## Data



# Indicator in Focus: Efficiency

## Performance observations

- The standard is delivery of the Trust Financial Improvement Plan (FIP).
- The Trust has a £45.83m efficiency programme for 2025/26, which is currently £11.95m behind plan YTD.
- As part of our revised forecast to a deficit of £34m, this includes an efficiency miss of £9.28m.

## Root causes

Non-delivery of Financial Improvement Programme.

## Actions and timescale

- A financial recovery plan is in place consisting of six workstreams, covering every pound spent and received.
- Control totals set for each programme and division/directorate, aligned to the Trust requirement to deliver a break-even plan.
- PA Consulting support has been in place; this ceased at the end of Oct-25.
- Increased workforce controls established.
- New non-pay oversight group is being developed for implementation to create the same clarity, consistency and control environment that the HR Playbook has delivered for pay.
- New Finance Recovery Cabinet (FRC) governance framework in place for 2026/27 with divisions and corporate progressing with efficiency ideas and their development for 2026/27.
- Enhanced oversight and grip strengthened to support delivery within the financial year.

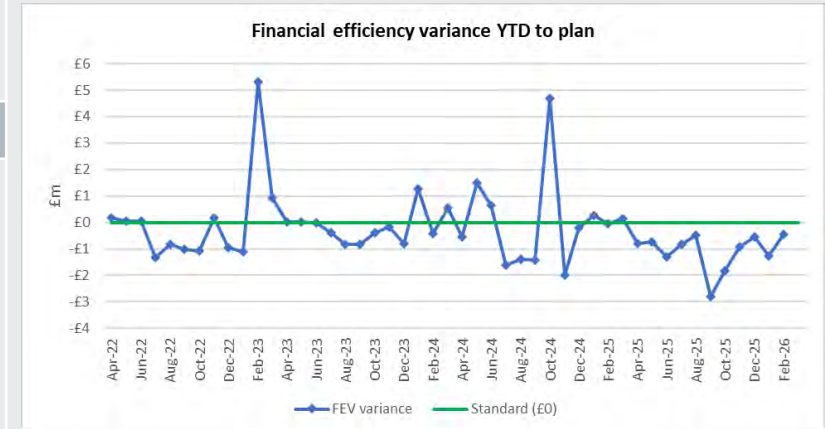
Risk adjusted forecast.

- Currently, the weighted target at Feb-26 is £36.55m, which is 80% of the target and inline with the expected forecast deficit in 2025/26.

## Impact

Deliver annual plan.

## Data

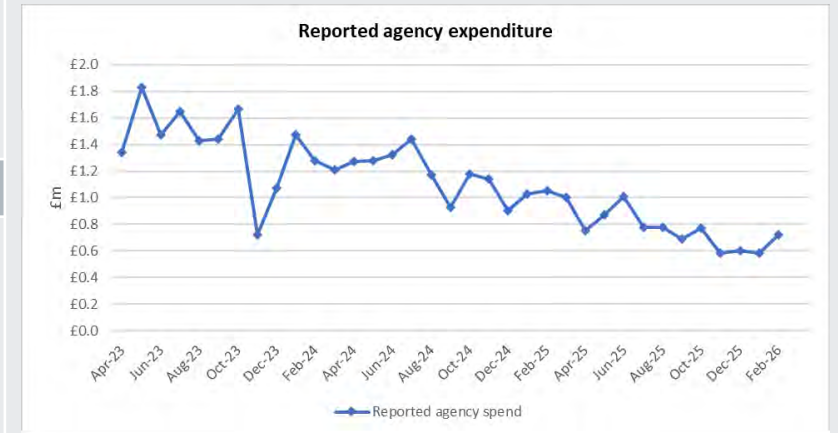


# Indicator in Focus: Agency Pay

## Performance observations

- The standard is the planned agency expenditure for 2025/26.
- The Trust has reported agency expenditure of £8.13m YTD.
- Agency expenditure accounts for 3% of our total pay bill YTD, a reduction from our 2024/25 run rate.
- Agency reduction relative to the 40% target for 2025/26 is 40% YTD.

## Data



## Root causes

Level of vacancies and sickness.

## Actions and timescale

- Medical and Nursing and Allied Health Professional (AHP) transformation programmes are tasked with achieving the required 40% reduction in agency expenditure compared to our Nov-24 forecast.
- Enhanced financial governance focus on agency spend and compliance at Divisional Performance Reviews and Divisional Finance Committees.
- Workforce performance group is in place. Weekly workforce meetings with increased workforce controls established and major interventions in place.
- No new agency bookings. Any exceptions to be signed off by the Executive lead.
- All medical agency bookings that are above cap are reviewed at bi-weekly vacancy control panels. There are still shifts filled over-cap, but this has begun to reduce.
- The use of off-framework agencies is not permitted. Any exceptions are to be approved by the Chief Executive Officer. All internal escalation forms have been updated to reflect this.

## Impact

Reduced agency run rate to achieve financial plan.

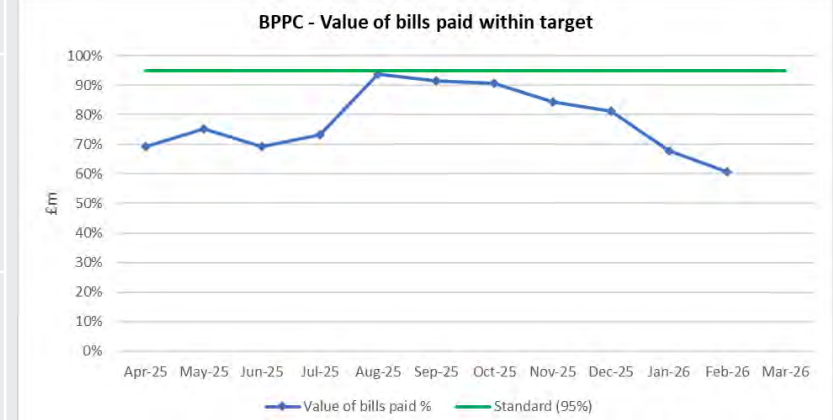
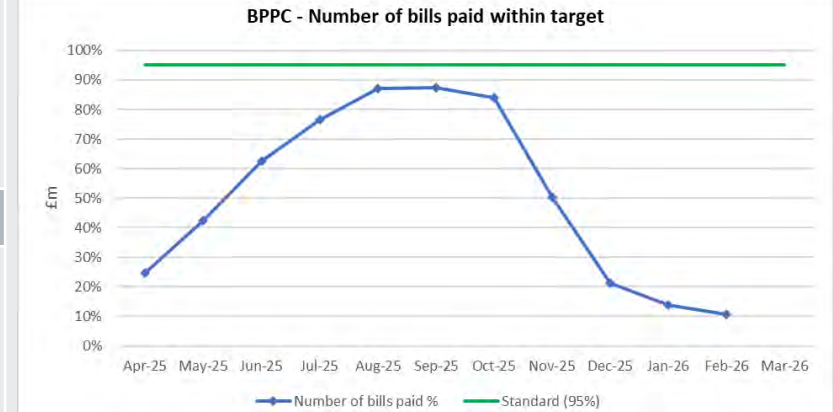
# Indicators in Focus: Cash and Liquidity

## Performance observations

- The standard is the minimum cash balance (£1.45m) as set by the Department of Health and Social Care (DHSC) as a condition of revenue cash support.
- At the end of Feb-26, cash in bank was £18.55m, which is above plan and the minimum cash balance.
- The submitted plan for 2025/26 does not require revenue borrowing Public Dividend Capital (PDC). However, there was significant capital PDC planned in-year to support the ICB allocation and national schemes.

Root causes	Actions and timescale	Impact
Standard is the plan and the minimum cash balance required by DHSC of £1.45m as part of our support.	<ul style="list-style-type: none"> <li>• Management of available cash balances to accounts payable payments due.</li> <li>• Prioritisation matrix of supplier payments agreed at the Trust Management Team.</li> </ul>	<ul style="list-style-type: none"> <li>• Requirement to ensure minimum balance is met/maintained.</li> <li>• Disruption to services if suppliers cannot be paid in a timely manner.</li> </ul>
Plan requires significant capital PDC in year of £15.23m to support the ICB allocation.	<ul style="list-style-type: none"> <li>• Capital PDC cash support from DHSC submitted Aug-25 and formally approved in Jan-26. Drawn down in 2025/26 quarter four.</li> </ul>	<ul style="list-style-type: none"> <li>• Extended payment terms to suppliers.</li> <li>• Failure to achieve Better Payment Practice code (BPPC).</li> <li>• Unsupportable capital plan.</li> </ul>
Failure to deliver efficiency programme on a cash releasing basis.	<ul style="list-style-type: none"> <li>• Delivery of efficiency improvement programme, which includes full year savings in 2025/26 of £45.83m.</li> </ul>	<ul style="list-style-type: none"> <li>• Requirement to submit working capital applications to support payments.</li> </ul>

## Data



# Indicator in Focus: Capital

## Performance observations

- The standard is the 2025/26 Capital Expenditure Plan.
- The plan requires capital borrowing support from the Department of Health and Social Care (DHSC).
- There are known risks due to the value of pre-commitments in the 2025/26 plan.
- Return to constitutional standards funding requires further supporting submission in 2025/26 relating to the Emergency Department (ED). The Elective and Diagnostics have been approved and memorandum of understandings received. Detailed monitoring to ensure delivery in-year to plan.

## Root causes

## Actions and timescale

## Impact

Pre-commitments to Trust priorities limiting business as usual capital.

- Monitoring of spend to ensure pre-commitments deliver within plan.
- Allocation agreed with Integrated Care System partners for 2025/26.

Delivery of Capital Expenditure Plan.

Requirement for Public Dividend Capital (PDC) to support ICB plan £15.23m and national schemes £15.77m.

- PDC request submitted in Aug-25 and approved in Jan-26.

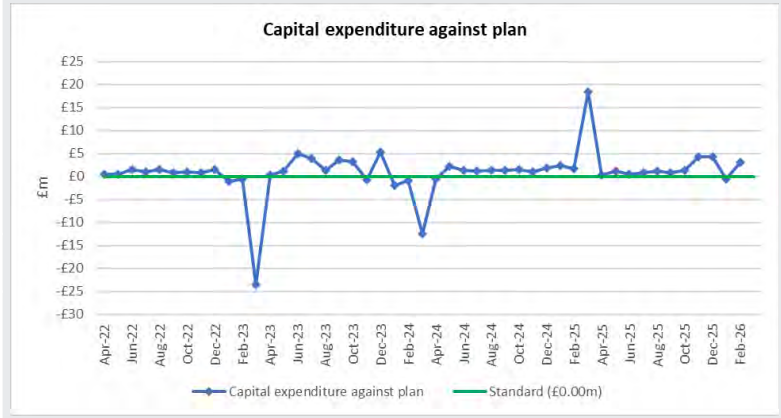
Spending at risk without formal approval, impacting available cash to meet revenue payments as they fall due.

Significant national funding for return to constitutional standards for which submissions are required to NHS England.

- All submissions made.
- Monitoring of in-year spend to ensure delivery to funding envelope.

Overspends impacting other capital delivery requirements.

## Data



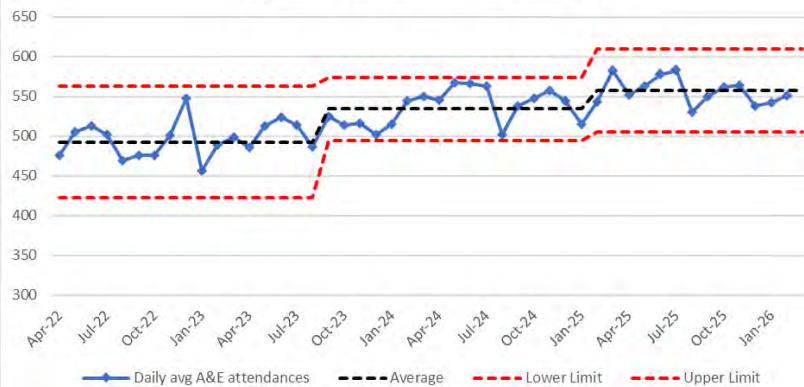
# Activity Data and Trends (1/2)

## Activity (for context)

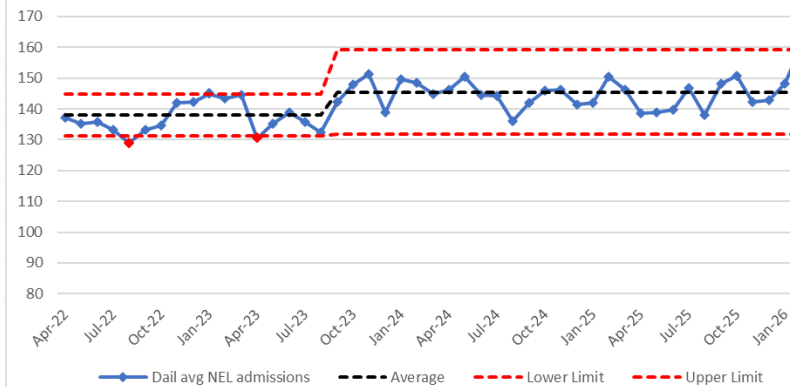
Based on daily averages

At a Glance	Indicator	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	2024/25 Final	2025/26 YTD
Urgent Care	A&E attendances (inc. PC24)	550	561	563	537	542	550	547	555
	Non-elective admissions	148	151	142	143	148	160	145	145
Electives	Average daily elective referrals	354	354	328	320	329	358	341	325
	Outpatients - first appointment	364	334	318	291	335	348	347	325
	Outpatients - follow up	891	854	812	774	837	834	852	833
	Outpatients - procedures	283	280	269	260	273	300	265	271
	Day case	121	125	121	115	121	125	122	120
	Elective inpatient	13	16	16	12	13	15	14	14
Diagnostics	Diagnostics	478	488	481	459	469	-	479	-

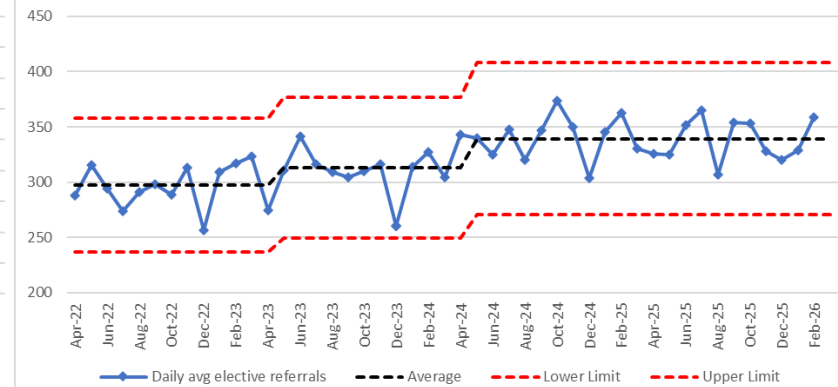
Daily average A&E attendances (inc. PC24)



Daily average non-elective admissions

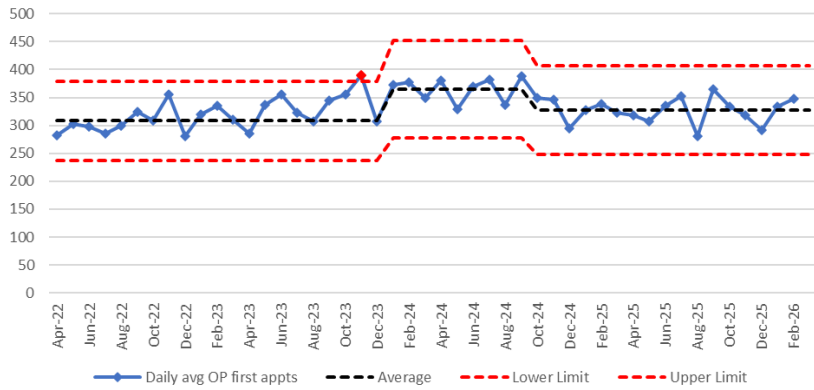


Average daily elective referrals

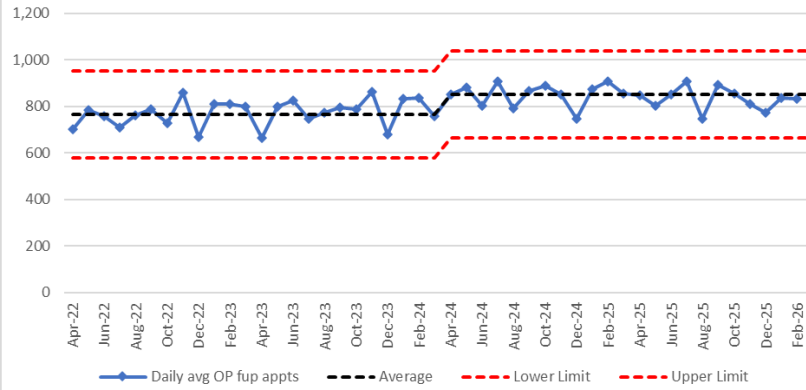


# Activity Data and Trends (2/2)

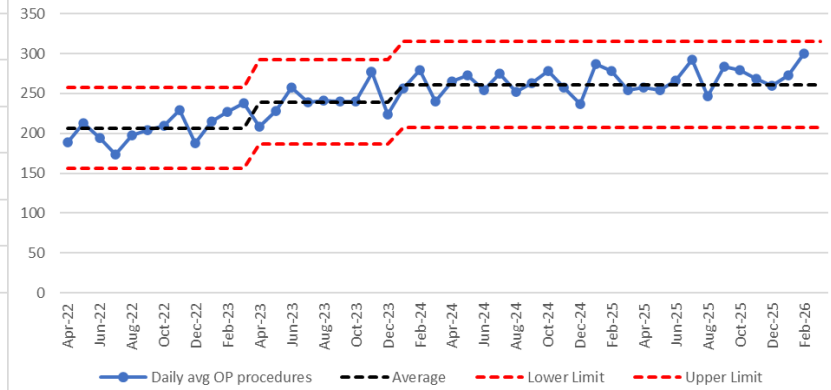
Daily average outpatient first appointments



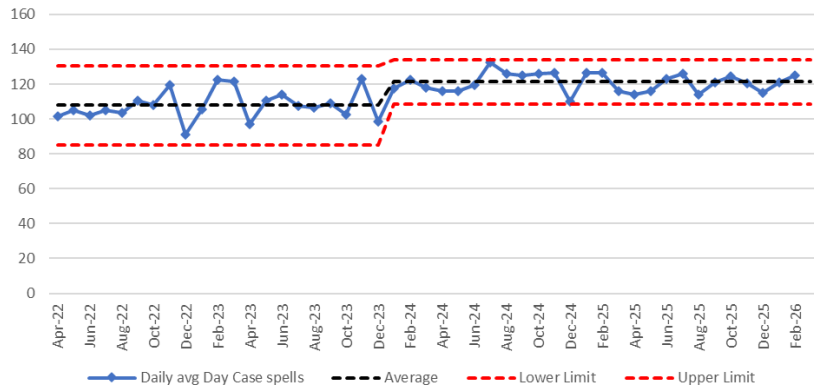
Daily average outpatient follow-ups



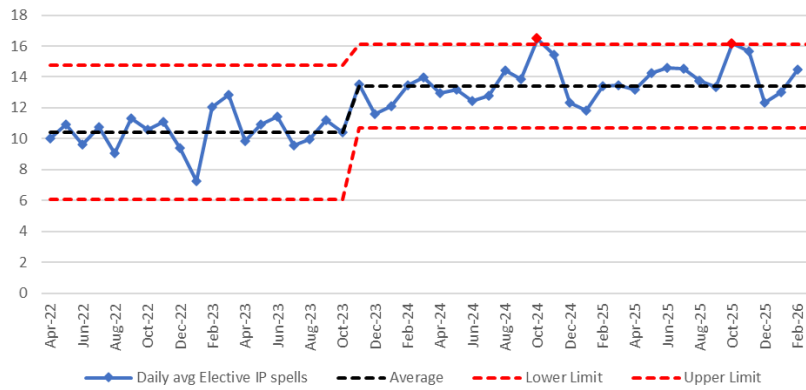
Daily average outpatient procedures



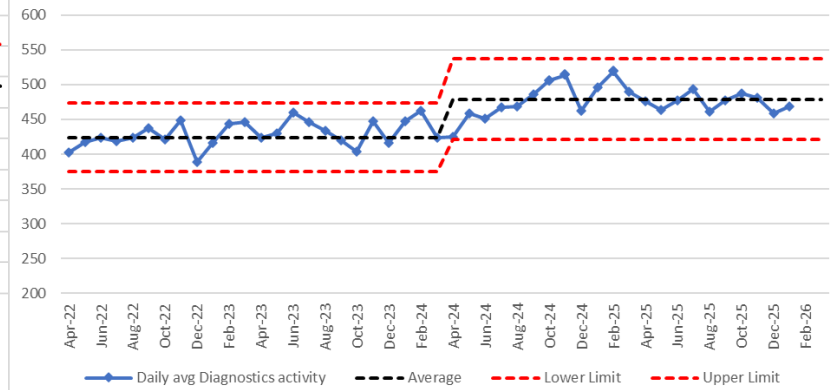
Daily average day case activity



Daily average elective inpatient activity



Daily average diagnostics activity



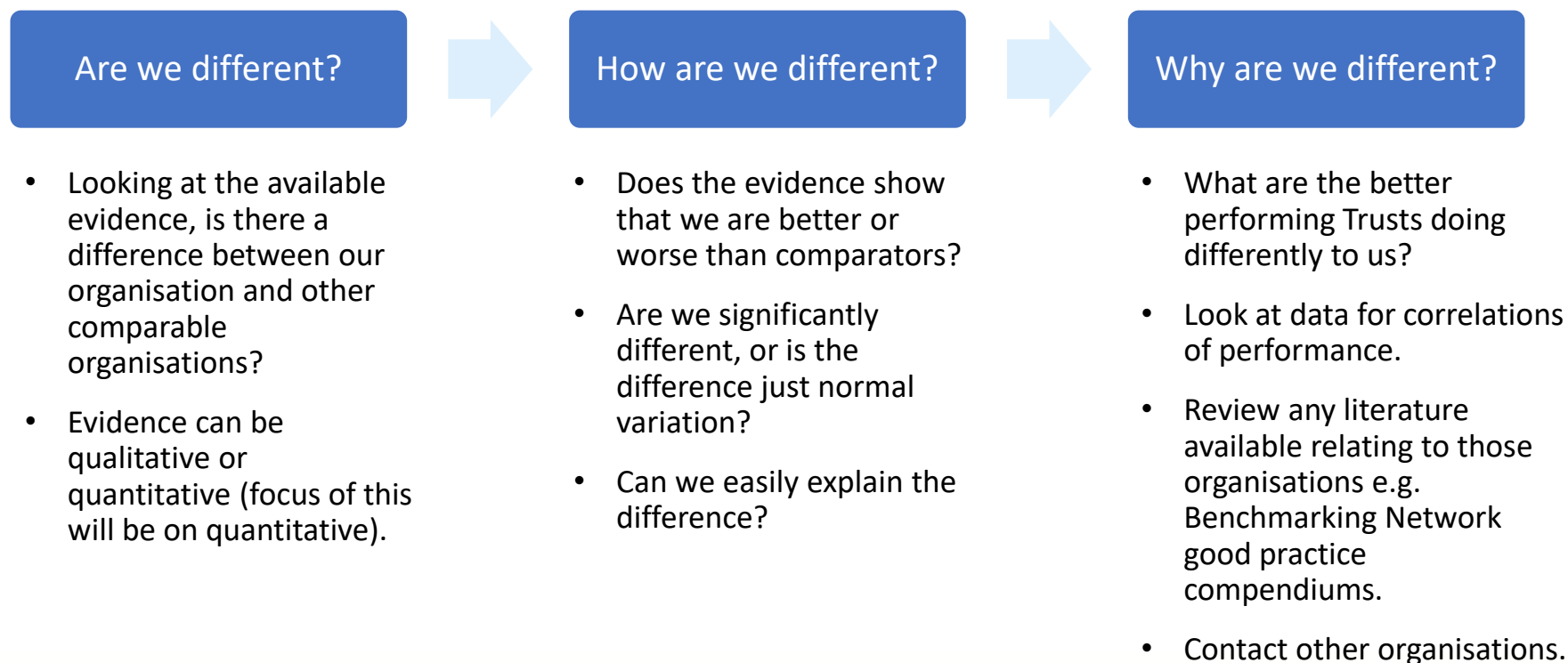
# Appendix A: Integrated Scorecard & Graphs for each indicator

The Integrated Scorecard together with graphs for all indicators is included as a separate file.

