MEETING OF THE BOARD OF DIRECTORS IN PUBLIC

AGENDA

Date: **Thursday 4th December 2025**
Time: **09:00 – 12:30**
Venue: **Boardroom, King's Mill Hospital**

	Time	Item	Status	Paper
1.	09:00	**Welcome**		
2.		**Declarations of Interest** To declare any pecuniary or non-pecuniary interests not already declared on the Trust's Register of Interest **:-** Register of Interest | Sherwood Forest Hospitals *Check – Attendees to declare any potential conflict of items listed on the agenda to the Director of Corporate Affairs on receipt of agenda, prior to the meeting.*	Declaration	Verbal
3.		**Apologies for Absence** Quoracy check: *(s3.22.1 SOs: no business shall be transacted at a meeting of the Board unless at least 2/3rds of the whole number of Directors are present including at least one ED and one NED)*	Agree	Verbal
4.	09:00	**Patient Story – The launch of new spirometry tests at Mansfield Community Hospital, as part of the Community Diagnostics Centre project** Aimee Allsop, Senior Respiratory & Sleep Assistant	Assurance	Presentation
5.	09:20	**Minutes of the meeting held on 2nd October 2025** To be agreed as an accurate record	Agree	Enclosure 5
6.	09:25	**Action Tracker**	Update	Enclosure 6
7.	09:30	**Chair's Report** • **Council of Governors Highlight Report**	Assurance Assurance	Enclosure 7 Enclosure 7.1
8.	09:35	**Chief Executive's Report**	Assurance	Enclosure 8
	Strategy			
9.	09:45	**Making Tomorrow Better – Strategy Delivery Update** Report of the Director of Strategy and Partnerships	Assurance	Enclosure 9
10.	10:00	**Strategic Objective 1 – Provide outstanding care in the best place at the right time** • **Maternity and Neonatal Update** Report of the Director of Midwifery ○ **Safety Champions update** ○ **Maternity Perinatal Quality Surveillance Model**	Assurance	Enclosure 10.1
11.	10:15	**Strategic Objective 5 – Sustainable use of resources and estate** • **Green Plan Refresh** Report of the Chief Financial Officer	Approve	Enclosure 11.1

	Time	Item	Status	Paper
	BREAK (10 mins)			
	Operational			
12.	10:45	**Integrated Performance Report (IPR)** Report of the Executive Team	Consider	Enclosure 12
	Governance			
13.	11:30	**Emergency Preparedness (EPRR) Annual Report** Report of the Emergency Planning & Business Continuity Officer	Assurance	Enclosure 13
14.	11:40	**Provider Board Capability Self-Assessment** Report of the Director of Corporate Affairs	Assurance	Enclosure 14
15.	11:45	**Review of Public Board Workplan** Report of the Director of Corporate Affairs	Approve	Enclosure 15
16.	11:50	**Assurance from Sub Committees** • Finance Committee Report of the Committee Chair (last meeting) • Quality Committee Report of the Committee Chair (last meeting) • People Committee Report of the Committee Chair (last meeting) • Partnerships and Communities Committee Report of the Committee Chair (last meeting) • Charitable Funds Committee Report of the Committee Chair (last meeting)	Assurance Assurance Assurance Assurance Assurance	Enclosure 16.1 Enclosure 16.2 Enclosure 16.3 Enclosure 16.4 Enclosure 16.5
17.	12:15	**Spotlight on – Healthy Welcome: The fruit and veg stall at King's Mill Hospital**	Assurance	Presentation
18.	12:20	**Communications to wider organisation** (Agree Board decisions requiring communication to Trust)	Agree	Verbal
19.	12:25	**Any Other Business**		
20.		**Date of next meeting** The next scheduled meeting of the Board of Directors to be held in public will be **5th February 2026, Boardroom, King's Mill Hospital**		
21.		**Chair Declares the Meeting Closed**		
22.		**Questions from members of the public present** (Pertaining to items specific to the agenda)		
		Resolution to move to the closed session of the meeting In accordance with Section 1 (2) Public Bodies (Admissions to Meetings) Act 1960, members of the Board are invited to resolve: *"That representatives of the press and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest."*		

Board of Directors Information Library Documents

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

Enc 9.1 **Enc 9.1** **Enc 16.1** **Enc 16.2** **Enc 16.3** **Enc 16.4** **Enc 16.5**	• **Perinatal Safe Staffing Report** • **Nursing Monthly Safe Staffing** • **Finance Committee – previous minutes** • **Quality Committee – previous minutes** • **People Committee – previous minutes** • **Partnerships and Communities Committee – previous minutes** • **Charitable Funds Committee – previous minutes**

Outstanding Care, Compassionate People, Healthier Communities

NHS Sherwood Forest Hospitals NHS Foundation Trust

UN-CONFIRMED MINUTES of the Board of Directors meeting held in Public at 09:00 on Thursday 2nd October 2025, in the Boardroom, King's Mill Hospital

Present:	Graham Ward	Chair	GW
	Steve Banks	Vice Chair	SB
	Andrew Rose-Britton	Non-Executive Director	ARB
	Neil McDonald	Non-Executive Director	NM
	Lisa Maclean	Non-Executive Director	LM
	Richard Cotton	Non-Executive Director	RC
	Manjeet Gill	Non-Executive Director	MG
	Barbara Brady	Non-Executive Director	BB
	Jonathan Van Tam	Associate Non-Executive Director	JVT
	David Selwyn	Acting Chief Executive	DS
	Richard Mills	Chief Financial Officer	RM
	Rob Simcox	Chief People Officer	RS
	Sally Brook Shanahan	Director of Corporate Affairs	SBS
	Simon Illingworth	Chief Operating Officer	SI
	Simon Roe	Chief Medical Officer	SR
	Phil Bolton	Chief Nurse	PB
In Attendance:	Phaedra Kay	Department Lead in Adult Critical Care Unit	PK
	Paula Shore	Director of Midwifery	PS
	Rebecca Herring	Associate Director of Nursing Workforce	RH
	Kerry Bosworth	Freedom to Speak Up (FTSU) Guardian	KB
	Alison Steel	Head of Research and Innovation	AS
	Mark Bolton	Associate Director of Operational Performance	MB
	Sue Bradshaw	Minutes	
	Olivia Bower	Producer for MS Teams Public Broadcast	
	Caroline Kirk	Communications Specialist	
Observers:	Stella Garrett-Anderson	CQC	
	Michelle Dunna	CQC	
	Jill Smallwood	Volunteers' Finance Committee	
	Margaret Pritchard	Volunteers' Finance Committee	
	Margaret Hurrell	Volunteers' Finance Committee	
	Aaron Clark	Patient	
	Alix Barker	Patient's partner	
	Jane Hildreth	Communications Specialist	
	Debbie Kearsley	Deputy Chief People Officer	
	Rich Brown	Head of Communications	
	Claire Hinchley	Director of Strategy and Partnerships	
	Claire Page	360 Assurance	
	Joseph Connolly	Nottingham Post	
	2 members of the public		
Apologies:	None		

Item No.	Item	Action	Date
25/191	**WELCOME**		
1 min	The meeting being quorate, GW declared the meeting open at 09:00 and confirmed that the meeting had been convened in accordance with the Trust's Constitution and Standing Orders. The meeting was held in person and was streamed live. This ensured the public were able to access the meeting. The agenda and reports were available on the Trust Website and the public were able to submit questions via the live Q&A function.		
25/192	**DECLARATIONS OF INTEREST**		
1 min	There were no declarations of interest pertaining to any items on the agenda.		
25/193	**APOLOGIES FOR ABSENCE**		
1 min	There were no apologies for absence.		
25/194	**PATIENT STORY – A PATIENT'S ICU BATTLE WITH FLU - WHY THE JAB MATTERS**		
18 mins	PK joined the meeting. PK introduced the Patient Story, which highlighted a patient's battle with flu and why the flu vaccination is important. Members of the Board of Directors expressed gratitude to Aaron and Alix for sharing their story, recognising the power of personal testimony compared to statistics. Alix expressed thanks for the opportunity to visit the critical care unit to thank the team who had cared for Aaron. NM queried how the Trust can ensure the video is seen by all staff as a powerful message to encourage uptake of the flu vaccination. DS advised the video also needs to be shared with the wider community. PB advised the video has already been shared at leadership meetings and nursing forums and will be added to the Trust's website and cascaded as widely as possible. PK left the meeting.		
25/195	**MINUTES OF THE PREVIOUS MEETING**		
1 min	Following a review of the minutes of the Board of Directors meeting in Public held on 7th August 2025, the Board of Directors APPROVED the minutes as a true and accurate record.		
25/196	**MATTERS ARISING/ACTION LOG**		
1 min	The Board of Directors AGREED that action 25/168 was complete and could be removed from the action tracker.		

	Action 25/129 – PB confirmed the deep dive into third and fourth degree tears had been presented to the Quality Committee on 29th September 2025. The Board of Directors AGREED this action was complete and could be removed from the action tracker. *Action 25/133* – SBS confirmed this is on the list for a future Board of Directors' Workshop, but a date has not yet been set.		
25/197	**CHAIR'S REPORT**		
10 mins	GW presented the report, which provided an update regarding some of the most noteworthy events and items over the past two months from the Chair's perspective, highlighting the Annual General Meeting (AGM), Staff Excellence Awards, long service awards, work of the Trust's volunteers and Andrew Rose-Britton's sponsored walk in aid of the Trust's Charity. It was noted this was David Selwyn's last Board of Directors' meeting held in Public and GW expressed thanks to DS for his work for the Trust, particularly during his time as Acting Chief Executive. The Board of Directors were ASSURED by the report. **Council of Governors Highlight Report** GW presented the report, highlighting concerns raised by governors regarding the poor attendance at the meeting by Non-Executive Directors (NEDs), the radiology reception area and visibility of quality impact assessments for decisions made by the Integrated Care Board (ICB). Other areas highlighted were approval to proceed with the external audit tender process and approval of the reappointment of Barbara Brady and Manjeet Gill as NEDs for a further term of one year. The Board of Directors were ASSURED by the report.		
25/198	**ACTING CHIEF EXECUTIVE'S REPORT**		
22 mins	DS presented the report, which provided an update regarding some of the most noteworthy events and items over the past two months from the Acting Chief Executive's perspective, highlighting publication of NHS England's (NHSE) new National Oversight Framework (NOF), which ranks SFHFT 48th of 134 acute trusts nationally, operational performance, industrial action by resident doctors, partnerships, funding for integrated neighbourhood respiratory health service, signing of Memorandum of Understanding (MoU) with Nottingham Trent University (NTU), recognition of the Trust's work with Armed Forces veterans at the recent Boots and Beret ceremony, Carer Friendly Employer Quality Mark, Bliss Baby Charter accreditation and the work of the Emily Harris Foundation in support of the neonatal unit. DS expressed thanks to the Communications Team for their work in organising the Staff Excellence Awards. RS advised a letter had been received from NHSE outlining a 10-point plan to improve the working lives of resident doctors. This was discussed at the meeting of the People Committee on 30th September		

	2025, where it was noted actions are underway. A further update will be provided to the People Committee in November 2025 and it was agreed an update on the Trust's response to the plan will be included in the next Guardian of Safe Working report. **Action** • **Trust's response to the 10-point plan to improve the working lives of resident doctors to be included in the next Guardian of Safe Working report to Board.** SB referenced a recent interaction with a patient and their daughter relating to discharge during a 15 Steps visit and queried if there is a mechanism in place to measure the effectiveness of communication relating to discharge. PB advised there are no specific measures, but acknowledged discharge and communication is a theme of patient dissatisfaction. DS advised national direction is awaited in relation to capturing patient experience information. However, once the Electronic Patient Record (EPR) system is implemented information on time points, for example, decision to discharge, To Take Out (TTO) medication being available, can be captured. SR acknowledged there is work to do and there is variability across the organisation, noting board rounds are key to improving the discharge process. NM referenced the funding which has been secured for the funding for an integrated neighbourhood respiratory health service and queried if the impact on patients not coved by the service has been considered. SR advised the bid includes a detailed analysis plan and, once complete, the Trust will analyse the results to inform future service development. The Board of Directors were ASSURED by the report.	**SR**	**02/04/26**
25/199	**STRATEGIC OBJECTIVE 1 – PROVIDE OUTSTANDING CARE IN THE BEST PLACE AT THE RIGHT TIME**		
21 mins	JVT and PS joined the meeting. **Maternity Update** ***Safety Champions update*** PB presented the report, highlighting activity levels, Safety Champions walkarounds, recruitment process for a consultant midwife, national recognition for the Trust's Obstetric and Gynaecology Department, vaccinations in pregnancy, national maternity review and challenges on the neonatal pathway. PS highlighted engagement with the specialist midwife and development of a maternity 'Winter' Plan. BB queried if there will be any targets for vaccine uptake and if it will be possible to analyse uptake in terms of inequalities. PS advised additional resources had been allocated to improve data collection and outreach.		

	MG noted the Thirlwall Inquiry and queried what the emerging themes are, what some of the gaps in controls are and what actions the Trust is taking proactively in anticipation of the recommendations. PS advised the Trust has a strong relationship with maternity and neonatal voice partners. Parents' voices had been pivotal in raising issues, such as access to pain relief. MG requested information viewed through an equalities lens, such as data on families for whom English is a second language, be included in future reports. The Board of Directors were ASSURED by the report. ***Maternity Perinatal Quality Surveillance Model*** PB presented the report, highlighting the number of stillbirths and the recent deep dive into third and fourth degree tears. PB advised during July and August five diverts had occurred, resulting in ten women being transferred to other centres. LM noted some women had declined diversion to another unit and queried what the outcome was. PB confirmed they remained at the Trust and received care, noting women are not delivering at the same time. At times of pressure, leaders within maternity will step in to assist. ARB queried if there was any information available on the number of still births in September 2025. PS advised there was one stillbirth in September, which was an antenatal case involving complex foetal medicine care and altered movements. BB noted several areas on the scorecard remained red, but noted plans to introduce Statistical Process Control (SPC) charts as these better illustrate variability and identify true outliers. PS advised this is the national scorecard, but the Trust wants to slightly change how the data is presented, as it is known SFHFT is not an outlier in some areas. The Board of Directors were ASSURED by the report. PS left the meeting.		
10 mins	**Learning from Deaths** SR presented the report, highlighting the key metrics of Summary Hospital-Level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio+ (HSMR+), coding, end of life audit, learning from the Coronial process and the new system for structured judgement reviews (SJRs). SB supported the decision not to extend the contract with Telstra (Dr Foster), but noted the need for robust internal processes and peer benchmarking. DS sought assurance the Trust's SHMI and internal data collection processes will flag up any areas of concern.		

	SR acknowledged the valuable analytical support provided by Telstra and noted the Trust will need to ensure equivalent support is available internally. The need for ongoing review and adaptation of processes was noted. ARB queried what the timeframe is for the internal audit review by 360 Assurance. SR stated he was unsure of the timescale, but this may not be within the current calendar year. The Board of Directors were ASSURED by the report.		
25/200	**STRATEGIC OBJECTIVE 2 – EMPOWER AND SUPPORT OUR PEOPLE TO BE THE BEST THEY CAN BE**		
15 mins	**Nursing, Midwifery and Allied Health Professions (AHP) Staffing bi-annual report** RH joined the meeting. RH presented the report, highlighting fill rates, temporary staffing usage, recruitment and adherence to the three expectations of the National Quality Board and compliance with the 14 recommendations from the Developing Workforce Safeguards document. BB acknowledged the report provides a clear picture of nursing and AHP staffing, but professional groups, for example pharmacists and non-clinical staff, are not included. BB queried how assurance can be provided that all staff groups are appropriately staffed. SB noted pharmacy staffing had previously been a major concern and assurance reports had been received by the People Committee, acknowledging the importance of keeping such issues on the work plan. SB noted healthcare assistant (HCA) vacancies had been a concern raised through the Risk Committee and People Committee, advising progress has been made, but further work is required to address these issues. RS advised there is a varied but structured work plan in place which captures other professions, noting this can be built in when developing the work plan for the People Committee for 2026, to ensure regular review of all staff groups. GW advised it would also be useful to capture information on staff groups covered by the Hard FM and Soft FM PFI contract. DS advised there are consequences for any actions taken, for example, reducing the workforce. Such reductions will have an impact on quality and performance. Early triggers for negative consequences should be identified, rather than relying on retrospective data. GW acknowledged the NHS as a whole is not good at understanding the implications of staff reductions and Quality Impact Assessments (QIAs) should be used to predict and manage these consequences. **Action** • **People Committee to consider how early triggers of the impact of staff reductions on quality and performance can be identified.**	**RS**	**04/12/25**

	JVT expressed the view the Trust should be open with the public about the direct consequences of staff reductions. The Board of Directors were ASSURED by the report. RH left the meeting.		
21 mins	**Guardian of Safe Working** NS joined the meeting. NS presented the report, highlighting vacancies, number of exception reports, reasons for exception reports, time to review and close reports, action taken to close reports, rota gaps, immediate safety concerns raised, support for doctors, visits to clinical areas, resident doctor forums and national review of the exception reporting process. NS raised the issue of working environments for doctors, noting hot-desking is common and improvements are needed to provide quiet spaces for clinical work. NS advised an induction package is being developed to support prioritisation and resilience among resident doctors. NS noted a substantial amount of milk is wasted in the Trust and suggested a proportion of milk is allocated for staff tea and coffee per week, as a morale booster and to reduce waste. MS sought assurance that actions from exception reports are embedded and consistently applied. NS advised ongoing assurance requires regular visits to clinical areas, confidential conversations with doctors and feedback to decision makers. SB asked about the process for addressing immediate safety concerns, referencing a graph showing a reduction in anaesthetics concerns and an increase in endocrinology. NS advised the process is robust and issues are addressed promptly, but acknowledged the risk that problems could go unreported if staff felt discouraged. The Board of Directors were ASSURED by the report. NS left the meeting.		
23 mins	**Freedom to Speak up (FTSU)** KB joined the meeting. SBS introduced the report, noting progress on actions from the 360 Assurance Internal Audit report and recommendations from the well-led review. KB presented the report, highlighting the number of concerns raised, shift to concerns being raised confidentially, actions taken to handle concerns, divisional and people profile of concerns, themes, new database system, number of FTSU Champions and the withdrawal of the clinical psychology service.		

	LM noted the common themes, particularly in relation to handling concerns and lack of resolution, suggesting leadership issues might be at play, and queried if this should be an area of focus for training. RS advised leadership development training was ongoing, with efforts to improve integration and ownership at divisional level. A 'helicopter' role has been introduced to escalate points where progress is lacking. RM noted the concerns in relation to the impact of financial savings on staff willingness to speak up, emphasising the need to dispel myths and ensure staff feel safe to speak up. BB queried how intelligence from FTSU, exit interviews and the Staff Surveys is triangulated, suggesting a holistic view would be more powerful than considering each data source in isolation. BB queried if a report could be presented to the Board of Directors when the next staff survey results are issued. RS advised there is a challenge in aligning data points taken at different times of the year, but acknowledged the importance of triangulating themes across different sources. It was noted some of the domains in Staff Survey link to FTSU. DS suggested using the quarterly Pulse surveys, as this allows the targeting of questions which can link to themes raised through FTSU. However, it was noted the response rate to Pulse surveys is lower than the Staff Survey. **Action** • **Consider how a report can be developed triangulating information from FTSU, exit interviews, Staff Survey, etc.** GW felt it would be helpful to obtain feedback from people who have gone through the FTSU process, to assess whether it was helpful and fair, even if the desired outcome was not achieved. JVT acknowledged some use of the FTSU and Staff Survey system may be malicious or less constructive, but the majority was assumed to be genuine, and sought reassurance that substantiated leadership concerns were fed back into performance appraisal and review processes. RS advised concerns raised and substantiated are linked to the informal and formal stages of the HR policy. There is a feedback loop to the appropriate leadership teams regarding the consequences derived from such concerns. The Board of Directors were ASSURED by the report KB left the meeting	**RS**	**04/12/25**
25/201	**STRATEGIC OBJECTIVE 3 – IMPROVE HEALTH AND WELLBEING WITHIN OUR COMMUNITIES**		
11 mins	**Flu Annual Checklist** RS presented the report, outlining the Trust's approach to the flu vaccination programme for 2025/2026, and highlighting the target for vaccine uptake and incentives for staff to have the vaccine. It was noted uptake will be tracked via the Integrated Performance Report (IPR).		

	LM referenced recent public statements about vaccine safety and the use of paracetamol by the President of the United States of America and queried if these comments had had any impact on uptake of vaccinations in general among the local population. DS advised the regulatory authorities in Great Britain had robustly refuted such claims and emphasised the importance of vaccination as a major healthcare advance. The Board of Directors were ASSURED by the report		
25/202	**STRATEGIC OBJECTIVE 4 – CONTINUOUSLY LEARN AND IMPROVE**		
12 mins	**Research Report** AS joined the meeting AS presented the report, highlighting the opening of the Clinical Research Facility (CRF), strong relationships with partners across Nottinghamshire, patient experience, mobile research unit, funding, recruitment and clinician engagement. The Board of Directors were ASSURED by the report AS left the meeting		
5 mins	**NHS Impact** SR presented the report, outlining recent significant changes within the Improvement Faculty. SR acknowledged the landscape had changed and suggested the function and future direction of the Improvement Faculty needed to be reviewed. SR highlighted two positives, the recruitment of three clinical leaders into the faculty and the piloting of the 'Wave methodology', a continuous improvement approach pioneered by Nottingham University Hospitals (NUH). SR acknowledged he does not have formal expertise in improvement methodology and recommended bringing in external support to help determine the right approach for the faculty's next steps, noting previous use of external support had received mixed feedback but internal expertise is currently insufficient. ARB questioned the relevance and purpose of the improvement faculty, suggesting its terms of reference and function should be reviewed. SR advised the issue was more about function than terms of reference and raised the possibility of devolving improvement work to divisions rather than maintaining a centralised faculty. GW acknowledged the need to review the Improvement Faculty's function, with further discussion to follow at upcoming sessions. MG advised she would welcome a greater shared understanding of the distinction between transformation and improvement strategies, as well as clear priorities within each.		

	Action • **Review the next steps for the Improvement Faculty.** The Board of Directors were ASSURED by the report	**SR**	**04/12/25**
25/203	**INTEGRATED PERFORMANCE REPORT (IPR)**		
50 mins	**QUALITY CARE** PB highlighted still births, hospital acquired pressure ulcers and infection prevention and control. SR highlighted mortality metrics, clostridium difficile (C.diff) and Venous Thromboembolism (VTE). **PEOPLE AND CULTURE** RS highlighted time to hire, job planning, vacancy rate, appraisals, sickness absence and bank and agency usage. LM queried if there were any themes emerging from the reasons for sickness absence. RS advised there are a variety of themes, which range from challenging long-term conditions to short-term, intermittent burnout when the Trust is particularly busy. RS emphasised the importance of policy application, particularly around well-being and regular check-ins. NM felt consistency of approach from leadership and management teams is key to applying policies effectively. **TIMELY CARE** In terms of the emergency pathway, SI highlighted ED 4-hour wait performance and actions being taken to improve the position, including work to improve the discharge process. In terms of elective care, SI highlighted Referral to Treatment (RTT) and outpatient capacity. In terms of the cancer pathway, SI highlighted diagnostics and advised the backlog has reduced. LM queried when the ward rounds take place, suggesting that morning rounds could facilitate earlier discharges. SI advised the discharge lounge was being used, but cultural changes are required to improve its utilisation. DS advised financial decisions, such as removing shifts, had a direct impact on performance and quality. The importance of transformational and productivity opportunities was emphasised, with a warning to avoid 'swinging the pendulum' too far towards finance at the expense of quality and performance. LM queried if there had been any discussions with patient groups in terms of the pressures faced by the Trust. SI advised the issues were discussed with the governors at their recent conference and it was also raised at the AGM.		

	DS advised the Trust has set up 'coffee and chat' sessions for colleagues, patients and relatives to discuss the future of health services and capture feedback. MG sought assurance on the granularity of discharge data and benchmarking against best practice nationally. SI advised 80–85% of discharges are pathway zero, i.e. home with no support, and delays are more common in pathways 1–3. Benchmarking data is available for the Midlands and East, as well as some national comparisons. **BEST VALUE CARE** RM outlined the Trust's financial position at the end of Month 5, highlighting deficit support funding, efficiency savings, bank and agency spend, control totals and cash position. The Board of Directors CONSIDERED the report.		
25/204	**WINTER PLAN**		
6 mins	MB joined the meeting. MB presented the report, highlighting data from the Australian flu season, bed modelling, Winter reserve and key mitigations. The Board of Directors APPROVED the Winter Plan for 2025/2026. JVT and MB left the meeting.		
25/205	**BOARD ASSURANCE FRAMEWORK (BAF)**		
1 min	DS presented the report advising all the principal risks (PR) have been discussed by the relevant sub committees. In addition, the BAF in its entirety is subject to quarterly review by the Risk Committee. The changes, and amendments which have been made, are highlighted in the report. It was noted five risks, namely PR1 (Significant deterioration in standards of safety and care), PR2 (Demand that overwhelms capacity), PR3 (Critical shortage of workforce capacity and capability), PR4 (Failure to achieve the Trust's financial strategy) and PR7 (Major disruptive incident) remain as significant risks. All risks, with the exception of PR5 (Inability to initiate and implement evidence-based Improvement and innovation), are above their tolerable risk ratings. The Board of Directors REVIEWED and APPROVED the Board Assurance Framework.		
25/206	**ASSURANCE FROM SUB COMMITTEES**		
9 mins	**People Committee** SB presented the report, highlighting the 'No Hate Here' campaign, noting the need for senior level conversations with the Police to re-invigorate partnership working.		

	Action • **Senior-level engagement with the Police regarding hate crime reporting to be pursued.** The Board of Directors were ASSURED by the report. SB left the meeting. **Audit and Assurance Committee** MG presented the report, highlighting EPR, Fire Safety Audit, positive implementation rate for actions highlighted by Internal Audit and conflicts of interest compliance rate. The Board of Directors were ASSURED by the report. **Finance Committee** RC presented the report, highlighting work in relation to the workforce Whole Time Equivalent (WTE) trajectory and theatres utilisation assessment. The Board of Directors were ASSURED by the report. **Quality Committee** LM presented the report, highlighting persistent delays in accessing mental health support and Multi Agency Safeguarding Hub (MASH) referrals affecting timely discharges, concerns regarding the establishment of an EPR delivery team and frequency of Committee meetings. The Board of Directors were ASSURED by the report.	**RS**	**04/12/25**
25/207 **5 mins**	**SPOTLIGHT ON – THE ONE BEAT CARDIAC CT - REVOLUTIONISING HEART SCANNING** A short video was played highlighting the implementation of a specialised CT cardiac scanner.		
25/208 **2 mins**	**COMMUNICATIONS TO WIDER ORGANISATION** The Board of Directors AGREED the following items would be disseminated to the wider organisation: • Promotion of the Patient Story. • Flu Vaccination Campaign. • Winter Plan. • Balanced messaging on performance. • Research. • Integrated Neighbourhood Respiratory Health Service. • Cardiac CT Scanner implementation. • Staff Survey.		

25/209	**ANY OTHER BUSINESS**		
1 min	No other business was raised.		
25/210	**DATE AND TIME OF NEXT MEETING**		
	It was CONFIRMED the next Board of Directors meeting in Public would be held on 4th December 2025 in the Boardroom at King's Mill Hospital. There being no further business the Chair declared the meeting closed at 13:15.		
	Signed by the Chair as a true record of the meeting, subject to any amendments duly minuted. Graham Ward **Chair** **Date**		

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

25/212	**QUESTIONS FROM MEMBERS OF THE PUBLIC PRESENT**		
1 min	GW reminded people observing the meeting that the meeting is a Board of Directors meeting held in Public and is not a public meeting. Therefore, any questions must relate to the discussions which have taken place during the meeting. No questions were raised from members of the public.		
25/213	**BOARD OF DIRECTOR'S RESOLUTION**		
1 min	**EXCLUSION OF MEMBERS OF THE PUBLIC - Resolution to move to a closed session of the meeting.** In accordance with Section 1 (2) Public Bodies (Admissions to Meetings) Act 1960, members of the Board are invited to resolve: "That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest." Directors AGREED the Board of Director's Resolution.		

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

Outstanding Care,
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PUBLIC BOARD ACTION TRACKER

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

Item No	Date	Action	Committee	Sub Committee	Deadline	Exec Lead	Action Lead	Progress	Rag Rating
25/133	05/06/2025	Consideration of a 'making data count' approach to the IPR to be a topic for a future Board of Directors workshop	Public Board of Directors	None	TBC	S Roe		**Update 02/10/2025** On list for a future Board Workshop. Date note yet allocated.	Grey
25/198	02/10/2025	Trust's response to the 10-point plan to improve the working lives of resident doctors to be included in the next Guardian of Safe Working report to Board	Public Board of Directors	None	02/04/2026	S Roe			Grey
25/200.1	02/10/2025	People Committee to consider how early triggers of the impact of staff reductions on quality and performance can be identified.	Public Board of Directors	People Committee	05/02/2026	R Simcox		**Update 14/10/2025** To be discussed at Januaury meeting of the People Committee.	Grey
25/200.2	02/10/2025	Consider how a report can be developed triangulating information from FTSU, exit interviews, Staff Survey, etc.	Public Board of Directors	People Committee	05/02/2026	R Simcox		**Update 14/10/2025** To be discussed at Januaury meeting of the People Committee.	Grey
25/202	02/10/2025	Review the next steps for the Improvement Faculty	Public Board of Directors	None	02/12/2025	S Roe		**Update 27/11/2025** Update provided to Quality Committee in November 2025. Update covered delivery against workplan and proposals as to how the effectiveness of the Improvement Faculty's support will be measured. The planned external review of the Improvement Faculty function is progressing. An external provider who can undertake the work has been identified, scope defined and procurement approval awaited. Anticipated start date early 2026. **Complete**	Green
25/206	02/12/2025	Senior-level engagement with the Police regarding hate crime reporting to be pursued.	Public Board of Directors	None	02/12/2025	J Melbourne		**Update 17/11/2025** Contact made with Chief Constable's PA. Meeting to be scheduled for early in 2026 **Complete**	Green

Outstanding Care, Compassionate People, Healthier Communities

Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Chair's report	**Date:**	4th December 2025
Prepared By:	Rich Brown, Head of Communications and Graham Ward, Trust Chair		
Approved By:	Graham Ward, Trust Chair		
Presented By:	Graham Ward, Trust Chair		

Purpose		
An update regarding some of the most noteworthy events and items the past two months from the Chair's perspective.	**Approval**	
	Assurance	
	Update	**Y**
	Consider	

Strategic Objectives					
Provide outstanding care in the best place at the right time	Empower and support our people to be the best they can be	Improve health and wellbeing within our communities	Continuously learn and improve	Sustainable use of resources and estates	Work collaboratively with partners in the community
Y	**Y**	**Y**	**Y**	**Y**	**Y**

Principal Risk		
PR1	Significant deterioration in standards of safety and care	
PR2	Demand that overwhelms capacity	
PR3	Critical shortage of workforce capacity and capability	
PR4	Insufficient financial resources available to support the delivery of services	
PR5	Inability to initiate and implement evidence-based Improvement and innovation	
PR6	Working more closely with local health and care partners does not fully deliver the required benefits	
PR7	Major disruptive incident	
PR8	Failure to deliver sustainable reductions in the Trust's impact on climate change	

Committees/groups where this item has been presented before

None

Acronyms

DL = Deputy Lieutenant
EMAS = East Midlands Ambulance Service
HIE = Hypoxic-ischaemic encephalopathy
ICB = Integrated Care Board
NICU = Neonatal Intensive Care Unit
NHS = National Health Service
NLS = Newborn Life Support
NUH = Nottingham University Hospitals
OBE = Order of the British Empire
SFH = Sherwood Forest Hospitals

Executive Summary

An update regarding some of the most noteworthy events and items the past two months from the Chair's perspective.

Recognising the difference made by our Trust volunteers

November was another busy period for our Trust's Community Involvement Team, both in how they encouraged financial donations to be made via our Trust Charity and through the thousands of hours that continue to be committed to support the Trust by our volunteers across our hospitals. In November alone, 380 Trust volunteers generously gave over 4,700 hours of their time to help make great patient care happen across the 28 services they have supported during the month.

The countdown to Christmas is on!

With just under a month to go until Christmas, we are encouraging anyone who wants to support our patients this Christmas to buy an item from Sherwood Forest Hospitals Charity's Amazon Wish Lists.

Lists have been created with gifts suitable for our older patients, those receiving end of life care or experiencing bereavement, and patients who have additional needs, in addition to children and babies.

The majority of patients across our three hospitals are adults, particularly older people, and the selected gifts are well-received and can really help to boost morale.

If items from our wish lists can be found cheaper elsewhere, we are more than happy to accept these kind donations. All gifts must be new and unwrapped. Another option is to make a cash donation. Even small amounts of money add up and can go towards providing innovative pieces of equipment that fall outside of NHS funding.

It is quick and easy to donate money – either online, at the Community Involvement Hub at King's Mill or Newark Hospitals, or by phoning 01623 676011 to pay by card.

Supporters can choose to donate to a specific service, ward or clinic or to the charity's general fund, which is used to provide improvements and enhancements where required across the Trust's three hospitals.

Our Children's Ward is keen for any monetary donations to go towards a gaming cart – a mobile unit containing a console and video games.

Although the thought is kind, not all patients in our care can eat sweet treats because of dietary and medical issues, which is why we're asking people to avoid donating chocolates or sweets.

Charity abseil raises over £35,000 for Trust Charity

On Friday 21st and Saturday 22nd November 2025, the Sherwood Forest Hospitals Charity teamed-up with Big Bang Experiences to give thrill-seekers the opportunity to take a leap of faith and abseil down six storeys of King's Mill Hospital.

In total, 135 people abseiled down the side of the hospital, raising over £35,000 in net profits for the Sherwood Forest Hospitals Charity. Thank you to everyone who helped to organise the event and support the Charity in this way.

Chorus for Compassion charity concert

Held in November, the 'Chorus for Compassion' charity concert was a chance to celebrate those living with dementia while raising vital funds for the dementia services at Sherwood Forest Hospitals.

The evening was organised by one of our trust governors, Nabeel Khan, and included a concert from Vicky McClure's Dementia Choir, before ending with a performance by local dance company Sidds Studio. There was also a talk by the Sherwood Forest Hospitals Research and Innovation team about how the Trust is supporting research into dementia.

The event, including a raffle, raised around £1,500 for the Sherwood Forest Hospitals Charity Dementia Fund. Thank you to everyone involved for their incredible support!

Donations help fund Criticool system for Trust's Neonatal Intensive Care Unit (NICU)

The Sherwood Forest Hospitals Charity and the Emily Harris Foundation have provided funding that has helped to bring the Criticool system to the Trust's Neonatal Intensive Care Unit (NICU).

Babies in our NICU sometimes face a serious condition called hypoxic-ischaemic encephalopathy (HIE), which happens when the brain doesn't get enough oxygen around birth. This can lead to long-term problems like cerebral palsy if not treated quickly. The best treatment is therapeutic hypothermia, cooling the baby's body to 33–34°C within the first six hours of life. Evidence from the trials shows this can protect the brain and improve outcomes.

Without Criticool, if there's a delay in transferring a baby to a specialist centre, we would rely on passive cooling methods, which aren't as precise.

Having CritiCool in our NICU means we can begin vital, brain-protective treatment immediately, helping to prevent further injury and giving babies the best possible chance for a healthy future.

We are incredibly grateful to the charitable funds for making this possible.

New standardised kits help to transform homebirth experience

The Trust Charity has helped our Community Midwifery Team to transform the way we support homebirths, thanks to the provision of new standardised homebirth kits.

The kits are designed to be delivered directly to families planning to welcome their baby at home, helping to reduce waste, save money, and improve care.

Instead of each of our community midwives carrying individual kits, we will now maintain a smaller stock of 15 to 20 kits across King's Mill and Newark Hospitals. These kits will be delivered to families around 36 weeks of pregnancy and returned after use, allowing any unused items to be reused on our birthing unit or maternity ward.

This approach will reduce the amount of unused or expired equipment and also means we can meet the latest Newborn Life Support (NLS) requirements by including essential resuscitation equipment in each kit.

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

Notable engagements from over the past month

- I enjoyed the latest of my regular catch-ups with the Trust's Lead Governor, Liz Barrett OBE DL.
- I undertook walkarounds of the Trust's People Services function and our Adult Critical Care Unit alongside the Trust's staff-side lead, Roz Norman.
- I undertook 15 steps visit to Chatsworth Ward and Ward 31.
- The Trust's Chief Executive, Jon Melbourne, and I visited the Trust's Urgent & Emergency Care areas.
- I joined the latest of our monthly catch-up meetings with the Regional Director of NHS England (Midlands), Dale Bywater, and the Midlands chairs and chief executives event in Leicester.
- I joined both the NHS Providers and NHS Confed Chairs Forums virtually.
- I very much enjoyed attending the opening of the Trust's new Clinical Research Facility, an asset that will help make a huge difference to our research capabilities going forward, for the benefit of our patients.
- I was privileged to be able to attend the Trust's Celebrating Excellence Event and hearing about the tremendous projects that our nursing staff have been involved in over the last 12 months and the beneficial impact that they have had on our patients.

- I attended an event at the University of Nottingham, which included a tour of the University's research facilities.

- I joined a briefing from the NHS England national chair, Penny Dash.

- I had my first monthly catch up with Kathy McLean in her extended role as Chair of the ICB Cluster (Derbyshire, Nottinghamshire and Lincolnshire).

Outstanding Care,
Compassionate People,
Healthier Communities

Sherwood Forest Hospitals
NHS Foundation Trust

Council of Governor's Chair's Highlight Report to Board of Directors

Subject:	Council of Governors highlight report	**Date:**	4th December 2025
Prepared By:	Sally Brook Shanahan, Director of Corporate Affairs		
Approved By:	Graham Ward, Chair		
Presented By:	Graham Ward, Chair		
Purpose:			
To provide assurance to the Board of Directors from the CoG meeting held on 11th November 2025.			

Matters of Concern or Key Risks Escalated for Noting / Action	**Major Actions Commissioned / Work Underway**
• Cancer treatment performance: The Trust's low ranking compared to peers was raised, with concerns about risks for patients and the organisation. Improvement efforts are ongoing, but the backlog and demand remain significant. This risk is escalated for continued monitoring and action. • Phlebotomy waiting times: Extended waiting times for blood tests and issues with the ticketing system were highlighted. The Chief Executive committed to visiting the department and addressing patient experience concerns. • Electronic Patient Record (EPR) programme: Risks associated with staffing and financial constraints were noted. • Meal service delivery: Inconsistencies across wards were raised, with actions commissioned to review and improve the service. • Use of main reception area by uniformed staff: Complaints persist regarding staff using the area as a rest space. The action to monitor and address this issue has been reopened.	• Monitoring and addressing the use of the main reception area by uniformed staff. • A working group is being established to support the procurement process for external auditors. • Planning for a future governor workshop on patient flow and ED waiting times. • Reminders to be issued to 15 Steps team leaders to share visit feedback forms with governors. • The EPR Team to provide an update to the Council of Governors. • The Quality Committee to review and drive improvement of meal service delivery and provide feedback. • Ongoing collaboration with community partners for winter planning and patient flow.
Positive Assurances to Provide	**Decisions Made** *(include BAF review outcomes)*
• The Council was assured by the Chair's, Chief Executive's, Lead Governor's, and Board Sub Committees' reports. • The Trust's culture was highlighted as outstanding, with a commitment to maintaining it.	• Approval of the job description and person specification for the role of Chair. • Approval of the timeline for recruitment of a new Chair.

• Improvement efforts in cancer treatment, dermatology, and operational performance were noted. • Assurance was provided regarding winter planning, system-wide collaboration, and contingency measures. Patient and public involvement in improvement initiatives are being strengthened.	• Approval to apply to NHSE for an extension to Graham Ward's term of office to September 2026. • Approval of updated terms of reference for the Governor Remuneration and Nomination Committee.
Comments on effectiveness of the meeting	
The meeting was quorate and well-attended, with active participation from governors and executives. Discussions were robust, with clear escalation of concerns and effective commissioning of actions. Assurance was provided across multiple domains, and the meeting facilitated collaborative problem-solving and decision-making. No significant issues regarding meeting effectiveness were noted.	
Items recommended for consideration by other Committees	
• Feedback on meal service delivery to be discussed by the Quality Committee. • Staffing arrangements for the Community Diagnostic Centre to be presented to the People Committee and Quality Committee.	
Progress with Actions	
Please answer the following regarding progress on actions: Number of actions considered at the meeting - 5 Number of actions closed at the meeting – 5 Number of actions carried forward - Nil Any concerns with progress of actions –No	

Note: this report does not require a cover sheet due to sufficient information provided.

Note: This report was prepared with the assistance of Copilot.

Outstanding Care, Compassionate People, Healthier Communities

Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Chief Executive's report	**Date:**	4th December 2025
Prepared By:	Rich Brown, Head of Communications and Jon Melbourne, Chief Executive Officer		
Approved By:	Jon Melbourne, Chief Executive Officer		
Presented By:	Jon Melbourne, Chief Executive Officer		

Purpose		
An update regarding some of the most noteworthy events and items the past two months from the Chief Executive's perspective.	**Approval**	
	Assurance	
	Update	**Y**
	Consider	

Strategic Objectives					
Provide outstanding care in the best place at the right time	Empower and support our people to be the best they can be	Improve health and wellbeing within our communities	Continuously learn and improve	Sustainable use of resources and estates	Work collaboratively with partners in the community
Y	**Y**	**Y**	**Y**	**Y**	**Y**

Principal Risk		
PR1	Significant deterioration in standards of safety and care	
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Committees/groups where this item has been presented before

None

Acronyms

A&E = Accident and Emergency
ATTFE = Academy Transformation Trust Further Education
BAF = Board Assurance Framework
CDC = Community Diagnostic Centre
CEO = Chief Executive Officer
CIC = Community Interest Company
COPD = Chronic Obstructive Pulmonary Disease
CRF = Clinical Research Facility
DM01 = Diagnostic Waiting Times and Activity (NHS performance standard code)
EMCCA = East Midlands Combined County Authority
IAOCR = International Accrediting Organisation for Clinical Research
NHS = National Health Service
OPEL = Operational Pressures Escalation Level
OPAT = Outpatient Parenteral Antimicrobial Therapy
PIFU = Patient Initiated Follow Up
PTL = Patient Tracking List
RTT = Referral to Treatment
UEC = Urgent and Emergency Care
UTC = Urgent Treatment Centre
WNC = West Nottinghamshire College

Executive Summary

An update regarding some of the most noteworthy events and items the past two months from the Chief Executive's perspective.

Personal reflections

Reflections on my first month at Sherwood Forest Hospitals

At the end of October, I was proud to start in-post as the Chief Executive Officer (CEO) at Sherwood. It is a privilege to have joined Sherwood Forest and I would like to thank colleagues and partners for the welcome I have received.

On my first day in post, I wrote to colleagues across the Trust to set-out three priorities for my first 100 days and I write my update today through the lens of those priorities:

Listen

I want to hear from colleagues, patients and partners about their experiences, challenges, opportunities and everything else.

I have already visited many services across our sites and have met various groups, including our medical, nursing and operational leaders. I have also been contacted by many colleagues inviting me to a discussion – and I will visit all of them.

I have met many colleagues and teams absolutely committed to doing things in the right way and to putting patients at the centre of our services, aims and ambitions. I have also heard about a challenging operational environment, with our financial challenges and urgent & emergency pressures in particular putting a strain on our services and colleagues.

I am committed to continue to listen and we must also take action to lead improvement for our patients and colleagues.

Deliver our plan in 2025/26

As described above, the challenges the NHS is facing at the moment are significant: we must continue to improve access, safety and quality whilst delivering our financial plan – and balancing all of those priorities during what will be a difficult winter is difficult.

We are seeing demand increasing and winter pressures are already impacting us, with the volumes of patients urgent and emergency care services leading to pressures across our sites and services.

There are areas we need to improve, including in our four- and 12-hour performance in our Emergency Department, in bringing our waiting list down and our financial delivery.

Yet there are areas where we are showing strong performance, including our ambulance handover position. Our flu vaccine uptake has been good so far, with 44.4% of frontline colleagues having received their free flu vaccines by the time of writing. The majority of colleagues have now also had their say in this year's *NHS National Staff Survey*.

I have seen a drive and commitment from colleagues in balancing our priorities, delivering our plan, and continuing to put patients first.

Plan for the future

While focusing on the day-to-day, we must ensure that we plan for the future.

There is so much to be proud of at Sherwood Forest Hospitals and, of course, there is much to improve too. We must build upon the platform which we have at Sherwood Forest to rise to the challenges and opportunities in the NHS, including in digital development, transformation, the hospital to community shift and more.

I have already met many partners across Nottinghamshire and will be meeting more over the coming weeks to discuss how we can best work together to drive improvement for our patients and communities.

I look forward to working with you all to ensure that Sherwood Forest Hospitals is a great place to work and a great place to receive care – and I am excited about what we can achieve together.

Remembering colleagues who passed away recently

It is with great sadness that I report the deaths in service of three colleagues over recent months in Ken Godber, Andy Howard and Sebin Varghese.

Ken Godber, the Trust's Head of Charity Development and Corporate Partnerships, passed away on 5th November 2025. Ken was a driving force behind the launch of the Sherwood Forest Hospitals Charity Lottery and arranging the Trust's first sponsored abseil.

Andy Howard from the Trust's Theatres Department at King's Mill Hospital passed away suddenly at the end of October 2025. After serving his country in the Royal Navy, Andy brought that same dedication, discipline, and heart to his work as an Operating Department Practitioner, serving in our department for over 20 years.

Sebin Raj Varghese (known as 'Seb') was a Registered Nurse in the Outpatient Parenteral Antimicrobial Therapy (OPAT) team at King's Mill, who passed away on 1st November 2025. Sebin will be fondly remembered by his colleagues as a man whose kindness, compassion and spirit touched everyone he met.

All three were brilliant colleagues who will be sadly missed by us all. Our thoughts are with their loved ones at this difficult time.

Organisational updates

Operational updates

Overview of operational activity

During recent months and as we head into winter, we have seen deterioration in several Urgent and Emergency Care (UEC) metrics.

We have seen increased levels of medically-safe patients remaining in our hospitals in recent months and have had four consecutive months of 'net in-flow' to our hospitals, where we have seen more admissions than discharges. This net in-flow can be seen in our bed occupancy, which has been steadily increasing month-on-month in 2025 to date. While admission demand has been

at similar levels to 2024, Emergency Department attendances have increased at our King's Mill 'type one' service and at our 'type three' Urgent Treatment Centre (UTC) at Newark Hospital.

The pressure of increased attendance demand and delays in admitting patients due to hospital flow challenges resulted in our Emergency Department frequently being overcrowded, leading to increased waiting times which can increase the risk of delay-related harm. This overcrowding has meant that we have not always been able to accept patients arriving by ambulance as promptly as we have previously.

Our headline A&E (Accident and Emergency) four-hour performance metric has been under 70% since August 2025, falling below our operational plan.

Operational Pressures Escalation Level (OPEL) four actions, together with the deployment of our Full Capacity Protocol, were implemented throughout this period of challenging patient flow.

Operating in escalation places pressure on our people and heightens financial pressures, as well as risking the quality, safety and timeliness of care we provide to our patients.

In terms of planned care, we have continued to reduce the proportion of long wait patients. Our 52-week wait backlog was at 0.9% of the total patient tracking list (PTL) and therefore ahead of the 1% operational planning guidance target to be achieved by the end of 2025/2026.

However, 18-week referral to treatment (RTT) performance deteriorated to 60.4% in October. While the Trust continues to benchmark well nationally, we must improve to deliver our plan. Actions have been developed, particularly on the non-admitted pathway, to recover performance back to plan in 2025/2026.

We continue with strong performance providing patient initiated follow up (PIFU), delivering performance consistently better than the standard.

Our diagnostic DM01 performance has been relatively stable since October 2024, aside from two very strong months in February and March 2025. This is reflected in our benchmarking position which is now consistently above the national average. Previously released insourcing capacity has been reinstated for Echocardiography, which has supported small improvement in September and October 2025.

Our cancer performance for the 28-day faster diagnosis standard and the 62-day treatment standard remain favourable to plan. Cancer 31-day treatment performance (first treatment) has been moving within standard variation since mid-2024. For 31-day and 62-day treatment standards, we benchmark in the lower quartiles nationally.

We remain grateful to all Trust colleagues who have been working hard to provide the best and most timely care possible over recent months.

More details about our operational performance are provided in the Integrated Performance Report, which will be discussed later in the meeting.

Reflecting on the impact of recent industrial action

November saw the return of industrial action nationally, as resident doctors chose to take industrial action as part of their ongoing dispute with the government over pay and conditions. The latest industrial action took place between Friday 14th and Wednesday 19th November 2025.

While industrial action did affect a small proportion of our elective activity as we rearranged some non-urgent elective and outpatient procedures to allow us to focus on delivering safe urgent and emergency care services, proactive planning meant that the amount of activity that needed to be rearranged was kept to a minimum.

We recognise the vital role our resident doctors play in delivering excellent patient care here at Sherwood, which is why their presence was so deeply felt. Work is now well underway to reschedule the appointments that were postponed so that patients can continue to be seen as quickly as possible.

Our Trust's industrial action management team met regularly throughout the industrial action to ensure swift escalation of issues and to highlight any patient safety concerns.

A huge thank you to everyone who helped ensure our patients remained safe and well cared for throughout this latest period of industrial action.

Updates from the Community Diagnostic Centre (CDC)

Mansfield Community Diagnostic Centre begins offering additional lung tests

The Mansfield Community Diagnostic Centre has begun offering additional respiratory lung health tests for asthma, Chronic Obstructive Pulmonary Disease (COPD) and similar conditions, adding around 60 appointments a month ahead of its full opening.

Since starting in October 2023, the CDC has delivered over 86,000 diagnostic tests – including a range of blood tests, X-rays, MRI and ultrasound scans – across our Mansfield Community and Newark Hospital sites. Further tests have been offered from a mobile unit at the Nottingham Road Clinic.

Once built, the new site will allow patients to access thousands of tests each week, improving access and convenience especially for those who currently face long travel or difficulty accessing larger hospital sites.

We look forward to hearing more about this development in the Patient Story video that will be shared in the Public Board meeting.

From Classroom to construction: Mansfield CDC inspires next generation as local student joins project team

A local student's journey from a T-Level placement at West Nottinghamshire College to a key role in constructing the Mansfield Community Diagnostic Centre has highlighted the power of strong partnerships in creating career opportunities while building vital NHS healthcare facilities for the local community.

Niall Clapperton began his journey with a placement at the Mansfield Community Diagnostic Centre (CDC) while studying at West Nottinghamshire College (WNC), a key education partner of Sherwood Forest Hospitals NHS Foundation Trust. Delivered by leading contractor Kier, the CDC is currently under construction on the site of the Mansfield Community Hospital.

Niall Clapperton

Niall's placement experience gave him valuable insight into how NHS services are delivered and inspired him to pursue a career supporting healthcare in a different but equally vital way.

After completing his course, Niall secured a five-year degree apprenticeship in Construction Management with Kier, the contractor delivering the CDC project. Niall is now working on the same site where his career journey began.

Niall's story perfectly demonstrates how our partnerships with local colleges and contractors create real opportunities for young people whilst helping us build better healthcare facilities for our communities.

The new diagnostic centre will transform access to testing for thousands of patients across Mansfield and Ashfield, and it's genuinely inspiring to know that local talent like Niall is helping to deliver it.

Partnership updates

Nottinghamshire Health and Wellbeing Board workshop

Members of the Trust attended the Nottinghamshire Health and Wellbeing Board's workshop, which focused on how we collectively vision and deliver on the Neighbourhood Health agenda.

Discussions were wide-ranging across health and care partners, education providers and local councillors seeking to ensure neighbourhoods have a strong voice in development of a service offer that meets their needs and supports them to make sustainable changes.

East Midlands Combined County Authority (EMCCA) workshop

The Trust was invited to the Mayor's workshop which focused on a healthier East Midlands and how we prioritise prevention at all levels.

Discussions centred on co-designing what a healthy East Midlands looks like for the future. Valuable partnership discussions took place around the table and in between sessions with a broad range of partners across health, public health, patient advocate services, fire and rescue service and the Mayor's team.

This was the first workshop of its kind, bringing together Nottinghamshire and Derbyshire colleagues across the EMCCA area to learn from one another and build new relationships.

Sustainability

The Trust is building relationships with Nottinghamshire Healthcare Trust's Sustainability Team and the local ranger from the Centre for Sustainable Healthcare to maximise the sustainability and biodiversity of the King's Mill site.

SFH's Sustainability Service Lead and the local ranger led a walking meeting around King's Mill and Blossomwood to learn about each organisation's progress so far.

The meeting identified a number of areas where the two trusts can amplify the impact of their individual actions, strengthen the partnership working and ultimately benefit the environment for patients, our communities and our people.

Ukrainian Mayoral visit

Representatives from the Trust and local partners enjoyed a mayoral visit from Stryi, Mansfield's twin city in Ukraine, on 10th November 2025, which was hosted by Mansfield District Council. The aim of the visit was to discuss the partnership between both councils.

The visit provided the opportunity to show solidarity for the people of Ukraine and share knowledge and good practice from local business and public services in the Mansfield area.

The Mayor of Stryi explained how his town is actively moving forward, delivering infrastructure projects, restoring social facilities, supporting educational and cultural initiatives, and creating new opportunities for business and young people.

Vision West Notts College workshop

The Trust joined a systems-thinking event hosted by Vision West Notts College to contribute to the Mayor's East Midlands Growth Plan with focus on The Heartlands, which includes much of the Ashfield, Mansfield, Newark and Sherwood communities served by Sherwood Forest Hospitals.

The event was attended by local businesses, education providers, local government and community organisations.

The contributors were tasked by the Mayor to shape her plans for The Heartlands.

The passion and commitment to The Heartlands area was evident in the discussions and challenge during the day. The workshop attempted to identify the plan's enablers, those local high impact sectors and how businesses and other organisations can contribute.

Other Trust updates

Successful launch of new Clinical Research Facility marks major milestone for local healthcare

In October, Sherwood opened its new, purpose-built Clinical Research Facility (CRF) at King's Mill Hospital, as Sherwood Forest Hospitals continues its work to advance clinical research and improve patient care across the local community.

A specially arranged opening event showcased the CRF's potential to support and deliver pioneering clinical studies. Attendees toured the state-of-the-art facility, met members of the Research and Innovation team and heard from key speakers about the CRF's role in shaping the future of healthcare innovation and discovery.

Located at the King's Mill Hospital site, the new CRF is designed to enable high-quality, cutting-edge research. It has modern facilities that will attract many industry partners and multi-centre national and international studies. Most importantly, it provides local people with new opportunities to take part in clinical trials that were previously unavailable in the Mid-Nottinghamshire area.

We are incredibly grateful to everyone who attended and contributed to the success of the launch. Special thanks also go to our early supporters and sponsors, including The International Accrediting Organisation for Clinical Research (IAOCR), whose contributions helped make this important milestone possible.

The launch of this new Clinical Research Facility marks a pivotal moment for Sherwood Forest Hospitals and the wider region. It brings world-class research opportunities closer to home for patients, while helping to embed research as a core part of everyday clinical care. This is how we turn innovation into better outcomes for patients.

We're proud to officially open a dedicated space where research can thrive. The new facility reflects our long-term commitment to advancing healthcare through innovation and collaboration and ensures that local people have access to the very latest in clinical trials and treatments.

As the Clinical Research Facility begins to welcome more participants and partners, Sherwood Forest Hospitals reaffirms its commitment to delivering research that makes a meaningful difference to patients now and in the future.

Endoscopy Service successfully achieves full 'JAG' accreditation

We are thrilled to share that our Endoscopy Service has successfully achieved full accreditation from the Joint Advisory Group on GI Endoscopy, following a thorough five-year review. This is a major milestone that reflects the outstanding quality, safety, and compassion the team delivers every day.

JAG accreditation is the national benchmark for excellence in endoscopy services. The full accreditation process is a significant undertaking, involving an on-site review of clinical quality, governance, leadership, and patient experience. The assessors visited in June 2025 and were truly impressed by what they saw.

From waiting list management to service standards, the team's portfolio showcased a culture of openness, professionalism, and teamwork.

The feedback was exceptional, as patients described the staff as “brilliant” and “kind and supportive”, with one patient saying: “I felt they were genuinely concerned about me as an individual and my experience.”

The JAG report outlines that ‘accreditation is awarded to services that have demonstrated they meet best practice quality standards covering all aspects of an endoscopy service’, highlighting this achievement as a testament to the team’s long-term planning and commitment to providing excellent patient care.

Gaining the accreditation really showcases the hard work and determination each and every person shows not only to the running of the service, but to our patients. Congratulations to everyone involved in this fantastic achievement.

Supporting our local Armed Forces

On Saturday 1st November 2025, the Trust was honoured to host the Ashfield Festival of Remembrance here at Sherwood Forest Hospitals. The Festival is a shared collaboration between Together in Ashfield Community Interest Company (CIC), ATTFE College, and this year, Sherwood Forest Hospitals NHS Foundation Trust.

The day began with a service at St Mary’s Cenotaph in Sutton-in-Ashfield, before guests joined us at King’s Mill Hospital for a series of inspiring presentations and refreshments that were kindly provided by volunteers from ATTFE College.

We were proud to welcome Ed Attenborough, High Sheriff of Nottinghamshire; Lieutenant Colonel Keith Spiers; and Nora Senior, Vice Lord-Lieutenant of Nottinghamshire, who joined us alongside colleagues from across our Trust — including members of our Veterans Network, Lead Governor Liz Barrett, and the Principal of ATTFE College, together with learners, volunteers, and members of our local community.

This year’s theme focused on remembering and acknowledging the local people who supported the war efforts from a medical perspective.

Across our site, visitors will have seen ‘Tommies’ on display, created and donated by ATTFE College staff, learners, and volunteers. These intergenerational creations provide a real time for reflection on life in modern Britain for all involved. Thank you to everyone who took part, contributed, and joined us in remembrance.

Trust risk ratings reviewed

The Board Assurance Framework (BAF) Principal Risk 7 – ‘A major disruptive incident’ – for which the Risk Committee is the lead committee, has been scrutinised by the Trust’s Risk Committee. Committee members discussed the risk scores and assurance ratings but decided that they should remain unchanged.

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

Outstanding Care, Compassionate People, Healthier Communities

Sherwood Forest Hospitals NHS Foundation Trust

Public Board of Directors - Cover Sheet

Subject:	Making Tomorrow Better – Strategy Delivery Update	**Date:**	4th December 2025
Prepared By:	Paula Longden, Associate Director of Strategy and Partnerships		
Approved By:	Jon Melbourne, Chief Executive Officer		
Presented By:	Claire Hinchley, Director of Strategy and Partnerships		

Purpose		
This report provides a progress report and assurance of deliverables towards delivery of the Trust's strategy 'Improving Lives'.	**Approval**	
	Assurance	**X**
	Update	
	Consider	

Strategic Objectives					
Provide outstanding care in the best place at the right time	Empower and support our people to be the best they can be	Improve health and wellbeing within our communities	Continuously learn and improve	Sustainable use of resources and estates	Work collaboratively with partners in the community
X	**X**	**X**	**X**	**X**	**X**

Identify which Principal Risk this report relates to:		
PR1	Significant deterioration in standards of safety and care	**X**
PR2	Demand that overwhelms capacity	**X**
PR3	Critical shortage of workforce capacity and capability	**X**
PR4	Insufficient financial resources available to support the delivery of services	**X**
PR5	Inability to initiate and implement evidence-based Improvement and innovation	**X**
PR6	Working more closely with local health and care partners does not fully deliver the required benefits	**X**
PR7	Major disruptive incident	**X**
PR8	Failure to deliver sustainable reductions in the Trust's impact on climate change	**X**

Committees/groups where this item has been presented before

All supporting strategies have been presented to their relevant Committee during April and May 2025

Acronyms

DNA – did not attend (the appointment)
MECC - making every contact count
NHS IMPACT – improving patient care together (NHS improvement approach)

Executive Summary

The Trust's five year 'Improving Lives' strategy was approved and launched on 1 April 2024 and the Board receive an update on a 6 monthly basis towards progress made against the six strategic objectives. This is the update of delivery for the period April 2025 to September 2025.

Each supporting strategy has been reviewed in Board committees during October and November 2025 against expected progress, and this has been amalgamated into demonstrating delivery of the overarching Trust strategy 'Improving Lives'.

The following report provides a summary of progress towards delivery of each strategic objective.

Current context

This period has seen continued fast paced change both locally and nationally including the release of the national 10-year plan, a round of applications to join the national neighbourhood improvement programme, the new medium term planning framework and significant change across the Integrated Care Board expanding into a cluster arrangement encompassing Nottinghamshire, Derbyshire and Lincolnshire. This is alongside a sustained effort on improving our quality, performance and financial sustainability of services provided.

The 10-year health plan – fit for the future (released in July 2025) confirmed three national strategic shifts:

- From hospital to community
- From analogue to digital
- From sickness to prevention

Within the report are examples of where the Trust is actively delivering new ways of working across these national shifts.

With the continued changes surrounding the NHS alongside the 10-year plan and planning guidance, delivery of the Trust strategy will need to embrace agility to respond in an informed and timely way that still delivers the original aims and ambitions.

Supporting strategies have been reviewed for alignment with the 10-year plan and, although substantially in line, delivery plans will be refined to ensure new targets are incorporated and timeframes are appropriately adjusted.

Further national policy, guidance and consultations are expected imminently clarifying expectations, timeframes and approaches, which may require further refinement.

Developing and refining the strategy for 2026-2029

Work undertaken to date has confirmed that the Improving Lives strategy is substantially in line with the 10-year plan and a period of review and refinement will lead to an improved focus on deliverables over the next three years.

Over the next three months, a period of engagement will take place across the Trust and with our partners to identify clear deliverables that are both in line with the three national shifts and drive us towards being a trusted local provider of care that improves health outcomes for our local populations and neighbourhoods.

Recommendation

Board is asked to NOTE progress made since April 2025 towards achieving our strategic objectives and NOTE the plan for developing years 3-5 of the strategy in line with the NHS 10-year plan.

Introduction

The Trust's five year 'Improving Lives' strategy was approved and launched on 1 April 2024 and the Board receive an update on a 6 monthly basis towards progress made against the six strategic objectives. This is the update of delivery for the period April 2025 to September 2025.

The Improving Lives vision of delivering consistently outstanding care by compassionate people, leading to healthier communities is underpinned by six strategic objectives:

- Strategic objective 1 – Provide outstanding care in the best place at the right time
- Strategic objective 2 – Empower and support our people to be the best they can be
- Strategic objective 3 – Improve health and wellbeing within our communities
- Strategic objective 4 – Continuously learn and improve
- Strategic objective 5 – Sustainable use of resources and estate
- Strategic objective 6 – Work collaboratively with partners in the community

The Trust's overarching strategy is delivered through five supporting strategies which set out principles and actions that deliver against these objectives and collectively achieve the Improving Lives strategy. The supporting strategies are:

- Clinical services strategy
- Quality strategy
- People plan
- Partnership strategy
- Finance strategy

Each supporting strategy has been reviewed in Board committees during October and November 2025 against expected progress and this has been amalgamated into demonstrating delivery of the overarching Trust strategy 'Improving Lives'.

Committees have also reviewed key strategies against the Ten-Year Health Plan for assurance that the Trust remains in line with national policy direction. More detailed guidance is expected through the next quarter and once received, the Trust will continue to review, reframe and refresh delivery plans.

The long-term delivery outcome measures over the 5-year strategy timeframe are:

- Be rated Outstanding by the CQC
- Increase the percentage of our people who recommend Sherwood Forest Hospitals as a place to work
- Increase the percentage of people who recommend Sherwood Forest Hospitals as a place to be cared for
- Increase the percentage of our local population engaging in healthy choices and behaviours
- Be recognised locally and nationally as a committed Anchor organisation who works in partnership by default

Summary of progress September 2024-March 2025

The following section of the report provides a summary of progress against each strategic objective.

Strategic objective 1 – Provide Outstanding care in the best place at the right time

The Trust is committed to providing high quality clinical services that are right for its communities and sustainable. In its journey to be rated outstanding across all its services, the Trust continues to take steps to be at the forefront of service provision with innovative, safe and efficient healthcare.

In response to national healthcare reform and local system evolution, SFH has refreshed its Clinical Services Strategy for 2025–2029. This review and refresh of the original strategy has tested its alignment to new national priorities and resilience in the face of local developments. From this the Trust has developed a stronger vision of what SFH will look like in 2029. This refreshed document provides the opportunity to clarify the original strategic intentions.

Progress has been made in an environment of heavy demand and financial pressures. Strategic focus has been on developments that mitigate these challenges and provide a foundation for the Trust to deliver the three national shifts of treatment to prevention, hospital to community and analogue to digital.

Service developments and achievements focused on improving patient care and experience include:

- Strengthened patient-centred services for frail patients with an improved acute frailty unit within the short stay unit, designed from best practice and learning from the 2024/25 winter pilot. The unit aims to reduce length of stay for this vulnerable cohort of patients who can be at risk in a hospital environment.
- Improving productivity in outpatient services, with the service achieving its highest patient initiated follow up rates ever and sustaining the did not attend rate reduction. Better utilisation of outpatient appointments protects the capacity for those patients who need it, contributing to reducing the waiting list size and waiting times for patients.
- Taking the first steps in delivering the national shift from hospital to community with a respiratory integrated neighbourhood teams pilot. More than a dozen partners are involved including public health, community services, general practice and community and voluntary organisations. The service will strengthen respiratory care across community, primary, and acute settings, improving early intervention, reducing hospital admissions, and supporting patients to manage their conditions closer to home. Faster and closer to home interventions improve patient experience and achieve better patient outcomes.

Strategic objective 2 – Empower and support our people to be the best they can be

Making the Trust a great place to work and belong is a key focus of its refreshed People Strategy 2025–2029. The publication of the Ten-Year Health Plan prompted a review of the strategy with particular emphasis on Chapter 7, An NHS Workforce Fit for the Future. The national approach largely validates the direction SFH has pursued in recent years while raising the bar on transparency, leadership accountability, skills modernisation and sustainability of supply. The Trust needs to make targeted adjustments to meet national expectations and delivery plans are being developed.

The Trust, led by the People Team, continues to progress against the four pillars of its strategy and the NHS People Plan.

Looking after our people

- Continuing the improvements focused on the wellbeing of people involved with employee relations including a staff wellbeing toolkit, enhanced physiotherapy service, greater management guidance and visual aids.
- Ensuring the safety of all people with the refresh of the Violence and Aggression improvement plan, the No Hate Here Campaign, sexual safety manager training and additional support and guidance for managers.

Belonging in the NHS

- Expanding the ways that the Trust recognises and rewards the achievements of its people. The Great-ix initiative was launched across the Trust and the first Trust-wide Celebration and Recognition Event was successfully held, which included the presentation of TULIP and DAISY awards. These specific events and activities are underpinned by the publication of practical guidance for managers for celebrating their team's achievements.
- Gaining insight into retention through the trust wide launch of an enhanced thinking of moving and exit interviews process. Insights gathered will inform future developments.
- Enhancing the Trust's ability to monitor progress and target actions effectively through greater understanding of SFH's people gathered through widened equality, diversity and inclusion data.

Growing for the future

- Ensuring that all SFH people have the opportunity to develop through the promotion of the importance of appraisals and additional support for those teams with low rates during the quarter. A new approach was fully piloted in Women and Children's Division and subsequently refined following that learning.
- Identifying and developing, through talent conversations, those first-line and mid-level managers who will be critical in leading the delivery of the Trust's strategic aims. A talent tool is now live on the intranet with comms launched with training videos. Talent tool training is also included in the Established Leaders programme and it will be explored within all appraisal training which is also in the emerging and new leaders' programme.
- Expansion of the existing in-house coaching network, now with a membership of 37 coaches, with increased focus on qualifications, continuing professional development and supervision. The first cohort is now qualified and putting their skills into practice, with a further fifteen coaches working towards qualification.
- Effective partnership working with Vision West Notts College focusing on embedding local talent pipelines. All entry level apprenticeships are now undertaken with the support of the College and twelve of the College's students completed work experience placements.

New ways of working and delivering care

- Refreshing workforce models to ensure that the Trust is fit for the future and enabled to support the trust in achieving the three national shifts. Workforce plans and forecasts for the 2025/26 period have been remodelled to ensure alignment with the Trust's Financial Plan, supporting a sustainable approach to workforce supply and productivity.
- Expanding and enabling automation and artificial intelligence to improve productivity and data accuracy. The Trust is scoping opportunities for enhancing alignment and integration across the Trust's people systems to support a data driven culture and

improved decision making through greater accuracy, integration and access management.

Strategic objective 3 – Improve health and wellbeing within our communities

The Trust continues to strengthen its approach to prevention, one of the national shifts, through focusing on making every contact count. It is committed to improving health and wellbeing within those people who work and live in our local population.

The Trust is taking action to address health inequalities:

- Improving the health of communities through the introduction and embedding of a consistent trust-wide approach to behaviour change conversations with our patients. This prevention approach is also known as making every contact count. The Trust has established a community of practice, undertaken targeted engagement, agreed a shared vision and governance, clarified signposting pathways and co-designed a tiered training package. The project has strengthened local partnerships including with public health, the place team, the community and voluntary sector and district council partners and mapped local support offers that staff can signpost to and developed practical resources to support this. Supporting patients to adopt healthy behaviours and access wider social support reduces their need for medical interventions and increases their healthy life expectancy.
- Embedding public health expertise in the Trust to boost understanding of health inequalities and facilitate specialties to make improvements to services that reduce inequalities. Making access to services more equitable, ensures that the Trust provides an NHS for all.
- Development of the Trust's health inequalities organisational development plan to support the national shift of treatment to prevention, build the population health management approach and widen knowledge and understanding of health inequalities. Work has commenced in the first two divisions, Medicine and Clinical Services, Therapies and Outpatients (CSTO).
- Improving access to and understanding of inequalities intelligence through the launch of the inequalities index. An improvement methodology for specialties to identify the services that require greater focus and to assess the impact of interventions on inequalities. Providing specialities with appropriate improvement tools, empowers clinical teams to target their efforts on those areas that genuinely improve services for patients. The index is currently being promoted and trialled in the Medicine Division and focused on planned care.

