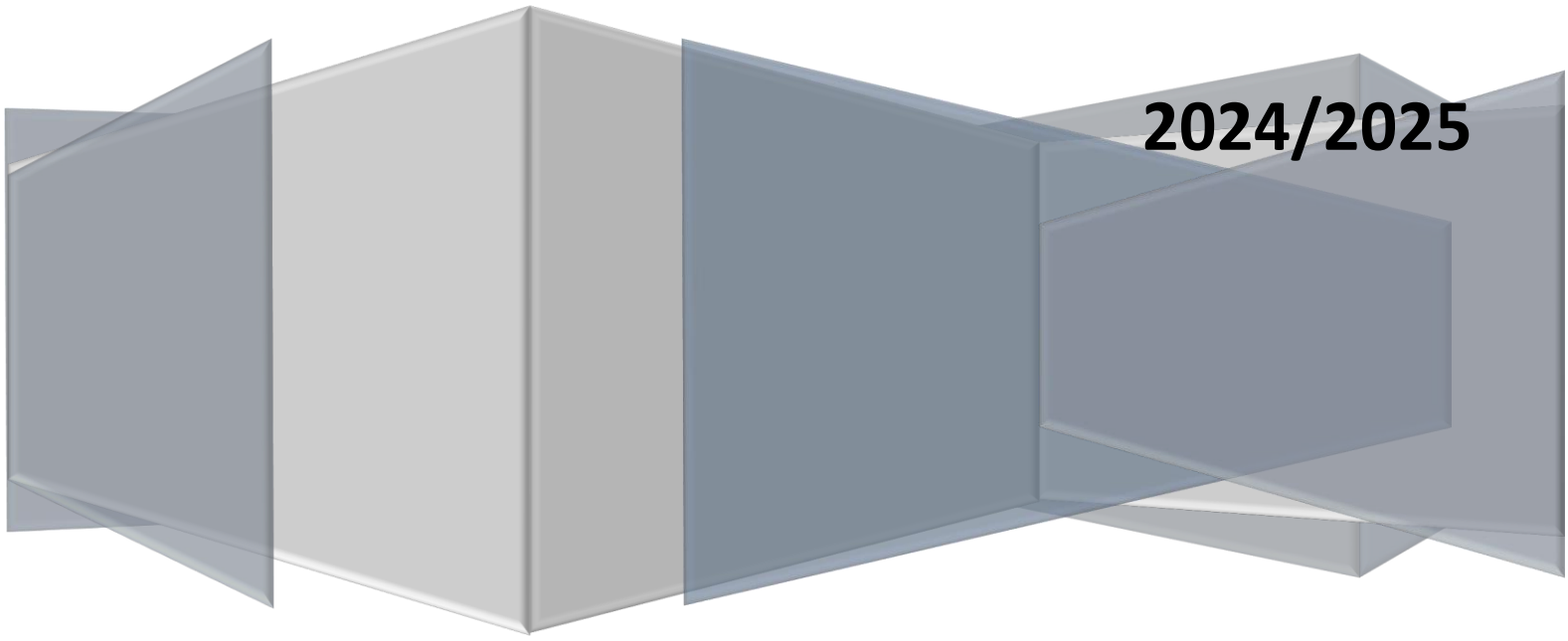
Sherwood Forest Hospitals NHS Foundation Trust

Annual Report and Accounts



2024/2025

Sherwood Forest Hospitals NHS Foundation Trust

Annual Report and Accounts 2024/2025

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

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Statement from the Chair

It is my pleasure to present this year's annual report at the end of what has been another hugely challenging year for the Trust – but a year that showed we still have so much to be proud of, too.

I will start my introduction by paying tribute to the Trust's Chief Executive, Paul Robinson, whose passing in February left colleagues across our NHS devastated, following his year-long battle with illness.

Paul had worked in the NHS for more than 30 years and had been a well-loved member of 'Team SFH' since the moment he joined Sherwood Forest Hospitals in May 2015 as our Director of Finance. He was a significant force behind helping SFH exit special measures and the enormous progress we have made together since. He will be sorely missed and we are honoured to build upon his proud legacy.

When Paul first announced his decision to temporarily step-away from the role he loved in May 2024 to focus on his treatment and recovery, the huge void he left coincided with the departure of the Trust's former Chair, Claire Ward, who stepped-down from her role to lead the new East Midlands Combined County Authority (EMCCA) for Derby, Derbyshire, Nottingham and Nottinghamshire.

Those changes saw a number of acting appointments made to the Trust's Board of Directors which were vital to bring stability to the Trust's leadership during a period of change. I have been so grateful to everyone who has helped to provide that stability and leadership over the past year.

Over time, those temporary arrangements have been made permanent – including my own appointment to the role of Chair and the appointment of Dr Simon Roe to the role of Chief Medical Officer, with plans to permanently recruit to the role of Chief Executive over the coming year.

In July, we also look forward to welcoming the Trust's new Chief Operating Officer, Simon Illingworth, to the Trust.

Nationally, a change of government has changed the landscape that our country's NHS operates within – not least through the planned changes to the operational model of NHS England, local Integrated Care Boards (ICBs) and the planned announcement of the NHS 10-year plan promising more changes to the way we work.

The new government has brought little change to the incredibly challenging financial position that the Trust – like the whole of our NHS – operates within.
A clear expectation has been set by the government and NHS England that all NHS organisations must live within their means and Sherwood Forest Hospitals will be no different in that.

During the financial year, the Trust's hard-working colleagues delivered more than £38.5million in efficiency savings – an incredible achievement that we are grateful to them for, as they have balanced the need to live within our means while providing the best possible care to the patients they are proud to serve.

Those efforts simply must continue into the new fiscal year and the Trust's leadership already has plans to further improve that financial position over the coming year to balance our books and deliver on our commitment to being a patient-led but financially-sound organisation that our local communities can be proud of.

Those new and increasing challenges will require new and creative solutions, including working differently within the local communities we serve and looking across geographical boundaries to deliver the same great care differently – and more efficiently.

Those important conversations are already gathering pace, as we have drawn on the expertise of our Trust colleagues who know their services and patients best to help shape the future of the services we provide.

I look forward to seeing how that work develops over the year ahead.

Graham Ward,
Chair
Sherwood Forest Hospitals NHS Foundation Trust

Statement from the Acting Chief Executive

The financial picture that Graham describes has dominated much of our work over the past year and we are clear that the incredible efficiency savings made by the Trust simply could not have been delivered without the ideas and commitment of our hard-working Trust colleagues.

The Trust's financial efficiency programme of £38.5million was the organisation's largest ever and I pay tribute to Trust colleagues and thank them for the way they have shared our commitment to continuing to provide ‘efficient and safe’ care to the communities we serve.

Their achievements over the past year have been all-the-more impressive when you consider how those financial pressures have been compounded with rising operational pressures that have made their already challenging work even more complex.

Year-on-year attendances to our Urgent and Emergency Care services increased, which speaks to the rising levels of demand seen at the front doors of our hospitals due to a range of societal and system challenges.

During the financial year, the Trust also delivered more elective procedures and operations than we had originally planned to at the start of the year – something that we are clear is good news for our finances, but even better news for our patients.

Despite those challenges, there remains so much to be proud of from over the past year, as well as there being so much for us to look forward to over the year ahead.

Our most recent *NHS National Staff Survey* results continue to show strong performance nationally by Sherwood Forest Hospitals, with the Trust remaining the best acute trust to work for anywhere in the East Midlands – a title we have been proud to hold every year since 2018.

The Trust continues to be the top-performing NHS organisation of its kind in the survey for staff engagement, staff morale and as a place that Trust staff would recommend as a place to receive care if a friend or relative needed treatment.

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

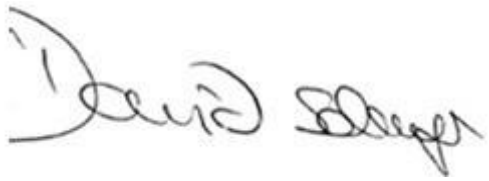
2025/26 promises to be another big year for Sherwood Forest Hospitals, as we continue to look forward to some significant multimillion-pound commitments being taken forward.

Construction is continuing at pace to bring Nottinghamshire’s first Community Diagnostic Centre to Mansfield, with work now beginning on the exciting phase of the development before it is due to open its doors in spring 2026.

Elsewhere, our work to introduce Sherwood’s first Electronic Patient Records (EPR) system is also progressing well and we have recently announced plans to start

another significant building project to bring all of the Trust's MRI scanners under one roof to improve patient experience.

It is that balance of continuing to provide outstanding patient care while aspiring and improving to do better – even within a strict financial envelope – that will be a key focus for us to maintain as we enter a new financial year.



Dr. David Selwyn
Acting Chief Executive Officer
Sherwood Forest Hospitals NHS Foundation Trust

Overview of Performance

This section summarises the Trust's purpose, history, objectives and key risks.

History and Structure of the Trust

Sherwood Forest Hospitals was formed in 2001 and gained Foundation Trust status in 2007. The Trust provides outstanding healthcare across the community to 500,000 people in Mansfield, Ashfield, Newark, and Sherwood and parts of Derbyshire and Lincolnshire. the Trust employs more than 6,000 people across three hospitals – King's Mill, Newark and Mansfield Community - and at Ashfield Health and Wellbeing Centre.

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

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

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

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

Safe, patient-centred care is delivered by well supported people and in 2024 colleagues at Sherwood rated the Trust as being the best place to work across all acute trusts in the Midlands region in the National Staff Survey.

The Trust enjoys positive partnerships with public bodies including its three district councils and the County Council. This means the Trust can actively contribute to the wider determinants of health and wellbeing through its collective work on the levelling

up partnership and shared prosperity agenda. The Trust has a strategic compact with Vision West Notts College and Nottingham Trent University which is delivering on meaningful employment opportunities for local people and in support of the local economy. The Trust plays an active role in the Nottingham and Nottinghamshire Integrated Care System (ICS).

The Trust's purpose and activities

This year was the first of the Trust's **Improving Lives Strategy**. During the year the Trust achieved the following:

Provide outstanding care in the best place at the right time	In the Trust's journey to be rated outstanding across all of its services, the Trust has taken steps to be at the forefront of service provision with innovative, safe and efficient healthcare. Service developments and achievements focused on improving patient care and experience include: • Being the first Trust in the Midlands to administer a new Parkinson's drug which made significant impact on patients' lives and ability to complete daily tasks. This development received worldwide media interest • The new discharge lounge providing purpose-built accommodation for patients waiting to leave the hospital. Patient activity has doubled since the service transferred to its new environment • Improved access to diagnostic services at the existing site of the Mid Nottinghamshire Community Diagnostic Centre. The construction of the new facility commenced in 2024/25, with further access improvements expected once operational in 2026. • Technology improvements increasing efficiency with a new cardiac CT scanner significantly reducing waits in cardiology reducing and a new hybrid MRI increasing operational activity. • Implementation of Vantage pharmacy system which provides timely tracking of samples throughout the department resulting in a better response for patients • The Trust has achieved new and maintained existing nationally recognised accreditations across divisions and specialties including, in pathology services, cellular

	pathology, clinical chemistry and clinical microbiology[1] and, in maternity services, the Baby friendly initiative • Ongoing preparation for the electronic patient record working alongside clinical teams to map opportunities that digital working and digital records will bring • The Trust is 6th best in England for its performance in emergency department patient flow and for ambulance handovers, meaning patients are assessed and treated as early as possible in the right place • The Trust has issued 167 carers passports to ensure carers are identified and supported by our specialist teams
Empower and support our people to be the best they can be	Looking after our people • The Trust has undertaken high profile campaigns on 'Expect respect, not abuse' and sexual safety through the year • Development of a health and wellbeing survey to canvass staff on their knowledge of the health & wellbeing offer, exploring barriers to engagement Belonging in the NHS • The Trust has developed and successfully piloted exit interviews and 'thinking of moving' conversations to identify reasons why people leave the organisation and to support retention, a key initiative of the People Promise Exemplar programme • Delivery of the Equality, Diversity & Inclusion Improvement Plan has prompted a relaunch of the Trust's staff networks and recruitment of inclusive recruitment champions Growing for the future • Working towards its strategic aim to be the local employer of choice, the Trust has continued with its Step into the NHS programme of events, and embedded its strategic partnership with Vision West Nottinghamshire College • The Trust now has 172 apprenticeships and 50 work experience placements.

[1] *ISO 15189:2012 Medical laboratories – requirements for quality and competence (assessed by the United Kingdom Accreditation Service)*

	• The establishment of a new coaching and mentoring network with formal qualifications and continuing professional development available. New ways of working and delivering care • The Trust's new Community Diagnostics Centre services at Mansfield Community Hospital continue to be supported with workforce models and mobilisation plans • Revised processes have been developed utilising efficiencies in the Trust's electronic staff record and health roster systems, with the aim of removing duplications in processes
Improve health and wellbeing within our communities	The Trust is taking action to address health inequalities: • Digital 'flag' now in place for patients with cancer who also have a learning disability enabling adjustments to be made in their care • Creation of a health inequalities steering group, which has agreed priority areas of focus over the rest of the year • Cultural competency training delivered in women and children's division which supports our people to engage effectively with people from different cultures and countries in a way that best meets their needs • A focus on reducing DNAs (Did Not Attend the appointment) with a health inequalities lens, which has already seen reductions in DNAs and abandoned call rates • Working with our partners to establish and embed MECC (Making Every Contact Count) within the Trust to raise competencies and look at different ways to provide each contact
Continuously learn and improve	To embed a strong culture of continuous improvement the Trust has: • Embedded improvement culture through mechanisms such as the Patient Safety Incident Response Framework, which seeks to identify learning from incidents • Completed a self-assessment against improvement domains set out in NHS IMPACT's national tool which puts us on a journey of improvement across the organisation

	• Appointed a citizen improvement partner to engage the patient voice in improvement programmes • Delivered improvement ambassador awards to our People who have demonstrated great service improvement projects in their area of work that have positively impacted on patient care • Delivered a successful Celebrating Excellence event which showcases the outcomes of improvement through our nursing, midwifery, allied health professionals and pharmacy colleagues • Promoted patient engagement through the in-patient survey to identify real time improvements
Sustainable use of resources and estate	To deliver the best possible care for the community we serve, and using our resources wisely the Trust has: • Focussed on core financial controls, assurance and pace of improvement with the aim for financial breakeven in 2026 and a contribution to the ICS financial position • Achieved its financial improvement plan, delivering £38.5m savings during the year • Eliminated the use of desflurane across the Trust supporting delivery of its Green Plan • Added additional electric vehicle charging points and a new bus stop to promote sustainable and greener travel • Worked with clinical fellows to develop further plans for decarbonisation and competencies for the workforce to tackle the impacts of climate change
Work collaboratively with partners in the community	The Trust has a long history of working in partnership, recognising delivery of the strategic objectives cannot be achieved by the Trust alone. The Trust has developed several relationships into deliverable partnerships including: • Focussed work within provider collaboratives to build resilience in fragile services • Established a collaborative programme of work with primary care to respond to problems that occur when patients move to and from the Trust's care to general practice • Embedded knowledge hour sessions into GP protected learning time and focused on key priorities, including frailty and urgent care with increasing numbers of GP teams attending

- Working closely with Vision West Nottinghamshire College to increase work experience and apprenticeships, and aligning a practice development nurse to work with students at the college, which is improving professional behaviours
- Developed a partnership canvas to model the Trust's partnerships and the value exchanged through working in collaboration

Risks to delivery of objectives

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

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

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

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

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

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

How the Trust is using its FT status to develop services and improve patient care

The Trust is dedicated to realising its vision of improving lives through outstanding care, provided by compassionate people, enabling healthier communities. This vision statement includes the commitment and ambition to excel and continually improve the quality of Trust services. Its four core "CARE" values underpin this and describe the way in which we will operate:

- Communicating and working together,
- Aspiring and improving,
- Respectful and caring,
- Efficient and safe.

The Trust develops its services and improves patient care based on evidence. It proactively seeks and uses feedback from patients and staff, as well as analysing data that benchmarks the performance of its services against other Trusts. It is vital that its culture engenders a desire to improve and innovate. That is why it trains colleagues in the Trust's improvement methodology. This supports them to take a systematic approach to improvement, empowering colleagues to turn good ideas into sustainable reality.

Going concern

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

The majority of the Trust's funding for 2024/25 came through the Nottingham & Nottinghamshire ICB (N&NICB) via an Aligned Payment Incentive (API) contract, which includes both fixed and variable elements. The API variable element means trusts are paid 100% of NHS Payment Scheme (NHSPS) unit prices for elective activity, which covers most elective ordinary and day case outpatient procedures with an NHSPS unit price, outpatient first attendances, unbundled diagnostic imaging and nuclear medicine, and chemotherapy delivery. The fixed element includes funding for all expected activity other than the variable elements. Similar contracts are in place with Derbyshire and Lincolnshire ICBs. During the financial year there has been a change to the Elective Activity element of the variable part of the contract, where a cap has been placed on the level of income the ICS can generate through elective activity.

As part of the 2024/25 plan an efficiency target of £38.45m was built in to meet the planned deficit position of £14.05m. In year additional funding support was received to offset the planned deficit, resulting in an adjusted break-even financial plan. This includes centrally managed cost savings and income generation schemes, as well as a Financial Improvement Programme which is managed by divisions with the support of the Trust's Improvement Faculty. The reported financial efficiency delivery for the year is *£38.52m*, of which *£23.78m* is recurrent and *£14.74m* non-recurrent.

Throughout the year the trust has continued to review pay, non-pay and income in order to agree the efficiency target/plan for 2025/26. This has been set at *£45.83m* which represents 7.55% of the gross turnover.

For the year ending 2024/25 the Trust is reporting a deficit of *£4.78m* which includes the impact of impairments/gains on the valuation of buildings. Removing this impairment loss/gain and adjusting the PFI charge to a UK GAAP basis we are reporting a surplus of *£0.01m*. This is an improvement on our target outturn for 2024/25, agreed with NHSE in quarter 4 2025.

A breakdown of the adjusted Financial position is detailed below:

Surplus / (deficit) for the year		**(4,777)**	**(56,283)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	8	1,126	(1,213)
Total comprehensive income / (expense) for the period		**(3,651)**	**(57,496)**
Adjusted financial performance (control total basis):			
Surplus / (deficit) for the period		(4,777)	(56,283)
Remove net impairments not scoring to the Departmental expenditure limit		3,557	855
Remove I&E impact of capital grants and donations		107	163
Remove I&E impact of IFRIC 12 schemes on an IFRS 16 basis		64,000	63,055
Add back I&E impact of IFRIC 12 schemes on former UK GAAP basis		(62,877)	
Add back I&E impact of IFRIC 12 schemes on an IAS 17 basis			(21,758)
Adjusted financial performance surplus / (deficit)		**10**	**(13,968)**

Due to the original in year additional deficit to the plan, revenue support of £9.125m was requested and received in 2024/25 against a planned full year outturn of £14.05, adjusted to nil. At the time of writing this update no request has been received from the Department of Health & Social Care (DHSC) for any return of this additional revenue Public Dividend Capital (PDC). In addition, a working capital support application was approved for £8.30m.

Due to the Private Finance Initiative (PFI) liabilities and associated repayment of borrowing, depreciation does not self-fund the Trust's capital expenditure, therefore a

PDC request for £13.35m was submitted and agreed to support the capital programme.

During the year a range of additional National capital programmes were initiated by NHSE, and the Trust was successful in obtaining funding for some of these programmes. This has resulted in the Trust being awarded additional PDC of £3.84m above the agreed ICB base capital funding for 2024/24. Funding was also received in respect of National capital programmes approved in 2022/23 of £7.30m relating to the Electronic Patient Record (EPR) and Mansfield Community Diagnostic Centre (CDC).

In year the Trust did not pay any PDC, based on 3.5% of the net average value of assets due to the impact of IFRS 16 re-measurement in 2023/24, which has resulted in negative net assets.

The financial framework for 2025/26 has been issued and in line with this guidance a financial plan, which includes capital, was submitted on the 20 March 2025. A resubmission for data quality purposes is scheduled for the 30th April 2025. The plan submitted was agreed with the ICS partners and indicates a break-even position and a capital programme of (*£39.11m*). As detailed above the plan includes forecast efficiencies of (*£45.83m*)

The 2025/26 plan assumes the continuation of funding mechanisms in place throughout the 2024/25 financial year.

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

Operational Performance Overview

The NHS operational priorities for 2024/25 provided focus for acute Trusts to continue to recover core services to improve patient safety, outcomes, and experience. The key areas of focus included improving cancer diagnostic and treatment times, speeding up access to key diagnostic tests, reducing the number of long waiting elective patients, and speeding up access to Urgent and Emergency Care (UEC) by reducing the number of patients waiting over four and twelve hours within Accident and Emergency (A&E) departments.

The national position for both UEC and planned care (diagnostics, cancer, and elective care) remained challenged in 2024/25 due to three key reasons:

1. The NHS continued to deal with repercussions of the significant patient backlogs that developed during the Covid-19 pandemic.

2. Frequent instances of Industrial Action throughout 2023/24 and into 2024/25 that resulted in curtailments in planned care activity (hindering backlog reduction/recovery) across the NHS with staff working hard to maintain access to services for those patients presenting with urgent clinical needs.
3. Demand for UEC hospital services was high with attendance and admission surges and growth outstripping planned levels.

Key initiatives that we delivered in 2024/25 included:

- Invested to further increase the substantive workforce in the Emergency Department (ED) during the summer of 2024 and opened a new Clinical Decisions Unit (CDU) area within our ED in March 2025.
- Launched a surgical Same Day Emergency Care (SDEC) service in May 2024.
- Trialled a new Acute Frailty Unit over the 2024/25 winter period.
- Opened a new discharge lounge at the King's Mill Hospital site in April 2024.
- Increased the number of Discharge Coordinators (who support our ward-based teams and work with patients and their families) and worked with system partners to improve discharge processes to reduce the number of patients medically safe (clinically ready to proceed) within the Trust's hospitals. This supported a reduction in the number of step-down beds required from summer 2024 with a further reduction in spot purchasing of beds outside of Sherwood Forest Hospitals in October 2024 (instead of a usual seasonal rise over winter).
- Delivered an outpatient improvement programme to reduce do not attend (DNA) levels and increase outpatient clinic utilisation, together with a focus on increasing the number of 'one-stop' clinics where patients receive their procedure during their first appointment.
- Recovered Echocardiography wait times by investing in additional capacity to support timely patient care.
- Worked together with system partners and local providers to offer support (mutual aid) to help provide equitable access to planned care services and equalise patient waiting times across our health and care system. Additionally, the Trust invested in several services to increase capacity to maximise the volume of elective patients seen, diagnosed and treated, reducing the number of long wait elective patients.
- Opened a new cardiac 'one-beat' CT scanner in early 2025 that enables cardiac scans without the need to slow the patient's heart first.

The challenges the Trust faced entering and during the year, which are common across the whole NHS, meant that performance against some of its key targets fell short despite its best efforts. However, there are also several areas of success to celebrate.

- Delivered strong cancer 28-day faster diagnostic standard performance often outperforming the national ambition. Unfortunately, the Trust's cancer 62-day treatment performance has been variable in-year and not at the level it aspires to deliver for patients. The Trust has some key challenged tumour sites where we have focused recovery plans in place.
- Recovered diagnostic DM01 performance (national standard for a bundle of 15 diagnostic tests) from 71.3% in April 2024 to 93.4% in March 2025. The 2025 position is the Trust's best post-pandemic.
- Reduced the 52-week wait referral to treatment backlog from 1,312 patients in April 2024 to 447 patients in March 2025. The March 2025 value represents 1.3% of the total patient tracking list size. The national ambition for 2025/26 is to reduce to 1% which is deliverable based on progress over the last year.
- Increased performance against the, returning to prominence, 18-week referral to treatment standard moving from 58.9% in April 2024 to 64.6% in March 2025. The Trust's ambition in 2025/26 is to deliver performance of 68.2% (ahead of the national average ambition).
- Despite reaching a monthly high of 82% against the national four-hour emergency access standard in August 2024 (when patient demand eased beyond our expectations); performance deteriorated over winter to a low of 61.7% in December 2024 as hospital flow was compromised due to the high patient demands on the Trust's services. As winter pressures eased, the Trust has managed to recover to 75.2% in March 2025, delivering its second strongest position of 2024/25 for year-end.

In common with previous years, throughout 2024/25 patients in most need of clinical attention were prioritised for treatment.

Operational Performance Analysis

The Trust has set out to deliver 'outstanding care, provided by compassionate people, enabling healthier communities.' Together, this will improve lives of its local population. To achieve this, the Trust has a Performance Management Framework (PMF) that tracks and evaluates progress with routine performance reporting to the Trust Board and sub-committees.

Performance Management Framework

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

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

The Trust reviews its key performance indicators and performance report on at least an annual basis to remain aligned to both external and local strategic priorities. It also considers its performance against local Trusts and nationally with benchmarking reports shared with the clinical divisions and benchmark data sitting alongside our local data in many of our Trust Board and sub-committee reports.

Performance against key operational standards in 2024/25

In the sections below a summary of operational performance for each patient care pathway is described.

Urgent and Emergency Care (UEC)

Demand for UEC services has been high throughout 2024/25. The pressure on services from high patient demand has been sustained, much like many acute Trusts across the country. The combination of high attendance and admission demand, length of stay pressures and mismatches in admission and discharge times meant that, at times, patient demand exceeded the capacity of our hospitals preventing patients being admitted in a timely basis.

The Trust experienced a challenging winter period, with patient acuity being higher than the previous year as demonstrated by the number of patients admitted with a National Early Warning Score (NEWS) or four or more. Winter 2024/25 was also challenging from an infection perspective with high prevalence of influenza and multiple instances of norovirus across our hospitals.

The increased pressure due to the volume of patients accessing our services was evident across our frontline services. This placed pressure on the clinical workforce, and at times the Trust struggled to fill additional clinical shifts to cope with the level patient demand. At times during winter it was necessary to go ‘two-over’ on our wards to balance risk across the organisation; this action was taken under our Full Capacity Protocol.

While performance across the UEC pathway has not always been where the Trust would like it to be, staff continue to work relentlessly to care for patients in as timely and dignified a manner as possible in, at times, very challenging circumstances.

The Trust has worked well together with local system partners to deliver relatively low levels of medically safe for transfer (or clinically ready to proceed) patients in its hospitals over the winter period. Low medically safe patient numbers have been essential to maintain hospital patient flow over, and as the Trust exited, the winter period.

The Trust’s four-hour emergency access performance has varied in-year with a significant deterioration as it exited the summer period dropping to a low of 61.7% in December 2024. It has recovered strongly in the final part of the year to close the year at 75.2% in March 2025, against a national ambition of 78% in March 2025.

Despite the demand challenges, the Trust continued to benchmark well in terms of timely ambulance handover. It also continues with a strong medical Same Day Emergency Care (SDEC) offer exceeding national targets and successfully launched the surgical SDEC in May 2024.

The Trust has six times daily capacity and flow meetings to provide oversight and to agree actions to mitigate potential flow issues that might delay timely patient transfer into, through and out of its hospitals. It continues to develop and improve the ways in which it uses its information systems to gain real-time oversight of key performance indicators to support decision-making to provide the best possible care to patients. The Trust is excited about the future digital landscape as it progress on its Electronic Patient Record journey.

Delivering consistently better access to emergency care remains one of the Trust’s top priorities for 2025/26, making sure there is sufficient system capacity to care for emergency patients alongside delivering planned care to those who have been waiting.

Planned Care

The Trust continues to deal with heightened backlogs of elective patients that developed over the course of the pandemic. Elective recovery continued in 2024/25 with some key successes detailed in the performance overview section above.

Planned care activity levels were strong in 2024/25 as investments were made in several services to increase capacity to maximise the volume of elective patients seen, diagnosed and treated. The Trust also continued to work together with system partners and local providers to offer support (mutual aid) to help provide equitable access to planned care services and equalise patient waiting times across the health and care system.

In early 2024/25 the Trust had a further instance of Industrial Action where staff working on planned care pathways were needed to support patients presenting at its hospitals requiring immediate clinical attention. Fortunately, Industrial Action was not at the frequency and scale experienced in 2023/24 as a national pay settlement was reached in summer 2024.

Within outpatients there has been continued strong performance in the delivery of Advice and Guidance to patients as well as expanding and making excellent use of Patient Initiated Follow Up (PIFU) pathways ensuring patients only return to hospital when needed. The Trust's outpatient improvement programme has reduced do not attend (DNA) levels and increased outpatient clinic utilisation, as well as increasing the number of 'one-stop' clinics where patients received their procedure during their first appointment.

Additional capacity was invested in Echocardiography to recover what was the most challenged diagnostic test. This, together with improvement activities in other modalities, recovered diagnostic DM01 performance (national standard for a bundle of 15 diagnostic tests) from 71.3% in April 2024 to 93.4% in March 2025. The 2025 position is the Trust's best post-pandemic. The development of a Community Diagnostic Centre at Mansfield Community Hospital is progressing well with building works continuing into 2025/26.

Throughout 2024/25 the Trust has successfully reduced the number of patients on its elective waiting list including those with long waits (over 52-weeks). It has also increased the proportion of patients on a referral to treatment pathway treated within 18-weeks which is encouraging as it progresses into 2025/26.

Cancer standards

For its cancer patients, the Trust consistently delivered against the national ambition for the 28-day faster diagnosis standard during 2024/25. Trust performance against the 31-day and 62-day treatment standards has not been at a level that it aspires to deliver for patients. It has some issues affecting multiple tumour sites that it has worked (and in some instances continue to work) to resolve that include histopathology and radiology capacity constraints and theatre capacity challenges, in part, driven by constrained anaesthetic capacity. Alongside these overarching challenges the Trust has some specific service-related issues, for example, a significant and unexpected increase in the number of breast cancer patients requiring surgery.

The Trust remains focussed on progressing actions to mitigate the risks to its cancer standards on a month-by-month basis, while addressing the underlying challenges. Recovery plans are in place with regular performance reporting taking place in-year via Integrated Performance Reports to the Trust Board.

Forward look

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

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

Throughout 2024/25 the Trust has innovated and developed its services and collaborated with system partners with some key initiatives listed in the earlier performance overview section.

As we look forward to 2025/26, the Trust has further exciting developments including:

- Building new MRI facility at King's Mill Hospital that will deliver two new MRI scanners and bring all of the Trust's MRI scanners under one roof.
- Completing the building works and opening a new Community Diagnostic Centre at Mansfield Community Hospital – estimated to be Spring 2026.
- Dependent on the availability of capital funding, expanding the footprint of the Emergency Department.
- Delivering key improvement programmes for outpatients, theatres and to support optimised patient length of stay.

Emergency Planning Resilience & Response (EPRR)

The Trust has an Accountable Emergency Officer (its Chief Operating Officer) with Board level responsibility for Emergency Preparedness.

As a category One responder under the Civil Contingencies Act 2004 the Trust has several obligations:

- Assess the risk of emergencies occurring and use this to inform contingency planning
- Put in place Emergency Plans
- Put in place Business Continuity management arrangements
- Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency
- Share information with other local responders to enhance co-ordination
- Co-operate with other local responders to enhance co-ordination and efficiency

Annually, the Trust is assessed against the EPRR Core Standards. This involves raising evidence against 62 standards. The Trust is currently rated as 'Substantial' in compliance, with a 90 % compliance, meaning the organisation is fully compliant against 89-99% of the relevant NHS EPRR Core Standards. See Figure 1.

The Trust, on an on-going basis engages with its partners to assess risk and plan for nay system-wide incidents and emergencies and responds to any business continuity, critical or major incident using robust plans and policies.

Reporting to the Accountable Emergency Officer (AEO) vias the Associate Director of Operations - Urgent and Emergency Care, the Emergency Planning and Business Continuity Officer operates within an annual work plan. This includes regular exercising of emergency plans and the training of relevant staff within the Command- and-Control sector.

Organisational rating	Criteria
Fully compliant	The organisation if fully compliant against 100% of the relevant NHS EPRR Core Standards
Substantial compliance	The organisation is fully compliant against 89-99% of the relevant NHS EPRR Core Standards
Partial compliance	The organisation is fully compliant against 77-88% of the relevant NHS EPRR Core Standards
Non-compliant	The organisation is fully compliant up to 76% of the relevant NHS EPRR Core Standards

Figure 1 – EPRR Core Standards compliance rating

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

Accountability Report

Directors' Report

Board of Directors

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

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

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

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

Name	Job Title	Commenced in post	Seconded to another role	Termination date
Claire Ward	Substantive Chair	01/10/2021		24/05/2024
Barbara Brady	Non -Executive Director	01/10/2018		
	Senior Independent Director	01/11/2021		
Graham Ward	Non-Executive Director	01/12/2015		
	Acting Chair	25/05/2024		
	Substantive Chair	11/02/2025		
Manjeet Gill	Non-Executive Director	01/11/2018		
Steve Banks	Non-Executive Director	01/12/2021		
Dr Aly Rashid	Non-Executive Director	10/01/2022		09/01/2025
Dr Andy Haynes	Specialist Advisor	18/04/2021		
Andrew Rose-Britton	Non-Executive Director	01/04/2022		
Neil McDonald	Non-Executive Director	07/12/2023		
Richard Cotton	Non-Executive Director	01/02/2025		
Lisa Maclean	Non-Executive Director	01/02/2025		
Sir Jonathan Nguyen-Van Tam	Associate Non-Executive Director	01/02/2025		
Paul Robinson	Interim CEO	01/10/2021		31/03/2022
	Substantive CEO	01/04/2022		16/02/2025
Dr David Selwyn	Executive Medical Director	09/12/2019		19/05/2024
	Acting Chief Executive	20/05/2024		
Philip Bolton	Chief Nurse	30/05/2022		
Rachel Eddie	Chief Operating Officer	25/07/2022		

Richard Mills	Interim Chief Finance Officer	01/10/2021		
	Chief Finance Officer	10/06/2022		
Rob Simcox	Director of People	10/06/2022		
Sally Brook Shanahan	Director of Corporate Affairs	15/05/2023		
Claire Hinchley	Acting Director of Strategy and Partnerships	29/02/2024		31/03/2025
Dr Simon Roe	Acting Medical Director	20/05/2024		
	Chief Medical Officer	03/02/2025		

The balance, completeness and appropriateness of the Board membership is reviewed periodically and upon any vacancies arising among either the Executive or Non-Executive Directors. The balance of skills is appropriate to the requirements of the organisation. Board Directors are required to declare any interests that are relevant and material on appointment, or should a conflict arise during their term. A register of Board members' interests is maintained by the Director of Corporate Affairs and is published annually as covered later in this Annual Report. Board Directors are also required to meet the Fit and Proper Persons Test which is evidenced in their individual personal files.