# Appendix B: Benchmarking Guidance (1/2)

How can we use benchmarking?

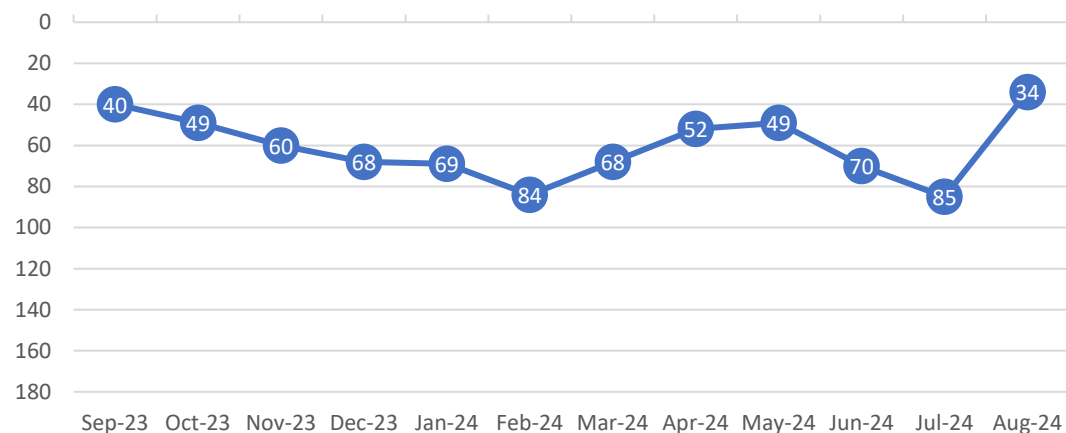
Benchmarking can tell us:



# Appendix B: Benchmarking Guidance (2/2)

Reading the benchmarking charts:

## The Trend Chart

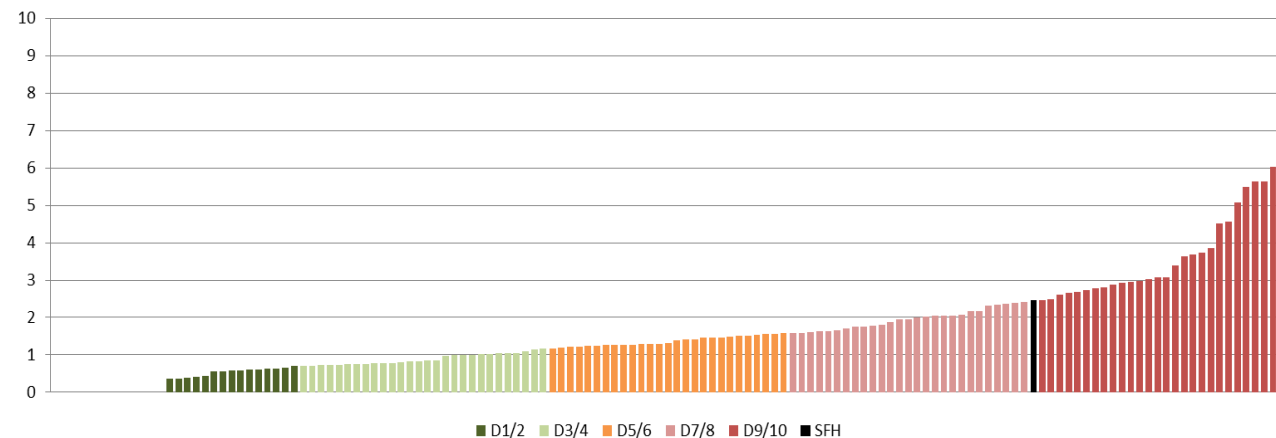


The trend chart shows the SFH position relative to other Trusts nationally over time.

This gives us an indication if changes to our own rates are internally driven i.e. something the Trust is doing differently, or if the changes are related to wider environmental factors that will impact every Trust.

In the case of these charts, a lower number is always considered to be the better performing i.e. the chart shows our rank with 1 being the best in the country.

## The Bar Chart



The bar chart shows the SFH position compared to other acute Trusts nationally; each bar represents a Trust, with the different colours each representing two deciles, or 20% of Trusts nationally (dark red being the worst performing 20%, dark green being the best performing) with SFH coloured black.

This allows us to see the comparative spread of performance, and the gap from the SFH position to the national average (median).

# Appendix C: Data Quality Indicator Guidance

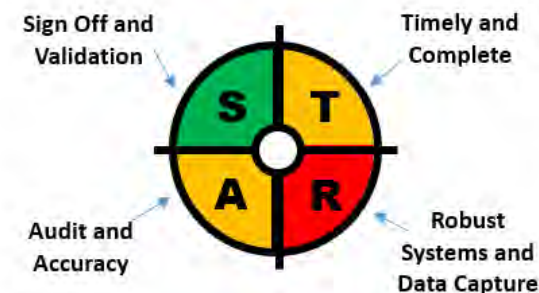
The Data Quality STAR Indicators are being used to provide assurance around the IPR metrics. They assess the quality and reliability of the data and systems used to populate the report.

The assurance indicators have been split into four domains (see below), and the level of assurance is shown using a red/amber/green (RAG) rating.

The scores for each metric are generated through answers to a standard set of questions which evaluate the assurance we have against each domain for each IPR metric.

Domain		Explanation
S	Sign-off and validation	Is the data checked for validity and consistency with the appropriate executive oversight. Is there a named accountable senior manager who signs off the data as a true reflection of the trust activity.
T	Timely and complete	Is the data complete at the time of publication, and it is readily available. Does any part of the data require changing at a later date.
A	Audit and accuracy	Is there processes in place for audits (either internal or external), and how often to these happen. Is there accuracy checks built in to data collection or reporting processes?
R	Robust systems and data capture	Are there robust systems which have been documented according to data dictionary standards for data capture.

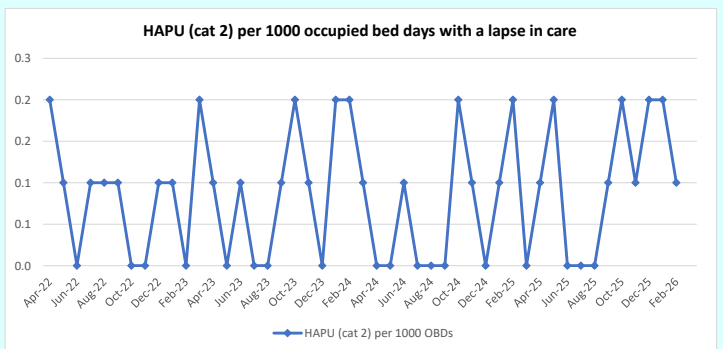
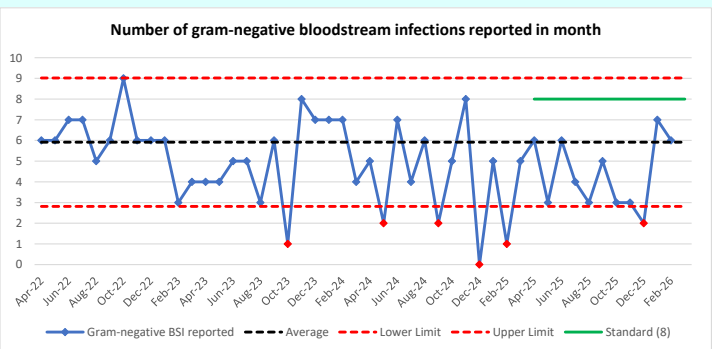
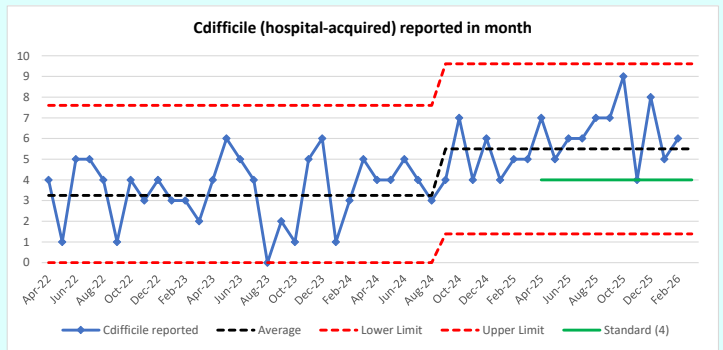
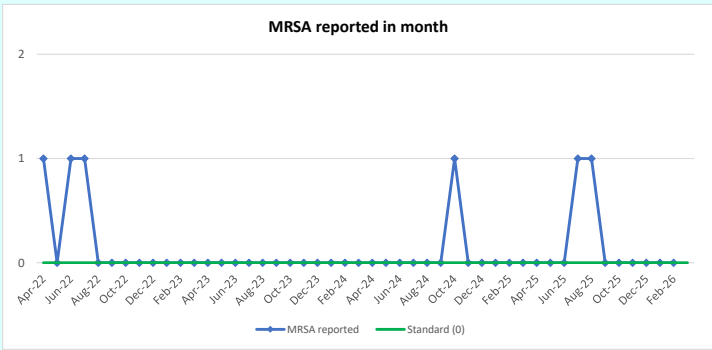
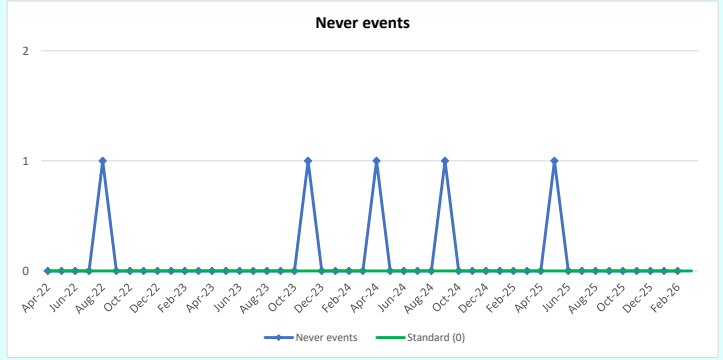
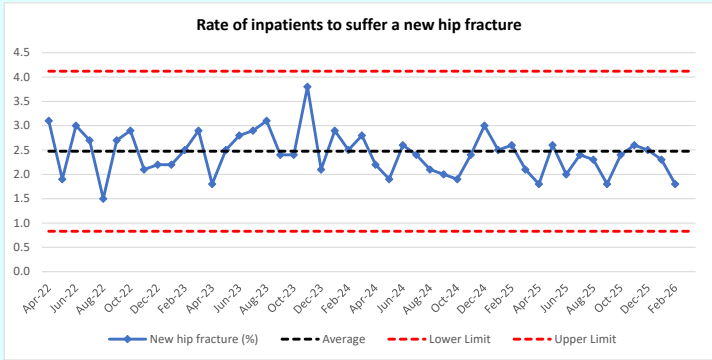
Total Score	Overall KPI Rating Key
0 to 11	No Assurance
12 to 15	Limited Assurance
16 to 19	Reasonable Assurance
20 to 24	Substantial Assurance

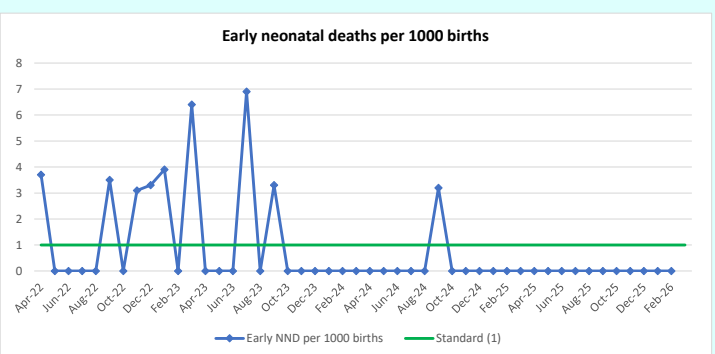
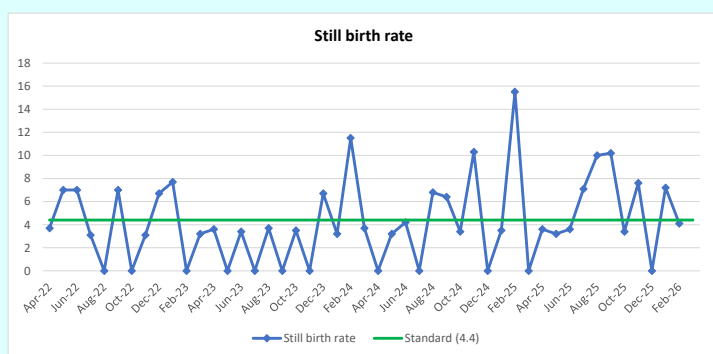
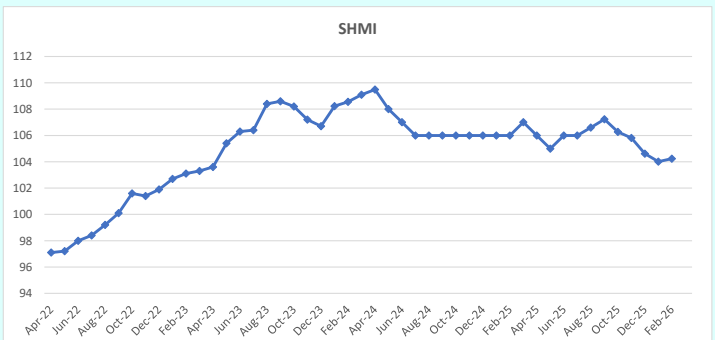
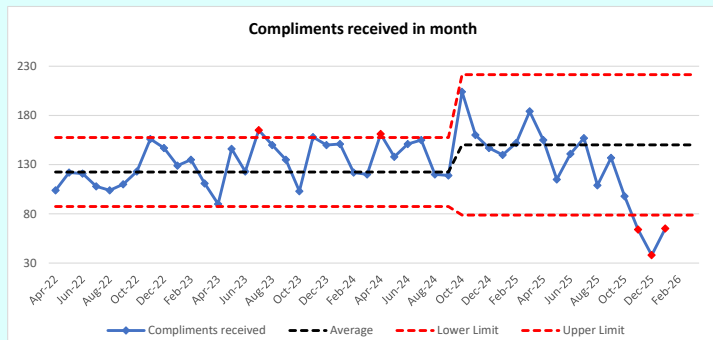
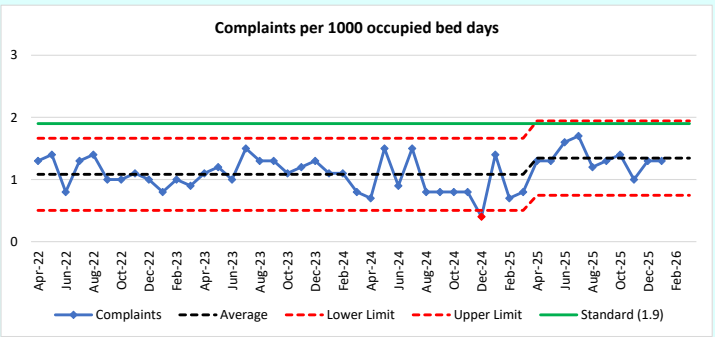
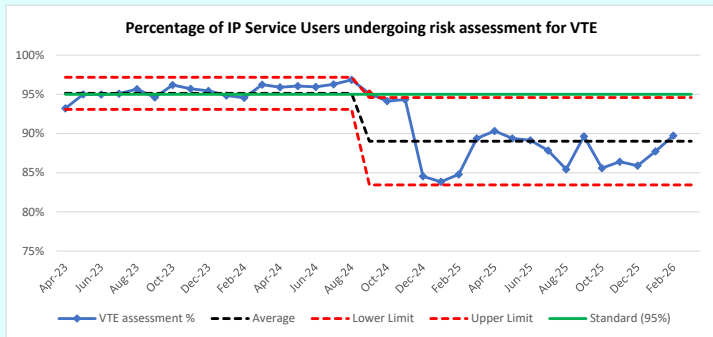
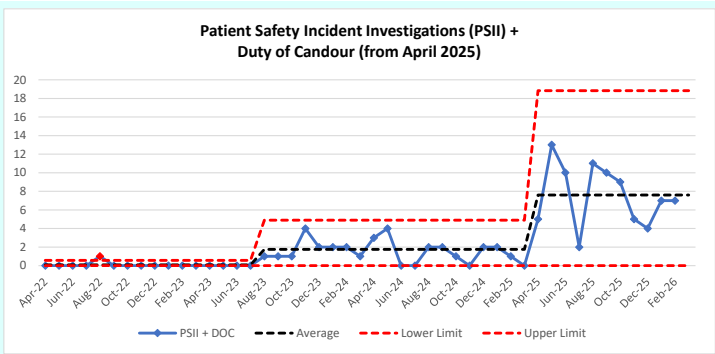
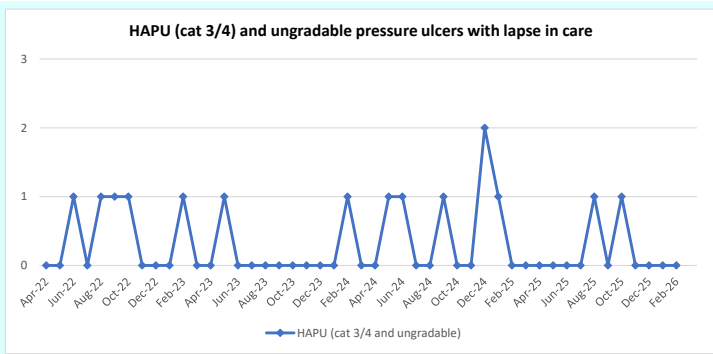