Strategic objective 4 – Continuously learn and improve

The Trust is taking steps to embed a strong culture of continuous improvement ensuring that teams are supported by quality data and intelligence, take a collaborative approach and ensure that the patient voice is present at all stages. Intelligence-driven improvement allows focus on those areas where there is the greatest benefit to patient care and experience.

- Made progress in its commitment to collaborative and data-driven decision making through embedding the principles of the working to achieve value and excellence (WAVE) approach. The approach draws in specialist knowledge and expertise from clinical, operational, finance, information and improvement colleagues. The first WAVE project is now concluded with a triumvirate-owned action plan and the next specialty has been agreed.

- Widened access to intelligence through developing an Improvement Insights tool, which provides a heatmap of key indicators which are compared at a regional and/or national level to identify areas of opportunity for improvement. The tool was built by combining data and benchmarking sources such as Model Hospital, British Association of Day Surgery and getting it right first time (GIRFT).
- Adopted artificial intelligence with the introduction of Microsoft 365 Co-Pilot, with corporate teams making immediate administrative efficiencies and scoping projects to explore opportunities for automation and enhanced analytics. By being efficient with our corporate and administrative resources allows greater investment in patient care.

Strategic objective 5 – 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:

- Increased focus on the underlying financial position through routine reporting and the Trust's productivity metrics. The Trust's implied productivity growth is 4.2% compared to prior year to July 2025 (based on data from the national benchmarking tool Model Hospital). Within this, the Trust's -2.7% real terms resource growth is the 2nd best in the Midlands and 12th best in the NHS.
- Enhanced longer term financial planning through a methodology to support the building up of a challenging but deliverable financial, activity and workforce plans. This has moved in line with the way that in year financial budgets are being managed, with a focus on control totals and run rates.
- Strengthened its financial reporting and business intelligence to further the Trust's ambition to be intelligence and data led in its decision making. All finance, costing and operational performance information has been brought into one location and the Trust has reviewed and refined financial reporting packs to ensure that they remain fit for the organisation.
- Improved financial governance and efficiency through the introduction of a new finance ledger. The new ledger will be at a lower cost and facilitate NHS standardisation. It also provides the Trust with a platform for the adoption of new technologies and continuous developments.

Strategic objective 6 – 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:

- Improving outcomes for patients and contributing to sustainability and resilience through its bilateral partnership with NUH. The collaboration is enabling both trusts to implement solutions to two significantly at-risk support services, aseptic pharmacy and sterile services.
- Strengthening its partnerships with its priority educational partners to develop opportunities for its people and make a civic contribution to communities. It has expanded and strengthened its work experience offer for Vision West Notts College students, enabled Project Search graduates and is partnering with Nottingham Trent University to encourage students to explore NHS careers at the same time as developing SFH staff skills.

- The Trust is also taking a greater system leadership role as it focuses on its strategic commitment for neighbourhood health. This greater partnership working has enabled two national bids, one successful and one not, aiming to accelerate implementation for Mid Notts patients.
- Maintained a commitment to making a positive contribution as an anchor organisation through supporting local workforce pipelines and managing creditor payments for small and medium size organisations

Measures

The Trust has chosen the following five key overarching measures to evaluate achievement of the strategy. These are shown below and will be included at each annual report through the five years.

Performance against these is shown below:

Measure	**March 2024**	**March 2025**	**Sept 2025**
Be rated Outstanding by the CQC	GOOD	No change	No change
Increase the percentage of our people who recommend Sherwood Forest Hospitals as a place to work	74.52%	70.57%	No change
Increase the percentage of people who recommend Sherwood Forest Hospitals as a place to be cared for	95.1%[1] 93.5%[2]	95.4% [1] 93.4% [2]	95.4% [1] 94.3% [2]
Increase the percentage of our local population engaging in healthy choices and behaviours: Smoking prevalence Obesity Alcohol misuse	 16.0% 28.6%[3] 16.7%[3]	 15.3% 29.1% 17.1%	 14.8% 29.1% 17.1%

[1] % of outpatients who had a positive experience at SFH
[2] % of inpatients who had a positive experience at SFH
[3] % at June 2024 – data not available for March 2024

Outstanding Care, Compassionate People, Healthier Communities

Sherwood Forest Hospitals NHS Foundation Trust

Cover Sheet – Public Board

Subject:	Maternity and Neonatal (Perinatal Services) Safety Champions Report – Perinatal Services	**Date:**	4th December 2025
Prepared By:	Sarah Ayre, Head of Midwifery		
Approved By:	Philip Bolton, Executive Chief Nurse		
Presented by:	Sarah Ayre, Head of Midwifery		

Purpose

The purpose of this paper is to provide a monthly update on maternity and neonatal (Perinatal) safety activity, highlighting progress against local and national priorities, quality improvement initiatives, cultural transformation programmes, and workforce developments. The report offers assurance on current performance, shares key achievements and challenges, and outlines the forward view to sustain and enhance safe, personalised care for women, birthing people, babies, and their families.	**Approval**	
	Assurance	**X**
	Update	**X**
	Consider	

Strategic Objectives

Provide outstanding care in the best place at the right time	Empower and support our people to be the best they can be	Improve health and wellbeing within our communities	Continuously learn and improve	Sustainable use of resources and estates	Work collaboratively with partners in the community
X	**X**	**X**	**X**	**X**	**X**

Principal Risk

PR1	Significant deterioration in standards of safety and care	
PR2	Demand that overwhelms capacity	
PR3	Critical shortage of workforce capacity and capability	
PR4	Failure to achieve the Trust's financial strategy	
PR5	Inability to initiate and implement evidence-based Improvement and innovation	**X**
PR6	Working more closely with local health and care partners does not fully deliver the required benefits	
PR7	Major disruptive incident	
PR8	Failure to deliver sustainable reductions in the Trust's impact on climate change	

Committees/groups where items have been presented before

- Nursing and Midwifery AHP Committee
- Perinatal Assurance Committee
- Divisional Governance Meeting
- Maternity and Gynaecology Clinical Governance
- Paediatric Clinical Governance
- Service Line
- Divisional Performance Review
- Perinatal Forum (formally Maternity Forum)
- Divisional People Committee
- Senior Management Team weekly meeting

Acronyms

- Maternity and Neonatal Safety Champion (MNSC)
- Care Quality Commission (CQC)
- Maternity and Neonatal Voice Champion (MNVP)
- Perinatal Assurance Committee (PAC)
- Local Maternity and Neonatal System (LMNS)
- Neonatal Intensive Care Unit (NICU)
- Maternity Support Workers/Maternity Care Assistants (MSW/MCA)
- Head of Midwifery (HoM)
- Deputy Director of Nursing (DDoN)
- Non-Executive Director (NED)
- Saving Babies' Lives Version Three: A care bundle for reducing perinatal mortality (SBLCBV3)

- Transitional Care (TC)
- Royal College of Midwives (RCM)
- Trust Management Team (TMT)
- Maternity Outcomes Signal System (MOSS)
- Perinatal Mortality Review Tool (PMRT
- Maternity and Neonatal Safety Improvement Programme (MNSI)
- Operational Delivery Network (ODN)
- Obstetric Anal Sphincter Injury (OASI)
- Perinatal Safety Oversight Group (PSOG)
- Maternity and Neonatal Digital Improvement Programme (MNDIP)

Executive Summary

Maternity and Neonatal Safety Champions play a pivotal role in delivering safer outcomes for pregnant women, birthing people, and their babies, acting as the local link to regional and national Safety Champions. At the provider level, they:

- Lead and grow the local maternity and neonatal safety movement, working closely with clinical network champions to maintain the momentum of the maternity transformation programme and the national ambition.
- Provide visible organisational leadership, acting as change agents across the multidisciplinary perinatal team to embed safe, personalised care.
- Serve as conduits for sharing learning and best practices from national and international research, as well as local investigations and quality improvement initiatives.

This report presents key achievements, developments, and challenges from the past month, assuring progress against our safety, quality, and cultural improvement priorities.

Maternity and Neonatal (Perinatal Services) Safety Champion (MNSC) oversight, October 2025 data

1. Staff Engagement

1.1 Safety Champion Walkaround

The Safety Champions Walk-around was held on Friday 10th October 2025. NED (NM) has now completed his first 12 months in post and has taken time across the year to 'walk' the woman's/birthing individual's journey; this has supported many opportunities to receive quality feedback and robust solutions to many of the challenges we have faced. We would like to formally acknowledge and thank NM for his continued commitment to his role as Non-Executive Director and Maternity and Neonatal Safety Champion. His active engagement, constructive challenge, and visible support provide valuable assurance to both the Board and the clinical teams. We are extremely grateful for the time and insight he dedicates to understanding our services and championing safety, quality, and staff wellbeing across the perinatal pathway. We are genuinely pleased to have him on board and greatly appreciate his ongoing partnership and advocacy for our teams, women, birthing people, and families.

1.2 Perinatal Services Forum

The Forum was chaired by the Director of Midwifery/Divisional Director of Nursing (PS) on Friday, 3rd October 2025. Apologies from CN (PB) and Medical Director (SR). The forum was well attended across the Perinatal Services MDT. An update included emphasis on the importance of the Flu Vaccine and Staff Survey engagement. The Division has welcomed Steve Jenkins as the new Divisional General Manager, providing leadership across Women & Children's and Urgent & Emergency Care. PS highlighted the pace of ongoing organisational change and the importance of transparent communication and engagement with staff. The Division continues to face workforce challenges, including high sickness rates, high maternity leave, and several recent resignations from midwives leaving the NHS. Permission has been granted to over-recruit in response to maternity leave cover, enabling retention of most student midwives. Staff morale remains under pressure, with national trends of job insecurity reflected locally. An action was to ensure all leaders offer and facilitate exit interviews in line with Trust process and work towards sharing the feedback and making improvements as identified.

2. Service User Voice

2.1 Complaints, Concerns and Compliments.
Following the Complaint Summit, chaired by the Chief Nurse (PB) and Medical Director (SR) in October, it was agreed that an update for assurance would be provided through the Divisional Service Line. The summit highlighted delays in meeting agreed response timeframes as a key concern, attributed to recent changes in the divisional process and the associated impact on medical engagement.

Agenda Item 13, the report from the *Patient Safety and Oversight Group (PSOG)*, will continue to present to PAC an overview of current themes and the corresponding action log for assurance.

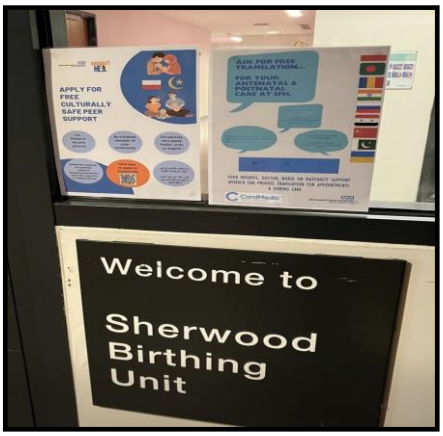
2.2 Maternity and Neonatal Voices Partnership (MNVP)
Agenda Item 10 – *Neonatal Focus for November 2025.*

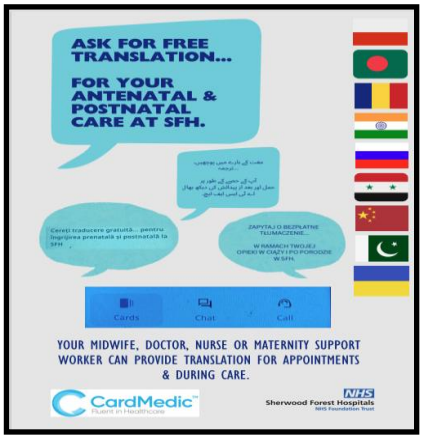
3. Quality Improvements

3.1 Training Equipment Showcase – Simulation Innovation
On 17 October 2025, Julie Vizzard (JV), Clinical Facilitator, coordinated a visit from simulation specialists to facilitate a full-day interactive training session, providing staff across the maternity and neonatal teams with the opportunity to trial two advanced simulators – MamaAnne™, a high-fidelity pregnant person simulator, and a newborn baby simulator. The showcase generated significant interest and engagement from multidisciplinary staff, enabling hands-on experience and discussion around the use of simulation to enhance confidence, communication, and teamwork in managing complex clinical scenarios. Feedback from attendees was overwhelmingly positive, highlighting the value of realistic, immersive learning environments to support safe and effective care. While the equipment represents a notable financial investment, its potential impact on improving multidisciplinary training, promoting safety culture, and delivering safer outcomes for women, birthing people, and families is considerable. Options for sustainable implementation and funding models are being explored.

3.2 Health Inequality Projects

Launching in November 2025, Specialist Midwife Natalie Boxall (NB) has led collaborative work to address perinatal health inequalities through both community and digital innovation. This includes participation in the Support ME Maternal Project, providing culturally appropriate peer support for Polish and Urdu-speaking families to improve communication, confidence, and continuity of care. Complementing this, the Language Interpreting and Translation SOP and rollout of CardMedic® now ensure equitable access to real-time translation in over 50 languages, including British Sign Language and Easy Read formats. Together, these initiatives strengthen SFH's commitment to delivering inclusive, person-centred care and improving outcomes across the perinatal pathway.





3.3 Homebirth Service

In October 2025, part one of the delivery of the new and improved Homebirth Kits was received. This update marks an important step in enhancing the safety, efficiency, and experience of homebirths across the perinatal pathway. The redesigned kits provide midwives with high-quality, standardised equipment to support optimal infection prevention, emergency preparedness, and a more streamlined set-up during homebirths. Implementation planning is now underway, including familiarisation sessions for community midwives and a phased distribution approach to ensure all kits are in circulation by the end of November. This initiative supports our commitment to safe, responsive, and well-equipped community birth services, aligned with national guidance on homebirth safety and the Trust's ongoing drive to modernise perinatal care.

3.4 Maternity Triage Centre (MTC)

As per the paper presented at PAC in July 2025, the relocation of the Maternity Triage service to Clinic 12, forming the new Maternity Triage Centre (MTC), remains on track for go-live on 1 December 2025. This development represents a key milestone in enhancing the safety, privacy, and efficiency of urgent and unscheduled maternity care. All environmental works are now captured and on track, with final checks on equipment, signage, and access arrangements underway. Operational pathways will be tested throughout November, and communication materials are being designed to support a smooth transition.

The first week of December will include enhanced senior presence on-site to troubleshoot any early challenges and support staff and service users during the settling-in period. This project demonstrates a strong multidisciplinary effort, aligning with our perinatal service improvement priorities and commitment to delivering safe, high-quality, and person-centred care.

4. Culture Improvements

4.1 National Staff Survey
Weekly updates demonstrate that Divisionally, we are not delivering in line with last year's position, and a more concentrated approach is requested across all leaders within the Division. Positivitea Trolley planned for Friday, 7th November, will deliver a face-to-face approach for teams on site that day. Renewed efforts across all digital platforms encouraged and daily walkarounds. OD Support

4.2 Quad+3
The Perinatal Culture and Leadership Programme (PCLP), a national initiative led by NHS England, was established to strengthen maternity and neonatal services through the development of positive, safe, and inclusive workplace cultures. The programme supported senior leadership teams, known as the quadrumvirate, to embed compassionate leadership, safety-focused behaviours, and continuous improvement, with the overarching aim of enhancing the experiences and outcomes of women, birthing individuals, babies, and families.
Building on this foundation, a renewed and refreshed approach to the original NICU Plan is now underway. An assurance paper, setting out the revised plan, key actions, and trajectory for delivery, will be presented to PAC in January 2026 for review and endorsement.

5. National Programmes
5.1 CQC Action Plan
The 'Should Do' action plan, based on the CQC visit 2023, has been completed and embedded; however, we will continue to monitor success and additional actions through the peer review process, and further action plans will be presented through PAC as identified. Quality and Safety Lead Midwife Sarah Sarjant has oversight for this action plan.

5.2 Three-Year Maternity and Neonatal Delivery Plan
We continue to collaborate with the LMNS on the 4 main themes and 12 objectives of the 3-year delivery plan. The collaborative LMNS mapping process against this plan is currently being overseen by Sarah Ayre (SA), Head of Midwifery. The 4 main themes of the delivery plan are summarised below:

Theme 1: Listening to women and families with compassion, which promotes safer care.
Theme 2: Supporting our workforce to develop their skills and capacity to provide high-quality care.
Theme 3: Developing and sustaining a culture of safety to benefit everyone.
Theme 4**:** Meeting and improving standards and structures that underpin the national ambition.

Overall, our current benchmarking demonstrates we are working well to meet each of the themes and the 12 objectives, with the introduction of the new Maternity and Neonatal Digital Improvement Programme (MNDIP) being led by Clare Madon (CM), Chief Nursing Information Officer, which will support objective 12.

5.3 NHSR – MIS Year 7
SGM Samantha Barlow (SB) will lead the collation of our evidence once again, with safety action owners assigned as per below. As per the previous process, SB will report via PAC.

Safety Action 1 PMRT – Sarah Sarjant
Safety Action 2 MSDS – Lisa Butler
Safety Action 3 Transitional Care – Rachael Giles

Safety Action 4 Clinical Workforce – Samantha Barlow
Safety Action 5 Midwifery Workforce – Lisa Butler
Safety Action 6 Saving Babies Lives – Sarah Sarjant
Safety Action 7 Listening to service users – Sarah Ayre
Safety Action 8 Training – Lisa Butler
Safety Action 9 Board Assurance – Sarah Ayre
Safety Action 10 MNSI – Sarah Sarjant

5.4 Ockenden
The report received following our annual Ockenden visit in October 2023 forms the basis of the robust action plan embedded within Maternity. The visit's findings supported the self-assessment completed by the Trust.

5.5 National Survey - CQC
The 2025 Maternity survey was launched in April 2025, and those who gave birth in January or February of this year will be invited to give feedback.

5.6 MBRRACE-UK
Saving Lives, Improving Mothers' Care 2024 - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2020-22. Governance Lead Midwife HL is currently benchmarking against the report, and her updates will be shared via PAC once completed.

5.7 10 Year Health Plan
The newly published Fit for the Future: 10-Year Health Plan for England sets out three transformational shifts for the NHS: moving care from hospital to community, embedding digital and AI for proactive patient-controlled care, and prioritising prevention over treatment. For maternity and neonatal services, the Plan signals major reform. An independent national investigation will review up to ten trusts and shape a new action plan, led by a Secretary of State-chaired Taskforce. Implications for SFH: For Sherwood Forest Hospitals, the 10-Year Plan reinforces the need to align maternity and neonatal services with national priorities for safety, equity and digital innovation

5.8 Maternity Outcomes Signal System (MOSS)
From November, the Maternity Outcomes Signal System (MOSS) will use near-real-time data and AI to identify early risks of stillbirth, neonatal death and brain injury, enabling rapid intervention. The Plan also commits to co-producing a maternity and neonatal action plan with bereaved families, expanding Family Hubs and Start for Life services, and developing new quality metrics, including PROMs and PREMs, to improve safety, personalisation and equity. Maternity and neonatal services are positioned centrally in NHS reform, with a clear emphasis on innovation, safety, and family engagement.

5.9 Summary of the Thirlwall Inquiry
The statutory Thirlwall Inquiry, chaired by Lady Justice Thirlwall, was established following the convictions of neonatal nurse Lucy Letby and formally commenced in September 2024. Implications for SFH: The Thirlwall Inquiry underscores the need to maintain robust governance, clear escalation processes, and a culture where staff feel safe to raise concerns. Anticipated recommendations will likely require strengthened safeguarding systems, integrated oversight between maternity and neonatal services, and greater board visibility of safety risks.
5.10 Review of Fetal Growth Surveillance Systems
NHS England (Midlands) has issued a regional directive requiring all Trusts to undertake a clinically led review of their fetal growth surveillance systems and associated safety risks: as per the attached letter.

The review is being undertaken collaboratively by clinical, digital, and governance leads to ensure that all systems supporting fetal growth monitoring are accurate, interoperable, and compliant with national standards. Key stakeholders have been identified, and the initial meeting took place in October. An action plan has been agreed upon, and an assurance paper is being developed by CMIO and HoM, scheduled for submission to PAC in January 2026 for awareness.

5.11 The Safety, Performance and Effectiveness Network (SPEN)
From 3rd November 2025, the Safety, Performance and Effectiveness Network (SPEN) has been introduced as part of NHS England's national maternity and neonatal improvement programme to strengthen local oversight, data transparency, and assurance around safety and quality outcomes. SPEN provides a single, standardised platform for submitting, reviewing, and triangulating key maternity and neonatal indicators at Trust, LMNS, and regional levels. The system supports proactive identification of trends, themes, and outliers, enabling earlier intervention and shared learning across services. For SFH, the introduction of SPEN enhances the way we monitor and evidence safety, supporting the delivery of robust governance. Divisional leads and key stakeholders have been given access to the portal and have completed the relevant training.

6. Perinatal Quality Surveillance Scorecard, October 2025 data

6.1 Dashboard
The October 2025 Quality Surveillance data, monitoring key safety outcomes, were not available at the time of preparing this report. A verbal update will be provided at the November PAC meeting, and the scorecard will be submitted as a subsequent addendum, subject to the Chair's approval.

6.2 Workforce Metrics – Provider Workforce Returns (PWR)
Aligned with the Three-Year Delivery Plan, an improved approach to reporting workforce metrics will be added to the Maternity Dashboard and Scorecard from November 2025. This will include the midwifery turnover rate and will align with our PWR data submitted nationally each month.
This will support the current system working and the 6-monthly updates required through the LMNS Perinatal Quality Surveillance Group (PQSG).

7. Neonatal Services Update

A review of leadership portfolios within the Women and Children's Division is underway to strengthen alignment across the perinatal pathway. This will see Transitional Care (TC) and the Neonatal Intensive Care Unit (NICU) formally integrated within a unified Perinatal Services structure, ensuring seamless governance, consistent standards, and improved continuity of care for mothers and babies. Matron and senior leadership portfolios are being realigned accordingly to provide clear accountability, enhanced multidisciplinary collaboration, and strengthened oversight from admission to discharge across maternity, TC, and NICU services.

This realignment will also enable this report to evolve into a more collaborative and succinct mechanism for assuring the safety and quality of care delivered across the entire perinatal pathway.

It will bring together learning, performance data, and improvement actions from maternity, neonatal, and transitional care services, aligned with the expectations of the Maternity and Neonatal Safety Champions. The full handover of portfolios will be completed by the end of November 2025.

Outstanding Care, Compassionate People, Healthier Communities

Sherwood Forest Hospitals NHS Foundation Trust

Public Board of Directors - Cover Sheet

Subject:	Perinatal Quality Oversight Model- November 2025	**Date:**	4th December 2025
Prepared By:	Paula Shore, Director of Midwifery and Divisional Director of Nursing.		
Approved By:	Phillip Bolton, Executive Chief Nurse.		
Presented By:	Paula Shore, Director of Midwifery and Divisional Director of Nursing.		

Purpose		
To update and assure Board members of the Perinatal Quality Surveillance Model data review and any additional points for Board members awareness.	**Approval**	
	Assurance	**X**
	Update	**X**
	Consider	

Strategic Objectives					
Provide outstanding care in the best place at the right time	Empower and support our people to be the best they can be	Improve health and wellbeing within our communities	Continuously learn and improve	Sustainable use of resources and estates	Work collaboratively with partners in the community
X			**X**		

Identify which Principal Risk this report relates to:		
PR1	Significant deterioration in standards of safety and care	
PR2	Demand that overwhelms capacity	
PR3	Critical shortage of workforce capacity and capability	
PR4	Insufficient financial resources available to support the delivery of services	
PR5	Inability to initiate and implement evidence-based Improvement and innovation	
PR6	Working more closely with local health and care partners does not fully deliver the required benefits	
PR7	Major disruptive incident	
PR8	Failure to deliver sustainable reductions in the Trust's impact on climate change	

Committees/groups where this item has been presented before

- Perinatal Assurance Committee

Acronyms

- PAC- Perinatal Assurance Committee
- PQOM-Perinatal Quality Oversight Model
- SFH-Sherwood Forest Hospitals

Executive Summary

The Perinatal Quality Oversight Model (PQOM) has been developed by NHS England in response to the need to proactively identify trusts that require support before serious issues arise. It provides consistent and methodical oversight of NHS perinatal services and ensures we collect the information and insight we need to drive service improvement.

This model has been in place at Sherwood Forest Hospitals (SFH) since it was first launched in 2020. This monthly report is present through divisional governance, Executive lead meeting and Board as a way to ensure that all have oversight of the key metrics and any areas of concerns that require review.

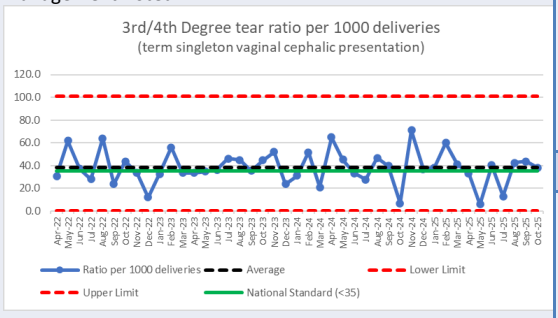
Perinatal Quality Surveillance Model for Nov 2025 (Oct 2025 data)

Sherwood Forest Hospitals
NHS Foundation Trust

Exception report based on highlighted fields in the monthly scorecard using October 2025 data (Slide 2)

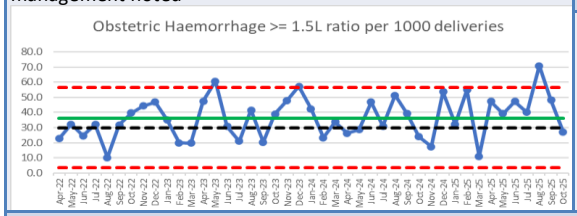
3rd/4th Degree Tear 38.2% (Oct 2025)

No themes identified – all cases reviewed, and appropriate management noted



Postpartum Hemorrhage 27.2% (Oct 2025)

No themes identified – all cases reviewed, and appropriate management noted



Stillbirth Rate

1 stillbirth in October: No themes identified.
External review is ongoing with support from the LMNS: MOSS signal – historical and no further action required.

MIS Year 7 update: (Oct 25)

Plans to sign off Safety Action 2 and 4 at next PAC.

Progress meetings planned with action owners to obtain final evidence required to show compliance.

Plan made re training and proposed IA – forecast shows compliance for training will be above 90%.

Triage Relocation

Update re progress for the relocation - weekly task and finish, on target for opening MTC 1st Dec in Clinic 12. SOP planned for ratification at Governance - Nov meeting. Medical staffing model being finalised.

Workforce (Oct 2025)

Maternity

HoM working with Regional Workforcce Lead to understand PWR data as anomalies noted - update to PAC in Jan 26

Maternity Ward Leader (Maternity Cover) is now live so will be interviewing this post soon.

11 New starters planned for Sep/Oct

Neonatal

There are no vacancies within the team.

Currently, two staff members are on maternity leave with only a small crossover period. This does not represent a high maternity rate.

NICU B7 Ward leader interviews held on 12 November 2025.

Paediatric medical workforce - Intentions to move medical workforce (NICU) to full day to commence from April 2026.

Staffing Red Flags (Oct 2025)

Homebirths

3 Homebirths in September 2025, 1 suspension in service (since 24/04/25) due to staff short-notice sickness

Diversion of services

1 divert in Oct –based on acuity

25 Oct – 6 hours – 1 divert

Support not available from other Units, no women diverted.

All diversions reported via Datix and reviewed to ensure safe practices and appropriate escalations.

Saving Babies Lives Care Bundle (SBLCB v3) 94% complaint

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)
Element 1	Smoking in pregnancy	Partially implemented	70%	Partially implemented	70%
Element 2	Fetal growth restriction	Partially implemented	95%	Partially implemented	95%
Element 3	Reduced fetal movements	Fully implemented	100%	Fully implemented	100%
Element 4	Fetal monitoring in labour	Fully implemented	100%	Fully implemented	100%
Element 5	Preterm birth	Fully implemented	100%	Fully implemented	100%
Element 6	Diabetes	Fully implemented	100%	Fully implemented	100%
All Elements	TOTAL	Partially implemented	94%	Partially implemented	94%

Perinatal Assurance

NHSR

- Year 6 MIS achieved
- Planning for Year 7 underway – monthly assurance meetings underway

National Reporting

- Ockenden - Initial 7 IEA- 100% compliant
- 3 yr. Delivery plan – delivery plan overseen by ICB
- 10-year Plan launched

Incidents reported Sept: 136 (134 low harm, 2 moderate or above)

MDT reviews	Comments
Triggers x 11 Rapid Review x 3	No themes identified

MOD HARM:

DW229678 Baby temp and management

DW230439 PPH management

Both planned for Trigger review wk/c 17/11

Perinatal Quality Surveillance scorecard November 2025 (Oct 2025 data)

Sherwood Forest Hospitals
NHS Foundation Trust

CQC Maternity Ratings- assessed 2023	Overall	Safe	Effective	Caring	Responsive	Well led
	Good	Requires Improvement	Good	Outstanding	Good	Good
Unit on the Maternity Improvement Programme				No		

Maternal Perinatal Quality Surveillance Scorecard

Sherwood Forest Hospitals
NHS Foundation Trust

Quality Metric	Standard	Running Total/ average YTD	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Trend
1:1 care in labour	>95%	100.00%	100%	100%	100%	100%	100%	100%	100%	
Normal birth delivery (vaginal cephalic)		49.38%	51%	52%	49%	52%	49.7%	46.4%	46.6%	
3rd/4th degree tear overall ratio per 1000 deliveries	<35/1000	30.7	33.1	5.9	40.3	12.9	42.4	43.8	38.2	
3rd/4th degree tear overall number		34	5	1	6	2	7	7	6	
Obstetric haemorrhage >1.5L number		92	13	12	13	11	21	14	8	
Obstetric haemorrhage >1.5L ratio per 1000 deliveries	<36/1000	45.7	47.3	39.2	47.3	40.1	70.9	48.1	27.2	
Term admissions to NICU	<6%	4.09%	4.23%	4.14%	2.29%	2.35%	4.93%	6.18%	4.24%	
Stillbirth number		12	1	1	1	2	3	3	1	
Stillbirth rate	<4.4/1000	5.90			3.5			9.2		
Rostered consultant cover on SBU - hours per week	60 hours	60	60	60	60	60	60	60	60	
Dedicated anaesthetic cover on SBU - pw	10	10	10	10	10	10	10	10	10	
Midwife / band 3 to birth ratio (establishment)	<1:28		1:19.50	1:21.63	1:19.03	1:17.91	1.19.06	1.18.81	1.19.06	
Midwife/ band 3 to birth ratio (in post)	<1:30		1:21.30	1:23.74	1:21.02	1:20.07	1.21.17	1.20.91	1.20.27	
Number of compliments (PET) as reported on DATIX			2	3	1	12	8	2	5	
Number of concerns (PET) as reported on DATIX			0	0	0	2	1	1	5	
Complaints (PET) as reported on DATIX			0	1	1	2	0	4	3	
FFT recommendation rate - COMMUNITY POSTNATAL touch point 4	>93%		100%	78%	100%	100%	100%	100%	100%	
FFT recommendation rate - MATERNITY WARD touch point 3	>93%		88%	82%	82%	78%	73%	83%	88%	
FFT recommendation rate - SBU touch point 2	>93%		95%	97%	89%	90%	90%	90%	92%	

External Reporting	Standard	Running Total/ average	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Trend
Maternity incidents no harm/low harm			89	124	131	74	105	136	110	
Maternity incidents moderate harm & above			0	1	2	2	4	2	0	
MNSI/CQC/NHSR with a concern or request for action		Y/N	1	N	N	N	N	N	N	
Coroner Reg 28 made directly to the Trust		Y/N	0	0	0	0	0	0	0	
Progress in Achievement of MIS YEAR 7 - from May 2025		<4 <7 7 & above								

Findings of review of all perinatal deaths using the real time monitoring tool	Oct-25	No themes identified in month
Findings of review all cases eligible for referral to MNSI	Oct-25	No new cases for referral
Service user voice feedback	Oct-25	Q4 Theming report shared
Staff feedback from Safety Champions and walk-abouts	Oct-25	Relocation of Triage remains focus

Outstanding Care, Compassionate People, Healthier Communities

Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	SFH Green Plan 2025-2028	**Date:**	4th December 2025
Prepared By:	Kimberley Cannon – Sustainability Service Lead		
Approved By:	Richard Mills – Chief Financial Officer		
Presented By:	Mark Jackson – Director of Estates and Facilities		

Purpose		
The Trust's Second Green Plan (Strategy) which covers 2025 to 2028	**Approval**	**X**
	Assurance	
	Update	
	Consider	

Strategic Objectives					
Provide outstanding care in the best place at the right time	Empower and support our people to be the best they can be	Improve health and wellbeing within our communities	Continuously learn and improve	Sustainable use of resources and estates	Work collaboratively with partners in the community
				X	
Indicate which strategic objective(s) the report support					

Identify which Principal Risk this report relates to:		
PR1	Significant deterioration in standards of safety and care	
PR2	Demand that overwhelms capacity	
PR3	Critical shortage of workforce capacity and capability	
PR4	Insufficient financial resources available to support the delivery of services	
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PR6	Working more closely with local health and care partners does not fully deliver the required benefits	
PR7	Major disruptive incident	
PR8	Failure to deliver sustainable reductions in the Trust's impact on climate change	**X**

Committees/groups where this item has been presented before

Sustainable Development Strategic Group
Sustainable Development Operational Group
Trust Management Team
Finance Committee

Acronyms

ICB – Integrated Care Board
NHS – National Health Service
NUH – Nottingham University Hospitals NHS Trust
PFI - Private Finance Initiative
SDOG – Sustainable Development Operational Group
SDSG – Sustainable Development Strategic Group
SFH – Sherwood Forest Hospitals NHS Foundation Trust

Executive Summary

All NHS Organisations in mid-2025 were asked to refresh their green plans in line national guidance and have a Trust Board Approved plan before the beginning of 2026.

The attached document is the second Green Plan for SFH which is a more strategic document in line with NHSE recommendations and replaces the existing 2021 to 2026 SFH Green Plan. It is underpinned by various actions which have been set out into 10 areas of interest which are noted below: -

1. Workforce and Leadership
2. Net Zero Clinical Transformation
3. Digital Transformation
4. Medicines
5. Travel and Transport
6. Estates and Facilities
7. Supply Chain and Procurement
8. Food and Nutrition
9. Adaptation
10. Green Plan Governance

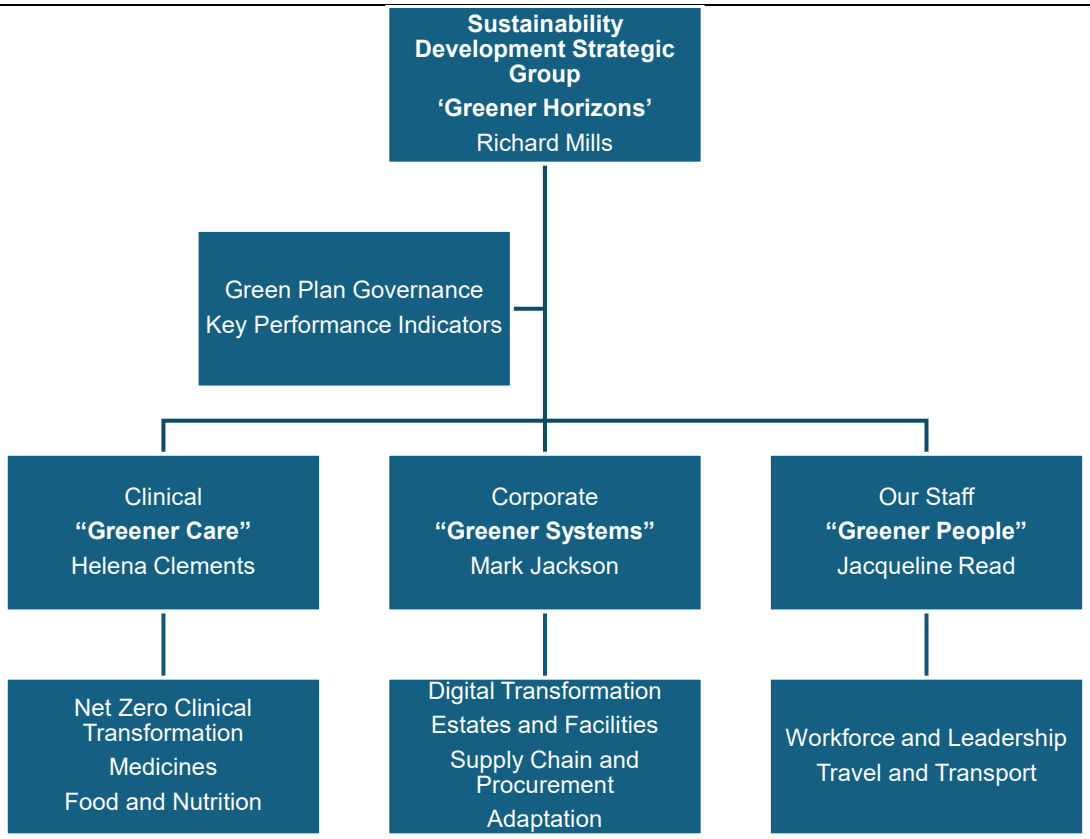
Delivering a Net Zero NHS is the framework from which all NHS Organisations are working towards to enable a more sustainable future. SFH have worked closely with various clinical and non-clinical colleagues within the organisation and wider afield to develop this Plan.

Thanks to all the following staff who have had input into this Green Plan and supported the set actions identified within the plan. This has included Morgan Thanigasalam (Associate Chief Clinical Information Officer), Bob Trustwell (Strategic Head of Procurement), Jim Millns (Associate Director of Transformation), Jacqueline Read (Associate Director of People - Operations), Patrick Wilson (Chief Pharmacist and Clinical Director of Medicines Optimisation), Lauren Ward (Emergency Planning and Business Continuity Officer), Helena Clements (Consultant Paediatrician & Service Director for Paediatrics), Richard Mills (Chief Finance Officer), George Nelson (CNH General Manager), Neil Jones (Head of PFI Operations – Medirest) and Jason Norton (Sustainability – Skanska).

As part of the new Green Plan, we will also be looking to reinvigorate the various sustainability groups across our organisation. Overarching there will continue to be the Sustainability Development Strategic Group with three pillars supporting this to deliver the various aspects of this green plan – Clinical, Corporate and Our Staff. This has also been shared with Nottingham University Hospitals, and we are potentially looking to have joint groups across all 4 areas (SDSG, Clinical, Corporate and Our Staff) to support our own plans, NUH and the ICB to move quicker, faster and together as a region.

To deliver our strategy effectively, we will implement a series of targeted actions designed to enhance outcomes without placing significant demands on people's time. These actions will focus on streamlining existing processes, leveraging available resources, and embedding improvements into current workflows wherever possible. By prioritising efficiency and minimising disruption, we aim to ensure that these steps are practical, achievable, and integrated seamlessly into day-to-day operations, supporting progress without adding unnecessary burden.

The proposed new governance structure is set out below to support the organisation in achieving its objectives.



The paper is for Trust Board **APPROVAL** of the Green Plan for 2025 to 2028.

Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Green Plan

2025-2028

003139

Contents

Message from the Chief Executive

Dear colleagues,

I am delighted to introduce our Green Plan, which sets out our Trust's sustainability strategy for 2025 to 2028. This plan marks a significant step in our ongoing commitment to reducing our carbon footprint and building a more sustainable future for our patients, staff, and communities.

Our Green Plan reflects our shared ambition to embed sustainability into what we do across Sherwood Forest Hospitals. By considering the environmental impact of our choices, we not only contribute to the fight against climate change but also identify opportunities to operate more efficiently and responsibly.

Collective leadership and ambition is essential for success, and we must work together to deliver upon this plan.

We can be proud of the progress we have made in recent years, whilst acknowledging that there is much more to do. Together, we can make a real difference - not only for our Trust but for the wider NHS and the communities we serve.

Thank you for your continued support and dedication to sustainability.

Jon Melbourne *Chief Executive*
Sherwood Forest Hospitals NHS Foundation Trust

Foreword

Green Plan 2025-2028

We are delighted to publish our Green Plan for 2025-2028 which sits alongside the Trust Strategy. This is the Trust's second green plan and whilst we are proud of our achievements so far there is much to do to achieve Net Zero across all our activity in line with the NHS commitment.

This second Green Plan is a more strategic document in line with NHSE recommendations, but this will be underpinned by many actions led by the areas of focus outlined below. As we turn our attention to emissions not made directly by the Trust, but related to all the goods and services we bring in to deliver our clinical care, we will need to increase our focus on clinical procurement, the medicines, tools and consumables that we use every day in our clinics, theatres and wards. To this end, we now have named leads in all our Divisions who will focus on sustainable quality improvement, lean pathways and prevention aiming to improve health, reduce health inequalities and demand on our services. This is in line with the NHS 10-Year Plan and our overarching strategy.

Our direct emissions are mostly about the energy used in our estate, such as gas, oil and electricity. It also includes anaesthetic gases. This is an area of considerable success. We have stopped using Desflurane, moved from piped to bottled Nitrous oxide and reduced the use of Entonox by 40%. These gases have significant greenhouse gas potential and have been a focus of NHSE.

Unfortunately, our energy use has not yet started to come down. This is partly due to increased clinical demand and also to increased additional clinical activity to address the backlog of work following the COVID19 pandemic. Some of this is worsened by climate change as we see spikes in energy use during the increasingly frequent heatwaves which require our buildings to be cooled. However, in the last 12 months we have initiated and completed some important energy saving projects detailed in the Green Plan which will start to make a significant difference.

Energy for heating our buildings and water supply mostly comes from gas and again we have not yet made an inroad into this. We are developing our heat decarbonisation plan and will work with our partners to identify funding streams to support this. This is a priority for NHSE and a challenge for all NHS Trusts. Working to generate on-site renewable energy is also very firmly in our new Green Plan. For a sustainable energy strategy, we need to first limit demand by improving the buildings we already have and ensure that any new capital projects are as energy efficient and resilient as possible. We need to reduce energy waste in our estates and in all the activities that we do inside those buildings and ultimately move from fossil fuels completely to clean renewable energy, including where possible, energy generated on site.

There are well-recognised challenges faced by SFH and the NHS Nationally. We are operating in a very restricted financial envelope and are meeting increasing demand. Our local population experiences high levels of health inequalities and we are expecting an increase in clinical demand from an aging and medically complex population. To deliver our Green Plan we require resources in terms of capital and also a workforce who are equipped to deliver Net Zero innovation. Much has been achieved by our Sustainability Leads and enthusiastic colleagues over the last 4 years. But the pace and urgency needed to move towards our Net Zero targets is such that we need to embed sustainability and Net Zero in everything we do.

The Divisional leadership model has the potential to be a game changer and enable sustainable clinical innovation to be embedded and amplified at pace. National schemes such as the RCEM Greener ED challenge and the Greener Pharmacy toolkit are examples which our teams have taken up, making use of tried and tested projects to avoid re-inventing the wheel. Fostering a multidisciplinary approach to sustainability brings in colleagues right across teams increasing buy in and providing positive hope for individuals who are often overwhelmed by the weight of demand in the NHS. The brand-new EXCEPTIONAL CONTRIBUTION TO SUSTAINABILTY

award in the Staff Excellence awards serves to emphasize our commitment to our Green Plan and celebrate the efforts of those who are striving to deliver it.

Finally, we should acknowledge the importance of partnership working which is vital in delivering our Green Plan but also in our joint efforts to address the impact of climate change. Those partnerships include with our PFI partners, our joint work with sustainability teams across the ICS and more locally with Primary Care and local services.

Richard Mills *Chief Financial Officer & SFH Sustainable Development Strategy Group*

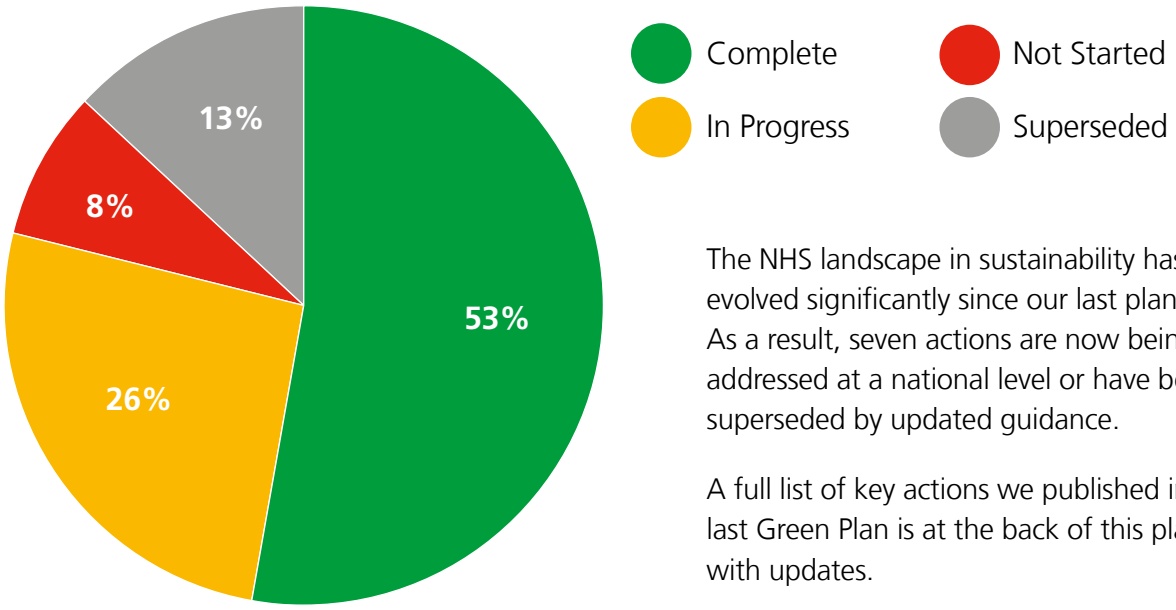
Introduction

In 2020, the NHS became the world's first healthcare system to commit to reaching Net Zero emissions. This commitment was reinforced by the Health and Care Act 2022, which introduced new duties requiring integrated care boards (ICBs), NHS trusts, and foundation trusts to consider statutory emissions and environmental targets in their decision-making. These responsibilities are expected to be fulfilled through the development and implementation of board-approved Green Plans.

Our last Green Plan

Since our last plan, we have successfully completed 28 Key Actions, with a further 14 currently in progress – including ongoing improvement initiatives that are continuous by nature. 4 actions have not been started.

2021 SFH Green Plan Actions



The NHS landscape in sustainability has evolved significantly since our last plan. As a result, seven actions are now being addressed at a national level or have been superseded by updated guidance.

A full list of key actions we published in our last Green Plan is at the back of this plan, with updates.

Our Successes

The first SFH Green Plan gave the sustainability leads and climate action team a structure and actions to work on. There have been significant successes both in our scope one emissions and in our scope 2 and 3 emissions with increasing clinical engagement over time. Some examples of these include:-

- Ceased use of Desflurane from our Theatres
- Decommissioned piped Nitrous oxide from theatres switching to bottles and reducing waste
- Pop the Nox – reduced leakage/waste of Mixed Nitrous oxide and air (Entonox) in maternity
- Introduced Coolsticks – a reuseable alternative to Ethyl Chloride spray
- Walking Aid Return, Reuse and Recycle Scheme
- HVAC sensors project – switching off services in innactive theatres
- LED lighting projects – energy reduction
- BMS – Air Conditioning Project – efficient use of air conditioners with energy reduction
- Identifying senior sustainability leads in each division to support clinical projects
- Implementing a Green Champion network across the Trust
- Delivering Bus Stops on site at Kings Mill Hospital to encourage staff and patients to use public transport
- Excellence Awards – New Exceptional contribution to Sustainability Award for 2025

NHS Core Carbon Footprint and Footprint Plus

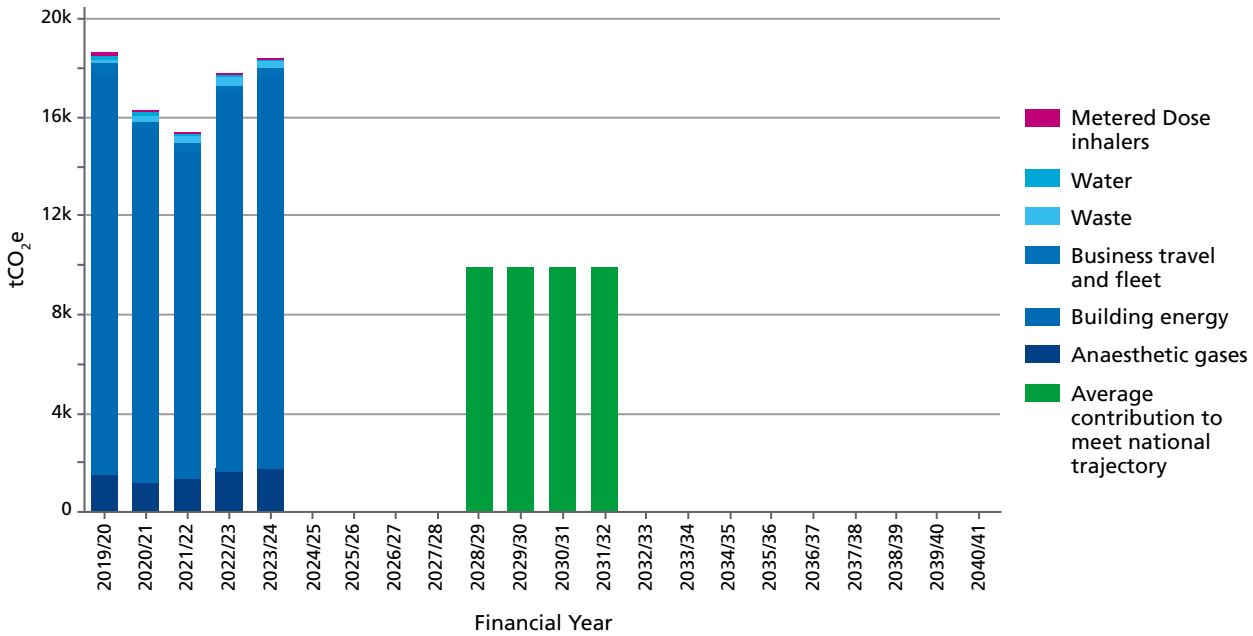
What is the Trust's current Carbon Footprint?

The national NHS targets are defined against 1990 levels to allow comparison with the UK Climate Change Act (2008):

- Reach net zero by 2040 for the emissions we control directly (the NHS Carbon Footprint), with an **80% reduction by 2028-2032 against 1990 levels;**
- Reach net zero by 2045 for the emissions we can influence but don't directly control (the NHS Carbon Footprint Plus), with an **80% reduction by 2036-2039 against 1990 levels**

Those national targets – defined against the 2019/20 emissions footprint calculated in line with the Delivering a Net Zero NHS report – are equivalent to:

- Reach net zero NHS Carbon Footprint by 2040, reducing emissions by at least **47% by 2028-2032;**
- Reach net zero NHS Carbon Footprint Plus by 2045, reducing emissions by at least **73% by 2036-2038.**
- The graph below illustrates our current carbon footprint trajectory, with emissions for 2023/24 at 18,665 tCO_2e and a 2032 target of 9,893 tCO_2e.



Our Carbon Footprint Plus baseline is 65,800 tCO_2e, with 39,668 tCO_2e attributed to our supply chain. We expect this to decrease as our suppliers progress on their journeys toward Net Zero. To support this, our procurement team has implemented a sustainable procurement policy aimed at meeting the reduction targets outlined above. Further details are provided in the Procurement section of this plan.

Collaboration

Delivering a Net Zero NHS is the framework from which all NHS Organisations are working towards a more sustainable future.

Understanding that working together can lead to faster change through shared knowledge SFH is part of the following regional groups:

- **Greener ICS (Integrated Care Board) – Nottingham & Nottinghamshire ICB**, collaborating with colleagues from
- **Nottingham City Council**
- **Nottinghamshire County Council**
- **Nottingham University Hospitals NHS Trust**
- **Nottinghamshire Healthcare NHS Foundation Trust**
- **East Midlands Ambulance NHS Trust**
- **Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust**
- **PFI partner Project Co** working in collaboration with their service providers Skanska & Medirest.

Our New Green Plan

This Green Plan is for 2025-2028 has 10 specific areas of focus;

- **Workforce and Leadership**
- **Net Zero Clinical Transformation**
- **Digital Transformation**
- **Medicines**
- **Travel and Transport**
- **Estates and Facilities**
- **Supply Chain and Procurement**
- **Food and Nutrition**
- **Adaptation**
- **Green Plan Governance**

Although our previous Green Plan was originally set to run until 2026, we have incorporated both ongoing actions and new initiatives informed by team input, updated guidance, and our continued commitment to achieving Net Zero across the NHS.

A complete list of these actions can be found at the end of this plan.

Workforce and Leadership

Since our last Green Plan, we have established the Climate Action Team (CAT), the Sustainable Development Strategy Group (SDSG), and the Sustainable Development Operational Group (SDOG). These groups work collaboratively to identify opportunities for improving sustainability across the Trust, support the development of business cases, and assist with project implementation.

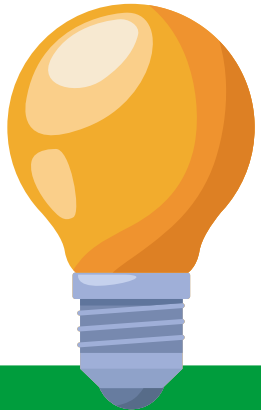
This structure has enabled us to secure over £3 million in sustainability funding over the past five years, with several projects currently underway across our sites.

We also have a board-level Net Zero Lead in place, who regularly reports our progress to the Trust Board.

Actions
Review the Trust's working policies to identify where reductions in travel to work can be implemented.
Identify suitable training opportunities for our staff on sustainability, including using NHS resources.
Encourage key members to undertake specialist sustainability training to ensure deliverability of the Green Plan.
Assign each area of the Green Plan to the relevant stakeholders.
Identify sustainability leads for each department to ensure that good practice is shared with all.
Refresh our communications plan around the promotion of sustainable development to staff and visitors.
Identify funding opportunities to support the transition to a sustainable Trust.

Metric

- Named board-level lead for green plan delivery.



Net Zero Clinical Transformation

At SFH, we are committed to empowering both staff and visitors to help reduce our carbon footprint – across clinical and non-clinical settings.

We are actively reviewing our clinical pathways to identify where sustainability can be integrated, recognise what is working well, and highlight opportunities to progress Net Zero aligned to the new NHS 10 Year Plan.

Fit for the Future: 10 Year Health Plan for England

The 10 Year Health Plan is part of the government's health mission to build a health service fit for the future. It sets out how the government will reinvent the NHS through 3 radical shifts:

- **Hospital to Community**
- **Analogue to Digital**
- **Sickness to Prevention**

Since the last Green Plan, we have made progress in incorporating preventative care into our clinical pathways and using patient feedback to ensure our services remain appropriate and effective.

A clinical lead for Net Zero transformation is in place, reporting directly to the board. They are working with a wide range of departments to drive quality and service improvements that align with our sustainability objectives.

Actions
Establish a clinical lead and multidisciplinary working group responsible for reducing emissions in the clinical areas (e.g. Single Use items, plus consumables such as couch roll).
Complete quality improvement projects that have a measurable reductions in emissions – whether it be related to medicines, waste, energy use, or other areas.
Identify co-benefits of projects for quality of care, efficiency and reducing healthcare inequalities.
Work with system partners to deliver system transformation as per the NHSE 10-year plan.
Share our good practices with our clinical groups, the wider Trust, and NHS England.

Metric

- Number of named clinical leads specified for clinical departments supporting green plan delivery.

Digital Transformation

Over the last Green Plan cycle the Digital team have led the way in reducing environmental impact through work such as using the NHS App to send out patients letters digitally. This has seen a significant reduction on carbon emissions, less paper and less road traffic that also saves the Trust money.

Our NHIS partners have also undertaken a project to reduce our carbon emissions through the automatic power saving initiative, which uses PC and Laptop settings to go into standby mode after a period of inactivity.

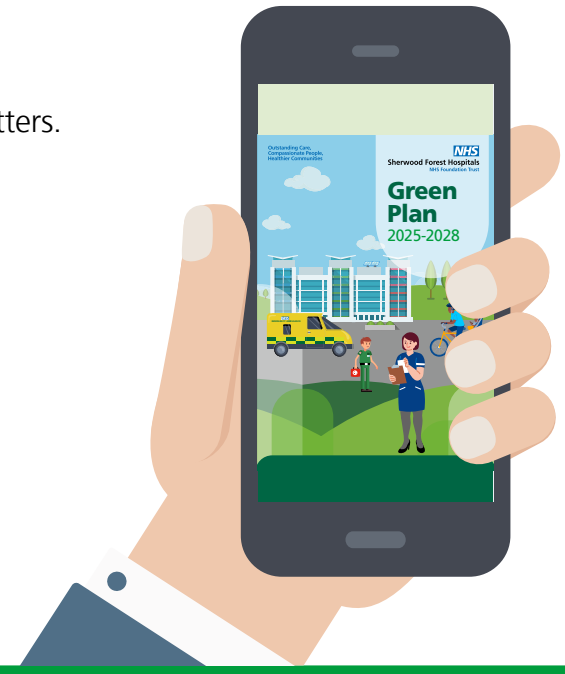
These examples and others also support the sustainability of the Trust through being both greener and cheaper.

Analogue to Digital is one of the triple shifts in the NHS 10 year plan – the actions below speak to this, but we will also be a key enabler for other Green Plan programmes.

Actions
Increase the uptake of the NHS App and Patient Engagement Portal.
Reduce use of paper through introduction of Electronic Patient Record.
Ensure that all Digital Transformation projects include environmental impact assessments and sustainability benefits.
Review IT management processes and hardware to minimise environmental impact.
Utilise Artificial Intelligence and other emerging technologies such as ambient voice to streamline processes.

Metric

- Percentage of SFH patients receiving digital NHS letters.



Medicines

Since our last Green Plan, we have continued to review our medicines to improve sustainability, guided by both internal initiatives and NHS-wide policies and targets.

Our teams have eliminated the use of desflurane across all sites and are actively assessing other anaesthetic gases for further environmental improvements.

Nitrous oxide usage is now reported monthly, and we have received a grant from NHSE to remove piped nitrous from our sites. This has been implemented with the final manifold decommissioning scheduled.

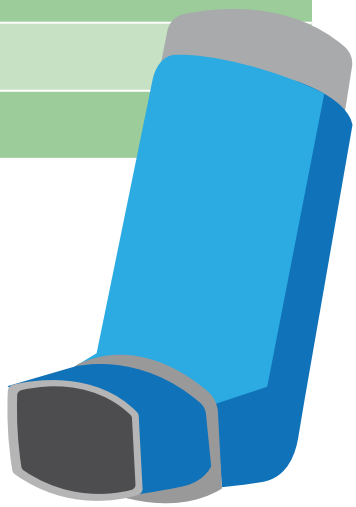
With our Entonox, we are assessing our use against birth rate on our sites, to understand usage per birth, and identify any ways to reduce. Pop the Nox intervention has resulted in circa 40% saving with no impact on patient care.

Our major pharmaceutical suppliers are progressing toward Net Zero, which will positively influence our Carbon Footprint Plus.

Our pharmacy team is also exploring lower-emission treatment options, including switching from metered-dose propellant inhalers to dry powder alternatives.

Sustainable use of medicine is embedded in the medicine's optimisation strategy which includes a commitment to sign up to the Greener Pharmacy Toolkit.

Actions
Roll out Electronic Prescription Service (EPS).
Review of clinical stock levels.
Continue our plans for reducing Nitrous Oxide and Entonox usage.
Review plans for reducing Metered Dose Inhalers (MDI).
Proactively switching intravenous to oral medicines earlier.
Encouraging the reuse of patients' own medicines.
Rationalising use of less effective medicines.



Metric

- Meet the regional target for 2025/26 which is a 19-24% reduction in emissions from pure nitrous oxide, compared to 24/25 emissions.
- Meet the regional target for 2025/26 which is a 5%-8% reduction in emissions from mixed nitrous oxide (gas & air), compared to 24/25 emissions. These targets will be revised annually.

Travel and Transport

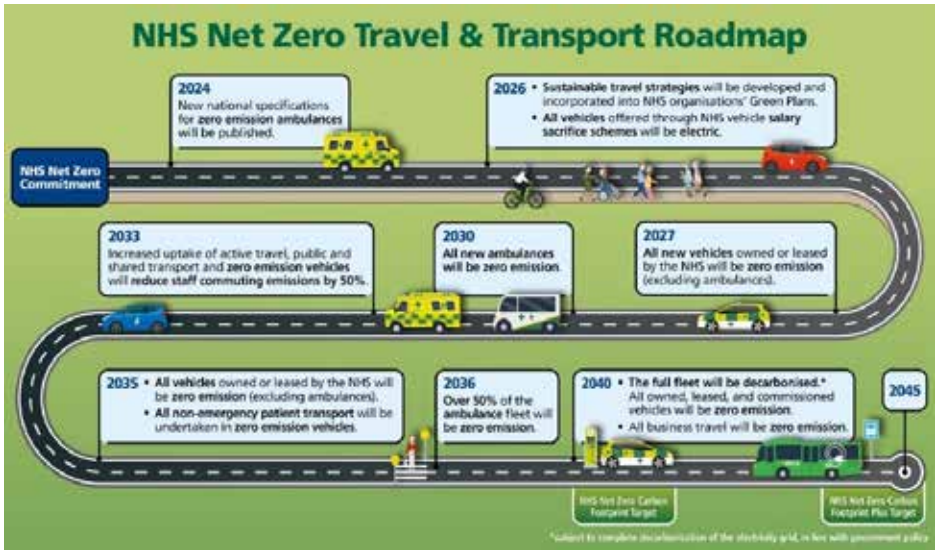
Since the last Green Plan, the Trust has taken several steps to promote sustainable travel. Travel advice is now available via our online Staff Zone.

A salary sacrifice scheme is in place to support staff in purchasing bicycles, accessories, and safety equipment. We have installed secure cycle storage across our sites. Changing rooms and shower facilities are available to all staff, including those who cycle, walk, or run to work.

Our sites are also served by a range of bus routes, including SmartCommute – a low-fare option available to all Trust employees. We have also added bus stops to our sites to make commuting easier and safer for our staff and visitors.

To support the shift to electric vehicles, 24 EV chargers have been installed at King's Mill and 8 at Newark, with plans to expand this provision over the next three years.

These efforts align with the NHS Net Zero Travel and Transport Roadmap.



Actions
A review of changing facilities to include the facilities available, their condition, the number of lockers available to staff and the maximum occupancy.
A review of current bike storage and improvements that can be made.
Adjust the salary sacrifice scheme coverage to EV only.
Continue to identify areas for EV charging for staff and visitors.
Continue to assess our vehicle fleet to move to hybrid and ZEV.
Develop our Sustainable Travel Plan.

Metric

- Percentage of owned and leased fleet that is ultra-low emission vehicle (ULEV) or zero-emission vehicle (ZEV).

Estates and Facilities

Since our last Green Plan, activity across our sites has increased significantly, leading to a rise in carbon emissions from building energy use. This has highlighted the urgent need to reduce emissions in line with our 2032 targets.

In response, we have secured over £3 million in central government funding this year to support upgrades to LED lighting and cooling systems. As part of this investment, over 14,000 new LED lights are being installed across the estate, alongside the implementation of smart controls to optimise cooling system efficiency and automatically power them down when not in use.

We are also conducting a comprehensive review of our heating plant and systems to identify baseline requirements ahead of full decarbonisation planning.

All of these projects will inform the development of our new Heat Decarbonisation Strategy, to be delivered during this Green Plan cycle.

All large projects and new builds will comply with the NHS Net Zero Carbon Hospital Standard. To support this, a sustainability statement is now included in every capital funding request.

In addition, we have engaged a specialist consultancy team to act as our energy managers. They provide monthly reports on building energy use, identify areas for investigation, and assist in developing robust business cases for improvements.

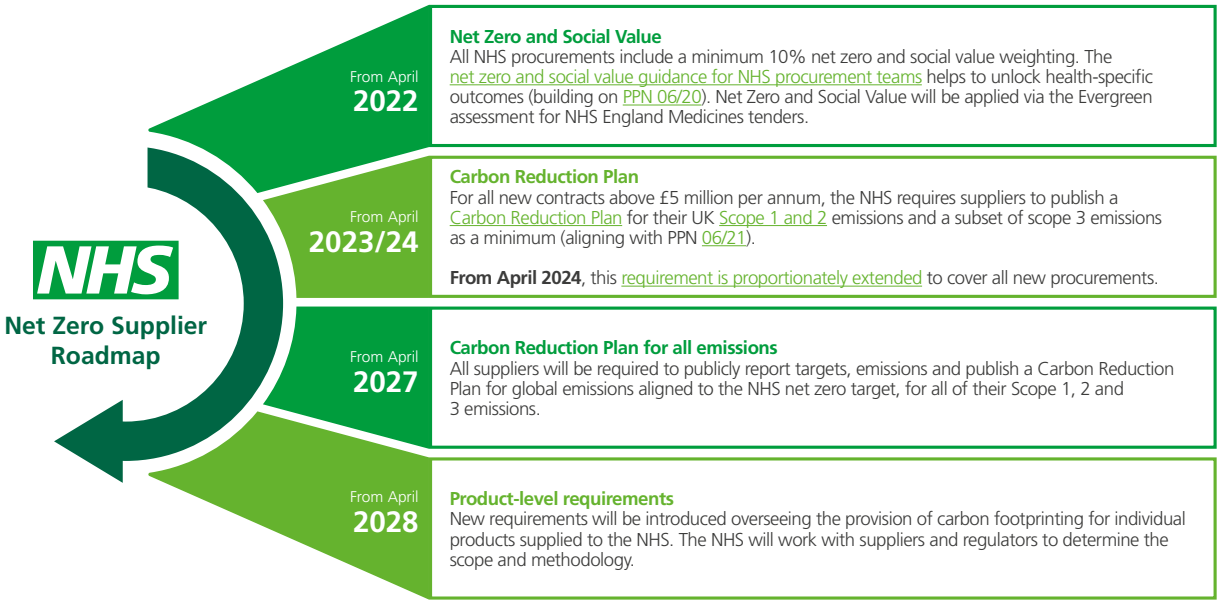
Actions
Review how we use the space in our buildings.
Review our estate to understand the minimum energy requirements for electricity, heating and cooling.
Undertake the Heat Decarbonisation Plan (HDP) and begin implementation.
Review our on-site resources for mechanical and electrical engineering efficiency improvements.
Continue to apply for External and Internal funding for building improvements.
Identify and implement Solar PV on our sites.
Create a set of scalable sustainability aims for all capital projects and major refurbishment.
Create a sustainable capital projects process to ensure sustainability is maximised on new builds and major refurbishments.
Work collaboratively with PFI partners on sustainability initiatives and opportunities.
Align to the Net Zero Estates Technical Annex Guidance.
Increase efficiency of boiler systems and reduce demand for 7% gas savings per year
Reduce Oil use by 4% per year
Reduce electricity consumption
Reduce waste tonnage by 7% per year

Metric

- Emissions from fossil-fuel-led heating sources.
- Percentage of gross internal area covered by LED lighting.

Procurement

Emissions from procurement are more than double those of our core carbon footprint – a trend consistent across the wider NHS. To address this, we are aligning with the NHS Net Zero Supplier Roadmap to reduce emissions associated with the goods and services we purchase.



We have adopted the first two Procurement Policy Notes (PPNs), focusing on Social Value and Carbon Reduction Planning.

From April 2024, all prospective suppliers are required to submit a Carbon Reduction Plan alongside their bids. From 2027, this requirement will extend to all existing suppliers, who must also publicly report their carbon reduction targets.

By April 2028, all products listed on the Shared Business Services catalogue will include a declared carbon footprint. While this will enhance reporting and transparency, we will also continue to explore more sustainable alternatives to commonly used items, such as single-use products and reusable PPE.

Actions
Review our largest suppliers to understand their carbon emissions due to our activities.
Identify our largest contributors to our carbon emissions, including goods and delivery options, and encourage them to share data to show their improvements.
Capture and quantify the sustainability improvements directly attributable to procurement.

Metric

- Inclusion of Carbon Reduction Plan and Net Zero Commitment requirements in all relevant procurements.
- Inclusion of requirements for a minimum 10% net zero and social value weighting in procurements, including defined KPIs.

Food and Nutrition

We are committed to providing food that is not only nutritious and high in quality, but also sustainably and ethically sourced.

Wherever possible, the Trust sources its catering supplies from British and Irish producers, with all beef products coming from Farm Assured British and Irish farms. All fish served is sustainably sourced, with wild-caught fish certified by the Marine Stewardship Council to ensure minimal environmental impact.

Our catering team operates a seasonal menu to promote sustainability, with a particular emphasis on fruit and vegetable-based options. In recent years, we have moved away from a standardised menu model to allow greater local variation and flexibility – an approach we are committed to developing further.

We are also actively working to reduce waste across our sites, including food waste.

Actions
Ensure that all single use plastics are removed from use.
Progress and promote healthy plant based menu options across our menus – in line with dieticians' advice.
Promote and educate around healthy food choices for patients, staff and the wider community.
Ensure that all contractors have their own carbon reduction plans when tendering their services for catering and waste.
Identify and review current food waste percentages with a goal of remaining below the guidance levels.

Metric

- Weight (tonnes) of food waste, with further break down by spoilage, production, unserved and plate waste.

Adaptation

Climate adaptation relates to actions that protect us against the impacts of climate change. This includes reacting to the changes we have seen already, as well as preparing for what will happen in the future.

Climate change threatens the ability of the NHS to deliver its essential services in both the near and longer term. Resilience and adaptation should be built into business continuity and longer-term planning to avoid climate-related service disruptions.