Up until she left the Trust on 24th May 2024, the Chair, Claire Ward, was also a Non-Executive Director of Institute for Collaborative Working, a not for profit membership organisation and professional business institute working across a number of different sectors to promote collaborative working and the implementation of ISO 44001, Director of Pharmacists Defence Association Ltd, a Non-Executive Director of Groupe Eurocom Ltd., a member of the Advisory Board to Alliance Healthcare Limited and owner of Capewells Limited, a consultancy company which acts for a number of pharmacy and pharmaceutical companies and organisations. Claire was selected as the Labour Party candidate for the East Midlands Regional Mayor (covering Nottinghamshire and Derbyshire) on 3rd August 2023 and subsequently elected. Her successor, Graham Ward, who is not related, has declared an interest as a Non-Executive Director at Queen Elizabeth Hospital, King's Lynn.

Attendance at Board meetings

	Public		Private	
Name	Actual	Possible	Actual	Possible
Paul Robinson	2	2	2	2
Dr David Selwyn	10	11	13	14
Dr Simon Roe	9	9	11	12
Sally Brook Shanahan	9	11	12	14
Richard Mills	9	11	12	14
Rob Simcox	10	11	13	14
Philip Bolton	10	11	13	14
Rachel Eddie	10	11	12	14
Claire Hinchley	10	11	9	14
Claire Ward	2	2	1	2
Graham Ward	11	11	14	14
Barbara Brady	10	11	12	14
Manjeet Gill	9	11	11	14
Steve Banks	11	11	14	14
Dr Aly Rashid	8	9	9	11
Dr Andy Haynes	7	11	8	14
Andrew Rose-Britton	10	11	13	14
Neil McDonald	10	11	13	14
Richard Cotton	2	2	3	3
Lisa Maclean	1	1	1	2
Sir Jonathan Nguyen Van-Tam	0	1	0	2

Register of Interests

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

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

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

Cost allocation

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

Political donations

In accordance with historical and intended future practice, no political donations were made during the year ended 31st March 2025.

Better Payment Practice Code

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

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

Trust performance against this metric is shown as follows:

	2024/25		2023/24	
	Number	£000s	Number	£000s
Total non-NHS trade invoices paid in the year	66,694	324,466	72,235	296,459
Total non-NHS trade invoices paid within target	17,790	235,856	59,737	276,716
Percentage of non-NHS trade invoices paid within target	27%	73%	83%	93%
Total NHS trade invoices paid in the year	2,250	30,258	2,185	29,794
Total NHS trade invoices paid within target	632	24,196	1,768	28,301
Percentage of NHS trade invoices paid within target	28%	80%	81%	95%

Late Payment Interest

Legislation is in force which requires Trusts to pay interest to small companies if payment is not made within 30 days, known as the Late Payment of Commercial Debts (Interest) Act 1998. The Trust paid £1k in claims under this legislation. The total potential liability to pay interest on invoices paid after their due date during 2024/25 would be £ 295.68k. (2023/24 £25.61k) There have been minimal claims under this legislation, therefore the liability is only included within the accounts when a claim is received.

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

Income Disclosures

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

Well Led Framework

Grant Thornton UK LLP was commissioned to undertake a developmental Well-Led Governance Review in the context of the CQC's updated assessment framework, that delivered its final report in January 2025 and built on the previous external Well-Led review of the organisation, that reported in March 2022.

The Well-Led review is an important assessment for the Trust, because trusts are expected to advise NHSE of any material governance concerns that have arisen from the review and the action plan in response to those concerns. Importantly it also provides the opportunity for the Trust to fully understand the strengths and weaknesses of its current governance arrangements and implement actions at an appropriate pace.

The Review's overall conclusion is that the Trust is a well-led trust. It reported that compared to the initial developmental review, the Trust has maintained strong assessments in the majority of the areas covered by the Well-Led Key Lines of Enquiries (KLOEs) and has delivered on most of the actions agreed as part of that previous review. It went on to confirm the Trust has strong governance processes which contain many elements of good practice and with no significant development areas, and for those development areas that were identified, the Trust was aware of them and already in the process of discussing and implementing actions to address them.

Given the contextual changes and challenges in 2024/25 compared with the previous review, it was acknowledged it was a testament to the Trust's strong processes and leadership that it had been able to maintain the assessments when many other trusts

would have struggled with their impact. These challenges included the transitional period for leadership, challenges within the wider system and financial pressures and enhanced scrutiny.

The recommendations detail the development areas, with the 16 identified being largely as a consequence of these challenges. The Board received the final Review in February 2025 with progress reporting to the Board agreed to coincide with action due dates, commencing August 2025.

The review also identified the continuation and operation of many good practice areas across the framework including:

Trusted, supportive and open leadership style

Succession planning evident and delivering in leadership roles

Development and mentoring programmes for all staff levels

Strong and deep affinity across the organisation to its CARE values.

Care Quality Commission

The Care Quality Commission undertook an inspection of the Emergency Department in September 2024. The focus was on the sepsis pathway. Initial feedback from the inspection was positive however, the Trust is awaiting the final report.
CQC IR(ME)R inspected the Nuclear Medicine department in September 2024. The report was extremely positive, and an action plan to address the issues raised was developed and completed within the agreed timescales.

The Trust maintains an excellent relationship with the CQC who are invited to the Patient Safety Incident Review panels, the Patient Safety Committee, and the Patient Safety Incident Response Oversight Group. The Trust encourages colleagues from the CQC and the Integrated Care Board to visit wards and departments regularly.

Patient Care

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

Communicating and working together

Aspiring and improving

Respectful and caring

Efficient and safe.

The Trust has robust systems and processes in place to enable colleagues to celebrate where excellent, safe, high-quality care is provided, and also to identify quickly areas of focus for further improvement.

Patients at King's Mill Hospitals' Emergency Department have reported that they are some of the most respected patients in the region and are receiving some of the best care and treatment, according to the latest independent Care Quality Commission Urgent and Emergency Care patient survey. Sherwood Forest Hospitals has scored well for the way that following a first assessment, the nurses/doctors kept patients informed of next steps (9.5 out of 10), information provided by hospital staff enabled them to care for their condition at home (9 out of 10) and the respect and dignity patients received (8.3 out of 10).

Quality Strategy

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

As the 2022-2025 Quality Strategy comes to an end, the Trust can reflect on its achievements over the last year. Sustained improvements in quality and safety have continued whilst facing significant operational pressures.

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

How have we performed?

1. Accredited as a 'Pathway to Excellence' organisation
2. Implemented electronic prescribing and medicines administration systems
3. Maintained low rates of hospital-acquired infections
4. Gained external accreditation of our Radiology, Cardiology, Ophthalmology & Haematology services
5. Embedded learning from critical medication incidents
6. Increased mobilisation of patients to reduce deconditioning and falls

Campaign Two: Excellent patient experience for users and the wider community

How have we performed?

- Raised the visibility of carers passports
- Increased service user/citizen engagement at key SFH meetings, appointing 4 Patient Safety partners

- Increased the number of Citizen Improvement Partners, appointing 4 Patient Safety partners
- Reduced the number of complaints referred outside of the organisation
- Reduced the response time to complaints

Campaign Three: Strengthen and sustain a learning culture of continuous improvement.

How have we performed?

- Embedded the national patient safety incident framework
- Oversight Group continues to provide assurance to the Quality Committee and Board
- Gained ‘exemplar status’ in our Improvement maturity

Campaign Four:

Deliver high quality care through kindness and supporting each other.

How have we performed?

- We have improved engagement in the NGS staff survey
- introduced ‘6-steps to support’ poster which has been disseminated to colleagues to enable easy access to prompt support following an incident

Patient Safety and Quality Strategy for 2025 – 2029

The Trust’s Patient Safety & Quality strategy sets out where it aims to be by 2029 and what needs to be done to get there. The strategy is shaped by the National Patient Safety Strategy, the Trust’s ICS vision, its current position, and the views of service users, carers, staff, and partners within the Integrated Care System (ICS). Following feedback from engagement events held with staff, the Trust’s patient safety and quality campaigns have been refreshed.

Insight - Develop robust systems for understanding patient safety

Involve - Elevating Care through Compassionate Communication

Improve - Design and support programmes that deliver effective and sustainable change

There is a clear plan for consistently delivering high-quality healthcare, focusing on patient safety, clinical effectiveness, and positive patient experience. Using insight to understand the challenges ahead, by involving patients and the community around them areas for improvement will be identified, goals set, and performance monitored

against them. Ensuring safety and quality of care for every patient is the Trust's top priority. It is ambitious about the quality of care it provides and wants its services to provide outstanding care, delivered by compassionate people every day of the week, helping the community to be healthier, and able to access care in the community whilst reducing inequalities. With this vision, the Trust is committed to fostering a culture of continuous quality improvement having consistently delivered against the previous Quality Strategy aims and goals.

Patient safety and clinical quality are the foundations on which the Trust has built its strategic vision and ambition. Every day, colleagues demonstrate their commitment to providing outstanding patient-focussed care, as they strive to do their very best, in often difficult circumstances. To support all colleagues, the Trust remains committed to being an organisation that will 'c*ontinuously learn and improve*', a commitment which is firmly embedded within the Trust Strategy '*Improving Lives*' (strategic objective 4). This is an important statement, given it aims to highlight the importance of delivering patient-centred care and supporting our colleagues by providing the best possible practice environment and by exploring, scoping, and adopting examples of clinical best practice. The Trust will do this through collaboration with health and social care partners across Nottinghamshire and through the work of the Improvement Faculty, a multi-professional, centrally located team which was established to provide a single point of contact for all colleagues and teams seeking help and advice on any aspect of improvement, change management and transformation.

The overarching aims of the Improvement Faculty are to improve the quality of patient care, improve the experience of those who use our services, improve clinical outcomes, improve the working lives of our colleagues, and help the Trust to make best use of its resources. The approach to improvement is therefore evidence-based, which will help the Trust to embrace the cultural aspects of improvement as well as addressing the immediate priorities.

The work of the Improvement Faculty will be supported by the development and implementation of a Continuous Quality Improvement Strategy (CQIS). This will clearly set out the Trust's ambition and aspirations in terms of delivering '*strategic objective 4*' (see above). A strong culture of continuous improvement will enable better outcomes for patients, better staff experience, more effective use of finances and a more targeted approach to improving population health and wellbeing.

The CQIS will be launched during 2025, and through the development and delivery of an associated action plan, the emphasis in terms of measuring impact will move away from being focused on the role of the Improvement Faculty (inputs), and instead focus on the impact of the CQIS (outputs). This will include a broad range of measures, including (but not limited to) how effectively is learning implemented from patient safety incidents, clinical audits and other sources of clinical data and intelligence, how it is measured against nationally set improvement maturity standards and the knowledge

and skills of the wider organisation and whether those who have undertaken improvement training are given opportunities to undertake improvement activity.

Enhanced Quality Governance

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

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

Involvement of Governors

The Council of Governors has continued to play an important role in the delivery of safe, high-quality care, working in partnership with the Board of Directors, giving it support and advice to help shape the Trust's plans and ensure high quality services are delivered. During 2024/25 members of the Governing Body have taken an active role in formal and informal visits to wards and departments, and have provided an invaluable, impartial, and observational perspective on how the Trust conducts its business.

The Council of Governors continues to support the Quality Committee acting as representatives of patients, the public and staff and providing a direct link between the Trust and the communities they represent.

Patient Care: Improvements in patient/carer information

The patient information service continues to provide evidence-based, clinically accurate, easily understandable and up-to-date information that aims to improve patient satisfaction, experience and safety by helping patients and their families/carers to better understand their care and treatment.

Around 780 patient information leaflets are stored in an easily accessible patient information library on the Trust's public-facing website. Following the May 2025 launch of the Trust's new public-facing website to ensure we meet EU accessibility standards, provide up-to-date content and improve security, further improvements to the patient information leaflet library are planned. This includes plans to convert leaflets from PDF format into individual HTML webpages to make them even easier for patients to access.

On the Trust intranet, the patient information leaflet section has information to help colleagues to produce patient information leaflets for their respective specialties/services. There is a policy and guides on how to create a new leaflet or review and update an existing leaflet, and advice on writing a leaflet in line with the average reading age of local communities.

As a signatory to the Patient Information Forum (PIF) Health and Digital Literacy Charter, the Trust is committed to tackling health equalities, mainly poor health, and digital literacy among the local population. Aspiring to become health and digital literacy friendly, training is in place for Trust staff to learn how to support people with low levels of health and digital literacy.

To improve further, effective patient communication, an increasing number of QR code posters are in use across the Trust linking to relevant Trust-approved patient information leaflets or official sources such as the NHS website. The aim is for patients to access the information they need more quickly and easily on digital devices, while also reducing the use of print and paper in line with the Trust's Green Plan ambitions. While these posters do not completely replace direct website downloads or paper copies (due to poor digital literacy) they aim to enhance patient and staff experience.

Complaint Handling

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

SFH operates a centralised complaints service. It ensures that a patient-centred approach is taken to the management of complaints. All complaints received are

thoroughly investigated and responded to within a timely manner, within an agreed timescale ranging from 25 to 60 working days dependent on complexity. This means that complainants will be advised of a more realistic expected response date and therefore reducing the frustration often felt by complainants when responses are overdue.

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

During 2024/25 to date we have received 270 complaints, a 15% increase compared to 2023/24. Of the complaints closed in 2024/25 37% were completed in agreed timescales which is unchanged from the previous year. Whilst performance against the time frames standard was noted to be reduced, all complainants were kept updated on the progress of their complaint and an apology was provided to all complainants.

The top five themes for complaints 2024/25 are highlighted below.

	Clinical Support, Therapies & Outpatients	Corporate	Urgent Emergency Care	Medicine	Surgery	Women and Children's	Total
Clinical - Diagnosis	2	0	15	6	5	2	30
Clinical - Delay	2	0	6	4	11	6	29
Clinical - Treatment	1	0	10	6	5	3	25
Nursing - Care and Treatment	0	0	3	13	6	1	23
Admissions / transfers / discharge procedure	1	2	5	5	2	1	16
Total	6	2	39	34	29	13	123

Clinical diagnosis and clinical treatment continue to feature within the top three most frequently reported subjects of dissatisfaction. Throughout 2024/25, the Trust has received an increased number of concerns regarding clinical delays compared to the previous year. Complaints regarding admissions, transfers and discharge procedures remain within the top 5 themes whilst concerns relating to Nursing Care and Treatment

have replaced Clinical Discharge concerns during this reporting period. These complaints have been triangulated, to ensure safeguarding, any patient safety issues and concerns are escalated and managed via the appropriate routes, and to analyse further for themes and trends for escalation to the relevant divisions.

Of the complaints responded to within 2024/25, 50% were upheld or partially upheld, showing a decrease of 20% with previous year. This has provided an opportunity for learning and service improvements.

A total of 19 complaints were re-opened in 2024/25 because the complainant had raised additional concerns to the original complaint. This demonstrates a decrease in re-opened complaints from 2023/24. All requests are formally responded to, reiterating the options relating to the next steps, which include Public Health Service Ombudsman (PHSO), independent advocate and access to medical records procedures.

In 2024/25, the PHSO initiated 7 additional new complaints reviews, 3 of which were closed with no further investigation. 1 of these new cases has been closed after financial redress was awarded and 3 cases remain under investigation. Two historic cases were closed in 2024/25 and were upheld. The Patient Experience Team anticipates that correspondence from the PHSO will continue to increase during 2025/26 and that new referrals will include requests for further Local Resolution, written responses of meetings that have taken place and financial remedies for cases partially or fully upheld.

The Trust is taking action to improve these percentages, including sharing data with all divisions, enabling learning in all areas, and triangulating with other data collection sources to improve patient feedback.

Action plans will be developed, around learning and improvements from the complaints received, and the data will be collated and analysed for any themes and trends that could be occurring, enabling service improvements.

Working in partnership and stakeholder relations

The Trust has continued in its commitment to work in partnership when that better serves our patients and communities and contributes towards the strategic aim of improving lives. The strategy is focused on delivering those strategic aims and, through collaboration, the Trust will be able to improve patient care and the health of everyone it serves.

2024/25 was the first year of the Trust's partnerships strategy, Improving Lives Through Partnerships, against which the Trust has made strong progress. The priorities in this first year were to:

- strengthen relationships with other healthcare providers working towards seamless transitions between providers
- build resilience in those challenged and fragile services

- identify efficiencies and those areas where productivity could be enhanced
- strengthen population health and prevention activities and reduce health inequalities
- take action to secure the Trust's future workforce

The Trust's partnership work during 2024/25 has been focused on these priorities and its strategic objectives. Its strategic partnerships and their delivery against these aims are summarised below.

The Trust continues to have a leading role in the Nottingham and Nottinghamshire Integrated Care System (ICS), which brings together local NHS services, councils and the voluntary sector. Its ambition is for people living in Nottingham and Nottinghamshire to live longer, happier, healthier and more independent lives. During 2024/5, the Trust has contributed to delivery of the ICS's Joint Forward Plan, which sets out how partner organisations will deliver the ICS strategy.

A key strategic ICS priority is to focus on prevention of ill-health, for there to be equity in everything and integration by default. This is also reflected in the Trust's Clinical Services Strategy (CSS) 2024-2029.

During the first year of Improving Lives Through Partnerships, the Trust has strengthened its approach to health inequalities and prevention recognising the importance of partnerships.

This work has been supported through the Mid Nottinghamshire Place-based Partnership (PBP), which covers Ashfield, Mansfield, Newark and Sherwood and comprises of local statutory and voluntary, community and social enterprise organisations. It is a collaboration of six primary care networks, community and voluntary services, district councils, NHS trusts, other healthcare providers and public health.

In 2024/25 the PBP refreshed its vision to "*working together to enable everyone across Ashfield, Mansfield, Newark and Sherwood to live happier, healthier lives, to prosper in their communities and remain independent throughout life*". Its ambitions are:

- Give every child the best chance of maximising their potential
- Create healthy and sustainable places
- Everyone can access the right support to improve their health
- Keep our communities safe and healthy

The Trust sees its membership of the PBP as key in preventing the onset and development of disease; facilitating the Trust to contribute to population health management and increase healthy life expectancy; and for patients' and carers'

experiences of health and social care to be seamless regardless of the provider organisation.

The Trust is also a partner in two provider collaboratives. These are partnerships that bring together NHS trusts to work together at scale to benefit their populations.

Provider collaboratives are partnerships of at least two trusts working across multiple places with a shared purpose. All statutory NHS Providers have to be involved in at least one provider collaborative. National guidance on the role and function of the Provider Collaboratives[2] set out three key aims:

- To reduce unwarranted variation and inequality in health outcomes, access to services and experience
- To improve resilience by, for example, providing mutual aid
- To ensure that specialisation and consolidation occur where this will provide better outcomes and value.

Provider collaboratives are a component of integrated care systems. Effective collaboratives can help streamline the relationships between ICSs, providers and wider partners to integrate care and respond to the needs of local communities.

One is a county-wide partnership, the Nottingham(shire) Provider Collaborative at Scale. It brings together the five statutory NHS providers across Nottingham and Nottinghamshire - Sherwood Forest Hospitals NHS Foundation Trust (SFH), Nottinghamshire Healthcare NHS Foundation Trust (NHT), Nottingham University Hospitals NHS Trust (NUH), Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (DBH) and East Midlands Ambulance Service NHS Trust (EMAS). The Trust contributed overarching resource across the structure providing representatives at the Chair and CEO Forum, Provider Leadership Board, Distributed Executive Group and working groups. During 2024/25, the partnership has focused on building resilience in fragile acute services with priority services identified and engaged. It has also continued to work on productivity opportunities in people and corporate services.

The Trust's second provider collaborative is the East Midlands Acute Provider Network, which is a partnership of acute trusts across the East Midlands primarily focused on specialist areas identified as challenged or fragile. The partnership has made progress in developing the network's long-term approach to haematology. It has also progressed workstreams where there are productivity benefits of working on a larger footprint, including pathology and radiology.

The Trust also works with local general practice colleagues. It has established and embedded a primary secondary care interface partnership during 2024/25. The partnership aims to agree approaches to ensure that the patient is treated in the right

[2] B0754-working-together-at-scale-guidance-on-provider-collaboratives.pdf (england.nhs.uk)

environment for them, smooth the transition for those patients moving into and out of secondary care and reduce the instances of inappropriate transfer of workload.

During 2024/25 the partnership developed the 5 asks, which aims to clarify some key workload principles, established a mechanism for GP colleagues to feedback concerns and built relationships between senior secondary care and general practice clinical leaders.

Consultation with local groups and organisations

Engagement with local groups and organisations has continued over the past year, following the introduction of the Trust's new five-year *Improving Lives* Strategy. Through those conversations, our communities stressed the need for:

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

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

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

The Trust continues to maintain strong relationships with Nottingham and Nottinghamshire Healthwatch and has also strengthened its links with Primary Care with regular attendance in each other’s key meetings opening channels between GPs and the Trust and it is now part of the Integrated Care Board.

The Mid-Nottinghamshire Place Based Partnership continues to meet in public monthly, with our Acting Chief Executive now the vice chair of the partnership, bringing together key partners, including the voluntary sector and local authorities, in ways that add value to the communities served.

A key part of how the Trust engages with its local communities over the coming year will involve a refreshed approach to how it engages with its public members. This work will continue with our elected Council of Governors under the leadership of Lead Governor, Liz Barrett.

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

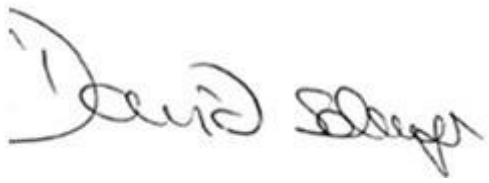
The Patient Experience Team is often the first point of call for patients with both negative and positive experiences of the Trust's services. The team works closely with the divisions to ensure individuals receive appropriate and timely responses. The service has a clear governance process for reporting themes or concerns for oversight and action via the Patient Safety Committee. The team responds to comments made via Care Opinion, and regularly shares both positive and negative comments on social media, encouraging patients to share their feedback to help the Trust to improve.

The Trust continues to encourage patients to share their experiences through *Patient Story* videos and presentations which are presented to each public meeting of its Board of Directors.

The Trust continues to meet with MPs, local politicians and other partners and stakeholders, including district council leaders and Healthwatch representatives.

The Trust is the largest employer in its area by a significant margin and knows that by engaging effectively with its staff (evidenced by staff engagement which remains the best in the country in the *NHS National Staff Survey*) it is, by extension, also communicating effectively with its service users and community.

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



Dr. David Selwyn
Acting Chief Executive Officer **19th June 2025**

Statement of Health Inequalities 2024-25

Health inequalities are unfair and potentially avoidable differences in health outcomes, access to healthcare, and quality of care experienced by different groups of people. These disparities are influenced by socioeconomic, geographical, and demographic factors, and they have direct implications for patient care, service delivery, hospital performance and patient outcomes.

In accordance with NHS England's statement on information on health inequalities, this report provides an overview and update on behalf of Sherwood Forest Hospitals NHS Trust (SFH) in relation to the domains relevant to the Trust:

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

The health inequalities data and intelligence contained within this report provides an insight into the information collated and analysed by SFH that is being utilised to identify areas of priority and to drive service improvement to reduce health inequalities. Therefore, in addition to these areas, the Trust has identified local priorities that are key to supporting the local population for which it serves.

Population profile

SFH serves a population of approximately 350,000 people across Ashfield, Mansfield, Newark and Sherwood (Mid Nottinghamshire) and beyond. Local demographic data demonstrates a slight female majority (50.2%). The area has experienced a 9.6% population increase over the past decade. Notably, 20.6% of residents are aged 65 and over, surpassing the national average of 18.6%. This older demographic is associated with higher levels of frailty, leading to increased hospital admissions and healthcare needs[3].

The population is predominantly White British (90.2%), which is higher than the national average of 74.4%. The second largest (known) ethnic group is Asian/Asian British, comprising 2.4% of the population[4].

The region's Index of Multiple Deprivation (IMD) score is 24.6%, higher than the England average of 21.7%.

This socioeconomic deprivation correlates with poorer health outcomes. For instance, 78% of residents report being in good or very good health, below the England and Wales average of 80%. Additionally, 21.3% are classified as 'disabled under the Equality Act', and 6.7% have a long-term physical or mental condition but are not classified as disabled[5].

[3] KMH_002346_Mid_Notts_Place-Based-Partnership-Plan_2023-1
[4] KMH_002346_Mid_Notts_Place-Based-Partnership-Plan_2023-1
[5] Health Inequalities - Nottinghamshire Medicines Optimisation Team

Life expectancy in Mid-Nottinghamshire is lower than the national average:

- **Females**: 82.1 years (England average: 83.1 years)
- **Males**: 78.1 years (England average: 79.4 years)

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

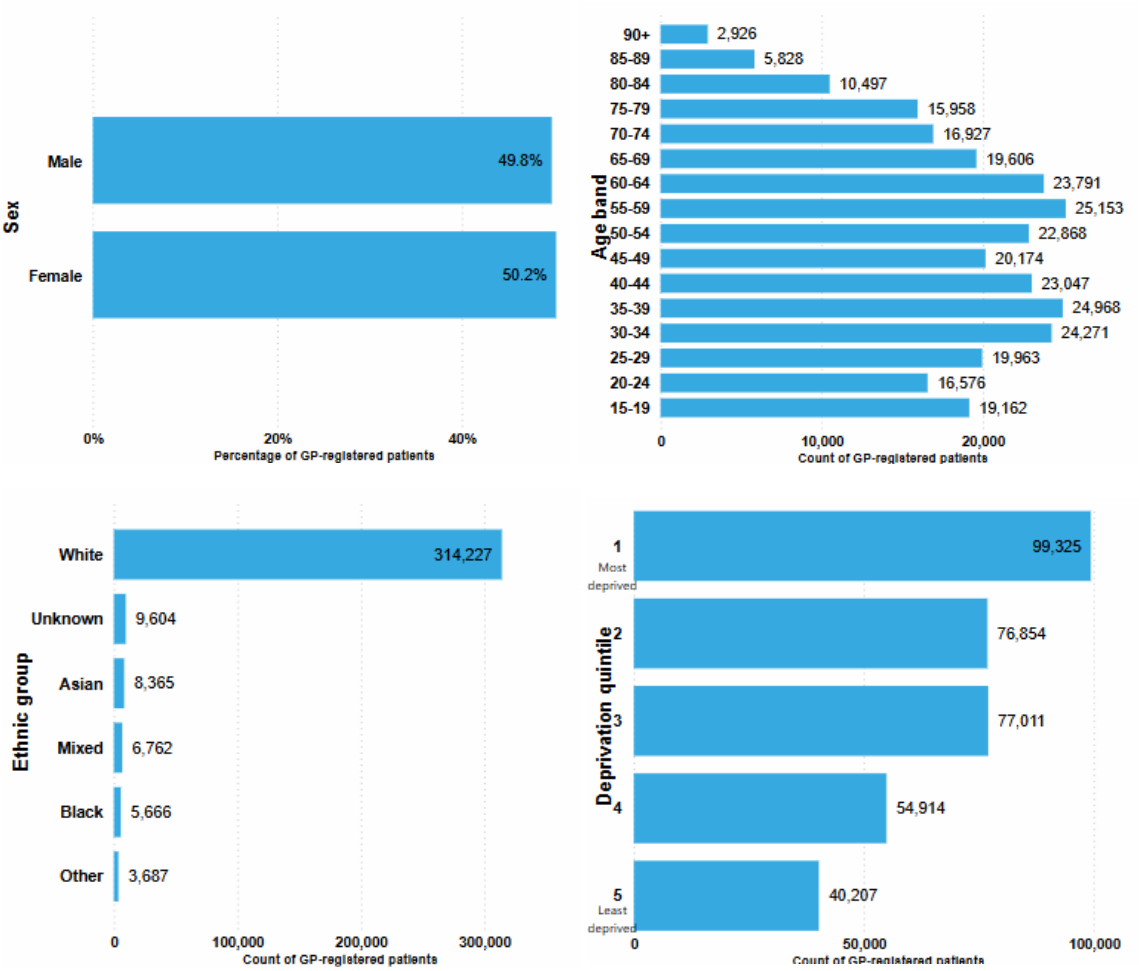
There are also disparities between men and women when looking at years spent in good health. Although women may live longer, they are living in poorer health for longer than men.

The gap between life expectancy and healthy life expectancy indicates that individuals in more deprived areas not only live shorter lives but also spend more years in poor health[6].

The region exhibits higher prevalence rates of certain health risk factors and conditions:

- **Smoking**: Ashfield, Mansfield, Newark and Sherwood have some of the highest smoking prevalence rates in Nottinghamshire, ranging from 16.5% to 23.1%, compared to the county average of 15.4%[7].
- **Physical Activity**: Residents of Mansfield and Ashfield are 10% below the national average in achieving recommended physical activity levels. [8]
- **Obesity**: Approximately 66.1% of adults in Nottinghamshire are classified as overweight or obese, higher than the England rate of 63.8%. For the Mid-Nottinghamshire district of Mansfield, this is even higher, at approximately 67.3%.
- **Alcohol use**: Alcohol consumption at levels posing a risk to health is high. It is estimated that 160,206 adults in Nottinghamshire drink at levels that pose a risk to their health, and 8,506 are estimated to have alcohol dependency.

[6] hfma.org.uk+3healthandcarenotts.co.uk+3Nottinghamshire Medicines Management+3
[7] healthandcarenotts.co.uk+1sfh-tr.nhs.uk+1
[8] healthandcarenotts.co.uk



The prevalence of long-term conditions such as diabetes, respiratory illness, heart failure, dementia, asthma and stroke is higher in Mid Nottinghamshire than the national average, (however this is not equally distributed across all areas). This impacts negatively on the healthy life expectancy of the local population and has wider reaching economic consequences for the local system. If people become ill at a younger age it can increase the risk of economic inactivity, creating losses for the local economy in addition to increased costs incurred by the NHS.

SFH action in response to Health Inequalities

SFH has a Health Inequalities Steering Group, chaired by the Chief Medical Officer. It consists of health inequalities leaders and champions driving a move to embed health inequalities considerations into normal Trust operations.

To support local priorities, SFH has seven Core20Plus5 Champions, who are leading on areas of health equity improvement locally. They have actively prioritised understanding the health inequalities affecting the local population.

A Heath Inequalities Index is under development to provide a robust evidence base for change and improvement through data and intelligence, in relation to patients facing health inequalities.

Work is underway to consider how to better identify patients experiencing health inequalities that all points of their healthcare journey.

A “Making Every Contact Count” programme of work is in its infancy, aiming to integrate brief interventions into everyday conversations with patients, in order to promote health through addressing challenges and issues in relation to the building blocks for health.

The Trust has recognised the need to support its workforce as part of the health inequalities strategy because a healthy, supported, and inclusive workforce is essential for delivering equitable care to patients and communities.

Elective care

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

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

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

<u>Elective Admissions</u>

As of April 2025, the Trust has delivered 49,944 elective spells, representing 100.4% of its planned activity for 2024/25. This shows a significant increase from the baseline in 2019/20 where elective admissions were at 43,082, as well as a significant increase when compared to the last financial year at 44,634. Data quality on missing postcodes and ethnicity has remained comparable.

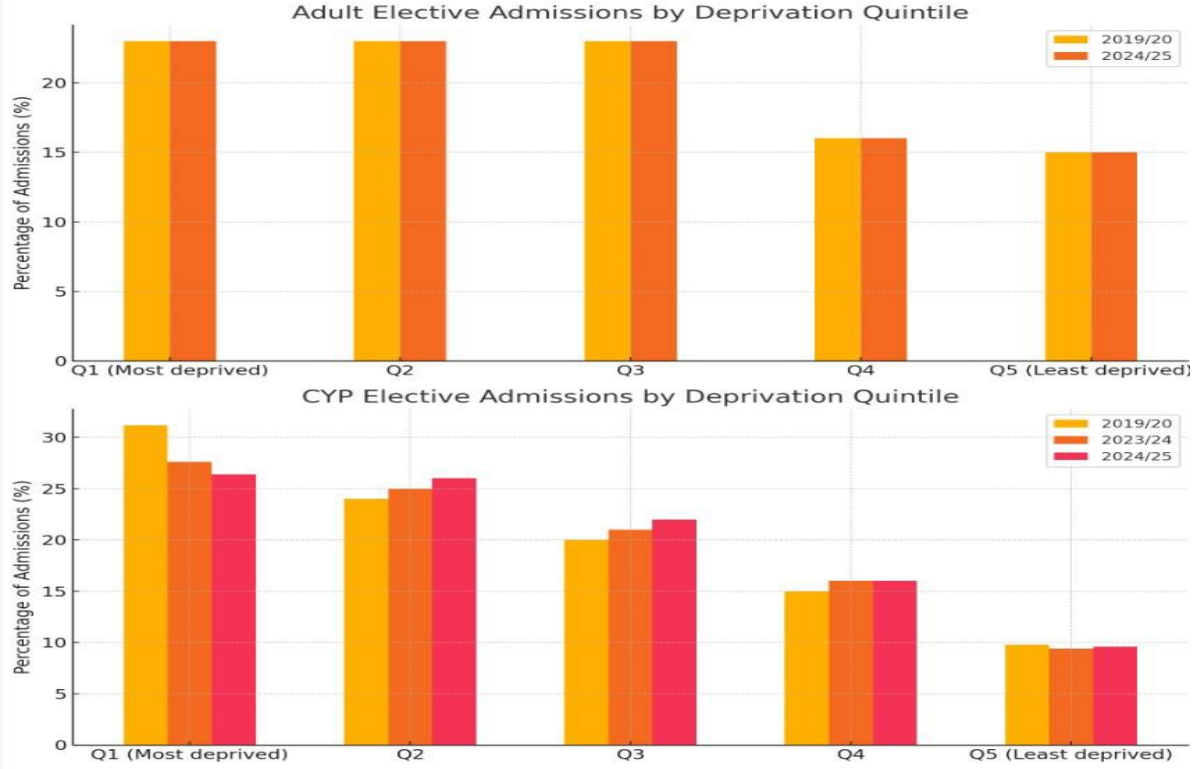
This consistent performance demonstrates SFH’s commitment to restoring services post-pandemic, while also actively addressing the backlog that disproportionately impacts those in the most deprived communities.

The distribution of adult elective admissions by deprivation remains broadly consistent with previous years. In line with 2019/20 and 2023/24 data, Quintiles 1, 2, and 3 continue to account for the majority of adult elective admissions, each contributing approximately 23% of total activity. The most deprived quintile (Q1) remains the single largest contributor by volume, with around 10,000 admissions again recorded in 2024/25 YTD.

While elective recovery volumes are generally improving, a reduction in the proportion of admissions from the most deprived quintile (Q1) remains evident in the data.

- In 2019/20, 31.2% of children and young people elective admissions were from Quintile 1.
- By 2023/24, this had dropped to 27.6% — a reduction of 3.6 percentage points.
- 2024/25 data continues this trend, with Quintile 1 now accounting for 26.4% of under-18 elective admissions.

  This represents a further reduction of 1.2 percentage points compared to the previous year and a cumulative drop of 4.8 percentage points since pre-pandemic levels. Quintiles 2 and 3 have shown the largest increases in proportional share.



- **Fig 1**: Adult elective admissions remain stable across 2019/20 and 2024/25, with the highest proportion in the most deprived quintiles (Q1–Q3).
- **Fig 2**: Children and young people (CYP) elective admissions show a clear decline in the most deprived quintile (Q1) over time, with corresponding increases in Q2 and Q3.