**Charts**

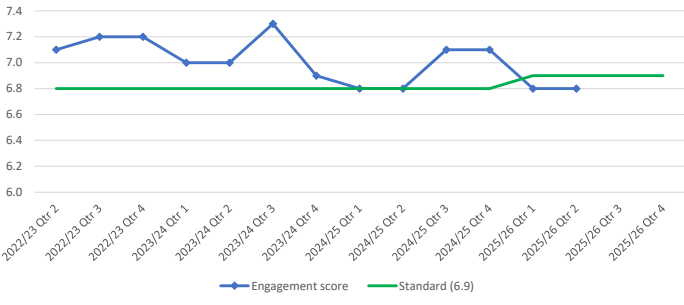
**Quality of Care**



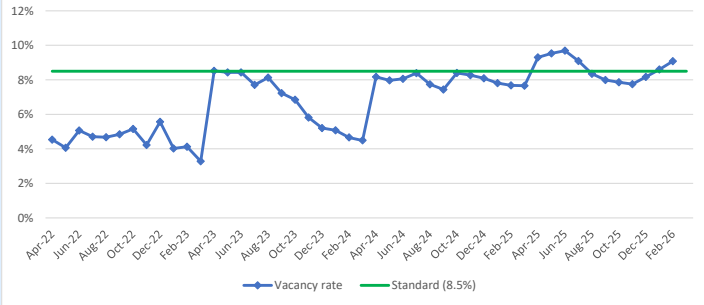


## People and Culture

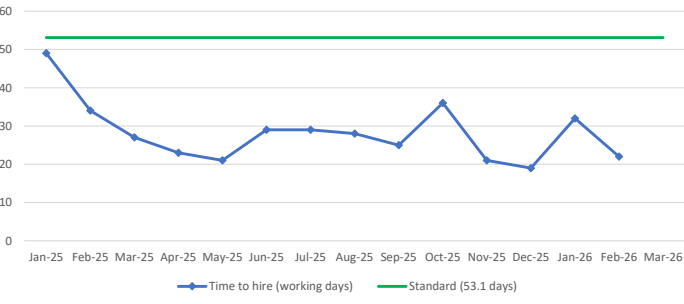
### Engagement score



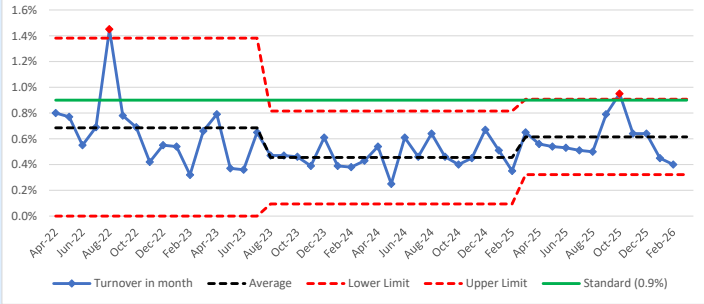
### Vacancy rate



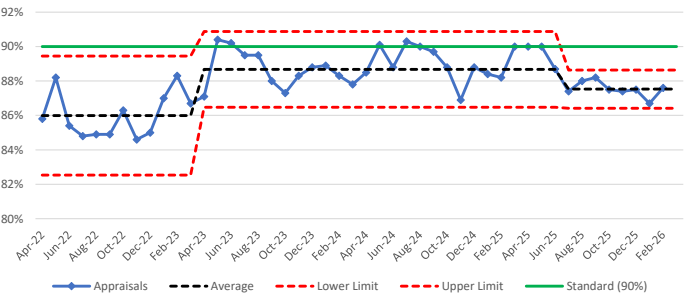
### Time to hire



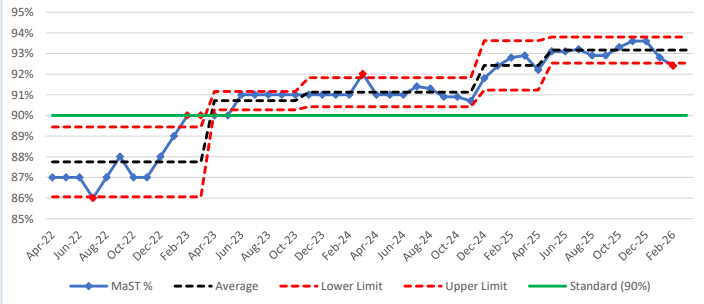
### Turnover in month



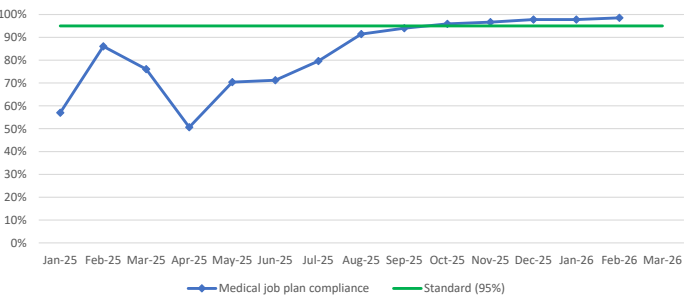
### Appraisals



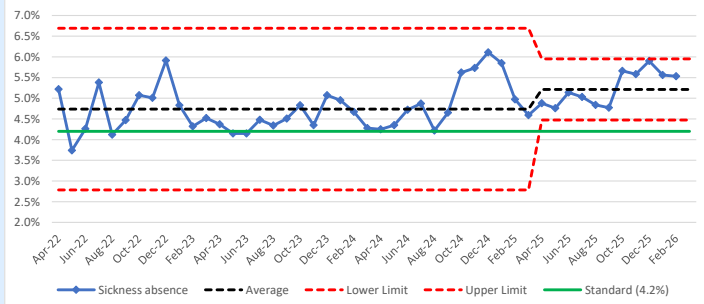
### Mandatory & statutory training



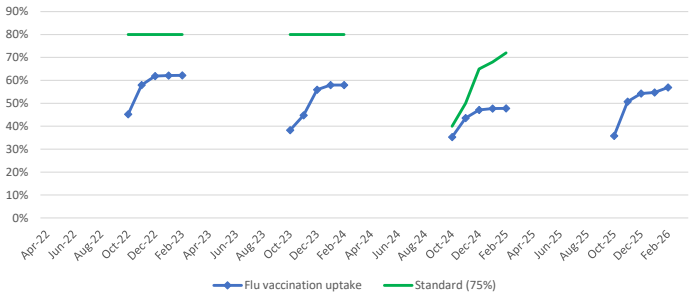
### Medical job plan compliance



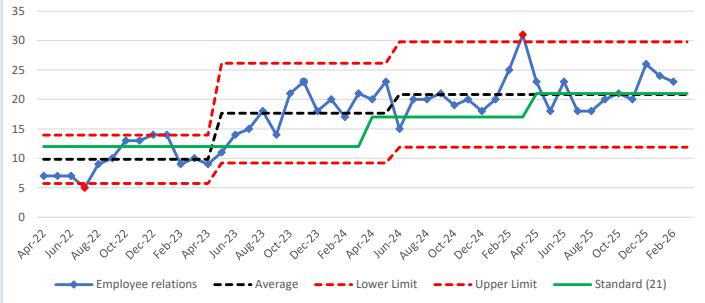
### Sickness absence



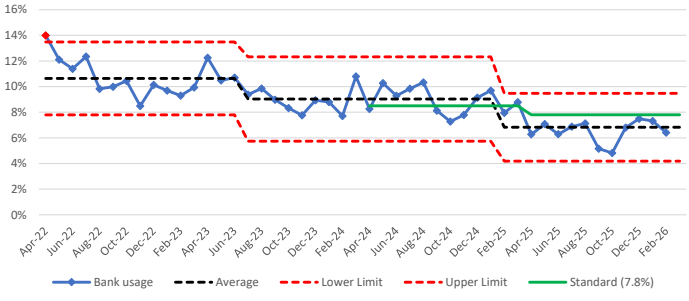
Flu vaccinations uptake (front line staff)



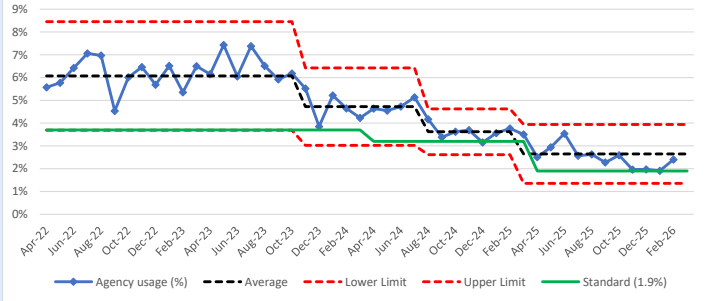
Employee relations management



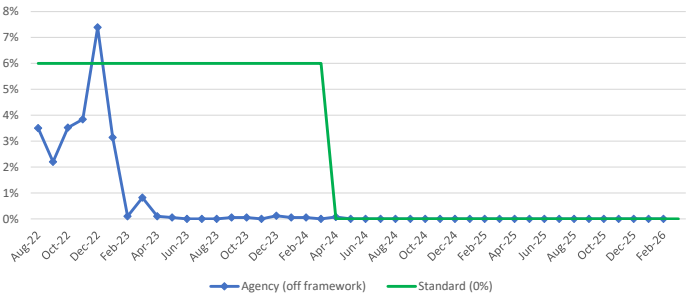
Bank usage



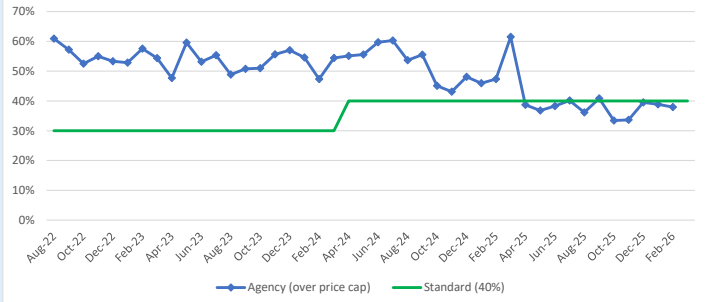
Agency usage



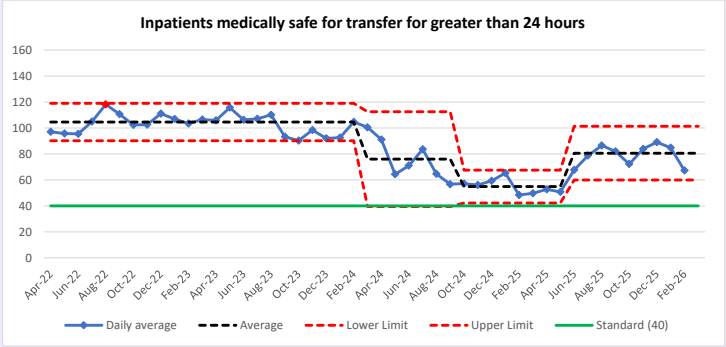
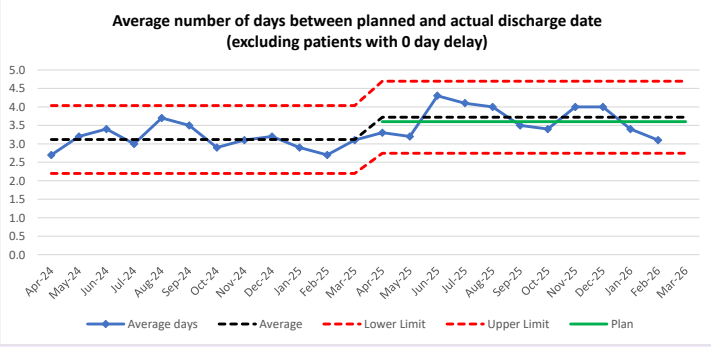
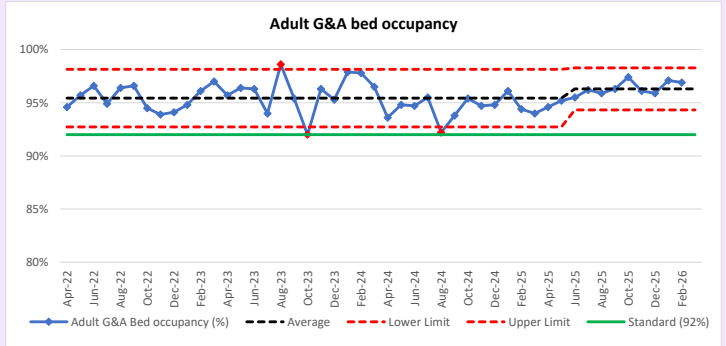
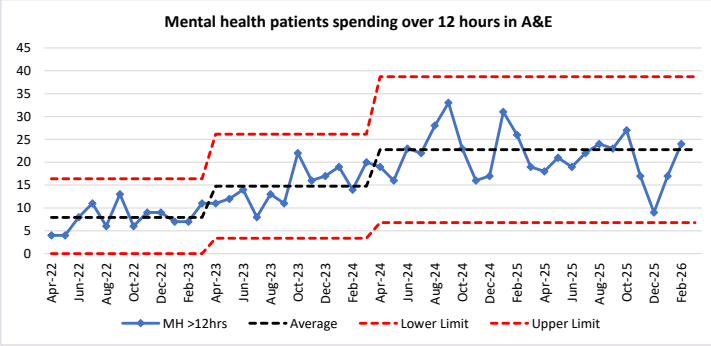
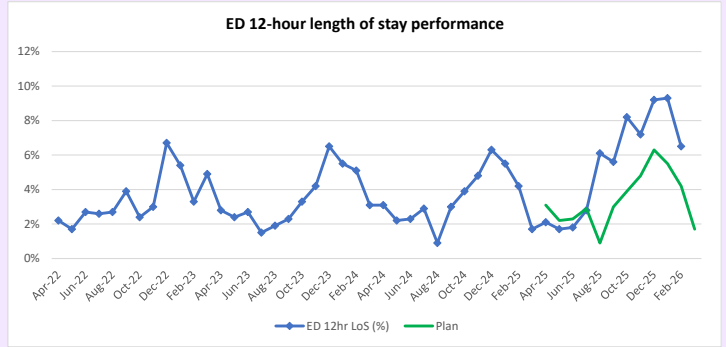
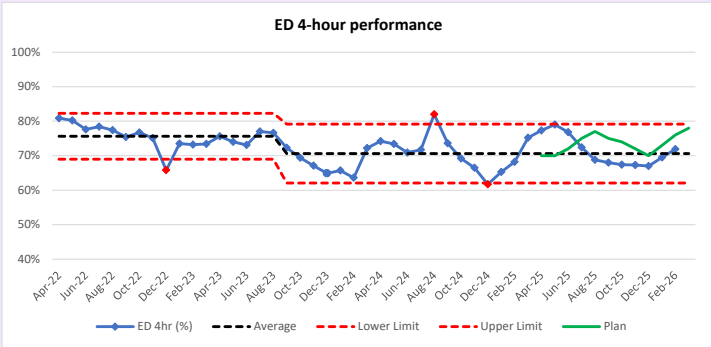
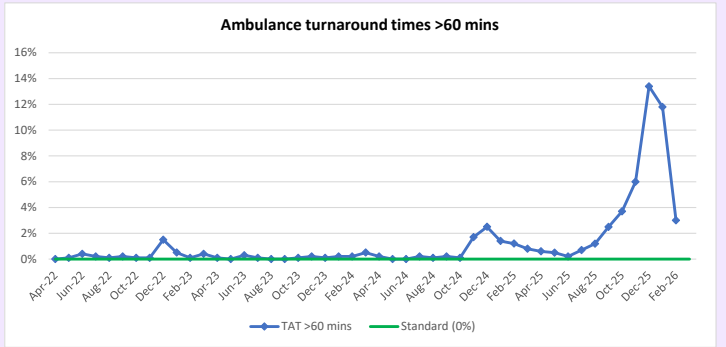
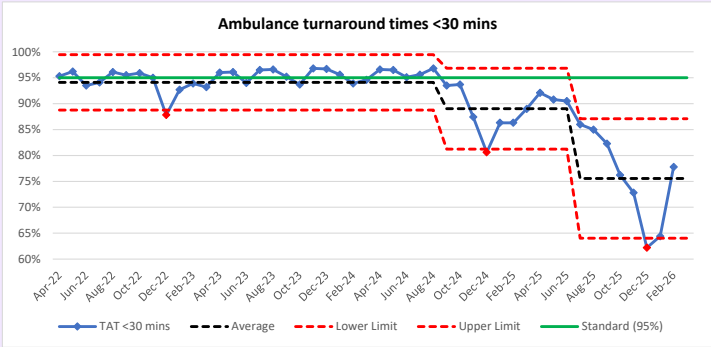
Agency (off framework)



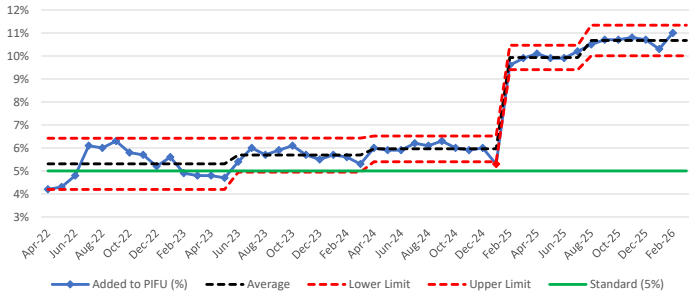
Agency (over price cap)



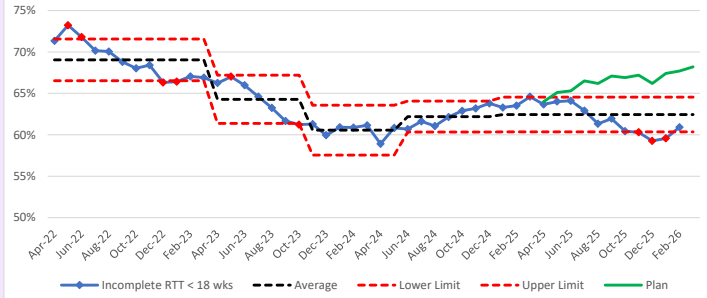
## Timely Care



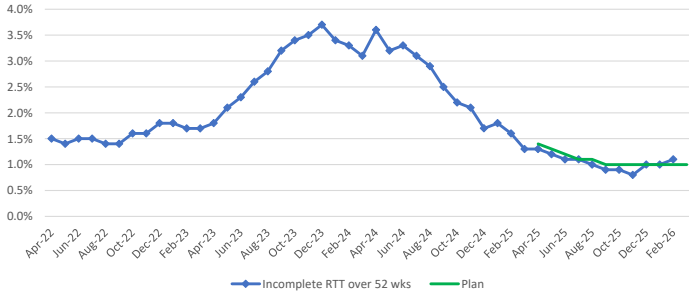
**Added to Patient Initiated Follow Up (PIFU) pathway**



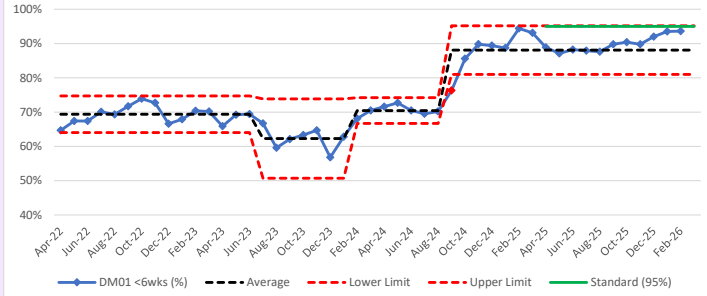
**Percentage of incomplete (RTT) pathways completed < 18 weeks**



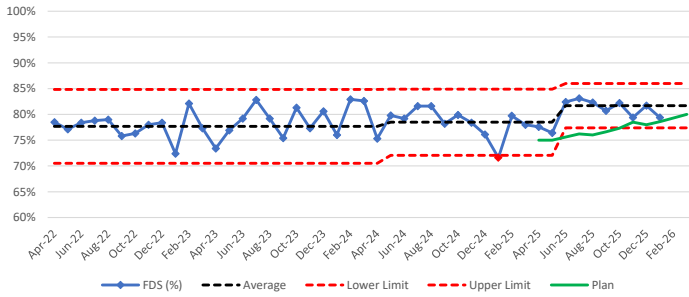
**Percentage of RTT waits over 52 weeks for incomplete pathways**



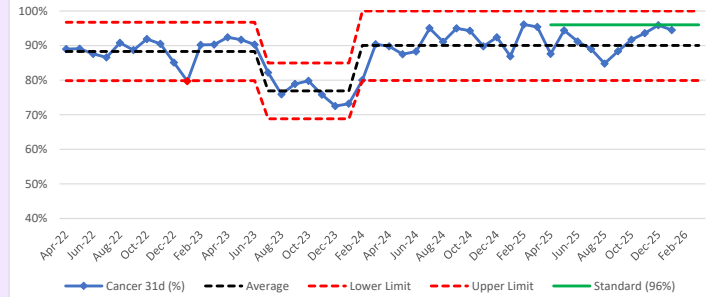
**Diagnostic DM01 performance under 6-weeks**



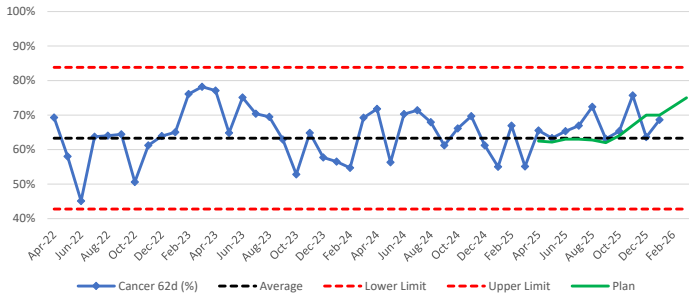
**Cancer 28-day faster diagnosis standard**