Our sites have local risk registers and business continuity plans which help them to keep their service running in the event of a disruption. These are reviewed and updated on an annual basis.

We have received guidance that providers of NHS services must comply with the adaptation provisions within the NHS Core Standards for emergency preparedness, resilience and response (EPRR) to support business continuity during adverse weather events. We are pleased to say that owing in no small part to the excellent work of our Emergency Planning team we fully meet the requirements of the NHS Core Standards and have done so for the last three years.

Actions
Implement a Climate Change Risk Assessment.
Align to Task Force on Climate-Related Financial Disclosures (TCFD) reporting guidance from the NHS (DHSC GAM).
Ensure all new Capital Projects incorporate Climate Change Risk Assessment & adaptation plans.
Identify the risks to service provision specifically from climate related events, and incorporate these within our risk register.

Metric

- Number of overheating occurrences triggering a risk assessment (in line with trust's "heatwave" plan).
- Number of flood occurrences triggering a risk assessment.

Governance

We have established a Climate Action Team (CAT), a Sustainable Development Steering Group (SDSG), and a Sustainable Development Operational Group (SDOG). These groups work collaboratively to drive sustainability across the Trust, support project delivery, and gather evidence to inform business cases.

This structure has enabled us to secure over £3 million in sustainability funding over the past five years, with several projects currently underway across our sites.

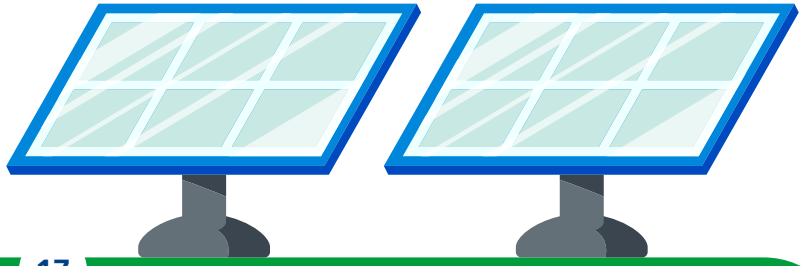
We also review our Green Plans annually to ensure that objectives remain on track and are being met.

Our Net Zero Board Lead, provides regular updates to the Board, and key progress highlights and risks are included in the Trust's annual report.

Actions
Receive feedback from the CAT, SDSG and SDOG on improvements to our Green Plan.
Review and develop Board Assurance Framework PR8 – relating to climate change.
Review Green Plan progress with the board annually for new actions and targets.
Identify KPIs for all areas, including NHS metrics and carbon emissions, that can be reported at least quarterly.

Metric

- Number of Board Assurance Framework document PR8 updates during the Financial Year.



2021-2026 Green Plan Action Updates

Green Plan 2021 actions which have been completed

Chapter	Key Actions	Status	Comments
Delivering Net Zero	Create relationships with recognised organisations	Green	Various initatives have taken place ensuring engagement with both public and private sector including Dr Bike, NHS Forest and numerous Healthcare Organisations
Communication	Develop a communications plan	Green	Developed
	Support the development of the CAPG and CATs	Green	Supported and now embedded
G1 Corporate Approach	Report Sustainability KPIs to the Board on a regular basis (at least 6 monthly)	Green	Sustainability Development Strategic Group reports on a quarterly basis
	Produce a Green Plan that is approved by Board	Green	Signed off by Trust Board in April 2021
	Assigned responsibility for the action plan points in the Green Plan	Green	All action plan points were assigned to Chapter Chairs in 2023
	Benchmark our performance/approach to sustainable development and social value with the rest of the NHS (via SDU)	Green	Regular benchmarking taken place withFutures NHS Energy and Waste dashboards as well as the yearly ERIC returns

2021-2026 Green Plan Action Updates

Chapter	Key Actions	Status	Comments
G2 Asset Management & Utilities	Develop plans to reduce our energy and water demand	Green	Plans developed and various submissions made throughout the past 4 years for both internal capital funds and external funding (eg NEEF)
	Create a measurement and validation process for future energy and water projects	Green	Implemented in 2023
	Buy green energy and assess the carbon benefits	Green	100% Green Electricity for SFH until 31/3/2023, joining the Crown Commercial Services contract in 2026 as requested by NHSE
	Utilise funding options outside capital for reducing energy and water usage	Green	PSDS £4m funding offered in 2023, NEEF3 £3m grant accepted for LED lighting, BMS upgrades & Submeters in 2025
G3 Travel & Logistics	Report our carbon emissions from travel and transport and show their reduction	Green	Travel and Transport emissions are reported via Greener NHS Fleet returns. Data demonstrates a decrease in Trust vehicle fuel purchases for 2023/24 and 2024/25. Staff business miles have decreased in the latest 2024/25 report.
	Implement electric vehicle charging points at our main sites	Green	Implemented at KMH & NH
G4 Adaptation	Designate a key lead responsible for coordination of climate change adaptation and resilience planning	Green	Key lead designated
	Update the Trust Risk register to include climate change effects	Green	Board Assurance Framework PR8

2021-2026 Green Plan Action Updates

Chapter	Key Actions	Status	Comments
G5 Capital Projects	Identify and appoint a Sustainable Capital project lead	Green	Head of Estate Development now in post 2025
	Deliver new buildings that are rated "Excellent" by BREEAM, and "Very Good" for major refurbishments	Green	BREEAM references are within both capital briefing documents and the Trust Energy Policy
G6 Green Space & Biodiversity	Provide green and natural areas on our estate even where land is constrained	Green	We have a variety of green outdoor spaces, ranging from wildlife & vegetable gardens, a pond, wildflower grass borders and green spaces within the building courtyards that have all been developed
	Engage staff and patients in food growing onsite or at home, and local sustainable food sourcing	Green	We have a vegetable garden at KMH as well as a local greengrocer selling fresh produce at KMH 3 times per week
	Work closely with local partners and stakeholders to plan, protect and promote the use of our local green spaces	Green	Undertake annual Bioblitz events and share knowledge within the ICS. Involvement with NHS Forests & Natural England plus shared feedback on Nottinghamshire County Council's Local Nature Recovery Strategy
	Provide staff with opportunities to engage in local volunteering activities in the maintenance of green spaces, biodiversity and food growing areas	Green	Advertise SFH Bioblitz event for colleagues to participate in during July each year, share information on tree planting events and how colleagues can volunteer in the vegetable garden

2021-2026 Green Plan Action Updates

Chapter	Key Actions	Status	Comments
G7 Sustainable Care Models	Include sustainability as a part of the quality of care we provide	Green	Sus QI projects have been implemented and this is a continuous cycle. Schemes have included Gloves Off, Healthier Meals, Coolsticks, Nitrous Oxide Reduction, Walking Aid Re-use Programmes and 'Pop the Entonox'
	Quantify the financial, economic, social and health benefits of some of our sustainable care models	Green	Projects often include a case study to demonstrate the environmental benefit and cost savings as well as post project evaluation
	Calculate the environmental and carbon impact of a specific care model to inform improvement plans	Green	Implemented
G8 Our People	Provide learning, development and training opportunities so that our workforce is highly aware of our organisation's sustainable development objectives	Green	Carbon Literacy training available to CAT & medical doctor trainees. Two Sustainability courses available via ESR for all employees to access from the Centre for Sustainable Healthcare
G9 Sustainable Use of Resources	Engage in dialogue with our key suppliers to encourage them to use resources sustainably in their own operations	Green	Working with NHS Supply Chain on Carbon Reduction Plan, Net Zero Commitment & New Supplier Roadmap.
	Support staff to minimise waste and expense at home	Green	Various initatives have taken place ensuring engagement with our staff including food initiative, recycling ideas, energy saving ideas
	Actively promote access to sustainable products to our staff and patients	Green	Various initatives have taken place ensuring engagement with our staff including events such as Dr Bike, ebikes, discounted travel, salary sacrifice offers, green initatives

2021-2026 Green Plan Action Updates

Green Plan 2021 actions which SFH have made progress with but not fully completed

Chapter	Key Actions	Status	Comments
G2 Asset Management & Utilities	Offer energy efficiency advice to patients, staff, carers and the local community	Amber	Advice offered internally but further work is required into the local community
G3 Travel & Logistics	Assess our transport and travel and calculate the carbon footprint for business, patient and staff transport	Amber	All areas assessed except patient transport which is on going
	Update and review our travel plan to create our board approved green travel plan	Amber	Travel Plan due in 2026
	Monitor the levels of working from home and e-medicine to reduce travel	Amber	Ad-hoc reviews are undertaken but regular monitoring is to be devleoped
	Introduce secure cycle parking, bike lock ups, showers, and lockers that are accessible to staff and visitors	Amber	Areas are available to staff but need to develop the visitor availability
G4 Adaptation	Create a board approved adaptation plan	Amber	Climate Change Adaptation working group in place – documents to be created
	Develop a Climate Change Risk Assessment (CCRA)	Amber	Climate Change Adaptation working group in place – documents to be created
G5 Capital Projects	Create a sustainable capital projects process to ensure sustainability is maximised on new builds and major refurbishments	Amber	Briefing document developed and due to be implemented
	Create a set of scalable sustainability aims for all capital projects and major refurbishment	Amber	Briefing document developed and due to be implemented

2021-2026 Green Plan Action Updates

Chapter	Key Actions	Status	Comments
G6 Green Space & Biodiversity	Create a board approved green space and biodiversity strategy	Amber	Green Space and Biodiversity Strategy due in 2026
G8 Our People	Provide information about the Trust's sustainability plans and objectives at induction	Amber	Not currently included, initiated discussions regarding sustainability information sharing at induction
	Add sustainability to our staff annual appraisals	Amber	Not currently included, initiated discussions regarding sustainability information sharing at induction
G9 Sustainable Use of Resources	Put in place initiatives to reduce overall material use in the products we buy and the services we deliver	Amber	Within procurement, packaging related initiatives with NHS supply chain are being built into tender documentation
G10 Carbon & Greenhouse Gases	Create a carbon reduction programme that is approved by the board and supported financially	Amber	Awaiting finalisation of Heat Decarbonisation Plan to influence future low carbon decision making

2021-2026 Green Plan Action Updates

Green Plan 2021 actions which were not started

Chapter	Key Actions	Status	Comments
Delivering Net Zero	Increase efficiency of boiler systems and reduce demand for 7% gas savings per year	Red	Gas consumption increasing YOY since 2021, plans to look to reduce as part of investments
	Reduce Oil use by 4% per year	Red	Red Diesel consumption increasing 58% in 2022/23 then declining 11% in 2023/24 & 22% decline in 2024/25 (mainly due to TRIADS)
	Continue to reduce electricity consumption	Red	Electricity consumption increased since 2021/22 although NEEF funding will see a dramatric reduction from 2026
	Reduce waste tonnage by 7% per year	Red	Not reducing significantly (8% reduction 2024/25 compared with previous year) but tonnages are similar to original 2021/22 data (1% reduction), plans to look to reduce

2021-2026 Green Plan Action Updates

Green Plan 2021 actions which were superseded by updated guidance, or are now being addressed at a national level

Chapter	Key Actions	Status	Comments
Delivering Net Zero	Incorporate offsetting into our green spaces strategy	N/A	Superseded
G5 Capital Projects	Design our capital projects and major refurbishments to be usable during future projected weather profiles such as extreme heat	N/A	Superseded
	Design our capital projects and major refurbishments to be usable during future projected weather profiles such as extreme heat	N/A	Superseded
G7 Sustainable Care Models	Publicise International Health Partnership schemes such as THET to clinical staff	N/A	Superseded
G8 Our People	Reduce sickness absences and conduct staff health and wellbeing surveys to show our workforce wellbeing is improving	N/A	Superseded
G10 Carbon & Greenhouse Gases	Set new carbon targets for all carbon hotspots including energy, travel and goods	N/A	Superseded
	Estimate the carbon emissions of our procurement to identify areas for targeted action	N/A	Superseded
	Invite our providers and suppliers to share their carbon and environmental impacts with us and support them to reduce	N/A	Superseded

Glossary

Adaptation – Climate adaptation relates to actions that protect us against the impacts of climate change. This includes reacting to the changes we have seen already, as well as preparing for what will happen in the future.

BAF – Board Assurance Framework

BMS – Building Management System

BREEAM - Building Research Establishment Environmental Assessment Method

CAT – Climate Action Team

CAPG – Climate Action Project Group

DHSC GAM – The Department of Health and Social Care (DHSC) group accounting manual (GAM)

E&F – Estates & Facilities

ED – Emergency Department

EPRR – Emergency Preparedness, Resilience and Response

EPS – Electronic Prescription Service

ESR – Electronic Staff Record

EV – Electric Vehicle

FM – Facilities Management

HDP – Heat Decarbonisation Plan

HVAC – Heating, Ventilation, and Air Conditioning

ICB – Integrated Care Board

ICS – Integrated Care System

IT – Information Technology

KMH – Kings Mill Hospital

KPI – Key Performance Indicators

LED – Light-Emitting Diode

MDI – Metered Dose Inhalers

NEEF – National Energy Efficiency Fund

NH – Newark Hospital

NHS – National Health Service

NHSE – National Health Service England

PFI – Private Finance Initiative

PPE – Personal Protective Equipment

PPNs – Procurement Policy Notes

PR8 – Principal Risk 8

RCEM – Royal College of Emergency Medicine

Scope 1 – Scope 1 refers to direct greenhouse gas (GHG) emissions that a company generates from sources it owns or controls. Examples include emissions from on-site fuel combustion (like in boilers), process emissions from industrial activities, and emissions from company-owned vehicles. It also includes fugitive emissions, such as refrigerant leaks.

Scope 2 – Scope 2 refers to indirect greenhouse gas (GHG) emissions from the generation of purchased energy, such as electricity, steam, heat, or cooling.

Scope 3 – Scope 3 refers to all indirect greenhouse gas (GHG) emissions that are a consequence of a company's activities but occur from sources not owned or controlled by the company.

SDOG – Sustainable Development Operational Group

SDSG – Sustainable Development Strategy Group

Solar PV – Solar Photovoltaic refers to systems that use solar panels to convert sunlight directly into electricity

TCFD – Task Force on Climate-related Financial Disclosure

THET – Tropical Health and Education Trust

SFH – Sherwood Forest Hospitals NHS Foundation Trust

Sus QI – Sustainability in Quality Improvement

ULEV – Ultra-Low Emission Vehicle

WG – Working Group

YOY – Year On Year

ZEV – Zero Emission Vehicle


NHS
EMERGENCY AMBULANCE

Outstanding Care, Compassionate People, Healthier Communities

Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Integrated Performance Report – To October 2025	**Date:**	4th December 2025
Prepared By:	Domain leads and Mark Bolton, Associate Director of Operational Performance		
Approved By:	Domains approved by lead Executive		
Presented By:	Domains to be presented by lead Executive		

Purpose		
To provide assurance to Trust Board regarding the performance of the Trust as measured in the Integrated Performance Report (IPR).	**Approval**	
	Assurance	✓
	Update	
	Consider	

Strategic Objectives					
Provide outstanding care in the best place at the right time	Empower and support our people to be the best they can be	Improve health and wellbeing within our communities	Continuously learn and improve	Sustainable use of resources and estates	Work collaboratively with partners in the community
✓	✓	✓	✓	✓	

Principal Risk		
PR1	Significant deterioration in standards of safety and care	✓
PR2	Demand that overwhelms capacity	✓
PR3	Critical shortage of workforce capacity and capability	✓
PR4	Insufficient financial resources available to support the delivery of services	✓
PR5	Inability to initiate and implement evidence-based Improvement and innovation	
PR6	Working more closely with local health and care partners does not fully deliver the required benefits	
PR7	Major disruptive incident	
PR8	Failure to deliver sustainable reductions in the Trust's impact on climate change	

Committees/groups where this item has been presented before

Domain reports have been considered by the appropriate Trust Board sub-committee.
The full report was approved by Trust Management Team on 26 November 2025.

Acronyms

All acronyms are defined within the paper.

Executive Summary

The Integrated Performance Report (IPR) provides the Board with assurance regarding the performance of the Trust in respect of the indicators allocated under the following domains: Quality of Care, People and Culture, Timely Care and Best Value Care. Key activity metrics are provided as context to support all domains.

This report covers performance to October 2025. Performance indicators are marked as 'met' or 'not met' using a green tick and red cross respectively where a standard or plan value exists. The main report includes domain summaries that provide the opportunity to celebrate successes and identify areas of challenge. The indicators in focus pages provide an overview against each underperforming indicator together with details of the root causes and actions being taken to improve performance.

The integrated scorecard is included at the start of the report and in appendix A. Appendix A also includes graphs for each indicator that identify trends over a two-year period and the plan or standard for the rest of 2025/26. Appendix B contains benchmarking data for the timely care domain to show our performance relative to other Trusts in England.

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

During September and October 2025, the Trust faced sustained operational pressures, particularly across urgent and emergency care, with emergency access four-hour performance falling below 70% and increasing delays in patient flow. Quality of Care saw four off-track metrics, including rising clostridioides difficile infections and Venous Thromboembolism (VTE) risk assessment compliance challenges. Positive outcomes included zero MRSA bacteraemia, strong gram-negative performance, and zero never events. Eight of thirteen people and culture metrics were on track in the latest period with reduced bank and agency (over price cap) usage. However, sickness absence remains above target, reflecting national trends. Planned care performance deteriorated against referral to treatment 18-week performance standards, with enhanced scrutiny on recovery plans. Financially, the Trust reported a £5.66m year-to-date deficit, driven by cost improvement programme underperformance and industrial action, however, forecasts remain aligned to the break-even plan.

There were five reported metrics triggering special cause variation in Sep-25 or Oct-25. These were all displaying performance challenges and include:

- Turnover in month with the Oct-25 position above the upper control limit.
- Ambulance turnaround 30-minute performance being below the lower control limit.
- Emergency Department 12-hour length of stay performance remaining above the upper control limit for the third consecutive month in Oct-25.
- The number of inpatients medically safe for transfer for greater than 24 hours was above the upper control limit in Aug-25 and Sep-25. This has reduced to fall back within control limits in Oct-25; however, levels remain elevated.
- 18-week referral to treatment performance fell below the lower control limit in Oct-25.

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

Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Sherwood Forest Hospitals

Integrated Performance Report

Reporting Period: To October 2025

Outstanding Care, Compassionate People, Healthier Communities

Integrated Scorecard

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

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

The graphs present monthly data typically from Apr-22. Where appropriate, the graphs are statistical process control (SPC) charts.

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

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

Integrated Report

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

Category	At a Glance	NOF	Indicator	2024/25 Standard	2025/26 Standard	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	2024/25 Final	2025/26 YTD	STAR Data Quality Assurance S	T	A	R
Quality of Care	Safe		Rate of inpatients to suffer a new hip fracture	n/a	No Standard	2.4	2.6	2.1	1.7	2.6	1.9	2.4	2.2	1.7	2.3		2.1				
			Never events	0	0	✓ 0	✓ 0	✓ 0	✓ 0	✗ 1	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✗ 2	✗ 1				
		✓	MRSA reported in month	0	0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✗ 1	✗ 1	✓ 0	✓ 0	✗ 1	✗ 2				
		✓	Cdifficile (hospital-acquired) reported in month	≤13 qtr	4	4	5	5	✗ 7	✗ 5	✗ 6	✗ 6	✗ 7	✗ 7	✗ 9	✗ 55	✗ 47				
		✓	Number of gram-negative bloodstream infections reported in month	n/a	8	5	1	5	✓ 6	✓ 3	✓ 6	✓ 4	✓ 3	✓ 5	✓ 3	50	✓ 30				
			HAPU (cat 2) per 1000 occupied bed days with a lapse in care	No Standard	No Standard	0.1	0.2	0.0	0.1	0.2	0.0	0.0	0.0	0.1	0.1	0.1	0.1				
			HAPU (cat 3/4) and ungradable pressure ulcers with lapse in care	0	0	✗ 1	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✗ 1	✓ 0	✗ 1	✗ 6	✗ 2				
			Patient Safety Incident Investigations (PSII) and Duty of Candour	No Standard	No Standard	2	1	0	5	13	10	2	11	10	9	17	60				
			Percentage of inpatient Service Users undergoing risk assessment for VTE	≥95%	≥95%	✗ 84.1%	✗ 85.1%	✗ 89.6%	✗ 90.5%	✗ 89.7%	✗ 89.4%	✗ 88.0%	✗ 85.3%	✗ 89.5%	✗ 85.9%		✗ 88.3%				
	Caring		Complaints per 1000 occupied bed days	≤1.9	≤1.9	✓ 1.4	✓ 0.7	✓ 0.8	✓ 1.3	✓ 1.3	✓ 1.6	✓ 1.7	✓ 1.2	✓ 1.3	✓ 1.4	✓ 0.9	✓ 1.4				
			Compliments received in month	No Standard	No Standard	140	152	184	155	115	141	157	109	137	98	1831	912				
	Effective	✓	SHMI	As Expected	As Expected	✓ 106	✓ 106	✓ 107	✓ 106	✓ 105	✓ 106	✓ 106	✓ 107	✓ 107	✓ 106	✓ 107	✓ 107				
			Still birth rate	≤4.4	≤4.4	✓ 3.5	✗ 15.5	✓ 0.0	✓ 3.6	✓ 3.2	✓ 3.6	✗ 7.1	✗ 10.0	✗ 10.2	✓ 3.4	✓ 4.3	✗ 5.9				
			Early neonatal deaths per 1000 live births	≤1	≤1	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.3	✓ 0.0				
People and Culture	Belonging in the NHS	✓	Engagement score	≥6.8%	≥6.9%			✓ 7.1			✓ 6.8					✓ 7.1	✓ 6.8				
	Growing the Future		Vacancy rate	≤8.5%	≤8.5%	✓ 7.8%	✓ 7.7%	✓ 7.7%	✗ 9.3%	✗ 9.5%	✗ 9.7%	✗ 9.1%	✓ 8.4%	✓ 8.0%	✓ 7.9%	✓ 8.0%	✗ 8.8%				
			Time to hire	n/a	≤53.1 days	✓ 49.0	✓ 34.0	✓ 27.0	✓ 23.0	✓ 21.0	✓ 29.0	✓ 29.0	✓ 28.0	✓ 25.0	✓ 36.0		✓ 29.2				
			Turnover in month	≤0.9%	≤0.9%	✓ 0.5%	✓ 0.4%	✓ 0.7%	✓ 0.6%	✓ 0.5%	✓ 0.5%	✓ 0.5%	✓ 0.5%	✓ 0.8%	✗ 1.0%	✓ 0.7%	✓ 0.6%				
			Appraisals	≥90%	≥90%	✗ 88.4%	✗ 88.2%	✓ 90.0%	✓ 90.0%	✗ 90.0%	✗ 88.7%	✗ 87.4%	✗ 88.0%	✗ 88.2%	✗ 87.5%	✗ 89.0%	✗ 88.6%				
			Mandatory & statutory training	≥90%	≥90%	✓ 92.4%	✓ 92.8%	✓ 92.9%	✓ 92.2%	✓ 93.1%	✓ 93.1%	✓ 93.2%	✓ 92.9%	✓ 92.9%	✓ 93.3%	✓ 91.5%	✓ 93.0%				
			Medical job plan compliance	n/a	≥95%	✗ 57.0%	✗ 86.1%	✗ 76.1%	✗ 50.6%	✗ 70.4%	✗ 71.3%	✗ 79.6%	✗ 91.4%	✗ 94.0%	✓ 95.9%		✗ 79.7%				
	Looking after our People	✓	Sickness absence	≤4.2%	≤4.2%	✗ 5.9%	✗ 5.0%	✗ 4.6%	✗ 4.9%	✗ 4.8%	✗ 5.1%	✗ 5.0%	✗ 4.8%	✗ 4.8%	✗ 5.7%	✗ 5.0%	✗ 5.0%				
			Flu vaccinations uptake (front line staff)	≥75%	≥75%	✗ 47.7%	✗ 47.8%	-	-	-	-	-	-	-	✗ 35.8%	✗ 58.0%					
			Employee relations management	<17	<21	✗ 20	✗ 25	✗ 31	✗ 23	✓ 18	✗ 23	✓ 18	✓ 18	✓ 20	✗ 21	✗ 21	✓ 20				
	New Ways of Working		Bank usage	≤8.5%	≤7.8%	✗ 9.7%	✓ 8.0%	✗ 8.8%	✓ 6.3%	✓ 6.4%	✓ 5.9%	✓ 6.8%	✓ 7.1%	✓ 5.1%	✓ 4.8%	✗ 8.9%	✓ 6.1%				
			Agency usage	<3.2%	<1.9%	✗ 3.6%	✗ 3.8%	✗ 3.5%	✗ 2.5%	✓ 2.9%	✓ 3.5%	✓ 2.6%	✗ 2.6%	✗ 2.3%	✗ 2.6%	✗ 4.0%	✗ 2.7%				
			Agency (off framework)	0.0%	0.0%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✗ 0.01%	✓ 0.0%				
			Agency (over price cap)	≤40.0%	≤40.0%	✗ 46.0%	✗ 47.3%	✗ 61.5%	✓ 38.7%	✓ 36.8%	✓ 38.3%	✗ 40.2%	✓ 36.1%	✗ 40.9%	✓ 33.4%	✗ 52.9%	✓ 37.8%				
Timely Care	Urgent Care		Ambulance turnaround times <30 mins	≥95%	≥95%	✗ 86.3%	✗ 86.3%	✗ 89.0%	✗ 92.1%	✗ 90.8%	✗ 90.5%	✗ 86.0%	✗ 85.0%	✗ 82.3%	✗ 76.2%	✗ 91.4%	✗ 86.1%				
			Ambulance turnaround times >60 mins	0.0%	0.0%	✗ 1.4%	✗ 1.2%	✗ 0.8%	✗ 0.6%	✗ 0.5%	✗ 0.2%	✗ 0.7%	✗ 1.2%	✗ 2.5%	✗ 3.7%	✗ 0.7%	✗ 1.4%				
		✓	ED 4-hour performance	≥76%	≥Plan	✗ 65.3%	✗ 68.2%	✗ 75.2%	✓ 77.3%	✓ 79.0%	✓ 76.8%	✗ 72.4%	✗ 68.8%	✗ 68.0%	✗ 67.4%	✗ 71.0%	✗ 72.8%				
		✓	ED 12-hour length of stay performance	≤2%	≤2024/25	✗ 5.5%	✗ 4.2%	✓ 1.7%	✓ 2.1%	✓ 1.7%	✓ 1.8%	✓ 2.8%	✗ 6.1%	✗ 5.6%	✗ 8.2%	✗ 3.4%	✗ 4.0%				
			Mental health patients spending over 12 hours in A&E	n/a	No Standard	31	26	19	18	21	19	22	24	23	27	23	154				
			Adult G&A bed occupancy	≤92%	≤92%	✗ 96.1%	✗ 94.4%	✗ 94.0%	✗ 94.6%	✗ 95.2%	✗ 95.5%	✗ 96.2%	✗ 95.9%	✗ 96.3%	✗ 96.5%	✗ 94.5%	✗ 95.7%				
		✓	Average number of days between planned and actual discharge date	n/a	≤Plan	2.9	2.7	3.1	✓ 3.3	✓ 3.2	✗ 4.3	✗ 4.1	✗ 3.8	✓ 3.4	✓ 3.0		✓ 3.6				
			Inpatients medically safe for transfer for greater than 24 hours	≤40	≤40	✗ 65	✗ 48	✗ 50	✗ 53	✗ 51	✗ 68	✗ 79	✗ 87	✗ 82	✗ 72	✗ 64	✗ 70				
	Electives		Added to Patient Initiated Follow Up (PIFU) pathway	≥5%	≥5%	✓ 5.3%	✓ 9.6%	✓ 9.9%	✓ 11.1%	✓ 10.7%	✓ 10.5%	✓ 10.7%	✓ 10.9%	✓ 11.2%	✓ 11.3%	✓ 6.0%	✓ 10.9%				
		✓	Percentage of incomplete Referral to Treatment (RTT) pathways completed in less than 18 weeks	n/a	≥Plan	63.3%	63.5%	64.6%	✗ 63.7%	✗ 64.0%	✗ 64.1%	✗ 62.9%	✗ 61.3%	✗ 61.9%	✗ 60.4%		✗ 62.6%				
		✓	Percentage of RTT waits over 52 weeks for incomplete pathways	n/a	≤Plan	1.8%	1.6%	1.3%	✓ 1.3%	✓ 1.2%	✓ 1.1%	✓ 1.1%	✓ 1.0%	✓ 0.9%	✓ 0.9%		✗ 1.1%				
	Diagnostics		Diagnostic DM01 performance under 6-weeks	≥Plan	≥Plan	✓ 88.7%	✓ 94.4%	✓ 93.1%	✗ 88.9%	✗ 87.1%	✗ 88.2%	✗ 87.9%	✗ 87.6%	✗ 89.8%	✗ 90.4%	✓ 93.1%	✗ 90.4%				
	Cancer	✓	Cancer 28-day faster diagnosis standard	≥75%	≥Plan	✗ 71.6%	✓ 79.7%	✓ 78.0%	✓ 77.6%	✓ 76.4%	✓ 82.4%	✓ 83.1%	✓ 82.3%	✓ 80.7%		✓ 78.3%	✓ 80.5%				
			Cancer 31-day treatment performance	≥Plan	≥96%	✗ 86.9%	✓ 96.1%	✓ 95.4%	✗ 87.6%	✗ 94.4%	✗ 91.2%	✗ 89.0%	✗ 84.8%	✗ 88.4%		✓ 91.9%	✗ 89.3%				
		✓	Cancer 62-day treatment performance	≥Plan	≥Plan	✗ 55.0%	✗ 66.9%	✗ 55.1%	✓ 65.5%	✓ 63.3%	✓ 65.3%	✓ 66.9%	✓ 72.4%	✓ 63.1%		✗ 64.4%	✓ 66.0%				
Best Value Care	Financial Performance	✓	Financial surplus / deficit	n/a	≥£0.00m				✗ -£0.90	✗ -£0.70	✗ -£0.20	✓ £0.10	✓ £0.02	✗ -£1.62	✗ -£2.37		✗ £5.67				
		✓	Variance YTD to financial plan	≥£0.00m	≥£0.00m	✗ -£2.68	✗ -£2.60	✓ £7.14	✓ £0.00	✓ £0.00	✓ £0.00	✗ -£0.40	✗ -£0.58	✗ -£2.08	✗ -£2.95	✓ £0.01	✗ £6.01				
	Efficiency		Financial efficiency variance YTD to plan	≥£0.00m	≥£0.00m	✓ £0.26	✗ -£0.04	✓ £0.15	✗ -£0.81	✗ -£0.72	✗ -£1.30	✗ -£0.83	✗ -£0.48	✗ -£2.81	✗ -£1.83	✓ £0.08	✗ £8.78				
			Risk adjusted efficiency forecast to plan (%)	n/a	100%				✗ 46.5%	✗ 55.0%	✗ 56.6%	✗ 65.0%	✗ 68.0%	✗ 74.0%	✗ 81.0%		-				
	Variable Pay		Reported agency expenditure	No Standard	No Standard	£1.03	£1.05	£1.00	£0.75	£0.87	£1.01	£0.78	£0.78	£0.69	£0.77	£13.70	£5.65				
			Reported bank expenditure	No Standard	No Standard	£2.81	£2.22	£2.51	£1.88	£1.90	£1.70	£2.09	£2.12	£1.57	£1.43	£30.55	£12.69				
	Rate of Productivity	✓	Implied productivity growth (YTD compared to last year)	£0.03m	2.0%	✓ 3.3%	✓ 4.3%	✓ 3.1%	✗ 0.9%	✓ 3.8%	✓ 5.0%	✓ 4.2%	-	-	-		-				
	Cash & Liquidity		BPPC - Number of bills paid within target	n/a	≥95%				✗ 24.7%	✗ 33.5%	✗ 62.6%	✗ 76.6%	✗ 87.2%	✗ 87.5%	✗ 83.9%		✗ 66.0%				
			BPPC - Value of bills paid within target	n/a	≥95%				✗ 69.2%	✗ 75.2%	✗ 69.3%	✗ 73.3%	✗ 93.9%	✗ 91.6%	✗ 90.6%		✗ 80.5%				
			Operating expenditure days	n/a	≥5				✓ 16	✓ 16	✓ 13	✓ 10	✓ 10	✓ 6	✓ 5		✓ 11				
	Capital		Capital expenditure against plan	≤£33.61m	≤£0.00m	£2.43	£1.62	£18.40	✗ £0.35	✗ £1.10	✗ £0.44	✗ £0.78	✗ £1.07	✗ £0.85	✗ £1.36	✓ £33.58	✗ £5.94				
Activity (for context)	Urgent Care		A&E attendances (inc. PC24)			515	543	582	552	562	577	582	530	550	561	547	559				
			Non-elective admissions			142	150	146	139	139	140	147	138	148	157	145	144				
	Electives		Average daily elective referrals			346	362	330	326	325	352	365	307	354	354	341	340				
			Outpatients - first appointment			327	339	323	318	308	335	352	281	367	331	347	327				
			Outpatients - follow up			875	907	855	849	802	853	907	748	899	831	852	841				
			Outpatients - procedures			287	278	254	257	254	267	293	247	282	269	265	267				
			Day case			127	126	116	114	116	123	126	114	121	128	122	120				
			Elective inpatient			12	13	13	13	14	15	15	14	13	14	14	14				
	Diagnostics		Diagnostics			496	518	490	476	464	477	494	461	478	488	479	477				

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Quality of Care

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Scorecard: Quality of Care

Quality of Care

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

At a Glance	Indicator	2024/25 Standard	2025/26 Standard	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	2024/25 Final	2025/26 YTD	STAR Data Quality Assurance S	T	A	R
Safe	Rate of inpatients to suffer a new hip fracture	n/a	No Standard	2.4	2.6	2.1	1.7	2.6	1.9	2.4	2.2	1.7	2.3		2.1				
	Never events	0	0	✓ 0	✓ 0	✓ 0	✓ 0	✗ 1	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✗ 2	✗ 1				
	MRSA reported in month	0	0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✗ 1	✗ 1	✓ 0	✓ 0	✗ 1	✗ 2				
	Cdifficile (hospital-acquired) reported in month	≤13 qtr	4	4	5	5	✗ 7	✗ 5	✗ 6	✗ 6	✗ 7	✗ 7	✗ 9	✗ 55	✗ 47				
	Number of gram-negative bloodstream infections reported in month	n/a	8	5	1	5	✓ 6	✓ 3	✓ 6	✓ 4	✓ 3	✓ 5	✓ 3	50	✓ 30				
	HAPU (cat 2) per 1000 occupied bed days with a lapse in care	No Standard	No Standard	0.1	0.2	0.0	0.1	0.2	0.0	0.0	0.0	0.1	0.1	0.1	0.1				
	HAPU (cat 3/4) and ungradable pressure ulcers with lapse in care	0	0	✗ 1	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✗ 1	✓ 0	✗ 1	✗ 6	✗ 2				
	Patient Safety Incident Investigations (PSII) and Duty of Candour	No Standard	No Standard	2	1	0	5	13	10	2	11	10	9	17	60				
	Percentage of inpatient Service Users undergoing risk assessment for VTE	≥95%	≥95%	✗ 84.1%	✗ 85.1%	✗ 89.6%	✗ 90.5%	✗ 89.7%	✗ 89.4%	✗ 88.0%	✗ 85.3%	✗ 89.5%	✗ 85.9%		✗ 88.3%				
Caring	Complaints per 1000 occupied bed days	≤1.9	≤1.9	✓ 1.4	✓ 0.7	✓ 0.8	✓ 1.3	✓ 1.3	✓ 1.6	✓ 1.7	✓ 1.2	✓ 1.3	✓ 1.4	✓ 0.9	✓ 1.4				
	Compliments received in month	No Standard	No Standard	140	152	184	155	115	141	157	109	137	98	1831	912				
Effective	SHMI	As Expected	As Expected	✓ 106	✓ 106	✓ 107	✓ 106	✓ 105	✓ 106	✓ 106	✓ 107	✓ 107	✓ 106	✓ 107	✓ 107				
	Still birth rate	≤4.4	≤4.4	✓ 3.5	✗ 15.5	✓ 0.0	✓ 3.6	✓ 3.2	✓ 3.6	✗ 7.1	✗ 10.0	✗ 10.2	✓ 3.4	✓ 4.3	✗ 5.9				
	Early neonatal deaths per 1000 live births	≤1	≤1	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.3	✓ 0.0				

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Domain Summary: Quality of Care

NHS
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Overview	Lead: Executive Chief Nurse/Chief Medical Officer

During Sep-25 and Oct-25, our hospitals have continued to experience busy periods with urgent and emergency care pathways feeling highly pressured. The Trust has often been in escalation and using surge capacity.

Within the Quality of Care domain, there were four off-track metrics during Sep-25 and Oct-25:

- **Clostridioides difficile (C. diff):** During Sep-25 and Oct-25 we have reported 16 hospital onset, hospital acquired (HOHA) and four community onset, hospital acquired (COHA) infections. We have continued to observe an increase in our rates compared to the same period last year. This is something that is being observed across the region and nationally. Following the NHS England Midlands Infection Prevention Control (IPC) C. diff focus review visit on 11 Sep-25, a sustained and comprehensive programme of staff engagement and environmental review has been implemented, led by matrons and overseen by the divisional triumvirates. On 13 Nov-25, a peer review was conducted by the Governance Support Unit, which identified significant improvements had been made. The findings from this review will be reported to the IPC Committee to provide assurance.
- **Hospital Acquired Pressure Ulcer (HAPU) - Cat 3 / 4:** One avoidable category three heel pressure ulcer following elective surgery. Division are reporting progress against actions at summits (held at quarterly intervals) chaired by the Director of Nursing.
- **Percentage of inpatient service users undergoing risk assessment for Venous Thromboembolism (VTE):** Year-to-date compliance with inpatient VTE risk assessment is 88.3%. The Patient Safety Committee has held robust discussions, and a multi-divisional task and finish group has been rapidly established to:
    - Review the current VTE risk assessment process
    - Evaluate the effectiveness of existing actions
    - Identify further measures to improve compliance.

  Although performance improved in Sep-25 (89.5%), this was not sustained in Oct-25 (85.9%), prompting divisions to develop and amend recovery plans targeting key areas of concern.
- **Still birth rate:** During Sep-25 and Oct-25 we reported four cases of antenatal stillbirth. Each case received an individual review and has been reported through the Perinatal Mortality Review Tool (PMRT) and Maternity and Newborn Safety Investigations (MNSI) process, where they will receive a further review. All cases were reported within the Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE) recommended timescales.

We saw strong performance across several key metrics. In Sep-25 and Oct-25 there were zero MRSA bacteraemia, recovering from the instances we saw in Jul-25 and Aug-25. Benchmarking against our peer organisations indicates there has been an increase in cases both regionally and nationally. For gram-negative bacteraemia we remain on track. We are in a strong position for Ecoli and close to our trajectory for both Klebsiella and Pseudomonas cases. Benchmarking against our peers indicates that we remain one of the three Trusts with the lowest numbers. We reported zero Never Events during this reporting period. One Patient Safety Incident Investigation (PSII) was commissioned in Oct-25 by the Patient Safety Incident Response Group (PSIRG). Summary Hospital-level Mortality Indicator (SHMI) remains as expected.

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

Indicator in Focus: Infection Prevention and Control

Sherwood Forest Hospitals NHS Foundation Trust

Performance observations

The national trajectories for healthcare-associated infections have been published, with the following annual targets:

- Clostridioides difficile (C diff): 65 cases - year to date (YTD) 57 cases
- Ecoli: 80 cases - YTD 44 cases
- Klebsiella: 15 cases - YTD 12 cases
- Pseudomonas: 9 cases - YTD 8 cases
- MRSA: 0 cases - YTD 3

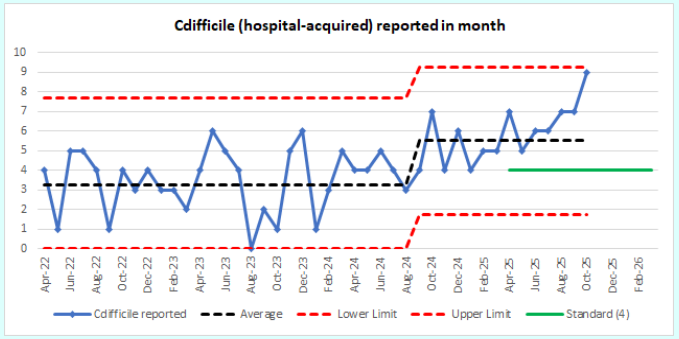
During Sep-25 and Oct-25, for C. diff we have had 16 HOHA and four COHA infections. We have continued to observe an increase in our rates compared to the same period last year. This is something that is being observed across the region and nationally.

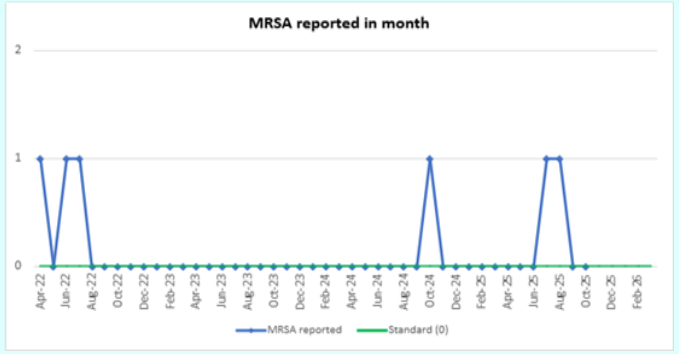
For MRSA bacteraemia we have had zero HOHA in Sep-25 and Oct-25. When considering benchmarking against our peer organisations, there has been an increase in cases both regionally and nationally.

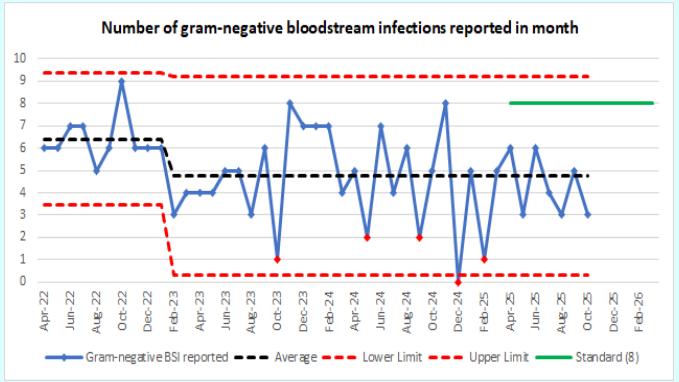
For gram-negative bacteraemia we are currently in a good position for Ecoli, although we are close to our trajectory for both Klebsiella and Pseudomonas cases and when benchmarking against our peers, we remain one of the three Trusts with the lowest numbers.

Root causes	Actions and timescale	Impact
Increase in our rates of C. Diff	NHS England onsite review undertaken in Sep-25 with recommendations following observations and discussions with team members.	Improve patient environment.
	Improve environmental and patient equipment cleanliness with weekly Matron review of all areas.	Improve patient environment and reduce cross infection.
	Changes to Medirest pathway cleaning program.	
	Improve compliance with Personal Protective Equipment (PPE) and uniform policy.	Promote knowledge and improve practice.
	Improve antimicrobial stewardship, work being undertaken within Nervecentre to support this.	Improve compliance with antimicrobial guidelines.
	Training sessions for Matrons/Senior Clinical Leaders and IPC team from NHS England.	Promote knowledge and improve practice.

Data







Indicator in Focus: Hospital Acquired Pressure Ulcers (HAPU)

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Overview and national position

Pressure ulcers are in the 'top 10 harms' to patients (NHS England, 2024). Although there is no longer a national recommendation for identifying avoidable/unavoidable pressure damage, our position is that all Trust acquired pressure ulcers are investigated to identify learning.

Pressure ulcers are categorised as 'avoidable' where learning is identified or there is a lapse in care. We remain on track for hospital acquired (category two) pressure ulcers per 1,000 occupied bed days.

For the period Sep-25 to Oct-25, SFH reported one avoidable category three heel pressure ulcer on a gentleman with multiple comorbidities who had elective surgery. The incident investigation revealed lapses in recognising his comorbidities as contributory factors to increased risk of pressure damage, and lapses in providing appropriate pressure relieving equipment as a preventative action.

Initial planned timescale for actions below to be completed by 30 Nov-25. Current auditing of the ward involved has already demonstrated good standards of documentation for pressure ulcer prevention since the incident.

Root causes	Actions and timescale	Impact
Lapses in recognising comorbidities as risk factors for pressure ulceration / lapses in skin checks and recognising early skin changes.	Increase in monitoring, auditing by ward senior team and Tissue Viability Nurses (TVNs). Ward based training from senior team and TVNs to provide further support with Nervecentre records. Spot checks to be carried out by senior ward team specifically on patients with comorbidities and increased risk of pressure ulcers Incident will be incorporated into Tissue Viability training updates to share learning.	Reduce likelihood for similar incidents; improve knowledge of team in recognising comorbidities as risks for pressure ulcer development. Improve quality of skin checks.

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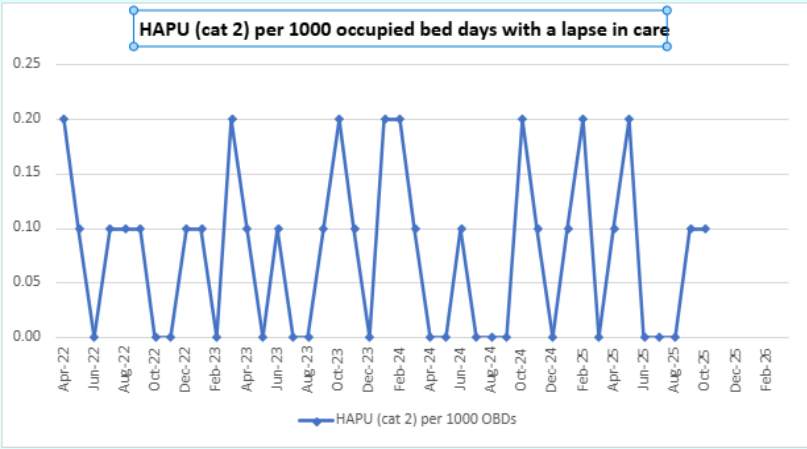

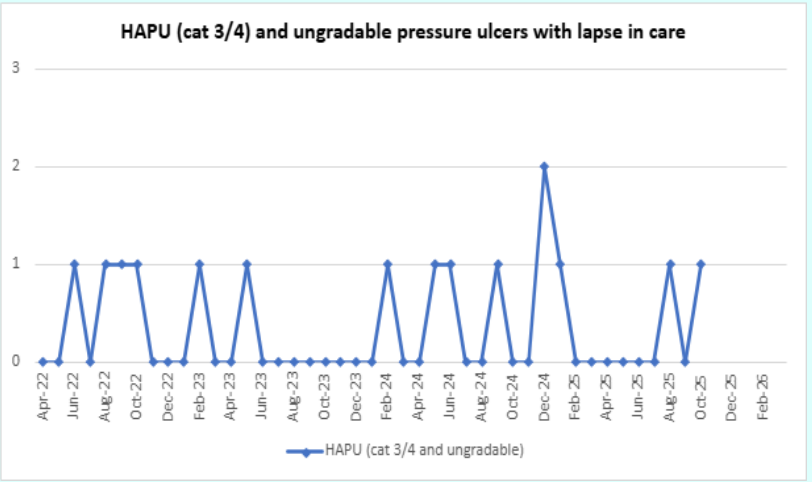

Indicator in Focus: Patient Safety Incident Investigations (PSII)

Sherwood Forest Hospitals NHS Foundation Trust

Overview and national position

In line with SFH's Patient Safety Incident Response Plan, one PSII was commissioned (Oct-25) by the Patient Safety Incident Response Group (PSIRG) following in-depth discussion during which the Integrated Care Board (ICB) were present. Three reportable incidents to Maternity and Newborn Safety Investigations (MNSIs) were identified, three in Sep-25, one in Oct-25, all relating to Intrauterine Fetal Demise (IUFD).

PSII with potential coronial interest	MSNI investigation	Never Events
None commissioned.	Three commissioned	None reported in Sep-25 and Oct-25

Two after-action reviews were commissioned in Sep-25:

- A near-miss never event regarding a blood transfusion within the Emergency Department was presented, and key stakeholders met the same day to agree and implement immediate learning. An after-action review has been commissioned to review the incident and blood administration process in greater detail.
- A seven-week post-partum patient with a complex medical history was found to have a subarachnoid haemorrhage and cerebral vasospasm consistent with reversible cerebral vasoconstriction syndrome prior to her death. Due to concerns with potential delays in care, a review has been commissioned.

During Sep-25, one PSII (maxillofacial patient with a delayed diagnosis) was signed off. The key learning points were identified as follows:

- SFH Pathologists to perform a peer review audit of reporting differences for Head and Neck cases with second opinion from NUH (completed).
- Consider how absences are covered within the Maxillofacial Patient Pathway Co-ordinator (PPC) team and the reception team.
- Add a discrepancy management section to supplementary and amended reports to instruct on how to handle discrepancies either internally, or with external referral centres (completed).

One PSII was commissioned in Oct-25:

- A theme in relation to dosages of Lorazepam across the trust was identified. Immediate actions included setting up a Lorazepam Electronic Prescribing and Medicines Administration (EPMA) working group to review and update the EPMA system, clarify lorazepam prescribing limits and ensure safe dosing.

During Oct-25, an after-action Review (delays in Dermatology referral) was signed off. The key learning points were identified as follows:

- System improvements and clear documentation
- The need for a formal escalation process and improved tracking of action plans from structured judgement reviews (SJR's).

The action plan from a PSII previously signed off was returned for discussion prior to inquest. It was confirmed, that resuscitation training for doctors would be re-introduced on induction training, and that a study regarding the location of defibrillator pads had been completed.

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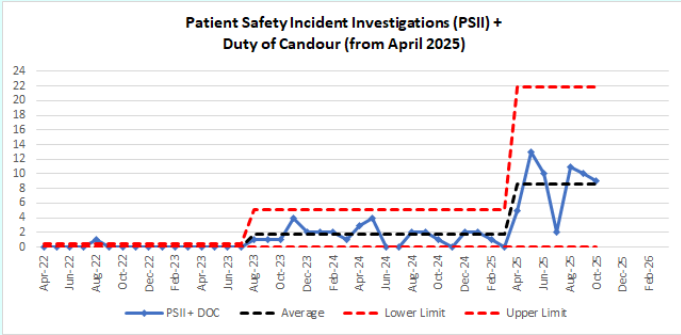

Root causes	Actions and timescale	Impact
IUFD	It was agreed by the division that no immediate actions were required; await the MNSI investigation. Resuscitation had been undertaken at the time of incident.	MNSI ongoing.
Emergency caesarean section	It was agreed by the division that no immediate actions were required.	Reported to MNSI, awaiting their response.
IUFD	It was agreed by the division that no immediate actions were required.	MNSI ongoing.

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

NHS
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Performance observations

Historically, we have delivered a consistent and relatively strong position until Nov-24. There was a small decline in May-24 as the risk assessment process transferred from a paper-based process to Nervecentre (computer system). In Nov-24 we saw a more significant decline driven by two main factors: data quality, and clinicians bypassing the automatic prompt.

Actions to date have not improved VTE compliance. Following discussion at Patient Safety Committee, a multi-divisional task and finish group is to be rapidly established to review the VTE risk assessment process, review the effectiveness of current actions and identify additional actions to improve compliance.

Actions taken to date include:

- Emergency Assessment Unit (EAU) have 12-hourly consultant ward rounds at 8am and 8pm. They have an EAU dashboard which shows if any patients have an outstanding review. This will form part of the consultant reviews.
- All specialities have been reminded to check VTE risk assessments have been completed on all patients transferred to them from EAU. Areas that take direct admissions from ED (Stroke Unit/RSU) will be additionally vigilant.
- Nurse in Charge, Heads of Service and Speciality Clinical Governance Leads have been asked to remind members of their clinical teams to review Nervecentre.
- Ensure that the VTE assessments are completed for all medical bed waiters in ED (post-take ward round [PTWR]).
- Identification of required VTE assessments now forms part of the EAU clinical safety board- easily identifiable for PTWR/reviews

During Sep-25 and Oct-25, there were 28 patients identified as requiring a VTE case review following positive diagnostic results. Of these 28, four remain outstanding.
Of the 24 reviews completed, 21 were found to be not preventable and three were found to be preventable.

Root causes	Actions and timescale	Impact
EAU identified as issue due to volume of patients going through the department.	Urgent & Emergency Care (UEC) to continue to focus on EAU performance.	Improve compliance.
	Multi-divisional task and finish group has been established to review VTE risk assessment process, review effectiveness of current actions and identify additional actions to improve compliance.	Improve compliance.

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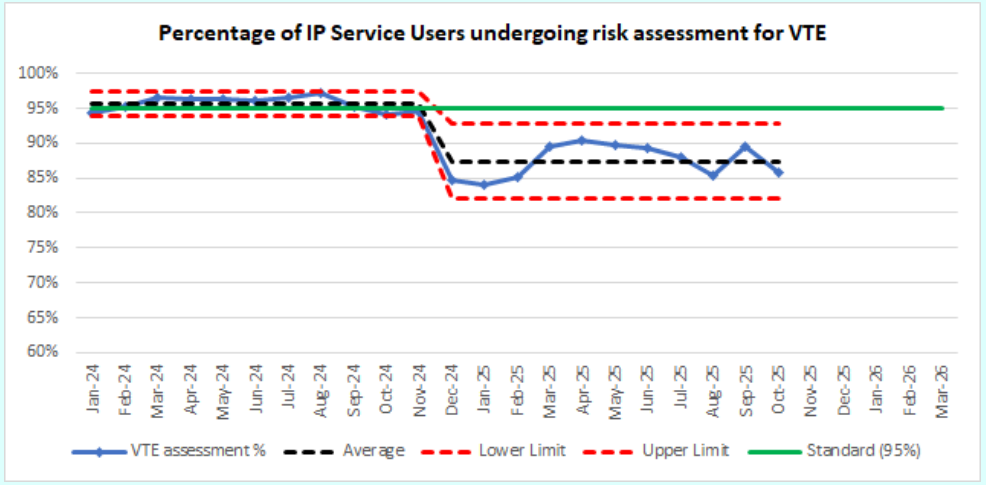

Indicator in Focus: Still Birth Rate

Sherwood Forest Hospitals NHS Foundation Trust

Overview and national position

During Sep-25 and Oct-25, we have reported four cases of antenatal stillbirth. Each case received an individual review as outlined below and has been reported through the Perinatal Mortality Review Tool (PMRT) and Maternity and Newborn Safety Investigations (MNSI) process, where they will receive a further review. All cases were reported within the Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE) recommended timescales.

Sep-25

- High risk pregnancy under tertiary care for fetal medicine. Attended at 27+6 weeks to fetal medicine for planned ultrasound scan and IUFD found.
- Low risk pregnancy attended triage at 25+3 weeks with an Antepartum Haemorrhage (APH) and was found to have a confirmed IUFD.
- Low risk pregnancy, contacted 39+2 weeks with spontaneous rupture of membranes, unit on divert advised to attend NUH for review. Plan made for augmentation. Contacted in interim with altered fetal movements and uterine activity – IUFD found on arrival. PMRT and MNSI reported.

Oct-25

- Complex monochorionic monoamniotic (MCMA) pregnancy under tertiary care, known cardiac and hydrops. Twin B confirmed Intrauterine Fetal Demise (IUFD) on 8 Oct-25 at 29+1/40. Twin A delivered by Category 1 lower (uterine) segment caesarean section(LSCS) at 30+1/40.

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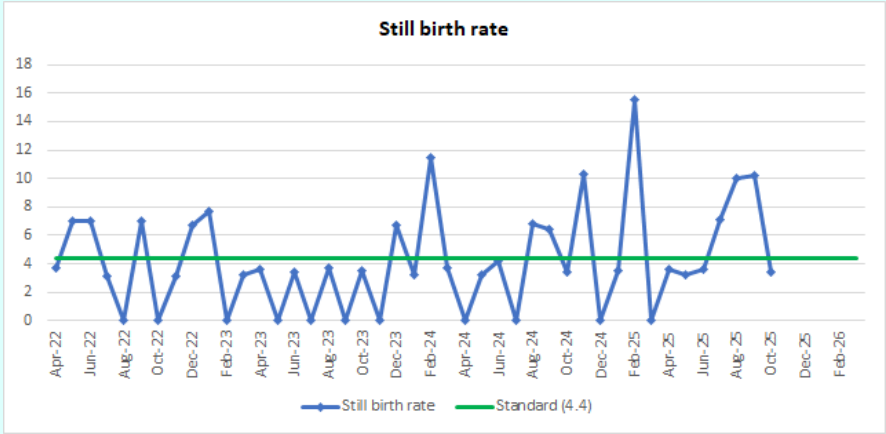

Root causes	Early/ urgent learning identified
Due to increased reporting of intrapartum still births, cases to be reviewed collectively for themes.	Governance team are supporting an external review in the local maternity and neonatal system (LMNS) to look at previously reported cases of intrapartum still births.
	No further alerts from the Maternity Outcomes Signaling System (MOSS). New Submit a Perinatal event Notification (SPEN) portal is now live at SFH and is the national tool which is hoped to reduced the complexities of reporting cases.

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People and Culture

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Domain Summary: People and Culture

Overview	Lead: Chief People Officer

Our People and Culture performance continues to strengthen, with eight of thirteen indicators meeting or exceeding standards year-to-date (YTD), reflecting significant progress and commitment to our workforce. Key areas of compliance include turnover, which remains below the standard at 0.6% YTD, although it increased to 1% in Oct-25. Mandatory and Statutory Training (MaST) compliance has consistently surpassed targets throughout 2025. Recruitment timelines, bank usage, and off-framework agency levels remain compliant, and vacancy levels have improved, maintaining compliance in the last reported period.

Appraisal compliance stands at 88.6% YTD prompting focused efforts to promote the benefits and ensure quality. Divisions and services, supported by executives during Divisional Performance Reviews (DPRs), are actively challenging and addressing this position.

Sickness absence levels are reported at 5% YTD, above the 4.2% standard but within statistical control limits. This trend aligns with national benchmarks, where NHS sickness absence for 2025/26 quarter one was 5.2%, and Acute Trusts slightly lower at 5.1%. NHS England attributes these higher levels to increased physical and emotional demands on frontline staff, greater exposure to infectious diseases, and stress-related burnout, particularly in emergency and inpatient services. Targeted interventions are underway within the Trust to address this issue.

Employee relations cases remain high but below the standard, with elevated levels of grievances and disciplinaries largely due to stronger application of policies and procedures; an anticipated outcome. All cases are being managed in line with established processes. Bank usage continues to improve in line with NHS planning expectations of a 15% reduction, though fluctuations occur during periods of high Operational Pressures Escalation Levels (OPEL) and Full Capacity Protocol (FCP) activation. Plans include ceasing all administrative and clerical (A&C) bank usage, with exceptions requiring executive approval, and strengthening governance around clinical bank usage. Financial measures have also been implemented, reducing Agenda for Change (AfC) bank rates from the top to mid-point of the scale and lowering unsocial hours payments below AfC levels. These changes deliver savings of approximately £20k per week. Combined with improved rostering and recruitment to vacancies, these actions have reduced the bank usage to 4.8% in Oct-25.

Agency usage remains above standard, with spikes linked to operational pressures. However, zero off-framework agency use has been maintained, and over-price-cap agency compliance achieved. Plans are in place to cease new agency bookings, with exceptions requiring executive sign-off, and exit strategies for current agency workers are being implemented. Medical job plan compliance is a notable success, with the Trust improving to 95.9% in Oct-25 against a 95% target. Benchmarking confirms the Trust is in the upper quartile nationally.

The flu vaccination campaign is underway, with internal uptake at 35.8% against a 53.2% target, while NHS England reports 42.2% due to inclusion of external vaccinations. This is marginally above last year's level. To improve uptake, roaming clinics, out-of-hours coverage, and targeted communications supported by executives have been introduced, alongside pop-up messages addressing vaccine hesitancy.

The second Mutually Agreed Redundancy Scheme (MARS) is open, with staff exits over the coming months supporting planned workforce reductions.

The following pages provide more detailed performance information across the People and Culture domain.

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Scorecard: People and Culture

People and Culture

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

At a Glance	Indicator	2024/25 Standard	2025/26 Standard	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	2024/25 Final	2025/26 YTD	STAR Data Quality Assurance S	T	A	R
Belonging in the NHS	Engagement score	≥6.8%	≥6.9%			✗ 7.1			✗ 6.8			✓ 0.0		✓ 7.1	✓ 6.8				
Growing the Future	Vacancy rate	≤8.5%	≤8.5%	✓ 7.8%	✓ 7.7%	✓ 7.7%	✗ 9.3%	✗ 9.5%	✗ 9.7%	✗ 9.1%	✓ 8.4%	✓ 8.0%	✓ 7.9%	✓ 8.0%	✗ 8.8%				
	Time to hire	n/a	≤53.1 days	49.0	34.0	27.0	✓ 23.0	✓ 21.0	✓ 29.0	✓ 29.0	✓ 28.0	✓ 25.0	✓ 36.0		✓ 29.2				
	Turnover in month	≤0.9%	≤0.9%	✓ 0.5%	✓ 0.4%	✓ 0.7%	✓ 0.6%	✓ 0.5%	✓ 0.5%	✓ 0.5%	✓ 0.5%	✓ 0.8%	✗ 1.0%	✓ 0.7%	✓ 0.6%				
	Appraisals	≥90%	≥90%	✗ 88.4%	✗ 88.2%	✓ 90.0%	✓ 90.0%	✗ 90.0%	✗ 88.7%	✗ 87.4%	✗ 88.0%	✗ 88.2%	✗ 87.5%	✗ 89.0%	✗ 88.6%				
	Mandatory & statutory training	≥90%	≥90%	✓ 92.4%	✓ 92.8%	✓ 92.9%	✓ 92.2%	✓ 93.1%	✓ 93.1%	✓ 93.2%	✓ 92.9%	✓ 92.9%	✓ 93.3%	✓ 91.5%	✓ 93.0%				
	Medical job plan compliance	n/a	≥95%	57.0%	86.1%	76.1%	✗ 50.6%	✗ 70.4%	✗ 71.3%	✗ 79.6%	✗ 91.4%	✗ 94.0%	✓ 95.9%		✗ 79.7%				
Looking after our People	Sickness absence	≤4.2%	≤4.2%	✗ 5.9%	✗ 5.0%	✗ 4.6%	✗ 4.9%	✗ 4.8%	✗ 5.1%	✗ 5.0%	✗ 4.8%	✗ 4.8%	✗ 5.7%	✗ 5.0%	✗ 5.0%				
	Flu vaccinations uptake (front line staff)	≥75%	≥75%	✗ 47.7%	✗ 47.8%	-	-	-	-	-	-	-	✗ 35.8%	✗ 58.0%					
	Employee relations management	<17	<21	✗ 20	✗ 25	✗ 31	✗ 23	✓ 18	✗ 23	✓ 18	✓ 18	✓ 20	✗ 21	✗ 21	✓ 20				
New Ways of Working	Bank usage	≤8.5%	≤7.8%	✗ 9.7%	✓ 8.0%	✗ 8.8%	✓ 6.3%	✓ 6.4%	✓ 5.9%	✓ 6.8%	✓ 7.1%	✓ 5.1%	✓ 4.8%	✗ 8.9%	✓ 6.1%				
	Agency usage	<3.2%	<1.9%	✗ 3.6%	✗ 3.8%	✗ 3.5%	✗ 2.5%	✗ 2.9%	✗ 3.5%	✗ 2.6%	✗ 2.6%	✗ 2.3%	✗ 2.6%	✗ 4.0%	✗ 2.7%				
	Agency (off framework)	0%	0%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✗ 0.01%	✓ 0.0%				
	Agency (over price cap)	≤40.0%	≤40.0%	✗ 46.0%	✗ 47.3%	✗ 61.5%	✓ 38.7%	✓ 36.8%	✓ 38.3%	✗ 40.2%	✓ 36.1%	✗ 40.9%	✓ 33.4%	✗ 52.9%	✓ 37.8%				

Indicator in Focus: Appraisals

Sherwood Forest Hospitals NHS Foundation Trust

Overview and national position

Our appraisal level sits below the Trust target (90%). Performance has deteriorated during Jul-25 and has remained at a level lower than the standard. The year-to-date position is at 88.6%. Performance during 2025/26 continues to fall between the upper and lower statistical control limits demonstrating movement within usual variation. Although the position is below standard, this is a strong level compared to the wider ICB level (84.5%).

The NHS Corporate Benchmarking exercise indicates that over 2024/25, our appraisal compliance is in the upper quartile. The national median is reported at 84.7%, with the upper quartile at 88.6%.

Root causes

Patient demand and hospital acuity has impacted on compliance.

Annual leave and absence levels.

Actions and timescale

- Service lines with low appraisal rates are supported to develop trajectories for improvement.
- Service lines are sighted on non-compliance rates and assurance is sought via monthly service-line performance meetings. This is in addition to monthly People and Performance review meetings within each department.

Impact

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

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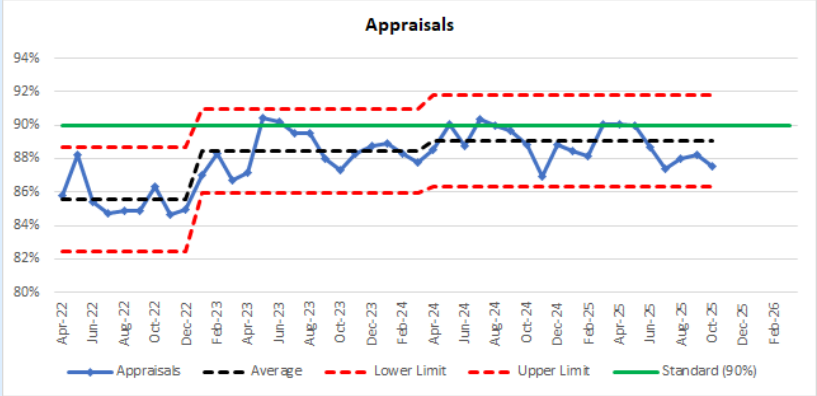

NHS Corporate Benchmarking (2024/25)

National quarter				National LQ	National median	National UQ
1	2	3	4			
			4	79.0%	84.7%	88.6%

Indicator in Focus: Sickness Absence

NHS Sherwood Forest Hospitals NHS Foundation Trust

Overview and national position

The year-to-date sickness position is reported at 5.0%, sitting above our standard (4.2%), but within the upper and lower statistical process control levels. We are noting an increase to sickness absence levels, reported at 5.7% in Oct-25. Increases are noted across all divisions, with 0.6% increase in sicknesses related to increases in cold/influenza and gastrointestinal reasons which are noted as the top two reasons above anxiety and musculoskeletal (MSK).

We report and discuss the sickness absence position at a divisional and service line level meetings monthly. We review absences over 28 days and provide a case review on each long-term absence. This is to provide assurance that the management of absences falls in line with our policy. We review the root causes; these are mainly personal issues. However, we are seeing rising instances relating to NHS waits for treatment; personal issues such as family illness, bereavement and financial worries; and safeguarding.

The wider NHS sickness absence for 2025/26 quarter two was 5.2%, with Acute Trusts sitting slightly lower at 5.1%. It is recognised by NHS England that this higher level is attributed to higher physical and emotional demands on frontline staff, greater exposure to infectious diseases and increased stress and burnout, especially in emergency and inpatient services.

We have received the Trust NHS Oversight Framework (NOF) ratings. Across the people domains the provider score for sickness absence is scored at 2.47 (segment 2).

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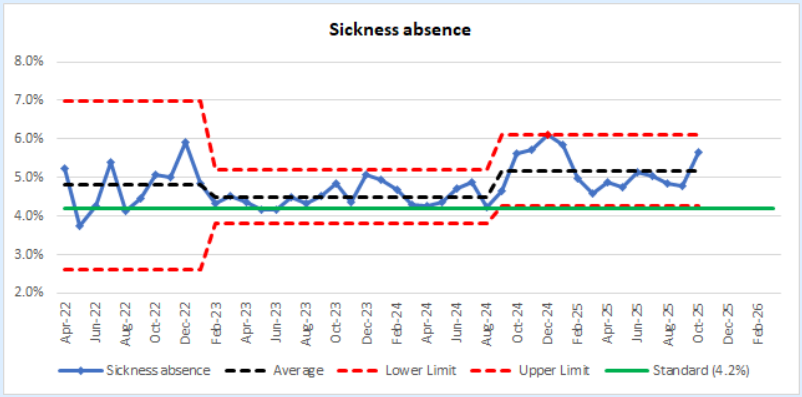

NHS Oversight Framework – Sickness Absence

Q1 2025/26	2.47	NOF Score	Provider value

Root causes

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

We are noting an increase in length of absences due to the impact of NHS waiting and treatment times.

Actions and timescale

- Sickness absence support and guidance given through dedicated members of People Services team. New process with one-to-one support from the People Service teams with sickness absence management on a case-by-case basis and in line with policy re-focusing on fundamentals.
- Medical sickness absence management reinforced at medical managers and exploration of inclusion with new Medical Leaders programme.
- Focus on absence prevention and support for colleagues in conjunction with People Occupational Health and Wellbeing Team, including targeted wellbeing promotion.
- Sickness absence key performance indicators are monitored through People and Performance meetings, service-line meetings and via Divisional Performance Reviews.
- The Deputy Chief People Officer is meeting monthly with the People Service team to review all sickness cases and provide guidance and support in terms of management.

Impact

Reduce levels of sickness.

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

Indicator in Focus: Agency Usage

Sherwood Forest Hospitals NHS Foundation Trust

Overview and national position

The year-to-date agency position is reported at 2.7%, with the Oct-25 position at 2.6%. This sits above the standard (1.9%). Our current agency position for Oct-25 shows a zero usage of off-framework agencies and a strong performance within 'on-framework, over-price-cap' position.

In Oct-25, we delivered a 40.8% reduction to bank usage and 32.9% reduction to agency usage from the Nov-24 baseline level. Reduction in both metrics is aligned to our workforce efficiency programmes and the work we are undertaking on the 'on-framework, over-price-cap', as key reductions in over-price-cap support reductions to the overall agency target. We are also working towards the East Midlands Acute Provider work on rate compliance by 2025/26 quarter three.