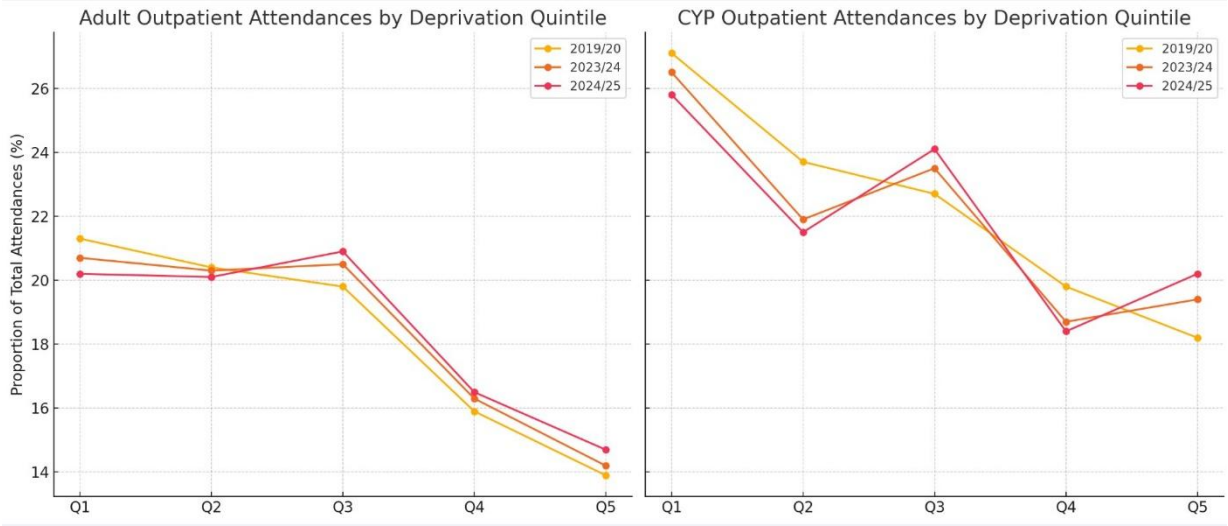
Outpatients

The Trust continues to make strong progress in outpatient recovery, with overall attendances increasing year-on-year since the pandemic. However, the latest data from 2024/25 shows continued shifts in access by deprivation.

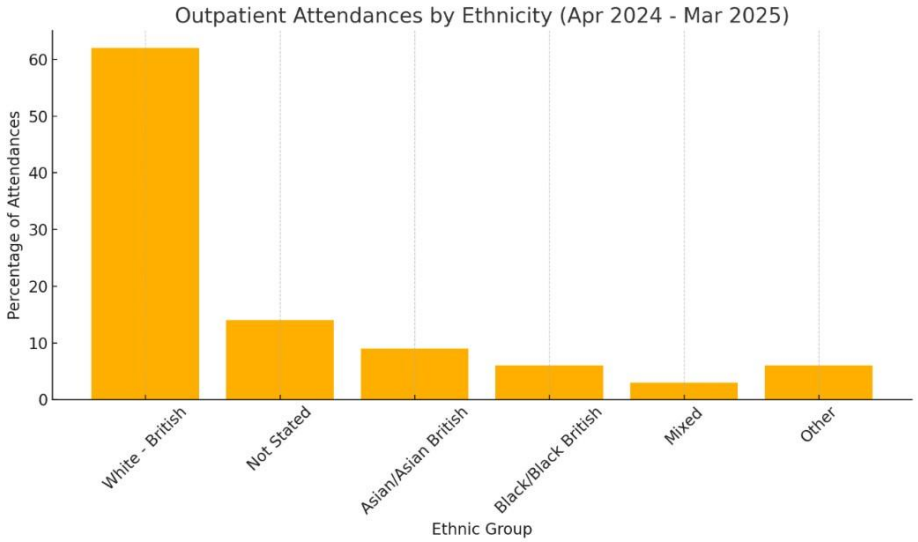
Outpatient attendances rose from 445,280 in 2019/20 to 477,665 in 2023/24 and again rose in 2024/25 to 522,864.

Postcode completeness remains strong but has seen a slight decline, impacting deprivation analysis marginally. However, Trust data does show that attendances have increased across all deprivation quintiles since 2019/20.

However, the most deprived quintile (Q1) has seen its proportion of total attendances fall for a third consecutive year, from 21.3% in 2019/20 → 20.7% in 2023/24 → 20.2% in 2024/25 for adult outpatient activity and 27.1% in 2019/20 → 26.5% in 2023/24 → 25.8% in 2024/25 for paediatric outpatient activity.



While overall access has grown, these proportional shifts suggest that adults in the most deprived areas may be experiencing slower recovery or more barriers to timely care and highlight growing inequality in access among children, with those from more deprived backgrounds less likely to be represented in activity growth.



SFH Action to Respond to Health Inequalities in Elective Care

The Trust continues to make strong progress in restoring elective services, with a focus on ensuring equitable access and reducing variation in health outcomes across

its patient population. The Trust is currently delivering at 101% of the elective recovery fund threshold, enabling reinvestment into measures that promote access and reduce waiting times including:

- Enhanced weekend and evening capacity to support working-age adults and carers.
- Targeted delivery in high-demand specialties such as Ophthalmology and General Surgery, where delays can have significant impact on quality of life and independence.
- Waiting list validation and patient-initiated follow-up options helping to ensure that those most in need are prioritised.
- Where variation is evident – for example, in Ear, Nose and Throat and Urology – SFH is implementing targeted approaches to tackle service bottlenecks, by focusing resources where the need is greatest.

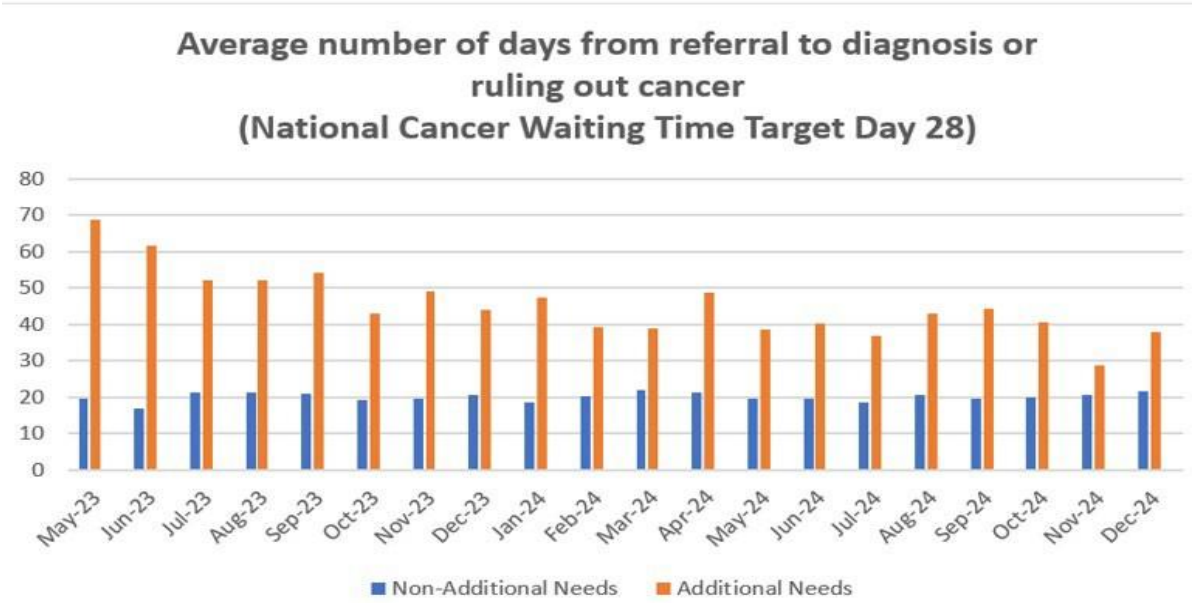
The Trust continues to monitor the distribution of this activity to ensure equity of access, particularly for those in the most deprived communities and minoritised ethnic groups.

A new tele-dermatology service has been introduced, facilitating rapid diagnostic pathways for early skin cancer detection. This service allows patients to receive quicker reassurance if they do not have cancer or to commence treatment sooner when necessary. This service was co-produced with members of the public who have accessed support from SFH and continues proactively engage with patients to drive ongoing improvement.

Patient Experience Survey Results

- *92/98 rated their experience with the service as "Excellent" and 6/98 rated their experience as "good".*
- *87/97 strongly agreed with the statement: I was satisfied with how quickly I received my tele dermatology appointment date.*
- *95/97 strongly agreed that they were made to feel at ease and comfortable during their tele dermatology appointment 2/97 agreed with the statement.*

The Trust is implementing "About Me" forms across some specialities. This is a personalised communication tool designed to help health and care professionals better understand and support individuals — especially those are at risk of exclusion due to a difficulty communicating their needs, preferences, or background due to their condition. In dementia care this tool provides support to patients who otherwise might struggle to communicate their needs clearly.



Patients on a cancer pathway with marginalised characteristics, pre-existing conditions or additional needs may have hugely different experiences of healthcare services, often with longer wait times to access. In response to this a digital flagging system within info-flex has been developed to identify the needs of patients on pre-diagnostic cancer pathways, in order to proactively offer reasonable adjustments. Over the development year, over 15 flags have been created to identify risk factors. These mechanisms have allowed for the development of more personalised patient journeys that take into account potential barriers to access.

The Trust offers prehabilitation options for patients who are waiting for planned surgery. The aim being that the patient's journey to recovery starts before surgery has even begun, through physical, nutritional, and psychological support. Patients with potential health disparities and complex needs on waiting lists are identified through a risk stratification process and those who may benefit from additional external support are proactively contacted and signposted towards the relevant services.

The Trust has implemented a digital pre-operative assessment project aimed at enhancing early screening and triage through patient-facing digital questionnaires.

- Patients that flag with BMI over 30 can be referred to 'Your Health Notts' for a weight management plan & support. This involves weekly classes that support the patient with nutritional information and advice and exercise programmes.
- Patients are proactively screened for their smoking status and offered support to give up or reduce the amount they are smoking.

While virtual appointments and digital tools have expanded healthcare access for many, the Trust acknowledges the importance of addressing digital exclusion; factors contributing to which include age, ethnicity, and deprivation.

To mitigate these challenges, the Trust is implementing measures to ensure that all patients, regardless of their digital literacy or access, receive equitable care. This includes offering alternative assessment methods and providing support to those at risk of digital exclusion.

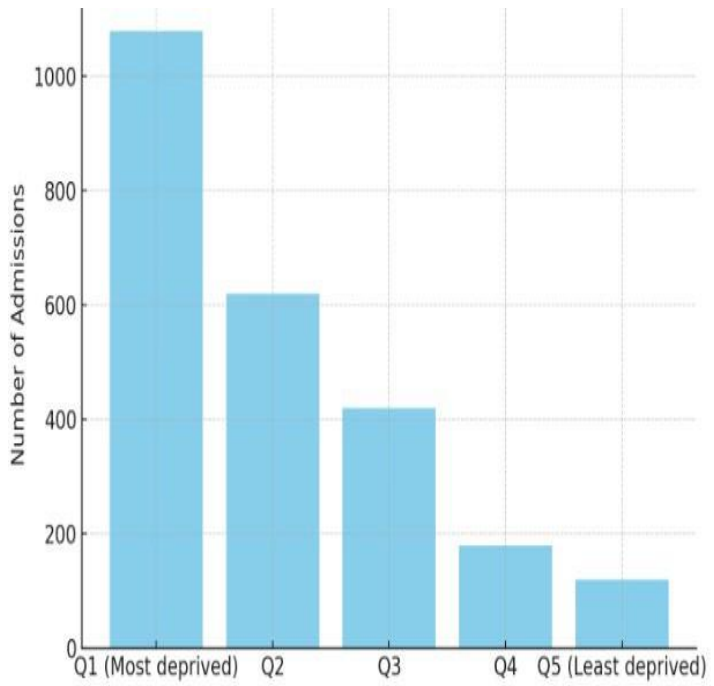
Urgent and emergency care

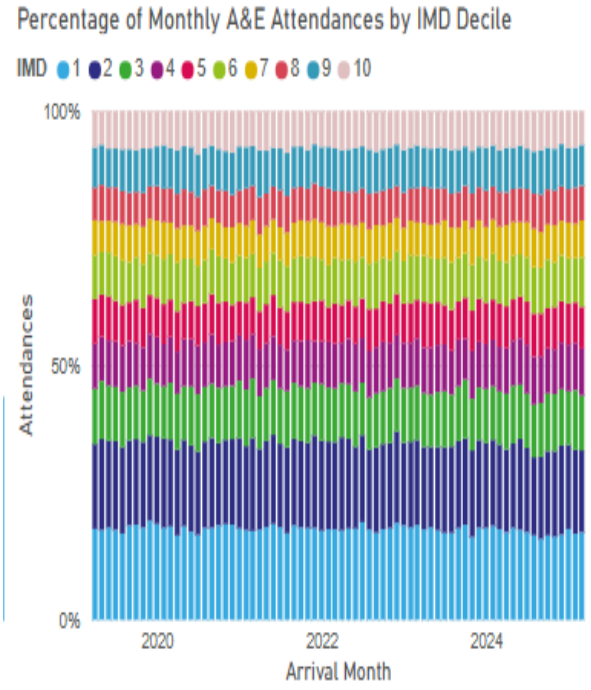
Urgent and emergency care services provide a critical role in healthcare, often treating people with serious or life-threatening injuries or illnesses who cannot be treated in primary care or in the community. National data shows that people living in the most deprived areas are 1.7 times more likely to attend an emergency department than those in the least deprived areas[9]. This statement will focus on emergency admissions for under 18's (by ethnicity and deprivation).

During the last financial year, 2024/25 there were 2,519 emergency admissions for children and young people under 18 years old:

- Deprivation data was available for 2,480 cases (98.5%)
- Ethnicity data was recorded for 2,500 cases (99.2%)

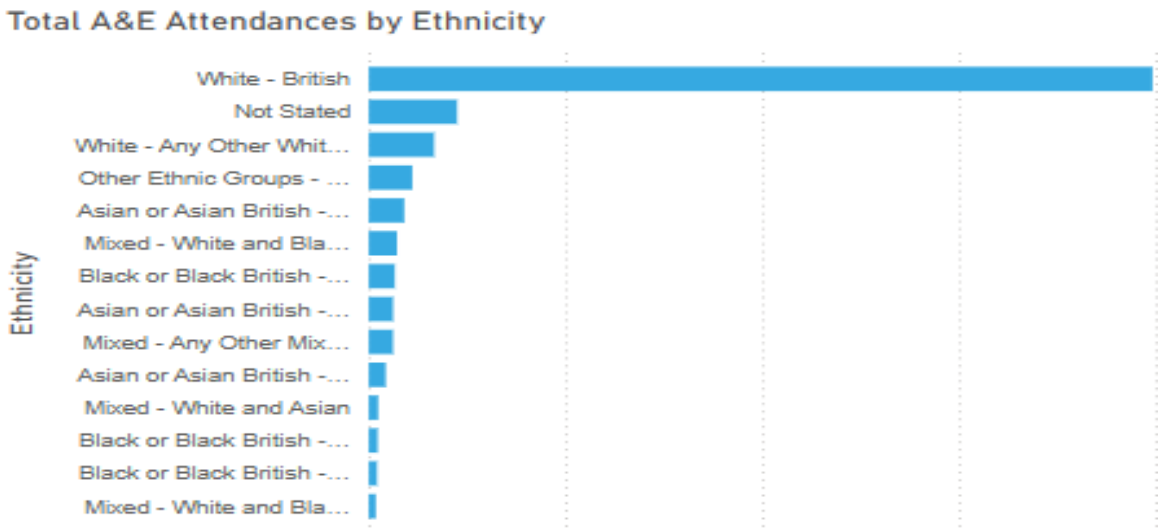
  Emergency admissions for children and young people living in the 20% most deprived populations - Q1 were more than nine times higher than those from the least deprived (Q5) .There is also a clear trend across the deprivation quintiles over the last five financial years, showing the higher the deprivation, the higher the proportion of emergency admissions for under 18's.



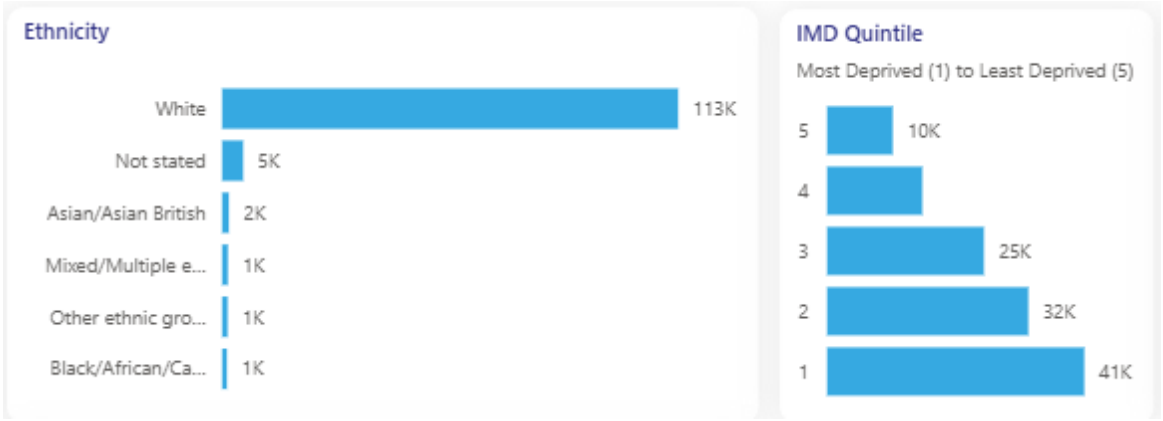


Emergency admissions in the White - British population account for over 90% of activity and this is consistent year-on-year (Figure 9). Excluding this population, the mixed and Asian groups comprise nearly 70% of the ethnic minority groups. The size order of the ethnic minority groups has remained consistent over the past five financial years.

[9] Inequalities in Accident and Emergency department attendance, England: March 2021 to March 2022 Inequalities in Accident and Emergency department attendance, England - Office for National Statistics (ons.gov.uk)



These are trends that are followed into adulthood with emergency admissions being 4x as likely for those living in the top 20% most deprived areas in Mid-Nottinghamshire, and over 90% of emergency admissions being for the white-British population.



Actions to respond to Health Inequalities in Urgent and Emergency Care

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

Triage documentation completed by nursing staff in Paediatric Urgent and Emergency care has dedicated sections designed to highlight risk factors, including special needs and requirements for reasonable adjustments that can be made to support the child or young person during their time within the hospital setting.

The Paediatric Liaison Team referral criteria has a clear health inclusion focus, ensuring a focus on behalf of vulnerable children and young people.

There are translation services available where required, utilised by Paediatric (and adult) Urgent and Emergency Care Services, and provision readily available for families including access to meals and basic comfort items.

The Service is currently undertaking a postcode analysis of incident reviews to look at potential support needs and areas for development within areas of deprivation. There is also a planned expansion of play therapy services to support acute admissions and emergency care pathways.

Health and care organisations in Ashfield, Mansfield, Newark and Sherwood work together through the Mid Nottinghamshire Health Inequalities Oversight Group to coordinate efforts aimed at reducing health disparities. This group has developed a comprehensive Health Inequalities Plan, which has been integrated into the broader Integrated Care System (ICS) strategy.

This includes developing integrated urgent care services to provide a unified point of access, ensuring timely and appropriate crisis responses. For instance, the clinical navigator service, Call for Care, provides support to patients over 18 with complex physical health and care needs who are at risk of hospital attendance are supported through clinical triage and a two-hour response to find alternative care options.

There are also four Network Navigators working across Mid Nottinghamshire. They provide a link between acute, community, general practice, adult social care, public health and the third sector. They aim to reduce the need for non-elective care and to support patients in having a better quality of life.

The Trust's Drug and Alcohol Liaison Team (DALT) continues to improve the health and wellbeing of patients affected by substance misuse. Delivered by Change Grow Live and commissioned by Nottinghamshire County Council, the team supports both inpatients and outpatients across the Trust and the community.

In 2024/25, DALT's work has focused on:

- Specialist assessment, harm reduction and motivational support
- Health promotion and safer discharge planning
- Education and training for hospital and community clinicians
- Signposting and referral into ongoing treatment pathways

  Working closely with the Trust's Gastroenterology service, DALT supports FibroScan diagnostics – identifying liver damage early and targeting interventions for some of the most complex and high-intensity service users.

Evidence shows that teams like DALT can:

- Reduce ED attendances related to alcohol by 43%
- Cut hospital admissions and re-admissions by up to 3%

This reduces pressure on urgent and emergency care, while supporting long-term recovery and reducing wider social and economic harms associated with drug and alcohol use.

Smoking cessation

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

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

Patient Experience

""The Phoenix Team was absolutely amazing. I felt like a friend rather than a patient. They are not here to judge and there was no pressure. I was able to try different nicotine replacement products for free and do it in my own time."

Oral health

Tooth decay remains the most common oral disease affecting children and young people in England – yet it is largely preventable. Despite public health efforts, hospital tooth extraction continues to be the most common reason for hospital admissions among children aged 6 to 10, and the vast majority of extractions in 0 to 5-year-olds are still due to avoidable tooth decay.

The most recent national and local data confirms that oral health inequalities persist:

- Children in the most deprived communities experience more than twice the levels of tooth decay compared to those in the least deprived.
- These inequalities reflect wider barriers to prevention, including access to fluoride toothpaste, regular dental care, healthy nutrition, and early education.

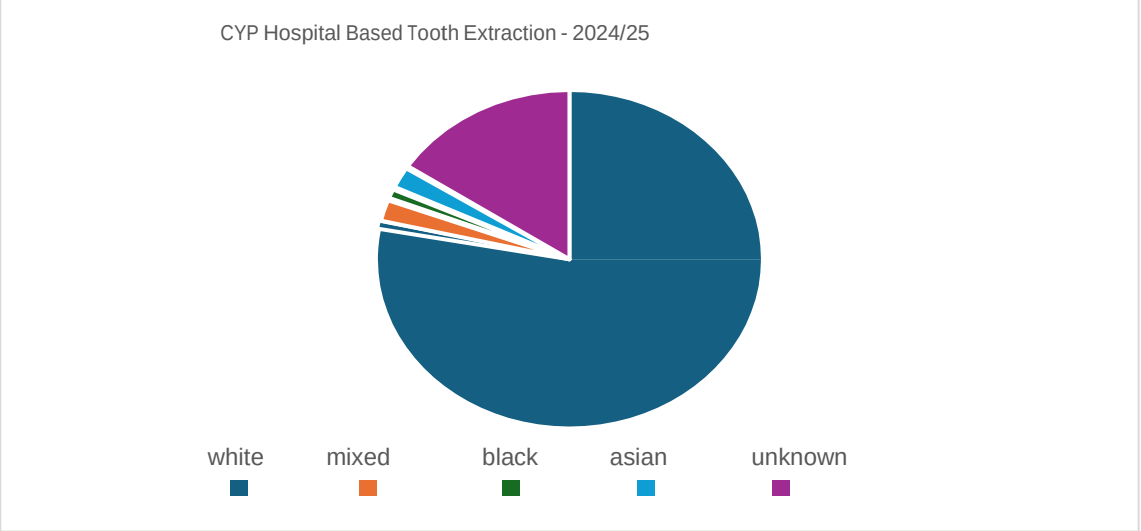
Of the 90 children and young people having a hospital tooth extraction procedure in 2024/25 41.1% were from the 20% most deprived areas in our communities.

Poor oral health, particularly gum disease (periodontal disease), can have significant long-term health consequences, potentially increasing the risk of heart disease, stroke, diabetes, and respiratory problems, among other condition, which are significantly more prevalent in more deprived populations.

Patient Experience*

*"I had no idea that oral health and making sure XXX brushes their teeth properly can impact on their health or increase his risk of pneumonia or future health problems. I'm really grateful that the nurse has told us this – I'll pay more attention!" **Parent in paediatric resp, 2025

The majority of patients having hospital tooth extractions have been white, however there is a significant portion of patients whose ethnicity has not been recorded, meaning this may not be as reflective as we would hope of the issues for our local population.



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

In 2024/25, addressing inequalities in oral health remains a key public health priority across Mid Nottinghamshire, particularly in the context of persistent deprivation-related disparities and rising pressures on paediatric dental services.

It is recognised that the most common oral diseases – tooth decay and gum disease – as well as oral cancers, share many of the same common risk factors (e.g. smoking, alcohol misuse, obesity and poor diet) as other common diseases, such as cardiovascular disease and other cancers – so addressing these risk factors can benefit more than one aspect of health and support in prevention of future complications.

Water fluoridation, a scientifically proven method of adding small amounts of fluoride to drinking water, is a key player in the fight against tooth decay. Already, 30% of Nottinghamshire residents, around 247,000 people, have access to fluoridated water.

However, this coverage does not extend across the whole ICS geography, leading to inequalities in oral health outcomes.

To address this Nottinghamshire County Council has continued to explore extending fluoridation schemes, particularly to areas of higher need within Mid Nottinghamshire and Mansfield. Evidence suggests this could lead to a 35% reduction in decayed, missing and filled teeth in five-year-olds and a 56% decrease in hospital admissions for tooth extractions among children in the most deprived areas. This is anticipated to see a return on investment of £12.71 per £1 within five years, and £21.98 per £1 after ten years.

In 2023, Nottingham City Council and Nottinghamshire County Council secured £100,000 of ring-fenced funding from NHS England to buy and distribute toothbrushing packs to foodbanks and other organisations in the community, who provide support for vulnerable people and families who may be most at risk of experiencing poor oral health. The packs are being distributed to help enable people who are currently unable to purchase these supplies, to brush their teeth by the recommended two times a day. Nottinghamshire County Council also commission an oral health promotion service that offers training to services that work with children and vulnerable adults. The service runs a supervised tooth brushing programme in targeted schools in areas of high need, produces resources for parents of young children and runs oral health promotion campaigns.

Remuneration Report

Scope of the report

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

Annual Statement on Remuneration from the Chair of the Remuneration Committee

The Remuneration Committee met nine times during the year and key decisions made included: exceptional acting-up arrangements as a consequence of the sudden, unplanned absence of the Chief Executive and in relation to the appointment of the Chair as Acting Chair following the election of the previous Chair as East Midlands Mayor, and subsequently his appointment to the substantive position. In addition, the Committee transacted its regular business in relation to executive team remuneration, approval of a pension restructuring payment, approval of the salary increases for VSM staff and the consideration of executive directors' appraisals.

Senior managers' remuneration policy

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

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

There are, however, no contractual provisions for performance-related pay for executive directors and senior managers and, as such, no performance related payments were made relating to 2024/25.

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

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

Executive appointments to the Board of Directors continue under permanent contracts

Governance for the approval of remuneration packages, in line with the policy, is in place through the Remuneration Committee, which considers pay on an individual basis attributed to scope and remit of role. Through the Remuneration Committee, the Board assures itself that salaries are commensurate with other organisations of similar size and complexity. It also considers the nature of the patient, quality, and safety challenges to provide assurance that any given salary reflects the degree of responsibility and accountability.

Senior manager remuneration

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

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

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

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

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

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

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

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

From 1st April 2024, the Committee approved: to align the Executive Directors salary to the medium quartile of the Very Large acute hospital senior manager pay benchmark. The alignment resulted in five Executive Directors receiving a pay increase.

In 2024/2025 the Trust did not appoint any new Executive Directors.

In accordance with the NHS England (NHSE) letter to Chief People Officers of Trusts and NHS Foundation Trusts dated 18 September 2024, the Senior Salaries Review Body (SSRB) made recommendations regarding the 2024/2025 pay award for Very Senior Managers (VSMs), which were accepted in full by the government. The SSRB recommended an across the board increase of 5% for all VSMs to be applied and back dated to 1 April 2024. The Remuneration Committee accepted and have implemented the principles of the letter from NHSE with Executive Directors on VSM contracts receiving a 5% pay increase (on basic pay) from 1 April 2024. Any salary which exceeded or further exceeded the £150,000 threshold did not require His Majesty Treasury (HMT) approval providing the 5% was not exceeded.

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

Senior managers paid more than £150,000 per annum

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

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

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

Non-Executive Directors' remuneration

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

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

Non-Executive Directors each have terms of no more than three years and can serve two concurrent terms (no more than six years), dependent on formal assessment and confirmation of satisfactory on-going performance. Non-executive directors may be able to serve for a maximum total of nine years, with years seven to nine requiring annual approval by the Council of Governors and subject to NHSE scrutiny and agreement.

Their remuneration framework, as agreed previously by the Council of Governors, is consistent with best practice and external benchmarking, and remuneration during 2024/25 has been consistent with that framework. Benchmarking is provided via the NHS provider annual remuneration survey. There were no cost-of-living increases applied for non-executive directors during 2024/25.

None of the Non-Executive Directors are employees of the Trust; they receive no benefits or entitlements other than fees and expenses incurred while on Trust business

and are not entitled to any termination payments. The Council of Governors determines the terms and conditions of the Non-Executive Directors.

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

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

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

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

Entitlements to severance payments are in line with those of other employees within the Trust, namely those provisions contained in section 16 of Agenda for Change: National NHS terms. This is based on length of continuous and reckonable NHS service and basic pay. The basic pay element had a salary cap of £80,000 during 2024/2025.

Statement of consideration of employment conditions elsewhere in the Foundation Trust

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

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

Annual Report on Remuneration (not subject to audit)

Senior manager remuneration

Name	Title	Start Date	Expiry	Notice Period
Paul Robinson	Chief Executive	01/04/2022	17/02/2025	6 months
Rachel Eddie	Chief Operating Officer	25/07/2022		6 months
Dr David Selwyn	Acting Chief Executive	20/05/2024		6 months
Dr David Selwyn	Medical Director	09/12/2019		6 months
Dr Simon Roe	Acting Medical Director	20/05/2024		6 months
Sally Brook Shanahan	Director of Corporate Affairs	15/05/2023		6 months
Robert Simcox	Director of People	10/06/2022		6 months
Philip Bolton	Chief Nurse	30/05/2022		6 months
Richard Mills	Chief Finance Officer	10/06/2022		6 months

Non-Executive Directors' remuneration

Service Contracts

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

Name	Title	Start Date	Expiry	Notice Period
Claire Ward	Non-Executive Director (Chair)	01/10/2021	24/05/2024	1 month
Graham Ward	Non-Executive Director (Acting Chair)	01/12/2015	24/05/2024	1 month
Graham Ward	Non-Executive Director	25/05/2024	31/03/2026	1 month
Barbara Brady	Non-Executive Director	01/10/2018	30/09/2025	1 month
Manjeet Gill	Non-Executive Director	01/11/2018	31/10/2025	1 month
Steven Banks	Non-Executive Director	01/12/2021	30/11/2027	1 month
Dr Aly Rashid	Non-Executive Director	10/01/2022	09/01/2025	1 month

Andrew Rose Britton	Non-Executive Director	01/04/2022	28/04/2026	1 month
Richard Cotton	Non-Executive Director	01/02/2025	31/01/2028	1 month
Lisa McLean	Non-Executive Director	01/02/2025	31/01/2028	1 month
Professor Sir Jonathan Nguyen Van-Tam	Specialist Non-Executive Advisor to the Board	01/02/2025	31/01/2028	1 month
Dr Andrew Haynes	Specialist Non-Executive Advisor to the Board	19/04/2021	18/04/2025	1 month

Major decisions on senior managers' remuneration

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

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

Payments for loss of office

No payments for loss of office were made during 2024/25.

Payments to past senior managers

No payments to past senior managers were made during 2024/25, or to any individual who was not a senior manager during the financial year but has previously been a senior manager at any time.

Remuneration and Nomination Committees

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

The Board appoints the Remuneration and Nomination Committee membership of which comprises exclusively Non-Executive Directors. The committee meets to determine, on behalf of the Board, the remuneration strategy for the Trust, including the framework of executive and senior manager remuneration.

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

Name	Meetings attended out of possible total
Barbara Brady (Committee Chair)	9/9
Manjeet Gill	8/9
Steve Banks	7/8
Dr Aly Rashid	5/6
Richard Cotton	2/2
Graham Ward	1/1

The committee also invited the assistance of the Trust's Chief Executive (Paul Robinson)/Acting Chief Executive (Dr David Selwyn), Director of People (Robert Simcox) and the Director of Corporate Affairs (Sally Brook Shanahan). None of these individuals, nor any other executive or senior manager, participated in any decision relating to their own appointment or remuneration.

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

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

Name	Meetings attended out of possible total
Claire Ward (Chair) to 24/05/24	1/1
Graham Ward (Chair) from 25/05/24	3/3
Liz Barrett (Lead Governor)	5/5

Ian Holden (Public Governor)	5/5
John Wood (Public Governor)	0/1
Nikki Slack (Appointed Governor)	0/1
Vikram Desai (Staff Governor)	3/5
Kevin Stewart (Appointed Governor)	4/4
Tracy Burton (Public Governor)	2/4
Dean Wilson (Public Governor)	4/4

The Committee also invited the assistance of the Director of Corporate Affairs (Sally Brook Shanahan) and the Trust's Senior Independent Director (Barbara Brady) who chaired the meeting at which the Chair's appraisal was considered. Neither they, nor any other executive or senior manager, participated in any decision relating to their own remuneration.

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

- Chair's Appraisal Outcome and Objectives
- The appointment of a new Non-Executive Director
- The appointment of an Associate Non-Executive Director
- Acting Chair's objectives and personal development plan
- The re-appointment of two Non-Executive Directors who had reached the end of their tenure.
- Appointment of Vice Chair, and
- The appointment of a Non-Executive Director to fill a vacant post

Disclosures required by Health and Social Care Act

Governor and Director Expenses

During the year the total number of Directors who served on the Board was 19 and the number of Governors serving on the Council of Governors totalled 22 during the year. We reimbursed expenses incurred in respect of Trust business as follows:

Directors		**Total paid 2024/2025 £'00**	**Total paid 2023/2024 £'00**
Claire Ward	Chair (to 24th May 2024)	5.17	13.40
Graham Ward	Acting Chair (from 25th May 2024) Chair (from 11th February 2025)	0	0
Barbara Brady	Non-Executive Director	3.76	0
Manjeet Gill	Non-Executive Director	0	0
Steve Banks	Non-Executive Director	0	0
Dr Aly Rashid	Non-Executive Director	5.48	7.27

Directors		Total paid 2024/2025 £'00	Total paid 2023/2024 £'00
Andrew Rose-Britton	Non-Executive Director	0	0
Neil McDonald	Non-Executive Director	0	0
Dr Andrew Haynes	Specialist Adviser to the Board	0	0
Richard Cotton	Non-Executive Director	0	N/A
Lisa Maclean	Non-Executive Director	0	N/A
Sir Jonathan Nguyen Van-Tam	Associate Non-Executive Director	0	N/A
Paul Robinson	Chief Executive	1.30	
Dr David Selwyn	Acting Chief Executive Officer	2.81	5.75
Dr David Selwyn	Medical Director	0	4.36
Richard Mills	Chief Finance Officer	0	0
Rob Simcox	Director of People	2.36	2.00
Philip Bolton	Chief Nurse	0	0
Rachel Eddie	Chief Operating Officer	0.98	0.85
Sally Brook Shanahan	Director of Corporate Affairs	7.34*	0.99
	TOTAL	**14.79**	**34.62**

*comprises £337.00 (2023/24) and £397.00 (2024/25) for SRA Practising Certificate and Compensation Fund contribution enabling previously outsourced legal work to be carried out in-house.