**Cancer 31-day treatment performance**

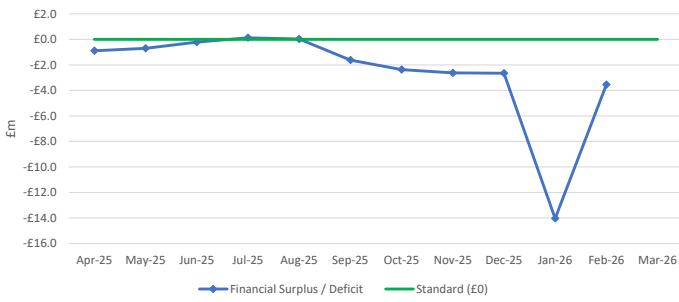


**Cancer 62-day treatment performance**

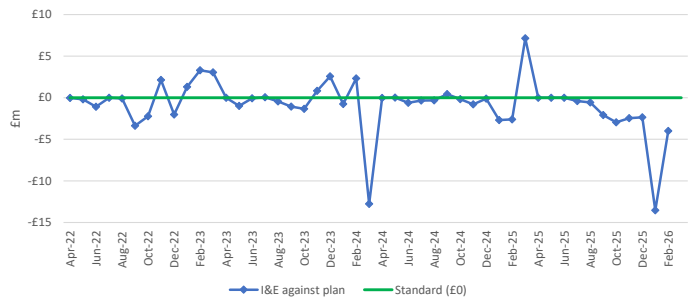


## Best Value Care

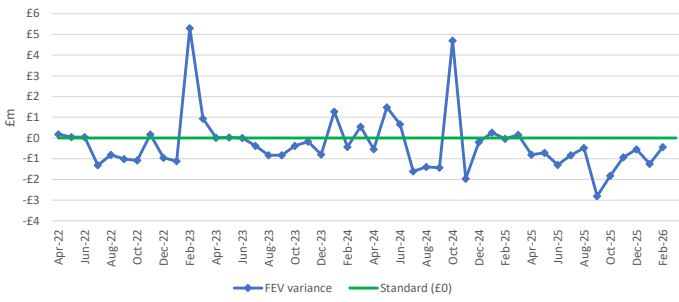
### Financial Surplus / Deficit



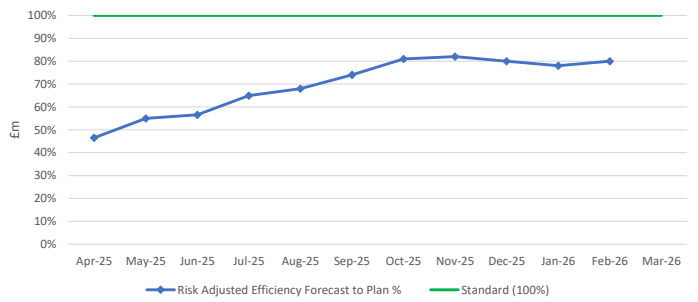
### Variance YTD to financial plan



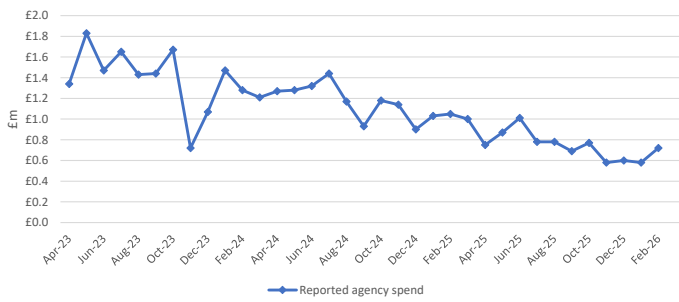
### Financial efficiency variance YTD to plan



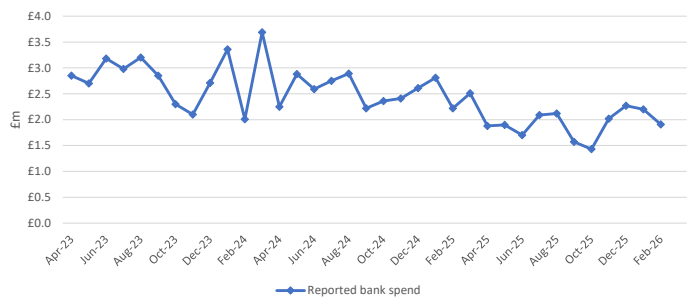
### Risk adjusted efficiency forecast to plan (%)



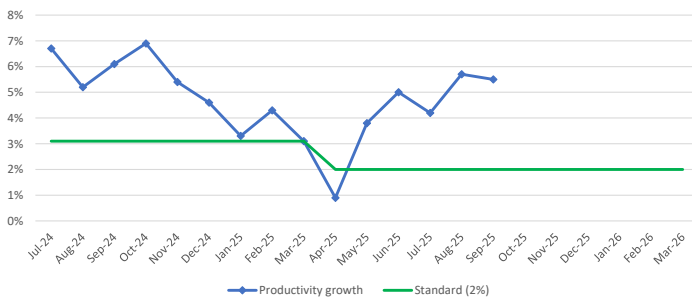
### Reported agency expenditure



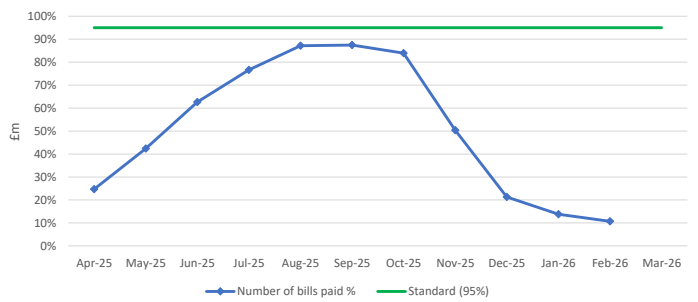
### Reported bank expenditure



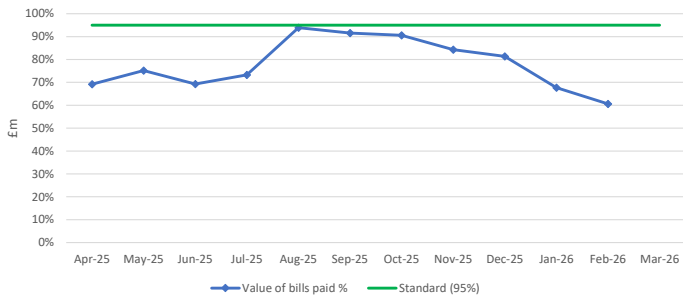
### Implied productivity growth (YTD compared to last year)



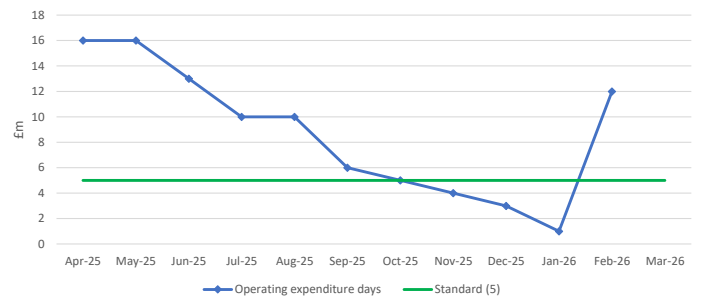
### BPPC - Number of bills paid within target



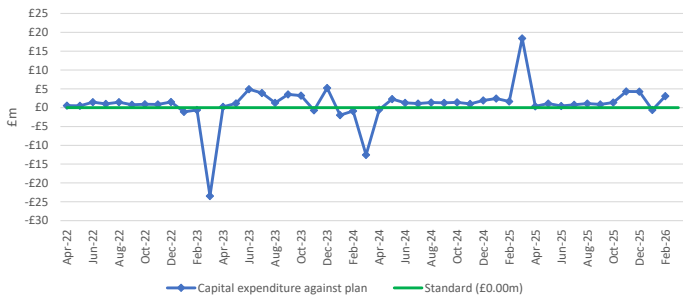
**BPPC - Value of bills paid within target**



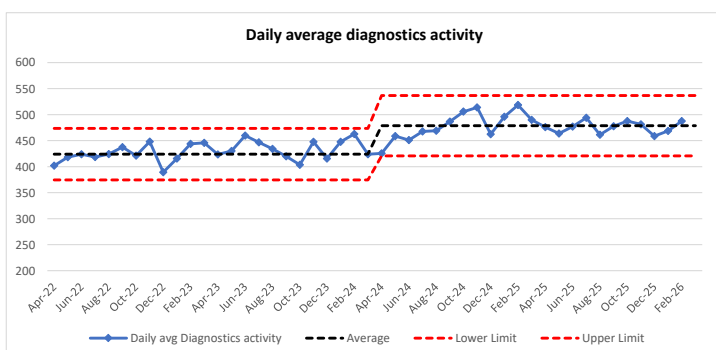
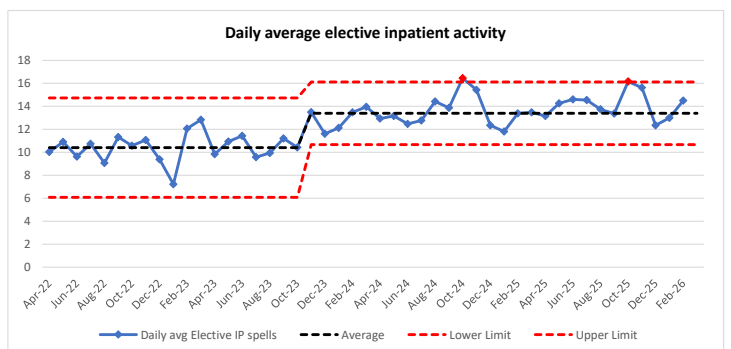
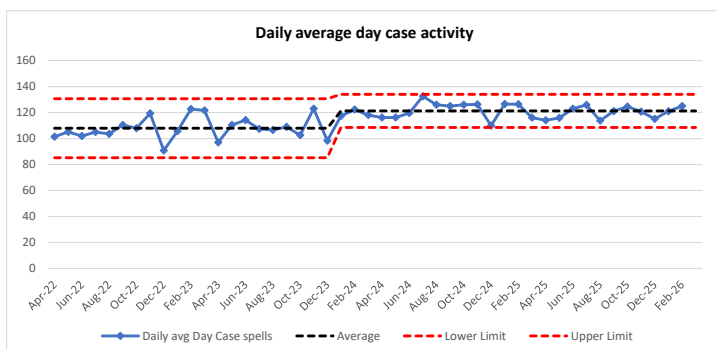
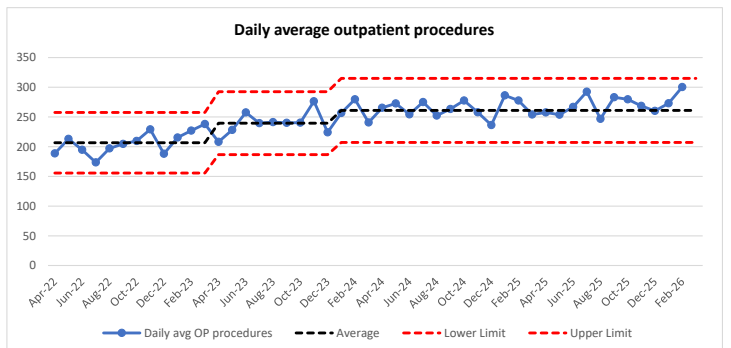
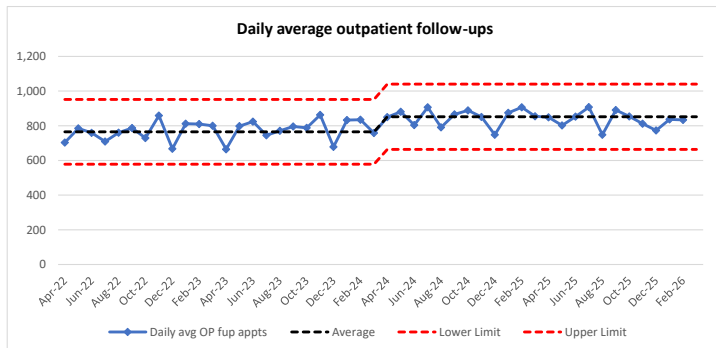
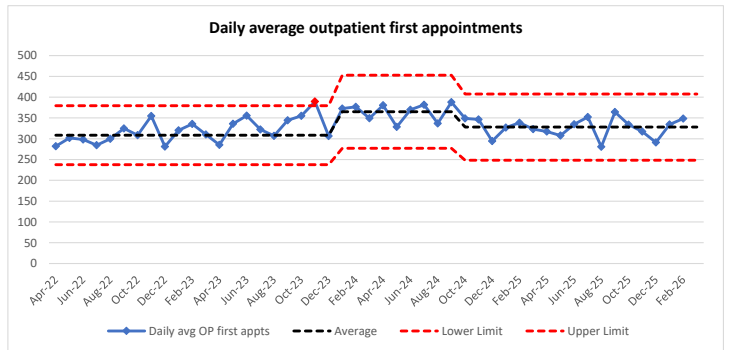
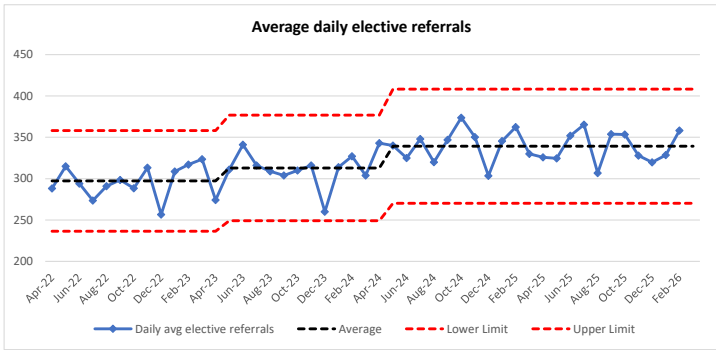
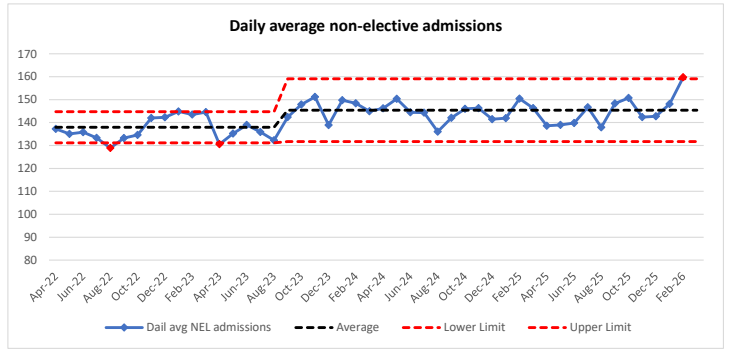
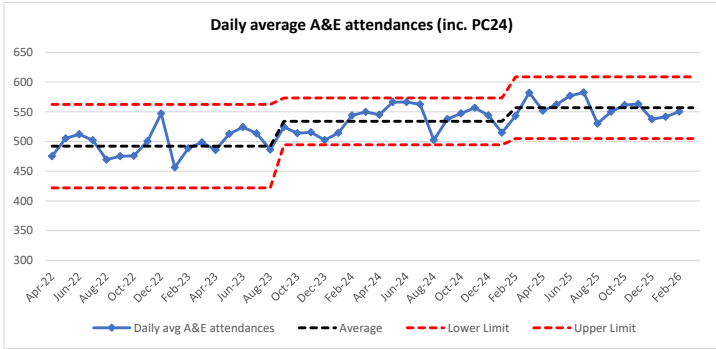
**Operating expenditure days**



**Capital expenditure against plan**



Activity (for context)



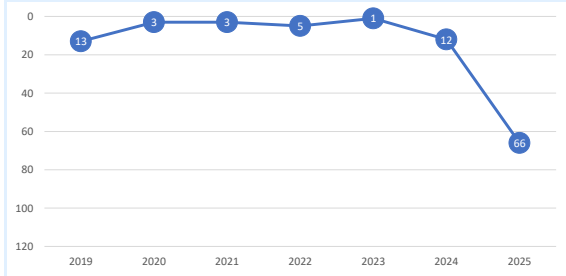
**People and Culture Benchmarking**

At a Glance	Indicator	Source	Rate	Rank	Of	Decile	Period
Belonging	Engagement Score	NHS Staff Survey	6.7	66	121	6	2025
Growing the future	Turnover in month	NHS Hospital and Community Health Services (HCHS) monthly workforce statistics	1.1%	108	118	10	Dec-25
Looking after our People	Sickness absence	NHS Sickness Absence Rates	5.7%	67	118	6	Nov-25
New Ways of Working	Bank usage	Model Hospital	7.5%	115	195	6	Dec-25
	Agency usage	Model Hospital	2.0%	150	187	9	Dec-25

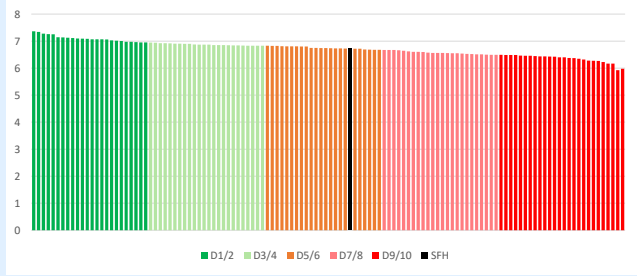
**People and Culture Benchmarking Charts**

**People + Culture Benchmarking**

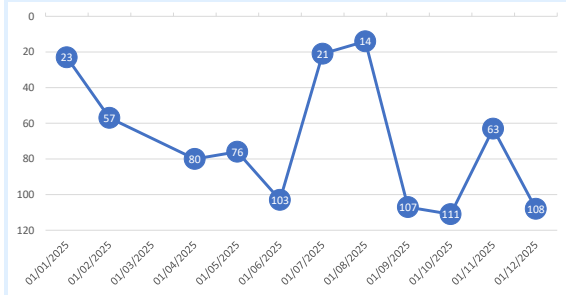
**Overall Staff Engagement (NSS)**



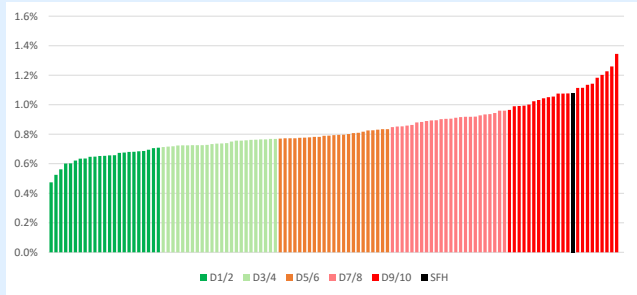
**2025 Position**



**Turnover in month**

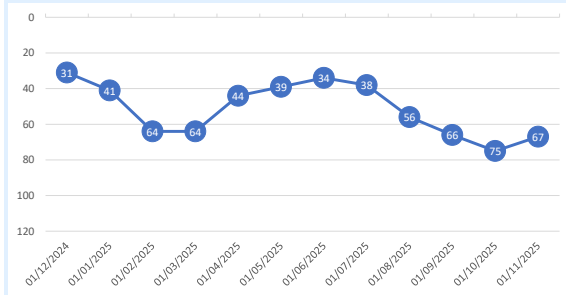


**Dec 25 Position**

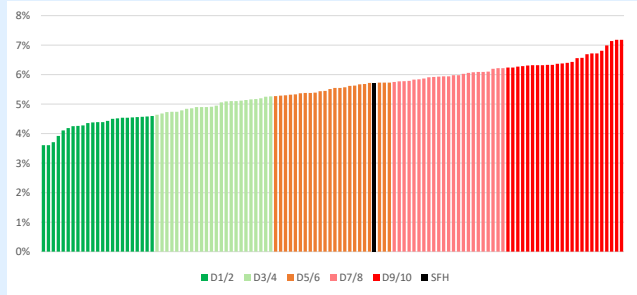


NB: Benchmark not published for March 25

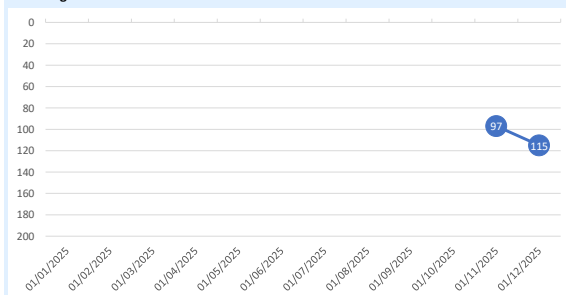
**Sickness absence**



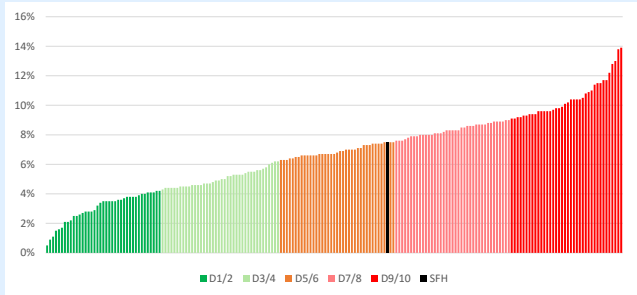
**Nov 25 Position**



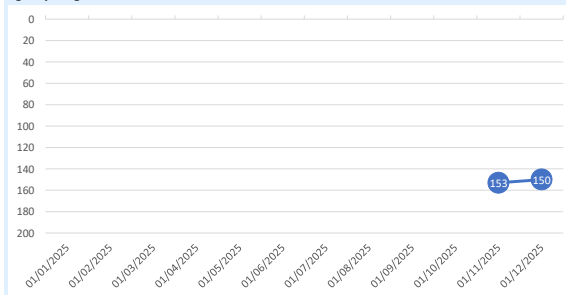
**Bank usage**



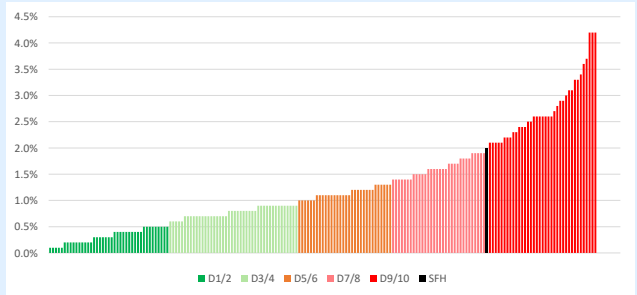
**Dec 25 Position**



**Agency usage**



**Dec 25 Position**



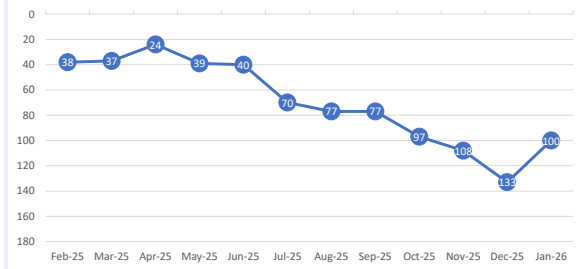
**Timely Care Benchmarking**

At a Glance	Indicator	Source	Rate	Rank	Of	Decile	Period
Urgent Care	Ambulance turnaround times <30 mins	Summary Emergency Department Indicator Table (SEDIT)	64.6%	100	176	6	Jan-26
	Ambulance turnaround times >60 mins	Summary Emergency Department Indicator Table (SEDIT)	12.0%	115	176	7	Jan-26
	ED 4-hour performance	NHS England A&E Attendances and Emergency Admissions	69.5%	77	141	6	Jan-26
	ED 12-hour length of stay performance	Summary Emergency Department Indicator Table (SEDIT)	11.6%	68	177	4	Jan-26
Electives	Adult G&A bed occupancy	Summary Emergency Department Indicator Table (SEDIT)	96.9%	125	179	7	Jan-26
	Added to Patient Initiated Follow Up (PIFU) pathway	Model Hospital	10.5%	6	134	1	Jan-26
	Elective RTT 18-Week Performance	RTT waiting times data	59.6%	96	149	4	Jan-26
Diagnostics	Incomplete RTT pathways +52 weeks	RTT waiting times data	0.9%	50	149	4	Jan-26
	Diagnostic DM01 performance under 6-weeks	Diagnostics Waiting Times and Activity data	93.5%	23	133	2	Jan-26
Cancer	Cancer 28-day faster diagnosis standard	Cancer Waiting Times standards	79.4%	35	133	3	Jan-26
	Cancer 31-day treatment performance	Cancer Waiting Times standards	94.5%	63	134	5	Jan-26
	Cancer 62-day treatment performance	Cancer Waiting Times standards	68.6%	74	135	6	Jan-26