The run rate chart shows a reduction to a current position in Oct-25 at 2.6%. In 2023/24, the average rate was 5.8% and 4% within the 2024/25 period, with the current year-to-date rate at 2.7%. The Trust has undertaken significant work where we are showing sustained reduction in agency usage.

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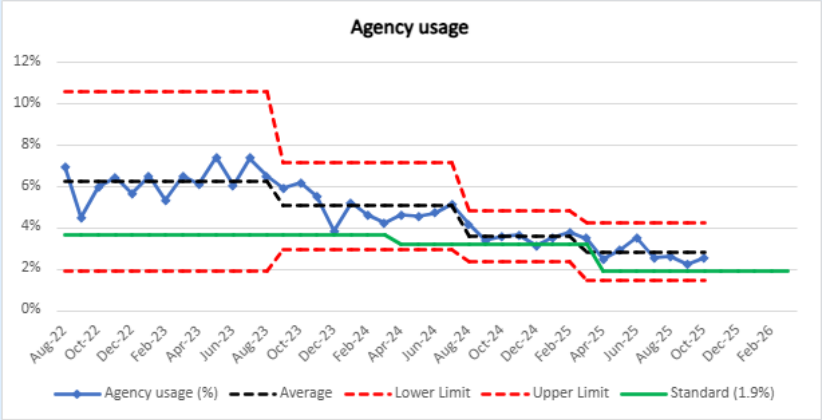

Root causes	Actions and timescale	Impact
Our biggest risk is medical and dental staff over the NHS England price cap; these are also impacted by some of our fragile services where there are national specialty shortages. There has been an increase to the agency position over the last two months that is largely due to the submission of late timesheets, which is distorting the position.	• To cease all new agency bookings, with any exceptions to be signed off by the Executive lead.	Target to reduce the agency level to 1%.
	• We continue to advertise and fill medical posts, that has gradually reduced our agency level. We organise medical speciality groups where there is a focus on agency spend and vacancies, with a view to support our service lines in filling these roles substantively, if not moving staff where possible onto direct engagement contracts.	Over the 2025/26 period, we are focusing on medical staff who are on-framework, but over the NHS England price-cap and are developing plans to exit these agency workers and replace with substantive roles.
	• Develop exit strategies with clear timescales for all agency workers to be developed and presented to Transformation Groups for agency staff and escalated to our Trust Management Team.	

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Timely Care

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Domain Summary: Timely Care

Overview	Lead: Chief Operating Officer

During recent months and as we head into winter, we have seen significant deterioration in several Urgent and Emergency Care (UEC) metrics. A&E 4-hour performance has tracked under 70% since Aug-25, closing at 67.4% in Oct-25; below our operational plan. A&E 12-hour length of stay and ambulance handover performance have also deteriorated to the most challenged levels observed in recent years. Delays in admitting patients in a timely manner have resulted in our Emergency Department (ED) being overcrowded (particularly our majors department). This overcrowding has meant that we have not always been able to accept patients arriving by ambulance as promptly as we have previously. The outflow issues from ED are due to hospital flow challenges. We have seen increased levels of medically safe patients in our hospitals in recent months and have had four consecutive months of net inflow to our hospitals (more admissions than discharges). This net inflow can be seen in our bed occupancy, which has been steadily increasing month-on-month in 2025 to date. Whilst admission demand has been at similar levels to 2024, A&E attendance demand has increased in our King's Mill type one service and the Newark type three Urgent Treatment Centre (UTC). Since Sep-25, the Nottingham Emergency Medical Services (NEMS) primary care 24 service has seen less patients than in the same periods in the last two years. The A&E overcrowding increases the risk of delay-related harm and deteriorated patient experience. To ease pressures, we have opened a new Transitional Care Unit following reconfiguration of our medical Same Day Emergency Care (SDEC) service, which is now co-located in our Medical Day case Unit. We remain focused on actions to improve board round processes on our wards and reduce discharge delays.

In terms of planned care, our 52-week wait backlog was at 0.9% of the total patient tracking list (PTL) in Oct-25 and therefore below the 1% operational planning guidance target to be achieved by the end of 2025/26. However, 18-week referral to treatment (RTT) performance has deteriorated to 60.4% in Oct-25. Whilst we benchmark well nationally, we have fallen further from our plan which was to deliver a mandated 5% improvement on Nov-24 performance. 18-week first appointment performance has also deteriorated, and our total PTL size is growing. Our deviation from our 18-week plan triggered us to be put into tiering over the summer, resulting in more intense scrutiny from the NHS England regional and national team. Actions have been developed, particularly on the non-admitted pathway, to recover performance back to plan in 2025/26. We continue with strong performance providing patient initiated follow up delivering performance consistently better than the standard.

Our diagnostic DM01 performance has been relatively stable since Oct-24, aside from two very strong months in Feb-25 and Mar-25. This is reflected in our benchmarking position which is now consistently above the national average. Previously released insourcing capacity has been reinstated for Echocardiography, which has supported small improvements in Sep-25 and Oct-25.

Our cancer performance for the 28-day faster diagnosis standard and the 62-day treatment standard remains favourable to plan. Cancer 31-day treatment performance (first treatment) has been moving within standard variation since mid-2024, closing in Sep-25 at 88%. This is below the 96% national standard, which is our operational plan. For 31-day and 62-day treatment standards we benchmark in the lower quartiles nationally. The cancer 62-day backlog has reduced in recent weeks with recovery plans in place across several tumour sites and further details included in this report.

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

Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Scorecard: Timely Care

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

Timely Care

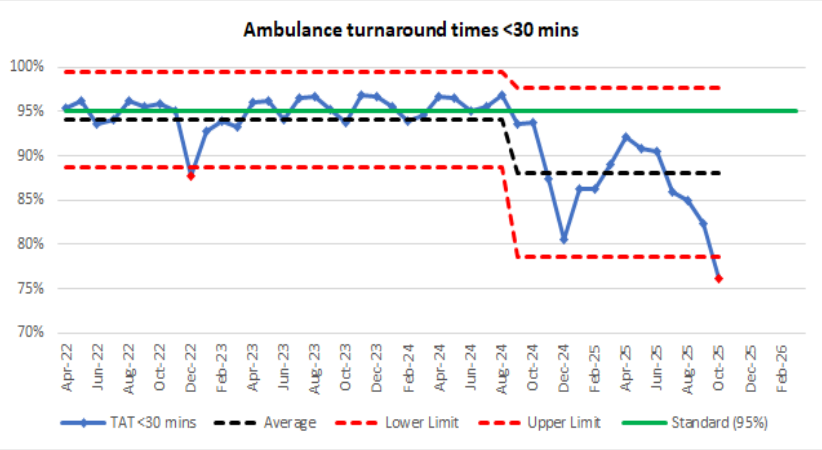
Green tick = target met/exceeded; Red cross = target not met

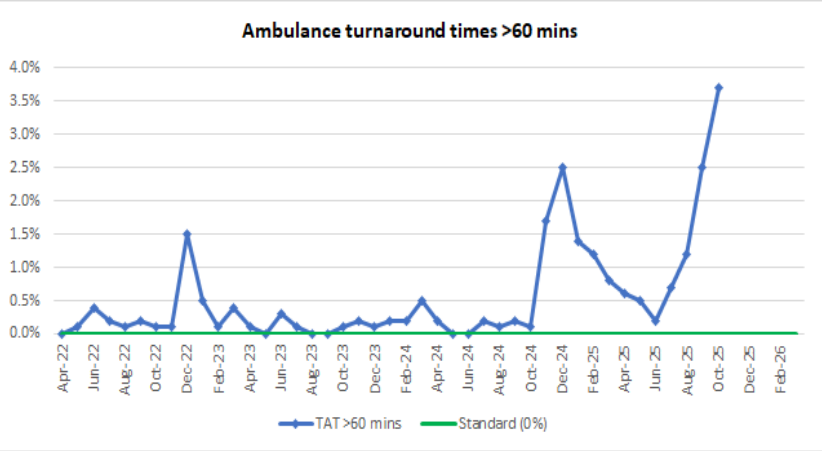
At a Glance	Indicator	2024/25 Standard	2025/26 Standard	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	2024/25 Final	2025/26 YTD	Latest Benchmark Position (Jul 25)	STAR Data Quality Assurance S	T	A	R
Urgent Care	Ambulance turnaround times <30 mins	≥95%	≥95%	✗ 86.3%	✗ 86.3%	✗ 89.0%	✗ 92.1%	✗ 90.8%	✗ 90.5%	✗ 86.0%	✗ 85.0%	✗ 82.3%	✗ 76.2%	✗ 91.4%	✗ 86.1%	– 77 / 176				
	Ambulance turnaround times >60 mins	0.0%	0.0%	✗ 1.4%	✗ 1.2%	✗ 0.8%	✗ 0.6%	✗ 0.5%	✗ 0.2%	✗ 0.7%	✗ 1.2%	✗ 2.5%	✗ 3.7%	✗ 0.7%	✗ 1.4%	– 90 / 176				
	ED 4-hour performance	≥76%	≥Plan	✗ 65.3%	✗ 68.2%	✗ 75.2%	✓ 77.3%	✓ 79.0%	✓ 76.8%	✗ 72.4%	✗ 68.8%	✗ 68.0%	✗ 67.4%	✗ 71.0%	✓ 72.8%	✗ 109 / 152				
	ED 12-hour length of stay performance	≤2%	≤2024/25	✗ 5.5%	✗ 4.2%	✓ 1.7%	✓ 2.1%	✓ 1.7%	✓ 1.8%	✓ 2.8%	✗ 6.1%	✗ 5.6%	✗ 8.2%	✗ 3.4%	✗ 4.0%	✓ 48 / 176				
	Mental health patients spending over 12 hours in A&E	n/a	No Standard	31	26	19	18	21	19	22	24	23	27	23	154					
	Adult G&A bed occupancy	≤92%	≤92%	✗ 96.1%	✗ 94.4%	✗ 94.0%	✗ 94.6%	✗ 95.2%	✗ 95.5%	✗ 96.2%	✗ 95.9%	✗ 96.3%	✗ 96.5%	✗ 94.5%	✗ 95.7%	✗ 111 /179				
	Average number of days between planned and actual discharge date	n/a	≤Plan	2.9	2.7	3.1	✓ 3.3	✓ 3.2	✗ 4.3	✗ 4.1	✗ 3.8	✓ 3.4	✓ 3.0	3.1	✓ 3.6					
	Inpatients medically safe for transfer for greater than 24 hours	≤40	≤40	✗ 65	✗ 48	✗ 50	✗ 53	✗ 51	✗ 68	✗ 79	✗ 87	✗ 82	✗ 72	✗ 64	✗ 70					
Electives	Added to Patient Initiated Follow Up (PIFU) pathway	≥5%	≥5%	✓ 5.3%	✓ 9.6%	✓ 9.9%	✓ 11.1%	✓ 10.7%	✓ 10.5%	✓ 10.7%	✓ 10.9%	✓ 11.2%	✓ 11.3%	✓ 6.0%	✓ 10.9%	✓ 4 / 134				
	Percentage of incomplete Referral to Treatment (RTT) pathways completed in less than 18 weeks	n/a	≥Plan	63.3%	63.5%	64.6%	✗ 63.7%	✗ 64.0%	✗ 64.1%	✗ 62.9%	✗ 61.3%	✗ 61.9%	✗ 60.4%	64.6%	✗ 62.6%					
	Percentage of RTT waits over 52 weeks for incomplete pathways	n/a	≤Plan	1.8%	1.6%	1.3%	✓ 1.3%	✓ 1.2%	✓ 1.1%	✓ 1.1%	✓ 1.0%	✓ 0.9%	✓ 0.9%	1.3%	✗ 1.1%					
Diagnostics	Diagnostic DM01 performance under 6-weeks	≥Plan	≥Plan	✓ 88.7%	✓ 94.4%	✓ 93.1%	✗ 88.9%	✗ 87.1%	✗ 88.2%	✗ 87.9%	✗ 87.6%	✗ 89.8%	✗ 90.4%	✓ 93.1%	✗ 90.4%	✓ 35 / 134				
Cancer	Cancer 28-day faster diagnosis standard	≥75%	≥Plan	✗ 71.6%	✓ 79.7%	✓ 78.0%	✓ 77.6%	✓ 76.4%	✓ 82.4%	✓ 83.1%	✓ 82.3%	✓ 80.7%		✓ 78.3%	✓ 80.5%	✓ 24 / 134				
	Cancer 31-day treatment performance	≥Plan	≥96%	✗ 86.9%	✓ 96.1%	✓ 95.4%	✗ 87.6%	✗ 94.4%	✗ 91.2%	✗ 89.0%	✗ 84.8%	✗ 88.4%		✓ 91.9%	✗ 89.3%	✗ 120 / 134				
	Cancer 62-day treatment performance	≥Plan	≥Plan	✗ 55.0%	✗ 66.9%	✗ 55.1%	✓ 65.5%	✓ 63.3%	✓ 65.3%	✓ 66.9%	✓ 72.4%	✓ 63.1%		✗ 64.4%	✓ 66.0%	– 62 / 134				

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

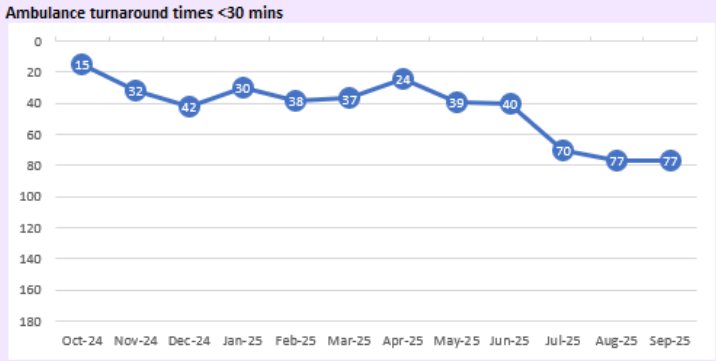
Sherwood Forest Hospitals NHS Foundation Trust

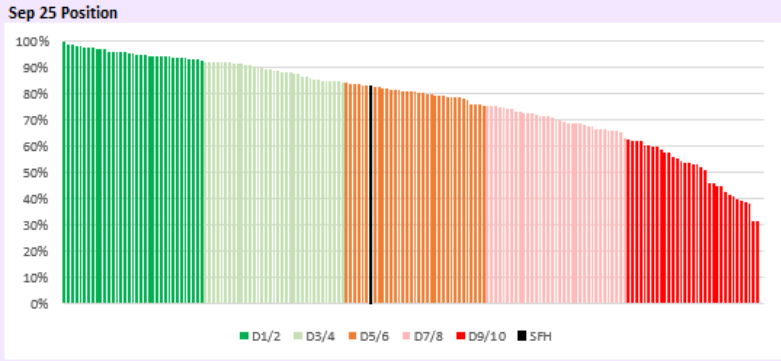
Local data (to Oct-25)

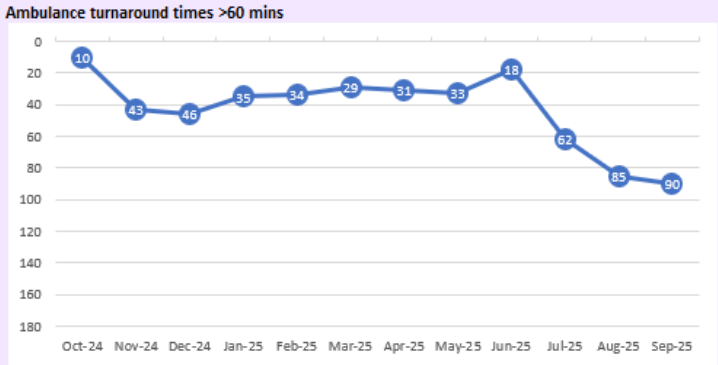


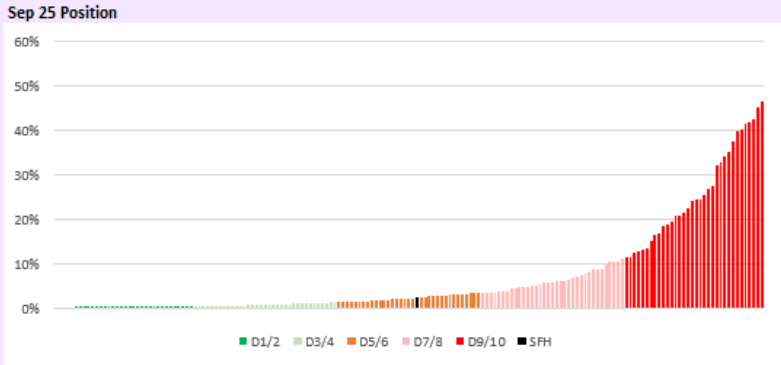


Benchmark position (to Sep-25)





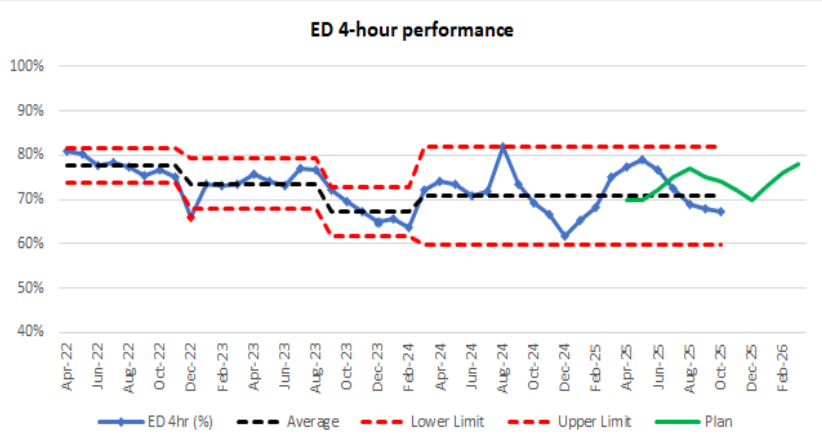


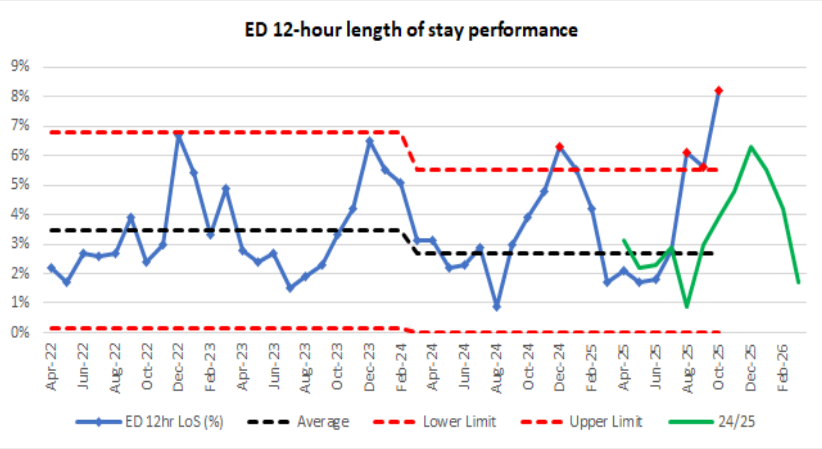


Indicators in Focus: Urgent Care – A&E (2/4)

Sherwood Forest Hospitals NHS Foundation Trust

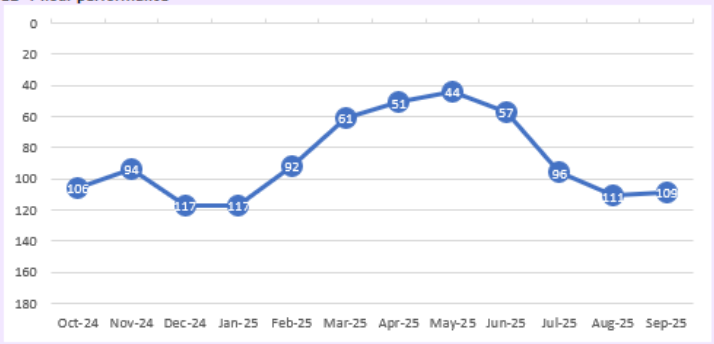
Local data (to Oct-25)



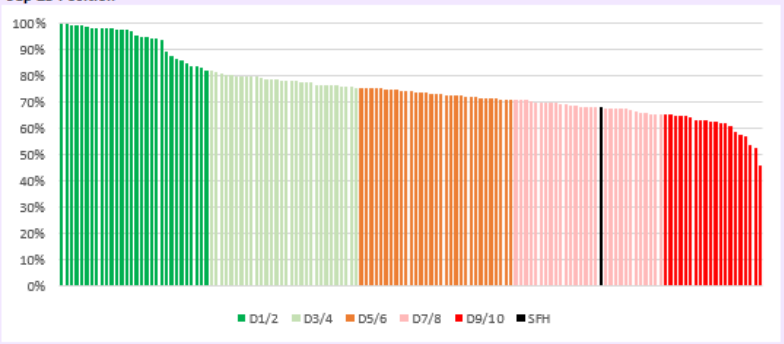


Benchmark position (to Sep-25)

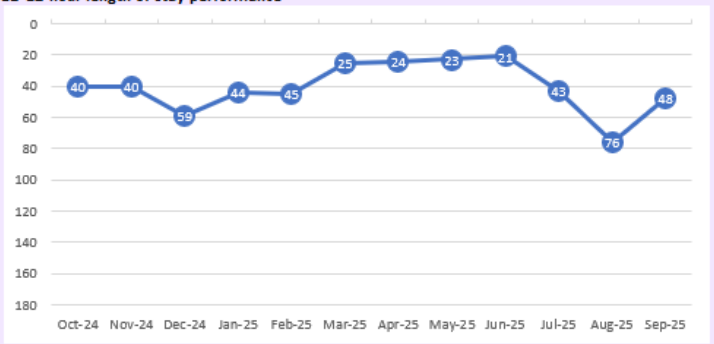
ED 4-hour performance



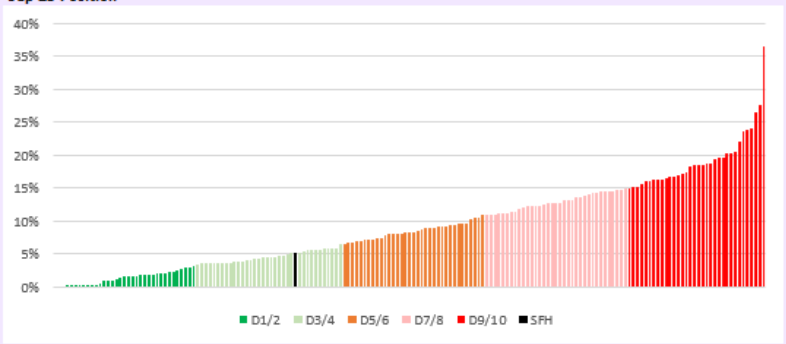
Sep 25 Position



ED 12-hour length of stay performance



Sep 25 Position



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

Sherwood Forest Hospitals NHS Foundation Trust

Performance observations

Ambulance 30-minute handover performance deteriorated to 76.2% in Oct-25, having peaked at 92.1% in Apr-25. This drop in performance has triggered as special cause variation. Our deterioration is reflected in our benchmarking position, which has dropped into the fifth decile; in 2024 we were in the top 10%.

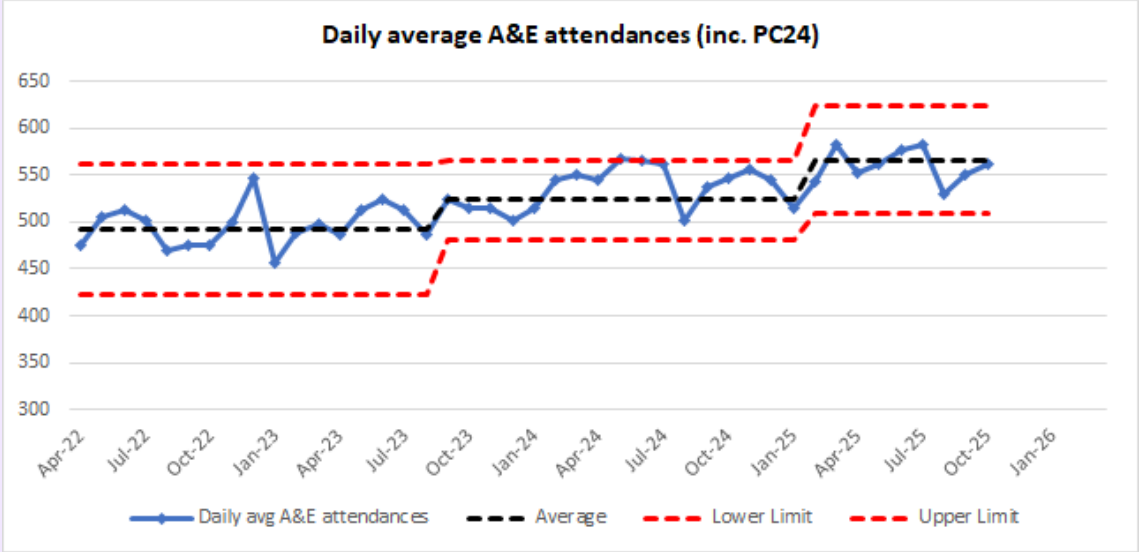
Ambulance 60-minute handover performance also deteriorated in the last two months, with 3.7% of arrivals being handed over in more than one-hour in Oct-25; this is our poorest performance since the pandemic. This deterioration is also reflected in our benchmarking position trend where we have dropped into the sixth decile of Trusts nationally in Sep-25.

A&E 4-hour performance deteriorated further in Sep-25 and Oct-25, remaining below our operational plan (by circa 6.5%) and below the performance we achieved during the same period last year. Daily average A&E attendances are following a similar seasonal trend as in 2024; however, at circa 2.5% higher levels (circa 12-14 more patients per day in Sep-25 and Oct-25 compared to the previous year). Hospital flow challenges are causing outflow issues in our A&E department and causing overcrowding, which is driving the poor 4-hour emergency access and ambulance handover performance. Our benchmarking position has deteriorated during the last two months, and we are 109th nationally out of 152 Trusts in Sep-25.

A&E 12-hour performance triggered as special cause variation for the third consecutive month in Oct-25 following a significant deterioration during Aug-25. In Oct-25 the proportion of 12-hour length of stay waits was the highest level we have seen and worse than previous winter periods. From a benchmarking perspective, we have dropped out of the top 20% to be 48th best the country, placing us in the third decile. Whilst the Oct-25 position is our worst on record, it remains better than the national average.

Following a positive beginning of 2025/26 in terms of A&E performance, the last four months have been very challenging. We must recover performance by reducing hospital length of stay, which will in turn reduce the risk of delay-related harm and improve waiting times in our A&E. Specific actions are described in the subsequent pages.

Additional data



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

Sherwood Forest Hospitals NHS Foundation Trust

Root causes	Actions and timescale	Impact

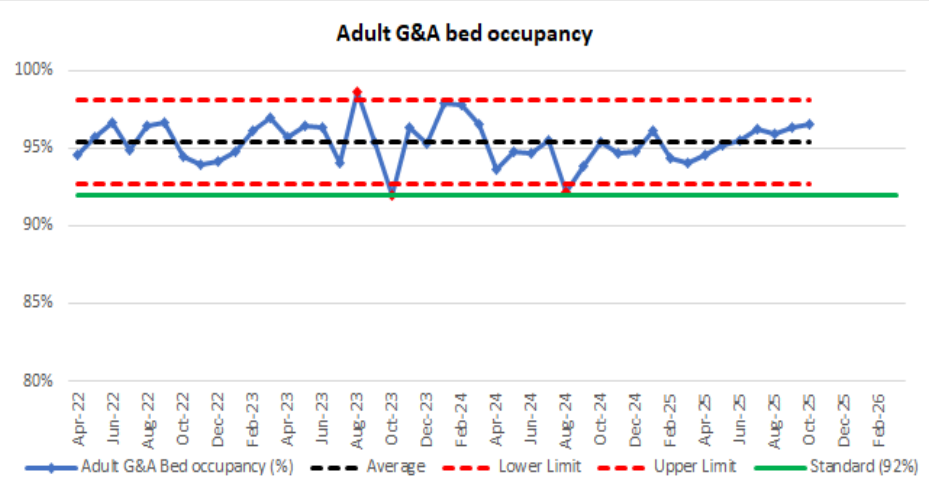
Surges in Accident and Emergency (A&E) attendance demand.	• Admission and attendance avoidance with system partners include:
	  - Regular engagement with East Midlands Ambulance Service (EMAS) to discuss out of area conveyances.
	  - Focus on frailty attendances: Call before you convey; use of urgent care community response teams.
	  - Development of alternatives to ED workstream in line with the Emergency Care Improvement Plan.
	  - Redirection of patients to Urgent Treatment Centres.
		• Reduction in out of area conveyances.
		• Reduction in category 3 ambulance conveyances.
		• Reduction in over 65-year-olds where length of stay is one day plus.

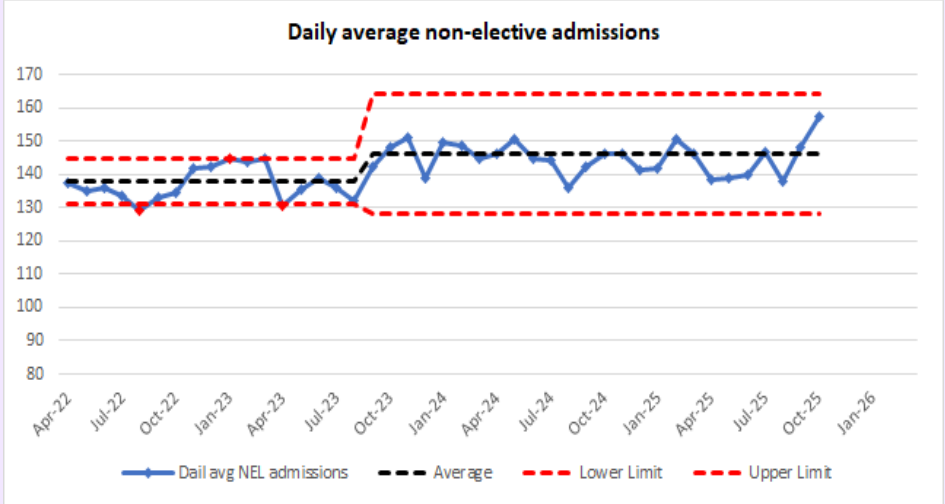
	• Optimise approach to Same Day Emergency Care (SDEC) for GP referral attendances.	• Increase in patients through Frailty and Surgical SDEC. • Early identification of Frailty through Clinical Frailty Scale (CFS) score being recorded in our Emergency Department (ED). • Decrease in mean time in department for non-admitted patients identified with a Clinical Frailty Score (CFS) >6.
	• Implement learnings from the Criteria to Admit audit – cross Divisional co-design of alternative pathways to reduce admissions and length of stay.	
	• Develop new streaming model at the front door to immediately direct patients to an alternative e.g. SDEC/admissions area.	
	• Mental Health workshop with system partners planned in Nov-25 to agree actions to improve the patient pathway.	• Reduce ED overcrowding and improve staff to patient ratio through reduction in 1:1s required.
Insufficient staffing to manage A&E demand.	• Recruit five new ED Consultants following review of all vacancies with a move to Consultant on site cover until 2am. Expected start date Dec-25/Jan-26.	• Decrease in mean time in department for non-admitted patient to <180 minutes.
	• Implement ED Nervecentre in Nov-25 to improve visibility of tasks and escalations to progress patients care and journey.	
	• Pre-allocate Consultant to dedicated areas with clear expectations for oversight for each area including two-hourly huddles and monitoring of performance for the day.	
A&E overcrowding driven by bed capacity pressures and mismatches in admission and discharge demand.	• Wards go one/two-over when in high local escalation level as part of our Full Capacity Protocol to accommodate more patients on our wards earlier in the day and thereby improve hospital flow and bedded capacity, reducing clinical risk due to overcrowding in ED.	• Time to initial assessment for arrivals to A&E seen within 15 minutes to greater than 60%. • Reduce and sustain 12-hour length of stay to less than 2%.
	• Patient flow actions detailed on the following slides.	

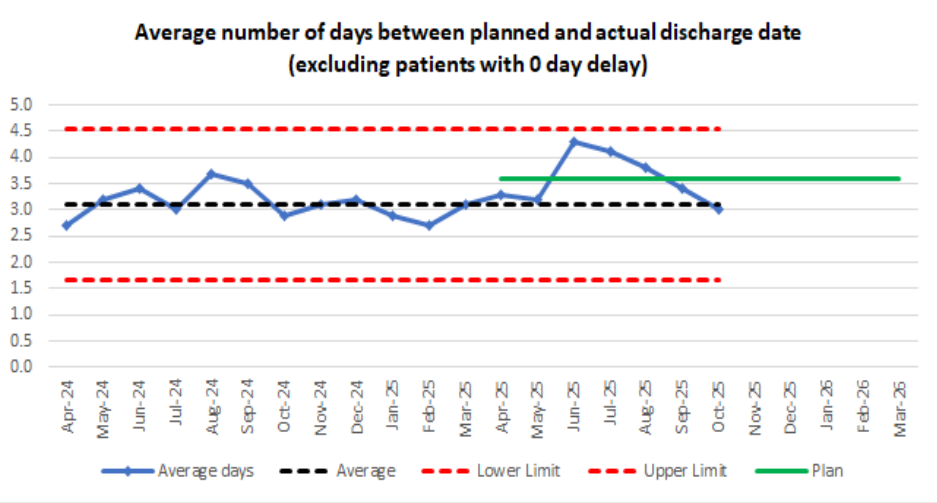
Indicators in Focus: Urgent Care – Hospital Flow (1/2)

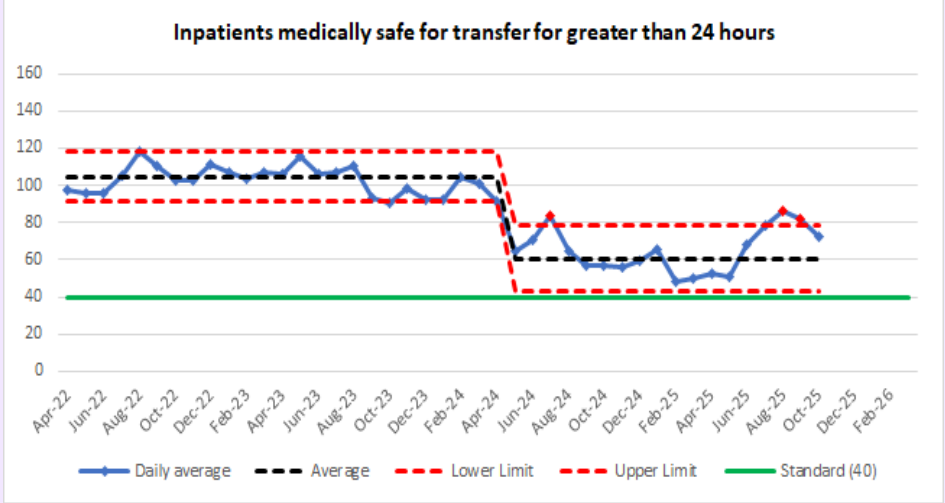
Sherwood Forest Hospitals NHS Foundation Trust

Data (to Oct-25)









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

Sherwood Forest Hospitals NHS Foundation Trust

Performance observations

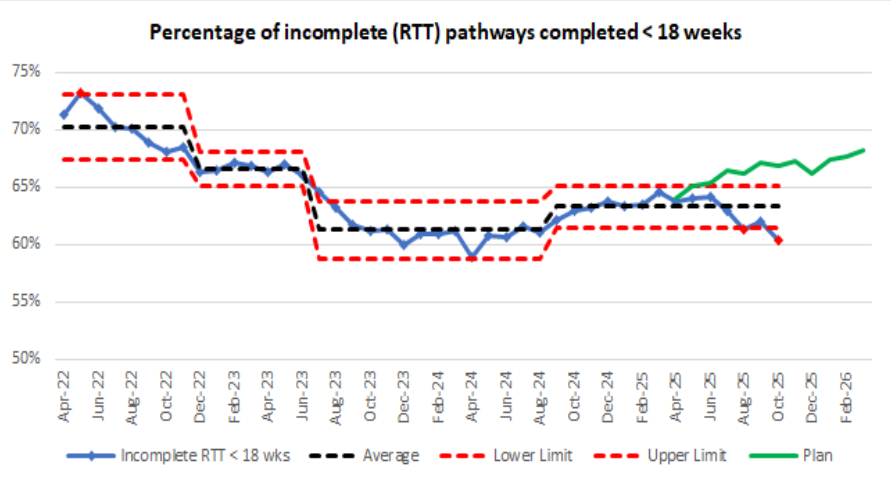
- General and Acute (G&A) bed occupancy is trending within statistical process control limits, with no unexpected variation but above 95% for the fifth consecutive month and rising.
- The daily average number of non-elective admissions increased to the highest level in Oct-25. Most of this increase was seen in our maternity services; however, there were also increases observed in paediatric and geriatric services (the latter who create challenges in flow across our adult bed base).
- The number of patients Medically Safe For Transfer (MSFT) for greater than 24 hours increased in Jun-25 following a reporting change. This reporting change will have also driven the increase in the reported average discharge delays. While this change was reversed in Oct-25, MSFT numbers did not reduce by the same degree, remaining at elevated levels and highlighting the outflow challenges across our discharge pathways. However, the average number of days between planned and actual discharge have consistently reduced month-on-month since the rise in Jun-25.

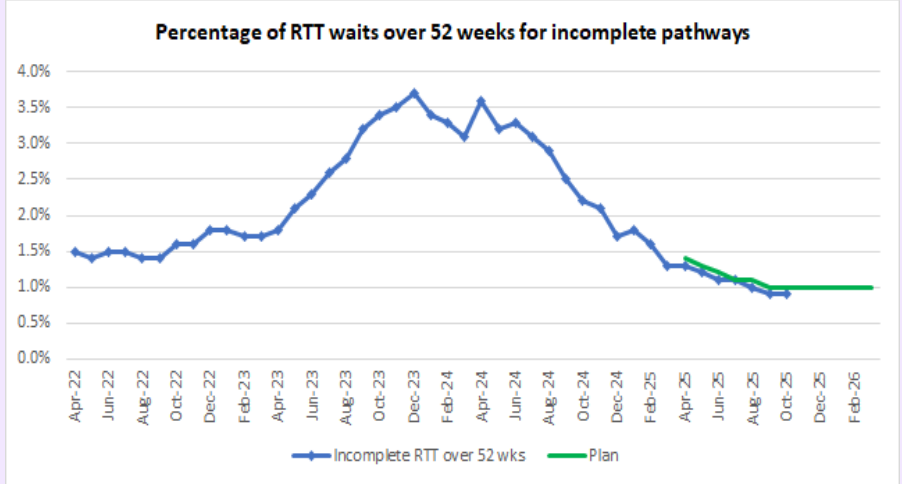
Root causes	Actions and timescale	Impact
Delays to pre-medically safe processes on inpatient wards.	• The 'Getting the Basics Right' programme and Trust Recovery Group championed by the Chief Operating Officer and Chief Medical Officer. Focus on board rounds and ward processes to reduce delays and improve patient length of stay.	• Reduced delays and improved patient length of stay across all discharge pathways.
	• Multi-Agency Discharge Event (MADE) conducted with system partners facilitated ahead of industrial action.	• Reduced discharge delays, improved MSFT position, improved hospital outflow.
Delays to post-medically safe discharge processes.	• The discharge team undertake a daily review of all patients medically safe for greater than 24 hours to identify actions to support timely discharge. Actions are on a live patient tracking list with updates and resolutions monitored throughout the day. Shared medically safe list embedded across all Divisions, enabling timely updates of actions to assist patient discharge.	• Improve length of stay (LOS) for complex discharges across our hospitals. • Eliminate barriers to discharge and further reduction in the number of abandoned discharges (good progress already seen).
	• Strict adherence to use of 'Criteria to Reside' letters to encourage patients and families to engage with discharge planning.	
	• Patient Transport Services (PTS) continue to be a challenge to timely discharge. EMED Group and Ambicorp conveyances continue to be under local and system-wide review.	• Identify opportunity for operational and financial efficiency. • Eliminate barriers to discharge and further reduction in the number of abandoned discharges (good progress already seen).
Insufficient community capacity to meet supported discharge demand.	• Working with health and care partners (predominantly adult social care) to resolve issues with a lack of Packages of Care (POCs) and delays in allocation of social workers to complex cases.	• Reduce the number of medically safe patients in our hospitals, which will improve hospital flow, enabling improved ED performance and patient experience.
	• Working with Derbyshire social care to address delays in placing pathway two patients.	
	• Working with partners within Nottinghamshire and Derbyshire on timely transfer of inpatients requiring support from mental health services. There has been increasing pressure in this area due to mental health bed capacity constraints. New targets to prevent 24 hour stays in ED for mental health patients resulting in increased focus on mental health discharges.	• Reduce discharge delays for patients requiring mental health beds and reduce the number of medically safe patients in our hospitals.

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

Sherwood Forest Hospitals NHS Foundation Trust

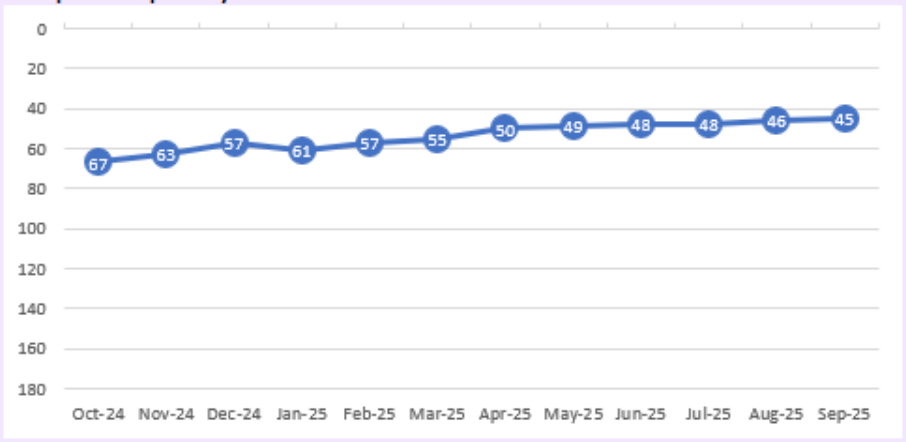
Data



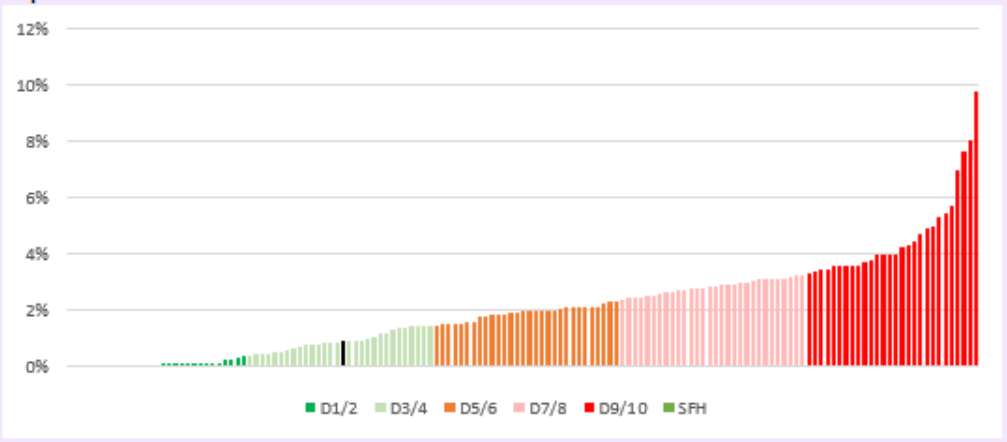


Benchmarking Position and Standings (to Sep-25)

Incomplete RTT pathways +52 weeks



Sep 25 Position



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

Sherwood Forest Hospitals NHS Foundation Trust

Performance observations

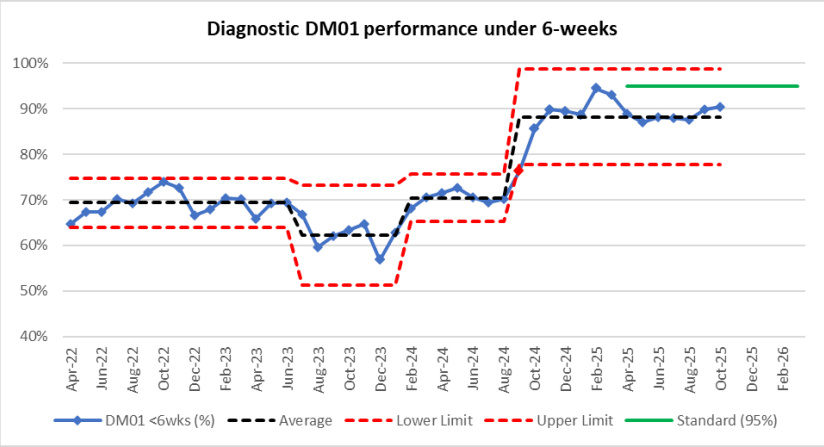
- Referral to Treatment (RTT) 18-week performance at SFH has decreased to trigger special cause variation in Aug-25 and Oct-25. Performance in Oct-25 was 6.5% below our operational plan, which is set to deliver a 5% improvement on our Nov-24 position (as mandated in the national planning guidance). This is, in part, being driven by a deteriorating position in the proportion of patients receiving a first outpatient appointment within 18-weeks. Latest national benchmarking data places us just above the national median.
- 52-week wait pathways remain inside our operational plan target for the end of 2025/26 (to achieve 1% of the total incomplete PTL [Patient Tracking List]). Our benchmarking position continues to improve.

Root causes	Actions and timescale	Impact
Insufficient capacity within key specialities to meet demand.	• Cross-provider PTL and support for patients in place.	• Treat longest waiting patients first regardless of provider.
	• Ongoing insourcing to increase ENT capacity.	• Reduce the number of long wait patients.
	• Ongoing support provided to Nottingham University Hospitals for Urology long waits.	• Increase in SFH PTL size and 52-week wait.
Insufficient anaesthetic capacity (deficit of seven WTE consultant vacancies) increasing the risk of list cancellation due to insufficient staffing cover.	• Strategy for anaesthetic staffing levels and recruitment plan in place including: – Continue insourcing for priority areas until sustainable internal solutions are in place. – Substantive appointment made, commencing Feb-26 (additional appointments were made but candidates withdrew). Opportunities to recruit to two further posts are being explored. – Building relationships with University Hospitals of North Midlands to enhance specialist registration opportunities for neuro and cardiothoracic surgery training.	• Enable reduction in theatre list cancellations due to anaesthetic availability, reducing risk to RTT long wait cancellations. • Sufficient and sustainable workforce.
Insufficient capacity to reduce first appointment backlogs within our baseline capacity.	• Outsourcing ENT first appointments commenced in Aug-25 and is ongoing.	• Reduce waits for first ENT outpatient appointments – 264 patients successfully transferred. • Equalise first appointment waits in ENT sub-specialties. • Increase skin cancer first appointment capacity (preventing increased capacity for long waiters). • Reduced waits for first Ophthalmology appointments – 160 patients successfully transferred. • Improve Trust performance against first activity trajectory.
	• Revision of ENT and Audiology capacity to increase new appointments for referrals.	
	• Dermatology locum appointments due to commence in Jul-25 to release consultant capacity for clinics (cancer) deferred to Nov-25.	
	• Outsourcing Ophthalmology first appointments commenced in Sep-25 and is ongoing.	
	• Additional Ophthalmology staffing in place and training underway to increase clinic capacity in 2025/26 quarter four.	
	• Gastroenterology Referral Assessment Service introduced Jul-25 and replacement locum appointment made Nov-25 to increase new capacity by appropriately directing referrals and offsetting lost capacity.	
PTL data quality and ability to sustain a 'clean' PTL and management of all failsafe reports due to insufficient validation resource.	• Robotic Process Automation (RPA) pilot and Federated Data Platform (FDP) project commenced in Jun-25, both supported by NHS England, deferred to go live in 2025/26 quarter four.	• PTL will be ‘clean’ and represent only those patients genuinely waiting treatment. • Reduce incomplete PTL size through validation.
	• Workforce change to increase validation capacity to be completed by the end of 2025/26 quarter three.	

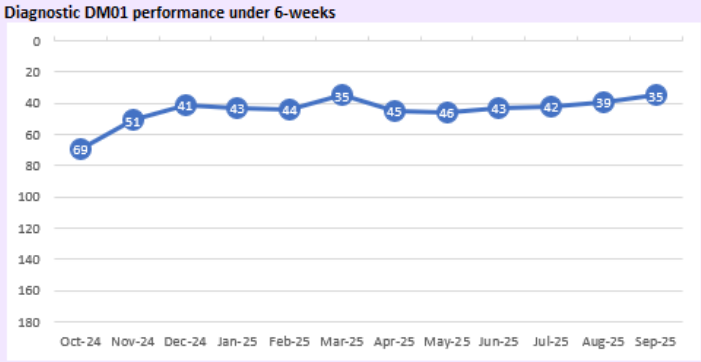
Indicators in Focus: Diagnostics (1/2)

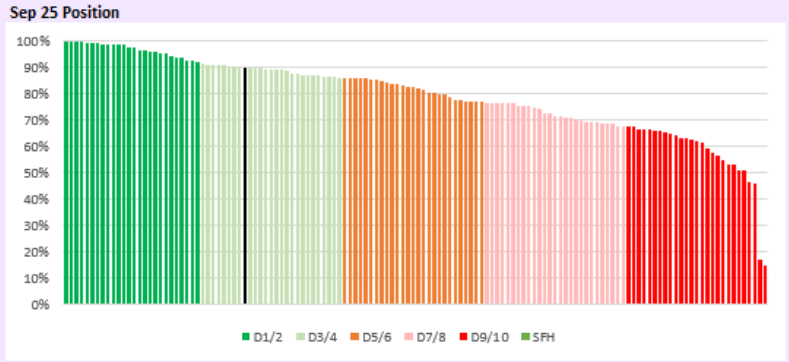
Sherwood Forest Hospitals NHS Foundation Trust

Local data (to Oct-25)



Benchmark position (to Sep-25)





Performance observations

- Our diagnostic DM01 performance has been relatively stable since Oct-24, aside from two very strong months in Feb-25 and Mar-25. This is reflected in our benchmarking position which is now consistently above the national average.
- The 2024/25 improvement and subsequent deterioration in Apr-25 from Feb/Mar-25 highs was driven by Echocardiography following the introduction and then the release of insourcing capacity. Echocardiography is the main driver of overall Trust DM01 performance. Trends in the service generally result in a similar overall position trend; this includes the improved performance in Sep-25 and Oct-25 which was driven by Echocardiography.
- Sleep studies is the second most challenged modality with performance trending in recent months between 65 and 70%.

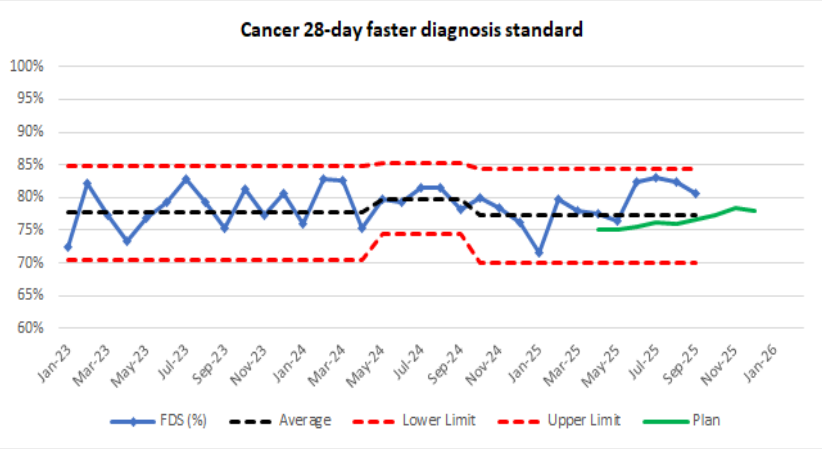
Indicators in Focus: Diagnostics (2/2)

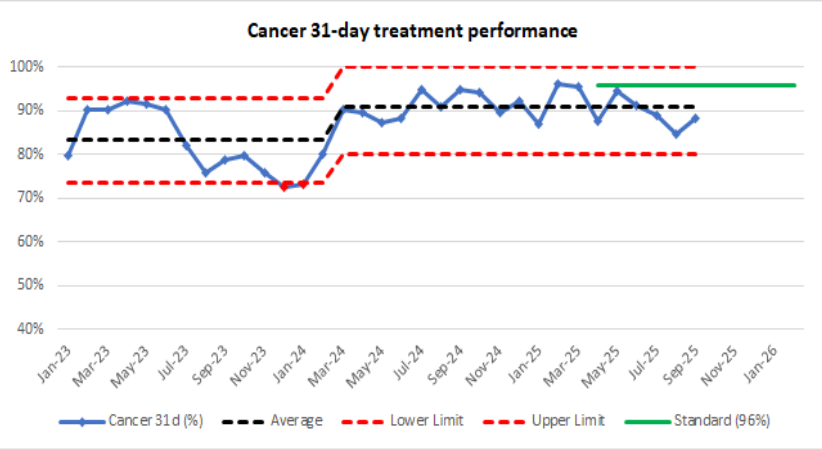
Root causes	Actions and timescale	Impact
Insufficient Echocardiography baseline capacity to reduce the number of patients waiting and reduced Administration and Clerical (A&C) capacity to manage booking capacity.	• Insourcing remains in place to support delivery of planned activity levels.	• Reduction in backlogs to eliminate patients waiting over 13-weeks and improve DM01 performance.
	• Move to Health Roster for rota planning to ensure rotas are available to schedule patients a minimum of six weeks in advance is taking place during 2025/26 quarter three.	• Advanced booking of appointments to enable greater patient choice, improved scheduling and better utilisation of capacity.
Insufficient baseline capacity to reduce backlogs in Sleep (impacted by an increase in out of area referrals throughout 2024 which has now stabilised in 2025).	• Additional backflash devices and storage lockers procured for us from end Nov-25. Scoping the potential to expedite Community Diagnostic Centre (CDC) is underway.	• Improved DM01 performance. • Reduction in long waiters and prevention of 13-week breaches. • Additional 16 sleep studies per week.
	• Successful recruitment to technician and physiologist capacity to increase sleep studies following a successful bid to purchase an additional 11 devices.	

Indicators in Focus: Cancer (1/3)

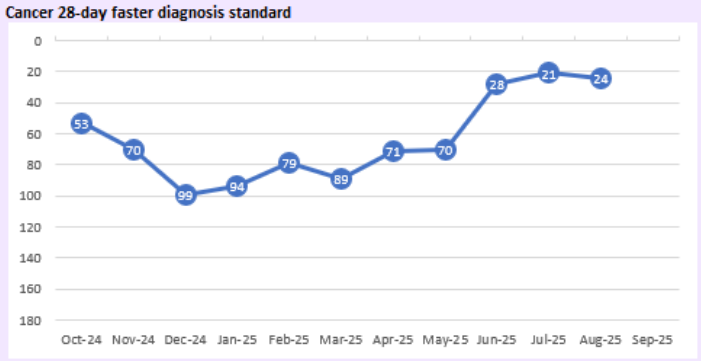
Sherwood Forest Hospitals NHS Foundation Trust

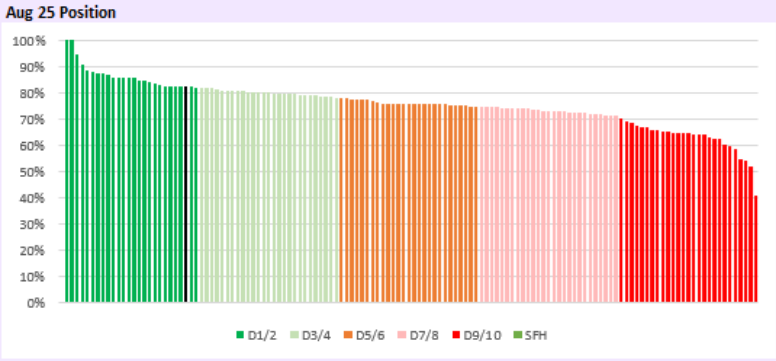
Local data (to Sep-25)

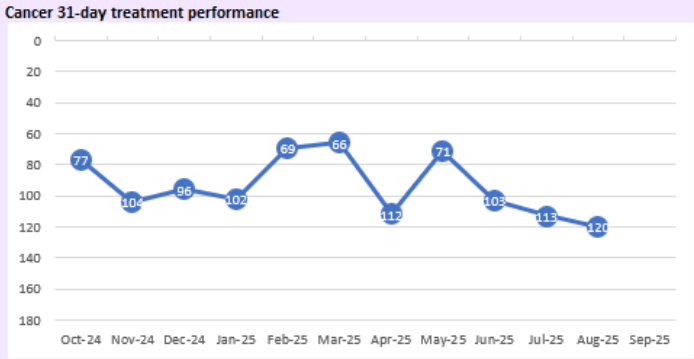


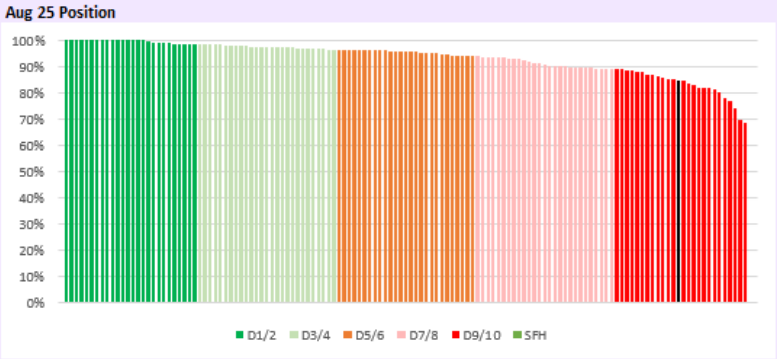


Benchmark position (to Aug-25)





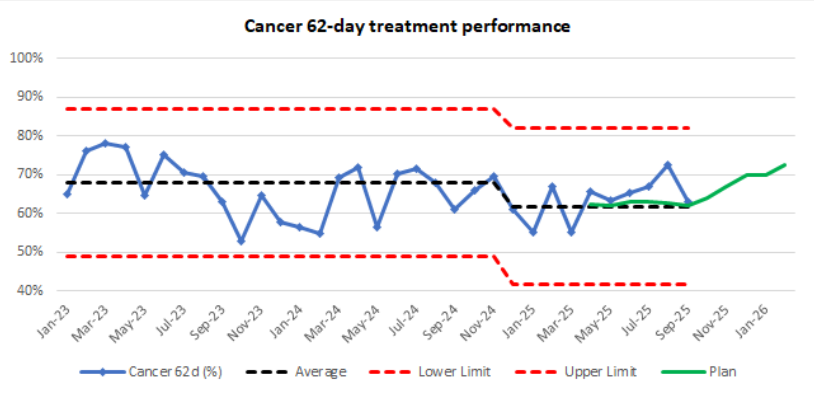




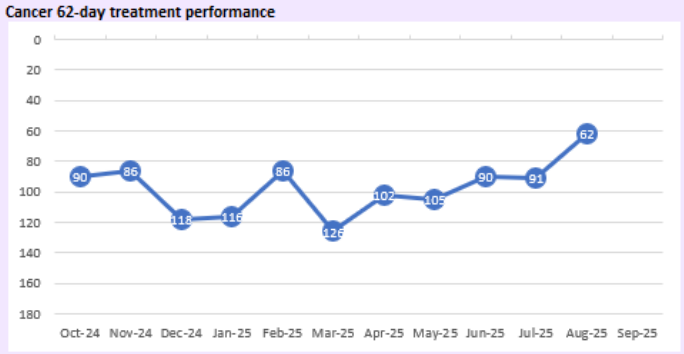
Indicators in Focus: Cancer (2/3)

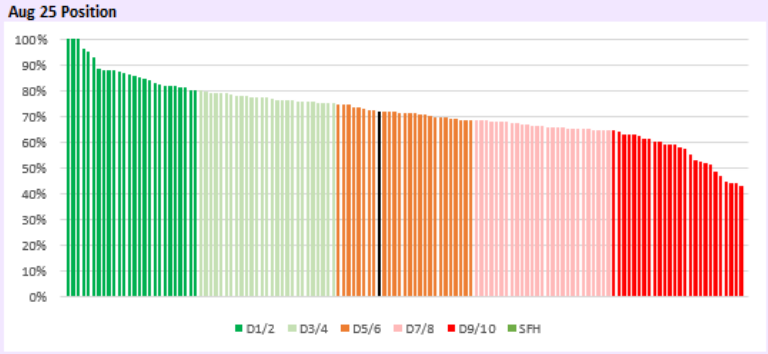
Sherwood Forest Hospitals NHS Foundation Trust

Local data (to Sep-25)



Benchmark position (to Aug-25)





Performance observations

- Cancer 28-day Faster Diagnosis Standard (FDS) is moving within statistical process control limits and is better than our operational plan, which requires performance of 80% by the end of 2025/26 as part of the national ambition. Our benchmark position remains in the top quartile nationally.

- Cancer 31-day treatment performance (first treatment) has been moving within standard variation since mid-2024, closing in Sep-25 at 88%. This is below the 96% national standard, which is our operational plan. Unfortunately, we continue to fall down the national benchmarking order and currently sit in the ninth decile. To benchmark in the upper quartile, we need to exceed the 96% national standard. Performance in this metric is significantly impacted by our low Skin position, which sits at 75%. Underperformance in this tumour site alone is adversely impacting our overall position by circa 6%.

- Cancer 62-day treatment performance has remained above plan throughout the first half of 2025/26 but reduced to the lowest position of the financial year in Sep-25, closing at 63.1%. We have further work to do this year to sustainably recover the position and achieve our plan for the second half of 2025/26. The operational plan requires improvement to 75% by the end of 2025/26 as part of the national ambition. Our improved Aug-25 performance saw us benchmark in the fifth decile nationally, though the deterioration in Sep-25 is likely to see us drop back into the eighth decile once the national benchmarking dataset is confirmed.

Indicators in Focus: Cancer (3/3)

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Root causes	Actions and timescale	Impact
Insufficient capacity to meet Radiology reporting turnaround targets.	• Recruitment to four WTE Consultant Radiologists to commence for 2026/27 deployment.	• Improve Radiology reporting turnaround.
	• Review of Head and Neck ultrasound referrals and demand to understand capacity issues and increase volume. • Appointment of substantive Head and Neck Radiologist to commence 2026/27.	• Reduce backlog.
	• Revision to PET scan capacity and booking processes to increase capacity to support the Lung pathway. • Ongoing review of lung biopsy capacity and flexibility, noting restrictions due to specialist capacity.	• Reduce backlog and improve 62-day performance.
Increase in Urology demand driving insufficient capacity and complex patients requiring multiple investigations.	• Establishment of working group to identify actions to improve pathways and align to national best practice timed pathways at the end of 2025/26 quarter two set out a 12-week plan to commence and complete in quarter three.	• Improvement in cancer waiting times standards.
Insufficient Histopathology workforce to meet demand creating pathway delays across multiple tumour sites.	• Recruitment process for additional Consultant capacity complete. Nine Consultants in post (four substantive, five locums). • Successful recruitment to 6.8WTE Medical Laboratory Assistant (MLA) posts. • Ongoing pay per point scheme to support additional cancer reporting.	• Improved histopathology turnaround and increased compliance with the 10-day standard. • Turnaround increased to a high of 79% in Oct-25 from a low 45% in May-25.
	• East Midlands Cancer Alliance (EMCA) funding to implement seven-day working across Histopathology commenced in 2025/26 quarter three and is gradually being introduced.	
Insufficient capacity to meet demand for Oncological treatment.	• All patients requiring oncology are now transferred to Nottingham University Hospitals (the Oncology service provider) to ensure a single PTL of patients for booking and prioritisation.	• Equalising waits for patients.
	• Review of the Oncology service and partnership arrangements that need to be in place is underway to ensure appropriate governance is in place. This is to increase cross provider working and to support the management of actions to improve patient pathways.	• Improve Oncology pathway.
Insufficient capacity to meet demand in Lower Gastrointestinal (LGI) and patient compliance issues.	• Implementation of revised faecal immunochemical test (FIT) criteria to align with the Nottinghamshire System agreed referral pathway to go live Oct-25 to impact end of 2025/26 quarter three.	• Improved FDS performance. • Reduced 62-day backlog – achieved an all time low of 10 patients in Nov-25. • First seen within 7-days sustained >50%.
Consultant capacity gaps in Skin exacerbated by seasonal demand.	• Locum Consultant in Skin recruited in Oct-25.	• Improve 31-day performance.

Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Best Value Care

Outstanding Care,
Compassionate People,
Healthier Communities

Domain Summary: Best Value Care

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Overview	Lead: Chief Financial Officer

The financial plan for 2025/26 is to deliver a break-even plan.

The Trust has reported an in-month deficit position of £2.37m in Oct-25; this is £2.95m behind the £0.58m surplus plan with the inclusion of the impact of International Financial Reporting Standard 16 (IFRS16) on the Private Financial Initiative (PFI). The year-to-date deficit is £5.66m, £6.01m behind plan. The reasons for the year-to-date position being behind plan are: five days of resident doctor Industrial Action during Jul-25 of £0.4m, £8.77m adverse Cost Improvement Programme (CIP) performance, £0.6m adverse variable income performance, £0.8m removal of deficit support funding, £0.77m MARS payments and £0.76m of other small pressures which is offset by £4m benefit from rephased income, £1.2m of balance sheet benefits and £0.9m of re-phased non-pay.

We are currently forecasting the achievement of the financial plan.

Given the challenging nature of the financial plan, there are key risks. These include: non-delivery of efficiency, finalisation of 2025/26 contracts with Integrated Care Boards (ICB) in line with Trust income plan, under delivery of elective activity, payback of 2024/25 financial support within the Nottinghamshire system and the financial impact of Industrial Action.

The annual Financial Improvement Programme (FIP) target is £45.83m in 2025/26. Month seven saw a year-to-date (YTD) delivery of £16.76m against a YTD plan of £25.54m. Control totals have been issued to divisions to recover the break-even position.

The 2025/26 Capital Expenditure Plan (CEP) has been prepared and submitted as part of the overall financial plan with an in-year plan of £39.52m. Expenditure for month seven totalled £1.36m, which was £2.17m below plan. Year to date expenditure totals £5.94m, which is £11.51m below plan, with the variance relating to the quarterly phasing of the Electronic Patient Record (EPR) system and month six and seven MRI planned expenditure and constitutional standards expenditure.

Closing cash on 31 Oct-25 was £7.89m, a reduction of £1.60m in-month and £18.64m year-to-date. The large cash balance is due to the receipt of capital funding in 2024/25 quarter four of £24.49m, additional ICB funding received in Mar-25 and working capital support of £8.31m received in Mar-25. The balance is unwinding and there remains an underlying pressure on available revenue cash resource due to the requirement to deliver significant efficiency savings in 2025/26, which will be managed by extending payment terms to suppliers if required. The forecast for Nov-25 onwards assumes delivery of efficiency savings, without which creditors will have to be extended to manage available cash.

The Trusts agency expenditure in Oct-25 is £0.77m and YTD £5.65m, which is 34% lower than the 2024/25 YTD expenditure due to the increased grip and control placed through the medical agency programme alongside some Elective Recovery Fund (ERF) schemes not having been fully re-instated during 2025/26. The 2024/25 run rate was £1.14m with £1.05 in the second half of the year and £1.03m in quarter four. Total agency expenditure as a proportion of our total pay spend is 3% YTD compared to an average of 4% in 2024/25. The largest proportion of our agency spend is on medical pay.

The Trusts bank expenditure in Oct-25 is £1.43m and YTD is £12.68m, which is 29% lower than the 2024/25 YTD expenditure. The target reduction set in the Trust plan was 15%, therefore we are significantly exceeding performance.

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

Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Scorecard: Best Value Care

Best Value Care

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

At a Glance	Indicator	2024/25 Standard	2025/26 Standard	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	2024/25 Final	2025/26 YTD	STAR Data Quality Assurance S	T	A	R
Financial Performance	Financial surplus / deficit	n/a	≥£0.00m				✗-£0.90	✗-£0.70	✗-£0.20	✓£0.10	✓£0.02	✗-£1.62	✗-£2.37		✗-£5.67				
	Variance YTD to financial plan	≥£0.00m	≥£0.00m	✗-£2.68	✗-£2.60	✓£7.14	✓£0.00	✓£0.00	✓£0.00	✗-£0.40	✗-£0.58	✗-£2.08	✗-£2.95	✓£0.01	✗-£6.01				
Efficiency	Financial efficiency variance YTD to plan	≥£0.00m	≥£0.00m	✓£0.26	✗-£0.04	✓£0.15	✗-£0.81	✗-£0.72	✗-£1.30	✗-£0.83	✗-£0.48	✗-£2.81	✗-£1.83	✓£0.08	✗-£8.78				
	Risk adjusted efficiency forecast to plan (%)	n/a	100%				✗46.5%	✗55.0%	✗56.6%	✗65.0%	✗68.0%	✗74.0%	✗81.0%		-				
Variable Pay	Reported agency expenditure	No Standard	No Standard	£1.03	£1.05	£1.00	£0.75	£0.87	£1.01	£0.78	£0.78	£0.69	£0.77	£13.70	£5.65				
	Reported bank expenditure	No Standard	No Standard	£2.81	£2.22	£2.51	£1.88	£1.90	£1.70	£2.09	£2.12	£1.57	£1.43	£30.55	£12.69				
Rate of Productivity	Implied productivity growth (YTD compared to last year)	3.1%	2%	✓3.3%	✓4.3%	✓3.1%	✗0.9%	✓3.8%	✓5.0%	✓4.2%	-	-	-		-				
Cash & Liquidity	BPPC - Number of bills paid within target	n/a	≥95%				✗24.7%	✗33.5%	✗62.6%	✗76.6%	✗87.2%	✗87.5%	✗83.9%		✗66.0%				
	BPPC - Value of bills paid within target	n/a	≥95%				✗69.2%	✗75.2%	✗69.3%	✗73.3%	✗93.9%	✗91.6%	✗90.6%		✗80.5%				
	Operating expenditure days	n/a	≥5				✓ 16	✓ 16	✓ 13	✓ 10	✓ 10	✓ 6	✓ 5		✓ 11				
Capital	Capital expenditure against plan	≤£33.61m	≤£0.00m	£2.43	£1.62	£18.40	✗£0.35	✗£1.10	✗£0.44	✗£0.78	✗£1.07	✗£0.85	✗£1.36	✓£33.58	✗£5.94				

Indicator in Focus: Financial Performance

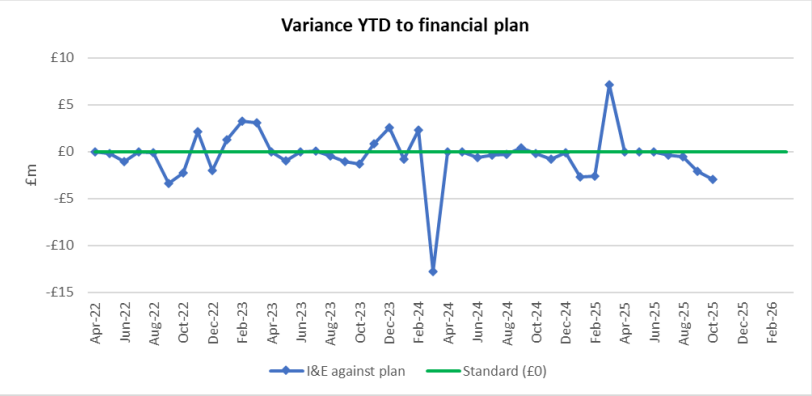
Sherwood Forest Hospitals NHS Foundation Trust

Performance observations

- The standard is the Trust financial plan, which is a break-even position for 2025/26. This is aligned to the Trust's share of the 2025/26 Revenue Plan Limit set for the Nottingham and Nottinghamshire ICB by NHS England.
- The Trust has a YTD £5.66m deficit, which is £6.01m behind the planned surplus of £0.35m for the YTD position at month seven.