Governors	Constituency	Area	Total 2024/25 £'00	Total 2023/24 £'00
Angie Jackson	Appointed Governor	Mansfield District Council	No claim	No claim
David Walters	Appointed Governor	Ashfield District Council	No claim	No claim
Dean Wilson	Public Governor	Rest of East Midlands	No claim	No claim
Ian Holden	Public Governor	Newark and Sherwood	No claim	No claim
Jane Stubbings	Public Governor	Rest of East Midlands	£1.32	£2.34
John Doddy	Appointed Governor	Nottinghamshire County Council	No claim	No claim
John Dove	Public Governor	Rest of East Midlands	No claim	£0.07
John Wood	Public Governor	Rest of East Midlands	No claim	No claim
Justin Wyatt	Staff Governor	Staff	No claim	No claim

Governors	Constituency	Area	Total 2024/25 £'00	Total 2023/24 £'00
Karen Nadin	Public Governor	Newark and Sherwood	N/A	£0.79
Kevin Stewart	Appointed Governor	Sherwood Forest Hospitals Volunteers	No claim	No claim
Linda Dales	Appointed Governor	Newark and Sherwood District Council	No claim	No claim
Liz Barrett	Public Governor	Rest of East Midlands	No claim	No claim
Neal Cooper	Public Governor	Rest of East Midlands	No claim	No claim
Nikki Slack	Appointed Governor	West Notts College	No claim	No claim
Pam Kirby	Public Governor	Rest of East Midlands	No claim	No claim
Peter Gregory	Public Governor	Newark and Sherwood	No claim	£1.20
Ruth Scott	Public Governor	Rest of East Midlands	No claim	No claim
Samantha Musson	Staff Governor	Staff	No claim	No claim
Shane O'Neill	Public Governor	Newark and Sherwood	No claim	No claim
Steven Hunkin	Public Governor	Rest of East Midlands	N/A	No claim
Susan Holmes	Public Governor	Rest of East Midlands	N/A	No claim
Tracy Burton	Public Governor	Rest of East Midlands	No claim	No claim
Vikram Desai	Staff Governor	Staff	No claim	No claim
TOTAL			**1.32**	**4.40**

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

Remuneration report – salaries and allowances (sibject to audit)

		2024/25						2023/24					
		Salary (Bands of £5,000)	Expense payments (taxable) total to nearest £100	Performance pay and bonuses (Bands of £5,000)	Long term performance pay and bonuses (Bands of £5,000)	All pension-related benefit (Bands of £2,500)	TOTAL (Bands of £5,000)	Salary (Bands of £5,000)	Expense payments (taxable) total to nearest £100	Performance pay and bonuses (Bands of £5,000)	Long term performance pay and bonuses (Bands of £5,000)	All pension-related benefit (Bands of £2,500)	TOTAL (Bands of £5,000)
		£'000	£	£'000	£'000	£'000	£'000	£'000	£	£'000	£'000	£'000	£'000
Executive Directors													
Mr P Robinson (1)	Chief Executive	180-185	100	-	-		180-185	205-210	5,300	-	-	-	210-215
Mr P Bolton (2)	Chief Nurse	160-165	-	-	-		160-165	150-155	-	-	-	-	150-155
Ms R Eddie	Chief Operating Officer	145-150	100	-	-	20.0-22.5	170-175	140-145	-	-	-	-	140-145
Dr D Selwyn (3)	Medical Director and Acting Chief Executive	265-270	300	-	-		265-270	205-210	-	-	-	-	240-245
Mr R Simcox	Director of People (HR)	140-145	200	-	-	25.0-27.5	165-170	130-135	-	-	-	50.0-52.5	185-190
Mr R Mills	Chief Financial Officer	150-155	-	-	-		150-155	145-150	1,100	-	-	155.0-157.5	300-305
Mrs S Brook Shanahan (4)	Director of Corporate Affairs	105-110	700	-	-	27.5-30.0	140-145	75-80	100	-	-	15.0-17.5	95-100
Ms C Hinchley (5)	Interim Director of Strategy and Partnerships	110-115	-	-	-		110-115	5-10	100	-	-	0-2.5	10-15
Mr S Roe (6)	Deputy Medical Director	100-105	-	-	-	70.0-72.5	265-270	-	-	-	-	-	-
Ms S Higginbotham (7)	Director of Corporate Affairs						-	15-20	-	-	-	-	15-20
Mr D Ainsworth (8)	Director of Strategy and Partnerships						-	125-130	-	-	-	2.5-5.0	130-135
Non Executive Directors													
Ms C Ward (9)	Chair	5-10	500	-	-	-	5-10	50-55	1,300	-	-	-	50-55
Mr G Ward (10)	Acting Chair	40-45	-	-	-	-	40-45	0	-	-	-	-	-
Ms B Brady	Non-Executive Director	10-15	400	-	-	-	15-20	10-15	-	-	-	-	10-15
Ms M Gill	Non-Executive Director	10-15	-	-	-	-	10-15	10-15	-	-	-	-	10-15
Mr G Ward	Non-Executive Director	0-5	-	-	-	-	0-5	10-15	-	-	-	-	10-15
Dr A Rashid (11)	Non-Executive Director	10-15	700	-	-	-	10-15	10-15	700	-	-	-	10-15
Mr S Banks	Non-Executive Director	10-15	-	-	-	-	10-15	10-15	-	-	-	-	10-15
Mr A Rose-Britton (12)	Non-Executive Director	10-15	-	-	-	-	10-15	10-15	-	-	-	-	10-15
Mr N McDonald	Non-Executive Director	10-15	-	-	-	-	10-15	0-5	-	-	-	-	0-5
Sir J Nguyen Van-Tam (13)	Non-Executive Director	0-5					0-5	-	-	-	-	-	-
Ms L Mclean (14)	Non-Executive Director	0-5					0-5	-	-	-	-	-	-
M R Cotton (15)	Non-Executive Director	-	-	-	-	-	-	0-5	-	-	-	-	0-5
Dr A Haynes	Specialist Advisor to the Board	10-15	-	-	-	-	10-15	10-15	-	-	-	-	10-15

Notes (2024/25)

1 - Mr P Robinson chose not to be covered by the pension arrangements during the reporting year. Death in service 17th February 2025.

2 - Mr P Bolton chose not to be covered by the pension arrangements during the reporting year.

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

6 - Dr S Roe on secondment from NUH as Deputy Medical Director appointed 20th May 2024

9 - Ms C Ward left 24th May 2024

10 - Mr G Ward appointed Acting Chair 25th May 2024

11 - Dr A Rashid left 9th January 2025

12 - Sir Jonathan Nguyen Van-Tam appointed 1st February 2025

13 - Ms L Mclean appointed 1st February 2025

14 - Mr R Cotton appointed 1st February 2025

Notes (2023/24)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Pensions Disclosure

	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2025 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2025 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2024	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2025	Employer's contribution to stakeholder pension
Executive Directors	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Mr P Robinson **	-	-	-	-	-	-	-	-
Mr P Bolton **	-	-	-	-	-	-	-	-
Ms R Eddie	0-2.5		50-55.	135-140	1,142	27	1,264	-
Dr D Selwyn **	-	-	-	-	-	-	-	-
Mr R Simcox *	0-2.5		35-40.	85-90.	612	16	688	-
Mr R Mills *	-	-	35-40.	80-85.	617	-	638	-
Mrs S Brook Shanahan	0-2.5	-	5-10.	0-5	62	27	107	-
Ms C Hinchley	-	-	30-35.	85-90.	717	-	688	-
Mr S Roe	2.5-5.0	5-7.5	75-80.	200-205	1,590	82	1,820	-
	2023/24							
Mr P Robinson **	-	-	-	-	-	-	-	-
Mr P Bolton **	-	-	-	-	-	-	-	-
Ms R Eddie		37.5-40.0	45-50.	130-135	840	197	1,142	-
Dr D Selwyn **	-	-	-	-	-	-	-	-
Mr R Simcox *	0-2.5	32.5-35.0	30-35.	80-85.	372	184	612	-
Mr D Ainsworth *	-	32.5-35.0	50-55.	145-150	914	212	1,238	-
Mr R Mills *	5-7.5	42.5-45.0	30-35.	85-90.	310	256	617	-
Mrs S Brook Shanahan	0-2.5	-	0-5	-	29	15	62	-
Ms C Hinchley	0-2.5	0-2.5	35-40.	95-100.	449	9	717	-

* These members' pension entitlements relate to the total values under two different NHS schemes

** chose not to be covered by the pension arrangements during the reporting year. Involvement in the NHS pension scheme terminated from Feb 20

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

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

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

Fair Pay Multiple

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

The banded remuneration of the highest paid director in the Foundation Trust in the financial year 2024-25 was £265,000 - £270,000 (2023-24 was £215,000 - £220,000. This is a change in salary between years of 22.99%. (2023-24 3.5%). Excluding 5 agency and bank staff who worked on the 31 March 2025, where their salary has been extrapolated to full year equivalent costs, no employees (2023-24, 0) received remuneration more than the highest-paid director.

For all employees of the Trust as whole the remuneration ranged from £12,514 to £268,297, (2023-24, £10,324 to £207,496). This excludes the agency and bank salaries more than the highest paid director, which have been extrapolated to yearly cost. The percentage change in average employee remuneration (based on total for all employees on an annualised basis divided by full time equivalent number of employees) between years is 5.21% (2023-24 0.06%.).

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

The median remuneration is based on annualised, full-time equivalent remuneration of all employees as at the reporting date. This has been calculated excluding any enhancements or overtime payments.
Staff benefits in kind are not included as the information is not available until July.

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

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

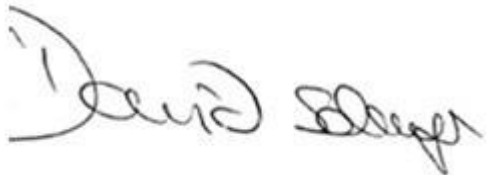
2024/25	25th Percentile £	Median £	75th Percentile £	2023/24	25th Percentile £	Median £	75th Percentile £
Salary Component of Pay	24,071	32,324	44,962	Salary Component of Pay	22,816	30,639	43,742
Total benefits excluding pension benefits	24,071	32,324	44,962	Total benefits excluding pension benefits	22,816	30,639	43,742
Pay and Benefits:Pay ratio for highest pay director	11.1	8.3	5.9	Pay and Benefits:Pay ratio for highest pay director	9.09	6.77	4.74

Related party transactions

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

Compliance statement

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



Dr. David Selwyn
Acting Chief Executive Officer **19th June 2025**

Staff Report

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

The Trust's average workforce numbers from 1st April 2024 to 31st March 2025 are:

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

		2024/25		2023/24
	Total	**Permanent**	**Other**	**Total**
Medical and dental	**919**	826	93	**856**
Ambulance	**3**	3		**2**
Administration and estates	**1,364**	1,318	46	**1,311**
Healthcare assistants and other support staff	**1,301**	1,111	190	**1,337**
Nursing, midwifery and health visiting staff	**1,758**	1,581	177	**1,687**
Nursing, midwifery and health visiting learners	**7**	7		**19**
Scientific, therapeutic and technical staff	**476**	444	32	**440**
Healthcare science staff	**159**	157	2	**157**
Other	**39**	39	0	**40**
Total average numbers	**6,026**	**5,486**	**540**	**5,849**
Of which:				
Number of employees (WTE) engaged on capital projects	**1**	1		**2**

While only one full time member of staff was employed to permanently manage capital, other staff costs have been incurred and capitalised relating to specific 2024/25 capital projects.

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

Breakdown of staff (actual headcount at 31 March 2025)

	Male	Female	Total
Director	9	5	14
Other Senior Manager	97	206	303
Employee	1225	4722	5947
Grand Total	**1331**	**4933**	**6264**

Staff Costs - Subject to audit

	Total	Permanent	Other	Total
	31-Mar-25	31-Mar-25	31-Mar-25	31-Mar-24
	2024/25	2024/25	2024/25	2023/24
Salaries and wages	270,118	270,118	0	244,165
Social security costs	30,016	30,016	0	28,105
Apprenticeship levy	1,379	1,379	0	1,240
Pension cost - employer contributions to NHS pension scheme	30,106	30,106	0	27,186
Pension cost - employer contributions paid by NHSE on provider's behalf (6.3%)	19,669	19,669	0	11,857
Pension cost - other*	74	74	0	131
Other post employment benefits	0	0	0	0
Other employment benefits	0	0	0	0
Termination benefits	0	0	0	0
Temporary staff - external bank	0	0	0	0
Temporary staff - agency/contract staff	13,699	0	13,699	16,580
TOTAL GROSS STAFF COSTS	**365,061**	**351,362**	**13,699**	**329,264**
Recoveries from DHSC Group bodies in respect of staff cost netted off expenditure	0	0	0	0
Recoveries from other bodies in respect of staf	0	0	0	0
TOTAL STAFF COSTS	**365,061**	**351,362**	**13,699**	**329,264**
Included within:				
Costs capitalised as part of assets	1,234	1,234	0	409

Sickness absence

Information regarding the Trust's sickness absence data is published by NHS Digital at: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates

The sickness absence data for the Trust is outlined below. Please note the figures given are in calendar years (January 2024 to December 2024).

	Figures converted by DH to Best Estimates of Required Data Items			Statistics Published by NHS Digital from ESR Data Warehouse	
	Average FTE for 2023	Adjusted FTE days lost to Cabinet Office definitions	Average Sick Days per FTE	FTE-Days Available	FTE-Days Lost to Sickness Absence
Sherwood Forest Hospitals NHS Foundation Trust	5,405	61,530.7	11.4	1,978,339.2	99,243.1

Health and Safety at Work 2024/25

The Trust is committed to safeguarding the health, safety, and well-being of its employees, as outlined in the NHS Constitution and the People Strategy for 2025 to 2029. The Trust's goal is to provide a safe and healthy working environment for all staff.

The Health and Safety Team collaborates with various organisations, managers, specialist teams, and individuals to ensure the safety of staff, patients, visitors, and contractors. This approach aligns with the Health and Safety at Work Act 1974, which emphasises shared responsibility for safety.

Divisional management teams and staff representatives are encouraged to work together on health and safety matters, fostering a collaborative approach across the organisation.

The Health and Safety Committee serves as the main forum for consultation on work-related safety issues. This committee meets bi-monthly and reports to the Risk Committee, chaired by the Chief Executive. Additionally, it collaborates with the People Wellbeing Cabinet, the Estates Governance Group, and the Infection Prevention and Control Committee to address all health and safety risks comprehensively.

To monitor performance, the Trust employs both proactive and reactive measures. One key metric is the rate of non-fatal injuries reported to the Health and Safety Executive under RIDDOR (2013). In 2024/25, the Trust reported 11 injuries, the same as the previous year, with a staff headcount of 6,253 (compared to 6,139 in the previous year).

The Trust's RIDDOR injury rate per 100,000 employees was 176, lower than the national average of 294 for the human health activities sector. This marks an improvement from last year's rate of 179, compared to the national average last year of 259. There has been no increase year or year in serious work-related injuries at the Trust since 2017/18.

Looking ahead, the Trust's health and safety priorities for the coming year will align with its people priorities and focus on reducing workplace ill-health, improving staff wellbeing, and preventing work-related violence and aggression. These initiatives aim to contribute to excellent patient care by ensuring a safe working environment for all staff.

Staff policies and actions applied during the financial year

People policies and actions applied during the financial year

The Trust follows a clear governance structure for the approval and ratification of policies and procedures for matters relating to current and prospective staff members. Each of the Trust's policies for its people requires the completion of an Equality Impact Assessment covering all protected characteristics; the purpose of the assessment is

to mitigate any possible areas of direct or indirect discrimination and/or inequity as part of the approval and ratification process.

The Trust's Equality Impact Assessment guidance has updated to ensure clarity for policy writers on the appropriate completion of an assessment and the governance process that should be followed which includes review of all People Policy Equality Impact Assessments by the People EDI Team. The Equality Impact Assessment form has also been updated and simplified to support assessors in the completion of the form and providing the necessary data and consultation information that may have been used in the assessment.

The Trust's People policies cover the journey of employment in Sherwood from recruitment, commencement of employment, identifying statutory and mandatory training, and ensuring development to support career progression. The People policies also establish minimum expectations in relation to conduct, behaviour and performance, as well as supportive approaches to allow staff members to raise matters of concern in a safe and protected way.

The Trust continues to operate fair recruitment practices to ensure equal access to employment opportunities for all.

The Trust has been awarded 'Disability Confident Employer' status until March 2026 which supports the Trust to make the most of the talents disabled people can bring to the workplace. As an employer this status means the Trust is committed to the following:

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

The Trust has signed up to the Mindful Employer charter which is in place until July 2026. In signing the Charter, the Trust has committed to the following:

- To provide non-judgemental and proactive support to staff experiencing mental ill-health.
- To not make assumptions about a person with a mental health condition and their ability to work.

- To be positive and enabling toward all employees and applicants with a mental health condition.
- To support line managers in managing mental health in the workplace.
- To ensure we are fair in the recruitment of new staff in accordance with the Equality Act (2010).
- To make it clear that people who have experienced mental ill-health will not be discriminated against, and that disclosure of a mental health conditions will enable both the employee and employer to assess and provide the right level of support or adjustment.

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

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

Table 1: Relevant union officials

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

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
33	24.66

Table 2: Percentage of time spent on facility time

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

Percentage of time	Number of employees
0%	23
1-50%	7
51%-99%	0
100%	3

Table 3: Percentage of pay bill spent on facility time

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

First Column	Figures
Provide the total cost of facility time	106,639.56
Provide the total pay bill	363,483,000
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.03%

Table 4: Paid trade union activities

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

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100	8.78%

Expenditure on consultancy

Consultants have been used where specific expertise is required which is not available in- house or where the capacity to complete a time limited exercise does not exist. No consultancy has been used for Executive level appointments. The Trust spent £0.59m on consultancy during the year, (2023/24 £0.23m).

Off-payroll engagements

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

Table 1: For all off-payroll engagements as of 31 March 2025, for more than *£245* per day and that last for longer than six months

Number of existing engagements as of 31 March 2025	0
Of which...	
No. that have existed for less than one year at time of reporting	0
No. that have existed for between one and two years at time of reporting.	0
No. that have existed for between two and three years at time of reporting.	0
No. that have existed for between three and four years at time of reporting.	0
No. that have existed for four or more years at time of reporting.	0

Table 2: For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2024 and 31 March 2025, for more than *£245* per day and that last for longer than six months

Number of new engagements, or those that reached six months in duration, between 1 April 2024 and 31 March 2025	0
Of which:	
Number assessed as within the scope of IR35	0
Number assessed as not within the scope of IR35	0
Number engaged directly (via PSC contracted to trust) and are on the trust's payroll	0
Number of engagements reassessed for consistency/assurance purposes during the year	0
Number of engagements that saw a change to IR35 status following the consistency review	0

Table 3: For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2024 and 31 March 2025

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

Process for off-payroll arrangements

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

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

Exit packages (subject to audit)

	2024/25			2023/24		
	Number of Compulsory Redundancies	Number of Other Departures agreed	Total Number of exit Packages by Cost Band	Number of Compulsory Redundancies	Number of Other Departures agreed	Total Number of exit Packages by Cost Band
<£10,000	0	1	1	0	3	3
£10,001 - £25,0000	0	4	4	0	2	2
£25,001 - £50,000	0	0	0	0	1	1
£50,001 - £100,000	0	2	2	0	0	0
£100,001 - £150,000	0	1	1	0	0	0
£150,001 - £200,000	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0
Total number of packages by type	0	8	8	0	6	6
Total resource used	0	363	363	0	81	81

	2024/25		2023/24	
	Agreements Number	Total Value of Agreements £000	Agreements Number	Total Value of Agreements £000
Voluntary redundancies including early retirement	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	0	0	0	0
Early retirement in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	8	363	5	66
Exit payments following Employment Tribunals or court orders	0	0	1	16
Non contractual payments requiring HMT approval	0	0	0	0
Total	8	363	6	82
Of which:				
non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months of their annual salary	0	0	1	16

Staff Survey

National Staff Survey

Staff Experience and Engagement

An essential vehicle for hearing the voices of the Trust's staff is through the annual National Staff Survey. Each year, the Trust's culture improvement priorities are reviewed and refreshed in line with the results from this, along with feedback from quarterly pulse surveys, the Freedom to Speak Up Guardian, HR workforce information, and Divisional feedback. Evidence from these sources suggests that Sherwood maintains a high-quality, positive culture overall, and when challenges arise, teams and individuals receive support in resolving them.

Engagement with colleagues remains a Trust priority, with the People Directorate working closely with the Trust Communications team to maximise internal communication channels and provide opportunities for two-way communication wherever possible through a "Your Voice" counts approach.

NHS Staff Survey

The NHS staff survey is conducted annually with the survey questions aligning with the seven elements of the NHS 'People Promise' along two previous themes of engagement and morale. All indicators are based on a score out of 10 for specific questions, with the indicator score being the average of those.

The response rate to the 2024/25 survey among Trust staff was 63% (compared to 62% in 2023/24), which is higher than the national average of 48%. This is the highest number of colleagues completing the survey over the last five years.

2024/25 and 2023/24

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

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

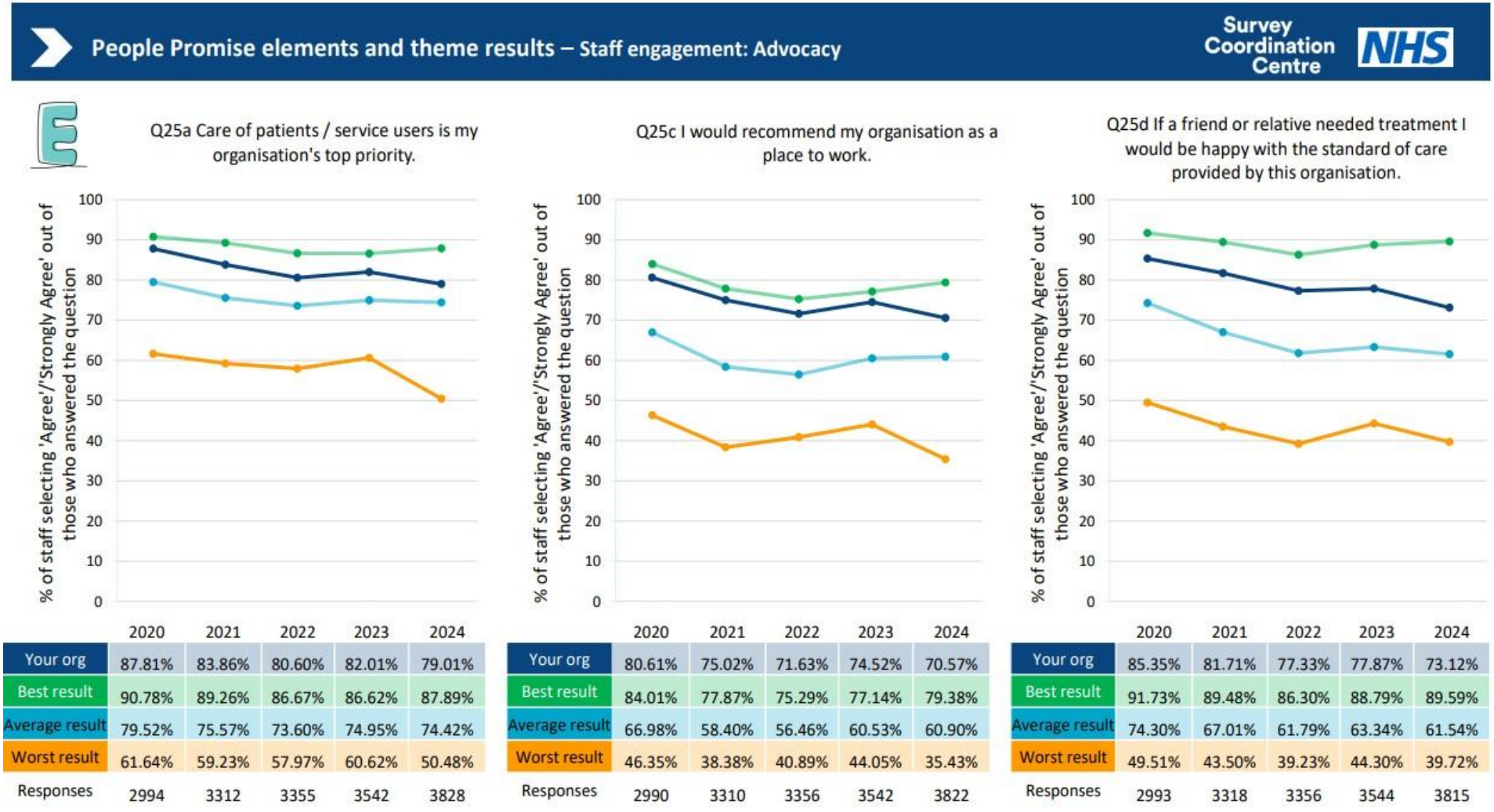
For 2024/25 the Trust's benchmarking position nationally, regionally and East Midlands is as follows:

Theme	National Position (/124 Acute/Acute Community Trusts)	Regional Position (/21)	East Midlands (/9)
We are compassionate and inclusive	9th	2nd	1st
We are recognised and rewarded	17th	3rd	1st
We each have a voice that counts	9th	2nd	1st
We are safe and healthy	11th	3rd	2nd

We are always learning	6th	2nd	1st
We work flexibly	21st	6th	3rd
We are a team	9th	2nd	1st
Staff Engagement	12th	2nd	1st
Morale	13th	2nd	1st

Sherwood Forest Hospitals is above the national average for its comparator peer group in all nine themes.

The graphs below summarise the Trust 2024 National Staff Survey results for three key questions:



	2020	2021	2022	2023	2024
Your org	87.81%	83.86%	80.60%	82.01%	79.01%
Best result	90.78%	89.26%	86.67%	86.62%	87.89%
Average result	79.52%	75.57%	73.60%	74.95%	74.42%
Worst result	61.64%	59.23%	57.97%	60.62%	50.48%
Responses	2994	3312	3355	3542	3828

	2020	2021	2022	2023	2024
Your org	80.61%	75.02%	71.63%	74.52%	70.57%
Best result	84.01%	77.87%	75.29%	77.14%	79.38%
Average result	66.98%	58.40%	56.46%	60.53%	60.90%
Worst result	46.35%	38.38%	40.89%	44.05%	35.43%
Responses	2990	3310	3356	3542	3822

	2020	2021	2022	2023	2024
Your org	85.35%	81.71%	77.33%	77.87%	73.12%
Best result	91.73%	89.48%	86.30%	88.79%	89.59%
Average result	74.30%	67.01%	61.79%	63.34%	61.54%
Worst result	49.51%	43.50%	39.23%	44.30%	39.72%
Responses	2993	3318	3356	3544	3815

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

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

2024/25 and 2023/24

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

	2024/25		2023/24	
	Trust	Benchmarking Group	Trust	Benchmarking Group
We are compassionate and inclusive				
Compassionate Culture	7.45	7.05	7.64	7.06
Compassionate Leadership	7.29	6.98	7.32	6.96
Diversity and Equality	8.41	8.08	8.48	8.12
Inclusion	6.95	6.81	7.08	6.86
We have a voice that counts				
Autonomy and Control	7.14	6.96	7.26	6.99
Raising Concern	6.81	6.38	6.94	6.41
We are safe and healthy				
Health and Safety Climate	5.89	5.49	6.08	5.45
Burnout	5.10	5.01	5.23	5.00
Negative Experience	7.91	7.79	7.87	7.75
We are always learning				
Development	6.67	6.40	6.83	6.44
Appraisals	5.35	4.86	5.29	4.74
We Work Flexibly				
Support for work-life balance	6.58	6.30	6.75	6.25
Flexible Working	6.36	6.17	6.53	6.15
We are a team				

Team Working	6.84	6.67	6.96	6.68
Line Management	7.12	6.82	7.15	6.80
Staff Engagement				
Motivation	7.12	6.98	7.28	7.04
Involvement	7.02	6.83	7.18	6.86
Advocacy	7.25	6.70	7.50	6.74
Morale				
Thinking about leaving	6.47	6.04	6.74	6.06
Work Pressure	5.91	5.36	6.17	5.13
Stressors	6.55	6.38	6.65	6.38

The benchmarking data from 2023/24 to 2024/25 shows that even though scores have deteriorated in some areas, Sherwood Forest Hospitals NHS Foundation Trust remains a high performing Trust compared with the benchmark group.

Future Priorities and Targets:

The Trust's priority areas for 2025 will be:

- Retention - Thinking of Moving and Exit interviews will help the Trust understand what colleagues like and dislike about their jobs and highlight potential areas for improvement.
- Ensuring colleagues have the right equipment they need to do their jobs, so they have adequate materials and supplies.
- Celebration and Recognition across the Trust will be reviewed to increase colleagues' feelings of being valued and recognised.
- To ensure CARE Values are at the heart of everything we do.
- Reporting and addressing unsafe clinical practices so that people feel confident that the Trust would address concerns.

The Trust aims to continue improving these percentages and the quality of its services by focusing on key areas.

The Trust also recognise a need to ensure that it engages with colleagues more meaningfully through one-to-one interactions with its teams, ensuring that everyone's

voice is heard, including those who choose not to participate in the survey. The Trust wants to ensure that for the National Staff Survey in 2025, its response rates improve by reaching those whose voices it hasn't yet heard.

Actions and Monitoring

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

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

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

The results are triangulated with other data sources such as the quarterly pulse surveys, workforce Key Performance Indicators (KPIs) and Speaking Up concerns. This enables more targeted actions and interventions to be identified and supported by People Directorate teams. In 2021/22 we designed an in-house survey explorer tool hosted on the intranet to allow any leader or individual in the organisation to review their own area's results which has again been updated with 2024/25 results.

The diversity and inclusivity results will be scrutinised by the Trust's staff networks and appropriate actions incorporated into their work programmes. The performance of the programme is reported through to the People Committee. Such performance and activity is also reviewed in light of key priorities associated with the Trust's requirements under the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) for example.

Equality Reporting

During the last year, delivery has continued on the Trust's EDI Improvement Plan following the publishing of the NHS EDI Improvement Plan in June 2023. The three-year plan sets out targeted actions to address the prejudice and discrimination – direct and indirect – that exists through behaviour, policies, practices and cultures against certain groups and individuals across the NHS workforce.
The Improvement plan will support continued efforts to ensure that the Trust is an inclusive place to work. In a recent self-evaluation for NHS Midlands, it has been able

to evidence good progression in all areas of the plan and is on track to deliver the actions for 2025/26.
Highlights from Year Two include;

- Completion of Ethnicity and Disability Pay Gap reports this year.
- The launch of Inclusive Recruitment Champions including six champions recruited from the Ethnic Minority network to support diversity on recruitment panels for senior appointments. More champions are planned to be recruited during 2025/26.
- The Board Chair and Executive Directors signed a new Staff Network Pledge in May 2024 outlining the importance of networks and highlighting their support for colleagues to be members and have the time to attend network activities; they are keen that we're able to hear the voices of colleagues as much as possible through the networks. Each Staff network has an Executive Sponsor and they attend meetings when possible.
  Executive team members have attended events in the Trust including but not limited to PRIDE, REACH OUT! and International Women's Day.
- EDI sessions have been designed and delivered as part of the new Leadership Development Programme (Fundamentals, Emerging, and Established).

One of the highlights of 2024/25 was the Staff Excellence Awards where EDI was recognised for the first time with a new award 'Outstanding contribution to EDI'. The deserving winner of the award was Jacqueline Wix who has been instrumental in the success of the Project Search programme at Sherwood.

Amelia Tsolakis, People EDI Support Officer was awarded 'Best Newcomer' at the People Directorate Christmas team brief in December 2024.

Other highlights during 2024/25 include;

- A new EDI calendar was developed and published in 2024 which has supported the EDI team and organisation to celebrate several EDI events throughout the year. Key events that have been celebrated this year include, International Women's Day, LGBTQ+ History Month, Carers Rights Day, Overseas NHS Workers Day, Disability History Month, Neurodiversity Awareness Week, Deaf Awareness week and Carers Week.
- The Equality Impact Assessment guidance and template for People policies has been reviewed and updated. E-learning and lunch and learn sessions are being developed to support policy writers in the effective completion of assessments.
- For the second year running, the Trust had a stand at Nottinghamshire PRIDE where it was able to engage with thousands of local citizens and colleagues showcased the Trust as a place to work and receive care. It also celebrated with two local SFH marches at Kings Mill and Newark Hospitals.
- New Neurodiversity Guidance and Carers' Guidance has been created following feedback through the WAND Staff Network and Carers Staff Network.

- The annual REACH OUT! event took place in September during National Inclusion Week and was very well received by those in attendance. The event was supported by various colleagues from across the Trust who joined on the day to discuss and promote their areas of work and the support available to colleagues. For the third year running, feedback from colleagues in attendance was very positive.
- The NHS Health Passport was promoted during Disability History Month in November and December as outlined within the WDES Action Plan and lunch and learn sessions were provided to support colleagues and managers in the effective use of the passport.
- The Project Search programme continues to be successful and from the first 2-years of the programme six interns have gone into employment in the Trust.
- The organisation's EDI training offer has been extended by creating a package of EDI training that has been added to the E-Academy. This includes, hearing loss awareness training, neurodiversity training, carers awareness training, and disability awareness training.
- The EDI team has delivered several face-to-face EDI training sessions during the year including Allyship in Sherwood Training which is available for all colleagues and runs monthly and bespoke EDI training for various teams.
- A new Faith and Belief Staff Network was launched In February.
- We have reviewed the Anti-Racism strategy and made recommendations for a new No Hate Here approach which will launch during Q2 of 2025/26.

Mandatory Reporting

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

Gender Pay Gap

Sherwood Forest Hospitals has complied with the expectations associated with the gender pay regulations. The Trust's report for 2024/25 can be viewed via the following link: Sherwood Forest Hospitals (sfh-tr.nhs.uk)

WRES and WDES

The Trust's reports for 2024/25 can be accessed via its website Sherwood Forest Hospitals (sfh-tr.nhs.uk)

The Trust also met its obligation to report compliance with the Public Sector Equality Duty through the annual EDI Activity Report which is published in June each year. The latest report can be accessed via the Trust website Sherwood Forest Hospitals (sfh-tr.nhs.uk).

Staff Networks

In May 2024, the Trust relaunched its Staff Networks with a new structure including individual network Safe Spaces, an all-networks support group and an all-networks action group.
The new structure enables members to use their protected time for the network activity that matters most to them.