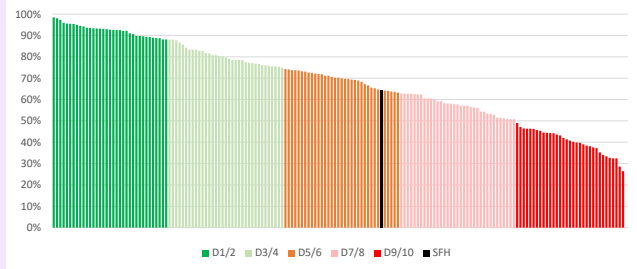
**Timely Care Benchmarking Charts**

**Timely Care Benchmarking**

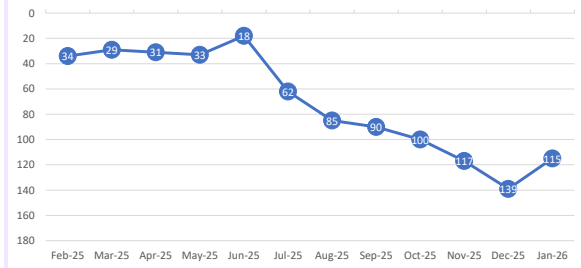
**Ambulance turnaround times <30 mins**



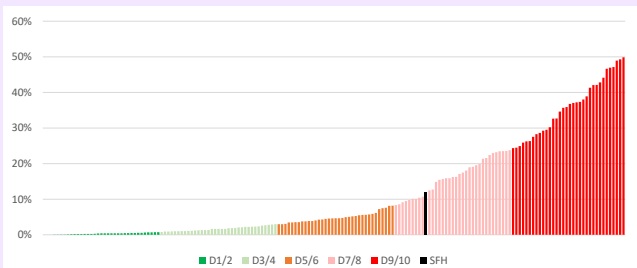
**Jan 26 Position**



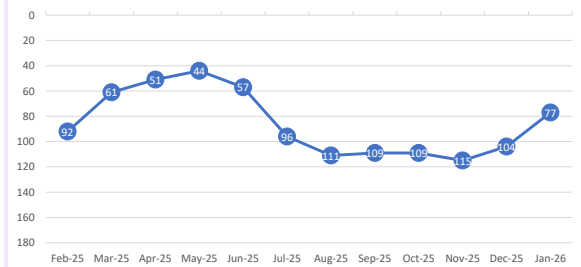
**Ambulance turnaround times >60 mins**



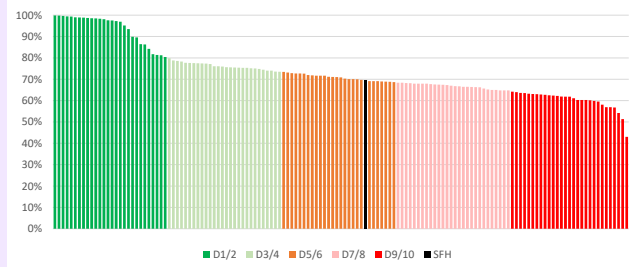
**Jan 26 Position**



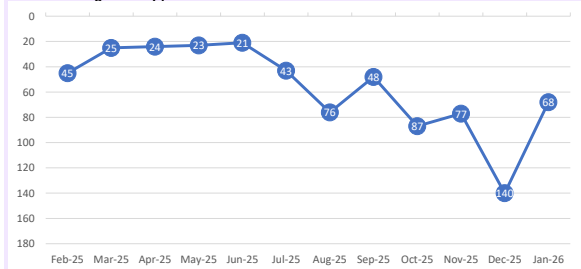
**ED 4-hour performance**



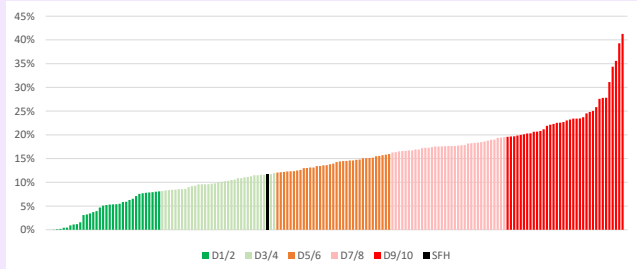
**Jan 26 Position**



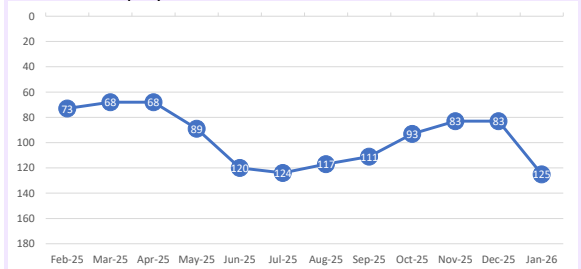
**ED 12-hour length of stay performance**



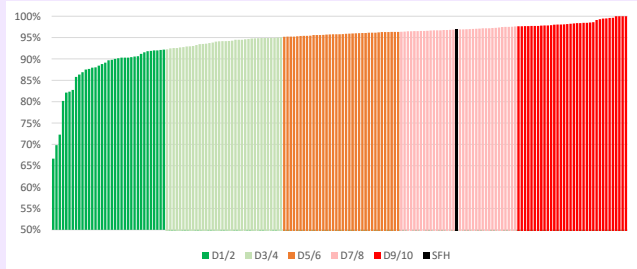
**Jan 26 Position**



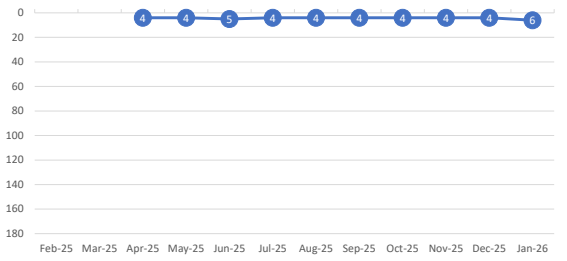
**Adult G&A bed occupancy**



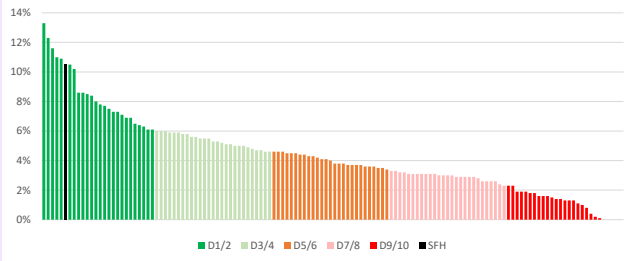
**Jan 26 Position**



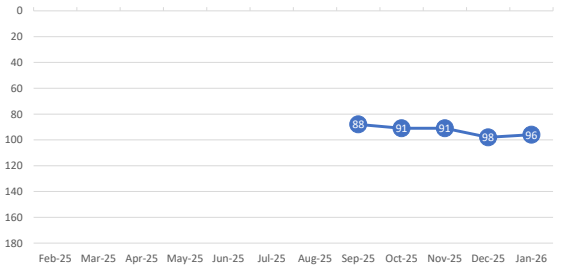
**Added to Patient Initiated Follow Up (PIFU) pathway**



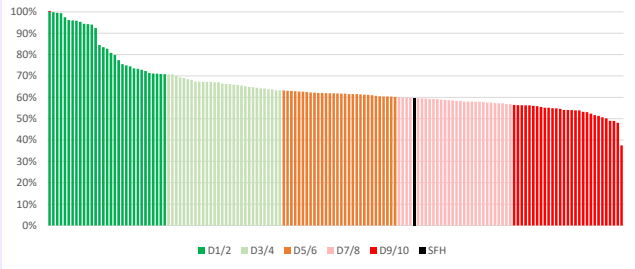
**Jan 26 Position**



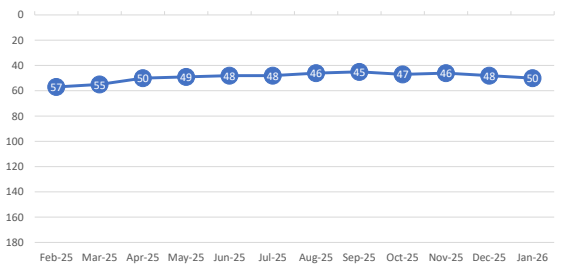
**Elective RTT 18-week performance**



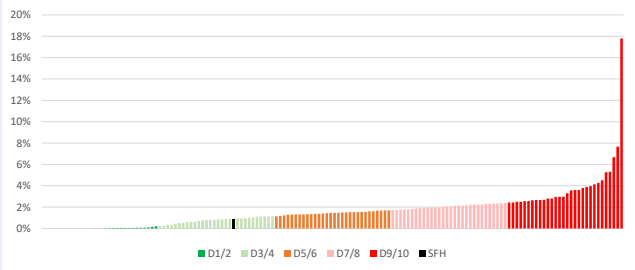
**Jan 26 Position**



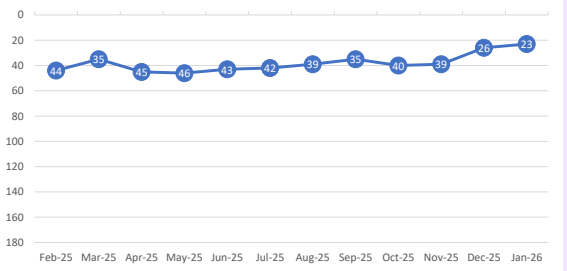
**Incomplete RTT pathways +52 weeks**



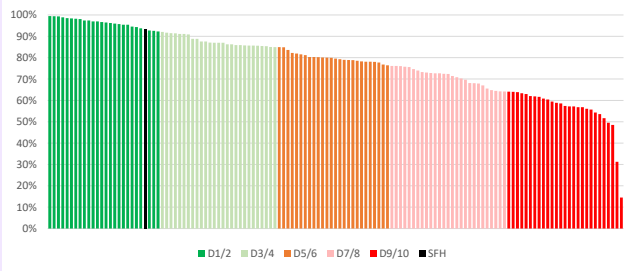
**Jan 26 Position**



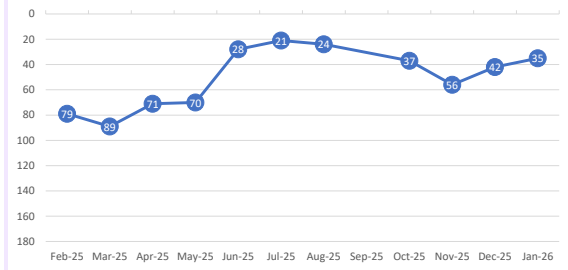
**Diagnostic DM01 performance under 6-weeks**



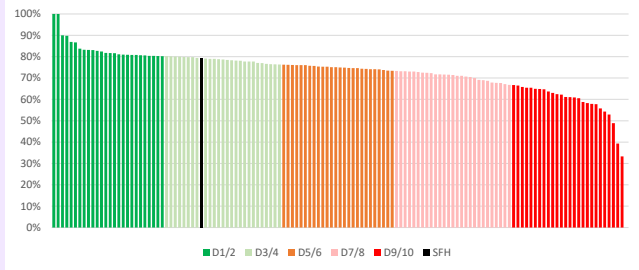
**Jan 26 Position**



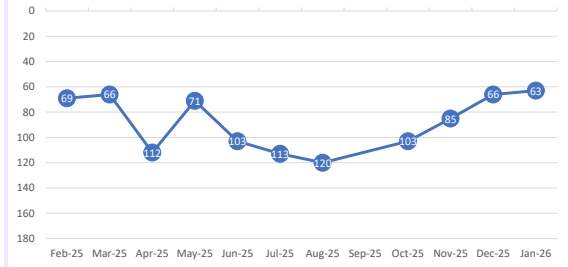
Cancer 28-day faster diagnosis standard



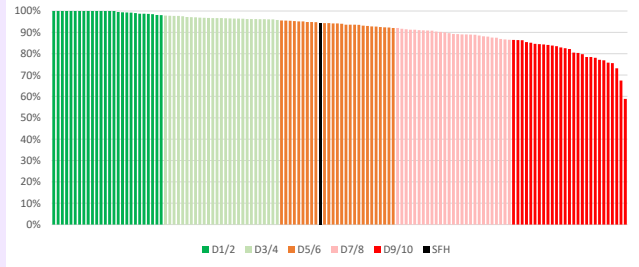
Jan 26 Position



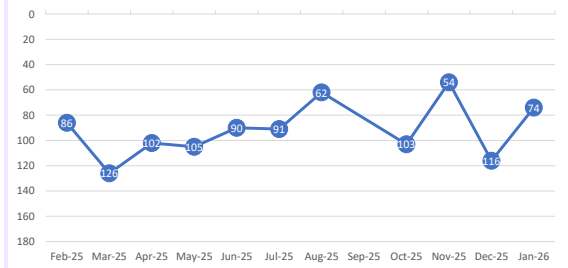
Cancer 31-day treatment performance



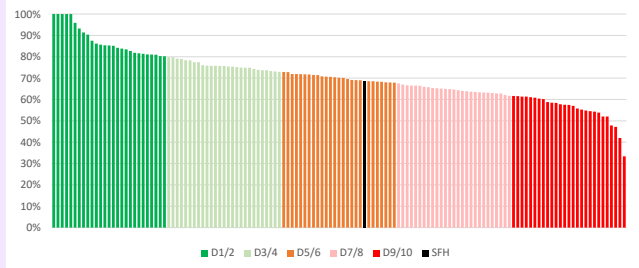
Jan 26 Position



Cancer 62-day treatment performance



Jan 26 Position



Board of Directors - Cover Sheet

<b>Subject:</b>	Failure to Prevent Fraud	<b>Date:</b>	2 <sup>nd</sup> April 2026		
<b>Prepared By:</b>	360 Assurance				
<b>Approved By:</b>	Richard Mills, Chief Financial Officer				
<b>Presented By:</b>	Jon Melbourne, Chief Executive				
<b>Purpose</b>					
To approve a Chief Executive statement on the Failure to Prevent Fraud offence and other financial crimes against the NHS, to be published on the Trust website.				<b>Approval</b>	<b>X</b>
				<b>Assurance</b>	
				<b>Update</b>	
				<b>Consider</b>	
<b>Strategic Objectives</b>					
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 estates	Work collaboratively with partners in the community
				<b>X</b>	
<b>Identify which Principal Risk this report relates to:</b>					
<b>PR1</b>	Significant deterioration in standards of safety and care				
<b>PR2</b>	Demand that overwhelms capacity				
<b>PR3</b>	Critical shortage of workforce capacity and capability				
<b>PR4</b>	Insufficient financial resources available to support the delivery of services				<b>X</b>
<b>PR5</b>	Inability to initiate and implement evidence-based Improvement and innovation				
<b>PR6</b>	Working more closely with local health and care partners does not fully deliver the required benefits				
<b>PR7</b>	Major disruptive incident				
<b>PR8</b>	Failure to deliver sustainable reductions in the Trust's impact on climate change				
<b>Committees/groups where this item has been presented before</b>					
Audit & Assurance Committee					
<b>Acronyms</b>					
<ul style="list-style-type: none"> <li>CFA – Counter Fraud Authority</li> </ul>					
<b>Executive Summary</b>					
<p>The Economic Crime and Corporate Transparency Act 2023 (the Act) introduced a new corporate criminal offence of failure to prevent fraud. This came into effect from 1 September 2025. This applies to all large organisations, including NHS bodies.</p> <p>Under this legislation, an organisation can be held criminally liable if a person associated with it commits a specified fraud offence intending to benefit the organisation, or a person to whom it provides services, and the organisation did not have reasonable fraud prevention procedures in place.</p> <p>Responsibilities are as follows:</p> <ul style="list-style-type: none"> <li>Board and Executive Team are accountable for ensuring the organisation complies with the legislation and for setting a clear tone from the top.</li> </ul>					

- Managers are responsible for embedding fraud prevention controls within their areas and supporting staff to act with integrity.
- Staff and associated persons are required to act honestly, comply with policies and procedures, and report any concerns about fraud.

360 Assurance provide a specialist Counter Fraud service for the Trust, working to an annually agreed workplan to ensure adequate support in terms of proactive fraud prevention and detection work, as well as reactive response & investigative work.

The Audit and Assurance Committee has been delegated responsibility by the Board to consider assurance on counter fraud activities for the Trust and the Trust's Chief Financial Officer has regular meetings with the designated Counter Fraud Specialist.

**The Board of Directors are asked to approve the attached Chief Executive statement on the Failure to Prevent Fraud offence and other financial crimes against the NHS, which will be published on the Trust's website.**

## **Chief Executive statement on the Failure to Prevent Fraud offence and other financial crimes against the NHS**

As Chief Executive of Sherwood Forest Hospitals NHS Foundation Trust I am pleased to set out our commitment to remaining transparent, ethical and accountable in all that we do. In line with our overall mission to deliver safe, high-quality care for patients and communities, we also recognise our responsibility to maintain the highest standards of integrity, including preventing and detecting fraud.

On 1<sup>st</sup> September 2025 a new fraud offence came into force. This is a corporate offence of '*failure to prevent fraud*', which is part of the Economic Crime and Corporate Transparency Act 2023.

Under the "failure to prevent fraud" offence, organisations may be held criminally liable when a person associated with the organisation (for example an employee, agent or subsidiary) commits a specified fraud offence for the benefit of the organisation, and the organisation did not have reasonable procedures in place to prevent that fraud.

In that context, I confirm that Sherwood Forest Hospitals NHS Foundation Trust has in place, and will maintain, procedures which we believe to be reasonable and proportionate in preventing fraud, consistent with the guidance issued by government. Specifically:

### **1. Leadership & culture**

We are committed to fostering a culture of honesty, trust and transparency across the organisation. I personally endorse the principle that any suspected fraudulent or dishonest behaviour should be reported, investigated and addressed appropriately.

### **2. Risk assessment**

We undertake regular assessments of the fraud risk profile facing the Trust, considering where and how fraudulent activity might arise within our operations, including the supply chain, agency arrangements and other partnerships. These assessments are reviewed and updated periodically.

### **3. Prevention procedures**

We have implemented proportionate, risk-based procedures designed to prevent fraud. These include, but are not limited to, due diligence checks, financial controls, procurement oversight, contract monitoring, segregation of duties, clear scheme of delegations, and a whistle-blowing mechanism. Where appropriate, we provide fraud-awareness training to our staff, contractors and partners.

### **4. Communication and training**

We communicate clearly to all staff and partners that fraud is unacceptable and that we expect conduct in line with the Trust values and standards of behaviour. We provide guidance, policies and training to support staff in identifying and reporting concerns.

### **5. Monitoring, review and continuous improvement**

We monitor our procedures and controls to ensure they remain effective and relevant. Where weaknesses or control gaps are identified, we act promptly to remediate them. We review our policy and governance framework to ensure alignment with evolving risks and external guidance.

### **6. Whistle-blowing & speaking up**

We have in place mechanisms for staff, contractors, agency workers and others to raise concerns without fear of reprisal. We encourage openness and will treat as a priority any

reports suggesting potential fraud or misconduct, investigating them thoroughly and impartially.

#### **7. Governance and accountability**

The Board of Sherwood Forest Hospitals NHS Foundation Trust receives regular assurance on fraud risk, prevention activity and control effectiveness, through reports from the Audit and Assurance Committee. I, as Chief Executive, take ultimate responsibility for the arrangements and for embedding the anti-fraud culture within the organisation.