Root Causes	Actions and timescale/areas of risk	Impact
Urgent and Emergency Care demand pressures.	• If the emergency care pathway growth is higher than the planned levels, then it will cause pressure on our income and expenditure position.	Deliver annual plan.
Non-delivery of the FIP.	• At month seven the Trust is £8.78m behind the plan. Divisional and corporate areas have been given control totals to enable the Trust to achieve a break-even position. This recovery approach combines workforce controls, divisional and corporate accountability and income recovery measures.	
Variable activity plan.	• We need to ensure as a Trust that we maintain the variable elements of our activity to ensure we maintain the level of income associated with this.	
Industrial action.	• There is no national funding available to cover this and we will need to minimise costs where possible, as well as recovering the lost activity in line with the variable activity plan.	
Finalisation of 2025/26 contract with ICBs.	• Trust is still negotiating 2025/26 contract values with Nottinghamshire and Lincolnshire ICBs. If contract values are not aligned to Trust internal assumptions, then it will cause pressure on our income and expenditure position.	
Payback of 2024/25 financial support within the Nottinghamshire system.	• Current plan does not assume any payback of the financial support that delivered the 2024/25 financial position.	
	• The payback value expected from SFH is £4.1m. There is an expectation that this is transacted through a reduced contract value in 2025/26. Any payback will cause pressure on our income and expenditure position.	

Data



Indicator in Focus: Efficiency

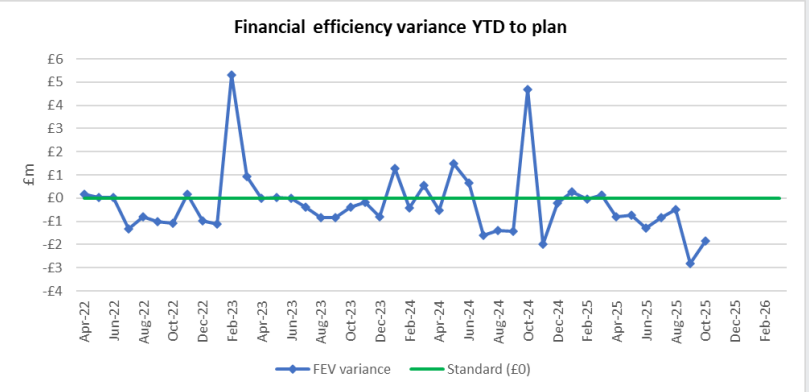
Sherwood Forest Hospitals NHS Foundation Trust

Performance observations

- The standard is the Trust Financial Improvement Plan (FIP).
- The Trust has a £45.83m efficiency programme for 2025/26, which is currently £8.78m behind plan YTD.

Root causes	Actions and timescale	Impact
Non-delivery of Financial Improvement Programme.	• A financial recovery plan is in development. Six workstreams have been established, covering every pound spent and received.	Deliver annual plan.
	• Control totals set for each programme and division / directorate, aligned to the Trust requirement to deliver a break-even plan.	
	• PA Consulting support has been in place; this ceased at the end of Oct-25.	
	• Increased workforce controls established. • New non-pay oversight group is being developed for implementation to create the same clarity, consistency and control environment that the HR Playbook has delivered for pay.	
	• Enhanced oversight and grip strengthened to support delivery within the financial year.	
Risk adjusted forecast.	• Currently the weighted target at month seven is £37.2m, which is 81% of the target. An increase to this is required at pace, supported by the new workstreams.	
	• The unweighted forecast reported to NHS England is full delivery of the target.	

Data



Indicator in Focus: Agency Pay

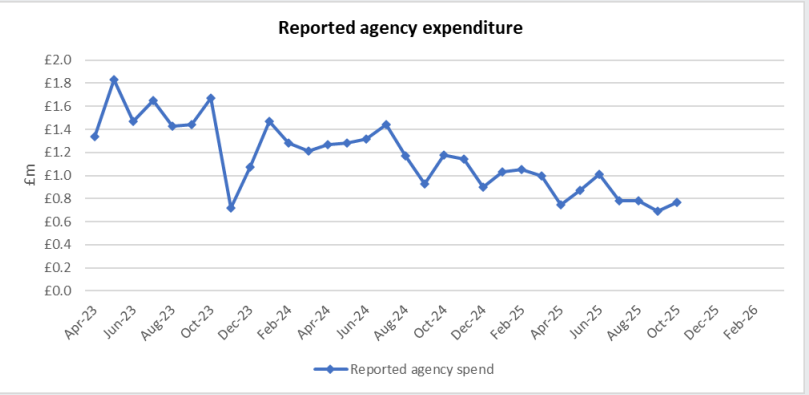
Sherwood Forest Hospitals NHS Foundation Trust

Performance observations

- The standard is the planned agency expenditure for 2025/26.
- The Trust has reported agency expenditure of £5.65m YTD.
- Agency expenditure accounts for 3% of our total pay bill YTD, a reduction from our 2024/25 run rate.
- Agency reduction relative to the 40% target for 2025/26 is 34% YTD.

Root causes	Actions and timescale	Impact
Level of vacancies and sickness.	• Medical and Nursing and Allied Health Professional (AHP) transformation programmes are tasked with achieving the required 40% reduction in agency expenditure compared to our Nov-24 forecast. • Enhanced financial governance focus on agency spend and compliance at Divisional Performance Reviews and Divisional Finance Committees. • Clinical pay workstream is in place. Weekly workforce meetings with increased workforce controls established and major interventions in place. • PA Consulting support has been in place; this ceased at the end of Oct-25. • All medical agency bookings that are above cap are reviewed at bi-weekly vacancy control panels. There are still shifts filled over-cap, but this has begun to reduce. • The use of off-framework agencies is not permitted. Any exceptions are to be approved by the Chief Executive Officer. All internal escalation forms have been updated to reflect this.	Reduced agency run rate to achieve financial plan.

Data



Indicators in Focus: Cash and Liquidity

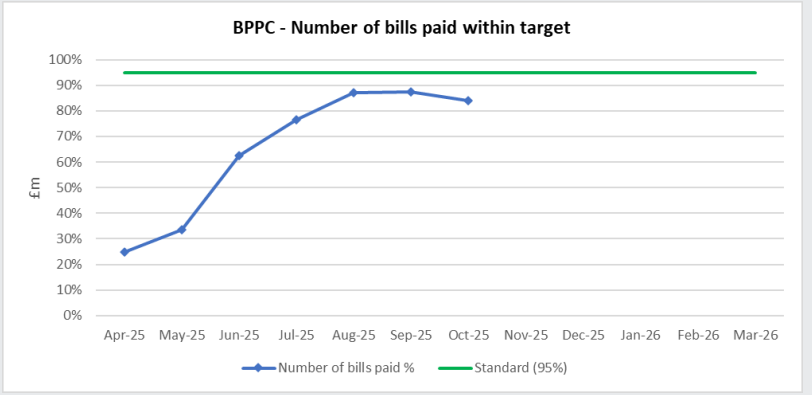
Sherwood Forest Hospitals NHS Foundation Trust

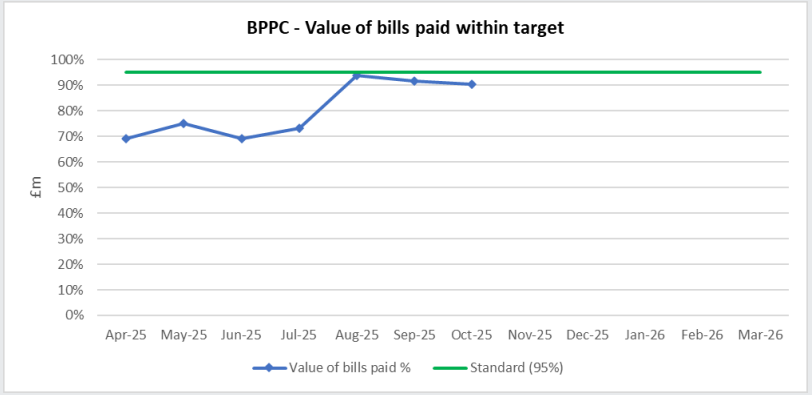
Performance observations

- The standard is the minimum cash balance (£1.45m) as set by the Department of Health and Social Care (DHSC) as a condition of revenue cash support.
- At the end of Oct-25, cash in bank was £7.89m, which is above plan and above the minimum cash balance.
- The submitted plan for 2025/26 does not require revenue borrowing Public Dividend Capital (PDC). However, there is significant capital PDC £32.93m planned in-year to support the ICB allocation and national schemes.

Root causes	Actions and timescale	Impact
Standard is the plan and the minimum cash balance required by DHSC of £1.45m as part of our support.	• Management of available cash balances to accounts payable payments due. • Prioritisation matrix of supplier payments agreed at the Trust Management Team.	• Requirement to ensure minimum balance is met/ maintained. • Disruption to services if suppliers cannot be paid in a timely manner.
Plan requires significant capital PDC in year £15.23m to support the ICB allocation.	• Capital PDC cash support from DHSC submitted Aug-25.	• Extended payment terms to suppliers. • Failure to achieve Better Payment Practice code (BPPC). • Unsupportable capital plan.
Failure to deliver efficiency programme on a cash releasing basis.	• Delivery of efficiency improvement programme, which includes £21.06m of savings in 2025/26 quarter one and two, of a full year plan of £45.83m.	• Requirement to submit working capital applications to support payments.

Data





Indicator in Focus: Capital

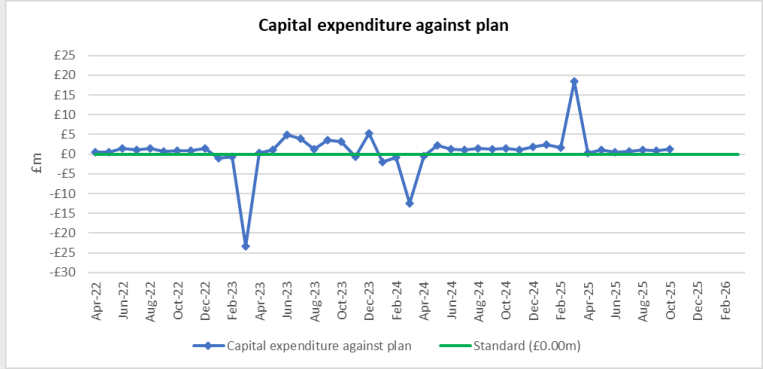
Sherwood Forest Hospitals NHS Foundation Trust

Performance observations

- The standard is the 2025/26 Capital Expenditure Plan.
- The plan requires capital borrowing support from the Department of Health and Social Care (DHSC).
- There are known risks due to the value of pre-commitments in the 2025/26 plan.
- Return to constitutional standards funding requires further supporting submission in 2025/26 relating to the Emergency Department (ED). The Elective and Diagnostics have been approved and memorandum of understandings received. Detailed monitoring to ensure delivery in-year to plan.

Root causes	Actions and timescale	Impact
Pre-commitments to Trust priorities limiting business as usual capital.	• Monitoring of spend to ensure pre-commitments deliver within plan. • Allocation agreed with Integrated Care System partners for 2025/26.	Delivery of Capital Expenditure Plan.
Requirement for Public Dividend Capital (PDC) to support ICB plan £15.23m and national schemes £17.72m.	• PDC request submitted 4 Aug-25.	Spending at risk without formal approval, impacting available cash to meet revenue payments as they fall due.
Significant national funding for return to constitutional standards for which submissions are required to NHS England.	• All submissions made, further information is required in respect of ED, which will need to be submitted by the end of Jan-26. • Monitoring of in-year spend to ensure delivery to funding envelope.	Overspends impacting other capital delivery requirements. Loss of part of ED funding if submission is not approved by DHSC.

Data



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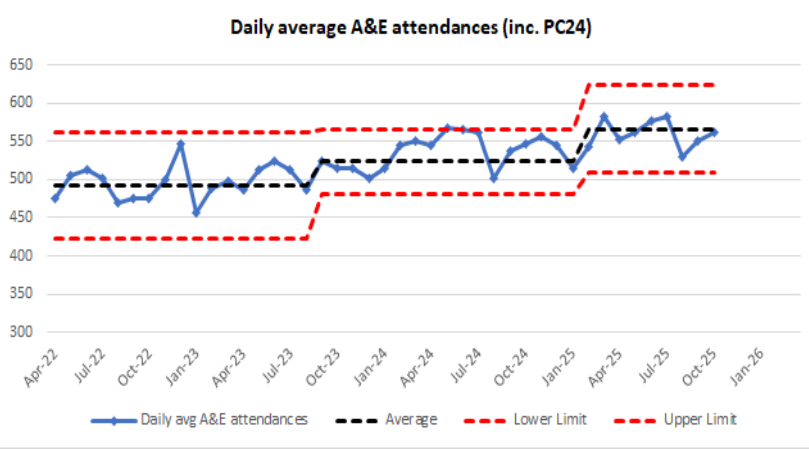
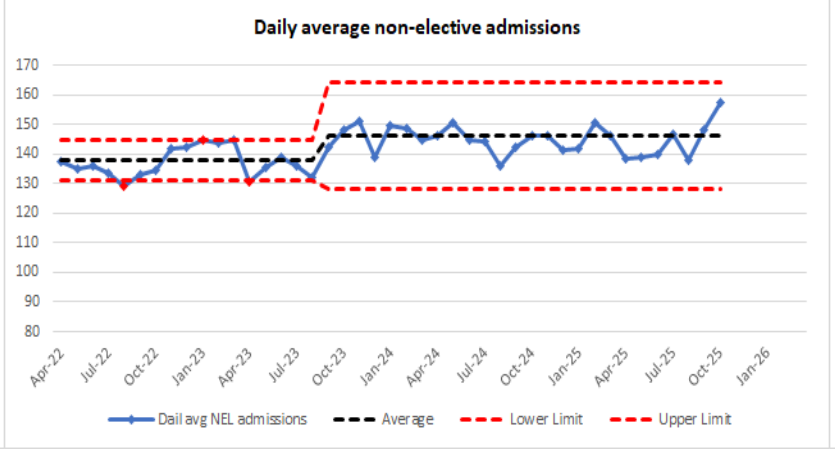
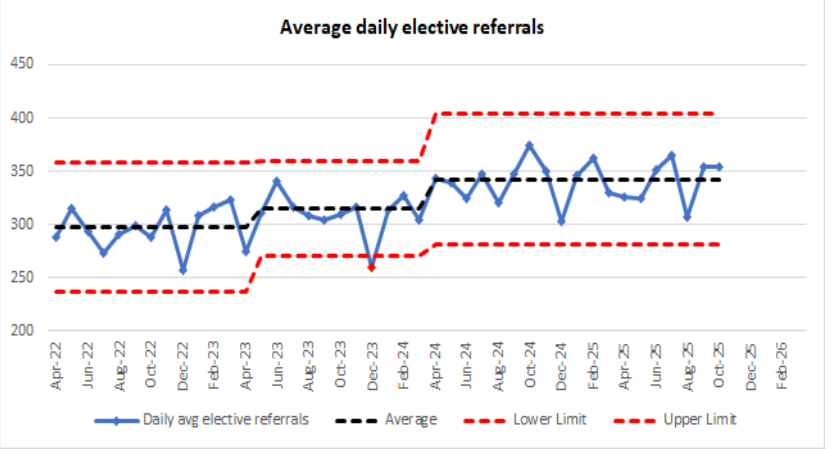
Activity Data and Trends (1/2)

Based on daily averages

At a Glance	Indicator	2024/25 Standard	2025/26 Standard	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	2024/25 Final	2025/26 YTD
Urgent Care	A&E attendances (inc. PC24)			515	543	582	552	562	577	582	530	550	561	547	559
	Non-elective admissions			142	150	146	139	139	140	147	138	148	157	145	144
Electives	Average daily elective referrals			346	362	330	326	325	352	365	307	354	354	341	340
	Outpatients - first appointment			327	339	323	318	308	335	352	281	367	331	347	327
	Outpatients - follow up			875	907	855	849	802	853	907	748	899	831	852	841
	Outpatients - procedures			287	278	254	257	254	267	293	247	282	269	265	267
	Day case			127	126	116	114	116	123	126	114	121	128	122	120
	Elective inpatient			12	13	13	13	14	15	15	14	13	14	14	14
Diagnostics	Diagnostics			496	518	490	476	464	477	494	461	478	488	479	477







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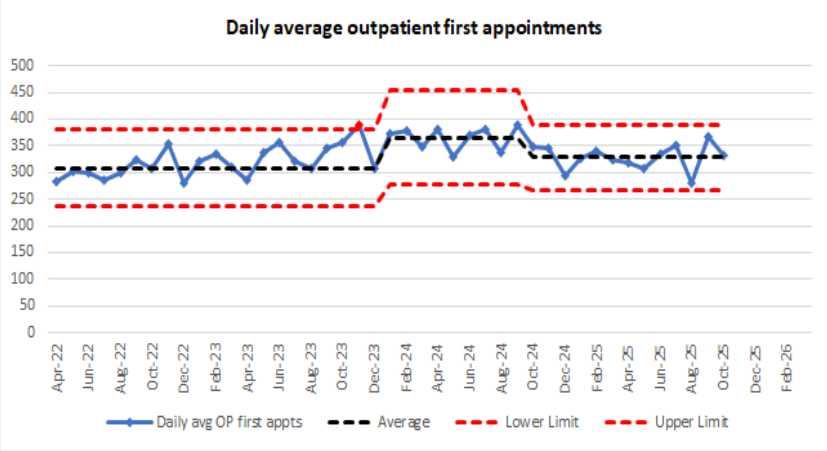
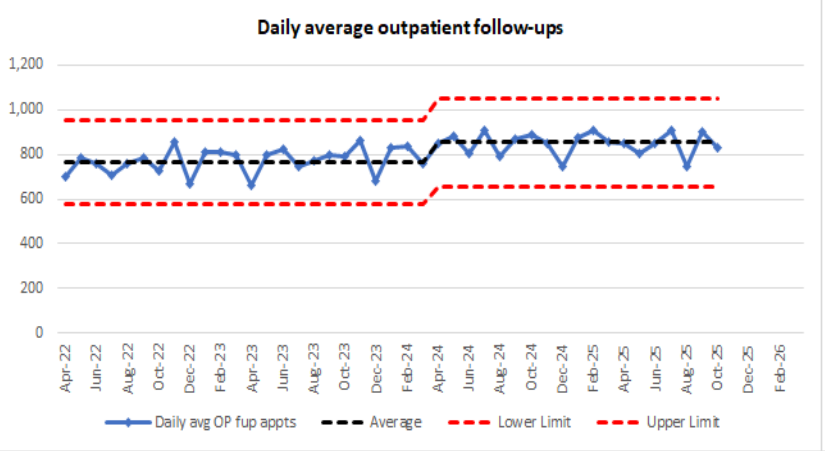
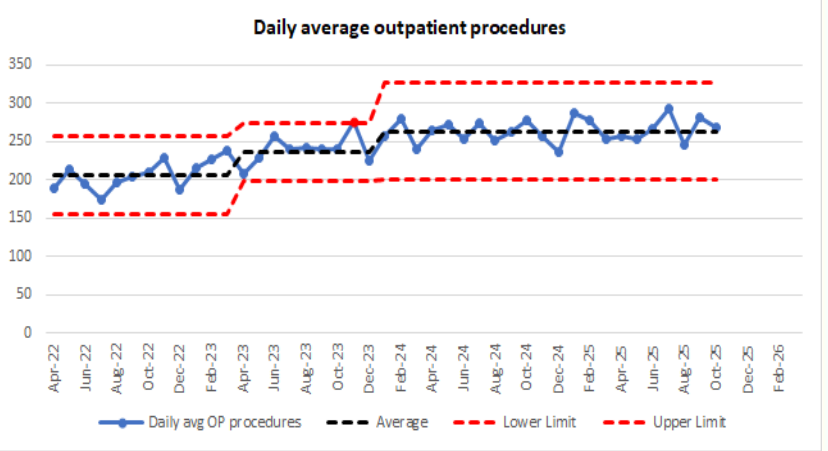
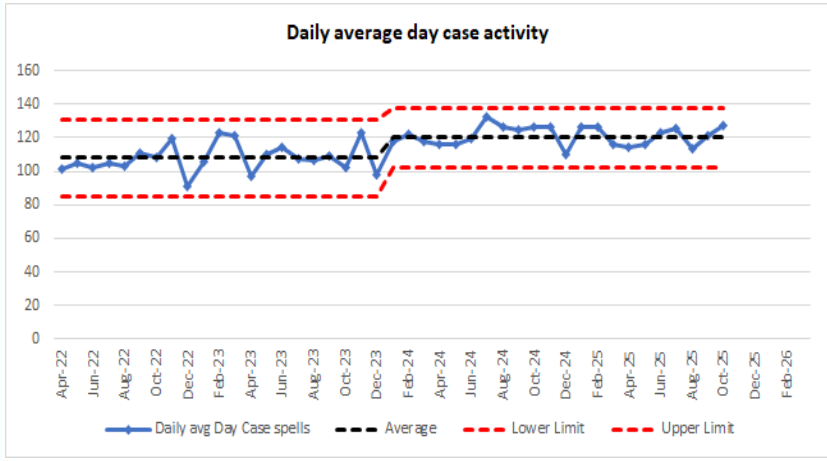
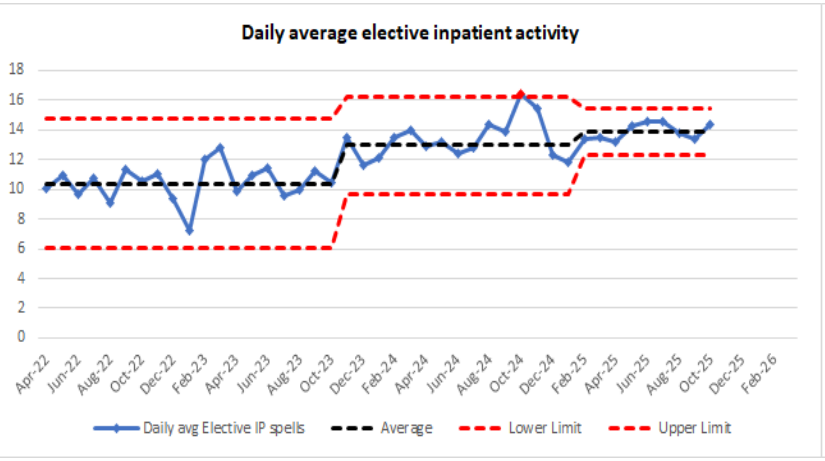
Activity Data and Trends (2/2)

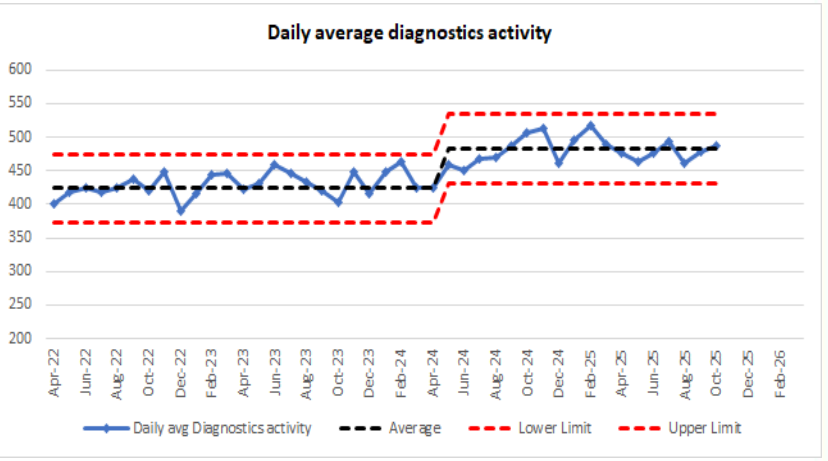












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Appendix A: Integrated Scorecard & Graphs for each indicator

The Integrated Scorecard together with graphs for all indicators is included as a separate file.

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Appendix B: Benchmarking Guidance (1/2)

How can we use benchmarking?

Benchmarking can tell us:

Are we different?

- Looking at the available evidence, is there a difference between our organisation and other comparable organisations?
- Evidence can be qualitative or quantitative (focus of this will be on quantitative).

How are we different?

- Does the evidence show that we are better or worse than comparators?
- Are we significantly different, or is the difference just normal variation?
- Can we easily explain the difference?

Why are we different?

- What are the better performing Trusts doing differently to us?
- Look at data for correlations of performance.
- Review any literature available relating to those organisations e.g. Benchmarking Network good practice compendiums.
- Contact other organisations.

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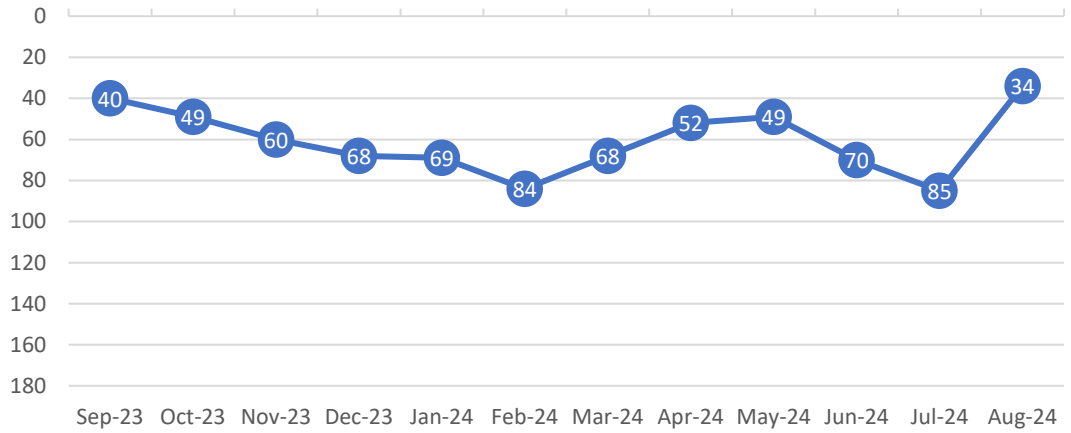
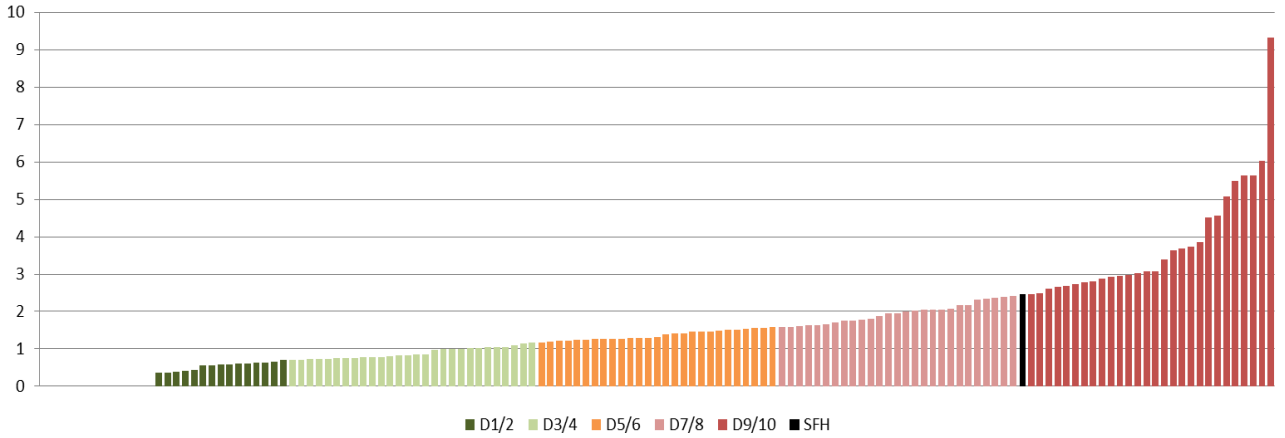
Appendix B: Benchmarking Guidance (2/2)

Reading the benchmarking charts:

The Trend Chart



The Bar Chart



The trend chart shows the SFH position relative to other Trusts nationally over time.

This gives us an indication if changes to our own rates are internally driven i.e. something the Trust is doing differently, or if the changes are related to wider environmental factors that will impact every Trust.

In the case of these charts, a lower number is always considered to be the better performing i.e. the chart shows our rank with 1 being the best in the country.

The bar chart shows the SFH position compared to other acute Trusts nationally; each bar represents a Trust, with the different colours each representing two deciles, or 20% of Trusts nationally (dark red being the worst performing 20%, dark green being the best performing) with SFH coloured black.

This allows us to see the comparative spread of performance, and the gap from the SFH position to the national average (median).

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Appendix C: Data Quality Indicator Guidance

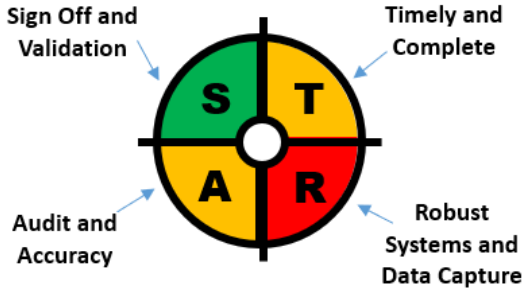
The Data Quality STAR Indicators are being used to provide assurance around the IPR metrics. They assess the quality and reliability of the data and systems used to populate the report.

The assurance indicators have been split into four domains (see below), and the level of assurance is shown using a red/amber/green (RAG) rating.

The scores for each metric are generated through answers to a standard set of questions which evaluate the assurance we have against each domain for each IPR metric.

Domain		Explanation
S	Sign-off and validation	Is the data checked for validity and consistency with the appropriate executive oversight. Is there a named accountable senior manager who signs off the data as a true relfection of the trust activty.
T	Timely and complete	Is the data complete at the time of publication, and it is readily available. Does any part fo the data require changing at a later date.
A	Audit and accuracy	Is there processes in place for audits (either internal or external), and how often to these happen. Is there accuracy checks built in to data collection or reporting processes?
R	Robust systems and data capture	Are there robust systems which have been documented according to data dictionary standards for data capture.

Total Score	Overall KPI Rating Key
0 to 11	No Assurance
12 to 15	Limited Assurance
16 to 19	Reasonable Assurance
20 to 24	Substantial Assurance



Sherwood Forest Hospitals NHS Foundation Trust

Integrated Performance Report 2025/26

October 2025 (Qtr 3)

Cover Page | Charts | Definitions

Integrated Report

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

Category	At a Glance	NOF	Indicator	2024/25 Standard	2025/26 Standard	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	2024/25 Final	2025/26 YTD	STAR Data Quality Assurance S	T	A	R
Quality of Care	Safe		Rate of inpatients to suffer a new hip fracture	n/a	No Standard	2.4	2.6	2.1	1.7	2.6	1.9	2.4	2.2	1.7	2.3		2.1				
			Never events	0	0	✓ 0	✓ 0	✓ 0	✓ 0	✗ 1	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✗ 2	✗ 1				
		✓	MRSA reported in month	0	0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✗ 1	✗ 1	✓ 0	✓ 0	✗ 1	✗ 2				
		✓	Cdifficile (hospital-acquired) reported in month	≤13 qtr	4	4	5	5	✗ 7	✗ 5	✗ 6	✗ 6	✗ 7	✗ 7	✗ 9	✗ 55	✗ 47				
		✓	Number of gram-negative bloodstream infections reported in month	n/a	8	5	1	5	✓ 6	✓ 3	✓ 6	✓ 4	✓ 3	✓ 5	✓ 3	50	✓ 30				
			HAPU (cat 2) per 1000 occupied bed days with a lapse in care	No Standard	No Standard	0.1	0.2	0.0	0.1	0.2	0.0	0.0	0.0	0.1	0.1	0.1	0.1				
			HAPU (cat 3/4) and ungradable pressure ulcers with lapse in care	0	0	✗ 1	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✗ 1	✓ 0	✗ 1	✗ 6	✗ 2				
			Patient Safety Incident Investigations (PSII) and Duty of Candour	No Standard	No Standard	2	1	0	5	13	10	2	11	10	9	17	60				
			Percentage of inpatient Service Users undergoing risk assessment for VTE	≥95%	≥95%	✗ 84.1%	✗ 85.1%	✗ 89.6%	✗ 90.5%	✗ 89.7%	✗ 89.4%	✗ 88.0%	✗ 85.3%	✗ 89.5%	✗ 85.9%		✗ 88.3%				
	Caring		Complaints per 1000 occupied bed days	≤1.9	≤1.9	✓ 1.4	✓ 0.7	✓ 0.8	✓ 1.3	✓ 1.3	✓ 1.6	✓ 1.7	✓ 1.2	✓ 1.3	✓ 1.4	✓ 0.9	✓ 1.4				
			Compliments received in month	No Standard	No Standard	140	152	184	155	115	141	157	109	137	98	1831	912				
	Effective	✓	SHMI	As Expected	As Expected	✓ 106	✓ 106	✓ 107	✓ 106	✓ 105	✓ 106	✓ 106	✓ 107	✓ 107	✓ 106	✓ 107	✓ 107				
			Still birth rate	≤4.4	≤4.4	✓ 3.5	✗ 15.5	✓ 0.0	✓ 3.6	✓ 3.2	✓ 3.6	✗ 7.1	✗ 10.0	✗ 10.2	✓ 3.4	✓ 4.3	✗ 5.9				
			Early neonatal deaths per 1000 live births	≤1	≤1	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.3	✓ 0.0				
People and Culture	Belonging in the NHS	✓	Engagement score	≥6.8%	≥6.9%			✓ 7.1			✓ 6.8					✓ 7.1	✓ 6.8				
	Growing the Future		Vacancy rate	≤8.5%	≤8.5%	✓ 7.8%	✓ 7.7%	✓ 7.7%	✗ 9.3%	✗ 9.5%	✗ 9.7%	✗ 9.1%	✓ 8.4%	✓ 8.0%	✓ 7.9%	✓ 8.0%	✗ 8.8%				
			Time to hire	n/a	≤53.1 days	✓ 49.0	✓ 34.0	✓ 27.0	✓ 23.0	✓ 21.0	✓ 29.0	✓ 29.0	✓ 28.0	✓ 25.0	✓ 36.0		✓ 29.2				
			Turnover in month	≤0.9%	≤0.9%	✓ 0.5%	✓ 0.4%	✓ 0.7%	✓ 0.6%	✓ 0.5%	✓ 0.5%	✓ 0.5%	✓ 0.5%	✓ 0.8%	✗ 1.0%	✓ 0.7%	✓ 0.6%				
			Appraisals	≥90%	≥90%	✗ 88.4%	✗ 88.2%	✓ 90.0%	✓ 90.0%	✗ 90.0%	✗ 88.7%	✗ 87.4%	✗ 88.0%	✗ 88.2%	✗ 87.5%	✗ 89.0%	✗ 88.6%				
			Mandatory & statutory training	≥90%	≥90%	✓ 92.4%	✓ 92.8%	✓ 92.9%	✓ 92.2%	✓ 93.1%	✓ 93.1%	✓ 93.2%	✓ 92.9%	✓ 92.9%	✓ 93.3%	✓ 91.5%	✓ 93.0%				
			Medical job plan compliance	n/a	≥95%	✗ 57.0%	✗ 86.1%	✗ 76.1%	✗ 50.6%	✗ 70.4%	✗ 71.3%	✗ 79.6%	✗ 91.4%	✗ 94.0%	✓ 95.9%		✗ 79.7%				
	Looking after our People	✓	Sickness absence	≤4.2%	≤4.2%	✗ 5.9%	✗ 5.0%	✗ 4.6%	✗ 4.9%	✗ 4.8%	✗ 5.1%	✗ 5.0%	✗ 4.8%	✗ 4.8%	✗ 5.7%	✗ 5.0%	✗ 5.0%				
			Flu vaccinations uptake (front line staff)	≥75%	≥75%	✗ 47.7%	✗ 47.8%	-	-	-	-	-	-	-	✗ 35.8%	✗ 58.0%					
			Employee relations management	<17	<21	✗ 20	✗ 25	✗ 31	✗ 23	✓ 18	✗ 23	✓ 18	✓ 18	✓ 20	✗ 21	✗ 21	✓ 20				
	New Ways of Working		Bank usage	≤8.5%	≤7.8%	✗ 9.7%	✓ 8.0%	✗ 8.8%	✓ 6.3%	✓ 6.4%	✓ 5.9%	✓ 6.8%	✓ 7.1%	✓ 5.1%	✓ 4.8%	✗ 8.9%	✓ 6.1%				
			Agency usage	<3.2%	<1.9%	✗ 3.6%	✗ 3.8%	✗ 3.5%	✗ 2.5%	✗ 2.9%	✗ 3.5%	✗ 2.6%	✗ 2.6%	✗ 2.3%	✗ 2.6%	✗ 4.0%	✗ 2.7%				
			Agency (off framework)	0.0%	0.0%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✗ 0.01%	✓ 0.0%				
			Agency (over price cap)	≤40.0%	≤40.0%	✗ 46.0%	✗ 47.3%	✗ 61.5%	✓ 38.7%	✓ 36.8%	✓ 38.3%	✗ 40.2%	✓ 36.1%	✗ 40.9%	✓ 33.4%	✗ 52.9%	✓ 37.8%				
Timely Care	Urgent Care		Ambulance turnaround times <30 mins	≥95%	≥95%	✗ 86.3%	✗ 86.3%	✗ 89.0%	✗ 92.1%	✗ 90.8%	✗ 90.5%	✗ 86.0%	✗ 85.0%	✗ 82.3%	✗ 76.2%	✗ 91.4%	✗ 86.1%				
			Ambulance turnaround times >60 mins	0.0%	0.0%	✗ 1.4%	✗ 1.2%	✗ 0.8%	✗ 0.6%	✗ 0.5%	✗ 0.2%	✗ 0.7%	✗ 1.2%	✗ 2.5%	✗ 3.7%	✗ 0.7%	✗ 1.4%				
		✓	ED 4-hour performance	≥76%	≥Plan	✗ 65.3%	✗ 68.2%	✗ 75.2%	✓ 77.3%	✓ 79.0%	✓ 76.8%	✗ 72.4%	✗ 68.8%	✗ 68.0%	✗ 67.4%	✗ 71.0%	✗ 72.8%				
		✓	ED 12-hour length of stay performance	≤2%	≤2024/25	✗ 5.5%	✗ 4.2%	✓ 1.7%	✓ 2.1%	✓ 1.7%	✓ 1.8%	✓ 2.8%	✗ 6.1%	✗ 5.6%	✗ 8.2%	✗ 3.4%	✗ 4.0%				
			Mental health patients spending over 12 hours in A&E	n/a	No Standard	31	26	19	18	21	19	22	24	23	27	23	154				
			Adult G&A bed occupancy	≤92%	≤92%	✗ 96.1%	✗ 94.4%	✗ 94.0%	✗ 94.6%	✗ 95.2%	✗ 95.5%	✗ 96.2%	✗ 95.9%	✗ 96.3%	✗ 96.5%	✗ 94.5%	✗ 95.7%				
		✓	Average number of days between planned and actual discharge date	n/a	≤Plan	2.9	2.7	3.1	✓ 3.3	✓ 3.2	✗ 4.3	✗ 4.1	✗ 3.8	✓ 3.4	✓ 3.0		✓ 3.6				
			Inpatients medically safe for transfer for greater than 24 hours	≤40	≤40	✗ 65	✗ 48	✗ 50	✗ 53	✗ 51	✗ 68	✗ 79	✗ 87	✗ 82	✗ 72	✗ 64	✗ 70				
	Electives		Added to Patient Initiated Follow Up (PIFU) pathway	≥5%	≥5%	✓ 5.3%	✓ 9.6%	✓ 9.9%	✓ 11.1%	✓ 10.7%	✓ 10.5%	✓ 10.7%	✓ 10.9%	✓ 11.2%	✓ 11.3%	✓ 6.0%	✓ 10.9%				
		✓	Percentage of incomplete Referral to Treatment (RTT) pathways completed in less than 18 weeks	n/a	≥Plan	63.3%	63.5%	64.6%	✗ 63.7%	✗ 64.0%	✗ 64.1%	✗ 62.9%	✗ 61.3%	✗ 61.9%	✗ 60.4%		✗ 62.6%				
		✓	Percentage of RTT waits over 52 weeks for incomplete pathways	n/a	≤Plan	1.8%	1.6%	1.3%	✓ 1.3%	✓ 1.2%	✓ 1.1%	✓ 1.1%	✓ 1.0%	✓ 0.9%	✓ 0.9%		✗ 1.1%				
	Diagnostics		Diagnostic DM01 performance under 6-weeks	≥Plan	≥Plan	✓ 88.7%	✓ 94.4%	✓ 93.1%	✗ 88.9%	✗ 87.1%	✗ 88.2%	✗ 87.9%	✗ 87.6%	✗ 89.8%	✗ 90.4%	✓ 93.1%	✗ 90.4%				
	Cancer	✓	Cancer 28-day faster diagnosis standard	≥75%	≥Plan	✗ 71.6%	✓ 79.7%	✓ 78.0%	✓ 77.6%	✓ 76.4%	✓ 82.4%	✓ 83.1%	✓ 82.3%	✓ 80.7%		✓ 78.3%	✓ 80.5%				
			Cancer 31-day treatment performance	≥Plan	≥96%	✗ 86.9%	✓ 96.1%	✓ 95.4%	✗ 87.6%	✗ 94.4%	✗ 91.2%	✗ 89.0%	✗ 84.8%	✗ 88.4%		✓ 91.9%	✗ 89.3%				
		✓	Cancer 62-day treatment performance	≥Plan	≥Plan	✗ 55.0%	✗ 66.9%	✗ 55.1%	✓ 65.5%	✓ 63.3%	✓ 65.3%	✓ 66.9%	✓ 72.4%	✓ 63.1%		✗ 64.4%	✓ 66.0%				
Best Value Care	Financial Performance	✓	Financial surplus / deficit	n/a	≥£0.00m				✗ -£0.90	✗ -£0.70	✗ -£0.20	✓ £0.10	✓ £0.02	✗ -£1.62	✗ -£2.37		✗ -£5.67				
		✓	Variance YTD to financial plan	≥£0.00m	≥£0.00m	✗ -£2.68	✗ -£2.60	✓ £7.14	✓ £0.00	✓ £0.00	✓ £0.00	✗ -£0.40	✗ -£0.58	✗ -£2.08	✗ -£2.95	✓ £0.01	✗ -£6.01				
	Efficiency		Financial efficiency variance YTD to plan	≥£0.00m	≥£0.00m	✓ £0.26	✗ -£0.04	✓ £0.15	✗ -£0.81	✗ -£0.72	✗ -£1.30	✗ -£0.83	✗ -£0.48	✗ -£2.81	✗ -£1.83	✓ £0.08	✗ -£8.78				
			Risk adjusted efficiency forecast to plan (%)	n/a	100%				✗ 46.5%	✗ 55.0%	✗ 56.6%	✗ 65.0%	✗ 68.0%	✗ 74.0%	✗ 81.0%		-				
	Variable Pay		Reported agency expenditure	No Standard	No Standard	£1.03	£1.05	£1.00	£0.75	£0.87	£1.01	£0.78	£0.78	£0.69	£0.77	£13.70	£5.65				
			Reported bank expenditure	No Standard	No Standard	£2.81	£2.22	£2.51	£1.88	£1.90	£1.70	£2.09	£2.12	£1.57	£1.43	£30.55	£12.69				
	Rate of Productivity	✓	Implied productivity growth (YTD compared to last year)	£0.03m	2.0%	✓ 3.3%	✓ 4.3%	✓ 3.1%	✗ 0.9%	✓ 3.8%	✓ 5.0%	✓ 4.2%	-	-	-		-				
	Cash & Liquidity		BPPC - Number of bills paid within target	n/a	≥95%				✗ 24.7%	✗ 33.5%	✗ 62.6%	✗ 76.6%	✗ 87.2%	✗ 87.5%	✗ 83.9%		✗ 66.0%				
			BPPC - Value of bills paid within target	n/a	≥95%				✗ 69.2%	✗ 75.2%	✗ 69.3%	✗ 73.3%	✗ 93.9%	✗ 91.6%	✗ 90.6%		✗ 80.5%				
			Operating expenditure days	n/a	≥5				✓ 16	✓ 16	✓ 13	✓ 10	✓ 10	✓ 6	✓ 5		✓ 11				
	Capital		Capital expenditure against plan	≤£33.61m	≤£0.00m	£2.43	£1.62	£18.40	✗ £0.35	✗ £1.10	✗ £0.44	✗ £0.78	✗ £1.07	✗ £0.85	✗ £1.36	✓ £33.58	✗ £5.94				
Activity (for context)	Urgent Care		A&E attendances (inc. PC24)			515	543	582	552	562	577	582	530	550	561	547	559				
			Non-elective admissions			142	150	146	139	139	140	147	138	148	157	145	144				
	Electives		Average daily elective referrals			346	362	330	326	325	352	365	307	354	354	341	340				
			Outpatients - first appointment			327	339	323	318	308	335	352	281	367	331	347	327				
			Outpatients - follow up			875	907	855	849	802	853	907	748	899	831	852	841				
			Outpatients - procedures			287	278	254	257	254	267	293	247	282	269	265	267				
			Day case			127	126	116	114	116	123	126	114	121	128	122	120				
			Elective inpatient			12	13	13	13	14	15	15	14	13	14	14	14				
	Diagnostics		Diagnostics			496	518	490	476	464	477	494	461	478	488	479	477				

Sherwood Forest Hospitals NHS Foundation Trust

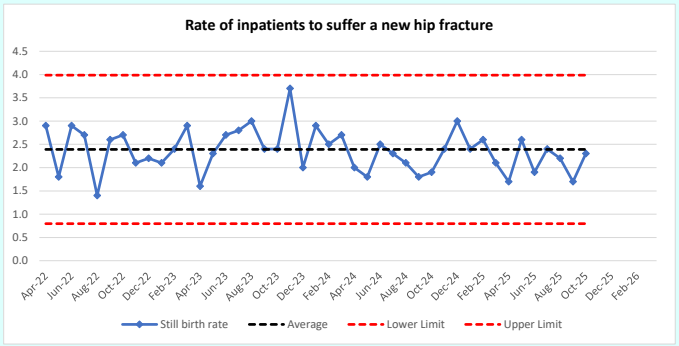
Integrated Performance Report 2025/26

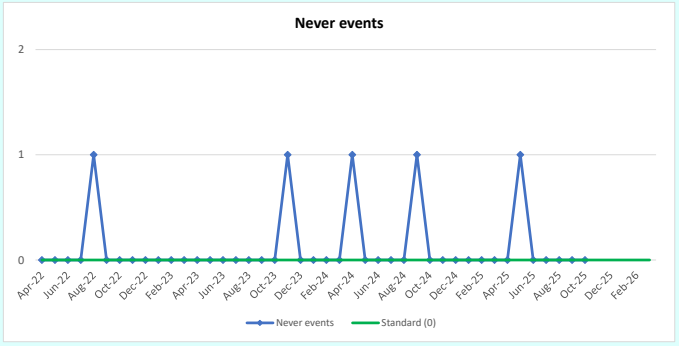
October 2025 (Qtr 3)

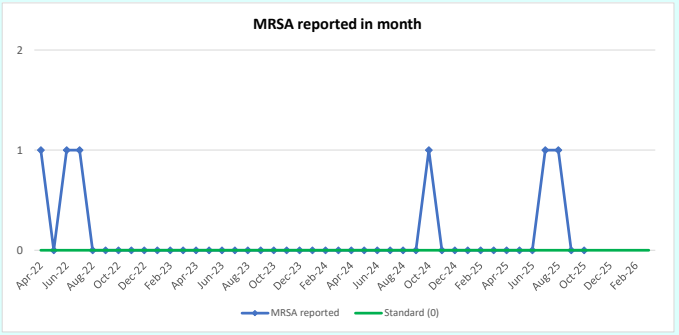
Cover Page | Definitions

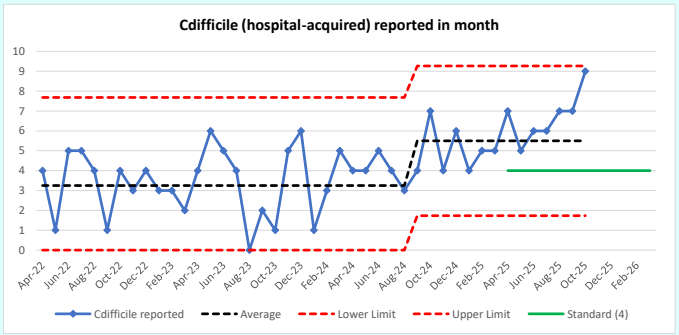
Charts

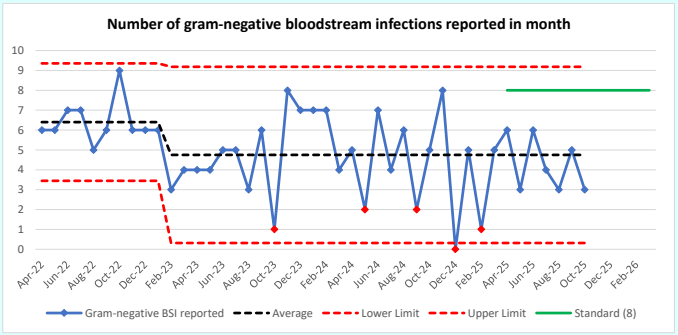
Quality of Care

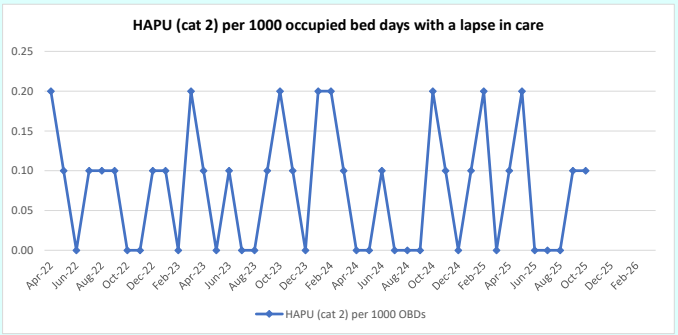


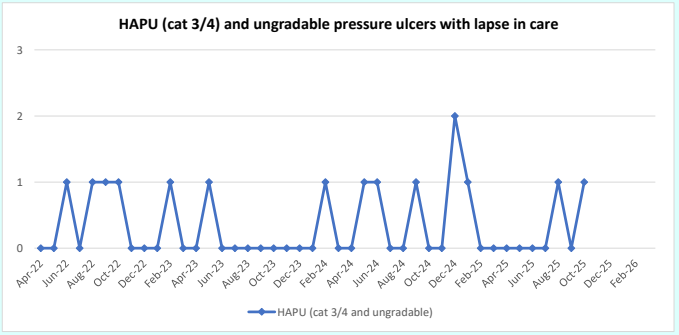


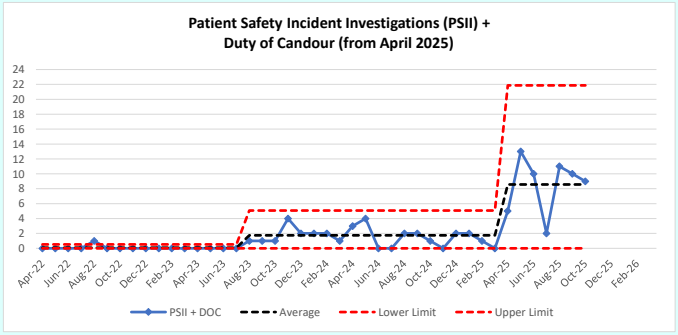


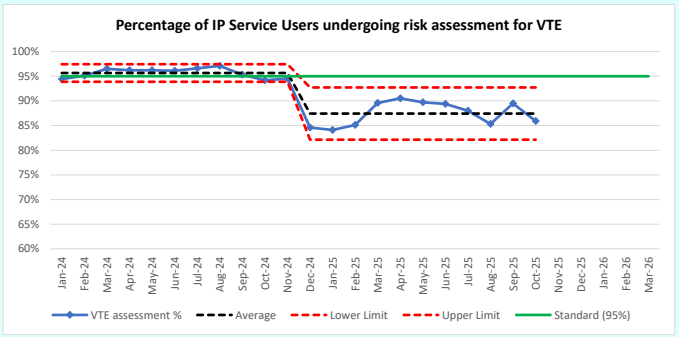


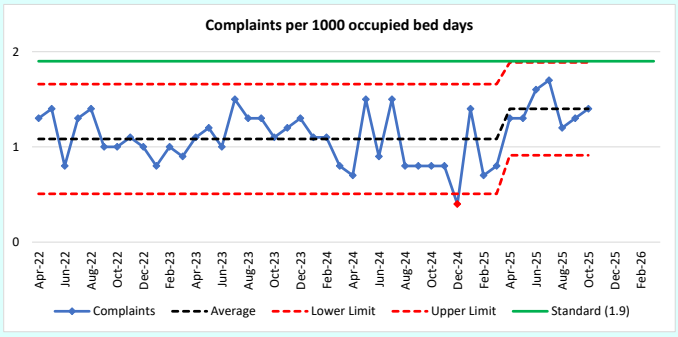


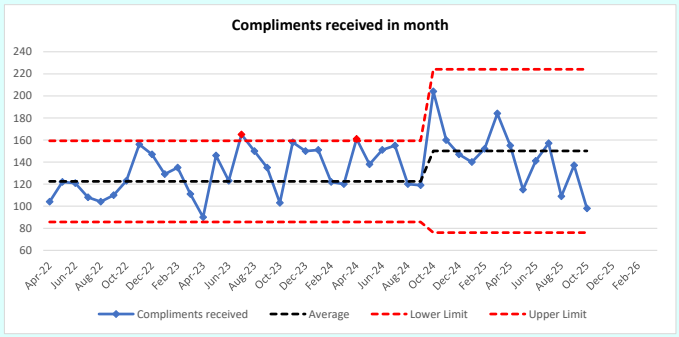


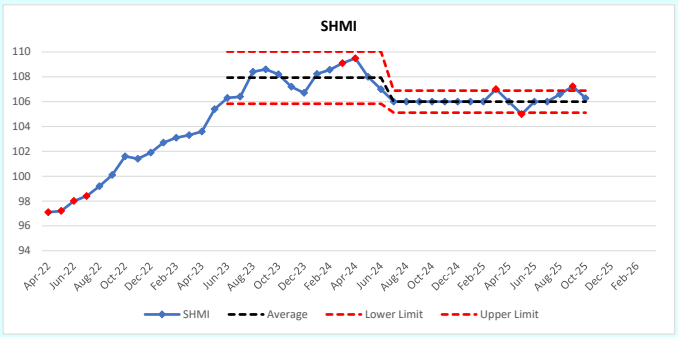


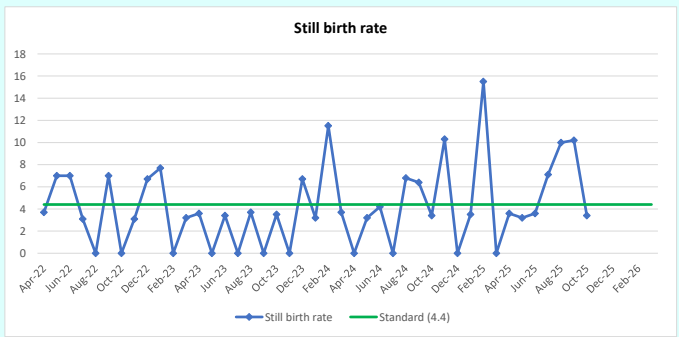


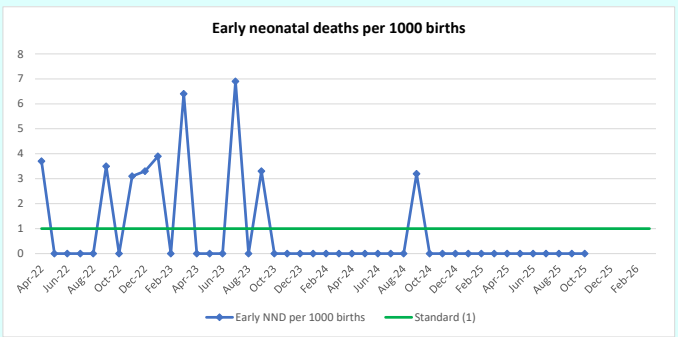

Percentage of IP Service Users undergoing risk assessment for VTE
100%
95%
90%
85%
80%
75%
70%
65%
60%
Jan-24
Feb-24
Mar-24
Apr-24
May-24
Jun-24
Jul-24
Aug-24
Sep-24
Oct-24
Nov-24
Dec-24
Jan-25
Feb-25
Mar-25
Apr-25
May-25
Jun-25
Jul-25
Aug-25
Sep-25
Oct-25
Nov-25
Dec-25
Jan-26
Feb-26
Mar-26
VTE assessment %
Average
Lower Limit
Upper Limit
Standard (95%)


Complaints per 1000 occupied bed days
2
1
0
Apr-22
Jun-22
Aug-22
Oct-22
Dec-22
Feb-23
Apr-23
Jun-23
Aug-23
Oct-23
Dec-23
Feb-24
Apr-24
Jun-24
Aug-24
Oct-24
Dec-24
Feb-25
Apr-25
Jun-25
Aug-25
Oct-25
Dec-25
Feb-26
Complaints
Average
Lower Limit
Upper Limit
Standard (1.9)


Compliments received in month
240
220
200
180
160
140
120
100
80
60
Apr-22
Jun-22
Aug-22
Oct-22
Dec-22
Feb-23
Apr-23
Jun-23
Aug-23
Oct-23
Dec-23
Feb-24
Apr-24
Jun-24
Aug-24
Oct-24
Dec-24
Feb-25
Apr-25
Jun-25
Aug-25
Oct-25
Dec-25
Feb-26
Compliments received
Average
Lower Limit
Upper Limit

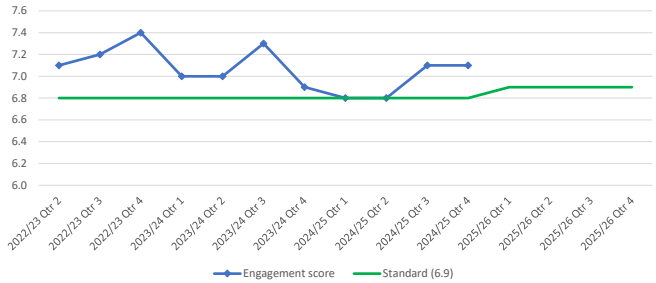

SHMI
110
108
106
104
102
100
98
96
94
Apr-22
Jun-22
Aug-22
Oct-22
Dec-22
Feb-23
Apr-23
Jun-23
Aug-23
Oct-23
Dec-23
Feb-24
Apr-24
Jun-24
Aug-24
Oct-24
Dec-24
Feb-25
Apr-25
Jun-25
Aug-25
Oct-25
Dec-25
Feb-26
SHMI
Average
Lower Limit
Upper Limit


Still birth rate
18
16
14
12
10
8
6
4
2
0
Apr-22
Jun-22
Aug-22
Oct-22
Dec-22
Feb-23
Apr-23
Jun-23
Aug-23
Oct-23
Dec-23
Feb-24
Apr-24
Jun-24
Aug-24
Oct-24
Dec-24
Feb-25
Apr-25
Jun-25
Aug-25
Oct-25
Dec-25
Feb-26
Still birth rate
Standard (4.4)

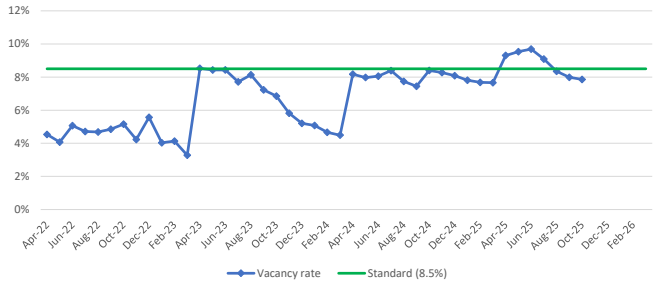

Early neonatal deaths per 1000 births
8
7
6
5
4
3
2
1
0
Apr-22
Jun-22
Aug-22
Oct-22
Dec-22
Feb-23
Apr-23
Jun-23
Aug-23
Oct-23
Dec-23
Feb-24
Apr-24
Jun-24
Aug-24
Oct-24
Dec-24
Feb-25
Apr-25
Jun-25
Aug-25
Oct-25
Dec-25
Feb-26
Early NND per 1000 births
Standard (1)

People and Culture

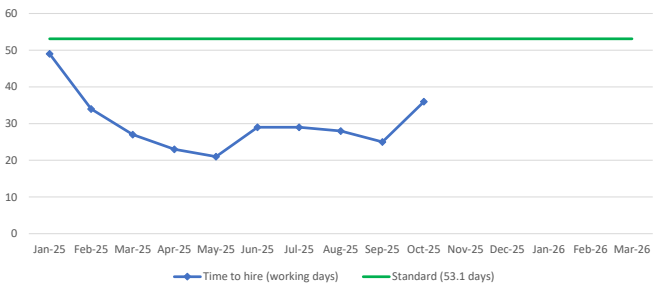
Engagement score



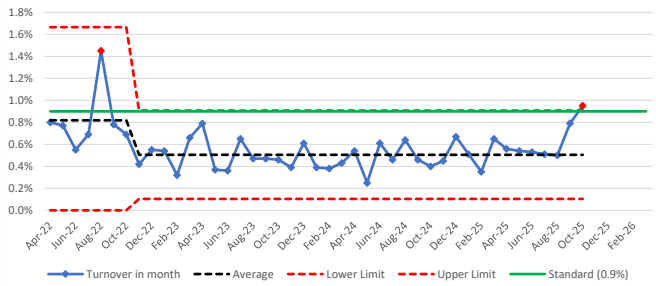
Vacancy rate



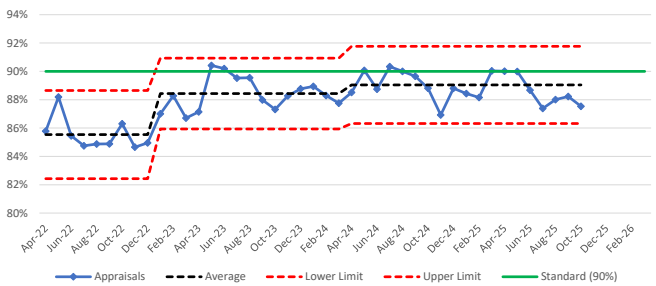
TIme to hire



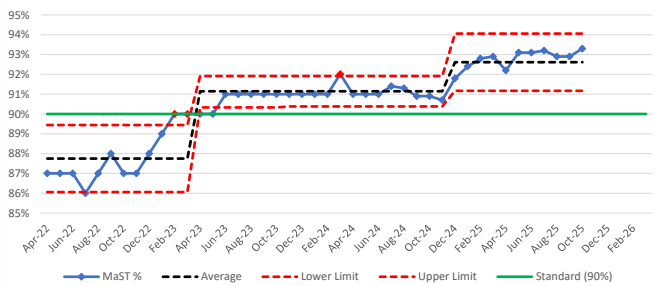
Turnover in month



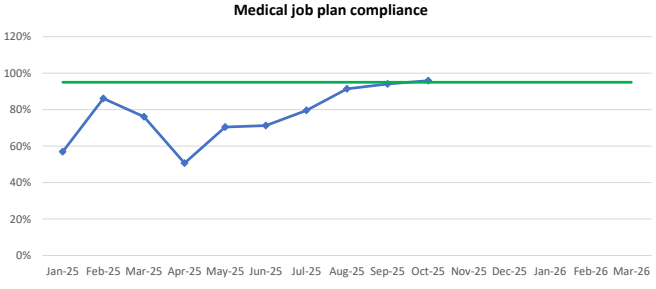
Appraisals



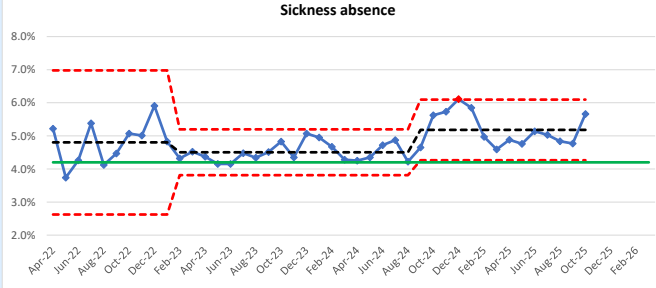
Mandatory & statutory training



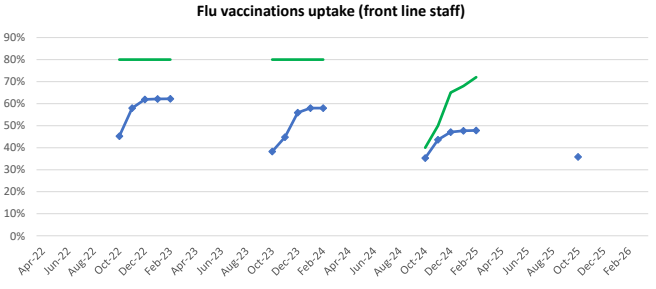
Medical job plan compliance



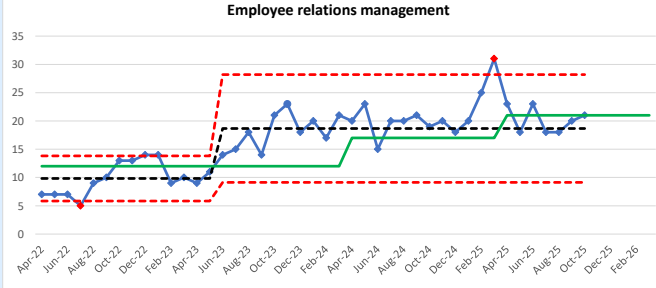
Sickness absence

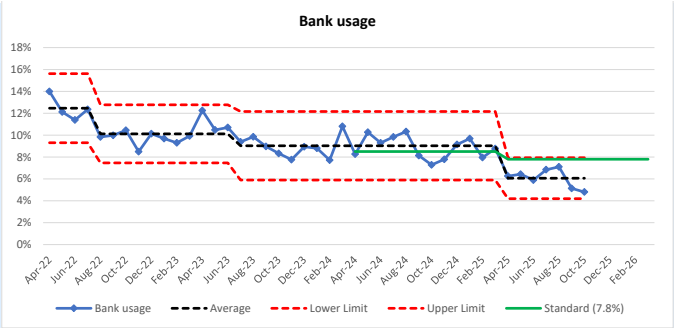


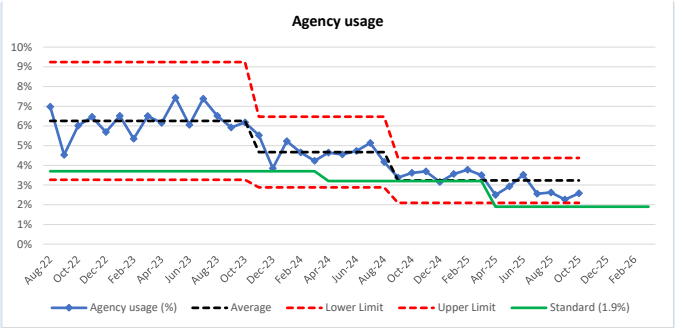
Flu vaccinations uptake (front line staff)