By bringing all the networks together for the support and action groups the Trust is achieving greater allyship across all networks and has been able to consolidate actions from all networks into one action plan.

Throughout the year, the Trust has recruited to vacant Chair and Co-Chair positions, so all networks now have both a Chair and Co-Chair.

Modern Slavery

This section details the Trust's obligations and actions in relation to Section 54 of the Modern Slavery Act 2015. It describes the measures the Trust has implemented and continues to pursue to prevent modern slavery and human trafficking within the Trust's operations and supply chain.

Modern slavery includes practices such as slavery, servitude, human trafficking, and forced labour. At SFHFT, we acknowledge the crucial role the NHS plays in both fighting against these issues and supporting victims of modern slavery and human trafficking. The Trust is fully aligned with the government's goals to eliminate such abuses and its commitment to ethical conduct, integrity, and transparency in all business transactions is unwavering. Robust systems and controls have been established to protect against any form of modern slavery.

On its website the Trust provide assurance that it does not engage in commissioning services associated with modern slavery and participates in local and national reviews concerning patients who may have experienced modern slavery.

Every staff member bears a personal responsibility for effectively preventing modern slavery and human trafficking, with the Procurement Department assuming primary responsibility for compliance within the supply chain.

Throughout 2024/25, the procurement team and the Trust safeguarding team have collaborated to ensure that all procurement staff are informed about the risks of modern slavery and the necessary actions to take when such risks are identified.

Policies on Slavery and Human Trafficking

The Trust recognises its obligations to patients, caregivers, employees, and the surrounding community, and expects all its suppliers to uphold the same ethical standards. The Trust's supply chain encompasses the procurement of agency personnel, medical services, medical and other consumables, facilities maintenance, utilities, and waste management. The Trust is dedicated to ensuring that modern slavery and human trafficking are absent from its supply chains and all aspects of its operations. It's internal policies reflect a commitment to ethical conduct and integrity in all business interactions.

Currently the Trust requires all contracted suppliers to agree to its terms and conditions, which include provisions that ensure their commitment to combating slavery and human trafficking within their supply chains, as well as conducting their operations in alignment with Trust policies.

The Trust implements various internal policies to guarantee that its business practices are ethical and transparent. These policies include:

Recruitment Policy

The Trust maintains a comprehensive recruitment policy and, through due diligence, aims to identify and mitigate the risks of modern slavery and human trafficking within its organisation and supply chain by:

• Conducting pre-employment checks on staff to verify their identities and eligibility to work in the United Kingdom.

• Ensuring that agencies are part of NHS England's nationally approved frameworks and are subject to audits to confirm that pre-employment clearances have been secured for agency personnel, thereby protecting against human trafficking and forced labour.

• Adhering to NHS Agenda for Change Terms and Conditions to guarantee that staff receive equitable pay rates and contractual terms.

• Engaging with Trade Unions regarding any proposed modifications to employment terms and conditions.

Equal Opportunities: The Trust implements various measures to safeguard employees from mistreatment and exploitation, ensuring adherence to legal and regulatory standards. These measures encompass employment terms and conditions, compulsory training on Equality, Diversity, and Inclusion for all personnel, as well as opportunities for additional training and professional development.

Safeguarding Policies inc. Managing Allegations Policy: The Trust follows the principles outlined in its Think Family Safeguarding Adult and Safeguarding Children policies. These policies align with the multi-agency safeguarding arrangements in Nottinghamshire and offer clear guidance to assist staff in addressing safeguarding concerns related to the treatment of colleagues or individuals utilising the Trust's services, as well as practices within its business or supply chain

Speaking Up Policy: The Trust operates a Speaking Up Policy to empower all employees to voice their concerns regarding the treatment of colleagues or individuals utilising its services, as well as any practices within its organisation or supply chain, without the fear of retaliation.

Employment policies (including Policy and Procedure for Disclosure and Barring Service (DBS) Checks, Employment Records and Information Policy and Procedures, Professional Registration Policy, Induction Policy). These policies outline the Trust's procedures for vetting and barring, which encompass verifying the eligibility to work in the UK for all employees. This is part of a commitment to protect against human trafficking and the exploitation of individuals forced to work involuntarily. The Trust complies with the National NHS employment checks and standards, which include guidelines for health staff on recognising and assisting victims of modern slavery, as well as the obligation to inform the Home Office about potential victims.

Working with Suppliers

The Trust is committed to identifying and addressing risks related to slavery and human trafficking by implementing contractual provisions that ensure these issues are not present in its operations. The Trust will collaborate with its suppliers to ensure they prioritise their responsibilities regarding modern slavery as highly as it does.

Before any supplier is appointed to a framework agreement, they undergo a thorough vetting process through a Selection Questionnaire.

All contracts are issued under the NHS Terms and Conditions, which include provisions that allow the Trust to terminate agreements if there is a failure to adhere to labour laws.

In the procurement of goods and services, the Trust also applies NHS Terms and Conditions for non-clinical purchases and the NHS Standard Contract for clinical acquisitions, both of which mandate compliance with applicable legislation by suppliers.

Staff members at the Trust are required to engage with the procurement department when seeking to establish relationships with new suppliers to ensure that necessary checks are performed.

If it is confirmed that a subcontractor has violated child labour laws or engaged in human trafficking, that subcontractor will be excluded in line with Regulation 57 of the Public Contracts Regulation 2015, and the main contractor will be required to replace them with a compliant subcontractor.

The Procurement team adheres to the Code of Professional Conduct set forth by the Chartered Institute of Procurement and Supply (CIPS)

Training

Staff receive guidance and training on modern slavery and human trafficking through the Trust's required safeguarding programmes for adults and children, as well as its safeguarding policies and procedures, supported by the Trust Safeguarding team. This topic is also addressed during the mandatory safeguarding induction day for new Trust employees.

The Trust is committed to enhancing awareness throughout the organisation and ensuring a comprehensive understanding of the risks associated with modern slavery and human trafficking within its supply chains and business operations.

Performance Indicators

The Trust will assess the effectiveness of its measures to prevent modern slavery and human trafficking within its business and supply chain through the following indicators:
- no reports received from employees, the public, or law enforcement suggesting that modern slavery practices are occurring within the Trust.
- keeping track of referrals to Social Care and proactively reporting any cases identified during service delivery that may suggest service users have fallen victim to modern slavery in the community.

Additionally, the Trust provides quarterly and annual reports through its safeguarding reporting systems, detailing any safeguarding concerns, as well as identifying trends and themes.

Sustainability

Task force on climate-related financial disclosures (TCFD)

NHS England's NHS foundation trust annual reporting manual has adopted a phased approach to incorporating the TCFD recommended disclosures as part of sustainability annual reporting requirements for NHS bodies, stemming from HM Treasury's TCFD aligned disclosure guidance for public sector annual reports. TCFD recommended disclosures as interpreted and adapted for the public sector by the HM Treasury TCFD aligned disclosure application guidance, will be implemented in sustainability reporting requirements on a phased basis up to the 2025/26 financial year. Local NHS bodies

are not required to disclose scope 1, 2 and 3 greenhouse gas emissions under TCFD requirements as these are computed nationally by NHS England.

This phased approach incorporates the disclosure requirements of the governance, risk management and metrics and targets pillars for 2024/25.

These disclosures are provided below with appropriate cross referencing to relevant information elsewhere in the annual report and accounts and in other external publications.

Trust Board oversight of climate-related issues.

The Board is provided with oversight of climate related issues via the Board Assurance Framework (BAF) in which Principal Risk 8 (PR8) is recorded as Failure to deliver sustainable reductions in the Trust's impact on climate change. The Finance Committee leads in relation to the management of Principal Risk 8 and updates are reported to the Board of Directors on a quarterly basis, but the document is reviewed at each monthly Finance Committee meeting via the Committee's quadrant report.

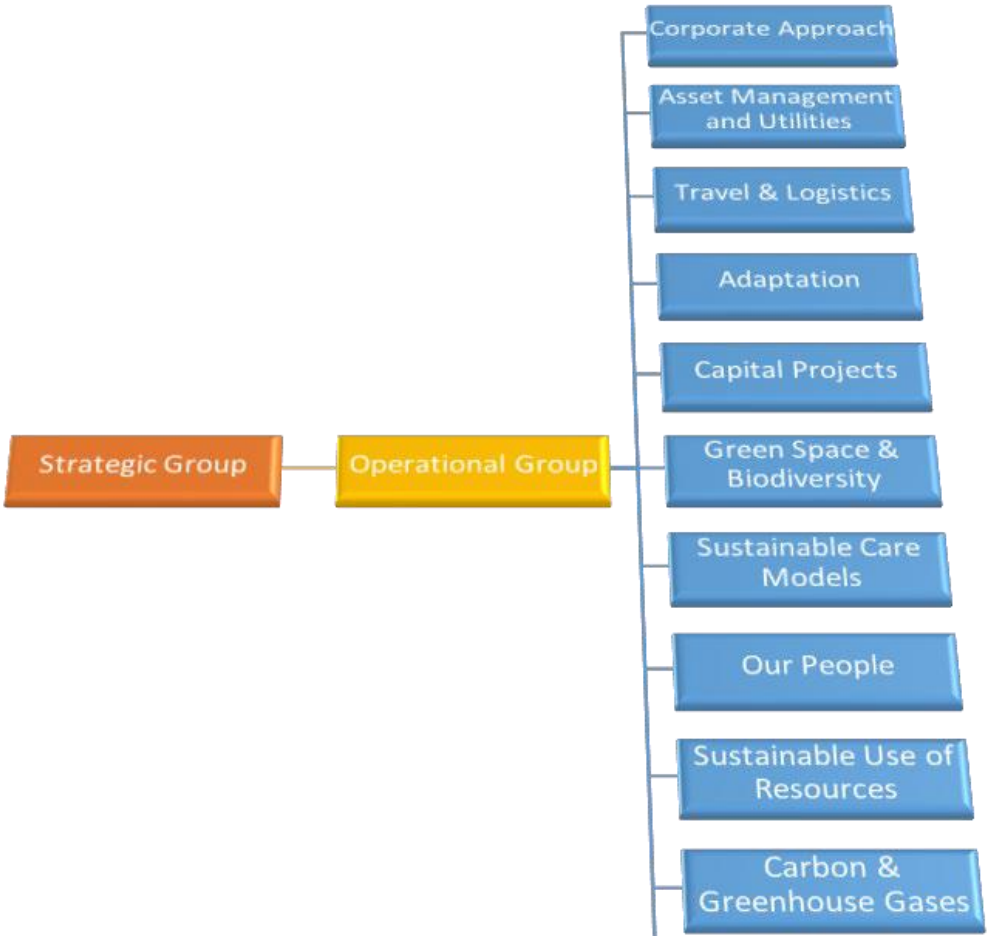
PR8 is reviewed at the Sustainability Development Operational Group (SDOG) chaired by the Director of Estates & Facilities, with oversight from the Sustainability Development Strategic Group (SDSG) chaired by the Chief Financial Officer.

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

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

Management's role in assessing and managing climate-related issues

The Trust utilises a sustainability reporting structure to ensure that key areas of focus are considered on a regular basis. It has a basis of 10 chapter groups comprising of a variety of roles from within the Trust. These report in to the Sustainable Development Operational Group, which reports into the Sustainable Development Steering Group that provides assurance to the Finance Committee and the Board.



In addition to the reporting structure, the Trust employs a Sustainability Service Lead and a Climate Action Clinical Lead (who is also the Royal College of Paediatrics and Child Health's first officer for climate change and clinical lead for the Greener ICS) and Clinical Sustainability Fellows all of whom have a focus on increasing sustainability within the Trust and working collaboratively with colleagues from across the Trust within the Climate Action Team.

Risk Management pillar

Describe the organisation's processes for identifying and assessing climate related risks

The Trust identifies climate change risks through:

- Incident themes and trends
- Issues arising within a speciality/service/department
- National or regional events or issues

Risks are managed in accordance with the Risk Management and Assurance Policy that means things that are identifying and their management are all controlled via a defined policy. The policy outlines responsibilities, prioritisation and monitoring of risks to ensure appropriate mitigation.

In managing climate change risks, the Trust is proactive in accessing any available funding to minimise emissions and energy usage. The Trust aims to prevent financial penalties and any associated reputational damage. The Trust's senior management structure aligns financial decision making with sustainability so that all procurement and investment decisions consider the impact on climate change, whilst accepting that this has to be managed within available financial resources.

Describe the organisation's processes for managing climate-related risks

All risks are managed in accordance with the Risk Management and Assurance Policy, considering risk appetite and available resources.

Priority is given to patient care and safety. With regard to materiality and judgement, the highest scored risks are more robustly addressed than low scoring risks.

In relation to climate related risks and external frameworks, the Trust is a member of the LHRP Risk Management Group which considers the risk to the health care system in Nottingham and Nottinghamshire. The outcomes from the Local Resilience Forum's Risk Advisory Group feeds into the LHRP Risk work. For example, at a recent meeting the central government forward look from April to September included potential extended periods of hot weather and associated disruption, putting additional pressures on fire and health services.

Describe how processes for identifying, assessing, and managing climate-related risks are integrated into the organisation's overall risk management

Climate related risk is captured on the Board Assurance Framework as Principal Risk 8: Failure to deliver sustainable reductions in the Trusts impact on climate change. Potential financial and operational impacts are also contained within other elements of the board assurance framework, for example major disruptive incidents caused by climate change.

Metrics and target pillar

Disclose the metrics used by the organisation to assess climate-related risks and opportunities in line withs its strategy and risk management process

The Trust monitors energy metrics on a monthly basis; by monitoring consumption it can mitigate the likelihood of adverse impacts. By maintaining oversight of the metrics the Trust can monitor progress of energy reduction projects and celebrate the successes. Carbon emission values are calculated utilising the relevant UK Government Conversion Factors for greenhouse gas (GHG) reporting

The SFH Green Plan details a range of targets. Section 7, Tracking Progress, demonstrates performance over the years for a variety of metrics such as energy emissions, waste volumes.

The Trust has appointed an Energy Apprentice to assist the Trust in further monitoring and the development of energy reduction initiatives.

Describe the targets used by the organisation to manage climate-related risks and opportunities and performance against targets.

The Trust monitors a variety of absolute targets which are updated for each SDSG meeting. These include percentage of Green Plan Actions completed, energy costs & consumption.

The Trust's Green Plan includes targets to reduce energy, oil and waste by a fixed percentage annually. In 2021 the Trust Declared a Climate Emergency which reinforced the challenge set in the SFH Green Plan to meet the NHS Net Zero Commitment of an 80% reduction in emissions the Trust directly controls (NHS Carbon Footprint by 80% by 2028-2032, with an ambition to be Net Zero by 2040.

Throughout the reporting year, the Trust has been working on several Sustainability projects. In September 2024 it was successful in securing a £22,000 grant from NHS England (NHSE) to support capping off the Nitrous Oxide manifolds at both Kings Mill and Newark Hospitals. Nitrous Oxide manifolds are a known source of NHS Greenhouse Gas emissions. By moving away from manifold delivery and using smaller cylinders at the point of use a significant amount of fugitive Greenhouse Gas emissions can be avoided. The works at Newark Hospital are now complete and those at Kings Mill are undergoing final tests before the switch is completed.

In January 2025 the Trust was successful with 3 of the 4 National Energy Efficiency Fund (NEEF3) project grant applications submitted to NHSE.

The Trust secured £676,962 to support an upgrade to the Building Management System at Kings Mill and Newark Hospitals which involves expansion of controls to chilling systems which, when complete, will result in a significant energy reduction.

An application for £2,344,486 was approved for LED lighting upgrades at Kings Mill Hospital which will also save significant amounts of electricity.

Finally, a grant of £61,479 was approved for sub-metering upgrades, to allow more accurate measurement and monitoring of specific areas of site with resultant savings through energy efficient working methods identified using the technology.

During 2024 the Trust had 24 EV chargers installed at Kings Mill hospital and new EV chargers within a newly built car park at Newark Hospital supporting greener travel.

The Trust continues to support biodiversity in a variety of ways. The Trust allows the grass at the Kings Mill site to grow long throughout the summer months encouraging wild bee orchids to grow and takes part in an annual Bio-Blitz event to track and identify flora and fauna species on site. In March 2025 it participated in a new NHS Orchard scheme via the NHS Forest which is supported by The Centre for Sustainable Healthcare. Ten orchard trees have been planted in the Trust's Wildlife Garden with varieties of apple, pear, plum, damson and cherry trees now growing for all to enjoy.

Valuing our Members

Changes to the Trust's membership in 2024/25

Changes in the Trust's Constitution during the year have better aligned its constituency boundaries to the core communities the Trust serves, with existing constituencies renamed to make them more meaningful to local communities and encourage better engagement from Trust members and governors.

The changes to the Constitution also created a new 'Rest of England' constituency to represent the views of patients from outside of the local area, with the introduction of that constituency also supporting the Trust to recruit the highest calibre of non-executive directors, associate non-executive directors and governors from outside the communities nearest to the Trust's hospitals.

The changes in the Constitution have also created a 'digital only' election model which has supported the Trust in its efforts to improve its financial position by significantly reducing the cost of running Council of Governor elections.

The changes resulted in all nine vacancies on the Trust's Council of Governors being filled at its latest Council of Governor elections in April 2025.

Membership information post-election April 2025

Public breakdown by constituency

Mansfield, Ashfield and surrounding wards	2,209	60.21%
Newark, Sherwood and surrounding wards	819	22.32%
Rest of England	641	17.47%

Public breakdown by constituency

Constituency	**Number of members**	**% of membership**
Mansfield, Ashfield and surrounding wards (formerly 'Rest of East Midlands')	2,209	60.21%
Newark, Sherwood and surrounding wards (formerly 'Newark and Sherwood')	819	22.32%
Rest of England	641	17.47%

Public membership breakdown

	Membership profile	**Population profile**
Age (years)		
0-16	0.14%	19.59%
17-21	2.20%	6.04%
22-29	3.62%	9.90%
30-39	8.08%	12.50%
40-49	8.06%	11.81%
50-59	13.26%	13.91%
60-74	27.49%	16.69%
75+	26.54%	9.56%
Not stated	10.62%	N/A
Ethnicity		
White	80.43%	82.06%
Mixed	0.65%	1.75%
Asian	1.82%	5.93%
Black	1.39%	1.65%
Other	0.16%	0.52%
Not stated	15.54%	8.09%
Gender		
Male	38.57%	49.51%
Female	58.60%	50.49%
Transgender	0.03%	Unknown
Not stated	2.80%	N/A

Membership activity, events, and communication

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

A refreshed approached to how governors engage with the members they serve has also seen the introduction of new 'hot topics' to the existing programme of 'Meet your governor' activities, helping to provide greater focus to membership engagement and generating more specific, actionable insights to the Trust.

Annual General Meeting / Annual Members' Meeting

The AGM was held at the King's Mill Hospital site on 24th September 2024.

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

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

Valuing our Governors

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

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

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

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

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

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

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

Governor elections were held during April 2025 with the results announced on the 29th of that month to fill the six vacancies in the Mansfield, Ashfield and surrounding Wards public constituency, the two vacancies in the Newark and Sherwood public constituency and the one vacancy in the Rest of England, and for two staff governors.

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

Attendance at Council of Governor meetings

There have been four full general Council of Governors meetings and one Extraordinary meeting during the year. The following tables details the Governors, the constituency they represent, their attendance, the date they were elected/appointed and the date their current term of office ends.

Attendance at Full COG (scheduled meetings)

NAME	AREA COVERED	CONSTITUENCY	FULL COG MEETING DATES				TERMS OF OFFICE	DATE ELECTED	TERM ENDS
			14/05/2024	13/08/2024	12/11/2024	11/02/2025			
Angie Jackson	Mansfield District Council	Appointed	A	P	P	A	4	23/05/23	31/05/27
Bethan Eddy	Nottinghamshire County Council	Appointed		P	P	P	1	01/07/24	31/05/25

David Walters	Ashfield District Council	Appointed	**P**	**P**	**P**	**A**	1	23/04/20	31/05/25
Dean Wilson	Rest of East Midlands	Public	**P**	**P**	**P**	**A**	3	06/07/23	31/10/26
Ian Holden	Newark & Sherwood	Public	**P**	**P**	**P**	**P**	3	01/05/22	30/04/25
Jane Stubbings	Rest of East Midlands	Public	**P**	**P**	**P**	**P**	3	01/05/22	30/04/25
John Doddy	Nottinghamshire County Council	Appointed	**P**				4	14/07/21	31/05/25
John Dove	Rest of East Midlands	Public	**P**	**P**	**P**	**P**	3	07/07/23	06/07/26
John Wood	Rest of East Midlands	Public	**P**	**P**	**A**		3	01/05/22	30/04/25
Justin Wyatt	Staff	Staff	**P**	**P**	**P**	**P**	3	01/05/22	30/04/25
Kevin Stewart	Volunteers	Appointed	**P**	**A**	**P**	**P**	3	28/02/23	28/02/26
Linda Dales	Newark & Sherwood District Council	Appointed	**A**	**P**	**P**	**A**	1	15/07/21	31/05/25
Liz Barrett	Rest of East Midlands	Public	**P**	**P**	**P**	**P**	3	01/05/22	30/04/25
Neal Cooper	Rest of East Midlands	Public	**P**	**P**	**P**	**P**	3	13/05/22	30/04/25
Nikki Slack	Vision West Notts	Appointed	**P**	**X**	**P**	**P**	N/A	17/07/19	N/A
Pam Kirby	Rest of East Midlands	Public	**P**	**P**	**A**	**P**	3	07/07/23	06/07/26
Peter Gregory	Newark & Sherwood	Public	**P**	**A**	**P**	**P**	3	07/07/23	06/07/26
Ruth Scott	Rest of East Midlands	Public	**P**	**P**	**P**	**X**	3	01/05/22	30/04/25
Sam Musson	Staff	Staff	**P**	**P**	**P**	**P**	3	07/07/23	06/07/26
Shane O'Neill	Newark & Sherwood	Public	**P**	**A**	**P**	**P**	3	07/07/23	06/07/26
Steven Hunkin	Rest of East Midlands	Public	**X**				3	07/07/23	17/05/24
Tracy Burton	Rest of East Midlands	Public	**P**	**P**	**A**	**A**	3	07/07/23	06/07/26

Vikram Desai	Staff	Staff	**A**	**P**	**A**	**P**	3	01/05/22	30/04/25

Key: P = Present A = Apologies X = Absent

Attendance at Extraordinary COG meetings

NAME	AREA COVERED	CONSTITUENCY	EO COG 17/01/2025	TERMS OF OFFICE	DATE ELECTED	TERM ENDS
Angie Jackson	Mansfield District Council	Appointed	**A**	4	23/05/23	31/05/27
Bethan Eddy	Nottinghamshire County Council	Appointed	**P**	1	01/07/24	31/05/25
David Walters	Ashfield District Council	Appointed	**P**	1	23/04/20	31/05/25
Dean Wilson	Rest of East Midlands	Public	**P**	3	06/07/23	31/10/26
Ian Holden	Newark & Sherwood	Public	**P**	3	01/05/22	30/04/25
Jane Stubbings	Rest of East Midlands	Public	**P**	3	01/05/22	30/04/25
John Dove	Rest of East Midlands	Public	**X**	3	07/07/23	06/07/26
Justin Wyatt	Staff	Staff	**A**	3	01/05/22	30/04/25
Kevin Stewart	Volunteers	Appointed	**A**	3	28/02/23	28/02/26
Linda Dales	Newark & Sherwood District Council	Appointed	**A**	1	15/07/21	31/05/25
Liz Barrett	Rest of East Midlands	Public	**A**	3	01/05/22	30/04/25
Neal Cooper	Rest of East Midlands	Public	**A**	3	13/05/22	30/04/25
Nikki Slack	Vision West Notts	Appointed	**A**	N/A	17/07/19	N/A
Pam Kirby	Rest of East Midlands	Public	**A**	3	07/07/23	06/07/26
Peter Gregory	Newark & Sherwood	Public	**A**	3	07/07/23	06/07/26
Ruth Scott	Rest of East Midlands	Public	**X**	3	01/05/22	30/04/25
Sam Musson	Staff	Staff	**A**	3	07/07/23	06/07/26

Shane O'Neill	Newark & Sherwood	Public	**X**	3	07/07/23	06/07/26
Tracy Burton	Rest of East Midlands	Public	**X**	3	07/07/23	06/07/26
Vikram Desai	Staff	Staff	**X**	3	01/05/22	30/04/25

Non-Executive Director Attendance at Council of Governors

NAME	FULL COG MEETING DATES			
	14/05/2024	13/08/2024	12/11/2024	11/02/2025
Claire Ward	P			
Graham Ward	A	P	P	P
Barbara Brady	P	P	P	P
Manjeet Gill	A	P	P	P
Steve Banks	P	P	P	P
Dr Aly Rashid	P	P	A	
Andrew Rose-Britton	A	P	P	P
Neil McDonald	P	A	P	P

P = Present
A = Apologies
X = Absent

Lead Governor annual report 2024/25

It has been another busy year for the governors at Sherwood Forest Hospitals, as efforts have continued to improve how we engage with the members we serve across the Mid-Nottinghamshire area and beyond.

The Trust's Council of Governors remain a well-engaged group who are passionate about making the patient voice well-heard in the running of their local hospitals – a commitment that has been reflected in their work throughout the past year.

As a team of governors, we have continued to routinely engage in the fabulous '15 Steps' initiative which enables us to work alongside the executive team to 'temperature check' different wards and areas across the Trust's hospitals.

The 15 Steps process also enables us to learn more about the Trust and to spend time with patients and staff to understand what matters most to them. It also allows us to 'sense check' information presented in meetings by the SFHFT team, as well as to relay positives and identify areas for improvement to the Trust's leadership team.

Governors also actively participate in 'Meet your governor' engagement sessions on a monthly basis, which is another important way for patients and members to feedback issues, concerns and praise.

In last year's annual report, I shared how we felt that improvements could be made to that process by ensuring that the engagement we undertake is more focused and provides more actionable insights for the Trust. I am delighted to say that we have delivered on that ambition through a refreshed 'hot topics' format.

The new format, which provides more intense focus on a specific topic, has already helped to provide the Trust's Discharge Lounge service with more specific, actionable insights on the thoughts of their patients – insights that can be used to help improve services for the future.

We look forward to extending that model into more areas of the Trust over the year ahead.

As an active governing body, we also engage in Governwell courses, along with attending different trust meetings as observers. This approach facilitates even greater transparency over critical areas such as finance and quality.

The past year has also seen Trust governors shape a number of key appointments in the Trust, including through a governor-led recruitment process to appoint two new Non-Executive Directors and one Associate Non-Executive Director during the year.

Governors also comprised the majority of panel members during the governor-led recruitment to a number of Trust non-executive director posts advertised during the reporting year.

This represents a very tangible example of how governors are having a meaningful say in the running of their local hospitals by ensuring that high-calibre Non-Executive Directors are appointed to hold the Trust's leadership to account. This is a vital part of governors work to support the Trust to continue to provide the best possible care in future.

And finally, I will start the new financial year by saying how much I am looking forward to working with a new cohort of governors, after nine vacancies were filled on the Trust's Council of Governors at our latest Council of Governor elections in April 2025.

I look forward to taking forward this important work with them, as we work alongside Trust colleagues as part of the commitment we share to *Improving Lives* together.

Liz Barrett OBE, Lead Governor

Code of Governance for NHS Provider Trusts

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

Part of Schedule A	***Code section***	**Summary of requirement**	**Reference Page numbers**
Disclose	A.2.1	The board of directors should assess the basis on which the trust ensures its effectiveness, efficiency and economy, as well as the quality of its healthcare delivery over the long term, and contribution to the objectives of the ICP and ICB, and place-based partnerships. The board of directors should ensure the trust actively addresses opportunities to work with other providers to tackle shared challenges through entering into partnership arrangements such as provider collaboratives. The trust should describe in its annual report how opportunities and risks to future sustainability have been considered and addressed, and how its governance is contributing to the delivery of its strategy.	10-14, 39-40, 98 & 139
Disclose	A.2.3	The board of directors should assess and monitor culture. Where it is not satisfied that policy, practices or behaviour throughout the business are aligned with the trust's vision, values and strategy, it should seek assurance that management has taken corrective action. The annual report should explain the board's activities and any action taken, and the trust's approach to investing in, rewarding and promoting the wellbeing of its workforce.	12,15, 20, 32-34, 86, 90, 92, 121, 140, 142-143 & 156-157
Disclose	A.2.8	The board of directors should describe in the annual report how the interests of stakeholders, including system and place-based partners, have been considered in their discussions and decision-making, and set out the key partnerships for collaboration with other providers into which the trust has entered. The board of directors should keep engagement mechanisms under review so that they remain effective. The board should	9, 12, 25, 41,128, 136,146 & 157

		set out how the organisation's governance processes oversee its collaboration with other organisations and any associated risk management arrangements.	
Disclose	A.2.6	The board of directors should identify in the annual report each non-executive director it considers to be independent. Circumstances which are likely to impair, or could appear to impair, a non-executive director's independence include, but are not limited to, whether a director: • has been an employee of the trust within the last two years • has, or has had within the last two years, a material business relationship with the trust either directly or as a partner, shareholder, director or senior employee of a body that has such a relationship with the trust • has received or receives remuneration from the trust apart from a director's fee, participates in the trust's performance-related pay scheme or is a member of the trust's pension scheme • has close family ties with any of the trust's advisers, directors or senior employees • holds cross-directorships or has significant links with other directors through involvement with other companies or bodies • has served on the trust board for more than six years from the date of their first appointment • is an appointed representative of the trust's university medical or dental school. Where any of these or other relevant circumstances apply, and the board of directors nonetheless considers that the non-executive director is independent, it needs to be clearly explained why.	24, 68, 118-119 & 126
Disclose	B.2.13	The annual report should give the number of times the board and its committees met, and individual director attendance.	27-28 & 118
Disclose	B.2.17	For foundation trusts, this schedule should include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also	9, 28, 35, 41, 64-65, 68-69, 103, 105-106,109,110-

		describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by the board, the council of governors, board committees and the types of decisions which are delegated to the executive management of the board of directors.	111, 118-119 & 124-127
Disclose	C.2.5	If an external consultancy is engaged, it should be identified in the annual report alongside a statement about any other connection it has with the trust or individual directors.	83
Disclose	C.2.8	The annual report should describe the process followed by the council of governors to appoint the chair and non-executive directors. The main role and responsibilities of the nominations committee should be set out in publicly available written terms of reference.	68-69, 103, 105-106 & 124-125
Disclose	C.4.2	The board of directors should include in the annual report a description of each director's skills, expertise and experience.	27-28, 118 & 125
Disclose	C.4.7	All trusts are strongly encouraged to carry out externally facilitated developmental reviews of their leadership and governance using the Well-led framework every three to five years, according to their circumstances. The external reviewer should be identified in the annual report and a statement made about any connection it has with the trust or individual directors.	30-31
Disclose	C.4.13	The annual report should describe the work of the nominations committee(s), including: • the process used in relation to appointments, its approach to succession planning and how both support the development of a diverse pipeline • how the board has been evaluated, the nature and extent of an external evaluator's contact with the board of directors and individual directors, the outcomes and actions taken, and how these have or will influence board composition	31, 58,121, 124-125 & 144

		• the policy on diversity and inclusion including in relation to disability, its objectives and linkage to trust vision, how it has been implemented and progress on achieving the objectives • the ethnic diversity of the board and senior managers, with reference to indicator nine of the NHS Workforce Race Equality Standard and how far the board reflects the ethnic diversity of the trust's workforce and communities served • the gender balance of senior management and their direct reports.	
Disclose	C.5.15	Foundation trust governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.	9 & 35
Disclose	D.2.4	The annual report should include: • the significant issues relating to the financial statements that the audit committee considered, and how these issues were addressed • an explanation of how the audit committee (and/or auditor panel for an NHS trust) has assessed the independence and effectiveness of the external audit process and its approach to the appointment or reappointment of the external auditor; length of tenure of the current audit firm, when a tender was last conducted and advance notice of any retendering plans • where there is no internal audit function, an explanation for the absence, how internal assurance is achieved and how this affects the external audit • an explanation of how auditor independence and objectivity are safeguarded if the external auditor provides non-audit services.	121–124 146-147, 150 & 158
Disclose	D.2.6	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that	26

		they consider the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's performance, business model and strategy.	
Disclose	D.2.7	The board of directors should carry out a robust assessment of the trust's emerging and principal risks. The relevant reporting manuals will prescribe associated disclosure requirements for the annual report.	14, 121 & 137
Disclose	D.2.8	The board of directors should monitor the trust's risk management and internal control systems and, at least annually, review their effectiveness and report on that review in the annual report. The monitoring and review should cover all material controls, including financial, operational and compliance controls. The board should report on internal control through the annual governance statement in the annual report.	121-122, 130-131, 137,146-147, 158 & 160
Disclose	D.2.9	In the annual accounts, the board of directors should state whether it considered it appropriate to adopt the going concern basis of accounting when preparing them and identify any material uncertainties regarding going concern. Trusts should refer to the DHSC group accounting manual and NHS foundation trust annual reporting manual which explain that this assessment should be based on whether a trust anticipates it will continue to provide its services in the public sector. As a result, material uncertainties over going concern are expected to be rare.	128 & 150
Disclose	E.2.3	Where a trust releases an executive director, eg to serve as a non-executive director elsewhere, the remuneration disclosures in the annual report should include a statement as to whether or not the director will retain such earnings.	Not applicable in the reporting year
Disclose	Appendix B, para 2.3 (not in Schedule A)	The annual report should identify the members of the council of governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual	41, 68, 70-71, 103-106 & 110-111

		report should also identify the nominated lead governor.	
Disclose	Appendix B, para 2.14 (not in Schedule A)	The board of directors should ensure that the NHS foundation trust provides effective mechanisms for communication between governors and members from its constituencies. Contact procedures for members who wish to communicate with governors and/or directors should be clear and made available to members on the NHS foundation trust's website and in the annual report.	41 & 105
Disclose	Appendix B, para 2.15 (not in Schedule A)	The board of directors should state in the annual report the steps it has taken to ensure that the members of the board, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS foundation trust, eg through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations.	105-106 & 109
Disclose	Additional requirement of FT ARM resulting from legislation	If, during the financial year, the Governors have exercised their power* under paragraph 10C** of schedule 7 of the NHS Act 2006, then information on this must be included in the annual report. This is required by paragraph 26(2)(aa) of schedule 7 to the NHS Act 2006, as amended by section 151 (8) of the Health and Social Care Act 2012. * Power to require one or more of the directors to attend a governors' meeting for the purpose of obtaining information about the foundation trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the foundation trust's or directors' performance). ** As inserted by section 151 (6) of the Health and Social Care Act 2012)	Not applicable in the reporting year

The Trust's Board of Directors is focused on achieving long-term success for the organisation and its vision of becoming an outstanding organisation, through the application of sound business strategies and the maintenance of high standards in corporate governance and corporate responsibility.

The Trust commissioned Grant Thornton UK LLP to undertake a Developmental Well Led Governance Review in the context of the CQC's updated assessment framework, that delivered its final report in January 2025 and built on the initial external Well-led review of the organisation, that reported in March 2022.