I believe the procedures set out above reflect our commitment to acting ethically, lawfully and in the best interests of patients, staff, public funds and the public we serve. We will continue to review and refine our approach to ensure that we remain vigilant and compliant with the requirements of the Act and the associated guidance.

This statement has been approved by the Board of Sherwood Forest Hospitals NHS Foundation Trust and is published on the organisation's website and internal governance portal.

#### **Reporting Concerns**

If you have any concerns or suspicions regarding bribery, corruption, or fraud, please contact:  
[360assurance.counterfraud@nhs.net](mailto:360assurance.counterfraud@nhs.net)

Or alternatively please contact:  
NHS Fraud & Corruption Reporting Line  
**Tel – 0800 028 4060**  
<https://cfa.nhs.uk/report-fraud>

**Board of Directors - Cover Sheet**

<b>Subject:</b>	Well Led Action Plan – Update		<b>Date:</b>	2 <sup>nd</sup> April 2026	
<b>Prepared By:</b>	Sally Brook Shanahan, Director of Corporate Affairs				
<b>Approved By:</b>	Executive Team				
<b>Presented By:</b>	Sally Brook Shanahan, Director of Corporate Affairs				
<b>Purpose</b>					
This paper asks the Board of Directors to review for the final time the updates on the actions from the Grant Thornton LLP developmental Well-Led Review and give them their final approval.				<b>Approval</b>	<b>X</b>
				<b>Assurance</b>	
				<b>Update</b>	
				<b>Consider</b>	
<b>Strategic Objectives</b>					
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 estates	Work collaboratively with partners in the community
<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>
<b>Identify which Principal Risk this report relates to:</b>					
<b>PR1</b>	Significant deterioration in standards of safety and care				<b>X</b>
<b>PR2</b>	Demand that overwhelms capacity				<b>X</b>
<b>PR3</b>	Critical shortage of workforce capacity and capability				<b>X</b>
<b>PR4</b>	Failure to achieve the Trust's financial strategy				<b>X</b>
<b>PR5</b>	Inability to initiate and implement evidence-based Improvement and innovation				<b>X</b>
<b>PR6</b>	Working more closely with local health and care partners does not fully deliver the required benefits				<b>X</b>
<b>PR7</b>	Major disruptive incident				
<b>PR8</b>	Failure to deliver sustainable reductions in the Trust's impact on climate change				
<b>Committees/groups where this item has been presented before</b>					
Board – most recently in February 2026 Executive Committee – most recently in January 2026 Board Committees					
<b>Acronyms</b>					
FTSU – Freedom to Speak Up DoCA - Director of Corporate Affairs					
<b>Executive Summary</b>					
<p>The Board is familiar with the findings from the Developmental Well Led Governance Review concluded by Grant Thornton LLP in January 2025 that were first reported to the Board at its meeting on 6<sup>th</sup> February 2025 at which the action plan and associated progress monitoring arrangements were agreed in respect of each of its five sections: Leadership, Improvement Strategy, Partnerships and FTSU.</p> <p>This paper follows on from the update on progress with the actions presented most recently to the Board meeting in Public on 5<sup>th</sup> February 2026 and at which the final approval of all five sections of the Action updates was scheduled at this, April 2026, Board meeting in public.</p> <p>Prior to this meeting, Executives were asked to review the sections for which they are the designated owner and provide any final updates, if required, to the Director of Corporate Affairs.</p> <p>Appendix 1 to this paper comprises the full action plan in its final iteration, noting that the nature of many of the actions means that they will continue to evolve beyond the time of this request for</p>					

approval. Since its presentation to the February 2026 Board (version issued as at 28.01.2026), the FTSU section of the Action Plan (comprising 11 of the total 33 recommendations) has been the subject of further updating and is presented in its final form for approval, together with the remaining four sections that remain unaltered: Leadership, Improvement, Strategy and Partnerships.

As it is important to ensure evidence of the changes implemented as a consequence of the actions is maintained, a central repository to enable rapid one stop access has been established with Executives sighted on the need for them to ensure supporting information is saved for future use, particularly in the event of an inspection.

As change will inevitably occur in the development areas identified the Action Plan will continue to be maintained as a live resource and record for the assigned committees from whom on-going feedback can be provided to the Board via their meeting Highlight Reports.

This is, as agreed previously by the Board, the final scheduled paper about progress against the Action Plan from the developmental Well-Led report.

### **Recommendations**

The Board is asked to:

1. Review and approve the final scheduled updates to the Leadership, Improvement, Strategy, Partnerships and FTSU sections of the Action Plan.
2. Note the arrangements made for supporting information to be saved in the central evidence repository and for on-going review of the Action Plan in relevant Board Committees to promote continuous improvement.
3. Note that consideration will be given to the commissioning of a further developmental Well-Led review in 2027/28.

# **Well-Led Review January 2025**

## **Action plan for development areas**

KEY:

ACE	Acting Chief Executive (ended 27/10/2025)
DCE	Deputy Chief Executive (ended 06/11/2025)
CE	Chief Executive (from 27/10/2025)
COO	Chief Operating Officer
DSP	Director of Strategy & Partnerships
CPO	Chief People Officer
DoCA	Director of Corporate Affairs
FTSUG	Freedom to Speak Up Guardian
NGO	National Guardian's Office
	Action signed off by the Board

## Actions – Leadership

No.	Area of Development	Action	Action Lead	Task Lead(s)	Delivery Date	Progress Update	Committee sign off
1	Unitary Board development	The Chair and ACE/DCE should design a structured board development plan to include actions and activities that support effective onboarding and integration of the new NEDs and other directors. The plan should include protected time to invest in “team building” and softer skills to ensure the Trust maintains a unitary board.	Chair and CE	CE	31/10/2025	<p>In September 2025 an application was submitted for the NHSE Board Development Programme. Unfortunately, the response to it was that NHSE had taken a decision to pause the Programme for the remainder of the financial year 2025/26.</p> <p>We maintain and regularly update a planner of Board development activities, time for which has been enhanced by the move to bi-monthly formal Board meetings in the even numbered months and a greater focus on developmental activities in odd numbered months.</p> <p>We hold an annual Board Development event in November. In 2025 this included a half day session led by PTS Insight that provided protected team building time and from which commitments to on-going development actions have been shared.</p> <p>In 2025 the Chair’s appraisal included 360-degree feedback for the first time. Building on that success, this feedback is being rolled out to all Board</p>	Executive 18/03/2026

No.	Area of Development	Action	Action Lead	Task Lead(s)	Delivery Date	Progress Update	Committee sign off
						members, NED and Executive for appraisals in 2026/27.	
2	Unitary Board development	Review and agree how appropriately detailed information on Trust performance/issues is shared with NEDs between committee meetings, to ensure NEDs are kept up to date in a timely manner.	ACE/DCE	ACE/DCE and COO	30/06/2025	NEDs now receive at least monthly updates. IPR reporting to the Board has now increased from quarterly to bi-monthly at public Board meetings. Additional performance information is shared at the Executive & NED Update meetings in the “odd” numbered months when no public Board meeting is convened.	Executive Committee 30/07/2025
3	Unitary Board development	The Chair and NEDs should agree the schedule of regular NED group catch-ups, given the context of new NED member appointments over the next few months.	Chair	DoCA	30/06/2025	The Board’s decision to move to bi-monthly formal meetings in the “even” months from June 2025, has enabled the “odd” months to be focussed on NED catch ups, including workshops. Positive feedback received from NEDs following the changes. A forward plan for 2025/26 has been agreed with the Chair.	Executive Committee 30/07/2025
4	Skills and experience	The Trust’s effective succession planning arrangements have ensured that the Board has remained stable following key Board changes over the last year. There remain recognised gaps at board level covering the areas of improvement, transformation and research. The Trust is recruiting to a Director of Improvement and NED	CE	All Exec Dirs.	31/03/2026	Following an unsuccessful recruitment exercise to the Executive Director of Improvement and Change role the new Chief Executive, who took up the post on 27 <sup>th</sup> October 2025, has reviewed the position resulting in agreement to proceed, the launch of the	Executive 18/03/2026

No.	Area of Development	Action	Action Lead	Task Lead(s)	Delivery Date	Progress Update	Committee sign off
		<p>recruitment is planned. The Chair and ACE/DCE should consider how experience and skills gaps can be closed as part of the ongoing Executive and NED recruitment process and as part of the board development programme.</p>				<p>advertisement/search and a recruitment decision by the end of February 2026. That process concluded on 3<sup>rd</sup> March 2026 with no appointment made. The planned NED recruitment took place and wef 6<sup>th</sup> February 2025 two NEDs one a finance specialist and the other with a background in nursing and quality have been recruited. Both NEDs have since succeeded as the respective chairs of the Finance Committee and the Quality Committee following induction to these roles.</p> <p>In addition, an exceptionally well qualified and experienced Associate NED recruit (the first for the Trust) is focused on the support and development of the Trust's research function.</p>	

## Actions – Improvement

No.	Area of Development	Action	Action Lead	Task Lead(s)	Due Date	Progress Update	Committee sign off
1	Prioritise and monitor	Establish buy in and support from the Board on the Trust improvement strategy and approach. This would include agreeing key improvement priorities and what can be achieved by when, and setting out key terms and definitions (e.g. improvement – quality, operational and financial, transformation, multi-year etc)	Chair	All Exec Dirs.	31/03/2026	The Trust strategies refresh cycle is being used as an opportunity to define and prioritise improvement targets. Sub-board committees hold the reins on these plans. Segmentation reports that are presented to relevant subcommittees also support visibility. In terms of improvement strategy, the key areas are the AQUA review of the Improvement Faculty, that is in progress, and to review the appointment of an Executive Director of Improvement following the non-appointment in the recruitment exercise that concluded on 3 <sup>rd</sup> March 2026.	Quality
2	Embedding improvement culture	Revisit and reset governance processes and groups for developing and monitoring improvement work across the Trust. This would include consideration of the role of the Financial Improvement Cabinet/Improvement Cabinet and Quality and Safety Committee.	DoI	All Exec Dirs.	31/03/2026	Separation of Financial Improvement and Quality Improvement. Revised arrangements implemented for financial governance via the Financial Recovery Cabinet. Regular improvement updates provided to Board along with other related events supported by Board members including Improvement Week events, Improvement Showcases, Step	Quality

No.	Area of Development	Action	Action Lead	Task Lead(s)	Due Date	Progress Update	Committee sign off
						into the NHS events and Celebrating Excellence events. The GIRFT oversight group - supports key GIRFT workstreams across the organisation	
3	Embedding improvement culture	The Trust should develop a clear and detailed plan to share learning from improvement projects and agree the approach widely communicate improvement activities.	Dol	DSP	31/03/2026	NMAHP Committee receives dissertation research from funded degrees. The Chief Nurse Fellowship quality improvement is shared with a wide audience. The Ward Sisters and Matrons Development Days are an environment to discuss quality improvements. The Chief Nurse Bulletin published quarterly has examples of quality improvements. Nominations to national conferences (Nursing Times, HSJ and British Journal of Nursing) demonstrate the ongoing development of quality improvement in NMAHP.	Executive 18/03/2026
4	Embedding improvement culture	The Trust should consider how all senior leaders at the Trust can input into the Trust improvement programme and activities, to drive and support delivery and send a message that improvement	Dol	DSP	31/03/2026	Chief Nurse Fellowship actively promoted the QSIR programme and has a taster day on the programme. All Fellowships have to undertake a quality improvement project. All senior leaders within	Executive 18/03/2026

No.	Area of Development	Action	Action Lead	Task Lead(s)	Due Date	Progress Update	Committee sign off
		work is a responsibility of all leaders.				NMAHP and significant amount of the workforce now have completed the QSIR programme. All Wards/Depts conduct at least 1 QI project as part of ward accreditation.	
5	Developing capability and capacity	The Trust should consider how it can ringfence clinical and operational staff time to ensure improvement work is given more priority and focus.	DoI	DSP	31/03/2026	Senior leaders within NMAHP have QSIR practitioner training. QI project now built into annual ward accreditation for all ward/Dept areas. 8 PAs of clinical time have been recruited to support the improvement faculty. However, the faculty is approximately 20% smaller than it was a year ago as a result of staff reductions through MARS/holding vacancies so this does impact on what the team can deliver as it is under resourced in terms of specialist improvement skills. PMO staff resources have been deployed into the Finance team to support the Corporate Optimisation Programme. The AQUA review of the Improvement Faculty is in progress.	Executive Committee 18/03/2026

## Actions – Strategy

No.	Area of Development	Action	Action Lead	Task Lead(s)	Due Date	Progress Update	Committee sign off
1	Long term trajectory	Build a clear and detailed plan based on the Board development day sessions to build longer term strategy	ACE/DCE	DSP	31/10/2025	All Board development sessions and private board updates have led towards a plan to become an Integrated Health Organisation, with a strong Place and neighbourhood offer. This will be transacted into the Trust Strategy 'Improving Lives' for years 3-5 (2026-2029) with a delivery plan in place by April 2026. Enabling actions underway through inviting external partners to the November 2025 Board development session and taking a leadership role in the PBP.	Executive 18/03/2026
2	Long term trajectory	Link actions into three pillars of NHS plan alongside ICB plans and strategy, in particular PLACE based delivery.	ACE/DCE	DSP	31/10/2025	ICB plans and strategy are under review due to national guidance requiring a population health and neighbourhood plan in early 2026 (plus change to clustering). The Trust are actively involved in this process and translating plans back into the Trust through the strategy refresh for 2026-2029. This includes a co-developed Mid & North Notts Neighbourhood	Executive 18/03/2026

No.	Area of Development	Action	Action Lead	Task Lead(s)	Due Date	Progress Update	Committee sign off
						plan led by the Trust. All refreshed plans to be in place in April 2026.	
3	Long term trajectory	Identify and release capacity to develop strategy, considering broader input/leadership at Board level and wider organisation.	ACE/DCE	DSP	31/10/2025	The Strategy Steering Group has met monthly during 2025 including Exec directors and NEDs, led by the Director of Strategy and Partnerships to inform strategic direction. Additional 1 day a week resource identified to co-develop neighbourhood plan with partners across the Mid and North Notts area. A new delivery plan due April 2026 will review resources and leadership required for success.	Executive 18/03/2026
4	Long term trajectory	Establish governance processes and groups for monitoring delivery, development and engagement of strategy.	ACE/DCE	DSP	31/10/2025	The Strategy steering group has met monthly over 2025. Group on pause whilst 'Improving Lives' strategy refresh is transacted for 2026, which will identify most appropriate governance route once deliverables are clear, due in April 2026. Commercial strategy group has met monthly over 2025. All supporting strategies (partnership, clinical services, finance, people, quality) have governance routes into the	Executive 18/03/2026

No.	Area of Development	Action	Action Lead	Task Lead(s)	Due Date	Progress Update	Committee sign off
						appropriate Board committee which then feeds a 6 monthly overarching strategy update at Board.	
5	Underpinning strategies	Reset, align and further develop underpinning strategies that enable the delivery of the longer-term strategy.	ACE/DCE	DSP	31/03/2026	All supporting strategies (partnership, clinical services, finance, people, quality) are aligned to the Improving Lives strategy including same end dates (2029). Further work underway on Digital and Estates strategies to align to the Improving Lives Trust strategy.	Executive 30/07/2025
6	Underpinning strategies	Develop a long-term financial strategy that demonstrates the financial sustainability of the Trust which links into the system plans and strategy.	ACE/DCE	CFO	31/03/2026	Finance strategy developed and approved during 2025. Aligned to the Improving Lives and ICS strategies.	Executive 30/07/2025
7	Underpinning strategies	Ensure clinical, operational, workforce and financial strategies are further developed and aligned.	ACE/DCE	DSP	31/03/2026	Operational, workforce and financial plans are enacted through the national planning round and aligned to the appropriate supporting strategy.	Executive 30/07/2025

## Actions – Partnerships

No.	Area of Development	Action	Action Lead	Task Lead(s)	Due Date	Progress Update	Committee sign off
1	External perceptions and relationships	Continue to push as being active player in system and develop system working and approach with ICB on financial improvement in particular.	CE	DSP	31/03/2026	The Partnerships and Communities Committee's role and work is developing and maturing. The Trust contributes to the ICB as a provider representative. Establishment of Executive-to-Executive meetings with NUH. Committee in Common with NUH. East Midlands Acute Providers Network collaboration initiatives. In relation to financial improvement, we are actively involved in the Cluster Financial Recovery Group and the Provider Recovery Assurance Group.	Partnerships (unavoidably deferred to 14/04/2026)
2	External perceptions and relationships	Take leadership responsibilities on key areas of system development plans and pushing PLACE.	CE	DSP	31/03/2026	Director of Strategy & Partnerships is the SRO for the Ageing Well workstream and contributes to the development of the PBP. The Associate Director of Strategy & Partnerships attends the Place Boards. We have contributed to the development of the Health and Wellbeing Board development.	Partnerships
3	Strategic alignment	Use development of long-term strategy as	CE	DSP	31/03/2026	Our Partnerships and Clinical Services Strategy includes aspects of	Partnerships

No.	Area of Development	Action	Action Lead	Task Lead(s)	Due Date	Progress Update	Committee sign off
		basis of discussion, direction and leadership on system and ICB plans.				population health and our Trust Strategy "Improving Lives" aligns to the 5-year strategy of the ICS. Year 3 plans for the Trust's strategy for 2026/27 will be updated to include neighbourhood working.	
4	Strategic alignment	Fully engage with ICB on development of strategic plans and underpinning strategies.	CE	DSP	31/03/2026	As noted above, the Trust's Strategy is aligned to that of the ICS. We are a part of the ICS strategic approach to population health. All our supporting Strategies align to the ICS Strategy – Clinical Services, Partnerships, Finance, People Plan and Quality. The ICB were participants at our November 2025 Board Development Workshop with positive feedback received.	Partnerships
5	Collaborate and co-develop	Work jointly with partners (system and wider) to co-develop and deliver plans and strategies which support the delivery of agreed long term plans.	CE	DSP	31/03/2026	The Nottinghamshire Directors of Strategy Group meets to review and avoid duplication of plans in order to maximise resources and achieve outcomes. The EMAP Network works on shared plans. The Trust is integral to the PBP.	Partnerships
6	Governance	Use the Partnerships and Communities Committee to monitor actions and ensure strategic alignment.	CE	DSP	31/03/2026	A specific duty of the Partnerships and Communities Committee is to "Receive and assess key updates from Strategic forums in the System and provide assurance to the Board that the Trust is championing those aspects of its overall strategy that are	Partnerships

No.	Area of Development	Action	Action Lead	Task Lead(s)	Due Date	Progress Update	Committee sign off
						<p>executed through strategic partnerships.” The partnership landscape is rapidly changing across the health and care sector, the committee ensures a regular agenda item on the state and pace of change, and impact/risks for the Trust. This action plan is updated and approved via the committee.</p>	

## Actions – Freedom to Speak Up

No.	Area of Development	Action	Action Owner	Task Lead	Due Date	Progress Update	Committee sign off
1	Governance route	Review and streamline the governance route to Board for FTSU ensuring accountability at Committee level is clear.	DoCA	DoCA	30/06/2025	Following a thorough review a schedule of quarterly reporting has been agreed and implemented that sees FTSU reports presented to the People Committee and the SFH Board on an alternate cycle each quarter with reports to People Committee in January and July and to the Board in April and October.	People 29/07/2025
2	Governance route	Create time and space for discussion of FTSU concerns e.g. FTSU sub-cabinet.	DoCA	DoCA	31/08/2025	The Executive Lead and FTSUG meet fortnightly to discuss concern themes and support as required. Outstanding concerns are passed to the FTSU Operational catch-up Meetings, attended by the Chief People Officer, the Director of Corporate Affairs and the FTSUG, for discussion. The FTSUG has established regular Divisional catch ups with Divisional Triumvirates in the Women's & Children's, Surgery, U&EC and Medicine Divisions to create space and ownership of FTSU themes and current concerns. The outputs from	People 29/07/2025 Executive 18/03/2026

No.	Area of Development	Action	Action Owner	Task Lead	Due Date	Progress Update	Committee sign off
						these meetings are reported up to the People Committee and Board in the FTSUG's reports that are presented to those forums on the agreed alternating 3-monthly cycle.	
3	Governance route	Divisional leads to sit on this sub-cabinet (along with Executive Lead) to secure buy in from divisions which is currently variable. Consider whether the Executive Lead should be within the triumvirate to strengthen engagement across the divisions.	DoCA	DoCA	30/06/2025	An alternative approach to convening a FTSU Sub Cabinet has been agreed. Instead, a FTSU Operational catch-up meeting has been established that had its inaugural meeting on 25/06/25 and is developing its membership and purpose with reviewing outstanding FTSU cases and support for resolution its current focus.	People 29/07/2025
4	Governance route	Consider implementing a tenure for the FTSU Guardian and Champion role, with an option to extend if both parties agree.	DoCA	DoCA	31/05/2025	This recommendation is not practical, affordable or appropriate in the context that the FTSUG is a substantive member of staff with long service, the growth in FTSU referrals and the cost & quality implications of buying in an external service (that would not include pro-active support and services) which is the only current alternative option as neither NUH nor NH is currently willing and able to support a shared service.	People 29/07/2025
5	Responsiveness	Review concerns raised to understand trends and activity and use this intelligence to redesign	DoCA	DoCA	30/09/2025	Collaborative work with NHIS enabled the development and launch of a new FTSU database platform that went live in September 2025 to replace the	People 29/07/2025 Executive 18/03/2026