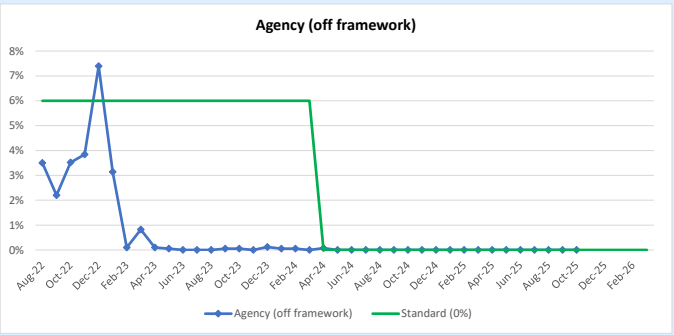


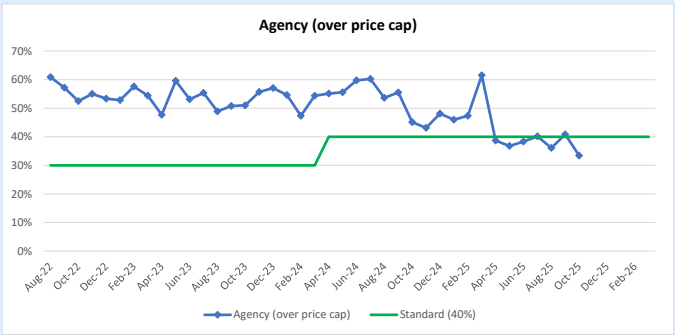
Employee relations management




Bank usage
18%
16%
14%
12%
10%
8%
6%
4%
2%
0%
Apr-22
Jun-22
Aug-22
Oct-22
Dec-22
Feb-23
Apr-23
Jun-23
Aug-23
Oct-23
Dec-23
Feb-24
Apr-24
Jun-24
Aug-24
Oct-24
Dec-24
Feb-25
Apr-25
Jun-25
Aug-25
Oct-25
Dec-25
Feb-26
Bank usage
Average
Lower Limit
Upper Limit
Standard (7.8%)

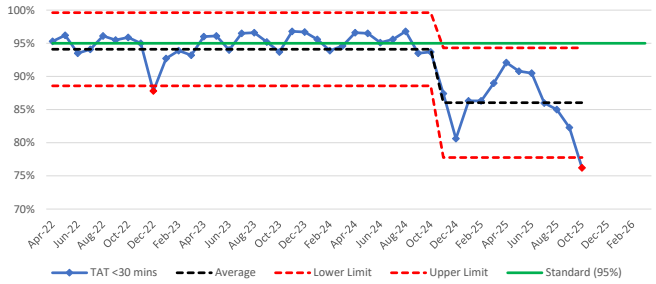

Agency usage
10%
9%
8%
7%
6%
5%
4%
3%
2%
1%
0%
Aug-22
Oct-22
Dec-22
Feb-23
Apr-23
Jun-23
Aug-23
Oct-23
Dec-23
Feb-24
Apr-24
Jun-24
Aug-24
Oct-24
Dec-24
Feb-25
Apr-25
Jun-25
Aug-25
Oct-25
Dec-25
Feb-26
Agency usage (%)
Average
Lower Limit
Upper Limit
Standard (1.9%)


Agency (off framework)
8%
7%
6%
5%
4%
3%
2%
1%
0%
Aug-22
Oct-22
Dec-22
Feb-23
Apr-23
Jun-23
Aug-23
Oct-23
Dec-23
Feb-24
Apr-24
Jun-24
Aug-24
Oct-24
Dec-24
Feb-25
Apr-25
Jun-25
Aug-25
Oct-25
Dec-25
Feb-26
Agency (off framework)
Standard (0%)

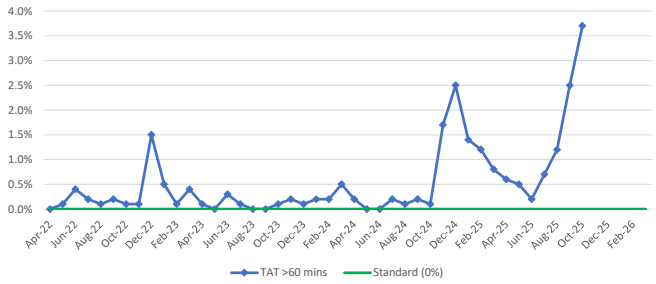

Agency (over price cap)
70%
60%
50%
40%
30%
20%
10%
0%
Aug-22
Oct-22
Dec-22
Feb-23
Apr-23
Jun-23
Aug-23
Oct-23
Dec-23
Feb-24
Apr-24
Jun-24
Aug-24
Oct-24
Dec-24
Feb-25
Apr-25
Jun-25
Aug-25
Oct-25
Dec-25
Feb-26
Agency (over price cap)
Standard (40%)

Timely Care

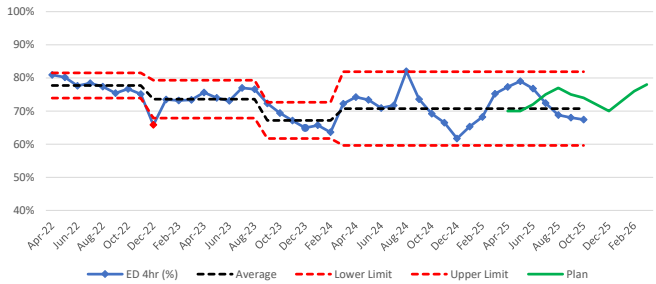
Ambulance turnaround times <30 mins



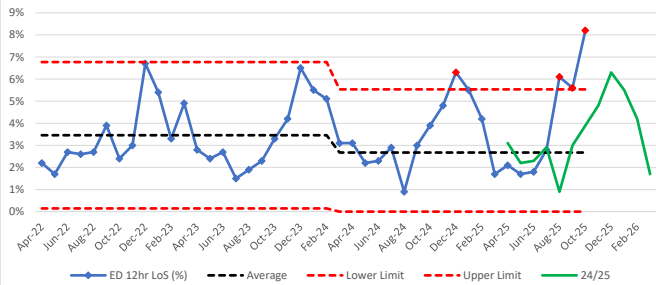
Ambulance turnaround times >60 mins



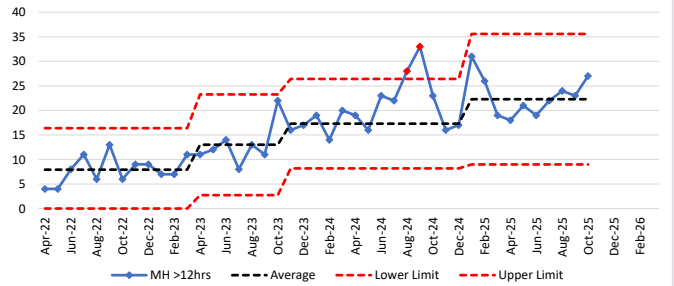
ED 4-hour performance



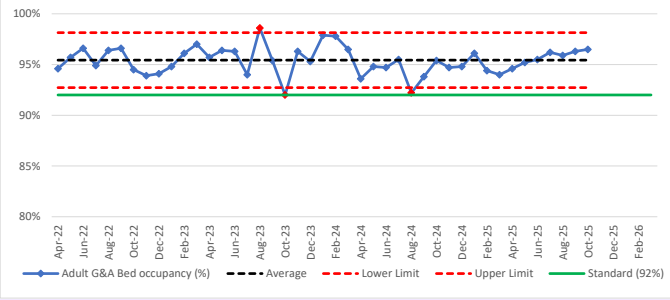
ED 12-hour length of stay performance



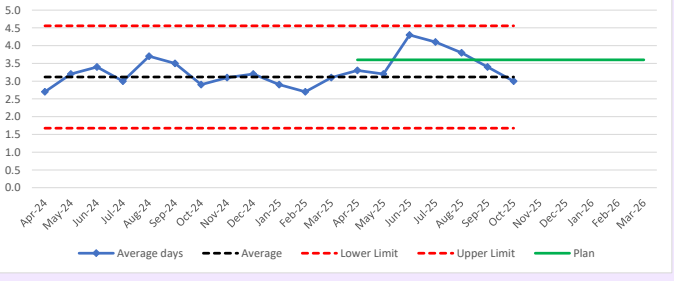
Mental health patients spending over 12 hours in A&E



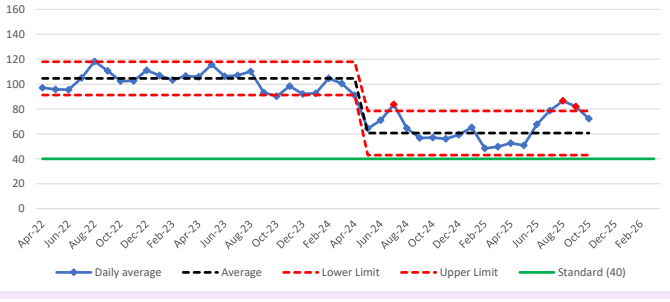
Adult G&A bed occupancy

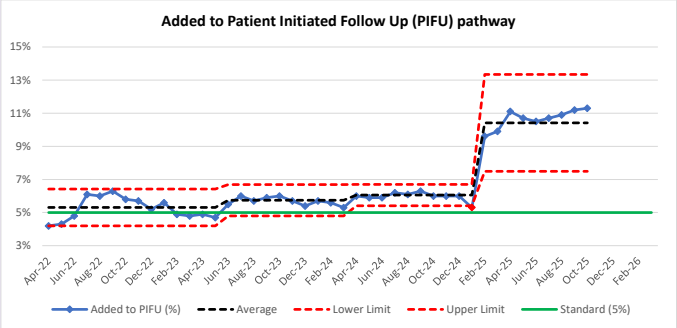


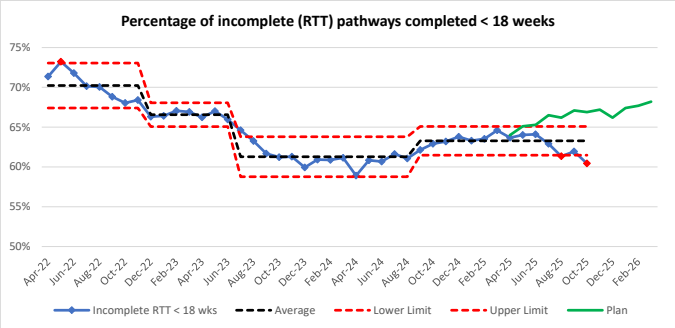
Average number of days between planned and actual discharge date (excluding patients with 0 day delay)

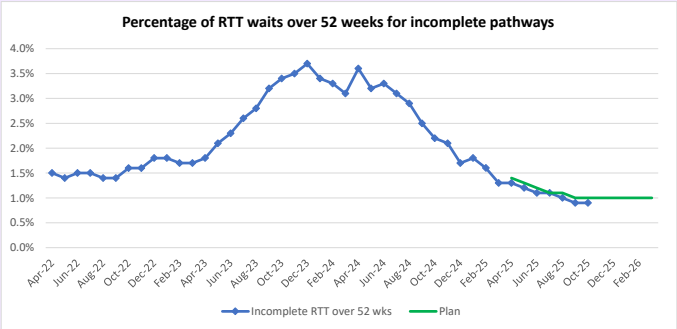


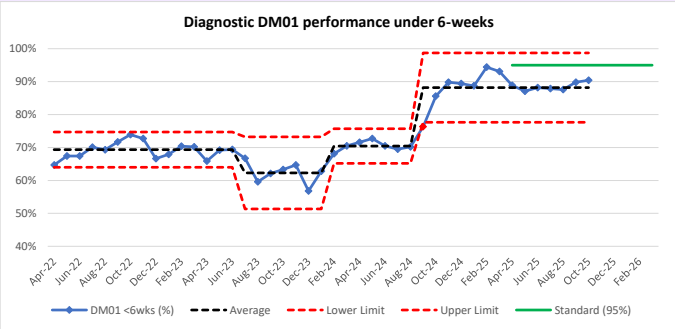
Inpatients medically safe for transfer for greater than 24 hours

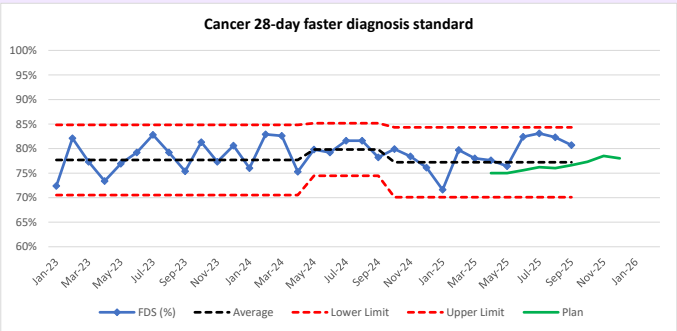


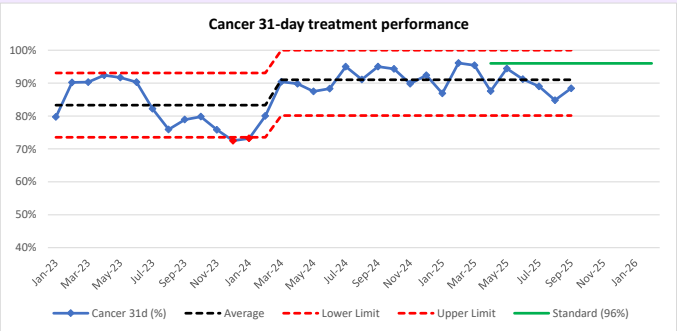

Added to Patient Initiated Follow Up (PIFU) pathway
Added to PIFU (%)
Average
Lower Limit
Upper Limit
Standard (5%)

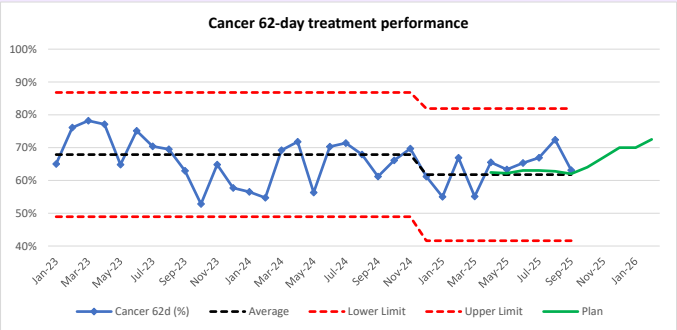

Percentage of incomplete (RTT) pathways completed < 18 weeks
Incomplete RTT < 18 wks
Average
Lower Limit
Upper Limit
Plan


Percentage of RTT waits over 52 weeks for incomplete pathways
Incomplete RTT over 52 wks
Plan


Diagnostic DM01 performance under 6-weeks
DM01 <6wks (%)
Average
Lower Limit
Upper Limit
Standard (95%)

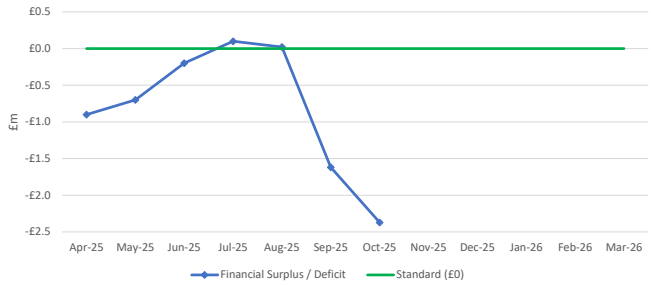

Cancer 28-day faster diagnosis standard
FDS (%)
Average
Lower Limit
Upper Limit
Plan


Cancer 31-day treatment performance
Cancer 31d (%)
Average
Lower Limit
Upper Limit
Standard (96%)


Cancer 62-day treatment performance
Cancer 62d (%)
Average
Lower Limit
Upper Limit
Plan

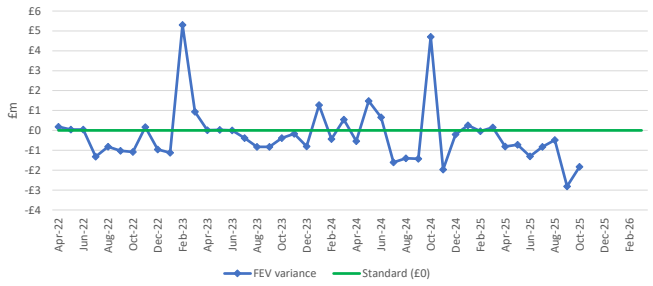
Best Value Care

Financial Surplus / Deficit

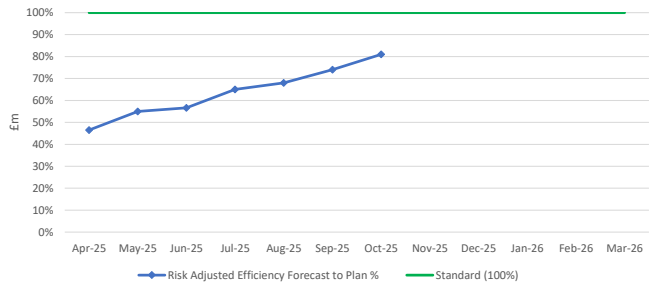


Variance YTD to financial plan

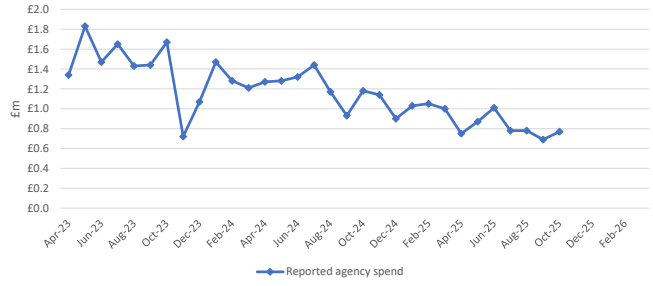
Financial efficiency variance YTD to plan



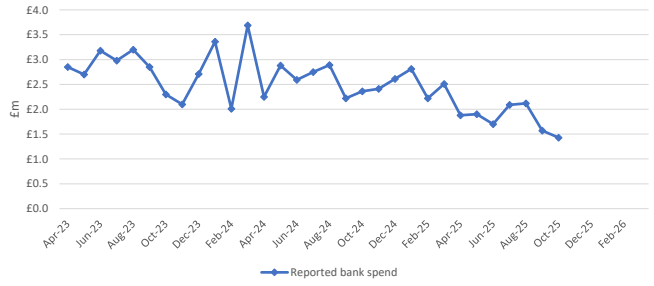
Risk adjusted efficiency forecast to plan (%)

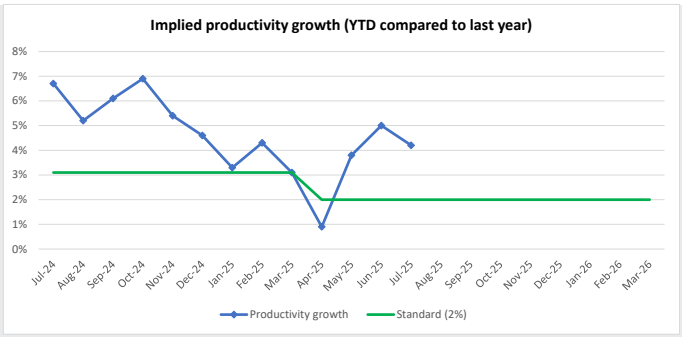


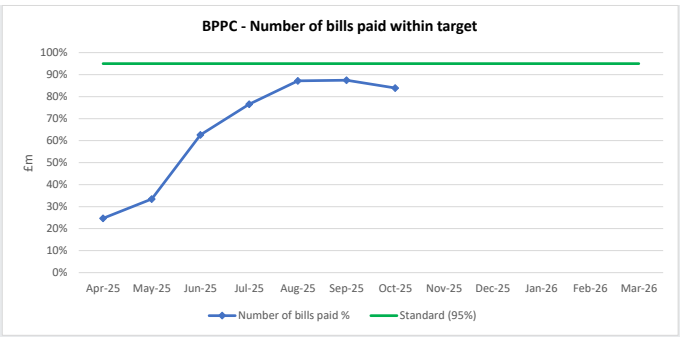
Reported agency expenditure

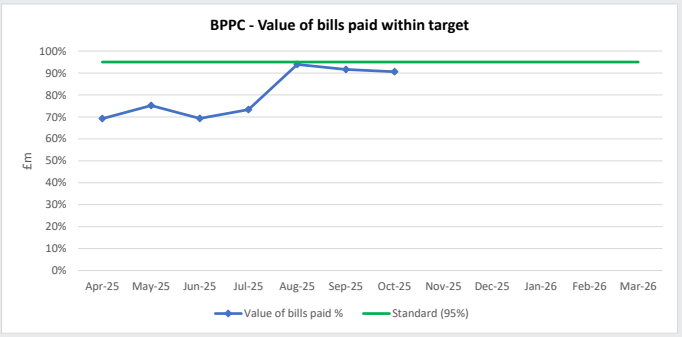


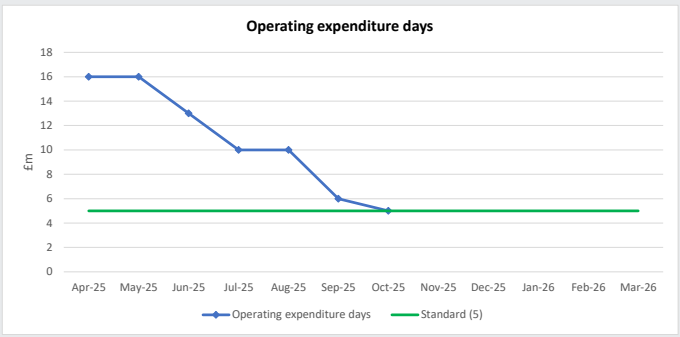
Reported bank expenditure

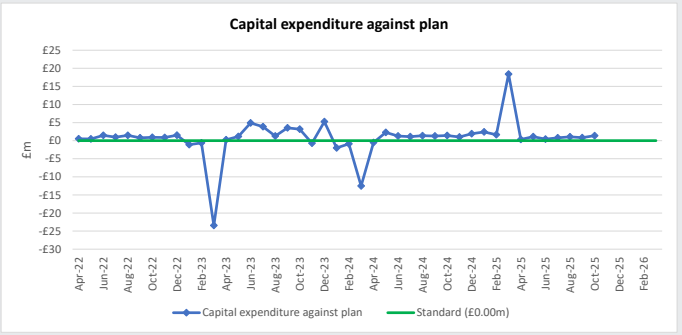



Implied productivity growth (YTD compared to last year)
8%
7%
6%
5%
4%
3%
2%
1%
0%
Jul-24
Aug-24
Sep-24
Oct-24
Nov-24
Dec-24
Jan-25
Feb-25
Mar-25
Apr-25
May-25
Jun-25
Jul-25
Aug-25
Sep-25
Oct-25
Nov-25
Dec-25
Jan-26
Feb-26
Mar-26
Productivity growth
Standard (2%)


BPPC - Number of bills paid within target
£m
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Apr-25
May-25
Jun-25
Jul-25
Aug-25
Sep-25
Oct-25
Nov-25
Dec-25
Jan-26
Feb-26
Mar-26
Number of bills paid %
Standard (95%)

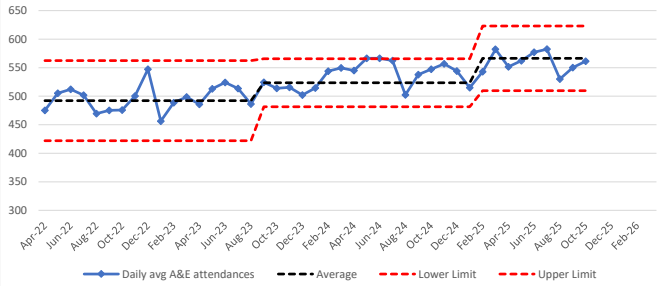

BPPC - Value of bills paid within target
£m
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Apr-25
May-25
Jun-25
Jul-25
Aug-25
Sep-25
Oct-25
Nov-25
Dec-25
Jan-26
Feb-26
Mar-26
Value of bills paid %
Standard (95%)


Operating expenditure days
£m
18
16
14
12
10
8
6
4
2
0
Apr-25
May-25
Jun-25
Jul-25
Aug-25
Sep-25
Oct-25
Nov-25
Dec-25
Jan-26
Feb-26
Mar-26
Operating expenditure days
Standard (5)

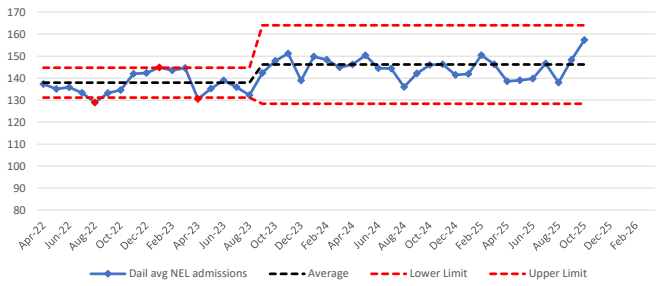

Capital expenditure against plan
£m
£25
£20
£15
£10
£5
£0
-£5
-£10
-£15
-£20
-£25
-£30
Apr-22
Jun-22
Aug-22
Oct-22
Dec-22
Feb-23
Apr-23
Jun-23
Aug-23
Oct-23
Dec-23
Feb-24
Apr-24
Jun-24
Aug-24
Oct-24
Dec-24
Feb-25
Apr-25
Jun-25
Aug-25
Oct-25
Dec-25
Feb-26
Capital expenditure against plan
Standard (£0.00m)

Activity (for context)

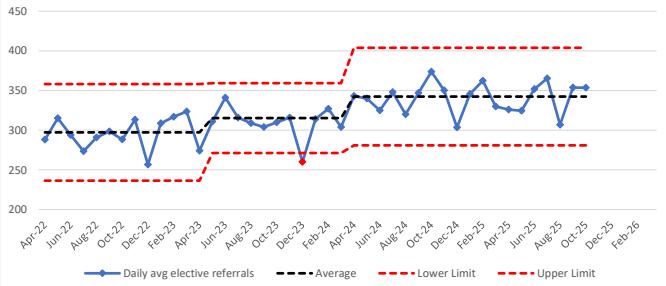
Daily average A&E attendances (inc. PC24)



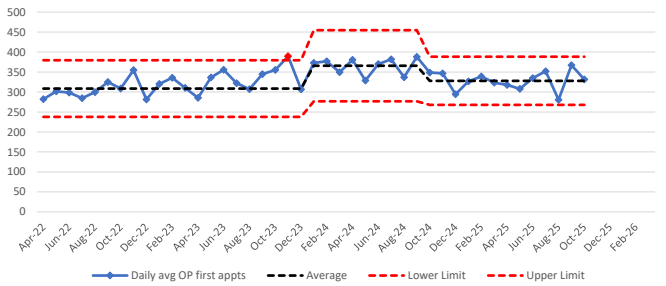
Daily average non-elective admissions



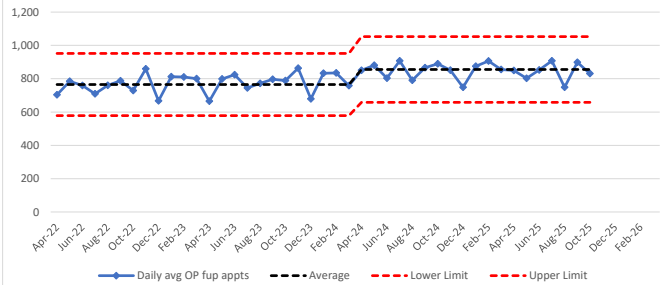
Average daily elective referrals



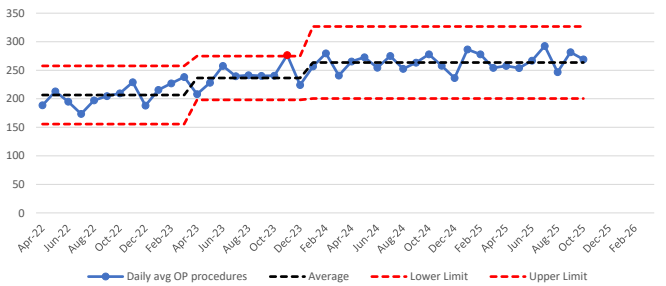
Daily average outpatient first appointments



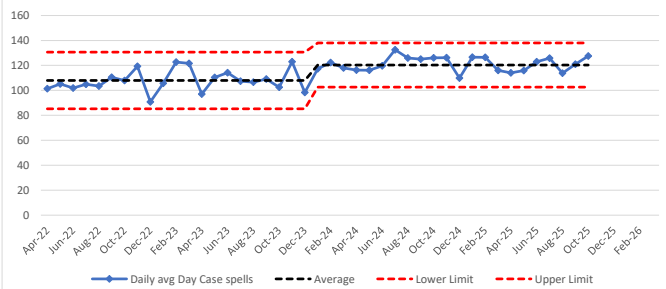
Daily average outpatient follow-ups



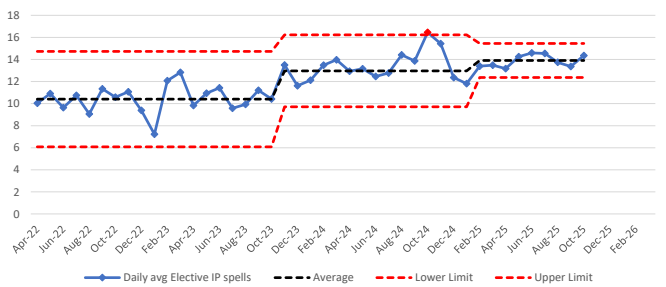
Daily average outpatient procedures



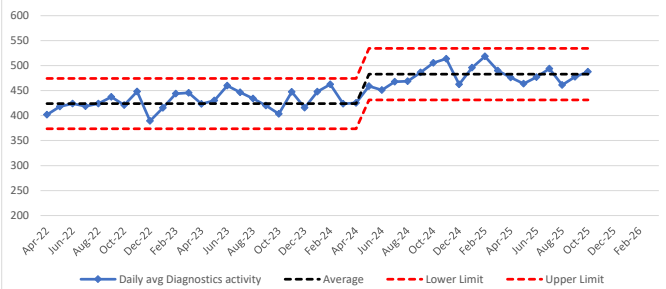
Daily average day case activity



Daily average elective inpatient activity



Daily average diagnostics activity



Sherwood Forest Hospitals NHS Foundation Trust

Integrated Performance Report 2025/26

October 2025 (Qtr 3)

Timely Care Benchmarking

Sep-25

At a Glance	Indicator	Source	Rate	Rank	Of	Decile
Urgent Care	Ambulance turnaround times <30 mins	Summary Emergency Department Indicator Table (SEDIT)	82.7%	77	176	5
	Ambulance turnaround times >60 mins	Summary Emergency Department Indicator Table (SEDIT)	2.5%	90	176	6
	ED 4-hour performance	NHS England A&E Attendances and Emergency Admissions	68.0%	109	152	8
	ED 12-hour length of stay performance	Summary Emergency Department Indicator Table (SEDIT)	5.2%	48	176	3
	Adult G&A bed occupancy	Summary Emergency Department Indicator Table (SEDIT)	95.4%	111	179	7
Electives	Added to Patient Initiated Follow Up (PIFU) pathway	Model Hospital	11.3%	4	134	1
	Incomplete RTT pathways +52 weeks	RTT waiting times data	0.9%	45	150	3
Diagnostics	Diagnostic DM01 performance under 6-weeks	Diagnostics Waiting Times and Activity data	89.8%	35	134	3
Cancer	Cancer 28-day faster diagnosis standard *	Cancer Waiting Times standards	82.3%	24	134	2
	Cancer 31-day treatment performance *	Cancer Waiting Times standards	84.8%	120	134	9
	Cancer 62-day treatment performance *	Cancer Waiting Times standards	72.1%	62	134	5

* August 25 position

Sherwood Forest Hospitals NHS Foundation Trust

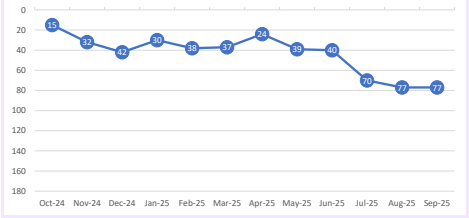
Integrated Performance Report 2025/26

October 2025 (Qtr 3)

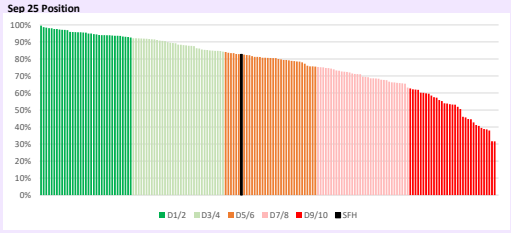
Timely Care Benchmarking Charts

Timely Care Benchmarking

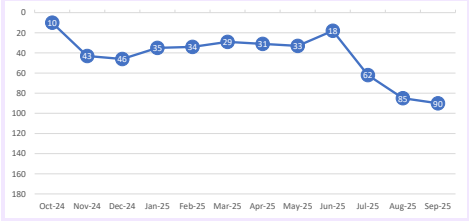
Ambulance turnaround times <30 mins



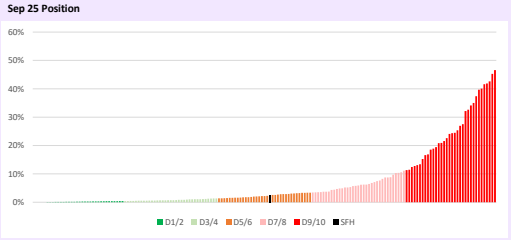
Sep 25 Position



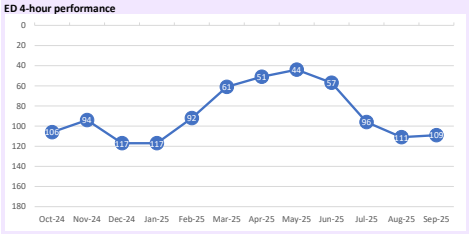
Ambulance turnaround times >60 mins



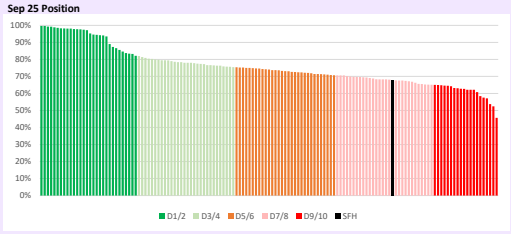
Sep 25 Position



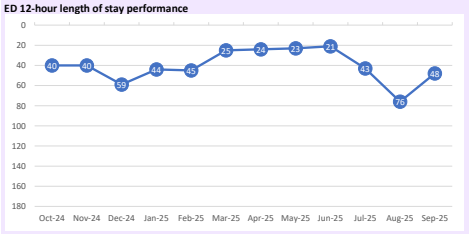
ED 4-hour performance



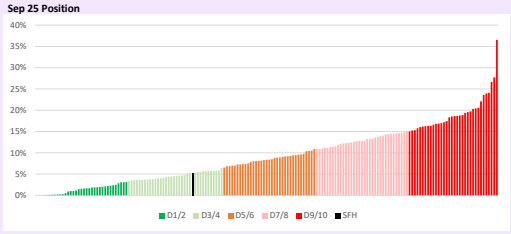
Sep 25 Position



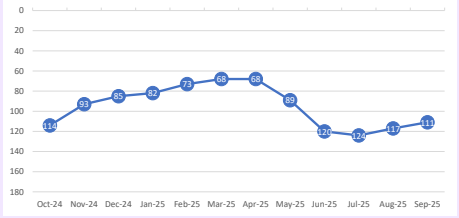
ED 12-hour length of stay performance



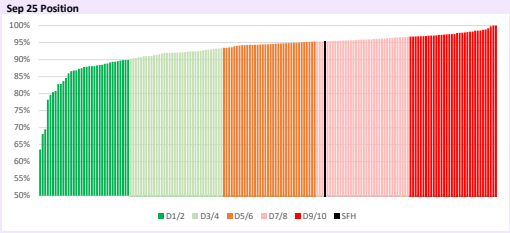
Sep 25 Position



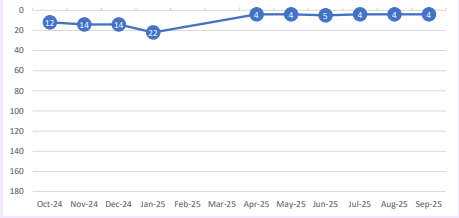
Adult G&A bed occupancy



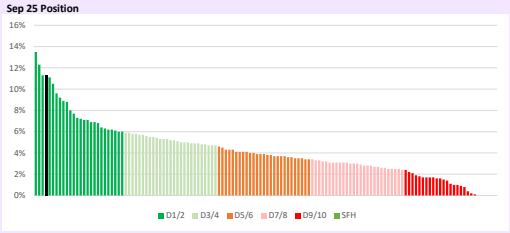
Sep 25 Position



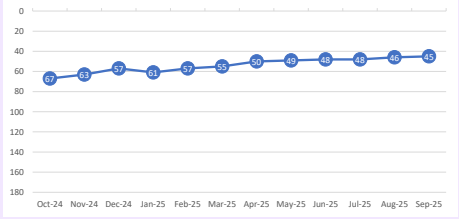
Added to Patient Initiated Follow Up (PIFU) pathway



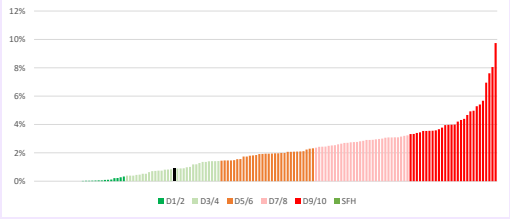
Sep 25 Position



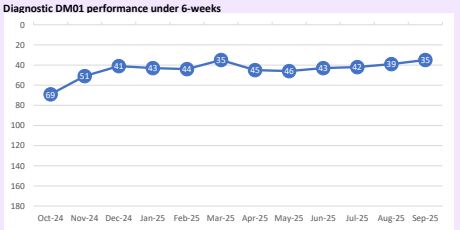
Incomplete RTT pathways +52 weeks



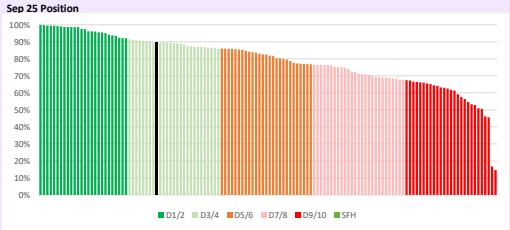
Sep 25 Position



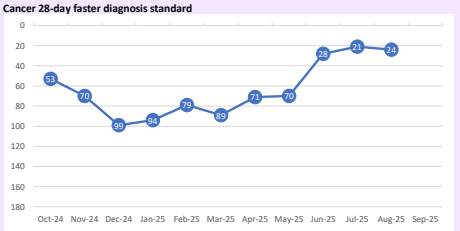
Diagnostic DM01 performance under 6-weeks



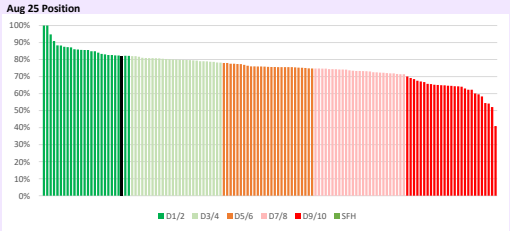
Sep 25 Position



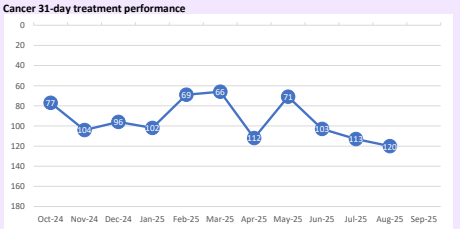
Cancer 28-day faster diagnosis standard



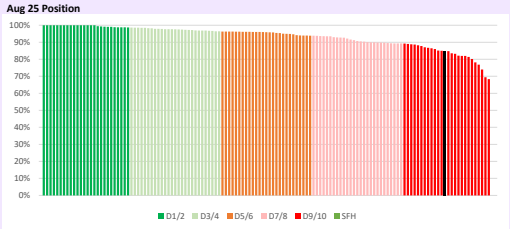
Aug 25 Position



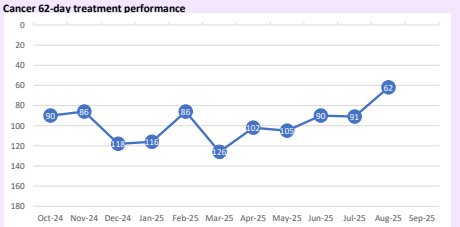
Cancer 31-day treatment performance



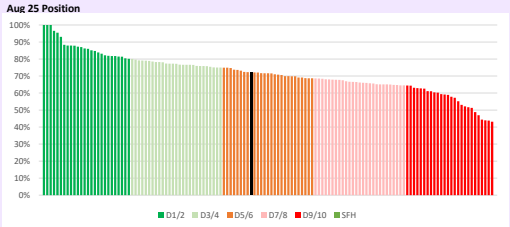
Aug 25 Position



Cancer 62-day treatment performance



Aug 25 Position



Outstanding Care, Compassionate People, Healthier Communities

Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	**Emergency Preparedness Overview**	**Date:**	4th December 2025
Prepared By:	Lauren Ward - Emergency Planning & Business Continuity Officer		
Approved By:	Simon Illingworth – Chief Operating Officer (and Accountable Emergency Officer)		
Presented By:	Lauren Ward - Emergency Planning & Business Continuity Officer		

Purpose

The purpose of this paper is to provide the Board with an overview of the Emergency Preparedness workstream and to present the outcomes of the 2025 annual compliance assessment against NHS England's Core Standards for Emergency Preparedness, Resilience and Response (EPRR). This report is intended to offer assurance regarding the Trust's current level of organisational preparedness.	**Approval**	
	Assurance	**x**
	Update	
	Consider	

Strategic Objectives

Provide outstanding care in the best place at the right time	Empower and support our people to be the best they can be	Improve health and wellbeing within our communities	Continuously learn and improve	Sustainable use of resources and estates	Work collaboratively with partners in the community
			x		**x**

Principal Risk

PR1	Significant deterioration in standards of safety and care	
PR2	Demand that overwhelms capacity	
PR3	Critical shortage of workforce capacity and capability	
PR4	Insufficient financial resources available to support the delivery of services	
PR5	Inability to initiate and implement evidence-based Improvement and innovation	
PR6	Working more closely with local health and care partners does not fully deliver the required benefits	
PR7	Major disruptive incident	**x**
PR8	Failure to deliver sustainable reductions in the Trust's impact on climate change	

Committees/groups where this item has been presented before

Quality Committee 24th November 2025

Acronyms

RAC – Resilience Assurance Committee
EPO – Emergency Planning Officer
EPRR – Emergency Planning Resilience and Response
AEO – Accountable Emergency Officer
LHRP – Local Health Resilience Partnership
ICB = Integrated Care Board
BCMS – Business Continuity Management System

Executive Summary

The report aims to provide an overview of the Trust's current state of Emergency Preparedness, through highlighting the improvement in its percentage compliance rating against the national EPRR Core Standards.

The Trust's main governance forum for EPRR is the Resilience Assurance Committee, which is chaired by the Chief, or Deputy Chief Operating Officer. The COO is also assigned as the Accountable Emergency Officer (AEO) with responsibility for EPRR to the Board.

There have been excellent attendance levels at the RAC, across all disciplines.

The Trust has maintained its overall EPRR Core Standards compliance rating of 'Substantial', with an improvement of compliance percentage from 90% to 97%, with no areas deemed non-compliant. The overall outcome is described in the following table:

Final position – 2025 EPRR Core Standards Compliance

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	6	0	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	11	11	0	0
Command and control	2	2	0	0
Training and exercising	4	4	0	0
Response	7	7	0	0
Warning and informing	4	4	0	0
Cooperation	4	4	0	0
Business Continuity	10	8	2	0
Hazmat/CBRN	12	12	0	0
CBRN Support to acute Trusts	0	0	0	0
Total	62	60	2	0

The formal letter, received via email, confirmed the final rating.

There is an in-depth action plan to improve the outstanding two standards which are deemed as 'partial' over the next year, to gain 'full' compliance status in 2026.

There is excellent completion rate on the RAC annual workplan, throughout a very busy year. The Trust has engaged in many exercises and is compliant with the national standard in this respect.

The Trust trains all on-call staff before they are placed on a rota, and this training is refreshed annually. Current training completion stands as follows:

Strategic (Gold) = 100%
Tactical (Silver) = 96% (One commander is unable to refresh their training due to sickness)

In addition to coordinating formal training, the EPO has developed and continues to support each commander in maintaining an individual Personal Development Portfolio (PDP), aligned to the requirements of NHS England and the EPRR Core Standards. These portfolios provide structured evidence of competence, ongoing learning, and reflective practice, ensuring sustained assurance of capability across all incident command levels.

There have been few declared EPRR incidents of note in 2024, but the Trust has successfully managed lengthy periods of industrial action using the EPRR structures and processes.

The Risk of a major disruptive incident is captured within the Board Assurance Framework (PR7), and reviewed on a monthly basis by the AEO, the EPO and the Risk & Assurance Manager.

The Trust is committed to, and fully engages with, the principles of learning lessons from incidents and exercises. The Emergency Planning Team is currently developing a dedicated Emergency Preparedness (EP) database to systematically capture and monitor lessons learned as part of the Trust's continuous improvement and learning cycle. This will enhance visibility, accountability, and assurance of learning outcomes across all divisions.

The Business Continuity Management System has been improved and now provides "Significant" assurance to the Board. This was also reflected in the Core Standards outcome in the Business Continuity domain.

The Board is asked to be updated and **ASSURED** by this overview report.

SFH Public Board – Emergency Preparedness, Resilience & Response (EPRR) Annual Report

December 2025

Introduction

The report will highlight the status of the Trusts Emergency Preparedness, and the governance processes in place to ensure compliance with legal requirements and national standards.

It will cover.

- Resilience Assurance Committee (RAC) Attendance
- Governance Arrangements
- The EPRR Core Standards Submission
- Annual EPRR Workplan
- Training Compliance Levels
- Exercises Completed
- Incidents
- Risks Identified
- Lessons Learned

In doing so, the report should provide an overview of the current state of preparedness for incidents and emergencies.

RAC Attendance

RAC is Chaired by the Chief or Deputy Chief Operating Officer.

There is excellent attendance and engagement from all areas of the Trust, as depicted in the following table:

Resilience Assurance Committee – Attendance Update Oct 2024 - Sept 2025		
Chief Operating Officer/Deputy Chief Operating Officer (Chair) - Chair	10 of 12	83%
Associate Director of Operations – Emergency Pathway (from Feb 25) - Chair	7 of 7	100%
Emergency Planning and Business Continuity Officer	11 of 12	92%
Risk and Assurance Manager	4 of 12	33%
Head of Communications	11 of 12	92%
EPRR Lead for Division of Urgent and Emergency Care – Divisional General Manger for UEC	12 of 12	100%

EPRR Lead for Division of Medicine - Divisional General Manager for Medicine	12 of 12	100%
EPRR Lead for Division of Surgery - Divisional General Manager for Surgery	11 of 12	92%
EPRR Lead for Division of Women and Children's – Divisional General Manager for Women's and Children's	12 of 12	100%
EPRR Lead for CSTO – Divisional General Manager for CSTO	12 of 12	100%
Associate Director of Estates & Facilities	12 of 12	100%
EPRR Lead - NHIS Head of Corporate and Business Support	12 of 12	100%
Operations Manager – Central Nottinghamshire Hospitals Plc	11 of 12	92%
Contract Director – Medirest	12 of 12	100%
Senior General Manager – Skanska	12 of 12	100%

In 2025 there have been no concerns to escalate in respect of attendance by any core member. All meetings have been deemed quorate in accordance with the Terms of Reference.

Governance

The Emergency Planning service within SFH currently comprises one full-time Emergency Planning Officer (EPO) and one full-time Emergency Planning Support Officer (EPSO). It is pertinent to note the recent change in personnel, with a new EPO joining the Trust in February 2025 and a new EPSO in May 2025.

It provides support to and facilitates the Resilience Assurance Committee (RAC), which is chaired by the Chief or Deputy Chief Operating Officer and has membership at a senior level across the organisations' both clinical and corporate areas.

The RAC reports and escalates into the Risk Committee, which is Chaired by the Chief Executive, with monthly reports prepared by the EPO capturing the outputs from RAC.

Notts ICB and NHS England Midlands Region host the Local Health Resilience Partnership (LHRP) which is a system wide forum, containing all the health organisations in the Nottinghamshire area, and is attended on SFH's behalf by the Trusts' Accountable Emergency Officer (AEO). This is currently Chief Operating Officer.

The EPRR Core Standards

The Emergency Planning service is responsible for ensuring that the Trust remains prepared to respond effectively to all types of emergencies, in line with the requirements of the Civil Contingencies Act (2004). Each year, Nottingham and Nottinghamshire ICB and NHS England region review and validate the Trust's self-assessed compliance against the national EPRR Core Standards. Following this assurance process, the final compliance position and overall rating are presented to the Trust's Board of Directors in a public forum.

By law, the Trust must meet its duties as a Category One Responder under the Civil Contingencies Act (2004). These include:

a) To assess the risk of emergencies

b) To plan for emergencies

c) To develop business continuity management

d) To cooperate with other responders

e) To share information

f) To communicate (warning and informing)

The Trust is assessed against 62 NHS England Emergency Preparedness, Resilience and Response (EPRR) Core Standards, which are grouped into 10 domains. These domains provide the framework through which the Trust demonstrates its ability to plan for, respond to, and recover from a wide range of emergencies.

The 10 domains are:

1. **Governance** – ensuring clear leadership, structures, and oversight are in place to deliver EPRR arrangements effectively.
2. **Duty to risk assess** – identifying and understanding risks that may impact service delivery, aligned to the Local Resilience Forum Community Risk Register.
3. **Duty to maintain plans** – maintaining up-to-date emergency and business continuity plans that are regularly reviewed and exercised.
4. **Command and control** – demonstrating clear arrangements for activating, escalating, and coordinating an incident response both in and out of hours.
5. **Training and exercising** – ensuring staff are appropriately trained and that regular exercises test and strengthen organisational resilience.
6. **Response** – maintaining the capability to respond effectively to incidents in line with national and local frameworks.
7. **Warning and informing** – ensuring timely communication with staff, patients, and the public before, during, and after an incident.
8. **Cooperation** – working in partnership with other Category One and Category Two responders, including the Nottingham and Nottinghamshire Integrated Care Board (ICB) and Local Resilience Forum (LRF).
9. **Business Continuity –** embedding continuity arrangements to maintain critical services during disruption.
10. **CBRN** – ensuring the Trust is prepared for any CBRN related incident.

There are four levels of compliance available as follows:

Full Compliance = 100% compliant across all domains

Substantial Compliance = 89-99%

Partial Compliance = 77-88%

Non-Compliant = below 77%

While the formal confirmation letter from NHS England is awaited, the Trust has reached agreement on its final EPRR assurance position with the NHS England Regional Team and the Integrated Care Board (ICB). The Trust has demonstrated continued improvement, increasing its overall compliance rating from 90% in 2024 to **97% in 2025,** thereby maintaining a position of **Substantial Compliance**. Notably, there were no standards assessed as non-compliant. The overall outcome is presented in the table below

SFH 2024-2025 EPRR Core Standards Final Assessment:

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	6	0	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	11	11	0	0
Command and control	2	2	0	0
Training and exercising	4	4	0	0
Response	7	7	0	0
Warning and informing	4	4	0	0
Cooperation	4	4	0	0
Business Continuity	10	8	2	0
Hazmat/CBRN	12	12	0	0
CBRN Support to acute Trusts	0	0	0	0
Total	62	60	2	0

The Trust has achieved full compliance with the following standards, which were previously recorded as partial or not fully compliant in the 2023/24 outcome:

- **Core Standard 13** – New and Emerging Pandemics
- **Core Standard 21** – Trained On-call Staff
- **Core Standard 26** – Incident Coordination Centre
- **Core Standard 47** – Business Continuity Plans

In addition, the team are developing a targeted action plan to further strengthen the Trust's position. This includes work to achieve full compliance in the following areas which are currently assessed at partial compliance:

- Core Standard 50 – BCMS Monitoring – KPI information will be embedded in the next review of the Business Continuity Management System.

- Core Standard 53 – Business Continuity – Assurance of commissioned providers/suppliers BCPs- insufficient evidence.

The formal letter of confirmation, addressed to the Chief Executive, is expected shortly.

RAC Annual Workplan

The annual EPRR work plan is presented to the Resilience Assurance Committee (RAC) each November for review and approval as the schedule of planned activity for the following year. The work plan underpins delivery of the NHS England EPRR Core Standards and incorporates actions and learning from incidents, exercises, and recommendations identified through the annual Core Standards assessment process. It also outlines the training and exercise programme for the year ahead.

Progress against the work plan is routinely monitored by the RAC, with any significant risks or challenges to delivery escalated to the Risk Committee via the monthly Quadrant report for oversight and assurance. The workplan for 2025 is set out in appendix 1.

Training Compliance

One of the primary responsibilities of the Emergency Planning Officer (EPO) is to ensure that all Incident Commanders, at both Strategic (Gold) and Tactical (Silver) levels, are fully trained and equipped to lead an effective response to any incident.

In addition to coordinating formal training, the EPO has developed and continues to support each commander in maintaining an individual Personal Development Portfolio (PDP), aligned to the requirements of NHS England and the EPRR Core Standards. These portfolios provide structured evidence of competence, ongoing learning, and reflective practice, ensuring sustained assurance of capability across all command levels.

Significant work is also undertaken monthly to deliver emergency preparedness training for staff within the Emergency Department, focusing particularly on readiness for Chemical, Biological, Radiological and Nuclear (CBRN) and Hazardous Materials (HazMat) incidents.

All responders receive comprehensive training in incident response, command, and control before being enrolled onto the on-call rota, with annual refresher training provided thereafter. All in-house training is aligned with the National Occupational Standards for Resonding to Incidents and Emergencies.

Compliance levels for 2025 among Strategic and Tactical Commanders remain exceptionally high, demonstrating strong organisational preparedness and positioning the Trust as a leader in EPRR training and assurance when benchmarked against peer organisations. See below:

Strategic (Gold) = 100%

Tactical (Silver) = 96% (One commander is unable to refresh their training due to sickness)

Exercises

In accordance with the NHS England EPRR Framework guidance the trust has an obligation to carry out exercises, as follows:

ICC Equipment test – every three months

Communications (Cascade test) exercise – every six months

Tabletop exercise – annually

Live Play exercise – every three years

ICC Command Post exercise – every three years

This is rigorously examined as part of the Trust core standards submission, and we are again fully compliant with this section, as more exercises are being conducted now than at any time in the past.

The Trust has conducted or taken part in the following exercises in line with the above:

- Equipment tested every 3 weeks – major incident radios
- Incident Command Centre (ICC) testundertaken every month by EPSO, supported by the EPO – testing Telecomms and virtual ICC arrangements.
- Exercise Sentinel – Command Post exercise
- NHIS Cyber resilience Business Continuity exercise– tabletop.
- Exercise White Star - Business Continuity exercise around CSSD failure – tabletop.
- Exercise Dragon Shield – a rolling monthly Fire Evacuation exercise – simulation/discussion exercise on clinical wards.
- Exercise Blue Hammer – Doncaster and Bassetlaw tabletop evacuation exercise
- Exercise Pegasus – NHSE National Pandemic exercise

The last SFH live play exercise was Exercise Cool Water in July 2023 – early planning has begun for the Trust to undertake the next live play exercise in Spring 2026 – in conjunction with Women's and Children's division.

The Trust has also carried four incident cascade tests (two in hours and two out of hours) to test the switchboard function in a major incident.

Incidents

There have been no Critical or Major Incidents declared to the ICB and NHSE through 2025, which is a positive reflection on the robust Business Continuity Plans of both our clinical and corporate divisions/services.

It is worthy of note however that the Trust has managed extended periods of industrial action as EPRR events and three internal Business Continuity incidents, using SFH incident response processes alongside command and control arrangements.

All incidents and exercises are debriefed in accordance with the NHS England Emergency Preparedness, Resilience and Response (EPRR) Framework, with agreed actions recorded and monitored through the Resilience Assurance Committee (RAC) Action Log to ensure timely completion and accountability. In addition, the SFH EPRR Database is being developed to systematically capture lessons identified, continuous learning, and evidence of improvement activity, further strengthening the Trust's organisational resilience.

Risks Identified

Risks of a major disruptive incident are captured in and managed through the Board Assurance Framework, Principal Risk no.7. The National and Regional Risk Registers are regularly reviewed by the EPO with any new risks escalated to the Risk and Assurance Manager.

This is reviewed monthly with the Trusts Risk & Assurance Manager, the Accountable Emergency Officer and the Emergency Planning Officer, and is currently rated as a 16, high risk, predominantly due to threat of cyber-attack.

Other than cyber, there are no high risks currently deemed a significant threat to the Trust.

Lessons Learned

In line with the Trust's Emergency Planning Policy, there is a clear commitment to learning from incidents and exercises to strengthen organisational resilience. The policy sets out a defined and structured process to ensure that all lessons identified are reviewed, actions are assigned, and progress is tracked to completion.

The Emergency Planning Team is currently developing a dedicated Emergency Preparedness (EP) database to systematically capture and monitor lessons learned as part of the Trust's continuous improvement and learning cycle. This will enhance visibility, accountability, and assurance of learning outcomes across all divisions.

At a regional level, the Trust actively participates in the Health Emergency Planners Group (HEPOG), sharing and receiving lessons through submission of post-incident and post-exercise reports. This process is overseen by NHS England to promote consistent learning and collaboration across the system.

The Trust remains fully engaged with regional partners, demonstrating a proactive and transparent approach to sharing learning and adopting best practice from other organisations.

Business Continuity Management System

Throughout 2025, the Trust has continued to strengthen and modernise its Business Continuity Management System (BCMS), aligning it fully with the NHS England Business Continuity Management Toolkit, which is underpinned by the international standard ISO 22301. This work reflects the Trust's ongoing commitment to maintaining robust continuity arrangements that safeguard the delivery of critical services during periods of disruption.

All Divisions now have up-to-date and approved Business Continuity Plans (BCPs) in place, each of which aligns with the Resilience Assurance Committee (RAC) workplan to ensure consistency, governance oversight, and assurance across the organisation. These plans are reviewed and tested in accordance with the BCMS framework and inform both local and corporate-level resilience planning.

The BCMS was independently audited by 360 Assurance in September 2024, with the outcome report issued in November 2024 providing "Significant" assurance to the Trust Board. This three-yearly audit recognised the strength of the Trust's governance, control environment, and continued investment in resilience.

Building on this positive outcome, the next phase of development will focus on the introduction of measurable Key Performance Indicators (KPIs) within the 2025–26 review cycle, in line with the latest NHS EPRR Core Standards guidance. These KPIs will enable clearer monitoring of business continuity maturity, governance, and continuous improvement across Divisions and Corporate Services.

Summary

During 2025, the Trust has further strengthened its Emergency Preparedness, Resilience and Response (EPRR) arrangements, achieving an improved 97% compliance against the NHS Core Standards and has maintained a rating of Substantial compliance. Governance and training remain robust, with excellent RAC engagement and near-complete delivery of the annual work plan. A full programme of training, exercising and incident responses demonstrates strong organisational resilience, whilst the Business Continuity Management System - aligned to the NHS BC Toolkit and ISO 22301 - continues to mature, following a significant assurance audit. The Trust remains well-positioned to respond effectively to any emergency or disruption.

Report produced by Lauren Ward

Emergency Planning & Business Continuity Officer

December 2025

Appendix 1

EPRR Work Programme 2026

Emergency Planning Officer

ANNUAL PLANNER – SCHEDULE OF WORK 2026

Item	Action	Lead	J	F	M	A	M	J	J	A	S	O	N	D
Business Items														
Complete Review of Actions from 2024 CSSA and prepare 2026 submission	Review	Emergency Planning Officer	**P**	**P**	**P**	**P**	**P**	**P**	**P**	**P**	**P**	**P**	**P**	**P**
Complete Review of EMAS CBRN audit complete any outstanding actions	Review	Emergency Planning Officer				**P**								
Carry Out Radio and Battery Checks	Check	Emergency Planning Officer	**P**	**P**	**P**	**P**	**P**	**P**	**P**	**P**	**P**	**P**	**P**	**P**
Carry Out ICC Audit	Check	Emergency Planning Officer	**P**	**P**	**P**	**P**	**P**	**P**	**P**	**P**	**P**	**P**	**P**	**P**
Produce Tactical and Strategic On-call rotas	Update	Emergency Planning Support Officer			**P**						**P**			
Review Stock and Serviceability of Radio Pagers	Review	EPO & Skanska Lead			**P**			**P**			**P**			**P**
Conduct Stock and Serviceability Check on Mobiles at NWK & MCH	Check	Emergency Planning Officer	**P**	**P**	**P**	**P**	**P**	**P**	**P**	**P**	**P**	**P**	**P**	**P**

Item	Action	Lead	J	F	M	A	M	J	J	A	S	O	N	D
Review Community/ National Risk Register and Escalate to Risk Committee any Appropriate Concerns	Review	Emergency Planning Officer			P			P			P			P
Create EPRR Database	Create	Emergency Planning Officer	P	P	P	P	P	P	P	P	P	P	P	P
Chair Martyn's Law Working Group	Review	Emergency Planning Officer	P		P		P		P		P		P	
Training Activity														
Complete Training Needs Analysis to include EPO	Create	Emergency Planning Officer	P											
Tactical Command	Conduct	Emergency Planning Officer	P		P		P		P		P		P	
Strategic Command	Conduct	Emergency Planning Officer				P		P			P			P
Loggist	Conduct	Emergency Planning Officer	P		P		P		P		P		P	
CBRN/Major Incident Training with ED Staff	Conduct	Emergency Planning Officer		P			P			P			P	
Exercise Activity														
Plan Trust wide Business Continuity Exercise	Plan	Emergency Planning Officer	P											
Conduct Trust Wide BC Exercise	Test	Emergency Planning Officer				P								
Plan Cyber Security Exercise	Plan	Emergency Planning Officer			P									
Carry Out Cyber Security Exercise	Test	Emergency Planning Officer				P								
Carry Out Six-Monthly Cascade Test	Test	Emergency Planning Officer				P							P	
Carry Out Blackstart test at KMH	Test	EPO & Skanska Lead										P		
Carry Out Blackstart Test at NWK	Test	EPO & Skanska Lead												P
Carry Out Test of NHIS IRP	Test	Emergency Planning Officer					P							

Item	Action	Lead	J	F	M	A	M	J	J	A	S	O	N	D
Agree Exercise with UEC	Plan	EPO & DGM (UEC)	P											
Carry Out UEC exercise	Test	Emergency Planning Officer			P									
Plan Command Post Exercise	Plan	Emergency Planning Officer						P						
Carry Out Command Post Exercise	Test	Emergency Planning Officer							P					
Business Continuity														
Divisions to conduct review of all BCP's and bring up to date	Review	Service Leads										P	P	P
All Updated BCP's to be uploaded on to intranet site	Update	Emergency Planning Officer	P											P
All updated BCP's to be placed in Divisional folders and DNM Master Folder	Update	Emergency Planning Officer												P
Arrange Meeting of the Adverse Weather Planning Group	Arrange	Emergency Planning Officer					P					P		
Review BC Policy and present to Public Board	Review	Emergency Planning Officer						P					P	
Emergency Planning														
Complete Review of Actions from 2025 CSSA and prepare 2026 submission	Complete	Emergency Planning Officer	P	P	P	P	P	P	P	P	P	P	P	P
Arrange for Ramgene Calibration	Arrange	Emergency Planning Officer									P	P		
Arrange for PRPS Suit Servicing	Arrange	Emergency Planning Officer			P			P			P			P
Arrange CBRN Equipment Service	Arrange	Emergency Planning Officer						P						
Arrange Decon Tent Service	Arrange	Emergency Planning Officer			P									

Item	Action	Lead	J	F	M	A	M	J	J	A	S	O	N	D
Plans & Policies														
Pandemic Surge Plan	Review	Emergency Planning Officer	**P**											
Move to Critical Plan	Review	Emergency Planning Officer		**P**										
Adverse Weather Plan	Review	Emergency Planning Officer			**P**									
Emergency Planning Policy	Review	Emergency Planning Officer				**P**								
Business Continuity Policy	Review	Emergency Planning Officer				**P**								
Emergency VIP Admissions Policy	Review	Emergency Planning Officer					**P**							
SFH Incident Response Plan	Review	Emergency Planning Officer					**P**							
Emergency Mortuary Plan	Review	Emergency Planning Officer						**P**						
Bomb Threat & Suspect Package Policy	Review	Emergency Planning Officer						**P**						
Incident Response Plan	Review	Emergency Planning Officer						**P**	**P**					
Mass Countermeasures/Prophylaxis Plan	Review	Emergency Planning Officer							**P**					
Lockdown Policy	Review	Emergency Planning Officer									**P**			
Fuel Shortage Policy	Review	Emergency Planning Officer									**P**			
Loss of Mains Water BCP	Review	Emergency Planning Officer											**P**	
CBRNe Plan	Review	Emergency Planning Officer										**P**		
KMH Evacuation & Shelter Plan	Review	Emergency Planning Officer										**P**		
NGH Evacuation & Shelter Plan	Review	Emergency Planning Officer										**P**		
MCH Fire & Evacuation Plan	Review	Emergency Planning Officer										**P**		

BUSINESS CONTINUITY POLICY

POLICY

Reference	Business Continuity Policy (BCP0519)		
Approving Body	Resilience Assurance Committee		
Date Approved	Thursday 19th June 2025		
For publication to external SFH website	**Positive confirmation received from the approving body that the content does not risk the safety of patients or the public:**		
	YES	**NO**	**N/A**
			x
Issue Date	Friday 20th June 2025		
Version	Version 8.1		
Summary of Changes from Previous Version	Updating to incorporate		
Supersedes	Version 8		
Document Category	Business Continuity		
Consultation Undertaken	NHS Midlands Region Nottingham and Nottinghamshire Integrated Care System Resilience Assurance Committee		
Date of Completion of Equality Impact Assessment	June 2025		
Date of Environmental Impact Assessment (if applicable)	June 2025		
Legal and/or Accreditation Implications	Civil Contingencies Act 2004 Health and Social Care Act 2012 NHS EPRR Core Standards NHSE EPRR Framework		
Target Audience	All service leads, Business Support Managers, Resilience Assurance Committee, EPRR leads		
Review Date	June 2026		
Sponsor (Position)	Chief Operating Officer		
Author (Position & Name)	Lauren Ward - Emergency Planning & Business Continuity Officer		
Lead Division/ Directorate	Corporate		
Lead Specialty/ Service/ Department	Emergency Planning		
Position of Person able to provide Further Guidance/Information	Emergency Planning & Business Continuity Officer		
Associated Documents/ Information			**Date Associated Documents/ Information was reviewed**

N/A	**N/A**

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APPENDICES

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CONSULTATION

The plan has been circulated internally to all divisional, department and corporate leads at all three Trust hospital sites.

The following Collaborative Planning Form outlines the external organisations with whom the plan has been shared and any comments received.

Collaborative Planning Form

Purpose: To evidence that plans and arrangements have been developed in collaboration with relevant stakeholders, including, where appropriate, emergency services and health partners to enhance joint working arrangements and to ensure the whole patient pathway is considered.

Title of policy/plan: Business Continuity Policy

Date of review: June 2025

Issued for collaboration (date): 3rd June 2025

Partners consulted:

Organisation	Consulted Yes/No	Comments Received Yes/No	Comments included in policy/plan Y/N Including detail
NHSE Region	Y	N	
Notts ICB	Y	N	
NUH	Y	Y	Y – definition of critical service
EMAS	Y	N	
Bassetlaw	Y	N	
Notts Healthcare	Y	N	
NEMS	Y	N	
Notts CityCare	N		
Police	N		
Fire Service	N		

Date of next review: June 2026

1.0 INTRODUCTION

1.1 Sherwood Forest Hospitals NHS Foundation Trust (SFH) is a Category 1 responder under the Civil Contingencies Act (2004) and as such, there is a requirement to create and publish Business Continuity Plans. SFH is an Acute Trust which operates from three sites:

- King's Mill Hospital in Sutton-in-Ashfield
- Newark General Hospital and Urgent Treatment Centre
- Mansfield Community Hospital

To comply with the Act, the Trust needs to be able to demonstrate that an effective Business Continuity Management System (BCMS) has been established and embedded across the organisation. As part of the Trust commitment to align its BCMS with recognised standards it will adopt the NHS England Business Continuity Toolkit, which aligns with the ISO22301 standard.

1.2 Business Continuity Plans will therefore be created to define the response to all identified threats contained within the Nottingham and Nottinghamshire Local Resilience Forum Risk Register, the Trust's Risk Register and any potential threats identified at a service/ward level. Plans will need to be exercised and reviewed regularly.

1.3 The plans will be designed initially to minimise and control harm arising from the identified risk. Thereafter, the plans will assist in the return to normal activity as soon as possible.

1.4 Where appropriate, the plans should be compiled in conjunction with partner agencies and other Category 1 responders.

1.5 The process of ensuring Business Continuity will include:

- A continued process of Risk Assessment based on knowledge of the organisation and the likely threats to it.
- An assessment of the impact those risks would have should they materialise, including longer term risks, such as climate change.
- Development of plans to mitigate the adverse effects of the identified risk.
- Training and education of staff in the plans.
- Regular testing, maintenance and review of the plans.
- Regular independent audit of the BCMS, with follow up report to the Board.

1.6 This Policy should be read in conjunction with the following Trust Policies and Procedures;

- **Risk Management and Assurance Policy**
- **Emergency Planning Policy**
- **Incident Response Plan**
- **SFH Business Continuity Management Framework**

2.0 POLICY STATEMENT

2.1 The Trust is committed to its obligations under the Civil Contingencies Act (2004) to enable it to respond effectively to threats and disruptions to the organisations ability to perform its critical functions. The Trust will also comply as far as is reasonably practicable with all statutory requirements concerning Business Continuity.

2.2 The Trust will develop, maintain and test its Business Continuity plans to ensure they are fit for purpose and provide an effective response to any event, internal or external, which threatens the continuity of care offered by the Trust.

2.3 The Trust will ensure that appropriate structures and resources are made available to support the delivery and implementation of this policy.

2.4 The Trust is committed to ensuring that none of its policies, procedures and guidelines discriminate against individuals directly or indirectly on the basis of gender, colour, race, nationality, ethnic or national origin, age, sexual orientation, marital status, disability, religion, beliefs, political affiliation, trade union membership, and social and employment status.

2.5 An equality impact assessment (EIA) of this policy has been conducted by the author using the EIA tool developed by the diversity and inclusivity committee. The score of this policy when assessed by the tool in June 2025 was, rated as **'low'.**

3.0 SCOPE AND OBJECTIVES

Scope

3.1 This policy applies to all critical activities and functions carried out by Trust in delivery of its services.

3.2 The policy will apply to all sites which form part of Sherwood Forest Hospitals NHSFT, as listed in section 1.1

3.3 The policy will apply to Trust services and those provided by third parties across each site.

3.4 The policy will not apply to any agency, or building located on any of its sites, which are not involved in the delivery of services which SFH is commissioned to deliver.