The recommendations detail the development areas, with the 16 identified being largely as a consequence of these challenges. The Board received the final Review in February 2025 with progress reporting to the Board agreed to coincide with action due dates, commencing August 2025.

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

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

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

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

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

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

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

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

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

The Board committees report annually on their effectiveness and review their terms of references and work plans to ensure alignment with the Trust's priorities and the Board work schedule.

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

Counter fraud

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

Functional Standard Summary:

The Trust is required to self-assess against the 13 requirements of the Counter Fraud Functional Standard (CFFS) annually by completing and submitting the Trust's Counter Fraud Functional Standard Return (CFFSR). The assessment for 2025 is expected to be a 'Green' rating in all 13 requirements.

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

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

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

Colleagues have access to counter fraud awareness training which forms part of employee induction training, and several bulletins were issued during the year to

highlight how colleagues should raise concerns and suspicions. The CFS has also developed a range of role specific training sides which are available to all staff.

The Trust continue to work to maintain an anti-fraud culture and has a range of policies and procedures in place to minimise risk in this area. This includes the Fraud, Bribery and Corruption Policy, most recently updated in July 2024, that is designed to make all staff aware of their responsibilities, should they suspect offences are being committed.

NHS Resolution

The Trust's Clinical Negligence Scheme for Trusts (CNST) premium increased by £0.53m in 2024/25 (£15.24m to £15.77m).

Committees of the Board

All committees of the Board are chaired by a Non-Executive Director. In 2024/24 these committees included:

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

Audit and Assurance Committee

The Audit and Assurance Committee has been chaired by Non-Executive Director Manjeet Gill since the July 2023 meeting, around which time all Committee Chairs changed. Manjeet has extensive experience from both the NHS and other sectors, especially in relation to wider system working. Andrew Rose-Britton is the Vice Chair and also meets the requirement in the Committee's terms of reference that one or other of the Chair and Vice Chair should have recent relevant financial experience. The terms of Reference also make it clear that the membership exclusively comprises Non-Executive Directors, with executives and others considered being 'in attendance'.
Attendance of Non-Executive members at meetings is detailed below:

Manjeet Gill	6/7
Steve Banks	5/6
Andrew Rose-Britton	5/7
Neil McDonald	1/1
Graham Ward	1/1

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

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

Principal review areas

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

1. <u>Governance and internal control</u>

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

The Committee has received update reports on Information Governance including that the Data Security Protection Toolkit compliance was Met. The internal auditors provided their overall assessment on compliance with the toolkit as Substantial, with all of the 10 NDG Standards individually rated as Substantial.

2. Internal audit

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

- Reviewed and approved the internal audit operational plan and more detailed programme of work initially and then on an on-going basis, while ensuring the provision of the internal audit service continued to be sufficient in supporting the Committee to fulfil its role

- Considered the major findings of internal audit and are assured that the Head of Internal Audit Opinion and AGS reflect any significant internal control issues.

- Invited the lead directors of the three internal audit reports issued with Limited Assurance to attend Committee meetings, present the report, and provide assurance actions will be implemented within agreed timescales.

- Worked with colleagues internally and externally to maintain and improve performance regarding the provision of evidence and the achievement of internal audit actions.

- Held regular review of outstanding audit actions and are assured a robust progress monitoring process is in place.

3. Counter Fraud Service

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

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

4. External audit

The Committee reviewed and agreed the external audit annual plan, noting that the Trust's significant risks are Fraud risk – expenditure recognition and Management

override of controls, with a higher assessed risk relating to the Valuation of Land & Buildings.

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

5. Management

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

Standards of business conduct

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

Internal audit (360 Assurance)

The Audit Plan for 2024/25 was developed in line with the mandatory requirements of the Public Sector Internal Audit Standards. 360 Assurance, an external service, has worked with the Trust to ensure the plan was aligned to the risk environment. In accordance with the internal audit work plan, full scope audits of the adequacy and effectiveness of the control framework in place are either complete or under way. All audits with Limited or Moderate Assurance are reported directly to the Audit and Assurance Committee and the lead director is asked to present the findings and confirm agreement of the actions and timescales. Audits with Significant Assurance are reported directly to the most appropriate Board committee with the Audit and Assurance Committee then receiving a report stating which reports have been reported to other committees. Outstanding recommendations from internal audit are reported to the Risk Committee and then to the Audit and Assurance Committee. This ensures all recommendations are sustainably implemented within the Trust. Where owners of recommendations have not completed the actions by the implementation date they are invited to Audit and Assurance Committee to report on progress.

External Audit Service

The Trust spent £190k net of VAT in audit service fees in relation to the statutory audit of the accounts for the 12-month period to 31 March 2024 (£175k net of VAT for the period to 31 March 2024). Non-audit services amounted to £Nil net of VAT (£Nil net of VAT for the period to 31 March 2024) in respect of the Quality Report.

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

Remuneration and Nomination Committee

As of 31 March 2025, membership of the Remuneration and Nomination Committee comprises Barbara Brady as Chair, Manjeet Gill and Steve Banks, all Non-Executive Directors who have served throughout the reporting year with Non-Executive Director Richard Cotton joining the membership in February 2025. The attendance of Non-Executive Directors is detailed within the Remuneration Report.

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

Remuneration and Nomination Committee of the Council of Governors

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

Compliance with the Code of Governance for NHS Provider Trusts

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

The Board of Directors is committed to high standards of corporate governance. Throughout the year ending 31 March 2025, the Board considers that it was compliant with the Code of Governance for NHS Provider Trusts.

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

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

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

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

As Sherwood Forest Hospitals is an NHS Foundation Trust, the authority for appointing and dismissing the Chair rests with the Council of Governors. The appraisal of the Chair is therefore carried out for and on behalf of the Council of Governors by the Senior Independent Director, supported by the lead Governor. Together they review the Chair’s performance against agreed objectives and discuss any development needs before reporting the outcome of the appraisal to the Remuneration and

Nomination Committee of the Council of Governors. This Committee in turn reports to the Council of Governors.

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

NHS Oversight Framework

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

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

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

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

Segmentation

The latest information published on the NHS England's website places Sherwood Forest Hospitals Foundation Trust in segment 2 (as of 9 May 2025) and the Nottingham and Nottinghamshire Integrated Care Board in segment 3 (as of 20 May 2025).

Current segmentation information for NHS trusts and foundation trust is published on the NHS England website: https://www.england.nhs.uk/publication/nhs-system-oversight-framework-segmentation/

Foundation Trust Licence

There are no additional conditions on the Trust's Foundation Trust Licence.

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

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

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

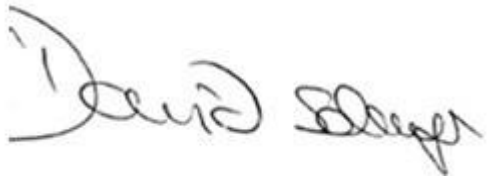
In preparing the accounts and overseeing the use of public funds the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care Group Accounting Manual and in particular to:

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

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable them to ensure that the accounts comply with requirements outlined in the 2006 Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

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

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



Dr. David Selwyn
Acting Chief Executive Officer **19th June 2025**

Annual Governance Statement

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an on-going process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Sherwood Forest Hospitals NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively, and economically. The system of internal control has been in place in Sherwood Forest Hospitals NHS Foundation Trust for the year ended 31 March 2025 and up to the date of approval of the annual report and accounts.

Regulation

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

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

An extract from the Final CQC report states:

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

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

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

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

Capacity to handle risk & prepare for emergencies

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

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

The Trust also prepares an annual submission relating to its level of compliance with the sixty plus NHSE Core Standards for Emergency Preparedness. Its current rating is “Substantial” compliance of 91% against the standards.

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

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

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

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

The risk and control framework

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

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

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

3. **Risk Assessment**
   Risk assessment involves the analysis of individual risks, including any plausible risk aggregation (the combined effect of different risks) where

relevant. The assessment evaluates the severity and likelihood of each risk and determines the priority based on the overall level of risk exposure.

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

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

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

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

The most significant strategic risks facing the Trust are: (i) Significant deterioration in standards of safety and care (ii) Demand that overwhelms capacity (iii) Critical shortage of workforce capacity and capability; (iv) Insufficient financial resources available to support the delivery of services; (v) Major disruptive incident. These risks

are inter-related and incorporated into the Board Assurance Framework (BAF). Should one or more of these risks materialise, or any other risk captured in the BAF, it may trigger a compound effect upon the safety/quality of care and/or financial sustainability. The Board of Directors has focused throughout the year on delivering sustainable improvements in the quality and safety of clinical services, and strengthening the Trust's ability to meet demand, supported by refreshed recruitment and retention strategies and prudent financial management.

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

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

Table 1: Clinical, Operational and Financial Sustainability Risks

Potential Risk	How the risk might arise	How the risk is being mitigated	How are the outcomes assessed
Significant deterioration in standards of safety and care.	This may arise if safety-critical controls are not complied with, there are shortfalls in staffing to meet patient need, demand exceeds capacity for a prolonged period, or there is a loss of organisational focus on safety and quality in the governance of Sherwood Forest Hospitals.	Maintaining a strong emphasis and focus on safety, clinical outcomes and patient experience as part of the Trust's governance and performance management framework; striving for excellence and challenging unsatisfactory performance regarding organisational control; delivering training, complying with safety-critical organisation policies and procedures, and learning from adverse events are ways we are currently mitigating this risk.	Progress and outcomes are monitored through the Quality Committee, supported by the Patient Safety Committee and other sub-groups. This includes safety and quality indicators, incident investigations and key performance indicators.
Demand that overwhelms capacity.	This risk may arise if growth in demand for care exceeds planning assumptions and capacity in	Managing patient flow, developing and maintaining effective working relationships with primary and social care teams, working	Progress and outcomes are monitored through the Quality Committee, supported by the Patient Safety Committee. This includes safety and quality

	secondary care; primary care is unable to provide the service required or there is a significant failure of a neighbouring acute provider. The risk may also arise if there are unexpected surges in demand, such as those created by pandemic disease.	collaboratively across the wider health system to reduce avoidable admissions to hospital are some of the risk treatment strategies that will feature in how we mitigate this risk going forward.	indicators, incident investigations and key performance indicators.
A critical shortage of workforce capacity and capability.	Due to workforce gaps across key areas such as Medical, Nursing, AHP and Maternity, the availability of newly qualified practitioners, and increasing competition for the clinical workforce, we anticipate the staffing challenges continue to be significant.	The People Strategy is specifically designed to help mitigate this risk. By focussing on attracting and retaining high calibre practitioners, building and sustaining high-performing teams, by engaging and developing clinical teams, and adapting to meet the needs of a changing workforce, we aim to make Sherwood Forest Hospitals the employer of choice.	Progress and outcomes are monitored through the People Committee, supported by the People Cabinet. This includes vacancy levels, training and development progress.
Insufficient financial resources available to support the delivery of services.	Financial funding allocated to and generated by the Trust does not cover the costs of services provided. This risk may arise if the trust is not able to secure sufficient funds to meet planned expenditure, maintain or replace vital assets, and/or is not able to reduce expenditure in line	Local and system-wide Financial Plans are specifically designed to address the financial challenge and deliver financial outturn in accordance with agreed control totals, gradually progressing towards break-even (no surplus or deficit at the year-end). To safeguard quality, proposals to reduce expenditure are subject to Quality Impact Assessment – overseen by the Medical Director and Chief Nurse.	Frequent assessment of performance and forecast trajectories is monitored through the Finance Committee.

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

Failure to deliver sustainable reductions in the Trust's impact on climate change.	This risk may arise if the Trust's vision to further embed sustainability, through actions outlined in its Green Plan, are not achieved.	This risk is mitigated through management of the action plan, engagement and awareness campaigns (internal/external stakeholders) and Environmental Sustainability Impact Assessments built into project implementation processes.	This is monitored through the Finance Committee, supported by various sub-groups. It includes reporting of progress and emerging risks to ensure effective management.

It is not envisaged these risks will change over the coming year. The Internal Audit Plan and Counter Fraud Plan are approved by Board members and are aligned, where appropriate, with the principal risks in the BAF. The Audit and Assurance Committee uses the reports of management and internal audit to provide assurance to the Board as to the effectiveness of the BAF as a component of the internal control framework.

Clinical Audit 2024/25

At the beginning of the 2024/2025 financial year, we set out the following priorities:

- Strengthen both the assurance and the visibility of clinical audit within the wider organisation via the *Improvement in Clinical Audit Group* and by learning from, and sharing activities on, key Trust-wide themes.

- Further align Clinical Audit and Quality Improvement with key organisational strategies. The vision for Continuous Improvement at SFH is driven by the Quality Strategy, which is a key enabler to achieving both clinical effectiveness and efficiency. In May 2023 the Trust created an Improvement Faculty, a multi-professional team whose remit includes all aspects of Improvement and Transformation. Clinical Audit is a key component of the Improvement Faculty which has allowed Audit to become a key tool in terms of identifying areas that need improvement support. This has helped to drive forward the continuous improvement of care at the Trust's Hospitals.

- Further connect audit to the continuous improvement and learning cycle. This will focus on process outcomes by aligning clinical audit at a Divisional governance level. This will help to pull forward learning and good practice across the organisation. The team has attended over 50% of the Trust's specialty governance meetings.

There is of course still work to do in relation to the above areas and the focus around these is detailed in the plan for the forthcoming financial year (see below).

National clinical audits 2024/25

During 2024/25, the Trust participated in 50 out of 54 (93%) of national clinical audits and 100% of national confidential enquiries which it was eligible to participate in. The number of clinical audits both at a national and local level which formed part of the 2024/25 Audit Plan were as follows:

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

Some of the key learning from National Audit during 2024/25 is as follows:

National Joint Registry (NJR)

The Trust is doing better than expected in every metric recorded and analysed in the national joint registry. The quality of the data submitted by the Trust (across different sites including Kings Mill Hospital and Newark Hospital) is excellent, and it has been given the gold award for the 7th year running for this. This level of accurate data ensures that the Trust is focused on data quality which allows it to have a much more accurate picture of patient outcomes and safety.

National Respiratory Audit Programme – Adult Asthma

The Trust continues to perform well against a number of metrics as part of the audit, including the percentage of patients with SpO2 measurement taken following arrival (where we've achieved 99.2% compliance) as well as the percentage of patients with a peak flow measurement completed (where we've achieved 98.4%).

Perioperative Quality Improvement Project (PQIP)

The aim of PQIP is to look at the perioperative care of patients undergoing major non-cardiac surgery and measure complication rates in the UK. The results show that over 80% of patients of the Trust were eating within 24 hours of surgery which is above the national target.

Looking forward to 2025/26 the Trust's aim is to:

- Continue to strengthen the link between Audit and Improvement to deliver the '*So What*' of Clinical Audit.

- Reduce the number of ‘single cycle’ audits being undertaken and promote the importance of the audit cycle being completed to deliver improvement in outcomes.

- Ensure that we are appraising the outcomes taken from National Clinical Audits and using these to drive the local audit agenda by offering increased support to clinicians.

- Utilising other data types such as patient level costing information (PLICS) to demonstrate the benefits of clinical audit.

- Highlighting other areas of learning from audit such as the impact on health inequalities and sustainability to strengthen the overall ‘*outcomes*’ narrative.

Workforce and supporting strategies

The Trust’s People Strategy for 2025-2029 and supporting Strategic People Plan are linked to the national NHS People Plan and associated People Promise. Both the People Strategy and Strategic People Plan were introduced in Spring/Summer 2022 and are underpinned by an annual implementation plan, with progress regularly reported to the Board and associated Committees. The People Strategy 2025-2029 has recently been updated and refreshed and will be launched in May 2025.

In the recent National Staff Survey 2024 the Trust has had a response rate of 63%, which was its highest ever response, with more colleagues sharing their voices than ever before. The Trust has been voted Best Acute Trust in the East Midlands for the 7th year running, with 70.6% of colleagues recommending Sherwood Forest Hospitals as a place to work.

The Trust will continue to use this message as a positive recruitment tactic to support workforce growth and its People Strategy ambitions of ‘Growing for the future’ and the revised pillar of ‘Improving ways of working and delivering care’.

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

Regular, staffing establishment reviews are also carried out and the Trust has invested in E-Rostering, E-Job Planning and Clinical Activity Manager system. These all help better align staffing to activity and acuity levels. In 2023/24 there has been a high level of focus to reduce agency usage and support staffing and financial efficiencies as a Trust.

Following successful delivery of the Trust’s previous strategy, it has reviewed its People Strategy for 2025-2029 and supporting action plans. The People Strategy

embraces all people including medical staff, nursing, allied health professionals, administrative and clerical, recognising the importance of everyone's contribution to delivering outstanding care to patients.

The Trust's vision of the People Strategy continues to be: Empower and support our people to be the best they can be

The Trust has continued to embed and deliver actions against its People Strategy delivery pillars which deliberately anchor back to the NHS People Plan. Following engagement over the last year with colleagues the Trust has adapted its delivery pillars based on colleague feedback which are

People Strategy – delivery pillars:

1. Looking after our people
2. Belonging in Sherwood and the NHS – previously Belonging in Sherwood.
3. Growing for the future
4. Improving ways of working - previously - new ways of working and delivering care

Strategic People Plan:

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

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

- In 2024 the Trust had a National Staff Survey response rate of 63%, which was its highest ever response, with more colleagues sharing their voices than ever before
- Sherwood Forest Hospitals is the best Acute Trust in the East Midlands for the 7th year running, with 70.6% of colleagues recommending it as a place to work.
- Sherwood Forest Hospitals is the best Acute Trust in the East Midlands for receiving care with 73.1% of colleagues recommending a friend or relative needed treatment would be happy with the standard of care provided.
- The 'Expect Respect, Not Abuse' campaign was launched as part of several actions being made by the Trust's internal Violence and Aggression Working Group. This group was established to address growing concerns about staff safety, develop strategies and reduce workplace violence
- 81% of staff have not experienced physical violence, and 75.3% have not faced harassment or abuse from patients, relatives, or the public. This is one of the most improved areas over the past year.
- The Occupational Health Team has conducted 33,458 staff appointments over 100 wellbeing sessions and over 5,000 staff members have received their flu jab. A

successful and well attended Menopause Conference was held on World Menopause Day 2024.

- Launching the Armed Forces Network network was a notable achievement showcasing the Trust's commitment to inclusivity, support, and community building. The network has enriched workplace culture, bringing a unique set of skills, experiences, and perspectives into the fold.
- The continued development of a Wellbeing Improvement Plan aligned to NHS England Wellbeing Framework.
- Significant assurance provided via the newly launched Appraisal and 121 paperwork in for all Managers and employees on Agenda for Change contracts, giving less paperwork to complete and an easy-to-use template.
- Continuing to embed Step into the NHS careers' fairs throughout 2024/25 to support organisational recruitment needs which has been recognised through the Excellence Awards 2024
- Making flexible working more accessible. From 1st October 2024 colleagues were asked to submit new flexible working requests through ESR. Support was provided through training videos and the Trust can now track requests and produce detailed reports.
- Continuing to lead in key system meetings, representing the Trust in groups such as the ICS People Collaborative and the ICS Organisational Development and Improvement Community of Practice.

Assurance of legal obligations:

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

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

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

NHS England's Workforce Safeguards (2018) were adopted in 2021/22 and continue to be reported to the People Committee. These standards ensure staffing governance processes are informed, safe and sustainable. They include:

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

Principal Risk 3: Workforce capacity and capability

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

- Inability to attract and retain staff, resulting in critical workforce gaps in some clinical and non-clinical services
- A significant loss of workforce productivity arising from short-term reduction in staff availability or a reduction in morale and engagement

Key risks concerning workforce capacity and capability were regularly reviewed by the People Committee during 2024/25. They will continue to be reported in 2025/26 as part of the Board Assurance Framework.

Over the last 12 months the action plans delivered as part of the People Strategy have supported mitigation of these risks, for example; enhancing Step into the NHS careers fairs, a focus on sexual safety at the Trust, the violence and aggression agenda, and recognition, wellbeing support and staff networks. The Trust continues to embrace the People Promise agenda focusing on the key people promise themes to support its people in their roles.

Beneath the strategic risks are operational risks specific to the running of services within the People Directorate. All operational risks are logged on DATIX with appropriate action plans and any risks mitigation plans in place. At the time of this report, 12 operational risks are logged on the DATIX Risk Register for the People Directorate.

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

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

People Strategy 2025 to 2029

Following successful delivery of the previous People Strategy, the Trust has developed its People Strategy for 2025 to 2029 and supporting action plans for 2025/26. The People Strategy embraces all the Trust's people including medical and nursing staff, allied health professionals, administrative and clerical, recognising the importance of each individual's contribution to delivering outstanding patient care.

The People Strategy 2025 to 2029 sets the vision for the next 4 years and outlines the ways the Trust will empower and support its people to be the best they can be. The People Strategy supports the Trust's vision of providing outstanding care delivered by compassionate people to promote healthier communities. It was built in line with the NHS People Plan and is underpinned by the Trust's CARE values.

People priorities 2025/26

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

Looking after our people

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

Our vision - What does this mean in practice?

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

Our priorities - How will we deliver this?

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

Belonging in the NHS

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

Our vision - What does this mean in practice?

- We have a culture of kindness, civility and respect within the organisation, where our EDI, CARE values and People Promise are at the heart of everything we do.

Our priorities - How will we deliver them?

- We will create an inclusive culture and take action to reduce our people's experience of violence, bullying and discrimination. We will encourage our people to have a voice through Freedom to Speak Up, Staff Networks, National Staff Survey plus Quarterly Pulse Surveys. We will recognise and reward our people through key celebration events.

Growing for the future

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

Our vision - What does this mean in practice?

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

Our priorities - How will we deliver them?

- We will support our leaders to provide meaningful appraisals, manage talent and develop succession plans. We will enhance our training, apprenticeship and work experience offer. Our Step into the NHS programme and partnerships with local educational providers will be key to growing our future workforce.

Improving ways of working and delivering care

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

Our vision - What does this mean in practice?

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

Our priorities - How will we deliver them?

- We will work more digitally and efficiently by simplifying people processes and where possible removing duplications. We will utilise people information to create workforce plans that support services to fill roles with the right people at the right time.

During Spring and Summer 2024 Trust wide engagement provided feedback around what is important to its people. The feedback has been collated into the People

Strategy; designed by our people, for our people. Despite an ever-changing NHS landscape and increased demand for its services the Trust is proud to say that 71% of colleagues voted it as a great place to work.

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

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

a) Effective systems to ensure compliance with the conditions of the NHS provider licence, NHS legislation and the duty to have regard to the NHS Constitution (Condition G6) and a reasonable expectation that required resources will be available to deliver the designated services for the 12 months from the date of the statement (Condition CoS7) by 31st May 2024, and
b) Complied with the required governance arrangements (condition FT4) by 30th June 2024.

The Trust's self-certification was approved by the Board in May 2024. The self-certification process required a response to the following five questions:

1. The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.

2. The Board has regard to such guidance on good corporate governance as may be issued by NHS England from time to time .

3. The Board is satisfied that the Licensee has established and implements:
   (a) Effective board and committee structures
   (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees
   (c) Clear reporting lines and accountabilities throughout its organisation.

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

   a. To ensure compliance with the Licensee's duty to operate efficiently, economically, and effectively
   b. For timely and effective scrutiny and oversight by the Board of the Licensee's operations

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

5. The Board is satisfied that there are systems and /or processes referred to in paragraph 4 (above) that should include but not be restricted to systems and processes to ensure:
   a. That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided
   b. That the Board's planning and decision-making processes take timely and appropriate account of quality-of-care considerations
   c. The collection of accurate, comprehensive, timely and up to date information on quality of care
   d. That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care
   e. That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders
   f. That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.

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

The Board considered the risks to each element of the self-certification and confirmed evidence of compliance with condition FT4; the key elements are noted below.

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

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

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

During 2024/25 the Trust was registered to provide healthcare on the following hospital sites – King's Mill Hospital, Newark Hospital, Mansfield Community Hospital, Sherwood Community Unit and Ashfield Health Village.

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

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

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

As an employer with employees entitled to membership of the NHS Pension Scheme, control measures are in place to ensure compliance with all employer obligations contained within the Scheme regulations. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are

in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

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

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

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

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

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

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

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

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

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

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

Financial Recovery Cabinet - the Cabinet leads on the delivery of Financial Improvement and Productivity on behalf of the Trust Board with a nominated executive lead supporting respective programme leads. The cabinet meets monthly to review the Trust's Financial Efficiency Programme and to assist delivery by providing executive level support and guidance.

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

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

Throughout the financial year 2024/25, income and expenditure has been received on an actuals basis and changes to run rate are reviewed and explained as part of the monthly reporting process.

The Trust ended the year with a surplus of £0.01m after adjusting for asset impairments and other non-control total items. This value is aligned with the forecast outturn agreed between the Nottinghamshire ICS and NHSE for the financial year 2024/25. Details relating to this position are included elsewhere in this report. Although the financial outturn is consistent with the agreed position, the Trust remains in a financially challenged position with a significant underlying deficit.

During 2024/25 the Trust has accessed additional interim revenue support of £17.44m and, capital of £24.49m which was agreed with NHSE and drawn down in the form of Public Dividend Capital. The forecast cash position remains challenged due to timing of cash receipts and the significant efficiency programme built into the 2024/25 plan. The cash forecast is monitored and reported to the Finance Committee and Board.

The Trust continues to work on its planned reduction in agency expenditure but incurred costs of £13.67m in 2023/24 against a plan of £13.00m. There is a target reduction for 2025/26 with a planned spend of £9.672m. The Trust has also relied upon the use of bank employees which has in part mitigated the need and cost of agency expenditure, however, remains committed to reductions in all variable pay including bank workers in line with NHSE targets.

The Trust's overall Efficiency Plan delivered savings of £38.52m against planned savings of £38.44m. The efficiency plan consists of four primary parts:

- The Financial Improvement Programme (FIP) is led by the Divisional Triumvirates supported by the Improvement Faculty. For 2024/25 we achieved £13.02m FIP against a plan of £15.18m.
- Vacancy Control Process is executive led controls for approval of recruitment to posts within the Trust plus non-recurrent underspends on pay. For 2024/25 this delivered £19.44m against the £11.93m plan.
- Elective Recovery Fund (ERF) aims to reduce backlogs for elective care whilst attracting financial incentive which exceeds the cost of delivery. For 2024/25 this contributed a stretch achievement above base activity plan of £3.17m benefit (Income less cost to deliver) against a plan of £3.10m
- Other Income stretch targets aim to look to seek additional funding opportunities which have supported £2.89m against a plan of £8.23m in 2024/25.

The Trust uses benchmarking information from the Model Hospital and other sources including the Trusts Patient Level Information and Costing System (PLICS) to help to identify efficiency opportunities. Overall, the Trust achieved £38.52m efficiencies in 2024/25 and is in the process of development of the efficiency plan for 2025/26 which amounts to a total of £45.83m.

During the year, the Nottingham and Nottinghamshire ICS has continued to strengthen its system governance arrangements to enable collective responsibility and mutual accountability between partners for the delivery of system strategies and plans. There has been a particular focus in-year on the arrangements supporting system financial sustainability, through the work of the System Financial Recovery Group and the System Transformation Delivery Group.

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

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

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

Information Governance

Information Governance (IG) is the responsibility of both the Director of Corporate Affairs, who is also the Senior Information Risk Owner (SIRO) and the Medical Director who is the Caldicott Guardian. The SIRO is supported by a network of information asset owners, who ensure the integrity of, and monitor access to, the systems for which they are responsible. The Director of Corporate Affairs as SIRO and the Caldicott Guardian share the chair of the IG Committee. A working group also operates as part of the IG governance structure. The reporting and management of risks relating to data and security are safeguarded by ensuring all employees are reminded of their data security responsibilities through education, at induction and through mandatory training requirements. More than 4,000 colleagues received mandatory IG training in 2024/25, and regular reminders are shared via internal communications. Near misses and lessons learned are used to inform the training programme, ensuring the programme remains dynamic and reflects current and meaningful issues to facilitate greater employee engagement and ownership of IG processes.

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

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

Risk Management and Assurance

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

- Information security
- Data quality
- Digital continuity
- Records management
- Information disclosure
- Information sharing

- Legal and regulatory compliance.

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

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

The SIRO and Caldicott Guardian received formal training on their statutory responsibilities during 2024/25 to refresh skills and ensure awareness of legislative changes.

Data Flow Mapping

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

The SIRO is responsible for the development and implementation of the organisation's Information Risk agenda. During 2024/25 an annual review of information flow mapping has been carried out to ensure the Trust can be assured information flows into and out of the organisation are identified, risk assessed and addressed. This is then expanded to ensure there is assurance that all information is stored securely and appropriately and any partners in delivery of either shared care or information storage achieve the same high levels of information governance assurance.

Serious Incidents Requiring Investigation (SIRI)

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

There have been five incidents reported to the ICO. No further action has been taken by the regulators after investigation. Incidents varied from data not being stored correctly to inappropriate sharing of information.

Information Sharing

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

Freedom of Information (FOI)

During 2024/25 the Trust processed a total of 842 FOI requests. This function is managed by the Information Governance Team and the activity is demonstrated in the table below.

Total	Breached timeframe of 20 days	Escalated to ICO
842	445	0

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

Of the requests, 744 are completed, eight are on hold waiting further information, three have been rejected due to details not being provided and eight have ceased due to clarification not received from the requester and 79 are still in progress. Of the requests completed 378 have been completed within 20 days which show a compliance rate of 45% (378/842).

Subject Access Requests (SARs)

The Trust has received 4,245 requests for access to patient records. Cases are processed in line with national guidance which is exemplary given some of these cases represent hundreds of pages of information and require methodical attention to detail to ensure information is released appropriately.

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

The Trust has also received 40 requests for access to staff employment records.

The table below shows the requests processed by the Access to Health Record Team in 2024/25:

April 2024 to March 2025		Completed in 30 days	Completed in more than 30 days
Patient records	4245	4167	78
Staff employment records	40	32	8

Horizon Scanning

The digital landscape continues to evolve at an expeditious rate which means that information governance becomes more important than ever. The Trust face new challenges in managing, holding, securing and using data. New emerging technologies and regulatory changes will mean the Trust's approach to information governance will change.

Artificial intelligence (AI) and robotic process automation (RPA) will transform how the Trust delivers healthcare by automating and completing tasks.

The new UK's Data (Use and Access) Bill will amend the UK GDPR and Data Protection Act 2018. It will introduce a new legal basis for data processing 'Recognised Legitimate Interests' and enhance the safeguards for children's data. The Act will also focus on improving Health Data Standards for Health and Social Care to drive greater standardisation of information technology.

Data Quality and Governance

SOP – Quality Assurance and sign off process

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

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

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

waiting time data is quality assured pre submission by the Divisional General Manager before signing off by the relevant Executive Director.

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

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

- **Validation** – in response to known areas of data quality concern (as identified through reporting or operational processes), we will:
    - Actively validate data sets to ensure decision making is based on accurate information.
    - Ensure operational/clinical teams are informed to enable necessary action to be taken in cases where patient care is affected.

- **Addressing errors** – where data errors are identified, in addition to informing operational/clinical teams to enable the patient impact to be understood and addressed, we will:
    - Identify the root cause.
    - Correct the information, as necessary.
    - Ensure feedback is provided to the originator of the root cause (for example user, system provider, etc.)
    - Ensure action is taken to reduce or prevent repetition of the issue.

- **Reporting** – use of key performance indicators (KPIs) to:
    - Monitor levels of data quality
    - Identify improvements or deterioration in data quality.
    - Identify areas for validation, corrections, training, process improvements or ad hoc audits.

- **Auditing** – delivery of an audit programme to:
    - Systematically check for data quality issues across the Trust, through sampling of records and providing appropriate feedback
    - Allow for ad hoc audits in response to suspected Data Quality weaknesses.

- **Training** – delivery of Data Quality training for relevant members of staff. In addition, we provide targeted training in response to themes or repeated errors, as identified through:
    - Audit

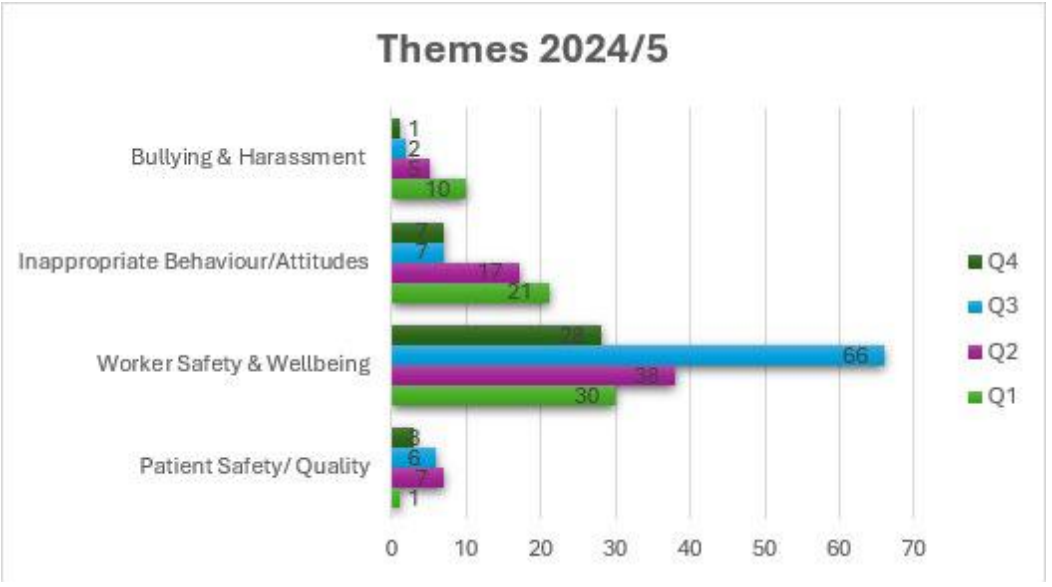
- Reporting
- Operational issues

- **Process improvements** – where necessary, we systematically change operational processes to maximise data quality. Any such process changes are:
  - Clinically and operationally owned, designed and supported.
  - Underpinned by procedural documents.
  - Not be to the detriment of patient care.
  - Reviewed once implemented.

Freedom to Speak Up

During the year 2024/25, 202 cases were raised to the FTSU Guardian. This is a 33% increase on the previous year, demonstrating a growing engagement with the FTSU route. The majority of concerns are raised openly – meaning the vast majority of concern raisers are open to progression of their concerns with their identity known, which in turn allows a more supportive approach, with higher chance of a resolution. Supporting the FTSUG, and creating visibility across SFH, there are 30 trained FTSU Champions.

Themes from concerns are shown in the table below:



Top themes raised were:

1. Worker safety and Wellbeing - which includes the emotional impact of people related processes, mental health impacts of working in pressurised teams and impact on emotional wellbeing from behaviours outside the SFH Care Values . Processes not followed causing impact on wellbeing.
2. Inappropriate Behaviour / Attitudes – ingrained poor behaviour. Care Values not adhered to and not managed when reported. Impact on teams as well as individuals creating poor culture in teams.