No.	Area of Development	Action	Action Owner	Task Lead	Due Date	Progress Update	Committee sign off
		and promote pathways supported by clear support for managers to enable resolution.				previous Excel spreadsheet. The FTSU has retrospectively populated the FTSU database with all the information on cases opened in Q1 & Q2 2025/26 so that the full year's reporting is available to provide information to support managers and enhance reporting of trends, themes and activity and enable presentation of bespoke reports, as required. The introduction of the FTSU Process & Timescale Guidance (in September 2025) is supporting managers in their handling of concerns and sharing learning.	
6	Responsiveness	Develop a communications plan – to include promotion of FTSU, sharing of success stories, and also promote other existing routes.	DoCA	DoCA	30/09/2025	A FTSU Communications document for 2025/26 has been prepared by the FTSUG. Progress against it will be monitored, including feedback from the Chief People Officer, at the regular operational catch-up meetings with the FTSUG and DoCA.	People 29/07/2025 Executive 18/03/2026
7	Responsiveness	Establish a triage system to determine how concerns of varying natures will be dealt with, including expected response and resolution timeframes. This should be communicated to staff so there is a mutual understanding.	DoCA	DoCA	30/09/2025	The FTSU Process and Timescale Guidance was approved by the JSPF in May 2025. Its roll out was cascaded through TMT and Divisional communications, with support from the FTSU Champions and went live in September 2025. It is being utilised when FTSU escalations are required. We agreed to review the operation of the Guidance after 6 months in operation. Feedback has been sought	People 29/07/2025 Executive 18/03/2026

No.	Area of Development	Action	Action Owner	Task Lead	Due Date	Progress Update	Committee sign off
						from TMT generally and specifically on 1) whether it should be separated into two parts, one for concern raisers and the other for line managers, and 2) on whether the timescales should be aligned to the Grievance Policy and 3) Triage of what NGO category concerns fall into, to assist with their prioritisation. In March 2025, following the 6 monthly review of the above guidance and acting on feedback on the use of the guidance, the guidance has now been separated into two documents – one for staff and one for managers. This will help identify roles and responsibilities clearer and make clear expectations of the FTSU pathway for all. It was agreed that the timelines should not be aligned to ER Grievance policy .These guidance documents are currently being approved via the JSPF pathway.	
8	Responsiveness	Identify training requirements for managers and determine frequency to empower and support managers to resolve concerns.	DoCA	DoCA	30/09/2025	Training requirements are an integral part of the FTSU Operational Group meeting’s discussions building on the learning from the way in which cases are handled and how this can be improved. The Chief People Officer’s perspective is key to the Operational catch-up meetings and will influence the manner and pace at which training can be shaped and delivered in collaboration with the FTSUG.	People 29/07/2025 Executive 18/03/2026

No.	Area of Development	Action	Action Owner	Task Lead	Due Date	Progress Update	Committee sign off																
						<p>The FTSUG has submitted a request to the Mandatory and Statutory Learning Group for FTSU training to be mandated for line managers as currently there isn't a mandatory training plan for leaders who handle concerns. Meanwhile, via the Trust's e-learning platform, Sherwood e-academy, there is direct access to e-learning for health (elfh), which provides three FTSU training packages: Speak-up, Listen-up and Follow-up. As of 1<sup>st</sup> March 2026, the following training, that started in December 2025, had been completed:</p> <table border="1"> <thead> <tr> <th></th> <th>Speak Up:</th> <th>Listen Up:</th> <th>Follow Up:</th> </tr> </thead> <tbody> <tr> <td>Dec-25</td> <td>149</td> <td>25</td> <td>16</td> </tr> <tr> <td>Jan-26</td> <td>175</td> <td>124</td> <td>73</td> </tr> <tr> <td>Feb-26</td> <td>204</td> <td>147</td> <td>86</td> </tr> </tbody> </table> <p>By 31<sup>st</sup> December 2025, all Band 7 staff, Matrons, Divisional Directors of Nursing, Divisional General Managers and non-operational teams had been sent the links for the three e-learning packages, that they were asked to disseminate through their teams to all line managers. The resulting increase in uptake is noted in the table. The Executive and Deputy Directors were also sent the links to complete their</p>		Speak Up:	Listen Up:	Follow Up:	Dec-25	149	25	16	Jan-26	175	124	73	Feb-26	204	147	86	
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No.	Area of Development	Action	Action Owner	Task Lead	Due Date	Progress Update	Committee sign off
						training, in line with the recommendations.	
9	Support	Ensure appropriate training is provided to managers to ensure they are supported in listening to and resolving concerns raised.	DoCA	CPO	30/09/2025	The three online courses - Speak-up, Listen-up and Follow-up – is available to all line managers via the Sherwood e-academy. The Director Of Corporate Nursing is managing the communications to trust leadership teams regarding need to complete and the compliance is being monitored monthly as seen above. The DoCA and FTSUG have completed them with the plan that all Executives and TMT members will follow suit.	People 29/07/2025 Executive 18/03/2026
10	Support	Divisional buy-in/engagement through FTSU sub-cabinet – this will provide opportunity to close feedback loops, identify trends and share learning more widely.	DoCA	DoCA	30/06/2025	The FTSU sub-cabinet was progressed through People Committee, but TMT agreed an alternative approach being taken (see 3 above).	People 29/07/2025
11	Support	Consider how to make best use of FTSU Champions – e.g. signpost, triage, cover/alternative point of contact for FTSUG.	DoCA	FTSUG	30/09/2025	We aim to maintain a network of around 25 FTSU Champions. Five new Champions were trained in October and November 2025 to maintain that number of FTSU Champions. Champions are encouraged and recruited from services where clinical pressure is consistently high – e.g. ED, medical workforce and Maternity. This helps promote speaking up visibility and	People 29/07/2025 Executive 18/03/2026

No.	Area of Development	Action	Action Owner	Task Lead	Due Date	Progress Update	Committee sign off
						<p>to signpost workers to appropriate routes. Champions and the FTSUG have forums at 6 weekly intervals that enable the FTSUG to pick up soft intelligence and proactively engage with those leaders / teams. FTSU Champions are informed when the FTSUG is taking annual leave and are briefed appropriately so they can support signposting during absences.</p>	

**Board of Directors Meeting in Public - Cover Sheet**

<b>Subject:</b>	Annual Reflection Report - Documents Sealed and Signed (1 <sup>st</sup> April 2025 – 31 <sup>st</sup> March 2026)		<b>Date:</b>	2 <sup>nd</sup> April 2026	
<b>Prepared By:</b>	Clare Jones, Corporate PA				
<b>Approved By:</b>	Sally Brook Shanahan, Director of Corporate Affairs				
<b>Presented By:</b>	Sally Brook Shanahan, Director of Corporate Affairs				
<b>Purpose</b>					
This report serves to provide the Board with a comprehensive overview of the Trust's use of the Official Seal, ensuring transparency and accountability in its application.				<b>Approval</b>	
				<b>Assurance</b>	<b>X</b>
				<b>Update</b>	
				<b>Consider</b>	
<b>Strategic Objectives</b>					
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 estates	Work collaboratively with partners in the community
<b>Principal Risk</b>					
<b>PR1</b> Significant deterioration in standards of safety and care					
<b>PR2</b> Demand that overwhelms capacity					
<b>PR3</b> Critical shortage of workforce capacity and capability					
<b>PR4</b> Insufficient financial resources available to support the delivery of services					
<b>PR5</b> Inability to initiate and implement evidence-based Improvement and innovation					
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<b>PR7</b> Major disruptive incident					
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<b>Committees/groups where this item has been presented before</b>					
N/A					
<b>Acronyms</b>					
None					
<b>Executive Summary</b>					
This annual reflection report provides an overview of the documents sealed and signed by the Board during the period 1 <sup>st</sup> April 2025 – 31 <sup>st</sup> March 2026. In accordance with Standing Order 10 and the delegated authority in the Scheme of Delegation, the Sherwood Forest Hospitals (NHS) Foundation Trust Official Seal has been affixed to the following documents during the 2025/2026 financial year:					
<b><u>Seal number 121</u></b>					
<b>Between:</b> Sherwood Forest Hospitals NHS Trust (Trust), Central Nottinghamshire Hospitals PLC (Project Co) and AECOM Limited (External Consultant)					

**Details of the contract:**

Letter of Appointment of Electrical Consultant (relating to electrical compliance requirements at KMH, MCH and Newark) signed by the Chief Financial Officer and Director of Corporate Affairs on Friday 13<sup>th</sup> June 2025.

The Board is asked to NOTE the use of the Trust Seal.

**Board of Directors Meeting in Public - Cover Sheet**

<b>Subject:</b>	Provider Licence Self Certification declaration		<b>Date:</b>	2 <sup>nd</sup> April 2026	
<b>Prepared By:</b>	Sally Brook Shanahan, Director of Corporate Affairs				
<b>Approved By:</b>	Richard Mills, Chief Financial Officer				
<b>Presented By:</b>	Sally Brook Shanahan, Director of Corporate Affairs				
<b>Purpose</b>					
The Board is asked to approve the self-certification against provider licence condition CoS7 (Continuity of Services condition – Availability of Resources) for signature by the Chair and Chief Executive and to note the requirement for its publication on the Trust website.			<b>Approval</b>	<b>X</b>	
			<b>Assurance</b>		
			<b>Update</b>		
			<b>Consider</b>		
<b>Strategic Objectives</b>					
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 estates	Work collaboratively with partners in the community
<b>X</b>					
<b>Principal Risk</b>					
<b>PR1</b>	Significant deterioration in standards of safety and care				<b>X</b>
<b>PR2</b>	Demand that overwhelms capacity				
<b>PR3</b>	Critical shortage of workforce capacity and capability				
<b>PR4</b>	Insufficient financial resources available to support the delivery of services				
<b>PR5</b>	Inability to initiate and implement evidence-based Improvement and innovation				
<b>PR6</b>	Working more closely with local health and care partners does not fully deliver the required benefits				
<b>PR7</b>	Major disruptive incident				
<b>PR8</b>	Failure to deliver sustainable reductions in the Trust's impact on climate change				
<b>Committees/groups where this item has been presented before</b>					
N/A					
<b>Acronyms</b>					
NHSE – National Health Service England CoS – Continuity of Service					
<b>Executive Summary</b>					
<p>The Trust holds a provider licence which forms part of NHS England's (NHSE) oversight arrangements for NHS providers. As part of the April 2023 updates described in last year's paper to the Board on this subject, the requirement for licensees to self-certify against a number of specific licence conditions and the requirement to prepare a Corporate Governance Statement were removed. The resulting new licence continues to retain the requirement for NHS Foundation Trusts to self-certify against condition CoS7 (Availability of Resources).</p> <p>The Board is expected to make a self-certification, not later than two months from the end of the financial year (i.e.by the end of May), as to the availability of the Required Resources for the period of 12 months commencing on the date of the certificate. Following the agreed change to schedule public Board meetings bi-monthly with effect from June 2025, this item was re-allocated</p>					

on the Board workplan to annually in April in order to meet the May deadline for certification.

The form of this certification (at Appendix 1) must be one of the three options - (a), (b) or (c) – specified under CoS7 and set out in the declaration that comprises the attachment to this paper. In making its certificate the Board is required to describe the main factors it has considered.

It is recommended that statement (a) be made that states:

- (a) After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.

From feedback provided in relation to the external audit progress to the Audit and Assurance Committee at its meeting on 17<sup>th</sup> March 2026, set out in the extract from the draft minutes, below, this is expected to align with the conclusions from the going concern assessment process that forms part of the compilation of the Trust's 2025/26 Accounts about which a further update will be presented to the Audit Committee on 16<sup>th</sup> April 2026.

<b>26/042</b>	<b>GOING CONCERN ASSESSMENT</b>
<b>Length of Discussion 1 minute</b>	RM introduced the draft Going Concern Assessment to the Committee emphasising the key wording: the trust had a reasonable expectation that services would remain provided by the public sector for the foreseeable future.  The Committee were ASSURED by the report.

When agreed, the Trust is required to publish its self-certification, signed by the Chair and Chief Executive, on its website and retain copies for record keeping purposes, noting there is no longer a requirement to submit them to NHSE.

## **RECOMMENDATION**

That the Board **APPROVES** the self-certification against provider licence condition CoS7 (Continuity of Services condition – Availability of Resources) at Appendix 1 to this paper for signature by the Chair and Chief Executive.

This template may be used by Foundation trusts and NHS trusts to record the self-certifications that must be made under their NHS Provider Licence.  
You do not need to return your completed template to NHS Improvement unless it is requested for audit purposes.

## **Self-Certification Template - Conditions CoS7**

*Insert name of organisation*



Foundation Trusts and NHS trusts are required to make the following self-certifications to NHS Improvement:

*Availability of resources and accompanying statement - in accordance with Continuity of Services condition 7 of the NHS provider licence (designated CRS providers only)*

These self-certifications are set out in this template.

### **How to use this template**

- 1) Save this file to your Local Network or Computer.
- 2) Enter responses and information into the yellow data-entry cells as appropriate.
- 3) Once the data has been entered, add signatures to the document.

**Declarations required by Continuity of Service condition 7 of the NHS provider licence**

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

**1 Continuity of services condition 7 - Availability of Resources (designated CRS only)**

**EITHER:**

1a After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.

Confirmed

Please fill details in cell E22

**OR**

1b After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.

Please Respond

**OR**

1c In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.

Please Respond

**Statement of main factors taken into account in making the above declaration**

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

Going Concern Statement within the draft Accounts with the statement for 2025/26 reviewed by the Audit Committee on 17 April 2025 and scheduled for approval on 16 April 2026.  
 Operational and Financial Plan 2026/27 - 2028/29 approved and submitted in line with NHSE timescale requirements on 12 February 2026  
 Financial Forecast Outturn 2025/26 Enhanced financial management oversight including via Finance Recovery Cabinet and Vacancy Control Panel  
 Corporate Optimisation process, including completion of efficiency trackers  
 Annual Governance Statement 2024/25  
 Board Committee Terms of Reference and Workplans  
 Board Assurance and Governance Frameworks Risk  
 Management processes Internal Audit Plans and reports 2025/26 and 2026/26 including on Strengthening Financial Management. NHS Oversight Framework  
 and Segmentation Capital Resource Oversight Group  
 External Well Led Reviews 2021 and 2024/25

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature

Signature

Name: Graham Ward

Name: Jon Melbourne

Capacity: Chair

Capacity: Chief Executive

Date:

Date:

Further explanatory information should be provided below where the Board has been unable to confirm declarations.

Trust Board of Directors - Cover Sheet

<b>Subject:</b>	Declaration of Interests Progress Report		<b>Date:</b>	2 <sup>nd</sup> April 2026	
<b>Prepared By:</b>	Clare Jones, Corporate PA				
<b>Approved By:</b>	Sally Brook Shanahan, Director of Corporate Affairs				
<b>Presented By:</b>	Sally Brook Shanahan, Director of Corporate Affairs				
<b>Purpose</b>					
To provide an annual summary of the status of the Trust's Register of Interests and to seek approval for its publication on the Trust's website.				<b>Approval</b>	<b>X</b>
				<b>Assurance</b>	
				<b>Update</b>	
				<b>Consider</b>	
<b>Strategic Objectives</b>					
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 estates	Work collaboratively with partners in the community
<b>X</b>					
<b>Principal Risk</b>					
<b>PR1</b>	Significant deterioration in standards of safety and care				<b>X</b>
<b>PR2</b>	Demand that overwhelms capacity				
<b>PR3</b>	Critical shortage of workforce capacity and capability				
<b>PR4</b>	Insufficient financial resources available to support the delivery of services				
<b>PR5</b>	Inability to initiate and implement evidence-based Improvement and innovation				
<b>PR6</b>	Working more closely with local health and care partners does not fully deliver the required benefits				
<b>PR7</b>	Major disruptive incident				
<b>PR8</b>	Failure to deliver sustainable reductions in the Trust's impact on climate change				
<b>Committees/groups where this item has been presented before</b>					
Audit and Assurance Committee – 17 <sup>th</sup> March 2026					
<b>Acronyms</b>					
<b>ESR</b> – Electronic Staff Record <b>AAC</b> – Audit and Assurance Committee <b>SFHFT</b> – Sherwood Forest Hospitals NHS Foundation Trust <b>TMT</b> – Trust Management Team					
<b>Executive Summary</b>					
<p>All staff are required to submit an annual declaration of interest if they have an actual or potential conflict. This must be made upon appointment with the Trust and renewed annually on 1<sup>st</sup> April or at any other time when a conflict or potential conflict arises during their employment. Staff who are Band 7 or above, currently 1260 individuals, who do not have interests to declare are required to submit a nil declaration when they have no interests to declare.</p> <p>As of 10<sup>th</sup> March 2026, <b>17 employees</b> within the Trust who are band 7+ remain non-compliant; this is a slight increase from <b>15 employees</b> who were non-compliant in March 2025. Of these employees, <b>3</b> are currently on maternity leave and <b>none</b> are recorded as being off sick for over 90 days which are potential reasons for non-compliance.</p> <p>New starters have been contacted to ask that they complete their declaration of interests. Emails targeting non-compliant staff members at band 7 and above continue to be sent weekly.</p>					

Recipients' line managers are automatically copied-in which provides an avenue for additional support to ensure compliance particularly in the context of performance review meetings. Improving compliance was raised at TMT and Divisions have been proactive in reinforcing the absolute requirement for Band 7+ staff to make a nil return/declare if they have interests which has contributed to the significant improvement in Band 7+ compliance.

In addition, the Director of Corporate Affairs continues to send individual targeted messages to post holders (other than Consultants) and is engaged with the Chief Medical Officer to ensure that Consultants, who are amongst the residual non-compliant staff number, receive personal reminders.

Overall, the Corporate Secretariat team is driving compliance with disclosure requirements by using a bespoke approach to the remaining non-compliant staff and maximising the benefits of automated reminders and Divisional engagement.

The table below shows the improvement in the reduction of non-compliance calculated at the end of March each year:

2022/23	<b>96 employees</b>
2023/24	<b>51 employees</b>
2024/25	<b>15 employees</b>
2025/26	<b>17 employees</b>

Work in the new reporting year 2026/27 will, at the suggestion of the AAC, focus on the selection of a sample of staff at Band 7+ to verify, using publicly available information including the Companies House and private hospital websites, that their disclosures are accurate. The Director of Corporate Affairs is working with the Counter Fraud Team of the Trust's Internal Auditors to select the roles/individuals and report on the findings to the AAC with the overall objective to build on the improvements to date.

The documents associated with this report are attached.

The Board of Directors is asked to **approve** publication of this report and note the steps being taken and planned to further enhance compliance and accuracy of disclosures made.

### Data as of 10<sup>th</sup> March 2026



### Recent Actions Undertaken

- Automated reminder emails have been issued to all non-compliant Band 7 and above colleagues. These communications now include their line managers in copy, reinforcing accountability and enabling local support to encourage timely completion.
- An information slide has been incorporated into the Trust's Orientation Day presentation to ensure that new starters are made aware of their obligations from the outset.

- Divisional triumvirates have been contacted to support in ensuring that non-compliant colleagues within their departments are followed up and reminded to complete their declaration.

### Declaration Compliance Report by Division

Division	Active Staff	Declared	Nil Returns	Non-compliant Staff	Staff Compliance (%)
214 Clinical Support, Therapies and Outpatients - L2	252	40	208	4	98.4%
214 Corporate - L2	219	24	194	1	99.5%
214 Medicine Division - L2	224	25	197	2	99.1%
214 NHIS - L2	45	2	42	1	97.8%
214 Surgery Division - L2	246	54	189	3	98.8%
214 Urgent & Emergency Care Division - L2	132	6	121	5	96.2%
214 Women & Childrens Division - L2	129	15	111	3	97.7%

### Declaration Compliance Report by Staff Group

Division	Active Staff	Declared	Nil Returns	Non-compliant Staff	Staff Compliance (%)
Add Prof Scientific and Technic	47	7	39	1	97.9%
Administrative and Clerical	220	17	202	1	99.5%
Allied Health Professionals	122	21	100	1	99.2%
Healthcare Scientists	63	9	53	1	98.4%
Medical and Dental	418	91	317	10	97.6%
Nursing and Midwifery Registered	392	23	364	5	98.7%

Finance Committee Chair’s Highlight Report to Board of Directors

<b>Subject:</b>	Finance Committee (“FC”) Meeting	<b>Date:</b>	24/02/2026
<b>Prepared By:</b>	Marie McAllister, Corporate PA		
<b>Approved By:</b>	Richard Mills, Chief Financial Officer		
<b>Presented By:</b>	Richard Cotton, Finance Committee Chair		
<b>Purpose:</b>	To provide an overview of the key discussion items from the Finance Committee (deep dive) meeting of 24 <sup>th</sup> February 2026.		