Objectives

3.5 To identify critical functions which if interrupted would have a detrimental effect on patient care, Trust reputation and Trust finances.

3.6 To provide a framework for critical functions to be able to continue during periods of disruption.

3.7 To provide SFH staff with a structure for developing plans based on Business Impact Assessments and Risk Assessments.

3.8 To provide assurance to commissioners and external partners that SFH has robust planning arrangements in place in order to continue to deliver its key services during disruptions of any foreseeable nature.

4.0 RESOURCE REQUIREMENTS

4.1 The Trust is committed to ensuring sufficient resources in terms of staff and equipment are available in order to ensure its Business Continuity Management System is robust. The Accountable Emergency Officer will provide an annual update to the Board in this respect. Funding for the EPRR/BCMS resources is provided within the overall budget of the Chief Operating Officer (AEO).

5.0 DEFINITIONS/ ABBREVIATIONS

5.1 **Trust**: *means the Sherwood Forest Hospitals NHS Foundation Trust.*

5.2 **Staff:** *means all employees of the trust including those managed by a third party organisation on behalf of the Trust.*

5.3 **Category 1 Responder:** as defined in the Civil Contingencies Act 2004**,** *Category 1 Responders are those emergency services which are likely to be at the forefront of the response, such as Health, Police and Fire and Rescue, Category 2 responders are those organisations whose role is likely to be supportive such as transport or the utilities.*

5.4 **Business Continuity Management System (BCMS)** is defined as "a *holistic management process that identifies potential threats to an organisation and the impacts to business operations those threats, if realised, might cause, and which provides a framework for building organisational resilience with the capability of an effective response that safeguards the interests of its key stakeholders, reputation, brand and value-creating activities".* *(The Business Continuity Institute (BCI) "Good Practice Guidelines, Global Edition, 2013)*

6.0 ROLES AND RESPONSIBILITIES

6.1 The Chief Executive

The Chief Executive has overall accountability for Business Continuity Management across the organisation including compliance and adherence to the requirements of legislation and guidance.

As part of this accountability the Chief Executive will;

- Implement effective management structures and processes to ensure compliance with this policy and delivery of the required compliance outputs.
- Seek assurance that the organisation has robust Business Continuity plans in place.
- (response and recovery) to respond to identified events which could impact on safety and service delivery.
- Ensure that the Board of Directors are regularly updated with BCMS performance and matters of escalation.

Whilst the Chief Executive accepts overall accountability for the delivery of this policy, the operational day to day delivery has been delegated to the Chief Operating Officer, who will act on their behalf, as the Trust's Accountable Emergency Officer (AEO).

6.2 Chief Operating Officer (AEO and Chair of the Resilience Assurance Committee)

The Chief Operating Officer is responsible for the operational delivery of all roles and responsibilities delegated to him/her by the Chief Executive; and for the escalation of issues to the Trust Management Board that have arisen from the Resilience Assurance Committee. The COO will identify, monitor and arrange appropriate resources to ensure BCM procedures are embedded across the organisation.

The COO will also ensure partner agencies are updated with accurate and timely submission of situation reports, signed off by the appropriate Executive lead.

6.3 Risk Committee

The Risk Committee will;

- Recommend the Business Continuity Policy, for approval by the Board.
- Ensure that the Business Continuity Management System is appropriately resourced, managed and embedded within the culture of the organisation.
- Receive a regular update reports from the Resilience Assurance Committee detailing the organisation's preparedness in relation to all aspects of Emergency Planning and Business Continuity management and compliance.
- Act as a point of escalation for any risks or concerns regarding the BCMS and its implementation.

6.4 The Emergency Planning and Business Continuity Officer

The Emergency Planning and Business Continuity Officer is responsible for the day-to-day management of the Trust BCMS.

Specifically he/she will be responsible for:

- Ensuring all critical functions have a business continuity plan in place. A critical service is any function, service, or process that is essential for the continued operation and delivery of an organization's core mission, especially in times of disruption or crisis. These services are crucial for maintaining the integrity of the organization's operations and preventing significant harm to its stakeholders,
- To ensure the plans are readily accessible by key stakeholders during any incident.To arrange an annual programme of testing divisional and service-line BCP's.
- Carry out training on producing BCP's.
- Provide advice and guidance to service leads on all matters relating to the BCMS.
- Report to the Risk Committee any concerns in respect of Trust preparedness for BC incidents.

6.5 Divisional Clinical Directors, Divisional General Managers, Corporate Service and Contracted Function Managers

Divisional Clinical Directors, Divisional General Managers, Directors of Nursing, Corporate and Contracted Service Managers will;

- Nominate a senior manager to act as the Divisional Lead for Business Continuity who will lead and oversee the production and implementation of local business continuity plans across the Division.
- Ensure that Business Continuity compliance is reviewed regularly at the Divisional Governance meetings to ensure agreed plans are being delivered and key performance indicators met.
- Annually produce and agree with the Resilience Assurance Committee a work plan for the updating, testing and review of Business Continuity plans.
- Update RAC regularly in respect of the plan review process and any risks/escalations.

6.6 Divisional Leads for Business Continuity

Divisional Leads for Business Continuity will:

- Oversees the production, maintenance and validation of their area plans and action cards in accordance with Trust policy and procedures.
- Attend the Trust's internally run training programme on developing Business Continuity Plans (BCM02) and subsequent refresher programme every 18 months. The training schedule will be included in the Annual Workplan and regularly reviewed by the Resilience Assurance Committee. All training is captured and recorded on the Trust electronic training records log.
- As part of the Business Continuity Plan; ensure each area undertakes a Business Impact Analysis and Risk Assessments in accordance with the guidance contained in this policy and the BCMS Framework Document.
- Identify local leads (where necessary) to assist in the development of local plans and action cards.
- Undertake an annual audit of the Divisions level of Business Continuity preparedness.

- Oversee and ensure staff participation in mandated training and exercises.
- Oversee learning and improvement from Business Continuity exercises and incidents; and where relevant, reflect these in local plans and action cards.
- Ensure that staff attend BC-related training, as set out in the Trust's Training Needs Analysis.

6.7 Heads of Service, Ward and Departmental Managers

Heads of Service, Ward and Departmental Managers will;

- Have input to the development of local Business Continuity plans and action cards.
- Through documented local induction, ensure that all staff have a detailed working understanding of local business continuity plans and their individual / collective roles and responsibilities.
- Facilitate the Communications cascade to all staff.
- Be proactive in determining/assessing risks to business continuity and reflect these in local risk registers with appropriate escalation via the agreed risk management processes.
- Share and disseminate plans as part of local induction and ongoing staff update training.
- Complete training module (BCM02) and subsequent refresher programme every 18 months.

6.8 All Staff

Staff play a vital role in Business Continuity planning and delivery.

Staff should;

- be aware of your role in any Business Continuity incident / event.
- be familiar with local Business Continuity plans and action cards.
- report any deficiencies in Business Continuity provision or arrangements.
- attend Business Continuity training provided commensurate with their role.
- participate fully in all Business Continuity exercises and provide feedback.
- have an understanding of local Business Continuity risks and the actions in place to mitigate them.
- undertake Business Continuity Training (BCM02) on an annual basis.

6.8.1 Resilience Assurance Committee (RAC)

The Resilience Assurance Committee will oversee all aspects of BCM and compliance. In fulfilling this function, the RAC will;

- provide a focus for all Business Continuity activity.
- produce an annual work plan detailing all Business Continuity activity.
- develop key performance indicators based upon the agreed terms of reference and work

plan outputs.

- receive the annual Divisional Business Continuity work plans to ensure quality and consistency with Policy and the RAC work plan outcomes .
- oversee training delivery plans.
- oversee and respond to changes in the Nottingham and Nottinghamshire Local Resilience Forum Risk Register and Trust Risk Register relating to BC requirements.

- escalate concerns to appropriate Committees for review and action in accordance with Trust Risk Management Policies and processes.
- complete annual training to support their role on an annual basis.

7.0 APPROVAL

7.1 This Policy has been approved at the following:

Group	Date
Resilience Assurance Committee	
Risk Committee	
Public Board	

8.0 DOCUMENT REQUIREMENTS

The aim of this Policy is to provide an understanding of the requirements of business continuity planning to enable the production of robust plans detailing the actions and arrangements that will be taken to mitigate the impact of foreseeable events that could adversely impact on service provision.

The process centres around a business impact assessment which identifies both generic and service specific impacts which need to be prioritised and encapsulated in local and trust wide business continuity plans.

8.1 Trust Wide Business Continuity Plans

Support functions such as Estates and Facilities, HR and ICT, in addition to their own local Business Continuity Plans, will also develop Trust wide infrastructure focused business continuity response plans to ensure prompt correction of the fault / issue in order for the Trust to revert back to normal operation. These plans will often run in addition to Local Business Continuity Plans across the Trust.

8.2 Local Business Continuity Plans

Through the Business Impact Assessment areas will identify a range of hazards where loss of provision will / could adversely impact on service delivery.

Whilst the list of hazards will vary from one location to the next; they will fall into either generic (common to all areas) or specific to the location (service specific hazards).

8.2.1 **Generic Hazards**

- Loss of Utilities (including water, electricity, gas and drainage)
- Infrastructure failures (Heating, Cooling, Fire Alarm, Access Control)
- ICT System (Network, Information systems, Telecommunications failure / loss)
- Delay or Loss in Internal / External Supply (for example, food, consumables, linen)

- Staff Shortage (Influenza, Infectious Disease, Industrial action)
- Evacuation (triggered by Fire, Bomb Threat, Flood etc.)

8.2.2 **Service Specific Hazards**

- Ventilation Failure in critical areas (Theatres, Pharmacy Production etc.)
- Spillage / exposure from hazardous substances / materials
- Radiation sources
- Service critical equipment failures (e.g. CT scanner, ophthalmic microscopes, scavenging, piped medical gases and suction etc.)

  Such threats should be captured on the relevant divisional or corporate risk register.

8.3 **Stakeholders**

8.3.1 There are multiple stakeholders with an interest in the BCMS, these include:

a) All patients of SFH
b) SFH staff and contractors
c) Divisional/Service leads
d) Board of Directors
e) Integrated Care Boards
f) NHS England

8.4 **Guidance**

The quality of your local plans will be dependent on care taken to identify potential threats and hazards (Business Impact Assessment).

This requires a full and accurate assessment of activities as it will enable services to assess the threats and therefore form the basis of a risk assessment and mitigating contingency plans.

The Forms provided in **Appendices 3 & 4** (Business Impact Analysis and Risk Assessment) will help to identify the critical services and equipment required to deliver the described activity.

A generic list is pre-populated on the forms, however there may be additional ones that apply only to specific areas. These must all be included on the form.

The form format will then guide you through the factors that need to be considered or described in order to define the impacts of the specified loss in provision / failure.

It is important to consider the unusual causes and consequential causes: for example, loss of mains failure may be mitigated by local equipment UPS (Uninterruptable Power Supply) but this will only last so long and is dependent on battery condition, servicing and maintenance. The effectiveness of the UPS as a control needs to be considered along with an understanding of what you would do if this failed.

The thought process applied needs to consider all impacts. For example; whilst the obvious impact of a telecommunications failure will cause the loss of telephone communications it could also impact on the bleep system as well as the ability to communicate with other areas. Different options to cope with the failure may be needed to be considered for each consequence.

Once you have considered and documented the failures that could impact on service delivery (generic and specific) the next step is to identify the alternative actions or systems available to eliminate or mitigate the loss, and assessing their potential effectiveness in maintaining the ability to deliver critical functions

For each consequence, it is necessary to develop ways of minimising the impact. They may appear to be simple, but they must also be robust and practical. For example, if heating is lost in winter, the use of extra blankets may form part of your mitigation. It is important however to check and confirm that the source for extra blankets is identified and is sufficient to ensure supply (particularly as other areas may also be seeking extra blankets as well).

It is also important that roles are identified to undertake these actions. For example, it may be appropriate for a Ward Manager to ring the Duty Nurse Manager and ask for assistance, but a porter could go for blankets.

Once the potential mitigations are defined the formwork provides a second risk assessment score to assess the impact of the mitigation (controls) on the initial risk score. This will indicate if the proposed mitigations will effectively manage the risk.

If the assessment is that the risk is satisfactorily contained, you should proceed to the next stage, if not, you should look for further ways to reduce it, seeking advice if required.

Completion of the form confirms that all risks described are managed / mitigated. If identified risks cannot be satisfactorily mitigated, they should be reported and escalated through the Trust Risk Management process and structures.

The completed forms will provide a series of Action Cards / Contingency Plans to respond to specific risks at local level. It is important that the contents of the action cards are shared with staff at local induction and ongoing in service training and exercises.

These separate action cards plans should also be drawn together into the Department/Ward/Service Area Business Continuity Plan. The Plan should follow a prescribed standard format, provided in **Appendix 7**. This is to ensure that local procedures within the Trust take a consistent approach.

Once in place and trained it is important the plans remain fit for purpose, are updated and quality assured. This will be undertaken through learning from enaction of plans in real incidents and/or as part of incident drills and exercises. The Resilience Assurance Committee will ensure that incidents which result in plans being activated are reviewed and lessons learned and reflected in plan amendments and improvements. The process of BC planning is cyclic with each cycle leading to ongoing refinement and improvement of plans based on experience and learning.

Plans should always be reviewed;

a) annually
b) if a new piece of equipment, or system is introduced
c) if an incident has occurred
d) following an exercise
e) in order to capture learning

9.0 MONITORING COMPLIANCE AND EFFECTIVENESS

The Trust will monitor its Business Continuity Management System through a set of key performance Indicators, listed below:

1) The service has a detailed BC Plan to take account of (as a minimum) the effect the following likely disruptions would have on its critical functions;
    a) Utilities Failure
    b) Denial of Access
    c) Staff Shortage
    d) Infrastructure Failure
    e) Supply Chain Disruption
    f) IT Failure
    g) Service Specific Breakdown
2) A Business Impact Analysis has been carried out using the required Trust template (Appendix 3).
3) A Risk Assessment has been completed with clear mitigations outlined (see Appendix 4). Risk scores should aim to comply with the Trust target risk scores, as follows:

Risk Type	Risk Appetite	Target Risk
Patient Harm	Minimal	Low
Public Harm	Minimal	Low
Staff Harm	Minimal	Low
Services	Cautious	Medium
Reputation/Regulatory Action	Cautious	Medium
Finances	Cautious	Medium

4) Workable, easy to use Action Cards have been developed.as per Appendix 6.
5) Properly structured BC Plans have been produced, in line with the BC Toolkit and which align to ISO22301(see Appendix 7)
6) 20% of the plans been tested annually.
7) 95% of the plans are up to date at any time of review.
8) 100% of the plans have been written by a staff member trained on producing BC Plans.
9) The Trust will aim for an overall target 90% compliance rate for all areas in all of the foregoing points.
10) This will be regularly subject to independent audit, minimally every three years.

The review and testing schedule will be captured in and monitored through the Resilience Assurance Committee Annual Workplan

Minimum Requirement to be Monitored (WHAT – element of compliance or effectiveness within the document will be monitored)	Responsible Individual (WHO – is going to monitor this element)	Process for Monitoring e.g. Audit (HOW – will this element be monitored (method used))	Frequency of Monitoring (WHEN – will this element be monitored (frequency/ how often))	Responsible Individual or Committee/ Group for Review of Results (WHERE – Which individual/ committee or group will this be reported to, in what format (eg verbal, formal report etc) and by who)
Effectiveness of the BCMS	Author, Ward / Service, Dept Managers, EPO, Resilience Assurance Committee	Annual review and report to Risk Committee followed independent formal audit every 3 years	Review annually and audit every three years	Author, Resilience Assurance Committee, Risk Committee 360 Assurance
Compliance with the KPI's	Author, Ward / Service, Dept Managers, EPO, Resilience Assurance Committee	Monthly RAC meetings update. Regular update reports into Risk Committee. Annual EPRR Core Standards Self-Assessment	6-monthly and annually	EPO RAC Risk Committee External Partners (ICB/NHSE) 360 Assurance
Monitoring Incidents and Learning	EPO, Resilience Assurance Committee, Board Risk Committee	Activity within the Incident De-brief process and in line with the Procedure. Reports every six months to NHSE.	Six monthly, or after any serious incidents	Emergency Planning Officer reporting to the Resilience Assurance Committee

10.0 TRAINING AND IMPLEMENTATION

10.1 Annual training in Business Continuity Planning and Business Continuity Plan review will be provided by the Emergency Planning Department which all nominated BC Leads and appropriate staff will be required to attend. Training will be recorded on the Trust electronic register.

10.2 A record of any training will be made and sent to the Training, Education & Development Department.

10.3 Following approval, the Emergency Planning Team will make this Policy available to:

- All Trust staff via the Intranet.
- Emailed to RAC members.
- Emailed to Departmental Managers.
- Emailed Managers of Contracted Functions.

11.0 IMPACT ASSESSMENTS

- This document has been subject to an Equality Impact Assessment, see completed form at Appendix One
- This document has been subject to an Environmental Impact Assessment, see completed form at Appendix Two

12.0 EVIDENCE BASE (Relevant Legislation/ National Guidance) AND RELATED SFHFT DOCUMENTS

- Civil Contingencies Act 2004
- NHS Act
- Health and Care Act 2022
- NHS EPRR Framework (Guidance)
- ISO 22301

Related SFHFT Documents:
SFH – Incident Response Plan
SFH – Corporate Risk Register
Risk Management and Assurance Policy
Emergency Planning Policy
BCMS Framework Document

12.0 APPENDICES

13.1 APPENDIX ONE - EQUALITY IMPACT ASSESSMENT FORM (EQIA)
13.2 APPENDIX TWO - ENVIRONMENTAL IMPACT ASSESSMENT
13.3 APPENDIX THREE - BUSINESS IMPACT ANALYSIS
13.4 APPENDIX FOUR - RISK ASSESSMENT TEMPLATE
13.5 APPENDIX FIVE - RISK ASSESSMENT MATRIX
13.6 APPRNDIX SIX - BUSINESS CONTINUITY ACTION CARD
13.7 APPENDIX SEVEN - BC PLAN CHECKLIST

13. 1 APPENDICES

APPENDIX ONE – EQUALITY IMPACT ASSESSMENT FORM (EQIA)

Name of service/policy/procedure being reviewed: Emergency Planning Policy			
New or existing service/policy/procedure: Existing Policy			
Date of Assessment: June 2025			
For the service/policy/procedure and its implementation answer the questions a – c below against each characteristic (if relevant consider breaking the policy or implementation down into areas)			
Protected Characteristic	**a) Using data and supporting information, what issues, needs or barriers could the protected characteristic groups' experience? For example, are there any known health inequality or access issues to consider?**	**b) What is already in place in the policy or its implementation to address any inequalities or barriers to access including under representation at clinics, screening?**	**c) Please state any barriers that still need to be addressed and any proposed actions to eliminate inequality**
The area of policy or its implementation being assessed:			
Race and Ethnicity	None	Not Applicable	None
Gender	None	Not Applicable	None
Age	None	Not Applicable	None
Religion	None	Not Applicable	None
Disability	None	Not Applicable	None
Sexuality	None	Not Applicable	None
Pregnancy and Maternity	None	Not Applicable	None

Gender Reassignment	None	Not Applicable	None
Marriage and Civil Partnership	None	Not Applicable	None
Socio-Economic Factors (i.e. living in a poorer neighbourhood / social deprivation)	None	Not Applicable	None

What consultation with protected characteristic groups including patient groups have you carried out?
None

What data or information did you use in support of this EqIA?
None

As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments?
No

Level of impact

From the information provided above and following EQIA guidance document Guidance on how to complete an EIA (click here), please indicate the perceived level of impact:

Low Level of Impact

Name of Responsible Person undertaking this assessment:
Lauren Ward – Emergency Planning Officer

Signature:
Lauren Ward

Date:
June 2025

13.2 APPENDIX TWO – ENVIRONMENTAL IMPACT ASSESSMENT

The purpose of an environmental impact assessment is to identify the environmental impact, assess the significance of the consequences and, if required, reduce and mitigate the effect by either, a) amend the policy b) implement mitigating actions.

Area of impact	Environmental Risk/Impacts to consider	Yes/No	Action Taken (where necessary)
Waste and materials	• Is the policy encouraging using more materials/supplies? • Is the policy likely to increase the waste produced? • Does the policy fail to utilise opportunities for introduction/replacement of materials that can be recycled?	No	N/A
Soil/Land	• Is the policy likely to promote the use of substances dangerous to the land if released? (e.g. lubricants, liquid chemicals) • Does the policy fail to consider the need to provide adequate containment for these substances? (For example bunded containers, etc.)	No	N/A
Water	• Is the policy likely to result in an increase of water usage? (estimate quantities) • Is the policy likely to result in water being polluted? (e.g. dangerous chemicals being introduced in the water) • Does the policy fail to include a mitigating procedure? (e.g. modify procedure to prevent water from being polluted; polluted water containment for adequate disposal)	No	N/A
Air	• Is the policy likely to result in the introduction of procedures and equipment with resulting emissions to air? (For example use of a furnaces; combustion of fuels, emission or particles to the atmosphere, etc.) • Does the policy fail to include a procedure to mitigate the effects? • Does the policy fail to require compliance with the limits of emission imposed by the relevant regulations?	No	N/A
Energy	• Does the policy result in an increase in energy consumption levels in the Trust? (estimate quantities)	No	N/A
Nuisances	• Would the policy result in the creation of nuisances such as noise or odour (for staff, patients, visitors, neighbours and other relevant stakeholders)?	No	N/A

13.3 Appendix 3: - Business Impact Analysis

"BIA is a process for identifying, quantifying and qualifying the impacts on a service of a loss, interruption or disruption of a critical activity and it's supporting processes and resources". **(BS NHS 25999-2:2009, Part 2: Specification)**

Business Impact Analysis

1. Service Details **Purpose: to gather basic details about your service**

Directorate		Service Manager	Claire Haywood
Service/ Team/ Function		Manager responsible for BC	
Does service support MI response		Contact Information	

2. Impact Assessment

Purpose: to assess how quickly an incident disrupting your service would damage the hospital and your Service.

Nursing Team Shortages (-50%)

4 hrs	1
8 hrs	1

	Impact Guide
1	Insignificant cost increase/schedule slippage, unsatisfactory patient experience not directly related to patient care, locally resolved complaint, short term low staffing level, temporarily reduces service quality (< 1 day), Small loss <£1,000, Minor non-compliance with standards, Rumours
2	<5% over budget/schedule slippage, Minor injury or illness requiring first aid treatment, Increase in length of stay 1-3 days, unsatisfactory patient experience, Justified complaint peripheral to clinical care, reduces service quality, Loss <£5,000, Non–compliance with standards, Local Media interest. Minor effect on staff morale
3	5-10% over budget/schedule slippage, Mismanagement of patient care, short term effects, increase in length of stay (< than a week), Justified complaint involving lack of appropriate care, Loss < £100,000, Local Media – long term. Significant effect on staff morale

24 hrs	2
48 hours +	3
Your Service Priority is	Low
Your Recovery Time Objective is	24 hours

4	10-25% over budget/schedule slippage, Serious mismanagement of patient care, long term effects, in crease in length of stay (> than a week), Justified multiple complaints, Loss < £500,000, Enforcement action, Low rating, Non-compliance with core standards, National Media < 3 days
5	25% over budget/schedule slippage, Death or permanent incapacity, Totally unsatisfactory patient outcome or experience, Multiple claims or single major claim, Loss > £500,000, Prosecution, Zero rating, Severely Critical Report, National Media > 3 days. MP concern (Question in House)

3. Resources **Purpose: to determine what your service needs to recover after an incident**

	Resources					Dependents/Notes/Critical Periods
Function	Inputs from	Outputs to	Support Services	Management Services	IT Systems	

Staff Breakdown					
Role/Type	Usual Number		Specific Requirements of role		

Key Partners and Contractors				
Organisation Name	Impact of Failure	Time Needed	BCP Seen	Test Evidence

13.4 Appendix Four : - Risk Assessment Template

Risk Area		Critical Impact of Hazard	Initial RAG Assessment			Risk Reduction Contingencies / Controls already in place	Actions	Timescale	Revised RAG Assessment		
Operational Requirements	Hazards Identified		Impact	Likelihood	Score				Impact	Likelihood	Score
Utilities	Loss of water, electricity gas or drainage										
Infrastructure	Loss of heating, cooling, fire alarm, access control										
ICT Systems	Loss of Network information systems, telecoms.										
Supply Chain	Delay loss of internal/external supply (e.g. Food, consumables, linen)										
Staff	Loss of staff due to infectious disease, industrial action, adverse weather.										

Evacuation	Loss of access to work area as a result of Fire, Flood, Bomb Threat.										
Service Specific Requirements	Detailed as required.										

13.5 Appendix Five:- Risk Assessment Matrix

In terms of assessing business continuity risks, the Trust has adopted the following risk categorisations:

	Consequence score and descriptor with examples				
Risk type	**Very low 1**	**Low 2**	**Moderate 3**	**High 4**	**Very high 5**
a. Patient harm or **b. Staff harm** or **c. Public harm**	Minimal physical or psychological harm, not requiring any clinical intervention. e.g.: Discomfort.	Minor, short term injury or illness, requiring non-urgent clinical intervention (e.g. extra observations, minor treatment or first aid). e.g.: Bruise, graze, small laceration, sprain. Grade 1 pressure ulcer. Temporary stress / anxiety. Intolerance to medication.	Significant but not permanent injury or illness, requiring urgent or on-going clinical intervention. e.g.: Substantial laceration / severe sprain / fracture / dislocation / concussion. Sustained stress / anxiety / depression / emotional exhaustion. Grade 2 or 3 pressure ulcer. Healthcare associated infection (HCAI). Noticeable adverse reaction to medication. RIDDOR reportable incident.	Significant long-term or permanent harm, requiring urgent and on-going clinical intervention, or the death of an individual. e.g.: Loss of a limb Permanent disability. Severe, long-term mental illness. Grade 4 pressure ulcer. Long-term HCAI. Retained instruments after surgery. Severe allergic reaction to medication.	Multiple fatal injuries or terminal illnesses. e.g.: Major incident casualties. Multiple missed cancer diagnoses. Outbreak of serious infectious disease.
d. Services	Disruption to peripheral aspects of service affecting one or more services.	Disruption to essential aspects of service affecting one or more services.	Temporary service closure affecting one or more services or disruption to services across multiple divisions.	Extended service closure affecting one or more services or prolonged disruption to services across multiple divisions.	Hospital or site closure.
e. Reputation / regulatory action	Minimal reduction in public, commissioner and regulator confidence. e.g.: Concerns expressed / small number of complaints received.	Minor, short term reduction in public, commissioner and regulator confidence. e.g.: Recommendations for improvement. Multiple complaints received.	Significant, medium term reduction in public, commissioner and regulator confidence. e.g.: Improvement / warning notice. Independent review. Adverse local media coverage.	Widespread reduction in public, commissioner and regulator confidence. e.g.: Prohibition notice. Sustained adverse national / social media coverage.	Widespread loss of public, commissioner and regulator confidence. e.g.: Special Administration. Suspension of CQC Registration. Parliamentary intervention.
f. Finances	Adverse financial impact but not sufficient to affect the achievement annual budgets for any service / department.	Adverse financial impact affecting the ability of one or more services / departments to operate within their budget in the current year.	Adverse financial impact affecting the ability of one or more divisions to achieve their financial control total in the current year.	Adverse financial impact affecting the ability of the organisation to achieve its financial control total in the current year.	Adverse financial impact affecting the long-term financial sustainability of the organisation.

	Likelihood score and descriptor with examples				
	Very unlikely 1	**Unlikely 2**	**Possible 3**	**Somewhat likely 4**	**Very likely 5**
Frequency How often might/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally or there are a significant number of near misses / incidents at a lower consequence level	Will probably happen/recur, but it is not a persisting issue/ circumstances	Will undoubtedly happen/recur, possibly frequently
Probability Will it happen or not?	Less than 1 chance in 1,000 (< 0.1%)	Between 1 chance in 1,000 and 1 in 100 (0.1 - 1%)	Between 1 chance in 100 and 1 in 10 (1- 10%)	Between 1 chance in 10 and 1 in 2 (10 - 50%)	Greater than 1 chance in 2 (>50%)

Risk scoring matrix						
Consequence	**5**	**5**	**10**	**15**	**20**	**25**
	4	**4**	**8**	**12**	**16**	**20**
	3	**3**	**6**	**9**	**12**	**15**
	2	**2**	**4**	**6**	**8**	**10**
	1	**1**	**2**	**3**	**4**	**5**
		1	**2**	**3**	**4**	**5**
		Likelihood				
Rating		Very low (1-3)	Low (4-6)	Medium (8-9)	High (10-12)	Significant (15-25)

13.6 Appendix Six:-

Business Continuity Action Card

Standardised Trust Format for All BCM Action Cards

Title:
Department / Area Covered:
Specific Failure / Hazard: ***to which the action card relates***
Date of Issue:
Review Date;
Author:

- Risk
  Describe the risk.
  Will the risk impact on patient safety, staff safety, damage to the infrastructure or disruption to day to day operations?

- Communication
  Who to contact in the event of the risk materializing? i.e. Switchboard, Security, Estates etc. (Remember to include specific contact numbers)

- Action
  What action do we need to take to affect an appropriate response? E.g. Evacuate the building, turn off all power, shut windows and doors, responsibility for patient safety etc.
  Ensure that your actions follow a logical sequence and that they do not compromise the Health, Safety & Welfare of staff, patients and visitors.

- Recovery
  Describe the actions that would be undertaken to ensure that normal services are resumed as soon as possible. These actions will differ for every type of situation e.g. if there has been major structural damage then it would be unlikely that you would be able to go back into the building. An incident debrief should also be included as part of these actions.

Notes:
When the plan has been finalised and agreed by the Division / Corporate function to which it relates, an educational plan should be agreed. This will vary from area to area but should ensure that all members of staff are familiar with its contents.
Thereafter, the plan should be tested and lessons learned used to refine and improve the plan.

The Action Card must include Author and Review details.

13.7 Appendix 7:- Business Continuity Plan Checklist

Cover Document

- Name of Trust
- Name of Document and Logo.

Plan Administration and Maintenance

- Version control and distribution list
- Security classification
- Document author and business continuity accountable officer
- Review date and schedule
- Exercising and testing schedule
- Plan approval and distribution information
- Planned review of BC Plan should documented for audit and assurance purposes.

Introduction

- Aim of the plan
- Objectives of the plan
- Scope of the plan
- List of legal and regulatory requirements for BC as well as associated guidance
- Key plans linked to the business continuity plan

Roles and Responsibilities within the Plan

- Identification of key roles and responsibilities within the plan (include who has authority to invoke the procedures)
- Individual responsibilities and authorities of team members.
- Prompts for immediate action any specific decisions the team may need to make e.g. activating an alternative site.

Business Impact Analysis and Risk Assessment Outputs

- BC risk assessment and treatment
- Prioritised activities including Recovery Time Objective (RTO) / Maximum Tolerable Period of Disruption (MTPoD)
- Resource requirements for priority services
  - People
  - Premises
  - Technology
  - Information
  - Supplies

Plan Activation

- What are the triggers for activation/standby with appropriate incident response levels
- Activation procedures including implementation procedures i.e. invocation of continuity solutions and team mobilisation structures.
- Escalation procedures
- Stand down procedures
- There should be a relationship between business continuity plans and the organisations incident plans. This is because if a business continuity incident occurred that lead to a critical incident there would only be one level of command and control.

Incident Response

- Incident response procedures/command and control
- Incident response structure (incident response teams and single points of contact)
- A relationship between both the BC plan and incident response plan should be considered e.g. if a BC incident occurred that leads to a critical incident there would only be one level of command and control.
- Action Cards (may be in an annex of the plan)
- Incident Coordination Centre facilities (primary and backup)
- Logging of decision making
- Decision support checklists

Recovery

- BC and recovery strategies
- Debrief/post incident reports/action plans

Communications

- Internal and external comms procedures
- Procedures for warning and informing public
- Info sharing procedures aligned to IG standards
- Media management

Annexes

- Reference to Business Impact Analysis
- Contact directory (Internal and External)
- Internal and external interdependencies
- Reporting tools (e.g. sitrep template)
- Template meeting agenda/s
- Action cards
- Any mutual aid agreement

EMERGENCY PLANNING POLICY

POLICY

Reference	MS/009/2024
Approving Body	Resilience Assurance Committee
Date Approved	Thursday 19th June 2025
Issue Date	Friday 20th June 2025
Version	V2.1
Summary of Changes from Previous Version	Numerous changes to capture suggestions made in the EPRR Core Standards evidence gathering process, Martyn's Law information now included
Supersedes	V2.0
Document Category	Emergency Planning
Consultation Undertaken	Resilience Assurance Committee
Date of Completion of Equality Impact Assessment	June 2025
Date of Environmental Impact Assessment (if applicable)	June 2025
Legal and/or Accreditation Implications	Civil Contingencies Act 2004 NHS England EPRR Framework Guidance 2022 Health and Care Act 2022
Target Audience	Incident Command Teams (Strategic, Tactical & Operational) Communications Team Local Partner Agencies
Review Date	June 2026
Sponsor (Position)	Chief Operating Officer
Author (Position)	Lauren Ward – Emergency Planning & Business Continuity Officer
Lead Division/ Directorate	Corporate
Lead Specialty/ Service/ Department	Emergency Planning
Position of Person able to provide Further Guidance/Information	Emergency Planning & Business Continuity Officer

Associated Documents/ Information	**Date Associated Documents/ Information was reviewed**
None	

Collaborative Planning Form

Purpose: To evidence that plans and arrangements have been developed in collaboration with relevant stakeholders, including, where appropriate, emergency services and health partners to enhance joint working arrangements and to ensure the whole patient pathway is considered.

Title of policy/plan: Emergency Planning Policy

Date of review: June 2025

Issued for collaboration (date): 3rd June 2025

Partners consulted:

Organisation	Consulted Yes/No	Comments Received Yes/No	Comments included in policy/plan Y/N Including detail
NHSE Region	Y	Y	Y Version Control and review schedule.
Notts ICB	Y	N	
NUH	Y	Y	Y
EMAS	Y	N	
Bassetlaw	Y	Y	Y
Notts Healthcare	Y	N	
NEMS	Y	N	
Notts CityCare	N		
Police	N		
Fire Service	N		

Date of next review: June 2026

1.0 INTRODUCTION

The Civil Contingencies Act 2004 (CCA) places a number of statutory duties on NHS organisations which are classed as either Category 1 or Category 2 Responders.

As a Category 1 Responder, Sherwood Forest Hospital NHS Foundation Trust (SFHFT) is required to prepare for emergencies in line with its responsibilities under the CCA.

Other requirements are captured in the CQC Outcome 6(D) and HIS Operating Framework, as well as the NHS Standard Contract (section 30) which stipulates all staff will comply included in NHS Core Standards for EPRR and the associated NHS EPPR Framework.

This Policy outlines how SFHFT will meet the duties set out in legislation and associated guidelines, as well as any other issues identified by way of risk assessments and identified capabilities.

This Policy is not intended to be used for the response to a Major Incident in those circumstances staff should refer to the Trusts' **Incident Response Plan** which details the Trusts operational response to a Major, Critical or serious Trust-wide Business Continuity Incident. This could be a sudden onset, rising tide, cloud on the horizon type incident, or even a Chemical, Biological, Radiological or Nuclear (CBRN) or HAZMAT (Hazardous Material) incident.

The policy should be read in conjunction with the Trusts' Business Continuity Policy and Incident Response Plan.

2.0 POLICY STATEMENT

The primary purpose of this policy is to optimise the safety of SFH patients, its staff and visitors to its premises, as a result of a serious incident.

SFHFT has a responsibility to ensure that it is capable of managing risks at corporate and service level and responding to Critical or Major Incidents of any scale in a way that delivers optimum care and assistance to the victims, that minimises the consequential disruption to healthcare services and that it brings about a speedy return to normal levels of functioning.

Aligning with the Trust strategic objectives:

To continuously learn and improve, and

To work collaboratively with partners in the community,

SFHFT will meet this responsibility through:

- Building upon the existing strengths of current multi-agency and Health Trusts co-ordination and co-operation in Emergency Planning, Resilience and Response.

- Fully integrating with partner agencies' emergency arrangements, in particular providing Mutual Aid in supporting Nottinghamshire Integrated Care System and other Acute Trusts with receiving Emergency Departments and other local NHS Providers (MOU).

- Reviewing the Trusts state of readiness and operability to deal with a Major, Critical or Business Continuity Incident, with the assistance of new and improved partnerships, to ensure the Trusts capability to handle any new kind and potential magnitude of threat.

- Ensuring that plans for Business Continuity (BC) are in place right across the organisation, with special emphasis on critical functions.

- Engendering a culture within SFHFT to make emergency preparedness, resilience and response an intrinsic element of management and operations.

- Having a process in place for learning from incidents and exercises from both within the Trust and from external agencies.

- Ensuring there is a process in place to monitor the RAC annual workplan with regular update reports provided to the Risk Committee.

- Embedding a culture of continuous improvement in line with recognised business continuity standards.

- Regularly reviewing risks to the organisation and its critical functions, as captured in Principal Risk no.7 on the Board Assurance Framework.

- Working with partners in identifying risks to the community and escalating where appropriate to LHRP/LRF.

- Ensuring that EPRR is adequately resourced and given appropriate access to funding.

In order to deliver this, the Board is committed to maintaining a dedicated EPRR asset within the organisation, which it will review on a regular basis, and for which it will provide adequate funding and resources to ensure it is able to discharge its responsibilities and to ensure it has both the required competencies and capacity. Funding for the Emergency Planning workstream will sit within the domain of the Chief Operating Officer's overall budget.

The policy has also been subject to Equality and Environmental Impact Assessments. No issues were identified as a result of these checks and the policy has been registered having a "Low" impact (see appendices one and two).

3.0 DEFINITIONS/ ABBREVIATIONS

Acronym	Term/Definition
AEO	Accountable Emergency Officer
BCMS	Business Continuity Management System
BCP	Business Continuity Plan
BoD	Board of Directors
RC	Risk Committee
CQC	Care Quality Commission
CBRN	Chemical, Biological, Radiological & Nuclear
CCA	Civil Contingencies Act - 2004
CE	Chief Executive
CRR	Community Risk Register
DH	Department of Health
EPRR	Emergency Preparedness, Resilience and Response
EMAS	East Midlands Ambulance Service
EPO	Emergency Planning Officer
ICB	Integrated Care Board
NHSE	NHS England
LHRP	Local Health Resilience Partnership
LRF	Local Resilience Forum (Nottinghamshire)
MOU	Memorandum of Understanding
NHS	National Health Service
RAC	Resilience Assurance Committee
SFHFT	Sherwood Forest Hospitals NHS Foundation Trust

4.0 ROLES AND RESPONSIBILITIES

The following roles and responsibilities relate to how SFHFT and key individuals will prepare for emergencies.

Emergency response roles and responsibilities are provided in the Trust's generic Incident Response Plan.

4.1 Chief Executive

The Chief Executive (CE) has overall responsibility for emergency planning and is accountable to the Trust's Board of Directors for ensuring systems are in place to facilitate an effective Major Incident response. The CE will:

Ensure that the Chief Operating Officer is nominated as the Accountable Emergency Officer (Executive Lead for Emergency Preparedness).

4.2 Accountable Emergency Officer

The Chief Operating Officer is nominated by the CE to act as the Accountable Emergency Officer as required by the NHS Act.

The Accountable Emergency Officer will:

- Chair the Trust's Resilience Assurance Committee, or delegate to another person of competence, as per its Terms of Reference.
- Work closely with the EPO to implement the Emergency Planning Policy.
- Prepare and submit, with the assistance of the EPO, an annual report to the Trust Board summarising the current state of preparedness.
- Attend meetings of the Local Resilience Forum (LRF) if requested or send a nominated deputy.
- Attend meetings of the Local Health Resilience Partnership (LHRP) as SFH Executive level representative.
- To ensure EPRR training is delivered across the organisation in accordance with the training needs analysis.
- To review the EPRR resource and funding on a regular basis.
- Ensure, with the assistance of the EPO, that an on-call rota is developed and maintained for the provision of Senior Manager availability to respond to incidents at both tactical and strategic levels.
- In conjunction with the Trust's Medical Director, will sign off the mass casualty dispersal figures for SFH as part of the Trusts' response to a regional mass casualty incident.

In his/her absence, the Deputy Chief Operating Officer will assume these responsibilities.

4.3 Emergency Planning Officer

The main duties of the EPO are:

- To ensure the Trust is prepared to respond to incidents and emergencies.
- To advise the Executive Team and/or the Risk Committee of emerging and/or escalating risks and threats, as and when required.
- To provide assurance to the Board about Trust preparedness and the working of the Resilience Assurance Committee, including progress on the RAC Annual Workplan, via a formal Trust Board Report not less than annually.
- To develop tests and exercises of trust-wide and service level plans
- To provide on-going training to all relevant staff.
- To ensure relevant plans, policies and procedures are kept up to date.
- To represent the Trust on external meetings, training and exercises related to emergency preparedness.

- To lead the process of learning from incidents which occur within the Trust and those which occur within partner agencies
- Provide training and expertise in specific risk areas, such as CBRN (Chemical, Biological, Radiological, Nuclear)

4.4 Resilience Assurance Committee (RAC)

The Resilience Assurance Committee is a multi-disciplinary team representing all key areas of the Trust who have responsibility for emergency response, including all divisions, specific clinical areas and other departments. Their role is:

- To develop the organisations statutory responsibility as a Category 1 Responder to plan and respond to a major incident/incidents or emergencies and manage recovery within the context of the Civil Contingencies Act 2004 (CCA) and NHS Guidance through robust planning and associated activities.

- To provide objective assurance to the Executive that systems and processes are in place to ensure emergency preparedness and that any resource implications are identified to enable the Trust to discharge its legal responsibilities.

- To provide a forum for, the exchange of information and discussion and debate concerning strategic, operational, educational, clinical and professional issues relating to emergency preparedness.

4.5 The Risk Committee (RC)

The role of the Risk Committee is to ensure the Trust Board of Directors are kept informed of EPRR matters escalated from the RAC and to provide support in resolving issues. New policies related to Emergency Planning and Business Continuity Management should be approved by the Risk Committee.

The Risk Committee will manage EPRR risks in accordance with the Trust's Risk Management and Assurance Policy.

4.6 Generic Trust Roles and Responsibilities

The following generic roles and responsibilities have been identified within the EPRR guidance.

- To mobilise and direct healthcare resources within the hospital at short notice.
- To sustain patient care in the hospital throughout the duration of a Major or Critical Incident.
- To ensure clinicians, nursing and other staff can respond to an incident.
- To assess the effects of an incident on and consider the needs of vulnerable care groups, such as children, dialysis patients, elderly, medically dependent or physically or mentally disabled.

- Plan to harness and effectively utilise the widest range of resources needed to treat any casualties transported to hospital by EMAS or Self Presenters.
- Have systems and facilities in place to ensure the health safety and welfare of all staff during a Major or Critical Incident.
- Provide suitable and sufficient training arrangements to ensure the competence of staff in performing emergency planning roles.
- In preparing for emergencies, it is essential to develop and embed a culture of resilience within the organisation. As such, emergency preparedness should be a consideration for all of the Trust's staff.
- To ensure that the Trust completes and submits situation reports in line with system requirements and agreed battle rhythm, and that such reports are completed on up to date report templates and signed off by an Executive.

Reporting Templates are appended to this policy:

SBAR = Appendix 3 (for Critical and Business Continuity Incident declarations)
METHANE = Appendix 4 (for Major Incident declarations)

4.7 CBRN Trained Staff

- Will support the Trust response to a CBRN incident
- Ensure their training on CBRN is up to date
- Will be familiar with the Equipment, where it is stored, how to access it and how it is to be used.

4.8 Trust Staff will:

- Ensure that they are familiar with the arrangements detailed in the Trust's Incident Response Plan and related documents.
- Ensure that they are familiar with their roles and responsibilities.
- Undertake training commensurate with their emergency response role.

5.0 APPROVAL

The Policy, which has several amendments resulting from previous feedback from external agencies and in readiness for the NHS Core Standards for EPRR self-assessment review of 2025. These amendments are set out on page 3.

This updated policy was approved at the RAC in June 2025 and will be ratified at Trust Board.

6.0 DOCUMENT REQUIREMENTS

The Trust has statutory duties as a Category 1 responder, under the CCA to assess local risks and put in place emergency plans, co-operating with other local responders to enhance co-ordination and efficiency.

The Trust is also required to have in place contingency plans that allow it to continue to provide services during a Major Incident, so far is practicable and to recover from the additional pressure that an incident would place on the organisation.

6.1 Statutory Duties / Risk Register

The Civil Contingencies Act (2004) delivers a single statutory framework for civil protection in the United Kingdom capable of meeting the challenges of the 21st century.

The Act is separated into two substantive parts:

- Part 1: focuses on local arrangements for civil protection, establishing a statutory framework of roles and responsibilities for local responders.
- Part 2: focuses on emergency powers, establishing a modern framework for the use of special legislative measures that might be necessary to deal with the effects of the most serious emergencies.

The Act defines an Emergency as:

'An event or a situation which threatens serious damage to human welfare in a place in the UK, the environment of a place in the UK, or war, or terrorism which threatens serious damage to the security of the UK'

The definition is concerned with the consequences rather than the course or source.

The Trust manages risks through a process of local risk assessment, and interaction with regional partners regularly reviewing the community and national risk registers, through the Local Health Resilience Partnership and the Health Risk Management Group.

Risks which are identified as prevalent are captured on the Trust's DATIX risk management system.

Principle Risk no.7 on the Board Assurance Framework highlights the risk of a serious untoward incident affecting the Trust, and is regularly reviewed by the Accountable Emergency Officer, Emergency Planning Officer and Risk & Assurance Manager. This review is presented to the Risk Committee each month.

6.2 Definitions:

NHS Major Incident

The Cabinet Office, and the Joint Emergency Services Interoperability Principles (JESIP), define a Major Incident as an event or situation with a range of serious consequences that require special arrangements to be implemented by one or more emergency responder agency. In the NHS this will cover any occurrence that presents serious threat to the health of the community

or causes such numbers or types of casualties, as to require special arrangements to be implemented. For the NHS, this will include any event defined as an emergency. A Major Incident may involve a single agency response, although it is more likely to require a multi-agency response, which may be in the form of multiagency support to a lead responder. The severity of the consequences associated with a Major Incident are likely to constrain or complicate the ability of responders to resource and manage the incident, although a Major Incident is unlikely to affect all responders equally. The decision to declare a Major Incident will always be made in a specific local and operational context. There are no precise, universal thresholds or triggers. Where Local Resilience Forums (LRFs) and responders have explored these criteria in the local context and ahead of time, decision makers will be better informed and more confident in making that judgement.

NHS Critical Incident

Any localised incident where the level of disruption results in an organisation temporarily or permanently losing its ability to deliver critical services; or where patients and staff may be at risk of harm. It could also be down to the environment potentially being unsafe, requiring special measures and support from other agencies, to restore normal operating functions. A Critical Incident is principally an internal escalation response to increased system pressures/disruption to services.

NHS Business Continuity Incident

An event or occurrence that disrupts, or might disrupt, an organisation's normal service delivery, to below acceptable predefined levels. This would require special arrangements to be put in place until services can return to an acceptable level. Examples include surge in demand requiring temporary re-deployment of resources within the organisation, breakdown of utilities, significant equipment failure or hospital acquired infections. There may also be impacts from wider issues such as supply chain disruption or provider failure.

An event or occurrence that disrupts, or might disrupt, an organisation's normal service delivery, to below acceptable predefined levels. This would require special arrangements to be put in place until services can return to an acceptable level. Examples include surge in demand requiring temporary re-deployment of resources within the organisation, breakdown of utilities, significant equipment failure or hospital acquired infections. There may also be impacts from wider issues such as supply chain disruption or provider failure.

The Trust has statutory duties as a Category 1 responder, under the CCA to assess local risks and put in place emergency plans, co-operating with other local responders to enhance co-ordination and efficiency.

The Trust is also required to have in place contingency plans that allow it to continue to provide services during a Major Incident, so far is practicable and to recover from the additional pressure that an incident would place on the organisation.

Local Health Resilience Partnerships (LHRPs) with responsibility for EPRR across all relevant health bodies in Nottinghamshire have been established and are the forum for coordination, joint working and planning.

NHS organisations are required to nominate Accountable Emergency Officer (SFHFT – Chief Operating Officer) to assume executive responsibility and leadership at service level for EPRR.

The Act places six statutory obligations on Category 1 Responders:

- Duty to Plan for Emergencies
- Duty to Assess Risk
- Business Continuity Management
- Duty to cooperate
- Duty to share information
- Duty to communicate

6.3 Planning for Emergencies

As a Category 1 Responder, the Trust has a duty to prepare and maintain plans to respond to emergencies.

The Trust will develop, disseminate and maintain an Incident Response Plan detailing how the organisation will respond to an emergency, including:

- Definition of Major Incident and increase in Emergency Department thresholds
- Activation, notification and stand-down procedures
- Roles and responsibilities
- Control and coordination arrangements
- Communication arrangements
- Response activities
- Standard operating procedures
- Recovery arrangements

Where appropriate, the Trust will develop, disseminate and maintain specific emergency plans for identified hazards and threats, e.g. Severe Weather, Infectious Disease, Pandemic or CBRN Plan.

All emergency plans will be validated by tests and exercises conducted where possible within 12 months of the publication of the arrangements.

6.4 Martyn's Law

The Terrorism (Protection of Premises) Act 2025, also known as Martyn's Law, received Royal Assent on Thursday 3 April 2025.

This Act delivers the Government's manifesto commitment to strengthen the security of public premises and events. The legislation mandates that venues and public spaces are required to implement measures to mitigate the risks of terrorist attacks, with a focus on preparedness, security, and response. The law outlines a tiered approach, with specific obligations placed on different types of venues based on size and risk. As an NHS Trust, SFH falls under the 'enhanced tier' of the legislation, which applies to public venues and organisations that are at a moderate risk of terrorist attacks. In line with this, the Trust strives to ensure it is as prepared as possible for any such risk, implementing proportionate security measures, conducting regular risk assessments, and ensuring staff training. These efforts are aimed at safeguarding our patients, visitors, and staff members in the event of a terror-related incident.

6.5 Risk Assessment

The Trust has assessed risks contained within the Community Risk Register and Local Health Resilience Partnership (LHRP) risk register and has included the impact of a Major Incident on the Corporate Risk Register and within the Board Assurance Framework (BAF), under Principal Risk 7.

Where appropriate the Trust will develop specific plans to manage risks with a high likelihood of occurring, or those which would have a serious impact on the delivery of its services.

The process for reporting escalating and managing risks is captured in the Trust Risk Management and Assurance Policy.

6.6 Business Continuity Management System

As a Category 1 responder, the Trust has a duty to develop and maintain arrangements to ensure continuity of service whilst responding to an emergency is it internal or external.

The Trust recognises ISO 22301 as the definitive guidance for Business Continuity Management and is committed to working towards this standard.

In accordance with ISO 22301, the Trust will develop, disseminate and maintain business continuity policies, strategies and plans and work to embed a culture of business continuity management and continuous improvement across the organisation.

Through debriefing both local and regional incidents and planned exercises a formal process of learning will continue to be embedded across the Trust. Lessons will be captured in a post incident/ exercise report by the EPO. The report will contain recommendations for improvement and will be passed for approval to the RAC. Once approved at the RAC, the recommendations will be assigned to the relevant service leads and placed on the RAC Action Tracker, through which they will be monitored up to completion. Should the recommended actions require a sufficient amount of work for individuals or teams over a period of time, it will be placed on the RAC Annual Workplan, through which its updates to RAC can be planned and monitored.

This process demonstrates the Trust commitment to its strategic objective to continuously learn and improve.

All suppliers of essential services and equipment to the Trust must have a BCMS process in place.

The Trust is committed to ensuring the robustness of its supplies of equipment and services. To this end it will endeavour to exclusively utilise suppliers from the NHS Procurement Framework, or indeed NHS Supply Chain itself. This ensures that the companies from whom it procures have robust business continuity processes in place.

6.7 Cooperation

As a Category 1 responder the Trust has a duty to cooperate with other Category 1 and 2 responders within the local area.

The Trust recognises the Nottinghamshire LRF as the principal mechanism for multi-agency cooperation.

As the Trust is a Foundation Trust its contract is with the ICB, but the Trust will endeavour to cooperate with other providers in emergency planning matters.

The ICB coordinates EPRR across all relevant health bodies in Nottinghamshire. A Local Health Resilience Partnership (LHRPs) has been established and is the forum for coordination, joint working and planning.

6.8 Information Sharing

As a Category 1 Responder, the Trust has a duty to share information requested by other Category 1 Responders.

Information requests between NHS organisations within the East Midlands Health Community will be addressed informally through the Resilience Assurance Committee.

Where informal requests for information cannot be resolved within the business of the RAC, they will be escalated to the Risk Committee and/or be referred to the Accountable Emergency Officer.

Where informal requests for information cannot be resolved within the business of the Risk Committee, a formal request for information will need to be made under the provisions of the CCA using the pro-forma supplied in the statutory guidance document ‘CCA Emergency Preparedness’.

Information sharing will be based on the Caldicott Principles:

1. Justify the purpose
2. Use only when necessary
3. Use minimum amount of information required
4. Access based on a strict "need to know" basis
5. Everyone who has access is aware of responsibilities
6. All staff should comply with data protection law
7. Duty to share information is as important as protecting confidentiality
8. Inform patients and service users of how their information is used

6.9 Communication (Warning & Informing)

As a Category 1 responder the Trust has a responsibility for advising the public of risks before an emergency by warning and keeping the public informed in the event of an emergency.

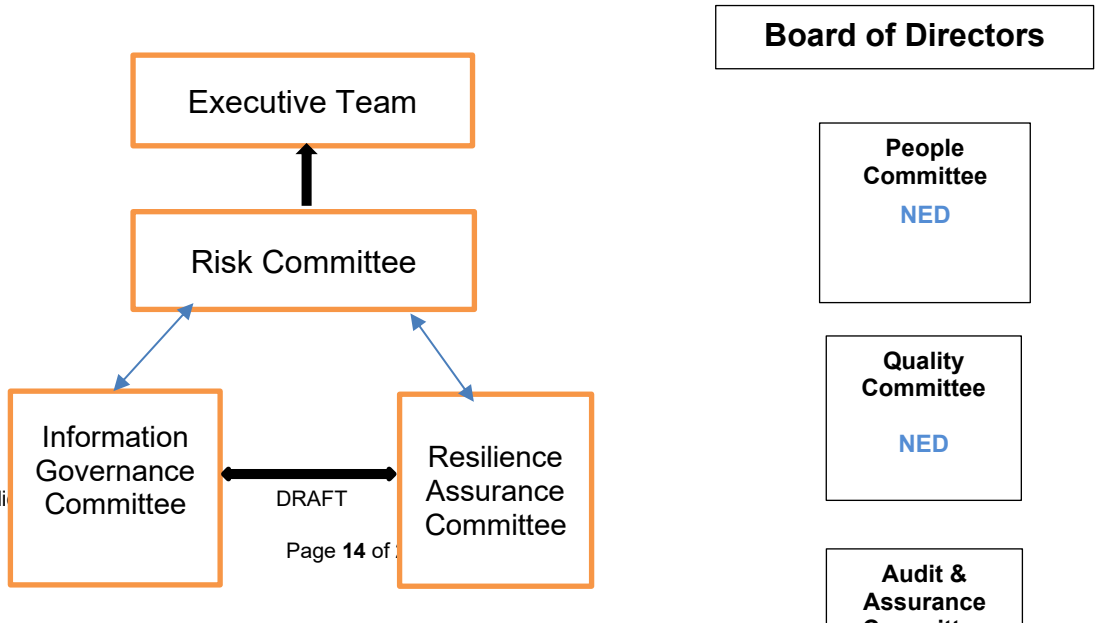
The NHS England acts on behalf of the Trust for communications within the LRF Nottinghamshire Communications Sub group. The Trust along with the ICB will develop, disseminate and maintain arrangements for communicating with the public before and during an emergency. The Trust will work with the ICB and NHS England when developing messages for the public.

These arrangements will be included in the Trust's Incident Response Plan.

6.9.1 EPRR Structure

Fig 1

SFH – Organisational Structure for EPRR



7.0 MONITORING COMPLIANCE AND EFFECTIVENESS

Minimum Requirement to be Monitored (WHAT – element of compliance or effectiveness within the document will be monitored)	Responsible Individual (WHO – is going to monitor this element)	Process for Monitoring e.g. Audit (HOW – will this element be monitored (method used))	Frequency of Monitoring (WHEN – will this element be monitored (frequency/ how often))	Responsible Individual or Committee/ Group for Review of Results (WHERE – Which individual/ committee or group will this be reported to, in what format (eg verbal, formal report etc) and by who)
Effectiveness of the Procedure	Author, Ward / Service, Department Managers, EPO, Resilience Assurance Committee	Formal Review on an annual basis and in line with Trust Risk Assessment and local / national guidance	Annually	Author, Resilience Assurance Committee, Risk committee
Monitoring Incidents and Learning	EPO, Resilience Assurance Committee Risk Committee	Activity within the Incident De-brief process and in line with the Procedure	Annually or after any serious incidents	Emergency Planning Office reporting to the Resilience Assurance committee

Monitoring Compliance:

The Trust's Chief Executive will be responsible for ensuring that the Trust has effective arrangements in place to respond to a major incident or emergency. The Chief Operating Officer has been delegated as the Accountable Emergency Officer

- The monitoring and enforcement of compliance with the duties and statutory provisions of the CCA will be undertaken through mainstream performance monitoring arrangements.
- Within the Trust, the Accountable Emergency Officer will ensure that annual reports are submitted to the board outlining the current state of preparedness.
- Comply with any requests from Internal Audit, ICB or NHS England.
- Comply with any requirements under the CQC's emergency preparedness standard.

8.0 TRAINING AND IMPLEMENTATION

Training:

The Trust will identify individuals by a Training Needs Analysis, staff who have specific responsibilities when responding to an emergency and ensures that they are given adequate and appropriate training, in line with recognised best practise to enable them to discharge their roles.

The Trust recognises the need for collaboration with other Trusts and partner agencies in organising, running and participating in exercises.

The Trust will, in partnership with other organisations within the Local Health Resilience Partnership, support the joint training strategy for the effective delivery of emergency preparedness and response training.

Formal training will take place within the Trust as determined by the Resilience Assurance Committee, which includes input on mandatory training sessions and exercises.

Informal guidance, advice and support can be provided on an 'as and when needed' basis to small groups or on an individual basis to meet identified needs. Please contact the Emergency Planning Officer to arrange.

A record of any training will be made and sent to the Training, Education & Development Department.

A training needs analysis has identified the following requirement for the Trust Strategic (Gold) commanders:

Portfolio Reference	Requirements	Frequency	Provider	ICB	Region
SHC01	Strategic Health Commander Portfolio Workbook	Every 3 years			
SHC02	Principles of Health Command – Strategic Health Commander	Every 3 years			
SHC03	Legal Awareness Training	Every 3 years			
SHC04	Defence Contribution to Resilience (or equivalent)	Every 3 years	Optional		
SHC05	MAGIC or Magic-Lite course	Every 3 years	Optional		
SHC06	Media Training/Awareness	Every 3 years			
SHC07	Working with your loggist	Every 3 years			

Portfolio Reference	Requirements	Frequency	Provider	ICB	Region
SHC08	Business Continuity Awareness	Every 3 years	AEO only		
SHC09	Joint Decision-Making Awareness (initially through training and then annually through exercise application)	Annually			
SHC10	Local Resilience Forum Awareness	Every 3 years	Optional		
SHC11	Specialist Asset Awareness	Every 3 years	Optional		
SHC12	EPRR Communications Awareness (initially through training and then annually through exercise application)	Annually			
SHC13	Incident Response Plan/ Command & Control familiarisation (inc through exercise application)	Annually			
SHC14	Writing a Strategy (inc. through exercise application)	Annually			
SHC15	Chair a Strategic Level Meeting	Annually			
SHC16	Act as a Strategic Health Commander at an incident or exercise	Annually			
SHC17	Act as a Strategic Health Commander at an Incident or Exercise with Multi-agency Partners	Annually	Optional		
SHC18	Accountable Emergency Officers – Role & Expectations	Every 3 years	AEO only		

Incident commanders are required to maintain a training portfolio as personalised evidence of this training.

The following table describes the training requirements identified in a TNA for all Tactical (Silver) commanders, who should also maintain a personal training portfolio:

Portfolio Reference	Requirements	Frequency	Provider	ICB	Region
THC01	Tactical Health Commander Portfolio Workbook	Every 3 years			
THC02	Principles of Health Command – Tactical Health Commander	Every 3 years			
THC03	Legal Awareness Training	Every 3 years	Optional	Optional	
THC04	Working with your loggist	Every 3 years			

Portfolio Reference	Requirements	Frequency	Provider	ICB	Region
THC05	Joint Decision-Making Awareness (initially through training and then annually through exercise application)	Annually			
THC06	Local Resilience Forum Awareness	Every 3 years	Optional		
THC07	Specialist Asset Awareness	Every 3 years	Optional		
THC08	EPRR Communications Awareness (initially through training and then annually through exercise application)	Annually			
THC09	Incident Response Plan/Command & Control familiarisation (inc. through exercise application)	Annually			
THC10	Writing a Tactical Plan (inc. through exercise application)	Annually			
THC11	Chair a Tactical Level Meeting	Annually			
THC12	Act as a Tactical Health Commander at an incident or exercise	Annually			
THC13	Act as a Tactical Health Commander at an Incident or Exercise with Multi-agency Partners	Annually	Optional		

Green boxes indicate mandatory requirement

The TNA also identified a need to train a sufficient cadre of log-keepers in line with national guidance.

Exercises:

In line with the NHS Core Standards for EPRR, the Trust will test its emergency arrangements through:

- Live exercises run at least every three years.
- Table-top exercises run at least every year.
- Communications tests run at least every six months.
- Command post exercises run at least every three years.

9.0 Impact Assessments

- This document has been subject to an Equality Impact Assessment, see completed form at Appendix 1
- This document has been subject to an Environmental Impact Assessment, see completed form at Appendix 2

10.0 EVIDENCE BASE (Relevant Legislation / National Guidance) AND RELATED SFHFT DOCUMENTS

Evidence Base:

Civil Contingencies Act 2004

NHS Act

Health and Care Act 2022

NHS EPRR Framework (Guidance)

Related SFHFT Documents:

- SFH – Incident Response Plan
- SFH – Corporate Risk Register
- Board Assurance Framework
- CBRN Plan
- Pandemic Surge Plan
- Business Continuity Policy

11.0 APPENDICES

Appendix 1	Equality Impact Assessment
Appendix 2	Environmental Impact Assessment

APPENDIX ONE - EQUALITY IMPACT ASSESSMENT FORM (EQIA)

Name of service/policy/procedure being reviewed: Violence and Aggression			
New or existing service/policy/procedure: Policy			
Date of Assessment: 24th June 2024			
For the service/policy/procedure and its implementation answer the questions a – c below against each characteristic (if relevant consider breaking the policy or implementation down into areas)			
Protected Characteristic	**a) Using data and supporting information, what issues, needs or barriers could the protected characteristic groups' experience? For example, are there any known health inequality or access issues to consider?**	**b) What is already in place in the policy or its implementation to address any inequalities or barriers to access including under representation at clinics, screening?**	**c) Please state any barriers that still need to be addressed and any proposed actions to eliminate inequality**
The area of policy or its implementation being assessed:			
Race and Ethnicity	None	Not applicable	None
Gender	None	Not applicable	None
Age	None	Not applicable	None
Religion	None	Not applicable	None
Disability	None	Not applicable	None
Sexuality	None	Not applicable	None
Pregnancy and Maternity	None	Not applicable	None

Gender Reassignment	None	Not applicable	None
Marriage and Civil Partnership	None	Not applicable	None
Socio-Economic Factors (i.e. living in a poorer neighbourhood / social deprivation)	None	Not applicable	None

What consultation with protected characteristic groups including patient groups have you carried out? None for this version, in that all previous principles remain in accordance with previous version (which was subject to consultation) and this version is primarily a reformat and codification of agreed practices. None

What data or information did you use in support of this EqIA?
Trust policy approach to availability of alternative versions.

None

As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments? No.

Level of impact

From the information provided above and following EQIA guidance document Guidance on how to complete an EIA (click here), please indicate the perceived level of impact:

Low Level of Impact *(Delete as appropriate)*

Name of Responsible Person undertaking this assessment:
Mark Stone – Emergency Planning Officer

Signature:

Date: 24th June 2024

APPENDIX TWO – ENVIRONMENTAL IMPACT ASSESSMENT

The purpose of an environmental impact assessment is to identify the environmental impact, assess the significance of the consequences and, if required, reduce and mitigate the effect by either, a) amend the policy b) implement mitigating actions.

Area of impact	Environmental Risk/Impacts to consider	Yes/No	Action Taken (where necessary)
Waste and materials	• Is the policy encouraging using more materials/supplies? • Is the policy likely to increase the waste produced? • Does the policy fail to utilise opportunities for introduction/replacement of materials that can be recycled?	No	N/A
Soil/Land	• Is the policy likely to promote the use of substances dangerous to the land if released? (e.g. lubricants, liquid chemicals) • Does the policy fail to consider the need to provide adequate containment for these substances? (For example bunded containers, etc.)	No	N/A
Water	• Is the policy likely to result in an increase of water usage? (estimate quantities) • Is the policy likely to result in water being polluted? (e.g. dangerous chemicals being introduced in the water) • Does the policy fail to include a mitigating procedure? (e.g. modify procedure to prevent water from being polluted; polluted water containment for adequate disposal)	No	N/A
Air	• Is the policy likely to result in the introduction of procedures and equipment with resulting emissions to air? (For example use of a furnaces; combustion of fuels, emission or particles to the atmosphere, etc.) • Does the policy fail to include a procedure to mitigate the effects? • Does the policy fail to require compliance with the limits of emission imposed by the relevant regulations?	No	N/A
Energy	• Does the policy result in an increase in energy consumption levels in the Trust? (estimate quantities)	No	N/A
Nuisances	• Would the policy result in the creation of nuisances such as noise or odour (for staff, patients, visitors, neighbours and other relevant stakeholders)?	No	N/A

Outstanding Care, Compassionate People, Healthier Communities

Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Provider Board Capability Self-Assessment	**Date:**	4th December 2025
Prepared By:	Sally Brook Shanahan, Director of Corporate Affairs		
Approved By:			
Presented By:	Sally Brook Shanahan, Director of Corporate Affairs		

Purpose

The purpose of this paper is to confirm in the public domain that the Provider Board Capability Self-Assessment submission has been made to NHS England and to record formally its content and ownership by the contributing Executive directors and approval by the full Board.	**Approval**	
	Assurance	**X**
	Update	
	Consider	

Strategic Objectives

Provide outstanding care in the best place at the right time	Empower and support our people to be the best they can be	Improve health and wellbeing within our communities	Continuously learn and improve	Sustainable use of resources and estates	Work collaboratively with partners in the community
			X		

Principal Risk

PR1	Significant deterioration in standards of safety and care	
PR2	Demand that overwhelms capacity	
PR3	Critical shortage of workforce capacity and capability	
PR4	Insufficient financial resources available to support the delivery of services	
PR5	Inability to initiate and implement evidence-based Improvement and innovation	
PR6	Working more closely with local health and care partners does not fully deliver the required benefits	
PR7	Major disruptive incident	
PR8	Failure to deliver sustainable reductions in the Trust's impact on climate change	

Committees/groups where this item has been presented before

Private Board – 2nd October and 6th November 2025
Executive Committee, most recently 22nd October 2025

Acronyms

NHSE – National Health Service England
SID – Senior Independent Director
ICB – Integrated Care Board

Executive Summary

On 2nd October 2025, in its private session, the Board received a paper informing it about the new NHSE Assessing Provider Capability Guidance that instructs Boards to perform an annual self-assessment against the following six domains derived from its "Insightful Provider Board" framework:

- Strategy, leadership and planning
- Quality of care
- People and culture
- Access and delivery of services
- Productivity and value for money
- Financial performance and oversight

The intended purpose of the self-assessment is described as being to strengthen board assurance and self-awareness, provide a holistic view of a trust's capability, encourage a "no surprises" culture between trusts and oversight teams and enable support from NHSE to be appropriately directed to trusts most in need.

Process

The internal process to conduct the self-assessment was co-ordinated by the Director of Corporate Affairs and involved each Executive Director, self-assessing the contribution and performance of their directorate against the total of sixteen self-assessment criteria that fall under the six domains listed above.

At an Executive Committee meeting on 22nd October 2025 the individual Executive leads to whom the various self-assessment criteria in the narrative self-assessment had been allocated confirmed they acknowledged ownership of their contributions and collectively agreed the Committee's final draft of the narrative submission to accompany the self-assessment.

The Executive directors then discussed the statements that the Board is required to self-assess against for the six domains listed above in order to complete the template self-assessment document itself. In response to the Statement that "The Board is satisfied that……" a decision was made about which of the three alternative statements – "Confirmed", "Partially confirmed" , or "not confirmed" would be recommended to the full Board in respect of each of the six domains. The recommendations of the Executive Committee for the "Access and Delivery of services" and the "Financial performance and oversight" domains was that the statements should be "Partially Confirmed" and that in respect of the remaining four domains, based on the evidence provided, the recommendation was that each of those statements could be "Confirmed". Mitigating and contextual information was added to the template to explain why the Board could only partially confirm in those two instances. In formulating their recommendations, the Executive Committee was mindful of the comments made by the Board when this matter was discussed at its meeting on 2nd October 2025 to encourage a critical examination of whether it was appropriate to self-assess all domains as "Confirmed".

The Template self-assessment, supporting narrative and list of evidence were then scrutinised in detail by the Chair and SID on behalf of the Board. With the benefit of their contributions the final version proposed for submission was circulated to all Board members to seek their support to the Chair signing off the statements on behalf of the full Board, including confirmation that it had not received any relevant third-party information contradicting or undermining the statements made.