Learning from themes is reported through the People Committee and its subgroups, regular and direct communication with the Executive Team and the FTSU Guardian involvement in Training & Development Programmes to support upskilling leaders and future leaders using FTSU cases.

Results from the 2024 National Staff Survey, show the Trust is above the national average in domains related to confidence in speaking up and the organisation responding to the concerns.

Quality

A review of the Trust's performance from 1st April 2024 to 31st March 2025 indicates there are appropriate controls in place. These controls include:

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

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

Ockenden Report

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

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

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

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

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

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

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

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

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

Review of effectiveness

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

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

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

The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through an annual programme of internal audit work. The Head of Internal Audit has provided me with an opinion for 2024/25 below:

I am providing an opinion of significant assurance that there is a generally sound framework of governance, risk management and control designed to meet the organisation's objectives, and controls are generally being applied consistently.
It should be noted that a number of reviews were issued with moderate or limited assurance opinions; two of these contained high risk issues which have subsequently been addressed by the Trust. Whilst we note that the overall implementation rate of actions was 90%, the Trust needs to seek an improvement on the first follow up rate for high and medium risks which is at 68%.

There have been 15 internal audit assignments completed during the year, including one advisory report on System wide discharge arrangements. The reports ar3e as follows:

Audit *	**Assurance level**
Operational planning (2023/24)	Significant
Capital programme (2022/23)	Significant
Fit and proper persons	Significant
Business continuity	Significant
Freedom to speak up	Significant
Board Assurance Framework	Significant
Financial systems – accounts receivable and asset register	Significant
Safe staffing	Significant
Patient experience	Moderate
Patient tracking list management and data quality	Moderate
Safeguarding (2023/24)	Limited
Outpatients, appointments and remote consultations (2023/24)	Limited
Mental Capacity Act and Deprivation of Liberty Safeguards	Limited
Data Security and Protection Toolkit	Substantial (NHSE opinion level)
System wide discharge arrangements (2023/24)	Advisory
Capital schemes	Limited
Fire safety	Limited
PSIRF	Significant
System wide system governance	Advisory

* Some reviews relate to previous years' internal audit plans.

In relation to the Limited Assurance opinions report issued in 2024/25, progress in implementing the agreed actions is as follows:

2024/25 Internal Audit Report	High Risk Actions	Medium Risk Actions	Low Risk Actions	Current Progress
Safeguarding	4	7	0	3 high risk actions and 3 medium risk actions were implemented after the due date. All actions were implemented by the year end.
Outpatients, appointments and remote consultations	0	7	0	4 actions were overdue for implementation at the year-end, 3 of which have subsequently been implemented.
Mental Capacity Act and Deprivation of Liberty Safeguards	3	1	2	The 3 high risk actions and 1 medium risk action are not yet due for implementation. 2 low risk actions were overdue for implementation at the year end, both of which have subsequently been implemented.

The internal audit reports providing Limited Assurance have been presented to the Audit and Assurance Committee by the executive lead.

All internal audit reports are presented to the most appropriate committee, where the implementation of actions is also monitored.

Any actions which become overdue are reported back to the Audit and Assurance Committee and the action owners are invited to attend to discuss progress.

The Audit and Assurance Committee has maintained good oversight of the position and challenges throughout the year and the Trust has enhanced its internal processes for monitoring of the implementation of actions to ensure managers are supported in achieving the deadlines agreed in the individual internal audit reports.

Managers and Executive Directors provide me with assurance through regular Board and management reports, all which evidence areas of effective internal control and risk management. The Audit and Assurance Committee and the Risk Committee ensure effective operation of risk management and focus on the establishment and maintenance of controls designed to give assurance that assets are safeguarded,

waste and inefficiency are avoided, reliable information is produced and value for money is sought continuously.

My review for 2024/25 is also informed by:

- Regular executive reporting to Board and escalation processes through the Board Committees
- Assessment of financial reports submitted to NHS England
- NHS Oversight Framework segmentation for providers – the segmentation score for the Trust is 2.
- NHS Oversight Framework segmentation for ICSs – the segmentation score for the Nottinghamshire ICS changed remains at 3 due to the system financial position. The segmentation score indicates the scale and general nature of NHSE support needed by the system. A score of 3 means bespoke, mandated support being provided.

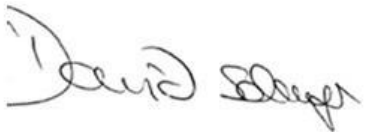
2024 National Staff Survey

- The Trust's results show scores from the National Staff Survey have declined; Sherwood Forest Hospitals NHS Foundation Trust is still a high performing Trust. The decline is in line with national staff survey scores, which have nationally seen either no improvement or a decline in results. The Trust remains the best acute Trust in the East Midlands and has achieved this for 7 years in succession.

Conclusion

There are no significant control issues.

I am satisfied the organisation has a sound system of internal control supported by a robust governance structure.



Dr. David Selwyn
Acting Chief Executive Officer **19th June 2025**

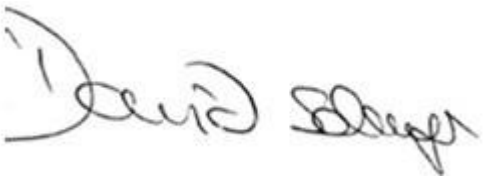
Sherwood Forest Hospitals NHS Foundation Trust

Annual accounts for the year ended 31 March 2025

Foreword to the accounts

Sherwood Forest Hospitals NHS Foundation Trust

These accounts, for the year ended 31 March 2025, have been prepared by Sherwood Forest Hospitals NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.



Signed **…….**

Name **Dr. David Selwyn**
Job title **Acting Chief Executive Officer**
Date **19th June 2025**

Statement of Comprehensive Income

	Note	2024/25 £000	2023/24 £000
Operating income from patient care activities	3	517,090	453,180
Other operating income	4	64,983	62,562
Operating expenses	7,9	(558,988)	(510,050)
Operating surplus/(deficit) from continuing operations		**23,085**	**5,692**
Finance income	11	1,388	1,294
Finance expenses	12	(29,055)	(63,198)
PDC dividends payable		-	-
Net finance costs		**(27,667)**	**(61,904)**
Other gains / (losses)	13	(195)	(71)
Surplus / (deficit) for the year from continuing operations		**(4,777)**	**(56,283)**
Surplus / (deficit) on discontinued operations and the gain / (loss) on disposal of discontinued operations	14	-	-
Surplus / (deficit) for the year		**(4,777)**	**(56,283)**

Statement of Financial Position

	Note	31 March 2025 £000	31 March 2024 £000
Non-current assets			
Intangible assets	15	2,967	3,185
Property, plant and equipment	16	350,114	335,698
Right of use assets	19	5,948	4,812
Receivables	21	531	1,451
Other assets	23	-	-
Total non-current assets		**359,559**	**345,145**
Current assets			
Inventories	20	6,356	6,161
Receivables	21	32,912	31,010
Cash and cash equivalents	22	26,528	4,736
Total current assets		**65,796**	**41,907**
Current liabilities			
Trade and other payables	23	(52,177)	(52,383)
Borrowings	25	(21,108)	(19,069)
Other financial liabilities	26	-	-
Provisions	26	(299)	(238)
Other liabilities	24	-	(1,193)
Total current liabilities		**(73,584)**	**(72,883)**
Total assets less current liabilities		**351,771**	**314,169**
Non-current liabilities			
Trade and other payables	23	-	-
Borrowings	25	(403,681)	(404,343)
Other financial liabilities	26	-	-
Provisions	26	(743)	(757)
Other liabilities	24	-	-
Total non-current liabilities		**(404,424)**	**(405,100)**
Total assets employed		**(52,653)**	**(90,931)**
Financed by			
Public dividend capital		538,242	496,313
Revaluation reserve		15,375	14,548
Income and expenditure reserve		(606,270)	(601,792)
Total taxpayers' equity		**(52,653)**	**(90,931)**

The notes on pages 170 to 209 form part of these accounts.

Name David Selwyn
Position Acting Chief Executive Officer
Date 19 June 2025

Statement of Changes in Taxpayers Equity for the year ended 31 March 2025

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2024 - brought forward	**496,313**	**14,548**	**(601,792)**	**(90,931)**
Surplus/(deficit) for the year	-	-	(4,777)	**(4,777)**
Other transfers between reserves	-	(25)	25	**-**
Impairments	-	1,126	-	**1,126**
Revaluations	-	-	-	**-**
Public dividend capital received	41,929	-	-	**41,929**
Other reserve movements	-	(274)	274	**-**
Taxpayers' and others' equity at 31 March 2025	**538,242**	**15,375**	**(606,270)**	**(52,653)**

Statement of Changes in Taxpayers Equity for the year ended 31 March 2024

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2023 - brought forward	**462,632**	**16,022**	**(381,113)**	**97,541**
Prior period adjustment	-	-	-	**-**
Taxpayers' and others' equity at 1 April 2023 - restated	**462,632**	**16,022**	**(381,113)**	**97,541**
Application of IFRS 16 measurement principles to PFI liability on 1 April 2023	-	-	(164,657)	**(164,657)**
Surplus/(deficit) for the year	-	-	(56,283)	**(56,283)**
Other transfers between reserves	-	(21)	21	**-**
Impairments	-	(1,213)	-	**(1,213)**
Revaluations	-	-	-	**-**
Public dividend capital received	33,681	-	-	**33,681**
Other reserve movements	-	(240)	240	**-**
Taxpayers' and others' equity at 31 March 2024	**496,313**	**14,548**	**(601,792)**	**(90,931)**

Information on reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the trust.

Statement of Cash Flows

	Note	2024/25 £000	2023/24 £000
Cash flows from operating activities			
Operating surplus / (deficit)		23,085	5,692
Non-cash income and expense:			
Depreciation and amortisation	7.1	15,549	15,722
Net impairments	8	3,557	855
Income recognised in respect of capital donations	4	(114)	(92)
(Increase) / decrease in receivables and other assets		(915)	(3,719)
(Increase) / decrease in inventories		(195)	(476)
Increase / (decrease) in payables and other liabilities		2,510	(9,753)
Increase / (decrease) in provisions		45	(69)
Other movements in operating cash flows		1	1
Net cash flows from / (used in) operating activities		**43,523**	**8,161**
Cash flows from investing activities			
Interest received		1,318	1,314
Purchase and sale of financial assets / investments		-	-
Purchase of intangible assets		(635)	(176)
Sales of intangible assets		-	-
Purchase of PPE and investment property		(34,516)	(31,411)
Sales of PPE and investment property		88	40
Net cash flows from / (used in) investing activities		**(33,745)**	**(30,233)**
Cash flows from financing activities			
Public dividend capital received		41,929	33,681
Capital element of lease rental payments		(1,085)	(903)
Capital element of PFI, LIFT and other service concession payments		(18,727)	(19,049)
Interest on loans		-	-
Other interest		(1)	(2)
Interest paid on lease liability repayments		(194)	(141)
Interest paid on PFI, LIFT and other service concession obligations		(9,908)	(9,906)
PDC dividend (paid) / refunded		-	(413)
Net cash flows from / (used in) financing activities		**12,014**	**3,267**
Increase / (decrease) in cash and cash equivalents		**21,792**	**(18,805)**
Cash and cash equivalents at 1 April - brought forward		**4,736**	**23,541**
Prior period adjustments			-
Cash and cash equivalents at 1 April - restated		**4,736**	**23,541**
Cash and cash equivalents transferred under absorption accounting	35	-	-
Unrealised gains / (losses) on foreign exchange		-	-
Cash and cash equivalents at 31 March	22.1	**26,528**	**4,736**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

NHS England has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2024/25 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.2 Going concern

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case. The Trust has a negative statement of financial position however, this is not a concerm as the organistion is a government body.

Note 1.3 Interests in other entities

The Trust is the Corporate Trustee of Sherwood Forest Hospitals General Charitable Fund. The Charity is not consolidated as the balances are not deemed material, however, the revenue and capital grants are reflected in the accounts. Non consolidated balances as at 31 March 2023 were £1.79m.This decision is ratified by the Board on an annual basis.

Note 1.4 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Standard credit terms apply to invoiced revenue with all NHS debt due for payment within 14 days and all non NHS receivables due within 30 days of the invoice date. Invoices are not raised where revenue is recognised on performance of a contractual obligation until this has been met.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. Funding envelopes are set at an Integrated Care System (ICS) level. The majority of the Trust's NHS income is earned from NHS commissioners under the NHS Payment Scheme (NHSPS). The NHSPS sets out rules to establish the amount payable to trusts for NHS-funded secondary healthcare.

Aligned payment and incentive contracts form the main payment mechanism under the NHSPS. API contracts contain both a fixed and variable element. Under the variable element, providers earn income for elective activity (both ordinary and day case), out-patient procedures, out-patient first attendances, diagnostic imaging and nuclear medicine, and chemotherapy delivery activity. The precise definition of these activities is given in the NHSPS. Income is earned at NHSPS prices based on actual activity. The fixed element includes income for all other services covered by the NHSPS assuming an agreed level of activity with 'fixed' in this context meaning not varying based on units of activity. Elements within this are accounted for as variable consideration under IFRS 15 as explained below.

The Trust also receives income from commissioners under Commissioning for Quality Innovation (CQUIN) and Best Practice Tariff (BPT) schemes. Delivery under these schemes is part of how care is provided to patients. As such CQUIN and BPT payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the overall contract with the commissioner and are accounted for as variable consideration under IFRS 15. Payment for CQUIN and BPT on non-elective services is included in the fixed element of API contracts with adjustments for actual achievement being made at the end of the year. BPT earned on elective activity is included in the variable element of API contracts and paid in line with actual activity performed.

Elective recovery funding provides additional funding to integrated care boards to fund the commissioning of elective services within their systems. Trusts do not directly earn elective recovery funding, instead earning income for actual activity performed under API contract arrangements as explained above. The level of activity delivered by the trust contributes to system performance and therefore the availability of funding to the trust's commissioners.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when performance obligations are satisfied. In practical terms this means that treatment has been given, it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Note 1.5 Other forms of income

Grants and donations

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grants is used to fund capital expenditure, it is credited to the Statement of Comprehensive Income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship service income

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's apprenticeship service account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Other income

Income from various sources including items such as pharmacy sales and on site creche services.

Note 1.6 Expenditure on employee benefits

Short-term employee benefits
Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

Note 1.7 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.8 Discontinued operations

Discontinued operations occur where activities either cease without transfer to another entity, or transfer to an entity outside of the boundary of the Whole of Government Accounts, such as private or voluntary sectors. Such activities are accounted for in accordance with IFRS 5. Activities that are transferred to other bodies within the boundary of the Whole of Government Accounts are ‘machinery of government changes’ and treated as continuing operations.

Note 1.9 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

• it is held for use in delivering services or for administrative purposes
• it is probable that future economic benefits will flow to, or service potential be provided to, the trust
• it is expected to be used for more than one financial year
• the cost of the item can be measured reliably
• the item has cost of at least £5,000, or
• collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives. The Trust following advice from an external Valuer does not separately recognise any components within the PFI property as it is the responsibility of the PFI provider to maintain all assets at condition B until the date of transfer to the Trust in 2043.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.
Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (ie operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the location requirements of the services being provided.

Valuation guidance issued by the Royal Institute of Chartered Surveyors states that valuations are performed net of VAT where the VAT is recoverable by the entity. This basis has been applied to the trust's Private Finance Initiative (PFI) scheme where the construction is completed by a special purpose vehicle and the costs have recoverable VAT for the trust.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'held for sale' cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenditure.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments
In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised. Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

De-recognition

Assets intended for disposal are reclassified as 'held for sale' once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.
This includes assets donated to the trust by the Department of Health and Social Care or NHS England as part of the response to the coronavirus pandemic. As defined in the GAM, the trust applies the principle of donated asset accounting to assets that the trust controls and is obtaining economic benefits from at the year end.

Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) transactions

PFI and LIFT transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's *FReM*, are accounted for as 'on-Statement of Financial Position' by the trust. Annual contract payments to the operator (the unitary charge) are apportioned between the repayment of the liability including the finance cost, the charges for services and lifecycle replacement of components of the asset.

Initial recognition

In accordance with HM Treasury's FReM, the underlying assets are recognised as property, plant and equipment, together with an equivalent liability. Initial measurement of the asset and liability are in accordance with the initial measurement principles of IFRS 16 (see leases accounting policy).

Subsequent measurement

Assets are subsequently accounted for as property, plant and equipment and/or intangible assets as appropriate.

The liability is subsequently reduced by the portion of the unitary charge allocated as payment for the asset and increased by the annual finance cost. The finance cost is calculated by applying the implicit interest rate to the opening liability and is charged to finance costs in the Statement of Comprehensive Income. The element of the unitary charge allocated as payment for the asset is split between payment of the finance cost and repayment of the net liability.

Where there are changes in future payments for the asset resulting from indexation of the unitary charge, the Trust remeasures the PFI liability by determining the revised payments for the remainder of the contract once the change in cash flows takes effect. The remeasurement adjustment is charged to finance costs in the Statement of Comprehensive Income.

The service charge is recognised in operating expenses in the Statement of Comprehensive Income.

Lifecycle replacement costs are reviewed and charged to revenue or capital when they meet the capital definition and are then accounted for as part of the annual valuation assessment." In 2024/25 all lifecycle replacement costs were capitalised in line with the PFI model.

Initial application of IFRS 16 liability measurement principles to PFI and LIFT liabilities in 2023/24

IFRS 16 liability measurement principles were applied to PFI, LIFT and other service concession arrangement liabilities in these financial statements from 1 April 2023. The change in measurement basis was applied using a modified retrospective approach with the cumulative impact of remeasuring the liability on 1 April 2023 recognised in the income and expenditure reserve.

Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	1	57
Dwellings	1	57
Plant & machinery	5	15
Transport equipment	-	-
Information technology	5	8
Furniture & fittings	5	10

Note 1.10 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance controlled by the Trust. They are capable of being sold separately from the rest of the trust's business or arise from contractual or other legal rights. Intangible assets are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised. Expenditure on development is capitalised where it meets the requirements set out in IAS 38.

Software

Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset where it meets recognition criteria.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Intangible assets held for sale are measured at the lower of their carrying amount or fair value less costs to sell.

Amortisation

Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

Useful lives of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	**Max life Years**
Software licences	5	10

Note 1.11 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method.

Between 2020/21 and 2023/24 the Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department. Distribution of inventories by the Department ceased in March 2024.

Note 1.12 Investment properties

Investment properties are measured at fair value. Changes in fair value are recognised as gains or losses in income/expenditure.

Only those assets which are held solely to generate a commercial return are considered to be investment properties. Where an asset is held, in part, for support service delivery objectives, then it is considered to be an item of property, plant and equipment. Properties occupied by employees, whether or not they pay rent at market rates, are not classified as investment properties.

Note 1.13 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.14 Financial assets and financial liabilities

Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets or financial liabilities in respect of assets acquired or disposed of through leasing arrangements are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets are classified as subsequently measured at amortised cost, fair value through income and expenditure.

Financial liabilities classified as subsequently measured at amortised cost fair value through income and expenditure.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Derecognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Note 1.15 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

The Trust as a lessee

Recognition and initial measurement
At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments includes fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 4.72% applied to new leases commencing in 2024 and 4.81% to new leases commencing in 2025.

The Trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight-line basis over the lease term or other systematic basis. Irrecoverable VAT on lease payments is expensed as it falls due.

Subsequent measurement

As required by a HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

The Trust as a lessor

The Trust assesses each of its leases and classifies them as either a finance lease or an operating lease. Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Where the Trust is an intermediate lessor, classification of the sublease is determined with reference to the right of use asset arising from the headlease.

Finance leases

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Operating leases

Income from operating leases is recognised on a straight-line basis or another systematic basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.16 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective from 31 March 2025:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	4.03%	4.26%
Medium-term	After 5 years up to 10 years	4.07%	4.03%
Long-term	After 10 years up to 40 years	4.81%	4.72%
Very long-term	Exceeding 40 years	4.55%	4.40%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective from 31 March 2025:

	Inflation rate	Prior year rate
Year 1	2.60%	3.60%
Year 2	2.30%	1.80%
Into perpetuity	2.00%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's post-employment benefits discount rate of 2.40% in real terms (prior year: 2.45%).

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at Note 26.2 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

The trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.17 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in Note 27 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in Note 27, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.18 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined by the Department of Health and Social Care.

This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.19 Value added tax

Most of the activities of the trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.20 Climate change levy

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

Note 1.21 Foreign exchange

The functional and presentational currency of the trust is sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

• monetary items are translated at the spot exchange rate on 31 March
• non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and
• non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

Note 1.22 Third party assets

Assets belonging to third parties in which the Trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's *FReM*.

Note 1.23 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.24 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

Note 1.25 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2024/25.

Note 1.26 Standards, amendments and interpretations in issue but not yet effective or adopted

Other standards, amendments and interpretations

Financial year for which the change first applies	**Standard**
Not EU-endorsed. Applies to first time adopters of IFRS after 1 January 2016. Therefore not applicable to DHSC group bodies.	IFRS 14 Regulatory Deferral Accounts
Application required for accounting periods beginning on or after 1 January 2021. Standard is not yet adopted by the FReM which is expected to be from April 2025	IFRS 17 Insurance Contracts
Application required for accounting periods beginning on or after 1 January 2027. Standard is not yet UK-endorsed and not yet adopted by the FReM. Early adoption is not permitted.	IFRS 18 Presentation and Disclosure in Financial Statements
Application required for accounting periods beginning on or after 1 January 2027. Standard is not yet UK-endorsed and not yet adopted by the FReM. Early adoption is not permitted.	IFRS 19 Subsidiaries without Public Accountability: Disclosures
Following a thematic review of non-current asset valuations for financial reporting in the public sector, HM Treasury has made a number of changes to valuation frequency, valuation methodology and classification which are effective in the public sector from 1 April 2025 with a 5 year transition period. NHS bodies are adopting these changes to an alternative timeline.	Changes to non-investment asset valuation
A mandated quinquennial revaluation frequency (or rolling programme) supplemented by annual indexation in the intervening years.	Changes to valuation cycles and methodology

Removal of the alternative site assumption for buildings valued at depreciated replacement cost on a modern equivalent asset basis. The approach for land has not yet been finalised by HM Treasury.	
Withdrawal of the revaluation model for intangible assets. Carrying values of existing intangible assets measured under a previous revaluation will be taken forward as deemed historic cost. Removal of the distinction between specialised and non-specialised assets held for their service potential. Assets will be classified according to whether they are held for their operational capacity.	Changes to subsequent measurement of intangible assets and PPE classification. **Implentation April 2025**

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

In applying the Trust's accounting policies management are required to make judgements, estimates and assumptions concerning the carrying amounts of assets and liabilities that are not readily apparent from other sources. Estimates and assumptions are based on historical experience and any other factors that are deemed relevant. Actual results may differ from these estimates and are continually reviewed to ensure validity remains appropriate. These revisions are recognised in the period in which they occur or the current and future periods, as appropriate. In relation to buildings a 2% change in value would equate to £5.1m.

Assumptions have been made regarding the treatment of Lifecycle costs which have all been capitalised in year, £5.72m based on the PFI model.

External Valuation where reliance has been placed on the valuation report as at 31 March 2025, as this represents the best available evidence of current value. Further details are included in note 1.9, and note 17.

Assumptions regarding sums due in regard to the PFI and ongoing discussions around an agreed settlement position.

Note 2 Operating Segments

No segmental analysis is shown as Sherwood Forest Hospitals NHS Foundation Trust acts solely in the UK and operates as a segment providing healthcare. The "Chief Operating Decision Maker" is deemed to be the Trust Board.

The Board currently receives only high level financial information and does not therefore review information or allocate resources in any way that could be perceived to represent operating segments.

The Trust is split into 5 clinical divisions, Urgent and Emergency Care, Medicine, Surgery, Women's and Children’s and Clinical Support Therapies & Outpatients. In addition there is a supporting corporate function. All of these divisions are engaged directly in the provision of healthcare and hence are reported as one segment."

A detailed analysis of all income is disclosed in note 3 to these accounts.

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4

Note 3.1 Income from patient care activities (by nature)	2024/25 £000	2023/24 £000
Acute services		
Income from commissioners under API contracts - variable element*	97,832	91,817
Income from commissioners under API contracts - fixed element*	356,690	314,167
High cost drugs income from commissioners	20,691	16,875
Other NHS clinical income	-	-
Community services		
Income from commissioners under API contracts*	18,338	14,376
Income from other sources (e.g. local authorities)	1,619	3,070
All services		
Private patient income	123	23
National pay award central funding***	1,020	183
Additional pension contribution central funding**	19,669	11,857
Other clinical income	1,108	812
Total income from activities	**517,090**	**453,180**

*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2023/25 NHS Payment Scheme documentation.

https://www.england.nhs.uk/pay-syst/nhs-payment-scheme/

**Increases to the employer contribution rate for NHS pensions since 1 April 2019 have been funded by NHS England. NHS providers continue to pay at the former rate of 14.3% with the additional amount being paid over by NHS England on providers' behalf. The full cost of employer contributions (23.7%, 2023/24: 20.6%) and related NHS England funding (9.4%, 2023/24: 6.3%) have been recognised in these accounts.
***Additional funding was made available directly to providers by NHS England in 2024/25 and 2023/24 for implementing the backdated element of pay awards where government offers were finalised after the end of the
financial year. NHS Payment Scheme prices and API contracts are updated for the weighted uplift in in-year pay costs when awards are finalised.

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2024/25 £000	2023/24 £000
NHS England	46,799	27,947
Integrated care boards	465,655	421,188
Department of Health and Social Care	-	-
Other NHS providers	1,786	13
NHS other	-	-
Local authorities	1,619	3,070
Non-NHS: private patients	123	23
Non-NHS: overseas patients (chargeable to patient)	10	127
Injury cost recovery scheme	1,098	812
Non NHS: other	-	-
Total income from activities	**517,090**	**453,180**
Of which:		
Related to continuing operations	517,090	453,180
Related to discontinued operations	-	-

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	2024/25	2023/24
	£000	£000
Income recognised this year	10	127
Cash payments received in-year	26	15
Amounts added to provision for impairment of receivables	-	-
Amounts written off in-year	39	34

Note 4 Other operating income

	2024/25			2023/24		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	947	-	**947**	865	-	**865**
Education and training	15,483	934	**16,417**	14,820	971	**15,791**
Non-patient care services to other bodies	41,901		**41,901**	36,740		**36,740**
Income in respect of employee benefits accounted on a gross basis	281		**281**	217		**217**
Receipt of capital grants and donations and peppercorn leases		114	**114**		92	**92**
Charitable and other contributions to expenditure		367	**367**		374	**374**
Revenue from operating leases		827	**827**		725	**725**
Amortisation of PFI deferred income / credits		-	**-**		-	**-**
Other income	4,129	-	**4,129**	7,755	3	**7,758**
Total other operating income	**62,741**	**2,242**	**64,983**	**60,397**	**2,165**	**62,562**
Of which:						
Related to continuing operations			64,983			62,562
Related to discontinued operations			-			-

Note 5.1 Additional information on contract revenue (IFRS 15) recognised in the period

	2024/25	2023/24
	£000	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	1,193	

Note 5.2 Income from activities arising from commissioner requested services

The trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2024/25	2023/24
	£000	£000
Income from services designated as commissioner requested services	514,839	452,218
Income from services not designated as commissioner requested services	2,251	962
Total	**517,090**	**453,180**

Note 5.3 Profits and losses on disposal of property, plant and equipment

No land and buildings assets used in the provision of commissioner requested services have been disposed of during the year.

Note 6 Operating leases - Sherwood Forest Hospitals NHS Foundation Trust as lessor

This note discloses income generated in operating lease agreements where Sherwood Forest Hospitals NHS Foundation Trust is the lessor.

Note 6.1 Operating lease income

	2024/25	2023/24
	£000	£000
Lease receipts recognised as income in year:		
Minimum lease receipts	827	725
Variable lease receipts / contingent rents	-	-
Total in-year operating lease income	**827**	**725**

Note 6.2 Future lease receipts

	31 March 2025	31 March 2024
	£000	£000
Future minimum lease receipts due in:		
- not later than one year	890	767
- later than one year and not later than two years	870	590
- later than two years and not later than three years	748	570
- later than three years and not later than four years	561	465
- later than four years and not later than five years	561	456
- later than five years	375	456
Total	**4,005**	**3,304**

Note 7.1 Operating expenses

	2024/25	2023/24
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	2,030	1,931
Purchase of healthcare from non-NHS and non-DHSC bodies	5,997	3,982
Purchase of social care	-	-
Staff and executive directors costs	363,483	328,809
Remuneration of non-executive directors	156	158
Supplies and services - clinical (excluding drugs costs)	43,234	38,581
Supplies and services - general	5,589	3,789
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	34,079	30,388
Inventories written down	-	-
Consultancy costs	593	231
Establishment	3,323	3,940
Premises	25,957	24,356
Transport (including patient travel)	631	894
Depreciation on property, plant and equipment	14,738	13,956
Amortisation on intangible assets	811	1,766
Net impairments	3,557	855
Movement in credit loss allowance: contract receivables / contract assets	134	221
Movement in credit loss allowance: all other receivables and investments	-	-
Increase/(decrease) in other provisions	115	70
Change in provisions discount rate(s)	(2)	(8)
Fees payable to the external auditor		
audit services- statutory audit	190	170
other auditor remuneration (external auditor only)	-	-
Internal audit costs	162	147
Clinical negligence	15,772	15,964
Legal fees	126	232
Insurance	-	-
Research and development	-	-
Education and training	2,082	2,258
Expenditure on short term leases	1,698	1,633
Expenditure on low value leases	-	-
Variable lease payments not included in the liability	-	-
Early retirements	36	30
Redundancy	308	17
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	31,696	27,660
Charges to operating expenditure for off-SoFP PFI / LIFT schemes	155	92
Car parking & security	-	-
Hospitality	420	494
Losses, ex gratia & special payments	9	124
Other	1,909	7,310
Total	**558,988**	**510,050**
Of which:		
Related to continuing operations	558,988	510,050
Related to discontinued operations	-	-

Note 7.2 Other auditor remuneration

	2024/25	2023/24
	£000	£000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the trust	-	-
2. Audit-related assurance services	-	-
Total	**-**	**-**

Note 7.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £1,000k (2023/24: £1,000k).

Note 8 Impairment of assets

	2024/25	2023/24
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	3,557	855
Other	-	-
Total net impairments charged to operating surplus / deficit	**3,557**	**855**
Impairments charged to the revaluation reserve	(1,126)	1,213
Total net impairments	**2,431**	**2,068**

The Valuer has undertaken a desktop exercise in year (walk round review of the Trust estate in 2023/24). This takes account of numerous factors contributing to an overall assessment of each building asset on a modern equivalent basis: these include functional and external obsolescence, investment into the property since the previous valuation and any changes of use.

Note 9 Employee benefits

	2024/25	2023/24
	Total	Total
	£000	£000
Salaries and wages	270,118	244,166
Social security costs	30,016	28,105
Apprenticeship levy	1,379	1,240
Employer's contributions to NHS pensions	49,775	39,043
Pension cost - other	74	131
Temporary staff (including agency)	13,699	16,580
Total gross staff costs	**365,061**	**329,265**
Recoveries in respect of seconded staff	-	-
Total staff costs	**365,061**	**329,265**
Of which		
Costs capitalised as part of assets	1,234	409

Note 9.1 Retirements due to ill-health

During 2024/25 there were 10 early retirements from the trust agreed on the grounds of ill-health (6 in the year ended 31 March 2024). The estimated additional pension liabilities of these ill-health retirements is £776k (£654k in 2023/24).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

Note 10 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation
A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2025, is based on valuation data as at 31 March 2023, updated to 31 March 2025 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by the scheme Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 to 23.7% of pensionable pay . The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

National Employment Savings Trust (NEST)
The National Employment Savings Trust (NEST) Corporation is the Trustee of the NEST occupational pension scheme. The scheme, which is run on a not-for-profit basis, ensures that all employers have access to suitable, low-charge pension provision. The Trust is required to comply with workplace pension legislation and to auto enrol employees into a pension scheme. Where employees are ineligible to join the NHS Pension Scheme the Trust enrols the employee into NEST. NEST is a defined contribution scheme.

As at 31 March 2025 there were 8,022 members of the NHS Pension Scheme, 427 are enrolled within NEST and 4,788 are not currently contributing through a workplace pension scheme.

Note 11 Finance income

Finance income represents interest received on assets and investments in the period.

	2024/25	2023/24
	£000	£000
Interest on bank accounts	1,388	1,294
Total finance income	**1,388**	**1,294**

Note 12.1 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money or asset financing.