Matters of Concern or Key Risks Escalated for Noting / Action	Major Actions Commissioned / Work Underway
<p><b>Financial Outturn 2025/26:</b></p> <ul style="list-style-type: none"> <li>The Committee noted the forecast year-end deficit position (including deficit support) and the associated correspondence submitted to NHS England. This represents the downside scenario previously reported. The anticipated response from NHS England is expected to be challenging, with a strong focus on delivery assurance and productivity improvement.</li> </ul> <p><b>Workforce Cost and Productivity Risk:</b></p> <ul style="list-style-type: none"> <li>Workforce remains a significant cost pressure. While improvements have been made in agency expenditure, overall productivity metrics and workforce growth since 2019/20 remain areas of concern.</li> </ul> <p><b>Sterile Services Department (CSSD) Resilience:</b></p> <ul style="list-style-type: none"> <li>The current CSSD (sterile services) facility presents a critical operational and patient safety risk, with increasing equipment failures and a history of associated procedure cancellations. The risk is rated high on the Trust risk register and represents a material threat to elective and emergency care continuity.</li> </ul> <p><b>Digital and Contractual Risks:</b></p> <ul style="list-style-type: none"> <li><b>Patients Know Best (PKB):</b> Indexation (RPI) was not fully reflected in the original business case, resulting in the contract value exceeding previous approval thresholds.</li> <li><b>Ledger Replacement (SBS):</b> Delay to go-live presents ongoing system resilience risk given the age of the current ledger.</li> </ul>	<p><b>Financial Recovery Programme:</b></p> <ul style="list-style-type: none"> <li>The Financial Recovery Cabinet (chaired by the Chief Executive) driving current-year controls and shaping medium-term transformation schemes. Divisions re-engaged to accelerate development of 2026/27 efficiency plans - particular emphasis on pathway redesign and outpatient productivity.</li> </ul> <p><b>Elective Sprint (Q4):</b></p> <ul style="list-style-type: none"> <li>A programme has been mobilised to deliver additional outpatient activity above plan, supporting RTT performance and generating marginal income. Weekly tracking and national reporting are in place, with early delivery challenges being actively managed.</li> </ul> <p><b>Digital Transformation:</b></p> <ul style="list-style-type: none"> <li><b>Ambient Voice Technology:</b> Approval for contract award to replace the current digital dictation solution, enabling productivity gains, improved turnaround times, and patient service / safety benefits.</li> <li><b>NHIS / Sherwood Digital Services Expansion:</b> Strategic support to develop full business case to expand hosted digital services into Derbyshire, s/t due diligence, cost neutrality, workforce risk mgt.</li> </ul> <p><b>CSSD Mitigation:</b></p> <ul style="list-style-type: none"> <li>Approval supported for progression of a mobile CSSD (sterile services) solution as an interim mitigation, providing resilience while longer-term system or on-site solutions are developed.</li> </ul> <p><b>Ledger Replacement (SBS):</b></p> <ul style="list-style-type: none"> <li>Engagement with SBS continues. July or October go-live being assessed, balancing delivery risk with benefits of early adoption / enhanced supplier support.</li> </ul>

<b>Positive Assurances to Provide</b>	<b>Decisions Made (include BAF review outcomes)</b>
<ul style="list-style-type: none"> <li>• Strong and visible executive leadership through the Financial Recovery Cabinet, with clear governance and escalation.</li> <li>• Robust scrutiny and challenge of business cases, including explicit learning applied to future contract approvals (e.g. indexation, extensions, VAT).</li> <li>• High levels of clinical engagement in digital transformation programmes, particularly AVT and outpatient pathway redesign.</li> <li>• Active engagement with system partners (ICB, NHS England, neighbouring providers) on capital, digital, service sustainability risks.</li> </ul>	<ul style="list-style-type: none"> <li>• Contract award for Ambient Voice Technology (subject to Board ratification).</li> <li>• Strategic approval to develop the NHIS / Sherwood Digital Services expansion business case.</li> <li>• Progression of the CSSD mobile (sterile services) mitigation solution.</li> </ul> <p><b>Noted:</b></p> <ul style="list-style-type: none"> <li>• Financial outturn position and NHS England correspondence.</li> <li>• PKB contract value increase due to RPI indexation and corrective actions for future cases.</li> <li>• Elective Sprint delivery approach and monitoring arrangements.</li> </ul>
<b>Comments on effectiveness of the meeting</b>	
<p>The Committee was effective in providing robust challenge while maintaining pace on critical decisions. Deep dive discussions enabled balanced consideration of risk, affordability, and strategic opportunity. Clear linkage was maintained between operational delivery, financial recovery, and longer-term transformation.</p>	
<b>Items recommended for consideration by other Committees</b>	
<p><b>Board of Directors:</b></p> <ul style="list-style-type: none"> <li>• Approval of AVT contract award.</li> <li>• Approval of CSSD mitigation business case.</li> <li>• Review of financial outturn correspondence and implications.</li> </ul> <p><b>Audit Committee:</b></p> <ul style="list-style-type: none"> <li>• Oversight of single tender actions and waivers.</li> <li>• Assurance over SBS ledger implementation and control environment.</li> </ul> <p><b>People / Workforce Committees:</b></p> <ul style="list-style-type: none"> <li>• Alignment of workforce productivity, transformation plans, and engagement approach.</li> </ul>	
<b>Progress with Actions</b>	
<p>Number of actions considered at the meeting – 9  Number of actions closed at the meeting – 9  Number of actions carried forward – 8 actions not yet due.  Any concerns with progress of actions – No</p>	

**Note: this report does not require a cover sheet due to sufficient information provided.**

**Finance Committee Chair’s Highlight Report to Board of Directors**

<b>Subject:</b>	Finance Committee (“FC”) Meeting	<b>Date:</b>	02/04/2026
<b>Prepared By:</b>	Marie McAllister, Corporate PA		
<b>Approved By:</b>	Richard Mills, Chief Financial Officer		
<b>Presented By:</b>	Andrew Rose Britton, Finance Committee Chair		
<b>Purpose:</b>	To provide an overview of the key discussion items, risks, assurances, decisions and actions from the Finance Committee (core) meeting held on 31 March 2026, for the Board of Directors and other relevant committees.		

Matters of Concern or Key Risks Escalated for Noting / Action	Major Actions Commissioned / Work Underway
<ul style="list-style-type: none"> <li>• Business case recommendations (see Decisions Made).</li> <li>• Challenging discussion on proposed contract awards, due to timeliness of requests and the balance of financial opportunity, supplier resilience and clinical preference.</li> <li>• 2025/26 financial forecast variance to plan (as previously notified to NHSE).</li> <li>• 2025/26 efficiency shortfall; savings of £33.8m expected against £45.8m plan, i.e. a shortfall of £12.0m.</li> <li>• For 2026–27 the efficiency requirement of 6.1% is highly challenging.</li> <li>• 2026/27 plan demonstrates a need to deliver on cash-releasing efficiency schemes early in the financial year, as cash limits are close to thresholds between June and October.</li> <li>• BAF PR4 (Financial Resources) and PR8 (Climate Change) remain above tolerable levels.</li> <li>• For 2026–27 the efficiency requirement of 6.1% is highly challenging.</li> </ul>	<ul style="list-style-type: none"> <li>• Expansion to Finance &amp; Performance Committee to commence from Apr-27, with additional clinical representation and oversight of operational performance.</li> <li>• Ongoing triangulation between finance, activity and workforce plans.</li> <li>• Further assurance on the balance between clinical preference, supplier resilience and financial opportunity associated with the proposed Cardiology Pacing contract.</li> <li>• Annual review to be undertaken on the 2025/26 financial position following year-end closedown.</li> <li>• Financial ledger implementation programme ongoing.</li> <li>• Further development of the 2026/27 efficiency programme, noting the aim to reach 75% fully developed by the end of March 2026.</li> <li>• 2026/27 Contract with ICBs to be finalised and signed.</li> <li>• Quality implications of Capital Expenditure Plan to be reviewed and reported to Quality Committee.</li> </ul>
Positive Assurances to Provide	Decisions Made <i>(include BAF review outcomes)</i>
<ul style="list-style-type: none"> <li>• Understanding of Martyn’s Law requirements and proactive approach to preparedness.</li> <li>• Improvement actions underway following debrief of Business Continuity and Critical Incidents.</li> <li>• Contract Forward View in place to identify upcoming decisions.</li> <li>• Although short of the target, the forecast efficiency delivery is just under 6.0% for 2025/26.</li> </ul>	<p>Items approved within Finance Committee delegated authority:</p> <ul style="list-style-type: none"> <li>• N/A</li> </ul> <p>Items recommended for approval within Board delegated authority:</p> <ul style="list-style-type: none"> <li>• Nottinghamshire Health Informatics business case</li> <li>• ME2 Pathology Contract</li> <li>• Cardiology Pacing Contract</li> </ul>

- Presented cases demonstrate opportunities to deliver additional financial savings.
- 6.0% year-on-year productivity improvement to Nov-25 by NHSE measures, including a real-terms cost reduction of 3.1%.
- Financial ledger implementation on track for 'go-live' in October 2026.
- Financial Recovery Cabinet (FRC) and Capital Resources Oversight Group (CROG) highlight reports demonstrate robust discussions on relevant issues.
- Provider Board Capabilities Self-Assessment (Nov-25 submission) considered and scores deemed relevant.
- Cross-Committee information sharing evident through circulation of People Committee AfC Uplift paper and relevant internal audit reports.
- 2026/27 Plan Resubmission exercise completed, with additional cash-backed funding allocations identified to improve the planned financial position.
- Additional capital has been secured to enable the progression of works to address some long-standing infrastructure risks.

- Trauma & Orthopaedics Contract
- IT Hardware Recycling Contract

Business items approved:

- 2026/27 Capital Expenditure Plan
- Committee Annual Report
- Committee Governance Health Check
- Committee Terms of Reference
- Committee Work Programme
- Committee Maturity Assessment Action Plan (follow up)

BAF PR4 (Financial Resources) remains at a score of 20 (Significant) and PR8 (Climate Change) remains at a score of 12 (High).

### Comments on effectiveness of the meeting

- Members considered the meeting effective, with good attendance and constructive challenge from both executive and non-executive members.
- The Committee was able to interrogate complex business cases (digital services, pathology, procurement contracts) and request appropriate additional assurance before Board decisions.
- Data and papers were generally of good quality, although members requested that future procurement reports include clearer clinical rationale and quantified comparison of options to support value for money judgements.
- The alignment between the work plan, financial performance reporting and planning papers was noted as positive, with a further ask to ensure consistent workforce data across committees.

### Items recommended for consideration by other Committees

#### People Committee

- Workforce reporting triangulation, particularly WTE movements and workforce assumptions underpinning the financial plan.
- Staff implications of digital services expansion (TUPE, recruitment and retention).

#### Quality Committee

- Review of 2026/27 capital programme, including schemes not prioritised, with explicit linkage to quality and safety risks.

### **Progress with Actions**

Number of actions considered at the meeting – 6

Number of actions closed at the meeting – 5

Number of actions carried forward – 3 actions not yet due.

Any concerns with progress of actions – No

***Note: this report does not require a cover sheet due to sufficient information provided.***

**Quality Chair’s Highlight Report to the Trust Board of Directors**

<b>Subject:</b>	Quality Committee	<b>Date</b>	<b>Monday 23<sup>rd</sup> February 2026</b>
<b>Prepared By:</b>	Esther Smith, PA to Deputy Chief Nurse & Director of Nursing Quality & Governance		
<b>Approved By:</b>	Lisa Maclean, Non-Executive Director/Committee Chair		
<b>Presented By:</b>	Lisa Maclean, Non-Executive Director		
<b>Purpose:</b>	Assurance report to the Trust Board of Directors following the Quality Committee Meeting		

<b>Matters of Concern or Key Risks Escalated for Noting / Action</b>	<b>Major Actions Commissioned / Work Underway</b>
<ul style="list-style-type: none"> <li>- Sustained flow and capacity issues, primarily drive by bed availability and discharge delays.</li> <li>- System level discharge delays linked to availability of social care packages with local performance lagging.</li> <li>- Rising ambulance arrivals from outside the Trusts core geography</li> <li>- Mortuary estate and infrastructure risks.</li> <li>- Maternity Voices Partnership funding uncertain, with potential impact on patient voice and co-production.</li> <li>- Noted actions underway in relation to overuse of Lorazepam, particularly in patients with a Dementia diagnosis.</li> </ul>	<ul style="list-style-type: none"> <li>- Emergency Care Steering Group overseeing delivery of actions from the UEC external review, including frailty model review, discharge processes and specialty configuration.</li> <li>- System Analytical Intelligence Unit undertaking detailed analysis of ambulance demand, geography and demographic drivers.</li> <li>- Capital business case progressing for mortuary infrastructure replacement through Trust governance.</li> <li>- Continued rollout of protected mealtimes, volunteer support and nutrition improvement initiatives.</li> <li>- External diagnostic review of Improvement Faculty nearing completion; recruitment underway for Director of Improvement.</li> </ul>

<b>Positive Assurances to Provide</b>	<b>Decisions Made (include BAF review outcomes)</b>
<ul style="list-style-type: none"> <li>- HTA inspection actions substantially closed with remaining actions focusses on security and estates</li> <li>- Improvement in four-hour ED performance compared with the same period in 2025.</li> <li>- Positive feedback with regard to mealtime volunteers and protected mealtimes and nutritional care,</li> <li>- Positive assurance taken from the IPC annual report.</li> <li>- Positive assurance taken from the PSC, NMAHP and PAC</li> </ul>	<ul style="list-style-type: none"> <li>- APPROVAL of the Quality Committee Annual Report.</li> <li>- Approved suggestion of the inclusion of the Director of Improvement in the membership of the QC once recruited.</li> </ul>

reports.

- Positive assurance taken from the Dementia Update.
- Positive assurance taken from the discussion around GIRFT.
- Positive assurance taken from actions underway following the 360 Assurance audit into Learning from Deaths.

#### **Comments on effectiveness of the meeting**

It was agreed the Committee demonstrated strong, open and constructive challenge. Papers were of high quality, and discussions were robust, transparent and focused on system-level solutions and patient safety.

#### **Items recommended for consideration by other Committees**

None

#### **Progress with Actions**

Number of actions considered at the meeting – 0

Number of actions closed at the meeting – 0

Number of actions carried forward - 0

Any concerns with progress of actions – **No**

If Yes, please describe –

**Quality Chair's Highlight Report to the Trust Board of Directors**

<b>Subject:</b>	Quality Committee	<b>Date</b>	<b>Monday 23<sup>rd</sup> March 2026</b>
<b>Prepared By:</b>	Esther Smith, PA to Deputy Chief Nurse & Director of Nursing Quality & Governance		
<b>Approved By:</b>	Lisa Maclean, Non-Executive Director/Committee Chair		
<b>Presented By:</b>	Lisa Maclean, Non-Executive Director		
<b>Purpose:</b>	Assurance report to the Trust Board of Directors following the Quality Committee Meeting		

<b>Matters of Concern or Key Risks Escalated for Noting / Action</b>	<b>Major Actions Commissioned / Work Underway</b>
<ul style="list-style-type: none"> <li>- Ongoing dependence on additional capacity, including 25<sup>th</sup>/26<sup>th</sup> beds and continued use of escalation beds on Ward 53.</li> <li>- Care package delays continue to impede discharges, Notts Healthcare capacity remains a challenge leading to prolonged length of stay and poor patient experience.</li> <li>- AMG contract for external care package support is ending with no successor arrangement yet in place.</li> <li>- Increasing mental health delays due to lack of appropriate mental health beds, several cases require system-level escalation.</li> </ul>	<ul style="list-style-type: none"> <li>- Improvement group established with the ICB and system partners to address discharge performance and AMG withdrawal.</li> <li>- Continued roll-out and optimisation of Nervecentre EPR including successful go-live at Newark and upcoming ED go live post April 1<sup>st</sup>.</li> <li>- Audit programme strengthened to address medicines management issues raised during CQC review.</li> </ul>
<b>Positive Assurances to Provide</b>	<b>Decisions Made (include BAF review outcomes)</b>
<ul style="list-style-type: none"> <li>- Positive assurance from the Hot Topic exploring the correlation between deprivation, patient safety and experience in Maternity. Specifically noting the major improvement programmes for smoke free pregnancies and preterm birth prevention sustained with substantive staffing in place.</li> <li>- Positive assurance taken from the Patient Safety Committee Report.</li> <li>- Positive assurance from the update relating to EPR progress</li> <li>- Positive assurance from the progress with the quality account</li> </ul>	<ul style="list-style-type: none"> <li>- APPROVAL of the Quality Committee Annual Workplan following removal of IPR for Timely Care as this will be moved under the Finance and Performance Committee as of April 2026.</li> <li>- APPROVAL of the Quality Committee Terms of Reference following removal of IPR for Timely Care as this will be moved under the Finance and Performance Committee as of April 2026.</li> <li>- APPROVAL of the Quality Committee Governance Health Check.</li> </ul>

- Positive assurance from the PSIRF oversight group update

- APPROVAL of BAF Principal Risks 1, 2 and 5 with no changes proposed to current risk scores.
- APPROVAL of the Integrated Performance Reports for Timely and Quality Care ahead of presentation to the Board of Directors.

**Comments on effectiveness of the meeting**

The high quality of papers were noted, prompting well thought through discussions and positive contributions from attendees.

**Items recommended for consideration by other Committees**

None

**Progress with Actions**

Number of actions considered at the meeting – 2

Number of actions closed at the meeting – 0

Number of actions carried forward - 0

Any concerns with progress of actions – **No**

If Yes, please describe –

**Audit and Assurance Committee Chair’s Highlight Report to Board**

<b>Subject:</b>	Audit and Assurance Committee	<b>Date:</b>	17th March 2026
<b>Prepared By:</b>	Manjeet Gill – Chair of Audit and Assurance Committee		
<b>Approved By:</b>	Manjeet Gill		
<b>Presented By:</b>	Manjeet Gill		
<b>Purpose:</b>			
		<b>Assurance</b>	

Matters of Concern or Key Risks Escalated for Noting / Action	Major Actions Commissioned / Work Underway
	Amend and circulate final Committee Annual report for virtual approval. Further assurance on the final fire safety audit action as proposed amendment to seek assurance on contractors’ implementation. Review any recommendations arising from the recent CQC inspection
Positive Assurances to Provide	Decisions Made <i>(include BAF review outcomes)</i>
<b>Assurance received on:</b> Failure to prevent Fraud checklist Counter Fraud Progress Report, with an effective balance of days for training, proactive work and referrals for investigation. Internal Audit progress report External Audit Progress update. Outstanding Audit actions including the completion of fire safety actions, with one remaining under review. Draft Going Concern Assessment Register of Interest with good progress made.	<b>Approved the Annual Counter Fraud Plan</b> <b>Approved the Annual Internal Audit Plan</b> <b>Approved the unamended Committee Terms of Reference.</b> <b>Approved the Losses and Payments report.</b>
Comments on effectiveness of the meeting	

**Items recommended for consideration by other Committees**

**Finance Committee has reviewed single tender waivers following prompts from last Audit Committee and confirmed assurance on controls and related discussions.**

**Escalate wider considerations of the Nottingham Inquiry report to Quality Committee.**

***Note: this report does not require a cover sheet due to sufficient information provided.***

**People Committee Chair’s Highlight Report to Board**

<b>Subject:</b>	Chair’s Report	<b>Date:</b>	24 <sup>th</sup> March, 2026
<b>Prepared By:</b>	Steve Banks Non-Executive Director		
<b>Approved By:</b>	Steve Banks Non-Executive Director		
<b>Presented By:</b>	Steve Banks Non-Executive Director		
<b>Purpose:</b>	For Assurance		

Matters of Concern or Key Risks Escalated for Noting / Action	Major Actions Commissioned / Work Underway
<p><b>Areas of Concern or Key Risks Escalated for Update:</b></p> <ul style="list-style-type: none"> <li>• A slightly shortened People Committee allowed for an development workshop on the results National Staff Survey (NSS), (See Reading Room)</li> <li>• Continuing impact of financial challenges and demand pressures on staff morale and wellbeing, compounded by Industrial action, and now reflected in NSS</li> <li>• On-going work required to understand delivery plans by area of actions to achieve 26/27 WTE and financial targets</li> <li>• Continuing concern of likely impact and potential knock-ons across the Agenda for Change workforce as part of the Fairer Deal for Nurses announcement</li> <li>• Positive progress in some IPR measures, however agency, turnover and absence remain above target</li> </ul>	<p><b>Area of focus and update in advance of the next People Committee included:</b></p> <ul style="list-style-type: none"> <li>• High level response to NSS already communicated Trust Wide, with Executive champions. Analysis by team and theme begun which is on-going. Agreed regular updates through People Committee across the rest of the year</li> </ul>

**Positive Assurances to Provide****Decisions Made** *(include BAF review outcomes)***There was much positive assurance provided including:**

- Progress on 10 point plan for improving Doctors lives, including welcomed news of the newly opening Doctors mess
- Process to minimise payroll errors and ongoing monitoring
- Early indicators of morale in corporate services following the MARS programmes ran in 2025 are not significantly worsening (absence, engagement and appraisal levels), committee agreed to keep this under review
- Gender Pay Gap report and requirement met
- Organisational Development and Equality, Diversity and Inclusion update
- Resident Doctors Bi-Annual update including Guardian of Safe Working

**Decisions made at the March People Committee included:**

- 26/27 Priorities to support the delivery of year 2 People Strategy approved (see Reading Room)
- BAF reviewed and mitigating actions considered; risks and assurance levels remain as is

**Comments on effectiveness of the meeting**

Good preparation and papers led to right debate and actions

**Items recommended for consideration by other Committees****Following the March People Committee, the following items**

- Finance Committee and Quality Committee with regard to continued triangulation of financial imperative, quality delivery and staff morale.
- Finance Committee to be informed regarding the continuing concern of likely impact and potential knock-ons across the Agenda for Change workforce as part of the Fairer Deal for Nurses announcement
- Audit Committee to ensure ongoing monitoring of over and under payments.

## Progress with Actions

Number of actions considered at the meeting - 4

Number of actions closed at the meeting – 4

Number of actions carried forward - 0

Any concerns with progress of actions – No

If Yes, please describe –

***Note: this report does not require a cover sheet due to sufficient information provided.***