Jon Melbourne, who at that time was Chief Executive designate, was kept abreast of the progress of the submission and made contributions to it that enabled him to give it his agreement. Accordingly, on 27th October 2025 the submission, comprising the three elements detailed above, was returned to NHSE Region together with the two pieces of independent evidence described in Part 0 of the List of evidence that was also submitted. They are the Grant Thornton LLP Well Led developmental review that reported in January 2025 and the feedback from the CQC provided following the attendance of two of its representatives at the October 2025 public Board meeting.

A copy of the completed template self-assessment is at Appendix 1 to this paper and the supporting narrative at Appendix 2. NHSE Region has acknowledged receipt of our submission. As at the time of preparing this paper the Capability Rating Assignment based on the self-assessment and third-party information remains to be notified.

Next steps

The NHSE Oversight team will review our self-assessment submission and use the information in it to form its view of the overall capability of the trust and tailor its oversight relationship with us accordingly. This review will include triangulating the information we have provided with other insights such as our recent operational history, track record of delivery and third-party intelligence and information including from the ICB, patients, staff, professional bodies and other sources including coroners and auditors. This will result in one of the four available capability ratings being assigned to the Trust: Green (High confidence in management), Amber-Green (Some concerns or areas requiring attention), Amber-Red (Material issues need addressing, or major issues haven't been resolved over time) or Red (Significant concerns regarding poor delivery, governance, and other critical issues).

We are required to inform NHSE of any significant in-year changes to our ability to meet the criteria. In future the Board capability self-assessment will form an integral part of our Trust governance with a new item added to the Board workplan for the April meeting to align with the next submission expected to be required in Spring 2026 and annually thereafter.

Recommendations

- To be assured that the Provider Board Capability Self-assessment submission has been made to NHS England on behalf of the Board.
- To note the submission has been put into the public domain via this paper as agreed it would be by the Board at its meeting in private session on 6th November 2025.
- To note that our assigned rating and follow-up actions will be the subject of a further report to the Board.

Provider Capability - Self-Assessment Template

	The Board is satisfied that…		*(Mitigating/contextual factors where boards cannot confirm or where further information is helpful)*
Strategy, leadership and planning	• The trust's strategy reflects clear priorities for itself as well as shared objectives with system partners • The trust is meeting and will continue to meet any requirements placed on it by ongoing enforcement action from NHSE • The board has the skills, capacity and experience to lead the organisation • The trust is working effectively and collaboratively with its system partners and provider collaborative for the overall good of the system(s) and population served	Confirmed	
Quality of care	• Having had regard to relevant NHS England guidance (supported by Care Quality Commission information, its own information on patient safety incidents, patterns of complaints and any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients • Systems are in place to monitor patient experience and there are clear paths to relay safety concerns to the board	Confirmed	
People and Culture	• Staff feedback is used to improve the quality of care provided by the trust • Staff have the relevant skills and capacity to undertake their roles, with training and development programmes in place at all levels • Staff can express concerns in an open and constructive environment	Confirmed	
Access and delivery of services	• Plans are in place to improve performance against the relevant access and waiting times standards • The trust can identify and address inequalities in access/waiting times to NHS services across its patients • Appropriate population health targets have been agreed with the ICB	Partially confirmed	The Trust has strong mechanisms in place for the oversight and management of all aspects of performance and to identify health inequalities. Performance is reviewed regularly in established specialty, divisional and Trust level meetings. Standards that are off plan have underpinning action plans and recovery trajectories in place to improve access, quality and safety. More recently plans have been put in place to tackle a reduction in first appointment waits to enable a sustained reduction in patients waiting >52 weeks for treatment, and to recover our Emergency Department 4 hour performance. The Trust has a number of reports and dashboards to monitor performance to understand why challenges in performance occur and where actions could be targeted to improve performance and address health inequalities. The Trust works closely with system partners to improve performance and where appropriate mutually support one another to deliver plans. Further work is required with the ICB to agree appropriate population health targets. The Board is aware that there are appropriate steps in place to monitor performance and mitigate risks to delivery of plan whilst recognising that there are significant risks that exists to the delivery of performance and plan across the Trust including but not limited to finance, industrial action, increased demand and patient complexity, clinical capacity and administrative capacity to manage and validate pathways. Management of recovery plans and performance trajectories, ensuring we focus on upstream actions to prevent long waits/breaches, continue to be our priority working with our system partners.
Productivity and value for money	• Plans are in place to deliver productivity improvements as referenced in the NHS Model Health System guidance, the Insightful board and other guidance as relevant	Confirmed	
Financial performance and oversight	• The trust has a robust financial governance framework and appropriate contract management arrangements • Financial risk is managed effectively and financial considerations (for example, efficiency programmes) do not adversely affect patient care and outcomes • The trust engages with its system partners on the optimal use of NHS resources and supports the overall system in delivering its planned financial outturn	Partially confirmed	The Trust has a strong financial governance framework in place. The adequacy of arrangements is regularly reviewed and tested, for example through self-assessments against grip & control checklists as well as internal audit. An established QIA process is in place, aligned to the NHSE QIA toolkit. The Trust engages with system partners and supports the overall system ambition to deliver financial plans. The Board is confident that appropriate actions are being taken to manage and mitigate financial risks within the trust. However, the Board is mindful that significant financial challenges exist at the Trust, as well as across the system, which may jeopardise the delivery of collective financial targets. Challenges include external factors, such as the financial implications of ongoing industrial action, as well as the impact of deficit support funding being withdrawn and limitations in the availability of funding required to support largescale workforce change. Ongoing actions, including recovery and transformational plans with associated projections on financial, workforce and activity figures, continue to be developed and refined, with updates provided through relevant sub-committee and Board meetings.
	In addition, the board confirms that it has not received any relevant third-party information contradicting or undermining the information underpinning the disclosures above.	Confirmed	

Signed on behalf of the board of directors

Name: Graham Ward

Date: 27th October 2025

Appendix 1 : Assessing Provider Capability – self-assessment

Self-assessment criteria	Executive Lead(s)	Indicative evidence or lines of enquiry	Evidence
I. Strategy, leadership and planning –			
1. The Trust's strategy reflects clear priorities for itself as well as shared objectives with system partners.	Jon Melbourne and Richard Mills	Are the Trust's financial plans linked to and consistent with those of its commissioning integrated care Board (ICB) or ICBs, in particular regarding capital expenditure?	The Trust is currently in year 2 of both its "Improving Lives" Strategy 2024 – 2029 and its Clinical Services Strategy 2024-2029 that are closely aligned with the three principles and four aims of the Nottingham and Nottinghamshire Integrated Care System (ICS) Strategy 2023 – 2027. Likewise, the Trust's financial plans are fully aligned with the Nottingham and Nottinghamshire Integrated Care Board (ICB), particularly regarding capital expenditure. Our annual and medium-term financial planning is developed in partnership with the ICB, ensuring consistency in priorities, investment, and delivery. Our capital programme is agreed with system partners and supports both local and system-wide transformation, as evidenced in our Annual Report and the ICS Joint Forward Plan. Our financial strategy is designed to support sustainable service delivery, with a focus on efficiency, value for money, and supporting the ICS's financial recovery and sustainability goals.
		Are the Trust's digital plans linked to and consistent with those of local and national partners as necessary?	Our digital strategy is aligned to both local and national digital transformation priorities. We are implementing an Electronic Patient Record (EPR) system, which is a key enabler for both internal improvement and integrated care and is being developed in partnership with ICS digital leads to ensure interoperability and data sharing across the system.

Self-assessment criteria	Executive Lead(s)	Indicative evidence or lines of enquiry	Evidence
			Our digital plans are consistent with the ICS Digital Strategy and NHS England's digital maturity ambitions, supporting seamless patient care, improved communication, and enhanced data-driven decision-making. We are a member of the East Midlands Acute Providers (EMAP) Digital Collaborative and part of an East Midlands Group looking at the opportunities for the development of Artificial Intelligence in healthcare.
		Do plans reflect and leverage the Trust's distinct strengths and position in its local healthcare economy?	The Trust leverages its position as a leading provider in Mid-Nottinghamshire, serving a population of over 350,000. Our strategy builds on our strengths in clinical excellence workforce engagement (best acute Trust to work for in the East Midlands), and innovation (e.g., first in the Midlands to deliver a new Parkinson's drug and the expansion of diagnostic and elective capacity). We actively engage with local partners, including district councils, colleges, and voluntary sector organisations, to address health inequalities and improve population health outcomes. We are working with the local healthcare economy wherever possible to leverage collective bargaining and shared ownership. Examples include the Laboratory Informatics Management System (LIMS) where we have a joint contract with NUH; Badgernet, which is shared across and used in both acute Trusts and in community midwifery; and the support around the ICB digital inclusion programme Board with a wide range of local partners leveraging our status as an anchor organisation. We host Nottinghamshire Health Informatics Service (NHIS) that provides infrastructure, technical expertise and services across the ICB which brings

Self-assessment criteria	Executive Lead(s)	Indicative evidence or lines of enquiry	Evidence
			potential digital opportunities as we move into the new cluster arrangements. We understand our local population's health needs and deprivation challenges and strategically plans to integrate as a community asset rather than solely as an acute Trust, as we are seen as a local provider of local healthcare. We also have workplans on reducing health inequalities, anchor status and the impact that has on employment and money spent in the local community. These strategic plans align with the East Midlands Combined County Authority (EMCCA) for skills and economic development. We are working alongside our Local Government colleagues to support the discussions about local government reorganisation and what makes sense for our shared local populations. We are leading the development of the North Notts Place Based partnership which supports delivery of several strategic objectives in our Trust strategy Improving Lives (2024-2029). We are an active member of the System wide transformational group with a number of key workstreams across Pharmacy, patient Pathways, Hospital avoidance and outpatients. Our successful application to the national health inequalities programme to develop a respiratory service was led by the Trust and supported by multiple partners – driving improvements in a cohort of patients who frequently use all health and care services.

Self-assessment criteria	Executive Lead(s)	Indicative evidence or lines of enquiry	Evidence
			Our unsuccessful application to the national neighbourhoods programme was again led by the Trust and supported by over 20 health, care and VCSE partners. We have found resource to co-develop the neighbourhood plans with all of these partners despite not being accepted onto the pilot scheme, and this is in alignment with both national and local priorities. Our developing plan places a focus on supporting people with frailty and 2 or more long term conditions – working with our partners to deliver improved population health outcomes whilst making best use of resources within the services we offer/co-develop. This work will incorporate out-patients redesign and improved patient experience.
		Are plans for transformation aligned to wider system strategy and responsive to key strategic priorities agreed at system level?	Our transformation plans are fully aligned with the ICS's four aims: improving population health, tackling inequalities, enhancing productivity, and supporting broader social and economic development. We have contributed to the ICS Joint Forward Plan and are a key partner in provider collaboratives and place-based partnerships, ensuring that transformation initiatives (e.g., community diagnostic centres, elective hubs, digital innovation) are responsive to system-level priorities and deliver benefits across the local health economy. We have a proven track record of delivering transformation in partnership, including the development of new care models, service reconfiguration, and collaborative workforce planning.

Self-assessment criteria	Executive Lead(s)	Indicative evidence or lines of enquiry	Evidence
2. The Trust is meeting and will continue to meet any requirements placed on it by ongoing enforcement action from NHS England.	Sally Brook Shanahan Simon Illingworth	Is the Trust currently complying with the conditions of its licence? Is the Trust meeting requirements placed on it by regulatory instruments – for example, discretionary requirements and statutory undertakings – or is it co-operating with the requirements of the national Performance Improvement Programme (PIP)?	Yes. The annual self-assessment is approved by the Board. There are currently no conditions on the licence. We have recently been placed into Tier 2 for our elective performance and have held a meeting with Region and National NHSE to describe and agree recovery action plans which are currently being tracked under the leadership of the Chief Operating Officer (COO).
3. The Board has the skills, capacity and experience to lead the organisation.	Sally Brook Shanahan	Are all Board positions filled and, if not, are there plans in place to address vacancies? What proportion of Board members are in interim/acting roles? Is an appropriate Board succession plan in place?	Yes. There are currently no vacancies on the Board. With effect from 27th October 2025, when our new Chief Executive takes up his position, there will be no acting roles on the Board. There are no interim roles on the Board. Board succession is reviewed by the Remuneration Committee. Executive portfolio succession planning is a component part of the VSM appraisals process and plans have been used during recent unforeseen Board absences/changes.

Self-assessment criteria	Executive Lead(s)	Indicative evidence or lines of enquiry	Evidence
			Whilst overall staffing at the Trust is diverse, we recognise Board diversity needs to improve. The forthcoming Chair recruitment provides an opportunity to attract candidates from diverse backgrounds.
		Are there clear accountabilities and responsibilities for all areas of operations including quality, delivering access standards, operational planning and finance?	Accountabilities and responsibilities are detailed in job descriptions and supported and captured in the appraisal process and supported in regular one-to-one meetings. We recognise that all Executives and Non-Executive Board members act together as a unitary Board. All Board members have passed the Fit and Proper Person Test (FPPT) checks, and our internal processes audited with significant assurance provided.
4. The Trust is working effectively and collaboratively with its system partners and NHS Trust collaborative for the overall good of the system(s) and population served.	Jon Melbourne and Simon Roe	Is the Trust contributing to and benefiting from its NHS Trust collaborative?	We provide operational and digital mutual aid across Nottingham & Nottinghamshire ICB. EMAP, East Midlands Radiology Consortium (EMRAD), and Midlands and East Pathology Network (ME2) are all active Provider Collaboratives driving patient quality initiatives across the healthcare system. We actively contribute to the North Notts Place Based Partnership and is involved in developing its maturity and several workstreams. This benefits the Trust through developing shared plans to common challenges and it provides a strong source of patient/citizen feedback about health and care needs which are used in service redesign.
		Does the Board regularly meet system partners, and does it consider there is an open and transparent review	Board to Board meetings take place with the ICB and Nottingham University Hospitals NHS Trust (NUH) as well as regular touchpoints with Chesterfield Royal Hospital NHS Foundation Trust and Doncaster & Bassetlaw NHS

Self-assessment criteria	Executive Lead(s)	Indicative evidence or lines of enquiry	Evidence
		of challenges across the system?	Trust. We recognise that new partners may become apparent in our new ICB footprint. Executive to Executive meetings take place with NUH which have enabled us to establish a Committee in Common to take forward strategic and operational initiatives. In addition, we have Chief Executive conversations with City Care and EMAS. Our Chief Executive is the provider ICB representative for Nottinghamshire and will succeed as vice chair of the Place Based Partnership. Outside of health services we have a quarterly partnership meeting with each of the CEOs of local District Councils and their Leader/Elected Mayor, some of which also include Councillors and Primary Care Colleagues. We have strong relationships across our local Place Boards and with local education providers (across Adult skills, college and university sectors). These additional partnerships support the broader health challenges that we can all contribute to improving.
		Can the Board evidence that it is making a positive impact on the wider system, not just the organisation itself – for example, in terms of sharing resources and supporting wider service reconfiguration and shifts to community care where appropriate and agreed?	We are an active member of the integrated care system partnership. We contribute to the ICB and Mid Notts Health inequalities steering groups which impacts on future service redesign across partners. The Trust's anchor plan aligns to the ICS fourth aim and identifies areas where our communities can gain a wider benefit from our activities. For example, where skills can be developed through actively recruiting apprentices in the local area through our estates partners – bringing much needed skills development to local citizens. Our Community Diagnostic Centre at Mansfield District Hospital, the first in Nottinghamshire, has already provided construction opportunities in partnership with a local college. It

Self-assessment criteria	Executive Lead(s)	Indicative evidence or lines of enquiry	Evidence
			will, when fully operational in 2026, make a significant step towards improving healthcare accessibility, reducing waiting times and enhancing healthcare services for the community. There are examples across the Trust of reviewing the traditional out-patient model and moving to a modern out-patient offer using community facilities e.g. family hubs which encourages people to access care more locally (and then engage in other support services whilst there). Our estates team is working with the clinical teams to identify the best use of our community hospitals to meet the hyper-local health needs and to consider providing a base for integrated neighbourhood teams. We recognise that, to make a positive impact on the wider system, we cannot work in isolation. To this effect, we are actively building our system leadership role in the maturing Place Based Partnership space. The partnership is becoming the forum for strategic development and is focused on delivery of the 10-year plan including neighbourhood health; aligning to and supporting the local authority partner's thriving communities initiative and the combined authority's (EMCCA) ambitions; impacts of local government reorganisation; and achieving improved outcomes from local commissioning intentions. The maturing Place Based Partnership space is becoming the forum for further development against the 10-year plan delivery, thriving communities, impacts of local government reorganisation, achieving improved outcomes from local commissioning intentions and aligning with EMCCA ambitions.

Self-assessment criteria	Executive Lead(s)	Indicative evidence or lines of enquiry	Evidence
			Through our provider collaborations and committee in common, we have several plans in place to ensure sustainable service delivery across partners for our most fragile services. Our primary and secondary care interface workstream has built solid relationships over the last 18 months and is now maturing towards tackling bigger issues impacting on the local population across providers. Our Partnerships and Communities Committee provides check and challenge across several of these areas to gain assurance on direction of travel, delivery and risks – health inequalities, provider collaboration, value gained from partnerships, primary and secondary care interface, anchor status.
II. Quality of care			
5. Having had regard to relevant NHS England guidance (supported by Care Quality Commission information, its own information on patient safety incidents, patterns of complaints and any further metrics it chooses to adopt), the Trust has, and will keep in place, effective	Phil Bolton	The Trust can demonstrate and assure itself that internal procedures: • ensure required standards are achieved (internal and external) • investigate and develop strategies to address substandard performance • plan and manage continuous improvement	We have robust and evolving arrangements in place to monitor and continually improve the quality of care, including through the Getting It Right First Time (GIRFT) programme, in line with NHS England guidance and CQC expectations. We regularly reviews and incorporate national guidance, including the NHS Patient Safety Strategy, National Quality Board publications, and relevant National Institute for Health and Clinical Excellence (NICE) guidelines. CQC inspection reports, thematic reviews, and benchmarking data are used to identify improvement opportunities and assure compliance. Patient safety incidents are logged and analysed through Datix. Trends are reviewed monthly by the Quality and Patient Safety Committees. Learning from incidents, complaints, and external reviews is shared through learning bulletins, staff briefings, and clinical governance meetings.

Self-assessment criteria	Executive Lead(s)	Indicative evidence or lines of enquiry	Evidence
arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.		• identify, share and ensure delivery of best practice • identify and manage risks to quality of care • There is Board-level engagement on improving quality of care across the organisation. • Board considers both quantitative and qualitative information, and directors regularly visit points of care to get views of staff and patients. • Board assesses whether resources are being channelled effectively to provide care and whether packages of care can be better provided in the community.	The Patient Safety and Quality Strategy ensures that care is consistently safe, effective, and centred around the needs of patients. It provides a clear framework for identifying risks, learning from incidents, and driving continuous improvement Culture and Capability. We have a dedicated Improvement Faculty that supports frontline staff in delivering change using structured methodologies (e.g. Plan, Do, Study, Act (PDSA) and Quality Service Improvement and Redesign (QSIR)). A comprehensive risk register is maintained and reviewed by the Board and quality committees. Patterns in complaints and patient feedback are monitored to identify recurring issues and inform service redesign. We also track Friends and Family Test (FFT) scores, staff survey results, mortality reviews, and clinical audit outcomes. Non-Executive Directors, and Governors via their 15 Steps visits, participate in quality walkarounds and engage directly with staff and patients to gather qualitative insights. A Quality Governance Framework ensures that data is triangulated and escalated appropriately from ward to Board. The Quality Committee – the Board sub-committee which oversees quality and safety - meets monthly to review performance, oversee improvement plans, and ensure alignment with strategic objectives. Annual Quality Priorities are co-developed with stakeholders and progress is reported publicly via the Quality Account. The Patient Safety and Quality Strategy ensures that care is consistently safe, effective, and centred around the needs of patients. It provides a clear framework for identifying

Self-assessment criteria	Executive Lead(s)	Indicative evidence or lines of enquiry	Evidence
		• Board looks at learning and insight from quality issues elsewhere in the NHS and can in good faith assure that its Trust's internal governance arrangements are robust. • Board is satisfied that current staff training and appraisals regarding patient safety and quality foster a culture of continuous improvement.	risks, learning from incidents, and driving continuous improvement Culture and Capability Staff receive training on patient safety, human factors, and Quality Improvement (QI) tools as part of mandatory and ongoing development. Appraisals include objectives related to quality and safety, fostering a culture of accountability and learning. We promote a Just Culture, encouraging open reporting and learning without blame.
6. Systems are in place to monitor patient experience and there are clear paths to relay safety concerns to the Board.	Phil Bolton	Does the Board triangulate qualitative and quantitative information, including comparative benchmarks, to assure itself that it has a comprehensive picture of patient experience?	The Board actively triangulates qualitative and quantitative information, including comparative benchmarks, to assure itself of a comprehensive understanding of patient experience across the Trust. The Board reviews key performance indicators such as FFT scores, complaints volumes, incident trends, and patient survey results. Benchmarking against national datasets (e.g. NHS Benchmarking Network, CQC intelligence) allows the Board to assess performance relative to peers.

Self-assessment criteria	Executive Lead(s)	Indicative evidence or lines of enquiry	Evidence
			Patient stories are presented as the first substantive item at all Board meetings held in public to provide lived experience context. Feedback from complaints, compliments, Patient Advice and Liaison Service (PALS), and engagement events is analysed thematically and shared with the Board, and non-Executive Directors conduct regular walkarounds and speak directly with patients and staff to gather real-time insights. The Quality Committee reviews data from multiple sources to identify trends, risks, and opportunities for improvement. Reports to the Board include both narrative and statistical analysis, enabling informed decision-making. This approach ensures the Board maintains a balanced and evidence-based view of patient experience, supporting its duty to drive quality and safety.
		Does the Board consider variation in experience for those with protected characteristics and patterns of actual and expected access from the Trust's communities?	The Board actively considers variation in patient experience and access for individuals with protected characteristics, as well as patterns of actual and expected access across our communities. We analyse patient experience data broken down by protected characteristics (e.g. age, ethnicity, disability, gender identity) to identify disparities in care quality, outcomes, and satisfaction. Complaints, FFT scores, and survey responses are reviewed with an equity lens, and findings are reported to the Board via the Quality Committee. Insights from this data inform targeted interventions, such as culturally appropriate services & inclusive communication strategies.

Self-assessment criteria	Executive Lead(s)	Indicative evidence or lines of enquiry	Evidence
			Our People Strategy is embedded into Board-level decision-making, ensuring that equity is a core component of service planning and quality improvement.
		Is the Board satisfied that it receives timely information on quality that is focused on the right matters?	The Board receives timely, accurate, and appropriately focused information on quality to support effective oversight and decision-making. The Board receives monthly quality and safety reports that include key performance indicators, patient experience data, incident trends, and progress against quality priorities. Reports are aligned with strategic objectives and regulatory requirements, ensuring attention is given to areas of greatest risk and opportunity. Emerging concerns are escalated promptly through the Quality Committee, enabling the Board to respond quickly to issues affecting patient safety or care standards. Information includes both quantitative metrics and qualitative insights such as patient stories and staff feedback providing a rounded view of quality performance. The format and content of Board reports are regularly reviewed to ensure they remain relevant, actionable, and aligned with evolving priorities.
		Does the Board consider volume and patterns of patient feedback, such as the Friends and Family Test or other real-time measures, and explore whether staff effectively respond to this?	The Board actively considers both the volume and patterns of patient feedback including the FFT, complaints, compliments, and other real-time measures to gain insight into patient experience and service responsiveness. The Board receives regular reports summarising FFT results, PALS contacts, and formal complaints, with breakdowns by service area and demographic group.

Self-assessment criteria	Executive Lead(s)	Indicative evidence or lines of enquiry	Evidence
			Trends and themes are analysed to identify areas of concern, improvement, or excellence, and are benchmarked against national averages where applicable. The Quality Committee monitors whether feedback is being used to drive improvement and whether staff are supported to act on it. Patient feedback is triangulated with other quality metrics to inform Board-level decisions on service design, workforce development, and resource allocation. Non-Executive Directors and Governors engage directly with staff and patients during walkarounds to validate reported experiences and assess responsiveness in practice.
		How does the organisation involve service users in quality assessment and improvement and how is this reflected in governance?	Patient and Public Involvement forums and focus groups, are regularly held to gather insights and co-develop service improvements. Patient Safety Partners are involved in quality improvement projects, helping to identify priorities and test solutions alongside clinical teams. Service users contribute to patient safety walkarounds, and peer reviews, offering lived experience perspectives on care environments and processes. Patient representatives sit on key governance groups, including the Patient Experience Committee, Patient Safety Committee and Quality Committee, ensuring their voice is embedded in decision-making. The Board possesses the appropriate mix of skills, experience, and insight to effectively oversee all aspects of quality and respond to emerging concerns.

Self-assessment criteria	Executive Lead(s)	Indicative evidence or lines of enquiry	Evidence
		Is the Board satisfied it is equipped with the right skills and experience to oversee all elements of quality and address any concerns?	The Board includes individuals with clinical, operational, financial, and governance expertise, ensuring a well-rounded understanding of quality from multiple perspectives. Non-Executive Directors bring external experience from healthcare, regulation, and service user advocacy, providing constructive challenge and independent scrutiny. Board members participate in regular development sessions, including updates on national quality standards, patient safety frameworks, and emerging best practice. Induction and refresher training ensure all members remain informed about their responsibilities under the NHS Quality Governance Framework. The Board receives timely, triangulated information on quality, enabling it to identify risks, monitor performance, and support continuous improvement.
		Is the Board satisfied that the Trust has a clear system to both receive complaints from patients and escalate serious and/or re-occurring complaints to the relevant executive decision-makers?	We have a clear and effective system in place to receive, manage, and escalate patient complaints, particularly those that are serious or recurring. We operate a well-publicised complaints process, accessible via multiple channels including PALS, online forms, written correspondence, and verbal feedback. All complaints are logged, acknowledged promptly, and managed in line with NHS complaints regulations and Trust policy. Recurring themes, or those indicating systemic risk are escalated to divisional leadership and reviewed by the Patient Experience Team. The Quality Committee and Executive Team receive regular reports highlighting complaint trends, severity, and learning outcomes. Where appropriate, complaints are linked to incident reporting and risk registers to ensure a joined-up response.

Self-assessment criteria	Executive Lead(s)	Indicative evidence or lines of enquiry	Evidence
			The Board receives quarterly assurance reports detailing complaint volumes, themes, response times, and actions taken. Learning from complaints is shared across the organisation and informs service improvement, staff training, and patient engagement strategies.
III. People and culture			
7. Staff feedback is used to improve the quality of care provided by the Trust.	Rob Simcox	Does the Board look at the diversity of its staff and staff experience survey data across different teams (including trainees) to identify where there is scope for improvement?	The People Committee's annual workplan includes the published reviews of Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) data, the Equality, Diversity and Inclusion (EDI) annual report and the Gender Pay Gap report together with their associated action plans. The cultural heat map is shared with the People Committee and assists with the triangulation of information to support areas which require focussed support. All trainees, as Trust employees, are supported in relation to diversity and inclusion. We act upon the surveys carried out by the Universities, Educational institutions, General Medical Council (GMC), and the National Education and Training Survey for healthcare trainees and students in the UK to improve experiences. Equality and Diversity is a golden thread throughout all workforce audits, all of which go through the People Committee with their associated action plans. Recent audits include e. Rostering and absence management, with a Workforce planning audit in progress.
		Does the Board engage with staff forums to continually consider how care can be improved?	The EDI Annual Report highlights the well-established Staff networks each of which is sponsored by an Executive director. The Chair of the People Committee, at least on an annual basis, observes the People Cabinet to ensure that the people agenda remains relevant, and discussions are appropriately focussed.

Self-assessment criteria	Executive Lead(s)	Indicative evidence or lines of enquiry	Evidence
		Can the Board evidence action taken in response to staff feedback?	The Board has a planned calendar of "15 steps" walkarounds in clinical and non-clinical areas where staff are engaged to understand their experience and seek feedback on improvements on their experience and on patient care. National Staff Survey (NSS) results are broken down by area and action plans developed by area/themes that are reviewed by the People Committee. Executive Board members conduct informal walkarounds with Network Chairs to engage with staff and seek their feedback. Staff Survey outcomes are presented to the Board each year. Outcomes are monitored via Divisional Performance Reviews, the People Cabinet and the People Committee.
8. Staff have the relevant skills and capacity to undertake their roles, with training and development programmes in place at all levels.	Rob Simcox	Does the Trust regularly review skills at all levels across the organisation?	We review the skills of all staff through the annual appraisal process which is reported bi-monthly to the Board via the Integrated Performance Report (IPR) with a 90% compliance target set and regularly maintained. Skills are also an integral part of the Workforce Plan which is reviewed bi-monthly by the People Committee. The Chief People Officer presents an annual report to the Remuneration Committee regarding Executive appraisals that encompasses skills.
		Does the Board see and, if necessary, act on levels of compliance with mandatory training?	Mandatory training compliance is monitored and managed locally through the Divisional Performance reviews with People Committee and Board visibility of compliance through the IPR at Board.

Self-assessment criteria	Executive Lead(s)	Indicative evidence or lines of enquiry	Evidence
9. Staff can express concerns in an open and constructive environment.	Sally Brook Shanahan	Does the Board engage effectively with information received via Freedom To Speak Up (FTSU) channels, using it to improve quality of care and staff experience?	Bi-Annual reporting to Board and the People Committee includes progress with learning, triangulation and developments from FTSU concerns. Quarterly meetings are held between the Board member with designated responsibility for FTSU, the FTSU Guardian (FTSUG) and the Director of Corporate Affairs (DoCA), who is the Executive lead for FTSU, to ensure visibility of speaking up themes and timely progress with cases. Patient safety and quality concerns are referred to senior nursing/executive lead with action plans put in place. Triangulation of themes and areas of concern are shared regularly with the Wellbeing Team, Organisational Development (OD) Team, EDI Team and Occupational Health (OH), via one-to-one meetings or monthly intelligence sharing catch ups. This is to support a joined-up approach to concerns and support colleagues who may not want to take formal steps with concerns but to ensure support and guidance is available.
		Are all complaints (*we have interpreted this as being FTSU concerns*) treated as serious and do complex complaints receive senior oversight and attention, including executive level intervention when required?	Under the leadership of the Director of Corporate Affairs recent improvements to the oversight of FTSU now include fortnightly operational catchups between the FTSUG, Chief People Officer (CPO) and the DoCA as FTSU Executive lead, to ensure all concerns have senior oversight and timely attention.
		Is there a clear and streamlined FTSU process	In response to recommendations in the developmental Well-Led review concluded by Grant Thornton LLP in January 2025 and in conjunction with

Self-assessment criteria	Executive Lead(s)	Indicative evidence or lines of enquiry	Evidence
		for staff and are FTSU concerns visibly addressed, providing assurance to any others with similar concerns? Is there a safe reporting culture throughout the organisation? How does the Board know? Is the Trust an outlier on staff surveys across peers?	the Speaking Up Policy, we have launched a Speaking Up Process and Timescale Guidance document to assist staff to raise concerns and support line/receiving managers to respond in line with their responsibilities. Board reports evidence consistent engagement throughout the divisions with Speaking Up aligned with National Guardian's Office (NGO) benchmarks with the significant majority raised openly. We are a positive outlier. The Trust had a 63.1% response rate in the 2024 survey (an increase of 1% from 2023) and saw positive improvements in scores relates to violence and aggression, health and wellbeing and appraisal. The Trust has ranked as the best acute Trust to work for in the East Midlands in recent years.
IV. Access and delivery of services			
10. Plans are in place to improve performance against the relevant access and waiting times standards.	Simon Illingworth	Is the Trust meeting those national standards in the NHS planning guidance that are relevant to it? If not, is the Trust taking all possible steps towards meeting them, involving system partners as necessary?	Led by the COO, with contributions from the wider Executive team, there are robust Divisional Performance Reviews (DPRs) that take place bi-monthly. This allows Divisions and Executives to discuss performance around access, quality and safety. DPRs are built around a balanced scorecard card to ensure that areas of Quality, Safety, Finance and Human Resources (HR) are balanced against Operational Performance . Exception meetings are in place particularly around Emergency Department (ED) and Cancer performance, with senior oversight in addition to existing leadership as well as an Urgent and Emergency Care (UEC) Recovery Plan

Self-assessment criteria	Executive Lead(s)	Indicative evidence or lines of enquiry	Evidence
		Where waiting time standards are not being met or will not be met in the financial year, is the Board aware of the factors behind this? Is there a plan to deliver improvement?	with its monitoring by the Emergency Care Steering Group. Led by the COO, we plan deliver our performance trajectories submitted to the ICB and NHSE and in line with National Standards. The Board are aware of the factors which are providing challenges to access standards and have sight of the recovery plans in place. Our Improvement Faculty, led by the Chief Medical Officer (CMO), supports continuous improvement. Model Hospital and GIRFT informs some of the Improvement faculty work programme. There is a comprehensive structure in place at sub-Board level to identify and manage risks relating performance, quality and safety. This is achieved through TMT (Trust Management Team) DPRs and Divisional Leadership Teams, Quality Committee, Risk Committee and Finance Committee. We have a 15-steps process in place to support all Executive Directors to visit clinical and non-clinical areas.
11. The Trust can identify and address inequalities in access/waiting times to NHS services across its patients.	Simon Roe	The Board can track and minimise any unwarranted variations in access to and delivery of services across the Trust's patients/population and plans to address variation are in place.	The Health Inequalities Index dashboard has been drafted, and due to be completed by the end of Quarter(Q)3 25/26. This dashboard will highlight areas where further investigation or a different way of working needs to take place. Our Planned Care team holds data on Did Not Attend (DNA) rates by deprivation and this information has been used to reduce DNAs but has increased the gap in inequalities warranting further investigation in Q4.

Self-assessment criteria	Executive Lead(s)	Indicative evidence or lines of enquiry	Evidence
			There is a health inequalities development plan that reports into Partnerships and Communities Committee and a Board development session scheduled in November 2025 to assess Board level competencies on Health Inequalities.
12. Appropriate population health targets have been agreed with the integrated care Board.	Simon Roe	Is there a clear link between specific population health measures and the internal operations of the Trust?	We work closely with the ICB in understanding and managing population health needs, including engaging closely in the planning round. We recently refreshed Clinical Services Strategy (CSS) 2024-2029 in response to the 10-Year Health Plan. Its priorities are informed by our population health intelligence including many that are exacerbated by high health inequalities, for example, diabetes, frailty and cardiovascular disease. The Draft 2026 Commissioning Intentions released by the ICB are centred around improving population health. The priorities of which areas we focus on are in discussion with the ICB and system partners. This will feed into the Trust's health Inequalities development plan, and the newly established community of practice.
		Do teams across the Trust understand how their work is improving the wider health and wellbeing of people across the system?	The ICS's exemplar Strategic Analytics and Intelligence Unit (SAIU) has well-established data sharing arrangements across health and care partners, enabling full use of the Nottingham Shared Care Record (SCR). This provides a self-service portal that we actively draw upon for population intelligence that proactively supports decision making, for example, the current task and finish group focussed on equity of access to services at Newark Urgent Treatment Centre (UTC). The Health Inequalities Index dashboard will enable teams to understand whether their work is improving the wider health and wellbeing of our communities.

Self-assessment criteria	Executive Lead(s)	Indicative evidence or lines of enquiry	Evidence
V. Productivity and value for money			
13. Plans are in place to deliver productivity improvements as referenced in the NHS Model Health System guidance, the Insightful Board and other guidance as relevant.	Richard Mills	Board uses all available and relevant benchmarking data, as updated from time to time by NHS England, to: ○ review its performance against peers ○ identify and understand any unwarranted variations ○ put programmes in place to reduce unwarranted negative variation. The Trust's track record of delivery of planned productivity rates.	Financial Efficiencies and Productivity is a standing agenda item on the Finance committee (Board sub-committee). These reports provide updates in terms of improvement programmes and refer to benchmarking data, including Model Hospital information. Relevant updates are escalated/highlighted to the Trust Board by the Finance Committee. The IPR that is presented to the Trust Board also includes relevant metrics and benchmarking information. The IPR includes a Rate of Productivity metric, which is based on the Implied Productivity values reported through the Model Hospital. Other benchmarking information published by NHSE, for example Corporate Benchmarking information, is shared with Board and/or relevant sub-committees as and when necessary. Our business case template for service change includes section on productivity and requires narrative to explain how any new proposals deliver on the 10-year health plan for 2% productivity improvement. We have other cabinets that report into the Finance Committee and consider benchmarking in more detail, for example an Executive level Financial Recovery Cabinet. This Cabinet oversees our strong grip and control on our finances. However, we recognise there is further work to do to move from grip and control to transformation.

Self-assessment criteria	Executive Lead(s)	Indicative evidence or lines of enquiry	Evidence
VI. Financial Performance and oversight			
14. The Trust has a robust financial governance framework and appropriate contract management arrangements.	Richard Mills	Trust has a work programme of sufficient breadth and depth for internal audit in relation to financial systems and processes, and to ensure the reliability of performance data.	The annual Internal Audit (IA) plan is reviewed and approved by the Audit and Assurance Committee (AAC) on an annual basis. Any changes to the IA Plan in-year also require AAC approval. The annual plan includes reviews of financial systems and process, with all elements reviewed on a cyclical basis over a 3-year period. Significant assurance received from head of Internal audit opinion, along with an unqualified and 'clean' opinion from External Audit as evidenced in the ISA 260.
		Have there been any contract disputes over the past 12 months and, if so, have these been addressed?	There have been no formal contract disputes in the last 12 months. A Contract Executive Board is established for our main contract (Nottingham & Nottinghamshire ICB).
		[Potentially more appropriate for acute Trusts] Are the Trust's staffing and financial systems aligned and show a consistent story regarding operational costs and activity carried out? Has the Trust had to rely on more agency/bank staff than planned?	Workforce information is reported in the financial ledger, in terms of Whole Time Equivalent (WTE) budgeted, contracted and worked, to enable triangulation with financial information. Activity information is also reported alongside workforce and financial information in the Board IPR. Supplementary information is provided to the Board as and when necessary. Combined Agency and Bank costs are lower than planned and have significantly reduced year-on-year. Agency and bank usage is routinely reported through the Board IPR.

Self-assessment criteria	Executive Lead(s)	Indicative evidence or lines of enquiry	Evidence
15. Financial risk is managed effectively and financial considerations (for example, efficiency programmes) do not adversely affect patient care and outcomes.	Richard Mills	Does the Board stress-test the impact of financial efficiency plans on resources available to underpin quality of care? Are there sufficient safeguards in place to monitor the impact of financial efficiency plans on, for example, quality of care, access and staff wellbeing? Does the Board track performance against planned surplus/deficit and where performance is lagging it understands the underlying drivers?	We have a robust Quality Impact Assessment (QIA) process in place, which is used to consider the impact of efficiency plans and is aligned to the NHSE QIA toolkit. The QIA process includes staged approval requirements, with those scoring 8 and above requiring submission to a bi-weekly QIA panel for review by the Chief Nurse and the CMO. For those that are approved, a continued review process is in place. Our continued review process provides a safeguard to monitor the impact of efficiency schemes and are actioned, where required As an example, Urgent and Emergency staff reductions had a significant impact on performance and consequently have been partially reversed. Any subsequent risks are added to the risk register and those above a certain threshold are reported to the Risk Committee (sub-committee of the Board) for further assurance on management and mitigation. The Finance Committee receives a monthly report on financial performance, which includes performance against plan and the underlying position, and includes understanding of the drivers and the actions taking place to improve.
16. The Trust engages with its system partners on the optimal use of NHS resources and supports the overall	Richard Mills	Is the Board contributing to system-wide discussions on allocation of resources? Does the Trust's financial plan align with those of its	Trust executives are regular attendees at the ICB Financial Delivery & Recovery Group (FDRG). The FDRG provides a forum for discussion on the allocation of resources and ensures alignment of financial plans across partner organisations.

Self-assessment criteria	Executive Lead(s)	Indicative evidence or lines of enquiry	Evidence
system in delivering its planned financial outturn.		partner organisations and the joint forward plan for the system? Would system partners agree the Trust is doing all it can to balance its local/organisational priorities with system priorities for the overall benefit of the wider population and the local NHS?	Consolidated updates on financial and workforce performance are provided to the FDRG, via ICS Chief Financial Officer (CFO) and CPO forums. Plans are agreed at a system level, and system partners recognise the actions that we are taking to balance priorities.

Outstanding Care, Compassionate People, Healthier Communities

Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Public Board Workplan	**Date:**	4th December 2025
Prepared By:	Sally Brook Shanahan, Director of Corporate Affairs		
Approved By:	Sally Brook Shanahan, Director of Corporate Affairs		
Presented By:	Sally Brook Shanahan, Director of Corporate Affairs		

Purpose

To approve the Board of Directors' Annual programme of work for 2026.	**Approval**	**X**
	Assurance	
	Update	
	Consider	

Strategic Objectives

Provide outstanding care in the best place at the right time	Empower and support our people to be the best they can be	Improve health and wellbeing within our communities	Continuously learn and improve	Sustainable use of resources and estates	Work collaboratively with partners in the community

Principal Risk

PR1	Significant deterioration in standards of safety and care	
PR2	Demand that overwhelms capacity	
PR3	Critical shortage of workforce capacity and capability	
PR4	Insufficient financial resources available to support the delivery of services	
PR5	Inability to initiate and implement evidence-based Improvement and innovation	
PR6	Working more closely with local health and care partners does not fully deliver the required benefits	
PR7	Major disruptive incident	
PR8	Failure to deliver sustainable reductions in the Trust's impact on climate change	

Committees/groups where this item has been presented before

Executive team meeting – 26th November 2025

Acronyms

AMR – Antimicrobial resistance

Executive Summary

The Public Board Workplan was last reviewed by the Board in December 2024. The Workplan supports the Board in fulfilling its responsibilities for all aspects of the Trust's performance and governance. A review of how we document these requirements on an annual basis provides a framework to support good governance and to provide evidence the arrangements to do so are in place.

Recommendations

That the Board:

- receives the draft Workplan
- notes that additional items have been added to the 2026 Workplan to reflect the requirements for the Board Capability Self-Assessment to be updated and re-approved annually in April and for the scheduling of a joint presentation to the Board in June 2026 in order to meet the requirements of the national action plan for AMR

- that the final approval of the Well-Led Action Plan has been brought forward from June to April 2026
- takes assurance from its content noting the need for the Workplan to be responsive to strategic, cultural, operational and regulatory/statutory requirements and that it may require updating in-year, and
- notes the next formal review of the Public Board Workplan will take place annually in December.

PUBLIC BOARD ANNUAL PLANNER – SCHEDULE OF REPORTING (Rolling 12 Months)

REPORT		Assurance, approval, etc?	J	F	M	A	M	J	J	A	S	O	N	D
BUSINESS ITEMS														
Intro, apologies, declarations of interest	**Chair**			/		/		/		/		/		/
Minutes, matters arising, action update	**Chair**			/		/		/		/		/		/
Patient Story	**CN**					/		/				/		/
Staff Story	**CPO**			/						/				
CEO Report	**CEO**	Assurance		/		/		/		/		/		/
Chair's Report	**Chair**	Assurance		/		/		/		/		/		/
CoG Highlight Report (bullet point under Chair's report)	**Chair**	Assurance				/		/				/		/
Spotlight On Video		Assurance		/		/		/		/		/		/
STRATEGY AND CULTURE														
Making Tomorrow Better – Strategy Delivery Update	**DS&P**	Assurance						/						/
The following sub-Strategies to be presented to Public Board as required for re-ratification / updating: • Quality Strategy (QS) • People Strategy (Pe) • Financial Strategy (FS) • Partnerships Strategy (Pa) DUE 2029 • Clinical Services Strategy (CS) DUE 2029 • Digital Strategy (DS) DUE 2029 • Estates Strategy (ES) DUE 2029	**CN** **CPO** **CFO** **DS&P** **CMO** **ACEO/CDIO** **CFO**	Assurance												
STRATEGIC OBJECTIVE 1 - Provide outstanding care in the best place at the right time														
Maternity and Neonatal Update: • Safety Champions update • Maternity Perinatal Quality Surveillance Model	**CN**	Assurance		/		/		/		/		/		/
Learning from Deaths Report	**CMO**	Assurance				/						/		
Antimicrobial resistance (AMR) – annual update	**CMO / CN**	Assurance						/						

REPORT		Assurance, approval, etc?	J	F	M	A	M	J	J	A	S	O	N	D
STRATEGIC OBJECTIVE 2 – Empower and support our people to be the best they can be														
Staff Survey	**CPO**	Assurance				/								
Nursing, Midwifery and Allied Health Professions (AHP) Staffing bi-annual report	**CN**	Assurance		/								/		
Guardian of Safe working	**CMO / Guardian of safe working**	Assurance				/						/		
Freedom to Speak Up	**FTSU Guardian**	Assurance				/						/		
STRATEGIC OBJECTIVE 3 - Improve health and wellbeing within our communities														
Health Inequalities Annual Statement	**CMO**	Approval						/						
Health Inequalities Update	**CMO**	Assurance												/
STRATEGIC OBJECTIVE 4 – Continuously learn and improve														
Research Strategy – update	**Head of R&I / Director of R&I**	Assurance										/		
Research Strategy – Annual report	**Head of R&I / Director of R&I**	Assurance				/								
NHS Impact	**CMO**	Assurance										/		
STRATEGIC OBJECTIVE 5 – Sustainable use of resources and estate														
Financial Efficiency Plan	**CFO**	Assurance						/						
Capital Expenditure Plan	**CFO**	Approval				/								
Annual Update on the Trust's Green Plan	**CFO**	Assurance		/										
STRATEGIC OBJECTIVE 6 – Work collaboratively with partners in the community														
Partnerships Annual Review	**DS&P**	Assurance						/						
OPERATIONAL / STRATEGY														
Annual Plan	**CFO**	Assurance						/						
IPR (Integrated Performance Report)	**CN, CFO, CPO, COO**	Consider		/		/		/		/		/		/
IPR (Integrated Performance Report) Annual Review	**COO**	Approval						/						

REPORT		Assurance, approval, etc?	J	F	M	A	M	J	J	A	S	O	N	D
Winter Plan	**COO**	Approval										/		
Post-Winter Plan de-brief	**COO**	Review/ Assurance				/ **26**								
GOVERNANCE														
Board Assurance Framework (BAF) *(prior approval by risk Cttee)*	**CEO**	Review / Approval		/				/				/		
Well Led Action Plan Review	**Dir Corp Affairs**	Assurance		/		/								
Use of Trust Seal *Dir of Corp Affairs to advise if Seal used in month*	**Dir Corp Affairs**	Assurance												
Use of Trust Seal – Annual Summary Report	**Dir Corp Affairs**	Assurance				/ **26**								
Fit and Proper Person	**Dir Corp Affairs**	Assurance								/				
NHSE Provider Licence Self Certification declarations	**Dir Corp Affairs**	Approval				/ **26**								
Provider Board capability self-assessment	**Dir Corp Affairs**	Approval				/ **26**								
Emergency Preparedness (EPRR) Annual Report	**Emergency Planning & Business Continuity Officer**	Assurance												/
Escalation of any issues from Board Committees via Quadrant Reports (Committee Annual Reports to be presented to first Board after April Committee meetings, alongside usual assurance report)	**NEDs**			/		/		/		/		/		/
Audit & Assurance	**Chair of Cttee**	Assurance		/		/		/		/		/		/
Finance	**Chair of Cttee**	Assurance		/		/		/		/		/		/
Quality	**Chair of Cttee**	Assurance		/		/		/		/		/		/
Charitable Funds	**Chair of Cttee**	Assurance		/				/		/				/
People	**Chair of Cttee**	Assurance		/		/		/		/				/
Partnerships and Communities	**Chair of Cttee**	Assurance		/				/		/				/
SFIs *(prior approval by Audit Committee) every 2 years **Due 2026/2027***	**CFO**	Approval												/
Standing Orders and Scheme of Delegation *(prior approval by Audit Committee) every 2 years **Due 2026/2027***	**CFO**	Approval												/

REPORT		Assurance, approval, etc?	J	F	M	A	M	J	J	A	S	O	N	D
Constitution Review *(as required)*	**Dir Corp Affairs**	Approval												
Committee terms of reference, workplans and effectiveness reviews (on the recommendation of the appropriate committees of the Board)	**Dir Corp Affairs**	Assurance						/						
IG / Data Security Protection Toolkit Submission (assurance from Audit Committee)	**SIRO**	Approval								/				
Annual Sign Off of Declarations of Interest (assurance from Audit Committee)	**Dir Corp Affairs**	Approval				/								
Review of Workplan	**Dir Corp Affairs**	Approval												/
READING ROOM														
Approved Minutes – Sub Committees				/		/		/		/		/		/
Equality and Diversity Annual Report (People) Including Workforce Race Equality Standard Report (WRES) and Workforce Disability Equality Standard Report (WDES) and Gender Pay Gap *(prior to publishing on Website)*								/						

NOTE

Decision taken April 2025 to move Public Board meetings to bi-monthly

Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Finance Committee Chair's Highlight Report to Board of Directors

Subject:	Finance Committee ("FC") Meeting (Deep Dive and Core)	**Date:**	28th October 2025
Prepared By:	Richard Cotton, Finance Committee Chair		
Approved By:	Richard Mills, Chief Financial Officer		
Presented By:	Richard Cotton, Finance Committee Chair		
Purpose:			
To provide an overview of the key discussion items from the Finance Committee (Deep Dive and Core) meeting of 28th October 2025.			

Matters of Concern or Key Risks Escalated for Noting / Action	Major Actions Commissioned / Work Underway
M6 Financial Position: In month deficit position (£1.62m) (Plan surplus £0.46m); YTD deficit (£3.28m) (Plan deficit (£0.23m)). Full year reported forecast break-even (Best Case), Likely Current Case deficit (£12.32m) **M6 Financial Efficiency Programme:** YTD savings £14.07m (Plan £21.02m). Full year forecast achievement in full of £45.83m, but with delayed implementation affecting FY income / cash savings. **Cash Position and Deficit Support:** Withholding of Q3 deficit support funding by NHS England (£2.5m), with recovery contingent on financial delivery. Tight cash scenarios modelled, with risk of breaching cash limits after March 2026. **High Remuneration for Medical Staff:** Report on ten highest paid employees (YTD), each individual earning over £250,000, with some exceeding £300,000 (FYE), raising concerns about value for money, working hours, and governance. ***Action:*** Extend analysis to include all earning above £200,000, add length of service and actual hours worked, and escalate to People Committee for further oversight. **Industrial Action Risk:** Ongoing and planned industrial action poses a significant risk to financial and operational performance. **Workforce Pressures:** Persistent agency and bank spend in Medicine Division (5.7% agency, 10.7% bank vs. targets of 1% and 5%), and challenges in substantive recruitment across divisions, especially in Cardiology, Anaesthetics, and Radiology.	**Workforce Controls:** Weekly Workforce Performance Group established; Divisional General Managers to provide assurance on high-paid locums and substantive consultants also doing bank work. Exit plans for high-cost locums underway. **Efficiency and Financial Recovery:** Achievement of (£12.3m) Current case FY forecast includes recovery plan in progress with £7.2m weighted efficiency identified to date. Major interventions include workforce reviews, service reductions, and enhanced governance. Divisions presenting intervention plans to TMT for approval and implementation. Further recovery actions identified to close current case FY deficit to break even. **Cash Management:** Deep dive analysis completed; creditors at lowest level in recent years (£2.34m). Draft Internal Audit report on cash management provides significant assurance. **Contract and Procurement:** Ledger migration project progressing; enhanced purchase-to-pay system under review with a hybrid procurement team recommended. Cost-benefit analysis requested before approval. **Service Delivery:** Improvements in cleaning standards and food testing following audits; ongoing monitoring and feedback loops established.

Positive Assurances to Provide	Decisions Made *(include BAF review outcomes)*
Medicine Division: Leadership stabilised, governance strengthened, and operational improvements made (e.g., cardiology capacity, cancer recovery meetings, chemotherapy chairs increased from 10 to 15). Quick wins in reducing bank & agency spend and improving specialty pay controls. **Financial Controls:** Significant progress in grip and control checklist; areas scored as red being addressed with action plans. Cash management audit outcome positive. **Capital Projects:** MRI project on budget and on schedule for July 2026 opening; positive morale impact for teams involved. **Theatres:** Newark theatres reopening 6 November; King's Mill theatre utilisation rates back up to 80–85%. Cancellations for non-clinical reasons reduced to near zero. Ongoing cultural and scheduling matters being progressively resolved.	**Approval of strategic WAN contract approach:** TMT approval for contract proposals, with strategic procurement alignment for future savings. Hybrid mail contract extension agreed for governance alignment. **Deferred Approval:** Enhanced purchase-to-pay system approval deferred pending full cost-benefit analysis and hybrid team costing. **Board Assurance Framework:** No changes to risk ratings; updates noted for strengthening financial management and cash controls. **Green Plan:** Update scheduled for Board approval in December. Efficiency savings linked to LED lighting projects starting to materialise.

Comments on effectiveness of the meeting

The meeting was thorough, with robust challenge and constructive debate on financial recovery, workforce, and operational issues. Members demonstrated strong engagement, and divisional leaders provided clear updates and assurances. Action tracking and follow-up were effective, with clear escalation pathways for unresolved risks.

Items recommended for consideration by other Committees

People Committee: Escalation of high remuneration analysis, including longevity and hours worked for non-executive medical staff.
Audit Committee: Strengthening financial management checklist and cash management audit for assurance and oversight.
Board: High remuneration analysis, MRI project progress, and financial recovery trajectory.

Progress with Actions

Number of actions considered at the meeting – 11
Number of actions closed at the meeting – 9
Number of actions carried forward – 2 that are not due to be updated until November 2025.
Any concerns with progress of actions – No

Key Figures:

- ***£250,000+ annualised earnings for top 10 medical staff***
- ***£2.5m Q3 deficit support funding withheld***

- ***£13.2m financial recovery plan £7.2m weighted efficiency plans identified / WIP***
- ***Further £12.3m recovery plan under development to deliver FY break-even***
- ***£2.34m creditors (lowest in recent years)***
- ***80–85% KM theatre utilisation rate***
- ***Chemotherapy chairs increased from 10 to 15***

Note: this report does not require a cover sheet due to sufficient information provided.

Finance Committee Chair's Highlight Report to Board of Directors

Subject:	Finance Committee ("FC") Meeting	**Date:**	25th November 2025
Prepared By:	Richard Cotton, Finance Committee Chair		
Approved By:	Richard Mills, Chief Financial Officer		
Presented By:	Richard Cotton, Finance Committee Chair		
Purpose:			
To provide an overview of the key discussion items from the Finance Committee (Deep Dive and Core) meeting of 25th November 2025			

Matters of Concern or Key Risks Escalated for Noting / Action	Major Actions Commissioned / Work Underway
• M7 in month deficit £2.37m (Budget surplus £0.58m), adverse variance of £2.95m. • M7 YTD deficit £5.66m (Budget surplus £0.35m), adverse variance of £6.01m. Adverse performance includes effects of M4 Industrial Action £0.4m; £8.77m shortfall in the financial efficiency program; £0.6m shortfall in variable revenue; Q3 removal of NHSE deficit Support of £0.8m. • M7 Cash at bank £7.89m – favourable due to capital timing, but unwinding rapidly in Q3. • M7 Forecasted P&L: achievement of breakeven plan for FY, with current case £10.4m deficit (£2.0m improvement over M6 projection. • M7 Forecasted Cash: positive headroom of c. £5m in tightest months of December and January, with some residual risks. • Risks remain around the accuracy of workforce reduction trajectories and the phasing of savings, especially given the late impact of schemes such as MARS (Mutually Agreed Resignation Scheme). • UEC Four-hour performance targets are not being met, with admitted patient performance significantly below expectations.	• *Financial Recovery Plan:* Enhanced scenario modelling for workforce reductions and efficiency savings; focus on divisional ownership and phasing of interventions. Establishment of a non-pay oversight group to drive further savings in non-pay expenditure. Ongoing engagement with the ICB regarding deficit support and system-level flexibility. • *Sustainable Development and Green Plan:* Bids submitted of £6.2m (solar), £1.2m (BMS upgrades), £400k (LED at King's Mill), and £150k (LED at Mansfield Community Hospital) for decarbonisation projects. C.10,000 LED lights have so far been installed at King's Mill. The Green Plan was approved by the Committee and will proceed to Trust Board. • *Digital Transformation:* The EPR (Electronic Patient Record) programme is progressing: emergency department go-live rescheduled for January 2026 due to software change. Ongoing collaboration with regional partners to support implementation and workforce challenges.

Winter pressures have arrived early, and performance has plateaued at a lower level than desired. Flow bottlenecks, particularly in gastroenterology and cardiology, are contributing factors. • Concerns over sustainability and safety of high programmed activity (PA) allocations among medical staff, with some exceeding 14 PAs (over 60 hours/week). Need for better alignment between job planning, activity, and value for money.	• *Procurement Transformation:* Approval of a hybrid procurement model, reducing the Trust-side procurement team by 40% and shifting low-value sourcing to SBS, with ongoing review of value-added by the retained team. • *UEC Improvement Actions:* Review of PC-24 service, implementation flow team, and targeted actions in gastroenterology and cardiology to address bottlenecks. Increased use of discharge lounge and early morning discharges being monitored for impact. • *Financial Planning:* Significant effective work is underway in Financial Planning for 2026/27, 2027/28 and 2028/29, with first submissions due 17 December 2025 (day after next scheduled FC).
Positive Assurances to Provide	**Decisions Made** *(include BAF review outcomes)*
• *Workforce Controls:* Medical agency numbers have fallen from 40 to 20 over the past year. Over 95% of consultants and SAS doctors have signed-off job plans, ahead of regional peers. • *Sustainability:* The Trust's track record in delivering decarbonisation projects is recognised, with strong system assurance and external support in place. • *Cash Management:* Positive Cash Management Audit Report received with one minor action acknowledged by management for December 2025 resolution.	• Approval of the Green Plan for submission to Trust Board. • Approval of the hybrid procurement model and associated business case. • Agreement to circulate EPR implementation lessons learned and to maintain robust risk management for the go-live phase. • Endorsement of ongoing scenario modelling for workforce and efficiency planning, with a request for clearer visibility and accountability at divisional level. • BAF left unchanged on PR4 (Balance sheet) – residual risks on Cash high through winter period. PR8 (Sustainability) left unchanged: to revisit following Board debate of Green Plan in December 2025.

Comments on effectiveness of the meeting

- Papers were of a high quality, and mostly timely. Papers were generally well presented, with a good quality of debate and scrutiny.
- The agenda was very full (as ever): FC Chair and CFO continue to work together to ensure FC reviews of sufficient depth as well as breadth of the Trust's Financial Operations, particularly given current financial performance challenges.

Items recommended for consideration by other Committees

- **People Committee** to review HR controls around high earning medial staff PA allocations / workforce planning, and to continue to monitor workforce modelling considerations on Financial Recovery.
- **Audit Committee** to monitor SBS Ledgers migration plan (with risks to Accounting post go-live), and to note Cash Management Internal Audit Report.
- **Board** to consider SFH Green Plan 2025 – 2028, to consider Financial Recovery plans evolution, and to consider Financial Planning assumptions / risks / timescales.

Progress with Actions

Number of actions considered at the meeting - 9
Number of actions closed at the meeting – 7
Number of actions carried forward – 2
Any concerns with progress of actions – No

Note: this report does not require a cover sheet due to sufficient information provided.

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Quality Chair's Highlight Report to the Trust Board of Directors

Subject:	Quality Committee	**Date**	**Monday 27th October 2025**
Prepared By:	Esther Smith, PA to Deputy Chief Nurse & Director of Nursing Quality & Governance		
Approved By:	Lisa Maclean, Non-Executive Director/Committee Chair		
Presented By:	Lisa Maclean, Non-Executive Director		
Purpose:			
Assurance report to the Trust Board of Directors following the Quality Committee Meeting			

Matters of Concern or Key Risks Escalated for Noting / Action	**Major Actions Commissioned / Work Underway**
- Discussion held regarding the continued significant challenges facing flow and capacity, impacting patient experience, discharges and increasing the potential harm, staff morale and sickness. Actions are underway to address where possible. - Concerns raised pertaining to the lack of apprenticeship pathways for staff to progress within NMAHP posts, this is to be escalated to People Cabinet and up to the People Committee.	- Patient Experience update to be shared with the Board of Directors for discussion.
Positive Assurances to Provide	**Decisions Made** *(include BAF review outcomes)*
- Positive assurance taken from the update to the Value Circle Theatre Culture Review, with the first meeting expected on 30th October 2025 to start addressing the 21 actions outlined. - Positive assurance provided against the Medically Safe for Transfer update. - Positive assurance taken from the NMAHP Strategy update against the KPI' outlined for Objective 1. - Positive update provided against the Infection Prevention and Control Board Assurance Framework. - Positive assurance taken with regard to the Quality Impact Assessment Process for Stage 2 updates. - Positive update taken from the Patient Experience Committee update, to be shared with the Board of Directors.	- Patient Story to be added to the workplan for presentation to the Quality Committee ahead of the Board of Directors Meeting . - Following discussion, it was agreed to continue with the increased scores for PR1 and 2 of the BAF.

- Positive assurance take from the update from the Perinatal Assurance Committee, NMAHP Committee and Patient Safety Committee.	

Comments on effectiveness of the meeting

Positive meeting held with in depth discussions around the issues facing the Trust as a result of significant challenges with flow and capacity and the impacts on discharges, patient experience and staff morale. With assurance taken from the actions underway to address, while recognising this is a long journey,

Items recommended for consideration by other Committees

NA

Progress with Actions

Number of actions considered at the meeting - 0
Number of actions closed at the meeting – 1
Number of actions carried forward - 0
Any concerns with progress of actions – No
If Yes, please describe –

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Quality Chair's Highlight Report to the Trust Board of Directors

Subject:	Quality Committee	**Date**	24th November 2025
Prepared By:	Esther Smith, PA to Deputy Chief Nurse & Director of Nursing Quality & Governance		
Approved By:	Lisa Maclean, Non-Executive Director/Committee Chair		
Presented By:	Lisa Maclean, Non-Executive Director		
Purpose:			
Assurance report to the Trust Board of Directors following the Quality Committee Meeting			

Matters of Concern or Key Risks Escalated for Noting / Action	Major Actions Commissioned / Work Underway
- Two recent inquests raised significant concerns resulting in Regulation 28: Preventing Future Death orders. Work is underway to address gaps in guidelines for managing patients deliberately inserting foreign bodies into their limbs and engagement with mental health services. The second highlighted a missed congenital Long QT Syndrome and delays in resuscitation die to equipment access. A detailed PSII has produced an action plan for this to include resuscitation training. - Operational update provided- the Trust are currently operating at 98% bed occupancy despite opening 74 additional beds which continues to create flow pressures. Bed modelling highlights increased lengths of stay in key specialties such as acute and geriatric medicine and stroke. Actions are being coordinated through weekly recovery meetings, focussing on board rounds, discharge lounge usage and length of stay reduction.	- One action underway in response to the Regulation 28-PFD includes the move of the Resuscitation Team into the Chief Medical Officer portfolio and will sit as part of the simulation team under medical education.

Positive Assurances to Provide	Decisions Made *(include BAF review outcomes)*
- Reflections shared post-industrial action; planning went well though it was noted that 8% of activity has been disrupted mostly within Outpatients. - Positive Assurance taken following the EPRR Annual Report with 97% compliance recorded. Actions are underway to meet the remaining requirements expected to complete in 2026. - 360 Assurance Report into Medical Staffing, noted and further updates to be confirmed and tracked through the People Committee. - Positive assurance taken from the current actions and plans underway through the Medicines Optimisation Strategy. - Positive assurance taken from the improvement updates and plans to improve reporting etc. - Positive Assurance provided from the Patient Safety Committee. - Positive assurance taken from the Clinical Policies Annual Report.	- APPROVED PR1 of the BAF with no changes suggested to the current risk scores. - APPROVED PR2 of the BAF with no changes suggested to the current risk scores. - APPROVED PR5 of the BAF with no changes suggested to the current risk scores. - The Committee APPROVED the IPR reports for Timely and Quality Care following discussion.

Comments on effectiveness of the meeting
Positive meeting held with in depth discussions prompted by high quality reports.
Items recommended for consideration by other Committees
SFHFT Final Report – Medical Staffing (360 Assurance) Limited Assurance Report for People Committee.
Progress with Actions
Number of actions considered at the meeting - 0 Number of actions closed at the meeting – 0 Number of actions carried forward - 0 Any concerns with progress of actions – No If Yes, please describe –

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People Committee Chair's Highlight Report to Board

Subject:	Chair's Report	**Date:**	25th November, 2025
Prepared By:	Steve Banks Non-Executive Director		
Approved By:	Steve Banks Non-Executive Director		
Presented By:	Steve Banks Non-Executive Director		
Purpose:			
For Assurance			

Matters of Concern or Key Risks Escalated for Noting / Action	**Major Actions Commissioned / Work Underway**
• Continuing potential impact of financial challenges for 25/26 on staff morale, compounded by potential Industrial action. • Need clarity on most likely trajectory towards WTE target and into next year, not currently on track, with Agency usage also off track • Assuring progress on 10-point plan to improve Resident Doctors lives, but re-raises issue of lack of basic provision of hot food (for all staff). Requirement needs to be understood and addressed	• Engagement with staff survey so far at similar levels to prior year
Positive Assurances to Provide	**Decisions Made** *(include BAF review outcomes)*
There was much positive assurance provided including: • Resourcing plan for CDC, although repeat assurance requested for future People Committees (January and March meetings in 2026) • Safe Effective Quality Occupational Health Service accreditation achieved • Approach to celebration and recognition • Increasing grip on Training and Education provision • 360 assurance reports on Medical Staffing and e-roster usage	• BAF reviewed and new mitigating actions considered; risks and assurance levels remain as is. • Committee assured the NHS England Annual Board Report (Medical Workforce) so that Board can approve. Report in reading room

Comments on effectiveness of the meeting
Good preparation and papers led to right debate and relevant actions
Items recommended for consideration by other Committees
Finance Committee and Quality Committee with regard to continued triangulation of financial imperative, quality delivery and staff morale.
Progress with Actions
Number of actions considered at the meeting - 6 Number of actions closed at the meeting – 6 Number of actions carried forward - 0 Any concerns with progress of actions – No If Yes, please describe –

Note: this report does not require a cover sheet due to sufficient information provided.

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Partnership and Communities Chair's Highlight Report to Trust Board

Subject:	Partnership and Communities Committee	**Date:**	4th December 2025
Prepared By:	Barbara Brady, Non-Executive Director/Chair		
Approved By:	Barbara Brady, Non-Executive Director/Chair		
Presented By:	Richard Cotton, Non-Executive Director/Committee member		
Purpose:			
To provide a brief overview of the key discussions from the committee meeting on the 21st October 2025			

Matters of Concern or Key Risks Escalated for Noting / Action	**Major Actions Commissioned / Work Underway**
• Ongoing concern regarding the QIAs undertaken by partners with the system where a direct or indirect impact on SFHT might occur •	•
Positive Assurances to Provide	**Decisions Made** *(include BAF review outcomes)*
• Steady progress on the primary/secondary care interface group • Good progress on the Health inequalities program of work • 6 monthly partnership strategy progress report with more detailed partnership delivery plan which is overall on track. • Development and submission of 2 neighbourhood proposals (Neighbourhood respiratory service and Neighbourhood health framework). Whilst the former has been successful in attracting external support both submissions evidence good work relationships with our local partners •	• BAF minor changes approved with overall scores remaining unchanged • Terms of reference for the Partnership Oversight Group approved • Committee annual report approved
Comments on effectiveness of the meeting	
Good meeting enabled by good quality papers and effective engagement by committee members	
Items recommended for consideration by other Committees	

Progress with Actions
Number of actions considered at the meeting 3 Number of actions closed at the meeting – 2 Number of actions carried forward - 1 Any concerns with progress of actions –No If Yes, please describe –

Note: this report does not require a cover sheet due to sufficient information provided.

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Charitable Funds Committee Highlight Report to the Board of Directors

Subject:	Charitable Funds Committee update	Date:	21st October 2025
Prepared By:	Andrew Rose-Britton, Non-Executive Chair		
Approved By:	Andrew Rose-Britton		
Presented By:	Andrew Rose-Britton		
Purpose:			
To provide an overview of the key discussion items from the Charitable Funds Committee held on 21st October 2025			

Matters of Concern or Key Risks Escalated for Noting / Action	**Major Actions Commissioned / Work Underway**
	End of life wards fitting out be completed by the end of November 2025. Abseil delayed until November 2025. Planning going ahead for a similar event in 2026. Runner has been selected for the London Marathon in 2026. Payroll giving to be promoted shortly. Review of Investment strategy to be undertaken and recommendation made to January 2026 committee meeting.
Positive Assurances to Provide	**Decisions Made** *(include BAF review outcomes)*
Operational group highlight report. Community Involvement headline report. The number and details about projects completed and future projects planned. Charity development update. Finance update. Investment update from Investec. Risk register.	SFH FT Hospital Annual accounts and letter of representation to be recommended to the Corporate Trustee for approval. Approved the purchase of two Transoesophageal echocardiography probes at a cost of £40,913. The recommendations made in the Charity Lottery plan for up to two further periods of canvassing at a cost of up to £75K were agreed. Agreement to amend Risk No. 3 (Reputation – Loss of key staff) to add "/inadequate staff to develop the charity" and increase the Likelihood score from 2 to 3, resulting in the Risk Rating increasing from 8 to 12.
Comments on effectiveness of the meeting	
LB (Governor): "thanked the committee for what we were doing." Good discussion and challenge.	
Items recommended for consideration by other Committees	
none	

Progress with Actions
Number of actions considered at the meeting-5 Number of actions closed at meeting-5 Number carried over-0 Any concerns of actions-0

Note: this report does not require a cover sheet due to sufficient information provided.