	2024/25	2023/24
	£000	£000
Interest expense:		
Interest on lease obligations	191	141
Interest on late payment of commercial debt	1	2
Finance costs on PFI, LIFT and other service concession arrangements:		
Main finance costs	9,908	9,906
Remeasurement of the liability resulting from change in index or rate	18,953	53,149
Total interest expense	**29,053**	**63,198**
Unwinding of discount on provisions	2	-
Other finance costs	-	-
Total finance costs	**29,055**	**63,198**

Note 12.2 The late payment of commercial debts (interest) Act 1998

	2024/25	2023/24
	£000	£000
Total liability accruing in year under this legislation as a result of late payments	-	-
Amounts included within interest payable arising from claims made under this legislation	1	2
Compensation paid to cover debt recovery costs under this legislation	-	-

Note 13 Other gains / (losses)

	2024/25	2023/24
	£000	£000
Gains on disposal of assets	88	40
Losses on disposal of assets	(283)	(111)
Total gains / (losses) on disposal of assets	**(195)**	**(71)**
Gains / (losses) on foreign exchange	-	-
Total other gains / (losses)	**(195)**	**(71)**

Note 14 Discontinued operations

	2024/25	2023/24
	£000	£000
Operating income of discontinued operations	-	-
Operating expenses of discontinued operations	-	-
Gain on disposal of discontinued operations	-	-

(Loss) on disposal of discontinued operations	-	-
Total	**-**	**-**

Note 15.1 Intangible assets - 2024/25	**2024/25**	**2023/24**
	Software licences	**Software licences**
	£000	
Valuation / gross cost at 1 April 2024 - brought forward	**11,673**	**11,497**
Transfers by absorption	-	**-**
Additions	646	**176**
Reclassifications	(49)	**-**
Disposals / derecognition	(33)	**-**
Valuation / gross cost at 31 March 2025	**12,237**	**11,673**
		-
Amortisation at 1 April 2024 - brought forward	**8,488**	**6,722**
Transfers by absorption	-	**-**
Provided during the year	811	**1,766**
Reclassifications	-	**-**
Disposals / derecognition	(29)	**-**
Amortisation at 31 March 2025	**9,270**	**8,488**
Net book value at 31 March 2025	**2,967**	
Net book value at 1 April 2024	**3,185**	**4,775**

Note 16.1 Property, plant and equipment - 2024/25

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2024 - brought forward	**15,475**	**252,284**	**2,975**	**15,569**	**60,323**	**38,763**	**614**	**386,002**
Additions	-	13,798	215	8,894	4,324	3,418	64	**30,713**
Impairments	-	(8,864)	-	-	-	-	-	**(8,864)**
Reversals of impairments	-	6,499	-	(66)	-	-	-	**6,433**
Revaluations	-	(6,481)	-	-	-	-	-	**(6,481)**
Reclassifications	-	2,113	-	(2,324)	388	(137)	9	**49**
Disposals / derecognition	-	-	-	-	(2,812)	(828)	(294)	**(3,934)**
Valuation/gross cost at 31 March 2025	**15,475**	**259,349**	**3,190**	**22,073**	**62,223**	**41,216**	**393**	**403,918**
Accumulated depreciation at 1 April 2024 - brought forward	**-**	**-**	**-**	**-**	**28,749**	**21,011**	**545**	**50,305**
Provided during the year	-	6,481	-	-	5,045	2,085	24	**13,635**
Impairments	-	-	-	-	-	-	-	**-**
Reversals of impairments	-	-	-	-	-	-	-	**-**
Revaluations	-	(6,481)	-	-	-	-	-	**(6,481)**
Reclassifications	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	(2,556)	(805)	(293)	**(3,654)**
Accumulated depreciation at 31 March 2025	**-**	**-**	**-**	**-**	**31,238**	**22,291**	**276**	**53,805**
Net book value at 31 March 2025	**15,475**	**259,349**	**3,190**	**22,073**	**30,985**	**18,925**	**117**	**350,114**
Net book value at 1 April 2024	**15,475**	**252,284**	**2,975**	**15,569**	**31,574**	**17,752**	**69**	**335,698**

Note 16.2 Property, plant and equipment - 2023/24

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2023 - as previously stated	**17,793**	**244,326**	**2,767**	**8,343**	**56,764**	**34,548**	**602**	**365,143**
Prior period adjustments	-	-	-	-	-	-	-	**-**
Valuation / gross cost at 1 April 2023 - restated	**17,793**	**244,326**	**2,767**	**8,343**	**56,764**	**34,548**	**602**	**365,143**
Additions	-	8,460	208	12,668	4,609	4,215	12	**30,172**
Impairments	(2,318)	(14,463)	-	-	-	-	-	**(16,781)**
Reversals of impairments	-	14,713	-	-	-	-	-	**14,713**
Revaluations	-	(6,194)	-	-	-	-	-	**(6,194)**
Reclassifications	-	5,442	-	(5,442)	-	-	-	**-**
Disposals / derecognition	-	-	-	-	(1,050)	-	-	**(1,050)**
Valuation/gross cost at 31 March 2024	**15,475**	**252,284**	**2,975**	**15,569**	**60,323**	**38,763**	**614**	**386,002**
Accumulated depreciation at 1 April 2023 - as previously stated	**-**	**-**	**-**	**-**	**26,794**	**17,116**	**521**	**44,431**
Prior period adjustments	-	-	-	-	-	-	-	**-**
Accumulated depreciation at 1 April 2023 - restated	**-**	**-**	**-**	**-**	**26,794**	**17,116**	**521**	**44,431**
Provided during the year	-	6,194	-	-	2,894	3,895	24	**13,007**
Impairments	-	-	-	-	-	-	-	**-**
Reversals of impairments	-	-	-	-	-	-	-	**-**
Revaluations	-	(6,194)	-	-	-	-	-	**(6,194)**
Reclassifications	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	(939)	-	-	**(939)**
Accumulated depreciation at 31 March 2024	**-**	**-**	**-**	**-**	**28,749**	**21,011**	**545**	**50,305**
Net book value at 31 March 2024	**15,475**	**252,284**	**2,975**	**15,569**	**31,574**	**17,752**	**69**	**335,698**
Net book value at 1 April 2023	**17,793**	**244,326**	**2,767**	**8,343**	**29,970**	**17,432**	**81**	**320,712**

Note 16.3 Property, plant and equipment financing - 31 March 2025

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	15,475	11,732	(0)	21,917	30,059	18,924	76	**98,183**
On-SoFP PFI contracts and other service concession arrangements	-	246,588	-	156	-	-	-	**246,744**
Off-SoFP PFI residual interests	-	-	3,190	-	-	-	-	**3,190**
Owned - donated/granted	-	1,029	-	-	926	1	41	**1,997**
Total net book value at 31 March 2025	**15,475**	**259,349**	**3,190**	**22,073**	**30,985**	**18,925**	**117**	**350,114**

Note 16.4 Property, plant and equipment financing - 31 March 2024

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	15,475	14,057	1	15,569	30,527	17,751	58	**93,438**
On-SoFP PFI contracts and other service concession arrangements	-	237,167	-	-	-	-	-	**237,167**
Off-SoFP PFI residual interests	-	-	2,974	-	-	-	-	**2,974**
Owned - donated/granted	-	1,060	-	-	1,047	1	11	**2,119**
Total net book value at 31 March 2024	**15,475**	**252,284**	**2,975**	**15,569**	**31,574**	**17,752**	**69**	**335,698**

Note 16.5 Property plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2025

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Subject to an operating lease								-
Not subject to an operating lease								-
Total net book value at 31 March 2025	-	-	-	-	-	-	-	-

Note 16.6 Property plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2024

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
Subject to an operating lease								-
Not subject to an operating lease								-
Total net book value at 31 March 2024	-	-	-	-	-	-	-	-

Note 17 Donations of property, plant and equipment

The Trust received donations during the year of £426k. (2023/24 £281k). No restrictions were placed on these donations of which 114k funded the purchase of tangible capital assets.

Note 18 Revaluations of property, plant and equipment

An independent revaluation was undertaken of the Trust's buildings by the Clark Weightman with an effective date of 31st March 2025. The review was performed by Rob Mapletoft, (MRICS), RICS registered valuer.

Assets in existing use:

For specialised properties (i.e. those for which no active market exists), depreciated replacement cost has been used and is considered to be a satisfactory approximation of current value in existing use.

Within this methodology, consistent with previous years, a Modern Equivalent Asset (MEA) approach was undertaken referenced to National Indices acceptable to the RICS. Consideration was given to improvements carried out during the year and where appropriate asset lives were adjusted accordingly based on the remaining useful life advised by the District Valuer. This had minimal effect on remaining lives. Modern Equivalent Asset (MEA) concept is applied: the “replacement cost” being based on the cost of a modern replacement asset that has the same productive capacity as the property being valued.

The Trust has no assets identified as no longer in operational use and therefore ' surplus' or any assets held for sale.

The carrying value of land building and dwellings valued on an open market valuation basis at 31 March 2025 is detailed in note 15.1.

The useful economic asset lives for intangibles and plant and equipment are initially assessed when an asset is first recognised. Periodically the Trust does review these lives to identify and adjust for any assets impaired or where the useful economic life requires adjustment. This exercise was undertaken in 2019/20 for I.T assets.

The asset lives for individual buildings and dwellings are in accordance with the latest valuation report prepared by the external valuer.

The valuer has utilised assumptions with the valuation report to determine the conclusion, but responsibility over challenging the assumptions used is management’s responsibility.
The following assumptions have been utilised in the report:
1. Index – This is used as part of desktop review which is undertaken annually between full valuations. Utilising BCIS indexation figures to consider for inflation in building trade i.e., additional inflation cost for building a new build This is a consistent method used and is industry standard in line with RIC’s and accounting standards. Therefore, we have no issue in the index used in the valuation. There are no alternatives to compare with, therefore current indexation method the most appropriate.
2. Building Cost Information Service (BCIS) Rates – the valuation reflects construction cost increases this year in view of evidence coming through from industry data produced by the RICS Building Cost Information Service (BCIS).
3. Depreciation - Essentially the valuation has resulted in depreciation being one year less than last year, which is line with expectations. Continue to apply design and remaining lives elements of each building where they are present. No change has occurred from previous year’s calculations, therefore, applies a consistent approach and we would not expect a change in depreciation methodology as there has been neither change in guidance from RICS nor any change in accounting standards to facilitate any change in depreciation calculation. The depreciation has not adjusted the residual values.
4. Land - It is difficult to prove the price for commercial land, as it is commercially sensitive and not advertised publicly to be able to test exactly what land is going for currently. Therefore, it is reasonable to use the information the valuer provides, particularly as they are involved in selling and valuing of commercial land so understand the market.

Based on the valuation report if there was a 5% positive or negative movement in the valuation of buildings this would have resulted in a movement of £12.83m in the value of assets. This movement would have been reflected in either the revaluation reserve or income and expenditure as a revaluation adjustment as appropriate, however, It would have had no impact of the depreciation charge in year or the underlying reported position.

Note 19 Leases - Sherwood Forest Hospitals NHS Foundation Trust as a lessee

This note details information about leases for which the Trust is a lessee.

The Trust has entered into a number of leases as per IFRS16. These relate solely to equipment and buildings. The only material lease relates to wards at Mansfield Community Hospital

Note 19.1 Right of use assets - 2024/25

	Property (land and buildings)	Plant & machinery	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024 - brought forward	**6,169**	**606**	**6,775**	**274**
Additions	254	1,753	**2,007**	-
Remeasurements of the lease liability	232	-	**232**	-
Reclassifications	-	-	**-**	-
Valuation/gross cost at 31 March 2025	**6,655**	**2,359**	**9,014**	**274**
Accumulated depreciation at 1 April 2024 - brought forward	**1,468**	**495**	**1,963**	**-**
Provided during the year	1,103	-	**1,103**	69
Reclassifications	-	-	**-**	-
Accumulated depreciation at 31 March 2025	**2,571**	**495**	**3,066**	**69**
Net book value at 31 March 2025	**4,084**	**1,864**	**5,948**	**205**
Net book value at 1 April 2024	**4,701**	**111**	**4,812**	**274**

Net book value of right of use assets leased from other NHS providers	-
Net book value of right of use assets leased from other DHSC group bodies	205

Note 19.2 Right of use assets - 2023/24

	Property (land and buildings)	Plant & machinery	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2023 - brought forward	**4,440**	**577**	**5,017**	**-**
Prior period adjustments	-	-	**-**	-
Valuation / gross cost at 1 April 2023 - restated	**4,440**	**577**	**5,017**	**-**
Additions	1,370	114	**1,484**	-
Remeasurements of the lease liability	274	-	**274**	274
Reclassifications	85	(85)	**-**	-
Disposals / derecognition	-	-	**-**	-
Valuation/gross cost at 31 March 2024	**6,169**	**606**	**6,775**	**274**
Accumulated depreciation at 1 April 2023 - brought forward	720	294	**1,014**	-
Prior period adjustments	-	-	**-**	-
Accumulated depreciation at 1 April 2023 - restated	**720**	**294**	**1,014**	**-**
Provided during the year	748	201	**949**	-
Reclassifications	-	-	**-**	-
Accumulated depreciation at 31 March 2024	**1,468**	**495**	**1,963**	**-**
Net book value at 31 March 2024	**4,701**	**111**	**4,812**	**274**
Net book value at 1 April 2023	**3,720**	**283**	**4,003**	**-**

Net book value of right of use assets leased from other NHS providers	-

Net book value of right of use assets leased from other DHSC group bodies	274

Note 19.3 Revaluations of right of use assets

No external valuations have been made in year relating to building or PPE.

Note 19.4 Reconciliation of the carrying value of lease liabilities

Lease liabilities are included within borrowings in the statement of financial position. A breakdown of borrowings is disclosed in note 25.1.

	2024/25	2023/24
	£000	£000
Carrying value at 1 April	**4,878**	**4,023**
Prior period adjustments		-
Carrying value at 1 April - restated	**4,878**	**4,023**
Transfers by absorption	-	-
Lease additions	2,007	1,484
Lease liability remeasurements	232	274
Interest charge arising in year	191	141
Early terminations	-	-
Lease payments (cash outflows)	(1,279)	(1,044)
Other changes	-	-
Carrying value at 31 March	**6,029**	**4,878**

Lease payments for short term leases, leases of low value underlying assets and variable lease payments not dependent on an index or rate are recognised in operating expenditure.

These payments are disclosed in Note 7.1. Cash outflows in respect of leases recognised on-SoFP are disclosed in the reconciliation above.

Note 19.5 Maturity analysis of future lease payments

	Total	Of which leased from DHSC group bodies:	Total	Of which leased from DHSC group bodies:
	31 March 2025	31 March 2025	31 March 2024	31 March 2024
	£000	£000	£000	£000
Undiscounted future lease payments payable in:				
- not later than one year;	1,467	62	1,158	-
- later than one year and not later than five years;	3,439	123	4,581	274
- later than five years.	2,174	-	-	-
Total gross future lease payments	**7,080**	**185**	**5,739**	**274**
Finance charges allocated to future periods	(1,051)	-	(861)	-
Net lease liabilities at 31 March 2025	**6,029**	**185**	**4,878**	**274**
Of which:				
Leased from other NHS providers		-		-
Leased from other DHSC group bodies		185		274

Note 20 Inventories

	31 March 2025	31 March 2024
	£000	£000
Drugs	2,018	2,407
Work In progress	-	-
Consumables	4,131	3,549
Energy	207	205
Other	-	-
Total inventories	**6,356**	**6,161**
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £27,532k (2023/24: £32,544k). Write-down of inventories recognised as expenses for the year were £0k (2023/24: £0k).

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2023/24 the Trust received £132k of items purchased by DHSC. Distribution of inventory by the Department ceased in March 2024.

These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in the expenses disclosed above.

The deemed cost of these inventories was charged directly to expenditure on receipt with the corresponding benefit recognised in income.]

Note 21.1 Receivables

	31 March 2025	31 March 2024
	£000	£000
Current		
Contract receivables	29,195	26,409
Allowance for impaired contract receivables / assets	(282)	(418)
Allowance for other impaired receivables	-	-
Prepayments (non-PFI)	1,731	2,491
Interest receivable	193	123
VAT receivable	2,052	2,372
Other receivables	23	33
Total current receivables	**32,912**	**31,010**
Non-current		
Contract receivables	897	2,647
Allowance for impaired contract receivables / assets	(897)	(1,740)
PFI lifecycle prepayments	36	39
Interest receivable	-	-
Other receivables	495	505
Total non-current receivables	**531**	**1,451**

Of which receivable from NHS and DHSC group bodies:

Current	13,681	21,010
Non-current	495	505

Note 21.2 Allowances for credit losses

	2024/25		2023/24	
	Contract receivables and contract assets	All other receivables	Contract receivables and contract assets	All other receivables
	£000	£000	£000	£000
Allowances as at 1 April - brought forward	**2,158**	**-**	**1,937**	**-**
Prior period adjustments			-	-
Allowances as at 1 April - restated	**2,158**	**-**	**1,937**	**-**
Transfers by absorption	-	-	-	-
New allowances arising	354	-	221	-
Changes in existing allowances	-	-	-	-
Reversals of allowances	(220)	-	-	-
Utilisation of allowances (write offs)	(1,113)	-	-	-
Allowances as at 31 Mar 2025	**1,179**	**-**	**2,158**	**-**

Note 21.3 Exposure to credit risk

The majority of carrying debt relates to NHS organisations, therefore no significant credit risk is assumed in non impaired receivables.

Note 22.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2024/25	2023/24
	£000	£000
At 1 April	**4,736**	**23,541**
Prior period adjustments		-
At 1 April (restated)	**4,736**	**23,541**
Transfers by absorption	-	-
Net change in year	21,792	(18,805)
At 31 March	**26,528**	**4,736**
Broken down into:		
Cash at commercial banks and in hand	6	6
Cash with the Government Banking Service	26,522	4,730
Deposits with the National Loan Fund	-	-
Other current investments	-	-
Total cash and cash equivalents as in SoFP	**26,528**	**4,736**
Bank overdrafts (GBS and commercial banks)	-	-
Drawdown in committed facility	-	-
Total cash and cash equivalents as in SoCF	**26,528**	**4,736**

Note 22.2 Third party assets held by the trust

Sherwood Forest Hospitals NHS Foundation Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties and in which the trust has no beneficial interest. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2025	31 March 2024
	£000	£000
Bank balances	-	-
Monies on deposit	3	3
Total third party assets	**3**	**3**

Note 23.1 Trade and other payables

	31 March 2025	31 March 2024
	£000	£000
Current		
Trade payables	10,779	5,253
Capital payables	13,748	17,657
Accruals	11,450	14,016
Receipts in advance and payments on account	238	-
Social security costs	3,285	3,459
VAT payables	-	-
Other taxes payable	3,912	3,790
PDC dividend payable	-	-
Pension contributions payable	4,146	3,894
Other payables	4,619	4,314
Total current trade and other payables	**52,177**	**52,383**
Non-current		
Other payables	-	-
Total non-current trade and other payables	**-**	**-**
Of which payables from NHS and DHSC group bodies:		
Current	3,712	1,955
Non-current	-	-

Note 23.2 Early retirements in NHS payables above

The payables note above does not include any liabilites in relation to early retirements.

Note 24 Other liabilities

	31 March 2025	31 March 2024
	£000	£000
Current		
Deferred income: contract liabilities	-	1,193
Total other current liabilities	**-**	**1,193**
Non-current		
Deferred income: contract liabilities	-	-
Total other non-current liabilities	**-**	**-**

Note 25.1 Borrowings

	31 March 2025	31 March 2024
	£000	£000
Current		
Lease liabilities	1,467	1,158
Obligations under PFI, LIFT or other service concession contracts	19,641	17,911
Total current borrowings	**21,108**	**19,069**
Non-current		
Lease liabilities	4,562	3,720
Obligations under PFI, LIFT or other service concession contracts	399,119	400,623
Total non-current borrowings	**403,681**	**404,343**

Note 26.2 Clinical negligence liabilities

At 31 March 2025, £144,773k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Sherwood Forest Hospitals NHS Foundation Trust (31 March 2024: £146,941k).

Note 27 Contingent assets and liabilities

	31 March 2025	31 March 2024
	£000	£000
Value of contingent liabilities		
NHS Resolution legal claims	(125)	(107)
Employment tribunal and other employee related litigation	-	-
Redundancy	-	-
Other*	(560)	-
Gross value of contingent liabilities	**(685)**	**(107)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(685)**	**(107)**
Net value of contingent assets	**-**	**-**

* Relates to band 2 to 3 arrears.

Note 28 Contractual capital commitments

	31 March 2025	31 March 2024
	£000	£000
Property, plant and equipment	25,642	11,283
Intangible assets	-	-
Total	**25,642**	**11,283**

Note 29 Other financial commitments

The trust is committed to making payments under non-cancellable contracts (which are not leases, PFI contracts or other service concession arrangement), analysed by the period during which the payment is made:

	31 March 2025	31 March 2024
	£000	£000
not later than 1 year	-	-
after 1 year and not later than 5 years	-	-
paid thereafter	-	-
Total	**-**	**-**

Note 30 On-SoFP PFI, LIFT or other service concession arrangements

The Trust is currently committed to two on-statement of financial position PFI schemes as the transaction meets the IFRIC 12 definition of a service concession, as interpreted in the Government Accounting Manual. The Trust is required to account for the PFI scheme 'on-statement of financial position' and therefore the Trust treats the assets as if it were assets of the Trust.

The Trust has entered into private finance initiative contracts with:

a) Central Nottinghamshire Hospitals plc to construct and refurbish the Trust's buildings on the King's Mill and Newark hospital sites and then to operate them (estates, facilities management and life cycle replacement) for the Trust for the period to 2043. The contract requires that throughout the contract they are maintained to category B building standards. This PFI is known as the Modernisation of Acute Services (MAS). The MAS PFI scheme was completed and all assets were brought into use by 31 March 2012, with an estimated capital value of £366.5m.

b) Leicester Housing Association (LHA)*, to construct a day nursery and out of hours facility, on the King's Mill hospital site. All assets were brought into use by 2002, with a capital value of £1.3m. Throughout the term of the agreement there is a requirement to keep the premises clean, tidy and in good order and to keep in good and substantial repair and condition in accordance with the Operating Agreement.

In respect of both PFI schemes the Trust has the rights to use the specified assets for the length of the Project Agreements. At the end of the Project Agreements the assets of both schemes will transfer to the Trust's ownership for no additional consideration.

The annual charge relating to the MAS scheme is subject to an annual inflation uplift based on RPI. The LHA schemes are a fixed charge over the life of the contract. All liquidity and associated market and financing risks for both schemes rests with Central Nottinghamshire plc and Leicester Housing Association respectively.

* Leicester Housing Association is now known as Paragon Asra Housing (PA Housing).

Note 30.1 On-SoFP PFI, LIFT or other service concession arrangement obligations

The following obligations in respect of the PFI, LIFT or other service concession arrangements are recognised in the statement of financial position:

	31 March 2025	31 March 2024
	£000	£000
Gross PFI, LIFT or other service concession liabilities	**513,279**	**518,430**
Of which liabilities are due		
- not later than one year;	29,110	27,362
- later than one year and not later than five years;	113,577	109,183
- later than five years.	370,592	381,885
Finance charges allocated to future periods	(94,519)	(99,896)
Net PFI, LIFT or other service concession arrangement obligation	**418,760**	**418,534**
- not later than one year;	19,641	17,911
- later than one year and not later than five years;	80,252	75,567
- later than five years.	318,867	325,056

Note 30.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

Total future commitments under these on-SoFP schemes are as follows:

	31 March 2025	31 March 2024
	£000	£000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**1,190,350**	**1,202,080**
Of which payments are due:		
- not later than one year;	66,169	63,304
- later than one year and not later than five years;	264,538	253,126
- later than five years.	859,643	885,650

Note 30.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the unitary payments made to the service concession operator:

	2024/25	2023/24
	£000	£000
Unitary payment payable to service concession operator	**66,051**	**60,528**
Consisting of:		
- Interest charge	9,908	9,906
- Repayment of balance sheet obligation	18,727	19,048
- Service element and other charges to operating expenditure	31,695	27,659
- Capital lifecycle maintenance	5,721	3,915
Other amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment	1	1
Total amount paid to service concession operator	**66,052**	**60,529**

Note 31 Off-SoFP PFI, LIFT and other service concession arrangements

Sherwood Forest Hospitals NHS Foundation Trust incurred the following charges in respect of off-Statement of Financial Position PFI and LIFT arrangements:

	31 March 2025	31 March 2024
	£000	£000
Charge in respect of the off SoFP PFI, LIFT or other service concession arrangement for the period	**155**	**92**
Commitments in respect of off-SoFP PFI, LIFT or other service concession arrangements:		
- not later than one year;	435	420
- later than one year and not later than five years;	1,897	1,822
- later than five years.	3,249	3,678
Total	**5,581**	**5,920**

Note 32 Financial instruments

A financial instrument is a contract that gives rise to a financial asset in one entity and a financial liability or equity instrument in another entity. The nature of the Trust's activities means that exposure to risk, although not eliminated, is substantially reduced.

Note 32.1 Financial risk management

Because of the continuing service provider relationship that the Trust has with Integrated Care Boards (ICB's) and the way those ICB's are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the Board of Directors. Trust treasury activity is subject to review by the Finance Committee.

Note 31.2 Currency Risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and Sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Note 31.3 Market (Interest Rate) Risk

All of the Trust financial assets and all of its financial liabilities carry nil or fixed rates of interest. The Trust is not therefore, exposed to significant interest rate risk.

Note 31.4 Liquidity Risk

The Trust's net operating costs are incurred under annual service agreements with Integrated Care Boards (ICB's) and NHS England, which are financed from resources voted annually by Parliament. The Trust ensures that it has sufficient cash to meet all its commitments when they fall due. This is regulated by the Trust's compliance with the 'Use of Resources Risk Rating' system created by NHSI, the Independent Regulator.

The Board continues to monitor its monthly and future cash position and has governance arrangements in place to manage cash requirements throughout the year. The Trust is not, therefore, exposed to significant liquidity risks.

Note 31.5 Fair Values

All of the financial assets and all of the financial liabilities of the Trust are measured at fair value on recognition and subsequently amortised cost.

The fair values recognised in these accounts do not differ materially from the carrying amounts.

Note 31.6 Credit Risk

The majority of the Trust's income comes from contracts with other public sector bodies, resulting in low exposure to credit risk. The Trust mitigates its exposure to credit risk relating to receivables from customers through regular review of debtor balances and by calculating an expected allowance for credit losses at the end of the year. Changes have been made to funding flows at least for the period April to July 2020 as part of the COVID 19 response. These changes are not seen as an increase to credit risk as the operational expenditure and related financing is provided by the DHSC.

Note 32.7 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2025	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	29,624	-	-	**29,624**
Other investments / financial assets	-	-	-	**-**
Cash and cash equivalents	26,528	-	-	**26,528**
Total at 31 March 2025	**56,152**	**-**	**-**	**56,152**

Carrying values of financial assets as at 31 March 2024	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	27,559	-	-	**27,559**
Other investments / financial assets	-	-	-	**-**
Cash and cash equivalents	4,736	-	-	**4,736**
Total at 31 March 2024	**32,295**	**-**	**-**	**32,295**

Note 32.8 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2025	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Loans from the Department of Health and Social Care	-	-	**-**
Obligations under leases	6,029	-	**6,029**
Obligations under PFI, LIFT and other service concession contracts	418,760	-	**418,760**
Other borrowings	-	-	**-**
Trade and other payables excluding non financial liabilities	40,038	-	**40,038**
Other financial liabilities	-	-	**-**
Provisions under contract	1,042	-	**1,042**
Total at 31 March 2025	**465,869**	**-**	**465,869**

Carrying values of financial liabilities as at 31 March 2024	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Loans from the Department of Health and Social Care	-	-	**-**
Obligations under leases	4,878	-	**4,878**
Obligations under PFI, LIFT and other service concession contracts	418,534	-	**418,534**
Other borrowings	-	-	**-**
Trade and other payables excluding non financial liabilities	43,026	-	**43,026**
Other financial liabilities	-	-	**-**
Provisions under contract	995	-	**995**
Total at 31 March 2024	**467,433**	**-**	**467,433**

Note 32.9 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	31 March 2025	31 March 2024
	£000	£000
In one year or less	70,914	71,784
In more than one year but not more than five years	117,308	114,022
In more than five years	373,217	382,384
Total	**561,439**	**568,190**

Note 33 Losses and special payments

	2024/25		2023/24	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	14	9	2	8
Bad debts and claims abandoned	35	40	75	35
Stores losses and damage to property	4	95	1	1
Total losses	**53**	**144**	**78**	**44**
Special payments				
Compensation under court order or legally binding arbitration award	1	6	-	-
Ex-gratia payments	26	373	24	76
Special severance payments	-	-	1	16
Total special payments	**27**	**379**	**25**	**92**
Total losses and special payments	**80**	**523**	**103**	**136**

Note 34 Related parties

The Trust undertakes a large number of related party transactions with other Government bodies. Related parties include but are not limited to

Department of Health and Social Care ministers

The Department of Health and Social Care

Board members of the Trust

Nottingham University Hospitals NHS Trust

University Hospitals of Leicester NHS Trust

Chesterfield Royal Hospital NHS Foundation Trust

Nottinghamshire Healthcare NHS Foundation Trust

Northampton General Hospital NHS Trust

University Hospitals of Derby and Burton NHS Foundation Trust

Leeds Teaching Hospitals NHS Foundation Trust

NHS Lincolnshire ICB

NHS Derby and Derbyshire ICB

NHS Nottingham and Nottinghamshire ICB

NHS England

Health Education England

NHS Resolution

NHS Property Services

NHS Providers

Department of Health and Social Care

HM Revenue & Customs

NHS Pension Scheme

NHS Blood and Transplant

Criminal Injuries Compensation Authority

Nottinghamshire County Council

NHS charitable funds (where not consolidated)

The Trust as Corporate Trustee also has a relationship with Sherwood Forest Hospitals General Charitable Fund. Charitable Income of £312k (2023/24 £281k) has been recognised in these accounts all of which relates to Sherwood Forest Hospitals General Charitable Fund. In addition a recharge of £55k (2023/24 £53k) has been made to Sherwood Forest Hospitals General Charitable Fund in relation to management / staff costs.
The accounts are not consolidated on the basis of materiality as approved by the Trustees subject to annual review and approval.

The Trust made no payments to related parties for whom the Chair, Non Executive or Executive Directors are named Directors.

Note 35 Prior period adjustments

No prior period adjustments have been recognised in this accounting period.

Note 36 Events after the reporting date

There are non events after the reporting date that impact on theses financial statements and disclosures.

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of Sherwood Forest Hospitals NHS Foundation Trust ("the Trust") for the year ended 31 March 2025 which comprise the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Taxpayers' Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2025 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by NHS England with the consent of the Secretary of State in February 2025 as being relevant to NHS Foundation Trusts and included in the Department of Health and Social Care Group Accounting Manual 2024/25; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006 (as amended).

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the Trust in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Going concern

The Accounting Officer has prepared the financial statements on the going concern basis as they have not been informed by the relevant national body of the intention to either cease the Trust's services or dissolve the Trust without the transfer of its services to another public sector entity. They have also concluded that there are no material uncertainties that could have cast significant doubt over its ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

In our evaluation of the Accounting Officer's conclusions, we considered the inherent risks associated with the continuity of services provided by the Trust over the going concern period.

Our conclusions based on this work:

- we consider that the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate; and
- we have not identified and concur with the Accounting Officer's assessment that there is not, a material uncertainty related to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a going concern for the going concern period.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the above conclusions are not a guarantee that the Trust will continue in operation.

Fraud and breaches of laws and regulations – ability to detect

Identifying and responding to risks of material misstatement due to fraud

To identify risks of material misstatement due to fraud ("fraud risks") we assessed events or conditions that could indicate an incentive or pressure to commit fraud or provide an opportunity to commit fraud. Our risk assessment procedures included:

- Enquiring of management, the Audit and Assurance Committee and internal audit and inspection of policy documentation as to the Trust's high-level policies and procedures to prevent and detect fraud, including the internal audit function, and the Trust's channel for "whistleblowing", as well as whether they have knowledge of any actual, suspected, or alleged fraud.
- Assessing the incentives for management to manipulate reported financial performance because of the need to achieve financial performance targets delegated to the Trust by NHS England.
- Reading Board and Audit and Assurance Committee minutes.
- Using analytical procedures to identify any unusual or unexpected relationships.
- Reading the Trust's accounting policies.

We communicated identified fraud risks throughout the audit team and remained alert to any indications of fraud throughout the audit.

As required by auditing standards, we performed procedures to address the risk of management override of controls in particular the risk that Trust management may be in a position to make inappropriate accounting entries. On this audit we did not identify a fraud risk related to revenue recognition due to the block nature of the funding provided to the Trust during the year. We therefore assessed that there was limited opportunity for the Trust to manipulate the income that was reported.

We also identified a fraud risk related to non-pay expenditure recognition, particularly in relation to year-end accruals.

We performed procedures including:

- Identifying journal entries to test based on risk criteria and comparing the identified entries to supporting documentation. These included unusual entries impacting cash accounts.
- Assessing whether the judgements made in making accounting estimates are indicative of a potential bias.
- Inspecting cash payments and purchase invoices in the period prior to and following the 31 March 2025 to verify expenditure had been recognised in the correct accounting period.

Identifying and responding to risks of material misstatement related to compliance with laws and regulations

We identified areas of laws and regulations that could reasonably be expected to have a material effect on the financial statements from our general sector experience and through discussion with the Accounting Officer (as required by auditing standards), and discussed with the Accounting Officer the policies and procedures regarding compliance with laws and regulations.

We communicated identified laws and regulations throughout our team and remained alert to any indications of non-compliance throughout the audit.

The potential effect of these laws and regulations on the financial statements varies considerably.

Firstly, the Trust is subject to laws and regulations that directly affect the financial statements, including the financial reporting aspects of NHS legislation. We assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items.

Secondly, the Trust is subject to many other laws and regulations where the consequences of non-compliance could have a material effect on amounts or disclosures in the financial statements, for instance through the imposition of fines or litigation. We identified the following areas as those most likely to have such an effect: health and safety, data protection laws, anti-bribery, employment law, recognising the nature of the Trust's activities. Auditing standards limit the required audit procedures to identify non-compliance with these laws and regulations to enquiry of the Accounting Officer and inspection of regulatory and legal correspondence, if any. Therefore if a breach of operational regulations is not disclosed to us or evident from relevant correspondence, an audit will not detect that breach.

Context of the ability of the audit to detect fraud or breaches of law or regulation

Owing to the inherent limitations of an audit, there is an unavoidable risk that we may not have detected some material misstatements in the financial statements, even though we have properly planned and performed our audit in accordance with auditing standards. For example, the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely the inherently limited procedures required by auditing standards would identify it.

In addition, as with any audit, there remained a higher risk of non-detection of fraud, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal controls. Our audit procedures are designed to detect material misstatement. We are not responsible for preventing non-compliance or fraud and cannot be expected to detect non-compliance with all laws and regulations.

Other information in the Annual Report

The Accounting Officer is responsible for the other information, which comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work:

- we have not identified material misstatements in the other information; and
- in our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Remuneration and Staff Reports

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared, in all material respects, in accordance with the NHS Foundation Trust Annual Reporting Manual 2024/25.

Accounting Officer's responsibilities

As explained more fully in the statement set out on page 129, the Accounting Officer is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for: such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to either cease the services provided by the Trust or dissolve the Trust without the transfer of its services to another public sector entity.

Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities.

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

Report on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report if we identify any significant weaknesses in the arrangements that have been made by the Trust to secure economy, efficiency and effectiveness in its use of resources.

We have nothing to report in this respect.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

As explained more fully in the statement set out on page 129, the Accounting Officer is responsible for ensuring that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Under Section 62(1) and paragraph 1(d) of Schedule 10 of the National Health Service Act 2006 we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively. We are also not required to satisfy ourselves that the Trust has achieved value for money during the year.

We planned our work and undertook our review in accordance with the Code of Audit Practice and related statutory guidance, having regard to whether the Trust had proper arrangements in place to ensure financial sustainability, proper governance and to use information about costs and performance to improve the way it manages and delivers its services. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice to report to you if:

- we issue a report in the public interest under paragraph 3 of Schedule 10 of the National Health Service Act 2006; or
- we make a referral to the Regulator under paragraph 6 of Schedule 10 of the National Health Service Act 2006 because we have reason to believe that the Trust, or a director or officer of the Trust, is about to make, or has made, a decision which involves or would involve the incurring of expenditure which is unlawful, or is about to take, or has taken, a course of action which, if pursued to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We have nothing to report in these respects.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust, as a body, for our audit work, for this report, or for the opinions we have formed.

DELAY IN CERTIFICATION OF COMPLETION OF THE AUDIT

As at the date of this audit report, we are unable to confirm that we have completed our work in respect of the trust accounts consolidation pack of the Trust for the year ended 31 March 2025 because we have not received confirmation from the NAO that the NAO's audit of the Department of Health and Social Care accounts is complete.

Until we have completed this work, we are unable to certify that we have completed the audit of Sherwood Forest Hospitals NHS Foundation Trust for the year ended 31 March 2025 in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the NAO Code of Audit Practice.

Richard Walton

for and on behalf of KPMG LLP

Chartered Accountants
EastWest
Tollhouse Hill
NG1 5FS

25 June 2025